NHS
West Hertfordshire Hospitals
NHS Trust

Annual Report 2016/17

Welcome – a message from our Chair and Chief Executive

Welcome to our Annual Report for 2016/17. This document provides an overview to a year of significant improvement and should be read in partnership with our Quality Account, which is accessible from the NHS Choices website.

In September 2016 we welcomed the inspectors from the Care Quality Commission (CQC) to our hospital sites in Watford, St Albans and Hemel Hempstead. The inspectors appreciated our willingness to engage positively with the process and to talk about the significant progress we've made on our improvement journey since the previous inspection in March 2015.

The inspection results were received in February. Whilst we were disappointed to remain in special measures, we were pleased to have moved from 'inadequate' to 'requires improvement' as an overall rating.

Looking in more detail, the number of 'good' ratings in the overall report increased from 25 in 2015 to 40 and the number of 'inadequates' more than halved – from 31 in 2015 to 15.

The inspection provided a wealth of evidence about the quality and safety of care provided in our hospitals. Our consistently low mortality rates and infection rates were highlighted by inspectors, as was our stroke care, the treatment for hip fracture patients and our children's emergency department.

However, there were areas where more work is still required. Urgent and emergency care at Watford General Hospital was rated 'inadequate' for a second year running. Whilst individual care is often very good in this area, we know that the experience of patients is not always as we would like it to be.

There are plans for the estate which would help us expand the capacity in our emergency department and there is a real determination to provide a better experience for our patients and an improved working environment for our staff.

Inspectors praised progress with recruitment and also noted the percentage of savings made in 2015/16 – these are areas where the trust is bucking the national trend. Reducing our reliance on agency nurses and doctors helps to improve patient care and is also likely to save around £10m compared to the amount we spent in 2015/16.

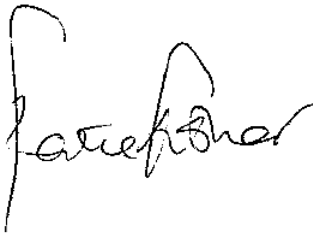
In terms of our strategy, the *Your Care, Your Future* programme – which has been developed with local communities – drives us forward and now forms part of our Sustainability and Transformation Partnership with our partners in Hertfordshire and west Essex.

The fact that we are working with partners across a wider geography has not affected our plans regarding the future location of planned and specialised care and the Board's decision to pursue funding for a radical redevelopment of our Watford site in preference to a completely new hospital on a greenfield site. This topic has and will continue to generate a lot of public and media interest.

Our rationale for keeping our emergency and specialised services on the Watford site stems from the Board's belief in the potential for the Watford site to deliver benefits sooner, at less cost and with a far simpler and quicker planning process than the greenfield option.

Alongside this, we will strengthen the role of St Albans as a site for planned care and review the range of services that will be provided in Hemel Hempstead. The information which informed our decision is in the 'strategic outline case' February 2017 board paper located on our website.

We could not end this introduction without paying tribute to our wonderful, hardworking staff whose standards of care have been widely complimented by inspectors, in peer reviews and by patients. Our clinical, administrative, support staff and managers all work tirelessly to reflect our values - Commitment, Care and Quality. We also like to say a special thank you to our large team of first class volunteers.



Professor Steve Barnett
Chairman

Katie Fisher
Chief Executive

Overview

This report is divided into three sections, as follows:

- ***Our Performance*** – a summary of our performance against key national and local standards in 2016/17 (with information about where to find more details)

- ***The Accountability Report*** - an accountability report that sets out how the Trust's governance has ensured full compliance with all relevant guidance and legislation and details of the remuneration of directors and senior managers

- ***Our Finance*** – a summary of our financial performance in 2016/17

The report addresses all the areas we are required to formally report on an annual basis.

OUR PERFORMANCE

Our Vision

Our **mission** is to provide excellent local acute services, integrated across care settings and delivered in partnership.

Our **vision** is to provide *"the very best care for every patient, every day"*

Our mission and vision statements were finalised early in the year and are now firmly part of who we are. They are underpinned by our **values**:- commitment, care, quality.

More specifically, we set ourselves these strategic objectives

Aim One	To deliver the best quality care for our patients
Aim Two	To be a great place to work and learn
Aim Three	To improve our finances
Aim Four	To develop a strategy for the future

This section of this report provides an update on aims one, two and four. Information on aim three ~ *improve our finances*, is provided in the final section of the report.

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, but there are some areas of deprivation.

With around 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 care centre – which is pre-arranged, non-emergency care. 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 delivery unit, a midwife-led birthing centre, antenatal and postnatal clinics
- emergency care, including accident and emergency, acute admissions unit
- ambulatory care unit, acute wards, a frailty unit, intensive care and emergency surgery
- planned care, including outpatients and complex surgery
- medical care, including endoscopy, cardiology and chemotherapy
- clinical support, including X-ray, CT, MRI, ultrasound and urgent and non-urgent pathology

In 2016/17:

- 40,714 emergency patients (including ambulatory care) and 46,907 elective patients were admitted to our hospitals
- 138,330 attendances at our A&E, urgent care centre and minor injuries unit
- 482,701 attendances at outpatient appointments
- 4,827 babies were born under our care

Our performance management systems

The trust is required to meet national standards as defined within the NHS Operating Framework. Our performance is monitored by NHS improvement, Herts Valleys Clinical Commissioning Group, the Department of Health, NHS England and the Care Quality Commission.

We also select additional measures which form part of our integrated performance report which is discussed at each month's Board meeting and which is available via our website www.whht.nhs.uk

In addition to national and self-determined metrics, the Care Quality Commission (CQC) inspected the trust to examine its performance against CQC standards.

Overall, the trust made great strides in terms of quality in 2016/17.

Highlights

We were recognised as one of just 15 out of 136 non specialist trusts nationally to have a 'significantly lower than expected' mortality rate. Put simply, ratios under 100 mean there are fewer in hospital deaths than expected. Our HSMR of 90.6 compares well nationally and was praised by the CQC as "outstanding practice".

This is extremely good news for our patients and demonstrates the work undertaken to improve safety in our hospitals.

There was also significant success for our stroke care which was placed in the highest category in a national audit. The Trust also met and in some cases exceeded best practice guidelines for end of life care, infection control and harm-free care.

Areas identified for improvement include the experience of patients in our emergency department, the quality of our estate, our complaints process and the roll-out of new technologies for clinicians. Further details are covered in our Quality Account which gives a full description of our Quality Improvement Plan.

National standards

Indicator	National Standard	2015/16	2016/17
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	81.5% - Under achieved
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	20 cases recorded – Achieved
Hospital acquired MRSA Bacteraemias should be identified and steps taken to reduce them	Trust target was to have zero cases	1 case - Under achieved	1 case - Under achieved
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.	2WW suspected cancer referrals, 94.9% seen within 14 days - Achieved Breast symptomatic patients, 88.8% seen within 14 days – Under achieved	2WW suspected cancer referrals, 91.7% seen within 14 days – Under achieved Breast symptomatic patients, 81.9% seen within 14 days – Under achieved

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	97.4% patients seen within 31 days – Achieved
All cancers – patients should have a maximum wait of 62 days between urgent GP referral or screening service to first treatment	National target was to see: 90% of those referred by the screening service; and 85% referred by GP	93.6% of patients referred by screening service seen within 62 days – Achieved 87.1% of patients referred by GPs seen within 62 days – Achieved	89.0% of patients referred by screening service seen within 62 days – Under achieved 87.7% 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	97.7% 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	88.1% - Under achieved

A comprehensive summary of our performance against national and local indicators can be found in our integrated performance report and Quality Account, which is accessible from the NHS Choices website.

CQC visits and findings

The CQC visited the trust in early 2015 and whilst it highlighted many areas of excellent practice, it found services provided by the Trust to be inadequate overall. Working with the CQC and others, a trust-wide Quality Improvement Plan was developed and delivered and a follow-up inspection was carried out in September 2016 to review progress.

This follow-up inspection led to an improved rating for the trust. Our overall rating is now 'requires improvement' which demonstrates significant progress. The number of 'goods' given as an overall rating or as a grade to show performance against the five key CQC questions has increased from 25 in 2015 to 40 in 2016. The number of 'inadequates' is now less than half that in the previous year. In 2015 there were 31 'inadequates' – including the overall rating for the Trust. The report following the 2016 inspection contains 15 'inadequate' ratings.

Some of the headlines from the visit include:

- Two areas made a significant improvement by moving up two ratings from 'inadequate' to 'good' - maternity & gynaecology and critical care.
- Inspectors commended the Trust's children's emergency department, the treatment of patients with hip fractures and the hard work of the trust's estate team in keeping the hospital's estate as safe and clean as possible and contributing to low infection rates
- Our extremely low mortality rates and our stroke care were praised.

- At Hemel Hempstead, the overall rating has moved from 'requires improvement' down to 'inadequate', despite outpatients & diagnostic services improving one rating to 'good'.
- Inspectors were concerned by the high number of delayed transfers of care. They observed that this limited the flow of patients through the trust.
- At St Albans City Hospital, the overall rating had moved up from 'inadequate' to 'requires improvement' but for the minor injuries unit the rating was down from 'good' to 'requires improvement'.
- While progress has been noted in urgent and emergency care at Watford General Hospital it was rated 'inadequate'.
- Inspectors praised progress with recruitment and also noted the percentage of savings made in 2015/16 – these are areas where the trust is bucking the national trend.
- More work is required around the management of patients with limited capacity.
- No enforcement actions were issued during the inspection and the vast majority of issues raised by the CQC were addressed immediately or within a matter of weeks.

The CQC ratings from the two inspections are shown below. The full reports are available on the CQC website (http://www.cqc.org.uk/)

From:

CQC Review Findings for the Trust – September 2015				
Are services safe?	Are services effective?	Are services caring?	Are services responsive?	Are services well led?
Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate

To:

CQC Review Findings for the Trust – March 2017				
Are services safe?	Are services effective?	Are services caring?	Are services responsive?	Are services well led?
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

The Trust is currently preparing or a full re-inspection of our hospitals by the CQC in August 2017. A comprehensive Quality Improvement Plan is in place setting out all the actions we are taking to address the findings of the September 2016 inspection. This is monitored by the safety and compliance sub-committee and the Trust Board. Further improving the quality and responsiveness of our emergency care services is the key priority for the coming year.

Quality highlights from 2016/17

These are measures selected by the trust which underline our commitment to patient safety and high quality care.

Quality improvement successes 2016/17		
PRIORITY	**2016/17 TARGET**	**YEAR END RESULTS (OR LATEST RESULTS AVAILABLE)**
Hospital mortality	Sustain better than expected mortality rates (SHMI) (target below 100)	**Met** 89.6
Hospital mortality	Sustain better than expected mortality rates (in Hospital Standardised Mortality Ratio) (target below 100)	**Met** 90.6
Venous thromboembolism	Reduction in fatal cases on 2015/16 numbers (Baseline = 9)	**Met** 2
Infection prevention control Medication errors	Compliance with the 2016/17 target of 23 or less cases of *Clostridium difficile* infections Reduction in number of medication-related serious incidents on 2015/16 numbers (Baseline = 9)	**Met** 20 **Met** 0
Cancer waiting times	Achievement of 4 cancer waiting times standards (1) 31 day – decision to treat to 1st treatment at WHHT = 96.0% (2) 31 day subsequent drug treatment = 98.0% (3) 31 day subsequent surgery = 94.0% (4) 62 day urgent GP referral to 1st treatment = 85.0%	**Met** (1) 97.4% (2) 100% (3) 97.7% (4) 87.7%
Infection Prevention & Control	Improved antibiotic prescribing	**Met** Met target of 1% reduction across all 3 antibiotics
Maternity care	Increase in the number of women who would recommend our maternity services as part of the NHS friends and family test (Baseline = 94%)	**Met** 98.6%
Harm free care	Score 90% for harm free care	**Met** 91.3%
Planned Care	99% of patients requiring diagnostic investigations will have their test within six weeks	**Met** 99.9%
Workforce	Maximum of 10% agency spend as a proportion of total staffing cost	**Met** 8%

Areas for further improvement		
PRIORITY	**2016/17 TARGET**	**DECEMBER 2016 (OR LATEST RESULTS AVAILABLE)**
Cancer waiting times	Achievement of the symptomatic breast 2-week wait standard of 93% and sustained achievement of the other cancer waiting times standards (1) 2 week wait from urgent GP = 93.0% (2) 2 week wait breast symptoms = 93.0% (3) 62 day screening referral to 1st treatment = 90.0%	**Not met** (1) 91.7% (2) 81.9% (3) 89%
Caesarean sections	Reduction in caesarean sections (national C-section target = 26%; local target agreed with HVCCG = 27%)	Not met 30.2%
Workforce strategy	Reduced vacancy rate from 14% to 8%	Not met 12.5%
Pressure ulcers	Zero grade 3 hospital-acquired pressure ulcers	**Not met** 33 grade 3 pressure ulcers
Pressure ulcers	60% reduction in hospital-acquired grade 2 pressure ulcers (Baseline = 98)	**Not met** 186
Infection Prevention Control	Zero cases of avoidable MRSA bacteraemia	**Not met** 1 case in Feb 2017
Sepsis	95% of patients who are red flag sepsis or severe sepsis, receiving antibiotics within an hour of screening	**Not met** 92%
Emergency Care	Compliance with national 4-hour A&E and ambulance handover standards from September 2016 (Targets: 4-hour wait = 85.9% Ambulance handover - 30-60 mins = 4,394 Ambulance handover >60mins = 1,711)	**Not met** ED 4-hour waits = 81.4% Ambulance handover 30-60 min handover is 5,531 YTD >60 min handover position is 3,151 mins
Emergency Care	Reduction in formal delayed transfers of care and decrease in the number of 'stranded' patients (i.e. patients in our hospital who are assessed as no longer needing acute care). (Target = 3.5%)	**Not met** 6.9%
Listening and learning	85% of complaints responded to within agreed timescale	**Not met** 42.8%
Risk management and quality governance	Zero never events	**Not met** 2

Better than national average and improved on previous year	Better than national average	Achieved & improved on previous year	Achieved but no improvement on previous year	Not achieved but improved on previous year	Improved on previous year – thresholds still to be determined

Quality Governance and risk management

During 2016/17 we continued to review and improve our governance and risk management arrangements. We implemented an upgrade to Datix - our risk management system, 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

During 2016/17 a total of 70 serious incidents were reported. Further to a change in processes for serious incident investigations in 2015/16, to ensure the organisation reflected the focus of the revised national Serious Incidents framework, in 2016/17 the trust has focussed on improving the quality of the serious incident investigations, with a particular focus on:

i) identifying from the outset of the investigation all the key questions for the investigation (including any questions or concerns raised by the patient or their family), what information is required and who are the appropriate experts to advise the investigation;

ii) Focussing on identifying more clearly the contributory factors and root causes; and iii) on ensuring the actions are SMART.
To achieve this we have introduced to the serious incident investigation process a scoping meeting, which is to take place at the outset of the investigation; introduced an additional review by the senior corporate team; and revised the Serious Incident investigation report template.

We have also commenced a comprehensive review of how we investigate all incidents, including those which are not serious incidents and are investigated locally by service managers and clinicians, with the aim to have a unified approach to all incident investigations.

Harm free care

Test Your Care was introduced in March 2014 initially with the adult in patient areas and the involving the specialist areas. To date we have 55 clinical areas undertaking the audit. At the end of March 2017, the overall trust average rate for the adult inpatient areas was 89.2%, although on a monthly basis there are many wards scoring 90% and above. In March 2017 there were 18 out of the 25 adult inpatient areas scoring over 90% with six of them scoring above 95% .We had set ourselves a target of 95% in the quality account for 2016/17.

The Test Your Care data is incorporated into the new ward-level dashboards and an integrated performance report enable staff to be aware of the performance in their area and across the trust. The year has seen the embedding of the new nursing documentation that has supported both staff and patients with the delivery of safe patient care.

Listening and learning

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

The patients' panel

The patients' panel has continued throughout 2016/17 to act as 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 continue to see themselves as 'critical friends' 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 lots of projects and have 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 2016/17 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 its 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 understand whether patients are happy with the service provided, or where improvements are needed.

The response of positive responses that said they "would recommend our hospital" is at 93.9%.

The survey results are displayed on the 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.

NHS Choices

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

NHS Choices comments

- Hemel Hempstead 35
- St Albans 52
- Watford 112

We replied directly to this feedback offering advice on where to get further information or on how to contact our Patient Advice and Liaison Service (PALS) or complaints team.

Patient stories at the Board

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

Patient Advice & Liaison Service (PALS)

Our Patient Advice and Liaison service (PALS) is 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, sensitive service and tries, wherever possible, to offer on-the-spot support to help resolve any problems.

In 2016/17, the PALS team dealt with a total of 3202 reported concerns, which is a 22% decrease on last year. Approximately 28% of concerns raised related to appointments. This can include delays, cancellations, changing appointments and waiting for appointments.

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.

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.

For 2016/17 we received 737 formal complaints, almost exactly the previous year where 734 formal complaints were logged. Of these, 46% were founded compared to 47% the previous year.

We aim to respond to 85% of all complaints on time. As a trust we averaged at responding to 45% of all complaints. In 2016/2017 the complaints team focused on ensuring the quality of responses improved and this led to a massive decrease in reopened complaints compared to the previous year.

Every complaint is considered and focus given on resolution with openness, transparency and with the patient and their relatives central to the process taking into consideration their needs and requests. Whether that resolution takes place in a meeting between service users and staff members, by telephone directly with the treating clinicians or by providing a written response to any concern raised, our aim is always to focus on our ongoing commitment towards service improvement.

Principles of 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
- Acting fairly and proportionately
- Putting things right
- Being customer focused
- Being open and accountable
- Seeking continuous improvement

Further information is available here:-
www.ombudsman.org.uk/about-us/our-principles/principles-remedy

Progress towards achieving equality

The trust continues to work towards achieving the Equality Delivery System (EDS2) standards for services and employment, to improve the experiences of people who belong to vulnerable and protected groups. Additionally, the trust reported for the first time on the new Workforce Race Equality Standard, mandated to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. WRES has been part of the NHS standard contract, starting in 2015/16 and included in the 2016/17 NHS standard contract. We have also published our annual public sector equality duty report showing progress and commitment.

A really positive development in 2016 was the establishment of the Trust's equality and diversity workforce forum, with membership drawn from across the trust including chair of our staff side. The forum has developed new ED objectives endorsed at board level and part of the updated workforce and development strategy, 2016 – 2019.

The trust has signed up to the 'disability confident' scheme. We have also extended training for recruiting managers to raise awareness of unconscious bias and to ensure recruitment and selection processes are fair and transparent. All our human resources staff processes are aligned with our trust values.

Other important initiatives include the new apprenticeship levy which will widen access to work and training opportunities, for young people and those looking to return and retrain.

The trust is also proactively reviewing implementation of the accessible information standard to ensure the needs of all patients are met for communications and information, so that the very best care is provided to all.

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

In addition to this, the trust is working towards compliance for the accessible information standard.

Support for disabled patients

We are a member of the Sensory & Physical Disability Service Watch Group, chaired by Healthwatch Hertfordshire and we work closely with Herts Hearing Advisory Service (HHAS) who supply hearing loss packs to support our patients and support with sensory training for frontline staff.

Furthermore, the 'Let Me Hear You' panel, which was established in 2015/16 has focused on other sensory impairments, such as blind and deaf/blind.

Lesbian, Gay, Bisexual & Transgender

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

Our Workplace, Our Commitment, Our Future

2016 saw the trust making real progress on implementing its 2016-19 workforce strategy (the workforce strategy is reviewed in the Quality Account) which is focused upon making the trust a great place to work by focusing upon four key priorities:

- **Laying firm foundations**; ensuring we have the right people in the right roles, with the right skills, doing the right things, in the right way - adding up to the right culture.
- **Finding the right people;** recruiting and retaining a stable, competent, cost effective permanent and temporary workforce that is agile and future-proof.
- **Supporting our people**; retaining and looking after our people's well-being, listening to staff and recognising efforts, creating a better place to work so people will stay and flourish.
- **Developing our people**: ensuring people have the required knowledge and skills, strengthening leadership capability and offering great education and training to equip our staff to work safely and effectively now, and in the future.

Laying firm foundations

We're delighted that our staff survey results for 2016 have continued to improve. Our overall staff engagement score improved for the third year running and we are now in the top third of UK Trust's for staff engagement, an increase of 11 places since the last survey. The survey highlighted real improvements in areas such as the support colleagues feel they have from their line managers, their perception of how the organisation takes positive action in relation to health and well-being and staff feeling that care of our patients is the organisation's top priority. As a result of this work we have created 'staff survey action plans' both at an organisational and divisional level to help us on our journey of making West Herts a great

place to work. We have also devised a quarterly staff engagement questionnaire that allows us to produce a consistent engagement score for the trust and each division.

Finding the right people

Recruitment particularly for nurses, but also for a number of other specialist clinical roles, continued to be a challenge in 2016/17. Nonetheless, we increased the actual total number of people working for us over this period by 215 whole-time equivalent (wte) employees.

Overall, the Trust vacancy rate peaked at 15.9% in August 2016, and has fallen to 12.5% at the end of March 2017. This is against a background of the Trust increasing its establishment i.e. the number of posts we have in the organisation, by over 300 wtes since March 2016. This was mainly to create additional capacity in A&E and in Castle and Tudor wards. Had our establishment remained at March 2016 levels then our average vacancy rate for the last year would have been closer to 8-9%.

We have enjoyed particular success in reducing vacancy rates for consultant doctors, and healthcare support workers, with both areas seeing rates fall to below 5%. Whilst we have been successful in recruiting nurses both domestically and from overseas, the overall UK shortage, combined with a relatively volatile workforce, means we must continue to give priority to recruitment for this staff group into the coming year.

Our turnover rate has remained fairly static over the year, at around 16%, which is broadly in line with rates for comparable organisations.

Our spend on agency workers has also very significantly reduced over the last year with around £10m less being spent in this area.

Supporting our people

We continue to run an extensive health and wellbeing programme for our staff in order to support them to be healthy and well. Our Balance4Life programme has this year provided workshops on managing stress, mindfulness and mental health, and offered health MOTs across all sites. We offer onsite classes such as yoga, Pilates and tai chi, and in response to feedback have introduced new activities over the year. Monthly relaxation days provide staff with the opportunity to book massage.

Developing our people

We have continued to invest in the development and leadership of staff in the organisation. In particular we have continued to support staff in leadership roles at all levels across the organisation to develop their knowledge and skills through a range of leadership development programmes. These are run in conjunction with the University of Hertfordshire and offer colleagues the opportunity to also achieve credits towards postgraduate study up to Masters level. The programmes are usually multidisciplinary so as to enable networking across the organisation to effect positive culture change.

Our non-medical education and training was inspected in December 2016 by the Quality Improvement and Performance Framework team who reported further significant improvements had been made since their previous visit and this was showing a positive improvement trend in the trust's approach to education.

In particular the trust has implemented a new education governance structure with an education panel attended by a number of senior leaders committed to the education agenda

and also patient panel representation to ensure wider engagement.

Equality and diversity

New ED Workforce Forum established

The new internal Workforce Equality Forum chaired by the Associate Director, OD, Engagement determined ED priorities for 2016-19 informed by the EDS2, PSED, WRES and Staff Survey.

Supporting our multicultural staff network

We continue to support our multicultural staff network 'Connect' run by staff for staff and aimed at providing support to BME staff. It seeks to enable staff from these groups to feed in issues to policy development and review and provide a consultation forum for the Trust to gather views on particular developments.

Let me hear / see you panel

Extending engagement with under-represented groups such as people with visual or hearing impairments, through the newly formed Let me hear / see you panel has helped us identify root causes and potential solutions to address the less positive staff and patient experience. The panel is chaired by a member of staff with a disability and includes representatives from community organisations.

Key achievements in 2015/16:

- Refreshed mandatory ED training incorporating unconscious bias awareness
- Refreshed ED policy
- Roll out of national NHS Workforce Race Equality Standard
- Launch of a new resolution guide which provides clearer support for staff
- Portal and suite of tools developed to support staff and managers on a range of ER issues
- B&H advisers allocated to specific divisions & hotspot areas
- New B&H intranet site with a wealth of information to support staff including external support
- We have accreditation as a 'Two Ticks, positive about disabled people' employer. This demonstrates that we encourage applications from disabled people and make commitments towards our disabled staff.

Emergency preparedness and resilience

Emergency preparedness and resilience is at the forefront of the drive to maintain operational capability and provide an effective and efficient response any business continuity or critical incident. A multi-agency exercise at St Albans Hospital in June provided an opportunity to work in partnership to test our resilience and responses. The event was judged to be highly successful with follow-up actions having been completed and relationships strengthened in this important area of our work.

Each year the Trust undergoes an assurance process with NHS England to confirm arrangements are in place in relation to Emergency Preparedness, Resilience and Response. This process ensures we are meeting our responsibilities as outlined in the NHS England EPRR Framework and the Civil Contingencies Act 2004. For 2016 the Trust achieved a fully compliant status.

Looking after your data

We have implemented a number of additional controls to strengthen governance arrangements, communication and compliance. This included 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 annual governance statement on page 24.

Freedom of Information requests

In 2016/17 we received a total of 662 Freedom of Information requests, of which 94.3% were responded to within the mandatory 20 day time frame

Our environment, IT and support services

Improving the quality of our Information Management & Technology

We have made significant progress in 2016/17 in the deployment of new ICT infrastructure in order to support the transfer of vital information about our patients' health from paper to digital. However significant challenges remain and pursuing additional funding to improve our IT infrastructure is a key priority for the year ahead.

Other improvements include the development of our integrated performance report, with comprehensive suites of reports, now available to inform operational delivery of emergency and planned care and to support clinical decision making. This is available to the public via the board papers on our website.

Improvements to the hospital environment and infrastructure

Our estate across all sites has areas that require more than just maintenance. The trust is pursuing central government funding for this and in the meantime continues to invest in keeping our sites safe and as clean as possible. Recognising the length of time a major estate redevelopment would take; investments have been made in new and current facilities which have resulted in benefits to our patients. These include:-

- Installation of three 1 megawatt emergency generators was undertaken in 2016 to serve our high voltage network at Watford Hospital. These generators provide 100% electrical backup to the site in the event of a main power failure from the national grid supply, previously the site was only able to support 50% of patient areas and some building were without power supplies in the event of a mains power failure.
- Installation of an additional CT and MRI scanners at Watford
- Refurbished endoscopy department
- Improvement of cardiology, respiratory, vascular lab, surgical assessment and day surgery facilities
- 24/7 security, additional patrols and CCTV

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.

The 2016 inspection looked at five key areas - cleanliness; food and hydration; privacy, dignity and wellbeing; condition; appearance and maintenance and suitability of the hospital environment for people with dementia.

Our scores for 2016/17 were:

Category	Trust average
Cleanliness	98.09%
Food	80.57%
Food Organisation	82.20%
Ward Food Service	80.25%
Privacy, Dignity and Wellbeing	69.62%
Condition, Appearance and Maintenance	89.01%
Dementia	53.41%
Disability (new for 2106)	60.41%

Following the inspection, meetings were held with Healthwatch Hertfordshire to develop a detailed action plan to maintain the continuous improvement programme.

Actions undertaken as a result included:

- Monthly mock PLACE audits with patient 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

Sustainability

We are committed to embedding sustainable practices across our hospitals and will be reviewing our Sustainable Development Management Plan this year.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020 using 2013 as the baseline year.

Combined Heat and Power Unit (CHP) – the Trust's CHP unit located on the Watford Hospital site continues to save the Trust in energy costs and carbon reduction. The unit is set to run 17 hours per day. For the year 2016/17 the CHP unit generated cost savings against utilities of £220,828 and also contributed greatly to a carbon reduction of 1,007 tons of CO2 for the Watford Site.

The increased oil consumption, in comparison to the baseline in 13/14 is due to instigation of compliant testing schedule of our existing standby generators, the additional hours run by the standby generators in preparation for the installation of the new High Voltage generators at Watford in 2016 and the requirement to burn off existing oil stocks via Boilers (heating &

hot water) at Hemel to enable the Estates Team to undertake essential repairs to the oil fuel storage tanks.

The increase in gas consumption is attributable to the running of the CHP unit at Watford but this is offset by a consequential reduction in imported electricity.

Resource (Baseline)	2013/14	2014/15	2015/16	2016/17	% Change on Baseline
Gas Usage (kWh)	40,620,606	41,920,825	44,997,895	43,529,517	7.16%
Electricity Usage (kWh)	17,010,202	16,452,870	17,546,952	17,241,183	1.36%
Oil (kWh)	26,423	160,611	189,419	441,584	1571%
CO2 (tonne)	16,701	16,231	15,811	16,876	1.05%
Total Energy Spend	£3,118,866	£3,218,042	£3,034,019	£2,827,000	N/A
Figures as reported in ERIC and equate to approximately 22% of the Trusts total carbon footprint. The remainder is made up of Procurement (64%) and Travel (14%)					

NOTE:
Provisional figures for 2016/17. These must remain provisional as all invoices are not in and calculations on CO2 have not been finalised.

Procurement – sustainability has been embedded in all Trust tendering processes and Hertfordshire NHS Procurement hub always includes requests for environmental sustainability policies in all tenders and scores on this.

Overall the amount of waste produced by the Trust is in line with the increased clinical activity. With recent refurbishment projects there has been a separate exercise to de-clutter wards by removing surplus equipment.

Year	Total Waste (tonnes)	Waste Recycling (tonnes)
2013/14	1509	334
2014/15	1695	306
2015/16	1856	351
2016/17	2097	514

Our future

Trust strategy – 2016/17 and beyond

There were several strategic pieces of work in 2016/17 which will remain a major focus for us and provide a sound base for our onward development.

Our clinical strategy was finalised, having had a wide range of staff input. This sets out our priorities as delivering more care locally, strengthening core services and excellent extended care where we have the appropriate skills and opportunities. This is embedded and accepted as our strategy.

It fits well within *Your Care, Your Future* – a programme between this trust and local NHS partners which was driven by the principles of delivering more care closer to home. This programme also considered the role and location of acute care.

During 2016/17 we determined, following engagement with the local community, that emergency and specialised care will be provided at our site in Watford. St Albans will be developed as a centre for planned care and the range of services to be delivered in Hemel Hempstead will be considered in late 2017.

2017/18 will be vital in terms of moving our Watford and St Albans plans from Strategic Outline Case towards Outline Business Case and for working with stakeholders to develop the Strategic Outline Case for services in Hemel Hempstead. The trust will be pursuing central government funds to bring about a much-needed transformation of our hospitals.

The principles behind these plans remain a constant – providing high quality, sustainable care in the best and most appropriate setting. However, we are now working across a wider geography as part of the Hertfordshire and west Essex Sustainability and Transformation Partnership (STP) which covers a population of 1.5 million people. Our plans are in line with and not threatened by proposals which relate to the STP.

Further information can be found at www.healthierfuture.org.uk.

Watford Health Campus

We continue to work with Watford Borough Council and Keir Property Ltd as part of the Watford Health Campus which was launched in 2013 with the aim of redeveloping the land around the current 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 which opened in November 2016.

The Accountability Report

Director's report

The names of the chair and chief executive and the names of 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 director's remuneration on page 48, which also sets out full details of remuneration for board members during 2016/17.

The composition of the 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 on page 57.

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.

Director's 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 the chief executive's responsibilities as the accountable officer of the trust

The chief executive of NHS Improvement 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:

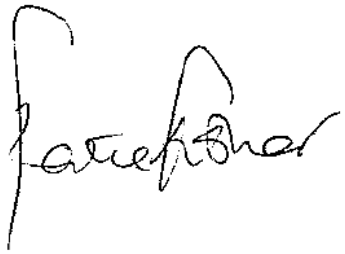
- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended 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.

Signed



Chief Executive Officer

30 May 2017

Annual Governance statement 2016/17

Scope of responsibility

All NHS trust accountable officers are required to give assurance about the stewardship of their organisations and include an annual governance statement in the organisation's annual report and accounts. The statement draws together position statements and evidence on both corporate and quality governance, risk management and control, providing for a coherent and consistent reporting mechanism.

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 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.

The governance framework

The board comprises of 11 directors: chair, five non-executive directors and five executive directors including the chief executive. The members of the board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies and the private sector. In reviewing the skills and experience of the board, the non-executive directors are considered to be independent in character and judgement and the board believes it has the correct balance in its composition to meet the requirements of an NHS trust. Non-executive directors do not have executive powers and are not involved in the day to day running of the business. Their role is to seek assurance on behalf of stakeholders on the governance process and monitor executive activity, as well as contributing to the development of strategy. All executives have been assessed as meeting the fundamental standards of the fit and proper persons test.

As an NHS trust, compliance with the UK Corporate Governance Code is not required, however, it has reported on its corporate governance arrangements by drawing upon the best practice available, including those aspects of the UK Corporate Governance Code its considers to be relevant to the trust.

Standing orders sets out the role of the board and its standing committees, together with the individual responsibilities of the executive and non executive directors was endorsed by the board in August 2016.

The board met in public on 11 occasions throughout the reporting period. I joined the trust as chief executive officer in July 2016, replacing Jacqueline Kelly who had been the interim chief executive since January 2015. In June 2016 Paul Cartwright was reappointed as a non-executive director and Sally Tucker joined the board, replacing Lynn Hill as chief operating officer.

In the reporting year, a board membership review was undertaken and it was agreed that additional executive directors and divisional directors would attend board meetings to bring their specialist advice and expertise to board discussions. The divisional directors are all senior clinicians and bring an extra clinical and service level perspective to the board.

Details of the voting board members and their attendance at meetings are given in appendix 1. The board ensured quality remained a focus on each board agenda and patients were invited to attend meetings on a regular basis to inform the board of their experience. A fundamental priority for the board is to formulate and drive strategic objectives and during the reporting year the board received regular strategy updates, including the Your Care, Your Future and the Sustainability and Transformation Plan (STP). As well as the trust's clinical strategy and a strategic outline case for the configuration of acute hospital services, the board also approved a number of internal strategies in 2016/17, including interim estates, workforce, end of life, patient and carers experience, nursing, midwifery and allied health professionals.

During the year, a comprehensive executive visibility programme was introduced which provided structure to directors visits across the trust sites.

The board considered the effectiveness of each of its meetings and feedback was used to introduce improvements, in 2016/17 this included the establishment of a register of decisions taken by the board and committees. A register of conflict of interests was presented at board and committee meeting and members were asked to declare conflicts with agenda items.

As well as the statutory committees, the board had a number of additional committees which assisted it in carrying out its duties effectively. Each committee has terms of reference and a work plan and these were reviewed for scope, responsibilities and membership by the respective committee and formally adopted by the board between May and July 2016. With the exception of the trust executive committee which I chair, all committees are chaired by a non executive director and the chair of each committee routinely provides the board with an exception report following each of the meetings. Details of committee meetings and attendance can be found on page 53.

The board endorsed a comprehensive scheme of delegation in August 2016 which details items reserved for the board, those delegated to committees and those delegated to individuals.

The audit committee is the senior independent non-executive committee of the board and met five times in 2016/17 on regular business and twice to consider and approve the annual accounts, report, governance statement and quality account. It provides independent and objective assurance on the effectiveness of the organisation's governance, risk management and internal control. It also reviews the work of internal and external audit and local counter fraud provider and any actions arising from that work.

Internal audit and local counter fraud services are provided by an independent external expert who attends all meetings of the audit committee. Members of the executive team and key staff attend audit committee meetings, although they are not members of the committee. The audit committee has reviewed reports during the year, including internal and clinical audit and has monitored the integrity of the trust's financial statements, in particular, the annual report, accounts and governance statement, as well as reviewing the strength of the whistle-blowing arrangements and the effectiveness of the other committees.

The audit committee reports to the board following each meeting and escalates areas of concern or underperformance if required. The committee undertakes a yearly self-assessment of effectiveness and provides an annual report on its performance to the board.

The audit committee terms of reference were extended in 2016/17 to take on the accountability and reporting arrangements for the auditor panel, which was established to advise and oversee the appointment of the external audit function.

In addition to the audit committee, the following committees make up the corporate governance
structure:

Remuneration committee is established to agree the overall remuneration policy of the trust, set individual remuneration for executive directors, ensure that appropriate processes are in place to provide performance management of the chief executive and approve agreements and redundancy payments to very senior management.

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 to support charitable activities within the trust.

Safety and quality committee was an assurance committee of the board and responsible for the monitoring of patient safety, estates, health and safety, serious incidents, complaints and incidents and the patient experience.

Finance, investment and performance committee was established to provide the board with assurances that financial expectations were being met. As well as monitoring the financial position, the committee was also responsible in 2016/17 for seeking assurance on operational and information communication technology performance.

Workforce committee was responsible for providing assurance concerning all aspects of workforce, organisational development and learning.

Integrated risk and governance committee was established on a short-term basis to provide assurance on the development and delivery of the quality improvement programme and the development of risk management processes, including the maintenance of the corporate risk register and board assurance framework.

Trust executive committee has revised its monthly trust executive cycle, structure and membership in 2016/17. As well as regular business, specific agendas have been developed which focus on the delivery of the strategy programme and on the monitoring of corporate, quality and financial performance.

Operational performance was reviewed by the finance, performance and investment committee, the trust executive committee and the board at each meeting. Where there was sustained adverse performance in any indicator, this was reviewed in detail by the appropriate board committee. Indicators relating to the quality of patient care were reviewed by the safety and quality committee.

Responsibility for patient, staff and corporate risk issues were monitored by the appropriate committee and the integrated risk and governance committee brought these together to ensure cross reporting and that the full risk profile was considered.

In order to further strengthen governance arrangements, the board approved changes to its committee structure, roles and membership. These changes will be reflected in individual committee's terms of references and work plans in 2017/18 and will include the introduction of an annual self-assessment for each committee.

A robust process for evaluating the performance of the chair and non-executive directors has been developed. The chair's performance is evaluated by NHS Improvement and the chair evaluates the chief executive's performance, taking into account the views of the other non executive directors.

The performance of the executive directors is reviewed by the chief executive and all executive and non-executive directors have an annual appraisal and a personal development plan which forms the basis of their individual development and aligns with the trust's strategic objectives.

Members of the board undertook personal development during the year in addition to attending collective training as part of regular development sessions. A board development programme was designed to ensure that it was relevant and applicable to the board's responsibilities and was aligned with the recommendations of an external leadership capacity and capability review. The objectives of the board development programme were to ensure that the board was fit to run the trust, could set performance standards, operate as a unitary function and was aware of, and was able to successfully manage, competing priorities and future challenges.

The publication "Delivering the Forward View: NHS Planning guidance", published in December 2015 by NHS England, sets out the mandate to deliver a five year Sustainability and Transformation Partnership (STP). The trust has been placed in the Herts and west Essex STP, along with Essex County Council, Hertfordshire County Council, East and North Herts Clinical Commissioning Group (CCG), Herts Valleys CCG, West Essex CCG, East and North Herts NHS Trust, Hertfordshire Community Trust, Hertfordshire Partnership Foundation Trust, North Essex Partnership Foundation Trust, Princess Alexandra Hospital NHS Trust and South Essex Partnership Foundation Trust.

The trust has continued to take an active role in discussions with its constituent STP organisations regarding building new collaborative provider arrangements to support the delivery of integrated care and pathway redesign. The trust's chief executive was appointed as the chair of the local delivery board and the chair is an active member of the chair's oversight STP group.

Governance processes have been developed to support implementation of the STP whilst recognising the statutory responsibilities and accountabilities of constituent organisations. The focus in 2016/17 has been on developing clear implementation plans and milestones for the next two years and strengthening the programme management structures to support delivery of the STP. Activity and financial modelling has been undertaken to ensure all assumptions are robust and interdependencies are understood and appropriately mapped.

The trust has also been working collaboratively with the Royal Free London NHS Foundation Trust (RFL) through a 'buddying' arrangement. This has included staff participating in a leadership programme and support in the preparation for a Care Quality Commission (CQC) follow-up inspection. In 2017/18, the leadership of both organisations will consider further collaboration opportunities which could deliver mutual benefit.

Since the publication of the outcome of a planned CQC inspection in September 2015, the trust has been in special measures. A quality improvement plan (QIP) has been developed which identifies actions required to clinical and operational practices in order to address concerns raised by the CQC. The QIP is clinically owned by teams and departments at specialty level and is divided into five key areas; our people, getting the basics right, patient focused care, improving our infrastructure and governance, risk management and making informed decisions. An oversight group, led by NHS Improvement (NHSI), has regularly reviewed the progress the trust is making against the QIP throughout 2016/17.

In a follow-up inspection undertaken in September 2016, the CQC recognised the demonstrable improvements and moved the trust from 'inadequate' to 'requires improvement'. The CQC inspection report highlighted a significant increase in the number of services graded as 'good' and the number rated 'inadequate' had nearly halved from the

initial inspection. However, the trust remained in special measures as the CQC had not been fully assured that the improvements it had seen were completely embedded and transferred to future practice. The QIP has been refreshed to include actions to address concerns raised in the follow-up inspection and a further targeted inspection is expected to be carried out before the end of 2017 (calendar year) in order for the CQC to fully assure itself that improvements are embedded and sustained.

The QIP was assessed by internal audit in 2016/17 and partial assurance was given to the board of its efficiency and effectiveness.

Quality governance continues to be a principal driver of the trust's focus which is being developed into a quality strategy. This strategy will drive a culture of continuous quality improvement across the trust and will be developed in consultation with staff, patients and other key stakeholders. The strategy will provide a coherent view to the trust's approach to quality, by bringing together organisational quality priorities, compliance against the fundamental standards of care, the Commissioning for Quality and Innovation (CQUINs) payments framework, contractual requirements set out in the trust's quality schedule and any outstanding QIP activity.

The trust was registered fully with the CQC without compliance conditions on 01 April 2010. It is registered for eight regulated activities. Under the single oversight framework, which is designed to help NHS providers attain and maintain, CQC ratings of 'Good' or 'Outstanding', NHSI has segmented provider organisations based on the level of support each provider requires.
The segmentation is based on five themes; quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capabilities. The trust has been placed in category four (providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues).

The trust regularly reports to a range of regulatory bodies on relevant performance and compliance matters as required and in the prescribed format. The board is responsible for ensuring compliance with the trust's provider licence, mandatory guidance issued by NHSI and other relevant statutory requirements. The trust is required to meet national standards as defined within the NHS operating framework. Operational performance is monitored by NHSI, Herts Valleys Clinical Commissioning Group (HVCCG), Department of Health, NHS England and the CQC. Performance against the national standards can be found on page 7.

The quality and accuracy of performance information, including elective waiting time data, is continually assessed. Each division operates a weekly access meeting where patient tracking lists are scrutinised in detail by the service team and the senior divisional team. Divisions have processes that validate patient pathways prior to any monthly performance information being produced and/or submitted externally. Performance assurance is underpinned by the referral to treatment programme board, which is chaired by the chief operating officer. Any issues highlighted within the data are reported by the service team through to the information team for investigation and are acted upon appropriately.

The trust is required under the Health Act 2009 and the National Health Service (quality account) Regulations 2010 to prepare a quality account for each financial year. The trust has produced a quality account in accordance with relevant national guidance, which summarises the performance of the trust against the key performance measures, including the NHS operating framework, CQUIN payment framework, advancing quality and local quality measures. The quality account has been reviewed by the trust executive committee and the safety and quality committee to guarantee the 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). The account also provides a look forward to

future priorities and comments have been provided by local stakeholders, including commissioners, patients and the local authority. The quality account will be assessed by the audit committee prior to board review and publication in June 2017.

Controls are in place to ensure the trust remains compliant with all its statutory workforce requirements, including the equality, diversity and human rights legislation and all trust policies are subject to an equality and diversity impact assessment. In addition, measures are in place to ensure that the trust complies with its obligations regarding the NHS pension scheme.

The overall financial risk rating in 2016/17 was 4 (1 indicates the least risk and 4 the highest risk). The trust's improvement programme achieved £14.7m, (4.6% of revenue), which is the highest ever recorded in the trust and higher than the original budget of £14.5m, although it was below the stretch target of £18.3m. All efficiency schemes were quality impact assessed and approved by the chief nurse and medical director prior to implementation.

Clinical audit within the trust is multi-professional and occurs in various formats. During 2016/17, the trust has continued to work to improve weaknesses within clinical audit that were identified by the CQC in 2015. 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.

The trust has a clinical audit strategy and clinical audit policy in place and these set out clinical audit objectives, priorities in relation to resource allocation and corporate, divisional and individual responsibilities. The clinical audit database continues to be populated and updated with all registered local and national audits.

A divisional audit planner for 2017/18 has been developed and dissemination of learning will continue to be a key focus, with the conclusion of clinical audits discussed at departmental, divisional and cross divisional forums.

'Never events' are potentially very serious incidents which, by their definition, "should never happen". Two Never Events were reported in 2016/17. One Never Event was reported under the Surgery, Anaesthetics and Cancer division relating to wrong site surgery and the second Never Event was reported under the Women's and Children division relating to a retained foreign object following a procedure. Both were subject to intense investigation and scrutiny, with immediate changes put in place when the incidents occurred, followed by comprehensive action plans drawn up with the multi-disciplinary teams with the learning from the investigations to ensure that there are changes in practice to prevent these occurring again. Substantial changes have been made in both the departments involved in the Never Events. The findings and learning from the Serious Incident investigations have been shared widely throughout the trust.

There were 70 Serious Incident investigations in 2016/17, which is in line with 2015/16 when 69 SIs were reported. Further to the work done in 2015/16 to ensure the organisation reflected the focus of the revised national Serious Incidents framework; in 2016/17 the trust focused on improving the quality of the Serious Incident investigations, with a particular focus on:

- identifying from the outset of the investigation all the key questions for the investigation (including any questions or concerns raised by the patient or their family), what information is required and who are the appropriate experts to advise the investigation.

- focusing on identifying more clearly the contributory factors and root causes.
- ensuring the actions are SMART (specific, measurable, attainable, relevant and time-based).

These improvements were achieved by:

- introducing a scoping meeting taking place at the outset of the investigation to agree on the key questions (including any questions raised by the patients and their families) and all the evidence and expert advice required to address them. As a result, our investigations have more focus from the outset and the appropriate experts are engaged in the investigation;

- introducing a meeting with the senior corporate team with the lead investigator half-way through the investigation (30-day meeting); this ensures that the investigation is on track and the right questions are being asked to identify the root causes; it is also an opportunity to resolve any obstacles to the investigation and provide support and guidance for the lead investigator;

- revising the Serious Incident investigation report template to make it more user friendly with including clearer guidance for the investigators with examples;

- standardising the agenda for the 45-day meeting (this includes the investigation panel, the clinical experts, the Corporate team, the Duty of Candour lead and the senior divisional managers) to facilitate a constructive discussion about the key findings in the report, what actions are required to address these, and a plan for sharing the findings with the patients and their families.

In the second half of 2016/17 the Herts Valleys Clinical Commissioning Group has recognised and commended the significant improvements to the quality of the Serious Incident investigation reports as well as the trust's commitment to build and develop on these.

The trust has prepared a plan for a comprehensive review of how it investigates all incidents, including those which are not Serious Incidents and are investigated locally by service managers and clinicians, with the aim to have a unified approach to all incident investigations. The plan has been through a series of consultations resulting in an improvement plan to take forward in the early 2017/18.

In June 2016 an independent enquiry commissioned by the trust was completed, which had investigated the perinatal care of four babies. The enquiry was completed by The Infant Mortality and Morbidity Studies organisation, and included independent reviews of each case by an obstetrician, a neonatologist and a midwife, who were all from different trusts, and in addition by a neonatologist. In response to the issues identified in the enquiry, the trust developed an extensive action plan covering both obstetric/maternity and neonatal specialties. The action plan has been monitored within the division and at a sub-board committee level.

In November 2016 the trust completed a thematic review of 15 hospital acquired pressure ulcers following an increase in the number of grade 3 hospital acquired pressure ulcers during the period of July to September 2016. In response to the recommendations set out within the thematic review a comprehensive action plan has been developed with both division-specific and trust-wide actions; this action plan has since been incorporated into a

comprehensive pressure ulcer improvement plan in response to the recently re-launched Stop the Pressure Campaign.

The trust has continued to focus on monitoring of, and learning from, the actions identified through Serious Incident investigations to ensure they have been completed and there is evidence of learning; the trust has continued to hold two-monthly Serious Incident Review Group meetings where the divisional teams present evidence of completion of actions from the closed Serious Incident investigations and present evidence of learning taken from the investigation.

Serious Incidents and Never Events	**Actions taken**
Maternity/obstetric and neonatal incidents	• The type of swab used has been changed; whiteboards have been installed in the delivery rooms to be used to record swab and needle count during procedures; a repeat audit of swab count practice found marked improvement in compliance. The WHO surgical safety checklist has been introduced for the maternity areas and included in the mandatory training. • Increased staff awareness through mandatory training sessions, clinical briefing sheets and posters, and discussions at the Divisional Clinical Governance meeting as well as a Trust-wide Stories around Safety event. • Work is underway to facilitate the introduction of customised growth charts to monitor fetal growth. Implementation of the SBAR for communication between teams. Workshops including training on fundal height measurement. Hypothermia sticker and poster have been developed. A parent information leaflet has been produced on Group B Streptococcus. • Several audits have been completed by the Neonatal teams with the learning shared throughout department; they included the audit on appropriate room environment in delivery rooms, resuscitative readiness; neonatal documentation resuscitation records, a sepsis audit and a review of First Hour Care guidelines with audit. • A new Paediatric and Neonatal induction administrator was created and appointed to in April 2016.
Surgical invasive procedures	• Implementation of the 5 step WHO surgical check list in the eye injection clinic. Business case approved for a second treatment room and for an additional injection staff to increase capacity of the age-related macular degeneration clinic. • Daily safety huddles and a Standard Operating Procedure have been introduced at the injection clinic. Sharing of lessons learnt from the Never Event Serious Incident at the divisional Quality Governance meeting. • Recruitment of an additional Urology Consultant. Trial of new bipolar resection equipment for the transurethral resection of the prostate procedure, which is considered safer. • Creation and implementation of a pleural procedures register to record competence for pleural procedures. Business case has been approved for the creation of a dedicated room for pleural procedures.

Serious Incidents and Never Events	Actions taken
Hospital acquired Pressure ulcers	• Ward based bullet training provided by the Tissue Viability Nurses has been introduced for clinical staff. Delivery of 1.5 hour training sessions on pressure area care to the Transitional nurses; a number of training sessions were delivered in 2016 with more planned in 2017. • Harm Free Care quizzes undertaken regularly in clinical areas as a fun way of engaging and training staff; Mr B Harmfree – a doll used as a symbolic patient representing Harm Free Care used for training and promotional activities with staff; including a twitter account @MrBHarmfree. • Patient Safety Huddles undertaken daily on wards where staff discuss patients at risk of pressure ulcer damage; and also on start of a Serious Incident investigation into pressure ulcers. Focus on learning from the thematic review at a Trust-wide Stories around Safety event.
Sub-optimal care of the deteriorating patient	• Patients receiving NAC treatment following paracetamol overdose are now kept on the Acute Admissions Unit for monitoring and not transferred to another acute ward. Revised Pathology policy for telephoning critical blood test results to the wards to ensure that results are reported to registered clinical staff only. • The trust resuscitation training plan and has been amended to include to include checking that extension lead for oxygen masks is connected to an oxygen source; the induction booklet has been amended to include to include instructions on how to correctly apply extension lead for oxygen masks. Focus on ensuring oxygen mask is connected to an oxygen source via staff communications and presentation at the Trust-wide Stories around Safety event in March 2016.

Stakeholders are actively encouraged to become involved in the work of the trust and to raise issues relating to risks which impact upon them. Key external stakeholders include CQC, NHSI, the Health and Safety Executive (HSE), the NHS Litigation Authority (NHSLA), HVCCG (who commission more than 96% of the trust activity), Medicines and Healthcare Products Regulatory Agency; the Information Commissioner's Office, Hertfordshire Health and Wellbeing Board, Hertfordshire Healthwatch; Local Members of Parliament; NHS England (NHSE) and other local NHS trusts.

Risk assessment

As chief executive, I have overall responsibility for risk management in the trust, which is discharged clearly amongst the executive and non-voting directors of the board, who have a collective responsibility for maintaining a system of sound internal control. The executive director with responsibility for risk management in 2016/17 was the deputy chief executive. The trust executive committee, which I chair, has the remit to ensure the adequacy of structures, processes and responsibility for identifying and managing key risks facing the organisation, prior to board discussion.

The trust recognises that it is not possible to eliminate all elements of risks and has a risk management policy which sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. The board has overall responsibility but in 2016/17 it delegated the work to the integrated risk and governance committee, which is chaired by a non-executive director.

The board brings together the corporate, financial, workforce, clinical, information governance risk agendas. The Board Assurance Framework (BAF) ensures that the board has clarity about the risks that may impact on the trust's ability to deliver its strategic objectives together with any gaps in control or assurance. The BAF was further refined and embedded in 2016/17 to provide greater assurance to the board that major risks are being tracking appropriately. The board agenda is aligned with the principal risks of the BAF and the board receives a quarterly report on changes to the BAF and corporate risk register.

In 2016/17 the BAF had ten principal risks and during the year the rating of a number of risks moved, as shown in the table below.

Principal Risk	Description	Apr-16	Jul-16	Oct-16	Feb-17
PR1	Failure to provide safe, effective, high quality care (insufficiently robust and embedded quality governance and risk management)	A	A	A	A
PR2	Failure to recruit to full establishments, retain and engage workforce	AR	AR	A	A
PR3	Current estate and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care	AR	AR	AR	AR
PR4	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care	AR	AR	AR	AR
	4A) IM&T 4B) Information and information governance	AG	AG	AG	AG
PR5	Inability to deliver and maintain performance standards	R	R	R	R
	5A) Unscheduled care 5B) Elective care (including RTT, diagnostics and cancer	AG	AG	A	A
PR6	Failure to maintain business continuity	AR	AR	AR	G
PR7	7A) Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes	AR	AR	AR	AR
	7B) Failure to secure sufficient capital, delaying needed improvements in the patient care environment, security and safe infrastructure	R	R	R	R
PR8	Failure to sustain key external stakeholder relationships and communications compromises the organisation's strategic position and reputation	A	AG	AG	AG
PR9	9A) Failure to develop a sustained long term clinical, financial and estates strategy	AR	AR	AG	AG
	9B) Failure to deliver a sustained long term clinical, financial and estates strategy	New	New	AR	AR
PR10	System pressures adversely impact on the delivery of the Trust's aims and objectives	New	AR	AR	R

Information governance provides a framework for handling information in a secure and confidential manner. Covering the collection, storage and sharing of information, it provides assurance that personal and sensitive data is managed legally, securely, efficiently and effectively in order to deliver the best possible care and service.

The chief information officer chairs the informatics group, the principal body overseeing the management of information risks. The group reports into the finance, investment and performance committee and oversees submission of the trust's information governance toolkit.

The trust has a trained caldicott guardian, a trained senior information risk owner and a trained data protection officer. Information governance incidents classified as serious incidents requiring investigation (SIRI) level 2 are those that are classed as a personal data breach (as defined in the Data protection Act) or high risk of reputational damage, reportable to the Department of Health and the Information Commissioner's Office. The trust reported no information governance SIRI level 2 cases in 2016/17. Incidents classified at lower

severity level 1 have been aggregated and reported in the format provided in the table below.

Category	Breach type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	22
C	Lost in transit	4
D	Lost or stolen hardware	0
E	Local or stolen paperwork	0
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	1
K	Other	4

The risk and control framework

The trust has one system for the management of risk, which can be distilled at three levels across the organisation: 1) divisional and corporate risk registers, 2) the highest scoring risks on divisional risk registers are reviewed and escalated where necessary to the corporate risk register (CRR) and 3) strategic risks which directly impact on the delivery of the organisations principal objectives are reviewed through the board assurance framework.

Day to day management of risk is undertaken by the operational teams, who are charged with ensuring risk assessments are undertaken proactively throughout their areas of responsibility and remedial action is carried out where problems are identified. There is a process of escalation in place where there are difficulties in implementing mitigations.

The use of risk registers is fundamental to the control process and each division maintains a risk register containing clinical and non-clinical risks. Risks are identified through third party inspections, recommendations, comments, guidelines from external stakeholders and interlay though incident forms, complaints, risk assessments, audit (both clinical and internal), benchmarking, claims and national survey results. All unresolved divisional risks are placed on divisional risk registers, which are monitored on a quarterly basis by a risk review group. Risks are reviewed and scoring agreed and where extreme risks are confirmed, these are reviewed for potential inclusion on the CRR.

Divisional management groups ensure that operational staff identify and mitigate risk and committees provide internal assurance to the board that the mitigations are effective and the risks are adequately controlled. An internal audit programme, clinical audits, external reviews of the organisation, such as clinical pathology accreditation review, NHSLA assessment, HSE and CQC inspection, are the sources used to provide assurance that these processes are effective and risk monitoring is fully embedded.

The day to day maintenance of the BAF is the responsibility of the trust secretary and responsibility for each principal risk is assigned to an individual executive with oversight by a designated lead committee. The BAF is reviewed quarterly by each lead committee and by the board. Risks scores are graded from green to red.

The corporate induction programme ensures that all new staff are provided with details of the risk management systems and processes and is augmented by local induction organised by line managers. This includes comprehensive induction for all junior doctors with regard to

key policies, standards and practice prior to commencement in clinical areas. Mandatory training, reflects essential training needs, and includes risk management processes such as fire safety, health and safety, manual handling, resuscitation, infection control, safeguarding patients, blood transfusion and information governance. The majority of these processes is included within an e-learning programme available to staff. Root cause analysis training is provided to staff who have direct responsibility for risk management within their area of work. Lessons learnt when things go wrong are shared via corporate and divisional governance systems.

An annual work plan of local counter fraud activity was approved and monitored by the audit committee. The proactive plan focused on key areas for NHS Protect standards for providers and in addition, this work programme was supplemented with additional resource for investigative activities.

The audit committee oversees and monitors the performance of the risk management system. Internal auditors (RSM) and external auditors (Grant Thornton) work closely with this committee.

An internal audit of risk management was completed in April 2017 to assess the policies, procedures and staff training in place, the use of and monitoring of risk registers throughout the governance structure and the control framework in place for the management of divisional and corporate risk registers. The management of the BAF was also assessed as part of the audit. The overall conclusion was that the board could take reasonable assurance that the controls upon which the organisation relies on to manage risk were suitably designed and consistently applied. Some recommendations were identified in order to strengthen the processes further and the trust is committed to delivering these in 2017/18.

Review of the effectiveness of risk management and internal control

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical 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 quality account and other performance information available to me. 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 audit committee; the finance, investment and performance committee; the safety and quality committee; and the integrated risk and governance committee and am assured that there are plans in place to address weaknesses and ensure continuous improvement of the system.

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the internal audit work. The BAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its objectives have been reviewed.

The board reviews risks to the delivery of the trust's performance objectives through monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety, quality and workforce. This enables the executive team and the board to focus and address key issues as they arise.

The audit committee oversees the effectiveness of the trust's overall risk management and internal control arrangements. On behalf of the board, it independently reviews the effectiveness of risk management systems and the integrated risk and governance committee ensures all significant risks are identified, assessed, recorded and escalated appropriately. The audit committee regularly receives reports on internal control and risk management matters from the internal and external auditors.

The internal audit programme has flagged no significant control issues however; the following reviews have received partial assurance. The outcome of all final internal audit reports is reviewed by the responsible lead committee, prior to presentation to the audit committee.

Area reviewed	**Actions being taken**
Information security and data protection	• Updating policies and procedures relating to information security and data protection • Improvement to controls relating to staff connecting to the trust's computer system • Improving staff training • Ensuring that data relating to actions taken and lessons learnt from serious • incidents are accurately recorded • Improving data reporting
Budgetary control and financial reporting	• Exploring system wide solutions as part of the System Resilience Group to address potential cost pressure issues around unscheduled care system capacity • Continuing work on bring the position back into line with the financial plan, including managing medical agency spend • Developing a standard operating procedure for processes for setting, monitoring and approving the annual budget • Establishing a formal programme of induction and refresher training for new budget holders
IT asset and configuration management	• Updating the ICT configuration management plan • Improving the recording processes for equipment requests and lost or stolen equipment • Establishing ICT asset audit
Data quality, accident and emergency, four hour wait key performance indicators	• Creating a standard operation procedure for all specialties • Implementing a validation issues log to pick up trends to be addressed • A further audit into referral to treatment data and CAS cards to confirm that the data is being accurately recorded
Key financial controls – accounts payable and payroll	• Improving processes around changes to the bank details of suppliers • Exception reporting undertaken prior to each payment run • Enhancing controls around new starter forms and leaver forms
Procurement and contract management	• Improving recording of tender waivers and contracts

	• Enhancing contract management controls • Working with budget holders to ensure goods and services are ordered through the purchase order system
Cost improvement plans	• Developing governance and planning frameworks to maximise identification and achievement of savings • Strengthening governance arrangements within the divisions to ensure that schemes are set up in line with best practice
Consultant job planning	• Developing a standard operating procedure for consultant job planning • Reviewing the approval process • Establishing a Team job plan tracker • Implementing a system to monitor job planning

The effectiveness of the system of internal control is monitored and maintained through:

- Monthly finance and operational performance reviews by the finance, investment and performance committee, reporting to the board
- Bi-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 assurance committee and the board
- Internal and external audit reviews
- Comment on the internal controls from the head of internal audit in their annual report.

The responsibility for compliance with the CQC essential standards is allocated to lead executive directors who are charged with maintaining evidence of compliance. The trust is addressing all areas of under-performance and non-compliance either through external inspections and patient and staff surveys, issued raised by stakeholders, including patients, staff and others or identified by internal peer review.

The highest scoring key risks to the trust achieving its strategic objectives are listed below, together with a summary of the mitigation taken during the year and action planned for 2017/18.

Risk	**Actions**
Failure of the "Make IT Happen" ICT transformation programme to de-risk IT business continuity and realise key benefits	• Prioritisation of existing ICT projects against the infrastructure programme • Review of suitability of a VDI solution • Parallel activity to increase desktop rollout (commenced) and to re-assess VDI suitability. • ICT Strategy and progress review added to Board Development programme. • LAN remediation 100% complete, Wifi deployment complete. 23 of 40 applications migrated to offsite data centres. • Formal contract variation and weekly contract meetings with supplier

Herts Valleys Clinical Commissioning Group's (HVCCG) financial situation and consequent impact on the trust in 2017/18	• Maintain relations with HVCCG to ensure that the agreed 2017/18 contract is upheld • Continue to monitor HVCCG's situation for early identification of risks relating to specific items
Failure to achieve sufficient efficiencies to support annual and longer term plans	• Detailed plans for 2017/18 with full divisional target identified.
Patient medical notes missing, delayed or poor condition.	• Business case for medical records storage in development.
Emergency care pathway/patient flow	• Unscheduled care action plan developed with clinical leads aligned to four strands of work: front door, wards, length of stay and discharge planning and aftercare.

Head of Internal Audit Opinion

We note that the Trust has been on a journey of improvement compared to the previous year with regards to its arrangements for risk management and governance. However, there are weaknesses within the internal control framework that need to be addressed. Action plans have been agreed with management to improve performance in these areas.

Conclusion

The board is committed to continuous improvement of its governance arrangements to ensure risks are correctly identified and managed, that serious incidents and cases of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action. This ensures that patients, staff, volunteers and stakeholders can be confident in the quality of the service delivered by the trust and the effective, economic and efficient use of its resources.

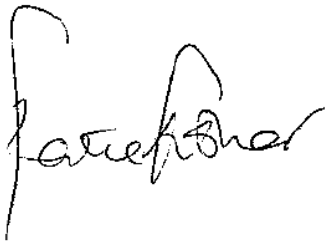
Details of the company directorships and other significant interests held by members of the board which may conflict with their management responsibilities are shown in the conflicts of interest table on page 59.

Internal auditors have confirmed that the trust has adequate and effective framework for risk management and governance. Whilst this is positive, seven reviews have resulted in a partial assurance being provided by internal audit and these are the areas which the trust will focus on in 2017/18.

I am pleased that the CQC has recognised the work undertaken by the trust to deliver improvements since its initial inspection in April 2015. The board is dedicated to continuing on its objective to deliver its quality improvement plan, with the aim of coming out of the special measures regime.

With the exception of the issues that I have outlined in this statement, I am satisfied that the trust had appropriate stewardship in place in 2016/17 to secure economy, efficiency and effectiveness of its use of resources. My review confirmed that a system of internal control is established that supports the achievement of the trust's policies, aims and objectives and any issues highlighted have been or are being addressed.

The trust recognises that the control environment can always be strengthened and this will continue in 2017/18.



Katie Fisher
Chief Executive Officer

30 May 2017

Remuneration and staff report

Our board

The names of the chair and chief executive and the names of 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 director's remuneration on page 48, which also sets out full details of remuneration for board members during 2016/17.

Director and very senior manager remuneration

We have a very active Remuneration Committee made up entirely of Non-Executive Directors who are responsible for approving remuneration decisions linked to all directors and a limited number of other senior managers. Decisions are undertaken using a mixture of benchmarking data with other NHS Trusts taken from a range of sources, NHSI guidance and consideration of prevailing market conditions. As well as approving remuneration decisions for all new appointments into VSM roles, the Committee also undertakes an annual review of remuneration for its existing VSM population. The Committee adheres to all NHSI requirements in relation to Executive remuneration as set out in a number of different documents. This year it is the intention of the committee to formalise its current approach into a single VSM Remuneration policy.

Staff profile table - banding 2016/17

Headcount	Gender		
Banding	Female	Male	Total
Band 1 - 7	3181	604	3785
Band 8A and above	196	72	268
Medical	270	308	578
Non-Exec Directors	1	5	6
Totals	3648	989	4637

Staff profile - banding by ethnicity 2016/17

Ethnicity	Band 1-7	Band 8A and Above	Medical	Non-Exec Directors	Total
White - British	1928	189	144	5	2266
White - Irish	101	10	3	1	115
White - Any other White background	426	7	74		507
Mixed - White & Black Caribbean	13		1		14
Mixed - White & Black African	11		3		14
Mixed - White & Asian	8	1	5		14
Mixed - Any other mixed background	21	1	11		33
Asian or Asian British - Indian	287	22	126		435
Asian or Asian British - Pakistani	82	2	38		122
Asian or Asian British - Bangladeshi	14	1	8		23
Asian or Asian British - Any other Asian background	276	7	40		323
Black or Black British - Caribbean	69	7	2		78
Black or Black British - African	206	9	22		237
Black or Black British - Any other Black background	41	1	1		43
Chinese	34		12		46
Any Other Ethnic Group	85	2	24		111
Undefined	80	4	49		133
Not Stated	103	5	15		123
Totals	3785	268	578	6	4637

Staff numbers and composition (audited)

Staff Numbers & Composition (Audited)

	2016-17						2015-16	
	Total		Permanently employed		Other		Total	
	Number	£' 000	Number	£ '000	Number	£ '000	Number	£' 000
Average Staff Numbers								
Medical and dental	581	66,362	544	53,179	37	13,183	618	
Ambulance staff	0	-	0	-	0	-	0	
Administration and estates	1090	35,495	944	29,268	146	6,227	1069	
Healthcare assistants and other support staff	968	17,886	817	14,112	151	3,774	908	
Nursing, midwifery and health visiting staff	1592	70,204	1249	54,331	343	15,873	1463	
Nursing, midwifery and health visiting learners	10	4,385	10	4,385	0		7	
Scientific, therapeutic and technical staff	510	24,229	433	19,540	77	4,689	492	
Social Care Staff	0	-	0	-	0	-	0	
Other	42	5,554	42	5,554	0	-	38	
TOTAL	**4793**	**224,115**	**4039**	**180,369**	**754**	**43,746**	4595	217,520

*** 2015-16 comparators not available**

Sickness absence data (audited)

An average of 7.21 working days were lost per staff member in 2016/17 in comparison to 8.26 in 2015/16.

Pensions

Past and present employees are covered by the NHS Pension Schemes. 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 10.7 of the accounts.

Expenditure on consultancy

Total expenditure on consultancy services in 2016/17 was £1.7m of which £0.7m relates to establishment and initial operation of the Trust's Programme Management Office (PMO), and £0.5m within the Environment (Estates & Facilities) division on a variety of professional fees.

Director's salary relative to workforce (audited)

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 2016-17 was £283k (2015-16 £288k). This was 8.1 times the median remuneration of the workforce, which was £34.9k) (2015-16 £36.7k). In 2016-17 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 £280-285k. Total remuneration includes salary, non-consolided 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.

Off payroll engagements

Table 1: Off-payroll engagements for longer than 6 months

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months

	Number
Number of existing engagements as of 31 March 2017	5
of which, 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	2

Table 2: New off-payroll engagements

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, 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 2016 and 31 March	7
Number of new engagements which include contractual clauses giving WHHT the right to request assurances	7
Number for which assurance has been requested	7
of which:	
assurance has not been received	7

Table 3: Off-payroll board members (including non-executive directors)/senior official engagements

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

Number of off-payroll engagements of board members, and/or senior officers with significant financial respons	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officials with significant financial responsibility, during the financial year. This figure should include both on payroll and off-payroll engagements	20

Exit packages agreed in 2016-17 (audited)

Exit Packages agreed in 2016-17 (Audited)

	2016-17						
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed.**	**Total number of exit packages**	**Total cost of exit packages**	**Number of Departures where special payments have been made**
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**
Less than £10,000	0	0	12	42,334	**12**	**42,334**	0
£10,000-£25,000	1	21,519	1	23,000	**2**	**44,519**	0
£25,001-£50,000	0	0	1	37,500	**1**	**37,500**	0
£50,001-£100,000	0	0	0	0	**0**	**0**	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0
>£200,000	0	0	0	0	**0**	**0**	0
Total	**1**	**21,519**	**14**	**102,834**	**15**	**124,353**	**0**

	2015-16						
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed.**	**Total number of exit packages**	**Total cost of exit packages**	**Number of Departures where special payments have been made**
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**
Less than £10,000	0	0	0	0	**0**	**0**	0
Less than £10,000	0	0	11	41,799	**11**	**41,799**	0
£10,000-£25,000	1	20,043	0	0	**1**	**20,043**	
£25,001-£50,000	1	44,721	0	0	**1**	**44,721**	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0
>£200,000	0	0	0	0	**0**	**0**	0
Total	**2**	**64,764**	**11**	**41,799**	**13**	**106,563**	0
Total	**2**	**64,764**	**11**	**41,799**	**13**	**106,563**	**0**

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 10.2 of the financial statements and are not included in this note.

Exit packages - Other Departures analysis

	2016-17		2015-16	
	Agreements	**Total value of agreements**	**Agreements**	**Total value of agreements**
	Number	**£000s**	**Number**	**£000s**
Contractual payments in lieu of notice	14	103	11	42
Total	14	103	11	42

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 Directors Remuneration includes disclosure of exit payments payable to individuals named in that report.

Staff policies applied during the financial year

We have a Recruitment & Selection policy in place, which is committed to supporting our employees whilst also delivering 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.

Modern Slavery Act

The Trust when contracting with key suppliers uses the latest NHS Standard terms and conditions, which contain clauses requiring suppliers to comply with all relevant law and guidance to ensure that there is no slavery or human trafficking in their supply chains. Suppliers are required to notify the Trust immediately if they become aware of actual or suspected incidents of slavery or human trafficking; the Trust to date has not been made aware of any such occurrences.

Parliamentary accountability and audit report

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF WEST HERTFORDSHIRE HOSPITALS NHS TRUST

We have audited the financial statements of West Hertfordshire Hospitals NHS Trust (the "Trust") for the year ended 31 March 2017 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, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the "2016/17 GAM") and the requirements of the National Health Service Act 2006.

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 Trust's Directors 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 Trust's Directors, 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, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") 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 by exception where we are not satisfied.

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 Performance Report and the Accountability 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 2016, 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 that 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 2017, 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.

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 2017 and of its expenditure and income for the year then ended; and

- the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006.

Emphasis of matter - Going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.3.1 to the financial statements concerning the Trust's ability to continue as a going concern. The Trust incurred a retained deficit of £39.855 million (Adjusted retained deficit of £29.431 million) during the year ended 31 March 2017 and, at that date, had net current liabilities of £20.24 million. As disclosed in note 1.3.1 to the financial statements, the Directors are seeking additional support from NHS Improvement for 2017/18 of £32.0 million. NHS Improvement has not, at the date of our report, confirmed this support. These conditions, along with the other matters explained in note 1.3.1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Opinion on other matters

In our opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006; and

- the other information published together with the audited financial statements in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared 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 30 May 2017, we referred a matter to the Secretary of State under section 30a 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 2019.

Auditor's responsibilities

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 qualified conclusion

The Trust's outturn position for 2016-17 was a £29.43 million deficit which is an increase of £6.88 million compared to the Trust's budget deficit of £22.55 million agreed with NHS Improvement. This movement was due to an unplanned reduction in anticipated income of £3.88 million; which resulted in the loss of £3.0 million Sustainability and Transformation Funding. In addition, the Trust's medium term financial plan shows a further forecast deficit of £15.0 million in 2017/18 and £10.9 million in 2018/19.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2016, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are 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 2017.

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

- in our opinion the Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have made a written recommendation to the Trust under section 24 of the Act in the course of, or at the conclusion of the audit.

Certificate

We certify that we have completed the audit of the financial statements of West Hertfordshire Hospitals NHS Trust in accordance with the requirements of the Act and the Code of Audit Practice.

Elizabeth Jackson

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

Grant Thornton UK LLP
Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

31 May 2017

DIRECTORS' REMUNERATION 2016-2017 (Audited)

NAME	TITLE	In year start/ leave dates	2016/17 SALARY bands of £5,000	2016/17 Expense payments (taxable) total to nearest £100	2016/17 Performance pay and bonuses bands of £5,000	2016/17 TOTAL bands of £5,000	2015/16 SALARY bands of £5,000	2015/16 Expense payments (taxable) total to nearest £100	2015/16 Performance pay and bonuses bands of £5,000	2015/16 TOTAL bands of £5,000
M. Hasan	Chairman	Left Nov 15	-	-	-	-	10-15	0	0	10-15
Prof Steve Barnett	Chairman	Start Nov 15	40-45	13400	0	40-45	15-20	9000	0	20-25
K. Fisher	Chief Executive	Start Jul 2016	135-140	0	0	135-140	-	-	-	-
J. Kelly	Interim Chief Executive	Start Jan 15 - left Jul 2016	45-50	0	0	45-50	190-195	0	0	190-195
L. Hill (note 1)	Deputy Chief Executive	Left Jun 2016	105-110	0	0	105-110	150-155	0	0	150-155
P. Townsend	Non-Executive Director (vice Chair)		5-10	100	0	5-10	5-10	100	0	5-10
V. Edwards	Non-Executive Director Freedom to speak up Guardian		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		165-170	100	0	165-170	160-165	0	0	160-165
S. Tucker	Chief Operating Officer	Start June 2016	100-105	100	0	90-95	-	-	-	-
T. Carter	Chief Nurse & Director of Infection Prevention and Control		115-120	0	0	115-120	110-115	0	0	110-115
H. Brown	Deputy Chief Executive and Director of Strategy		115-120	200	0	115-120	115-120	0	0	115-120
L. Emery	Chief Information Officer		110-115	0	0	110-115	110-115	0	0	110-115
A. Tiernan (note 2)	Director of Corporate Affairs & Communications	Secondment from May 15	-	0	0	0	10-15	0	0	10-15
P. Da Gama	Director of Human Resources and Organisational Developm	Start Aug 14	110-115	200	0	110-115	110-115	100	0	110-115
M. Van Der Watt (note 3)	Medical Director/ Director of Patient Safety		280-285	100	0	280-285	285-290	0	0	285-290
H Reeves (note 4)	Director of Communications	Start April 15 - Left Dec 15	-	0	0	0	100-105	0	0	100-105
K Howell	Director of Environment	Start Aug 15	115-120	1000	0	115-120	75-80	300	0	75-80
L Halfpenny	Director of Communications	Start Apr 2016	90-95	0	0	90-95	-	-	-	-
J Shentall	Director of Performance		100-105	0	0	100-105	-	-	-	-
F Carlowe	Director of Integrated Care	Start Feb 2017	15-20	0	0	15-20	-	-	-	-

NOTES

Note 1: Salary includes exit package as disclosed in the remuneration and staff section of the annual report.

Note 2: Salary recharged to NHS England from May 2015

Note 3: 79% of salary as Medical Director/Director of Patient Safety and 21% for clinical work.

Note 4: Off payroll arrangement to Sept 2015 and then joined the Trust on fixed term contract, continued at the Trust as a non board member to April 2016.

Note 5: S Jones (previous Chief Executive) is on secondment to NHS England from January 2015.

The salaries above may include salary sacrifice schemes.

DIRECTORS' PENSION ENTITLEMENT 2016-2017 (Audited)

	Real increase in pension (bands of £2,500)	Real increase in pension lump sum at (bands of £2,500)	Total accrued pension at 31 March 2017 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2016	Real increase/(decrease) in Cash Equivalent Transfer Value (bands of £1,000)	Employer's contribution to stakeholder pension
K Fisher	**5-7.5**	**5-7.5**	**40-45**	**105-110**	611,076	534,654	76	0
D Richards	**0-2.5**	**0-2.5**	**35-40**	**85-90**	853,181	792,406	61	0
S Tucker	**10-12.5**	**25-27.5**	**50-55**	**145-150**	933,232	753,066	180	0
T. Carter	**0-2.5**	**0-2.5**	**35-40**	**95-100**	527,866	493,719	34	0
H. Brown	**0-2.5**	**0-2.5**	**35-40**	**95-100**	570,031	532,712	37	0
L. Emery	**0-2.5**	**0-2.5**	**10-15**	**10-15**	162,864	132,450	30	0
P. Da Gama	**0-2.5**	**0-2.5**	**5-10**	**0-5**	80,607	63,637	17	0
M. Van Der Watt	**10.0-12.5**	**32.5-35.0**	**50-55**	**155-160**	1,071,366	794,033	277	0
K. Howell	**0-2.5**	**2.5-5.0**	**40-45**	**125-130**	812,546	765,122	47	0
L Halfpenny	**5.0-7.5**	**10.0-12.5**	**10-15**	**35-40**	213,623	136,673	77	0
J Shentall	**0.0-2.5**	**0.0-2.5**	**50-55**	**75-80**	650,719	614,339	36	0
F Carlowe	**2.5-5.0**	**2.5-5.0**	**20-25**	**60-65**	351,312	322,847	28	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 particular 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.

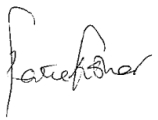
The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional benefit accrued to the member as a result of their purchasing additional years of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

* Staff Numbers and Composition
* Sickness Absence Data
* Director's salary relative to workforce
* Exit packages
* Director's Remuneration
* Director's Pension Entitlement

* I certify that the above are a true and accurate reflection of the remuneration and other associated staff reports.

Signed by: 

Katie Fisher
Chief Executive

The financial headlines

The 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.

The Trust started 2016/17 with a plan to end the year with a revenue deficit of £22.6m. This planned deficit matched the NHSI derived 'Control Total'. The plan assumed full receipt of £12m of Sustainability and Transformation Funds (STF), which were conditional upon achieving certain financial and clinical targets. £3.0m of the available STF total was available for setting a plan in line with the Control Total; £1.8m was available for achieving clinical targets relating to cancer, inpatient waiting times and A&E waiting times; and £7.2m was available for achieving quarterly planned financial performance (£2.1m per quarter for quarters two and three plus £3.0m for achieving quarter four targets). The quarter four financial targets included the effects of an agreement that Hertfordshire Valleys Clinical Commissioning Group (HVCCG) would reimburse the Trust for the full cost of certain clinical readmissions to the Trust at a total value of £3.9m. The Trust also set a savings target of £18.3m to underpin achievement of the Control Total.

In order to ensure that sufficient cash remained available for operating needs, the deficit was supported by revenue loans from the Independent Trust Financing Facility (ITFF). Capital expenditure was supported by an additional capital loan application for £12.6m, later revised to £7.5m, reflecting the short space of time between loan approval and year end in which to complete funded projects.

The Trust ended 2016/17 with a revenue deficit of £29.4m. Income in 2016/17 increased to £322.6m in comparison to £299.8m in 2015/16. In respect of clinical readmissions reimbursement from HVCCG, the Trust was unsuccessful in securing the necessary £3.9m payment, which in turn meant that the overall Trust control total was not met. This meant that the Trust was ineligible for the final quarter's STF income (£3m). In addition, £0.75m of STF money was withheld due to not meeting a small number of clinical waiting times targets. However the Trust as agreed with NHS Improvement included a further anticipated STF bonus income of £0.70m.

Trust operating costs (excluding impairments) rose from £336.9m in 2015/16 to £348.6m in 2016/17. After excluding the costs of clinical negligence premium payments, Trust costs rose by 3.0% (from £323.0m in 2015/16 to £332.7m in 2015/16).

Agency costs have reduced by a highly significant £10.3m to £26.5m from 2015/16. In order to meet its 2017/18 financial targets it is necessary to reduce agency expenditure by a similar amount, and the Trust plans to achieve this by making substantive appointments more attractive and encouraging staff to join the internal bank.

The relatively modest rise in operating costs is also due to the success of the Trust's efficiency programme in 2016/17. Staff at all levels within the Trust have helped to improve operational performance and underpin financial sustainability in future years through planning and implementation of a large number of innovative schemes throughout the year. As a consequence the Trust achieved its highest recorded level of savings at £14.7m (4.6% of operating revenue) for 2016/17.

As the Trust recorded a revenue deficit in 2016/17, and did so in previous years, the Trust was unable to discharge its duty to break even over a five year period, taking one year with another.

The Trust spent £13.9m on new, refurbished and replacement capital assets in line with the agreed financial plan. Major items included an MRI and CT scanner, becoming operational in April 2017 at a total investment of £2.3m; A new refurbished and expanded endoscopy unit opened in 2016/17 at a total investment of £2.4m; estate's backlog maintenance programme and an ongoing programme to replace ageing medical equipment accounted for a further £4.7m; the roof on the Shrodells building at Watford General Hospital was replaced at a cost of £1.5m; and the Trust also agreed a liability of £2m to Watford Borough Council as its contribution to the new access road to Watford General Hospital. For further details of the payment to Watford Borough Council please refer to note 18 in the annual accounts section of the Annual Report.

In developing the 2017/18 and 2018/19 financial plan, the Trust has ensured that it responds to NHS Improvement (NHSI) financial challenges whilst drawing on existing plans, knowledge and skills within divisional teams. An executive director and a responsible manager lead on developing different elements of the plan, ensuring consistency with longer term planning and strategic documents, such as the estate, quality, and workforce strategies. Work continues to ensure consistency with the Sustainability & Transformation Plan (STP) area plan and incorporation into the Trust's financial strategy and long-term financial model.

The Trust has, for a number of years, operated in deficit (expenditure exceeding funding). The size of the deficit increased, following a series of risk assessments undertaken by the Board and publication of the Francis report[1]. Unfunded investment was made in quality, increased staffing and infrastructure costs in order to comply with Francis' recommendations. In 2015/16, the Trust incurred costs relating to the creation of additional clinical capacity to accommodate increasing numbers of patients delayed in their transfer of care, as well as corrective actions following the Trust's Care Quality Commission (CQC) inspection in 2015. In 2016/17, the position has stabilised somewhat with a follow-up review from the CQC in September 2016 which highlighted many significant improvements.

In order to achieve operational and financial goals in the future the Trust will continue to work in partnership with other health organisations in the STP footprint and with the Royal Free Hospitals NHS Foundation Trust to pursue efficiencies and increased clinical standardisation.

The Trust requires significant investment in its estate to realise its proposed vision for new seamless models of care.

The starting position for the 2017/18 plan is the forecast deficit for 2016/17, adjusted for events unique to 2016/17. Financial forecasts are aligned with quality, workforce and activity plans and priorities.

The planning framework for 2017/18 retained conditional access to STF revenue. The Trust was notified that, if it could develop a plan for a deficit of no greater than £25.7m in 2017/18 and £21.6m in 2018/19 (both excluding STF monies), incur no more than £24.4m of agency costs in each of these years and comply with a number of quality measures, it could access the fund up to £10.7m in both years, thus reducing the deficit plan to £15.0m in 2017/18 and £10.9m in 2018/19.

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

This reinforces the need for improvements in financial performance at all levels in 2017/18 and 2018/19, reflected in the efficiencies required to meet national and local cost pressures (c £21.9m saving in 2017/18).

Going Concern Statement

Due to historic adjusted cumulative deficit of £83.5m to 31 March 2017 and future two year plan to 2018/19 showing significant planned deficits as stated in the financial commentary above, the directors have considered all factors, and although there are material uncertainties that may cast significant doubt in the trust continuing as a going concern, it is reasonable to expect that the trust will have adequate resources to continue for the foreseeable future in operational existence and pay its liabilities, loan repayments and taxes.

As directed by Department of Health Group Accounting Manual for Accounts the financial statements are prepared on going concern basis, as the service to its local population will exist for the foreseeable future, and has not included adjustments if it was unable to continue as going concern.

Financial Risk

The Trust's financial risk is assessed against a four-point rating developed by NHSI. The Trust's performance for the year against these financial indicators provides an overall score of four which is the lowest score (one being the highest), and reflects the current cash situation alongside the ongoing operating deficit. The Board uses this each month, together with other information to manage its finances. An overall score of greater than 2 is unsatisfactory.

The outcome of strategic work on the provision of healthcare to West Hertfordshire will support the Trust's longer term financial plans to address the overall financial risk score. As cash flow is a key component of any future financial recovery, future plans and agreements with regulators will need to address the schedule of loan repayments to the Department of Health. A key milestone in this area is December 2018, where loans taken out in 2015/16 must be repaid.

Internal audit

During 2015/16 the Trust concluded a competitive tendering exercise to provide its Internal Audit service, and duly appointed RSM Risk Assurance Services LLP (RSM) with effect from 1 April 2017. With Trust input, RSM 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. For further details please refer to the Head of Internal Audit Opinion in the Trust's Annual Governance Statement on page 24.

External audit

The Audit Commission has a statutory duty to appoint external auditors to local government and NHS bodies under Section 3 of the Audit Commission Act 1998. The Trust's external auditors are Grant Thornton UK LLP. The Audit Commission passed on the responsibility for managing audit contracts to a transitional body, Public Sector Audit Appointment Ltd and this ended on 31 March 2017, with the Local Audit and Accountability Act 2014 applying thereafter. After a competitive

tender exercise the Trust duly appointed Grant Thornton UK LLP for two years as from 1 April 2017 for the provision of external audit services.

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

Related parties

The Trust has received declarations from all Board and Trust Executive Committee (TEC) members relating to any potential conflicts of interest in conducting NHS business (e.g. external appointments, suppliers etc). Any member associated with the organisations thus disclosed will be shown in the register of interest held by the Corporate Affairs Office.

Note 33 of the accounts sets out transactions with related parties, which are mainly other NHS bodies commissioning patient activity provided by the Trust, or other government bodies with which the Trust has financial transactions. There is one related transaction involving a Board member.

Better payment practice code

The Trust strives to pay its suppliers on time. Performance in achieving this is set out in note 11 of the accounts. There was a marked deterioration in performance during 2016/17 as cash management challenges continued. The Trust actively engages with suppliers where issues may arise in order to put in place arrangements which are appropriate to both parties’ needs.

Fraud

The Trust’s counter fraud policy is available on the Trust’s intranet and internet to provide advice for staff in relation to reporting and dealing with suspected fraud. The Trust has a nominated Local Counter-Fraud Specialist (LCFS) who assists the Chief Financial Officer in raising awareness and dealing with fraud matters.. The Trust has developed an action plan to improve its counter-fraud effectiveness after consulting with NHS Protect (http://www.nhsbsa.nhs.uk/Protect). The Local Counter Fraud Services contract was awarded to RSM with effect from 1 April 2016 following a competitive tendering process. More information on the fraud policy can be obtained from the Trust offices at Watford General Hospital

Pensions

Past and present employees are covered by the NHS Pension Schemes. 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 10.7 of the accounts.

Income generation activities

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

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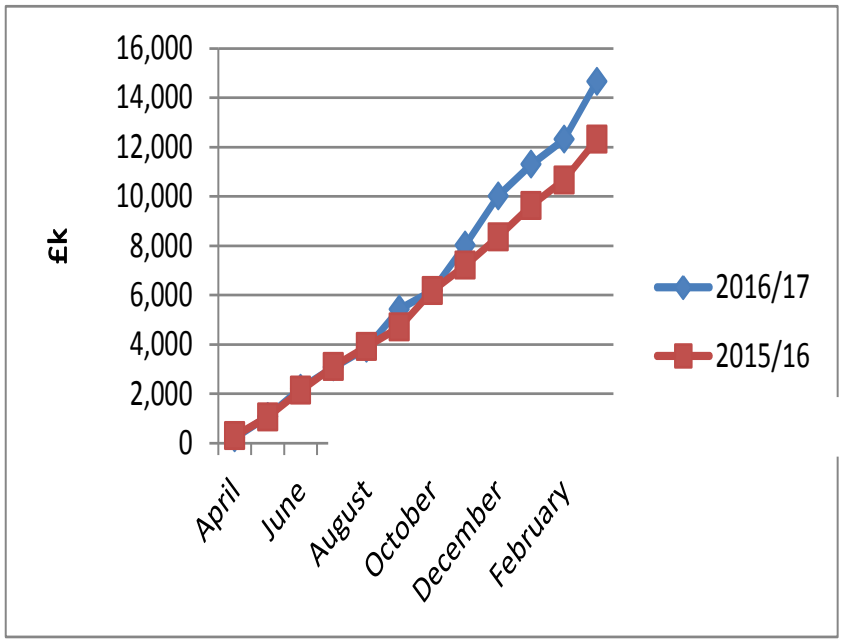
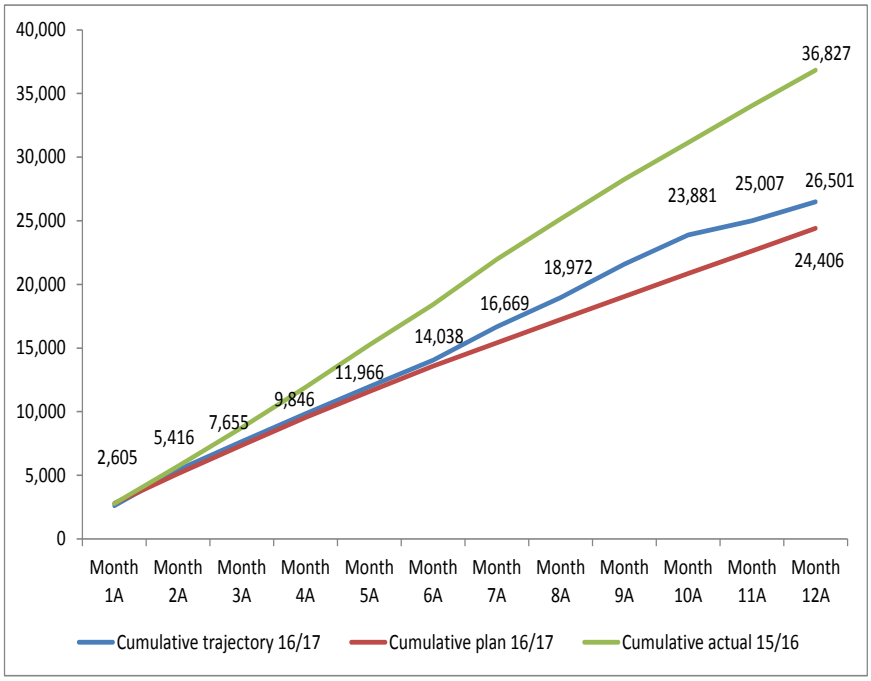
The trust does not conduct material income generation activities outside of its usual business, where the aim is to achieve profit. Any financial benefit derived from these activities is used in patient care.

Progress made in achieving cost savings and reducing agency costs in comparison to 2015-16.

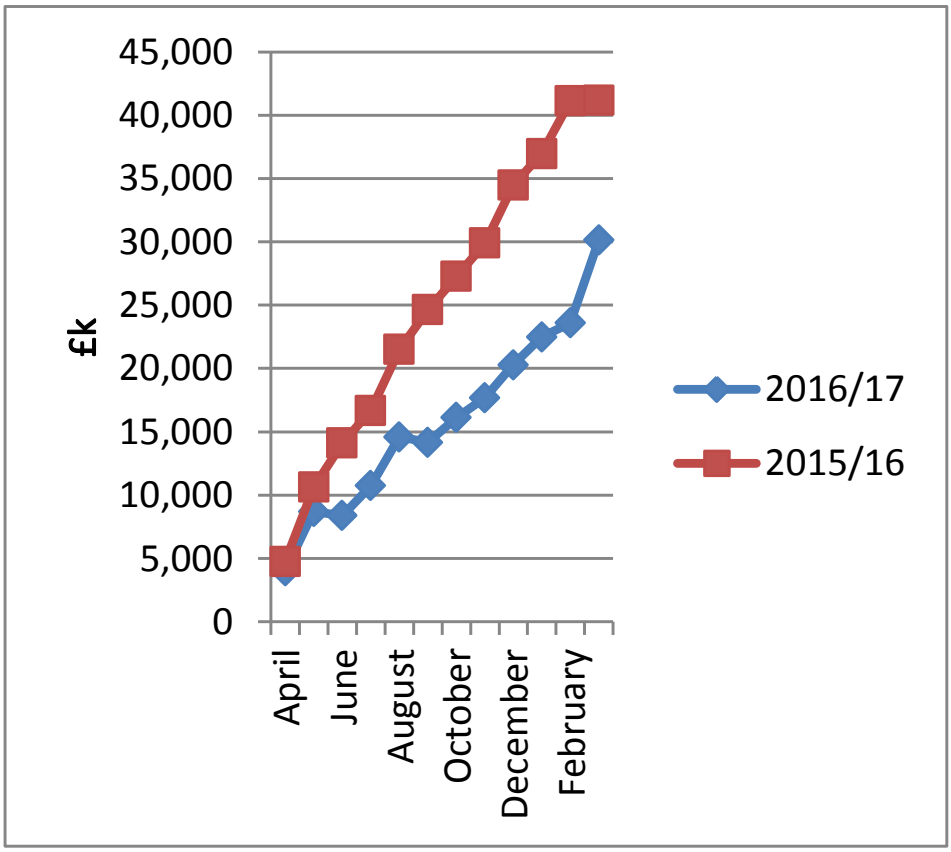
Cost Saving



Agency Costs



Deficit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Board and committee membership and attendance

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

Conflicts of interest for the board and executive team

Name	Title	Declared interest
Dr Tammy Angel	Divisional Director, Unscheduled Care	None
Dr Andrew Barlow	Divisional Director, Women's and Children's	Barlow Medical Services Ltd
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
		Member of the East Midlands Regional Committee for Clinical Excellence Awards
		Wife is CEO of Rotherham NHS Foundation Trust
John Brougham	Non-Executive Director	Non-Executive Director and Chair of the Audit Committee of Technetix Ltd
Helen Brown	Deputy Chief Executive	None
Fran Carlowe	Director of Integrated Care	None
Professor 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
		Charitable Funds for West Hertfordshire Hospitals NHS Trust
Paul da Gama	Director of Human Resources	None
Dr Anthony Divers	Divisional Director, Clinical Support	None
Lisa Emery	Chief Information Officer	None
Ginny Edwards	Non-Executive Director	Trustee Peace Hospice Care
		Global Action Plan; providing support to their programme called Operation TLC
		Director of Edwards Consulting Ltd
		Husband is CEO of Nuffield Trust
		Husband is Director of Edwards Consulting Ltd
		Husband is a non-remunerated member of the Strategy Committee of Guy's and St Thomas's Charitable Trust

		Charitable Funds for West Hertfordshire Hospitals NHS Trust
Katie Fisher	Chief Executive	None
Louise Halfpenny	Director of Communications	None
Lynn Hill (left July 2016)	Chief Operating officer	None
Kevin Howell	Director of Environment (formally Estates and Facilities)	None
Jac Kelly (left July 2016)	Chief Executive	None
Mr Jeremy Livingstone	Divisional Director, Surgery, Anaesthetics and Cancer	Jeremy Livingstone Ltd - Private Practice
Dr Arla Ogilvie	Divisional Director, Medicine	Private Practice
Jonathan Rennison	Non-Executive Director	Trustee of Rising Tides Ltd
		Change Management and strategy support with Kings College London
		Director of Yellow Chair Ltd
		Edgecumbe Consulting - Consultancy
		Association of NHS Charities
		The Teapot Trust - Coaching
		Swindon Museum and Art Gallery
		BNET - Consultancy
		Centre for Sustainable Working Life, Birbeck College
		Evidence Aid
Don Richards	Chief Financial Officer	None
Jane Shentall	Director of Performance	None
Phil Townsend	Non-Executive Director	None
Sally Tucker	Chief Operating Officer	None
Dr Mike van der Watt	Medical Director	Owner Heart Consultants Ltd

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	**2016-17 £000s**	2015-16 £000s
Gross employee benefits	10.1	**(224,115)**	(217,520)
Other operating costs	8	**(134,907)**	(125,050)
Revenue from patient care activities	4	**286,358**	274,994
Other operating revenue	5	**36,285**	24,775
Operating surplus/(deficit)		**(36,379)**	(42,801)
Investment revenue	12	**23**	46
Other gains and (losses)	13	**(33)**	0
Finance costs	14	**(1,834)**	(937)
Surplus/(deficit) for the financial year		**(38,223)**	(43,692)
Public dividend capital dividends payable		**(1,632)**	(3,239)
Retained surplus/(deficit) for the year		**(39,855)**	(46,931)

Other Comprehensive Income

		2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	16.3	**(21,722)**	0
Net gain/(loss) on revaluation of property, plant & equipment		**0**	4,419
Total comprehensive income for the year		**(61,577)**	(42,512)

Financial performance for the year

Retained surplus/(deficit) for the year		**(39,855)**	(46,931)
Impairments (excluding IFRIC 12 impairments)	8	**10,410**	5,631
Adjustments in respect of donated gov't grant asset reserve elimination		**14**	145
Adjusted retained surplus/(deficit)		**(29,431)**	(41,155)

The adjusted retained deficit of £29.4m is after excluding impairments and the net of donated income and depreciation. The Trust performance is measured on this adjusted deficit.

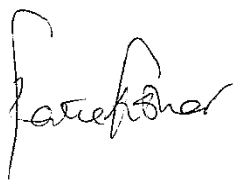
The notes on pages 5 to 32 form part of this account.

Statement of Financial Position as at 31 March 2017

		31 March 2017	31 March 2016
	NOTE	**£000s**	£000s
Non-current assets:			
Property, plant and equipment	16	**141,763**	167,774
Intangible assets	17	**2,024**	1,537
Trade and other receivables	21.1	**1,594**	1,565
Total non-current assets		**145,381**	170,876
Current assets:			
Inventories	20	**4,428**	4,171
Trade and other receivables	21.1	**21,336**	20,422
Cash and cash equivalents	22	**4,623**	1,739
Sub-total current assets		**30,387**	26,332
Total current assets		**30,387**	26,332
Total assets		**175,768**	197,208
Current liabilities			
Trade and other payables	24	**(45,459)**	(46,717)
Provisions	29	**(645)**	(673)
DH capital loan	26	**(4,523)**	(3,637)
Total current liabilities		**(50,627)**	(51,027)
Net current assets/(liabilities)		**(20,240)**	(24,695)
Total assets less current liablilities		**125,141**	146,181
Non-current liabilities			
Provisions	29	**(4,381)**	(4,787)
Borrowings	26	**(2,000)**	0
DH revenue support loan	26	**(73,512)**	(39,000)
DH capital loan	26	**(15,830)**	(11,399)
Total non-current liabilities		**(95,723)**	(55,186)
Total assets employed:		**29,418**	90,995
FINANCED BY:			
Public Dividend Capital		**223,076**	223,076
Retained earnings		**(211,286)**	(171,431)
Revaluation reserve		**17,628**	39,350
Total Taxpayers' Equity:		**29,418**	90,995

The notes on pages 5 to 32 form part of this account.

The financial statements on pages *1 to 4* were approved by the Board on 30 May 2017 and signed on its behalf by



Katie Fisher
Chief Executive: Date: **31.05.2017**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**223,076**	**(171,431)**	**39,350**	**90,995**
Changes in taxpayers' equity for 2016-17				
Retained surplus/(deficit) for the year		(39,855)		**(39,855)**
Impairments and reversals			(21,722)	**(21,722)**
Net recognised revenue/(expense) for the year	**0**	**(39,855)**	**(21,722)**	**(61,577)**
Balance at 31 March 2017	**223,076**	**(211,286)**	**17,628**	**29,418**
Balance at 1 April 2015	**223,076**	**(124,504)**	**34,935**	**133,507**
Changes in taxpayers' equity for the year ended 31 March 2016				
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**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to the Trust by the Department of Health. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS trust.

Revaluation Reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(36,379)**	(42,801)
Depreciation and amortisation	8	**7,349**	7,647
Impairments and reversals	18	**10,410**	5,631
Donated Assets received credited to revenue but non-cash	5	**(127)**	(5)
(Increase)/Decrease in Inventories		**(257)**	254
(Increase)/Decrease in Trade and Other Receivables		**(1,014)**	758
Increase/(Decrease) in Trade and Other Payables		**2,030**	7,252
Provisions utilised		**(767)**	(807)
Increase/(Decrease) in movement in non cash provisions		**274**	144
Net Cash Inflow/(Outflow) from Operating Activities		**(18,481)**	(21,927)
Cash Flows from Investing Activities			
Interest Received		**25**	43
(Payments) for Property, Plant and Equipment		**(14,890)**	(15,805)
(Payments) for Intangible Assets		**(2,400)**	(1,079)
Net Cash Inflow/(Outflow) from Investing Activities		**(17,265)**	(16,841)
Net Cash Inform / (outflow) before Financing		**(35,746)**	(38,768)
Cash Flows from Financing Activities			
Loans received from DH - New Capital Investment Loans		**9,100**	7,100
Loans received from DH - New Revenue Support Loans		**34,987**	63,700
Other Loans Received		**2,000**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(3,782)**	(2,772)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(475)**	(24,700)
Interest paid		**(1,648)**	(756)
PDC Dividend (paid)/refunded		**(1,552)**	(3,354)
Net Cash Inflow/(Outflow) from Financing Activities		**38,630**	39,218
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**2,884**	450
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,739**	1,289
Cash and Cash Equivalents (and Bank Overdraft) at year end	**22**	**4,623**	1,739

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 Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2016-17 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 DH Group Accounting Manual 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 2017-18 and 2018-19 to the NHS Improvement (NHSI) which delivers a £25.7m deficit for 2017-18 and £21.6m for 2018-19 excluding any support from sustainability and transformation fund. This includes a savings target of £21.9m for 2017-18 and £14.6m for 2018-19. This is equivalent to 6.5% of income in 2017-18, a challenging target with over 50% identified to date. A requirement for £32.0m for 2017-18 and £42.0m for 2018-19 of cash support for capital and revenue is also planned. Directors are seeking additional cash support of £32.0m from NHSI for 2017-18. NHSI has not confirmed this support. Uncommitted Single Currency Interim Revenue Support Facility will be available when required with effect from 1 April 2017.

  As part of the two year Annual Plan the revenue loan repayment of £32.0m on the 18 December 2018 will need to be extended for a further three years, and restructuring of all loans will need to be considered as part of the Trust's overall strategy and its work with suitable partner organisations.

  Although these factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Department of Health Group Accounting Manual 2016-17 the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

- 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 Watford Health Campus committed the Trust to share the costs relating to a major road development* providing alternative access to Watford General Hospital (WGH). The road development has to date benefitted from NHS grants of £7m. These grants were received from Department of Health to be paid to Watford Borough Council as contribution to the cost of construction of the access road.

  The monies paid to Watford Borough Council for the construction of this 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. For further details 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 Accounting Manual 2014-15. In future years any provision will form part of Agreement of Balance exercise; see note 21.3
- Some IT assets purchased under agreement by IT sub contractor, mainly end users devices, which have been deployed for use in the Trust. Standard number 4 of the International Financial Reporting Interpretations Committee (IFRIC4) provides guidance on whether or not an asset purchased by third party and used by an organisation should be regarded as an asset of that organisation. The Trust has capitalised these devices under terms of IFRIC4 on the basis that the Trust:
  i) uses the end user devices
  ii) owns risks and rewards associated with the devices
  iii) use these devices for the term of their economical useful lives

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 16.3. 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).
- The land at St Albans, Watford and Hemel Hempstead sites has been valued under the Modern Equivalent Asset (MEA) methodology in 2016-17. The approach to the MEA technique used for land valuation allows an alternative site to be used where the location requirements of the service being provided can be met from this location. Should the MEA have the potential to be relocated to a less expensive area due to changes in the nature of how existing facilities are used, the value of land in this alternate location should be adopted for valuation. This principle was applied to all three Trust sites in 2016-17, details of the impact of which can be found in note 16.3.
- Sustainability & Transformation Fund (STF) income, up to a maximum of £12.0m, was allocated to the Trust by NHS Improvement based on the achievement of certain financial and clinical targets. The financial targets were set with an expectation that the Trust would achieve its planned deficit (control total) in any given quarter. The clinical performance targets were set around the key areas of referral to treat (RTT), accident & emergency waiting times (A&E), and cancer treatment.
  STF outcomes were estimated in the financial statements throughout the year, including appeals on certain performance measures. Further details can be found in notes 5 and 7.

*From Wiggenhall Road to the hospital and through to Vicarage Road for emergency vehicles and buses only.

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 34.

1.5. Revenue

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

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

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

1.6. Employee Benefits

Short-term employee benefits

Salaries, 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 16.3.

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 16.3.

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 DH Group Accounting Manual, 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. The related Trust impairment is classified as AME and is detailed in note 16.3.

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 2.70%, 5 to 10 years at minus 1.95% and beyond 10 years at minus 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 37 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.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

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 2016-17. 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 14 Regulatory Deferral Accounts - Not yet endorsed by The European Financial Reporting Advisory Group hence early adoption is not 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

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - aggregate of all schemes	**2016-17 £000s**	2015-16 £000s
Income	**1,975**	1,868
Full cost	**1,306**	1,509
Surplus/(deficit)	**669**	359

4. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**225**	1,054
NHS England	**18,663**	16,500
Clinical Commissioning Groups	**265,798**	249,226
NHS Other (including Public Health England and Prop Co)	**0**	400
Additional income for delivery of healthcare services	**0**	5,172
Non-NHS:		
Local Authorities	**0**	647
Private patients	**408**	661
Overseas patients (non-reciprocal)	**391**	500
Injury costs recovery	**834**	790
Other Non-NHS patient care income	**39**	44
Total Revenue from patient care activities	**286,358**	274,994

5. Other operating revenue

	2016-17 £000s	2015-16 £000s
Education, training and research	**9,194**	8,603
Charitable and other contributions to revenue expenditure -non- NHS	**235**	0
Receipt of charitable donations for capital acquisitions	**127**	5
Non-patient care services to other bodies	**14,695**	12,550
Sustainability & Transformation Fund Income - see Note 7	**8,949**	0
Income generation (Other fees and charges)	**2,441**	2,258
Rental revenue from operating leases - see below i)	**0**	1,359
Other revenue	**644**	0
Total Other Operating Revenue	**36,285**	24,775
Total operating revenue	**322,643**	299,769

ii) The rental income from hire of accommodation is now shown in Non-patient care services to other bodies of £1,620,000 for 2016-17.

6. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**391**	**500**
Cash payments received in-year (re receivables at 31 March 2016)	**74**	**123**
Cash payments received in-year (iro invoices issued 2016-17)	**147**	**78**
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**105**	**32**
Amounts added to provision for impairment of receivables (invoices issued 2016-17)	**209**	**191**
Amounts written off in-year (irrespective of year of recognition)	**182**	**283**

7. 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 derived from the supply of services; Income from the sale of goods is immaterial. As shown in note 4 and 5, the Trust may receive additional funds outside the main contract.

The Trust received £8.25m out of a maximum possible £12.0m Sustainability & Transformation Fund (STF) in 2016-17. Quarter 1 payments were based solely on financial performance (£3.0m), quarters 2 and 3 were based on a combination of financial and operational performance (£5.25m combined), and quarter 4 was again based solely on financial performance (£nil, as the deficit target was not met). Indicative STF bonus income of £699k was also accrued as agreed with NHS Improvement.

In 2015-16 the Trust received £5.2m from the Department of Health as part of a package of measures to assist it in progressing out of 'special measures', following an adverse inspection by the Care Quality Commission. No STF income was received in 2015-16.

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

8. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**2,863**	2,458
Services from other NHS bodies	**264**	242
Services from NHS Foundation Trusts	**106**	438
Total Services from NHS bodies - see i) below	**3,233**	3,138
Purchase of healthcare from non-NHS bodies - see ii) below	**3,661**	3,217
Trust Chair and Non-executive Directors	**77**	66
Supplies and services - clinical	**51,238**	46,792
Supplies and services - general	**11,771**	11,838
Consultancy services - see iii) below	**1,685**	2,937
Establishment	**3,924**	3,621
Transport	**629**	773
Business rates paid to local authorities	**1,460**	1414
Premises	**15,794**	15,712
Hospitality	**7**	26
Insurance	**210**	223
Legal Fees	**113**	213
Impairments and Reversals of Receivables - see iv) below	**74**	757
Depreciation	**7,298**	7,525
Amortisation	**51**	122
Impairments and reversals of property, plant and equipment - see v) below	**8,410**	5,631
Impairments and reversals of intangible assets - see vi) below	**2,000**	0
Internal Audit Fees	**128**	112
Audit fees - see vii) below	**75**	75
Other auditor's remuneration - see viii) below	**10**	14
Clinical negligence - see ix)	**15,864**	13,971
Education and Training	**544**	485
Change in Discount Rate	**0**	(17)
Other - see x) below	**6,651**	6,405
Total Operating expenses (excluding employee benefits)	**134,907**	125,050
Employee Benefits		
Employee benefits excluding Board members	**222,904**	216,490
Board members	**1,211**	1,030
Total Employee Benefits	**224,115**	217,520
Total Operating Expenses	**359,022**	342,570

i) Total 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 and estates strategy and project management for efficiency savings programme.

iv) Increase in Non NHS bad debt provision.

v) The Trust's revaluation of its land and buildings has generated impairments. See note 16.3 and 1.3.2 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 17.1 and 18 in 2016-17. No impairment in 2015-16.

vii) The audit fees is only for the external audit of the Trust for the year.

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:

- £2,056,000 for portering
- £963,000 for linen
- £487,000 for contract management
- £467,000 for security
- £583,000 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

	2016-17				2015-16
	Land £000s	**Buildings £000s**	**Other £000s**	**Total £000s**	£000s
Payments recognised as an expense					
Minimum lease payments				**457**	365
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**457**	365
Payable:					
No later than one year		0	489	**489**	380
Between one and five years	0	0	1,160	**1,160**	852
After five years	0	0	76	**76**	0
Total	**0**	**0**	**1,725**	**1,725**	1,232

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.

	2016-17	2015-16
Recognised as revenue	**£000s**	£000s
Rental revenue	0	1,359
Contingent rents	0	0
Total	**0**	1,359
Receivable:		
No later than one year	0	1,359
Between one and five years	0	4,474
After five years	0	1,118
Total - see below i)	**0**	6,951

i) The income from hire of accommodation to other trusts is no longer recognised as an operating lease arrangement in 2016-17. Income from hire of accomodation is now shown in Non-patient care service to other bodies in Note 5.

10. Employee benefits

10.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**190,949**	189,076
Social security costs	**14,902**	11,301
Employer Contributions to NHS BSA - Pensions Division	**18,135**	17,033
Other pension costs	**5**	3
Termination benefits	**124**	107
Total employee benefits	**224,115**	217,520
Employee costs capitalised	**0**	0
Gross Employee Benefits excluding capitalised costs	**224,115**	217,520

10.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**4**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**196**	118

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

10.3 Staff Numbers

The average number of staff employed at the Trust during 2016-17 was 4,793 of which 4,039 were permanently employed. This compares to 4,595 total average number of staff employed in 2015-16. Further details on staff numbers are reported in remuneration and staff section of the annual report.

10.4 Staff Sickness absence

An average of 7.2 working days were lost per staff member in 2016/17 in comparison to 8.26 in 2015/16. Further details on staff sickness are reported in the remuneration and staff section of the annual report.

10.5 Exit Packages agreed in 2016-17

The total number of exit packages agreed in 2016-17 was 15 compared to 13 for 2015-16. Further details on exit packages are reported in remuneration and staff section of the annual report.

10.6 Exit packages - Other Departures analysis

The total number of other departures in exit packages agreed in 2016-17 was 14 compared to 11 for 2015-16. Further details on other departures in exit packages are reported in remuneration and staff section of the annual report.

10.7 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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

11.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**53,340**	**152,114**	55,535	160,060
Total Non-NHS Trade Invoices Paid Within Target	**23,835**	**61,987**	47,963	120,217
Percentage of NHS Trade Invoices Paid Within Target	**44.69%**	**40.75%**	86.37%	75.11%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,405**	**7,862**	2,484	**7,794**
Total NHS Trade Invoices Paid Within Target	**1,131**	**3,497**	1,939	**5,480**
Percentage of NHS Trade Invoices Paid Within Target	**47.03%**	**44.48%**	78.06%	70.31%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**87**	10
Total	**87**	10

12. Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**23**	46
Subtotal	**23**	46
Total investment revenue	**23**	46

13. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(33)**	**0**
Total	**(33)**	0

14. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**1,688**	**866**
Interest on late payment of commercial debt	**87**	**10**
Total interest expense	**1,775**	876
Provisions - unwinding of discount	**59**	**61**
Total	**1,834**	937

15. Other auditor remuneration

15.1. Other auditor remuneration

	2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services - see note 8	**10**	14
Total	**10**	**14**

15.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016-17 or 2015-16.

16. Property, plant and equipment

16.1. Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2016-17									
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Cost or valuation:									
At 1 April 2016	58,734	87,014	698	20,635	39,778	176	12,709	2,407	**215,346**
* *Adjustment*		(6,514)	(375)					84	**(6,889)**
Cost at 1 April 2016 after adjustment	58,734	80,500	323	20,635	39,778	176	12,709	2,491	**208,457**
Additions of Assets Under Construction				11,463					**11,463**
Additions Purchased	0	0	0		0	0	0	0	**0**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	60	67	0	0	0	**127**
Reclassifications	0	8,354	5	(11,044)	2,203	0	26	318	**(138)**
Disposals other than for sale	0	0	0	0	(205)	0	0	0	**(205)**
Impairments/reversals charged to operating expenses	(1,172)	(7,238)	0	0	0	0	0	0	**(8,410)**
Impairments/reversals charged to reserves	(22,430)	(2,906)	(131)	0	0	0	0	(363)	**(25,830)**
At 31 March 2017	**35,132**	**78,710**	**197**	**21,114**	**41,843**	**176**	**12,735**	**2,446**	**185,464**
Depreciation									
At 1 April 2016	0	12,380	441		29,130	176	11,967	283	**47,572**
*Adjustment**		(6,514)	(375)					84	**(6,889)**
Depreciation at 1 April 2016 after adjustment	0	5,866	66		29,130	176	11,967	367	40,683
Reclassifications	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(172)	0	0	0	**(172)**
Impairment/reversals charged to reserves	0	(3,898)	(66)		0	0	0	(144)	**(4,108)**
Charged During the Year	0	4,224	28		2,562	0	368	116	**7,298**
At 31 March 2017	**0**	**6,192**	**28**	**0**	**31,520**	**176**	**12,335**	**339**	**43,701**
Net Book Value at 31 March 2017	**35,132**	**72,518**	**169**	**21,114**	**10,323**	**0**	**400**	**2,107**	**141,763**
Asset financing:									
Owned - Purchased	35,132	72,418	169	20,899	9,955	0	400	2,107	**141,080**
Owned - Donated	0	100	0	215	368	0	0	0	**683**
Total at 31 March 2017	**35,132**	**72,518**	**169**	**21,114**	**10,323**	**0**	**400**	**2,107**	**141,763**

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 2016	31,216	7,374	0	180	580	0	0	0	**39,350**
Movements	(22,430)	709	0	0	0	0	0	0	**(21,721)**
At 31 March 2017	**8,786**	**8,083**	**0**	**180**	**580**	**0**	**0**	**0**	**17,629**

Additions to Assets Under Construction in 2016-17

Buildings excl Dwellings	7,705
Plant & Machinery	3,758
Balance as at YTD	**11,463**

16. Property, plant and equipment

16.2. Property, plant and equipment prior-year

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)**
Revaluation	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)**
Revaluation	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**

* Note: The opening balances for buildings and dwellings are reclassified for 2016-17 in order to reflect the correct values as recorded in primary source, the fixed asset register. This reclassification has no impact on the net valuation of these assets and does not require prior year adjustment.

16.3. (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 2016-17 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.
All three sites land have been valued on 'alternative site basis' in 2016-17 which has given a rise to a decrease in valuation by £23.6m.

	Watford Hospital	Hemel Hempstead Hospital	St Albans Hospital	Total
	2016-17			
	£000s	£000s	£000s	£000s
Operating expenses - note 8				
Land - MEA (alternative site valuation)	0	0	1172	1,172
Buildings, dwellings and fittings - MEA	5,583	338	1,317	7,238
Total	5,583	338	2,489	8,410
Statement of change in taxpayers equity				
Land - MEA (alternative site valuation)	1,861	(75)	20,644	22,430
Buildings, dwellings and fittings - MEA	325	(1,487)	454	(708)
	2,186	(1,562)	21,098	21,722
Total impairment/(reversal) 2016-17	7,769	(1,224)	23,587	30,132

	2015-16			
	£000s	£000s	£000s	£000s
Operating expenses - note 8				
Land - MEA	0	0	0	0
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

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 £33.1m of fully depreciated assets.

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

	As at 31 March 2017		As at 31 March 2016	
Asset Class	Maximum remaining asset life Years	Minimum remaining asset life Years	Maximum remaining asset life Years	Minimum remaining asset life Years
Buildings	**47**	**2**	48	3
Dwellings	**7**	**7**	28	28
Plant and machinery	**9**	**1**	9	1
Transport	**0**	**1**	1	0
Information Technology	**5**	**1**	5	1
Furniture and Fittings	**47**	**2**	48	3

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 17 and 31 March 16 do not necessarily reduce by one year. Cherry Tree House is the only dwelling in both 2016-17 and in 2015-16.

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

The Trust provides accomodation facilities 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.

17. Intangible non-current assets

17.1. Intangible non-current assets

2016-17	IT - in-house & 3rd party software	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's
At 1 April 2016	**6,913**	**6,421**	**0**	**13,334**
*Adjustment**		(5,000)		
Additions Internally Generated	0	0	2,400	**2,400**
Reclassifications	138	0	0	**138**
Impairments - see note i) below	0	0	(2,000)	**(2,000)**
At 31 March 2017	**7,051**	**1,421**	**400**	**13,872**
Amortisation				
At 1 April 2016	**6,797**	**5,000**		**11,797**
*Adjustment**		(5,000)		
Charged During the Year	**51**	**0**		**51**
At 31 March 2017	**6,848**	**0**	**0**	**11,848**
Net Book Value at 31 March 2017	**203**	**1,421**	**400**	**2,024**
Asset Financing: Net book value at 31 March 2017 comprises:				
Purchased	203	1,421	400	**2,024**
Donated	0	0	0	**0**

***** The opening balances for development expenditure - internally generated are reclassified for 2016-17 in order not to carry forward the impact of £5.0m of money paid to Watford Borough Council for the costs relating to a major road development providing alternative access to Watford General Hospital. See accounting treatment explained in note 1.3.1.

17.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's
Cost or valuation:				
At 1 April 2015	6,903	5,342	0	12,245
Additions - purchased	0	1,079	0	1,079
Reclassifications	10	0	0	10
At 31 March 2016	6,913	6,421	0	13,334
Amortisation				
At 1 April 2015	6,675	5,000	0	11,675
Charged during the year	122	0	0	122
At 31 March 2016	6,797	5,000	0	11,797
Net book value at 31 March 2016	116	1,421	0	1,537
Net book value at 31 March 2016 comprises:				
Purchased	115	1421	0	1,536
Donated	1	0	0	1
Total at 31 March 2016	116	1,421	0	1,537

17.3. 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

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

i) See impairments in note 18.1 for further explanations

18. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment	**Intangible Assets**	**Total**
	£000s	**£000s**	**£000s**
Other	0	2,000	**2,000**
Changes in market price	8,410	0	**8,410**
Total charged to Annually Managed Expenditure	**8,410**	**2,000**	**10,410**
Total Impairments of Property, Plant and Equipment changed to SoCI	**8,410**	**2,000**	**10,410**

18.1 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 Equipment charged to SoCI	5,631	0	5,631

There are no donated or governement granted assets impaired.

The analysis by site of the impairment on property, plant and equipment is shown in note 16.3. £2m impairment in intangible assets in 2016-17 relates to final payment to Watford Borough Council for the construction of new access road at Watford General Hospital which has been capitalised and impaired. No impairment on intangible assets in 2015-16 is incurred. See note 1.3.1 and 8.

19 Commitments

19.1 Capital commitments

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

	31 March 2017	31 March 2016
	£000s	£000s
Property, plant and equipment	**795**	3,509
Intangible assets	**149**	209
Total	**944**	3,718

19.2 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 in 2015-16.

	31 March 2017	31 March 2016
	£000s	£000s
Later than five years	**0**	2,000
Total	**0**	**2,000**

The financial liability has crystallised in 2016-17 and the loan of £2.0m from Watford Borough Council is shown in note 26.

20. Inventories

	Drugs	Consumables	Energy	Total
	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**940**	**3,115**	**116**	**4,171**
Additions	20,558	10,362	30	**30,950**
Inventories recognised as an expense in the period	(20,474)	(10,177)	(42)	**(30,693)**
Balance at 31 March 2017	**1,024**	**3,300**	**104**	**4,428**

21. Trade and other receivables

21.1 Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**11,787**	10,571	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**4,233**	2,955	**0**	0
Non-NHS receivables - revenue	**2,571**	3,733	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**2,436**	2,849	**0**	0
PDC Dividend prepaid to DH	**139**	219	**0**	0
Provision for the impairment of receivables	**(1,742)**	(1,855)	**0**	0
VAT	**1,372**	1,324	**0**	0
Interest receivables	**1**	4	**0**	0
Other receivables	**539**	622	**1,594**	1,565
Total	**21,336**	20,422	**1,594**	1,565
Total current and non current			**22,930**	21,987
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 2017 £000s	31 March 2016 £000s
By up to three months	**4,125**	5,605
By three to six months	**7,543**	3,396
By more than six months	**0**	0
Total	**11,668**	9,001

21.3 Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	**(1,855)**	(1,419)
Amount written off during the year	**187**	321
(Increase)/decrease in receivables impaired	**(74)**	(757)
Balance at 31 March 2017	**(1,742)**	(1,855)

22. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**1,739**	1,289
Net change in year	**2,884**	450
Closing balance	**4,623**	1,739
Made up of		
Cash with Government Banking Service	**4,592**	1,667
Commercial banks	**26**	66
Cash in hand	**5**	6
Cash and cash equivalents as in statement of financial position	**4,623**	1,739
Cash and cash equivalents as in statement of cash flows	**4,623**	1,739
Third Party Assets - Monies on deposit	**3**	3

23. Non-current assets held for sale

There are no non current assets held for sale in 2016-17 or in 2015-16

24. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**2,054**	1,713	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**4,513**	7,648	**0**	0
Non-NHS payables - revenue	**15,615**	9,523	**0**	0
Non-NHS payables - capital	**2,381**	5,807	**0**	0
Non-NHS accruals and deferred income	**16,381**	18,016	**0**	0
Social security costs	**2,256**	1,849		
Accrued Interest on DH Loans	**259**	133		
Tax	**2,000**	2,028		
Total	**45,459**	46,717	**0**	0
Total payables (current and non-current)	**45,459**	**46,717**		
Included above:				
outstanding Pension Contributions at the year end	**2,575**	2,452		

25. Other liabilities

The Trust has no other payables or financial liabilities.

26. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Loans from Department of Health	**4,523**	3,637	**89,342**	50,399
Loans from other entities	**0**	0	**2,000**	0
Total	**4,523**	**3,637**	**91,342**	**50,399**
Total other liabilities (current and non-current)	**95,865**	**54,036**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	4,523	0	**4,523**
1 - 2 Years	33,760	0	**33,760**
2 - 5 Years	46,782	0	**46,782**
Over 5 Years	8,800	2,000	**10,800**
TOTAL	**93,865**	**2,000**	**95,865**

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 General 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. Balance outstanding as at 31 March 2017 is £2.8m.

£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 £1.6m in 2016-17 (£2.4m in 2014-15 and £7.1m in 2015-16) 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. Balance outstanding as at 31 March 2017 is £10.1m.

£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 had approved loan facility of £26.8m, 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. This loan has been fully paid on the 3rd February 2017.

£26.8m loan accessed in February 2017. The loan was taken to finance the deficit in 2016-17 and was used to fully pay the Interim Revolving Working Capital Facility loan of £26.8m in February 2017. It is repayable fully on 18 January 2020. Interest is at a rate of 1.5% payable twice-yearly.

£7.5m capital loan accessed in March 2017 to support the capital programme in 2016-17. It is repayable on twice yearly equal instalments over ten years ending in March 2027. Interest is payable at 0.63%. Balance outstanding as at 31 March 2017 is £7.5m.

The Trust also accessed from October 2016 to February 2017 a total of £14.7m, as separate monthly loans, as Uncommitted Single Currency Revenue Support Facility to support the deficit and working capital of the Trust. All loans are at 1.5% interest rate and fully repayable in 3 years time.

27. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**1,568**	1,753	**0**	0
Deferred revenue addition	**593**	481	**0**	0
Transfer of deferred revenue	**(474)**	(666)	**0**	0
Current deferred Income at 31 March 2017	**1,687**	1,568	**0**	0
Total deferred income (current and non-current)	**1,687**	1,568		

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

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**5,460**	5,092	1	367
Arising during the year	**282**	129	0	153
Utilised during the year	**(767)**	(619)	0	(148)
Reversed unused	**(8)**	0	0	(8)
Unwinding of discount	**59**	59	0	0
Balance at 31 March 2017	**5,026**	**4,661**	**1**	**364**
Expected Timing of Cash Flows:				
No Later than One Year	**645**	509	0	136
Later than One Year and not later than Five Years	**645**	645	0	0
Later than Five Years	**3,736**	3,507	1	228

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2017	250,188
As at 31 March 2016	237,832

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).

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 contigent assets and 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 Improvements. 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.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed and fixed by the Department of Health (the lender) at the point borrowing is undertaken. 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 2017 are in receivables from customers, as disclosed in the trade and other receivables note 21.1.

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 2016-17 and 2015-16 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 £26.8m (£32.0m in 2015-16) which partly funds the deficit and repayment of capital loans. The Trust has also used loan finance of £9.1m in 2016-17 (£7.1m in 2015-16) approved by the Department of Health to fund capital projects. Partly through the year 2016-17 the Trust had access to £19.8m of it's interim revolving working capital facility (IRWC £24.7m in 2015-16) to meet it's liabilities. In February 2017, the Trust converted the IRWC to interim revenue support loan of £26.8m and additionally borrowed £14.7m Uncommitted Single Currency Interim Revenue Support 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		11,787		**11,787**
Receivables - non-NHS		446		**446**
Cash at bank and in hand		4,623		**4,623**
Total at 31 March 2017	**0**	**16,856**	**0**	**16,856**
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

31.3 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0		**0**
NHS payables		2,053	**2,053**
Non-NHS payables		11,720	**11,720**
Other borrowings		95,865	**95,865**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2017	**0**	**109,638**	**109,638**
Embedded derivatives	0		0
NHS payables		1,712	1,712
Non-NHS payables		6,029	6,029
Other borrowings		54,036	54,036
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2016	0	61,777	61,777

32. Events after the end of the reporting period

There are no adjusting or non-adjusting 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
2016-17	**£000**	**£000**	**£000**	**£000**
Spire Healthcare Ltd - see i) below	575	0	45	**0**
Department of Health	32,631	34,987	93,865	139
Foundation Trusts				
Chelsea and Westminster NHS Foundation Trust	54	2,755	9	325
Hertfordshire Partnership NHSFT	1,061	1,194	175	294
Southend University Hospitals NHS FT	561		43	0
Trusts				
Central London Community Healthcare NHST	162	747	56	603
Barts Health NHS Trust	2	615	1	11
East & North Hertfordshire NHS Trust	1,040	1,112	281	394
Hertfordshire Community NHS Trust	780	2,628	104	438
Imperial College NHS Trust	546	466	168	209
Clinical Commissioning Groups (CCG)				
Barnet CCG		777		200
Bedfordshire CCG		1,111	35	38
Brent CCG		532		46
Chiltern CCG		753	41	30
East and North Hertfordshire CCG	1	2,692	165	
Harrow CCG	54	2,852	233	
Herts Valley CCG		249,310	3,550	6,528
Hillingdon CCG		4,323		25
Luton CCG		981		114
NHS England				
NHS England Core	22	9,167		1,678
Central Midlands Local Office		3,265		158
East Commissioning Hub		14,436	32	884
Special Health Authorities				
Health Education England	3	9,269	274	655
NHS Litigation Authority	16,061			
NHS Blood & Transplant	1,509		9	7
2016-17	**54,487**	**343,972**	**99,041**	**12,776**
2015-16	51,230	353,023	62,458	11,017

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
2016-17	**£000**	**£000**	**£000**	**£000**
HM Revenue and Customs	48,587	11,625	4,256	1,372
NHS Pension Scheme	30,509		2,575	
Watford Borough Council	3,129	2,000	2,000	
2016-17	**82,225**	**13,625**	**8,831**	**1,372**
2015-16	**72,193**	**11,231**	**6,329**	**2,283**

Note i) M Van Der Waat, the Medical Director/Director of Patient Safety, see his private patients at Spire Healthcare Ltd.

The Trust has also received revenue and capital payments from a number of charitable funds, the corporate trustee is the Trust's Board.

34. Summary of West Hertfordshire Hospitals NHS Charity activities

	2016-17 £000s	2015-16 £000s
Income	**237**	154
Expenditure	**(457)**	(254)
Net Incoming/Outgoing Resources Before Transfers	**(220)**	(100)
Gains/(losses) on Revaluation and Disposals of Investment Assets	**124**	(56)
Funds B/wfd	**1,133**	1,289
Funds c/wfd - Net Assets	**1,037**	1,133

The Trust does not consolidate charitable funds into the financial statements. Pleae refer to Note 1.4

35. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	186,708	66
Special payments	25,534	47
Gifts	0	0
Total losses and special payments and gifts	212,243	113

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

No single item over £300,000

36. Financial performance targets

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

36.1 Breakeven performance

	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	2016-17 £000s
Turnover	218,248	232,967	241,684	254,308	260,398	266,716	278,230	291,119	313,291	299,769	322,643
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)	(39,855)
Adjustment for:											
Timing/non-cash impacting distortions:											
Adjustments for impairments	0	0	0	57,866	6,178	(1,512)	2,811	(2,252)	6,198	5,631	10,410
Adjustments for impact of policy change re donated/government grants assets						(100)	(39)	(10)	83	145	14
Other agreed adjustments	26,785	0	0	0	172	0	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)**	**(29,431)**
Break-even cumulative position	**(11,413)**	**(8,918)**	**(4,513)**	**1,186**	**8,716**	**12,373**	**14,277**	**907**	**(12,930)**	**(54,085)**	**(83,516)**

* 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 %	2016-17 %
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	-4.42	-13.73	-9.12
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	-4.13	-18.04	-25.88

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 2016-17 and 2015-16 achieving a cumulative deficit of -26.2%, above the -0.5% permitted. The Trust is working with NHS Improvement and the local economy to develop a recovery plan to achieve the breakeven duty in future years.

36.2 Capital cost absorption rate

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

36.3 External financing

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

	2016-17	2015-16
	£000s	£000s
External financing limit (EFL)	41,969	43,017
Cash flow financing	38,946	42,878
External financing requirement	**38,946**	42,878
Under/(over) spend against EFL	**3,023**	**139**

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

36.4 Capital resource limit

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

	2016-17	2015-16
	£000s	£000s
Gross capital expenditure	13,989	16,595
Less: book value of assets disposed of	(33)	0
Less: donations towards the acquisition of non-current assets	(126)	(5)
Charge against the capital resource limit	**13,830**	16,590
Capital resource limit	16,548	16,600
(Over)/underspend against the capital resource limit	**2,718**	10

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

37 Third party assets

The Trust held cash and cash equivalents 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 2017	31 March 2016
	£000s	£000s
Third party assets held by the Trust	**3**	3

Annual Report 2016/17

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