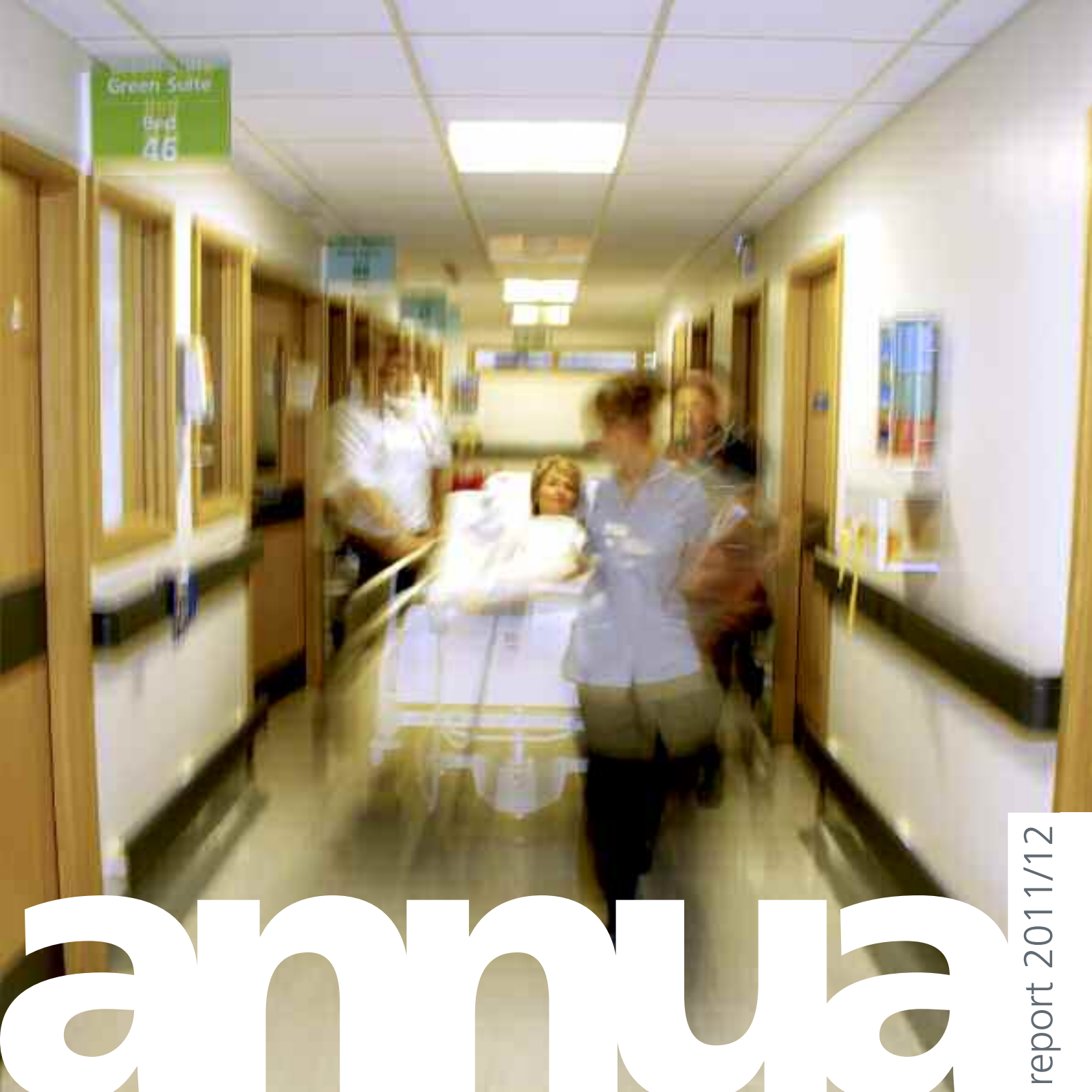


annual report 2011/12

Contents

Welcome by Chief Executive and Chair

Thomas Hanahoe
Chairman

Jan Filochowski
Chief Executive

The Annual Report is an opportunity for us to look back over the past year and take stock. It is a chance to recognise our achievements and where we need to focus our efforts further.

We are delighted to report that have had a really good year. We have provided more services, we've provided better services and we've provided better value.

The Trust has been nationally recognised for the quality of its services and has won or been short-listed for the following awards:

- In Top 6 hospitals for CHKS Quality of Care
- In CHKS 40 top hospitals for 2011
- Healthcare People Management Association Awards 2011 – Finalist and Overall Winner of all Categories
- HSJ Patient Safety Awards 2011 – Enhanced recovery – Finalist
- HSJ Best Social Marketing Project 2011 for 'Going for Gold' – Finalist
- HSJ Staff Engagement 2011 - Outpatient Service Development – Finalist

We have seen a further improvement in our infection control and the number of cases of Clostridium difficile and MRSA bacteraemias have continued to reduce. We have achieved a lot, but we need to do more and eliminate such infections completely from our hospitals.

The latest national patient surveys have revealed that our patients are more than satisfied with the service they receive and their overall experience in our hospitals is good. The outpatient and inpatient surveys show an impressive across the board improvement compared to the results of the previous year's surveys, one of the most improved in the east of England. This is very pleasing as it reflects the hard work of staff over the past year to make the patient experience better.

Our staff survey results also show significant improvements compared to last year's survey. This is really good news as it demonstrates an important overall improvement in morale within the Trust.

We now have some of the shortest waiting times in A&E in England in spite of significantly higher demand. Our emergency admissions continue to rise in number and the Trust has already acted to increase the capacity at Watford, the emergency acute care site.

During 2011 the Trust created an additional fifteen beds within the main hospital buildings by converting administrative areas into clinical bed bays. This released valuable clinical space and facilitated greater team working as a result of open plan spaces. Crucially the

Trust opened a new "Surge Ward", which was intended to be utilised when the hospital was experiencing severe operational pressures. The dramatic rise in emergency admissions due to changes in patient flows across and around Hertfordshire has resulted in this additional capacity being operational on a full time basis. With the support of NHS Hertfordshire and Herts Valleys Clinical Commissioning Group the hospital's capacity will be further increased in the forthcoming year with new state of the art mobile bedded units and we expect to have a new 36-bedded unit by the end of the 2012. We've also improved the way in which we treat and admit patients using a new Clinical Decision Unit.

We now have a strong financial track record and we are pleased to report a financial surplus of £3.6m. The financial regime in future years will be just as demanding and we need to continue to find new ways of working within tight budgets without compromising quality.

We remain on track to become a Foundation Trust well before the national deadline of 2014. We are currently being considered by the Department of Health and the Secretary of State, before being referred to Monitor for a full inspection. Our current timeline suggests we will be a Foundation Trust in 2012/13.

The Watford Health Campus development has had it own successes this year. We were delighted when the Trust was allocated £7m in February 2012 to support the construction of a new road to Watford General Hospital. This investment will radically improve access from the M1, avoiding the town centre. Furthermore, the Croxley Rail Link was also awarded the necessary central government funding required for its construction. These developments will substantially improve access to the hospital for the hundreds of thousands of patients, staff and visitors who use the services at Watford. It will also reduce traffic in other key locations in Watford. In addition, the Trust received £2.9m funding for a combined heat and power plant which will significantly reduce the Trust's carbon footprint.

Our staff, both clinical and support, are important to us and to the quality of services we provide; we will continue to invest in them. With the help of our Foundation Trust members, volunteers and supporters we are confident that we will continue to meet the many challenges we face in providing a top drawer service for the people of west Hertfordshire.

Many people give their time and effort freely to the Trust and it is greatly appreciated, especially by our patients. We would like to place on record our thanks to all our volunteers and supporters. Together we will work constantly to improve the way we care for our patients and the services we provide for them.

About West Hertfordshire Hospitals NHS Trust

West Hertfordshire Hospitals NHS Trust provides acute healthcare services to a core catchment population of approximately half a million people living in west Hertfordshire and the surrounding area. The Trust also provides a range of more specialist services to a wider population, serving residents of north London, Bedfordshire, Buckinghamshire and east Hertfordshire. As an employer of over 4000 people the Trust is one of the biggest employers in the area and sees nearly a million patients each year.

Within the NHS Midlands and East Strategic Health Authority cluster, NHS Hertfordshire is the main commissioner with over 300 GPs in west Hertfordshire.

Our Hospitals

During 2011/12:	
78,922	people attended A&E (on average, more than 200 a day)
14,444	people attended the Minor Injuries Unit
30,158	people attended the Urgent Care Centre
402,354	people attended Outpatient Departments (more than 1,500 a day)
79,585	people attended as inpatients and day cases
5,896	babies were born in hospital (plus 134 home births)

Watford General Hospital

Watford is at the heart of the Trust's acute emergency services – the core location for inpatient emergency care, and for all patients who need the specialist emergency facilities (such as intensive care) of a major district general hospital. It also provides elective care for higher risk patients together with a full range of outpatient and diagnostic services. There are approximately 600 beds and nine theatres (including one local theatre). Watford is also the focus of the Trust's Women's and Children's services, including neonatal care. In 2011/12 the Trust increased capacity on the Watford site with a new Clinical Decision Unit (CDU) and an eighteen bed "surge" ward.

The Trust's maternity service is amongst the largest in south-east England with almost 6000 deliveries per annum. A £750k investment in maternity services has delivered an increase in capacity, with a new six bedded transitional care unit (step up and down from the Special Care Baby Unit) for mothers and babies; three extra delivery beds; two antenatal beds; and four additional triage beds.

Hemel Hempstead Hospital

Hemel Hempstead has a 24/7 urgent care centre and offers other local healthcare facilities such as diagnostic services, including MRI and cold pathology, and an outpatient service that sees in excess of 100,000 patients per year. In addition it provides twelve stroke rehabilitation beds. Hertfordshire Community Trust also operates intermediate care beds on site.

St Albans City Hospital

St Albans is the Trust's elective care centre. It provides a wide range of elective care (both inpatient low risk surgery and day-case) and a wide range of outpatient and diagnostic services with in excess of 70,000 outpatient appointments. It has forty beds and six theatres (including one procedure room for ophthalmology) and a Minor Injuries Unit (MIU), open every day of the week from 9am to 8pm.

About the Trust Board and Current Members

Chair

Prof Thomas Hanahoe
(2005)

Chief Exective

Jan Filochowski
(2007)

Patricia Duncan
Company Secretary (2011)

Non Executive Directors

Sarah Connor
(2009)

Katharine Charter
Vice Chair (2006)

Mahdi Hasan
Senior Independent Director (2006)

Chris Green
(2010)

Phil Townsend
(2011)

Robin Douglas
Co-opted
(2000)

Executive Directors (Voting)

Dr Colin Johnston
Medical Director/ Director of Patient Safety (2009)

Natalie Forrest
Director of Nursing
(2010)

Anna Anderson
Director of Finance
(2010)

Chris Pocklington
Chief Operating Officer (2010)

Executive Directors (Non Voting)

Mark Vaughan
Director of Workforce
(2011)

Elizabeth Rippon
Director of Communications
(2011)

Louise Gaffney
Director of Strategy and Infrastructure (2012)

Paul Jenkins
Director for Partnerships (2011)

The Trust Board meets in public six times a year. It also meets privately for specific development sessions, which focus on the way the Board operates as a team and include in-depth discussions and briefing sessions on operational and strategic developments.

The Board has a structured programme of monthly ward and departmental visits which occur prior to each Board meeting. In addition, individual Non Executive Directors make ad hoc visits outside these times. Staff are invited to attend the public Board meeting to listen to feedback from the visits and a short written feedback note is also circulated to the relevant staff.

The Trust has also introduced a "Back to the Floor" programme this reporting year. This programme encourages Directors to actively work a shift in areas of the Trust, such as wards, medical records and kitchens to get a real 'feel' for the organisation and understand more about how it really works.

In addition and as part of the Trust's new five year Nursing and Midwifery Strategy, Non Executive Directors are 'championing' a ward in order to give Board Members more active involvement in clinical areas.

Divisional structure

Clinical services are organised into four Divisions; Surgery, Medicine, Women's and Children's Services and Clinical Support. Each of these Divisions has a Divisional Clinical Director, Divisional Manager, and where appropriate, a Head of Nursing. A tier of Clinical Directors, Service Managers, and Matrons supports this core Divisional Management team. The Clinical Divisions are supported by various corporate functions, including Finance, Human Resources and Information, Management and Technology. The Divisions are responsible for the day-to-day management and delivery of services within their areas in line with Trust strategies, policies and procedures.

Changes to the Trust Board

Phil Townsend joined the Trust in December 2011 as a Non Executive Director. Phil has worked for over twenty years leading highly complex and very large business transformations in the telecommunications industry.

Paul Jenkins took up the position of Director for Partnerships in February 2012. Paul has worked in the NHS for over twenty years, including Chief Executive of NHS Westminster and Managing Director of the North West London Acute Commissioning Agency.

Elizabeth Rippon took up the post of Director of Communications in June 2011. Elizabeth has worked with and in the Trust since 2002 and has extensive experience in service redesign, health planning and whole system transformation and has led the FT application since 2008.

Louise Gaffney was appointed Director of Strategy and Infrastructure in 2012. Louise has worked in the NHS in Hertfordshire for over fifteen years with a career spanning the Health Authority, the Ambulance Trust and both primary and secondary care. Her expertise is in strategic health planning and in the successful delivery of complex programmes, for which she has won a number of national awards.

Trust Board in Action

If you would like to attend a public meeting of the Trust Board as an observer, dates can be found on the 'About Us' section of the Trust website www.westhertshospitals.nhs.uk. The website also provides Board meeting agendas and minutes, as well as detailed papers which support the decision-making process.

What the Trust sets out to achieve

The Vision

The Trust's vision is to embody in its hospitals all the principles, values and the sense of service that created the NHS by providing consistently good, safe care in a friendly, listening and informative way, as and when people need and want it and always with dignity and respect.

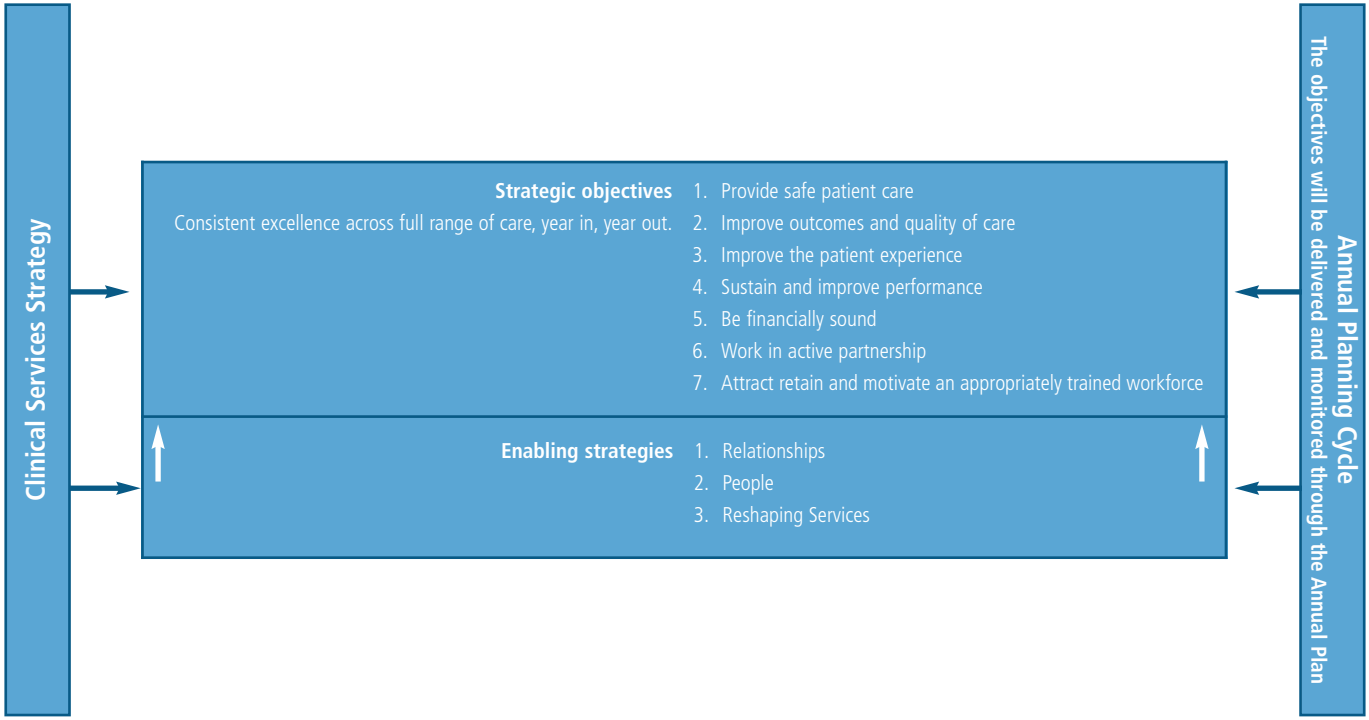
Making it happen

The Trust Board informed by the business planning of the organisation has set seven strategic objectives (see table below) which the Board monitor year by year. These objectives focus on the consistent delivery of high quality, safe services whilst ensuring the organisation remains financially robust. In the Integrated Business Plan (IBP) the strategic objectives are supported by a set of business objectives. The Trust has also agreed three enabling strategies to support the delivery of the IBP and the objectives.

This Annual Report highlights the work that has taken place during 2011/12 to move the Trust towards achieving its objectives.

The Bribery Act

The Bribery Act 2010 came into effective from 1 July 2011. It introduced changes in the law that have an impact on the conduct of the Trust's business. In the light of the new Act, the Board reviewed its procedures to ensure they are sufficiently robust to prevent bribery and to mitigate the risk of committing an offence under the Act.



Objective 1:
Provide safe patient care

Key Points
• Reducing the risk to patients, including vulnerable patients
• Achieved Level 2 from NHSLA
• Improving security
• Being prepared for emergencies
• Reducing hospital acquired infections
• Learning from complaints
• All hospital sites achieved a positive score from PEAT

Care Quality Commission Registration

The Trust received unconditional registration from the Care Quality Commission supported by five unannounced visits during 2011/12, none of which resulted in any major concern.

Managing risk

The Trust is committed to promoting safe patient care with the aim to achieve 'no avoidable deaths' and 'no avoidable harm'. The Trust has a robust system of identifying, investigating and learning from incidents, which provides a key lever for change and improvement in relation to patient safety.

A Serious Incident Reporting Policy is in place which sets out the actions required following a potential serious incident and identifies key controls to manage and reduce the risks of events reoccurring. During 2011/12 the Trust developed a process for incidents not deemed serious but nonetheless have implications for patient safety – these incidents are designated significant incidents and warrant similar robust investigation as those for serious incidents.

The Trust also uses a Global Trigger Tool to identify and measure the rate of adverse events over time. The Trigger Tool methodology involves a retrospective review of a random sample of patient records using "triggers" (or clues) to identify possible adverse events. The Trust's patient safety team review up to 20 notes of patients every month using this tool.

NHSLA Level 2

In 2011/12 the Trust successfully attained Level 2 compliance against the NHS Litigation Authority's (NHSLA) Risk Management Standards for Acute Trusts. The assessment was conducted over a two day period in June 2011 where assessors reviewed evidence collected over the previous twelve months. The Trust achieved a final score of forty one out of fifty standards. This Level 2 rating not only provides strong reassurance to patients that the quality of care that they receive is high, but it also reduces insurance costs for the Trust.

National award recognition

Once again this year, the Trust was named amongst the CHKS 40 Top Hospitals in the country. This award scheme celebrates excellence across the UK and is based upon the evaluation of twenty-one key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. The Trust was also shortlisted for this year's Quality of Care Award, having been one of only six acute Trusts across the UK to have excelled in all quality of care indicators to meet the nomination criteria, including the length of time patients stay in hospital, the rate of emergency re-admissions and whether the care pathway proceeded as originally intended.

The Trust also reached the finals of the prestigious Health Service Journal Awards, for the second time in three years. The Trust was short-listed under the 'Staff Engagement' category for the work done to improve the outpatient service and under the 'Best Social Marketing Project' category for the 'Going for Gold' Campaign. In 2009 the Trust was runner up in the Health Service Journal awards for Acute Hospital Trust of the Year and since then has been recognised nationally in a further seven award schemes. These are huge achievements and show the sustained progress the Trust has made over the past few years.


DON'T
INFECT
PROTECT
• CLEAN YOUR HANDS BEFORE AN
ALL PATIENT CONTACT
• USE GLOVES FOR SPECIFIC TA
REMOVE IMMEDIATELY AND
• PATIENT WITH DIARRHOE
CLEAN YOUR HANDS
• HANDS LOOK CLEA
HANDS LOOK DIRT

Patient Safety Week

The Trust took part in National Patient Safety Week in September 2011. This was a great opportunity to raise awareness and to share good practice. During the week, staff were encouraged to take part in patient safety-orientated activities. One of the highlights of the week was the introduction of a new national patient observation chart which improves patient assessments, detection of deterioration and provides a timely response. A series of daily communications was also distributed throughout Patient Safety Week to raise awareness on core safety issues, such as infection control, pressure ulcers, and managing medicines.

Security

The Trust takes security of its patients, visitors and staff very seriously. A "pro-security" culture is strongly encouraged to ensure a safe and secure environment for patients and staff to work in. The Trust continues to develop good working relationships with Community Safety Partnerships and local police and crime prevention teams in order to maximize protection of its staff, property and assets. This reporting year, the Trust installed several additional security measures, including the installation of CCTV across the hospital sites, additional specified security patrols and increased lighting.

Learning from complaints and compliments

Complaints are taken seriously and every effort is made to resolve them either in writing or through local resolution meetings. During this reporting year, 510 complaints resulted in formal responses from the Chief Executive. In addition, many more were dealt with informally. The total number of complaints remains at less than 1% of patients seen during the year. The key themes of complaints remain similar to the previous year and cover clinical treatment, staff attitude and communication/information. In 2011/12, the Trust made the following changes as a direct result of comments made in complaint letters:

- Encouraged family members to participate in therapy in order to provide added motivation and support to patients,
- Recommended staff not to use medical terminology during patient consultations,
- Improved a number of processes in relation to the appointment system for patients attending for hip and knee replacement surgery.

During the period of this report, the Chief Executive received 174 compliment letters from service users. In addition to the formal letters received by the Chief Executive, many hundreds of informal compliments in the form of letters, cards, notes and small gifts went directly to wards, departments and named staff.

Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) offers advice and information to patients, relatives and their carers and assists them in raising any concerns they have regarding their treatment or the way the Trust functions. In 2011/12 the PALS team dealt with a total of 1887 reported concerns.

Patient Environment Action Team

During the past year the Trust has continued to carry out monthly internal Patient Environment Action Team (PEAT) audits on all three hospital sites. The inspection team includes representatives from the Patients' Panel, Facilities, Estates and Nursing. The overall results in 2011/12 were as follows:

- Hemel Hempstead scored 73% for cleanliness (acceptable), 71% for the environment (acceptable), 83% for privacy and dignity (good) and 96% for food (excellent),
- St Albans scored 79% for cleanliness (good), 72% for the environment (acceptable), 88% for privacy and dignity (good) and 96%for food (excellent),
- Watford scored 93% for cleanliness (good), 74% for the environment (acceptable), 70% for privacy and dignity (acceptable) and 96% for food (excellent).

Norovirus

Despite the immense efforts of staff to prevent the highly contagious Norovirus reaching our hospitals last winter, a small number of cases were confirmed at Watford and Hemel Hempstead in January 2012. This resulted in the closure of two wards to new admissions and transfers for a few days.

Planning for emergencies

Emergency planning is important for an NHS Trust as it sets out how the organisation would respond in the face of a major incident.

The Trust regularly tested its Business Continuity and Internal Incident plans throughout 2011/12 for the management of minor incidents such as lighting and lift failures, as well as the management of large scale emergency training exercises, the majority of which have had an Olympics focus. The Trust has brought its major incident training in-house this year, which reduced the costs significantly.

Infection control

The Trust met its national infection control targets in 2011/12, which again puts the Trust amongst the best in the country for infection control rates.

The Trust maintains strict infection control precautions and once again this year, organised a variety of activities to raise awareness of the importance of preventing serious hospital-acquired infections, including its successful annual Think Clean Week.

Safeguarding

The safeguarding of children and adults is a high priority for the Trust. The Trust works closely with its community partners to improve services for vulnerable patients.

During 2011/12 a new safeguarding intranet site was developed which allows staff to find referral forms, up-to-date local and national information and links to additional useful resources. The Trust has also been proactive in taking forward the National Dementia strategy and has appointed a Dementia Lead Nurse, who works closely with Clinical Consultant Leads.

Nursing Quality Indicators

A new Nursing Quality Indicator report was developed in March 2012 and is now presented to the Trust Board quarterly. This report sets out core quality indicators and targets for every department that delivers patient services. The indicators include slips, trips and falls, commode audits, hand hygiene, avoidable pressure ulcers, medication errors, nutrition and complaints. The report has proved to be a valuable tool in reviewing the quality of the care the Trust provides and highlighting areas which need extra focus.

The Patients' Panel

The Patients' Panel continues to work diligently for the Trust to ensure that the healthcare and facilities that the Trust offers are appropriate and accessible to all services users. As 'critical' friends of the Trust, the Panel is linked to many groups, meetings and initiatives to improve the experiences for all our patients and carers.

Volunteers

Volunteers play an invaluable role in the Trust. They support staff to offer an enhanced service to patients. The Trust's Volunteer Coordinator manages 500 volunteers, who annually give up more than 164,400 hours of their own time to work at the Trust. Volunteers help in all areas of the Trust and do a wide range of jobs, including talking to patients, helping at mealtimes on wards, providing a friendly welcome and giving directions and supporting staff with administration duties. At the Trust's annual 'Thank You' event volunteers were joined by Actress Pam St. Clement who presented certificates to the volunteers in recognition of their hard work and dedication.

Objective 2:

Improve outcomes and quality of care

Key Points
• New nursing and midwifery strategy
• Improving nutrition
• Piloting new tool to monitor patient harm
• New IT system to avoid delays in treatment
• Getting people on their feet quicker
• Increasing time spent on direct patient care
• Extending cancer screening service

Nursing and Midwifery Strategy

The Trust launched a new five year Nursing and Midwifery Strategy in 2011/12. The aim of this strategy is to liberate the skills and talent of every nurse and midwife to allow them to be the best professional they can be. The four key elements of the nursing and midwifery strategy are:

- Competent workforce:
  an effective workforce is fundamental to success,
- Confident to deliver safe quality care:
  safety is a patient's right and the obligation of staff,
- Committed to delivering efficiencies:
  ensuring resources are used in an optimum way to deliver better services,
- Caring for patients:
  the primary goal is to meet the needs of patients in a professional and compassionate environment.

NHS Safety Thermometer

The Trust has been working with the Strategic Health Authority to pilot an NHS Safety Thermometer, as part of the 'Harm Free Care' campaign. This is a measurement tool that monitors patient harm as a result of pressure ulcers, patient falls, urinary tract infection in patients with catheters and venous thrombo embolism (VTE). Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day, for example at a shift handover or during ward rounds. The NHS Safety Thermometer provides a 'temperature check' on harm and can be used alongside other methods to measure local and system progress.

The 15 Steps Challenge

We all know that first impressions count and therefore the Trust is working with The NHS Institute for Innovation and Improvement on a new initiative called 'The 15 Steps Challenge'. This initiative focuses on the initial impression that an individual gets when they take their first 15 steps onto a ward or department.

Improving nutrition

A Mealtime Volunteer Scheme has been introduced in the Trust this year. This role has proved important in helping patients to eat and support nursing staff at mealtimes. To date the Trust has sixteen regular mealtime volunteers from both within and outside of the Trust and is seeking to increase this number in the coming year.

In addition, the Trust piloted the 'MUST' nutrition screening tool, as recommended by the National Patient Safety Agency (NPSA) in three clinical areas in 2011/12. 'MUST' is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan. The 'MUST' tool will now be rolled out Trust wide.

Revolutionary new IT system

The Trust has been involved in the development of a new clinical computer system, which enables information from a large number of individual clinical systems to be brought together and viewed from one collective 'portal'. This allows clinical staff to get real-time patient and clinical data, test results and imaging, such as x-rays and scans wherever and whenever they need to across the hospital sites. The system is proving to be an invaluable tool for clinicians and is delivering genuine benefits to patients by reducing delays in the consultation and treatment process.

Organ donation

The Trust is committed to raising awareness around organ donation. Staff hosted drop-in sessions in June and September 2011 offering patients, visitors and hospital staff advice and free information packs. In this reporting year, the Trust identified five organ donors resulting in one heart transplant, eight kidney transplants, five liver transplants, one pancreas transplant plus four corneas and two heart valves. To register as an organ donor or to find out more please look on www.uktransplant.org.uk/ukt.

Bowel Cancer Screening

Since the West Hertfordshire Bowel Cancer Screening Centre opened over three years ago at Hemel Hempstead it has performed over 1000 screening tests and detected 103 cancers, potentially saving dozens of lives of people from across the region. The Centre initially offered screenings to all west Hertfordshire residents registered with a GP aged between 60-69 years old, however due to the success of the Screening Centre, the programme has been extended to residents of up to 75 years old.

Enhanced Recovery Programme

The Trust's Enhanced Recovery Programme was short-listed in the prestigious National Patient Safety Awards 2011. The highly-praised treatment programme offers patients advice on what food to eat and how to mobilise joints in the lead up to their operation, which is proven to give patients the maximum opportunity to get their bodies as fit as possible for surgery and anaesthesia. To celebrate the success of the programme, two hundred patients who had previously undergone hip and knee surgery as part of the ER Programme took part in a sponsored walk in June 2011. The event raised over £3,000.

The Productive Ward Programme

The Productive Ward Programme has continued to be rolled out across the Trust over the past year. The majority of clinical areas are now embracing the programme and using it to streamline processes, allowing ward staff to increase time spent on direct patient care. Many wards have worked through the Productive Ward modules and have made improvements to processes like their shift handover, meal rounds and patient discharges. One of the tools that is helping staff manage patient flow better is a Patient Status at a Glance Board (PSAG). Each patient's care and treatment is carefully planned and recorded on the board with input from a multidisciplinary team, so all staff are aware of each patient's medical and care needs.

Objective 3:

Improve the patient experience

Key Points
• Focus on improving experience of patients
• Capturing and using feedback
• Improving services for bereaved families
• Making systems work better for patients and staff
• Improving the physical environment
• Delivering services that are fair and personal to all

Real focus on making improvements

In 2011/12 the Trust paid a real focus on making changes to services and the environment in order to make the patient experience better, including:

- Arranging for senior nurses to be on site at the weekends for patients and relatives with questions, concerns or queries,
- Sewing up the curtains around beds on wards to provide better privacy and dignity,
- Putting in new TVs in the Acute Admissions Unit at Watford,
- Giving the Discharge Lounge at Watford a makeover to make it more 'patient-friendly' and welcoming.

Capturing patient feedback

Patient feedback is a valuable way of measuring the quality of the services the Trust provides and a key driver in identifying problems. The results of the 2011/12 national independent surveys of patients who used the Trust's inpatient and outpatients services have shown a continuing rise in patient satisfaction.

The 2011 National Outpatient's Survey results revealed 53 out of the 62 questions to show an improvement in performance– a total of 85% - across all areas of the survey; including waiting times, the environment, information about medication and overall satisfaction and care. These are the fourth set of survey results which show evidence of steady improvement in the Trust's outpatient service.

The results of the National Inpatient Survey 2011 were just as impressive, showing an improvement in nearly every category; including admission, care, treatment and discharge, compared to the results of the previous year's survey.

The NHS Midlands and East Strategic Health Cluster described the Trust as one of the most improved Trusts in the east of England region, for receiving a positive inpatient experience.

Although these results continue to be encouraging, the surveys did pinpoint some areas which need further improvement and the Trust has action plans in place to address specific issues in order to continue to make services even better.

As well as the national patient surveys, the Trust continues to develop its own internal processes for recording and reporting patient experience. In 2011/12 the Trust purchased a new piece of software that enables staff to design and run specifically tailored patient surveys and analyse the results instantly.

Furthermore, in order to gain valuable feedback and improve outcomes, patients who had used the Trust's Acute Admissions Unit (AAU) were invited to talk to staff about their personal experiences. These feedback events are excellent opportunities for real engagement between patients and staff and resulted in positive outcomes for all.

The Trust has also been working with the Young Carer's Reference Group and the Carers in Hertfordshire Young Carers Project to identify how it can improve services for vulnerable groups of children and young people.

Another tool that is used widely by the Trust to gauge patient satisfaction is the NHS Choices website. This website is accessible to

all via www.nhs.uk and offers an opportunity for patients and visitors to leave feedback about their experience.

Equality and Diversity

Over the last year the Trust has been working hard to ensure the quality of its services takes account of the many different communities that it serves and the diversity of its skilled and talented workforce. The Trust has set itself the following four equality specific objectives:

- To know enough about patients needs and requirements to provide high quality services that raise the satisfaction bar to new heights,
- To continue to work with patients, carers and families to ensure services and buildings are right,
- To continue to develop flexible and accessible places for staff to flourish,
- To continue to develop and support leaders who can make this Trust a personal, fair and diverse place for the people who matter.

Bereavement

The Trust's Bereavement and Spiritual and Pastoral Care service has held a number of workshops this year, bringing together religious leaders from across west Hertfordshire. The workshops aimed to find out how the Trust can support religious and cultural needs following bereavement. Additional workshops have also been arranged to listen to religious leader's views on organ donation and involve them in emergency major incident planning.

Modernising communications

As well as the well established methods of communication that the Trust uses to engages with its service users, it is now using social media, including Twitter and Flickr to update on Trust news, events and other information. Both these new communication channels can be accessed by clicking on the appropriate links on the homepage of the Trust website www.westhertshospitals.nhs.uk.

Single Sex Accommodation

The Trust remains compliant with the Government's requirement to provide single sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

Better environment

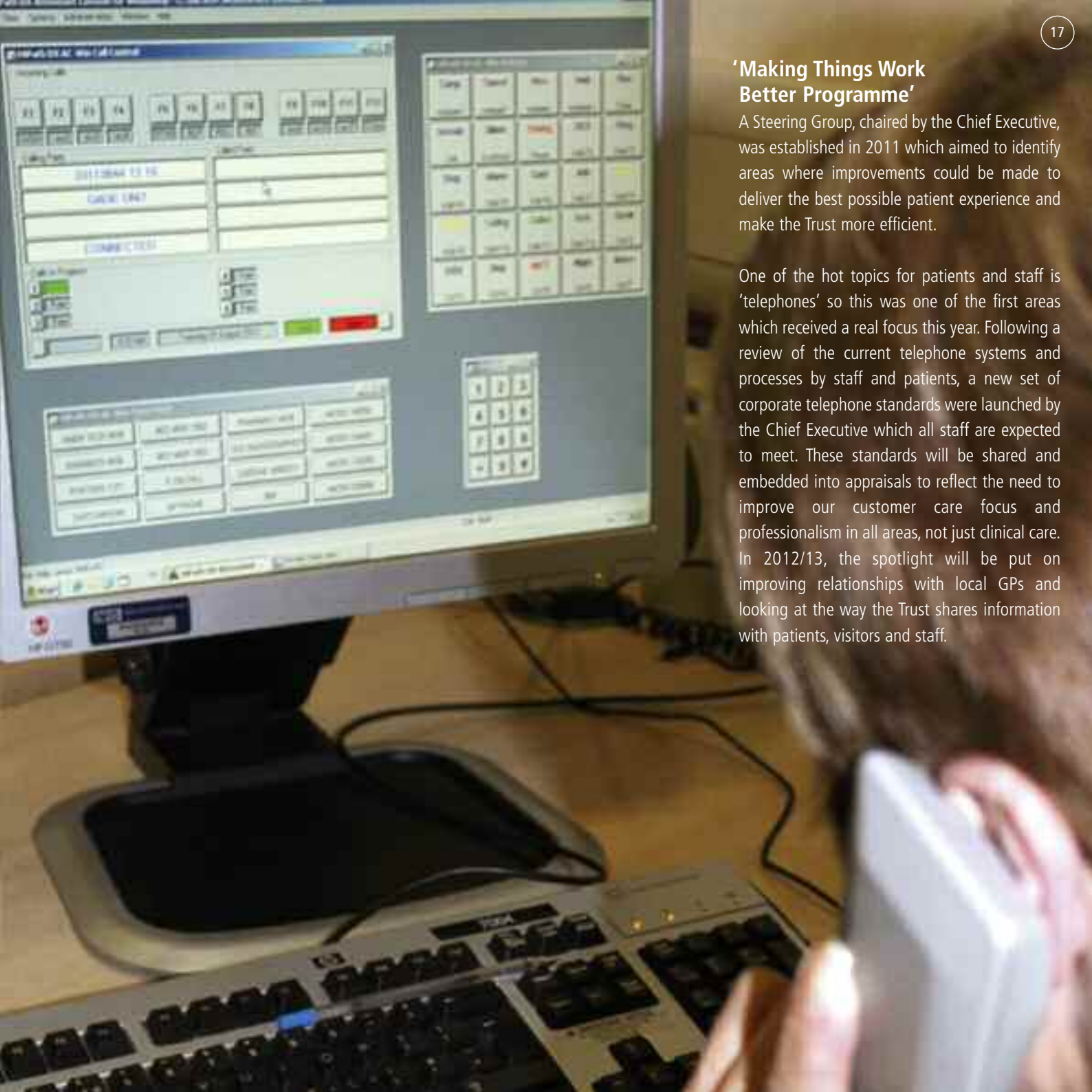
During 2011/12 the Trust strived to improve the facilities in its three hospitals. There have been a wide range of redevelopment and refurbishment projects, some of which are listed below:

- The Discharge Lounge at Watford was given a facelift and now offers a "home from home" atmosphere for patients who are waiting to return home following a stay on one of the hospital wards.
- A new six bedded Neonatal Transitional Care Unit opened in spring 2012. The Unit provides care at the mother's bedside for babies who need closer monitoring, treatment and support.
- The A&E waiting area at Watford was refurbished to improve the environment for patients and their friends and families.
- St Albans received a refurbished main entrance which offers a café-style environment, longer opening hours and a greater variety of food. The new entrance has modern automatic opening doors to allow easier and more convenient access and exit, particularly for those patients in wheelchairs or with walking devices.
- The Chapels of Rest at Watford and Hemel Hempstead were refurbished to improve the environment for bereaved relatives. The redevelopments were supported by contributions from local businesses and donations from bereaved families.
- A refurbished Decontamination Unit opened at Hemel Hempstead in February 2012 with a further refurbished Decontamination Unit expected to be operational at Watford in early 2013.
- The toilets in the Spice of Life Restaurant at Watford were refurbished and an additional disabled toilet installed.

'Making Things Work Better Programme'

A Steering Group, chaired by the Chief Executive, was established in 2011 which aimed to identify areas where improvements could be made to deliver the best possible patient experience and make the Trust more efficient.

One of the hot topics for patients and staff is 'telephones' so this was one of the first areas which received a real focus this year. Following a review of the current telephone systems and processes by staff and patients, a new set of corporate telephone standards were launched by the Chief Executive which all staff are expected to meet. These standards will be shared and embedded into appraisals to reflect the need to improve our customer care focus and professionalism in all areas, not just clinical care. In 2012/13, the spotlight will be put on improving relationships with local GPs and looking at the way the Trust shares information with patients, visitors and staff.



Objective 4:

Sustain and improve performance

Key Points
• Increased capacity to manage demand
• Achieved A&E target
• Achieved infection control target
• Action taken to address the Energy and Sustainability Agenda

Increasing capacity

During 2011/12 it became apparent that the Trust's emergency activity was higher than it had expected to be when plans had been made for the year. Therefore, during 2011 the Trust reviewed this demand and its capacity and examined what should be done in order to respond to the pressure. The review concluded that A&E and the Acute Admissions Unit at Watford had insufficient capacity and the Maternity Unit had a similar problem as more and more families continue to select Watford as the place of choice to deliver their babies.

The Board made a decision in July 2011 to invest in a new Clinical Decision Unit (CDU) in A&E, an 18 bedded Surge Ward (now known as AAU, Red Suite), a new area for treating minor injuries in A&E and extra capacity in Maternity and Neonatal Care. The funding for this scheme was found internally and with the support of the Primary Care Trust. Work on the projects began very quickly and the new areas were all completed around the end of 2011/beginning of 2012.

This additional capacity has enabled the Trust to achieve its admissions targets, despite the continuing upward trend in attendances.

Meeting targets

The Trust's performance is monitored by NHS Hertfordshire (our local Primary Care Trust), NHS Midlands and East Strategic Health Authority, the Department of Health, and the Care Quality Commission. Each body uses a slightly different set of indicators and measures, but there is a core group used by all of them. The Trust's performance against these is summarised below:

Indicator	National Standard	West Herts Performance
95% of patients should be seen within 4 hours in A&E	>95%	Achieved
Incidence of *C difficile* should be identified and the numbers minimised	Trust target was to have less that 33 cases of *C difficile* throughout the year	Achieved
Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have less than 4 for the whole year	Achieved
All cancers – patients should not wait more than 31 days for second or subsequent treatment	National target was to have 96% patients seen within 31 days	Achieved
All cancers – patients should have a maximum wait of 62 days between urgent referral and first treatment	The national target was to see 90% of those referred by the screening service and 85% referred by GPs%	Underachieved Achieved

Maximum wait of 18 weeks referral to treatment:	National Standard	West Herts Rating
Admitted patients	>90%	Achieved
INon-admitted patients	>95%	Achieved

The Trust has sustained and continued to improve the reductions in infections seen in the past two years. Despite much higher demand than expected in the last quarter of the year, with the Trust recording some of the highest number of A&E attendances it has ever experienced, the Trust has achieved its A&E target. There was a consequential impact on elective admissions which resulted in lower than the 90% standard in the last quarter of the year, although the annual figure was achieved.

Pathology services

Following the Carter review of NHS Pathology services, the East of England Strategic Health Authority started a procurement process in 2011/12 to centralise GP pathology work into three or four hubs within the area to achieve significant savings.

The Trust has formed a consortium called Consolidated Pathology Services (CPS) with Luton & Dunstable, Bedford and Princess Alexandra Hospital Trusts. CPS responded to this procurement and has been selected as provisional preferred provider of GP pathology for Beds, Herts and parts of Essex.

Transforming pathology will bring significant change to the way in which pathology services are provided and the Trust will continue to work through the implications to ensure that high quality viable services can be provided for GPs and for our hospitals.

A final decision on this change is expected in later 2012.

Delayed transfer of care

Pressures have been increased on many of the Trust's services by the long standing issue for health and social care in west Hertfordshire. A large number of patients in the Trust's hospitals are medically fit for discharge, but are unable to leave hospital due to non-clinical reasons. The Trust continues to work with its partners in primary and social care to ensure that this issue is seen as a priority.

Freedom of Information requests

The Freedom of Information Act 2000 gives everyone the right of access to publish information, subject to exemptions. In 2011/12, the Trust received 292 requests for information with many multiple questions. The Trust has an efficient system in place for management of these requests. In this reporting year, 100% were responded to within the required twenty working days.

Environmental/Sustainability

As a leading healthcare provider working to ensure the well-being of patients and the community, the Trust recognises it has a vital responsibility to minimise impact on the environment, prepare for changes in climate, ensure efficient resource use and maximise funds for patient care.

The Trust's Sustainable Development Management Plan was approved by the Board in September 2011 and a Sustainability Programme Board established. The management plan outlines the Trust's commitment to sustainability, and will shape future planning and service delivery. It is guided by the NHS Sustainable Development Unit's Carbon Reduction Strategy for England and Saving Carbon, Improving Health, Feedback and recommendations on the plan were received from the Sustainability Development Unit (SDU) and these were incorporated into the Trust's plan.

Key projects within the Sustainability Development Management Plan are as follows:

- Energy Efficiency: A programme of replacing light fittings with state of the art, low energy fittings thus reducing energy usage, cutting costs and reducing the carbon footprint,
- Combined Heat and Power Plant: (CHP) The Trust has received funding to develop a CHP plant for the Watford site. This will significantly improve energy efficiency, reduce costs and reduce the carbon footprint,
- Waste Minimisation: Currently the Trust recycles only 6% of waste. This will be increased to 50% by March 2014,
- Roof Insulation: The Trust will shortly implement a roof insulation project to reduce heating costs, save energy and reduce carbon emissions,
- Transport Reduction: The Trust aims to encourage staff to reduce the carbon emissions associated with travelling to and from work. Car share schemes, buses, and encouraging cycling all have a part to play.

The Trust actively participated in the National NHS Sustainability Day on 28 March 2012 by raising staff awareness in four key areas:

- "Turn it off" campaign,
- "Recycle Recycle Recycle",
- Car share day,
- Bike to work day.

Objective 5:
Be financially sound

Key Points
• Delivered a surplus of £3.6m
• £13.4m savings achieved
• Aspiration to become a Foundation Trust in the next year

The financial headlines

The 2011/12 financial plan set a surplus target of £4.4m. This included the requirement to deliver £15.5m of savings. The size of the surplus was a balance between what was considered achievable and what was needed to keep the Trust's liquidity and cash balance in order, assuming the Trust's loans with the Department of Health (DH) were re-phased.

In the autumn of 2011 the position was clarified and the Trust was supported in continuing its Foundation Trust (FT) application in that the loans would be rescheduled at the point of authorisation. The Trust revised its surplus target to £3.6m to take account of the extra loan interest payable and revised its cash and liquidity plans accordingly. The re-phasing of the loans is critical to the Trust's future finances and the Trust remains confident that at the point of FT authorisation the existing terms will be adjusted.

The Trust's savings target of £15.5m to reduce inefficiencies and improve performance included £2m savings through reduced capacity, in total around 6% of turnover, proved quite a challenge, particularly on the back of savings made in the two previous years. In delivery of savings the Trust followed the same 'Big Ask' process developed in 2010/11. This was an all staff inclusive process as detailed in last year's Annual Report. Capacity was an issue all year, and in the event, the Trust did not reduce this, receiving more income

than planned from NHS Hertfordshire and narrowly missing delivery of £13.5m of other savings. Of course, the challenge does not stop here. Additional savings need to be made to replace those that were one-off but covered costs that occur each year, as well as achieving the efficiency savings inherent in the level of funding that the Trust is contracted to receive in 2012/13. Additional savings of £11.5m need to be achieved in 2012/13.

Late in the reporting year, the Trust received the welcome news that it would receive £7m from the DH towards the cost of a new road accessing the back of Watford Hospital. The Trust has temporarily retained this funding and is working with Watford Borough Council on the initiative. The DH has also agreed to fund a combined heat and power plant at Watford in 2012/13 which will greatly improve the Trust's energy efficiency and carbon footprint.

Internal audit

During 2011/12 the Trust re-appointed RSM Tenon as its Internal Audit provider for a further year. An annual plan of work is approved by the Trust's Audit Committee. Progress reports highlighting any significant weaknesses identified are reviewed at each committee meeting and the Audit Committee ensures action is taken to resolve these. The Internal Audit Report for the year is shown on page 44.

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 Commission appointed Grant Thornton as the Trust's external auditors for a period of five years ending 31 August 2012. Subject to consultation with the Trust the Audit Commission propose to reappoint Grant Thornton for a further five years.

In the event the Trust appoints Grant Thornton for work other than that of external audit, the expense is shown separately in the Annual Accounts as "other auditor's remuneration" (see note 6 of the Trust's accounts). Any such work is subject to competition and assurance obtained that there is no conflict of interest with the role of external auditor.

Related parties

Note 31 of the Trust's accounts sets out the transactions with related parties. These are mainly other NHS bodies commissioning patient activity provided by the Trust or other government bodies with which the Trust has financial transactions. There are no related transactions involving Non Executive Directors, all of whom are independent of the Trust.

Your hospital
Your NHS

Becoming a Foundation Trust

The Trust remains fully engaged in the process to become a Foundation Trust and has made good progress this year. In January 2012, the Trust was reviewed by Ernst & Young. The feedback was again very positive and the Strategic Health Authority passed the Trust's application to the DH. The Trust is now working through the points raised by the DH's Technical Committee before the application is progressed to the DH's Application Committee and Monitor, the independent regulator (similar to Ofsted for Education). Following an extensive sixteen week assessment, the Trust is confident the process will be completed during 2012/13.

FT status means the Trust has members whose views contribute to its future plans – tailoring local services to local needs. The Trust currently has over 6,600 public members (not including members of staff). This is obviously great news, but the Trust needs as many members as possible to support its hospitals and the application to become a Foundation Trust. If you would like to become a Member or find out more about becoming a Governor, please contact the Foundation Trust Office on WGH 01923 436280 or email Foundation.Trust@whht.nhs.uk.

The Trust has begun the process of forming a Council of Governors, to be ready to take its place once it becomes a Foundation Trust. Governors are democratically elected from the membership, and sit on a Council of Governors. There will be twenty-six Governors in total, fifteen public, six stakeholders and five staff Governors.

The Trust held a number of Governor Awareness Sessions this year to explain the role of a Governor to members and these will continue with an expectation to begin the election process in 2012/13.

Objective 6:

Work in active partnership

Key Points
• Close working relationship with primary care
• Working in partnership with Unions
• Plans for the Watford Health Campus move forward
• Building community relationships
• Support of local businesses

Primary Care Liaison

The Trust has continued to work closely with GPs this year and, more latterly with the emerging Clinical Commissioning Groups. The Trust attends regular bi-monthly meetings of the Clinical Partnerships Board comprising of Chairs of the GP localities, Trust Executives and lead clinicians. In addition, meetings are held regularly throughout the year with Practice Managers where specific operational issues are discussed and resolved. The Trust's Pathology service has also set up a bi-monthly liaison meeting with primary care to resolve issues following the introduction of a new Pathology computer system. A survey will be undertaken of all GP practices in west Hertfordshire during April and May 2012 to form the basis for prioritising future liaison efforts.

Working with Unions

The Trust views working in partnership with the Unions as a fundamental principle underpinning the implementation of its workforce strategy. The Trust believes it has an effective and constructive relationship with Staff-side and the Unions. The Trust meets on a regular basis with Union representatives, engages on the design of future services and updates of policies and procedures.

Watford Health Campus

Plans for the Watford Health Campus moved forward significantly in 2011/12. The Trust was allocated £7million by the Department of Health to support the construction of a new road to Watford General. This road will radically improve access from the M1 and avoid the town centre. Furthermore, the project was awarded a additional £6million of funding from the Hertfordshire Local Enterprise Partnership (LEP) Growing Places Fund to support improvements in the access to the Campus site.

The Croxley Rail Link was also approved by the Government in December 2011. Although the rail link is not part of the Health Campus, it would compliment the Campus as it would allow staff, patients and visitors to travel to and from the Campus without the need for a car. The rail link will divert the Metropolitan Line to Watford Junction, via intermediate stations using a reopened section of track. Construction work on the rail link is expected to start in June 2014 with a view to being completed by January 2016.

An intensive and thorough procurement process has progressed, with the Campus team, including this Trust, Watford Borough Council and Watford Football Club, working with the potential private sector partners to build understanding and confidence in the submitted proposals.

Local apprentice scheme for young people

The Trust welcomed an initial cohort of six young students in 2011/12 on a new Estates Apprentice scheme, designed to develop active working skills whilst still in education. Undertaking work across all of the Trust sites, the group split their time between their work at the Trust and studying at West Herts College in a range of electrical, mechanical and building disciplines.

Community relationships

The last year has seen the Trust working in partnership with other NHS organisations and statutory agencies to improve the services and experiences of people from a wide range of community interest

groups. These groups included hard to reach and seldom heard groups, such as lesbian, gay, bi-sexual, transgender and gypsy and travellers.

One particular engagement event which proved particularly successful this year was a Muskaan Pakistani Women's Group workshop. The workshop, organised through the EACH (Embedding Ambassadors in Community Health) project invited frontline staff to gain a better understanding of the culture and religion of the group. Staff found the experience extremely valuable and, through listening to the personal stories, have developed care which fits with personal.

Working with the National Childbirth Trust

Maternity Services have developed a new, valuable partnership this year with voluntary support workers from the National Childbirth Trust (NCT), with the aim of providing additional support to new mothers in the development of essential breastfeeding skills. As part of the Primary Care Trust's Health Promotion Programme, NCT support workers provide regular breastfeeding support to women under the supervision of Trust-employed midwives. A pilot scheme proved very successful during 2011/12 and the Trust hopes to continue this partnership in the future.

Support of local businesses

Over the past year, the Trust has been overwhelmed by the time, support and sheer generosity it has received from local businesses. This has made a real impact on the lives of our patients. Some of the generous donations are listed below:

- The children on the Safari Day Unit, Starfish Ward and Children's Emergency Department at Watford were delighted to receive over 200 Easter eggs which had been collected from local business by the staff of the Watford branch of Office Angels.
- A 'Music in Hospitals' charity, supported by the Harlequin Shopping Centre, visited a number of wards at Watford to brighten up the day for patients. The charity produces concerts by an array of professional musicians from all genres and cultural backgrounds for hospital wards and healthcare settings.
- The Watford branch of the Hilton hotel chain organised a Christmas party for the children of Starfish ward. The Hilton staff also raised additional money which was used to buy presents for the children on the ward who were too ill to attend the party.

Working with the police

Police officers from West Hertfordshire Police Force teamed up with the Trust's Local Security Management Specialist (LSMS) to hold a 'Police Surgery' at Hemel Hempstead Hospital this year. This was an opportunity for local people to talk and get to know their local neighbourhood officers. Officers were available for patients, visitors and staff to have an informal chat and discuss some of the issues they have - whether at work or at home.

Keeping people healthy

The Trust continues to be committed to supporting the Public Health agenda. During the last year health awareness events of particular interest included:

- Bowel Cancer Awareness Month (April 2011)
- Hertfordshire Alcohol Awareness Month (June 2011)
- No Smoking Day (14 March 2012)

Objective 7:

Attract, retain and motivate an appropriately trained workforce

Key Points
• Staff continue to demonstrate their skills and professionalism
• Significant improvement in staff survey
• New People's strategy launched
• New uniforms for nursing and midwifery staff
• Staff Awards for Excellence

During 2011/12 staff have continued to respond well to the particular challenges facing the Trust, which included financial and emergency activity pressures. The Trust held a further 'Thank You' week in May 2011 to acknowledge the great efforts made by staff and this was very well received by staff.

Staff Survey

The Trust's results from the National Staff Survey carried out in the autumn of 2011 showed significant improvements in the vast majority of the 38 indicators compared to last year's survey. The Trust had improved in 33 of the 38 indicators.

These results demonstrate a significant overall improvement in morale within the Trust. Of particular interest is the 'overall staff engagement indicator' which increased dramatically. This indicator is put together by the Department of Health and is calculated by combining questions from the three following indicators:

- Staff reporting that they believe they can contribute to improvements at work which moved from being in the lowest 20% to above average,
- Staff recommending the Trust as a place to work or be treated which moved from worst 20% to just below average,
- Staff reporting motivation at work from below average to above average.

Following last year's survey an action plan was developed by the Human Resources Department in partnership with Staff side representatives and incorporated feedback from a wide cross section of staff across the organisation. The Director of Workforce presented the results from last year's survey to over 200 staff at around 20 departmental and team meetings. At these events staff were asked for their views and ideas on how the Trust could address the issues raised by the survey.

Engaging with staff

Over the last year, the Trust's Leadership Academy has hosted engagement programmes with staff working with the Outpatients departments, Pharmacy and the Acute Admissions Unit. The success of these programmes has been evidenced by the Trust receiving two awards:

- Overall Winner and Category Winner, Healthcare People Management Association for excellence in organisational development; Developing Outpatient Services 2011,
- Health Service Journal finalist for Staff Engagement, 2011.

The Trust will build upon the success of its staff engagement programmes and extend these to other services in the forthcoming year. The Trust has a well-established, comprehensive health and wellbeing programme for staff, which includes activities such as fitness classes and lunchtime health awareness sessions. In September 2011, the Trust launched a redesigned health and wellbeing programme called 'Balance4Life', which will continue to be developed throughout 2012/13.

Appraisal

A major drive has taken place over the last year to increase staff appraisals and the Trust's record now shows that 93% of its staff have had an appraisal over the last year.

Recognising staff

Many of the actions initiated across the Trust during the reporting year have been aimed at recognising staff and making them feel

more valued. Simple actions such as giving thank you letters and gifts to staff and teams who have been praised by patients have been particularly well received and will continue alongside the well established monthly and yearly staff awards in 2012/13.

Developing our staff

The Leadership Academy continues to deliver high quality leadership programmes, accredited by the University of Hertfordshire up to Masters Level. Around sixty staff drawn from many disciplines are participating in the Trust's Senior Leaders' and Middle Managers' development programmes. The Trust has also increased the number of staff who have trained to become accredited coaches offering better access across local coaching networks.

A new people strategy was launched this year which aims to develop the organisation and workforce to provide high quality, effective and responsive services, enhancing staff and patient experience.

The Trust has reviewed its Human Resources Department in order to ensure appropriate support for the implementation of the People Strategy. Staff are working together in new ways to support a range of projects and new initiatives.

Changes to uniforms

Nurses and midwives in the Trust wear many different colours of uniforms which often cause confusion for both patients and staff. The uniforms are not always comfortable or practical for staff working in hot and busy environments and do not portray the smart and professional. Therefore, a new 'smart scrubs' uniform was introduced in the Emergency Department, Minor Injuries and Urgent Care Centre this year. The remainder of the nursing and midwifery workforce have been consulted on the changes to uniforms and the new uniforms will be rolled out across the Trust over the forthcoming year.

Celebrating our wonderful staff

The Trust held its annual award ceremony in early December 2011 to thank and recognise staff who were nominated in the Going for Gold Awards for Staff Excellence and also staff who had achieved 15 years or more continuous service with the Trust. Actor Adam Astill, of BBC One's 'Holby City', was guest of honour at the awards ceremony.

During 2011, the Trust received hundreds of nominations from grateful patients and colleagues, which were short listed by an external panel of judges to find the ultimate winners in five categories:

- Exceptional Patient Care/Service Award,
- Unsung Hero of the Year,
- Volunteer of the Year,
- Employee of the Year,
- Team of the Year.

Changes to temporary staffing

The Trust has signed an agreement with NHS Professionals to manage its temporary staffing bank. NHS Professionals are run by the Department of Health and are one of the largest providers of managed flexible workforce services to the NHS. The Trust is confident that this new arrangement will improve the management of temporary staffing in the Trust and ensure resources are managed efficiently and effectively.

Annual Governance Statement

Organisation Code

1. Scope of responsibility

The Board of Directors (the Board) is accountable for internal control. As Accountable Officer and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. I also have responsibility for safeguarding public funds and the organisation's assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Accountable Officer Memorandum.

As Accountable Officer, I have put in place arrangements to review the individual objectives of the Executive Directors through both one to one sessions and appropriate meetings with the Executive Director Team, such as the Delivery Support Group, which meets bi-weekly. This enables me to review progress against the key strategic objectives and to hold Directors to account. These processes also enable the team to develop and strengthen its dual operational focus of delivery and implementation across the organisation.

I have overall accountability for risk management in the Trust. The control of risk is embedded into the roles of the Executive Directors, and specifically for clinical risks, the Medical Director, who leads on clinical risk and, for operational risks, the Chief Operating Officer, given his prime responsibility for the delivery of operational services.

2. The Governance Framework of the Organisation

The Board has delegated oversight of certain activities to its Board Sub-committees:

The Audit Committee provides assurance to the Board on the maintenance of the system of internal control. The Committee comprises of three Non-Executive Directors and is attended by the Director of Finance, Director of Patient Safety, the Medical Director, the Associate Director of Clinical Governance and Risk, who is also the Company Secretary. Representatives of internal audit (including the Local Counter Fraud Officer) and external audit are also in attendance. I attend meetings as required. The Chair of the Audit Committee is a qualified accountant.

The role of the Integrated Risk and Governance Committee is to promote integrated risk management as intrinsic to all of the organisation's activities and specifically to promote local level responsibility and accountability for identifying and managing risks. The Committee reviews the Board Assurance Framework, the Trust's high level risk register, as well as the corporate risk register and, via the Integrated Standards Executive meetings (including Divisional meetings), the divisional risk registers. The risk registers support the achievement of a high level of internal control by providing tools that facilitate the management of risks to patient safety, clinical quality, efficient operational delivery and inform risk based decision making. The Committee works closely with the Trust's Audit Committee to ensure there are no significant overlaps or gaps between their respective remits. The Chair of the Committee is a non-executive Director with a background in Risk Management and the Deputy Chair is also the Chair of the Audit Committee.

Membership includes executive directors, including the Director of Patient Safety, the Medical Director, the Director of Nursing, Clinical Directors and the Associate Director of Clinical Governance and Risk who is also the Company Secretary. I am also a member of the Committee.

The Remuneration Committee advises the Trust Board on the appropriate levels of remuneration and terms of employment for the Chief Executive and other Very Senior Managers and Executive Directors of the Trust. The CEO and Director of Workforce attend for all items except those that concern them personally. The Trust Chair and three non-executive directors are members of this Committee. The Committee also advises the Board on any termination settlements for the CEO or Directors or other very senior managers following all appropriate processes as set out in relevant guidance from the DH, SHA and other government departments. The Committee, on behalf of the Trust Board, approves the recommendations of the Clinical Excellence Awards Committees in relation to:

- Consultants
- Associate Specialists
- Staff Grades

The Finance Committee maintains an oversight of and receives assurances about the robustness of the Trust's financial management systems. The Committee is chaired by a Non-Executive director, and includes two other non-executive directors as members. The Chief Executive attends as required.

In 2011 the Trust established a Strategy sub-committee of the Board. Chaired by a Non Executive Director, membership includes one further Non Executive Director, the Chief Executive, Director of Strategy and the Director of Nursing. Other Directors may be co-opted as necessary.

The Charitable Funds Committee ensures there are robust processes in place to manage funds donated to the Trust for the benefit of the hospital and patients. The Committee monitors the disposition of funds held on Trust to ensure they are utilised in a way that takes into account any stipulations set out by donors and ensures best value is obtained from the funds donated. The Committee is chaired by a Non-Executive Director and includes a further non-executive director and the Director of Finance in its membership.

With effect from March 2012, the Chairs of the Board sub-committees are required to provide a written report to the Board following the meeting of the sub-committee.

The Board has conducted a review of its performance using the Board Governance Memorandum developed by the Department of Health, as part of the Board Governance Assurance Framework review facilitated externally. The self assessment has informed the 2012/13 Board Development Programme.

The Board can report a successful year in the achievement of the Trust's key objectives for 2011/12:

Achieving our planned surplus: After adjustment for delay in loan re-scheduling agreed with the SHA the Trust achieved the revised figure of £3.6m

Foundation Trust status: During 2010/11 the Trust's application was delayed pending a response to a proposal for loan rescheduling. The position changed in mid-year when the Department of Health (DH) indicated loan re-scheduling would be agreed at the point of authorization. The Trust signed a Tri-partite Formal Agreement (TFA) with the SHA and the DH on projected progress in September 2011. The Trust met the milestones as set out in the TFA culminating in a submission to the Technical Committee in April 2012.

Quality and Safety: NHSLA level 2 was successfully achieved last summer and The Trust awaits confirmation of full compliance with CQC requirements following the progress report to CQC about a minor concern in relation to Outcome 14.

Dealing with emergency pressures: The greatest operational challenge has been to respond to increasing numbers of patients attending for emergency care (an increase of c.15%). The Trust created additional bed capacity and achieved the 4–hour wait target in A&E.

Patient experience: The results from the latest 2011 outpatient survey show a dramatic improvement on 2009, when the last national survey took place. The 2011 in-patient survey results also show a major improvement on 2010. Against the measures used by the SHA, the Trust is the most improved in the East of England.

Contract with our Commissioners: The in-year management of the PCT contract was constructive and informed a mutually satisfactory contract for 2012/13.

Appraisals and training: We have continued to make good progress in increasing appraisal and mandatory training levels. We have achieved the 90% target set for appraisals and seen significant improvement in mandatory training, achieving close to the 80% target set.

3. Risk Assessment

Risk assessment is undertaken in line with the Trust's Risk Management Policy which sets out clear guidance on how risks should be identified, treated and managed. The process of risk assessment requires completion of the template, local review and escalation to the relevant divisional management team to agree the score and approve the mitigations to be implemented to ensure the risk is managed.

3.1 Risk escalated to the Board Assurance Framework (BAF) during 2011/12:

Risk to maintaining delivery of high quality maternity services and Risks related to maternity staffing and failure to achieve 1:30 ratio for midwives.

This risk reflected a number of factors that increased risk to delivery of high quality services. The factors were: a sustained increase in admissions, a shortage of supervisors of midwives and challenges in achieving cost reduction and required increases in midwifery ratios. The Trust introduced additional capacity in year, has increased its ratio of midwives with a commitment to achieving 1:30 by December 2012 and has successfully recruited to senior midwifery vacancies. In addition, following an in year review of maternity theatres, management responsibility has been transferred to Surgery, to achieve consistency in securing Association for Perioperative Practice (AfPP) standards for all theatres.

Risk to status of Trust as provider of postgraduate medical education.

This followed concerns raised during a visit by the East of England Deanery in June and October 2011 relating to insufficient supervision of junior doctors in A&E overnight. The Trust has now put in place sufficient middle grade support for junior doctors during the midnight to 8 am shift in A&E and undertaken a number of improvement actions to enhance the learning experiences of junior doctors at the Trust.

Risk of exceeding monthly Healthcare Associated Infections (HCAI) targets will impact on Governance rating and lack of confidence in effectiveness of HCAI controls.

This related to the achievement of monthly targets however the Trust completed the year with 1 reported MRSA (target 4) and 17 Clostridium Difficiles (target 33).

Risks relating to poor functionality of DATIX risk and incident system.

This risk is linked to underlying issues with the Trust's IT infrastructure and potential interruption of services due to ageing IT infrastructure. The Trust has commissioned an external review to refresh its IT strategy and prioritise investment needed.

Risk from sustained high levels of emergency demand, including admissions.

The Board agreed to invest in the creation of additional bed capacity and in late 2011 a Clinical Decision Unit and a surge unit were opened. Trends have been analysed to inform a Business Case to expand capacity further as well as to inform PCT led work in the community and with social services.

3.2: Existing BAF risks have been closely monitored to ensure controls and mitigating actions provide the Board with assurance that the risks, despite being high, are being managed.

3.3: The Trust is implementing a sustained programme of improvement based on prioritized risks relating to the organisation's estate. A report commissioned by the Trust in 2011 identified areas of non-compliance for which a comprehensive set of action plans are in place.

3.4: Financial risks remain but the 2011/12 outturn shows that the Trust achieved the planned surplus of £3.6m with an I&E surplus margin ratio of 1.4%, achieving an overall financial risk rating (FRR) of 3. The Trust's Cost Improvement Programme (CIP) yielded £13.4m of savings.

3.5: The Trust reported two lapses of data security in year, one related to a lapse that occurred as a result of a member of staff inadvertently emailing to unintended persons a personal identifiable communication and the second the loss of personal identifiable information relating to the recruitment of a volunteer. Both were investigated robustly and remedial actions taken to prevent recurrence. Both were caused by individual failures to follow Trust policies. Neither required reporting to the Information Commissioner.

4. The Risk and Control Framework

The Trust considers the management and handling of risk as integral to the internal control process, and to the effective delivery of its services. The Trust's Risk Management Strategy sets out the accountabilities and responsibilities for managing risk. Ultimate accountability for risk management rests with the Chief Executive but is delegated through the executive portfolio bringing together the corporate, financial, workforce, clinical, information and governance risk agendas.

The processes of risk management apply to operational and strategic issues including service planning and commissioning, performance management, research, education and clinical services, workforce and estates services. Issues arising from such work are fed into the Trust's risk capture process (process of risk identification, assessment and treatment as described in the Trust's Risk Management Strategy) and are subject to risk action plans if the risk is graded sufficiently highly on the risk grading matrix.

The Trust continues to build upon the Board Assurance Framework (BAF), the high level risk register. Once the objectives for the Trust are agreed, the principal risks to achieving them are identified, risk assessed and captured on the BAF. The Board Assurance Framework is subject to an Executive Director led review process which is considered at each meeting of the Board that provides assurance as to the effectiveness of the controls in place to manage the risk.

Underpinning the Board Assurance Framework are the corporate and divisional risk registers and risk processes which are overseen through the Integrated Standards Executive meetings and monitored by the Integrated Risk and Governance Sub Committee (IRaGC) a sub-committee of the Board, chaired by a Non Executive Director.

This enables clinical risk and corporate risk issues to be brought together and reviewed within an integrated approach to risk management.

The Integrated Risk and Governance Committee is closely allied to the Clinical Quality Advisory Committee, the executive led committee focusing on clinical quality – with common membership and co-located meetings.

Board members receive training in risk management and an overview of the risk systems on an annual basis, as do the Trust's senior managers. All staff receive training in identification and reporting of risk on induction and through annual updating sessions. The Trust's approach is to promote the benefits of proactive rather than reactive risk management and to strengthen the processes of reviewing and further strengthening of controls as necessary, through robust action plans.

In June 2011 the Trust was assessed against general standards at Level 2 of the National Health Service Litigation Authority's Risk Management Standards and achieved a score of at least 7 out of 10 in each of the 5 domains and a total score of 41 out of 50 standards compliance, resulting in a Level 2 accreditation. The Trust initiated an action plan to address issues that impacted on compliance in 9 standards.

The Trust assesses compliance with Care Quality Commission (CQC) outcomes for safety and quality within a defined assurance system, set out in the CQC Assurance Policy. This is structured around executive lead accountability for each standard, a nominated standard lead and a responsible committee. The Trust Board receives reports on compliance at regular intervals –assessing against the CQC's Quality and Risk profiles and providing assurance about actions under way to maintain and further enhance compliance. The NHSLA assessment preparation involved linking NHSLA standards to relevant CQC outcomes and this integration is an ongoing feature of maintaining and assuring compliance.

Following an unannounced inspection of A&E in December, the Trust was deemed to have 'minor concerns' on the Watford site with Outcome 14, supporting workers. This related to a concern that the plans in place to improve middle grade support for junior doctors were not sustainable. The inspection found the Trust was compliant with Outcome 16 (assessing the quality of service provision and Outcome 9, Management of Medicines.

The Trust submitted a progress report on its action plan to CQC at the end of March demonstrating full compliance with Outcome 14 and awaits confirmation from the CQC that they accept this.

On 21 March 2012 the Trust's termination of pregnancy service was subject to an unannounced inspection by CQC as part of a nationwide review commissioned by the Secretary of State for Health. The Trust has received a report confirming that the Trust was found to be compliant with Outcome 21, that people's personal records, including medical records, are accurate and kept safe and confidential.

The Trust's processes for maintaining assurance of compliance with CQC outcomes was subject to an internal audit which concluded the Trust had adequate controls in place but highlighted further work was required to ensure consistent application of the assurance framework for CQC compliance – this is being addressed.

In 2011/12 the Trust reviewed its management of risks associated with the capital programme to ensure investment priorities are closely aligned to stratified risks and the system revised to strengthen controls.

The Trust's cost improvement programme (CIP) 2011/12 was reviewed and a revised governance structure put in place for

2012/13 to strengthen assurances relating to risks to quality of care from proposed savings plans. Progress will be scrutinized via the Finance Committee. Where clinical or patient safety risks are an issue they will be escalated to the Integrated Risk and Governance Committee to review mitigations planned and this will be reported to the Board via the relevant committee report.

The Audit Committee oversees and monitors the performance of the risk management system. Internal Audit (RSM Tenon) and External Audit (Grant Thornton) work closely with the committee. An annual programme of internal and external audit is in place to support the system of risk and control. Clinical assurance has been strengthened through regular updates on the Clinical Audit programme.

5. Risks to Clinical Quality and Patient Safety

Risks are identified and assessed in accordance with the processes set out in the Risk Management Strategy. Patient safety incidents are recorded on a bespoke database and the Trust undertakes regular surveillance of incidents, complaints and litigation claims to ensure understanding of causation and impact which in turn informs remedial actions for implementation. The Trust uploads all clinical incidents onto the National Reporting and Learning System (NRLS) and reporting trends are benchmarked against peers.

Serious Incidents are subject to a rigorous process of investigation and scrutiny and improvement actions are monitored for implementation. All serious incidents are reported to the commissioning PCT in accordance with the Trust's obligations under the Acute Contract. The Trust also operates a system of robust investigation and learning for 'significant incidents' which may not fulfil the criteria for reporting externally (such as a 'near miss') but may signal issues related to processes or task/environmental factors that need to be robustly addressed in a timely manner.

The Board receives a summary of all serious incidents at each meeting and a report on learning from incidents, complaints, litigation and PALS referrals is presented to the Board annually (in addition to summary quarterly reports to Board).

Processes for auditing and monitoring clinical activity are in place in all the clinical divisions. Clinical processes are updated when national guidance is published or in response to adverse events. Guidance is also updated when national safety notices are issued via the Central Alerting System (CAS) and all are monitored closely via the Divisional Integrated Standards Executive, an executive led group that reports by exception to the Integrated Risk and Governance Committee. The Trust maintained an alert closure rate of 67% within deadline in 2011/12. There are currently no alerts outstanding beyond their closure date.

Standard Clinical Data sets have been established and are reviewed via the CHKS database by clinical divisions to provide assurance on clinical outcomes and to identify any emerging risks that warrant further investigation and action. The Medical Director receives ongoing notification of unexpected complications and all deaths and issues are escalated if appropriate via the Trust's reporting processes.

The Trust undertakes case note review using the Global Trigger Tool (GTT) methodology to identify specific harms. Trends are reported annually to the Clinical Quality Advisory Committee, an executive led Committee chaired by the Medical Director reporting by exception to the Integrated Risk and Governance Committee.

The Trust reported 3 never events during 2011/12, all relating to retained material following maternity procedures. This triggered a high level review of maternity theatre practice which has resulted in significant changes in clinical processes to meet the Association for Perioperative Practice (AfPP) guidelines.

Following publication of an extended list of Never Events in April 2011, the Trust developed a bespoke Never Events Gap Analysis tool

designed to ensure that appropriate processes are in place and also to identify potential gaps in evidence based processes designed to ensure such events do not occur.

The Trust's Clinical Audit Strategy commits the Trust to ensure that the clinical audit forward plan is based on prioritized clinical risk areas and to secure the fullest participation in national clinical audits.

6. Internal Audit

The results of Internal Audit reviews are reported to the Audit Committee which ensures that action plans are implemented on a 'comply or explain' basis. An internal audit action recommendation tracking system is in place which records progress in completing recommendations. The Audit Committee Chair provides a report to the Board at each meeting.

7. Counter Fraud activities

The Trust's counter fraud programme is also monitored by the Audit Committee. The Committee receives regular reports on progress in reducing the risk of fraud and the effectiveness of controls in place to do so.

8. Information Governance (IG)

The Trust has an Information Governance Group (IGG) which is chaired by the Director for Partnerships who is also the Trust's Senior Information Risk Owner. This group includes the Caldicott Guardian, the Trust's Medical Director, and senior management and representatives from across the organisation. The IGG reports to the Integrated Risk and Governance Committee.

The Trust's Information Risk Management Framework is integrated with the Trust's broader risk management arrangements. This includes a documented Information Risk Management Policy, the appointment of a Senior Information Risk Officer (SIRO), Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) and a comprehensive Information Asset Register. All Information Assets of the Trust are assessed annually to ensure all threats, vulnerabilities and impacts are properly assessed and included within the Trust-wide risk register.

The IGG approves the Trust's annual Information Governance Toolkit (IGT) self assessment and monitors progress against the annual IG action plan. The Trust completes the IGT to demonstrate and provide assurance that all aspects of information risk management are appropriately managed. The IGT assessment is reviewed by the Trust's Internal Auditors for compliance. The Trust Board is regularly apprised of IGT compliance and risk.

One of the key priorities for this financial year will be to continue raising the IG training compliance figures in order to achieve level 2 in IG 2012.

9. Equality and Diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality Impact Assessments are carried out when reviewing policies and service changes. The Trust has published its commitment to its Public Sector Equality Duty (PSED). The Trust has published its Equality Delivery System grading together with objectives for 2012/13 in accordance with its PSED.

10. NHS Pension Scheme

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

11. Carbon Reduction and Sustainability

Risk assessments are undertaken and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

12. Performance Reporting

There are a number of controls in place to ensure the quality of the regular Board Performance Report. The key controls are:

- Corporate objectives for data quality are defined
- Data quality priorities are monitored
- Comprehensive guidance on data quality in the data capture policy
- Data quality reports are provided to divisions
- Director Lead delegated authority to support the performance management requirements
- Performance is monitored and reviewed at weekly performance meetings with the Divisions, chaired by the CEO and is reported to the Board
- Divisional Boards monitor and manage performance
- Clinical and quality data is reported to the Board and scrutinised and challenged at Board sub-Committees

External assurance statements on the Quality Account are provided by our local commissioners and the Local Involvement Network (LINks) as required by Quality Account Regulations.

External audit is undertaken by Grant Thornton as required and their report and findings on the 2011/12 Quality Report have been considered by the Audit Committee on behalf of the Board. The recommendations included in the report have been actioned and reassessed internally for their effective implementation.

The Audit Committee's terms of reference require it to review all risk and control related disclosure statements prior to endorsement by the Board, and the effectiveness of the management of principal risks, including risk review procedures and reports.

13. Stakeholder Engagement in Risk Management

In order to ensure that risk management is not seen only as an issue that needs to be addressed within the organisation alone the Trust continues to work collaboratively with both the Strategic Health Authority and the local Primary Care Trust (NHS Hertfordshire) in respect of the issues affecting the health economy locally and nationally. The following arrangements are in place:

- I have monthly 1:1 meetings with the CEO of Hertfordshire PCT and the Chair of Herts Valleys CCG;
- I attend meetings of Chief Executive Officers of Trusts, drawn from the East of England;
- I meet with the Chief Executive Officers and Chairs of Hertfordshire-wide Trusts on a regular basis;
- I meet as needed with the CEO and executive directors of the SHA;
- The Trust attends regular meetings with the SHA's Provider Development Team;
- I and other executives attend Health Economy planning meetings convened to achieve whole systems planning;
- Routine performance/contract monitoring/quality meetings with the PCT take place once a month to look specifically at the performance of the service level agreements (SLAs);
- Senior Trust staff meet regularly with locality groups of GPs and with GP practice managers to discuss matters of concern or common interest;
- Trust staff are actively engaged with GPs, Clinical Commissioning Groups and PCT staff in a series of service re-design projects which have emerged from the QIPP plan for Hertfordshire;

- We continue to develop relationships with Clinical Commissioning Groups notably via a bimonthly meeting between leading GPs and Trust consultants to discuss key clinical policy and practice issues.

The Trust continues to work with the Hertfordshire County Health Scrutiny Committee (HSC) and participated in the scrutiny meetings held during 2011/12.

The Trust has many established and effective arrangements for working with stakeholder communities, including patients and carers. The Trust engages with patients and public specifically through the Patient Advice and Liaison Service (PALS) and the Trust's Patient Experience and Involvement Committee.

The Trust continues to work with Local Involvement Networks (LINks) and is engaged with the newly emerging Healthwatch.

The Trust consulted with the HSC as well as the Local Involvement Networks on proposals for its Quality Account 2011/12 and received constructive feedback which will be reflected in the Account to be published in 2012/13.

During 2011/12 the Trust participated in joint working with Hertfordshire Partnership Foundation Trust to enhance liaison psychiatry services in its emergency department. It has close operational and policy links with the County Council Social Service department and Hertfordshire Community Trust principally to ensure speedy and appropriate discharge of patients requiring some form of post acute care.

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

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of West Hertfordshire Hospitals NHS Trust. The system ensures proactive evaluation of the likelihood of those risks being realised and the impact, should they be realised, in order to determine the most appropriate treatment of the risks and to ensure they are managed efficiently, effectively, economically and progress reviewed and reported in a timely manner.

The system of internal control has been in place West Hertfordshire Hospitals NHS Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

The system of internal control is founded upon having a number of individual controls in place; policies and procedures covering important business activities, how staff are appointed and managed, Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation together with the checks and balances inherent in internal and external audit reviews, Executive Board and Board of Director oversight.

15. Review of economy, efficiency and effectiveness of the use of resources

Finance and performance reports are presented to the Board. External Audit is required as part of its annual audit to be assured that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and report by exception if in their opinion the Trust has not done so.

16. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the

work of the internal auditors and Executives and managers within the Trust who have responsibility for the development and maintenance of the internal control framework and the Board Assurance Framework. I have drawn on the content of the Quality Account attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the internal auditors in their Head of Internal Audit Opinion and other reports, including those from sub-Committee Chairs.

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 and the Integrated Risk and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The assessment of compliance and the work of Internal Audit through the year, including advice and support on the development of the Board Assurance Framework, have provided assistance in the ongoing development and maintenance of robust controls. The results of External Audit's work on the Trust's Annual Accounts and the Quality Account are key assurances together with patient and staff surveys and the NHSLA Level 2 Risk Management Standards assessment.

The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through regular monitoring and discussion of performance reports in the areas of finance, activity, national targets, patient safety and quality and workforce. This enables the Executive and the Board to focus on key issues as they arise and address them.

The Head of Internal Audit Opinion has given significant assurance that based on their work undertaken during 2011/12 there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However some weaknesses in the design and inconsistent application of controls relating to 18 weeks targets were identified and have been addressed. The Trust achieved its target for treating patients within 18 weeks of referral. An audit of divisional risk management arrangements confirmed there were gaps in compliance with defined policies and procedures within one division but this was not represented across the wider Trust.

The Audit Committee has overseen the effectiveness of the Trust's risk management arrangements and internal control and has reviewed and acted upon a self assessment of its own role and effectiveness.

Conclusion

With the exception of the internal control issues outlined in this statement, my review confirms that West Hertfordshire Hospitals NHS Trust has a generally sound system of governance that supports the achievement of its policies, aims and objectives and that the control issues identified have been or are being addressed. There are no significant control issues.

Jan Filochowski
Chief Executive Officer
West Hertfordshire Hospitals NHS Trust
June 2012

Financial Review 2011/12

2011/12 is the fifth year in succession that the Trust delivered a surplus outturn. This is important both to ensure the Trust is a going concern and in meeting the breakeven duty detailed in note 33 of the accounts.

Year	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
In year surplus/(deficit)	£(11.4m)	£2.5m	£4.4m	£5.7m	£7.5m	£3.6m
Cumulative surplus/(deficit)	£(11.4m)	£(8.9m)	£(4.5m)	£1.2m	£8.7m	£12.3m

Financial Risk Matrix

Set out below is the Trust's performance for the year against the financial indicators developed by Monitor. The Board uses this each month, together with other information to ensure the Trust's finances are in order. An overall score of 3 is satisfactory.

Financial Risk

Criteria	Metric	Weight	5	4	3	2	1	Rating 2011/12
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	3
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	4
Financial effciency	Return on assets %	20%	6	5	3	2	<-2	5
Financial effciency	I&E surplus margin %	20%	3	2	1	-2	<-2	3
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	2
Overall rating	Overall rating							3

How the overall rating is calculated	Overall
One financial criterion scored at '1'	2
One financial criterion scored at '2'	3
Two or more financial criteria scored at '2'	2
Two or more financial criteria scored at '1'	1

The EBITDA margin is earnings before non operating costs compared with income as shown below.

EBITDA margin

	£m
Surplus	3.6
Depreciation	7.2
Dividend	3.3
Interest	1.2
EBITDA	15.3
Operating revenus and other income	266.7
EBITDA margin	5.6%

The Trust changed its financial plan in-year to take into account a delay in re-phasing of loans so scored 4 in respect to achievement of plan.

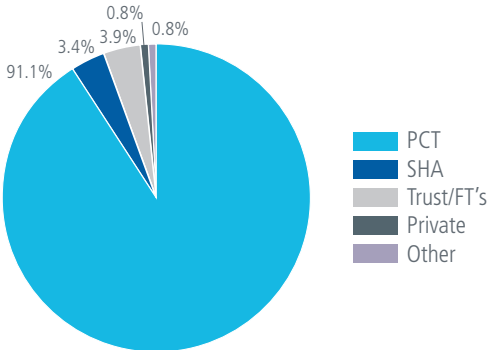
There are two elements to financial efficiency: Surplus adjusted for dividend as a percentage of assets employed adjusted for borrowings; here the Trust scores highly because of its heavily depreciated estate (see note 14 of the accounts). Secondly the level of surplus as a percentage of revenue, this is satisfactory.

Liquidity is a test as to how much lee-way the Trust has to meet its bills. The Trust's ratio remains poor from the deficits it made prior to

2007/08. Because the Trust's income is certain this is generally not critical but to improve things the Trust is planning on re-phasing its loans prior to becoming a FT. It is planned this will improve the level of cash as well as reduce the annual loan payments.

Trust source of income and details of costs

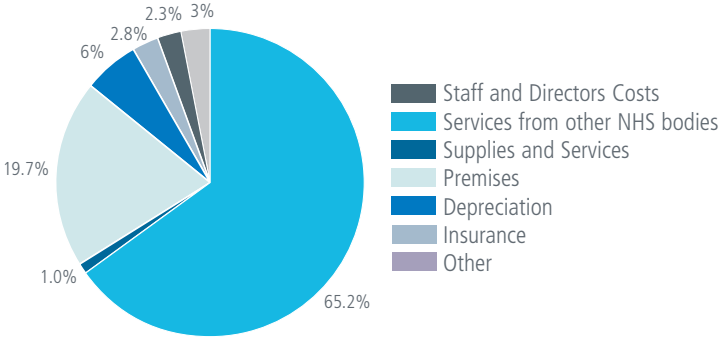
Sources of Income 2011/12



Most of the Trust's income comes from PCTs for commissioned NHS patient activity. Some of the funds from the Trust's main commissioner NHS Hertfordshire also relates to improving and enhancing services and operation of the estate. Funds from the SHA mainly relate to education and those from other Trusts/FTs are for services provided by the Trust. Private patient income including those from overseas and income from insurance companies for treatment related to insured accidents accounts for 0.8% of the Trust's income.

Just over 65% of Trust spending is on staffing and nearly 20% on supplies. Premises costs include energy, rates and the cost of facility services. Insurance is the Trust's contribution to the NHS Litigation Authority to cover clinical negligence and other third party liabilities. It also provides some insurance relating to Trust properties.

Where the money was spent in 2011/12



Financial Strategy – Looking Forward

The Finance Department continues to work closely with key stakeholders both within and outside of the Trust to deliver improved health to the population served by the Trust within the envelope of funds available. The Finance Department strives to support the Board in balancing the competing demands for resources of an aging estate and facilities, with treating as many patients as possible in the most appropriate and effective way. The five year forward look, used as part of the FT application process is continually being refreshed to take account of changes on the horizon including the government NHS reforms currently being implemented.

Conclusion

Financially 2011-12 was another tough year in which the Trust rose to the challenge meeting all of its financial duties as set out in note 33 of the accounts.

The accounts are dedicated to the memory of Eileen Kelly who sadly died towards the latter end of the year. Eileen had worked in the Finance department for twenty two years and was highly regarded in her role in keeping the capital finances, particularly the Trust's asset register in order. Eileen was an integral member of the accounts team, her "no problem too difficult approach" and professional manner will be greatly missed.

The role of the Non Executive Director

Non-Executive Directors are appointed by the NHS Appointments Commission on behalf of the Secretary of State to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.

The duties of non-executive directors are to:

- constructively challenge and contribute to the development of strategy;
- scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance;
- satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible;
- determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning; and
- ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

Non-executive directors also have a key role in a small number of permanent board committees such as the Audit Committee, Remuneration Committee and the Integrated Risk and Governance Committee.
For further information and details on the terms and conditions of appointment of a Non Executive Director, please to the www.audit-commission.gov.uk.

The Trust Board and its Sub Committees

The Trust Board is the body that discharges the responsibilities of the Trust. The Board has agreed systems of delegated responsibilities and governance systems to support it in this role. These delegated responsibilities are to individuals, formally identified groups (sub-committees and working parties) or external parties. The Sub-Committees of the Board, all of which are chaired by Non-Executive Directors, provide scrutiny of the key areas of Trust business and meet statutory requirements. Sub committees of the Board meet at regular intervals as agreed with each committee chairman.

The Trust held seven Trust Board meetings in public during 2011/12.

Membership (attendance in brackets)

- Thomas Hanahoe, Chair (100%)
- Katherine Charter, NED & Vice Chair (100%)
- Mahdi Hasan, NED (86%)
- Chris Green, NED (100%)
- Sarah Connor, NED (100%)
- Robin Douglas, NED (100%)
- Stuart Lacey, NED, left 30/11/11 (80%)
- Phil Townsend, NED, from 01/12/ 11 (100%)
- Jan Filochowski, Chief Executive (100%)
- Colin Johnston, Medical Director (86%)
- Natalie Forrest, Director of Nursing (100%)
- Anna Anderson, Director of Finance (100%)
- Nick Evans, Director for Partnerships, left 30/09/11 (100%)
- Chris Pocklington, Chief Operating Officer, from 29/03/12 (100%)

The Trust Board has established the following Sub-Committees:

- Audit
- Remuneration
- Finance
- Charitable Funds
- Integrated Risk & Governance Committee
- Strategy

In addition, the Trust will need to establish a Nominations Committee when it achieves Foundation Trust status.

Audit Committee

The aim of this committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that support the achievement of the organisation's objectives. The Trust held six Audit Committee Meetings during 2011/12.

Membership (attendance in brackets)

- Sarah Connor, NED Chair (100%)
- Mahdi Hassan, NED (83%)
- Stuart Lacey, NED, left 30/11/11 (100%)
- Phil Townsend, NED, from 01/11/11 (0%)

Remuneration Committee

The committee has formal and transparent procedures for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. The Remuneration Committee met once during 2011/12.

Membership (attendance in brackets)

- Katherine Charter NED (100%)
- Thomas Hanahoe NED Chair (100%)
- Sarah Connor NED (100%)

Charitable Funds Committee

The role of this committee is to ensure funds held on Trust/Charitable Funds are managed in accordance with the Trust's Standing Financial Instruction, as approved by the Trust Board. The Trust held three Charitable Funds Committee Meetings during 2011/12.

Membership (attendance in brackets)

- Katherine Charter, NED& Chair (100%)
- Robin Douglas, NED (100%)
- Stuart Lacey, NED, left 30/11/11 (100%)
- Anna Anderson, Director of Finance, from 29/03/12 (0%)

Finance Committee

The Finance committee maintain an oversight of, and receive assurances on the robustness of the Trust's key income sources and contractual safeguard. The Trust held six Finance Committee meetings during 2011/12.

Membership (attendance in brackets)

- Stuart Lacey, NED & Chair, left 30/11/11 (75%)
- Chris Green, NED & Chair, from 12/01/12 (100%)
- Sarah Connor NED (83%)
- Robin Douglas, NED (83%)
- Anna Anderson, Finance Director (100%)
- Jan Filochowski, Chief Executive (83%)
- Chris Pocklington, Chief Operating Officer (67%)

Integrated Risk & Governance Committee

The Integrated Risk and Governance Committee (IRaGC) promotes Integrated risk management, consistent with the Board's appetite for risk. The committee has delegated authority from the Board to investigate any activity within its terms of reference. It is also authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The Trust held six Integrated Risk and Governance Committee Meetings during 2011/12.

Membership (attendance in brackets)

- Mahdi Hasan, NED (Chair) (83%)
- Sarah Connor, NED (83%)
- Chris Green, NED (83%)
- Jan Filochowski, Chief Executive (67%)
- Colin Johnston, Medical Director (83%)
- Chris Pocklington, Chief Operating Officer (83%)
- Nick Evans, Director of Partnerships, left 30/09/11 (67%)
- Paul Jenkins, Director of Partnerships, from 01/03/12 (100%)
- Anna Anderson, Director of Finance (83%)
- Natalie Forrest, Director of Nursing (83%)
- Mark Vaughan, Director of Workforce (100%)
- Sarah Wiles, Director of Strategy, left 30/11/11 (50%)
- Louise Gaffney, Interim Director of Strategy, from 01/12/11 (100%)

Strategy Committee

The Trust established a new Strategy sub –committee in February 2012, which periodically reviews the Trust's long term strategy. One meeting of the committee was held during 2011/12.

Membership (attendance in brackets)

- Chris Green, NED Chair (100%)
- Mahdi Hassan, NED (100%)
- Jan Filochowski, Chief Executive (100%)
- Natalie Forrest, Director of Nursing (100%)
- Louise Gaffney, Interim Director of Strategy and Infrastructure (100%)
- Elizabeth Rippon, Director of Communications, from 01/12/11 (100%)

Declarations of Interest

It is a requirement that chairs and all board directors should declare any conflict of interest that arise in the course of conducting NHS business. All Board members are therefore expected to declare any personal or business interests that may influence or may be perceived to influence their judgement. The Register of Interest for the Trust at the end of 2011/12 is shown below.

Register of Interests (as at March 2011)

Name	Date Declaration Noted by the Board	Interest Declared
Professor Thomas Hanahoe	September 2011 November 2011	- Member of the University Court, University of Hertfordshire - Honorary Degree of Doctor of Science from the University of Hertfordshire
Robin Douglas	September 2011	- Chair of the Health and Social Care Advisory Service - Chair of The Who Cares? Trust - Associate of the Centre for Innovation in Health Management Leeds University - Independent consultant in public services via Douglas Consulting - Member Herts LINk
Chris Green	September 2011	- Non Executive Director of Dover Harbour Board
Mahdi Hasan	September 2011	- Member on the Patients Safety Council at Addenbrookes Hospital in Cambridge - Project Management Advisor, OMV gmbh, Austria - Volunteer Driver, West Hertfordshire Hospitals NHS Trust - Vice President Engineering and Projects, Gulfsands Petroleum plc - Project Management Advisor to Rocksource Gulf of Mexico Corporation
Katherine Charter	September 2011	- Teaching Assistant employed by Herts County Council
Sarah Connor	January 2012	- Employee of Calloway Group
Phil Townsend	May 2012	- Jointly employed by BT Openreach and BTID. Neither bid for external IT systems-based work with the NHS. If the Trust offered out an ITT or tender that BT PLC as the legal entity did bid on in any form, I would declare that interest at that time and excuse myself form the discussions and any decisions.

Directors Remuneration

			2011/12				2010/11			
Name	Title	In year start / leave dates	Salary (Bands of £5,000)	Other Remuneration (Bands of £5,000)	Bonus Payments (Bands of £5,000)	Benefits in Kind (£100)	Salary (Bands of £5,000)	Other Remuneration (Bands of £5,000)	Bonus Payments (Bands of £5,000)	Benefits in Kind (£100)
			£	£	£	£	£	£	£	£
T. Hanahoe	Chairman		20-25	0	0	0	25-30	0	0	0
J. Filochowski	Chief Executive		240-245	0	30-35	6	240-245	0	35-40	2
R. Douglas	Non-Executive Director		5-10	0	0	0	5-10	0	0	0
K. Charter	Non-Executive Director		5-10	0	0	0	5-10	0	0	0
M. Hasan	Non-Executive Director		5-10	0	0	0	5-10	0	0	0
S. Lacey	Non-Executive Director	Left post Nov '11	0-5	0	0	0	5-10	0	0	0
S. Connor	Non-Executive Director		5-10	0	0	0	5-10	0	0	0
C. Green	Non-Executive Director		5-10	0	0	0	0-5	0	0	0
P. Townsend	Non-Executive Director		0-5	0	0	0	0	0	0	0
A. Anderson	Director of Finance		115-120	0	15-20	0	115-120	0	0	0
N. Forrest	Director of Nursing		95-100	0	10-15	0	75-80	0	0	0
C. Pocklington	Director of Delivery		115-120	0	0	0	0	0	0	0
N. Evans	Director of Partnerships	Left post Sept '11	45-50	0	10-15	0	95-100	0	10-15	0
P. Jenkins	Director of Partnerships	Start March '12	5-10	0	0	0	0	0	0	0
M. Vaughan	Director of Workforce		95-100	0	0	0	20-25	0	0	0
S. Wiles	Director of Strategy & Infrastructure	Left post Jan '12	60-65	0	5-10	16	65-70	0	5-10	30
D. McNeil	Director of Corporate Affairs	Left post July '11	20-25	0	10-15	4	80-85	0	10-15	16
C. Johnston	Medical Director		135-140	55-60	20-25	0	125-130	55-60	5-10	0

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 banded remuneration of the highest paid director in the financial year 2011-12 was £277.5k. This was 9.5 times the median remuneration of the workforce, which was £29.3k. In 2011-12, no employee received remuneration in excess of the highest-paid director. Remuneration ranged for full time employees from pay banding £10k to £15k to pay banding £275-£280k. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions nor the additional cash equivalent transfer value of pensions.

Directors Pension Remuneration

	Real increase in pension at 60 (bands of £2,500)	Real increase in pension lump sum at ages 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012 £1000	Cash Equivalent Transfer Value at 31 March 2011 £1000	Real increase /decrease in Cash Equivalent Transfer Value £1000	Employer's contribution to stakeholder pension £100
J. Filochowski	see below*							
A. Anderson	5-7.5	17.5-20	55-60	165-170	1,257	1,049	175	0
N. Forrest	0-2.5	2.5-5	10-15	30-35	173	127	42	0
C. Pocklington	0-2.5	0-2.5	30-35	90-95	471	398	60	0
P. Jenkins	0-2.5	0-2.5	30-35	95-100	551	490	4	0
M. Vaughan	2.5-5	7.5-10	25-30	85-90	539	428	97	0
S. Wiles	0-2.5	2.5-5	10-15	40-45	211	149	45	0
C. Johnston	0-2.5	0-2.5	85-90	255-260	1,996	1,866	72	0
N. Evans	see below*							
D. McNeil	see below*							

*Where no Cash Equivalent Transfer Value (CETV) is shown the Director no longer has the ability to transfer their pension entitlement. Non-Executive members do not receive pensionable remuneration, therefore there are no entries in respect of pensions for these Directors. A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a paticular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme or chooses to transfer the benefits accrued in their former pension scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme,not just their service in a senior capacity to which the disclosure applies. 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 price base using common market valuation factors.

Auditor's report

Independent auditor's report to the Directors of West Hertfordshire Hospitals NHS Trust

We have audited the financial statements of West Hertfordshire Hospitals NHS Trust for the year ended 31 March 2012 under the Audit Commission Act 1998. 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 the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the Nation Health Service in England.

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

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

This report is made solely to the Board of Directors of West Hertfordshire Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of Directors and auditor

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

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 Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of West Hertfordshire Hospitals NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and auditor

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

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

We report if significant matters have come to our attention which prevent us from concluding that the Trust ha put in place proper managements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, not have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2011, as to whether the Trust has proper arrangements for:

- Securing financial resilience
- Challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for u 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 2012.

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

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit commission in October 2011, I am 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 resouces for the year ending 31 March 2012.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to provide assurance over the Trust's annual quality accounts. We are satisfied that this work does not have a material effect on the financial statements or on our value for money conclusion.

Paul Dossett
Senior Statutory Auditor
Senior Statutory Auditor for and on behalf of Grant Thornton UK LLP
Grant Thornton UK LLP
Address: Grant Thornton House Melton Street, London NW1 2EP
Date: 8 June 2012

Statement of comprehensive income for the year ended 31 March 2012

	NOTE	2011/12 £000	(restated) 2010/11 £000
Revenue			
Employee benefits	8	**(167,403)**	(162,375)
Other operating expenses	8	**(89,615)**	(91,928)
Revenue from patient care activities	4	**236,610**	232,705
Other operating revenue	5	**30,106**	27,600
Operating surplus		**9,698**	6,002
Investment revenue	12	**31**	25
Finance costs	13	**(1,326)**	(1,633)
Surplus/(deficit) for the financial year		**8,403**	4,394
Public dividend capital dividends payable		**(3,134)**	(3,135)
Retained surplus for the year		**5,269**	1,259
Other comprehensive income			
Impairments on revaluation of property, plant and equipment	14	**(725)**	(6,988)
Net gain on revaluation of property, plant and equipment	14	**1,601**	547
Total comprehensive income for the year		**6,145**	(5,182)
Financial performance for the year			
Retained surplus/(deficit) for the year		**5,269**	
Impairments		**(1,512)**	
Less Donations in excess of depreciation on donated assets		**100**	
Adjusted retained surplus		**3,657**	
PDC dividend: balance receivable at 31 March 2012		**189**	

The notes on pages 1 to 33 form part of this account.

Statement of financial position as at 31 March 2012

	NOTE	31 March 2012 £000	(restated) 31 March 2011 £000	(restated) 31 March 2010 £000
Non-current assets				
Property, plant and equipment	14	**121,895**	119,022	131,615
Intangible assets	15	**2,243**	3,327	3,325
Trade and other receivables	19	**1,187**	1,683	1,575
Total non-current assets		**125,325**	124,032	136,515
Current assets				
Inventories	18	**3,032**	3,542	3,530
Trade and other receivables	19	**9,378**	10,485	13,306
Cash and Cash equivalents	21	**9,851**	1,785	1,776
Total current assets		**22,261**	15,812	18,612
Non-current assets held for sale	22	0	0	260
Total current assets		**22,261**	15,812	18,872
Total assets		**147,586**	139,844	155,387
Current liabilities				
Trade and other payables	23	**(18,171)**	(16,991)	(20,780)
Provisions	27	**(541)**	(562)	(550)
Working capital loan from Department	24	**(1,400)**	(3,640)	(3,640)
Capital loan from Department	24	**(2,772)**	(2,772)	(2,772)
Total current liabilities		**(22,884)**	(23,965)	(27,742)
Non-current assets plus/less net current assets/liabilities		**124,702**	115,879	127,645
Non-current liabilities				
Provisions	27	**(5,280)**	(5,430)	(5,602)
Working capital loan from Department	24	**(2,800)**	(4,200)	(7,840)
Capital loan from Department	24	**(13,851)**	(16,623)	(19,395)
Total non-current liabilities		**(21,931)**	(26,253)	(32,837)
Total Assets Employed:		**102,771**	89,626	94,808
Financed by taxpayers' equity:				
Public dividend capital		**180,668**	173,668	173,668
Retained earnings		**(92,434)**	(97,719)	(99,405)
Revaluation reserve		**14,537**	13,677	20,545
Total taxpayers' equity		**102,771**	89,626	94,808

31 March 2011 and 31 March 2010 figures are restated to reflect the change in accounting policy relating to donated assets - see note 1.10. The financial statements on pages 1 to 33 were approved by the Board on 6 June and signed on its behalf by:

Jan Filochowski, Chief Executive
Date: 6 June 2012

Statement of changes in taxpayers' equity for the year ended 31 March 2012

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Total £000
Balance at 1 April 2011	173,668	(97,719)	13,677	**89,626**
Changes in taxpayers' equity for 2011/12				
Retained surplus/(deficit) for the year		5,269		**5,269**
Net gain on revaluation of property, plant and equipment			1,601	**1,601**
Net gain / (loss) on revaluation of assets held for sale			0	**0**
Movements in other reserves				**0**
Impairments on revaluation of property, plant and equipment			(725)	**(725)**
Transfers between reserves		16	(16)	**0**
Originating capital for Trust established in year	0			**0**
New PDC received	7,000			**7,000**
PDC repaid in year	0		860	**0**
PDC written off	0			**0**
Net recognised revenue/(expense) for the year	7,000	5,285	860	**13,145**
Balance at 31 March 2010	**180,668**	**(92,434)**	**14,537**	**102,771**
Included above:				
Transfer from revaluation reserve to retained earnings in respect of impairments		1,521	(1,512)	0
Balance at 1 April 2010	173,668	(99,233)	20,545	**94,980**
Changes in taxpayers' equity for 2010/11				
Retained surplus/(deficit) for the year		1,087		1,087
Net gain / (loss) on revaluation of property, plant, equipment			547	547
Impairments and reversals			(6,988)	(6,988)
Transfers between reserves		427	(427)	0
Net recognised revenue/(expense) for the year	0	1,514	(6,868)	(5,354)
Balance at 31 March 2011	**173,668**	**(97,719)**	**13,677**	**89,626**
Included above:				
Transfer from revaluation reserve to retained earnings in respect of impairments		6,159	(6,159)	0

Statement of cash flows for the year ended 31 March 2012

	2010/12 £000	(restated) 2009/11 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**9,698**	6,002
Depreciation and amortisation	**7,244**	6,921
Impairments and reversals	**(1,512)**	6,178
Donated assets received credited to revenue but non-cash	**(327)**	(134)
Interest paid	**(1,200)**	(1,500)
Dividends paid	**(3,323)**	(2,999)
(Increase)/decrease in inventories	**510**	(12)
(Increase)/decrease in trade and other receivables	**1,791**	2,578
(Increase)/decrease in trade and other payables	**2,346**	(2,876)
Provisions utilised	**(619)**	(620)
Increase/(decrease) in provisions	**308**	312
Net cash inflow/(outflow) from operating activities	**14,916**	13,850
Cash flows from investing activities		
Interest received	**32**	25
(Payments) for property, plant and equipment	**(7,276)**	(7,178)
(Payments) for intangible assets	**(194)**	(880)
Proceeds of disposal of assets held for sale (PPE)	**0**	604
Net cash inflow/(outflow) from investing activities	**(7,438)**	(7,429)
Net cash inflow/(outflow) before financing	**7,478**	6,421
Cash flows from financing activities		
Public dividend capital received	**7,000**	0
Loans repaid to DH - Capital investment loans repayment of principal	**(2,772)**	(2,772)
Loans repaid to DH - Working capital loans repayment of principal	**(3,640)**	(3,640)
Net cash inflow/(outflow) from Financing Activities	**588**	(6,412)
Net increase/(decrease) in cash and cash equivalents	**8,066**	9
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**1,785**	1,776
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**9,851**	1,785

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 NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011-12 NHS Trusts Manual for Accounts 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the 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 (see below) 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.

- The Trust has considered its position with regard to financial, operating and other associated risks and determined it is a going concern. These accounts have been prepared on this basis.
- 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 7.
- 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 Trust Board is corporate Trustee for West Hertfordshire NHS Trust charitable funds. Under IAS 27, this common control means that the charitable accounts should be consolidated. However, HM Treasury has granted a divergence from this requirement until March 2013 and the accounts have not therefore been consolidated.

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 basis of estimate are explained in the related notes. The only significant assumption made is the necessary level of provision for impairment of receivables as detailed in note 19.

1.4 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 the financial years on the basis of length of stay at the end of the reporting period compared to 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.

1.5 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.

1.6 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.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or

- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous 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.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

Until 31 March 2009, the depreciated replacement cost of specialised buildings had been estimated for an exact replacement of the asset in its present location. With effect from 1 April 2009, through its appointed valuers GVA Grimleys Ltd, the Trust has adopted the HM Treasury standard approach to depreciated replacement cost valuations based on modern equivalent assets. The effect of this change in estimation technique is detailed in note 14.5.

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 when they are brought into use.

Until 31 March 2009, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic 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.

1.8 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 £5000.

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 and 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
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

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

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

1.9 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 detail of each class of asset is shown in note 14.

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 not yet available for use are tested for impairment annually.

1.10 Donated assets

The Trust has amended its approach to accounting for donated assets in line with the accounting policy change in the Treasury FREM for 2011/12. 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 as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition. This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.11 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, which 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. With effect from 2011-12, at the point of reclassification sales value is assessed, and any loss in carrying value immediately recognised. Any subsequent gain or loss on sale is recognised as profit or loss.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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

1.12 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 7.

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.

1.13 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.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. 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 any such 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.

1.15 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 HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

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

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

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

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. 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 27.

1.17 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.

1.18 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.

1.19 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 derecognised when the contractual rights have expired or the asset has been transferred or paid.Financial assets are initially recognised at fair value.

1.20 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.

1.21 Value added tax

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.

1.22 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.

1.23 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 34 to the accounts.

1.24 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 public dividend capital dividend. 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 cash balances with the Government Banking Service. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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.

1.25 Losses and special payments

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 NHS Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.26 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 Operating Cost Statement 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.

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

The Treasury FReM does not require the Trust to apply the following Standards and Interpretations, most of which are subject to consultation, in 2011-12. The application of these would not have a material impact on these accounts were they to be applied:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
IAS 12 - Income Taxes (amendment) - subject to consultation
IAS 19 Post-employment benefits (pensions) - subject to consultation
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation

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 89% of the total, further analysis of which is shown in note 4. This is managed through contracts established with commissioners, mainly primary care trusts (PCTs), each contract covering the complete range of activities provided. The Trust's assets are used collectively to deliver the range of activities encompassed within PCT contracts.

3. Income generation activities

The income generation activities aim to achieve 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.

	2010/12 £000	2009/11 £000
Prescription Packaging Unit		
Income generation	1,351	1,552
Full cost	1,173	1,380
Surplus	178	172

The pill packing unit (PPAS) is a department that sells re-packed and patient ready packed medicines, multi component medical kits, and replenished cardio respiratory emergency boxes to NHS hospital pharmacies, PCTs GP out of hour services, and HM Prisons in addition to supplying the Trust itself.

PPAS operated throughout 2011-12.

4. Revenue from patient care activities

	2011/12 £000	2010/11 £000
Primary care trusts - tariff	161,508	162,142
Primary care trusts - non-tariff	41,072	40,180
Primary care trusts - market forces factor	27,580	27,947
Primary care trusts - transformation funds	4,206	0
Local authorities	122	249
Non-NHS:		
Private patients	1,392	1,155
Overseas patients (non-reciprocal)	108	137
Injury costs recovery	595	868
Other	27	27
	236,610	232,705

5. Other operating revenue

	2011/12 £000	2010/11 £000
Education, training and research	8,858	8,828
Charitable and other contributions to expenditure	38	96
Receipt of donations for capital acquisitions	327	134
Non-patient care services to other bodies	13,364	14,997
Income generation	2,612	3,051
Rental revenue from operating leases	509	494
Primary care trusts - transformation funds	4,198	0
Other revenue	200	0
	30,106	27,600
Total operating revenue	266,716	260,305

The Trust received £8.4m of transformation funds from its main commissioner NHS Hertfordshire. £4.2m relates to patient care activities relating to emergency activity over winter and patients requiring readmission. The remaining £4.2m relates to funds to keep the Trust's three hospitals operational and support initiatives to improve efficiciency.

Income generation includes the prescription packaging unit as detailed in note 3, car parking, use of the Trust's roofs for aerials and a few other minor health related services.

Other revenue in 2011/12 relates to the sale of printers and related consumables pending the implementation of a Trust wide print management service.

Revenue is almost entirely from the supply of services. Revenue from the sale of goods being immaterial.

6. Operating expenses

	2011/12 £000	2010/11 £000
Services from other NHS trusts	1,924	2,334
Services from other NHS bodies	163	135
Services from foundation trusts	557	0
Purchase of healthcare from non NHS bodies	277	430
Trust chair and non executive directors	64	64
Supplies and services - clinical	39,717	38,309
Supplies and services - general	9,089	8,457
Consultancy services	1,441	853
Establishment	2,776	2,995
Transport	2,434	2,378
Premises	12,723	12,090
Impairments and reversals of receivables - see ii) below	1,365	243
Inventories write down	23	0
Depreciation	6,371	6,016
Amortisation	873	905
Impairments and (reversals) of property, plant and equipment	(1,512)	6,178
Audit fees	174	175
Other auditor's remuneration	0	0
Clinical negligence	5,829	5,726
Education and Training	784	641
Other	4,543	4,171
	89,615	92,100

i) The purchase of healthcare from non-NHS bodies relates to the outsourcing of activity to meet waiting time targets.
ii) The Trust has increased its impairment of receivables in line with Strategic Health Authority guidance, reducing the Trust's exposure to debt over 3 months old.

Employee benefits		
Employee benefits excluding Board members	166,477	161,629
Board members	926	746
Total employee benefits	167,403	162,375
Total operating expenses	257,018	254,475

7. Operating leases

7.1 As lessee

Leases relate mainly to hire of medical equipment. Contracts are entered into using standard NHS conditions. These 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 to be used by the Trust for its intended purpose.
- Options for the Trust to extend the Lease period or return early on payment of amounts agreed by the Lessor.
- The equipment to be returned complete and in reasonable condition.

Payments recognised as an expense	2011/12 £000	2010/11 £000
Minimum lease payments	429	569
	429	569

Total future minimum lease payments	2011/12 £000	2010/11 £000
Payable:		
Not later than one year	279	358
Between one and five years	393	450
After 5 years	0	0
Total	672	808

7.2 As lessor

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

Rental Revenue	2011/12 £000	2010/11 £000
Total rental revenue	509	494
Receivable:		
Not later than one year	509	495
Between one and five years	2,545	2,473
After 5 years	615	580
Total	3,669	3,548

8. Employee benefits and staff numbers

8.1 Employee benefits

Employee Benefits 2011/12	Total £000	Permanently employed £000	Other £000
Salaries and wages	141,258	125,236	16,022
Social security costs	10,866	9,955	911
Employer contributions to NHS Pensions scheme	15,227	14,009	1,218
Termination benefits	280	280	0
Total Employee Benefits	167,631	149,480	18,151
Employee costs capitalised	228	228	0
Net Employee Benefits excluding capitalised costs	167,403	149,252	18,151

Employee Benefits 2010/11	Total £000	Permanently employed £000	Other £000
Salaries and wages	137,500	121,744	15,756
Social security costs	10,349	9,503	846
Employer contributions to NHS Pensions scheme	14,884	13,630	1,254
Termination benefits	81	81	0
Total employee benefits	162,814	144,958	17,856
Employee costs capitalised	439	439	0
Net Employee Benefits excluding capitalised costs	162,375	144,519	17,856

8.2 Staff Numbers

	2011/12			2010/11
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	543	509	35	528
Administration and estates	949	888	61	980
Healthcare assistants and other support staff	687	581	106	600
Nursing, midwifery and health visiting staff	1,227	1,082	146	1,206
Nursing, midwifery and health visiting learners	9	9	0	9
Scientific, therapeutic and technical staff	419	394	25	419
Social Care Staff	0	0	0	0
Other	33	31	1	32
TOTAL	3,867	3,493	374	3,774
Of the above - staff engaged on capital projects	4	4	0	8

8.3 Staff Sickness absence and ill health retirements

	2011/12 Number	2010/11 Number
Total calendar days lost	**24,760**	25,666
Total staff years employed (wte)	**3,465**	3,390
Average calendar days lost per staff year employed	**0.14**	0.13

8.4 Retirements due to ill-health

	2011/12 Number	2010/11 Number
Number of persons retired early on ill health grounds	**9**	8
	£000s	£000s
Total additional pensions liabilities accrued by NHS Business Authority	**504**	449

8.5 Exit Packages agreed in 2011/12

	2011/12			2010/11		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	**7**	**5**	**12**	1	0	1
£10,001-£25,000	**2**	**8**	**10**	1	1	2
£25,001-£50,000	**1**	**0**	**1**	0	0	0
£50,001-£100,000	**0**	**0**	**0**	1	0	1
Total number of exit packages by type	**10**	**13**	**23**	3	1	4
Total resource costs	**113**	**157**	**270**	69	12	81

This note shows the number and value of exit packages taken by staff leaving in the year. Exit costs are accounted for in full in the year of departure.

Redundancies have been paid in accordance with NHS agenda for change terms and conditions. Other departure costs have been paid in accordance with the Trust's voluntary resignation scheme. 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 and are not included in this note.

9. Pension cost

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

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004. Consequently a formal acturarial valuation was due 31 March 2008, however, formal valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently determined under the new scheme design.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant financial reporting interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions

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

Annual pensions

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

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

Pensions indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

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 statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Additional Voluntary Contributions (AVCs)

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

10. Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust approach is to measure payments 36 days from invoice payment due date. This allows for variation between invoice and goods received compared with invoice date.

10.1 Better Payment Practice Code - Measure of compliance

	2011/12		2010/11	
	Number	£000	Number	£000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	53,027	72,785	54,314	70,219
Total Non NHS trade invoices paid within target	45,419	57,362	45,319	57,498
Percentage of Non-NHS trade invoices paid within target	86%	79%	83%	82%
NHS Payables				
Total NHS trade invoices paid in the target	2,535	16,930	2,450	18,419
Total NHS trade invoices paid within target	2,223	15,180	2,010	14,475
Percentage of NHS trade invoices paid within target	88%	90%	82%	79%

11. Investment Income

	2011/12 £000	2010/11 £000
Bank interest	31	25

12. Other gains and losses

The Trust had no other gains or losses.

13. Finance Costs

	2011/12 £000	2010/11 £000
Interest		
Interest on loans with the Department of Health	1,186	1,485
Other finance costs relate to unwinding of discount in determining fair value of provisions.	140	128
Total	1,326	1,633

14. Property, plant and equipment

14.1 2011/12:

2011/12	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 31 March 2011- Note 14.3	29,364	82,532	1,379	4,153	29,564	176	10,612	4,687	**162,467**
Prior period adjustments (See below)	0	49,029	5,169	0	0	0	0	0	**54,198**
Adjusted cost or valuation at 1 April 2011	29,364	131,561	6,548	4,153	29,564	176	10,612	4,687	**216,665**
Additions purchased	0	1,931	0	3,429	742	0	7	249	**6,358**
Additions donated	0	0	0	0	327	0	0	0	**327**
Reclassifications	0	1,469	0	(3,360)	186	0	1,786	90	**171**
Disposals other than for sale	0	0	0	0	(929)	0	0	0	**(929)**
Upward revaluation/positive indexation	232	1,324	0	0	0	0	0	45	**1,601**
Impairments/negative indexation	0	(725)	0	0	0	0	0	0	**(725)**
Cumulative dep'n adjustment following revaluation	0	(54,650)	(5,699)	0	0	0	0	0	**(60,349)**
Adjusted cost or valuation at 31 March 2012	29,596	80,910	849	4,222	29,890	176	12,405	5,071	**163,119**
Depreciation as at 31 March 2011 - Note 14.3	0	11,764	698		19,776	144	8,271	2,792	**43,445**
Prior period adjustments	0	49,029	5,169		0	0	0	0	**54,198**
Depreciation at 1 April 2011	0	60,793	5,867		19,776	144	8,271	2,792	**97,643**
Disposals other than for sale	0	0	0		(929)	0	0	0	**(929)**
Impairments	0	2,627	0	0	0	0	0	0	**2,627**
Reversal of Impairments	(2,336)	(1,746)	(54)	0	0	0	0	(3)	**(4,139)**
Charged during the year	0	3,162	41		2,187	7	881	93	**6,371**
Cumulative dep'n adjustment following revaluation	0	(54,650)	(5,699)	0	0	0	0	0	**(60,349)**
Depreciation at 31 March 2012	(2,336)	10,186	155	0	21,034	151	9,152	2,882	**41,224**
Net book value at 31 March 2012	31,932	70,724	694	4,222	8,856	25	3,253	2,189	**121,895**
Purchased	31,932	70,587	694	4,222	8,119	25	3,252	2,188	**121,019**
Donated	0	137	0	0	737	0	1	1	**876**
Total at 31 March 2012	31,932	70,724	694	4,222	8,856	25	3,253	2,189	**121,895**
Asset financing:									
Owned	31,932	70,724	694	4,222	8,856	25	3,253	2,189	**121,895**
Total at 31 March 2012	31,932	70,724	694	4,222	8,856	25	3,253	2,189	**121,895**

14.2 Revaluation Reserve Balance for Property, Plant and 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	£000's	£000's	£000's	£000's	£000's
At 1 April 2011	5,800	7,321	0	0	556	0	0	0	13,677
Movements (see note 14.5)	232	645	0	0	(17)	0	0	0	860
At 31 March 2012	6,032	7,966	0	0	539	0	0	0	14,537

The prior period adjustment relating to buildings and dwellings, required of all Trusts in 2011/12, to support the national consolidation of NHS accounts shows their adjusted value prior to impairment. This has no impact om the SOCI or SOFP.

14.3 Property, plant and equipment

2010/11	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	29,364	81,806	2,160	6,469	30,020	196	9,579	4,812	**164,406**
Additions - purchased	0	1,522	0	3,712	539	31	475	0	**6,279**
Additions - donated	0	0	0	17	117	0	0	0	**134**
Reclassifications	0	5,850	(785)	(6,045)	375	0	558	20	**(27)**
Reclassified as held for sale	(34)	0	(88)	0	0	0	0	0	**(122)**
Disposals other than by sale	0	(215)	0	0	(1,487)	(51)	0	(9)	**(1,762)**
Revaluation & indexation gains	34	414	92	0	0	0	0	7	**547**
Impairments	0	(6,845)	0	0	0	0	0	(143)	**(6,988)**
Cost or valuation at 31 March 2011	29,364	82,532	1,379	4,153	29,564	176	10,612	4,687	**162,467**
Depreciation at 1 April 2010	0	3,100	366		18,923	193	7,522	2,687	**32,791**
Reclassifications		269	(269)		0	0	0	0	**0**
Disposals other than for sale	0	(2)	0		(1,487)	(51)	0	0	**(1,540)**
Impairments	0	5,621	530	0	0	0	0	27	**6,178**
Charged during the year	0	2,776	71		2,340	2	749	78	**6,016**
Depreciation at 31 March 2011	0	11,764	698	0	19,776	144	8,271	2,792	**43,445**
Net book value	29,364	70,768	681	4,153	9,788	32	2,341	1,895	**119,022**
Purchased	29,364	70,621	681	4,136	9,178	32	2,338	1,894	**118,244**
Donated	0	147	0	17	610	0	3	1	**778**
Total at 31 March 2011	29,364	70,768	681	4,153	9,788	32	2,341	1,895	**119,022**
Asset financing:									
Owned	29,364	70,768	681	4,153	9,788	32	2,341	1,895	**119,022**
Total at 31 March 2011	29,364	70,768	681	4,153	9,788	32	2,341	1,895	**119,022**

14.4 Revaluation reserve balance for property, plant and 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	£000's	£000's	£000's	£000's	£000's
At 1 April 2010	5,820	13,171	53	0	571	0	0	930	**20,545**
Movements (see note 14.5)	(20)	(5,786)	(53)	0	(15)	0	0	(930)	**(6,804)**
Elimination of donated asset reserve (see note 1.10)		(64)							
At 31 March 2011	5,800	7,321	0	0	556	0	0	0	**13,741**

14.5 Property, plant and equipment

Of the £6,685k additions, £327k was donated by West Hertfordshire Hospitals NHS Trust Charitable Funds.

The effective date of the annual valuation of Land, Buildings and Dwellings is 31 March. The valuation is undertaken by an independent valuer GVA Grimleys 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 can result in an impairment details of which are shown below.

2011/12	Watford Hospital	Hemel Hempstead Hospital	St Albans Hospital	Total
	£000	£000	£000	£000
Operating expenses - note 6				
Land - MEA	(1,916)	(419)	0	(2,335)
Buildings, dwellings and fittings - MEA	1,641	(338)	(480)	823
	(275)	(757)	(480)	(1512)
Other comprehensive income (SOCI)				
Land - MEA	0	0	(232)	(232)
Buildings, dwellings and fittings - MEA	457	(819)	(266)	(628)
	457	(819)	(498)	(860)
Total impairment (reversal) 2011/12	182	(1,576)	(978)	(2,372)
2010/11	£000	£000	£000	£000
Operating expenses - 2010/11				
Buildings, dwellings and fittings - MEA	4,565	1,077	44	5,686
Buildings, dwellings and fittings no longer in use	547	(55)	0	492
	5,112	1,022	44	6,178
Other comprehensive income (SOCI)				
Buildings, dwellings and fittings - MEA	491	6,035	278	6,804
Buildings, dwellings and fittings no longer in use	0	184	0	184
	491	6,219	278	6,988
Total impairment 2010/11	5,603	7,241	322	13,166

The impairment charged to operating expenses is classified as annually managed expenditure for the purposes of NHS consolidated accounts - see note 1.9.

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 1.7).

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

	As at 31 March 2012		As at 31 March 2011	
Asset Class	Maximum remaining asset life Years	Minimum remaining asset life Years	Maximum remaining asset life Years	Minimum remaining asset life Years
Buildings	**57**	**3**	**58**	**8**
Dwellings	**22**	**8**	**23**	**9**
Plant and machinery	**9**	**1**	**10**	**1**
Transport	**4**	**2**	**5**	**3**
Information Technology	**5**	**1**	**5**	**1**
Furniture and Fittings	**57**	**3**	**58**	**8**

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

The gross carrying amount of fully depreciated assets that are still in use totals £13,825k.

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

15. Intangible non-current assets

15.1 2011/12 Intangible non-current assets

	Computer Software - in use	Computer software in development	**Total**
	£000	£000	**£000**
Gross cost at 1 April 2011	6,457	697	**7,154**
Additions - purchased	0	(40)	**(40)**
Additions - donated	0	0	**0**
Reclassifications	446	(617)	**(171)**
Gross cost at 31 March 2012	6,903	40	**6,943**
Amortisation at 1 April 2011	3,827	0	**3,827**
Charged during the year	873	0	**873**
Amortisation at 31 March 2012	4,700	0	**4,700**
NBV at 31 March 2012	2,203	40	**2,243**
Net book value at 31 March 2012 comprises:			
Purchased	2,203	40	**2,243**
Donated	0	0	**0**
Total at 31 March 2012	2,203	40	**2,243**

15.2 2010/11 Intangible non-current assets

	Computer Software - in use	Computer software in development	**Total**
	£000	£000	**£000**
Gross cost at 1 April 2010	5,976	271	**6,247**
Additions - purchased	186	694	**880**
Reclassifications	295	(268)	**27**
Gross cost at 31 March 2011	6,457	697	**7,154**
Amortisation at 1 April 2010	2,922	0	**2,922**
Charged during the year	905	0	**905**
Amortisation at 31 March 2011	3,827	0	**3,827**
Net book value at 31 March 2011	2,630	697	**3,327**
Net book value at 31 March 2011 comprises:			
Purchased	2,630	697	**3,327**
Donated	0	0	**0**
Total at 31 March 2011	2,630	697	**3,327**

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 recgnised during the period for assets in use.

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

16. Capital commitments

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

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	**387**	691
Intangible assets	**0**	0
Total	**387**	691

17. Intra-Government and other balances

	£000s	£000s	£000s	£000s
Balances with other central government bodies	4,487	0	3,409	0
Balances with local authorities	0	0	0	0
Balances with NHS trusts and foundation trusts	1,663	0	713	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	3,228	1,187	14,049	0
At 31 March 2012	**9,378**	**1,187**	**18,171**	**0**
Balances with other central government bodies	4,981	0	3,479	0
Balances with local authorities	479	0	0	0
Balances with NHS trusts and foundation trusts	1,940	0	823	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	3,085	1,683	12,689	0
At 31 March 2011	**10,485**	**1,683**	**16,991**	**0**

18. Inventories

	Drugs £000	Consumables £000	Energy £000	Total £000
Balance at 1 April 2011	803	2,543	196	**3,542**
Additions	0	0	16	**16**
Inventories recognised as an expense in the period	(116)	(387)	0	**(503)**
Write-down of inventories (including losses)	0	(23)	0	**(23)**
Balance at 31 March 2012	687	2,133	212	**3,032**

19. Trade and other receivables

19.1 Trade and other receivables

	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
NHS receivables - revenue	**2,092**	2,774	**0**	0
NHS prepayments and accrued income	**3,348**	3,676	**0**	0
Non-NHS receivables - revenue	**1,706**	2,271	**0**	0
Non-NHS prepayments and accrued income	**2,778**	1,201	**0**	0
Non-NHS prepayments and Provision for the impairment of receivables	**(1,792)**	(499)	**0**	0
VAT	**710**	511	**0**	0
Interest receivables	**4**	0	**0**	0
Injury cost recovery receivables	**532**	551	**1,187**	1,683
Total	**9,378**	10,485	**1,187**	1,683
Total current and non current	**10,565**	12,168		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

Trade and other receivables are carried at the original invoice amount. As the majority of trade is with primary care trusts, (PCTs) 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 that 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.

19.2 Non NHS receivables past their due date but not impaired

	31 March 2012 £000	31 March 2011 £000
By up to three months	**178**	113
By three to six months	**128**	310
By more than six months	**542**	499
Total	**848**	922

19.3 Provision for impairment of receivables

	2011/12 £000	2010/11 £000
Balance at 1 April	**(499)**	(388)
Amount written off during the year	**72**	132
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(1,365)**	(243)
Balance at 31 March	**(1,792)**	(499)

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

20. Other financial assets

The Trust has no other financial assets.

21. Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
Balance at 1 April	**1,785**	1,776
Net change in year	**8,066**	9
Made up of		
Cash with Government Banking Service	**9,822**	1,802
Commercial banks	**23**	55
Cash in hand	**6**	(72)
Cash and cash equivalents as in statement of cash flows	**9,851**	1,785
Patients' money held by the Trust, not included above	3	55

22. Non-current assets held for sale

	Land £000	Dwellings £000	Total £000
Balance at 1 April 2011	0	0	0
Balance at 31 March 2012	**0**	**0**	**0**
Balance at 1 April 2010	73	187	260
Plus assets classified as held for sale in the year	0	122	122
Less assets sold in the year	(73)	(309)	(382)
Balance at 31 March 2011	**0**	**0**	**0**

23. Trade and other payables

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Interest payable	**44**	59		
NHS payables-revenue	**566**	1,024	**0**	0
NHS payables-revenue	**0**	0	**0**	0
Non NHS trade payables - revenue	**1,465**	1,227	**0**	0
Non NHS trade payables - capital	**5,470**	4,597	**0**	0
Accruals and deferred income	**354**	1,505	**0**	0
Non NHS accruals and deferred income	**10,210**	8,447	**0**	0
Social security costs	**(47)**	0	**0**	0
VAT	**86**	106	**0**	0
Tax	**23**	26	**0**	0
Total	**18,171**	16,991	**0**	0

24. Borrowings

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Loans from Department of Health	4,172	6,412	16,651	20,823
Total (current and non-current)	20,823	27,235		

Repayment of principal falling due from 31 March 2012	£000
0-1 years	4,172
1 - 2 Years	4,172
2 - 5 Years	9,716
Over 5 Years	2,763
TOTAL	20,823

The borrowings relate to three Department of Health loans:

- £11.2m accessed in March 2007 to support working capital. The final repayment was made in March 2012.
- £27m loan; £13.5m accessed in July 2008 and a further £13.5m in September 2008. The loan was taken to finance the build of the Acute Assessment Unit at Watford Hospital and other site improvements . It is repayable by twice yearly equal instalments over ten years ending March 2018. Interest is at a rate of 5.4% payable twice-yearly on a reducing balance.
- £7m loan accessed in March 2010 to support working capital. It is repayable by twice-yearly equal instalments over five years ending March 2015. Interest is at a rate of 1.8% payable twice-yearly on a reducing balance.

25. Other liabilities

The Trust has no other payables or financial liabilities.

26. Deferred income

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Opening balance at 1 April 2011	2,924	1,247	0	0
Deferred income addition	368	2,182	0	0
Tax	(1,272)	(505)	0	0
Transfer of deferred income	2,020	2,924	0	0

27. Provisions

27.1 Trust Provisions

	Pensions non directors relating to early retirement	Staff and public liability claims	Tota
	£000	£000	£000
Balance at 1 April 2011	5,654	338	5,992
Arising during the year	243	65	308
Utilised during the year	(517)	(102)	(619)
Reversed unused	0	0	0
Unwinding of discount	132	8	140
Balance at 31 March 2012	5,512	309	5,821
Expected Timing of Cash Flows:			
No Later than One Year	434	107	541
Later than One Year and not later than Five Years	3,084	202	3,286
Later than Five Years	1,994	0	1,994

i) Pensions provision for early retirement is assessed using information provided by the Pensions Agency and Government Actuary Department Tables.

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

iii) The fair value of the provision for future pension payments is determined by discounting the forecast cashflow in accordance HM Treasury prescribed discount rates (see note 1.15).

27.2 NHS Litigation Provisions relating to the Trust

Not included in the Trust accounts (see note 1.16) but included in the provisions of the NHS Litigation Authority in respect of Trust clinical negligence liabilities.

	£000
31 March 2012	84,612
31 March 2011	85,580

28. Contingencies

The Trust has no contingent assets or liabilities.

29. Financial Instruments

29.1 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. In respect to the Trust this is negligible as explained below:

The continuing service provider relationships that the Trust has with its commissioners (Primary Care Trusts) and the way these are financed, means the Trust is not exposed to the degree of financial risk faced by business entities. 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 specifically 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. 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 Strategic Health Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with commissioners, (primary care trusts) the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in the trade and other receivables note 19.

Liquidity risk

The Trust's operating costs are incurred under contracts with commissioners (primary care trusts), which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its limit set by the Department of Health. The Trust is not, therefore, exposed to significant liquidity risks.

29.2 Financial assets

	At 'fair value through profit and loss' £000	Loans and receivables £000	Total £000
Receivables - NHS		1,966	1,966
Receivables - non-NHS		1,291	1,291
Cash at bank and in hand		9,851	9,851
Total at 31 March 2012	0	13,108	13,108
Receivables - NHS		5,012	**5,012**
Receivables - non-NHS		2,062	**2,062**
Cash at bank and in hand		1,785	**1,785**
Total at 31 March 2011	**0**	**8,859**	**8,859**

29.3 Financial Liabilities

	At 'fair value through profit and loss' £000	Other £000	Total £000
NHS payables		566	566
Non-NHS payables		2,652	2,652
Other borrowings		20,823	20,823
Total at 31 March 2012	0	24,041	24,041
NHS payables		395	**395**
Non-NHS payables		2,342	**2,342**
Other borrowings		27,235	**27,235**
Total at 31 March 2011	**0**	**29,972**	**29,972**

30. Events after the end of the reporting period

There are no post balance sheet events.

31. Related party transactions

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

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities and the transactions where over £1m are:

	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Department of Health	11,698	7,095	123	189
Trusts				
East and North Hertfordshire NHS Trust	542	1,509	75	383
Hertfordshire Partnership NHS Foundation Trust	1,129	2,261	53	141
Hertfordshire Community Trust	854	3,736	40	614
Imperial College Healthcare NHS Trust	74	919	60	156
Primary Care Trusts (PCT)				
Barnet PCT	0	1,276	55	0
Bedfordshire PCT	0	1,744	1	63
Buckinghamshire PCT	0	1,045	0	63
Harrow PCT	0	3,379	158	0
Hillingdon PCT	0	5,516	445	0
NHS Hertfordshire	6	220,372	98	2,185
Luton PCT	0	1,744	0	100
South East Essex PCT	0	4,111	78	7
Health Authorities				
East of England Strategic Health Authority	0	8,636	0	100
National Blood Authority	1,862	26	0	1
Other Bodies				
NHS Business Authority	8,457	0	621	0
	24,622	**263,369**	**1,807**	**4,002**
2010/11	24,183	264,573	321	4,996

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies:

2011/12	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
HM Revenue and Customs	43,506	4,410	75	710
NHS Litigation Authority	5,976	0	0	0
Dept of Work and Pensions	23,210	0	2,017	0
	72,692	**4,410**	**2,092**	**710**
2010/11	69,763	3,332	2,075	511

32. Losses and special payments

The total number of losses cases in 2011/12 and their total value was as follows:

	2011/12 Total Value of Cases £s	2011/12 Total Number of Cases	2010/11 Total Value of Cases £s	2010/11 Total Number of Cases
Losses	726,554	450	142,014	127
Special payments	14,701	31	9,210	24
Total losses and special payments	741,255	481	151,224	151

Included in losses in 2011/12 is £363k and 366 cases relating to injury cost recovery scheme - see note 1.4.

33. Losses and special payments

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.

33.1 Breakeven performance

	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000
Turnover	209,199	218,248	232,967	241,684	254,308	260,398	266,716
Retained surplus/(deficit) for the year	(26,785)	(11,413)	2,495	4,405	(52,167)	1,352	5,269
Adjustment for:							
Impairments				0	57,866	6,178	(1,512)
Impact of policy change - donated assets							(100)
Other agreed adjustments	14,111	26,785	0	0	0	0	0
Break-even in-year position	(12,674)	15,372	2,495	4,405	5,699	7,530	3,657
Break-even cumulative position	(26,785)	(11,413)	(8,918)	(4,513)	1,186	8,716	12,373

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 1.10 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 reale 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.

33.2 Interpreting breakeven performance

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
	%	%	%	%	%	%	%
Break-even in-year position as a percentage of turnover	(6)	7	1	2	2	3	1
Break-even cumulative position as a percentage of turnover	(13)	(5)	(4)	(2)	0	3	5

i) The breakeven duty is met if the breakeven cumulative net deficit is less than 0.5% of the turnover of the reporting year or there is a cumulative surplus.

ii) The Trust achieved a cumulative net surplus in 2009-10 and has met the breakeven duty in all subsequent years.

33.3 Capital cost absorption rate

From 2009/10 the dividend payable on public dividend capital is based on the actual average relevant net assets (rather than as earlier periods 3.5% of forecast). This is explained further in note 1.24.

33.4 External financing

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

	2011/12		2010/11
	£000	£000	£000
External financing limit		2,373	(4,712)
Cash flow financing	(7,478)		(6,421)
Finance leases taken out in the year	0		0
External financing requirement		(7,478)	(6,421)
Undershoot		9,851	1,709

- A negative external financing limit (EFL) indicates the cash to be generated from business activities to pay for other cash outgoings such as repayment of loans. A positive EFL allows the Trust to access external funds, from for example, the Department of Health.
- In 2011/12 the Trust accessed £7m of funds from the Department of Health towards the cost of road construction at the back of Watford Hospital.

33.5 Capital cost absorption rate

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

	2011/12	2010/11
	£000	£000
Gross capital expenditure	6,645	7,293
Less: book value of assets disposed of	0	(604)
Less: donations towards the acquisition of non-current assets	(327)	(134)
Charge against the capital resource limit	6,318	6,555
Capital resource limit	15,200	8,188
Underspend against the capital resource limit	8,882	1,633

34. Third party assets

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

	31 March 2012	31 March 2011
	£000s	£000s
Patients monies held by the Trust	3	55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Punjabi ਵਧੇਰੇ ਜਾਣਕਾਰੀ ਲਈ ਸਾਡੀ ਜਾਣਕਾਰੀ ਲਾਈਨ ਨੂੰ **01442 287620** 'ਤੇ ਟੈਲੀਫ਼ੁਨ ਕਰੋ.

Spanish Para mas information, por favor llama **01442 287620**

Urdu مزید معلومات کے لئے ہماری ان فارمیشن لائن (معلوماتی لائن) پر اس نمبر پر فون کریں **01442 287620**

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