annual report 10 11

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Welcome by Chief Executive and Chair

Thomas Hanahoe
Chairman

Jan Filochowski
Chief Executive

The Annual Report is an opportunity for us to look back over the past year and take stock. It is a chance to recognise our achievements and where we need to focus our efforts further. We are delighted that our services have been recognised as of good quality by the Care Quality Commission in that we received an unqualified registration, but we are not complacent and recognise that we have to continue to improve.

We want our patients to have a good experience at our hospitals and the quality of the services we provide to our local community is at the heart of everything we do. We are pleased to announce that in December 2010, the Trust received a national award from the Patient Experience Network for its work entitled Going for Gold to improve the patients' experience. This work is being recognised nationally and shared with other Trusts as evidence of good practice; however, we recognise this is an area where we still have more to do.

Many areas affect public confidence in healthcare, but paramount amongst them are healthcare acquired infections. We have seen significant reductions in cases of clostridium difficile and the numbers of MRSA bacteraemias are now less than 5 a year (and none in the last 6 months of 2010/11). We have achieved a lot, but we need to do more and eliminate such infections from our hospitals.

The winter of 2010 was one of the most severe for a number of years and the Trust faced unprecedented pressures. This did mean that in December 2010, January and February 2011 these pressures affected our services. We have struggled, but will meet the target of seeing 95% of people within 4 hours in A&E and we will come close to meeting the requirement of treating people within 18 weeks of referral from their GP.

We now have a strong financial track record and once again we are pleased to report a financial surplus. 2010/11 was another tough year as the Trust aimed to achieve, what is one of the biggest hospital cost improvement programmes in the NHS, around 8% of budget or in hard terms £19.3m. Of this, the Trust received £18.5m - a fantastic result. The financial regime in future years will be just as demanding and we need to continue to find new ways of working within tight budgets without compromising quality. With this in mind, we are co-operating with our partners in primary care to make sure we integrate services and improve the patient pathway to avoid repetition, and to improve the patients' experience.

If we wish to stay strong in a challenging environment, we cannot afford to stand still. The Coalition Government has stated that all Trusts need to be Foundation Trusts by 2014 and we remain on track to become a Foundation Trust in 2011/12. We have been successful

at Board to Board meetings with the Strategic Health Authority, had a very vigorous review as part of the Monitor process by auditors Ernst & Young and received a seal of approval from Medical Directors nationally for our clinical outcomes and processes. We are currently been considered by the Department of Health and the Secretary of State, before being referred to Monitor for a full inspection. Our current timeline suggests we will be a Foundation Trust in 2011/12.

We are still very much part of the Watford Campus development and were very pleased to see that the Croxley Rail Link is now in its final planning stages. Plans, which include the new hospital at Watford, are progressing. The Campus has achieved formal outline planning permission, which means the new access road from the Dalton Way gyratory to the hospital can now be created. We continue to develop our plans to improve our estate at both Hemel Hempstead and St Albans.

The coming year will, of course, present new challenges. The Coalition Government's White Paper proposes fundamental changes to how NHS services are commissioned, with the abolition of Primary Care Trusts and Strategic Health Authorities, the establishment of the proposed new NHS Commissioning Board and the direct purchase of hospital services by GPs. We will embrace these challenges to work in tandem with GPs, as they become the new commissioners, and continue to provide excellent, safe services, some of which will be provided in new and different ways, probably in out-of-hospital settings.

The Health & Social Care Bill 2011 is now making its way through Parliament and is subject to change, but it is worth noting that amongst its many recommendations, the Bill proposes to enhance the role of Governors in Foundation Trusts and to change the responsibilities of the Directors and the Board. We will respond positively and adapt to these changes.

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

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


Introducing the Trust

West Hertfordshire Hospitals NHS Trust provides acute healthcare services to a core catchment population of approximately half a million people living in west Hertfordshire and the surrounding areas. The Trust also provides a range of more specialist services to a wider population, serving residents of north London, Bedfordshire, Buckinghamshire and east Hertfordshire.

The Trust is one of the biggest employers in west Hertfordshire, employing around 4,000 people and seeing nearly a million patients each year.

The Trust operates from three main hospitals:

Watford General Hospital

Watford General Hospital is at the heart of the Trust's acute emergency services, the core location for inpatient emergency care and for all patients who need the specialist emergency facilities (such as intensive care) of a major district general hospital. It also provides elective care for high risk patients together with a full range of outpatient and diagnostic services. There are 531 beds and 9 theatres (including 1 local theatre). Watford is also the focus of the Trust's Women's and Children's services, including neonatal care.

Hemel Hempstead Hospital

Hemel Hempstead Hospital has an urgent care centre and offers other local healthcare facilities, such as diagnostic services including MRI, pathology, and an outpatient service that sees in excess of 100,000 patients per year. In addition, it provides 28 stroke rehabilitation beds. The local Primary Care Trust also operates intermediate care beds on site.

During 2010/11:	
77,103	people attended A&E (on average, more than 200 a day)
13,937	people attended the Minor Injuries Unit
30,227	people attended the Urgent Care Centre
399,149	people attended Outpatient Departments (more than 1,500 a day)
76,630	people attended as inpatients and day cases
5,735	babies were born in hospital (plus 150 home births)

St Albans City Hospital

St Albans City Hospital is the Trust's elective care centre. It provides a wide range of elective care (both inpatient low risk surgery and day case) and a wide range of outpatient and diagnostic services with in excess of 70,000 outpatient appointments. It has 42 beds and 6 theatres (including 1 procedure room for ophthalmology) and a Minor Injuries Unit.

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 believes that the needs and experiences of patients are the first and uppermost consideration. The 10-point Heart of Herts Pledge is designed to commit the Trust to providing the highest possible quality of care to patients and their families.

The Trust Board

Photo from left to right: Nick Evans, Director of Partnerships; Mark Vaughan, Director of Workforce; Professor Thomas Hanahoe, Chairman; David McNeil, Director of Communications & Corporate Affairs (Board Secretary); Sarah Wiles, Director of Strategy & Infrastructure; Chris Pocklington, Director of Delivery; Katharine Charter, Non Executive Director (Vice Chair); Colin Johnston, Medical Director; Robin Douglas, Co-opted Non Executive Director; Sarah Connor, Non Executive Director; Stuart Lacey, Non Executive Director; Chris Green, Non Executive Director; Jan Filochowski, Chief Executive; Natalie Forrest, Director of Nursing; **In forefront:** Anna Anderson, Director of Finance; Mahdi Hassan, Non Executive Director

Welcome to new members of the Trust Board

Natalie Forrest took up the post of Director of Nursing in June 2010 and has over twenty years experience in nursing. She was Director of Nursing and Midwifery at Newham University Hospitals and led on some significant quality improvement initiatives.

Chris Green took up the position of a Non Executive Director in August 2010. Chris was Chief Executive of Virgin trains until 2004 and Non-Executive Chairman in 2004/05. Chris has also more than ten years' experience as a Non-Executive Director on large private rail company Boards.

Chris Pocklington joined the Trust as Director of Delivery in October 2010. Previously Chris was the Chief Executive of Princess Alexandra Hospital in Harlow following four years in the role of Director of Operations.

Mark Vaughan joined the Trust as Director of Workforce in January 2011. Mark has worked in Human Resources for 20 years, 13 of which have been in the NHS. Mark came to the Trust from the Royal National Orthopaedic Hospital, where he was Director of Human Resource and Corporate Affairs for 10 years.

Do you want to know more about the Trust?

The Trust Board meets in public six times a year and any member of the public is welcome to attend as an observer. Dates can be found on the 'About Us' section of the website www.westhertshospitals.nhs.uk. The website also provides board agendas and minutes, as well as detailed papers which support the decision-making process.

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. This report highlights the work that has taken place in 2010/11 to move the Trust towards achieving these objectives.

Objective 1:

Provide safe patient care

Key Points
• Unqualified registration from Care Quality Commission
• Reducing falls
• Reducing hospital acquired infection
• Reducing the risk of patients suffering from an avoidable blood clot protecting vulnerable patients
• Learning from complaints
• All hospital sites achieved a 'good' score from PEAT

The Trust aims for all patients to feel safe and well cared for and to have every confidence in the services it provides. A Board Assurance Framework is presented to every meeting of the Board to ensure that appropriate systems, policies and people are in place to deliver a safe service and effectively manage risk in the organisation.

Care Quality Commission Registration

Following legislative changes in early 2010, the Trust was required to register its services, in all of its locations, with the Care Quality Commission (CQC). NHS health organisations have to demonstrate they are meeting Care Outcomes service standards, which have been defined by the CQC. The Trust was registered successfully on 1 April 2010 and no conditions were applied to its registration. Since then the Trust has maintained ongoing review of its compliance and publishes quarterly reports. The Trust continues to achieve compliance with the CQC outcomes.

Leading Improvements in Patient Safety

In March 2010 the Trust joined the sixth wave of Leading Improvements in Patient Safety (LIPS), a national patient safety development programme run by the NHS Institute for Improvement and Innovation. The Trust has workstreams in place to reduce falls, maintain achievements in reducing hospital acquired infection and working to ensure it reduces the risk of patients suffering from an avoidable blood clot. Regular reviews are undertaken of health records to identify whether unreported harm events have occurred and the lessons learned from this work will influence further developments in the Trust's campaign for safer care.

National Patient Safety Alerts

The Trust has made significant progress in improving the time it takes to act on and implement National Patient Safety Alerts, e.g. electronic patient wristbands and 'Being Open'. A robust system is now in place to initiate action immediately an alert is received.

Serious Incidents

Despite the best efforts of staff, there are occasions when a poor outcome may be the result of a patient safety incident which could have been avoided. Following new guidance in 2010, the Trust developed a standalone policy on Serious Incidents, which identifies

Our Trust Board ask...

Controlling infection

The practice of audit, surveillance and continually finding ways to enhance best practice has reduced infection rates. Especially impressive is the fact that throughout the month of September 2010, for the first time in many years, the Trust was able to report no cases of hospital acquired infections in any of its hospitals. This is a glowing testament to the massive team effort, with staff understanding that infection control is everyone's responsibility and patients and visitors embracing the Trust's strict infection control procedures, such as using hand gel before entering patient areas and not sitting on hospital beds. However, the Trust is not complacent and remains vigilant.

the processes to be observed in the event of a potential serious incident. This clarity has promoted a better understanding of events that should be robustly investigated, a greater understanding of the many things that can contribute to a safety incident and the importance of developing a safety culture across the organisation.

Managing risk

The Trust promotes a risk management culture through implementing the 50 risk standards set out by the National Health Service Litigation Authority (NHSLA). These standards cover governance, environment of care, clinical care, learning from experience and supporting staff. All staff are made aware of their responsibilities to manage risk through the Trust's Risk Management Strategy. An Integrated Risk & Governance Committee, chaired by a Non Executive Director, meets to discuss high level risks and assess whether they are being managed effectively. In addition, Divisional risk registers are scrutinised by a Risk Standards Group, chaired by the Medical Director. The Trust's key risks to achieving its strategic objectives are reflected in its Board Assurance Framework and these represent a mix of clinical, operational and financial risks which are reflective of an integrated approach to managing risk in a complex organisation.

Learning from others

In response to the independent inquiry into the care provided by mid Staffordshire NHS Foundation Trust ('the Francis inquiry'), the Board studied the report in detail to highlight any areas of potential concern within the Trust. Consultants and Senior Managers were provided with a synopsis of the report and discussions took place at key meetings. This focussed approach allowed the Trust Board to be assured that the organisation not only has a good culture of care in place, but it also has robust processes to ensure that this is sustained and any learning is embedded.

Improving security

During 2010/11 the Trust made significant progress towards developing a fully security conscious culture. A series of surveys and assessments were conducted by various statutory authorities in conjunction with the Trust's newly appointed Local Security Management Specialist and these now form the foundation of a fully robust security strategy and policy. The four key areas of focus are:

- Violence and aggression
- Asset protection
- Drugs and pharmacy security
- Maternity and paediatrics

The centralisation of acute services to Watford in March 2009 generated a number of challenges from a security perspective, not least of which was the increased opportunity for vandalism and theft on the Hemel Hempstead site. Increased activity and operational pressures on the Watford site also generate a greater risk of security breaches. However, the total number of reported incidents remains the same.

Safeguarding vulnerable patients

The Trust has continued to actively develop actions to protect vulnerable patients and address their specific needs. In particular, children and those with learning disabilities and vulnerable older people with dementia. A training and education programme has been developed and people with learning disabilities and carers are represented on the Trust's Patients' Panel and Patient and Public Involvement group.

In 2010/11 the Trust developed a Dementia Strategy to ensure that staff are appropriately trained to care for such patients and that their special requirements are recognised and catered for. Safeguarding children also remains high profile and the Safeguarding Children Team continues to work towards the goal of ensuring the safe admission and discharge of all children. A robust and comprehensive Safeguarding Children training strategy has been developed and all

staff who have contact with children attend yearly mandatory training updates.

Learning from complaints and compliments

Complaints are taken seriously and every effort is made to resolve them at a local level following a thorough investigation into the root cause of the patient's, or in some instances, relative's concerns. The Trust has trialled an alternative approach to responding to complaints, which will lead to further improvements in the processes introduced last year.

During the year, the Trust received 450 complaints that resulted in formal responses from the Chief Executive and a great number were dealt with informally. The total number of complaints remains at less than 1% of patients seen during the year. The key themes of complaints remain similar to the previous year and cover clinical treatment, staff attitude and communication/information. There has been a reduction in the number of complaints relating to outpatient services and no complaints in respect of MRSA and clostridium difficile reinforcing the excellent work that has been done to almost eliminate these infections from our hospitals.

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

- the provision of information on wards about the availability of Sister's surgeries where patients and relatives can discuss issues of concern with senior nursing staff on the ward
- the arrangements for patients coming to day surgery at St Albans to ensure that their arrival time is more aligned to the anticipated time of their procedure
- the provision of a fresh water drinking fountain in the pathology waiting area at Hemel Hempstead Hospital

During 2010/11 the Trust received many hundreds of letters, cards, notes and small gifts complimenting the standard of service provided by staff.

Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) continued to play a vital role in supporting members of the public in 2010/11. During the reporting year the team moved to a new prominent location in the main reception area which now allows better access for patients. The new department also incorporates a drop-in information centre for patients to browse and pick-up leaflets. The team dealt with around 1,500 enquiries during the year.

Patient Environment Action Team

The Trust continued its run of excellent results in the annual Patient Environment Action Team (PEAT) assessments. This year, cleanliness was identified as a discrete item for reporting on, whereas last year a combined "environment" score was provided. The Trust is pleased to note that all its hospital sites achieved a 'good' score for this more targeted assessment on cleanliness.

While Hemel Hempstead and Watford maintained their 'good' and 'excellent' scores in all categories, St Albans was noted as having a couple of areas where only an 'acceptable' score was achieved. This related to two specific areas, both of which are planned for upgrade and improvement.

A new catering system will be introduced at St Albans in 2011. This system is already in use in Watford and Hemel Hempstead and routinely scores 'excellent' for food ratings and is very well received and regarded by patients.

Clinical audit

The Trust's Clinical Audit Department has supported a wide variety of audits this year, ranging from those agreed at a local divisional level through to national audits, ad hoc audits and mandatory audits. Some of the projects the team have worked on include whether referrals to a privately financed organisation help to reduce length of stay (LOS) figures for surgical patients, do patients stay longer on our wards than necessary and whether the World Health Organisation's surgical safety checklist is being used effectively.

Objective 2:

Improve outcomes and quality of care

Key Points
• Getting people on their feet quicker
• Stroke service with video links to experts across the east of England
• Stimulating and engaging memories to reduce anxiety
• Allowing an MRI scan for patients without removing their pacemaker
• Empower frontline staff to streamline day to day activities
• Cardboard clock system – to alleviate pressure ulcers

New schemes and initiatives were developed during 2010/11 which brought significant improvements to the quality of care provided to patients.

Enhanced Recovery programme

The Enhanced Recovery Programme (ERP) was established this year. This programme is designed to offer pre-operative planning, such as advice on what to eat and how to mobilise joints. The ER treatment programme also focuses on ensuring patients receive appropriate pain relief during and after surgery, as well as the management of fluids and diet. All this has been proven to help patients to get on their feet quickly post-operatively and, in most cases, patients are ready to be discharged from hospital a day earlier than was previously possible.

Medical simulation training

Following a successful pilot scheme in 2009, the Trust continued to develop its medical simulation programme in 2010/11. The training uses lifelike human mannequins in a number of different scenario ward environments. Audio-visual feedback from the training is used to develop clinical skills in caring for acutely ill patients, as well as developing communication, team working and delegating abilities.

Telemedicine Stroke programme

In November 2010 Watford became part of a new telemedicine programme. This service enables patients who have suffered a stroke and arrive in A&E out-of-hours to receive expert assessment and management from a Stroke Physician via a video link across the east of England. The Physician is able to see and examine brain scans on their laptop and advise on how to treat patients in the crucial first few hours after stroke.

Dementia distraction therapy

A new distraction therapy was introduced this year which has been proven to help patients with delirium and dementia. The therapy consists of a therapeutic activity toolkit, known as a 'Tiptree Box', which contains familiar everyday and older items such as coins, dominoes, memory jogger cards and newspapers. The initiative helps patients to interact by stimulating and engaging memories, thus reducing their stress levels.

Cancer screening programme

In November 2010 the Trust extended its bowel cancer screening programme to people between the ages of 60-75 registered with a GP. Since 2008, every resident aged between 60-69 has been given the opportunity of a free home screening kit to identify the disease before it has a chance to take hold.

Revolutionary pacemaker

A new groundbreaking pacemaker that allows patients to have an MRI scan without the pacemaker being affected by the scanner was introduced at Watford in 2010. The Trust was one of the first in the world to use this new device outside of clinical trials.

Emergency blood tests

The Trust has introduced a new analyser which has significantly reduced the time it takes to process a 'full blood count' in the A&E Department down from an hour to just two minutes. This has resulted in not only reduced waiting times for emergency blood results, but has also freed up lab time to deal with other blood samples from across the Trust, thus speeding up the blood testing process for all patients.

Productive Ward programme

The Productive Ward service improvement programme has been running for 18 months and currently 20 wards are working through the module framework. Each module is designed to empower frontline staff to streamline day to day activities thus releasing time that can be invested at the bedside. This year a number of wards have worked through the 'Shift Handover Module', which has helped to streamline the handover process by up to 50%. Another module has led to multi-professional teams designing new patient display boards that ensure that the patient's journey from admission to discharge runs smoothly without delays. This patient board includes magnetic indicators highlighting patients at risk. In 2011/12 a further five modules will be introduced which focus on nutrition, medication and patient observations and three additional ward areas will join the programme.

Pressure ulcer reduction programme

The Trust has designed an innovative, simple and effective method to help alleviate the problem of pressure ulcers. Ward staff have produced a cardboard clock system, which measures the length of time patients have been in their beds or wheelchairs and the next time they require repositioning. Since the new cardboard clock system has been in place the Trust has seen a reduction in the number of pressure ulcers and fewer patients are experiencing discomfort.

Organ donation

A clinical lead was appointed in 2010 to take forward policy and practice to ensure that a discussion about donation features in all end of life care. An Organ Donation Committee has been established, chaired by a lay-person and supported by the Trust's Medical Director, a Specialist Nurse for Organ Donation from NHS Blood & Transplant (NHSBT) and other key Clinical Specialists and Senior Managers.

Objective 3:

Improve the patient experience

Key Points

- Inpatients have contact with a member of staff at least once every hour
- Award winning programme – Going for Gold
- Capturing 'real-time' patient feedback from wards and departments
- Improving the physical environment
- Single Equality Scheme published

"Words cannot express the gratitude I feel for the doctors, nurses and receptionists at Hemel Urgent Care Centre and the two wonderful paramedics who looked after my partner so well"

Improving the experience for our patients and visitors has been a focus for the Trust in 2010/11. A new Patient Experience Manager was appointed and a Patient Experience Group and Outpatient Steering Group were established to work with staff and patients.

A number of measures were introduced this year to improve the patients' experience, including improvements to the environment, uniforms for frontline staff and better signage for outpatients. A new system was introduced to ensure inpatients have contact with a member of staff at least once every hour, streamlining the discharge process and minimising the noise levels on wards at night.

'Going for Gold' programme

The Trust's commitment to improving the experience of patients in its hospitals was recognised in January 2011 when the Trust received a Patient Experience Network Award under the category of 'Setting the Stage/Support for Caregivers, staff and family'. This award scheme is aimed at recognising examples of excellent patient-focused initiatives across the UK. The Trust was the only acute hospital trust in the east of England to reach the final. The winning campaign, known as 'Going for Gold' was developed by the Trust to support staff in the delivery of a gold standard level of care to patients.

The campaign, designed to incorporate a topical Olympic theme, was launched in August 2010. Patients, visitors and staff were consulted on their top five suggestions for improving their hospital experience and from this feedback, five gold standards of care were developed, which all staff are expected to maintain. These standards are:

The awards judging panel described the campaign as "creative and imaginative using minimal expenditure and maximum engagement of staff".

Patient surveys

This intensive focus has resulted in the Trust seeing a steady improvement in the results of a number of national patient satisfaction surveys over 2010/11. The surveys showed the Trust had generally maintained the progress it had made in the previous years and had made further improvements in some areas, including shorter outpatient waiting times, more choice of appointment, increased privacy and dignity, cleanliness, and better information given to patients, particularly on discharge.

A national survey on maternity services in 2010/11 revealed that women who have recently used the Trust's maternity service were happy with the care they received before, during and after birth and women particularly highlighted parent education and encouragement to make birth plans as being good in west Hertfordshire. These latest maternity survey results corroborated the improvements reported earlier in 2010 when the maternity service was assessed by the Clinical Negligence Scheme for Trusts (CNST) and was elevated from a Level 1 to a Level 2.

Furthermore, a reputation audit conducted in April 2010 concluded that there had been a positive increase in the way stakeholders think and feel about the Trust since a previous audit was undertaken in September 2009.

Although these improving results are very encouraging, the Trust recognises there is still a lot of work to do and is committed to keeping up the effort and improve even further in the future.

Capturing timely patient feedback

The Trust captures local 'real-time' patient feedback in wards and departments using an electronic Patient Experience Tracker (PET) device. In 2010/11 this programme helped the Trust focus on appropriate areas and has shaped improvements on cleanliness and neatness within the Outpatient Department and patients being kept better informed on wards. Patients, carers and members of the public are informed of the results and action by posters within the relevant wards and departments.

Most patients discharged from hospital receive a telephone call from the Trust 48 hours after leaving hospital to check how they are, particularly to ensure that they have all the information they require and during which we also ask them about their care and treatment during their stay. Information that is received from the call is fed back to the wards to be used to improve treatment and care. Both the PET and 48hr post hospital discharge call initiatives use questions linked to the five Department of Health Commissioning for Quality and Innovation (CQUIN) targets.

Patients' Panel

Since 2002 the Trust's Patients' Panel has worked tirelessly to 'be a critical friend' to the Trust by highlighting areas of the patient experience that needed attention and offered advice on ways the Trust could improve services for its patients. The Panel's support has been invaluable this year on many committees and projects and in particular in the review of the outpatient service.

Equality and Diversity

The Trust is committed to promoting an environment that values diversity and is responsible for ensuring that patients, their carers and staff are treated equally and fairly and not discriminated against on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason.

The Trust has published a Single Equality Scheme incorporating its specific duties and highlighting the changes brought forward by the Equality Act 2010. A mentoring programme and equality and diversity training will be developed in 2011/12.

The launch of a new Diversity Champions Network resulted in the recruitment of over 40 people who are now diversity champions to promote equality and diversity throughout the Trust. The Trust also hosted an Equality & Diversity Summit in November 2010, attended by over 200 people from all sectors and organisations.

Better environment

Work continued in 2010/11 on a range of projects to improve the physical environment on the hospital sites. The major redevelopment which began on the Hemel Hempstead site in 2009 was completed in 2010. This included new and updated signage, better security arrangements, and a painting and maintenance programme.

Work will begin in June 2011 to improve the front of house at St Albans Hospital. The £250,000 refurbishment includes moving the main restaurant to the entrance area and transforming it into a modern café-style environment offering longer opening hours and a greater variety of food. It will also allow easier and more convenient access to the entrance and exit areas, particularly for those patients waiting for transport.

Following the significant redevelopment programme to the Watford estate over previous years, including the opening of a new 120-bed Acute Admissions Unit, a lesser degree of investment was required in 2010/11. Some office accommodation has been remodelled to create increased bed capacity and there have been significant improvements to the mortuary provision on the site.

Objective 4:

Sustain and improve performance

Key Points
• Tough winter – but maintained high quality service
• Achieved the A&E target and waiting time targets
• Active role in European Union Civil Protection exercise.
• Action taken to address the Energy and Sustainability agenda

Winter pressures

The hard winter of 2010/11 once again saw staff come to the fore – the immense effort shown in keeping the services running was outstanding. A combination of the worst winter weather for ten years, seasonal flu, and an extended bank holiday period over Christmas and New Year when many community services were closed, resulted in the hospitals being kept very busy. The A&E department and ITU service treated unprecedented high numbers of seriously ill emergency patients. Although the Trust has a clear business continuity policy in place, the circumstances were very exceptional. Due to the efforts of all staff, the Trust was able to avoid any major problems and remained open to all admissions and able to deal with them safely and effectively, although to do that compromises had to be made on aspects of the patient experience and that patients clinical care was not compromised. Staff worked incredibly hard to ensure everyone got the treatment they needed and patient care was not compromised. The Trust undertook an internal review of how it managed during this period to see what lessons could be learnt. The review looked at decisions taken, analysed specific cases and recommended ways to reduce the risk of problems occurring in the future.

Meeting targets

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

Indicator	National Standard	West Herts Rating
95% of patients should be seen within 4 hours in A&E	>95%	Achieved
Incidence of C difficile should be identified and the numbers minimised	Trust target was to have less that 57 cases pf C difficile throughout the year	Achieved
Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have less than 6 for the whole year 6	Achieved
All cancers- patients should not wait more than 31 days for second or subsequent treatment	National target was to have 96% patients seen within 31 days	Underachieved
All cancers – patients should have a maximum wait of 62 days between urgent referral and first treatment	The national target was to see 90% of those referred by the screening service and 85% referred by GPs%	Achieved Achieved

The Trust is also expected to ensure that patients are treated in accordance with the requirements of the NHS Constitution, in particular those relating to waiting time for elective treatment.

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

The Trust has sustained and further improved the reductions in infections seen in the past 2 years. Despite the bad weather conditions seen during the winter, and the impact of influenza on emergency and elective services, the Trust has achieved the A&E target and the waiting time targets elective admissions.

Being prepared

In September 2010, the Cabinet Office published the results of a national capabilities study and the Trust was considered resilient and prepared to deal with any threats or hazards that may cause disruption to normal daily services.

The Trust is a member of the East of England Strategic Health Authority's project board which develops sub national lockdown and full scale hospital evacuation plans. These plans will be rolled out by the Department of Health to other SHAs in England over the forthcoming year.

In September 2010, the Trust participated in the UK's first live European Union Civil Protection exercise. The scenarios for Exercise Orion, led by Hertfordshire Fire and Rescue Service, were based on an earthquake and tested the implications of rescuing and treating casualties from collapsed buildings and structures, fires, explosions and traffic collisions.

The exercise ran over two days and allowed staff to practice their major incident response roles and for the Trust to fully test its new major incident plan. A further planning exercise took place in March 2011 involving a chemical spill. This exercise gave the Trust an excellent opportunity to test its capabilities for decontaminating patients who may have been exposed to a hazardous material.

The Trust has also been working closely with the East of England Ambulance Service this year to develop suitable competency based training courses for staff that could be part of an internal response team in the event of a major incident.

Environment/sustainability

The Trust recognises the importance of positive action to address the Energy and Sustainability agenda and to meet or even exceed the targets given to us by the Department of Health, and the Sustainable Development Unit.

The Trust spends £5.51 every minute on its energy costs. In order to address this £2.9m expenditure, the Trust has identified a number of key actions needed and over the past twelve months the following works have been carried out:

- Undertaken European Union Emissions Trading Scheme (EUETS) and Carbon Reduction Commitment (CRC) compliance and registration reports
- Registered for the CRC and will continue to manage CRC requirements over the next three years
- Established an Environmental Steering Group
- Reviewed the opportunity of installing dual fuel burners to deliver financial savings in 2011/12. This includes the conversion of the main boiler plant at Watford from heavy fuel oil to natural gas. This will save 1500 tonnes CO2e per year and also save the Trust around £200K p.a. revenue costs.
- Continued to develop a cost benefit analysis to support a Combined Heat and Power plant at Watford site. This could provide the Trust with significant savings
- Worked with the East of England EValu8 team on new electric charging points at Watford and St Albans
- Installed intelligent metering (Automatic Meter Reading), which was undertaken as part of the Trusts enrolment in the Carbon Reduction Commitment Energy Efficiency Scheme (CRC). The purpose of this project was to install meters on all our utilities to enable the Trust Estates Energy and Sustainability team to identify savings and reduce our financial and carbon burden
- Registered and completed the Good Corporate Citizen application process with clear actions for improvement over the next 12 months

Objective 5:

Be financially sound

Key Points
• Delivered a surplus of £7.5m
• £18.5m savings achieved
• Expect to become a Foundation Trust in 2011/12

The financial headlines

The 2010/11 financial plan set a surplus target of £8.1m. This included the requirement to deliver £19.3m of savings (see following section). The size of surplus was predicated on the requirement to generate sufficient cash to service the Trust's three loans and to marginally improve the Trust's liquidity position, which is at the lowest level upon which to go forward as an FT.

In the autumn of 2010 it became apparent that the Trust would not be able to achieve the £8.1m planned surplus and, following discussions with the SHA, the Trust Board agreed a financial recovery plan and a revised £7.5m surplus target. At the end of the 2010/11 financial year the Trust delivered a surplus of £7.5m.

In order to ensure that the Trust maintained its financial viability and continued to eliminate inefficiencies and improve performance, it set itself a tough savings target of £19.3m for 2010/11. This represented around 8% of the overall Trust budget, a significant challenge in % of turnover terms, and very high compared to the vast majority of NHS providers.

The Trust felt this challenge was best met by adopting an evolutionary approach grounded in realistic assumptions. Staff across the organisation were asked for contributions with the aim to engage everyone, to get them to take responsibility and to make the whole organisation part of the solution.

A Senior Programme Board was established with representation from all parts of the organisation. Ideas were requested from staff, and all contributions were explored. In excess of 500 ideas were received, logged and reviewed. The savings programme was christened 'The Big Ask', keeping it simple, yet relevant and striking a chord. The Trust supported people who identified opportunities to effect the changes needed. The strategy applied was to be sensitive to the local circumstances and to avoid a top-down approach which had no ownership. The engagement of staff meant people took responsibility, had space to be innovative and were supported in progression of their ideas to their conclusion.

Without creating an industry of the process, a system of review was established, with an underlying principle that patient safety was not to be compromised and that schemes must be deliverable. To this end, a "gateway" process was followed, which rated the schemes into 3 distinct categories: Gateway 1 - the idea stage with high level estimate of savings; Gateway 2 – details worked up and savings identified; finally Gateway 3 – scheme confirmed as viable with a confident savings figure and implementation plan.

The types of schemes identified have been wide ranging, from changing the type of hand towels used, to the improvement of efficiency of theatre use, to re-negotiated prices for cardiology consumables. It was realised early on that Divisions required additional support to deliver such a significant savings programme, so project managers were established within Divisions to concentrate on the delivery of the ideas with strong links to finance and other departments.

The system has provided the opportunity to think about how the Trust delivers its services and to question and find other ways, to be

painstaking in attention to detail and persistent in determination to deliver improvements.

Progress against the respective schemes was monitored fortnightly at Divisional review meetings and monthly Programme Board meetings via monthly reports to the Trust Board.

Whilst 'The Big Ask' savings plan has been challenging, staff have risen to the task in an extremely positive way and all levels of staff have contributed and worked hard to ensure that the Trust delivers the schemes to achieve the target. Savings to the value of £18.5m have been realised and out of this, there are service redesign options emerging that will further improve the way the Trust delivers services to its patients.

The delivery of the Big Ask savings enabled the Trust to hit a £7.5m surplus and has ensured that the Trust met the minimum of a 3 on the Financial Risk Ratings used by both the SHA and Monitor to assess the financial performance of Trusts. (1 is the lowest score with 5 being the highest, best performing score).

The Trust continues to work closely with its Internal Audit provider, RSM Tenon, and all audits relating to the Finance function received positive assurance. The overall Head of Internal Audit Opinion shown within the Statement on Internal Control (see page 24), provides the Trust with 'significant assurance'.

On track to become 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 fit for purpose and robust. In July 2010 the Trust had an Historic Due Diligence (HDD) review by Ernst & Young (E&Y). The HDD review of governance and future plans was one of the steps in the process of gaining FT status. The feedback was extremely positive with E&Y commending the Trust by stating that the HDD process was amongst the best they had undertaken. Following a successful Board to Board meeting in July 2010, the Strategic Health Authority put the Trust forward to the Department of Health Applications Committee. The Trust is currently waiting for a national decision from the Department of Health and HM Treasury on technical and financial issues, before the application can proceed to the Secretary of State.

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 an engaged and representative membership enabling a better dialogue with people using its services. It has over 6500 public members, which is 1500 more than the required 5000 Public Members (1% of the population the Trust serves). All Trust staff are also Members.

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.

Objective 6:

Work in active partnership

Key Points
• Excellent relationships with the local health community
• Dedicated staff have the knowledge and experience to know what really works
• Worked with the multi-agency Hertfordshire Migration Partnership Forum
• Embedded new arrangements for Community Diabetes and COPD
• Health Campus continues to make good progress
• Working in partnership with the unions

Internal partnerships

Partnership working transforms relations between all staff – clinical, front-line and managerial, and is an important factor in the management of change and reform in the NHS. Staff are a key factor in any successful change programme and the Trust is committed to engaging and involving its staff at all levels. It is through partnership between patients, users, managers and employees that organisations can innovate. The views of staff matter – staff have the knowledge and experience to know what really works and the Trust constantly strives to harness this knowledge and engage the experience to help facilitate change.

Stakeholder relationships

The Trust has a long history of building good relationships with the local health community stakeholders, commentators, such as the Care Quality Commission, and the public that it serves. The Trust recognises that it cannot work in isolation and therefore plays an active role within its communities and with partners to improve health in the area. The Trust's key partner relationships are with NHS Hertfordshire, East of England Strategic Health Authority, Hertfordshire County Council (particularly Health Scrutiny) and local district or borough councils, where it participates in Local Strategic Partnerships. As the consequences of the current economic environment and the resulting pressures on the public sector work their way through to public spending levels, the Trust will face serious challenges. The commitment to a partnership approach to dealing with these will stand the Trust in good stead in the years ahead.

Community relationships

The Trust continues to work with external organisations and agencies to support improvements for patients and carers. This year in particular the Trust has worked with members of the multi-agency Hertfordshire Migration Partnership Forum, to identify, understand and address the needs of individuals who have migrated into Hertfordshire from elsewhere in the world and ensure this information is used to inform strategic planning and service delivery to support their needs.

The Trust also has an active public membership approaching 6,500, which is fundamental in its progress to become a Foundation Trust.

GP liaison

During the year, the Trust has worked with Primary Care colleagues to embed the new arrangements for Community Diabetes and COPD. Trust clinicians now see patients in community settings assisted by specialist community nurses. This change has resulted in more than 4,000 patient attendances taking place outside a hospital setting. Work is jointly underway to see what other services might be provided in this way. The Trust also works closely with GPs through its Conclave meetings and will be working closely with GP Consortia as they become established during 2011/12.

Watford Health Campus

The Trust's relationship with its partners in the Watford Health Campus remains strong and the Campus has continued to make

good progress this year. A development appraisal analysing the investment opportunities in the scheme has been completed and demonstrates that the scheme is commercially viable, even in the current economic climate. This position has been significantly boosted by the recent announcement from the Department for Transport that the Croxley Rail Link has been included within the 'Development Pool' of transport projects, meaning that the chances of the hospital having a Metropolitan Line Tube station within 300m have taken a huge stride forwards.

The Campus also secured a formal Outline Planning Permission this year and appointed a new Development Director to lead the scheme through the complex procurement and commercial negotiation phases. With the "first phase" of the Campus, the key worker accommodation around the Watford Football Club has fully opened and is occupied by Trust staff.

Maternity scanning

The Trust and My UltraBaby Limited joined in partnership in 2010/11 to offer all pregnant women in the west Hertfordshire area a specialist ultrasound test to check for Down's syndrome. Previously the Trust was only able to provide this test to women who were assessed as significantly at risk of having a child with Down's Syndrome. The big advantage of this scan is that it is done at week 12 , providing reassurance to families much earlier in the pregnancy.

Public health

The Trust takes its responsibility for contributing to the improvement in the public health of our local community very seriously and works closely with colleagues in NHS Hertfordshire on this issue as well as with partner organisations in the wider community. Specific initiatives have been put in place regarding smoking cessation, Chlamydia screening, drug and alcohol abuse and domestic abuse.

Working with unions

The Trust views working in partnership with the unions as a fundamental principle underpinning the implementation of its workforce strategy. It believes it has an effective and constructive relationship with staff side and the unions and this has been demonstrated through successfully implementing "Delivering a Healthy Future" which was a major reconfiguration of acute services involving the redeployment of over 1000 staff. The Trust is committed to continue to consult and communicate regularly on any planned changes, to work in partnership on development of policies and procedures through the Policy Sub Group, and ensure the early involvement of staff side in designing future service changes.

Objective 7:

Attract, retain and motivate an appropriately trained workforce

Key Points
• The staff continue to demonstrate their professionalism and expertise
• Sickness levels have fallen during the year
• Leadership Academy supports staff from Board to Ward
• County-wide Staff Wellbeing programme hosted by the Trust
• Staff Awards for Excellence
• 548 volunteers gave up more than 164,400 hours of their valuable time

Our staff

During 2010/11 staff have responded magnificently to the particular challenges facing the Trust, which included financial pressures and winter pressures. The Trust held a 'Thank You' week in May 2010 (repeated in May 2011) to acknowledge the great efforts made by staff and this was very well received.

Listening to staff

The Trust uses the results of the staff survey each year to focus on the areas needing improvement in relation to staff and to highlight where we are doing well. The Trust holds regular 'Open Door' sessions with Executive Directors where staff can ask questions and make any comments on the Trust and how it operates. This year staff have also been encouraged to feedback to help shape our plans for staff health and wellbeing events in the Trust. The 2010 staff survey has shown improvements in staff undertaking training and development activities and managers encouraging staff to suggest new ideas for improving services.

Staff wellbeing

During the year the Trust has further developed its Health and Wellbeing Plan with a focus on the priorities of:

- Raising awareness of stress and offering tools to deal with it
- Raising physical activity levels
- Increasing attendance at work
- The Trust has continued with classes in Pilates, Yoga and Tai Chi and introduced new Zumba classes this year which are proving popular

Sickness levels have fallen during the year and with the additional support for staff suffering from stress and musculoskeletal disorders there has been a further decrease this year in these absences.

The Trust has in place a policy in relation to disabled employees and equal opportunities.

Leadership Academy

The Trust continues to invest in staff development at all levels. The Leadership Academy supports staff from Board to Ward with a key focus on improving patient and staff experience, communications, staff wellbeing and engagement. New programmes in 2011/12 directly involve patients, patient groups and the Patients' Panel, using their feedback and stories to support learning and improvements.

The Academy works in partnership with the University of Hertfordshire to deliver 'in-house', high quality accredited programmes up to Masters Level, for those staff who wish to follow the accreditation route. In 2010/11 the Trust launched a new Medical Leadership Programme as well as continuing the successful programmes for Senior and Middle Managers.

Support and development opportunities for staff

A new county-wide Staff Wellbeing programme, hosted through the Leadership Academy was launched in February 2011 to support frontline staff, teams and managers during service transitions and change. As many staff work under pressure and it is not always possible to release staff to attend development events, the Academy launched a new intranet site in 2010, so that all staff can access information and resources to support their development.

Corporate Welcome

Following its implementation in January 2010, 91% of all new staff attended the Corporate Welcome programme which includes sessions on conflict resolution, equality and diversity, bullying and harassment, health and wellbeing and safeguarding children and vulnerable adults.

'From Recruitment to Practitioner'

A suite of sustainable training programmes has been established for staff within Bands 1-4 (which includes Assistant Practitioners and Apprentices) to provide opportunity for development and achievement of formal qualifications. The programme aims to develop new healthcare roles, raise awareness of learning and career opportunities and build confidence and skills to encourage greater ownership of personal development. In 2010, 54 clinical staff and 32 non-clinical staff joined the programme and are working towards Foundation Degrees and National Vocational Qualifications at levels 1 and 2.

'Passport to Practice'

The Passport to Practice folder is now firmly established in the Trust and contains important information to help new staff identify the knowledge and skills needed to do their job and how to access learning and training opportunities. Core Knowledge and Skills Framework competencies (KSF) can be accessed on the training intranet site to assist managers set objectives as part of the appraisal process.

Staff accommodation

Over the last year the Trust has conducted a detailed review of its accommodation stock and identified that given the condition of the buildings and the level of backlog maintenance it is no longer tenable to provide the current residential accommodation for its staff, with the exception of medical students. The Trust has however negotiated with the local housing association and staff are now able to lease brand new purpose built flats in Watford Football Club's new apartment complex.

Volunteers

This Trust's 548 volunteers gave up more than 164,400 hours of their valuable time to help patients, visitors and staff. To mark their outstanding commitment, a series of tea parties was held to thank all the volunteers for their dedication and hard work over many years - in some cases over twenty years. A successful recruitment drive was also held during the year to actively encourage more volunteers to work within the Trust.

Celebrating staff photos: staff awards ceremony

The Trust once again held a joint annual Long Service and Staff Awards for Excellence ceremony in December 2010. Actress Linda Robson presented a host of prizes to hospital staff and volunteers who had been nominated over the previous twelve months for their outstanding hard work and commitment to providing the best possible patient care. During 2010, the Trust received hundreds of nominations from grateful patients and Trust staff, which were shortlisted by an external panel of judges to find the ultimate winners in the following five categories:

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

Statement of Internal Control 2010/11

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 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.

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 2011 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 2010/11, 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, the Medical Director. This responsibility is discharged throughout the organisation in accordance with the accountability structures set out in the Trust's Risk Management Strategy. Risk management is supported through the Assistant Director of Clinical Governance and Risk, together with a small central team and through the offices of divisional and corporate risk leads. The Risk Management Strategy was reviewed and formally endorsed by each member of the Board through a statement of support.

The control of risk is embedded into the management roles of Executive Directors and through the four Divisions, each led by a Clinical Divisional Director supported by a Divisional Manager and a Divisional Board. Each of these accountable managers has a 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.

Processes for auditing and monitoring clinical activity are in place in all the clinical divisions and clinical processes are updated in line with national guidance or in response to serious incidents or national safety notices.

The risk management process is supported by a risk database, DATIX, administered by a member of the risk team. All staff are trained to report incidents or risks on DATIX and risk leads in clinical divisions and directorates are trained to use DATIX to extrapolate information in order to identify themes or issues to ensure that risks are appropriately dealt with.

Management of the organisation's strategic risks is undertaken through the organisational management structure and key risks are recorded on the Board Assurance Framework, each having an Executive Director assigned to ensure robust management through the use of effective controls and valid assurances. The Board Assurance Framework is reviewed by Executive owners of the risks recorded on it.

The risk sub-committee is 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 Board Assurance Framework and for ensuring the processes supporting the Board Assurance Framework are working effectively.

Risk management is monitored operationally via the quarterly Integrated Standards Executive, chaired by the Director of Patient Safety, the Medical Director. These meetings review progress in relation to quality standards, including compliance with CQC registration and also review 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 2010/11 to support improvements in 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.

Induction training, risk assessment and management training are 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 incident reporting 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 Training has been reviewed in 2010/11 and e-learning introduced to improve the uptake of Root Cause Analysis training generally but particularly amongst medical staff.

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

DATIX entries can be reviewed by divisional and corporate risk leads and risks and incidents are recorded and identified in a standardised way. Further work has been undertaken to improve the utilisation of DATIX to improve the functioning of risk registers to support risk-based decision-making. During 2010/11 further work was undertaken to ensure full integration of the assurance systems underpinning CQC registration compliance. In addition, the assurance system is being applied to NHSLA standards 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, ie CQC registration outcomes, National Health Service Litigation Authority (NHSLA) standards.

As Accountable Officer I seek to learn from good practice via exchange of information with other Chief Executives and experts in the field regarding good practice in their organisations, reading 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 other partners in managing elements of risk through the health economy meetings described later.

4. The risk and control framework

The Trust Board approved the updated Risk Management Strategy in January 2011.

As indicated, the Trust has implemented a process for identifying, evaluating and managing risks faced by the Trust throughout the financial year and up to the approval date of the annual accounts. In January 2011 a risk assessment template was developed to ensure the risk is accurately described, graded and controlled and that risk mitigation activities are reviewed through consideration of the assurances identified. This enhances the basis on which the risk owner can determine the effectiveness of the controls in place.

The process is subject to regular scrutiny by the Audit Committee on behalf of the Board and is implemented under the oversight of the Integrated Risk and Governance Committee, chaired by a Non-Executive Director.

The Integrated Standards Executive, the Clinical Quality Advisory Committee and the Integrated Risk and Governance Committee provide the appropriate focus and control for managing the organisation's risks, including clinical risks, 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
- Adult and Children's Safeguarding Groups
- Transfusion Committee
- Medicines Safety Committee
- Multi-disciplinary Falls Group

As part of the preparation for Foundation Trust status a five year Integrated Business Plan was developed in 2010/11 and the key strategic (or major) risks to the organisation identified within it are reflected in the Board's Assurance Framework (BAF).

The key strategic risks are reviewed annually to take into account emerging themes both internal and external to the Trust. The 2010/11 BAF was updated following SWOT and PEST analysis against the Trust's strategic objectives.

Internal Audit and Counter Fraud

The results of internal audit reviews are reported to the Audit Committee and where system weaknesses are identified these are subject to an action plan monitored by the Committee. The Trust was awarded Level 2 by the Counter Fraud Service for 2010/11.

Information Governance

The Trust's Information Governance Committee oversees issues relating to the risk assessment and safeguarding of data security. Chaired by the Executive Director with responsibility for data security, who is the Senior Information Risk Officer, the Committee also includes the Caldicott Guardian (The Director of Patient Safety, Medical Director) and the Data Protection Manager. The Committee provides assurance that practices and processes are in place to ensure the safety of Trust-wide data. 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 which oversees the implementation of recommendations arising out of incidents or serious incident investigations.

Information Incidents

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

- Unintended faxing of a patient transfer list to the SHA. This was identified immediately upon receipt and notified to the Trust and the breach was contained.
- Loss of Staff Registration Authority forms at Hemel Hempstead.

Embedding Risk Management

Risk Management is embedded into all of the activities of the organisation. In addition to the arrangements for service divisions other (corporate) risks are reviewed through the Integrated Standards Executive. Those deemed to pose a threat to the achievement of the organisation's objectives are proposed for inclusion on the Board Assurance Framework and reviewed for this purpose by the Integrated Risk and Governance Committee. The Committee can make recommendations to the Board via the BAF report that is reviewed at each meeting of the Board and which informs the Board's agenda. All Trust policies (key risk controls) are equality impact assessed.

The Assurance Framework is based upon the DH model and is 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 2010/11 following which a conclusion of substantial assurance was recorded by the Internal Auditor. Board Assurance updates are cross-referenced to Board reports to ensure ongoing synergy and influence on the Board agenda.

Quality Account

There are a number of controls in place to ensure the adequacy of the Quality Account, including monitoring of performance and scrutiny at Board sub-committees.

Stakeholder Involvement in Managing Risks

The Trust has continued to work collaboratively with both the Strategic Health Authority and the local Primary Care Trust in respect of the issues affecting the health economy. The following arrangements are in place:

- I attend regular meetings of Chief Executive Officers of Trusts, drawn from the East of England;
- I meet with the Chief Executive Officers and Chairs of Hertfordshire-wide Trusts on a regular basis;
- The Trust attends regular meetings with the SHA's Provider Development Team, Chaired by the Director of Provider Development;
- I attend health economy planning meetings convened to achieve whole systems planning;
- Board to Board meetings and seminars between the Trust and NHS Hertfordshire take place as required;
- A series of routine performance / contract monitoring meetings with the PCT take place once a month to look specifically at the performance of the SLAs;
- Senior Trust staff meet regularly with GP practice managers to discuss matters of concern or common interest;
- Trust staff are actively engaged with GPs and PCT staff in a series of service redesign projects which have emerged from the QIPP Plan for Hertfordshire;
- We are seeking active engagement with emerging GP Consortia;
- We continue to work to develop existing relationships with practice-based commissioning groups and the local GP Conclave.

The Trust continues to work with the Hertfordshire County Health Scrutiny Committee (HSC) and has built upon the previous good relationships during 2010/11. The Trust attends the HSC meetings on a regular basis as well as participating in the relevant health topic groups.

The Trust consulted with the HSC and the Local Involvement Networks on proposals for its Quality Account 2010/11 and received constructive feedback which will be reflected in the Account to be published during 2011/12. In particular it has worked closely with the HSC to develop arrangements for in-year consultation and co-operation in relation to the Quality Account.

The Trust has many established and effective arrangements for working with the wider stakeholder communities, including patients and carers.

The Trust continues to develop its shadow membership drawing from the local population in preparation for achieving Foundation Trust status. We have a current membership of 6,600 people drawn from our constituencies.

Following the introduction of registration with the Care Quality Commission, the Trust has developed its assurance processes to support ongoing compliance with registration outcomes. In the reporting year the Trust maintained compliance, with no qualifications.

The Trust received an unannounced inspection of the Urgent Care Centre at Hemel Hempstead on 22 December 2010 and an unannounced inspection of the Accident and Emergency department, based at Watford General Hospital, on 7 January 2011. Both these were undertaken as part of a nationwide programme of visits at the direction of the Secretary of State for Health.

The report following the visit to the Urgent Care Centre found that the service was meeting CQC registration outcomes. It did, however, note a minor concern in relation to achieving Outcome 4, focusing on keeping patients informed. An improvement action plan was developed to address these concerns and is being implemented. A draft report has been received following the visit to the Accident and Emergency department which also found that the service was meeting CQC registration outcomes although some improvement actions were suggested.

The Trust is currently working towards achieving Level 2 of the National Health Service Litigation Authority (NHSLA) risk management standards, with an assessment scheduled for June 2011. The Trust's maternity services achieved Level 2 under the maternity related NHSLA standards, CNST, in 2010 and are working towards achieving Level 3 compliance in 2013.

Public and Patient Involvement

The Trust actively involves and seeks the views of patients. The Trust's Patients' Panel has been established for five years and is linked into a wide range of committees, meetings and projects within the Trust. Panel members are also members of Internal Patient Environment Action Team (iPEAT) inspections and take part in the Trust's Observation of Care, Pride in Our Workplace 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 in helping to drive forward its objectives. They are also regular attendees at the Patient Involvement & Experience Group chaired by the Director of Nursing and Patients' Champion.

The Trust has maintained good relationships with the Local Involvement Network (LINks). I hold regular meetings to brief them on developments and receive feedback from them on any concerns raised following visits to departments within the Trust. The Trust takes steps to address the issues relating to these concerns. A LINk representative attends Board meetings and is invited to report on issues it wishes to raise with the Board.

Health and Safety

The Trust was inspected by the Health and Safety Executive during 2010/11 during which it was identified that specific actions were required to ensure compliance with Health and Safety legislation. These are being taken forward.

Equality, Diversity and Human Rights

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

NHS Pensions Scheme

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

Climate Change

The Trust has undertaken a climate change risk assessment and developed an Adaptation Plan. This supports its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met

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 has provided 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 for the year 2010/11 and the opinion is as follows:

"Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk".

The Trust has reviewed the weaknesses identified in the design and/or inconsistent application of controls reviewed and which the organisation relies upon as part of its system of internal control and action plans have been developed and implemented to address these.

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
- CQC Monitoring Reports
- In-year Performance Monitoring

- The National Inpatient Survey
- The Staff Survey
- External benchmarking data
- NHSLA compliance reports
- Participation rates for national clinical audits
- The Trust's Clinical Audit programme
- PCT contract reviews
- External Agency Reports

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

The following groups have a responsibility to maintain and review the effectiveness of the system of internal control:
The **Trust Board** has endorsed a mechanism to gain assurances about the effectiveness of the controls in place to manage its principal 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** provides assurance to the Board on the maintenance of the system of internal control. The Committee comprises three Non-Executive Directors and is attended by the Director of Finance, Director of Patient Safety, the Director of Patient Safety, the Medical Director, the Assistant Director of Clinical Governance and Risk, the Director of Corporate Affairs with other representatives including Internal and External Audit in attendance. I attend meetings as required.

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 reports from the Director of Patient Safety, the Medical Director, ensuring that appropriate issues are escalated to the Audit Committee from the ISE and the Clinical Quality Advisory Committee.

The role of the **Integrated Risk and Governance Committee** is to promote integrated risk management as intrinsic to all of the organisation's activities and specifically promote local level responsibility and accountability for identifying and managing the organisation's risks.

The Integrated Risk and Governance Committee reviews the maintenance and further development of the Board Assurance Framework and, via the Integrated Standards Executive, the Trust Risk Registers. The Risk Registers support the achievement of a high level of internal control by providing tools that facilitate the management of risks to patient safety and clinical quality and inform risk-based Board decision-making. The Committee works closely with the Trust's Audit Committee to ensure there are no significant overlaps or gaps between their respective remits.

The **Clinical Quality Advisory Committee** is responsible for the quality assurance processes in place to ensure the Trust continues to meet CQC and related standards of quality and safety. 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 CQC, and the quality element of the Acute Commissioning Contract.

The Director of Patient Safety, the Medical Director chairs the **Integrated Standards Executive**. His 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. These committees also review risk registers and attend to detailed consideration of the management of risks and the effectiveness of mitigation/control activities. The Chair is accountable to the Chief Executive Officer and ISE provides data to support the work of the Clinical Quality Advisory Committee (CQuaC) for quality and safety issues and to the Integrated Risk and Governance Committee for matters relating to risk management.

Executive Directors have overall responsibility for the implementation of the risk management strategy. They are responsible for overseeing the processes for identifying and assessing risk, and for advising me as necessary.

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

The **Board Assurance Framework** provides a tool to support the Board in managing the organisation's key risks.

CQC and NHSLA Compliance

The Trust has a policy document setting out responsibilities, process requirements and reporting arrangements in relation to CQC outcomes for quality and safety and for the NHSLA risk management standards. The CQC process was subject to an internal audit which concluded the controls support a sound system of internal control.

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

Financial Disclosure

The Trust produced a surplus of £7.5m after adjusting for an impairment of assets as shown in the Statement of Comprehensive Income for year ended 31 March 2011.

For 2011/12 the Trust has agreed a plan of £4.4m surplus. This plan is on the basis of restructuring the loans that the Trust has with the Department of Health. Going forward the restructuring will strengthen the Trust's statement of financial position (Balance Sheet).

While the £4.4m surplus is lower than that of 2010/11 it still represents a substantial challenge and is dependent on the successful deliver of a £15.5m savings programme.

This will be achieved from the solid base established:

- Continuation of regular performance reviews across the Trust
- Delivering savings Big Ask Mark 2
- Strong budgetary control across both pay and non pay
- Ensuring managers have the information they need both financial and patient numbers
- Changes to the Trust's infrastructure to support the delivery of patients efficiently and effectively.

Strategic risks to the Trust are reviewed on a continual basis both by the Board and the Trust's managers 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: 8 June 2011

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: 8 June 2011

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

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

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

By order of the Board

Jan Filochowski, Chief Executive
Date: 8 June 2011

Anna Anderson, Finance Director
Date: 8 June 2011

Financial Review 2010/11

2010/11 is the fourth year in succession that the Trust has delivered a surplus outturn.

The Trust narrowly missed its plan of an £8.1m surplus achieving one of the highest surpluses in the country with an outturn of £7.5m. The main reasons behind missing the target was the cost of providing a higher than planned level of emergency activity, for which the Trust received a 30% marginal cost payment and the higher costs associated with the bad winter experienced in December 2010 and also narrowly missing the ambitious programme of savings.

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

In achieving £7.5m surplus the Trust planned a £19.3m, (8%) savings target. This was named the "Big Ask" and involved staff at all levels of the organisation both to develop and implement ideas. Staff achieved £18.5m, which is a remarkable achievement, particularly as it was achieved without compromising patient safety.

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, as required by HM Treasury. Also the Trust has repaid £6.4m of its loans with the Department of Health.

Finance Developments

The Finance Department has completed its roll-out of electronic authorisation of invoices enabling the Trust to continue its improvement of paying suppliers promptly.

78% of all invoices were paid on or before their due date in 2009/10 and 83% in 2010/11. The Trust continues to strive in line with the better payment practice code at least 95% of suppliers are paid promptly.

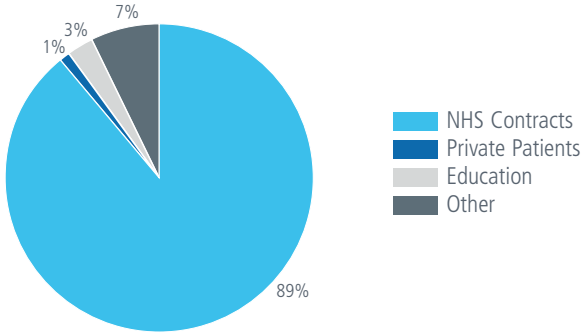
A new budgeting system, integrated within the general ledger, has been implemented and was in use to aid 2011/12 budget setting.

Service Line Reporting (SLR) reports are now produced and in-house data analysis skills developed. Their use to support efficiency initiatives is being assessed together with how best to provide relevant financial and other information to inform clinicians in their work.

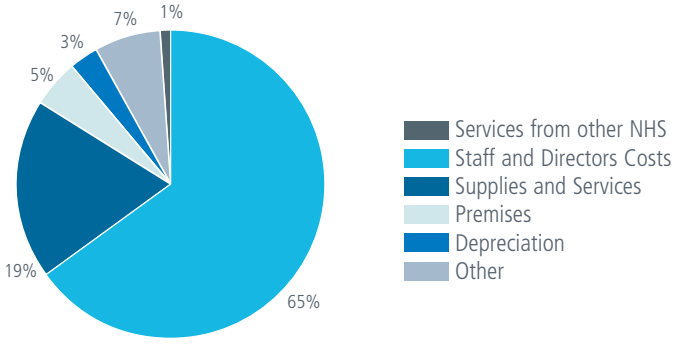
Financial Strategy

The Trust has continued to work closely with stakeholders to update its financial strategy to reflect NHS changes and the economic climate. These are reflected in a 5 year plan used as part of the assessment of the Trust's suitability for Foundation Trust status.

Sources of Income 2010/11



Where we spent our money 2010/11



The Trust Board and its Sub Committees

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

The Trust Board has established the following Sub-Committees:

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

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

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.

Membership:

Three 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 three Non Executive Directors

Charitable Funds Committee

To ensure funds held on Trust/Charitable Funds are managed in accordance with the Trust's Standing Financial Instruction, as approved by the Trust Board.

Membership:

Three Non Executive Directors are members of this committee.

Finance Committee

To maintain an oversight of, and receive assurances on the robustness of the Trust's key income sources and contractual safeguard.

Membership:

Three Non Executive Directors are members of this committee.

Integrated Risk and Governance Committee

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

Membership:

Two Non Executive Directors are members of this committee.

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 2010/11 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 Leadership centre for Local Government
Chris Green	November 2010	- Non Executive Director of Dover Harbour Board
Mahdi Hasan	March 2010 November 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 - Member on the Patients Safety Council at Addenbrookes Hospital in Cambridge
Katherine Charter	March 2010	- Teaching Assistant employed by Herts County Council
Stuart Lacey	September 2010	- CEO of ElectraLink
Sarah Connor	March 2010	- None
Jan Filochowski	March 2010	- None
Dr Colin Johnston	March 2010	- None
Natalie Forrest	December 2010	- None
Nick Evans	March 2010	- None
Sarah Wiles	March 2010	- None
Mark Vaughan	January 2011	- None
David McNeil	May 2011	- Member of Independent Remuneration Committees at Watford Borough Council and East Herts Borough Council - Member of the Advisory Board at Watford Vibe Radio
Anna Anderson	March 2010	- None

Directors Remuneration

			2010/11			2009/10		
Name	Title	In year start / leave dates	Salary (Bands of £5,000)	Other Remuneration (Bands of £5,000)	Benefits in Kind (£100)	Salary (Bands of £5,000)	Other Remuneration (Bands of £5,000)	Benefits in Kind (£100)
			£	£	£	£	£	£
T. Hanahoe	Chairman		20-25	0	0	25-30	0	0
J. Filochowski*	Chief Executive	Permanently appointed Sept'09	280-285	0	2	140-145	0	18
R. Douglas	Non-Executive Director		5-10	0	0	5-10	0	0
C. Gordon	Non-Executive Director	Left June '10	0-5	0	0	5-10	0	0
K. Charter	Non-Executive Director		5-10	0	0	5-10	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	5-10	0	0	0-5	0	0
C. Green	Non-Executive Director	Start Aug '10	0-5	0	0	0	0	0
A. Anderson	Director of Finance	Start Jan '10	115-120	0	0	25-30	0	0
T. Moran	Acting Director of Nursing	Left post May '10	10-15	0	0	15-20	0	0
N. Forrest	Director of Nursing	Start June '10	75-80	0	0	0	0	0
N. Evans	Director of Partnerships		110-115	0	4	105-110	0	4
S. Childerstone	Director of Human Resources	Left June '10	50-55	0	5	100-110	0	14
M. Vaughan	Director of Workforce	Start Jan '11	20-25	0	0	0	0	0
S. Wiles	Director of Strategy & Infrastructure		75-80	0	30	65-70	0	30
D. McNeil	Director of Corporate Affairs		95-100	0	16	110-115	0	3
R. Harrison	Director of Delivery	Left Sept '10	65-70	0	0	105-110	0	0
C. Johnston	Medical Director	Start Sept'09	135-140	55-60	0	60-65	115-120	0

* During 2008/09 and the start of 2009/10 the Chief Executive was seconded to the Trust on an agreed contract with South East Coast Strategic Health Authority. The cost charged to the Trust for the first 6 months of 2009/10 which includes salary, employers national insurance, superannuation contributions and benefits in kind was £248k. For 2010/11 the Chief Executive salary is inclusive of a bonus relating to the Trust's performance in 2009/10.

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 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011 £1	Cash Equivalent Transfer Value at 31 March 2010 £1	Real increase /decrease in Cash Equivalent Transfer Value £1	Employer's contribution to stakeholder pension £1
J. Filochowski	15-17.5	45-47.5	135-140	415-420	see below	see below	see below	0
C. Johnston	27.5-30	82.5-85	80-85	245-250	1,865,867	1,311,334	555	0
A. Anderson	5-7.5	15-17.5	45-50	145-150	1,049,201	980,900	68	0
N. Evans	7.5-10	22.5-25	50-55	160-165	1,215,899	1,106,212	110	0
N. Forrest	0-2.5	2.5-5	0-10	25-30	127,097	120,549	5	0
T. Moran	0-2.5	0-2.5	15-20	45-50	221,883	225,590	-1	0
S. Childerstone	0-2.5	2.5-5	30-35	95-100	see below	see below	see below	0
M. Vaughan	0-2.5	0-2.5	25-30	75-80	428,257	443,865	-4	0
R. Harrison	2.5-5	0-2.5	15-20	55-60	192,285	163,084	15	0
D. McNeil	2.5-5	12.5-15	40-45	125-130	see below	see below	see below	0
S. Wiles	0-2.5	5-7.5	10-15	35-40	148,846	150,801	-2	0

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for these Directors.
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 the 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. Where no CETV figure is shown the Directors no longer have the ability to transfer their pension entitlement. The CETV 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 which the individual has transferred to the NHS pension scheme. They also include any additional benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
Real Increase / Decrease in CETV - reflects the change in-year of CETV after adjusting the start of the year CETV price base using common market valuation factors.

Auditor's report

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

We have audited the financial statements of West Hertfordshire Hospitals NHS Trust for the year ended 31 March 2011 under the Audit Commission Act 1998. The financial statements 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 financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies. We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and
- the table of pension benefits of senior managers

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

Respective responsibilities of Directors and auditor

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

Scope of the audit of financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. We read all the information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the West Hertfordshire Hospitals NHS Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly 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 in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report to be audited has been properly 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 in England; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We have nothing to report in respect of the Statement on Internal Control on which we report to you if, in our opinion the Statement on Internal Control does not reflect compliance with the Department of Health's requirements.

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

Trust's responsibilities

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

Auditor's Responsibilities

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

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

Basis of conclusion

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2010, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use or resources for the year ending 31 March 2011.

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

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, we are satisfied that, in all significant respects, The West Hertfordshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2011.

Certificate

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

Paul Dossett, Senior Statutory Auditor
Senior Statutory Auditor for and on behalf of Grant Thornton UK LLP
Registered Auditor, Chartered Accountants
Date: 9 June 2011
Address: Grant Thornton House Melton Street, London NW1 2EP

Statement of comprehensive income for the year ended 31 March 2011

	NOTE	31 March 2011 £000	Restated 31 March 2010 £000
Revenue			
Revenue from patient care activities	4	**232,705**	227,443
Other operating revenue	5	**27,693**	26,865
Operating expenses	6	**(254,303)**	(299,504)
Operating surplus/(deficit)		**6,095**	(45,196)
Finance costs:			
Investment revenue	12	**25**	31
Other gains and losses	13	**0**	(11)
Finance costs	14	**(1,633)**	(1,763)
Surplus/(deficit) for the financial year		**4,487**	(46,939)
Public dividend capital dividends payable		**(3,135)**	(5,228)
Retained surplus/(deficit) for the year		**1,352**	(52,167)
Other comprehensive income			
Impairments and reversals	15.1	**(6,988)**	(68,270)
Gains on revaluations	15.1	**547**	0
Receipt of donated/government granted assets	15.1	**134**	49
Reclassification adjustments:			0
- Transfers from donated asset reserves		**(227)**	(226)
Total comprehensive income for the year		**(5,182)**	(120,614)
The notes on pages 1 to 35 form part of these accounts.			
Reported NHS financial performance position [Adjusted retained surplus/(deficit)]			
Retained surplus/(deficit) for the year		**1,352**	(52,167)
Impairment	6	**6,178**	57,866
Reported NHS financial performance position [Adjusted retained surplus/(deficit)]		**7,530**	5,699

The Trust's reported NHS financial performance position is derived from its retained surplus/(deficit) adjusted for impairment charged to revenue because this is not considered part of the Trust's operating activities.
The reported impairments relate to valuing the Trust's land and buildings on the basis of modern equivalent assets (MEA) as explained in note 1.7 and detailed in note 15.4.

Statement of financial position as at 31 March 2011

	NOTE	31 March 2011 £000	Restated 31 March 2010 £000
Non-current assets			
Property, plant and equipment	15	**119,022**	131,615
Intangible assets	16	**3,327**	3,325
Trade and other receivables	19	**1,683**	1,575
Total non-current assets		**124,032**	136,515
Current assets			
Inventories	18	**3,542**	3,530
Trade and other receivables	19	**10,445**	13,306
Cash and cash equivalents	21	**1,785**	1,776
		15,772	18,612
Non-current assets held for sale	22	**0**	260
Total current assets		**15,772**	18,872
Total assets		**139,804**	155,387
Current liabilities			
Trade and other payables	23	**(16,951)**	(20,780)
DH Loans	24	**(6,412)**	(6,412)
Provisions	26	**(562)**	(550)
Net current assets/(liabilities)		**(8,153)**	(8,870)
Total assets less current liabilities		**115,879**	127,645
Non-current liabilities			
DH Loans	24	**(20,823)**	(27,235)
Provisions*	26	**(5,430)**	(5,602)
Total assets employed		**89,626**	94,808
Financed by taxpayers' equity:			
Public dividend capital		**173,668**	173,668
Retained earnings*		**(98,561)**	(100,340)
Revaluation reserve		**13,741**	20,545
Donated asset reserve		**778**	935
Total taxpayers' equity		**89,626**	94,808

*31 March 2010 figures restated to reflect the prior period adjustment explained in the statement of changes in taxpayers equity (page 4). The financial statements on pages 40 to 51 were approved by the Board on 8 June 2011 and signed on its behalf by:

Jan Filochowski, Chief Executive
Date: 8 June 2011

Statement of changes in taxpayers' equity

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Total £000
Changes in taxpayers' equity for 2009/10					
Balance at 31 March 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 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
Balance at 1 April 2010					
As previously stated	173,668	(100,168)	20,545	935	94,980
Prior Period Adjustment*	0	(172)	0	0	(172)
Restated Balance	173,668	(100,340)	20,545	935	94,808
Changes in taxpayers' equity for 2010/11					
Total comprehensive income for the year					
Retained surplus/(deficit) for the year	0	1,352	0	0	1,352
Transfers between reserves	0	427	(427)	0	0
Impairments and reversals	0	0	(6,924)	(64)	(6,988)
Net gain on revaluation of property, plant, equipment	0	0	547	0	547
Receipt of donated assets	0	0	0	134	134
Reclassification adjustments:					
- transfers from donated asset reserve	0	0	0	(227)	(227)
Balance at 31 March 2011	173,668	(98,561)	13,741	778	89,626

* The prior period adjustment relates to change in accounting policy concerning the discount rate used to estimate the current fair value of the future cash flows relating to early retirement pension. This is explained in note 1.3.1 and note 26.

Statement of cash flows for the year ended 31 March 2011

	2010/11 £000	2009/10 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**6,095**	(45,196)
Depreciation and amortisation	**6,921**	8,671
Impairments and reversals	**6,178**	57,866
Transfer from donated asset reserve	**(227)**	(226)
Interest paid	**(1,500)**	(1,645)
Dividends paid	**(2,999)**	(5,364)
(Increase)/decrease in inventories	**(12)**	(618)
(Increase)/decrease in trade and other receivables	**2,618**	375
Increase/(decrease) in trade and other payables	**(2,916)**	(3,859)
Increase/(decrease) in provisions	**(308)**	(400)
Net cash inflow/(outflow) from operating activities	**13,850**	9,604
Cash flows from investing activities		
Interest received	**25**	34
(Payments) for property, plant and equipment	**(7,178)**	(18,003)
Proceeds from disposal of plant, property and equipment	**604**	1,129
(Payments) for intangible assets	**(880)**	(329)
Net cash inflow/(outflow) from investing activities	**(7,429)**	(17,169)
Net cash inflow/(outflow) before financing	**6,421**	(7,565)
Cash flows from financing activities		
Public dividend capital received	**0**	2,068
Loans received from the DH	**0**	7,000
Loans repaid to the DH	**(6,412)**	(5,012)
Net cash inflow/(outflow) from financing	**(6,412)**	4,056
Net increase/(decrease) in cash and cash equivalents	**9**	(3,509)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**1,776**	5,285
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year (Note 21)	**1,785**	1,776

Notes to the accounts

1. Accounting policies

The Secretary of State for Health has directed that these financial statements shall meet the accounting requirements of the NHS Trusts Manual for Accounts, as agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 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 has extended its facilities services contract, the benefit in so doing has been accrued to be matched over the period to which it relates (see note 23).
- HM Treasury advises the discount rate used in determining the pension provisions value (see note 1.15 and note 26). The change in discount rate from 3.2% to 1.8% as at 31 March 2010 was not used for the Trust's 2009/10 accounts but has been accounted for as a prior period adjustment. In line with HM Treasury advice the discount rate of 1.8% has been revised to 2.9% in these accounts as at 31 March 2011.
- The risks and rewards of ownership of assets leased by the Trust rest with the leasing company; rental payments are charged to the period to which they relate; see note 7.
- Some of the Trust's buildings are used by other organisations, either for NHS purposes or staff welfare. These are not investment properties and rental is credited to the period to which it relates. The associated buildings are included within the total value of Trust properties.
- The Trust Board is corporate Trustee for West Hertfordshire NHS Trust charitable funds. Under IAS 27, this common control means that the charitable accounts should be consolidated, However, HM Treasury has granted a divergence from this requirement in 2010/11; the accounts have not therefore been consolidated.

1.3.2 Key sources of estimation uncertainty

In preparing these accounts the Trust might make assumptions concerning the future affecting the amounts of assets, liabilities, revenue or expenses reported. Any such assumptions and basis of estimate are explained in the related notes. There are no significant assumptions in 2010/11.

1.4 Revenue

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

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

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

1.5 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

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

For early retirements other than those due to ill health approved by the Trust, additional pension cost is not funded by the NHS Pension 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 with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

Until 31 March 2009, the depreciated replacement cost of specialised buildings was estimated on the basis of an exact replacement of the asset in its present location. With effect from 1 April 2009, through its appointed valuers GVA Grimleys Ltd, the Trust has adopted the HM Treasury standard approach to depreciated replacement cost valuations based on modern equivalent assets. The effect of change in estimation technique is detailed in note 15.4.

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses arising from a loss of service potential are charged to expenditure. This is a change in accounting policy from previous years where all impairments were charged to the revaluation reserve to the extent that a balance was held for that asset and only 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 detail for each class of asset is shown in note 15.4.

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 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 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, its leases are classified as operating leases; further details of which are contained in note 7.

The Trust as lessee

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

The Trust as lessor

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

1.13 Inventories

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

1.14 Cash and cash equivalents

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

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

1.15 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's prescribed discount rates.

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

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

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

1.16 Clinical negligence costs

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

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

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

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

1.19 Contingencies

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

1.20 Financial assets

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

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

1.21 Financial liabilities

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

1.22 Value added tax

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

1.23 Foreign currencies

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.

1.24 Third party assets

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for 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 disclosed 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.

1.25 Public Dividend Capital (PDC) and PDC dividend

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

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

1.26 Losses and special payments

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

2. Operating segments

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

Revenue relating to NHS patient care accounts for 89.4% of the total, further analysis of which is shown in note 4. This is managed through contracts established with commissioners, mainly primary care trusts (PCTs), each contract covering the complete range of activities provided. The Trust's assets are used collectively to deliver the range of activities encompassed within PCT contracts.

3. Income generation activities

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

	2010/11 £000	2009/10 £000
Prescription Packaging Unit	1,552	1,385
Full cost	-1,328	-1,124
Surplus	224	261

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

4. Revenue from patient care activities

	2010/11 £000	2009/10 £000
Strategic health authorities	**4,321**	6,015
Primary care trusts	**225,948**	219,027
Local authorities	**249**	238
Non-NHS:		
Private patients	**1,155**	1,050
Overseas patients (non-reciprocal)	**137**	193
Injury costs recovery	**868**	900
Other	**27**	20
	232,705	227,443

Injury cost recovery income is subject to a provision for impairment of receivables of 9.6% to reflect expected rates of collection.

5. Other operating revenue

	2010/11 £000	2009/10 £000
Education, training and research	8,828	8,338
Charitable and other contributions to expenditure	96	98
Transfers from donated asset reserve	227	226
Non-patient care services to other bodies	14,997	13,940
Income generation	3,051	2,269
Rental revenue	494	494
Other revenue	0	1,500
	27,693	26,865

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

Other revenue 2009/10 relates to funds received from the Trust's main commissioner NHS Hertfordshire 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

	2010/11 £000	2009/10 £000
Services from other NHS Trusts	2,334	2,424
Services from other NHS bodies	135	121
Services from Foundation Trusts	0	0
Purchase of healthcare from non NHS bodies	430	1,095
Trust chair and non executive directors	64	66
Employee Benefits	162,375	156,963
Supplies and services - clinical	38,309	35,008
Supplies and services - general	8,457	7,851
Consultancy services	853	696
Establishment	2,995	3,381
Transport	2,378	2,550
Premises	12,090	11,947
Provision for impairment of receivables	243	134
Depreciation	6,016	7,465
Amortisation	905	1,206
Impairments and reversals of property, plant and equipment	6,178	57,866
Audit fees	175	169
Other auditor's remuneration	0	0
Clinical negligence	5,726	5,364
Education and Training	641	588
Other	3,999	4,610
	254, 303	299,504

The purchase of healthcare from non-NHS bodies relates to the outsourcing of activity to meet 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	2010/09 £000	2009/10 £000
Minimum lease payments	569	559
	569	559

Total future minimum lease payments	2010/11 £000	2009/10 £000
Payable:		
Not later than one year	358	536
Between one and five years	450	401
After 5 years	0	21
Total	808	958

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	2010/11 £000	2009/10 £000
Total rental revenue	494	494

Total future minimum lease payments	2009/10 £000	2008/09 £000
Receivable:		
Not later than one year	495	512
Between one and five years	2,473	2,562
After 5 years	580	553
Total	3,548	3,627

8. Employee costs and numbers

8.1 Employee costs

	2010/11 Total £000	Permanently Employed £000	Other £000	2009/10 Total £000	Permanently Employed £000	Other £000
Salaries and wages	137,500	121,744	15,756	132,578	118,802	13,776
Social Security Costs	10,349	9,503	846	10,574	9,919	655
Employer contributions to NHS Pension scheme	14,884	13,630	1,254	14,318	13,346	972
Termination benefits	81	81	0	0	0	0
Employee benefits expense	162,814	144,958	17,856	157,470	142,067	15,403
Of the total above:						
Charged to capital	439			507		
Employee benefits charged to revenue	162,375			156,456		
	162,814			157,470		

8.2 Average number of people employed

	2010/11 Total Number	Permanently Employed Number	Other Number	2009/10 Total Number	Permanently Employed Number	Other Number
Medical and dental	528	500	28	529	499	30
Administration and estates	980	902	78	941	854	87
Healthcare assistants and other support staff	600	528	72	583	509	74
Nursing, midwifery and health visiting staff	1,206	1,048	158	1,150	1,057	93
Nursing, midwifery and health visiting learners	9	9	0	4	4	0
Scientific, therapeutic and technical staff	419	387	32	403	370	33
Other	32	31	1	38	37	1
Total	3,774	3,405	369	3,648	3,330	318
Of the above:						
Number of whole time equivalent staff engaged on capital projects	8			10		

8.3 Staff sickness absence

	2010/11 Number	2009/10 Number
Total days Total calendar days lost	**25,666**	26,837
Total staff years employed (wte)	**3,390**	3,281
Average days lost per staff year employed	**7.57**	8.18
Total staff employed in period (headcount)	**3,946**	3,848
Total staff employed in period with no absence (headcount)	**1,203**	1,388
Percentage staff with no sick leave	**30.5%**	36.1%

8.4 Management costs

	2010/11 £000	2009/10 £000
Management costs	**14,472**	13,992
Income	**260,398**	254,308
Percentage of Management costs to income	**5.56%**	5.50%

9. Pension cost

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

The scheme was subject to a full actuarial valuation as at 31 March 2004 and an accounting valuation is performed every year. An outline of these valuations 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 covered the period 1 April 1999 to 31 March 2004.The conclusion 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, and after consideration of changes to the NHS Pensions 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 by the scheme actuary as at the end of the reporting period 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 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 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 2010/11 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual pensions

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

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

Pensions indexation

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

Ill-health retirement

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

Death benefits

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

Early Retirement

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Additional Voluntary Contributions (AVCs)

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

10. Retirements due to ill-health

During the year early retirements from the Trust may be agreed on the grounds of ill-health. The cost of these ill-health retirements are borne by the NHS Business Services Authority (NHSBA)-Pensions Division. With effect from 1 April 2010 the NHSBA no longer advises the Trust of the related cost, reporting the total number across the NHS to the Department of Health to disclose in its consolidated accounts.

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

	2010/11 Number	2010/11 £000	2009/10 Number	2009/10 £000
Total Non-NHS trade invoices paid in the year	54,314	70,219	54,527	68,238
Total Non NHS trade invoices paid within target	45,319	57,498	42,684	52,014
Percentage of Non-NHS trade invoices paid within target	83%	82%	78%	76%
Total NHS trade invoices paid in the year	2,450	18,419	2,716	22,425
Total NHS trade invoices paid within target	2,010	14,475	1,883	17,622
Percentage of NHS trade invoices paid within target	82%	79%	69%	79%

12. Investment revenue

	2010/11 £000	2009/10 £000
Interest revenue:		
Bank accounts	25	31
Total	25	31

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

	2010/11 £000	2009/10 £000
Gain/(loss) on disposal of property, plant and equipment	0	(11)

14. Finance Costs

	2010/11 £000	2009/10 £000
Interest on loans with the Department of Health	1,485	1,638
Other finance costs relate to unwinding of discount in determining fair value of provisions.	148	125
Total	1,633	1,763

15. Property, plant and equipment

15.1 2010/11:

	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 2010	29,364	130,835	7,329	6,469	30,020	196	9,579	4,812	218,604
Additions purchased	0	1,522	0	3,712	539	31	475	0	6,279
Additions donated	0	0	0	17	117	0	0	0	134
Additions government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	5,850	(785)	(6,045)	375	0	558	20	(27)
Reclassified as held for sale	(34)	0	(88)	0	0	0	0	0	(122)
Disposals other than by sale	0	(215)	0	0	(1,487)	(51)	0	(9)	(1,762)
Revaluation/indexation gains	34	414	92	0	0	0	0	7	547
Impairments	0	(6,845)	0	0	0	0	0	(143)	(6,988)
At 31 March 2011	29,364	131,561	6,548	4,153	29,564	176	10,612	4,687	216,665
Depreciation at 1 April 2010	0	52,129	5,535	0	18,923	193	7,522	2,687	86,989
Reclassifications		269	(269)		0	0	0	0	0
Reclassified as held for sale	0	0	0		0	0	0	0	0
Disposals other than by sale	0	(2)	0		(1,487)	(51)	0	0	(1,540)
Revaluation/indexation gains	0	0	0		0	0	0	0	0
Impairments	0	5,621	530	0	0	0	0	27	6,178
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	2,776	71		2,340	2	749	78	6,016
Depreciation at 31 March 2011	0	60,793	5,867	0	19,776	144	8,271	2,792	97,643
Net book value									
Purchased	29,364	70,621	681	4,136	9,178	32	2,338	1,894	118,244
Donated	0	147	0	17	610	0	3	1	778
Total at 31 March 2011	29,364	70,768	681	4,153	9,788	32	2,341	1,895	119,022
Asset financing									
Owned	29,364	70,768	681	4,153	9,788	32	2,341	1,895	119,022
Total 31 March 2011	29,364	70,768	681	4,153	9,788	32	2,341	1,895	119,022

15.2 Revaluation reserve balance for property, plant & equipment

	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
At 1 April 2010	5,820	13,171	53	0	571	0	0	930	20,545
Movements (see note 15.4)	(20)	(5,786)	(53)	0	(15)	0	0	930	(6,804)
At 31 March 2011	5,800	7,385	0	0	556	0	0	0	13,741

Prior year:

15.3 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

15.4 Property, plant and equipment

Of the £6,413k additions, £134k was donated by West Hertfordshire Hospitals NHS Trust Charitable Funds.

The effective date of the annual valuation of Land, Buildings and Dwellings is 31 March. The valuation is undertaken by an independent valuer GVA Grimleys Ltd. Because of the specialised nature of hospital buildings, i.e. they would not normally be sold on the open market, the valuations are based on the depreciated replacement cost method (DRC) using the modern equivalent asset (MEA) technique.

This valuation technique can result in an impairment details of which are shown below.

2010/11:	Watford Hospital £000	Hemel Hempsted Hospital £000	St Albans Hospital £000	Total £000
Operating expenses (note 6)				
Buildings, dwellings and fittings - MEA	4,565	1077	44	5,686
Buildings, dwellings and fittings no longer in use	547	-55	0	492
	5,112	1,022	44	6,178
Other comprehensive income (SOCI)				
Buildings, dwellings and fittings - MEA	491	6,035	278	6,804
Buildings, dwellings and fittings no longer in use	0	184	0	184
	491	6,219	278	6,988
2009/10:				
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

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)

Asset Class	As at 31 March 2011 Maximum remaining asset life Years	As at 31 March 2011 Minimum remaing asset life Years	As at 31 March 2010 Maximum remaining asset life Years	As at 31 March 2010 Minimum remaing asset life Years
Buildings	58	8	59	9
Dwellings	23	9	24	10
Plant and machinery	10	1	9	1
Transport	5	3	4	0
Information Technology	5	1	7	1
Furniture and Fittings	58	8	59	9

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 £18,872k (2009/10 £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 £2,935k and depreciation for the period is £90k.

16. Intangible assets

2010/11:

2010/11:	Computer software - in use £000	Computer Software in development £000	Total £000
Gross cost at 1 April 2010	5,976	271	6,247
Additions purchased	186	694	880
Reclassifications	295	(268)	27
Gross cost at 31 March 2011	6,457	697	7,154
Amortisation at 1 April 2010	2,992	0	2,992
Charged during the year	905	0	905
Amortisation at 31 March 2011	3,827	0	3,827
Net book value			
Purchased	2,630	697	3,327
Donated	0	0	0
Total at 31 March 2011	2,630	697	3,327

Prior year:

2009/10:

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

The maximum remaining asset life of computer software in use is 5 years.
There are no material intangible assets fully amortised in use.
There were no changes in asset lives, residual values, or impairment loss recognised during the period for assets in use.
Intangible assets are held at depreciated cost as a proxy for fair value; there are no associated revaluation reserves.

17. Capital commitments

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

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	691	1,062
Intangible assets	0	0
Total	961	1,062

18. Inventories

	31 March 2011 £000	31 March 2010 £000
Drugs	803	1,089
Consumables	2,543	2,177
Energy	196	264
Total	3,542	3,530

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 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
NHS receivables-revenue	6,410	0	9,801	0
NHS receivables-capital	0	0	0	0
Non-NHS receivables-revenue	2,271	0	1,342	0
Non-NHS receivables-capital	0	0	0	0
Provision for the impairment of receivables	(499)	0	(388)	0
Prepayments and accrued income	1,201	0	0	0
Operating lease receivables	0	0	1,803	0
VAT	511	0	325	0
Other receivables	551	1,683	423	1,575
Total	10,445	1,683	13,306	1,575

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

19.2 Receivables past their due date but not impaired

	31 March 2011 £000	31 March 2010 £000
By up to three months	113	227
By three to six months	310	222
By more than six months	499	472
Total	922	921

19.3 Provision for impairment of receivables

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	(388)	(384)
Amount written off during the year	132	130
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(243)	(134)
Balance at 31 March	(499)	(388)

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 2011 £000	31 March 2010 £000
Balance at 1 April	1,776	5,285
Net change in year	9	(3,509)
Balance at 31 March	1,785	1,776
Made up of		
Cash with Government Banking Service	1,802	1,802
Commercial banks and cash in hand	(17)	(26)
Current investments	0	0
Cash and cash equivalents as in statement of financial position and cash flows	1,785	1,776

22. Non-current assets held for sale

	Land £000	Dwellings £000	Total £000
Balance at 1 April 2010	73	187	260
Revaluation in 2011/12	0	122	122
Less assets sold in the year	(73)	(309)	(382)
Balance at 31 March 2011	0	0	0

	Land £000	Dwellings £000	Total £000
Balance at 1 April 2009	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 at 31 March 2010	73	187	260

Due to the change in use of Hemel Hempstead Hospital, the Trust agreed in 2009/10 a number of dwellings owned by the Trust adjacent to the hospital were surplus to requirements. The sale of these was completed during 2010/11.

No gains 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 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Interest payable	59	73		
NHS payables-revenue	2,211	5,248	0	0
NHS payables-revenue	0	0	0	0
Non NHS trade payables - revenue	4,597	5,191	0	0
Non NHS trade payables - capital	1,505	2,404	0	0
Accruals and deferred income	8,447	5,426	0	0
Social security costs	0	1,556		
VAT	106	18	0	0
Tax	26	864		
Total	16,951	20,780	0	0

*Includes £1.8m relating to the future benefit derived from extending the Trust's contract with its facilities service provider.

24. Borrowings

	Current		Non-current	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Bank overdraft - Government Banking Service	0	0		
Bank overdraft - Commercial banks	0	0		
Loans from:				
Department of Health	6,412	6,412	20,823	27,235
Total	6,412	6,412	20,823	27,235

There are three Department of Health loans as detailed below:

£11.2m loan accessed 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 loan; £13.5m accessed in July 2008 and a further £13.5m in September 2008. The loan was taken to finance the build of the Acute Assessment Unit at Watford Hospital and other site improvements, 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 loan accessed 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 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Pensions non directors - early retirement	531	534	5,123	5,128
Staff and public liability claims managed by NHSLA and NHS Pensions Authority	31	16	307	302
At 1 April 2010	562	550	5,430	5,430
Prior period adjustment (see note (iii) below)	0	0	0	172
Total	562	550	5,430	5,602

	Pensions relating to staff £000	Staff and public liability claims managed by NHSLA and NHS Pensions Authority £000	Total £000
At 1 April 2010	5,662	318	5,980
Prior period adjustment for change in discount rate (see note (iii) below)	172	0	172
Restated 1 April 2010	5,834	318	6,152
Adjusted for change in discount rate (see note (iii) below)	(241)	17	(224
Arising during the year	508	112	620
Used during the year	(502)	(118)	(620
Reversed unused	(84)	0	(84
Unwinding of discount	139	9	148
At 31 March 2011	5,654	338	5,992
Expected timing of cash flows:			
Within one year	515	120	635
Between one and five years	2,192	119	2,311
After five years	2,947	99	3,046

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

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

(iii) The fair value of the provision for future pension payments is determined by discounting the forecast cashflow in accordance HM Treasury prescribed discount rates (see note 1.3.1). The fair value has been adjusted to a discount rate of 1.8% as at 1 April 2010 and 2.9% 31 March 2011.

(iv) £85,580k is included in the provisions of the NHS Litigation Authority at 31/3/2011 in respect of clinical negligence liabilities of the Trust (£68,221k at 31 March 2010).

27. Contingencies

The Trust has no contingent assets or liabilities.

28. Financial Instruments

28.1 Financial assets

	At fair value through and loss	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Cash at bank and in hand	0	1,785	0	1,785
Other financial assets	0	7,074	0	7,074
Total at 31 March 2011	0	8,859	0	8,859
Cash at bank and in hand	0	1,776	0	1,776
Other financial assets	0	5,281	0	5,281
Total at 31 March 2010	0	7,057	0	7,057

28.2 Financial liabilities

	At fair value through and loss	Other	Total
	£000	£000	£000
DH Loans	0	27,235	27,235
Other financial liabilities	0	2,737	2,737
Total at 31 March 2011	0	29,972	29,972
DH Loans		33,647	33,647
Other financial liabilities	0	4,838	4,838
Total at 31 March 2010	0	38,485	38,485

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 relationships that the Trust has with its commissioners (Primary Care Trusts) and the way these are financed, means the Trust is not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held specifically to change the 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 commissioners (Primary Care Trusts), the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2011 are in receivables from other customers, as disclosed in the Trade and other receivables note 19.

Liquidity risk

The Trust's operating costs are incurred under contracts with commissioners, Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its 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	2010/11 £000
Turnover	209,199	218,248	232,967	241,684	254,308	260,398
Retained surplus/(deficit) for the year	(26,785)	(11,413)	2,495	4,405	(52,167)	1,352
Adjustment for:						
Impairments				0	57,866	6,178
Other agreed adjustments	14,111	26,785	0	0	0	0
Break-even in-year position	(12,674)	15,372	2,495	4,405	5,699	7,530
Break-even cumulative position	(26,785)	(11,413)	(8,918)	(4,513)	1,186	8,716

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.

Materiality test (I.e. is it equal to or less than 0.5%):	2005/06 %	2006/07 %	2007/08 %	2008/09 %	2009/10 %	2010/11 %
Break-even in-year position as a percentage of turnover	-6%	7%	1%	2%	2%	3%
Break-even cumulative position as a percentage of turnover	-13%	-5%	-4%	-2%	0%	3%

30.2 Capital cost absorption rate

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

30.3 External financing

The Trust is set an external financing limit by the Department of Health that it is not permitted to exceed.

	2010/11 £000	2009/10 £000
External financing limit	(4,712)	9,341
Cash flow financing	(6,421)	7,565
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	(6,421)	7,565
Undershoot/(overshoot)	1,709	1,776

A negative external financing limit (EFL) indicates the cash to be generated from business activities to pay for other cash outgoings such as repayment of loans. In 2010/11 the Trust EFL set the requirement to generate £4.712m and the Trust generated £6.421m.

30.4 Capital Resource Limit

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

	2010/11 £000	2009/10 £000
Gross capital expenditure	7,293	15,625
Less: book value of assets disposed of	(604)	(1,131)
Plus: loss on disposal of donated assets	0	1
Less: donations towards the acquisition of non-current assets	(134)	(49)
Charge against the capital resource limit	6,555	14,446
Capital resource limit	8,188	18,668
(Over)/Underspend against the capital resource limit	1,633	4,222

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 transactions are:

2010/11	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	10,911	253	0	107
Trusts				
East and North Hertfordshire NHS Trust	580	1,975	84	348
Hertfordshire Partnership NHS Foundation Trust	1,376	2,626	56	188
Hertfordshire Community Trust	1,006	6,031	80	847
Imperial College Healthcare NHS Trust	103	1,002	34	212
Primary Care Trusts (PCT)				
Barnet PCT	0	1,363	0	33
Bedfordshire PCT	0	1,350	0	273
Buckinghamshire PCT	0	1,401	0	0
Harrow PCT	0	3,706	0	9
Hillingdon PCT	0	5,421	0	526
NHS Hertfordshire	127	220,456	32	1,901
Luton PCT	0	2,337	1	169
South East Essex PCT	0	6,359	0	320
Health Authorities				
East of England Strategic Health Authority	1,102	10,293	2	59
National Blood Authority	2,107	0	32	4
Other Bodies				
NHS Purchasing and Supply Agency	6,871	0	0	0
	24,183	**264,573**	**321**	**4,996**
2009/10	24,723	284,865	2,364	8,476

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

2010/11	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	41,615	3,332	132	511
NHS Litigation Authority	5,312	0	0	0
NHS Pensions Agency	22,836	0	1,943	0
	69,763	**3,332**	**2,075**	**511**
2009/10	62,720	5,013	3,433	325

32. Third Party Assets

The Trust held £55k cash and cash equivalents at 31 March 2011 (£1k - at 31 March 2010) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

33. Intra-Government and other balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other government bodies	5,021	0	3,463	0
Balances with local authorities	479	0	0	0
Balances with NHS Trusts and foundation Trusts	1,900	0	823	0
Balances with public corporations and trading funds	0	0	0	0
Intra government balances	7,400	0	4,286	0
Balances with bodies external to government	3,045	1,683	12,665	0
At 31 March 2011	10,445	1,683	16,951	0
Balances with other government bodies	9,462	0	7,119	0
Balances with local authorities	0	0	0	0
Balances with NHS Trusts and foundation Trusts	664	0	640	0
Balances with public corporations and trading funds	0	0	0	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

34. Losses and Special Payments

There were 151 cases of losses and special payments (2009/10: 126 cases) totalling £151,224 (2009/10: £386,903) accrued during 2010/11.

West Hertfordshire Hospitals NHS
NHS Trust

For further **information** please call 01923 436227

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