

Annual report

2014/15








Our vision:

To embody in our hospitals all the principles, values and the sense of service that created the NHS by providing consistently good, safe care in a friendly, listening and informative way, as and when people need and want it and always with dignity and respect.

Contents

Welcome – a message from our Chief Executive and Chairman

Welcome to the annual report for 2014/15

The last year has been one of significant change for our organisation and we have made real strides in improving the safety and effectiveness of our services. Perhaps our proudest achievement is that we reduced mortality by 21% between April 2013 and September 2014, compared to a national decrease of 3.3%. Between April and June 2013, the hospital standardised mortality ratio (HSMR) for our hospitals was 108. By the end of September 2014, it had dropped to 85 and we maintained this level to the end of 2014/15.

This is a considerable achievement. HSMR is an important measure of how our mortality rates compare with the overall average across England.

This improvement is evidence that the changes we are making, in a wide range of areas, are delivering higher quality care.

Strengthening leadership and creating an open culture was a priority in 2014/15 and we continue to make it easier for staff to raise concerns and make suggestions for improving the way we care for our patients.

Our daily 'Onion' meetings, where we peel back layers to enable staff to raise concerns and improve how we do things, are an excellent tool for putting the patient at the centre of all that we do and making sure that we address patient safety issues as they arise. This was acknowledged nationally when 'Onion' was highly commended in the patient safety category at the HSJ awards in December 2014.

January saw our Chief Executive Samantha Jones, who was presented with the HSJ Chief Executive of the Year Award 2014, leave our hospitals for NHS England where she is now Director for the New Care Models Programme, working on the NHS Five Year Forward View. Jacqueline Kelly has since been appointed as interim Chief Executive. 2015/16 will see both a new Chief Executive appointed substantially, as well as a new Chairman, as Mahdi Hasan is retiring when his term ends in October 2015.

We also received national recognition for our services for older people with dementia. Staff on Bluebell ward won the NHS Employers' Compassion in Practice Award at the Chief Nursing Officer for England Summit in December.

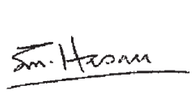
While we have improved the quality of our cancer care, we still have some way to go to fully meet national standards for cancer waiting times. We know that early diagnosis and treatment of cancer has an impact on outcomes so it is essential we continue to drive improvements in this area. Similarly, while we nearly halved the number of patients waiting more than 18 weeks for planned care between January 2015 and March 2015, too many patients are waiting too long for treatment and we need to do better.

Our hospitals continue to face significant clinical, workforce, estates and financial challenges. Our staff survey results tell us that we need to do more to support and engage our staff so that they are able to give the very best care to our patients. This is a key priority for next year. Continuing to work to improve our buildings and the environment from which we offer care is also a priority, and last year we spent £16.5m in improving the condition of our estate, but long term solutions are needed. We ended the financial year with a £13.8m deficit, £0.2m better than we forecast (see page 76 for further details on our accounts).

To address these challenges in the long term we have begun a vital piece of work to develop our clinical strategy which will identify our clinical priorities and set out a plan for how we best deliver care for our patients in the future. This work will continue in 2015/16 and will feed into *Your Care, Your Future*, the whole system review of health and social care across west Hertfordshire. It will also support the development of our long-term estates and financial strategies which will be vital to delivering sustainable healthcare in West Hertfordshire. 2014/15 saw the start of the construction of a new road which will greatly improve access to Watford Hospital.

We would like to acknowledge the part that our many partners and stakeholders play in helping us to deliver excellent care, and to our patients and their families who have taken the trouble to give us feedback about our services, whether verbally, in writing or through social media. Only by listening to what those people who use our services are saying about the care we provide can we learn, share best practice and transform healthcare provision in west Hertfordshire.

We would finally like to take this opportunity to thank our staff and volunteers for the care and support they give to patients, their families and friends, using our services at Hemel Hempstead, St Albans and Watford hospitals.



Mahdi Hasan
Chair

Jac Kelly
Chief Executive

Perhaps our proudest achievement is that we reduced mortality by 21% between April 2013 and September 2014, compared to a national decrease of 3.3%.

Our services

West Hertfordshire Hospitals NHS Trust provides acute healthcare services to a core catchment population of approximately half a million people living in west Hertfordshire and the surrounding area. The Trust also provides a range of more specialist services to a wider population, serving residents of North London, Bedfordshire, Buckinghamshire and East Hertfordshire. Overall the population served by the Trust is relatively affluent, but there are some areas of deprivation.

With around 4,300 staff and 350 volunteers at our three hospitals in Watford, St Albans and Hemel Hempstead, we are one of the largest employers locally.

Together with our staff, patients, volunteers and health and social care partners, we strive to provide consistently good, safe care in a friendly, listening and informative way, as and when people need and want it and always with dignity and respect.

Hemel Hempstead Hospital

The clinical services offered at Hemel Hempstead include:

- antenatal and community midwifery;
- outpatients;
- step down beds;
- urgent care centre;
- medical care, including endoscopy and cardiac lung function testing;
- clinical support, including X-ray, CT, MRI, ultrasound and non-urgent pathology.

St Albans Hospital

St Albans is our elective care centre. The clinical services offered include:

- antenatal and community midwifery;
- outpatients;
- minor injuries unit;
- elective and day surgery;
- sexual health;
- clinical support, including X-ray, ultrasound, mammography and blood and specimen collection.

Watford Hospital

Watford is at the heart of our acute emergency services. The clinical services offered include:

- women's and children's services, including a consultant delivery unit, midwife birthing unit, antenatal and postnatal clinics;
- emergency care, including accident and emergency, acute admissions unit; ambulatory care unit, acute wards, intensive care unit, and emergency surgery;
- planned care, including outpatients and complex surgery;
- medical care, including endoscopy, cardiology and chemotherapy;
- sexual health;
- clinical support, including X-ray, CT, MRI, ultrasound and urgent and non-urgent pathology.

In 2014/15:

52,000 emergency patients and

43,000 elective patients were admitted to our hospitals

136,000 patients attended our A&E, Urgent Care Centre and Minor Injuries Unit

433,000 people attended outpatient appointments

5,600 babies were born under our care

Our achievements

Our former CEO Samantha Jones won the HSJ's Chief Executive of the Year Award in 2014

Our objective is to deliver improvements in the quality, deliverability and sustainability of our services through:

- Achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas;
- Setting out our future clinical strategy through clinical leadership in partnership with whole system working;
- Creating clear and credible long-term financial and estates strategies which will ensure our services are, sustainable and delivered in appropriate settings.

Delivering continuous improvements to patient care

We delivered some significant improvements for patients in 2014/15. In our most recent staff survey (see page 37), an increased proportion of our staff report that care is our top priority. In an inpatient survey published by the Care Quality Commission in April 2014, nine out of ten patients admitted to our hospitals in 2013 said they were treated with dignity and respect. In September 2014, a national cancer experience survey reported that 83% of our cancer patients rated their care as excellent or good.

During the year, we sustained and accelerated many of the achievements made during 2013/14, including maintaining a low mortality rate. Figures published in March 2015 by Dr Foster (the UK's leading provider of healthcare analysis) showed that mortality (death) rates at Watford, Hemel Hempstead and St Albans hospital have dropped significantly over the past year.

The figures show that between April 2013 and September 2014 mortality at our hospitals dropped by more than 21% (compared to a national decrease of 3.3%).

This year, we focused on areas of historical challenge for our hospitals, including unscheduled care, cancer care and planned care. While we still have further to go, we are seeing improvements in the quality and patient experience of our cancer and planned care services, including reduced waiting times (see page 19, Our Performance).

Our key achievements in 2014/15:

- Reduced the number of patients waiting more than 18 weeks for planned care by 46 per cent, from 4,657 patients in January 2015 to 2,537 in March 2015;
- Reduced waiting times for patients with cancer – 98.4% of patients requiring secondary treatment had their surgery within the target of 31 days;
- Achieved a 21% reduction in our hospital standardised mortality rate (HSMR) and a 25% reduction in crude mortality during the 18 months between April 2013 and September 2014, compared to a national decrease of 3.3%;
- Maintained a 40% reduction in Clostridium difficile (C.difficile also known as antibiotic associated diarrhoea) ;
- Increased labour ward consultant cover from 66 to 98 hours per week in line with national standards;
- Opened an ambulatory care unit (ACU) and began work on creating a dedicated ACU for our Gynaecology patients
- Invested £16.5m in improving the condition of our buildings;
- Launched iWantGreatCare (see page 31 'Our patients');
- We were highly commended in the patient safety category at the HSJ Awards 2014 for 'Onion';
- Won the NHS Employers' Compassion in Practice Award at the Chief Nursing Officer for England Summit.
- Our Annual Plan sets out our challenges for the next year, 2015/16.

Clinical strategy and partnership working

NHS England's Five Year Forward View sets out the challenges that face health and social care services across the country. The situation in west Hertfordshire reflects the national picture; the population is growing, people are living longer, resources (both people and money) are limited and we need to transform services to meet the changing needs of the local population.

Three key pieces of work began in 2014 to plan for future health and social care provision over the next five to ten years:

- Working with our partners, *Your Care, Your Future*, a strategic review of health and social care services across west Hertfordshire, was launched in November 2014 (see page 25 'Our future');
- We have begun work on a new 'West Hertfordshire Hospitals clinical strategy', which will consider how we can improve the quality and sustainability of our services for patients (see page 25 'Our future');
- An urgent review of services for older people and those living with frailty will make recommendations for an overarching model of care to be taken forward as part of the *Your Care, Your Future* review.

A strong leadership

During 2014/15, we strengthened our leadership with the appointment of a new Board and executive team which has added energy, experience and commitment.

Working with the Good Governance Institute, we have also significantly strengthened our governance and assurance processes including the development of a new Board Assurance Framework. Jacqueline Kelly, a highly experienced NHS leader, joined as our new interim Chief Executive in January 2015, following our former Chief Executive Samantha Jones' secondment to NHS England.

In 2013/14, we launched our 'Developing our Organisation' (Known as "DO") programme and it continued to gain visibility across our hospitals. Our Board recognises the DO programme as the path to the long-term transformation of the organisation, and work has continued in 2014/15 to embed our new values into every aspect of our work. For more information on DO see page 38 ('Our staff').

The opening of our new £1.6 million winter ward

In January 2015 we opened our new £1.6 million winter ward with 36 beds, which helped us during the exceptionally busy winter period, including helping to speed up the time it takes to admit patients from our A&E into our wards.

The new ward was built specifically to care for patients who are ready to return home or transfer to another form of care, for instance a care home, but this has been delayed perhaps because they are waiting for care to be arranged by the local council or by their community NHS Trust. We continue to work with our partners to ensure that those patients who are medically fit to be discharged can be, thus freeing up beds for our more seriously ill patients.

"Our Ambulatory Care Unit, which officially opened in January 2014, offers urgent care to patients on a day case basis, avoiding an unnecessary hospital admission."

Faster, better, safer urgent and emergency care

In common with other hospitals in England, we experienced unprecedented demand for our emergency services this winter and as a result, we found it difficult to maintain the A&E standard to discharge, admit or transfer 95% of patients within four hours. We saw 91.8% of A&E patients within four hours in 2014/15; the England average was 92%.

This was despite a number of new initiatives helping us manage the extra demand during this period, treat people faster and help patients get home sooner and to improve patient experience. We continue to strive to ensure we meet the standard.

Emergency nurse practitioner service/ observation bay

In January 2015, we opened a new, dedicated emergency nurse practitioner service for children with minor injuries or illnesses. The new service aims to see children within 15 minutes of arriving at hospital. A new children's observation bay is also improving care for our young patients who do not require admission but need a period of observation to check they are fit and well to return home.

Ambulatory care

Our new, dedicated ambulatory care unit – or ACU – at Watford Hospital which provides faster treatment for people who need care urgently, is proving extremely successful and provides a much improved experience for our patients.

Since it first opened its doors in January 2014, following an investment of approximately £1.4 million the ACU has treated more than 3,000 new patients. Open every day (including weekends) from 8am to 9pm, the unit handles up to 25%-30% of people attending our Accident & Emergency department.

Our new care of the elderly ambulatory care service helps to prevent the unnecessary admission of elderly patients to hospital. Patients are assessed, receive diagnostic tests and are treated so that they can go home the same day, along with any support they require.

Work also began in 2014/15 on creating a dedicated ACU for patients using our Gynaecology services.

Staff from the ACU were presented with the award at an Ambulatory Emergency Care Network meeting in October 2014 by a judging panel at NHS Elect. Competing against 14 other trusts, the award was won for the most improved overall NHS Trust for ambulatory care.

A video has also been produced to showcase the work of the unit which has been shown to NHS teams around the UK.

Emergency surgical assessment unit

In May 2014, we introduced a new service to make faster decisions about patients who may require emergency surgery at Watford Hospital.

Our new emergency surgical assessment unit (ESAU) is open 24 hours a day, 7 days a week and sees patients who may need surgery for a wide range of conditions, including problems with their arteries, bladder, kidneys or appendix.

Once patients have been assessed in ESAU, a clear treatment plan is quickly put in place to ensure they receive the specialist surgical care they need.

"Our occupational and physio therapists play a vital role in helping our patients recover from their illness and return home."

In December 2014, 93% of our patients were extremely likely or likely to recommend our services to friends and family

Listening to and learning from our patients

In the summer of 2014, we launched iWantGreatCare, an initiative to listen to and get feedback from our patients. In December 2014, 93% of our patients were extremely likely or likely to recommend our services to friends and family – a 9% increase since July 2014 (for more information see page 31 (Our patients').

In the 2014 national A&E patient survey, our patients gave A&E a score of 8.5 out of 10 for overall experience and rated us 'above average' or 'average' in all 33 sub-categories.

National recognition for our hospitals

'Onion' wins HSJ award

'Onion' - our process of peeling back the layers to enable staff to raise concerns and challenge the way we do things - was highly commended in the patient safety category at the HSJ (Health Service Journal) awards in November.

The judges acknowledged it as a 'unique initiative' aimed at improving the way patients are looked after and for how it empowers doctors, nurses, midwives and other staff, to raise concerns they have about the quality of care we provide. 'Onion' was borne out of our commitment to the Francis Report.

Compassion in Practice award

In December, Bluebell ward, our unit that provides care for patients with both physical and mental ill health, was presented with an NHS Employers' Compassion in Practice award at the Chief Nursing Officer's Summit.

The award recognises the unique way in which our staff are supported to provide safe, personal and compassionate care for each patient during their stay on the ward.

The same team developed the innovative Delirium Recovery Programme (see page 21) which enables patients to return home to recover faster if they have suffered from an acute state of confusion. Working with our social care partners, we can support patients at home with 24 hour live-in care for a short period of time.

"Staff on Bluebell ward, which cares for patients who have dementia, won a 'Compassion in Practice' award in November 2014."

WINNER 2014 Compassion in Practice Awards NHS England

Patients and staff will benefit from improved communication and information sharing; during 2015/16 we will be introducing WiFi across our sites

Investing in information technology

In June 2014 we signed a major new £25.5 million contract over seven years with IT provider CGI to invest in our IT systems to improve the quality of our clinical data and governance. As part of a programme called 'make IT happen' this investment will bring significant benefits for our patients and revolutionise the way that we work.

The rollout of new technology began in late August 2014 with a new 24/7 helpdesk to improve the reliability of IT support services. Work is now underway to replace networks at our three hospitals and to move our key clinical and business systems to offsite data centres. Patients and staff will benefit from improved communication and information sharing; during 2015/16 we will be introducing WiFi across our sites (including access for patients), rolling out new modern devices for our staff to exploit mobile working and enable them to access business and clinical information in a streamlined way, from a variety of devices. We will also be introducing SMS text messaging services for appointment reminders.

Engaging with our local community

In 2014/15 people living in and around Watford, Hemel Hempstead and St Albans were invited to attend a series of 'meet the boss' events in December to learn more about the work of our hospitals.

Meetings were held at each of our three sites at Watford, St Albans and Hemel Hempstead hospitals.

It was an opportunity for local people to come and meet our Chief Executive and hear from her directly about the latest news from our hospitals. People attending the 90-minute events were also able to give their feedback about the services we provide and to ask any questions.

Our performance

In 2014/15 we continued to work with our partners in primary, community and secondary care to ensure service provision meets the needs of our patients through all settings. For information on how we performed against the nationally set targets see the Annual Governance Statement on page 54.

Improving planned care and reducing waiting times

Patients who are referred to our hospitals for planned care should be able to start their treatment within 18 weeks of their referral but meeting national standards for referral to treatment has historically been difficult for our hospitals. We now have a plan in place to ensure that 25 beds are reserved for elective patients, and not used by emergency patients, which will mean fewer cancellations and much improved referral to treatment times next year.

Following an external audit in 2013/14, in 2014/15 our priority was to improve the systems and processes supporting our planned care services, by focusing our efforts during 2014/15 on reducing the number of patients awaiting care, in particular, those patients waiting the longest.

We provided additional clinics and theatre sessions seven days a week and worked with other providers so that our patients received their treatment faster. We continued to improve underlying systems, including the information that is available to service teams, continuous data validation and refinements to booking processes, to ensure that patients are seen in a clinically appropriate and equitable order.

We have more than halved the number of patients waiting more than 18 weeks, reducing from 4,659 patients to 2,537 patients. Due to our focus on those patients waiting the longest we did not meet the national waiting time standards in 2014/15; 71.3% of admitted and 87.6% of non-admitted patients started treatment within 18 weeks.

In 2015/16 we will further improve our planned care so that 90% of admitted and 95% of non-admitted patients start their treatment within 18 weeks, across all clinical services. We aim to see 99% of patients requiring diagnostics within six weeks. We will continue to cut our backlog of people waiting a long time for planned treatment.

Cancer services

Meeting the standards for cancer waiting times has also been an historic challenge for our hospitals, in particular, the requirement for patients with suspected cancer to see a specialist within two weeks after referral from their GP.

In response to an external review commissioned by the NHS Trust Development Authority (TDA) in 2014, we developed an overarching cancer improvement plan and started to implement the following:

- Establishing a peer review process;
- Improving cancer care pathways including a new 'GPs to test' pathway to enable patients to have a CT scan at their first hospital appointment;
- Improving the quality of information;
- Infrastructure and administration – a restructuring of the cancer services department and strengthened leadership has seen new roles introduced, current roles refined and additional resources agreed to meet demand;
- Improving cancer patient experience by providing patients with a named cancer nurse specialist whom they can contact and a new Macmillan volunteers inpatient visiting service.

In the latest national cancer patient survey we were among the top 20% of trusts in helping our patients to understand information about their cancer, giving patients a choice of treatments and helping to control the pain (see page 32 'Our patients' for more information).

Providing safe, high quality and compassionate care

'Test Your Care'

'Test Your Care' is a collection of nursing care indicators and patient experience questions to monitor and improve standards of patient care. It covers nine key care indicators, such as patient observations and tissue viability.

Following the launch of 'Test Your Care' – in March 2014 into adult ward areas, we introduced the scheme to our children's wards in December 2014. Over half of our wards are now achieving 80% or more. New metric boards are being rolled out in wards and will display the monthly overall result, ensuring we are being open and transparent with our data.

BEST SHOT campaign

In November 2014, we launched the BEST SHOT initiative across our hospitals to provide nursing staff with a checklist to help prevent pressure ulcers. This tool is now used on a daily basis by nursing staff when caring for patients who may be at risk of pressure damage, with the aim of reducing the number of avoidable pressure ulcers.

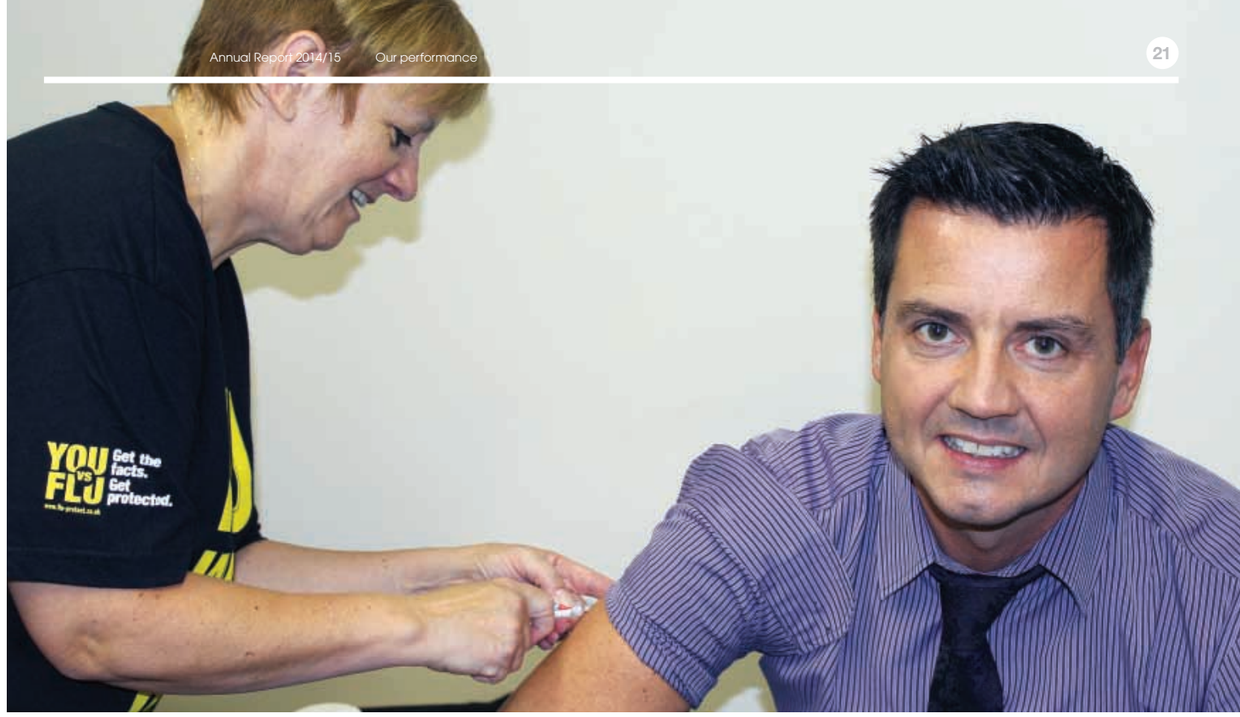
Stamping out Sepsis – YouTube hit

To mark World Sepsis Day, our nursing team produced a video which became a YouTube hit. The aim of the campaign was to better identify sepsis when patients are admitted to our hospitals.

In the latest national cancer patient survey we were among the top 20% of trusts in helping our patients to understand information about their cancer, giving patients a choice of treatments and helping to control the pain

Care Quality Commission

In November 2014 the Care Quality Commission (CQC) carried out an unscheduled inspection of our hospitals, the report of which is due to appear in 2015/16. The CQC were due to carry out a planned inspection during April 2015 and work began in the latter part of 2014/15 to prepare for this.



"More than 80 per cent of our staff, including all our Trust Board, had the flu jab this year, a significant improvement on last year."

Safer staffing levels

Establishing and maintaining safe staffing levels is essential to the delivery of high quality and safe care to patients. We are able to openly demonstrate to patients the number of staff on duty compared to the expected levels of staffing and where these fall short the actions being taken to maintain the agreed staffing levels. Staffing levels are reviewed daily at our 'Onion' meetings and are published on our website.

The Trust has faced the challenge of a significant national shortage of qualified nurses. We welcomed 110 overseas nurses to the Trust in the early part of the year, which has been invaluable, and we have also been running proactive and frequent nurse recruitment events.

Flufighter campaign

Following a robust and enthusiastic flu campaign in the run-up to winter, we were the fourth most improved Trust in the country for staff flu vaccines in 2014/15. The percentage of our staff who had the vaccine went from 48% last year to just under 80% this year – a considerable achievement.

Delirium recovery programme

Our delirium recovery programme involves a multidisciplinary approach with patients firmly at the centre of how we provide care.

A team of professionals – including physicians, psychiatrists, care workers, social workers, and occupational therapists – work together with patients and their families to put in place a care plan that enhances their recovery.

The programme aims to reduce the need for long-term care and long stays in hospital, limit antipsychotic prescribing and help patients get home faster.

Improving care at end of life

National care of the dying audit

A national care of the dying audit published in May 2014 showed that we were performing well against other hospitals in England when it comes to the care we provide to our patients in their final days of life, and the support we give to their families and carers. The audit showed that we were one of only 21% of trusts nationally who provide face to face palliative care services seven days a week. End of life care now has representation at board level and we have also established a Compassionate Care Group.

Rose project

In 2014/15 we launched the Rose project - an initiative to promote dignity, respect and compassion at the end of life through the use of a pink rose symbol. The rose symbol is seen on the wards immediately prior to and following the death of a person and on our cards and other items associated with end of life (For more information see page 35 'Our patients').

"We are now using the rose symbol to promote dignity and respect at end of life."

Hospital infections

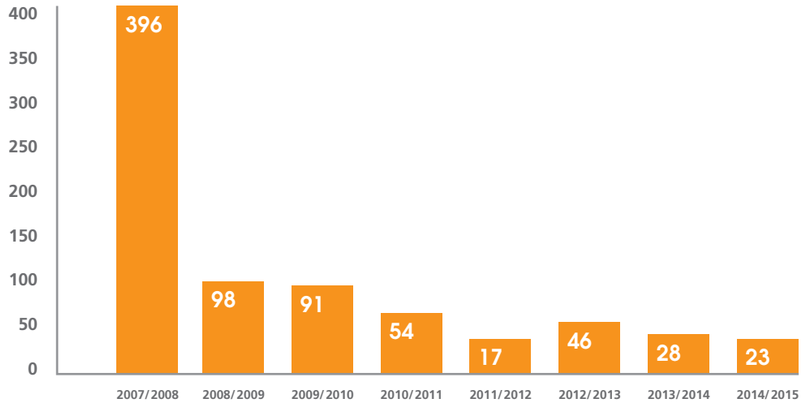
Reducing healthcare associated infections has been a key priority for our hospitals over recent years and in 2014/15 our rates of infection continued to fall.

Over the last year, we recorded 23 cases of C-difficile in our hospitals, against a target of 31. This compared to 28 cases in 2013/14.

While our aim was to have no cases of MRSA (methicillin resistant staphylococcus aureus) this year, we did have one case and an investigation was held by our infection control and clinical teams into how the infection originated. All staff are required to undertake mandatory training in infection control and prevention, and the trust has a detailed action plan to ensure that infection control practices in the trust are in line with national guidance.

The Trust board receives monthly reports on infection control and regularly seeks assurance that, despite the small number of cases being reported, all possible actions are being taken to reduce the risk of infection across all areas of our hospitals.

Cdiff Infections: April 2007 to March 2015



Serious incidents

In 2014/15 we continued to focus on reporting and acting on serious incidents and "never events" in order to ensure that we learn from every incident. We introduced a new system of RCA (root cause analysis) investigations and a programme of training for RCA investigators .

During 2014/15, we reported 207 potential serious incidents, although once reviewed a number of these were found to be non reportable incidents. This compares with 149 serious incidents in 2013/14, a rise which may be down to our better reporting systems. Although serious incidents are never acceptable, they do provide opportunities for change and improvements. As a result of the serious incidents reported in 2014/15 we have been able to make a number of changes to the way services are provided.

'Never events' are potential very serious incidents which should never happen. We reported three such events in 2014/15. These never events were subject to intense investigation and scrutiny with action plans drawn up with the inter-professional teams to ensure that there are changes in practice to prevent these occurring again.

Management of risk

In 2014/15 we continued to work on strengthening our risk management procedures and to ensure that all staff are properly trained, particularly around mitigating risk, the reporting of incidents and the learning from these incidents. We have also addressed some historic issues relating to complaints.

We know we need to further strengthen our strategic risk management arrangements and make sure there is a clear line of sight from 'ward to board' on how well we are doing and what our key clinical and organisational risks are. In 2015/16, we will undertake a review of our quality governance and risk management structures to ensure we have robust and effective systems in place.

For further information on risk management in our hospitals please see the Annual Governance Statement on page 54.

"Thank you to the League of Friends who fundraised for a new handheld ultrasound scanner for our ICU unit."

Maintaining a safe environment

In June 2014 the Trust pleaded guilty to five offences under the Health and Safety at Work Act 1974.

The offences related to the management of asbestos at our three hospital sites over a period in excess of ten years dating from the creation of West Hertfordshire Hospitals NHS Trust in 2000.

Asbestos is common in buildings of the age of our hospitals, but the court found that the Trust had not taken its responsibilities as seriously as it should have done in relation to the safe management of asbestos and we have apologised for this.

Importantly we have made significant changes in recent years to the way we manage and control asbestos across our hospitals, ensuring the risk of exposure is at the lowest possible level. This includes:

- Undertaking new and detailed surveys to show where the asbestos is on our sites;
- Implementing dedicated asbestos management plans for each hospital and ensuring they are shared with relevant staff and contractors;
- Improved training for appropriate staff about the risks relating to asbestos and a detailed induction for all contractors;
- Appointing a dedicated senior manager who has overall responsibility for the control and management of asbestos at our hospitals;
- Safely removing a significant amount of asbestos.

Since 2012, we have spent almost £2million in the safe removal and management of asbestos across our three sites.

Principles of remedy

We adhere to the Parliamentary and Health Services Ombudsman's Principles for Remedy, which provide guidance on the way public bodies respond to complaints and concerns raised by patients and members of the public.Those principles are:

Getting it right

- Quickly acknowledging and putting right cases of maladministration or poor service that have led to injustice or hardship;
- Considering all relevant factors when deciding the appropriate remedy, ensuring fairness for the complainant and, where appropriate, for others who have suffered injustice or hardship as a result of the same maladministration or poor service.

Being customer focused

- Apologising for and explaining the maladministration or poor service;
- Understanding and managing people's expectations and needs;
- Dealing with people professionally and sensitively;
- Providing remedies that take account of people's individual circumstances.

Being open and accountable

- Being open and clear about how we decide remedies;
- Operating a proper system of accountability and delegation in providing remedies;
- Keeping a clear record of what has been decided on remedies and why.

Acting fairly and proportionately

- Offering remedies that are fair and proportionate to the complainant's injustice or hardship;
- Providing remedies to others who have suffered injustice or hardship as a result of the same maladministration or poor service, where appropriate;
- Treating people without bias, unlawful discrimination or prejudice;
- Operating a proper system of accountability and delegation in providing remedies;
- Keeping a clear record of what has been decided on remedies and why.

Putting things right

- If possible, returning the complainant and, where appropriate, others who have suffered similar injustice or hardship, to the position they would have been in if the maladministration or poor service had not occurred;
- If that is not possible, compensating the complainant and such others appropriately;
- Considering fully and seriously all forms of remedy (such as an apology, an explanation, remedial action, or financial compensation);
- Providing the appropriate remedy in each case.

Seeking continuous improvement

- Using the lessons learned from complaints to ensure that maladministration or poor service is not repeated;
- Recording and using information on the outcome of complaints to improve services;
- There are no automatic or routine remedies for injustice or hardship and such remedies need to be considered on an individual basis and will include actions such as an apology or explanation, changing a decision, revising public documentation and training or re-training staff.

Learning from complaints and compliments

Patient Advice and Liaison Service

Our Patient Advice and Liaison service (PALS) continues to be an integral part of the service we provide to our patients, relatives and carers, acting as a vital channel for feedback. PALS provides a professional, friendly, sensitive service and tries, wherever possible, to offer on-the-spot support to help resolve any problems.

In 2014/15, the PALS team dealt with a total of 2,259 reported concerns, which is a 4% increase on last year. Approximately 40% of concerns are related to appointments, assessments and waiting times, and a further 24% are about admissions.

Formal complaints

Having an effective complaints process in place is extremely important because complaints provide an important barometer of how patients and families feel about the care and services we provide. Over the last year, we have made changes to the way we manage and respond to complaints, which has seen our average response time for complaints drop from 56 days in 2013/14 to 38 days in 2014/15, representing a considerable improvement. The second half of the year showed average response times further reduced to 32 days.

In 2014/15, the Trust received 599 formal complaints, compared to 619 in 2013/14, representing a decrease of 3%. In addition, 143 enquiries were received from GPs, MPs and patients who did not wish to make a formal complaint but who wanted to make the Trust aware of their experiences.

In addition to the many cards, letters, notes and small gifts received directly by wards and departments, during the period of this report; the Chief Executive received 84 formal compliment letters from satisfied patients and visitors.

We also monitor our Trust Twitter account and respond both to complaints and compliments about our services.

Information governance

All our staff have a duty to uphold the highest standards of Information Governance (IG) at all times. IG relates to the safe handling of clinical or personal identifiable information.

In October 2014 we discovered an IG breach relating to staff personal identifiable information which we reported to the Information Commissioner's Office (ICO – the body which oversees the use of personal data). We immediately launched an investigation and also commissioned an independent review into our approach to IG and the need for additional training and education for staff around the handling of clinical or personal identifiable information.

Register of gifts

Our staff are not expected to accept gifts offered to them. There is a limited set of exceptions and if gifts are accepted, staff are expected to declare them. A register of gifts and hospitality is reviewed by the Audit Committee (see page 57) on a regular basis.

Freedom of Information requests

In 2014/15 we had a total of 585 Freedom of Information requests, representing a 19% increase on the previous year when we had 493. Unfortunately two of these were not completed within the 20 day working day time frame. Our aim for next year will be 100% compliance.

Over the last year, we have made changes to the way we manage and respond to complaints, which has seen our average response time for complaints drop from 56 days in 2013/14 to 38 days in 2014/15, representing a considerable improvement.

Medical appraisal and revalidation

We have a number of statutory duties in relation to medical appraisal and revalidation. The purpose of these is to ensure that all doctors employed across our hospitals are subject to effective systems of medical appraisal, performance monitoring and support.

In 2014/15, we continued to make significant progress in raising the annual appraisal rate of our doctors, completing 96% (or 99% taking into account those with approved delays). In the next 12 months, the system of appraisal and revalidation will be further enhanced by increasing the number of qualified appraisers, through a tailored training programme, compliant with General Medical Council regulations. As a result, every doctor within the Trust will receive an annual appraisal and undergo revalidation where appropriate.

Completed appraisals	**311**	**95.7%**
Consultants	**187/190**	**98.4%**
Staff Grade	**72/73**	**98.6%**
Temporary short-term staff	**52/62**	**83.9%**
With approved reasons for missing appraisal (sickness, maternity leave, new starters)	**12**	
Unapproved	**2**	
Total	**325**	

Improvement to the hospital environment and infrastructure

Over the last year we have spent more than £8m on backlog maintenance to our aged infrastructure including (add more):

- In November, a six bedded Children's Observation unit opened in the Children's Emergency Department at Watford Hospital;
- To help relieve winter pressures on the Trust, a £1.6 million investment into the Shrodells building on the Watford site created a new winter ward;
- The creation of a palliative care room outside Red Suite, in which to break bad news to families;
- The installation of a wet room on our children's ward – this was in direct response to a young patient's story related to the Board by his mother (see page xxx);
- We have carried out fire prevention work across our buildings, including upgrades to ceilings and replacing 120 fire doors;
- We have made improvements to our Renal unit at Watford Hospital;
- The Moynihan building at St. Albans Hospital received a face lift, window repairs and a complete re-surface of the roof ;
- We invested £600,000 in refurbishing ward areas, bays, side rooms, patient kitchens, bathrooms and common areas;
- Work started on creating a six-bedded Ambulatory Care Unit for our Gynaecology patients, located in the Maternity Block at Watford Hospital;
- We have begun the process of opening a new 28 surgical bed ward within the Moynihan building at St Albans hospital due to open in summer 2015;
- We have invested in automated doors to improve access to key areas within our buildings.

PLACE – patient led assessment of the hospital care environment

PLACE was introduced in 2013 to provide an independent measure of the quality of the hospital care environment. The inspection is carried out by a team of patients, carers, relatives and external bodies with an involvement in local healthcare, including Healthwatch Hertfordshire. The 2014 inspection looked at four key areas - cleanliness; food and hydration; privacy, dignity and well-being; and condition, appearance and maintenance.

"Our catering for patients was given a thumbs up by our Board members who sampled patient meals at their meeting in October 2014."

Our scores for 2014 were:

Site name	Cleanliness	Food and Hydration	Privacy, dignity and well-being	Condition, appearance and maintenance
Watford	95.6	91.1	70.7	85.2
St Albans	98.0	90.8	85.1	81.6
National average	97.3	88.8	87.7	92.0

Although the low scores can in part be attributed to the age and layout of our estate, the results were disappointing. The Trust put an immediate action plan in place to address the areas of concern, focusing on physical improvements to the ward environment and on a number of initiatives to improve the privacy and dignity of patients.

Much of this work was complete before the 2015 PLACE inspection, which took place at Watford Hospital on 19 March 2015. The Trust was aiming to achieve results above the national average in all areas, except where the physical limitations of our estate restrict our ability to meet the required target. The results are expected to be published in September 2015.

Sustainability

We are committed to embedding sustainable practices across our hospitals and have a robust Board approved Sustainable Development Management Plan. We continue to use the Good Corporate Citizen Model.

Resource		2011/12	2012/13	2013/14	2014/15 Estimated
Gas:	Use (kWh)	38,026,702	36,898,214	40,620,606	41,980,382
	tCO2e	6,997	6,789	7,474	7,708
Electricity:	Use (kWh)	16,547,671	17,167,977	17,010,202	17,920,885
	tCO2e	8,952	9,322	9,220	9,693
Oil:	Use (kWh)	213,214	1,798,066	26,423	164,991
	tCO2e	59	500	7	46
Total Energy Spend		£2,770,832	£3,058,695	£3,118,866	£3,206,909

Source ERIC (Estates Return Information Collection)

Electricity for 2014/15 includes 1,457,832 kWh from on site CHP

These figures include a amendment to the figures report in last year's annual report. Key activities this year include:

- Replacement of pipe work insulation;
- Installing new energy efficient lighting;
- Installing software to enable Trust computers to be turned off when not in use;
- Further funding for electric car charging provision;

Our patients

"Our play specialists on Starfish and Safari wards help our younger patients relax when they are in hospital."

Our patients - listening and learning

Engaging and communicating with our patients, carers and families is key to delivering good and safe care and we do this in a number of ways, in partnership with a variety of local organisations including Herts Valleys Clinical Commissioning Group, other NHS providers, Hertfordshire Healthwatch, the Patients Association, and our own Patients Panel.

One of the ways we do this is via patient surveys which give us invaluable feedback on our services and help us focus on the things we need to do better.

iWantGreatCare

The NHS friends and family test gives us real time feedback that we use to improve care and treatment for everyone using our hospitals.

In the summer of 2014, we launched iWantGreatCare, an initiative to listen to and get feedback from our patients. We now survey patients in 75 clinical areas across our hospitals, with one in two patients admitted for inpatient care giving us their feedback.

In December 2014, 93% of our patients were extremely likely or likely to recommend our services to friends and family – a 9% increase since July 2014.

We have also more launched an inpatient 'ward of the month' scheme to reward those areas which are receiving the best feedback from patients. Congratulations to all the teams who have won an award:

- August 2014 – Bluebell ward (our first winners!)
- September – Winyard ward
- October – Cleves ward
- November – Langley ward
- January 2015 – AAU Level 1 Green
- February – AAU Level 1 Green
- March – De La Mare

A&E patient survey

In December, the Care Quality Commission (CQC) published the results of their 2014 A&E patient survey.

They surveyed patients who attended one of the 142 acute and specialist NHS trusts with a major A&E department between January and March. Responses were received from almost 40,000 patients.

A&Es were rated against eight national categories (on a scale of 'below average', 'average' and 'above average'):

- Overall experience;
- Arrival at A&E;
- Waiting times;
- Doctors and nurses;
- Care and treatment;
- Tests;
- Hospital environment and facilities;
- Leaving A&E

For all categories, we scored 'average', which included a best score of 8.5 out of ten for 'overall experience'. In addition, the eight categories are broken down into 33 sub-categories, with us scoring 'above average' in five areas and 'average' in 28. The areas where we scored 'above average' included patients feeling their test results were provided quickly and that the purpose of their medication was explained.

Cancer patient experience survey

A national cancer patient experience survey, commissioned by NHS England, was published in September 2014. It was carried out by Quality Health and included the views of 196 patients who used our cancer services in September, October and November 2013.

The data contained in the survey is invaluable because it gives us the opportunity to learn from what our patients are telling us about the care they receive.

Overall, the survey showed that the care we provide is improving, which was very encouraging, but that we need to focus our efforts on improving the patients' experience on our wards, and partnership working with other NHS and community organisations.

A comprehensive cancer plan was put together and has been implemented during 2014/15, delivering real improvements to our patients' overall experience of cancer care in our hospitals.

National inpatient survey

A national survey of inpatient care was published in April 2014. It showed that in 2013 we were performing in line with most other hospitals in the country and that the majority of our inpatients felt that they were treated with dignity and respect, and that they had confidence in the medical and nursing staff caring for them.

The survey, which published responses from 772 people who used our service, took place in August 2013. Results were split into ten categories, which are then broken down into 60 subsets providing more detailed information about what patients are saying about their stay in our hospitals.

Our patients also gave us high scores on many other aspects of our care, including important issues like how they were treated in A&E, whether or not their admission date was changed, and their experience of being transferred between different services within the hospital. We also received good feedback about levels of both privacy, and cleanliness, on our wards.

There were only four areas out of 60 where our performance was 'worse' than other hospitals for the last year and we have been working closely with our staff and patient representatives to improve on these. They related to the ward environment being noisy, and to patients not being given enough information about what will happen before or after their operation or procedure.

NHS Choices/Patient Opinion

Obtaining first hand feedback from our patients on their experience of our hospitals is extremely important and one of the ways we gain this is by monitoring comments made on the NHS Choices and Patient Opinion websites. Last year, we received a number of posts relating to our hospitals in Hemel Hempstead, St Albans and Watford:

NHS Choices comments

- **Hemel Hempstead 45**
- **St Albans 52**
- **Watford 109**

Patient Opinion comments

- **Hemel Hempstead 0**
- **St Albans 4**
- **Watford 20**

Patient Opinion banners are now on display across all three of our hospital sites, encouraging our patients and their families and carers to give us their feedback on our services.

Using social media

We are committed to using social media to engage and communicate with our patients, staff and our local community so that we can learn from the feedback we receive about our services and continually improve them.

We now have 4,000 followers on our Twitter account which is monitored 24/7 so that we can respond promptly to comments, particularly if they are from patients who are currently using our services, and they are experiencing a problem. We will aim to resolve it as soon as possible by liaising with our staff from different departments and wards. Similarly when we receive compliments we feed these back to the department, and members of staff, involved.

Patient stories at the Board

At each monthly Trust Board meeting, a patient, carer or member of staff is invited to come along and tell their story. This gives our Board members an opportunity to hear first hand from the people using our services, and to learn how we can work together to make improvements where needed and to share learning. As a direct response to a patient story, for example, a new wet room was fitted on our children's ward. We would like to thank all those patients who came along to share their experience.

Working in partnership

'Kissing it Better'

In 2014/15 we began our partnership with the national charity 'Kissing It Better' who bring activities such as pet therapy and music into our hospitals to help brighten patients' days.

Working with 'Kissing it Better', we aim to provide the little things that make a big difference to our patients on our wards, to improve their well-being and to aid in their recovery.

We have had several visits from 'PAT (pets as therapy) dogs to our wards at Watford and Hemel Hempstead, including our care of the elderly, dementia and children's wards.

Other activities have included a jazz singer and guitarist playing to patients and visitors at Hemel Hempstead hospital, as well as some pampering sessions provided for our elderly patients by beauty therapy students from Stanmore College.

We will continue to build on our partnership with the Kissing it Better charity in 2015/16.

Rose project

Working in partnership with the Hospice of St Frances and Peace Hospice Care In December 2014 we formally launched the Rose Project across our three hospitals which uses a rose symbol to promote dignity and respect at the end of life.

This symbol is seen on the wards, immediately prior to and following the death of a person and is part of our commitment to promote dignity, respect and compassion at the end of life.

The rose is a gentle but clear way of raising awareness of this significant event - its presence on the ward should prompt all staff to foster an atmosphere of quiet and respect, to be considerate in their activity and be prepared to meet people who are grieving or distressed.

Signing up to a dementia awareness charter

In March 2015, we joined forces with Herts Valleys Clinical Commissioning Group and Hertfordshire Alzheimer's Society to hold our first dementia awareness training day, as part of a new dementia hospital charter.

More than 150 people attended the sessions at St Albans hospital and another training session is currently being planned for July at Watford Hospital.

Equality and Diversity

In 2014/15 we continued to build long-term relationships with a number of different groups in the community to help ensure that our frontline health services deliver good health outcomes for those people who experience the greatest inequalities. In addition to the 'Kissing it Better' initiatives training mentioned above, other highlights in 2014/15 include:

- Equality and diversity talk given to children at Limewalk School;
- 'Watching' to support the Jewish community has been put in place at Watford Hospital to ensure that Rabbis and relatives can 'watch' the body before the deceased is released from the Trust for funeral;

"In 2014/15 we began our partnership with the charity 'Kissing it Better' who brought song, dance and gorgeous Pets as Therapy Cockapoo Teddy into our hospitals to help brighten patients' days."

Our staff

Consulting with our staff

National NHS staff survey 2014

The National NHS staff survey was conducted in the autumn of 2014 and 1,703 members of our staff took part. This amounted to 43% of our staff, similar to the 44% who participated the year before, and in line with other hospitals.

Our results published in February 2015, showed that we made improvements in a number of areas, including staff saying that:

- we are good at team working;
- our incident reporting process is fair and effective;
- we act on concerns raised by patients;
- care of patients is their organisation's top priority.

For the vast majority of topics surveyed (22 out of 29) we saw little change in our result compared to 2013. However, we were worse off in two areas, including the percentage of staff who said they had had an appraisal in the last year.

We were in the worst 20% of all hospitals nationally in seven areas, including the percentage of staff:

- having had an appraisal in the last 12 months;
- having a well structured appraisal in the last 12 months;
- agreeing that they would feel secure raising concerns about unsafe clinical practice;
- experiencing physical violence from patients, relatives or the public in the last 12 months;
- experiencing physical violence from staff in the last 12 months;
- experiencing discrimination at work in the last 12 months.

We were also very disappointed to see that fewer staff would recommend our hospitals as a place to work or to their friends/family as a place to receive care.

We have already started to address some key areas, in partnership with staff from across our hospitals, as well as with colleagues from unions and professional bodies.

Developing our Organisation

Our values:

- We involve others – in all that we do our patients, their families and carers are involved and their voices are clear and influential.
- We are transparent – it's safe to admit mistakes and speak out when things don't seem right, this helps us learn and improve.
- We are all leaders – we value our teams and we value each other. Investment is made in all of us because, in our own way, we are all talented and we all lead.
- We are proud – we are proud of our hospitals and ambitious when it comes to the quality of our services and calibre of staff we employ.
- We work in partnership – we work together as part of a bigger team with people within and outside our hospitals to join things up for individual patients and the wider community.
- We add value – through being innovative and spending our time on the things that matter we each add value and continuously look to improve what we do.

In 2013/14, we launched our 'Developing our Organisation' (Known as "DO") programme continued to gain visibility across our hospitals. Our Board recognises the DO programme as the path to the long-term transformation of the organisation.

Over the past year, we strived to make our hospitals a better place for our staff and volunteers to work:

- As part of the DO programme, we launched a new values-based appraisal system to help our staff to be clearer about the role they play in achieving our overall objectives and to better recognise the work our staff do. We trained 650 managers in this new appraisal system;
- We introduced a new values-based assessment which supports recruitment to key roles within the organisation. We developed a similar approach for nursing and midwifery roles to ensure that we only recruit people who share and live our values;
- A review of our human resources function saw the introduction of HR Business Partners and a number of online systems to help improve efficiencies and processes;
- An official review of our learning and development approach from Health Education East of England found 'significant improvements' following their previous visit.

January 2015 saw the publication of a new newsletter specifically designed to update staff on all the latest news around DO.

In 2015/16, we will be launching a new core skills programme for our managers, based around our values and the priorities for development that we have identified, largely through our new appraisals process.

Recognising exceptional staff – our new monthly staff award

In May 2014 we launched a new Monthly Staff Award for staff who go above and beyond the call of duty. Staff can be nominated by patients, families and other members of staff. Congratulations to all the staff who were nominated and to those who won:

- Jane Roberts, lead nurse for patient experience - May 2014
- Ken Burry, porter - June 2014
- Jeremy Ruppersburg, dementia activity co-ordinator, Bluebell ward - July 2014
- Jean Hickman, Trust secretary, corporate affairs and communications - August 2014
- Dawn Moore, ward sister, AAU Level 3 - September 2014
- David Sear, porter - October 2014
- Dominic Futter, physiotherapist - November 2014
- Ernesto Tamayo, intensive care unit - December 2014
- Isabel Hlomani, senior sister, pre-operative assessment department - January 2015
- Claire Nicell, Hospice champion, palliative care - February 2015
- Shahid Mahmood, domestic, Acute Admissions Unit - March 2015

The health and wellbeing of our staff

The average sickness rate in 2014/15 was 3.78%, slightly higher than last year's average of 3.5%.

We are committed to positively improving the health and wellbeing of our staff through various initiatives, as part of our Balanc4Life programme which offers a variety of activities and schemes for staff to support them in their working life.

Recruiting and retaining staff

Recruitment, particularly for nurses, continues to be challenging but in 2014/15 we have managed to keep our vacancy rate more or less stable.

Since October, we have been successful in recruiting unregistered nurses through monthly Open Days, which we are now increasing to twice-monthly. We have also been holding twice-monthly Open Days for qualified nurses since the autumn. We are also attending numerous job fairs and University events.

In addition, we plan to visit The Philippines in June 2015 with a view to recruiting 100 qualified and experienced nurses. We have also streamlined the process for recruiting student nurses who undertake their final placement at this Trust.

Equal opportunities

We are committed to encouraging equality and diversity so that our workforce reflects the diverse population that we serve.

We have a responsibility to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between different groups which have the following protected characteristics: disability, gender, reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, age, sex and sexual orientation.

Our aim continues to be to improve the way frontline health services deliver good health outcomes for the protected groups who experience the greatest inequalities and to support an inclusive and fair workplace.

Key achievements in 2014/15:

- We have accreditation as a 'Two Ticks, positive about disabled people' employer. This demonstrates that we encourage applications from disabled people and make commitments towards our disabled staff;
- We refreshed our harassment & bullying policies;
- We updated our equality and diversity training, covering equality legislation, unconscious bias, personal responsibility, inappropriate behaviour'
- Further development of our Trust-wide Connect BME (black and minority ethnic) network.

Breakdown of staff groups

(as at 31 March 2015)

Banding By Gender	2014-15		
Headcount	Gender		
Band	Female	Male	Grand Total
Band 1 – 7	2954	504	3458
Band 8A and above	178	55	233
Medical	267	306	573
Non-Exec Directors	1	5	6
Grand Total	3401	870	4271

Banding By Ethnicity

Ethnicity	Band 1 - 7	Band 8A and above	Medical	Non-Exec Directors	Grand Total
Asian and Asian British - Any other Asian background	233	6	39		278
Asian and Asian British - Bangladeshi	9		3		12
Asian and Asian British - Indian	265	20	129		414
Asian and Asian British - Pakistani	60	1	34	1	96
Black and Black British - African	160	5	27		192
Black and Black British - Any other Black background	15		2		17
Black and Black British - Caribbean	59	4	2		65
Mixed - Any other mixed background	15	1	5		21
Mixed - White and Asian	9	1	5		15
Mixed - White and Black African	10		1		11
Mixed - White and Black Caribbean	10	1	3		14
Not stated	193	5	40		238
Other Ethnic Groups - Any other ethnic group	75	2	18		95
Other Ethnic Groups - Chinese	37	1	16		54
White - Any other White background	236	5	53		294
White - British	1969	168	190	5	2332
White - Irish	103	13	6	1	123
Grand Total	3458	233	573	7	4271

Thank you to all our volunteers

More than 80 volunteers attended a special annual 'thank you' lunch on 24 February 2015. The event gave Trust Board members and staff the opportunity to acknowledge and celebrate the continued commitment of our volunteers who are aged between 18 and 90 years of age, and who this year donated a staggering 80,000 hours of time to our hospitals.

Our volunteers do a huge variety of jobs, including driving patients to and from their hospital appointments, supporting the League of Friends tea bars and helping out on wards, reception desks and information centres, for instance the Macmillan Cancer Support centre at Watford Hospital.

Eleven volunteers were presented with awards for long service, including one who has volunteered for an amazing 50 years. Watford Hospital Radio received a special 'thank you', with two of their volunteers being given awards for 30 years long service.

"A huge thank you to our team of volunteers who donated a staggering 80,000 hours of time to our hospitals in 2014/15."

Our future

"A new garden with benching opened in March at Watford Hospital thanks to a generous donation from Watford Rotary Club."

Your Care, Your Future

Your Care, Your Future, a strategic review of health and social care services across west Hertfordshire, was launched in November 2014, a piece of work which aims to transform primary and specialist care services in order to make them sustainable for the future.

Our commissioners, Herts Valleys Clinical Commissioning Group, are leading the review together with key partners: West Hertfordshire Hospitals NHS Trust, Hertfordshire Community Trust, Hertfordshire Partnership University NHS Foundation Trust, and Hertfordshire County Council. Engagement with staff, patients and local people has informed the development of a draft case for change which was published in March 2015.

Our clinical and estates strategies

We have begun work on developing a new 'West Hertfordshire Hospitals clinical strategy', which will consider how we can improve the quality and sustainability of our services for patients. The clinical strategy will help to define our clinical priorities and support the development of our long-term estates and financial strategies. It will also inform Your Care, Your Future.

Much of our estate is old, costing huge amounts in backlog maintenance every year, and not suitable for providing the kind of care we want to be able to provide. So once the clinical strategy has been ratified, we will be producing an estates strategy, which will look at what buildings will be needed across our three sites at Watford, St Albans and Hemel Hempstead hospitals in order to deliver the services needed for a twenty first century health service in west Hertfordshire.

Watford Health Campus

The Watford Health Campus project was launched in 2013 and is looking to redevelop the land around the current hospital site, bringing new hospital buildings, new homes, new jobs, accessible open green space, and a mix of facilities and services.

The project is a partnership between our Trust, Watford Borough Council, and Kier Property Ltd. The nature of the work required for the hospital element will be strongly influenced by the results of the estates strategy.

As part of the project, work began in 2014/15 on construction of a new road to the hospital site, following NHS funding, public dividend capital from the Department of Health, of £7m.

The Croxley Rail Link was also given the go-ahead this year and will bring a new London Underground station to within a three minute walk of the Watford site, which will greatly help patients, staff and visitors alike.

Emergency preparedness and resilience

Emergency preparedness and resilience is vital to the operational running of our hospitals. We need to be ready to respond to any situation, and to ensure that vital services are maintained. This might be anything from an internal power or equipment failure, to an external major incident like a serious road traffic accident involving multiple casualties, or a chemical spill.

We have in place plans that are fully compliant with the requirements of the NHS Commissioning Board Emergency Preparedness Framework 2013 and associated guidance.

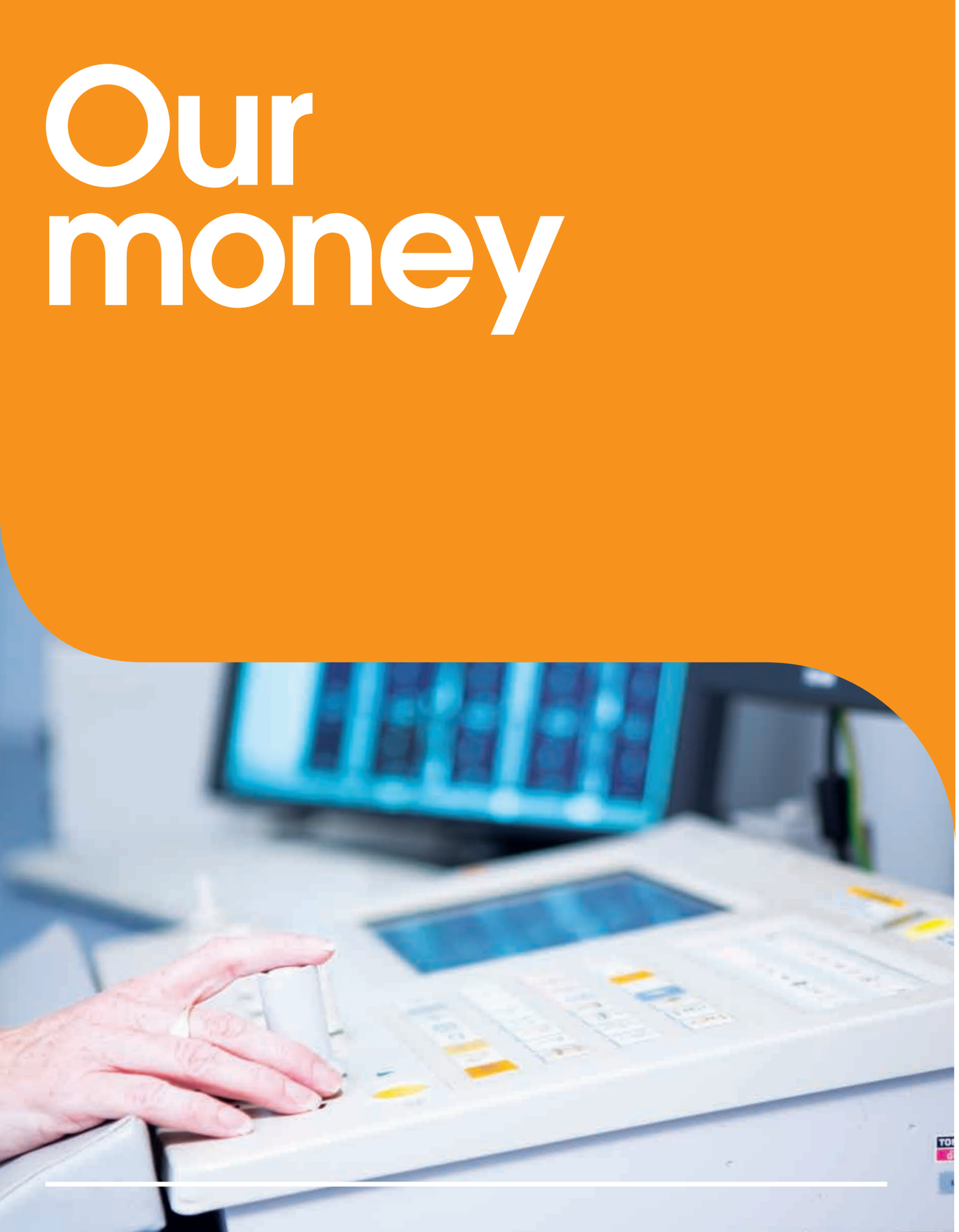
As part of our business continuity and internal incident planning, in 2014/15 we carried out planned exercises to test our response to emergency conditions, providing operational experience and live training.

We will continue this work with a structured programme of scenario-based exercises such as a chemical or biological decontamination, power and other utility failures, severe weather and loss of communications, working with partner organisations for Hertfordshire-wide multi agency responses.

In addition to the planned exercises we will continue to learn from real time live incidents like a burst water main, or an equipment failure, which require our emergency plans to be put into action.

“This has been an extremely busy year for our hospitals and I would like to thank all our staff for their tremendous hard work, and for the commitment they show, every day, to provide the very best possible care for our patients – Jac Kelly”

Our money



The financial headlines

After ending the 2013/14 year with an income and expenditure deficit of £13.4m, the Trust started the 2014/15 year with a plan to end the year with a deficit of no greater than £14.0m. However the Trust signalled early into the year that treating the predicted volume of patients safely and maintaining the deficit to £14m would prove to be a significant challenge most notably because: (a) the plan relied on being paid for emergency activity at levels much higher than tariff rules allowed. (This was yet to be agreed with Commissioners) and (b) the Trust had identified the need for significant investment in a programme of transformation to underpin risk management, operational delivery and the development of an efficiency programme. In response to these and other challenges the Trust secured non recurrent Provider Deficit Funding of £12.0m.

The Trust ended the 2014/15 year with a deficit of £13.8m. The cash flow consequences of the deficit and the Trust's capital programme left the Trust needing to apply to the Independent Trust Financing Facility for additional loans (£11.1m[1] to support capital expenditure over the 2014/15 and 2015/16 years including critical infrastructure works) and Public Dividend Capital £22.7m to support cash consequences of revenue trading.

All of this performance was underpinned by a much better developed efficiency programme that, despite a late start, delivered savings of £9m in year. The Trust appointed Ernst & Young LLP (EY) to support the Trust to both maximise delivery in 2014/15 and to support improved performance, and financial sustainability, in future years. As a consequence, planning for 2015/16 began much earlier in the year; opportunities were identified and worked up and the Trust is forecasting a significant improvement in delivery.

In recording such a large deficit for the 2014/15 year the Trust was unable to break-even over even a 5 year period, taking one year with another. The financial statements, on note 36, shows the cumulative breakeven position of -4.1%, which is not consistent with the breakeven duty imposed on NHS Trusts.

The Trust spent £17.0m on capital against a plan of £17.5m, thus underspent on the programme by £0.5m. Good progress has been made on the estates backlog maintenance programme and in replacing much of the Trust's ageing medical equipment. In total the Trust spent £8.2m on its backlog maintenance programme and £3.2m on new and replacement medical equipment.

Financial forecasts suggest that the Trust may reach a deficit of £32.8m by the end of the 2015/16 year. The increase is mainly due to the Trust's reliance on significant amounts of non-recurrent income in 2014/15 and a large increase in the cost of clinical negligence scheme contributions to the NHS Litigation Authority. The plan includes saving programmes forecast to reach £12m and a capital expenditure plan of £18.2m. The plan will be subject to finalising plans for a potential reconfiguration of Watford General Hospital's A&E department and operating theatres. This size of deficit will require additional revenue cash support of £35.5m to maintain liquidity. In addition the Trust will seek external finance to support its capital expenditure programme.

Delivery of savings each year becomes increasingly difficult however this is a requirement across all NHS organisations. The Trust has strengthened its savings programme through the appointment of specialist external consultancy and without compromising patient safety or quality of care hopes to restore confidence in the Trust's ability to achieve its savings target.

[1] £2.4m of this loan was drawn down for 2014/15.

Financial Risk

Set out below is the Trust's performance for the year against the financial indicators used by the Trust Development Authority. The Board uses this each month, together with other information to manage its finances. An overall score of less than 3 is unsatisfactory. A review is underway as to how NHS healthcare across West Hertfordshire is best provided. The outcome of this will enable the Trust to prepare longer term financial plans to address its overall financial risk score of 1. This will include addressing the two main causes that of a deficit financial plan and poor liquidity.

Financial Risk Ratings

March 2015

Criteria	Metric	Weight	5	4	3	2	1	Annual Plan 14/15	YTD Risk ratings 14/15	Forecast Risk ratings 14/15
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	1	1	1
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	1	1	1
Financial efficiency	Net return after financing %	20%	3	2	-0.5	-5	<-5	1	1	1
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	1	1
Liquidity	Working capital balance x 360 / Operating expenses	25%	0	-2	-7	-12	<-12	1	1	1
Average	Weighted Average rating							1.0	1.0	1.0
Overriding rules	Limit due to overriding rules							1	1	1
Overall rating	Financial Risk Rating For Trust							1	1	1

Internal audit

The Trust's internal auditors are BDO LLP. With Trust input, BDO develops an annual plan of work that is approved by the Trust's Audit Committee. Progress reports highlighting any significant weaknesses identified are reviewed at each committee meeting to ensure action is taken to resolve these.

The head of internal audit (BDO LLP representative) is shown in the annual governance report on page 54.

External audit

The Audit Commission has a statutory duty to appoint external auditors to local government and NHS bodies under Section 3 of the Audit Commission Act 1998. The Trust's external auditors are Grant Thornton UK LLP.

In the event the Trust appoints Grant Thornton for work other than that of external audit, the expense is shown separately in the Annual Accounts as "other auditor's remuneration" (see note 8 of the Trust's accounts). Any such work is subject to competition and assurance obtained that there is no conflict of interest with the role of external auditor.

Related parties

The Trust has received declarations of all Board and Trust Leadership Executive Committee (TLEC) members for any conflict of interest in conducting the NHS business. Any member associated with the organisations will be shown in the register of interest held by the Corporate Affairs Office. Note 33 of the Trust's accounts sets out the transactions with related parties. These are mainly other NHS bodies commissioning patient activity provided by the Trust or other government bodies with which the Trust has financial transactions. There are no related transactions involving any Board or TLEC members.

Better payment practice code

The Trust strives to pay its suppliers on time. Performance in achieving this is set out in the annual accounts note 11.

Exit packages agreed in 2014-15

There were 2 agreed exit packages agreed in 2014-15 further details are included in note 10.4 of the accounts.

Fraud 2014-15

Counter fraud policy is available on Trust's intranet and internet for staff to follow advice on any suspected fraud. The Trust has a nominated local counter specialist who assists the Chief Financial Officer in raising awareness and dealing with fraud. More information on the fraud policy can be obtained from the Trust offices at Watford General Hospital. The Trust has developed an action plan to improve its counter fraud effectiveness after consulting with NHS Protect.

Sickness Absence Data

Sickness absence data for the Trust is 8.32 average working days lost per staff in comparison to 7.56 in 2013-14. This is reported in note 10.3 of the accounts.

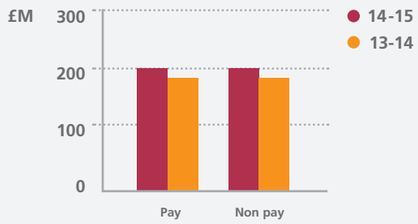
Pensions 2014-15

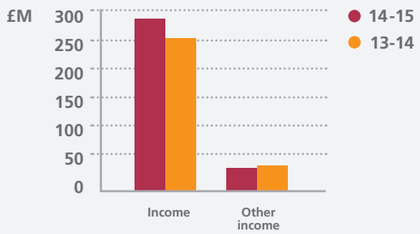
Past and present employees are covered by the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Further details can be found in note 10.6 of the accounts.

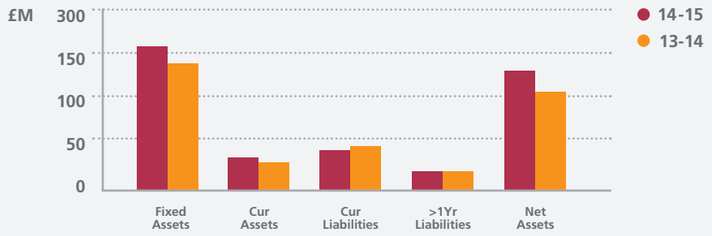
Income generation activities

The Trust does not conduct material income generation activities outside of its usual business, where the aim is to achieve profit. Any contribution made on these activities is used in patient care.

Analysis of Income and Expenditure and Statement of Financial Position as at 31 March 2015







Annual Governance Statement 2014/15

1. Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that support the achievement of West Hertfordshire Hospitals NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the Trust is administered prudently and economically, and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum, including recording the stewardship of the organisation to supplement the annual accounts.

In the delivery of my responsibilities and objectives, I am accountable to the Board and my performance is reviewed regularly and formally by the Chairman on behalf of the Board. I have processes in place to ensure good working arrangements with partner organisations and the NHS Trust Development Authority.

2.The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the policies, aims and objectives of West Hertfordshire Hospitals NHS Trust,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in West Hertfordshire Hospitals NHS Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

3. Governance

The governance framework of the organisation

An integrated corporate and clinical governance structure has been established within the Trust to ensure that the organisation is able to facilitate the system of internal control. The governance structure has continued to operate throughout the year. This brings together all the elements of risk management and clinical governance under a single co-ordinated management structure.

To ensure the corporate and clinical governance structure continues to meet all the needs of the Trust, it will be fully reviewed and updated in 2015/16.

The Trust's divisional structure was reviewed and updated during the reporting year. In addition to its four established clinical divisions, namely medicine, surgery and anaesthetics, clinical support and women and children's, the Trust introduced a pilot of a new clinical division to specifically oversee unscheduled care services. Cancer services were also moved to form part of the surgery and anaesthetics division to improve focus and leadership. Each clinical division is managed by a triumvirate of a divisional director, divisional manager and head of nursing.

The Trust Board met on a monthly basis and consisted of the Chair, five Non Executive Directors, the Chief Executive and four Executive Directors. The Chief Information Officer, Director of Transformation, Director of Human Resources, Director of Governance and Corporate Affairs and Director of Communications were also in attendance at Board meetings.

A central register of interests was presented at each Board and Committee meeting and members were asked to declare any conflicts with agenda items.

The Trust undertook a 360 degree appraisal of all Board members in 2013/14 which informed the Board Development Programme in 2014/15. A further 360 degree review will be undertaken in May 2015, feedback from which will be used to monitor improvement.

During the reporting year, a series of dedicated development sessions were held to consider key areas of strategic significance and risk. Topics included reviewing the Trust's strategic objectives and risks and understanding the impact of behaviour and decisions upon frontline culture.

Two specific facilitated Board development sessions focussed on the process of the development of a comprehensive Board Assurance Framework to provide the Trust with an effective management system of the significant risks that could impact on the delivery of the annual and strategic objectives. Work will continue in 2015/16 to redefine the Board Assurance Framework further.

The Board also observed and shadowed members of staff in clinical areas and departments across the three hospitals. In addition, a patient was invited to attend each Board meeting to inform the Board of their experience.

The Board has also been observed on a number of occasions by the Good Governance Institute, an external company engaged to deliver elements of the Board Development Programme. Feedback from the observations has been largely positive. Behaviours were reported as 'good', with Board members understanding their roles and endeavouring to improve the performance of the Trust and outcomes for patients. The meetings were reported as 'well managed', with Board reports significantly improving throughout the year and substantial progress made in aligning the business cycle with the strategic objectives of the Trust. However, it was recognised that there were still issues to resolve and the Trust was endeavouring to address these.

In response to continual review of its effectiveness, the Board undertook a number of initiatives to improve strategy development whilst assuring itself of the performance of the Trust. It did this by:

- improving the Integrated Performance Report which was presented at each Board meeting;
- revising the structure of the Board agenda and improving the quality of Board reports;
- arranging a series of Board development sessions to debate key strategic and development issues.

The Trust's strategic objectives were reflected in each of the Executive Directors' personal objectives and appraisals. These objectives were monitored by the Chief Executive using the Trust's valued-based appraisal system.

As a Trust, we are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the Trust.

Changes to the Board

In 2014/15, the Trust strengthened its leadership with the appointment of a new Board and executive team. The changes are detailed below.

- Louise Gaffney, Director of Strategy and Service Improvement took up a year long secondment as a Programme Director with the Herts Valleys Clinical Commissioning Group in April 2014;
- Paul Jenkins left as Director of Partnerships and Performance in April 2015 and was replaced by Lisa Emery in the role of interim Chief Information Officer;
- Don Richards joined as Chief Financial Officer in June 2014, replacing Clare Stafford, who had been Acting Chief Financial Officer since March 2014;
- Paul Cartwright started in the role of Non-Executive Director in June 2014. He replaced Katharine Charter who stood down as a Non-Executive Director in January 2014;
- Professor Tracey Carter started as Chief Nurse in August 2014 and replaced Jackie Ardley who was in the role on an interim basis since winter 2013. Jackie took on the role of Director of Clinical Governance on a fixed term basis until April 2015;
- Paul da Gama started as Director of Human Resources in August 2014. He replaced Anne Robson who was in the role on an interim basis from winter 2013.
- Natalie Forrest left her post as Acting Chief Operating Officer in September 2014. Karen Hayes and Ed Donald worked as Chief Operating Officers on an interim basis, until Lynn Hill joined as Deputy Chief Executive in October 2014;
- Helen Brown started in the role of Director of Transformation in September 2014; replacing Sara Coles who covered the position on an interim basis from April 2014;
- Non Executive Director, Stephen Hay left in December 2014 following completion of his fixed term assignment. Jonathan Rennison took over the role of Senior Independent Director from Stephen in January 2015;
- Jac Kelly joined in January 2015, replacing Samantha Jones as acting Chief Executive until a substantive appointment is made.

In addition, the Trust recruited a new substantive company secretary in February 2015.

Board meetings

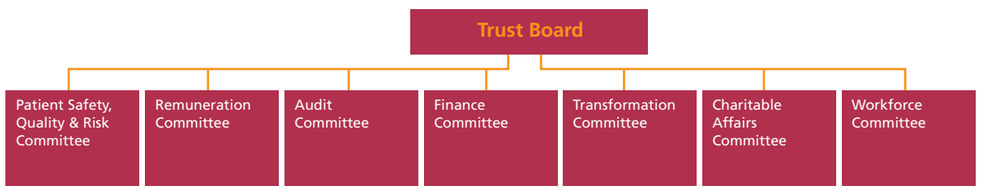
The Board met publicly ten times during the year. A breakdown of attendance of Board meetings is presented below:

- Chairman (attended 10 out of 10);
- Non - Executive Director - Jonathan Rennison (attended 9 out of 10);
- Non - Executive Director - John Brougham (attended 10 out of 10);
- Non - Executive Director - Ginny Edwards (attended 9 out of 10);
- Non - Executive Director - Phil Townsend (attended 10 out of 10);
- Non - Executive Director - Stephen Hay left December 2014 (attended 3 out of 7);
- Non - Executive Director - Paul Cartwright from June 2014 (attended 8 out of 8);
- Chief Executive (attended 10 out of 10);
- Deputy Chief Executive/Chief Operating Officer (attended 10 out of 10);
- Medical Director (attended 8 out of 10);
- Chief Nurse (attended 9 out of 10);
- Chief Information Officer/Director of Performance (attended 7 out of 10);
- Director of Transformation/Director of Strategy (attended 6 out of 10);
- Director of Human Resources/Director of Workforce (attended 9 out of 10);
- Director of Governance – from August 2014 (attended 3 out of 6);
- Chief Financial Officer/Director of Finance (attended 10 out of 10);
- Director of Communications and Corporate Affairs (attended 7 out of 10).

Committees of the Board

To support the Board in discharging its duties effectively, a number of Committees of the Board were in place during 2014/15 (see figure 1). These were constituted as key assurance Committees under the Code of Governance. An annual review of the terms of reference and work plan for each Committee was undertaken to ensure they continued to meet all requirements.

All Committees were chaired by a Non-Executive Director.



Audit Committee

The Audit Committee is established to critically review governance and assurance processes on which the Board places reliance.

The Committee met six times during the year. During the year, the Chair of the Audit Committee completed his fixed term assignment and a new Chair was appointed.

A breakdown of attendance of Board meetings is presented below:

- Non - Executive Director - Stephen Hay left December 2014 (attended 4 out of 5);
- Non - Executive Director - Paul Cartwright from June 2014(attended 4 out of 5);
- Non - Executive Director - Jonathan Rennison (attended 5 out of 6);

Key areas of focus in 2014/15 included:

- Finances, losses and compensations, gifts and hospitality;
- Clinical audit plan;
- Counter fraud service;
- Risk management strategy;
- Internal and external audit reports;
- Review and recommendation for approval of the annual accounts, annual governance statement and quality account.

In addition to the work listed above, the Audit Committee played a key role in the development of the Board Assurance Framework. To gain assurance that the Framework reflects the high risks to the Trust not achieving its strategic objectives, a benchmarking exercise will be carried out to review whether the risks identified within the Assurance Framework link with the Trust's risk register. The results of this exercise will be presented to the Audit Committee. Going forward, this review will be undertaken bi-annually and become part of the Audit Committee's work plan.

Remuneration Committee

The Remuneration Committee is established to review the remuneration, terms and conditions and performance of the Executive and Senior Managers.

The Committee meets on an ad hoc basis, meeting twice in 2014/15. A breakdown of attendance is presented below:

- Non - Executive Director - Phil Townsend (attended 2 out of 2);
- Non - Executive Director - Paul Cartwright from June 2014 (attended 2 out of 2);
- Non - Executive Director - Jonathan Rennison (attended 2 out of 2);
- Non - Executive Director - John Brougham (attended 2 out of 2);
- Non-Executive Director - Stephen Hay left December 2014 (attended 1 out of 1);
- Director of Workforce – (attended 2 out of 2).

Charitable Funds Committee

The Charitable Funds Committee is established to ensure that all charitable funds received by the Trust are used in line with Charitable Commission requirements.

The Committee met three times during the reporting year. A breakdown of attendance of Committee meetings is presented below:

- Non - Executive Director - Johnathan Rennison (attended 3 out of 3);
- Non - Executive Director - Ginny Edwards (attended 1 out of 3);
- Non - Executive Director - Paul Cartwright started June 2014 (attended 3 out of 3);
- Chief Financial Officer/Director of Finance (attended 3 out of 3).

Patient Safety, Quality and Risk Committee

The Patient Safety, Quality and Risk Committee is established to ensure that good and appropriate risk and governance structures, processes and controls are in place.

The Committee met ten times during 2014/15. A breakdown of attendance of Committee meetings is presented below:

- Non - Executive Director - John Brougham (attended 10 out of 10);
- Non - Executive Director - Ginny Edwards (attended 8 out of 10);
- Chairman (attended 10 out of 10).

Finance Committee

The Finance Committee is established to provide the Board with assurances that the Trust's financial expectations are met.

The Committee met ten times during the reporting year. A breakdown of attendance of Committee meetings is presented below:

- Non - Executive Director - John Brougham (attended 10 out of 10);
- Non - Executive Director - Phil Townsend (attended 9 out of 10);
- Non - Executive Director - Stephen Hay left December 2014 (attended 5 out of 7);
- Chairman (attended 9 out of 10);
- Chief Executive (attended 10 out of 10);
- Deputy Chief Executive/Chief Operating Officer (attended 6 out of 10);
- Chief Financial Officer/Director of Finance (attended 10 out of 10).

At the end of 2014/15, the Board reviewed the role of the Finance Committee and expanded its area of responsibility to include performance. The terms of reference were amended and the name changed to the Finance and Performance Committee.

Workforce Committee

The Committee is established to provide the Board with assurance concerning all aspects of workforce, organisational development and learning.

The Committee met six times during the year. A breakdown of attendance of Committee meetings is presented below:

- Non - Executive Director - Ginny Edwards (attended 6 out of 6);
- Non - Executive Director - Jonathan Rennison (attended 4 out of 6);
- Non - Executive Director - Paul Cartwright from June 2014 (attended 4 out of 5);
- Chairman (attended 3 out of 6).

Transformation Committee

The Transformation Committee was established in 2014/15 in replacement of the Risk Summit Response Committee. The Transformation Committee was established to provide the Board with an oversight of strategic planning and effectiveness of the Transformation Programme. The role of the Committee was reviewed at the end of 2014/15 and it was agreed that, despite operational actions being placed with the divisions, the Committee continued to provide a valuable oversight to the Board.

The Committee met three times in 2014/15. A breakdown of attendance of Committee meetings is presented below:

- Non - Executive Director - Ginny Edwards (attended 2 out of 3);
- Non - Executive Director - Phil Townsend (attended 3 out of 3);
- Chairman (attended 3 out of 3);
- Chief Executive (attended 3 out of 3);
- Director of Transformation/Director of Strategy (attended 1 out of 3);
- Chief Nurse (attended 1 out of 3);
- Director of Human Resources/Director of Workforce (attended 2 out of 3);
- Chief Financial Officer/Director of Finance (attended 3 out of 3);
- Director of Communications and Corporate Affairs (attended 2 out of 3).

Reporting to Board

The minutes and a Chair's summary of all of the Committees were submitted to the Board following each meeting.

Over the year, the Trust has further developed the use of an integrated performance report (IPR) for monitoring performance. The IPR presents quality, operational (including elective waiting times) and financial performance data. This will be further developed in the forthcoming year.

The Trust assures the quality and accuracy of elective waiting time data through the use of automated patient tracking lists which include the provision of prospective patient level information and a series of data quality reports. Assurance is received through weekly patient access meetings and at monthly Divisional performance reviews.

Performance against NHS Operating Framework

In 2014/15 we continued to work with our partners in primary, community and secondary care to ensure service provision meets the needs of our patients through all settings. Our key partners included Herts Valleys Clinical Commissioning Group (Herts Valleys CCG), who commission more than 96% of our activity, other CCGs and the NHS England, which commissions all specialised services from the Trust.

The Trust is required to meet national standards as defined within the NHS Operating Framework 2014/15. Our performance is monitored by the Trust Development Authority, Herts Valleys CCG, the Department of Health, NHS England and the Care Quality Commission. The core group of indicators and measures used by each body and the Trust's performance against these is summarised below. Performance against the targets relevant to the Trust can be found below:

Indicator	National Standard	West Herts Performance	Actions being taken to improve performance
95% of patients should be treated, admitted or discharged in 4 hours in accident and emergency	National target was for over 95% patients to be within 4 hours	91% - Under achieved	• Redesign and development of unscheduled care services including: • improved A&E facilities • a GP-led urgent care centre • a single, expanded pit-stop area • dedicated, co-located emergency and ambulatory care facilities for children and young people • expanded emergency surgery ambulatory care services • Strengthened operational policies and patient-tracking processes
Incidence of C.difficile should be identified and numbers minimised	Trust target was to have fewer than 31 cases of C. difficile through the year	23 cases recorded - Achieved	
Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have zero cases	Under achieved by 1 case	The Trust's Infection Prevention and Control Plan includes comprehensive actions to manage and monitor the prevention and control of infection The action plan is reviewed monthly by the Infection Prevention and Control Panel
All cancers – patients should have a maximum wait of 14 days for all urgent referrals of suspected cancer and referrals for breast symptoms	National target was to see 93% of those referred within 14 days	Urgent referrals, 91.6% seen within 14 days - Under achieved	
		Breast symptomatic patients, 67.6% seen within 14 days – Under achieved	The Trust will continue to work with the NHS Intensive Support Team to model demand and capacity for all tumour sites and develop actions plans to improve cancer patient pathways, eliminate bottlenecks and deliver sustained performance.
All cancers – patients should have a maximum wait of 31 days for diagnosis to first treatment	National target was to have 96% of patients seen within 31 days	95.6% patients seen within 31 days - Under achieved	
All cancers – patients should have a maximum wait of 62 days between urgent GP referral or screening service to first treatment	National target was to see: 90% of those referred by the screening service; and 85% referred by GPs	86.6% of patients referred by screening service seen within 62 days - Under achieved 79.7% of patients referred by GPs seen within 62 days – Under achieved	
All cancers – patients should have a maximum wait of 31 days for second or subsequent treatment	National target was to have 94% patients seen within 31 days for surgery and 98% for anti cancer drugs.	96.1% patients for surgery seen within 31 days – Achieved 100% of patients for anti-cancer drugs seen within 31 days - Achieved	
Maximum wait time of 18 weeks referral to treatment – admitted patients treated	>90%	69.9% - Under achieved	The Trust's operational recovery plan includes a range of short, medium and long term actions which support the transition to a compliant position by the end of 2015/16. An improvement team is in place with regular reporting from ward to board. The Trust will continue to work closely with Herts Valleys Clinical Commissioning Group to streamline planned care services in the future and introduce 'one stop' services where appropriate.
Maximum wait time of 18 weeks referral to treatment – non admitted patients treated	>95%	86.7% - Under achieved	
Maximum wait time of 18 weeks referral to treatment – patients not yet treated	>92%	84.2% - Under achieved Please note, the Trust was working to a planned under achievement in order to achieve a target to reduce its backlog by the end of the first quarter of 2015/16.	

Low hospital mortality (death) rates is a recognised indicator of safe and effective clinical services and West Herts' HSMR is 'statistically lower than expected'.

Development of a Board Assurance Framework has been ongoing throughout 2014/15. The format and the governance process for the BAF will be further reviewed and developed in 2015/16 to ensure that effective controls are in place to manage the risks to the organisation achieving its principle objectives.

Through the Board business cycle, the Board also received reports throughout the year on:

- Serious incidents and Never Events;
- National patient and staff surveys;
- Patient experience, including information control, staffing levels and safeguarding;
- NHS Trust Governance Declaration;
- Health and safety risk report;
- Patient-led assessment.

4. Capacity to handle risk

As Accountable Officer, I have overall responsibility for risk management, with the Director of Governance taking a lead in this area. Each Executive Director is responsible for managing the risks within their area. Each Division has an identified risk lead who works in conjunction with the Trust's Risk Managers to develop and oversee the risk management process.

The Trust has continually developed its risk registers in 2014/15. The risk register assists with the development of an organisation-wide risk awareness culture and enables risk management decision making to occur as near to the risk source as possible. This process will be reviewed in 2015/16 to ensure that it still meets our requirements.

A process of review and challenge of divisional risks within the corporate risk register was conducted through a Risk Review Group, which reports into a Quality and Safety Group, and ultimately into the Patient Quality Safety and Risk Committee.

A common risk score matrix was used by the Trust with risks logged onto 'local' and 'corporate' risk registers. This tool enabled staff to quantify risks in their respective areas and decide what action, if any, needed to be taken with a view to reducing or eliminating those risks.

Going forward, the newly established Board Assurance Framework will be further developed to provide the Trust with a comprehensive method for the effective and focused management of significant risks that could impact on the delivery of the Trust's annual and strategic objectives. Through this framework the Board will gain assurance from the appropriate Executive Director that risks are being appropriately managed throughout the organisation.

To support the organisation to maintain good practice in risk management, a multi-channel approach to staff training has been adopted. Risk management training was included in the Trust's induction and mandatory training programme, which all staff are expected to attend annually. In addition to the formal processes, good practice and learning was shared with all staff though governance sessions and informal methods such as internal e-bulletins and the intranet.

5.The Risk and Control Framework

A new Quality Governance and Risk Management Strategy was introduced in 2014/15 and will be further refined and embedded into the organisation over the coming year.

A comprehensive list of key policies was in place in 2014/15 which supported the risk management framework and were accessible via the Trust's intranet site. These included:

- Information Risk Management Policy;
- Incident and Serious Incidents Reporting and Management Policy;
- Risk Management Strategy;
- Management of Violence and Aggression Policy;
- Policy for the Requirements of Workplaces;
- Request for staff appointment DBS risk assessment;
- Security Policy.

Data security risks are managed through strict controls on the management of data. Policies were in place to provide guidance on the use of data within the organisation and an approval process to agree movement of data.

Assurance of effective controls for information governance was provided through the completion of the Information Governance Toolkit.

At year end, the Trust had achieved an overall score of 67% (unsatisfactory) against the requirements of the Information Governance Toolkit. This was as a result of two requirements failing to meet the necessary attainment level. The Trust is undertaking the necessary work to meet the required level, ahead of a re-submission in July 2015.

In 2014/15 the Trust reported a total of six Level 2 (reportable to the Information Commissioners Office (ICO) information governance (IG) breaches. No further action was taken by the ICO in relation to these reported incidents.

In December 2014, the Trust undertook an external review of its Information Governance systems and processes and has now adopted recommendations from this report, including the establishment of an Information Governance Steering Group. This group includes representation from across the organisation to drive forward adoption of best practice and improve training uptake and IG awareness across the Trust.

The current CNST (Clinical Negligence Scheme for Trusts) levels for the Trust are NHSLA Level 2.

During the year, the Trust will assess itself against Monitor's Well-led framework for governance reviews. A dedicated Board development session will be held in 2015/16 to undertake this self assessment and an action plan will be developed to target areas highlighted as requiring improvement.

The Trust was subject to reviews of its management and governance processes by internal auditors. The following reviews received limited assurance during the year.

Area reviewed	Actions being taken
Complaints and incidents (draft report received)	The Trust has an action plan in place to improve performance in dealing with complaints. The Trust will also strengthen how it learns from complaints and serious incidents by introducing quarterly 'lesson learned' reporting to the Patient Safety Quality Committee.
Contract management	A number of recommendations have been implemented, including identifying accountable managers for each department who authorise any variations to contracts. Also suppliers have been informed that conditions of non payment will be imposed where variations are carried out without appropriate authorisation.
Private patient income	As from 14 May 2015, the Trust agreed to permanently discontinue its private obstetric service to allow maternity staff to focus on NHS patients. The Trust still continues to offer mothers a choice of NHS or amenity beds following the birth of their baby.

The outcome of all reviews were presented to the Audit Committee, acting on behalf of the Board.

The Trust had a clear framework in place to ensure the effective monitoring and control of the use of Trust resources.

Public stakeholders were involved in managing risk through members of Healthwatch and the Patients' Panel attending the Patient Safety, Quality and Risk Committee. The Trust ensured that all cost improvement measures, service changes and developments received clinical sign-off by the Medical Director and Chief Nurse.

Control measures were in place to ensure that the Trust was compliant with all its statutory requirements, including the equality, diversity and human rights legislation. The utilisation of quality and diversity impact assessment is the norm with all Trust policies subject to review.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures were in place to ensure all employer obligations contained within the Scheme regulations were complied with. This included ensuring that deductions from salary, employer's contributions and payments into the scheme were made in accordance with the Scheme rules and that member's pension scheme records were accurately updated in accordance with the timescales detailed in the regulations.

The Trust was registered fully with the Care Quality Commission (CQC), without compliance conditions on 1 April 2010. It is registered for eight regulated activities. The Trust continued to monitor compliance against all the essential standards of quality and safety on an on-going basis and maintained an improved CQC Quality Risk Profile (QRP).

The CQC Intelligence Monitoring Report categorises trusts into one of six summary bands, with band 1 representing highest risk and band 6 with the lowest. These bands are assigned based on the proportion of indicators that have been identified as 'risk' or 'elevated risk' or if there are known serious concerns. In 2014/15 the Trust progressed from a band 3 (above 4.5%) into a band 5 (above 2.5 %).

During 2015/16, the Trust will seek to improve further upon this performance with regulators such as the Care Quality Commission, NHS Litigation Authority (NHSLA) risk management standards and, continue a programme of self-assessment against the standards required by Monitor.

The Trust did not receive any improvement notices during 2014/15 nor had any risk assessments or reports published.

In November 2014, the Care Quality Commission (CQC) made a routine unannounced inspection of Watford Hospital. The outcome of the visit revealed that the Trust had met two out of the seven standards and needed to take action against five standards. None of the standards were assessed with a rating of a need for enforcement action.

The inspectors were complimentary of much of what they saw, including staff being kind and compassionate in their approach to patient care, patients' dignity being respected and the hospital seeking meaningful feedback from patients and their advocates. Even in areas where we had to take action to meet the required standard, there was praise for improvements the Trust had made in recent years.

During the inspection, concerns were raised by the CQC in relation to the Trust's process surrounding the application of the Mental Capacity Act and ensuring any Deprivation of Liberty Safeguards were adhered to. In response to the report, the Trust undertook detailed audits across all clinical specialties and hospital sites to ensure that all patients and especially vulnerable patients were being well cared for. A detailed action report was produced, which was shared with the CQC.

The Trust was also inspected in April 2015 as part of the Care Quality Commission (CQC) new acute hospital inspection model. In line with its process, the CQC will issue a formal report within two to three months of the visit and the Trust will respond to the findings at that time. In the meantime, some immediate feedback was given, including praise for the quality of care provided by the paediatric service and the dual frailty service at Watford Hospital. In addition, the inspection team gave feedback aimed at helping the Trust to improve its services. As a result, the Trust made some changes, including to the triage process within the accident and emergency department at Watford and the suspension of the private obstetric service to allow the maternity team to focus on NHS patients.

The Trust introduced a daily patient safety meeting, known as Onion, in 2013/14, the aim of which is to encourage staff to raise concerns and report incidents. This meeting continued to prove extremely successful in 2014/15 in highlighting and addressing issues. It was Highly Commended in the Health Service Journal Awards in 2014/15 and was mentioned as best practice in the Department of Health's response to the Francis Report. As part of the Trust's Quality Governance Improvement plan, over the past year substantial development has taken place in the field of Clinical Audit. This included the redevelopment of the Clinical Audit Strategy, the creation of a dedicated intranet site, the redesign of tools used to support clinical audit and strengthening of the Clinical Audit team.

The Trust's financial risk rating was one (rated one to five, where one represents the highest risk and five the lowest) and 66% of a cost improvement programme was delivered.

The formulation of a Quality Account for 2014/15 was led by the Director of Governance and was designed to meet all relevant Department of Health and Monitor requirements. It provides a 'look-back' against identified priorities and overall progress with improving quality (safety, effectiveness and experiences). It also provides a look forward to future priorities.

The 2014/15 Quality Account will be published in June 2015. It will be available to download at www.westhertfordshirehospitals.nhs.uk.

6. Serious incidents

During 2014/15 the redevelopment of the Trust's incident reporting system continued, with the transition to an online system. Full redevelopment is expected to be completed in 2015/16.

There was a sustained focus on ensuring reported incidents were investigated locally and lessons were learnt to reduce the risk of reoccurrence. The Trust worked closely with the Herts Valleys Clinical Commissioning Group to provide assurance that serious incidents are being addressed and within an appropriate timescale. The management of all incidents were reported to the Board on a monthly basis.

During the year, the Trust reported 207 potential Serious Incidents which was an increase of approximately 30 from the previous year. This reflected an internal focus which had been put on raising the profile of incident reporting.

The highest number of potential Serious Incidents was in the category of Hospital Acquired Pressure Ulcers. To help to reduce the number of Hospital Acquired Pressure Ulcers, the Trust embarked on an improvement programme, which included the launch of the 'Best Shot' campaign, a review and update of all pressure ulcer documentation and the introduction of a campaign which educated staff to look and inspect heels. Furthermore, the Trust's incident reporting system is now being used to collect and validate all pressure ulcers.

Of the 207 potential Serious Incidents, three potential Never Events were reported in 2014/15. The outcome of two of the Never Events is still under investigation with the Clinical Commissioning Group. Two related to a swab retained after surgery and the third to the use of an incorrect prosthesis. All Never Events were fully investigated and robust actions have been introduced to reduce the risk of reoccurrence.

A summary of the actions taken is detailed below.

Serious Incident	Actions undertaken
Pressure ulcers	• Waterlow risk assessments carried out • Patients informed regarding risk factors of developing pressure damage • Awareness raised with staff of the need to document to a high standard • Review of all documentation
Venous thrombo embolism (VTE) – prevention and treatment	The Trust declared a series of thematic root cause analysis on failures to comply with the VTE prevention and treatment policy. The full investigation is not yet complete.
Unexpected death (note – this is not ***preventable*** death)	• Fractured neck of femur pathway to be reviewed with regard to enabling junior doctors to prescribe the correct pain relief • National early warning scores (NEWS) charts to be used as a guide and staff to escalate if the NEWS chart does not appear to reflect the clinical condition of the patient they are assessing • Care records to clearly reflect what has being happening with the patient. • Additional training to be provided to nurses to help them to recognise a deteriorating patient • Raise awareness of tools available to support staff with regard to NEWS and sepsis.
Slips, trips and falls	• Review and update of the falls prevention policy • Staff to contact the falls nurse specialist at the earliest opportunity • Where possible avoid moving patients to new areas overnight • Raise awareness that, even in mobile patients, there is still a risk of falling • Patients not to stay in hospital in unfamiliar environments longer than is necessary • Minor injuries unit and urgent care centre to follow the same guidelines and policies as the A&E department
Information governance breach	• Raising staff awareness of the information governance guidelines and policy • Reinforcing information governance compliance via internal communication channels and local staff meetings • Creation of an information governance intranet page • Review of corporate induction and mandatory training, demonstrating real time examples • Senior managers to recognise staff workloads and expected delivery dates • Remote working to be available where appropriate for staff to allow secure working at all times
Infection control	• Staff to be up to date with mandatory training • A programme of deep cleaning to continue • Continue daily and weekly infection control audits • Update infection control polices • Environmental audits to be expanded to include the special care baby unit.

7. Significant issues

Based on my assessment of the assurances and evidence to support the review of the system of internal control for the period 2014/15, a summary of the significant risks and actions taken to address these are detailed below.

Significant risk	Actions taken
Risk that quality and safety of services will not be maintained due to lack of embedded assurance framework, risk register and continued limited internal audit opinion.	The Trust's risk and governance arrangements will be comprehensively reviewed in 2015/16. The risk registers and the Board Assurance Framework will be further developed to ensure the Trust has effective controls in place to manage the risks within organisation.
Risk that quality and safety of services will not be maintained due to residual estates issues – compliance and functional suitability/ capacity issues.	In 2015/16 the Trust will commission a feasibility study that considers the range of options for improving the estate, building from a clearly defined clinical strategy. In the shorter term, an interim estates strategy has been commissioned for 2015/16 and the Trust will continue to address the backlog of maintenance works required.
Risk that quality and safety of services will not be maintained due to inability to recruit, retain and engage an appropriately trained workforce.	The Trust has developed a strategy which identifies actions to improve how it recruits and retains staff. Targeted recruitment will be a key priority in the next 12 months, including participating in external recruitment activities and running an overseas recruitment and workforce integration programme. The Trust also aims to strengthen its internal staffing bank. To support the current workforce to achieve a better work/life balance, the Trust will review its approach to flexible working and look for opportunities to revise shift working arrangements, in particular for highly pressured environments.
Risk to the delivery of the Trust's activity and finance plan including delivery of 2015/16 cost improvement programme.	Despite a large increase anticipated in the Trust's deficit for 2015/16, a steady improvement in performance over the next five years is expected, supported by a robust efficiency programme and a clear strategy for service provision. Following a number of internal and external reviews regarding historical delivery of savings a series of recommendations have been made to improve both the management and performance of the Trust's savings programme. To support internal capacity and capability, an advisory firm has been commissioned to support the Trust to manage the cost improvement programme.
Risk that the cost improvement plan will impact on safety or unacceptably reduce service quality.	Every potential cost improvement plan is reviewed by the Medical Director and Chief Nurse to ensure patient safety and quality is not compromised.
Risk to delivery of emergency care standards due to internal and external factors.	The Trust is working closely with Herts Valleys Clinical Commissioning Group and partners through the whole system resilience group to ensure that a coordinated approach to address pressures and to reduce length of stay.
Risk that the development of a long term clinical finance and estate strategy will be delayed due to internal and external factors.	The Trust has started to develop a new clinical strategy which will consider how it can improve the quality and sustainability of services for patients. The clinical strategy will help to define the Trust's clinical priorities and support the development of long term estates and financial strategies.
Risk that the culture of the organisation does not sufficiently focus on patient safety and quality of service provision.	A programme of work called 'Listening into Action' is underway which aims to engage clinicians to identify and take responsibility for delivering changes to improve staff experience, behaviours and values.
Risk that Board effectiveness is adversely impacted by changes in leadership (Chair and Chief Executive)	A process is underway to recruit substantively to the Chief Executive and Chair roles. Jacqueline Kelly, a highly experienced NHS leader, will continue as Chief Executive until a substantive appointment is made.

The Trust launched a review in November 2013 after it was found that the administrative process being used to monitor patients referred with suspected cancer was not always followed in line with NHS guidelines. This related specifically to patients who had missed their initial outpatient appointment. The review was completed in March 2014. The Trust contacted 807 patients to inform them that their care had been reviewed and that no concerns had been found. In addition, the care of three patients was found to have been compromised.

An external independent investigation was undertaken and the findings published in July 2014 which included 25 recommendations for the Trust, Herts Valleys Clinical Commissioning Group and for other national bodies. The Trust has put a significant number of measures in place to help prevent this kind of incident happening again, including a new overarching cancer improvement plan.

A further review was commenced in April 2014 after concerns were raised about the quality of scans undertaken and/or interpreted by four members of its echocardiogram team. In January 2015, the Trust wrote to 3,312 patients to inform them that a scan of their heart had been reviewed and correctly reported. A further 108 patients returned to be rescanned, and of these, 74 had their care changed. There is no current evidence to suggest that any of these patients suffered long term harm. As a result of the review, a number of changes were implemented, including enhancing the way scans are reported and the introduction of a new assessment to check the competency of staff who undertake/interpret scans.

In addition, the Trust received sentence for five offences under the Health and Safety at Work Act 1974. The offences related to the management of asbestos between 2000 and 2011. As a result, the Trust was fined £55,000 and ordered to pay costs to the Health and Safety Executive of £34,000. Over recent years, the Trust has made significant changes to the way it manages and controls asbestos to ensure the risk of exposure is at the lowest possible level. This included undertaking detailed surveys to show where the asbestos is located, implementing dedicated asbestos management plans, improving training and appointing a dedicated senior manager.

8. Head of Internal Audit Opinion

The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- An assessment of the range of individual opinions arising from risk based audit assignments contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- Any reliance that is being placed upon third party assurances.

Overall, we are able to provide limited assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently. In forming our view we have taken into account that:

- The Trust is currently reporting a deficit of £13.8 million and has significant financial challenges for 2015/16. Some operational targets have been missed, e.g. referral to treatment;
- We have given a number of limited assurance opinions including contract management, agency spend, absence management and private patient income. The Trust's record on implementing audit recommendations is patchy, with some still outstanding from 2012/13;
- However we recognise that the Trust has made improvements in the year, including establishing new risk management processes and strengthening its efficiency programme. These need to become embedded throughout the Trust – if they are, the Trust has the potential to receive a higher rating on its internal controls next year.

9.Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

The overall opinion provided for 2014/15 is one of limited assurance. The Trust has plans in place for a steady improvement to be seen in its financial performance over the next five years. Furthermore, actions are being taken to improve the controls around contract management, agency spend and staff sickness.

Executive Directors have responsibility for the development and maintenance of the system of internal control which provides me with assurance.

Internal audit undertook a risk management assessment in October 2014. This provided a snapshot of the Trust's maturity level of its risk management approach, with a view to highlighting progress and key areas to improve. This assessment concluded that the Trust was at level 2 ('aware') across all elements and on the border of level 3 ('defined') in one risk assessment.

Taking into account the starting point, internal auditors considered the Trust to be in a reasonable position and on a firm foundation on which to build further.

My review is also informed by:

- Accreditation by the external review agencies;
- External audit;
- Health and Safety Executive;
- NHS Security Management Service;
- Local Counter Fraud Specialist Service;
- Care Quality Commission's Essential Standards of Quality and Safety;
- Trust Board;
- Audit Committee;
- Patient Safety, Quality and Risk Committee;
- CQC registration;
- Achievement/maintenance of CNST Level 2 (maternity).

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the above mentioned processes and Committees.

In 2015/16, the Trust will further address areas of weaknesses and ensure continuous improvement of the risk management and clinical governance systems currently in place.

Where internal control issues are identified the risk management process resulted in the establishment of specific action plans to control, as far as is practicable, the risk involved. Management of the implementation of the actions is the responsibility of a designated Executive Director. Progress in implementing these actions plans was monitored by the Risk Management Department, via the Risk Review Group, and the Trust's internal performance management arrangements.

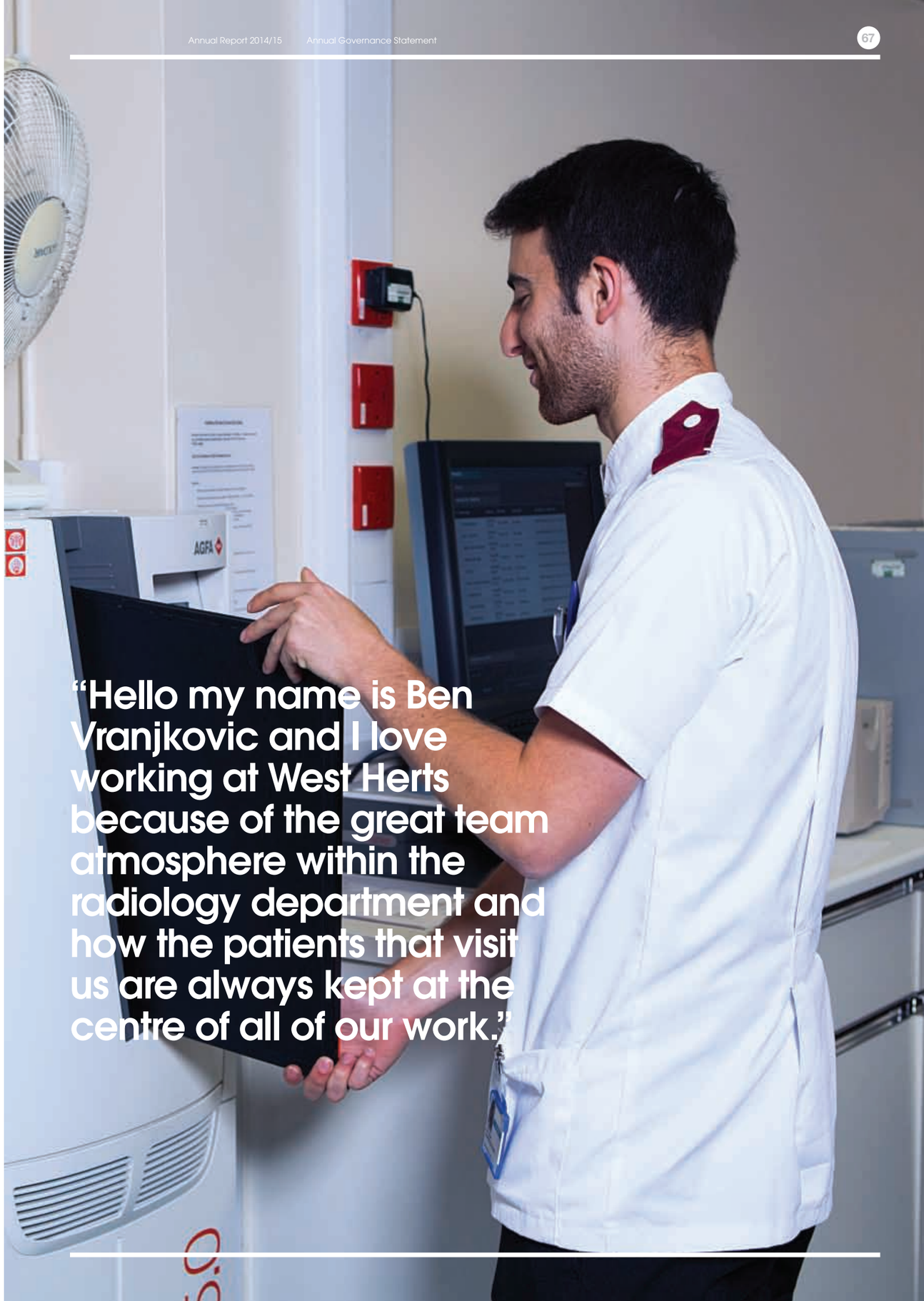
This process will be further strengthened in 2015/16 to ensure a clear line of sight between divisional risk registers and the Board Assurance Framework, which will support the Board to efficiently manage risk.

The Audit Committee received bi-monthly reports from Internal Audit and details of any actions which remained outstanding following previous audit work.

My review confirms that West Hertfordshire Hospital NHS Trust has made progress this year towards enhancing its system of internal control that support the achievement of its organisation's objectives. However the Trust recognises the internal control environment needs to be strengthened further and this work will continue in 2015/16.

Jacqueline Kelly
Chief Executive
On behalf of the Trust Board

Date:



Declarations of Interest

Register of Board Members' Interests as at April 2015

Name	Title	Declared Interests
Jackie Ardley	• Director of Governance	• Director of Jackie Ardley Consulting Ltd
John Brougham	• Non-Executive Director	• Non Executive Director Technetix Ltd • Non Executive Director and Chair of the Audit Committee of eg Solutions plc
Helen Brown	• Director of Transformation	• None
Tracey Carter	• Chief Nurse and Director of Infection Prevention and Control	• School Governor at Pixies Hill Primary School
Paul Cartwright	• Non-Executive Director Committee for The Church Lands, St Albans.	• Trustee and Chair of Finance and Audit • Volunteer for Open Door, St Albans • Chairman of St Peter's Church Yard Project for St Peter's Church, St Albans
Sara Coles	• Interim Transformation Director	• None
Ed Donald	• Interim Chief Operating Officer	• Director of Ed Donald Consulting Ltd
Paul da Gama	• Director of Workforce	• None
Virginia Edwards	• Non-Executive Director	• Trustee Peace Hospice Care • Trustee Hertsmere CAB • Director Edwards Consulting Ltd • Member of Rotary Club of Watford • Associate GGI • Husband Nigel Edwards is CEO of Nuffield Trust from 01/04/14 • Husband Nigel Edwards is a non-remunerated member of the Strategy Committee of Guys and St. Thomas's Charitable Trust • Associate of Waveney Partnership
Lisa Emery	• Chief Information Officer	• None
Natalie Forrest	• Chief Nurse	• None
Louise Gaffney	• Director of Strategy and Service Improvement	• None
Mahdi Hasan	• Trust Chairman	• Projects Advisor to Japan Canada Oil Sands Ltd, Calgary • Member of Consultants of Distinction Forum, The Hague • Volunteer Driver, West Hertfordshire Hospitals NHS Trust
Stephen Hay	• Non – Executive Director	• Associate of Good Governance Institute
Karen Haynes	• Interim Chief Operating Officer	• Director of Haynes Solutions
Jean Hickman	• Trust Secretary	• None
Lynn Hill	• Deputy Chief Executive	• None
Paul Jenkins	• Director of Partnerships	• Trustee for Terrence Higgins Trust
Samantha Jones	• Chief Executive	• Husband Joe Harrison is Chief Executive of Milton Keynes Hospital Foundation Trust
Jac Kelly	• Chief Executive	• None
Jonathan Rennison	• Non-Executive Director	• Director of Yellow Chair Ltd • Fundraising consultancy with the Royal College of Ophthalmologists • Coaching and mentoring services with Sarcoma UK • Change Management fundraiser, vInspired
Don Richards	• Chief Financial Officer	• Director of 7M Ltd
Anne Robson	• Interim Director of Workforce	• None
Clare Stafford	• Director of Operational Finance and Efficiency	• None
Antony Tiernan	• Director of Corporate Affairs & Communications	• Management Committee Member for the Association for Healthcare Communications and Marketing (AHCM) - unpaid
Phil Townsend	• Non-Executive Director	• None
Dr Mike van der Watt	• Medical Director	• Owner and Director Heart Consultants Ltd • Private Practice

Directors' remuneration 2014/15

Name and title		In year start/ leave dates	2014-15 SALARY bands of £5,000	2014-15 Expense payments (taxable) total to nearest £100	2014-15 Performance pay and bonuses bands of £5,000	2014-15 TOTAL bands of £5,000	2013-14 SALARY bands of £5,000	2013-14 Expense payments (taxable) total to nearest £100	2013-14 Performance pay and bonuses bands of £5,000	2013-14 TOTAL bands of £5,000
T. Hanahoe	Chairman	Left Apr 13	-	-	-	-	0-5	0	0	0-5
M. Hasan	Chairman		20-25	1	0	20-25	20-25	0	0	20-25
S. Jones (note 1)	Chief Executive	Secondment from Jan 15	150-155	0	0	150-155	190-195	2	0	190-195
J. Kelly	Interim Chief Executive	Start Jan 15	40-45	0	0	40-45	-	-	-	-
L. Hill	Deputy Chief Executive	Start October 14	70-75	0	0	70-75	-	-	-	-
R. Douglas	Non-Executive Director	Left Nov 13	-	-	-	-	0-5	0	0	0-5
K. Charter	Non-Executive Director	Left Jan 14	-	-	-	-	5-10	2	0	5-10
M. Hasan	Non-Executive Director	Left Apr 13	-	-	-	-	0-5	0	0	0-5
S. Connor	Non-Executive Director	Left Nov 13	-	-	-	-	0-5	2	0	0-5
C. Green	Non-Executive Director	Left Nov 13	-	-	-	-	0-5	0	0	0-5
P. Townsend	Non-Executive Director		5-10	1	0	5-10	5-10	1	0	5-10
S. Hay	Non-Executive Director	Left Dec 14	0-5	0	0	0-5	0-5	0	0	0-5
V. Edwards	Non-Executive Director		5-10	0	0	5-10	0-5	0	0	0-5
J. Brougham	Non-Executive Director		5-10	0	0	5-10	0-5	0	0	0-5
J. Rennison	Non-Executive Director		5-10	0	0	5-10	0-5	0	0	0-5
P. Cartwright	Non-Executive Director	Start Jun 14	5-10	0	0	5-10	-	-	-	-
D. Richards	Chief Financial Officer	Start Jun 14	125-130	0	0	125-130	-	-	-	-
A. Anderson	Director of Finance	Left Jun 13	-	-	-	-	25-30	0	0	25-30
P. Butterworth	Director of Finance	Start Jun 13 - Left Dec 13	-	-	-	-	70-75	1	0	70-75
M. Dennett	Interim Director of Finance & Infrastructure	Start Oct 13 - Left Mar 14	-	-	-	-	75-80	0	0	75-80
C. Stafford (note 2)	Acting Chief Financial Officer	Start Mar 14	25-30	0	0	25-30	-	-	-	-
K. Haynes (note 3)	Interim Chief Operating Officer (Unscheduled Care)	Start Apr 14 - Left Sept 14	-	-	-	-	-	-	-	-
E. Donald (note 4)	Interim Chief Operating Officer (Planned Care and Cancer Services)	Start Jun 14 - Left Oct 14	-	-	-	-	-	-	-	-
N. Forrest	Acting Chief Operating Officer, Chief Nurse	Left Sept 14	50-55	0	0	50-55	110-115	0	0	110-115
B. Bluhm (note 5)	Interim Chief Operating Officer	Left Mar 14	-	-	-	-	-	-	-	-
T. Carter	Chief Nurse	Start Aug 14	75-80	0	0	75-80	-	-	-	-
M. McVey	Acting Director of Nursing	Left Jun 13	-	-	-	-	20-25	1	0	20-25
J. Ardley (note 6)	Interim Chief Nurse	Start Jul 13	-	-	-	-	-	-	-	-
H. Brown	Director of Transformation	Start Sept 14	60-65	0	0	60-65	-	-	-	-
S. Coles (note 7)	Interim Director of Transformation	Start May 14 - Left Aug 14	-	-	-	-	-	-	-	-
L. Emery	Chief Information Officer	Start Apr 14	110-115	0	0	110-115	-	-	-	-
P. Jenkins	Director of Partnership and Performance	Left Apr 14	0-5	0	0	0-5	105-110	2	0	105-110
A. Tiernan	Director of Corporate Affairs & Communications		105-110	0	0	105-110	70-75	0	0	70-75
P. Da Gama	Director of Human Resources	Start Aug 14	65-70	0	0	65-70	-	-	-	-
M. Vaughan (Note 8)	Director of Workforce	Left Feb 14	-	-	-	-	155-160	3	0	155-160
A. Robson (note 9)	Interim Director of Workforce	Start Dec 13 - Left Aug 14	-	-	-	-	-	-	-	-
L. Gaffney (note 10)	Director of Strategy & Service Improvement	Secondment from Oct 14	55-60	0	0	55-60	95-100	3	0	95-100
M. Van Der Watt (note 11)	Medical Director		310-315	0	0	310-315	250-255	0	0	250-255
J. Ardley (note 12)	Interim Director of Governance	Start Aug 14	-	-	-	-	-	-	-	-

Director's Salary Relative to Workforce

The Trust is required to disclose the relationship between the remuneration of the highest-paid director and the median remuneration of the organisation's workforce. The mid point of the banded remuneration of the highest paid director in the financial year 2014-15 was £311.6k. This was 10.5 times the median remuneration of the workforce, which was £29.8k. In 2013-14 the highest paid director banding was £252.5k, 8 times the median of £31.4k. No employee received remuneration in excess of the highest paid director. Remuneration ranged for full time employees from pay banding £10-15k to £310-315k. Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions nor the additional cash equivalent transfer value of pensions.

Notes

Note 1: Salary recharged to NHS England from Jan 2015
Note 2: Continues at the Trust as a non board member from Jun 2014
Note 3: Agency appointment, the cost includes salary, employers N.I., agency costs and VAT was £142k
Note 4: Off payroll arrangement, invoiced total of £96.3k 2014/15
Note 5: Off payroll arrangement, invoiced total of £195.8k in 2013/14 includes daily rate plus VAT.
Note 6: Agency appointment, the cost charged to the trust in 2014/15 which includes salary, employers N.I., agency costs and VAT was £82.3k (2013/14 £206.5k). Continues as Interim Director of Governance, see note 12.
Note 7: Off payroll arrangement. invoiced total of £71.6k 2014/15
Note 8: 2013/14 salary includes lump sum payment under Voluntary Resignation Scheme. This is included in 2013/14 Exit packages note 9.4 of the Trust Accounts
Note 9: Agency appointment, the cost charged to the trust in 2014/15 which includes salary, employers N.I., agency costs and VAT was £96k (2013/14 £86.4k)
Note 10: Salary recharged to Herts Valley CCG from October 2014
Note 11: 82% of salary as Medical Director and the balance for clinical work. The gross pay in 14/15 includes Clinical Excellence Award and pay arrears.
Note 12: Agency appointment, the cost charged to the trust in 2014/15 which includes salary, employers N.I., agency costs and VAT was £167k (2013/14 £0).

Jacqueline Kelly
Chief Executive

3rd June 2015

Directors' pension entitlement

	Real increase in pension at 60 (bands of £2,500)	Real increase in pension lump sum at ages 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real increase in Cash Equivalent Transfer Value (bands of £1,000)	Employer's contribution to stakeholder pension
S. Jones	(0-2.5)	(0-2.5)	30-35	90-95	467,265	444,815	8	0
N. Forrest	0-2.5	2.5-5	15-20	50-55	298,893	256,600	18	0
L. Hill	0-2.5	5-7.5	50-55	155-160	1,083,524	960,525	47	0
L. Gaffney	0-2.5	0-2.5	25-30	80-85	462,488	428,642	13	0
D. Richards	0-2.5	(0-2.5)	35-40	85-90	762,446	713,071	25	0
A. Tiernan	0-2.5	5.0-7.5	10-15	40-45	201,340	168,627	28	0
L. Emery	0-2.5	(0-2.5)	5-10	10-15	111,478	92,550	16	0
C. Stafford	0-2.5	5-7.5	25-30	80-85	403,396	277,802	27	0
T. Carter	0-2.5	2.5-5	30-35	90-95	444,782	392,330	28	0
H. Brown	(0-2.5)	(0-2.5)	30-35	90-95	491,543	473,398	3	0
P. Da Gama	0-2.5	0-2.5	0-5	0-5	43,064	23,791	12	0
P. Jenkins	(0-2.5)	(0-2.5)	30-35	95-100	598,557	597,698	-1	0
M. Van Der Watt	5-7.5	20-22.5	45-50	135-140	859,518	682,267	162	0

Non-Executive members do not receive pensionable remuneration, therefore there are also no entries in respect of pensions for these Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed value of the pension scheme benefits accrued by a member at a paticular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme or chooses to transfer the benefits accrued in their former pension scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute of Faculty of Actuaries.

Real Increase / Decrease in CETV - This reflects the change in-year of CETV after adjusting the start of the year CETV for the change in consumer price indice.

Jacqueline Kelly
Chief Executive

3rd June 2015

Off Payroll Engagements Table 1

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	24
Of which, the number that have existed:	
for less than one year at the time of reporting	18
for between one and two years at the time of reporting	6

Of the above assurance on tax have been sought from 22 engagements

Off Payroll Engagements Table 2

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	38
Number of new engagements which include contractual clauses giving West Hertfordshire Hospitals NHS Trust the right to request assurance in relation to income tax and national insurance obligations	38
Number for whom assurance has been requested	38
Of which:	
Assurance has been received	35
Assurance has not been received	3
Engagements terminated as a result of assurance not being given	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the year	5
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This fugure includes both off-payroll and on-payroll engagements	0

Auditor's report

Independent Auditor's Report to the Directors of West Hertfordshire Hospitals NHS Trust

We have audited the financial statements of West Hertfordshire Hospitals NHS Trust for the year ended 31 March 2015 under the Audit Commission Act 1998. Thefinancial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes
- the table of pension benefits of senior managers and related narrative notes
- the table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of West Hertfordshire Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report which comprises Welcome, Our Services, Our Achievements, Our Performance, Our Patients, Our Staff, Our Future, Our Money, the Annual Governance Statement and Director Reports to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of West Hertfordshire Hospitals NHS Trust as at 31 March 2015 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the NHS Trust Development Authority's Guidance
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial resilience, we identified the following matters:

- the Trust reported a deficit of £13.8 million against an original planned £14 million deficit in 2014-15;
- the Trust is projecting a deficit of £32.8m for 2015-16. The deficit plan for 2015-16 has not yet been agreed with relevant stakeholders and the Trust has not fully identified savings of £12 million to achieve this level of planned deficit;
- arrangements in respect of risk management and the Trust's Board Assurance Framework are not yet embedded.

The actual and planned deficits and risk management issues are evidence of weakness in arrangements in respect of the Trust's financial control, financial governance and strategic financial planning.

Adverse Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, the matters reported in the basis for adverse conclusion paragraph above prevent us from being satisfied that in all significant respects West Hertfordshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of West Hertfordshire Hospitals NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Andy Mack

for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House
Melton Street, Euston Square
London
NW1 2EP

4 June 2015

The accounts 2014/15

Statement of Comprehensive Income for year ended 31 March 2015

	Note	2014/15 £000s	2013/14 £000s
Gross employee benefits	10.1	**(206,926)**	(194,383)
Other operating costs	8	**(122,843)**	(103,948)
Revenue from patient care activities	4	**287,575**	259,298
Other operating revenue	5	**25,716**	31,821
Operating surplus/(deficit)		**(16,478)**	(7,212)
Investment revenue	12.1	**42**	39
Other gains and (losses)	12	**561**	0
Finance costs	13	**(642)**	(838)
Surplus/(deficit) for the financial year		**(16,517)**	(8,011)
Public dividend capital dividends payable		**(3,601)**	(3,097)
Retained surplus/(deficit) for the year		**(20,118)**	(11,108)
Other Comprehensive Income			
Impairments and reversals taken to the revaluation reserve		**0**	(1,198)
Net gain/(loss) on revaluation of property, plant & equipment		**16,226**	6,285
Total comprehensive income for the year		**(3,892)**	(6,021)

Financial performance for the year		
Retained surplus/(deficit) for the year	**(20,118)**	(11,108)
Impairments	**6,198**	(2,252)
Adjustments in respect of donated gov't grant asset reserve elimination	**83**	(10)
Adjusted retained surplus/(deficit)	**(13,837)**	(13,370)

The adjusted retained deficit of £13.8m is after reversal of impairments and the net of donated income and depreciation. The Trust performance is measured on this adjusted deficit. The notes on pages 5 to 32 form part of these accounts.

Statement of Financial Position as at 31 March 2015

	Notes	31 March 2015 £000s	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	14	**161,005**	141,812
Intangible assets	15	**570**	665
Trade and other receivables	20.1	**1,438**	1,386
Total non-current assets		**163,013**	143,863
Current assets:			
Inventories	19	**4,425**	3,813
Trade and other receivables	20.1	**21,192**	13,845
Cash and cash equivalents	22	**1,289**	6,314
Sub-total current assets		**26,906**	23,972
Non-current assets held for sale	23	**0**	323
Total current assets		**26,906**	24,295
Total assets		**189,919**	168,158
Current liabilities			
Trade and other payables	24	**(39,626)**	(41,412)
Provisions	29	**(860)**	(826)
Working capital loan from Department of Health	26	**0**	(1,400)
Capital loan from Department of Health	26	**(2,772)**	(2,772)
Total current liabilities		**(43,258)**	(46,410)
Net-current assets/(liabilities)		**(16,352)**	(22,115)
Total assets less current liabilities		**146,661**	121,748
Non-current liabilities			
Provisions	29	**(5,219)**	(5,313)
Capital loan from Department of Health	26	**(7,935)**	(8,307)
Total non-current liabilities		**(13,154)**	(13,620)
Total Assets Employed:		**133,507**	108,128
FINANCED BY: TAXPAYERS' EQUITY			
Public Dividend Capital		**223,076**	193,805
Retained earnings		**(124,504)**	(104,404)
Revaluation reserve		**34,935**	18,727
Other reserves		**0**	0
Total Taxpayers' Equity:		**133,507**	108,128

The notes on pages 5 to 32 form part of these accounts.

The financial statements on pages 1 to 32 were approved by the Board on 02 June 2015 and signed on its behalf by

Chief Executive

2nd June 2015

Statement of Changes in Taxpayers' Equity For the year ended 31 March 2015

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2014	**193,805**	**(104,404)**	**18,727**	**108,128**
Changes in taxpayers' equity for 2014-15				
Retained surplus/(deficit) for the year		(20,118)		**(20,118)**
Net gain / (loss) on revaluation of property, plant and equipment			16,226	**16,226**
Transfers between reserves		18	(18)	**0**
Reclassification Adjustments				
New temporary and permanent PDC received - cash	57,271			**57,271**
New temporary and permanent PDC repaid in year	(28,000)			**(28,000)**
Net recognised revenue/(expense) for the year	**29,271**	**(20,100)**	**16,208**	**25,379**
Balance at 31 March 2015	**223,076**	**(124,504)**	**34,935**	**133,507**
Balance at 1 April 2013	**181,968**	**(93,296)**	**13,640**	**102,312**
Changes in taxpayers' equity for the year ended 31 March 2014				
Retained surplus/(deficit) for the year		(11,108)		(11,108)
Net gain / (loss) on revaluation of property, plant and equipment			6,285	6,285
Impairments and reversals			(1,198)	(1,198)
Reclassification Adjustments				
New temporary and permanent PDC received - cash	11,837			11,837
Net recognised revenue/(expense) for the year	**11,837**	**(11,108)**	**5,087**	**5,816**
Balance at 31 March 2014	**193,805**	**(104,404)**	**18,727**	**108,128**

Statement of Cash Flows for the Year ended 31 March 2015

	2014-15 £000s	2013-14 £000s
Cash Flows from Operating Activities		
Operating surplus/(deficit)	**(16,478)**	(7,212)
Depreciation and amortisation	**7,947**	8,184
Impairments and reversals	**6,198**	(2,252)
Donated Assets received credited to revenue but non-cash	**(72)**	(210)
Interest paid	**(582)**	(758)
Dividend (paid)/refunded	**(3,655)**	(2,971)
(Increase)/Decrease in Inventories	**(612)**	(707)
(Increase)/Decrease in Trade and Other Receivables	**(7,345)**	(3,643)
Increase/(Decrease) in Trade and Other Payables	**(2,993)**	13,123
Provisions utilised	**(637)**	(629)
Increase/(Decrease) in movement in non cash provisions	**512**	890
Net Cash Inflow/(Outflow) from Operating Activities	**(17,717)**	3,815
Cash Flows from Investing Activities		
Interest Received	**41**	40
(Payments) for Property, Plant and Equipment	**(10,576)**	(12,426)
(Payments) for Intangible Assets	**(5,172)**	(2,127)
Proceeds of disposal of assets held for sale (PPE)	**900**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(14,807)**	(14,513)
Net Cash Inflow/(Outflow) before Financing	**(32,524)**	(10,698)
Cash Flows from Financing Activities		
Gross Temporary and Permanent PDC Received	**57,271**	11,837
Gross Temporary and Permanent PDC Repaid	**(28,000)**	0
Loans received from DH - New Capital Investment Loans	**2,400**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**(2,772)**	(2,772)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans	**(1,400)**	(1,400)
Net Cash Inflow/(Outflow) from Financing Activities	**27,499**	7,665
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(5,025)**	(3,033)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**6,314**	9,347
Cash and Cash Equivalents (and Bank Overdraft) at year end	**1,289**	6,314

Notes to the accounts

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention; modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (note 1.3.2) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector such as the Trust, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements are prepared on a going concern basis unless there were plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

  In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future financial support. The Trust has submitted a financial plan for 2015-16 to the NHS Trust Development Authority (NHS TDA) which delivers a £32.8m deficit. This includes a savings target of £12.0m and an expectation that emergency activity will be paid at marginal tariff. The plan includes a requirement for £35.5m of cash support from the Department of Health to maintain the Trust's cash flows in 2015-16.
- The Directors have received confirmation from the NHS TDA that they will make sufficient cash financing available to the organisation over the next twelve month period such that the organisation is able to meet its current liabilities.
- The risks and rewards of ownership of assets leased by the Trust rest with the leasing company; rental payments are charged to the period to which they relate; see note 9.
- Some of the Trust's buildings are used by other organisations, either for NHS purposes or staff welfare. These are not investment properties and rental is credited to the period to which it relates. The associated buildings are included within the total value of Trust properties.
- The monies paid to Watford Borough Council for the construction of a new access road to Watford General Hospital have been capitalised and impaired as the road will not be owned by the Trust; see note 16.
- The fair value of early retirement provisions has been reassessed using the latest information from Pensions Agency and the Government Actuary Department (GAD) tables detailing revised life expectancy. The combination of latest GAD tables and change in discount rate has resulted in an estimated increase in costs; see note 29.1.

- NHS debtor provision as from 2014-15 has been reversed out and will not be provided unless agreed with the creditor NHS organisation as required by the DH Group Manual for Accounts 2014-15. In future years any provision will form part of Agreement of Balance exercise; see note 20.3.

1.3.2 Key sources of estimation uncertainty

In preparing these accounts the Trust might make assumptions concerning the future affecting the amounts of assets, liabilities, revenue or expenses reported. Any such assumptions and the basis of estimate are explained in the related notes. These include:

- the value of patient care spells that are part-completed in note 1.5. An estimate is made using statistics from earlier in the year because the actual value at year end will not be known until those patients in hospital are discharged some time into the new year.
- from 1 April 2013 income from commissioners for maternity care is received at commencement of the Care Pathway. An estimate of partially completed activity at year end has been deferred.
- the valuation of land and buildings using the modern equivalent asset discounted replacement cost method detailed in note 14.3. The basis of estimate for Watford site includes changes to internal area informed by new drawings and revised build dates.

1.4 Charitable Funds

Following Treasury's agreement to apply IFRS 10 to NHS Charities from 1 April 2013, the Trust has assessed whether it is appropriate to group the Trust's accounts and those of West Hertfordshire Hospitals NHS Trust Charity. The Trust Board as corporate trustee of the charity has the power to exercise control so as to obtain economic benefits therefore consolidation is appropriate. However the transactions are immaterial in the context of the group and are therefore not consolidated. A summary of the Charity's activities are disclosed in note 34.

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across financial years based on the length of stay at the end of the reporting period compared to the expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred and matched to the period in which it is undertaken.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

Short-term employee benefits

Salaries and employment-related payments are recognised in the period in which the service is employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements, other than those due to ill health, approved by the Trust the additional pension is not funded by the NHS Pension Scheme. The full cost is a liability of the Trust and is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the period over which the Trust pays its liability.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had similar purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Capital expenditure on strategic schemes, i.e. those schemes which are of a longer-term nature such as building or large infrastructure projects, is initially charged to assets in the course of construction during the construction phase. Capital schemes are regularly assessed for progress, and once completed, costs are transferred from assets in the course of construction to the appropriate asset category and are recognised as coming into full use.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2009, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. With effect from 1 April 2009, through its appointed valuers GVA Grimley Ltd the Trust has adopted the HM Treasury standard approach to depreciated replacement cost valuations based on modern equivalent assets. The effect of this estimation technique is detailed in note 14.3.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences once they are brought into use.

Until 31 March 2009, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historical cost. From 1 April 2009 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a loss of service potential are charged to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5k.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant or equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land, properties under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Further details of each class of asset is shown in note 14.3.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets which are not yet available for use are tested for impairment annually.

If there has been an impairment loss the asset is written down to its recoverable amount with the loss charged to the revaluation reserve to the extent there is a balance on the reserve for the asset and thereafter, to expenditure. Unless the impairment results from use of the asset where the impairment is charged fully to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there, and thereafter, to the revaluation reserve.

In compliance with the NHS Trust Manual for Accounts, from 2011-12, impairments relating to property, plant and equipment are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). The analysis is used by the Department of Health in consolidating the accounts of NHS bodies. In summary, DELs are set as part of NHS spending are not expected to be exceeded. AME is less predictable and, subject to Treasury approval, may be revised. Further information on these limits can be found on HM Treasury website at www.hm-treasury.gov.uk/pes_overview.htm. The related Trust impairment is classified as AME and is detailed in note 14.3.

1.11 Donated assets

The Trust amended its approach to accounting for donated assets in line with the accounting policy change in the 2011-12 Treasury Financial Reporting Manual (FREM). Consequently 2014-15 and the 2013-14 comparative figures reflect this change. A donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are also as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition.

1.12 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale and it is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses. The profit or loss arising on the disposal of an asset equals the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. Upon disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. The Trust does not hold any finance leases, its leases are classified as operating leases, further details of which are contained in note 9.

The Trust as lessee
Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

The Trust as lessor
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.15 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of 24 hours or less. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. The Trust does not hold cash equivalents.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation The amount recognised as a provision is the best estimate of the obligation. expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the appropriate HM Treasury's discount rate. Liabilities expected to be settled in 0 to 5 years are discounted at minus 1.5%, 5 to 10 years at minus 1.05% and beyond 10 years at 2.2%. Those relating to employee early retirement obligations are discounted at 1.30%.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.17 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA who in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 29.2.

1.18 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.19 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.20 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or in the or, case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value.

1.21 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.22 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input tax is recoverable, the amounts are stated net of VAT.

1.23 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 36 to the accounts.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and average daily cleared cash balances with the Government Banking Service which are excluded. The average carrying is calculated as a simple average of opening and closing amounts.

1.26 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.27 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except in so far as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. Deferred expenditure is revalued on the basis of current cost where material. Amortisation is calculated on the same basis as depreciation.

1.28 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the Trust to apply the following Standards and Interpretations in 2014-15; each of which are subject to consultation. The application of these would not have a material impact were they to be applied:

IFRS 9 - Financial Instruments

IFRS 13 - Fair Value

IFRS 15 - Revenue for Contracts with Customers

2. Operating segments

The Trust's activities are managed collectively as a single operating segment to provide the wide range of patient healthcare usually available from a district general hospital; predominately for the population of West Hertfordshire.

Revenue relating to NHS patient care accounts for 90% of the total, further analysis of which is shown in note 4. This is managed through contracts established with commissioners, mainly Clinical Commissioning Groups (CCGs) which are the main commissioners, each contract covering the complete range of activities provided. The Trust's assets are used collectively to deliver the range of activities encompassed within these contracts.

3. Income generation activities

The Trust does not conduct material income generation activities outside of its usual business, where the aim is to achieve a profit, to be used in patient care.

4. Revenue from patient care activities

	2014/15 £000s	2013/14 £000s
NHS England	**19,037**	18,435
Clinical Commissioning Groups	**247,245**	231,744
CCGs - transformation funds	**2,240**	1,350
NHS Other (including Public Health England and NHS Property Services Ltd)	**100**	279
Additional income for delivery of healthcare services (see note 6)	**12,000**	0
Non-NHS:		
Local Authorities	**4,398**	4,898
Private patients	**1,091**	1,151
Overseas patients (non-reciprocal)	**470**	212
Injury costs recovery	**955**	1,193
Other	**39**	36
Total Revenue from patient care activities	**287,575**	259,298

5. Other operating revenue

	2014/15 £000s	2013/14 £000s
Education, training and research	**8,680**	10,020
Charitable and other contributions to revenue expenditure -non- NHS	**42**	89
Receipt of donations for capital acquisitions - Charity	**72**	210
Non-patient care services to other bodies	**13,814**	10,672
Income generation	**2,066**	1,977
CCGs - Other (see note 6)	**0**	3,713
CCGs - transformation funds	**0**	4,147
Rental revenue from operating leases	**1,042**	993
Total Other Operating Revenue	**25,716**	31,821
Total Revenue from patient care activities	**313,291**	291,119

6. Details of Trust Revenue

Most of the Trust's income is derived through contracts with Clinical Commissioning Groups and other NHS organisations and is almost entirely from the supply of services; income from the sale of goods being immaterial. As shown in note 4 and 5 the Trust may receive additional funds outside of the main contract. Transformation funds relating to patient care activities helped the Trust manage capacity during periods of increased activity e.g. over winter. Transformation funds for non patient activities support the costs of maintaining the Trust's three hospitals and initiatives to improve efficiency were received in 2013-14 but not in 2014-15.

Additional income for delivery of healthcare services - In 2014-15 non recurrent funding of £12m from the Department of Health was received to support in year deficit but not in 2013-14.

CCGs - Other in note 5 relates to investments in service delivery to reduce avoidable readmissions and penalties. In 2014-15 there was no investment.

Income generation includes car parking revenue, use of the Trust's roofs for aerials and other minor health related services.

7. Overseas Visitors Disclosure

	2014/15 £000s	2013/14 £000s
Income recognised during 2014-15 (invoiced amounts and accruals)	**470**	212
Cash payments received in-year (re receivables at 31 March 2014)	**21**	54
Cash payments received in-year (re invoices issued 2014-15)	**155**	100
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**9**	73
Amounts added to provision for impairment of receivables (re invoices issued 2014-15)	**93**	0
Amounts written off in-year (irrespective of year of recognition)	**65**	70

8. Operating expenses

	2014/15 £000s	2013/14 £000s
Services from other NHS Trusts	**2,534**	2,027
Services from CCGs/NHS England	**17**	0
Services from other NHS bodies	**243**	218
Services from NHS Foundation Trusts	**449**	816
Total Services from NHS bodies	**3,243**	3,061
Purchase of healthcare from non-NHS bodies - see i) below	**3,645**	2,082
Trust Chair and Non-executive Directors	**62**	58
Supplies and services - clinical	**48,430**	44,544
Supplies and services - general	**11,502**	10,547
Consultancy services	**3,202**	2,127
Establishment	**3,556**	4,110
Transport	**2,240**	2,382
Premises	**17,620**	15,550
Hospitality	**39**	28
Insurance	**208**	220
Legal Fees	**290**	201
Impairments and Reversals of Receivables - see ii) below	**(763)**	448
Depreciation	**7,680**	7,337
Amortisation	**267**	847
Impairments and reversals of property, plant and equipment - see iii) below	**1,198**	(4,252)
Impairments and reversals of intangible assets - see iv) below	**5,000**	2,000
Audit fees - see v) below	**90**	99
Other auditor's remuneration - see vi) below	**16**	18
Clinical negligence - see vii) below	**9,014**	6,700
Education and Training	**480**	543
Change in Discount Rate	**408**	700
Other - see viii) below	**5,416**	4,598
Total Operating expenses (excluding employee benefits)	**122,843**	103,948
Employee Benefits		
Employee benefits excluding Board members	**205,983**	193,191
Board members	**943**	1,192
Total Employee Benefits	**206,926**	194,383
Total Operating Expenses	**329,769**	298,331

i) Purchase of healthcare from non NHS bodies relates to the outsourcing of activity both to meet waiting time targets and manage bed capacity.
ii) Includes reversed/unused NHS bad debt provisions. See note 1.3.1
iii) The Trust's revaluation of its land and buildings has generated impairments. See note 14.3 for further details.
iv) The payment to Watford Borough Council for the new access road to Watford General Hospital is charged to expenses as per notes 15.2 and 16.
v) The net audit fees include a rebate from the Audit Commission of £10,000.
vi) The other auditors remuneration of £16,000 relates to Quality Accounts review in 2014-15. Quality accounts fees was included in audit fees in 2013-14.
vii) Contribution paid as agreed with NHS Litigation Authority - see notes 1.17 and 1.18
viii) Other expenditure in 2014-15 includes the following services:
- £1,934,000 for portering
- £1,102,000 for linen
- £525,000 for security
- £506,000 for waste disposal

9 Operating Leases

9.1 Trust as Lessee

Leases relate mainly to the hire of medical equipment: contracts are entered into using standard NHS conditions that include:

- Retained asset ownership by the Lessor;
- Fixed rental payments over the agreed lease period;
- Residual value being the property of the Lessor;
- The equipment used by the Trust is for its intended purpose;
- Options for the Trust to extend the lease period or return early on payment of amounts are determined by the Lessor;
- The equipment when returned is complete and in reasonable condition.

	2014/15 £000s	2013/14 £000s
Payments recognised as an expense		
Minimum lease payments	**363**	348
Total	**363**	348
Payable:		
No later than one year	**330**	268
Between one and five years	**786**	661
After five years	**11**	11
Total	**1,127**	940

9.2 Trust as lessor

The Trust permits the use of accommodation within its hospitals to be used by other NHS organisations for NHS services provided by those organisations and also creche facilities for the children of staff.

	2014/15 £000s	2013/14 £000s
Recognised as revenue		
Rental revenue	**1,042**	993
Total	**1,042**	993
Receivable:		
No later than one year	**1,042**	993
Between one and five years	**5,210**	4,963
After five years	**0**	619
Total	**6,252**	6,575

10 Employee benefits and staff numbers

10.1 Employee benefits

		2014-15	
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure 2014-15			
Salaries and wages	**180,027**	135,589	44,438
Social security costs	**10,912**	10,912	0
Employer Contributions to NHS BSA - Pensions Division	**16,384**	16,384	0
Other pension costs	**3**	3	0
Termination benefits	**55**	55	0
Total employee benefits	**207,381**	**162,943**	**44,438**
Employee costs capitalised	**455**	73	382
Gross Employee Benefits excluding capitalised costs	**206,926**	**162,870**	**44,056**

		2013-14	
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure 2013-14			
Salaries and wages	166,957	133,617	33,340
Social security costs	10,725	10,725	0
Employer Contributions to NHS BSA - Pensions Division	16,061	16,061	0
Termination benefits	672	672	0
TOTAL - including capitalised costs	**194,415**	**161,075**	**33,340**
Employee costs capitalised	**32**	**0**	**32**
Gross Employee Benefits excluding capitalised costs	**194,383**	**161,075**	**33,308**

10.2 Staff Numbers

	2014-15			2013-14
	Total Number	Permanently Employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	600	527	73	559
Administration and estates	1,024	879	145	947
Healthcare assistants and other support staff	797	668	129	632
Nursing, midwifery and health visiting staff	1,459	1,229	230	1,526
Nursing, midwifery and health visiting learners	8	8	0	8
Scientific, therapeutic and technical staff	487	402	85	463
Other	33	33	0	45
Total	**4,408**	**3,746**	**662**	**4,180**
Of the above - staff engaged on capital projects	**14**	**2**	**12**	1

10.3 Staff Sickness absence and ill health retirements

	2014-15	2013-14
	Number	Number
Total Days Lost	31,023	27,329
Total Staff Years	3,727	3,615
Average working Days Lost	**8.32**	7.56
Number of persons retired early on ill health grounds	1	4
	£000s	£000s
Total additional pensions liabilities accrued in the year by NHS Pension Agency	**181**	177

There are no additional pension liabilities accrued in the year by the Trust

10.4 Exit Packages agreed in 2014-15

	2014-15					
Exit package cost band (including any special payment element)	Number of compulsory redundancies,	Cost of compulsory redundancies	Number of other departures agreed,	Cost of other departures agreed	Total number of exit packages by cost band	Total cost of exit packages by cost band
	Number	£s	Number	£s	Number	£s
£10,000-£25,000	0	0	1	17,698	1	17,698
£25,001-£50,000	1	37,084	0	0	1	37,084
Total number of exit packages by type						
Total cost	**1**	**37,084**	**1**	**17,698**	**2**	**54,782**

10.4 Exit Packages agreed in 2013-14

	2013-14					
Exit package cost band (including any special payment element)	Number of compulsory redundancies,	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages by cost band	Total cost of exit packages by cost band
	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	3	25,715	3	25,715
£10,000-£25,000	2	34,182	4	71,031	6	105,213
£25,001-£50,000	2	58,373	10	370,971	12	429,344
£50,001-£100,000	0	0	2	112,000	2	112,000
Totals	**4**	**92,555**	**19**	**579,717**	**23**	**672,272**

This note provides an analysis of exit packages agreed during the year. Exit costs are accounted for in full in the year agreement of departure is reached.

Redundancies have been paid in accordance with NHS agenda for change terms and conditions. Other departures is analysed in note 10.5.

Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme detailed in note 10.3 and are not included in this note.

10.5 Exit packages - Other Departures analysis

	2014-15		2013-14	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Trust voluntary resignation scheme	0	0	19	580
Contractual payments in lieu of notice	1	18	0	0
Total	**1**	**18**	**19**	**580**

There was no non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary.

In 2014-15 there was no Trust voluntary resignation scheme, whilst 19 agreements with a cost of £580,000 in 2013-14.

Above does not includes any non-contractual severance payment made following judicial mediation or relating to non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

10.6 Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Ill- health retirement
Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Early retirement
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Additional voluntary contributions (AVC)
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by their due date or within 30 days of receipt of goods or valid invoice, whichever is later. The Trust approach to measuring its performance in compliance with this code is to compare the date payments are made with 36 days from invoice payment due date; this allows for variation between invoice and goods received.

11.1 Measure of compliance

	2014-15		2013-14	
	Number	**£000s**	**Number**	**£000s**
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**58,996**	**154,303**	55,720	129,418
Total Non-NHS Trade Invoices Paid Within Target	**48,765**	**112,967**	44,904	92,804
Percentage of NHS Trade Invoices Paid Within Target	**83%**	**73%**	**81%**	**72%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,753**	**7,487**	2,710	7,834
Total NHS Trade Invoices Paid Within Target	**2,211**	**5,646**	1,920	5,081
Percentage of NHS Trade Invoices Paid Within Target	**80%**	**75%**	**71%**	**65%**

12. Other Gains and Losses

	2014-15	2013-14
	£000s	£000s
Gain/(Loss) on disposal of assets held for sale	**561**	0
Total	**561**	0

Gain on disposal of Highfield Lane in St Albans. See note 23.

12.1 Investment Income

	2014-15	2013-14
	£000s	£000s
Bank Interest	**42**	39
	42	39

13 Finance Costs

	2014-15	2013-14
	£000s	£000s
Interest		
Interest on loans and overdrafts	**576**	746
Provisions - unwinding of discount in determining the fair value of provisions	**66**	92
Total	**642**	838

14. Property, plant and equipment

14.1 Property, plant and equipment

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2014	**34,739**	**82,160**	**713**	**18,983**	**32,010**	**176**	**12,613**	**2,474**	**183,868**
Additions of Assets Under Construction				10,781					**10,781**
Additions Purchased	0	0	0		942	0	66	0	**1,008**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	72	0	0	0	**72**
Reclassifications	0	7,779	11	(12,430)	4,640	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(168)	0	0	0	**(168)**
Upward revaluation/positive indexation	14,109	2,118	(1)	0	0	0	0	0	**16,226**
At 31 March 2015	**48,848**	**92,057**	**723**	**17,334**	**37,496**	**176**	**12,679**	**2,474**	**211,787**
Depreciation									
At 1 April 2014	**0**	**5,948**	**408**	**0**	**24,547**	**165**	**10,724**	**264**	**42,056**
Disposals other than for sale	0	0	0		(152)	0	0	0	**(152)**
Impairments	0	3,677	0	0	0	0	0	0	**3,677**
Reversal of Impairments	(147)	(2,136)	(10)	0	0	0	0	(186)	**(2,479)**
Charged During the Year	0	4,476	29		2,268	8	723	176	**7,680**
At 31 March 2015	**(147)**	**11,965**	**427**	**0**	**26,663**	**173**	**11,447**	**254**	**50,782**
Net Book Value at 31 March 2015	**48,995**	**80,092**	**296**	**17,334**	**10,833**	**3**	**1,232**	**2,220**	**161,005**
Asset financing:									
Owned - Purchased	48,995	79,984	296	17,184	10,253	3	1,232	2,219	**160,166**
Owned - Donated	0	108	0	150	580	0	0	1	**839**
Total at 31 March 2015	**48,995**	**80,092**	**296**	**17,334**	**10,833**	**3**	**1,232**	**2,220**	**161,005**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Revaluation Reserve Balance for Property, Plant & Equipment									
At 1 April 2014	8,429	9,516	0	180	602	0	0	0	**18,727**
Movements (specify)	14,108	2,118	0	0	(18)	0	0	0	**16,208**
At 31 March 2015	**22,537**	**11,634**	**0**	**180**	**584**	**0**	**0**	**0**	**34,935**

Additions to Assets Under Construction in 2014/15	£000s
Buildings excl Dwellings	8,279
Plant & Machinery	2,502
Balance as at YTD	**10,781**

14.2 Property, plant and equipment prior-year

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2013	**31,801**	**72,610**	**692**	**13,066**	**29,757**	**176**	**12,335**	**2,195**	**162,632**
Additions of Assets Under Construction				15,431					**15,431**
Additions Purchased	0	0	0		5	0	0	0	**5**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	210	0	0	0	**210**
Reclassifications	40	6,816	63	(9,514)	2,038	0	278	279	**0**
Revaluation	2,898	3,889	0	0	0	0	0	0	**6,787**
Impairments/negative indexation charged to reserves	0	(1,155)	(42)	0	0	0	0	0	**(1,197)**
At 31 March 2014	**34,739**	**82,160**	**713**	**18,983**	**32,010**	**176**	**12,613**	**2,474**	**183,868**
Depreciation									
At 1 April 2013	0	5,362	541	0	22,301	159	9,892	214	**38,469**
Impairments/negative indexation charged to operating expenses	0	2,738	0	0	0	0	0	0	**2,738**
Reversal of Impairments charged to operating expenses	0	(6,175)	(183)	0	0	0	0	(130)	**(6,488)**
Charged During the Year	0	4,023	50		2,246	6	832	180	**7,337**
At 31 March 2014	**0**	**5,948**	**408**	**0**	**24,547**	**165**	**10,724**	**264**	**42,056**
Net Book Value at 31 March 2014	**34,739**	**76,212**	**305**	**18,983**	**7,463**	**11**	**1,889**	**2,210**	**141,812**
Asset financing:									
Owned - Purchased	34,739	76,095	304	18,833	6,808	11	1,888	2,209	**140,887**
Owned - Donated	0	117	1	150	655	0	1	1	**925**
Total at 31 March 2014	**34,739**	**76,212**	**305**	**18,983**	**7,463**	**11**	**1,889**	**2,210**	**141,812**

14.3 Property, plant and equipment

Annual valuation of Land, Buildings and Dwellings is a forecast as at 31 March. The valuation is undertaken by an independent valuer; RICS Registered Valuers of GVA Grimley Ltd. Because of the specialised nature of hospital buildings, i.e. they would not normally be sold on the open market, the valuations are based on the depreciated replacement cost method (DRC) using the modern equivalent asset (MEA) technique. This valuation technique estimates the cost of a MEA; for buildings, this is then adjusted to reflect the age, condition and functionality of the buildings to which the valuation relates and can result in an impairment or reversal,details of which are shown below. The approach adopted by the Trust is for a full revaluation to be undertaken every five years with a desktop review in the interim years. Valuation reflects the capital investment to September each year, after which it is included at cost. VAT is added to the valuations to the extent it would be payable were the Trust to construct the MEA. In 2014-15 a desk top valuation has been carried out by GVA Grimley Ltd.

14.3 (cont). Property, plant and equipment

	Watford Hospital	Hemel Hempstead Hospital	St Albans Hospital	Total
	2014-15			
	£000s	£000s	£000s	£000s
Operating expenses - note 8				
Land - MEA	0	(147)	0	(147)
Buildings, dwellings and fittings - MEA	2,097	(1,190)	438	1,345
Total	**2,097**	**(1,337)**	**438**	**1,198**
Statement of change in taxpayers equity				
Land - MEA	(2,840)	(1,672)	(9,597)	(14,109)
Buildings, dwellings and fittings - MEA	(1,927)	(402)	212	(2,117)
	(4,767)	(2,074)	(9,385)	(16,226)
Total impairment/(reversal) 2014-15	**(2,670)**	**(3,411)**	**(8,947)**	**(15,028)**

	2013-14			
	£000s	£000s	£000s	£000s
Operating expenses - note 8				
Land - MEA	(74)	(428)	0	(502)
Buildings, dwellings and fittings - MEA	(4,728)	364	614	(3,750)
Total	**(4,802)**	**(64)**	**614**	**(4,252)**
Statement of change in taxpayers equity				
Land - MEA	(979)	0	(1,417)	(2,396)
Buildings, dwellings and fittings - MEA	(1,974)	330	(1,047)	(2,691)
	(2,953)	330	(2,464)	(5,087)
Total impairment/(reversal) 2013-14	**(7,755)**	**266**	**(1,850)**	**(9,339)**

The impairment charged to operating expenses is classified as annually managed expenditure for the purposes of NHS consolidated accounts - see note 1.10.

Assets under construction are transferred to the relevant class of assets when complete and depreciated in accordance with that class.

For plant and machinery, transport, information technology, the carrying value as at 1 April 2009 is written off over their remaining lives. Net assets in these classes are carried at depreciated historic cost as this is not considered to be materially different from fair value (see note 1.8). Property Plant and Equipment includes £25.9m of fully depreciated assets.

Details of asset life across the Trust's three hospital sites are tabled below:

	As at 31 March 2015		As at 31 March 2014	
	Maximum remaining asset life	Minimum remaining asset life	Maximum remaining asset life	Minimum remaining asset life
Asset Class	**Years**	**Years**	**Years**	**Years**
Buildings	49	4	50	5
Dwellings	29	29	30	8
Plant and machinery	9	1	9	1
Transport	2	1	2	1
Information Technology	5	1	5	1
Furniture and Fittings	49	4	50	5

The full valuation exercise included revision to the remaining asset lives of some buildings and their fittings, consequently the maximum remaining lives between 31 March 2015 and 31 March 2014 do not necessarily reduce by one year. Dwellings in 2013-14 included two residential buildings Cherry Tree House and Sycamore House and only Cherry Tree House in 2014-15. In 2014-15 Sycamore House has been transferred to buildings as it is now used as a hospital building.

For all classes of asset residual value is estimated at nil.

The Trust is lessor to a number of other NHS organisations and a creche provider, where these organisations occupy accommodation within the Trust's buildings. The net carrying amount of these facilities and related depreciation are included in the Trust's figures.

15. Intangible non-current assets

15.1 Intangible non-current assets

	IT - in-house & 3rd party software	Development Expenditure - Internally Generated	Total
2014-15			
	£000s	£000s	£000s
At 1 April 2014	**6,903**	**170**	**7,073**
Additions Purchased	0	5,172	**5,172**
At 31 March 2015	**6,903**	**5,342**	**12,245**
Amortisation			
At 1 April 2014	**6,408**	**0**	**6,408**
Impairments charged to operating expenses	0	5,000	**5,000**
Charged during the year	267	0	**267**
At 31 March 2015	**6,675**	**5,000**	**11,675**
Net Book Value at 31 March 2015	**228**	**342**	**570**
Asset Financing: Net book value at 31 March 2015 comprises:			
Purchased	228	342	**570**
Donated	0	0	**0**
Total at 31 March 2015	**228**	**342**	**570**

15.2 Intangible non-current assets prior year

2013-14	IT - in-house & 3rd party software	Development Expenditure - Internally Generated	Total
Cost or valuation	**£000s**	**£000s**	**£000s**
At 1 April 2013	**6,903**	**43**	**6,946**
Additions Purchased	0	2,126	2,126
At 31 March 2014	**6,903**	**2,169**	**9,072**
Amortisation			
At 1 April 2013	**5,560**	**0**	**5,560**
Impairments charged to operating expenses	0	2,000	2,000
Charged during the year	847	0	847
At 31 March 2014	**6,407**	**2,000**	**8,407**
Net Book Value at 31 March 2014	**496**	**169**	**665**
Asset Financing: Net book value at 31 March 2014 comprises:			
Purchased	496	169	665
Donated	0	0	0
Total at 31 March 2014	**496**	**169**	**665**

The maximum remaining asset life of computer software in use is 5 years.

There are no material intangible assets fully amortised in use.

There were no changes in asset lives, residual values, or impairment loss recognised during the period for assets in use. The impairment charged to operating expenses relates to the new access road to Watford Hospital see note 1.3.1 and 8.

Intangible assets are held at depreciated cost as a proxy for fair value; there are no associated revaluation reserves.

16 Analysis of impairments and reversals recognised in 2014-15

	Total	Property Plant and Equipment	Intangible Assets	Financial Assets Number	Non-Current Assets Held for Sale
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Other	**5,000**	0	5,000	0	0
Changes in market price	**1,198**	1,198	0	0	0
Total charged to Annually Managed Expenditure	**6,198**	**1,198**	**5,000**	**0**	**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**6,198**	**1,198**	**5,000**	**0**	**0**

There are no donated or government granted assets impaired.

The analysis by site of the impairment on property, plant and equipment is shown in note 14.3. The impairment on intangibles relates to Watford Borough Council, in 2014-15 £5m (2013-14 £2m) for the construction of a new access road at Watford General Hospital which has been capitalised and impaired. See note 1.3.1 and 8.

17 Commitments

17.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2015	31 March 2014
	£000s	£000s
Property, plant and equipment	**3,662**	2,784
Intangible assets	**76**	0
Total	**3,738**	2,784

18 Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000s	**£000s**	**£000s**	**£000s**
Balances with Other Central Government Bodies	1,268	0	6,021	0
Balances with Local Authorities	381	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	17	0
Balances with NHS bodies inside the Departmental Group	12,900	0	6,805	7,935
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	6,643	1,438	29,555	0
At 31 March 2015	**21,192**	**1,438**	**42,398**	**7,935**
prior period:				
Balances with Other Central Government Bodies	8,327	0	7,787	0
Balances with Local Authorities	493	0	0	0
Balances with NHS bodies outside the Departmental Group	19	0	0	0
Balances with NHS Trusts and FTs	1,947	0	1,189	0
Balances with Bodies External to Government	2,362	1,386	32,436	0
At 31 March 2014	**13,148**	**1,386**	**41,412**	**0**

The analysis of intra-government and other balances in 2014-15 is different to 2013-14. In 2014-15 the balances with Clinical Care Groups are included in 'Balances with NHS bodies inside the Departmental Group' whilst in 2013-14 it was included in 'Balances with Other Central Government Bodies'. In 2014-15 loans with Department of Health has been included in current payables and non-current payables, no loans with Department of Health were included in 2013-14.

19 Inventories

	Drugs	Consumables	Energy	Total
	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**851**	**2,722**	**240**	**3,813**
Additions	19,086	15,874	0	34,960
Inventories recognised as an expense in the period	(18,991)	(15,225)	(132)	(34,348)
Balance at 31 March 2015	**946**	**3,371**	**108**	**4,425**

20. Trade and other receivables

20.1 Trade and other receivables

	Current		Non-Current	
	31 March 2015 £000s	31 March 2014 £000s	31 March 2015 £000s	31 March 2014 £000s
NHS receivables - revenue	**4,722**	4,608	**0**	0
NHS prepayments and accrued income	**8,309**	4,193	**0**	0
Non-NHS receivables - revenue	**2,312**	2,462	**0**	0
Non-NHS prepayments and accrued income	**5,142**	2,720	**0**	0
PDC Dividend prepaid to DH	**104**			
Provision for the impairment of receivables	**(1,419)**	(2,330)	**0**	0
VAT	**1,268**	1,492	**0**	0
Interest receivables	**4**	3	**0**	0
Other receivables	**750**	697	**1,438**	1,386
Total	**21,192**	13,845	**1,438**	1,386
Total current and non current	**22,630**	15,231		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

Trade and other receivables are carried at the original invoice amount. As the majority of trade is with Clinical Commissioning Groups (CCGs), as commissioners funded by government to buy NHS patient care services, no credit scoring of these is considered necessary. Other trade receivables mainly relate to private patients who are generally covered by insurance. No formal credit scoring is undertaken. Injury cost recovery relates to patients with personal injury claims, as this is administered centrally for the NHS, no credit scoring is undertaken.

The provision for the impairment of receivables relates to Non NHS, over 90 days old.

20.2 Receivables past their due date but not impaired

	31 March 2015	31 March 2014
	£000s	£000s
By up to three months	**1,165**	1,549
Greater than three months	**1,609**	0
Total	**2,774**	1,549

20.3 Provision for impairment of receivables

	31 March 2015	31 March 2014
	£000s	£000s
Balance at 1 April	**(2,330)**	(1,965)
Amount written off during the year	**148**	83
Amount recovered/reversed during the year	**557**	16
Amount unused during the year	**437**	0
(Increase)/decrease in receivables impaired	**(231)**	(464)
Balance at 31 March	**(1,419)**	(2,330)

The provision for impairment of receivables in 2014-15 is for Non NHS debtors only.

21 Other Financial Assets

The Trust has no other financial assets.

22 Cash and Cash Equivalents

	31 March 2015	31 March 2014
	£000s	£000s
Opening balance	**6,314**	9,347
Net change in year	**(5,025)**	(3,033)
Closing balance	**1,289**	6,314
Made up of		
Cash with Government Banking Service	**1,207**	6,278
Commercial banks	**76**	31
Cash in hand	**6**	5
Cash and cash equivalents as in statement of financial position	**1,289**	6,314
Cash and cash equivalents as in statement of cash flows	**1,289**	6,314
Patients' money held by the Trust, not included above	**3**	3

23 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Total
	£000s	£000s	£000s
Balance at 1 April 2014	131	192	**323**
Less assets sold in the year	(131)	(192)	**(323)**
Balance at 31 March 2015	**0**	**0**	**0**
Balance at 1 April 2013	131	192	**323**
Balance at 31 March 2014	**131**	**192**	**323**

The Highfield Lane land in St Albans, was sold on 26 March 2015 for a value of £900,000. The profit on disposal of £577,000 has been recognised in Statement of Comprehensive Income. See note 12.

24 Trade and other payables

	Current		Non-Current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
NHS payables - revenue	**1,692**	1,413	**0**	0
NHS accruals and deferred income	**2,358**	1,669	**0**	0
Non-NHS payables - revenue	**7,544**	9,055	**0**	0
Non-NHS payables - capital	**6,102**	4,889	**0**	0
Non-NHS accruals and deferred income	**18,207**	20,767	**0**	0
Social security costs	**1,689**	1,682		
VAT	**189**	61	**0**	0
Tax	**1,822**	1,847		
Other	**23**	29	**0**	0
Total	**39,626**	41,412	**0**	0

Total payables (current and non-current)	**39,626**	**41,412**

25 Other liabilities

The Trust has no other payables or financial liabilities.

26 Borrowings

	Current		Non-Current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Loans from Department of Health	**2,772**	4,172	**7,935**	8,307
Total	**2,772**	**4,172**	**7,935**	**8,307**

Total other liabilities (current and non-current)	**10,707**	**12,479**

Borrowings / Loans - repayment of principal falling due in:

	31 March 2015 £000s
0-1 Years	2,772
1-2 Years	2,990
2-5 Years	3,418
Over 5 Years	1,527
Total	**10,707**

The borrowings relate to three Department of Health loans:

£27m loan; £13.5m accessed in July 2008 and a further £13.5m in September 2008. The loan was taken to finance the Acute Assessment Unit at Watford Hospital and other site improvements. It is repayable by twice yearly equal instalments, over ten years, ending March 2018. Interest is at a rate of 5.4% payable twice-yearly on a reducing balance.

£7m loan accessed in March 2010 to support working capital. It is repayable by twice-yearly equal instalments over five years ending March 2015. Interest is at a rate of 1.8% payable twice-yearly on a reducing balance.

£11.1m capital loan has been agreed by Department of Health; loan drawdown of £2.4m in 2014-15 is included above. The term of the loan is for 12 years commencing repayment from September 2016. Interest is at rate of 1.51% payable twice yearly.

27 Deferred income

	Current		Non-Current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Opening balance at 1 April 2014	**1,305**	1,746	**0**	0
Deferred revenue addition	**666**	1,312	**0**	0
Transfer of deferred revenue	**(218)**	(1,753)	**0**	0
Current deferred Income at 31 March 2015	**1,753**	1,305	**0**	0

Total deferred income (current and non-current)	**1,753**	1,305

Deferred income includes maternity pathway care income received in advance from 2013-14 as per the accounting policy note 1.3.2.

28 Finance lease obligations as lessee

The Trust has no finance lease obligations.

29 Provisions

29.1 Provisions

	Total	Pensions non directors relating to early retirement	Legal Claims	Staff and public liability claims
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2014	**6,139**	5,586	4	549
Arising during the year	**211**	59	0	152
Utilised during the year	**(637)**	(531)	0	(106)
Reversed unused	**(108)**	(70)	0	(38)
Unwinding of discount	**66**	64	0	2
Change in discount rate	**408**	408	0	0
Balance at 31 March 2015	**6,079**	**5,516**	**4**	**559**
Expected Timing of Cash Flows:				
No Later than One Year	**860**	507	4	349
Later than One Year and not later than Five Years	**2,957**	2,775	0	182
Later than Five Years	**2,262**	2,234	0	28

i) The fair value of the provision for future pension payments relating to early retirement is assessed using information provided by the Pensions Agency and Government Actuary Department (GAD) tables concerning life expectancy. The forecast cashflow is discounted in accordance HM Treasury prescribed discount rates (see note 1.16). The use of more recent GAD tables and change in discount rate has resulted in an estimated increase in cost.

ii) Staff and public liability claims are managed by NHSLA and NHS Pensions Authority. The provision relates to the excess for which the Trust is liable.

29.2 NHS litigation provisions relating to the Trust

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	2014-15
	£000s
As at 31 March 2015	121,994
As at 31 March 2014	94,712

30 Contingencies

The Trust has no contingent assets or liabilities.

31 Financial Instruments

31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners (Clinical Commissioning Groups) and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the NHS Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note 20.1.

Liquidity risk

The Trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament and funds its capital expenditure within its limit set by the Department of Health. The Trust is not, therefore, exposed to significant liquidity risks. However the Trust deficit position in 2013-14 and 2014-15 and insufficient surpluses to finance loan repayments means liquidity is weaker than the board of directors would wish. This has partially been addressed with additional Public Dividend Capital funding of £22.7m from Department of Health in March 2015 to fund in year deficit, loan repayment and improve on liquidity. The Trust has also called down £2.4m of loan approved by Department of Health in March 2015 to fund capital projects. In 2015-16 the Trust has received approval of £16.4m as interim revolving working capital facility to meet it's liabilities until funding is agreed with Department of Health.

31.2 Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS		4,690		**4,690**
Receivables - non-NHS		1,891		**1,891**
Cash at bank and in hand		1,289		**1,289**
Total at 31 March 2015	**0**	**7,870**	**0**	**7,870**
Receivables - NHS		4,567		**4,567**
Receivables - non-NHS		1,936		**1,936**
Cash at bank and in hand		6,314		**6,314**
Total at 31 March 2014	**0**	**12,817**	**0**	**12,817**

31.3 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables		1,692	**1,692**
Non-NHS payables		3,909	**3,909**
Other borrowings		10,707	**10,707**
Total at 31 March 2015	**0**	**16,308**	**16,308**
NHS payables		1,592	1,592
Non-NHS payables		6,268	6,268
Other borrowings		12,479	12,479
Total at 31 March 2014	**0**	**20,339**	**20,339**

32 Events after the end of the reporting period

There are no post balance sheet events

33 Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities and the transactions where over £0.5m are:

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
2014-15	**£000s**	**£000s**	**£000s**	**£000s**
Department of Health	36,409	63,876	0	104
Trusts				
Barts Health NHS Trust		581	0	0
East and North Hertfordshire NHS Trust		620	453	414
Hertfordshire Partnership NHS Foundation Trust	784	1,582	33	263
Hertfordshire Community NHS Trust	1,197	1,225	634	633
Imperial College Hospitals NHS Trust		548	113	275
Clinical Commissioning Groups (CCG)				
Barnet CCG		1,163	0	356
Bedfordshire CCG		1,321	156	0
Chiltern CCG		800	0	133
East and North Hertfordshire CCG		2,749	214	0
Harrow CCG		3,229	21	0
Herts Valley CCG		227,476	1,090	8,262
Hillingdon CCG		5,326	0	58
Luton CCG		1,338	134	0
Area Teams				
East Anglia		16,320	0	223
Hertfordshire and South Midlands		3,421	267	232
Special Health Authorities				
Health Education England		10,480	0	231
NHS Litigation Authority	9,222		0	0
NHS Blood & Transplant	1,734		17	
	49,346	**342,055**	**3,132**	**11,184**
2013-14	17,790	279,992	1,789	6,025

In addition, the Trust has had a number of material transactions with public corporations government departments and local authorities:

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
2014-15	**£000s**	**£000s**	**£000s**	**£000s**
HM Revenue and Customs	41,697	10,887	3,700	1,268
NHS Pension Scheme	27,981			
Hertfordshire County Council		4,217	0	250
Watford Borough Council	6,080	7	0	0
	75,758	**15,111**	**3,700**	**1,518**
2013-14	66,994	13,787	5,894	1,866

34 Summary of West Hertfordshire Hospitals NHS Charity activities

	2014-15	2013-14
	£000s	£000s
Income	**192**	389
Expenditure	**(354)**	(671)
Net Incoming/Outgoing Resources Before Transfers	**(162)**	(282)
Gains/(losses) on Revaluation and Disposals of Investment Assets	**77**	57
Funds B/fwd	**1,374**	1,599
Funds c/fwd - Net Assets	**1,289**	1,374

35 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases	Total Number of Cases
2014-15	**£s**	
Losses	78,721	39
Special payments	212,406	41
Total losses and special payments	**291,127**	**80**

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases	Total Number of Cases
2013-14	**£s**	
Losses	83,240	58
Special payments	23,380	58
Total losses and special payments	**106,620**	**116**

36. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

36.1 Breakeven performance

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Turnover	209,199	218,248	232,967	241,684	254,308	260,398	266,716	278,230	291,119	**313,291**
Retained surplus/(deficit) for the year	(26,785)	(11,413)	2,495	4,405	(52,167)	1,180	5,269	(868)	(11,108)	**(20,118)**
Adjustments for impairments				0	57,866	6,178	(1,512)	2,811	(2,252)	**6,198**
Adjustments for impact of policy change re donated/government grants assets							(100)	(39)	(10)	**83**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*					0	0	0	0	0	**0**
Absorption accounting adjustment								0	0	**0**
Other agreed adjustments	14,111	26,785	0	0	0	172	0	0	0	**0**
Break-even in-year position	**(12,674)**	**15,372**	**2,495**	**4,405**	**5,699**	**7,530**	**3,657**	**1,904**	**(13,370)**	**(13,837)**
Break-even cumulative position	**(26,785)**	**(11,413)**	**(8,918)**	**(4,513)**	**1,186**	**8,716**	**12,373**	**14,277**	**907**	**(12,930)**

i) Impairments are excluded from the break-even duty as they are "non cash impacting" in the year that they occur.

ii) In line with note 1.11 the Trust no longer maintains a donated asset reserve. Donations are credited to income, the extent that this differs from depreciation of donated assets (expense) improves the reported position. As this is not an operational activity it is excluded from the break-even duty.

iii) The "Other" agreed adjustments relates to the East of England Strategic Health Authority formal agreement in 2006-07 to adjust the Trust's breakeven duty over a 5 year period commencing from the 2006-07 financial year.

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
	%	%	%	%	%	%	%	%	%	%
Materiality test (i.e. equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	(6.1)	7.0	1.1	1.8	2.2	2.9	1.4	0.7	(4.6)	**(4.4)**
Break-even cumulative position as a percentage of turnover	(12.8)	(5.2)	(3.8)	(1.9)	0.5	3.3	4.6	5.1	0.3	**(4.1)**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

The Trust has breached the breakeven duty in 2014-15 achieving a cumulative deficit of -4.1% above the -0.5% permitted. The Trust is working with NHS Trust Development Authority and the local economy to develop a recovery plan to achieve the breakeven duty in future years.

36.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%. See note 1.25 for how this is calculated.

36.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2014-15	2013-14
	£000s	£000s
External financing limit (EFL)	**33,568**	17,113
Cash flow financing	**32,524**	10,698
Unwinding of Discount Adjustment		92
External financing requirement	**32,524**	10,790
Under/(over) spend against EFL	**1,044**	6,323

The Trust has met it's statutory duty by not exceeding it's EFL.

36.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2014-15	2013-14
	£000s	£000s
Gross capital expenditure	**17,032**	17,772
Less: book value of assets disposed of	**(323)**	0
Less: donations towards the acquisition of non-current assets	**(72)**	(210)
Charge against the capital resource limit	**16,637**	17,562
Capital resource limit	**17,540**	18,208
(Over)/underspend against the capital resource limit	**903**	646

The Trust has achieved its administrative duty of not exceeding the CRL.

37 Third party assets

The Trust held cash on behalf of patients This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2015	31 March 2014
	£000s	£000s
Patients' monies held by the Trust	**3**	3

"Hello our names are Christiana and Sika and we love working in the eye department because there is good team work, our patients come first and we enjoy sincere patient appreciation."

West Hertfordshire Hospitals NHS
NHS Trust

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