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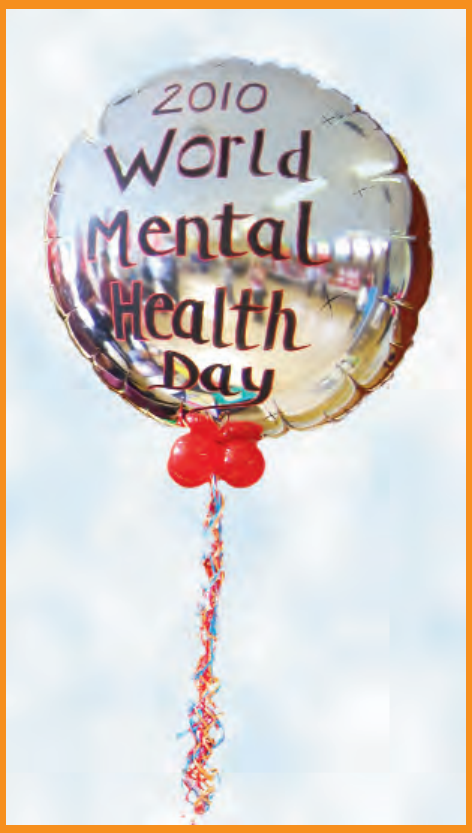
Hertfordshire Partnership NHS
NHS Foundation Trust

Annual Report 2010-2011



Hertfordshire Partnership NHS Foundation Trust
Annual Report April 2010 - March 2011

Presented to Parliament pursuant to Schedule 7,
paragraph 25(4) of the National Health Service Act 2006.

Annual Report 2010 - 2011

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Introduction from Chair and Chief Executive

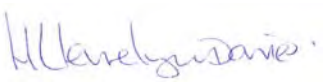
We are delighted to be able to report on another good year in the Trust. We were delighted with the appointments made to the Board, a new Director of Finance following the retirement of John Jones after 36 years of NHS service and the formal appointment of the Executive Director Strategy and Organisational Development.

We are particularly proud to be able to say we were the first Mental Health and Learning Disability Trust to host the national LGBT conference back in October of last year. We should also note the excellent work done by the team at Victoria Court in securing £100k funding from The Kings Fund to make improvements as part of the Enhancing the Healing Environment initiative. As usual there are many examples of good practice and improvements to the services the Trust provides. These include:

- Opening of the new acute day treatment unit in Watford
- Creation of a sensory recovery garden at Logandene inpatient unit for older people
- Showcasing of the Early Memory Diagnosis and Support Service (EMDASS) and the Black and Minority Ethnic (BME) dementia project on the NHS East of England good practice, innovation and improvement website
- Newly qualified Social Worker project winning the award for the most effective employer (HPFT in partnership with ACS)
- The featuring of the Cassio Unit (Watford) on the NHS Institute of Innovation and Improvement website as an example of best practice for its Productive Ward strategy
- We were the first mental health trust to be inspected by The NHS East of England Intensive Support Team and we had excellent feedback from the visit
- Two members of staff shortlisted in the International Dementia Excellence Awards 2010
- The launch of the Peer Support Scheme
- Winning the RoSPA Occupational Health and Safety Gold Medal in recognition of five consecutive annual awards
- Achieving our target of 12,000 members

Looking forward we know that there will be financially challenging times ahead and are planning how we can continue to improve the quality and safety of services within a restricted budget. Over the next three years the Trust will continue to focus on the Leading by Design programme that aims to transform all services, to deliver consistently excellent care, quality and support the Trusts vision and goals. Our plans for the future have been developed in partnership with service users, carers and relatives as well and commissioners and other key stakeholders.

We also want to thank our staff, service users and carers for their support over the last year, their contribution makes the difference.



Hattie Llewelyn-Davies
Chair
27 June 2011

Tom Cahill
Chief Executive
27 June 2011

Directors' Report

Introduction and Background Information

Hertfordshire Partnership NHS Foundation Trust obtained its Foundation Trust status on 1 August 2007, under the National Health Service Act 2006 and is regulated by Monitor, the Independent Regulator of Foundation Trusts.

This Directors' report covers the year ending 31 March 2011.

We provide:

- Child and adolescent mental health services in Hertfordshire
- Specialist health services to people with learning disabilities in Hertfordshire, Norfolk and North Essex
- Integrated health and social care to people who need mental health services in Hertfordshire, which has a population of one million.

Our strategic objective is to become the leading provider of Mental Health and Specialist Learning Disability services in the country.

We plan to deliver quality services, make good use of resources, be an excellent employer, create a learning organisation and, with others, promote mental well-being.

The Trust was very proud to be accepted as the first Mental Health and Specialist Learning Disability Health and Social Care Foundation Trust. Foundation Trust status gives us a number of opportunities to improve the service we provide to the community by:

- A stronger involvement with local communities through membership
- The ability to re-invest finance in local service developments
- Increased stability from longer term contracts with commissioners.

Financial Review

Overview

This section of the Directors' report provides a commentary on the continued excellent financial performance of the Trust, leading to a net surplus (excluding accounting for impairments) of £3.6m for the financial year 2010/2011. The commentary provides an overview of the accounting processes and an analysis of the financial performance. To supplement this analysis and provide an indication of future financial performance, appropriate financial trends through comparison with last year's performance are included.

Financial Statements and Accounting Policies

The full set of financial accounts and accounting policies are set out within this report. These have been prepared in accordance with International Financial Reporting Standards (IFRS), completed in accordance with the directions given by Monitor and are designed to show a true and fair view of the Trust's financial activities. 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 (SOCI)	page 2
Statement of Financial Position	page 3
Statement of Cash Flows	page 5

Accounting policies relating specifically to pensions and other retirement benefits are set out in note 2.5.2 to the accounts. Details of staff who retired early on ill health grounds are set out on page 25 of the accounts.

Going Concern

The accounts have been prepared on the basis that the Trust continues to operate as a 'going concern', reflecting the ongoing 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 reviewed by the Trust's external auditors, the Audit Commission, who issued an unqualified opinion. So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken all the steps they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The Audit Commission have been approved as the Trust's external auditors by the Board of Governors through to 2011/2012. The Trust's Engagement Lead is Mark Hodgson and Cathy Smith is the Trust's External Audit Manager. The focus of the Audit Commission's work centres on the audit requirements of the Code of Audit Practice but can also cover some non-audit work as directed by the Trust. The cost of these other services is shown separately in the accounts. Any additional non-audit work can only be requested on the basis of an agreed protocol as it remains important that the external auditors independence from management and objective approach is both maintained and transparent. The total external audit fee for 2010/2011 was £85,605 comprising:

Audit Area	Audit Fee £
Statutory Audit Work	68,875
Other work	16,730

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 on page 39.

Private Patient Income

The Private Patients Income Cap is set in accordance with section 44 of the NHS Act 2006 revised by the Health Act 2009. Mental Health NHS Foundation Trusts must 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.

Consequently the Trust's PPI cap is now set at £3,070,000 (zero in 2009/10).
No private patient income was generated in 2010/11 (non in 2009/10).

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 2010/2011 are available separately on request from the Director of Finance and Performance Improvement. There is no charge for this.

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 Outturn

This has been another successful year with the Trust achieving an underlying year end surplus of £3.6m (before accounting for impairments). This surplus is available for reinvestment in programmes to continually improve the quality of our services and service user experience. In 2010/2011 we have invested in a range of developments, including:

- Upgrade to a range of mental health inpatient services
- Reprovision of day service accommodation at Little Plumstead, Norfolk
- Low secure learning disability services
- Security and refurbishment of medium secure services.

We have also been successful in securing a parcel of land at our Harperbury site, which will enable us to develop our plans for a high quality, safe and modern inpatient facility, accelerating the long term strategy for 'Investing in Your Mental Health', moving away from accommodation which is no longer 'fit for purpose'.

Accounting for impairments

The net impairment gain of £688k arises from the annual review of fixed asset values (in line with all NHS organisations) by the Trust. The net gain arises from the reversal of previous impairment losses (£780k), where asset values have now recovered and an impairment loss of £92k for Forest House. These impairments are 'non-cash' items and in line with accounting rules have been treated as a 'technical' gain during the year. This net gain increases the underlying surplus of £3.6m to a technical surplus of £4.3m. As a technical accounting adjustment there is no effect on the financial risk rating assessment by Monitor.

The Directors are of the opinion that there are no fixed assets where the market value is significantly different from the value included in the financial statements.

Financial Risk Rating

Monitor has assessed and awarded the Trust a Financial Risk Rating of 4 for 2010/2011 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 82 of this report (E – Regulatory ratings section).

Key Metrics (financial indicators)

The Financial Risk Rating is comprised of key metrics drawn from the financial statements and incorporates four key criteria which further demonstrate the strong financial performance of the Trust:

Financial Criteria	Metric	2010/2011	2009/2010
Underlying Performance	EBITDA Margin	5.5%	5.6%
Financial Efficiency	Income & Expenditure Surplus Margin	1.7%	2.0%
Financial Efficiency	Return on Assets	5.1%	5.3%
Liquidity	Liquidity Ratio	58 days	57 days

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. This yields interest which is reinvested in services, but due to minimal interest rates available, these returns have reduced to £210,000 for 2010/2011 (£302k 2009/2010). The Statement of Cash Flows illustrates the sources and uses of cash generated by the Trust during the financial 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. Therefore it does not hold any complicated financial instruments to hedge against such risks. Details are shown on pages 18, 19 and 37 of the annual accounts.

Summary of Key Results from the Accounts

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

	2010/2011 £000	2009/10 £000
Total Income	211,445	198,098
Income from Mandatory Clinical Services	204,681	190,959
Surplus for the Year (excluding Impairments and Exceptional Items)	3,617	3,936
Capital Expenditure	8,711	9,905
Capital Charges (Depreciation & Public Dividends)	7,588	6,993

Income

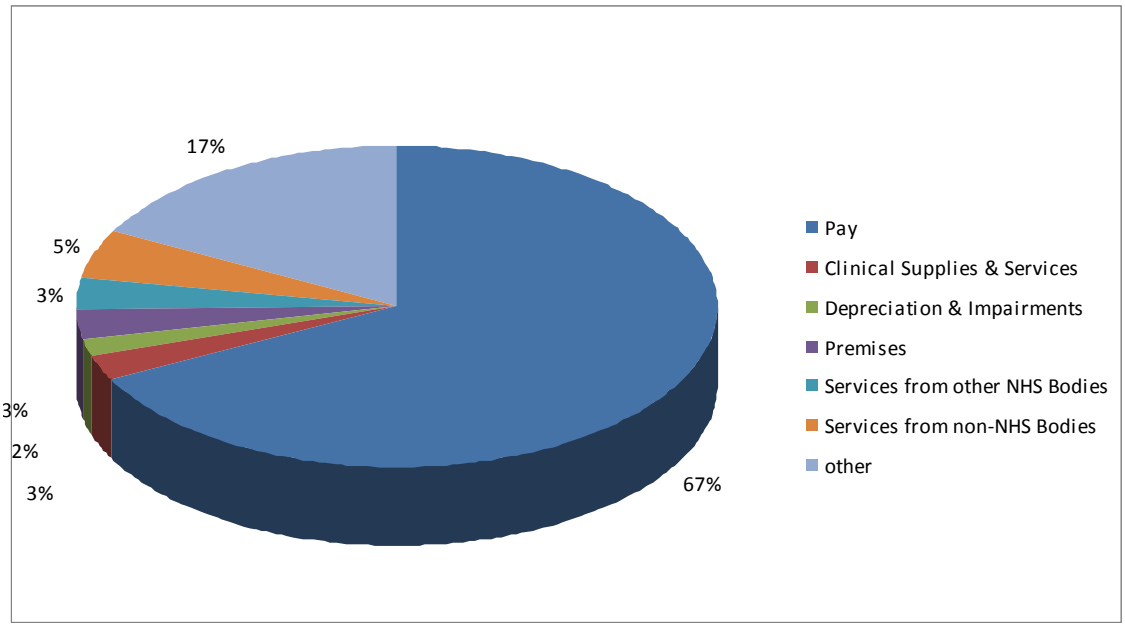
In the financial year 2010/2011 the Trust generated income totalling £211m of which the majority relates to income from activities as illustrated below:

	£000	%
Income from Activities	204,681	96.8%
Other Operating Income	6,764	3.2%

The 2010/2011 Operating Framework included 1.5% uplift on allocations available to Trusts as a condition of achieving Commissioning for Quality Improvement and Innovation (CQUIN) goals. The Trust agreed a schedule of CQUIN targets with the Hertfordshire Joint Commissioning Team and an associated monetary value of £1.933m. The Trust was successful in securing £1.43m (74%) against the agreed schedule.

Operating Expenses

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



In common with other Trusts, the most valuable and 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 6 (page 21) of the accounts.

Management Costs

Management costs, as defined by the Department of Health guidelines, represent 5.9% of Trust turnover for the financial year (6.0% 2009/10) 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

Specific reference to senior managers' remuneration is detailed at note 6.2 of the accounts and within the remuneration report (pages 22 & 23).

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 2011	35,292	59,443
Total within target	30,692	51,704
Percentage within target	87%	87%
Total NHS invoices paid to 31st March 2011	1,727	27,769
Total within target	1,404	25,902
Percentage within target	81%	93%

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 and have achieved 38% success in making payments at least 20 days earlier than required.

Capital Programme

During 2010/2011 we invested £8.7m in providing new or improved assets (land, property and equipment) through the capital programme agreed and reviewed by the Directors. The key features funded through the 2010/2011 capital programme are:

- The purchase of land at the Harperbury site (through circular flow of funds)
- Improving security at Warren Court
- Completion of the Little Plumstead day service reprovision in Norfolk
- Development of a new Acute Day Treatment Unit in the Shrodells Unit at Watford General Hospital
- Investment in Information Technology to support mobile working

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 'credit worthiness' (page 19 of the accounts). These limits are:

- £41,200,000 for long term borrowing
- £13,000,000 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

The Operating Framework published by the Department of Health in December 2010 indicated that the tariff will reduce by a net 1.5% in 2011/12 (0% in 2010/11). For the following three years (2012-15) allocations are expected to reduce further due to the need to 'manage the downturn' of public finances. Hertfordshire County Council have indicated that over the same period a similar picture is expected. Efficiency savings over this period are likely to be a minimum of 4.0% for each year. A comprehensive 'Leading by Design' programme is being developed in order to deliver service transformation, maintain quality and safety and to meet these efficiency requirements. This approach will focus on the transformation and reconfiguration of current provision, encouraging innovation in the approach to the delivery of high quality services. The implementation phase of 'Leading by Design' is expected to commence during 2011/12.

In addition the Directors have agreed a list of development proposals based on our strategic priorities taking into account:

- the Trust Strategy and Integrated Business Plan; and
- backlog maintenance and asset registers.

The 2011/2012 capital programme totals £30m investment and an outline plan for the following two years illustrates the significant investment of a further £46m envisaged over this period.

The major investments in 2011/12 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; the replacement of our electronic patient record system; and investment required to meet our carbon reduction targets.

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 Boards of Governors and 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 Boards

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 were appointed for terms of four years to ensure that there would be some continuity on the board and to prevent all non-executives coming up for re-appointment at the same date which could have destabilised the board in the longer term

The Board of Directors, Chair and Executive, and Board Balance Directors

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 Governors, and, the executive responsibility for the running of the Foundation Trust's Business. The Chair is responsible for providing leadership to the Boards of Directors and Governors ensuring governance principles and processes of the Boards 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 Boards 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 Llewellyn-Davies (Chair)	1.8.2007 - 31.7.2013 (2 terms)
Colin Sheppard (SID)	1.8.2007 - 31.7.2013 (2 terms)
Ruth Sawtell	1.8.2007 – 31.7.2012 (2 terms)
Bill Brown	1.8.2007 – 31.7.2011 (1 term)
Carol Kennedy Filer	1.8.2007 – 31.7.2011 (1 term)
Steve Marsden	1.8.2009 – 31.7.2012 (1 term)
Manjeet Gill	1.6.2009 – 31.5.2012 (1term)

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 6 Executive Directors including the Chief Executive and the posts are as follows:

Executive Director Quality and Medical Leadership
Executive Director Strategy and Organisational Development
Executive Director Finance and Performance Improvement
Executive Director Service Delivery and Transformation
Executive Director Quality and Safety.

The post of Executive Director Strategy and Organisational Development was filled from 1 April 2010 – 31 December 2010 by a seconded from Pricewaterhouse Coopers. Substantive appointment to the post following the recruitment process and approval by the Board was Iain Eaves.

From December 2010 Keith Loveman was appointed as Executive Director of Finance and Performance Improvement, following the retirement of John Jones.

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 Board 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, is considered on an ongoing basis via the regular reports presented to the Board of Directors at their monthly meetings. Each Committee and the Board of Directors is appraised annually.

So far as the Directors are aware there is no relevant audit information of which the Auditors are 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 auditors are aware of that information.

There were 13 Board of Directors meetings between 1 April 2010 and 31 March 2011. This includes the Annual General Meeting for members. The individual attendance of each Board member is indicated in brackets.

Tom Cahill, Chief Executive
(12 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, manage external relationships and develop 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 Organisational Development (formally appointed from 1 January 2011, from 1 April to 31 December 2010 was employed on a secondment from Pricewaterhouse Coopers)
(13 out of a possible 13)

- Responsible for planning, securing and developing the future workforce of the organisation
- Responsible for organisational development, which includes learning education and a leadership development
- Responsible for strategy and business planning
- Lead for human resource management, including medical staffing.

Geraldine O'Sullivan, Executive Director Quality and Medical Leadership
(12 out of a possible 13)

- Provides advice and guidance on professional issues including medicines management, medical staff and revalidation, as well as training of future doctors
- Oversees clinical risk in the organisation and leads on the accessibility of clinically effective care within available resources across the organisation
- Takes an overview of issues around quality of clinical care
- Caldicott Guardian for Trust
- Is a qualified Psychiatrist.

John Jones, Executive Director Finance and Performance Improvement (to 30 November 2010)
(9 out of a possible 9)
Keith Loveman, Executive Director Finance and Performance Improvement (from 1 December 2010**)**
(4 out of a possible 4)

- Responsible for ensuring that the Trust meets all its financial targets and makes best use of its funding
- Responsible for the informatics service within the Trust
- Leads on ensuring that the Trust will be able to continue to provide services in the event of a major incident within Hertfordshire
- Qualified accountant.

Stanley Riseborough, Executive Director Service Delivery and Transformation
(12 out of a possible 13)

- Responsible for the transformation and operational management of the services of the Trust, including both health and social care within mental health services, for adults of working age, older people and child and adolescent services, Drug and Alcohol services, Specialist Learning Disability Services and Forensic Services. Also manages the informatics and facilities support services
- Works closely with service users and carers to engage them in the process and with the Assistant Director of Mental Health and Learning Disabilities within the County Council to ensure both the social care and health aspects of our services are addressed
- Is the Board lead for Mental Health Act legislation, Protection of Vulnerable adults and the management of violence and aggression.

Oliver Shanley, Executive Director Quality and Safety
(9 out of a possible 13)

- Is Executive/Board lead for Nursing, Social Care, Allied Health Professionals and Psychology
- Responsible for risk management and safety, equality and diversity, communications and partnerships and standards
- Qualified Mental Health Nurse
- Has a MSc Mental Health

Hattie Llewelyn-Davies, Chair
(12 out of a possible 13)

- Background is in social housing and the voluntary sector and has successfully run own business for the past 15 years providing services on governance, mergers and regulation matters
- Has a number of other Non-Executive roles including chairing a commercial audit firm, Vice-Chair of a building society and a Governor of Peabody Trust
- Has an OBE for services to homeless people.

Bill Brown, Non Executive Director
(13 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 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
(11 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
(12 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 three years has been Managing Director of Healthcare On Call Ltd, an occupational health company addressing health and safety issues and absence management
- Has a Masters in Business Administration.

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
- Member of the Institute of Directors.

Ruth Sawtell, Non-Executive Director
(12 out of possible 13)

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

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, Centrepoint, 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.

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 or are seeking to do business with the Trust.

Committees

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 (4 of 5)
- Steve Marsden, Non-Executive Director (5 of 5)
- Ruth Sawtell, Non-Executive Director (5 of 5)

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.

Integrated Governance Committee:

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 (3 of 4)
- Steve Marsden, Non-Executive Director (4 of 4)
- Tom Cahill, Chief Executive (Chair) (4 of 4)
- Iain Eaves, Executive Director Strategy and Organisational Development (4 of 4)
- John Jones, Executive Director Finance and Performance Improvement (to 30 November 2010) (2 of 3)
- Keith Loveman, Executive Director Finance and Performance Improvement (from 1 December 2010) (0 of 1)
- Geraldine O'Sullivan, Executive Director Quality and Medical Leadership (4 of 4)
- Stanley Riseborough, Executive Director Service Delivery and Transformation (4 of 4)
- Oliver Shanley, Executive Director Quality and Safety (4 of 4)

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

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 four 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 4)
• Hattie Llewelyn-Davies, Non-Executive Director	(3 of 4)
• Ruth Sawtell, Non-Executive Director	(4 of 4)
• Bill Brown, Non-Executive Director	(4 of 4)
• Carol Kennedy Filer, Non-Executive Director	(3 of 4)
• Manjeet Gill, Non-Executive Director	(4 of 4)
• Steve Marsden, Non-Executive Director	(4 of 4)
• Tom Cahill, Chief Executive	(3 of 4)
• Iain Eaves, Executive Director Strategy and Organisational Development	(4 of 4)
• John Jones, Executive Director Finance & Performance Improvement	(3 of 3)
• (to 30 November 2010,	
• Keith Loveman, Executive Director Finance & Performance Improvement	(1 of 1)
• (from 1 December 2010)	(4 of 4)
• Geraldine O'Sullivan, Executive Director Quality & Medical Leadership	(3 of 4)
• Stanley Riseborough, Executive Director Service Delivery and Transformation	(3 of 4)
• Oliver Shanley, Executive Director Quality & Patient Safety	(2 of 4)
In attendance	
• Barbara Suggitt, Company Secretary	(3 of 4)

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 Head of Workforce and Organisational Development are normally in attendance.

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)
- Carol Kennedy Filer, Non-Executive Director (4 of 4)
- Hattie Llewelyn-Davies, Chair (4 of 4)
- Steve Marsden, Non-Executive Director (4 of 4)
- Ruth Sawtell, Non-Executive Director (3 of 4)
- Colin Sheppard, Non-Executive Director (3 of 4)

Board of Governors Appointments and Remuneration Committee
The committee is responsible for making recommendations to the Board 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 five Governors: three public, one staff and one appointed. The Chair, Company Secretary and Executive Director of Workforce and Organisational Development are usually in attendance.

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

- Alan Franey (Chair of committee/Public Governor) (to 1.1.11) (3 of 4)
- Sheena Garbutt (Public Governor) (Chair from 1.1.11) (5 of 6)
- Glyn Trollope (Public Governor) (5 of 6)
- Irma Mullins (Staff Governor) (6 of 6)
- Hazel Jones (Appointed Governor) (to 1.8.10) (1 of 1)
- Eddie Veale (Appointed Governor) (from 1.8.10) (2 of 5)
- Stuart Asher (Public Governor) (from 1.3.11) (1 of 1)

The Trust has a pay framework for the remuneration of senior managers which relates to the standing financial instructions which state that the committee will make such recommendations to the Board on the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust having proper regard to the Trust's financial circumstances and performance and to the provision of any national arrangements for such staff, where appropriate.

Executive Directors of the Trust have defined annual objectives agreed with the Chief Executive. A report on their performance is received by the Committee annually. The performance of directors is linked to pay through a performance bonus scheme.

Executive Directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures and NHS guidance, including the requirement for external assessors. All Executive Directors covered by this report hold appointments which are permanent.

Robust processes are in place for the annual appraisal of the Board of Directors. The Chair leads the non-executive directors in their appraisal and the Chief Executive leads the process for executive directors. The Chief Executive is appraised by the Chair and the Chair is appraised by representatives from the Board of Governors and the Board of Directors.

No significant awards were made to past senior managers during 2010/11.

The salary, allowances and benefits of senior managers are included on pages 22 and 23 of the annual accounts.

BOARD OF GOVERNORS

The Board 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. It also has five Staff Governors elected by Trust staff and 13 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 Electoral Reform Society during July 2010.

The Public Governors elected for Hertfordshire were:

- Stuart Asher
- Ida Glen Brown
- Harvey Griffiths
- Jake Griffiths
- Fran Hook.

The Public Governors who were re-elected in the Hertfordshire constituency were:

- Sheena Garbutt
- Ray Gibbins
- Catherine Hislop
- Paul Mosley
- Steve Wright.

The Staff Governors elected were:

- Janice Lepori representing LD & Forensic Services was elected in July 2010
- Divya Acton represented Acute Services up until 31 July 2010 but changed service streams and was elected as staff governor representing Specialist Services on 1 September 2010 taking over the role from Peter Cargill who resigned in July 2010.
- John Lavelle was elected on 11 October 2010 to take on the role representing Acute Services.

During the year resignations were received from:

Public Governors:	John S Biggs Alan Franey Lesley Morris Mary Antony Harvey Griffiths
Staff Governors:	Peter Cargill
Stakeholder Governors:	Mike Paul Dennis Edwards Brian Littlechild Ian McCreath Hazel Jones

Resignations from stakeholder Governors were received due to changes within their organisations. A seat remains vacant for Carers in Herts as they are unable to nominate a Governor, however an observer attended some of the Board of Governors meetings.
We would like to thank all the Governors for their contribution to the Trust.

The Board of Governors and the Board of Directors have a good working relationship both chaired by the Trust Chair, Hattie Llewelyn-Davies and have three joint meetings annually, one of which is the Annual Members Meeting. In addition, the Board of Directors have an open invitation to attend all the Board 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 Board of Governors has dealt with a range of issues as part of their statutory duties including the appointment of the auditors and the performance appraisal of the Chair.

They have also been involved in the Trusts Annual Members Day, the Kaleidoscope Festival and World Mental Health Week as well as several workshops.

There were four Board of Governors meetings each Governor's attendance is shown in the constituency table below:

Board of Governors

PUBLIC GOVERNORS	Attendance	Appointment
Pamela Dossang	0/2	01/07/08 – 31/07/10
Richard Adkin	0/2	01/08/07 – 31/07/10
Mary Antony	1/4	01/08/09 – 31/07/12
Stuart Asher	2/2	01/08/10 – 31/07/13
Stephen Behrman	4/4	01/08/09 – 31/07/12
John S Biggs	0/2	01/08/07 – 31/07/10
Ida Glen Brown	2/2	01/08/10 – 31/07/13
Alan Franey	2/3	01/08/09 – Dec 2010
Sheena Garbutt	4/4	01/08/10 – 31/07/13
Ray Gibbins	4/4	01/08/10 – 31/07/13
Harvey Griffiths	0/2	01/08/10 – 05/02/11
Jake Griffiths	1/2	01/08/10 – 31/07/13
Catherine Hislop	4/4	01/08/10 – 31/07/13
Fran Hook	2/2	01/08/10 – 31/07/13
Carol Jeavons	4/4	01/08/09 – 31/07/12
Michelle Karpus	1/2	Feb 09 – 31/07/10
Paul Mosley	4/4	01/08/10 – 31/07/13
Neela Mukhapadya	2/4	01/08/09 – 31/07/12
Mary Porter	4/4	01/08/09 – 31/07/12
Chris Reynolds	1/2	01/08/07 – 31/07/10
Anne-Marie Smith	4/4	01/08/09 – 31/07/12
Glyn Trollope	4/4	01/08/09 – 31/07/12
Hazel Ward	4/4	01/08/09 – 31/07/12
Steve Wright	3/4	01/08/10 – 31/07/13
Celia Young	4/4	01/08/09 – 31/07/12
Lesley Morris	1/3	01/08/09 – Dec 2010

STAFF GOVERNORS		
Divya Acton	0/4	Jan 09 – 31/07/13
Peter Cargill	0/2	Nov 09 – 26/07/10
Tara Gouldthorpe	1/4	Nov 09 – 31/07/12
John Lavelle	1/2	11/10/10 -31/08/13
Janice Lepori	2/2	01/08/10 – 31/07/13
Irma Mullins	4/4	01/08/09 – 31/07/12
APPOINTED GOVERNORS		
Erika Aldridge	1/2	01/08/10 – 31/07/13
Leslie Billy	0/2	01/08/10 – 31/07/13
Peter Brown	2/2	01/08/10 – 31/07/13
Dennis Edwards	1/2	01/08/07 – 31/07/10
Tracey Graily	1/2	01/08/10 – 31/07/13
Chris Hayward	3/4	25/10/07 – 31/07/13
Dorothy Hone	3/4	01/08/07 – 31/07/13
Hazel Jones	0/2	01/08/07 – 31/07/10
Jackie Knight	1/2	01/08/10 – 31/07/13
Brian Littlechild	0/2	June 08 – 31/07/10
Ian McCreath	0/2	June 08 – 31/07/10
Julie Nicholson	2/4	01/08/07 – 31/07/13
Mike Paul	0/2	01/08/07 – 31/07/10
Mary Pedlow	2/4	Sept 08 – 31/07/13
David Thomson	2/4	Nov 09 – 31/07/13
Eddie Veale	1/2	01/08/10 – 31/07/13

The Board of Governors had two sub-groups which met regularly to take forward work plans on behalf of the Governors, and report to each of the meetings of the Board of Governors. The areas in which the groups worked on last year continued until July 2010.

Quality:

- Reviewed reports of the Having Your Say forms and the Patient Experience Trackers
- Developed a protocol for visits to units
- The action plan to improve in-patient services
- Trust processes for eliciting feedback from service users and carers
- The Trust's response to feedback from service users and carers i.e. concerns about medication highlighted in the voluntary sector's user and carer questionnaire
- The mechanisms service user and carer involvement
- The development of recovery approaches across the Trust
- The role of the third sector in supporting recovery and the extent to which there is collaboration with CMHT's
- Progress in recording advanced decisions.

Communications:

- Reviewed the Terms of Reference to clarify the role and purpose of the group
- Considered ways to recruit new members
- Discussed and agreed the proposal to have a themed approach to topics for the Trust magazine and that the magazine should be Governor influenced
- Raised issues of improving input from less well represented and vulnerable groups in consultative forums
- Ideas for the Annual Members Day

In July 2010 the Board of Governors were asked to review and approve new ways for working groups to develop this included:

- Yearly review of working groups and their function
- Yearly review of the membership of each group – working numbers 8 to 10
- Annual election of Chair and Vice Chair for each group
- Annual review of terms of reference
- Agreed notes to be circulated to all Governors
- To agree with the full governing body the work plan and outcomes for the working groups over the life of the group
- Twice yearly presentation to the Board of Directors of progress against work plan
- The individual groups will nominate a group member to attend the appropriate Integrated Governance Sub-group.

Three new working groups were formed and all agreed a work plan with the full board of Governors. Each group chose two or three objectives from the Trust Business Plan to look at as part of their role in holding the Board of Directors to account for the work of the Trust. Each group and the objectives they chose for their work plan is set out below.

Quality & Effectiveness

Work Plan:

- Develop a simpler, streamlined system of access into and from our services that will improve the experience of service users, carers and referrers and support more productive working

- Establish core care pathways, to reduce unnecessary delays and ensure that for each individual the care provided is the most effective and appropriate

- Remodel day services for adults to make sure they are providing up to date care based on commissioning intentions.

Performance

Work Plan:

- New Business; Budget for 2011/12 and Productivity Savings
- CIPs for 2011/12 how will the Board be monitoring effects on quality
- Financial plan for next year.

Engagement

Work Plan:

- Suicide prevention and mental health promotion
- Workforce capability and development plan
- Health and Wellbeing strategy
- Promotion of equality and diversity in the workplace

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 0.40p per mile as well as other reasonable expenses incurred on Trust business. They are not otherwise remunerated.

Membership:

In line with our membership strategy, public membership numbers grew to 12,061 during the year.

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:

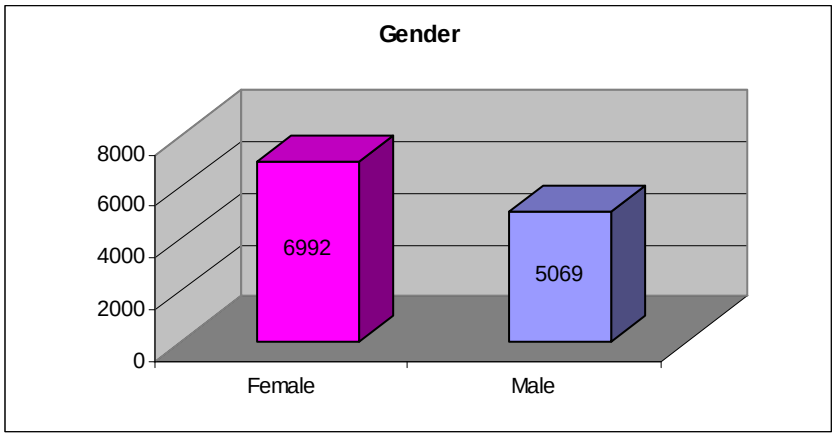
Acute and Rehabilitation Services	528
Community Services	880
Learning Disability and Forensic Services	866
Specialist Services	650
Corporate Services	311

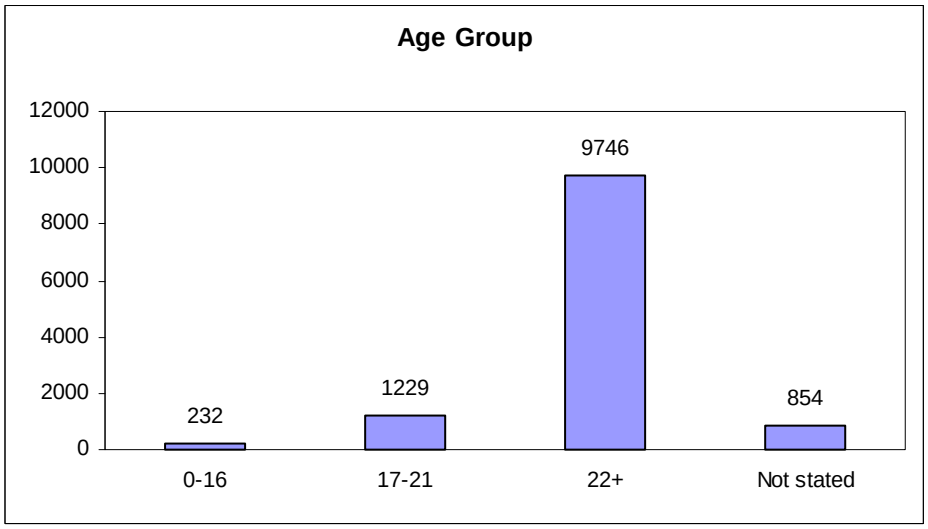
Increasing our membership
Growing and engaging a diverse and representative membership which reflect the population and communities we serve continues to be a focus for the Trust and the Governors.

Members receive quarterly editions of As One, the member's magazine, and have access to further information about the Trust and the work of the Board of Governors and Directors through the website. We are planning developments that will highlight information of particular interest to members and enable them to take part in workshops and discussions around issues such as health promotion and anti-stigma campaigns.

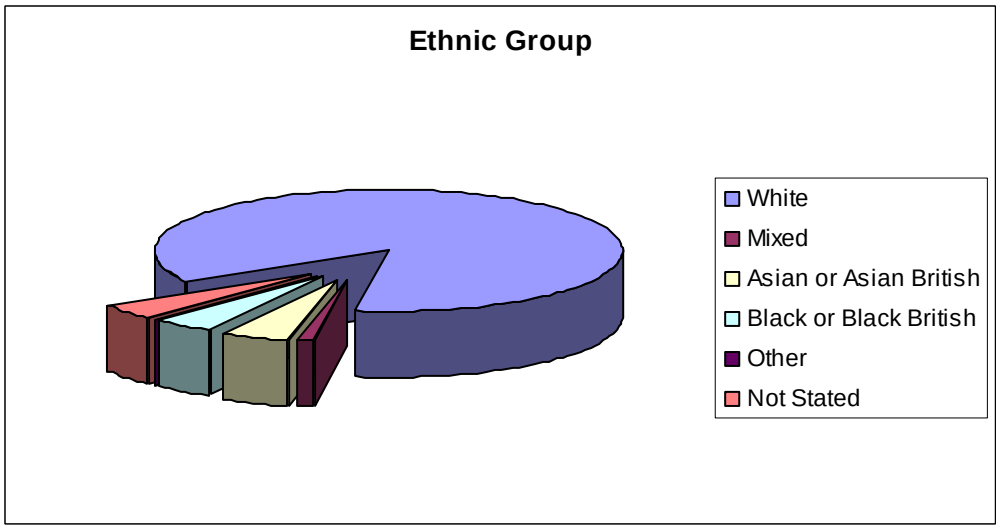
Membership levels are increased through regular recruitment drives, through the local press, As One and direct mailings as well as public health events. We are also discussing how we may work jointly with our neighbouring acute trusts who are moving to foundation status in the coming year about joint recruitment ventures.

We continue to try and ensure that membership reflects the diversity of our communities and have worked with our Equality and Diversity lead in the Trust to ensure that we make contact with hard to reach groups. We plan to remain at our standing target of 12,000 members over the coming year with a view to increase the number of members in Norfolk and North Essex. Members are encouraged through public website and the member's newsletter, to communicate with Governors via the Membership Office.





Ethnic Group			
White	10305	Black or Black British	481
Mixed	142	Other	6
Asian or Asian British	591	Not Stated	536



Membership Size and Movements:

Public Constituency (England & Wales)	Last Year	New Year (estimated)
At year start (April 1)	667	672
New Members	14	30
Members Leaving	9	16
At Year End (March 31)	672	686

Public Constituency (Hertfordshire)	Last Year	New Year (estimated)
At year start (April 1)	11366	11389
New Members	171	200
Members Leaving	148	160
At Year End (March 31)	11389	11429

Staff Constituency	Last Year	New Year (estimated)
At year start (April 1)	2994	2953
New Members	574	320
Members Leaving	382	363
At Year End (March 31)	2949	2808

Quality Account

Part 1 Statements by the Chief Executive

1.1 Foreword

In Hertfordshire Partnership NHS Foundation Trust we remain absolutely committed to quality as the yardstick by which we would want to be judged.

Our vision continues to be:

"to become the leading provider of mental health and specialist learning disability services in the country"

and to achieve this it is clear that we should expect to provide excellent services.

The Quality Account gives the Trust a great opportunity to tell the story of the quality of our services through the year now ended in a straightforward and open way. We do this so that any of our stakeholders - including those who use our services now or may do so in the future - can see what sort of organisation we are, and what we have achieved.

For me, the second main value of the Account is that it enables the Board to take charge and drive up quality through the year. This rightly includes a strong element of challenge to the Executive team and to senior managers and clinicians responsible for delivering the best possible services.

The Trust continues to provide an extensive range of services in Hertfordshire and beyond. In North Essex and Norfolk we provide specialist learning disability services. In Hertfordshire we also provide mental health treatment for those under the care of their GP, and a full range of mental health services for children, young people and all adults, plus drug and alcohol services and other specialist units.

The last year has seen the first steps in our major programme of service transformation that we call Leading by Design – which sets out to improve the quality of our care and treatment at a time of significantly reduced funding. We have recognised that simply cutting away at services in order to make the necessary savings year on year is not a good way to ensure the quality and safety of the care we provide to often very vulnerable individuals and their carers. We have grasped the fact that it is possible for our services to be more efficient and less complicated for those using them, and for the face to face time between our staff and service users to be both increased and more effective. With the support of our commissioners we have therefore committed ourselves to this plan to improve the quality of what we do by simplifying the ways we do it. We know this is easier said than done – but we are ready for the challenges.

I would like to thank the range of individuals and partner agencies who have contributed to this Quality Account and the important information it contains.

Service users and carers, though their councils and other means, staff with varied roles within the Trust, and Governors have helped shape our priorities and at times pushed us to do more. The Joint Commissioning Team, the Hertfordshire Primary Care Trust, the Local Involvement Network (LINk) and the Hertfordshire County Council Health Scrutiny Committee have formally taken a close interest in what we are doing and have supported our overall approach. Internally our Performance Team

and Informatics Team have been crucial in gathering a full set of data so that we can measure progress through the year.

In this account:

Part 1 is made up of the statements required to introduce the account and confirm its accuracy.

Part 2 presents the quality priorities for 2011-2012 and says how they were chosen; it also contains the descriptions of how we have performed on aspects of quality that all NHS Trusts must cover.

Part 3 tells how we did in 2010-2011 in terms of our chosen priorities, with some added information about other achievements and issues in the year, and some examples of what service users have said.

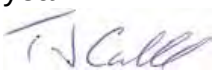
Part 4 briefly adds final comments.

Annex 1 gives the data set for performance against quality priorities in 2010-2011
Annex 2 then contains the comments from partner agencies.
Annex 3 gives the statement of directors' responsibilities as required by Monitor

Some final points:

- The full account will be published before the end of June on the NHS Choices website and on the Trust's website www.hertspartsft.nhs.uk
- Paper versions and other formats will be available via our Communications Department on 01727 804700
- Anyone with queries about the account or other aspects of quality of care in the Trust is most welcome to contact Jonathan Wells Head of Practice Governance at jonathan.wells@hertspartsft.nhs.uk

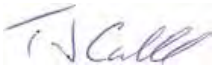
I do hope that this account is widely read and that it discusses the aspects of care that you would expect to find, and in a way that is open and clear. We were delighted last year that the East of England Strategic Health Authority commended our first account as "an open and understandable statement….. The language used is very accessible and easy to read, excellent." They found no areas of the account that needed improvement, and so we are approaching it very much in the same spirit this year.



Tom Cahill
Chief Executive

1.2 Statement by senior employee

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



Tom Cahill
Chief Executive

Date: 28th April 2011

Part 2 Priorities for Improvement in 2011-2012 and Statements of Assurance

2.1. Priorities for Improvement

This section looks ahead to the year that has just started. It shows how we chose where to focus our efforts in improving quality in the coming year. It lists what these priorities are, and how progress will be measured and reported so that where progress is not happening we can redirect our efforts during the year.

2.1.1 Building on 2010/2011

There needs to be a clear relationship between the quality priorities from one year to the next, so that everyone can see whether improvements are maintained over time.

A detailed description of how we did in 2010-2011 is given in Part 3.

Bearing in mind that our planning for 2011-2012 started before our results for the last three months of 2010/2011 were available, we made decisions on priorities for the coming year based on our performance so far and feedback from our stakeholders.

Our overall priorities for this year are about the Service User and Carer Experience, Patient Safety and Clinical Effectiveness – which are the same as last year. This year we have added a further priority around our workforce. This is for a number of reasons; it came across strongly at consultation that staff confidence in providing a quality service, and their morale, are very important factors in deciding a Trust's ability to deliver excellent quality. It is recognised that the significant changes to services planned for this year could have a negative impact on staff morale if not well managed. Therefore it has been added as a priority area.

The specific quality measures that are **not** carried over to this year are as follows:

1. Maintain compliance with PCT same sex accommodation measures.
This is about making sure that men and women when inpatients are looked after so that they are safe from each other with their privacy and dignity guaranteed. The Trust has to report any breaches of these standards to the PCT and there were none in the year. This level of monitoring continues this year outside the quality account.

2. Rate of absconsions by detained inpatients.
This patient safety measure has not been carried over because performance was showing signs of improvement and it was not a clear priority for stakeholders. However improvement has not been maintained. Therefore the future pattern of numbers of such incidents will be closely monitored outside the quality account, and actions to reduce the risks of detained patients absconding from wards through better security and joint working with the Police will continue.

3. Rate of those admitted who had access to Crisis Assessment and Treatment Teams (CATT).
This measure has not been carried over because performance was consistently good throughout 2010/2011.

4. Rate of service users with paired Health of the Nation Outcome Scores (HoNOS).
Performance on this measure was below target through the year although there was steady improvement. It has been left out as a quality account priority this year as we are confident the improvement will accelerate anyway – as recording HoNOS scores is now necessary as part of recording data for Payment by Results (this is the way commissioners will decide on the cost of services in future).

5. Rate of inpatient service users with reduced HoNOS scores on discharge.
This showed an encouraging trend last year although it fell below target. Although it is no longer a quality account priority, the practice governance lead (acute services) will continue to work with ward managers to ensure the 90% target is achieved and maintained.

6. Rate of those in employment.
This has not been carried over because performance has been above target for three quarters of the year. It will continue to be monitored.

7. Rate of those in settled accommodation.
This has not been carried over because performance has been consistently good.

8. Rate of those saying they are making progress in their recovery
This has been replaced with what the Trust and stakeholders consider to be a better question.

9. Rate of service users helped to take part fully in planning their care.
This has not been carried over because performance has been consistently good.

10. Rate of inpatients who felt informed and involved in decision-making about themselves.
This has not been carried over because performance has been relatively good, and will continue to be a focus of attention through our participation in the National Acute Inpatient survey 2011.

11. Rate of carers feeling valued as partners in care planning.
This has been replaced with what the Trust and stakeholders consider to be a better question.

12. Rate of carers receiving support or advice/information.
This has not been carried over because performance has been consistently good.

13. Rate of service users experiencing delayed transfers of care.
This has not been carried over because performance has been consistently good.

The new full list of Quality Account indicators for 2011/2012 is shown in 2.1.3.

2.1.2 Consultation

In February to March 2011 a consultation on priorities for quality improvement took place, with a “long list” of possible indicators being circulated to:

- Service users
- Carers
- Staff
- Joint Commissioning Team (JCT) and Primary Care Trust (PCT)

- Governors
- Local Involvement Network (LINk)
- County Council Topic Group

The long list was taken from:
- The previous list of quality account measures
- Monitor's Compliance Framework 2011-2012 Chapter 7
- The list of expected Commissioning for Quality and Innovation (CQUIN) measures for 2011-2012
- Measures to be used to evaluate the impact of the Trust's planned programme of radical service change (Leading by Design)
- Measures developed via the work with Quality Intelligence East (QIE) and other Mental Health Trusts in the region to put together a common set of quality indicators
- The national resource Indicators for Quality Improvement
- Other local ideas about how best to measure quality

The stakeholders were invited to vote for their top priorities and 48 replies were received.

Of the 53 possible indicators shown in the "long list" all but 5 received some votes in the consultation exercise. This illustrates the wide range of areas which are felt by at least some parties to be of considerable importance in terms of quality improvement.

During this time, the Head of Practice Governance also attended the Service User Council, Carers' Council, Hertfordshire County Council Topic Group and Governors' Quality and Effectiveness Group to explain and discuss.

All Trust services were considered in agreeing the final list of indicators. Our performance dashboard reports were used for this, as they summarise how we are doing against key targets, and in terms of service user and staff survey results.

Three other key principles were applied in selecting indicators:
- To reflect the different care groups who receive services and to include indicators relevant for services in Norfolk and North Essex
- To place the greatest emphasis on customer experience – which is both a priority area in its own right and the source of evidence for how we do on many other indicators
- To maintain a strong overlap between quality account indicators and CQUIN targets. CQUIN is about funding being made available by commissioners if the Trust achieves stretching targets about improving quality and being innovative, so that it is clearly of considerable importance to the Trust.

On the basis of views expressed through the year, and more particularly this consultation exercise, a proposed list was presented to the Trust Board on 23 March and agreed.

2.1.3 Final Priorities and Indicators

The table below shows the full list of Quality Account indicators agreed for 2011-2012, combining those that are carried over and those that are new.

The column headed “QA 10/11” shows indicators which are carried over from 2010-11 because insufficient progress has been made (with some slight modifications to make them more focussed).

The column headed “CQUIN 11/12” shows indicators which are expected to feature as CQUIN targets in the coming year.

Area	Indicator	QA 10/11	CQUIN 11/12
1. Service User and Carer Experience	Access to psychological therapies (working age mental health)	yes	
	Access to out of hours support from helpline		yes
	Rate of service users saying they could get help when they needed it		
	Rate of service users saying they had a choice in the time and day they were seen		yes
	Rate of service users saying they had a say in the choice of their medication		yes
	Rate of service users saying that if they needed it, they would recommend this service to family and friends		
	Rate of service users saying Trust services have helped them see a positive future for themselves		yes
	Rate of carers saying they are sufficiently involved in discharge planning (with service user consent)		yes
2. Safety	Rate of inpatients saying they feel safe	yes	
	7 Day Follow Up after inpatient care	yes	
	Rate of actual physical assaults on staff on LD inpatient units	yes	
	Rate of falls on MHSOP inpatient units		yes
	Rate and type of serious incidents as a proportion of total incidents reported		
3. Clinical Effectiveness	Rate of readmission within 28 days		
	Use of “You’re Welcome” standards in CAMHS to drive up quality of clinics		yes
	Rate of inpatient LD service users with Health Action Plans (“purple folders”)		yes
	Rate of older people accessing IAPT services		yes
	Rate of service users finding psychological therapy helpful (working age mental health)	yes	
	Rate of service users offered advance statements		yes
	Performance on national service user surveys		
4. Workforce	Sickness rate		
	Rate of completion of mandatory training		
	Rate of staff saying they would recommend HPFT as a place to work		

2.1.4 Measuring and Reporting Progress

As previously, the indicators listed above have been chosen partly because we are confident that we have full accurate sets of data to enable measurement of progress. In most cases, this is via our customer experience surveys such as Having Your Say, our incidents data and our electronic patient record (EPR). In the coming year there will be a phased introduction of a new patient record system and we are clear that this transition must not impede our ability to gather data.

Quarterly reports on progress will be made to the Quality and Risk Committee and then to Board. This will make sure that the Board continue to be closely informed about our performance, and they will highlight to the Executive team where extra actions are needed to make improvements through the year.

Team managers already receive performance reports which show how their teams are doing on quality account measures and this will continue in the coming year.

A small number of indicators require further work to set up a reporting system. For example, "Access to out of hours helpline" will be measured through a mystery shopper exercise where some service users and carers will be organised to evaluate their experience of the helpline against specific standards when they come to use it. This is unlikely to be suitable for quarterly reporting. "Performance on national service user surveys" will be more closely defined so that the measure is taken from a subset of service user replies to questions, based on areas that are particularly important to them.

News Item 1

In February 2011 the Head of Patient Experience and Safety at the Hertfordshire PCT visited Albany Lodge acute inpatient unit (St Albans), Glaxo Day Unit for older people in Stevenage and Edenbrook ward for older people in Stevenage. She wrote to Oliver Shanley Executive Director – Quality and Patient Safety to say*: "it was a pleasure to meet committed and enthusiastic staff clearly delivering excellent care to their patients. … I would feel happy leaving a relative in their care."*

2.2. Statements of Assurance

2.2.1. Review of Services

During 2010-2011 the Trust provided NHS services through 80 teams in 29 main locations as registered with the Care Quality Commission.

The Trust has reviewed all the data available to it on the quality of care in all these services. This was done in terms of the three dimensions of quality – safety, clinical effectiveness and service user and carer experience. There was sufficient data available for this to be done across the whole Trust.

The income generated by the NHS services reviewed in 2010-2011 represents 100% of the total income generated from the provision of services by the Trust in this period.

2.2.2. Participation in Clinical Audits

During 2010-2011, 5 national clinical audits and one national confidential enquiry covered NHS services that this Trust provides.

During that period we took part in 83% of the national clinical audits and 100% of the national confidential enquiries that it was eligible to participate in.

Those that the Trust was eligible to participate in are as follows:

- National Audit of Psychological Therapies
- Monitoring of patients prescribed lithium (Prescribing Observatory for Mental Health – UK)
- Medicines Reconciliation (POMH-UK)
- Use of anti-psychotics in people with learning disability (POMH-UK)
- Use of anti-psychotic medication in CAMHS (POMH-UK)
- National Confidential Enquiry into Suicides and Homicides

The Trust's level of participation is shown in the table below:

audit	participation	Number of cases
National Audit of Psychological Therapies (NAPT)	yes	24 teams, approx. 500 cases
Monitoring of patients prescribed lithium	yes	230
Medicines Reconciliation	no	n/a
Use of anti-psychotics in people with learning disability	yes	272
Use of anti-psychotic medication in CAMHS	yes	62
National Confidential Enquiry into Suicides and Homicides (NCISH)	yes	10 (April to September 2010)

In this table, the number of cases is not shown as a proportion of the number required for each audit as no such requirement is stated for these audits in the national guidance.

In addition to the list provided by the Royal College of Psychiatrists' Centre for Quality Improvement, the Trust took part in the POMH-UK audit on the prescribing of anti-psychotic medication for people with dementia, collecting the data in March 2011. 361 patients were enrolled in the audit.

The NAPT audit has not yet reached the stage of carrying out actions in response to what is learnt.

The POMH-UK audits have led to improvements in patient safety, for example a greater consistency between the Trust and GPs in how lithium monitoring is done and reported across the county.

The NCISH annual report is used to compare this Trust's performance against national patterns alongside other regional and national benchmarking data with regard to suicides and homicides. This year it has provided some reassurances to the Trust that we are below national averages, whilst also raising questions about a higher than expected number of suicides by people with a diagnosis of personality disorder over the past 10 years (which encouraged us in our decision to set up a specialist community personality disorder service two years ago).

The reports of 83 audits were reviewed in the year. Each audit report has an action plan whose implementation is monitored by the audit team. As one of many examples, a Consultant Psychiatrist audited the service user experience of acute inpatient care – using a range of methods including patient, carer and staff interviews and information gathered from patient records. Standards were derived from national survey results and local policies. Results showed improvements compared to previously, but still highlighted areas to be addressed such as routine physical examination on admission and checking mental capacity of inpatients. This has led to performance in national service user surveys being included as an indicator in the quality account priorities for 2011-2012.

2.2.3. Research

The number of service users receiving services provided by this Trust in 2010-2011 that were recruited during that period to participate in research approved by a research ethics committee was 375.

This compares to 386 in the previous year.

In a Mental Health Trust there can be many technical reasons why service users are excluded from studies often to do with having more than one diagnosis; this can mean that there is not a clear relationship between participation in research studies and receiving the best possible treatment.

However, this year we are encouraged by the progress of several studies – above all the Whole Life study, a project which investigates the benefits of a one to one recovery-focussed therapeutic intervention for people with schizophrenia. All follow up assessments have now been completed, and qualitative assessments suggest that the approach was well received by most participants. The research is now being written up for publication.

One benefit to the Trust has been the number of staff who have now been trained in this approach and who will continue to use it in everyday practice. We will also be making the Whole Life Coaching manual available to other NHS Trusts, once the work has been published.

2.2.4. Commissioning for Quality and Innovation (CQUIN)

A proportion of the Trust's income (1.5%) in 2010-2011 was conditional on achieving quality improvement and innovation goals agreed between the Trust and its commissioners, through the Commissioning for Quality and Innovation payment framework.

Inevitably, these targets represent a significant aspect of the Trust's quality account priorities each year.

For 2011-2012 – against very challenging targets – the Trust was successful in gaining 74% of the funding, a total of £1,430,420.

One target is still subject to agreement between the Trust and its commissioners. If this is agreed to have been achieved, the income will rise to £1,546,400.

The agreed CQUIN goals for 2010/2011 are shown below:

- to reduce waiting times
- to improve service user and carer experience
- to support the transformation of mental health services, improving effectiveness and productivity
- to streamline and improve pathways for mental health services for older people
- to reduce out of county placements in Child and Adolescent Mental Health Services (CAMHS)
- to increase community detoxification programmes for people with problems of alcohol misuse
- to develop recovery based services

The goals for 2011/2012 are not yet agreed with commissioners.

2.2.5. Statements from the Care Quality Commission (CQC)

The Trust is required to register with the CQC and its current registration status is that is fully registered. It has no conditions on registration.

The CQC has not taken enforcement action against the Trust during this period.

The Trust has not taken part in any special reviews or investigations by the CQC during the reporting period.

We have welcomed the monthly quality and risk profiles provided by CQC and use them to develop actions in any areas of concern. During the year CQC visits to the learning disability inpatient site at Lexden Hospital, Colchester highlighted some issues of poor patient care which needed addressing urgently.

2.2.6. Data Quality

It is recognised that if quality accounts are to have equivalent status to financial accounts further work is needed to ensure complete accuracy of the supporting data.

As a Foundation Trust we had external audit of our data quality in summer 2010 leading to some recommendations and actions. Progress on these was then checked via internal audit in January 2011 and the next external audit is expected shortly.

The Trust has taken the following actions to improve data quality:

- Recruitment of a Performance Information Officer to add expertise and capacity to this team
- Provision of training to staff including all new starters on data inputting

- Elimination where possible of manual approaches to data gathering (for example, Crisis Teams used to report on their own activity, this is now taken from the patient records by the Informatics team centrally)

- Audit of supervision to check whether it was being used as it should to address recording issues with staff, leading to raised awareness of their managers
- Revision of the Data Quality Policy to state clearly the Executive lead for data quality and the importance of the accuracy of information for the quality account
- Introduction of more robust audit trails re decisions about data, and stronger internal assurance such as random checks by the Informatics Manager in his team
- Temporary data quality officers reporting to the Performance team recruited to work alongside teams to assist in full and accurate use of the patient record system

This much closer attention to data quality has led to some errors being highlighted in the year – both through audit and through our stronger routine systems for checking. When these have occurred they have been put right (both for the present and the future), and the errors have been explained in the next quarterly report to Board.

2.2.7. NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2010-2011 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records at end of year which included the patient's valid NHS number was:

- 98.5% for admitted patient care
- 99.7% for outpatient care

The percentage of records at end of year which included the patient's valid General Medical Practice code was:

- 97.5% for admitted patient care
- 99.8% for outpatient care

2.2.8. Information Governance Toolkit

The Trust's Information Governance Assessment Report overall score for 2010-2011 was 60% and was graded Red.

This low score has been of considerable concern to the Trust. It occurred for a number of reasons including a failure to ensure all staff had had the necessary training in information governance. An action plan has now been urgently agreed by the Executive team to remedy the situation by June.

2.2.9. Clinical Coding Error Rate

The Trust was not subject to the Payment by Results clinical coding audit in 2010/2011 by the Audit Commission.

News Item 2

Between August and December 2010 the Hertfordshire Local Involvement Network (LINk) inspected all six acute inpatient units, Oak and Beech wards at Harperbury and the adolescent unit at Harperbury, Forest House. In a glowing report they found:

" Generally, the provision was…. of a quality from good to outstanding"
"All internal environments are kept scrupulously clean and clutter-free."
"Service users all felt safe and well looked after in the units."
"All units take care to prepare service users properly for discharge."
"There is good access to psychiatrists."
"None of the service users interviewed had any complaints about their care."

Part 3 Review of Quality Performance

3.1. Introduction

This section is the heart of the quality account. It is where we describe our performance against the priorities agreed at the start of 2010-2011. But as well as the hard numbers, wider information is also included – about significant developments, events during the year and also service user comments. It is very true that the essence of mental health care is not captured by data alone; quality of care can and should be described in terms of individual service user and carer experiences too, and we have tried to do that here.

3.2. Selection of Priorities

In early 2010 stakeholders were consulted about what the most important areas for quality improvement in the Trust should be – using a long list refined on the basis of the feedback and then signed off at Board in March 2010.

The 3 overall priorities, each with a set of indicators, were:

1. Inpatient Safety

Advancing patient safety for all inpatients, including promoting dignity, privacy and sexual safety, minimising absconsions of detained patients, and ensuring safe and effective arrangements for admission and discharge

2. Successful and recovery-oriented outcomes

Clinically effective services with a positive impact, with better access to helpful psychological therapies, greater use of outcomes measures to show the benefits of services, and more service users being helped into employment and settled housing

3. Positive and therapeutic engagement with service users and carers

Involving service users and carers more effectively in all aspects of care, by developing care plans together, providing good information and explanations of care at all stages, and treating people well

3.3. How Did We Do?

Note 1: please see annex 1 for detailed data set.

Note 2: this progress report does not include historical nor national benchmarked data as in many cases it is not available. Where there is relevant data, it is often not comprehensive or is unreliable, so would not support our aim of progress being presented clearly and simply.

Note 3: These indicators use standard national definitions: 1.1., 1.2., 1.3., 1.4., 1.5., 1.6., 1.7., 2.5., 2.6., 3.4., 3.5.

1. Patient Safety

1.1. Compliance with PCT measures for same sex accommodation

Definition: Compliance is measured by whether or not there any breaches (that are not clinically justified) of the rules for delivering same sex accommodation on inpatient units.

Data source: Any formal breaches are confirmed at Executive team level before being reported to the PCT.

Rationale: It has been recognised for several years across the NHS that inpatients should always be able to feel safe and that this includes preserving the dignity and privacy of men and women separately.

Progress: The Trust has a 100% success record on this indicator this year, with no breaches reported. Quarterly surveys also found that around 80% of inpatients said they had felt safe during that admission. Both the 80% figure, and sessions with ward staff where some inconsistent practice is still found, indicate that we cannot be complacent about this area, and it will remain a focus of attention by the Deputy Director of Nursing and Patient Safety this year.

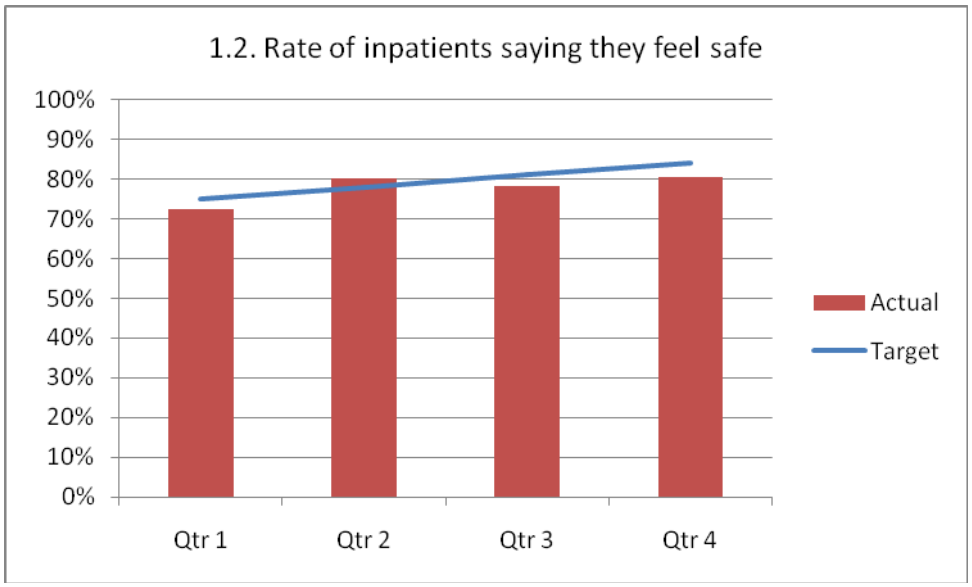
1.2. Rate of inpatients saying they feel safe

Definition: Number of service users completing a Having Your Say inpatient form who say they felt safe each quarter (as a %).

Data source: Having Your Say forms (paper, phone or Trust website).

Rationale: This complements the indicator above. It makes sure that we see whether inpatients actually experience inpatient care as safe, as well as declaring as a Trust that we comply with the rules.

Progress:



Performance has improved through the year but was narrowly below target. There is still a volatile mixture of inpatients on wards at times – both on acute units where there are more detained patients, and on older people's units where relatively young and fit individuals with functional illnesses such as depression can often share the same space with much frailer patients with severe dementia.

At the QE2 Hospital, Welwyn the two wards have separated into male and female units with positive results, but we cannot wait for newly designed units to make further improvements on inpatient safety.

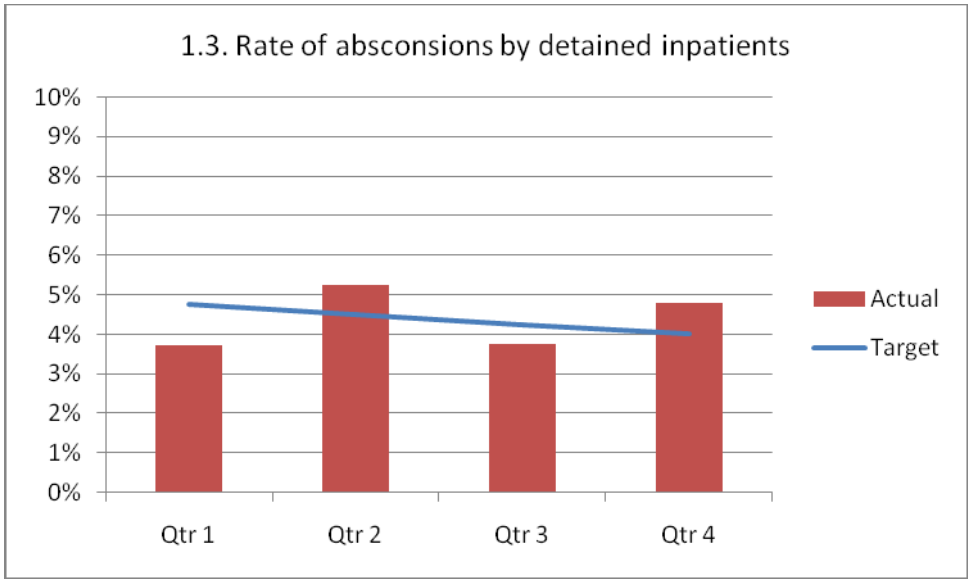
1.3. Rate of detained patients absconding

Definition: Number of detained patients who absconded as a proportion of number of inpatients who have been on any section at any time in that quarter. The aim is to be below the "target" figure.

Data source: Incident reports.

Rationale: Service users and their families quite rightly expect that when someone is unwell enough to need compulsory admission to a mental health unit, to ensure they are safe and receive good care and treatment they should not be able to abscond.

Progress:



Fewer than 5% of detained patients abscond, but the figure has not decreased through the year, despite increased attention on security of inpatient units and on working effectively with the Police. There is some evidence that more unwell service users are often now receiving care outside hospital with the effect that inpatient units have a higher proportion of disturbed individuals and a higher proportion detained.

These pressures have so far made it difficult to steadily reduce the rate of absconding.

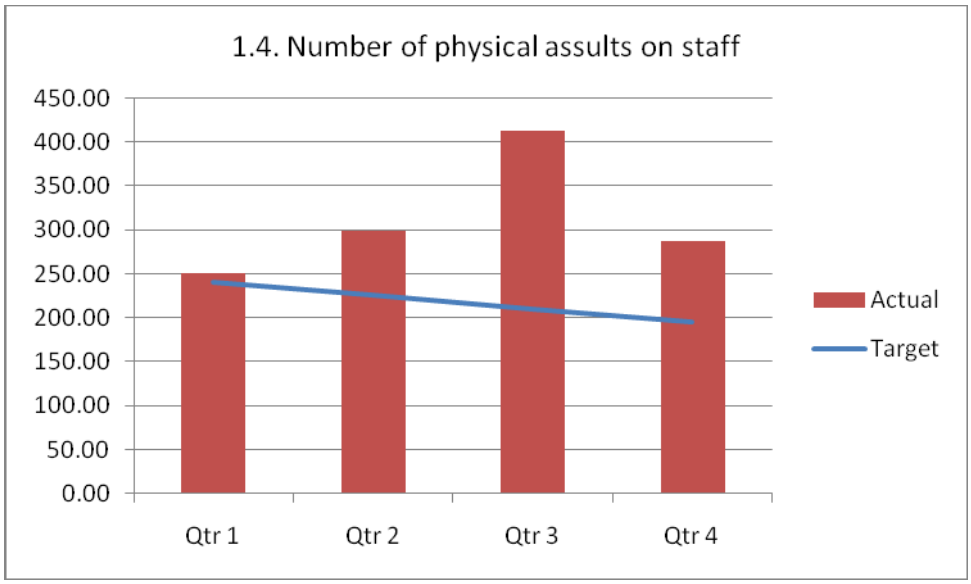
1.4. Number of physical assaults on staff

Definition: Number of reported incidents of actual physical assault by inpatients on staff.

Data source: Incident reports.

Rationale: The Trust was aware that it was a relatively high reporter of this type of incident. It is clearly another important measure of whether inpatient units are experienced as safe – by both patients and staff.

Progress:



There has been no progress on this indicator through the year which is clearly disappointing. In mid-year when the numbers were seen to be increasing, further analysis was done and it was clear that one factor was the high number of incidents being reported from North Essex Inpatient Services for people with learning disabilities (in Quarter 3 North Essex had 226 incidents of actual or threatened physical assaults). These services came into the Trust in April 2010 and there were time lags with their incident reporting, which meant that the full effect of their numbers of physical assaults was not appreciated until Quarter 3.

Whilst full reporting is always important as a starting point in learning from incidents, there is no doubt that these figures and the upward trend are concerning and steps have been taken to:

- Standardise de-escalation training across inpatient units
- Provide more hands on support from trainers and experienced staff especially at the Lexden site (Essex)
- Improve support to staff who have been assaulted, building on de-briefing and confidential counselling that is already available
- Introduce more activities on units, including physical exercise regimes and gym work often led by occupational therapists

This area is agreed as a major quality account priority for 2011-2012 with a special focus on learning disability units where the rate is highest.

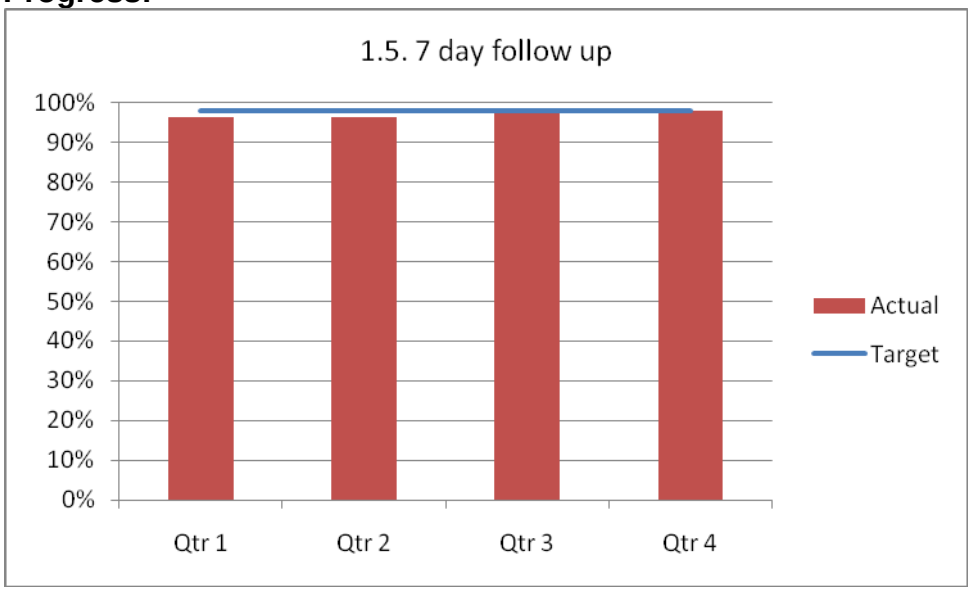
1.5. 7 Day Follow Up

Definition: Number of service users who were followed up after discharge from inpatient care (by phone or face to face) within 7 days – excluding CAMHS and LD discharges, as a proportion of the number of discharges from inpatient units into the community.

Data source: The electronic patient record.

Rationale: A well known measure of effectiveness and safety in mental health services is the extent to which service users are supported within 7 days of discharge from inpatient care. The target remains as important as ever as over 1,000 service users move in and out of inpatient care each year.

Progress:



Performance in many ways can be seen as consistently good, although it has at times been narrowly below target. When this has happened, individual cases are scrutinised and the reasons (which are sometimes valid, such as discharge of a stable patient to a registered care home) are given to commissioners.

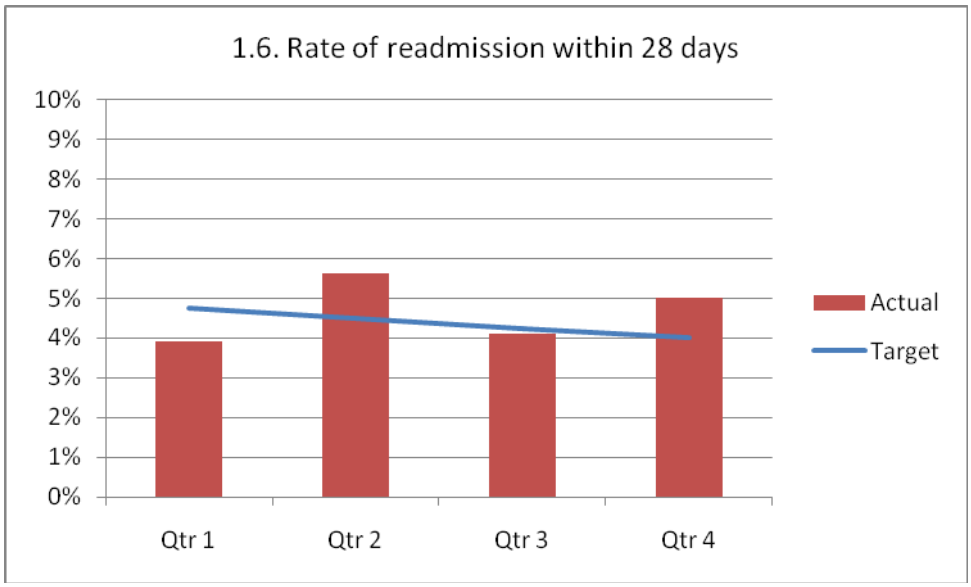
1.6. Rate of readmission within 28 days

Definition: Number of emergency readmissions within 28 days of discharge from inpatient care, excluding those who self-discharged, as a proportion of the number of discharges in the period. The aim is to be below the “target” figure.

Data source: The electronic patient record.

Rationale: This is a well known measure of the clinical effectiveness of mental health services and an important target.

Progress:



Consistent progress has not been made on this indicator although the rate has not gone above 5.6%. It has not proved possible in the past year to reduce the readmission rate in the face of the rapid pace of movement in and out of inpatient care.

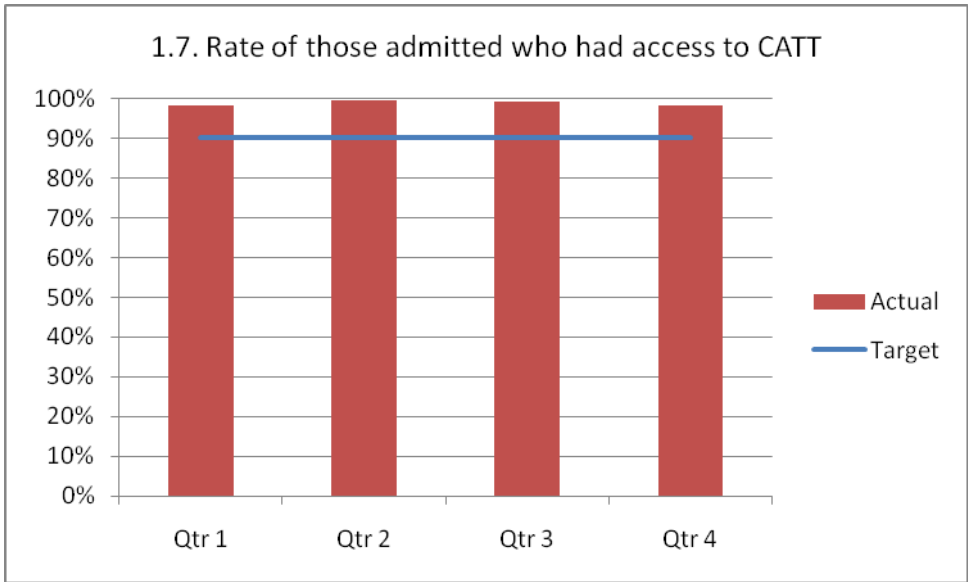
1.7. Rate of those admitted who had access to CATT

Definition: Number of service users who were assessed by CATT prior to admission to acute inpatient unit, as a proportion of all admissions to acute inpatient units.

Data source: The electronic patient record

Rationale: This is a Monitor target which examines the Trust's ability to provide care and treatment wherever possible at home.

Progress:



Performance has been consistently good throughout the year.

2. Clinical Effectiveness

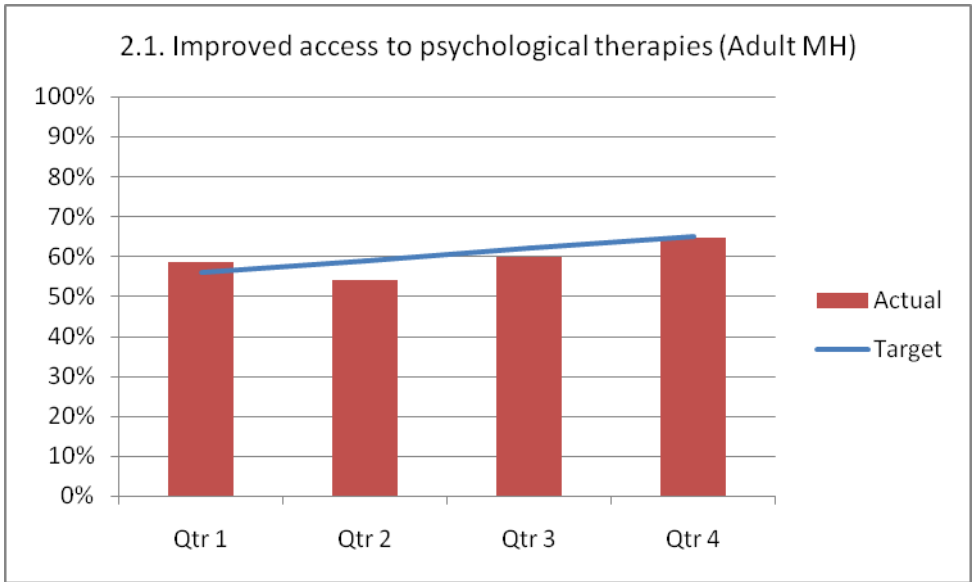
2.1. Access to psychological therapies (adult mental health)

Definition: Number of service users who said they had received psychological therapies when they wanted them as a proportion of all those responding (excluding Learning Disabilities (LD) responses)

Data source: Having Your Say

Rationale: Stakeholders continue to say they want better access to psychological therapies. We have made some changes to our services to provide this, but we need to see if access is being experienced as better.

Progress:



Access has improved slightly through the year. It has been hard to make faster improvement with no increase in the numbers of clinical psychologists and other staff, despite extra training in psychological therapies, also having to manage other increasing demands on their time.

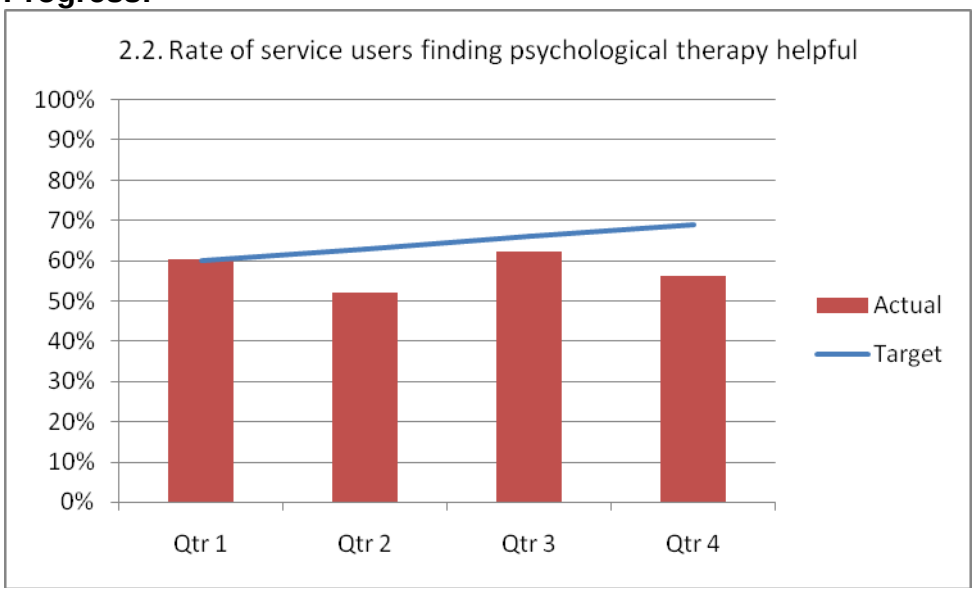
2.2. Rate of service users finding psychological therapies helpful.

Definition: Number of service users who said they had found psychological therapies helpful as a proportion of all those who responded (excluding LD).

Data source: Having Your say

Rationale: Having aimed to improve access to these treatments and bearing in mind there are fewer resources, it is crucial to make them as effective as possible.

Progress:



There has been no steady progress through the year, and no decline in effectiveness either. The Head of Psychological Therapies has further plans to ensure treatments are evidence based, having already strengthened lines of accountability for psychologists and confirmed the status of NICE guidelines.

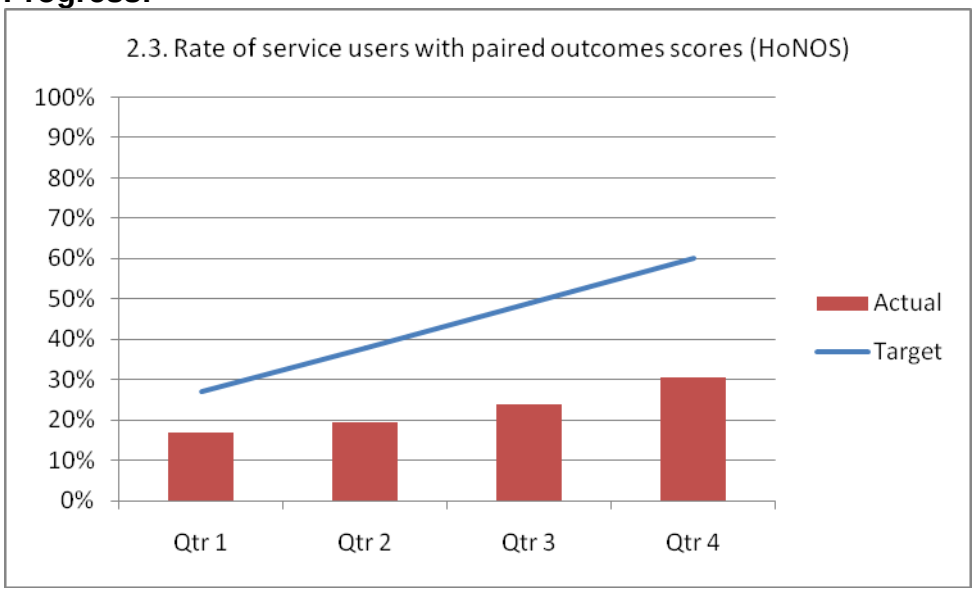
2.3. Rate of service users with paired outcomes scores

Definition: Number of service users with two or more HoNOS scores in the past 12 months (excluding Child and Adolescent Mental Health Services (CAMHS)) as a proportion of all service users (excluding CAMHS).

Data source: The electronic patient record.

Rationale: HoNOS scores compared over time give a powerful picture to teams of whether their services are producing positive results. These reports can then be used to demonstrate effectiveness of services both internally and externally and for staff to reflect on their practice and consider what is most helpful to their service users.

Progress:



There has been a steady increase in the rate of service users with paired scores but this is well below the target given by Commissioners (as a CQUIN target). Progress is expected to continue in the coming year as HoNOS is part of the system the Trust is now having to use for all its service users to allocate a cluster to them as part of Payment By Results, so that the Trust receives payment accoring to the numbers of service users provided with care and treatment according to differing levels of need.

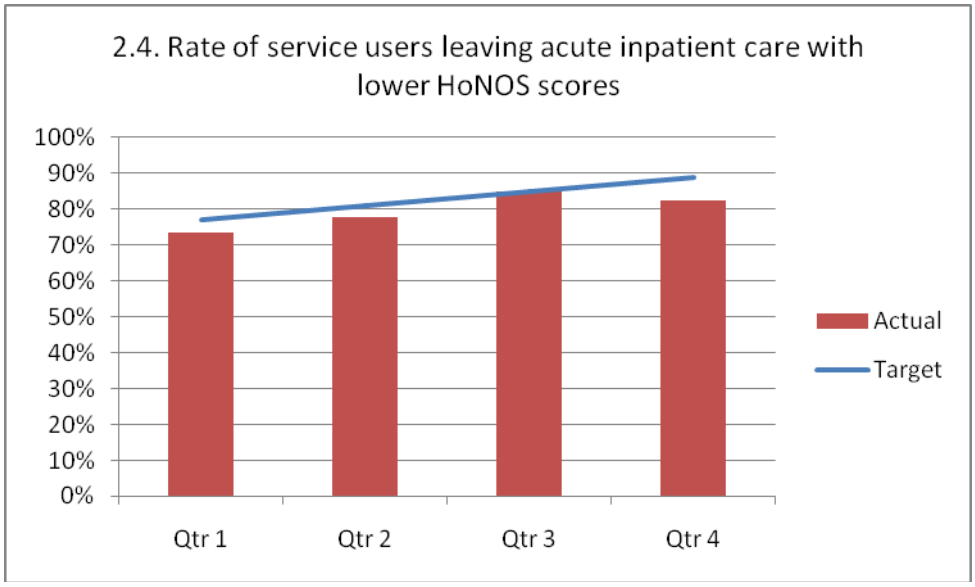
2.4. Rate of service users with lower HoNOS scores leaving acute inpatient care.

Definition: Rate of those with lower HoNOS scores on discharge compared to on admission to acute inpatient units, as a proportion of those with paired scores.

Data source: The electronic patient record.

Rationale: Acute inpatient care is a much valued resource and the Trust needs to make it as effective as possible. The vast majority of those having acute inpatient care should be shown by having reduced scores to have benefitted from it.

Progress:



There has been progress, but at a lower rate than planned. It could be that prompt use of the Crisis Assessment and Treatment Teams (CATTs) to provide treatment at home as soon as someone can accept it means that more inpatients are being discharged before their level of illness has reduced.

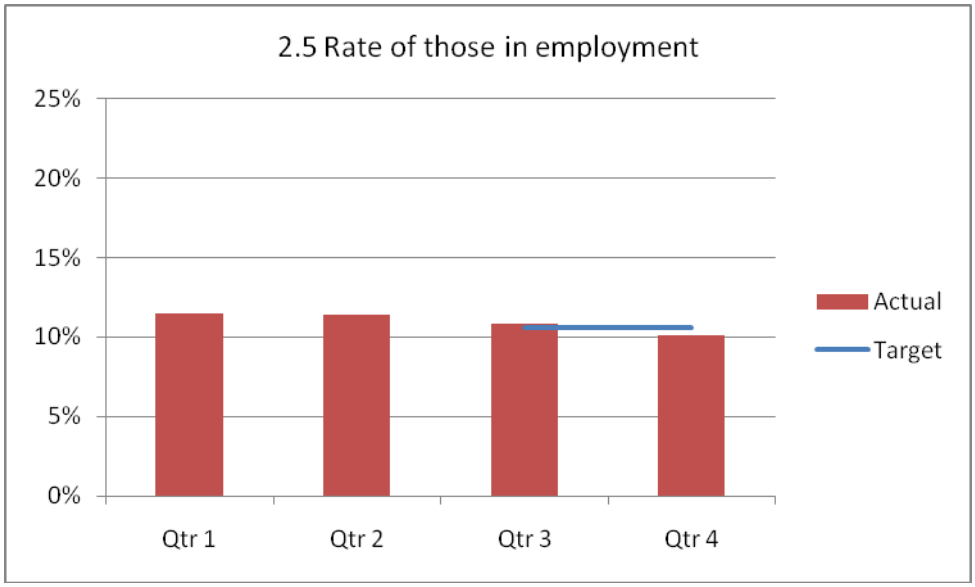
2.5. Rate of those in employment

Definition: Number of service users aged 18 to 69 on the Care Programme Approach receiving mental health services with employment as a proportion of those with emplyment status recorded

Data source: The electronic patient record

Rationale: We want to measure and improve the effectiveness of both the health and social care that we provide. The social care includes working with empoyment agencies and through our own welfare to work schemes to help people participate fully in their communities as workers.

Progress:



Progress has been fairly static as would be expected in the current economic climate. It has dropped narrowly below the target that was given by commissioners in mid -year

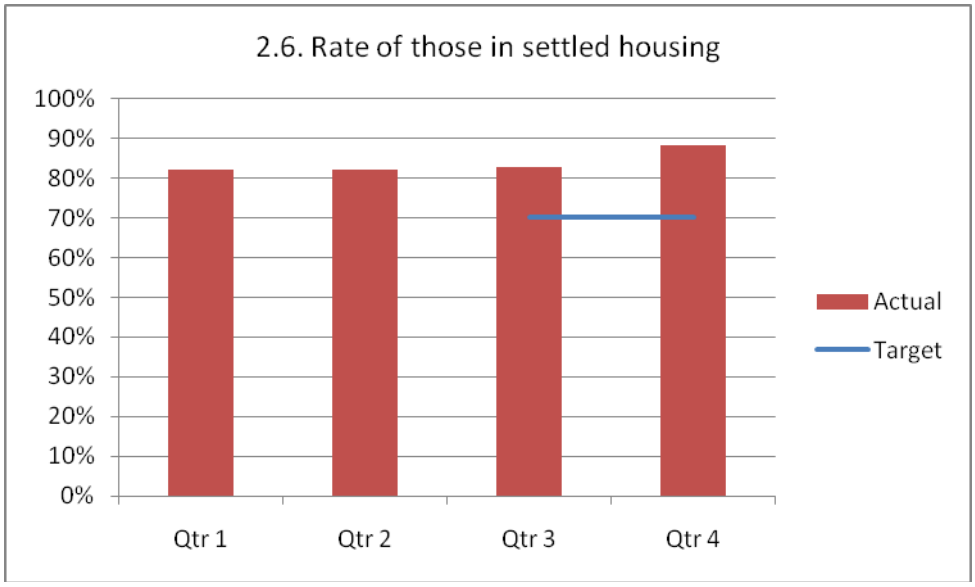
2.6. Rate of those in settled housing.

Definition: Number of service users aged 18 to 69 on the Care Programme Approach receiving mental health services in settled housing as a proportion of those with emplyment status recorded

Data source: The electronic patient record

Rationale: We want to measure and improve the effectiveness of both the health and social care that we provide. The social care includes working with housing agencies to help people participate fully in their communities by having stable accommodation.

Progress:



Performance has been consistently above the target set in mid-year by commissioners**.**

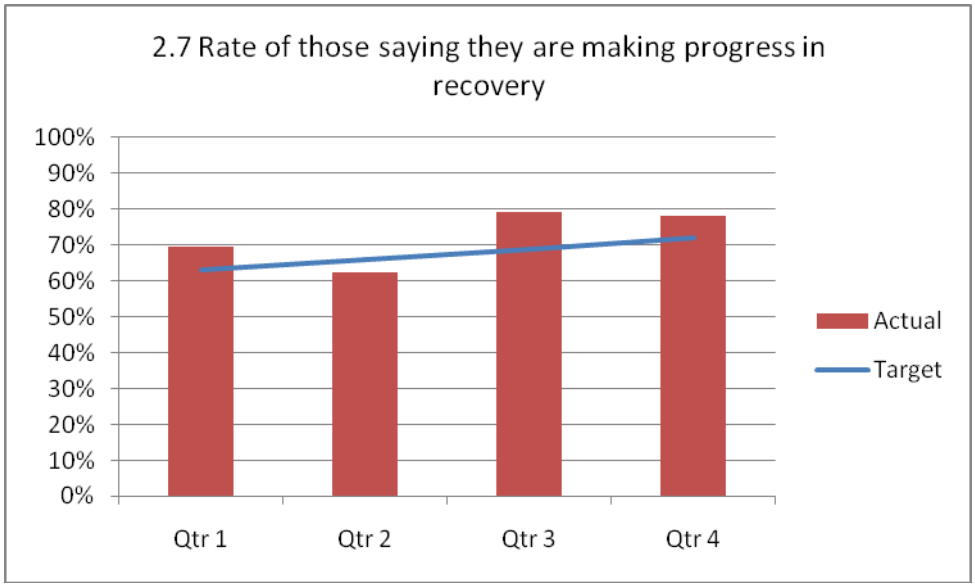
2.7. Rate of those saying they are making progress in recovery

Definition: Number of service users saying they are making progress in their recovery as a proportion of all respondents.

Data source: Having Your Say.

Rationale: The Trust has fully adopted the recovery model as a way of working and seeks more evidence of this having the intended impact on the lives of those who use its services, so that they retain their strengths and their individuality and are not prevented from leading fulfilling lives. This question, (although open to wide interpretation), offers one way of judging how we are doing.

Progress:



It is very encouraging to see the steady progress that was made on this indicator, with the internally set target being achieved. It is not the only way of exploring the impact of the recovery model and we know from our service users that we have a long way to go.

3. Service User and Carer Experience

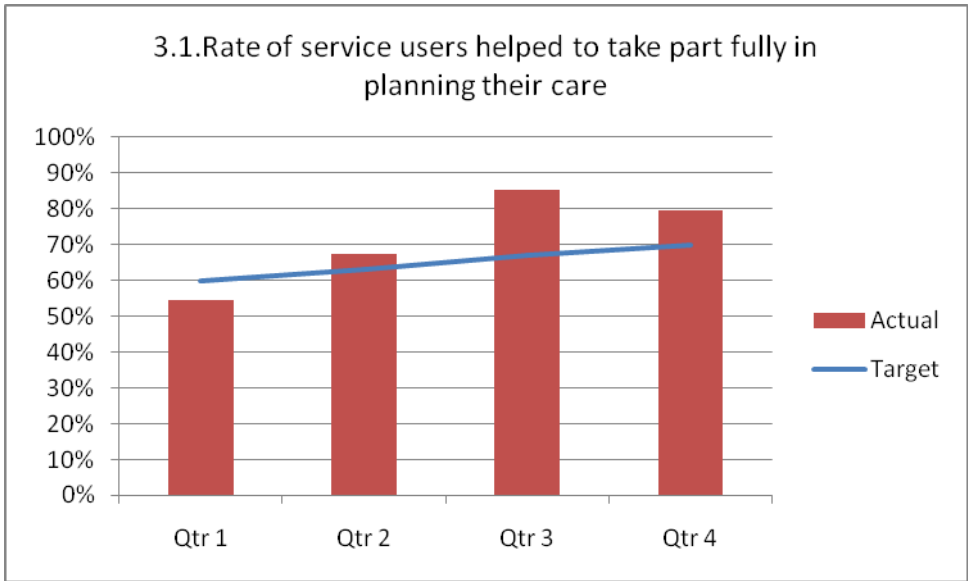
3.1. Rate of service users helped to take part fully in planning their care.

Definition: Number of service users who responded that they felt supported to fully participate in care planning, as a proportion of all respondents (including LD).

Data source: Having Your Say.

Rationale: As a Trust we are committed to respecting and valuing the lived experience of service users and doing things with them rather than to them. We hear from service users that they still at times feel excluded from decisions about their own care. Through customer care training, better availability of information and awareness raising with staff we have been working to improve our practice in this field; we want to see if this is having an impact.

Progress:



This progress indicates that our efforts have been worthwhile. We would expect to see these results repeated via the national community service user survey that will report in May 2011.

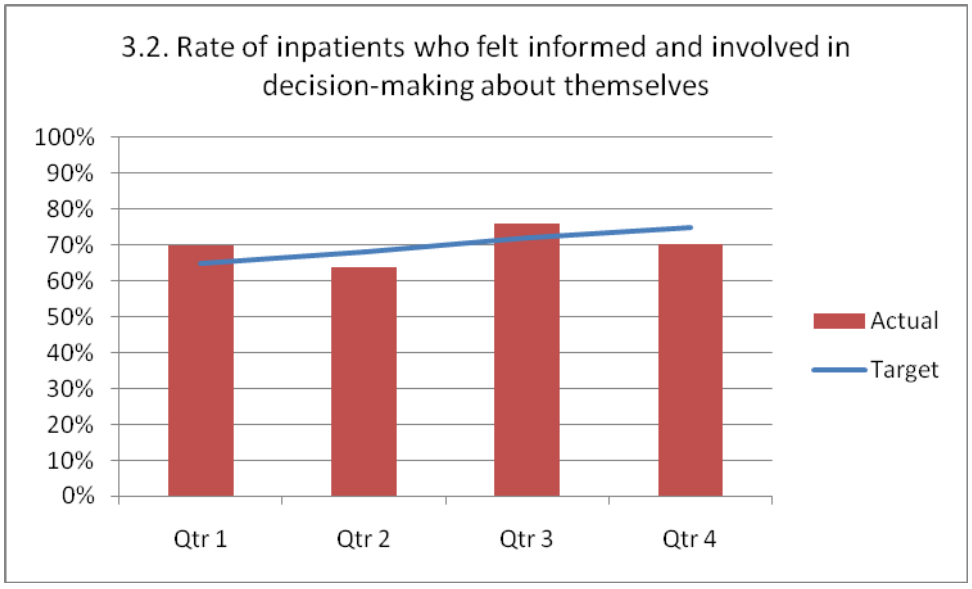
3.2. Rate of inpatients who felt informed and involved in decision-making about themselves

Definition: Number of inpatient service users who responded that they felt informed and involved in decision making as a proportion of all respondents (excluding LD)

Data source: Having Your Say.

Rationale: This also is about working effectively with service users and making acute inpatient care as therapeutic as possible. The 2009 national acute inpatient service user survey had produced disappointing results and we have wanted to see continued improvements in this area.

Progress:



Progress has been inconsistent with no clear trend in either direction, in the face of continued pressures on inpatient care. The Joint Heads – Acute Services in particular will expect further improvements to be reflected in the results of the acute inpatient service user survey which we are repeating now.

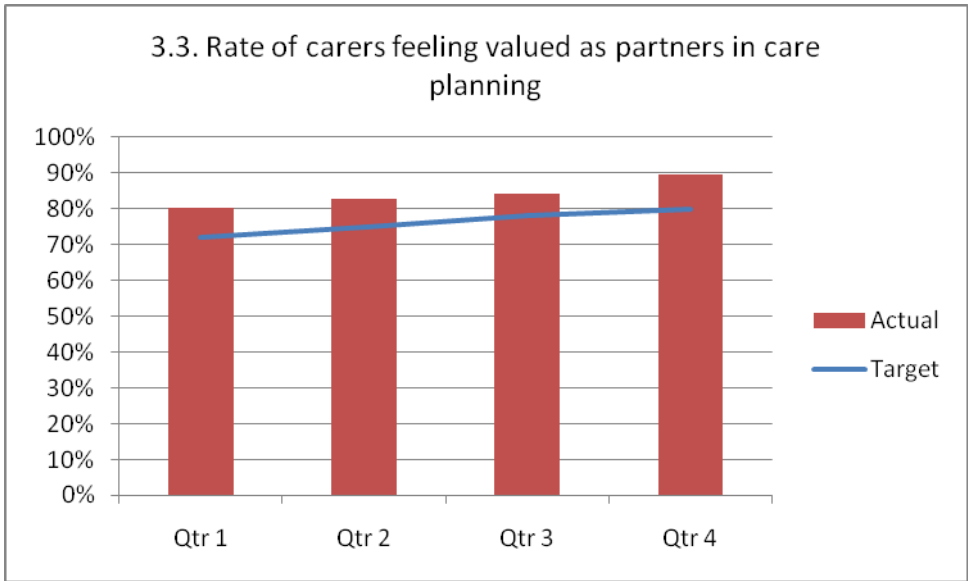
3.3. Rate of carers feeling valued as partners in care planning

Definition: Number of carers who responded that they felt valued as proportion of all carer responses

Data source: Having Your Say.

Rationale: Carers are key partners of staff and service users where they tend to do most of the responding to the needs of the service user and to know them better than anyone else - as is only natural. They still too often feel excluded from care planning as our carer surveys in 2010 indicated. Through the carer project manager's leadership, distribution of carers' packs and carer-led training for staff, we have aimed to improve this aspect of working with carers and we wanted to see if this had made a difference.

Progress:



It is good to see this gradual progress which reflects hard work and some changed attitudes amongst staff. There is more to be done.

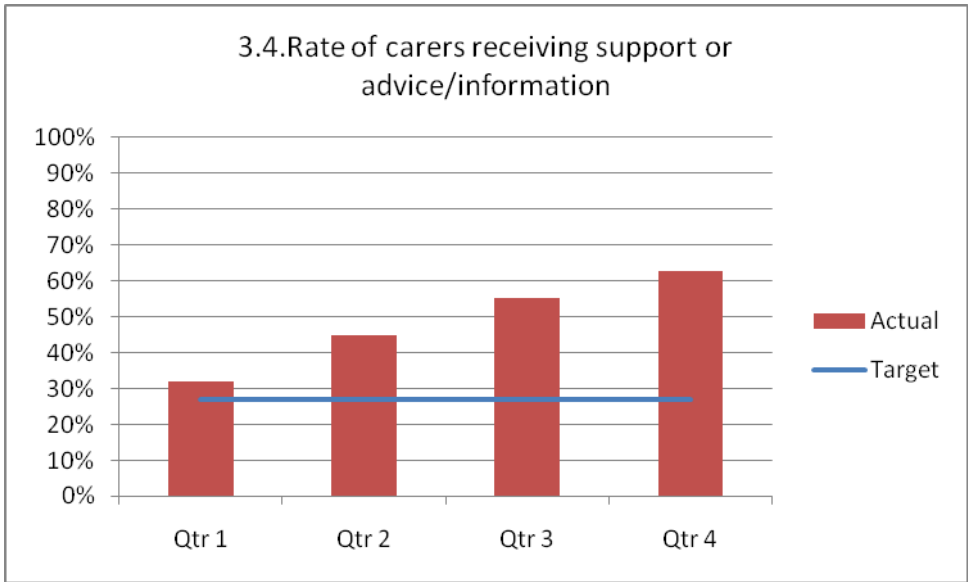
3.4. Rate of carers receiving support or advice/information

Definition: Number of carers having had a Carer's assessment / Carer's care plan / Carer's contingency plan / Carer's information pack / advice / support – as a proportion of the number of service users on the Trust caseload (excluding CAMHS and LD).

Data source: The electronic patient record.

Rationale: This remains an important social care target and a fundamental measure of whether carers are getting the help they need.

Progress:



Good progress has been made on this indicator this year with the target achieved for each quarter.

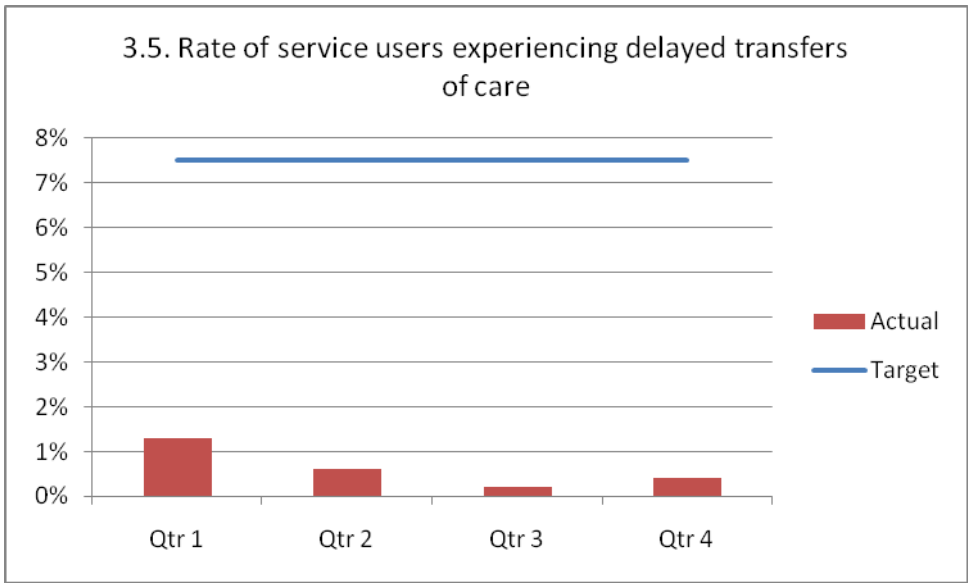
3.5. Rate of service users experiencing delayed transfers of care

Definition: Number of patients whose transfer of care was delayed during the quarter, as a proportion of the number of patients on wards in the quarter (excluding CAMHS). The aim is to stay below the "target" figure.

Data source: The electronic patient record.

Rationale: It is unhelpful and inefficient for service users to be on inpatient units when this is no longer needed. It is demoralising and can in itself have an adverse effect on inpatients' mental health.

Progress:



This target has been achieved throughout the year, demonstrating effective joint working between ward and community teams and between the Trust and partner agencies.

3.4. Summary of Performance

The quality account indicators strongly reflect the key national priorities in the Department of Health's Operating Framework 2010/2011, whilst also retaining a local flavour.

All targets in Monitor's Compliance Framework 2010/2011 (appendix B) were achieved as follows:

indicator	Achieved?	Performance for the year
Those on the care programme approach receiving 7 day follow up after discharge	Yes	97.1%
Those on the care programme approach with review within 12 months	Yes	96.5%
Minimising delayed transfers of care	Yes	0.6%
Those admitted being assessed by the crisis resolution and home treatment team	Yes	98.6%
Numbers of new cases for the Early Intervention in Psychosis Service	Yes	159 (target 150)
Data completeness: identifiers	Yes	99.1%
Data completeness: outcomes	Yes	64.8%

The Trust achieved its quality indicator targets in 7 of 19 cases (as shown above), and if to this figure is added those indicators where performance at end of year had improved from the start the figure rises to 13 of 19, which is 68%.

The only significant decline in performance is around physical assaults, which as previously stated also reflects an improvement in reporting. This will be a particular focus of attention now.

It may be that we were over ambitious in the targets we set ourselves at a time of service reductions before the benefits of our service transformation programme are fully felt. It may also be that the figures do not tell the whole story.

Therefore in the next sections some other aspects of quality in the past year are presented.

3.5 Some Events

2010-2011 saw considerable pressures on some services. As personal budgets have been used much more, so that individuals can buy the social care they want rather than fitting in with what is generally provided, mental health resource centres can no longer be seen as the preferred way of meeting these social care needs. This has had to be explained to current service users and has understandably led to uncertainty and anxieties.

As previously mentioned the inpatient services for people with learning disabilities at the Lexden site in North Essex, which became part of the Trust in April 2010, have been subject to negative reports from the Care Quality Commission (incorporating the Mental Health Act Commission). In 2010 key managers from outside North Essex were introduced to the service to implement the highest standards of care. This has taken longer than we would have liked but a full new management team is now in place, with a strong practice governance structure

using clinical audit, service user feedback and examination of incidents and any complaints to monitor quality.

At the same time, a great many positive events illustrate exciting new developments in the Trust as we strive to provide the best possible care in ways which are service user centred, evidence based and innovative.

These include:

- Participation in accreditation programmes and quality improvement networks, usually with the Royal College of Psychiatrists

  Accreditation Programmes
  The Psychiatric Intensive Care Unit (Oak Unit, Harperbury)
  Older People's Inpatient Units (2)

  Quality Improvement Networks
  Inpatient Child and Adolescent Unit (Forest House)
  Forensic Mental Health Services (2)
  Perinatal Mental Health Inpatient Unit (Thumbswood at QE2, Welwyn)

- Peer Support Scheme
  A first cohort of service users have had 10 days training as peer support workers and been appointed to these new posts. This new role is an excellent example of valuing what service users can offer each other in terms of support and positive messages about self help rather than being passive recipients of care. They have been welcomed and will be developed further as the use of personal budgets increases.

- Productive Wards Project "Releasing Time to Care"
  Through two tempoary posts the Trust has used this nationally recognised approach to stimulate inpatient units to become more efficient and thus provide more direct care time with inpatients. 24 wards have been involved so far, reducing waste and clutter, saving money, reducing bureaucracy where possible and feeding back to inpatients what is being done and why via "At a Glance" noticeboards.

- Elizabeth Court
  This ward for older people with dementias provides long term care where the physical environment makes a big difference; it has won £100,000 from the Enhancing the Healing Environment fund to modernise the ward and provide a unit to be proud of.

- Singing Project
  Older people's inpatient units can sometimes be neglected, with a lack of stimulation for service users. As well as the input of Occupational Therapists which they celebrated at their conference last year, as part of spiritual care the Trust obtained funding to introduce singing groups on these wards. 60 volunteers came forward to be trained and to work with our spiritual project manager to start singing groups on these wards.

- Conferences
  The Trust has held a range of conferences and events through the year, which offer ways of sharing good practice across the Trust and of showing staff new ideas for best practice. Sometimes, as with the Recovery conference, the End of Life Care for People with Dementia workshop, or the Eric Shepherd Unit's hosting of the inaugural meeting of the South of England Learning Disability Forensic Network, we are telling the rest of the

country (or indeed an international audience) about developments that excite us. We are also in this way casting the net widely to extend our own learning.

A carer at the End of Life workshop said: “Congratulations on your workshop! Your presentation was brilliant and really made me think”. These events are generally very well received.

- Asperger’s Syndrome/High Functioning Autism
  We have been conscious of some minority groups at times “falling through the net “ of sevices, and one example of this is people with Asperger’s. With the support of commissioners, staff county wide were trained at events with strong carer and service user involvement to gain an understanding of how to work effectively with this group. Clinical psychologists have provided expertise in assessment and now the Trust is able to provide services that it could not before.

- Other Developments
  In Watford an acute day treatment unit has been set up as a way of providing intensive care and treatment to people with acute mental health problems who would otherwise have been admitted. This will be evaluated shortly. At Harperbury we set up a new short stay recovery unit so that those who no longer needed acute inpatient care could be supported in a more relaxed environment which could help them build on their strengths. This has been positively evaluated by commissioners and will continue for at least another year.

3.6. Some comments

Finally as a reminder that Trust services are made up of many thousands of different and individual encounters between service users, carers and staff, a selection of quotes from the past year are presented.

These illustrate that the work remains complex and at times challenging – with sometimes situations where the impact of Trust services is limited or not sustained, and at other times instances of staff and service users working closely together to achieve mutually agreed goals. These experiences remain greatly rewarding for service users and staff alike, and we expect to see more of them in the coming year.

A. What could be improved?

"Appointments could be quicker. I have to wait 3 months at a time!"

"I should have received talking therapy much earlier. It could have prevented me becoming ill after the birth of my second child."

"I need a care plan to see the long term objectives."

"The consultant's attitude towards medication; not everyone wants to take it straight away – that doesn't mean shut the door on the person."

"Nurses in hospital can be unnecessarily pedantic. They need to be more understanding of a patient's needs."

"More support groups should be available."

"Yes, not listening to parents! Being seen alone and parents not involved."

"More day care opprtunities for elderly people with dementia eg. classes, groups, pottery, arts based, exercise classes and music etc locally."

"Group therapy does not work for everyone. There are no alternatives."

"More understanding and listening, and not being told what you should be doing."

"I have never been told about side effects before starting medications. I feel I should have. I was not informed about crisis cards – I had to ask for one. I was not aware that there was help available for financial advice."

"Communication with psychiatrist has been difficult."

"I did not think they had very good people skills, and dismissed my difficulties and worries too quickly. Sometimes I think they did not have a very good approach."

"Continuity – each time I have seen a psychiatrist in the past couple of years, it has been a different person. So they have to go over my history, and don't really know me as an individual."

"I wish I could get someone when I need them. Every time I need someone there is nobody there."

B. What is particularly good about your care?

"I attended a very good psychiatric day hospital where many activities were on offer. *The staff were particularly supportive and each client was treated with very great respect and dignity."*

"I have a good relationship with my psychiatrist. He is always willing to listen and can take criticism."

"The regular contact and support from my CPN is invaluable. I would have benefitted from this years ago when the doctor diagnosed depression."

"Excellent consultant. Treats me as an individual. Is very up to date. Caring co-ordinator."

"My CPN is great. Without her I don't know where I would be."

"I have been given tablets that are suited to the treatment I need."

"I am very pleased with the quality of care I am receiving and it is helping me learn to cope with OCD."

"The care team was amazing! Very supportive, helpful and kind."

"Home assessment by a multi-disciplinary team was quick and efficient."

"They are very helpful at the early intervention team and keep in contact very regularly."

"Staff have been very kind and considerate to me."

"I do art therapy and find this is good for me. It has been one of the best ways for me to talk and find out why I feel bad at times."

"Psychologist has been a big help and support."

"I have been treated with kindness and given the support I need. I have found the day hospital a very friendly place."

"I was under the care of the crisis team for a fortnight. Their care was outstanding."

"Very caring health team. Very clean, well-kept health centre."

Source: National Community Mental Health Service User Survey (2010)

News Item 3

During the year the Chief Executive and Chair of the Nursing and Midwifery Council visited the Trust. After meeting senior staff at Trust Head Office they went to Forest House adolescent unit and the Cassio Unit, an inpatient unit for adults with learning disabilities in Watford.

After the visit Tony Hazell the Chair said:*" It is quite clear that HPFT is a very dynamic and proactive organisation and I was hugely impressed with the wide range of exciting and innovative services that are being provided. The enthusiasm and commitment of the staff was clearly evident."*

Part 4. Final Notes

4.1. This document has been produced in accordance with the NHS (Quality Accounts) Amendment Regulations 2011 (No. 269)

4.2. The main guidance used in its preparation is the Quality Accounts Toolkit 2010-2011 (Department of Health December 2010).

4.3. It also fulfils the additional reporting requirements of Monitor. It is written to form the quality report section of the Trust's Annual Report, as well as being the Quality Account.

4.4. Where acronyms are used, they are spelt out in full the first time in order to be as clear as possible.

4.5. It is planned to produce a summary version of the Quality Account after the full document is published at the end of June. Any comments on lay out or content of this report would be welcomed by Jonathan Wells, Head of Practice Governance
jonathan.wells@hertspartsft.nhs.uk

News Item 4

The Trust claimed funding for one year to carry out a service user and carer led project to evaluate the quality of our services with respect to assessments under the Mental Health Act. It can be very traumatic for service users when they are acutely unwell and being considered for compulsory admission to hospital. At such times their rights need to be clearly respected, and the highly charged situation needs to be handled as sensitively as possible.

Service users and carers were trained as peer listeners to conduct interviews with people who had been assessed under the MHA. A questionnaire using standards taken from the code of practice to the Mental Health Act was used. Results highlighted some areas for improvement around information-sharing and involvement of carers; these will be used in future training of the professionals who have these roles.

Afterwards, one of the service users wrote to Tom Cahill to say this was the best such project she had ever carried out with the Trust. She said the two staff leading the project were "true stars in the world of service user and carer involvement."

Annex 1. Quality Account Indicators 2010-2011: Data Set

Quality Account		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Safety					
1.1. Maintain compliance with PCT same sex accommodation measures	Target	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes	Yes
1.2. Rate of inpatients saying they feel safe	Target	75%	78%	81%	84%
	Actual	72.4%	80.0%	78.0%	80.5%
1.3. Rate of incidents of absconding by detained inpatients	Target	4.75%	4.50%	4.25%	4%
	Actual	3.7%	5.2%	3.8%	4.8%
1.4. Number of physical assaults on staff	Target	240	225	210	195
	Actual	250	298	412	287
1.5. 7 day follow up	Target	98%	98%	98%	98%
	Actual	96.3%	96.3%	97.6%	97.9%
1.6. Rate of readmission within 28 days	Target	4.75%	4.5%	4.25%	4.0%
	Actual	3.9%	5.6%	4.1%	5.0%
1.7. Rate of those admitted who had access to CATT	Target	90%	90%	90%	90%
	Actual	98.1%	99.5%	99.1%	98.2%
Clinical effectiveness					
2.1. Improved access to psychological therapies (Adult MH)	Target	56%	59%	62%	65%
	Actual	58.7%	54.1%	60.0%	64.8%
2.2. Rate of service users finding psychological therapy helpful	Target	60%	63%	66%	69%
	Actual	60.3%	52.1%	62.4%	56%
2.3. Rate of service users with paired outcomes scores (HoNOS)	Target	27%	38%	49%	60%
	Actual	16.9%	19.3%	23.7%	30.4%
2.4. Rate of service users leaving acute inpatient care with lower HoNOS scores	Target	77%	81%	85%	89%
	Actual	73.4%	77.6%	85.1%	82.4%
2.5 Rate of those in employment	Target			10.6%	10.6%
	Actual	11.5%	11.4%	10.8%	10.1%
2.6. Rate of those in settled housing	Target			70%	70%
	Actual	82%	82.1%	82.7%	88.3%
2.7 Rate of those saying they are making progress in recovery	Target	63%	66%	69%	72%
	Actual	69.4%	62.2%	79.3%	78.0%
Service user and carer experience					
3.1.Rate of service users helped to take part fully in planning their care	Target	60%	63%	67%	70%
	Actual	54.4%	67.6%	85.1%	79.7%
3.2. Rate of inpatients who felt informed and involved in decision-making about themselves	Target	65%	68%	72%	75%
	Actual	70.1%	64%	75.9%	70.3%
3.3. Rate of carers feeling valued as partners in care planning	Target	72%	75%	78%	80%
	Actual	80.4%	82.7%	84.2%	89.6%
3.4.Rate of carers receiving support or advice/information	Target	27%	27%	27%	27%
	Actual	32.1%	44.7%	55.1%	62.9%
3.5. Rate of service users experiencing delayed transfers of care	Target	<7.5%	<7.5%	<7.5%	<7.5%
	Actual	1.3%	0.6%	0.2%	0.4%

Annex 2. Statements from Partner Agencies

Hertfordshire Partnership NHS Foundation Trust
Quality Account 2010/11 – PCT Response

I can confirm that NHS Hertfordshire has received the Quality Account 2010/11 from Hertfordshire Partnership Foundation Trust. The PCT has shared the Quality Account with our pathfinder GP Commissioning Consortia for comment as part of developing our assurance statement.

The PCT has undertaken a review of the information provided within the Quality Account and checked the accuracy of data within the account which was submitted to us as part of HPFT's contractual obligation. All data provided corresponds with data submitted during the year as part of the ongoing contract monitoring process.

The PCT congratulates HPFT on the overall strong performance they demonstrate in the account and recognise the commitment made by all staff to achieve this.

The PCT commends HPFT in the approach they have taken to achieving the Same Sex Accommodation standards. Improvements in patients reporting they feel safe need to be sustained and the PCT is pleased that this remains a focus for 2011/12.

The fluctuations in the rate of absconsions is of concern but the PCT is aware of the challenges in sustaining a reduction. Independent feedback from the Police on this matter has been positive and recognises the effort made by the staff to address this issue.

The PCT shares HPFT's disappointment in the failure to reduce the number of physical assaults on staff and in particular in Learning Disability services. The PCT would expect to see the actions taken so far resulting in reductions in assaults over the next year.

A number of indicators reported in the Quality Account relate to the effectiveness of services and the benefit felt by service users. The measures of effectiveness and the reported patient benefit are a key to helping the PCT review the overall quality of services commissioned. HPFT need to sustain improvements in access alongside reported patient benefits.

In 2010/11 the Trust actively engaged with service users, carers, staff and stakeholders to ensure quality was measured and standards driven up. There has been substantial improvement in the way information from service users and carers is sought and acted upon. The PCT is pleased with the progress made in service user and carer experience and the continued focus for 2011/12 is noted. The PCT would wish to see HPFT make improvements in waiting times for all patient groups. Whilst this is not included in the Quality Account priorities for 2011/12 the PCT will continue to monitor this as part of the overall assessment of quality during the next year.

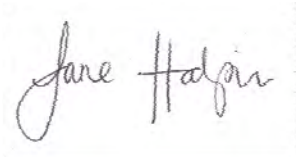
During 2010/11 the PCT has made a number of quality visits to HPFT services and has provided positive feedback to HPFT. These visits will continue in 2011/12.

NHS Hertfordshire endorses the Trust's priorities for quality improvement in 2011/12. NHS Hertfordshire expects the Trust to continue the focus on patient safety, clinical effectiveness and user/carer experience, giving significant emphasis to all three elements. We expect continued improvement in the quality of services provided, and acknowledge HPFT's aspiration to provide the best possible care. As the NHS undergoes reform the need to focus

on quality is essential. As part of this a number of measures will be used to develop a scorecard that will include indicators not currently included in the quality indicators for 2011/12. HPFT will need to ensure that these are also recognised as ways to demonstrate service quality to their users, carers and the PCT during 2011/12.

As the health economy works together to meet the QUIP challenges and work to maintain financial balance it is essential that HPFT contribute to this and ensure that the quality of services is not compromised during this time.

We look forward to working with the Trust in the coming year to ensure it delivers outstanding standards of clinical care, which reflect the needs and preferences of patients, families and carers, in the most financially efficient way.



Dr Jane Halpin
Chief Executive
NHS Hertfordshire

Hertfordshire County Council Health Scrutiny Committee (HSC) QA statement for HPFT

Members welcome the opportunity to comment on the Trust's Quality Account.

Members have held in-depth discussion with the Trust over a series of meetings. This has included consideration of progress on the previous year's priorities and the implications for the Trust's ability to maintain and further improve this year. The Trust has been open in these discussions and responded to the concerns raised.

At a meeting in March the Trust shared the QA due for discussion by the Board. Members made the following observations:

- they noted that measurements and benchmarks would be included by the Board and would be achievable but stretching
- the Topic Group highlighted the priority around 'discharge planning' as being particularly important.

HSC were involved in the short listing exercise to identify the Priorities which appear in this QA. It endorsed the Priorities and the indicators to measure achievement against the specific Priorities selected as being appropriate to the needs and interests of users and carers.

To enable members to engage with this activity with greater understanding of the data and challenges faced by the Trust when implementing the Priorities the Trust agreed it would provide an in-year progress report later in the year.

The Trust has engaged with Committee more widely and members would like to commend the scrutiny earlier in the year considering the provision of acute inpatient beds. Members raised concerns regarding involvement of partners, especially local government (officers and members) and MPs. The Trust then undertook formal consultation to address these concerns.

Hertfordshire LINk
Local Involvement Network

Hertfordshire LINk's response to Hertfordshire Partnership Foundation Trust (HPFT) Quality Account

All the priorities together cover all the major concerns of the public and consumers of the services. The primary emphasis on looking at how the service user and carer is experiencing all the services is paramount in our view, and needs to be a permanent priority with the specific indicators changing in response to feedback each year.

Patient safety has been a concern for us in recent years, and whilst we are aware that a lot of work has been put into this year, we agree that it should remain a priority this year to allow for further improvement.

There are a number of indicators of Clinical Effectiveness that we particularly welcome: the drive for higher standards in CAMHS (Child and Adolescent Mental Health Services) provision all round, the emphasis on improvement in the effectiveness of IAPT (Improving Access to Psychological Therapies) provision. We are also very pleased to see that there is an official drive to ensure service users all have 'Purple Folders', which we have been promoting for some time, as we feel this will help particularly service users attending for physical health care treatment and enable those providers to better meet the needs of this group of service users.

We very much support the inclusion of workforce development in the HPFT priorities, as we feel it essential for a provider aspiring to be the best in the country to have a thorough and responsive CPD (Continuing Professional Development) programme in place permanently which keeps staff abreast of the best possible practice. HPFT could look at how far its staff could help to train staff in other areas of health to move towards a greater understanding of these services users' needs.

Is the report well written and understandable?

By comparison with other organisational and professional documents in the health arena, this report is written in a way which is very accessible to the lay person, on the whole. However, care needs to be taken to reduce substantially the use of acronyms (eg. Honos) or provide a glossary as an appendix. If the report is intended to be accessible to users and carers, it does need to take account of those for whom reading is a difficulty and use relevant expertise to change the syntax and complexity of sentence structure in parts. The Trust should also bear in mind that increasingly material needs to be accessible to those whose first language is not English.

Any important issues missing from the report?

- The new Causeway proposals, which arose from a listening exercise with service users, carers and the public over a proposed closure
- The response to the Alliance Report on service quality and the subsequent great success of the 'All Together Now' jointly sponsored conference on service transformation. This conference has fed directly into the various initiatives of the Trust on service design change, including the major 'Leading By Design' project.
- However, there does need to be more liaison work and collaborative workforce development with other parts of the health and social care services in order to transfer

skills and knowledge about the needs of this patient group which will help to create a seamless service for users and carers across the whole field. They should be able to expect that GPs, hospitals, clinics, emergency serves, etc. should all be well versed in their needs when they enter those services.

Good points that should be applauded?

- Responsiveness and listening has also become a strength for the Trust. In particular it is clear that strong practice governance has an important role in this improvement.
- Full participation in the Herts County Council scrutiny process

Is it evident that patients and the public have been involved with the report?
Throughout the report there is consistent and strong evidence of consultation with patients in services, carers, local government, voluntary organisations and the public through the Hertfordshire LINk. This trend should continue. There is more to be done, but openness and responsiveness are continually improving at the Trust.
Hertfordshire LINk is also pleased that HPFT is taking the lead on the implementation of the Equality Delivery Systems (EDS) and looks forward to working with them to improve quality and outcomes for service users.

Henry Goldberg, Chair Hertfordshire LINk , May 2011

Annex 3. 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 2010 to June 2011;
    - Papers relating to Quality reported to the Board over the period April 2010 to June 2011;
    - Feedback from the commissioners received 27th May 2011
    - Feedback from governors dated 7th February 20112011
    - Feedback from LINks received 2nd June 2011
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2011
    - The 2011 national patient survey
    - The 2010 national staff survey
    - The Head of Internal Audits annual opinion over the trusts control environment dated 25th May 2011
    - Care Quality Commission quality and risk profiles dated April 2011
- the Quality Report presents a balanced picture of the NHS foundation trusts performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate;

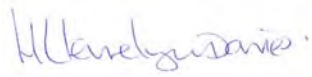
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- 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 Monitors annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.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/annualreportingmanual).

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



Chair
Date 27 June 2011

Chief Executive
Date 27 June 2011

Independent Assurance Report to the Board of Governors of Hertfordshire Partnership NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Board of Governors of Hertfordshire Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Hertfordshire Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

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 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to March 2011.
- Papers relating to quality reported to the Board over the period April 2010 to March 2011.
- Feedback from the Commissioners - NHS Hertfordshire - dated 27 May 2011.
- Feedback from Governors dated 7 February 2011.
- Feedback from Hertfordshire LINK 2 June 2011.
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2011.
- The 2011 national patient survey.
- The 2011 national staff survey.
- The Head of Internal Audit's annual opinion over the trust's control environment dated 25 May 2011.
- Care Quality Commission quality and risk profiles dated April 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Board of Governors of Hertfordshire Partnership NHS Foundation Trust as a body, to assist the Board of Governors in reporting Hertfordshire Partnership NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Board of Governors as a body and Hertfordshire Partnership NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I 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'). My limited assurance procedures included:

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents listed above.

A limited assurance engagement is less 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

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

…… **Date:** 27 June 2011

Mark Hodgson

Officer of the Audit Commission
Audit Commission, 3rd Floor, Eastbrook, Shaftesbury Road, Cambridge, CB2 8BF.

Service User, Carer and Stakeholder Involvement

'*The Trust believes it can only achieve its corporate vision of becoming the country's leading mental health and specialist learning disability provider by serving the needs of and learning from the experience of its customers and stakeholder groups, each of which has a unique expertise*.' (HPFT Involvement Strategy 2009 – 2012)

This year, the focus has been on increasing the number of people involved in the Trust's work and in tailoring involvement opportunities to the needs of our diverse customers and stakeholders.

Large scale engagement events for Acute Inpatient Reprovision and Leading by Design have enabled more people to join in planning and commenting on our services.

The councils and networks for groups of service users and carers have continued to provide extremely valuable comments and contributions.

In particular, this year:

- Service User and Carer Councils have continued to contribute enthusiastically to the work of the Trust. A service user led audit 'the use of the recovery model and principles within crisis teams' is now underway; organised by members of the Service User Council. The Carer Council are currently deciding a suitable topic for a carer-led audit
- Accessible workshops were held for clients with learning disabilities to comment on the NHS White Paper and Leading by Design service planning
- A dedicated Involvement Worker for users of mental health services for children & young people (CAMHS) has been recruited
- Members of Councils and other service users have been offered the opportunity to take a much greater role in staff inductions
- Peer Listening and Peer Support work have provided valuable opportunities for former service users and carers to work with current service users.

Plans for the next year include:

- Continuing with council and network development
- Increasing diversity in involvement opportunities, to ensure that as many people as possible can access these (for example, more local/virtual work with older people and their carers, website development for children and younger people)
- Development of focus groups to provide in depth feedback and information for service development under Leading by Design
- A recruitment drive - to increase the number of people undertaking involvement work and volunteering with the Trust
- Development of the role of members – to offer more active involvement opportunities
- Continuation and expansion of our work with third sector partners.

Compliments, comments and complaints

The Trust places considerable 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 or to use the *Comments, Compliments and Complaints* leaflets available on all wards and outpatient units. In addition, all service users and carer's are encouraged to complete Having Your Say forms during their recovery journey.

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 units are encouraged to send details of compliments received to the PALS (Patient Advice and Liaison Service) and Complaint team for logging.

Over the past year the team has worked with unit managers to raise awareness of the service to enable and encourage service users, carers, advocates and others to comment on the services that we provide. As a result there has been a continued increase in both PALS contacts and complaints.

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 changes made as a result.

Following the 48% increase in the number of complaints in 2009/10 compared to 2008/9, there has been a further 5% increase during the year. This further increase can partly be attributed to the expansion of Trust services to include Specialist Learning Disability Services in North Essex. Table B shows the number and main categories of complaints, comparing 2008/09, 2009/10 and 2010/11.

Table B: Number of formal complaints and main issues

Main complaint issue	01/04/08 – 31/03/09	01/04/09- 31/03/10	01/04/10- 31/3/11
Assault / abuse	5	3	9
Clinical practice	50	67	83
Communication	27	39	27
Environment etc.	3	2	4
Staff attitude	7	26	28
Security	3	1	1
Systems & Procedures	42	65	60
Transport	0	0	1
Total	**137**	**203**	**213**

Of the 213 complaints received during this year 176 were responded to within 25 working days and 27 were responded to over 25 working days. Ten complaints were still open at the time this report was prepared, all of which were still within time. 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 that they do not wish to raise as a formal complaint with the Trust. The number of contacts continues to increase with a further 75% increase over last year.

Table A shows the number and main categories of PALS contacts, comparing 2010/11 with 2008/09 and 2009/10.

Table A: Number of PALS contacts and main categories

Category	01/04/08 – 31/03/09	01/04/09- 31/03/10	01/04/10- 31/3/11
Advice	42	67	109
Issues for resolution	44	89	134
Feedback	2	4	30
Other	1	5	15
Translation request	0	0	1
Total	**89**	**165**	**289**

Emerging themes from the PALS issues and complaints received
Some of the PALS 'Issues for Resolution' are transferred to the formal complaints process, either because they can not be resolved within one working day, or due the serious nature of the issues raised.

Of the 83 clinical practice complaints, 35 concerned direct care, 29 care planning, eight concerned administration of drugs and medicines, eight about the diagnosis and three about privacy and dignity. The 60 Systems and Procedures complaints fell into 16 categories, including 14 about assessment and treatment, seven about alleged breach of confidentiality, five about managing service user's money, four about policy decisions of the Trust, three about detention under the Mental Health Act, three about resettlement and three about respite care arrangements.

During the year we received ten requests for files from the Parliamentary and Health Services Ombudsman, with eight returned as no further action. We are waiting for the decision on the remaining two cases, one of which is a shared complaint with an acute trust. The Local Government Ombudsman has requested information about two cases, but has not asked for the files.

Compliments
The units are asked to forward letters of thanks from service users, carers, advocates and visitors to the PALS and Complaints Department by the services 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; this has lead to a significant increase in the number of compliments forwarded to the team.

01/04/08 – 27/02/09 315
01/04/09 – 31/03/10 308
01/04/10 - 31/04/11 432

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

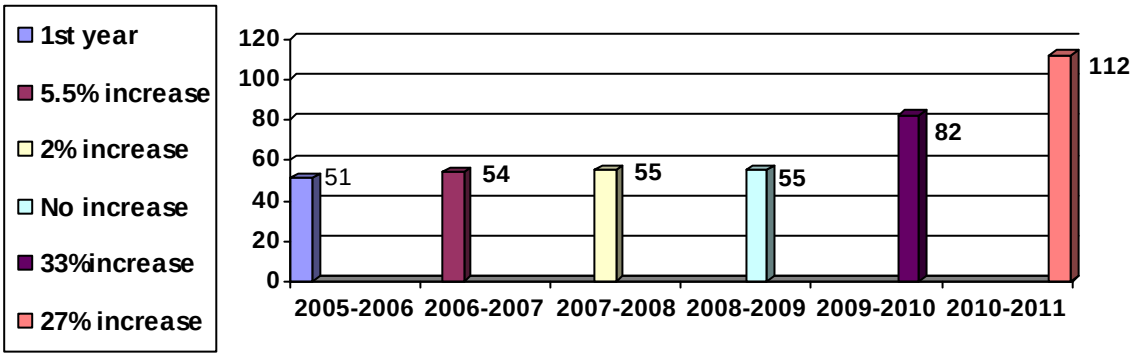
Requests for Information

Introduction

The Freedom of Information Act (FOIA) came into effect in January 2005, the number of requests received by the Trust remained fairly stable for the first years. However, from 2009 it appears that the public have become far more aware of the FOIA and their legal right to request and be provided with information from public authorities.

Increase in Requests

From the first year of FOIA being implemented (2005-2006) to 2010/11, there has been a **112%** increase in the number of requests we have received.



Complex Requests

Requests have not only increased but the nature and complexity of the information has become far more involved.

Information may need to be gathered from a number of sources and the time taken to locate it has increased.

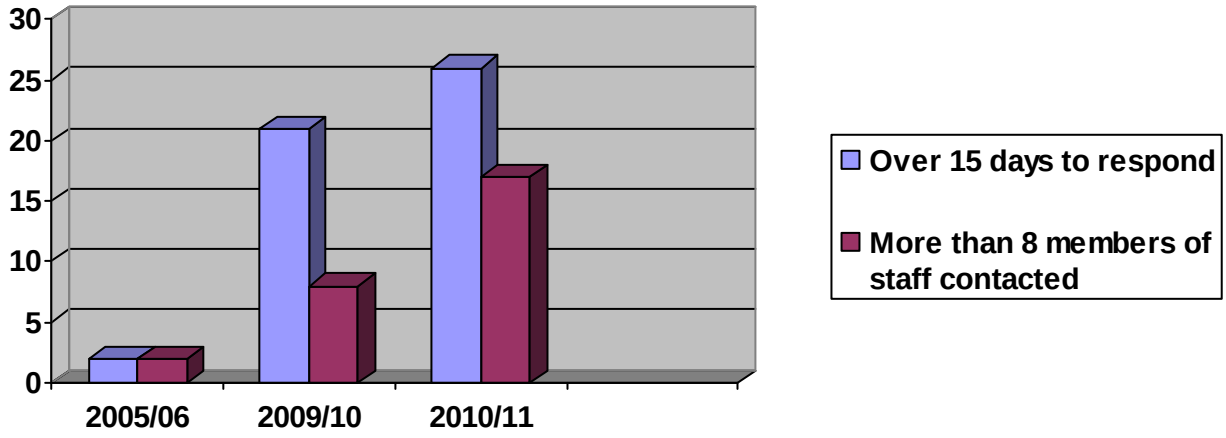
Determining 'Complex' Requests

Rationale:

- Requests that took over 15 days to respond (this *excludes* when key staff are unavailable)
- Multiple staff contacted to supply requested information
- Exemptions were considered and applied
- Multiple questions per request. (18 requests (2010/11) had between 8 and 22 questions to respond to).

Years	Total No of requests	Exemptions used and frequency	No. taking over 15 days to respond	%	No. involving multiple contacts	%
2005-2006	51	S.21 x2 S.40 x2 S.44 x 1	2	4%	2	4%
2009-2010	82	S.21 x 12 S.12 x 2 S.22 x 3 S.40 x 2	21	25%	8	10%
2010-2011	112	S.40 x 5 S.21 x 20 S.12 x 1 S.43 x 3 S.22 x 4 S.30 x 2	26	23%	17	15%

Section 12: Cost of compliance exceeds appropriate limit
Section 21: Information available by other means
Section 22: Information intended for future publication
Section 30: Investigations and proceedings conducted by public authorities
Section 40: Personal Information
Section 44: Information prohibited by another enactment



You can refer to the 'disclosure log' for further details on the information which has been requested and disclosed in the 'Freedom of Information' section of our website www.hertspartsft.nhs.uk

Reporting of Personal Data Related Incidents

Loss of personal data is a risk which is nationally monitored and the table below shows incidents within 2010/11 for the Trust which were at the lowest recorded severity level.

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2010-11		
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	4*
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	11
V	Other	3

These losses are purely paper based records – or part of.

Sustainability reporting

Commentary

In 2008 HPFT was responsible for emissions of 10,646 tCO_2. It was calculated that a Business As Usual scenario would result in a rise in carbon emissions of 4% and a rise in overall costs from £2.3 million p.a. to £3.6 million p.a. by April 2013 - 56% increase. In February 2010, the Board formally adopted a Carbon Management and Implementation Plan (CMIP) that set out a range of actions enabling HPFT to reduce our carbon emissions by 25% by 2013 based on 2008 levels.

The Carbon Management Team has had a number of notable successes during 2010/11 and these include:

- ✓ 43% reduction in waste to landfill
- ✓ 34% reduction in courier miles
- ✓ 17% reduction in business miles
- ✓ 28% rise in uptake of public transport
- ✓ Support to Phase 1 of mobile working – resulting in 7,000 miles less travelled so far
- ✓ Sustainable Standard Specification for redecoration
- ✓ Development of Sustainable Estates and Facilities Team
- ✓ Development of bespoke Sustainable Development Management Plan
- ✓ Pro-active engagement campaign delivering training to a group of 'carbon pathfinders', creating a myth buster and holding a pedometer challenge.

By its nature, the NHS must be sustainable – HPFT must meet the needs of our service users today, while ensuring we have a service fit for tomorrow and beyond. At a time when we are driving forward significant change to improve outcomes and meet the financial and practical challenges of increasing demand for our services, we have the opportunity to create a truly sustainable and low carbon HPFT. This is not limited to financial sustainability, but must focus too on social and environmental sustainability, so that the HPFT of the future remains in the best possible position to improve quality and to limit its impact on the environment within which it works.

The challenge ahead remains significant, particularly around estates driven carbon reduction, helping HPFT to deliver a sustainable health system will require transformation and a new way of thinking. As stated earlier, HPFT is currently on a programme of significant change to improve outcomes and meet the financial and practical challenges of increasing demand for our services. As a result we are presented with the opportunity to create a truly sustainable and low carbon HPFT.

Summary of Carbon Reduction Performance

- Carbon emissions related to operating our buildings has risen by 14% from our baseline year of 2008/09. However there are plans to tackle this through direct building intervention and rationalisation of the estate. We remain confident that we will successfully meet our targets.

- Carbon emissions related to travel have reduced by 5% from our baseline year of 2008/09.

- Carbon emissions related to waste have reduced by 43% from our baseline year of 2008/09.

SD Governance

Carbon management and SD are corporate responsibilities and taking them seriously is integral to providing a high quality health service. They are an inherent part of HPFT's performance and governance mechanisms.

Currently responsibility for delivering the sustainability agenda sits within the Facilities Department with ultimate responsibility sitting with the Director of Finance reporting back to the Board on a six monthly basis. Whilst they have made good progress to date delivering elements of carbon reduction and sustainable development, the Facilities team are struggling to achieve the leverage to maximise the potential that sustainable development brings. As with Transport, Procurement and Communications, Facilities are stakeholders in the Sustainable Development agenda, not the drivers.

It is essential that sustainable development is embedded into HPFT management and governance processes. This requires our Board, Managers, Clinicians, Nurses and many other staff groups to champion sustainability at the highest level.

Re-aligning responsibility for this broad agenda, with ultimate responsibility given to the Executive Director Strategy and Organisational Development, will ensure the principles become truly embedded within the organisation at both a strategic and an operational level. It will enable both tangible and intangible savings to be realised and will ensure that the ethos is adopted throughout all future plans, policies and visions.

Emergency Planning

The heightened awareness in the NHS of possible terrorist attacks required the Trust to review the Trust Major Incident and Business Continuity plan. This was redrafted in a new format and included change in some of the service streams. Cambridge Solutions consultancy set up a test and a run through for the Trust Executive and Response team. The Service streams will be testing their plans later in the year.

We continue to work with Herts Environmental Forum (HEF) and are active partners in the Herts Resilience Forum taking part in relevant exercises. Such exercises include Flood and Heat wave as part of the civil contingencies requirements based on UKCIP 2009 weather projects, and linking with our Carbon Reduction Strategy and Plan.

'Sustainability report'

Area	Type		Non-Financial Information			Financial Information (£)		
			2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
Greenhouse Gas Emissions	Scope 1 (Direct) GHG Emissions	Gas	22,896MWh	23,019MWh	26,740MWh*	803,694	805,661	935,913
		Fleet vehicles	885,204km	1,682,881km	1,158,059km	136,480	152,585	176,215
	Scope 2 (Energy Indirect) Emissions	Electricity	7,151MWh	7,742MWh	7,871MWh*	607,857	658,081	669,053
		Other energy consumption	8,333kWh	85,015kWh	85,015kWh*	333	3,401	3,401
	Scope 3 Official Business Travel Emissions		5,768,096km	6,243,746km	5,171,420km	1,236,611	1,332,355	1,132,991
Waste minimisation and management		(a) total waste arising (b) waste sent to landfill (c) waste recycled / reused (d) waste incinerated	919T 834T 0T 85T	933T 834T 0T 99T	933T 459T 375T 99T	£41,510 incineration & clinical waste. £142,878 other waste	£39,159 incineration & clinical waste. £185,521 other waste	£43,980 incineration & clinical waste. £183,861 other waste
Finite Resources		Water (m^3)	142,798	105,032	120,299*	175,549	105,032	120,299

*Some assumptions have been made due to outstanding data.

2013 Targets

Target
Reduce carbon emissions from our estate by 10% by 2013
Reduce carbon emissions related to staff business travel by 30% by 2013
All lease vehicles to have a maximum emissions cap of 120gCO_2/km by 2013
Reviewing the way the Trust works across a large geographical area to ensure services and facilities are provided in such a way that minimises as far as practicable the environmental impact of travel
Include environmental criteria in specifications for third party non-emergency and emergency transport contracts by 2013
Rationalise deliveries to all HPFT sites by 15% by 2013
To reduce waste *production* by 15% by 2013 relative to 2008 levels
To increase waste recycling by 50% of the Trusts total waste arisings by 2013

Equality and Diversity

2010/11 has seen the Equality & Diversity agenda become further embedded into the work of the Trust and really pick up speed.

The Trust continues to monitor its performance against equality and diversity criteria through the Trust Equality Steering Group, Chaired by the Executive Director of Quality and Safety and supported by the Trust Equalities Manager.

As with previous years, the Trust has met its publication duties for race, disability and gender through its Single Equality Scheme (SES) which also picks up on priorities for age, religion, beliefs and sexual orientation. The Trust also continues to meet it's publishing duties as required within the public duties for race, disability and gender up until April 2011 (when these are replaced by the public equality duty).

Some key successes for the past year include:

- Developmental work around the new NHS Equality Delivery System (EDS) to be launched April 2012. HPFT is providing assistance to NHS East of England with roll out of the EDS across the East. In addition HPFT is leading the implementation group for Hertfordshire comprising membership from all NHS Trusts and Hertfordshire LINks
- Being the first mental health Trust to host the national Lesbian, Gay, Bisexual, Transgender (LGBT) Health Summit which took place in September 2010
- For the second year running getting into the Stonewall Workplace Equality Index as one of the top 50 gay friendly employers in the country. (Moving up 25 places from 2009/10)
- Rapid expansion of spiritual care volunteer projects focused on pastoral visitors within all services and a music project focused on singing within dementia care units
- Development of staff networks for Disability and LGBT/Straight Allies
- Roll out of the Trailblazers cultural awareness programme to all Trust services following completion of pilot within inpatient services
- Development and launch of a new mandatory e-learning package for all Trust staff that mirrors the content of the Trust one day Equality Matters training.

Statistics

The Trust is required under the public duty for equality to collect and publish diversity data for staff. It is also required to publish this for its Foundation Trust membership. Whilst the data for staff is not required to be published for Trusts until July 2011 (pending a review of the Public Equality Duty specific duties) this information is included in the table below.

We have seen an increase in the proportion of ethnic minorities represented in our members rising from 10.5% in 09/10 to 14.5% in 10/11 to reflect more accurately the local population of 11.2%. We have also seen a small increase in BME staff from 30% in 09/10 to 31% in 10/11 (this does not take into account those who chose not to disclose their ethnicity).

The Trust publishes a full equality profile covering access to training, disciplinary and grievance, professional development, promotions and Agenda for Change banding which is available via the Trust website. However this is currently being reviewed in line with new public equality duty criteria for reporting equality data.

	Staff (April 2011)	**Membership** (April 2011)
Age		
0-16	-	221 (2%)
17-25	163 (5%)	1691 (14%)
26-35	541 (16%)	1225 (10%)
36-59	2482 (73%)	4220 (35%)
60+	250 (6%)	3858 (32%)
Not Stated		850 (7%)
Ethnicity		
Asian or Asian British		
Indian	131 (4%)	111 (1%)
Pakistani	28 (1%)	31 (>1%)
Bangladeshi	5 (>1%)	8 (>1%)
Other Asian	146 (4%)	392 (3%)
Black or Black British		
Black African	214 (6%)	139 (1%)
Black Caribbean	75 (2%)	82 (>1%)
Other Black	19 (>1%)	262 (2%)
Mixed		
White & Black Caribbean	10 (>1%)	-
White & Black African	8 (>1%)	-
White & Asian	16 (>1%)	27 (>1%)
Other Mixed	21 (>1%)	115 (1%)
White		
White British	1824 (51%)	9732 (81%)
White Irish	94 (3%)	163 (1%)
White Other	192 (5%)	413 (3%)
Other		
Chinese	21 (3%)	50 (>1%)
Any other group	96 (>1%)	6 (>1%)
Not stated	646 (18%)	532 (4.5%)
Gender		
Female	2460 (69%)	6996 (58%)
Male	1086 (31%)	5067 (42%)
Recorded Disability	1%[1]	283 (2.5%)

[1] The Trust is currently implementing a new way of collecting data from employed staff on disability in an effort to improve monitoring of disability given low numbers of reporting.

Priorities and Targets

The key priority areas for equality in 2010/11 have continued to be:

- Age
- Disability
- Ethnicity/Race
- Gender
- Sexual Orientation
- Religion and beliefs
- Human rights

In addition to this the equality agenda also takes account of the wider determinants of health e.g. housing, social status, finances etc.

From October 2010 the Trust has been required to ensure compliance with the Equality Act 2010 and associated regulations. As the act has extended equality protections to cover other groups (now called protected characteristics) the following have been added to the above list:

- Pregnancy & Maternity
- Gender Reassignment (previously included within gender)
- Marriage & Civil Partnership

In addition to this – from April 2012 – the Trust will set four yearly equality objectives as required by the Public Equality Duty Specific duties as well as the NHS Equality Delivery System (EDS) framework.

Achievements against key priorities

Age
This year the Trust Equality Steering Group has been discussing how the Single Equality Bill will affect the provision of services with the introduction of protections based on age in the provision of goods and services. In response to this the Trust had developed an audit tool to assess a sample of our services for compliance with the Equality Act, in anticipation of forthcoming legislation on outlawing age discrimination in the provision of goods & services. This proposed legislation has now been put back to April 2012 and the audit put on hold pending a national review of the public equality duty.

In December the Trust began working with Hertfordshire Care Services and Watford Community Housing Trust on a project focused on the needs of older adults who are lesbian, gay, bisexual & transgender (LGBT) given the significant disadvantage that these groups can face in health & social care settings. A jointly funded training project will be offered to a range of health & social care staff across the county by Age UK national educating staff on the needs of older LGBT people and how these issues can be approached within a care setting.

Additionally the Trust Equality Steering Group now has regular representation from CAMHS.

Disability
From an employment perspective, the Trust has once again achieved the disability Two Ticks Charter, identifying the Trust as a positive employer for disabled employees. The Trust is still seeing a significantly low number of staff reporting that they have a disability and the staff data monitoring on

Electronic Staff Record has created some problems including data not being carried across effectively from the EREC recruitment system.

In December 2010 the Trust launched the first HPFT staff disability network. There has been a good deal of interest in the group and representatives are currently in discussion with the Trust Equality & Diversity Team about the best format for the group in the future.

Ethnicity/Race
The Trust has continued work on the Clinical Trailblazer Programme using Experts by Experience (EbE) to train inpatient staff in Cultural Competence. This is funded with a grant from the London Development Centre that was received in the previous financial year. This project has now rolled out to all Trust Mental Health services following a successful pilot that took place in Watford inpatient services. The programme is currently also under review to identify ways to further streamline the learning.

Gender
The LGBT Health Summit 2010 was hosted by the Trust in September which included some of the best representation from the Trans community that the summit has ever seen including some poignant stories re: how Trans people have struggled with mental health issues through gender reassignment. In the next year the Trust will be developing a new protocol for how Trans people can be better supported in services and the workplace.

Following a review of the Community Development Worker (CDW) service it has become apparent that there needs to be a clearer focus on development work with men experiencing mental health issues and this has now been prioritised for the coming year.

Religion & Beliefs
The Spiritual Care department has this year continued its pastoral visitors' programme that offers a six week training programme to members of the community interested in becoming volunteers in spiritual care for the Trust. To date 50 volunteers have been trained from a variety of different faiths. All volunteers are on contract and are enhanced CRB checked.

In addition to this the Spiritual Care department has launched a singing project within HPFT dementia services based on a national model that uses music from people's past to help stimulate early memories. The project is working well and has seen some positive interactions from staff and service users as well as their families and carers.

Sexual Orientation
For the second year running the Trust achieved a place in the Stonewall Workplace Equality Index (WEI) rising 25 places up to 50th place. The index ranks the top 100 gay friendly employers in the UK. There is still a great deal of work to do, however it is a great achievement for the Trust and will hopefully continue into 2012.

The Trust hosted the LGBT Health Summit in September 2010, the largest annual gathering of professionals focused on improving LGBT health in the UK. HPFT is the first mental health trust to host the summit and as such ensured the theme of emotional wellbeing was a major thread throughout the two day event. The final report of the summit can be found on the summit website www.lgbthealth.co.uk

SUMMARY OF OTHER ACHIEVEMENTS

- Continued presence as a statutory advisor to the Hertfordshire Equality Council (HEC) of which HPFT is a primary funder
- LGBT Health Summit 2010 Hosts
- HPFT Chief Executive Tom Cahill leading for East of England on the national NHS Equality & Diversity Council (EDC) chaired by Sir David Nicholson.

In accessing these groups the Trust continues to monitor all of these groups at:

- Staff level – application for employment, successful employment, accessing training, promotions, pay band, disciplinary and grievances, leaver
- Service level – service users entering the service via the Electronic Patient Record system.

The key priority areas for the Trust over the next year will be the full implementation of the NHS Equality Delivery System (EDS) which will replace the Trust single equality scheme and embed the views of the public more heavily into all the work of the Trust around Equality & Diversity.

Our Staff

Staff Engagement

The Trust is committed to staff engagement, has a strong track record of engagement at all levels throughout the Trust and values the input of all members of staff. The Trust score in relation to engagement in the National Staff Survey remained in the top 20% for MH/LD Trusts.

The Trust has a rolling programme of engagement events with key stakeholders to ensure effective two way participation in key decision making and formation of Trust strategy.

As part of this programme a number of key events were held with staff in relation to the service transformation. Output of the events from first round of engagement sessions was used to help shape the Trust's plans. These plans were then shared with staff in a series of further engagement events in November 2010.

In addition the Trust has a robust mechanism for monitoring and ensuring learning from staff feedback, is embedded into practice. The programme management office (PMO) for Leading by Design remains in place. As we move into the testing and implementation phase of the transformation programme stakeholder engagement has been strengthened with the appointment of dedicated resource to further enhance this.

The staff survey action plan has been formulated in partnership with staff side, governors and managers. Progress against this plan is monitored through the Workforce and Organisational Development Group.

Summary of performance – NHS Staff Survey 2010

	2009/2010		2010/2011		Trust Improvement/ Deterioration
Response rate	**Trust**	**National Average**	**Trust**	**National Average**	
	54.7%	55%	57%	54%	Increase of 2.3%

	2009/2010		2010/2011		Trust's score Increase/ Decrease
Top 4 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
KF29. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell. (KF30 in 2009 survey)	15%	19%	14%	19%	Decrease by 1%

KF35. Staff motivation at work. (KF37 in 2009 survey)	3.92	3.84	3.91	3.82	Decrease by 0.01
KF21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month. (KF22 in the 2009 survey)	97%	97%	99%	97%	Increase by 2%
KF19. Percentage of staff saying hand washing materials are always available. (KF20 in the 2009 staff survey)	64%	59%	63%	58%	Decrease by 1%

KF19. Percentage of staff saying hand washing materials are always available. (KF20 in the 2009 staff survey)	64%	59%	63%	58%	Decrease by 1%
	2009/2010		**2010/2011**		**Trust's score Increase/ Decrease**
Bottom 4 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
KF23. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months. (KF24 in 2009 survey)	Because of changes to the format of the survey questions this year comparisons with the 2009 score is not possible		21%	14%	Score has remained the same.

KF8. Percentage of staff working extra hours. (KF9 in 2009 staff survey)	68%	63%	73%	65%	Increase by 5%
KF36. Percentage of staff having equality and diversity training in last 12 months. (KF38 in 2009 survey)	35%	42%	31%	47%	Decrease by 4%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. (KF27 in 2009 survey)	18%	16%	17%	14%	Decrease by 1%

Largest local changes since the 2009 Survey –
Key areas where staff experience has deteriorated

Question	Trust Score 2009	Trust Score 2010	Trust deterioration
KF11. Percentage of staff receiving job-relevant training, learning or development in last 12 months.	84%	79%	Decreased by 5%
KF10. Percentage of staff feeling there are good opportunities to develop their potential at work.	51%	43%	Decreased by 8%

KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver.	80%	74%	Decreased by 6%
KF4. Quality of job design (clear job content, feedback and staff involvement)	3.48	3.37	Decreased by 1.1

The Trust results in relation to the National Staff Survey were mixed, whilst our scores for engagement at work and motivation at work ranked in the top 20%. Advocacy of the organisation i.e. recommending of HPFT as a good place to work and receive treatment ranked above average. Other findings such as the level of harassment and bullying, violence and aggression, access to job related training ranked within the bottom 20% or below average. A number of these areas were in the bottom 20% last year and improvement plans were identified and implemented to address these.

Given the mixed results of the survey, the Trust has planned a series of large scale listening events, to further hear directly from staff about the areas they seek improvement in relation to their working experience. These sessions are held under the umbrella of the "Big Listen". These events will be held across the three counties to ensure as many staff as possible are able to participate. The first of which has was held in early May 2010.

The 2010 survey had 38 Key Findings (KF) of which 8 ranked better than average, 5 of which were in top 20% and 13 average whilst 18 were below average of which were 5 were in the bottom 20%.

Safer staffing for our Trust

On the 1 April 2008 the Department of Health introduced a revised system of vetting and selection processes for new applicants recruited to any NHS organisation. The title of this vetting is called the '6 Check Standards'. Hertfordshire Partnership NHS Foundation Trust implemented this immediately. We have a rigorous system of checking 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. We are working with Herts County Council and lead professionals to make sure that vulnerable adults and children are fully protected. The lead nurse for child protection and other senior leaders in the Trust are on county wide strategic groups to ensure that good practice is followed in all organisations for safer staffing.

Fair consideration for applications from staff with a disability

Our Recruitment, Selection and Vetting Policy ensures that all applicants with a disability who meet the shortlist are offered an interview and are asked prior to an interview what adjustments they require for the interview. They are also asked when successful what adaptations they may require to be able to fulfil their post. Staff are supported during all phases of their employment should a disability occur during their working lives. Flexible working, working at home, using adapted equipment, working differently are all successful tools that the Trust has used to take positive action for people with a disability.

Employee Relations
The Trust has worked hard to ensure that our employee relations processes for engaging with staff and our Trade Union colleagues are robust. The Trust has monthly meetings with the Trade Unions both formally and informally.

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 has a proactive occupational health service which aims to help our staff keep physically and mentally well. Stress awareness sessions are delivered to managers and staff to help them to identify stress, both in themselves and in their workforce. There are additional services for our staff across the geographical spread of the Trust on a monthly basis to improve the well being of our staff. Healthy living is the key focus of occupational health's support for our staff.

Mindful Employer
The Trust has become a Mindful Employer and aims to be proactive and positive about mental health and the Charter for this was signed in February 2009. This underpins our good practice to ensure that any applicant with a mental health issue is fully supported, both at the recruitment stage and during their employment.

Workforce and Organisational Development

Developments in the past year include:

Learning and Development
The learning programme for the year is developed based on the training needs analysis which have been submitted by teams using data identified within individual Performance Development Plans (PDPs). In addition priorities have been agreed with Professional Leads to ensure staff receive access to CPD which meet the requirements of professional bodies as well as CQC and NHSLA standards. Additional support is also provided to each Business Stream by an identified Learning and Development Lead who ensures that learning priorities and initiatives are identified within Business Plans.

The Trust has now fully embedded the Organisational Learning Management System (OLM), detailed compliance reports for all aspects of training are sent regularly to team leaders and managers, enabling them to follow up gaps regularly. The Trust is now moving to the next phase of OLM which will be the e-learning platform.

Leadership and Organisational Culture
An overall strategy for leadership and management has been developed, emphasising the need for assessment of need, support, development and evaluation. The majority of senior managers have now undertaken 360 degree appraisals and this opportunity is now open to managers of band 7 and above. The HPFT Coaching Network has been launched, with over 50 managers undertaking coaching training, supervision and CPD. These coaches have been matched with staff across the organisation. A mentoring hub has also been launched to provide an alternative approach.

A rolling programme of development sessions for the senior leader are held throughout the year, these sessions have been refreshed and are now more focused. These events provide development opportunity for leaders and a chance to focus on key areas to improve the customer and staff

experience, staff motivation and leadership. In addition similar events are now run for the next tier of management.

The Trust induction has been further improved to enable a more interactive experience, with closer direct involvement from service users and carers.

Sickness Absence Data

Staff Group	FTE Days Available	FTE Days Sickness	% FTE Days Sickness
Add Prof Scientific and Technic	87,235.39	2,180.83	2.50
Additional Clinical Services	312,835.75	25,432.96	8.13
Administrative and Clerical	214,413.16	9,012.44	4.20
Allied Health Professionals	34,174.04	923.57	2.70
Estates and Ancillary	14,437.45	1,189.40	8.24
Healthcare Scientists	591.50	0.00	0.00
Medical and Dental	67,738.39	940.20	1.39
Nursing and Midwifery Registered	353,064.89	18,505.24	5.24
Students	2,600.00	0.00	0.00
	1,087,090.57	58,184.63	5.35

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 a risk rating for finance, governance and mandatory goods and services for 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 if its terms of authorisation**.**

NHS Foundation Trusts are also rated for the provision of mandatory goods and services, as defined in their terms of authorisation. Again green/amber/red indicates the level of compliance.

The regulatory performance for Hertfordshire Partnership NHS Foundation Trust for 2010/11 is summarised as follows which also includes the previous year's ratings for comparison:

	Annual Plan 2009/10	*Q1 2009/10*	*Q2 2009/10*	*Q3 2009/10*	*Q4 2009/10*
Financial risk rating	*4*	*4*	*4*	*4*	*4*
Governance risk rating	*Green*	*Green*	*Green*	*Green*	*Green*
Mandatory services	*Green*	*Green*	*Green*	*Green*	*Green*

	Annual Plan 2010/11	*Q1 2010/11*	*Q2 2010/11*	*Q3 2010/11*	*Q4 2010/11*
Financial risk rating	*4*	*4*	*4*	*4*	*4*
Governance risk rating	*Green*	*Green*	*Green*	*Green*	*Green*
Mandatory services	*Green*	*Green*	*Green*	*Green*	*Green*

In addition it is imperative that the Trust maintains, and improves, its performance against its national, contractual and local targets. Failure to do so would give the perception of a Trust not performing to expected levels and thus could have a detrimental effect on tender applications and/or commissioner perception.

Section Two

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

1 April 2010 – 31 March 2011

FOREWORD TO THE FINANCIAL STATEMENTS

HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST

Hertfordshire Partnership NHS Foundation Trust ('the Trust') 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 Trust 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 Trust's activities (paragraph 25(3), Schedule 7 to the 2006 Act).

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

Executive Director of Finance and Performance Improvement
Hertfordshire Partnership NHS Foundation Trust
99 Waverley Road
St Albans
Hertfordshire
AL3 5TL
Telephone number: 01727 804265

Signed 

Mr Tom Cahill, Chief Executive Date 25th May 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2011

	note	2010/11 £000	2009/10 £000
Operating Income from continuing operations	5	211,445	198,098
Operating Expenses of continuing operations	6	(203,076)	(190,703)
OPERATING SURPLUS BEFORE EXCEPTIONAL ITEMS		**8,369**	**7,395**
Exceptional items	7		(7,121)
OPERATING SURPLUS AFTER EXCEPTIONAL ITEMS		**8,369**	**274**
FINANCE COSTS			
Finance income	11	210	302
Finance expense - financial liabilities	11	(91)	(101)
Finance expense - unwinding of discount on provisions	11	(479)	(285)
PDC Dividends payable		(3,704)	(3,375)
NET FINANCE COSTS		(4,064)	(3,459)
SURPLUS / (DEFICIT) FOR THE YEAR*		**4,305**	**(3,185)**
Other comprehensive income			
Impairments		(1,021)	(1,407)
Revaluations		4,881	5,350
Asset disposals		(42)	1
Movements arising from classifying non current assets as Assets Held for Sale		0	0
Other reserve movements		3,088	(16)
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		**11,211**	**743**
Prior period adjustments		0	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**11,211**	**743**

*The surplus for the year, before accounting for the reversal of impairments (see note 15) is £3,617k (2009/10 £3,936k before impairments).

STATEMENT OF FINANCIAL POSITION
31 March 2011

	note	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Intangible assets	12	265	372
Property, plant and equipment	13	138,951	131,015
Trade and other receivables	18	11,362	7,305
Total non-current assets		**150,578**	**138,692**
Current assets			
Inventories	16	13	12
Trade and other receivables	18	4,163	4,077
Non-current assets for sale and assets in disposal groups	17	491	0
Cash and cash equivalents	19	38,669	38,152
Total current assets		**43,336**	**42,241**
Current liabilities			
Trade and other payables	23	(18,464)	(20,725)
Borrowings	21	(156)	(156)
Provisions	22	(2,072)	(2,095)
Tax payable (employee national insurance and other taxes payable to HMRC)	23	(2,831)	(2,380)
Other liabilities (Government Grants)	24	(26)	(34)
Total current liabilities		**(23,549)**	**(25,390)**
Total assets less current liabilities		**170,365**	**155,543**
Non-current liabilities			
Borrowings	21	(729)	(795)
Provisions	22	(19,445)	(15,768)
Total non-current liabilities		**(20,174)**	**(16,563)**
Total assets employed		**150,191**	**138,980**
Financed by (taxpayers' equity)			
Public Dividend Capital	20	83,260	79,370
Revaluation reserve		50,325	47,480
Donated Asset Reserve		372	377
Income and expenditure reserve		16,234	11,753
Total taxpayers' equity		**150,191**	**138,980**

The financial statements on pages 2 to 5, together with the notes on pages 6 to 39 were approved by the Board and signed on its behalf by:

Other liabilities

Mr Tom Cahill, Chief Executive Date 25th May 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED

31 March 2011

	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	**138,980**	**79,370**	**47,480**	**377**	**11,753**
Surplus/(deficit) for the year	4,305	0	0	0	4,305
Impairments	(1,021)	0	(1,021)	0	0
Revaluations	4,881	0	4,864	17	0
Asset disposals	(42)	0	(42)	0	0
Public Dividend Capital received	3,890	3,890	0	0	0
Other reserve movements	(802)	0	(956)	(22)	176
Taxpayers' Equity at 31 March 2011	**150,191**	**83,260**	**50,325**	**372**	**16,234**

Actuarial gains/(losses) on defined benefit pension schemes

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2011

	note	2010/11 £000	2009/10 £000	£000
Net cash inflow from operating activities	26	**8,909**	**7,419**	
Cash flows from investing activities				
Interest received		210	302	
Purchase of intangible assets		0	(78)	
Purchase of Property, Plant and Equipment		(9,061)	(9,870)	
Sales of Property, Plant and Equipment		220	217	
Net cash generated from/(used in) investing activities		**(8,631)**	**(9,429)**	
Cash flows from financing activities				
Public dividend capital received		3,890	0	
Capital element of finance lease rental payments		(66)	(55)	
Interest element of finance lease		(91)	(101)	
PDC Dividend paid		(3,494)	(3,600)	
Net cash generated from/(used in) financing activities		**239**	**(3,756)**	
Increase/(decrease) in cash and cash equivalents		**517**	**(5,766)**	
Cash and Cash equivalents at 1 April		**38,152**	**43,918**	
Cash and Cash equivalents at 31 March		**38,669**	**38,152**	

1 General Information

1.1 The principal activity of the Trust is the provision of mental health and specialist learning disability services in the East of England. Hertfordshire Partnership NHS Foundation Trust is an independent public benefit corporation authorised and monitored by Monitor, the independent regulator of NHS Foundation Trusts. It is domiciled in Great Britain. The address of the Trust's registered office is 99 Waverley Road, St Albans, Herts AL3 5TL. The Trust's financial statements are presented in Pounds Sterling (£), which is also its functional currency.

These financial statements have been approved for issue by the Board of Directors on 25th May 2011.

2 Accounting Policies and Other Information

2.1 Basis of preparation

These financial statements have been prepared in accordance with the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (previously titled: Foundation Trust Financial Reporting Manual) which has been agreed with HM Treasury and mandated for all foundation trusts by Monitor. The accounting policies set out in that manual follow International Financial Reporting Standards (IFRS) as adopted by the European Union and also HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. These financial statements have been prepared under the historic cost convention and modified to account for the revaluation of property, plant and equipment. The policies set out below have been consistently applied to all the years presented.

2.2 Consolidation

The directors have taken advantage of the dispensation obtained by Monitor from HM Treasury from consolidating the accounts of the Trust's charitable funds.

2.3 Acquisitions and Discontinued Operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:
• the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;

• if a termination, the former activities have ceased permanently;

• the sale or termination has a marked effect on the nature and focus of the Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the Trust's continuing operations; and

• the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all of these conditions are classified as 'continuing'.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

2.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health and social care services.

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

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.

2.5 Expenditure on Employee Benefits

2.5.1 **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 annual leave entitlement 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.

2.5.2 **Pension costs**

NHS Pension scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenditure 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 Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

The Trust is also an admitted fully funded member of the Hertfordshire Local Government Pension Scheme (LGPS), for those staff who have transferred under TUPE (Transfer of Undertakings (Protection of Employment)) from Hertfordshire County Council, to the Trust's employment since 2004/05. The LGPS is a defined benefit statutory scheme administered by Hertfordshire County Council, in accordance with the Local Government Pension Scheme Regulations 1997, as amended.

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

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

Expenditure on Employee Benefits (continued)

As the scheme is accounted for on a defined contributions basis, the following LGPS figures are not included in these accounts but are disclosed separately as follows:

Based on IAS19, the Actuary has estimated for the Trust that, for the year ended 31 March 2011, the net pension asset is £958,000 (£7,027,000 net pension liability as at 31 March 2010). The gain is £2,026,000 (£540,000 chargeable to the operating profit as at 31 March 2010) and £5,462,000 (£6,634,000 loss as at 31 March 2010) is the gain recognisable in the Hertfordshire County Council Statement of Total Income and Expense.

2.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as Property, Plant and Equipment.

2.7 Property, Plant and Equipment

2.7.1 Recognition

Property, Plant and Equipment is capitalised where:
- 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 be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

2.7.2 Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:
- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up 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 e.g. plant and equipment, then these components are treated as separate assets and are depreciated over their own useful economic lives.

2.7.3 Valuation

All Property, Plant and Equipment (PPE) assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

All land and buildings are re-valued using professional valuations every five years. The District Valuer, who are professionally qualified valuers in accordance with the Royal Institute of Charted Surveyors (RICS) Appraisal and Valuation Manual, are employed by Hertfordshire Partnership NHS Foundation Trust to carry out valuations.

The latest five yearly valuation was undertaken as at 31st March 2010. An interim 'desk top' valuation was undertaken as at 31st March 2011 and these values are accounted for in these Financial Statements.

The valuations are carried out primarily on the basis of modern equivalent asset approach for specialised operational property and existing use value for non-specialised operational property.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three yearly valuation or when they are brought into use.

Operational equipment, other than IT equipment which is considered to have no inflation, is valued at the net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

2.7.4 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

2.7.5 Depreciation

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:

	Years
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 their expected useful lives as determined by the District Valuer or over the term of the lease, if shorter.

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.

2.7.6 Impairment loss

At each balance sheet date, the Trust reviews the carrying amounts of its non- current assets to determine whether there is any indication that those assets have suffered an impairment loss.

For the purpose of assessing impairments, assets are grouped at the lowest levels for which there are separately identifiable cash flows (cash generating units). As a result some assets are tested individually for impairment and some are tested at cash generating unit level.

Individual assets or cash generating units containing assets with an indefinite useful life or those not yet available for use are tested for impairment annually. All other individual assets or cash generating units are tested for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable.

An impairment loss is recognised for the amount by which the asset's or cash generating unit's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of fair value less cost to sell and value in use based on an internal discounted cash flow evaluation. Impairment losses attributable to revalued Property, Plant and Equipment are charged against the revaluation reserve to the extent that this has been credited, any surplus fall in value is recorded in the income statement.

Assets are subsequently reassessed for indications that an impairment loss previously recognised may no longer exist. Any reversal to an impairment loss is recognised in the income statement to the extent that any previous charge was booked to the income statement, the remaining part of the increase is booked to equity.

2.7.7 Revaluation

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expense in which case they are recognised in operating income.

Decreases in asset values and impairments 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. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

2.7.8 Assets held for sale

Assets intended for disposal are re-classified 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 re-classification, 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 and the assets are not devalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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.

2.8 Donated Assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets.

Gains and losses on revaluation are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

2.9 Intangible Assets

2.9.1 Recognition

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

2.9.2 Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant items 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.

2.9.3 Measurement

Intangible Assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently Intangible Assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income.' Intangible Assets held for sale are measured at the lower of their carrying amount or 'fair value less cost to sell'.

2.9.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

2.10 Government Grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

2.11 Inventories

Inventories are valued at the lower of cost and net realisable value.

2.12 Financial Instruments and Financial Liabilities

2.12.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent to which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

2.12.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

2.12.3 Classification and measurement

Financial assets are classified as loans and receivables.
Financial liabilities are classified as 'Other Financial Liabilities'.

2.12.4 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.
The Trust's loans and receivables comprise of cash and cash equivalents, NHS receivables, accrued income and other receivables.
Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost.

2.12.5 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

2.12.6 Determination of fair value

For financial assets and financial liabilities carried at fair value, this is the amount at which the asset or liability can be exchanged or settled. For finance lease obligations over one year the fair value is based on the discounted cash flow. The nominal value of short-term receivables and payables is deemed to be a reasonable approximation of their fair value.

2.12.7 Impairment of financial assets

At the Statement Of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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 has an impact on the estimated future cash flows of the asset.

The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

2.13 Leases

2.13.1 Finance leases

Where the substance of a lease arrangement is such that substantially the risks and rewards related to ownership of the asset are transferred to the lessee, then this lease is accounted for as a finance lease. The related asset is recognised at the time of inception of the lease at its fair value or, if lower, the present value of the lease payments. A corresponding amount is recognised as a finance lease liability.

The subsequent accounting for these assets is consistent with the policies applied to comparable, owned assets. The corresponding finance lease liability is reduced by lease payments less finance changes, which are expensed to finance costs. Finance charges represent a constant periodic rate of interest on the outstanding balance of the finance lease liability.

2.13.2 Operating Leases

All other leases are treated as operating leases. Payments on operating lease agreements are recognised as an expense on a straight-line basis. Associated costs such as maintenance and insurance are expensed as incurred.

2.13.3 Leases of land and buildings

Leases of land and buildings are split into land and buildings elements according to the relative fair values of the leasehold interests at the date the asset is initially recognised.

Where the portion of the lease element that would be recognised for the land element is immaterial, the land and buildings are treated as a single unit for the purpose of classification and classified as a finance or operating lease as described above.

2.14 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

2.14.1 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.

The total value of clinical negligence provisions carried by the NHS Litigation Authority on behalf of the Trust is disclosed as part of 'Legal and other claims' at note 22.

2.14.2 Non-clinical Risk Pooling

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

2.14.3 Back to Back Provisions

Of the provisions totalling £17,456k (£13,516k as at 31 March 2010) for pensions and injury benefits, £11,929k (£7,893k as at 31 March 2010) of these are subject to "Back to Back" agreements with a consortium of North West London and Hertfordshire PCT's. These agreements are shown as NHS Receivables in the accounts of the Hertfordshire Partnership NHS Foundation Trust.

2.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 31, 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.

2.16 Public Dividend Capital (PDC)

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 forecast cost of capital utilised by the Trust, is paid over as the PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust.

Public Dividend Capital (PDC) (continued)

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (1) donated assets, (2) net cash balances held with the Government Banking Service (GBS) (3) and 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 Financial Statements. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

2.17 Value Added Tax

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

2.18 Corporation Tax

The directors have determined that the Trust has no liability to corporation tax on the grounds that it is not engaged in the provision of services to any party other than NHS commissioning bodies. As a result of this, its income is wholly attributable to contracts with NHS bodies and others for the provision of patient related health and social care services and is not therefore subject to corporation tax. Since there is no liability to corporation tax, no deferred tax assets or liabilities arise in the preparation of the Trust's accounts.

2.19 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 29 to the Financial Statements in accordance with the requirements of the HM Treasury Financial Reporting Manual.

2.20 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 each individual case is handled.

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

Note 28 is compiled directly from the losses and compensations register.

2.21 Exceptional Items

Exceptional items are items of a material sum which are irregular and unusual. They are classified as exceptional to aid a more informed view of the interpretation of the financial statements.

2.22 Segmental Reporting

A business segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are different from those of other business segments. A geographical segment is engaged in providing products or services within a particular economic environment that is subject to risks and returns that are different from those of segments operating in other economic environments. The directors consider that the Trust's activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all assets are managed as one central pool.

3 Financial Risk Management

3.1 Financial Risk Factors

The Trust's activities expose it to a variety of financial risks: credit risk, liquidity risk, cash flow risk and fair value interest-rate risk. The Trust's overall risk management programmes focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the Trust's financial performance.

Risk management is carried out centrally under policies approved by the Board of Directors.

3.1.1 Credit risk

Over 95% of the Trust's income is from contracted arrangements with commissioners. As such, any material credit risk is limited to administrative and contractual disputes. Where a dispute arises, provision will be made on the basis of the age of the debt and the likelihood of a resolution being achieved.

Note 18.3 shows the analysis of impaired debts and non-impaired debts which are past their due date.

3.1.2 Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with Primary Care Trusts and Hertfordshire County Council, which are financed from resources voted annually by Parliament. The Trust also finances its capital expenditure from funds made available from the Government via Commissioners. The Trust is not, therefore, exposed to significant liquidity risks.

3.1.3 Cash flow and fair value interest-rate risk

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

Prudential Borrowing Limit (PBL)

3.1.4 The Trust 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 Monitor's Prudential Borrowing Code. One of these ratios, the financial risk rating is set under Monitor's Compliance Framework and therefore can impact on the long term borrowing limit.
- The amount of any working capital facility approved by Monitor.

Financial Risk Factors (continued)

	31 March 2011 £000	31 March 2010 £000
Long term borrowing limit set by Monitor	41,200	39,300
Working capital facility	13,000	13,000
Total Prudential Borrowing Limit	54,200	52,300

The Trust has no borrowings in the period.

Whilst the Monitor regime enables the Trust to finance capital expenditure through borrowing, the current capital programme is affordable from within internally generated resources and, therefore, no formal loan application has been submitted. Consequently the borrowing code ratios are of limited relevance until such time as a loan request has been drawn down, but the compliance with the ratio is as follows:-

3.1.5 Financial ratios

	2010/11			2009/10		
	Approved PBL ratios	Actual ratio	Headroom cover	Approved PBL ratios	Actual ratio	Headroom cover
Minimum dividend cover	>1	3.2	8,287	>1	3.4	8,152
Minimum interest cover	>3	21.0	10,281	>3	29.6	10,362
Minimum debt service cover	>2	18.9	10,719	>2	25.6	10,632
Maximum debt service to revenue	<2.5%	0.3%	5,707	<2.5%	0.2%	5,493

The Trust has been set a Tier 1 limit by Monitor, based on its 2010/11 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.

3.1.6 Key estimates and judgements

The directors believe that the key estimates and judgements made in preparing these Financial Statements relate to the provision made for irrecoverable receivables and the provisions made for pensions and litigation costs incurred by the Trust.

More details regarding the provision against potential bad debts can be found in note 18.3. Note 22 contains further information regarding other provisions.

4 Segmental Information

The Trust operates as a single operating segment as interpreted within IFRS8 since each of its elements have similar economic characteristics and are similar in:
• the nature of service provided – provision of healthcare.
• the nature of the 'production process' and methods used – face to face contact between service user and healthcare professional.
• the type of 'customer' – individuals with mental health needs and/or with learning disabilities.

5 Operating Income (by classification)

	2010/11 Total £000	2009/10 Total £000
Income from Activities		
Cost and Volume Contract income	1,629	5,062
Block Contract income	182,074	160,449
Clinical Partnerships providing mandatory services (including S31 agreements)	1,777	1,996
Other clinical income from mandatory services	19,201	23,452
Total income from activities	**204,681**	**190,959**
Other operating income		
Research and development	230	238
Education and training	3,337	3,053
Transfer from donated asset reserve in respect of depreciation on donated assets	21	16
Non-patient care services to other bodies	1,517	1,879
Other *** (see below)	1,659	1,946
Profit on disposal of land and buildings	0	7
Total other operating income	**6,764**	**7,139**
Total Operating Income	**211,445**	**198,098**

*** **Analysis of Other Income (above)**	2010/11 Total £000	2009/10 Total £000
Staff recharges	3	318
Staff accommodation rentals	74	130
Property rentals	0	1
Grossing up consortium arrangements	294	459
Other	1,288	1,038
Total	**1,659**	**1,946**

5.1 Analysis between Mandatory and Non Mandatory Income from Activities

Under the Trusts' terms of authorisation, the Trust is required to provide mandatory health and social services. The allocation of income from activities between mandatory services and other services is shown below.

	2010/11 £000	2009/10 £000
Mandatory income from activities	**204,681**	**190,959**

5.2 Private Patients Income Cap

The Private Patients Income Cap is set in accordance with section 44 of the NHS Act 2006 revised by the Health Act 2009. Mental Health NHS Foundation Trusts must 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 was zero.

Consequently the Trust's PPI cap is now set at £3,070,000 (zero in 2009/10). No private patient income was generated in 2010/11 (none in 2009/10).

6 Operating Expenses (by type)

	2010/11	2009/10
	£000	£000
Services from NHS Foundation Trusts	385	1,168
Services from NHS Trusts	3,491	5,134
Services from other NHS Bodies	2,669	2,624
Purchase of healthcare from non NHS bodies	9,863	11,962
Employee Expenses - Executive directors	993	1,120
Employee Expenses - Non-executive directors	156	154
Employee Expenses - Staff	135,888	121,026
Drug costs	4,716	4,612
Supplies and services - clinical (excluding drug costs)	378	313
Supplies and services - general	4,754	4,464
Establishment	4,113	3,823
Transport	1,826	1,885
Premises	6,277	6,570
Increase / (decrease) in bad debt provision	(22)	(12)
Depreciation on property, plant and equipment	3,777	3,526
Amortisation on intangible assets	107	91
Audit services - statutory audit	68	68
Audit services - other services	18	18
Clinical negligence	366	308
Loss on disposal of land and buildings	17	58
Legal fees	200	181
Consultancy costs	885	940
Training, courses and conferences	840	575
Patient travel	63	38
Car parking & Security	317	333
Redundancy	321	(383)
Early retirements	226	228
Insurance	84	31
Other services, eg external payroll	5,625	6,767
Losses, ex gratia & special payments	28	10
Packages Of Social Care	14,046	13,198
Other	1,289	(127)
Total Operating Expenses of continuing operations	**203,764**	**190,703**
Impairments of property, plant and equipment	92	7,121
Reversal of impairments of property, plant and equipment	(780)	0
Total Operating Expenses	**203,076**	**197,824**

6.1 Limitation on Auditor's Liability

The Trust's external auditors, the Audit Commission, do not have a liability cap in relation to the annual statutory audit. They do however include liability caps in relation to any additional service work undertaken and they set the relevant caps out in the engagement letters for each specific piece of work.

6.2 Salary and Pension Entitlements of Senior Managers

6.2.1 Remuneration

Name and Title	2010/11			2009/10		
	Salary (bands of £5,000)	Other re-muneration (bands of £5,000)	Benefits in kind * (nearest £00)	Salary (bands of £5,000)	Other re-muneration (bands of £5,000)	Benefits in kind * (nearest £00)
	£000	£000	£00	£000	£000	£00
Hattie Llewelyn-Davies (Chair)	50 - 55	0	0	50 - 55	0	0
Y Batilwala (Non Executive Director) *Left June 2009*				5 - 10	0	0
Ruth Sawtell (Non Executive Director)	15 - 20	0	0	15 - 20	0	0
Bill Brown (Non Executive Director)	15 - 20	0	0	15 - 20	0	0
Carol Kennedy Filer (Non Executive Director)	15 - 20	0	0	15 - 20	0	0
Colin Sheppard (Non Executive Director)	15 - 20	0	0	15 - 20	0	0
Manjeet Gill (Non Executive Director) *Appointed June 2009*	15 - 20	0	0	10 - 15	0	0
Stephen Marsden (Non Executive Director) *Appointed August 2009*	15 - 20	0	0	10 - 15	0	0
Tom Cahill (Chief Executive)	150 - 155	0	60	160 - 165	0	55
John Jones (Executive Director of Finance & Performance) *Left December 2010*	90 - 95	0	0	160 - 165	0	0
Keith Loveman (Executive Director of Finance & Performance) *Appointed December 2010. Previously Deputy Director Of Finance*	30 - 35	0	30			
Geraldine O'Sullivan (Medical Director)	140 - 145	50 - 55	0	150 - 155	50 - 55	0
Barbara Suggitt (Company Secretary)	85 - 90	0	0	90 - 95	0	
Stanley Riseborough (Executive Director of Service Delivery & Transformation) *Appointed November 2009*	115 - 120	0	0	50 - 55	0	0
Keith Moullin (Acting Executive Director of Service Delivery & Transformation) *April to November 2009*				60 - 65	0	0
Oliver Shanley (Executive Director of Quality & Safety) *Appointed November 2009*	115 - 120	0	33	50 - 55	0	12
Iain Eaves (Executive Director of Strategy & Organisational Development) *Appointed January 2011*	30 - 35	0	0			
Jim Andrews (Executive Director of Workforce and Organisational Development) *Left March 2010*				120 - 125	0	33

Senior Managers are defined as "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust".
* Benefits in kind represent the liability for tax payable by Executive Directors who are members of the Trust lease car scheme. Each Executive Director pays for their own private fuel consumption.

Signed Tom Cahill

Mr. Tom Cahill. Chief Executive 25th May 2011

6.2.2 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 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer value at 31 March 2011	Cash Equivalent Transfer value at 31 March 2010	Real increase (-decrease) in Cash Equivalent Transfer value	Employer contribution to stakeholder pension (nearest £000)
	£000	£000	£000	£000	£000	£000	£000	£000
Tom Cahill	0.0 - 2.5	2.5 - 5.0	65 - 70	195 - 200	943	1,029	-96	0
John Jones	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Keith Loveman	0.0 - 2.5	2.5 - 5.0	20 - 25	65 - 70	315	305	-1	0
Iain Eaves	0.0 - 2.5	0.0 - 2.5	0 - 5	0	3	0	1	0
Barbara Suggitt	0.0 - 2.5	0.0 - 2.5	15 - 20	55 - 60	378	377	-13	0
Geraldine O'Sullivan	0.0 - 2.5	2.5 - 5.0	50 - 55	150 - 155	908	941	-56	0
Stanley Riseborough	7.5 - 10.0	27.5 - 30.0	55 - 60	170 -175	1,138	988	70	0
Oliver Shanley	2.5 - 5.0	10.0 - 12.5	35 - 40	115 - 120	569	570	-20	0

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. In the budget of 22nd July 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI). As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in the above calculations and are lower than the previous factors used therefore the value of the CETV's for some members has fallen since 31.03.2010.

Signed 

Mr. Tom Cahill. Chief Executive 25th May 2011

7 Exceptional Items

	2010/11 £000	2009/10 £000
Exceptional items		
Reversal of impairments of property, plant and equipment	0	0
Impairments of property, plant and equipment	0	7,121
Total	**0**	**7,121**

Detail of the accounting for impairments in 2010/11 can be found in note 15.

8 Commitments

The Trust leases various premises and equipment under non-cancellable operating lease agreements. The leases have varying terms, escalation clauses and renewal rights.

The total expenditure on operating leases in 2010/11 is £2,416k comprising expenditure against minimum lease payments.

The future aggregate minimum lease payments under non-cancellable operating leases are as follows:

	31 March 2011 £000	31 March 2010 £000
Future minimum lease payments due:		
- not later than one year;	2,163	1,120
- later than one year and not later than five years;	3,817	2,656
- later than five years.	1,277	1,260
Total	**7,257**	**5,036**

9 Employee benefits

9.1 The employee benefit expenses incurred during the year were as follows

	2010/11	2009/10
	£000	£000
Salaries and wages	110,861	99,625
Social security costs	8,465	6,967
Pension costs - defined contribution plans Employers contributions to NHS Pensions	12,241	10,790
Other pension costs	483	639
Termination benefits	547	(155)
Agency/contract staff	4,830	4,124
Total	**137,427**	**121,990**

Other pension costs relate to Hertfordshire Council's Local Government Pension Scheme. See Note 2.5.2

Total employer pension contributions totalled £12,724k (£11,430k 2009/10)

9.2 Number of employees

The average number of employees during the year was as follows (expressed in full time equivalents)

	2010/11	2009/10
	FTE's	FTE's
Medical and dental	195	186
Administration and estates	635	571
Healthcare assistants and other support staff	749	630
Nursing, midwifery and health visiting staff	989	856
Scientific, therapeutic and technical staff	244	216
Social care staff	174	218
Bank and agency staff	507	498
Other	7	7
Total	3,500	3,182

9.3 Retirements due to ill-health

During 2010/11 there were 11 early retirements from the Trust on the grounds of ill-health with an estimated additional pension liability of £654k. In 2009/10 there were 4 early retirements on the grounds of ill-health with a liability of £384k. The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

These retirements represent 3.59 people per 1000 active scheme members (1.47 2009/10).

10 Better Payment Practice Code

10.1 Better Payment Practice code

The measure of compliance for 2010/11 has been analysed and can be found in the Trust's Annual Report on page 9.

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

There are no amounts included within Finance Costs (note 11.2) arising from claims made under this legislation.

There is no compensation paid to cover debt recovery costs under this legislation.

11 Finance Costs

11.1 Finance Income

	2010/11 £000	2009/10 £000
Interest receivable	210	302

11.2 Finance Expenses

	2010/11 £000	2009/10 £000
Finance leases	91	101
Unwinding of discount on provisions	479	285
Total	**570**	**386**

12 Intangible Assets

	2010/11 Software licences £000	2009/10 Software licences £000
Opening cost at 1 April	533	455
Additions - purchased	0	78
Gross cost at 31 March	**533**	**533**
Opening amortisation at 1 April	161	70
Provided during the year	107	91
Amortisation at 31 March	**268**	**161**
Net book value		
Purchased at 31 March (opening cost less opening amortisation)	372	385
Purchased at 31 March (gross cost less amortisation)	**265**	**372**

The economic life of these assets varies between 2 and 4 years.

13 **Property, Plant and Equipment**

13.1 Balances as at 31 March 2011	Total	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant & machinery	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2010 - as previously stated	156,244	55,751	91,729	1,116	1,021	1,136	3,744	1,747
Additions - purchased	8,711	3,790	346	0	4,081	32	409	53
Impairments charged to the Revaluation Reserve	(1,021)	(160)	(861)	0	0	0	0	0
Reclassifications	0	0	3,309	0	(3,407)	0	0	98
Revaluation surpluses	4,881	1,345	3,488	48	0	0	0	0
Transferred to disposal group as asset held for sale	(491)	(162)	(329)	0	0	0	0	0
Disposals	(275)	(275)	0	0	0	0	0	0
Valuation/Gross cost at 31 March 2011	**168,049**	**60,289**	**97,682**	**1,164**	**1,695**	**1,168**	**4,153**	**1,898**
Accumulated depreciation at 1 April 2010 - as previously stated	25,229	2,848	17,498	80	0	661	2,998	1,144
Provided during the year	3,777	0	3,192	33	0	51	373	128
Impairments charged to operating expenses	92	0	92	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2011	**29,098**	**2,848**	**20,782**	**113**	**0**	**712**	**3,371**	**1,272**
Net book value - 31 March 2011								
Owned	138,005	57,441	75,954	1,051	1,695	456	782	626
Finance Lease	574	0	574	0	0	0	0	0
PFI	0	0	0	0	0	0	0	0
Donated	372	0	372	0	0	0	0	0
NBV total at 31 March 2011	**138,951**	**57,441**	**76,900**	**1,051**	**1,695**	**456**	**782**	**626**
Protected assets	125,891	54,561	71,330	0	0	0	0	0
Unprotected assets	13,060	2,880	5,570	1,051	1,695	456	782	626
Total at 31 March 2011	**138,951**	**57,441**	**76,900**	**1,051**	**1,695**	**456**	**782**	**626**

Property, Plant and Equipment

13.2 Balances as at 31 March 2010	Total	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant & machinery	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2009 - as previously stated	142,733	55,641	69,925	1,006	10,284	1,069	3,423	1,385
Additions - purchased	9,905	0	8,196	0	1,021	40	321	327
Impairments	(1,407)	(315)	(1,092)	0	0	0	0	0
Reclassifications	0	0	10,284	0	(10,284)	0	0	0
Revaluations	5,342	575	4,595	110	0	27	0	35
Disposals	(329)	(150)	(179)	0	0	0	0	0
Valuation/Gross cost at 31 March 2010	**156,244**	**55,751**	**91,729**	**1,116**	**1,021**	**1,136**	**3,744**	**1,747**
Accumulated depreciation at 1 April 2009 - as previously stated	14,643	2,798	7,620	50	0	552	2,601	1,022
Provided during the year	3,526	0	2,868	30	0	109	397	122
Impairments	7,121	50	7,071	0	0	0	0	0
Disposals	(61)	0	(61)	0	0	0	0	0
Accumulated depreciation at 31 March 2010	**25,229**	**2,848**	**17,498**	**80**	**0**	**661**	**2,998**	**1,144**
Net book value - 31 March 2010 (restated)	0	0	0	0	0	0	0	0
Owned	129,995	52,903	73,211	1,036	1,021	475	746	603
Finance Lease	643	0	643	0	0	0	0	0
PFI	0	0	0	0	0	0	0	0
Donated	377	0	377	0	0	0	0	0
NBV total at 31 March 2010 (restated)	**131,015**	**52,903**	**74,231**	**1,036**	**1,021**	**475**	**746**	**603**
Protected assets	117,497	49,623	67,873	1	0	0	0	0
Unprotected assets	13,518	3,280	6,358	1,035	1,021	475	746	603
Total at 31 March 2010	**131,015**	**52,903**	**74,231**	**1,036**	**1,021**	**475**	**746**	**603**

Transfers from Assets Under Construction related to the new Psychiatric Intensive Care Unit and the development of the Child & Adolescent Mental Health Unit, both based at Harperbury site.

Impairments recognised in operating expenses relate to the formal 5 yearly revaluation and a specific exercise undertaken to reflect the two new assets above being brought into use.

13.3 Disposal Of Property, Plant and Equipment

	2010/11 £000	2009/10 £000
Profit on disposal of other tangible fixed assets	0	7

	2010/11 £000	2009/10 £000
Loss on disposal of land and buildings	17	58

Profits/Gains and losses on disposal are for non protected assets in both years.

14 Assets held under Finance Leases

	2010/11 £000	2009/10 £000
Opening cost at 1 April	**2,125**	**2,125**
Accumulated depreciation at 1 April	1,482	1,413
Provided during the year	69	69
Accumulated depreciation at 31 March	**1,551**	**1,482**
Net book value		
NBV total at 1 April	643	712
NBV total at 31 March	**574**	**643**

The Trust 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 in St. Albans.

15 Impairment of Assets (Property, Plant & Equipment and Intangibles)

	2010/11 £000	2009/10 £000
Impairments of property, plant and equipment	92	7,121
Reversal of impairments of property, plant and equipment	(780)	0
Total impairments and reversal of impairments	**(688)**	**7,121**

The impairment charge for 2009/10 includes a re-valuation by the District Valuer for the redeveloped Child & Adolescent Mental Health Unit and the new Psychiatric Intensive Care Unit, both based at the Harperbury site (£6,534k) and other assets (£587k) following the five yearly revaluation.

The £780k reversal of impairments in 2010/11 include £207k that relates to the subsequent 'desk top' valuation of the Psychiatric Intensive Care Unit as at 31 March 2011. The other reversals relate to other land and buildings previously impaired through the the Statement Of Comprehensive Income.

16 Inventories

	31 March 2011 £000	31 March 2010 £000
Pharmacy stock	13	12
Total	**13**	**12**

In 2010/11 a total of £738 (£734 in 2009/10) of inventories was included in the Statement Of Comprehensive Income as an expense.

17 Assets Held For Sale

	Property, Plant and Equipment	
	31 March 2011 £000	31 March 2010 £000
Plus assets classified as available for sale in the year	491	0
NBV of non-current assets for sale at 31 March 2011	**491**	**0**

Assets held for sale are held at the price the asset is currently being marketed at.

18 Trade Receivables and other Receivables

18.1 Trade Receivables and other Receivables

	31 March 2011 £000	31 March 2010 £000
Current		
NHS Receivables	2,291	2,520
Other receivables with related parties	907	775
Provision for impaired receivables	(344)	(430)
Prepayments	761	713
Accrued income	244	0
PDC receivable	15	225
Other receivables	289	274
Total current trade and other receivables	4,163	4,077
Non-Current		
NHS Receivables	11,341	7,285
Other receivables	21	20
Total non-current trade and other receivables	11,362	7,305

NHS Receivables includes £11,929k as at 31 March 2011 (£7,893k as at 31 March 2010) relating to back to back pension provisions.

18.2 Provision for irrecoverable debts

	2010/11 £000	2009/10 £000
At 1 April	430	442
Increase in provision	192	93
Amounts utilised	(64)	0
Unused amounts reversed	(214)	(105)
Balance at 31 March	344	430

18.3 Analysis of impaired debts and non-impaired debts past their due date

	30 March 2011 £000	31 March 2010 £000
Ageing of impaired receivables		
Up to three months	50	23
In three to six months	153	57
Over six months	141	350
Total	**344**	**430**
Ageing of non-impaired receivables past their due date		
Up to three months	1,913	851
In three to six months	174	191
Over six months	712	337
Total	**2,799**	**1,379**

19 Cash and cash equivalents

	2010/11 £000	2009/10 £000
Cash and Cash equivalents at 1 April	38,152	43,918
Net change in cash and cash equivalents	517	(5,766)
Cash and Cash equivalents at 31 March	**38,669**	**38,152**
Comprising:		
Cash at commercial banks and in hand	0	37
Cash with the Government Banking Service	38,669	38,115
	38,669	**38,152**

Royal Bank Of Scotland and Citibank are collectively known as the Government Banking Service. The accounts operate as one account and there is no operational impact on the Trust.

20 Public Dividend Capital

	2010/11 £000	2009/10 £000
Taxpayers' Equity at 1 April	79,370	79,370
Public Dividend Capital received	3,890	0
Taxpayers' Equity at 31 March	**83,260**	**79,370**

Public Dividend Capital received in year relates mainly to the transfer to the Trust of land at Harperbury.

21 Finance Lease Obligations

	31 March 2011 £000	31 March 2010 £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.	512	655
Gross lease liabilities	**1,291**	**1,434**
Less: Finance charges allocated to future periods	(406)	(483)
Net lease liabilities	**885**	**951**
Split into current and non-current on the Statement Of Financial Position:		
- current	156	156
- non current	729	795
	885	**951**
Expected timing of cashflows:		
- not later than one year;	76	66
- later than one year and not later than five years;	402	362
- later than five years.	407	523
	885	**951**

Details of Finance Leases are included in note 14.

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2011

22 Provisions for liabilities and charges (held in current and non-current liabilities)

	Total	Pensions relating to other staff	Legal and other claims	Agenda for Change	Injury Claims
	£000	£000	£000	£000	£000
At 1 April 2010	17,863	12,289	1,807	2,539	1,228
Arising during the year	7,926	6,684	596	628	18
Utilised during the year	(1,082)	(918)	(128)	0	(36)
Reversed unused	(3,669)	(1,791)	(550)	(833)	(495)
Unwinding of discount	479	459	0	0	20
At 31 March 2011	**21,517**	**16,723**	**1,725**	**2,334**	**735**
Expected timing of cashflows:					
- not later than one year;	2,073	917	747	372	37
- later than one year and not later than five years;	6,752	3,667	978	1,962	145
- later than five years.	12,692	12,139	0	0	553
Total	**21,517**	**16,723**	**1,725**	**2,334**	**735**

The 'Pensions relating to other staff' provison 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 'Pension' and 'Injury claims' provisions together total £17,456k (£13,516k as at 31 March 2010. Of this £11,929k (£7,893k as at 31 March 2010) is subject to 'Back to Back' agreements.

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.

The 'Legal and other claims' provision includes provisions in respect of the Trust's employer and public liabilities, the amount stated is subject to uncertainty about the outcome of legal proceedings. £1,918k (£50k as at 31 March 2010) is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust.

The 'Agenda for Change' provision is the estimated liability for pay backdated to 1st October 2004 under the new NHS pay system.

The 'Injury Claims' provision is the capitalised cost of injury benefits as defined by the NHS Pension scheme, for scheme members who are permanently incapable of fulfilling their duties effectively through injury.

23 Trade and other payables

	31 March 2011 £000	31 March 2010 £000
Current		
Receipts in advance	1,604	1,194
NHS payables	3,540	4,224
Amounts due to other related parties	1,446	386
Trade payables - capital	284	634
Taxes payable (employee national insurance and other employee related taxes payable to HMRC)	2,831	2,380
Other payables	2,895	4,831
Accruals	8,695	9,456
Total current Trade and other payables	**21,295**	**23,105**

The following amounts included in NHS Payables (above) relate to outstanding pension contributions:

£1,606k as at 31 March 2011
£1,488k as at 31 March 2010

24 Other liabilities (Government Grants)

These comprise Government Grants used to purchase miscellaneous IT equipment and furniture.

25 Financial assets and liabilities

25.1 Financial assets by category

	31 March 2011 £000	31 March 2010 £000
NHS Receivables	3,442	3,315
Provision for irrecoverable debts	(344)	(430)
Other Receivables	289	274
Cash and cash equivalents (at bank and in hand) at 31 March	38,669	38,152
Total at 31 March	**42,056**	**41,311**

25.2 Financial liabilities by category

	31 March 2011 £000	31 March 2010 £000
Obligations under finance leases	885	951
NHS payables	3,540	4,224
Trade and other payables	4,341	5,218
Accruals	8,695	9,456
Capital payables	284	634
Provisions under contract	4,062	4,346
Total at 31 March	**21,807**	**24,829**

25.3 Fair value of financial assets

	Book value	Fair value
	£000	£000
NHS Receivables	3,442	3,442
Provision for irrecoverable debts	(344)	(344)
Other Receivables	289	289
Cash and cash equivalents (at bank and in hand) at 31 March 2011	38,669	38,669
Total at 31 March 2011	**42,056**	**42,056**
NHS Receivables	3,295	3,295
Provision for irrecoverable debts	(430)	(430)
Other Receivables	294	294
Cash and cash equivalents (at bank and in hand) at 31 March 2010	38,152	38,152
Total at 31 March 2010	**41,311**	**41,311**

25.4 Fair value of financial liabilities

	Book value	Fair value
	£000	£000
Obligations under finance leases at 31 March 2011	885	763
NHS payables	3,540	3,540
Trade and other payables	4,341	4,341
Accruals	8,695	8,695
Capital payables	284	284
Provisions under contract at 31 March 2011	4,062	4,062
Total at 31 March 2011	**21,807**	**21,685**
Obligations under finance leases at 31 March 2010	951	826
NHS payables	4,224	4,224
Trade and other payables	5,218	5,218
Accruals	9,456	9,456
Capital payables	634	634
Provisions under contract at 31 March 2010	4,346	4,346
Total at 31 March 2010	**24,829**	**24,704**

26 Reconciliation of operating surplus to net cash flow from operating activities

	2010/11		2009/10	
	£000	£000	£000	£000
Operating Surplus		8,369		274
Non cash flow movements:				
Depreciation and amortisation	3,884		3,618	
Impairments	92		7,121	
Reversals of impairments	(780)		0	
Transfer from the donated asset reserve	(21)		(17)	
		3,175		10,722
Movement in Working Capital:				
(Increase) / Decrease in inventories	(1)		(4)	
(Increase) / Decrease in receivables	(4,353)		1,223	
Increase / (Decrease) in trade and other payables	(1,912)		(3,816)	
Increase / (Decrease) in other liabilities	(8)		(8)	
Tax (employee national insurance and other employee related taxes payable to HMRC) (paid) / received	451		0	
		(5,823)		(2,605)
Increase / (Decrease) in provisions		3,654		(972)
Other movements in operating cash flows		(466)		0
Net cash inflow from operating activities		**8,909**		**7,419**

27 Related Party Transactions

During the year none of the Board Members, Governors or members of the key management staff or parties related to them has undertaken any material transactions with the Trust.

Board members, Governors and other key management staff take decisions on Charity and Exchequer matters but endeavour to keep the interests of each discreet and do not seek to benefit personally from such decisions. Declarations of personal interest have been made and are available for inspection.

2010/11	Income from Related Party	Expenditure payments to Related Party	Receivables from Related Party	Payables to Related Party
	£000	£000	£000	£000
Central Government				
Department Of Health	224	327	63	0
Other Central Government	0	8,640	248	17
NHS				
East of England Strategic Health Authority	2,421	22	6	13
Barnet PCT	657	48	1,203	0
Brent Teaching PCT	381	0	1,075	0
Ealing PCT	855	0	1,355	0
Hillingdon PCT	135	0	1,112	0
Hounslow PCT	1,076	0	851	0
North East Essex PCT	0	1,067	0	0
South East Essex PCT	6,304	1,061	12	494
West Essex PCT	12,299	153	103	68
Westminster PCT	5	0	1,520	0
East & North Hertfordshire NHS Trust	14	3,015	14	54
South Essex Partnership University NHS Foundation Trust	0	437	4	215
West Hertfordshire Hospitals NHS Trust	1,111	1,929	96	360
NHS Business Services Authority	0	3,313	0	47
National Heath Service Pension Scheme	0	12,241	0	1,844
Other NHS	5,938	6,311	6,424	2,803
Local Government				
Barnet London Borough Council	1,709	0	0	0
Hertfordshire County Council	171,676	459	305	1,413
Norfolk County Council	2,000	0	30	0
Westminster City Council	1,021	0	45	0
Other Local Government	1,683	1,219	344	16
Totals	**209,509**	**40,242**	**14,810**	**7,344**

The Trust has also received revenue payments from a number of charitable funds, the Corporate Trustees for which are also members of the Trust Board. These transactions are not included in the Financial Statements for the Trust (see Note 2.2).

Remuneration of key management is disclosed in note 6.21

28 Losses and Special Payments

There were 65 cases (50 cases in 2009/10) of losses and special payments totalling £39k (£43k in 2009/10) paid during 1st April 2010 to 31 March 2011. These are the cash payments made in the year and are not calculated on an accruals basis.

29 Third Party Assets

The Trust held £2,336k cash at bank and in hand at 31st March 2011 (£2,178k at 31st March 2010) which relates to monies held by the Trust on behalf of service users. This had been excluded from the cash and cash equivalents figure reported in the accounts.

30 Post Balance Sheet Events

There are none.

31 Contingencies

	31 March 2011 £000	31 March 2010 £000
Value of contingent liabilities	**(29)**	**(59)**

There are no recoverable values from third parties (contingent assets).
Contingent liabilities consist of liabilities to third parties.
The very nature of contingent liabilities means there are uncertainties regarding timing and amount of settlement.

32 Commitments under capital expenditure contracts

	31 March 2011 £000	31 March 2010 £000
Property, Plant and Equipment	332	2,036
Total as at 31 March	**332**	**2,036**

The commitment as at 31 March 2011 relates to a contract for a new care records system.

Hertfordshire Partnership NHS
NHS Foundation Trust

Annual Governance Statement
April 2010 - March 2011

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 2011 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.

During the past year, the Foundation Trust has also won a number of awards for good and excellent practice, demonstrating that we operate, as far as possible, as a "learning organisation" which communicates well and provides staff with every opportunity to learn from each other and from the high quality leadership training provided.

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.

Our Communications team constantly uses new and innovative approaches to inform staff of opportunities to learn from others internally and externally, and to celebrate and communicate all examples of good practice to ensure learning is ongoing and continuous.

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 Executive Director Service Delivery and Transformation** 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 specifically identifies potential risks to the achievement of each of the Trust's Strategic Goals and monitors the actions being taken to control them. It 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 formally reviewed 4 times a year. Two of these are full reviews reported to the Risk Management and Patient Safety Group, 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 two, routine quarterly reviews, are reported to the Risk Management and Patient Safety Group and 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 control measures for risks of all types. The moderate and high risks and the overall process is monitored and reviewed by the Integrated Governance Committee via the Risk Management and Patient Safety Group.
The 'Top Ten 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 5.2 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 March 2011 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 and there have been no SUIs relating to potential or actual breaches of confidentiality involving person identifiable data. Progress has been made as measured against Information Governance Standards with continued improvement being targeted through a robust plan to achieve compliance with Level 2 as assessed against the Information Governance Toolkit.

4.7 The Organisations current major Risks.
The Top Three Risks on the Trust Risk Register which are managed and controlled via the Risk Register mechanisms described in section 4.4 are:

- Managing the Financial downturn in the longer term

Risk of continued financial challenges of the next three years
Specifically, failure to break even through:

a) Non-achievement of saving requirements, and
b) Reduction in turnover as a result of the new public expenditure settlement 2011/2012.

- Transformational Leadership

Risk that the organisation, having made significant investment in the Leading by Design Programme fails to deliver and embed a transformed and improved care and support model due to:
-lack of visible leadership of the Leading by Design Programme at all levels from the Board to Team Leaders, and/or
-lack of or limited buy in from the key stakeholder groups.

- Quality & Safety Risk

Risk that our modernisation of service design does not achieve the required quality and safety, in the environment of increased financial pressure.

4.8 Embedding Risk Management
Although there are many initiatives to describe, some of the further key mechanisms to facilitate the ongoing embedding of Risk Management activities into the business of the Trust, in addition to everything described above in the Control Framework are:

- The strategic objectives for Risk Management at service level in the Risk Management Strategy.
- The linking processes between Local & Trust Risk Registers: i.e. Service Stream Local Risk Registers can refer risks to the Trust RR at any time and particularly at the start of each quarterly cycle. Risks can also be referred back from the TRR to the Service Stream LRR during any quarterly review, and there are scheduled meetings to facilitate this.
- The Learning Lessons and Clinical Risk Group: sharing intelligence from all sources.
- Promotion of the CQC Framework and the NHSLA Standards across all services.

4.9 Internal and External Stakeholders are informed and involved in the activities of the Trust in a variety of ways. The Trust has a framework of forums for consultation with public stakeholders, e.g. service users and carers, which advise on key areas of risk as appropriate, an example of which is adherence to delivery of same sex accommodation. Service User Representatives also hold membership on various committees and groups. Responsibility for ensuring relevant stakeholders involvement in Risk Management issues is indicated in the relevant policies and procedures. The SHA and Joint Commissioning Partnership Board are informed if any risks are identified which seriously threaten the achievement of the Trust's objectives or which cannot be adequately managed.

4.10 CQC Essential Standards for Quality The Foundation Trust is fully compliant with the requirements of registration with the Care Quality Commission.

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

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 Major Incident and Business Continuity Management
The Foundation Trust's Major Incident, Emergency & Business Continuity Procedure has been developed and tested in year. This demonstrated our robust control systems designed to mitigate the risk to continuity of our services in the event of any type of major incident. We are also founder members of the Herts Environmental Forum (HEF) and are active partners in the Herts Resilience Forum (HESMIC) taking part in relevant exercises, including exercises for Flood, Heat wave, electricity & fuel shortages.

4.14 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.

4.15 Policy and Procedure Framework

The approach to Risk Management is embedded within the organisation in numerous ways. A key aspect of this is that Trust staff operate within a framework of policies and procedures designed to ensure that the service users receive care in a physical and clinical environment in which risk levels are controlled and reduced to a minimum. These policies are introduced to staff on induction and as part of the Risk Management Training Prospectus. Policy and Procedure documents are readily available in each site and via the Trust Intranet and key policies which assist in the assessment and management of specific risks are a particular focus of mandatory training. Managers are involved in the effective use of these policies in their teams day-to-day.

For example, amongst other things there are policies for:

- Risk Management
- Care Records of Service Users
- Consent to Examination and Treatment
- Learning from Adverse Events (including Serious Untoward Incidents)
- Complaints
- Clinical Risk Assessment and Management of Individual Service Users
- Supportive Observation of Service Users at Risk
- Prevention and Management of Violence
- Integrated Programme Approach and Care Management (CPA)
- Do the Right Thing (whistle blowing)
- Health and Safety (including COSHH)
- Infection Control

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 Financial Instructions
- Scheme of Delegated Authority
- Anti-fraud and corruption

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 reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

5.2 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 has put in place the following 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 has put in place the following steps to assure the Board that there are appropriate controls to ensure the quality of data:

- Recruitment of a Performance Information Officer to add expertise and capacity to this team.
- Provision of training to staff including all new starters on data inputting.
- Elimination where possible of manual approaches to data gathering.
- Audit of supervision to check whether it was being used as it should to address recording issues with staff, leading to raised awareness of their managers.
- Revision of the Data Quality Policy to state clearly the Executive lead for data quality and the importance of the accuracy of information for the quality account.
- Introduction of more robust audit trails re decisions about data, and stronger internal assurance such as random checks by the Informatics Manager in his team.
- Temporary data quality officers reporting to the Performance team recruited to work alongside teams to assist in full and accurate use of the patient record system.

The performance information for quality reports is assessed via:

- Checks within the informatics and Performance 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.

The Quality & Standards 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. Trusts compliance with the Essential Standards of Quality and Safety are 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.

6. 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 high level co-ordination and monitoring 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 review of the Trust systems.
- **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 his draft HOIA Opinion that "based on the work undertaken in 2010-2011, significant assurance can be given that there is a sound system of internal control, designed to meet the organisations objectives, and that controls are being applied consistently".
- **Monitor** monitors the Trust's Performance.

7. Conclusion

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

Signed.....
Tom Cahill, Chief Executive
Date: 25 May 2011

Hertfordshire Partnership NHS
NHS Foundation Trust

as one

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 accounting officer's 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: 25 May 2011

Independent auditor's report to the Board of Governors of Hertfordshire Partnership NHS Foundation Trust

I have audited the financial statements of Hertfordshire Partnership NHS Foundation Trust for the year ended 31 March 2011 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

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

- the table of salaries and allowances of senior managers and related narrative notes on page 22 and
- the table of pension benefits of senior managers and related narrative notes on page 23.

This report is made solely to the Board of Governors of Hertfordshire Partnership NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Audit Commission, 3rd Floor, Eastbrook, Shaftesbury Road, Cambridge, CB2 8BF
T 0844 798 4200 F 01223 353073 www.audit-commission.gov.uk

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Hertfordshire Partnership NHS Foundation Trust as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Annual Governance Statement on which I report to you if, in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements.

Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide external assurance over the Trust's annual quality report. I am satisfied that this work does not have a material effect on the financial statements.

.....

Date: 26th May 2011

Mark Hodgson

Officer of the Audit Commission

Audit Practice, Audit Commission, 3rd Floor, Eastbrook, Shaftesbury Road, Cambridge, CB2 8BF.

Independent auditor's report to the Board of Governors of Hertfordshire Partnership NHS Foundation Trust

I have considered the information given in the revised annual report of Hertfordshire Partnership NHS Foundation Trust for the year ended 31 March 2011. The revised Annual Report replaces the original report approved by the Accounting Officer on 25 May 2011.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer is responsible for preparing the revised Annual Report. I am required to report to you whether the revised Annual Report is consistent with the financial statements.

Basis of opinion

My consideration has been directed on matters of consistency alone and not to whether the revised Annual Report complies with the requirements of Monitor's Annual Reporting Manual 2010/11.

Opinion

In my opinion the information given in the revised Annual Report is consistent with the financial statements for the year ended 31 March 2011 which were approved by the Accounting Officer on 25 May 2011 and on which I gave an unqualified opinion on 26 May 2011.

Certificate

In my report dated 26 May 2011, I explained that I could not formally conclude the audit on that date until I had completed the work to provide external assurance on the Trust's annual quality report. I have now completed this work. No matters have come to my attention since that date that would have a material impact on the financial statements on which I gave an unqualified opinion.

I certify that I have completed the audit of the accounts Hertfordshire Partnership NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

…… Date: 27 June 2011

Mark Hodgson
Officer of the Audit Commission

Audit Commission, 3rd Floor, Eastbrook, Shaftesbury Road, Cambridge, CB2 8BF.

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 innymformacie
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 unformato
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 برائے مہربانی ذیل سے رابطہ کریں:

پیشنٹ ایڈوائس اینڈ لیزاں 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 NHS Foundation Trust
works toward eliminating all forms of discrimination and
promoting equality of opportunity for all

www.hertspartsft.nhs.uk
Date of publication June 2011