annual report 09 10

Contents

Welcome by Chief Executive and Chair

The 2009/10 annual report for West Hertfordshire Hospitals NHS Trust

Thomas Hanahoe
Chairman

Jan Filochowski
Chief Executive

As we moved into 2009/10, there was an undeniable level of optimism in the Trust. Performance against all national targets had been sustained and we were now compared to some of the best hospitals in the country. We had established a robust and stable financial position, and had produced a surplus for the third year running, meaning that the Trust had cleared its historical financial debt – a fantastic performance.

The Trust rose from being rated by the Healthcare Commission (HCC) as 'Weak' in 2005/06 and 2006/07, to 'Fair' in 2007/08 and 'Good' in 2008/09, a remarkable achievement by the staff in consecutive years. The inspection system changed in 2009/10 with the creation of the Care Quality Commission (CQC) to replace the HCC. It is not clear exactly how the new registration process will be rated, but on our calculation, our rate of improvement has been sustained and we would be rated as good or even excellent for 2009/10.

A year on since the centralisation of acute services onto one site and it is perhaps a time to reflect on whether it worked. The answer is an emphatic yes! Not only did we see the safe and successful transfer of emergency and acute services onto one site, we also saw the opening of a new 120-bed emergency admissions building, known as the Acute Admissions Unit, attracting national interest from other trusts and collecting two national building awards.

Our mortality rates have fallen across all specialties, making our hospitals amongst the safest in the country. This was recognised nationally with the Trust reaching the finals of the Health Service Journal Acute Healthcare organisation of the Year, narrowly missing out on the first prize. We have more work to do to continue to improve the services we provide. We know, for example, that we have not performed well in recent patient experience surveys and we are working hard to make improvements in this area.

We all know that the country faces uncertain economic times and that there will be a reduction in public spending. Health will not be exempt from these pressures and this poses a challenge for us. What the Board has made absolutely clear is that, however savings are made or efficiencies achieved, patient safety will not be compromised. The Trust is proud of its staff and of its sustained and significant improvements achieved by the determination, professionalism and creativity of people working in and with the Trust. We will continue to deliver high level services for the people of west Hertfordshire.



Introducing the Trust

The West Hertfordshire Hospitals NHS Trust was created on 1 April 2000 and is one of eighteen acute and specialist trusts in the East of England Strategic Health Authority. The Trust manages three hospitals; Hemel Hempstead Hospital, St Albans City Hospital and Watford General Hospital. The population covered by the Trust is approximately 500,000 and it is one of the largest employers in west Hertfordshire, employing around 4,000 people, plus 548 volunteers.

During 2009/10:	
75,675	people attended A&E (on average, more than 200 a day)
14,015	people attended the Minor Injuries Unit
24,494	people attended the Urgent Care Centre
374,652	people attended Outpatient Departments (more than 1400 a day)
76,724	people attended as inpatients and day cases
5,602	babies were born in hospital (plus 162 home births)

Watford General Hospital

Watford General Hospital is a large acute hospital with a new 120-bed Acute Admissions Unit (AAU) offering first class emergency care. The emergency service is supported by a state-of-the art Intensive Care Unit, a Children's Emergency Department and two Catheterisation Laboratories. Watford also provides a full range of other services, including maternity, outpatients, specialist wards and sexual health.

Hemel Hempstead Hospital

Hemel Hempstead Hospital is a local general hospital which has recently undergone a significant £7million redevelopment programme to improve the general environment for patients and staff. It provides a wide range of outpatient services, intermediate care, tests and investigations. It also offers a GP-led urgent care and out of hours health service.

St Albans City Hospital

St Albans City Hospital is the Trust's Elective Centre. It is a local general hospital offering a wide number of services, planned surgery, minor injuries and breast care. The hospital also provides a wide range of diagnostics, outpatients, sexual health and ophthalmology facilities.

The Trust's 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.

Our Pledge to Patients

heart of Herts

The Trust is committed to providing the right services, buildings and staff to deliver care 24 hours a day, 365 days a year. Our Heart of Herts Pledge to patients was launched in 2008 and has had real influence on the way our patients experience their time with us.

The Trust board

Back row from left to right: Russell Harrison, Director of Delivery; Sarah Connor, Non-Executive Director; Mahdi Hasan, Non-Executive Director; Stuart Lacey, Non-Executive Director; Katharine Charter, Non-Executive Director; Anna Anderson, Director of Finance; David McNeil, Director of Communications and Corporate Affairs; Nick Evans, Director of Partnerships. **Front row from left to right:** Sarah Childerstone, Director of Workforce; Colin Gordon, Non-Executive Director; Colin Johnston, Medical Director; Jan Filochowski, Chief Executive; Thomas Hanahoe, Chairman; Robin Douglas, Non-Executive Director. **Not shown:** Sarah Wiles, Director of Strategy and Infrastructure.

Welcome to new members of the Trust Board

Dr Colin Johnston, a Consultant in General Medicine, Diabetes and Endocrinology at Hemel Hempstead and St Albans hospitals since 1989, was appointed as the Medical Director and Director of Patient Safety in November 2009.

Anna Anderson took up the role of Director of Finance in January 2010. Anna was previously the Finance Director at the Homerton NHS Foundation Trust and has many years' experience working in the NHS.

Natalie Forrest joined the Trust as Director of Nursing in June 2010. Natalie began her career as an intensive care nurse and was previously the Director of Nursing at Newham University NHS Trust.

Sarah Connor joined the Trust as a Non-Executive Director in December 2009. Sarah is a Chartered Accountant and for the previous two years she was the Business Finance Director for Enforcement & Compliance in HM Revenue & Customs.

Do you want to know more about the Trust?

For members of the public interested in the detail of how the Trust functions on a day-to-day basis, the best place to start is the Trust website www.westhertshospitals.nhs.uk, which has lots of background information. The Trust Board meets in public six times a year and any member of the public is very welcome to attend as an observer. Dates can be found on the homepage of the website. The website also provides board agendas and minutes, as well as detailed papers which support the decision-making process.

Changes prove a success

Over the last year, the Trust has successfully managed a significant improvement in the delivery of its services. In March 2009, the Trust transferred all acute services from Hemel Hempstead to Watford and opened a new 120-bed Acute Admissions Unit (AAU). These major service changes were delivered safely with minimum disruption to patient care and managed on time and on budget.

The Trust undertook an internal review of the first 100-days following the changes and the opening of the AAU. This review concluded that the Trust was providing care which compared favourably with that of other similar acute trusts. Although bed numbers had reduced and activity had increased, the Trust had been able to maintain its key performance targets, and in some cases, even improved on them. The review also reported that the majority of emergency patients were being seen within thirty minutes and patients had much better access to specialist services, such as stroke and vascular care. Fewer patient deaths had been reported and fewer patients were being re-admitted following discharge, which meant that, as predicted, patients were being admitted, diagnosed, treated and discharged quickly and appropriately.

A second internal post-project report into the functioning of the AAU since it became operational was undertaken in the first quarter of 2010.

Performance against high-level quality indicators such as infection control and standardised mortality ratio has continued to improve and there has been no adverse change in the proportion of patients who are subsequently re-admitted to hospital as a result of the new model of care. Patients are staying longer in the AAU than originally envisaged and the unit is not currently set-up to best accommodate these longer-stay patients. Patients then experience a greater number of transfers between wards than is ideal and are transferred to an appropriate specialty ward later in their stay. The acuity and complexity of patients being cared for on specialist wards has increased and bed occupancy rates are higher, which is placing pressure on medical and nursing teams particularly in the larger medical wards. The AAU model is kept under review by the Trust to ensure that it is not a static process.

Also in 2009, a major £7million redevelopment programme got underway at Hemel Hempstead to significantly improve the environment by providing high quality, up-to-date facilities. To avoid fragmentation of services following the transfer of acute services to Watford, some buildings on the Hemel Hempstead site were vacated and secured and appropriate services, including inpatient beds, were relocated into the newest hospital building, Verulam Wing. In addition, a new purpose-designed Outpatients Department, including a state-of-the-art Audiology Department, opened to patients in September 2009. A new West Herts GP-led Medical Centre also opened on the Hemel Hempstead hospital site in June 2009.

Feedback from patients on the changes has also been very encouraging. As part of the 100-day review, 200 patients were contacted following their discharge from the Acute Admissions Unit and the response was resoundingly positive. However, the review did highlight a number of areas that needed changing and a Service Improvement Group was established to ensure progress was made.

West Herts on display

Over 2009/10, the word spread about the changes that had been made in west Hertfordshire and, in particular, the success of the new model of emergency care that the Trust was offering. Sir David Nicholson, Chief Executive of the NHS, paid a return visit to Watford General in January 2009. Sir David had previously visited Watford in early 2008 and at that time had said that the changes the Trust were about to make were some of the biggest changes happening anywhere in the NHS. During his visit in January 2009, Sir David spent time talking to staff about the new model of care and commented, "Most of the good practices that I see demonstrated up and down the country can be found here at Watford General. Patients get a top drawer service."

In June 2009, the Trust's two new Cardiac Catheterisation Laboratories at Watford were formally opened by Professor Sir Bruce Keogh, Medical Director of the NHS and Professor Roger Boyle, National Director for Heart Disease and Stroke. The new enhanced facilities enable the Trust to continue to provide an emergency keyhole technique called primary percutaneous coronary intervention. At the official opening Professor Roger Boyle remarked, "Primary angioplasty is the international gold standard of heart attack treatment and the new facilities at Watford will undoubtedly save lives."

The Trust was also delighted to welcome the then Secretary of State for Health, Rt Hon Andy Burnham, to Watford in February 2010 to officially open the new Acute Admissions Unit. During his visit, the Health Secretary had a tour of the new facilities, met patients and staff and commented: "I was very pleased to be able to see firsthand how the new improved model of care works and to hear from the dedicated staff who are providing excellent medical care, how this system really benefits their patients."

Improving our services for patients

What the Trust sets out to achieve

At the beginning of 2009/10, the Trust agreed a number of high-level strategic objectives. These were to provide safe patient care, improve the outcomes and quality of that care, improve the patient experience, and sustain and improve its performance. During the year, the Trust introduced a number of measures to achieve these objectives and some of these are highlighted here.

Strategic objectives
Consistent excellence across full range of care, year in, year out

1. Provide safe patient care
2. Improve outcomes and quality of care
3. Improve the patient experience
4. Sustain and improve performance
5. Be financially sound
6. Work in active partnership
7. Attract, retain and motivate workforce

Business objectives

Core:
1. Sustain market share
2. Reshape and rationalise services to ensure financial viability

'Stretch' objectives:
3. Increase market share at periphery
4. QIPP Programme
5. Increase range of specialist care provided locally
6. Deliver more care in community settings

Key strategic initiatives to deliver
The main projects and programmes ensuring the Trust will hit its objectives

Clinical services strategy to deliver the base case:
1. Consolidate and embed emergency care
2. Reshape planned care
3. Develop service range and increase local access

Supported through:
4. Reshape the estate
5. Reshaping the workforce
6. Developing information systems
7. Corporate efficiency/effectiveness

Annual planning care
The objectives will be delivered and monitored through the Annual Plan

Re-engineering Pharmacy Services

The Pharmacy Service centralised to the second floor of the new Acute Admissions Unit (AAU) at Watford in early 2009. The centralised department includes a new production unit, store and dispensary that incorporates a state-of-the art robotic dispensing system. The service has also extended its opening times to seven days a week and introduced a Patient Medication Helpline.

Improving Discharge

The Trust recently opened a new discharge lounge for patients who were medically fit to leave a hospital ward, but who needed to wait for medication or transport before being discharged from hospital. A review of the discharge process highlighted two main areas for improvement, one about the time of finally leaving the hospital and the other that patients were bored.

A number of changes were made including involving volunteers to support patients, providing daily newspapers and weekly magazines, and improving the quality of the television reception. An information leaflet and posters were developed that explained the discharge process and the time patients may have to wait in the lounge. A significant reduction was also made in the waiting times for medication and patient transport.

Improving the Outpatient Experience

Following disappointing results in the National Outpatient Survey 2009/10, an in-depth review was launched into the Outpatient service. Staff who deliver the service worked closely with patients to highlight the problem areas and to find solutions.

Some of these measures included:

- Improvements to the outpatient environment
- Uniforms for frontline staff
- Improvements to storage and distribution of health records
- Better external signage to the Outpatient Departments
- A patient queuing system at some booking-in desks
- New and updated outpatient information on the website
- A new outpatient telephone system at St Albans
- A reminder card for patients to jot down any questions they would like answered during their visit

The outpatient service review and subsequent changes will continue in 2010 and the Trust is confident that the results of the next National Outpatient Survey will show a significant improvement in the service.

New Cancer Information and Support Centre at Watford

Macmillan Cancer Information and Support Service Centre opened in the newly refurbished main reception at Watford in December 2009. This new service provides vital information and support for anyone living with cancer, their relatives and friends and gives free information and support in a relaxed and informal environment. Patients and their carers can also find out about available financial support, counselling, support groups and other local services.

Digital Mammogram

Breast care patients in west Hertfordshire are now benefiting from a new state-of-the-art digital mammogram machine which opened in September 2009 at the Breast Unit in St Albans. This machine, one of the first of its kind in the East of England, allows radiographers to better detect small subtle abnormalities in the breast tissue and reduces the need to recall patients for additional scans.

One Stop Clinics

The introduction of One Stop Oral Surgery Clinics at Watford has made the service much quicker, easier and more convenient for patients. Patients requiring oral surgery now meet up with the Waiting List Coordinator immediately following their outpatient appointment to agree a date for their surgery.

Watford Health Campus Moves Forward

During 2009/10, detailed viability studies concluded that the Watford Health Campus, which includes a new hospital, is commercially viable, even in the current economic climate. Initial negotiations for the scheme have been concluded with the Borough and County Councils, which means that Watford Borough Council has now formally granted outline planning permission for the Health Campus. The stakeholders also expect to commence the process to procure a development partner in 2010.

The Trust's relationship with its partners in the Watford Health Campus, including Watford Borough Council, East of England Development Agency, Watford Football Club and other NHS trusts, remains very strong. This partnership working means that the plans for a new link road giving dual carriageway access from the M1 are moving forward.

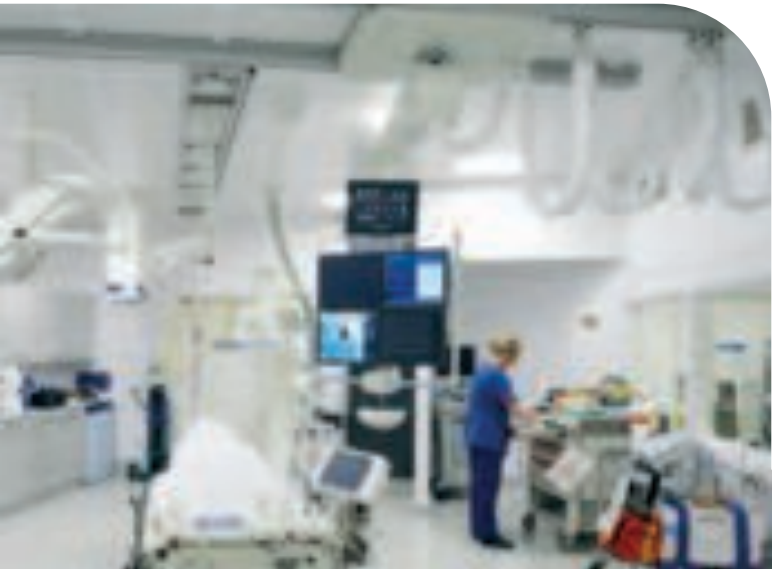
Setting standards

Improving Patient Safety

The Trust takes patient safety extremely seriously and is continually looking at ways to raise a positive safety culture and implement improvements.

Listed below are some of the measures that the Trust has put in place over the last year:

- The Trust signed up to the Patient Safety First Campaign, which looks for examples of harm, examines the causes and learns how to avoid future incidences. As part of this campaign, the Trust has introduced a new Modified Early Warning Score (MEWS) in all its general wards. This simple, physiological score system helps ward staff to identify when to call for specialist advice and aims to prevent delays in intervention or transfer of critically ill patients.
- To reduce the risk of patient identification issues, the Trust is currently installing electronically printed wristbands including full name, date of birth, NHS and hospital numbers.
- A new national surgical safety checklist has been introduced into the Trust's operating theatres to help reduce the number of patient safety incidents relating to surgical procedures.



Dealing with Complaints and Appreciation

Complaints are taken seriously and every effort is made to resolve them at a local level following a thorough and impartial investigation into the root cause of the patient's concerns. The Trust has reviewed its complaints policy and processes this year and has further strengthened them to ensure that it has better assurance that agreed actions are implemented. Performance on acknowledging and responding to complaints is now consistently high.

During the year, the Trust received 539 complaints that resulted in formal responses from the Chief Executive. This number accounts for less than 1% of the total number of patients seen in the Trust during the year. The key themes of complaints for the past year have been clinical treatment, staff attitude, admissions, discharge and transfer arrangements and finally communication and information.

Over the last year, as a direct result of complaints, the Trust has made a number of changes to:

- the organisation of day surgery procedures
- the communication with GPs in respect of the outcomes of certain radiological reports
- the hot meal service on Level 1 of the Acute Admissions Unit

During 2009/10, the Trust received many hundreds of letters, cards, notes and small gifts complimenting the standard of service provided by its staff.

Managing Risk

In November 2009, an Integrated Risk and Governance Committee was established as the key risk scrutiny committee which provides assurance to the Board about the processes to manage risk in the Trust. A governance audit by the Trust's internal auditors gave the Board 'Significant' assurance that the management of risk was robust.

In February 2010, the Trust's acute services were assessed against the National Health Service Litigation Authority's (NHSLA) standards at Level I and achieved a comprehensive 50 out of 50 score. The Maternity Service was assessed via the clinically-focused Clinical Negligence Scheme for Trusts (CNST) Standards and as a result the Trust was elevated from Level I to Level II. The Trust believes it has developed a solid foundation for risk management practice, which will be maintained and further improved to ensure full embedding of risk management practice from Ward to Board.

Serious Untoward Incidents

Through its clinical governance processes, the Trust seeks to reduce the occurrence of adverse events. In the rare circumstances in which a serious incident occurs, these are reported to the Strategic Health Authority in accordance with the Trust's Serious Untoward Incident Policy. All incidents are properly investigated and action taken to improve clinical quality and to learn lessons in order to minimise the risk of similar incidents occurring in the future.

The Trust's Serious Untoward Incident Policy is currently being updated to incorporate the "Being Open" framework. The new framework is a best practice guide for all healthcare staff and offers information and advice on how to communicate openly and honestly with patients, their families and carers following a patient safety incident.

Central Alerting System

This year, the Trust has reviewed and improved its processes for implementing actions in response to national alerts issued by the Central Alerting System. Alerts could include issues of health and safety, medical devices, medicines and aspects of clinical care. The Trust is confident that it has a robust monitoring system in place to ensure that timescales for implementing alerts are met, responsibilities are assigned and progress is reported to the committee with responsibility for patient safety.

Slips, Trips and Falls (STFs)

The Trust has reported an impressive overall drop of 38.3% in serious reported incidents with the lowest reported number for the past five years. Incidences of STFs are also down to an all time low of just 26 in 2009 (14 staff and 12 patient) compared to 45 in 2008 (29 staff and 16 patient). This is good news as it demonstrates the effectiveness of the Trust's Health and Safety measures.

Major Incident Plan

The Trust's Major Incident Plan is currently being redrafted to reflect the relocation of some of the Trust's services. The new plan incorporates new command and control structures and responsibilities, and will provide Trust staff with clearer instructions as to their roles during a major incident.

Pandemic Influenza

Following the identification of swine flu (H1N1) in Mexico in April 2009, the Trust implemented its Pandemic Flu Plan in line with national guidance. Over the following ten months, a Silver (operational) Command Group was established to co-ordinate the Trust's response to the escalating situation. Chaired by the Director of Delivery, the group met frequently to gather information on the current situation and plan future actions. The Trust worked closely with the Hertfordshire Swine Flu Co-ordinating Group, hosted by NHS Hertfordshire.

In the initial stages of the outbreak, the Trust saw many suspected swine flu cases, some of which required admission; however, the majority of patients' symptoms subsequently proved to be unrelated to swine flu. The Trust reported two deaths, both patients having been admitted with swine flu with other underlying medical conditions. In line with national guidance, Silver Command stood down in February, although planning for a potential further outbreak is still ongoing.

Business Continuity Plans

The Trust's Business Continuity Plans were tested a number of times this year, namely during the Pandemic Flu episode as mentioned on page 12 and also when the country experienced several bouts of unprecedented severe weather. The winter months always put pressure on the Trust but this year the inclement weather added an additional strain, with the largest number of ambulances ever turning up at A&E. However, thanks to the dedication and commitment by staff, all services were kept running with minimal disruption to patients.

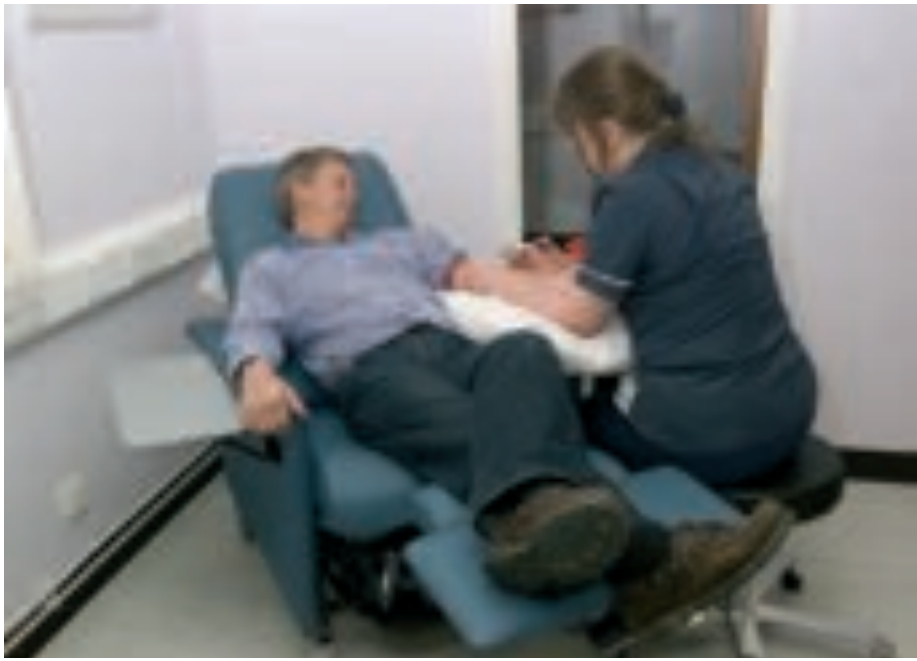
To stress test its Business Continuity Plans, the Trust took part in an exercise in April 2010, which involved 41 other NHS Trusts in the East of England, as well as the police, fire and rescue services. The exercise tested whether health trusts had appropriate business continuity plans in place to continue to provide services during a national major disruption such as a fuel crisis.

Fuel Plans

The Cabinet Office has reissued a national plan for fuel shortages and, as such, the Trust has developed its own local fuel plan.

Emergency Planning – Embedding the Plans

Public and staff will soon be able to access the Trust's emergency plans via the Trust website. Over the next year, these plans will also be incorporated into the Trust's induction programme for new staff and formal emergency preparedness training will be developed for staff that have been identified as key first responders.



Our Achievements

The Trust was awarded a rating of 'good' for the use of resources and 'fair' for the quality of its services by the Care Quality Commission (CQC), the national regulator for NHS services, in October 2009. This showed a further improvement in the Trust's overall performance compared to previous years.

Furthermore, in April 2010, the Trust met all 16 of the Care Quality Commission's core standards and received unconditional registration in the new system that replaced the Standards for Better Health assessment. This means that the CQC is fully satisfied that the Trust provides safe, high-quality care.

Fighting Infection

Huge efforts have been put into tackling instances of healthcare-associated infections in our hospitals over the past year. Hand washing gels are prominently available at the bedside, in all departments and at the entrances and exits to wards and other clinical areas. The Trust's Infection Control Team proactively visit clinical areas on a daily basis to audit and offer staff support and the team also run regular staff training courses, which are well attended. These actions have enabled the Trust's infection levels to continue to be amongst the best in the country.

Meeting Targets

The Trust's performance is monitored by the NHS Hertfordshire Primary Care Trust, the Strategic Health Authority (SHA), the Department of Health (DH) and The Care Quality Commission (CQC). Each body uses a slightly different set of indicators 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 Rating
A&E maximum wait of 4 hours	98%	Underachieved
MRSA bacteraemias	Trust target <18	Achieved
Incidence of C. Difficile	Trust target <165	Achieved
Maximum wait of 18 weeks referral to treatment: - Admitted patients - Non-admitted patients	 >90% >95%	 Achieved Achieved
All cancers – 2 week maximum wait for urgent GP referrals	>93%	Achieved
All cancers – maximum wait of 31 days from referral to treatment	>97%	Achieved

The major reductions in infections and the delivery of the 18-week maximum wait targets achieved in 2008/09 have been sustained and performance further improved during the year. Unfortunately, sustained high levels of activity over the winter period, combined with poor weather conditions, had an impact on the Trust's A&E services resulting in a performance of 97.8% (an 'underachievement' against a target of 98%) over the year as whole.

Improving the Environment

The Trust received excellent results in the annual Patient Environment Action Team (PEAT) assessments which are independently published by the National Patient Safety Agency. All three hospitals were rated as 'good' for the privacy and dignity afforded to patients. Furthermore, the food at Watford was assessed as 'excellent', which is the highest rating possible, and St Albans and Hemel Hempstead were both assessed as 'good'.

Your hospital Your NHS

Becoming Closer to Being a Foundation Trust

The application process to become a Foundation Trust is extremely rigorous and ensures that the Trust's governance arrangements, finances and future plans are robust and fit for purpose. The Trust expects to be put before the Department of Health Applications Committee in the summer of 2010.

Foundation Trust status means that the Trust will:

- have Members and Governors whose views will contribute to future planning, giving the Trust a better understanding of local needs
- have more financial control locally

The Trust has a very engaged and representative membership enabling a better dialogue with people using its services. It has well over the required 5000 Public Members (1% of the population the Trust serves) and all Trust staff are also Members. The Trust is particularly proud of the diversity of its membership and of the recruitment of young people and those in hard to reach and seldom heard groups.

Membership is free and people can join by phone, post or online. Members can stand for election as Governors and join the Governing Council which will contribute to planning the future direction of the Trust. For further information on the Trust's plans to become a Foundation Trust or to become a Member, please go to www.westhertshospitals.nhs.uk/ft.

Gaining Recognition

Throughout 2009/10, the Trust and its staff received local and national recognition:

- The Trust was "highly commended" under the Acute Healthcare Organisation of the Year category in the prestigious Health Service Journal Awards scheme and also shortlisted in two further categories, Using Data to Improve Care and Workforce Development
- The design and construction of the Acute Admissions Unit won two prestigious building industry awards for its groundbreaking healthcare project
- Four midwives from the Maternity Unit at Watford were nominated for the Mama's and Papa's Midwife of the Year 2009 Award, the only publicly voted midwifery award scheme
- Dr Ashish Bhagat, a Consultant Radiologist at Watford, was shortlisted for the development of a unique databased intelligence system in the National GC awards 2010: Rewarding excellence in public sector IT
- An independent survey of hospitals published by Dr Foster in November 2009 awarded the Trust a Band 4 rating for patient safety, with a 5 being the highest rating overall
- The Trust's Practice and Innovation Team was shortlisted for a People's Dignity Award run by the East of England's Health and Social Care Awards. This award recognised the efforts of "shop floor" nurses to improve the patient experience
- Dr Val Page, Consultant Anaesthetist was awarded a prize by the European Delirium Association and also won first prize at the West Herts and Watford Medical Society for her work around delirium
- Dr Tammy Angel and Specialist Nurse Anne Carroll won acclaim from the Bupa Foundation for their work in decreasing the number of unnecessary catheterisations.

The Environment and Sustainability

The Trust recognises that its day-to-day activities affect the environment in a number of ways and is taking steps to control its energy use, taking into consideration the NHS Carbon Reduction Strategy published at the end of May 2008.

The Trust Board approved an updated Estates Strategy in January 2010. This Strategy clearly describes how the Trust's estate and built environment will meet the Trust's vision, respond to service needs and comply with statutory legislation and guidance over the next five years. The Strategy will be further complimented by an annual Estate Plan that will describe overall progress and identify a clear work programme for the year ahead within the overarching Strategy.

During 2009/10, the Trust undertook a comprehensive review of its carbon reduction commitment and has developed an action plan. The implementation of this plan will ensure that the Trust meets the challenges of carbon reduction, avoids financial penalties and strives to establish itself as a leader within the NHS.

In addition, the Trust has taken a proactive approach towards carbon reduction, including the formation of an Energy Group within the Estates Department that meets monthly to discuss energy reduction measures that are planned and in progress. One of the boldest proposals is to reduce the Trust's CO_2 emissions with the replacement of existing main boilers with Bio Mass alternatives. In December 2009, the Trust Board approved this project to proceed to a preferred bidder stage, and subsequently four companies have been invited to present proposals. On completion of this project, the Trust would expect to significantly reduce its CO_2 emissions.

During the year, the Trust has greatly improved its waste management service in a number of ways across all three of its hospitals sites.

These include:

- The introduction of a mixed dry recycling service for paper, cardboard, plastic bottles and glass
- Better segregation of clinical waste from general domestic waste
- The launch of a battery recycling service

The Trust's Environmental Strategy will be developed further in 2010/11 with the setting up of an Environment Task Group, championed by a Non-Executive Director. The group will prepare, develop and implement the Trust's environmental policy.

The policy will incorporate:

- Continuing to develop and implement the green travel plan for Watford hospital, and develop plans for St Albans and Hemel Hempstead hospitals
- Reducing the use of energy and utilities through awareness training
- Improving the efficiency and effectiveness of waste management systems.

Listening to our Patients

National Inpatient Survey 2008/09

In 2007, the Trust was dissapointed to find itself in the worst 20% of trusts in six of the eight domains measured in the National Inpatient Survey. However, in the latest 2008 survey, the Trust had reduced this to only two, "leaving hospital" and "operations and procedures". Significantly, the Trust moved out of the bottom 20% in terms of patients' overall feelings about the Trust and also moved from being the worst performing Trust in the East of England to a position near the middle of the table. These results are encouraging, showing an across the board improvement in patient experience, but also telling the Trust it still has significantly more to do.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service continues to be an essential part of the service provided for patients, carers and members of the public. The PALS office at Watford relocated this year into new accommodation in the main reception area to allow the service to be more patient-centred and accessible. During 2009/10, the PALS team dealt with a total of 957 reported concerns, as well as making over 7600 calls to patients relating to the 48-hour post-discharge project.

Reputation Audit

During the months of August and September 2009, the Trust conducted a reputation audit to assess how the Trust is viewed locally and to help plan strategic measures to build on its public reputation. A total of 139 people were surveyed face-to-face and via the Trust website from all areas of west Hertfordshire and across a wide range of age and ethnic groups. The overall survey results showed that people rate the Trust positively, mainly based upon their own and their family and friends' experience. 89% rated the services

overall at the Trust as 'fair' to 'very good' and they are generally confident about the quality of services they receive.

In the subsequent months, a reputation management and staff motivation programme was launched and a further audit was undertaken during April 2010 to assess the impact and effectiveness of the programme on the reputation of the Trust, both externally and internally.

Patients' Panel

The Patients' Panel continues to play an active part in the Trust. This year, the Panel has recruited two new members who now work alongside their colleagues and show the same remarkable enthusiasm and commitment that the Panel has shown since it was formed in 2002. The Patients' Panel is linked into a range of committees and projects, including PEAT inspections and the reviewing of all patient information to ensure it is 'patient-friendly'.

Our Staff

New Beginnings

As 2008/09 was a year of change for staff, 2009/10 was a year of building new relationships and consolidation. The service moves across all three sites have impacted significantly on staff, but the changes have been managed amazingly well by staff at every level in the organisation. The Trust held a 'Thank-You' week in May 2009 to acknowledge the enormous effort staff had put into making the changes happen.

Listening to Staff

The results of the staff survey for 2009/10 were published in March 2010 which recognises that, whilst the Trust is not up there with the best in the country, it has made strides in creating a better place for staff to work. The single biggest improvement was in staff motivation, but staff do feel under greater pressure and this is in line with the increased pace of the organisation. The Trust is working on how it can support staff to enable them to do their very best whilst at work.

Staff Wellbeing

During the year, the Trust has developed a Health and Wellbeing Plan with a focus on spiritual and mental wellbeing, as well as the more traditional physical wellbeing. This has been well received and supported by staff.

Along with most NHS Trusts, absences due to stress and musculo-skeletal disorders (MSD) make up a major proportion of the reasons why staff have to take time off work. Particular attention has been given to fast track the Occupational Health service for those staff suffering with stress and this has resulted in a 30% reduction in these absences. There is more work to be done on MSD and the Trust is hoping that it will be able to provide a fast track treatment to physiotherapy in 2010/11.

Equality and Diversity

The Trust remains committed to delivering equality of opportunity for staff, patients and other service users. Its Equalities Framework, including the Race Equality Scheme (RES), the Disability Equality Scheme (DES) and the Gender Equality Scheme (GES) is at the heart of the drive to achieve this. Over the past year, Wellbeing at Work advisers have continued to support staff with any sort of disability that impacts on them at work and an Equality and Diversity Lead has been appointed to work as part of the Patient Services Team. The Trust's "Connect" Black & Minority Ethnic (BME) Staff Network has also met regularly over the past year and a number of events have been organised, including a week of menus from different parts of the world being available in the restaurant at Watford.

Training

The Trust's Leadership Academy continues to thrive. One of the flagship programmes was shortlisted for the Health Service Journal (HSJ) Workforce Development Initiative of the Year award. While it didn't win, it was a great fillip to have the excellent work of the Academy acknowledged on a national stage. Over the past year, 118 members of staff at Bands Levels 1 - 4 undertook an accredited qualification, such as a National Vocational Qualification (NVQ). The major training initiative in 2010/11, as well as continuing with the programmes for senior and middle managers, is to launch a Medical Leadership programme that will support the existing medical leaders and nurture emerging talent too.

Passport to Practice

In January 2010, a new Corporate Welcome Programme was launched for all new members of staff. The programme includes sessions on conflict resolution, equality and diversity, health and wellbeing, and child protection. From April 2010, staff will also have electronic access to the Knowledge and Skills Framework (KSF), which will have useful suggestions to help staff work towards achieving KSF competencies. Managers and reviewers will be able to use this new service to help staff to set objectives as part of their appraisal process.

Celebrating Success

Once again, the annual combined Long-Service and Staff Awards for Excellence ceremony in December 2009 proved a great success. Over a hundred staff and invited guests attended the award ceremony with many staff being recognised for their continued commitment to the Trust, ranging from fifteen to forty years. Awards were also presented to the winners and finalists in the Staff Awards for Excellence Scheme in the following categories:

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

Innovation on our Wards

A raft of new initiates and pilot schemes has been developed on our hospital wards during 2009/10. Some of these are highlighted below:

Improving Privacy and Dignity

Between April and June 2009, a £1.5m programme, funded by the Department of Health, took place to eradicate mixed sex accommodation in the Trust. Over 100 toilets and showers were refurbished with modern, high quality wet rooms. A second stage of the programme took place in February to March 2010, which has resulted in the virtual eliminated of mixed sex accommodation in all areas of the Trust. The way the Trust managed this programme, on time and on budget with minimal disruption to patients, received national recognition and the template has since been followed by other NHS health trusts.

The Productive Ward Programme

The Productive Ward Programme, sometimes referred to as Releasing Time to Care, was introduced in 2009/10. This service improvement initiative increases the amount of time clinical staff spend directly caring for patients. A series of modules seeks out ways to eliminate areas of 'waste' by ensuring that the right things, get to the right places, at the right time and in the right quantities. The programme has already delivered significant improvements, including reducing short-term staff sickness rates on one ward from 9% to 4% and improving patient observation audits by 40% in another ward. The programme will be rolled out across the organisation during 2010/11 which will undoubtedly lead to further improvements in the patients experience.

Silent Night Project

A new initiative called 'The Silent Night Project' was developed and implemented this year which aims to reduce noise at night on wards. Noisy bins, telephones ringing, and moving and admitting patients during the night have all been highlighted by patients as things that disturb their sleep when on the ward. Measures will be put in place to address these issues and allow patients to have a good nights sleep.

The NHS Constitution

The NHS Constitution was launched in January 2009 and establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Trust is required by law to take account of the Constitution in its decisions and actions and manages the rights and responsibilities as follows:

Quality of care and environment

- The Trust has virtually eliminated mixed sex accommodation in its hospitals. The final phase will focus on the sustainability and monitoring of compliance

Nationally approved treatments, drugs and programmes

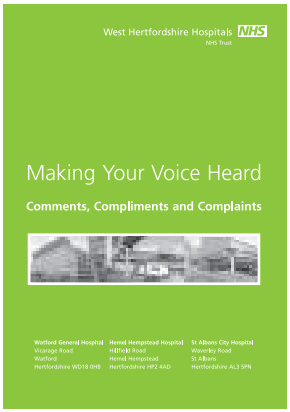
- The Trust's Drugs and Therapeutics Committee (DTC) is responsible for ensuring that appropriate policies and procedures are in place to promote, facilitate and audit the safe and cost-effective use of drugs
- The DTC works closely with the West Herts Joint Prescribing Group and Herts Medicines Management Committee to manage the entry of new drugs across the health economy
- The National Institute for Health and Clinical Excellence (NICE) drugs introduction is managed across Hertfordshire by the Herts Medicines Management Committee to ensure consistent use of drugs and treatments that have been recommended by NICE for use in the NHS
- The Trust implements vaccination programmes under the recommendation of the Joint Committee on Vaccination and Immunisation

Respect, consent and confidentiality

- The Trust constantly monitors compliance with relevant confidentiality-related laws, such as the Data Protection Act, through the use of compliance checks and external audits
- Information Security & Confidentiality awareness training is mandatory for all staff and focuses on current legislation and guidelines
- A number of information security policies are available that define what security measures have been implemented
- Patients are provided with leaflets on their rights under the Data Protection Act 1998
- Any incident involving personal information is dealt with and investigated in accordance with the Trust's Incident Reporting and Serious Untoward Incident Policy
- The Trust has a current Consent Policy and delegation of consent training is provided to appropriate staff. A consent audit is being developed with the aim to assess whether or not patients have been informed of the benefits and risks of a procedure and that an appropriate clinician has taken the consent

Complaint and redress

- The Trust's 'Making Your Voice Heard', Complaints Policy and claims and litigation systems are used to ensure an appropriate level of compliance with the Constitution



Statement of Internal Control 2009/10

1. Scope of responsibility

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 organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the 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 that 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.

The Trust has continued to work collaboratively with both the Strategic Health Authority (SHA) and the local Primary Care Trust (PCT) in respect of the issues affecting the health economy.

The following arrangements are in place:

- A series of routine performance / contract monitoring meetings with the PCT once a month to look specifically at the performance of the SLAs
- A regular CEO meeting between CEOs of various NHS organisations
- A regular meeting between the Trust and SHA monthly

I believe we have identified the key areas of common purpose that will enable us to work as a health economy to deliver the improvements in service that are required locally. We have worked with the PCT to develop robust processes in respect of commissioning arrangements. We will continue to maintain good relationships with the Practice Based Commissioning Groups and the GP Conclave. In particular, we have worked with the PCT and PBCs to implement a prior approval system, and to develop innovative approaches to service delivery for the future.

The Trust continues to work with the County Health Scrutiny Committee (HSC) and has built upon the previous good relationships during 2009/10. The Trust attends the HSC meetings on a regular basis as well as participating in the relevant health topic groups.

The Trust has consulted with the HSC and the Local Involvement Networks on proposals for its quality account and received constructive feedback, which will be reflected in the account published later in the year.

The Trust has many established and effective arrangements for working with the wider stakeholder communities, including patients and carers. This year has seen the Trust working more closely with local people as we move towards Foundation Trust status. As part of the work to develop the Foundation Trust application the Trust has been seeking membership from the local communities who will, once Foundation Trust status has been achieved provide a platform from which we can develop the Board of Governors. The current public membership stands at over 6000.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide

reasonable and not absolute assurance of effectiveness. **The system of internal control is based on an ongoing process designed to:**

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

The system of internal control has been in place in West Hertfordshire Hospitals NHS Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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 has a Risk Management Strategy, updated during 2009/10, which sets out the responsibilities of all staff in managing risk. Specific responsibilities are identified and I am ultimately responsible for ensuring robust processes for risk management are in place, and are implemented. The Executive Director with responsibility for risk management is the Director of Patient Safety/Medical Director. This responsibility is discharged throughout the organisation through the Trust's Assistant Director of Clinical Governance and Risk, supported by a small central team and through the offices of divisional and corporate risk leads.

The structure for risk management reflects the organisational structures for service delivery – executive led divisions and corporate functions, each with responsibility for ensuring the processes of risk management are implemented and that risks are recorded and monitored via divisional and corporate risk registers in accordance with the processes of risk identification, assessment, analysis and mitigation outlined in the Risk Management Strategy.

The risk management process is supported by a bespoke risk management database which is managed by a dedicated risk analyst who provides information to divisions and corporate functions on a regular basis, and by exception as required, e.g. in the event of potential themes emerging.

Management of the organisation's strategic risks is undertaken via the Board Assurance Framework – this is linked to the organisation's strategic objectives, and each risk identified has an executive Director assigned to ensure robust management through the use of effective controls and valid assurances. The Board Assurance Framework is reviewed by the Delivery Service Group (DSG) regularly and is presented to each meeting of the Audit Committee and the Trust Board.

The Audit Committee also reviews the Trust's High Level Risk Register at each meeting and on a rotating basis, each divisional top ten risks.

Following in year internal audit reviews, the Audit Committee determined that it should focus less on the detail contained within the BAF and High Level Risk Registers and more on ensuring the maintenance of a robust system of assurance, and ensuring that the Board Assurance Framework and supporting risk registers were functioning effectively. In consequence, in November 2009 the Trust Board directed the constitution of a formal sub-committee of the Board, the Integrated Risk and Governance Committee, chaired by a non-executive Director of the Board. This Committee has responsibility for ensuring the monitoring of the high-level risk register and for ensuring the processes supporting the Board Assurance Framework are working effectively.

Risk management is monitored operationally by the quarterly Divisional Integrated Standards Executive Committees, chaired by the Director of Patient Safety/ Medical Director. These meetings have reviewed progress in relation to quality standards, including compliance with Core Standards for Better Health and also reviewed each Division's risk register, to ensure risks are being actively managed where necessary, and that controls remain effective.

Where risks have not been closed in line with agreed action plans these are followed up with the Division concerned. Work has continued during 2009/10 to review Divisional systems and processes to ensure that the risk registers are being used as effectively as possible. The Trust has ensured that Divisional Boards are notified of further developments to enhance the process as identified through the internal audit programme.

In order to support this work the Divisional Risk Leads Forum provides a focus for driving actions to mitigate risk as well as a support structure for the risk Managers to enable them to better discharge their responsibilities.

Induction training and risk assessment and management training is provided on an ongoing basis to support staff to fulfil their responsibilities in relation to risk. The Trust induction programme for new staff provides a session on risk and incidents and is delivered by the Clinical Governance and Risk team. In addition, the Trust provides a series of risk management update sessions as well as specific training undertaken by the Health and Safety Advisor and Manual Handling Advisor.

Risk Management Training sessions have been delivered to the Trust Board and to senior clinical and managerial staff during the year and a Risk Management module has been incorporated into the Senior Leaders' Development Programme, a validated programme delivered in collaboration with the University of Hertfordshire.

The risk management database and risk register can be viewed both within the Divisions and at Executive level. Risks are clearly recorded and identified in a standardised way. Work initiated in 2008/09 to improve the way in which information within the risk registers is presented has continued in 2009/10. This work has ensured that there is now greater integration between the Assurance Framework, strategic objectives and risk registers. During 2010/11 further work will be undertaken to ensure full integration of the assurance systems underpinning Care Quality Commission (CQC) registration compliance.

Risk Management is an integral part of overall Trust governance in accordance with the principles of Integrated Governance. Divisional performance is reviewed regularly across a range of key indicators, including the identification and management of risk. At a strategic level the Board reviews the reporting arrangements for strategic risks and the requirement that this process links directly to the Assurance Framework. All risks are referenced to the Trust's strategic objectives and against relevant key deliverables, i.e. Core Standards for Better Health, and from 1 January 2010, CQC registration outcomes, National Health Service Litigation standards, as relevant.

From January 2010 the Trust was required to be registered with the CQC for the provision of services it provides on each of the three hospital sites. Confirmation was received from the CQC that registration had been approved without qualification.

In February 2010 the acute services of the Trust received an assessment at Level I of the NHSLA Risk Management standards and achieved a score of 50 out of 50 for its policies. The Trust is currently working towards assessment at Level II during 2010/11. The Trust's maternity services were also assessed under CNST standards at Level II and achieved a score of 49 standards out of 50.

As Accountable Officer I seek to learn from good practice via exchange of information with other Chief Executives regarding good

practice in their organisations, reading of relevant articles and documentation and advice from managers and staff within the Trust as to what has worked well in handling risk and should be rolled out across the organisation.

In addition, the Trust works with the other partners in managing elements of risk. The Trust works with the Strategic Health Authority via various structures. Chief Executives across the health economy meet regularly and I have regular meetings with colleagues from the SHA. Chairs across the Health Economy also meet on a regular basis and there are a number of other functional groups e.g. Directors of Finance who have a formal programme of meetings across the year.

4. The risk and control framework

The Trust Board approved the updated Risk Management Strategy in August 2010. Key elements included within it are:

- Statement of philosophy
- Definitions
- Key principles
- Roles & responsibilities
- Committees with responsibilities for Risk Management
- Risk Analysis Tools
- Risk Management Process
- Training
- Monitoring and review of strategy
- Proposed work programme for 2009/10

As indicated, the Trust has implemented a process for identifying, evaluating and managing the significant risks faced by the Trust throughout the financial year and up to the approval date of the annual accounts. The process is subject to regular review directly by the Board and by the Audit Committee. The Trust has reviewed its governance arrangements this year and decided that the previous Executive led committee on integrated governance should be formally constituted as a Trust Board sub-committee with responsibility for risk; this is the Integrated Risk and Governance Committee.

As far as the risk and control framework is concerned the Business Integrated Standards Executive, the Clinical Quality Committee and the Integrated Risk and Governance Committee provide the appropriate focus and control and have had the support of the following groups:

- Infection Control Committee
- Drugs and Therapeutics Committee
- Complaints, Litigation, Incidents and PALS Group (CLIP)
- Clinical Audit Strategy Group
- Health and Safety
- Child Protection Steering Group
- Transfusion Committee
- Medicines Safety Committee

As part of the preparation for Foundation Trust status a five year Integrated Business Plan has been developed, together with a yearly Operational Plan. This one year plan formed the basis of the Trust Board Assurance Framework in 2009/10 and will be further developed in 2010/11 to ensure that the Board Assurance Framework high level strategic risks are fully integrated.

All risks, or changes in risk, are identified and described in the Trust's Risk Register. They are then evaluated and prioritised so that an action plan can be devised for the most significant risks. The Trust's Governance and Risk Management Team reviews and monitors this process. Risk registers are reviewed operationally within Divisional Boards and corporately through the monthly meetings of the Business Integrated Standards Executive, escalating to the Integrated Risk and Governance Committee as required. The high-level Risk Register and Board Assurance Framework have been reviewed by the Audit Committee and are presented to each meeting of the Board.

Performance management arrangements have been enhanced during 2009/10 to ensure greater scrutiny of Divisional and Corporate risks via the Divisional Integrated Standards Executive meetings.

The Complaints, Litigation, Incident and PALS Group (CLIP) meets quarterly to review, on behalf of the Business Integrated Standards Executive, an integrated report that provides analysis of key areas of concern and reviews how the Trust has responded to these. The CLIP reports quarterly to the Trust Board. Where there are issues of concern that further actions are required, they are escalated to the Complaints, Litigation, Incidents and PALS Group. This process ensures that the Clinical Quality Committee can advise the Board of significant clinical issues that create a risk to the Trust.

The Assurance Framework is based upon the Department of Health (DH) model and contains all appropriate elements (objectives; key risk; key controls; assurance on controls; gaps in controls; assurance and gap in assurance) and contents are reviewed and presented to the Audit Committee and Trust Board at each meeting. The Framework was subject to considerable development during the reporting year and was reviewed as part of the Trust's internal audit programme for 2009/10 following which a conclusion of substantial assurance was recorded by the Internal Auditor.

The Trust's Information Governance Committee, chaired by the Executive Director with responsibility for data security, the Senior Information Risk Officer, oversees issues relating to the risk assessment and safeguarding of data security. The Caldicott Guardian and the Data Protection Manager are both members of this Committee and provide assurance that practices and processes are in place to ensure the safety of Trust-wide data. During the year the Trust has implemented .a system of encryption for all of its desktop and lap top computers. In addition a dedicated Data Security Officer has implemented a range of improvements aimed at improving data security across the IT infrastructure. The Trust will continue to review and enhance its data security arrangements in line with best practice and central requirements. Data Security incidents are reviewed by the Committee, including Serious Untoward Incidents and the Committee oversees the implementation of recommendations arising out of incidents or serious untoward incident investigations.

Gaps In Control

As a result of non-compliance with certain elements of Standards For Better Health the Trust was not in a position to declare full compliance at the November declaration deadline. Details of the Standards affected are set out in section 5 below.

There were two Serious Untoward Incidents that required the Trust to report breaches of data security.

The Trust were inspected by the Health and Safety Executive during 2009/10 during which it was identified that specific actions were required to ensure compliance with Health and Safety legislation. A limited assurance internal audit report on Safeguarding Children required the Trust to take a number of actions to achieve an acceptable level of service delivery in this important area.

Whilst the Trust achieved against the majority of national targets in 2009/10 it failed to deliver at the expected 98% for waiting times in Accident and Emergency, delivering 97.7%. Regrettably the Trust also declared breaches of the 26 week waiting time due to an administrative oversight that came to light at the end of March.

Public and Patient Involvement

The Trust actively involves and seeks the views of our patient's via the following groups/panels:

The Trust's Patients' Panel has been established for seven years. It continues to play an active part in the Trust. The Panel continues to be linked into a wide range of committees, meetings and projects within the Trust in order to help develop services and to pro-actively drive forward the issues raised from the results of the both local and national patient surveys. They are also members of Internal Patient Environment Action Team (iPEAT) inspections on a monthly basis and take part in the Trust's Observation of Care and 'Think Clean' days. Panel members continue to review all patient information and questionnaires to ensure they are 'user friendly' before being officially ratified by the appropriate committees and published.

The Patients' Panel and other external patient representatives and voluntary organisations have been instrumental in the production of the Patient Involvement & Experience Strategy and subsequently with helping to drive forward its objectives. They are also regular attendees of the Patient Involvement & Experience Group chaired by the Director of Nursing.

The Trust has maintained good relationships with Local Involvement Networks (LiNKS). I hold regular meetings to brief them on developments and receive feedback from them on relevant issues.

Staff Pensions

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with, including the requirement to undertake equality impact assessments.

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 in to 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

The Trust has undertaken risk assessments 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 this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust is not fully compliant with the core Standards for Better Health.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- Internal Audit Reports
- External audit reports
- Standards for Better Health self assessment and declaration
- Performance Monitoring
- National Inpatient Survey
- Staff Survey

I have been advised on the implications of the result of my review of effectiveness of the system of internal control by the Trust Board, Audit Committee, Integrated Risk and Governance Committee, Clinical Quality Committee and the Integrated Standards Executive. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Below describes the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including some comment on the respective roles.

The Board

The Trust Board has endorsed a mechanism to gain assurances about the effectiveness of the controls in place to manage principal and strategic risks. This mechanism ensures that risks are presented to the Board through the organisational structure in place within the Trust.

The Board reviews and maps these to its own assurance needs, enabling the Trust Board to address and put in place any improvements necessary.

The Audit Committee

The Audit Committee reports directly to the Board providing assurance on the maintenance of the system of internal control. The Committee comprises at least three Non-Executive Directors and is attended by the Director of Finance, Director of Patient Safety, Associate Director of Integrated Governance, Assistant Director of Clinical Governance and Risk, Director of Corporate Affairs and other representatives including Internal and External Audit in attendance. I attend meetings on a regular basis.

The Audit Committee's primary role is to independently oversee the governance and assurance process on behalf of the organisation and to report to the Trust Board on whether the systems in place for risk management and internal control are robust and effective. The Audit Committee receives regular reports from the Assistant Director of Clinical Governance and Risk ensuring that appropriate issues are escalated to the Audit Committee from the ISE and the Clinical Quality and Governance Committee. The Audit Committee ensures that audit plans are drawn up with full consideration of all risks as detailed within the Trust Risk Register.

The Integrated Risk and Governance Committee

During 2009/10 the Board constituted a formal sub-committee to take responsibility for risk management, the Integrated Risk and Governance Committee. This Committee's role is to promote integrated risk management as intrinsic to all of the organisation's activities and specifically promote local level responsibility and accountability for identifying and managing the organisation's risks.

The IRaGC oversees the maintenance and further development of the Board Assurance Framework and Trust Risk Registers to support the achievement of a high level of internal control, patient safety and clinical quality and to inform risk-based Board decision-making. The Committee works closely with the Trust's Audit Committee to ensure the two Board Committees maintain no significant overlaps or gaps between the remit and overview.

The Clinical Quality Committee

The Clinical Quality Committee is responsible for assessing the extent to which there is continuous and measurable improvement in the quality of the Trust's services and in patient safety. The role of the Committee is to monitor the quality assurance processes in place to ensure the Trust continues to meet the standards of quality and safety set out in the registration requirements of the Care Quality Committee. The Committee ensures a focus on all aspects of quality, specifically, clinical effectiveness, patient experience and patient

safety. The Committee is responsible for monitoring overall compliance with the registration requirements set out by the Care Quality Commission and is also responsible for monitoring performance of the quality element of the Acute Commissioning Contract.

Integrated Standards Executive

The Director of Patient Safety/Medical Director chairs the Business Integrated Standards Executive Committee. Its role is to advise Executive Management on matters of patient safety and the maintenance of clinical standards, taking reports from a number of Executive level groups that have responsibilities for aspects of patient safety. It is also responsible for review of risk registers and for more detailed consideration of the management of risks and the effectiveness of mitigation/control activities. The reporting lines for BISE are to the Clinical Quality Committee (CQuaC) for quality and safety issues and to the Integrated Risk and Governance Committee for matters relating to risk management.

Executive Directors

Executive Directors have overall responsibility for the implementation of the risk management strategy. They are responsible for the overseeing of the processes for identifying and assessing risk, and for advising me as necessary. They ensure that so far as it is reasonably.

Internal Audit

Internal Audit reviews the system of internal control throughout the year and reports accordingly to the Audit Committee.

Significant Internal Control Issues

The Trust declared in November that it was not fully compliant with the core Standards for Better Health.

Under the Standards for Better Health regime each standard was assigned to an Executive Director and operational lead who took responsibility for the monitoring and compliance of each standard. For 2009/10 the Trust declared compliance against 38 of the standards, declaring not met for 2 standards and insufficient assurance for the remaining standards.

The Trust declared not met for standard C1b (systems to ensure that patient safety notices, alerts and other communications which require action are acted upon within required timescales).

The Trust was subject to a CQC inspection against this standard on the 1 July 2009, which concluded the Trust was not achieving this standard.

An action plan was developed which involved a review of the policy governing this standard, a review and updating of the processes for identifying and approving a delivery plan to provide training and assess staff competency as required for each alert issue. The plan identified the need to ensure alert-related Clinical Audits are incorporated into the Trust's Clinical Audit Programme and that appropriate arrangements are in place to notify the SHA/PCT and the CQC where there are delays to implementation.

The Trust declared this standard would be met by 31 March 2010 and considers it is now compliant.

The Trust declared not met for standard C4d (systems to ensure that medicines are handled safety and securely).

The Trust was subject to a CQC inspection against this standard on 1 July 2009 which concluded there were gaps in the assurance processes for monitoring and implementing the findings of pharmacy audit and that the Trust did not demonstrate that all recommendations following medication audit activity are implemented or followed up.

An action plan was developed to address all the issues raised and included the establishment of a Medicines Safety Committee and the appointment of a Medicines Safety Pharmacist. The Trust has reviewed findings of previous audits and outstanding actions have been pursued. The Trust declared this standard would be met by 31 March 2010 and considers it is now compliant.

The Trust declared insufficient assurance for standard C4e (systems to ensure the prevention, segregation, handling, transport and disposal of waste). The concerns emerged following the appointment in July of a Waste Management Consultant who identified the problems through a series of intensive audits and review of policies and procedures. The audits revealed breaches of policy in relation to segregation of waste with specific issues relating to hospital site and variance in practice. Further analysis revealed problems with waste disposal facilities and lack of awareness of requirements by staff.

These concerns were reviewed at the October meeting of the Business Integrated Standards Executive and it was agreed the issue would be reported to the Board.

The action plan developed by the Consultant was further refined and actions were taken forward and reviewed by the Estates Division Integrated Standards Executive. The Trust identified the Trust would be fully compliant by 31 March 2010 and this was achieved.

The Trust identified a period of insufficient assurance for standard C14c (Complaints) as a result of a reduction in the level of response times for answering complaints during the first quarter of 2009/10. Whilst it was acknowledged that a new complaints system was being embedded, the Trust concluded that, notwithstanding this, it had committed to ensuring that all complaints were dealt with in a timely manner. Given that this was failing, insufficient assurance was declared. The Board was particularly concerned that a delay in response times would inevitably delay any actions required to address problems identified, and a potential failure to ensure timely improvements in service delivery. The Board requested that an action plan was developed and this was taken forward immediately. Complaint response compliance was monitored as part of the weekly performance meetings that I hold with the Divisional Managers. Systems within the Complaints Department for monitoring compliance were strengthened and more robust, weekly meetings initiated with key divisions to maintain the focus on delivering responses on time. In January this year a new policy was published and new documentation issued. Systems are now in place to better record the actions that have been taken following the conclusion of a complaint investigation as well as being able to further refine the key themes of complaints. Training continues to be provided to staff on complaints handling and presentations have been made to groups of staff about the importance of learning from the experience of complainants.

The Trust achieved compliance with this standard in February 2010.

The Trust reported 2 Serious Untoward Incidents, which threatened Data Security:

- The theft of 10 encrypted laptops and a blackberry from the Clinical Informatics Department during the weekend of 9th and 10th May. All media were encrypted
- On 2nd December 2009 documentation containing patient identifiable information was left on a train. The documentation was returned to the Trust and reviewed. The Information Commissioner was informed. The staff member was advised of the inappropriateness of exposing patient confidential information to such a risk and all staff were reminded of the requirement and their responsibility to ensure the security of patient confidential information

I believe that whilst the issues highlighted above were matters of significant internal control they have all been addressed and resolved within 2009/10. However, I have set out below a summary of the significant control issues and the actions being taken to rectify these.

My review confirms that West Hertfordshire Hospitals NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Jan Filochowski, Chief Executive

Principal objective	Gaps in controls	Action Plan and Implementation Date	Board Lead
Delivery of a compliant decontamination service	Current service is non-compliant	The Trust is working with a private sector provider to contract out TSSU services and considering estate reconfiguration options at Watford for endoscopy services	Director of Strategy
Delivery of an effective Safeguarding Childrens training programme for Trust staff and GPs working in the Urgent Care Centre	Failure to have an adequate recording system for staff undertaking child protection training and records of CRB checks for GPs in the Urgent Care Centre following limited assurance internal audit report	Action is in train to ensure that all relevant information is recorded onto the Trust's main training data base in respect of Trust staff training. Confirmation has been received that all GPs working in the Urgent Care Centre have up to date CRB checks	Director of Nursing

Financial Disclosure

The Trust produced a surplus of £5.7m after adjusting for an impairment of assets as shown in the Trust's Statement of Comprehensive Income for year ended 31 March 2010.

For 2010/11 the Trust has agreed a target of £8.1m surplus. This takes into consideration the need to make loan repayments and improve the Trust's liquidity. It will be achieved through:

- Continuation of the PMO review process
- Delivering a savings plan called The Big Ask
- Continuation and strengthening the controls on pay and non-pay spend
- Roll-out of service line management and reporting
- Further restructuring of the Trust's infrastructure to suport the delivery of patient care as efficiently and effectively as possible.

Strategic risks are reviewed on a continual basis to ensure that potential gaps in control and / or assurance are managed effectively with action plans to address them as required.

Jan Filochowski, Chief Executive
Date: 9 June 2009

Statement of the Accountable Officer of the Trust

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

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

To the best of my knowledge and belief; I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Jan Filochowski, Chief Executive
Date: 9 June 2009

Statement of Directors Responsibilities

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

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

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

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

By order of the Board

Jan Filochowski, Chief Executive
Date: 9 June 2009

Anna Anderson, Finance Director
Date: 9 June 2009

Annual Report 2009/10: Financial Review

2009/10 was the third year in succession that the Trust has delivered a surplus outturn.

The Trust's plan for the year was to deliver a surplus of £4.6m. The Trust achieved a surplus of £5.7m[1]. This has enabled it to achieve its statutory break-even duty:

Year	2006/07	2007/08	2008/09	2009/10
In year surplus/(deficit)	£(11.4m)	£2.5m	£4.4m	£5.7m
Cumulative surplus/(deficit)	£(11.4m)	£(8.9m)	£(4.5m)	£1.2m

The Trust delivered £8.8m efficiency savings in 2009/10. Following the revaluation of Trust assets, the Trust's depreciation and dividend costs were reduced by a further £2m. These enabled the Trust to achieve its target of £10.8m savings.

Statement of Financial Position

The most significant impact on the Statement of Financial Position (Balance Sheet) has been the reduction in plant, property and equipment values in line with the modern equivalent assets valuations[2], as required by the Treasury. The value of some of the Trust's buildings were reduced significantly owing to their age.

Finance Developments

The Trust has successfully implemented International Financial Reporting Standards for its 2009/10 reporting.

The roll-out of electronic authorisation of invoices has continued. This has enabled the Trust to improve its performance against the Better Payment Practice Code.

Service Line Reporting system is online to be implemented in 2010/11.

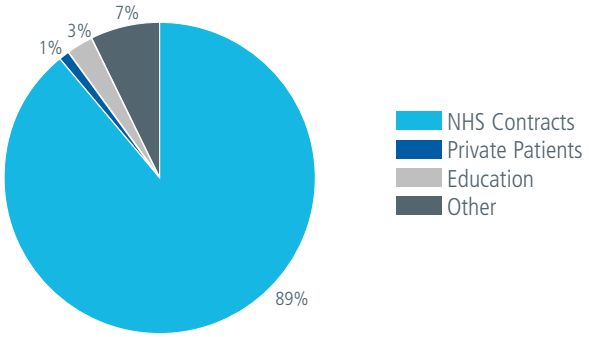
The Trust has achieved a "Good" rating for its financial management in 2008/09. Work has continued to improve processes over 2009/10 with the result that the Trust expects to maintain its "Good" level in 2009/10.

As a back office function, the department continually strives to deliver better value for money. It identified significant savings from its budget in 2009/10.

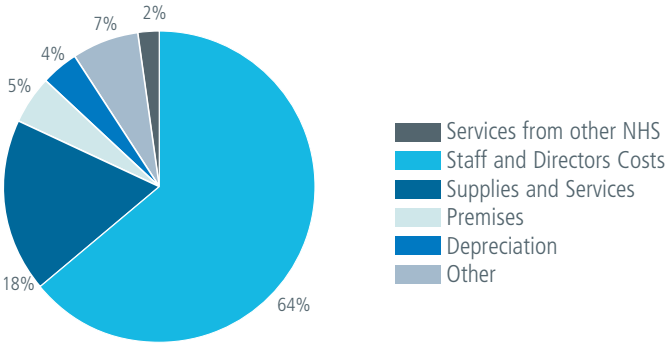
Financial Strategy

The Trust has worked closely with key stakeholders both within and outside the Trust during 2009/10 to develop the Trust's long-term financial strategy and to contribute the development of the Long Term Financial Model which supports the Trust's Foundation Trust application.

Sources of Income 2009/10



Where we spent our money 2009/10



[1]£5.7m excludes the technical effect of an impairment to asset values of £57.9m. This did not have a cash effect and did not count against the Trust's duty to deliver a surplus. [2]The modern equivalent asset approach assesses the building value based on the cost of modern buildings required for services to be provided, adjusted for the age and condition of the actual buildings.

Formal Sub Committees of the Board

During the latter part of 2009/10, the Trust reviewed the Board's sub-committee structure and approved a document – Scheme of Governance - establishing the governance arrangements for the Trust, with a revised committee structure. The sub committees reporting directly to the Board are:

- Audit Committee
- Remuneration Committee
- Charitable Funds Committee
- Finance Committee
- Integrated Risk and Governance Committee

In addition, the Clinical Quality and Governance Groups will report via the Medical Director and/or the Chief Executive.

Audit Committee

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 committee is chaired by a Non Executive Director.

Membership:
All Non Executive Directors are members of this committee.

Remuneration Committee

Has formal and transparent procedures for developing policy on executive remuneration and for fixing the remuneration packages of individual directors.

Membership:
The Trust Chair and two other Non-Executives will be members of this committee.

Charitable Funds Committee

To ensure Funds Held on Trust/Charitable Funds are managed in accordance with the Trust's Standing Financial Instruction No 29, as approved by the Trust Board. A Non Executive Director chairs this committee.

Membership:
Three Non-Executives Directors will be members of this committee.

Finance Committee

To consider the Trust's strategic financial plans as set out in the Long Term Financial Model, to assess whether they will achieve financial viability and to maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and contractual conditions.

Membership:
Three Non-Executives Directors will be members of this committee.

Integrated Risk and Governance Committee

Provides the Board with assurance and a shared and clear understanding of the key risks in the Trust, linking clinical, financial and non clinical risks, by reviewing the mitigation in place to minimise risks and set the Trust's appetite for risk. The committee also assesses and reviews the Trust's High Level Risk Register, which records all risks scoring 20 or above, not on the Board Assurance Framework.

Membership: Chaired by a Non-Executives, with the chair of the Audit Committee as deputy. Executive team members, senior clinicians and the integrated risk team are also members.

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 2009/10 is shown below.

Register of Interests (as at March 2010)

Name	Date Declaration Noted by the Board	Interest Declared
Professor Thomas Hanahoe	March 2010	- None
Robin Douglas	March 2010	- Chair of the Health and Social Care Advisory Service - Chair of The Who Cares? Trust - Independent consultant in public services via Douglas Consulting - National Advisor to the Local Govt Leadership Centre and Coach with the NHS Institute
Colin Gordon	March 2010	- Governor of the University of Hertfordshire - Chair of company PJ Pipe & Valve Co Ltd
Mahdi Hasan	March 2010	- Project Management Advisor, OMV gmbh, Austria - Business Advisor, Hertfordshire Schools Young Enterprise Scheme - Volunteer Driver, West Hertfordshire Hospitals NHS Trust - Project Management Advisor to Gulfsands Petroleum plc - Project Management Advisor to Rocksource Gulf of Mexico Corporation
Katherine Charter	March 2010	- Teaching Assistant employed by Herts County Council
Stuart Lacey	March 2010	- Commercial Director, BT plc
Sarah Connor	March 2010	- None
Jan Filochowski	March 2010	- None
Dr Colin Johnston	March 2010	- None
Tracy Moran	March 2010	- None
Nick Evans	March 2010	- None
Sarah Wiles	March 2010	- None
Sarah Childerstone	March 2010	Married to UK Director of BUPA Care Homes Trustee of the Council of the Tavistock Institute of Human Relations in London.
David McNeil	March 2010	- None
Russell Harrison	March 2010	- None
Anna Anderson	March 2010	- None

Directors Remuneration

Name	Title		2009-10 Salary (Bands of £5,000)	2009-10 Other Remuneration (Bands of £5,000)	2009-10 Benefits in Kind (£100)	2008-09 Salary (Bands of £5,000)	2008-09 Other Remuneration (Bands of £5,000)	2008-09 Benefits in Kind (Bands of £100)
			£	£	£	£	£	£
T. Hanahoe	Chairman		25-30	0	0	20-25	0	0
J. Filochowski*	Chief Executive	Permanently appointed Sept'09	140-145	0	18		See below	
R. Douglas	Non-Executive Director		5-10	0	0	5-10	0	0
C. Gordon	Non-Executive Director		5-10	0	0	0-5	0	0
K. Charter	Non-Executive Director		5-10	0	0	0-5	0	0
M. Hasan	Non-Executive Director		5-10	0	0	5-10	0	0
S. Lacey	Non-Executive Director		5-10	0	0	5-10	0	0
S. Connor	Non-Executive Director	Start Dec'09	0-5	0	0	0	0	0
M. Ashworth	Director of Finance	Left April'09	80-85	0	3	70-75	0	38
P. Bradley	Acting Director of Finance	Acting May'09	10-15	0	0	0	0	0
M. Salter**	Interim Director of Finance	Secondment start June'09 end Jan'10						
A. Anderson	Director of Finance	Start Jan'10	25-30	0	0	0	0	0
G. Etheridge	Director of Nursing	Left Sept'09	55-60	0	7	90-95	0	28
S. Osbourne	Interim Director of Nursing	Start Oct'09	40-45	0	0	0	0	0
T. Moran	Acting Director of Nursing	Start Jan'10	15-20	0	0	0	0	0
N. Evans	Director of Partnerships		105-110	0	4	95-100	0	400
S. Childerstone	Director of Human Resources		100-105	0	14	90-95	0	0
R. Harrison	Director of Delivery		105-110	0	0	95-100	0	0
S. Wiles	Director of Strategy & Infrastructure		65-70	0	30	0	0	0
G. Ramsey	Medical Director	Left Aug'09	120-125	0	10	185-190	0	55
C. Johnston	Medical Director	Start Sept'09	60-65	115-120	0	0	0	0

*The Chief Executive was not an employee of the Trust during 2008-09 and the start of 2009-10 but was seconded to the Trust on an agreed contract from South East Coast Strategic Health Authority. The costs charged for 2008-09 were £308k and £248k for the first 6 months of 2009-10 this includes, salary, employers national insurance, superannuation contributions and benefits in kind. **From June 2009 to January 2010 M. Salter was not an employee of the Trust but during this period was seconded to the Trust on an agreed contract from Imperial College Healthcare NHS Trust The costs charged for the secondment period, includes, salary, employers national insurance, superannuation contributions and benefits in kind totalled £109k.

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 2010 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real increase in Cash Equivalent Transfer Value (bands of £1,000)	Employer's contribution to stakeholder pension
J. Filochowski	12.5-15	37.5-40	120-125	370-375	3,152,837	2,576,316	298	0
M. Ashworth	0-2.5	0-2.5	0-5	10-15	84,319	54,092	1	0
A. Anderson	0-2.5	0-2.5	40-45	125-130	980,900	886,987	8	0
P. Bradley	0-2.5	0-2.5	30-35	100-105	601,912	492,098	5	0
G. Etheridge	0-2.5	0-2.5	25-30	80-85	499,430	455,089	7	0
T. Moran	0-2.5	0-2.5	10-15	40-45	225,590	182,853	5	0
N. Evans	0-2.5	0-2.5	45-50	135-140	1,106,212	1,025,854	18	0
R. Harrison	0-2.5	0-2.5	10-15	35-40	163,084	149,756	4	0
S. Childerstone	0-2.5	2.5-5	5-10	20-25	681,328	595,601	36	0
S. Wiles	0-2.5	0-2.5	10-15	30-35	150,801	128,926	10	0
G. Ramsay	0-2.5	5-7.5	5-10	25-30	201,825	110,179	28	0
C. Johnston	2.5-5	10-12.5	50-55	160-165	1,311,334	1,054,502	74	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost, this particularly applies to J. Filochowski. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. particularly applies to J. Filochowski. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Auditor's report

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

Opinion on the annual accounts

We have audited the annual accounts of West Hertfordshire Hospitals NHS Trust for the year ended 31 March 2010 under the Audit Commission Act 1998. The annual accounts comprise of 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. These annual accounts have been prepared 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 set out within them.

We have also audited the information in the Remuneration Report that is described as having been audited.

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 49 of the Statement of Responsibilities of Auditors and of Audited Bodies published by the Audit Commission in April 2008. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

The directors' responsibilities for preparing the annual accounts in accordance with directions made by the Secretary of State are set out in the Statement of Directors' Responsibilities.

Our responsibility is to audit the annual accounts in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

We report to you our opinion as the whether the annual accounts give a true and fair view in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. We report whether the annual accounts and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. We also report to you whether, in our opinion, the information which comprises the commentary on the financial performance included within the Directors' Report, included in the Annual Report, is consistent with the annual accounts.

We review whether the directors' Statement on Internal Control reflects compliance with the Department of Health's requirements, set out in 'Guidance on Completing the Statement on Internal Control 2009/10' issued in February 2010. We report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information we are aware of from our audit of the annual accounts. We are not required to consider, nor have we considered, whether the directors' Statement on Internal Control covers all risks and controls. Neither are we required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We read the other information contained in the Annual Report and consider whether it is consistent with the audited annual accounts. This other information comprises the unaudited part of the Remuneration Report and the remaining elements of the Director's Report. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the annual accounts. Our responsibilities do not extend to any other information.

Basis of audit opinion

We conducted our audit in accordance with the Audit Commission Act 1998, the Code of Audit Practice issued by the Audit Commission and International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the annual accounts and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the annual accounts, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that:

- the annual accounts are free from material misstatement, whether caused by fraud or other irregularity of error; and
- the annual accounts and the part of the Remuneration Report to be audited have been properly prepared

In forming our opinion we also evaluated the overall adequacy of the presentation of information in the annual accounts and the part of the Remuneration Report to be audited.

Opinion

In our opinion:

- the annual accounts give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2010 and of its income and expenditure for the year then ended;
- the annual accounts and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England; and
- information which comprises the commentary on the financial included within the Directors' Report, included within the Annual Report, is consistent with the annual accounts.

Conclusion on arrangements for securing economy, efficiency and effectivemess in the use of resources.

Directors' Responsibilities

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

Auditor's Responsibilities

We are required by the Audit Commission Act 1998 to be satisfied that proper arrangements have been made by the Trust for securing economy, efficiency and effectiveness in is use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion in relation to proper arrangements, having regard to the criteria for NHS bodies specified by the Audit Commission. We report if significant matters have come to our attention which prevent us from concluding that the Trust has made such proper arrangements. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Conclusion

We have undertaken our audit in accordance with the Code of Audit Practice and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, we are satisfied that, in all significant respects, West Hertfordshire Hospitals NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2010.

Certificate

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

Paul Dossett

Paul Dossett, Senior Statutory Auditor for and on behalf of Grant Thornton UK LLP
Date: 10 June 2010
Address: Grant Thornton House Melton Street, London NW1 2EP

Statement of comprehensive income for the year ended 31 March 2010

	NOTE	2009/10 £000	2008/09 £000
Revenue			
Revenue from patient care activities	4	**227,443**	214,288
Other operating revenue	5	**26,865**	27,396
Operating expenses	6	**(299,504)**	(227,537)
Operating surplus (deficit)		**(45,196)**	14,147
Finance costs:			
Investment revenue	12	**31**	615
Other gains and (losses)	13	**(11)**	(5)
Finance costs	14	**(1,763)**	(1,478)
Surplus/(deficit) for the financial year		**(46,939)**	13,279
Public dividend capital dividends payable		**(5,228)**	(8,849)
Retained surplus/(deficit) for the year		**(52,167)**	**4,430**
Other comprehensive income			
Impairments and reversals		(68,270)	(30,708)
Gains on revaluations		0	6,688
Receipt of donated assets		49	31
Reclassification adjustments:			
- Transfers from donated asset reserve		(226)	(303)
Total comprehensive income for the year		**(120,614)**	**(19,862)**

The notes on pages 41 to 51 form part of these accounts.
Operating expenses include an impairment to asset values of £57,866k see note 6 and note 15. Adjusting for this, the retained surplus would be £5,699k.

Statement of financial position as at 31 March 2010

	NOTE	31 March £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Property, plant and equipment	15	**131,615**	251,421	253,048
Intangible assets	16	**3,325**	4,092	4,074
Trade and other receivables	19	**1,575**	1,618	1,408
Total non-current assets		**136,515**	257,131	258,530
Current assets				
Inventories	18	**3,530**	2,912	2,987
Trade and other receivables	19	**13,306**	13,514	11,580
Cash and cash equivalents	21	**1,776**	5,285	0
		18,612	21,711	14,567
Non-current assets held for sale	22	**260**	0	0
Total current assets		**18,872**	21,711	14,567
Total assets		**155,387**	278,842	273,097
Current liabilities				
Trade and other payables	23	**(20,780)**	(27,402)	(25,179)
DH Working capital loan	24	**(3,640)**	(2,240)	(2,240)
DH Capital loan	24	**(2,772)**	(2,772)	0
Provisions	26	**(550)**	(529)	(1,063)
Net current assets/(liabilities)		**(8,870)**	(11,232)	(13,915)
Total assets less current liabilities		**127,645**	245,899	244,615
Non-current liabilities				
DH Working capital loan	24	**(7,840)**	(4,480)	(6,720)
DH Capital loan	24	**(19,395)**	(22,167)	0
Provisions	26	**(5,430)**	(5,726)	(6,123)
Total assets employed		**94,980**	213,526	231,772
Financed by taxpayers' equity:				
Public dividend capital		**173,668**	171,600	169,984
Retained earnings		**(100,168)**	(48,832)	(54,727)
Revaluation reserve		**20,545**	89,001	114,552
Donated asset reserve		**935**	1,757	1,963
Total Taxpayers' Equity		**94,980**	213,526	231,772

The financial statements on pages 41 to 51 were approved by the Board on 9th June 2010 and signed on its behalf by:

Jan Filochowski, Chief Executive
Date: 9 June 2009

Statement of changes in taxpayers' equity

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Total
	£000	£000	£000	£000	£000
Balance at 31 March 2008					
As previously stated	169,984	(54,727)	105,013	1,963	222,233
Prior Period Adjustment *	0	0	9,539	0	9,539
Restated balance	169,984	(54,727)	114,552	1,963	231,772
Changes in taxpayers' equity for 2008/09					
Total Comprehensive Income for the year:					
Retained surplus/(deficit) for the year	0	4,430	0	0	4,430
Transfers between reserves	0	1,465	(1,465)	0	0
Impairments and reversals	0	0	(30,708)	0	(30,708)
Net gain on revaluation of property, plant, equipment	0	0	6622	60	6688
Receipt of donated/government granted assets	0	0	0	31	31
Reclassification adjustments:					
- transfers from donated asset reserve	0	0	0	(303)	(303)
New PDC received	10,616	0	0	0	10,616
PDC repaid in year	(9,000)	0	0	0	(9,000)
Balance at 31 March 2009	171,600	(48,832)	89,001	1,757	213,526
Changes in taxpayers' equity for 2009/10					
Balance at 1 April 2009	171,600	(48,832)	89,001	1,757	213,526
Total Comprehensive Income for the year					
Retained surplus/(deficit) for the year	0	(52,167)	0	0	(52,167)
Transfers between reserves	0	831	(831)	0	0
Impairments and reversals	0	0	(67,625)	(645)	(68,270)
Receipt of donated/government granted assets	0	0	0	49	49
Reclassification adjustments:					
- transfers from donated asset reserve	0	0	0	(226)	(226)
New PDC received	2,068	0	0	0	2,068
Balance at 31 March 2010	173,668	(100,168)	20,545	935	94,980

*The Prior period adjustment relates to a change in accounting policy concerning the valuation of new buildings and enhancements fully brought into use. Variation between cost and ideal conditions assumed by the Valuers were previously adjusted through the revaluation reserve; from 1 April 2008 this practice was no longer permitted.

Statement of cash flows for the year ended 31 March 2010

	NOTE	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**(45,196)**	14,147
Depreciation and amortisation		**8,671**	10,505
Impairments and reversals		**57,866**	0
Transfer from donated asset reserve		**(226)**	(303)
Interest paid		**(1,645)**	(1,287)
Dividends paid		**(5,364)**	(8,849)
(Increase)/decrease in inventories		**(618)**	75
(Increase)/decrease in trade and other receivables		**375**	(2,189)
Increase/(decrease) in trade and other payables		**(3,859)**	276
Increase/(decrease) in provisions	26	**(400)**	(1,063)
Net cash inflow/(outflow) from operating activities		**9,604**	11,312
Cash flows from investing activities			
Interest received		**34**	684
(Payments) for property, plant and equipment	15	**(18,003)**	(30,697)
Proceeds from disposal of plant, property and equipment		**1,129**	187
(Payments) for intangible assets	16	**(329)**	(516)
Net cash inflow/(outflow) from investing activities		**(17,169)**	(30,342)
Net cash inflow/(outflow) before financing		**(7,565)**	(19,030)
Cash flows from financing activities			
Public dividend capital received		**2,068**	10,616
Public dividend capital repaid		**0**	(9,000)
Loans received from the DH		**7,000**	27,000
Loans repaid to the DH		**(5,012)**	(4,301)
Other capital receipts		**0**	0
Net cash inflow/(outflow) from financing		**4,056**	24,315
Net increase/(decrease) in cash and cash equivalents		**(3,509)**	5,285
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**5,285**	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	21	**1,776**	5,285

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 2009/10 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 Trust received from its main purchaser £1.5m for the successful delivery of a project established to eliminate mixed sex inpatient accommodation by June 2009. This funding is included within other operating revenue see note 5;
- 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. For 2009/10 these charitable funds have not been consolidated into these accounts. This divergence from IAS 27 has been agreed by HM Treasury for 2010/11 also.

1.3.2 Key sources of estimation uncertainty

In preparing these accounts the Trust has made assumptions concerning the future that affect the amounts of assets, liabilities, revenue and expenses reported. The assumptions and basis of estimate are explained in the related notes. There are no significant assumptions likely to affect the reported figures.

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 recover the cost of treating injured individuals who subsequently obtain personal injury compensation through e.g. 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 made 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, additional pension cost is not funded by the NHS Pensions Scheme. The 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 forming 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 annually 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.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS trusts must apply these new valuation requirements by 1 April 2010 at the latest. The Trust has adopted this approach with effect from 1 April 2009 through its appointed valuers GVA Grimleys Ltd. The effect of change in estimation technique is detailed in note 15.3.

Properties in the course of construction for service or administrative 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 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. 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 details for each class of asset is shown in note 15.3.

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

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for

the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to offset the expenditure. On sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

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. Fair value is open market value including alternative uses.

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. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then 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. All other leases are classified as operating leases, these are shown 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.

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.

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 arsing from the restructuring, which are those amounts that are 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 26.

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 EU Emmissions Trading Scheme

Because the aggregated rated thermal input capacity of combustion plant is less than 20MW the Trust is not registered with the EU Emissions Trading Scheme.

1.19 Contingencies

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

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

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

1.20 Financial assets

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

1.21 Financial liabilities

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

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

1.22 Value added tax

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.

1.23 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 32 to the accounts.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS 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 donated assets and 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. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts (see note 30.2) discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.26 Losses and special payments

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

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

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

The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2010/11. None of them are expected to impact upon the Trust financial statements.

IAS 27 (Revised) Consolidated and separate financial statements (see note 1.3.1)
Amendment to IAS 32 Financial instruments: Presentation on classification or rights issues
Amendment to IAS 39 Eligible hedged items
IFRS 3 (Revised) Business combinations
IFRIC 17 Distributions of Non-cash Assets to Owners
IFRIC 18 Transfer of assets from customers

1.28 Accounting standards issued that have been adopted early

The Trust has adopted the amendments to IFRS 8 Operating segments. This requires additional information relating to reported segments. Note 2 explains that the Trust operates as a single segment: the delivery of healthcare.

1.29 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. It is revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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, predominantly 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 in total through agreements established with primary care trusts (PCTs), each agreement covering the complete range of activities provided. The Trust's assets are also used collectively to deliver the range of activities encompassed within PCT agreements.

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:

	2009/10 £000	2008/09 £000
Prescription Packaging Unit	1,385	1,325
Full cost	(1,124)	(1,193)
Surplus/(deficit)	261	132

The 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 hours services and HM Prisons in addition to supplying the Trust itself.

4. Revenue from patient care activities

	2009/10 £000	2008/09 £000
Strategic health authorities	6,015	0
Primary care trusts*	219,027	181,590
Local authorities	238	0
Department of Health*	0	30,270
Non-NHS:		
Private patients	1,050	1,194
Overseas patients (non-reciprocal)	193	196
Injury costs recovery	900	1,023
Other	20	15
	227,443	214,288

Injury cost recovery income is subject to a provision for impairment of receivables of 2.2% to reflect expected rates of collection.
*Prior to 2009/10 the Department of Health funded the cost of patient care estimated to reflect the geographical variations in cost. This element of funding is termed market forces factor and for 2009/10 is paid for by PCTs.

5. Other operating revenue

	2009/10 £000	2008/09 £000
Education, training and research	8,338	8,014
Charitable and other contributions to expenditure	98	57
Transfers from Donated Asset Reserve	226	303
Non-patient care services to other bodies	13,940	16,495
Income generation	2,269	2,180
Rental revenue	494	347
Other revenue	1,500	0
	26,865	27,396

Other revenue relates to funds received from the Trust's main commissioner West Hertfordshire PCT for the successful delivery of a project to eliminate mixed sex inpatient accommodation. Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

6. Operating expenses

	2009/10 £000	2008/09 £000
Services from other NHS Trusts	2,424	1,392
Services from other NHS bodies	121	0
Services from Foundation Trusts	0	1,732
Purchase of healthcare from non NHS bodies	1,095	2,299
Directors' costs	1,114	1,037
Other Employee Benefits	155,915	147,410
Supplies and services - clinical	35,008	31,353
Supplies and services - general	7,851	7,225
Consultancy services	696	807
Establishment	3,381	3,313
Transport	2,550	2,306
Premises	11,947	11,400
Provision for impairment of receivables	134	36
Depreciation	7,465	9,826
Amortisation	1,206	679
Impairments and reversals of property, plant and equipment	57,866	0
Audit fees	169	269
Other auditor's remuneration	0	18
Clinical negligence	5,364	2,782
Education and Training	588	503
Other	4,610	3,150
	299,504	227,537

Directors' costs above exclude non voting directors who are included in staff costs.
The purchase of healthcare from non-NHS bodies relates to the outsourcing of activity to meet national waiting time targets.

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	2009/10 £000	2008/09 £000
Minimum lease payments	559	724
	559	724

Total future minimum lease payments	2009/10 £000	2008/09 £000
Payable:		
Not later than one year	536	625
Between one and five years	401	752
After 5 years	21	27
Total	958	1,404

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	2009/10 £000	2008/09 £000
Total rental revenue	494	347

Total future minimum lease payments	2009/10 £000	2008/09 £000
Receivable:		
Not later than one year	512	350
Between one and five years	2,562	1,880
After 5 years	553	0
Total	3,627	2,230

8.1 Employee costs

	2009/10 Total £000	Permanently Employed £000	Other £000	2008/09 Total £000	Permanently Employed £000	Other £000
Salaries and wages	132,071	118,295	13,776	125,765	113,080	12,685
Social Security Costs	10,574	9,919	655	10,046	9,546	500
Employer contributions to NHS Pension scheme	14,318	13,346	972	13,312	12,570	742
Employee benefits expense	156,963	141,560	15,403	149,123	135,196	13,927
Of the total above:						
Charged to capital	507			539		
Employee benefits charged to revenue	156,456			148,584		
	156,963			149,123		

8.2 Average number of people employed

	Total	2009/10 Permanently Employed	Other	Total	2008/09 Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	529	499	30	518	489	29
Ambulance staff	0	0	0	0	0	0
Administration and estates	941	854	87	890	794	96
Healthcare assistants and other support staff	583	509	74	540	497	43
Nursing, midwifery and health visiting staff	1,150	1,057	93	1,135	1,069	66
Nursing, midwifery and health visiting learners	4	4	0	2	2	0
Scientific, therapeutic and technical staff	403	370	33	362	342	20
Social care staff	0	0	0	0	0	0
Other	38	37	1	41	33	8
Total	3,648	3,330	318	3,488	3,226	262
Of the above:						
Number of staff engaged on capital projects	17			16		

Staff numbers are an average of monthly establishment.

8.3 Staff sickness absence

	2009/10 Number
Days lost (long term)	0
Days lost (short term)	26,837
Total days lost	**26,837**
Total staff years employed (wte)	**3,281**
Average days lost per staff year employed	8.18
Total staff employed in period (headcount)	3,848
Total staff employed in period with no absence (headcount)	1,388
Percentage staff with no sick leave	**36.1%**

8.4 Management costs

	2009/10 £000	2008/09 £000
Management costs	13,992	13,070
Income	254,308	241,684
Percentage of Management costs to income	**5.50%**	5.41%

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, 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. 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 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually at the end of the reporting period by the scheme actuary. This is undertaken by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

In 2009-10 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.

Lump sum allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-health retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment through illness or infirmity.

Death benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)
Members can purchase additional years 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.

Transfer between funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved benefits
Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for early retirement
Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

10. Retirements due to ill-health
During 2009/10 there were 12 (2008/09, 5) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £596k (2008/09: £171k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division. These early retirements represented 2.9 per 1,000 active scheme members.

11. 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.

11.1 Better Payment Practice Code - measure of compliance

	2009/10		2008/09	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	54,527	68,238	58,153	61,154
Total Non NHS trade invoices paid within target	42,684	52,014	39,164	40,112
Percentage of Non-NHS trade invoices paid within target	78%	76%	67%	66%
Total NHS trade invoices paid in the year	2,716	22,425	3,367	19,115
Total NHS trade invoices paid within target	1,883	17,622	2,107	16,218
Percentage of NHS trade invoices paid within target	69%	79%	63%	85%

12. Investment revenue

	2009/10 £000	2008/09 £000
Interest revenue:		
Bank accounts	31	615
Total	31	615

The Trust was not permitted to actively invest surplus cash. Interest revenue relates to interest earned on average cash balances held with the Government banking service.

13. Other gains and losses

	2009/10 £000	2008/09 £000
Gain/(loss) on disposal of property, plant and equipment	(11)	(5)

14. Finance Costs

	2009/10 £000	2008/09 £000
Interest on loans with the Department of Health	1,638	1,346
Other finance costs relate to unwinding of discount in determining fair value of provisions.	125	132
Total	1,763	1,478

15. Property, plant and equipment

15.1 2009/10:

	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	65,956	146,437	10,413	12,191	28,693	196	8,235	5,253	277,374
Additions purchased	0	8,022	366	5,924	566	0	252	117	15,247
Additions donated	0	0	0	0	49	0	0	0	49
Reclassifications	0	6,934	1,422	(11,646)	2,024	0	1,092	64	(110)
Reclassified as held for sale	(385)	0	(1,005)	0	0	0	0	0	(1,390)
Disposals other than by sale	0	0	0	0	(1,312)	0	0	0	(1,312)
Impairments	(33,223)	(30,558)	(3,867)	0	0	0	0	(622)	(68,270)
At 31 March 2010	32,348	130,835	7,329	6,469	30,020	196	9,579	4,812	221,588
Depreciation at 1 April 2009	0	0	0	0	17,148	185	6,735	1,885	25,953
Disposals other than by sale	0	0	0	0	(1,311)	0	0	0	(1,311)
Impairments	2,984	48,801	5,366	0	0	0	0	715	57,866
Charged during the year	0	3,328	169	0	3,086	8	787	87	7,465
Depreciation at 31 March 2010	2,984	52,129	5,535	0	18,923	193	7,522	2,687	89,973
Net book value									
Purchased	29,364	78,467	1,794	6,469	10,411	3	2,049	2,123	130,680
Donated	0	239	0	0	686	0	8	2	935
Total at 31 March 2010	29,364	78,706	1,794	6,469	11,097	3	2,057	2,125	131,615
Asset financing									
Owned	29,364	78,706	1,794	6,469	11,097	3	2,057	2,125	131,615
Total 31 March 2010	29,364	78,706	1,794	6,469	11,097	3	2,057	2,125	131,615

Major building additions include the reconfiguration and refurbishment at Hemel Hempstead Hospital. Further detail of the impairment of land and buildings is provided in note 15.3.

Prior year:

15.2 2008/09:

	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	96,671	114,751	10,326	19,343	22,186	187	7,916	4,571	275,951
Additions purchased	180	17,814	0	9,000	4,865	4	189	513	32,565
Additions donated	0	0	0	17	14	0	0	0	31
Reclassifications	0	15,142	7	(16,934)	1,492	0	130	2	(161)
Disposals other than by sale	(187)	0	0	0	(445)	0	0	0	(632)
Revaluation/indexation gains	0	5,176	437	765	581	5	0	167	7,131
Impairments	(30,708)	0	0	0	0	0	0	0	(30,708)
At 31 March 2009	65,956	152,883	10,770	12,191	28,693	196	8,235	5,253	284,177
Depreciation at 1 April 2008	0	0	0	0	15,293	171	5,894	1,545	22,903
Disposals other than by sale	0	0	0	0	(416)	0	0	0	(416)
Revaluation/indexation gains	0	0	0	0	400	4	0	39	443
Charged during the year	0	6,446	357	0	1,871	10	841	301	9,826
Depreciation at 31 March 2009	0	6,446	357	0	17,148	185	6,735	1,885	32,756
Net book value									
Purchased	65,956	145,739	10,413	12,174	10,724	4	1,487	3,167	249,664
Donated	0	698	0	17	821	7	13	201	1,757
Total at 31 March 2009	65,956	146,437	10,413	12,191	11,545	11	1,500	3,368	251,421
Asset financing									
Owned	65,956	146,437	10,413	12,191	11,545	11	1,500	3,368	251,421
Total 31 March 2009	65,956	146,437	10,413	12,191	11,545	11	1,500	3,368	251,421

Major building additions include the Acute Assessment Unit and Princess Michael of Kent refurbishment at Watford General Hospital. The impairment of land value is based on indexation produced by the Valuation Office January 2008 to January 2009 and reflects the general economic fall in value.

15.3 Property, plant and equipment

Of the £15,296k additions, £49k 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 method (DRC) using the modern equivalent asset (MEA) technique. This technique has been used for the first time in 2009/10 (see note 1.7). The 2008/09 valuations (note 15.2) are based on DRC using exact replacement.

The impairment shown in 2009/10 relates to the following:

	Watford Hospital £000	Hemel Hempsted Hospital £000	St Albans Hospital £000	Total £000
Operating expenses (note 6)				
Land - MEA	1,990	994	0	2,984
Buildings, dwellings and fittings - MEA	37,522	3,376	5,691	46,589
Buildings, dwellings and fittings no longer in use	0	8,293	0	8,293
	39,512	12,663	5,691	57,866
Other comprehensive income (SOCI)				
Land - MEA	22,831	8,468	1,924	33,223
Buildings, dwellings and fittings - MEA	9,194	12,173	5,004	26,371
Buildings, dwellings and fittings no longer in use	0	8,676	0	8,676
	32,025	29,317	6,928	68,270

Included within the above is a 3.1% estimated fall in the value of Buildings, dwellings and fittings during the year 1 April 2009 to 31 March 2010.

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 are tabled below:

	As at 31 March 2010		As at 31 March 2009	
Asset Class	Maximum remaining asset life Years	Minimum remaing asset life Years	Maximum remaining asset life Years	Minimum remaing asset life Years
Buildings	59	9	61	1
Dwellings	24	10	53	3
Plant and machinery	9	1	10	2
Transport	4	0	3	0
Information Technology	7	1	7	1
Furniture and Fittings	59	9	26	1

Buildings, dwellings and fittings asset lives have been revised in adopting the MEA valuation technique.

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 £13,881k.

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 is estimated at £3.1m and depreciation for the period is £95k.

16. Intangible assets

2009/10:

	Computer software - in use £000	Computer Software in development £000	Total £000
Gross cost at 1 April 2009	4,760	1,048	5,808
Additions purchased	272	57	329
Reclassifications	944	(834)	110
Gross cost at 31 March 2010	**5,976**	**271**	**6,247**
Amortisation at 1 April 2009	1,716	0	1,716
Charged during the year	1,206	0	1,206
Amortisation at 31 March 2010	**2,922**	**0**	**2,922**
Net book value			
Purchased	3,054	271	3,325
Donated	0	0	0
Total at 31 March 2010	**3,054**	**271**	**3,325**

Prior year:

2008/09:

	Computer software - in use £000	Computer Software in development £000	Total £000
Gross cost at 1 April 2008	4,349	762	5,111
Additions purchased	23	513	536
Reclassifications	388	(227)	161
Gross cost at 31 March 2009	4,760	1,048	5,808
Amortisation at 1 April 2008	1,037	0	1,037
Charged during the year	679	0	679
Amortisation at 31 March 2009	1,716	0	1,716
Net book value			
Purchased	3,044	1,048	4,092
Donated	0	0	0
Total at 31 March 2009	3,044	1,048	4,092

Details of intangible asset life are tabled below:

	Maximum remaining asset life Years
Computer software in use	5

There are no material intangible assets fully amortised still in use.
There were no changes in asset lives or residual values for software in use made during the year.
Intangible assets are held at depreciated cost as a proxy for fair value; there are no associated revaluation reserves.

17. Capital commitments

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

	31 March 2010 £000	31 March 2009 £000
Property, plant and equipment	**1,062**	1,734
Intangible assets	**0**	0
Total	**1,062**	**1,734**

18. Inventories

	31 March 2010 £000	31 March 2009 £000
Drugs	1,089	990
Consumables	2,177	1,808
Energy	264	114
Total	3,530	2,912

During the period there was no write-down of inventories or reversal of write-down. Reported fair value is not materially different from net realisable value.

19. Trade and other receivables

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
NHS receivables-revenue	9,801	9,963	0	0
NHS receivables-capital	0	24	0	0
Non-NHS receivables-revenue	1,342	1,369	0	0
Provision for the impairment of receivables	(388)	(384)	0	0
Accrued income	1,803	1,440	0	0
VAT	325	656	0	0
Other receivables	423	446	1,575	1,618
Total	13,306	13,514	1,575	1,618

Trade and other receivables are carried at the original invoice amount. As the majority of trade is with primary care trusts, 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 Receivables past their due date but not impaired

	31 March 2010 £000	31 March 2009 £000
By up to three months	424	232
By three to six months	221	188
By more than six months	1,728	2,539
Total	2,373	2,959

19.3 Provision for impairment of receivables

	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	(384)	(448)
Amount written off during the year	130	100
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(134)	(36)
Balance at 31 March	(388)	(384)

In respect of non government related receivables an estimate of doubtful receivables is based on periodic review of outstanding amounts, which includes an analysis of age, creditworthiness and change in payment terms. The Injury Cost Recovery Unit's guidance is used to determine the provision for impairment of these receivables. Bad debt is written off when identified.

20. Other financial assets

The Trust has no Other Financial Assets.

21. Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	5,285	0
Net change in year	(3,509)	5,285
Balance at 31 March	1,776	5,285
Made up of		
Cash with Government Banking Service	1,802	5,335
Commercial banks and cash in hand	(26)	(50)
Current investments	0	0
Cash and cash equivalents as in statement of financial position and cash flows	1,776	5,285

22. Non-current assets held for sale

	Land £000	Dwellings £000	Total £000
Balance brought forward	0	0	0
Plus assets classified as held for sale in the year	385	1,005	1,390
Less assets sold in the year	(312)	(818)	(1,130)
Balance carried forward	73	187	260

The assets held for sale and sold relate to residential properties adjacent to Hemel Hempstead Hospital.

Due to the change in use of Hemel Hempstead Hospital, the Trust agreed in 2009/10 the properties are surplus to requirements and should be sold.

No gain or loss has been recognised on becoming classified as held for sale or subsequently. On disposal, the balance of related revaluation reserve has been transferred to retained earnings.

23. Trade and other payables

	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
Interest payable	73	80		
NHS payables-revenue	5,248	7,165	0	0
Non NHS trade payables - revenue	5,191	5,080	0	0
Non NHS trade payables - capital	2,404	5,159	0	0
Accruals and deferred income	5,426	6,609	0	0
Social security costs	1,556	1,480		
VAT	18	21	0	0
Tax	864	1,808		
Total	20,780	27,402	0	0

24. Borrowings

	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
Bank overdraft - Government Banking Service	0	0		
Bank overdraft - Commercial banks	0	0		
Loans from:				
Department of Health	6,412	5,012	27,235	26,647
Total	6,412	5,012	27,235	26,647

There are three Department of Health loans as detailed below:

£11.2m in March 2007 to support working capital. Repayable by twice-yearly equal instalments over five years ending March 2012. Interest at a rate of 5.45% is payable twice-yearly on a reducing balance.

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

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

25. Other liabilities

The Trust has no other payables or financial liabilities.

26. Provisions

	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
Pensions relating to staff	534	519	5,128	5,394
Other	16	10	302	332
Total	550	529	5,430	5,726

Other relates to staff and public liability claims managed by NHSLA and NHS Pensions Authority.

	Pensions relating to staff £000	Other £000	Total £000
At 1 April 2008	6,340	846	7,186
Arising during the year	144	89	233
Used during the year	-507	-314	-821
Reversed unused	-189	-286	-475
Unwinding of discount	124	8	132
Transfers in year	0	0	0
At 1 April 2009	5,912	343	6,255
Arising during the year	139	114	253
Used during the year	-507	-146	-653
Reversed unused	0	0	0
Unwinding of discount	118	7	125
Transfers in year	0	0	0
At 31 March 2010	5,662	318	5,980
Expected timing of cash flows:			
In the remainder of the spending review period to 31 March 2011	523	32	555
Between 1 April 2011 and 31 March 2016	2,818	170	2,988
Between 1 April 2016 and 31 March 2021	2,216	116	2,332
Thereafter	105	0	105

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

£68,221k is included in the provisions of the NHS Litigation Authority (NHSLA) as at 31 March 2010 in respect of clinical negligence liabilities of the Trust (£58,567k at 31 March 2009). Other relates to injury claims managed by the NHS Litigation Authority.

27. Contingencies

The Trust has no contingent assets or liabilities.

28. Financial Instruments

28.1 Financial assets

	At fair value through profit and loss £000	Loans and receivables £000	Available for sale £000	Total £000
Cash at bank and in hand		5,285		5,285
Other financial assets	0	0	0	0
Total at 31 March 2009	0	5,285	0	5,285
Cash at bank and in hand		1,776		1,776
Other financial assets	0	0	0	0
Total at 31 March 2010	0	1,776	0	1,776

28.2 Financial liabilities

	At fair value through profit and loss £000	Other £000	Total £000
DH Loans		31,659	31,659
Other financial liabilities	0	344	344
Total at 31 March 2009	0	32,003	32,003
DH Loans		33,647	33,647
Other financial liabilities	0	318	318
Total at 31 March 2010	0	33,965	33,965

28.3 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 relationship that the Trust has with primary care trusts and the way those primary care trusts 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 specificallty to change the risk 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 other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

29. Events after the reporting period

There are no post balance sheet events.

30. Financial performance targets

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

30.1 Breakeven Performance

	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000
Turnover	209,199	218,248	232,967	241,684	254,308
Retained surplus/(deficit) for the year	(26,785)	(11,413)	2,495	4,405	(52,167)
Adjustment for:					
Impairments				0	57,866
Other agreed adjustments	14,111	26,785	0	0	0
Break-even in-year position	(12,674)	15,372	2,495	4,405	5,699
Break-even cumulative position	(26,785)	(11,413)	(8,918)	(4,513)	1,186

1. Impairments are excluded from the break-even duty as they are "non cash impacting" in the year that they occur.
2. The "Other" agreed adjustments relate 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.
3. 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 net surplus.
4. The Trust achieved a cumulative net surplus in 2009/10 and has met the breakeven duty performance.

	2005/06 %	2006/07 %	2007/08 %	2008/09 %	2009/10 %
Materiality test (I.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	-6%	7%	1%	2%	2%
Break-even cumulative position as a percentage of turnover	-13%	-5%	-4%	-2%	0%

30.2 Capital cost absorption rate

For 2008/09 the Trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £8.8m, are of the actual average relevant net assets of £219.0m, that is 4%. This is within the Department of Health's materiality range of 3% to 4% (2007/08 3.7%).

From 2009/10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

30.3 External financing

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

	2009/10 £000	2008/09 £000
External financing limit	**9,341**	24,315
Cash flow financing	7,565	19,030
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	**7,565**	19,030
Undershoot/(overshoot)	**1,776**	5,285

30.4 Capital Resource Limit

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

	£000	£000
Gross capital expenditure	**15,625**	**33,132**
Less: book value of assets disposed of	**(1,131)**	**(216)**
Plus: loss on disposal of donated assets	**1**	**1**
Less: capital grants	**0**	**0**
Less: donations towards the acquisition of non-current assets	**(49)**	**(31)**
Charge against the capital resource limit	**14,446**	32,886
Capital resource limit	**18,668**	**37,752**
(Over)/Underspend against the capital resource limit	**4,222**	4,866

31. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of key management staff, or parties related to any of them, entered into 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 material transactions are (right column):

2009/10	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	1,062	2,068	0	0
Trusts				
East and North Hertfordshire NHS Trust	1,048	1,808	233	233
Hertfordshire Partnership NHS Foundation Trust	1,216	3,020	0	303
Primary Care Trusts (PCT)				
Barnet PCT	0	1,259	0	89
Bedfordshire Primary Care Trust	0	1,346	0	61
East and North Hertfordshire PCT	0	1,990	254	457
Harrow PCT	0	3,961	0	90
Hillingdon PCT	0	6,012	0	502
Luton PCT	0	1,511	1	551
South East Essex PCT	0	5,851	0	518
West Hertfordshire PCT	1,466	243,309	43	5,580
Health Authorities				
East of England Strategic Health Authority	5	10,086	1,100	86
National Blood Authority	2,030		27	4
Other Bodies				
NHS Business Services	1,001	0	78	0
NHS Purchasing and Supply Agency	6,520	0	629	0
	14,347	**282,221**	**2,364**	**8,476**
2008/09	27,397	275,434	1,404	607

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

	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	36,480	7,657	0	0
NHS Litigation Authority	5,521	0	0	0
NHS Pensions Agency	20,719	0	0	0
	62,720	**7,657**	**0**	**0**
2008/09	57,171	5,761	2	1

32. Third Party Assets

The Trust held £1k of cash and cash equivalents at 31 March 2010 (£2k - at 31 March 2009) which relate to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other Central Government Bodies including primary care trusts	9,462	0	7,119	0
Balances with NHS Trusts and Foundation Trusts	664	0	640	0
Intra Government balances	10,126	0	7,759	0
Balances with bodies external to Government	3,180	1,575	13,021	0
At 31 March 2010	**13,306**	**1,575**	**20,780**	**0**
Balances with other Central Government Bodies	9,561	0	9,508	0
Balances with Local Authorities	23	0	1	0
Balances with NHS Trusts and Foundation Trusts	402	0	948	0
Intra Government balances	9,986	0	10,457	0
Balances with bodies external to Government	3,528	1,618	16,945	0
At 31 March 2009	13,514	1,618	27,402	0

34. Losses and Special Payments

There were 126 cases of losses and special payments (2008/09: 121 cases) totalling £386,903 (2008/09: £179,503) accrued during 2009/10.

35. Transition to IFRS

Reconciliation of taxpayers equity as at 31 March 2009 as reported under UK GAAP with that under IFRS is shown below:

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 31 March 2009 under UK GAAP:	(47,975)	89,001	1,757	171,600	214,383
Adjustments for: Cost of leave not taken (see note 1.5)	(857)	0	0	0	(857)
Taxpayers' equity at 1 April 2009 under IFRS:	(48,832)	89,001	1,757	171,600	213,526

	£000
Surplus/(deficit) for 2008/09 under UK GAAP	14,117
Adjustments for: Reduced cost of leave not taken (see note 1.5)	30
Surplus/(deficit) for 2008/09 under IFRS	14,147

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £5,285k. This net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cash flows under IFRS.

West Hertfordshire Hospitals NHS
NHS Trust

For further **information** please call 01923 436227

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