West Hertfordshire Hospitals NHS
NHS Trust

FOR HEALTHCARE LEADERS HSJ 2015 AWARDS WINNER

Annual Report 2015/16

our vision: the very best care for every patient, every day

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1. The Performance Report

1.1. Overview

Welcome – a message from our Chair and Chief Executive

Welcome to our annual report for 2015/16

2015/16 was another very busy year for our hospitals, with our staff and volunteers working hard to provide the very best care for our patients, their families and friends.

In April 2015, the Care Quality Commission (CQC) undertook an inspection of our hospitals in Watford, St Albans and Hemel Hempstead. The CQC raised a number of significant concerns about how we systematically ensure the quality and safety of our services, for all of our patients, every day. The CQC was particularly concerned about staffing levels, organisational culture and staff morale, the quality and sustainability of some of our facilities and our overall governance and risk management processes.

Following the inspection we developed a comprehensive quality improvement plan (QIP). We have been making good progress in implementing the more than 200 actions set out in our QIP and expect the majority to be completed by September 2016, which is the date for our CQC re-inspection visit.

We are very proud of the many improvements that we have delivered over the year, including:

- the recruitment of nearly 300 new nursing and midwifery staff through a concerted local, national and international recruitment drive - significantly reducing our reliance on agency staff;
- the establishment of a new hospital at night team which provides additional expert multi-disciplinary support to the wards to care for acutely unwell patients overnight (helping to deliver a 50% reduction in cardiac arrest rates on our wards);
- the opening of the 'Windsor Unit' next to our emergency care department at Watford. The service provides rapid access to specialist assessment for older people with complex needs who attend our emergency care department, enabling treatment to be started more quickly and community support packages to be put in place as alternatives to hospital admission for nearly half of all patients;
- a complete overhaul of our quality governance and risk management processes - these are the processes that help us to ensure our services provide consistent, safe, evidenced-based care and are an essential foundation for ensuring we provide the very best care, for every patient every day.

We are also extremely proud that we have sustained excellent mortality rates across the Trust over the past year. The Hospital Standardised Mortality Ratio (HSMR) indicator compares observed deaths to expected deaths. Put simply, ratios under 100 mean there are fewer in-hospital deaths than expected. Our HSMR of 85.25 is lower than expected and our Trust compares very favourably against others nationally. We have the 15th lowest HSMR out of 136 non specialist trusts nationally. This statistic - based on figures from March 2015 to February 2016 - puts us in the top 11% of trusts when compared across England.

Whilst we are proud of our achievements in 2015/16, we recognise that there is much still to do. Further improvement is needed in many areas including: improving emergency care access (waiting times), improving communication with patients and their carers, better discharge processes, improving our estate and information technology and improving our finances.

Of course, healthcare is not limited to hospitals and we are working with our partners elsewhere in the NHS and in local authorities to improve the health of our communities and the smooth running of our services. You can read more about future plans affecting the local health economy in the 'Our Future' section of the report.

We would like to end this message with a very big thank you to our staff and volunteers, who work extremely hard, for their ongoing commitment and support. We would also like to thank our partners, including Herts Valley Clinical Commissioning Group and Healthwatch Hertfordshire, who have supported us with improving quality and patient experience over the past year.

Steve Barnett
Chairman

Tracey Carter
Acting Chief Executive

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. Our 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 our hospitals is relatively affluent, although there are some areas of deprivation.

With approximately 4,500 staff and 450 volunteers at our three hospitals in Watford, St Albans and Hemel Hempstead, we are one of the largest employers locally.

Hemel Hempstead Hospital

The clinical services offered at Hemel Hempstead include:

- Antenatal and community midwifery.
- Outpatients.
- Step-down beds for patients.
- Urgent care centre.
- Medical care, including endoscopy and cardiac lung function testing.
- Diagnostic support, including X-ray, CT, MRI, ultrasound and non-urgent pathology.

St Albans City Hospital

St Albans is our elective, i.e. pre-arranged and non-emergency, care centre. The clinical services offered include:

- Antenatal and community midwifery.
- Outpatients.
- Minor injuries unit.
- Elective and day surgery.
- Clinical support, including X-ray, ultrasound, mammography and blood and specimen collection.

Watford General Hospital

Watford is the main site for emergency and specialist care. The clinical services include:

- Women's and children's services, including a consultant-led delivery unit, midwife-led 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 cardiology, care of the elderly, dermatology, endocrinology-diabetes, gastroenterology, haematology, neurology, respiratory, rheumatology and stroke.
- Clinical support, including X-ray, CT, MRI, ultrasound, pathology, pharmacy, radiology, physiotherapy, occupational therapy and dietetic services.

In 2015/16, there were approximately:

- 39,000 emergency patients admitted.
- 45,000 elective patients admitted.
- 136,000 attendances at A&E, Urgent Care Centre and Minor Injuries Unit.
- 475,000 attendances at outpatient appointments.
- 5,300 babies born under our care.

Our CQC report

In April 2015, the Care Quality Commission (CQC) undertook a full inspection of our three hospitals. The CQC's report, published in September 2015, highlighted a number of areas where significant improvements were required, including quality, safety and staffing levels. They also highlighted some areas of outstanding practice. As a consequence of the report, the NHS Trust Development Authority (known, since April 2016, as NHS Improvement) placed our Trust into special measures. Special measures are designed to help organisations to improve care by providing tailored support where it is most needed.

The inspectors were complimentary about how, in most areas, patients were treated with dignity and respect and were provided with the appropriate emotional care. They also said that most staff were friendly and welcoming and that the majority of staff were caring, compassionate and kind.

However, the overall report rated our Trust as 'inadequate' with a significant number of concerns. These related to all three of our hospitals, with six of the 13 services inspected, receiving a rating of 'inadequate'. In summary, the most serious issues raised were:

- Risk and governance, with lack of a systematic approach to reporting and analysis of incidents.
- Safety not a sufficient priority, with staff not always reporting incidents and lack of a learning/safety culture.
- Staffing levels and staff morale.
- Performance and quality of performance data.
- Equipment and environment.
- A significant change of Board membership.

With over 200 actions identified by staff, an improvement plan is well underway. A monthly Oversight Group, chaired by a representative from NHS Improvement, brings together all partners to review the progress being made and identify ways in which partners can support our improvement journey. Further details relating to improvements following the inspection, will be highlighted throughout this report.

We produce an annual Quality Account each financial year. This is a quality-focused report, approved by the Trust board and published on the Trust's website www.westherts.nhs.uk. The 2015/16 Quality Account looked at the Trust's services and how well they met the CQC's five categories of safe, effective, caring, responsive and well-led. It then set out the priorities for 2016/17 using the Trust's five themes of Our people, Getting the basics right, Patient focus, Infrastructure and Governance, risk management and decision-making. The primary aim is to support the NHS in improving the quality of healthcare services by improving the organisation's accountability to the public.

1.2. Performance analysis

Our Improvement Journey

Reduced death rates: among the best in the country

In October 2015, we were recognised as having a 'significantly lower than expected' mortality rate. This impressive achievement was outlined in more detail on pages 3-4.

Of key importance to our patients is the quality and safety of our services. We are proud of our sustained reduction in the Hospital Standardised Mortality Ratio, which compares observed deaths to expected deaths. This is extremely good news for our patients and demonstrates the work undertaken to improve patient safety in our hospitals.

HSJ Award winners for Patient Safety

FOR HEALTHCARE LEADERS HSJ 2015 AWARDS WINNER

As a result of the success of improvements in the hip fracture project, **we won the Patient Safety award at the Health Service Journal's prestigious annual awards ceremony.** The panel of judges, drawn from experts from around the country, cited the "value-driven" and "patient-centred" approach and said the Trust was "a clear winner in this category" for which there were more than 150 nominations.

Following the results of an audit in 2013 into the number of deaths within 30 days of a patient being treated for a hip fracture, the orthopaedic team introduced a number of measures which have revolutionised the care provided to patients. These included the establishment of a dedicated hip fracture unit, an increase in the use of spinal anaesthesia, the employment of a dedicated nurse specialist and the introduction of an out-of-hours outreach service to support patients post-operatively.

Patients admitted to hospital with a hip fracture, are often seriously ill, elderly and frail, resulting in poor outcomes. The revolutionary changes introduced, now recognised by the Royal College of Physicians, resulted in a greater than 50% reduction in mortality rate since 2013 and the average 'length of stay' has gone down by more than two days.

Hospital at Night team helping to improve patient care

During 2015/16 we introduced a new Hospital at Night team (8pm – 8.30am, seven nights a week) at Watford General Hospital to support the clinical care of acutely unwell patients overnight. The team's responsibilities include responding to calls to take bloods, inserting new drips and reviewing patients when there are concerns.

This innovative service represents a significant improvement to patient care, as patients' clinical needs are responded to promptly. Since the Hospital at Night team started in April 2015, the number of cardiac arrest calls has reduced by approximately 50%.

A survey of junior doctors in the Trust found that 100% felt that the Hospital at Night had improved patient safety and audits show that there have been measurable improvements in:

- Mortality.
- Visits to the ward from specialist Intensive Treatment Unit (ITU) clinicians.
- Numbers of patients needing transfer to ITU.
- Length of stay.

Reduction in the number of hospital-acquired pressure ulcers

An initiative called 'BEST SHOT' has been implemented and has achieved a significant reduction in the number of patients who develop pressure ulcers whilst in hospital. Over the past two years, we have had no grade 4 ulcers (the most severe) and the number of grade 3 ulcers has reduced by 80%, down from 66 in 2014/15 to 13 in 2015/16. We are also making great inroads with grade 2 ulcers, which have reduced by 41%, down from 166 in 2014/15 to 98 in 2015/16.

This major improvement has been as a result of the introduction of a number of developments, including better pressure ulcer documentation, the introduction of 'skin champions', matrons regularly checking the status of pressure ulcers, reviews of equipment, easier access to pressure-relieving mattresses and new pressure-relieving cushions.

Pressure ulcers are not only extremely painful for patients, they can also be life-threatening. These improvements therefore represent significant steps forward in terms of better care and improved patient experience.

Improvements in stroke services

We have made significant improvements to our stroke service in 2015/16. We are now in the top 52% (Grade B) of 213 hospitals participating in the national stroke audit, compared to 2014/15 when we were in the bottom 6% (Grade E).

Two of the measures introduced to strengthen the service are a seven-day consultant ward round and a seven-day stroke and transient ischaemic attack (TIA or 'mini stroke') service. This means that all new stroke admissions are reviewed by a consultant on weekends and there are also stroke prevention clinics at weekends and improved collaborative working within a multidisciplinary team.

We have stroke nurse specialists available 24 hours a day, 7 days a week, which ensures that all patients arriving at the hospital with suspected stroke symptoms are reviewed by a specialist very quickly. We have also increased the number of specialist stroke physicians from two to three and hope to increase this further as we aim to provide full hyper-acute stroke services in west Hertfordshire.

We have established an Early Supportive Discharge team that aims to get patients home very quickly by providing the same level of therapy in their own home as they would have received in hospital. This service improves a patient's chances of achieving the best recovery possible without becoming more dependent or seriously unwell.

Strengthening safeguarding

During 2015/16, our safeguarding systems and policies were updated so that we now have the right infrastructure and processes in place, including system-wide multi-agency partnerships. We have re-established named professional safeguarding leads, ensured all staff had the relevant Disclosure and Barring Service clearance and expanded safeguarding training.

Improving the sustainability and quality of planned care

At the beginning of 2015, we worked closely with the NHS Interim Management and Support Team (IMST) to support our referral to treatment programme. The IMST team was impressed with our progress in achieving our target and signed off our Trust in June 2015 as not requiring continual formal support.

The improvements we have made to the quality of planned care include:

- Achieving the 92% referral to treatment standardfor five months of the years, from July to November 2015. (The national standard is that 92% of patients should have started non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral). However, we had challenges around theatre capacity, both from unprecedented levels of activity from winter pressures which resulted in the prioritisation of emergencies and from cancelled activity in response to the junior doctors' strike, which meant that we did not achieve the target from December 2015 to March 2016 and our full year figure was 91.3%.
- Achieving and sustaining the 99% diagnostic standard.
- Consistently achieving the 62 day cancer waiting times standard in each quarter of 2015/16 and our full year performance was 87.1%.
- Making significant progress on data quality, reporting, audit and 'cleansing' the current system, to ensure it is fit for purpose.
- Developing a robust governance process for Cancer Services.
- Ensuring that serious incidents, incidents, risks, complaints, peer review and Care Quality Commission plans are all now key items discussed in local, divisional and Trust meetings.
- Delivering ad hoc Saturday clinics to support the 18-week Referral to Treatment compliance.

For further detailed information on our performance against the NHS Operating Framework see the section titled 'Annual Governance Statement'.

Improving End of Life Care in 2015/16

During 2015/16, we made improvements in the service we provide to our patients in their final days of life and the support we give to their families and carers, including:

- Agreement that End of Life Care teaching will form part of the core training for new starters.
- Macmillan funding secured for an End of Life Educator post.
- Review of the governance and reporting structures for End of Life Care.
- Roll out of the Individualised Care Plan for the Dying Person.
- Recruitment of a Non-Executive Director and executive lead for End of Life Care.

We participated in the 2015/16 National End of Life Care Audit which showed:

- Doctors and nurses working in our hospitals said that we were good at recognising when someone is dying and documenting this so that improved and more appropriate care can be given.
- Doctors working in our hospitals ensured that 'do not resuscitate' decisions were made, communicated and documented appropriately so that the indignity of a futile attempt at resuscitation is avoided and people can die peacefully and with dignity. This was discussed with the family in 91% of cases (national average 78%).

The use of the Rose symbol in the Trust is now used to promote dignity and respect at the end of life. It 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.

Positive Feedback from an external source

When the School of Anaesthetics visited Watford General Hospital in January 2016, they commended our process for learning from mistakes, saying that it was "one of the best we have seen".

Excellence in dementia care

We are continuing to make improvements to our dementia service, such as developing a specific policy and care plan for challenging behaviours. The delirium recovery programme is now being adopted by a number of other hospitals across the country.

Signing up to become dementia friends

As a Trust we have been offering dementia friends training to staff on a regular basis. These training sessions give people an understanding of the condition and the small things everyone can do to make a difference to those living with dementia.

In addition to Trust staff receiving this training, staff working across our hospitals who are employed by our facilities contractor, Medirest, such as porters, domestic and catering staff, have also received training to become Dementia Friends. Medirest aims to train all 420 of its staff by the end of the year. Furthermore, as part of this programme, Medirest has introduced, for elderly patients with dementia, specific foods which they might remember from their younger days and which they would find comforting.

Working in partnership ~ 'Kissing it Better'

Our Trust began a partnership with the national charity 'Kissing It Better' in early 2015. Working with 'Kissing it Better', the aim is to provide the little things that make a big difference to our patients to improve their wellbeing and aid their recovery.

In 2015/16, we provided activities such as pet therapy and music into our hospitals to help brighten patients' days and to enhance our patient experience in many different ways. We will continue to build on our partnership with the Kissing it Better charity during 2016/17.

In the year to March 2016, we estimate that the Kissing it Better project has delivered approximately 4,687 hours of contact time with patients:"Kissing it better has been such a pleasant and meaningful experience. This is the first time that I've done something like this and I believe throughout this year I'm going to learn a lot of things which will help me in the future if I do decide to carry on with medicine.

Talking to the patients is such a rewarding experience. I'm able to relate to some things patients talk about and I feel very satisfied if I'm able to put a smile on the patient's face.

I just want to say thank you to you for keeping us as a group in check and to be able to provide this experience for us."
Aswin, Watford Grammar School for Boys.

Hello my name is...

We are proud to support the national "Hello, my name is..." campaign, aimed at helping to improve the hospital experience for all our patients. The #hellomynameis campaign was created by Dr Kate Granger, a doctor from Yorkshire, who was diagnosed with terminal cancer. She became frustrated by the number of staff who failed to introduce themselves to her during her time in hospital. The campaign, which has had a great impact via social media, helps to remind staff to go back to basics and introduce themselves to patients properly, to improve patient experience. The campaign continues to inspire nurses, doctors, therapists, receptionists, porters, domestics and staff in all roles.

Areas for further improvement

Improving emergency care

We know we need to make improvements in our emergency care. However, following a visit in November 2015 by the National Emergency Care Improvement Programme (ECIP) to review our unscheduled care service, feedback was extremely positive.

During 2015/16, 85.9% of patients in our emergency department were seen, treated, admitted or discharged within four hours, against the national four-hour standard of 95%.

Improvements that have been made this year include:

- Faster access to expert specialist assessment for patients with respiratory and cardiac conditions.
- Improved facilities for triage, ensuring that all patients are initially assessed within 30 minutes of arrival.
- Developing a frailty service to increase the number of frail patients being seen faster and to ensure that our most frail and often elderly patients get access to expert care and treatment in the most appropriate environment. A designated frailty space was made available in March 2016.
- Health and social care staff being co-located as one integrated discharge team to enable greater partnership working.

Another significant improvement includes quicker discharges. The pharmacy department trialled a new system for dispensing medications to take home on a number of inpatient wards at Watford General Hospital. The aim of the trial was to get patients discharged more quickly from hospital by using a mobile dispensing unit to process medication for patients who are medically fit to leave hospital. The results of the trial showed that medication orders for nearly half of the patients were completed in around 15 minutes, compared to around two hours previously. Following the success of the trial, the new process will be rolled out across our hospitals.

Hospital Infections

Reducing healthcare-associated infections continues to be a priority for our hospitals. In 2015/16, we reported 28 Clostridium difficile infection (CDI) cases against a target threshold of fewer than 23 cases. Although we did not meet the target, there were no outbreaks and no cross-infections, with all cases having been isolated.

We reported one MRSA bacteraemia against a target of zero and successfully managed two Norovirus outbreaks.

Future work is underway to ensure that we meet the 2016/17 targets for CDI and MRSA bacteraemia.

All staff (clinical and non-clinical) are required to undertake mandatory training in infection prevention and control (IPC) and we have a detailed action plan to ensure that our infection control practices are in line with national guidance. We updated a number of Trust policies which deal with infection.

The Board receives monthly reports on IPC and every six months an IPC compliance report is submitted to the Board as an assurance that all necessary actions are being taken to reduce the risk of infection across all areas of our hospital sites.

We have also seen an improvement in hygiene, equipment, environmental and Test Your Care scores. Test Your Care is a collection of nursing care indicators and patient experience questions used to monitor and improve standards of patient care.

Never Events

'Never events' are potentially very serious incidents which, by their definition, "should never happen". Two such events were reported in 2015/16. 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.

Strengthening Governance and Risk Management

Strengthened risk management

During 2015/16, we continued to review and improve our governance and risk management arrangements. We implemented an upgrade to 'Datix', our computerised risk management tool, updated our risk management policy, provided training to staff and comprehensively reviewed our risk register. As a result of this work, we now have a much clearer understanding of our risks and can ensure that, where significant risks are identified, clear actions are taken to reduce the risk of harm.

Serious Incidents

In 2015/16, we also made some changes to how we investigate and learn from serious incidents, responding to the findings of the CQC that our processes were not working effectively. Our Serious Incident policy was rewritten to reflect the new NHS England Serious Incident Framework and we recruited additional staff into a central serious incident support team so that we can provide more support to clinical services and provide greater assurance that lessons are being learned when mistakes happen.

We have worked hard to strengthen our serious incident and incident reporting processes, eliminating the backlog of overdue serious incidents from previous years by the end of February 2016. Since that time, 100% of serious incidents have been submitted to commissioners within the agreed deadlines. The quality of the reports has improved along with our performance and adherence to target dates. We have also strengthened processes to track delivery of actions and shared learning from serious incidents (SIs).

We reported 69 SIs in 2015/16. This was a significant reduction from the 207 SIs reported in 2014/15. This was largely due to better application of SI criteria in line with national guidance, systematic application of the criteria when assessing incidents and also as a result of the significant reductions of hospital-acquired pressure ulcers.

Harm-free care

Test Your Care was introduced in March 2014. By the end of March 2016, the overall Trust average rate was 86.0%, with some specialist areas coming on board throughout the year. We have set ourselves a target of 95% for 2016/17. New ward-level dashboards and an integrated performance report enable staff to be aware of the performance in their area and across the Trust.

Medical documentation has improved significantly within the last year with the production of a standardised medical clerking proforma. This contains important documentation in a more prominent place within the proforma, such as Venous thromboembolism (VTE) risk assessment, treatment escalation plan and Do Not Attempt Cardio Pulmonary Resuscitation statements.

We also introduced new nursing documentation throughout our hospitals and reviewed and amended maternity hand-held antenatal notes to bring them in line with screening and risk assessment requirements.

We use the 15 Steps Challenge to improve the quality of the care we deliver. This is a set of toolkits which have been co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders to look at care in a variety of settings through the eyes of patients and service users, to help capture what good quality care looks, sounds and feels like.

Emergency preparedness and resilience

Emergency preparedness and resilience remains at the forefront of the drive to maintain operational capability and provide an effective and efficient response to any critical incident.

All of this is achieved with a focus firmly on normalisation of services and maintenance of business continuity, protecting critical and essential services across our three hospitals sites.

We continue to provide a relevant training and development programme to staff, with an emphasis on preparedness and resilience and in conjunction with tests and exercises.

We have participated in a number of planned communications tests and practice exercises in 2015/16 and continue to draw benefit and learning from real time live critical incidents and business continuity incidents, in areas such hostile threat, utilities failures, capacity pressures and IT infrastructure failures.

These incidents provide an invaluable insight and affirmation of our response and business continuity capabilities, demonstrating our ability to effectively and efficiently respond to these incidents.

Looking after your data

In response to an external review of information governance systems and processes in December 2014, we have implemented a number of additional controls to strengthen governance arrangements, communication and compliance. These include improving how we ensure patient records are kept safe and secure, with better adherence to policy and new lockable medical records trolleys and cabinets and confidential waste bins. For full details, please see the section titled 'Annual Governance Statement'.

A patient representative said: "I was heartened to observe tangible improvements in areas of safety and governance, improved team/staff morale and patient experience"

Freedom of Information requests

In 2015/16, we received a total of 591 Freedom of Information requests, of which 92% were responded to within the mandatory 20-day time frame.

More details on how we have strengthened governance and risk management can be found in the Annual Governance Statement section and in our 2015/16 Quality Account (available on our website).

Our Environment, IT and support services

Improving the quality of our Information Management & Technology (IM&T)

We have made significant progress in 2015/16 in the deployment of new IM&T infrastructure across our estate, including the commissioning of new offsite data centres which will host Trust applications and provide business continuity and failover (automatic switching to a standby computer system to provide continuous availability and reliability). We have also started to roll out WiFi across our estate. This will enable mobile working for Trust staff, offering improved efficiencies and steps towards paperless working, for example, use of 'workstations on wheels' to allow for mobile prescribing. In addition, free WiFi access will be offered to our patients and visitors.

We have also started to roll out new devices (PCs, laptops and tablets) as part of the £25m investment into technology infrastructure which includes new clinical systems.

Other improvements include the development of our integrated performance report, with comprehensive suites of reports on operational delivery of emergency and planned care, to support clinical decision-making. This has included enhancements to patient tracking lists and development of data quality reports to manage patient pathways prospectively and also cancer information reporting, including the Cancer Performance Dashboard and improved submission of Cancer Outcomes and Service Data set.

Investment in day surgery services

Substantial improvements have been achieved in our day surgery services based at St Albans City Hospital during 2015/6. We decided to invest £900,000 towards making necessary upgrades which included moving and upgrading areas for patients recovering after their surgery. This included opening a number of high dependency beds, which means the unit can treat a greater number of patients, including patients with conditions that previously could not be catered for.

We have invested in new hand sinks, toilets and floors for the changing rooms and further money during 2016/17 will be spent on building a new centralised admissions lounge for patients prior to having their day surgery. This includes pre-assessment clinics, which have helped to reduce significantly the number of cancelled operations.

Day surgery allows patients to be admitted to hospital for surgery or a procedure and be discharged home on the same day.

In 2015/16 more than 9,000 operations were performed at our day surgery unit at St Albans.

Sign-up to Safety

In April 2015, we were successful in a bid for funding from the NHS Litigation Authority as part of the Sign-up to Safety campaign.

Approximately £800,000 was awarded and this is being used to improve patient safety, including critical simulation and the purchase of additional CT monitoring equipment.

New dedicated cancer room

We are creating a dedicated space at Watford General Hospital where clinicians are able to meet and discuss care for cancer patients. The new room will be supported by up-to-date technology, including video conferencing facilities and a pathology microscope which allows images to be projected onto a screen. This room will enable specialists working from different hospitals to come together in this complex work.

Care and treatment can be discussed by a team of relevant specialists to make sure that all available options are considered. This helps patients make informed choices about what treatment options are best for them as an individual.

Improvements to the hospital environment and infrastructure

In the year in review, we spent more than £6m on backlog maintenance to our aged infrastructure. The work included the following:

- Upgrades to operating theatres across all sites.
- Installation of High Voltage (HV) generators at Watford General Hospital to provide resilience and support business continuity.
- Upgrades to the heating and hot water systems across all sites.
- Continuation of Asbestos Management Plan tasks.
- Improvements to water distribution systems across all sites.
- Upgrade and expansion of piped medical gas system at Watford General Hospital.
- Refurbishment of clinical inpatient areas including the Special Care Baby Unit.
- Refurbishment of the Shrodells building at Watford General Hospital to enable expansion of clinical services across the site.

Improving radiology services

The radiology service has implemented a 24-hour system which will provide an extended MRI service at Watford General Hospital. This includes providing additional support to staff working on site out of hours.

A number of pieces of new equipment were installed in May 2016, including a dental x-ray machine, a new state of the art digital radiography room and a replacement fluoroscopic room to replace the ageing fluoroscopy unit at Watford General Hospital. The new equipment is faster and provides higher quality images which will help to improve diagnosis and will allow a reduction in radiation dose.

We have also made significant investments in new equipment in 2015/16 to make our services more efficient and effective. These include:

- Bariatric equipment.
- Pathology equipment.
- Replacement of ultrasound machines.
- Replacing obsolete equipment in the microbiology department which now

gives the opportunity to provide in-house, some diagnostics which are currently sent to outside laboratories. This will give us the ability to speed up the generation of patients' results and reduce the cost of sending these externally.

Improvements have been made to the main accident and emergency department at Watford General Hospital to reduce waiting times and improve patient flow. Refurbishment of the Shrodells Building, has enabled us to expand our endoscopy service and will provide the opportunity to provide further improvements to services over the next 12 months.

Multi-faith Room

NHS Blood and Transplant (a specialist health authority) continues to support our Organ Donation Committee. This year the committee has supported the refurbishment of a Multi-Faith room at Watford General Hospital. This refurbishment was greatly appreciated by all and the room now accommodates all religions and is also a pleasant space for people of no religious faith.

PLACE – patient-led assessment of the hospital care environment

PLACE provides 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 (HwH). The 2015 inspection looked at five key areas – (1) cleanliness; (2) food and hydration; (3) privacy, dignity and wellbeing; (4) condition, appearance and maintenance and (5) suitability of the hospital environment for people with dementia.

Our scores for 2015/16 were:

PLACE RESULTS	Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition, appearance and maintenance	Dementia
2014/15	95.81	91.13	71.59	84.99	Not Tested
2015/16	94.02	80.53	77.71	83.54	60.94

We allocated resources and considerable effort in order to improve areas of poor performance identified in the 2014 PLACE report. During the inspection, the team (including HwH) commented on the marked improvement in the ward environment and cleanliness across all sites and were very positive about the engagement of Trust staff in the PLACE process.

Following the inspection, meetings were held with HwH to develop a detailed action plan to maintain the continuous improvement. Actions undertaken include:

- Monthly mock PLACE audits with Patients' Panel representatives.
- Improvements to compliance reporting for cleanliness audits.
- Review of dementia requirements across all clinical areas.
- A series of measures to improve patient privacy in ward areas.
- Review of car parking arrangements on all sites.

Improving security

With many staff working shifts, plus the hospital operating 24/7 and a constant flow of patients and visitors, maintaining hospital security is a real challenge.

During 2015/16, there have been a number of additional security initiatives, including updating CCTV systems on all three sites. This system includes a feature

which automatically sends an email alert to the security team, notifying them of a security breach.

We have also invested in the installation of a new security door access system at Watford General Hospital, including in the maternity unit.

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 Assessment Model (a national self-assessment tool to help NHS organisations to measure and improve their sustainable development performance).

Resource	2011/12	2012/13	2013/14	2014/15	Provisional 2015/16
Gas (kWh)	38,026,702	36,898,214*	40,620,606	41,920,825	43,749,853
Electricity (kWh)	16,547,671	17,167,977	17,010,202	17,910,702	13,992,258
Oil (kWh)	213,214	1,798,066*	26,423	160,611	19,545
CO2 (tonne)	16,008	16,611	16,701	7,808	16,000
Total Energy Spend	2,770,832	3,058,695	3,118,866	3,218,042	3,373,101

Source: ERIC (Estates Return Information Collection)

* During 2012/13 we undertook a planned asbestos removal programme, which required a higher usage of oil but a lower usage of gas.

3,923,891 kWh from onsite combined heat and power provided 6,160,511 kWh of heat.

These figures include an amendment to the figures reported in last year's Annual Report.

Key activities this year include:

- Installing new energy-efficient lighting as part of all refurbishment works.
- Upgrades to Building Management Systems across all sites.
- Provision of electric car charging points.
- Upgrades to heating and hot water systems.

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, Healthwatch Hertfordshire, the Patients' Association and our own Patients' Panel.

The Patients' Panel

Throughout 2015/16 the Patients' Panel has continued its work. The panel is a small group of ordinary people living in West Hertfordshire, who have been, and in several cases currently are, patients and carers of the Trust.

The Panel continues to see itself as a 'critical friend' of the Trust – supporting us in many ways but not hesitating to act when finding things that could be improved upon and then helping to put things right.

The Patients' Panel has supported many projects and has been involved in service improvements by contributing to the Patient Experience Group and the End of Life, Bereavement, Patient & Public Involvement and Equality and Diversity Panels.

Some of the individual projects that they have been involved in during 2015/16 include:

- Assistance with quality standards – including PLACE audits, clinical audits and CQC mock reviews.
- Input into policy documents.
- Input into staff training documents.
- Review of patient communications, including leaflets and posters.
- Staff awards shortlisting.
- Interview of key staff appointments.
- Signage checks.
- Major incident planning.
- Naming of wards and commenting on colour schemes for wards and communal areas.
- Feeding of patients on wards.

In addition, many of the panel's members provide a valuable contribution to numerous committees across the Trust.

The Friends and Family Test

The Friends and Family Test (FFT) is a quick and anonymous way for patients to give their views after receiving care or treatment and helps us to understand whether patients are happy with the service provided, or where improvements are needed.

The FFT has been rolled out across more than 80 wards and departments across all three hospitals.

The target response rate of patients completing the survey is 54%. The 2015/16 rate of positive responses from patients saying that they "would recommend our hospital" was 94% across all areas. The target for 2016/17 is 95%.

The survey results are displayed on ward and department Quality Boards which include statistics covering infection control, slips, trips and falls. These boards also include comments from patients – both good and bad - visible to staff, patients, visitors and carers.

Maternity Survey

One of the methods used to engage with patients is through patient surveys which provide invaluable feedback on our services and help us focus on the things we need to do better.

The results of the National Maternity Survey 2015 were published in December 2015 and, when compared with other Trusts nationally, we were:

- Significantly BETTER than average on three questions.
- Significantly WORSE than average on four questions.
- Average on 44 questions.

An action plan has been developed to address the areas where improvement is required. These actions will be incorporated into the wider improvement plan for the Maternity Service that has been developed in response to the CQC inspection visit.

NHS Choices

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

Hospital	Number of NHS Choices comments
Hemel Hempstead	43
St Albans	65
Watford	168

We replied directly to this feedback, offering advice on where to get further information or details on how to contact our Patient Liaison and Advice service or complaints team.

Patient stories at the Board

Throughout the reporting year, patients, carers and members of staff have been invited to public Board meetings to tell their story. This gives Board members an opportunity to hear firsthand from those using services or their friends and relatives, and to learn how to make improvements where needed and to share learning.

We are extremely grateful to those patients who came along to the Board meeting to share their experience.

Listening to patients – a patient's story
Mr C said that he had had fantastic care during his admission. However, he said that the environment was poor and there was a lot of noise at night.

What we did:
Much work has taken place around 'noise at night', either from patients or staff, also highlighted in our National Inpatient survey 2015/16. Processes have been put in place to ensure that patients are not moved late at night. Ward phones are switched to silent and lights are dimmed. 'Ssshhhh…' posters, supported by the Chief Nurse, have also been placed on all wards and earplugs are handed out to patients during drug dispensing.
All these have been set in place to improve the patient experience and to highlight the importance of a good restful sleep for our patients.

Our 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. We have more than 5,000 Twitter followers, so why not follow us:

@westhertsNHS

www.facebook.com/westhertsnhs

www.youtube.com/user/westhertsnhs

Patient Advice & Liaison Service (PALS)

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 offers, wherever possible, on-the-spot support to help resolve any problems.

PALS has maintained its position with patients, the public, staff and external organisations as a department that is responsive and proactive to queries and concerns. PALS remains an effective resource in supporting patients, their representatives and staff by responding to 'real time' queries and concerns.

In 2015/16, the PALS team dealt with a total of 3,202 reported concerns, which is a 67% increase on last year. Approximately 25% of concerns raised, related to delayed appointments, assessments, waiting times and admissions.

Formal complaints

We understand that every concern or complaint is an opportunity to learn and make improvements in the areas that patients, their relatives and carers say matter most to them. Our aim is to address concerns and resolve problems quickly and effectively at the point of care to ensure the satisfaction of all involved. We believe that where possible, putting things right immediately will have the most positive impact upon the quality of care and on complaint handling.

Effective concerns and complaint handling is an important part of ensuring that people receive high quality care. In 2015/16, we revised and updated our policy for the management of concerns and complaints to ensure that we listen and respond to complaints appropriately. All formal complaints are monitored on a regular basis to enable us to address all issues in a timely manner, with an escalation process in place to ensure executive support.

During 2015/16, we received 979 formal complaints, a slight reduction on the previous year where 998 formal complaints were logged. Of these, 47% were founded.

Our new process has also seen a reduction in the response time from an average of 70 days to approximately 30 days, depending on the complexity of the complaint. Every complaint is considered and there is a focus on resolution with openness and transparency. Whether that resolution takes place in a meeting between service users and staff members or by providing a written response to any concern raised, our aim is always to focus on our ongoing commitment towards service improvement.

Principles for Remedy

We follow 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 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 what remedies may be available to them and in what circumstances.
- 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 which has remedy has been decided on 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.
- As there are no automatic or routine remedies for injustice or hardship, considering such remedies on an individual basis, including such actions as an apology or explanation, changing a decision, revising public documentation and training or re-training staff.

Progress towards achieving equality and diversity

The Trust is committed to promoting a productive, harmonious environment that values diversity. We aim to be an inclusive provider of healthcare and to create an environment in which the services we provide and our workplace are free from unfair or unlawful discrimination, harassment or bullying and where the human rights principles of fairness, respect, equality, dignity and autonomy are upheld.

We have a comprehensive Equality and Diversity policy which is updated regularly and is accessible to all staff via the Trust's internal website.

We use the NHS England Equality Delivery System 2 (EDS2) performance framework to help us monitor and improve the services we provide. The EDS2 will help us to meet the Public Sector Equality Duty of the Equality Act 2010.

EDS2 has four key goals:

- Better health outcomes for all.
- Improved patient access and experience.
- Empowered, engaged and well-supported staff.
- Inclusive leadership at all levels.

The system is now mandatory and in the NHS Contract, which means that wherever you go for NHS services they will be working towards the same set of equality, diversity and human rights goals.

Interpreting support for patients

We serve a diverse patient population and are committed to ensuring that there is effective communication with non-English speakers, with people for whom English is a second language and with those patients with a sensory impairment who require communication support.

Information on our interpreting services is available on our public website:

www.westhertshospitals.nhs.uk/visitors/translating_interpreting_visitors.asp

Sensory & Physical Disability Service Watch Group

We are a member of the Sensory & Physical Disability Service Watch Group, chaired by Healthwatch Hertfordshire. This year the group looked at disabled access to healthcare buildings and fed back from patients and service users. Herts Hearing Advisory Service also supplied our hospitals with hearing loss packs to support our patients. Sensory training for frontline staff also formed part of the group's work.

This year, we established the Let Me Hear You panel, for the deaf and hard of hearing, chaired by a member of staff who has impairment. We have already extended this to include blind, deaf/blind and partially sighted patients and staff and the panel is now the Let Me Hear You/See You panel.

Lesbian, Gay, Bisexual & Transgender

We continue to be a member of the Hertfordshire LGBT Partnership and the Transgender Implementation Steering Group.

Help from our friends

Our volunteers

During 2015/16, we recruited 116 volunteers giving us a total of 446 volunteers across our three hospitals at the end of March 2016. This includes 20 voluntary drivers who provide a service taking patients to and from hospital appointments.

We also thank the Royal Voluntary Services, Macmillan cancer support workers and Watford and Hemel Hempstead Hospital Radio volunteers for their continued support.

Volunteers play an important role in our hospitals. Their contributions enable us to enrich and extend the range of services offered to patients, their relatives and carers. They give their valuable time and provide our patients with a better experience. Their activities range from supporting staff on reception desks, looking after patients in the discharge lounge, feeding patients on the wards, carrying out mystery shopping, giving views on patient information to ensure it is 'user friendly' and supporting PLACE visits (patient-led assessments of the care environment) and 15 Steps inspections.

Volunteers also help to provide a wide range of activities and services that contribute to the quality of the patient experience and volunteering enables those who take part to participate and make a real difference.

In January 2016, we recruited a new Voluntary Services Co-ordinator who is introducing new ways of recruiting and retaining volunteers and ensuring that they feel valued and are offered opportunities to further their knowledge and skills.

Our charity

In 2015/16, our charity, West Herts Hospitals Charity (WHHCh), received a very significant pledge of £148k from the League of Friends of WHHT and their team of volunteers – for which we are very grateful. Their donation has made a great difference to patient experience by enabling works to a range of really important projects including:

- Two projects (the breaking bad news room and the Rose project), designed to support patients at the worst of times.
- The new simulation suite which will enhance the training of medical and nursing staff.
- The purchase of much needed equipment (resuscitation trolleys, phlebotomy chairs, reclining chairs, electrical treatment couches for the antenatal clinics, cardiac arrest trolleys and ward clocks for dementia patients).
- Refurbishment of 'quiet rooms' for relatives.

Other income came from staff who raised £103k whilst £19k was raised on our behalf by others and investment income was £31k.

Expenditure through WHHCh was £255k (2014/15: £364k), including allocations as follows: £41k for improved patient outcomes, £28k for better patient experience, £44k for staff development and welfare and £66k for staff training. WHHCh still holds significant money in restricted or designated reserves and in order to meet the ambition of spending charitable funds in a timely fashion, continues to work with the 118 designated fundholders and divisional managers to forecast and manage spending plans. To support this process and to put fundraising on a more professional footing, a Head of Fundraising has been appointed. This post holder will also work to develop a range of new fundraisable projects.

Our Future

Your Care, Your Future

In 2015/16, we worked with local partners as part of Your Care, Your Future (west Hertfordshire's system-wide health and social care plan) to look at how well current services meet the needs of our population and to develop proposals for how services need to change and develop over the next 10 years, in order to ensure that we can support the health and wellbeing of local people and provide the very best care for people when they are unwell.

> **Your Care, Your Future Vision**
>
> Our vision is that people are healthier – we want to prevent people from becoming ill in the first place. We want people to get the care they need in the right place – often close to where they live – at the right time. More joined up community health and social care services will help people stay well and get the support they need. It will also help us live within our means.

In November 2015, Your Care, Your Future published a strategic outline case (SOC) which describes the future model of care for west Hertfordshire. We have formally confirmed our support for the vision and principles set out in the SOC and have been working with partners to agree how, together, we can start to make the changes that are needed.

We have also started work on our own clinical strategy, to be published in during 2016/17, which will set out our vision for the contribution we can make to meeting the future health and well-being of local residents.

We have also started work on planning for the future redevelopment of our estate – our current buildings make it difficult for us to provide the very best care for our patients and provide a poor environment for our staff. We are working on an interim estates strategy which will cover the next five years, whilst also working on a long-term strategy to redevelop and upgrade our buildings for the foreseeable future. Securing investment for this long-term project is a real priority for the future.

Watford Health Campus

We continue to work with Watford Borough Council and Keir Property Ltd as part of the 'Watford Health Campus'. The Watford Health Campus was launched in 2013 with the aim of redeveloping the land around the Watford General Hospital site, bringing new homes, new jobs, accessible open green space and a mix of facilities and services.

As part of the project, work began in 2014/15 on the construction of a new road to the health campus and hospital site. Construction work started on the road in June 2015 and the road is expected to be completed by October 2016.

The Accountable Officer affirms that this is a fair and balanced Performance Report.

Signed

Tracey Carter

Acting Chief Executive Officer

2. The Accountability Report

2.1. Corporate governance report

Directors' report

The names of the Chair and Chief Executive and the names of any individuals who were directors of the Trust at any point in the financial year and up to the date that the annual report and accounts were approved, are contained in the Directors' remuneration table.

The composition of the management board (including advisory and non-executive members) having authority or responsibility for directing or controlling the major activities of the Trust during the year, is shown in the Annual Governance Statement.

The names of the directors forming the audit committee or committees are shown in the Annual Governance Statement, in the Board and Committee attendance table.

Details of company directorships and other significant interests held by members of the management board which may conflict with their management responsibilities are shown in the Declarations of interest table.

There have been no incidents reported to the Information Commissioner's Officer during this period.

Directors' statement

Directors of the Trust have confirmed that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and they have taken all the steps required to ensure that they have made themselves aware of any such information and to establish that the auditors are aware of it.

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, Directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

31 / 5 / 16

Acting Chief Executive

Tracey Carter

31 / 5 / 16

Chief Financial Officer

Don Richards

ANNUAL GOVERNANCE STATEMENT 2015/16

1. SCOPE OF RESPONSIBILITY

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our 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. In addition to this I am also responsible for ensuring our system for internal control supports the safety and quality of care given to patients. I can confirm that arrangements are in place for the discharge of statutory functions, and that these have been checked for any irregularities, and that they are legally compliant.

I also acknowledge my responsibilities as set out in the NHS Accounting Officer Memorandum.

2. GOVERNANCE FRAMEWORK OF THE ORGANISATION

Governance framework

The governance framework of the Trust is designed to manage risk to a reasonable level rather than to eliminate all risk; therefore it can only provide reasonable and not absolute assurance of its effectiveness.

The overarching governance framework of the organisation ensures that there is an overall system of internal control that is reviewed on an on-going basis in order to ensure a proactive approach is in place for the assessment and management of risk in relation to achievement of our aims and objectives.

Trust Board

The Trust Board has formally met ten times this financial year and conducted its business in accordance with its Standing Orders and Standing Financial Instructions. The Trust Board consists of a Non-Executive Chair and five Non Executive-Directors, five voting Executive Directors (including the Chief Executive) and four non-voting Executive Directors.

In 2015/16, the Board also had non-voting Directors in attendance, including the Director of Workforce, Director of Operations (elective care), Director of Operations (unscheduled care) Director of Strategy and Corporate Services, Director of Environment and Director of Communications. The Company Secretary also attended all Board meetings.

In line with recommendations from a Leadership Review commissioned by the Trust Development Authority, in 2016/17 the Board membership will be streamlined to bring it in line with comparable NHS organisations and only voting members will attend Board meetings. The Director of Strategy and Corporate Services will also attend on a regular basis to represent corporate areas and Executive Directors will be invited to attend to present specific items as required.

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

In 2015/16, membership of the Board changed as follows:

- Mahdi Hasan retired as Chair in October 2015 and Professor Steve Barnett took over the post in November 2015;
- Phil Townsend was re-appointed as a Non-Executive Director and Vice Chair for a further two-year term;
- Lisa Emery was substantively appointed to the role of Chief Information Officer in September 2015;
- Kevin Howell was substantively appointed to the role of Director of Environment in September 2015;
- Helena Reeves took over the post of Director of Communications on an interim basis when Antony Tiernan left in May 2015;
- Jonathan Rennison was appointed as the Senior Independent Director in April 2015.

Two recruitment campaigns were undertaken in 2015/16 to appoint a substantive Chief Executive. However, both were unsuccessful and I therefore agreed to continue in the post of interim Chief Executive until an appointment was made. The Trust will continue to try and recruit to this key post in 2016/17.

The Board attendance for 2015/16 is attached at Appendix 1.

CQC inspection

In April 2015, the Care Quality Commission (CQC) undertook a full inspection of our three hospitals. Their report was published in September 2015. Whilst our mortality rates are better than expected when compared to other acute hospitals, the CQC identified a range of significant concerns in relation to how the Trust systematically ensures the quality and safety of its services. The CQC was particularly concerned with organisational culture and staff morale, the quality and suitability of some of our facilities and our overall governance and risk management processes. A key issue of concern raised by the CQC was in relation to staffing levels, in particular in the maternity service. The Trust responded rapidly to this issue and chose to suspend its private obstetric service from 01 May 2016 to allow the maternity team to focus on NHS patients.

Special measures

Following the outcome of the CQC Inspection, the NHS Trust Development Authority (NHS TDA) placed our hospitals in 'special measures' to ensure that the recommendations were fully implemented and rapid progress made in delivering the required improvements. This has given us extra help and support to make the necessary improvements to our services. Following the publication of the reports in September 2015 we developed a comprehensive quality improvement plan under five key themes: Our People; Getting the Basics Right; Patient Focus; Infrastructure and Governance, Risk Management and Decision-making.

The focus on delivering the quality improvement plan and the Trust being taken out of Special Measures have been the principal drivers of the Trust's programme of work throughout this financial year. We have made good progress in implementing more than 200 actions set out in our quality improvement plan and expect the majority to be completed by June 2016.

The TDA appointed an Improvement Director for the Trust, who has been working closely with the Trust Board on the delivery of the quality improvement plan, board performance and corporate and clinical governance. A monthly Oversight Group, chaired by the TDA, brings together all partners to review the progress we are making and identify ways in which partners can support us with our improvement journey.

In addition, the Trust has agreed an official 'buddying' arrangement with the Royal Free London NHS Foundation Trust to collaborate/support on governance and risk; clinical leadership and engagements; end of life care and pathology. The Royal Free has an international reputation in many areas of specialist care and is one of the NHS organisations drafted in by the Health Secretary, Jeremy Hunt, to help prevent future failures of care and safety at NHS hospitals.

As part of the Special Measures support package, a leadership capacity and capability review was undertaken by Deloitte in December 2015, on behalf of the Trust Development Authority. The review recognised excellent leadership experience and potential at board level and the significant progress that had been made by the Trust in a number of areas. It also offered a series of recommendations to strengthen leadership, which were welcomed by the Trust. Implementation of the recommendations aimed at improving our governance mechanisms, tightening accountabilities, improving performance management and establishing clinical leadership and development programmes began in 2015/16 and will continue in throughout the year ahead.

Committee structure

A supporting corporate governance structure assists the Board in carrying out its duties effectively. During the year, the Board has completed a review of its corporate governance structure which resulted in the frequency of the Safety and Quality Committee and the Workforce Committee being moved to a bi-monthly basis to allow sufficient time for actions to be addressed. Also, following the outcome of the CQC findings on our risk and governance arrangements, a short-term Integrated Risk and Governance Committee was established to strengthen oversight of the Trust's risk and governance arrangements.

Each committee formally provides an assurance report to the Board following each meeting and Executive and Non-Executive members highlight specific areas of exception which need to be discussed by the Board, including ratification of key strategies and associated reports.

In April 2015, the terms of reference and annual work plan for each committee was reviewed and endorsed by the Board.

All Committees of the Board were chaired by a Non-Executive Director.

Audit Committee

The Audit Committee met seven times in 2015/16 and provided the Board with assurance on the key aspects of their work, including:

- Internal controls, i.e. finances, losses and compensations, gifts and hospitality;
- Clinical audit;
- Process for the development and maintenance of the Board Assurance Framework;
- Counter fraud service;
- Internal and external audit reports;
- Review and recommendation for approval of the annual accounts, annual governance statement and quality account;
- Monitoring effectiveness of other Board Committees;
- Arrangements for establishing an auditor panel.

The Audit Committee reports to the Board following each meeting and highlights specific issues to the Board. The Audit Committee has reviewed specific reports including limited assurance internal audit reports and progress with implementing recommendations.

Internal audit and local counter fraud services are provided by an independent external expert.

The Audit Committee produces an annual report which is formally reported to the Board outlining the activity undertaken during the year against the committee's terms of reference.

Remuneration Committee

The Remuneration Committee is established to review the remuneration, terms and conditions and performance of the Executive and Senior Managers and to monitor succession planning. The Committee meets on an ad hoc basis.

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 and to encourage donations and fundraising in order to support charitable activities within the Trust.

Safety & Quality Committee

The Trust revised the terms of reference of the Patient Safety, Quality and Risk Committee in 2015/16 due to the establishment of a new Committee which has a key focus on risk management within the organisation. In line with this, in July 2015 the Patient Safety Quality and Risk Committee became the Safety and Quality Committee and the frequency changed from monthly to bi-monthly.

Finance & Performance Committee

The Committee was established to provide the Board with assurances that the Trust's financial expectations are met and at the end of 2014/15 the terms of reference were expanded to include the responsibility for performance. The Committee meets on a monthly basis and, as well as the financial position, it monitors ICT (information communication technology) performance.

Workforce Committee

The Committee is established to provide the Board with assurance concerning all aspects of workforce, organisational development and learning. Following a Board and Committee structure review, the frequency of the Committee was revised to bi-monthly in July 2015.

Transformation Committee / Strategy Committee

The role of the Transformation Committee was reviewed during the year and it was agreed that as the Trust's transformation programme had moved into an operational phase, the terms of reference for the Committee had been completed. The Committee therefore transferred to the role of a Strategy Committee to provide the Board with assurance on the development and oversight of the long term strategy of the organisation, including clinical, financial, IT and estates.
The Committee also monitors relationships and communications with key external stakeholders and the development and delivery of the annual plan.

Integrated Risk and Governance Committee

As a result of feedback on the risk management arrangements within the Trust from the CQC, a new Integrated Risk and Governance Committee was established on a 'short term, as required, basis. The role of the Committee is to provide Board assurance on the management of risks within the Trust, including the controls in place and the progress of mitigating actions and to ensure that the Corporate Risk Register and Board Assurance Framework are maintained and updated appropriately.

The Committee attendance for 2015/16 is shown on page 44.

Board's assessment of its effectiveness

In June 2015, the Board undertook the Well-Led Framework for Governance Reviews. The outcome of this work has been incorporated into a quality improvement plan which responds to CQC concerns.

In 2015/16, the Board also introduced a self-assessment item into its agenda to review and strengthen the effectiveness of Board meetings.

Board development

During the reporting year, a series of dedicated development sessions were held to consider key areas of strategic significance and risk. Topics included the strategic aims and objectives, the Board Assurance Framework, completing the Well-led Framework for Governance and development of a quality improvement plan.

As part of this programme, in May 2015 the Board received feedback from the Good Governance Institute (GGI) on a review of its effectiveness. The report noted that, although it was recognised that the Board had changed significantly over the preceding year, the Board was functioning well, having appropriate discussions and showing good team spirit. GGI provided a number of recommendations for further improvement.

Each Board member underwent a 360 degree appraisal in 2015/16 and the Trust's strategic objectives were reflected in each Board member's personal objectives and appraisals.

During the reporting year, the Board also visited a range of clinical areas and departments across the three hospitals. In addition, a patient was invited to attend Board meetings on a regular basis to inform the Board of their experience.

A Board Development Programme in 2016/17 will link into the outcome of the leadership capacity and capability review carried out as part of the Special Measures support package. The programme will contain of a series of development sessions and business workshops including training and development events, as well as information and knowledge updates. These sessions will be facilitated internally and focus on strategic direction.

The UK Corporate Governance Code

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.

Performance against NHS Operating Framework

In 2015/16 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 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 2015/16. Our performance is monitored by the Trust Development Authority, Herts Valleys CCG, the Department of Health, NHS England and the Care Quality Commission.

Performance against the national targets 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	85.9% - 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 23 cases of C. difficile through the year.	28 cases recorded – Under achieved	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.
Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have zero cases	1 case - Under achieved	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, 94.9% seen within 14 days - Achieved Breast symptomatic patients, 88.8% 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	98.6% patients seen within 31 days – 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 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	93.56% of patients referred by screening service seen within 62 days - Achieved 87.1% of patients referred by GPs seen within 62 days – 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.	97.3% 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 – patients not yet treated	>92%	91.3% - 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.

Reporting to the Board

Throughout the year, the Board's reporting cycle has focused on delivering the organisation's key objectives. The Board agenda has been streamlined to focus on the key actions following the CQC inspection report, operational performance, the Board Assurance Framework and the financial position of the Trust. An integrated performance report has improved greatly over the year and further development will continue in 2016/17.

The Board received reports in the year on:

- Quality Improvement Plan to address CQC concerns;
- Serious incidents and Never Events;
- Financial performance and plans;
- National patient and staff surveys;
- Patient & public engagement;
- Patient experience & safety, including infection control, staffing skill mix reviews and

  Safeguarding, complaints and PALs;
- NHS Trust Governance Declaration;
- Health and safety risk report;
- Operational updates;
- Patient-led assessment;
- Strategy updates;
- Assurance reports from Committees;
- Equality and Diversity.

Stakeholder engagement

The Board has continued to engage with a range of stakeholders throughout the year including:

- Care Quality Commission;
- Trust Development Authority;
- Herts Valleys Clinical Commissioning Group;
- Hertfordshire Health and Wellbeing Board;
- Healthwatch Hertfordshire;
- Local Members of Parliament;
- NHS England;
- Staff side representatives;
- Other local NHS trusts.

3. RISK ASSESSMENT & CONTROL FRAMEWORK

As Accountable Officer, I have overall responsibility for risk management in the Trust, which is discharged clearly amongst the Executive and non-voting Directors of the Trust Board, who have a collective responsibility for maintaining a system of sound internal control. The Executive Director with responsibility for governance is the Director of Strategy and Corporate Services.

Driven by the recommendations highlighted in the Care Quality Commission's review, the Trust has focused strongly on a major review and restructure of its risk

and governance arrangements, including processes, staffing, how the management of risk works in practice and the role that Committees have in relation to the mitigation and management of risk.

A new Integrated Risk and Governance Committee was established to provide greater assurance to the Board on the scrutiny of risks, including associated mitigation plans and that the Corporate Risk Register and Board Assurance Framework are maintained and updated appropriately.

The continued development and refinement of the Board Assurance Framework (BAF) has also been a specific focus in 2015/16. The BAF was scrutinised by the Board on a quarterly basis during the year and a process to develop a set of scoring metrics by which each principal risk within the BAF is reviewed and updated, was put in place. This work will continue in 2016/17. Furthermore, the Audit Committee has regularly monitored the arrangements for maintaining and updating the BAF and the Board agenda was re-aligned to each of the principal risks within the BAF.

The Trust's risk registers have also been fully reviewed and updated and the management database has been upgraded this year to enable better ease of recording and reporting.

The Trust's Risk Review Group has been re-invigorated and met every month during the year with good executive and cross divisional representation.

A staff awareness programme has been ongoing throughout the year, including the publication of a new practical guide and information leaflet on risk management. A comprehensive risk management training programme for senior managers within the organisation has also been introduced this year with the aim of supporting the practical application of risk management.

The Trust has one system for the management of risk, which can be distilled at three levels across the organisation:

1. Strategic risks which directly impact on the delivery of the organisation's principal objectives are updated and reviewed through the Board Assurance Framework;
2. The highest scoring risks from within the divisions are reviewed and escalated through the Corporate Risk Register. This ensures that the risks being identified within the clinical teams, which are high scoring, can be clearly identified;
3. The Trust-wide risk register is an amalgamation of all risks across the wards and departments which are broken down into the specific risk registers for each of the divisions and corporate functions.

In 2016/17, the Trust will be reviewing all risks on the Corporate Risk Register and agreeing target dates for de-escalation to an agreed target risk scoring, in line with an assessment of the organisational risk appetite.

Significant strategic risks

The highest scoring key strategic risks recorded on our Board Assurance Framework (BAF) in 2015/16 are listed below, together with a summary of the mitigation taken during the year and action planned for 2016/17.

The BAF has been refreshed and the ten risks carried over into 2016/17. It has been agreed that a risk of system pressures adversely impacting on the delivery of Trust aims and objectives will be added to the BAF in 2016/17.

- **Failure to provide safe, effective, high quality care**

  This risk has been managed in 2015/16 by the development and continued delivery of the CQC's quality improvement plan. In 2016/17, the Trust aims to fully deliver the improvement plan, implement a compliance framework and further strengthen clinical governance arrangements.

- **Failure to recruit to full establishment, retain and engage the workforce**

  To mitigate against this risk, the Board approved a workforce strategy this year, which includes robust plans to improve recruitment and retention and health and wellbeing of staff. The Trust also joined a nationally acclaimed staff engagement programme, called Listening into Action. Going forward, the key focus will be to deliver the workforce strategy and develop a supporting strategy on training and development.

- **Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care**

  The risk has been mitigated in 2015/16 by the creation of an Environmental Division which now provides a structure and staffing levels which support the delivery of effective estates and facilities services. The Board also approved the first phase of an interim estates strategy in January 2016. In 2016/17, this strategy will continue to be delivered and a second phase will be presented to the Board for endorsement.

- **Underdeveloped information and communication technologies (ICT) infrastructure which compromises the Trust's ability to deliver safe, responsive and efficient patient care**

  The risk has been managed this year by a robust governance structure and agreeing a rebased programme plan with suppliers. Resources have also been increased to support the delivery of the plan. In 2016/17, the Trust will implement a plan to mitigate the issues and assure delivery of the programme.

- **Underdeveloped information/information governance to safe, responsive and efficient patient care**

  During the year, a comprehensive patient tracking system and data quality reports have been in place to mitigate this risk. Also regular information governance and data quality audits have been undertaken. In the forthcoming year, learning from these audits will be embedded within the divisions and a business case for a new cancer information system will be developed.

- **Inability to deliver and maintain unscheduled care performance standards**

  During the reporting year, the Trust has worked closely with the Emergency Care Improvement Team to mitigate risks relating to unscheduled care. A new weekly Emergency Care Taskforce was established and divisional emergency improvement plans were developed and performance arrangements strengthened. Going forward, the Finance and Performance Committee will monitor delivery of an emergency care improvement plan.

- **Inability to deliver and maintain elective care standards**

  In year, this risk has been managed by increasing clinical engagement, updating and raising staff awareness of the Access policy and establishing an Outpatient Programme Board. Work to further embed the Access Policy will continue in 2016/17 and demand and capacity modelling will be undertaken.

- **Failure to maintain business continuity**

  The Trust has been actively involved in the Local Health Resilience Partnership in 2015/16, which has helped to mitigate this risk. Divisional emergency preparedness, resilience and response meetings have also been established and initial business continuity plans have been put in place. These will be updated and further embedded, following a national resilience event in June 2016 led by the Trust.

- **Failure to achieve financial targets, maintain financial control and realise and sustain benefits from cost improvement and efficiency programmes**

  In the reporting year, the Trust delivered significantly more cost improvements than in recent years, however it still exceeded the planned deficit, and the focus continues to be to agree and deliver action plans to reduce the level of deficit in the Trust. Financial control was maintained and benefits from cost improvement and efficiency programmes realised through improved governance and engagement of external expertise. These skills are being transferred to an internal team. The Executive continues to develop a culture where cost benefit analysis takes place and options appraised before any decision to overspend.

- **Failure to secure sufficient capital, delaying needed improvements in patient care environment securing healthy safe infrastructure**

  In 2015/16 and each of the two prior years, the Trust has spent an average of £17m to maintain its infrastructure to provide for increased patient numbers. The Trust will develop robust business cases, demonstrating the case of need to access limited national available funds to continue with this level of investment.

- **Failure to sustain key external stakeholder relationships and communications comprises the organisation's strategic position and reputation**

  The risk is being managed by the development of a new communications and stakeholder strategy, which will be presented to the Board for endorsement in early 2016/17. The Communications Team will also benefit from the appointment of a substantive Director of Communications and GP Liaison Manager.

- **Failure to develop a sustainable long term clinical, financial and estates strategy**

  During 2015/16, the Trust has actively participated in the whole system review, Your Care Your Future. In 2016/17, funding and a programme plan for the development of the Strategic Outline Business case to optimise acute service configuration and associated estate development will be confirmed and the Board will approve the Trust's clinical strategy

Information governance

Risks to data security are actively managed and monitored by the Informatics Group, which reports through to the Finance and Performance Committee. The Chief Information Officer is the Senior Information Risk Owner for the organisation and the Medical Director is the Trust's Caldicott Guardian.

All data security incidents are reported using the Trust's Incident Management Reporting System and national reporting requirements are met through use of the Health and Social Care Information Centre Serious Incident Requiring Investigation (SIRI) process.

Between April 2015 and March 2016, the Trust had no serious incidents relating to information governance with a severity rating of level two.

The Trust also assesses itself against the Department of Health's information governance standards using the information governance toolkit, an online system which members of the public can also view.

Through the toolkit, the Trust has developed a strategy and annual work programme to raise its level of compliance and improve its information risk management processes.

Each standard is scored on a scale of level zero to three, with zero or one resulting in a red rating and two to three a green grading. This year the Trust achieved the required minimum level two or above attainment level on all 45 standards, which is graded green (satisfactory).

Identification of fraud and corruption

The Trust places high importance upon the identification, deterrence and detection of fraud and corruption issues within the NHS. The Trust's Local Counter Fraud Service work plan focused on the four key areas for NHS Protect standards for providers and, in addition to proactive activities, the Trust supplemented this work programme with additional resource for investigative activities.

All activities, both planned and investigative, are reported to and discussed within the Trust's Audit Committee to ensure planned activities are delivered in supporting organisational objectives and investigative activities are appropriately investigated and concluded in a timely way to minimise potential future risks within the Trust's systems of internal control.

The importance of fraud and corruption issues is also reflected in the Trust's Induction programme with all new starters within the organisation being provided with information on fraud awareness issues.

Incident management

The Trust's serious incidents policy was revised to reflect the updated NHS England's serious incident framework and the updated never events list for 2015/16. This now has a greater focus on enabling quality investigations with tangible learning outcomes.

The Trust has worked closely with the Herts Valleys Clinical Commissioning Group this year to provide assurance that serious incidents are being addressed within an appropriate timescale. A backlog of overdue serious incidents was cleared and measures put in place to ensure that the Trust submits all serious incidents reports to commissioners within the agreed deadlines. Assurance of the appropriate management of all incidents was reported to the Board on a monthly basis.

During 2015/16, the Trust reported 69 serious incidents, which is a significant reduction on last year's figure. This reduction is due to adherence of the updated NHS England's framework and also the Trust's consistent and systematic application of the criteria when reviewing incidents. Following investigation, ten serious incidents were de-escalated as assurances were provided through the investigative process that no acts or omission of care at the Trust were causative to the outcome for the patient.

'Never events' are potential very serious incidents which should never happen. We reported two such events in 2015/16, one a naso-gastric (NG) tube misplacement and a retained surgical tampon. These never events were subject to full investigation and scrutiny with action plans drawn up with the inter-professional teams to ensure that changes were made in practice to prevent these occurring again.

A summary of the actions taken is detailed below.

Serious incidents and never events	Actions undertaken
Hospital acquired pressure ulcer	• BEST SHOT care plan now in place. • Ward skin champions were introduced • Additional equipment ordered and in place on all wards • Training delivered on wards
Surgical/invasive procedures meeting serious incident criteria	• New stickers to be placed in notes when surgical tampons are used (maternity) • New standard operating procedure introduced regarding safe insertion of nasogastric (NG) tubes • Staff competency checks for insertion of NG • Recruitment of additional consultants (Urology)
Venous thromboembolism (VTE) incidents	• VTE proforma now included in the care plan • Clinical nurse specialist increased to a full time post • E-learning programme written and available on line • Weighing of patients now included in Test Your Care audits
Diagnostic incidents (including delays)	• Emergency Surgical Assessment Unit (ESAU) management of patients on oxygen changed locally • Review of admission criteria for ESAU patients • All red flag reports to be fed back to consultants for inpatients as well as outpatient reports • Centralising of the cardiology administration support at Watford
Maternity/obstetric Incidents meeting criteria (baby only)	• Consultants must demonstrate cardiotocography (CTG) training compliance before working on delivery suite • External thematic review commissioned • Multiple pregnancy and birth guideline to be updated • Standardising of resuscitation documentation

Clinical audit

Clinical audit within the Trust is multi-professional and occurs in various formats. During 2015/16, the Trust has been working to improve weaknesses within clinical audit that were identified by the CQC. These included an inability to evidence and articulate the large amount of audit activity happening across the Trust, inadequate implementation of actions and learning or changes to practice.

In the reporting year, a new clinical audit policy has been developed which sets out priorities in relation to resource allocation and corporate, divisional and individual responsibilities. An audit database has also been updated with all known trust audits and, going forward, will incorporate all registered local and national audits. A divisional audit planner for 2016/17 will also be developed and dissemination of learning will be a key focus, with the conclusion of any clinical audit discussed at departmental, divisional and cross divisional forums.

The Trust continues to support the national '15 Steps Challenge' programme to assess quality from a patient's perspective. Feedback from the programme is reviewed on a weekly basis by the Trust Executive Committee and action taken as appropriate.

Financial risk

The Trust's financial risk rating was one (rated one to five, where one represents the highest risk and five the lowest). A total of £12m of cost improvements were achieved as planned at the start of the year and all efficiency schemes were quality impact assessed and approved by the Chief Nurse and Medical Director prior to implementation.

Workforce control measures

Measures were in place to ensure that the Trust was compliant with all its statutory requirements including the equality, diversity and human rights legislation. All Trust policies are subject to an equality and diversity impact assessment.

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 members' pension scheme records were accurately updated in accordance with the timescales detailed in the regulations.

Internal audit

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

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

Area reviewed	Actions being taken
HR (Training)	The Trust has approved an investment in a new fit for purpose Learning Management System that will fundamentally resolve all risks to mandatory training and bring a range of additional benefits that will drive improved mandatory training compliance. In the short-term, work is underway to find an expedient solution to mitigate the issues identified with the current reporting system.
Consultants' Job Planning	The Trust has been working in the context of the BMA Job Planning guidance 2011 and has developed detailed job planning principles and guidance. The new job planning principles embrace rules for supporting professional activities allocation and ensure these are all duly recorded as part of timetabled programmed activities in the job plan. Reports from e-job plans are being used to identify inconsistencies across subspecialty teams. Significant progress has been made to build a foundation for business aligned job plans from 2016/17. This includes facilitation of team job planning sessions with reference to detailed capacity and demand data.
Performance Improvement (Private Patient Income & Consultants' Job Planning Detailed Follow Up)	The Trust chose to close its private obstetric service on 01 May 2015 to allow staff to focus on NHS patients. The clinicians in the department no longer undertake any private practice on Trust premises.

Quality Account

The Trust is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare a Quality Account for each financial year. The Trust has produced a Quality Account in accordance with the Department of Health Guidance.

The Quality Account has been reviewed by the Trust Executive Committee and the Safety and Quality Committee to ensure accuracy of content and to ensure it reflects the quality of care against identified priorities and overall progress with improving quality (safety, effectiveness and experiences). It also provides a look forward to future priorities. The Quality Account will be reviewed by the Audit Committee prior to the Board review and publication in June 2016.

The Quality Account summarises the performance of the Trust against the key performance measures, including the NHS operating framework, commissioning for quality and innovation (CQUIN) payment framework, advancing quality and local quality measures.

4. REGISTRATION WITH THE CARE QUALITY COMMISSION

The Trust was registered fully with the CQC, without compliance conditions on 1 April 2010. It is registered for eight regulated activities.

The CQC Intelligence Monitoring Report categorises Trusts into one of six summary bands, with band one representing highest risk and band six the lowest. If a Trust is in Special Measures it will automatically be categorised as band one unless it has been re-inspected and this is the banding currently applied to the Trust. The organisation will be re-inspected from 06 to 09 September 2016.

During 2016/17, the Trust will continue to implement and embed the actions included in the quality improvement programme and deliver the quality compliance framework, developed during 2015/16, to provide assurance of compliance against the CQC fundamental standards and other quality and safety work streams.

The Trust received one improvement notice during 2015/16 relating to its risk management processes. The Trust provided a comprehensive response in line with the required time and no further action was requested.

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;
- 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 reporting a year-end deficit of £41.2 million, including adjustments for contract penalties and CQUIN, and faces significant financial challenges for 2016/17. Cost improvement programme inspections in the year have been critical, and have prompted the cessation of Maternity private practice at the Trust.

- We have issued a number of limited assurance opinions, including HR(Training); Consultants' Job Planning and Private Patient Income & Consultants' Job Planning Detailed Follow Up. Consequently, the finalising of reports currently in draft will not affect our overall opinion.
- However, we recognise that the Trust has made improvements in the year, including increasing its capacity to deal with complaints and incidents, and in delivering a record total of £12.6m in cost improvement programme savings, up from £9.0m the previous year.

5. REVIEW OF EFFECTIVENESS

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors and clinical audit as well as the delivery of the NHS Operating Framework and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the contents of the Annual Quality Account and other performance information available to me and my review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Integrated Risk and Governance Committee, Audit Committee, Finance and Performance Committee and the Safety and Quality Committee and am assured that there are plans in place to address weaknesses and ensure continuous improvement of the system. The effectiveness of the system of internal control is monitored and maintained through:

- Monthly financial and operational performance reviews by the Finance and Performance Committee, reporting to the Board;
- Monthly review of the Corporate Risk Register by the Integrated Risk and Governance Committee and Board;
- Input into the controls and risk management processes from Executive Directors, senior managers and clinicians;
- Quarterly review of the Board Assurance Framework by the Safety and Quality Committee, Finance and Performance Committee, Integrated Risk and Governance Committee and Workforce Committee and the Board;
- Internal and external audit reviews;
- Comment on the internal controls from the Head of Internal Audit in their annual report.

As advised earlier in this statement, during April 2015 the CQC carried out an inspection which resulted in the Trust being placed into Special Measures. One of the key areas highlighted by the CQC was our overall governance and risk management processes. During the reporting year, these areas have been a key area of focus for action by the Trust, including a major review and restructure of the risk and governance arrangements, the introduction of a dedicated Integrated Risk and Governance Committee, further development and establishment of a robust monitoring process for a Board Assurance Framework and a full review of the risk registers and the recording and reporting process.

In addition, the Trust has developed a quality improvement plan to address other issues highlighted by the CQC in its inspection. The action plan has been tested and monitored by relevant external scrutiny and review processes, including the Oversight Group established by NHS Improvement (formerly Trust Development Authority) and any improvements made will be reviewed in the planned follow-up inspection by the CQC Chief Inspector of Hospitals in September 2016.

6. CONCLUSION

The Trust has continued to experience challenges in 2015/16. The historical financial challenges facing the Trust have persisted and are expected to continue during 2016/17. The Trust is operating in a difficult health economy and is working with commissioners, local health and social care partners and local authorities to review care pathways and explore alternative models of care in an attempt to address these challenges and deliver a sustainable five year plan.

Workforce remains a significant strategic challenge. Plans for 2016/17 and beyond are focusing on improving retention, making the Trust a more attractive place to work and reducing dependency on agency staff.

The Trust Internal Auditors provided the Trust with a limited assurance from the Head of Internal Audit Opinion for 2015/16 and highlighted three reviews which had resulted in a limited assurance being provided.

Going forward, the Board will continue to work towards a more stable position with the aim of coming out of the Special Measures regime. With the exception of the issues that I have outlined in this statement, my review confirms that West Hertfordshire Hospitals NHS Trust has a system of internal control that supports the achievement of its policies, aims and objectives and that those issues highlighted have been or are being addressed.

The Trust recognises that the control environment can always be strengthened and that this will continue in 2016/17.

Date 31 / 5 / 16

Professor Tracey Carter
Acting Chief Executive Officer

Board and Committee attendance

Appendix 1

Name of voting Board member	Board	Audit Committee	Safety & Quality Committee	Finance and Performance Committee	Strategy Committee	Workforce Committee	Remuneration Committee	Charitable Funds Committee	Integrated Risk and Governance Committee
Chairman	10/10		5/7	6/12	1/1		6/6		
Mr John Brougham Non Executive Director	10/10	7/7	7/7	12/12	1/1		6/6		6/7
Paul Cartwright Non Executive Director	10/10	6/7			1/1	6/7	6/6	5/5	
Ginny Edwards Non Executive Director	9/10		5/7		1/1	7/7	3/6	3/5	5/7
Jonathan Rennison Non Executive Director	9/10	6/7			1/1	7/7	5/6	5/5	
Phil Townsend Non Executive Director	10/10			8/12	1/1		6/6		6/7
Chief Executive	10/10		4/7	9/12	0/1	1/7			3/7
Deputy Chief Executive	6/10		5/7	9/12	0/1	2/7			1/7
Medical Director/ Director of Patient Safety	9/10		7/7	11/12	0/1	4/7			5/7
Chief Nurse/ Director of Infection Prevention & Control	10/10		6/7	7/12	1/1	3/7		3/5	6/7
Chief Financial Officer	9/10			11/12	1/1	1/7		5/5	

Central record of declarations of interest for Board and Executive Team		
		Last updated 17 May 2016
Name	Title	Declared Interests
Professor Steve Barnett	Chairman	Chair and Client Partner of SSG Health Ltd Non-Executive Chairman of Finegreen Associates Trustee and Director of the Institute of Employment Studies Visiting Professor University of West London Business School. Honorary Visiting Professor Cranfield University School of Management Wife is CEO of Rotherham NHS Foundation Trust Member of the East Midlands Regional Committee for Clinical Excellence Awards
John Brougham	Non-Executive Director	Non Executive Director and Chair of The Audit Committee of Technetix Ltd Non Executive Director and Chair of the Audit Committee of eg Solutions plc
Helen Brown	Director of Transformation & Corporate Affairs	None
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	None
Paul Cartwright	Non-Executive Director	Trustee and Chair of Finance and Audit Committee for the Church Lands, St Albans Treasurer of St Peter's Church, St Albans Chair of The Church Yard project Volunteer at Open Door Project
Paul da Gama	Director of Human Resources	None
Lisa Emery	Chief Information Officer	None
Ginny Edwards	Non-Executive Director	Trustee Peace Hospice Care Trustee Hertsmere CAB Director of Edwards Consulting Ltd (plus husband) Husband is CEO of Nuffield Trust Husband is a non-remunerated member of the Strategy Committee of Guy's and St Thomas's Charitable Trust
Louise Halfpenny	Director of Communications	None
Mahdi Hasan	Chairman	Projects Advisor to Japan Canada Oil Sands Ltd, Member of Consultants of Distinction Forum, The Hague MH Consulting
Lynn Hill	Deputy Chief Executive	None
Kevin Howell	Director of Environment (formally Estates and Facilities)	None
Jac Kelly	Chief Executive	None
Caroline Landon	Director of Operations, Unscheduled Care	None
Helena Reeves	Interim Director of Communications	Helena Reeves Associates Ltd
Jonathan Rennison	Non-Executive Director	Trustee of Rising Tides Ltd Change Management and strategy support with Kings College London Director of Yellow Chair Ltd Fundraising Consultancy with the Royal College of Ophthalmologists Coaching and mentoring Services with Sarcoma UK Council Member for the Association of NHS Charities Affiliate of Edgecumbe Consulting
Don Richards	Chief Financial Officer	Director of 7M Ltd
Jane Shentall	Director of Operations, Elective Care	None
Antony Tiernan	Director of Communications	None
Phil Townsend	Non-Executive Director	None
Sally Tucker	Chief Operating Officer	None
Dr Mike Van der Watt	Medical Director	Wife is Director of Hearts Consultants Ltd

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the Trust's Auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

31 / 5 / 16

Acting Chief Executive

Tracey Carter

DIRECTORS' REMUNERATION 2015-2016

NAME	TITLE	In year start/ leave dates	2015/16				2014/15			
			SALARY bands of £5,000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	TOTAL bands of £5,000	SALARY bands of £5,000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	TOTAL bands of £5,000
M. Hasan	Chairman	Left Nov 15	10-15	0	0	10-15	20-25	1	0	20-25
Prof Steve Barnett	Chairman	Start Nov 15	15-20	9000	0	20-25	-	-	-	-
S. Jones (note 1)	Chief Executive	Secondment from Jan 15	-	-	-	-	150-155	0	0	150-155
J. Kelly	Interim Chief Executive	Start Jan 15	100-105	0	0	100-105	40-45	0	0	40-45
L. Hill	Deputy Chief Executive	Start Oct 14	150-155	0	0	150-155	70-75	0	0	70-75
F. Townsend	Non-Executive Director (vice Chair)		5-10	100	0	5-10	5-10	1	0	5-10
S. Hay	Non-Executive Director	Left Dec 14	-	-	-	-	0-5	0	0	0-5
V. Edwards	Non-Executive Director		5-10	0	0	5-10	5-10	0	0	5-10
J. Brougham	Non-Executive Director		5-10	0	0	5-10	5-10	0	0	5-10
J. Rennison	Non-Executive Director (Senior Independent Director)		5-10	0	0	5-10	5-10	0	0	5-10
P. Cartwright	Non-Executive Director		5-10	0	0	5-10	5-10	0	0	5-10
D. Richards	Chief Financial Officer	Start Jun 14	160-165	0	0	160-165	125-130	0	0	125-130
C. Stafford (note 2)	Acting Chief Financial Officer	Start Mar 14 - left Jun 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. Forest	Acting Chief Operating Officer, Chief Nurse	Left Sept 14	-	-	-	-	50-55	0	0	50-55
T. Carter	Chief Nurse & Director of Infection Prevention and Control	Start Aug 14	110-115	0	0	110-115	75-80	0	0	75-80
J. Ardley (note 5)	Interim Chief Nurse	Start Jul 13	-	-	-	-	-	-	-	-
H. Brown	Director of Strategy and Corporate Services	Start Sept 14	115-120	0	0	115-120	60-65	0	0	60-65
S. Coles (note 6)	Interim Director of Transformation	Start May 14 - Left Aug 14	-	-	-	-	-	-	-	-
L. Emery	Chief Information Officer	Start Apr 14	110-115	0	0	110-115	110-115	0	0	110-115
P. Jenkins	Director of Partnership and Performance	Left Apr 14	-	-	-	-	0-5	0	0	0-5
A. Tiernan (note 7)	Director of Corporate Affairs & Communications	Secondment from May 15	10-15	0	0	10-15	105-110	0	0	105-110
P. Da Gama	Director of Human Resources and Organisational Development	Start Aug 14	110-115	100	0	110-115	65-70	0	0	65-70
A. Robson (note 8)	Interim Director of Workforce	Start Dec 13 - Left Aug 14	-	-	-	-	-	-	-	-
L. Gaffney (note 9)	Director of Strategy & Service Improvement	Career break from Sept 15	-	-	-	-	55-60	0	0	55-60
M. Van Der Watt (note 10)	Medical Director/ Director of Patient Safety		280-290	0	0	280-290	310-315	0	0	310-315
H Reeves (note 11)	Director of Communications	Start April 15 - Left Dec 15	100-105	0	0	100-105	-	-	-	-
K Howell	Director of Environment	Start Aug 15	75-80	300	0	75-80	-	-	-	-
J Ardley (note 12)	Interim Director of Governance	Start Aug 14 - Left March 15	-	-	-	-	-	-	-	-

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 2015-16 was £288K (2014-15 £311.6K). This was 7.8 times the median remuneration of the workforce, which was £36.7k (2014-15 £39.8k). In 2015-16 the median pay calculation includes agency staff that increases the median pay in comparison to 2014-15. In 2015-16 no employee received remuneration in excess of the highest paid director. Remuneration ranged for full time employees from pay banding £10-15k to pay banding £285-290k.
Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance pay. It does not include 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 for 2014/15. No costs in 2015/16.
Note 4: Off payroll arrangement, invoiced total of £96.3k 2014/15. No costs in 2015/16
Note 5: Agency appointment, the cost charged to the Trust in 2014/15 which includes salary, employers N.I., agency costs and VAT was £82.3k, continued at the Trust as a Interim Director of Governance, see note 13. No cost in 2015/16.
Note 6: Off payroll arrangement, invoiced total of £71.6k 2014/15. No cost in 2015/16
Note 7: Salary recharged to NHS England from May 2015
Note 8: Agency appointment, the cost charged to the trust in 2014/15 which includes salary, employers N.I., agency costs and VAT was £96k. No cost in 2015/16.
Note 9: Salary recharged to Herts Valley CCG from October 2014 to August 2015 followed by career break
Note 10: 79% of salary as Medical Director/Director of Patient Safety and 21% for clinical work. The gross pay in 14/15 includes Clinical Excellence Award and pay arrears.
Note 11: Off payroll arrangement to Sept 2015 and then joins the Trust on fixed term contact, continues at the Trust as a non board member from Jan 2016.
Note 12: Agency appointment, the cost charged to the Trust in 2014/15 which includes salary, employers NI, agency costs and VAT was £167k. No cost incurred in 2015/16.

The salaries above may include salary sacrifice schemes.

Signed by:

Professor Tracey Carter
Acting Chief Executive

Date: 31/5/16

DIRECTORS' PENSION ENTITLEMENT 2015-2016

	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 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2015	Real increase/(decrease) in Cash Equivalent Transfer Value (bands of £1,000)	Employer's contribution to stakeholder pension
L. Hill	2.5-5.0	10.0-12.5	55-60	170-175	1,193,254	1,083,524	97	0
A. Tiernan	0-2.5	0-2.5	15-20	45-50	241,816	201,340	4	0
L. Emery	0-2.5	(0-2.5)	5-10	10-15	132,450	111,478	20	0
T. Carter	2.5-5.0	2.5-5.0	30-35	95-100	493,719	444,782	44	0
H. Brown	2.5-5.0	0-2.5	30-35	95-100	532,712	491,543	35	0
P. Da Gama	0-2.5	0-2.5	5-10	0-5	63,637	43,064	20	0
M. Van Der Watt	(2.5-5.0)	(12.5-15.0)	40-45	120-125	794,033	859,518	-76	0
H. Reeves	0-2.5	0-2.5	15-20	50-55	359,861	314,625	10	0
K. Howell	0-2.5	0-2.5	40-45	120-125	765,122	727,423	19	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.

Signed by: _____

Professor Tracey Carter
Acting Chief Executive

Date: 31/5/16

Off Payroll Engagements Tables 1 & 2

Off Payroll Engagements Table 1

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016	7
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	3
for between two and three years at the time of reporting	1
Of the above assurance on tax have been sought from 7 engagements	

Off Payroll Engagements Table 2

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, 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 2015and 31 March 2016	7
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	7
Number for whom assurance has been requested	7
Of which:	
assurance has been received	6
assurance has not been received	1
engagements terminated as a result of assurance not being given	0
	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the year	1
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	0

Our Staff

Ensuring we have sufficient skilled, well supported and happy staff is absolutely essential to the delivery of safe, high quality patient care.

Recruiting and retaining staff

Recruitment, particularly for nurses, has continued to be a challenge but in 2015/16 we have managed to significantly reduce our vacancy rate through a targeted approach to recruitment both overseas and in the UK. A concerted local, national and international recruitment drive has helped us recruit more than 300 new nurses to our hospitals.

From a peak of 32.4% in September 2015, we have reduced the nursing Band 5 vacancy rate to 6.8% in April 2016, with 151 domestic and 154 overseas nurses and midwives joining us over this period.

The overall Trust vacancy rate peaked at 15.9% in April 2015, and has fallen to 11.4% in March 2016.

Our recruitment service has been transformed and we have significantly reduced the average time taken to hire an employee. We have also launched a new vibrant recruitment micro-site to set us apart from other NHS recruiters. The website www.westhertshospitals.nhs.uk/joinourteam/ has direct links to vacancies and videos of staff talking about why they love working for the Trust. The site also helps people looking to relocate to west Hertfordshire with information about living in the area, including transport, education and housing. Mobile-friendly, the site enables candidates to apply for a job whilst on the move.

Supporting our new starters

We have put a number of support mechanisms in place for new starters to help improve one-year retention rates including 10-, 20- and 30-week 'reconnection' group sessions where staff meet up with their colleagues who started at the same time as them.

New starters are provided with a welcome pack which includes all the essential information needed, including advice on travel, accommodation and information on the local areas. For overseas nurses, a bank appointment is arranged so that they can open a bank account. They are also provided with support to find accommodation and pay for their deposit.

We recognise that for the nurses who trained overseas it can be a very daunting time for them and they will need support to adapt to a new way of working. We have listened to what the nurses have said about how we can support them in their new environments and have tailored a programme specifically for them. They are given special uniforms to distinguish the transition into their new roles and to help others see that they might need more support.

We have provided buddies and tailored a development programme, including additional English language skills training and help with understanding our basic abbreviation and Trust paperwork. In the first few days we also ensure that a hospital tour is given, with the opportunity to see the ward they will be working and to meet their managers.

Listening into Action

We implemented the Listening into Action (LiA) programme in March 2015.

LiA is a proven method for engaging with staff which has been trialled and proven in a number of 'pioneer' trusts over the last seven years. The method has led to sustained improvements in patient safety and quality, efficiency, productivity and staff morale.

A series of 'Big Conversations' were held, including in our maternity, human resources and finance departments. These conversations revealed what staff felt was stopping them from being able to do their work efficiently and suggestions for improvements to alleviate some of the issues were made.

One of the suggested improvements was the need to change our induction programme for new staff. The programme has now been updated to allow all newly appointed staff to attend a Corporate Welcome day on their first working day of employment and they will be asked to complete all modules of mandatory training relevant to their post before starting their duties in the ward or department. New staff will also be offered a blend of classroom and online learning.

Our Workplace, Our Commitment, Our Future

We have developed new values for the Trust - Commitment, Care and Quality. All Trust staff have had an opportunity to contribute to this process.

We have continued to invest in the development and leadership of staff in the organisation. A key aspect of this has been the Leading for Excellence Programme which 105 staff have completed. The programme offers staff in leadership positions an opportunity to develop their knowledge and skills and, through a multidisciplinary approach, an opportunity to network with colleagues across the organisation to effect positive culture change.

Medical appraisal revalidation

To maintain their registration with the General Medical Council and their licence to practise, doctors are required to undertake an annual appraisal and to be revalidated once every five years. The revalidation process requires a doctor to satisfy and evidence the four domains of 'Good Medical Practice' (GMC, 2013):

- Knowledge, skills and performance.
- Safety and quality.
- Communication, partnership and teamwork.
- Maintaining trust.

During 2015/16, we maintained a very high revalidation rate of 97.4% of all doctors with a prescribed connection completing an appraisal (unless they had a valid reason not to) and we are therefore able to offer firm assurance to our patients, commissioners and regulators regarding compliance with the standards of good medical practice. This is an improvement on last year's figure of 95.7%. During 2015/16, 98.1% of consultants completed their annual appraisal.

Appraisers received further training in March 2016. For the year ahead, appraisers will be paired with those whom they will appraise, which will improve productivity. Processes have been streamlined and the team is proactively supporting doctors to ensure timely compliance with associated deadlines.

Nursing revalidation and training

In April 2016, the Nursing and Midwifery Council (NMC) introduced a revised process of registration for nurses and midwives, known as revalidation. Revalidation is designed to strengthen the three-yearly registration renewal process and increase professionalism across the nursing and midwifery workforce. It exists to improve public protection by ensuring that nurses and midwives remain fit to practise in line with the requirements of their professional standards and Code of Conduct.

The Trust's Senior Nurse for Education has prepared our nurses and midwives for revalidation, building on existing arrangements, including appraisal and clinical supervision, to encourage nurses to seek regular feedback from service users and colleagues, to reflect on the code and to seek confirmation from a third party that the necessary requirements have been met.

Improvements in education and training

The Trust's non-medical education and training service was inspected in 2015/16 by the Quality Improvement and Performance Framework team from Health Education East of England. They reported that significant improvements had been made since their previous visit in 2014/15.

Non-medical education and training is rated on six key performance indicators. The service was rated as green in four indicators and amber and red in the other two indicators.

Improvements to nursing and midwifery education and professional development

Building on the recommendations set out by Lord Willis in 'Raising the Bar: Shape of Caring review of the future education of registered nurses and care assistants' (published by Health Education England in March 2015), we have focused on celebrating existing good practice across the nursing and midwifery workforce. We are encouraging new and innovative ways of working and are strengthening the education programmes and clinical learning environment of our entire workforce in these ways:

- All our healthcare assistants now undertake the Care Certificate which will enable them to have access onto foundation degree programmes.
- We have supported five assistant practitioners to undertake their nurse training through the Flexible Nursing Pathway. This is where there are routes into nurse education for staff in Bands 1-4 who hold a Foundation Degree, which enables more individuals to access pre-registration nursing degrees.
- All final year 3 nursing and midwifery students were offered roles within the Trust on qualifying; they are supported through a period of preceptorship (structured period of transition where newly qualified practitioners are guided to develop their practice further), with specialist areas offering rotational programmes if requested.
- Our band 5 nurses and midwives have access to a wide range of clinical skills programmes.
- We have supported two cohorts of Band 6 Sisters through a leadership programme.
- Our Clinical Leaders Forum offers a bi-monthly programme of learning and clinical support for all our nurses and midwives, where external speakers and internal experts present new and innovative developments.

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 to advance equality of opportunity and to foster good relations between different groups and individuals who have protected characteristics.

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 2015/16:

- Accreditation as a 'Two Ticks, positive about disabled people' employer which demonstrates that the Trust encourages applications from disabled people and makes commitments towards its disabled staff.
- The Trust refreshed its harassment and bullying policies and aligned advisors to divisions so that staff know whom to contact when they have a concern.
- The Trust updated equality and diversity training, covering equality legislation, unconscious bias, personal responsibility and inappropriate behaviour.

Supporting our multicultural staff network

Our multicultural staff network 'Connect' is run *for* staff *by* staff and aims to provide support to Black and minority ethnic (BME) staff and enable them to contribute to policy development and review and provide a consultation forum for the Trust to gather their views on particular developments.

Connect is independent with three main functions:

- To support individual members.
- To help BME staff as a group.
- To help the Trust Board and managers understand the needs of BME staff and patients.

The health and wellbeing of our staff

We are committed to improving the health and wellbeing of our staff. As part of our Workforce and Development Strategy, our *Balance4Life* programme continues to offer a variety of initiatives to support staff in their working life. Some events for staff this year have included emotional resilience and stress management training, mental health workshops and wellbeing events offering mini health checks.

The national staff survey results, published in February 2016, showed that we had made a number of improvements in relation to such areas as staff motivation at work, staff satisfaction with the level of responsibility and involvement, support from immediate managers and organisational / managerial interest in and action on health and wellbeing.

Within all of these areas, we fall in the best 20% of acute trusts; however, we did not score well on questions about the organisation as a whole, and were rated below the national average with regard to staff recommending the Trust as a place to work.

An action plan will be developed to tie in with our new corporate values which will be supported by our HR Business Partners and progress will be closely monitored.

Junior doctors' strikes

During the junior doctors' strikes in 2015/16, which followed ongoing disagreement between the Government and the British Medical Association over proposed new contracts, we had robust plans in place. These had been drawn up through close collaboration between senior clinicians, managers and with an executive lead. Discussions included all the divisions who developed detailed plans which gave assurance of consultant cover for the care of patients from the Emergency department through to all wards on all three sites.

These plans were made available to all staff and were posted on our intranet. Letters were sent to patients informing them of any postponements to their appointments or admissions.

The whole process ran extremely smoothly during all of the strikes and this is really down to the hard work and commitment of the staff both during the preparation stage and on the day itself, with comprehensive cover being provided by our consultants, which ensured the complete safety of all our patients across our three sites.

Recognising our exceptional staff

We have an amazing team of staff and we like to recognise one of them on a monthly basis.

The twelve monthly winners for the year in review were:

- 2015 – April winner: Clive Banzon, nurse
- 2015 – May winner: Emma Pope, ward manager
- 2015 – June winners: Sunil Parmar, Isabel Mansilla, Rajesh Vasiraju, A&E doctors
- 2015 – July winner: Monika Kalyan, equality and diversity manager
- 2015 – August winner: Adrian Vyse, clinical specialist physiotherapy
- 2015 – September winner: Nata Ogoola, midwife
- 2015 – October winner: Michelle East, midwife
- 2015 – November winner: Josephine Harding, senior healthcare assistant
- 2015 – December winner: Sue White, midwife
- 2016 – January winner: Jose Berbel, staff nurse
- 2016 – February winner: Louise Bryan, nurse
- 2016 – March winner: Theresa Hamilton, housekeeper

Each year, we also hold an annual awards ceremony. The *Celebrating Excellence* annual award is an opportunity to acknowledge publicly and celebrate individuals and teams who have made an outstanding contribution to our care for patients. More than 100 members of staff and volunteers were nominated in nine categories by colleagues, patients, visitors and carers, all of whom wanted to thank people who have really shone.

In 2015/16 the winners were:

- **Allied health professional of the year** - Gemma Holland, specialist occupational therapist
- **Doctor of the year** - Meera Thavarajah, speciality grade
- **Nurse of the year** - Amber Fernandes-Todd, senior nurse
- **Midwife of the year** - Johanna Arundel, midwife
- **Healthcare/support worker of the year** - Frances Tallboy, healthcare assistant
- **Patient Experience** - Linda Bradshaw, PALS officer
- **Non-clinical team member of the year** - Mark Currie, Associate Director, Performance and Information
- **Team of the year** – Acute Therapies service
- **Volunteer of the year** - Chris Banks, volunteer

There is also a tenth category, the Chair's award for excellence, which brings together the winners of the monthly staff awards. The Chair found it impossible to select a single winner in this category and as a result, he provided the funds to ensure that all of the nominees received a prize.

- Clive Banzon, nurse
- Ken Burry, porter
- Dominic Futter, physiotherapist
- Jean Hickman, Trust secretary
- Isabel Hlomani, senior sister
- Monika Kalyan, equality and diversity manager
- Shahid Mahmood, domestic
- Dawn Moore, ward sister
- Claire Nicell, hospice champion
- Emma Pope, staff nurse
- Jane Roberts, lead nurse for patient experience (retired)
- Jeremy Ruppersburg, PA to head of nursing for medicine
- David Sear, porter
- Ernesto Tamayo, nurse
- Sunil Parmar, Isabel Mansilla, Rajesh Vasiraju, A&E doctors

Schwartz Rounds

The *Schwartz Center for Compassionate Healthcare* was established in the USA in 1995 to increase compassion and more meaningful collaboration between patients and medical professionals. There are now over 550 organisational members in the USA, UK and Canada, supporting 200,000 health care professionals each year by providing education and resources and convening regular conferences to advance compassionate care.

The Trust has recently implemented regular Schwartz 'rounds' – meetings which provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. These have 'exceeded all expectations' and have been hailed a success, with 87% of attendees rating the sessions as excellent or exceptional.

Breakdown of staff groups (as at 31 March 2016)

Banding By Gender 2015-16			
Headcount	Gender		
Banding	Female	Male	Total
Band 1 - 7	3036	575	3611
Band 8A and above	191	64	255
Medical	258	298	556
Non-Exec Directors	1	5	6
Totals	3486	942	4428

Banding by Ethnicity					
Ethnicity	Band 1 - 7	Band 8A and Above	Medical	Non-Exec Directors	Total
Asian or Asian British - Any other Asian background	254	8	45		307
Asian or Asian British - Bangladeshi	10	2	5		17
Asian or Asian British - Indian	280	17	110		407
Asian or Asian British - Pakistani	63	1	28		92
Black or Black British - African	188	7	29		224
Black or Black British - Any other Black background	17		2		19
Black or Black British - Caribbean	65	5	3		73
Mixed - Any other mixed background	16	1	12		29
Mixed - White & Asian	8	1	7		16
Mixed - White & Black African	13		1		14
Mixed - White & Black Caribbean	15	1	2		18
Not Stated	182	5	43		230
Other Ethnic Groups - Any other ethnic group	74	3	18		95
Other Ethnic Groups - Chinese	40	1	18		59
White - Any other White background	348	5	66		419
White - British	1940	186	166	5	2297
White - Irish	98	12	1	1	112
Totals	3611	255	556	6	4428

Staff policies

We have a Recruitment & Selection policy in place, which supports our employees whilst also encouraging delivery of the highest standards of care and service to patients and services users. We aim to be the 'employer of choice' locally, and we draw on a wide and diverse range of people with a variety of skills and talents to deliver and manage our services, concentrating positively on the real requirements of jobs and the individual abilities of people who seek employment with our hospitals. We use NHS Jobs to advertise all posts and applicants are asked about disabilities as part of the process. Any candidate who has declared a disability and invoked the '2 Ticks' scheme within their application is guaranteed an interview provided they meet the minimum criteria for the post. A functional requirement form is also completed as part of the pre-employment checks and where a disability is identified, a discussion is held with the line manager as to what adjustments need to be made in conjunction with Occupational Health.

Where staff become disabled during employment, the Trust has a Managing Attendance Policy to inform the need for reasonable adjustments and support as required. Close links take place with our Occupational Health team in order to ensure we do all we can to support staff with disabilities at work.

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 (the "Trust") for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the "Act"). The financial 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

This report is made solely to the Directors of West Hertfordshire Hospitals NHS Trust, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, 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 require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Act to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act. 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 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 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.

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 issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these 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 2016, and to report by exception where we are not satisfied.

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.

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 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion would be unlawful and likely to cause a loss or deficiency.

On 11 January 2016, we referred a matter to the Secretary of State under section 30 of the Act in relation to West Hertfordshire Hospitals NHS Trust's breach of its break-even duty for the three year period ended 31 March 2016.

We report to you if we are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for adverse value for money conclusion

Our review of the Trust's arrangements identified a number of matters:

Financial sustainability

- The Trust outturn position for 2015/16 was a deficit of £41.2 million, which compares with the Trust's original budget forecast deficit of £32.8 million.
- The Trust's financial plan for 2016/17 shows a projected deficit of £36.9 million. This is dependent on achieving savings of £14 million, of which £10.5 million had fully developed implementation plans in place at the end of May 2016.
- The Trust's financial outturn was partly due to lower than expected income as a result of contractual penalties of £6.4 million and £2.7 million budgeted funding for winter pressures not being provided.

These reflect weaknesses in the Trust's arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions and for using appropriate and reliable financial information to support informed decision making.

Care Quality Commission (CQC) Rating

The CQC inspected the Trust's three sites in April and May 2015 and, in September 2015, issued the Trust an overall rating of 'Inadequate'. The report highlighted concerns in respect of quality, safety and staffing levels. As a result of the issues raised, the NHS Trust Development Authority placed the Trust in special measures in September 2015. The Trust has not yet been subject to reinspection by CQC.

This issue is evidence of weaknesses in arrangements for planning and deploying workforce to deliver the Trust's priorities effectively.

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, because of the significance of the matters described in the basis for adverse conclusion paragraph, we are not 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 ended 31 March 2016.

We have nothing to report in respect of the following matters where we are required to report by exception if:

- in our opinion the governance statement does not comply with guidance issued by the NHS Trust Development Authority; or
- we issue a report in the public interest under section 24 of the Act; or
- we make a written recommendation to the Trust under section 24 of the Act.

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 Act and the Code of Audit Practice.

Andy Mack
for and on behalf of Grant Thornton UK LLP, Appointed Auditor
Grant Thornton House
Melton Street, Euston Square
London
NW1 2EP

1 June 2016

3. The Financial Statement

3.1. Our money – financial headlines

Our Trust has relied on non-recurrent funds for a number of years to support the challenge of providing safe services within the confines of the tariff payment structure.

In 2013/14, we invested significantly in our clinical workforce to respond to the Francis Report, following investigations into deaths and poor care at Mid Staffordshire NHS Foundation Trust. We recorded an income and expenditure deficit of £13.4m in that year despite receiving £2.2m to support additional overhead costs linked to providing services across three sites and £7m to support unusual winter pressures, including delays in the transfer of care for elderly patients.

In 2014/15, we recorded a deficit of £13.8m after receiving £2.5m funding for winter pressures (reduced from £7m received in the previous year) and non-recurrent Provider Deficit Funding (from the Department of Health) of £12m. Underlying costs, necessary to support quality standards, therefore considerably outstripped income funded through tariff for many years prior to the 2015/16 year.

We started 2015/16 with a plan to end the year with a revenue deficit of £32.8m which took into account a cessation of Provider Deficit Funding but included a savings target of £12m, necessary to cope with cuts in the national tariff.

Our Trust, however, signalled early into the year that treating the predicted volume of patients safely and maintaining the deficit to £32.8m would prove to be a significant challenge. This was because (a) the plan (in line with national guidance) did not include the financial effects of penalties that could be levied for meeting national performance standards and (b) some of the extra clinical capacity required in 2014/15 to manage the increasing numbers of elderly patients delayed in their care transfer was funded non-recurrently. In addition to these challenges, part way through the year we had to prepare and respond to findings reported by a Care Quality Commission inspection.

We ended the year with a revenue deficit of £41.2m which included the levying of £4.7m of contract penalties mainly related to worse than targeted performance in meeting A&E waiting standards, elective waiting time targets and targets for ambulance waiting. We also fell £2.5m short of full achievement of commissioning for quality and innovation (CQUIN) income. Thirdly, we sought additional funding valued at £2.6m for the net costs in caring for elderly patients delayed in their transfer to community healthcare and social care facilities. This funding was not made available, as it had been in 2014/15. However, we maintained the availability of the necessary capacity in order to maintain safety, in particular, within the emergency department. Our costs in preparing and responding to the Care Quality Commission visit were fully funded and the cash flow consequences of the revenue deficit were supported with loan finance of £35.5m.

The Trust's income in 2015/16 fell to £299.8m in comparison to £313.3m in 2014/15 while our operating costs (excluding impairments) rose from £323.6m to £336.9m. After excluding the costs of clinical negligence premium payments, Trust costs rose by 2.6% (from £314.6m in 2014/15 to £322.9m in 2015/16).

The relatively modest rise in costs is partly due to the success of our efficiency programme in 2015/16. Trust managers worked particularly hard - supported by Ernst & Young - to help improve operational performance and underpin financial sustainability in future years. As a consequence we achieved our highest recorded level of savings at £12.3m (4.1% of operating revenue) for 2015/16. This achievement exceeded the 3.5% level of savings required to match the difference between anticipated cost inflation and the reduction in the tariff.

The cash flow consequences of the deficit and our capital programme left us needing to apply to the Independent Trust Financing Facility for loan finance to meet our current liabilities which would be increased by the forecast deficit.

In recording such a large deficit for 2015/16, we were unable to break even over even a five-year period, taking one year with another.

We spent £16.6m on new, refurbished and replacement assets in line with the revised financial plan. Good progress has been made on the estates backlog maintenance programme and in replacing much of our ageing medical equipment. In total we spent £8.2m on our backlog maintenance programme and £3.2m on new and replacement medical equipment. The large projects completed in year included the purchase of Shrodells building from Hertfordshire Partnership Foundation Trust which meant that the building could be used to accommodate patients delayed in their transfer of care. We also purchased a new CT and MRI scanner at Watford, upgraded our high voltage electricity generators and further developed our combined heat and power system to improve energy efficiency.

Financial forecasts for the 2016/17 year currently exclude any benefit from the national Sustainability and Transformation fund and the adverse consequences of more contract penalties. Even with a planned £14m of new savings, we are currently forecasting a deficit of £36.9m in 2016/17. This size of deficit will require additional cash support loans to maintain liquidity. In addition, we will seek external finance to support our capital expenditure programme. In 2016/17, it is planned to open the new MRI/CT scanner at Watford General Hospital, invest in modern medical technology and improve the estate by continuing to invest in backlog maintenance.

Delivery of savings each year becomes increasingly difficult. We have strengthened our internal capacity to support efficiency development with reduced reliance on external consultancy.

A key part of our financial strategy is to find efficiencies worth 4% of revenue on a consistent basis. This target arose from a benchmarking of our operations with current upper quartile levels of performance and has been applied to the 2016/17 financial plan. We recognise that even over five years, this level of efficiency performance will be insufficient to return us to breakeven unless the funding environment significantly improves. We therefore continue to work on a major estate redevelopment to transform the way that acute services are delivered to west Hertfordshire. The redevelopment will complement the strategic direction set for the commissioning of healthcare for Hertfordshire as a whole.

Financial Risk

Our financial risk is assessed against a rating developed by the NHS Trust Development Authority building on the risk rating approach used by Monitor in regulating NHS Foundation Trusts (Note: NHS Trust Development Authority and Monitor merged on 1 April 2016 to become NHS Improvement). Our performance for the year against these financial indicators provides an overall a score of 1 which is the lowest score. The Board uses this each month, together with other information to manage its finances. An overall score of less than 3 is unsatisfactory. The outcome of strategic work on the provision of healthcare to west Hertfordshire will support our longer term financial plans to address the overall financial risk score. Our plans and future agreements with regulators will need to address the schedule of loan repayments to the Department of Health. A key milestone is December 2018 to repay loans taken out in 2015/16.

Internal audit

During the 2015/16 year, our Internal Audit service was provided by BDO. 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 manage risks and resolve weaknesses in the system of internal control. In November 2015, we re-tendered for a new contract for the provision of internal audit and counter fraud services, including reviewing controls over the management of charitable funds. We are pleased to announce that from 1 April 2016, a contract for two years has been awarded to RSM Risk Assurances. We will work with BDO and RSM to ensure that there is a seamless transition from the existing to the new service provision. We would like to thank BDO LLP for the services provided for the past three years

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. Our external auditors are Grant Thornton. The Audit Commission has now passed on the responsibilities of audit contracts to a transitional body, Public Sector Audit Appointment Ltd, until this contract ends on 31 March 2017. The Local Audit and Accountability Act 2014 will apply after this contract ends and we will tender for external audit services during the 2016/17 year with an appointment being confirmed by 31 December 2016.

In the event that we appoint 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 that there is no conflict of interest with the role of external auditor.

Related parties

We have received declarations from all Board and Trust Executive Committee (TEC) members relating to any conflicts of interest in conducting NHS business. Any member associated with the organisation will be shown in the register of interest held by the Corporate Affairs Office. Note 33 of the Trust's accounts sets out transactions with related parties. The related parties are mainly other NHS bodies commissioning patient activity provided by our Trust or other government bodies with which we have financial transactions. There are no related transactions involving any Board members or executive directors.

Better payment practice code

We strive to pay our suppliers on time. Performance in achieving this is set out in the annual accounts note 11.

Exit packages agreed in 2015-16

There were 13 agreed exit packages agreed in 2015/16. Further details are included in note 10.4 of the accounts.

Expenditure on Consultancy

The total consultancy costs in 2015/16 was £2.9m, mainly spent with Ernest and Young LLP to provide support and advice on the savings programme for the year and advice on clinical strategy.

Fraud 15-16

Our counter fraud policy is available on our intranet and internet to provide advice for staff relating to a suspected fraud. We have a nominated local counter specialist who assists the Chief Financial Officer in raising awareness and dealing with fraud matters. More information on the fraud policy can be obtained from the Trust offices at Watford General Hospital. We have developed an action plan to improve our counter fraud effectiveness after consulting with NHS Protect. The Local Counter Fraud Services contract has been awarded to RSM Risk Assurances with effect from 1 April 2016.

Staff Numbers

We employed 4,595 staff, as at March 2016. Permanently employed staff numbered 3,808 in 2015/16. For further details see note 10.2 in the accounts.

Sickness Absence Data

Sickness absence data for 2015/16 is 8.26 average working days lost per staff member in comparison to 8.32 in 2014/15. This is reported in note 10.3 of the accounts.

Pensions 15-16

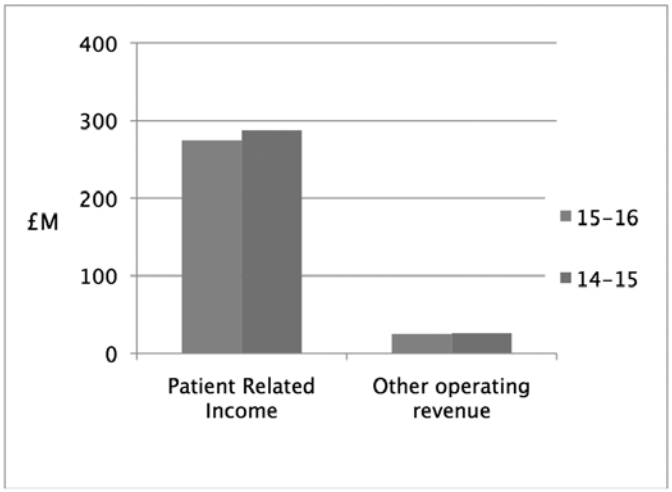
Past and present employees are covered by the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Further details can be found in note 10.6 of the accounts.

Income generation activities

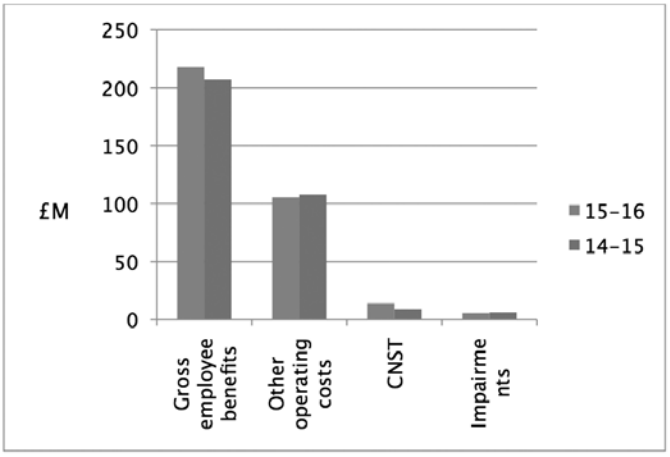
We do not conduct material income generation activities outside of our usual business, where the aim is to achieve profit. Any contribution made on these activities is used in patient care.

Analysis of Income and Expenditure and Statement of Financial Position as at 31 March 2016

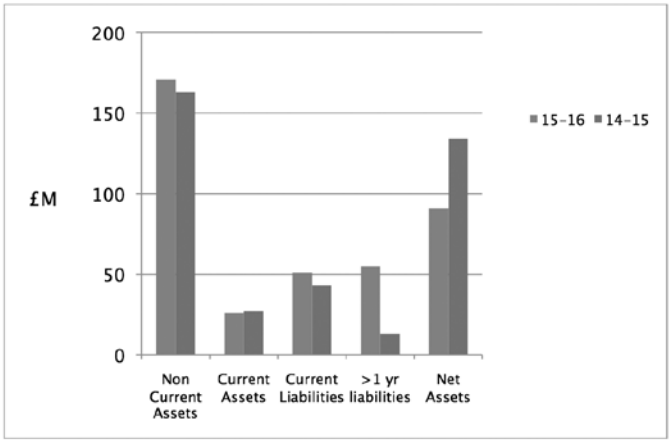
Income



Expenditure



Balance Sheet



West Hertfordshire Hospitals NHS Trust

Annual Accounts for the period

1 April 2015 to 31 March 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	10.1	**(217,520)**	(206,926)
Other operating costs	8	**(125,050)**	(122,843)
Revenue from patient care activities	4	**274,994**	287,575
Other operating revenue	5	**24,775**	25,716
Operating surplus/(deficit)		**(42,801)**	(16,478)
Investment revenue	12	**46**	42
Other gains and (losses)	13	**0**	561
Finance costs	14	**(937)**	(642)
Surplus/(deficit) for the financial year		**(43,692)**	(16,517)
Public dividend capital dividends payable		**(3,239)**	(3,601)
Retained surplus/(deficit) for the year		**(46,931)**	(20,118)

Other Comprehensive Income

	2015-16 £000s	2014-15 £000s
Net gain/(loss) on revaluation of property, plant & equipment	**4,419**	16,226
Total Other Comprehensive Income	**4,419**	16,226
Total comprehensive income for the year	**(42,512)**	(3,892)

Financial performance for the year

Retained surplus/(deficit) for the year		**(46,931)**	(20,118)
Impairments (excluding IFRIC 12 impairments)	17	**5,631**	6,198
Adjustments in respect of donated gov't grant asset reserve elimination		**145**	83
Adjusted retained surplus/(deficit)		**(41,155)**	(13,837)

The adjusted retained deficit of £41.2m is after excluding impairments and the net of donated income and depreciation. The Trust performance is measured on this adjusted deficit.

The notes on pages 72-103 form part of this account

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	15	**167,774**	161,005
Intangible assets	16	**1,537**	570
Trade and other receivables	21.1	**1,565**	1,438
Total non-current assets		**170,876**	163,013
Current assets:			
Inventories	20	**4,171**	4,425
Trade and other receivables	21.1	**20,422**	21,192
Cash and cash equivalents	22	**1,739**	1,289
Total current assets		**26,332**	26,906
Total assets		**197,208**	189,919
Current liabilities			
Trade and other payables	24	**(46,717)**	(39,626)
Provisions	29	**(673)**	(860)
DH capital loan	26	**(3,637)**	(2,772)
Total current liabilities		**(51,027)**	(43,258)
Net current assets/(liabilities)		**(24,695)**	(16,352)
Total assets less current liablilities		**146,181**	146,661
Non-current liabilities			
Provisions	29	**(4,787)**	(5,219)
DH revenue support loan	26	**(39,000)**	0
DH capital loan	26	**(11,399)**	(7,935)
Total non-current liabilities		**(55,186)**	(13,154)
Total assets employed:		**90,995**	133,507
FINANCED BY:			
Public Dividend Capital		**223,076**	223,076
Retained earnings		**(171,431)**	(124,504)
Revaluation reserve	15	**39,350**	34,935
Total Taxpayers' Equity:		**90,995**	133,507

The notes on pages 72-103 form part of this account

The financial statements on pages 67-103 form part of this account were approved by the Board on 31 May 2016 and signed on its behalf by

Signed 31 / 5 / 16

Tracey Carter
Acting Chief Executive

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2015	**223,076**	**(124,504)**	**34,935**	**133,507**
Changes in taxpayers' equity for 2015-16				
Retained surplus/(deficit) for the year		(46,931)		**(46,931)**
Net gain / (loss) on revaluation of property, plant, equipment			4,419	**4,419**
Transfers between reserves		4	(4)	**0**
Net recognised revenue/(expense) for the year	**0**	**(46,927)**	**4,415**	**(42,512)**
Balance at 31 March 2016	**223,076**	**(171,431)**	**39,350**	**90,995**
Balance at 1 April 2014	**193,805**	**(104,404)**	**18,727**	**108,128**
Changes in taxpayers' equity for the year ended 31 March 2015				
Retained surplus/(deficit) for the year		(20,118)		(20,118)
Net gain / (loss) on revaluation of property, plant, equipment			16,226	16,226
Transfers between reserves		18	(18)	0
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**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(42,801)**	(16,478)
Depreciation and amortisation	8	**7,647**	7,947
Impairments and reversals	17	**5,631**	6,198
Donated Assets received credited to revenue but non-cash	5	**(5)**	(72)
Interest paid		**(756)**	(582)
PDC Dividend (paid)/refunded		**(3,354)**	(3,655)
(Increase)/Decrease in Inventories		**254**	(612)
(Increase)/Decrease in Trade and Other Receivables		**758**	(7,345)
Increase/(Decrease) in Trade and Other Payables		**7,252**	(2,993)
Provisions utilised		**(807)**	(637)
Increase/(Decrease) in movement in non cash provisions		**144**	512
Net Cash Inflow/(Outflow) from Operating Activities		**(26,037)**	(17,717)
Cash Flows from Investing Activities			
Interest Received		**43**	41
(Payments) for Property, Plant and Equipment		**(15,805)**	(10,576)
(Payments) for Intangible Assets		**(1,079)**	(5,172)
Proceeds of disposal of assets held for sale (PPE)		**0**	900
Net Cash Inflow/(Outflow) from Investing Activities		**(16,841)**	(14,807)
Net Cash Inform / (outflow) before Financing		**(42,878)**	(32,524)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		**0**	57,271
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**0**	(28,000)
Loans received from DH - New Capital Investment Loans		**7,100**	2,400
Loans received from DH - New Revenue Support Loans		**63,700**	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		**(24,700)**	(1,400)
Net Cash Inflow/(Outflow) from Financing Activities		**43,328**	27,499
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**450**	(5,025)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,289**	6,314
Cash and Cash Equivalents (and Bank Overdraft) at year end	22	**1,739**	1,289

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 2015-16 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 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 2016-17 to the NHS Improvement (NHSI) which delivers a £36.9m deficit. This includes a savings target of £14.0m and an expectation that emergency activity will be paid at marginal tariff. The plan includes a requirement for £36.9m of cash support from the Department of Health to maintain the Trust's cash flows in 2016-17.

  The Directors have received confirmation from the NHSI that they will make sufficient cash financing available to the organisation over the next twelve months 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 17.1.
- 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.
- 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 21.3.

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:

- from 1 April 2013 income from commissioners for maternity care is received at commencement of the Care Pathway. An estimate of incompleted elements of the pathway has been deferred.
- the valuation of land and buildings using the modern equivalent asset discounted replacement cost method detailed in note 15.3. The basis of estimate for Watford site includes changes to internal area informed by new drawings and revised build dates.
- management have determined that it is appropriate for surplus assets to be held at nil value and not at fair value because they were held for their service potential and there are restrictions that would prevent the marketing of the assets for sale (ie that they are specialist hospital buildings that are integral parts of the Trust's sites).

Notes to the Accounts - 1. Accounting Policies (Continued)

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 disclosed in note 33.1.

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, wages and employment-related payments are recognised in the period in which the service is received from 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

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 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 current 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 current 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. Current 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 15.3.

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.

Notes to the Accounts - 1. Accounting Policies (Continued)

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 it 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

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 15.3.

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 15.3.

1.11. Donated assets

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 of the gain.

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.

Notes to the Accounts - 1. Accounting Policies (Continued)

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 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 1.55%, 5 to 10 years at minus 1.00% and beyond 10 years at 0.8%. Those relating to employee early retirement obligations are discounted at 1.37%.

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.

Notes to the Accounts - 1. Accounting Policies (Continued)

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.

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 case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised 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 VAT is recoverable, the amounts are stated net of VAT.

Notes to the Accounts - 1. Accounting Policies (Continued)

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 42 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 insofar 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 HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

Summary Table - aggregate of all schemes (see note 6)	**2015-16 £000s**	2014-15 £000s
Income	**1868**	1,591
Full cost	**1509**	1,591
Surplus/(deficit)	**359**	0

4. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**1,054**	0
NHS England	**16,500**	19,037
Clinical Commissioning Groups	**249,226**	247,245
CCGs - transformation funds	**0**	2,240
NHS Other (including Public Health England and Prop Co)	**400**	100
Additional income for delivery of healthcare services (see note 6)	**5,172**	12,000
Non-NHS:		
Local Authorities	**647**	4,398
Private patients	**661**	1,091
Overseas patients (non-reciprocal)	**500**	470
Injury costs recovery	**790**	955
Other	**44**	39
Total Revenue from patient care activities	**274,994**	287,575

5. Other operating revenue

	2015-16 £000s	2014-15 £000s
Education, training and research	**8,603**	8,680
Charitable and other contributions to revenue expenditure -non- NHS	**0**	42
Receipt of donations for capital acquisitions - Charity	**5**	72
Non-patient care services to other bodies	**12,550**	13,814
Income generation (Other fees and charges)	**2,258**	2,066
Rental revenue from operating leases	**1,359**	1,042
Total Other Operating Revenue	**24,775**	25,716
Total operating revenue	**299,769**	313,291

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. No additional Transformation funds were received in 2015-16 while in 2014-15 Transformation funds relating to patient care activities in 2014-15 helped the Trust manage capacity during periods of increased activity e.g. over winter.

Additional income for delivery of healthcare services - In 2015-16 to fund for Care Quality Commission inspection outcome which has put the Trust in 'Special Measures' the Trust received £5.2m from Department of Health, in 2014-15 non recurrent funding of £12m from the Department of Health were received to support in year deficit.

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

7. Overseas Visitors Disclosure

	2015-16 £000s	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**500**	470
Cash payments received in-year (re receivables at 31 March 2015)	**123**	21
Cash payments received in-year (re invoices issued 2014-15)	**78**	155
Amounts added to provision for impairment of receivables (re receivables at 31 March 2015)	**32**	9
Amounts added to provision for impairment of receivables (re invoices issued 2015-16)	**191**	93
Amounts written off in-year (irrespective of year of recognition)	**283**	65

8. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	2,458	2,534
Services from CCGs/NHS England	0	17
Services from other NHS bodies	242	243
Services from NHS Foundation Trusts	438	449
Total Services from NHS bodies - see i) below	3,138	3,243
Purchase of healthcare from non-NHS bodies - see ii) below	3,217	3,645
Trust Chair and Non-executive Directors	66	62
Supplies and services - clinical	46,792	48,430
Supplies and services - general	11,838	11,502
Consultancy services - see iii) below	2,937	3,202
Establishment	3,621	3,440
Transport	773	2,240
Business rates paid to local authorities	1,414	947
Premises	15,712	16,673
Hospitality	26	39
Insurance	223	208
Legal Fees	213	290
Impairments and Reversals of Receivables - see iv) below	757	(763)
Depreciation	7,525	7,680
Amortisation	122	267
Impairments and reversals of property, plant and equipment - see v) below	5,631	1,198
Impairments and reversals of intangible assets - see vi) below	0	5,000
Internal Audit Fees	112	116
Audit fees - see vii) below	75	90
Other auditor's remuneration - see viii) below	14	16
Clinical negligence - see ix) below	13,971	9,014
Education and Training	485	480
Change in Discount Rate	(17)	408
Other - see x) below	6,405	5,416
Total Operating expenses (excluding employee benefits)	125,050	122,843
Employee Benefits		
Employee benefits excluding Board members	216,490	205,983
Board members	1,030	943
Total Employee Benefits	217,520	206,926
Total Operating Expenses	342,570	329,769

i) Services from NHS bodies does not include expenditure which falls into a category below

ii) Purchase of healthcare from non NHS bodies relates to the outsourcing of activity both to meet waiting time targets and manage bed capacity.

iii) Consultancy services includes costs of support on clinical strategy and efficiency savings programme.

iv) Non NHS bad debt provision in 2015-16 and in 2014-15 reversed/unused NHS bad debt provisions. See note 1.3.1

v) The Trust's revaluation of its land and buildings has generated impairments. See note 14.3 for further details.

vi) 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 in 2014-15. No impairment in 2015-16.

vii) The audit fees in 2014-15 include a rebate from the Audit Commission of £10,000. No rebate received in 2015-16.

viii) The other auditors remuneration relates to Quality Accounts Review.

ix) Contribution paid as agreed with NHS Litigation Authority - see notes 1.17 and 1.18

x) Other expenditure includes the following services:

- £2,003,000 for portering
- £1,011,000 for linen
- £1,111,000 for contract management
- £509,000 for security
- £530,000 for waste disposal

9. Operating Leases

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
- The equipment when returned is complete and in reasonable condition.

9.1. West Hertfordshire Hospitals NHS Trust as lessee

	2015-16 £000s	2014-15 £000s
Payments recognised as an expense		
Minimum lease payments	**365**	363
Total	**365**	363
Payable:		
No later than one year	380	330
Between one and five years	852	786
After five years	0	11
Total	**1,232**	1,127

9.2. West Hertfordshire Hospitals NHS 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.

	2015-16 £000s	2014-15 £000s
Recognised as revenue		
Rental revenue	1,359	1,042
Contingent rents	0	0
Total	**1,359**	1,042
Receivable:		
No later than one year	1,359	1,042
Between one and five years	4,474	5,210
After five years	1,118	0
Total	**6,951**	6,252

10. Employee benefits and staff numbers

10.1. Employee benefits

Employee Benefits - Gross Expenditure	2015-16 Total £000s	2015-16 Permanently employed £000s	2015-16 Other £000s
Salaries and wages	189,076	137,583	51,493
Social security costs	11,301	11,301	0
Employer Contributions to NHS BSA - Pensions Division	17,033	17,033	0
Other pension costs	3	3	0
Termination benefits	107	107	0
Total employee benefits	217,520	166,027	51,493
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	217,520	166,027	51,493

Employee Benefits - Gross Expenditure	2014-15 Total £000s	2014-15 Permanently employed £000s	2014-15 Other £000s
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

10.2. Staff Numbers

	2015-16 Total Number	2015-16 Permanently employed Number	2015-16 Other Number	2014-15 Total Number
Average Staff Numbers				
Medical and dental	618	531	87	600
Administration and estates	1,069	916	153	1,024
Healthcare assistants and other support staff	908	761	147	797
Nursing, midwifery and health visiting staff	1,463	1,124	339	1,459
Nursing, midwifery and health visiting learners	7	7	0	8
Scientific, therapeutic and technical staff	492	431	61	487
Other	38	38	0	33
TOTAL	4,595	3,808	787	4,408
Of the above - staff engaged on capital projects	0	0	0	14

10.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	31,039	31,023
Total Staff Years	3,756	3,727
Average working Days Lost	8.26	8.32

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	2	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	118	181

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

10.4. Exit Packages agreed in 2015-16

Exit package cost band (including any special payment element)	2015-16 Number of compulsory redundancies	2015-16 Cost of compulsory redundancies	2015-16 Number of other departures agreed	2015-16 Cost of other departures agreed.	2015-16 Total number of exit packages	2015-16 Total cost of exit packages
	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	11	41,799	11	41,799
£10,000-£25,000	1	20,043	0	0	1	20,043
£25,001-£50,000	1	44,721	0	0	1	44,721
Total	2	64,764	11	41,799	13	106,563

Exit package cost band (including any special payment element)	2014-15 Number of compulsory redundancies	2014-15 Cost of compulsory redundancies	2014-15 Number of other departures agreed	2014-15 Cost of other departures agreed.	2014-15 Total number of exit packages	2014-15 Total cost of exit packages
	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	1	37,084	1	17,698	2	54,782

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS agenda for change terms and conditions. Exit costs in this note are accounted for in full in the year of departure. 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

	2015-16 Agreements	2015-16 Total value of agreements	2014-15 Agreements	2014-15 Total value of agreements
	Number	£000s	Number	£000s
Contractual payments in lieu of notice	11	42	1	18
Total	11	42	1	18

This note reports the number and value of exit packages agreed in the year.

There was no Trust's voluntary resignation scheme.

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

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

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 three NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. All are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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. These accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The Scheme Regulations allow for the level of contribution rates to be changed 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

Annual Pensions

The 95 and 2008 schemes are "final salary" schemes. 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. The 2015 Scheme pays a pension based on the average of a members pensionable earnings throughout their whole career - calculated as 1/54th of each years pensionable earnings revalued each year in line with the CPI plus 1.5%

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 Pension Purchase

Members can purchase additional pension in the NHS Scheme in units of £250.

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 a 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

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**55,535**	**160,060**	58,996	154,303
Total Non-NHS Trade Invoices Paid Within Target	**47,963**	**120,217**	48,765	112,967
Percentage of NHS Trade Invoices Paid Within Target	**86.37%**	**75.11%**	82.66%	73.21%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,484**	**7,794**	2,753	7,487
Total NHS Trade Invoices Paid Within Target	**1,939**	**5,480**	2,211	5,646
Percentage of NHS Trade Invoices Paid Within Target	**78.06%**	**70.31%**	80.31%	75.41%

11.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**10**	2
Total	**10**	2

12. Investment Revenue

	2015-16 £000s	2014-15 £000s
Bank interest	**46**	42
Total investment revenue	**46**	42

13. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain (Loss) on disposal of assets held for sale	**0**	561
Total	**0**	561

2014-15 gains on disposals relate to Highfield Lane in St Albans. See note 25.

14. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**866**	576
Interest on late payment of commercial debt	**10**	0
Total interest expense	**876**	576
Provisions - unwinding of discount	**61**	66
Total	**937**	642

15. Property, plant and equipment

15.1. Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	48,995	92,057	723	17,334	37,496	176	12,679	2,474	211,934
Additions of Assets Under Construction				14,365					14,365
Additions Purchased	1,060	0	0		86	0	0	0	1,146
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	5	0	0	0	0	5
Reclassifications	0	8,666	31	(11,069)	2,332	0	30	0	(10)
Disposals other than for sale	0	0	0	0	(136)	0	0	0	(136)
Upward revaluation/positive indexation	8,679	(8,106)	(28)	0	0	0	0	(67)	478
Impairment/reversals charged to operating expenses	0	(5,603)	(28)	0	0	0	0	0	(5,631)
At 31 March 2016	**58,734**	**87,014**	**698**	**20,635**	**39,778**	**176**	**12,709**	**2,407**	**222,151**
Depreciation									
At 1 April 2015	0	11,965	427		26,663	173	11,447	254	**50,929**
Disposals other than for sale	0	0	0		(136)	0	0	0	**(136)**
Upward revaluation/positive indexation	0	(3,838)	(15)		0	0	0	(88)	**(3,941)**
Charged During the Year	0	4,253	29		2,603	3	520	117	**7,525**
At 31 March 2016	**0**	**12,380**	**441**	**0**	**29,130**	**176**	**11,967**	**283**	**54,377**
Net Book Value at 31 March 2016	**58,734**	**74,634**	**257**	**20,635**	**10,648**	**0**	**742**	**2,124**	**167,774**
Asset financing:									
Owned - Purchased	58,734	74,534	257	20,480	10,209	0	742	2,124	**167,080**
Owned - Donated	0	100	0	155	439	0	0	0	**694**
Total at 31 March 2016	**58,734**	**74,634**	**257**	**20,635**	**10,648**	**0**	**742**	**2,124**	**167,774**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	22,537	11,634	0	180	584	0	0	0	**34,935**
Movements	8,679	(4,260)	0	0	(4)	0	0	0	**4,415**
At 31 March 2016	**31,216**	**7,374**	**0**	**180**	**580**	**0**	**0**	**0**	**39,350**

Additions to Assets Under Construction in 2015-16

Land	0
Buildings excl Dwellings	11,353
Plant & Machinery	3,012
Balance as at YTD	**14,365**

15. Property, plant and equipment

15.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
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)**
Revaluation	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/negative indexation charged to operating expenses	0	3,677	0	0	0	0	0	0	**3,677**
Reversal of Impairments charged to operating expenses	(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**

15.3. (cont). 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 2015-16 a desk top valuation has been carried out by GVA Grimley Ltd.

The approach to MEA technique used for land valuation is based on 'alternative site basis'. Should the MEA have the potential to be re-located to a less expensive area due to changes in the nature of how the existing facility is used, the value of the land in this alternate location should be adopted for valuation.
Watford and St Albans sites would need to be located in the immediate vicinity of their exisiting locations, whereas Hemel Hempstead could be re-located closer to motorway.

	Watford Hospital	Hemel Hempstead Hospital	St Albans Hospital	Total
	2015-16			
	£000s	£000s	£000s	£000s
Operating expenses - note 8				
Buildings, dwellings and fittings - MEA	5,484	(12)	159	5,631
Total	5,484	(12)	159	5,631
Statement of change in taxpayers equity				
Land - MEA	(3,928)	(1,802)	(2,949)	(8,679)
Buildings, dwellings and fittings - MEA	2,421	544	1,295	4,260
	(1,507)	(1,258)	(1,654)	(4,419)
Total impairment/(reversal) 2015-16	3,977	(1,270)	(1,495)	1,212

	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)

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 £18.9m of fully depreciated assets.

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

	As at 31 March 2016		As at 31 March 2015	
Asset Class	Maximum remaining asset life Years	Minimum remaining asset life Years	Maximum remaining asset life Years	Minimum remaining asset life Years
Buildings	**48**	**3**	49	4
Dwellings	**28**	**28**	29	29
Plant and machinery	**9**	**1**	9	1
Transport	**1**	**0**	2	1
Information Technology	**5**	**1**	5	1
Furniture and Fittings	**48**	**3**	49	4

The full valuation exercise included revision to the remaining asset lifes of some buildings and their fittings, consequently the maximum remaing lives between 31 March 16 and 31 March 15 do not necessarily reduce by one year. Cherry Tree House is the only dwelling in both 2015-16 and in 2014-15.

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.

16. Intangible non-current assets

16.1. Intangible non-current assets

2015-16	IT - in-house & 3rd party software	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's
At 1 April 2015	6,903	5,342	**12,245**
Additions Purchased	0	1,079	**1,079**
Reclassifications	10	0	**10**
At 31 March 2016	**6,913**	**6,421**	**13,334**
Amortisation			
At 1 April 2015	6,675	5,000	**11,675**
Charged During the Year	122	0	**122**
At 31 March 2016	**6,797**	**5,000**	**11,797**
Net Book Value at 31 March 2016	**116**	**1,421**	**1,537**
Asset Financing: Net book value at 31 March 2016 comprises:			
Purchased	115	1,421	**1,536**
Donated	1	0	**1**
Total at 31 March 2016	**116**	**1,421**	**1,537**

16.2. Intangible non-current assets prior year

2014-15	IT - in-house & 3rd party software	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's
Cost or valuation:			
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
Net book value at 31 March 2015 comprises:			
Purchased	228	342	570
Donated	0	0	0
Total at 31 March 2015	228	342	570

16.3. Intangible non-current assets

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.

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

17. Analysis of impairments and reversals recognised in 2015-16

2015-16	Property Plant and Equipment	Intangible Assets	Total
	£000s	£000s	£000s
Changes in market price	5,631	0	5,631
Total charged to Annually Managed Expenditure	**5,631**	**0**	**5,631**
Total Impairments of Property, Plant and	**5,631**	**0**	**5,631**

17.1. Analysis of impairments and reversals recognised in 2014-15

2014-15	Property Plant and Equipment	Intangible Assets	Total
	£000s	£000s	£000s
Other	0	5,000	5,000
Changes in market price	1,198	0	1,198
Total charged to Annually Managed Expenditure	1,198	5,000	6,198
Total Impairments of Property, Plant and Equipment changed to SoCI	1,198	5,000	6,198

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 15.3. No impairment on intangibles in 2015-16 is incurred (2014-15 impairment relates to Watford Borough Council, £5m payment, 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.

18. Commitments

18.1. Capital commitments

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

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	3,509	3,662
Intangible assets	209	76
Total	3,718	3,738

18.2 Other financial commitments

The Trust has entered into non-cancellable contract (which are not leases or PFI contracts or other service concession arrangements), for building of the new access road with Watford Borough Council. The payments to which the Trust is committed is as follows

	31 March 2016	31 March 2015
	£000s	£000s
Later than five years	2,000	0
Total	2,000	0

19. 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	2,283	0	6,329	0
Balances with NHS bodies outside the Departmental Group	0	0	55	0
Balances with NHS bodies inside the Departmental Group	13,744	0	12,943	50,399
Balances with Bodies External to Government	4,395	1,565	31,027	0
At 31 March 2016	20,422	1,565	50,354	50,399
prior period:				
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 Bodies External to Government	6,643	1,438	29,555	0
At 31 March 2015	21,192	1,438	42,398	7,935

20. Inventories

	Drugs	Consumables	Energy	Total
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**946**	**3,371**	**108**	**4,425**
Additions	18,985	16,293	37	**35,315**
Inventories recognised as an expense in the period	(18,991)	(16,549)	(29)	**(35,569)**
Balance at 31 March 2016	**940**	**3,115**	**116**	**4,171**

21. Trade and other receivables

21.1 Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**10,571**	4,722	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**2,955**	8,309	**0**	0
Non-NHS receivables - revenue	**3,733**	2,312	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**2,849**	5,142	**0**	0
PDC Dividend prepaid to DH	**219**	104		
Provision for the impairment of receivables	**(1,855)**	(1,419)	**0**	0
VAT	**1,324**	1,268	**0**	0
Interest receivables	**4**	4	**0**	0
Other receivables	**622**	750	**1,565**	1,438
Total	**20,422**	21,192	**1,565**	1,438
Total current and non current	**21,987**	22,630		
Included in NHS receivables are prepaid pension contributions:	**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.

21.2. Receivables past their due date but not impaired

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	5,605	1,165
By three to six months	3,396	1,609
By more than six months	0	0
Total	9,001	2,774

21.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	(1,419)	(2,330)
Amount written off during the year	321	148
Amount recovered during the year	0	557
Amount unused during the year	0	437
(Increase)/decrease in receivables impaired	(757)	(231)
Balance at 31 March 2016	(1,855)	(1,419)

22. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	1,289	6,314
Net change in year	450	(5,025)
Closing balance	1,739	1,289
Made up of		
Cash with Government Banking Service	1,667	1,207
Commercial banks	66	76
Cash in hand	6	6
Cash and cash equivalents as in statement of financial position	1,739	1,289
Cash and cash equivalents as in statement of cash flows	1,739	1,289
Third Party Assets - Monies on deposit	3	3

23. Non-current assets held for sale

	Land £000s	Buildings, excl. dwellings £000s	Total £000s
Balance at 1 April 2014	131	192	323
Plus assets classified as held for sale in the year	0	0	0
Less assets sold in the year	(131)	(192)	(323)
Balance at 31 March 2015	0	0	0

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 in 2014-15. See note 13. There are no non-current assets held for sale in 2015-16.

24. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
NHS payables - revenue	1,713	1,692	0	0
NHS payables - capital	0	0	0	0
NHS accruals and deferred income	7,648	2,358	0	0
Non-NHS payables - revenue	9,523	7,544	0	0
Non-NHS payables - capital	5,807	6,102	0	0
Non-NHS accruals and deferred income	18,016	18,207	0	0
Social security costs	1,849	1,689		
Accrued Interest on DH Loans	133			
VAT - i) see below	0	189	0	0
Tax	2,028	1,822		
Other	0	23	0	0
Total	46,717	39,626	0	0
Total payables (current and non-current)	46,717	39,626		
Included above:				
outstanding Pension Contributions at the year end	2,452	2,321		

i) VAT has been shown as net in note. 21.1 in 2015-16

25. Other liabilities

The Trust has no other payables or financial liabilities.

26. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Loans from Department of Health	3,637	2,772	50,399	7,935
Total	3,637	2,772	50,399	7,935
Total other liabilities (current and non-current)	54,036	10,707		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016 DH £000s
0-1 Years	3,637
1 - 2 Years	3,627
2 - 5 Years	41,592
Over 5 Years	5,180
TOTAL	54,036

The borrowings relate to five 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 ended March 2015.

£11.1m capital loan agreed by Department of Health; loan drawdown of £7.1m in 2015-16 (£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.

£32.0m loan accessed in January 2016. The loan was taken to finance the deficit and loan repayments in 2015-16. It is repayable fully on 18 December 2018. Interest is at a rate of 1.5% payable twice-yearly.

£7m loan accessed on 14 March 2016 from the Revolving Working Capital loan (RWC) to support liquidity. The Trust has approved loan facility of £24.7m, to be accessed when required, by the Department of Health. The loan facility is available until 13 April 2020. Interest is at rate of 3.5% payable twice yearly.

27. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Opening balance at 1 April 2015	1,753	1,305	0	0
Deferred revenue addition	481	666	0	0
Transfer of deferred revenue	(666)	(218)	0	0
Current deferred Income at 31 March 2016	1,568	1,753	0	0
Total deferred income (current and non-current)	1,568	1,753		

Deferred income includes maternity pathway care income received in advance with effect 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

	Total	Comprising: Early Departure Costs	Legal Claims	Other
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**6,079**	5,516	4	559
Arising during the year	**170**	55	0	115
Utilised during the year	**(807)**	(520)	0	(287)
Reversed unused	**(26)**	0	(3)	(23)
Unwinding of discount	**61**	58	0	3
Change in discount rate	**(17)**	(17)	0	0
Balance at 31 March 2016	**5,460**	**5,092**	**1**	**367**
Expected Timing of Cash Flows:				
No Later than One Year	**673**	507	0	166
Later than One Year and not later than Five Years	**2,360**	2,167	0	193
Later than Five Years	**2,427**	2,418	1	8

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

	£000s
As at 31 March 2016	**237,832**
As at 31 March 2015	121,994

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.

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 2016 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 limits set by the Department of Health. The Trust is not, therefore, exposed to significant liquidity risks. However the Trust deficit position in 2015-16 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 an interim revenue loan of £32m which partly funds the deficit and repayment of capital loans in 2015-16 and in 2014-15 Public Dividend Capital funding of £22.7m from the Department of Health to fund the Trust's deficit. The Trust has also used loan finance of £7.1m in 2015-16 (£2.4m in 2014-15) approved by the Department of Health to fund capital projects. Before loans were agreed in 2015-16 the Trust had access to £24.7m (£16.4m in 2014-15) as an interim revolving working capital facility to meet it's liabilities. In March 2016 the Trust accessed £7.0m in 2015-16 (£0m in 2014-15) of it's interim revolving working facility.

31.2 Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS		10,624		**10,624**
Receivables - non-NHS		1,359		**1,359**
Cash at bank and in hand		1,739		**1,739**
Total at 31 March 2016	0	13,722	0	13,722
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

31.3 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables		1,712	**1,712**
Non-NHS payables		6,029	**6,029**
Other borrowings		54,036	**54,036**
Total at 31 March 2016	0	61,777	61,777
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

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. Trust Board members remuneration is shown in the Annual Report in Directors' remuneration and pension entitlement.

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
2015-16	**£000**	**£000**	**£000**	**£000**
Department of Health	31,586	75,972	54,036	219
Trusts/Foundation Trusts				
Central London Community Healthcare NHST	33	1,367	33	436
Chelsea and Westminster NHS Foundation Trust	56	2,205	4	527
Hertfordshire Community NHS Trust	1,241	238	229	740
Hertfordshire Partnership NHSFT	776	718	294	310
Southend University Hospitals NHS FT	766	4	205	0
Barts Health NHS Trust	0	666	11	13
East & North Hertfordshire NHS Trust	522	835	618	1,475
Imperial College NHS Trust	333	581	183	362
Clinical Commissioning Groups (CCG)				
Barnet CCG		1,019	153	307
Bedfordshire CCG		1,083	55	0
Chiltern CCG		764	48	17
East and North Hertfordshire CCG	10	2,670	175	82
Harrow CCG		2,973	297	0
Herts Valley CCG		230,246	5,216	5,190
Hillingdon CCG		5,224	397	286
Luton CCG		1,037	245	0
NHS England				
NHS England Core	25	624		120
Central Midlands Local Office		3,500	104	572
East Commissioning Hub		12,829		88
Special Health Authorities				
Health Education England	3	8,449	94	273
NHS Litigation Authority	14,168		6	
NHS Blood & Transplant	1,711	19	55	
	51,230	**353,023**	**62,458**	**11,017**
2014-15	49,346	342,055	3,132	11,184

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
2015-16	**£000**	**£000**	**£000**	**£000**
HM Revenue and Customs	42,228	10,626	3,877	2,283
NHS Pension Scheme	28,768		2,452	
Hertfordshire County Council		605		
Watford Borough Council	1,197			
	72,193	**11,231**	**6,329**	**2,283**
2014-15	**75,758**	**15,111**	**3,700**	**1,518**

33.1. Summary of West Hertfordshire Hospitals NHS Charity activities

	2015-16 £000s	2014-15 £000s
Income	154	192
Expenditure	(254)	(354)
Net Incoming/Outgoing Resources Before Transfers	(100)	(162)
Gains/(losses) on Revaluation and Disposals of Investment Assets	(56)	77
Funds B/wfd	1,289	1,374
Funds c/wfd - Net Assets	1,133	1,289

34. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	321,650	217
Special payments	39,093	66
Total losses and special payments	360,743	283

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

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

35. 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. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	218,248	232,967	241,684	254,308	260,398	266,716	278,230	291,119	313,291	**299,769**
Retained surplus/(deficit) for the year	(11,413)	2,495	4,405	(52,167)	1,180	5,269	(868)	(11,108)	(20,118)	**(46,931)**
Adjustment for:										
Adjustments for impairments			0	57,866	6,178	(1,512)	2,811	(2,252)	6,198	**5,631**
Adjustments for impact of policy change re donated/government grants assets						(100)	(39)	(10)	83	**145**
Other agreed adjustments	26,785	0	0	0	172	0	**0**	0	0	**0**
Break-even in-year position	**15,372**	**2,495**	**4,405**	**5,699**	**7,530**	**3,657**	**1,904**	**(13,370)**	**(13,837)**	**(41,155)**
Break-even cumulative position	**(11,413)**	**(8,918)**	**(4,513)**	**1,186**	**8,716**	**12,373**	**14,277**	**907**	**(12,930)**	**(54,085)**

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.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	7.04	1.07	1.82	2.24	2.89	1.37	0.68	-4.59	-4.40	**-13.73**
Break-even cumulative position as a percentage of turnover	-5.23	-3.83	-1.87	0.47	3.35	4.64	5.13	0.31	-4.10	**-18.04**

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 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 2015-16 and 2014-15 achieving a cumulative deficit of -18.04% 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.

37. Capital cost absorption rate

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

38. External financing

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

	2015-16	2014-15
	£000s	£000s
External financing limit (EFL)	**43,017**	33,568
Cash flow financing	**42,878**	32,524
External financing requirement	**42,878**	32,524
Under/(over) spend against EFL	**139**	1,044

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

39. Capital resource limit

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

	2015-16	2014-15
	£000s	£000s
Gross capital expenditure	**16,595**	17,032
Less: book value of assets disposed of	**0**	(323)
Less: donations towards the acquisition of non-current assets	**(5)**	(72)
Charge against the capital resource limit	**16,590**	16,637
Capital resource limit	**16,600**	17,540
(Over)/underspend against the capital resource limit	**10**	903

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

40. Third party assets

The Trust held cash which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016	31 March 2015
	£000s	£000s
Third party assets held by the Trust	**3**	3

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