report 2012/13

Contents

Welcome by Chief Executive

Samantha Jones, Chief Executive

It is with great pleasure that I welcome you to our annual report for 2012/13.

This year I have had the great privilege of being entrusted with the role of Chief Executive of this Trust.

The job of the Chief Executive is to be accountable for everything that happens across our hospitals, from the care we provide to our patients to how we spend our money. It is also about making sure the environment in which we discharge our responsibilities is one of openness, honesty, transparency and above everything else, that we put the patient first and at the heart of everything we do.

Learning from the Francis Report

Within my first few weeks at the Trust, the Francis Report was published. This set out in the clearest terms the catastrophic failings that led to so many patients being let down by Mid Staffordshire NHS Foundation Trust.

The Francis Report offers a sobering lesson for us all. The safety of our patients is of paramount importance and they must remain our number one priority – above targets, above finances and other challenges which come our way.

As an organisation, we have reviewed the recommendations laid out in the Francis Report and are using them to improve the care that we provide.

In addition, following discussion with a number of our stakeholders over recent months, we have identified key areas which we will be focussing on over the forthcoming year in order to ensure that improvements are made.

New nurses

This has included undertaking a detailed review of nursing numbers across our hospitals, which, for adult inpatient wards, has led to us making an annual £3.9 million investment in 149 new nurses (whole time equivalent).

We have strived over the past year to become even more open and transparent with the information that really matters to our patients and local people, including details of our performance, the number of healthcare acquired infections we have (such as MRSA (bacteraemia) and Clostridium difficile), and how we spend our money.

Onion – peeling back the layers

Over the year we have continued to focus on improving the quality of our services. I was concerned following a difficult weekend that we, as a Trust and health professionals within it, had become accepting of a level of care and service to our patients that was not good enough. I called a summit to ask the question 'what can we do to make a difference to our patients today'.

'Onion' was born, listening to our clinical and non-clinical staff, peeling back the layers. I have been overwhelmed with the response from staff at all levels and across the organisation at ways we can make immediate changes to ensure our patients are treated quickly, efficiently and correctly, first time.

'Onion' is set to continue and is the basis of our new organisational development plan, which sets out how we intend to develop our staff – from Board to ward – to become high performing hospitals which are recognised for providing the best possible care for our patients and local people.

Secretary of State visit

I was extremely pleased to welcome the Secretary of State for Health, Rt Hon Jeremy Hunt to Watford Hospital to spend some time in our A&E (accident and emergency) department in April. I was proud that he saw first hand the commitment, energy and passion of our staff, especially when delivering high quality care under significant pressure.

Inpatient survey results

I am also pleased to report that the annual NHS National Inpatient Survey showed that the vast majority of our patients feel that we treat them with privacy, dignity and respect. This is excellent news as it is absolutely critical to ensuring our patients have a positive experience.

However, the survey also clearly showed that there is a lot more we need to do in order to make our services better and we will be focussing on this over the next year.

Staff survey results

Our annual NHS Staff Survey results also showed an improvement, with staff reporting increased satisfaction as employees of our Trust.

Our 2012 staff awards event in December was an opportunity to recognise the commitment and excellent work of our staff, both as teams and individuals. It also allowed us to recognise staff who have long service within the Trust and wider NHS.

Developing our clinical strategy

A key part of our focus over the next year will be to deliver a long term clinical strategy which sets out our vision for the future.

We are currently working with doctors, nurses, midwives, other staff, patient representatives and partners in health and social care on the strategy and aim to launch it in autumn 2013.

The strategy will help determine the clinical services we provide across the local area and, as such, to put forward proposals for the long term future shape of our three hospital sites. This includes our work on the Watford Health Campus scheme, which is in partnership with Watford Borough Council and others and will also inform our timetable to get to foundation trust status.

I hope this report demonstrates that the experience patients have in our hospitals, the quality of care they receive, and the safety of the service we provide are top priorities for us.

Thank you to our staff

Working in this organisation every day I meet caring clinical leaders, compassionate frontline staff and hard working managers, and I would like to take this opportunity to say thank you on behalf of myself and the Trust Board to all our staff for their continued hard work over the past year to improve the quality of care, safety and treatment for people who use our services.

As I set out on my first full year with the Trust I am committed to ensuring that this organisation fulfils its potential and inspires pride in its staff and our patients and local community.

The Trust Board

Members correct as of 1 September 2013

Interim Chair (Voting)

Mahdi Hasan
(2013)

Chief Exective (Voting)

Samantha Jones
(2013)

Executive Directors (2012)

Chair:
Prof Thomas Hanahoe (2005)

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

Director of Finance:
Anna Anderson (2010)

Chief Operating Officer:
Chris Pocklington (2010)

Director of Communications & Transformation:
Elizabeth Rippon (2011)

Non-Executive Directors

Sarah Connor
(2009)

Katharine Charter
Vice Chair (2006)

Robin Douglas
Co-opted
(2000)

Chris Green
(2010)

Phil Townsend
(2011)

Executive Directors (Voting)

Dr Mike Van Der Watt
Medical Director
(2013)

Bernie Bluhm
Acting Chief Operating Officer (2013)

Patrick Butterworth
Director of Finance
(2013)

Natalie Forrest
Director of Nursing
(2010)

Jackie Ardley
Interim Chief Nurse/Director of Infection Prevention & Control (2013)

Executive Directors (Non Voting)

Mark Vaughan
Director of Workforce
(2011)

Louise Gaffney
Director of Strategy and Infrastructure
(2012)

Antony Tiernan
Director of Communications & Corporate Affairs (2013)

Paul Jenkins
Director for Partnerships (2011)

About the Trust Board

West Hertfordshire Hospitals NHS Trust is led by a Board of Directors with responsibility for the exercise of the powers and the performance of the Trust. The Board ensures that adequate systems and processes are maintained to deliver the Trust's objectives, as well as to measure and monitor effectiveness; the economy and deliver high quality healthcare.

The Assurance Framework enables a continuous and comprehensive review of the performance of the Trust against the agreed plans and objectives.

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

In addition, members attend Board Development Days which provides an opportunity to undertake their responsibilities in relation to developing the Trust's strategy and considering issues of concern in relation to its delivery. They enable Board members to be updated on national and local health system changes and challenges in order to inform strategy development. They also provide an opportunity for the Board to receive information on changes to legislation affecting the activities of the Trust, and to participate in mandatory and statutory training as well as wider Board development.

The Board has a structured programme of monthly ward and departmental visits which take place prior to every public Trust Board meeting. During 2012/13 the Board visited the majority of clinical and non-clinical areas across the Trust and spent time meeting staff and discussing issues relating to their specific areas. Following each visit, verbal reports were presented at the public Board meeting and any related actions officially noted and followed-up. Staff who work in areas that received a visit were invited to attend the public Board meeting to listen to feedback. A short written feedback note was also circulated to the relevant staff.

As part of the Trust's five year Nursing and Midwifery Strategy, Non-Executive Directors 'champion' a ward in order to give Board Members more active involvement in clinical areas. Currently the 'adopted' wards include the Watford Stroke Unit, Gynaecology, Paediatrics and Maternity. Individual Directors and Non Executive Directors also made adhoc visits outside of the structure programme.

In 2012/13 members of the Executive Team undertook a 'shift' in areas of the Trust to get a real 'feel' for the organisation and to understand more about how it really works. The areas they worked in included the Surgical Appliances Department, Accident and Emergency Department and the Acute Admissions Unit.

Changes to the Trust Board

Over this reporting year, there have been a number of changes to the membership of the Trust Board, as follows:

Samantha Jones joined the Trust as Chief Executive in February 2013, replacing Jan Filowchowski who left the Trust in October 2012 to take up the position of Chief Executive of Great Ormond Street Hospital. Sam has a clinical background and brings substantial experience of the NHS to the Trust, as well as senior leadership in the private health care sector. She was previously the Chief Executive of Epsom and St Helier Hospitals NHS Trust before taking up the role as a Director of Care UK, the largest independent provider of healthcare services in the country.

Professor Thomas Hanahoe retired in May 2013 after eight years as Chairman of the Trust. Thom had worked tirelessly in his role as Chairman and showed strong personal commitment to championing our hospitals during a period of substantial challenge, both within the Trust and in the wider NHS. Mahdi Hasan, previously a Non-Executive Director, is the current Interim Chairman for the Trust.

Natalie Forrest, the Trust's Director of Nursing acted as Chief Executive from October 2012 to January 2013, before taking up the position of Chief Operating Officer and Deputy Chief Executive in April 2013. The Trust's previous Chief Operating Officer, Chris Pocklington left the Trust to take up a similar position at North West London Hospital NHS Trust.

Louise Gaffney was appointed into the substantive post of Director of Strategy and Infrastructure in August 2012 following a period as interim Director. Louise has worked in the NHS in Hertfordshire for over fifteen years and has expertise in strategic health planning and delivering complex programmes.

Maxine McVey was Acting Director of Nursing between October 2012 and February 2013. She was reappointed to the temporary role in March 2013. Maxine has worked within the Trust since 1999, most recently as a Deputy Director of Nursing.

Patrick Butterworth took up the post of Director of Finance in June 2013, replacing Anna Anderson who served the Trust since 2010 and left to pursue other interests outside the NHS. Patrick was the Commercial Director at Hinchingbrooke Healthcare NHS Trust, which works in partnership with Circle, the employee co-owned hospital group.

Dr Michael Van der Watt was appointed as the Medical Director in March 2013. Michael has worked within the Trust for 12 years, as a Consultant Cardiologist in addition to his most recent role as the Divisional Director of Medicine. He replaces Dr Colin Johnston who stepped down from the post after four years to continue his clinical work as a Consultant in General Medical, Diabetes and Endocrinology.

Governance

Governance is based on a set of principles to meet challenges in areas such as: risk, finance, quality, probity, commerce and reputation. The Trust's Standing Financial Instructions Policy sets out the powers reserved for the Board of Directors and the Scheme of Delegation sets out its other responsibilities. Decisions taken by the Board include the following:

- formulating the financial strategy
- requiring the submission and approval of budgets within approved allocations/overall income
- defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); defining specific responsibilities placed on members of the Board and employees as indicated in the Reservation of Powers and Scheme of Delegation document.

Decisions delegated to the management include policy implementation and operational management. The Trust's Leadership Executive Committee meets fortnightly which looks at key performance issues.

In order to ensure that the Trust is in a position of continual preparedness for an ever-changing world where significant demands are placed on the organisation and budgets, the Trust has commissioned the Good Governance Institute to review its current governance arrangements. This review will be used to help to ensure future arrangements are based on good governance principles and established best practice.

The Audit Committee

The Audit Committee is formally constituted as a sub-committee of the Trust Board and its main purpose is to independently contribute to the Board's overall process for ensuring that an effective internal control system is maintained. In particular the committee has the following key objectives:

- Providing confidence in the objectivity and fairness of financial reporting
- Providing assurance about the adequacy of internal control
- Safeguarding of assets
- Reducing the risk of illegal and improper acts
- Reinforcing the importance, independence and effectiveness of internal and external audit.

Trust Board in Action

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

About West Hertfordshire Hospitals NHS Trust

During 2012/13:	
103,767	people attended A&E (on average, more than 200 a day)
47,769	people were treated as an emergency admission
39,445	people received elective surgery
412,814	people attended Outpatient Departments (more than 1,500 a day)
5,748	babies were delivered

Who we are

West Hertfordshire Hospitals NHS Trust is a large acute Trust providing inpatient, outpatient and diagnostic services to a catchment population of approximately 500,000 people living in west Hertfordshire and the surrounding areas. As an employer of around 4,000 people the Trust is one of the biggest employers in the area.

Why we are here

The Trust's daily mission is to:

- Deliver a full range of emergency secondary care services, including intensive and high dependency care
- Provide a comprehensive range of planned in and outpatient services in an environment of patient choice and contestability
- Ensure a broad span of diagnostic services is available locally.

Where we serve

The Trust provides services at three hospitals, which have complementary and differing roles:

Watford General Hospital

Watford is at the heart of the Trust's acute emergency service. The clinical services offered include:

- Women's and Children's services, including a consultant delivery unit, midwife birthing unit, antenatal and postnatal clinics
- Emergency care, including A&E, acute admissions unit, acute wards, intensive care unit, and emergency surgery
- Planned care, including outpatients and complex surgery
- Medical care, including endoscopy, cardiology and chemotherapy
- Sexual health
- Clinical support, including X-ray, CT, MRI, ultrasound and urgent and non-urgent pathology.

Hemel Hempstead Hospital

The clinical services offered at Hemel Hempstead include:

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

St Albans City Hospital

St Albans is the Trust's elective care centre. The clinical services offered include:

- Antenatal and community midwifery
- Outpatients
- Minor Injuries Unit
- Elective and day surgery
- Sexual health
- Clinical support, including X-ray, Ultrasound, Mammography and blood and specimen collection.

Where we are heading

Our 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 Strategy

The Trust's main focus is to deliver the Trust's core range of services to the highest possible quality standards, aiming to achieve excellence, through ongoing service modernisation and productivity improvements, in an environment of partnership.

The Trust is working closely with primary, community and secondary care partners to ensure our service provision covers patient pathway needs and is seamless through all settings. It is imperative that the patient is at the centre of all our future planning discussions and decision making and that clinical safety is a given priority in any future changes.

The Health and Social Care Act 2012 has changed where clinical decision making sits in the system, replacing much of the existing hierarchy and moves from quasi-markets to market mechanisms and involving a large structural reorganisation of the NHS. The central priorities are:

- patients at the centre of the NHS
- changing the emphasis of measurement to clinical outcomes
- empowering health professionals, in particular GPs.

The Health and Social Care Act 2012 touches every part of the NHS and has had an impact on almost every organisation that delivers NHS care. The Trust is working with local Clinical Commissioning Groups and previously with the Primary Care Trust (PCT) to assist in managing this immense change. The role of Trust's Director for Partnerships has been designed to give the highest priority to developing constructive relationships with GPs as the new commissioners.

Over the past year, the Trust has been reviewing its clinical services, looking at what we do, how we do it and where we do it. The focus is on looking at how we can do things differently, putting the patient at the centre of everything we do and looking at our clinical strategy with our partners across the system. We have been looking at the options for the use of space and under utilised buildings across our hospital sites. This work needs to be aligned with the Trust's future clinical strategy once it has been confirmed. Going forward, the Trust recognises the need for public engagement in all that we do.

How we provide services

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

Strategic objectives

Due to the need for a stable, sustained approach to bringing about improvements, the Trust decided to keep the same framework for delivery of its priorities for 2012/13.

The Board has monitored the seven strategic objectives throughout the reporting year. The key objectives focus on the consistent delivery of high quality, safe services whilst ensuring the organisation remains financially robust. They are:

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

This Annual Report is structured in such a way as to highlight the work that has taken place during 2012/13 to move the Trust towards achieving each of its key objectives.

Objective 1:
Provide safe patient care

Key Points
• Learning from the Francis Report
• Care Quality Commission assessments
• Reducing risk
• Maternity service achieved NHSLA Level 2
• Improving security
• Protecting our patients from infections
• Safeguarding vulnerable patients

The Francis Report

The Trust continues to work hard to ensure that all possible measures are in place to safeguard against similar circumstances occurring within our hospitals as those highlighted in the Francis Report. The Trust firmly believes that high quality, safe patient care can only be achieved in an open culture where patients and their voices are at the heart of the system. We actively seek patient feedback on a daily basis and encourage our staff to raise concerns if they feel that clinical standards are not to an acceptable level. The Trust Board have had a number of focussed and detailed discussions on the issues arising from the Francis Report and will continue to review the recommendations to ensure that it continues to safeguard from any potential challenges to patient safety in the future.

Care Quality Commission registration

The Care Quality Commission (CQC), the national health regulator, paid a routine unannounced visit to the Trust in January 2013. Inspectors spoke to many patients who reported positively about the care they received in our hospitals. The report acknowledged how busy the Trust is and how this puts considerable strain on our services. The inspection team was clearly impressed with the way staff managed this demand and make difficult decisions in the best interests of patient care. The CQC had some moderate concerns over staffing levels in some areas. As a result of the feedback from this visit, and actions already underway in the Trust such as a full establishment review for nursing, the Trust will be closely reviewing this and will take any necessary actions required to address the concerns. Furthermore, following an evidence review process by the CQC in October 2011 relating to concerns around junior doctors not receiving relevant safeguarding training, the CQC reported in August 2012 that the Trust had made considerable progress in this and was now meeting this standard.

Reducing risk

The Trust's Risk Management system has been further developed and strengthened this year across clinical divisions and corporate functions. Risk Assessment processes have been the focus of attention during the year to ensure that approval processes are coherent and traceable and that there is a clear line of accountability for their management and mitigation. The Trust's Integrated Risk and Governance Committee has influenced a strengthening of links between clinical risks identified and clinical audit to ensure that improvements are monitored for implementation and effectiveness.

A high level risk profile summary report was developed to provide at a glance highlights of the status of the organisation's critical risks as reflected on the Board Assurance Framework. This is linked to board reports and provides an integrated approach to risk management that informs key decisions.

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

A Serious Incident Reporting Policy is in place which sets out the actions required following a potential serious incident and identifies key controls to manage and reduce the risks of events reoccurring. Serious Incidents are reported externally in accordance with the requirements of the Trust's contract with its lead commissioners. Incidents deemed not to be serious but significant enough to warrant further investigation are designated Significant Incidents and provide an opportunity to understand and learn from incidents that may not have resulted in serious harm but could have been avoided.

Serious and Significant Incidents are subject to robust review to understand what happened, how it happened and why it happened.

Once the Trust is able to understand the reasons for a serious or significant events occurring, recommendations are put in place to prevent recurrence and to share the learning across the organisation and with other health providers to make the NHS safer for all.

In this financial year, the Trust reported no incidents of data loss or confidentiality breaches.

NHSLA Level 2

In February 2013 the Trust's Maternity Services retained Level 2 compliance against the NHS Litigation Authority's (NHSLA) Clinical Negligence Scheme for Trusts (CNST). The Trust achieved a total score of 44 out of 48 standards assessed. A Level 2 rating demonstrates that the Trust's maternity services are meeting high standards of care and patient safety.

Colposcopy Assessment

The Colposcopy Service was assessed by the National Colposcopy Quality Assurance Team in March 2013, with no major concerns raised. The assessment found that the service is well run and assessors were impressed by the service provided.

Patient Safety

Patient Safety is a continuing theme in the Trust and the Board receives regular progress reports on the work-streams in place to address patient safety indicators, including patient falls, VTE risk assessments, hospital acquired infections, pressure ulcers, and early warning systems. The Trust took part in National Patient Safety Week again this year, which was an opportunity to raise awareness and share good practice.

Improving security

The Trust continues to develop excellent working relationships with community safety partnerships and local crime prevention teams in order to maximize protection of its staff, property and assets. This reporting year has seen an increase in security awareness, the facility for A&E staff to secure a 'lockdown' of their department for safety, an increase in CCTV across the hospital sites and part-funding of two Police Community Support Officers (PCSO's).

Planning for emergencies

This year the Trust has continued to make progress in reviewing and updating policies, guidance and practices and in testing and exercising its resilience arrangements both locally and nationally. The Trust is well placed with other organisations to manage major emergency events should they occur, although clearly, any such occurrence would place great pressure on the organisation's staffing and infrastructure and test its ability to recover.

Safeguarding

Safeguarding all our patients, whatever their age, remains a high priority for the Trust. The Trust has active safeguarding children and vulnerable adult committees with support at Executive level. Over the last twelve months a number of initiatives have been completed to raise the profile of safeguarding across the Trust; for example an annual safeguarding staff newsletter is produced and a dedicated safeguarding intranet site has been established to allow staff to access information easily. Mandatory safeguarding children training rates have improved, which has been reflected in an increase in the number of referrals received as staff recognise their responsibility to act on safeguarding concerns.

Top hospitals award

The Trust was once again named as one of the UK's top 40 hospitals in 2012 in the prestigious CHKS Top Hospital awards. This awards programme provides reassurance that the Trust is amongst the highest performers when it comes to data quality, safety and quality of care.

Infection control

Infection prevention and control continues to be a high focus for the organisation with a drive to reduce healthcare associated infections (HCAI). The Trust had one reported case of hospital acquired Methicillin Resistant Staphylococcus Aureus (MRSA) in 2012/13 against a trajectory of 4. Disappointingly, the Trust reported 46 cases of Clostridium difficile (C-diff) against a trajectory of 33. Despite immense efforts to prevent Norovirus reaching our hospitals, a number of cases were confirmed on two wards at Watford in February 2013. We are pleased to report that due to immediate actions taken, the infection was contained within the two ward areas and did not spread to other areas of the hospital.

Good management and organisational processes are crucial to ensure that high standards of infection prevention and control are set up and maintained. An update on infection control is discussed at Board level to raise awareness of the Board's collective responsibility for minimising the risk of healthcare associated infections, ensuring the protection of service users, their carers and families, and healthcare staff from infections. Responsibility of the Director of Infection Prevention and Control recently transferred to the Director of Nursing when the previous Medical Director stepped down in March 2013.

Objective 2:

Improve outcomes and quality of care

Key Points
• Ensuring patients are treated quickly, efficiently and correctly, first time
• Refurbished Maternity Unit
• Delivering a digital hospital environment
• New Diabetes Centre opens
• Improving care pathways and services
• MRI-safe pacemaker comes to the Trust

Real focus on making improvements

Our patients expect and deserve safe, high quality services; therefore the Trust is always looking at ways in which things can be done differently in order to improve the way care is delivered to our patients. A new initiative called 'Onion' was launched this year which looks for immediate changes the Trust can make to ensure patients are treated quickly, efficiently and correctly, first time. In short, peeling back the layers to get to the nub of an issue and stripping out anything unnecessary. All members of staff have an opportunity to be involved in this important initiative. Some of the actions put in place include faster turnaround for testing in the Acute Admissions Unit, reviewing portering requirements in particular areas, providing additional patient transport to avoid delays, and ensuring decisions made during ward rounds are acted upon without delay. Feedback has been very positive and the overall success of the initiative will be reviewed and any actions which have been seen to make significant improvements will be considered on a permanent basis.

Rapid Assessment, Interface and Discharge (RAID)

The new Rapid Assessment, Interface and Discharge (RAID) service at Watford is ensuring people in hospital with any kind of mental health problem are swiftly assessed and supported. RAID is a partnership between the Trust and the Hertfordshire Partnership NHS Foundation Trust and is funded for a year by Herts Valleys Clinical Commissioning Group. The consultant led, seven day a week service is a single point of access for mental health input for patients in hospital, age 17 and over and referrals are accepted from any professional involved in a patient's care.

Improvement in dementia care

The excellent work of the Trust's Dementia Therapy Team was recognised this year in Hertfordshire's Dementia Champion Awards. It has been a very busy year in dementia care within the Trust with the post of Dementia Nurse Specialist made substantive and a Dementia Activity Coordinator appointed. A robust system has been introduced which identifies patients with cognitive difficulties in cases where there are family concerns but no formal diagnosis. The Trust has achieved a 'stretch' CQUIN target to find, assess and treat more than 90% of patients with dementia and memory difficulties and also took part in the National Dementia audit. A training strategy, led by the Dementia Nurse Specialist, is now in place which includes dementia awareness training as part of mandatory training. Furthermore, the new RAID (Rapid Assessment, Interface and Discharge) service has added real value to dementia care and treatment with its specialist expertise. The Trust plans to continue this important work over the forthcoming year by canvassing carers for feedback on the measures they would most like to see.

Delivering a digital hospital environment

In May 2012 a five-year Information, Management and Technology (IM&T) Strategy was approved by the Trust Board. Central to this strategy is a vision that focuses on the development of a digital hospital environment which will exploit new technology to support agile working, eliminate paper, enable service transformation, reduce administrative overheads and improve patient experience.

In parallel to this work, a number of projects have also been completed this year that focused on delivering more immediate improvements to the patient and user experience.

- The patient management system used by the cancer services department has been improved to facilitate multidisciplinary team working and enhanced reporting.
- Staff on the Acute Admissions Unit have been equipped with computers on wheels to improve access to patient information and new electronic whiteboards have been installed in A&E
- Midwives can now access their IT systems out in the community, enabling them to spend more time with patients.

Ambulatory Care Service

A trial of a new Ambulatory Care Service, which identifies patients who may not need an inpatient stay but do require investigations and medical opinion, began in February 2012. Originally, the service was limited with one nurse identifying suitable patients and seeing them with the Acute Physician. However, the service has grown throughout the year and pathways for specific conditions have been developed. Since August 2012 the service has been available 12 hours a day, 7 days a week.

Michael Clements Diabetes Centre Opens

The Michael Clements Diabetes Centre opened at Watford in October 2012 which aims to become a beacon site for the management of diabetes locally and an important resource for the community. It provides increasing availability to structured education for patients with diabetes and members of staff and allows patients, particularly those with type 1 diabetes, more direct access to specialist teams. The new centre will also provide enhanced training for the next generation of diabetes clinicians.

Stroke Services

In 2012 the East of England Strategic Health Authority carried out a review of stroke services, in which all providers of acute stroke services had to bid to deliver an improved model including the provision of a Hyper Acute Stroke Unit (HASU) and providing 7-day a week consultant in-put, including thrombolysis. The outcome of this review is still awaited.

Deep Vein Thrombosis care

Over the past year, the Trust has made some important changes to its Deep Vein Thrombosis (DVT) pathway to incorporate blood tests before anti-coagulants are prescribed. There are plans in 2013 to further improve this pathway by introducing a new anti-coagulant to replace Clexane.

Nursing Quality Indicators

Clinical review days have been established on a monthly basis to focus on monitoring specific aspects of quality, as part of a rolling programme. A set of clearly defined nursing indicators have been established which reflect what matters to patients in terms of their experience in our hospitals. Workforce indicators such as skill mix and staffing will be considered as factors that underpin quality. These indicators will be used to ensure meaningful comparison at ward level and enable the Trust to work towards the development of a ward based accreditation scheme.

NHS Thermometer

The NHS Safety Thermometer provides a 'temperature check' to monitor patient harm as a result of pressure ulcers, falls, venous thrombo embolism (VTE) and catheter associated urinary tract infections (CAUTI's). In 2012/13 all eligible patients were surveyed on one day each month using the NHS Safety Thermometer and it has been successfully embedded into routine practice. A baseline has been established which will be used to monitor future improvements.

15 steps challenge

The 15 steps challenge helps the Trust to understand and identify the key components of high quality care that are important to patients and carers from their first contact with the ward. It also aligns with the strategic initiatives of supporting improvements to quality, safety and patient experience. The Trust undertook a 15 steps challenge as part of a Clinical Leader's Day where themes were identified and an action plan developed. Building on this exercise the Trust will formalise the process, by ensuring the walkabout teams include staff with different perspectives as well as volunteers who represent patients' views.

Maternity upgrade

In January 2013, the Trust was successful in securing £537,000 funding from the Department of Health to enhance its birthing environments. This money has been used to refurbish existing bathrooms and showers, completely refurbish the Alexandra Birth Centre, and update the parent's kitchen and breastfeeding room in the Woodland Neonatal Unit.

Pressure ulcers

In 2012 the Trust committed to the former Midlands and East Strategic Health Authority's ambition to completely eradicate category 2, 3 and 4 pressure ulcers. A number of strategies were employed to deliver on this ambition, but disappointingly the ambition was not fully realised this year and pressure ulcers remain an ongoing challenge. However, there have been significantly fewer incidences of hospital acquired pressure damage in comparison to 2011/12. The Trust reported no hospital acquired Grade 4 pressure ulcers during the reporting year and no avoidable Grade 4 pressure ulcers for more than two years.

The Trust remains committed to eliminate avoidable hospital acquired pressure damage.

Single sex accommodation

The Trust declared one breach with the Government's requirement to provide single sex accommodation.

Nursing and Midwifery Strategy

Following the launch of a new five year Nursing and Midwifery Strategy in 2011/12, the following actions have been achieved over the past year:

- Work streams are now led by the Matrons for each of the four key areas within 'Harm Free Care' reporting to a Multidisciplinary Harm Free Group
- A Standards of Care booklet has been developed to provide expectations for staff in delivering the fundamentals of care
- Nursing documentation has been reduced by nine pages with the introduction of the 72 hour care record
- Hourly rounding has been incorporated within the 72 hour care record
- The Nursing and Midwifery Quality indicators has been utilised to drive improvements in practice at every level from board to ward
- The nutrition status of our patients has been reviewed by implementing the MUST (Malnutrition Universal Screening Tool)
- 'Place mats' have been launched to empower and prompt patient involvement in preventing pressure damage, eating well, and managing pain and as a form of communication
- Competences have been development for health care assistants and clinical programmes
- Competences and focused appraisals have been development of for staff nurses.

The Productive Ward Programme

Twenty six ward areas are currently engaged with the Productive Ward programme across all three hospital sites. Seven areas have completed the project with a total of 190 modules completed. Evidence of service improvement skills being developed are clearly evident at ward level, as well as evidence of how the project is now embedded systematically within the organisation. In 2013/14 the focus will be on medicines and nursing procedures modules. In addition the 15 Steps Challenge will give a valuable understanding of the overall progress that has been made by the Productive Ward project and how the improvements are being maintained.

Making Every Contact Count

During 2012/13 the Trust participated in the East of England Strategic Health Authority's initiative to increase the awareness of healthy living and lifestyles of all those patients that attended the hospital. "Making Every Contact Count" provided a framework for staff to ask patients about their lifestyles and to give them advice about how they could become healthier especially if they smoked, had higher than recommended levels of alcohol consumptions or felt they needed to loose weight. All of the outpatient departments, fracture clinics and community maternity services were provided with training to help patients who indicated that they did want to improve their health in relation to one or all of these areas. With the support of NHS Hertfordshire's pubic health team staff in the Trust were able to refer patients onto specialist services to help their patients who had asked for support.

Objective 3:
Improve the patient experience

Key Points
• Capturing and learning from patient feedback
• Delivering services which are fair and equitable to all
• Improving the physical environment
• Communicating with service users
• Providing spiritual and pastoral care
• Our volunteers

Inpatient survey results

The Trust achieved an amber rating in the national NHS 2012 inpatient survey, indicating that the level of patient satisfaction is very similar to many other Trusts in the country. The independent survey published by the Care Quality Commission (CQC) showed:

- 94% of patients said their privacy was respected when being examined or treated
- 96% of inpatients said the specialist they saw had all the necessary information
- 87% thought they were treated with respect and dignity throughout their hospital experience
- 90% said their admission date was not changed
- 86% said the purpose of their medication was explained to them

Disappointingly, the Trust received low scores in a number of categories, including:

- 52% of patients felt that they were not told about danger signs to watch for after going home
- 53% complained about wards being noisy at night
- 17% of patients said they were asked to give their views about the quality of care they received
- 22% felt that they received enough information on how to complain if they needed to about the care they received.

This survey has clearly shown that there is a lot more the Trust can do in order to make its services better. Staff have been working hard this year to look at ways where immediate changes can be made and it is hoped that this focussed work will be reflected in future survey results.

Learning from complaints and compliments

Our patients and relatives appreciate a speedy response when things do not go according to plan and our Patient Advice and Liaison Service (PALS) continues to be the first point of contact for most people who experience problems or concerns regarding the Trust's services. During the year, PALS handled a total of 2317 enquiries, with the majority addressed within 24 hours. This represents approximately a 15% increase over last year's figures.

In some cases, patients prefer to complain formally to the Trust and in 2012/13 the Trust's Complaints Team investigated 530 formal complaints. We recognise that informal and formal complaints provide an important resource of information that helps the Trust to understand the patient experience and improve services.

Where appropriate, following a formal investigation, improvements and changes are implemented to avoid the risk of similar situations arising in future. This year, the following changes were made as a direct result of complaints from service users:

- Honed the process to ensure family members are contacted when a patient is being discharged
- Increased the number of slots and the timings of appointments in the Fracture Clinic
- Reviewed and reissued the Trust's Do Not Attempt to Resuscitate policy.

The Trust's complaints handling procedure and remedy aims to follow the Ombudman's Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy. The Trust tries, wherever possible, to achieve remedy that is reasonable and proportionate. Full details can be found at www.ombudsman.org.uk.

In addition to many hundreds of letters, cards, notes and small gifts received directly by wards and departments, during the period of this report the Chief Executive received 109 formal compliment letters from satisfied patients and visitors.

Equality and Diversity

The Trust appointed a new dedicated lead for equality over the past year, which has resulted in a significant increase in activity and improvements across the equality agenda. Amongst many improvements, the following have had a noticeable impact on the Trust:

- Reintroduced mandatory equality training as part of the Learning and Development programme
- Worked with Hertfordshire's trans-community to develop a best practice workplace guide for staff
- Supported National Dignity Day by raising awareness of Dignity in Care
- Introduced a revised Equality and Human Rights policy to ensure compliance with the Equality Act 2010 and the Human Rights Act 1998
- Developed and delivered a 'Accessing Our Services' improvement plan
- Improved the governance structures and processes for equality to ensure fairness, accessibility and dignified care are core aspects of the Trust's activities.

The Patients' Panel

Sadly, Jessie Winyard, Chair of the Patients' Panel died in January 2013. Jessie was a founder member since the Panel was established in 2003 and greatly supported the Trust's work to improve the experience for all patients. Jessie will be deeply missed by everyone who knew her in the Trust and by her colleagues on the Patients' Panel.

Gill Balen has taken up the post of Chair and will lead the Patients' Panel to continue their important work. The Panel's support has been invaluable this reporting year on many committees and projects, in particular with the 'Making Things Work Better project'.

Volunteers

The Trust is proud of its volunteers and the enormous contribution they make. It is committed to engaging volunteers in meaningful roles that enhance our services and add value to the patient and family experience. As such, the Trust looks to ensure that volunteers are well placed, inducted, trained and supported. In total, over 500 volunteers collectively provide more than 3000 hours of their own time every week by supporting the voluntary driving scheme and information centres, offering admin support, reception, bedside and ward services. If you know anyone who would like to become a volunteer, please ask them to call 01923 217307 or e-mail wherts-tr.volunteers@nhs.net.

Spiritual and Pastoral Care

The Trust's Bereavement Spiritual and Pastoral Care Department cares for the spiritual, pastoral and religious needs of patients, staff, and relatives of all faiths (and of none). The Trust continues to work with a variety of organisations, agencies, communities and religious leaders and feedback is used to make further improvements to the bereavement service.

Talking to our communities

The Trust works closely with its local communities to get a better understanding of their healthcare needs. Often this work is in conjunction with our partners in health and social care, voluntary and statutory partners, together with Hertfordshire LINKs (HealthWatch). The Trust is engaging with seldom heard groups, including gypsies and travellers, Pakistani Muskaan women's group, lesbian, gay, bi-sexual and transgender (LGBT). Listening to our patients and local disability forums

and groups has led to a focus on improving access for those who need extra assistance. Disability audits have been carried out, in conjunction with Hertfordshire Hearing Advisory Service and Watford Disability Forum. A new DVD for the Deaf has been developed and Sign Translate and BrowseAloud have been implemented to help us improve our services for all.

Modernising communications

As alternative means of engaging with its internal and external stakeholders become more important, the Trust has adopted a much greater use of Twitter, Flickr, YouTube and Facebook this year. You can keep up-to-date on Trust news by following:


Twitter Newsfeeds: @WestHertsNHS and @SamanthaJNHS


Facebook Page: http://www.facebook.com/westhertsnhs


Flickr Photostream: http://www.flickr.com/photos/westhertsnhs

YouTube Channel: http://www.youtube.com/user/westhertsnhs

Car parking

The Trust conducted a listening exercise in 2012/13 to ask local people for their opinion on the best way to deliver transport and parking facilities which were cost effective, fair and accessible to everyone who needs to use them. This exercise took place from 8 March 2013 to 5 April 2013 and over 3,000 responses and thousands of comments were received. It was clear from the feedback that the majority of people wanted a car parking charging structure based on an hourly rate. We therefore we worked with our car parking contract to come up with a pricing structure which we believe to be reasonably priced and covers the cost of running and maintaining the car parking facilities, including security and lighting. The new patient and visitor parking charges were introduced as from 1 August 2013.

'Making Things Work Better Programme'

Following a focus in 2011 on improving telephone systems and processes.

The 'Making Things Work Better' Programme continued in 2012/13. One key focus was on how patient information is produced within the Trust and the development of a new policy that ensures all patients and carers receive high quality, cost-effective information that meets their needs.

Clean Bright Environment

A new environmental programme came into being in April 2013, replacing the former Patient Environment Action Team (PEAT) programme. As a result of these changes the Annual PEAT assessments scheduled for February 2013 were not undertaken. The new Patient-Led Assessments of the Care Environment (PLACE) programme requires that at least fifty per cent of those involved in undertaking assessments are either a patient or user of our services. The Trust welcomes this change as it is firmly believes that inviting patients to have a real voice in assessing the quality of our healthcare is the best way to bring about effective, meaningful changes. Each PLACE visit will generate a score in four separate domains of cleanliness, food, privacy and dignity, and general maintenance/décor. The results will be published locally and an action plan will be developed to set out how the Trust expects to improve its services before the next assessment.

Maintaining and improvement the environment

During the reporting year, the Trust made improvements to the environment and facilities across its three hospital sites. There have been a wide range of large and small redevelopment and refurbishment projects, some of which are listed below:

- Refurbished main theatres at St Albans and Watford
- Created two new wards at Watford in modular buildings, known as the White Suite and Red Suite
- Replacement of the CT scanner at Hemel Hempstead
- Major upgrade to wiring and other improvements to the kitchens and nursery at Watford
- Improvements and resurfacing of the access roads on all three hospital sites
- Structural repairs and external fabric improvements to the Pathology Department at Watford
- Asbestos management across the Trust
- Work undertaken to minimise the risk from Legionella.

Objective 4:

Sustain and improve performance

Key Points
• Improving the patient journey
• Achieved A&E target
• Responding to Freedom of Information requests
• Action taken to address the energy and sustainability agenda

Improving the patient journey

Overall, the Trust achieved the national target (95%) for seeing all A&E patients within 4 hours in 2012/13. This was in spite of much additional unexpected activity. In order to respond to the demand and to reflect best practice and experience of other parts of the NHS, the Trust has reviewed its models of care and ways of working. The Trust has added three new modules to the physical accommodation at Watford this year, a Clinical Decisions Unit close to the A&E department, and two new wards, Red Suite and White Suite. These ward areas support additional bed capacity and the ability to offer the services of a dementia unit in due course. In addition, the measures below have also been introduced:

- Establishment of Emergency Ambulatory Care Service
- Setting up of a Navigation Team (nursing and therapy)
- Development of a ward efficiency programme, e.g. increased consultant ward rounds and daily review morning board rounds
- Setting up of a Discharge Task Group and the appointment of a Discharge Manager

Another major change initiative this year has been to develop a new bed reconfiguration at Watford to allow individual services to work across fewer locations and prevent patients needing to be moved between wards.

The improvements detailed above are enabling the Trust to move ahead, where appropriate, with the closure of beds at Hemel Hempstead, which were being used for patients who had been assessed as medically fit, reaching the end of their acute pathway and/or awaiting discharge.

Meeting targets

The Trust's performance is monitored by Herts Valley Clinical Commissioning Group, the Department of Health, and the Care Quality Commission. Each body uses a slightly different set of indicators and measures, but there is a core group used by all of them. The Trust's performance against these is summarised below:

Indicator	National Standard	West Herts Performance
95% of patients should be seen within 4 hours in A&E	>95% (achieved 95.2%)	Achieved
Incidence of *C difficile* should be identified and the numbers minimised	Trust target was to have less than 33 cases of *C difficile* throughout the year (46 cases)	Under achieved
Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have no more than 2 for the year (1 case)	Achieved
All cancers- patients should not wait more than 31 days for second or subsequent treatment	National target was to have 96% patients seen within 31 days (achieved 100%)	Achieved
All cancers – patients should have a maximum wait of 62 days between urgent referral and first treatment	The national target was to see 90% of those referred by the screening service (achieved 98%) and 85% referred by GPs (achieved 100%)	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 90%, although not at all specialty levels)	Achieved
INon-admitted patients	>95% (achieved 98%)	Achieved

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

Freedom of Information requests

Over the past few years the Trust has seen a significant increase in requests. From 1 April 2012 to 31 March 2013 the Trust received 312 requests many of which are complex with multiple questions. The Trust has an efficient system in place for the management of FOI requests and in this reporting year, 100% were responded to within the required twenty working days.

Pathology services

In line with Managed Pathology Networks, a consortium known as "Consolidated Pathology Services" (CPS) comprising of four Trusts, West Hertfordshire, Luton & Dunstable Hospital, Bedford Hospital and Princess Alexandra Hospital was formed to bid for part of the East of England GP pathology work. However, plans to centralise GP pathology have been put on hold and the Clinical Commissioning Group are currently reviewing the future plans for direct access pathology.

Environmental/Sustainability

Sustainability is about balance and it includes three key areas: 'Economic Sustainability', 'Social Sustainability' and 'Environmental Sustainability'. All NHS Trusts are now required to report on sustainability as part of their annual reporting process.

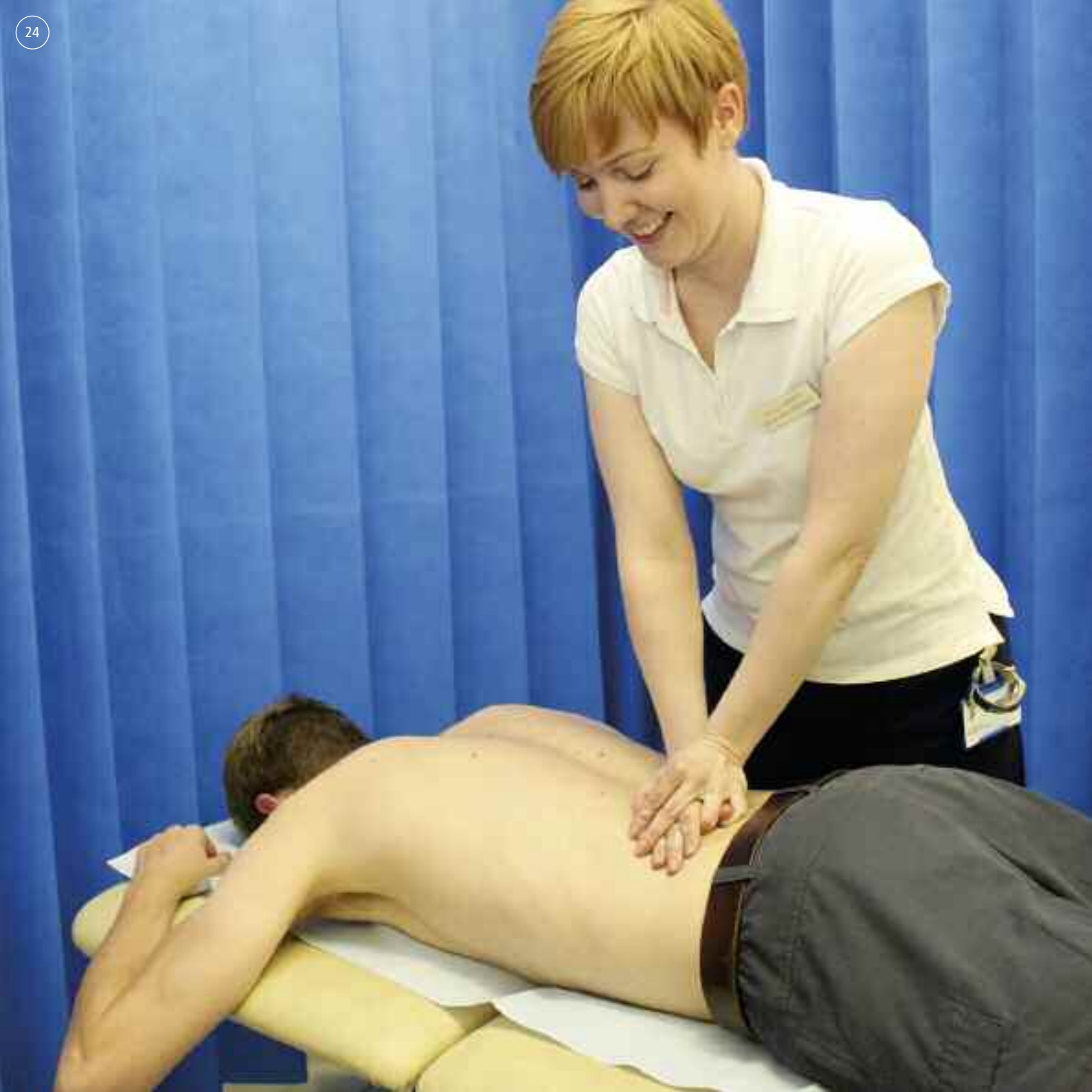
The Trust has adopted the Good Corporate Citizen Assessment Model which focuses on six key areas travel, procurement, facilities management, workforce, community engagement and building. The results of an assessment in October 2012 confirmed the position already known about the Trust's buildings and highlight the need for more communication and engagement with staff across all of these areas to raise the profile of the sustainability agenda and the specifics of what is involved and what can be done. Specific groups have been initiated to take action in the six areas which will take ownership of the targets and how the Trust intends to measure and monitor progress.

CO2 emissions have been reduced in the reporting year 2011/12 due to the change of main boiler fuel at Watford General from heavy fuel oil to natural gas. This resulted in a reduction of the predicted cost of the new CRC Scheme to the Trust of £50,220 (actual amount paid £189,780). Validation of the Trust's processes is being undertaken by AEA our external Carbon consultants.

The Trust is in the process of implementing a business case to improve the insulation of some of the Trust's buildings, plant and equipment. This involves a one off spend of £90K in 2012/13 to release £100K recurrent savings by increasing the quantity and quality of insulation on pipe work, replacing valve and boiler jackets, providing and increasing thermal insulation in roof spaces. Also underway is a scheme to replace inefficient electric motors throughout the Trust.

The most significant project underway is the Combined Heat and Power (CHP) installation at Watford. The project cost is £2.9m and will realise savings of approx. £400,000 pa and result in a further 23% reduction in carbon emissions. The project is being reviewed by the Watford Health Campus partners to find the best solution of incorporating this into the wider scheme plans.

Over the year the Trust has substantially increased its recycling which stood at around 4% in April 2012; latest figures in December 2012 show that across the three sites they are between 35-43% with the Trust aiming for approximately 60-70% by Autumn 2013.



Objective 5:
Be financially sound

Key Points

- Achieved a surplus of £1.9m
- £8.7m savings achieved safely
- Increasing quality whilst delivering financial improvements

The financial headlines

The original financial plan for 2012/13 was a surplus target of £2.8m. This was necessary to generate the required 1% surplus, in line with Monitor requirements, and included a modest margin for risk. As in the past, the target was a balance between what was considered achievable and what was needed to keep the Trust's liquidity and cash balance in order. The target was facilitated by anticipated lower loan repayments which were expected as a result of refinancing in September 2012, when authorisation as a Foundation Trust (FT) was complete.

The surplus target was revised to £3.1m, in July 2012, to meet a higher efficiency requirement from Monitor. This increase was expected to be achieved through the delivery of additional savings; increasing the overall savings target to £11.9m.

In the autumn of 2012 it became apparent that, due to both operational and financial performance, the Trust would not be able to progress with its FT application. This in turn meant that the existing loans were not refinanced. The re-phasing of the loans remains critical to the Trust's future finances and an interim solution has been identified in the meantime.

The Trust has had a challenging year but, in an environment which included significant increases in the number of patients needing care, the requirement for extra ward capacity and investment in quality, still managed to achieve a surplus of £1.9m and savings of £8.7m.

Additional savings of £15m need to be achieved in 2013/14. Given the difficulties experienced in delivering the savings target in the current financial year the Trust has proposed a different approach for the forthcoming year. A management consultancy service, KPMG have been appointed to work with the Trust to complete a savings plan for the next two years. This work has already started and includes a review of governance, and advice on how to strengthen it, an assessment of existing plans and further identification of the scope for savings.

Late in the reporting year, the Trust received news that it would receive £0.5m from the Department of Health towards the cost of improving the birthing environment at Watford General Hospital. This initiative was designed to help to provide women and their families using our services with the best possible care.

Financial Risk

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

Criteria	Metric	Weight	5	4	3	2	1	Rating 2012/13
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	2
Achievement of plan	EBITDA margin %	10%	100	85	70	50	<50	4
Financial effciency	Net return after financing	20%	6	5	3	2	<-2	3
	I&E surplus margin %	20%	3	3	2	1	<-2	2
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3
Overall rating	Overall rating							3

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

EBITDA Margin

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

	£m
Surplus	1.9
Depreciation	7.1
Dividend	3.2
Interest	0.9
EBITDA	**13.1**
Operating revenus and other income	**278.2**
EBITDA margin	**4.7%**

The table above shows how the level of surplus affects EBITDA. The Trust missed its planned surplus for the year affecting the EBITDA achieved and the I&E surplus score both being less than the Trust would have liked.

Internal audit

In 2012/13, the Trust undertook a tendering exercise for the provision of Internal Audit and Local Counter Fraud Services. BDO LLP was appointed, for a period of up to 5 years, and the contract commenced on the 1 April 2013. BDO LLP will, with Trust input, develop an annual plan of work which will be approved by the Trust's Audit Committee. Progress reports highlighting any significant weaknesses identified will be reviewed at each committee meeting and the Audit Committee will ensure action is taken to resolve these.

RSM Tenon, the outgoing auditors, has prepared the Internal Audit Report for the year. This is shown on page 46.

External audit

The Audit Commission has a statutory duty to appoint external auditors to local government and NHS bodies under Section 3 of the Audit Commission Act 1998. Post-consultation with the Trust, the Commission have re-appointed Grant Thornton as the Trust's external auditors.

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

Related parties

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

Becoming a Foundation Trust

Your hospital Your NHS

Our Foundation Trust application was temporarily delayed in the autumn of 2012 in agreement with our Primary Care Trust and Strategic Health Authority. We are now in the process of developing a revised clinical strategy which, combined with updated financial modelling, will allow us to agree a new timetable for achieving Foundation Trust status.

FT status means the Trust has members whose views contribute to its future plans – tailoring local services to local needs. The Trust currently has over 6,600 public members, not including members of staff. This is obviously great news, but the Trust needs as many members as possible to support its hospitals and the application to become a Foundation Trust.

Governors are democratically elected from the membership, using an independent election service, and sit on a Council of Governors, chaired by the Chairman of the Trust. The Governors role is to represent members – the public, patients, carers, staff and the organisations that the Trust works most closely with to deliver local healthcare services. The Trust will appoint twenty-six Governors in total, fifteen public, six stakeholders and five staff Governors.

If you would like to become a Member or find out more about becoming a Governor, please contact the Foundation Trust Office on WGH 01923 436280 or email foundation.trust@whht.nhs.uk.

Objective 6:

Work in active partnership

Key Points
• Building and maintaining community relationships
• Working in partnership with unions
• Watford Health Campus moves forward
• Support of local businesses
• Bringing together NHS colleagues

Community relationships

Over the past year the Trust has placed a new emphasis on improving its programme of engagement and communication activities with stakeholders and values the importance of external stakeholders to its activities. Key external relationships include those with the local authorities; Local Involvement Networks (LINks), private sector and education partners. The Trust also works closely with local councils, in particular with their Health Overview and Scrutiny committees and with local MPs. The Health and Social Care Act has transformed the stakeholder landscape involving health and care organisations in changing relationships with Clinical Commissioning Groups, Regulators, Local Authorities and patient/public representative bodies.

Working with our NHS partners

The Trust has continued to work closely with local General Practitioner's (GP) during the year and, has steadily built a relationship with Herts Valley Clinical Commissioning Group (CCG) that became our host commissioner as from April 2013. The Trust attends regular bi-monthly meetings of the Clinical Partnerships Board which is chaired by the Acute Contract Lead GP from the CCG and has other CCG Board members attending together with Trust Executives and Clinical Directors. The Trust continues to meet with Practice Managers in the localities to discuss specific operational issues and to brief them and, through them, their GPs on service changes. The Pathology User Group, chaired by two GPs, meets bi-monthly to discuss service issues and developments with the lead Pathologist and discipline managers. During the reporting year a survey was undertaken of all West Herts GP Practices. Whilst the response was poor there were themes that the Trust was able to take forward and incorporate in the development of a Relationship Strategy.

Working with Unions

The Trust continues to work in partnership with Staffside union representatives at the monthly Joint Consultative Committee meetings where any staffing changes or changes to Trust policies are discussed and agreed. The Staff-side Chair has recently sat as a member of the appointment panels to appoint new Executive Directors.

Watford Health Campus

The Watford Health Campus, currently led by Watford Borough Council, has selected Kier Property Ltd as its development partner to deliver the scheme. This includes the redevelopment of the areas around the existing Watford hospital site, the new access road, for which the Trust secured £7m of NHS funding, and the Croxley Rail Link, which will bring a station within three minutes walking distance. In addition to the road, these plans will initially see the creation of a new staff car park; new patient car park; a range of new, well-designed homes, including affordable homes; office developments; new retail; catering and other outlets.

Support of local businesses

Over the past year, the Trust has been overwhelmed by the time, support and sheer generosity it has received from local businesses. This has made a real impact on the experience of patients.

Objective 7:

Attract, retain and motivate an appropriately trained workforce

Key Points
• The People Strategy in practice
• More staff than in previous years would recommend as a place to work
• Learning from our staff
• Thanking and recognising our staff

During 2012/13 staff have responded magnificently to the particular challenges facing the Trust, which included increases in the number of patients attending, winter and financial pressures. 2012 saw Great Britain celebrate two auspicious historical events; the Queen's Diamond Jubilee in May and the Olympic Games in July and Trust staff enthusiastically joined together to celebrate both these events.

The People Strategy in Practice

Following on from the launch of the People Strategy in early 2012, the Trust has undertaken a number of successful staff engagement initiatives. This brings together work to address issues raised in the staff survey and brings a new Trust-wide approach to workforce and organisational development. The People Strategy is based on the premise that improving the experience of staff leads to a better patient experience and improved outcomes.

In 2013/14, the Trust will continue to focus on staff engagement, wellbeing, equality and diversity and improved communications. A key group of managers with responsibilities in people management will participate in staff development. Priorities going forward include agreeing core values, standards and competencies for all staff and implementing these Trust-wide. The Trust will also be implementing a new Organisational Development strategy over the forthcoming year, based upon core values, behaviours and competencies, as well as redesigning our appraisal and recruitment processes to reflect the competencies and values, implementation of this strategy will involve engagement with all staff.

Staff Survey

The results of the annual national NHS staff survey are reported to the Trust Board and used to create key objectives and actions to drive improvements in staff experience. This year's results were positive in terms of the number of improvements made. The survey showed that more staff than in previous years would recommend the Trust to their friends and family as a place to work. It also found that Trust staff are amongst some of the most highly motivated staff in acute NHS Trusts in the UK and that they feel the Trust engages with them more, they receive regular appraisals and they are experiencing better job satisfaction. In addition, 92% of staff who completed the survey also felt that their role really made a difference to patients. Despite the encouraging results, the survey identified areas where further improvements could be made, including the perception of incident reporting procedures and further equality and diversity training. Over the coming year, the Trust will be looking in detail at the results and working with staff, unions and our partners to put steps in place to make further improvement to the working lives of all its staff.

Developing Our Staff

The Leadership Academy continues to deliver high quality leadership programmes, accredited by the University of Hertfordshire up to Masters Level. Completion of our third-cohort of Senior Leaders' programme means 93 staff have successfully participated; 63 achieving Post-Graduate Certificates in Leadership (60-credits at Masters-Level). The Middle Managers' programme has also successfully completed the second cohort. The Trust launched two new programmes in 2012/2013 that are ongoing; Business Skills and 'Using Patient Insights/Feedback to Transform Services'. The accreditation-pathway is building towards offering a full local MSc; with many staff well on the way. Furthermore, the Trust has continued to increase the numbers of staff trained as accredited coaches, as well as being a host 'of choice' for NHS National Graduate Trainees.

Continuing Professional Development (Bands 5-9)

The Trust received a total of £276,271 funding for the professional workforce (Bands 5-9) of which £43,750 was used to support project developments for diathermy in Theatres, Advanced Life Support in Obstetrics, Emergency Nurse Practitioners, Pharmacy, Radiology & IV competence, Business Skills and Simulation training and £232,521 to support Continuing Professional Development.

Workforce Development (Bands 1-4)

As part of the Trusts' workforce development plan, 'From Recruitment to Practioner,' 16 apprentices were recruited into the Nursing workforce in October 2012 and March 2013. The Trust views apprenticeships as a key means of implementing the skills agenda and an excellent way of ensuring it builds capacity and capability of all pay bands of staff. The apprentices are all on a one year fixed term contract with the view to recruiting into vacant band 2 Healthcare Assistant posts.

Trainee Assistant Practitioners

The Trust currently has 36 Trainee Assistant Practitioners (TAPS) employed within Band 2, and 3 Health Care Worker posts. 10 TAPS are expected to qualify in September 2013 and will be recruited to vacant band 4 posts.

Performance and Quality Assurance

The Trust has continued to build close relationships with the new Local Education and Training Board, namely the Bedfordshire and Hertfordshire Workforce Partnership (BHWP) during the year. A Performance and Quality Assurance Framework (PQAF) was used to review quality and performance of education delivery and the Trust achieved two green and three amber RAG ratings. Work to embrace the PQAF process and align organisational architecture were acknowledged and commitment and engagement in partnership working were recognised. Furthermore, BHWP felt the Trust had a good foundation in place to build and demonstrate quality improvements.

Induction and Mandatory Training

The Trust reported year end attendance rates of 94% on its corporate welcome programme, 75% on mandatory training and 72% on statutory training. In January 2013, work commenced on reviewing the timeliness and quality of local inductions for new staff, identifying good practice and highlighting where practice needed improving. Work also began on enhancing the Learning Management System to offer a more flexible training needs analysis. The Trust is also reporting a greater uptake of e-learning with some mandatory topics being delivered solely using this method.

Appraisal

A major drive has taken place over the last year to increase appraisals and 91% of staff had an appraisal in the past twelve months.

Whistleblowing

The Trust has processes in place which ensure any concerns raised by staff are dealt with confidentially, responsibly and professionally. All concerns are treated in the strictest confidence and harassment or criticism of staff who raise concerns is not tolerated. Staff are also made aware of the National Whistleblowing Helpline which provides free confidential advice to those people working in the NHS.

Celebrating our wonderful staff

The Trust held its annual Going for Gold Awards for Staff Excellence ceremony in December 2012 to pay tribute to the efforts and achievement of its staff over the year. In May 2013 the Trust also held its annual 'Celebrating Our Success' nursing conference which offered a valuable opportunity for nurses and midwives to share and understand current best practices, future opportunities and challenges. The climax to the day was the announcement of the Nurse and Midwife of the Year Awards.

National award recognition

Over the reporting year, the Trust has been recognised in a number of national and local award schemes, including the following:

- The Trust was a finalist for the second year running in the 2012 Health Service Journal Awards; Staff Engagement category. This years' entry demonstrated how the Trust successfully extended staff engagement work in the Acute Admissions Unit, Patient Services, Pharmacy, Equality and Diversity, Balance4Life and Making Things Work Better initiatives.
- The Trust was a finalist in the Patient Experience Network National Awards for the same staff engagement project as detailed above.
- The Trust received numerous team and individual accolades at the Hertfordshire's Dementia Champion Awards 2012. A team award went to The Care of the Elderly Inpatient Therapy Team at Watford and further recognition went to Churchill Ward who were runners-up under the category of Best Team Supporting People with Dementia.

Annual Governance Statement 2012/13

1. Scope of responsibility

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

I work closely with the Clinical Commissioning Groups, and NHS Hertfordshire prior to its disestablishment on 31 March, through regular meetings to review strategic issues and to ensure the Trust is contributing positively to the overall performance of health services in Hertfordshire. In developing the Trust's objectives, a broad base of issues is taken into account and consideration given to the interests of stakeholders.

As Accountable Officer, effective 4 February 2013, I can confirm that there are arrangements in place to review the individual objectives of the Executive Directors. This enables me to review progress against the key strategic objectives and to hold Directors to account.

I have overall accountability for risk management in the Trust and the requirements for the management of risk are set out in the Trust's Risk Management Strategy. Responsibility for risk is embedded into the roles of all staff led by the Executive Directors, and specifically for clinical risks, the Medical Director, and, for operational risks, the Chief Operating Officer. The Executive Team is collectively responsible for maintaining the systems of internal control and directors are accountable to me for ensuring effective governance arrangements in their individual areas of responsibility.

2. The Governance Framework of the Organisation

The Trust's arrangements for Governance are set out in its Scheme of Governance which describes the delegated powers of Board sub-committees in order to ensure compliance with the five main principles of the Corporate Governance Code: leadership, effectiveness, accountability, remuneration and relations with stakeholders. The Trust Board (the Board) has overall responsibility for the effectiveness of the governance framework and as such requires that each of its sub-committees has agreed terms of reference which describes the duties, responsibilities and accountabilities and describes the process for assessing monitoring effectiveness.

I can confirm there are arrangements in place for the discharge of statutory functions however the Trust identified that two additional activities required to be registered under the Health and Social Care Act and this was undertaken in liaison with Care Quality Commission (CQC). A review of registration compliance was undertaken and a number of actions taken to the Trust Leadership Executive Committee which were endorsed for implementation. Otherwise the Trust remains legally compliant.

The Board itself has Standing Orders, reservation and delegation of powers and Standing Financial Instructions in place which are reviewed annually.

As the Accountable Officer I support the Chairman in ensuring the effective performance of the Board and its sub-committees. I achieve this in a number of ways:

- Monitoring of attendance;
- Maintaining an overview of the quality of the presented information, including agenda items and supporting evidence;
- Requesting the attendance of representatives from across the Trust as required;
- Ensuring there is an annual declaration of interests by the members and by exception, as required;
- Ensuring that each of the Board sub-committees reviews its own performance and reports to the Board.

The Board undertook a Board Governance Assurance Framework (BFAF) self assessment between April to June 2012 in partnership with KPMG. This was a comprehensive review of Board functioning intended to assure the line of sight between Board and clinical quality. It encompassed a review of stakeholder perceptions of Board effectiveness and impact, undertaken via focus groups with staff and also with key stakeholders. The self assessment was conducted across 4 key themes:

1. Board composition and commitment
2. Board evaluation, development and learning
3. Board insight and foresight
4. Board engagement and involvement

The assessment identified areas that required further strengthening to improve the line of sight particularly in relation to safety and quality. Further work was required to develop an Integrated Performance Report and to undertake a stakeholder mapping exercise.

The Board also undertook a Board Self Assessment against the Corporate Governance Code, facilitated by the Senior Independent Director. The review identified that more emphasis should be given in Board meetings to strategy and sustainability and also of a need to strengthen the link between financial outlook and strategic direction.

Prior to the implementation of the new structures agreed in March 2013, the Board delegated oversight of certain activities to its Board Sub-committees:

- The Audit Committee provides assurance to the Board on the maintenance of the system of internal control. The Committee comprises three Non-Executive Directors and is attended by the Director of Finance, and the Medical Director. Representatives of internal audit and external audit are also in attendance. The Chair of the Audit Committee is a qualified accountant.

- The Integrated Risk and Governance Committee promotes integrated risk management. The Committee reviewed the Board Assurance Framework and the corporate risk register. The Committee works closely with the Trust's Audit Committee. The Chair of the Committee is a Non-Executive Director with a background in Risk Management and the Deputy Chair is also the Chair of the Audit Committee.

- The Remuneration Committee advises the Trust Board on the appropriate levels of remuneration and terms of employment for the Chief Executive and other Very Senior Managers and Executive Directors of the Trust. The CEO and Director of Workforce attend for all items except those that concern them personally. The Trust Chair and three Non-Executive directors are members of this committee. The Committee also advises the Board on any termination settlements for the CEO or Directors or other very senior managers following all appropriate processes. The Committee, on behalf of the Trust Board, approves the recommendations of the Clinical Excellence Awards Committees in relation to:
  - Consultants
  - Associate Specialists
  - Staff Grades

- The Finance Committee maintains an oversight of and receives assurances about the Trust's financial management systems. The Committee is chaired by a Non-Executive Director, has two other Non-Executive Directors as members as well as the Director of Finance, the Chief Executive and the Chief Operating Officer and senior finance staff. The Chief Executive attends as required.

- In 2011 the Trust established a Strategy sub-committee of the Board but this Committee was disestablished in November 2012 and a Strategy Sub Group formed to support the Board in the development of its Clinical and Financial Strategy

- The Charitable Funds Committee ensures there are robust processes in place to manage funds donated to the Trust for the benefit of the hospital and patients. The Committee monitors the disposition of funds held on Trust and ensures best value is obtained from the funds donated. The Committee is chaired by a Non-Executive Director and includes a further Non-Executive Director and the Director of Finance in its membership.

Page 42 sets out attendance at Board and subcommittees for 2012/13.

In addition to the regular review of effectiveness of Board governance I initiated an external systems review of the Board sub-committees and

supporting arrangements following concerns that there was not a sufficient line of sight between ward to Board. The Board agreed a revised Board governance structure at its March meeting with the addition of two new sub Committees of the Board, including a Patient Safety, Quality and Risk Sub-committee of the Board and the introduction of the Trust Leadership Committee, an executive led Committee through which all Trust business must be considered and actions agreed. This Committee consists of the Executive Team, Divisional Directors and Divisional Managers and key leadership roles within the organization. It is responsible for the management of the Trust's operational activities and for implementation of controls that ensure the organisation's risks are managed.

Governance arrangements are also being revised in each of the Divisions to ensure a consistent approach to governance based on central direction and oversight within the context of local ownership, responsibility and accountability.

Aligned to improvements in governance systems is the further development of the Trust's performance management framework to better integrate all aspects of performance to achieve truly integrated governance.

I have also commissioned an external review of Ward to Board assurance by the Good Governance Institute which will inform further improvements in 2013/14.

The following outlines progress against achievement of the Trust's objectives:

- **Provide Safe Patient Care**

The Trust has systems in place to ensure that risks to patient safety are identified and managed. These include systems to respond to patient safety related alerts and to ensure that learning from external agency reports is reflected in service provision. The Trust reports all clinical incidents on the National Reporting and Learning System from which its quarterly data analysis is reviewed and actions taken to address issues identified. This information is aligned to analysis of complaints, claims and other patient intelligence derived through external and internal surveys and through issues raised through the Patients' Advice and Liaison Service. The Trust reported 2 Never Events in February 2013, which have been subject to robust investigation and an action plan has been developed for each.

- **Improve Outcome and Quality of Care**

The Trust has seen sustained increases in emergency admissions for which it created further capacity during 2013/14. A number of work streams were introduced to respond to increases by improving internal processes and the Trust has been working with community and social care to improve timely discharge of patients once their acute needs have been met. The Trust exceeded its trajectory for Clostridium Difficile and I invited a number of external reviews, including from the Trust Development Authority and Public Health professionals of the Trust's systems for infection prevention and control which confirmed that there were weaknesses in controls and assurance. These are being addressed in a number of ways, both in relation to governance systems and in relation to management arrangements for infection prevention and control. A revised action plan has been developed which reflects a more focused application of the Hygiene Code.

The Trust continues to be registered without conditions with the Care Quality Commission and was subject to an unannounced but scheduled inspection in January 2013. Following a 3 day inspection of the Watford, Hemel Hempstead and St Albans sites the CQC concluded that the Trust met all outcomes reviewed with the exception of Outcome 13, staffing, which was determined to be non compliant on the Watford site because there may not always be sufficient staffing – this was deemed to have a moderate impact on patients in the areas affected. The Trust has an action plan to mitigate the risk and address the longer term staffing issues.

- **Improve the Patient experience:**

The Trust's focus on improving the patient experience is reflected in a number of ways, through ensuring clinical care is based on best practice and appropriately monitored, ensuring that key quality targets are met and reducing error and harm through learning from incidents and feedback. Overall the results for the 2012 survey showed little change on 2011 although there were five areas based on the CQC ratings where the Trust

was rated red. This compares with only one in 2011. The Trust was significantly better in 2012 than 2011 on 5 questions and significantly worse on 1 question. Sixty seven questions showed no significant difference between 2011 and 2012 and compared to other Trusts in the Picker Institute group the Trust performed significantly 'better than average' on 1 question, 'significantly worse than average' on 24 questions and recorded 'average' on 61 questions. The Trust Leadership (Executive) Committee will oversee a robust improvement Plan that achieves measurable improvement in the 5 areas rated as red as well as seeking to continuously improve in all areas surveyed.

- **Sustain and improve performance**

  The following targets were achieved for 2012/13:

- Met the 95% A&E target across the Trust (95.2%)
- Delivered the 95% non-admitted RTT
- Narrowly missed the 90% overall admitted target for the Trust, achieving 88.94% overall and the target was missed in Urology, Trauma and Orthopedics, Ear, Nose and Throat, Ophthalmology, Oral surgery and Pediatrics. A recovery plan is in place.
- Delivered dementia screening for more than 90% of over 75 years old admissions in the last 6 months
- Met the cancer targets overall
- Increased the number of discharge summaries sent electronically within 24 hours of discharge
- Reported no Grade 4 pressure ulcers for the year

- **Be financially Sound**

The impact of the sustained increase in emergency admissions required additional funds to be committed in year to expand capacity to reflect rising demand for beds. The full costs of additional activity could not be fully met as a result of the marginal tariff applied to additional activity. This had an impact on the achievement of the Cost Improvement Plans (CIP). In addition, the controls supporting delivery of the CIP targets were lacking robustness and the year-end position reflects a shortfall. The Trust commissioned an external review of management arrangements for the savings programme and this has influenced a robust framework which will be stringently applied in 2013/14.

The delay in achieving Foundation Trust status has resulted in a delay in loan re-scheduling with a consequent impact on liquidity.

- **Work in active partnership**

The Trust has made good progress in securing collaborative working with key stakeholders, including NHS Hertfordshire and the recently established Clinical Commissioning Groups and Hertfordshire Community Trust. The Trust is developing productive partnerships with Adult Care Services and two new care multi agency pathways have been developed. The Trust enjoyed constructive relationships with Hertfordshire Local Involvement Network and is developing opportunities to work with the successor organisation Health Watch. The Trust anticipates significant opportunities to contribute to the planning agenda of the Health and Wellbeing Board and has fully participated in all Hertfordshire County Council scrutiny events.

- **Attract, retain and motivate an appropriately trained workforce**

The Trust has developed a Staff Engagement Strategy within which there are a number of work streams designed to ensure staff are equipped and supported to deliver safe, high quality care.

3. Risk Assessment

Divisional and corporate risk registers reflect business as usual risks and risks that threaten achievement of strategic objectives are escalated to the Board Assurance Framework if approved by the Integrated Risk and Governance Committee.

3.1 Progress in managing risks escalated to the BAF during 2012/13:

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

  This risk has been reduced following the implementation of mitigating actions relating to maternity theatres, a further reduction in the midwifery ratio to 1:29, improvements in supervisors of midwives cover and improvements in clinical audits influencing the retention of CNST Risk Management Standard Assessment for Maternity Services at Level 2.

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

This resulted in a minor concern being raised by CQC which was removed during the year when the CQC had received confidence the Trust was robustly addressing issues relating to medical cover. However further work is required to sustain improvements.

- Risk of exceeding monthly HCAI targets will impact on Governance rating and lack of confidence in effectiveness of HCAI controls

  This related to the achievement of monthly targets however it has remained on the Board Assurance Framework and whilst within trajectory for MRSA, reporting 1 MRSA against a target of 2, the Trust reported 46 Clostridium Difficiles against a target of 33. As indicated a number of external reviews have been undertaken and a recovery action plan has been developed.

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

  The Board agreed to invest in the creation of further bed capacity and this was achieved in early 2013 in line with the planned expansion outlined in the last statement.

- Risk from challenging estate and infrastructure

  The challenges of the organisation's estate continue to present risks. The Trust is implementing a sustained programme of improvement based on prioritized risks. In year adjustments have been required to address compliance issues revealed following a report commissioned by the Trust in 2011 which identified a number of areas of non compliance for which a comprehensive set of action plans are in place.

- Financial risks

  The Trust has yet to achieve a re-scheduling of loans and this presents an ongoing risk to liquidity. The Trust's Cost Improvement Programme targets were not met and the Trust has commissioned external consultants to provide support to ensure the Cost Improvement Targets are fully met for 2013/14.

- Foundation Trust

  Support for the Trust's application to become a Foundation Trust was withdrawn by the SHA in January 2012. This related partly to concerns about the impact of the amount of backlog maintenance on the Trust's long term financial model but also to concerns about consistent achievement of key quality targets. A revised and significantly strengthened structure will be put in place to manage the Foundation Trust application process which will be progressed under the executive leadership of the recently appointed Director of Corporate Affairs and Communication.

3.2 Risk Escalated to the BAF 2012/13

July 2012

- Risk 2872 Risk Health Records Management Aggregated Risk

January 2013

- Risk 2899 Safeguarding Adults
- Risk 2883 ITU Legionella Outbreak

4. The Risk and Control Framework

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

The processes of risk management apply to operational and strategic issues such as service planning and commissioning, performance management, research, education and clinical services, workforce and estates services. Issues arising from such work are fed into the Trust's risk capture process (process of risk identification, assessment and treatment as described in the Trust's Risk Management Strategy) and are subject to risk action plans if the risk is graded sufficiently highly on the risk grading matrix. The Trust uses the standard 5 x 5 scoring matrix which considers the likelihood of the risk occurring and its impact if realized.

The Trust continues to build upon the Board Assurance Framework (BAF) which is considered at each meeting of the Board in particular to receive assurance as to the effectiveness of the controls in place to manage the risk recorded.

Underpinning the Board Assurance Framework are the corporate and divisional risk registers and risk processes which are overseen through the Integrated Standards Executive meetings and monitored by the Integrated Risk and Governance Sub Committee (IRaGC) a sub-committee of the Board, chaired by a Non-Executive Director. Divisional Integrated Standards Executive meetings focus on division specific risks providing quarterly review of (divisional) risk registers, incidents, CAS alerts, complaints and claims/Rule 43 data. The Integrated Risk and Governance Committee is closely allied to the Clinical Quality Advisory Committee, the executive led committee focusing on clinical quality – with common membership and co-located meetings for both Committees. However, as indicated, there is a new Board subcommittee structure which took effect from 1 April 2013 and the structure underpinning the newly created Patient Safety, Quality and Risk subcommittee will be presented to the Board in July 2013.

Board members receive training in risk management and an overview of the risk systems on an annual basis, as do the Trust's senior managers. All staff receive training in identification and reporting of risk on induction and through annual updating sessions. The Trust promotes the benefits of proactive rather than reactive risk management linked to robust action plans.

The Trust assesses compliance with Care Quality Commission outcomes for safety and quality as, set out in the Trust's Assurance Policy, which is aligned to NHSLA risk standards. This is structured around executive lead accountability for each standard, a nominated standard lead and a responsible committee. The Trust Board receives reports on compliance at regular intervals – assessing against the CQC's Quality and Risk profiles and providing assurance about actions under way to maintain and further enhance compliance. The Trust's processes for maintaining assurance of compliance with CQC outcomes was subject to an internal audit in February 2013 which concluded the Trust had adequate controls in place but highlighted further work was required to ensure consistent application of the assurance framework for CQC compliance – this is being addressed.

During 2012/13 the Trust reviewed its management of risks associated with the capital programme to ensure investment priorities were closely aligned to stratified risks and the system revised to strengthen controls.

An updated cost improvement programme (CIP) governance structure was put in place for 2012/13 to strengthen assurances relating to risks to quality of care from proposed savings plans. Progress is scrutinized by the Finance Committee. A revised governance structure to support Quality Impact Assessment of savings has been introduced.

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

Audit Committee issues highlighted to the Board

Losses and Compensation The Audit Committee reported a high level of write-off of overseas patient debt and noted that the External Auditors have provided a check-list of best practice to inform a review of Trust processes. This has been completed and is being implemented.

Gifts and Hospitality Register The Committee reported limited assurance from the review of the application of the Trust's Gifts and Hospitality policy and processes have been reviewed to ensure ongoing compliance with the requirement to register gifts and hospitality.

Processes for auditing and monitoring clinical activity are in place in all the clinical divisions. Clinical processes are reviewed when national guidance is published or in response to adverse events. Guidance is also updated when national safety notices are issued via the Central Alerting System (CAS) and all are monitored closely via the Divisional Integrated

Standards Executive. There remained one alert outstanding beyond closure date. This relates to the replacement of epidural equipment and is scheduled to be compliant when new equipment is purchased followed completion of trials which took place in April. The risks are being mitigated pending compliance.

Standard Clinical Data sets are reviewed via the CHKS database by clinical divisions to provide assurance on clinical outcomes and to identify any emerging risks that warrant further investigation and action. The Medical Director receives ongoing notification of unexpected complications and all deaths and issues are escalated if appropriate via the Trust's reporting processes. However the Trust has strengthened processes for specialty review and reporting of mortality and morbidity and a regular Mortality meeting has been instituted.

As indicated, the Trust reported 2 never events (NE) during 2012/13, and has further reinforced the processes in place to ensure ongoing monitoring of Never Events risks through regular review of the Never Event Gap Analysis.

The Trust's Clinical Audit Strategy requires that the clinical audit forward plan is based on prioritized clinical risk areas and to secure the fullest participation in national clinical audits. The Clinical Audit Plan for 2013/14 is further developed with improved linkages to clinical risks and the Trust is sustaining its increased participation in national audits.

Internal Audit

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

Counter Fraud activities

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

Information Governance

The Director for Partnerships, who is also the Trust's Senior Information Risk Owner, (SIRO), chairs the Information Governance Implementation Group (IGIG). Membership of the IGIG includes the Caldicott Guardian and senior management and representatives from across the organisation and reports to the Integrated Risk and Governance Committee. The IGIG approves the Trust's end of year Information Governance Toolkit (IGT) self-assessment and monitors progress against the annual IG action plan.

The Trust exchanges data with a number of organisations. The toolkit includes a requirement to undertake an annual "data mapping" exercise to identify and review all routine inbound and outbound data flows containing personal identifiable information within the Trust and across organisational boundaries. All data flows are risk assessed and significant risks reported to the SIRO and the IGIG.

The Trust's Information Risk Management Framework sets out a structured approach to information risk that is integrated with the Trust's broader risk management arrangements. All Information Assets of the Trust are assessed annually to ensure all vulnerabilities and impacts are properly assessed and included within the Trust-wide risk register.

Although the Trust has seen a 2% decrease in its overall percentage score for the Information Governance Toolkit in 2012/13, the submission has resulted in a 'not satisfactory status'. This has been due to the ongoing difficulties in meeting the requirement for training within the IG framework. It was also affected by requirements in relation to data quality and clinical coding. The Trust has an action plan in place to improve compliance with this requirement.

The Trust reported one incident of data security to the Information Commissioner. The Information Commissioner confirmed that he would take no further action and was satisfied with the investigation undertaken by the Trust and the recommendations resulting from that investigation.

Equality and Diversity

The Equality and Diversity Group monitor the organisation's obligations under equality, diversity and human rights legislation. Equality Impact Assessments are carried out when reviewing policies and service changes. The Trust has published its commitment to its Public Sector Equality Duty (PSED) and its Equality Delivery System grading together with objectives for 2013/14 in accordance with its PSED.

NHS Pension Scheme

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

Carbon Reduction and Sustainability

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

Performance Reporting

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

- Corporate objectives for data quality are defined
- Data quality priorities are monitored
- Comprehensive guidance on data quality in the data capture policy
- Data quality reports are provided to divisions
- Performance is monitored and reviewed at regular performance meetings with the Divisions and reported to the Board
- Divisional Boards monitor and manage performance
- Clinical and quality data is reported to the Board and scrutinised and challenged at Board sub-Committees

Our local commissioners provide external assurance statements on the Quality Account and the Local Involvement Network (and from 1 April 2013, Health Watch) as required by Quality Account Regulations. The Audit Committee's terms of reference require it to review all risk and control related disclosure statements prior to endorsement by the Board, and the effectiveness of the management of principal risks, including risk review procedures and reports.

The Trust worked collaboratively with the Strategic Health Authority, the Primary Care Trust and the Clinical Commissioning Groups in respect of the issues affecting the health economy locally and nationally and in doing so managed the risks of transition to new structures from 1 April 2013.

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

During 2012/13 the Trust continued to work with Hertfordshire Partnership Foundation Trust to enhance liaison psychiatry services in its emergency department. It has close operational and policy links with the County Council Social Service department and Hertfordshire Community Trust principally to ensure speedy and appropriate discharge of patients requiring some form of post acute care.

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

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

effectively, economically and progress reviewed and reported in a timely manner.

The system of internal control has been in place in the Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

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

Finance and performance reports are presented to the Board. The Trust achieved an overall Financial Risk Rating of 3 for 2012/13. External Audit is required as part of its annual audit to satisfy themselves the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and report by exception if in their opinion the Trust has not done so.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive directors within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account attached to this annual report and other performance information available to me. My review is also informed the Head of Internal Audit Opinion and other reports, including those from sub Committee Chairs.

The Board, the Audit Committee and the Integrated Risk and Governance Committee have advised me of the implications of the result of my review of the effectiveness of the system of internal control. Executives and managers within the organisation, who have responsibility for the development and maintenance of the system of internal control and the Assurance Framework, also inform my review. The responsibility for compliance with the Care Quality Commission Essential Outcomes is allocated to lead Executive Directors who are responsible for maintaining evidence of compliance.

The Board regularly reviews risks to the delivery of the Trust's performance objectives through monitoring and discussion of reports in the key areas of finance, activity, national targets, patient safety and quality and workforce aligned to the regular review of the Board Assurance Framework.

The assessment of compliance and the work of Internal Audit through the year, including advice and support on the development of the Board Assurance Framework have provided assistance in the ongoing development and maintenance of robust controls. The results of External Audit's work on the Trust's annual accounts and the Quality Account are key assurances together with patient and staff surveys and the CNST Level 2 Risk Management Standards assessment for Maternity Services. The Trust's assurance processes ensure ongoing compliance with NHLSA Level 2 standards for general services achieved in June 2011.

8. DRAFT HEAD OF INTERNAL AUDIT OPINION

Based on the work undertaken in 2012/13, 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 weaknesses were identified that put the achievement of particular objectives at risk:

- Our Review of Estates Business Cases resulted in a Red Opinion as it highlighted that failure to robustly forecast and model levels of patient activity and service demand had resulted in reactive unplanned expenditure to increase capacity. An action plan is in place to address the deficiencies identified in the planning process.

- Our review of Data Quality – Data capture resulted in a Red Opinion as from our review of CAS cards in A&E and the PAS reports produced outlining the data captured during five days of May 2012, we found significant data quality weaknesses, increasing the likelihood that the Trust is losing income from inaccurate record keeping.

The above opinion can be considered as through we are providing an unqualified opinion.

9. Conclusion

The internal auditors have reported no significant control issues and, with the exception of the control weaknesses identified in the red rated audit, I am satisfied of the adequacy of plans in place to address weaknesses and ensure continuous improvement in the control systems in place.

The Board and subcommittee structure has been subject to review and refresh with the introduction of a Patient Safety, Quality and Risk subcommittee of the Board, which replaces the Integrated Risk, and Governance Sub Committee. A Workforce Sub Committee has also been introduced and the Board approved these changes in March. This and the establishment of the Trust Leadership (Executive) Committee will enhance the controls in place to ensure proactive identification and management of the organisation's risks.

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

Samantha Jones

Chief Executive Officer

West Hertfordshire Hospitals NHS Trust

5 June 2013

The role of the Non-Executive Director

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

The duties of Non-Executive Directors are to:

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

Non-Executive Directors also have a key role in a small number of permanent board committees such as the Audit Committee, Remuneration Committee and the Integrated Risk and Governance Committee.

For further information and details on the terms and conditions of appointment of a Non-Executive Director, please refer to www.audit-commission.gov.uk.

The Trust Board and its Sub Committees

The Trust Board is the body that discharges the responsibilities of the Trust. The Board has agreed systems of delegated responsibilities and governance systems to support it in this role. These delegated responsibilities are to individuals, formally identified groups (sub-committees and working parties) or external parties. The Sub-Committees of the Board, all of which are chaired by Non-Executive Directors, provide scrutiny of the key areas of Trust business and meet statutory requirements. Sub committees of the Board meet at regular intervals as agreed with each committee chairman. The Trust held 8 Trust Board meetings in public during 2012/13.

Membership (attendance in brackets)

- Thomas Hanahoe, Chair (78%)
- Katharine Charter, NED & Vice Chair (78%)
- Mahdi Hasan, NED (100%)
- Chris Green, NED (100%)
- Sarah Connor, NED (67%)
- Robin Douglas, NED (89%)
- Phil Townsend, NED (67%)
- Jan Filochowski, Chief Executive, left 11/10/12 (100%)
- Samantha Jones, CEO, started 04/02/13 (100%)
- Colin Johnston, Medical Director (78%)
- Natalie Forrest, Director of Nursing (Acting Chief Executive 12/10/12 to 03/02/13) (100%)
- Anna Anderson, Director of Finance (89%)
- Chris Pocklington, Chief Operating Officer, left 14/03/13 (88%)
- Paul Jenkins, Director of Partnerships (89%)
- Louise Gaffney, Director of Strategy and Infrastructure, started 16/08/12 (100%)
- Maxine McVey, Interim Director of Nursing, started 12/10/12 (67%)
- Elizabeth Rippon, Director of Communications and Transformation, left 01/02/13 (88%)
- Mark Vaughan, Director of Workforce (100%)

In addition, to the following established Sub-Committees, the Trust will need to establish a Nominations Committee when it achieves Foundation Trust status.

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

Audit Committee

The aim of this committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that support the achievement of the organisation's objectives. The Trust held six Audit Committee Meetings during 2012/13.

Membership (attendance in brackets)

- Sarah Connor, NED Chair (83%)
- Mahdi Hassan, NED (83%)
- Phil Townsend, NED, (100%)
- Colin Johnston, Medical Director (83%)
- Anna Anderson, Director of Finance (100%)

Remuneration Committee

The committee has formal and transparent procedures for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. The Remuneration Committee met five times during 2012/13.

Membership (attendance in brackets)

- Katherine Charter, NED, Chair (100%)
- Thomas Hanahoe, NED (80%)
- Sarah Connor, NED (40%)
- Chris Green, NED (80%)
- Phil Townsend, NED (40%)

Charitable Funds Committee

The role of this committee is to ensure funds held on Trust/Charitable Funds are managed in accordance with the Trust's Standing Financial Instruction, as approved by the Trust Board. The Trust held two Charitable Funds Committee Meetings during 2012/13.

Membership (attendance in brackets)

- Katherine Charter, NED, Chair (50%)
- Robin Douglas, NED (100%)
- Anna Anderson, Director of Finance (50%)

Finance Committee

The Finance committee maintain an oversight of, and receive assurances on the robustness of the Trust's key income sources and contractual safeguard. The Trust held seven Finance Committee meetings during 2012/13.

Membership (attendance in brackets)

- Chris Green, NED & Chair (100%)
- Sarah Connor NED (57%)
- Robin Douglas, NED (14%)
- Anna Anderson, Finance Director (100%)
- Jan Filochowski, Chief Executive, left 11/10/12 (67%)
- Chris Pocklington, Chief Operating Officer, left 14/03/13 (67%)
- Thomas Hanahoe, Chairman (71%)
- Natalie Forrest, Chief Operating Office/Deputy Chief Executive, from 15/03/13 (43%)
- Louise Gaffney, Director of Strategy and Infrastructure, started 16/08/12 (57%)
- Paul Jenkins, Director for Partnerships (14%)
- Elizabeth Rippon, Director of Communications and Transformation, left 01/02/13 (40%)
- Samantha Jones, Chief Executive, from 04/02/13 (50%)

Integrated Risk and Governance Committee

The Integrated Risk and Governance Committee (IRaGC) promotes Integrated risk management, consistent with the Board's appetite for risk. The committee has delegated authority from the Board to investigate any activity within its terms of reference. It is also authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The Trust held six Integrated Risk and Governance Committee Meetings during 2012/13.

Membership (attendance in brackets)

- Mahdi Hasan, NED (Chair) (67%)
- Sarah Connor, NED (50%)
- Jan Filochowski, Chief Executive, left 11/10/12 (67%)
- Colin Johnston, Medical Director (100%)
- Anna Anderson, Director of Finance (50%)
- Chris Pocklington, Chief Operating Officer, left 14/03/13 (60%)
- Paul Jenkins, Director of Partnerships (83%)
- Mark Vaughan, Director of Workforce (83%)
- Louise Gaffney, Director for Strategy and Infrastructure, started 16/08/12 (83%)
- Samantha Jones, Chief Executive, started 04/02/13 (0%)
- Natalie Forrest, Chief Operating Officer, started 15/03/13 (83%)
- Maxine McVey, Interim Director of Nursing, started 12/03/12 (67%)

Declarations of Interest

It is a requirement that all Trust Board members 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 Interests for the Trust at the end of 2012/13 is shown below:

Register of Interests

Name	Title / Responsibility	Declared Interests
Professor Thomas Hanahoe	Chairman	• Member of University Court, University of Hertfordshire • Honorary Degree of Doctorate of Science from University of Hertfordshire
Mahdi Hasan	Non-Executive Director Senior Independent Director Vice-Chairman Trust Board Chair of Integrated Risk and Governance Committee	• Projects Advisor to Japan Canada Oil Sands Ltd, Calgary • Vice-President Engineering Projects, Gulfsands Petroleum Plc, London • Project Advisor to Maersk Drilling, Copenhagen • Member of Consultants of Distinction Forum, The Hague • Volunteer Driver, West Hertfordshire Hospitals NHS Trust
Sarah Connor	Non-Executive Director Chair of Audit Committee	• Employee of Calloway Group
Katharine Charter	Non-Executive Director Chair of Charitable Funds Committee Chair of Remuneration Committee	• Teaching Assistant employed by Herts County Council
Chris Green	Non-Executive Director Chair of Finance Committee	• Non-Executive Director of Dover Harbour Board
Phil Townsend	Non-Executive Director	• Jointly employed by BT Limited & BTID
Robin Douglas	Non-Executive Director (co-opted)	• Chair of Health & Social Care Advisory Service • Chair of Who Cares? Trust • Associate of Centre for Innovation in Health Management, Leeds University • Independent Consultant in public services via Douglas Consulting • Member of Herts LINk (Healthwatch)
Samantha Jones	Chief Executive (from Feb 2013) Chair of Trust Leadership Executive	• Husband Joseph Harrison, CEO, Milton Keynes Foundation Trust

Directors Remuneration 2012/13

Name	Title	In year start/ leave dates	2012/13 SALARY (bands of £5,000)	2012/13 Other Remuneration (bands of £5,000)	2012/13 Bonus Payments (bands of £5,000)	2012/13 Benefits in kind (£100)	2011/12 SALARY (bands of £5,000)	2011/12 Other Remuneration (bands of £5,000)	2011/12 Bonus Payments (bands of £5,000)	2011/12 Benefits in kind (£100)
T. Hanahoe	Chairman		20-25	0	0	4	20-25	0	0	1
J. Filochowski	Chief Executive	Left post Oct'12	125-130	0	40-45	0	240-245	0	30-35	0
S. Jones	Chief Executive	Start date Feb'13	25-30	0	0	0	0	0	0	0
R. Douglas	Non-Executive Director		5-10	0	0	0	5-10	0	0	0
K. Charter	Non-Executive Director		5-10	0	0	0	5-10	0	0	1
M. Hasan	Non-Executive Director		5-10	0	0	0	5-10	0	0	0
S. Connor	Non-Executive Director		5-10	0	0	0	5-10	0	0	0
C. Green	Non-Executive Director		5-10	0	0	0	5-10	0	0	0
P. Townsend	Non-Executive Director		5-10	0	0	0	0-5	0	0	0
A. Anderson	Director of Finance		115-120	0	20-25	2	115-120	0	15-20	3
N. Forrest	Director of Nursing, Acting Chief Executive		120-125	0	15-20	0	95-100	0	10-15	0
M. McVey	Acting Director of Nursing	Start date Oct'12	35-40	0	0	0	0	0	0	0
C. Pocklington	Chief Operating Officer	Left post Mar'13	125-130	0	15-20	0	115-120	0	0	0
P. Jenkins	Director of Partnerships		105-110	0	0	3	5-10	0	0	0
M. Vaughan	Director of Workforce		95-100	0	15-20	3	95-100	0	0	3
L. Gaffney	Director of Strategy & Infrastructure		95-100	0	0	2	15-20	0	0	0
L. Rippon	Director of Communications & Transformation	Left post Jan'13	70-75	50-55	0	0	60-65	0	0	1
C. Johnston	Medical Director		125-130	60-65	25-30	0	135-140	55-60	20-25	0

Director's Salary Relative to Workforce

The Trust is required to disclose the relationship between the remuneration of the highest-paid director and the median remuneration of the organisation's workforce.

The mid point of the banded remuneration of the highest paid director in the financial year 2012-13 was £252.5k. This was 8.5 times the median remuneration of the workforce, which was £29.4k.

In 2011-12 the highest paid director banding was £277.5k, 9.5 times the median of £29.3k. Due to changes in directors and because figures relate to staff in post as at 31 March; the two years are not directly comparable.

In 2012-13, no employee received remuneration in excess of the highest-paid director. Remuneration ranged for full time employees from pay banding £10- £15k to pay banding £250-£255k.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions nor the additional cash equivalent transfer value of pensions.

Directors Pension Remuneration

	Real increase in pension at 60 (bands of £2,500)	Real increase in pension lump sum at ages 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value (bands of £1,000)	Employer's contribution to stakeholder pension
S. Jones	0-2.5	0-2.5	25-30	75-80	371,609	340,337	2	0
A. Anderson	0-2.5	2.5-5	60-65	180-185	1,392,940	1,257,224	70	0
N. Forrest	2.5-5	10-12.5	15-20	45-50	247,905	173,425	65	0
C. Pocklington	0-2.5	5-7.5	30-35	95-100	537,137	470,660	42	0
P. Jenkins	-0 -2.5	-5 -7.5	30-35	95-100	559,856	551,205	0	0
M. Vaughan	0-2.5	0-2.5	30-35	90-95	582,274	538,942	15	0
L. Gaffney	2.5-5	7.5-10	20-25	70-75	385,035	311,096	58	0
L. Rippon	0-2.5	2.5-5	10-15	35-40	162,718	137,484	15	0
M. McVey	0-2.5	2.5-5	25-30	85-90	485,262	418,499	22	0

Directors where there has been no increase in their pension value are excluded from the table above. Non-Executive members do not receive pensionable remuneration, therefore there are also no entries in respect of pensions for these Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed value of the pension scheme benefits accrued by a member at a paticular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme or chooses to transfer the benefits accrued in their former pension scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute of Faculty of Actuaries.

Real Increase / Decrease in CETV - This reflects the change in-year of CETV after adjusting the start of the year CETV for the change in consumer price indice.

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 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers
- the table of pension benefits of senior managers
- the pay multiples disclosure

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

Respective responsibilities of Directors and auditor

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of West Hertfordshire Hospitals NHS Trust as at 31 March 2013 and of its expenditure and income for the year then ended
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and auditor

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

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

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its 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.

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

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in November 2012, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these to criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2013.

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 November 2012, we are satisfied that in all significant respects West Hertfordshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013.

Delay in certification of completion of the audit

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

Paul Dossett
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London NW1 2EP

5 June 2013

Statement of comprehensive income for the year ended 31 March 2013

	NOTE	2012/13 £000s	2011/12 £000s
Employee benefits	8	**(175,017)**	(167,403)
Other operating expenses	6	**(99,864)**	(89,615)
Revenue from patient care activities	4	**249,024**	236,610
Other operating revenue	5	**29,206**	30,106
Operating surplus		**3,349**	9,698
Investment revenue	11	**43**	31
Finance costs	13	**(1,037)**	(1,326)
Surplus for the financial year		**2,355**	8,403
Public dividend capital dividends payable		**(3,223)**	(3,134)
Retained surplus/(deficit) for the year		**(868)**	5,269
Other Comprehensive Income			
Impairments on revaluation of property, plant & equipment	14	**(1,052)**	(725)
Net gain/(loss) on revaluation of property, plant & equipment	14	**161**	1,601
Total comprehensive income for the year		**(1,759)**	6,145
Financial performance for the year			
Retained surplus/(deficit) for the year		**(868)**	5,269
Impairments		**2,811**	(1,512)
Less Donations in excess of depreciation on donated assets		**39**	100
Adjusted retained surplus/(deficit)		**1,904**	3,657
PDC dividend: balance receivable at 31 March		**176**	189

The notes on pages 1 to 32 form part of this account.

Statement of financial position as at 31 March 2013

	NOTE	31 March 2013 £000s	31 March 2012 £000s
Non-current assets:			
Property, plant and equipment	14	**124,163**	121,895
Intangible assets	15	**1,386**	2,243
Trade and other receivables	19	**1,325**	1,187
Total non-current assets		**126,874**	125,325
Current assets:			
Inventories	18	**3,106**	3,032
Trade and other receivables	19	**10,389**	9,378
Cash and cash equivalents	21	**9,347**	9,851
Total current assets		**22,842**	22,261
Non-current assets held for sale	22	**323**	0
Total current assets		**23,165**	22,261
Total assets		**150,039**	147,586
Current liabilities			
Trade and other payables	23	**(25,290)**	(18,171)
Provisions	27	**(811)**	(541)
Working capital loan from Department	24	**(1,400)**	(1,400)
Capital loan from Department	24	**(2,772)**	(2,772)
Total current liabilities		**(30,273)**	(22,884)
Non-current assets plus/less net current assets/liabilities		**119,766**	124,702
Non-current liabilities			
Provisions	27	**(4,975)**	(5,280)
Working capital loan from Department	24	**(1,400)**	(2,800)
Capital loan from Department	24	**(11,079)**	(13,851)
Total non-current liabilities		**(17,454)**	(21,931)
Total Assets Employed:		**102,312**	102,771
FINANCED BY: TAXPAYERS' EQUITY			
Public Dividend Capital		**181,968**	180,668
Retained earnings		**(93,296)**	(92,434)
Revaluation reserve		**13,640**	14,537
Total Taxpayers' Equity:		**102,312**	102,771

The notes on pages 1 to 32 form part of this account, were approved by the Board on 5 June, and signed on its behalf by:

Samantha Jones, Chief Executive
Date: 5 June 2013

Statement of changes in taxpayers' equity for the year ended 31 March 2013

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
Changes in taxpayers' equity for 2012-13	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2012	**180,668**	**(92,434)**	**14,537**	**102,771**
Retained surplus/(deficit) for the year		(868)		(868)
Net gain / (loss) on revaluation of property, plant, equipment			161	161
Impairments and reversals			(1,052)	(1,052)
Transfers between reserves		6	(6)	0
New PDC Received	1,300			1,300
Net recognised revenue/(expense) for the year	**1,300**	**(862)**	**(897)**	**(459)**
Balance at 31 March 2013	**181,968**	**(93,296)**	**13,640**	**102,312**
Changes in taxpayers' equity for 2011-12				
Balance at 1 April 2011	**173,668**	**(97,719)**	**13,677**	**89,626**
Retained surplus/(deficit) for the year		5,269		5,269
Net gain / (loss) on revaluation of property, plant, equipment			1,601	1,601
Impairments and reversals			(725)	(725)
Transfers between reserves		16	(16)	0
New PDC received	7,000			7,000
Net recognised revenue/(expense) for the year	7,000	5,285	860	13,145
Balance at 31 March 2012	**180,668**	**(92,434)**	**14,537**	**102,771**

Statement of cash flows for the year ended 31 March 2013

	2012/13 £000s	2011/12 £000s
Cash flows from operating activities		
Operating Surplus/Deficit	**3,349**	9,698
Depreciation and Amortisation	**7,122**	7,244
Impairments and Reversals	**2,811**	(1,512)
Donated Assets received credited to revenue but non-cash	**(268)**	(327)
Interest Paid	**(933)**	(1,200)
Dividend Paid	**(3,210)**	(3,323)
(Increase)/Decrease in Inventories	**(74)**	510
(Increase)/Decrease in Trade and Other Receivables	**(1,163)**	1,791
Increase in Trade and Other Payables	**5,598**	2,346
Provisions Utilised	**(563)**	(619)
Increase in Provisions	**421**	308
Net cash inflow from operating activities	**13,090**	14,916
Cash flows from investing activities		
Interest Received	**44**	32
Payments for Property, Plant and Equipment	**(10,763)**	(7,276)
Payments for Intangible Assets	**(3)**	(194)
Proceeds of disposal of assets held for sale (PPE)	**0**	0
Net cash outflow from investing activities	**(10,722)**	(7,438)
Net cash inflow before financing	**2,368**	7,478
Cash flows from financing activities		
Public dividend capital received	**1,300**	7,000
Loans repaid to DH - Capital investment loans repayment of principal	**(2,772)**	(2,772)
Loans repaid to DH - Working capital loans repayment of principal	**(1,400)**	(3,640)
Net cash (outflow)/inflow from financing activities	**(2,872)**	588
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS	**(504)**	8,066
Cash and cash equivalents at the beginning of the financial year	**9,851**	1,785
Cash and cash equivalents at the end of the financial year	**9,347**	9,851

Notes to the accounts

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts' Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012/13 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 for the purpose of giving a true and fair view has been selected. The particular policies adopted 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 (note 1.3.2) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities such as the Trust, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements are prepared on a going concern basis unless there were plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity. The Directors consider the contracts it has agreed with commissioning bodies for 2013-14 and progress made with the NHS Trust Development Authority for additional borrowing (£15m) is sufficient evidence that the Trust will continue as a going concern for the foreseeable future. These accounts have been prepared on this basis.
- The risks and rewards of ownership of assets leased by the Trust rest with the leasing company; rental payments are charged to the period to which they relate; see note 7.
- Some of the Trust's buildings are used by other organisations, either for NHS purposes or staff welfare. These are not investment properties and rental is credited to the period to which it relates. The associated buildings are included within the total value of Trust properties.
- The Trust Board is corporate Trustee for West Hertfordshire NHS Trust charitable funds. Under IAS 27, this common control means that the charitable accounts should be consolidated. However, HM Treasury has granted a divergence from this requirement until March 2013 and the accounts have not therefore been consolidated.

1.3.2 Key sources of estimation uncertainty

In preparing these accounts the Trust might make assumptions concerning the future affecting the amounts of assets, liabilities, revenue or expenses reported. Any such assumptions and basis of estimate are explained in the related notes. These include:

- the cost attributable to NHSLA change in methodology in calculating its members contributions as detailed in note 1.16.
- the value of patient care spells that are part-completed in note 1.4. An estimate is made using statistics from earlier in the year because the actual value at year end will not be known until those patients in hospital are discharged some time into the new year.
- the valuation of land and buildings using the modern equivalent assset discounted replacent cost method in note 14.5.

1.4 Revenue

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

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

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

1.5 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

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

For early retirements, other than those due to ill health, approved by the Trust the additional pension is not funded by the NHS Pension Scheme. The full cost is a liability of the Trust and is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the period over which the Trust pays its liability.

1.6 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a loss of service potential are charged to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

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

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

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Further detail of each class of asset is shown in note 14.

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

If there has been an impairment loss the asset is written down to its recoverable amount with the loss charged to the revaluation reserve to the extent there is a balance on the reserve for the asset and thereafter, to expenditure. Unless the impairment results from use of the asset where the impairment is charged fully to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

In compliance with the NHS Trust Manual for Accounts, from 2011/12 impairments relating to property, plant and equipment are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). The analysis is used by the Department of Health in consolidating the accounts of NHS bodies. In summary, DEL set as part of NHS spending is not expected to be exceeded, while AME is less predictable, and subject to Treasury approval, may be revised. Further information on these limits can be found on HM Treasury website at www.hm-treasury.gov.uk/pes_overview.htm. The related Trust impairment is classified as AME and is detailed in note 14.5.

1.10 Donated assets

The Trust amended its approach to accounting for donated assets in line with the accounting policy change in the 2011/12 Treasury FREM. Consequently 2012/13 and the 2011/12 comparative figures reflect this change. A donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are also as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition.

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.

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 the appropriate HM Treasury's discount rate. Liabilities expected to be settled in 0 to 5 years are discounted at minus 1.8%, 5 to 10 years at minus 1% and beyond 10 years at 2.2%. Those relating to employee early retirement obligations are discounted at 2.35%.

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 NHSLA has changed its methodology in determing member contributions to include claims history. In addition to the annual premium the Trust has charged to expenditure an estimated £0.5m increased cost resulting from this change. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 27.2.

1.17 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 Contingencies

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

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

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

1.19 Financial assets

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

1.20 Financial liabilities

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

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

1.21 Value added tax

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

1.22 Foreign currencies

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

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 34 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for cash balances with the Government Banking Service. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.25 Losses and special payments

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

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

1.26 Research and Development

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

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

The Treasury FReM does not require the Trust to apply the following Standards and Interpretations in 2012/13; each of which are subject to consultation. The application of these would not have a material impact were they to be applied:

IAS 19	(Revised 2011) Employee Benefits
IAS 27	Separate Financial Statements
IAS 28	Investments in Associates and Joint Ventures
IAS 32	Financial Instruments: Presentation
IFRS 7	Financial Instruments: Disclosures
IFRS 9	Financial Instruments - subject to consultation
IFRS 10	Consolidated Financial Statements
IFRS 11	Joint Arrangements

2. Operating segments

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

Revenue relating to NHS patient care accounts for 89% of the total, further analysis of which is shown in note 4. This is managed through contracts established with commissioners, mainly Primary Care Trusts (PCTs), each contract covering the complete range of activities provided. The Trust's assets are used collectively to deliver the range of activities encompassed within these contracts.

3. Income generation activities

The Trust no longer conducts material income generation activities outside of its usual business, where the aim is to achieve a profit, to be used in patient care. In prior years the Trust operated a prescription packing unit; a department that sold re-packed and patient ready packed medicines and other pharmacy products. This ceased trading in March 2012. In 2011/12 the department generated income of £1,351k and incurred full costs of £1,173k, generating a profit of £178k.

4. Revenue from patient care activities

	2012/13 £000s	2011/12 £000s
Primary Care Trusts - tariff	**168,282**	161,508
Primary Care Trusts - non-tariff	**47,279**	41,072
Primary Care Trusts - market forces factor	**28,736**	27,580
Primary Care Trusts - transformation funds	**2,357**	4,206
Local Authorities	**142**	122
Non-NHS:		
Private patients	**1,156**	1,392
Overseas patients (non-reciprocal)	**119**	108
Injury costs recovery	**921**	595
Other	**32**	27
Total revenue from patient care activities	**249,024**	236,610

5. Other operating revenue

	2012/13 £000s	2011/12 £000s
Education, training and research	**8,910**	8,858
Charitable and other contributions to expenditure	**66**	38
Receipt of donations for capital acquisitions - NHS Charity	**268**	327
Non-patient care services to other bodies	**13,821**	13,364
Income generation	**1,550**	2,612
Rental revenue from operating leases	**989**	509
Primary Care Trusts - transformation funds	**3,602**	4,198
Other revenue	**0**	200
Total other operating revenue	**29,206**	30,106
Total Operating Revenue	**278,230**	266,716

The Trust receives funds from its main commissioner NHS Hertfordshire outside of the main contract. These are described in note 4 and 5 as transformation funds and relate to specific initiatives. Those for patient care activities help the Trust with capacity needed to manage higher than expected patient levels including in particular emergency activity over winter. Non patient related funds help with the costs of keeping the Trust's three hospitals operational and support initiatives to improve efficiency.

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

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

6. Operating expenses (excluding employee benefits)

	2012-13 £000s	2011-12 £000s
Services from other NHS trusts	**1,415**	1,924
Services from other NHS bodies	**211**	163
Services from foundation trusts	**1,023**	557
Purchase of healthcare from non NHS bodies - see i) below	**2,606**	1,474
Trust Chair and Non-executive Directors	**62**	64
Supplies and services - clinical	**42,075**	39,717
Supplies and services - general	**9,516**	9,089
Consultancy services	**1,473**	1,441
Establishment	**3,116**	2,776
Transport	**2,535**	2,434
Premises	**14,894**	12,723
Impairments and reversals of receivables - see ii) below	**247**	1,365
Inventories write down	**0**	23
Depreciation	**6,262**	6,371
Amortisation	**860**	873
Impairments and reversals of property, plant and equipment - see iii) below	**2,811**	(1,512)
Audit fees	**127**	174
Other auditor's remuneration	**0**	0
Clinical negligence see iv) below	**6,746**	5,829
Education and Training	**587**	784
Other	**3,298**	3,346
Total Operating expenses (excluding employee benefits)	**99,864**	89,615
Employee benefits		
Employee benefits excluding Board members	**174,147**	166,477
Board members	**870**	926
Total employee benefits	**175,017**	167,403
Total operating expenses	**274,881**	257,018

i) Purchase of healthcare from non NHS bodies relates to the outsourcing of activity both to meet waiting time targets and manage bed capacity. (2011/12 figure adjusted with Other costs to reflect comparison).
ii) In 2011/12 the Trust reduced its exposure to debts over 3 months old, this position has been maintained in 2012/13.
iii) The Trust's revaluation of its land and building charged to expenses per note 1.9
iv) The increase in cost of clinical negligence relates to the change in the way NHSLA assesses its members contributions per note 1.16.

7. Operating Leases

7.1 Trust as lessee

Leases relate mainly to the hire of medical equipment: contracts are entered into using standard NHS conditions that include:

- Retained asset ownership by the Lessor
- Fixed rental payments over the agreed lease period
- Residual value being the property of the Lessor
- The equipment used by the Trust is for its intended purpose
- Options for the Trust to extend the lease period or return early on payment of amounts are determined by the Lessor
- The equipment when returned is complete and in reasonable condition

Payments recognised as an expense	**£000s**	2011-12 £000s
Minimum lease payments	**350**	429
Payable:		
No later than one year	**255**	279
Between one and five years	**280**	393
After five years	**0**	0
Total	**535**	672

7.2 Trust as lessor

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

	2012-13 £000s	2011-12 £000s
Rental revenue	**989**	509
Receivable:		
No later than one year	**750**	509
Between one and five years	**3,748**	2,545
After five years	**599**	615
Total	**5,097**	3,669

8. Employee benefits and staff numbers

8.1 Employee benefits

	2012/13 Total £000s	2012/13 Permanently employed £000s	2012/13 Other £000s
Employee Benefits			
Salaries and wages	149,035	128,879	20,156
Social security costs	10,680	10,167	513
Employer Contributions to NHS Pensions Scheme	15,338	14,652	686
Termination benefits	232	232	0
Total employee benefits	**175,285**	**153,930**	**21,355**
Employee costs capitalised	**268**	0	268
Net Employee Benefits excluding capitalised costs	**175,017**	**153,930**	**21,087**

	2011/12 Total £000s	2012/13 Permanently employed £000s	2012/13 Other £000s
Employee Benefits			
Salaries and wages	**141,258**	125,236	16,022
Social security costs	**10,866**	9,955	911
Employer Contributions to NHS Pensions Scheme	**15,227**	14,009	1,218
Termination benefits	**280**	280	0
Total employee benefits	**167,631**	**149,480**	**18,151**
Employee costs capitalised	**228**	**228**	0
Net Employee Benefits excluding capitalised costs	**167,403**	**149,252**	**18,151**

8.2 Staff Numbers

	2012/13 Total Number	2012/13 Permanently employed Number	2012/13 Other Number	2011/12 Total Number
Average Staff Numbers				
Medical and dental	**567**	526	42	543
Ambulance staff	**0**	0	0	0
Administration and estates	**934**	870	64	949
Healthcare assistants and other support staff	**699**	597	102	687
Nursing, midwifery and health visiting staff	**1,303**	1,136	167	1,227
Nursing, midwifery and health visiting learners	**8**	8	0	9
Scientific, therapeutic and technical staff	**446**	403	43	419
Other	**33**	33	0	33
TOTAL	**3,990**	**3,573**	**417**	3,867
Of the above - staff engaged on capital projects	**3**	0	3	4

8.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	27,707	24,760
Total staff years employed (wte)	3546	3,465
Average calendar days lost per staff year employed	7.8	7.1

8.5 Exit Packages

Exit package cost band (including any special payment element)	2012/13 Number of compulsory redundancies	2012/13 Number of other departures agreed	2012/13 Total number of exit packages by cost band	2011/12 Number of compulsory redundancies	2011/12 Number of other departures agreed	2011/12 Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	2	3	5	7	5	12
£10,001-£25,000	2	2	4	2	8	10
£25,001-£50,000	0	2	2	1	0	1
£50,001-£100,000	0	1	1	0	0	0
Total number of exit packages	**4**	**8**	**12**	10	13	23
Total cost (£000s)	**49**	**197**	**246**	113	157	270

This note provides an analysis of Exit Packages agreed during the year. Exit costs are accounted for in full in the year agreement of departure is reached.

Redundancies have been paid in accordance with NHS agenda for change terms and conditions. Other departure costs have been paid in accordance with the Trust's voluntary resignation scheme.

Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme detailed in note 8.4 and are not included in this note.

9 Pension costs

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 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 Trust is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation was undertaken as at 31 March 2004. The next full acturarial valuation was due 31 March 2008, however, formal valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension due in 2015.

The scheme regulations were changed to allow contribution rates to be set by the Secretary of State with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives. The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform contribution rates from 1 April 2015.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated

membership data. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2013, is based on detailed membership data as at 31 March 2011, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant financial reporting interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Scheme Provisions

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

Annual Pensions

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

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

Pensions Indexation

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

Ill-Health Retirement

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Early Retirement

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

Additional Voluntary Contributions (AVCs)

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

10 Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by their due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust approach to measuring its performance in compliance with this code is to compare the date payments are made with 36 days from invoice payment due date; this allows for variation between invoice and goods received.

10.1 Better Payment Practice Code - measure of compliance

	2012/13	2012/13	2011/12	2011/12
Non-NHS Payables	**Number**	**£000s**	Number	£000s
Non-NHS Trade Invoices paid in the year	52,798	100,737	53,027	72,785
Non-NHS Trade Invoices paid within target	45,228	80,233	45,419	57,362
Percentage of Non NHS Trade Invoices paid within target	86%	80%	86%	79%
NHS Payables				
NHS Trade Invoices paid in the year	2,533	10,447	2,535	16,930
NHS Trade Invoices paid within target	2,125	8,779	2,223	15,180
Percentage of NHS Trade Invoices paid within target	84%	84%	88%	90%

Between 20011-12 and 2012-13 NHS Supplies has been reclassified from NHS to Non NHS. This change is particularly reflected in the value of invoices paid.

11 Investment Income

	2012-13 £000s	2011-12 £000s
Bank interest	**43**	31

12 Other Gains and Losses

The Trust has no other gains or losses.

13 Finance Costs

	2012-13	2011-12
Interest	**£000s**	£000s
Interest on loans and overdrafts	**930**	1,186
Other finance costs relating to unwinding of discount in determining fair value of provisions	**107**	140
Total	**1,037**	1,326

14.1 Property, plant and equipment

2012/13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2012	**29,596**	**80,910**	**849**	**4,222**	**29,890**	**176**	**12,405**	**5,071**	**163,119**
Additions of assets under construction	0	0	0	**9,784**	0	0	0	0	9,784
Additions purchased	0	1,963	0		525	0	15	0	2,503
Additions donated	0	0	0	150	118	0	0	0	268
Reclassifications	0	1,075	0	(1,090)	0	0	15	0	0
Reclassifications as held for sale and reversals	(131)	(192)	0	0	0	0	0	0	(323)
Brought forward netted off following revaluation	2,336	(10,186)	(155)	0	(841)	0	(100)	(2,882)	(11,828)
Upward revaluation/positive indexation	0	92	0	0	69	0	0	0	161
Impairments/negative indexation	0	(1,052)	(2)	0	(4)	0	0	0	(1,058)
Reversal of Impairments	0	0	0	0	0	0	0	6	6
At 31 March 2013	**31,801**	**72,610**	**692**	**13,066**	**29,757**	**176**	**12,335**	**2,195**	**162,632**
Depreciation									
At 1 April 2012	0	0	0	0	21,034	151	9,152	0	30,337
Disposals other than for sale	0	0	0		(841)	0	(100)	0	(941)
Impairments	0	2,252	501	0	0	0	0	62	2,815
Reversal of Impairments	0	0	0	0	(4)	0	0	0	(4)
Charged during the year	0	3,110	40		2,112	8	840	152	6,262
At 31 March 2013	**0**	**5,362**	**541**	**0**	**22,301**	**159**	**9,892**	**214**	**38,469**
Net Book Value at 31 March 2013	**31,801**	**67,248**	**151**	**13,066**	**7,456**	**17**	**2,443**	**1,981**	**124,163**
Purchased	31,801	67,123	151	12,916	6,819	17	2,442	1,980	123,249
Donated	0	125	0	150	637	0	1	1	914
Total at 31 March 2013	**31,801**	**67,248**	**151**	**13,066**	**7,456**	**17**	**2,443**	**1,981**	**124,163**
Asset financing:									
Owned	31,801	67,248	151	13,066	7,456	17	2,443	1,981	124,163
Total at 31 March 2013	**31,801**	**67,248**	**151**	**13,066**	**7,456**	**17**	**2,443**	**1,981**	**124,163**
Analysis of additions of assets under construction									
Buildings excl Dwellings				8,728					
Plant & Machinery				1,056					
Balance as at YTD				**9,784**					

14.2 Revaluation Reserve Balance for Property, Plant and Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
At 1 April 2012	**6,032**	**7,966**	**0**	**0**	**539**	**0**	**0**	**0**	**14,537**
Movements (see note 14.5)	0	(951)	(9)	0	63	0	0	0	(897)
At 31 March 2013	**6,032**	**7,015**	**(9)**	**0**	**602**	**0**	**0**	**0**	**13,640**

14.3 Property, plant and equipment prior-year

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

14.4 Revaluation Reserve Balance for Property, Plant & Equipment prior-year

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
At 1 April 2011	5,800	7,321	0	0	556	0	0	0	**13,677**
Movements (see note 14.5)	232	645	0	0	(17)	0	0	0	**860**
At 31 March 2012	**6,032**	**7,966**	**0**	**0**	**539**	**0**	**0**	**0**	**14,537**

14.5 Property, plant and equipment (continued)

Of the £12,555k additions, £268k was donated by West Hertfordshire Hospitals NHS Trust Charitable Funds.

Annual valuation of Land, Buildings and Dwellings is a forecast as at 31 March. The valuation is undertaken by an independent valuer; RICS Registered Valuers of GVA Grimley Ltd. Because of the specialised nature of hospital buildings, i.e. they would not normally be sold on the open market, the valuations are based on the depreciated replacement cost method (DRC) using the modern equivalent asset (MEA) technique. This valuation technique estimates the cost of a MEA; for buildings, this is then adjusted to reflect the age, condition and functionality of the buildings to which the valuation relates and can result in an impairment,details of which are shown below. The approach adopted by the Trust is for a full revaluation to be undertaken every five years with a desktop review in the interim years. Valuation reflects the capital investment to September each year, after which it is included at cost. VAT is added to the valuations to the extent it would be payable were the Trust to construct the MEA.

	Watford General Hospital	Hemel Hempstead Hospital	St Albans City Hospital	Total
	£000s	£000s	£000s	£000s
2012/13				
Operating expenses - note 6				
Buildings, dwellings and fittings - MEA	2,312	275	224	2,811
Statement of change in taxpayers equity				
Buildings, dwellings and fittings - MEA	(19)	847	69	897
Total impairment (reversal) 2012-13	2,293	1,122	293	3,708
2011/12	£000s	£000s	£000s	£000s
Operating expenses - 2011-12				
Land - MEA	(1,916)	(419)	0	(2,335)
Buildings, dwellings and fittings - MEA	1,641	(338)	(480)	823
	(275)	(757)	(480)	(1,512)
Statement of change in taxpayers equity				
Land - MEA	0	0	(232)	(232)
Buildings, dwellings and fittings - MEA	457	(819)	(266)	(628)
	457	(819)	(498)	(860)
Total impairment (reversal) 2011-12	182	(1,576)	(978)	(2,372)

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

Assets under construction are transferred to the relevant class of assets when complete and depreciated in accordance with that class.

For plant and machinery, transport, information technology, the carrying value as at 1 April 2009 is written off over their remaining lives. Net assets in these classes are carried at depreciated historic cost as this is not considered to be materially different from fair value (see note 1.7). Plant and machinery includes £14.8m of fully depreciated assets.

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

Asset Class	As at 31 March 2013 Maximum remaining asset life	As at 31 March 2013 Minimum remaining asset life	As at 31 March 2012 Maximum remaining asset life	As at 31 March 2012 Minimum remaining asset life
	Years	Years	Years	Years
Buildings	**56**	**2**	57	3
Dwellings	**32**	**7**	22	8
Plant and machinery	**9**	**1**	9	1
Transport	**3**	**1**	4	2
Information Technology	**5**	**1**	5	1
Furniture and Fittings	**56**	**2**	57	3

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

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

15 Intangible non-current assets

15.1 2012/13 Intangible non-current assets

	Computer Software - in use	Computer Software in development	Total
	£000s	£000's	£000's
Gross cost as at 1 April 2012	**6,903**	**40**	**6,943**
Additions - purchased	0	3	3
Reclassifications	0	0	0
Gross cost as at 31 March 2013	**6,903**	**43**	**6,946**
Amortisation at 1 April 2012	**4,700**	**0**	**4,700**
Charged during the year	860	0	**860**
Amortisation at 31 March 2013	**5,560**	**0**	**5,560**
Net Book Value at 31 March 2013	**1,343**	**43**	**1,386**
Net book value at 31 March 2013 comprises:			
Purchased	1,343	43	1,386
Donated	0	0	0
Total at 31 March 2013	**1,343**	**43**	**1,386**

15.2 2011/12 Intangible non-current assets

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

The maximum remaining asset life of computer software in use is 4 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.

16 Capital commitments

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

	31 March 2013 £000s	31 March 2012 £000s
Property, plant and equipment	**1,935**	387
Intangible assets	**0**	0
Total	**1,935**	387

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other central government bodies	4,104	0	3,214	0
Balances with local authorities	216	0	0	0
Balances with NHS bodies outside the departmental group	3	0	10	0
Balances with NHS trusts and foundation trusts	1,630	0	1,375	0
Balances with bodies external to government	3,808	1,325	20,693	0
At 31 March 2013	**9,761**	**1,325**	**25,292**	**0**
Balances with other central government bodies	4,487	0	3,409	0
Balances with NHS trusts and foundation trusts	1,663	0	713	0
Balances with bodies external to government	3,228	1,187	14,049	0
At 31 March 2012	**9,378**	**1,187**	**18,171**	**0**

18 Inventories

	Drugs £000s	Consumables £000s	Energy £000s	Total £000s
Balance at 1 April 2012	687	2,133	212	**3,032**
Additions	30	119	0	**149**
Inventories recognised as an expense in the period	0	0	(75)	**(75)**
Balance at 31 March 2013	717	2,252	137	**3,106**

19 Trade and other receivables

19.1 Trade and other receivables

	Current 31 March 2013 £000s	Current 31 March 2012 £000s	Non-current 31 March 2013 £000s	Non-current 31 March 2012 £000s
NHS receivables - revenue	**2,618**	2,092	**0**	0
NHS prepayments and accrued income	**2,346**	3,348	**0**	0
Non-NHS receivables - revenue	**2,553**	1,706	**0**	0
Non-NHS prepayments and accrued income	**3,432**	2,778	**0**	0
Provision for the impairment of receivables	**(1,965)**	(1,792)	**0**	0
VAT	**773**	710	**0**	0
Interest receivables	**4**	4	**0**	0
Injury cost recovery receivables	**628**	532	**1,325**	1,187
Total	**10,389**	9,378	**1,325**	1,187
Total current and non current	**11,714**	10,565		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

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

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

19.2 Non NHS receivables past their due date but not impaired

	31 March 2013 £000s	31 March 2012 (restarted) £000s
By up to three months	**1,086**	903
Total	**1,086**	903

19.3 Provision for impairment of receivables

	2012/13 £000s	2011/12 £000s
Balance at 1 April 2012	**(1,792)**	(499)
Amount written off during the year	**74**	72
(Increase)/decrease in receivables impaired	**(247)**	(1,365)
Balance at 31 March 2013	**(1,965)**	**(1,792)**

20 Other financial assets

The Trust has no other financial assets.

21 Cash and Cash Equivalents

	31 March 2013 £000s	31 March 2012 £000s
Balance at 1 April	**9,851**	1,785
Net change in year	**(504)**	8,066
Balance at 31 March	**9,347**	9,851
Made up of		
Cash with Government Banking Service	**9,269**	9,822
Commercial banks	**72**	23
Cash in hand	**6**	6
Cash and cash equivalents as in statement of financial position	**9,347**	9,851
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**9,347**	9,851
Patients' money held by the Trust, not included above	**4**	3

22 Non-current assets held for sale

	Land £000s	Buildings £000s	Total £000s
Balance at 1 April 2012	0	0	**0**
Plus assets classified as held for sale in the year	131	192	**323**
Less assets sold in the year	0	0	**0**
Balance at 31 March 2013	**131**	**192**	**323**
Balance at 1 April 2011	0	0	**0**
Plus assets classified as held for sale in the year	0	0	**0**
Less assets sold in the year	0	0	**0**
Balance at 31 March 2012	**0**	**0**	**0**

The site used for income generation activity that has now ceased described in note 3 is classified as held for sale and the Trust is in the process of selling it. In line with the accounting policy in note 1.11 no gain or loss has been recognised in classifying the property as held for sale.

23 Trade and other payables

	Current 31 March 2013 £000s	Current 31 March 2012 £000s	Non-current 31 March 2013 £000s	Non-current 31 March 2012 £000s
Interest payable	**41**	44		
NHS payables - revenue	**1,849**	566	**0**	0
NHS accruals and deferred income	**374**	1,465	**0**	0
Non-NHS payables - revenue	**5,019**	5,470	**0**	0
Non-NHS payables - capital	**1,878**	354	**0**	0
Non-NHS accruals and deferred income	**15,875**	10,210	**0**	0
Social security costs	**4**	(47)		
VAT	**245**	86	**0**	0
Tax	**5**	23		
Total	**25,290**	18,171	**0**	0
Total payables (current and non-current)	**25,290**	18,171		

24 Borrowings

	Current 31 March 2013 £000s	Current 31 March 2012 £000s	Non-current 31 March 2013 £000s	Non-current 31 March 2012 £000s
Loans from Department of Health	**4,172**	**4,172**	**12,479**	**16,651**
Total other liabilities (current and non-current)	**16,651**	**20,823**		

Repayment of principal falling due from 31 March 2013	**£000s**
0-1 years	**4,172**
1 - 2 Years	**4,172**
2 - 5 Years	**8,307**
Over 5 Years	**0**
TOTAL	**16,651**

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

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

25 Other liabilities

The Trust has no other payables or financial liabilities.

26 Deferred income

	Current 31 March 2013 £000s	Current 31 March 2012 £000s	Non-current 31 March 2013 £000s	Non-current 31 March 2012 £000s
Opening balance at 1 April	2,020	2,924	0	0
Deferred income addition	177	368	0	0
Transfer of deferred income	(451)	(1,272)	**0**	0
Deferred income at 31 March	**1,746**	2,020	**0**	0
Total deferred income (current and non-current)	**1,746**	2,020		

27 Provisions

27.1 Trust Provisions

	Pensions non directors relating to early retirement £000s	Staff and public liability claims £000s	Total £000s
Balance at 1 April 2012	**5,512**	**309**	**5,821**
Arising During the Year	97	324	**421**
Utilised During the Year	(487)	(76)	**(563)**
Unwinding of Discount	101	6	**107**
Change in Discount Rate	0	0	**0**
Balance at 31 March 2013	**5,223**	**563**	**5,786**
Expected Timing of Cash Flows:			
No later than one year	526	285	**811**
Later than one year and not later than five years	2,748	175	**2,923**
Later than five years	1,949	103	**2,052**

i) Pensions provision for early retirement is assessed using information provided by the Pensions Agency and Government Actuary Department Tables.
ii) The fair value of the provision for future pension payments relating to early retirement is determined by discounting the forecast cashflow in accordance HM Treasury prescribed discount rates (see note 1.15). This rate changed in 2012-13, no charge is recorded because the Trust has assessed that the increase in fair value is off-set by the reduction in the number of future claimants.
iii) 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.

27.2 NHS Litigation provisions relating to the Trust

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

	£000s
As at 31 March 2012	84,612
As at 31 March 2013	86,870

28 Contingencies

The Trust has no contingent assets or liabilities.

29 Financial Instruments

29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. In respect to the Trust this is negligible as explained below:

The continuing service provider relationships that the Trust has with its commissioners (Primary Care Trusts) and the way these are financed, means the Trust is not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets are generated by day-to-day operational activities rather than being held specifically to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Strategic Health Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has no exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with commissioners, (PCTs) the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the trade and other receivables note 19.

Liquidity risk

The Trust's operating revenue is mainly from contracts with commissioners (PCTs), which are financed from resources voted annually by Parliament . The Trust manages its costs accordingly and funds its capital expenditure from funds obtained within its limit set by the Department of Health. The Trust is not, therefore, exposed to significant liquidity risks. However, over the last two years the Trust has generated insufficient surplus to finance its loan repayments and within its cash balance is £7m towards the cost of constructing a new access road to Watford Hospital. Liquidity is weaker than the board of directors would wish, going forward this will be addressed through additional borrowing.

29.2 Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS		2,618		**2,618**
Receivables - non-NHS		2,209		**2,209**
Cash at bank and in hand		9,347		**9,347**
Total at 31 March 2013	**0**	**14,174**	**0**	**14,174**
Receivables - NHS		1,966		1,966
Receivables - non-NHS		1,291		1,291
Cash at bank and in hand		9,851		9,851
Total at 31 March 2012	**0**	**13,108**	**0**	**13,108**

29.3 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables		1,849	**1,849**
Non-NHS payables		2,622	**2,622**
Other borrowings		16,651	**16,651**
Total at 31 March 2013	**0**	**21,122**	**21,122**
NHS payables		566	566
Non-NHS payables		2,652	2,652
Other borrowings		20,823	20,823
Total at 31 March 2012	**0**	**24,041**	**24,041**

30 Events after the end of the reporting period

There are no post balance sheet events.

31 Related party transactions

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

The Department of Health is regarded as a related party. During the year theTrust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities and the transactions where over £0.5m are:

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
2012/13	**£000**	**£000**	**£000**	**£000**
Department of Health	8,315	1,300	0	176
Trusts				
East and North Hertfordshire NHS Trust	510	1,127	121	381
Hertfordshire Partnership NHS Foundation Trust	1,183	1,476	232	225
Hertfordshire Community Trust	971	1,049	279	570
Imperial College Healthcare NHS Trust	222	629	120	227
Primary Care Trusts (PCT)				
Barnet PCT	0	981	357	0
Bedfordshire PCT	0	1,353	83	0
Buckinghamshire PCT	0	997	0	11
Harrow PCT	0	2,783	0	58
Hillingdon PCT	0	5,721	0	53
NHS Hertfordshire	25	231,583	11	1,896
North East Essex PCT	0	641	7	15
Luton PCT	0	1,928	29	0
South East Essex PCT	0	6,395	320	0
Health Authorities				
East of England Strategic Health Authority	0	8,485	4	0
National Blood Authority	1829	23	10	3
Other Bodies				
NHS Business Authority	552	67	148	45
	13,607	**266,538**	**1,721**	**3,660**
2011/12	24,622	263,369	1,807	4,002

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

2012/13	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
HM Revenue and Customs	41,466	5,970	250	773
NHS Litigation Authority	6,746	0	0	0
Dept of Work and Pensions	24,637	0	2,122	628
Watford Borough Council	1,022	0	0	158
	73,871	**5,970**	**2,372**	**1,559**
2011/12	**72,692**	**4,410**	**2,092**	**710**

32 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	2012/13 Total Value of Cases £s	2012/13 Total Number of Cases	2011/12 Total Value of Cases £s	2011/12 Total Number of Cases
Losses	82,676	69	726,554	450
Special payments	15,129	46	14,701	31
Total losses and special payments	97,805	115	741,255	481

The number of losses recorded in 2011-12 is particularly high as it includes 366 cases (£363k) relating to injury cost recovery scheme (see note 1.4) that the Trust judged it will never receive.

33 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.

33.1 Breakeven performance

	2005/06 £000s	2006/07 £000s	2007/08 £000s	2008/09 £000s	2009/10 £000s	2010/11 £000s	2011-/12 £000s	2012/13 £000s
Turnover	209,199	218,248	232,967	241,684	254,308	260,398	266,716	278,230
Retained surplus/(deficit) for the year	(26,785)	(11,413)	2,495	4,405	(52,167)	1,180	5,269	(868)
Adjustment for:								
Impairments				0	57,866	6,178	(1,512)	2,811
Impact of policy change - donated assets							(100)	(39)
Other agreed adjustments	14,111	26,785	0	0	0	172	0	0
Break-even in-year position	**(12,674)**	**15,372**	**2,495**	**4,405**	**5,699**	**7,530**	**3,657**	**1,904**
Break-even cumulative position	**(26,785)**	**(11,413)**	**(8,918)**	**(4,513)**	**1,186**	**8,716**	**12,373**	**14,277**

i) Impairments are excluded from the break-even duty as they are "non cash impacting" in the year that they occur.

ii) In line with note 1.10 the Trust no longer maintains a donated asset reserve. Donations are credited to income, the extent that this differs from depreciation of donated assets (expense) improves the reported position. As this is not an operational activity it is excluded from the break-even duty.

iii) The "Other" agreed adjustments relates to the East of England Strategic Health Authority formal agreement in 2006-07 to adjust the Trust's breakeven duty over a 5 year period commencing from the 2006-07 financial year.

33.2 Interpreting breakeven performance

	2005/06 %	2006/07 %	2007/08 %	2008/09 %	2009/10 %	2010/11 %	2011/12 %	2012/13 %
Break-even in-year position as a percentage of turnover	(6.1)	7.0	1.1	1.8	2.2	2.9	1.4	0.7
Break-even cumulative position as a percentage of turnover	(12.8)	(5.2)	(3.8)	(1.9)	0.5	3.3	4.6	5.1

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

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

33.3 Capital cost absorption rate

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

33.4 External financing

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

	2012/13 £000s	2011/12 £000s
External financing limit	**11,196**	2,373
External financing requirement	**(2,368)**	(7,478)
Undershoot/(overshoot)	**13,564**	9,851

33.5 Capital resource limit

The Trust is set a capital resource limit by the Department of Health which it is not permitted to exceed.

	2012/13 £000s	2011/12 £000s
Gross capital expenditure	**12,558**	6,645
Less: book value of assets disposed of	**0**	0
Less: donations towards the acquisition of non-current assets	**(268)**	(327)
Charge against the capital resource limit	**12,290**	6,318
Capital resource limit	**22,537**	15,200
Underspend against the capital resource limit	**10,247**	8,882

The undershoot in external financing limit and underspend against capital resource limit is mainly due to planned capital investment that did not occur.

34 Third party assets

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

	31 March 2013 £000s	31 March 2012 £000s
Patients monies held by the Trust	**4**	3

West Hertfordshire Hospitals NHS
NHS Trust

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