West Hertfordshire Hospitals NHS
NHS Trust

annual report 2013/14

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Welcome

A message from our Chair Mahdi Hasan and Chief Executive Samantha Jones

Mahdi Hasan
Chair

Samantha Jones
Chief Executive

Welcome to our annual report for 2013/14

2013/14 was another busy year for our hospitals with our staff and volunteers working hard to provide our patients, as well as their families and friends, with the best possible safe care.

There have been many highlights, including the opening of new facilities, such as The Granger suite and our ambulatory care unit.

In addition, we have invested heavily in improving the quality and safety of the care we offer, for instance spending nearly £4 million to recruit an additional 160 new nurses for our wards.

We were delighted to welcome Dr Kate Granger (second right) to Watford Hospital in February 2014 to open our new elderly care unit, named the Granger Suite in her honour.

Improving the care we provide to our patients

We have also recorded a significant reduction in our mortality rate (Standard Hospital-level Mortality Indicator (SHMI)) which is down by 20% and in the number of cases of Clostridium difficile we had in our hospitals (down by 40%). Whilst we cannot be complacent, this is great news for our patients and a clear sign that the hard work of our staff is paying off.

We performed well against the vast majority of the standards the Government sets for hospitals, including ensuring that at least 95% of the patients who used our A&E services were treated, admitted or discharged within a maximum of four hours (we achieved 95.6%).

We have also been investing in our buildings with more than £16 million being spent to improve our wards, clinics, theatres and other areas where patients are treated, as well as behind the scenes, for instance in upgrading our water and electricity supplies.

Senior team changes

We have seen a significant number of changes to the senior team, including the appointment of a new Medical Director, Chief Nurse, Director of Finance and, more recently, Deputy Chief Executive. We have also appointed several new Non-Executive Directors.

This change, which means almost every member of the Board is new, has brought with it added energy, vigour, experience and commitment, which will help us build on our successes as we move forward.

'Onion' – peeling back the layers

Patient safety continues to be our number one priority and 'Onion', which sees us 'peeling back the layers' across our hospitals, has played a key role here. Focusing on the basics, combined with openness, honesty and candour, 'Onion' has led to hundreds, if not thousands, of positive changes over the year with staff feeling they can more easily influence the running of our hospitals and, fundamentally, raise any concerns they may have.

We also launched our new organisational development programme, which is called 'Developing our Organisation (DO)'. DO is based on our six new values – which were created in consultation with more than 600 patients and staff from across our hospitals.

Our values are: we involve others; we are all leaders; we are proud; we work in partnership; we are transparent; and, we add value.

DO has a number of strands which will help us to build the team we need to support us as we move forward. This includes a new values-based

appraisal system, which measures staff against our values and, critically, aligns their priorities with the Trust's, as well as those of their own department.

Our finances

We ended the financial year with a deficit of £13.4 million which included numerous unplanned costs, for instance an investment of more than £7.9 million to improve the safety of the care we provide to our patients.

2014/15 will be another difficult year financially with a planned deficit of £14 million, which includes making quality and cost improvement (efficiency) savings of £13.4 million.

Addressing our challenges

We have of course faced challenges in the year. Whilst many of these are historic, our staff have tackled them head on and, working together, we have set in place plans to address those that need a longer term approach. This includes how we further improve our cancer services following the failings which were identified in late 2013 and had led to the care of three patients being compromised.

Sustainable quality healthcare

Moving forward, we are working with our local NHS and social care partners on the 'West Hertfordshire strategic review' which aims to provide us with detailed information, analysis and recommendations to help make decisions about what needs to happen to deliver sustainable quality healthcare for people living in west Hertfordshire.

The review is being coordinated by Herts Valleys Clinical Commissioning Group and also includes Hertfordshire Community NHS Trust, Hertfordshire Partnership University NHS Foundation Trust and Hertfordshire County Council.

The outcome of the strategic review will allow us to develop our own clinical strategy, which will include agreeing, with appropriate public engagement and consultation, longer term plans for the future of our hospital sites.

Working in partnership

We have continued to work closely with a wide range of partners over the year, including with our local politicians, charities, support groups,

In 2013/14 we spent £3.9 million to recruit an additional 160 new nurses, including nurses from Spain and Portugal, pictured here

staff unions, educational institutions, GPs, patient groups and councils. The latter includes working with Watford Borough Council on the Watford Health Campus scheme.

We have also worked hard to build and develop relations with our national partners, including the NHS Trust Development Authority, Care Quality Commission, NHS England, Health Education England and many others.

In addition, we welcomed many high profile visitors to our hospitals, including Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Ed Miliband MP, Leader of the Opposition and Julie Bailey CBE, founder of Cure the NHS.

We would like to end this message by thanking our staff and volunteers for their ongoing support and commitment. They work very hard and are the backbone of our organisation.

A special 'thank you' lunch was held to acknowledge the commitment of 400 volunteers who donated an amazing 140,000 hours in 2013/14 to help us run our hospitals at Watford, St Albans and Hemel Hempstead

Our services

West Hertfordshire Hospitals NHS Trust is a large acute trust providing hospital services to 550,000 people living in Hertfordshire, north London and further afield. We are one of the largest employers locally, with around 4,300 staff and 550 volunteers. We run services across three sites at Watford, St Albans and Hemel Hempstead.

Watford Hospital

Watford is at the heart of our acute emergency services. The clinical services offered include:

- women and children's services, including a consultant-led delivery unit, midwife birthing unit, antenatal and postnatal clinics;
- emergency care, including A&E (accident and emergency), acute admissions unit, ambulatory care 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 (UCC);
- 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 Hospital

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

- antenatal and community midwifery;
- outpatients;
- minor injuries unit (MIU);
- elective and day surgery;
- sexual health;
- clinical support, including x-ray, ultrasound, mammography and blood and specimen collection.

In 2013/14:

- 5,787 babies were born at Watford Hospital, cared for by our team of 200 midwives;
- A total of 127,200 patients attended our A&E department at Watford (83,433), the urgent care centre at Hemel Hempstead (29,356), and the minor injuries unit at St Albans(14,411);
- 425,813 patients attended outpatient appointments at our hospitals;
- There were 41,415 elective admissions;
- 49,934 people were treated as an emergency admission;
- 279,729 people used our website.

5,787 babies were born at Watford Hospital in 2013/14

Our achievements

2013/14 brought significant challenges, many successes, and most importantly provided new insight and inspiration into how we can change the way we work in order to improve every aspect of the care we provide so that our patients' experience of our hospitals is the very best that it can be.

We have worked hard to achieve the key objectives which we set ourselves last year, which were to improve the quality, deliverability and sustainability of our services through:

- achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas;
- setting out our future clinical strategy through clinical leadership in partnership and with whole system working;
- creating a clear and credible long term financial strategy.

Our new leadership team is 'peeling back the layers'

With a new leadership team in place, including a new Chair and four new Non-Executive Directors, as well as new Executive Directors, 2013/14 year was very much about reviewing how we work right across the Trust, and looking to see how we can do things better in order to improve the way we care for our patients on a day-to-day basis.

'Onion'

"What can we do today to make a difference to our patients now?"

Samantha Jones, Chief Executive

'Onion' (peeling back the layers) was born last year out of our commitment to respond to the Francis Report and is our way of enabling voices to be heard - those of our patients and their families, and our staff - and challenging what might have been 'the norm' yesterday to deliver a better experience if not today, then definitely tomorrow.

'Onion' has been commended in the Government's response to the Francis Report review and we have been invited to speak at European and other international conferences about the benefits it is bringing for our patients.

The daily 'Onion' meeting at Watford Hospital

All staff are welcome to attend 'Onion' sessions. At Watford Hospital, these are held every morning when the executive team meet with doctors, nurses, frontline staff and senior managers. Concerns are raised, particularly around patient safety, patient experience and other operational issues, and solutions are found to solve problems, both in the short and long term. Similar meetings are also held at St Albans and Hemel Hempstead hospitals, on a monthly basis.

'Onion': What have we done differently over the past year?

Some key achievements:

- Opening of a new emergency surgery assessment unit;
- Improving our patients' experience in the discharge lounge by increasing the number of staff on duty, by having hot meals available, and a supply of spare clothing for those patients who do not have appropriate clothes in which to travel home;
- The purchase of new wheelchairs;
- Better physio and occupational therapy provision on the wards, and better multi-disciplinary working;
- Increased provision of syringe drivers;
- Support and focus for clinic preparation;
- Improved mattresses on A&E trolleys.

Our team of physiotherapists and occupational therapists offer support to a range of services including stroke, respiratory, elderly care and orthopaedics

Ambulatory Care Unit (ACU)

A new ambulatory care unit at Watford Hospital was established in 2013/14 which is helping to speed up the time it takes for patients to be treated in an emergency and helping to reduce the number of people who are unnecessarily admitted to hospital.

The brand new unit, which opened in January 2014 following an investment of £1.4 million, means that patients who would previously have been admitted to hospital are now able to be diagnosed, treated and discharged on the same day.

The types of patients who are seen on the unit are often people who require quick assessment for conditions like anaemia, deep vein thrombosis (DVT), asthma and cellulitis (a common skin infection).

The ACU opened its doors on 19 January 2014

Improving care for the elderly and people with dementia

A new care of the elderly unit at Watford Hospital was officially opened in February 2014 by Dr Kate Granger, a doctor from Yorkshire who is living with a rare and aggressive type of cancer.

Dr Granger is well known within the NHS for blogging about her illness and for launching a national social media campaign called *"#hellomynameis…"* which aims to break down the barriers between healthcare professionals and the patients they care for.

The new elderly care unit, known as The Granger Suite, treats around 75 patients every month. It consists of two wards - Bluebell which provides care to frail elderly patients who also have dementia, and Winyard which is an elderly care ward, dedicated to the memory of Jessie Winyard, a former Chair of our Patients' Panel (a group which represents the views of patients).

Opening of the Emergency Surgery Assessment Unit (ESAU)

A dedicated rapid assessment area for emergency patients who may need surgery, including vascular, urology and breast, has been established at Watford Hospital. This will ensure that patients are seen and assessed more quickly and decisions made on whether a patient needs an operation are taken sooner.

Consultant appraisals and revalidation

In 2013/14, we worked with the General Medical Council to review the systems and processes we had in place to comply with new requirements for the appraisal and revalidation of our consultants. As a result, we are pleased to report that we now have one of the highest appraisal rates for consultants in the country. This work will continue in 2014/15 to ensure that every consultant has an appropriate appraisal and undergoes revalidation when appropriate.

Welcoming our colleagues from the Department of Health

Jeremy Hunt MP, the Secretary of State for Health, visited Watford Hospital in April 2013 and spent three hours meeting staff and patients in the A&E department, Flaunden ward and theatres, hearing their views on the NHS and their hospital experiences.

The Health Secretary spent time with staff from all areas and levels of the organisation. He was keen to discuss the achievements and challenges of the Trust and their opinion on what could be done in the future to improve the NHS, both for patients and staff.

We were also delighted to host a week long 'Back to the Floor' volunteering placement in August 2013 for five senior representatives from the Department of Health (DH).

Each member of staff from DH worked for five days in a variety of different departments, including A&E, outpatients, pharmacy and physiotherapy. Their feedback was very positive, in terms of both the experience they had on the 'frontline' and the varied programme organised for them.

Improving the hospital environment and infrastructure

In October 2013, £16 million was secured from the Department of Health to tackle backlog maintenance across all three of our hospital sites, with £6 million spent on improvements to the environment and infrastructure in 2013/14.

These include substantial refurbishment and modernisation of our four main operating theatres, and the corridors and communal areas at Watford and at the St Albans site (Gloucester Wing). Toilet facilities have also been adapted to improve wheelchair access.

In our radiology department at Watford Hospital the CT/MRI waiting room and corridor have been refurbished with new seats and tables. Artwork on the walls has also been installed, an initiative which came from listening to patients who gave feedback in our cancer survey. Upgrades have also been carried out to our heating plant, recycling and medical gas facilities, as well to lifts and electrical systems.

The launch of our cycle hub

Three-time Olympic medallist and double track world cycling champion Rob Hayles unveiled new specially-made cycling facilities at Watford Hospital in February 2014.

The hospital now boasts a unique, custom built combined shower and changing unit, located next to brand new secure bike storage 'pods', a bike repair stand, and a tyre pump.

New cycling facilities were opened in February

The project forms parts of the Trust's commitment to sustainability, encouraging patients, visitors, doctors, nurses, midwives and other staff to cycle to the hospital. The new facilities were funded through a £31,000 grant from Hertfordshire County Council and £5,000 from public donations to the Trust's charitable fund. Additional facilities for cyclists have also been introduced at Hemel Hempstead and St Albans hospitals.

Dietetic kitchen to help people with diabetes

A new dietetic educational kitchen was officially opened at Watford Hospital in December 2013. The kitchen, one of the first of its kind in the country, was created and developed to help educate patients with diabetes on the different ways in which they can control their own weight and blood sugar levels.

A new dietetic kitchen was opened in December thanks to a donation from The Michael Green Foundation

The £10,000 needed to make this new important facility a reality was donated by The Michael Green Foundation, a charity set up by the family of local man, Michael Green, who passed away in December 2012, aged just 53, from a heart attack due to type 2 diabetes.

Refurbishment of theatres

Following a £600,000 investment this year, the operating theatres at Watford Hospital are now able to provide a better working environment for staff and a better patient experience. The refurbishment included new lighting, flooring, wall coverings, patient monitors and improvements in the provision of medical gases.

£600,000 was spent refurbishing the operating theatres at Watford Hospital

Our performance

Working to provide good and safe patient care

Our work with our partners remained strong in 2013/14 and we will continue to work closely with primary, community and secondary care partners to ensure service provision meets the needs of our patients and is seamless through all settings.

Our key partners included Herts Valleys Clinical Commissioning Group, which commissions more than 96% of our activity, other clinical commissioning groups and the NHS Specialist Commissioning Group, which commission all specialised services from the Trust. With the support of our commissioners, the Trust will continue to place the patient at the centre of all planning discussions in 2014/15.

Our performance is monitored by the Herts Valleys Clinical Commissioning Group, the Department of Health and the Care Quality Commission. The core group of indicators and measures used by each body and the Trust's performance against these is summarised below.

Table 1: Trust's performance

Indicator	National standard	Performance	Actions being taken to improve performance
At least 95% of patients should be treated, admitted or discharged in a maximum of 4 hours in A&E	National target was for over 95% patients to be within 4 hours (95.6%)	Achieved	
Incidence of C. difficile should be identified and numbers minimised	Trust target was to have fewer than 24 cases of C. difficile through the year (28 cases recorded)	Under achieved by 4 cases	• Antimicrobial stewardship rounds • Continue to audit compliance to antibiotic guidelines • Audit availability of hand hygiene facilities in clinical areas • Launch new hand hygiene campaign
Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have zero cases	Under achieved by 3 cases	• Roll out blood culture collection training and competence to all staff who take blood cultures • Monitor blood culture contamination rates • Review blood culture policy
All cancers – patients should have a maximum wait of 14 days for all urgent referrals of suspected cancer and referrals for breast symptoms	National target was to see 93% of those referred within 14 days. (Urgent referrals: 95.8%. Breast symptomatic patients: 91.6%)	Under achieved	A comprehensive action plan has been developed to ensure improved performance against all cancer standards and pathway.
All cancers – patients should have a maximum wait of 31 days for diagnosis to first treatment	National target was to have 96% of patients seen within 31 days (98.1%)	Achieved	
All cancers – patients should have a maximum wait of 62 days between urgent GP referral or screening service to first treatment	National target was to see 90% of those referred by the screening service (89.9%) and 85% referred by GPs (85.3%)	Under achieved	
All cancers – patients should have a maximum wait of 31 days for second or subsequent treatment	National target was to have 94% patients seen within 31 days for surgery and 98% for anti cancer drugs. (Surgery: 99.0%, anti cancer drugs: 100%)	Achieved	
Maximum wait time of 18 weeks referral to treatment – admitted patients treated	>90% (78.0%)	Under achieved	A detailed action plan is in place to recover waiting times against all 18 weeks patient pathway.
Maximum wait time of 18 weeks referral to treatment – non admitted patients treated	>95% (85.0%)	Under achieved	
Maximum wait time of 18 weeks referral to treatment – patients not yet treated	>92% (78.5%)	Under achieved	

In 2013/14 we met our target for treating patients within a maximum of four hours in A&E

A&E

Against a very challenging climate, we achieved the national target (95%) for treating, admitting or discharging all patients within a maximum of four hours in 2013/14. This was an improvement on the previous year's performance, when we also achieved the national target.

Hospital infections

We recorded 28 cases of C. difficile in 2013/14, a 48% reduction compared to the previous year and a 94 percent decrease compared to 2007/08. Despite this improvement, the reported number of hospital attributed cases was above the agreed threshold for the year (24 cases).

Meticillin-resistant staphylococcus aureus (MRSA)

In 2013/14 three recorded cases of hospital acquired MRSA bacteremia were recorded. The Trust had set itself a challenging target of zero cases for the year so this indicator was not achieved.

Mortality rates

Low hospital mortality (death) rates are a recognised indicator of safe and effective clinical services. In 2013/14, we achieved a marked drop of 20% in our crude mortality rates, bringing us in line with expected limits.

In July 2013, we instigated a number of specific measures to improve our mortality rates in patients who have suffered a hip fracture (fractured neck of femur). This included ensuring that we adhere to national guidelines at all times and that patients are:

- Reviewed by a multi-disciplinary team (of doctors and nurses) before they undergo surgery;
- Anaesthetised and operated on by senior clinicians;
- Given appropriate time to recover after their operation (before returning to their ward);
- Seen by a specialist doctor in the days after their operation.

In addition, we recruited a nurse who specialises in caring for patients who have suffered a hip fracture and set up a dedicated committee of specialist doctors and nurses to regularly review the care provided to these patients. We are pleased to report that these measures resulted in the mortality rate for patients with a fractured neck of femur dropping by more than 4%.

Cancer waiting times

Cancer waiting time performance was better than target for all 31 day targets, the 62 day GP target and the 14 day urgent referral target. The 62 day cancer target for screening and 14 day breast symptomatic targets were not achieved. Improving cancer waiting times remains a priority and work is continuing in order to reduce waiting times for cancer services in 2014/15.

Cancer review

In 2014 we began a review of cancer two week pathways following a serious incident being raised about the application of NHS administrative rules for patients referred with suspected cancer.

The review highlighted a number of serious deficits concerning the administrative management of patients who did not attend their appointment and were not offered a second appointment, contrary to national guidelines.

We reviewed the notes of 810 patients who had not been correctly followed up, and contacted all of them, or their families, to inform them of the error. Of the 810 we believe that the care of three patients was compromised as a result of the error.

We have apologised to all those patients whose care was reviewed as part of the investigation, and offered them support, with the help of Macmillan Cancer Support.

A full clinical and administrative investigation was undertaken with lessons learned used to improve the measurement and management of all cancer pathways.

18 weeks referral to treatment

In 2013/14 our referral to treatment performance was below the national operational standards. An 18 week improvement plan has been established to deliver additional activity. This will reduce patient waiting times and ensure that we meet the 18 week waiting time standards. Additional capacity will be created internally and also by the support of selected third parties. All outsourcing decisions will occur in collaboration with clinicians to ensure arrangements are clinically appropriate and safe.

Stroke services

Despite our stroke service seeing a year of increased activity, it has achieved all performance targets relating to stroke, apart from patients being admitted to the stroke unit within four hours. Meeting this target next year will be a priority.

A 24/7 senior nurse stroke outreach service has been developed, which has significantly improved patient outcomes. The service is available all

Cases of the infection C. difficile dropped by 48% this year

day, every day and means that any patients who come in through A&E with signs of a stroke or high risk transchemic attack (mini stroke) are seen and assessed on arrival with thrombolysis treatment begun immediately, if appropriate.

Paediatric emergency/urgent care

This year we have been part of the emergency and urgent care project group, which was launched in December 2013 by Herts Valleys Clinical Commissioning Group. The aim of the project is to improve the experience and outcomes for children and families using urgent and emergency care services. A whole system consistent approach is embedded across primary and secondary care and other partners in order to reduce the incidence of inappropriate attendances in the emergency care department for children and young people.

Care Quality Commission inspection

The Care Quality Commission (CQC) visited Watford Hospital in December 2013 to carry out a routine unannounced inspection.

The feedback we received from the CQC highlighted many strengths, including that our patients are treated with respect and are involved in discussions about their care and treatment. They also said that our patients are able to influence how services are managed and that the organisation is well run.

In addition, the CQC reported good feedback from the patients they met, with often very complimentary remarks about the attention and attitude of our staff towards them.

Unfortunately, the CQC raised a number of minor concerns, including in relation to staffing, the control of infections, record keeping and the way in which we manage risk.

As a result, we submitted a detailed action plan to the CQC which was shared with our Trust Board and partners.

We were already aware of many of the issues raised by the CQC and work was underway to address them, including extra investment in nurses. We were also in the process of making significant changes to the way we prevent and control infections, with a specific focus on ensuring our cleaning teams meet the highest possible standards. We have also put in place new training for our staff and our senior nurses undertake formal spot checks to ensure our wards and clinics are clean.

Sustainability

We are committed to embedding sustainable practices across our hospitals and have a robust, Board approved, Sustainable Development Management Plan in place. We use the Good Corporate Citizen Model to benchmark our performance. Over the last year our score has gone from 20% to 43%, which is a significant achievement.

We are signed up to the carbon reduction commitment scheme, and although our use of carbon has increased this year, this is largely due to the increase in activity and the opening of our new ambulatory care unit.

Table 2: Commitment scheme

Resource		2011/12	2012/13	2013/14
Gas:	Use (kWh)	38026702	38360183	43105544.52
	tCO2e	7770.756554	7838.903396	9144.410214
Oil:	Use (kWh)	73294	31669	26423
	tCO2e	23.3697919	10.09766065	8.43818505
Coal:	Use (kWh)	0	0	0
	tCO2e	0	0	0
Electricity:	Use (kWh)	16547671	17757522	17699074
	tCO2e	9273.314828	10136.17113	9909.888523
		17067.44117	17985.17219	19062.73692
Total energy spend		£2,770,832.00	£3,058,695.00	£3,276,355.99

(Department of Health)

Key activities this year included:

- Provision of facilities for cyclists at the Watford, Hemel Hempstead and St Albans sites (noted in the new national strategy document);
- Grant funding for electric car charging provision;
- Movement to an energy efficient off-site data store of all IT storage;
- Improvements to the building fabric;
- Procurement of new theatre lights that use half the carbon of the old ones;
- Ambulatory care model which brings reduced inpatient stays;
- A procurement initiative that recycles all shrink wrap from deliveries, the Trust is only one of three in the country doing this;
- Centralisation of pharmacy procurement that reduces deliveries to our hospitals;
- Acceptance onto a national inhaler recycling programme;
- We are retrofitting high efficiency motors as motor failures occur;
- Replacing the wall finishes in some areas of Watford and St Albans hospitals, so that they are more reflective and brighter, also reducing maintenance costs;

- The choice of a light grey finish on some of the roof surfaces at Watford will reduce the overall "heating" effect during the summer months;
- We have improved the recycling rates and the recent change from the old "estates" yard to a modern segregated recycling facility will improve our recycling profile further;
- Consultant assessment at the front door;
- Ambulatory care to treat patients as outpatients rather than inpatients;
- A duty clinician in elderly care with access to immediate clinics to avoid unnecessary admissions and support early discharges;
- Provide advice to community health care providers so that they can treat patients in the community.

New cycling facilities at St Albans Hospital include showers and a bike repair stand

Care closer to home and reducing patient travel for care examples include:

- Repatriating care to our hospitals from central London hospitals;
- Diabetes patients have their own glucose monitoring machines and can contact specialist nurses for advice on their self care management;
- Clinical navigators are in post to prevent unnecessary admissions and to support patient care in the community through links to services for their care provision;
- Working with community partners to review patient pathways for patients with specific long term conditions.

PLACE - patient led assessment of the hospital care environment

PLACE is the new inspection regime introduced in 2013 to measure the quality of the hospital environment in which care is delivered. The inspection is carried out with patients and falls into four main categories: cleanliness; food and hydration; privacy, dignity and well-being; and condition, appearance and maintenance.

Table 3: Our scores were:

	Cleaning	Food and hydration	Privacy, dignity and well-being	Condition, appearance and maintenance
Watford Hospital	97.01%	87.21%	80.07%	89.60%
St Albans Hospital	95.14%	88.71%	72.37%	87.70%
National average	95.81%	85.31%	88.97%	88.89%

Principles of remedy: dealing with complaints and compliments

We adhere to the Parliamentary and Health Services Ombudsman's Principles for Remedy, which provide guidance on the way public bodies respond to complaints and concerns raised by patients and members of the public.

Those principles are:

Getting it right

- Quickly acknowledging and putting right cases of maladministration or poor service that have led to injustice or hardship;
- Considering all relevant factors when deciding the appropriate remedy, ensuring fairness for the complainant and, where appropriate, for others who have suffered injustice or hardship as a result of the same maladministration or poor service.

Being customer focussed

- Apologising for and explaining the maladministration or poor service;
- Understanding and managing people's expectations and needs;
- Dealing with people professionally and sensitively;
- Providing remedies that take account of people's individual circumstances.

Being open and accountable

- Being open and clear about how we decide remedies;
- Operating a proper system of accountability and delegation in providing remedies;
- Keeping a clear record of what has been decided on remedies and why.

Acting fairly and proportionately

- Offering remedies that are fair and proportionate to the complainant's injustice or hardship;
- Providing remedies to others who have suffered injustice or hardship as a result of the same maladministration or poor service, where appropriate;
- Treating people without bias, unlawful discrimination or prejudice;
- Operating a proper system of accountability and delegation in providing remedies;
- Keeping a clear record of what has been decided on remedies and why.

Putting things right

- If possible, returning the complainant and, where appropriate, others who have suffered similar injustice or hardship, to the position they would have been in if the maladministration or poor service had not occurred;
- If that is not possible, compensating the complainant and such others appropriately;
- Considering fully and seriously all forms of remedy (such as an apology, an explanation, remedial action, or financial compensation);
- Providing the appropriate remedy in each case.

Seeking continuous improvement

- Using the lessons learned from complaints to ensure that maladministration or poor service is not repeated;
- Recording and using information on the outcome of complaints to improve services;
- There are no automatic or routine remedies for injustice or hardship and such remedies need to be considered on an individual basis and will include actions such as an apology or explanation, changing a decision, revising public documentation and training or re-training staff.

Learning from complaints and compliments

Patient Advice and Liaison Service

Our Patient Advice and Liaison service (PALS) continues to be an integral part of the service we provide to our patients, relatives and carers, acting as a vital channel for feedback. PALS provides a professional, friendly, sensitive service and tries, wherever possible, to offer on-the-spot support to help resolve any problems. In 2013/14, the PALS team dealt with a total of 2,179 reported concerns, 6% less than last year.

Formal complaints

In 2013/14, we received 619 formal complaints representing an increase of 16.5% on the previous year, which reflects our increased activity levels. In addition, 186 enquiries were received from GPs, MPs and patients who did not wish to make a formal complaint but who wanted to make the Trust aware of their experiences.

The percentage of complaints responded to within the required time frame of 20 working days was only 54%, and improving this response rate will be a key focus for us over the coming year.

The most common complaints received related to clinical practice, communication, appointments/assessments/waiting times, staff attitude and nursing care.

In order to support staff in responding to complaints a training programme was developed in conjunction with the University of Hertfordshire and while this is aimed at staff who have direct responsibility for investigating complaints, it is open to all staff who may be involved in dealing with complaints.

Freedom of Information requests

We received 493 Freedom of Information requests in 2013/14. This is a significant increase on the year before of 48%, with half of the requests coming from the media.

Unfortunately two of the requests were not completed on time, therefore a total of 99.6% were responded to within the 20 working day time frame. Our aim for next year will be 100% compliance.

Management of risk

We are committed to continually improve risk management across all our divisions and departments. Two risk summits in May and July 2013, together with an unannounced visit by the Care Quality Commission in December 2013, have driven a renewed focus on issues that support improvements both in the management of risk and in patient safety.

This year additional members of staff have been recruited to the quality governance team, leading to a much higher profile of risk management across the Trust. This has served to ensure support is given at local level to review practice, comprehensively investigate incidents, and check and develop risk registers as a vehicle for monitoring and controlling risk. A clearer process around the management of incidents and serious incidents has given staff the confidence to report all incidents, with the resulting investigation demonstrating clearly the link between robust action planning, amending practice and mitigating risk.

All staff receive training on risk management at their induction, enabling them to fulfil their individual responsibility to protecting themselves, others and the organisation from risk.

For further information of risk management without our hospitals, please see the Annual Governance Statement on page 34.

Serious incidents

Our risk management policy ensures that all serious incidents are identified, reported and investigated, that immediate risks are managed and that timely action is taken. This is supported by the implementation of any recommendations following investigation and dissemination of learning across our three hospitals.

In 2013/14, we declared a total of 149 serious incidents which includes two 'never' events (eg something that should never have happened) one relating to 'wrong site surgery' and one to 'a retained swab during surgery'. For a breakdown of serious incidents see the Annual Governance Statement on page 34.

Our serious incident reporting and investigation process has been further aligned with the National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation 2010, and the NHS Commissioning Board Serious Incident Framework 2013. All internal and external incident investigations are completed using our formal root cause analysis template and the National Patient Safety Agency's toolkit.

During the latter part of the year, a significant overhaul of our serious incident process was undertaken, which has resulted in improved compliance with the national framework, and more robust investigations. It is expected that this will be strengthened further with the planned creation of a quality governance directorate, which will not only help embed a strong safety culture into our organisation, but also facilitate the need to learn lessons to minimise the number of serious incidents occurring in the future.

Counter fraud and corruption

We have a formal counter fraud and corruption policy which is available on both the Trust's website and on our intranet.

Register of gifts

Our staff are not expected to accept gifts offered to them. There is a limited set of exceptions and if gifts are accepted, staff are expected to declare them. A register of gifts and hospitality and entertainment received is available on our internal intranet site.

Information technology

Work continued throughout 2013/14 on creating a digital hospital environment, exploiting new technology to enable service transformation and improve patient experience.

Significant progress has been made this year on transforming our outdated information, communications and technology (ICT) infrastructure. This project, which is called 'make IT happen' will form the foundation for future improvements to our clinical and business information systems bringing tangible and long-lasting benefits to both patients and staff.

As well as investing to replace computers and other IT equipment, the project will put in place more reliable IT support services including a new 24/7 helpdesk for nurses, doctors and other staff who have IT problems. It will also deliver faster networks, improved telephone systems and increased IT security to support staff caring for patients and share information quickly and securely.

In parallel with this work, a number of projects have been completed which have focussed on delivering more immediate improvements:

- Patient tracking screens have been deployed in the A&E department;
- Electronic patient handovers have been introduced to support clinical teams;
- Technology has been implemented to support paperless Board meetings;
- Upgrading IT software so that staff can work more efficiently.

Our patients

Working with patients, carers and families to improve the experience of all patients using our hospital services

One of our key priorities for this year has been finding new ways of engaging with our patients, carers and families – so that we can identify together what is good, and what is not so good, and work to improve the experience of all patients using our services.

We do this in partnership with a variety of local organisations including Herts Valleys Clinical Commissioning Group, other NHS providers, Hertfordshire Healthwatch, the Patients Association, and our own Patients' Panel.

We involve patients in a number of different ways – through surveys, through the complaints and compliments we receive, as well as engaging fully via social media sites so that patients can give us feedback directly – for example on NHS Choices, Patient Opinion, Twitter – and via our website.

Inpatient survey

The Care Quality Commission published the results of its 2013 inpatient survey in early April of this year. The survey included 772 patients who used our hospitals in August 2013.

The survey, which applies to all hospitals across England, covers all of the different elements of a patient's time with us, from their initial admission through to their discharge home. The report was split into ten categories and compared to all other trusts nationally, we were 'about the same' for all of them (on a scale of 'better', 'about the same' or 'worse').

Our scores for the categories were:

- A&E department (emergency patients only) (we scored 8.2 out of 10);
- Waiting list and planned admissions (8.6/10);
- Waiting to go to a bed (7.8/10);
- Hospital and ward (8.1/10);
- Doctors (8.3/10);
- Nurses (8.2/10);
- Care and treatment (7.4/10);
- Leaving hospital (8/10);
- Operations and procedures (7/10);
- Overall views and experiences (5.3/10).

Within the ten categories, the areas where we did particularly well were:

- Patients saying we had not changed their admission date (we scored 9.3 out of 10);
- Patients saying they were treated with respect and dignity (9/10);
- Patients not feeling threatened by other patients or visitors during their stay (9.7/10);
- Hand wash gels being available (9.6/10);
- Patients being given enough privacy when being examined (9.5/10).

Importantly, our patients also reported that they had confidence and trust in our doctors and nurses, scoring us as 8.7 and 8.6 out of ten respectively.

The survey did show several areas where we need to improve, when comparing our performance with other hospitals. These are:

- Patients reporting noise from other patients (5/10);
- Patients reporting noise from staff on the ward at night (7.2/10);
- Patients feeling they were not given an explanation of what would happen during their operation or procedure (8/10);
- Patients feeling they were not given an explanation of how their operation or procedure had gone (7.2/10).

We are working with our staff, as well as our patients and patient representatives, to improve our results in all areas, especially those where we were not so strong.

Friends and Family

Figures published in August 2013 showed that the vast majority of patients who received care at Watford, St Albans and Hemel Hempstead hospitals would recommend us to their friends and family.

96% of patients who completed the Friends and Family test said they would recommend our hospitals

During July, 616 of our patients completed the Government's new NHS Friends and Family Test to rate our hospitals, with 470 patients (76%) saying they were 'extremely likely' and 125 (20%) 'likely' to recommend our wards and A&E services to their friends and family if they needed similar care or treatment.

Maternity survey

The results of an independent survey of maternity care across the country has shown that the majority of mothers who used our services in 2013 are happy with the care we provided.

Figures from the Care Quality Commission's 'Survey of women's experiences of maternity services 2013' show that the vast majority of new parents felt they were treated with respect and dignity (we scored 9.2 out of a possible 10) and were spoken to in a way they could understand during labour and birth (scoring 9.2 out of 10).

The Patients Association

We are a member of the Patients Association and in 2013 we jointly commissioned a project, 'Shaping the Future of Patient Engagement in west Hertfordshire'.

As part of the project, a workshop was held in November 2013 with patients, carers and staff. The aim was to create a shared overall picture of current patient experience, and to identify areas to be improved. The themes which emerged from this first workshop were around volunteering, patient communication, customer care and our patients' experience of arriving at hospital. A further workshop is planned for

The Care Quality Commission's inpatient survey carried out in August 2013 showed that 9/10 of our patients said they were treated with respect and dignity

next year to follow up on what has been done to improve the patient experience in these areas.

As part of this work, we have also been engaging with local schools so that the views of younger people in the local area can also be heard. This includes working with pupils from Hemel Hempstead School, and also with Kings Langley Secondary School whose students have also created artworks for display in our hospitals.

Working in partnership with Healthwatch Hertfordshire

Healthwatch Hertfordshire, the independent consumer champion for health and social care in our county, launched in April 2013. They represent the needs of everyone who uses health and social care services.

We are now working closely with Healthwatch in areas like patient information, equality and diversity, patient and public involvement panels, the 15 steps challenge, PLACE inspections, the physical and sensory disability forum, and the lesbian, gay, bisexual and transgender partnership (LGBT), as well with our own patient experience group.

Patient stories

Patients are regularly invited to our Board meetings to share their personal stories about their experiences of being an inpatient or carer in our hospitals.

The session is lead by our Chief Nurse and Board members are given an opportunity to ask questions. All of the stories are fed back to the wards and departments so that the experiences can be shared with frontline staff who can effect change and carry out service improvements, where necessary.

Patients' Panel

The Patients' Panel continue their invaluable work as 'critical friends', working on projects such as the 15 steps challenge and PLACE training and inspections, as well as being important members of our patient experience group; patient and public involvement panel; bowel cancer task force; equality and diversity and service improvement group, among others.

The Chair of the Patients' Panel is also involved with the appraisal of the Chief Executive, and with the recruitment of senior managers.

Patient Opinion

This year, we registered with the online service Patient Opinion which allows us to hear 'real time' and first hand patient feedback on our services, and to respond directly. We can then go on to share this with staff in our wards and departments.

In the last year, the Trust has received over 100 messages from Patient Opinion, all of which have provided invaluable feedback for us.

NHS Choices

We also gather both positive and negative instant feedback from our patients and carers by using the online NHS Choices website.

NHS Choices offers patients a wealth of information about conditions and treatments, lifestyle tips, tools for professionals and the workings of the NHS. It also allows people to rate their experiences of our hospitals from one to five stars.

In the last year the our hospitals received 161 comments on the NHS Choices website, with 66 relating to Watford, 67 to St Albans and 28 to Hemel Hempstead.

Twitter

This year we have fully engaged with the social media site Twitter. As well as a Trust account, various members of our executive team have their own individual Twitter accounts.

Equality and diversity

The Trust published its second Public Sector Equality Duty Report for 2013. In partnership with Hertfordshire Community NHS Trust we continued to embed equality and human rights into our core business processes during 2013/14. We carried out a review of progress against our equality objectives and continued to build long-term relationships with various groups in the community.

Our staff

2013 NHS Staff Survey

The annual NHS staff survey is invaluable in helping us to understand what staff think of the way we support, engage, train and develop them.

The 2013 national staff survey was conducted in the autumn and 1,743 members of our staff took part (44% - up from 38% last year), with the results published in February 2014.

Our results show that we have made improvements in a number of areas, including the percentage of staff that would recommend our organisation as a place to work or receive treatment (up by 4%).

We have also seen a significant increase in the number of staff who say:

- Care of patients is our top priority – rising from 64% in 2012 to 73% last year;
- We act on concerns raised by patients – rising from 66% to 74%;
- If a friend or relative needed treatment, they would be happy with the standard of care provided – rising from 53% to 57%.

In addition, the percentage of staff reporting good communication between senior management and staff is above the national average (32% compared to 29%).

However, we were still ranked as being below average for a number of areas (when compared to other hospitals). Overall, we were in the bottom 20% of all hospitals nationally in ten areas, including the percentage of staff:

- Experiencing harassment, bullying or abuse from staff in the last 12 months;
- Saying hand washing materials are always available;
- Saying they had a well structured appraisal in the last 12 months.

In addition, there were three areas where we saw a decrease in our score, including the percentage of staff believing the Trust provides equal opportunities for career progression or promotion, staff job satisfaction, and the percentage of staff receiving health and safety training in last 12 months.

We have developed a detailed action plan to address each and every area of concern, and started to address many of the issues raised.

Training and development

"Our values underpin everything that we do as an organisation – from the way we care for our patients to the way we work with each other."

Samantha Jones, Chief Executive

During 2013/14, we worked with more than 600 staff and patients to develop a new set of values around a new 'Developing our Organisation' (DO) initiative. This will guide how we recruit, induct, develop and manage our staff in the future and how we in turn provide services and care to our patients.

The six values are that we:

- **Involve** others;
- Are all **leaders**;
- Are **proud**;
- Work in **partnership**;
- Are **transparent**;
- Add **value**.

These values form the basis of a new appraisal system for all staff to be introduced in 2014/15.

We involve others: in all that we do our patients, their families and carers are involved and their voices are clear and influential.

We are all leaders: we value our teams and we value each other, investment is made in all of us because, in our own way, we are all talented and we all lead.

We are proud: we are proud of our hospitals and ambitious when it comes to the quality of our services and calibre of staff we employ.

We work in partnership: we work together as part of a bigger team with people within and outside our hospitals to join things up for individual patients and the wider community.

We are transparent: it's safe to admit mistakes and speak out when things don't seem right, this helps us learn and improve.

We add value: through being innovative and spending our time on the things that matter we each add value and continuously look to improve what we do.

More than 117 doctors, nurses and support staff, totalling 3,000 years of service at Watford, Hemel Hempstead and St Albans Hospitals, were honoured at a long service awards ceremony in March 2014

Throughout the year there have been many other initiatives across our hospitals aimed at improving retention, for example, staff training and development programmes.

On our neonatal unit, a 'growing our own initiative' has been introduced for band five nurses, which involves in-house training and development, with support in the clinical area, so that staff can achieve competences to look after babies needing high dependency levels of care. On completion of this course the nurses will be eligible to apply for band six posts.

Communicating with staff

Empowering staff through good communication is key to our success as an NHS Trust. This year has seen the introduction of a number of new ways for our staff to get involved, ask questions, raise concerns or simply have open conversations with our Chief Executive and other senior members of our management team across all three sites.

These include:

Meet the Chief Executive: a monthly opportunity for all staff to meet informally with the Chief Executive and share views, opinions and ask questions about all aspects of our work.

Senior Team Brief: the Chief Executive briefs the 130 most senior managers at a monthly meeting. From this meeting, the senior managers then cascade this information to their own staff, giving them the chance to ask questions about all aspects of our work which is then fed back at future Senior Team Briefs.

TalkTime: a weekly hour session in the restaurant, open to all staff, patients and members of the public who can come along and meet our executive team on an informal basis.

e-update: a twice-weekly email bulletin for all staff and volunteers with all the latest news and developments.

Herts & Minds: work began on the production of a bi-monthly magazine for staff and volunteers featuring all the latest news, awards, achievements, the latest patient feedback, and new policies to be launched in 2014/15.

Intranet: our internal website for staff and volunteers acts as an information sharing tool and is available across all sites.

Rumours@ page: this was set up on the intranet to give staff the opportunity to find out the truth around any rumours they may have heard.

Twitter: a regularly monitored Twitter account so staff and patients can have a two-way conversation with the executive team.

Recruitment and retention

A Trust review of staffing levels on our wards resulted in a £3.9 million investment in additional nursing staff during 2013/14. This has enabled us to recruit nursing staff both locally and overseas, and following a very successful overseas recruitment campaign we recruited 108 qualified nurses from Portugal, Spain and Italy. A training/induction programme specifically designed to welcome them to the Trust was provided during their first few weeks and they were supported by dedicated mentors in each area to help them settle into their new roles.

Selecting staff who display the right attitudes and behaviours is crucial to our success and this year has seen the introduction of recruitment and assessment processes aligned to our values - we have successfully implemented this approach for a number of executive and senior appointments. Throughout 2014/15, we will be working closely with key stakeholders to further develop and roll this out across our hospitals, to ensure we continue to attract and retain talented staff.

The health and wellbeing of our staff

Sickness rates for the year were 3.5% and overall, monthly rates for 2013/14 have been below those in 2012/13. Our sickness rates are lower than average when benchmarking ourselves against similar NHS trusts.

We regularly report sickness information in workforce reports which help managers intervene and deal with issues when staff are on sick leave, in accordance with the Trust's Management of Sickness Absence Policy.

We are committed to positively improving the health and wellbeing of our staff through various initiatives through our Balance4Life programme which has continued to support staff through 2013/14 with a variety of activities and schemes on offer.

Onsite classes in yoga, tai chi, pilates and zumba are available and a weight management group is now offered to staff at lunchtimes and has been much in demand. Help with giving up smoking is also available.

Improving the health and well-being of our staff is a key priority. In 2013/14 sickness rates fell

The Radiography team at Hemel Hempstead Hospital show their support for #hellomynameis… is campaign

National Heart Month in February 2014 saw health and wellbeing events held on each site, offering staff mini health checks, cholesterol tests, massage treatments and relaxation sessions.

Similar events were also held in September 2013 for 'Know Your Numbers' week. Lunchtime talks have been held on topics chosen by staff such as migraine, parenting skills and the menopause.

Information on pensions and personal financial planning continued to be available at seminars held across our hospitals for staff at all stages of their career, and financial support has been offered to staff onsite by the Credit Union in St Albans.

There are a number of award schemes in place which recognise and celebrate the achievements of our staff. These include long service awards, and monthly awards.

Equal opportunities

We are committed to encouraging equality and diversity so that our workforce reflects the diverse population that we serve. Therefore, in 2013/14, we introduced a new staff induction programme 'Equality, Diversity and Human Rights' which is aimed at supporting all our staff.

Connect BME (black and minority ethnic) staff group

Our staff BME network was re-launched in 2013. The BME group strengthened their relationship internally, particularly with the medical education centre. The group updated their intranet page, formulated new membership forms and produced banners, posters and cards to increase awareness.

Members of the "Connect" BME Network also had the opportunity to visit the Museum of Immigration and Diversity in London on 12 July 2013.

Lesbian, gay, bi-sexual and transgender (LGBT) partnership

As part of our joint membership with the LGBT Partnership in Hertfordshire, we were pleased to take part in the first Gay Pride event, which was held in Cassiobury Park in Watford in August 2013.

Breakdown of staff groups (as of 31 March 2014)

Table 4: Banding by gender

Band	Female	Male	Grand total
Band 1 - 7	2,975	501	3,476
Band 8A and above	171	63	234
Medical	260	307	567
Non-Exec Directors	2	5	7
Grand total	**3,408**	**876**	**4,284**

Table 5: Banding by ethnicity

Ethnicity	Band 1 - 7	Band 8A & above	Medical	Non-Exec Directors	Grand total
Asian and Asian British - Any other Asian background	220	4	38		262
Asian and Asian British - Bangladeshi	10		6		16
Asian and Asian British - Indian	262	17	123		402
Asian and Asian British - Pakistani	56		30	1	87
Black and Black British - African	176	4	29		209
Black and Black British - Any other Black background	19		1		20
Black and Black British - Caribbean	64	2	2		68
Local - Chosen to not state (Z equivalent)	1				1
Mixed - Any other mixed background	11	2	3		16
Mixed - White and Asian	8	1	4		13
Mixed - White and Black African	9		3		12
Mixed - White and Black Caribbean	9	1	2		12
Not stated	197	5	29		231
Other Ethnic Groups - Any other ethnic group	80	1	16		97
Other Ethnic Groups - Chinese	38	3	21		62
White - Any other White background	213	4	58		275
White - British	1,994	177	195	5	2,371
White - Irish	109	13	7	1	130
Grand total	**3,476**	**234**	**567**	**7**	**4,284**

Working in partnership with Unions

We continue 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.

Our future

A new clinical strategy for west Hertfordshire

Now that we have a new leadership team in place we can begin to design a strategy for west Hertfordshire which will provide health services that are sustainable, affordable and tailored to the needs of local people.

We are doing this in partnership with Herts Valleys Clinical Commissioning Group, other NHS partners and with our colleagues in social care.

One of our key areas of focus is on partnership working and promoting integrated working with primary and social care to achieve seamless care for patients.

In 2014/15, we will be dedicating time to the development of a long term financial model (LTFM) that we will model different options of service provision.

The strategy will help determine exactly how services will be configured across all three of our hospitals in the future.

Watford Health Campus

The Watford Health Campus is a long term (15-20 year) partnership to redevelop the redundant land around Watford Hospital into a vibrant and attractive new community bringing new hospital buildings, new homes, new jobs, accessible open green space, and a mix of facilities and services.

Our partnership with Watford Borough Council, and Kier Property Ltd, has been formally signed and established legally. The Campus plan includes all of the redevelopment of the area around the existing Watford Hospital, so light industry, residential developments, retail and significant environmental improvements are some key elements of the scheme, including the opportunity for new hospital buildings.

Most importantly at this stage is the new access road, for which we secured £7 million of NHS funding, with construction due to begin in late 2014. The Croxley Rail Link will be close to the road, and will bring a station within a three minute walk, greatly improving access to the hospital site.

Our approach for redevelopment is to deliver the hospital's facilities in a phased manner, while still allowing the Campus Development to progress. The flexibility offered by the Campus will provide many opportunities and more efficient ways of delivering redevelopment.

In essence, the current masterplan provides a flexible framework of uses and spaces into which we can integrate our own proposals, once our clinical strategy is more defined. We have made it clear that services such as the A&E department and maternity facilities are considered core services of an acute general hospital and would therefore remain on this site.

There has been a full review of the masterplan, including a public exhibition and consultation, prior to the planning application being submitted.

Being prepared

Emergency planning is important for an NHS trust as it sets out how the organisation would respond in the face of a major incident. A major incident is when the Trust needs to react quickly to an extraordinary or unpredictable situation, such as a serious road traffic accident involving multiple casualties, or a chemical spill.

We regularly tested our business continuity and internal incident plans throughout 2013/14 for the management of minor and major incidents. These included an incident in June 2013 when a clean water mains pipe burst at Watford Hospital causing significant problems to a number of services and in January 2014 when a routine test at Watford Hospital revealed that there was a problem with a back-up generator which would provide power to limited areas of the hospital in the event of a general power failure.

Foundation Trust status

We have not focussed on applying for foundation trust status in 2013/14, however it remains a future opportunity.

The planning application for a new road to serve the Watford Health Campus was approved in December 2013

Our money

The financial headlines

The financial plan for 2013/14 was to deliver a surplus of £600,000; however the outturn was a £13.4m deficit. As in previous years, the plan was a balance between what was considered achievable to meet the expected patient activity, offset by efficiency improvements. The plan included an application to the Department of Health for additional capital funds of £16.2m (£12.7m 13/14 and £3.5m 14/15) needed to address critical infrastructure works and revenue funding to improve the Trust's liquidity by £15m.

During the year, it became clear the plan would not be delivered. Efficiency initiatives would not be fully achieved and that essential investment in ward staffing levels and other transformation and quality agendas was needed. In addition emergency activity, for which the Trust was not being paid at full tariff, was higher than planned. The forecast outturn was revised from that planned to a deficit of £13.5m. The outturn was a £13.4m deficit.

Although the year concluded with a deficit, because of surpluses from the previous year, the Trust has not breached its statutory duty to breakeven.

The Trust's application for capital funding was successful and good progress has been made in delivering the identified critical infrastructure works and these will be completed during 2014/15. The application for revenue funds to support liquidity was deferred until 2014/15.

The full year costs of ward staffing levels and other quality improvements are factored into the Trust's financial plan for 2014/15. Accounting for a 4% efficiency (savings) target a deficit of £14m is planned. This has been agreed with the NHS Trust Development Authority (NTDA) and progress is expected through the year on how this may be improved through NTDA support.

Delivery of savings each year becomes increasingly difficult however this is a requirement across all NHS organisations.

The Trust has strengthened its savings programme through the appointment of a specialist external consultancy and without compromising patient safety or quality of care hopes to restore confidence in the Trust's ability to achieve its savings target.

To improve the Trust's liquidity position, we plan to apply for £30.2m of cash support from the Department of Health. This is of particular concern to the Trust as explained in note 1.3.1 of the Trust's accounts. The additional cash will enable the Trust to continue to deliver its patient services throughout 2014/15.

Financial risk

Set out below is the Trust's performance for the year against the financial indicators used by the NTDA. The Board uses this each month, together with other information to manage its finances. An overall score of less than 3 is unsatisfactory. A strategic review by commissioners is underway

Table 6: Trust's performance for the year

Criteria	Metric	Weight	5	4	3	2	1	Annual Plan 13/14	YTD Risk ratings13/14	Forecast Risk ratings 13/14
Underlying performance	EBITDA margin%	25%	11	9	5	1	<1	2	1	1
Achievement of plan	EBITDA achieved%	10%	100	85	70	50	<50	5	1	1
Financial efficiency	Net return after financing%	20%	3	2	-0.5	-5	<-5	3	1	1
	I&E surplus margin%	20%	3	2	1	-2	<-2	2	1	1
Liquidity	Liquid ratio days	25%	60	25	15	<10	<10	2	1	1
Average	Weighted average rating							2.5	1.0	1.0
Overriding rules	Limit due to overriding rules							2	1	1
Overall rating	Financial risk rating for Trust							2	1	1

Key: EBITDA = Earnings before interest, taxes, depreciation and amortisation. YTD = Year to date. I&E = Income & expenditure.

as to how NHS healthcare across west Hertfordshire is best provided. The outcome of this will enable the Trust to prepare longer term financial plans to address its overall financial risk score of 1. This will include addressing the two main causes of the poor risk score; that of a deficit financial plan and weak liquidity.

Internal audit

At the start of the year the Trust appointed new internal auditors, BDO LLP. With Trust input, BDO develops an annual plan of work that is approved by the Trust's Audit Committee. Progress reports highlighting any significant weaknesses identified are reviewed at each committee meeting to ensure action is taken to resolve these. The head of internal audit opinion (BDO LLP representative) is shown in the Annual Governance Statement on page 34. This provides a limited assurance opinion, particularly because the Trust determined that the risk register and Board Assurance Framework were not fit for purpose. Risk was however taken very seriously with action taken following Board risk summits including significant investment in clinical staffing levels to improve front line staff to patient ratio. Improved processes to better inform the Board as to on-going risks are being established and will be embedded by the second quarter of 2014/15.

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. The external auditor's opinion on our accounts is that they represent a true and fair view of the Trust's financial position (see page 54). External audit also assess the Trust in respect of its arrangements to secure financial resilience and for challenging how it secures economy, efficiency and effectiveness. Here, particularly, because the Trust has financial viability challenges and a major whole-system review is underway to establish how a sustainable system of healthcare can be reached in west Hertfordshire, external audit reached an adverse conclusion. The review also highlights major historical problems with the identification, working up and delivery of the savings programme, and similar governance issues as described in the internal audit opinion, notably in risk management and the Board Assurance Framework. The report recognises progress is being made in all the relevant areas, and that the Trust has employed an external firm to provide immediate support with the 2014/15 savings programme.

Because the Trust appoints Grant Thornton for work other than that of external audit, the expense is shown separately in the Annual Accounts as "other auditors' remuneration" (see note 7 of the Trust's accounts). Assurance is sought that there is no conflict of interest. The work undertaken related to review of the design and operations of the Trust's HR and payroll processes.

Related parties

The Trust has received declarations of all Board and Trust Leadership Executive Committee (TLEC) members for any conflict of interest in conducting the NHS business. Any member associated with the organisations will be shown in the register of interest held by the corporate affairs office. Note 33 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 any Board or TLEC members.

Better payment practice code

The Trust strives to pay its suppliers in line with the better payment practice code and performance in achieving this is set out in note 11 of the Trust's accounts.

Exit packages agreed in 2013/14

There were 23 agreed exit packages in 2013/14. Further details are included in note 9.4 and 9.5 of the Trust's accounts.

Annual governance statement 2013/14

1. Introduction

The NHS Chief Executive, in their capacity as Accounting Officer for the NHS in the Department of Health, requires the Accountable Officer (AO) for West Hertfordshire Hospitals NHS Trust to give assurance about the stewardship of their organisation.

For West Hertfordshire Hospitals NHS Trust, the Accountable Officer is Samantha Jones, Chief Executive.

2. Scope of responsibility

The Board of Directors is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

Accountability for risk management is set out in the Trust's Risk Management Strategy. The Executive Team is collectively responsible for maintaining the systems of internal control and Executive Directors are accountable to me for ensuring effective governance arrangements in their individual areas of responsibility. These areas of responsibility are detailed in the Scheme of Delegation.

During 2013/14 we have worked closely with NHS England (Midlands and East) and Herts Valleys Clinical Commissioning Group (HVCCG) and the Trust's performance was reviewed on a regular basis.

The HVCCG, Hertfordshire County Council's Health Scrutiny Panel, Healthwatch Hertfordshire and other partner organisations have been involved in helping to shape our work throughout the year, particularly related to patient experience.

3. The governance framework of the organisation

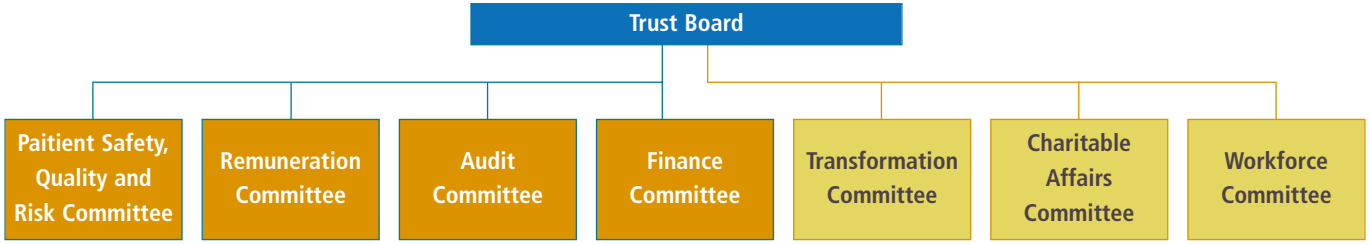
To fulfil my role as Accountable Officer, effective and strong governance arrangements are required. Following a review by the Good Governance Institute (GGI), the Board agreed a new governance structure (see figure 1) to deliver an integrated governance agenda and strengthen Board assurance. This ensures decision-making is informed by a full range of corporate, financial, clinical and information governance.

The Board of Directors leads on integrated governance and delegates key duties and functions to its seven committees (see section 4.4). Figure 1 below gives an overview of the integrated governance structure going forward. All the committees below met in 2013/14 except the Transformation Committee, which held its first meeting in June 2014 (having replaced the Risk Summit Response Committee).

4. The Board

The Board has overall responsibility for the effectiveness of the governance framework and requires that each of its committees has agreed terms of reference that describe the duties, responsibilities and accountabilities together with the process of assessing and monitoring effectiveness. The Board has standing orders, reservation, and delegation of powers and standing financial instructions in place which are reviewed regularly.

Figure 1: Integrated governance structure



Reporting to the Board is based on the principles of exception reporting to ensure that the Board considers the key issues and utilises its time effectively.

The Board received at each of its meetings an integrated balanced scorecard detailing finance and performance against the key performance indictors. In the months where the Board did not meet, this information was received by the Executive Directors.

Annual work plans and the terms of reference for each of the committees were approved by the Board and regular reports were presented by the Non-Executive Chair of each committee on the business covered, risks identified and actions taken.

Each Board agenda was based on four key areas of:
- Patient safety and quality;
- Performance;
- Strategic direction;
- Governance and regulatory.

Being open and transparent is a key focus and therefore each agenda also included an opportunity for the members of the public to ask questions related to the matters under discussion and all Board papers were published on the Trust's website: www.westhertshospitals.nhs.uk/about/board_meetings. Healthwatch Hertfordshire was also invited to each meeting and have time on the agenda to ask questions.

Membership of the Board is made up of the Chair, five independent Non-Executive Directors, five voting Executive Directors and three non-voting Executive Directors.

4.1 Changes to the Board

During the year there have been significant changes in the membership of the Board, which are detailed below. This has led to a number of interim Executive Director posts, which we aim to establish substantively as soon as possible.

- Mahdi Hasan became Acting Chair in May 2013, following the retirement of Professor Thomas Hanahoe in April 2013;
- Mahdi Hasan became substantive Chair in November 2013;
- Non-Executive Director, Robin Douglas left in November 2013;
- Non-Executive Director, Katharine Charter left in January 2014;
- Non-Executive Director, Sarah Connor left in November 2013;
- Non-Executive Director, Chris Green left in November 2013;
- Non-Executive Director, Stephen Hay joined in December 2013;
- Non-Executive Director, Ginny Edwards joined in January 2014;
- Non-Executive Director, John Brougham joined in January 2014;
- Non-Executive Director, Jonathan Rennison joined in January 2014;
- Anne Robson took on the role as Interim Director of Workforce from Mark Vaughan in December 2013;
- Director of Nursing, Natalie Forrest replaced Maxine McVey until June 2013 when Jackie Ardley took on the position of Interim Chief Nurse in July 2013;
- Anna Anderson left the Trust in June 2013 and was replaced by Patrick Butterworth until December 2013. Patrick was replaced by Malcolm Dennett who joined the organisation on an interim basis from October 2013 to March 2014.
- Kevin Howell joined the Trust as Director of Facilities and Estates in February 2014. This is a newly established role;
- Bernie Bluhm held the position of Interim Chief Operating Officer until Karen Haynes took on the interim role in March 2014;
- Dr Mike Van der Watt joined the Board as Medical Director on 1 April 2013 from Colin Johnson, who left in March 2013;
- Antony Tiernan joined the Board as Director of Corporate Affairs and Communications in July 2013.

4.2 Board development

A comprehensive Board development programme has continued this year, with protected time and mandated attendance. The topics included actions taken or proposed in response to the Francis Report, management of organisation risks relating to emergency activity and strategy setting.

4.3 Board meetings

The Board met publicly six times during the year. In addition to the regular meetings there was a meeting in June to approve the Annual Accounts and Report and in September for the Annual General Meeting.

A breakdown of attendance of Board meetings is presented below:
- Chair (attended 6 out of 6);
- Non-Executive Director - Jonathan Rennison (attended 2 out of 2) started January 2014;

- Non-Executive Director - Stephen Hay (attended 2 out of 2) started December 2013;
- Non Executive Director - Ginny Edwards (attended 2 out of 2) started January 2014;
- Non Executive Director - John Brougham (attended 2 out of 2) started January 2014
- Non Executive Director - Phil Townsend (attended 6 out of 6);
- Chief Executive (attended 6 out of 6);
- Chief Operating Officer (attended 6 out of 6);
- Chief Finance Officer (attended 6 out of 6);
- Medical Director (attended 6 out of 6);
- Director of Workforce* (attended 5 out of 6);
- Chief Information Officer* (attended 6 out of 6);
- Director of Strategy and Service Improvement/Director of Facilities and Estates* (attended 5 out of 6);
- Chief Nurse (attended 5 out of 6);
- Director of Corporate Affairs and Communications* (attended 3 out of 5) started July 2013.

* Non-voting members of the Trust Board

Details of the experience and qualifications of the Trust Board can be found on the Trust's website:
www.westhertshospitals.nhs.uk/about/whos_who

4.4 Committees of the Board

The roles and responsibilities of the Board's committees are described below.

Audit Committee

The Audit Committee is responsible for oversight and scrutiny of the Trust's systems of internal control and risk management. It takes a wide responsibility for scrutinising the risks and controls which affect all aspects of the organisation's business.

Some of the key areas of work in 2013/14 included:

- Regularly receiving updates on finances, losses and compensations, gifts and hospitality;
- Receiving progress reports on the local counter fraud service;
- Reviewing internal and external progress reports, as well as internal audit strategy, external audit plan and operational plans;
- Reviewing and recommending approval of the annual accounts, annual report, annual governance statement and quality account.

The Audit Committee met five times during 2013/14. It was initially chaired by a Non-Executive Director, who was a qualified accountant and then by a Non-Executive Director with extensive financial experience. Membership included internal and external auditors. The committee submitted regular reports to the Board, supported by the lead Executive Director, the Trust's Chief Financial Officer.

The attendance record for current Board members is listed below:

- Non-Executive Director, Stephen Hay (Chair) (1 out of 1) started December 2013;
- Non-Executive Director, John Brougham (1 out of 1) started January 2014;
- Non-Executive Director, Jonathan Rennison (1 out of 1) started January 2014;
- Non-Executive Director, Phil Townsend (5 out of 5);
- Chief Financial Officer (Lead Executive) (5 out of 5);
- Medical Director (attended 3 out of 5).

Patient Safety, Quality and Risk Committee

The Patient Safety, Quality and Risk (PSQR) Committee was established in July 2013 with the key objective of assuring the Board that high standards of care are provided throughout our three hospitals. In particular, the committee is responsible for ensuring that good and appropriate governance structures, processes and controls are in place.

Some of the key areas of work in 2013/14 included:

- Receiving a report on an audit regarding fractured neck of femur outcomes;
- Presentation on standardised hospital mortality index (SHMI);
- Receiving regular reports on serious incidents, infection prevention and control, patient experience and fundamentals of nursing care;
- Reviewing the results of the national cancer patient and maternity surveys and subsequent action plans.

The PSQR Committee met four times in 2013/14. The attendance record for current Board members is listed below:

- Chair (Chair) (attended 4 out of 4);
- Non-Executive Director, Ginny Edwards (attended 0 out of 1) started January 2014;
- Non-Executive Director, John Brougham (attended 1 out of 1) started January 2014;
- Chief Executive (attended 4 out of 4);

- Chief Operating Officer (attended 1 out of 4);
- Chief Nurse (Lead Executive) (attended 3 out of 4);
- Chief Information Officer (attended 3 out of 4);
- Director of Workforce (attended 2 out of 4);
- Director of Corporate Affairs and Communications (attended 2 out of 4);
- Medical Director (attended 3 out of 4).

In addition to the Board members detailed above, the attendance of the PSQR Committee also includes a representative from Healthwatch Hertfordshire and our Patients' Panel (a group which represents the views of our patients).

Finance Committee

The Finance Committee gave detailed consideration to the Trust's financial and performance issues and provided the Board with assurance that all issues were being appropriately managed and escalated where necessary.

Some of the key areas of work in 2013/14 included:

- Receiving regular reports on financial position, cash and liquidity, service line reporting, and capital and spend;
- Reviewing emerging financial issues;
- Reviewing the options and long term financial model;
- Agreeing financial and business plans.

The Finance Committee met four times in 2013/14. The attendance record for current Board members is listed below;

- Non-Executive Director, John Brougham (Chair) (1 out of 1);
- Chair (attended 3 out of 4);
- Non-Executive Director, Phil Townsend (attended 2 out of 4);
- Chief Executive (attended 3 out of 4);
- Chief Financial Officer (Lead Executive) (attended 3 out of 4);
- Chief Information Officer (attended 2 out of 4);
- Chief Nurse (attended 2 out of 4);
- Chief Operating Officer (attended 3 out of 4);
- Director of Corporate Affairs and Communications (attended two out of 4);
- Director of Workforce (attended 2 out of 4).

In addition to the Board members detailed above, the attendance of the Finance Committee also includes a representative from Healthwatch Hertfordshire and our Patients' Panel (a group which represents the views of our patients).

Remuneration Committee

The Remuneration Committee has formal and transparent procedures for developing policy on executive remuneration and agreeing remuneration packages of individual Executive Directors.

This committee meets on an ad hoc basis. The key piece of work undertaken in 2013/14 was to review Executive Director salaries.

In 2013/14 the Remuneration Committee met three times. However, the membership has recently changed as indicated below by the attendance of 0 out of 0:

- Non-Executive Director, Phil Townsend (Chair) (attended 3 out of 3);
- Non Executive Director - Jonathan Rennison (attended 0 out of 0) started January 2014;
- Non Executive Director - Stephen Hay (attended 0 out of 0) started December 2013;
- Non Executive Director - Ginny Edwards (attended 0 out of 0) started January 2014;
- Non Executive Director - John Brougham (attended 0 out of 0) started January 2014;
- Director of Workforce/Delegate (attended 3 out of 3).

Charitable Funds Committee

The role of the Charitable Funds Committee is to ensure funds are managed in accordance with the Trust's Standing Financial Instruction and donors' wishes.

Some of the key areas of work in 2013/14 included:

- Approving charitable accounts;
- Receiving reports on charitable activities;
- Receiving reports on staff welfare fund.

The Charitable Funds Committee met once in 2013/14. The membership and attendance has changed during the year and as a result the January meeting was cancelled.

One meeting was held in 2013/14. It was attended by two Non-Executive Directors, who have since left the Trust. Details of the current membership is as follows:

- Non Executive Director - Jonathan Rennison (Chair) (attended 0 out of 0) started January 2014;
- Non Executive Director - Ginny Edwards (attended 0 out of 0) started January 2014;
- Chief Financial Officer (Lead Executive) (attended 1 out of 1);
- Chief Nurse (attended 0 out of 0).

Workforce Committee

The purpose of the Workforce Committee is to provide the Board with assurance concerning all aspects of workforce, organisational development and learning development within our hospitals.

Some of the key areas of work in 2013/14 included:

- Reviewing the results of the national staff survey and subsequent action plan;
- Supporting a business case for an organisational development plan;
- Regularly reviewing workforce indicators, including staff turnover, pay rates and sickness;
- Identifying the workforce subjects required to create a workforce schedule.

The Workforce Committee met four times in 2013/14. The current membership and attendance is listed below:

- Non Executive Director - Ginny Edwards (Chair) (attended 1 out of 1) started January 2014;
- Non Executive Director - Jonathan Rennison (attended 1 out of 1) started January2014;
- Chief Executive (attended 0 out of 4);
- Director of Workforce (Lead Executive) (attended 4 out of 4);
- Chief Operating Officer (attended 1 out of 4);
- Medical Director (attended 1 out of 4).

In addition to the Board members above, the membership of the Workforce Committee also includes the Chair of Staffside.

Risk Summit Response Committee

The Risk Summit Response Committee was set up to provide assurance concerning delivery of the programme of work to address risks identified at the risk summits in May 2013 and July 2013. The committee, chaired by a Non-Executive Director, met three times in 2013/14 and having met its short term objectives has now been replaced with the Transformation Committee.

5. Key governance systems

In 2013/14, the Trust commissioned the Good Governance Institute (GGI) to undertake formal evaluation to support us in reviewing our governance structure and help to shape a board development plan.

In addition, GGI undertook a board member skills review and a 360 degree appraisal assessment of all Board members.

A review of the Audit Committee was also completed, as well as an external stakeholder review, including patients, visitors and carers.

Operational day-to-day management of the Trust is delegated to the Trust Leadership Executive Committee (TLEC). Membership includes Executive Directors, Divisional Directors (clinical) and Divisional Managers. Associate Medical Directors attend as required. TLEC implements the strategies and decisions of the Board and has responsibility for operational decision making.

All Divisions are led by a Divisional Director (clinical), Divisional Manager and Head of Nursing/Midwifery. This triumvirate has delegated responsibility for the professional and managerial performance of their division. Each Divisional Director remains a practising medical specialist.

The Trust has identified the following as key systems which support the delivery of the Trust's objectives:

- Risk management;
- Performance management;
- Business planning and budget setting.

Supporting these systems are sub-systems which include, but are not limited to:

- Workforce planning;
- Maintaining clinical and non-clinical competencies;
- Health and safety;
- Equality and diversity.

6. Board review of effectiveness

As the Accountable Officer, I support the Chair in ensuring the effective performance of the Board and its committees. I consider that the Board operated at a satisfactorily level in 2013/14. This is supported by the following evidence:

- Despite a number of changes to membership of the Board during the

reporting year, the Board maintained a full complement of Executive Directors and Non-Executive Directors, Board and committee meetings were well attended;
- High quality information, including agenda items and supporting evidence was presented;
- The attendance of representatives across the Trust was requested, as required;
- An annual declaration of interests was requested by the members and by exception, as required.

As a Trust, we are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the Trust.

6.1 Board member appraisals

Each member of the Board is appraised on their performance during the year, which culminates in an annual appraisal against their objectives for the year.

The appraisers for each group of Board members is as follows:

Appraisee	Appraiser
Chairman	NHS Trust Development Authority
Non Executive Directors	Chairman
Chief Executive	Chairman
Executive Directors	Chief Executive

6.2. Performance against NHS Operating Framework

The Trust is required to meet national standards as defined within the NHS Operating Framework 2013/14. Our performance against the national targets are detailed on page 12.

7. Strategic risks

The Trust was involved in two risk summits in 2013/14 which related to patient care. A risk summit was held in May 2013 and, following a number of additional risks which I highlighted in July 2013, a further risk summit took place on 5 July 2013. The risks highlighted in the summits were:
- Mortality ratios;
- Emergency care;
- Stroke;
- Infection prevention and control;
- Complaints;
- Obstetrics and gynaecology;
- Governance systems;
- Board leadership;
- Estates;
- Organisational culture.

I requested that a Risk Summit Response Committee, chaired by a Non-Executive Director, was established to provide assurance concerning delivery of a Risk Summit Response Programme to the Board. An experienced Executive Director was appointed as Interim Programme Director in July 2013 and a detailed programme plan was developed, specifically to ensure that the Trust had a single, prioritised plan to focus on the delivery of all key improvements identified at the risk summits within a given timeframe.

The programme structure is based on the 'Keogh Reviews' or 'Reviews into the Quality of Care and Treatment provided by 14 Hospital Trusts in England'. This approach shaped the development of 22 programme aims divided between six themes or work-streams (Governance; Leadership; Patient Experience; Workforce and Safety; Operational Effectiveness; and Clinical Effectiveness) each of which includes a number of separate projects. The Board continues to receive regular progress reports on the programme via its Transformation Committee (which replaced the Risk Summit Response Committee).

A further major risk in 2013/14 focused on a review of patients with suspected cancer. The review was launched in late November 2013 after an improvement programme raised concerns that the administrative process for monitoring patients referred with suspected cancer (by their GP or dentist) had not always followed NHS guidelines.

This related specifically to 810 patients who had missed their initial outpatient appointment. Of these, 686 were told that there were no clinical concerns about the care they received. A further 121 were told that their case was still being reviewed (in partnership with their GP or dentist). The care provided to three patients was compromised.

In March 2014, the Trust confirmed that the outstanding 121 cases had been completed and that all of the patients had been contacted to say that it had no clinical concerns about the care they received in relation to the review.

A full external independent investigation has been undertaken by a former NHS Chief Executive who specialises in patient safety, and other areas of our cancer care have been audited to ensure they are now in line with best practice. The investigation is due to report in summer 2014.

8. Arrangements in place for the discharge of statutory functions

The Board submits monthly declarations to the NHS Trust Development Agency (NHS TDA) to confirm that the Trust meets the standards set in the Quality Governance Framework. During 2013/14, the Trust identified a number of areas where improvement was needed particularly in relation to governance, risk management, cost improvement plans and consultant job planning.

Concerns were highlighted following an unannounced inspection at Watford Hospital by the Care Quality Commission (CQC) who found five out of six areas inadequate though not deemed critical. The Trust provides the NHS TDA with regular progress reports on a range of governance and quality improvements.

During the year, the Trust has declared breaches of the following standards which relate to the Compliance Framework:

- Governance;
- 18 week referral to treatment standard;
- 95% of patients to be treated, admitted or discharged within four hours in A&E (A&E).

The Trust worked closely throughout the year with key partner organisations to address risks in the community and for major incident planning. These organisations included ambulance, fire, police, health and safety executive and local authorities.

The Trust participated in multi-agency tabletop exercises during the year and has had a number of serious internal incidents which have tested its major incident and business continuity plans.

Control measures are in place to ensure that the Trust's obligations under equality, diversity and human rights legislation are complied with. Equality Impact Assessment forms parts of the Trust's policy for creation of all patient information.

During 2013/14, the Trust published its Equality Delivery System (EDS), which defines how the Trust is meeting general and specific duties of the Public Sector Equality Duty, in line with the statutory requirements.

As an employer, with staff entitled to membership of the NHS Pensions 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 payment into the Scheme are in accordance with the Scheme rules, and that Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

There is a sustainable development management plan in place, which was approved by the Board.

A comprehensive annual appraisal process is currently being introduced. This is linked to six new values and expected behaviours of the organisation (designed by 600 staff and patients). This is known as 'Developing our Organisation (DO)'. Further details can be found on page 24.

The Trust's training policy takes into consideration national imperatives, advice and guidance from professional bodies. The annual review of the policy includes the identification of statutory and mandatory training which forms the essential training matrix aimed at improving knowledge and understanding and increasing awareness of risk issues at all levels of the organisation. The Trust's mandatory induction programme covers a range of subjects and includes risk awareness, although it is recognised this aspect has been fairly limited and needs to be improved.

To support employees in identifying, assessing and managing risk, the Trust provides a suite of policies, strategies, procedures, protocols and guidelines together with information at levels that are relevant to an individual's role. During 2013/14 the Trust reviewed its processes for the updating of policies and has put plans in place to improve this process to ensure that policies are kept current.

The Trust has a policy for staff attendance at mandatory training aimed at managing health and safety and risk. The policy is clear that managers are responsible for ensuring staff attendance and compliance is monitored regularly and reported to a committee of the Board.

9. Risk assessment

The key aim of the Trust's risk management approach is to ensure that all risks to the Trust are identified, evaluated, monitored and managed appropriately.

I have overall responsibility for risk management and I endeavour to ensure that risk is an explicit process in every activity the Trust takes part in. This is managed through clearly focusing executive responsibility for all governance and risk management with the respective Executive Directors, who are supported by their teams.

The Trust is exposed to a wide range of potential risks. These include:

- Clinical risks (for example, in the delivery of effective care and treatment, safely);
- Health and safety risks (for example, preventing accidents, ensuring the safety and welfare of staff, patients and the people using Trust premises);
- Workforce and recruitment risks (for example, retention, training and skill shortages);
- Financial risks (for example, controlling money and remaining within budget, ensuring sufficient liquidity);
- Estate and environmental risks (for example, ensuring the Trust's buildings and equipment are operational and well-maintained and compliant);
- Decision making risks (for example, choosing to act or not and selecting priorities);
- Hidden risks (such as reputation and information).

Executive Directors have responsibility for all services and supporting corporate functions. The principal management lead for risk management is the Chief Nurse.

The Trust's Risk Management Strategy is in the process of being updated to reflect in-year changes and the governance arrangements, including where and how often risks will be reviewed at divisional, group, committee and Board level.

The updated strategy will clearly outline the leadership, responsibility and accountability arrangements required to strengthen the process for risk escalation from 'Ward to Board'. The strategy clearly defines accountability for managing risk, and restructuring the risk register to ensure risks are managed at the appropriate level in the Trust. This will be in accordance with the risk score, with the development of local risk registers and trust-wide risks whilst developing the further linkage between the Board Assurance Framework (BAF) and the risk registers.

Risks are identified as a result of incidents, complaints, claims or by proactive risk assessment, and are scored using the Trust's risk scoring five times five matrix where the likelihood and consequence scores are multiplied together to arrive at an overall risk score.

The Trust is taking a renewed approach to risk management based on Monitor's Quality Governance Framework. All risks are to be captured on the risk register, including current and future, actual and potential. This approach will be further developed and embedded during 2014/15.

9.1 Risk Register Review Group

A Risk Register Review Group, chaired by the Chief Nurse, with the Associate Director of Quality Governance as deputy Chair, was established in 2013/14. The terms of reference were approved by the Quality and Safety Group, which reports to the Patient Safety Quality and Risk Committee (PSQR).

The new group will review all risks scored 12 and above, check and challenge the scoring, require assurance that the risks are being managed towards their target score, and consider Trust-wide risks before their further review at Trust Leadership Executive Committee (TLEC), PSQR and the Board.

Risk register workshops are being rolled out across the Trust and plans are in place for a session on Risk and Assurance with the Board.

The Trust's risk register shows 74 new risks being opened and 61 being closed in 2013/14.

9.2 Divisional risk management

Each division within the Trust is required to hold a Divisional Governance and Quality Group meeting. These groups formally report into the Trust's Quality and Safety Groups. New standardised terms of reference have been issued, which require risk management to be a standing agenda item and risk registers to be reviewed at each meeting, alongside other key requirements of quality and integrated governance. Each clinical specialty has a nominated risk lead.

10. Incident management

The Trust's policy for reporting and managing incidents was revised in 2013/14 and a new policy approved in April 2014 by the PSQR Committee.

A total review was undertaken in 2013/14 of the Trust's incident management process and improvements have been made. All incidents, complaints and claims are recorded on an electronic database (DATIX).

In 2013/14, it became apparent that there was an issue with capacity on the server which supported the DATIX system. Therefore, a business case was approved by the Board which will allow the system to be hosted externally.

The PSQR Committee receives regular reports on the intelligence received from information on complaints, compliments, claims and other feedback from patients, their families and friends. The Board also receives a monthly report.

The organisation strongly promotes an open culture where staff can report and learn. Such a culture helps to encourage a high level of reporting. The more frequently occurring incidents and 'near misses' are reported, the more possible it becomes to address underlying causes, reduce recurrence and, as such, manage the identified risks.

Learning from good practice is encouraged, as is learning from mistakes in order to continually strive for better outcomes for patients. This area was developed during 2013/14 and requirements are now in place to ensure that learning is shared internally through team, professional and divisional meetings. Practice changes following incidents and complaints are also discussed and recommendations from solicitors following inquests and claims are shared.

The Trust is also further developing the use of its intelligence about the patient experience, gained through the national friends and family test, local patients surveys, as well as national patient surveys.

All patient safety incidents are reported to the National Reporting and Learning System (NRLS), and reports produced by them are used for both benchmarking and learning.

11. Serious incidents

In 2013/14, we declared a total of 149 serious incidents which included two 'never' events (eg something that should never have happened) one relating to 'wrong site surgery' and one to 'a retained swab during surgery'.

The serious incident reporting and investigation process has been further aligned in 2013/14 with the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation 2010 and with the NHS Commissioning Board Serious Incident Framework 2013.

All internal and external incident investigations are completed using the Trust's Root Cause Analysis (RCA) template and the NPSA's toolkit.

The table below shows the serious incidents declared by the Trust under their relevant categories.

Table 7: Serious incidents declared by the Trust

Serious incident category	Number reported
Allegation against healthcare professional	10
Care and treatment	21
Communicable disease and infection issue	16
Confidential information leak	3
Hospital transfer issue	3
Infrastructure / health and safety	5
Maternity	5
Medication	10
Misplaced nasogastric tube	2
Outpatient appointment delay / failure to follow-up	9
Pressure ulcer grade three	34
Retained swab	1
Safeguarding vulnerable adult	2
Attempted self-harm	4
Slips / trips / falls	13
Unexpected death	2
Wrong site operation	1
Others 1. Medication prescribing transcription error 2. Delay in disposing of foetal remains - check 3. On-site bereavement 4. Freezer failure in the mortuary 5. Missing specimen 6. Disclosure and barring service checks and processes 7. Electrocution of anaesthetist 8. Maternity capacity	8
Total number of serious incidents reported	**149**

During the latter part of the year, a significant overhaul of the Trust's serious incident process was undertaken. This has resulted in improved compliance with the national framework and more robust investigations. We will strengthen this further with the planned creation of a Quality Governance directorate, which will not only help embed a strong safety culture, but will facilitate the learning to ensure the number of serious incidents occurring is reduced.

12. The risk and control framework

The Trust embeds risk management through:

- Committees of the Board, their sub-groups and panels as outlined in the governance committee structure;
- Compliance with the registration by the CQC under the Health and Social Care Act 2008;
- Compliance with the Health and Social Care Act 2008;
- Risk register reviews;
- Internal performance management processes;
- Policies and procedures;
- Standing financial instructions and standing orders;
- Divisional Governance and Quality Groups.

12.1 Board Assurance Framework

A Board Assurance Framework (BAF) is a process by which the Trust gains assurance that it has a well-balanced set of objectives for the year and that there are controls and assurances in place to manage the key risks associated with achieving the objectives.

During 2013/14, the Board concluded, as identified in the risk summit, that the BAF was not sufficiently robust to give the Board assurance that all risks were being identified appropriately.

The corporate performance reports, with fewer risks, were being addressed through normal performance management arrangements, although this was not in a formalised and structured way. The Board therefore invested in a comprehensive review of the BAF and is confident that by summer 2014 new arrangements will be in place.

12.2 Other controls in place

- The Trust has in place a major incident plan in line with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance. All senior managers have received major incident training;

- The Trust's Business Continuity Plan was refreshed during 2013/14 in light of guidance issues in relation to the new arrangements for local health Emergency Planning Resilience and Response (EPRR);

- An Annual Plan, which was agreed by the Board and reported to the NHS TDA, includes specific and challenging but achievable objectives. These objectives have key performance indicators (KPIs), milestones and trajectories and are supported by enabling strategies for clinical quality, workforce, IT and estates which cross refer to divisional service plans and, in turn, contain KPIs, milestones and trajectories;

- An understanding of risk management and patient safety has been further embedded into the culture of the organisation through 'Onion' meetings, which are held every weekday morning. 'Onion' is about listening to clinical and non clinical staff and putting in place immediate changes to ensure patients are treated quickly, efficiently and correctly, first time. This provides a unique environment to highlight and escalate any patient safety concerns efficiently, thereby mitigating actual and potential risks and reducing the incidence of adverse events. This approach was credited within the Government's full response to the Francis Report as an example of best practice in preventing problems and delivering safe care to patients.

- Budgetary control processes and cost improvement management plans are in place. Outcomes are measured by monthly review of performance to the Board;

- As the nominated Senior Information Risk Officer (SIRO) the Chief Information Officer is responsible, along with the Medical Director as Caldicott Guardian, for ensuring there is a control system in place to maintain the security of information. The completion of the Information Governance Toolkit Assessment provides assurances that this is being managed;

- All serious incidents are reported to Commissioners via Strategic Executive Information Systems (STEIS) and to other bodies in line with current reporting requirements (e.g. the CQC). Root cause analysis investigation is undertaken for all Serious Incidents with action plans monitored through the Trust's Serious Incident Review Group and locally within the Divisions responsible for their implementation;

- All new members of staff are required to attend a mandatory induction, an element of which includes risk management. This is supplemented by local induction;

- Development of existing performance management framework for the divisions and the formal inclusion of this within the job description of the Chief Operating Officer;

- A quality governance review was completed during the year to inform the strategy for quality governance from 2014 onwards;

- Processes are in place to ensure that the Board has the suitable skills, knowledge and capacity to deliver the organisation's objectives. In 2013/14, this resulted in revised executive portfolios to ensure that the Board can adapt rapidly to changes in the local healthcare environment and sustain and speed up the pace of quality improvement;

- Revised methods of appraisal for Board members including a review of performance against individual objectives and the use of 360 degree appraisals;

- Key assurance committees of the Board focussing on quality and safety supported by formalised management groups led by accountable executives. Each has a work programme that reflects the expectations and performance of divisions and corporate activities;

- Formal processes to consider and document the potential impact on quality of cost improvement plans and other significant decisions. Cost improvements are agreed by Divisional Directors (clinical), Divisional Managers, Heads of Nursing, Members of the TLEC and the executive team. Quality impact assessments are signed off by the Medical Director and Chief Nurse;

- Improved communications through Chief Executive briefings and blogs, frequent executive 'walkabouts' during the day and night, 'unannounced' observational clinical visits and monthly divisional performance reviews against key metrics, including measures of service quality;

- The Trust has standing orders, standing financial instructions and a scheme of delegation in place, which are reviewed by the Board;

- The process to review, approve and disseminate policies and procedures to ensure they remain current and valid has been reviewed in 2013/14. This highlighted that the process needed strengthening. This is the focus of a specific piece of improvement work being delivered in early 2014/15;

- As reliance upon clinical audit for appropriate assurance has increased, the clinical audit plan has evolved to become more risk based and provides coverage across the Trust's activities and uses complaints, claims, incidents and negative assurance or concerns to drive audit. Following an in-year review of clinical audit, a new Clinical Audit Strategy has been developed;

- In 2013/14, a new integrated performance report was introduced as a standing Board agenda item. The report summarises the Trust's performance against all key quality, finance, compliance and workforce targets and indicators for 2013/14 and considers all elements of the provider management regime. In 2014/15 the Trust will further develop this and develop integrated quality reporting which will include trends analysis and the use of soft and hard intelligence to measure quality and identify early warning signs of failure. This is being led by the Chief Information Officer (SIRO).

- The Trust has a Local Counter Fraud Specialist (LCFS) whose work is directed by an annual workplan agreed by the Audit Committee. The LCFS has raised staff awareness and increased confidence this year with displays on the hospital sites to report suspicions of fraud to the LCFS whilst emphasising the zero tolerance approach of the Trust to fraud;

- Challenge by Board members, particularly the Non-Executive Directors, of the data presented and requests for more detailed underlying information in order to identify the root cause of potential issues of concern. Board challenge of this nature is documented in Board minutes and captured in any subsequent action plans.

13. Annual Quality Account

The Quality Account is developed by senior clinical managers and clinicians within the Trust in conjunction with stakeholders and partnership organisations. The Chief Nurse has overall responsibility to lead and advise on all matters relating to the preparation of the Quality Account.

The 2013/14 Quality Account was published in June 2014. It is available to download at www.westhertshospitals.nhs.uk, click on About us and key documents.

14. Quality governance

Quality Governance is a key element of the overall governance arrangements of the Trust. Quality is woven into all groups but the key groups involved in delivering the quality agenda are:

- Quality and Safety Group and its sub-panels;
- Divisional Governance and Quality Groups;
- PSQR Committee;
- Patient Experience Group;

The Trust has been registered with the CQC without conditions since March 2010.

The Trust recognises that the Health Act 2006 introduced a statutory duty on NHS organisations to observe the provisions of the Code of Practice on Healthcare Associated Infections. The Board is aware of its responsibilities in assuring that it has suitable systems and arrangements in place to ensure that the requirements of the code are being met.

14.1 Ward to Board

The Trust has further developed its key lines of communication between both the Trust Ward and Board level. The two main features of this communication are listed below:

- The introduction of a patient story at each Board meeting aligned to the Patient Experience Report. Patients are invited to attend the meeting to inform the Board of their experience. These stories ensure that positive and negative messages about the care being delivered within the Trust is visible to the Board, in the words of a patient;

- The Board has adopted the use of an integrated performance report for monitoring performance. The revised scorecard presents quality, operational and financial performance, so that an informed view can be taken across the whole without focusing solely on one area. This approach is being rolled out throughout the Trust to Divisional, specialty and ward levels.

15. Information governance

Responsibility for Information Governance in the Trust rests with the Chief Information Officer, who is the SIRO.

Risks relating to information governance are contained within the Information Governance Management Framework. An Informatics Group facilitates the work programme that ensures the Trust maintains compliance with relevant information governance legislation and good practice. The Trust has continued to review its data flows (both internal and external) during 2013/14 to ensure compliance with requests from the Department of Health ensuring bulk data is secure in transit.

The Trust Information Governance Assessment report overall score for 2013/14 was 69% and was rated satisfactory in the grading scheme. The annual self-assessment of information security was undertaken utilising the Information Governance Toolkit (IGT). This assessment enables the Trust to provide assurance of the provision and support to the Information Governance agenda and also highlights areas of weakness. The results of this assessment are used by the NHS TDA as part of the Compliance Framework and by the CQC as part of the Quality Risk Profiles (QRP).

In 2013/14, as in the previous year, the Trust achieved a satisfactory rating on the Information Governance Toolkit.

Information risks, either reactive (following incidents) or proactive (following risk assessments), are managed in the same way as all other risks identified in the Trust. They are reviewed by the Informatics Group and the TLEC.

There have been three serious breaches of the Data Protection Act (level 2 and above) in 2013/14 which required reporting to the Information Commissioner. These are summarised below:

Table 8: Serious breach

Serious breaches	Actions taken
1. A doctor's handover sheet and a multidisciplinary continuation sheet containing patient information were found by a member of the public.	Electronic handover is being rolled-out across the Trust, which will avoid the need to use paper. Introduction of bags that doctors can wear around their waist to allow papers to be carried around safely.
2. Two handover sheets containing patient information were found by a member of the public.	Electronic handover is being rolled-out across the Trust, which will avoid the need to use paper. Introduction of bags that doctors can wear around their waist to allow papers to be carried around safely.
3. An internal patient referral form with personal patient information was sent to the wrong patient.	Changes to the way referral forms are printed within the department, ie they are now printed on a secure print code rather than with other printing jobs.

16. Foundation Trust status

The Trust has not focussed on applying for Foundation Trust status in 2013/14 due to some of the issues discussed in this report. It remains a future opportunity.

17. Head of Internal Audit Opinion

The basis of the Opinion of the Internal Auditor is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;

- An assessment of the range of individual opinions arising from risk based audit assignments contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;

- Any reliance that is being placed upon third party assurances.

Overall, the internal auditors are able to provide limited assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently. In forming their view they took into account that;

- The Trust has made important strides forward this year in improving its governance and clinical processes. This has included Board changes, improvements to the Audit Committee and innovative arrangements, such as the risk summit and `Onion' to tackle deep seated issues such as lack of clinical ownership over required changes. There are clear signs of improvement to clinical outcomes, e.g. C. difficile;

- However, the internal auditor's opinion must reflect the year under audit and in the year there were some fundamental issues. The Trust determined that the risk register and Board Assurance Framework were not fit for purpose and they have not been maintained, to allow the Trust to focus on the risk summit process, which excluded finance. In terms of finance, the Trust has had four Directors of Finance during the year and the latest forecast is of a £13.5m deficit against a £0.6m forecast. The internal audit of cost improvement programme provided limited assurance on the effectiveness of controls;

- The Trust directed the internal auditors to problem areas, it responded to reports positively and the record on implementation of recommendations is good. The auditors believe the right steps are being taken to improve the control environment and, if implemented effectively, this would lead to a more positive internal audit opinion in future.

Internal audit assess level of assurance in terms of system design and system effectiveness. The following reports were considered with limited assurance in 2013/14:

- Clinical audit: limited system effectiveness
- Consultant job planning: limited design and system effectiveness
- Cost improvement plans and budgetary control: limited system effectiveness

The Trust is implementing the recommendations contained within these reports.

17. 1 Conclusion

I am satisfied of the adequacy of plans in place to address weaknesses identified by internal audit. In particular, the Trust has recruited a substantive Chief Financial Officer who will take up post in June 2014, and new arrangements for a Board Assurance Framework will be in place by early summer 2014. This will ensure continuous improvement in the Trust's control systems.

18. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

My review is also informed by:

- CQC registration;
- Internal Audit reports;
- External Audit reports;
- Auditors' Value for Money Assessment;
- CQC planned and responsive inspections;
- NHS Litigation Authority assessments;
- Clinical audits;
- Patient and staff surveys;
- Benchmarking information.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board; Audit Committee; PSQR Committee; Finance Committee and Workforce Committee. When issues are identified, plans are put in place to ensure that any learning is embedded in the organisation. This ensures that the system is subject to continuous improvement.

18.1 Significant risks

Based on my assessment of the assurances and evidence to support the review of the system of internal control for the 2013/14 period, a summary of the significant risks and actions taken to address these are detailed below.

Table 9: Significant risks

Significant risks	Actions taken
Failure to deliver services due to residual estates issues.	Funding sought and agreed to resolve significant residual estate issues. Work planned to be completed by Autumn 2014.
Risk that the cost improvement plan will impact on safety or unacceptably reduce service quality.	All potential cost improvement plans are reviewed by Chief Nurse and Medical Director to ensure patient safety and quality is not compromised.
Risk of exceeding the meticillin-resistant staphylococcus aureusis (MRSA) and C. difficile trajectory.	The Trust has robust systems in place, including auditing compliance to antibiotic guidelines and the availability of hand hygiene facilities in clinical areas. In 2014/15 the Trust will also launch a new hand hygiene campaign.
Completed 2013/14 with a £13.4 million deficit and achievement of 50% cost improvement programme.	External expertise engaged to support the Trust's capacity and capability in identifying and implementing cost improvement programme.
Cash liquidity.	The NHS Trust Development Authority has provided assurance that cash will be made available to meet the Trust's liabilities for the next 12 months.
Clinical strategy review of service provision across west Hertfordshire.	Active participation in review that is to be completed by the end of the year.
Lack of embedded assurance framework, risk register and continued limited internal audit opinion.	The importance of this is recognised and being reinvigorated through training across the Trust. The Trust has established a new risk register review group, which reports to the Risk Management Group.
Significant changes in Board membership, including Non-Executive Directors, Chief Operating Officer, Chief Finance Officer and chief nurse.	Substantive appointments are planned by early summer.
Inadequate resilience in core IT systems, coupled with inadequate fallback and disaster recovery arrangements will threaten the functioning of hospital information systems.	Significant investment planned over the next five years. Private sector partner with the requisite expertise appointed.
Inability to discharge patients when acute medical care no longer required impacts upon the Trust's ability to deliver elective workload and ability to achieve A&E targets.	The Trust is working closely with its community, social care and other NHS partners to ensure patients can promptly access the services they need, for instance support from a care worker in their own home or admission to a care home.
Failure to recruit, retain and motivate appropriately trained workforce will result in costly and inefficient services.	Significant investment being made in new organisation development programme, which will underpin the Trust's processes to recruit, induct, develop and manage staff.
Inability to organise and treat patients within the 18 week referral to treatment target because of a lack of capacity.	The Trust has a robust recovery plan in place which focuses specifically on the specialities where the Trust recognises targeted action is required.

The Board has a vital role in ensuring that the Trust has an effective system of internal control. 2013/14 has seen improvements in the system of internal control, which will be built upon in 2014/15.

My review confirms that, although we have had many challenges this year, West Hertfordshire Hospitals NHS Trust now has systems of internal control in place that support the achievement of its policies, aims and objectives. Going forward, these controls will be strengthened as described in the actions above.

Organisation: West Hertfordshire Hospitals NHS Trust
Accountable Officer:

Samantha Jones
Chief Executive Officer
West Hertfordshire Hospitals NHS Trust
4 June 2014

Our new Developing our Organisation (DO) initiative was launched in 2013/14

Declarations of interest

Table 10

Name	Title / Responsibility	Declared Interests
Mahdi Hasan	Non-Executive Director Senior Independent Director Vice-Chairman Trust Board Chair of IRaGC	• Projects Advisor to Japan Canada Oil Sands Ltd, Calgary • Project Advisor to Maersk Drilling, Copenhagen • Member of Consultants of Distinction Forum, The Hague • Volunteer Driver, West Hertfordshire Hospitals NHS Trust • Consultant to Schlamberger Business Consulting
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 Counci
Chris Green	Non-Executive Director Chair of Finance Committee	• Non-Executive Director of Dover Harbour Board
Phil Townsend	Non-Executive Director	None
Robin Douglas	Non-Executive Director (co-opted)	• Chair of Health and 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 Hospital NHS Foundation Trust
Natalie Forrest	Director of Nursing Interim Chief Executive Oct – Jan 2013) Interim Chief Operating Officer / Deputy Chief Executive (from Feb 2013)	None
Anna Anderson	Director of Finance	None
Patrick Butterworth	Director of Finance	None
Malcom Dennett	Interim Director of Finance and Infrastructure	None
Claire Stafford	Acting Director of Finance	None
Maxine McVey	Interim Director of Nursing (from Feb 2013)	None
Jackie Ardley	Chief Nurse	• Director of Jackie Ardley Consulting Ltd
Paul Jenkins	Director for Partnerships	• Trustee THT
Mark Vaughan	Director of Workforce	None
Anne Robson	Director of Workforce	None
Louise Gaffney	Director of Strategy and Infrastructure	None
John Brougham	Non-Executive Director	• Non Executive Director Technetix Ltd non executive director and chair of the audit committee of eg Solution
Jonathan Rennison	Non-Executive Director	• Director of Yellow Chair Ltd
Stephen Hay	Non-Executive Director	• Associate Good Governance Institute
Virginia Edwards	Non-Executive Director	• Trustee Peace Hospice • Director Edwards Consulting Ltd • Trustee Association for Preoperative Practice • Husband Nigel Edwards is CEO of Nuffield Trust from 01/04/14 • Husband Nigel Edwards is a non-remunerated board member of Guys and St. Thomas's Charitable Trust • Trustee Hertsmere CAB • Associate GGI • Member of Rotary Club of Bushey
Antony Tiernan	Director of Corporate Affairs and Communication	None
Bernie Bluhm	Interim Chief Operating Officer	• Director - Bernie Bluhm Consulting Ltd
Michael van der Watt	Medical Director	• Partner – Bushey Cardiac Centre • Owner and Director Heart Consultants Ltd • Private Practice

Directors' remuneration 2013/14

			2013/14				2012/13			
Name	Title	In year start/leave dates	SALARY (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	TOTAL bands of £5,000	SALARY (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	TOTAL bands of £5,000
T. Hanahoe	Chairman	Left Apr 13	0-5	0	0	0-5	20-25	4	0	20-25
M. Hasan	Chairman	Start May 13	20-25	0	0	20-25	0	0	0	0
J. Filochowski	Chief Executive	Left Post Oct 12	-	-	-	-	125-130	0	40-45	170-175
S. Jones	Chief Executive	Start Feb 13	190-195	2	0	190-195	25-30	0	0	25-30
R. Douglas	Non-Executive Director	Left Nov 13	0-5	0	0	0-5	5-10	0	0	5-10
K. Charter	Non-Executive Director	Left Jan 14	5-10	2	0	5-10	5-10	0	0	5-10
M. Hasan	Non-Executive Director	Left Apr 13	0-5	0	0	0-5	5-10	0	0	5-10
S. Connor	Non-Executive Director	Left Nov 13	0-5	2	0	0-5	5-10	0	0	5-10
C. Green	Non-Executive Director	Left Nov 13	0-5	0	0	0-5	5-10	0	0	5-10
P. Townsend	Non-Executive Director		5-10	1	0	5-10	5-10	0	0	5-10
S. Hay	Non-Executive Director	Start Dec 13	0-5	0	0	0-5	0	0	0	0
V. Edwards	Non-Executive Director	Start Jan 14	0-5	0	0	0-5	0	0	0	0
J. Brougham	Non-Executive Director	Start Jan 14	0-5	0	0	0-5	0	0	0	0
J. Rennison	Non-Executive Director	Start Jan 14	0-5	0	0	0-5	0	0	0	0
A. Anderson	Director of Finance	Left Jun 13	25-30	0	0	25-30	115-120	2	20-25	140-145
P. Butterworth	Director of Finance	Start Jun 13 - Left Dec 13	70-75	1	0	70-75	0	0	0	0
M. Dennett	Interim Director of Finance and Infrastructure	Start Oct 13 - Left Mar 14	75-80	0	0	75-80	0	0	0	0
C. Stafford (note 1)	Acting Chief Financial Officer	Start Mar 14	-	-	-	-	-	-	-	-
C. Pocklington	Chief Operating Officer	Left post Mar 13	-	-	-	-	125-130	0	15-20	145-150
N. Forrest	Acting Chief Operating Officer, Chief Nurse		110-115	0	0	110-115	120-125	0	15-20	140-145
B. Bluhm (note 2)	Interim Chief Operating Officer	Start Apr 13 - Left Mar 14	-	-	-	-	-	-	-	-
M. McVey	Acting Director of Nursing	Left Jun 13	20-25	1	0	20-25	35-40	0	0	35-40
J. Ardley (note 3)	Chief Nurse	Start Jul 13	-	-	-	-	-	-	-	-
P. Jenkins	Director of Partnerships and Performance		105-110	2	0	105-110	105-110	3	0	105-110
A. Tiernan	Director of Corporate Affairs and Communications	Start Jul 13	70-75	0	0	70-75	0	0	0	0
M. Vaughan (note 4)	Director of Workforce	Left Feb 14	155-160	3	0	155-160	95-100	3	15-20	115-120
A. Robson (note 5)	Interim Director of Workforce	Start Dec 13	-	-	-	-	-	-	-	-
L. Gaffney	Director of Strategy and Service Improvement		95-100	3	0	95-100	95-100	2	0	95-100
L. Rippon	Director of Communications and Transformation	Left Jan 13	-	-	-	-	120-125	-	-	120-125
C. Johnston	Medical Director / Clinician	Left post Mar 13	-	-	-	-	185-190	0	25-30	215-220
M. Van Der Watt (note 6)	Medical Director	Start Apr 13	250-255	0	0	250-255	0	0	0	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 2013/14 was £252.5k. This was 8 times the median remuneration of the workforce, which was £31.4k. In 2012-13 the highest paid director banding was £252.5k, 8.5 times the median of £29.4k. No employee received remuneration in excess of the highest paid director. Remuneration ranged for full time employees from pay banding £10-£15k to £250-255K. Total remuneration includes salary, non-consolidated performance related pay and benfits-in-kind. It does not include severance payments, employer pension contributions nor the additional cash equivalent transfer value of pensions.

The Trust has no directors with long term performance pay and bonuses or any pension-related benefits.

Notes

Note 1: Acting Chief Financial Officer at year end 2013/14. Director salary excluded from table.
Note 2: Off Payroll arrangement. Invoiced total of £195.8k includes daily rate plus VAT.
Note 3: Agency appointment. The cost charged to the Trust which includes salary, employers N.I., agency costs and VAT was £206.5k
Note 4: Salary includes lump sum payment under Voluntary Resignation Scheme. This is included in Exit Packages note 9.4 of the Trust Accounts.
Note 5: Agency appointment. The cost charged to the Trust which includes salary, employers N.I., agency costs and VAT was £86.4k
Note 6: 73% of salary relates to Director post. The balance is for clinical work.

Samantha Jones
Chief Executive
West Hertfordshire Hospitals NHS Trust
4 June 2014

Directors' pension remuneration

Name	Real increase in pension at age 60 bands of £2,500	Real increase in pension lump sum at age 60 bands of £2,500	Total accrued pension at age 60 at 31 March 2014 bands of £5,000	Lump sum at age 60 related to accrued pension at 31 March 2014 bands of £5,000	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Real increase in Cash Equivalent Transfer Value bands of £1,000	Employer's contribution to stakeholder pension
S. Jones	5-7.5	10-12.5	30-35	90-95	444,815	371,609	65	0
N. Forrest	0-2.5	0-2.5	15-20	45-50	256,600	247,905	1	0
P. Jenkins	0-2.5	0-2.5	30-35	95-100	597,698	559,856	0	0
M. Vaughan	0-2.5	0-2.5	30-35	95-100	627,788	582,274	22	0
L. Gaffney	0-2.5	2.5-5	25-30	75-80	428,642	385,035	35	0
M. McVey	0-2.5	0-2.5	30-35	90-95	527,119	485,262	8	0
A. Tiernan	0-2.5	0-2.5	10-15	35-40	168,627	118,664	12	0
P. Butterworth	0-2.5	0-2.5	0-5	0-5	7,188	0	2	0
M. Van der Watt (No prior year as Director wef Apr 13)	–	–	–	105-110	682,267	–	–	–

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 particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme or chooses to transfer the benefits accrued in their former pension scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

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

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

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

Samantha Jones
Chief Executive
West Hertfordshire Hospitals NHS Trust
4 June 2014

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 2014 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 and related narrative notes;
- The table of pension benefits of senior managers and related narrative notes;
- The table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of West Hertfordshire Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in April 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the accounts, the Directors and responsible for the preparation of the financial statements for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standard 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 and to identify any information that is apparently materially inconsistent with the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- Give a true and fiar view of the financial position of West Hertfordshire Hospitals NHS Trust as at 31 March 2014 and of its expenditure and income for the year then ended; and
- 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; and
- The information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- In our opinion the governance statement does not reflect compliance with the Trust Development Authority's Guidance;
- We refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have 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; or
- We issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and auditor

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

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

We report if significant matters have come to our attention which prevent us from concluding that the Trust 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 October 2013, as to whether the Trust has proper arrangements for:

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

The Audit Commissioner has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2014.

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 has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for adverse conclusion

In seeking to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, we have considered the following matters in relation to financial resilience:

- The Trust reported a deficit of £13.4m against an original planned £600,000 surplus in 2013/14;
- The Trust is projecting a deficit of £14m for 2014/15. The deficit plan for 2014/15 has been agreed with the relevant stakeholders;
- The Trust's risk management process and Board Assurance Framework were ineffective which resulted in a 'limited assurance' Internal Audit opinion for 2013/14; and
- There is no medium-term financial plan in place whilst the Trust awaits the outcome of a clinical review of healthcare in West Hertfordshire.

Adverse conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2013, the matters reported in the basis for adverse conclusion paragraph above prevent us from being 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 2014.

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 2014

Statement of comprehensive income for the year ended 31 March 2014

	NOTE	2013/14 £000s	2012/13 £000s
Employee benefits	9.1	**(194,383)**	(175,017)
Other operating expenses	7	**(103,948)**	(99,864)
Revenue from patient care activities	4	**259,298**	249,024
Other operating revenue	5	**31,821**	29,206
Operating surplus/(deficit)		**(7,212)**	3,349
Investment income	12	**39**	43
Finance costs	14	**(838)**	(1,037)
Surplus/(deficit) for the financial year		**(8,011)**	2,355
Public dividend capital dividends payable		**(3,097)**	(3,223)
Retained surplus/(deficit) for the year		**(11,108)**	(868)
Other Comprehensive Income			
Impairments on revaluation of property, plant & equipment	15.1	**(1,198)**	(1,052)
Net gain/(loss) on revaluation of property, plant & equipment	15.1	**6,285**	161
Total Comprehensive Income for the year		**(6,021)**	(1,759)
Financial performance for the year			
Retained surplus/(deficit) for the year		**(11,108)**	(868)
Impairments		**(2,252)**	2,811
Depreciation of donated assets in excess of donated income		**(10)**	(39)
Adjusted retained surplus/(deficit)		**(13,370)**	1,904

The adjusted retained deficit of £13.4m is after reversal of impairments and the net of donated income and depreciation. The Trust performance is measured on this adjusted deficit.

Statement of financial position as at 31 March 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	15.1	**141,812**	124,163
Intangible assets	16.1	**665**	1,386
Trade and other receivables	20.1	**1,386**	1,325
Total non-current assets		**143,863**	126,874
Current assets:			
Inventories	19	**3,813**	3,106
Trade and other receivables	20.1	**13,845**	10,389
Cash and cash equivalents	22	**6,314**	9,347
Total current assets		**23,972**	22,842
Non-current assets held for sale	23	**323**	323
Total current assets		**24,295**	23,165
Total assets		**168,158**	150,039
Current liabilities			
Trade and other payables	24	**(41,412)**	(25,290)
Provisions	29	**(826)**	(811)
Working capital loan from Department Health	26	**(1,400)**	(1,400)
Capital loan from Department Health	26	**(2,772)**	(2,772)
Total current liabilities		**(46,410)**	(30,273)
Net current assets/(liabilities)		**(22,115)**	(7,108)
Non-current assets plus/less net current assets/liabilities		**121,748**	119,766
Non-current liabilities			
Provisions	29	**(5,313)**	(4,975)
Working capital loan from Department Health	26	**0**	(1,400)
Capital loan from Department Health	26	**(8,307)**	(11,079)
Total non-current liabilities		**(13,620)**	(17,454)
Total Assets Employed:		**108,128**	102,312
FINANCED BY: TAXPAYERS' EQUITY			
Public Dividend Capital		**193,805**	181,968
Retained earnings		**(104,404)**	(93,296)
Revaluation reserve		**18,727**	13,640
Total Taxpayers' Equity:		**108,128**	102,312

The notes on pages 55 to 67 form part of this account, were approved by the Board on 4 June 2014 and signed on its behalf by:

Samantha Jones, Chief Executive
Date: 4 June 2014

Statement of changes in taxpayers' equity for the year ended 31 March 2014

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2013	**181,968**	**(93,296)**	**13,640**	**102,312**
Changes in taxpayers' equity for 2013/14				
Retained surplus/(deficit) for the year		(11,108)		**(11,108)**
Net gain/(loss) on revaluation of property, plant, equipment			6,285	**6,285**
Impairments and reversals			(1,198)	**(1,198)**
New PDC Received - Cash	11,837			**11,837**
Net recognised revenue/(expense) for the year	**11,837**	**(11,108)**	**5,087**	**5,816**
Balance at 31 March 2014	**193,805**	**(104,404)**	**18,727**	**108,128**
Balance at 1 April 2012	**180,668**	**(92,434)**	**14,537**	**102,771**
Changes in taxpayers' equity for the year ended 31 Mar '13				
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**

Statement of cash flows for the year ended 31 March 2014

	2013/14 £000s	2012/13 £000s
Cash flows from operating activities		
Operating Surplus/Deficit	**(7,212)**	3,349
Depreciation and Amortisation	**8,184**	7,122
Impairments and Reversals	**(2,252)**	2,811
Donated Assets received credited to revenue but non-cash	**(210)**	(268)
Interest Paid	**(758)**	(933)
Dividend (Paid)/Refunded	**(2,971)**	(3,210)
(Increase)/Decrease in Inventories	**(707)**	(74)
(Increase)/Decrease in Trade and Other Receivables	**(3,643)**	(1,163)
Increase in Trade and Other Payables	**13,123**	5,598
Provisions Utilised	**(629)**	(563)
Increase/(Decrease) in Provisions	**890**	421
Net Cash Inflow/(Outflow) from Operating Activities	**3,815**	13,090
Cash flows from investing activities		
Interest Received	**40**	44
(Payments) for Property, Plant and Equipment	**(12,426)**	(10,763)
(Payments) for Intangible Assets	**(2,127)**	(3)
Net Cash Inflow/(Outflow) from Investing Activities	**(14,513)**	(10,722)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(10,698)**	2,368
Cash flows from financing activities		
Public dividend capital received	**11,837**	1,300
Loans repaid to DH - Capital investment loans repayment of principal	**(2,772)**	(2,772)
Loans repaid to DH - Revenue Support Loans	**(1,400)**	(1,400)
Net cash (outflow)/inflow from financing activities	**7,665**	(2,872)
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS	**(3,033)**	(504)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**9,347**	9,851
Cash and Cash Equivalents (and Bank Overdraft) at year end	**6,314**	9,347

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, issued by the Department of Health, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013/14 NHS Trusts' Manual for Accounts. 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 those estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (note 1.3.2) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector such as the Trust, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements are prepared on a going concern basis unless there were plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future financial support. The Trust has submitted a financial plan for 2014/15 to the NHS Trust Development Authority (NHS TDA) which delivers a £14m deficit. This includes a savings target of £13.4m and an expectation that emergency activity will be paid at tariff. The plan includes a requirement for £30.2m of cash support from the Department of Health to maintain the Trust's cash flows in 2014/15.

The Directors have received confirmation from the NHS TDA that they will make sufficient cash financing available to the organisation over the next twelve month period such that the organisation is able to meet its current liabilities.

- 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 8.
- 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 monies paid to Watford Borough Council for the construction of a new access road to Watford General Hospital have been capitalised and impaired as the road will not be owned by the Trust; see note 16.1.
- The fair value of early retirement provisions has been reassessed using the latest information from Pensions Agency and the Government Actuary Department (GAD) tables detailing revised life expectancy. The combination of latest GAD tables and change in discount rate has resulted in an estimated increase in costs; see note 29.1.

1.3.2 Key sources of estimation uncertainty

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

- the value of patient care spells that are part-completed in note 1.5. 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.
- from 1 April 2013 income from commissioners for maternity care is received at commencement of the Care Pathway. An estimate of partially completed activity at year end has been deferred.
- the valuation of land and buildings using the modern equivalent assset discounted replacement cost method detailed in note 15.3. The basis of estimate for Watford site includes changes to internal area informed by new drawings and revised build dates.

1.4 Charitable funds

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has assessed whether it is appropriate to group the Trust's accounts and those of West Hertfordshire Hospitals NHS Trust Charity. The Trust Board as corporate trustee of the charity has the power to exercise control so as to obtain economic benefits therefore consolidation is appropriate. However the transactions are immaterial in the context of the group and are therefore not consolidated. A summary of the Charity's activities disclosed in note 33.1.

1.5 Revenue

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

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

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

1.6 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.7 Other expenses

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

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;

- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent had similar purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Capital expenditure on strategic schemes, i.e. those schemes which are of a longer-term nature such as building or large infrastructure projects, is initially charged to assets in the course of construction during the construction phase. Capital schemes are regularly assessed for progress, and once completed, costs are transferred from assets in the course of construction to the appropriate asset category and are recognised as coming into full use.

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

Valuation

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

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

Until 31 March 2009, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. With effect from 1 April 2009, through its appointed valuers GVA Grimley Ltd the Trust has adopted the HM Treasury standard approach to depreciated replacement cost valuations based on modern equivalent assets. The effect of this estimation technique is detailed in note 15.3.

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

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

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

Subsequent expenditure

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

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5k.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant or equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

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

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

1.10 Depreciation, amortisation and impairments

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Further details of each class of asset is shown in note 15.3.

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

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

In compliance with the 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, DELs are set as part of NHS spending are not expected to be exceeded. AME is less predictable and, subject to Treasury approval, may be revised. 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 15.3.

1.11 Donated assets

The Trust amended its approach to accounting for donated assets in line with the accounting policy change in the 2011-12 Treasury Financial Reporting Manual (FREM). Consequently 2013/14 and the 2012-13 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.

1.12 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale and it is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

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

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

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. The Trust does not hold any finance leases, its leases are classified as operating leases, further details of which are contained in note 8.

The Trust as lessee

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

The Trust as lessor

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

1.14 Inventories

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

1.15 Cash and cash equivalents

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

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

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the appropriate HM Treasury's discount rate. Liabilities expected to be settled in 0 to 5 years are discounted at minus 1.9%, 5 to 10 years at minus 0.65% and beyond 10 years at 2.2%. Those relating to employee early retirement obligations are discounted at 1.80%.

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.

1.17 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA who in return settles all clinical negligence claims.
Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 29.2.

1.18 Non-clinical risk pooling

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

1.19 Contingencies

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

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

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

1.20 Financial assets

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

1.21 Financial liabilities

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

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

1.22 Value added tax (VAT)

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

1.23 Foreign currencies

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

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 36 to the accounts.

1.25 Public Dividend Capital (PDC) and PDC dividend

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

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

1.26 Losses and special payments

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

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

1.27 Research and Development

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

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

The Treasury FReM does not require the Trust to apply the following Standards and Interpretations in 2013/14; 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 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
- IFRS 12 - Disclosure of Interests in Other Entities
- IFRS 13 - Fair Value Measurement
- IPSAS 32 - Service Concession Arrangement

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 Clinical Commissioning Groups (CCGs) which have replaced the Primary Care Trusts (PCTs) as the main commissioners, each contract covering the complete range of activities provided. The Trust's assets are used collectively to deliver the range of activities encompassed within these contracts.

3 Income generation activities

The Trust does not conduct material income generation activities outside of its usual business, where the aim is to achieve a profit, to be used in patient care.

4 Revenue from patient care activities

	2013/14 £000s	2012/13 £000s
NHS England	**18,435**	
Clinical Commissioning Groups	**231,744**	
Primary Care Trusts		244,297
CCGs previously PCTs- transformation funds	**1,350**	2,357
NHS Other (including Public Health England and NHS Property Services Ltd)	**279**	
Non-NHS:		
Local Authorities	**4,898**	142
Private patients	**1,151**	1,156
Overseas patients (non-reciprocal)	**212**	119
Injury costs recovery	**1,193**	921
Other	**36**	32
Total Revenue from patient care activities	**259,298**	249,024

5 Other operating revenue

	2013/14 £000s	2012/13 £000s
Education, training and research	**10,020**	8,910
Charitable and other contributions to revenue expenditure - NHS	**89**	66
Receipt of donations for capital acquisitions - NHS Charity	**210**	268
Non-patient care services to other bodies	**10,672**	13,821
Income generation	**1,977**	1,550
CCGs- Other (see note 6)	**3,713**	0
CCGs previously PCTs- transformation funds	**4,147**	3,602
Rental revenue from operating leases	**993**	989
Total Other Operating Revenue	**31,821**	29,206
Total operating revenue	**291,119**	278,230

6 Details of Trust revenue

Most of the Trust's income is derived through contracts with Clinical Commissioning Groups and other NHS organisations and is almost entirely from the supply of services; income from the sale of goods being immaterial. As shown in note 4 and 5 the Trust may receive additional funds outside of the main contract. Transformation funds relating to patient care activities helped the Trust manage capacity during periods of increased activity e.g. over winter. Transformation funds for non patient activities support the costs of maintaining the Trust's three hospitals and initiatives to improve efficiency.

CCGs - Other income in note 5 relates to investments in service delivery to reduce avoidable readmissions and penalties. In 2012-13 there was no investment.

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

7 Operating expenses

	2013/14 £000s	2012/13 £000s
Services from other NHS Trusts	**2,027**	1,415
Services from other NHS bodies	**218**	211
Services from NHS Foundation Trusts	**816**	1,023
Total Services from NHS bodies	**3,061**	2,649
Purchase of healthcare from non-NHS bodies - see i) below	**2,082**	2,606
Trust Chair and Non-executive Directors	**58**	62
Supplies and services - clinical	**44,544**	42,075
Supplies and services - general	**10,547**	9,516
Consultancy services	**2,127**	1,473
Establishment	**4,110**	3,116
Transport	**2,382**	2,535
Premises	**15,550**	14,894
Hospitality - see ii) below	**28**	41
Insurance - see ii) below	**220**	182
Legal Fees - see ii) below	**201**	113
Impairments and reversals of receivables	**448**	247
Depreciation	**7,337**	6,262
Amortisation	**847**	860
Impairments and reversals of property, plant and equipment - see iii) below	**(4,252)**	2,811
Impairments and reversals of intangible assets - see iii) below	**2,000**	0
Audit fees - see v) below	**99**	127
Other auditor's remuneration - see vi) below	**18**	0
Clinical negligence	**6,700**	6,746
Education and Training	**543**	587
Increase in current cost of provisions - see note 29	**700**	0
Other - see iv) below	**4,598**	2,962
Total Operating expenses (excluding employee benefits)	**103,948**	99,864
Employee Benefits		
Employee benefits excluding Board members	**193,191**	174,147
Board members	**1,192**	870
Total Employee Benefits	**194,383**	175,017
Total Operating Expenses	**298,331**	274,881

i) Purchase of healthcare from non NHS bodies relates to the outsourcing of activity both to meet waiting time targets and manage bed capacity.
ii) Additional analysis of expenditure compared with 2012/13. Other costs has been adjusted to reflect comparison.
iii) The Trust's revaluation of its land and building and investment in a new access road to Watford Hospital is charge to expenses per notes 15.3 and 16.1.
iv) The increase in other costs relates mainly to the Trust's share in developing the business case for the Watford Health Campus and appointing a private sector partner to take this development forward and investment in developing the Trust's future clinical strategy.
v) The net audit fees include a rebate from the Audit Commission of £13k.
vi) The other auditors remuneration of £18k relates to an HR payroll review.

8 Operating leases

8.1 Trust as lessee

- 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 and
- The equipment when returned is complete and in reasonable condition.

Payments recognised as an expense	**2013/14 £000s**	2012/13 £000s
Minimum lease payments	**348**	350
	348	350
Payable:		
No later than one year	**268**	255
Between one and five years	**661**	280
After five years	**11**	0
Total	**940**	535

8.2 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 the children of staff.

	2013/14 £000s	2012/13 £000s
Rental revenue	**993**	989
Receivable:		
No later than one year	993	750
Between one and five years	4,963	3,748
After five years	619	599
Total	**6,575**	5,097

9 Employee benefits and staff numbers

9.1 Employee benefits

2013/14	**Total £000s**	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**166,957**	133,617	33,340
Social security costs	**10,725**	10,725	0
Employer Contributions to NHS BSA - Pensions Division	**16,061**	16,061	0
Termination benefits	**672**	672	0
Total employee benefits	**194,415**	**161,075**	**33,340**
Employee costs capitalised	**32**	0	32
Gross Employee Benefits excluding capitalised costs	**194,383**	**161,075**	**33,308**

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

9.2 Staff numbers

	2013/14 Total Number	**Permanently employed Number**	**Other Number**	2012/13 Total Number
Average Staff Numbers				
Medical and dental	**559**	520	39	567
Ambulance staff	**0**	0	0	0
Administration and estates	**947**	884	63	934
Healthcare assistants and other support staff	**632**	632	0	699
Nursing, midwifery and health visiting staff	**1,526**	1,168	358	1,303
Nursing, midwifery and health visiting learners	**8**	8	0	8
Scientific, therapeutic and technical staff	**463**	404	59	446
Social Care Staff	**0**	0	0	0
Other	**45**	36	9	33
Totals	**4,180**	**3,652**	**528**	3,990
Of the above - staff engaged on capital projects	**1**	0	1	3

9.3 Staff sickness absence and ill health retirements

	2013/14 Number	2012/13 Number
Total Days Lost	27,329	27,707
Total Staff Years	3,615	3,546
Average working Days Lost	7.56	7.81

	2013/14 Number	2012/13 Number
Number of early on ill health grounds	4	0

There are no additional pension liabilities accrued in the year.

9.4 Exit packages agreed in 2013/14

Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed**	**Total number of exit packages**	**Total cost of exit packages**
	Number	**£s**	**Number**	**£s**	**Number**	**£s**
Less than £10,000	0	0	3	25,715	3	25,715
£10,000-£25,000	2	34,182	4	71,031	6	105,213
£25,001-£50,000	2	58,373	10	370,971	12	429,344
£50,001-£100,000	0	0	2	112,000	2	112,000
Totals	**4**	**92,555**	**19**	**579,717**	**23**	**672,272**

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 and does not include any other exit packages.

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 9.3 and are not included in this note.

9.4 Exit packages agreed in 2012/13

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	£s	Number	£s	Number	£s
Less than £10,000	2	15,568	3	19,160	5	34,728
£10,000-£25,000	2	33,860	2	35,540	4	69,400
£25,001-£50,000	0	0	2	87,648	2	87,648
£50,001-£100,000	0	0	1	54,600	1	54,600
Totals	4	49,428	8	196,948	12	246,376

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

Redundancies have been paid in accordance with NHS agenda for change terms and conditions. Other departure costs have been paid in accordance with the Trust's voluntary resignation scheme and does not include any other exit packages.

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 9.3 and are not included in this note.

9.5 Exit packages

	2013/14 Agreements	**Total value of agreements**	2012/13 Agreements	Total value of agreements
	Number	**£000's**	Number	£000's
Trust voluntary resignation scheme	**19**	**580**	8	197

The above does not include any non-contractual severance payment made following judicial mediation or relating to non-contractual payments in lieu of notice.

The remuneration report includes disclosure of exit payments payable to individuals named in that report.

10 Pension costs

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 NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. Details of these are as follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

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

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 13.3% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. 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.

c) Scheme provisions

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

Annual pensions

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

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

Pensions indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in 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 AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 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.

11.1 Better payment practice code - measure of compliance

	2013/14		2012/13	
Non-NHS Payables	**Number**	**£000s**	Number	£000s
Total Non-NHS Trade Invoices Paid in the Year	**55,720**	**129,418**	52,798	100,737
Total Non-NHS Trade Invoices Paid Within Target	**44,904**	**92,804**	45,228	80,233
Percentage of NHS Trade Invoices paid within target	**81%**	**72%**	86%	80%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,710**	**7,834**	2,533	10,447
Total NHS Trade Invoices Paid Within Target	**1,920**	**5,081**	2,125	8,779
Percentage of NHS Trade Invoices Paid Within Target	**71%**	**65%**	84%	84%

12 Investment income

	2013/14	2012/13
	£000s	£000s
Bank interest	**39**	43

13 Other gains and losses

The Trust has no other gains or losses.

14 Finance costs

	2013/14	2012/13
Interest	**£000s**	£000s
Interest on loans	**746**	930
Provisions - unwinding of discount in determining the fair value of provisions	**92**	107
Total	**838**	1,037

15 Property, plant and equipment

15.1 2013/14

	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 2013	**31,801**	**72,610**	**692**	**13,066**	**29,757**	**176**	**12,335**	**2,195**	**162,632**
Additions of Assets Under Construction	0	0	0	**15,431**	0	0	0	0	**15,431**
Additions Purchased	0	0	0	0	5	0	0	0	**5**
Additions Donated	0	0	0	0	210	0	0	0	**210**
Reclassifications	40	6,816	63	(9,514)	2,038	0	278	279	**0**
Upward revaluation/positive indexation	2,898	3,889	0	0	0	0	0	0	**6,787**
Impairments/negative indexation	0	(1,155)	(42)	0	0	0	0	0	**(1,197)**
At 31 March 2014	**34,739**	**82,160**	**713**	**18,983**	**32,010**	**176**	**12,613**	**2,474**	**183,868**
Depreciation									
At 1 April 2013	**0**	**5,362**	**541**	**0**	**22,301**	**159**	**9,892**	**214**	**38,469**
Impairments	0	2,738	0	0	0	0	0	0	**2,738**
Reversal of Impairments	0	(6,175)	(183)	0	0	0	0	(130)	**(6,488)**
Charged during the year	0	4,023	50	0	2,246	6	832	180	**7,337**
At 31 March 2014	**0**	**5,948**	**408**	**0**	**24,547**	**165**	**10,724**	**264**	**42,056**
Net Book Value at 31 March 2014	**34,739**	**76,212**	**305**	**18,983**	**7,463**	**11**	**1,889**	**2,210**	**141,812**
Asset financing:									
Purchased	34,739	76,095	304	18,833	6,808	11	1,888	2,209	**140,887**
Donated	0	117	1	150	655	0	1	1	**925**
Total at 31 March 2014	**34,739**	**76,212**	**305**	**18,983**	**7,463**	**11**	**1,889**	**2,210**	**141,812**
Revaluation Reserve Balance for Property, Plant & Equipment									
At 1 April 2013	6,032	7,015	(9)	0	602	0	0	0	**13,640**
Movements	2,397	2,501	9	180	0	0	0	0	**5,087**
At 31 March 2014	**8,429**	**9,516**	**0**	**180**	**602**	**0**	**0**	**0**	**18,727**
Additions to Assets Under Construction in 2013/14									
Buildings excl Dwellings				11,419					
Plant & Machinery				4,012					
Balance as at YTD				**15,431**					

15.2 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	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)
Revaluation & indexation gains	0	92	0	0	69	0	0	0	161
Impairments	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**

15.2 2012/13 (continued)

	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
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	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	0	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**

15.3 Property, plant and equipment (continued)

Of the £15,431k additions, £210k 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. In 2013-14 a full valuation has been carried out by GVA Grimley Ltd.

	Watford Hospital	Hemel Hempstead Hospital	St Albans Hospital	Total
	£000s	£000s	£000s	£000s
2013/14				
Operating expenses - note 7				
Land - MEA	-74	-428	0	(502)
Buildings, dwellings and fittings - MEA	(4,728)	364	614	(3,750)
Total	(4,802)	(64)	614	(4,252)
Statement of change in taxpayers equity				
Land - MEA	(979)	0	(1,417)	(2,396)
Buildings, dwellings and fittings - MEA	(1,974)	330	(1,047)	(2,691)
	(2,953)	330	(2,464)	(5,087)
Total impairment (reversal) 2013/14	(7,755)	266	(1,850)	(9,339)
2012/13	£000s	£000s	£000s	£000s
Operating expenses - 2012/13				
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

The impairment charged to operating expenses is classified as annually managed expenditure for the purposes of NHS consolidated accounts - see note 1.10.

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

For plant and machinery, transport, information technology, the carrying value as at 1 April 2009 is written off over their remaining lives. Net assets in these classes are carried at depreciated historic cost as this is not considered to be materially different from fair value (see note 1.8). Property Plant and Equipment includes £22.9m of fully depreciated assets.

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

	As at 31 March 2014		As at 31 March 2013	
	Maximum remaining asset life	Minimum remaining asset life	Maximum remaining asset life	Minimum remaining asset life
Asset Class	Years	Years	Years	Years
Buildings	**50**	**5**	56	2
Dwellings	**30**	**8**	32	7
Plant and machinery	**9**	**1**	9	1
Transport	**2**	**1**	3	1
Information Technology	**5**	**1**	5	1
Furniture and Fittings	**50**	**5**	56	2

The full valuation exercise included revision to the remaining asset lifes of some buildings and their fittings, consequently the maximum remaing lifes between 31 March 14 and 31 March 13 do not necessarily reduce by one year.

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.

16

16.1 Intangible non-current assets 2013/14

	IT - in-house & 3rd party software	Development Expenditure - Internally Generated	Total
	£000s	£000's	£000's
At 1 April 2013	**6,903**	**43**	**6,946**
Additions - purchased	0	2,126	**2,126**
At 31 March 2014	**6,903**	**2,169**	**9,072**
Amortisation			
At 1 April 2013	**5,560**	**0**	**5,560**
Impairment charged to operating expenses	0	2,000	**2,000**
Charged during the year	847	0	**847**
At 31 March 2014	**6,407**	**2,000**	**8,407**
Net Book Value at 31 March 2014	**496**	**169**	**665**
Net book value at 31 March 2014 comprises:			
Purchased	496	169	665
Donated	0	0	0
Total at 31 March 2014	**496**	**169**	**665**

16.2 Intangible non-current assets prior year 2012/13

	IT - in-house & 3rd party software	Development Expenditure - Internally Generated	Total
Cost or valuation:	£000s	£000's	£000's
At 1 April 2012	6,903	40	6,943
Additions - purchased	0	3	3
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
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
Total at 31 March 2013	1,343	43	1,386

The maximum remaining asset life of computer software in use is 5 years.

There are no material intangible assets fully amortised in use.

There were no changes in asset lives, residual values, or impairment loss recognised during the period for assets in use. The impairment charged to operating expenses relates to the new access road to Watford Hospital see note 1.3.1.

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

17 Commitments

17.1 Capital commitments

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

	31 March 2014	31 March 2013
	£000s	£000s
Property, plant and equipment	**2,784**	1,935
Intangible assets	**0**	0
Total	**2,784**	1,935

18 Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables
	£000s	£000s	£000s
Balances with other central government bodies	8,327	0	7,787
Balances with local authorities	493	0	0
Balances with NHS bodies outside the Departmental Group	19	0	0
Balances with NHS Trusts and Foundation Trusts	1,947	0	1,189
Balances with bodies external to government	2,362	1,386	32,436
At 31 March 2014	**13,148**	**1,386**	**41,412**
Balances with other central government bodies	4,732	0	3,214
Balances with local authorities	216	0	0
Balances with NHS bodies outside the Departmental Group	3	0	10
Balances with NHS Trusts and Foundation Trusts	1,630	0	1,375
Balances with bodies external to government	3,808	1,325	20,693
At 31 March 2013	**10,389**	**1,325**	**25,292**

19 Inventories

	Drugs	Consumable	Energy	Total
	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**717**	**2,252**	**137**	**3,106**
Movement on inventories	134	470	103	**707**
Balance at 31 March 2014	**815**	**2,722**	**240**	**3,813**

20

20.1 Trade and other receivables

	Current		Non-current	
	31 March 2014	31 March 2013	31 March 2014	31 March 2013
	£000s	£000s	£000s	£000s
NHS receivables - revenue	**4,608**	2,618	**0**	0
NHS prepayments and accrued income	**4,193**	2,346	**0**	0
Non-NHS receivables - revenue	**2,462**	2,553	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**2,720**	3,432	**0**	0
Provision for the impairment of receivables	**(2,330)**	(1,965)	**0**	0
VAT	**1,492**	773	**0**	0
Interest receivables	**3**	4	**0**	0
Injury cost recovery receivables	**697**	628	**1,386**	1,325
Total	**13,845**	10,389	**1,386**	1,325
Total current and non current	**15,231**	11,714		
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 Clinical Commissioning Groups (CCGs), as commissioners funded by government to buy NHS patient care services, no credit scoring of these is considered necessary. Other trade receivables mainly relate to private patients who are generally covered by insurance. No formal credit scoring is undertaken. Injury cost recovery relates to patients with personal injury claims, as this is administered centrally for the NHS, no credit scoring is undertaken.

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

20.2 Receivables past their due date but not impaired

	31 March 2014	31 March 2013
	£000s	£000s
By up to three months	**1,549**	1,086
Total	**1,549**	1,086

20.3 Provision for impairment of receivables

	2013/14	2012/13
	£000s	£000s
Balance at 1 April 2013	**(1,965)**	(1,792)
Amount written off during the year	**83**	74
Amount recovered during the year	**16**	0
(Increase)/decrease in receivables impaired	**(464)**	(247)
Balance at 31 March 2014	**(2,330)**	(1,965)

21 Other financial asset

The Trust has no other financial assets.

22 Cash and cash equivalents

	31 March 2014 £000s	31 March 2013 £000s
Balance at 1 April 2013	**9,347**	9,851
Net change in year	**(3,033)**	(504)
Balance at 31 March 2014	**6,314**	9,347
Made up of		
Cash with Government Banking Service	**6,278**	9,269
Commercial banks	**31**	72
Cash in hand	**5**	6
Cash and cash equivalents as in statement of cash flows	**6,314**	9,347
Patients' money held by the Trust, not included above	**3**	4

23 Non-current assets held for sale

	Land £000s	Buildings, excl. dwellings £000s	Total £000s
Balance at 1 April 2013	**131**	192	**323**
Balance at 31 March 2014	**131**	**192**	**323**
Balance at 1 April 2012	0	0	**0**
Plus assets classified as held for sale in the year	131	192	**323**
Balance at 31 March 2013	**131**	**192**	**323**

24 Trade and other payables

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
NHS payables - revenue	**1,413**	1,849	**0**	0
NHS accruals and deferred income	**1,669**	374	**0**	0
Non-NHS payables - revenue	**9,055**	5,019	**0**	0
Non-NHS payables - capital	**4,889**	1,878	**0**	0
Non-NHS accruals and deferred income	**20,767**	15,875	**0**	0
Social security costs	**1,682**	4		
VAT	**61**	245	**0**	0
Tax	**1,847**	5		
Interest payable	**29**	41	**0**	0
Total	**41,412**	25,290	**0**	0
Total payables (current and non-current)	**41,412**	**25,290**		

25 Other liabilities

The Trust has no other payables or financial liabilities.

26 Borrowings

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Loans from Department of Health	**4,172**	**4,172**	**8,307**	**12,479**
Total other liabilities (current and non-current)	**12,479**	**16,651**		

Loans - repayment of principal falling due from 31 March 2014

	£000s
0 – 1 years	4,172
1 – 2 Years	2,772
2 – 5 Years	5,535
Over 5 Years	0
TOTAL	**12,479**

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.

27 Deferred income

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Opening balance at 1 April 2013	**1,746**	2,020	0	0
Deferred income addition	**1,312**	177	0	0
Transfer of deferred income	**(1,753)**	(451)	**0**	0
Current deferred income at 31 March 2014	**1,305**	1,746	**0**	0
Total deferred income (current and non-current)	**1,305**	1,746		

Deferred income is mainly maternity pathway care income received in advance in 2013-14 as per the accounting policy note 1.3.2.

28 Finance lease obligations as lessee

The Trust has no finance lease obligations.

29 Provisions

29.1 Provisions

	Pensions non directors relating to early retirement £000s	Legal Claims £000s	Staff and public liability claims £000s	Total £000s
Balance at 1 April 2013	5,223	0	563	**5,786**
Arising During the Year	124	20	62	**206**
Utilised During the Year	(533)	(16)	(80)	**(629)**
Reversed Unused	(16)	0	0	**(16)**
Unwinding of Discount	88	0	4	**92**
In year cost of assesment of fair value - see i) below	700	0	0	**700**
Balance at 31 March 2014	**5,586**	**4**	**549**	**6,139**
Expected Timing of Cash Flows:				
No later than one year	505	4	317	**826**
Later than one year and not later than five years	2,908	0	232	**3,140**
Later than five years	2,173	0	0	**2,173**

i) The fair value of the provision for future pension payments relating to early retirement is assessed using information provided by the Pensions Agency and Government Actuary Department (GAD) tables concerning life expectancy. The forecast cashflow is discounted in accordance HM Treasury prescribed discount rates (see note 1.16). The use of more recent GAD tables and change in discount rate has resulted in an estimated increase in cost.

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

29.2 NHS litigation provisions relating to the Trust

Not included in the Trust accounts (see note 1.17) but included in the provisions of the NHS Litigation Authority in respect of Trust's clinical negligence liabilities.

	£000s
As at 31 March 2014	94,712
As at 31 March 2013	86,870

30 Contingencies

The Trust has no contingent assets or liabilities.

31 Financial instruments

31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners (Clinical Commissioning Groups) and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Currency risk

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

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from non NHS bodies, as disclosed in the trade and other receivables note 20.

Liquidity risk

The Trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament and funds its capital expenditure within its limit set by the Department of Health. The Trust is not, therefore, exposed to significant liquidity risks. However the Trust deficit position in 2013-14 and insufficient surpluses to finance loan repayments means liquidity is weaker than the board of directors would wish. This will be addressed in 2014-15 through additional funding from the Department of Health.

31.2 Financial assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS	0	4,567	0	**4,567**
Receivables - non-NHS	0	1,936	0	**1,936**
Cash at bank and in hand	0	6,314	0	**6,314**
Total at 31 March 2014	**0**	**12,817**	**0**	**12,817**
Receivables - NHS	0	2,618	0	2,618
Receivables - non-NHS	0	2,209	0	2,209
Cash at bank and in hand	0	9,347	0	9,347
Total at 31 March 2013	0	14,174	0	14,174

31.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables	0	1,592	1,592
Non-NHS payables	0	6,268	6,268
Other borrowings	0	12,479	12,479
Total at 31 March 2014	**0**	**20,339**	**20,339**
NHS payables	0	1,849	1,849
Non-NHS payables	0	2,622	2,622
Other borrowings	0	16,651	16,651
Total at 31 March 2013	0	21,122	21,122

32 Events after the end of the reporting period

There are no post balance sheet events.

33 Related party transactions

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

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 were over £0.5m are:

2013/14	Payments due to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	£000s	£000s	£000s	£000s
Department of Health	7,901	11,837	0	50
Trusts				
East and North Hertfordshire NHS Trust	656	1,513	220	264
Hertfordshire Partnership NHS Foundation Trust	892	1,397	84	552
Hertfordshire Community NHS Trust	930	190	17	502
Clinical Commissioning Groups (CCG)				
Barnet CCG	0	1,051	0	313
Bedfordshire CCG	0	1,299	63	106
Chiltern CCG	0	683	0	26
East and North Hertfordshire CCG	0	2,869	0	145
Harrow CCG	0	3,035	0	356
Herts Valleys CCG	0	221,719	1,174	1,700
Hillingdon CCG	0	4,604	0	54
Luton CCG	0	1,397	211	0
Area Teams				
East Anglia	0	14,937	0	336
Hertfordshire and South Midlands	0	3,387	0	257
Special Health Authorities				
Health Education England	3	10,074	20	1,364
NHS Litigation Authority	7,408	0	0	0
	17,790	**279,992**	**1,789**	**6,025**
2012/13	13,607	266,538	1,721	3,660

33 Related party transactions (continued)

In addition, the Trust has had a number of material transactions with public corporations government departments and local authorities:

2013/14	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	£000s	£000s	£000s	£000s
HM Revenue and Customs	37,024	9,170	3,586	1,492
NHS Pension Scheme	26,898		2,308	0
Hertfordshire County Council	0	4,394	0	374
Watford Borough Council	3,072	223	0	0
	66,994	**13,787**	**5,894**	**1,866**
2012/13	**73,871**	**5,970**	**2,372**	**1,559**

33.1 Summary of West Hertfordshire Hospitals NHS charity activities

	2013/14 £000s	2012/13 £000s
Income	**389**	462
Expenditure	**(671)**	(509)
Net Incoming/Outgoing Resources Before Transfers	**(282)**	(47)
Gains/(losses) on Revaluation and Disposals of Investment Assets	**57**	127
Funds B/fwd	**1,599**	1,519
Funds c/fwd - Net Assets	**1,374**	1,599

34 Losses and special payments

The total value and number of cases:

	2013/14 Total Value of Cases £s	2013/14 Total Number of Cases	2012/13 Total Value of Cases £s	2012/13 Total Number of Cases
Losses	**83,240**	**58**	82,676	69
Special payments	**23,380**	**58**	15,129	46
Total losses and special payments	**106,620**	**116**	97,805	115

35 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.

35.1 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	2013/14 £000s
Turnover	209,199	218,248	232,967	241,684	254,308	260,398	266,716	278,230	**291,119**
Retained surplus/(deficit) for the year	(26,785)	(11,413)	2,495	4,405	(52,167)	1,180	5,269	(868)	**(11,108)**
Adjustment for:									
Impairments				0	57,866	6,178	(1,512)	2,811	**(2,252)**
Adjustments for impact of policy change re donated/government grants assets							(100)	(39)	**(10)**
Other agreed adjustments	14,111	26,785	0	0	0	172	0	0	**0**
Break-even in-year position	**(12,674)**	**15,372**	**2,495**	**4,405**	**5,699**	**7,530**	**3,657**	**1,904**	**(13,370)**
Break-even cumulative position	**(26,785)**	**(11,413)**	**(8,918)**	**(4,513)**	**1,186**	**8,716**	**12,373**	**14,277**	**907**

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

ii) In line with note 1.11 the Trust no longer maintains a donated asset reserve. Donations are credited to income, the extent that this differs from depreciation of donated assets (expense) improves the reported position. As this is not an operational activity it is excluded from the break-even duty.

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

35.2 Interpreting breakeven performance

	2005/06 %	2006/07 %	2007/08 %	2008/09 %	2009/10 %	2010/11 %	2011/12 %	2012/13 %	2013/14 %
Materiality test (I.e. is it equal to or less than 0.5%)	(6.1)	7.0	1.1	1.8	2.2	2.9	1.4	0.7	(4.6)
Break-even in-year position as a percentage of turnover	(12.8)	(5.2)	(3.8)	(1.9)	0.5	3.3	4.6	5.1	0.31

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) Despite the 2013/14 deficit, the Trust's cumulative break-even position remains in surplus. The Trust therefore satisfied this duty in 2013/14.

35.3 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%. See note 1.25 for how this is calculated.

35.4 External financing

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

	2013/14 £000s	2012/13 £000s
External financing limit (EFL)	**17,113**	11,196
Cash flow financing	**10,698**	(2,368)
Unwinding of Discount Adjustment	**92**	0
External financing requirement	**10,790**	(2,368)
Under/(Over) Spend against EFL	**6,323**	13,564

The Trust has met its statutory duty by not exceeding its EFL.

35.5 Capital resource limit (CRL)

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

	2013/14	2012/13
	£000s	£000s
Gross capital expenditure	**17,772**	12,558
Less: book value of assets disposed of	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(210)**	(268)
Charge against the capital resource limit	**17,562**	12,290
Capital resource limit	**18,208**	22,537
(Over)/underspend against the capital resource limit	**646**	10,247

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

36 Third party assets

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

	31 March 2014	31 March 2013
	£000s	£000s
Patients' monies held by the Trust	**3**	4

In October 2013 £12.7 million was secured from the Department of Health to tackle backlog maintenance across our three hospitals

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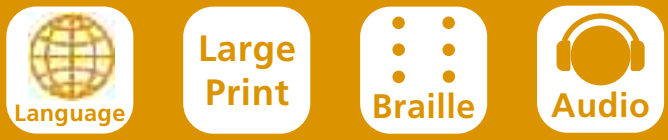

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