as one

Hertfordshire Partnership NHS
University NHS Foundation Trust

Annual Report and Accounts 2017 – 2018

Our Values
Welcoming Kind Positive Respectful Professional

Hertfordshire Partnership University NHS Foundation Trust

Annual Report and Accounts 2017-2018

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paragraph 25 (4) (a) of the National Health Service Act 2006

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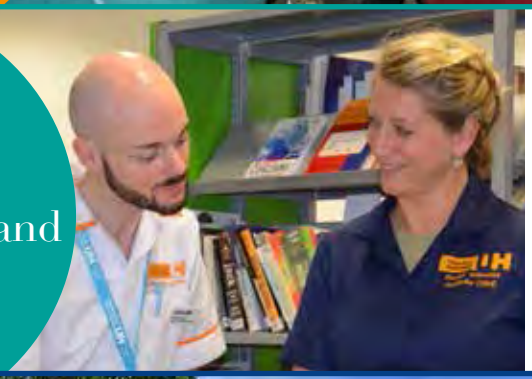

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My Story

"Being on the Service User Council has given me a sense of purpose"

A former high flyer, Michelle now plays a vital role in raising awareness of transgender issues and helping HPFT to adapt our services accordingly. Whilst there is much to celebrate in her life Michelle has faced tough challenges such as acceptance by some of her family members.

Michelle says "I was seven years old when I realised I was different." But it was the 1970s and information about transgendered (trans) people was scarce and often negative. "I grew up thinking I was a freak" she says. As she got older Michelle threw herself into body building in an attempt to 'fix' herself. "But at night I dreamed of being able to live as a female" she says.

Michelle married and had children but says that the constant fear of discovery lead her to attempt suicide. Eventually she was diagnosed with Gender Dysphoria "I was relieved beyond belief." Michelle finally told her wife who was initially supportive but eventually it led to a very acrimonious split.

Her first major outing as Michelle was to a trans club in London and she says "I no longer felt I was odd but that I belonged to a community". Michelle began her transition full time but it wasn't easy and following what she calls a "significant overdose" she was placed on life support, later being sectioned and transferred to HPFT's Swift Ward. "This was the only time I truly felt safe and I finally realised I needed help." Michelle says

Michelle continues "I'm now in a much better place due to a combination of getting my medications right and the support of the mental health teams. Being invited to join the Service User Council and other opportunities to represent the trans community within HPFT and the wider community has given me a sense of purpose. To be able to be honest and open about my journey and for my experiences to be valued is such a great outcome. I now live a life I could never have dared dream of and although I'm still not 100%, I am finally on a path to recovery."

The Performance Report

1.1 Overview of performance

1.1.1 Introduction

This report sets out how the Trust has performed over the last year, our aims and aspirations and the progress we have made towards achieving our aims.

Our Trust is a provider of services for people with mental health and learning disabilities. We are committed to providing excellent health and social care for everyone in our communities who needs our services.

We have been an NHS Foundation Trust since our authorisation in August 2007 and value the opportunities this gives us to build on and improve our services. These opportunities include:

- A strong involvement with local communities through our members and Council of Governors
- Working closely with our partner organisations, so that we can grow and develop our services to meet the specific needs of our service users and communities
- Retaining our surpluses to re-invest in local service developments and facilities
- The ability to borrow to support our capital investment programme.

Like all NHS foundation trusts, we are regulated by NHS Improvement (NHSI) under the Health and Social Care Act 2012. We provide integrated health and social care in community and inpatient settings, treating and caring for people across Hertfordshire and within Buckinghamshire, Norfolk and North Essex. Most of our income comes from contract arrangements with our commissioners. Our largest contract is with the Integrated Health and Care Commissioning Team who act on behalf of the East & North Clinical Commissioning Group (CCG), Herts Valleys CCG and Hertfordshire County Council. Currently our income is largely paid as a fixed sum and does not vary to reflect changes in activity levels, our service users' and carers' needs or variations in clinical outcomes.

Our vision, mission and Good to Great strategy

Our vision, mission and strategy were developed together with our service users and their carers.

Our vision:

Delivering great and great outcomes – together

Our mission:

We help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well

In 2018 the Trust was rated as 'Good' by the Care Quality Commission. The Trust is now focused on progressing its journey from **Good to Great**.

In 2016, we launched our Good to Great strategy to services users, partners and staff. It articulates the ways we want to deliver the highest quality services and become an outstanding Trust. We are working towards this vision by focusing on four themes that will underpin our work during 2018/19:

1. **Great Care, Great Outcomes:** Outcomes and experience will be amongst the best nationally
2. **Great People:** Colleagues can and do make decisions to improve care
3. **Great Organisation:** We continuously make measurable improvements in how services are delivered
4. **Great Networks and Partnerships:** Partnerships are in place that support the delivery of joined up care.

This means shaping services around the needs of service users, working closely with them to continuously improve the care we deliver.

Our vision is underpinned by seven objectives designed to help us progress this work:

Great Care, Great Outcomes

1. We will provide safe services, so people feel safe and are protected from avoidable harm
2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience
3. We will improve the health of our service users through the delivery of effective evidence-based practice.

Great People

4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment.

Great Organisation

5. We will improve, innovate and transform our services to provide the most effective, productive and high-quality care.

Great Networks & Partnerships

6. We will deliver joined-up care to meet the needs of our service users across mental, physical and social care services, in conjunction with our partners
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s).

This performance report covers the year ending 31 March 2018.

1.1.2 Performance overview

from the Chair and Chief Executive

2018 was a year in which the Trust continued to deliver against increased demand across all our services. We have performed very well against this increased demand, and this was reflected in our CQC rating of 'Good' with 'Outstanding' for our Learning Disability and Forensic Services.

This is an important achievement. We met our access targets while delivering great care and great outcomes for over 400,000 people across four counties. We have consistently maintained performance within Child and Adolescent Mental Health Services (CAMHS) and our Single Point of Access (SPA) – two very challenging areas for us. We were particularly pleased to receive a CQC commendation for meeting our CAMHS targets in September.

The CQC inspection included very positive feedback about our staff and the compassionate and caring way in which they deliver care. We were proud that the CQC said: "We were impressed by the way all staff embraced and modelled the values. The values were embedded in the services we visited and staff showed the values in their day-to-day work." The inspection also highlighted areas that needed more attention and focus in terms of safety and effectiveness. We take this very seriously and have already taken steps to address the concerns raised.

The CQC highlighted that our leaders and managers at all levels are visible and approachable. They noted our strong emphasis on co-production and good engagement with staff, service users and partners. As a Trust, we pride ourselves on co-production and were pleased to see the work we are doing with service users to improve services and change practice recognised in the report. For more detail go to page 134.

This feedback is also borne out in our National NHS Staff Survey results, where we have maintained our high scores for engagement over recent years. The results also indicated that our staff are very proud of the quality of services they provide and would recommend HPFT both as a place to work and as an employer.

The last year has seen us build on our Good to Great strategy, launched in 2016. This strategy puts our service users and their families at the heart of all we do, so we develop services in line with their needs. It also guides our work around the key areas of Great Care, Great People, Great Organisation and Great Partnerships. During 2017, we also worked with the Board and with our staff to develop five areas of focus to guide our work. Together with our Collective Leadership programme this

helps empower our staff to deliver the best quality of care for our service users, and to develop new services. Highlights from the year include the establishment of our Community Perinatal Service, introducing a 24-hour crisis service and winning an HSJ Award for our CAMHS Community Eating Disorders Service.

Delivering great care depends on our ability to attract and retain great people. Recruitment and retention remains a challenge for all areas of the NHS. Over the past year we have worked to develop our workforce in new and innovative ways which include working with the University of Hertfordshire to develop the Nurse Associate programme and train fast-track social workers. We also have a health hub in place, delivering a staff wellbeing programme that helps us support and retain out workforce.

Our staff are also supported in their daily roles with IT systems that deliver real-time information on safe staffing levels and bed management. Positive feedback from the CQC confirms that we are making excellent progress in our ambition to become a great organisation.

We are grateful for the work of our Board members in continuing to deliver strong and responsive leadership. We would like to thank our governors, too, who continue to play an important role in linking with communities and ensuring that the needs of service users and the wider population are always at the heart of everything we do.

We believe the effective partnerships and relationships we have built are key to tackling the challenges that face us. We have continued to play a full part in the local health and social care economies by promoting greater integration between mental and physical health and social care in the following ways:

- Local authorities and commissioners. We work closely with commissioners across the four counties that we serve. Our largest contract involves working with East and North Herts CCG, Herts Valleys CCG and Hertfordshire County Council to deliver integrated health and social care services.
- Leading the development of 'A Healthier Future', the Sustainability and Transformation Plan (STP) for Herts and West Essex, and ensuring that mental health is embedded throughout the Plan.
- Being a university Trust, with close links to the University of Hertfordshire. This strengthens clinical research and provides excellent learning and development opportunities for staff. For example, this enabled us to develop our new training programme for nurse associates.
- Working with our partners to deliver integrated services to treat the 'whole person' by managing people's mental and physical health together. One of the ways we will be doing this is through our newly-opened Marlowe's Health & Wellbeing Centre. We are also looking at how we can work with our NHS partners to better deliver care closer to people's homes, and give people greater access to mental health services through their GPs' surgeries.

Our Good to Great strategy has provided new energy and focus for the years ahead. There will undoubtedly be challenges ahead in 2018/19, but we are confident that we have the people, relationships and skills to continue to deliver great care and great outcomes.

Chris Lawrence, Chair
Dated: May 2018

Tom Cahill, Chief Executive
Dated: May 2018

1.1.2 Key issues and risks that could affect delivery of the Trust's objectives

The Trust has identified the key risks and issues that could affect our ability to achieve the goals set out within this strategy. The Annual Governance Statement set out in this report identifies the framework for managing these major risks to future performance. These form a core element of our quality improvement plans for 2017/18 (as set out in the Quality Report) and are summarised below:

Risk	Description	Mitigation
Management of Demand and Capacity	Volume, acuity and complexity of demand leading to inability to respond effectively	• Developing new approaches to demand management working closely with primary care • Reviewing staffing establishment and introduce new roles • Improving processes and systems within our Single Point of Access
Workforce Recruitment and Retention	Inadequate staffing levels or inappropriate mix of permanent and agency staff impacting on the quality of patient care	• Detailed recruitment planning with focused recruitment drives • Recruitment incentives • Mitigating action for cohort of potential retirees • Developing new roles and ways of working
Ability to achieve financial targets	Insufficient resources to manage demand and maintain quality and ensure long term financial sustainability	• Strengthening expenditure controls • Robust processes to ensure efficiency • Independent quality impact assessment assurance • Clinically led support to identify efficiency opportunities • Positive relationships with commissioners

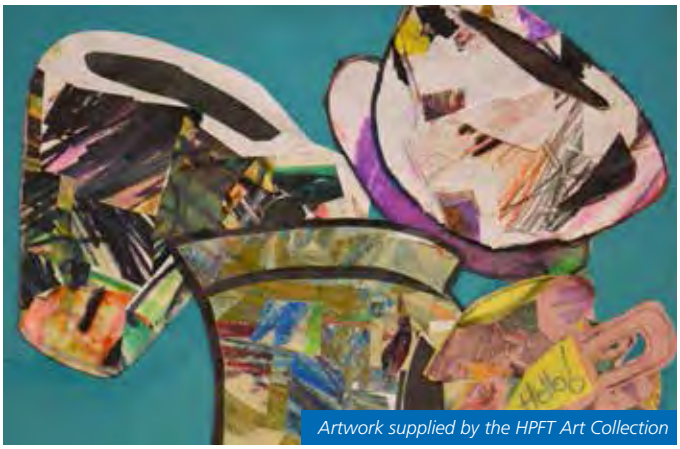
We also recognise that the current rapidly changing health and social care landscape – nationally and locally – combined with wider system pressures, poses a potential risk to the sustainability of high-quality service provision for people with mental illness or a learning disability. Our Board reviews this regularly, and the Trust provides strong leadership within the local STP and maintains good relationships with commissioners, local providers and other key stakeholders.

1.1.3 Going concern disclosure

The accounts have been prepared on the basis that the Trust continues to operate as a 'going concern', reflecting the on-going nature of its activities. After making enquiries, the directors have a reasonable expectation that we have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.1.4 Summary of performance matters (other than those set out earlier)

Our financial performance was above plan in the year, reflecting both higher-than-planned income levels and continuing cost savings. Because of this, the Trust secured £6.1m Sustainability and Transformation funding through NHS Improvement. We will use this to support the future capital investment programme that forms a key part of enabling us to continue to provide great care.



Artwork supplied by the HPFT Art Collection

1.2 Performance analysis

1.2.1 How the Trust measures performance (including details of KPIs and performance against KPIs)

Throughout the year, the Board receives regular reports on Trust performance. We base our quarterly formal Performance Review Meetings (held between the Executive Team and the Strategic Business Units) on these reports, which cover the following areas:

- The key performance measures agreed by the Board relating to areas of operational significance. These focus on the service quality measures of access, safety and effectiveness, workforce and finance. The reporting of these includes the trends in performance as well as deep dives in to specific issues requested by the Board and its sub-committees
- Regulatory requirements from NHS Improvement and others
- The contractual measures reported regularly to commissioners and other partner organisations
- Progress on the Trust Annual Plan and the achievement of the related objectives.

Our ambition to become an information-led organisation. One important development has been the implementation of the first phase of a new business intelligence system: SPIKE. This supports our service team's performance by significantly improving their access to information. The second release of SPIKE, planned for September 2018, will build on this success. The availability of high quality operational data, updated every day, will provide new opportunities for us to fine-tune how we monitor and manage our performance.

1.2.2 Detailed analysis of the development and performance of the Trust (including reference to KPIs and the financial statements)

Regulatory performance

The reporting of regulatory performance is governed by the NHS Improvement Single Oversight Framework first introduced in October 2016 to replace the previous Risk Assessment Framework.

The framework is designed to identify NHS providers' support needs across five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability.

Providers are monitored against each of these themes to identify any support needed to enable them to meet the agreed standards in each area. Individual Trusts are segmented into four categories according to the level of support each trust needs. Where improvements in performance are required, a package of support is agreed with the provider to help them achieve this.

This new uniform approach across all provider trusts was updated from 1 November 2017 to:

- Reflect changes in national policy priorities and standards
- Clarify certain processes and definitions
- Improve the structure and presentation of the document.

The performance framework

The framework sets out our key performance measures focussing on the four areas: access, safety and effectiveness, workforce and finance. Our performance against the framework has remained strong and this is pleasing given the context of the operational highlights below:

Increase in demand for our services

Throughout the year we have seen continuing growth in demand for our services and, consequently, a growth in activity. This growth in demand is a trend that is regularly reported across England and is shown within our Trust by the key headlines below;

- New referrals increased by 9% overall in the year to 28,668. The largest increase (13%) was in CAMHS services, followed by adult mental health services (up 11%).
- Inpatient admissions have increased to 1,336: a 16% increase on 2016/17. Bed numbers remain at 2016/17 levels (477 beds). This reflects the significant attention we give to ensure our bed capacity is well managed, so we minimise the need to commission bed placements outside Hertfordshire.
- There has been an increase in S.136 detentions.

Despite these pressures, 87% of those using our services would recommend them to their friends and family. This is testament to the quality, professionalism and commitment of our staff in ensuring people with mental health needs or a learning disability receive the care and support they need.

We also remain one of the only trusts in the UK to offer a wide range of genuine alternatives to inpatient admission, by providing acute day treatment, round-the-clock crisis and home treatment, and access to host families. We continue to invest in community care and support, responding to what our service users and their carers say they want us to do to help promote their independence.

Workforce

Like other NHS organisations, our Trust faces continuing challenges in recruiting and retaining staff. 504 new employees joined us last year, and 471 left (a net increase of 33). Overall our vacancy rate increased from 12% to 13.7%, although this was affected by the introduction of 125 new posts, and the underlying rate is 9.7%. While we are ambitious to improve on this, it presents a challenge as the recent review carried out by the Centre for Mental Health on behalf of the Mental Health Network shows:

Attracting people to work in mental health is a major challenge across a number of professions. Mental health is not routinely promoted as a career option for young people, and it is difficult to fill training places for some professional courses.

Attrition rates in mental health services are higher than for many other health services. Particular concerns were expressed about people leaving nursing after qualifying and the importance of retaining older staff members.

New services

This year saw the following additions to the services we provide to our communities:

As part of NHS England's new models of Care Programme from 1 December 2017 our CAMH service has been extended to provide the tier 4 services for children from Hertfordshire. Our new model of care transforms local service provision by integrating the tier (levels of need) 4 and 3 pathways, ensuring young people in Hertfordshire can access services to meet their needs in the right setting at the right time. The key components of this model are:

a) Enhanced services and choice for young people, where we provide support and treatment in the least restrictive environment, with the ability to step up/down seamlessly if clinically required. This includes home treatment delivered as an alternative to admission

b) Additional evidence-based treatments to reduce crisis presentations and the need for admission

c) Active case management of young people through their full episode of care, from crisis assessment through to supported discharge to reduce length of stay and achieve step down to community services in line with clinical need.

From 20 March 2017 we implemented a community based perinatal service offering pre-pregnancy counselling to women with mental ill-health and support to new mothers with conditions like severe postnatal depression, their babies and partners. We developed this service in partnership with GPs, obstetricians and gynaecologists, midwives and health visitors, and the two CCGs who secured the funding.

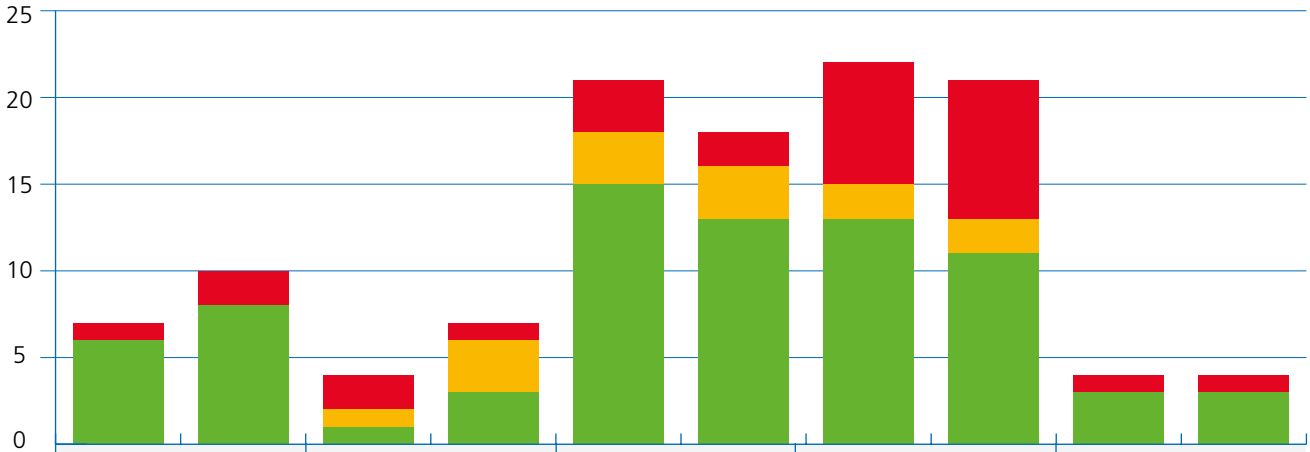
Working with two acute hospital providers in Hertfordshire, and in line with national policy, we extended our urgent and emergency liaison mental health services in emergency departments (EDs) and general hospital wards to provide full 24-hour seven-day coverage. This is known as Core 24.

[1] Centre for Mental Health REPORT The future of the mental health workforce September 2017

Our performance

Brief comments upon the four broad areas of performance are given below. For each metric we provide a 'RAG' (Red Amber Green) rating. These are reported monthly to the Board. The table below shows the summary position at 31 March 2018, with the comparable figures from 2016/17.

This shows that, overall, the strong performance of the previous year has been maintained. Most indicators – 65% (2016/17: 63%) were reported as Green, where Green represents a performance at or above the target (either locally or nationally set).



	SOF		Workforce		Safe & Effective		Access		Finance	
	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17
Blue	1	2	2	1	3	2	7	8	1	1
Amber	0	0	1	3	3	3	2	2	0	0
Green	6	8	1	3	15	13	13	11	3	3

Access:

Our most significant challenge has been to deliver consistently on our access targets. During 2017/18, we have particularly focussed on this in areas within:

- CAMHS
- Improving Access to Psychological Therapies (IAPT) services
- Adult community mental health services.

There are many areas of strong performance. Our Crisis Assessment and Treatment Teams (CATT) met the 4-hour referral target 99.9% of the time throughout the year, and the Community Eating Disorders Team achieved 98% over the year for routine referrals.

Within CAMHS, growing demand and ongoing recruitment challenges have meant that despite excellent improvement in the period September to December, we fell back slightly in the final quarter. For adult community services, our target, set with commissioners, is to provide a first appointment within 28 days of referral in 98% of cases. This has been a key area of focus which has seen our performance reach its highest level since June 2016 at 96%, although this is still below target.

We have comprehensive action plans focussed on

- referral management
- further enhancements to our SPA processes
- recruiting and retaining our staff

that ensure we strive consistently to address these challenges.

Safety and effectiveness of services:

The strength of our performance throughout this year is illustrated by high scores in our staff and service user Friends and Family tests. In the final quarter, we achieved at 73.9% (target: 70%) in the staff test, 87.6% in the service user test. Other areas of notable performance were within IAPT services where the recovery rate score was above 50% across all five contracts covering Hertfordshire and North Essex. The main area of concern carried over from 2016/17 was the level of delayed discharges from inpatient services. This had moved above the 7.5% threshold during the final quarter of 2016/17, but has now been managed down and is now consistently below the 7.5% target (4.8% in March 2018). This is a significant improvement.

Resources:

Workforce - Indicators have improved with some excellent outcomes in the National Staff Survey. However, as shown by the key risks for the organisation listed in the Annual Governance Statement, recruitment and retention are areas that continue to need focus. This is discussed further within the Staff Report. See page 49.

Finance -The full year financial position is a surplus which is above Plan. The Trust also reported below Agency Cap limit spending on agency staff. As a result, we achieved the highest NHS Improvement Use of Resource rating: 1.

Analysis of financial performance

Financial overview

This section provides a commentary on our financial performance. It shows another successful year. Highlights include:

1. A £3.5M surplus (before asset impairments and Sustainability and Transformation funding). The Trust continues to beat its NHS Improvement-set financial control total at a time when the NHS is facing significant financial challenges.
2. The continuing financial support of our commissioners in delivering "parity of esteem" between physical and mental health – an ambition set out in the Five Year Forward View.
3. Our capital investment programme which aims to provide the high quality accessible infrastructure needed to support our clinical teams.
4. We have been awarded £6,103,000 from the £1.8 billion Sustainability and Transformation Fund (STF) made available again to NHS providers during 2017/18. This is linked to the achievement of financial control totals and performance targets. Of the total, £3,993,000 was awarded for exceeding the financial control total.

This funding will help the Trust continue to invest in capital programmes and, where possible, to support the wider Sustainability & Transformation Plan for local health and social care.

Summary of key results from the financial statements

As an NHS foundation trust it is important that over a sustained period the Trust achieves financial surpluses both to maintain its resilience and to enable us to invest in the infrastructure we need to continue to deliver high quality services. Our Trust faced significant cost pressures particularly in areas of agency pay costs and in the commissioning of bed placements. We continue to work tirelessly with other organisations so we can manage these costs effectively.

Despite these pressures the Trust has maintained a surplus whilst ensuring we deliver high-quality services to increasing numbers of service users. This is a testament to the hard work and dedication of our staff who as the CQC inspectors noted in their report, have responded admirably to the challenges they faced during the year.

Summary of key results from the financial statements

Headline results from the Financial Statements are set out in the table below and explained in more detail later in this section.

	2017/18 £M	2016/17 £M
Income (excluding STF)	224.2	218.1
Expenditure – pay costs	(146.4)	(137.9)
Expenditure – non-pay costs (excluding impairments, VAT settlement)	(74.3)	(77.6)
Surplus for the year (excluding STF, impairments, VAT settlement)	3.5	2.6
Sustainability and Transformation Funding (STF)	6.1	6.7
Settlement of historic VAT claims		1.6
Impairment charged to expenses in the SOCI	(0.5)	(2.0)
Surplus/(Loss) for the year	9.1	8.9

	2017/18 £M	2016/17 £M
Capital spend (net of proceeds)	1.9	5.7
Loan finance liability from foundation trust financing facility	(17.4)	(17.9)
Cash flow from operations	17.7	18.3
Closing cash position	56.0	43.6

Income

	2017/18		2016/17	
	£M	%	£M	%
Income from activities	216.9	94.2	211.8	94.2
Other Income	13.4	5.8	13.0	5.8

Our income is earned largely from contracts with NHS commissioners, for activities relating to the provision of health and social care services. We have six main contracts several of which are commissioned jointly and these vary in length. Most are block contracts, where the income is fixed, irrespective of changes in activity levels. However income is linked to activity or outcomes for some services. In 2017/18 we secured additional funding for our services in Hertfordshire as commissioners increased investment in mental health.

In the financial year 2017/18 we generated income totalling £230.3m, an increase of 2.4% on the previous year. Most is income from activities. Our income from activities arises

principally from the contract we have through the Integrated Health and Care Commissioning Team acting on behalf of the Clinical Commissioning Groups of Herts Valleys CCG and East & North Hertfordshire CCG and Hertfordshire County Council. This accounts for about 80% of our total income. Our other main contracts are with NHS England (covering a number of specialist mental health and learning disability services) and NHS West Essex CCG (for learning disability services in North Essex). The contract with each of our commissioners sets out requirements that we must comply with. These include a range of performance targets. We meet with our commissioners regularly to review our performance against these targets and to discuss areas of future need.

In accordance with the National Commissioning for Quality and Innovation (CQUIN) payment framework, each year we agree a schedule of CQUIN goals with each commissioner. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of a provider income to the achievement of local quality improvement goals. We estimate that we have achieved 92% of the CQUIN target in our contract with Integrated Health and Care Commissioning Team and 100% in our other contracts.

Other income includes

- regular sources of income such as national funding to support the training of medical staff
- items such as the non-recurrent funding provided to support workforce development
- the total £6.1M STF funding (£6.7m in 2016/17) reported in point 4 of the Financial Overview opposite.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. We have met this requirement.

Expenditure

In common with other Trusts, our most significant area of spending is pay costs. Our total pay costs for the year are £146.4M and represent 67.1% of total Operating Expenses. The comparative figures for 2016/17 are £137.9M and 65.1%.

As a Partnership Trust with delegated secondary commissioning responsibilities, operating from more than 50 sites in Hertfordshire, Norfolk, North Essex, and Buckinghamshire, we have other significant costs to manage. For further details of expenditure for the financial year, see under note 5 (page 193) of the financial statements.

Surplus

Our financial statements show a surplus for the period of £9.1M compared to £8.9M last year. This is calculated by taking the income earned in the period and deducting the related expenditure. This calculation includes £6.1M of Sustainability and Transformation funding, and non-cash accounting items (£0.6M) relating to property impairments, which are not considered by the Trust to be part of its normal activities. Adjusting for this would give a surplus for the year of £3.5M which is ahead of the previous year's surplus of £2.6M after similar adjustments for items outside normal activities. Further detailed examination reveals an underlying surplus in the region of £1m for the year, having removed material non-recurrent items.

Cash flow from operations

The management of our cash balances is a critical aspect of our performance particularly as we continue with our major Capital Investment Programme (see below).

The Use of Resources rating applied by NHS Improvement as part of its regulatory Single Oversight Framework includes measures of the Trust's liquidity and its ability to meet its debt obligations. Both these measures are controlled by the implementation of effective Treasury Management policies.

The statement of cash flows is set out on page 179 of the financial statements and shows how we continued to manage our cash balances and working capital proactively, and ended the year with a strong cash position of £56.0M – an increase in the year of £12.4M. We had an approved 25-year loan facility of £32M to support our continuing investment programme, and a short-term loan of £6.9M which is repayable in 2018. Repayments of £0.5M were made in accordance with the loan terms, and the current loan amount is £17.4M. Any future requirements would require us to agree a new loan facility.

Capital programme

In 2017/18 we continued investing in various service developments, focusing on service improvement and environmental quality. The year also saw one asset disposal: we sold a building that we no longer required to generate additional funding to support future investments.

Financial risk rating

We have achieved a Use of Resource metric rating of 1 at 31 March 2018 (the highest possible) reflecting the strong financial position of the Trust. See page 193 for detailed and comparative data and an explanation of the regulatory rating framework.

Looking forward

2018/19 will undoubtedly be another challenging year as the Trust continues to manage the continuing financial constraints affecting the whole health and social care economy. Our contract income (our principal source of funding) has been agreed and will include a National Tariff efficiency requirement of 2%. We have an allowance of 2.1% to cover annual pay awards and inflation, and are expecting a further allowance to cover the full cost of the recent national pay award.

We are pleased that Hertfordshire commissioners have provided additional investment to help meet their parity of esteem commitments. This will support the Trust to respond to the continued growth in need for our services, and to develop new services in line with the Five Year Forward View for Mental Health.

Our strong financial position will help us meet the challenge of continuing to deliver and improve our high-quality services and reduce waiting times, and we remain committed to making significant efficiency and productivity savings.

Other financial information

Financial investments

We do not have any investments in joint ventures or significant exposure to interest rate or exchange rate risks and therefore do not hold any complicated financial instruments to hedge against such risks. We are the corporate trustee to Hertfordshire Partnership University NHS Foundation Trust Charity. Having assessed our relationship to the charitable fund we have determined it to be a subsidiary because we are exposed to, or have rights to, variable returns and other benefits for the Trust, service users and staff from our involvement with the charitable fund and have the ability to affect returns and other benefits through our power over the fund.

Financial statements and accounting policies

We have set out the full set of financial statements and details of the accounting policies applied within this report. These have been prepared according to International Financial Reporting Standards (IFRS) and HM Treasury's Financial reporting manual (FReM) in so far as they are appropriate to NHS foundation trusts. This is as directed by NHS Improvement, and the Department of Health Group Accounting Manual (DH GAM), so we show a true and fair view of our financial activities during the period.

The Financial Statements are presented as follows:

The Trust Board is required to review its accounting policies annually. We have done this, and there are no changes to our accounting policies as a result of that review.

External audit opinion

Our annual accounts were reviewed by our independent external auditors, Deloitte LLP, who issued an unqualified opinion. As far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all the steps they ought to have taken as directors to ensure they are aware of any relevant audit information, and to establish that the auditors are aware of that information.

Deloitte LLP has been approved as the Trust's external auditors by the Council of Governors through to 2017/18. The audit is conducted in accordance with International Standards on Auditing (UK and Ireland) as adopted by the UK Auditing Practices Board (APB), the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by NHS Improvement.

Related parties

During the year none of the Board Members, Governors or members of the key management staff or parties related to them, has undertaken any material transactions with the Trust. Details of other related party disclosures are set out in the financial statements under note 25 on page 213.

Charitable funds

As an NHS Foundation Trust we make no political or charitable donations. However, we do continue to benefit from the receipt of charitable funds arising from donations and fundraising activities and are extremely grateful to fundraisers and members of the public for this continued support. Members of the Trust Board act as Trustees, ensuring appropriate stewardship of these funds which are used for the purchase of equipment or services according to the purpose of the funds. Where funds are for 'general purpose', these are used more widely to benefit service users and staff. Further financial information on our charitable funds for the financial year 2017/18 is available on request from the Executive Director of Finance. There is no charge for the provision of this.

HPFT charitable funds fall within the definition of a subsidiary. The Trust has chosen not to consolidate the charitable funds into these financial statements as the amounts of the charitable funds are not material and would not provide additional value to the reader of the Financial Statements.

1.2.3 Information about environmental matters

Transport and travel

We have reduced the number of miles covered by our Transport Department from 994,349 last year to 858,528 in 2017/18 - a reduction of 13%. We have improved efficiency by using better systems and routes together with a greater use of taxis.

During 2017/18 we also replaced 28% of our vehicles with energy efficient vehicles.

Buildings

We have continued to reduce our estate portfolio where possible and to identify surplus land. We expect to release further sites in 2018/19.

Sustainable care models

We are working closely with partners within health and social care and the voluntary and charitable sectors to deliver an integrated approach to care. This will improve the way in which we use buildings across the whole healthcare system.

With the opening of The Marlowes Health & Wellbeing Centre in March 2018, we introduced an integrated approach to delivering mental and physical health services from a single location. We will apply this approach to future developments.

Resource impact

We have continued to improve the energy efficiency of our buildings, including improving our heating and boiler systems. In 2017/18 we also introduced automated metering and management systems within our buildings which will further improve our energy efficiency by identifying areas for improvement and investment.

	2016/17 (kWh)	2017/18 (kWh)	Variance (kWh)	% change	2016/17 (£)	2017/18 (£)	Variance (£)	% change
Electric	5,209,731.20	4,907,942.90	301,788.30	-6.15%	706,874.22	696,615.91	10,258.31	-1.47%
Gas	11,147,600.30	11,463,913,20	316,312.90	2.76	366,275.30	363,658.54	2,616.76	-0.72%
Water	113,124.50	116,104.50	2,980.00	2.57%	100,859.75	91,701.03	9,158.72	-9.99%
Sewerage	93,942.10	65,718.18	28,223,92	-42.95%	100,211.38	78,806.06	21,405.32	-27.16

Emergency planning and business continuity issues

We have updated our Major Incident and Business Continuity Plan and published it on our website. The plan was robustly tested this year when we experienced a serious IT infrastructure failure and, in smaller incidents, when boilers broke down on various sites.

We have again completed the NHS core standards self-assessment and are compliant with the core standards issued by NHS England for emergency planning, response and recovery. As such we are assured of resilience and readiness in the case of any business interruption.

We are working with NHS England and the local Health Resilience Partnership on all aspects of major incidents and business continuity planning. We are a partner in the memorandum of understanding including: Hertfordshire Health, social care organisations and local councils where we set out how we will work together should a major incident occur.

1.2.4 Social, community, anti-bribery and human rights issues

Highlights from 2017/18 have included:

- Awareness raising events on the themes of carers, LGBTQ, race equality, International Women's Day, and disability
- A new four-year plan for equality, diversity and inclusion
- A partial review of the HPFT Equality Delivery System in partnership with local stakeholders
- Compliance reporting for Public Sector Equality Duty
- Improving our approach to meeting the NHS Workforce Race Equality Standard (WRES)
- Preparatory work for ensuring we comply with the new NHS Sexual Orientation Information Standard (SOIS)
- Work with our disabled staff network and staff mental health network in preparation for the NHS Workforce Disability Equality Standard (WDES)
- Expanding our diversity role models programme
- Early development of a new training package for staff focused on improving support for gender identity across services
- The launch of our new four-year spiritual care strategy.

Our equality and diversity work is centred around ensuring that we comply with the Public Sector Equality Duty and are delivering best practice as a lead for equality and diversity. The sections below provide some examples of this activity.

Overview of our activity to eliminate unlawful discrimination

- ***Organisational values*** – we have continued to embed the Trust values across the organisation. Over the past year 91% of our staff completed an annual values-based appraisal. We have also disseminated the Trust values through promotional campaigns. For example, our flu jab campaign featured staff who are members of Trust staff networks and diversity role models.
- ***Anti-bullying and harassment pledge*** – we have published messages from each diversity role model about supporting someone who is experiencing bullying and harassment. In addition, our Freedom to Speak Up guardian has been offering open sessions encouraging staff to talk about their experiences.
- ***Workforce Race Equality Standard (WRES)*** – we have implemented a WRES action plan focusing on identifying and addressing inequalities within the Trust. The WRES data can be found on the public website. http://www.hpft.nhs.uk/about-us/equality-and-diversity/wres/ We are reviewing our annual work-plan to focus on making measurable improvements.
- ***New equality plan development*** – we have co-produced our new Trust Equality, Diversity and Inclusion plan. The plan was launched in May 2018

[2] The National Centre for Children and Families

Gender pay gap reporting

Legislation has made it statutory for organisations with 250 or more employees to report annually on their gender pay gap. We have a clear policy of paying employees equally for the same or equivalent work, regardless of their sex (or any other characteristic set out above). We deliver equal pay through a number of means, but primarily through adopting nationally agreed terms and conditions for our workforce.

Our gender pay gap analysis identifies a mean gender pay gap of 7.68% and median of 2.92% (national median = 9.7%). We are confident this pay gap does not stem from paying men and women differently for the same or equivalent work. Rather it is the result of the roles in which men and women work within the organisation and the salaries that these roles attract. Whilst reporting is in its early stages, we will continue to monitor the gender pay gap and, during 2018/19, will consider the next steps we should take to reduce it.

Advancing equality of opportunity

- Diversity role models - our role models programme engages staff who are BME, LGBTQ, women, carers or who have a disability as role models to support people from similar backgrounds. This has now been expanded to include mental health role models and spiritual care role models.
- Stonewall Diversity Champions – we have seen a significant improvement in our placement in the Stonewall Workplace Equality Index. We climbed 82 places, reflecting the work we have done over the past year.
- Staff networks – our staff networks are now setting annual objectives to support our Good to Great strategy.
- Implementation of Sexual Orientation and Gender Identity CAMHS guide – we developed this in partnership with the Anna Freud Centre and CYP (Children and Young People's) IAPT Collaborative. It was launched in May 2017, at our annual International Day Against Homophobia, Biphobia & Transphobia (IDAHOBIT) conference. We are doing more work with CAMHS staff to promote the use of this resource, which can be seen at https://cypiapt.com/2017/04/03/so-and-gi-guide/

Activity to foster good relations

- International Women's Day (IWD) Programme 2017 and 2018. 'Realising your full potential' and "Press for Progress" have been the themes of these events from our Women's Network.
- International Day Against Homophobia, Biphobia & Transphobia (IDAHOBIT). We delivered our annual event in May 2017 - on the theme of families and "The voice of parents" in partnership with the University of Hertfordshire.
- Equality, Diversity and Human Rights Week. We held several events, two of which focused on dementia with attendees from other NHS providers, the CCGs, the University of Hertfordshire, Hertfordshire County Council and our third sector partners.
- Carers Week Conference and Carers' Rights Day. We hosted an annual conference for Carers Week in June 2017 and a Carers Rights Day event for carers in November 2017 .
- Diversity and leadership. In October 2017, we hosted our third local WRES annual workforce conference with Unison and NHS England focused on 'Diversity and Leadership'. This emphasised how we can improve our approach to race equality and focused on retaining and promoting BAME staff.

Statistics

We are required by the Public Sector Equality Duty (PSED) to collect and publish diversity data for staff and service users. We are also required to publish one or more equality objectives spanning a four-year period. This has been done against the Trust annual objectives for the NHS Equality Delivery System 2.

All PSED compliance reporting is published through the Equality and Diversity section of the Trust website at http://www.hpft.nhs.uk/about-us/equality-and-diversity/our-performance/ (where you can find a full breakdown of statistics).

Equality Delivery System 2

We completed our most recent grading of the NHS Equality Delivery System 2 in January 2018. This review focused on these key areas:

- Individual patient's health needs are assessed, and resulting services provided, in appropriate and effective ways
- Transitions from one service to another, for people on care pathways, are made smoothly and everyone is kept well informed
- People report positive experiences of the NHS
- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
- When at work, staff are free from abuse, harassment, bullying and violence from any source.
- Managers support their staff to work in culturally competent ways within a work environment free from discrimination.

We chose these as they were identified as areas in which the Trust either excels or as requiring development during the Trust's last grading exercise. The following table provides an overview of those areas that were regraded in comparison to the previous period.

The grading colours for the EDS2 relate to:

- Red – Underdeveloped
- Amber – Developing
- Green – Achieving
- Purple – Excelling

Outcome	Previous Grading	Jan 2018 Grading
EDS2 Goal 1 – Better Health Outcomes		
Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways		
Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.		
EDS2 Goal 2 – Improved Patient Access & Experience		
People report positive experiences of the NHS.		
EDS2 Goal 3 - Empowered, engaged and well-supported staff		
Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.		
When at work, staff are free from abuse, harassment, bullying and violence from any source.		
EDS2 Goal 4 – Inclusive Leadership		
Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.		

In our assessment we have downgraded the area focussed on the way in which individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways. Whilst still rated as 'good' there was insufficient evidence to demonstrate how this was achieved universally for all service user and carer groups and challenges in ensuring we have a full data set of demography for people using our services.

Next year

Possibly our biggest development over the coming year will be the launch and implementation of our new equality plan, which links into our overall organisational strategy. Support for this will include:

- An increase in size and activity for the overall Equality, Diversity and Inclusion portfolio in HPFT
- Increased action on Workforce Race Equality Standard to address inequalities and promote workplace inclusion
- Opportunities for leaders to have more dialogue about equality within services and support with troubleshooting
- Implementation of new NHS standards for Sexual Orientation (in services) and Disability (at work)
- work on making our information more accessible to ensure we meet the NHS Accessible Information Standard Finding more opportunities to celebrate the positive impact diverse workforces and communities make to the culture of the Trust.

Modern Slavery Act Reporting

The Modern Slavery and Human Trafficking Act 2015

The Trust is committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation. We realise that slavery and human trafficking can occur in many forms, such as forced labour, domestic servitude, sex trafficking and workplace abuse.

Our policies, governance and legal arrangements are robust, ensuring that proper checks and due diligence take place in our employment procedures to ensure compliance with this legislation.

Anti-fraud and Corruption including the Bribery Act 2010

Under the Bribery Act 2010 it is a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. The Trust therefore has a duty to ensure that all its business is conducted to the highest possible standards of openness, honesty and probity. To support staff the 'Standards of Business Conduct' policy prescribes what is acceptable ethical and legal business conduct for all employees in respect of business conduct, sponsorship, hospitality and gifts. Provision is also made for the declaration and registration in certain circumstances of interests, hospitality and gifts received. This serves to demonstrate openness and protect employees from allegations of improper or illegal conduct.

Assurance in relation to governance and control systems is set out within the Annual Governance Statement (page 66).

1.2.5 Important events since the end of the financial year affecting the Trust

There have not been any important events since the end of the financial year that need reporting in the Annual Report.

Accounting Officer Approval

T J Cahill

Tom Cahill, Chief Executive

May 2018

Date:

HPFT and EEAS partnership: reducing ambulance call-outs by helping nervous patients

HPFT's Wellbeing Service collaborated with the East of England Ambulance Service (EEAS) to develop a more effective response to anxious patients.

The ambulance service is frequently called out to nervous patients but when the ambulance staff arrive the patients rarely require medical attention. Often what they would benefit from is some form of anxiety or mood intervention.

The Wellbeing Service offers short-term support to clients, often in the form of courses which aim to teach practical skills and techniques to help manage low mood and anxiety. They agreed with the EEAS to work together to ensure the right treatment gets to the right patients.

Information and posters about the Wellbeing Service were supplied to the EEAS who circulated it to their staff, to virtual crew rooms (closed Facebook groups) and included it on their rolling news website to promote wider awareness amongst ambulance staff. They also added the Wellbeing Service details to MiDos, (My Directory of Services) app used by all ambulance staff to quickly identify appropriate services for signposting when out. The EEAS passed details of the Wellbeing Service on to the ECAT (Emergency Clinical Advice Team) triage units across Hertfordshire which enabled the service to provide a signposting service to 999 callers assessed as not in need of an ambulance.

This innovative example of partnership working between HPFT's Wellbeing Service and the EEAS is providing a way for paramedics to support people in crisis at the point of contact, and will reduce in unnecessary ambulance call-outs.

Directors' Report

2.1.1 The Trust Board

The Trust is managed by full-time Executive, and part-time Non-Executive Directors who collectively make up the Trust's unitary Board of Directors. The Board considers all the Non-Executive Directors to be independent in accordance with the Code of Governance. A representative from Hertfordshire County Council receives all Board papers and is invited to attend key Board meetings to support partnership arrangements.

The NHS Foundation Trust Code of Governance specifies that Non-Executive Directors, including the Chairman, should be subject to re-appointment at intervals of no more than three years, following formal performance evaluation. Any term beyond six years should be subject to rigorous review and take into account the need for progressively refreshing the Board. Non-Executive Director appointments are made with support of an external recruitment company through open competition.

Executive Directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures. The period of notice for executives is six months.

Director's responsibility for the Annual Report and Accounts

The Directors are collectively and individually responsible for the preparation of the Annual Report and the Quality Report. Having reviewed all the information contained in the Annual Report and Accounts, and taking into account all other relevant information of which they are aware, the Directors confirm that they consider that (taken together) the Annual Report, Quality Report and Annual Accounts:

a. Are fair, balanced and understandable

b. Provide the necessary information for patients, regulators and other stakeholders to assess the performance, business model and strategy of the Foundation Trust.

Board Members

Chris Lawrence - Trust Chair and Chair of the Council of Governors

Qualifications: BA (Hons) Leeds University

Professional profile: A former partner of PricewaterhouseCoopers (PwC), Chris has had a career of 35 years in international merchant banking and professional services. Having studied Spanish and Portuguese, he spent much of his life working internationally. He specialised in international mergers and acquisitions and was part of the leadership team that managed the merger of Price Waterhouse and Coopers and Lybrand.

He also spent three years in the 1990s as CEO of the London Philharmonic Orchestra.

Tom Cahill - Chief Executive

As the Chief Executive, Tom is the accounting officer for the Trust and carries full responsibility for the Trust's strategic direction, performance, planning, business management and development. He also leads the Executive Team. Tom has overseen major transformation programmes that have covered the development of new models of care, new facilities and the Trust culture. Under his leadership, HPFT has rated been as 'good' by the CQC.

Tom has been recognised for his leadership, was included in the HSJ Top 50 Chief Executives in 2014 and 2016, and named HSJ Chief Executive of the Year in 2017.

Qualifications: Diploma in Company Direction - Institute of Directors 2012, Masters in Business Administration (MBA) 1999, Diploma in Management Studies (DMS) 1996, Registered Mental Health Nurse (RMN) 1987

Professional profile: Tom began his NHS career as a mental health nurse in 1987 and between 1998 and 2001 held senior posts with several trusts before being appointed to Director level roles with North Essex Mental Health Partnership Trust. He moved to HPFT in 2005 as Executive Director of Nursing and Practice Governance, became Deputy Chief Executive in late 2007 and Chief Executive in April 2009. Tom is a member of the NHS Providers Board.

Membership of professional bodies: Institute of Directors (IoD), Nursing and Midwifery (NMC) Registrant

Jinjer Kandola - Deputy CEO and Executive Director of Workforce & Organisational Development

As Deputy CEO, Jinjer plays a key role in overseeing the direction and development of the Trust.

Jinjer is also responsible for the management and development of the Trust's workforce and organisational development strategies. This includes recruiting the very best staff and developing their skills. She also oversees Marketing and Communications. Jinjer works closely with the Executive Team, staff and our union representatives to develop the workforce so our people can deliver the change needed to ensure that the Trust goes from Good to Great.

Qualifications: MSc in Human Resource Leadership, Manchester University, Chartered Fellow of Chartered Institute of Personnel and Development (MCIPD)

Professional profile: Jinjer has worked in human resources for over 20 years covering all aspects including recruitment, workforce planning and general HR. She joined the Trust in March 2010 on secondment from East and North Herts NHS Trust where she held the post of Deputy Director of Human Resources.

Dr Jane Padmore - Executive Director of Quality and Safety (Executive Nurse) and Director for Infection Prevention and Control (DIPC)

Jane is responsible for a diverse range of areas in HPFT including clinical and corporate risk and patient safety, compliance and governance, infection control and safeguarding. Jane is Board-level lead for all clinical disciplines (except medical staff) and is the Executive Nurse. She is also the Caldicott Guardian for the Trust. Jane is involved at a national and regional level in various areas including safe staffing.

Qualifications: Kings College London Doctorate in Healthcare, 2013, MSc Mental Health Studies, 2005, University of Surrey BSc (Hons) Specialist Practice in Community Health (Mental Health), 1997, Registered mental health nurse,1994.

Professional profile: Jane has worked in mental health services since 1990, initially as a healthcare assistant in learning disability services, before qualifying as a mental health nurse in 1994. She has worked clinically in a variety of mental health areas, predominantly in CAMHS, adult and forensic services. Jane has also worked in a range of nursing roles from staff nurse to consultant nurse and in multi-disciplinary clinical leadership and clinical academic roles.

Membership of professional, national and regional bodies: Royal College of Nursing

Jess Lievesley - Director of Service Delivery and Customer Experience

Jess is responsible for service delivery, customer experience and complaints

Qualifications: BSc (Hons) Specialist Nursing Practice, RN (MH) Dip HE

Professional profile: Jess began his career as a mental health nurse, working in inpatient services in Cambridge as a community psychiatric nurse. Following a series of roles in mental health commissioning within Hertfordshire, Jess spent a period at the East of England Strategic Health Authority within the Mental Health and Learning Disabilities Team before returning to a joint commissioning role within Hertfordshire County Council and the then primary care trust as HPFT's lead commissioner.

Jess then returned to HPFT as Managing Director, responsible for our transformation programme before moving into an Operational Managing Director role for the E&N Herts business unit. He then spent a short period as the Director of Integration for the Trust before taking up his current role.

Karen Taylor - Executive Director of Strategy and Integration

Karen leads HPFT's approach to developing integrated care around people's needs, looking specifically at how we can improve our service users' physical health. Karen also leads on how we can improve the health and wellbeing of the wider population through integrating mental health into physical health teams and services. She leads the Trust's Physical Health Strategy and public health responsibilities, as well as the development of new models of integrated care across primary and community services working with the wider health and social care system.

Qualifications: BSc (Hons) Psychology and Sociology, Diploma in Management

Professional profile: Karen has worked in the NHS for over 19 years in a range of senior operational delivery roles; including Director of Operations of an acute trust and Deputy CEO and Director of Operations of a community trust. She joined HPFT as Chief Operating Officer in 2012 and subsequently took up the role of Executive Director of Integration and Partnerships in January 2014.

Keith Loveman - Executive Director of Finance

Keith is responsible for financial performance, contracting and procurement, capital projects, estates and facilities.

Qualifications: IoD Certificate in Company Direction, Chartered Institute of Public Finance and Accountancy, BSc (Hons) Sports Science

Professional profile: Keith joined the NHS in 1990, qualifying as an accountant in 1994. He has worked in a range of NHS finance settings but predominately with organisations providing mental health and learning disability services in Hertfordshire. Previously Deputy Director of Finance and Performance Improvement with HPFT, he became Director in 2010.

Membership of professional, national and regional bodies: Chartered Institute of Public Finance and Accountancy

Dr Asif Zia - Executive Director Quality and Medical Leadership

Asif is responsible for medical leadership in the Trust, research and development, clinical effectiveness, pharmacy and medicines management.

Qualifications: Nye Bevan NHS Leadership Academy 2017, Professor of Psychiatry (Hon) (MRCPsych) 2016, Doctor of Medicine (MD) 2012

Membership of Professional Bodies: Royal College of Psychiatrists, Regional advisor Council member and member of independent clinical review panels for Clinical Senate, NHS East of England

Ronke Akelerle - Director of Innovation & Transformation

Ronke is responsible for promoting innovation, information management and technology, improving performance and leading the transformation of activities that result in improved outcomes for service users and their families.

She leads on developing a culture of change that promotes continuous improvements in clinical services and technologies, ensuring that technology is a key enabler of both organisational improvement and service transformation.

Qualifications: MBA - Masters in Business Administration, MSc (Hons) Information Technology, BSc (Hons) Economics

Professional profile: Prior to joining HPFT, Ronke spent 4 years as a Director in Imperial College Health Partners after spending 13 years of her career in management consultancy working on roles in strategy execution, business transformation, information technology, performance management, change and programme management within the private and public sector organisations. Ronke has held senior positions at BUPA, Care Quality Commission, NHS Croydon, NHS Westminster and Barking, Havering, Redbridge University Hospitals NHS Trust. She has undertaken Executive Education programmes from both London Business School and Harvard Business School. Ronke has recently completed her Doctorate in Organisational Change.

Sue Darker - Herts County Council Assistant Director for Learning Disabilities, Mental Health and Asperger's

Sue is Hertfordshire County Council's lead officer for safeguarding vulnerable adults, and is the statutory representative of the Herts Safeguarding Adults Board. Her role provides the link between HPFT and the County Council and she attends and contributes to many of the Trust's management Board forums.

Qualifications: Registered Nurse in Learning Disabilities (RNLD), Kings Fund Athena Programme in Executive Leadership

Professional profile: As Operations Director in Health and Community Services, Sue's portfolio includes all community learning disability teams and the social care team for people with Asperger's and high functioning autism. Sue also has oversight of the new 0 - 25 Together service for disabled children and young adults.

Catherine Dugmore - Non-Executive Director/Chair of the Audit Committee

Qualifications: Institute of Chartered Accountants in England and Wales

Professional profile: A former partner of PwC, Catherine specialised in financial service clients in South Africa. Since 2004 she has pursued a non-executive career across the charity and public sectors and has held previous roles in the NHS.

Loyola Weeks - Non-Executive Director

Qualifications: BSc Hons, RGN RHV SCM DPSN, NCAS trained Case Investigator

Professional profile: Loyola has been a Clinical and Executive Nurse for over 30 years as a provider and commissioner working across Commissioners and providers with Community and Learning Difficulty services. She is also a coach and mentor for aspiring directors and reviewer for local and national audits with health and social care.

Professional and national bodies: Clinical Advisor and Service Development Advisor to CCGs, Peer reviewer for NHS complaints

Michelle Maynard - Non-Executive Director

Michelle specialises in talent management, leadership development and organisational and culture change. She has studied psychotherapy and has an interest in mental health issues.

Qualifications: MSc Human Resource Management, Ashridge Accredited Executive Coach

Professional profile: A human resources senior executive with over 25 years' experience in a range of industry sectors.

Membership of professional bodies: Member of CIPD

Sarah Betteley - Non-Executive Director/Senior Independent Director

Qualifications: LLB Hons Solicitor, Post Graduate Diploma in EU Law

Professional profile: Sarah is a lawyer with significant non-executive experience in the NHS. For the last 10 years she has worked in senior executive commercial roles across BT. Sarah has also acted in a consultant capacity supporting small businesses with strategy and growth development

Simon Barter - Non-Executive Director

Qualifications: MSc Man. Boston University, BSc (Hons) University of London

Professional profile: Simon is a former pharmaceutical executive with 30 years experience in international pharmaceuticals, working in the UK, France, Belgium, The Netherlands and Sweden. He specialised in drug development and global marketing and ran the commercial merger of Astra and Zeneca Pharmaceuticals.

Robbie Burns - Non-Executive Director

Qualifications: MA (Cantab)

Professional profile: Robbie has over 25 years of experience in executive and non-executive positions in health, social care and children's services; ranging from hospitals to home healthcare, fostering to domiciliary care. He is currently chairman of Orchard Care Homes and The Garden Classroom.

Tanya Barron - Non-Executive Director

Qualifications: BA hons 2:1 Social Science , PGCE Special Needs and Politics, Doctorate Health Sciences honoris causa, OBE

Professional profile: CEO of Plan International UK. In this role Tanya leads an £80m turnover international development organisation, with a particular focus on girls rights and gender equality. Tanya has worked at Board level in an international disability organisation, the European commission as an external manager and Chaired the UNICEF NGO committee in Geneva for many years.

Dr Kaushik Mukhopadhaya - Executive Director Quality and Medical Leadership and Consultant Psychiatrist (stood down in July 2017)

Iain Eaves - Executive Director, Strategy & Improvement (left the Trust on 10 April 2017)

Audley Charles - Interim Company Secretary (left the Trust in June 2017)

Jonathan Elwood - Company Secretary (left the Trust in March 2018)

Manjeet Gill - Non-Executive Director (left the Trust in July 2017)

2.1.2 Board of Directors appointments and committee attendance

There were 10 Board of Directors meetings between 1 April 2017 and 31 March 2018. The Trust also holds an Annual General Meeting for members. The term of appointment and individual attendance of each Board member at Board of Director and sub-committee meetings is set out below.

Table 1 - Appointments and attendance at Board of Directors meetings and statutory and assurance committees

Table 1-1 - April 2017- 31 March 2018

Board Member	Term of Appointment	Trust Board	Nominations & Remuneration committee	Audit Committee	Integrated Governance Committee	Finance & Investment Committee
		Attendance/actual/maximum				
Non-Executive Directors						
Chris Lawrence	01/08/2012- 31/07/2017	11/11	5/5	-	1/7	-
Simon Barter	01/08/2016- 31/07/2019	11/11	5/5	3/5	-	5/5
Sarah Betteley	01/08/2014- 31/07/2017	11/11	5/5	-	7/7	5/5
Robbie Burns	01/08/2015- 31/07/2018	7/11	4/5	-	5/7	4/5
Catherine Dugmore	01/08/2016- 31/07/2019	10/11	4/5	5/5	-	3/5
Manjeet Gill	01/08/2016- 31/07/2017	4/11	1/5	1/5	-	-
Michelle Maynard	01/06/2015- 31/05/2018	4/11	2/5	2/5	3/7	-
Tanya Barron	01/09/2017-01/09/2020	5/8	2/2	-	1/3	-
Loyola Weeks	01/08/2014- 31/07/2017	10/11	5/5	4/5	5/7	-
Executive Directors In Attendance						
Tom Cahill	01/04/2009 – on-going	10/11	5/5	1/1	-	-
Jinjer Kandola	01/10/2010- on-going	10/11	5/5	5/5	6/7	3/5
Keith Loveman	04/10/2010 – on-going	11/11	-	5/5	-	5/5
Dr Asif Zia	01/07/2017-on-going	7/9	-	2/4	3/4	2/4
Kaushik Mukhopadhaya	07/08/2015 – 30/06/2017	3/11	-	1/5	2/7	-
Jane Padmore	17/11/2016- on-going	11/11	-	3/5	6/7	4/5
Karen Taylor	27/02/2012- 0n-going	11/11	-	-	5/7	4/5
Jess Lievesley	27/05/2016-on-going	11/11	-	2/5	6/7	4/5
Other Directors and Attendees						
Ronke Akerele	Director of Innovation and Transformation			04/09/2017	On-going	
Jonathan Elwood	Company Secretary			05/06/2017	01/03/2018	
Sue Darker*	Herts County Council Assistant Director, Learning Disability and Mental Health				On going	
Audley Charles	Interim Company Secretary			06/12/2016	09/06/2017	

*Non Voting

2.1.3 Details of company directorships

Details of Interest declared by members of the Board of Directors including Company Directorships are held in a register of Directors' Interests by the Company Secretary.

The register of Directors' Interests is available from the Company Secretary at: Hertfordshire Partnership University NHS Foundation Trust, The Colonnades, Hatfield, Hertfordshire Tel: 01707 253866

There are no company directorships held by the Directors where companies are likely to do business with, or seek to do business with the Trust.

2.1.4 Statement of compliance with cost allocation and charging guidance

We have complied with the cost allocation and charging requirements set out in the HM Treasury and Office of Public Sector Information Guidance.

2.1.5 Details of political donations

There were no political donations made during the reporting period.

2.1.6 Statement of better payment practice code

The Better Payment Practice Code, formerly known as the CBI policy on prompt payment, requires payment to creditors within 30 days of the receipt of goods, or a valid invoice, whichever is the later, unless covered by other agreed payment terms. The Trust's payment policy was consistent with this target and actual achievement in the year was as follows:

	£000's	Number
Total non-NHS bills paid in the year	80,675	44,918
Total non-NHS bills paid within target	68,856	35,223
Percentage of bills paid within target (2017/18 percentages)	85%	78%
Percentage of bills paid within target (2016/17 percentages)	92%	87%

	£000's	Number
Total NHS bills paid in the year	9,511	1,015
Total NHS bills paid within target	7,872	822
Percentage of bills paid within target (2017/18 percentages)	83%	81%
Percentage of bills paid within target (2016/17 percentages)	82%	82%

During the year ended 31 March 2018, no interest was charged to the Trust under the Late Payment of Commercial Debts (Interest) Act 1998.

2.1.7 Disclosure relating to quality governance

2.1.7.1 How the Trust has regard to the quality Governance Framework

Quality governance is the combination of structures and processes at and below Board level to lead on Trust-wide quality performance including:

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care

Table 2 - Quality Governance Framework

1. Strategy	Example good practice
1a: Does quality drive the trust's strategy?	• Quality is embedded in the trust's overall strategy – The trust's strategy comprises a small number of ambitious trust-wide quality goals covering safety, clinical outcomes and patient experience which drive year-on-year improvement – Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff – Quality goals are selected to have the highest possible impact across the overall trust – Wherever possible, quality goals are specific, measurable and time-bound – Overall trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service) – There is a clear action plan for achieving the quality goals, with designated lead and timeframes. • Applicants can demonstrate that the quality goals are effectively communicated and well-understood across the trust and the community it serves • The Board regularly tracks performance relative to quality goals
1b: Is the Board sufficiently aware of potential risks to quality?	• The Board regularly assesses and understands current and future risks to quality and is taking steps to address them • The Board regularly reviews quality risks in an up-to-date risk register • The Board risk register is supported and fed by quality issues captured in directorate/service risk registers • The risk register covers potential future external risks to quality (eg, new techniques/technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks • There is clear evidence of action to mitigate risks to quality • Proposed initiatives are rated according to their potential impact on quality (eg clinical staff cuts would likely receive a high risk assessment) • Initiatives with significant potential to impact quality are supported by a detailed assessment that could include: – 'Bottom-up' analysis of where waste exists in current processes and how it can be reduced without impacting quality (eg, Lean) – Internal and external benchmarking of relevant operational efficiency metrics (of which nurse/bed ratio, average length of stay, bed occupancy, bed density and doctors/bed are examples which can be markers of quality) – Historical evidence illustrating prior experience in making operational changes without negatively impacting quality (eg impact of previous changes to nurse/bed ratio on patient complaints) • The Board is assured that initiatives have been assessed for quality • All initiatives are accepted and understood by clinicians • There is clear subsequent ownership (eg relevant clinical director) • There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistle-blower policy • Initiatives' impact on quality is monitored on an ongoing basis (post-implementation) • Key measures of quality and early warning indicators identified for each initiative • Quality measures monitored before and after implementation • Mitigating action taken where necessary.

2. Capabilities and culture	Example good practice
2a. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	• The Board is assured that quality governance is subject to rigorous challenge, including full Non-Executive Director (NED) engagement and review (either through participation in Audit Committee or relevant quality-focused committees and sub-committees) • The capabilities required in relation to delivering good quality governance are reflected in the make-up of the Board • Board members can: – Describe the trust's top three quality-related priorities – Identify well- and poorly-performing services in relation to quality, and actions the trust is taking to address them – Explain how it uses external benchmarks to assess quality in the organisation (eg adherence to NICE guidelines, recognised Royal College or Faculty measures) – Understand the purpose of each metric they review, be able to interpret them and draw conclusions from them – Be clear about basic processes and structures of quality governance – Feel they have the information and confidence to challenge data – Be clear about when it is necessary to seek external assurances on quality, eg how and when it will access independent advice on clinical matters • Applicants can give specific examples of when the Board has had a significant impact on improving quality performance (eg must provide evidence of the Board's role in leading on quality) • The Board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained • Board members have attended training sessions covering the core elements of quality governance and continuous improvement.
2b. Does the Board promote a quality focused culture throughout the trust?	• The Board takes an active leadership role on quality • The Board takes a proactive approach to improving quality (eg it actively seeks to apply lessons learnt in other trusts and external organisations) • The Board regularly commits resources (time and money) to delivering quality initiatives • The Board is actively engaged in the delivery of quality improvement initiative (eg some initiatives led personally by Board members) • The Board encourages staff empowerment on quality • Staff are encouraged to participate in quality / continuous improvement training and development • Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment) • Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery) • Internal communications (eg monthly newsletter, intranet, notice Boards) regularly feature articles on quality.

3. Structures and processes	Example good practice
3a. Are there clear roles and accountabilities in relation to quality governance?	• Each and every Board member understands their ultimate accountability for quality • There is a clear organisation structure that cascades responsibility for delivering quality performance from 'Board to ward to Board' (and there are specified owners in post and actively fulfilling their responsibilities) • Quality is a core part of main Board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions • Quality performance is discussed in more detail each month by a quality-focused Board sub-committee with a stable, regularly attending membership
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	• Boards are clear about the processes for escalating quality performance issues to the Board – Processes are documented – There are agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints • Robust action plans are in place to address quality performance issues (eg, including issues arising from serious untoward incidents and complaints). With actions having: – Designated owners and time frames – Regular follow-ups at subsequent Board meetings • Lessons from quality performance issues are well-documented and shared across the trust on a regular, timely basis, leading to rapid implementation at scale of good-practice • There is a well-functioning, impactful clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns – Continuous rolling programme that measures and improves quality – Action plans completed from audit – Re-audits undertaken to assess improvement • A 'whistle-blower'/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle • There is a performance management system with clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels

3. Structures and processes	Example good practice
3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	• Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance • The Board actively engages patients on quality, for example: – Patient feedback is actively solicited, made easy to give and based on validated tools – Patient views are proactively sought during the design of new pathways and processes – All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the Board – The Board regularly reviews and interrogates complaints and serious untoward incident data – The Board uses a range of approaches to "bring patients into the Board room" (eg, face-to-face discussions, video diaries, ward rounds, patient shadowing) • The Board actively engages staff on quality, for example: – Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (eg, monthly "temperature gauge" plus annual staff survey) – All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the Board • The Board actively engages all other key stakeholders on quality, for example: – Quality performance is clearly communicated to commissioners to enable them to make educated decisions – Feedback from PALS and local Healthwatch groups is considered – For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway – The Board is clear about Governors' involvement in quality governance

4. Measurement	Example good practice
4a: Is appropriate quality information being analysed and challenged?	• The Board reviews a monthly 'dashBoard' of the most important metrics. Good practice dashBoards include: – Key relevant national priority indicators and regulatory requirements – Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each) – Selected 'advance warning' indicators – Adverse event reports/ serious untoward incident reports/ patterns of complaints – Measures of instances of harm (eg Global Trigger Tool) – NHS Improvement's risk ratings (with risks to future scores highlighted) – Segmentation against NHS Improvement's Single Oversight Framework – Where possible/appropriate, percentage compliance to agreed best-practice pathways – Qualitative descriptions and commentary to back up quantitative information The Board can justify the selected metrics as: – Being linked to the Trust's overall strategy and priorities – Covering all the Trust's major focus areas – The best available ones to use – Useful to review • The Board dashBoard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines • Quality information is analysed and challenged at the individual consultant level • The Board dashBoard is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the Board commits time and resources to developing new metrics
4b: Is the Board assured of the robustness of the quality information?	• There are clearly documented, robust controls to assure that information is consistently accurate, valid and comprehensive – Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the Board of the quality of its data – The clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (eg incidents) – Electronic systems are used where possible, generating reliable reports with minimal ongoing effort – Information can be traced to source and is signed-off by owners – There is clear evidence of action to resolve audit concerns – Action plans are completed from audit (and subject to regular follow-up reviews) – Re-audits are undertaken to assess performance improvement – There are no major concerns with coding accuracy performance
4b: Is quality information being used effectively?	• Information in Quality Reports is displayed clearly and consistently • Information is compared with target levels of performance (in conjunction with a RAG rating), historic own performance and external benchmarks (where available and helpful) • Information being reviewed must be the most recent available, and recent enough to be relevant • 'On demand' data is available for the highest priority metrics • Information is 'humanised'/personalised where possible (eg unexpected deaths shown as an absolute number, not embedded in a mortality rate) • The Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance.

2.1.7.2 Material inconsistencies in reporting

There are no material inconsistencies in reporting

2.1.7.3 Summary of service user care activities

Every service user has a comprehensive care plan which is co-produced with the service user. Where appropriate this co-production may also include a relevant carer. Direct care in the Trust takes many different forms including:

- round the clock medical and nursing care
- access to a range of therapies including:
  - occupational therapy
  - several types of talking therapies
  - physical health such as physiotherapy.

These are based on the principles of the Care Act. You can find more detail of service user and carer involvement in the Quality Report.

2.1.7.4 Summary of stakeholder relations

Hertfordshire Partnership University NHS Foundation Trust (HPFT) maintains significant partnerships and relationships which support and facilitate the delivery of care and benefits for our service users/carers. Our strong relationships with key commissioners across Hertfordshire, Essex, Buckinghamshire and Norfolk have secured ongoing income for services, and funding for a number of developments during 2017/18 and onwards into 2018/19.

HPFT operates within the West Essex and Hertfordshire STP footprint, and has positive and developing relations with all key stakeholders within that partnership. HPFT itself is leading or undertaking a support role across work streams including the STP-wide mental health work stream.

Within each geographical footprint (Herts, Essex, Bucks, Norfolk) there are also examples of good stakeholder relations across the full range of statutory and non-statutory partners. These include Mind, Age UK, the Police, local acute hospitals, local commissioners and county councils. Within Herts Valleys CCG, HPFT is part of a 'Provider Collaborative' – a grouping of the main providers across West Hertfordshire who are working together to improve outcomes for the local population.

HPFT has a strong history of co-production with both external stakeholders and importantly with service users and carers. We have demonstrated this throughout 2017/18 across our services both in the development of our Trust-wide strategies and in our individual services.

NHS Improvement's Well-Led Framework

The Trust has in place arrangements to ensure services are well-led and these have been developed to reflect NHS Improvement's well-led framework. These arrangements and approach are set out in more detail in the Annual Governance Statement (page 66).

2.1.8 Income disclosures

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) states that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. We have met this requirement.

In accordance with Section 43(3A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Trust confirms it has several income sources that are not directly linked to patient care of which the main sources are education grants and research funding. These income streams contribute positively to the provision of goods and services for the purposes of the health service in England.

Fees and charges (income generation)

The Trust has no fees and charges where the full cost exceeds £1 million or the service is otherwise material to the accounts.

2.1.9 Statement of disclosure of information to auditors (s418)

The Directors of the Trust are responsible for preparing the Annual Report and Financial Statements (annual accounts) in accordance with applicable law and regulations.

Each of the Directors, whose name and functions are listed in the Board of Directors section of this Annual Report and Accounts and was a director at the time the report is approved, confirms that, to the best of each person's knowledge and belief:

So far as the Director is aware, there is no relevant audit information of which the Company's auditors are unaware; and

The Director has taken all the steps that ought to have been taken as a Director in order to make him or herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

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Remuneration Report

2.2.1 Annual Statement on Remuneration

This report covers the remuneration of the most senior managers of the Trust – the Board of Directors, including both Executive Directors and Non-Executive Directors as those people have the authority and responsibility for controlling the major activities of the Trust.

Information is provided about the Remuneration Committees, the policy on remuneration and detailed information about the remuneration of the Executive and Non-Executive Directors of the Trust.

2.2.1.1 Substantial changes to senior managers' remuneration

An independent review of the senior managers' remuneration policy is provided to the Nominations and Remuneration Committee by an external pay specialist and no Board Director is involved in setting their own remuneration. In setting the remuneration levels, the Committee balances the need to attract, retain and motivate directors of the quality required. There have been no substantial changes made in relation to senior managers' remuneration during the year.

2.2.1.2 Major decisions on senior managers' remuneration

During the accounting period the major decision for the Nominations and Remuneration Committee relates to performance-related pay for Executive Directors. The remuneration for the Executive Team includes an element of performance-related pay where performance is assessed in relation to organisational performance against agreed objectives relating to the Trust's strategic goals, and individual performance against annual personal objectives and contribution to the performance of the organisation. Progress towards achievement of these objectives is reviewed and regularly recorded during the year by the Chief Executive for the Executive Directors and by the Trust Chair for the Chief Executive, and is subsequently reported to the Nominations and Remuneration Committee.

For 2017/18 the performance targets set at the beginning of the year and actual performance against those targets is set out in the following section. The estimated resultant performance payment payable is set out in Table 4 of the remuneration report on page 44. For 2017/18 any award remains subject to consideration of the performance of the Executive Team by the Nominations and Remuneration Committee.

The full remuneration report of salary, allowances and benefits of senior managers are set out at 2.2.3.4 of the Annual Report on Remuneration.

Remuneration for Non-Executive Directors is set out at 2.2.3.1 of the Annual Report on Remuneration and on page 22 of the Full Statutory Accounts. No additional fees are payable in the role of Non-Executive Director.

Chris Lawrence
Date: May 2018
Trust Chair and Chair of the Board of Directors' Nominations and Remuneration Committee

2.2.2 Senior Managers Remuneration Policy

The remuneration policy for the Trust's Executive Directors is to ensure remuneration is consistent with market rates for equivalent roles in Foundation Trusts of comparable size and complexity and that regardless of the level of pay the remuneration is reasonable. It also takes into account the performance of the Trust, comparability with employees holding national pay and conditions of employment, pay awards for senior roles elsewhere in the NHS and pay/price changes in the broader economy, any changes to individual roles and responsibilities, as well as overall affordability.

The senior managers' remuneration policy is periodically reviewed by an independent external pay specialist who provides expert advice to the Nominations and Remuneration Committee.

The remuneration of the Executive Team includes a deferred performance pay scheme, based on a two-year cycle. The principles of the performance framework focus on reinforcing the collective performance of the organisation rather than that of individual directors.

The scheme has a threshold performance level which has to be achieved before the scheme becomes applicable. These include factors such as CQC requirements, quality indicators,

and financial performance to ensure that basic performance is achieved before any consideration of any performance related payment can be made. There are a number of stretch objectives which focus on the advancement of the Trust against both its strategic objectives and annual plan.

The Nominations and Remunerations Committee annually reviews and determines the threshold/gateway parameters that will apply for performance pay and, in conjunction with the Chief Executive, agree the performance scheme measures and weighting for each measure at the commencement of the annual cycle. These measures are normally five or six stretch objectives with a number of sub-components.

On achievement of the entry threshold the Nomination and Remuneration Committee will consider performance against the stretch objectives and will award the percentage amount available to be paid as performance pay to the team. The value of the payment can be up to a maximum of 15% of an Executive team member's salary. The percentage awarded will be moderated by the Chief Executive through the annual performance review cycle to reflect the performance of the individual directors, the Chair making the award in respect of the Chief Executive. Based on this an individual director will receive a sum individual to them and reflective of their performance, but limited to the overall collective performance of the organisation.

For an individual director, the award is subsequently moderated as a percentage of the eligible payment as follows:

- 100% for excellent performance
- 75% for very good performance
- 50% for average performance
- 25% of eligible payment available for a director at a development stage or with adequate performance

Where performance is deemed below an adequate level or there are issues of conduct and capability there will be no entitlement to a performance payment. Only 50% of the payment award will be paid in any one year. The remaining 50% will be deferred to the following year.

2.2.2.1 Future policy

For 2017/18 the performance targets set at the beginning of the year and the actual performance against those targets are set out in the following table. An amount has been included in the Annual Accounts to reflect the estimated amount payable. The performance related payment for 2017/18 notes the maximum estimated level payable and is included as a potential payment within the annual accounts. No payment has been made and the award remains subject to consideration by the Remunerations and Nominations Committee in accordance with the terms of the deferred performance pay scheme.

Table 3 - Executive Team Performance Scorecard 2017/18

The Executive team has collective accountability for delivering against the plan as a whole. Within that, individual members of the Executive team lead on, and are accountable for delivery against individual objectives. The Executive Team Objectives have been developed to reflect those areas where the collective ownership, leadership and drive of the whole team are especially critical to delivering on a given priority:

Objective	Outcome	Success Measure
Great Care Great Outcomes		
Safe and responsive Acute and community services (25%)	Services user kept safe. Consistently positive service user experience. Improved access to services (CAMHS).	CQC – safety "good" validated
		Service Users feeling Safe on Inpatient Wards
		Service User Friends and Family Test
		Improvement in the Community Service User Survey
		CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS) (baseline 42%)
Our People		
We will recruit and retain staff, reducing our reliance on temporary staffing (20%)	Reduced staff turnover / increased workforce stability. Lower vacancy level. Reduced agency usage.	Staff Turnover Rate from the baseline of 13.4%
		Vacancy Rate from (baseline 13%) (baseline increased during year due to establishment of 125 fte vacant posts Service Development- EIP & Perinatal MH)
		Agency Shifts. Achievement of the cap £8.5 m.
We will improve staff engagement and motivation (10%)	Engaged and motivated workforce with teams working well together	% Staff reporting feeling engaged and motivated at work. Baseline 57.8%.
Great Organisation		
We will live within our means and secure the financial sustainability of our services (20%)	Recurrent delivery of CRES target. Delivery of control total (10%).	Delivery against £4.8 m CRES (10%). Delivery of control total (10%).
Data & Technology (10%)	Become a technology driven organisation.	Improved Business Intelligence System. Improvements to technology infrastructure. Improvements to Patient Information System.
Partnerships & Strategy		
Development of commercial strategy and strategic partnerships (10%)	Stakeholder management Revised commercial strategy Relationship with HCT Partnership and Alliances	Revised Commercial strategy agreed by the Board to fit the changing external environment. Stakeholder map and plan in place. Development of partnerships and alliances to further the objectives of the Good to Great Strategy. Particularly GP Federations, CCG, GPs, and other organisations. Building on relationships with HCT. (Alliance)
We will play proactive role in System leadership ensuring that HPFT is fully immersed in establishment of new Architecture	HPFT Executive Team positioned and recognised as system leaders within Hertfordshire. Strategic positioning of HPFT strengthened	Leadership of key areas of joined up work STP, ACO, ACS and other partnerships. Strong relationships with counterparts in other parts of the system including, GP providers, CCGs LAs, NHS Trusts. Positive feedback (e.g. through Chairs, Commissioners, partners) on HPFT system leadership role.
Total		

Value	Threshold (50%)	Target (100%)	Q4 position	Final Outcome
5%		Good	Overall Good Achieved	5%
5%	70%	80%	80%	5%
5%	80%	85%	85.5%	5%
5%	Three out of four improved	Improvement in all the following areas - CPA Review - Contact in crisis - Joint decisions - Overall care	CPA review = down, Contact in crisis = same Joint decision = down Overall care = same	0%
5%	75%	95% year-end position	88%	2.5%
5%	<12%		14.2%	0%
10%	<11%		13.4% (vacancy rate against starting position 9.7%)	0%
5%	Within 25% of cap		Fully achieved the cap.	5%
10%	60% EOY	62% EOY	66% EOY	10%
20%	80% delivered recurrently	100% delivered recurrently	75% of CRES delivered recurrently.	0%
		100% delivery	Delivered	10%
10%	80% delivered	100% delivered	4 out 4 indicators achieved in relation to Improved Business intelligence.	
			5 out of 7 indicators achieved in relation to technology infrastructure. 3 out of 4 indicators achieved in relation to patient information systems.	5%
10%	Three of four achieved as determined by Rem Com	To be accessed by Rem Com	Strategy Complete. Stakeholder map in development. Relationships with key players strengthening. eg GP providers. Partnership with HCT on a range of issues, but alliance now on hold. Board update due.	10% (max)
5%	As assessed by Rem Com	To be assessed by Rem Com	CEO & all exec leading or involved in Key STP work streams and other partnerships. Relationships with GP providers much improved Positive relationship with Commissioners and other partners.	5% (max)
				62.5%

2.2.2.2 Service Contract Obligations

The Trust is obliged to give Directors six months' notice of termination of employment, which matches the notice period expected of Executive Directors from the Trust. The Trust does not make termination payments beyond its contractual obligations which are set out in the contract of employment and related terms and conditions. Executive Directors' terms and conditions, with the exception of salary, shadow the national arrangements, inclusive of sick pay and redundancy arrangements and do not contain any obligations above the national level.

2.2.2.3 Policy on payment for loss of office

The principles of the determination of payments for loss of office are in accordance with the national agenda for change guidance and in accordance with employment legislation.

2.2.2.4 Statement of consideration of employment conditions

The Trust adheres to the national Agenda for Change guidelines for the setting of notice periods. Director contracts, however, are subject to six months' notice periods.

2.2.3 Annual Report on remuneration

2.2.3.1 Service contracts

As stated in 2.2.2.4 above, all directors are subject to six months' notice period. Table 4 below shows their start and finishing dates, where applicable or if their role is current:

Table 4 - Trust Board Members for the Year Ending 31 March 2018

Name	Title	Contract Date From	Contract Date To
Non-Executive Directors			
Chris Lawrence	Trust Chair	01 July 2014	30 June 2020
Simon Barter	Non-Executive Director	01 August 2016	31 July 2019
Sarah Betteley (Senior Independent Director)	Non-Executive Director	01 August 2014	31 July 2020
Robbie Burns	Non-Executive Director	01 August 2015	31 July 2018
Catherine Dugmore (Chair-Audit Committee)	Non-Executive Director	01 August 2016	31 July 2019
Manjeet Gill	Non-Executive Director	01 August 2016	31 July 2017 (left 31 July 2017)
Michelle Maynard	Non-Executive Director	01 June 2015	31 May 2018
Loyola Weeks	Non-Executive Director	01 August 2014	31 July 2020
Executive Directors			
Tom Cahill	Chief Executive	01 April 2009	Current
Iain Eaves	Director Strategy & Commercial Development	01 January 2011	10 April 2017
Jinjer Kandola	Deputy CEO and Executive Director Workforce & Organisational Development	01 October 2010	Current
Jess Lievesley	Director Delivery & Service User Experience	27 May 2016	On-going
Keith Loveman	Director Finance	14 October 2010	Current
Kaushik Mukhopadhaya	Director Quality & Medical Leadership	07 August 2015	Current (Left July 2017)
Asif Zia	Director of Quality & Medical Leadership	July 2017	Current
Jane Padmore	Director Quality & Safety	17 November2016	Current
Karen Taylor	Director of Strategy & Integration	27 February 2012	Current
Other Directors and Attendees			
Ronke Akerele*	Director of Innovation & Transformation	04 September 2017	Current
Audley Charles*	Interim Company Secretary	06 December 2016	Left 09 June 2017
Sue Darker*	Herts County Council Assistant Director, Learning Disability and Mental Health		On going
Jonathan Elwood*	Company Secretary	05 June 2017	28 February 2018

*Non Voting

2.2.3.2 Remuneration Committee

The Trust has two Remuneration Committees – the Board of Directors' Nomination and Remuneration Committee and the Council of Governors' Appointments and Remuneration Committee.

Nomination and Remuneration Committee

The Nomination and Remunerations Committee reviews and makes recommendations to the Board on the composition, skill mix and succession planning of the Executive Directors of the Trust and is chaired by the Trust Chair.

All Non-Executive Directors are members of the Committee, and the Chief Executive, Company Secretary, and the Executive Director of Workforce and Organisational Development are normally in attendance.

There were two meetings of the committee during the financial period and the members' attendance is shown below:

- Chris Lawrence (2 of 2)
- Loyola Weeks (1 of 2)
- Michelle Maynard (0 of 0)
- Robbie Burns (1 of 2)
- Sarah Betteley (2 of 2)
- Simon Barter (2 of 2)
- Catherine Dugmore (2 of 2)
- Tanya Barron (1 of 1).

Appointments and Remuneration Committee

The Board of Governors' Appointments and Remuneration Committee is responsible for making recommendations to the Council of Governors on the following:

- Appointment and remuneration of the Chair and Non-Executive Directors
- Appraisal of the Chair
- Approval of Appointment of the Chief Executive
- Succession planning for posts of Chair and Non-Executive Directors
- Analysis of action required following appraisal of performance of Board of Governors.

The committee is made up of six Governors: four from the public constituency, one staff governor and one appointed governor. The Chair, Company Secretary, Executive Director of Workforce and Organisational Development and the Chief Executive are normally in attendance. The committee is chaired by the Lead Governor.

There were two meetings of the committee during this financial period, and the members' attendance is shown below:

Caroline Bowes Lyon (Public Governor) (2 of 2)

Dr Michael Shortt (Staff Governor) (0 of 2)

Emma Paisley (Public Governor) (2 of 2)

Jon Walmsley (Public Governor) (2 of 2)

Richard Pleydell-Bouverie (Lead Governor) (2 of 2)

2.2.3.3 Disclosures required by the Health and Social Care Act

Remuneration for senior managers is set out within section 2.2.2.1 Table 5 of the Remuneration Report. For all other staff the Trust adheres to the national agenda for change guidelines for the setting of pay and notice periods.

Governors and Non-Executive Directors may claim travel expenses at the rate of 45p per mile as well as other reasonable expenses incurred on Trust business. Executive Directors may claim travel expenses in accordance with national Agenda for Change guidelines as well as other reasonable expenses. They are not otherwise remunerated. During the accounting period expenses were paid as follows:

	2017/18		2016/17	
	Number of Individuals	£	Number of Individuals	£
Governors	2	248	3	916
Non-Executive Directors	9	10,779	9	9,523
Executive Directors	10	13,503	10	7,144

In total 36 Governors, 10 Non-Executive Directors and 10 Executive Directors held office during either part of, or for the full reporting period.

2.2.3.4 Senior Managers' remuneration

Senior Managers remuneration details and pension benefits for 2017/18 are set out at Table 4 and 5.These are subject to audit. During the accounting period no payments were made to past senior managers and no payments were made for loss of office.

The median total remuneration is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Total remuneration includes salary, non-consolidated performance related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Table 5 - Salary and Pension Entitlements of Senior Managers – Remuneration

Name and Title	2017/18		
	Salary and fees (bands of £5,000) £000	Taxable benefits* (nearest £00) £	Performance related bonuses (bands of £5,000)** £000
Christopher Lawrence (Non Executive Director and Chair)	50 to 55		
Simon Barter (Non Executive Director)	15 to 20		
Sarah Betteley (Non Executive Director)	15 to 20		
Robert Burns (Non Executive Director)	15 to 20		
Catherine Dugmore (Non Executive Director) Appointed August 2016	15 to 20		
Michelle Maynard (Non Executive Director)	15 to 20		
Loyola Weeks (Non Executive Director)	15 to 20		
Manjeet Gill (Non Executive Director) Resigned August 2017	5 to 10		
Tanya Barron (Non Executive Director) Appointed September 2017	5 to 10		
Peter Baynham (Non Executive Director) Resigned September 2016	0 to 0		
Tom Cahill (Chief Executive)	180 to 185		15 to 20
Harjinder Kandola (Deputy CEO/ Director of Workforce & Organisational Development) Appointed Deputy CEO November 2016	140 to 145		10 to 15
Asif Zia (Director of Quality & Medical Leadership) Appointed July 2017 ***	130 to 135		0 to 5
Karen Taylor (Chief Operating Officer / Director of Community Services & Integration) on maternity leave to June 2016	130 to 135		10 to 15
Keith Loveman (Director of Finance & Performance)	125 to 130	5,100	10 to 15
Jess Lievesley (Director of Delivery and Service User Experience)	125 to 130		10 to 15
Jane Padmore (Director of Quality & Safety) Appointed November 2016	120 to 125		10 to 15
Kaushik Mukhopadhaya (Director Quality & Medical Leadership) Resigned from Executive post June 2017***	35 to 40		
Aderonke Akerele (Director of Innovation and Transformation) Appointed January 2018	30 to 35		5 to 10
Iain Eaves (Director of Strategy & Organisational Development) Resigned April 2017	0 to 5		
Oliver Shanley (Director of Quality & Safety) Resigned November 2016			
Paul Lumsdon (Interim Director of Services Delivery & Customer Experience) Interim to May 2016			
Jonathan Elwood (Company Secretary) Appointed June 2017 Resigned February 2018	45 to 50		
Audley Charles (Interim Company Secretary) Interim from December 2016 to June 2017	30 to 35		
Helen Potton (Company Secretary) Appointed June 2016, Resigned December 2016			
Barbara Suggitt (Company Secretary) Resigned May 2016			
Band of highest paid director's total remuneration	180 to 185		
Median total remuneration	£31,598		
Ratio	5.7		

Senior Managers are defined as "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust".

*Taxable benefits represents the liability for tax payable by Executive Directors who are members of the Trust lease car scheme. Each Executive Director pays for their own private fuel consumption.

**The performance related bonus for 2017/18 notes the maximum estimated amount payable. No payment has been made and the award remains subject to consideration by the Remunerations and Nominations Committee in accordance with the terms of the deferred performance pay scheme. The detail of

2017/18			2016/17					
Long term Performance related bonuses (bands of £5,000) £000	Pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Salary and fees (bands of £5,000) £000	Taxable benefits* (nearest £00) £00	Performance related bonuses (bands of £5,000)** £000	Long term Performance related bonuses (bands of £5,000) £000	Pension related benefits (bands of £2,500)*** £000	Total (bands of £5,000) £000
		50 to 55	50 to 55					50 to 55
		15 to 20	15 to 20					15 to 20
		15 to 20	15 to 20					15 to 20
		15 to 20	15 to 20					15 to 20
		15 to 20	10 to 15					10 to 15
		15 to 20	15 to 20					15 to 20
		15 to 20	10 to 15					10 to 15
		5 to 10	15 to 20					15 to 20
		5 to 10						
		0 to 0	5 to 10					5 to 10
	90 to 92.5	285 to 290	170 to 175		15 to 20			190 to 195
	132.5 to 135	285 to 290	130 to 135		15 to 20		90 to 92.5	240 to 245
	202.5 to 205	335 to 340						
	67.5 to 70	210 to 215	100 to 105		15 to 20		35 to 37.5	155 to 160
	42.5 to 45	185 to 190	125 to 130	3,600	15 to 20		40 to 42.5	190 to 195
	115 to 117.5	250 to 255	115 to 120		15 to 20		130 to 132.5	265 to 270
	220 to 222.5	355 to 360	100 to 105		5 to 10		105 to 107.5	215 to 220
		35 to 40	145 to 150		15 to 20		135 to 137.5	300 to 305
	147.5 to 150	185 to 190						
	0 to 2.5	5 to 10	140 to 145				32.5 to 35	175 to 180
			90 to 95				140 to 142.5	230 to 235
			20 to 25					20 to 25
		45 to 50						
		30 to 35	50 to 55					50 to 55
			55 to 60					55 to 60
			5 to 10					5 to 10
			170 to 175					
			£32,071					
			5.5					

the scheme is contained within the Remuneration section of the Annual Report.

***The salary & fees for the Director Quality & Medical Leadership includes £93k for Asif Zia and £26k for Kaushik Mukhopadjay in relation to their clinical role.

Signed

Mr. Tom Cahill. Chief Executive. Date: 24 May 2018

Pension benefits

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer value at 31 March 2018	Cash Equivalent Transfer value at 31 March 2017	Real increase in Cash Equivalent Transfer value
	£000	£000	£000	£000	£000	£000	£000
Tom Cahill	0 to -2.5	0 to -2.5	90 to 95	270 to 275	1,783	1,634	62
Kaushik Mukhopadhaya	-5 to -7.5	-27.5 to -30	35 to 40	100 to 105	717	821	-94
Iain Eaves	0 to -2.5	0 to 0	15 to 20	0 to 0	149	139	3
Harjinder Kandola	2.5 to 5	2.5 to 5	50 to 55	135 to 140	929	803	67
Keith Loveman	0 to -2.5	-2.5 to -5	35 to 40	110 to 115	752	697	21
Jess Lievesley	2.5 to 5	2.5 to 5	35 to 40	85 to 90	508	423	49
Jane Padmore	7.5 to 10	15 to 17.5	40 to 45	110 to 115	697	524	108
Karen Taylor	0 to 2.5	-2.5 to -5	30 to 35	80 to 85	488	434	27
Aderonke Akerele	2.5 to 5	0 to 0	5 to 10	0 to 0	61	0	25
Asif Zia	5 to 7.5	10 to 12.5	45 to 50	110 to 115	816	672	83

Non-Executive Directors do not receive pensionable remuneration.

*Tom Cahill has Mental Health Officer status and has reached maximum service of 40 years. There is no real increase to his pension or lump sum at age 60. His CETV has increased over the year as the calculation of this figure includes age specific factors.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Accounting Officer Approval

Tom Cahill, Chief Executive

May 2018

Date:

Staff Report

2.3.1 Analysis of staff costs April 2017 to March 2018

Staff Group	Permanently Employed £'000	Other £'000	Total £'000
Administration and Estates	£25,145	£3,095	£28,240
Healthcare Assistants and Other Support	£19,792	£8,062	£27,854
Medical and Dental	£18,925	£2,099	£21,024
Nursing and Midwifery	£31,062	£9,316	£40,378
Scientific, Therapeutic and Technical	£27,031	£1,777	£28,808
Grand Total	**£121,955**	**£24,349**	**£146,304**

2.3.2 Staff numbers analysis

Staff Group	Permanently Employed	Other	Total
Administration and Estates	704	211	915
Healthcare Assistants and Other Support Staff	761	348	1109
Medical and Dental	135	63	198
Nursing and Midwifery	707	133	840
Scientific, Therapeutic and Technical	663	83	746
Grand Total	**2970**	**838**	**3808**

Breakdown of the number of male and female staff

Staff Group	Female	Male	% Female	% Male	Total
Directors	4	5	44%	56%	9
Other Senior Managers	4	2	67%	33%	6
Employees	2762	1031	73%	27%	3793
Grand Total	**2770**	**1038**	**73%**	**27%**	**3808**

Sickness absence data

The Workforce and Organisational Development (OD) Team work closely with operational managers on managing sickness absence. Throughout 2017 we have taken a supportive approach towards staff who are absent from work due to sickness,

providing training sessions and one-to-one coaching to ensure the consistent and fair application of the sickness absence policy. Where required, we make reasonable adjustments in the workplace for staff returning to work after periods of absence.

We have focused on areas with high sickness absence in order to support staff back to work and to sustain their attendance in the workplace. We have also focused on managing long-term sickness absence cases as well as supporting those employees with high Bradford scores (the Bradford formula is used to measure absenteeism).

We work with our occupational health provider to identify trends and take the necessary action. The services we offer to staff include

- an employee assistance programme
- Cognitive Behavioural Therapy
- physiotherapy services.

We have run a significant number of health and wellbeing activities throughout the year, including

- mini health checks
- massages,
- mindfulness sessions
- hydration challenge,
- couch to 5k
- swimming challenge
- sports days.

We provide regular monthly reports to the Strategic Business Units and corporate (central support) areas. The sickness KPI is an indicator on the Trust performance dashBoard and we provide the Trust Board with workforce information including sickness absence every quarter.

The table below shows the number of full-time equivalent days available in 2017/18 against the full-time equivalent days lost to sickness.

Staff Group	FTE Days Available	FTE Days Sickness	% FTE Days Sickness
Administration and Estates	20137.78	825.34	4.10%
Healthcare Assistants and Other Support	23619.46	1418.22	6.00%
Medical and Dental	5327.95	116.50	2.19%
Nursing and Midwifery	21059.50	928.35	4.41%
Scientific, Therapeutic and Technical	18534.17	398.57	2.15%
Grand Total	**88678.87**	**3686.98**	**4.16%**

2.3.3 Staff policies and actions applied during the financial year

We have worked on streamlining policies, benchmarking where possible with other NHS Trusts and professional bodies. We aim to provide a streamlined process that is less onerous for all staff and managers. We are doing this work in partnership with our staff side colleagues. It is agreed at the Trust's Policy Group before final ratification at Joint Consultative Negotiating Committee (JCNC).

Our policy group is chaired by an operational manager with input and representation from operational and professional leads. This allows us to explore a variety of professional opinions and expertise when we consider how a new or amended policy will work in practice.

The work our change management group does is vital to considering changes to clinical teams and the workforce as a whole. It aims to ensure that employees' legal rights to consultation and representation are upheld when changes are made in the work place. Staff representatives are fully updated and take an active role in change management or TUPE transfers within the Trust.[3] They attend consultation meetings, and one-to-one meetings to discuss organisational change and are updated on the outcomes – including those involving staff redeployment – of any change management process.

We work in partnership with full-time and local staff representatives. The Trust has both formal and informal monthly meetings with the Trade Unions. We discuss strategic issues at JCNC meetings which take place once every two months, while operational issues and staff concerns are raised and addressed at operational Partnership Group meetings, which also run every other month. The Trust also works in partnership with staff representatives in applying the Agenda for Change job evaluation process.

We use a range of methods and media to share information on matters of concern to staff. Many of these are designed to ensure staff have a direct voice in decisions which will affect them or

[3] TUPE Regulations preserve employees' terms and conditions when an organisation, or part of one, is transferred to a new employer

where they are able to impact the performance of the Trust. These include, but are not limited to:

- Direct communication through e-mail cascade
- Working Together as One – the Trust magazine for staff
- The Trust intranet
- Big Listen events where staff can interact directly with members of the Executive Team
- Local Listen events for specific teams or service areas in their own locality, with Executive and senior management representation
- Specific locality-based Executive led events, such as the 'Good to Great' roadshows and subsequent follow-up events.

Our policies for training, career development and promotion of disabled employees are integral to our overall approach to organisational development. Following our staff survey results, and in collaboration with the disabled staff network, we are developing additional guidance for managers and staff around support for staff with disabilities.

Anti-fraud and corruption measures

The Trust engages a dedicated local counter-fraud specialist (LCFS) through RSM Risk Assurance Services LLP to counter fraud and corruption. Our Anti-fraud and Corruption Policy and work plan is approved by the Board of Directors' Audit Committee. It reflects the NHS Counter Fraud and Security Management Services framework, and the Audit Committee receives regular reports throughout the year. The Trust has also adopted a Standards of Business Conduct Policy and both policies are on the Trust website.

Our LCFS provides regular fraud awareness briefings and workshops, specific training for targeted groups and awareness raising as part of the Trust induction programme for all new employees.

Staff incidents

The Trust has reported a total of 41 staff incidents to the Health and Safety Executive (HSE) under the Reporting Injuries and Dangerous Occurrences Regulations (RIDDOR) during 2017/18. This compares to 34 in 2016/17.

33 of these incidents were as a result of a physical assault against staff, 6 as a result of a Slip, Trip or Fall incident, 1 as a result of a Moving and Handling incident and 1 other personal incident.

The Trust has issued over 897 lone working devices to those staff who undertake "High Risk" lone working duties. There have been no Red Alert activations during the year requesting the emergency services to attend to support and assist staff.

Artwork supplied by the HPFT Art Collection

2.3.4 NHS National Staff Survey results

2.3.4.1 Our approach to staff engagement

We recognise that engaging our workforce is the key to successfully increasing organisational performance.

The model of engagement within the Trust is the integrated model of employee engagement from Holbeche & Mathews. This model connects four areas between individuals and the organisation.

- Connection – This is about identification with the organisation, its values and core purpose the 'why'. To what extent is there a strong sense of belonging to the organisation, both in terms of sharing the same beliefs and/or values and in an individual's readiness to follow the direction of the organisation?
- Support – This is about the vital role of line managers. The practical help, guidance and other resources provided to help people do a great job. Ensuring that managers provide support both in good and bad times.
- Voice – This is about the opportunity to be involved and contribute. The extent to which people are informed, involved and able to contribute to shaping their work environments.
- Scope – This is about creating the environment in which people can thrive and flourish. Giving employees the opportunities to meet their own needs grow and develop and have control over their work. This is reliant on mutual trust underpinned by meaning and purpose.

Our new organisational development (OD) strategy will support us to:

- Achieve our purpose, mission and vision
- Deliver on our strategic plan over the next five years
- Achieve our ambition of going from 'Good to Great'.

Our OD activities will focus on culture, customer experience, leadership, organisational effectiveness and design, staff experience and capability. The ultimate success of the OD strategy and supporting activity plan will be demonstrated in our sustainable delivery of great care and great outcomes.

We are committed to staff engagement, and value the input of all members of staff at all levels. We run a programme of events throughout the year sponsored and delivered by the Executive Team to ensure effective two-way participation in decision-making. These events capture staff ideas and feedback, which is collated, analysed and reported in a 'you said we did' summary to which all staff have access.

Engagement events for the year included the Big Listen, and Local Listen events which take place in Buckinghamshire, Essex and Norfolk. These are open to all staff in the organisation. They provide the opportunity for the Executive Team to hear our staff's views on key topics and priorities, informing actions and improving employee satisfaction and wellbeing.

As a result of feedback from the Big Listens we have:

- Increased health and wellbeing activities locally including introducing mindfulness sessions, and locally delivered Schwartz rounds (these provide opportunities for staff to reflect on the emotional aspects of their work)
- Commissioned and completed a review of all hub working environments and recruited more staff.

The Senior Leaders' Forum brings together the top 70 leaders from across the organisation on a regular basis throughout the year for joint problem solving and development activities.

The Chief Executive holds breakfast meetings every two months, inviting different groups of staff to feedback their views and experiences of working for the Trust and explore how we can improve the quality of care for service users. This year, there were five breakfast meetings held with admin and clerical staff, allied health professionals, psychologists, social workers and health care assistants. The main themes arising from these meetings mirror the feedback from other forums and centre on workload pressures, and staffing shortages.

The Executive Team held more face-to-face engagement sessions with staff across the Trust, to develop our Good to Great Strategy. These roadshows enable staff to have conversations with the Executive Team and provide feedback on the five areas of interest so that we can put into action going from 'Good to Great'.

We also run quarterly 'pulse surveys' to review staff satisfaction levels throughout the year. The questionnaire is based on the national staff survey (see next section) with extra questions included relating to local evaluation or commissioner reporting. We analyse the quantitative and qualitative responses, and report them to the Trust Board. The results inform local activity and plans.

2.3.4.2 Summary of performance

The National NHS Staff Survey

Our 2017 National NHS Staff Survey results show further improvements, building on our progress since 2015.

- 13 of the key findings are above average across Mental Health Trusts
- 16 are average
- 3 below average
- 90% of our scores are in line with, or above the national average across Mental Health Trusts.

In the category of 'Your Organisation' our results were higher than average in all four categories focused on 'recommending the Trust as a place to work and receive treatment' and 'that care for service users is top priority'.

Our five highest ranking scores, all of which are above average are:

- Staff motivation
- The quality of non-mandatory training, learning and development

- The effective use of patient and service user feedback
- Staff confidence and security in reporting unsafe clinical practice
- Staff recommending the organisation as a place to work or receive treatment.

The Trust's bottom five ranking scores are:

- Staff working extra hours
- Staff experiencing physical violence from staff in the last 12 months
- Staff experiencing harassment, bullying or abuse from staff in the last 12 months
- Support from immediate managers
- Percentage of staff experiencing discrimination at work in the last 12 months.

We have maintained a good overall staff engagement score which demonstrates the value of our current Organisational Development, learning, development and wellbeing initiatives, and the benefits of our staff engagement events. We will continue to promote these as part of our employer brand and offering and address the issues that impact on the staff experience as a priority. The outcomes from the staff survey will inform the new organisational development activity plan for next year. These include:

- Manageable workloads
- Staff experiencing bullying, harassment and abuse from staff
- Staff experiencing physical violence from staff
- Support from immediate managers.

The continued development of the transformation and innovation hub and Quality Improvement initiatives will also facilitate employee engagement and feedback.

Table 6 - Summary of performance – NHS National Staff Survey 2017 response rate

Response rate				
	2016/17	2017/18		Trust improvement/ deterioration
	Trust	Trust	Mental health average	
Response rate	42%	47%	52%	Improvement +5%

Top 5 ranking scores				
	2016/17	2017/18		Trust improvement/ deterioration
	Trust	Trust	Mental health average	
Effective use of service user feedback	3.77	3.88	3.72	Improvement +0.11
Quality of non-mandatory training, learning or development	4.18	4.14	4.06	Deterioration -0.04
Staff motivation at work	4.04	3.97	3.71	Deterioration +0.07
Staff confidence and security in reporting unsafe clinical practice	3.80	3.80	3.71	No change
Staff recommendation of the organisation as a place to work or receive treatment	3.84	3.85	3.67	Improvement +0.01

Bottom 5 ranking scores				
	2016/17	2017/18		Trust improvement/ deterioration
	Trust	Trust	Mental health average	
Percentage of staff working extra hours	79%	76	72	Improvement -3%
Percentage of staff experiencing physical violence from staff in last 12 months	2%	3%	3%	Deterioration +1%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	35%	24%	21%	Improvement -11%
Support from immediate managers	3.87	3.89	3.95	Improvement +0.02
Percentage of staff experiencing discrimination at work in the last 12 months	16%	17%	14%	Deterioration +1%

2.3.4.3 Priorities and targets

Our priorities are to implement the actions from the Organisational Development activity plan:

- Embedding a culture of innovation and continuous improvement across the Trust
- Developing a team of change agents across the Trust who focus on cultural change around innovation and continuous improvement, building on the Collective Leadership model.
- Delivering master classes on external national policy initiatives in health and social care to specific leaders
- Building on the engagement activities within the Trust.
- Delivering key improvements identified in our collective leadership work:
  - supporting managers to delegate and take accountability
  - ensuring workloads are manageable
  - boosting empowerment and involvement in decision-making
- Reviewing the current leadership competencies and development opportunities in light of the new national framework and the requirements of the Good to Great strategy.
- Continuing the development of current clinical leaders.
- Developing our staff to better support service users to stay as well as possible as outlined in the Trust Quality and Service Delivery Strategy.

The Workforce and Organisational Development Group will measure how we perform against our priorities. We will also monitor the feedback received in the quarterly pulse survey and from staff during the various engagement events running throughout 2018/19.

2.3.5 Expenditure on consultancy

The total expenditure of consultancy for the year is £957k. This includes the provision of specific expertise or short-term project capacity on areas such as Estates development, Service redesign, project assurance and IT consultancy.

2.3.6 Off-payroll engagements

Table A - Off-payroll engagements as of 31 March 2018, for more than £245 per day and last for longer than six months

	Number
Total number of existing arrangements as of 31 March 2018	**8**
Of which the number that have existed for;	
less than one year at time of reporting.	**1**
between one and two years at time of reporting.	**3**
between two and three years at time of reporting.	**2**
between three and four years at time of reporting.	**1**
four or more years at time of reporting.	**1**

We confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Trust policy is to minimise the number of off-payroll engagements and to ensure strict compliance with the requirements of IR35. All off-payroll engagements are routinely reported and monitored as part of financial control processes. For highly paid staff, approval is required from the Executive Director of Finance (who is the executive lead for agency expenditure) and for Board level appointments approval would be by the Nominations and Remuneration Committee.

Table B - All new off payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	**3**
Of which	
No. assessed as within the scope of IR35	**0**
No. assessed as not within the scope of IR35	**3**
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	**0**
No. of engagements reassessed for consistency/ assurance purposes during the year	**0**
No. that saw a change to IR35 status following the consistency review	**0**

Table C: Off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

	Number
Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	**8**
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	**10**

2.3.7 Exit packages

There were three exit packages agreed in 2017/18 totalling £116k (2 in 2016/17 totalling £120k).

	Number of exit packages	Cost of exit packages	
Exit package cost band (including any special payment element)	**Number**	**£000s**	
<£10,000	**0 (0)**	**0**	**(0)**
£10,001 - £25,000	**0 (0)**	**0**	**(0)**
£25,001 - £50,000	**3 (1)**	**116**	**(27)**
£50,001 - £100,000	**0 (1)**	**0**	**(93)**
£100,001 - £150,000	**0 (0)**	**0**	**(0)**
>£200,000	**0 (0)**	**0**	**(0)**
Total	**3 (2)**	**116**	**(120)**

Artwork supplied by the HPFT Art Collection

Code of Governance Disclosure

The purpose of NHS Improvement's NHS Foundation Trust Code of Governance ('the Code') is to assist Trusts to deliver effective and quality corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients. The Code is best practice advice but imposes specific disclosure requirements. The Annual Report includes all the disclosures required by the Code.

Hertfordshire Partnership University NHS Foundation Trust (HPFT) has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

We have reviewed the make-up and balance of the Board, including the appropriateness of current appointments. The Board believes that its membership is balanced, complete and appropriate to the requirements of a foundation trust that no individual group or individuals dominate the Board meetings. The skills and experience of all Board members is set out in more detail in this report under 'Board Committees'.

The Trust complied throughout the review period with the main and supporting principles of the Code of Governance with no exceptions. The following information summarises the evidence against the Code of Governance.

The Trust is properly constituted and Well Led as the CQC Well-led Inspection Report (2018) demonstrated.

The Governance Structure in the Annual Governance Statement demonstrates the roles and relationships of the Council of Governors, the Board of Directors and its statutory committees (the Nominations and Remuneration Committee and the Audit Committee) and its two assurance committees: the Integrated Governance Committee and the Finance and Investment Committee. We have already made reference to the Remuneration Committees of the Council of Governors and the Board of Directors (see Section 2.2.3.2).

The Board of Directors, Chair and Executive

The Board of Directors believes the Foundation Trust is led by an effective Board as it is collectively responsible for the exercise and the performance of the Trust. This is evidenced through the periodic appraisal of Board performance.

Chair and Chief Executive

The Board of Directors has agreed a clear division of responsibilities between the chairing of the Board of Directors and Council of Governors and the executive responsibility for the running of the Foundation Trust's business.

The Chair is responsible for providing leadership to the Board of Directors and Council of Governors ensuring governance principles and processes are maintained while encouraging debate and discussion.The Chair is also responsible for ensuring the integrity and effectiveness of the relationship between the Governors and Directors. The Chair also leads the performance appraisals of both the Board and the Council, as well as the Non-Executive Directors' performance appraisals.

The appraisal of the Chair is led by the Lead Governor, who is Chair of the Appointments and Remuneration Committee. This includes input from the Senior Independent Director. This was felt appropriate due to the role of the Governors in the appointment and remuneration of the Chair.

The statutory and assurance committees of the Board

The Audit Committee provides assurance to the Board through oversight of the probity and internal financial control of the Trust, and works closely with external and internal auditors. Key activities include reviewing governance, risk management and assurance functions. The committee approves the annual plans for external and internal audit, and for counter fraud, receiving and reviewing regular reports, monitoring the implementation of recommendations, issues of risk and their mitigation.

The committee also reviews accounting policies and draft annual accounts prior to submission to the Board of Directors.

During the year the committee reviewed and updated its terms of reference and conducted private discussions with both sets of auditors.

The Audit Committee also received regular updates from management in relation to the financial position and, in particular, key risks and issues arising during the year, and their treatment and mitigation. During the year the key risks and issues considered were:

- Data Quality. The findings and recommendations from the 2016/17 NHS Quality Report External Assurance Review were considered by the committee with particular focus on data quality issues. On behalf of the Board the Audit Committee considered the programme to address data quality issues and the monitoring arrangements in place. This included detail of the Clinical Reporting Assurance Framework and programme and the work of Information Assurance Board
- Clinical Audit. The committee considered the 2016/17 Clinical Audit Annual Report and the 2017/18 annual programme including the scope of work and progress against this
- General Data Protection Regulation. Nicola Whiter, Head of Information Governance, presented the requirements, issues, risks and plans arising from the forthcoming introduction of enhanced Information Governance legislation. The committee also received a progress update in relation to 'readiness' and considered any additional risk mitigations required
- Cyber Security. Carol Sheridan, Associate Director of IM&T, presented a comprehensive update of the position for the Trust in relation to cyber security and potential risks, management of these risks and areas for further work. The issue was added to the Trust Risk Register
- Accounting issues. Paul Ronald, Deputy Director of Finance, presented key areas of management judgement in the preparation of the annual financial statements with particular reference to:
  - Continuing care obligations, which relate to claims for retrospective reimbursement of care costs met by individuals which potentially may qualify for NHS funding
  - Property Valuations and the use of 'Modern Equivalent Asset' valuations
  - Level and nature of provisions for potential future costs.

For each area, the approach being taken by management was set out and discussed and agreed by the committee.

External Audit

Deloitte LLP, our external auditor, was reappointed by our Council of Governors for 2017 following an effectiveness review by the Audit Committee which looked at seven key areas, designed to test performance against the terms of engagement. The outcome was a strong positive in relation to the performance of Deloitte LLP. During 2017/18 a competitive tender exercise for future external audit services has been undertaken in accordance with Trust Standing Financial Instructions. The outcome of this exercise will be subject to Council of Governor approval in May 2018.

The primary duty of our external auditors is to audit the Annual Report, financial statements and quality account of the Trust.

The Audit Committee approves the External Audit Plan before the audit starts, and receives regular updates as it progresses. The annual accounts were reviewed by our independent external auditors, Deloitte LLP, who issued an unqualified opinion. So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken all the steps they ought to have taken as Directors to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The audit is conducted in accordance with International Standards on Auditing (UK and Ireland) as adopted by the UK Auditing Practices Board ("APB"), the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by NHS Improvement.

It remains important that the external auditor's independence from management is both maintained and transparent. Therefore, any additional non-audit work carried out by Deloitte LLP has been requested on the basis of the agreed protocol and the cost of any non-audit work is shown separately in the accounts and in the table below.

The total external audit fee for 2017/18 (including VAT) was £76k, comprising:

Audit Area	Audit Fee £k
Statutory audit work	70
Quality Account	11

Anyone who may be concerned about a matter of corporate governance or probity can contact any member of the Audit Committee in confidence.

The Chief Executive is invited to attend the Audit Committee at least once a year to discuss, with the committee, the process for assurance that supports the Annual Governance Statement.

Integrated Governance Committee (IGC)

The role of the Integrated Governance Committee is to:

- Assure adherence to CQC and other relevant regulatory requirements for quality and safety and receive reports from all relevant quality and safety groups
- Receive minutes, reports, action plans and risk registers from the following standing sub-committees of the IGC:
  - Quality & Risk Management Committee
  - Workforce & Organisational Development
  - The following groups will also report on specific items relating to areas of regulatory compliance:
  - Operations Group
  - Information Governance Group
- Advise on the content and development of the Annual Governance Plan and supervise, monitor and review it and the Trust-wide Risk Register and make recommendations for improvement.

- Scrutinise and provide assurance to the Trust Board through providing regular reports on governance, quality and risk issues and to escalate any risks to the Board Assurance Framework (BAF) or concerns as appropriate where assurance is not adequate. Reports should also be sent to the Audit Committee for scrutiny and recommendations.
- Set standards for the Trust Governance systems in order to:
  - Meet performance targets,
  - Meet core and developmental standards
  - Manage risks
- Recommend to the Trust Board necessary resources needed for the IGC to undertake its work
- Advise on the production and content of the Annual Governance Statement and make recommendations to the Chief Executive as necessary prior to its review at Audit Committee, its approval at the Board and subsequent inclusion in the Annual Report
- Advise on the content, format and production of an Assurance Framework for the Trust Board and monitor its ongoing suitability and make recommendations to the Audit Committee and the Board as necessary
- Advise on the content, format and production of the annual Quality Accounts
- Ensure that appropriate risk management processes are in place that provide the Board with assurance that action is being taken to identify risks and manage identified risks within the Trust
- Be responsible for developing systems and processes for ensuring that the Trust implements and monitors compliance with the Care Quality Commission's registration requirements
- Oversee the establishment of appropriate systems for ensuring that effective practice governance arrangements are in place throughout the Trust
- Ensure that the learning from inquiries carried out in respect of Serious Incidents is shared across the Trust and implemented through policies and procedures as necessary
- Ensure that services and treatments provided to service users are appropriate, reflect best practice and represent value for money
- Ensure that plans are in place to improve the service user experience
- Ensure that services are accessible and responsive to service users' needs and reflect local "nuances"
- Ensure that the environments in which services are provided are appropriate and therapeutic
- Ensure that the organisation is engaged in public health programmes and these are integrated throughout the services we provide.

The Finance and Investment Committee

The role of the Finance and Investment Committee:

Financial Policy, Management and Reporting

- To consider the Trust's financial strategy, in relation to both revenue and capital
- To consider the Trust's annual financial targets and performance against them
- To review the annual budget, before submission to the Trust Board of Directors
- To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets
- To review proposals for major business cases and their respective funding sources
- To commission and receive the results of in-depth reviews of key financial issues affecting the Trust
- To maintain an oversight of, and receive assurances on the robustness of the Trust's key income sources and contractual safeguards
- To oversee and receive assurance on the financial plans of the transformation programme
- To consider the Trust's tax strategy
- To annually review the financial and accounting policies of the Trust and make appropriate recommendations to the Board of Directors.

Investment Policy, Management and Reporting

- To approve and keep under review, on behalf of the Board of Directors, the Trust's investment strategy and policy
- To maintain oversight of the Trust's investments, ensuring compliance with the Trust's policy and NHS Improvement's requirements.

Table 5 - Governors: 01 April 2017 to 31 March 2018

Public Governors	Date Appointed	End Date	Resignation/ End Date	Number of Terms
John Allen	01 August 2014	31 July 2017	End of Term	1
Tap Bali	01 August 2012	31 July 2018		2
Caroline Bowes-Lyon	01 August 2011	31 July 2020	Re-elected	3
Barry Canterford	01 August 2013	01 July 2019		2
Mark Edgar	01 August 2013	31 July 2019		2
Mathew Kunyeda	01 August 2015	31 July 2018		1
Verity Masters	01 August 2016	31 July 2019		1
Masood Moghual	01 August 2014	31 July 2017	End of Term	1
Kwasi Opoku	01 August 2013	31 July 2019		2
Bob Taylor	01 August 2016	31 July 2019		1
Jon Walmsley	01 August 2016	31 July 2019		1
Emma Paisley	01 August 2015	31 July 2018		1
Richard Pleydell-Bouverie	01 August 2013	31 July 2019		2
Ilana Rinkoff	01 August 2016	31 July 2019		1
Angelina Sclafani-Murphy	01 August 2013	31 July 2019		2
William Say	01 August 2017	31 July 2020	New Term Appointment	1
Colin Egan	01 August 2017	31 July 2020	New Term Appointment	1
Meredith Griffiths	01 August 2017	31 July 2020	New Appointment Term	1
Harinder Singh-Pattar	01 August 2017	31 July 2020	New Appointment Term	1
Appointed Governors				
David Andrews, Hertfordshire County Council	01 August 2013	31 July 2019		2
Leslie Billy, Viewpoint	01 August 2013	31 July 2019		2
Charles Allan, Herts Valley CCG	01 August 2014	31 July 2017	End of Term	1
Fran Deschampneufs, Mind	01 August 2012	01 July 2018		2
Rosemary Farmer, St Albans District Council	01 December 2014	31 July 2020	Re-appointed	2
Gayl Staines, The Alzheimer's Society	01 August 2013	31 July 2016	Resigned September 2017	2
Amy Wilcox-Smith, Housing Association	01 February 2016	31 July 2019		1
Eve Atkins, Hertfordshire Healthwatch	01 March 2017	31 July 2020		1
Staff Governors				
Graham Wright, Corporate	01 August 2017	31 July 2020	New Term Appointment	
Herbie Nyathi, Acute Services	01 August 2017	31 July 2020		1
Michael Shortt, Learning Disability and Forensic Services	01 August 2017	31 July 2020		1
Beke Tshuma, Specialist Services	01 August 2012	31 July 2018		2
Tara Gouldthorpe, Community Services	01 August 2012	31 July 2018		2

Other

- To make arrangements as necessary to ensure all Board of Directors members maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust
- To examine any other matter referred to the Committee by the Board of Directors
- To review performance indicators relevant to the remit of the Committee.

The frequency and attendance of Board members at Board and Committees are summarised in Table 1 of The Directors' Report.

Council of Governors

The Council of Governors is constituted to have 21 public governors from two constituencies namely Hertfordshire and the Rest of England. There should be five staff members and nine appointed governors from our partner organisations. The list of governors is at Table 5. We have 16 Public Governors, 5 Staff Governors and 5 Appointed Governors.

We thank all our governors for their valuable contribution to the Trust and, in particular, those who have served two terms with us. Their expertise and knowledge will be missed and we hope they will continue their involvement with the Trust by acting as mentors to new governors.

The Council of Governors and the Board of Directors have a good working relationship. Both are chaired by the Trust Chair, and they hold five joint meetings annually, including the AGM. The Directors also have an open invitation to attend all Council of Governors meetings. The Chair and the Company Secretary act as the main links between the Board and the Council,

and reports and briefings are shared by the Governors and Directors. The Trust Constitution include a process for settling any disagreements between the Council and the Board of Directors. This process was written by the Council and the Board.

Any other significant commitments the Trust Chair has are disclosed to the Council of Governors before appointment, and any changes to such commitments reported as they arise. The Trust Chair has made a formal declaration of interests and these are recorded and held in the register of Directors' interests maintained by the Company Secretary. The significant commitments declared by the Chair are:

- Chair of Trustees, The Horstead Residential Activities Centre, Norfolk
- Lay Canon & member of the Council of Norwich Cathedral
- Assistant & Liveryman, The Worshipful Company of Musicians
- Court Assistant & Liveryman.
- The range of issues the Council of Governors has dealt with as part of their statutory duties, includes:
- Appointing the Trust's External Auditors
- Electing a Lead Governor,
- The recruitment of Catherine Dugmore (non-executive director)
- The reappointment of Simon Barter for a second term (non-executive director).

The governors have also been involved in

- The Trust's Annual Members' Day and several members' workshops focusing on Trust Services
- Undertaking the Chair's performance appraisal of the Chair.

Once a year we hold a workshop with governors so they can contribute feedback – their own and the views of members, staff members and the public – to the Trust's forward plan.

The Council's three working groups continue to meet regularly to take forward work plans on behalf of the Governors, and provide a full report at each of the Council of Governors meetings. The three groups are:

- Engagement
- Performance
- Quality and effectiveness.

All governors are invited to participate in the groups. Group meetings have been attended by Board members and senior managers to support information sharing and engagement with governors.

Details of interests declared by members of the Council of Governors including Company Directorships are maintained in the register of Governors' interests. This is available from the Company Secretary at: Hertfordshire Partnership University NHS Foundation Trust, The Colonnades, Beaconsfield Road, Hatfield, Hertfordshire, AL10 8YE Tel: 01707 253866.

Governors hold no company directorships in companies likely to do business with, or that seek to do business with, the Trust.

Membership

Our public membership now stands at 10,149. During 2017, the membership office invested in a new data management system and as a part of the installation process we performed a data cleanse. The new system stores and manages the details provided by our members. As part of the new service, we carry out monthly and quarterly checks monthly and quarterly to make sure the data is accurate and up-to-date. This ensures communications are not going to members who have moved house or passed away.

Over the past 12 months we have been working closely with all our services to raise awareness of the Trust and build our membership numbers.

To be eligible for membership, people must be over the age of 14 and living either within the County of Hertfordshire or the Rest of England and Wales

or

Be employed by the Trust and have a permanent contract or a temporary contract lasting 12 months or more

Or, although not directly employed by the Trust, have been either employed for longer than 12 months by another organisation that is providing core services to the Trust, or seconded to the Trust to provide core services.

Members receive our magazine Partnership Matters twice a year; they also have access to further information about the Trust and the work of the Council of Governors and Board of Directors through the Trust website.

We encourage Members (through the public website and Partnership Matters) to communicate with Governors via the Membership Office.

We serve a diverse population and community, so the Trust and the Council of Governors continue to focus on engaging a diverse and representative membership.

We will continue to explore innovative ways of recruiting and retaining members. We will focus on actively recruiting members via clinical contact, particularly in our IAPT and Wellbeing services and will also use social media to promote membership.

Public constituency (Hertfordshire)	Year 2017/18
Year start (April 1)	9773
New members	53
Members leaving	247
Year end (March 31)	9473

Membership size and movements

Public constituency (England & Wales)	Year 2017/18
Year start (April 1)	382
New members	159
Members leaving	35
Year end (March 31)	576

Staff constituency	Year 2017/18
Year start (April 1)	3123
New members	504
Members leaving	471
Year end (March 31)	3156

0-16	3
17-21	10
22+	9,300
Not specified	736

White	8497
Mixed	461
Asian or Asian British	474
Black or Black British	122
Other	4
Not specified	491

Male	4150
Female	5883
Other/not specified	16

Disclosure issues

Requests for Information

Freedom of Information Act 2000 (FOIA)

The number of Freedom of Information Act 2000 (FOIA) requests received by the Trust during this year has decreased by 12%, however the complexity and number of questions asked have increased. The Trust received a total of 320 requests compared with 366 for 2016/17 and 242 for 2015/16.

The Information Commissioner's Office (ICO) has also seen record numbers of Freedom of Information applications to public authorities and of appeals to the ICO as the regulator. This

is a strong indication that the public appetite for freedom of information continues to grow.

Who has asked for information?

Under the FOIA an applicant does not need to inform us who they are, or give a reason why they want the information. However, where we have been able to establish the identity of a requester, year-on-year figures show that requests from journalists are becoming more frequent and the FOIA appears to be increasingly used as an investigative tool.

Response Time (in working days)	Number of requests 2017/18	Number of requests 2016/17
1 - 5 days	18	55
6 - 10 days	41	623
11 - 15 days	52	62
16 - 20 days	29	49
21+ days	145	127
Requests currently being processed	35	11

Requests have been received from the following applicants (where identifiable):

Timescales for responses

FOIA legislation requires that public authorities provide a response to requests for information within 20 working days. Whilst we make every effort to complete all requests within this timescale, the sheer complexity of some requests that require input from numerous teams means we can't always meet this target.

When it is evident that a request is going to take longer than 20 working days, we inform the applicant of the delay and provide regular updates.

Response Time (in working days)	Number of requests 2017/18	Number of requests 2016/17
1 - 5 days	18	55
6 - 10 days	41	623
11 - 15 days	52	62
16 - 20 days	29	49
21+ days	145	127
Requests currently being processed	35	11

Information has been provided to applicants within the following timescales:

Exemptions

The FOIA exemptions ensure a proper balance is achieved between the right to know and the right to personal privacy.

The following exemptions were considered and applied to all or part of a request during 2017/18:

- Section 1: Do not hold this information
- Section 12: Cost of compliance exceeds appropriate limit
- Section 21: Information available by other means
- Section 22: Information intended for future publication
- Section 31: Law enforcement
- Section 40: Personal information
- Section 43: Commercial interests.

Year	No of requests with exemptions applied	Exemptions used and frequency
2017/18	67	Section 1 x 21
		Section 12 x 8
		Section 21 x 27
		Section 22 x 2
		Section 31 x 2
		Section 40 x 5
		Section 43 x 2

Publication of information requested (disclosure log)

Requests from the previous 12 months are routinely published on the FOIA disclosure log on the Trust website. This enables us to direct applicants to information already available and to apply exemption Section 21 (information accessible by another means) where the same/similar information has been requested. The Trust has applied this exemption for 27 requests received during the period 2017/18.

Over the course of 2018/19, the Trust will identify trends in FOIA requests to understand the key areas of interest for the public, so we can make this information available on our website in a clear

and accessible format.

Data Protection Act 1998 (DPA)

The DPA gives an individual (or someone appointed on behalf of the individual with the appropriate authority) the right to apply to see the information we process on them. Below are the year-on-year figures for Subject Access Requests (SARs) received by the Trust.

Year	SARs Received	Continuing Care (CC)	SARs Processed (Excl. CC)	% Increase/ Decrease Year on Year
2017/18	465	8	457	6%
2016/17	437	22	415	-0.2%
2015/16	471	55	416	9%

In addition to the above figures for 2017/18, we were contacted by the Police for information relating to a specific operation they are conducting. This included 44 requests of which we have completed 25.

Timescale for responses

DPA legislation requires the Trust to provide information within 40 calendar days. However, Department of Health guidance advises that healthcare organisations should aim to respond within 21 days.

During the period 1 April 2017 – 31 March 2018, SARs were processed within the following timescales (this excludes the special project details above):

The Trust endeavours to respond to SARs within 21 calendar days. However, due to the number of requests we receive, and large volumes of notes that require processing, this is not always achievable. We aim to keep applicants informed of any delay and provide regular updates if a request is going to take longer than the statutory 40 calendar days.

Response Time	Number of SAR requests 2017/18
Within 21 calendar days	132
Within 30 calendar days	+45 (177)
Within 40 calendar days	+119 (296)
40+ calendar days	56
No longer required or closed during processing	89
In progress	24

In line with the General Data Protection Regulations that are due to come in to force on 25th May 2018, the statutory time limit to respond to a SAR will reduce to 30 calendar days. The Trust has been monitoring its compliance with the 30-day timescale throughout 2017/18 to assess whether additional resource is required to meet the new deadline.

We receive SARs from a variety of sources, the largest number came from the sources below.

Type of requester	East & North	Learning Disability & Forensic	West
Solicitors	73	32	73
Service users	43	21	48
Relatives	7	3	8
Other	96	18	43
Total Number	**219**	**74**	**172**

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework covers five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its license.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. We have omitted information from when RAF was in place, as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

This segmentation information shows our position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Artwork supplied by the HPFT Art Collection

The performance against the financial performance ratings for the Trust for 2017/18 are summarised in the table below and show that throughout the year the Trust achieved the highest financial rating in each quarter;

We exceeded our planned Use of Resources ratings for Capital Servicing Capacity and those relating to the I&E Margin. This was because our surplus was above plan, our capital spends lower than planned, and capital charges were reduced. In significantly reducing our agency costs from the previous year we achieved our agency spend target of £8.5m resulting in a rating of 1. We are continuing to work collaboratively with other local NHS organisations and NHS Improvement to continue to reduce agency spend for 2018/19: NHS Improvement have reduced the expenditure cap to £7.3m.

We met our planned target of achieving an overall 1 rating. This confirms the Trust's strong financial position and careful use of resources.

Area	Metric	2017/18 scores				2016/17 scores	
		Q1	Q2	Q3	Q4	Q3	Q4
Financial sustainability	Capital Service Capacity Rating	1	1	1	1	1	1
	Liquidity Rating	1	1	1	1	1	1
Financial efficiency	I&E Margin Rating	1	1	1	1	1	1
Financial controls	I&E Margin Variance Rating	1	1	1	1	1	1
	Agency Rating	2	2	2	1	2	2
Overall scoring	**1**	**1**	**1**	**1**	**1**	**1**	**1**

Statement of the chief executive's responsibilities as the accounting officer of Hertfordshire Partnership University NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Hertfordshire Partnership University NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Hertfordshire Partnership University NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgments and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS FoundationTrust and to enable him/her to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Tom Cahill, Chief Executive

May 2018

Date:

Annual Governance Statement 2017/18

2.7.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2.7.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Hertfordshire Partnership University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact, should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Hertfordshire Partnership University NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

2.7.3 Capacity to handle risk

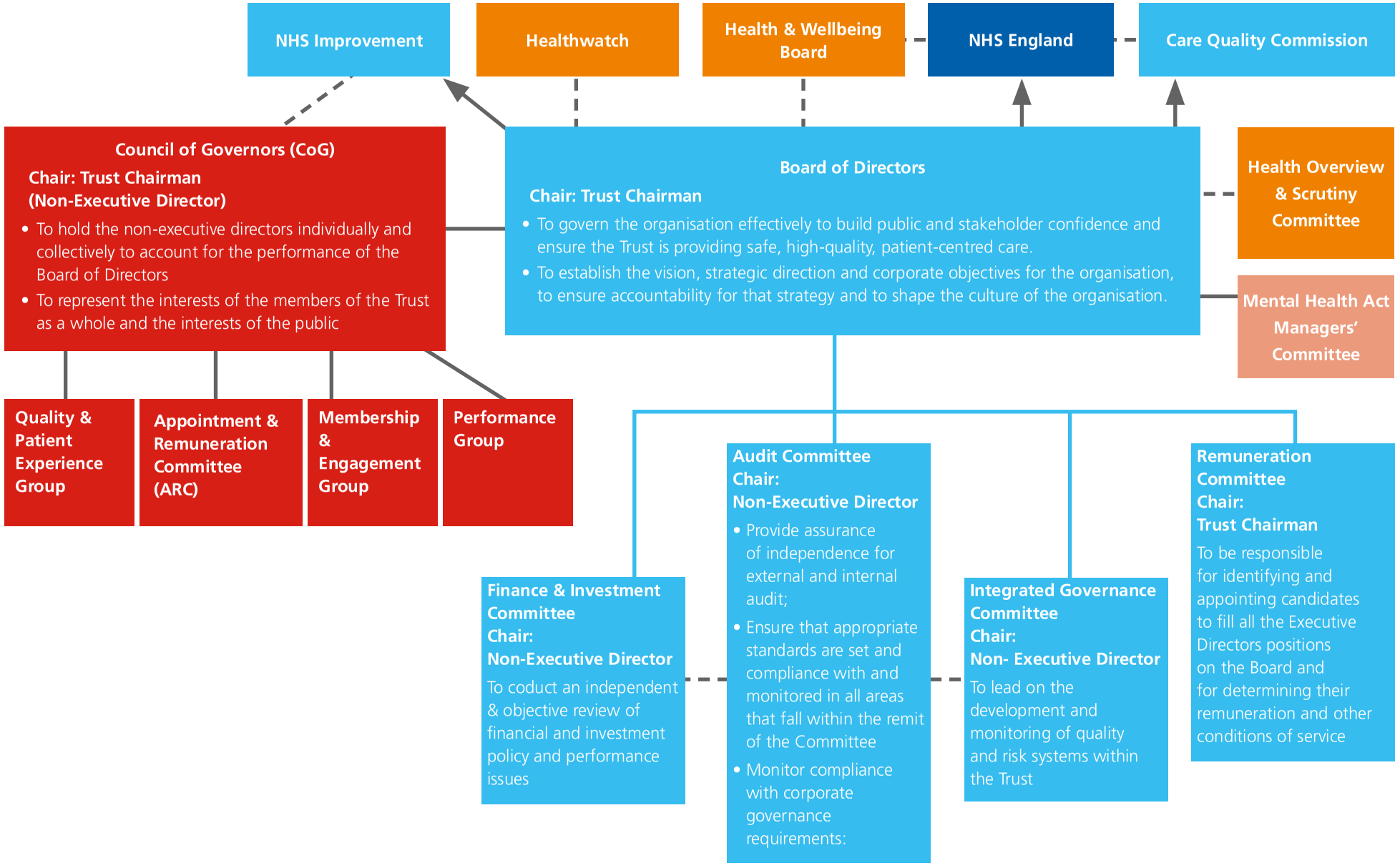
As Accounting Officer I am accountable for the quality of the services provided by the Trust. I have overall responsibility for risk management within the Trust and this responsibility is incorporated within the risk management strategy. Elements of risk management are delegated to members of my Executive Management Team and designated specialist staff:

Overall Risk Management	Executive Director of Quality & Safety (Caldicott Guardian)
Clinical Governance	Executive Director of Quality & Safety
Clinical Risk & Medical Leadership	Executive Director of Quality & Medical Leadership
Corporate Governance	Company Secretary
Board Assurance & Escalation	Company Secretary
Financial Risk	Executive Director of Finance
Compliance with NHS Improvement Regulatory Framework	Executive Director of Finance & Company Secretary
Compliance with CQC Regulatory Framework	Executive Director of Quality & Safety
Information Risk	Director of Innovation & Transformation (SIRO)

Figure 1 opposite illustrates the robustness and effectiveness of our risk management and performance processes via our governance structure

Our Governance structure

Figure 1



In addition, the Director of Service Delivery and Customer Experience is responsible for the day-to-day management of risk and performance within operational services and there are designated roles of Deputy Director, Safer Care and Standards and Deputy Director of Nursing & Quality providing leadership and support in their respective areas.

Staff members have a responsibility for handling the management of clinical and non-clinical risks according to their roles and duties within the Trust. All staff undertake mandatory training on key risk areas at induction into the Trust and on a regular refresh basis.

We develop capacity and capability across the Trust through training events commensurate with staff duties and responsibilities. This includes risk management training for all new staff. We have also run risk awareness sessions for existing staff teams.

Sharing the learning through risk-related issues, incidents, complaints and claims is essential to maintaining the risk management culture within the Trust. We share learning through Clinical Management Teams and Trust-wide forums including the Quality and Risk Management Committee and Health and Safety Committee. Learning is acquired from a variety of sources and through a number of processes. These include:

- Analysing incidents, complaints, claims and acting on investigation findings
- External Inspections
- Internal and external audit reports
- Clinical audits
- Outcome of investigations and inspections relating to other organisations.

In accordance with its Standing Orders and as required by NHS Improvement's Code of Governance, the Trust has an Audit Committee whose role is to review and report upon the adequacy and effective operation of the organisation's overall system of governance and internal control. This encompasses risk management – both clinical and non-clinical.

To assist both the Board and the Audit Committee, specific risk management is overseen by two Board Assurance Committees:

- Integrated Governance Committee (which receives reports from the Quality & Risk Management Committee and Workforce & Organisational Development Group) and has the specific purpose of delivering assurance to the Board on the management of clinical risk and operational performance against the CQC domains
- Finance and Investment Committee, which provides assurance on management of risks relating to resources – both financial and human, and the strategic direction of the Trust.
- Our Risk Management and Risk Escalation Models are set out at Figure 2 and Figure 3 respectively.

2.7.4 The risk and control framework

2.7.4.1 Risk management by the Board is underpinned by four interlocking systems of internal control:

1. The Board Assurance Framework
2. Trust Risk Register (informed by Strategic Business Units, Departments and Teams)
3. Audit Committee
4. Annual Governance Statement.

The Risk Management Strategy and Policy have continued to work effectively during 2017/18. Our Risk Management system, Datix, has continued to be a source of effective risk management across all levels and a source of just-in-time reports as required. The risk management processes remained as defined within the Board Assurance and Escalation Framework. This clearly outlines the Trust's risk leadership, responsibility and accountability arrangements. These responsibilities are then taken forward through the Assurance Framework, the Risk Registers, Business Planning and Performance Management processes, enabling us to deliver coherent and effective risk management throughout the organisation.

As Figure 2 below illustrates, risk management involves the identification, analysis, evaluation and treatment of risks – or more specifically recognising which events (hazards) may lead to harm and therefore minimising the likelihood (how often) and consequences (how bad) of these risks occurring:

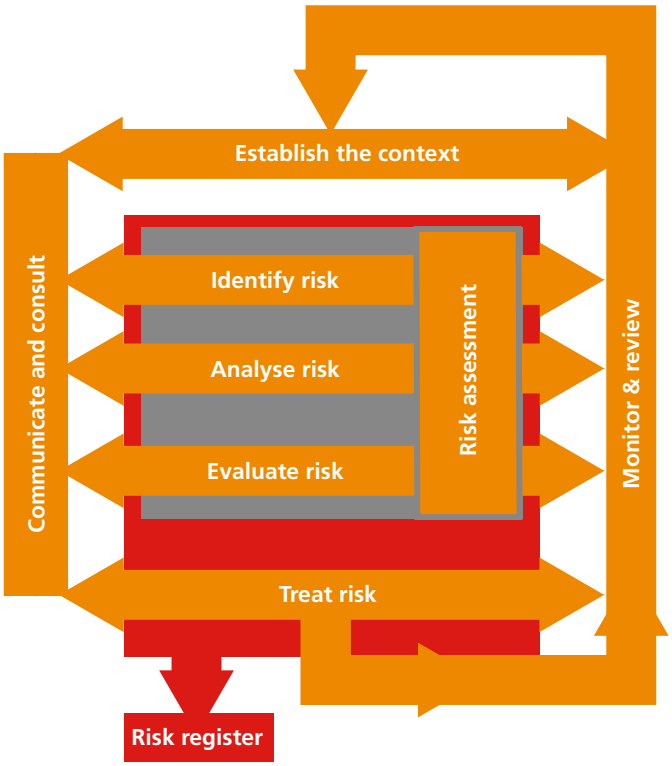


Figure 2 Source: AS/NZS 4360:1999

Risk is managed at all levels, both up and down the organisation and, to ensure consistency between the Annual Plan and the Board Assurance Framework (BAF), the Trust produces a Performance Report for the Board on activity within the Trust Risk Register. This details the risks that have come onto the Trust Risk Register and those that the Executive Team has approved to come off.

The Audit Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit, external audit and local counter fraud services. The Audit Committee reports to the Board quarterly after every meeting, and annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the BAF, the completeness and extent to which risk management is embedded in the Trust and the integration of governance arrangements.

The Integrated Governance Committee is responsible for the Risk Management Strategy and the Trust's internal control mechanisms. It reports regularly to the Trust Board on the risks faced by the organisation, and how these are being managed/controlled. This includes overseeing the performance and quality dashBoards which show compliance with CQC registration requirements and other statutory compliance, and scrutinising the quarterly reports before these are submitted to the Board.

The Trust recognises the need for a robust focus on the identification and management of risks. Therefore management of risk is both an integral part of our overall approach to quality, and an explicit process in every activity in which the Trust and its employees participates.

Risk management in the Trust is discharged through clearly focusing responsibility for all clinical governance and risks with the respective Directors. The Directors, working closely with the Chief Executive, have responsibility for all Trust care services and supporting corporate functions in this context. The management lead for risk rests with the Director of Quality and Safety who is also the Caldicott Guardian.

The Trust has a strong track record in:

- the identification and mitigation of risks
- responding quickly when there have been untoward and serious incidents,
- ensuring that the lessons learned are implemented swiftly across the organisation.

Our comprehensive approach to risk is embedded in the culture of the organisation and implement through robust processes and procedures including "concerns at work" and our "ward to Board" assurance processes.

These are supplemented by the Chief Executive's and Directors' 'Good to Great' and engagemented sessions. These have encouraged teams and individuals to share any risks and concerns openly as well as helping identify areas of good practice that should be celebrated. Our strong performance in the NHS Staff Survey, is particularly positive, and demonstrates how we are creating and reinforcing an open culture in which staff feel both motivated and safe to raise any concerns they may have.

Regular discussions take place at Board meetings concerning the Trust's appetite for risk. These set the strategic parameters within which staff can make decisions involving various types of risk on a sound and consistent basis.

2.7.4.2 Board Assurance Framework (BAF)

Board assurance is a systematic method of:

- Identifying
- Analysing
- Evaluating, treating, monitoring, reviewing
- Communicating

all clinical and non-clinical risks combined with the integration and management of both types of risk.

The requirement to develop a Board Assurance Framework (BAF) was established by the Department of Health (now NHS England), Assurance: The Board Agenda (July 2002). The BAF is designed to help the Board to satisfy itself that risks are being managed and strategic objectives are being achieved. The Board has established a robust BAF so that I, as Chief Executive, can confidently sign the Annual Governance Statement which deals with statements of internal control.

A Board Assurance Framework has been in place throughout the year which is designed and operating to meet the requirements of the 2017/18 Annual Governance Statement. The BAF, which is Board owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which could prevent the Trust's strategic objectives being achieved.

The BAF is robustly discussed and analysed at Board sub-committees before being discussed by the Board. Updates of progress against actions are provided at each meeting of the IGC, Audit Committee and quarterly by the Board.

The BAF provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives and therefore, the operational plan. It maps out the key controls to mitigate the risks and provide a mechanism to inform the Board of the assurances received about the effectiveness of these controls. The Board receives assurances directly or via its statutory and assurance Committees: Audit; Remuneration; Integrated Governance and Finance and Investment.

It is a dynamic tool which supports the Chief Executive to complete the Annual Governance Statement at the end of each financial year. It is part of this wider 'Assurance and Escalation Framework' to ensure the Trust's performance across the range of its activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for service users.

The formation and maintenance of the BAF is the responsibility of the Company Secretary and is regularly reviewed by each Principal Risk Owner (Executive Directors). This is to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions.

Risks monitored over the year included:

- Regulatory Compliance
- Quality and Safety including management of demand and capacity
- Safeguarding
- Financial Resources
- Workforce-recruitment and retention
- Cyber security and IT infrastructure
- Data Quality and General Data Protection Regulations.

The BAF has been updated during 2017/18 to reflect the Board's review of the Trust's strategic objectives and has, itself, been reviewed by the Board every quarter.

2.7.4.3 Trust's Risk Monitoring Escalation and Assurance Process

The Risk Management Strategy sets out how risk is identified and assimilated into the Risk Registers and reported, monitored and escalated throughout the directorate and corporate governance structures.

In addition to the Board Assurance Framework (BAF), the Trust operates five tiers of risk management which are all interlinked via an escalation process. The escalation of a risk depends on the level of the risk, or on whether it is felt that the risk needs specialist management at a higher tier – for example, if the risk requires a multi-directorate approach to management.

The registers are recorded using a standardised risk matrix and the severity of each risk is rated according to the Consequence x Likelihood risk assessment matrix within the Risk Management Strategy to establish the risk score which helps guide action at the appropriate level.

There is a clear process for escalating high or significant risks (see Figure 3 opposite). The Trust does not have a static risk appetite, which means that the Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. In any event, the Board must be consulted if directorates, departments or teams need to materially alter significant risk scores. The statutory and assurance committees and the Executive Team have regular oversight of all relevant risks in the Trust Risk Register.

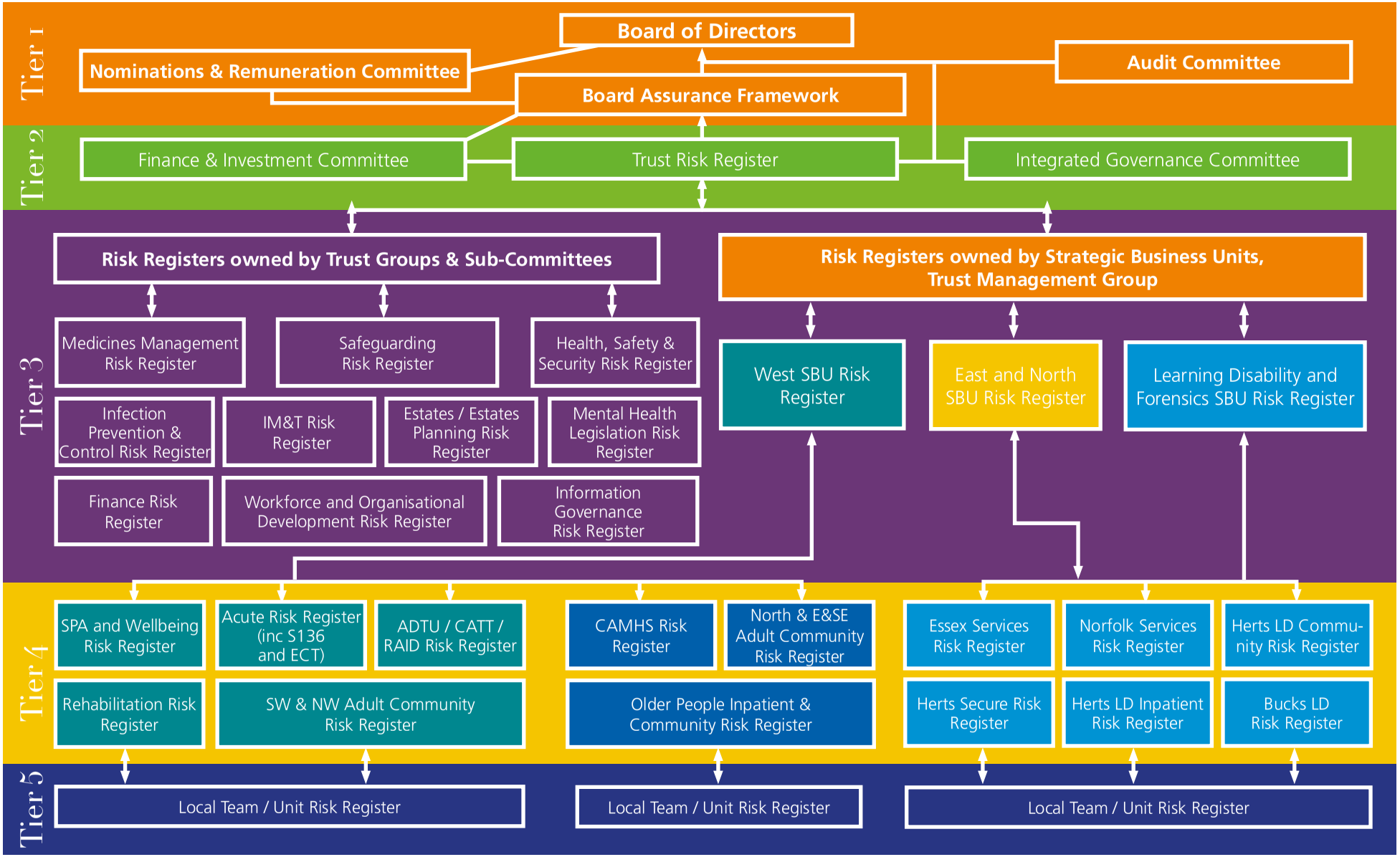
2.7.4.4 Local and Directorate Risk Registers

Every ward team or department produces a local risk register. This contains details of local risks that may impact on the delivery of their immediate service. Local risk registers are recorded using the risk module in Datix.

We have taken appropriate steps to ensure that processes are in place so both clinical service and departmental levels update and maintain their risk registers. Monthly updates from local and directorate risk registers are provided via Datix and the Risk and Compliance Manager reports on these for potential inclusion into the Trust's Risk Register.

Board to ward risk management and escalation structure

Figure 3



Local teams review all local risks systematically within a specified time frame. This enables them to ensure that the controls in place are effective, and assess if the risk changes over time.

Risks can be identified through internal processes: e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may also be identified via external events: e.g. national reports and recommendations or regulatory and enforcement notices etc.

2.7.4.5 Care Quality Commission essential standards of quality

HPFT is fully compliant with the registration requirements of the Care Quality Commission.

The Trust receives periodic unannounced CQC Mental Health Act inspections. Following an inspection at the Broadlands Unit, Little Plumstead, a section 29a notice was issued to the Trust in relation to improvement requirements. These focused on restraint and seclusion, staffing levels, timely updating of clinical records and environmental risks. The local team instigated an improvement plan and worked hard to address the issues identified. As a result, the s29a notice was lifted after a core service inspection in January 2018.

We have also included new seclusion facilities within our 2018/19 capital programme and these will be operational during the year and we have strengthened our internal 'peer-to-peer' quality visits to ensure these provide robust triangulation of quality and safety issues.

The Trust registered with the Care Quality Commission (CQC) on 1 April 2010 and received an unannounced core service inspection of four service lines in January 2018 followed by a planned well-led inspection in February. The Trust achieved an overall rating of 'Good' and two of the service lines reviewed – including the services provided at the Broadlands Unit were upgraded to outstanding. We have developed an Action Plan that focuses on some 'Must Dos' and 'Should Dos'. The Integrated Governance Committee will receive updates on the CQC action plan every two months.

2.7.5 Pension schemes

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

2.7.6 Equality, Diversity and Human Rights

We have control measures in place to ensure that the Trust complies with all its obligations under equality, diversity and human rights legislation.

We are committed to the principle of equal opportunities and equal treatment for all employees, regardless of sex, race, religion or belief, age, marriage or civil partnership, pregnancy and maternity, sexual orientation, gender reassignment or disability.

Our equality and diversity work is centred on ensuring that we comply with the Public Sector Equality Duty and are delivering best practice as a lead for equality and diversity. This work focusses on activity to:

- eliminate unlawful discrimination
- advance equality of opportunity
- foster good relations.

We completed our most recent grading of the NHS Equality Delivery System 2 in January 2018 with an overall outcome of 'good'and this reflects ongoing progress and improvement. During 2018/19 we will launch and implement our new equality plan which is linked into the overall organisational development strategy.

2.7.7 Energy and carbon reduction

The Trust has undertaken risk assesments and put Carbon Reduction Delivery Plans in place. This is in accordance with emergency preparedness and civil contingency requirements based on UKCIP 2009 weather projects and are designed to ensure that the Trust is fully compliant with its obligations under the Climate Change Act and the Adaptation Reporting requirements.

2.7.8 Internal and external stakeholders and service user and carer involvement

The Trust has

- a Service User Council
- Carer Council
- Young People's Group
- 'Making Services Better' Group for people with Learning Disabilities.

Service User and Carer Groups/Councils have been a significant presence in the Trust for over 10 years. They raise and discuss a variety of topics with Trust staff at all levels, and are vital critical friends that the Trust can approach for honest feedback and comment from the perspective of lived experience.

2017/2018 was a productive and active year for service user and carer involvement. Members of the service user and carer

councils have become Trust Governors and equality and diversity champions, and have supported raising awareness of disability, gender, mental health.

Over the past year, the Inclusion & Engagement Team have co-produced involvement feedback forms and developed personal development plans for Experts by Experience to reinforce the role of involvement activities in recovery. All our Experts by Experience and volunteers undertake the same induction. This covers topics including:

- Equality and diversity
- Safeguarding
- Living our values
- Conflict resolution
- Health and safety
- Information governance.

We will continue our ongoing review of involvement throughout 2018, and this will result in a revised policy for the Trust.

The Service User Council, Carer Council, Young People's Council and Making Services Better Group (for our learning disability and forensic services) all ensure that stakeholder views are embedded in the ways we work. We are also proud of our unique Peer Experience Listening project, which has been running successfully since 2010. This project is led by people who have a lived experience, who collect feedback from current service users. Over the last year, the Peer Experience Listeners have conducted 85 qualitative interviews with people using services including Street Triage, Host Families, Safety on Wards, and Improving the responsiveness of community services.

At every Board meeting, a service user, carer and professional from a specific service are invited to share their experiences and suggest Board actions for positive change. At one meeting during 2017/18, a service user presented to the Board, informing them of her struggles in gaining access to one of our Trust buildings. Her presentation and feedback led to the Trust making adjustments to the physical access to the building so she and others could access the building entrance.

Having service users and carers sharing their stories at the start of every Board meeting helps sets tone of the meeting and brings the focus back to the Trust vision to deliver Great Care and Great Outcomes for people, together.

All our groups have worked relatively intensively with staff on local projects that impact service users and carers day-to-day care. And it's not only the Trust that listens to, and acts on people's lived experience. Our third sector partners do too, and our service users' and carers feedback contributes to local commissioning decisions. HPFT groups have also contributed to national discussions and policy, for example, to the Green Paper and the recent Mental Health Act review.

2.7.9 Quality Governance Framework

The Trust's Risk Management Strategy details the relationship between the Trust's strategic goals, principal risks and the Board Assurance Framework. The Risk Management Policy outlines the process for assessing, prioritising and managing all types of risk through risk registers and includes:

- Risk Assessment and Risk Register flow charts
- Risk definitions including Risk Appetite
- Duties and responsibilities of individuals and committees
- The risk assessment process
- The risk management process
- The Integrated Governance and Risk Management Structure
- Board assurance framework and risk register templates.

The Risk Management Strategy and Policy are enhanced by the Practice Governance Framework and the Quality Strategy.

The principal strategic and operational risks are outlined in the Risk Strategy. This sets out how the Trust endeavours to ensure that risks do not prevent the Trust from achieving its strategic objectives. The Strategy, therefore, sets out the role of the Board, its statutory and assurance committees in the identification, management and mitigation of risks. Figure 3 illustrates the risk escalation process.

The Strategy emphasises the role of the Board Assurance Framework and Risk Register in the management of strategic and operational risks respectively.

The Internal Audit Plan has, as part of its remit, audit of the Risk Management processes and the Board Assurance Framework. The Integrated Governance Committee, the Finance and Investment Committee and the Audit Committee scrutinise and monitor clinical and non-clinical risks where appropriate, on behalf of the Board. Figure 1, our governance structure depicts the role of Board Committees and their inter-relationship in the management of quality and risk. The whole corporate and clinical structure is designed to ensure that the Trust has and maintains robust quality governance arrangements.

2.7.10 Information governance

Reporting of Personal Data Related Incidents

The Trust takes the management of risks to data security very seriously and the loss of data is a risk which is monitored nationally.

In accordance with the Health and Social Care Information Centre 'Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation' (29 May 2015 V5.1) incidents classified at a rating of level 2 are reported to the Information Commissioners Office (ICO). There have been 5 level 2 breaches during the reporting period (4 during 2016/17):

- Two incidents relating to inappropriate accessing of data
- One incident involving an incorrectly addressed envelope
- One incident involving the loss of paperwork
- On incident where paperwork was not appropriately disposed of.

All five were formally reported as potential or actual breaches of confidentiality involving person-identifiable data. For each breach, the Trust submitted an action plan setting out the remedial action taken. For one case the ICO considered the information provided by the Trust and was satisfied with the action taken and closed the incident with no further action deemed necessary. For one the ICO closed the case and made a recommendation for improved verification, checking and security procedures for addressing correspondence. We are awaiting ICO responses to the three remaining cases.

2.7.11 Review of economy, efficiency and effectiveness of the use of resources

The key financial policies and processes

As Accounting Officer, I have responsibility to the Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through good governance and systems of internal control designed to ensure that resources are applied efficiently and effectively.

The effective and efficient use of resources is managed by the following key policies:

Standing Orders

Standing Orders are contained within the Trust's Constitution and set out the regulatory processes and proceedings for the Board of Directors and the Council of Governors and their committees and working groups including the Audit Committee, whose role is set out below. They support the efficient use of resources.

Standing Financial Instructions (SFIs)

SFIs detail the financial responsibilities, policies and principles adopted by the Trust in relation to financial governance. They are designed to ensure that financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

They do this by laying out very clearly who has responsibility for each of the key aspects of policy and decision making in relation to key financial matters. This ensures that we have:

- A clear division of duties
- Completely transparent policies for
  - competitive procurement processes
  - effective and equitable recruitment and payroll systems and processes.

Our budget planning and allocation process is clear and robust and ensures costs are maintained within budget or highlighted for action.

The SFIs are used in conjunction with:

- The Trust's Standing Orders
- The Scheme of Delegated Authority
- Individual detailed procedures set by directorates.

Scheme of Delegated Authority

This sets out those matters reserved to the Board and the areas of delegated responsibility to committees and individuals. The document explains who is responsible and the nature and purpose of that responsibility. It assists in the achievement of the efficient and effective use of resources by ensuring that decisions are taken at an appropriate level within the Trust by those with the experience and oversight appropriate to the decision being made. It ensures that the focus and rigor of decision-making processes align with the strategic priorities of the Trust and that the Trust puts in place best practice in relation to its decision-making.

Anti-fraud and Corruption including the Bribery Act 2010

The Bribery Act which came into force in April 2011 makes it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery could lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This helps ensure that the taking or receiving of bribes is less likely, and improve the integrity and transparency of the Trust's transactions and decisions.

The Trust Board relies on the Audit Committee to ensure appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources and ensure the Trust's internal control systems are robust and can be evidenced.

The Audit Committee agrees an annual work programme for the Trust's Internal Auditors and the Counter Fraud Service, and reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by NHS Counter Fraud Authority, reports from which are reviewed by the Audit Committee. In addition, further assurance on the use of resources is obtained from external agencies, including External Audit and regulatory bodies.

2.7.12 Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards

on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust has continued with following these steps to assure the Board that the Quality Report presents a balanced view:

- A stakeholder consultation process to agree quality priorities for the reporting and coming year, involving service users, carers, staff, Governors and partner agencies
- A review of all Trust services before the priorities are agreed
- A Quarterly Quality report to the Board leading to scrutiny of whether the focus is right
- Sharing the draft Quality Account/report with partner agencies for comment, with the primary commissioners having the legal right to point out inaccuracies.

The Trust follows these steps to assure the Board that there are appropriate controls ensuring the quality of the data:

- We provide all staff – including all new starters – with appropriate training on inputting data.
- Where possible, we eliminate manual approaches to data gathering and analysis. This includes investing in new systems
- We audit supervision to gain assurances that our clinical record-keeping and data quality processes are robust
- We conduct a separate audit of Clinical Records Management.

The accuracy of information for Quality Reports is assessed via:

- Systematic checks within the Informatics and Performance Improvement teams
- Board scrutiny of the quarterly reports, ensuring that any errors and/or corrections are noted
- An annual External Audit assurance as mandated by NHS Improvement.

We continue to review our performance-reporting framework, taking into account the increasing size and complexity of quality measurement and reporting in the Trust. During 2017/18, our business intelligence system has been further developed and enhanced to provide additional real time information. We have also undertaken a full review of performance related data quality indicators by introducing a Clinical Reporting Assurance Framework (CRAF) and an Information Assurance Group.

The quality metrics which are contained in quarterly Board reports are agreed by the Board after a period of internal and external consultation. Each quality metric is reviewed quarterly at Board meetings, where they are checked for accuracy and relevance as well as progress made. Should an error occur during the year, the errors are corrected at the next Board quarterly report and the occurrence noted. For a more detailed description of these processes, please refer to the Quality Report itself.

Processes are established to monitor compliance against Care Quality Commission (CQC) regulations (Health and Social Care Act 2008 Regulated Activities, Regulations 2014) using the updated 'peer-to-peer' Quality Visit process, based on the CQC's key lines of enquiry. Quarterly reports are provided to the Quality and Risk Management Committee – a sub-committee of the Integrated Governance Committee. The Intelligence Monitoring Reports are used to check performance against what teams report and to anticipate any potential future risks. The Integrated Governance Committee is then kept informed of the completeness of the data and any areas of concern.

These internal quality visits are supported by external Integrated Health and Care Commissioning Team (IHCCT) Quality Assurance Visits. These are monitored at Quality Review Meetings.

The Trust has quarterly engagement meetings with the CQC and provides a quarterly monitoring report which includes the following:

Safety

- Incident analysis
- Significant safeguarding alerts
- Duty of Candour
- Safety Thermometer feedback
- Problems that might affect patient safety
- Use of restraint, seclusion and segregation
- Changes to NHS Improvement ratings
- The Coroners (investigations) Regulations 2013 – Section 28 Reports.

Effectiveness

- Results of trust-wide and national audits
- Update on national guidance implementation e.g. NICE/ Royal Colleges
- Deanery and other training issues.

Caring

- Significant staffing issues/developments that might affect the experience of care
- Patient survey results.

Responsiveness

- Significant capacity issues
- Serious complaints and complaints analysis
- Parliamentary and Health Service Ombudsman contact and action plans
- Public and Service User engagement.

Well Led

- Senior staff/organisational changes
- Changes in policy and/or practice
- Staff engagement
- Issues picked up by local media and, press releases
- Freedom of Information Act 2000 - Section 43 Requests

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Integrated Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that was applied in maintaining and reviewing the effectiveness of the system of internal control, I have set out below some examples of the work undertaken and the roles of the Board and Committees in this process:

- The Board reviews the Board Assurance Framework quarterly with the Risk Register
- A programme of Risk Management training for all staff

Artwork supplied by the HPFT Art Collection

- The internal audit plan which is risk based, is approved by the Audit Committee at the beginning of each year. Progress reports are then presented quarterly to the Audit Committee, with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, quickly escalate any areas of concern to the Board via a Committee Report and produces an annual report on the work of the Committee and a self-evaluation of its effectiveness.
- The Executive Team meets on a weekly basis and has a process whereby key issues such as performance management, serious incidents, recruitment and retention, safe staffing, action plans arising from external reviews and risk management are considered both on a planned timetable and an ad hoc basis if necessary. The Team also reviews the Trust Risk Register every month.
- The Board and its statutory and assurance committees have a clear cycle of business and a reporting structure that allows issues to be escalated via the 'ward to Board' risk escalation framework (see Figure 3). The work of each committee is outlined in the Governance Structure at Figure:1

The Board Assurance Framework provides me with evidence that the effectiveness of controls to manage the risks that might prevent the Trust achieving its principal objectives have themselves been reviewed. My review is also informed by our internal and external audits, the external review processes for the clinical negligence scheme and the NHS Litigation Authority (NHSLA) and the CQC.

During 2017/18 we have continued to embed our programme of collective leadership throughout and at all levels of the Trust. This has included comprehensive development programmes for future and existing leaders through our Leadership Academy and partnership work with the University of Hertfordshire. The February 2018 CQC Well-led inspection rated our leadership as 'Good' overall and 'Outstanding' in two service lines – Forensic services and Inpatient services for people with a learning disability.

2.7.12 Head of Internal Audit Opinion

Internal Audit review the system of internal control during the financial year and report accordingly to the Audit Committee. The Head of Internal Audit has provided an overall opinion of positive assurance based on their work during 2017/18, which gives me confidence that we have a solid foundation on which to build our improvement work. Specifically, the Head of Internal Audit has stated:

'The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'

The Head of Internal Audit considered a range of factors and findings in coming to her overall opinion, having issued eleven final assurance opinions and three final advisory reviews for the year. Of the eleven assurance opinions two were issued with substantial assurance, five reasonable assurance and four partial assurance across the areas of internal audit work undertaken. The partial assurance opinions related to

- Service User Monies Compliance
- Delegated Safeguarding Responsibilities
- Recruitment
- Responding to Medical Emergencies.

Follow-up internal audit work in relation to the areas of partial assurance has identified both reasonable progress with improvements and areas where further progress is required. We have addressed these issues by:

- Introducing pilot schemes for improved management of service users' property
- Reviewing the Recruitment and Retention Strategy and local SBU retention plans
- Implementing recruitment maps and checklists
- Revising safeguarding systems and processes with automatic reporting within our business intelligence system. This included:
  - refreshing our policy
  - redesigning record forms
- more robust management oversight ensuring medical emergency equipment is checked every day, with additional checks by Modern Matrons and periodic mock crash-calls to simulate emergencies.

2.7.13 Conclusion

There are no significant internal control issues that have been identified.

Tom Cahill, Chief Executive

May 2018

Date:

The Dove Ward Team received the Making a Difference award at our 2017 Staff Awards

My Story

The parents of a young person admitted to Dove Ward praise the team about the care their son received.

Our son was seriously unwell when he arrived on Dove Ward. When we went to visit him on day one, we were met by Team Leader, Craig. He gave us the reassurance we needed that our son was in the right place and in the right hands. We cannot tell you how much this helped.

From that point on the entire team was fantastic. Every single member of staff was terrific although we're sorry we cannot remember all of their names.

In the earlier days the brilliance of Chris, Serge and Mo (and all the others) in dealing with our son's aggressive outbursts in such a controlled, professional and frankly brilliant manner set the tone. The compassion and expertise shown by Marie and Hannah throughout was awe inspiring.

From beginning to end, the team have been amazing beyond words. The support from everyone involved in our son's care has been phenomenal. Bethany and Katy have both been so incredible and we cannot thank them enough for the efforts they went to in the care they provided.

Our job now is to make sure we spot any signs of deterioration long before it becomes serious again. Craig and the team have mended our boy and we will never forget you or be able to thank you enough for that. So thank you all so much.

Part 1 – Statement on quality from our Chief Executive

This Quality Account has been designed to report on the quality of our services. It offers you the chance to find out more about what we do and how well we are delivering. Our aim is to describe in a balanced and accessible way how we provide high-quality clinical care to our service users, the local population and our commissioners. It also shows where we could perform better and what we are doing to improve.

I am proud to present this Quality Account in a year when the awareness of mental health has been higher than ever and we have seen many more people accessing our services. Despite this, we not only achieved an overall 'Good' rating in our Care Quality Commission (CQC) inspection but an 'Outstanding' rating for our Leaning Disability and Forensic services.

Importantly, the CQC recognised the commitment of all our staff both in living the Trust values and demonstrating leadership at every level. I believe that this leadership of all our dedicated and hardworking staff has enabled us to perform well against increased demand – continuing to deliver great care and great outcomes for over 400,000 people across four counties.

In order to achieve our Vision of delivering great care and achieving great outcomes together we need to acknowledge where we are required to make improvements and take effective steps to address these. In November 2017 an unannounced inspection of the Broadland Clinic in Norfolk led to us receiving a warning notice from the CQC. We responded quickly to the issues around safety that were raised, completing the work in January 2018. As well as taking on responsibility for Tier 4 services for children and adolescent mental services (CAMHS).

During 2017 we have established new services including our Community Perinatal Service which supports pregnant women and new mothers. We have also expanded other services including delivering crisis care around the clock. This year we continued with our extensive transformation programme to improve the environments in our older people's services. This included the refurbishment of our state of the art dementia unit, Logandene, which won the 'External Environment' category at the Building Better Healthcare Awards 2017.

Delivering great care depends on our ability to attract and retain great people and, as with many NHS organisations across the country, ensuring we have a stable workforce remains a top priority. I am pleased to say that during 2017 we continued to develop our Collective Leadership initiative, engaging and empowering our staff. We have explored new ways of recruiting staff, including developing new roles such as nurse associates and fast track social workers, as well as ensuring that we support our staff with a bespoke health hub that delivers wellbeing initiatives – from mindfulness sessions through to physical health checks. These initiatives are reflected in us once again scoring highly in the NHS National Staff Survey. Over 90% of our scores are in line with or above the national average and we continue to score highly for staff engagement and staff motivation.

Our staff are also supported in their daily roles with IT systems that deliver real time information on safe staffing levels and bed management. Positive feedback from the CQC endorses the view that we are making excellent progress on our ambition to become a great organisation.

Part of that journey includes great partnerships and working with other organisations to deliver integrated services that treat the 'whole person'. We know that statistics show that our service users are more likely to die 20 years younger than the rest of the population and we are tackling this inequality by looking at how we can support both people's physical and mental health needs. Together with Hertfordshire Community NHS Trust, we are delivering services at our newly-opened Marlowes Health & Wellbeing Centre. We are also looking at how we can better deliver care closer to people's homes through our work with NHS partners on place-based care and on giving people greater access to mental health services through their GPs' surgeries.

I look forward to this coming year as one where we continue to champion the needs of people with mental ill health and learning disabilities across the four counties that we serve. I believe 2018 will be a year where we deliver more for our young people and their families by treating a greater number of our younger service users close to home and by developing a bespoke Place of Safety for those in crisis. We will continue to build and maintain key relationships with our colleagues across health and social care to tackle the challenges we face. As the NHS marks its 70th birthday, we will take the opportunity to celebrate all that is good about the NHS and our services.

Declaration

Data accuracy

There are factors involved in preparing this Quality Account that can limit the reliability or accuracy of the data reported, and we are required by NHS Improvement, the body responsible for overseeing our Trust, to tell you about these.

- Data is taken from many different systems and processes. Not all this information is checked for accuracy by independent assessors from other organisations, or audited by the Trust every year
- Information is collected by many different teams across the Trust. Sometimes different teams apply or interpret policies differently, which means they might collect different information or, perhaps, put it in different categories
- In many cases, the information provided is based on clinical judgements about individual cases. Because clinical judgements can vary, so can the data drawn from them
- National data definitions do not cover all circumstances and some local interpretations may differ
- We sometimes change how we collect, define and analyse data and it is often difficult or impossible to adjust older data to fit with a new method. To avoid confusion, we indicate when and where we have made these kinds of changes
- External auditors have identified issues relating to the data quality supporting the Early Intervention Psychosis (EIP) indicator. Further details and remedial actions we have taken can be found on page 90.

The Board of Directors and Executive Team have taken all reasonable steps and have exercised due diligence to ensure the accuracy of the data reported. However, we recognise that the data is subject to the limitations described above.

Tom Cahill, Chief Executive

May 2018

Date:

Background

Once a year, every NHS Trust is required to produce a Quality Account. This report includes information about the services the Trust delivers, how well we deliver them, and our plans for the following year.

Our aim in this Quality Account is to make sure that everyone who wants to know about what we do can access that information. All Quality Accounts are presented to Parliament before they are made available to service users, carers and members of the public on the NHS Choices website.

What is NHS Choices?

NHS Choices is the UK's biggest health website. It provides information about symptoms conditions, medicines and treatment, NHS services and advice about how to live as well as possible at www.nhs.uk

What the Quality Account includes

- What we plan to do next year (2018/19), what our priorities are, and how we intend to address them
- How we performed last year (2017/18), including where our services improved
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts
- Stakeholder and external assurance statements including our independent auditor's report, statements from Healthwatch Hertfordshire, Herts Valleys Clinical Commissioning Group (CCG), East and North CCG and Hertfordshire County Council Health Scrutiny Committee.

Understanding the Quality Account

We recognise that some of the information in this Quality Account may be hard to understand if you don't work in health care. We've used the coloured boxes to provide explanations and examples that should help.

This is a 'What is it?' box

These explain a term or abbreviation

This is a 'Quotes from staff, service users, carers and others' box

These support and illustrate the information in the report

This is a 'Comments' box

These include quotes from regulators and other governing bodies

See page 159 for a glossary of abbreviations we use in the Account.

Hertfordshire Partnership University NHS Foundation Trust

We provide mental health and learning disabilities inpatient care and treatment in the community for young people, adults and older people in Hertfordshire, along with:

- Learning disability services in Buckinghamshire
- Wellbeing and learning disability services in North Essex
- Forensic and learning disability services in Norfolk.

Our Vision:

Delivering great care, achieving great outcomes - together

Our Mission:

We help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well

Our principles

We provide services that make a positive difference to the lives of patients, service users and their carers and which are underpinned by the principles of choice, independence and equality.

Our strategy

In 2016, we launched our Good to Great strategy. This explains how we aim to deliver the highest quality services and become an outstanding Trust. We believe that Great Care and Great Outcomes are delivered by Great People supported by a Great Organisation and Great Partnerships and Networks. This means we shape our services around the needs of service users, involving them to continuously improve the care we deliver.

In 2017/2018 we continued to provide:

- A full range of mental health care and treatment for people in Hertfordshire with mental ill-health. This includes a comprehensive primary care service for those with more common mental health problems
- Inpatient and specialist community health care for adults with learning disabilities in Hertfordshire, North Essex and Buckinghamshire
- Secure inpatient services for adults with learning disabilities and challenging behaviour in Hertfordshire and Norfolk and an Assessment and Treatment unit for people with learning disabilities at Astley Court in Norfolk
- Specialist services for:
  - adolescents who need mental health inpatient care
  - community perinatal care (mother and baby)
  - treating severe obsessional-compulsive disorder.
- Enhanced primary care mental health services (in partnership with Mind) in Mid, North-East, and West Essex.

Across our 47 sites, we employed approximately 3000 permanent staff, with c200 on a fixed term/temporary contract and c650 bank staff, and budgeted to spend c£221m on our services. We aim to deliver Great Care and Great Outcomes, and are keen to share information about the quality of our services and how we are working to improve these. This report is one of the many ways in which we share information.

Our Partnerships

Our partnership with Hertfordshire County Council helps us to develop an approach based on a holistic assessment of each service user's health and social care needs, which focuses on recovery. Working in partnership with the Council also means we can help improve integration between mental health, physical wellbeing and social care services.

We also work with other NHS partners, including Hertfordshire Community NHS Trust (HCT). An example of this is the way in which we worked together to develop the Marlowes Health & Wellbeing Centre in Hemel Hempstead, where mental and physical health services share the same building.

As a University Trust, our close links to the University of Hertfordshire mean we can contribute to clinical research, and offer our staff excellent learning and development opportunities.

What is a Partnership University Foundation Trust?

NHS Foundation Trusts are not-for-profit, public benefit corporations. Like the rest of the NHS, they provide free care based on need, not ability to pay. FoundationTrusts have freedom to decide locally how to meet their health care obligations. These trusts are accountable to local people, who can become members and governors and are authorised and monitored by an independent regulator.

HPFT is a Partnership Trust meaning we provide health and social care for specific groups of people – people with mental and physical ill-health, and those with learning disabilities – in partnership with local authorities, the University of Hertfordshire and with the mental health charity, Mind.

Our Commissioners

We work closely with many organisations that commission and pay for our services.

What is commissioning?

Commissioning is the process of planning, agreeing and monitoring services. Commissioning groups

- **assess the health needs of their local population**
- **plan care pathways for people with specific health problems**
- **specify which services their local populations need**
- **negotiate contracts with the organisations that provide these services**
- **make sure the services those organisations provide are good enough.**

This report

If you have any questions about anything in this report, would like to comment on it or want to know more about HPFT, contact Jacky Vincent, Deputy Director of Nursing and Quality jacky.vincent@nhs.net

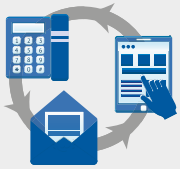
This Quality Account was published on 24 June 2018 on the NHS Choices website www.nhs.uk and on our website: www.hpft.nhs.uk.

If you would like a paper copy of this report, or to see it in other formats, please call our Communications team on 01707 253902, or email hpft.comms@nhs.net.

The Trust in 2017/2018

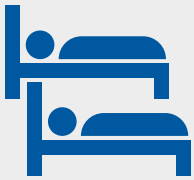
Mental Health
Community and Learning Disability Services for children and adults

335,516
secondary care contacts

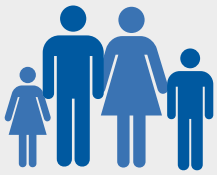


52,423
referrals through Single Point of Access (SPA)

155,159
IAPT (Improving Access to Psychological Therapies) contacts



160,288
occupied bed days



87%
would recommend us to friends and family

3,157
(permanent and temporary) Staff working across 47 Trust sites

What is SPA?

The Single Point of Access (SPA) is the telephone clinical triage service for all new referrals into the Trust. This service was set up in 2013 to ensure that that there was a single point of contact to access any our mental health care services, and it makes sure that service users are referred to the right service straight away.

What is IAPT?

IAPT is the government's Improving Access to Psychological Therapies initiative. Our Wellbeing Service is part of this and aims to reduce distress and improve general mental health through teaching coping strategies based on Cognitive Behaviour Therapy (CBT). CBT is an evidence-based psychological therapy recommended by National Institute for Clinical Excellence (NICE). It offers service users effective techniques and skills to manage distressing emotions. The Wellbeing Service is made up of a range of clinicians and mental health professionals who deliver treatment in a variety of flexible ways.

Part 2 – Priorities for Improvement and statement of assurance from the Board

We are committed to delivering great care and great outcomes for our service users. To help us achieve this, we work in partnership with other organisations, for example to identify areas for improvement. These fall into three categories:

- Patient (service user) Safety
- Clinical Effectiveness
- Patient (service user) Experience.

This part of the report sets out:

- The priorities we have identified for 2018/19 and how we decided on these
- Statements of assurance from our Trust Board
- How we performed in our priority areas during 2017/18.

In this report we show:

- how we performed in our priority areas during 2017/18
- describe our priority areas for 2018/19
- notable and innovative practices that we have introduced across our services during the past year.

What is assurance?

Data quality assurance is the process of ensuring that data is as accurate, relevant and consistent as it can possibly be.

What is the Trust Board?

The Trust Board is the Board of directors responsible for overseeing the running and management of the Trust. It is made up of Executive Directors, including the Chief Executive, who are full-time senior staff, an independent Chairman and Non-Executive Directors who do not work within the Trust.

What is a stakeholder?

A stakeholder is a person or organisation with an interest in the Trust who should be involved in our decision-making processes.

2.1 Priorities for Quality Improvement 2018/2019

Our Board agreed our 12 key quality priorities for 2018/19 at the Board meeting on 24 May 2018.

How we chose our Quality Priorities

We:

- consulted with stakeholders including service users, carers, staff, commissioners and others
- decided to continue to build on and monitor the work we did in 2017/18 and previous years that could potentially significantly improve our services.

The consultation process

We started by considering

- the feedback we have received on the quality of our services in surveys, reports and other documents

our stakeholders' (including our commissioners') priorities.

From this we developed 12 potential quality priorities.

We circulated these to our stakeholders so they could tell us which quality priorities they would like us to focus on next year.

We are grateful to all who have contributed to, supported and worked with us in reviewing and setting our quality plans for 2018/19, including:

- Adult Service User Council
- Young Person's Service User Council
- Commissioners – Norfolk, Essex, Buckinghamshire and Hertfordshire
- GPs
- Carers Council
- Trust Governors, through the subgroup that leads on Quality
- Trust Board of Governors
- Trust clinicians and managers
- Trust Audit Committee
- Trust Executive Team
- Hertfordshire Health Scrutiny Committee
- Healthwatch Norfolk, Essex, Buckinghamshire and Hertfordshire.

What we heard during the consultation

Our stakeholders reported that, overall, the proposed indicators were great and covered a wide range of service areas. One stakeholder group felt that we should choose to replace the IAPT indicator to focus on dementia treatment. Although dementia is not a priority, there is a section on our dementia services later in the document. Another group reported that the indicator on carers feeling valued by staff should include both carers supporting people with a lived experience of mental illness and carers who support individuals with a learning disability. The group felt that the goal is not enough of a stretch.

Carers expect to be valued by professionals and the group felt that the question to consider is *if the knowledge of the carers is valued by professionals*. The other aspect raised was the need for carers to be supported on their personal safety, for example what do carers do to de-escalate a potentially challenging situation other than calling the police, and for this to be in addition to the Carers Assessment.

Other feedback that the focus group would like to see us reporting on were:

- Incident data to have more detailed information provided, such as incidents per diagnosis
- Recovery rates data to also have more detailed information provided, such as breakdown of recovery rates by diagnosis
- Carers to have more robust information on the proportion of carers who receive support following their loved one/relative leaving hospital
- Service users with a learning disability and a diagnosis of dementia to have more detailed information on what support is provided
- To have more detailed information on what is available in our mental health services, what our criteria is and how this is accessed
- To have improved follow-ups after a Mental Health Act assessment
- For greater signposting to new resources as they become available in the local facility, such as New Leaf Recovery College, the Marlowes Health & Wellbeing Centre, psychosexual services etc.
- For a greater overlap between learning disabilities and mental health services with regards to knowledge, and understanding of and also the opportunity to discuss learning disabilities, as the symptoms are often similar and the conditions co-present
- Data regarding service users who access our services repeatedly
- Data regarding the proportion of mental health service users who receive written information and advice about their condition and support services
- Data regarding the proportion of service users who access DBT/emotional skills services
- An improvement in the consistency of accessing the same person in the Crisis Team and Care Coordinators.

Some areas identified in the consultation have not been included in our 2018/19 quality priorities. This is because they will be monitored and assessed through a different process, such as the Commissioning for Quality and Innovation (CQUIN). This means that our core targets represent only a small sample of the quality initiatives we are working on.

Selection and monitoring

This year, our priorities again cover all three areas of quality:

- **Safety**
  - avoiding preventable incidents whether serious (eg: suicides) or more minor (eg: slips, trips and falls)
  - helping inpatients to feel safer, reducing actual or threatened assaults in inpatient units, planning services so they are as safe as possible
  - working with service users to assess and manage their risks effectively
- **Clinical effectiveness:**
  - making sure people can access the services they need for urgent and routine care
  - enabling service users to move on when they are ready
  - providing interventions that work.
- **Service user and carer experience:**
  - recognising that a service is only good if users and carers experience it as good
  - having flexible ways of hearing from service users and carers and acting on what they tell us
  - using Friends and Family Test questions to measure quality.

Detail of each priority

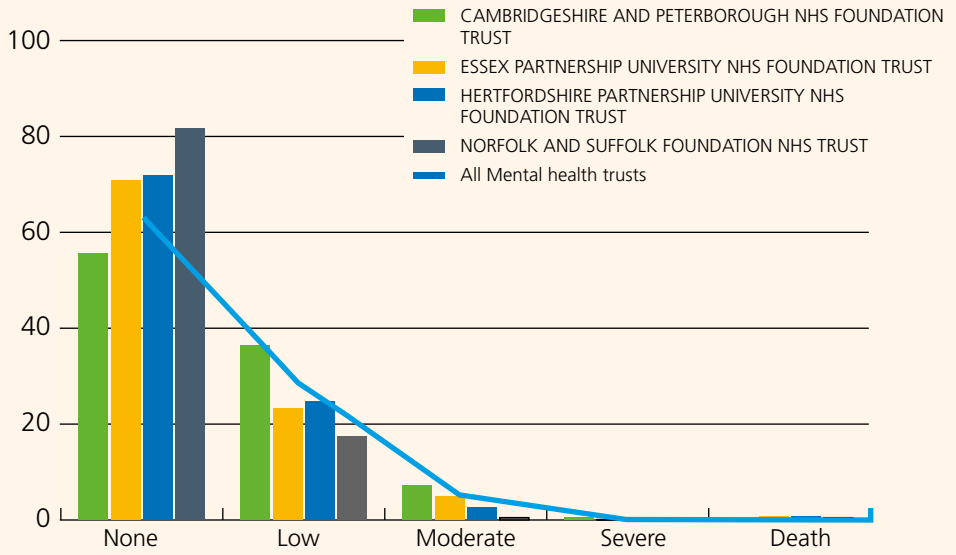
The Performance Team will report on all figures once a month for goals 1–10 and quarterly for 11–12. Data quality is important in ensuring the accuracy, validity and reliability of the Key Performance Indicators (KPIs). Where possible, the Performance Team will undertake work to ensure this. The Performance Team is internally and externally audited annually. Auditors check a sample of reports to ensure accuracy.

The quality priority areas for 2018/19 agreed by the Trust Board are:

Patient (service user) Safety	
1	100% of enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital (NHSI)
2	CAMHS 28-day target for routine referrals (chosen by the Council of Governors (COG) so is now a Mandated Indicator)
3	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)
4	Inappropriate out-of-area placements for adult mental health services (NHSI)
Clinical Effectiveness	
5	Emergency readmissions within 28 days (0-15 and adult acute) (NHSI)
6	Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)
7	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period (NHSI)
8	IAPT Recovery Rate Improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within 6 weeks of referral (NHSI)
Service User and Carer Experience	
9	Carers feeling valued by staff
10	Staff Friends and Family Test – Staff would recommend the service they work in to friends and family who may need treatment or care
11	Service Users Friends and Family Test. Service users report that they are treated according to Trust values
12	Service users reporting their experience of Community Mental Health Services (NHSI)

Name of Priority	Patient (service user) Safety 1 - 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital (NHSI)				
Related NHS Outcomes Framework Domain and who will report on them	1 - Preventing People from dying prematurely 2 - Enhancing quality of life for people with long-term conditions All Trusts providing mental health services				
Data Definition	Service user is followed up either by face to face contact or by telephone within 7 days of discharge, whether the Trust contacts the service user or the service user contacts the Trust. The 7 day period should be measured in days not hours and starts on the day after discharge.				
How this data will be collated	Data will be collated by the Performance Team and reported on a monthly basis to the Trust's Executive Team				
Validation	Data is validated and checked by Data Quality Officers and the Performance Team.				
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**2017/18**
	95.6%	96.8%	96.7%	96%	97%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**	**2016/17**
	97.4%	98.5%	97.3%	98.5%	98%
Target	95% rate of service users followed up after discharge from the Acute Care Pathway.				

Name of Priority	Patient (service user) Safety 2 - CAMHS 28 day target for routine referrals (chosen by the Council of Governors and is now a Mandated Indicator)			
Data Definition	Routine referrals are received in SPA and passed on to CAMHS for assessments. The indicator measures how many of the referrals that are passed on go on to be seen in a face to face appointment within 28 days of their original referral date. Applies to all Hertfordshire CAMHS routine waits.			
How this data will be collated	Data will be collated by the Performance Team and reported on a monthly basis.			
Validation	Validated by team managers and the Performance Team.			
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	95.4%	79.5%	98.6%	80.5%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	95.5%	94.6%	91.1%	41.6%
Target	95% of routine CAMHS Community Team referrals to be seen within 28 days.			

Name of Priority	**Patient (service user) Safety** **3 - Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)**
Related NHS Outcomes Framework Domain and who will report on them	Treating and caring for people in a safe environment and protecting them from avoidable harm
Data Definition	The number and rate of patient safety incidents during the reporting period and the percentage of such patient (service user) safety incidents that results in severe harm or death.
How this data will be collated	The Safer Care Team uploads data onto the National Reporting and Learning System (NRLS) which is a central database of patient (service user) safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of service user care.
Validation	This data is validated via the NRLS which is managed by NHSI.
Performance in Q1 to Q4 in 2017-18	

Name of Priority	**Patient (service user) Safety** **4 - Inappropriate out-of-area placements for adult mental health services (NHSI)**			
Data Definition	This indicator measures the number of days that service users inappropriately spent out of area.			
How this data will be collated	Data is collated by the Bed Management Team and submitted by the Information Team.			
Validation	The data quality supporting Q4 indicator data has been reviewed by Deloitte as part of their limited assurance review.			
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
				85.7 days
	The performance above is calculated as the average number of inappropriate out of area bed days per month, during the quarter			
Target	TBA			

Name of Priority	Clinical Effectiveness 5 - Emergency readmissions within 28 days (0-15 and adult acute) (NHSI)				
Related NHS Outcomes Framework Domain and who will report on them	3: Helping people to recover from episodes of ill health or following injury. All Trusts.				
Data Definition	This indicator measures the percentage of admissions of people who reside in Hertfordshire who have returned to hospital as an emergency within 28 days of discharge after an inpatient stay. It aims to measure the success of the NHS in helping people to recover effectively from illnesses. If a person does not recover well, it is more likely that they will require hospital treatment again within the 28 days following their previous admission. Thus, readmissions are widely used as an indicator of the success of healthcare in helping people to recover. This indicator is currently only reported for those residing in Hertfordshire, as required by the Hertfordshire Commissioners.				
How this data will be collated	Data will be collated by the performance team and reported on a monthly basis.				
Validation	Data is validated by the strategic business unit who look at all re-admissions each month to ensure accuracy of the report and explain why the re-admission occurred.				
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**2017/18**
	4.51%	7.8%	7.09%	5%	5.8%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**	
	4.31%	5.25%	4.8%	4.2%	
Target	<=7.5% of discharges from inpatient units excluding self-discharge.				

Name of Priority	Clinical Effectiveness 6 - Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)				
Data Definition	A maximum wait time of two weeks from referral to treatment.				
How this data will be collated	Data will be collated by the performance team and reported on a monthly basis.				
Validation	Performance and service validate the data on the waiting time.				
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**2017/18**
	82%	66%	69.5%	64.2%	69.7%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**	
	57.6%	78.41%	74.5%	78.8%	
Target	53% For 2018/19 – 50% for 2017/18 This indicator was subject to external audit as per NHSI requirements. Auditors have identified issues relating to the data quality supporting the reported performance". We are taking the following steps to address their findings, and improve the data quality support this indicator, going forward: • Review of auditor findings • Daily triage of new cases (already in place and on-going) • Improved clarity of expected assessment process with acute for all clinicians in PATH • Band 7 now responsible for activity recording and data entry on each assessment -clinicians are now not entering this, they are just doing relevant documents and case-notes • Operational Team Leader validating each clock stop case weekly and monthly before submission - Weekly operational oversight on assessments completed with check on appropriate use of clock stop.				

Name of Priority	Clinical Effectiveness 7 - The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period (NHSI)			
Data Definition	A Crisis Assessment and Treatment Team (CATT) provide intensive support for people in mental health crises in their own home so they receive prompt and effective home treatment, including medication. This helps prevent hospital admissions and gives support to informal carers. Teams are required to meet all of the fidelity criteria including gatekeeping all admissions to psychiatry inpatients wards and facilitate early discharge of service users. A crisis resolution team has acted as a gate-keeper for an admission if they have assessed the service user before admission and if the team was involved in the decision making-process which led to an admission.			
How this data will be collated	Data will be collated by the performance team and reported on a monthly basis.			
Validation	Validated by Data Quality Officers and the Senior Service Line Lead.			
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	96%	97.8%,	99.6%	98.2%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	100%	99.3%	88.5%	96%
Target	95% of those admitted to an inpatient unit should have been gate kept by CATT.			

Name of Priority	**Clinical Effectiveness** **8 - IAPT Recovery Rate. Improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within 6 weeks of referral (NHSI)**
Data Definition	The Improving Access to Psychological Therapies (IAPT) programme aims to implement National Institute for Health and Clinical Excellence (NICE) guidance for people with common mental health problems. NICE recommends a range of psychological therapies to treat people with depression and anxiety disorders and bring them to recovery. **Waiting times:** 75% of people referred to IAPT services should start treatment within 6 weeks of referral, and 95% should start treatment within 18 weeks of referral. **Recovery:** At least 50% of people who complete treatment should recover.
How this data will be collated	Data is collected on PC-MIS and submitted to NHS England by the Information Team.
Validation	Validated by service.

Performance in Q1 to Q4 in 2017-18

Recovery Rate:			
Q1	**Q2**	**Q3**	**Q4**
53.4%	54.1%	53%	53.1%
6 week wait:			
Q1	**Q2**	**Q3**	**Q4**
92.16%	94.81%	94.67%	92.53%
18 week wait:			
Q1	**Q2**	**Q3**	**Q4**
99.97%	99.93%	99.91%	99.96%

Performance in Q1 to Q4 in 2016-17

Recovery Rate:			
Q1	**Q2**	**Q3**	**Q4**
51.8%	52.6%	51.8%	54.7%
6 week wait:			
Q1	**Q2**	**Q3**	**Q4**
94.61%	94.19%	94.14%	91.26%
18 week wait:			
Q1	**Q2**	**Q3**	**Q4**
99.93%	99.96%	99.9%	99.9%

Target	50% recovery rate 75% 6 week wait 95% 18 week wait

Name of Priority	Service User and Carer Experience 9 - Carers feeling valued by staff				
Data Definition	Our Having your say questionnaire is offered to all carers. All questions are set against the Trust Values. One asks "Do you feel valued by staff as a key partner in care planning?" The carer can choose from: Yes; Sometimes; No; Don't Know. When we receive completed questionnaires we enter them onto the Membership Engagement System – the Trust's service experience dashBoard – and the performance team reports on them. Only replies that are recorded as 'Yes' are taken to be a positive answer				
How this data will be collated	The data quality supporting Q4 indicator data has been reviewed by Deloitte as part of their limited assurance review.				
Validation	All surveys are re-checked for accuracy and 5% of the monthly inputs are re-checked by the Service Experience Lead. Our external auditor (Deloitte) also validates the data.				
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**2017/18**
	72.2%	80.7%	76.8%	67.9%	74.0%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**	
	88.4%	89.3%	84%	88.1%	
Target	>/=75%				

Name of Priority	Service User and Carer Experience 10 - Staff Friends and Family Test (FFT) – Staff would recommend the service they work in to friends and family who may need treatment or care			
Related NHS Outcomes Framework Domain and who will report on them	4: Ensuring that people have a positive experience of care **All Trusts** **The primary purpose of the staff FFT is to support local service improvement work**			
Data Definition	The FFT is a feedback tool which allows staff to give their feedback on Trust services. It asks how likely staff are to recommend the services they work in to friends and family who may need treatment or care or as a place to work. Participants respond to FFT using a response scale, ranging from "extremely unlikely" to "extremely likely". They can also provide a free text comment after each of the FFT questions.The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. This question is in the Trusts Pulse survey. This is also an NHS England statutory submission.			
How this data will be collated	Staff FFT data is to be collected and submitted quarterly for Q1, Q2 and Q4 after the end of each quarter. For Q3 (when the annual NHS staff survey is undertaken).			
Validation				
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	57%	67.7%	67%	73.9%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	76.98%	77.4%	76.1%	75.3%
Target	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them >=70%			

Name of Priority	Service User and Carer Experience 11 - Service Users Friends and Family Test (FFT). Rate of service users that would recommend the Trust's Services to family and friends if they needed them			
Data Definition	Since 1 January 2015 all mental health trusts have been required to ask all service users the FFT question. Service users are asked to respond to the question on a scale of answers from "Extremely Likely" to "Extremely Unlikely". The recommend score is derived from "Extremely Likely" and "Likely" responses.			
How this data will be collated	We use Having Your Say surveys and FFT cards throughout the Trust to gather the FFT data. Survey links are available online through the Trust's website to complete FFT if people prefer this method. We input the data into the Membership Engagement System (MES). Each month, we submit our FFT figures to NHS England. We also report the figures monthly and quarterly within the Trust.			
Validation	All surveys are re-checked for accuracy and 5% of the monthly inputs are re-checked by the Service Experience Lead. Our external auditor (Deloitte) also validates the data.			
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	87.7%	88.0%	86.3%	85.5%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	86.8%	87%	86.3%	85.8%
Target	70%			

Name of Priority	Service User and Carer Experience 12 – Service users reporting their experience of Community Mental Health Services (NHSI)			
Data Definition	Service users are offered the Having your Say survey at their care review and on discharge. All questions are set against the Trust Values. Completed questionnaires are entered onto the Membership Engagement System (MES) and the Performance Team reports on them. Once a year an external audit is undertaken by The NHS Patient Survey Programme Team. They send a questionnaire to people's home addresses.			
How this data will be collated	Data collated by the Performance Team will be reported quarterly. Data collected by The NHS Patient Survey Programme Team will be reported annually.			
Validation	All surveys are re-checked for accuracy and 5% of the monthly inputs are re-checked by the Service Experience Lead.			
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	92.3%	94.7%	93.2%	90.3%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	90.1%	87.7%	92.2%	90.5%
Target	>=75%			

How these targets will be monitored

We will measure and monitor our progress on the implementation of each quality throughout the year. There will be additional audits to ensure that the data collected is reliable and valid.

What does reliable mean?

If data is reliable then it gives a consistent result. This means that if someone else was to collect the same information in the same way, the results would be the same.

What does valid mean?

If data is valid then it measures what it is supposed to measure.

We have put a robust reporting framework in place to make sure we keep progressing and can address any challenges that arise as early as possible. We will

- report our results to our Board and our commissioners every quarter at our Quality Review Meeting
- engage with our key stakeholders to discuss our progress throughout the year.

Once the Board has agreed targets, we will develop plans to ensure that these priorities are achieved and progress monitored quarterly.

We will report progress towards targets through our Governance structures. Our Performance Team will check and assure the quality and accuracy of our data in accordance with Trust policies.

2.2 Statements of assurances

This section of the report explains how we have provided assurance in relation to the services it provides. This is demonstrated through clinical networks, audit and our Care Quality Commission (CQC) inspection report. We have reviewed all the data available to us relating to the quality of care we provide in these services. Our total income from activities was £216.9m and out total income was £230.3m, thus 94.2%

Clinical Audits

Our Practice Audit and Clinical Effectiveness (PACE) team leads on our clinical audit work, offering guidance, support and assurance for quality and service improvement.

At the start of each financial year, our PACE team consults with our leaders and managers to develop a programme of audits. This includes the audits that every NHS Trust is required to complete, those needed to monitor our contractual arrangements, and those requested by our teams to assess and improve the quality of their own work.

When an audit is completed, we develop an action plan so that we can make and monitor improvements to our services. Our Practice Audit Implementation Group (PAIG – members include the Associate Medical Director, Chief Pharmacist and representation from other clinical disciplines) discusses and approves the reports. We then share them throughout the Trust so everyone can learn from the results.

What is a clinical audit?

Clinical audit is a way to find out if healthcare is being provided in line with standards and tells care providers and patients where their service is doing well, and where there could be improvements.

The aim is to allow improvements to take place where they will be most helpful and improve outcomes for service users.

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National clinical audits

Participating in National Quality Improvement Programmes (HQIP) and quality accreditation programmes helps us compare our performance against other mental health trusts across the country. This not only helps us to benchmark our performance, but also gives us an opportunity to provide assurances that our services are continuously striving to reach the highest standards set by the professional bodies, such as The Royal College of Psychiatrists and the National Prescribing Observatory for Mental Health (POMH-UK).

During 2017/18, we were eligible for 5 national clinical audits, all of which we participated in. We were also eligible to participate in 1 confidential enquiry which we also participated in, as detailed in the table opposite.

National Audit	Trust Participation	
	Number of cases required by the terms of the audit	Number of Cases Submitted by HPFT
POMH-UK Topic 1g & 3d Prescribing High Dose Antipsychotics	Information not available within HPFT	191
POMH-UK 17a Use of Depot / Long Acting Injectable (LAI) Antipsychotic Medication for Relapse Prevention	Information not available within HPFT	198
POMH-UK Topic 15b Prescribing Valproate for bipolar disorder	Information not available within HPFT	106 (subject to confirmation from POMH-UK)
National Clinical Audit of Psychosis	300	300 (100%)
Early Intervention in Psychosis Network	453	453 (100%)

*report not published to date – expected June 2018.

Results from national audits are as follows

The reports of 4 national clinical audits were reviewed by the provider in 2017/18; one report was not published at the time of writing this report. The results of these audits are summarised below along with the actions we intend to take to improve the quality of healthcare provided.

POMH-UK Prescribing Observatory for Mental Health) Topic 1g & 3d Prescribing High Dose Antipsychotics (Includes the following Services Adult acute, PICU, Forensic, Rehabilitation/complex needs).

There has been a reduction in the number of service users prescribed an antipsychotic above the British National Formulary (BNF) limits from the previous audit in 2012. An improvement of 21% for Acute/PICU and 47% for Forensic Services is noted. There are higher levels of prescribing above the BNF in Rehabilitation services 31% against a national average of 20%.

Proportion of service users where a single antipsychotic drug is prescribed. Compared to the previous audit in 2012, Acute/PICU demonstrated a 10% and forensic services a 40% improvement. These results were similar to national average data. Prescribing of multiple antipsychotics in rehabilitation services was 36% which is higher than the national average of 29%.

Proportion of service users prescribed regular standard dose of antipsychotic medication (as opposed to regular high dose). PRN not included. Percentage for Acute/PICU was 88% which is similar to the national average. Prescribing of regular standard dose antipsychotics in forensic services was 92%, slightly higher than the national average 86%. In rehabilitation services it was 78%, the national average was 85%.

A Statement was found in the care plan that the service users are prescribed high-dose antipsychotic medication. In Acute/PICU this occurred in just over half of the service users that were audited, more than double the national average. In forensic and rehabilitation services, no service users had a statement in their care plan regarding the prescription of high dose antipsychotic medication.

Where high-dose antipsychotics are prescribed, there should be a clear plan for regular clinical review including safety monitoring. This is a new standard for 2017. Results were for the whole sample and not separated for individual services. We achieved over 80% in 6 out of 7 measures and each one was higher than the equivalent national average result. We also achieved 69% for assessment of movement disorder over the past year; very slightly better than the national average 65%.

Actions:

- To share findings via our Quality and Risk meetings for services which participated
- To have Trust wide High Dose Antipsychotic Therapy (HDAT) guidelines
- To inform all services of updated Trust HDAT Guidelines and HDAT Alert Cards
- To re-audit HDAT prescribing in Rehabilitation Services in October 2018 (since 2017 was baseline audit).

POMH-UK Topic 17a Use of Depot/Long Acting Injectable (LAI) Antipsychotic Medication for Relapse Prevention.

Care plan

	Trust %	National average %
A service user's care plan should be accessible in the clinical records	98	93
There should be documented evidence that the service user was involved in the generation of their care plan	92	80
A service user's relapse 'signature' signs and symptoms should be documented in their care plan	63	73
The care plan should include a crisis plan	83	81
The care plan should include a clinical plan for response to default from treatment, i.e. if a service user fails to attend an appointment for administration of their depot injection or declines their depot injection	17	33

Depot/long-acting injectable antipsychotic medication: prescription and review

	Trust %	National average %
A clear rationale for initiating a depot/long-acting injectable antipsychotic medication should be documented in the clinical records	96	93
Review of antipsychotic medication should be conducted at least annually by the prescriber/psychiatrist in the responsible clinical team	92	87
Medication review should include consideration of		
• therapeutic response	91	80
• adverse effects	94	84
• adherence	82	79

The Trust's performance against the clinical practice standards was generally good overall.

Actions:

- To combine actions with the outcomes from our local depot audit
- To revise standard operating procedures for the administration of depot medication to include standards from the POMH-UK audit
- To ensure staff document service users' 'signature' relapse signs and symptoms in their care plans
- To ensure care plans include a clinical plan for responding if service users default from treatment
- To ensure care plans include a crisis plan for all service users on depot/LAI antipsychotic medication
- To remind staff to make sure the prescriber/psychiatrist/Non-Medical Prescriber (NMP) of the responsible team conducts and documents a face-to-face medication review at least every six months.

National Clinical audit of Psychosis.

A cardio metabolic screening for service users with serious mental illness undertaken within a 12 month period and a record of associated interventions recorded: areas included:

- Smoking status
- Lifestyle (including exercise, diet, alcohol and drugs)
- Body Mass Index
- Blood pressure
- Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
- Blood lipids.

	Trust Result (17/18)	Trust Result (16/17)	National Average
Inpatients staying on a ward 7 nights on more	91%	86%	56%
Community services on CPA	70%	48%	44%

No further information regarding other elements included in the audit have been published to date.

Early Intervention in Psychosis Network

	Trust Result (17/18)	Trust Result (16/17)	National Average
Percentage of people referred with suspected First Episode Psychosis (FEP) who commenced treatment within 2 weeks of referral	70%	64%	72%
People with an identified family member, friend or carer who supports them	81%	84%	70%
People with FEP who have been on the caseload for 6 months or more, who received a full physical health assessment and any relevant interventions in the last year	57%	21%	42%
People with FEP who had two adequate but unsuccessful trials of antipsychotic medications, that were offered clozapine	28%	1%	28%

Actions:

- We have recruited to a performance management band 7 role part of whose remit will be to monitor and prompt care coordinators when physical health checks are due
- We have established a physical health task and finish group looking at tightening up processes around how we carry out and record physical health checks
- Training is being currently delivered to band 5 and band 4 staff to establish competence in undertaking basic physical health checks
- We are also promoting venepuncture training to PATH staff.

Local clinical audit

We reviewed the reports of 97 local clinical audits in 2017/18. 59 were undertaken by the Practice Audit and Clinical Effectiveness (PACE) team as part of their annual programme and 38 were local audits registered with the PACE team by clinicians throughout the Trust. We intend to take the following actions to improve the quality of healthcare provided:

- Continue to ensure that audit findings are shared with the dedicated committees that champion that particular area of health improvement, including the Physical Health Committee, the Patient Safety Committee, the Quality and Risk Management Committees across each of our three Strategic Business Units as well as our Trust wide Quality and Risk Management Committee.
- During 2017/18, the PACE team has introduced a 2 page template report enabling staff to see the audit findings at a glance.
- We believe that the service user's voice is an invaluable part of audit; plans are now in place to ensure greater service user and carer participation in audit by inviting them to become standing members of our Audit Committee.

The full details of all these audits are beyond the scope of this report but detailed below are examples of the results that were found.

Where audits said we did well

Early Memory Diagnosis & Support Service (EMDASS)

This re-audit considered how our EMDASS East Team performed against the Royal College of Psychiatry and Trust standards in comparison to the first audit in 2016. The results demonstrate excellent levels of compliance across all standards and the actions identified in the initial audit have been implemented.

Is the service users consent to the sharing of clinical information outside the team recorded – 26% increase in 2017 from 2016 results.

Was the service user asked if they wanted to know their diagnosis – 31% increase in 2017 from 2016 results.

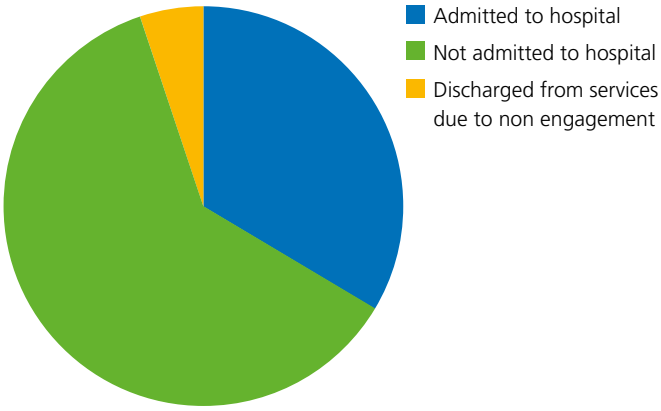
Basic Dementia and blood test completed by the GP prior to referral to EMDASS – 5% decline from 2016 results.

The recommendation to improve this was for discussions to take place on the importance of nurses ensuring that when triaging that GP referrals have dementia screening blood results attached.

Efficacy of Intensive Community Management of Anorexia Nervosa

This audit looked to determine how effectively our Community Eating Disorders Team's intensive community management (ICM) for adults with anorexia nervosa prevents admission to inpatient eating disorders units. Results suggest the treatment received by service users at risk of inpatient referrals successfully reduced hospital admissions. Of 20 service users admitted to our community eating disorders team between January 2014 and March 2017, 7 were admitted to hospital due to low weight and for 1, no recording could be found regarding possible admission to hospital as they were discharged from our services due to non-engagement (figure 1). All 7 admitted to hospital remained an inpatient 3 months after the ICM finished. For all 20 admitted to the Community Eating Disorders Service, medical monitoring, dietetics and support work input were provided.

Service users admitted/not admitted to hospital after ICM



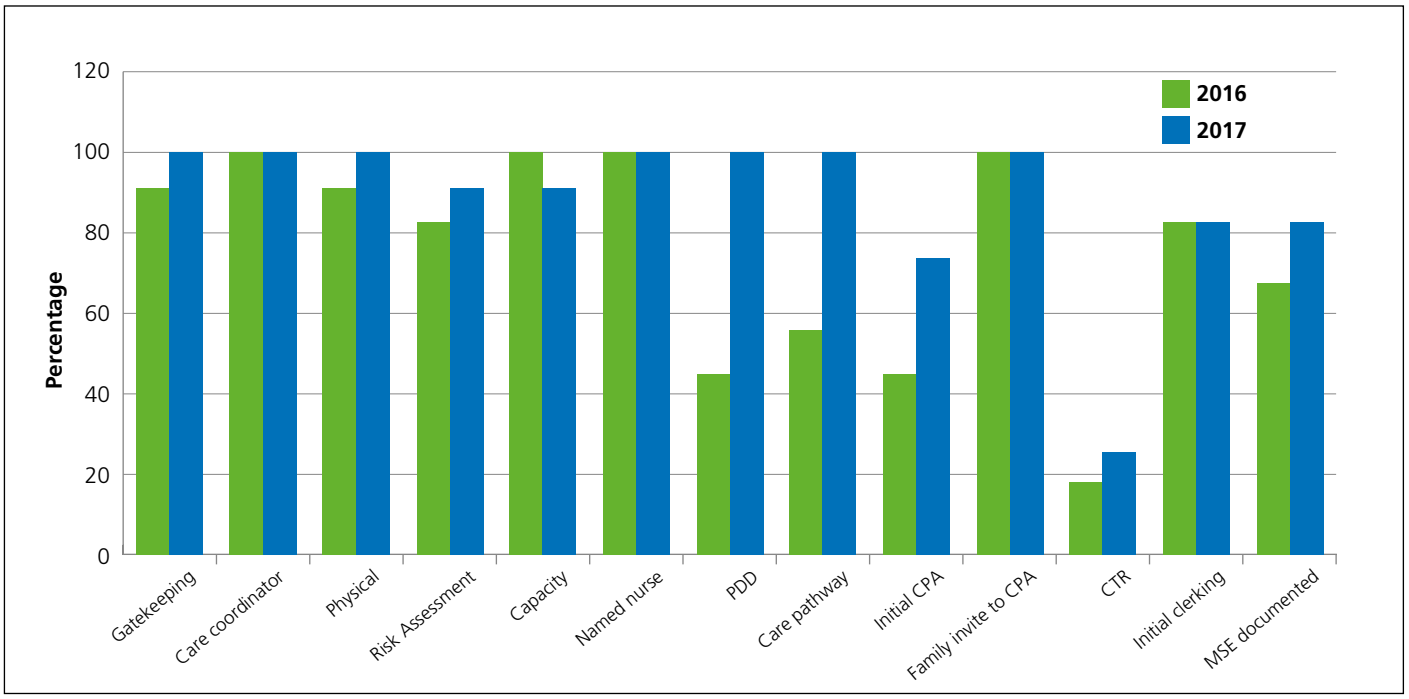
Inpatient care bundle for people with an intellectual disability and mental health or behavioural problems

This audit aimed to check that we are providing high quality inpatient care to people with a learning disability by:

- adhering to care pathways to support recovery and promote timely discharge
- effectively implementing care pathways based on evidence-based practice
- developing collaborative care plans.

The audit included all service users from one of our learning disability wards. As the graph opposite shows, our care bundle documentation has improved since the last audit in 2016. Inpatient physical health checks, risk assessments, Care Programme Approach (CPA) and Care and Treatment Review (CTR) documentation, care pathway and planned discharge date documentation have all improved. We are particularly pleased with the improvement in CPA documentation, as it follows the implementation of the previous audit's recommendations.

Percentage of tasks completed



Community Perinatal Team (CPT) accreditation baseline audit

The Community Perinatal Team (CPT) is a new service to the Trust. The team provides a specialist community psychiatric service in Hertfordshire for women with mental health problems related to pregnancy, childbirth and early motherhood.

We wanted to find out if the team meets the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) standards in initial assessments, risk assessments, care plans and discharges. The team aims to gain CCQI accreditation in 2018.

The results indicate that the team has built a strong foundation from which to achieve accreditation.

We discovered many areas of good practice, including CCQI compliance in initial assessment areas: mental health medication; psychosocial needs; medical history and physical health medication. We also identified good practice in risk assessment measures and care planning for agreed interventions for physical and mental health.

We identified some areas for improvement:

- discharge letters need to meet the standard and contain risk assessments of mother and child
- none of the initial assessments included the service user's strengths and weaknesses.

The team was also peer reviewed in November 2017. The results of the review were very positive. We have developed an action plan to address these areas, and will re-audit to ensure this is effective.

Where audit said we need to improve

Fit for the frail and functional? An audit of the frail and functional ward admission criteria

We aimed to explore whether service users on Wren Ward meet the admission criteria we set out and whether these admission criteria are practically appropriate for the ward, once put into practice.

29/40 (72.5%) of the service users admitted to Wren Ward did not fulfil the admission criteria set out in our policy:

- Only 11/40 (27.5%) were classified as frail according to the Rockwood Clinical Frailty Scale (CFS)
- 7/40 (17.5%) were classified as vulnerable
- The remaining 22/40 (55%) were "managing well" or better.

Most service users fell into category 3 of the CFS; "Managing well; People whose medical problems are well controlled, but are not regularly active beyond routine walking."

Older people: inpatient falls

The older people inpatient falls audit was originally conducted in 2016/17. This re-audit in 2017/18 aimed to provide assurance that the Trust policy is adhered to and that improvements have been made since the first cycle. Some standards increased marginally in compliance while others reduced. A decline of 10% in compliance was particularly seen in evidence of a falls risk assessment being carried out upon admission. A 20% decline was seen in the timeliness of this assessment being carried out.

Actions coming from the audit consisted of a learning note to

be created from serious incidents and to be presented at the Falls committee in addition to discussions and correspondence with local teams around adhering to the Falls Policy to ensure an improvement in compliance.

Continued improvement of physical health on the old age psychiatric ward - neurological observations following falls

Staff pay close attention to the service users' physical health; evidence for this can be found in how they monitor physical observations using the early warning score (EWS) system. However, we found that nursing staff may not be as familiar with monitoring neurological observations following a fall, especially in using the Glasgow Coma Scale (GCS) to assess consciousness.

We developed a questionnaire to assess staff knowledge of the Trust's post-fall protocol and their confidence in implementing this protocol. We then ran a workshop that covered the following key areas:

- falls
- our post-fall protocol
- how to carry out neurological observations and assess the GCS
- the frequency that neurological observations should be carried out
- the factors that indicate that an urgent reassessment by a doctor is needed.

After staff had completed their training, we asked them to complete the same questionnaire a second time to see if their knowledge and confidence had increased. While this work only involved one ward, our aim is to contribute to continuing to work to improve the physical health of service users with psychiatric illnesses.

Feedback from staff after training:

100% were aware of the Trust's post-fall protocol.

Confidence in managing falls increased.

Before training, most said they were "somewhat confident" in managing falls, afterwards most selected "very confident."

Increased confidence in assessing the GCS; the most common response before training was "neither confident/unconfident" and after training it was "somewhat improved their knowledge of how frequently neurological observations should be carried out after a fall."

100% identified the correct factors that require urgent reassessment when carrying out neurological observations.

Research and development

Research is key for us as a University Trust and we have an increasing number of staff involved in research. We work closely with, and receive research funding contracts from the National Institute of Health Research (NIHR) and Clinical Research Network (CRN) Eastern to help us deliver and participate in research programmes. As a Trust, we have funding contracts with the National Institute of Health Research (NIHR) and Clinical Research Network (CRN) Eastern. We also collaborate with several academic institutions including The University of Hertfordshire, University of East Anglia, University of Kent, University of Southampton, and The Anna Freud Centre.

We have recently secured NIHR funding for a new collaborative feasibility study to look at trans-cranial direct stimulation in the treatment of obsessive compulsive disorder. We will be the lead organisation for this trial, which we hope to start in the summer of 2018.

All NHS Trusts have an obligation to support the NIHR portfolio, and we have supported recruitment to 16 different research studies over the last year. All research that takes place within the Trust has the appropriate level of ethical approval in place.

The number of service users receiving relevant health services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 271. The feedback from those who took part has been very positive. Most of those who completed a questionnaire rated their overall experience as very good or excellent.

We are currently recruiting participants for the following studies:

- **Identifying the prevalence of antibodies to neuronal membrane targets in first episode psychosis (PPiP)** – This study aims to establish the prevalence of pathogenic antibodies in people with a diagnosis of psychosis, and to assess the acceptability of an immunological treatment protocol for patients with psychosis and antibodies. Participants will have a blood sample taken and undergo the PANSS (Positive and Negative Syndrome Scale) assessment
- **DNA Polymorphisms in Mental Health (DPIM)** – This study is concerned with studying DNA to identify a genetic cause of mental illness. We are recruiting patients with a history of Bipolar disorder and with Schizophrenia. Participants are only seen once. Our Clinical Studies Officer will take a blood sample and conduct a short interview to obtain information about the participants' family, medical and psychiatric history
- **The mATCH study** – Understanding the aetiology and improving care pathways for people with autism detained within hospitals. To investigate whether previously defined subtypologies of people with ASD within psychiatric hospitals are valid and whether different care is required by each subtype to reduce their likelihood of being kept in restrictive

hospital settings for longer than necessary. This involves following up patients in hospital for 12 months and speaking with staff

- **Learning about the lives of adults on the autism spectrum and their relatives** – We are looking to develop a better understanding of the lives of adults on the autism spectrum and their relatives. Participants will be provided with a contact booklet to complete and return to the study team in Newcastle. Then they will be asked to complete several questionnaires which will be sent by post
- **Detecting susceptibility genes for Alzheimer's disease** – We are looking to recruit individuals with a diagnosis of Alzheimer's Disease (AD), and their next-of-kin. Participants with AD will be asked to provide a blood sample. They and their carers will also be interviewed using several questionnaires. These interviews will each take around 90 minutes
- **Delivery of Cognitive Therapy for Young people after Trauma** – This study is examining the effectiveness of cognitive therapy in young people with post traumatic stress disorder, compared with treatment as usual
- **Validation of a new measure of the impact of voice hearing experiences: The Voice Impact Scale (VIS)** – This study aims to develop a questionnaire that can be used to measure the impact of voices on the person hearing them. The University of Sussex have developed a questionnaire with help from researchers, clinicians and other people who hear voices which will now be tested in a clinical population
- **ADU Care Study** – This study is comparing Acute Daycare Units (ADUs) with crisis assessment and treatment (CAT). A cohort of people attending the ADU for more than 1 week will be compared with a cohort of people discharged from CAT team care in the same locality without ADU input. The main outcomes are readmission to acute pathway at 6 months and satisfaction with services provided.

Please contact the Research and Development Department on 01707 253836 if you would like to find out more about any of the above studies. We will be taking on additional studies during 2018/19.

What is the National Institute of Health Research (NIHR)?

The NIHR funds health and care research and translates discoveries into practical products, treatments, devices and procedures. It helps patients gain earlier access to breakthrough treatments and trains and develops researchers. The NIHR is committed to involving patients and the public in all its work.

Commissioning for Quality and Innovation (CQUIN) 2017/18

What is Commissioning for Quality and Innovation (CQUIN)?

CQUIN is a payment framework which enables commissioners to reward excellence, by linking a proportion of the healthcare provider's income to the achievement of local quality improvement goals.

The Trust's CQUIN goals are agreed with our local and specialist commissioners at the beginning of each year. A proportion of the Trust's income is conditional on achieving these goals. Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically in 'Trust Papers' in the 'About Us' section of the Trust's website: www.hpft.nhs.uk/about-us/trust-papers

1.9% of our income (£4,422k) in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between us and our commissioners through the CQUIN payment framework. At the end of the 2017/18, the final amount achieved was £3,931k (89% of plan). Our CQUIN income received for 2017/18 was £3,931k. Details of the CQUIN amounts for each 2017/18 contract are set out below.

	Commissioner	Value	Achievements17-18	
1	Hertfordshire	£3,506,000	£ 3,015,160	86%
2	NHS England	£444,200	£444,200	100%
3	West Essex LD	£222,716	£222,716	100%
4	Essex IAPT	£143,894	£143,894	100%
5	Norfolk	£49,315	£49,315	100%
6	Bucks	£55,701	£55,701	100%
Total		**£4,421,826**	**£3,930,986**	**89%**

Hertfordshire Commissioning for Quality and Innovation (CQUIN) 2017/18 in relation to the main commissioner contract in Hertfordshire

	Goal	Description of goal	Goal value £	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues.	£420,720	£245,385 58%
2	Improving physical healthcare to reduce premature mortality in people with serious mental illness	Improving the physical healthcare for people with serious mental illness in order to reduce premature mortality in this patient group.	£420,720	£344,990 82%
3	Improving services for people with mental health needs who present at A&E	Reducing the number of attendances at A&E for those who would benefit from mental health and psychosocial interventions.	£420,720	£394,459 94%
4	Transitions out Children's and Young Peoples Mental Health Services	Improvement in the experiences and outcomes for young people as they transition of out CAMHS services to other providers.	£420,720	£315,541 75%
5	Preventing ill health by risky behaviours	Tobacco and alcohol screening and the offer of interventions if appropriate.	£420,720	£312,385 74%
6	Support engagement with STPs		£701,200	£701,200 100%
7	Linked to the Risk Reserve.		£701,200	£701,200 100%
		Total	**£3,506,000**	**£3,015,160 (86%)**

Norfolk Commissioning for Quality and Innovation (CQUIN) 2017/18

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1.	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues.	£4,392 0.25%	£4,932 100%
2	Integrated Pathway		£24,658 1.25%	£24,658 100%
3	Physical Health		£19,726 1%	£19,726 100%
		Total	**£ 49,315 (100%)**	**£ 49,315 (100%)**

Mid, West and North East Essex Learning Disability Commissioning for Quality and Innovation (CQUIN) 2017/18

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£22,272 0.25%	£22,217 100%
2	Outcomes		£89,086 1%	£89,086 100%
3	Personal Health Budgets		£89,086 1%	£89,086 100%
4	Health Equality Framework	Implementation of a systemic outcome measurement tool across Bucks learning disability services using a web based version of the Health Equality Framework	£22,272 0.25%	£22,272 100%
		Total	**£ 222,716 2.5%**	**£222,716 (100%)**

NE, Mid and West Essex IAPT Commissioning for Quality and Innovation (CQUIN) 2017/18

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£16,442 0.75%	£16,442 100%
2	Carers		£89,086 1%	£89,086 100%
		Total	**£ 143,894 6.5%**	**£ 143,894 (100%)**

Buckinghamshire Commissioning for Quality and Innovation (CQUIN) 2017/18

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Health Equality Framework	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£16,442 0.75%	£16,442 100%
		Total	**£ 55,701 1.5%**	**£ £55,701 (100%)**

NHS England Commissioning for Quality and Innovation (CQUIN) 2017/18

Goal	Goal value £ (%)	Achieved £ (%)
Recovery	£222,100 1.25%	£222,100 (100%)
Restrictive Practice	£222,100 1.25%	£222,100 (100%
	£222,100 1.25%	**£222,100 (100%**

Artwork supplied by the HPFT Art Collection

The income we generated by the health services we reviewed in 2017/18 represent 1.7% of the total income generated from the provision of health services by the Trust.

The Trust is registered with the Care Quality Commission (CQC) and is rated as 'Good'. As a Trust, we have had no conditions on our registration. The CQC has not taken enforcement action against the Trust during 2017/18. We were issued with a section 29A warning notice following an inspection undertaken to the Broadland Clinic between 27 to 28 September 2017. We have met the deadline to make significant improvements by 31 January 2018.

We participated in an unannounced core service inspection and an announced well led inspection by the CQC relating to the following areas during 23 January – 9 February 2018:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health ward
- Wards for people with a learning disability or autism
- Forensic inpatient or secure services.

As a Trust, we intend to take action to address the requirements reported by the CQC against regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulation 18 HSCA (RA) Regulations 2014 Staffing. We are required to submit an action plan to the CQC by 4 June 2018. We also participated in a thematic review of child and adolescent mental health services by the CQC during the reporting period.

Clinical coding

We use clinical coding to categorise the information we gather about our service users and the services and treatments they receive from us. This information is then used to analyse the data that informs our quality indicators.

Although we were not part of the Payment by Results (PbR) clinical coding audit conducted during 2017/18 by the Audit Commission, in November 2017, an external auditor carried out a clinical coding audit for inpatient discharges. The results were Primary diagnosis: 98% secondary diagnosis: 91.5%. This result ensured that we maintained level 3 for the Information Governance Toolkit submission expected in March 2018.

What is the Information Governance (IG) Toolkit?

The IG Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' assessments.

This year, our clinical coders have attended junior doctor workshops and induction days to raise awareness of clinical coding and the importance of good quality recording of patient (service user) information on Paris.

What is PARIS?

PARIS is the electronic patient record and information system that is used within our Trust.

What is Hospital Episode Statistics (HES)?

Hospital Episode Statistics is a database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals in England.

The Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the service users' valid NHS number was:

- 99.4% for admitted patient care
- 100% for outpatient care.

The percentage of records in the published data which included the service users valid General Medical Practice Code was:

- 99.5% for admitted patient care
- 99.9% for outpatient care.

Ethnicity April 2017 – March 2018

The percentage of records in the published data which included the service users' ethnicity was 90.2%. We plan to improve our data quality and clinical coding by:

- conducting regular audits
- supporting staff with data quality issues through reviewing Key Performance Indicator guides
- developing front end reports which are updated daily.

The Trust submitted our Information Governance Assessment Report (Toolkit) to the Health and Social Care Information Centre (HSCIC) at the end of March 2018. Our overall score for 2017/18 was 85% (82% in 2016/17) level 2, with a green satisfactory rating. The results were broken down into the following areas:

Information Governance Management	100%
Confidentiality & Data Protection Assurance	95%
Information Security Assurance	80%
Clinical Information Assurance	80%
Secondary Use Assurance	75%
Corporate Information Assurance	100%
Overall	**85%**

Patient safety

This section shows how we ensure that we are providing safe care.

Duty of Candour

We are committed to the principles of openness, honesty and transparency. We aim to learn from all incidents and engage service users and families in the review process. Our Duty of Candour policy defines the incidents to which Duty of Candour applies and sets out the duties and responsibilities of senior staff after an incident.

We have reviewed and updated the policy so that, where harm has been caused or may have been caused, staff have clear guidance on their roles and responsibilities in contacting service users and families in a way that is:

- timely
- embraces the principles of open, honest and transparent communication.

We have also included information on how we meet the duty for moderate harm incidents.

During 2017/18 we have continued to make progress with the implementation of the Duty of Candour policy. Clinical leads are being consistent in contacting bereaved families to offer condolences and identify support needs when a death has been reported as a serious incident. We acknowledge the impact on families and friends who are bereaved by suicide or a sudden unexpected death.

When a serious incident is reported, we send a Duty of Candour letter to the person who uses our services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment affected. This is to advise on:

- our internal investigation process
- how they can contribute to establishing a factual chronology of events and help us learn from what has happened.

The person leading the investigation contacts the family and any questions or concerns the family raises are gathered, considered and included in the serious incident report. Once completed, the full report is always shared with the family and the Coroner. Trust commissioners monitor compliance with our Duty of Candour and procedures when reviewing and quality assuring serious incident reports.

National Confidential Inquiry into Suicide and Homicide (NCISH)

We contribute to the NCISH. Clinical teams provide data to the national coordinating centre at Manchester University.

Our services also use the NCISH toolkit to ensure we use learning from the nationally published data to improve the services we provide. We review our self-assessment annually and use the new data published each year to benchmark our record on suicide.

Learning from deaths

From April 2017, all Trusts were required to collect and publish information on deaths and serious incidents, including evidence of learning and improvements being made as a result of that information. This is part of a systematic, NHS-wide approach to reviewing and learning from deaths, being led by the Department of Health, NHS Improvement and the Care Quality Commission (CQC). Guidance for Trusts was published in March 2017 to provide a consistent approach to identifying and reporting, investigating and learning from deaths, and where appropriate, sharing information with other services and organisations.

We have implemented the national guidance including meeting the requirement to publish a 'Learning from Deaths' policy by the end of quarter 2 and a dashBoard by the end of quarter 3. The data provided in this report reflects the work undertaken during the year and in particular the development of systems and processes to record and review deaths. This implementation during the year explains why data in quarters 1 and 2 is limited in comparison to quarters 3 and 4.

At the time of publication, there was no national guidance on the review of deaths for Trusts providing learning disability and mental health services. The Royal College of Psychiatrists is to commence a pilot to test the tools adapted from the Royal College of Physicians Structured Judgement Review used in acute care settings.

We have implemented interim arrangements to review deaths ahead of the outcome of the national pilot for mental health trusts. All deaths identified to us are reported onto Datix. All service user deaths and those service users who were discharged less than 12 months ago are considered by our Mortality Governance Group.

The deaths reported are those identified to us by families and carers, other health providers, the Coroner and other statutory bodies such as the police. There is no current system to ensure that we are notified of all deaths of service users previously known to us. One of the national actions arising from the guidance, is that NHS Digital will assess how to facilitate the development of provider systems and processes so that providers know when a service user/patient dies and information from reviews and investigations can be collected in standardised way. This work has yet to be completed.

The data reported in the table opposite is based on the information made available to us and reported by local teams onto Datix as our incident reporting system. Each death is categorised according to whether it was a result of natural causes and whether it was expected or unexpected (with reference to time frame).

During 2017/18, 350 service users (or those discharged in the last 12 months) were reported to have died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 81 occurred in the first quarter of which 73 were reported in the first quarter
- 76 occurred in the second quarter of which 68 were reported in the second quarter
- 96 occurred in the third quarter of which 95 were reported in the third quarter
- 97 occurred in the fourth quarter of which 111 were reported in the fourth quarter.

Of the service users who died, 37 were in our in-patient services at the time of death. A further 4 service users were transferred from our care shortly before their death. A more detailed analysis is presented of the 41 deaths of in-patients. 0 representing 100% of the in-patient service user deaths during the reporting period are judged to be more likely than not to have been owing to problems in the care provided to the service user. In relation to each quarter, this consisted of: 0 representing 100% for the first quarter; 0 representing 100% for the second quarter; 0 representing 100% for the third quarter; 0 representing 100% for the fourth quarter. These numbers have been estimated using the review of deaths at the Mortality Governance Group. One death reviewed in quarter 1 was subject to a serious incident investigation.

Quarter	Number of service user deaths	Detail
1	8	• All inpatient services • 6 older age adult services; on agreed end of life care pathway • 1 adult Psychiatric Intensive Care Unit (PICU) (investigated as SI with natural cause conclusion (physical health cause) reached after post mortem; no concerns raised regarding the care by the coroner • 1 learning disability ward; collapsed and transferred to acute hospital for care where later died. At the time of writing the inquest into the death of this service user is still to be held.
2	10	• All older age adult inpatient services • 6 on an agreed end of life care pathway • 4 died of physical health causes. No concerns have been raised regarding their deaths.
3	11	• All inpatient services • 2 in an acute hospital following appropriate escalation and transfer from older aged adult services • 9 in older aged adult services. 78% had an agreed end of life care pathway • All died of physical health causes. No concerns have been identified to indicate that any of the deaths were caused as a result of the care received by us.
4	12	• All older age adult inpatient services • 9 had an agreed end of life care pathway • 1 transferred to an acute hospital for care where they died • 2 died of physical health causes. No concerns have been raised regarding their deaths.

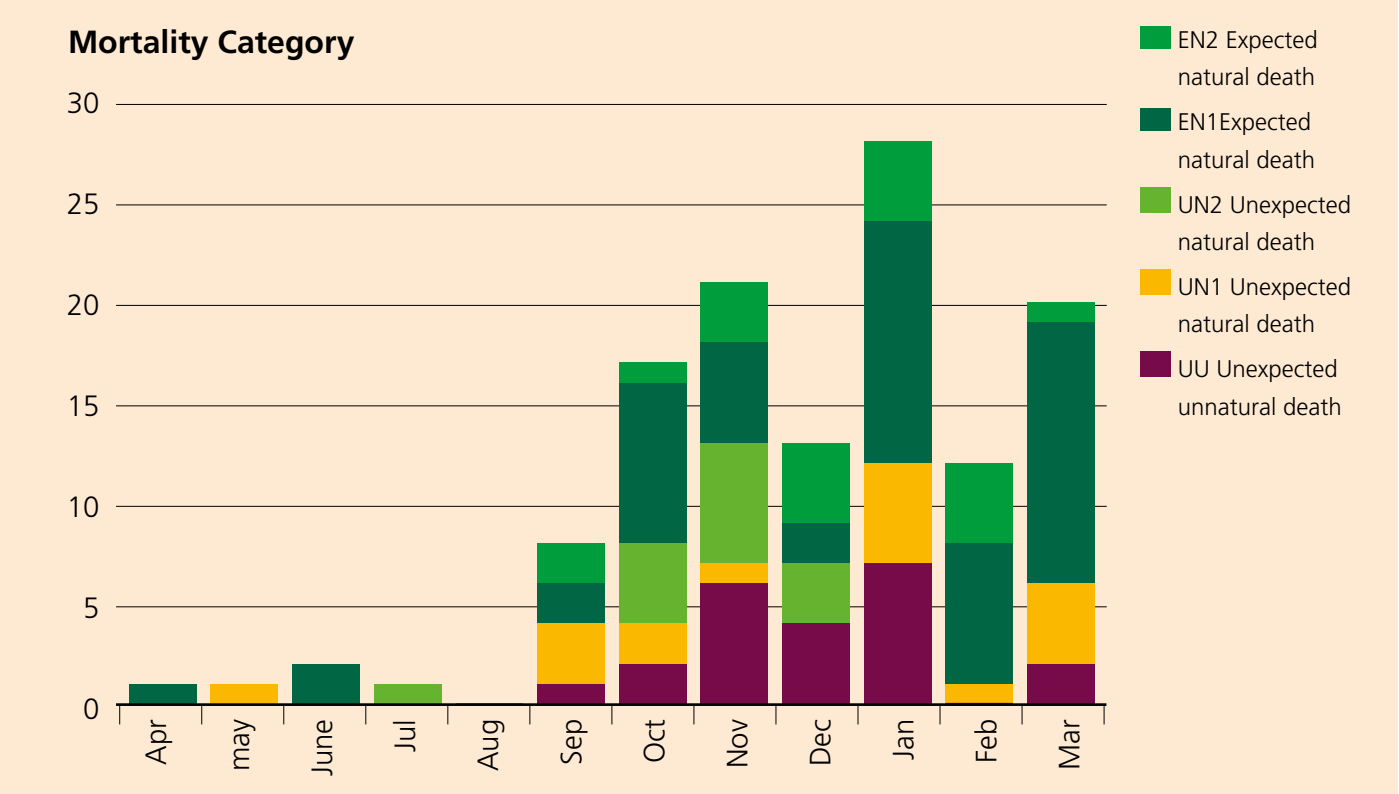
There were no unexpected unnatural deaths recorded in our in-patient services in 2017/18.

By 31 March 2018, 49 serious incident investigations have been carried out in relation to 350 deaths included above. The investigations were a full root cause analysis investigation as set out in the nationally prescribed Serious Incident Framework. By 31 March , 3 case record reviews and 49 investigations have been carried out in relation to 350 of the deaths. In one case, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 10 in the first quarter; 10 in the second quarter; 15 in the third quarter; 17 in the fourth quarter. 1 case note review was commenced in the fourth quarter.

2017/18 is the first year we have been required to include details on our approach to learning from deaths in the Quality Account. 24 serious incident investigations were completed after 31 March 2017 which related to deaths which took place before the start of the reporting period, as detailed below:

- 14 completed in quarter 1
- 4 completed in quarter 2
- 5 completed in quarter 3
- 1 completed in quarter 4.

Our policy on Learning from Deaths adopted the categorisation of deaths as set out above. From quarter 3, our Mortality Governance Group has assigned a category to a death where information is known about the cause of death. For some deaths, the information is lacking owing to delays in post mortem outcomes and lack of information on the cause of death made available by other health organisations. The table overleaf shows the breakdown of all the deaths reported during 2017/18 as at 18 April 2018.



As there is no agreed review tool for mental health trusts to review deaths, we have adapted the current Royal College of Physicians tools whilst waiting for the outcome of the national pilot. Without agreed methodology and definitions of problems with care, we are not able to report fully as set out in the Quality Account guidance.

The Learning Disability Mortality Review Programme (LeDeR) has been implemented in a phased way by the local areas where we provide services. During 2017/18, 61 deaths have been reported by us to the LeDeR programme.

- 12 in the first quarter
- 13 in the second quarter
- 15 in the third quarter
- 21 in the fourth quarter.

Each of the Local Authority Areas implementing the LeDeR programme have done so in a phased way with different approaches to the process. A significant number of reviews have still to be finalised and this process is overseen by the Local Authority. We have a number of reviewers trained in the LeDeR methodology to support the programme. Learning from the programme is shared via our Mortality Governance Group. Findings of reviews to date include:

- The need to ensure that Advanced Care Plans are in place for service users with dementia, in particular ensuring GPs are aware of how they can support service users
- The need to ensure end of life care is provided to service users with a learning disability
- The need to manage the risk of aspiration pneumonia.

All deaths in learning disability services are screened using an adapted screening tool. The outcomes of the reviews are discussed at our Mortality Governance Group. In quarter 3 and 4, no deaths required a more detailed review following this process. All the deaths will also be reviewed by the LeDeR programme. One review undertaken in quarter 3 identified a concern regarding the care home in which the service user had lived. This was referred through to the Local Authority as a safeguarding concern. The issue identified was unrelated to the care we provided.

During 2017/18, 7 cases were reviewed following receipt of a complaint letter. The details of the cases reviewed are set out below:

- Case 1, the complaint related to the contact we had with a Housing Association and was unrelated to the service users death which occurred in an acute hospital
- Case 2 was a case investigated as a serious incident
- Case 3, a family member raised concerns about the care provided to the service user. The case had been investigated as a serious incident. The next of kin did not have any concerns about the care and treatment we provided. The review did not find any evidence of concerns with care provided
- Case 4, a family member raised concerns about the care provided to the service user. An inquest was held into their death and no concerns were raised. The inquest recorded a natural cause conclusion. The family remain unhappy with the findings of the internal review. The case has been referred for an external review

- Case 5, a family member raised concerns about the care provided to the service user. A review was undertaken and no evidence was found to identify concerns with the care provided. We are meeting with the family to inform them of the findings of the review
- Case 6 related to the care provided by both us and another NHS provider who are leading on the complaint. We are undertaking a review to support the lead provider
- Case 7 is being investigated as a serious incident.

The reviews of in-patient deaths identify the need to ensure high quality end of life care and consideration of the physical health needs of service users being an important aspect of the agreed care plan. During the year, we have reviewed and updated our End of Life Care Policy to support the older aged adult wards in ensuring they are able to meet the needs of service users receiving end of life care. A number of staff have been trained in bereavement support and we have created a booklet for services to give to families and carers following the death of their loved one. We have also completed and submitted serious incident reports to our Commissioners as required in the National Serious Incident Framework. Actions plans are in place where learning was identified and learning has been shared across our services.

The reviews identified the following areas of importance:

- Robust handover/transfer of care between shifts and between teams
- Signposting on to other services where clinically indicated
- Offer of post incident support for staff involved in a critical incident
- Reviewing and Updating of risk assessment documentation
- Physical health monitoring
- Joint working with Spectrum Drug and Alcohol Service for service users with dual diagnosis
- Engagement with families
- Recording of significant other details on electronic patient records.

In response to the learning identified, we have undertaken a number of actions:

- Review and update of our physical health strategy and actions to improve physical health monitoring across all services
- Audit and re-audit of the quality of risk assessment documentation to ensure it
- captures the service users' mental health history, relapse signatures, early warning signs and symptoms and diagnosis
- Learning from incidents and serious incidents to inform the annual Clinical Audit programme and ad-hoc audits are identified and undertaken throughout the year as identified by Operational Service Leads and Medical Leads
- Updating and refreshing the mandatory clinical risk training programme to include key areas of learning from serious incident investigations and to also be informed by research and the NCISH Reports
- Learning from Prevention of Future Death Reports issued by Her Majesties Coroners is summarised and disseminated for discussion at the SBU Quality Risk and Patient Safety meetings to inform practice and policy.

At the end of quarter 3, we published what we have learned from our deaths dashBoard at a Public Board meeting the. Because the Trust is expanding the scope of our review processes, we are still developing this dashBoard. We have also reviewed the Terms of Reference and membership of the Mortality Governance Group, so we can widen representation to include CCGs and physical health leads. We ensure all deaths of service users with a Learning Disability are referred to the national mortality review programme (LeDeR).

2.3 Reporting against our core indicators

This section of our Quality Account sets out how we performed against our 2017/18 priorities. These are the priorities we set at the beginning of the year and published in the 2016/17 Quality Account. We will look at each of these in turn after considering the nationally mandated quality indicators set by the NHSI Regulation Framework.

What is the Single Oversight Framework (SOF)?

SOF is NHS Improvement's approach to overseeing and supporting NHS Trusts and NHS Foundation Trusts by providing an overall framework which helps NHS Improvement identify where providers may benefit from, or require, improvement support, if they are to meet the standards required of them, in a safe and sustainable way.

Core Indicators

1. **The Percentage of service users on CPA who were followed up within 7 days after discharge from psychiatric inpatient care during the reported period.** The Trust considers that this data is as described for the following reasons: extensive validation of this indicator takes place on a weekly and monthly basis to ensure accuracy. We have taken the following actions to improve this indicator and so the quality of its services, by implementing a stricter, 3 day follow-up for psychiatric inpatients after discharge.

Performance in Q1 to Q4 in 2017-18	Q1	Q2	Q3	Q4
	95.6%	96.8%	96.7%	96%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	97.4%	98.5%	97.3%	98.5%
Target	95% rate of service users followed up after discharge from the Acute Care Pathway.			

2. **The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.** We consider that this data is as described for the following reasons: extensive validation of this indicator takes place on a weekly and monthly basis to ensure accuracy. We have taken the following actions to improve this indicator and so the quality of its services, by implementing gatekeeping protocols and a review of recording in 2017/18 with an improved automated process of recording to be introduced in 2018/19.

Performance in Q1 to Q4 in 2017-18	Q1	Q2	Q3	Q4
	96%	98%	99%	98%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	88.8%	80.1%	88.5%	95.9%
Target	95% rate of service users to be gate-kept.			

While we want to share information about how our performance compares with other providers of health services, this has proved challenging, as many of the targets set are tailored to our local economy and we are therefore unable to benchmark ourselves against other mental health trusts.

National bench marking data comparing trust performance against other mental health Trusts

CPA 7 day follow ups:

	Highest	Lowest	National Average	Trust
Q1 2017/18	100%	71%	96.7%	98.1%
Q2	100%	87.5%	95.4%	96.6%
Q3	100%	69.2%	95.4%	96.4%
Q4	100%	68.8%	95.5%	96.2%

Crisis Assessment and Treatment Team (CATT) Gatekeeping

	Highest	Lowest	National Average	Trust
Q1 2017/18	100%	88.9%	98.7%	95.9%
Q2	100%	94%	99%	97.8%
Q3	100%	84.3%	98.5%	96.6%
Q4	100%	88.7%	98.7%	98.1%

Artwork supplied by the HPFT Art Collection

Quality priority areas for 2017/18

Patient (service user) Safety		Target	Q1	Q2	Q3	Q4	2017/18
1	Every discharge 7 day follow up (NHSI mandatory)	95%	95.6%	96.8%	96.7%	96.01%	96.60%
2	CPA Reviews within 12 months	95%	96.0%	93.5%	94.03%	97.42%	Snapshot
3	Service users receiving a physical health check within 24 hours of admission	90%	98.6%	93.1%	93.38%	95.51%	95.74%
4	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI mandatory)	-	1241* Incidents 1.13% (14)	1284* Incidents 0.78% (10)	1289** Incidents 0.69% (9)		
Clinical Effectiveness		**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**2017/18**
5	*Delayed Transfer of Care (DToC)	7.5%	7.94%	7.8%	6.83%	4.75%	7.09 %
6	Emergency readmission within 28 days (NHSI mandatory)	<=7.5%	4.5%	7.8%	7.09%	5.01%	5.83%
7	Improving Access to Psychological Therapies (IAPT) recovery rate	50%	53.4%	54.1%	53.0%	53.1%	53.36%
8	First Episode Psychosis (FEP) waits 14 days (NHSI mandatory)	50%	79.4%	66.0%	69.5%	64.18%	71.73%
Service User and Carer Experience		**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**2017/18**
9	Service users reporting their experience of Community Mental Health Services (NHSI mandatory)		92.3%	94.7%	93.2%	90.3%	93.75%
10	Carers feeling valued by staff	≥= 75%	68.7%	69.8%	71.43%	68.67%	72.49%
11	Staff Experience Friends and Family Test	≥= 70%	57.0%	67.7%	67.0%	73.90%	68.28%
12	Service Users Friends and Family Test	≥= 70%	87.7%	88.0%	86.3%	5.46%	86.9%

**As the incident data is subject to a quality assurance review at local level and also by the Safer Care Team prior to uploading to NRLS incident data provided for each quarter may be subject to change in future reports.

Part 3 – Other Information

This part of the report gives us an opportunity to celebrate some of the notable and innovative practice that has taken place across our services in 2017/18 and to present information relevant to the quality of the health services we provide. It is not meant to be an exhaustive list, rather a sample of the many and varied initiatives our staff, service users and carers have developed and implemented to improve the quality of our services.

Local Quality Indicators

The local quality indicators were set out in the Quality Account 2016/17. The performance against each target is set out in the table below. A brief narrative is provided on each of the indicators following the table.

Local Indicators	
Patient (service user) safety	
1	Feeling safe and protected from avoidable harm
2	Over prescribing of medication within LD services (STOMP)
3	SPIKE
Effectiveness	
4	Delayed Transfer of Care
5	New SPA operating process/model
6	EMDASS
Service user feedback	
7	Carer Pathway
8	Peer experience listeners work
9	Staff engaged and motivated

1. Feeling Safe and protected from avoidable harm

Making Our Services Safer (MOSS) has focused on four key areas to support the management of positive, proactive and safe care:

- Data informed care: review of incidents and data for themes and learning
- Restrictive intervention reduction: use of approaches, such as safewards
- Support planning: through positive behavioural support, wellbeing plans
- Post incident support: to offer support post incident.
- Local approaches focusing on feeling safe, by piloting the use of Safety Huddles (real time discussion on safety concerns)
- Safety Crosses (locally generated visual recording of incidents, shared with staff and services users). This was designed to empower staff at ward level to review incidents and take local actions, based on real-time feedback about issues and events
- Adding to the repertoire of proactive techniques already in place (Safewards) to support less restrictive approaches to care.

We wanted to see how effective these approaches were in helping people to feel safe, so we tested these in four clinical areas:

- Acute mixed gender mental health
- Child and adolescent mental health services (CAMHS)
- Learning disability services
- Women's acute mental health services.

We:

- Audited current interventions using an amended Safewards fidelity assessment
- Audited the use of pilot interventions (Safety Huddles and Safety Crosses)
- Agreed consent for the pilot interventions, and gave feedback to the wards that piloted them
- Undertook a pilot of interventions in the identified areas over 2 months
- Evaluated the effectiveness of the interventions.

Safety crosses: recording of Datix recordable incidents over a 24 hour period, using a visual 'at a glance' breakdown of incidents

These practice enhancements helped staff identify zones or trends where/when incidents are prevalent and also showed that incidents were not happening constantly. However, they also presented practice challenges, in terms of capacity and open sharing with the service users (examples including some who may deliberately show behaviour to get a 'score' on the safety cross and also some may be so unwell, they might not understand what the safety cross means). Our next step is to modify the safety cross methodology to record when a huddle was called to evaluate the frequency, time and location of the incident.

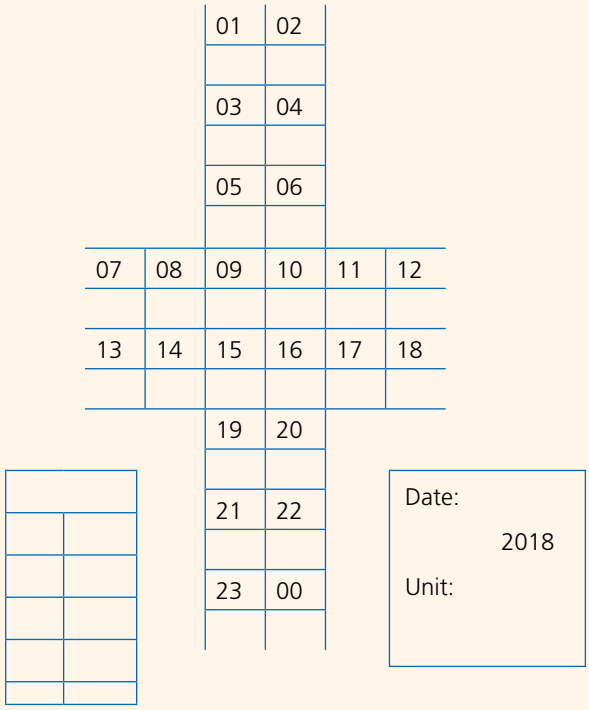
Safety huddles: The 'huddle' is a discussion of what is going on, clarifying strategy and who does what. It lasts no longer than 15 minutes and all the people involved usually remain standing. We conducted an audit to assess the current approaches within four contrasting clinical areas (wards) using both safety huddles and crosses.

The four wards reported that this model has had a positive impact in empowering staff to speak up when addressing local concerns. The methods used were staff members calling for a brief meeting to ask the following questions:

1. Do you feel safe or do you have a concern?
2. Which service user is unhappy with their care
3. What is the plan (and who is going to implement this and when?)

A whole team huddle at the start of the day is considered most effective. This approach has led to enhanced communication, continuity and a unified approach; and provided reassurance that everyone is aware of plans for the management of complex and challenging cases.

Safety Cross



Incident
Red – a DATIX reportable incident

Near miss
Yellow – warning behaviours.

Incident free
Green – incident free

Sexual
Blue – any sexual comment/innuendo - not Datix reportable

Huddle
Gold – if a huddle had taken place

"…it keeps us well informed and we are able to contribute in any changes or development that the nurse in charge or the team are not aware of"

Healthcare Assistants

What we learned from the audit:

- Identification of triggers is important, so we can avoid 'things that trigger events'
- Both care and positive behavioural support (PBS) plans are used in the clinical areas we investigated
- Wellbeing plans are used effectively in acute mental health services
- Care Plans support effective communication, medication management, alternative strategies, distraction, and work with a therapist
- The effective tools and techniques staff use to de-escalate and provide support include:
  - soft words
  - a 'calm down' box
  - 'Getting to know you' (Safewards)
  - a multi-sensory room, distraction activities combined with a supportive de-brief
  - bad news mitigation and talk down (Safewards)
  - engaging with and listening to the service user.

Child and Adolescent Mental Health Services (CAMHS) support through keyworker sessions using 'Who am I?' sheets, 'Getting to know you', and the use of positive words (Safewards). A key area of development was allowing the young person to RAG (Red, Amber Green) rate themselves after an incident by wearing a coloured wrist band to signal how they are feeling (i.e. green wrist band = 'I'm ok').

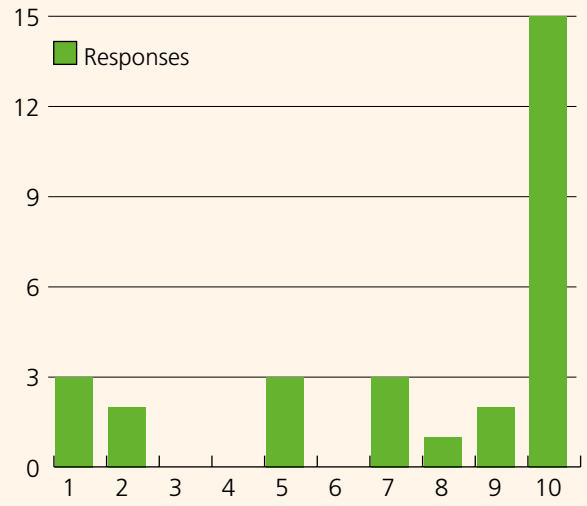
Key messages from the pilot interventions

Theme:	Comments
• Identification - times and situations in which incidents most likely to happen	• Fixed days identified, allowing targeted review • Focus on flashpoints, review of interventions • Highlight busy times and highest time for risk, which may impact on safety • Additional resources, post ward round, meal times, twilight periods or school holidays for Child and Adolescent Mental Health Services (CAMHS) • Visual data acts as a focus and supports thinking and 'hunches'.
• Clusters of events, happening at the same time, or on fixed days	• The visual display of the crosses has allowed a better understanding about "aggression" or "behaviours that challenge" in the unit; it's not happening all the time • Carers gave input on visual response to support service users.
• Huddles allowed for brief communication on safety issues at peak times of concern	• Huddles can be increased, dependent on needs, help team feel in control, share ideas and agree best approach • Health Care Assistants describe being empowered and more involved in care • During challenging situations shift leader acts as team leader • The huddles made the team feel that "they were always in control"; when service users' behaviours changed, staff would readily form another huddle • Huddles allow all team members "to share ideas and to come up with the best plan". They are quick and effective • Safety huddles have proved popular: there are at least 2 per day. During a recent emergency admission, one team were also using ad hoc huddles as the acuity had increased significantly. They used huddles between three and five times per day.

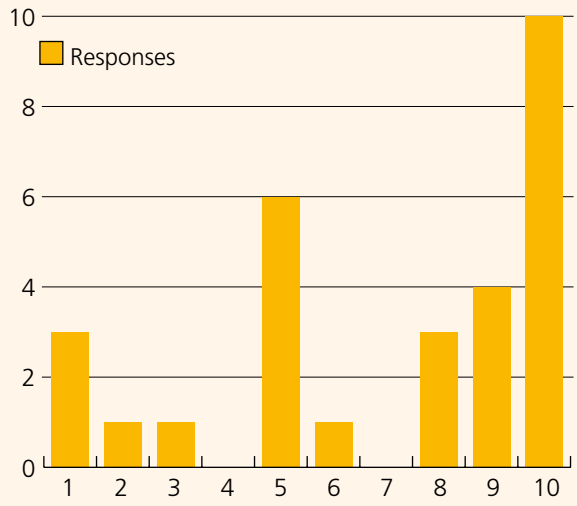
Our next step will be to scale up the use of safety huddles across all wards, using trigger risk assessments/criteria to activate the use of safety huddles.

We also aimed to measure the experiences of people using inpatient services. 52 service users agreed to participate in our survey. It was carried out by the Learning Disabilities and Forensic Practice Governance Team across selected wards. A majority of service users reported that they felt more safe when with staff.

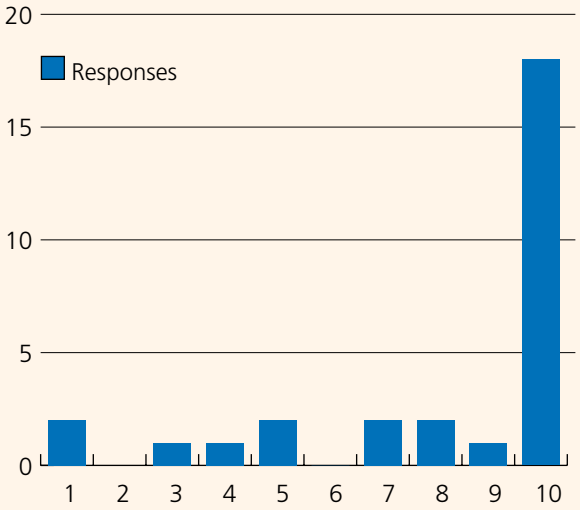
Q1. Do I feel safe when I am on my own?



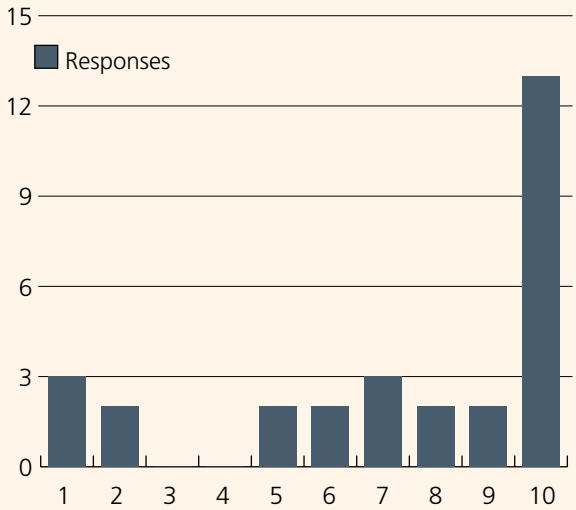
Q2. Do I feel safe when I am near other patients?



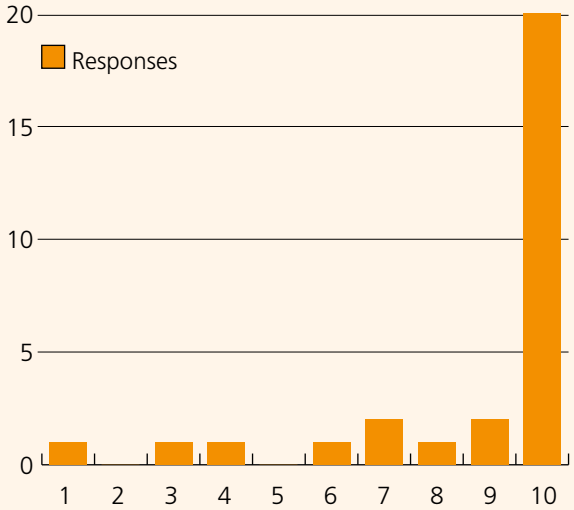
Q3. Do I feel safe when I have staff with me?



Q4. Do I feel safe on the ward (shared areas?)



Q5. Do I feel safe when people visit me?



2. Over prescribing of medication within learning disability services (STOMP)

As a result of the NHS England call to action regarding the overprescribing of psychotropic medicines in people with learning disability and/or autism who do not have a documented mental health diagnosis (STOMP), our Pharmacy and Medicines Optimisation Team together with the learning disability psychiatrists, have implemented the following:

- Developed a factsheet for healthcare professionals outlining information about the de-prescribing of antipsychotics in people with learning disability without a documented mental health diagnosis
- Developed a 'SMART' database to establish the baseline of psychotropic prescribing and to track the de-prescribing (or reduction/withdrawal of medication) of these medicines following each outpatient appointment.

The key performance indicator (KPI) consists of the number of service users currently undergoing the de-prescribing process. We have also documented reasons for not currently de-prescribing and how it contributes towards qualitative analysis. The database is not yet complete and therefore the data is currently unavailable.

3. Service user Practitioner Information Knowledge Excellence (SPIKE)

- SPIKE is our new reporting tool for the Trust, which went live on 16/01/17. It is one place stop for all information and reporting requirements. The vision is to have all information under one roof. The data on SPIKE is updated on a daily basis (7pm as of previous day).

"For me, SPIKE has proven extremely useful, in the past I would physically count the duty desk for the number of cases sitting in SPA which would usually take up to 90 minutes with all the filtering and sorting needed now it takes just a few minutes to run the report. A huge plus for me in time saving and accuracy of data"

SPA Administrator

Concurrent users

346,981+
Views or
report clicks

> "Managers use SPIKE during supervision to review staff performance on various aspects. SPIKE has made it easy for them to have these discussions"
>
> **Service Line Leader**

As part of our Good to Great strategy and on the success of SPIKE, we have agreed to invest and tackle the use of data and information within the Trust to the next level, therefore SPIKE version 2. This version will be rolled out during 2018/19 with different phases.

We will be using the best enterprise software in the market - Open Source – and will be one of the very few Trusts within the NHS sector to fully 'Go-live' using Open Source as platform for Business Intelligence purposes.

The data will enable us to minimise data accuracy issues and building a single data warehouse including data from all systems.

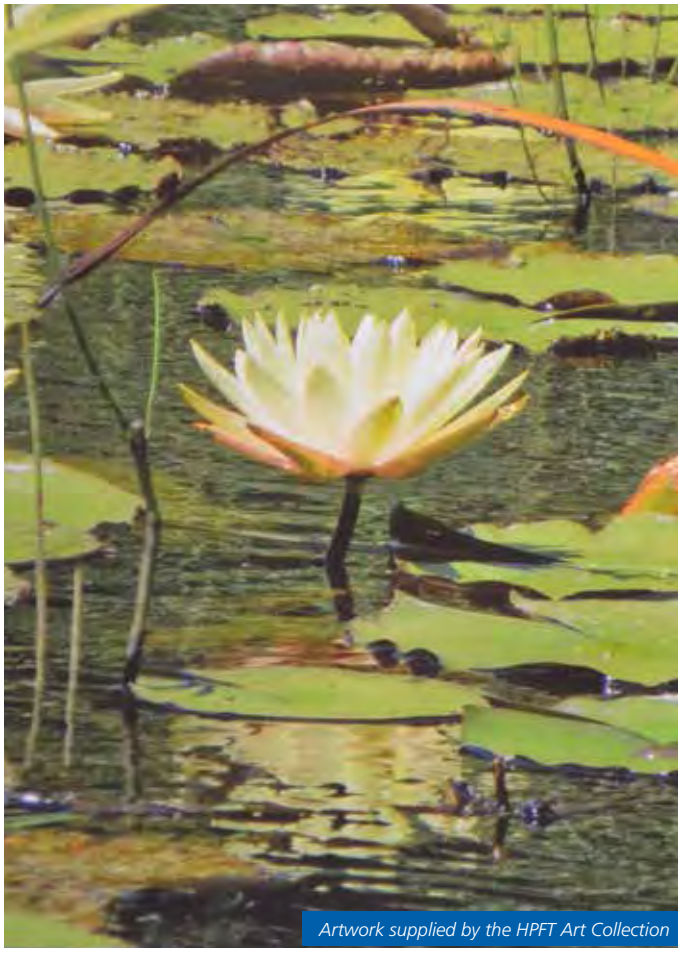
A wide range of reports that cover all information needs are available, which are highly interactive and accessible online. Some examples include:

- Service user dashBoard: Explains the journey of a service user within the Trust. Also includes past interactions with us
- Staff dashBoard: Tailor made dashBoard for staff from each profession, telling them at glance who they are responsible for and their status.

4. Delayed Transfer of Care (DToC)

By taking a cross-service approach to managing the flow of service users through the acute pathway, there has been a positive reduction in the number of people considered Delayed Transfers of Care and the number of resulting bed days lost.

A weekly system call reviews all service users either on the DToC list or whose predicted date of discharge is within the next week. This is to ensure plans are on track, that each adult treatment ward has a weekly bed monitoring meeting involving the inpatient team, bed management team, community and crisis teams and senior operational managers to oversee planning and progress using the principles of Red to Green. Also reports have been made available within SPIKE, our online performance monitoring system, for the community teams to see at a glance which service users are in a bed to support local multi-disciplinary team discussions. A series of Standardised Operating Procedures have been rolled out for community and inpatient staff to clarify roles, responsibilities and expectations relating to flow through inpatient services.



Artwork supplied by the HPFT Art Collection

5. New Single Point of Access (SPA) operating process/model

The Single Point of Access (SPA) is the telephone clinical triage service for all new referrals into the Trust. It was set up in 2013 to create a single point of contact to access our mental health care services.

The SPA team's target is to screen and triage referrals within 14 days of receipt. Early in 2017/18 the team's performance slipped, meaning service users were waiting longer than expected. To improve the performance of SPA this year, we have:

- Recruited to posts to ensure the team was stable
- Redesigned key leadership posts to refocus the team's performance. So, two of posts now require call centre management skills and knowledge together with an understanding of how data can be used to help predict demand, set standards and assess team performance against these standards
- Introduced team training posts to ensure that our team are well trained, skilled and knowledgeable
- Designed and implemented changes to the IT/telephony systems so our staff can respond to referrals in a timely manner and unnecessary administration is reduced.

The SPA team's current performance against the 14-day target (aiming for a target achievement of > 95%) in quarter 3 and quarter 4 of 2017/18 is:

Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
99.91%	99.95%	99.95%	99.67%	99.72%	97.80%

The people referred into our services now have their needs considered in a timely manner and their cases are passed quickly to community teams who carry out an in-depth assessment and agree a plan of care.

Throughout 2018/19, we intend to develop the SPA service further by:

- Implementing further changes to our IT/telephony system to further improve efficiency. Eg, we are planning to make some of our forms self-populating, and for our system to recognise caller ID to enable quick access to service user records
- Introducing an improved clinical triage tool to help our SPA clinicians ensure service users are referred to the appropriate clinicians and that treatment plans are implemented after initial consultation
- enabling SPA to provide intelligence data to the receiving community teams to help them understand and meet the referral demands for their areas.

6. Early Memory Diagnosis and Support Services (EMDASS)

We have provided Early Memory Diagnosis and Support Services (EMDASS) in Hertfordshire since 2011. Nationally, expectations are that service users receive their assessment and diagnosis in a timely way, enabling them to start treatment as soon as possible they have the best chance to live well with their dementia diagnosis. In 2017, EMDASS remodelled their memory service by implementing a One Stop Model in both the Northwest and East areas, using a single appointment system.

- The Single Point of Access (SPA) receives a referral from a GP
- SPA send it to the EMDASS nurse within 48 hours
- The nurse contacts the service user and performs an initial assessment over the phone, checking that
  - EMDASS is the right service for the individual
  - they can attend the One Stop Clinic
- If they can, an appointment is made for them to attend the clinic
- If they can't attend, we arrange an appointment at their home.

The benefits of the One Stop pathway:

- Improved service user/carer experience
- Immediate post-diagnostic support (PDS)
- Single appointment system delivering assessment and diagnosis
- Efficient and effective pathway aiming to reducing waiting time by 50%
- Service users seen and diagnosed within 6 weeks of referral, supporting the Five Year Forward View
- Nurses' role extends to give non-specific dementia diagnosis.

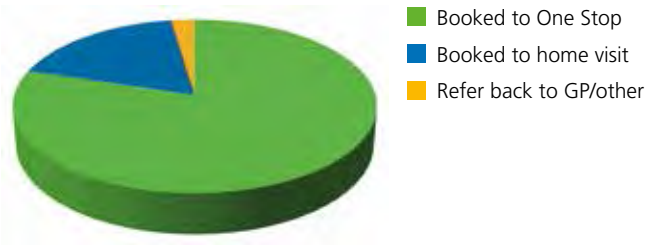
During the appointment, the service user and carer also receive initial post diagnostic support and are signposted towards further care and support. Results from the pilot in the Northwest shows we are consistently delivering appointments within 6 weeks of referral in at least 80%, and up to 92% of cases. Service users have given positive feedback. In a small survey of those who attended the One Stop clinic:

- 87.5% rated their overall experience as good
- 87.5% felt that the sensitive way in which their diagnosis was disclosed to them was very good.

> "It was nice that it was all done in one visit".
>
> **Service user**

Triage Outcome

Chart 1 - NW One Stop - Triage Outcome



Referral back to the GP at triage stage was associated either with the service user already having a dementia diagnosis or declining the offer of assessment and diagnosis at the triage stage. Each of the 4 EMDASS teams have all been accredited by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). This means that the teams have been measured against a set of national quality standards to check that the right things are in place to encourage good quality care.

Next Steps in 208/19

- GP with special interest Memory Clinic Pilot. This initiative forms part of our integrated working across the NHS boundaries and enabling GPs to work in partnership with us to diagnose and treat people with dementia within the primary care setting. A pilot project started in May 2018 in the Lower Lea Valley area. Two GPs are delivering this pilot service
- One Stop Pathway. Full implementation of the One Stop pathway
- Partnership working: Build on the services after diagnostic support through integrated work with the local Alzheimer's Society.

7. Carer Pathway

To increase the numbers of carers being identified and improve offers of carer support (including carer assessments) whilst embedding the Triangle of Care principles

What is the Triangle of Care?

The Triangle of Care is an alliance between service user, staff and carer that promotes safety, supports recovery and sustains wellbeing.

The Care Act 2014 clarified and enhanced the rights of carers in relation to their own support and wellbeing (independent from those they care for). Our carer pathway was co-produced and launched in 2016. Over the past year there has been a closer focus on scrutinising performance of teams. Additionally, all providers in Hertfordshire have since adopted our carer pathway focused around the following five principles:

1. Carers are identified
2. Carers are welcomed
3. Carers are supported
4. Carers are involved
5. Carers are supported through service changes/transitions.

In 2017/18, we

- Focused on embedding the carer pathway across our community services
- Met our target of offering 50% of carers a needs assessment within the previous 12 months by 1 April 2018 (our adult services achieved 53.8%, our older aged adult services, 71.3%). The biggest improvement was seen in quarter 4 after targeted work with teams addressing performance issues.
- Focused on ensuring all teams were working within Carer Pathway processes.
- Worked to increase the numbers of carers we are identifying.

We note when a carer assessment has been offered and accepted or declined on the service user's Paris record, and also combined this with data where an assessment was provided in the past 12 months, but no offer recorded. This helps ensure a more accurate overview of performance. Over the year we achieved a 41% increase in new carers identified (compared with the previous year).

The next 12 months will see:

- Further implementation of the pathway across community services
- A stronger local focus on the Triangle of Care through locality based practice groups focused on carer services
- All community teams recruiting new Carer Support and Wellbeing Workers.

Our audit schedule for 2018/19 includes an audit focused on the Triangle of Care and its impact within services. Our targets for increasing offers of assessments to carers are:

- Quarter 1 – 60%
- Quarter 2 – 70%
- Quarter 3 – 80%
- Quarter 4 – 90%.

8. Peer Experience Listeners work

To develop opportunities for gathering qualitative feedback from service users and carers: people with lived experience conduct semi-structured interviews. We developed the Peer Experience Listening Service (PELS) to provide an alternative way of gathering feedback from service users. We recruit and train volunteer Experts by Experience (EbE) who have a lived experience of mental illness, teaching them to conduct semi-structured interviews with current service users.

The programme is both directed and delivered through co-production: with departments including Practice Audit and Clinical Effectiveness (PACE) and Strategic Business Units' practice governance. Targets for peer listening are set on an individual basis depending on the project. These can vary from the numbers of interviews conducted, to the impact of the findings on improving quality of services. Overall, the programme aims to provide a varied programme of feedback led by people with lived experiences. Our target for 2017/18 was to complete projects gathering feedback on:

- Street Triage
- Host Families
- Safety on wards
- Improving the responsiveness of community services.

85 semi structured interviews were conducted across all projects during the year. By 1st April 2018, we had completed all data collection. In March 2018, PELS was included as a case study in Valued care in mental health: Improving for excellence a quality improvement guide published by NHS Improvement .

The next 12 months will see

- Further development of projects
- Revisiting key pieces of work to see if findings have affected service quality.
- A project focusing on quality around initial assessments
- A project exploring the quality of Rapid Assessment, Interface and Discharge (RAID) services.
- Discussion amongst EbEs to decide which areas to focus on for the rest of the year.

9. Staff engaged and motivated

We have maintained our commitment to staff engagement, and value the input of all staff at all levels. We have a planned programme of events throughout the year sponsored and delivered by our Executive Team to ensure staff can participate effectively in making key decisions. These events capture staff ideas and feedback. This is then collated, analysed and reported in a 'you said we did' summary to which all staff have access.

Engagement events for the year included the Big Listen events and Local Listen events in Buckinghamshire, Essex and Norfolk. These are open to all staff and give our Executive Team the opportunity to hear employees' views on key topics and priorities, informing actions and improving employee satisfaction and wellbeing.

Examples of activity resulting from feedback at Big Listen events are:

- More health and wellbeing activities – including mindfulness sessions –delivered locally
- Locally delivered Schwartz rounds (these provide opportunities for staff to reflect on the emotional aspects of their work)
- A review of all hub working environments
- Recruitment of more staff.

The Senior Leaders' Forum brings together the top 70 leaders from across our organisation regularly throughout the year for a multi-disciplinary, strategically focused engagement session, including joint problem solving and development topics. Our Chief Executive holds breakfast meetings to which he invites different groups of staff so they can:

- Express their views
- Describe their experiences of working for the Trust
- Suggest ways in which we can improve the quality of care for service users.

Our Executive Team have also held face-to-face engagement sessions with staff across the Trust. These

- Focus on the development of the Trust Strategy 'Good to Great
- Enable staff to discuss issues with our Executive Team and provide feedback on the five areas of interest so that we can go from 'Good to Great'. These five areas are service user and carer experience, staff experience, innovation and improvement, adds value and relationship and partnerships.

As well as these face-to-face engagement events and the national staff survey, we hold quarterly 'pulse surveys' to review staff satisfaction levels. We analyse the survey responses and they are reported to our Trust Board. The themes from this anonymised data inform local activity and plans.

Safeguarding adults and children at risk of abuse or neglect

In line with our strategy of delivering 'Great care, Great outcomes – Together' our Safeguarding Team aims to improve the quality of safeguarding practice so we can prevent harm and enable safety through:

- Vigilance
- Competence
- Personalised outcomes-focussed practice.

2017/18 has seen an increase in safeguarding activity for both adults and children. This is in response to increased awareness and action locally and nationally, particularly in the areas of:

- Historic child sexual abuse
- Domestic abuse
- Radicalisation.

To improve our vigilance and competence in recognising and responding to potential abuse and neglect, we:

- Reviewed mandatory adult and child safeguarding training for all staff in all areas during quarter 1 of 2017/18
- Introduced enhanced training for all clinical staff.

- Require non-clinical staff to undertake safeguarding training (e-learning).

Because the Trust now works across four counties, the Safeguarding Team has been expanded. It has also taken on additional responsibilities for specific groups including looked-after children and care leavers, and for risk areas (radicalisation). With the establishment of a new leadership team, additional team staffing resources and a clear vision for safeguarding to improve towards, 207/18 has laid the foundations for a focussed improvement in all aspects of safeguarding.

Spot the Signs and Save a Life

This suicide prevention initiative is delivered in collaboration with the two Mind organisations in Hertfordshire. It concentrates on training people in Herts who come into contact with those who may be in crisis and thinking about ending their lives.

Nationally, about two-thirds of people who kill themselves have not been in touch with mental health services in the weeks and months before doing so, and so it is important to try to build bridges and create opportunities for them to connect. Almost 200 GPs have participated in training sessions. During 2017, 700 staff from other public and private sector organisations have also attended.

The training aims to break down the myths that sustain the silence which leads to suicide. The suicide rate in the UK had been growing over the last few years but data for 2016 suggests a downturn and there are some strong indications that this is due in part to initiatives like Spot the Signs.

Safer Systems in Mental Health

In October 2016, a group involved in our Health Foundation Project learning from the aircraft industry about analysing systems and identifying hazards, started a new 12-month project to look at other areas within the crisis teams and Acute Day Treatment Unit (ADTU) services identified as potential hazards. We had already implemented a follow-up care call and a moving on plan in those services. Involving clinicians, service users and carers, we revisited our original maps of the services and carried out further safer systems analysis.

We all agreed it would be beneficial to look at how the crisis teams and ADTU work with carers. Our current project is "Improving Collaborative Working with Service Users' Support Networks". We surveyed crisis team staff about their knowledge and understanding of working with carers and confidentiality, and then co-produced a training package and posters to be delivered by service users and carers with clinicians.

The 2016 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness identified that a third of suicides in the community could have been prevented by involving a person's support network. Our aim is to give staff the confidence to work collaboratively with service users' support networks and understand what confidentiality allows so we can improve outcomes and reduce future deaths.

Absent Without Leave (AWOL)

The West Strategic Business Unit (SBU) led on a quality improvement initiative with a focus on improving on time return from section 17 leave. The Strategic Business Unit (SBU) produced a project plan which included visits to discuss and observe the management of leave with the allocated Security/Safety Nurse and Team Leader on the inpatient wards reporting the highest number of AWOLs.

On review of the AWOL incident data, the following actions, opportunities for improvement and learning were identified:

- Asking a carer to accompany the service user to the reception area to ensure they return safely at the agreed time
- Adding the time of return and the reason for not returning on time to the electronic patient record if a service user does not return from leave at the agreed time
- Considering the leave length and conditions when agreeing these with the service user, to ensure sufficient time to get to and from the agreed destination within the agreed leave period
- Reminding service users and carers where appropriate of the conditions of leave prior to them leaving the ward. This is an opportunity for service users to be made aware that staff may worry if they don't return at the agreed time. We have produced a leaflet for service users on this subject
- Checking the service user has a working, charged mobile phone and that the correct number is on the electronic patient record before the service user's leave starts.
- Using two-way radios during periods of escorted leave to aid timely communication with the ward should a problem arise or if an AWOL incident occurs.

The next phase of the project is to further engage all multi-disciplinary team members in the AWOL project.

Workforce

National NHS Staff Survey results for 2017

Our 2017 National NHS Staff Survey findings show further improvements, building on our a progress since 2015:

- 13 of the key findings are above average across Mental Health Trusts
- 16 average
- 3 below average
- 90% of our scores are in line with or above the national average across Mental Health Trusts.

Top five ranking scores (against other Mental Health and Learning Disability Trusts).

Top 5 ranking scores				
	2016	2017		Trust Improvement/ Deterioration
	Trust	Trust	National Average	
Effective use of service user feedback	3.78	3.88	3.72	Improvement
Quality of non-mandatory training, learning or development	4.18	4.14	4.06	Deterioration
Staff motivation at work	4.05	3.97	3.72	Deterioration
Staff confidence and security in reporting unsafe clinical practice	3.80	3.80	3.71	No change
Staff recommendation of the organisation as a place to work or receive treatment	3.84	3.85	3.67	Improvement
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	88%	85%	85%	Deterioration

Bottom 5 ranking scores				
	2016	2017		Trust Improvement/ Deterioration
	Trust	Trust	National Average	
Percentage of staff working extra hours	79%	76%	72%	Improvement
Percentage of staff experiencing physical violence from staff in last 12 months	2%	3%	3%	Deterioration
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	23%	24%	21%	Deterioration
Support from immediate managers	3.87	3.89	3.95	Improvement
Percentage of staff experiencing discrimination at work in the last 12 months	16%	17%	14%	Deterioration

The lowest five ranking scores are listed above and relate to errors and incidents, staff experience of bullying, harassment and violence from service users and members of the public, and staff working additional hours. Lowest five ranking scores (against other Mental Health and Learning Disability Trusts)

Our Pulse Survey

Every three months we run a survey, based on the National NHS Staff Survey questions, giving us consistent quantitative feedback from staff on their experience with the Trust. Scores indicating whether staff would recommend the Trust as a place to work or receive treatment are at an all-time high. They have improved by 30% over the last three years.

We will review the Pulse Survey during 2017/18 in the context of our new Organisational Development Strategy.

Health and wellbeing

In 2016/17 we introduced our Staff Health and Wellbeing Strategy. It focuses on providing consistent, evidence-based and evaluated wellbeing support to staff. We have also established a Health and Social Committee with representatives from each locality.

The Committee's remit is to:

- collect local intelligence about wellbeing needs
- communicate our initiatives
- encourage involvement in our initiatives.

In 2017/18, we ran team challenges, provided mini-health checks and piloted mindfulness programmes in four locations. Following evaluation this will be rolled out across the Trust.

Staff engagement

We continued with the staff engagement calendar, including:

- the Big Listen
- Inspire Awards
- Annual Staff Awards
- Chief Executive Breakfast meetings.

Over 200 staff, managers and Board members attended our Staff Awards ceremony on 30 November 2017, at Tewin Bury Farm. This year, we developed 'Local Listens' which take place shortly after the 'Big Listen', and occur locally at outlying sites such as Little Plumstead in Norfolk and Lexden in North Essex. The purpose of these is to provide additional opportunities for staff who may find it difficult to attend a Big Listen to speak directly to our Executive Team about issues that matter to them. A number of initiatives have arisen from our engagement events, including the creation of a Trust Leadership Academy, a Service Line Leader Development programme and the Staff Health Checks that are taking place across the Trust.

Collective Leadership

The Trust completed the discovery phase of the Collective Leadership programme during 2016/17. The project team, known as Lead Ambassadors, presented the findings to our Board in June 2016. Subsequently, the Lead Ambassadors participated in a Culture Workshop with members of the Board and Senior Leaders in the organisation.

The purpose of the workshop was to utilise Collective Leadership

findings and other available staff engagement intelligence to describe the next phase of our culture. This has been used to inform the Good to Great Strategy and the Organisational Development Strategy.

Leadership development

We continue to provide leadership development through our Leadership Academy. In addition to the Leaders and Emerging Leaders programmes, a new programme was developed this year, targeted at Service Line Leadership by our Chief Executive and Deputy Chief Executive. This programme was developed as a result of conversations within a Chief Executive breakfast meeting with Service Line Leaders and is co-produced with the attendees.

Additionally, we continue to provide the Managing Service Excellence programme – a management training programme targeted as a refresher for existing managers and a practical

course for new managers. We are working with neighbouring NHS Trusts within the Sustainability and Transformation Plan footprint into delivering a local version of the NHS Leadership Academy Mary Seacole Programme, of which this financial year cohort will commence during 2017/18.

We have continued to invest in our Senior Leaders Forum, which enables the top 70 leaders in the organisation to hear key messages directly from the Chief Executive and to work on key cultural and operational issues.

The table below shows how many staff benefited from each programme in 2017/18.

Senior Leaders Forum	70
HPFT Leadership Academy – Service Line Leaders	16
HPFT Leadership Academy – Leaders	19
HPFT Leadership Academy – Emerging Leaders	23
NHS Leadership Academy – Mary Seacole	5
HPFT Managing Service Excellence	56

Learning and development

As a University Trust, we recognise the importance of investing in our workforce to continue to deliver the right care in the most effective way, based on a sound evidence base and continuing professional development.

We provide opportunities for our staff to develop their full potential through defined career pathways. This is a core component of the NHS constitution on which we are focused. Continuing professional development (CPD) is an important requirement for professional and medical occupations within the Trust and is prioritised each year using an organisational training needs analysis working with partners such as the University of Hertfordshire, the University of Bedfordshire, Anglia Ruskin University and the University of Essex to deliver programmes of learning to enable our staff to provide the best support to service users.

153 staff have accessed short courses such as Physical Health Monitoring, Dementia, Asperger's Awareness and the popular Clinical Supervision.

30 staff attended Preparation for Mentorship module.

26 staff are currently on a pathway of study towards a BSc and an MSc and we currently have 41 people waiting to start.

A bespoke Care Coordination Training programme was developed and delivered by the University of Hertfordshire during 2017/18 and 100 staff were trained.

We have also supported 33 individuals to pass the NHS Leadership Academy Mary Seacole Programme and a total of 178 up to and including the current cohort 9 of our Leadership Academy.

Statutory and mandatory training

Over the last year, we have developed and then continued to streamline our mandatory courses and saved over 21,000 hours that can be re-focused on direct clinical care and related activities. Our induction programme was attended by over 500 new employees in the last financial year, giving them an early insight into our values and expectations.

Back to Basics training for independent assessors and frontline community clinicians

Two days in March 2018 have been booked for refresher training.

HEEoE Quality Performance Review

The first Highlight Summary Risk Report was submitted to HEE in January 2018.

Mock CASC Exam

For the first time we opened this event to all core trainees in the East of England region and was advertised by HEEoE and took place on Monday, 8 January 2018.

Library Services

Library and Knowledge Services hosted a two day conference on 'Dementia' which we collaborated with the University of Hertfordshire, Hertfordshire Public Libraries, and other Trusts in our region as well as Dementia Friends and our Research and Development team to form an informal partnership.

The Library subscribes to 'Knowledge Share', an alerting service for specialist area of interest. Updates are personalised and targeted to individuals. The updates focus on the evidence that can change practice and provide links the latest article, websites, reports and guidelines in chosen areas.

Our Library was assessed through the Library Quality Assurance Framework (LQAF) which correlates to the strategies of Health Education England's (NHS Library and knowledge services, 2017) and for the third year running obtained 94%.

Apprenticeships

We are now investigating additional Apprenticeships for all bands of our staff to enable upskilling the workforce. Since the start of the Levy in April 2017, we have engaged three independent providers to provide Adult Care Level 2 and Lead Adult Care Level 3, Business Administration and Medical Administration Apprenticeships. We are in the process of procuring another training provider to deliver Customer Service Apprenticeship Level 2 and Level 3 for receptionist and staff working in our Single Point of Access (SPA). The Nursing Associate Apprenticeship will commence in May 2018 with a further intact in September running alongside a Nursing Degree Apprenticeship. Other future Apprenticeships are being discussed but we are awaiting the standards to be agreed and then further providers identified.

Name of Priority	**11. Staff Experience Friends and Family test**			
Related NHS Outcomes Framework Domain and who will report on	4: Ensuring that people have a positive experience of care. All trusts. The primary purpose of staff Family and Friends Test (FFT) is to support local service improvement work.			
Data Definition	The FFT is a feedback tool which allows staff to give their feedback on Trust services. The FFT asks how likely staff are to recommend the services they work in to friends and family who may need treatment or care and also as the employer of choice. Participants respond to FFT using a response scale, ranging from "extremely unlikely" to "extremely likely". They also have the opportunity to provide a free text comment after each of the two FFT questions. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. This question is in the Trusts Pulse survey This is also an NHS England statutory submission.			
How this data will be collated	Staff FFT data is to be collected and submitted quarterly for Q1, Q2 and Q4 after the end of each quarter. For Q3 (when the annual NHS staff survey is undertaken).			
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	70.4%	68%	67%	74.9%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	76.98%	77.4%	76.1%	75.3%
Performance in Q1 to Q4 in 2015-16	**Q1**	**Q2**	**Q3**	**Q4**
	63.7%	62.3%%	70.7%	72.5%
Target	Staff Friends and Family Test (FFT) – recommending Trust services to family and friends if they need them >=70%.			

Name of Priority	12. The percentage of staff recommending the Trust as a place to work			
Data Definition	As stated above the FFT is a feedback tool which allows staff to give their feedback on Trust services. To measure this target the Trust will follow the process described above. The percentage of staff that would recommend the Trust as a place to work. This is an NHS England statutory submission.			
How this data will be collated	Staff FFT data will be collected and submitted quarterly for Q1, Q2 and Q4 after the end of each quarter. For Q3 (when the annual NHS staff survey is undertaken).			
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	56.1%	62.4%	66.6%	64.1%
Performance in Q1 to Q4 in 2016-17	**Q1**	**Q2**	**Q3**	**Q4**
	69.0%	67.8%	68.8%	65.8%
	How likely are you to recommend HPFT to friends and family as a place to work?			
Performance in Q1 to Q4 in 2015-16	**Q1**	**Q2**	**Q3**	**Q4**
	51.2%	49.6%	56.4%	55.6%
Target	>/=55%.			

Compliments, comments and complaints

We place great value on the comments, compliments and complaints sent in by service users, their carers, relatives and friends. We encourage people to raise concerns with staff on the units, to use the comments, compliments and complaints leaflets available on all wards and outpatient units. Alternatively they can complete a form on the Trust website at http://www.hpft.nhs.uk/contact-us/compliments-and-complaints/online-form/ or call our dedicated phone line 01707 253916.

We also invite all service users and carers to provide ongoing feedback on their experiences by completing *Having Your Say* forms or Friends and Family Test postcards, either on paper or electronically, during their recovery journey. Service Experience Volunteers visit our adult acute inpatient and rehabilitation units to provide an impartial listening ear as well as support for service users and carers providing feedback through *Having Your Say.*

What is the NHS Friends and Family Test (FFT)?

The NHS Friends and Family Test (FFT) was created to help service providers like the Trust understand whether service users are happy with the service we provide, or where we need to improve. It is a quick and anonymous way to give views after receiving care or treatment.

What we do with compliments, comments and complaints

We use information received through comments and complaints, together with the outcomes of any investigations to improve our services. We work closely with the Safer Care and Practice Governance Teams to ensure that lessons learnt are turned into action plans to change and develop practice. Each quarter, every team is required to produce a 'you said, we did' poster based on all the feedback they have received, sharing what they will do to improve the service with those who have taken the time to provide feedback.

We also feel it is important to celebrate what we do well, and all teams are encouraged to send details of compliments received to the Patient Advice and Liaison Service (PALS) and Complaints Team to make sure we capture the overall picture of service users and carers' experiences. We record all the compliments we receive and these are published in the e-magazine for staff. Satisfaction levels are monitored through Having Your Say and FFT.

Patient Advice and Liaison Service (PALS)

PALS provide people with advice and assistance if they have a concern or enquiry. This year we received 861 contacts - an increase of 13% on last year. The table below shows the number and main categories of PALS contacts, comparing 2017/18 with 2016/17, 2015/16 and 2014/15. As in previous years most contacts raised issues for resolution by the PALS team or, more commonly, by the clinical teams. This year we have added a new category of contact: 'informal complaints', which explains the reduction in the number of 'issues for resolution'

We are also being more rigorous about defining comments as feedback, which has meant an increase in contacts in that category compared to previous years.

Number of PALS contacts and main categories

Category	2014/15	2015/16	2016/17	2017/18
Advice	12	41	40	67
Enquiry	70	67	140	176
Feedback	76	98	100	240
Issues for resolution	387	363	446	183
Informal complaints	-	-	-	135
Other	0	0	1	0
Translation request	1	1	0	1
Non HPFT	16	36	32	59
Total	**562**	**606**	**759**	**861**

Formal complaints

When we investigate complaints we aim to provide a fair, open and honest response, and to learn from them, so service users and carers can benefit from the resulting changes. The number of complaints received in 2017/18 was 206 compared to 250 received in 2016/17. This is an 18% decrease. The table below shows the number of complaints categorised by the main issue each complaint focused on, comparing 2014/15, 2015/16, 2016/17 and 2017/18.

Category	2014/15	2015/16	2016/17	2017/18
Assault / abuse	11	11	3	3
Clinical practice	92	98	93	89
Communication	23	39	35	24
Environment etc.	7	3	2	4
Staff attitude	30	29	31	26
Security	0	3	0	6
Systems & Procedures	83	84	84	54
Transport	2	2	2	0
Total	**248**	**269**	**250**	**206**

Emerging themes

Some PALS 'issues for resolution' and 'Informal complaints' are transferred to the formal complaints process, either because they cannot be resolved within one working day, or because they raise the serious issues. Most issues and enquiries are dealt with immediately, or very quickly, by the clinical teams and do not result in a complaint.

The 89 complaints where clinical practice was the primary issue fell into 12 sub-categories. The majority of the complaints fell into the following groups:

- Direct care (38)
- Assessment and treatment (17).

The 54 Systems and Procedures complaints fell into 14 sub-categories. Most complaints were in the following groups:

- Access to treatment (19)
- Confidentiality Breach (11)
- Direct Payments (4)
- Discharge (4)

The 3 complaints of alleged assault were about

- use of restraint (under investigation and subject to safeguarding)
- alleged physical abuse to a service user by another service user (partially upheld)
- a service user being verbally abused by another service user (partially upheld).

All allegations were carefully considered by the multidisciplinary team, and through safeguarding where appropriate. During 2017/18, we received 7 requests for files from the Parliamentary and Health Services Ombudsman (PHSO)/Local Government Ombudsman (LGO):

- 3 decisions were received with no further action
- 4 complaints remain under investigation.

We were also notified of 1 complaint referred to the PHSO and which they decided not to investigate as it is out of time (we were not previously aware that the complainant had taken their case to the PHSO).

Compliments

All teams are asked to forward letters of thanks from service users, carers, advocates and visitors to the PALS and Complaints Team so that they can be logged and reported. In line with increased numbers of other contacts there has been a 3% increase in the number of compliments forwarded to the team.

Year	Compliments
April 2011 – March 2012	674
April 2012 – March 2013	673
April 2013 – March 2014	942
April 2014 – March 2015	1262
April 2015 – March 2016	1622
April 2016 – March 2017	1915
April 2017 – March 2018	1981

In 2017/18, we recorded nearly 10 times as many compliments as formal complaints.

Clinical Networks

What is a clinical network?

These networks are dedicated to providing assurance and sharing good practice so we can improve the health service for all those who work in and use it.

We are members of the following networks:

- Learning Disability Clinical Network
- Clinical Outcomes and Research Evaluation (CORE) CAMHS
- AIMS Accreditation Scheme (Royal College of Psychiatrists)
- East of England clinical senate
- The Trust is part of the larger Eastern Clinical Research Network (CRN). CRN Eastern is funding two consultant psychiatrist research sessions as well as one consultant psychologist research session.
- The Psychiatric Liaison Accreditation Network (PLAN)
- Quality Network for Forensic Mental health Services (Adult Forensic) Community
- Quality Networks for Community Forensic Mental Health Inpatient
- Quality Networks for Early Intervention Psychosis
- Quality Networks for Child & Adolescent Eating Disorder Community
- Quality Networks for Child & Adolescent Inpatient
- Quality Networks for Child & Adolescent Community
- Quality Networks Inpatients Child & Adolescent Inpatient
- Quality Networks for Peri-natal inpatients
- Quality Networks for Peri-natal community
- Quality Networks for Rehabilitation services Inpatient.

In 2017/18, all our acute assessment and treatment services for people with learning disabilities have been accredited as meeting the standards of AIMS-LD (Accreditation for Inpatient Mental Health Services – Learning Disabilities). We achieved this through

- 3 years of preparatory work
- membership of a quality network
- hosting and leading peer reviews of services nationwide.

Our forensic inpatient services

- belong to the Quality Network for Forensic Mental Health Services
- participate in peer review and annual audit of best practice standards

Our clinicians in learning disability services

- contribute to the development of transforming care partnership arrangements in all our service areas
- have supported the learning disability mortality review programmes by training clinicians as LeDeR reviewers in Norfolk, Essex, and Hertfordshire.

We continue to

- contribute to the regional and national transforming care programme through regional expert reference groups
- work with Health Education England on the development of competency frameworks to create and sustain models of good practice in community learning disability and forensic teams
- support NHS England in the development of service specifications and quality commissioning products through our membership of the regional senate and national clinical reference groups.

CAMHS Eating Disorders Team

The CAMHS Eating Disorder Team has signed up to the QNCC-ED quality network. This currently involves peer reviews but eventually we aim to seek accreditation once we can work together to facilitate this. We have had one peer review so far and are awaiting the report that will highlight actions points for the team to take forward. As part of the peer review system we also review other services and our team have completed one of these reviews.

We also participated in the following accreditation schemes:

Service Accreditation Programme and Quality Improvement Network			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
AIMS Rehab: A Quality Network for Mental Health Rehabilitation Services	Hampden House	Participating	66
AIMS Rehab: A Quality Network for Mental Health Rehabilitation Services	The Beacon	Participating	66
APPTS: Accreditation Programme for Psychological Therapies Services	Health in Mind - North East Essex	Not yet assessed	32
APPTS: Accreditation Programme for Psychological Therapies Services	Health in Mind - Mid Essex	Not yet assessed	32
APPTS: Accreditation Programme for Psychological Therapies Services	The Wellbeing Service	Accredited	32
APPTS: Accreditation Programme for Psychological Therapies Services	Healthy Minds - West Essex	Not yet assessed	32
EIPN: EIPN: Early Intervention in Psychosis Network	Hertfordshire Early Intervention Service	Accreditation not offered by this Network – No longer member	155
MSNAP: Memory Services National Accreditation Programme	Early Memory Diagnosis and Support Services North Hertfordshire	Accredited	75
	Early Memory Diagnosis and Support Services East Hertfordshire	Not yet assessed	
MSNAP: Memory Services National Accreditation Programme	Early Memory Diagnosis and Support Services South West Hertfordshire	Accredited	75
MSNAP: Memory Services National Accreditation Programme	Early Memory Diagnosis and Support Services North West Hertfordshire	Accredited	75
Perinatal: Perinatal	Hertfordshire Partnership Foundation Trust	Member	51
Perinatal: Perinatal	Thumbswood Mother and Baby Unit	Accredited	51
PLAN: Psychiatric Liaison Accreditation Network	Lister RAID (The Lister Hospital and Queen Elizabeth II Hospital)	Accredited	81
PLAN: Psychiatric Liaison Accreditation Network	Watford RAID Team (Watford General Hospital)	Accredited	81

Service Accreditation Programme and Quality Improvement Network			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
QNCC: Quality Network for Community CAMHS	CAMHS Eating Disorders	Participating but not yet undergoing accreditation	42
QNFMHS: Quality Network for Forensic Mental Health Services	Beech Ward (Kingsley Green)	Accreditation not offered by this Network	83
	Eric Shepherd Unit	Accreditation not offered by this Network	83
	Broadland Clinic	Accreditation not offered by this Network	
QNIC: Quality Network for Inpatient CAMHS	Forest House Adolescent Unit	Member	131
QNLD: Quality Network for Inpatient Learning Disability Services	Assessment and Treatment Unit Lexden	Accredited	41
QNLD: Quality Network for Inpatient Learning Disability Services	Dove Ward	Accredited	41
QNLD: Quality Network for Inpatient Learning Disability Services	Astley Court	Accredited	41
QNOAMHS: Quality Network for Older Adults Mental Health Services	Prospect House	Participating	87
QNPICU: AIMS PICU: Psychiatric Intensive Care Units	Oak Ward	Accredited	38
QNPMHS: QNPMHS: Prison Mental Health Service	HMP The Mount	Accreditation not offered by this Network	40

Care Quality Commission

As a Trust, we were registered with the Care Quality Commission (CQC) on 1 April 2010 to carry out the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

We were inspected in April 2015 as part of a planned comprehensive inspection and achieved an overall rating of 'Good'. The report focused on 5 different domains of quality:

- Safe
- Effective
- Caring
- Responsive
- Well-led.

The Trust received the written report in September 2015 and drew up an action plan with a list of 'Must do' and 'Should do' recommendations to address shortfalls that the CQC identified. The Integrated Governance Committee to the Board oversaw the implementation of the action plan and it was formally closed at the Committee meeting on 8 June 2017. We have completed the following actions:

Recruit to fill vacancies, decrease the number of agency staff and increase permanent staff:

- Recruitment and Retention Group continues to focus on initiatives to fill vacancies and decrease the number of agency staff. We have been proactive with our recruitment initiatives and the Trust has made progress with recruitment. The challenge continues to reduce vacancies while we are expanding our First Episode Psychosis and IAPT service and increasing staff numbers in Acute Services and the Perinatal community service
- We started increasing staff numbers in Acute Inpatient Services from May 2016. This is to help with high levels of acuity and to reduce pressures on staff working in a challenging environment. This increase enables services to be managed safely and effectively.

Environmental safety concerns addressed and improvements made. We have:

- Completed the removal of anchor point ligature risks through a planned programme of work. The installation of CCTV in key areas within units has also been completed, reducing the line-of-sight risk

- Redecorated one of our adult acute inpatient units and provided new furnishings, so the unit continues to meet the high standards of other, newer units, supporting the care, treatment and recovery of service users
- Sound-proofed therapy and interview rooms at one of our community hubs to improve the privacy, dignity and confidentiality of service users during sessions
- Created a new purpose built seclusion room in one of our forensic inpatient units, providing an improved and safer environment.

Ensure risk assessments and care plans are up to date, include risk histories and involve carers and service users.
We have:

- Developed our electronic patient (service user) record (Paris) to facilitate the documentation of service user, family and carer involvement
- Improved our initial assessment form and supporting letters now require the inclusion of service users' previous risk history. This is so care plans can include previous risk histories and evidence the service users' and their carers' involvement, so we can provide better care and treatment.

Medicines Management:
We have:

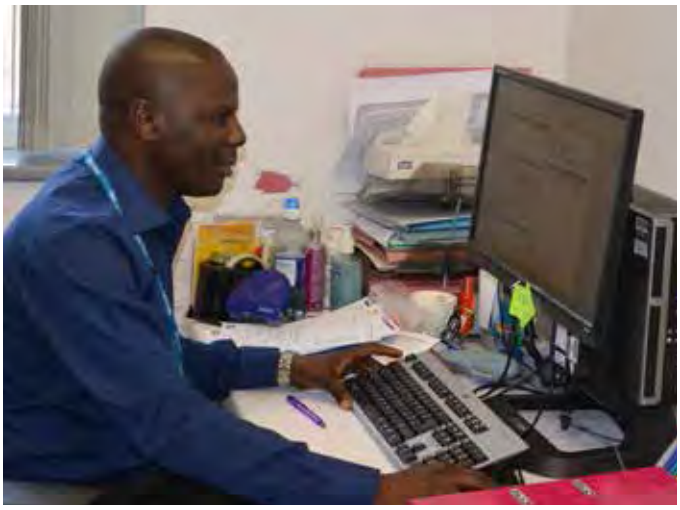
- Developed new Community Prescription Charts so community teams don't have to use inpatient prescription charts. This reduces confusion and improves accuracy of completion.
- Arranged for two identified older people inpatient units and two Rehabilitation units to receive their medicines from the Kingfisher Court dispensary. This provides a safer and standardised process for medicine supply.
- Embedded pharmacy-led Medicines Reconciliation as part of the routine clinical Pharmacy service. It is audited through the quarterly Medication Safety Key Performance Indicators.

Improved focus on Physical Health of service users:
We have:

- Launched our Physical Health Strategy. This aims to address the disparity in life expectancy and physical health outcomes between service users with mental health disorders and the general population.

On 1st November 2017, we were issued with a warning notice under section 29A of the Health and Social Care Act 2008, this was following the CQC's unannounced inspection of the Broadland Clinic (Medium Secure Forensic Inpatient Unit), Little Plumstead Hospital, Norfolk. We took this matter very seriously and implemented a comprehensive action plan to address the concerns raised. We completed this work in January 2018.

In September 2017, we received our Provider Information Request (PIR), this contained a mixture of quantitative and qualitative questions as well as a list of documents that we were required to submit to the CQC. The PIR is a pre-requirement of the Trust's annual CQC inspection which includes an unannounced inspection of core services and an announced inspection.



The unannounced inspection of core services started on 23 January 2018 and lasted 3 days.

The following services were inspected:

- Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units
- Forensic Inpatients wards
- Wards for People with Learning Disabilities or Autism
- Child and Adolescent Mental Health Wards.

The announced inspection started on 5 February 2018 and lasted 4 days. This was a Trust-wide assessment of leadership, governance, management and culture. It involved interviews with Board members and senior staff, staff focus groups, analysis of data, strategic and Trust-level policy documents, and information from external partners. It focused on discovering whether the Trust is well led.

Our Trust has been rated as 'Good' overall. Two core services – forensic inpatient services and wards for people with a learning disability – were rated 'Outstanding'. Full details of the ratings we received are shown in the matrix opposite.

The report included many examples of where staff are delivering good and outstanding care. The CQC saw that our staff are:

- Caring and compassionate
- Proud to work for the Trust
- Dedicated to their roles.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for sevices and using our professional judgement.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement → ← Apr 2018	Requires improvement ↓ Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Requires improvement ↓ Apr 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Forensic inpatient or secure wards	Good ↑ Apr 2018	Good → ← Apr 2018	Outstanding ↑ Apr 2018	Good → ← Apr 2018	Outstanding ↑ Apr 2018	Outstanding ↑ Apr 2018
Child and adolescent mental health wards	Requires improvement → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018
Wards for older people with mental health problems	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Wards for people with a learning disability or autism	Good → ← Apr 2018	Good ↑ Apr 2018	Outstanding ↑ Apr 2018	Good → ← Apr 2018	Outstanding ↑↑ Apr 2018	Outstanding ↑↑ Apr 2018
Community-based mental health services for adults of working age	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Mental health crisis services and health-based places of safety	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Specialist community mental health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community-based mental health services for older people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community mental health services for people with a learning disability or autism	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall	Requires improvement → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018

"We were impressed by the way all staff embraced and modelled the values. The values were embedded in the services we visited and staff showed the values in their day-to-day work CQC Report"

The CQC also recognised that:

- Our leaders and managers at all levels are visible and approachable
- We have a strong emphasis on co-production and good engagement with staff, service users and partners
- Our investment in IT systems and the innovation hub is having a positive impact, enabling us to deliver improved safety and better outcomes for service users.

They also praised our safeguarding and incident reporting for its transparency and the way our teams share lessons learnt.

There are areas where we need to improve and we will be working hard to address these. They include:

- Being responsive to changes in pressures within services
- Making sure that we address all ligature risks
- Reviewing our seclusion and restrictive practices.

We also need to maintain our focus on recruitment and retention to ensure that all services are staffed effectively.

You can read the full report at http:www.cqc.org.uk/provider/RWR/reports

Mental Health Services Data Set (MHSDS) Metrics

The MHSDS data set is a national reporting requirement designed to make sure all mental health service providers improve the accuracy of the data they report.

Our Sustainability and Transformation Plan (STP)

What is an STP?

Across England, NHS and Social care organisations have been encouraged to work together more closely to deliver more effective, joined up and affordable services. The country has been divided into 44 'Sustainability and Transformation Partnerships' or 'STP' areas by the national organisation, NHS England. Hertfordshire and west Essex is one of these 44 STP areas.

The STP for Hertfordshire and West Essex has gained momentum during the year. We now have mental health embedded in every part of the discussion and planning as we transform care and services for young people, adults and older adults. One of STP workstreams focuses on 'frailty'. Our mental health colleagues are providing leadership and influence in this work, so we can aim to meet the needs of people who are frail, and who have physical and mental health problems, including dementia.

The organisations involved in the STP have been developing care pathways for people, particularly for people who are frail. The aim is to provide care pathways that are joined up across physical and mental health services and which take account of the social needs of the person and their family.

We are also in the final stages of developing a template for a single personalised care plan for people. This can be used across all our services, ensuring our care and services are more 'joined up' for the person at the centre.

'Place-Based Care' is also key to us working differently. This means staff work across the usual organisational boundaries, coming together and thinking about how they might best meet the needs of people in a specific location. This has led to some excellent work, including:

- Our integrated multi-disciplinary teams for people with complex needs and frailty in Stort Valley and Villages
- The innovative approach to falls and fall prevention in Hertsmere
- Staff are working together across organisational boundaries to implement practical solutions creating more joined-up care for service users, including people
  - in care homes
  - with Chronic Obstructive Pulmonary Disease (COPD)
  - with complex needs.

Working across organisations has enabled our staff to develop and implement creative and practical ways of working more effectively.

> "We now have a joint agreement with our community service colleagues so that our Occupational Therapy staff can assess and prescribe basic physical equipment from the community trust's equipment service. This care supports people's independence and can reduce the risk of falls and importantly it happens more quickly now with less bureaucracy for the person, as we avoid the need to refer them on to another organisation"
>
> **Staff member**

A Healthier Future will map the improvement journey health and care services are committed to take in order to improve all of our vital NHS and social care services to help the people of Hertfordshire and west Essex live happier and healthier lives.

Quality Improvement

The Executive Director of Quality and Medical Leadership and the Executive Director of Quality and Safety/Chief Nurse lead the Trust's organisation-wide approach to quality improvement. Over the past 12 months more people have come forwards with ideas for innovations and improvement that boost safety, efficiency, effectiveness and the improve the experience of service users, carers and staff in receiving and delivering services.

Some examples:

Quality improvement project focused on outpatient appointment processes.

This has established a new, simplified and standardised appointment process across all our adult community services. We have changed the wording of our letters so they

- are clearer to service users
- better reflect our values.

We have also

- reduced the likelihood of mistakes and errors in our letters
- decreased the time it takes to complete the task
- removed some of the frustrating aspects of the work.

This makes better use of staff time and has increased staff satisfaction.

Improving access to services through our Single Point of Access

In early 2017, the volume of telephone calls coming into our Single Point of Access (SPA) meant that a typical waiting time for a call to be answered was 10 minutes. This was unacceptable, so we instigated a Quality Improvement initiative to tackle the problem.

Our Single Point of Access team were supported to use 'improvement thinking' and tools to understand the problem and think differently about how the work could be done. They came up with some simple ideas that we implemented. These led to the typical waiting time falling from 10 minutes to 1.5 minutes – an 85% improvement.

Patient Portal System

The Wellbeing Team at Tekhnicon House have set up a new electronic portal to improve service user engagement. The previous manual system was inefficient, requiring the information from approximately 1000 forms to be manually uploaded every month. With the new system:

- Service users receive automatically-generated text messages, reminding them to access the portal
- Staff can more easily identify and follow up with patients who have failed to access the portal
- Morale has improved and the discharge rate has dropped significantly as staff have more time to interact with service users.

The Innovation and Improvement Fund has also helped other ideas to be realised during 2017/18. These include:

- trialling the use of Nutritics, a dietary analysis computer package. As a result:
  - our dietician spends less time completing nutritional analyses (a 78.5% decrease)
  - we have increased the accuracy of dietary analysis of a person's food intake
  - staff have access to clear graphical reports to compare intake and requirement.
- testing a digital and portable tool (Talking Mats) that supports people with communication difficulties to express their wishes and concerns. The feedback on this tool has been that it has been an incredible enabler.

"I was genuinely touched to see a service user express so much and so easily via Talking Mats. It was like hearing her speak out for the first time despite having known her for four years"

Healthcare Assistant

"I didn't think (an individual service user) would have been able to engage in the discussion around her care and support plan without the use of the talking mats resource"

Psychologist

"I felt it was the first time people had properly explained about diabetes to me"

Service user

Service user and carer involvement

In 2017, our service users and carers – Experts by Experience – contributed to interview panels, forums, working groups and helped us design and deliver our services. In total, people with experience of our services participated in 2600 hours of involvement activity.

In October 2017, we began a co-produced review of involvement work to ensure the involvement opportunities we offer are recovery-focused, beneficial to the Trust and – most importantly – provide development for EbEs to move on from involvement programmes to other activities.

By January 2018 we had:

- reviewed all documentation
- introduced new feedback mechanisms for involvement

A new project this year sees a vocational service providing placements for people (from secondary services) in the Trust. These placements started in April 2018 and follow the Individual Placement and Support (IPS) model. The project is designed to ensure the Trust is an exemplar employer providing opportunities for people with experience of mental illness.

Carer engagement

Our carer engagement programmes have continued to grow over the past year, this in part is due to our dedicated works for carer services based within community teams.

We reviewed these services during 2017/18 and, as a result are bringing in more workers to support carers' needs and improve our performance in this area. During 2018/19, three areas of particular focus will be:

- Carer assessments
- Personal budgets
- How effectively we engage with carers across our acute settings.

Carer Council

Our Carer Council aims to help improve the Trust's services. It:

- comprises up to 15 members
- meets approximately every six weeks.

During the past year the Council has:

- Looked at scrutiny of care coordination and physical healthcare within the Trust
- Contributed to:
  - reviews of practice including survey reviews within community and inpatient settings
  - development of Trust policy and strategy.

11th Annual Recovery Events

This year we arranged five one-day events, four in Hertfordshire and one in Norfolk. The people of Watford, Bishops Stortford, Stevenage, Hatfield and Norfolk were invited to a celebration of Personal Development and Shared Decision Making with contributions from New Leaf, the new Wellbeing College in Herts.

The events attracted 177 people in Herts and 50 in Norfolk with over 35% of the attendees being carers or people with lived experience. More people attended for the first time than is usual. These events were interactive and co-produced from start to finish. They provided opportunities for people to share their experiences of mental health and recovery. Next year we may push the local theme further still!

"Reinstalled my faith in humanity"

Attendee

"Opportunity to be inspired and develop"

New Leaf: The Hertfordshire Wellbeing College

New Leaf College is based on the Recovery College model and provides a range of courses and workshops to enable people to take better control of their wellbeing, learn practical skills and provides an opportunity for people to reflect on their own situations and how they can build on their strengths to achieve better wellbeing.

Led by the Trust and run by Druglink Ltd, the college has been co-produced with stakeholders – including service users – across Hertfordshire. Since the college opened in November 2016, it has attracted 977 students (70% female). There are currently 37 students on the Peer Involvement Pathway, which supports students to give back to celebrate their learning achievements by getting involved in the college's activities, including Peer Tutoring.

Recovery stories

"Having now completed most of the courses the college offers, I have learnt so much about myself. The college has shown me what I am good at and given me added confidence in the skills that I always had but which were sometimes masked by my anxiety. … Since starting, my confidence levels have gone from strength to strength… I feel optimistic for the future"

Physical Healthcare

During 2017/18:

- More than 800 people in our services have had a physical health check conducted by our staff
- We have increased our staff's knowledge and awareness and developed new resources to help them support our service users' physical health. These include useful links, handouts and other services and community activities for our staff when working with people's physical health and a shared care agreement with our GP colleagues, ensuring we have a joined-up approach across primary care.

Integrated care

We are committed to bringing care together across physical and mental health, and removing the barriers to integrated care that can sometimes develop. Our projects in this field include

- three pilot programmes to provide mental health services closer to people's homes
- an integrated service for people with diabetes
- a state-of-the art building shared with community services colleagues.

We have been developing pilots in three different areas of Hertfordshire for mental health services to provide a service closer to home. Our new service is sited within GP practices, and aims to ensure people with mental health problems are seen by the right person much more simply and quickly. It also reduces bureaucracy.

Integrated service for people with diabetes

Working with our community Trust and acute care colleagues, we have been providing joined-up care for significant numbers of people with diabetes since April 2017. We train our staff so they have some specialist skills in treating long-term physical health conditions, and our recovery rates for our service users with diabetes are well above the national average.

We are keen to extend this joined-up approach to a range of other long term physical health conditions.

Clozapine Pathway Service Development and Improvement Plan

In October 2017, we convened a service development and improvement meeting. This generated a proposal to redesign the clozapine pathway, after which a senior pharmacist completed short scoping exercise on the current clozapine pathway.

Clozapine is an atypical antipsychotic used in the treatment of schizophrenia. It is the only antipsychotic shown to be effective for treatment-resistant schizophrenia. Clozapine treatment requires (1) regular blood monitoring in our clozapine clinics, (2) the responsible consultant and (3) dispensing pharmacy to be registered with the pharmaceutical company in order to prescribe and dispense clozapine.

As part of phase 1 of the quality improvement plan, a one-stop clozapine clinic model for care testing and medication supply was introduced in St Albans in March 2018. Where, previously, they had to wait three days for blood test results and medication, service users now receive results (samples are tested in the clinic, rather than sent off to a lab) and medication on the same day they have their bloods taken.

Early feedback from service users has been overwhelmingly positive. Clinic staff have also welcomed the changes which have significantly reduced the time they need to spend chasing blood results and ensuring that service users collect their medication. This frees them up to spend more time discussing other aspects of clinical care with service users.

In 2018/19, we a plan to roll out this the new clozapine clinic model to other sites throughout the Trust.

Pressure ulcers – zero tolerance

The Trust continues our zero tolerance approach to avoidable pressure ulcers. The past year has seen a further 16% reduction in pressure ulcer and moisture lesions reported by inpatient services in the Trust: 37 during 2017/18, compared to 44 in 2016/17. Of the 37 reported during the year 19 were acquired in the Trust and 18 were acquired external to the Trust.

We now have a robust system in place for providing medical devices, including pressure relieving mattresses, cushions and boots.

A dressing formulary is also available on each inpatient ward. Our local Pressure Ulcer champions monitor progress, and are having a positive impact promoting efficiency and evidence-based practice across the Trust. The procurement team and head of nursing continue to monitor the hire and use of air mattresses and cushions.

Staff continue to receive training in how to prevent and treat pressure ulcers and care for wounds from the Tissue Viability Nurse (TVN), seconded to the Trust from the Hertfordshire Community NHS Trust (HCT).

We:

- Now have a robust system in place for providing medical devices, including pressure relieving mattresses, cushions and boots
- Have made a dressing formulary available on each inpatient ward
- Have local Pressure Ulcer champions monitoring progress. They are having a positive impact promoting efficiency and evidence-based practice across the Trust
- Supported the 'Heel Alert' campaign in 2017: evidence suggests that heels are the second most common site for pressure ulcers, and that these are becoming more common
- Ran our annual 'Stop the Pressure Ulcer' conference on 16 November 2017. The TVN gave a presentation on pressure ulcers
- Have displayed 'React to red' screensavers and posters across the Trust and worked with the Bedfordshire and Hertfordshire Tissue Viability forum to send these out to GP surgeries across Hertfordshire, Bedfordshire and Essex
- Continue to monitor pressure ulcers and to report our findings to the Trust's Physical Health Committee.

The procurement team and head of nursing continue to monitor the purchase and use of pressure relieving mattresses and cushions, and staff continue to receive training in how to prevent and treat pressure ulcers and care for wounds from the Tissue Viability Nurse (TVN), who also works for the Hertfordshire Community NHS Trust (HCT).

Our audits suggest staff feel more confident and competent in preventing and managing pressure ulcers. This is predominantly due to the ongoing support from the TVN and discussions with other senior nurses.

Artwork supplied by the HPFT Art Collection

Nutrition and Dysphagia Steering Group

The Trust's Dysphagia and Nutrition Steering Group leads work across the Trust to make sure inpatient service users' nutritional needs are met. We use the Care Quality Commission (CQC) nutritional and hydration standards to guide our work.

Our work and future plans

- In March 2018 we launched new menus designed to meet the varying needs of all our service users.
- We are collecting instant feedback from service users to check they like the new food options.

Safe and effective screening
We are:

- Taking part in an NHS Improvement Nutrition Collaborative. This is helping us develop and test improvements in screening compliance and quality
- Building a screening tool into our electronic patient record. This will make completion easier for staff and help us monitor and evaluate our standards.

Supporting staff.
We are:

- In the final stages of developing our eLearning package for staff which is designed to provide the knowledge required to complete the screening tool
- Trialling training packs to use in our units for short, sharp training.

Nutrition and Hydration Week March 2018

- We celebrated the role food plays in our emotional wellbeing, encouraging all to share their food memories
- We shared knowledge of dysphagia signs and symptoms.

Medical education

We remain strongly committed to investing in learning and development for all our staff.

General Medical Council (GMC) Trainers and Trainees 2017 Survey

In the GMC Training Survey 2017, our clinical supervisors gave the Trust the highest score amongst the 5 mental health Trusts in the region. GP trainees and Foundation Year doctors placed in the Trust also rated their experiences very positively giving us a rating that made a joint top for trainees experiences amongst the 5 mental health Trusts. The survey outcome highlights the emphasis we place on Training and Development of our staff, both as supervisors and trainee doctors

Our Foundation Year 1 and 2 doctors rated us as highest in the region. The responses from the trainees' survey suggest we are also one of the top two Mental Health Trusts in the East of England.

One of the other academic highlights for the Trust in 2017/18 was the award of Doctor of Philosophy (PhD) to Dr Dilini Jayalath, a specialty doctor in old age psychiatry. Dilini was the first graduate of the MSc in Psychiatric Practice to obtain a PhD in the Postgraduate Medicine department at the university and their first one from Psychiatry.

At the 2017 graduation ceremony other Trust staff members were awarded the Master of Health and Medical Education and the MA in Contemporary Therapeutic Counselling.

What is the MSc in Psychiatric Practice and Mental Health Practice?

This MSc degree programme was jointly set up and funded by the University of Hertfordshire and the Trust to provide psychiatric trainees with an academic course to help prepare them for the Royal College of Psychiatrists examinations, and to give them and other members of staff the opportunity to obtain a master's degree.

Health Education England coaching and mentoring funding 2016/17

The Medical Education Team submitted a successful bid to Health Education England for funds to run a coaching and mentoring programme for trainee doctors. We were awarded the full amount: £1500.

Integrated GP teaching programme

In collaboration with Bedfordshire & Hertfordshire Local Medical Committees (LMC), the Trust ran an integrated GP teaching programme of six modules from February to June 2017. Senior clinicians and consultants in mental and physical health will facilitate each module.

We held the first module 'Mental and Physical Health during Pregnancy and the Postnatal Period' on 23 February 2017. The feedback was excellent.

Integrated GP teaching programme

In collaboration with Bedfordshire & Hertfordshire Local Medical Committees (LMC), the Trust ran an integrated GP teaching programme of six modules from February to June 2017. Senior clinicians and consultants in mental and physical health will facilitate each module. We held the first module 'Mental and Physical Health during Pregnancy and the Postnatal Period' on 23 February 2017. The feedback was excellent.

Homefirst

Run by Hertfordshire County Council and supported by the Trust, HomeFirst is one of the largest programmes helping integrate services across the areas we cover. It combines health and social care, providing a rapid response and case management service which supports the frail and elderly with multiple long term or complex conditions. Their services help service users stay:

- well
- independent
- in their own homes, rather than going into hospital or residential care.

HomeFirst teams operate across the North and East Hertfordshire including Lower Lea Valley, North Herts, Stort Valley and Villages, Upper Lea Valley, Stevenage, Hatfield and Welwyn. People using the service, carers, staff and GPs have provided excellent feedback. Since HomeFirst started, substantially fewer people have been admitted to the Emergency Department (ED), hospitals or referred iinto Secondary Care Services.

> "I can't believe the transformation in [patient name]… I recall this patient calling A&E all the time before the psychologist was involved and now she is so much more settled"
>
> **Age UK**

> "Sympathetic and very helpful with all my concerns – thank you"
>
> **Service user**

Crisis Assessment and Treatment Team

After a successful pilot our crisis service is now providing home treatment and urgent assessment to people in Hertfordshire 24 hours a day, 7 days a week. Out of hours GPs, Street Triage, Rapid Assessment Interface and Discharge (RAID) teams and others are all referring people to the service. People in crisis are seen in their own homes and offered detailed assessment of their needs and treatment.

This

- Prevents some people attending A&E to access mental health treatment
- Improves their experience of our services
- Provides an effective pathway from other services directly into mental health treatment. For example, someone might come to the attention of the police, be seen by Street Triage and then referred to the crisis team.

The service is offered in the community, meaning service users can continue to receive support from friends and family in a safe and familiar environment.

Section 136 Team

The dedicated Section 136 team is made up of registered nurses and health care assistants. Based at Kingfisher Court, the team supports both the Trust and Hertfordshire's Police Force in ensuring that, when a service user is detained under Section 136 of the Mental Health Act:

- The process causes as little distress as is possible
- They feel supported and cared-for.

The Section 136 team have been key in implementing the new standards relating to Section 136 by taking the lead in co-ordinating the assessing multi-disciplinary team and monitoring the time spent in the Section 136 suite. They work closely with:

- Our Acute Assessment Unit (Swift Ward) to ensure a seamless transfer for anyone requiring further assessment of their mental health
- CGL Spectrum to ensure that people requiring intervention relating to substance misuse can be provided with an assessment or appointment
- The Trust's community-based services for those requiring follow up.

Street Triage

Street Triage has now been operating for over a year and is achieving good outcomes. Clinicians are based with the Police at their Headquarters in Welwyn Garden City, and go out with them from 8.00pm to 4.00am seven days a week. We are seeing more and more people, and since December the Police now have to consult a health professional before using their powers to detain individuals under Section 136 of the Mental Health Act. The Street Triage team works with a paramedic on one of the shifts. By working together, we have been able to support and treat people in the community, which means they can avoid attending A&E and being detained under Section 136.

The feedback from the Police is overwhelmingly positive. They:

- Value the access to mental health expertise
- Say that Street Triage saves many hours of police time and ensures that people who need access to mental health services are supported to get it in a timely and efficient way
- Feel that working with the Street Triage team has increased their knowledge and understanding of mental health.

Our Street Triage team love their roles and value working with the police and ambulance services, sharing their expertise to bring a positive outcome for the person involved.

Extending services to new groups of people

Our Improving Access to Psychological Therapies (IAPT) services in West Hertfordshire have made great progress in supporting people with long-term physical health issues, such as diabetes or respiratory conditions, better manage the psychological effects of their condition.

The teams have had a specialist training to help improve health outcomes for people with long-term conditions and are also working with those who suffer with:

- chronic pain
- irritable bowel syndrome (IBS)
- fibromyalgia and ME/Chronic Fatigue Syndrome.

The teams work closely with community and hospital colleagues in physical health services, to help identify people who may need psychological support and provide them with Cognitive Behavioural Therapy (CBT), ensuring they receive care which takes into consideration both their physical and psychological needs. Early results are very promising with an approximate 39% reduction in physical health care appointments after treatment from an IAPT therapist. It is hoped that over the coming year the IAPT service can widen its scope to include people with cardiac problems and other long-term health issues.

Child and Adolescent Mental Health Services (CAMHS)

New models of care

Our new care model transforms the existing pathway of care to fully integrate the Tier 4 and Tier 3 pathways ensuring care is provided in the least restrictive environment close to home. Our model enhances and connects our existing services across:

- Community clinics
- Children's' CATT (C-CATT)
- High Risk Pathway and Forest House Assessment Unit, together with a combination of Dialectical Behaviour Therapy (DBT), Structured Clinical Management (SCM), Home Treatment and Supported Discharge functions.

The Home Treatment Team will provide:

- An alternative to admission by offering short-term intensive care in the community
- Supported discharge.

to ensure that young people are treated in the least restrictive environment and are cared for at home whereever possible, stepping up if/when appropriate.

Did Not Attend (DNA) in CAMHS

We have continued to monitor DNA rates through the year and report on the number of DNAs at our quarterly meetings with Commissioners. We have seen a decrease in the numbers of service users who DNA. As part of our practice governance agenda and working in conjunction with our Practice Audit and Clinical Effectiveness (PACE) team, there will be a repeat DNA audit taking place.

This will provide an overview and scrutiny of:

- The overall process
- How we manage DNAs including communicating with partner agencies.

DNA rates are discussed as part of a weekly conference call with senior managers and are closely monitored within local teams.

28-day waits

We worked hard throughout 2017 to bring our waiting times for routine appointments back in line with our agreed target of 28 days. To support this process we have collaborated closely with colleagues in the Performance Team and SPA.

We met our target by working to a clear recovery plan which enabled the team to better

- predict the number of appointments
- manage the demand for a service
- better move resources where they were needed.

After a challenging 8 months, we were back on target by September 2017.

Quality Network Decider Group, CAMHS West

The group is designed to deliver CBT mental health skills in a fun, interactive and easy to use format. It teaches 32 coping skills and strategies which aim is to help individuals cope effectively and positively with distressing emotions and situations. The skills focus on four key areas; distress tolerance, mindfulness, emotion regulation and interpersonal effectiveness.

Young people currently accessing Tier 3 CAMHS in the West quadrant were able to access the group and were referred by their care coordinators. Group members gave positive feedback, with one key area being young people appreciated having a space to meet others experiencing similar difficulties.

> "It was nice not to have to talk"
>
> **Young person**

Future groups will run, allowing more time for reflection on how the skills can be used effectively and some changes to the way the skills are illustrated to ensure they are relevant for young people.

The Skills Group, CAMHS West

The group was designed to deliver CBT mental health skills in a fun, interactive and easy to use format. It teaches 32 coping skills and strategies which aim to help individuals cope effectively and positively with distressing emotions and situations. The skills focus on four key areas; Distress Tolerance, Mindfulness, Emotion Regulation and Interpersonal Effectiveness.

Verbal feedback from group members suggested that they found it helpful in giving them tools to deal with their difficulties and validating to meet others experiencing difficulties. However it was felt that more robust measures were needed to evidence if the group was effective and the summer was not a good time to run the group as people were away and missed sessions.

Below is a table showing the verbal comments given in response to the ESQ question "What was really good?"

"The amount of advice and skills offered trying to help"
"I like the worksheets and different ways to tackle certain problems, always gave me ideas/ solutions for personal issues"
"I learnt new skills"
"They listened to me and made the meetings interesting so we didn't get bored"
"Different experiences, new people"
"The group was really helpful and if something was arranged like this again could you please let me know"

Introducing a three-day admission within Forest House Adolescent Unit

This initiative forms part of the Trust's drive to improve our 'Tier 4' service. We realised that many young people who needed to be admitted had lengthy waits in acute hospitals that, in some cases, had an impact on their recovery. We therefore developed a three-day admission, which started in December 2017.

Since then, we have had 6 such admissions. They focus on:

- Providing a break from the external factors which have led to the crisis
- Assessing the challenges in a low risk setting
- Sharing that assessment with the young person and all those involved in their care.

The CAMHS crisis teams have noted the ability to admit young people quickly. Referrers have also found the nursing and the multi-disciplinary team observations made during the brief admission very helpful. Young people have fed back positively about being able to return home after a short period of time and the parents have found the nursing feedback and advice practical and useful.

Think Ahead – the fast-track social worker scheme

As part of our recruitment, retention and workforce development initiative, the Trust hosts a national scheme to fast-track promising graduates into positions as mental health social workers.

Think Ahead places four graduates within the Trust. They receive intensive practice-based, 'on-the-job' training while studying for a Master's degree, with the prospect of full-time employment after the two year programme.

They are supervised and supported by the Think Ahead Consultant Social Worker who acts as an educator and a role model for Think Ahead participants in the workplace in Year One of the programme. The Think Ahead Consultant Social Worker post provides an exciting career development opportunity for social workers who want to remain in a practice-based role rather than move into management.

The trainee social workers start with a three-to-six week classroom-based curriculum, followed by a one-year practice placement during which they study for a postgraduate diploma in Social Work. In their second year, they undertake the Assessed and Supported Year in Employment (ASYE) and complete a Master's degree in Mental Health Social Work.

"Think Ahead provides a great opportunity to bring new talent into the Trust, and promote the valuable contribution that social work practice makes to transforming the lives of people experiencing mental ill health and their families. This initiative will also help address the recruitment shortfall in this area and develop potential leaders. These will be busy demanding placements but offer great opportunities for the right candidates in an interesting and highly rewarding field of work"

What is the Psychosis, Prevention, Assessment and Treatment (PATH)?

This is a specialist team who work specifically with individuals who are experiencing psychosis for the first time, referred to as a 'first episode of psychosis'.

The aim of this service includes:

- **Early detection, assessment and treatment of symptoms**
- **Optimistic views about recovery focused interventions**
- **Provide a wide range of psycho-social interventions and support**
- **Provide support and interventions for family and carers**
- **-Work in partnership with a range of statutory and non-statutory services.**

What is an Associate Practitioner (AP)?

This group of staff have gained a Psychology Degree and form part of the PATH workforce. They work alongside our qualified social workers, nurses and psychologists to provide specialist care, including the delivery of carers' programmes and family interventions.

What is a Support Time and Recovery (STaR) worker?

STaR workers also work with the PATH workforce, providing practical support for service users and carers.

In the PATH service, we have launched an innovative workforce model, aimed at delivering high quality, responsive care to people with higher levels of need. We call this our mini team model, in which a band 6 Care Co-ordinator works in partnership with a band 5 Associate Practitioner and band 4 STAR worker to manage a caseload together.

We have created a skills framework to support this model, which will ensure our staff develop the right skills and competencies to work together to support the recovery of people who use our service. We have now begun our evaluation of the of the mini-team model.

As part of this work, we have received feedback from service users and carers telling us that the mini teams have worked with them to go above and beyond in meeting people's complex needs.

In the cases we evaluated, we have seen that:

- Crisis situations were well managed
- Further mental health deterioration avoided
- Workloads were effectively shared.

This allowed the mini teams to provide a very supportive service where:

- people receive specialised, targeted and intensive interventions
- carers are given the time and support they need.

SafeCare programme update

The Allocate Safecare module is a software tool that allows us to compare staffing levels and skill mix to our service users' clinical needs. Following a successful pilot, our project team has implemented SafeCare in all our inpatient units and a small number of our community teams. All areas are using the system to input service user acuity data to enable them to match staffing levels and skill mix to the service user's needs and acuity level on a daily basis.

We have integrated the data available from the SafeCare system into some of our daily operational reporting structures to enable nurses on the wards and operational managers, to review the system each day. This allows access to real-time information so we can make decisions in a meaningful way to support safe care and treatment. The system:

- Enables us, as an organisation, to have visibility across services
- Transforms rostering into an acuity-based daily process that unlocks productivity and safeguards safety for service users and staff.

We are proud to be the first mental health trust to have implemented this solution in a community service.

Spotlight on Nurse Education

Trainee Nursing Associates

Last year, Health Education England (HEE) introduced the new role of Nursing Associate to support the work of Registered Nurses. The Trust has been the lead for the Nursing Associate programme implemented across the STP.

Working with five provider organisations and the University of Hertfordshire, the progamme provides 69 places, of which 11 were allocated to the Trust. Plans are in place to celebrate its first year. There are also plans to recruit to a further two cohorts during 2018/19. The Trust will continue to lead the programme.

"Nurse First" MSc accelerated nursing programme

We have been selected by Health Education England (HEE) to participate in an exciting pilot programme. Inspired by Teach First, the new accelerated postgraduate nurse programme is designed to encourage and incentivise high-potential graduates with leadership potential and relevant degrees to choose a career in nursing. We are one of three organisations piloting the mental health nursing strand and, of the ten graduates in this pilot cohort, four have been seconded from our Trust.

Working to the Boundary of Registration: Best Practice and Innovation in Mental Health

Our staff spoke on "Nurse Prescribing in 'depot' clinics: Back to Basics and Beyond" at the National Mental Health Nurse Director Forum event – "Working to the Boundary of Registration: Best Practice and Innovation in Mental Health" – at Warwick University in November 2017. This event enabled nurses to showcase innovative practice that demonstrates how they are working imaginatively to create the best services for the people that use them. It also showed how moving away from more traditional service models and practice can make nursing careers even more interesting and rewarding.

This innovative pilot involves nurses working with a specified group of service users who attend the depot clinic. Rather than being allocated a care co-ordinator in the community team, or seen in outpatient clinics for regular reviews by a psychiatrist, the nurse prescriber becomes the main clinician for service users who are happy to agree to this approach.

The nurse prescriber undertakes a review of the service user's mental, social and physical health needs; depot antipsychotic medication (including prescribing) and clinical care plan if/when the service users mental and physical health needs change.

They are also responsible for communicating with the service user's GP and depot clinic nurse about any prescribing decisions or changes regarding the depot medication and care plan.

The pilot is:

- Testing the appropriateness and safety of nurse prescribers leading care and treatment during the maintenance phase for service users who are 'stable' and prescribed maintenance treatment through depot antipsychotic medication.
- Aiming to discover whether nurse prescribers can:
  - have a positive impact in creating capacity in the team by reducing the need for care co-ordination and for outpatient reviews by psychiatrists for this group of service-users
  - enable quicker access to medication reviews for service-users who attend depot clinic.

The nurse prescribing-led depot clinic initiative is part of a wider initiative in East and South East Adult Community Team exploring the feasibility of developing a low intensity adult community team. This team will also include other new job roles including a community health care assistant and develop a clear pathway for social care, psychological and occupational therapy interventions for this service user group.

Modernising our estate

Through continued innovation, energy initiatives, refurbishment and upgrade programmes, during 2017/18 the Trust has continued to provide an improved, more aesthetically pleasing internal environment that contributes to our quality service and enhances user experience.

Some examples of refurbishments during the year include:

- Refurbishment at Centenary House for adult community mental health services; the building went live in 2018
- Refurbishment of Letchworth Wellbeing Centre, co-locating with Mind; the project went live in June 2017
- Upgrade and modernisation programme and future proofing of services at Lexden
- Six Facet survey (fire compliance) throughout the estate portfolio.

The Marlowes Health & Wellbeing Centre

We collaborated with colleagues in Hertfordshire Community NHS Trust to develop a state-of-the-art, integrated healthcare facility providing both mental and physical health care services.

The Marlowes Health and Wellbeing Centre, which opened in March 2018, is in the centre of Hemel Hempstead, a location selected to improve access for service users. The centre will offer the following mental and physical health services

Mental health services:

- outpatient clinics for Child and Adolescent Mental Health Services and Adults
- initial assessments
- CPA and clinical reviews
- one to one consultations
- group activities
- Clozapine and depot clinics
- blood tests
- physical health checks
- family therapies
- art therapy.

Physical health services:

- dentistry
- leg ulcer care
- sexual health services
- podiatry
- children's audiology, speech and language therapy, eye care and a range of other paediatric services.

The building also offers open plan office spaces and meeting rooms. Sharing the Centre with Hertfordshire Community NHS Trust enables us to work more closely together. We are introducing new ways of working to improve clinical outcomes and efficiency, enabling us to provide more holistic, seamless and integrated care for people using our services.

CAMHS Unit

In early 2017, we submitted a proposal to develop a Section 136 Place of Safety (PoS) for Children and Young People (CYP) for Hertfordshire. Despite the new building project's location within the Green Belt, we heard in December 2017 that we have secured planning permission. Our current facility does not have a CYP PoS, and lacks the space required to ensure the state-of-the-art CAMHS service we aspire to: we aim to provide a service that fully meets the needs of young people and the requirements of regulatory bodies.

The proposed Section 136 Place of Safety (PoS) suite will be designed to comply with the latest health building notes and health technical memoranda. It will include best practice from across the country. The facility will provide:

- a bedroom
- an ensuite shower room
- a receiving/sitting room
- staff areas including an office and a kitchenette.

The building will sit within its own gardens with a secure area provided. Our selected location also allows vehicles to park immediately adjacent to the building.

Logandene won Building Better Health Care Award

Logandene, a standalone NHJS dementia care assessment and treatment unit, was recognised in the 'External Environment' category at the Building Better Healthcare Awards in November 2017.

The state-of-the-art refurbishment is part of a £42 million investment into older aged adult services, which will ensure vulnerable and elderly adults always receive excellent care and treatment.

Buckinghamshire Services

Since joining the Trust, the Buckinghamshire Community Learning Disability Health Team has become an active part of the wider learning disability services, linking specifically with Dove Ward at Kingfisher Court and the Hertfordshire Assessment and Treatment services.

We have gained professional leads in:

- Occupational therapy
- Speech and Language Therapy
- Psychology, and
- secured a part-time Modern Matron position to support our nurses.

The Occupational Therapists continue to develop sensory integration services, attending the Sensory Special Interest group and submitting a quality improvement bid to develop specialist sensory assessment clinics and supporting the development of a bed rails risk assessment.

The Speech and Language Therapists successfully implemented the dysphagia and communication pathways and continue to provide local dysphagia training to carers and other health and social care professionals, to make sure they can spot the warning signs of a swallowing problem and also ensure our service users receive timely access to assessment and treatment.

The Allied Health Professionals within the team have taken on projects including the introduction of the East Kent Outcome System (EKOS) and a review of the falls pathway.

The Physiotherapy team have developed several complex health pathways including postural, falls/mobility and respiratory management. They have also created additional resources for the falls work. This includes producing an easy read leaflet on:

- being safe
- managing falls with exercise
- how to get up if you fall.

We have set up clinics to support people's transitions to hospitals and to help maintain chest health, one of the areas highlighted as an increased risk of poor health and death in people with a learning disability. The team have done some important work around the Epilepsy Pathway and their contribution to developing the epilepsy practice and pathway in Buckinghamshire for people with intellectual disabilities, has been acknowledged by the Royal College of Psychiatry.

Our Intensive Support Team now has more staff and is delivering a more comprehensive and wider service. We are also developing a positive behavioural support strategy and a threshold tool for those on the risk register.

Our nursing team has adopted the Health Equalities Framework which is based on an understanding of the factors that lead to health inequalities, and is designed to help commissioners, providers, people with learning disabilities and their families understand the impact and effectiveness of services.

In 2018/19, our Buckinghamshire services will be piloting a STOMP CQUIN (Stopping Over-Medication of People with Learning Disabilities) in order to inform a national STOMP CQUIN in 2019/2010.

Our Intensive Support Team will continue to

- Expand to ensure people can remain in their homes even at difficult times.
- Forge stronger and smoother links with our social care and mental health colleagues
- Ensure we participate in the development of the new Buckinghamshire Integrated Team processes led by the CCG.

We also intend to work closely with our hospital liaison learning disability nurses to review pathways and continue to improve service-user care for inpatients, ensuring that people with a learning disability are understood and treated as quickly and as safely as possible.

Learning Disability Occupational Therapy Services

The Learning Disability Occupational Therapy services across the Trust held a sharing good practice day in March 2018, featuring presentations from the different service areas. We plan to make this a regular event that will further strengthen networks. Regular meetings between the learning disability Occupational Therapy community services in Hertfordshire, Buckinghamshire and North Essex will also help develop shared aims for the service.

The Allied Health Practitioner Team will continue to review and develop our complex health pathway. We are also piloting a new cross-county initiative to solidify this work and provide support for people with personality disorders. Through this, Trust professionals will become trainers who train other staff to become competent in the AMBIT model.

What is AMBIT?

This is part of the development of the Personality Disorder pathway within our Learning Disability services, led by psychology. AMBIT is a metallisation based team approach for teams working with young people with severe and multiple needs, who do not tend to access mainstream services run by the Anna Freud Centre. The plan is to train members of the Learning Disability community teams in Hertfordshire, Buckinghamshire and Essex as trainers. It will be involving all members of the team, including psychology, Allied Health Professionals, nursing and psychiatry.

Independent auditor's report to the council of governors of Hertfordshire Partnership University NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Hertfordshire Partnership University NHS Foundation Trust to perform an independent assurance engagement in respect of Hertfordshire Partnership University NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Hertfordshire Partnership University NHS Foundation Trust as a body, to assist the council of governors in reporting Hertfordshire Partnership University NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Hertfordshire Partnership University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care;
- number of bed days patients have spent inappropriately out of area;

We refer to these collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period 1 April 2017 to 31 March 2018;
- feedback from the Commissioners dated 14 May 2018;
- feedback from the governors dated May 2018;
- feedback from local Healthwatch organisations, dated 21 May 2018;
- the latest national patient survey dated 6 March 2018;
- the national staff survey dated 6 March 2018;
- Care Quality Commission Inspection report dated 25 April 2018; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2018.
- Any other information included in our review

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

Proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care

The indicator for Early Intervention in Psychosis measures the percentage of referrals to and within the trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period within 2 weeks of referral as a proportion of the number of referrals to and within the trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period.

Our procedures included testing a risk based sample of 15 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

In respect of the population used to calculate this indicator we found that for:

- 33% of our sample the Trust had not retained an adequate audit trail to confirm the date that they met the following two conditions for the waiting time clock to be stopped:
  - Accepted on to the caseload of an EIP service capable of providing a full package of NICE-recommended care; and
  - Allocated to and engaged with an EIP care coordinator

As a result there is a limitation upon the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting the Early Intervention in Psychosis for the year ended 31 March 2018.

Our testing also identified the following errors:

- for 27% of items in our sample of referrals tested, one or both of the start and end date of the waiting period were not accurately recorded, and affected the calculation of the published indicator.

- For a further 27% of sample items, one or both of the start and end date of the waiting period were not accurately recorded, but did not affect the calculation of the published indicator;

As a result of the issues identified, we have concluded that there are errors in the calculation of the percentage of referrals to and within the trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period within 2 weeks of referral as a proportion of number of referrals to and within the trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period. We are unable to quantify the effect of these errors on the reported indicator.

The section on page 20 of the Trust's Quality Report summarises the actions the Trust is taking post year end to address the issues identified in relation to these issues.

Qualified conclusion

Based on the results of our procedures, except for the matters set out in the 'Basis for qualified conclusion' section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified above; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP

Deloitte LLP

St Albans
25 May 2018

Annexe 1 – Statements from Partners

Healthwatch Hertfordshire's Response to Hertfordshire Partnership University NHS Foundation Trust (HPFT) Quality Account 2018

Healthwatch Hertfordshire welcomes the opportunity to comment on HPFT's Quality Account. A Healthwatch Hertfordshire (HwH) Board member participated in the Health Scrutiny Committee's session to question the trust on the Quality Account priorities in March 2018. HwH agrees with the recommendations, good practice and risks identified at this two day event.

In addition we would like to make the following comments:

- The Quality Account clearly demonstrates how the Quality priorities have been chosen and that consideration was given to the feedback generated from the consultation around the priorities
- We have been pleased to work with the Trust on Dual Diagnosis (i.e. patients that use mental health and drug and alcohol services) and to see that our involvement has helped to improve pathways
- Service user feedback has Identified communication issues and long waits around the Single Point of Access (SPA – telephone clinical triage service) so it is good to see that the Trust has looked at how this can be remodelled to improve service user experience
- We are pleased to see that raising staff awareness on gender identity and sexual orientation is still very much a focus and that this is part delivered by volunteers who are willing to act as role models to improve services .
- HwH has raised that, from the perspective of mental health act managers, the biggest weakness in tribunals is that care coordinators do not always attend. We hope to see improvements in this area.
- HwH would like to congratulate the Trust for the achieving 'good' at their recent CQC inspection. Staff demonstrating good and outstanding care was noted in the report . However with increasing demand for services, recruiting and retaining staff to maintain good quality services will be a challenge. We know that this will be a focus for the Trust over the next year
- Partnership working is demonstrated throughout the Quality Account for example with commissioners and Hertfordshire County Council on learning disability services and the suicide prevention initiative delivered with the two MIND organisations
- Although dementia is not a priority, we are pleased to see that the Quality Account features the work around EMDASS (Early Memory Diagnosis and Support Services) and what is being done to improve access.

We look forward to working with HPFT in the coming year to continue to improve patient experience and outcomes.

Michael Downing, Chair (outgoing)
Healthwatch Hertfordshire, May 2018

Hertfordshire Partnership University Foundation NHS Trust Quality Account Statement from Herts Valleys CCG & East and North Herts CCG

The Trust continues to have a positive and constructive working relationship with commissioners, both through formal contract management processes and through discussions concerning service developments and changes. This has been the case both at an individual organisational level and through the development of the STP across Hertfordshire and west Essex.

Over the year the primary quality concern of commissioners has been the ongoing challenge of recruiting and retaining sufficient staff within HPFT to provide high quality services to people on a consistent basis. The CCGs are aware that HPFT share this concern and have implemented a range of measures during the year to address this. However users and carers tell us that the impact of staff turnover on their care is significant and this will continue to be an area of focus for the Trust over the coming year.

Within learning disability services the Trust continues to support the Transforming Care agenda effectively with good collaborative working with commissioners and other partners including the local implementation of Learning Disability Review of Mortality (LeDeR) and Stopping over-medication of people with a learning disability (STOMP) programmes. The Trust's Specialist Learning Disability

healthwatch Hertfordshire

service has co-operated well with partners across the health and social system. In particular improved joint working with Hertfordshire County Council's (HCC) community nursing and Health Liaison team has enhanced health pathways for people with learning disabilities. This is reflected in the recent CQC inspection which rated Learning Disability inpatient services as 'outstanding'.

During the year the CCGs have been pleased to support HPFT's proposal to take on the commissioning of Children and Adult Mental Health Services (CAMHS) inpatient (tier 4) beds under the New Models of Care programme. The CCGs see this pilot as having significant potential to improve outcomes for complex children and young people by better integrating community and inpatient services. During the year the staffing issues the Trust experienced in CAMHS led to a substantial drop in performance on waiting times for routine appointments. The Trust has focused on this as a priority and performance improved significantly towards the end of the year. The development of the Community Perinatal Team is positive. The expansion of the CAMHS Eating Disorder Team has allowed the Trust to see and treat people in the community in a more timely way.

Earlier in the year it was identified that an improvement in Safeguarding training compliance was needed. There have been substantial improvements in compliance against the new competencies since early February but the Trust have not achieved their commitment to meet their targets by 31st March 2018. The Trust has provided assurance that a significant focus is still being maintained to achieve compliance in all levels of safeguarding which is welcomed.

Commissioners are working with the Trust to ensure that all serious incidents reported are investigated within the required national timescales and support their ongoing work to embed learning from incidents.

The Quality Account refers to some of the long waiting times people were experiencing when they phoned the Single Point of Access (SPA). This led to waits for people who required a routine initial appointment for an adult mental health assessment. The Trust has made changes in SPA during the year and further work is underway in partnership with commissioners to explore models linked to primary care that will provide better outcomes and experience for people currently referred for an initial assessment. Management of demand in community teams is an area where the Trust and commissioners are working together to find ways to do this more effectively.

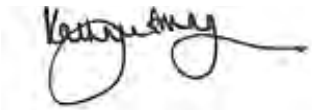
The Trust's ongoing commitment to modernising inpatient units is welcomed, with further work completed during the year. Bed occupancy rates are substantially higher than is ideal and this remains a concern for the CCGs, as well as being identified as an issue by CQC in their recent inspection.

We have worked with the Trust to consider ways to reduce waiting times for a dementia diagnosis and support the service redesign work that has taken place. This will continue to be a priority over the coming year.

The Trust plays a very active role in the Hertfordshire Suicide Prevention Strategy working groups and contributes by delivering the Spot the Signs training to GPs and members of the public.

The CCGs have been pleased to support the development of the specialist Early Intervention in Psychosis teams and will provide further investment in 2018/19 towards this important priority which should improve outcomes for people with a first episode of psychosis. The CCGs continue to work with the Trust to ensure reporting of performance against the two week wait target is accurate.

Overall the CCGs are pleased to endorse the Trust's Quality Account priorities for 2018/19 and the continued drive to improve outcomes for people who use their services.



Kathryn Magson

Chief Executive

Beverley Flowers

Chief Executive

Herts Valleys CCG East & North Herts

Seamus Quilty County Councillor Bushey South

County Hall
Postal Point: CH0147
Pegs Lane Hertford SG13 8DE

Tel 01992 556557
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Date: 23 May 2018

Chief Executive Officer
Hertfordshire Partnership University Foundation Trust
The Colonnades
Beaconsfield Road
Hatfield
Hertfordshire
AL10 8YE

Health Scrutiny Committee

Dear Tom Cahill

On behalf of the Hertfordshire Health Scrutiny Committee (HSC) I welcome the opportunity to comment on the Trust's quality account and the engagement of the Trust with the committee.

Members have held in-depth discussion with the Trust over a series of meetings. This has included consideration of the progress on the previous year's priorities and the implications for the Trust to maintain and further improve this year. The Trust has been open in these discussions and responded to the concerns raised.

The Trust attended the Hertfordshire Health Scrutiny of Quality Accounts held over two days in March this year (15 & 29 March 2018) to outline the proposed priorities for 2018/19. The Trust provided a written response to the agreed questions in advance of the meeting. The scrutiny was attended by the chief executive, the Director of Quality and Safety and the Director of Quality and Medical Leadership. The committee wanted it noted that it continues to be impressed with HPFT officers' open and candid responses to their questioning at this and other engagement sessions and believe it shows a strong commitment to delivering and seeking to improve mental health services in Hertfordshire.

Members endorse the priorities as being appropriate to the needs of the users and carers. The Committee is confident that the Trust is well placed to deliver on the priorities.

HSC appreciates the regular updates it receives from officers of the Trust. Participation in scrutiny by both the HSC and Overview & Scrutiny Committee (OSC) is a valuable component of the engagement between HPFT and Hertfordshire County Council's scrutiny committees.

Overall, members regarded the draft quality account priorities as sound and based on thorough consultation with service users, carers and staff. However, in last year's scrutiny of HPFT's quality account the committee requested that year-on-year performances and nationwide comparisons should be provided alongside the Trust's priorities to demonstrate its progress. This was again not provided in this year's written report.

Members also noted that

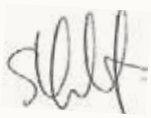
HPFT recognises the significant risk posed by increasing demand for mental health services in Hertfordshire above demographic trends (e.g. 25% for children and young people and 10% for adults). It was recognised that HPFT is well aware of the challenges posed and is taking actions to address them but the sheer size of the increased demand could create risks for all the quality account priorities.

The increase in demand creates additional risks for HPFT in achieving the priorities as the budget has not increased to match demand and nor has staffing.

A number of observations were also made during the scrutiny

- Members would like to see HPfT's Primary Care Mental Health Clinic pilot, being trialled with GP practices in Hertford, Watford and Stevenage, to be rolled out across Hertfordshire over the next 12 months.
- HPFT to consider ways of raising awareness of the trust's Single Point of Access (SPA), specifically with GPs and schools as key sources of referrals, to maximise impact, particularly for children and young people.
- Members were impressed by the Primary Care Mental Health Clinic pilot.

Yours sincerely



Seamus Quilty

Chair, Health Scrutiny Committee

Annexe 2 –

Statement of Directors' responsibilities for the quality account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to March 2018
  - Papers relating to quality reported to the Board over the period April 2017 to March 2018
  - Feedback from commissioners dated May 2018
  - Feedback from governors dated April 2018
  - Feedback from local Healthwatch organisations dated May 2018
  - Feedback form Overview and Scrutiny Committee dated May 2018
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2018
  - The national patient survey dated October 2018
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated May 2018
  - CQC inspection report dated March 2018
- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The Directors confirm to the best of their knowledge and believe they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chairman
24 May 2018

Chief Executive
24 May 2018

Glossary

AD	Alzheimer Disease
ADHD	Attention Deficit Hyperactivity Disorder
ADTU	Acute Day Treatment Unit
ADU	Acute Day care Unit
A&E	Accident and Emergency
Aetiology	The cause, set of causes, or manner of causation of a disease or condition.
AIMS	Accreditation for inpatient mental health services
AMBIT	A metallisation based team approach for teams working with young people
AMH	Adult Mental Health
AP	Associate Practitioner
APPTS	Accreditation Programme for Psychological Therapies Service
ASYE	Assessed and Supported Year in Employment
AWOL	Absent without leave
BMJ	British Medical Journal
BNF	British National Formulary
CAMHS	Child and Adolescent Mental Health Services
CASC	Clinical Assessment of Skills and Competencies
Caseness	Term used to describe a referral that scores highly enough on measures of depression and anxiety to be classed as a clinical case. It is measured by using the assessment scores that are collected at IAPT appointments; if a patient's score is above the clinical/ non-clinical cut off on either anxiety, depression, or both, then the referral is classed as a clinical case.
CATT	Crisis Assessment and Treatment Team
C-CATT	Children's Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCQI	Royal College of Psychiatrists' College Centre for Quality Improvement
CEDS	Community Eating Disorders Service
CGL	Change, Grow, Live – health
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CORE	Clinical Outcomes and Research Evaluation
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPT	Community Perinatal Team
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN	Clinical Research Network
CTR	Care and Treatment review
CYP	Children and Young People
DBT	Dialectical Behaviour Therapy
Datix	Trust incident reporting tool
DOLS	Deprivation of Liberty Safeguards
DNA	Did not attend
DPIM	DNA Polymorphisms in mental health
DToC	Delayed Transfer of Care
Dysphagia	Dysphagia is the medical term for the symptom of difficulty in swallowing
EbE	Experts by Experience
ED	Emergency Department
EDS	Equalities Delivery Scheme

EIP	Early Intervention Psychosis indicator
EIPN	Early Intervention in Psychosis Network
EKOS	East Kent Outcome System
EMDASS	Early Memory Diagnosis and Support Services
EPMHS	Enhanced Primary Mental Health Services (IAPT)
EQUIP	A group aiming to teach skills to offenders (or individuals at risk of offending; helping them to recognise and evaluate risky situations and make decisions which will keep themselves and others safe.
EWS	Early Warning Score
FEP	First Episode Psychosis
FFT	Friends and Family Test
GCS	Glasgow Coma Scale
GMC	General Medical Council
HoNOS	Health of the Nation Outcome Scales
HCC	Hertfordshire County Council
HCT	Hertfordshire Community NHS Trust
HDAT	High Dose Antipsychotic Therapy
HEE of E	Health Education East of England
HEE	Health Education England
HES	Hospital Episode Statistics
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HQUIP	Healthcare Quality Improvement Partnership
HSCA (RA)	Health and Social Care Act Regulated Activities
HSCIC	Health and Social Care Information Centre
HYS	Having Your Say
HSC	Hertfordshire Health Scrutiny Committee
IBS	Irritable Bowel Syndrome
IAPT	Improving Access to Psychological Therapies

ICM	Intensive Community Management
IG	Information Governance
IPS	Individual Placement and Support
JCT	Joint Commissioning Team
KPIs	Key Performance Indicators
LAI	Long Acting Injectable
LD	Learning Disabilities/Disability
LeDeR	Learning Disability Mortality Review Programme
LGO	Local Government Ombudsman
LMC	Local Medical Committees
LQAF	Library Quality Assurance Framework
ME	Myalgic Encephalomyelitis
MES	Member Engagement System
MH	Mental Health
MHMDS	Mental Health Minimum Data Set
MOSS	Making Our Services Safer
MSNAP	Memory Services National Accreditation Programme
NCISH	National Confidential Inquiry into Suicide and Homicide
NHSI	NHS Improvement
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
OCD	Obsessive Compulsive Disorder
OSC	Overview and Scrutiny Committee
PACE	Practice Audit and Clinical Effectiveness
PALS	Patient Advice and Liaison Service
PAIG	Practice Audit Implementation Group

PANSS	Positive and Negative Syndrome Scale
PARIS	Electronic service user record and information system that is used within our Trust
PATH	Psychosis, Prevention, Assessment and Treatment
PC-MIS	IAPT information recording system
PBR	Payment by Results
PBS	Positive Behavioural Support
PDS	Post Diagnostic Support
PELS	Peer Experience Listening Service
PHSO	Parliamentary and Health Services Ombudsman
PICU	Psychiatric Intensive Care Unit
PLAN	Psychiatric Liaison Accreditation Network
POMH UK	Prescribing Observatory for Mental Health – UK
POS	Place of Safety
PPiP	Identifying the prevalence of antibodies to neuronal membrane targets in first episode psychosis
PRN	Pro Re NATA ("when required") medicine
Q	Quarter (3 month period)
QNCC	Quality Network for Community Services
QNCC-ED	Quality Network for Community Services Eating Disorders
QNFMHS	Quality Network for Forensic Mental Health Services
QNIC	Quality Network for Inpatient Services
QNLD	Quality Network for Learning Disability Services
QNOAMHS	Quality Network for Older Adults Mental Health Services
QNPICU	Quality Network for Psychiatric Intensive Care Units
QNPMHS	Quality Network for Prison Mental Health Service
R and D	Research and Development
RAID	Rapid Assessment Interface and Discharge
RfPB	Research for Patient Benefit

Safety Crosses	recording of Datix recordable incidents over a 24 hour period, using a visual 'at a glance' breakdown of incidents
Safety Huddle	a discussion of what is going on, clarifying strategy and who does what. It lasts no longer than 15 minutes and all the people involved usually remain standing
SBU	Strategic Business Unit
SCM	Structured Clinical Management
SI	Serious Incident
SMART	specific, measurable, achievable, realistic and time-bound.
SOF	Single Oversight Framework
SPA	Single Point of Access
SPIKE	new reporting tool for the Trust, a one place stop for all information and reporting requirements
SSRI	Selective Serotonin Reuptake Inhibitor (a type of anti-depressant medication)
STaR	Support Time and Recovery
STOMP	Over prescribing of medication within LD services
STPs	Sustainability and Transformation Partnerships
SU	Service User
TVN	Tissue Viability Nurse
UK CRN	UK Clinical Research Network
VIS	Voice Impact Scale

"The Nursing Associate programme is opening up so many doors"

Former Health Care Assistant, Ian Costello, talks about this exciting new course

Ian Costello has spent 15 years working as a Health Care Assistant (HCA) at Warren Court's Forensic Unit and it is a role that he is passionate about. During his time there he has gained considerable experience and expertise so he felt it was time to take the next step. When his supervisor, recognising Ian's potential, encouraged him to apply to join HPFT's new Nursing Associate Programme he jumped at the chance.

"The Nursing Associate programme is a bridge between health care assistant and registered nurse. Upskilling knowledgeable HCA's to become Nursing Associates capable of delivering direct care frees up nurses and acts as a complimentary role" Ian explains. The course runs for two years during and Trainee Nursing Associates (TNA's) are skilled in all areas of nursing.

Much of the course is split between distance and work based learning but students also spend one day a week at university and go on regular placements. One of Ian's placements was to North West CATT (Crisis Assessment and Treatment Team) and he was clearly impressed. "The work they do supporting people in their homes is amazing. You can see the Trust's values in everything they do."

Ian is now looking forward to his next placement and top of his list is A&E and ITU.

Ian is thoroughly enjoying the Nursing Associate Programme "It's opening up so many doors for me" he says. "I was elected to be both the Student Representative for HPFT as well as for the University of Hertfordshire and I've been invited to sit on the National Implementation Panel NMC (Nursing and Midwifery Council) HEE (Health Education England). I was an HCA and I'm going to be so much more" he adds.

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Hertfordshire Partnership University NHS Foundation Trust (the 'foundation trust'):

- **give a true and fair view of the state of the foundation trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Changes in Equity;
- the statement of Cash Flows; and
- the related notes 1 to 31.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • Valuation of Trust's properties • Accounting for Capital Expenditure Valuation of Trust's properties was a key audit matter in 2016/17. In 2017/18, we have included accounting for capital expenditure as a key audit matter as we consider there to be some judgement required in determining whether spend is capital or revenue in nature, and in ensuring that previously capitalised works that are being replaced or refurbished are appropriately written down. In 2016/17, we identified a key audit matter in respect of the validity of the Continuing Healthcare Provision which we have not identified in 2017/18. We have not included this as a key audit matter in the current year as the balance is decreasing year on year due to utilisation of the provision. Within this report, any new key audit matters are identified with ⏫ and any key audit matters which are the same as the prior year identified with ⏭.
Materiality	The materiality that we used in the current year was £4.48m which was determined on the basis of approximately 2% of the Trust's total revenue (excluding Sustainability and Transformation Fund income) recognised in the year to 2017/18.
Scoping	Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's finance offices in St Albans directly by the audit engagement team, led by the audit partner.
Significant changes in our approach	Other than the reassessment to key audit matter as described above, there have been no significant changes in our approach to the audit in 2017/18 compared to 2016/17.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Valuation of Trust's properties

Key audit matter description	At the end of 2017/18, The Trust held property assets within Property, Plant and Equipment of £145.5 million (2016/17: £140.9 million) which underwent a full revaluation at year end. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas and alternative sites for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. As detailed in notes 1.6 and 11, the Trust has continued to use certain valuation assumptions in the current year, including the use of an alternative site valuation basis, reduced floor areas and reduced land area for some of its properties. The net revaluation gain shown in the Statement of Comprehensive Income is £5.0 million (2016/17: loss of £14.2 million). There is an incentive for the Trust to reduce its asset values because the Public Dividend Capital payment that the Trust pays to the Department of Health is calculated as a function of the Trust's asset values. Therefore there is a cash benefit to reducing the value of the Trust's estate. For this reason, there is a risk that the judgements involved in deriving the valuation of the Trust's estate could be manipulated.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. In respect of the assumptions made in the valuation of the Trust's estate, we integrated an internal property valuation specialist within our team to challenge management's assumptions and methodology for the valuation. We evaluated the rationale for amounts recognised in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and appropriate in the circumstances of the Trust. We have reviewed the accounting policy disclosures in note 1.6 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We assessed whether the valuation and the accounting treatment of the impairment was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Statement of Comprehensive Income for the year.

Key observations	We did not identify any material misstatements through our procedures in respect of this key audit matter, and we considered the assumptions made by the Trust to be reasonable.

Accounting for capital expenditure

Key audit matter description	The Trust's capital spend on Property Plant and Equipment was £6.9 million in 2017/18 (2016/17: £4.8 million). This is shown in note 11 of the Financial Statements. Determining whether expenditure should be capitalised under International Financial Reporting Standards and in identifying whether spend is capital in nature can involve significant judgement. In addition, previously capitalised works that are being replaced or refurbished need to be appropriately written down. There is a potential for fraud through misreporting this balance as there may be an incentive for the Trust to capitalise spend, in year, which does not meet the conditions for capitalisation to facilitate meeting its control total.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of key controls in place around the capitalisation of costs. We have tested capital spending on a sample basis to confirm whether it complies with the relevant accounting requirements and whether the previously capitalised were appropriately written down. We discussed each project undertaken in the year with management and noted that overall all capital projects are capital in nature.
Key observations	We did not identify any material misstatements through our procedures in respect of this key audit matter.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£4.48m (2016/17: £4.39m)
Basis for determining materiality	Approximately 2% of revenue excluding Sustainability and Transformation Fund income (2016/17: 2% of revenue excluding Sustainability and Transformation Fund income) Sustainability and Transformation Fund income has been excluded from our materiality calculation due to this income not being predictable over time.
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £224,000 (2016/17: £219,400), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control and assessing the risks of material misstatement. Audit work was performed at the Trust's offices directly by the audit engagement team, led by the audit engagement partner.

The audit team included integrated Deloitte specialists bringing specialist skills and experience in property valuations and information technology systems. Data analytic techniques were used as part of the audit testing, in particular to support profiling of populations to identify items of audit interest.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

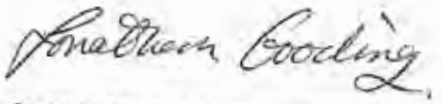
We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Hertfordshire Partnership University NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Jonathan Gooding (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
St Albans, United Kingdom
25 May 2018

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST ON THE TRUST ACCOUNTS CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated TAC02 to TAC29 for tables outlined in red, excluding TAC05A and TAC23 of Hertfordshire Partnership University NHS Foundation Trust for the year ended 31 March 2018, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Hertfordshire Partnership University NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.2 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also included in the audited financial statements.

Auditors are required to report on any differences over £300,000 between the audited financial statements and the consolidation schedules.

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Deloitte LLP.

Deloitte LLP
St Albans

25th May 2018

Artwork supplied by the HPFT Art Collection

My Story

"A great leader is one who creates leaders and helps others to improve"

Moses Mburu, Team Leader at the Trust's Psychiatric Intensive Care Unit (PICU), Oak Unit, talks about his inspiring leadership journey after being awarded a place on the Florence Nightingale Emerging Leaders Scholarship program.

Moses began his nursing career at HPFT in 2006 as a staff nurse on the male acute inpatient unit at QEII Hospital, in Welwyn. He worked his way up and in 2016, moved to his current Team Leader role.

Moses said he; "Wanted to be a good nurse and not only deliver quality care but cope with competing demands of health care, all whilst being a good leader."

This year he was one of only 12 people selected in the country for the Florence Nightingale Emerging Leaders Scholarship – an incredible opportunity to develop further. He said: "It was the most intense application I've ever had to do. The process involved convincing the panel why I deserved the scholarship - thousands apply each year."

Moses was also one of 60 people selected globally for the Emerging Leaders Programme at Harvard Kennedy Executive Business School (USA).

Throughout the scholarship and Harvard learnings, Moses has streamlined the way his team work together whilst effectively developing and supporting them through periods of change. Moses said: 'The key messages I took away were to lead with dignity, realising the value team members bring and learning how to connect the whole team to a shared purpose.

"I am always looking for areas and opportunities where each team member, regardless of their level and experience, can develop themselves."

Foreword to the financial statements of Hertfordshire Partnership University NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Hertfordshire Partnership University NHS Foundation Trust ('the Trust') in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

If you require any further information on these Annual Financial Statements please contact:

Matthew Hooper
Head of Financial Services

Hertfordshire Partnership University NHS Foundation Trust
99 Waverley Road
St Albans
Hertfordshire
AL3 5TL

Telephone number: 01727 804 764

Signed

Tom Cahill, Chief Executive

24 May 2018

Date:

Hertfordshire Partnership University NHS Foundation Trust - Annual Accounts 2017/18

		2017/17	2016/17
	note	£000	£000
Operating income from patient care activities	4	216,892	211,805
Other operating income	4	13,417	12,992
Operating expenses	5	(218,128)	(211,287)
OPERATING SURPLUS		**12,181**	**13,510**
FINANCE COSTS			
Finance income	9.0	142	103
Finance expense - financial liabilities	9.1	(377)	(394)
Finance expense - unwinding of discount on provisions	9.1	(5)	(13)
PDC dividend charge		(3,218)	(3,565)
NET FINANCE COSTS		(3,458)	(3,869)
Gains/(Losses) of disposal of assets	11.3	345	(768)
SURPLUS FOR THE YEAR		**9,068**	**8,873**
Other comprehensive income will not be reclassified to income and expenditure:			
Impairments	13	(3,290)	(13,203)
Revaluations	11	8,907	982
Remeasurements of net defined benefit pension scheme	26	(28)	0
Will not be reclassified to income and expenditure:		**5,589**	**(12,221)**
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**14,657**	**(3,348)**

Whilst the surplus for the financial year was £9,068k (£8,873k in 2016/17) as reported above, this includes a small number of material items which are unusual in nature and not considered by the Trust to be part of its normal activities. In order to assist the reader's understanding of the accounts the following clarifying information is provided:

		2017/18	2016/17
Financial performance for the year:		£000	£000
SURPLUS/(DEFICIT) FOR THE YEAR (as above)		9,068	8,873
Sustainability and Transformation Funding (STF)	4.1	(6,103)	(6,692)
Settlement of historic VAT claims*		0	(1,546)
Net Impairments charged to the SOCI following an independent revaluation	13	580	1,985
Surplus/(Deficit) after adjusting for the above items		**3,545**	**2,620**

*'Settlement of historic VAT claims' refers to agreement reached with HMRC regarding the entitlement to reclaim an element of the VAT incurred on expenditure through our s75 partnership arrangements.

Statement of financial position 31 March 2018

	note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	10	212	274
Property, plant and equipment	11	149,964	145,030
Total non-current assets		**150,176**	**145,304**
Current assets			
Inventories	14	38	27
Trade and other receivables	16	11,591	13,556
Assets held for sale	15	2,750	1,300
Cash and Cash Equivalents	17	56,018	43,561
Total current assets		**70,397**	**58,444**
Current liabilities			
Trade and other payables	21	(27,219)	(21,514)
Borrowings	19	(7,377)	(571)
Provisions	20	(4,195)	(3,227)
Other liabilities	22	(4,927)	(4,623)
Total current liabilities		**(43,718)**	**(29,935)**
Total assets less current liabilities		**176,855**	**173,813**
Non-current liabilities			
Borrowings	19	(10,058)	(17,431)
Provisions	20	(5,556)	(10,739)
Total non-current liabilities		**(15,614)**	**(28,170)**
Total assets employed		**161,241**	**145,643**
Financed by (taxpayers' equity)			
Public Dividend Capital	SOCIE	84,003	83,063
Revaluation Reserve	SOCIE	35,056	29,439
Other reserves	SOCIE	(28)	0
Income and expenditure reserve	SOCIE	42,210	33,141
Total taxpayers' and others' equity		**161,241**	**145,643**

The financial statements on pages 2 to 5, together with the notes on pages 6 to 42 were approved by the Board and signed on its behalf by:

Mr Tom Cahill, Chief Executive

Date 24 May 2018

Statement of changes in taxpayers equity for the year ended 31 March 2018

	note	Total	Public dividend capital	Revaluation reserve	Other Reserves	Income and expenditure reserve
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 01 April 2017 - brought forward		**145,643**	**83,063**	**29,439**	**0**	**33,141**
Surplus for the year	SOCI	9,068	0	0	0	9,068
Transfers between reserves		0	0	(1)	0	1
Net impairments	13	(3,290)	0	(3,290)	0	0
Revaluations - property, plant and equipment	11	8,907	0	8,907	0	0
Remeasurements of defined net benefit pension scheme	26	(28)	0	0	(28)	0
Public dividend capital received	18	940	940	0	0	0
Other reserve movements		1	0	1	0	0
Taxpayers' Equity at 31 March 2018		**161,241**	**84,003**	**35,056**	**(28)**	**42,210**

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential. There was no revaluation reserve held against the asset sold in 2017/18 and therefore no transfer to retained earnings on the disposal of an asset.

Other reserves

The other reserves relate to accounting for the Local Government Pension Scheme as a defined benefit scheme, see note 26 for further details.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

	note	Total	Public dividend capital	Revaluation reserve	Other Reserves	Income and expenditure reserve
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 01 April 2017 - brought forward		**148,991**	**83,063**	**44,929**	**0**	**20,999**
Surplus for the year	SOCI	8,873	0	0	0	8,873
Transfers between reserves		0	0	(218)	0	218
Net impairments	13	(13,203)	0	(13,203)	0	0
Revaluations - property, plant and equipment	11	982	0	982	0	0
Other reserve movements	26	0	0	(3,051)	0	3,051
Taxpayers' Equity at 31 March 2018		**145,643**	**83,063**	**29,439**	**0**	**33,141**

The £218k transfer between the Revaluation Reserve and the Income and Expenditure Reserve relates to excess depreciation where the Revaluation Reserve was greater than the carrying value of the asset.

The £3,051k transfer between the Revaluation Reserve and Income and Expenditure relates to realisation on disposal of an asset being the amount held in the Revaluation Reserve.

Statement of cash flows for the year ended 31 March 2018

	note	2017/18 £000	2016/17 £000
Net cash inflow from operating activities	24	**18,276**	**9,034**
Cash flows from/(used in) investing activities			
Interest received	9	101	129
Purchase of intangible assets		(344)	0
Purchase of property, plant and equipment and investment property		(5,969)	(6,846)
Proceeds from sales of property, plant and equipment and investment property		300	10,994
Net cash flows used in investing activities		**(5,912)**	**4,277**
Net cash generated from financing activities			
Public dividend capital received		940	0
Movement in loans from the Department of Health and Social Care		(530)	(530)
Capital element of finance lease rental payments		(45)	(45)
Interest paid		(372)	(387)
Interest element of finance lease		(6)	(8)
PDC dividend paid		(3,499)	(3,493)
Net cash generated (used in) financing activities		**(3,512)**	**(4,463)**
INCREASE IN CASH AND CASH EQUIVALENTS	17	12,457	7,901
Cash and Cash equivalents at 1 April	17	**43,561**	**35,660**
Cash and Cash equivalents at 31 March		**56,018**	**43,561**

The Statement of Cash Flows, reports transactions purely on a cash basis and not on an accruals basis as used in the other Financial Statements. For this reason some figures may appear different to the figures reported elsewhere. An example of this is 'PDC dividend paid' being £3,499k in the statement above, compared to £3,218k on the Statement of Comprehensive Income.

The 'Proceeds from sales of property, plant and equipment and investment property' in 2016/17 consist of the sales proceeds realised on the sale of a footprint of land at Little Plumstead, Norfolk. This excluded the £3,500k gross proceeds from sale of The Meadows which was completed on 31 March, however the cash was held with the solicitor at 31 March and transferred to the Trust in 2017/18. The Trust also sold the Old Laundry on the Kingsley Green site during 2017/18.

Accounting Convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment.

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM 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 GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to 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.

1.1.1 True and fair view

Foundation Trusts' financial statements should give a true and fair view of the state of affairs of the reporting body at the end of the financial year and of the results of the year. Section 393 of the Companies Act 2006 requires that Directors must not approve financial statements unless they are satisfied that they give a true and fair view as described above.

1.1.2 Going Concern

The Financial Statements have been prepared on the basis that the Trust is a going concern and will be in the foreseeable future. This is based upon the Directors' assessment of the Trust's current financial projections, its current levels of cash and borrowing capacity and the contractual agreements it has with its commissioners.

1.2 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. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of the revision and future periods, if the revision affects both the current and future periods.

1.2.1 Critical judgements in applying accounting policies

There are no critical judgements, apart from those involving estimations (see below note 1.2.2), 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.

1.2.2 Key sources of estimation uncertainty

There are no key assumptions concerning the future, or other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Estimates of the amount to provide for in Pensions provisions, with a carrying amount liability of £2,333k, and injury benefit provisions , with a carrying amount liability of £2,643k, are based on the latest estimates of life expectancy tables provided by the Government Actuary's Department (GAD).

Estimates of the amount to provide for in Continuing Health Care provisions, with a carrying amount liability of £3,712k, are based on the number of claims received with an average value for the claim (based on recent actual settlements) and related costs calculated.

Valuation assumptions for Property, Plant and Equipment, with carrying assets of £149,964k are based on valuations provided by the District Valuer, Giles Awford, as at 31 March 2018 in line with note 1.6.

Legal claims provisions, with a carrying amount liability of £137k, are based on the best estimate received from Solicitors involved in the case, and estimates of probability of as provided by the NHS Litigation Authority.

Estimates of the amount to provide for dilapidation costs, with a carrying amount liability of £925k, reflect the requirements obligated within individual lease agreements and estimated in value by the Associate Director of Estates."

1.3 Income

Income 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 income for the Trust is from commissioners for health and social care services and the majority is provided under a Block Contract arrangement jointly commissioned by NHS East & North Hertfordshire Clinical Commissioning Group, NHS Herts Valleys Clinical Commissioning Group and Hertfordshire County Council.

Where income is received for a specific activity that is to be delivered, fully or partly, in the following year, that income, or part thereof, is deferred.

Interest revenue is derived from balances held with the Government Banking Service and National Loan Fund. All investments have been undertaken in accordance with the Trust's Treasury Management Policy.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Local Government Superannuation Scheme

The Trust is also an admitted fully funded member of the Hertfordshire Local Government Pension Scheme (LGPS), for those staff who have transferred under TUPE (Transfer of Undertakings: Protection of Employment) from Hertfordshire County Council to the Trust's employment since 2004/05. The LGPS is a defined benefit statutory scheme administered by Hertfordshire County Council, in accordance with the Local Government Pension Scheme Regulations 1997, as amended."

The Trust was admitted into the scheme on a fully funded basis, whereby it was allocated assets equal to the value of the liabilities transferred. These assets are held by the Hertfordshire County Council. Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. Previously this was treated as a defined contribution scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.5 Expenditure on other goods and services

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 for the goods and services received. Expenditure is recognised as an operating expense, except where it results in the creation of a non-current asset such as property, plant and equipment and is therefore capitalised (see 1.6 below).

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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.

Measurement Valuation

All property, plant and equipment is 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 such assets are measured subsequently at fair value.

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; or
- Specialised buildings – depreciated replacement cost based on modern equivalent assets.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

A revaluation of all assets was conducted by the District Valuer, Giles Awford, as at 31st March 2018 and those values have been included. Giles Awford has full membership of the Royal Institution of Chartered Surveyors (MRICS).

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is either: probable that additional future economic benefits, or; service potential deriving from the cost incurred to replace a component of such item, will flow to the Trust and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Depreciation is provided at rates calculated to write off the cost of non-current assets, less their estimated residual value, over the expected useful lives on a straight line basis over the following terms:

	Years
Plant & machinery	5 - 15
Set up costs in new buildings	10
Furniture & Fittings	10
Information Technology	3

Buildings held under finance lease agreements are depreciated over the term of the lease.

Freehold land is considered to have an infinite life and is therefore not depreciated.

Refurbishment of leased buildings is depreciated over the term of lease.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

Revaluation gains and losses

Revaluation gains and losses are recognised in the revaluation reserve. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised.

Gains/surpluses and losses/impairments recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as separate items of 'other omprehensive income'.

Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of; (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales, and;
- the sale must be highly probable i.e.;
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and

– the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or"significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7 Intangible assets

Recognition

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

Internally generated goodwill, brands, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset throughout its remaining development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset and amortised over the useful life of the asset which is generally 5 years.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell."

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and a reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged as an expense within the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases and accounted for accordingly.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

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.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out approach to identify stock movements. This is considered to be a reasonable approximation to fair value.

1.10 Cash and cash equivalents

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

1.11 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

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 expenditure arising from the restructuring, which are those amounts that are necessarily entailed by the restructuring and not associated with the ongoing activities of the Trust.

1.12 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to operating expenses. 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 20 but is not recognised in the Trust's Financial Statements.

1.13 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 any claims arising for which the Trust is liable. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Contingencies

Contingent assets

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. The Trust does not hold any of these assets.

Contingent liabilities

Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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

1.15 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.

Financial assets are classified into the following categories: financial assets at fair value through income and expenditure; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets held at fair value through income and expenditure

These are financial assets held for trading. A financial asset is

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classified in this category if acquired principally for the purpose of selling in the short-term.

The Trust does not hold any of this class of assets.

Available for sale financial assets

These are financial assets held for sale. The Trust does not hold any of this class of assets.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Fair value is determined by reference to quoted market prices where possible, otherwise at amortised cost, using the effective interest method.

1.16 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.

Financial liabilities at fair value through income and expenditure

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through income and expenditure. They are held at fair value, with any resultant gain or loss recognised in the Trust's Statement of Comprehensive Income. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.17 Corporation Tax

The Trust had determined that it has no Corporation Tax liability on the basis that its principal purpose is a public service, rather than carrying on a trade or any commercial activity.

1.18 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and therefore, 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.

1.19 Foreign currencies

The Trust's functional currency and presentational currency is sterling. There are no material foreign currency transactions in the year.

1.20 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 28 to the accounts.

1.21 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.22 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 should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover, had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses. The detail can be found in note 27.

1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 Subsidiaries

The Trust is the corporate trustee to Hertfordshire Partnership NHS Foundation Trust Charity. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

The Trust has chosen not to consolidate the Charitable Funds into these Financial Statements as the amounts of the Charitable Funds are not material and would not provide additional value to the reader of the Trust's Financial Statements.

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

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

The Department of Health and Social Care (DH) General Accounting Manual (GAM) does not require the following Standards and Interpretations to be applied in 2017/18.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. It's adoption in 2018/19 is not expected to have a significant impact.
- IFRS 14 Regulatory Deferral Accounts - Not yet EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. It's adoption in 2018/19 is not expected to have a significant impact.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019."

1.27 Revenue – government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The Trust has no such grants.

2 Financial Risk Factors

The Trust's activities expose it to a variety of financial risks: credit risk, liquidity risk, cash flow risk and fair value interest-rate risk. The Trust's overall risk management programmes focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the Trust's financial performance.

Risk management is carried out centrally under policies approved by the Board of Directors.

2.1 Credit risk

Over 90% of the Trust's income is from contracted arrangements with commissioners. As such, any material credit risk is limited to administrative and contractual disputes. Where a dispute arises, provision will be made on the basis of the age of the debt and the likelihood of a resolution being achieved.
Note 16.3 shows the analysis of impaired debts and non-impaired debts which are past their due date.

2.2 Liquidity risk

The Trust's net operating costs are incurred under contract agreements principally with NHS Clinical Commissioning Groups and Hertfordshire County Council, which are financed from resources voted annually by Parliament. The Trust also finances its capital expenditure from internally generated resources, from funds made available by commissioners and from loan agreements with the National Loan Fund. The Trust is not, therefore, exposed to significant liquidity risks.

2.3 Cash flow and fair value interest-rate risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is therefore not exposed to significant interest-rate risk.

2.4 Borrowings

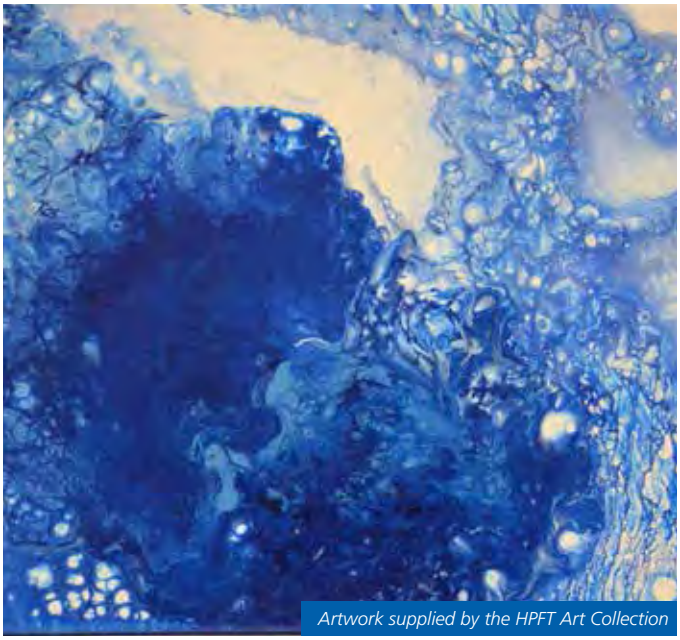
As an NHS Foundation Trust the Trust has the authority to finance capital expenditure through borrowing. Up until 2012/13 the Trust had financed its capital programme from existing cash balances. Two loan applications were approved by both Monitor and the Independent Trust Financing Facility to part fund the future capital investment programme up to a value of £38.8m. £19.2m was drawn down in previous years (£10.2m in 2014/15, £9m in 2013/14). No further drawdown against this facility is permitted. Any future requirements would require agreement of a new facility.

3 Segmental information

A business segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are different from those of other business segments.

A geographical segment is engaged in providing products or services within a particular economic environment that is subject to risks and returns that are different from those of segments operating in other economic environments.

The Directors consider that the Trust's activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all the assets are managed as one central pool.



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4 Operating Income from continuing operations

4.1 Operating Income (by classification)

Income is classified as "Income from Activities" when it is earned under contracts with NHS bodies and others for the provision of service user-related health and social care services. Income from non-patient-care services is classified as "Other operating income".

	2017/18 Total	2016/17 Total Restated
	£000	£000
Operating income from patient care activities		
Cost and volume contract income	5,154	5,359
Block contract income	207,806	203,426
Clinical partnerships providing mandatory services (including S75 agreements)	1,123	1,122
Other clinical income from mandatory services	2,809	1,898
Total income from activities	**216,892**	**211,805**
Other operating income		
Research and development	529	623
Education and training	4,420	2,823
Non-patient care services to other bodies	448	866
Sustainability and Transformation Fund income	6,103	6,692
Other	1,796	1,915
Rental revenue from operating leases	121	73
Total other operating income	**13,417**	**12,992**
Total operating Income	**230,309**	**224,797**

Income relating to Education and Training has increased in the year due to increased funding from Health Education England. This has been for programs including the Sustainability and Transformation Partnership (STP), Nursing associates program and Increasing Access to Psychological Therapies.

A £1.8 billion Sustainability and Transformation Fund (STF) has been made available again to NHS providers during 2017-18, linked to the achievement of financial control total and performance targets. Of this the Trust has been awarded a total of £6,103k comprising £1,262k in relation to its achievement of its control total, £2,731k in relation to its acheivement in excess of its control total, £475k in relation to incentive STF general distribution, £1,216k in relation to a bonus amount awarded, and £419k relating to 2016/17 post accounts allocation. This is a reduction on the £6,692k received in 2016/17.

4.2 Income from Activities (by source)

Income from Activities may also be analysed by the source of that Income.

	2017/18 Total	2016/17 Total
	£000	£000
Operating income from patient care activities		
NHS Foundation Trusts	0	4
NHS Trusts	456	539
Clinical commissioning groups	24,512	21,742
NHS England	18,364	18,627
Local authorities	173,546	170,889
NHS other (including Public Health England)	14	0
Non NHS	0	4
Total Income from activities	**216,892**	**211,805**

The Trust's main source of income (80%) is included in 'Income from Local Authorities' and is principally from the joint commissioning arrangement between East and North Hertfordshire Clinical Commissioning Group, Herts Valleys Clinical Commissioning Group and Hertfordshire County Council.

4.3 Analysis between Commissioner Requested Services and non-Commissioner Requested Services

Under the Trust's Provider Licence, the Trust is required to provide commissioner requested health and social services. The allocation of income from activities between Commissioner Requested Services and other services is shown below.

	2017/18	2016/17
	£000	£000
Income from Commissioner Requested Services	216,892	211,805
Income from non-Commissioner Requested Services	13,417	12,992
	230,309	**224,797**

4.4 Operating Lease Income

The Trust leases one of its properties (31/33 Hill End Lane) under a non-cancellable operating lease agreement.

The total annual income from this operating lease in 2017/18 is £13k (£13k in 2016/17).

The future aggregate minimum lease payments due to the Trust under non-cancellable operating leases are as follows:

	2017/18	2016/17
	£000	£000
on leases of Buildings expiring:		
- not later than one year;	13	13
- later than one year and not later than five years;	52	52
- later than five years.	0	0
	65	**65**

5 Operating Expenses of continuing operations

5.1 Operating Expenses (by type)

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,799	1,756
Purchase of healthcare from non-NHS and non-DHSC bodies	10,358	11,657
Purchase of social care	16,760	16,289
Non-executive directors	170	115
Staff and executive directors costs	146,438	137,588
Supplies and services – clinical (excluding drugs costs)	525	488
Supplies and services - general	7,192	6,194
Establishment	2,903	2,429
Research and development - non-staff	0	19
Research and development - staff costs	298	349
Transport (business travel only)	2,019	1,884
Transport - other (including patient travel)	1,450	1,257
Premises - business rates collected by local authorities	1,074	1,389
Premises - other	2,126	3,505
Increase/(decrease) in impairment of receivables	109	167
Provisions arising / released in year	(2,447)	0
Inventories written down (net including drugs)	3	3
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	2,974	2,474
Operating lease expenditure (net)	2,481	2,797
Depreciation	4,838	5,177
Amortisation	87	86
Impairments net of (reversals)	580	1,985
Audit services - statutory audit	69	65
Other auditor remuneration (payable to external auditor only)	9	11
Clinical negligence - amounts payable to NHS Resolution (premium)	569	518
Legal fees	176	255
Consultancy	957	1,074
Internal audit - non-staff	110	119
Education and training - non-staff	1,242	1,306
Car parking and security	989	594
Redundancy costs - staff costs	116	119
Hospitality	71	0
Insurance	334	439
Other services (e.g. external payroll)	8,380	8,874
Other losses and special payments - non-staff	0	12
Other	3,369	293
Total Operating Expenses	**218,128**	**211,287**

There has been an adjustment to 2016/17 published figures relating to 'Purchase of Healthcare from NHS and DHSC bodies' and 'Other Services' of £2,281k whereby a reclassification of IT related costs now allows for a more accurate comparison between financial years

Provisions arising / released in 2017/18 relates to the release of legal claims of £1,326k, redundancy of £121k and continuing health care of £1,000k. The remaining provision arising or released per note 20 were released or charged to other expenditure codes in year.

5.2 Limitation on Auditor's Liability

The Trust's external auditor, Deloitte LLP, does not have a liability cap in relation to the annual statutory audit.

5.3 Exit Packages

Reporting of other compensation schemes - exit packages There were 3 exit packages agreed in 2017/18 totalling £116k.	**Number of exit packages**	**Cost of exit packages**
Exit package cost band (including any special payment element)	Number	£000s
<£10,000	0	0
£10,000 - £25,000	0	0
£25,001 - 50,000	3	116
£50,001 - £100,000	0	0
£100,001 - £150,000	0	0
£150,001 - £200,000	0	0
>£200,000	0	0
Total	**3**	**116**

Reporting of other compensation schemes - exit packages There were 2 exit packages agreed in 2016/17 totalling £120k.	**Number of exit packages**	**Cost of exit packages**
Exit package cost band (including any special payment element)	Number	£000s
<£10,000	0	0
£10,000 - £25,000	0	0
£25,001 - 50,000	1	27
£50,001 - £100,000	1	93
£100,001 - £150,000	0	0
£150,001 - £200,000	0	0
>£200,000	0	0
Total	**2**	**120**

6 Commitments under Operating Leases

The Trust leases various premises and equipment under non-cancellable operating lease agreements. The leases have varying terms, escalation clauses and renewal rights.

During 2016/17 the Trust vacated Department of Health and Social Care land at Kingsley Green, which has led to a significant decrease in both annual lease expenditure and future minimum lease payments.

Analysis of operating lease expenditure 2017/18

	Total	Buildings	Other
	£000	£000	£000
Minimum lease payments	2,481	2,200	281
Total	**2,481**	**2,200**	**281**

Analysis of operating lease expenditure 2016/17

	Total	Buildings	Other
	£000	£000	£000
Minimum lease payments	2,797	2,498	299
Total	**2,797**	**2,498**	**299**

The future aggregate minimum lease payments under non-cancellable operating leases are as follows:

Arrangements containing an operating lease 2017/18

	Total	Buildings	Other
	£000	£000	£000
Future minimum lease payments due:			
- not later than one year;	1,632	1,503	129
- later than one year and not later than five years;	5,176	5,004	172
- later than five years.	8,961	8,961	0
	15,769	**15,468**	**301**

Arrangements containing an operating lease 2016/17

	Total	Buildings	Other
	£000	£000	£000
Future minimum lease payments due:			
- not later than one year;	1,684	1,540	144
- later than one year and not later than five years;	5,523	5,405	118
- later than five years.	7,093	7,093	0
Total	**14,300**	**14,038**	**262**

7 Employee expenses

7.1 The employee expenses incurred during the year were as follows

	2017/18	2016/17
	£000	£000
Salaries and wages	112,505	104,323
Social security costs	11,643	11,385
Apprenticeship levy	547	0
Pension cost - employer contributions to NHS pension scheme	13,671	13,542
Pension cost - other	32	51
Temporary staff - agency/contract staff	8,454	8,755
Total Gross Staff Costs	**146,852**	**138,056**
Analysed into Operating Expenditure in note 5.1:		
Employee expenses - staff & executive directors	146,438	130,832
Research and development	298	1,428
Redundancy	116	306
Total Employee benefits excluding capitalised costs	**146,852**	**138,056**

The restatement in 2016/17 relates to £119k of redundancy costs correctly analysed in employee expenses

7.2 Number of employees

The average number of employees during the year was as follows (expressed in full time equivalents)

	2017/18	2016/17
	FTE's	FTE's
	Number	Number
Medical and dental	186	182
Administration and estates	711	688
Healthcare assistants and other support staff	866	819
Nursing, midwifery and health visiting staff	865	862
Scientific, therapeutic and technical staff	572	515
Social care staff	116	105
Other	8	8
Total	**3,324**	**3,179**

The above numbers include those engaged through bank or agency.

7.3 Retirements due to ill-health

During 2017/18 there were 5 (1 in 2016/17) early retirements from the Trust on the grounds of ill-health with an estimated additional pension liability of £347k (£58k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

8 Better Payment Practice Code

The measure of compliance for 2017/18 has been analysed and can be found in the Trust's Annual Report .

8.1 The Late Payment of Commercial Debts (Interest) Act 1998

There are no material amounts included within Finance Expenses (note 9.1) arising from claims made under this legislation.

There is no compensation paid to cover debt recovery costs under this legislation.

9 Finance Income

	2017/18	2016/17
	£000	£000
Interest receivable on bank deposits	142	103

Interest receivable as stated in the Statement of Cash Flows is the actual cash received by the Trust in year (£101k relating to 2016/17 and £127k relating to 2017/18), whereas the figure above comprises the £142k received relating to 2017/18 and also includes £15k accrued interest receivable relating to 2016/17. Increases in the national interest rates resulted in increased interest receivable income.

9.1 Finance Expenses

	2017/18	2016/17
	£000	£000
Interest on capital loans from the Department of Health and Social Care	372	386
Interest on finance lease obligations	5	8
Unwinding of discount on provisions	5	13
Total	382	407

10 Intangible Assets

	2017/18 Software licences	2016/17 Software licences
	£000	£000
Opening cost at 1 April	771	427
Additions - purchased	25	344
Disposals	0	0
Gross cost at 31 March	**796**	**771**
Opening amortisation at 1 April	497	411
Provided during the year	87	86
Disposals	0	0
Amortisation at 31 March	**584**	**497**
Net book value		
At 1 April	274	16
At 31 March	**212**	**274**

The 2017/18 intangible asset addition relates to the purchase of staff appraisal software licences.

The 2016/17 intangible asset addition relates to the purchase of staff rostering software licences to replace the licences that expired within the year.

11 Plant and Equipment as at 31 March 2018

11.1 Balances as at 31 March 2018

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/ gross cost at 1 April 2016 – brought forward	**152,934**	27,442	117,471	195	311	803	3,718	2,994
Additions – purchased	**6,903**	0	5,200	0	549	0	803	351
Impairments charged to operating expenses	(2,506)	(569)	(1,911)	0	(7)	0	(7)	(12)
Impairments charged to the revaluation reserve	(3,290)	(1,383)	(1,907)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**1,940**	0	1,940	0	0	0	0	0
Reclassifications	**0**	0	254	0	(254)	0	0	0
Revaluations	**1,513**	1,671	(193)	35	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(1,450)	(887)	(563)	0	0	0	0	0
Disposals/derecognition	(3,980)	(74)	(682)	0	0	(47)	(2,974)	(203)
Valuation/gross cost at 31 March 2018	**152,064**	**26,200**	**119,609**	**230**	**599**	**756**	**1,540**	**3,130**
Accumulated depreciation at 1 Apr 2017 - brought forward	**7,904**	0	4,010	5	0	284	2,536	1,069
Provided during the year	**4,838**	0	3,664	5	0	71	807	291
Impairments charged to operating expenses	**14**	0	14	0	0	0	0	0
Revaluations	(7,394)	0	(7,384)	(10)	0	0	0	0
Disposals/derecognition	(3,262)	0	(38)	0	0	(47)	(2,974)	(203)
Accumulated depreciation at 31 March 2018	**2,100**	**0**	**266**	**0**	**0**	**308**	**369**	**1,157**
Net book value at 31 March 2018								
Owned	**149,933**	26,200	119,312	230	599	448	1,171	1,973
Finance Leased	**31**	0	31	0	0	0	0	0
NBV Total at 31 March 2017	**149,964**	**26,200**	**119,343**	**230**	**599**	**448**	**1,171**	**1,973**

The Trust's land and buildings underwent a full valuation at 31 March 2018.

Included within 'additions - purchased' are the following items:

Classified as 'Buildings, excluding dwellings';

- Centenary House refurbishment - £735k which was completed in Q4 2017/18
- The Marlowes Health and Wellbeing Centre - £2,433k which was completed in Q4 2017/18
- Broadlands Reception extension - £218k which was completed in Q3 2017/18
- Trust wide fire prevention works - £876k which was completed in Q4 2017/18
- Forest Lane Bungalows refurbishment - £264k which was completed in Q4 2017/18

Classified as 'Information technology';

- £777k to replace computers at the end of their economic life and improve cyber security"

See note 13 for details of Impairments.

Included within 'reclassifications' are the following items, previously held as 'Assets under Construction':

- The Marlowes Health and Wellbeing Centre - £208k which was completed and brought in to use in Q4 2017/18

- Centenary House refurbishment - £45k which was completed and brought in to use in Q4 2017/18"

See note 11.3 for details of property disposals. There were a number of items within Plant & Machinery, Furniture & Fittings and IT that have been de-recognised within the year due to them reaching the end of their economic life and having no carrying value

The Trust's land and buildings underwent a full valuation at 31 March 2018.

11.2 Balances as at 31 March 2017

	Total	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction	Plant & machinery	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2016 - restated	**171,179**	**40,032**	**117,224**	**195**	**3,782**	**1,472**	**5,316**	**3,158**
Additions - purchased (including capital lifecycle additions)	**4,824**	0	4,056	0	210	0	229	329
Impairments charged to operating expenses	(2,025)	(1,911)	(10)	0	(74)	0	0	(30)
Impairments charged to the revaluation reserve	(13,203)	(8,579)	(4,624)	0	0	0	0	0
Reclassifications	0	0	3,593	0	(3,607)	0	14	0
Revaluations	982	50	932	0	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(1,300)	(350)	(950)	0	0	0	0	0
Disposals/derecognition	(7,523)	(1,800)	(2,750)	0	0	(669)	(1,841)	(463)
Valuation/ gross cost at 31 March 2017	**152,934**	**27,442**	**117,471**	**195**	**311**	**803**	**3,718**	**2,994**
Accumulated depreciation at 1 Apr 2016 - restated	**5,740**	0	306	0	0	878	3,305	1,251
Provided during the year	**5,177**	0	3,744	5	0	74	1,072	282
Reversal of impairments credited to operating expenses	(40)	0	(40)	0	0	0	0	0
Revaluations	**0**	0	0	0	0	0	0	0
Disposals	(2,973)	0	0	0	0	(668)	(1,841)	(464)
Accumulated depreciation at 31 March 2017	**7,904**	**0**	**4,010**	**5**	**0**	**284**	**2,536**	**1,069**
Net Book Value at 31 March 2017								0
Owned	**144,975**	27,442	113,406	190	311	519	1,182	1,925
Finance Leased	**55**	0	55	0	0	0	0	0
Net Book Value at 31 March 2017	**145,030**	**27,442**	**113,461**	**190**	**311**	**519**	**1,182**	**1,925**

"Included within 'additions - purchased' are the following items:
Classified as 'Buildings, excluding dwellings';
- Logandene refurbishment- £2,476k which was completed in Q4 2016/17
- Little Plumstead anti-ligature works - £1,061k which was completed in Q4 2016/17
- Warren Court anti-ligature works - £739k which was completed in Q4 2016/17

Classified as 'Information technology';
- £229k to replace computers at the end of their economic life.

See note 13 for details of Impairments.

Included within 'reclassifications' are the following items, previously held as 'Assets under Construction':
- Lambourn Grove - £2,822k which was completed and brought in to use in Q1 2016/17
- Logandene - £248k which was completed and brought in to use in Q4 2016/17

See note 11.3 for details of property disposals. There were a number of items within Plant & Machinery, Furniture & Fittings and IT that have been de-recognised within the year due to them reaching the end of their economic life and having no carrying value

The Trust's land and buildings were not all revalued at 31 March 2017. The land and buildings deemed to be inefficient for service provision and therefore requiring an updated valuation, and those buildings that have had significant investment, were revalued.

11.3 Disposal of property, plant and equipment

	2017/18	2016/17
	£000	£000
Gains on disposal of property, plant and equipment	345	0
Gains on disposal of assets held for sale	0	296
Losses on disposal of property, plant and equipment	0	(1,064)
Total gain/loss on disposal recorded in the Statement of Comprehensive Income	**345**	**(768)**

Assets disposed in 2017/18 consisted of the Old Laundry on the Kingsley Green site.

Assets disposed in 2016/17 include; a footprint of land at Little Plumstead and The Meadows land and buildings.

12 Assets held under Finance Leases

	2017/18	2016/17
Opening cost at 1 April	**2,125**	**2,125**
Accumulated depreciation at 1 April	2,070	2,045
Provided during the year	24	25
Accumulated depreciation at 31 March	**2,094**	**2,070**
Net book value		
NBV total at 1 April	55	80
NBV total at 31 March	**31**	**55**

The Trust leases one premises under a finance lease agreement. The premises is 32 St. Peter's Street, St. Albans.

13 Impairment of Assets (Property, Plant & Equipment and Intangibles)

	2017/18	2016/17
	£000	£000
Impairments due to abandonment of assets under construction	0	74
Impairments of Property, Plant and Equipment charged to operating expenses due to changes in market price	2,505	1,951
Impairments of Property, Plant and Equipment charged to operating expenses due to unforseen obsolesence	15	0
Reversal of prior year impairments of Property, Plant and Equipment credited to operating income	(1,940)	(40)
Total impairments and reversal of impairments charged to the Statement of Comprehensive Income	**580**	**1,985**
Total Net Impairments of Property, Plant and Equipment charged to the Revaluation Reserve	3,290	13,203
Total impairment charged to the Revaluation Reserve	**3,290**	**13,203**

The impairment adjustments for 2017/18 follow a full revaluation and impairment review conducted by the District Valuer. The assets impaired to the 'Statement of Comprehensive Income' largely related to decreases in the value of buildings held by the Trust (£2,491k). These impairments were incurred as a result of consideration being taken of the modern equivalent asset value of some specialised assets and impairment reviews being undertaken on The Marlowes Health and Wellbeing Centre and Centenary House following recent refurbishment works being capitalised.

`The 'reversal of impairments credited to operating income' in 2017/18 are impairments incurred in prior years and the assets have since been revalued upwards. These largely relate to Broadlands Clinic, Little Plumstead (£406K), Albany Lodge (£270k), Waverley Road (£253k), Seward Lodge (£217k), Astley Court (£148k).

14 Inventories

	2017/18	2016/17
	£000	£000
Carrying Value at 1 April	27	19
Additions	531	364
Inventories recognised in expenses	(517)	(353)
Write-down of inventories recognised as an expense	(3)	(3)
Carrying Value at 31 March	**38**	**27**

15 Assets Held For Sale

	31 March 2018	31 March 2017
	£000	£000
Net Book Value of assets held for sale at 1 April	1,300	0
Plus assets classified as available for sale in the year	1,450	1,300
Net Book Value of assets held for sale at 31 March	**2,750**	**1,300**

Assets held for sale in 2017/18 comprise of 143 and 145 Harper Lane, Radlett and 305 Ware Road, Hailey.

Assets held for sale in 2016/17 comprise of 143 and 145 Harper Lane, Radlett.

16 Receivables

16.1 Trade and other Receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	3,948	1,758
Capital receivables (including accrued capital related income)	0	3,648
Provision for impaired receivables	(362)	(258)
Prepayments (revenue)	885	997
Accrued income	6,236	6,810
Interest receivable	20	5
PDC dividend receivable	467	186
VAT receivable	334	229
Other receivables	63	181
Total current trade and other receivables	**11,591**	**13,556**
Of which receivable from NHS and DHSC group bodies	**5,826**	**7,598**

Trade Receivables has increased due to a receivable (£797k) linked to the completion of the Marlowes Health & Wellbeing Centre in conjunction with Hertfordshire Community NHS Trust and delays in the receipt of payments from other NHS and Local Authority organisations.

Capital Receivables relates to the sale of the Meadows, Borehamwood. The sale was completed on the 31st March 2017 with the funds were held by the Trust solicitors at that date, which is no longer applicable in 2017/18.

16.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April	258	115
Increase in provision	145	190
Amounts utilised	(5)	(24)
Unused Amounts reversed	(36)	(23)
Balance at 31 March	**362**	**258**

16.3 Analysis of receivables past due or impaired

	31 March 2018	31 March 2017
	£000	£000
Ageing of impaired receivables		
Up to 30 days	0	0
Between 30 and 60 days	0	3
Between 60 and 90 days	4	14
Between 90 and 180 days	43	18
Over 180 days	315	223
Total	**362**	**258**
Ageing of non-impaired receivables past their due date		
Overdue by up to 30 days	382	880
Overdue between 30 and 60 days	147	435
Overdue between 60 and 90 days	460	232
Overdue between 90 and 180 days	207	250
Overdue over 180 days	256	37
Total	**1,452**	**1,834**

17 Cash and cash equivalents

	2017/18	2016/17
	£000	£000
Cash and Cash equivalents at 1 April	43,561	35,660
Net change in cash and cash equivalents	12,457	7,901
Cash and Cash equivalents at 31 March	**56,018**	**43,561**
Comprising:		
Cash at commercial banks and in hand	77	6
Cash with the Government Banking Service	55,941	6,055
Deposits with the National Loan Fund	0	37,500
	56,018	**43,561**

The Trust's cash reserves have increased substantially in year primarily due to sustainability and transformation funding received from NHS Improvement, the sale of property and the receipt of PDC.

18 Public Dividend Capital

	2017/18	2016/17
	£000	£000
Taxpayers' Equity at 1 April	83,063	83,063
Public Dividend Capital repaid	0	0
Public Dividend Capital receipts	940	0
Taxpayers' Equity at 31 March	**84,003**	**83,063**

PDC receipts during 2017/18 were for capital projects relating to childrens Places of Safety (£540k) and Cyber Security improvements (£400k).

19 Borrowings

19.1 Borrowings: Loans and Finance Leases

	31 March 2018	31 March 2017
	£000	£000
Current		
Capital loans	7,320	530
Obligations under finance leases	57	41
Total current borrowings	**7,377**	**571**
Non-current		
Capital loans	10,058	17,378
Obligations under finance leases	0	53
Total non-current borrowings	**10,058**	**17,431**
Total borrowings	**17,435**	**18,002**

The Trust has a loan arrangement with the Department of Health (see note 2.4). The movement of £6.79m from non-current to current reflects the expectation that the £6.79m bridging loan will be repaid within the next 12 months. This follows the sale of Kingsley Green land by the Department of Health and Social Care.

19.2 Finance Lease borrowings

	31 March 2018	31 March 2017
	£000	£000
Payable:		
- not later than one year;	60	52
- later than one year and not later than five years;	0	64
- later than five years.	0	0
Gross lease liabilities	**60**	**116**
Less: Finance charges/(income) allocated to future periods	(3)	(22)
Net lease liabilities	**57**	**94**
Split into current and non-current borrowings on the Statement Of Financial Position:		
- current	57	41
- non current	0	53
	57	**94**
Expected timing of cashflows:		
- not later than one year;	57	41
- later than one year and not later than five years;	0	53
- later than five years.	0	0
	57	**94**

Details of Finance Leases are included in note 12.

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20 Provisions for liabilities and charges

(held in current and non-current liabilities)

20.1 Provisions for liabilities and charges (held in current and non-current liabilities) 2017/18

2017/18	Total	Pensions relating to other staff	Other legal claims	Continuing Health Care	Redundancy	Other
	£000	£000	£000	£000	£000	£000
At 1 April - brought forward	13,966	2,544	1,463	6,489	121	3,349
Arising during the year	410	36	33	0	0	341
Utilised during the year - accruals	(86)	(55)	0	0	0	(31)
Utilised during the year - cash	(1,165)	(152)	0	(920)	0	(93)
Reversed unused	(3,379)	(42)	(1,359)	(1,857)	(121)	0
Unwinding of discount rate	5	2	0	0	0	3
Total at 31 March 2018	**9,751**	**2,333**	**137**	**3,712**	**0**	**3,569**
Expected timing of cashflows:						
- not later than one year (current)	4,195	221	137	3,712	0	125
- later than one year and not later than five years (non-current)	2,307	883	0	0	0	1,424
- later than five years (non-current)	3,249	1,229	0	0	0	2,020
Total	**9,751**	**2,333**	**137**	**3,712**	**0**	**3,569**

The 'Pensions relating to other staff' provision is the capitalised cost of early retirements as defined by the NHS Pensions Agency. This mainly relates to early retirements of staff resulting from the closure of long stay institutions, namely, Hill End, Leavesden, Cell Barnes and Harperbury Hospitals.

The 'Other legal claims' provision includes provisions in respect of the Trust's employer and public liabilities, the amount stated is subject to uncertainty about the outcome of legal proceedings. The reversal in year of £1,359k relates primarly to one legal claim which was succesfully defended. £26,603k (£20,713k as at 31 March 2017) is included in the provisions of the NHS Litigation Authority at 31 March 2018 in respect of clinical negligence liabilities of the Trust.

The 'Continuing Health Care' provision comprises the potential liability for claims to the Trust for the reimbursement of the costs of Continuing Health Care incurred by the claimant where the claimant considers the costs should have been met by the Trust. The reversal in year of £1,857 relates to a review of the outstanding claims leading to a significant reduction in the provision.

The 'Redundancy' provision is the estimated liability for the costs directly related to any formal restructuring plans announced. For 2017/18 there are none.

The 'Other' provision is the capitalised cost of injury benefits as defined by the NHS Pension scheme, for scheme members who have claimed that they are permanently incapable of fulfilling their duties effectively through injury, and a dilapidation provision for the cost to return leased buildings back to their original condition upon exit.

The very nature of these provisions means that there are uncertainties regarding timing and amount of settlement, though the amount provided is judged sufficient to meet these liabilities. See note 1.2.2 for details of the uncertainties about the amount and timing of outflows.

20.2 Provisions for liabilities and charges (held in current and non-current liabilities) 2016/17

2016/17	Total	Pensions relating to other staff	Other legal claims	Restructuring	Continuing Health Care	Redundancy	Other
	£000	£000	£000	£000	£000	£000	£000
At 1 April - restated	13,118	2,726	177	126	6,896	200	2,993
Arising during the year	2,647	37	1,428	0	429	120	633
Utilised during the year - accruals	(86)	(55)	0	0	0	0	(31)
Utilised during the year - cash	(1,476)	(154)	(90)	(105)	(836)	(199)	(92)
Reversed unused	(250)	(16)	(52)	(21)	0	0	(161)
Unwinding of discount rate	13	6	0	0	0	0	7
Total at 31 March 2017	**13,966**	**2,544**	**1,463**	**0**	**6,489**	**121**	**3,349**
Expected timing of cashflows:							
- not later than one year (current)	3,227	221	1,463	0	1,298	121	124
- later than one year and not later than five years (non current)	7,201	884	0	0	5,191	0	1,126
- later than five years (non current)	3,538	1,439	0	0	0	0	2,099
Total	**13,966**	**2,544**	**1,463**	**0**	**6,489**	**121**	**3,349**

The 'Pensions relating to other staff' provision is the capitalised cost of early retirements as defined by the NHS Pensions Agency. This mainly relates to early retirements of staff resulting from the closure of long stay institutions, namely, Hill End, Leavesden, Cell Barnes and Harperbury Hospitals.

The 'Other legal claims' provision includes provisions in respect of the Trust's employer and public liabilities, the amount stated is subject to uncertainty about the outcome of legal proceedings. £20,713k (£21,212k as at 31 March 2016) is included in the provisions of the NHS Litigation Authority at 31 March 2017 in respect of clinical negligence liabilities of the Trust.

The 'Restructuring' provision is the estimated liability for the protected salary costs of staff affected by the transformation programme.

The 'Continuing Health Care' provision comprises the potential liability for claims to the Trust for the reimbursement of the costs of Continuing Health Care incurred by the claimant where the claimant considers the costs should have been met by the Trust.

The 'Redundancy' provision is the estimated liability for the costs directly related to the formal restructuring plan announced.

The 'Other' provision is the capitalised cost of injury benefits as defined by the NHS Pension scheme, for scheme members who have claimed that they are permanently incapable of fulfilling their duties effectively through injury, and a dilapidation provision for the cost to return leased buildings back to their original condition upon exit.

The very nature of these provisions means that there are uncertainties regarding timing and amount of settlement, though the amount provided is judged sufficient to meet these liabilities. See note 1.2.2 for details of the uncertainties about the amount and timing of outflows.

21 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	2,775	4,170
Capital payables (including capital accruals)	795	447
Accruals (revenue costs only)	18,743	13,982
Social security costs	1,621	1,567
VAT payables	15	0
Other taxes payable	1,349	1,310
Accrued interest on DHSC loans	33	33
Other payables	1,888	5
Total Trade and other payables	**27,219**	**21,514**
Of which payable to NHS and DHSC group bodies	**4,695**	**3,010**

The reduction in Trade Payables is a result of a reclassification of pension contributions to be paid to the NHS Pension Authority, from 'Trade payables' to 'other payables'.

Accruals are the charges from suppliers for goods or services that have not been paid at 31 March.

22 Other liabilities

	31 March 2018	31 March 2017
Current		
Deferred income	4,927	4,623
Total Other liabilities	**4,927**	**4,623**

Other liabilities largely comprise income received from commissioners for a specific activity that will be delivered in a future period. As such, this income has been deferred and therefore not included in the Statement of Comprehensive Income in this reporting period.

23 Financial assets and liabilities

23.1 Financial assets by category

	31 March 2018	31 March 2017
	£000	£000
Trade and other receivables (excluding non financial assets) - with NHS and DH bodies	5,264	6,606
Trade and other receivables (excluding non financial assets) - with other bodies	4,641	5,958
Cash and cash equivalents (at bank and in hand) at 31 March	56,018	43,561
Total	**65,923**	**56,125**

23.2 Financial liabilities by category

	31 March 2018	31 March 2017
	£000	£000
Borrowings excluding Finance leases	17,378	17,908
Obligations under finance leases	57	94
Trade and other payables excluding non-financial liabilities	27,219	21,514
Provisions	6,039	7,477
Total	**50,693**	**46,993**

24 Reconciliation of operating surplus to net cash flow from operating activities

	2017/18		2016/17	
	£000	£000	£000	£000
Operating Surplus / (Deficit)		12,181		13,510
Non cash flow movements:				
Depreciation and amortisation	4,925		5,263	
Impairments and reversals	580		1,985	
		5,505		7,248
Movement in Working Capital:				
Increase in trade and other receivables	(1,377)		(4,961)	
SOFP Pension liability - employer contributions paid less net charge to the SOCI	(28)		0	
Increase in inventories	(11)		(8)	
Increase in trade and other payables	5,357		1,690	
Increase/(decrease) in other liabilities	304		(38)	
		4,245		(3,317)
(Decrease)/increase in provisions		(4,220)		835
Net cash inflow from operating activities		**17,711**		**18,276**

25 Related Party Transactions

25.1 Related Party Transactions 2017/18

The Trust is a body corporate established by the Secretary of State for Health. The Department of Health is regarded as a related party as it exerts influence over a number of transactions and operating policies of the Trust. During the year ended 31 March 2018 the Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department of those entities.

During the year none of the Board Members, Governors or members of the key management staff or parties related to them has undertaken any material transactions with the Trust.

Board Members, Governors and other key management staff take decisions on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made and are available for inspection on request from the Company Secretary.

	Income from Related Party	Expenditure payments to Related Party	Receivables from Related Party	Payables to Related Party
	£000	£000	£000	£000
Central Government				
National Heath Service Pension Scheme	0	13,702	0	86
HMRC - VAT	0	0	334	21
HMRC - other taxes & duties	0	12,190	0	2,964
Other Central Government	0	37	0	0
NHS				
Department Of Health	695	0	442	278
NHS England - Core	5,600	25	1,781	414
Foundation Trusts				
Central and North West London NHS FT	0	25	0	9
Colchester Hospital University NHS Foundation Trust	0	36	0	11
Norfolk and Norwich University Hospitals NHS FT	98	49	23	53
South London and Maudsley NHS FT	0	409	0	8
Clinical Commissioning Groups				
NHS Camden CCG	226	0	0	0
NHS Chiltern CCG	3,801	0	39	0
NHS Ealing CCG	331	0	35	0
NHS East and North Hertfordshire CCG	934	3,641	248	1,987
NHS Great Yarmouth and Waveney CCG	435	0	12	0
NHS Harrow CCG	34	81	8	0

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	Income from Related Party	Expenditure payments to Related Party	Receivables from Related Party	Payables to Related Party
	£000	£000	£000	£000
Clinical Commissioning Groups				
NHS Herts Valleys CCG	627	0	4	287
NHS Hounslow CCG	321	0	0	0
NHS Mid Essex CCG	4,646	0	27	0
NHS North East Essex CCG	7,274	0	209	200
NHS North Norfolk CCG	628	0	3	0
NHS Norwich CCG	241	0	1	0
NHS South Norfolk CCG	671	0	2	0
NHS West Essex CCG	5,218	0	0	220
NHS West Norfolk CCG	168	0	0	0
NHS Trusts				
East and North Hertfordshire NHS Trust	313	972	13	613
Hertfordshire Community NHS Trust	391	280	950	274
West Hertfordshire Hospitals NHS Trust	578	785	394	793
NHS Other				
Health Education England	4,584	0	293	0
East of England Specialised Commissioning hub	18,419	0	120	0
NHS Litigation Authority	0	930	0	0
Other NHS	1,547	613	755	660
Local Government				
Barnet London Borough Council	1,339	0	671	0
Hertfordshire County Council	171,468	628	1,038	1,999
Hammersmith and Fulham London Borough Council	456	0	7	0
Norfolk County Council	879	0	73	0
Other Local Government	728	325	115	185
Totals	**232,650**	**34,728**	**7,597**	**11,062**

There is no related receivable with the National Loan Fund (£37,500k in 2016/17) as the interest rates on cash balances held in the main NHS FT bank account were more favourable than the interest rates offered through investment with the National Loan Fund,so no investments were held at 31 March 2018.

25.2 Related Party Transactions (continued) 2016/17

During the year none of the Board Members, Governors or members of the key management staff or parties related to them has undertaken any material transactions with the Trust.

Board members, Governors and other key management staff take decisions on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made and are available for inspection.

	Income from Related Party	Expenditure payments to Related Party	Receivables from Related Party	Payables to Related Party
	£000	£000	£000	£000
Central Government				
National Heath Service Pension Scheme	0	13,542	0	1,822
HMRC - VAT	0	0	229	0
HMRC - other taxes & duties	0	11,385	0	2,877
National Loans Fund	0	0	37,500	0
Other Central Government	2	9	0	5
NHS				
Department Of Health	875	0	108	436
NHS England – Core	6,688	0	5,713	0
Foundation Trusts				
Central and North West London NHS FT	2	174	0	69
Colchester Hospital University NHS Foundation Trust	0	51	0	4
Norfolk and Norwich University Hospitals NHS FT	73	133	11	45
South London and Maudsley NHS FT	0	167	0	43
Clinical Commissioning Groups				
NHS Camden CCG	231	0	1	0
NHS Chiltern CCG	2,337	0	17	9
NHS Ealing CCG	326	0	27	0
NHS East and North Hertfordshire CCG	685	2,249	41	54
NHS Great Yarmouth and Waveney CCG	400	0	1	0
NHS Harrow CCG	133	0	97	0
NHS Herts Valleys CCG	18	15	0	410
NHS Hounslow CCG	327	0	28	0
NHS Mid Essex CCG	4,544	0	11	0
NHS North East Essex CCG	7,340	0	70	0
NHS North Norfolk CCG	603	0	0	0
NHS Norwich CCG	262	0	0	0
NHS South Norfolk CCG	672	0	0	0
NHS West Essex CCG	4,083	0	205	183
NHS West Norfolk CCG	239	0	0	0

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	Income from Related Party	Expenditure payments to Related Party	Receivables from Related Party	Payables to Related Party
	£000	£000	£000	£000
NHS Trusts				
East and North Hertfordshire NHS Trust	103	1,427	116	1,101
Hertfordshire Community NHS Trust	634	262	294	982
West Hertfordshire Hospitals NHS Trust	814	1,032	175	623
NHS Other				
Health Education England	2,631	3	247	65
East of England Specialised Commissioning hub	18,831	0	0	0
NHS Litigation Authority	0	751	0	302
Other NHS	703	156	6,257	615
Local Government				
Barnet London Borough Council	1,339	0	111	0
Hertfordshire County Council	167,466	199	977	2,617
Hammersmith and Fulham London Borough Council	455	0	0	0
Norfolk County Council	867	0	0	0
Other Local Government	946	230	149	179
Totals	**224,629**	**31,785**	**52,385**	**12,441**

Income received from Hertfordshire County Council includes all income received from the Integrated Health and Care Commissioning Team which includes the two Hertfordshire Clinical Commissioning Groups.

26 Pension

The Trust is also an admitted fully funded member of the Hertfordshire Local Government Pension Scheme (LGPS), for those staff who have transferred under TUPE (Transfer of Undertakings: Protection of Employment) from Hertfordshire County Council to the Trust employment since 2004/05.

The Trust has reviewed the accounting treatment and it is now accounted for from 2017/18 as a defined benefit scheme. The scheme is in a net asset position that cannot be realised by the Trust, so the asset ceiling is restricted to the value of the scheme liabilities. This has had no material impact on the Trust's SOCI or SOFP positions. It is estimated the Trusts employer's contributions for the period to 31 March 2019 will be approximately £40k.

In 2016/17 the Trust disclosed the net amounts allocable to the Trust with regards to the LGPS as a part of employee expenses note 7.1'

	2017/18
	£000
Present value of the defined benefit obligation at 1 April	(25,936)
Current service cost	(97)
Interest cost	(638)
Contribution by plan participants	(14)
Remeasurement of the net defined benefit (liability) / asset:	
- Actuarial (gains)/losses arising from financial assumptions	391
Benefits paid	905
Present value of the defined benefit obligation at 31 March	**(25,389)**

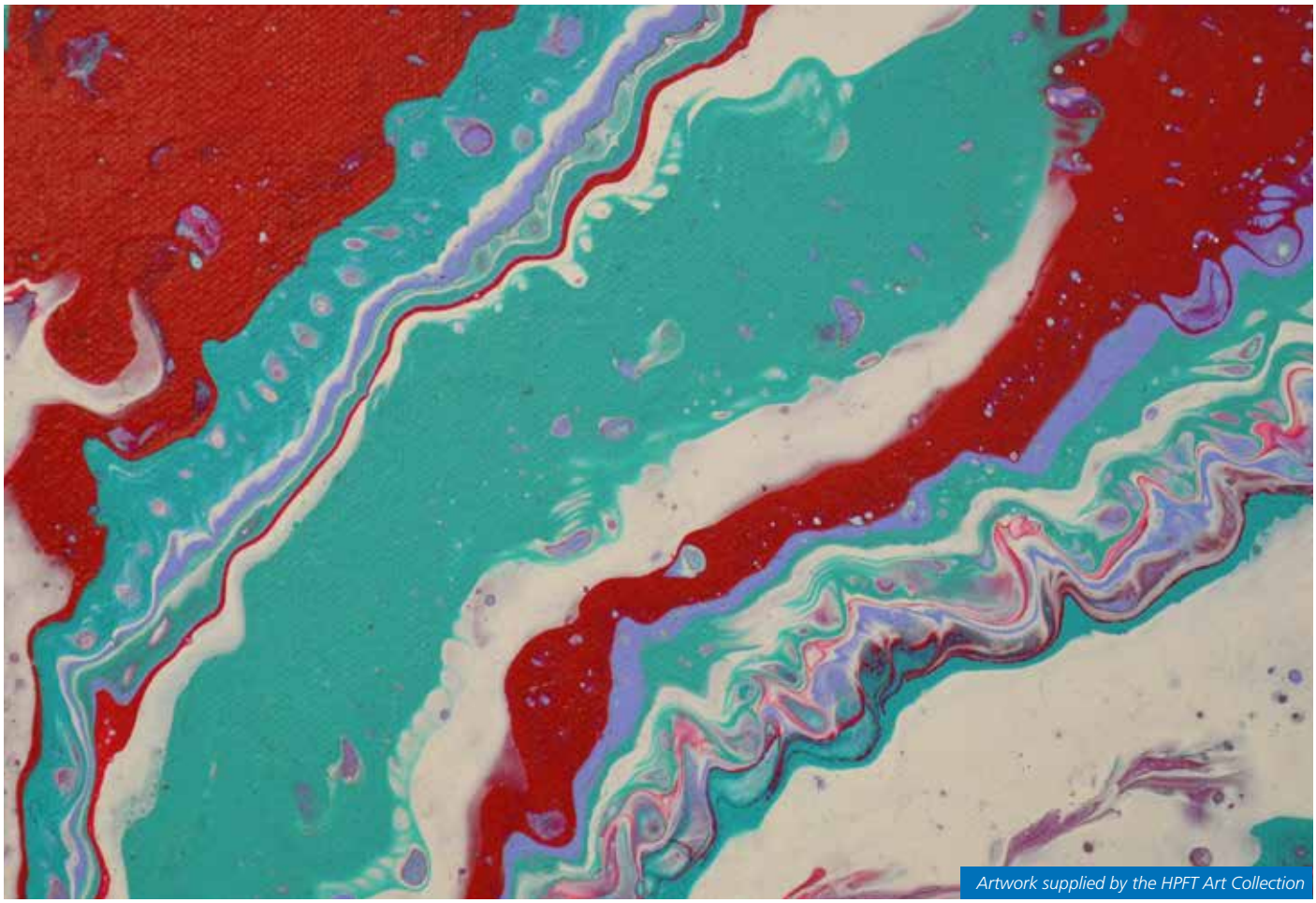
	2017/18
	£000
Plan assets at fair value at 1 April	29,371
Interest income	723
Remeasurement of the net defined benefit (liability) / asset	
- Return on plan assets (excludes any amounts already included in interest income above)	379
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling (excluding amounts included in interest income/expense)	(798)
Contributions by the employer	40
Contributions by the plan participants	14
Benefits paid	(905)
Plan assets at fair value at 31 March	**28,824**
Plan surplus/(deficit) at 31 March	**3,435**

Reconciliation of the present value of the defined benefit obligation and the plan assets to the assets and liabilities recognised on the SoFP

	2017/18
	£000
Present value of the defined benefit obligation at 31 March	(25,389)
Plan assets at fair value at 31 March	28,824
Fair value of any reimbursement right	0
The effect of the asset ceiling	(3,435)
Net (liability)/asset recognised in the SoFP at 31 March	**0**

Amounts recognised in operating expenses

	2017/18
	£000
Current service cost	(97)
Interest expense / income	85
Past service cost	0
Losses on curtailment and settlement	0
Total net (charge)/gain recognised in SOCI	**(12)**



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26.1 Pension Fair Value of Plan Assets

The table below disaggregates the fair value of the plan assets into classes that distinguish the nature and risks of those assets, subdividing each class of plan asset into those that have a quoted market price in an active market and those that do not.

The total of the fair value of the plan assets is the value shown on note 26 excluding the effect of the changes in the effect of limiting a net defined benefit asset to the asset ceiling of £798k.

Asset Category	Quoted prices in active market	Quoted prices not in active markets	Total	Percentage of Total Assets
	£000	£000	£000	£000
Equity Securities:				
Consumer	2,047		2,047	7%
Manufacturing	1,917		1,917	6%
Energy and Utilities	392		392	1%
Financial Institutions	3,107		3,107	10%
Health and Care	345		345	1%
Information Technology	1,359		1,359	5%
Other	97		97	0%
Debt Securities:				
Other		12	12	0%
Private Equity:				
All		1,130	1,130	4%
Real Estate:				
UK Property		978	978	3%
Overseas Property		979	979	3%
Investment Funds and Unit Trusts:				
Equities	6,878		6,878	23%
Bonds	7,588		7,588	26%
Infrastructure		79	79	0%
Derivatives:				
Foreign Exchange		43	43	0%
Cash and Cash Equivalents:				
All	1,048		1,048	4%
Totals	**24,979**	**4,643**	**29,622**	**100%**

26.2 Information about the Defined Benefit Obligation

	"Liability split £(000) as at 31 March 2018	"Liability split (%) as at 31 March 2018	Weighted Average Duration
	£000	£000	£000
Active members	2,076	8%	19.6
Deferred members	8,423	33%	20.9
Pensioner members	14,890	59%	12.5
Totals	**25,389**	**100%**	**15.3**

26.3 Sensitivity Analysis

The sensitivities regarding the principal assumptions used to measure the scheme liabilities are set out below:

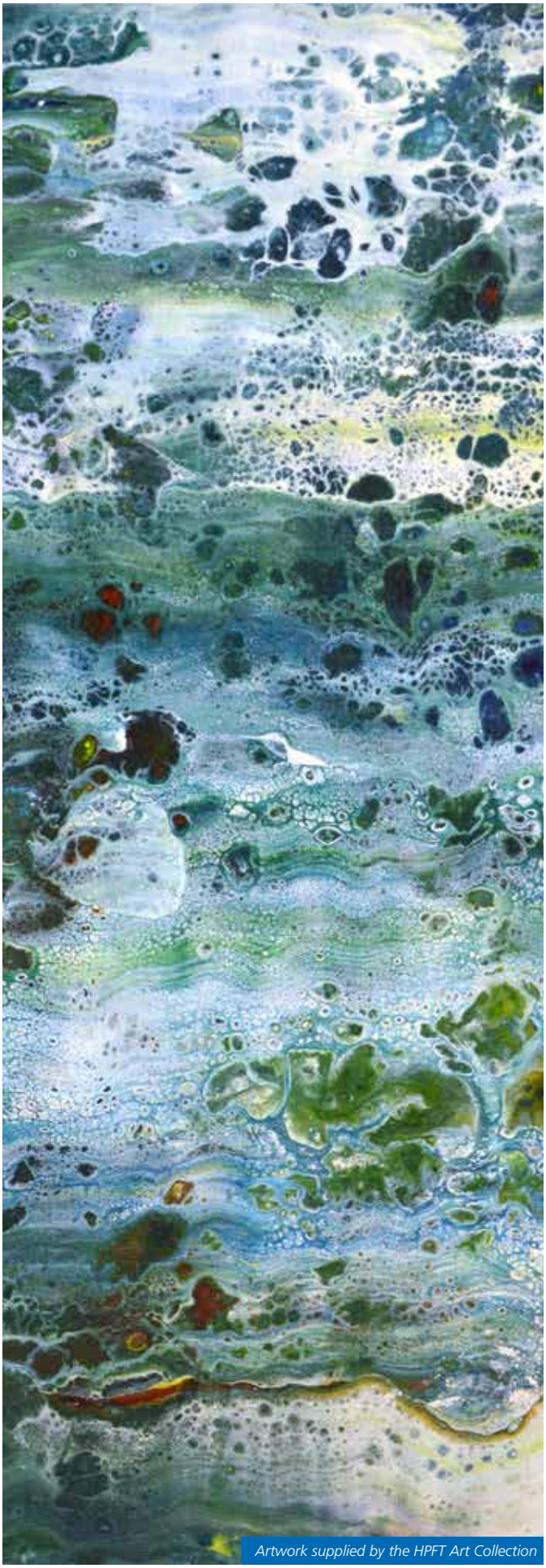
	"Liability split £(000) as at 31 March 2018	"Liability split (%) as at 31 March 2018
	£000	£000
0.5% decrease in Real Discount Rate	8%	2,017
0.5% increase in the Salary Increase Rate	0%	51
0.5% increase in the Pension Increase Rate	8%	1,956

The principal demographic assumption is the longevity assumption (i.e. member life expectancy). For sensitivity purposes, the acutuary estimate that a one year increase in life expectancy would approximately increase the Defined Benefit Obligation by around 3-5%. In practice the actual cost of a one year increase in life expectancy will depend on the structure of the revised assumption (i.e. if improvements to survival rates predominantly apply at younger or older ages). The approach taken in preparing the sensitivity analysis shown is consistent with that adopted in the previous year.

27 Losses and Special Payments

There were 33 cases (35 cases in 2016/17) of losses and special payments totalling £14k (£23k in 2016/17) during 1 April 2017 to 31 March 2018. These are reported on an accruals basis but exclude provisions for future losses.

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000's	Number	£000's
Losses				
Losses of cash due to:				
– theft, fraud	0	0	0	0
– other causes	4	0	6	1
Fruitless payments and constructive losses	0	0	0	0
Bad debts and claims abandoned	1	6	2	15
Damage to buildings, property etc. (including stores losses) due to:				
– theft, fraud etc.	0	0	0	0
– stores losses	0	0	0	0
– other	1	3	1	0
Total losses	**6**	**9**	**9**	**16**
Special Payments				
Compensation under legal obligation	0	0	0	0
Ex gratia payments in respect of:				
– loss of personal effects	26	4	26	7
– other negligence and injury	1	1	0	0
– other	0	0	0	0
Total Special Payments	**27**	**5**	**26**	**7**
Total losses and special payments	**33**	**14**	**35**	**23**



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28 Third Party Assets

The Trust held £3,829k cash at bank and in hand at 31 March 2018 (£3,392k at 31 March 2017) which relates to monies held by the Trust on behalf of service users.

This has been excluded from the cash and cash equivalents figure reported in the accounts.

29 Post Balance Sheet Events

There are no such events to be reported.

30 Contingencies

There are no contingent assets (recoverable values from third parties).

Contingent liabilities are a possible obligation depending on whether some uncertain future event occurs, or a present obligation but payment is not probable or the amount cannot be measured reliably.

The contingent liability is in respect of the potential to pay excesses to the NHS Litigation Authority in respect of current and ongoing LTPS scheme claims and is per the advice received from the NHS Litigation Authority, and legal claims where there is a possible obligation.

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities	**212**	**274**

31 Commitments under capital expenditure contracts

	31 March 2018	31 March 2017
	£000	£000
Property, Plant and Equipment	795	447
Total	**795**	**447**

The capital commitments as at 31 March 2018 relate to the agreement of the final account on a number of projects. The Marlowes Health and Wellbeing Centre and Centenary House refurbishments have completed and are awaiting final account confirmations. Albany Lodge, Forest House and Trust wide fire prevention works account for the majority of the remaining commitments along with retention payments against a number of completed projects.

The capital commitments as at 31 March 2017 relate principally to the agreement of the final account on Logandene refurbishment and retention payments against a number of completed projects.

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