



Hertfordshire Partnership  
University NHS Foundation Trust



# Annual Report and Accounts 2012-2013



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(a) of the National Health Service Act 2006.

# Annual Report 2012 - 2013

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### Section Two

Full Statutory Accounts including Statement of Accounting Officers responsibilities in respect of the accounts and Annual Governance Statement

## Better services in challenging times

The high quality of the care we offer to our service users, and the carers who support them – is, as always, our top priority. So it was really heartening to find that almost every one of our staff taking part in the national survey this year felt their role makes a difference to service users. Eighty per cent of them were satisfied with the quality of work and patient care they are able to deliver.

What was especially encouraging about this is that it has come at a time when the pace of change in the Trust has been steadily increasing. We are now in the implementation phase of our five-year transformation programme, albeit in a difficult financial climate. We are introducing new services, modernising and streamlining existing ones, and dramatically improving the buildings we deliver them in. And all this is happening with involvement and support from our service users and commissioners.

We are very proud to have won Health Service Journal's national award for our Host Families project, which offers service users a very supportive alternative to an inpatient stay. It also offers earlier discharge for those who are ready to leave acute inpatient care but need some extra backup as they adjust to life back in their local community.

We learned a lot from our pilot of the new Single Point of Access contact centre, which we mentioned in last year's report. Our aim has been to make it easier for people to access our services by replacing more than 30 different routes with just one clear gateway. Thanks to helpful feedback people using it we have an improved service now in place, ensuring we handle GPs' requests faster and more consistently.

Of course, the surroundings in which we give our care can make a big difference to the whole experience for service users and carers – and, indeed, for our staff. Light, airy, modern facilities have been shown to support recovery, not least by lifting everyone's mood. Buildings designed to offer inpatients free and safe access outside are a great improvement, so this year we have built a new assessment and treatment facility in Norfolk for people using our specialist learning disability services. Work has also started on a £40m state-of-the-art acute care centre at Kingsley Green, near Radlett, which will open in 2014.



We are also modernising the way we deliver community mental health services across Hertfordshire. Preparations for this are now under way and all these services will be offered in fit-for-purpose accommodation.

Another example of joined up working is the expansion of our liaison teams in Hertfordshire's two principal general hospitals, creating more capacity for mental health assessments in wards as well as in A&E. Our Rapid Assessment Interface and Discharge (RAID) service is now operating at Watford General Hospital, responding quickly to mental health needs, identified on wards by hospital clinicians, and enabling people to be discharged more quickly. The same approach will soon be implemented at the Lister Hospital in Stevenage.

For many years we have had a strong working relationship with the University of Hertfordshire, based on our shared interests in teaching and research. The University has now recognised this by granting us University Trust status and our name was formally approved by Monitor on 24 April 2013, following our application in February.

Despite the pressures arising from extensive organisational change, the Trust has continued to promote and implement the Equality and Diversity agenda and our achievements in this field were recognised in 2012/13 by a Business in the Community regional award for Equality and Diversity in the Workplace and our progress up 12 places in Stonewall's Equality Index of UK employers.

The last 12 months have made significant new demands on our staff, and they have responded magnificently. Our new organisational structures and accommodation plans are ambitious but will, we believe, support our staff to continue to deliver the high quality, modern services that we all so value.



Tom Cahill  
Chief Executive

28 May 2013



Hattie Llewelyn-Davies  
Chair

28 May 2013

# Directors' Report

## Introduction and Background Information

We were very proud to become one of the first Mental Health and Specialist Learning Disability Health and Social Care Foundation Trust, successfully achieving Foundation Trust status on 1 August 2007, and that we have successfully operated as a Foundation Trust throughout the subsequent period.

Foundation Trusts are membership based public benefit corporations with members electing Governors who as a body hold to account the Directors in relation to the management of the Trust. We greatly value the opportunities which being a Foundation Trust provides us to further build upon and improve the services for our community through the benefits of:

- A stronger involvement with local communities through our members
- The ability to borrow finance to support our investment programme
- The ability to re-invest our finances in local service developments and facilities specific to the needs of our community
- The increased stability provided from being able to negotiate longer term contracts with our commissioners.

Currently we provide the following services to the following populations and we work very closely with our commissioners to develop these services to best meet the needs of these communities:

- Integrated health and social care to people who need mental health services in Hertfordshire.
- Child and adolescent mental health services in Hertfordshire
- Specialist health services to people with learning disabilities in Hertfordshire, Norfolk and North Essex

Our strategic objective is to be the leading provider of Mental Health and Specialist Learning Disability services in the country. We will achieve this through the delivery of quality services, making best use of our resources, being an excellent employer, creating a learning organisation, and working with all our partners to promote mental well-being.

As a Foundation Trust we are regulated by Monitor, the Independent Regulator of Foundation Trusts under the provisions of the NHS Act 2006. The Health and Social Care Act 2012 has made changes to the way NHS service providers will be regulated in the future, and gives Monitor new duties and powers. These changes include the introduction of a Monitor licence for providers of NHS services which applies from April 1 2013.

This Directors' report covers the year ending 31 March 2013.

# Financial Review

## Overview

This section of the Annual Report provides a commentary on the financial performance of the Trust in the year. This shows that this has been another successful year for the Trust with each of the key financial targets met; the Trust exceeding its planned surplus and achieving a Monitor Financial Risk Rating of 4. This result includes an exceptional item in relation to the settlement of historic pension liabilities by other NHS organisations (see 'Financial Performance' below). By excluding this unusual, non-recurrent item the adjusted or underlying surplus would result in a Financial Risk Rating of 3, as planned.

This is particularly pleasing given the well-publicised and continuing financial challenges faced by healthcare organisations at this time. The requirement on the NHS to deliver £20billion of savings (circa 20% of its total budget) over a four year period has led to continuing reductions in commissioner funding to service providers. Our Trust was faced with a 4% efficiency requirement applied to each of the main commissioner contracts (£174m). Despite this reduction in income the Trust has achieved a surplus and continues to invest in developing and improving services.

## Financial Statements and Accounting Policies

The full set of financial accounts and details of the accounting policies applied are set out within this report. These have been prepared in accordance with International Financial Reporting Standards (IFRS), and the directions given by Monitor in order to show a true and fair view of the Trust's financial activities during the period. The detailed accounting policies comply with the NHS Foundation Trust Annual Reporting Manual and form the basis on which the financial statements have been compiled. The Financial Statements are presented as follows:

| Financial Statement                      | Annual Accounts ref. |
|--|----------------------|
| Statement of Comprehensive Income (SOI)  | page 2               |
| Statement of Financial Position          | page 3               |
| Statement of Changes in Taxpayers Equity | page 4               |
| Statement of Cash Flows                  | page 5               |

There is a requirement for the Trust Board to review its Accounting policies annually which we have done. There are no changes to our Accounting policies as a result of that review.

## Going Concern

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 the Trust has 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.

## External Audit

The annual accounts were audited by the Trust's 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 auditor is unaware. The Directors have taken all the steps they ought to have taken as Director's in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Deloitte LLP has been approved as the Trust's external auditors by the Council of Governors through to 2014/15. The Audit partner is Matthew Hall and Laura Rogers is the Audit Senior Manager. 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 Monitor.

It remains important that the external auditors' 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 2012/2013 was £71K, comprising:

| Audit Area           | Audit Fee £K |
|----------------------|--------------|
| Statutory Audit Work | 58           |
| Other work           | 13           |

## Counter Fraud Activities

In order to counter fraud and corruption, the Trust engages a dedicated Local Counter Fraud Specialist (LCFS) through RSM Tenon. The Trust has an Anti-fraud and Corruption Policy and Work Plan approved by the Board of Directors' Audit Committee, reflecting the NHS Counter Fraud and Security Management Services framework, with regular reports received throughout the year by the Audit Committee. The Trust has also adopted a Standards of Business Conduct Policy and both policies are accessible through the Trust website.

## 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 accounts under note 25 on page 40.



## **Private Patient Income**

The Private Patients Income Cap was set in accordance with section 44 of the NHS Act 2006 revised by the Health Act 2009. Mental Health NHS Foundation Trusts could not exceed a pre-determined Private Patient Income Cap (PPI), which is the greater of:

- 1.5% of patient related income (mandatory income from activities), or
- The proportion of the total income derived from private patient charges in 2002/03, which for this Trust was nil.

However an addendum supplemental to the Monitor Terms of Authorisation was issued effective from 1 October 2012 which removed the above requirement (formally Condition 10)

No private patient income was generated in 2012/13 (none in 2011/12).

## **Charitable Funds**

As an NHS Foundation Trust we make no political or charitable donations. However, the Trust does continue to benefit from the receipt of charitable funds arising from donations and fund raising activities and is extremely grateful to fundraisers and members of the public for this continued support. The Trust Board acts as Trustees ensuring appropriate stewardship for 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 for the benefit of service users and staff. The Annual Accounts and Report for these charitable funds for the financial year 2012/13 are available separately on request from the Director of Finance and Performance Improvement. There is no charge for the provision of these.

## **Cost Allocation and Charging Requirements**

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

# Analysis of Financial Performance

## Financial Performance

This has been another successful year with the Trust reporting a year end surplus of £3.897m (2011/12 £1.249m). This was on a revenue turnover of £203.6m (2011/12 £211.7m) with an EBITDA margin of 4.8% (5.0% 2011/12). These headline results provide a Monitor Financial Risk Rating of 4. However, in terms of understanding the underlying performance of the Trust, excluding the exceptional income arising from the settlement of historic pension liabilities and the impairment cost related to the property revaluation, the adjusted surplus is £2.4m (2011/12 £2.7m). This underlying position is in accordance with the current Three Year Financial Plan and would also provide a Monitor Financial Risk Rating of 3 as planned.

The Trust is reporting Net Assets of £154.2m (2011/12 £149.4m) which includes current bank and cash levels of £43.0m (2011/12 £41.3m).

The surplus represents an excellent performance by the Trust given the continued challenges to maintain and improve service quality whilst facing significant demands for efficiency savings from our commissioners. This surplus is available for reinvestment in programmes to continually improve the quality of services and service user experience. In 2012/13 the Trust has invested in a range of developments as well as continuing to implement the major transformation programme which is overseeing a series of work streams focussed on service improvement. Key highlights within 12/13 include:

- The implementation of the Single Point of Access for initial referral and screening
- The implementation of the new Electronic Record System PARIS on a pilot basis within the CAMHS services
- Obtaining planning approval and commencing the building of new inpatient facilities at Kingsley Green (the old Harperbury hospital site) and at the Little Plumstead site (Norfolk).

## Financial Risk Rating

The Trust has achieved a Monitor Financial Risk Rating (FRR) of 4 for 2012/13 (FRR 3 after excluding exceptional items) reflecting the strong financial performance of the Trust. Detailed and comparative data and an explanation of the regulatory rating framework are set out on page 109 of this report (Regulatory Ratings).

## Key Metrics (financial indicators)

The Financial Risk Rating is comprised of key metrics drawn from the financial statements as determined by Monitor and incorporates five key criteria:

| Financial Criteria        | Metric                                       | 2012/13 | 2011/12 |
|---------------------------|--|---------|---------|
| 1. Underlying Performance | EBITDA Margin                                | 4.9%    | 5.0%    |
| 2. Achievement of Plan    | EBITDA % of plan achieved                    | 85.9%   | 97.1%   |
| 3. Financial Efficiency   | (i) Income & Expenditure Surplus Margin      | 1.2%    | 1.2%    |
|                           | (ii) Return on Capital Employed 2011/12 only | -       | 4.0%    |
|                           | Net return after financing 2012/13 only      | 1.6%    | -       |
| 4. Liquidity              | Liquidity Ratio                              | 62 days | 63 days |

The 2012/13 metrics are based on the adjusted surplus of £2.4m as reported in page 2 of the Financial Statements (Section Two of this Annual Report)

\*There was a change in the Monitor reporting requirement for Financial Efficiency in 2012/13. The Return on Capital Employed Metric used in 2011/12 was replaced by the Net Return after Financing Metric in 2012/13. This change affected all NHS Foundation Trusts

## Working Capital and Liquidity

The Trust continues to proactively manage its cash balances and ended the year with a strong cash position, partly as a result of our close attention to the collection of income due. This strong position has enabled the Trust to manage its cash flow without recourse to the utilisation of its working capital loan facility during the year. Cash balances are prudently invested during the year in accordance with the Treasury Policy approved by the Directors, with security and liquidity of funds being paramount. The Statement of Cash Flows illustrates the sources and uses of cash generated by the Trust during the financial year.

The Trust obtained approval from both Monitor and the Foundation Trust Financing Facility for a 25 year term loan which will be used to support the Trusts continuing investment programme. No amounts were drawn on the available facility in the year.

## Financial Investments

The Trust does not have any investments in subsidiaries or joint ventures and does not have any significant exposure to interest rate or exchange rate risks and therefore does not hold any complicated financial instruments to hedge against such risks.

## Summary of Key Results from the Accounts

Headline information on the key results is set out in the following table:

| Financial Criteria  | 2012/13<br>£000 | 2011/12<br>£000 |
|---|-----------------|-----------------|
| Total Income  | 203,615         | 211,684         |
| Surplus for the Year (excluding Impairments and pension income) | 2,398           | 2,661           |
| Capital Charges (Depreciation & Public Dividends)               | 7,447           | 7,573           |

## Income

In the financial year 2012/13 the Trust generated income totalling £204m of which the majority relates to income from activities as illustrated below:

|                        | £000    | %    |
|------------------------|---------|------|
| Income from Activities | 190,643 | 93.6 |
| Other Operating Income | 12,972  | 6.4  |

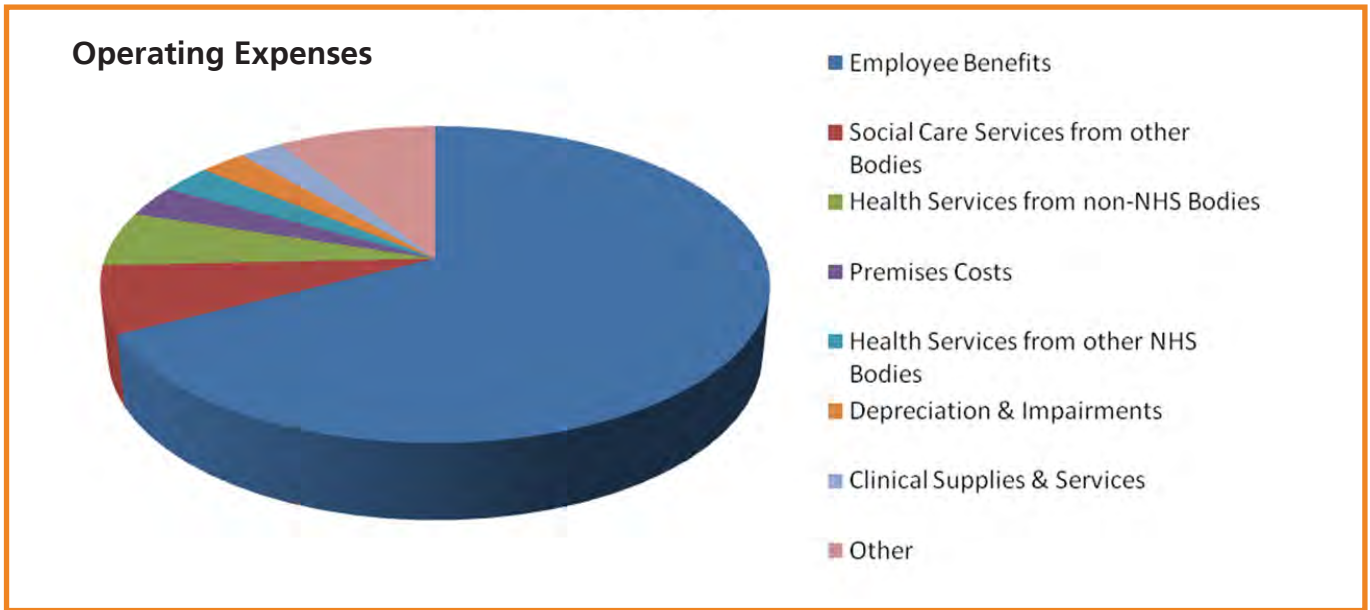
The Trust agreed a schedule of CQUIN targets with the Hertfordshire Joint Commissioning Team and an associated monetary value. The Trust has estimated that it has been successful in securing 100% against the agreed schedule.

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.

The NHS FT has met this requirement

## Operating Expenses

Total operating expenses can be analysed into the following main categories:



In common with other Trusts, the most significant area of resource is staffing. However, as a Partnership Trust with delegated secondary commissioning responsibilities and operating from over 100 sites in Hertfordshire, Norfolk and North Essex, there are other significant categories of cost to manage. Further detail of expenditure for the financial year can be found under note 5 (page 21) of the accounts.

## Management Costs

Management costs, as defined by the Department of Health guidelines, represented 6.5% of Trust turnover for the 2012/13 financial year (6.5% for 2011/12) and benchmark at or below that of our peer group. Further information detailing the costs to be included in this calculation can be found at:

[http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSmanagementcosts/DH\\_4000338](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSmanagementcosts/DH_4000338)

Specific reference to senior managers' remuneration is detailed at note 5.4 of the accounts and within the remuneration report (pages 23 and 24).

## Policy and Payment of Creditors

The Trust adopts the Confederation of British Industry (CBI) 'Better Payment Practice Code' in respect of invoices received from NHS and non-NHS suppliers. This requires payment to be made within 30 days of receipt of goods or a valid invoice (whichever is the later), unless other terms have been agreed. Our payment policy is consistent with this objective and our measure of compliance with the code is:

|  | Number of Invoices | Value £000 |
|--|--------------------|------------|
| Total non-NHS invoices paid to 31st March 2013 | 29,854             | 63,556     |
| Total within target                            | 26,268             | 55,134     |
| Percentage within target                       | 88%                | 87%        |
|  |                    |            |
| Total NHS invoices paid to 31st March 2013     | 1,333              | 14,859     |
| Total within target                            | 1,245              | 14,192     |
| Percentage within target                       | 93%                | 96%        |

In line with the Government's commitment to support local and national suppliers through the current financial downturn, we aim to make payments to non-public sector suppliers within a 10 day window.

## Capital Programme

During 2012/13 we invested £10.5m in providing new or improved assets (land, property and equipment) through the capital programme agreed and reviewed by the Directors.

## Prudential Borrowing Limit

As a Foundation Trust we have the freedom, within Monitor's Prudential Borrowing Code, to seek commercial borrowing to finance capital expenditure, or to manage working balances. The Trust has been set a limit based on this code to reflect its borrowing capacity (page 18 of the accounts). These limits are:

- £47.9m for long term borrowing
- £13.0m as a working capital facility.

The capital programme to date has been met from internally generated resources and therefore there has been no requirement to borrow any external finance on a commercial basis.

## Forward Look

2013/14 funding for the Trust has been agreed in line with the national payment by results tariff uplift that is

- Allowance for generic uplift to cover pay awards, agenda for change, capital charges indexation, new drugs and other reform measures = 2.7%
- Less:
 

|                                       |         |
|---------------------------------------|---------|
| Cash releasing efficiency requirement | = 4.0%  |
| Net reduction                         | = -1.3% |

The comprehensive Transformation programme continues to be developed in order to deliver service transformation, maintain quality and safety and to meet these efficiency requirements. This approach is focussing on the transformation and reconfiguration of current provision, encouraging innovation in the approach to the delivery of high quality services. The implementation phase will accelerate in 2013/14.

The 2013/2014 capital programme totals a £50.8m investment. The major investments relate to the development and improvement of mental health and learning disability inpatient facilities, the rationalisation and improvement of environments across Hertfordshire, North Essex and Norfolk, and the replacement of our electronic patient record system.

Our strong financial position will help the Trust meet the challenge of continuing to deliver improved high quality services and maintaining waiting times whilst needing to make significant efficiency and productivity savings.

# Operating Review

## Introduction

Hertfordshire Partnership NHS Foundation Trust (HPFT) provides health and social care both for people with mental ill health and those with a learning disability.

Our vision is: *'To be the leading provider of mental health and specialist learning disability services in the country'*.

At the heart of our vision is a commitment to providing excellent quality health and social care for the communities that we serve across Hertfordshire, Norfolk and North Essex. We aim to continually improve the services we provide to make a positive difference to the lives of service users and their carers, underpinned by the principles of involvement and independence.

This means delivering the highest quality care with excellent treatment outcomes, within a safe environment which meets the needs of service users and carers.

Our vision is underpinned by eight goals aligned to three strategic themes. Together these set out our strategic direction and how we wish to be viewed both within and outside of the trust:

## Customers and Communities

- To deliver high quality integrated health and social care services in accordance with recovery principles
- To be the provider of choice for service users, carers, the community and commissioners
- To work in partnership with the community to promote the wellbeing of others, whilst making a positive contribution to the environment

## People

- To be the employer of choice where staff are highly valued, well supported and rewarded
- To create a dynamic and flexible working environment where staff are motivated and committed to providing high quality care
- To embed a learning culture where staff develop their full potential and deliver excellent care

## Sustainability

- To ensure a sustainable future through income growth and efficient use of resources
- To be an innovative and learning organisation that embraces new and modern approaches to health and social care



# NHS Foundation Trust Code of Governance

## Board of Directors statement on corporate governance arrangements

The Council of Governors and Board of Directors fully support the main and supporting principles of the Code of Governance published by the Independent Regulator of NHS Foundation Trusts. In the Directors' opinion the Hertfordshire Partnership NHS Foundation Trust complied throughout the review period with the main and supporting principles of the Code of Governance with the following exceptions:

### Appointments and terms of office

- Appointments to the Board and Council

**C.1.3** Two committees have been established. One for the nomination of Executive Directors chaired by the Chair of the Board of Directors and a second for the appointment and remuneration of Non-Executive Directors. This committee is chaired by a Governor as it was felt this was more appropriate and the Chair attends the committee. The Annual Report includes a section concerning their work.

- Reappointment of Directors

**C2.2** Two Non-Executive Directors have been appointed for a further year over and above their six year term. Hattie Llewelyn-Davies (Chair) and Colin Sheppard (NED) would have both served six years on 31 July 2013. They were reappointed by the Governors for a further year, to run until 31 July 2014 due to the need for continuity on the board during this period of change. Governors felt the skills needed to lead the organisation at this time would be weakened if either left. Colin has particular skills in managing property portfolios and the Trust has just started a major building project. The re-appointments were made following a rigorous review by the Appointments and Remuneration Committee and approved by the Council of Governors.

## The Board of Directors, Chair and Executive

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

### Chair and Chief Executive

The Board of Directors has agreed on 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 whilst encouraging debate and discussion.

The Chair is also responsible for ensuring the integrity and effectiveness of the Governors and Directors relationship. The Chair also leads the performance appraisals of both the Board and the Council as well as the Non-Executive Directors' performance appraisals.

## Board of Directors

### Non-Executive Director Appointments

The Trust is managed by full-time Executive and part-time Non-Executive Directors. Together they make up the Trust's 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. The details of appointments are set out below:

|                                |                                  |
|--------------------------------|----------------------------------|
| Hattie Llewelyn-Davies (Chair) | 1.8.2007 – 31.7.2014 - (2 terms) |
| Colin Sheppard (SID)           | 1.8.2007 – 31.7.2014 - (2 terms) |
| Ruth Sawtell                   | 1.8.2007 – 31.7.2012 - (2 terms) |
| Bill Brown                     | 1.8.2007 – 31.7.2013 - (2 terms) |
| Carol Kennedy Filer            | 1.8.2007 – 31.7.2013 - (2 terms) |
| Steve Marsden                  | 1.8.2009 – 31.7.2015 - (2 terms) |
| Manjeet Gill                   | 1.8.2009 – 31.7.2015 - (2 terms) |
| Peter Baynham                  | 1.8.2012 – 31.7.2013 - (1 year)  |
| Christopher Lawrence           | 1.8.2012 – 31.7.2015 - (1 term)  |

Hattie Llewelyn-Davies and Colin Sheppard have been reappointed by the Board of Governors to serve a further one year from 1/8/2013. The Governors were concerned that during a period of transformation key skills would be lost from the Board and the reappointment was agreed following a formal performance evaluation by the Appointments and Remuneration Committee (see the section on Committees for further details of the Committee and its duties).

### Executive Director Appointments

Our 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. There are six Executive Directors including the Chief Executive and the posts are as follows:

Executive Director Quality and Medical Leadership  
Executive Director Strategy and Commercial Development  
Executive Director Finance and Performance Improvement  
Chief Operating Officer (replaced the Executive Director Service Delivery and Transformation)  
Executive Director Quality and Safety/Deputy Chief Executive.

The Board of Directors is responsible for all operational issues, the management of which is delegated to the Trust's operational staff in accordance with its Standing Orders and Standing Financial Instructions. It also, with input from the Council of Governors, sets the strategic direction of the Trust.

## Board Committees

The effectiveness of the Board Committees, Audit, Finance and Investment, Remuneration and Nomination and Integrated Governance and Mental Health Act Managers is considered on an ongoing basis via the regular reports presented to the Board at their meetings. Each committee and the Board of Directors is appraised annually. Membership of the committees is set out in the relevant terms of reference which are reviewed on a regular basis. Reports from the committees are publicly available.

So far as the Directors are aware there is no relevant audit information of which the auditor is unaware and the Directors have taken all of the steps they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

There were 13 Board of Directors meetings between 1 April 2012 and 31 March 2013. This includes the Annual General Meeting for members. The individual attendance of each Board member is indicated in brackets. Karen Taylor, Chief Operating Officer, has been absent from the Trust since December 2012 on maternity leave and her duties were taken on by other Executive Directors until her interim replacement joined the organisation in April 2013.

### **Hattie Llewelyn-Davies, Chair**

(13 out of a possible 13)

- As well as HPFT, Hattie is the Chair of Viridian Housing, a large national Housing Association
- Beyond her NED roles, Hattie works as a consultant for housing associations. Her expertise is in strategic development, governance and working as an interim Chief Executive. She has a very strong track record of working with tenants and other service users
- Hattie has a wide range of experience with other sectors and until recently she was the Vice Chair of a large building society and a chair of a firm of internal auditors
- Hattie was awarded an OBE for services to homeless people.

### **Tom Cahill, Chief Executive**

(11 out of a possible 13)

- To be accountable for the overall clinical and financial management performance of the Trust. Accountable means accountable to the Secretary of State and the Trust Board through the Chair
- To take the lead in driving the Trust towards continued improvement in service provision, managing external relationships and developing partnerships with stakeholder organisations, service users and the community at large
- Ensure the Trust's services are culturally sensitive, relevant and accessible to meet the diverse needs of the population
- To take forward the Trust's commercial approach, preparing and implementing business strategies for marketing and business development in order to win business within a competitive health market place
- Has a Masters in Business Administration.

### **Iain Eaves, Executive Director Strategy and Commercial Development**

(12 out of a possible 13)

- Lead on strategic and business planning for the organisation
- Responsible for developing partnerships and new income streams
- Oversees communications and marketing for the Trust

### **Geraldine O’Sullivan, Executive Director Quality and Medical Leadership**

(12 out of a possible 13)

- Provides advice and guidance on professional issues relating to doctors and is the Responsible Officer for revalidation of doctors. She oversees the training of trainee doctors.
- Oversees clinical risk in the organisation and leads on the accessibility of clinically effective care within available resources across the organisation and is also responsible for medicines management and Research & Development
- Takes an overview of issues around quality of clinical care and the impact of cost improvement plans on quality.
- Oversee the IM&T within the Trust and is the Trust’s Senior Information Responsible Officer
- Is a Consultant Psychiatrist and continues to practice clinically one day/week.

### **Keith Loveman, Executive Director Finance and Performance Improvement**

(12 out of a possible 13)

- Responsible for ensuring that the Trust meets all its financial targets and makes best use of its funding
- Leads on ensuring the Trust continues to provide good performance and meets statutory targets
- Qualified accountant.
- Responsible for performance improvements
- Responsible for contracts, estates and facilities

### **Dr Oliver Shanley, Executive Director Quality and Safety/Deputy Chief Executive**

(10 out of a possible 13)

- Is Executive/Board lead for Nursing, Social Care, Allied Health Professionals and Psychology
- Responsible for risk management, patient safety, equality and diversity, Care Quality Commissions and regulation, Involvement , Safeguarding and Health and Safety
- Caldicott Guardian for the Trust

### **Karen Taylor, Chief Operating Officer**

(8 out of a possible 10)

- Responsible for all operational service delivery
- Responsible for customer experience and complaints
- Is the Board lead and ensures compliance with the Mental Health Act. Leads on ensuring that the Trust will be able to continue to provide services in the event of a major incident within Hertfordshire

**Bill Brown, Non Executive Director**

(12 out of a possible 13)

- Chair of the Trust's Audit Committee.
- Has a law degree and is a chartered accountant.
- Retired as a partner in Pricewaterhouse Coopers in June 2004 after a long career with the firm where he specialised in audit, financial due diligence and corporate governance
- Currently a Non-Executive Director of Business Link for London and of AbilityNet and Greenwich Leisure Ltd and was previously a Non-Executive Director of Chase Farm Hospitals NHS Trust
- Is now in business as a consultant in financial accounting and corporate governance matters.

**Manjeet Gill, Non-Executive Director**

(9 out of a possible 13)

- Has been a Chief Executive of a local authority and is a Non-Executive Director in a social investment business
- Has a Masters in Business Administration as well as diplomas in health and safety and environmental health.

**Carol Kennedy Filer, Non-Executive Director**

(10 out of a possible 13)

- In 2002 started a management consultancy specialising in the strategic marketing for the healthcare industry, particularly supporting manufacturers of critical care disposables and equipment. With expertise across a number of hospital sectors, and a Masters Degree in Business, this new venture built upon over 13 years working within one of the largest British medical companies within Smiths Group plc, latterly as Strategic Marketing Director
- Has also had a number of years working within the voluntary sector, particularly as past secretaries of the Dacorum Macmillan Cancer Research Committee and Chartered Institute of Marketing – Medical Group. In addition, has worked alongside the Association of Anaesthetists to raise its profile with the public and had a short secondment to the Department of Health in 1997.
- For over four years was Managing Director of Healthcare On Call Ltd, an innovative start up in occupational health, addressing health and safety issues and absence management.
- Took a position as Director of Membership for the National Pharmacy Association in June 2012.

**Stephen Marsden, Non-Executive Director**

(11 out of a possible 13)

- Has experience as a global general manager and international business leader within a consultancy organisation is a Non-executive Director for a charitable housing association.
- Member of the Institute of Directors.

**Ruth Sawtell, Non-Executive Director**

(3 out of possible 5)

- Her career has spanned senior level experience in banking and social housing
- Is a Non-Executive Director of Metropolitan Housing Partnership and Avenir Solutions, council member of the Advertising Standards Authority and the Nursing and Midwifery Council.

### **Colin Sheppard, Non-Executive Director**

(12 out of a possible 13)

- Is the Senior Independent Director and Chair of the Finance and Investment Committee.
- Is a chartered surveyor and spent his 32 year executive career with substantial property organisations; in particular, 25 years with MEPC Plc - then the second largest UK property company and a FTSE 100 company
- Over the past decade, has widened his corporate, non-executive director and property experience and expertise including Board level roles with Arlington Securities, Chesterton, Barnardos, Centrepont, Family Mosaic Housing Group and National Counties Building Society. He also offers consultancy advice to several property owning bodies as well as running his own portfolio.

### **Peter Baynham, Non-Executive Director**

(7 out of a possible 8)

- Has had wide business experience at board level including FTSE 100 subsidiaries
- Has had broad experience in financial and operating officer roles including Strategic and Commercial Director, Operations Director and Director of Financial Control.
- Fellow of Institute of Chartered Accountants

### **Chris Lawrence, Non-Executive Director**

(5 out of a possible 8)

- 35 years experience in world class organisations: PwC, Credit Commercial de France, NM Rothschild and Citicorp
- His career has included specialisation in post acquisition integration, global cost reduction programmes, development of strategy and international experience of restructuring and issues resolution.
- Trustee of YMCA Norfolk
- Chair of Trustees Horstead Residential Activity Centre

### **Register of interests:**

The register of Directors' interests is available from the Company Secretary at Hertfordshire Partnership NHS Foundation Trust, 99 Waverley Road, St Albans, Hertfordshire AL3 5TL Tel: 01727 804642

There are no Company Directorships held by the Directors where companies are likely to do business with, or are seeking to do business with, the Trust.

## Committees 2012/13

### Audit Committee

The Audit Committee provides assurance to the Board. It oversees the probity and internal financial control of the Trust, working closely with external and internal auditors. Key activities include reviewing governance, risk management and assurance functions. It also approves the External Audit plan, the Internal Audit plan, Counter Fraud plan, accounting policies and reviews draft Annual Accounts before submission to the Board of Directors.

During the year the committee completed a self-assessment exercise to evaluate its effectiveness, reviewed and updated its terms of reference and conducted private discussions with both sets of auditors.

Anybody concerned about a matter of corporate governance or probity can contact any member of the Audit Committee in confidence.

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

- Bill Brown (Chair), Non-Executive Director (5 of 5)
- Carol Kennedy Filer, Non-Executive Director (5 of 5)
- Steve Marsden, Non-Executive Director (5 of 5)
- Ruth Sawtell, Non-Executive Director (1 of 2)
- Peter Baynham, Non-Executive Director (2 of 3)

The Director of Finance, the Company Secretary and appropriate internal and external audit representatives normally attend meetings. Other Executive Directors are invited to attend when the Committee is discussing areas of risk or operation that are their responsibility. The Chief Executive is invited to attend at least annually to discuss with the Committee the process for assurance that supports the Statement on Internal Control.

### Finance and Investment Committee

The Finance and Investment committee provides assurance to the Board that Board members have an adequate understanding of key financial issues. In particular it reviews investment decisions and policy, financial plans and reports and approves the development of financial reporting, strategy and financial policies, consistent with the Foundation Trust regime.

All members of the Board of Directors are members of the Finance and Investment Committee.

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

## Finance and Investment Committee Members

### Attended

|   |          |
|---|----------|
| • Colin Sheppard (Chair)  | (4 of 5) |
| • Hattie Llewelyn-Davies, Non-Executive Director                        | (3 of 5) |
| • Ruth Sawtell, Non-Executive Director                                  | (2 of 2) |
| • Bill Brown, Non-Executive Director                                    | (5 of 5) |
| • Carol Kennedy-Filer, Non-Executive Director                           | (3 of 5) |
| • Manjeet Gill, Non-Executive Director                                  | (2 of 5) |
| • Steve Marsden, Non-Executive Director                                 | (5 of 5) |
| • Chris Lawrence, Non-Executive Director                                | (2 of 3) |
| • Peter Baynham, Non-Executive Director                                 | (3 of 3) |
| • Tom Cahill, Chief Executive   | (4 of 5) |
| • Iain Eaves, Executive Director Strategy and Commercial Development    | (5 of 5) |
| • Keith Loveman, Executive Director Finance & Performance Improvement   | (5 of 5) |
| • Geraldine O'Sullivan, Executive Director Quality & Medical Leadership | (2 of 5) |
| • Oliver Shanley, Executive Director Quality & Patient Safety           | (4 of 5) |
| • Karen Taylor, Chief Operating Officer                                 | (2 of 3) |

### In attendance

The Company Secretary is usually in attendance.

## Integrated Governance Committee (IGC):

The key role and function of the IGC is to lead on the development and monitoring of quality and risk systems within the Trust to ensure that quality, patient safety and risk management are key components of all activities of the Trust. The Committee ensures that appropriate risk management processes are in place to assure the Board that action is taken to identify and manage risks within the Trust. It is also responsible for the development of systems and processes to ensure that the Trust implements and monitors compliance with the registration requirements of the Care Quality Commission. The Committee makes sure that treatments and services provided are appropriate, reflect best practice, represent best value for money and are responsive to service user needs and that the views and experiences of service users and carers are reflected in service delivery.

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

|   |          |
|---|----------|
| • Bill Brown, Non-Executive Director                                      | (4 of 4) |
| • Manjeet Gill, Non-Executive Director                                    | (2 of 4) |
| • Steve Marsden, Non-Executive Director                                   | (4 of 4) |
| • Chris Lawrence, Non-Executive Director                                  | (3 of 3) |
| • Tom Cahill, Chief Executive (Chair)                                     | (4 of 4) |
| • Iain Eaves, Executive Director Strategy and Commercial Development      | (3 of 4) |
| • Keith Loveman, Executive Director Finance and Performance Improvement   | (2 of 4) |
| • Geraldine O'Sullivan, Executive Director Quality and Medical Leadership | (4 of 4) |
| • Oliver Shanley, Executive Director Quality and Safety                   | (4 of 4) |
| • Karen Taylor, Chief Operating Officer                                   | (2 of 3) |

In attendance at the meeting are the Company Secretary, Chair of Medical Staff Committee, other nominated Directors and service user representation.



# Remuneration and Nomination Report

## Board of Directors Nomination and Remuneration Committee

The Nominations and Remuneration Committee reviews and makes recommendations to the board on the composition, skill mix and succession planning of the Executive Directors of the Trust. All Non-Executive Directors are members of the committee and the Chief Executive, Company Secretary and the Director of Workforce and Organisational Development are normally in attendance.

There were 5 meetings of the committee during the financial period and members' attendance is shown below:

- Bill Brown, Non-Executive Director (5 of 5)
- Manjeet Gill, Non-Executive Director (3 of 5)
- Carol Kennedy Filer, Non-Executive Director (4 of 5)
- Hattie Llewelyn-Davies, Chair (5 of 5)
- Steve Marsden, Non-Executive Director (4 of 5)
- Ruth Sawtell, Non-Executive Director (2 of 2)
- Colin Sheppard, Non-Executive Director (5 of 5)
- Christopher Lawrence, Non-Executive Director (2 of 3)
- Peter Baynham, Non Executive Director (3 of 3)

## Board of Governors Appointments and Remuneration Committee

The committee is responsible for making recommendations to the Council of Governors on the following:

- Appointment and remuneration of Chair and Non-Executive Directors
- Appraisal of Chair
- Approval of appointment of 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 6 Governors: 4 public, 1 staff and 1 appointed. The Chair, Company Secretary and the Chief Executive are usually in attendance.

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

- Sheena Garbutt (Public Governor and Chair) (3 of 3)
- Glyn Trollope (Public Governor) (0 of 2)
- Irma Mullins (Staff Governor) (2 of 2)
- Eddie Veale (Appointed Governor) (3 of 3)
- Stuart Asher (Public Governor) (2 of 3)
- Chris Brearley (Public Governor) (1 of 1)
- Caroline Bowes Lyon (1 of 1)
- John Lavelle (1 of 1)

## Remuneration Report

The full remuneration report of salary, allowances and benefits of senior managers are included on pages 23 and 24 of the Full Statutory Accounts, which form section 2 of this document.

## Council of Governors

The Council of Governors includes 21 Public Governors elected by the members of the Foundation Trust. There are two public constituencies: one for Hertfordshire and one for the Rest of England and Wales. The Council also has five Staff Governors elected by the Trust staff and 9 nominated representatives from our partner organisations.

An election to the seats falling vacant as a result of Governors reaching their end of term was held under the auspices of the UK Engage during June 2012.

### **The Public Governors elected for Hertfordshire were:**

- Tap Bali
- Michael Bradley
- Gary Brady
- Meredith Griffiths
- Sarah Hamilton
- John Ingram
- Colin Marvell
- Carole Osterweil
- Sue Ross
- Celia Young (for a second term)

### **The Public Governor elected for the Rest of England and Wales was:**

- Joe Clack

### **During the year resignations were received from:**

#### **Public Governors:**

- Ida Glen Brown
- Celia Young

The resignation received from Ida Glen Brown was due to ill health. The resignation received from Celia Young was due to personal circumstances. In addition Glyn Trollope, one of the first of our public governors died following a lengthy illness. His contribution to the Council of Governors will be greatly missed as he was a strong voice representing the views of carers in Hertfordshire.

Following the election Gary Brady left the county of Hertfordshire and was removed from the membership register and is no longer a Governor.

Four seats remain vacant at present: two for the PCT, one for Carers in Herts who are still unable to nominate a Governor and one for Herts CC. We will be reviewing the make up of the governing body in the light of the Health and Social Care Bill 2012.

We thank all of the Governors for their valuable contribution to the Trust and in particular those who have served with us for two terms of appointment. Their expertise and knowledge will be missed and we hope they will continue their involvement with the Trust through 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, Hattie Llewelyn-Davies and they hold joint meetings annually, one of which is the AGM. In addition, the Board of Directors have an open invitation to

attend all of the Council of Governors meetings. The Chair and the Company Secretary act as the main links between the two Boards, and reports and briefings are shared by the Governors and Directors.

The Council of Governors have dealt with a range of issues as part of their statutory duties including the recruitment of two Non-Executive Directors, Chris Lawrence and Peter Baynham, and the reappointment for a further year of Hattie Llewelyn-Davies and Colin Sheppard.

They have also been involved in the Trust's Annual Members' Day and several Members workshops focusing on Trust Services as well as undertaking the performance appraisal of the Chair.

Four Council of Governors meetings were held during the past year (including the Annual Members' Meeting), each Governors attendance is shown in the constituency table below. The Chair attended all meetings of the Governors.

## Board of Governors

| Financial Criteria  | Metric | Attendance | Appointment         |
|---------------------|--------|------------|---------------------|
| Stuart Asher        | Public | 3/4        | 01/08/10 – 31/07/13 |
| Tap Bali            | Public | 2/3        | 01/08/12 – 31/07/15 |
| Caroline Bowes-Lyon | Public | 3/4        | 01/08/11 – 31/07/14 |
| Michael Bradley     | Public | 1/3        | 01/08/12 – 31/07/15 |
| Gary Brady          | Public | 0/3        | 01/08/12 – 31/07/15 |
| Chris Brearley      | Public | 2/4        | 01/08/11 – 31/07/14 |
| Ida Glen Brown      | Public | 2/3        | 01/08/10 – 15/12/12 |
| Jo Clack            | Public | 3/4        | 01/08/11 – 31/07/14 |
| Sheena Garbutt      | Public | 4/4        | 01/08/10 – 31/07/13 |
| Ray Gibbins         | Public | 4/4        | 01/08/10 – 31/07/13 |
| Jake Griffiths      | Public | 3/4        | 01/08/10 – 31/07/13 |
| Meredith Griffiths* | Public | 0/3        | 01/08/12 – 31/07/15 |
| Sarah Hamilton      | Public | 2/3        | 01/08/12 – 31/07/15 |
| Fran Hook           | Public | 2/4        | 01/08/10 – 31/07/13 |
| John Ingram         | Public | 2/3        | 01/08/12 – 31/07/15 |
| Carol Jeavons       | Public | 1/1        | 01/08/09 – 31/07/12 |
| Dick Lovelace       | Public | 4/4        | 01/08/11 – 31/07/14 |
| Colin Marvell       | Public | 1/3        | 01/08/12 – 31/07/15 |
| Carole Osterweil    | Public | 2/3        | 01/08/12 – 31/07/15 |
| Mary Porter         | Public | 1/1        | 01/08/09 – 31/07/12 |
| Sue Ross            | Public | 3/3        | 01/08/12 – 31/07/15 |
| Anne Marie Smith    | Public | 1/1        | 01/08/09 – 31/07/12 |

|                       |           |     |                     |
|-----------------------|-----------|-----|---------------------|
| Glynn Trollope        | Public    | 0/1 | 01/08/09 – 31/07/12 |
| Hazel Ward            | Public    | 1/1 | 01/08/09 – 31/07/12 |
| Steve Wright          | Public    | 3/4 | 01/08/10 – 31/07/13 |
| Celia Young           | Public    | 3/3 | 01/08/12 – 16/01/13 |
| Tara Gouldthorpe      | Staff     | 3/4 | 01/08/12 – 31/07/15 |
| John Lavelle          | Staff     | 2/4 | 12/10/10 – 31/07/13 |
| Janice Lepori         | Staff     | 3/4 | 01/08/10 – 31/07/13 |
| Irma Mullin           | Staff     | 1/1 | 01/08/09 - 31/07/12 |
| Beke Tshuma           | Staff     | 2/3 | 01/08/12 – 31/07/15 |
| Andrew Wellings       | Staff     | 1/3 | 01/08/12 – 31/07/15 |
| Erika Aldridge        | Appointed | 3/4 | 01/08/10 – 31/07/13 |
| Leslie Billy          | Appointed | 2/4 | 01/08/10 – 31/07/13 |
| Peter Brown           | Appointed | 2/4 | 13/10/10 – 31/07/13 |
| Fran Deschampsneufs   | Appointed | 3/3 | 01/08/12 – 31/08/15 |
| Cllr. Teresa Heritage | Appointed | 1/4 | 01/08/12 – 31/07/15 |
| Cllr. Dorothy Hone    | Appointed | 3/4 | 01/08/10 – 31/07/13 |
| Jackie Knight         | Appointed | 0/4 | 01/08/10 – 31/07/13 |
| Julie Nicholson       | Appointed | 0/1 | 01/08/10 – 31/07/12 |
| Mary Pedlow           | Appointed | 3/4 | 01/08/10 – 31/07/13 |
| David Thomson         | Appointed | 0/1 | 01/08/10 – 17/04/12 |
| Eddie Veale           | Appointed | 3/4 | 01/08/10 – 31/07/13 |

\* Meredith Griffiths was absent following an operation.

The three working groups of the Council have continued 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 Quality and Effectiveness Group was not as active this year due to the resignation of its Chair and the loss of another member. However, it recovered its membership towards the end of the year and is now fully engaged with a work programme having agreed its terms of reference with the Council.

### The areas which the groups worked on last year are:

#### Engagement:

- The group delivered a successful members day' and increased the number of attendees
- Arranged monthly members' workshops in different Trust locations
- Work is in progress to develop a script to be used when talking to members and the public within their constituency

#### Performance:

- The group received performance reports and worked alongside a Non-Executive Director to note and develop future improvements
- The group discussed how CIPs were identified and agreed to ensure that safety and quality of service was not at risk by the impact of savings

**Quality & Effectiveness:**

- Quality Accounts – the group contributed to the process of choosing priorities for the year ahead
- The group has also received reports concerning Quality Accounts as well as information about performance against CQUIN targets.

**Register of Interests:**

The register of Governors' interests is available from the Company Secretary at Hertfordshire Partnership NHS Foundation Trust, 99 Waverley Road, St Albans, Hertfordshire AL3 5TL.  
Tel: 01727 804642

There are no company directorships held by the Governors where companies are likely to do business or are seeking to do business with the Trust.

**Expenses:**

Governors may claim travel expenses at the rate of 0.45p per mile as well as other reasonable expenses incurred on Trust business. They are not otherwise remunerated.

## Membership

Public membership declined this year to 11,191 due to our data cleansing project which is still on going. A large number of members have moved away without any forwarding addresses, and therefore have been removed from our database.

New members continued to develop as a result of attendance at workshops and members' day. In addition, relationships with core members strengthened and will be maintained by providing meaningful engagement with the Trust.

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
- a short term contract of 12 months or more
- although not directly employed by the Trust, have been employed in excess of 12 months by another organisation that is providing core services to the Trust
- seconded to the Trust to provide core services

During the year the staff constituencies were amended to reflect the new operational management structure following consultation with the Staff Governors and staff. Staff membership at the end of the year breaks down as follows:

- |   |     |
|---|-----|
| • Acute and Rehabilitation Services         | 429 |
| • Community Services                        | 791 |
| • Learning Disability and Forensic Services | 767 |
| • Specialist Services                       | 475 |
| • Corporate Services                        | 276 |

Engaging a diverse and representative membership which reflect the population and communities we serve continues to be a focus for the Trust and the Governors.

Members receive 'News from HPFT' twice per year and an 'ezine' twice per year; they also have access to further information about the Trust and the work of the Council of Governors and Directors through the website. We are continuing with developments to highlight information of particular interest to members and enable them to take part in workshops and discussions around issues such as wellbeing and anti-stigma campaigns.

We are looking to grow and maintain an active membership which represents the communities in which we serve. Action to increase membership includes attendance at local public events; joint working with other Trusts in particular acute Trusts whereby the public may have an interest in services offered by more than one Trust; actively recruiting through members of staff and the Council of Governors.

Members are encouraged through the public website and 'News from HPFT' to communicate with Governors via the Membership Office.

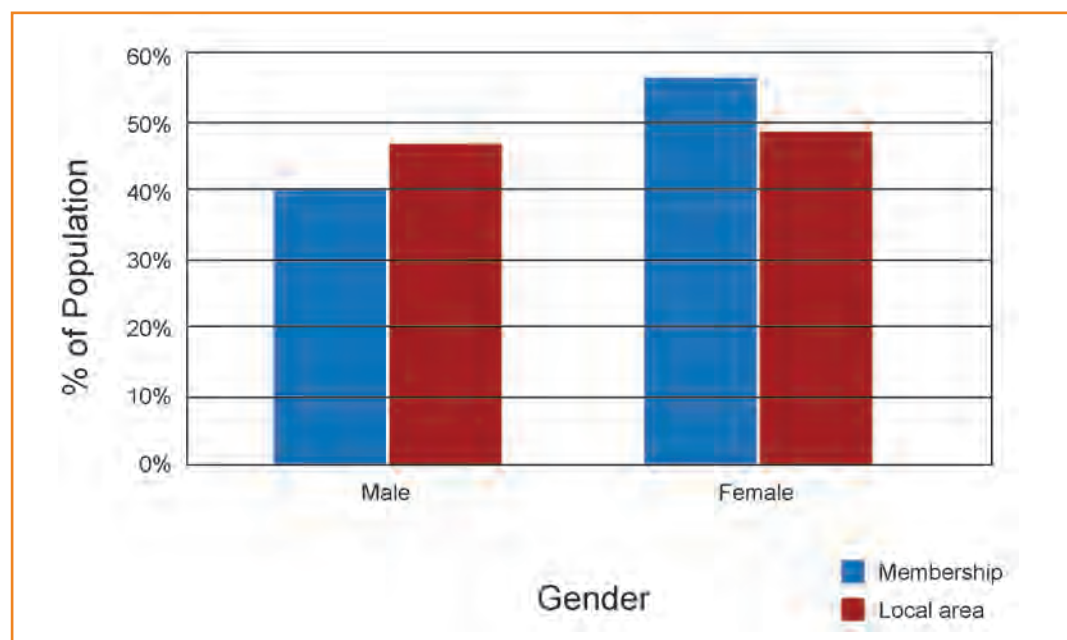
## Membership size and movements

| Public constituency (England & Wales) | Last year (2012/13) | Next year (estimated) (2013/14) |
|---------------------------------------|---------------------|---------------------------------|
| At year start (April 1)               | 680                 | 648                             |
| New members                           | 8                   | 10                              |
| Members leaving                       | 40                  | 20                              |
| At year end (March 31)                | 648                 | 638                             |

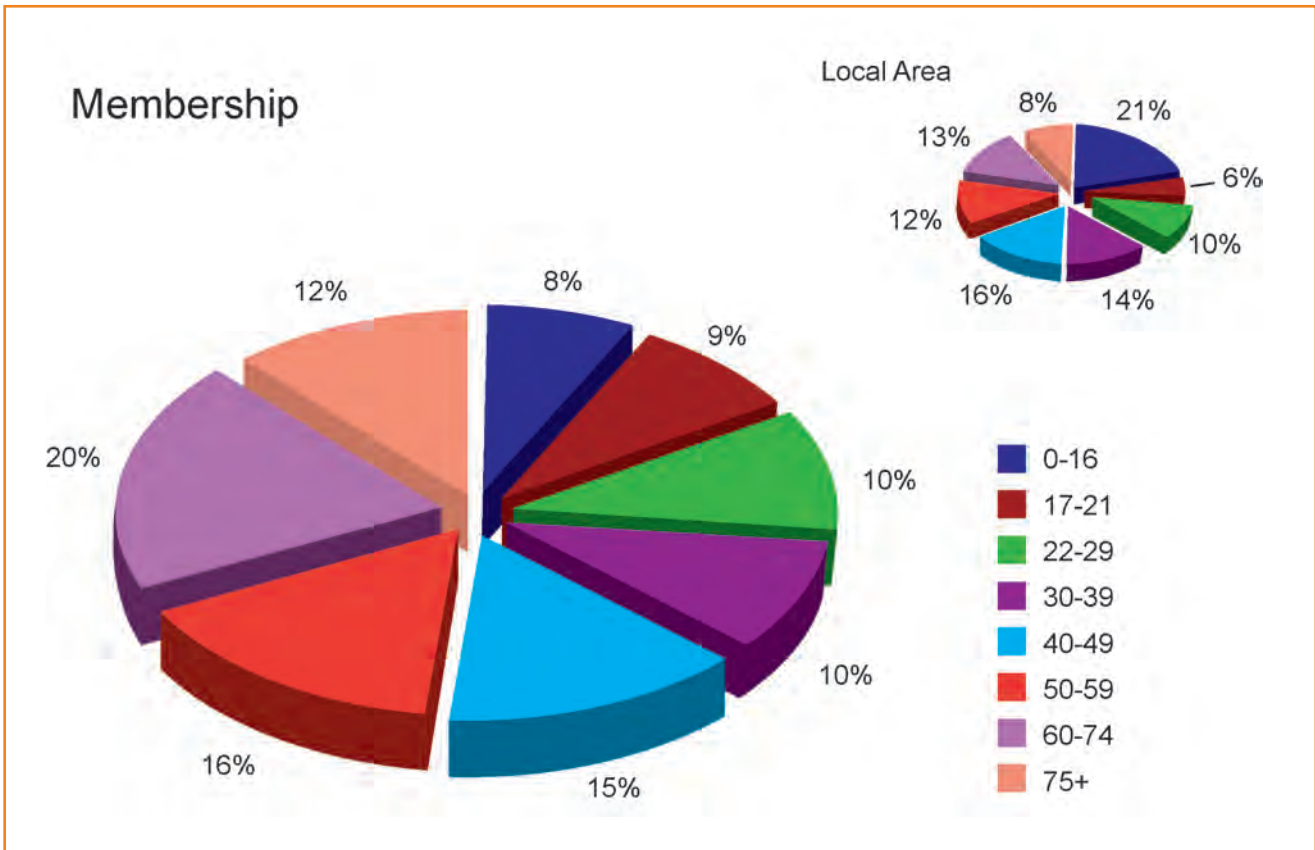
| Public constituency (Hertfordshire) | Last year (2012/13) | Next year (estimated) (2013/14) |
|-------------------------------------|---------------------|---------------------------------|
| At year start (April 1)             | 11,367              | 10,543                          |
| New members                         | 64                  | 50                              |
| Members leaving                     | 888                 | 100                             |
| At year end (March 31)              | 10,543              | 10,493                          |

| Staff constituency      | Last year (2012/13) | Next year (estimated) (2013/14) |
|-------------------------|---------------------|---------------------------------|
| At year start (April 1) | 3,015               | 2,738                           |
| New members             | 244                 | 270                             |
| Members leaving         | 521                 | 350                             |
| At year end (March 31)  | 2,738               | 2,658                           |

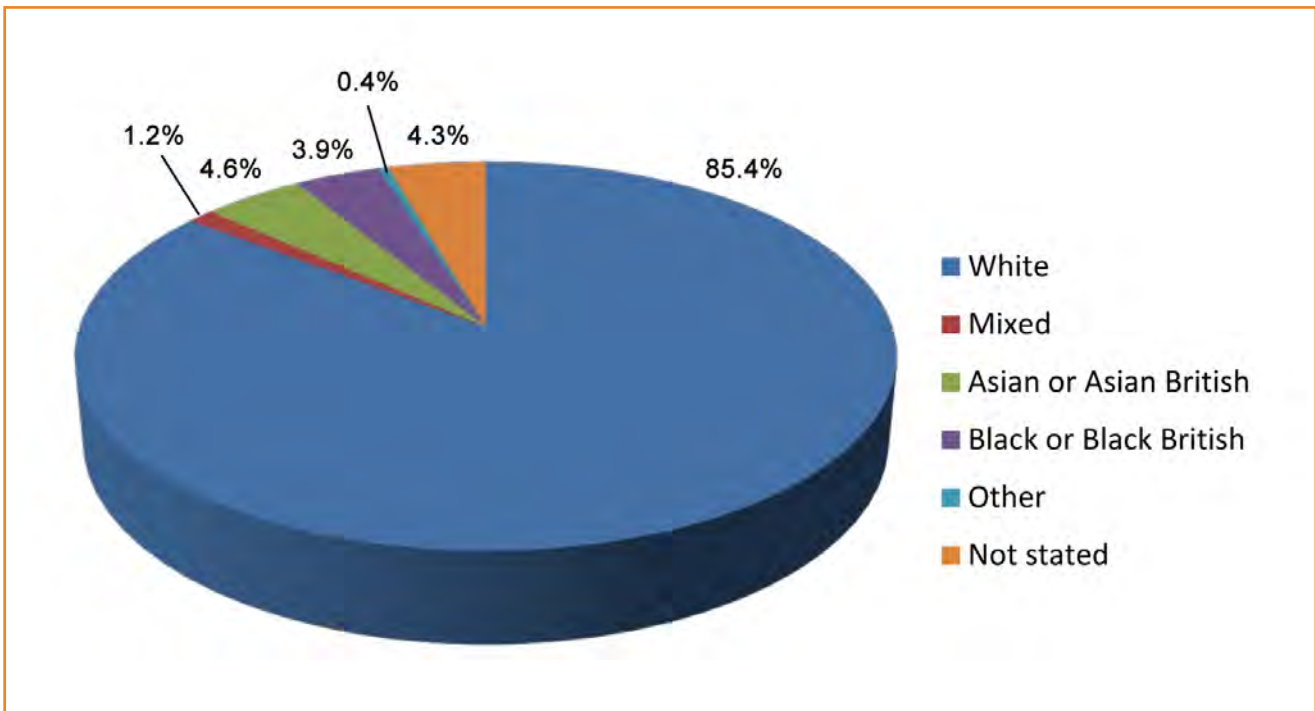
## Gender Distribution



## Age Distribution



## Ethnicity Distribution





# Quality Account

## Part 1 - Statement by the Chief Executive

I'm delighted to introduce our Quality Account for 2012/2013. This is our chance to describe the quality of our services in the past year to all those who are interested in the best possible mental health and learning disabilities services for those who need them – in Hertfordshire, but also in parts of Essex and Norfolk.

It has been a very busy and productive year for the Trust – at a time when the Francis Report into Mid-Staffordshire NHS Foundation Trust has reminded us all that quality and safety can never be taken for granted.

For us too, financial pressures have meant that we have had to close some services, and concentrate on being more effective and well-organised in what we do so that quality does not suffer.

I feel we have achieved this for three main reasons. One is our continued excellent record in terms of compliance with our external regulators – above all, the Care Quality Commission and Monitor – as well as our commissioners.

The second is the continued very positive feedback we receive from service users and carers about their experiences of what we do.

The third is the increased amount of innovative, fresh and service user centred practice which has been recognised regionally nationally and internationally – but also locally, by those who rely on them.

More details are provided in the body of this report, which I hope is an enjoyable and informative read.

In this account:

Part 2 provides a brief introduction to HPFT

Part 3 describes the quality of what we've done – with plenty of detail about performance on our chosen priorities and the many other areas that we are required to present.

Part 4 is about plans for the coming year.

Part 5 gives some final comments.

The account will be published before the end of June 2013 on the NHS Choices website and on ours [www.hpft.nhs.uk](http://www.hpft.nhs.uk)

Paper versions and other formats will be available via our Communications Team on 01727 804791.

In accordance with the NHS (Quality Accounts) Regulations 2011 No. 269 as senior employee I hereby state that to the best of my knowledge the information in this document is accurate.

Signed:



Tom Cahill  
Chief Executive

## Part 2 – Introduction

In HPFT we remain committed to our vision to be:

*“the leading provider of mental health and specialist learning disability services in the country.”*

We employ circa 2,700 staff - psychiatrists, psychologists, nurses, social workers, occupational therapists, art therapists, speech and language therapists, peer support workers, managers, administrators and others - who serve around 25,000 people at any one time.

In addition to these 25,000 service users, last year 7,100 people entered treatment with our Enhanced Primary Mental Health Service, where across Hertfordshire we provide treatment for people with anxiety and depression alongside GPs (this figure is set to rise considerably in the coming year).

In Hertfordshire we also provide services for children and young people, adults with more severe mental health problems and adults with learning disabilities .

In North Essex we provide community and inpatient services for adults with learning disabilities.

In Norfolk we provide inpatient services for adults with learning disabilities.

In 2012/2013 we developed our services for older people with memory difficulties and our primary mental health services, whilst at the same time we ceased to provide adult drug and alcohol services and social care for people with dementia.

## Part 3 – Review of Quality Performance

### 3.1 Background

This section is the heart of our report, where we give a comprehensive picture of the quality of our services over the past year.

A lot of the detail is about how we have done in the 16 areas we picked out as most important a year ago. But – as before – we are also keen to get beyond the numbers and convey the variety and complexity of our service users’ experiences and how we respond to them.

So we also provide some descriptions of services and we highlight new projects. Aspects of our performance are shown in comparison with other Mental Health Trusts.

## Good News Box

We were highly commended for the Care Programme Approach Association's 2012 award on monitoring and evaluation of the CPA.

Peer experience listener Chris Coote said:

"The Peer Experience Listening project has been exciting and very rewarding, with a lot of work and experience going into its actual existence, from many different quarters. The project involves the gathering of service user and carer feedback, no doubt extremely important, you could even say vital."

### 3.2 Selection of Priorities

From January 2012 we began to think about quality priorities for that year. We drew up a long list and used this as a basis for consultation with service users, carers, staff colleagues, HertsLINK, the Hertfordshire County Council Health Scrutiny Committee, commissioners and Governors.

A wide range of views were expressed – but it was clear that we needed to continue to use safety, service user /carer experience and clinical effectiveness as our three main headings. We were asked to strengthen our focus on staff, as there were signs that they were not as well engaged with the overall aims of the Trust as we would like. It was also suggested that we report separately on the experience of marginalised groups who can often still have difficulty accessing services when they need them.

As a result, in March 2012 the Board of Directors agreed 16 quality measures for the account:

- Safe Services (4 measures)
- Effective Services (3 measures)
- The Very Best Customer Experience (4 measures)
- Equalities (2 measures)
- Workforce (3 measures)

## What is... Having Your Say (HYS)

It's the main way we gather the views of services users and carers about the services we provide. It is well established and can be completed on paper, online or over the phone. At least 600 responses are received every three months and reported to teams. There are seven versions of HYS reflecting the different needs of children with mental health problems, adults with mental health problems, carers and people with learning disabilities.

People can say what they want on the forms, and teams are expected to say what they have done in response.

### 3.3 How We Did

Our performance on the 16 quality indicators is now outlined.

The table with all the figures is shown in appendix 2. In this section the numbers for each measure are shown in graphs together with brief written explanations.

In some cases, the “target line” begins in the middle of the year because we have had to set up ways of gathering the information and finding a baseline first.

Where figures are taken from Having Your Say the actual numbers of responses are shown as well as the percentages. Also, where possible, results are broken down between “True” and “Partly True”. A rating of “True” means that someone has the highest level of satisfaction available in the rating scale; inevitably these scores are lower than when they are joined up with responses of “Partly True”.

Overall, for the 16 measures of our 5 quality priorities, 8 were achieved and 8 were not.

## SAFE SERVICES

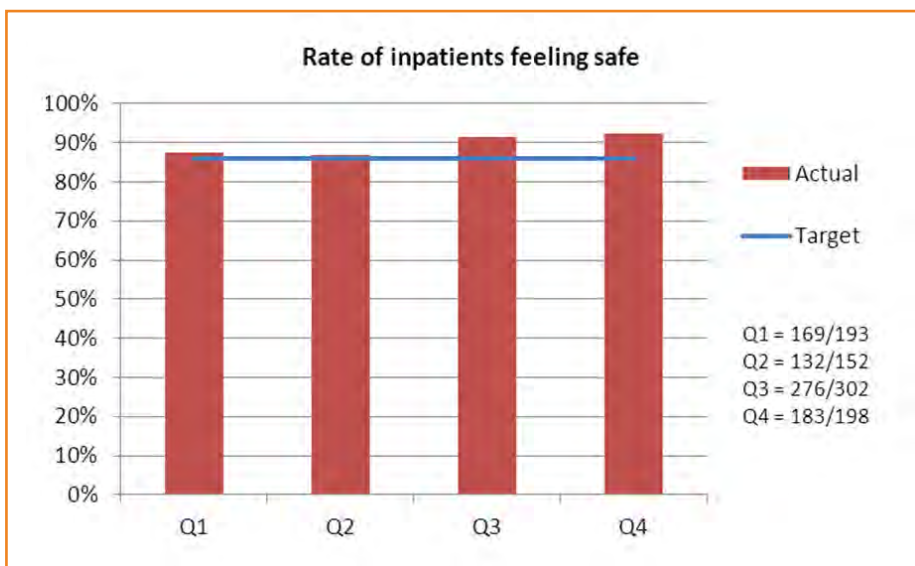
### 3.3.1. Inpatient Safety

**Definition:** The number of people saying that they have felt safe during their current inpatient stay as a proportion of all those answering the question.

**Rationale:** Mental health inpatient units can still be tense and anxious environments especially when it’s your first admission. There can still be stigma which doesn’t help. Thus it is vital that we do all we can through our environments - but above all through the quality of care - to keep inpatients safe.

**Data source:** Having Your Say

**Progress:**



It is very important to us that inpatients feel as safe as possible on our inpatient units. We now have fewer inpatient beds than we did with a transfer of services into the community. This means that those who do need inpatient care are often admitted compulsorily (48% of all inpatients in April 2013 had been admitted compulsorily, a figure that has been consistent through the year). They also tend to be increasingly severely mentally ill, and - especially on units for people with learning disabilities and challenging behaviour and for people with severe dementia - there continue to be incidents of actual or threatened physical violence.

In this context, we are very encouraged that we have **achieved our target** of over 86% of people saying they have felt safe during their current inpatient stay. This has been achieved through modifying the layout of wards wherever possible so that distressed patients are more easily managed. There has also been more nurse training in best practice in de-escalating incidents, and continued work with voluntary organisations and volunteers to make units places where inpatients can feel relaxed and have enough therapeutic and enjoyable things to do.

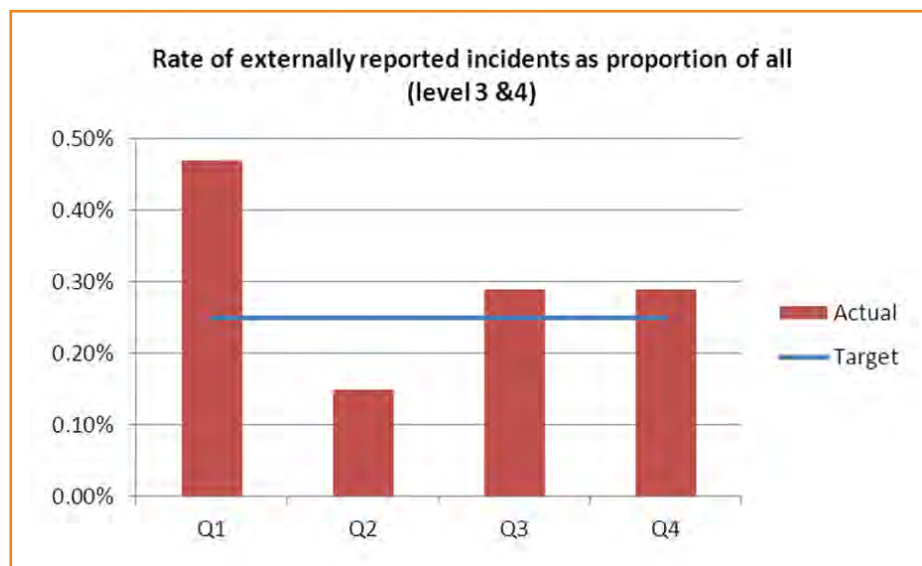
### 3.3.2 Reduced Serious Incidents

**Definition:** The number of serious incidents that have to be reported outside the Trust as a proportion of all incidents reported.

**Rationale:** It's important that staff continue to report all incidents so that trends can be analysed and actions taken to prevent them where possible. However we are also determined to reduce the numbers of major incidents, which (as with all Mental Health Trusts) are mainly suicides. This measure tries to capture how we are doing in both these areas.

**Data source:** Our e-reporting system for incidents (datix).

**Progress:**



In quarter 3 there were 7 and in quarter 4 there were 6 serious incidents which made up 0.29% of all incidents reported. This means that we narrowly **failed to achieve** our target for the end of the year. Most of the serious incidents are apparent suicides – we say “apparent” when the cause of death has not been confirmed by the coroner.

Each incident is thoroughly investigated internally with the report being shared outside the Trust with NHS commissioners. In some cases we have found that little more could have been done to prevent the incident, in others we have had to make sure we put aspects of our practice right, such as helping inpatient nurses better identify those at risk of absconding, or making sure those acutely unwell are properly transferred to community mental health services so that responsibilities are clear.

We know that Hertfordshire has a relatively low suicide rate. However the most recent statistics indicate a national increase in the rate; this tells us that our role in preventing suicides remains crucial.

Below is shown how we did this year compared to the previous two. The pattern is of a small decrease in serious incidents and unexpected deaths this year.

NB: data is accurate as at 10 May 2013.

|   | 2010/11 | 2011/12 | 2012/13 |
|---|---------|---------|---------|
| All serious incidents   | 23      | 26      | 22      |
| Those that were unexpected deaths (which may be confirmed as suicides by the coroner) | 17      | 17      | 15      |

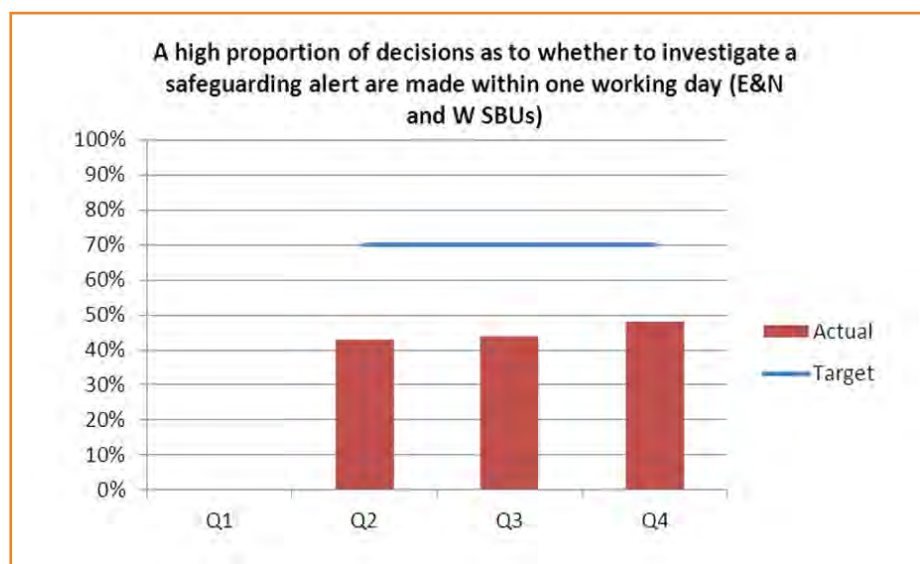
### 3.3.3. Safeguarding Adults – Mental Health

**Definition:** The number of decisions as to whether to investigate a safeguarding adult alert in mental health services made within one working day as a proportion of all alerts received.

**Rationale:** We haven't yet found a way of measuring how effectively we protect all vulnerable adults with mental health problems from abuse or exploitation. So at this stage we are examining how quickly we move to investigate all such referrals – whether under our care or in the local community.

**Data source:** Safeguarding adults database.

**Progress:**



Despite some improvement through the year, we have **failed to achieve** our target in this area. Our checks indicate that sometimes local managers have made the necessary decisions promptly, but have not recorded this in time. However, during the year Community Mental Health services have had wider responsibilities with no more staff, and it is likely that performance in this area reflects this level of pressure.

Our Head of Safeguarding is exploring how more significant improvements can be made and this quality measure has been carried over to the next year.

These figures do not include people with dementia for whom the responsibility to investigate alerts sits with Hertfordshire County Council.

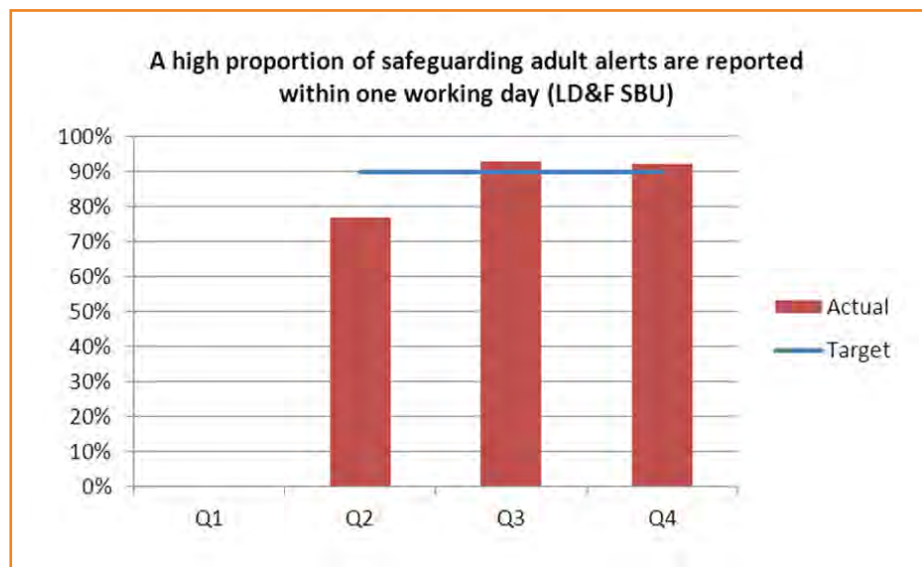
### 3.3.4 Safeguarding Adults – Learning Disability

**Definition:** The number of safeguarding adults alerts reported within one working day of the incident occurring for people under our care with learning disabilities.

**Rationale:** In these services we do not investigate alerts but we do refer such incidents to our colleagues in Health and Community Services (Hertfordshire County Council). It's important that we do this quickly and openly so that investigations to make sure the situation is safe proceed in good time.

Data source: Safeguarding adults database

**Progress:**



We provide inpatient care for adults with learning disabilities in Hertfordshire, North Essex and Norfolk. Since the Winterbourne View scandal there has been widespread public concern about the quality of care in this setting. Such facilities have sometimes been too institutional and too closed.

We have done a lot to open up the world of learning disabilities care through employing people with learning disabilities as colleagues, training staff and reviewing services with them, and hosting conferences. This measure is about one aspect of such openness, where

we make sure potential safeguarding incidents, where a service user might have been mistreated, are immediately reported. We are very encouraged to have **achieved** our target here, and also note that no such “alerts” have led to serious concerns being found throughout the year.

## EFFECTIVE SERVICES

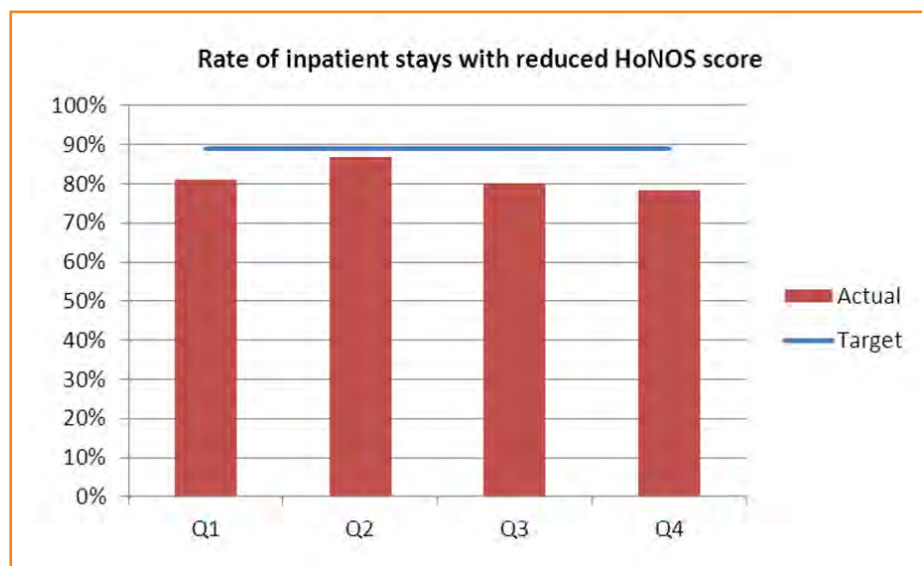
### 3.3.5 Impact of Acute Inpatient Care

**Definition:** The number of inpatients with reduced Health of the Nation Outcome Scale scores on discharge compared to on admission as a proportion of all those with paired scores.

**Rationale:** Acute inpatient care is a major experience for any service user, often effective, sometimes tense and relatively costly to the NHS. It needs to be shown whether it is as effective as it can be and the preferred national measure for this is HoNOS.

**Date source:** The electronic patient record

**Progress:**



Although performance has been consistently around 80% - meaning that 80% of those receiving acute inpatient care can be shown to have benefitted clinically – we have **not achieved** our stretching target of 90%.

The measure has some weaknesses; for example, our service users generally tell us that as soon as they can manage at home they would rather be treated there than in hospital, and this is what our Crisis Assessment and Treatment Teams can now do. So someone who is no better in terms of their mental health may leave inpatient care and be transferred to CATT, which would show on this measure as a failure to benefit from inpatient care.

But we need to become more sophisticated in showing whether acute care is effective in achieving positive clinical outcomes for service users. In the coming year we will be introducing a HoNOS measure for the whole acute care pathway.



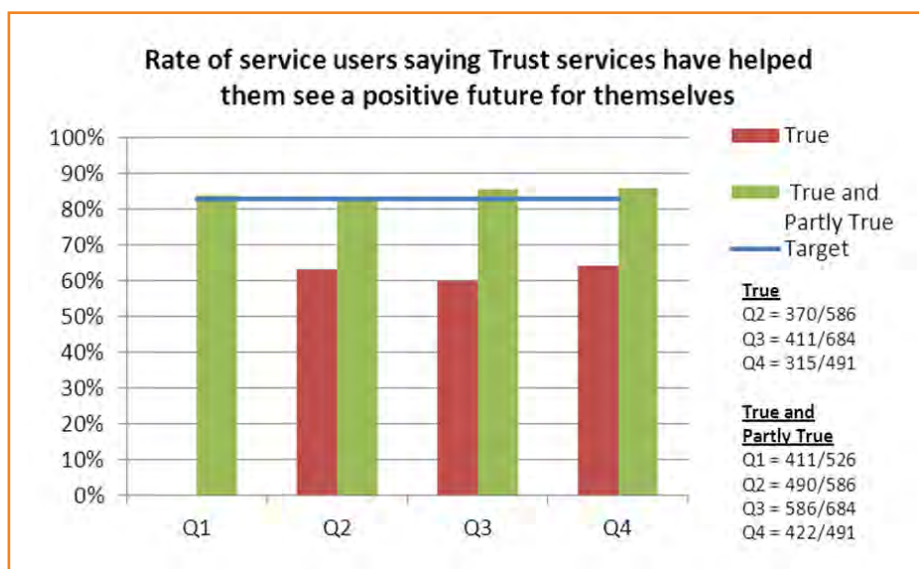
### 3.3.6 A Recovery Measure

**Definition:** The number of people saying Trust services have helped them to see a positive future for themselves as a proportion of all those answering the question.

**Rationale:** If we are to show that we are successful in helping our services users in their recovery - so that they can live their lives to the full whether or not they continue to have ill health - we need to give them some optimism and hope, even those with major depression. Our service users have mixed feelings about this question and it is not our only way of checking how we are doing in working in a recovery-oriented way. But it's a good start.

**Data source:** Having Your Say.

**Progress:**



We believe it's essential that our staff give service users a greater sense of hope and optimism for the future. When working with many people with severe depression, or other mental health problems that can be hard to treat or lead to social exclusion, staff need to remain positive and practical at all times. A positive future means different things to different people; it might be seen in terms of more friends or a job, or more ambitiously as a life free from mental illness.

We are delighted that we have **achieved** this target this year. This will form the basis of a further range of recovery-oriented initiatives in 2013/2014, when we will routinely support service users to decide how they will get well and stay well with our help, using all their strengths and what they have learnt through their experience of mental ill-health.

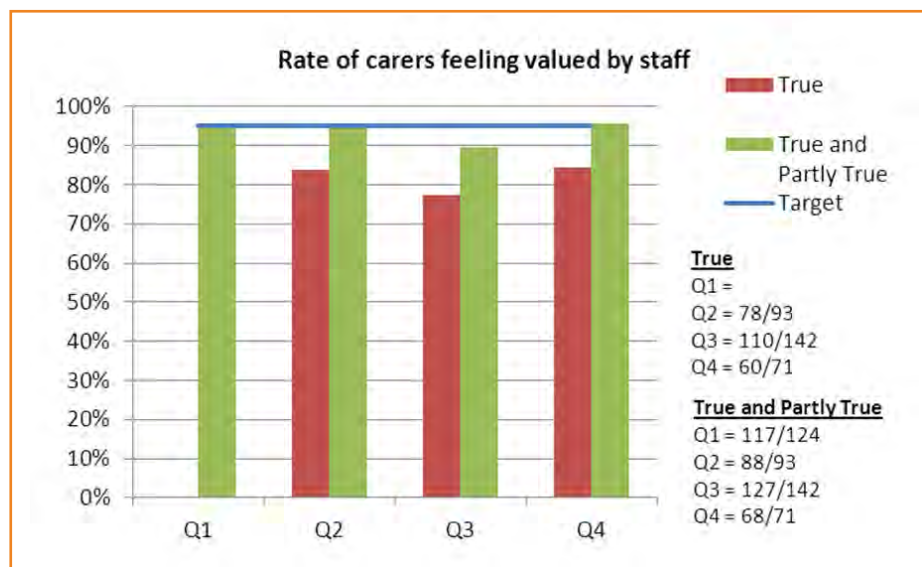
### 3.3.7 Valuing Carers

**Definition:** Number of carers of people with mental health problems saying they feel valued by staff as a proportion of all those answering the question.

**Rationale:** Carers of those who receive our services are key allies in helping us focus our efforts in the right way. They have a wealth of detailed information that can help us do our jobs better, and are often under considerable strain in carrying on in a caring role. Family relationships can be tense and complex and carers can sometimes feel ignored by services. This measure checks whether they feel valued.

**Data source:** Having Your Say

**Progress:**



Like service users, carers are experts by experience and although their relationships with their loved one can sometimes be fraught, care and treatment is much more likely to be effective when Trust staff involve carers as closely as possible.

We have **achieved** our target this year during a very busy year when there have been many varied demands on our resources. We have just launched a new Carers’ Strategy stating what carers can expect from us. To make sure this good performance is maintained we are carrying over this measure into the coming year.

## VERY BEST CUSTOMER EXPERIENCE

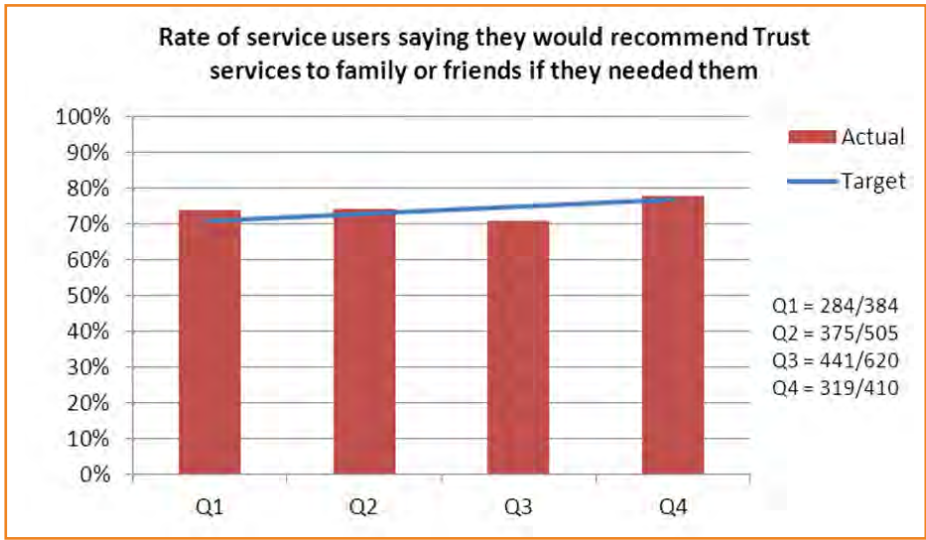
### 3.3.8 The Family and Friends Test

**Definition:** The number of those saying they would recommend Trust services to family or friends if they needed them as a proportion of all those answering the question.

**Rationale:** This question (also known as the “net promoter” question) is now compulsory for other NHS Trusts and their results are monitored at all levels of the NHS. It can provide a powerful statement about the quality of services as experienced – especially when put alongside the same question answered by staff (see below). As in any survey the wording of each question is very important if clear findings are to be derived from it; we are therefore grateful to our local commissioners for allowing us to continue with our preferred wording for this question which has made it more forceful.

**Data source:** Having Your Say (“True” responses only).

**Progress:**



We found a baseline of 69% from last year and set ourselves an improvement target which we have **achieved**. We have done this by making sure staff are aware that our performance is being measured in this way and that this means we must all focus on providing care and treatment which is easy to access, effective and based on what each individual needs.

This is a strong overall indicator of the quality of services and we are carrying it over into the coming year.

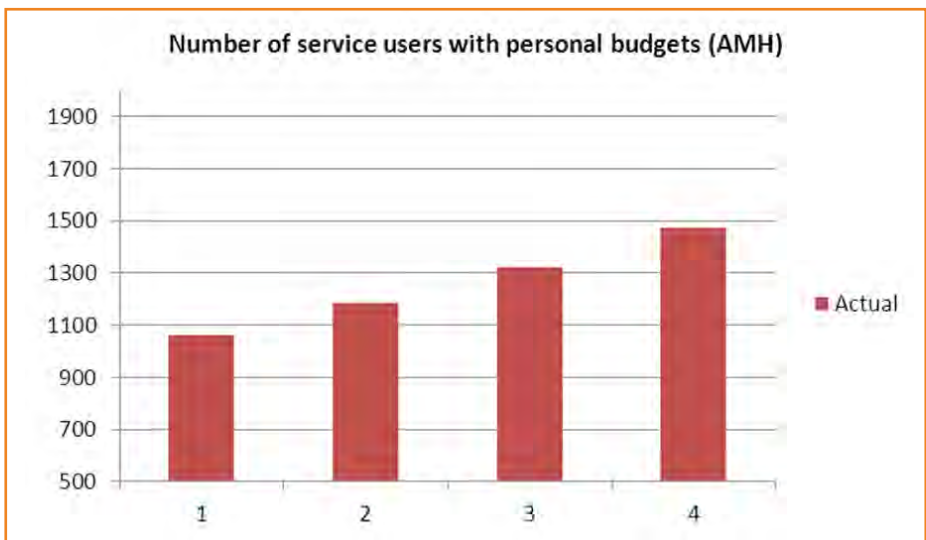
**3.3.9 Personal Budgets**

**Definition:** The number of people using working age mental health services with personal budgets.

**Rationale:** In recent years in social care nationally and locally there has been a big shift to enabling those with social care needs to have more control over how these needs are met. As a Partnership Trust, we have many statutory responsibilities delegated to us from Hertfordshire County Council, including those to use personal budgets to enable service users with social care needs to choose how these needs will be met.

**Data source:** Internal database (derived from the electronic patient record)

**Progress:**



Our target set by the local authority was to reach 1,667 by the end of the year and our final figure was 1,473 – so we have failed to achieve this. The closure of Community Support Teams in 2012 led to more service users being identified as entitled to personal budgets but delays in arranging these. It should also be remembered that service users can choose not to have their social care arranged in this way.

The figure of 1,473 represents 61% of those using working age mental health services who are entitled to social care. The target was 70%. The national performance for 2011/2012 was 43% with the 2012/2013 figure not yet available.

We are talking to our colleagues in Health and Community Services (Hertfordshire County Council) about how personal budgets can be more easily set up and administered in 2013/2014..

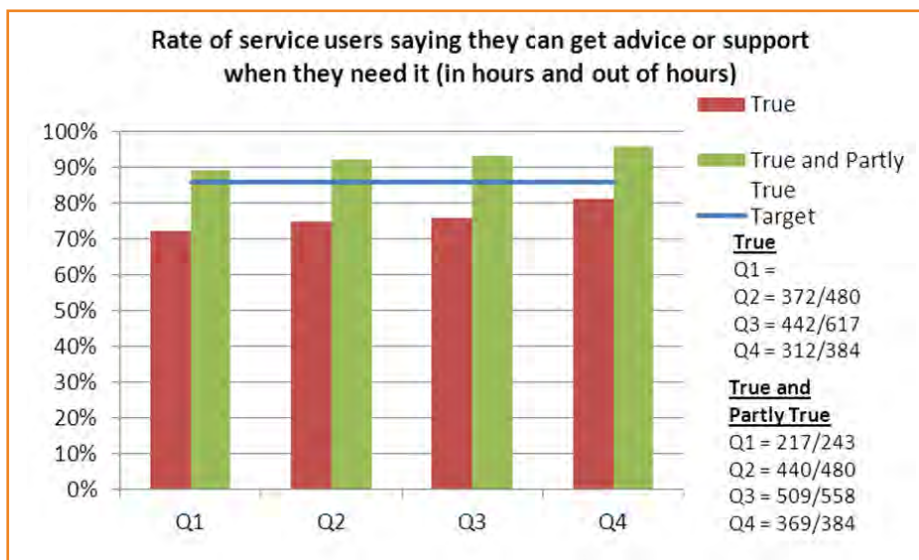
### 3.3.10 Service users getting advice or support when they need it

**Definition:** The number of people saying they could get advice or support when they needed it (both in normal working hours and at evenings and weekends).

**Rationale:** People with mental health problems or learning disabilities and their families need the right help at the right time. Access to services can be too complicated and too slow. In May 2012 the Trust set up a radical new way of providing access to services – the Single Point of Access. We wanted to measure its impact in terms of the service user experience.

**Data source:** Having Your Say

**Progress:**



Good progress has been made throughout the year and our target has been **achieved**. We know that - as with any major new service – the process has not always worked smoothly, but we are greatly encouraged that 90% of our service users tell us they are getting help when they need it.

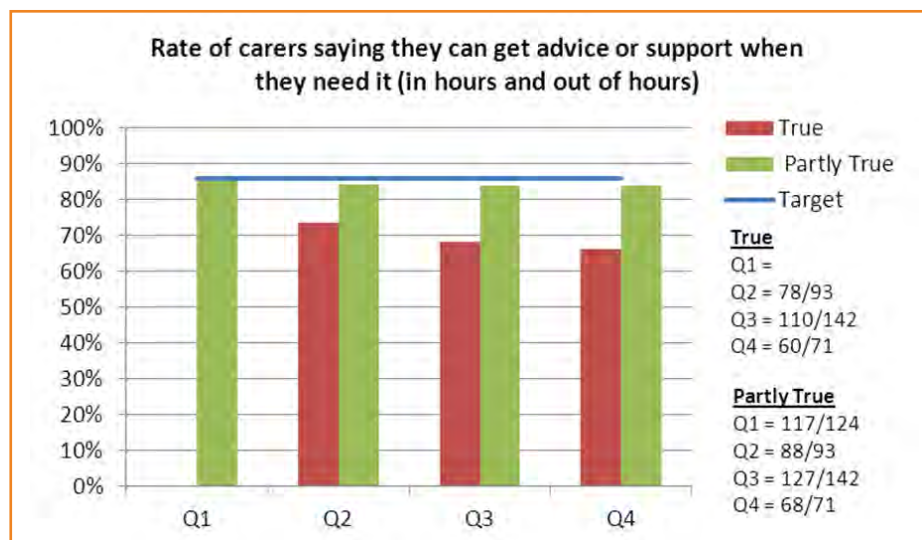
### 3.3.11 Carers getting advice or support when they need it

**Definition:** The number of carers saying they could get advice or support when they needed it (both in normal working hours and at evenings and weekends).

**Rationale:** As above, this measure is partly about the effectiveness of the new Single Point of Access. But carers also need to have good access to the care co-ordinator or other staff over considerable periods of time and this measure aims to consider this experience too.

**Data source:** Having Your Say.

**Progress:**



This target has **not been achieved** by a narrow margin. At times during the year community mental health services have struggled to respond to all the needs of carers. These services are being radically re-organised in the coming year with the aim of making them easier to access and more efficient. There will be fewer separate teams, with fewer transfers of care and fewer repeated assessments.

It should be noted that the number of carer responses is relatively low. We are revising our Having Your Say carers' form now with the aim of making it more user-friendly.

## EQUALITIES

### 3.3.12 Equalities - EDS

**Definition:** Progress on the Equalities Delivery Scheme (EDS), comparing results of our assessments in Spring 2012 and Spring 2013

**Rationale:** We agreed with our stakeholders in early 2012 that minority and marginalised groups can be doubly disadvantaged if they experience mental health problems, and that we need to make it a priority that we were reaching out effectively to all those who might need our help.

This area was therefore included in our priorities for the quality account, although it does not lend itself very well to being measured numerically.

**Data source:** EDS results

**Progress:**

The EDS ratings are made by service users and other agencies on the basis of information presented by the Trust which they are invited to challenge.

**Results:**

|                    | April 2012 | April 2013 |
|--------------------|------------|------------|
| Purple (excellent) | 1          | 0          |
| Green              | 13         | 17         |
| Amber              | 4          | 0          |
| Red                | 0          | 0          |
| Under review       | 0          | 1          |
| <b>Total</b>       | 18         | 18         |

The evidence of progress means that this indicator is **achieved**. There is a good baseline followed by further improvement. The “Ambers” in 2012 related to moves between teams for service users, access to services, staff experience of harassment and bullying from service users and colleagues, and whether the Trust considers equalities issues sufficiently when recruiting.

In 2013 there was positive feedback about the introduction of the Single Point of Access and the way we have made it easier for people to refer themselves for help. For staff, there was appreciation of the new mediation service that has been set up to resolve grievances within teams.

We are now setting out our actions to achieve a lot more ‘Purples’ in the coming year, with the aim of being fully at the ‘Purple’ level in two years time.

We recognise that we have more to do to show that all nine potentially disadvantaged groups (known as “protected groups”) are receiving as good a service as anyone else, provided flexibly to suit their particular needs.

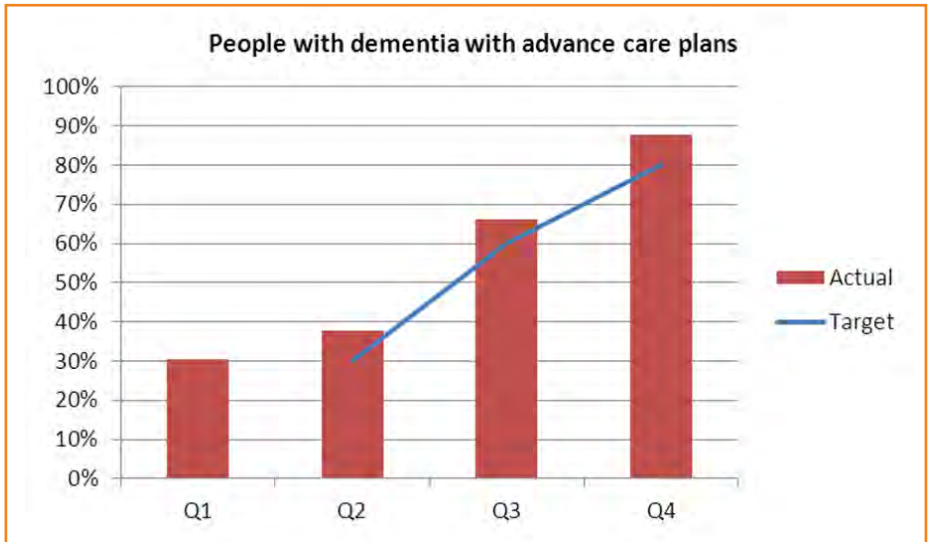
### 3.3.13 Helping people with dementia to have control over their future care

**Definition:** Number of people with dementia seen by the Early Memory Diagnosis and Support Service (EMDASS) who are offered an advance directive or advance care plan as a proportion of all those in EMDASS receiving a diagnosis of dementia

**Rationale:** The NICE (National Institute for Health and Clinical Excellence) Quality Standard for dementia care includes the expectation that people with dementia should always be offered advance care plans or advance statements. These are documents which allow the person, with support of their carers, to state how they wish to be treated by the Trust in the future.

**Data source:** The electronic patient record

**Progress:**



Considerable progress has been made in this area and the target has been **achieved**. This was a quality account measure which was also a Commissioning for Quality and Innovation (CQUIN) target. This meant that there was a financial incentive from commissioners to the Trust to make sure this aspect of dementia care was improved.

There is always a risk that the increasing numbers of people with dementia are felt to be “a burden” by health and social care services. Progress in this area is one way in which the Trust is making sure that they have every chance to have their voices heard.

**WORKFORCE**

**3.3.14 Staff recommending the Trust as a place to work**

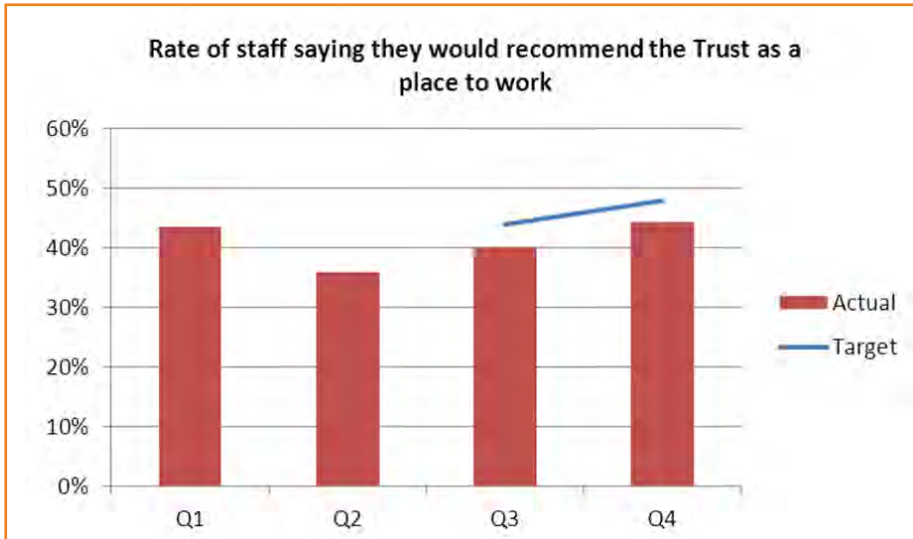
**Definition:** The number of Trust staff saying they would recommend the Trust as a place to work as a proportion of all staff completing the survey.

**Rationale:** If both service user and staff are prepared to recommend a Trust to others this is known to be a very powerful indicator of the quality of the services provided. In the previous year we had had some disappointing results in the national NHS staff survey, with a smaller proportion of our staff than the national average saying they felt able to recommend the Trust as an employer.

For both these reasons it was important for us to focus attention on this area and see how it could be improved.

**Date source:** Quarterly internal “Pulse” surveys.

## Progress:



A target was set after finding a baseline from the first two quarters. Limited progress was made and the target was **not achieved**.

National benchmarking data is not available as this result is based on our internal survey.

See below under 3.3.16 for further discussion.

### 3.3.15 Staff with a clear understanding of what is expected of them

**Definition:** This measure is made up of responses to two questions in the “Pulse” surveys about how well staff feel they understand how what they and their team do contributes to the Trust’s objectives. It is the number of respondents saying “Yes” to these questions as a proportion of all responses.

**Rationale:** It is important that staff are clear about what excellent care looks like and what the Trust expects of them. The Trust is going through a three to four year period of unprecedented change and we have had to acknowledge the extra pressures this puts on staff, which can get in the way of the provision of the best possible care. There have been a lot of new initiatives in the year to engage more effectively with staff and we have needed to see if they are working.

**Data source:** Quarterly internal “Pulse” surveys.





A target was set after finding a baseline from the first two quarters. Limited progress was made and the target was **not achieved**.

Whilst we know from our internal surveys that staff are generally proud of what they and their own teams are doing, they are also telling us that they do not always feel supported by their managers or by the organisation as a whole. There can be many reasons for this, some of which are hard to address quickly. The current four year programme of service transformation has been unsettling for many staff as well as service users and carers. The Trust has made sure that our internal communications are much more fluent and comprehensive than they were, but there is clearly more to be done.

National benchmarking data is not available as this result is based on our internal survey.

See below under 3.3.16 for further discussion.

### 3.3.16 Staff feeling more engaged and motivated

**Definition:** This measure is made up of responses to two other questions in the “Pulse” surveys about levels of motivation and engagement. It is the number of respondents saying “Yes” to these questions as a proportion of all responses.

**Rationale:** Again, we have wanted to check whether our initiatives to address low staff morale have had an impact.

**Data source:** Quarterly internal “Pulse” surveys.

## Progress:



A target was set after finding a baseline from the first two quarters. Limited progress was made and the target was **not achieved**.

National benchmarking data is not available as this result is based on our internal survey.

Initiatives in 2012/13 included:

- Continuation and accreditation of the Leadership Academy
- Launch of Management Development for first level managers (including change management, assertive leadership, coaching, managing stress, effective appraisals)
- Development of Managers' Induction and Handbook
- Big Listen events, extended Little Listen events, breakfast meetings for staff with the Chief Executive, and senior management visibility
- Implementation of steps to help staff feel able to deal more confidently with possible incidents of violence and aggression
- Health and Wellbeing staff magazine and initiatives
- Workplace Mediation Service to help staff resolve difficulties with colleagues

These have not yet had the desired impact. As we experience significant changes to services in response to reduced investment, the challenge of creating a framework within which staff can operate confidently and effectively clearly remains. Part of the solution will lie in forging strong relationships with the new NHS commissioners to explain what resources we need to provide the best possible services. There are encouraging signs that this understanding is rapidly developing.

In the meantime, we will continue to promote the wellbeing of our staff in other ways, including

- Development of a Customer Care Strategy, including listening to service users 'In your shoes' events, listening to staff 'In our shoes' events and staff graffiti boards, to define our values and behaviours framework
- Use of clear statements about our values and behaviours in recruitment, appraisal and training
- Development Centres for Management Teams and Corporate Heads of Service (to be delivered in May 2013 onwards)
- Change champions being introduced from June 2013 – to support transformational change
- Further review of harassment and bullying systems to support staff – and proactive communications in relation to existing mechanisms

## Good News Box

The Hertfordshire Joint Commissioning Team made several unannounced visits to Trust services and their findings were generally very positive.

At the Cassio Unit (Watford) for people with learning disabilities they found: *“All service users had up to date CPA documentation, risk assessments and care plans. These were all completed to a very high standard.”*

At Aston acute mental health unit (Stevenage) they found: *“A risk assessment picked at random was ... very thorough, concise and of an excellent quality.”*

At Forest Lane inpatient unit for people with learning disabilities (Kingsley Green) they found: *“The unit was very clean, tidy and well cared for. Great decorations made by service users for Christmas created a homely feel.”*

### 3.4 Mandated Quality Indicators

As well as the quality priorities described above, the Department of Health has specified six quality indicators on which they require all Mental Health Trusts to report. This allows for quality to be measured by comparing what each Trust says about its performance in these particular areas.

#### 3.4.1 Seven Day Follow Up

This refers to the percentage of service users on the Care Programme Approach (CPA) who were followed up within seven days of discharge from mental health inpatient care during the reporting period.

When defining this criterion, we apply two exclusions in addition to the national guidance:

- a. For patients who are discharged from inpatient care directly to the care of an out of area mental health provider Trust (whether inpatient or community services) or out of area prison outreach team, where we have verified that discharge documentation includes clearly set out arrangements for the handover of responsibility for care to the other provider, we have assumed the requirements under the indicator have been met.
- b. Patients who leave the country (other than as a result of forced removal which is a national exemption).

#### Results:

|       | Q3 11/12 | Q4 11/12 | Q1 12/13 | Q2 12/13 | Q3 12/13 | Q4 12/13 |
|-------|----------|----------|----------|----------|----------|----------|
| Score | 97%      | 98%      | 96%      | 97%      | 98%      | 99%      |

We consider that this data is as described for the following reasons:

- It has been subject to external audit in the past, and we have acted on the advice from such audits
- We have internal data quality controls with random checks by the responsible manager
- We have taken the following actions to improve this score – and so the quality of our services

Performance is closely monitored by senior managers as it is very important to us and to commissioners as an indicator of the safety of services. Individual cases that do not meet the target are each investigated with involvement of the local manager

Performance has been consistently good.

The data presented shows how we have done through 2012/13, and in the previous two reporting periods.

### 3.4.2 Crisis Resolution and Home Treatment

This refers to the percentage of admissions to acute wards for which the Crisis Team, (known in this Trust as the Crisis Assessment and Treatment Team – CATT), acts as a gatekeeper. This is to make sure that wherever possible people are being offered treatment in their own home rather than hospital even when they are acutely mentally ill.

**Results:**

|              | Q3 11/12 | Q4 11/12 | Q1 12/13 | Q2 12/13 | Q3 12/13 | Q4 12/13 |
|--------------|----------|----------|----------|----------|----------|----------|
| <b>Score</b> | 97%      | 98%      | 98%      | 97%      | 97%      | 97%      |

We consider that this data is as described for the following reasons:

- It has been subject to external audit in the past, and we have acted on the advice from such audits
- We have internal data quality controls with random checks by the responsible manager

We have taken the following actions to improve this score and so the quality of our services:

- Performance is closely monitored by senior managers as it is very important to us and to commissioners as an indicator of the effectiveness of services.

Performance has been consistently good.

The data presented shows how we have done through 2012/2013, and in the previous two reporting periods.

### 3.4.3 Readmission Rates

This refers to the percentage of patients readmitted to a hospital that forms part of the Trust within 28 days of being discharged from a hospital that forms part of the Trust.

It is an important measure of how transfers from hospital are planned and of the range and effectiveness of community mental health services. However, in mental health services where movement between acute inpatient care and CATT (see 3.4.2. above) can be a very positive experience for service users and something we are keen to provide, the measure can be misleading.

#### Results:

|              | Q3 11/12 | Q4 11/12 | Q1 12/13 | Q2 12/13 | Q3 12/13 | Q4 12/13 |
|--------------|----------|----------|----------|----------|----------|----------|
| <b>Score</b> | 3.3%     | 5.1%     | 4.2%     | 4.1%     | 5.6%     | 4.0%     |

We consider that this data is as described for the following reasons:

- It has been subject to internal audit in the past, and we have acted on the advice from such audits
- We have internal data quality controls with random checks by the responsible manager

We have taken the following actions to improve this score and so the quality of our services:

- Performance is closely monitored by senior managers as it is very important to us and to commissioners as an indicator of the effectiveness of services.
- Weaker performance in Q3 this year was checked. It was linked to a combination of factors including pressure on beds, and difficulties in handing over care smoothly to community services. Q4 shows better results, but these pressures remain and we will be working hard in the coming year to make sure that our changes to community mental health services are successful in preventing unnecessary readmissions to hospital.

The data presented shows how we have done through 2012/2013, and in the previous two reporting periods. It is included in this section in our own format because we do not report it to the Health and Social Care Information Centre.

#### 3.4.4. Staff recommending the Trust to family or friends.

This refers to the percentage of staff employed by or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends.

The wording of the statement in the survey is:

"If a friend or relative needed treatment, I would be happy with the standard of care provided by the organisation."

|              | 2010 | 2011 | 2012 |
|--------------|------|------|------|
| <b>Score</b> | 61%  | 52%  | 56%  |

These results compare to the national picture - the national average, the best performing NHS Mental Health Trust and the worst - as follows:

|             | Trust         | average | lowest | highest |
|-------------|---------------|---------|--------|---------|
| <b>2012</b> | 3.48          | 3.54    | 3.06   | 4.06    |
| <b>2011</b> | 3.38          | 3.42    | 3.07   | 3.94    |
| <b>2010</b> | not available |         |        |         |

We consider that this data is as described for the following reasons:

- It derives from the national NHS staff survey which is administered independently of the Trust to national standards. This includes data collection and reporting.

We have taken the following actions to improve this score and so the quality of our services:

- See 3.3.16 above

The data presented shows how we have done in 2012 and in the previous two reporting periods.

### 3.4.5 Service User experience of Community Mental Health Services

This refers to our score provided by the Care Quality Commission (CQC) with regard to a service user's experience of contact with a health or social care worker during the reporting period.

It is about whether the member of staff is felt by the service users responding to the national survey to listen carefully, take their views into account, and give them enough time. Also whether the service user has trust and confidence in staff and feels they are treated with respect and dignity.

#### **Result:**

8.6 out of 10.

This compares with the lowest 2012 score nationally by a Mental Health Trust of 8.2 and the highest of 9.1 and is rated as average.

We consider that this data is as described for the following reasons:

- It derives from the national NHS community mental health service user survey which is administered independently of the Trust to national standards. This includes data collection and reporting.

We have taken the following actions to improve this score and so the quality of our services:

- A project with psychiatrists to enable them to include service users more effectively in decisions about their medication
- Promotion of recovery-oriented ways of working to teams through training and events – so that staff see the value of paying attention to each service user's strengths, goals and aspirations when working with them
- Use of Having Your Say (HYS) – the service user feedback system – in teams to achieve a better fit between what service users want and what we offer

This forms one part of the Trust's results on the annual national community mental health service user survey. The Trust's performance overall on this was in the middle range. Especially good results were obtained on aspects of care planning and review – with service users feeling involved and informed. The two areas highlighted for improvement were out of hours support and information about medicines.

The out of hours helpline is now provided by designated staff with more training in phone counselling. Medicines information has been made easier to find on our website, and there have been one to one meetings with 30 community mental health Consultant Psychiatrists focussing on their practice in this area.

### 3.4.6. Safety Incidents involving serious harm or death as a proportion of all patient safety incidents.

3.3.2 above provides information on this area in a way that the Trust has found particularly useful, but does not use the definitions that are required for the quality account.

The detailed information derived from the National Reporting and Learning Service (NRLS) is show below.

It should be noted that this year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre. The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process.

To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to reports patient safety incidents under the NRLS's voluntary arrangements.

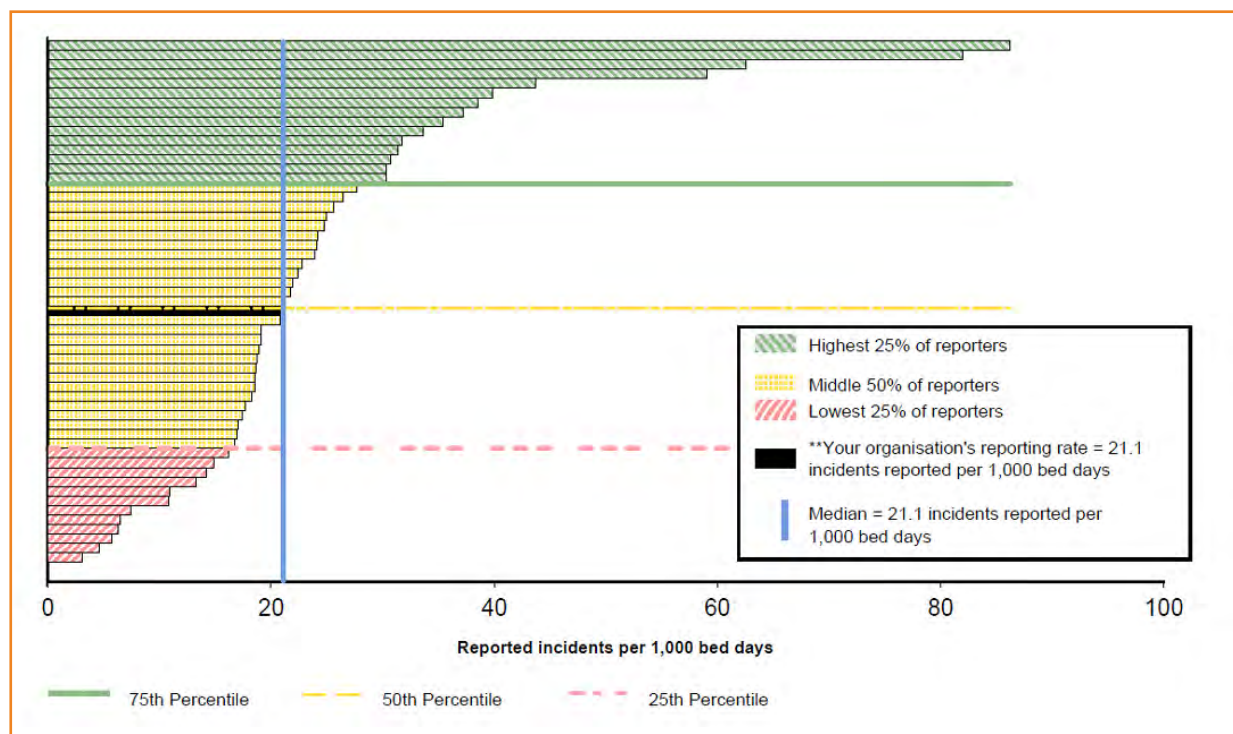
As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different Trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a Trust may not be the same as that held by the NRLS.

Therefore, it may be difficult to explain the differences between the data reported by the Trusts as this may not be comparable.

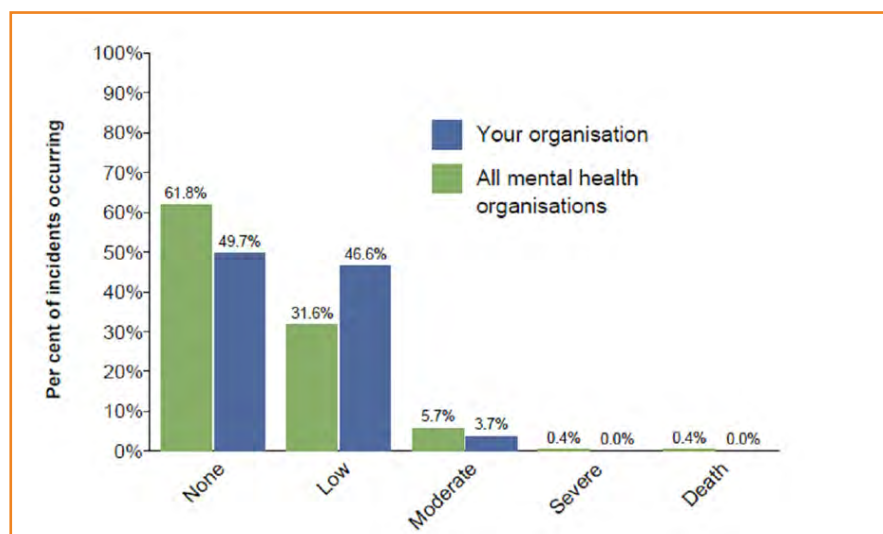
#### A. April 2011 - September 2011

- 1,615 incidents reported by the Trust
- Rate per 1,000 bed days - 21.06
- Severe Harm - no incidents reported
- Death - no incidents reported

## Comparative reporting rate per 1,000 bed days for 57 mental health organisations



## Incidents reported by degree of harm for mental health organisations



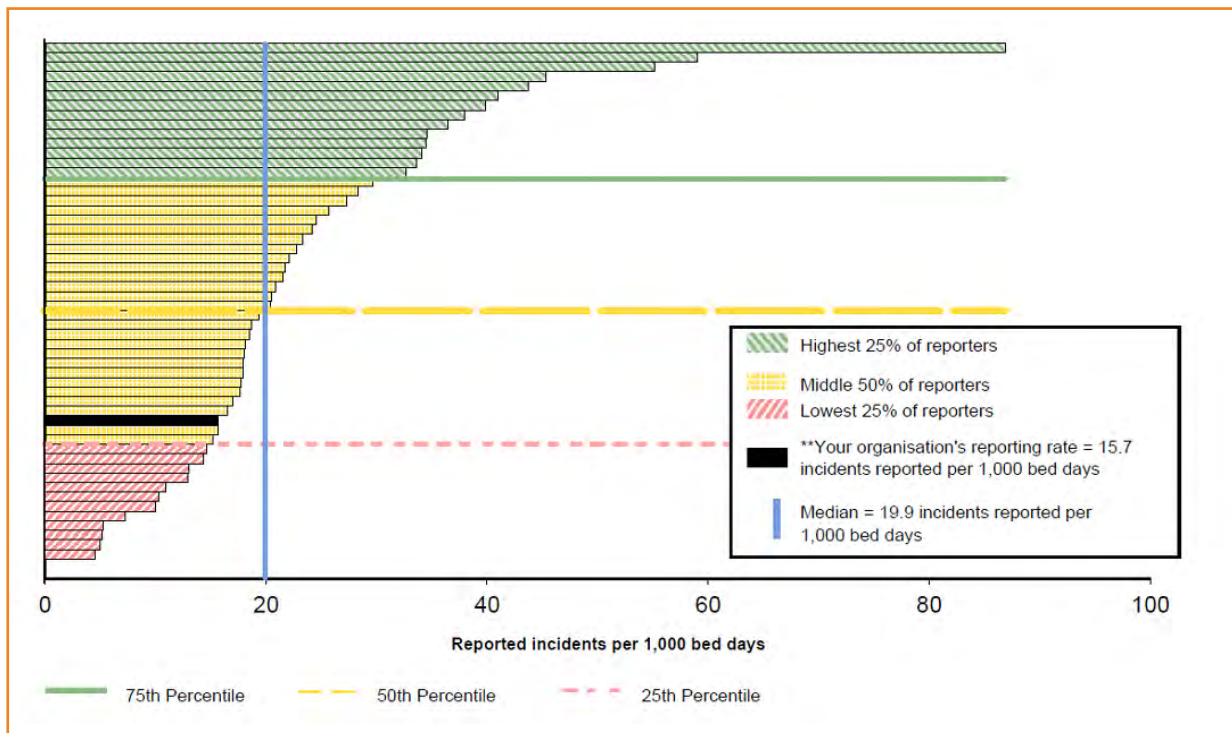
- Highest reporting MH Trust - 6,385 incidents
- Lowest reporting MH Trust - 24 incidents
- Highest number of incidents resulting in Severe Harm - 51 incidents
- Lowest number of incidents resulting in Severe Harm - 11 Trusts reported no Severe Harm incidents (including HPFT)
- Highest number of Deaths reported - 50 incidents
- Lowest number of Deaths reported - 10 Trusts reported no Deaths (including HPFT)



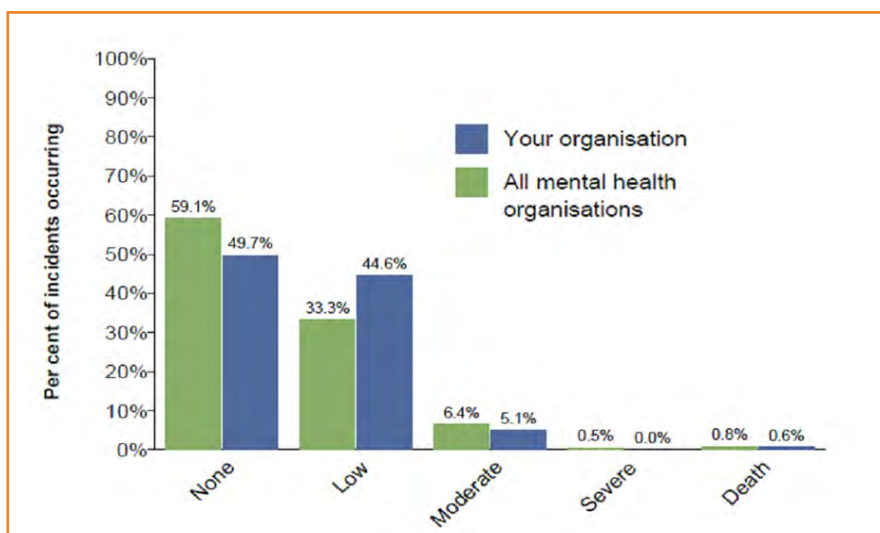
**B. October 2011 - March 2012 (revised guidance from NRLS & CQC regarding the reporting of community suicides came into effect from October 2011)**

- 1,424 incidents reported by the Trust
- Rate per 1,000 bed days - 15.68
- Severe Harm - no incidents reported
- Death - 8 incidents; 0.6% of all incidents reported

**Comparative reporting rate per 1,000 bed days for 56 mental health organisations**



**Incidents reported by degree of harm for mental health organisations**

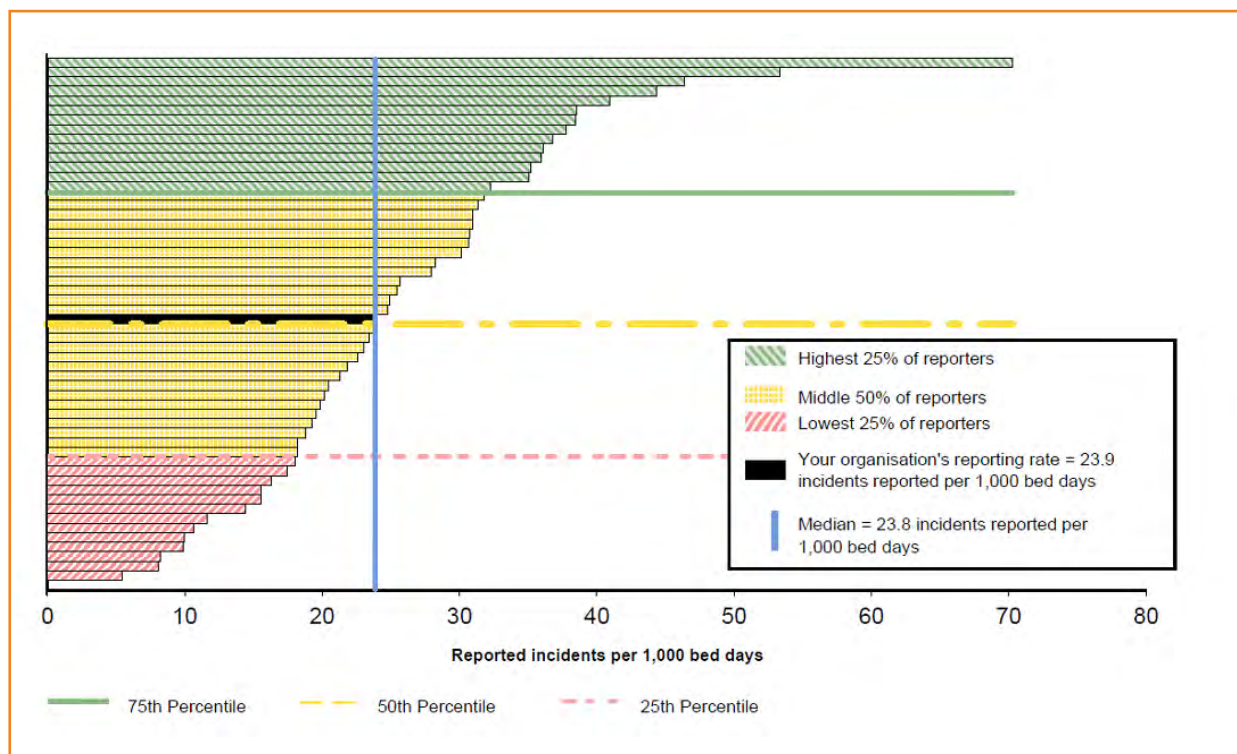


- Highest reporting MH Trust - 6,080 incidents
- Lowest reporting MH Trust - 44 incidents
- Highest number of incidents resulting in Severe Harm – 69 incidents
- Lowest number of incidents resulting in Severe Harm - 10 Trusts reported no Severe Harm incidents (including HPFT)
- Highest number of Deaths reported - 53 incidents
- Lowest number of Deaths reported - 5 Trusts reported no Deaths

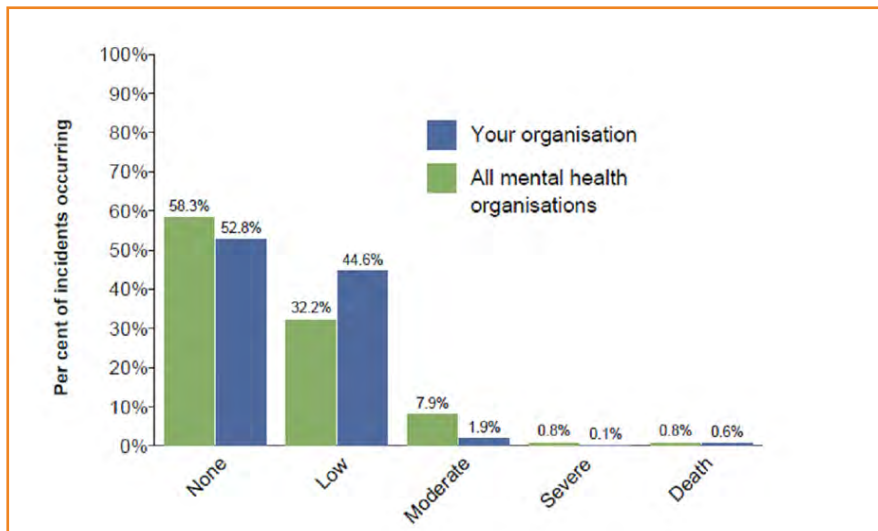
### C. April 2012 - September 2012

- 1,371 incidents reported by the Trust
- Rate per 1,000 bed days - 23.92
- Severe Harm - 2 incidents; 0.1% of all incidents reported
- Death - 8 incidents; 0.6% of all incidents reported

### Comparative reporting rate per 1,000 bed days for 56 mental health organisations



## Incidents reported by degree of harm for mental health organisations



- Highest reporting MH Trust - 6,903 incidents
- Lowest reporting MH Trust - 22 incidents
- Highest number of incidents resulting in Severe Harm - 316 incidents
- Lowest number of incidents resulting in Severe Harm - 7 Trusts reported no Severe Harm incidents
- Highest number of Deaths reported - 78 incidents
- Lowest number of Deaths reported - 5 Trusts reported no Deaths

### D. October 2012 to March 2013

This information is in a different format and should be treated with caution as it has not yet been validated by the NRSL.

- 1,304 incidents reported by the Trust
- Safety incidents involving severe harm (as a percentage of all patient safety incidents reported) – 0.
- Safety incidents involving death (as a percentage of all patient safety incidents reported) – 9 (0.7%).

NB: the third figure is expected to change as the Trust has asked the NRLS to remove two cases after the inquest returned verdicts of Accidental Death and Natural Causes.

### Summary:

|  | April 11 to Sep 11 | Oct 11 to March 12 | April 12 to Sep 12 | Oct 12 to March 13 |
|--|--------------------|--------------------|--------------------|--------------------|
| <b>Total patient safety incidents</b>    | 1 615              | 1 424              | 1 371              | 1 304              |
| <b>Rate per 1000 bed days</b>            | 21.06              | 15.68              | 23.92              | 22.76              |
| <b>Severe harm incidents as % of all</b> | 0                  | 0                  | 2 (0.1%)           | 0                  |
| <b>Deaths as % of all</b>                | 0                  | 8 (0.6%)           | 8 (0.6%).          | 9 (0.7%)           |

The Trust's reporting rates tend to be close to the national average which indicates that our systems are consistent and reliable.

Within overall patient safety incidents, we are a high reporter of patient accidents. This may be because we are a bigger provider of inpatient care for frail elderly patients than many mental Health Trusts. However, we have focussed on falls prevention on older people's units in the past year – with better awareness and more consistent practice using standard assessment tools – so that falls incidents have declined.

NB

- There are inconsistencies of reporting between Trusts which mean these results should be treated with caution
- The NRS system is about certain types of incident only; it does not include many of the Trust's incidents which occur in community settings

## Good News Box

Jane Cummings NHS Chief Nurse visited several Trust units by invitation.

She was impressed by what she saw.

*Afterwards she tweeted: "Great to visit Herts Partnership FT this morning. Met fab staff and great innovation that puts patients first and 6Cs into action. SPA streamlines access and supports right care first time. Great work on care planning with LD clients and support for those with dementia."*

## 3.5 Statements of Assurance

### 3.5.1 Review of Services

During 2012/2013 the Trust provided services through 23 locations as registered with the Care Quality Commission.

The number of locations reduced from 29 last year; this is mainly because the Trust ceased to provide Community Drug and Alcohol Services for adults from April 2012.

In compiling this quality account, the Trust has reviewed all the data available to it about quality of care across all services. This has been done in terms of the three domains of quality – safety, clinical effectiveness and service user and carer experience – but also with a focus on staff measures. There was enough information for this to be done across the whole Trust.

The income generated by the NHS services reviewed in 2012/2013 represents 100% of the total income generated from the provision of services by the Trust in this period.

### 3.5.2 Clinical Audits

#### National

In 2012/2013 two sets of national audits and confidential inquiries covered NHS services that this Trust provides, as confirmed by the Healthcare Quality Improvement Partnership (HQIP).

| Name   |           | National co-ordinator   | NHS area      |
|--|-----------|---|---------------|
| <b>Prescribing Observatory for Mental Health</b> | POMH - UK | Royal College of Psychiatrists (CCQI) POMH – UK Team                                  | Mental Health |
| <b>Suicide and Homicide in Mental Health</b>     | NCISH     | National Confidential Inquiry into Suicide and Homicide by People with Mental Illness | Mental Health |

We reviewed our performance against the findings of the annual National Confidential Inquiry into Suicides and Homicides by obtaining a breakdown of how we compare to the national average. Our share of actual suicides as a proportion of all those in our population remains lower than average (16% compared to a national figure of 26%).

Shown below is the information from the Royal College of Psychiatrists' Centre for Quality Improvement on our participation in POMH - UK audits.

| Topic  | Number of Trust teams | Number of Trust patients | Number of teams (nationally) | Number of patients (nationally) |
|--|-----------------------|--------------------------|------------------------------|---------------------------------|
| <b>Prescribing high dose and combination anti-psychotic medication</b> | 10                    | 150                      | 722                          | 9537                            |
| <b>Prescribing for people with personality disorder</b>                | 0                     | 0                        | 437                          | 2600                            |
| <b>Screening for side effects of anti-psychotic drugs</b>              | 5                     | 97                       | 372                          | 6078                            |
| <b>Prescribing anti-psychotic medication for people with dementia</b>  | 17                    | 257                      | 482                          | 12790                           |

Of POMH – UK audits, we did not take part in one – Topic 12 Prescribing for People with Personality Disorder. The clinical view at our Drugs and Therapeutics Committee was that the audit model as described was unlikely to generate much new learning for us. We know that this will be repeated in 2014 and will review our position before then.

Our performance was satisfactory in the other POMH – UK audits apart from Topic 1f Prescribing of High Dose and Combination Anti-Psychotics. Our Low Secure Unit (Beech), Psychiatric Intensive Care Unit (Oak) and some acute inpatient units performed worse than the national average on this. These results were highlighted to the Quality and Risk Management Committee which operates on behalf of the Board within the Integrated Governance committee structure. The committee has received details of the actions these units have taken to improve performance and has been reassured, subject to re-audit.

## Local

We undertook over 80 clinical audits in total through the year. All are checked and signed off at a sub-group of the Quality and Risk Management Committee.

It is not possible to describe the improvements made as a result of each audit but some examples are given here:

- The consistency of care planning in CATT teams was audited and re-audited, to make sure we are managing mental health crises as carefully as possible in an area where service users can be at considerable risk. Clear improvements were shown.
- The amount of consideration given to the physical health needs of service users at their annual reviews was audited and re-audited, to make sure we improved our practice in this important area. We improved from 30% of cases having evidence of this sort of discussion to 60% - there is clearly further to go.
- The accuracy of clustering cases for Payment by Results has been audited several times through the year. Although the proportion of cases allocated a cluster is good, the accuracy needs significant improvement and the audit results have informed the training now being delivered across the Trust.
- To support our colleagues in Acute Trusts we have audited the numbers of people on acute general wards who on interview can be found to be suffering from mental health problems such as anxiety and depression. As expected, this found considerable levels of under-reporting of mental health conditions, and these results have helped us develop a new service - Rapid Assessment Interface and Discharge (RAID) – at Watford General Hospital and The Lister, Stevenage.
- During the year, some areas of concern have arisen which needed quick checking and putting right. These included a reported increase in detained patients going absent without leave from inpatient units, risk issues not being always considered when people do not attend for outpatients appointments, and a small number of incidents when older people may have been admitted to an inpatient unit not best designed to meet their needs because of pressure on beds. In each of these cases audits have been key in either providing assurance about the issue or highlighting areas that can then be corrected.

Shown below is the Centre of Quality Improvement's statement on our use of national accreditation schemes currently.

| College Centre for Quality Improvement Programmes | Trust participation by unit/ward | National participation by unit/ward |
|---|----------------------------------|-------------------------------------|
| <b>Accreditation programmes</b>                   |                                  |                                     |
| ECT clinics                                       | 0                                | 93                                  |
| Working age adult wards                           | 0                                | 165                                 |
| Psychiatric intensive care units                  | 1                                | 34                                  |
| Older people mental health wards                  | 2                                | 57                                  |
| Inpatient learning disabilities units             | 0                                | 36                                  |
| Inpatient rehabilitation units                    | 0                                | 36                                  |
| Memory services                                   | 0                                | 61                                  |
| Psychiatric liaison teams                         | 0                                | 43                                  |

| Quality Improvement Networks                  |   |    |
|---|---|----|
| Inpatient child and adolescent units          | 1 | 91 |
| Child and Adolescent Community teams          | 0 | 45 |
| Therapeutic communities                       | 0 | 83 |
| Low secure forensic mental health services    | 2 | 66 |
| Medium secure forensic mental health services | 2 | 64 |
| Peri-natal mental health inpatient units      | 1 | 15 |

We also have two inpatient units for people with learning disabilities at Kingsley Green accredited with the National Autistic Society. We plan to focus on other learning disabilities units becoming accredited through CCQI in the coming year.

## What is... CQUIN?

This stands for “Commissioning for Quality and Innovation”.

The money for the NHS starts with commissioners who decide how it can best be used. At present, most of this funding in a Trust such as HPFT reflects the activity of the Trust.

But three years ago it was decided to reward Trusts for improving the quality of their services by setting goals. If these are all achieved we receive an incentive payment equal to 2.5% of our total funding.

### 3.5.3 Research and Development

During the last year we exceeded our recruitment targets for National Institute for Health Research (NIHR) portfolio studies, recruiting 143 Service users into 12 different studies. These are studies that are recognized as being of national priority within the NHS. We also had a number of smaller-scale studies running, which include collaborations between HPFT and the University of Hertfordshire, as well as projects being carried out as part of educational programs. All research studies within the Trust have full ethics and R&D approval.

We have started work on a collaborative study, funded by the NIHR Research for Patient Benefit Program (RfPB), which is reviewing strategies for the management of behavioural and psychological symptoms in people with dementia. This will involve a number of stakeholder groups and is likely to inform local approaches to implementing the National Dementia Strategy.

We have recently been awarded another NIHR RfPB grant to undertake a feasibility study of using a modified form of Cognitive Behavioural Therapy (CBT) to treat people with learning disabilities who have substance misuse problems (predominantly alcohol). This will begin in Autumn 2013.

Key findings from our research studies are disseminated and shared where appropriate to guide service developments.

### 3.5.4 Commissioning for Quality and Innovation (CQUIN)

2.5% of our income from commissioners in 2012/2013 was conditional on achieving quality improvement and innovation goals, through this payment framework.

The most significant set of CQUIN targets was set by our local Hertfordshire commissioners.

These have fallen under the following headings:

- Maintaining the wellbeing of carers
- Promoting healthy lifestyles for service users
- Improving the service user experience of mental health services
- Assessing the quality of our services for people with learning disabilities leading to improvements being made
- Ensuring standards for people with dementia are met
- Providing better evidence based services for children and young people
- Improving data collection with regard to pressure ulcers, falls and urinary tract infections
- Knowing how well we are doing in terms of whether service users would recommend the Trust to family and friends and making improvements where indicated

We expect to have achieved 100% of these goals and the accompanying payments, but await confirmation from commissioners.

For 2013/2014, local Hertfordshire CQUIN targets will cover these areas:

- Reducing harm with regard to pressure ulcers and falls
- Developing recovery-oriented care planning with adult mental health service users
- Improving support to carers of people with learning disabilities
- Reducing waiting times for EMDASS services (for people with early memory difficulties)
- Making assessments for children and young people with mental health problems more accessible and welcoming
- Increasing referrals to enhanced primary mental health services of people with long term medical conditions
- Increasing referrals to enhanced primary mental health services of older people
- Increasing self-referrals to enhanced primary mental health services
- Providing more meaningful and healthy activities for inpatients
- Helping more mental health service users access smoking cessation treatment and achieving healthier lifestyles

### 3.5.6 The Care Quality Commission (CQC)

Trust services remain fully registered with CQC without conditions.

There have been some requests from CQC for evidence of practice – for example about the rate of detained patients absconding from inpatient units. When we were prosecuted by the Health and Safety Executive over a homicide by a service user that occurred in 2008, the CQC quite rightly sought and was given evidence that our services in this area were now safe. All such requests have been promptly dealt with and they have led to no further actions.



Apart from the usual visits by the Mental Health Act Commission arm of CQC, the only inspection visit has been to our learning disabilities inpatient services in Norfolk at Little Plumstead. They were found to be fully compliant with the relevant essential standards of quality and safety.

We value the monthly Quality and Risk Profile reports from CQC and have not allowed any to reach the level of a serious ("Red") concern. We compare these reports with our internal sources of evidence about quality, and the Trust lead for the particular CQC standard is asked to address issues as they arise via these monthly reports.

### **3.5.7 Data Quality**

As a Foundation Trust which must provide an annual report to Monitor, we welcome the exposure of this report to thorough examination by external auditors. This follows the 2012/13 External Guidance for External Assurance on Quality Reports (March 2013).

Our confidence with regard to the quality of the data in this report increases year on year as we respond to the advice of successive audit reports, and is now high. We do however recognise that if these accounts are to equal financial accounts in their probity there is some way to go, partly because of the varied sources of data as measures of quality.

The Board is clear about its responsibility for the accuracy of the data. It ensures that the quarterly quality reports it receives highlight any adjustments to the data reported in-year, with reasons given and corrections made.

In view of the Francis Report (February 2013), we are also very keen to present all data straightforwardly. An example of this is the description of service user satisfaction rates now with "Partly True" responses separated from "True" only.

### **3.5.8 NHS Number and General Medical Practice Code Validity**

In 2012/13 the NHS number completion rate was 99.88% for outpatients and 99.79% for inpatients.

The General Medical Practice Code Validity was 98.73% for both outpatients and inpatients.

We are happy with these results, especially those on code validity.

### **3.5.9 Information Governance**

In 2012/2013 our information governance level of compliance with the national standards in the toolkit was 78%. We were rated "Green" in all areas. This is an improvement on the result for the previous year of 75%.

Staff receive mandatory training in information governance, with an emphasis on what is expected of them all with regard to accurate recording and confidential management of all types of clinical information. It is expected that staff in their recording will be ready as appropriate to share records with service users and also make them aware of their rights under Freedom of Information legislation.

### 3.5.10 Clinical Coding Error Rate

In 2012 we invested in two new permanent fulltime posts to ensure accuracy of clinical coding. They have completed their training with an accredited trainer.

Using the approved coding system has proved key – both to the best possible clinical treatment, but also to enable us to describe confidently the patterns of service use as a basis for the major changes to the organisation of services that we are having to make.

We were audited in March 2013 by the London Clinical Coding Academy.

#### Results:

| diagnosis | Correct (2009) | Correct (2011) | Correct (2013) |
|-----------|----------------|----------------|----------------|
| primary   | 42%            | 92%            | 100%           |
| secondary | 13.4%          | 84.3%          | 97.46%         |

Performance is now good. As with all Mental Health Trusts, clinical coding is not used at this stage to decide costs of services.

### What is... EMDASS?

This stands for Early Memory Diagnosis and Support Services.

It is nationally recognised that dementia is on the increase as people live longer and the impact of modern medicine is limited. But the progress of the illness can be delayed and more quality of life retained if diagnosis and medical treatment come early.

So we provide this new service across Hertfordshire, working closely with GPs and the Alzheimer's Society to bring many people the information, support and, where necessary, the treatment they need.

## 3.6 Other Aspects of Quality

### 3.6.1 Complaints and Compliments

Our new Inclusion and Engagement Team is responsible for making sure we learn as fully as possible from all those who rely on our services and their carers.

Information from Having Your Say is shown in other parts of this report.

The total number of complaints is slightly reduced from the figure of 246 last year. The numbers through the year do not change much.

Of the total number of complaints 125 were rated by us as fully or partially upheld. This result is made clear to complainants in the letter they receive.

The three main types of complaint are about clinical treatment, staff attitude and communication. Some have been directly linked to closures of services during the year – such as the loss of the Community Support Teams as part of community mental health services.

**Table: Complaints**

| Strategic Business Unit            | 2012 - 2013 |           |           |           |       |
|------------------------------------|-------------|-----------|-----------|-----------|-------|
|                                    | Quarter 1   | Quarter 2 | Quarter 3 | Quarter 4 | Total |
| Corporate Services                 | 0           | 0         | 0         | 1         | 1     |
| East and North Hertfordshire       | 31          | 34        | 21        | 22        | 108   |
| Learning Disabilities and Forensic | 3           | 3         | 10        | 6         | 22    |
| West Hertfordshire                 | 22          | 22        | 25        | 32        | 101   |
| <b>Totals:</b>                     | 56          | 59        | 56        | 61        | 232   |

Compliments that are forwarded by staff to the central office are reported below. East and North Herts SBU has the most mainly because they provide all mental health services for older people and we tend to receive more compliments from them.

Team managers use compliments to motivate their staff, and to show them what they need to aim to do more often!

**Table: Compliments**

| Strategic Business Unit            | 2012 - 2013 |           |           |           |       |
|------------------------------------|-------------|-----------|-----------|-----------|-------|
|                                    | Quarter 1   | Quarter 2 | Quarter 3 | Quarter 4 | Total |
| Corporate Services                 | 1           | 0         | 1         | 1         | 3     |
| East and North Hertfordshire       | 66          | 97        | 70        | 105       | 338   |
| Learning Disabilities and Forensic | 24          | 38        | 21        | 14        | 97    |
| West Hertfordshire                 | 49          | 57        | 61        | 68        | 235   |
| <b>Totals:</b>                     | 140         | 192       | 153       | 188       | 673   |

## Good News Box

Dr Duncan Law, Consultant Clinical Psychologist, is chair of the British Psychological Society's Faculty for Children and Young People and has been part of the expert reference group helping to implement improved access to psychological therapies for this group nationally. The Trust is piloting the development of this major scheme to help youngsters with emotional distress at an early stage and effectively.

The then Minister Paul Burstow described this scheme as his "*proudest achievement as a Minister to date.*"

### 3.6.2 The Rest of the Story

2012/13 was the second year of significant health and social care disinvestment from Trust services. We worked closely with commissioners to find ways of working more efficiently, and to be more effective in what we do so that people can become independent of our services whenever possible without developing dependency.

We know that our service users and carers very much value continuity of care and at times this year this has been hard to achieve. The level of change has been greater than we are used to, and whilst at times it has stimulated better ways of working it has also for some been unsettling.

So it has been a year of greater pressures on quality, but also greater levels of commitment and innovation by many teams.

In Child and Adolescent Mental Health Services a commissioner –led review took place which highlighted that clinics needed to be more consistent in the treatments they provide and more accessible to young people. Care pathways have now been developed specifying what treatments can be expected for particular mental health problems. Through the year, the CAMHS service had a national role in developing psychological treatments for young people with milder mental health problems (Children and Young People's Improved Access to Psychological Therapies CYP – IAPT).

For adults, the IAPT service was also greatly expanded during the year with special attention being paid to the needs of older people and those with long term medical conditions. Waiting times came under considerable pressure, linked to the introduction of the Single Point of Access. Despite this, levels of successful treatment were maintained at above the national average, being above 50% for each quarter of the year..

This year we have concentrated on opening our doors to more organisations who wish to support (or simply to know more about) what we do. We have celebrated more what our staff have achieved, and worked more in partnership with other agencies. All this has enabled us to challenge the stigma around mental health and learning disabilities, to show confidence in the care we provide, and often to simply enjoy ourselves as staff alongside service users and carers.

Some examples include:

- Winning national awards – Health Service Journal Innovation in Mental Health award for our host families scheme
- Being shortlisted for national awards – LD Nursing Mental Health Award to Melissa Wilton and John Fanning for their new approaches to care planning
- Being shortlisted for local awards – Hertfordshire Dementia Awards
- Participating in national or international “Days” or “Weeks” – Dignity Awareness Week, Learning Disability Awareness Day, LGBT History Month, World Mental Health Day, Nutrition and Hydration Week
- Hosting conferences – The Chief Nursing Officer’s Black and Minority Ethnic event, Recovery, Sharing Good Practice in Learning Disabilities Services, Sharing Good Practice (whole Trust), Social Work, Allied Health Professionals
- Hosting visitors from overseas to see what we do – Greece, South Africa
- Hosting high profile visitors – the High Sheriff’s visit to our new recovery unit in St Albans, ‘The Beacon’, Prof Louis Appleby’s visit to the new criminal justice team for people with mental health and learning disabilities in Norfolk; Jane Cummings, Chief Nursing Officer, visited several units including our Single Point of Access centre and ‘The Beacon’ in St Albans.
- Having our services highlighted in national reports – “Reasonably Adjusted?” from the National Development Team for Inclusion featuring the steps we are taking to make our mental health services acceptable to those with learning disabilities who need them; “Mental Health Crisis Care: Commissioning Excellence” from MIND referencing our host families scheme, peer support workers and Trailblazers Cultural Awareness programme
- Becoming only the third Mental Health Trust nationally to achieve University status through our partnership with the University of Hertfordshire

## Part 4 – Priorities for Improvement

### 4.1 Consultation

It can be seen from the previous detailed section that 2012/2013 was a year of considerable achievement and a degree of challenge.

2013/2014 promises to be more of the same.

In January 2013 we began to plan for the coming year.

We decided – as we already also produce an annual plan which sets out our priorities including those on quality – to combine the two processes as far as possible in order to reduce bureaucracy. So much of the discussion with staff about what our quality priorities should be was in terms of the annual plan and the plans that each SBU creates to help achieve this.

In February we also had meetings with:

Governors (via their Quality and Effectiveness Sub-committee)

Herts LINK

Hertfordshire County Council Health Scrutiny Committee Topic Group

Our Service User Council

Our Carer Council

The main feedback was that the coming year would be tough and it made sense for the Trust to retain many of the quality measures to make sure quality did not suffer. It was felt that the focus on staff should be even stronger, and that the total number of indicators could be reduced to make sure those that remain are truly treated as priorities.

## 4.2. Agreed Priorities for 2013/14

In March the HPFT Board supported the use of the following 13 quality priorities for the coming year:

| Area                               | Measure   | Carried over? |
|------------------------------------|---|---------------|
| <b>Safe services</b>               | Rate of externally reported incidents as % of all incidents   | yes           |
|                                    | Rate of inpatients feeling safe   | yes           |
|                                    | Decisions to investigate a safeguarding alert made within one day   | yes           |
| <b>Effective services</b>          | Number of waiting times targets met   | no            |
|                                    | Presentation of clinical outcomes scores by service   | no            |
|                                    | Rate of service users saying Trust services have helped them see a positive future                        | yes           |
|                                    | Rate of staff reporting they would recommend Trust services to family or friends if they needed them      | no            |
|                                    | Rate of staff saying they are satisfied with the quality of care they can deliver                         | no            |
| <b>Good experience of services</b> | Rate of service users saying they would recommend Trust services to family or friends if they needed them | yes           |
|                                    | Rate of service users saying they are treated in a way that is respectful and polite                      | no            |
|                                    | Rate of carers feeling valued   | yes           |
| <b>Good experience of staff</b>    | Rate of staff saying they would recommend the Trust a place to work                                       | yes           |
|                                    | Rate of staff saying their levels of engagement and motivation are good                                   | yes           |

The following measures are not carried over into the coming year:

| Measure                                     | Reason   |
|---|--|
| Safeguarding alerts reported in LD services | achieved   |
| Personal budgets                            | an unsatisfactory indicator – remains important but not to be judged in this way |
| Service users saying they could get help    | achieved   |
| Carers saying they could get help           | discarded to reduce total number   |
| Dementia care                               | achieved   |

## 4.3 Reporting Progress

The data sources for the indicators this year exclude the electronic patient record as we are moving from one (CareNotes) to another (Paris) for most of the Trust in mid-year and there is a risk that data quality may temporarily suffer.

Quarterly quality reports will be made to Board and the Quality and Risk Management Committee will have responsibility for overseeing implementation of progress. The Executive Director – Quality and Medical Leadership continues to be the accountable Executive Director.

### What is... IAPT?

This stands for Improving Access to Psychological Therapies.

Many mental health conditions respond best to combinations of medical and psychological treatments and are best treated early.

IAPT or Enhanced Primary Mental Health Services are the rapidly growing psychological therapy services for children and adults – provided by us in Hertfordshire.

7,100 people had treatment this way last year and in the coming year it will be made more widely available to older people and those with long term medical conditions.

## Part 5 - Final Notes

**5.1.** This report has been produced in accordance with the Quality Accounts Toolkit 2010-2011 (Department of Health 2010).

**5.2.** Other relevant documents are Quality Accounts: Reporting Arrangements for 2012/2013 (Department of Health 2013) and 2012/2013 Detailed Guidance for External Assurance on Quality Reports (Monitor 2013).

**5.3.** The report is written to form the quality report section of the annual report and to be the Quality Account.

**5.4.** After publication of the quality account at the end of June 2013 an easi-read version will be produced and made available.

**5.5.** Where acronyms are used, they are spelt out in full the first time in order to be as clear as possible. Some explanatory boxes are also shown, and a glossary at the end is provided.

**5.6.** Feedback on any aspect of this report is welcomed. Comments should be addressed to Jonathan Wells, Head of Practice Governance: [jonathan.wells@hpft.nhs.uk](mailto:jonathan.wells@hpft.nhs.uk)

## Appendix 1

### Glossary

|         |   |
|---------|---|
| AMH     | Adult Mental Health                                   |
| PBR     | Payment by Results                                    |
| CAMHS   | Child and Adolescent Mental Health Services           |
| CATT    | Crisis Assessment and Treatment Team                  |
| CQC     | Care Quality Commission                               |
| CQUIN   | Commissioning for Quality and Innovation              |
| EDS     | Equalities Delivery Scheme                            |
| EMDASS  | Early Memory Diagnosis and Support Services           |
| EPMHS   | Enhanced Primary Mental Health Services (IAPT)        |
| HoNOS   | Health of the Nation Outcome Scales                   |
| HQUIP   | Healthcare Quality Improvement Partnership            |
| HYS     | Having Your Say                                       |
| IAPT    | Improving Access to Psychological Therapies           |
| JCT     | Joint Commissioning Team                              |
| LD      | Learning Disabilities/Disability                      |
| NICE    | National Institute for Health and Clinical Excellence |
| NIHR    | National Institute for Health Research                |
| NRLS    | National Reporting and Learning System                |
| POMH UK | Prescribing Observatory for Mental Health – UK        |
| RAID    | Rapid Assessment Interface and Discharge              |
| RfPB    | Research for Patient Benefit                          |
| SBU     | Strategic Business Unit                               |
| SPA     | Single Point of Access                                |



## Appendix 2: Date Set Quality Indicators 2012/2013

| 2012/13 Quality Account Report   |   |  |        |        |        |        |
|--|---|--|--------|--------|--------|--------|
| Priority area  | measure   |  | Qtr 1  | Qtr 2  | Qtr 3  | Qtr 4  |
| 1. Safe Services   | Rate of inpatients feeling safe   | Target   | 86%    | 86%    | 86%    | 86%    |
|  |   | Actual   | 88%    | 86.84% | 91.39% | 92.40% |
|  | Rate of serious incidents as proportion of all incidents  | Target   | 0.25%  | 0.25%  | 0.25%  | 0.25%  |
|  |   | Actual   | 0.47%  | 0.15%  | 0.29%  | 0.29%  |
|  | A high proportion of decisions as to whether to investigate a safeguarding alert are made within one working day - mental health services | Target   | n/a    | 70%    | 70%    | 70%    |
|  |   | Actual   | n/a    | 43%    | 44%    | 48%    |
|  | A high proportion of safeguarding adult alerts are reported within one working day (LD&F SBU)   | Target   | n/a    | 90%    | 90%    | 90%    |
|  |   | Actual   | n/a    | 77%    | 93%    | 92.31% |
|  | 2. Effective Services   | Rate of inpatient stays with reduced HoNOS score (eg. evidence of positive clinical outcome) | Target | 89%    | 89%    | 89%    |
| Actual   |   |  | 81.20% | 86.77% | 80%    | 78.34% |
| Rate of service users saying Trust services have helped them see a positive future for themselves                        |   | Target   | 83%    | 83%    | 83%    | 83%    |
| Rate of service users saying Trust services have helped them see a positive future for themselves (True Only)            |   | True   | n/a    | 63.14% | 60.09% | 64.15% |
| Rate of service users saying Trust services have helped them see a positive future for themselves (True and Partly True) |   | True and Partly True   | 83.84% | 83.62% | 85.67% | 85.95% |
| Rate of carers feeling valued by staff   |   | Target   | 95%    | 95%    | 95%    | 95%    |
| Rate of carers feeling valued by staff (True Only)   |   | True   | N/A    | 83.87% | 77.46% | 84.51% |
| Rate of carers feeling valued by staff (True and Partly True)  | True and Partly True  | 94.35%   | 94.62% | 89.44% | 95.77% |        |

|   |   |                      |            |            |            |            |
|---|---|----------------------|------------|------------|------------|------------|
| <b>3. The very best customer experience</b> | Rate of service users saying they would recommend Trust services to family or friends if they needed them                                 | Target               | 71.00%     | 73.00%     | 75.00%     | 77.00%     |
|   |   | Actual               | 73.96%     | 74.26%     | 82.74%     | 77.80%     |
|   | Number of service users with personal budgets (AMH)   | Target               | 1906       | 1906       | 1906       | 1906       |
|   |   | Actual               | 1064       | 1187       | 1324       | 1473       |
|   | A high proportion of decisions as to whether to investigate a safeguarding alert are made within one working day - mental health services | Target<br>Actual     | n/a<br>n/a | 70%<br>43% | 70%<br>44% | 70%<br>48% |
|   | Rate of service users saying they can get advice or support when they need it (in hours and out of hours)                                 | Target               | 86%        | 86%        | 86%        | 86%        |
|   | Rate of service users saying they can get advice or support when they need it (in hours and out of hours) (True Only)                     | True                 | 72.2%      | 74.8%      | 76%        | 81.25%     |
|   | Rate of service users saying they can get advice or support when they need it (in hours and out of hours) (True and Partly True)          | True and Partly True | 89.3%      | 92.2%      | 93.4%      | 96.09%     |
|   | Rate of carers saying they can get advice or support when they need it (in hours and out of hours)  | Target               | 86%        | 86%        | 86%        | 86%        |
|   | Rate of carers saying they can get advice or support when they need it (in hours and out of hours) (True Only)                            | True                 | n/a        | 73.58%     | 68.30%     | 66.42%     |
|   | Rate of carers saying they can get advice or support when they need it (in hours and out of hours) (True and Partly True)                 | True and Partly True | 86.67%     | 84.28%     | 83.93%     | 83.96%     |

|                      |   |        |        |        |        |        |
|----------------------|---|--------|--------|--------|--------|--------|
| <b>4. Equalities</b> | Achieving or excelling in the Equality Delivery System (EDS) for the organisation, therefore evidencing support for service users, carers and staff across all protected groups |        | n/a    | n/a    | n/a    | n/a    |
|                      | Level of compliance with NICE quality standard for people with dementia and their carers  | Target | n/a    | 30%    | 60%    | 80%    |
|                      |   | Actual | 30.36% | 37.66% | 66.20% | 87.83% |
| <b>5. Workforce</b>  | Rate of staff saying they would recommend the Trust as a place to work  | Target | n/a    | n/a    | 44%    | 48%    |
|                      |   | Actual | 43.50% | 36.00% | 40.20% | 44.30% |
|                      | Rate of staff saying they have a clear understanding of what is expected of them  | Target | n/a    | n/a    | 66%    | 70%    |
|                      |   | Actual | 63.20% | 64.44% | 65.90% | 67.60% |
|                      | Rate of staff saying their levels of engagement and motivation increased  | Target | n/a    | n/a    | 53%    | 56%    |
|                      |   | Actual | 50%    | 50.22% | 53.70% | 54.50% |

## Appendix 3: Statements from Partner Agencies

### 3.1. Clinical Commissioning Groups



#### **Hertfordshire Partnership Foundation NHS Trust Quality Account Statement from Herts Valleys CCG & East and North Herts CCG**

The Herts Valleys Clinical Commissioning Group (HVCCG) and the East and North Herts Clinical Commissioning Group (ENCCG) welcome the steps that Hertfordshire Partnership Foundation NHS Trust (HPFT) is taking to improve the quality of services provided to patients, service users and carers.

Both CCGs have reviewed the information provided in the Quality Account and checked the accuracy of the data within it. The data submitted corresponds with the data submitted during the last year as part of the on-going quality contract monitoring process.

The Trust's 2012/13 Quality Account clearly evidences the improvements made and where improvements are still needed.

We would firstly like to congratulate the Trust on their performance against the 2012/13 Commissioning for Quality and Innovation (CQUIN) targets and are pleased to see the commitment made to continue to drive quality for the coming year.

Additionally it is pleasing to see that feedback from service users via the 'Having Your Say' Forms remains very positive and importantly service users feel safe in the care of HPFT.

HPFT have made significant improvements this year particularly in relation to helping people with dementia having control over their future care. The Trust have successfully reached their target of 80% of people with dementia being seen by the early Memory Diagnosis and Support Service (EMDASS) and being offered advanced care plans or advanced statements. The progress made will ensure that people with dementia, along with their carers, feel their voices are being heard by health and social care services.

We were pleased to note the consistently good performance in relation to the percentage of service users admitted to acute wards (97-98%) being assessed to be offered treatment in their own home rather than in hospital. There is no doubt of the significant benefits and increased service user satisfaction from treatment at home, as well as reducing pressure on hospital beds. We look forward to seeing this performance continue during the year.

It is encouraging that the rate of service users who would recommend the Trust's services to their friends and family has increased. Further work is required to ensure that improvement in this area grows as this is a powerful indication of the quality of the services provided. We look forward to seeing the improvements made.

The CCGs note the progress in relation to the number of service users accessing Improving Access to Psychological Therapies (IAPT) through the expansion of the service, particularly focussing on older patients and those with long term conditions.

The challenge for the coming year will be to ensure that service users are not waiting to access the service, and the drop-out rate is reduced. We know that actions have been identified to support continued improvements and are interested to see the progress throughout 2013/14.

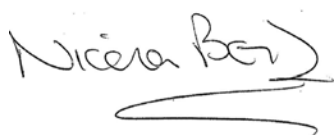
Following the commissioner led review of the Child and Adolescent Mental Health Services (CAMHS), both CCGs are also keen to see improvements in access to CAMHS through a reduction in the waiting times as well as increased delivery of specialist CAMHS in the community.

It is clear that HPFT have focussed their attentions on engaging with staff in relation to quality improvements and have invested time in gathering the views of their workforce. However progress in relation to the workforce quality priority has been limited, with metrics regarding staff's understanding of expectations and staff's levels of engagement and motivation not being achieved. Staff engagement will be key in relation to delivering the Trust's transformation programme

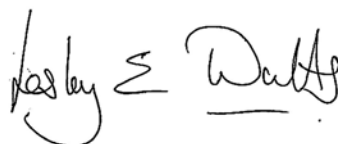
HPFT have made a commitment to continue their focus on improving the experience of staff and the delivery of safe services and we would wish to see this improvement delivered.

Overall we note the improvements HPFT have made to date, but these will require significant focus and progression in the year to come against a background of increased financial challenge.

Both CCGs look forward to working with HPFT to improve both the quality and safety of health services provided to their patients.



Nicola Bell  
Accountable Officer  
Herts Valleys CCG



Lesley Watts  
Chief Executive  
East & North Herts CCG

13th May 2013

## **3.2. Hertfordshire Healthwatch**

### **Healthwatch Hertfordshire's response to Hertfordshire Partnership Foundation Trust (HPFT) Quality Account 2013**

#### **General Comments**

Healthwatch Hertfordshire is pleased to make a comment on the Quality Account for HPFT. The report is very thorough, clearly written for external consumption and raises most of the issues that still need attention. Evidence of systematic internal review and clinical audit is quite strong and, together with the outcomes from external regulatory work, demonstrates an organisation focused on continual improvement towards its stated aim of excellence in provision. The CQUIN results also evidence this.

Although most of the priorities for 2013/14 follow on logically from the outcomes of this year, the Equalities indicators are no longer included. There is still much work to be done on this, particularly as the community and its needs change and develop in terms of diversity. Without an evaluative focus, recognition of the importance of this work will diminish within the organisation and lose its impetus. Equalities work related to both staff and customer needs to be included in HPFT priorities in order that it becomes fully embedded in the organisation's work in all its aspects.

#### **Safe Services**

It is not easy for the non-professional reader to understand the difference between the decision to investigate and reporting. Taken together, there seems to be more work to do involving staff training and awareness.

#### **Effective Services**

From both the staff, carer and service user perspective, there seems to be a real improvement in trust in the services, and in the quality of the relationships between them. But the treatment outcome measures are reducing. However, there may be some other reason for this which the simply numerical scoring cannot capture.

#### **Best Customer Experience**

This is the right time to begin to more thoroughly investigate how the personalisation process is working, and, in particular, whether the money, where the Service User or carers have been able to take that responsibility on, has been used wisely. The statement on personal budgets that says that failure to meet the Herts County Council target may be because the target itself is not well calculated is left unanswered. How can the truth be established and what can be done about it? A more specific, focused piece of research on this area may be required.

The low response from carers on the priority 'Carers getting advice or support when they need it' is noted, but not really commented on. What are the actual numbers and how will the Trust ensure that this figure improves in order to obtain meaningful data?

It is difficult to understand the logic in removing the indicator in Section 3 about the rate of carers saying they can get advice and support when they need it. While the desire to reduce the number of indicators is appreciated this seems, just after HPFT has formally approved an ambitious Carers Charter, to give the wrong message.

## **Equalities**

A lot of careful, collaborative work has been done on equalities and the Equality Delivery System, but this is not in any way adequately reflected in the chosen indicators. Equalities issues and practice is not as yet properly embedded in all the work of the Trust. For instance, there is very little information about differences in needs or treatment opportunities, styles and outcomes of male and female service users and carers. The indicators here need revising and keeping in the schedule for next year. The work is not yet complete.

## **Workforce**

This is perhaps the most worrying set of outcomes as the satisfaction rates are really quite low. However the body of the report (3.3.16) does indicate a clear and thorough plan for staff training and development, improved staff consultation and a recognition that the outcomes need to improve as a whole. If this really is an issue of resources, then maybe it is here that the difficulty of introducing positive change and improvement of service at a time of real diminution of resources becomes most apparent.

This may be an issue for Healthwatch to be particularly vigilant on, and to do some research on which could be helpful in raising staff motivation levels.

Healthwatch Hertfordshire looks forward to working with HPFT in the coming year.

A handwritten signature in blue ink, appearing to read 'Sarah Wren', with a long horizontal flourish extending to the right.

Sarah Wren MBE, Chairman Healthwatch Hertfordshire, May 2013

### **3.3. Hertfordshire County Council Health Scrutiny Committee.**

The Health Scrutiny Committee heard about the Trust's progress on its quality priorities through the year and advised on priorities for 2013/2014.

However, due to local elections, at the time when a written statement was requested, the membership and chair of the reconstituted Health Scrutiny Committee were awaiting confirmation.

Therefore no written response has been provided.



## STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;

The content of the Quality Report is not inconsistent with internal and external sources of information including:

Board minutes and papers for the period April 2012 to March 2013

Papers relating to Quality reported to the Board over the period April 2012 to March 2013

Feedback from the commissioners dated 13th May 2013

Feedback from governors

Feedback from local Healthwatch organisations (May 2013)

The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,

The 2012 national patient survey

The 2012 national staff survey

The Head of Internal Audit's annual opinion over the trust's control environment dated 18<sup>th</sup> April 2013

The latest Care Quality Commission quality and risk profile (March 2013)

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at [www.monitor-nhsft.gov.uk/annualreportingmanual](http://www.monitor-nhsft.gov.uk/annualreportingmanual)) as well as the standards to support data quality for the preparation of the Quality Report (available at [www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275](http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275)).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

Date: 28 May 2013

.....Chairman

Date: 28 May 2013

.....Chief Executive

## Independent Assurance Report

### Independent Auditor's Report to the Council of Governors of Hertfordshire Partnership NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Hertfordshire Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of Hertfordshire Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (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 NHS Foundation Trust as a body, to assist the Council of Governors in reporting Hertfordshire Partnership 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 2013, 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 NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

#### Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Access to Crisis Resolution Teams;
- CPA 7 day follow up.

We refer to these national priority indicators 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 Monitor.

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*;
- the Quality Report is not consistent in all material respects with the sources specified in the guidance; 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 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 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 the documents specified within the detailed guidance. 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.
- 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 impact 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 thereof, 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 governance over quality or non-mandated indicators which have been determined locally by Hertfordshire Partnership NHS Foundation Trust.

### **Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- 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 in Monitor's 2012/13 Detailed Guidance for External Assurance on Quality Reports; 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*.

*Deloitte LLP*

Deloitte LLP  
Chartered Accountants  
St Albans  
28 May 2013

## Quality in Service User Care and Stakeholder Relations

Service user involvement, stakeholder relations and quality are pivotal to the work we do within the Trust. Full details of the Trust's performance with regard to the quality of services provided in 2012/2013 are given in the quality report (see page 32).

Some aspects of the care provided to service users and carer which highlights quality are summarised in this section:

- The Trust has used its Foundation Trust status to implement an ambitious capital programme, which includes building a new unit providing inpatient care for adults with learning disabilities at Poplar House, Norwich – and a major new mental health inpatient service at Kingsley Green, due to open in Spring 2014
- “Quality in the New NHS System” (National Quality Board (July 2012)) was used as one basis for strengthening the Board's approach to quality governance during the year. Given the high levels of changes to services, a specific set of new reports was introduced so that the impact on quality on these major changes could be closely monitored and risk assessed. A Quality Strategy for 2012/2015 was also developed to map out how the Trust will monitor and where possible improve quality in the coming years and this was based on Monitor's Quality Governance Framework
- CQUIN targets set by each commissioner of services have been a major focus of attention through the year. The Trust enhanced its ways of managing progress energetically throughout the year with the result that we expect to achieve at least 95% of CQUIN targets for 2012/2013
- There have been no significant changes in the range of services which we were commissioned to provide. We have been an early implementer of enhanced mental health primary care services for children and young people in Hertfordshire. We have reorganised access to our services by introducing in May 2012 a Single Point of Access service to take on and direct promptly and appropriately over 100 referrals per day. We have continued to shift the emphasis of care from hospital to community settings, and to develop more consistent care pathways so that service users know better how we aim to help them in their recovery journeys
- We have created a new Engagement and Involvement Service which has spelt out more clearly to those who depend on our services what they can expect. For example, we have launched a new Carers' Strategy developed jointly with our Carers' Council
- Response rates to complaints through the year have been between 80% and 90% each quarter against an internal target of 90% of complaints being dealt with within 25 working days. Options for improving response rates, which include extra resource being provided to help managers resolve complaints in a timely manner, are being explored

## Compliments, comments and complaints

The Trust places great importance on the comments, compliments and complaints provided by service users, their carers, relatives and friends. We actively 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 or the link on the Trust Web site. In addition, all service users and carers are encouraged to complete Having Your Say forms during their recovery journey and to use the patient experience trackers where they are available. We now have a number of volunteers who visit some of our inpatient units to assist service users with completing Having Your Say forms.

We use the information provided in comments and complaints, together with the outcomes of our investigations, to improve our services and we work closely with the Risk Management and Practice Governance Teams to ensure that lessons learnt are turned into action plans, which are put into place and monitored.

We also celebrate what we do well, and all teams are encouraged to send details of compliments received to the PALS (Patient Advice and Liaison Service) and Complaints Team for logging.

### Formal Complaints

We investigate complaints with the aim of providing a fair, open and honest response and to learn from them so that other users/carers can benefit from the resulting changes.

There was a 5% decrease in formal complaints during 2012/13 compared to 2011/12. Table B shows the number and primary category for each complaint, comparing 2009/10, 2010/11, 2011/12 and 2012/13.

**Table A: Number of formal complaints and main issues**

| Main complaint issue | 01/04/09 - 31/03/10 | 01/04/10 - 31/03/11 | 01/04/11 - 31/03/12 | 01/04/12 - 31/03/13 |
|----------------------|---------------------|---------------------|---------------------|---------------------|
| Assault / abuse      | 3                   | 9                   | 5                   | 6                   |
| Clinical practice    | 67                  | 83                  | 79                  | 83                  |
| Communication        | 39                  | 27                  | 40                  | 38                  |
| Environment etc.     | 2                   | 4                   | 3                   | 6                   |
| Staff attitude       | 26                  | 28                  | 42                  | 41                  |
| Security             | 1                   | 1                   | 1                   | 3                   |
| Systems & Procedures | 65                  | 60                  | 74                  | 55                  |
| Transport            | 0                   | 1                   | 2                   | 0                   |
| <b>Total</b>         | <b>203</b>          | <b>213</b>          | <b>246</b>          | <b>232</b>          |

Of the 232 complaints received during the year, 200 were sent a first response within 25 working days and 26 were responded to over 25 working days. Six complaints were still open at the time this report was prepared, four of which were overdue. Permission is sought from complainants when it is known that a complaint is likely to go overdue.

## Patient Advice and Liaison Service (PALS)

PALS provides people with advice and assistance on who to contact and support if they have a concern or enquiry. The number of contacts continues to increase with a 3% increase over last year. Table A shows the number and main categories of PALS contacts, comparing 2012/13 with 2011/12, 2010/11 and 2008/09.

**Table B: Number of PALS contacts and main categories**

| Category              | 01/04/09 - 31/03/10 | 01/04/10 - 31/03/11 | 01/04/11 - 31/03/12 | 01/04/12 - 31/03/13 |
|-----------------------|---------------------|---------------------|---------------------|---------------------|
| Advice                | 67                  | 109                 | 66                  | 22                  |
| Enquiry               | -                   | -                   | 40                  | 99                  |
| Feedback              | 4                   | 30                  | 42                  | 71                  |
| Issues for resolution | 89                  | 134                 | 159                 | 223                 |
| Other                 | 5                   | 15                  | 3                   | 1                   |
| Translation request   | 0                   | 1                   | 3                   | 1                   |
| Not HPFT              | -                   | -                   | 19                  | 25                  |
| <b>Total</b>          | <b>165</b>          | <b>289</b>          | <b>332</b>          | <b>442</b>          |

## Emerging themes from the PALS issues and complaints received

Some PALS 'Issues for Resolution' are transferred to the formal complaints process, either because they can not be resolved within one working day, or due to the serious nature of the issues raised. Most issues and enquiries are dealt with immediately or very quickly by the clinical teams and do not result in a complaint.

Of the 83 complaints where clinical practice was the primary issue, 38 concerned direct care, 18 care planning, eight concerned diagnosis and seven concerns administration of drugs or medicines. The 55 Systems and Procedures complaints fell into 18 categories, with 10 complaints about breach of confidentiality, nine about assessment and treatment, nine about access to treatment and five about discharge. The six complaints about alleged assault were a mixture of alleged actual or threatened physical abuse to or by service users.

During 2012/13 we received 15 requests for files from the Parliamentary and Health Services Ombudsman (PHSO). Eight cases were returned as no further action and four were returned for further local resolution. One complaint was upheld. The Local Government Ombudsman returned a decision on one case as not upheld.

## 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. The team continues to remind all units of the importance of forwarding compliments to ensure that they are recorded accurately.

|                     |     |
|---------------------|-----|
| 01/04/09 – 31/03/10 | 308 |
| 01/04/10 – 31/03/11 | 432 |
| 01/04/11 – 31/03/12 | 674 |
| 01/04/12 – 31/03/13 | 673 |

The number of written compliments received does not reflect the very large number of verbal compliments received by staff.

## Service User and Carer Involvement

Continuation and expansion of involvement activities has been important for the Trust at a time of huge change. Over the past year there has been a 31% increase in the number of hours of involvement work that our service users and carers have claimed payment for. Over the past year we have seen 2146 hours of involvement work undertaken by people with lived experience either as a service user or carer.

This has included over 800 hours spent in formal committees, councils and forums (up 14% from last year), and 379 hours in staff interviews (up 50% from last year). Against a background of streamlining the number of meetings and the complexities of transformation of the workforce, this represents a substantial increase of service user and carer input to our day to day work.

We are very grateful for this input and, additionally, for the input of people who have undertaken involvement work on a voluntary basis.

Restructuring of the involvement department and its incorporation into the new Customer Inclusion and Engagement Team has already provided us with opportunities to work more creatively and inclusively, and ongoing changes over the next few months offer the chance to continue with this. Projects in the pipeline include:

- Imminent launch of the Trust's Involvement Principles, which have been developed over the past few months with input from service users and carers. This will provide a vital core of guidance for increased involvement activities as we move forward.
- Launch of a web-based toolkit - available to all - which will lay out clearly the basis of involvement work in the Trust, and provide valuable guidance to those organising and taking part in involvement activities.

The Service User Council and Carer Council remain important forums for discussion and input to our work. Both councils have this year completed a review of their Terms of Reference and planning their focus areas for the next year. The input of the councils has been much appreciated at a time of great change, as has the continued support of the Trust Chair to the councils.



Some of our targeted work with people across Child and Adolescent Mental Health Services (CAMHS) has seen some significant developments. Most recently this has seen the development of the Trust's first Youth Service User council.

Peer Experience Listening and Peer Support work have continued to develop within the Trust and teams of Peer Workers have worked with Development Workers to maintain the integrity and high standards of peer work in the Trust. The next challenge, currently underway, is to ensure that peer work is embedded as an integral part of our day to day work.

At the year end the following had been achieved by the Trust Peer Experience Listening Service – aimed at recruiting people with lived experience to garner feedback from service users and carers about their experiences:

- Recruitment of an additional 11 Peer Experience Listeners including people who have experience of Learning Disability Services
- Current total of service user and carer feedback interviews to date is 200.
- The collaborative document "What do you need to know about a Mental Health Act assessment" produced as a result of a piece of work carried out by Peer Experience Listeners in 2011/12. This is now being distributed to people at the point of assessment.
- Peer Experience Listeners have received further invitations to represent the project at regional and national events focusing on peer work and best practice. An interviewee and a Peer Experience Listener have also been interviewed about the project on BBC local radio about the project.
- The Peer Experience Listening project has been included as a case study for the RAISE Carers Research module (part of the international programme on recovery and social inclusion) with Hertfordshire University.
- The Peer Experience Listeners were rewarded with an award for volunteering team of the year at a staff awards ceremony in 2012.

In contrast the Peer Support Service exists to support service users and carers on a one-to-one basis to help address any concerns they may have about accessing services, accompany someone to their first visit to attend a support group or generally as a follow up contact.

In the past year the service:

- Had six active employed peer workers and four volunteer workers.
- Carried out 23 one-to-one interventions, with 12 ongoing at the year end. Interventions can last up to six weeks.
- Completed a total of 2845 hours of peer support work.

# Requests for Information

## Freedom of Information Act 2000 (FOIA)

The number of Freedom of Information Act 2000 (FOIA) requests received by the Trust during 2012/13 has remained consistent with last year at an average of 13 requests per month. Year on year comparisons below show that requests from the public remain stable but also highlight that companies are becoming more aware of the FOIA and their right to request information from public authorities.

## Who has asked for information?

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

| Type of requester      | Number of requests 2012/13 | Number of requests 2011/12 |
|------------------------|----------------------------|----------------------------|
| Other/Unknown          | 70                         | 70                         |
| Companies              | 52                         | 47                         |
| Journalists            | 11                         | 20                         |
| Staff/Other NHS Trusts | 9                          | 13                         |
| Students               | 9                          | 4                          |
| MPs                    | 0                          | 2                          |
| Service Users/Carers   | Recorded as other          | 2                          |
| <b>Total Number</b>    | <b>151</b>                 | <b>158</b>                 |

## Timescales for responses

FOIA legislation requires public authorities to provide a response to requests for information within 20 working days. Whilst every effort is made to complete all requests within this timescale, it is not always achievable due to the resource allocated within the team and the sheer complexity of some requests that require input from numerous staff.

When it is evident that a request is going to take longer than 20 working days, the Applicant is informed of any delay and regular updates are provided.

Not meeting this legal timescale may result in the Trust receiving a Practice Recommendation from the Information Commissioner and an adverse comment in a report to Parliament.

Information has been provided to applicants within the following timescales:

| Response Time (in working days)    | Number of requests 2012/13 | Number of requests 2011/12 |
|------------------------------------|----------------------------|----------------------------|
| 1 - 5 days                         | 29                         | 30                         |
| 6 - 10 days                        | 20                         | 28                         |
| 11 - 15 days                       | 18                         | 21                         |
| 16 - 20 days                       | 39                         | 49                         |
| 21+ days                           | 30                         | 30                         |
| Requests currently being processed | 15                         | 0                          |

## Exemptions

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

Exemptions which were considered and applied to all or part of a request are:

- Section 12: Cost of compliance exceeds appropriate limit
- Section 21: Information available by other means
- Section 22: Information intended for future publication
- Section 40: Personal information
- Section 43: Commercial interests

| Year      | No of requests with exemptions applied | Exemptions used and frequency |
|-----------|--|-------------------------------|
| 2012-2013 | 29                                     | s.12 x 6                      |
|           |  | s.21 x 17                     |
|           |  | s.22 x 4                      |
|           |  | s.40 x 5                      |
|           |  | s.43 x 2                      |

## Publication of information requested (disclosure log)

Requests from the previous 12 months are routinely published on the FOI disclosure log on the Trust website. This enables us to direct applicants to information already available and to apply exemption s.21 (information accessible by another means) where the same/similar information has been requested. The Trust has used s.21 for 17 requests received in 2012/13 (11% of total requests). We anticipate that this figure will increase over time.

The Records and Access to Information (RAI) team regularly monitors requests. Where information is frequently asked for (i.e. departmental structures, board papers, medicines management information etc) the RAI team will liaise with the relevant department to ensure that this information is made available on the website. The Trust Publication Scheme<sup>1</sup> will be updated to 'signpost' future applicants to the relevant section on the website.

<sup>1</sup> The Publication Scheme is a complete guide to the information routinely published by HPFT. It is a description of the information about our Trust which we make publicly available.

## 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 hold on them. During 2012/13 the Trust received 355 Subject Access Requests (SARs) for copies of individuals' care records. This is an increase of 2.5% compared to 2011/12 (346).

### 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.

**From April 2012 information was provided to applicants within the following timescales:**

| Response Time                                  | Number of requests<br>2012/13 | %   |
|--|-------------------------------|-----|
| Within 21 calendar days                        | 77                            | 22% |
| Within 40 calendar days                        | 125                           | 35% |
| 40+ calendar days                              | 17                            | 5%  |
| No longer required or closed during processing | 90                            | 25% |
| Currently pending                              | 46                            | 13% |

The Trust will endeavour to respond to SARs within 21 calendar days; however due to the number of requests 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.

## Reporting of Personal Data Related Incidents

Loss of personal data is a risk which is monitored nationally. The table below shows the incidents that have been classified at severity rating level 1/2 and occurred within the Trust in 2012/13. These figures have been aggregated in line with the Department of Health Reporting Checklist (ref:13177).

Incidents rated at a level 0 are not reflected in this report.

| Summary of Other Personal Data Related Incidents in 2012-13 |   |       |
|---|---|-------|
| Category  | Nature of incident  | Total |
| I   | Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises         | 0     |
| II  | Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises | 11*   |
| III   | Insecure disposal of inadequately protected electronic equipment, devices or paper documents                      | 0     |
| IV  | Unauthorised  | 10    |
| V   | Other   | 0     |

\*These loses are purely paper based records – or part of.

# Sustainability reporting

## A Year of Challenge – People Places and Profit: Year 2

### People

Our Staff are key players in delivering a sustainable Trust that inspires those who receive, buy and experience our services and environments with confidence and benefit.

To infuse sustainable development throughout the workforce, the Trust has innovated by designing publishing a interactive electronic sustainable management strategy and toolkit. This will ensure that professional information is available to all.

The Trust is reviewing the governance and reporting structures around sustainability and will be simplifying the framework to ensure speedy decision making can be achieved.

The Trust will be running special campaigns and features around specific sustainable topics over the next year.

### Places

In 2012/13 the Trust has faced many challenges in trying to reduce CO<sup>2</sup> emissions with older sites not running efficiently and maintenance of them creating many challenges.

With this in mind the Trust has embarked on a two year programme of reducing its estate from 60 sites across Hertfordshire to 30 and these buildings will be refurbished and redecorated putting in equipment and contracting utilities that will ensure that our CO<sup>2</sup> emissions reduce from the levels we were previously operating from.

The Trust is developing an 86 bedded unit in Kingsley Green, the design of which is based on the BREEAM very good standard. This building will deliver efficiency in Sustainable design and CO<sup>2</sup> efficiency savings.

### Profit

It is worth mentioning that over the last two years the UK has experienced the most severe winters and all the Trust teams have been focused on maintaining and delivering the highest quality services in a comfortable and safe environment. This has certainly challenged the CO<sup>2</sup> reduction figures and the Trust experienced a large loss of water due to underground pipe vandalism at one of its major sites and large leaks due to burst pipes. This situation has now been contained and the Trust is hopeful of publishing a usage reduction next year.

### Waste Disposal System

There has been a stabilising of waste control and there has been no change on last year's percentages of 52% waste recycling and 48% landfill. Clinical waste has not increased over the last year's levels 3%.

The Trust is confident of continuing a positive reduction for all its waste and in particular looking to reach the 80% recycled target by 2015.

## **Travel**

Travel has continued to show a reduction in absolute CO<sup>2</sup> emissions this has been achieved by fewer Trust meetings, better use of information technology, better understanding by staff of the need to be more fuel efficient when delivering services in their choice of transport. This has all added up to a further reduction of 15% against last year's mileage figures.

The Trust Transport department has achieved ISO14001 environmental standards which is monitored throughout the year to ensure the levels have not dropped against the required standards.

The transport department has increased by 0.43% against last year's figures due to winning two new contracts, but further rationalisation of activity and fleet control has kept CO<sup>2</sup> emissions on track. Target has continued reductions from 235 to 175.

The Trust is continuing to ensure that travel delivers continuous reduction in mileages, whilst at the same time contributing accessibility to our services. The business miles for the Trust have reduced by 16% on last year's figures.

## **Summary of Carbon Reduction Performance**

For the year 2012/13 there has been a positive decrease on the previous year's figures of 5% on CO<sup>2</sup> emissions on buildings.

Electricity has reduced by 15% against last year's level. We predict this will continue to reduce.

Gas has reduced by 36% on the 2011/12

We predict that there should be a continuing decrease as the Trust reduces its building stock.

Water consumption has decreased by 2%. Much more could have been achieved but the Kingsley Green site experienced major leaks due to vandalism and burst pipes. This should be set in context that Kingsley Green consumes 50% of the total water usage in the Trust.

We predict that consumption will continue to show further reductions as the Kingsley Green site reduces in 2013/14.

## **Emergency Planning**

The Trust has updated its Major Incident and Business Continuity Plan in line with the Trust's introduction of Strategic Business Units, and exercises to test local plans went ahead in April 2013. The Trust plan, together with local plans, will again be adjusted after lessons learnt from these exercises.

## Equality and Diversity – 2012/13

There has been a significant amount of change in how the Trust has structured its approach to Equality and Diversity. Throughout 2012 there has been a review of how equality and inclusion is mainstreamed more effectively throughout the organisation. This has resulted in the development of a new Customer Inclusion and Engagement Team. In order to develop this new way of working the Trust has now consolidated a number of projects into this new team which now has the remit for:

- Equality and Human Rights
- Service User and Carer Involvement
- Compliments, Concerns and Complaints
- Patient Advice and Liaison Service (PALS)
- Carer work
- Peer led work
- Advocacy
- Service Experience (service satisfaction)
- Mental Health Community Engagement (with marginalised groups)
- Volunteering
- Spiritual Care and Chaplaincy

In addition to a more mainstreamed approach – that should provide improved equality of opportunity for protected groups<sup>2</sup> – the reorganisation has also achieved efficiency savings for the organisation.

Whilst this still means that the team oversees its duties under the Equality Act 2010 (and associated public duties) it has improved synergy of a range of legal requirements that the Trust is required to comply with.

As with the previous year, the trust has been working hard to maintain a good level of achievement with the NHS Equality Delivery System (EDS) – the national framework for overseeing equality compliance across NHS organisations. Following our first grading in March 2012, the past year has been spent looking at improvements to our scores to reflect developments in the way we are supporting people from protected groups. One example of the work that has taken place this year is detailed below:

### **RESPECT framework for equality and dignity assurance**

This year we have been trialling a new framework that will allow services to look locally at how they are ensuring all services and workplaces are providing equality of opportunity and dignity for all. This focuses on what we are calling the seven elements of RESPECT. These are:

- Rights and Recovery
- Equality and Dignity
- Safety
- People
- Empowered staff
- 6 C's of Quality Care<sup>3</sup>
- Transparency

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<sup>2</sup> Age, Disability, Gender, Gender Reassignment, Marriage & Civil Partnership, Pregnancy & Maternity, Race, Religion & Beliefs, Sexual Orientation.

<sup>3</sup> Care, Compassion, Commitment, Communication, Courage, Competence



The framework was written with service users, carers and staff in 2012 and was trialled in our North East Essex Community Learning Disability Services up to the end of 2012/13. The next stage of the trial includes work with Hertfordshire Forensic Learning Disability and Mental Health Services.

The Trust continues to monitor its performance against equality and diversity criteria and is currently reviewing how this is best strategically managed in light of recent NHS and government changes re: equalities. This includes a national review of the Public Sector Equality Duty (PSED) and what this means for the Trust. Nevertheless until this is complete the Trust continues to work to the three aims of the PSED. Examples are listed below:

## Eliminate unlawful discrimination

- **Staff role models** – increased work with minority groups within the workforce to develop staff role models.
- **Trust RESPECT campaign** – As detailed above.
- **Staff support networks** – The Trust has three staff support network IMPACT BME Network, Disability Staff Forum and LGBT and Straight Allies Network.

## Advance equality of opportunity

- **Community Engagement Workers** – Project work that targets marginalised groups in the community and works with them around their mental health thereby reducing the need for compulsory admission to services.
- **Stonewall and LGBT Work** – Achieving placement in the 2013 Stonewall Workplace Equality Index for the fourth year running.
- **Employee Charters** – Maintaining staff charters for disability, sexual orientation, age and positivity about mental health.
- **Centre of Excellence for Equality** – HPFT hosted the 2012 Chief Nursing Officer's BME Nursing Conference - <http://www.youtube.com/watch?v=XiNblaARmts>

## Fostering Good Relations

In addition to the work listed above, the Trust is continually striving to improve liaison between different groups of staff. Some of the ways we have done this over the past year include:

- **IDAHO (International Day Against Homophobia) day conference** – focused on improving the response to Lesbian, Gay and Bisexual people using Trust services.
- **Equality Training** – achieving a top 20% performance rate in the 2012 national staff survey.
- **STRIDE men's health project** – Working with men over six week periods to help them address areas of concern with their own mental health and wellbeing.
- **Healthy and Happy Project** – Working with new mothers across children's centres in Herts to help them understand their emotional wellbeing.
- **Work with the Trust Board** – The Trust has an Executive and Non Executive Champion for Equality. On an Annual the board receives an Equality workshop looking at current issues as well as update reports on the progress on implementing the NHS Equality Delivery System.

## Statistics

The Trust is required under the PSED to collect and publish diversity data for staff and those affected by its policies and processes. In addition the Trust is 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.

All PSED compliance reporting is published through the Equality & Diversity section of the Trust website. However below is an overview of Trust staff, membership and service users for information as of 1st March 2013.

| Ethnic Group                         | Employed staff |        | Members       | Service Users |        |
|--------------------------------------|----------------|--------|---------------|---------------|--------|
|                                      | Number         | %      | Number        | Number        | %      |
| White British                        | 1,436          | 52.72% | 9,021         | 15,125        | 74.60% |
| White Irish                          | 83             | 3.05%  | 151           | 315           | 1.55%  |
| White - Any other white background   | 163            | 5.98%  | 387           | 661           | 3.26%  |
| Asian or Asian British - Indian      | 97             | 3.56%  | 104           | 168           | 0.83%  |
| Asian or Asian British - Pakistani   | 29             | 1.06%  | 28            | 104           | 0.51%  |
| Asian or Asian British - Bangladeshi | 7              | 0.26%  | 5             | 49            | 0.24%  |
| Asian or Asian British – Other Asian | 117            | 4.30%  | 375           | 194           | 0.96%  |
| Mixed - White & Black Caribbean      | 10             | 0.37%  |               | 132           | 0.65%  |
| Mixed - White & Black African        | 6              | 0.22%  |               | 76            | 0.37%  |
| Mixed - White & Asian                | 16             | 0.59%  | 26            | 86            | 0.42%  |
| Mixed – Other Mixed                  | 20             | 0.73%  | 107           | 142           | 0.70%  |
| Black or Black British - Caribbean   | 56             | 2.06%  | 77            | 169           | 0.83%  |
| Black or Black British - African     | 197            | 7.23%  | 122           | 135           | 0.67%  |
| Black or Black British – Other Black | 17             | 0.63%  | 237           | 71            | 0.35%  |
| Chinese                              | 11             | 0.40%  | 46            | 36            | 0.18%  |
| Any other ethnic group               | 77             | 2.83%  | 496           | 162           | 0.80%  |
| Undisclosed                          | 382            | 14.03% | 3             | 157           | 0.77%  |
| Undefined                            |                |        |               | 2,164         | 10.67% |
| <b>TOTAL</b>                         | <b>2,724</b>   |        | <b>11,185</b> | <b>20,274</b> |        |

|              | Employed staff |        |
|--------------|----------------|--------|
| Age Band     | Number         | %      |
| 0 - 16       | -              | -      |
| 17 - 20      | 2              | 0.08%  |
| 21 - 25      | 73             | 2.93%  |
| 26 - 30      | 166            | 6.54%  |
| 31 - 35      | 229            | 8.42%  |
| 36 - 40      | 368            | 13.57% |
| 41 - 45      | 426            | 16.04% |
| 46 - 50      | 478            | 18.37% |
| 51 - 55      | 436            | 16.79% |
| 56 - 60      | 325            | 11.95% |
| 61 - 65      | 163            | 5.30%  |
| 65+          | 0              | -      |
| <b>TOTAL</b> | <b>2,666</b>   |        |

|              | Members       |
|--------------|---------------|
| Age Band     | Number        |
| 0 - 16       | 10            |
| 17 - 24      | 1517          |
| 25 - 34      | 1146          |
| 35 - 59      | 4071          |
| 60+          | 3650          |
| No data      | 791           |
| <b>TOTAL</b> | <b>11,185</b> |

|              | Service Users |        |
|--------------|---------------|--------|
| Age Band     | Number        | %      |
| 0 - 16       | 2,726         | 13.45% |
| 16 - 18      | 958           | 4.73%  |
| 18 - 24      | 1,600         | 7.89%  |
| 25 - 34      | 2,110         | 10.41% |
| 35 - 44      | 2,282         | 11.26% |
| 45 - 54      | 2,575         | 12.70% |
| 55 - 64      | 1,705         | 8.41%  |
| 65 - 74      | 1,585         | 7.82%  |
| 75 - 84      | 2,716         | 13.40% |
| 85+          | 2,002         | 9.87%  |
| Unknown      | 15            | 0.07%  |
| <b>TOTAL</b> | <b>20,274</b> |        |

|              | Employed staff |        | Members       | Service Users |        |
|--------------|----------------|--------|---------------|---------------|--------|
| Gender       | Number         | %      | Number        | Number        | %      |
| Male         | 798            | 29.30% | 4653          | 9,351         | 46.12% |
| Female       | 1,926          | 70.70% | 6531          | 10,915        | 53.84% |
| Undisclosed  | -              | -      | 1             | 8             | 0.04%  |
| <b>TOTAL</b> | <b>2,724</b>   |        | <b>11,185</b> | <b>20,274</b> |        |

|              | Employed staff |        | Members       | Service Users |   |
|--------------|----------------|--------|---------------|---------------|---|
| Disability   | Number         | %      | Number        | Number        | % |
| Yes          | 30             | 1.10%  | 291           | 872           |   |
| No           | 740            | 27.17% | 10,889        | 287           |   |
| Undisclosed  | 609            | 22.36% | 5             | 4             |   |
| Undefined    | 1,345          | 49.38% |               | 19,110        |   |
| <b>TOTAL</b> | <b>2,724</b>   | -      | <b>11,185</b> | <b>20,274</b> |   |
|              |                |        |               |               |   |

|                 | Employed staff |        | Members       |
|-----------------|----------------|--------|---------------|
| Religion/Belief | Number         | %      | Number        |
| Agnostic        | -              | -      | 6             |
| Atheism         | 134            | 4.92%  | 22            |
| Buddhism        | 9              | 0.33%  | 4             |
| Christianity    | 634            | 23.27% | 59            |
| Hinduism        | 41             | 1.51%  | 1             |
| Islam           | 34             | 1.25%  | 3             |
| Jainism         | 19             | 0.70%  | -             |
| Judaism         | -              | -      | 3             |
| Sikhism         | 8              | 0.29%  | 1             |
| Other           | 85             | 3.12%  | -             |
| Undisclosed     | 248            | 9.10%  | 75            |
| Undefined       | 1,512          | 55.51% | 10,990        |
| <b>TOTAL</b>    | <b>2,724</b>   |        | <b>11,185</b> |

|                    | Employed staff |        | Members       | Service Users |        |
|--------------------|----------------|--------|---------------|---------------|--------|
| Sexual Orientation | Number         | %      | Number        | Number        | %      |
| Lesbian            | 6              | 0.22%  |               | 44            | 0.22%  |
| Gay                | 12             | 0.44%  | 2             | 30            | 0.15%  |
| Bisexual           | 9              | 0.33%  | 4             | 25            | 0.12%  |
| Heterosexual       | 964            | 35.39% | 125           | 4,740         | 23.38% |
| Other              |                |        |               | 28            | 0.14%  |
| Undisclosed        | 219            | 8.04%  | 175           | 196           | 0.97%  |
| Undefined          | 1,514          | 55.58% | 10,983        | 14,932        | 73.65% |
| <b>TOTAL</b>       | <b>2,724</b>   |        | <b>11,185</b> | <b>20,274</b> |        |

## Priorities and Targets

The key priority areas for equality in 2013/14 will be to focus on ensuring that the NHS Equality Delivery System (EDS) can be evidenced by all protected groups.

As the Trust is now in the second year of adopting the national NHS Equality Delivery System (EDS) as its method of assessing progress on Equality and Human Rights, the results of the second Trust assessment process are listed below. The graded colours correspond to the following:






- **Red** – Underdeveloped (Achieving for up to two out of nine protected groups)
- **Amber** – Developing (Achieving for three to five protected groups)
- **Green** – Achieving (Achieving for six to eight protected groups)
- **Purple** – Excelling (Achieving for all nine protected groups)














Over the past year this shows an improvement of three outcomes from amber to green.

This is working toward achieving the Trust four year objective of:

The Trust shows measurable improvement in EDS scores year on year, leading to the Trust achieving 100% purple (excellence) against all 18 EDS outcomes.

### Grades as agreed by HPFT stakeholders on 11/04/13

| Goal                                     | Narrative   | Outcome   |   |
|--|---|---|---|
| <b>1. Better Health Outcomes for All</b> | The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results | 1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities  |  |
|  |   | 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways  |  |
|  |   | 1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly  |  |
|  |   | 1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all |  |
|  |   | 1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups  |  |

|   |   |  |   |
|---|---|--|---|
| <b>2. Improved Patient Access &amp; Experience</b>    | The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience                   | 2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds  |    |
|   |   | 2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment  |    |
|   |   | 2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised  |    |
|   |   | 2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently   |    |
| <b>3. Engaged, empowered and well supported staff</b> | The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs     | 3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades  |    |
|   |   | 3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay   |    |
|   |   | 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately   |  |
|   |   | 3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all   |  |
|   |   | 3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.) |  |
|   |   | 3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population   |  |
| <b>4. Inclusive leadership at all levels</b>          | NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions | 4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond   |  |
|   |   | 4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination   |  |
|   |   | 4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes  |  |

## Our Staff

### Staff Engagement

The Trust maintains its commitment to staff engagement and values the input of all members of staff at all levels. There has been a rolling programme of engagement events throughout the year, both for staff and with key stakeholders to ensure effective two way participation in key decision making. These events include:

Big Listens, which were launched in May 2011, are held twice per year and give staff a platform to express their views and experiences directly with the Chief Executive and Executive team.

Senior Leaders' Forums take place six times per year for the Trust's senior leaders and are intended to be strategically focused and developmental sessions.

Monthly Breakfast meetings with the Chief Executive have also been developed whereby staff groups from across the Trust share what they are doing, and feedback their views and experiences on working for the Trust and how the Trust can improve on the quality of care for service users.

### Summary of performance – NHS Staff Survey 2012

| Response rate | 2011  |                  | 2012  |                  | Trust Improvement/<br>Deterioration |
|---------------|-------|------------------|-------|------------------|-------------------------------------|
|               | Trust | National Average | Trust | National Average |                                     |
|               | 61%   | 54.5%            | 54%   | 51%              | Decrease of 7%                      |

| Top 4 ranking scores  | 2010  |                  | 2011  |                  | Trust's Score Increase/<br>Decrease |
|---|-------|------------------|-------|------------------|-------------------------------------|
|   | Trust | National Average | Trust | National Average |                                     |
| KF26. Percentage of staff having equality and diversity training in last 12 months                            | 88%   | 53%              | 82%   | 59%              | Decrease of 6%                      |
| KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver | 77%   | 74%              | 80%   | 78%              | Increase of 3%                      |

|  |     |     |     |     |                |
|--|-----|-----|-----|-----|----------------|
| KF2. Percentage of staff agreeing that their role makes a difference to patients                 | 92% | 90% | 91% | 90% | Decrease of 1% |
| KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month | 98% | 97% | 94% | 93% | Decrease of 4% |

|   | 2011  |                  | 2012  |                  | Trust's Score Increase/Decrease  |
|---|-------|------------------|-------|------------------|--|
| Bottom 4 ranking scores   | Trust | National Average | Trust | National Average |  |
| KF22. Percentage of staff able to contribute towards improvements at work   | 67%   | 66%              | 65%   | 71%              | Decrease of 2%   |
| KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months |       |                  | 31%   | 20%              | The questions that have contributed to this KF have changed, so comparison with 2011 is not possible |
| KF17. Percentage of staff experiencing physical violence from staff in last 12 months                             |       |                  | 8%    | 4%               | The questions that have contributed to this KF have changed, so comparison with 2011 is not possible |
| KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months                 |       |                  | 26%   | 21%              | The questions that have contributed to this KF have changed, so comparison with 2011 is not possible |



## Largest local changes since the 2011 Survey – Key areas where staff experience has deteriorated

| Question   | Trust 2011 | Trust 2012 | Trust deterioration |
|--|------------|------------|---------------------|
| KF11. Percentage of staff suffering work-related stress in last 12 months          | 34%        | 41%        | 7%                  |
| KF12. Percentage of staff saying hand washing materials are always available       | 62%        | 50%        | 12%                 |
| KF10. Percentage of staff receiving health and safety training in last 12 months   | 81%        | 69%        | 12%                 |
| KF26. Percentage of staff having equality and diversity training in last 12 months | 89%        | 82%        | 7%                  |

## Key area where staff experience has improved

| Question   | Trust 2011 | Trust 2012 | Trust deterioration |
|--|------------|------------|---------------------|
| KF15 Fairness and effectiveness of incident reporting procedures | 3.43       | 3.53       | 0.1                 |

The Trust results in relation to the National Staff Survey were mixed. The Trust has continued to score well in key areas such as staff feeling satisfied with the quality of care they are able to deliver, agreeing their role makes a difference to our service users, access to equality and diversity training, appraisal completions and the reporting of errors and near misses. The Trust's overall engagement score has also improved since the 2011 survey.

Another area where the Trust saw positive change related to the visibility of, and confidence in, senior managers.

Findings in relation to staff support from immediate managers, staff involvement in decision making, violence and aggression and harassment have remained in the bottom 20% of mental health trusts.

The 2012 survey had 28 Key Findings (KF) of which 6 ranked better than average, 1 was in the top 20% and 4 were average whilst 20 were below Average and 10 were in the bottom 20%.

Staff survey action plans are currently being developed within the Strategic Business Units in relation to local priorities, and work will continue on the trust wide priorities as outlined in the Organisational Development plan for 2012-2015.

## **Safer staffing for our Trust**

Hertfordshire Partnership NHS Foundation Trust continues have a rigorous system for checking the identity of applicants; the right for applicants to work in this country; registration of professional staff and qualification checks; employment history and reference checks; criminal record checks and occupational health checks.

In 2012 the Trust was inspected by the UK Border Agency, who were satisfied with the procedures the Trust had in place for the vetting and selection of staff, and fulfilling its duties in relation to the sponsorship license.

The Trust has strong co-operative working with external organisations to ensure good practice is followed with regards to safeguarding and safer staffing.

## **Recruitment of staff with a disability**

The Trust's Recruitment, Selection and Vetting Policy ensures that all applicants with a disability who meet the essential criteria are offered an interview and are asked prior to attending an interview what adjustments they require for the interview. Successful candidates are asked what adaptations they may require to be able to fulfil their posts. In the past year, the Trust has sought advice from Access to Work to ensure that reasonable adjustments and adaptations are in place for successful candidates.

## **Employee Relations**

The Trust continues to work with in partnership with full-time and local Staff side representatives. The Trust has monthly meetings with the Trade Unions both formally and informally. Staff side representatives are fully updated and take a pro-active role on all changes or TUPE transfers within the Trust. This includes attending open meetings and one to one meetings with staff to discuss organisational change and being updated on the outcomes, including redeployment of any change management programme. Partnership working is key to ensuring that the Trust is able to meet its CRES and Transformation agenda.

## **NHS Graduate Scheme**

The Trust is an active supporter of the NHS National Graduate Scheme and gives graduates opportunities to learn about our Trust and our work. The aim of our involvement is to improve our succession planning for the future.

## Staff Wellbeing

The Trust's aspiration is to be an employer of choice, where employees are highly valued, well supported and rewarded. As part of this, the Trust is committed to ensuring that the health and wellbeing of all employees is integral in the way we manage and lead our teams.

The Trust was the first organisation in the East of England region to be awarded the Staying Healthy at Work aSHaWd Accreditation in 2011 in recognition of the strong health and wellbeing foundations it has put in place for staff . As part of this continuing commitment the Trust is working towards the Staying Healthy at Work Award.

The Trust has been producing a quarterly staff Health and Wellbeing magazine 'Working Together as One' since August 2011, which provides articles and expert advice on healthy lifestyles, emotional wellbeing, fitness, inspirational staff 'wellbeing' stories, and signposting support mechanisms for staff.

The Trust also promotes and encourages health and wellbeing initiatives including walk to work and pedometer challenges, team and individual participation in national initiatives such as Stoptober and Sports Relief, staff choir, and encourages teams to set up their own activities such as fitness sessions, alternative therapy sessions, and walking groups.

The Trust has been running quarterly staff pulse surveys since August 2011. These provide an opportunity for all staff to feedback their views on working for the Trust and are run alongside the annual National Staff Survey to develop action plans to focus on areas of concern to staff.

The Trust is committed to reducing violence and aggression towards members of staff whilst undertaking their duties. It is acknowledged that many of our staff work in high risk services which are prone to higher rates of violence and aggression. Following an external review commissioned by the Trust, it has reviewed and strengthened its Violence and Aggression and Lone Worker policies, targeted additional training in high risk areas, strengthened relations with the police, reviewed the critical incident de-briefing service and continues to promote the RESPECT campaign.

As part of its commitment to eliminating harassment and bullying in the workplace the Trust has continued to promote its 'Ban Bullying' pledge, and has reviewed its harassment and bullying policy. It also launched its Workplace Mediation service November 2012 which offers staff a positive, collaborative approach to resolving workplace conflict. The Trust has a pool of trained mediators from across the Trust who will mediate in pairs to provide a totally confidential and impartial service to staff.

Another key aim of the Trust's health and wellbeing strategy is to support the reduction of sickness. Many of these initiatives, along with a proactive occupational health service and employee assistance scheme, support our staff in their physical and emotional wellbeing.

## **Workforce and Organisational Development**

**Developments in the past year include:**

### **Organisational strategy and plan**

The Organisational Development strategy and plan was launched following approval by the board in July 2012 and sets out the direction for the development of the organisation in order to deliver on its strategic plan for the next three years, as well as supporting the Trust's ambition for sustainable growth and the Trust's wishes to continue to improve the services.

The Trust's Organisational Development vision is to create a high performing workforce that operates embracing the values and expected behaviours of the Trust consistently; to create a workforce that is highly engaged, motivated and fully aligned to the Trust objectives and vision; and to ensure that all employees are aware of levels of accountability for individual performance delivery in relation to their respective roles.

### **Leadership and Organisational Culture**

The Leadership Academy, which was launched in 2011 and aims to improve leadership capacity and capability in the organisation, completed its first cohort in July 2012. The second cohort, which is accredited by the University of Hertfordshire, started in February 2013, with two programmes – Emerging Leaders and Leaders.

A programme of management development sessions aimed at improving the confidence and competence of managers has been set up. Sessions on managing change and managing people assertively have taken place, with sessions on managing meaningful appraisals and managing resilience currently being developed.

### **Staff Reward and Recognition**

The Trust launched its refreshed Annual Staff Awards in November 2012. It introduced the Customer Care Award in association with John Lewis, Welwyn as well as the Chief Executive's awards in recognition for individuals who have made outstanding contribution or achievement.

The Trust has continued to promote the monthly Inspire Awards, launched in January 2011, as a mechanism for recognising staff who are enthusiastic and innovative, provide excellent customer care and are an inspiration to others. 57 staff have been recognised through this process. Winners of the monthly award are entered into the Annual Staff Awards.

### **Learning and Development**

Mandatory training rates have shown a significant and steady increase over the last year, which has been helped significantly with regular reporting, accessible by all staff. The trust has also increased significantly use of e-learning packages with the vast majority of staff having accessed training in this way during 2012/13.

The Strategic Business Units have been fully engaged with levels of learning activity, with regular discussions at meetings up to Board level.

HPFT has built on a long standing relationship with the University of Herts by achieving University Status which reflected the commitment to research development and learning across all staff groups.

During 2012/3 a range of Continuing Professional Development activities have been run for professional staff which have been developed in partnership with the university and other training providers. This provision has been aligned to service and professional needs and has been delivered in a range of locations including service areas.

## Sickness Absence Data

The Trust's sickness rate remains above the East of England target. The HR Department continues to work closely with and support managers on the sickness KPI. During 2012, the Trust ran a sickness absence session for managers facilitated by Bevan Britain to ensure that they understood the legal background and were equipped with the skills to tackle both long and short term sickness absence. This session was well received and will continue to be a feature in 2013/14's priorities. During 2012/13, the Trust has also commenced the process of tendering for a single occupational health provider.

Sickness data broken down by the Strategic Business Units and Corporate areas are regularly presented to the Trust Health and Safety Committees, and are a key factor of the Trust's dashboard.

| Staff Group                              | FTE Days Available | FTE Days Sickness | % FTE Days Sickness |
|--|--------------------|-------------------|---------------------|
| <b>Add Prof Scientific and Technical</b> | 93,191.43          | 2,439.11          | 2.62                |
| <b>Additional Clinical Services</b>      | 246,211.43         | 17,843.49         | 7.25                |
| <b>Administrative and Clerical</b>       | 188,319.04         | 6,267.49          | 3.33                |
| <b>Allied Health Professionals</b>       | 34,133.19          | 795.29            | 2.33                |
| <b>Estates and Ancillary</b>             | 11,499.61          | 773.60            | 6.73                |
| <b>Healthcare Scientists</b>             | 547.50             | 0.00              | 0.00                |
| <b>Medical and Dental</b>                | 62,705.36          | 1,241.35          | 1.98                |
| <b>Nursing and Midwifery Registered</b>  | 302,307.97         | 15,911.69         | 5.26                |
| <b>Students</b>                          | 457.00             | 0.00              | 0.00                |
|  | <b>939,372.53</b>  | <b>45,272.02</b>  | <b>4.82</b>         |

## Regulatory Ratings

Monitor is the independent regulator of NHS Foundation Trusts. They were established in January 2004 to authorise and regulate NHS Foundation Trusts. They are independent of central Government and directly accountable to Parliament. Once a Trust is authorised, they regulate Foundation Trusts to ensure they comply with their terms of authorisation and comply with the conditions they signed up to, that they are well led and financially robust.

Monitor assigns each NHS Foundation Trust risk ratings for finance and governance based upon the Trust's annual plan for the year ahead and then for the actual results for each quarter.

Financial risk ratings are allocated using a scorecard which compares key financial metrics consistently across all NHS Foundation Trusts and incorporates four key criteria:

- achievement of plan;
- underlying performance;
- financial efficiency; and
- liquidity.

The rating reflects the likelihood of a financial breach of their terms of authorisation. A rating of 5 reflects the lowest level of financial risk and a rating of 1 the greatest.

A green rating for governance risk indicates that an NHS Foundation Trust's governance arrangements comply with their terms of authorisation; an amber risk rating reflects that concerns exist about one or more aspects of governance; a red risk rating indicates that there are concerns that an NHS Foundation Trust is in significant breach of its terms of authorisation.

The regulatory performance for Hertfordshire Partnership NHS Foundation Trust for 2011/12 is summarised as follows which also includes the previous year's ratings for comparison. This result includes an exceptional item in relation to the settlement of historic pension liabilities by other NHS organisations (see 'Financial Performance' below). By excluding this unusual, non-recurrent item the adjusted or underlying surplus would result in a Financial Risk Rating of 3, as planned.

|                        | Annual Plan<br>2012/13 | Q1<br>2012/13 | Q2<br>2012/13 | Q3<br>2012/13 | Q4<br>2012/13 |
|------------------------|------------------------|---------------|---------------|---------------|---------------|
| Financial risk rating  | 3                      | 3             | 3             | 3             | 4             |
| Governance risk rating | Green                  | Green         | Green         | Green         | Green         |

|                        | Annual Plan<br>2011/12 | Q1<br>2011/12 | Q2<br>2011/12 | Q3<br>2011/12 | Q4<br>2011/12 |
|------------------------|------------------------|---------------|---------------|---------------|---------------|
| Financial risk rating  | 3                      | 3             | 3             | 3             | 3             |
| Governance risk rating | Green                  | Green         | Green         | Green         | Green         |



## Section Two

Full Statutory Accounts including Statement of Accounting Officers responsibilities in respect of the accounts and Annual Governance Statement

1 April 2012 – 31 March 2013



## FOREWORD TO THE FINANCIAL STATEMENTS

### HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST

Hertfordshire Partnership NHS Foundation Trust ('the NHS FT') is required to prepare Annual Financial Statements in such form as Monitor, the independent regulator of Foundation Trusts, may, with the approval of HM Treasury, direct. These requirements are set out in paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

In preparing the Financial Statements the NHS FT has complied with any directions given by Monitor, with the approval of HM Treasury, as to the methods and principles according to which the statements are to be prepared and the information to be given in the statements. The statements are designed to present a true and fair view of the NHS FT's activities (paragraph 25(3), Schedule 7 of the 2006 Act).

If you require any further information on these accounts please contact:

James Thackray  
Head of Financial Control & Governance  
Hertfordshire Partnership NHS Foundation Trust  
99 Waverley Road  
St Albans  
Hertfordshire  
AL3 5TL  
Telephone number: 01727 804731

Signed



Mr Tom Cahill, Chief Executive

Date 28th May 2013

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED  
31 March 2013**

|  |      | 2012/13        | 2011/12        |
|--|------|----------------|----------------|
|  | note | £000           | £000           |
| Operating Income from continuing operations                | 4    | 203,615        | 211,684        |
| Operating Expenses of continuing operations                | 5    | (196,017)      | (206,376)      |
| <b>OPERATING SURPLUS</b>                                   |      | <b>7,598</b>   | <b>5,308</b>   |
| <b>FINANCE COSTS</b>                                       |      |                |                |
| Finance income   | 9    | 318            | 258            |
| Finance expense - financial liabilities                    | 9    | (70)           | (80)           |
| Finance expense - unwinding of discount on provisions      | 9    | (118)          | (393)          |
| PDC Dividends payable                                      |      | (3,831)        | (3,844)        |
| <b>NET FINANCE COSTS</b>                                   |      | <b>(3,701)</b> | <b>(4,059)</b> |
| <b>SURPLUS FOR THE YEAR</b>                                |      | <b>3,897</b>   | <b>1,249</b>   |
| <b>Other comprehensive income</b>                          |      |                |                |
| Impairments to the Revaluation Reserve                     | 13   | (2,067)        | (2,426)        |
| Revaluation surpluses                                      |      | 2,952          | 370            |
| Public Dividend Capital received                           |      | 0              | 0              |
| <b>TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR</b> |      | <b>4,782</b>   | <b>(807)</b>   |

The surplus for the financial year was £3,897k (£1,249k in 2011/12) as reported above. This includes a small number of material items which are unusual in nature and not considered by the NHS FT to be part of its normal activities. In order to assist the readers understanding of the accounts the following clarifying information is provided:

|   |    | 2012/13      | 2011/12      |
|---|----|--------------|--------------|
|   |    | £000         | £000         |
| <b>Financial performance for the year</b>   |    |              |              |
| Surplus for the year (as above)   |    | 3,897        | 1,249        |
| Impairments charged to the SOCI following an independent revaluation  | 13 | 2,443        | 1,412        |
| Reversal of prior year's impairment charges no longer required  | 13 | (413)        | 0            |
| Net surplus income arising from the settlement of pension provision liabilities held on behalf of other NHS bodies. | 4  | (3,529)      | 0            |
| <b>Surplus after adjusting for the above items</b>  |    | <b>2,398</b> | <b>2,661</b> |

**STATEMENT OF FINANCIAL POSITION**  
**31 March 2013**

|  |      | 31 March 2013   | 31 March 2012   |
|--|------|-----------------|-----------------|
|  | note | £000            | £000            |
| <b>Non-current assets</b>                    |      |                 |                 |
| Intangible assets                            | 10   | 172             | 158             |
| Property, plant and equipment                | 11   | 140,225         | 136,154         |
| Trade and other receivables                  | 16   | 13              | 7,984           |
| <b>Total non-current assets</b>              |      | <b>140,410</b>  | <b>144,296</b>  |
| <b>Current assets</b>                        |      |                 |                 |
| Inventories                                  | 14   | 12              | 15              |
| Trade and other receivables                  | 16   | 6,433           | 8,570           |
| Assets held for sale                         | 15   | 1,622           | 0               |
| Cash and cash equivalents                    | 17   | 43,009          | 41,307          |
| <b>Total current assets</b>                  |      | <b>51,076</b>   | <b>49,892</b>   |
| <b>Current liabilities</b>                   |      |                 |                 |
| Trade and other payables                     | 21   | (17,818)        | (19,731)        |
| Borrowings                                   | 19   | (96)            | (87)            |
| Provisions                                   | 20   | (3,809)         | (5,123)         |
| Other liabilities                            | 22   | (8,171)         | (2,468)         |
| <b>Total current liabilities</b>             |      | <b>(29,894)</b> | <b>(27,409)</b> |
| <b>Total assets less current liabilities</b> |      | <b>161,592</b>  | <b>166,779</b>  |
| <b>Non-current liabilities</b>               |      |                 |                 |
| Borrowings                                   | 19   | (628)           | (723)           |
| Provisions                                   | 20   | (6,701)         | (16,646)        |
| <b>Total non-current liabilities</b>         |      | <b>(7,329)</b>  | <b>(17,369)</b> |
| <b>Total assets employed</b>                 |      | <b>154,263</b>  | <b>149,410</b>  |
| <b>Financed by (taxpayers' equity)</b>       |      |                 |                 |
| Public Dividend Capital                      | 18   | 83,331          | 83,260          |
| Revaluation reserve                          |      | 48,092          | 47,366          |
| Income and expenditure reserve               |      | 22,840          | 18,784          |
| <b>Total taxpayers' and others' equity</b>   |      | <b>154,263</b>  | <b>149,410</b>  |

There has been a reclassification of £2,468k balances between Trade and other Payables and Other Liabilities as at 31 March 2012. See notes 21 and 22 for details.

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 28th May 2013

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED  
31 March 2013**

|  | Total          | Public Dividend<br>Capital | Revaluation<br>Reserve | Income and<br>Expenditure<br>Reserve |
|--|----------------|----------------------------|------------------------|--------------------------------------|
|  | £000           | £000                       | £000                   | £000                                 |
| <b>Taxpayers' Equity at 1 April 2012</b>     | <b>149,410</b> | <b>83,260</b>              | <b>47,366</b>          | <b>18,784</b>                        |
| Surplus/(deficit) for the year               | 3,897          | 0                          | 0                      | 3,897                                |
| Transfers between reserves                   | 0              | 0                          | (159)                  | 159                                  |
| Impairments to the Revaluation Reserve       | (2,067)        | 0                          | (2,067)                | 0                                    |
| Revaluations - property, plant and equipment | 2,952          | 0                          | 2,952                  | 0                                    |
| Public Dividend Capital received             | 71             | 71                         | 0                      | 0                                    |
| <b>Taxpayers' Equity at 31 March 2013</b>    | <b>154,263</b> | <b>83,331</b>              | <b>48,092</b>          | <b>22,840</b>                        |

The £159k transfer between Revaluation Reserve and Income and Expenditure Reserve relates to an adjustment for excess depreciation on those properties where the amount held in the revaluation reserve for the asset is greater than its current value.

The £71k Public Dividend Capital received relates to funding from the Department of Health for computer equipment.

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED  
31 March 2012**

|   | Total          | Public Dividend<br>Capital | Revaluation<br>Reserve | Income and<br>Expenditure<br>Reserve |
|---|----------------|----------------------------|------------------------|--------------------------------------|
|   | £000           | £000                       | £000                   | £000                                 |
| <b>Taxpayers' Equity at 1 April 2011</b>            | <b>150,217</b> | <b>83,260</b>              | <b>50,420</b>          | <b>16,537</b>                        |
| Surplus/(deficit) for the year                      | 1,249          | 0                          | 0                      | 1,249                                |
| Transfers between reserves                          | 0              | 0                          | (334)                  | 334                                  |
| Impairments to the Revaluation Reserve              | (2,426)        | 0                          | (2,426)                | 0                                    |
| Revaluations - property, plant and equipment        | 370            | 0                          | 370                    | 0                                    |
| Transfer to retained earnings on disposal of assets | 0              | 0                          | (664)                  | 664                                  |
| <b>Taxpayers' Equity at 31 March 2012</b>           | <b>149,410</b> | <b>83,260</b>              | <b>47,366</b>          | <b>18,784</b>                        |

**STATEMENT OF CASH FLOWS FOR THE YEAR ENDED  
31 March 2013**

|   | note | 2012/13<br>£000 | 2011/12<br>£000 |
|---|------|-----------------|-----------------|
| <b>Net cash inflow from operating activities</b>              | 24   | <b>13,788</b>   | <b>10,063</b>   |
| <b>Cash flows from investing activities</b>                   |      |                 |                 |
| Interest received   | 9.1  | 318             | 258             |
| Purchase of intangible assets                                 |      | (125)           | 0               |
| Purchase of Property, Plant and Equipment                     |      | (8,546)         | (4,696)         |
| Sales of Property, Plant and Equipment                        |      | 0               | 1,149           |
| <b>Net cash generated from/(used in) investing activities</b> |      | <b>(8,353)</b>  | <b>(3,289)</b>  |
| <b>Cash flows from financing activities</b>                   |      |                 |                 |
| Public dividend capital received                              |      | 71              | 0               |
| Capital element of finance lease rental payments              |      | (86)            | (75)            |
| Interest element of finance lease                             |      | (70)            | (80)            |
| PDC Dividend paid   |      | (3,648)         | (3,981)         |
| <b>Net cash generated from/(used in) financing activities</b> |      | <b>(3,733)</b>  | <b>(4,136)</b>  |
| <b>Increase/(decrease) in cash and cash equivalents</b>       | 17   | <b>1,702</b>    | <b>2,638</b>    |
| <b>Cash and Cash equivalents at 1 April</b>                   | 17   | <b>41,307</b>   | <b>38,669</b>   |
| <b>Cash and Cash equivalents at 31 March</b>                  |      | <b>43,009</b>   | <b>41,307</b>   |

## NOTES TO THE ACCOUNTS

### 1. Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM for 2012/13 issued by Monitor. The accounting policies contained in the FT ARM follow International Financial Reporting Standards (IFRS) as adopted by the European Union and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The HM Treasury's FReM reflects the advice of the Financial Reporting Advisory Board (FRAB). The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

#### 1.1 Accounting convention

These Financial Statements have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

#### 1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS FT'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

The following are the critical judgements, apart from those involving estimations (see below note 1.2.2), that management has made in the process of applying the NHS FT's accounting policies and that have the most significant effect on the amounts recognised in the Financial Statements.

##### **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.

##### **Going Concern**

The Financial Statements have been prepared on the basis that the NHS FT is a going concern and will be in the foreseeable future. This is based upon the Directors assessment of the NHS FT's current financial projections, its current levels of cash and borrowing capacity and the contractual agreements it has with its commissioners

##### **Compliant with the NHS Foundation Trust Annual Reporting Manual**

The Financial Statements have been prepared in accordance with the 2012/13 Foundation Trust Annual Reporting Manual (FT ARM). The accounting policies contained in the FT ARM apply International Financial Reporting Standards as adapted or interpreted for an NHS Foundation Trust.

##### 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 and Injury Benefit provisions are based on the latest valuations provided by the Pensions agency. Valuation assumptions for Property, Plant and Equipment are based on valuations provided by the District Valuer, Giles Awford as at 31 March 2013.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 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 NHS FT is from commissioners for health and social care services and the majority is provided under a Block Contract arrangement jointly commissioned by NHS Hertfordshire and Hertfordshire County Council.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Interest revenue is derived from balances held with the Government Banking Services and on short term deposits with commercial banks. All investments have been undertaken in accordance with the NHS FT'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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS FT to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers' pension cost contributions are charged to operating expenses within the Statement of Comprehensive Income as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the NHS FT commits itself to the retirement, regardless of the method of payment.

##### *Local Government Superannuation Scheme*

The NHS FT 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 NHS FT'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 NHS FT was admitted into the scheme on a fully funded basis, whereby it was allocated assets equal to the value of the liabilities transferred.

As Hertfordshire County Council is responsible for any funding shortfall on this pension scheme, the NHS FT accounts for the pension scheme on a defined contribution basis.

## Notes to the Accounts - 1. Accounting Policies (Continued)

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

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

#### 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
- Specialised buildings – depreciated replacement cost

A full revaluation was conducted by the District Valuer, Giles Awford as at 31st March 2013 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 NHS FT and the cost of the item can be determined reliably.



## Notes to the Accounts - 1. Accounting Policies (Continued)

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 the following bases:

|   | <b>Years</b> |
|---|--------------|
| Medical equipment and engineering plant & machinery | 5 - 15       |
| Set up costs in new buildings                       | 10           |
| Furniture   | 10           |
| Soft furnishings                                    | 7            |
| Office and IT equipment                             | 5            |

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.

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 NHS FT, respectively.

### *Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income within the Statement of Comprehensive Income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses within the Statement of Comprehensive Income.

Gains/surpluses and losses/impairments recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as separate items of 'other comprehensive income'.

### *Impairments*

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or 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 arising from a loss of economic benefit or 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.

## Notes to the Accounts - 1. Accounting Policies (Continued)

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;
- 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 NHS FT'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 NHS FT 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 NHS FT intends to complete the asset and sell or use it;
- the NHS FT 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 NHS FT to complete the development and sell or use the asset; and
- the NHS FT 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.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### Measurement

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

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

### 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 NHS FT 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 on 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 NHS FT as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS FT'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 NHS FT'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. No amount is currently provided for any reduction in stock as the amount would not be material.

### 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.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS FT's cash management. There are no such bank overdraft balances in the reporting period.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 1.11 Provisions

Provisions are recognised when the NHS FT has a present legal or constructive obligation as a result of a past event, it is probable that the NHS FT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

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

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS FT has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it. There are no such contracts identified at the reporting date.

A restructuring provision is recognised when the NHS FT 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 NHS FT.

### 1.12 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS FT 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 NHS FT.

The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS FT is disclosed at note 20 but is not recognised in the NHS FT's financial statements.

### 1.13 Non-clinical risk pooling

The NHS FT participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS FT pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of any claims arising for which the NHS FT 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 EU Emission Allowance Trading Scheme

The NHS FT is not currently a member of the above and therefore there is no requirement to account for this at this time.

### 1.15 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 NHS FT. A contingent asset is disclosed where an inflow of economic benefits is probable. The NHS FT does not hold any these assets.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### Contingent liabilities

Contingent liabilities are not recognised, but are disclosed in note 29, 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.

### 1.16 Financial assets

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

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; 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 profit and loss

Financial assets at fair value through profit and loss are financial assets held for trading. A financial asset is classified in this category if acquired principally for the purpose of selling in the short-term.

The NHS FT does not hold any of this class of assets or liabilities.

#### Available for sale financial assets

The NHS FT 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.

At the end of the reporting period, the NHS FT assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 1.17 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS FT 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 profit and loss

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 profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS FT'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.

### 1.18 Corporation Tax

The NHS FT had determined that it has no Corporation Tax liability on the basis that its principle purpose is a public service, rather than carrying on a trade or any commercial activity.

### 1.19 Value Added Tax

Most of the activities of the NHS FT 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.

### 1.20 Foreign currencies

The NHS FT's functional currency and presentational currency is sterling. There are no foreign currency transactions in the period.

### 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS FT has no beneficial interest in them. Details of third party assets are given in Note 27 to the accounts.

### 1.22 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 FT, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS FT 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) net cash balances held with the Government Banking Services (GBS), 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 of the audit of the annual accounts.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 1.23 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS FTs 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 26.

### 1.24 Subsidiaries

The NHS FT does not have any subsidiary undertakings. In particular for 2012-13 in accordance with the directed accounting policy from the Secretary of State, the NHS FT does not consolidate the NHS charitable funds for which it is the Corporate Trustee.

### 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 Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income)

IAS 12 Income Taxes (amendment)

IAS 19 Employee benefits

IAS 27 Separate Financial Statements

IAS 28 Associates and Joint Ventures

IAS 32 Financial Instruments: Presentation

IFRS 7 Financial Instruments: Disclosures

IFRS 9 Financial Instruments

IFRS 10 Consolidated Financial Statements

IFRS 11 Joint Arrangements

IFRS 12 Disclosure of Interests in Other Entities

IFRS 13 Fair Value Measurement

IPSAS 32 Service Concession Arrangement

### 1.27 Operating Segments

The accounting standard IFRS8 sets out how entities should report information about their operating segments:

- 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.

Where the Directors consider the NHS FT has more than one operating segment then the financial performance of each business segment will be separately identified.

## Notes to the Accounts - 2. Financial Risk Management

### 2 Financial Risk Factors

The NHS FT's activities expose it to a variety of financial risks: credit risk, liquidity risk, cash flow risk and fair value interest-rate risk. The NHS FT's overall risk management programmes focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the NHS FT'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 NHS FT'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 NHS FT's net operating costs are incurred under contract agreements with Primary Care NHS FTs and Hertfordshire County Council, which are financed from resources voted annually by Parliament. The NHS FT also finances its capital expenditure from internally generated resources and from funds made available by commissioners. The NHS FT is not, therefore, exposed to significant liquidity risks.

#### 2.3 Cash flow and fair value interest-rate risk

100% of the NHS FT's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The NHS FT is not, therefore, exposed to significant interest-rate risk.

#### 2.4 Prudential Borrowing Limit (PBL)

The NHS FT is required to comply and remain within a prudential borrowing limit, which is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratio tests set out in the Prudential Borrowing Code for NHS Foundation Trusts. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and can therefore impact upon the long term borrowing limit; and
- the amount of any working capital facility that has been approved by Monitor.

|  | 31 March<br>2013<br>£000 | 31 March<br>2012<br>£000 |
|--|--------------------------|--------------------------|
| Long term borrowing limit set by Monitor | 47,900                   | 43,100                   |
| Working capital facility                 | 13,000                   | 13,000                   |
| Total Prudential Borrowing Limit         | <u>60,900</u>            | <u>56,100</u>            |

The NHS FT has borrowings of £724k (£810k 2011/12) for Property Plant and Equipment held under finance lease arrangements. The NHS FT did not draw down any of its working capital facility in either 2012/13 or 2011/12.

The current working capital facility expires on 31 October 2013.



**Notes to the Accounts - 2. Financial Risk Management (Continued)**

As an NHS Foundation Trust the NHS FT has the authority to finance capital expenditure through borrowing. To date the NHS FT has not done this with the current capital programme financed from existing cash balances.

Two loan applications have been approved by both Monitor and the Foundation Trust Financing Facility to part fund the future capital investment programme. These loans are expected to be drawn down in 2013/14

The NHS FT is in full compliance with the borrowing code ratios as follows:-

**2.5 Financial ratios**

|                                 | Approved<br>PBL ratios<br>2012/13 | Actual<br>ratio<br>2012/13 | Headroom<br>cover<br>2012/13<br>£000 |
|---------------------------------|-----------------------------------|----------------------------|--------------------------------------|
| Minimum dividend cover          | >1                                | 3.5                        | 9,667                                |
| Minimum interest cover          | >3                                | 193.8                      | 13,358                               |
| Minimum debt service cover      | >2                                | 81.7                       | 13,236                               |
| Maximum debt service to revenue | <2.5%                             | 0.1%                       | 4,924                                |

The NHS FT has been set a Tier 1 limit by Monitor, based on its 2012/13 Annual Plan submission.

|                                 | Approved<br>PBL ratios<br>2011/12 | Actual<br>ratio<br>2011/12 | Headroom<br>cover<br>2011/12<br>£000 |
|---------------------------------|-----------------------------------|----------------------------|--------------------------------------|
| Minimum dividend cover          | >1                                | 2.8                        | 6,890                                |
| Minimum interest cover          | >3                                | 135.2                      | 10,574                               |
| Minimum debt service cover      | >2                                | 74.1                       | 10,522                               |
| Maximum debt service to revenue | <2.5%                             | 0.1%                       | 5,146                                |

The NHS FT had a Tier 1 limit by Monitor, based on its 2011/12 Annual Plan submission.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the independent regulator of NHS Foundation Trusts.

**3 Segmental Information**

The directors consider that the NHS FT's activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all assets are managed as one central pool.

**Notes to the Accounts - 4 Operating Income**
**4 Operating Income**
**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 patient-related healthcare services. Income from non-patient-care services is classified as "Other operating income".

|   | 2012/13<br>Total | 2011/12<br>Total |
|---|------------------|------------------|
|   | £000             | £000             |
| <b>Income from Activities</b>   |                  |                  |
| Cost and Volume Contract income   | 10,178           | 1,993            |
| Block Contract income   | 174,554          | 183,987          |
| Clinical Partnerships providing mandatory services (including S31 agreements) | 2,943            | 907              |
| Other clinical income from mandatory services                                 | 2,968            | 14,217           |
| <b>Total Income from Activities</b>   | <b>190,643</b>   | <b>201,104</b>   |
| <b>Other operating income</b>   |                  |                  |
| Research and development  | 226              | 223              |
| Education and training  | 2,268            | 2,504            |
| Received from NHS charities   | 0                | 5                |
| Received from other bodies  | 2                | 0                |
| Non-patient care services to other bodies                                     | 1,179            | 1,355            |
| Other *   | 8,861            | 6,414            |
| Rental revenue from operating leases - minimum lease receipts                 | 13               | 8                |
| Rental revenue from operating leases - other                                  | 10               | 0                |
| Profit on disposal of land and buildings                                      | 0                | 63               |
| Reversal of impairments of property, plant and equipment                      | 413              | 0                |
| Income in respect of staff costs where accounted on gross basis               | 0                | 8                |
| <b>Total Other operating income</b>   | <b>12,972</b>    | <b>10,580</b>    |
| <b>Total Operating Income</b>   | <b>203,615</b>   | <b>211,684</b>   |

| <b>* Analysis of Other Income (above)</b>   | <b>2012/13<br/>Total</b> | <b>2011/12<br/>Total</b> |
|---|--------------------------|--------------------------|
|   | £000                     | £000                     |
| Staff accommodation rentals   | 22                       | 60                       |
| Catering  | 0                        | 1                        |
| Grossing up consortium arrangements   | 203                      | 523                      |
| Transformation Funding provided by commissioners  | 3,381                    | 4,832                    |
| Net surplus income arising from the settlement of pension provision liabilities held on behalf of other NHS bodies. | 3,529                    | 0                        |
| Other   | 1,726                    | 998                      |
| <b>Total</b>  | <b>8,861</b>             | <b>6,414</b>             |

**Notes to the Accounts - 4.2 Income from Activities (by source)**

**4.2 Income from Activities (by source)**

Income from Activities may also be analysed by the source of that Income.

|                                     | 2012/13<br>Total | 2011/12<br>Total |
|-------------------------------------|------------------|------------------|
|                                     | £000             | £000             |
| <b>Income from Activities</b>       |                  |                  |
| NHS Foundation Trusts               | 107              | 3                |
| NHS Trusts                          | 235              | 675              |
| Strategic Health Authorities        | 175              | 177              |
| Primary Care Trusts                 | 24,782           | 26,968           |
| Local Authorities                   | 165,259          | 173,147          |
| Bodies external to Government       | 85               | 134              |
| <b>Total Income from Activities</b> | <b>190,643</b>   | <b>201,104</b>   |

Income from Local Authorities includes income received from the joint commissioning arrangement between NHS Hertfordshire and Hertfordshire County Council

**4.3 Analysis between Mandatory and Non-Mandatory Operating Income**

Under the NHS FT's terms of authorisation, the NHS FT is required to provide mandatory health and social services. The allocation of income from activities between mandatory services and other services is shown below.

|   | 2012/13        | 2011/12        |
|---|----------------|----------------|
|   | £000           | £000           |
| Income from Activities - Mandatory Services     | 190,643        | 201,104        |
| Other operating income - Non-Mandatory Services | 12,972         | 10,580         |
|   | <b>203,615</b> | <b>211,684</b> |

**4.4 Private Patients Income Cap**

**This no longer applies**

The Private Patients Income Cap was set in accordance with section 44 of the NHS Act 2006 revised by the Health Act 2009. This prohibited Mental Health NHS Foundation Trusts exceeding a pre-determined Private Patient Income cap (PPI), which was the greater of:

- 1.5% of patient related income (mandatory income from activities), or
- the proportion of the total income derived from private patient charges in 2002/03 which was zero.

However an addendum supplemental to the Monitor Terms of Authorisation was issued effective from 1 October 2012 which removed the above requirement (formally Condition 10)

**Notes to the Accounts - 4.5 Operating Lease Income**

**4.5 Operating Lease Income**

The NHS FT leases one of its properties (31/33 Hill End Lane) in 2011/12 under a non-cancellable operating lease agreement.

The total income from this operating lease in 2012/13 is £23k including £13k minimum lease receipts.

The future aggregate minimum lease payments due to the NHS FT under non-cancellable operating leases are as follows:

|  | 2012/13<br>£000 | 2011/12<br>£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.                             | 44              | 57              |
|  | <u>109</u>      | <u>122</u>      |

**Notes to the Accounts - 5 Operating Expenses****5 Operating Expenses****5.1 Operating Expenses (by type)**

|   | 2012/13        | 2011/12        |
|---|----------------|----------------|
|   | £000           | £000           |
| Services from NHS Foundation Trusts                                       | 914            | 726            |
| Services from NHS Trusts  | 2,829          | 3,186          |
| Services from PCTs  | 2,239          | 2,010          |
| Purchase of healthcare from non NHS bodies                                | 10,664         | 11,454         |
| Employee Expenses - Executive directors                                   | 1,075          | 1,119          |
| Employee Expenses - Non-executive directors                               | 113            | 156            |
| Employee Expenses - Staff   | 122,360        | 133,852        |
| Supplies and services - clinical (excluding drug costs)                   | 378            | 376            |
| Supplies and services - general   | 5,042          | 5,282          |
| Establishment   | 4,767          | 3,923          |
| Transport   | 1,160          | 1,532          |
| Premises  | 4,456          | 4,733          |
| Increase/(decrease) in provision for impairment of receivables            | 109            | 108            |
| Inventories written down (net, including inventory drugs)                 | 1              | 0              |
| Drug costs (non inventory drugs only)                                     | 2,690          | 4,722          |
| Drugs Inventories consumed  | 170            | 0              |
| Rentals under operating leases - minimum lease payments                   | 1,953          | 2,191          |
| Depreciation on property, plant and equipment                             | 3,505          | 3,729          |
| Amortisation on intangible assets   | 111            | 107            |
| Impairments of property, plant and equipment                              | 2,443          | 1,412          |
| Audit fees  |                |                |
| - audit services- statutory audit   | 58             | 68             |
| - audit services -regulatory reporting                                    | 13             | 0              |
| - other auditor remuneration  | 0              | 23             |
| Clinical negligence   | 273            | 303            |
| Loss on disposal of land and buildings                                    | 0              | 5              |
| Loss on disposal of assets held for sale                                  | 0              | 53             |
| Legal fees  | 690            | 435            |
| Consultancy costs   | 721            | 567            |
| Training, courses and conferences   | 749            | 662            |
| Patient travel  | 37             | 73             |
| Car parking & Security  | 414            | 340            |
| Redundancy  | 3,848          | 3,238          |
| Early retirements   | 0              | 827            |
| Insurance   | 280            | 197            |
| Other services, eg external payroll                                       | 5,484          | 4,533          |
| Losses, ex gratia & special payments- (Not included in employee expenses) | 164            | 25             |
| Other   | 1,636          | 226            |
| Packages Of Social Care   | 14,671         | 14,183         |
| <b>Total Operating Expenses</b>   | <b>196,017</b> | <b>206,376</b> |

**Notes to the Accounts - 5.2 Limitation on Auditor's Liability**

**5.2 Limitation on Auditor's Liability**

The NHS FT's external auditor, Deloitte LLP, does not have a liability cap in relation to the annual statutory audit.

**5.3 Exit Packages**

There were 140 exit packages paid to individuals in 2012/13 totalling £4,501k. £3,116k of this amount was accrued for in 2011/12 (see note 5.1)

| Reporting of other compensation schemes - exit packages 2012/13 | Number of redundancies | Cost of redundancies | Total number of exit packages | Total cost of exit packages |
|---|------------------------|----------------------|-------------------------------|-----------------------------|
| Exit package cost band (including any special payment element)  |                        | £000s                |                               | £000s                       |
| <£10,000  | 34                     | 192                  | 34                            | 192                         |
| £10,001 - £25,000   | 46                     | 839                  | 46                            | 839                         |
| £25,001 - 50,000  | 33                     | 1,123                | 33                            | 1,123                       |
| £50,001 - £100,000  | 19                     | 1,329                | 19                            | 1,329                       |
| £100,001 - £150,000   | 7                      | 843                  | 7                             | 843                         |
| £150,001 - £200,000   | 1                      | 175                  | 1                             | 175                         |
| >£200,001   | 0                      | 0                    | 0                             | 0                           |
| <b>Total</b>  | <b>140</b>             | <b>4,501</b>         | <b>140</b>                    | <b>4,501</b>                |

There were two exit packages paid to individuals in 2011/12 totalling £122k.

| Reporting of other compensation schemes - exit packages 2011/12 | Number of redundancies | Cost of redundancies | Total number of exit packages | Total cost of exit packages |
|---|------------------------|----------------------|-------------------------------|-----------------------------|
| Exit package cost band (including any special payment element)  |                        | £000s                |                               | £000s                       |
| £25,001 - 50,000  | 1                      | 38                   | 1                             | 38                          |
| £50,001 - £100,000  | 1                      | 84                   | 1                             | 84                          |
| <b>Total</b>  | <b>2</b>               | <b>122</b>           | <b>2</b>                      | <b>122</b>                  |

Notes to the Accounts - 5.4 Salary and Pension Entitlements of Senior Managers

5.4 Salary and Pension Entitlements of Senior Managers

5.4.1 Remuneration

| Name and Title   | 2012/13                       |  | 2011/12                       |  |
|--|-------------------------------|--|-------------------------------|--|
|  | Salary (bands of £5,000) £000 | Other re-muneration (bands of £5,000)** £000 | Salary (bands of £5,000) £000 | Other re-muneration (bands of £5,000) £000 |
| Hattie Llewelyn-Davies (Chair)   | 50 - 55                       | 0  | 50 - 55                       | 0  |
| Bill Brown (Non Executive Director)  | 15 - 20                       | 0  | 15 - 20                       | 0  |
| Manjeet Gill (Non Executive Director)  | 15 - 20                       | 0  | 15 - 20                       | 0  |
| Carol Kennedy Filer (Non Executive Director)   | 15 - 20                       | 0  | 15 - 20                       | 0  |
| Colin Sheppard (Non Executive Director)  | 15 - 20                       | 0  | 15 - 20                       | 0  |
| Stephen Marsden (Non Executive Director)   | 15 - 20                       | 0  | 15 - 20                       | 0  |
| Ruth Sawtell (Non Executive Director) Left July 2012   | 5 - 10                        | 0  | 15 - 20                       | 0  |
| Christopher Lawrence (Non Executive Director) Appointed August 2012                              | 10 - 15                       | 0  | 15 - 20                       | 0  |
| Peter Baynham (Non Executive Director) Appointed August 2012                                     | 10 - 15                       | 0  |                               |  |
| Tom Cahill (Chief Executive)   | 160 - 165                     | 0  | 150 - 155                     | 0  |
| Iain Eaves (Executive Director of Strategy & Organisational Development)                         | 125 - 130                     | 0  | 125 - 130                     | 0  |
| Keith Loveman (Executive Director of Finance & Performance)                                      | 115 - 120                     | 0  | 110 - 115                     | 0  |
| Geraldine O'Sullivan (Executive Director Quality & Medical Leadership)                           | 145 - 150                     | 55 - 60                                      | 140 - 145                     | 50 - 55                                    |
| Karen Taylor (Chief Operating Officer) Appointed February 2012.                                  | 115 - 120                     | 0  | 10 - 15                       | 0  |
| Lisa Hunt (Chief Operating Officer) from March 2013  | 10 - 15                       | 0  |                               |  |
| Oliver Shanley (Executive Director of Quality & Safety)  | 120 - 125                     | 0  | 120 - 125                     | 0  |
| Stanley Riseborough (Executive Director of Service Delivery & Transformation) Retired March 2012 |                               |  | 120 - 125                     | 0  |
| Barbara Suggitt (Company Secretary)  | 85 - 90                       | 0  | 85 - 90                       | 0  |
| Harinder Kandola (Director of Human Resources and Workforce Development)                         | 110 - 115                     | 0  | 95 - 100                      | 0  |
| Maurice Burns (Director of Transformation) Appointed June 2012. Left February 2013               | 90 - 95                       | 0  |                               |  |
| Anni Hartley-Walder (Director of Transformation) Appointed October 2011. Left June 2012          | 20 - 25                       | 0  | 45 - 50                       | 0  |
| Band of highest paid director's total remuneration   | 160 - 165                     |  | 150 - 155                     |  |
| Median total remuneration  | £30,748                       |  | £28,527                       |  |
| Ratio  | 5.3                           |  | 5.3                           |  |

Senior Managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS FT\*. \* Benefits in kind represent the liability for tax payable by Executive Directors who are members of the NHS FT lease car scheme. Each Executive Director pays for their own private fuel consumption.

\*\* Other remuneration for Dr Geraldine O'Sullivan relate to payments for her Medical role

Signed



Mr. Tom Cahill, Chief Executive 28th May 2013

Notes to the Accounts - 5.4.2 Pension Benefits

5.4.2 Pension Benefits

| Name and Title       | Real increase in pension at age 60 (bands of £2,500) | Real increase in lump sum at age 60 (bands of £2,500) | Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) | Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) | Cash Equivalent Transfer value at 31 March 2013 | Cash Equivalent Transfer value at 31 March 2012 | Real increase in Cash Equivalent Transfer value |
|----------------------|--|---|--|--|---|---|---|
| Tom Cahill           | £000.<br>0 - 2.5                                     | £000<br>0 - 2.5                                       | £000<br>70 - 75  | £000<br>220 - 225  | £000<br>1,250                                   | £000<br>1,153                                   | £000<br>28                                      |
| Iain Eaves           | 0 - 2.5  | 0   | 0 - 5  | 0  | 41  | 22  | 12  |
| Keith Loveman        | 0 - 2.5  | 0 - 2.5   | 25 - 30  | 80 - 85  | 462   | 426   | 10  |
| Geraldine O'Sullivan | 2.5 - 5  | 10 - 12.5   | 60 - 65  | 180 - 185  | 1,230   | 1,073   | 72  |
| Stanley Riseborough  |  |   |  |  |   | 1,316   |   |
| Karen Taylor         | 0 - 2.5  | 0 - 2.5   | 20 - 25  | 60 - 65  | 268   | 250   | 4   |
| Oliver Shanley       | 0 - 2.5  | 5 - 7.5   | 45 - 50  | 140 - 145  | 810   | 721   | 36  |
| Barbara Suggitt      | 0 - 2.5  | 0 - 2.5   | 20 - 25  | 60 - 65  | 459   | 424   | 10  |
| Anni Hartley-Walder  | 0 - 2.5  | 0 - 2.5   | 0 - 5  | 0  | 33  | 11  | 2   |
| Harjinder Kandola    | 2.5 - 5  | 12.5 - 15   | 30 - 35  | 100 - 105  | 540   | 429   | 63  |

Non-Executive Directors do not receive pensionable remuneration.

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.

Signed



Mr. Tom Cahill, Chief Executive 28th May 2013



## Notes to the Accounts - 6 Commitments under Operating Leases

## 6 Commitments under Operating Leases

The NHS FT leases various premises and equipment under non-cancellable operating lease agreements. The leases have varying terms, escalation clauses and renewal rights.

**Analysis of operating lease expenditure 2012/13**

|                        | Total        | Land     | Buildings    | Plant & machinery | Other      |
|------------------------|--------------|----------|--------------|-------------------|------------|
|                        | £000         | £000     | £000         | £000              | £000       |
| Minimum lease payments | 1,953        | 0        | 1,761        | 0                 | 192        |
| <b>TOTAL</b>           | <b>1,953</b> | <b>0</b> | <b>1,761</b> | <b>0</b>          | <b>192</b> |

**Analysis of operating lease expenditure 2011/12**

|                        | Total        | Land     | Buildings    | Plant & machinery | Other      |
|------------------------|--------------|----------|--------------|-------------------|------------|
|                        | £000         | £000     | £000         | £000              | £000       |
| Minimum lease payments | 2,191        | 0        | 1,874        | 0                 | 317        |
| <b>TOTAL</b>           | <b>2,191</b> | <b>0</b> | <b>1,874</b> | <b>0</b>          | <b>317</b> |

The future aggregate minimum lease payments under non-cancellable operating leases are as follows:

**Arrangements containing an operating lease 2012/13**

|  | Total        | Land     | Buildings    | Plant & machinery | Other      |
|--|--------------|----------|--------------|-------------------|------------|
|  | £000         | £000     | £000         | £000              | £000       |
| Future minimum lease payments due:                   |              |          |              |                   |            |
| - not later than one year;                           | 1,079        | 0        | 867          | 0                 | 212        |
| - later than one year and not later than five years; | 998          | 0        | 650          | 0                 | 348        |
| - later than five years.                             | 67           | 0        | 67           | 0                 | 0          |
| <b>TOTAL</b>   | <b>2,144</b> | <b>0</b> | <b>1,584</b> | <b>0</b>          | <b>560</b> |

**Arrangements containing an operating lease 2011/12**

|  | Total        | Land     | Buildings    | Plant & machinery | Other      |
|--|--------------|----------|--------------|-------------------|------------|
|  | £000         | £000     | £000         | £000              | £000       |
| Future minimum lease payments due:                   |              |          |              |                   |            |
| - not later than one year;                           | 1,844        | 0        | 1,636        | 0                 | 208        |
| - later than one year and not later than five years; | 2,725        | 0        | 2,514        | 0                 | 211        |
| - later than five years.                             | 961          | 0        | 961          | 0                 | 0          |
| <b>TOTAL</b>   | <b>5,530</b> | <b>0</b> | <b>5,111</b> | <b>0</b>          | <b>419</b> |

**Notes to the Accounts - 7 Employee benefits**

**7 Employee benefits**

**7.1 The employee benefit expenses incurred during the year were as follows**

|  | 2012/13        | 2011/12        |
|--|----------------|----------------|
|  | £000           | £000           |
| Salaries and wages   | 98,571         | 105,304        |
| Social security costs  | 8,573          | 9,839          |
| Pension cost - defined contribution plans  |                |                |
| Employers contributions to NHS Pensions  | 11,683         | 13,437         |
| Pension cost - other contributions   | 191            | 383            |
| Termination benefits   | 3,848          | 122            |
| Agency/contract staff  | 4,417          | 6,487          |
| <b>Total gross employee benefits</b>   | <b>127,283</b> | <b>135,572</b> |
| less income in respect of Salaries and wages where netted off expenditure                        | 0              | (385)          |
| less income in respect of Social security costs where netted off expenditure                     | 0              | (34)           |
| less income in respect of Pension cost where netted off expenditure - defined contribution plans | 0              | (60)           |
| <b>Total net employee benefits</b>   | <b>127,283</b> | <b>135,093</b> |
| Analysed into Operating Expenditure in note 5.1  |                |                |
| Employee Expenses - Staff  | 122,360        | 133,852        |
| Employee Expenses - Executive directors  | 1,075          | 1,119          |
| Redundancy   | 3,848          | 122            |
| <b>Total Employee benefits excl. capitalised costs</b>   | <b>127,283</b> | <b>135,093</b> |

'Pension cost - other contributions' relate to Hertfordshire County Council's Local Government Pension Scheme. See Note 1.4.

As the Hertfordshire County Council's scheme is accounted for on a defined contributions basis, the following Local Government Pension Scheme figures are not included in these accounts but are disclosed

Based on IAS19, the Actuary has estimated for the Trust that, for the year ended 31 March 2013, the net pension liability is £1,709k (£795k net pension liability as at 31 March 2012). The amount chargeable to operating profit is £365k (£122k chargeable to operating profit as at 31 March 2012) and a loss of £895k (£1,995k loss as at 31 March 2012) recognisable in the Hertfordshire County Council Statement of Total Income and Expense.

Total employer pension contributions totalled £11,874k (£13,820k 2012/13)

**7.2 Number of employees**

The average number of employees during the year was as follows (expressed in full time equivalents)

|   | 2012/13      | 2011/12      |
|---|--------------|--------------|
|   | FTE's        | FTE's        |
| Medical and dental                            | 181          | 194          |
| Administration and estates                    | 545          | 613          |
| Healthcare assistants and other support staff | 610          | 694          |
| Nursing, midwifery and health visiting staff  | 835          | 921          |
| Scientific, therapeutic and technical staff   | 256          | 253          |
| Social care staff                             | 144          | 193          |
| Bank and agency staff                         | 473          | 515          |
| Other   | 8            | 7            |
| <b>Total</b>                                  | <b>3,052</b> | <b>3,390</b> |

**Notes to the Accounts - 7.3 Retirements due to ill-health**

**7.3 Retirements due to ill-health**

During 2012/13 there were 7 early retirements from the NHS FT on the grounds of ill-health with an estimated additional pension liability of £234k. In 2011/12 there were 9 early retirements on the grounds of ill-health with a liability of £605k. The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

**8 Better Payment Practice Code**

**8.1 Better Payment Practice Code**

The measure of compliance for 2012/13 has been analysed and can be found in the NHS FT's Annual Report .

**8.2 The Late Payment of Commercial Debts (Interest) Act 1998**

There are no amounts included within Finance Costs (note 9.2) arising from claims made under this legislation.

There is no compensation paid to cover debt recovery costs under this legislation.

**9 Finance Costs**

**9.1 Finance Income**

|                                      | 2012/13<br>£000 | 2011/12<br>£000 |
|--------------------------------------|-----------------|-----------------|
| Interest receivable on bank deposits | 318             | 258             |

**9.2 Finance Expenses**

|                                     | 2012/13<br>£000 | 2011/12<br>£000 |
|-------------------------------------|-----------------|-----------------|
| Finance leases                      | 70              | 80              |
| Unwinding of discount on provisions | 118             | 393             |
| <b>Total</b>                        | <b>188</b>      | <b>473</b>      |

Notes to the Accounts - 10 Intangible Assets

10 Intangible Assets

|  | 2012/13<br>Software<br>licences<br>£000 | 2011/12<br>Software<br>licences<br>£000 |
|--|---|---|
| Opening cost at 1 April  | 533                                     | 533                                     |
| Additions - purchased  | 125                                     | 0                                       |
| <b>Gross cost at 31 March</b>                                  | <b>658</b>                              | <b>533</b>                              |
| Opening amortisation at 1 April                                | 375                                     | 268                                     |
| Provided during the year                                       | 111                                     | 107                                     |
| <b>Amortisation at 31 March</b>                                | <b>486</b>                              | <b>375</b>                              |
| <u>Net book value</u>  |   |   |
| Purchased at 31 March (opening cost less opening amortisation) | 158                                     | 265                                     |
| <b>Purchased at 31 March (gross cost less amortisation)</b>    | <b>172</b>                              | <b>158</b>                              |

The economic life of these assets varies between 1 and 4 years.

There is expenditure to date of £114k on the development of a new Electronic Patient Record system (PARIS) which is currently included as 'Additions' to Assets Under Construction (see note 11). This expenditure will be capitalised as an intangible asset when the asset is commissioned.

Notes to the Accounts - 11 Property, Plant and Equipment as at 31 March 2013

11

Property, Plant and Equipment

| 11.1 Balances as at 31 March 2013                                    | 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 2012                                 | 170,334        | 60,079        | 98,297                        | 1,167      | 2,742                     | 1,308             | 4,778                  | 1,963                |
| Additions - purchased  | 10,343         | 0             | 286                           | 0          | 9,382                     | 178               | 209                    | 288                  |
| Impairments  | (2,067)        | (510)         | (1,550)                       | (7)        | 0                         | 0                 | 0                      | 0                    |
| Reclassifications  | 0              | 0             | 8                             | 0          | (8)                       | 0                 | 0                      | 0                    |
| Revaluations   | 2,952          | 20            | 2,864                         | 68         | 0                         | 0                 | 0                      | 0                    |
| Transfers to/from assets held for sale and assets in disposal groups | (1,871)        | (395)         | (635)                         | (841)      | 0                         | 0                 | 0                      | 0                    |
| Disposals  | (4,612)        | 0             | (579)                         | 0          | 0                         | (181)             | (2,975)                | (877)                |
| <b>Valuation/Gross cost at 31 March 2013</b>                         | <b>175,079</b> | <b>59,194</b> | <b>98,691</b>                 | <b>387</b> | <b>12,116</b>             | <b>1,305</b>      | <b>2,012</b>           | <b>1,374</b>         |
| Accumulated depreciation & impairments at 1 April 2012               | 34,180         | 2,848         | 25,033                        | 148        | 197                       | 824               | 3,751                  | 1,379                |
| Provided during the year   | 3,505          | 0             | 2,831                         | 28         | 0                         | 124               | 395                    | 127                  |
| Impairments  | 2,443          | 1,505         | 728                           | 0          | 210                       | 0                 | 0                      | 0                    |
| Reversal of impairments  | (413)          | 0             | (413)                         | 0          | 0                         | 0                 | 0                      | 0                    |
| Transfers to/from assets held for sale and assets in disposal groups | (249)          | 0             | (129)                         | (120)      | 0                         | 0                 | 0                      | 0                    |
| Disposals  | (4,612)        | 0             | (579)                         | 0          | 0                         | (181)             | (2,975)                | (877)                |
| <b>Accumulated depreciation at 31 March 2013</b>                     | <b>34,854</b>  | <b>4,353</b>  | <b>27,471</b>                 | <b>56</b>  | <b>407</b>                | <b>767</b>        | <b>1,171</b>           | <b>629</b>           |
| <b>Net book value at 31 March 2013</b>                               | <b>139,783</b> | <b>54,841</b> | <b>70,778</b>                 | <b>331</b> | <b>11,709</b>             | <b>538</b>        | <b>841</b>             | <b>745</b>           |
| Owned  | 442            | 0             | 442                           | 0          | 0                         | 0                 | 0                      | 0                    |
| Finance Leased   | 0              | 0             | 0                             | 0          | 0                         | 0                 | 0                      | 0                    |
| Donated  | 0              | 0             | 0                             | 0          | 0                         | 0                 | 0                      | 0                    |
| <b>NBV total at 31 March 2013</b>                                    | <b>140,225</b> | <b>54,841</b> | <b>71,220</b>                 | <b>331</b> | <b>11,709</b>             | <b>538</b>        | <b>841</b>             | <b>745</b>           |
| Net Book Value - Protected assets                                    | 118,696        | 51,961        | 66,735                        | 0          | 0                         | 0                 | 0                      | 0                    |
| Net Book Value - Unprotected assets                                  | 21,529         | 2,880         | 4,485                         | 331        | 11,709                    | 538               | 841                    | 745                  |
| <b>Total at 31 March 2013</b>  | <b>140,225</b> | <b>54,841</b> | <b>71,220</b>                 | <b>331</b> | <b>11,709</b>             | <b>538</b>        | <b>841</b>             | <b>745</b>           |

Included within the 'additions - purchased' are the following items categorised as Assets Under Construction:

- Kingsley Green development £5,426k
- Poplars, Norfolk development £3,590k

The disposal values above are assets that are fully depreciated and have no further material value to the NHS FT

Notes to the Accounts - Property, Plant and Equipment as at 31 March 2013

Property, Plant and Equipment

|  | Total           | Land           | Buildings excluding dwellings | Dwellings     | Assets Under Construction | Plant & machinery | Information Technology | Furniture & fittings |
|--|-----------------|----------------|-------------------------------|---------------|---------------------------|-------------------|------------------------|----------------------|
| Valuation/Gross cost at 1 April 2012                   | £000<br>168,049 | £000<br>60,289 | £000<br>97,682                | £000<br>1,164 | £000<br>1,695             | £000<br>1,168     | £000<br>4,153          | £000<br>1,898        |
| Additions - purchased                                  | 5,053           | 0              | 2,215                         | 3             | 2,041                     | 104               | 625                    | 65                   |
| Impairments  | (2,426)         | 0              | (2,426)                       | 0             | 0                         | 0                 | 0                      | 0                    |
| Reclassifications                                      | 0               | 0              | 958                           | 0             | (994)                     | 36                | 0                      | 0                    |
| Revaluations   | 370             | 0              | 370                           | 0             | 0                         | 0                 | 0                      | 0                    |
| Disposals  | (712)           | (210)          | (502)                         | 0             | 0                         | 0                 | 0                      | 0                    |
| <b>Valuation/Gross cost at 31 March 2012</b>           | <b>170,334</b>  | <b>60,079</b>  | <b>98,297</b>                 | <b>1,167</b>  | <b>2,742</b>              | <b>1,308</b>      | <b>4,778</b>           | <b>1,963</b>         |
| Accumulated depreciation & impairments at 1 April 2011 | 29,098          | 2,848          | 20,782                        | 113           | 0                         | 712               | 3,371                  | 1,272                |
| Provided during the year                               | 3,729           | 0              | 3,095                         | 35            | 0                         | 112               | 380                    | 107                  |
| Impairments  | 1,412           | 0              | 1,215                         | 0             | 197                       | 0                 | 0                      | 0                    |
| Disposals  | (59)            | 0              | (59)                          | 0             | 0                         | 0                 | 0                      | 0                    |
| <b>Accumulated depreciation at 31 March 2012</b>       | <b>34,180</b>   | <b>2,848</b>   | <b>25,033</b>                 | <b>148</b>    | <b>197</b>                | <b>824</b>        | <b>3,751</b>           | <b>1,379</b>         |
| <b>Net book value - 31 March 2012 (restated)</b>       | <b>135,267</b>  | <b>57,231</b>  | <b>72,409</b>                 | <b>1,019</b>  | <b>2,545</b>              | <b>484</b>        | <b>1,027</b>           | <b>552</b>           |
| Owned  | 504             | 0              | 504                           | 0             | 0                         | 0                 | 0                      | 0                    |
| Finance Leased   | 383             | 0              | 351                           | 0             | 0                         | 0                 | 0                      | 32                   |
| <b>NBV total at 31 March 2012 (restated)</b>           | <b>136,154</b>  | <b>57,231</b>  | <b>73,264</b>                 | <b>1,019</b>  | <b>2,545</b>              | <b>484</b>        | <b>1,027</b>           | <b>584</b>           |
| Net Book Value - Protected assets                      | 122,507         | 54,351         | 68,156                        | 0             | 0                         | 0                 | 0                      | 0                    |
| Net Book Value - Unprotected assets                    | 13,647          | 2,880          | 5,108                         | 1,019         | 2,545                     | 484               | 1,027                  | 584                  |
| <b>Total at 31 March 2012</b>                          | <b>136,154</b>  | <b>57,231</b>  | <b>73,264</b>                 | <b>1,019</b>  | <b>2,545</b>              | <b>484</b>        | <b>1,027</b>           | <b>584</b>           |

Notes to the Accounts - 11.3 Disposal Of Property, Plant and Equipment

11.3 Disposal Of Property, Plant and Equipment

|  | 2012/13<br>£000 | 2011/12<br>£000 |
|--|-----------------|-----------------|
| Profit on disposal of land and buildings   | 0               | 63              |
| <b>Total profit/gain on disposal recorded in the Statement of Comprehensive Income</b> | <b>0</b>        | <b>63</b>       |

|  | 2012/13<br>£000 | 2011/12<br>£000 |
|--|-----------------|-----------------|
| Loss on disposal of land and buildings   | 0               | 5               |
| Loss on disposal of assets held for sale                                       | 0               | 53              |
| <b>Total loss on disposal charged to the Statement of Comprehensive Income</b> | <b>0</b>        | <b>58</b>       |

12 Assets held under Finance Leases

|   | 2012/13<br>£000     | 2011/12<br>£000     |
|---|---------------------|---------------------|
| Opening cost at 1 April                     | <u>2,125</u>        | <u>2,125</u>        |
| Accumulated depreciation at 1 April         | 1,620               | 1,551               |
| Provided during the year                    | <u>63</u>           | <u>69</u>           |
| <b>Accumulated depreciation at 31 March</b> | <b><u>1,683</u></b> | <b><u>1,620</u></b> |
| <u>Net book value</u>                       |                     |                     |
| NBV total at 1 April                        | <u>505</u>          | <u>574</u>          |
| <b>NBV total at 31 March</b>                | <b><u>442</u></b>   | <b><u>505</u></b>   |

The NHS FT leases two premises under non-cancellable finance lease agreements. The leases have varying terms, escalation clauses and renewal rights. These premises are: Edinburgh House and 32 St. Peter's Street, both situated in St. Albans.

**Notes to the Accounts - 13 Impairment of Assets (Property, Plant & Equipment and Intangibles)****13 Impairment of Assets (Property, Plant & Equipment and Intangibles)**

|   | 2012/13<br>£000 | 2011/12<br>£000 |
|---|-----------------|-----------------|
| Impairments of property, plant and equipment  | 2,443           | 1,412           |
| Reversal of prior year impairments of property, plant and equipment                                   | (413)           | 0               |
| <b>Total impairments and reversal of impairments charged to the Statement of Comprehensive Income</b> | <b>2,030</b>    | <b>1,412</b>    |

|  |              |              |
|--|--------------|--------------|
| Impairments of property, plant and equipment               | 2,067        | 2,426        |
| <b>Total impairment charged to the Revaluation Reserve</b> | <b>2,067</b> | <b>2,426</b> |

The impairment adjustments for 2012/13 follow a full revaluation conducted by the District Valuer. The total net impairment was £4,097k of which £2,067k was offset against previous upward revaluations on those assets. The net impairment charged to the Statement of Comprehensive Income is £2,030k.

**14 Inventories**

|  | 2012/13<br>£000 | 2012/13<br>£000 |
|--|-----------------|-----------------|
| Carrying Value at 1 April                            | 15              | 13              |
| Additions  | 168             | 235             |
| Inventories recognised in expenses                   | (170)           | (232)           |
| Write-down of inventories recognised as an expense** | (1)             | (1)             |
| <b>Carrying Value at 31 March 2013</b>               | <b>12</b>       | <b>15</b>       |

The expense included in the Statement of Comprehensive Income for stock write off in 2012/13 is negligible.

**15 Assets Held For Sale**

|   | 31 March 2013<br>£000 | 31 March 2012<br>£000 |
|---|-----------------------|-----------------------|
| Net Book Value of assets held for sale at 1 April         | 0                     | 0                     |
| Plus assets classified as available for sale in the year  | 1,622                 | 0                     |
| Less assets sold in year                                  | 0                     | 0                     |
| <b>Net Book Value of assets held for sale at 31 March</b> | <b>1,622</b>          | <b>0</b>              |

The Assets Held For Sale as at 31 March 2013 comprise:  
1 Christchurch Road, Hemel Hempstead; 75 Hill End Lane, St Albans; 4 Beaumont House, Welwyn Garden City; 12 Lady's Close, Watford; 2 Harris House, Watford, and ; 47 Brookfield House, Hemel Hempstead.



**Notes to the Accounts - 16 Trade Receivables and other Receivables****16 Trade Receivables and other Receivables****16.1 Trade Receivables and other Receivables**

|  | 31 Mar 2013  | 31 Mar 2012  |
|--|--------------|--------------|
|  | £000         | £000         |
| <b>Current</b>                                       |              |              |
| NHS Receivables - Revenue                            | 1,577        | 1,207        |
| Other receivables with related parties - Revenue     | 1,318        | 3,185        |
| Provision for impaired receivables                   | (490)        | (450)        |
| Prepayments (Non-PFI)                                | 622          | 783          |
| Accrued income                                       | 3,049        | 3,255        |
| PDC dividend receivable                              | 0            | 152          |
| VAT receivable                                       | 149          | 262          |
| Other receivables - Revenue                          | 208          | 176          |
| <b>Total current trade and other receivables</b>     | <b>6,433</b> | <b>8,570</b> |
| <b>Non-Current</b>                                   |              |              |
| NHS Receivables - Revenue                            | 0            | 7,971        |
| Other receivables - Revenue                          | 13           | 13           |
| <b>Total non-current trade and other receivables</b> | <b>13</b>    | <b>7,984</b> |

At March 31st 2012 NHS Receivables included £8,317k relating to back to back pension provisions with other NHS bodies. These amounts have been settled in full during the current year.

**16.2 Provision for irrecoverable debts**

|                            | 2012/13    | 2011/12    |
|----------------------------|------------|------------|
|                            | £000       | £000       |
| At 1 April                 | 450        | 344        |
| Increase in provision      | 117        | 269        |
| Amounts utilised           | (69)       | (2)        |
| Unused amounts reversed    | (8)        | (161)      |
| <b>Balance at 31 March</b> | <b>490</b> | <b>450</b> |

**16.3 Analysis of impaired debts and non-impaired debts past their due date**

|   | 31 March 2013 | 31 March 2012 |
|---|---------------|---------------|
|   | £000          | £000          |
| <u>Ageing of impaired receivables</u>                         |               |               |
| Up to 30 days   | 62            | 5             |
| Between 30 and 60 days  | 3             | 11            |
| Between 60 and 90 days  | 27            | 2             |
| Between 90 and 180 days                                       | 13            | 82            |
| Over 180 days   | 385           | 350           |
| <b>Total</b>  | <b>490</b>    | <b>450</b>    |
| <u>Ageing of non-impaired receivables past their due date</u> |               |               |
| Overdue by up to 30 days                                      | 396           | 255           |
| Overdue between 30 and 60 days                                | (254)         | 37            |
| Overdue between 60 and 90 days                                | 118           | 44            |
| Overdue between 90 and 180 days                               | 82            | 70            |
| Overdue over 180 days   | 175           | 77            |
| <b>Total</b>  | <b>517</b>    | <b>483</b>    |

Notes to the Accounts - 17 Cash and cash equivalents

17 Cash and cash equivalents

|  | 2012/13<br>£000 | 2011/12<br>£000 |
|--|-----------------|-----------------|
| Cash and Cash equivalents at 1 April         | 41,307          | 38,669          |
| Net change in cash and cash equivalents      | 1,702           | 2,638           |
| <b>Cash and Cash equivalents at 31 March</b> | <b>43,009</b>   | <b>41,307</b>   |
| Comprising:                                  |                 |                 |
| Cash at commercial banks and in hand         | 34              | 16              |
| Cash with the Government Banking Service*    | 42,975          | 41,291          |
|  | <b>43,009</b>   | <b>41,307</b>   |

\*Royal Bank of Scotland and Citibank are collectively known as the Government Banking Service.

18 Public Dividend Capital

|                                      | 2012/13<br>£000 | 2011/12<br>£000 |
|--------------------------------------|-----------------|-----------------|
| Taxpayers' Equity at 1 April         | 83,260          | 83,260          |
| Public Dividend Capital received     | 71              | 0               |
| <b>Taxpayers' Equity at 31 March</b> | <b>83,331</b>   | <b>83,260</b>   |

The Public Dividend Capital received in 2012/13 is from the Department of Health for the purchase of computer equipment.

19 Finance Lease Obligations

|   | 31 March 2013<br>£000 | 31 March 2012<br>£000 |
|---|-----------------------|-----------------------|
| Payable:  |                       |                       |
| - not later than one year;  | 156                   | 156                   |
| - later than one year and not later than five years;                                  | 623                   | 623                   |
| - later than five years.  | 200                   | 355                   |
| <b>Gross lease liabilities</b>  | <b>979</b>            | <b>1,134</b>          |
| Less: Finance charges allocated to future periods                                     | (255)                 | (324)                 |
| <b>Net lease liabilities</b>  | <b>724</b>            | <b>810</b>            |
| Split into current and non-current borrowings on the Statement Of Financial Position: |                       |                       |
| - current   | 96                    | 87                    |
| - non current   | 628                   | 723                   |
|   | <b>724</b>            | <b>810</b>            |
| Expected timing of cashflows:   |                       |                       |
| - not later than one year;  | 96                    | 87                    |
| - later than one year and not later than five years;                                  | 482                   | 442                   |
| - later than five years.  | 146                   | 281                   |
|   | <b>724</b>            | <b>810</b>            |

Details of Finance Leases are included in note 12.

**Notes to the Accounts - 20 Provisions for liabilities and charges (held in current and non-current liabilities)**

**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) 2012/13**

| 2012/13  | Total         | Pensions relating to other staff | Other legal claims | Pay claims   | Continuing care | Redundancy   | Injury Claims |
|--|---------------|----------------------------------|--------------------|--------------|-----------------|--------------|---------------|
|  | £000          | £000                             | £000               | £000         | £000            | £000         | £000          |
| At 1 April 2012                                      | 21,769        | 13,909                           | 212                | 2,528        | 1,635           | 3,092        | 393           |
| Arising during the year                              | 4,710         | 0                                | 112                | 136          | 427             | 2,123        | 1,912         |
| Utilised during the year - accruals                  | (87)          | (54)                             | (9)                | 0            | (19)            | 0            | (5)           |
| Utilised during the year - cash                      | (13,489)      | (9,644)                          | 0                  | (196)        | (543)           | (3,092)      | (14)          |
| Reversed unused                                      | (2,511)       | (1,457)                          | (87)               | (462)        | (500)           | 0            | (5)           |
| Unwinding of discount                                | 118           | 65                               | 0                  | 0            | 0               | 0            | 53            |
| <b>Total at 31 March 2013</b>                        | <b>10,510</b> | <b>2,819</b>                     | <b>228</b>         | <b>2,006</b> | <b>1,000</b>    | <b>2,123</b> | <b>2,334</b>  |
| Expected timing of cashflows:                        |               |                                  |                    |              |                 |              |               |
| - not later than one year;                           | 3,809         | 219                              | 228                | 136          | 1,000           | 2,123        | 103           |
| - later than one year and not later than five years; | 3,158         | 874                              | 0                  | 1,870        | 0               | 0            | 414           |
| - later than five years.                             | 3,543         | 1,726                            | 0                  | 0            | 0               | 0            | 1,817         |
| <b>Total</b>   | <b>10,510</b> | <b>2,819</b>                     | <b>228</b>         | <b>2,006</b> | <b>1,000</b>    | <b>2,123</b> | <b>2,334</b>  |

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 Hill End, Leavesden, Cell Barnes and Harperbury Hospitals. During 2012/13 a number of these liabilities were settled by payment of the full liability to the Pensions Agency in accordance with settlement values provided.

The 'Other legal claims' provision includes provisions in respect of the NHS FT's employer and public liabilities, the amount stated is subject to uncertainty about the outcome of legal proceedings. £5,665k (£3,032k as at 31 March 2012) is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the NHS FT.

The 'Pay claims' provision is the estimated liability for outstanding pay claims backdated to 1st October 2004 made under the current NHS pay conditions.

The 'Continuing Care' provision comprises the potential liability for claims for the reimbursement of the costs of Continuing Care where the claimant considers this should have been met by the NHS FT.

The 'Redundancy' provision is the estimated liability for the costs directly related to the formal restructuring plan presented and approved by the March 2013 Board.

The 'Injury Claims' 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. The increase in the Provision was due to new claims received in 2012/13.

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.

Notes to the Accounts - 20.2 Provisions for liabilities and charges (held in current and non-current liabilities) 2011/12

20.2 Provisions for liabilities and charges (held in current and non-current liabilities) 2011/12

| 2011/12  | Total         | Pensions relating to other staff | Legal and other claims | Pay claims   | Continuing Care | Redundancy   | Injury Claims |
|--|---------------|----------------------------------|------------------------|--------------|-----------------|--------------|---------------|
|  | £000          | £000                             | £000                   | £000         | £001            | £000         | £000          |
| At 1 April 2011                                      | 21,517        | 16,723                           | 90                     | 2,334        | 1,635           | 0            | 735           |
| Arising during the year                              | 5,306         | 935                              | 178                    | 421          | 671             | 3,092        | 9             |
| Utilised during the year                             | (4,091)       | (3,967)                          | (21)                   | (20)         | (46)            | 0            | (37)          |
| Reversed unused                                      | (1,356)       | (164)                            | (35)                   | (207)        | (625)           | 0            | (325)         |
| Unwinding of discount                                | 393           | 382                              | 0                      | 0            | 0               | 0            | 11            |
| <b>Total at 31 March 2012</b>                        | <b>21,769</b> | <b>13,909</b>                    | <b>212</b>             | <b>2,528</b> | <b>1,635</b>    | <b>3,092</b> | <b>393</b>    |
| Expected timing of cashflows:                        |               |                                  |                        |              |                 |              |               |
| - not later than one year:                           | 5,123         | 716                              | 212                    | 421          | 664             | 3,092        | 18            |
| - later than one year and not later than five years: | 5,948         | 2,863                            | 0                      | 2,107        | 971             | 0            | 7             |
| - later than five years:                             | 10,698        | 10,330                           | 0                      | 0            | 0               | 0            | 368           |
| <b>Total</b>   | <b>21,769</b> | <b>13,909</b>                    | <b>212</b>             | <b>2,528</b> | <b>1,635</b>    | <b>3,092</b> | <b>393</b>    |

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 Hill End, Leavesden, Cell Barnes and Harperbury Hospitals.

The 'Pensions relating to other staff' and 'Injury claims' provisions together total £14,302k of these £8,317k was subject to 'Back to Back' agreements. These back to back agreements were settled in full during 2012/13.

The 'Other legal claims' provision includes provisions in respect of the NHS FT's employer and public liabilities, the amount stated is subject to uncertainty about the outcome of legal proceedings. £5,665k (£3,032k as at 31 March 2012) is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the NHS FT.

The 'Pay claims' provision is the estimated liability for outstanding pay claims backdated to 1st October 2004 made under the current NHS pay conditions.

The 'Continuing Care' provision comprises the potential liability for claims for the reimbursement of the costs of Continuing Care where the claimant claims this should have been met by the NHS FT.

The 'Redundancy' provision is the estimated liability for the costs directly related to the formal restructuring plan presented and approved by the Board.

The 'Injury Claims' 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.

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.

Notes to the Accounts - 21 Trade and other payables

21 Trade and other payables

|  | 31 March<br>2013<br>£000 | 31 March<br>2012<br>£000 |
|--|--------------------------|--------------------------|
| <b>Current</b>                                 |                          |                          |
| Receipts in advance                            | 0                        | 631                      |
| NHS payables - revenue                         | 1,131                    | 2,051                    |
| Amounts due to other related parties - revenue | 1,646                    | 1,921                    |
| Other trade payables - capital                 | 2,438                    | 641                      |
| Other trade payables - revenue                 | 759                      | 3,293                    |
| Social Security costs                          | 1,223                    | 1,338                    |
| Other taxes payable                            | 1,367                    | 1,486                    |
| Other payables                                 | 230                      | 0                        |
| Accruals                                       | 8,993                    | 8,370                    |
| PDC dividend payable                           | 31                       | 0                        |
| <b>Non-current</b>                             | 0                        | 0                        |
| <b>Total Trade and other payables</b>          | <b>17,818</b>            | <b>19,731</b>            |

22 Other liabilities

|                                | 31 March<br>2013<br>£000 | 31 March<br>2012<br>£000 |
|--------------------------------|--------------------------|--------------------------|
| <b>Current</b>                 |                          |                          |
| Other deferred income          | 8,171                    | 2,468                    |
| <b>Non-current</b>             | 0                        | 0                        |
| <b>Total Other liabilities</b> | <b>8,171</b>             | <b>2,468</b>             |

Other Liabilities is 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

To aid comparison between years the 31 March 2012 balances of 'Other trade payables - revenue' and 'Receipts in advance' in Trade and other Payables and 'Other deferred income' in Other Liabilities have been re-classified as follows:

- Increase to 'Other deferred income' £2,468k
- Decrease to 'Other trade payables - revenue' £2,200k
- Decrease to 'Receipts in advance' £268k

**Notes to the Accounts - 23 Financial assets and liabilities**

**23 Financial assets and liabilities**

**23.1 Financial assets by category**

|   | 31 March<br>2013<br>£000 | 31 March<br>2012<br>£000 |
|---|--------------------------|--------------------------|
| NHS Receivables   | 1,577                    | 1,207                    |
| Other Receivables   | 1,675                    | 3,166                    |
| Other Financial Assets                                      | 3,050                    | 3,394                    |
| Non Current Assets Held for Sale                            | 1,621                    | 0                        |
| Cash and cash equivalents (at bank and in hand) at 31 March | 43,009                   | 41,307                   |
| <b>Total at 31 March</b>                                    | <b>50,932</b>            | <b>49,074</b>            |

**23.2 Financial liabilities by category**

|                                  | 31 March<br>2013<br>£000 | 31 March<br>2012<br>£000 |
|----------------------------------|--------------------------|--------------------------|
| Obligations under finance leases | 724                      | 810                      |
| NHS Payables                     | 1,131                    | 2,027                    |
| Trade and Other Payables         | 7,695                    | 10,879                   |
| Other Financial Liabilities      | 8,993                    | 8,394                    |
| Provisions under contract        | 9,510                    | 20,133                   |
| <b>Total at 31 March</b>         | <b>28,053</b>            | <b>42,243</b>            |

**23.3 Fair value of non-current financial assets**

|   | Book value<br>£000 | Fair value<br>£000 |
|---|--------------------|--------------------|
| Non Current Trade and Other Receivables | 13                 | 13                 |
| <b>Total at 31 March 2013</b>           | <b>13</b>          | <b>13</b>          |

**23.4 Fair value of non-current financial liabilities**

|                               | Book value<br>£000 | Fair value<br>£000 |
|-------------------------------|--------------------|--------------------|
| Provisions Under Contract     | 6,701              | 6,701              |
| Other (Finance Leases)        | 568                | 568                |
| <b>Total at 31 March 2013</b> | <b>7,269</b>       | <b>7,269</b>       |

## Notes to the Accounts - 24 Reconciliation of operating surplus to net cash flow from operating activities

## 24 Reconciliation of operating surplus to net cash flow from operating activities

|  | 2012/13 |               | 2011/12 |               |
|--|---------|---------------|---------|---------------|
|  | £000    | £000          | £000    | £000          |
| <b>Operating Surplus</b>                           |         | 7,598         |         | 5,308         |
| <b>Non cash flow movements:</b>                    |         |               |         |               |
| Depreciation and amortisation                      | 3,616   |               | 3,836   |               |
| Impairments  | 2,443   |               | 1,412   |               |
| Reversals of impairments                           | (413)   |               | 0       |               |
| Unwinding of discount on provisions                | (118)   |               | (392)   |               |
|  |         | 5,528         |         | 4,856         |
| <b>Movement in Working Capital:</b>                |         |               |         |               |
| (Increase)/Decrease in Trade and Other Receivables | 9,956   |               | (893)   |               |
| (Increase)/Decrease in Inventories                 | 3       |               | (2)     |               |
| Increase/(Decrease) in Trade and Other Payables    | (3,741) |               | 547     |               |
| Increase/(Decrease) in Other Liabilities           | 5,703   |               | 0       |               |
|  |         | 11,921        |         | (348)         |
| Increase / (Decrease) in provisions                |         | (11,259)      |         | 252           |
| Net (gain) / loss on disposal of assets            |         | 0             |         | (5)           |
|  |         |               |         |               |
| <b>Net cash inflow from operating activities</b>   |         | <b>13,788</b> |         | <b>10,063</b> |

**Notes to the Accounts - 25 Related Party Transactions****25 Related Party Transactions****25.1 Related Party Transactions 2012/13**

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 NHS FT.

Remuneration of key management is disclosed in note 5.4.1

Board members, Governors and other key management staff take decisions on Charity and Exchequer matters but endeavour to keep the interests of each discreet and do not seek to benefit personally from such decisions. Declarations of personal interest have been made and are available for inspection.

| <b>2012/13</b>                             | Income from<br>Related Party | Expenditure<br>payments to<br>Related Party | Receivables<br>from Related<br>Party | Payables to<br>Related Party |
|--|------------------------------|---|--------------------------------------|------------------------------|
|  | £000                         | £000  | £000                                 | £000                         |
| <b><u>Central Government</u></b>           |                              |   |                                      |                              |
| National Health Service Pension Scheme     | 0                            | 11,683                                      | 0                                    | 1,524                        |
| National Insurance Fund                    | 0                            | 8,573                                       | 0                                    | 1,223                        |
| HMRC - other taxes & duties                | 103                          | 0   | 0                                    | 1,353                        |
| Other Central Government                   | 0                            | 344   | 208                                  | 14                           |
| <b><u>NHS</u></b>                          |                              |   |                                      |                              |
| Department Of Health                       | 118                          | 294   | 79                                   | 232                          |
| Other NHS                                  | 0                            | 484   | 0                                    | 0                            |
| <b><u>Strategic Health Authorities</u></b> |                              |   |                                      |                              |
| East of England Strategic Health Authority | 2,673                        | 17  | 113                                  | 503                          |
| Other Strategic Health Authorities         | 277                          | 4   | 0                                    | 6                            |
| <b><u>Foundation Trusts</u></b>            |                              |   |                                      |                              |
| Other Foundation Trusts                    | 111                          | 1,144                                       | 2                                    | 314                          |
| <b><u>NHS Trusts</u></b>                   |                              |   |                                      |                              |
| East & North Hertfordshire NHS Trust       | 65                           | 2,365                                       | 4                                    | 49                           |
| Hertfordshire Community NHS Trust          | 163                          | (27)  | 89                                   | 18                           |
| West Hertfordshire Hospitals NHS Trust     | 1,162                        | 1,476                                       | 154                                  | 150                          |
| Other NHS Trusts                           | 187                          | 329   | 62                                   | 24                           |
| <b><u>Primary Care Trusts</u></b>          |                              |   |                                      |                              |
| NHS Barnet                                 | 499                          | 52  | 26                                   | 0                            |
| NHS Brent                                  | 893                          | 0   | 3                                    | 0                            |
| NHS Ealing                                 | 1,263                        | 0   | (2)                                  | 0                            |
| NHS Hampshire                              | 786                          | 0   | 7                                    | 0                            |
| NHS Harrow                                 | 537                          | 0   | (32)                                 | 0                            |
| NHS Hertfordshire                          | 1,216                        | 2,216                                       | 3,943                                | 4,628                        |
| NHS Hillingdon                             | 423                          | 0   | 0                                    | 0                            |
| NHS Hounslow                               | 840                          | 0   | 4                                    | 0                            |
| NHS Norfolk                                | 2,044                        | 16  | 14                                   | 0                            |
| NHS North East Essex                       | 13                           | 821   | 0                                    | 121                          |
| NHS South East Essex                       | 6,418                        | 535   | (65)                                 | 582                          |
| NHS West Essex                             | 10,031                       | 36  | 87                                   | 193                          |
| NHS Westminster                            | 528                          | 0   | 0                                    | 0                            |
| Other Primary Care Trusts                  | 3,424                        | 0   | 149                                  | 0                            |
| <b><u>Local Government</u></b>             |                              |   |                                      |                              |
| Hertfordshire County Council               | 162,812                      | 1,401                                       | 639                                  | 3,449                        |
| Other Local Government                     | 4,214                        | 1,241                                       | 578                                  | 260                          |
| <b>Totals</b>                              | <b>200,800</b>               | <b>33,004</b>                               | <b>6,063</b>                         | <b>14,643</b>                |

The NHS FT has also received revenue payments from charitable funds, of which the Corporate Trustees are also members of the Trust Board. These transactions are not included in the Financial Statements of the Trust (see Note 1.21).



## Notes to the Accounts - 25.2 Related Party Transactions 2011/12

## 25.2 Related Party Transactions 2011/12

| 2011/12                                    | Income from<br>Related Party | Expenditure<br>payments to<br>Related Party | Receivables<br>from Related<br>Party | Payables to<br>Related Party |
|--|------------------------------|---|--------------------------------------|------------------------------|
|  | £000                         | £000  | £000                                 | £000                         |
| <b>Central Government</b>                  |                              |   |                                      |                              |
| National Health Service Pension Scheme     | 0                            | 0   | 0                                    | 1,795                        |
| National Insurance Fund                    | 0                            | 0   | 0                                    | 1,337                        |
| HMRC - other taxes & duties                | 0                            | 0   | 0                                    | 1,502                        |
| Other Central Government                   | 0                            | 201   | 262                                  | 0                            |
| <b>NHS</b>                                 |                              |   |                                      |                              |
| Department Of Health                       | 71                           | 3,529                                       | 21                                   | 41                           |
| East of England Strategic Health Authority | 2,452                        | 2   | 0                                    | 0                            |
| NHS Barnet                                 | 527                          | 52  | 1,305                                | 0                            |
| NHS Brent                                  | 510                          | 34  | 1,042                                | 0                            |
| NHS Ealing                                 | 909                          | 0   | 1,379                                | 0                            |
| NHS Hammersmith & Fulham                   | 0                            | 0   | 679                                  | 0                            |
| NHS Hertfordshire                          | 3,596                        | 2,213                                       | 2,941                                | 1,495                        |
| NHS Hillingdon                             | 124                          | 0   | 1,062                                | 0                            |
| NHS Hounslow                               | 872                          | 0   | 896                                  | 0                            |
| NHS Norfolk                                | 2,046                        | 0   | 30                                   | 0                            |
| NHS North East Essex                       | 7                            | 864   | 12                                   | 55                           |
| NHS South East Essex                       | 6,361                        | 288   | 4                                    | 38                           |
| NHS West Essex                             | 11,506                       | 302   | 3                                    | 220                          |
| NHS Westminster                            | 2                            | 0   | 1,495                                | 0                            |
| East & North Hertfordshire NHS Trust       | 82                           | 2,141                                       | 10                                   | 156                          |
| West Hertfordshire Hospitals NHS Trust     | 1,195                        | 2,264                                       | 53                                   | 104                          |
| Other NHS                                  | 5,032                        | 2,781                                       | 1,148                                | 504                          |
| <b>Local Government</b>                    |                              |   |                                      |                              |
| Barnet London Borough Council              | 1,674                        | 0   | 128                                  | 0                            |
| Hertfordshire County Council               | 171,627                      | 958   | 2,692                                | 650                          |
| Norfolk County Council                     | 424                          | 2   | 424                                  | 0                            |
| Westminster City Council                   | 676                          | 0   | 5                                    | 0                            |
| Other Local Government                     | 1,251                        | 1,114                                       | 289                                  | 197                          |
| <b>Totals</b>                              | <b>210,944</b>               | <b>16,745</b>                               | <b>15,880</b>                        | <b>8,094</b>                 |

**Notes to the Accounts - 26 Losses and Special Payments**

**26 Losses and Special Payments**

There were 73 cases (87 cases in 2011/12) of losses and special payments totalling £165k (£25k in 2011/12) paid during 1 April 2012 to 31 March 2013. These are the cash payments made in the year and are not calculated on an accruals basis. The largest single item was a payment of £150k relating to a Health & Safety Executive fine.

**27 Third Party Assets**

The NHS FT held £2,583k cash at bank and in hand at 31 March 2013 (£2,383k at 31 March 2012) which relates to monies held by the NHS FT on behalf of service users. This had been excluded from the cash and cash equivalents figure reported in the accounts.

**28 Post Balance Sheet Events**

There are no such events to be reported.

**29 Contingencies**

There are no contingent assets (recoverable values from third parties).

Contingent liabilities are liabilities to third parties where there are uncertainties regarding the timing and the amount of the settlement.

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.

|                                 | 31 March<br>2013<br>£000 | 31 March<br>2012<br>£000 |
|---------------------------------|--------------------------|--------------------------|
| Value of contingent liabilities | <u>(90)</u>              | <u>(110)</u>             |

**30 Commitments under capital expenditure contracts**

|                               | 31 March<br>2013<br>£000 | 31 March<br>2012<br>£000 |
|-------------------------------|--------------------------|--------------------------|
| Property, Plant and Equipment | 1,500                    | 503                      |
| Intangible Assets             | 951                      | 332                      |
| <b>Total as at 31 March</b>   | <u><b>2,451</b></u>      | <u><b>835</b></u>        |

The commitments as at 31 March 2013 relate principally to the Norfolk Poplars capital development and to a contract for the new electronic patient records system (PARIS).



**Annual Governance Statement  
April 2012 - March 2013**

**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. 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 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 NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

**3. Capacity to handle risk**

**3.1 Leadership of the risk management process**

As Accounting Officer, I am ultimately accountable for assuring the Board of the quality of the service provided by the Trust. This is achieved operationally through the delegation of the responsibility of executive lead for Risk Management (except for financial risk) to the Executive Director, Quality and Safety who also works with the officers responsible for ensuring, through the Risk Management Framework, that all Risk Management policies and procedures are in place and are competently used. The Trust's Risk Management Strategy approved by the Trust Board clearly defines levels of responsibility for Risk Management across the organisation and summarises the extensive tools and training available. The risk management process within the Trust is further underpinned by a robust Risk Management Policy. This policy describes the procedure for assessing, prioritising and managing all types of risk within the organisation. The Trust Risk Register forms an integral part of this and defines the process for grading and managing (or minimising) the organisations key operational and business risks. The highest level risks are reviewed regularly by the Trust Board.

**3.2 Training in the management of risk**

Staff are equipped to assess and manage risk through training in the use of the Risk Management Policy and Procedure which is cascaded to all staff via the Senior Managers, Professional Leads and Team Leaders and progress is monitored through the usual supervision /performance management process. Mandatory Training in Clinical Risk Management is also provided to all staff who work directly with service users, as they must be competent in recognising, assessing and managing the risks which our service users present to themselves and to others.

### 3.3 Learning from good practice

Analysis of 'adverse events' and sharing this intelligence through our extensive Practice Governance Framework to improve services across the Trust, is a key aspect of our approach to managing risk through service improvement. Our learning and development teams provide regular opportunities for all our staff to attend training updates and refresher programmes where these are deemed appropriate, or necessary, by line managers.

## 4. The risk and control framework

### 4.1 The Risk Management Strategy

This document sets the scene with our Vision and Goals, then details the way risks are identified, assessed and controlled in the Trust and contains the following key elements:

- Definition of the Risks and Risk Management
- The Strategic Objectives and Plans for Risk Management
- Responsibilities for Risk Management
- The Assurance and Risk Management Structure throughout the Trust
- The Risk Management Tools and Policies available
- The Risk Management Training and other resources available

**4.2 The Executive Directors** with specific responsibility for risk management are:

- **The Executive Director Quality and Safety** is the executive lead for Risk Management.
- **The Executive Director Quality and Medical Leadership** has lead responsibility for Practice Governance.
- **The Executive Director Finance and Performance Improvement** is responsible for the management of financial and performance risks.
- **The Chief Operating Office** is responsible for the day to day management of risk within operational services.

A number of other senior officers assist with these responsibilities and there are a variety of systems in place to enable those responsible to identify, assess, prioritise and control hazards and all types of risks on a regular and ongoing basis, listed in the Risk Management Strategy.

**4.3 Integrated Governance** Risk Management is one of the building blocks of Integrated Governance and the Trust's committee structure integrates Risk Management and other forms of Governance into a single structure. The Integrated Governance Committee is the central driving force for the Risk Management Strategy and the Trust's internal control mechanisms, regularly reporting to the Trust Board on the risks being faced by the organisation and how they are being managed/controlled.

Regular discussions take place at board meetings concerning the Trust's appetite for risk, determining the strategic parameters within which decisions involving various types of risk, can then be made on a sound consistent basis.

**4.4 The Board Assurance Framework and the Risk Register** are the key tools to facilitate and monitor the effects of systematic action plans to control and minimise identified risks. They are central planks in the System of Internal Control.

**The Board Assurance Framework (the BAF)** specifically identifies potential risks to the achievement of each of the Trust's Strategic Goals and monitors the systematic controls in place to protect against them. The BAF acts as a major assurance tool by detailing the independent sources and methods of assurance used to objectively measure the effectiveness of the controls being used to minimise the risk of not achieving the Trust's strategic objectives. The Board Assurance Framework is regularly reviewed in year. Two of these are full reviews reported to the Integrated Governance Committee, and to the Audit Committee which challenges the controls and assurance processes in order to assure the Board that they are working effectively as part of the Internal Systems of Control. The other routine reviews, are reported solely to the Integrated Governance Committee.

**The Risk Register** operates at several levels within the organisation and enables local Service Managers, Senior Managers and the Executive Team on behalf of the Board, to plan and monitor mitigating actions taken to reduce risks of all types. The moderate and high risks and the overall process is monitored and reviewed by the Integrated Governance Committee with key categories of risk being a focus of relevant Sub Groups.

Key organisational risks are reported to the Board 4 times a year, via the Integrated Governance Committee. For 2 of these reviews, the Integrated Governance Committee also reports the Risk Register to the Audit Committee to provide the challenge to the Assurance Processes.

#### **4.5 Quality Governance Arrangements**

The Trust's Quality Governance arrangements are described in section six as part of the description of the processes towards the Annual Quality Report.

#### **4.6 Risks to Data Security**

Risks to data security were reviewed by Internal Audit in January 2013 using the Department of Health's 'A Question of Balance' Guidance, identifying for the Board that controls to manage risks are suitable, consistently applied and effective, and recommending further actions in relation to information governance.

The Trust continues to take the management of risks to data security seriously. Following the DOH Serious Incident Reporting Guidelines (ref 13177), there have been no serious incidents relating to potential or actual breaches of confidentiality involving person identifiable data, which have scored a level 3 or above and would require an investigation (SIRI).

Progress is measured against Information Governance Standards with continued improvement being targeted through a robust plan to achieve compliance with Level 2 (March 2013 submission) as assessed against the Information Governance Toolkit.

#### **4.7 The Organisations current major Risks.**

The Top Three Risks on the Trust Risk Register at this time are managed and controlled via the Risk Register mechanisms described in section 4.4. They are current 'in-year' risks but in all 3 cases will continue into the future (i.e. 2013-14). The risks are:

##### **Risk 1 – Risk to the Trusts ability to provide safe high quality care**

Current financial constraints for both the NHS and Local Authorities have led to serial reductions in funding at an unprecedented level. The effects of these funding reductions have led to reductions in capacity within in-patient and community services.

**Key mitigating actions:** The Trust has developed a process of Quality Impact Assessments for all service reductions and the effect of these to ensure that mitigating action can be planned. This has led to detailed discussions with commissioners concerning the need for recurrent funding to support developments which will off-set the reduced capacity in in-patient and rehabilitation services. The successful negotiation of additional funding for the coming year has given a positive outcome for the future and this risk is now reducing.

##### **Risk 2 - Risk that the exceptional financial challenges facing us cannot be managed**

There is a risk that we fail to meet the financial targets set by our regulator due to the continued financial challenges during the final year of the three year planning cycle and then into the subsequent planning period, with specific additional risks at present concerning:

1. Possible one off redundancy costs
2. Possible loss of business through increased competition and new commissioning arrangements
3. Specialised commissioning arrangements changing

**Key mitigating actions:** Ongoing negotiations with commissioners for access to transformation funds held by them and to ensure that relationships are managed in respect of new commissioning bodies. The successful renegotiation of future contracts will enable us to judge

**4.12 Equality, Diversity and Human Rights.** Control measures are in place to ensure that the organisation complies with all relevant equality, diversity and human rights legislation.

#### **4.13 Carbon Reduction**

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that, together with Hertfordshire County Council, this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

### **5. Review of economy, efficiency and effectiveness of the use of resources**

#### **5.1 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 are governed by the following key policies  
Standing Orders

Standing Orders are contained with the Trust Constitution and set out the regulation and proceedings for the Board of Directors and the Council of Governors and their sub-committees including the Audit Committee, whose role is laid out below, thus ensuring the efficient use of resources.

#### **Standing Financial Instructions**

The SFIs detail the financial responsibilities, policies and principals adopted by the Trust in relation to financial governance. They are designed to ensure that its 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 all the key aspects of policy and decision making in relation to the key financial matters. This ensures that there are clear divisions of duties, very transparent policies in relation to a competitive procurement process, effective and equitable recruitment and payroll processes and there is set out a clear budget process to ensure costs are maintained within budget or highlighted for action.

They are to be used in conjunction with the Trust's Standing Orders and the Scheme of Delegation Authority and the individual detailed procedures set by directorates

#### **Scheme of Delegated Authority**

This sets out those matters that are reserved to the Board and the areas of delegated responsibility. The document sets out who is responsible and the nature and purpose of that responsibility. They assist in the achievement of the efficient and effective resources by ensuring that decisions are taken at an appropriate level within the organisation by those with the experience and oversight relevant to the decision being made. It ensures that the focus and priorities of the decision making processes are aligned with the strategic priorities of the trust and they allow the trust to put 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 made it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid (or at least minimise) the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem. This will help ensure that the taking or receiving of bribes is less likely and therefore will improve the equity and transparency of for example our procurement and recruitment decisions

The Trust Board places reliance on the Audit Committee, to ensure appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources.

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.

## 6. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2011 to prepare Quality Accounts for each financial year. 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 continues to follow these steps to assure the Board that the Quality Report presents a balanced view:

- A stakeholder consultation process to agree quality priorities for the coming year, involving staff, service users, carers, Governors and partner agencies.
- Review of all Trust services before priorities are agreed.
- Quarterly Quality reports to Board leading to scrutiny of whether the focus is right.
- Sharing of 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 to ensure the quality of data:

- Provision of appropriate training to all staff including all new starters on data inputting via the electronic patient record.
- Elimination where possible of manual approaches to data gathering and analysis, including investment in new systems.
- Audit of supervision to gain assurance that the process is robust in relation to data quality.
- Further development of more robust audit trails regarding decisions about data, with random checks by the Complaints and Customer Experience Manager of data reported by her team introduced in 2011.
- Continued use of data quality officers reporting to the Performance Improvement team who work alongside teams to assist in full and accurate use of the electronic patient record system.

The accuracy of information for quality reports is assessed via:

- Systematic checks within the Informatics and Performance Improvement Teams themselves.
- Scrutiny of quarterly reports at Board, with any errors and/or corrections being duly noted.
- Annual internal audit.
- Annual External Audit Assurance as mandated by Monitor.

Systems and processes have been further improved with the introduction of a Data Quality Steering Group chaired by the Informatics team manager with representation from across the Trust. This group ensures the Trust is compliant with relevant information governance standards. It will ensure that the new electronic patient record (PARIS) due to be introduced in 2012/2013 facilitates accurate data inputting by frontline staff.

The quality metrics contained in quarterly Board reports are agreed before the start of the financial year by the Board after a period of internal and external consultation. The quality metrics – their accuracy and relevance and progress on each – are reviewed quarterly at these Board meetings. Further description of these processes is given in the quality report itself.

Occasionally data errors in-year are found. If this happens, the errors are corrected in the next quarterly Board quality report and the occurrence is noted.

The Quality & Risk Manager has set up processes through the Trust for teams to collect evidence of compliance with Care Quality Commission Essential Standards of Quality & Safety. The monthly Quality and Risk Profiles are used to check performance against what teams report and to anticipate risks in the future. The Integrated Governance Committee (a Board sub-committee) is kept informed of the completeness of the data and any areas of concern.

The Integrated Governance Committee monitors the improvement of Quality and Safety through the Trust CQC Framework. Compliance with the Essential Standards of Quality and Safety is monitored through the following procedures;

- The CQC review and quality improvement plans by Team managers.
- The CQC Provider Compliance Assessment (PCA's) completed by service managers recording all evidence of quality improvement within their service area.
- The Quality and Risk Profile (QRP) provided by the CQC monthly is reviewed by the Registration Leads and risks are monitored and improvement plans advised to the Sub Groups of the IGC.
- Compliance with the above is advised in a bi annual report to the IGC.

## 7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, 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.

The process for maintaining and reviewing the effectiveness of the system of internal control involves review of all the mechanisms described particularly in section 4 of this statement (the risk and control framework).

The Trust response to any significant internal control issues or gaps in control is to assess and register the risk and develop and implement suitable mitigating actions, linking to the control mechanisms recorded in the BAF if necessary. Regular monitoring is built into the process.

The high level co-ordination and monitoring of the whole internal control system is mainly achieved through the following:

- **The Trust Board** places reliance upon the Audit Committee for assurance in respect to the soundness of the system of internal control, via regular reports concerning the Risk Register and Board Assurance Framework.
- **The Integrated Governance Committee** is responsible for ensuring that the Trust fulfils its governance and associated risk management duties. Regular reports are made to the Board on the management of the most serious risks on the Trust Risk Register and all aspects of risk management and the Board Assurance Framework.
- **The Audit Committee's** primary role is to independently oversee the governance and assurance process on behalf of the organisation and to report to the Trust Board on the soundness and effectiveness of the systems in place for risk management and internal control. In order for the Audit Committee to provide this assurance to the Board, Internal Audit undertake objective reviews of the Trust systems.



- **The Finance and Investment Committee** is responsible for providing independent and objective review of the financial and investment policy of the Trust, and performance against the associated targets and requirements. The Committee will commission and receive the results of in-depth reviews and reports in relation to key financial issues and business cases to support investment decisions.
- **The Practice Audit & Clinical Effectiveness Team** provide a variety of resources to support clinical teams to undertake practice audit in the context of the trusts strategic goals. Overseen by the Integrated Governance Committee, an Annual work programme is developed inclusive of clinical and regulatory requirements, and the outcomes are reported to the Board at year end.
- **Other assurance mechanisms** are accessed by commissioning external expertise and advice on specific areas of concern as appropriate.
- **Internal Audit** review the system of internal control during the course of the financial year and report accordingly to the Audit Committee.

The Head of Internal Audit has stated in the HOIA Opinion that “based on the work undertaken in 2012-2013, significant assurance can be given that there is a sound system of internal control which is designed to meet the organisations objectives, and that controls are being consistently applied in all the areas reviewed.”
- **Monitor** monitors the Trust's Performance.

## 8. Conclusion

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



Tom Cahill,  
Chief Executive  
Date: 28 May 2013



**Statement of the chief executive's responsibilities as the accounting officer of Hertfordshire Partnership 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 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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Hertfordshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Hertfordshire Partnership 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 *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- 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 foundation trust and to enable him 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 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 Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signed.....  
Tom Cahill, Chief Executive  
Date: 28 May 2013

## **INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST**

We have audited the financial statements of Hertfordshire Partnership NHS Foundation Trust for the year ended 31 March 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Cash Flow Statement and the related notes 1 to 30. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Hertfordshire Partnership 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 trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

### **Respective responsibilities of the accounting officer and auditor**

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. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

### **Scope of the audit of the financial statements**

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

### **Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view of the state of the trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

**Opinion on other matters prescribed by the National Health Service Act 2006**

In our opinion the information given in the Directors' 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**

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us 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 inconsistent with information of which we are aware from our audit. 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;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

**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 Audit Code for NHS Foundation Trusts.



Matthew Hall  
(Senior Statutory Auditor)  
for and on behalf of Deloitte LLP  
Chartered Accountants and Statutory Auditor  
St Albans, United Kingdom  
28 May 2013

**INDEPENDENT AUDITOR'S REPORT TO HERTFORDSHIRE PARTNERSHIP NHS  
FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION  
SCHEDULES**

We have examined the NHS foundation trust consolidation schedules (FTCs) numbered 1 to 38 and 40 of Hertfordshire Partnership NHS Foundation Trust for the year ended 31 March 2013, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to the Board of Hertfordshire Partnership NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act). Our audit work has been undertaken so that we might state to the Board 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, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Board, as a body, for this report, or for the opinions we have formed.

In our opinion these consolidation schedules are consistent with the statutory financial statements on which we have issued an unqualified opinion.

As agreed with Monitor, in forming our opinion on whether the consolidation schedules are consistent with the statutory financial statements, we have not considered inconsistencies below the clearly trivial threshold of £250,000.

*Deloitte LLP*

Deloitte LLP  
28 May 2013

Address: Deloitte LLP, 3 Victoria Square, Victoria Street, St Albans, AL1 3TF.

If you require this information in a different language or format please contact the Patient Advice and Liaison Service:  
Tel: 01727 804629, Fax: 01727 804967

W razie potrzeby powyższy tekst można otrzymać w innej formie lub innym języku. Informacji w tej sprawie udziela: Patient Advice & Liaison Service:  
Tel: 01727 804629, Fax: 01727 804967  
(Polish)

Se avete bisogno di queste informazioni in una lingua o in un formato differente, vi preghiamo di contattare: Patient Advice & Liaison Service (Servizio relazioni e consigli per i pazienti)  
Tel: 01727 804629, Fax: 01727 804967.  
(Italian)

اگر آپ کو یہ کسی دوسری زبان میں یا کسی دوسرے طریقہ سے درکار ہو تو براہ مہربانی ذیل سے رابطہ کریں:

ہیلتھ ایڈوائس اینڈ لیاژن سروس (Patient Advice & Liaison Service)

ٹیلیفون: 01727 804629

فیکس: 01727 804967

(Urdu)

আপনি যদি এই লেখাটি অন্য কোনও ভাষায় বা অন্য কোনও প্রকারে পেতে চান তাহলে অনুগ্রহ করে নিচের নাম্বারে যোগাযোগ করবেন :

পেশেন্ট অ্যাডভাইস অ্যান্ড লিয়েজন সার্ভিস

(রোগীদের পরামর্শ দেওয়া ও তাদের সাথে যোগাযোগ রাখার পরিষেবা)

টেলিফোন : 01727 804629

ফ্যাক্স : 01727 804967

(Bengali)

Hertfordshire Partnership University NHS Foundation Trust  
works toward eliminating all forms of discrimination  
and promoting equality of opportunity for all