



Annual Report 2011-2012



Annual Report 2011 - 2012

Contents

Section One

Introduction from the Chair and Chief Executive	3
Directors' Report	5
Financial Review	6
Analysis of Financial Performance	9
Operating Review	14
NHS Foundation Trust Code of Governance	15
Board of Directors	16
Committees	21
Remuneration and Nomination Report	23
Board of Governors	24
Membership	28
Quality Account	31
Service User Care and Stakeholder Relations	87
Information Requests	92
Sustainability and Climate Change	95
Equality and Diversity	99
Our Staff	106
Regulatory Ratings	113

Section Two

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

A GOOD YEAR FOR SERVICE USERS

This last year was good for Hertfordshire Partnership NHS Foundation Trust from many perspectives. As an organisation, we've grown in confidence which has manifested itself in changes to our services which made – and continue to make – a real difference despite reductions in our funding in line with NHS reductions nationwide.

Our determination to provide the best service we can has seen excellent improvements to the care received across Hertfordshire and in our services in North Essex and Norfolk.

The Trust's four year service transformation programme "Leading by Design" is ensuring that services improve, without reducing quality and safety. The introduction of a Single Point of Access removes over 30 ways services users have into care, to just one where trained staff provide clinical triage and help over the phone, improving the uniformity of our service. The first phase was having an impact before the end of the financial year, and will quickly see real improvements early in 2012/13. We look forward to sharing these with you next year.

The safety of those in our care is our top priority, together with the safety of our staff, above and beyond the requirements of the regulatory bodies. Our registration with CQC continues to be a badge of honour for the Trust and we are delighted that following regulatory visits, HPFT's criteria of registration remained unchanged.

The NHS Litigation Authority is another external body whose standards we take extremely seriously to demonstrate our systems for maintaining safe services – both clinically and corporately – are effective. We're delighted to have retained level 2 status after a very thorough inspection in September and we intend to



apply for the higher level 3 status within 18 months.

HPFT won its sixth consecutive Gold Award for outstanding achievement in health and safety at work from the Royal Society for the Prevention of Accidents. We were advised in March 2012 that we've been awarded the Gold Award for the seventh year running.

There's a pattern of consistently improved performance here at HPFT and it's good to note that the numbers of serious incidents also fell this year. We're also pleased to note that assaults on staff by our inpatient service users are down with incidents in the second half of 2011/12 almost halved compared to the same period in 2010/11. Investment in and revision of the training given to staff in the prevention and management of violence and aggression is a key factor.

We were Highly Recommended in the 'Excellence in Providing Care Programme Approach (CPA) Information for Service Users and/or Carers' category at this year's Care Programme Approach Association (CPAA) Good Practice Awards. HPFT can now use a kite mark on our publications in recognition of the achievement.

Both the Eric Shepherd Medium Secure Unit and its counterpart the Broadlands Clinic in Norfolk have been accredited with the forensic national quality network – a clear indication of the quality of care provided.

In July, members of the public were invited to witness the Trust Board signing the 'Time-to-Change' pledge. 'Time to Change' is an England-wide programme to end stigma and discrimination that people with mental health problems face, led by mental health charities Mind and Rethink. The campaign has been running for four years and is backed by celebrities such as Ruby Wax, Frank Bruno, Stephen Fry and Alistair Campbell.

We continue to invest heavily in the fabric of our buildings. A major refurbishment costing £350,000, providing extra facilities to promote recovery, has been completed at Albany Lodge – our inpatient mental health unit in St Albans. The Trust upgraded Church Crescent, to create a safer and more attractive environment for care and recovery.

In September, we unveiled the changes at Elizabeth Court in Stevenage where we secured funding from The King's Fund under the Enhancing the Healing Environment (EHE) programme. We've been asked to assist The King's Fund with the development of an audit tool for measuring the effect of environment on people with dementia.

We renamed the historic Harperbury as Kingsley Green as part of our plans for a state of the art acute inpatient mental health unit for Hertfordshire on the site. The land has been used for mental health and learning disability care since the 1930s. The Trust is investing £40m in the site and environment.

This is just a snapshot of our year and you will find far more evidence of the achievements made by the Trust in 2011/12 within this Annual Report. But as a Trust we do know that these are the first steps

on our journey. There is so much more we want to achieve.

Our determination to ensure that those in our care get equal access and the same excellent treatment irrespective of where they live remains a goal we want to achieve.

We've started to move in that direction with the Single Point of Access work, and we look forward to reporting how successful that is next year.

Our Single Point of Access work is just one of the many things that our users, Trust Board and Governors have helped to shape and we would like to thank everyone who has contributed to HPFT's work in this financial year.

Each of you has helped the Trust to look forward and shape services which make a real difference to people's lives and that, after all, is what we are here to do.



Tom Cahill
Chief Executive

29 May 2012



Hattie Llewelyn-Davies
Chair

29 May 2012

Directors' Report

Introduction and Background Information

Having successfully achieved Foundation Trust status on 1 August 2007, we are now regulated by Monitor, the Independent Regulator of Foundation Trusts under the provisions of the NHS Act 2006. We were very proud to be the first Mental Health and Specialist Learning Disability Health and Social Care Foundation Trust and have operated as a Foundation Trust throughout the subsequent period.

Foundation Trusts are membership based public benefit corporations with members electing Governors who as a body hold to account the Directors in relation to the management of the Trust.

We greatly value the opportunities which being a Foundation Trust provides us to further build upon and improve the services we provide to our community through the benefits of:

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

Currently we provide the following service streams:

- 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.

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

This Directors' report covers the year ending 31 March 2012.

Financial Review

Overview

This section of the Directors' report provides a commentary on the continued strong financial performance of the Trust in the year. This is particularly encouraging given the well publicised financial challenges faced by many health care organisations at this time.

Financial Statements and Accounting Policies

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

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

There is a requirement for the Trust Board to review its accounting policies annually. This year as a result of this review and in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual the Trust has revised its policies in relation to the treatment of both Donated Assets and Government Grants. These changes have been applied retrospectively through a prior period adjustment as required by IAS 8.

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 has 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 and can also cover some non-audit work as directed by the Trust. The cost of these other services is shown separately in the accounts and in the table below. Any additional non-audit work can only be requested on the basis of an agreed protocol. It remains important that the external auditor's independence from management and objective approach is both maintained and transparent. The total external audit fee for 2011/2012 was £91K, comprising:

Audit Area	Audit Fee £
Statutory Audit Work	80k
Other work	11k

Counter Fraud Activities

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

Related Parties

During the year none of the Board Members, Governors or members of the key management staff or parties related to them, has undertaken any material transactions with the Trust. Details of other related party disclosures are set out in the accounts under note 24 on page 42.

Private Patient Income

The Private Patients Income Cap (PPI) 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, which is the greater of:

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

No private patient income was generated in 2011/12 (none in 2010/11).

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 2011/12 are available separately on request from the Director of Finance and Performance Improvement. There is no charge for the provision of these.

Cost Allocation and Charging Requirements

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

Analysis of Financial Performance

Financial Performance

This has been another successful year with the Trust reporting a year end surplus of £2.7M (2011/12 £3.6M) on a Revenue Turnover of £211.7M (2010/11 £212.2M) with an EBITDA margin of 5% (5.5% 2010/11) (before adjusting for impairments). This surplus is before impairment of fixed assets of £1.4M. After impairments the surplus is £1.2M (£4.3M in 2010/11). This is in line with our 3 Year Financial Plan and provides a Monitor Financial Risk Rating of 3 as planned.

The Trust is reporting Net Assets of £149.4M (2010/11 £150.2M) which includes current bank and cash levels of £41.3M (2010/11 £38.7M).

The surplus represents an excellent performance by the Trust given the continued challenges of the needs to redesign and re locate services whilst facing significant demands for efficiency savings from our commissioners.

This surplus is available for reinvestment in programmes to continually improve the quality of our services and service user experience. In 2011/12 we have invested in a range of developments as well as embarking upon a major transformation programme (entitled Leading by Design) which is overseeing a series of work streams focussed on service improvement. Key highlights within 11/12 include:

- The development of a Single Point of Access for initial referral and screening which will commence in the early part of 2012
- The scoping and early development work on the replacement of the existing Electronic Record System
- The design of the state of the art facility at Kingsley Green (the old Harperbury hospital site)
- The design of new build Assessment & Treatment services to reprovide The Poplars, Little Plumstead, Norfolk
- Security and refurbishment of medium secure services.

Impairments

The net impairment loss reported of £1.4m arises from an impairment review carried out on those assets acquired or enhanced during 2011/12 (including those which were assets under construction at March 31st 2010/11). The impairment was based upon the valuations provided by the District Valuer.

No general revaluation of assets was carried out in 2011/12. 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

The Trust has achieved a Monitor Financial Risk Rating of 3 for 2011/2012 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 113 of this report (Section E – Regulatory ratings).

Key Metrics (financial indicators)

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

Financial Criteria	Metric	2011/2012	2010/2011
Underlying Performance	EBITDA Margin	5.0%	5.5%
	Achievement of Plan	98.9%	105.8%
Financial Efficiency	Income & Expenditure Surplus Margin	1.3%	1.7%
Financial Efficiency	Return on Assets	4.0%	5.1%
Liquidity	Liquidity Ratio	63 days	58 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. 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 and therefore does not hold any complicated financial instruments to hedge against such risks.

Summary of Key Results from the Accounts

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

Financial Criteria	2011/2012 £000	2010/2011 £000
Total Income	211,684	212,204
Surplus for the Year (excluding Impairments. There were no Exceptional Items)	2,661	3,596
Capital Expenditure	5053	8,711
Capital Charges (Depreciation & Public Dividends)	7,573	7,481

Income

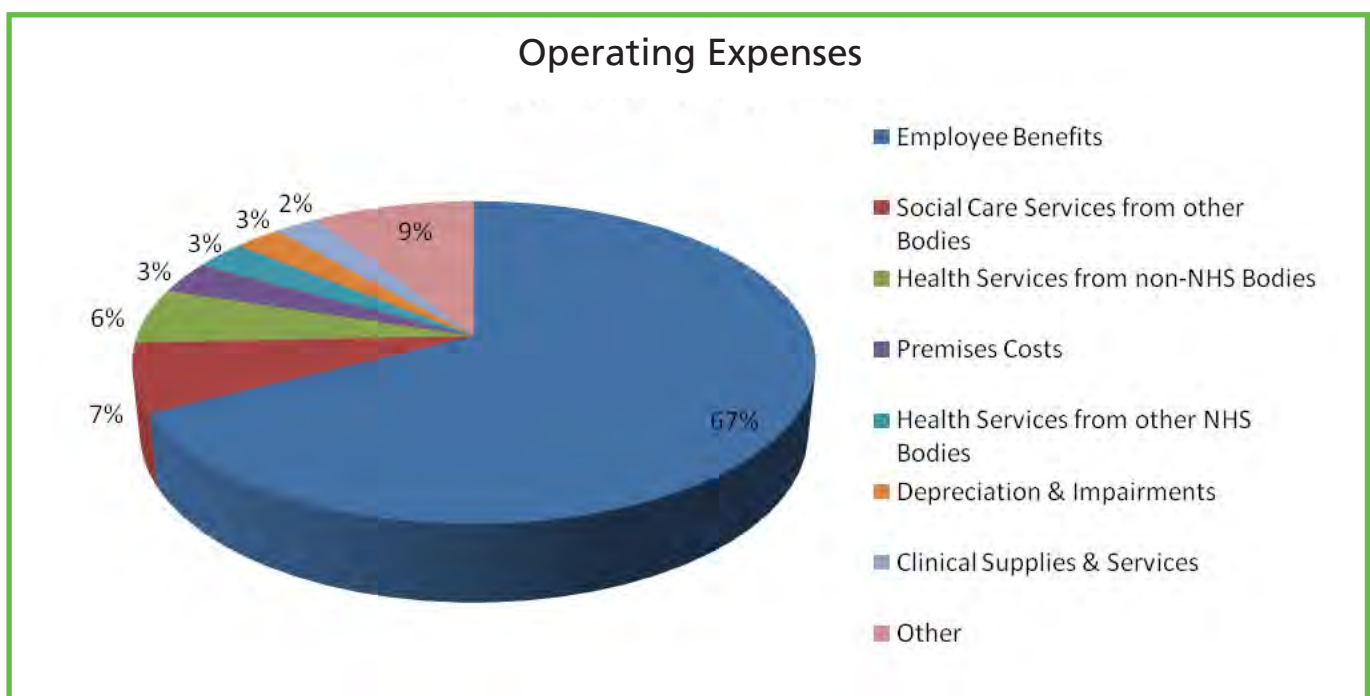
In the financial year 2011/2012 the Trust generated income totalling £211.7m of which the majority relates to income from activities as illustrated below:

	£000	%
Income from Activities	201,104	95.0
Other Operating Income	10,580	5.0

The 2011/12 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. The Trust has estimated that it has been successful in securing 89% against the agreed schedule.

Operating Expenses

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



In common with other Trusts, the most significant area of resource is staffing. However, as a Partnership Trust with delegated secondary commissioning responsibilities and operating from over 100 sites in Hertfordshire, Norfolk and North Essex, there are other significant categories of cost to manage. Further detail of expenditure for the financial year can be found under note 5 (page 23) of the accounts.

Management Costs

Management costs, as defined by the Department of Health guidelines, represent 6.5% of Trust turnover for the financial year (5.9% 201011) 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 5.2 of the accounts and within the remuneration report (pages 24 & 25).

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 2012	32,453	59,427
Total within target	28,383	51,658
Percentage within target	87.46%	86.93%
Total NHS invoices paid to 31st March 2012	1,483	16,029
Total within target	1,303	14,981
Percentage within target	87.86%	93.46%

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

Capital Programme

During 2011/12 we invested £5M in providing new or improved assets (land, property and equipment) through the capital programme agreed and reviewed by the Directors.

Prudential Borrowing Limit

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

- £43.1m for long term borrowing
- £13.0m as a working capital facility.

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

Forward Look

2012/13 funding for the Trust has been agreed in line with the national payment by results tariff uplift, that is

- allowance for generic uplift to cover pay awards, agenda for change, capital charges indexation, new drugs and other reform measures = 2.2%
- Less:
cash releasing efficiency requirement = 4.0%
net reduction = -1.8%

The additional 0.3% reduction in comparison to 2011/12 translates to an increase in the cash releasing efficiency savings (CRES) of approximately £750k.

In addition to the tariff uplift, PCTs have been allocated 2.5% for Commissioning for Quality and Innovation (CQUIN). This is a 1% increase in available funding, worth approximately an additional £1.5m to the Trust.

The comprehensive 'Leading by Design' programme continues to be developed in order to deliver service transformation, maintain quality and safety and to meet these efficiency requirements. This approach is focussing on the transformation and reconfiguration of current provision, encouraging innovation in the approach to the delivery of high quality services. The implementation phase of 'Leading by Design' will accelerate in 2012/13.

The 2012/2013 capital programme totals £32.7m investment with a further £42m to be invested in 2013/14.

The major investments relate to the development and improvement of mental health and learning disability inpatient facilities; the rationalisation and improvement of environments across Hertfordshire, North Essex and Norfolk; 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 initially appointed for terms of 4 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 balance of Board 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 Llewelyn-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 – 31.7.2013 (2 terms)
Carol Kennedy Filer	1.8.2007 – 31.7.2013 (2 terms)
Steve Marsden	1.8.2009 – 31.7.2012 (1 term)
Manjeet Gill	1.6.2009 – 31.7.2012 (1term)

Steve Marsden and Manjeet Gill have been reappointed by the Board of Governors to serve a further three years from 31.7.2012 following a formal performance evaluation by the Appointments & Remuneration Committee (see the section on Committees for further details of the Committee and its duties).

Executive Director Appointments

Our Executive Directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures. The period of notice for Executives is six months. There are six Executive Directors including the Chief Executive and the posts are as follows:

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

The Board of Directors is responsible for all operational issues, the management of which is delegated to the Trust's operational staff in accordance with its Standing Orders and Standing Financial Instructions. It also, with input from the 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 14 Board of Directors meetings between 1 April 2011 and 31 March 2012. This includes the Annual General Meeting for members. The individual attendance of each Board member is indicated in brackets.

Hattie Llewelyn-Davies, Chair

(14 out of a possible 14)

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

Tom Cahill, Chief Executive

(13 out of a possible 14)

- 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 Commercial Development

(12 out of a possible 14)

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

Geraldine O’Sullivan, Executive Director Quality and Medical Leadership

(11 out of a possible 14)

- 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.

Keith Loveman, Executive Director Finance and Performance Improvement

(13 out of a possible 14)

- 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

(10 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/Deputy Chief Executive

(12 out of a possible 14)

- 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.

Karen Taylor, Chief Operating Officer (from 27 February 2012)

(2 out of a possible 2)

- Responsible for all operational service delivery including estates and facilities.
- Responsible for customer experience and complaints.
- Is the Board lead and ensures compliance with the Mental Health Act.

Bill Brown, Non Executive Director

(13 out of a possible 14)

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

Manjeet Gill, Non-Executive Director

(11 out of a possible 14)

- 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

(13 out of a possible 14)

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

Stephen Marsden, Non-Executive Director

(13 out of a possible 14)

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

Ruth Sawtell, Non-Executive Director

(12 out of possible 14)

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

Colin Sheppard, Non-Executive Director

(12 out of a possible 14)

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

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 2011/12

Audit Committee

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

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

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

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

- Bill Brown (Chair), Non-Executive Director (5 of 5)
- Carol Kennedy Filer, Non-Executive Director (5 of 5)
- Steve Marsden, Non-Executive Director (5 of 5)
- Ruth Sawtell, Non-Executive Director (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 Annual Governance Statement.

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 | (4 of 4) |
| ● Ruth Sawtell, Non-Executive Director | (3 of 4) |
| ● Bill Brown, Non-Executive Director | (3 of 4) |

- Carol Kennedy-Filer, Non-Executive Director (3 of 4)
- Manjeet Gill, Non-Executive Director (2 of 4)
- Steve Marsden, Non-Executive Director (2 of 4)
- Tom Cahill, Chief Executive (4 of 4)
- Iain Eaves, Executive Director Strategy & Organisational Development (4 of 4)
- Keith Loveman, Executive Director Finance & Performance Improvement (4 of 4)
- Geraldine O'Sullivan, Executive Director Quality & Medical Leadership (3 of 4)
- Stanley Riseborough, Executive Director Service Delivery & Transformation (3 of 4)
- Oliver Shanley, Executive Director Quality & Patient Safety/Deputy Chief Exec (2 of 4)

In attendance

- Barbara Suggitt, Company Secretary (4 of 4)
- Anni Hartley-Walder, LbD Interim Project Director (3 of 4)

Integrated Governance Committee (IGC):

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

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

- Bill Brown, Non-Executive Director (4 of 4)
- Manjeet Gill, Non-Executive Director (3 of 4)
- Steve Marsden, Non-Executive Director (4 of 4)
- Tom Cahill, Chief Executive (Chair) (1 of 4)
- Iain Eaves, Executive Director Strategy and Commercial Development (2 of 4)
- Keith Loveman, Executive Director Finance and Performance Improvement (4 of 4)
- Geraldine O'Sullivan, Executive Director Quality and Medical Leadership (3 of 4)
- Stanley Riseborough, Executive Director Service Delivery and Transformation (4 of 4)
- Oliver Shanley, Executive Director Quality and Safety? Deputy Chied Exec (4 of 4)

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

Remuneration and Nomination Report

Board of Directors Nomination and Remuneration Committee

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

There were 6 meetings of the Committee during the financial period and members' attendance is shown below:

- Bill Brown, Non-Executive Director (5 of 6)
- Manjeet Gill, Non-Executive Director (5 of 6)
- Carol Kennedy Filer, Non-Executive Director (5 of 6)
- Hattie Llewelyn-Davies, Chair (6 of 6)
- Steve Marsden, Non-Executive Director (5 of 6)
- Ruth Sawtell, Non-Executive Director (5 of 6)
- Colin Sheppard, Non-Executive Director (6 of 6)

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 5 Governors: 3 public, 1 staff and 1 appointed. The Chair, Company Secretary and the Chief Executive are usually in attendance.

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

- Sheena Garbutt (Public Governor & Chair) (3 of 3)
- Glyn Trollope (Public Governor) (2 of 3)
- Irma Mullins (Staff Governor) (3 of 3)
- Eddie Veale (Appointed Governor) (3 of 3)
- Stuart Asher (Public Governor) (3 of 3)

Remuneration Report

The full remuneration report of salary, allowances and benefits of senior managers are included on pages 25 and 26 of the Full Statutory Accounts which form section 2 of this document.

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 the 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 June 2011.

The Public Governors elected for Hertfordshire were:

- Caroline Bowes-Lyon
- Chris Brearley
- Dick Lovelace
- Chris Fowler

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

- Jo Clack

During the year resignations were received from:

Public Governors:

- Chris Fowler
- Catherine Hislop
- Paul Mosley
- Neela Mukhpadya

Staff Governor:

- Divya Acton

Stakeholder Governors:

- Chris Hayward

The resignation received from Chris Hayward (Stakeholder Governor Hertfordshire County Council) was due to changes within his organisation and a new candidate Teresa Heritage has now been appointed to this position.

Sadly Tracey Graily (Stakeholder Governor PCT) passed away due to a tragic accident. Tracey was a very active member of the Governors' Engagement Group and supported the planning and development of the Annual Members day.

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

We thank all of the Governors for their valuable contribution to the Trust and in particular those that have served with us for two terms of appointment, their expertise and knowledge will be missed and we are hoping they will continue their involvement with the Trust through acting as mentors to new Governors.

The Board of Governors and the Board of Directors, both chaired by the Trust Chair, Hattie Llewelyn-Davies, have a good working relationship and they hold three joint meetings annually, one of which is the AGM. In addition, the Board of Directors have an open invitation to attend all of 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 have dealt with a range of issues as part of their statutory duties including the reappointment of two Non-Executive Directors, whose term of office comes to an end at the end of July 2012 and the performance appraisal of the Chair.

They have also been involved in the Trust's Annual Members Day and several Members workshops focussing on talking therapies to stay well and cope with stress and EMDASS (Early Memory Diagnosis Assessment Service).

Four Board of Governors meetings were held during the past year, each Governor's attendance is shown in the constituency table below:

Board of Governors

Financial Criteria	Metric	Attendance	Appointment
Stuart Asher	Public	4/4	01/08/10 – 31/07/13
Caroline Bowes-Lyon	Public	2/2	01/08/11 – 31/07/14
Chris Brearley	Public	2/2	01/08/11 – 31/07/14
Ida Glen Brown	Public	4/4	01/08/10 – 31/07/13
Jo Clack	Public	1/2	01/08/11 – 31/07/14
Chris Fowler	Public	1/1	01/08/11 – 11/01/12
Sheena Garbutt	Public	2/4	01/08/10 – 31/07/13
Ray Gibbins	Public	4/4	01/08/10 – 31/07/13
Jake Griffiths	Public	1/4	01/08/10 – 31/07/13
Catherine Hislop	Public	2/4	01/08/10 – 31/02/12
Fran Hook	Public	3/4	01/08/10 – 31/07/13
Carol Jeavons	Public	4/4	01/08/09 – 31/07/12
Dick Lovelace	Public	2/2	01/08/11 – 31/07/14
Paul Mosley	Public	3/3	01/08/10 – 09/01/12
Neela Mukhapadyha	Public	1/4	01/08/09 – 12/03/12
Mary Porter	Public	4/4	01/08/09 – 31/07/12
Anne-Marie Smith	Public	1/4	01/08/09 – 31/07/12
Glyn Trollope	Public	4/4	01/08/09 – 31/07/12
Hazel Ward	Public	3/4	01/08/09 – 31/07/12
Steve Wright	Public	3/4	01/08/10 – 31/07/13
Celia Young	Public	1/4	01/08/09 – 31/07/12

Divya Acton	Staff	1/3	Jan 09 – 01/11/11
Tara Gouldthorpe	Staff	3/4	15/10/09 – 31/07/12
John Lavelle	Staff	4/4	12/10/10 – 31/07/13
Janice Lepori	Staff	2/4	01/08/10 – 31/07/13
Irma Mullins	Staff	4/4	01/08/09 – 31/07/12
Julie Nicholson	Appointed	1/4	01/08/10 – 31/07/13
Cllr. Dorothy Hone	Appointed	2/4	01/08/10 – 31/07/13
Mary Pedlow	Appointed	4/4	01/08/10 – 31/07/13
David Thomson	Appointed	3/4	01/08/10 – 31/07/13
Tracey Graily	Appointed	3/4	01/08/10 – 20/02/12
Leslie Billy	Appointed	3/4	01/08/10 – 31/07/13
Erika Aldridge	Appointed	1/4	01/08/10 – 31/07/13
Peter Brown	Appointed	4/4	01/08/10 – 31/07/13
Eddie Veale	Appointed	4/4	01/08/10 – 31/07/13
Jackie Knight	Appointed	0/4	01/08/10 – 31/07/13
Chris Hayward	Appointed	1/1	01/08/10 – 16/07/11
Teresa Heritage	Appointed	0/0	16/03/12 – 31/07/13

Since the formation of the three new working groups they have continued to meet regularly to take forward work plans on behalf of the Governors, and provide a full report at each of the Board of Governors meetings.

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

Engagement:

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

Performance:

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

Quality & Effectiveness:

- Quality Accounts – the group contributed to the process of choosing priorities for the year ahead

Register of Interests:

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

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

Expenses:

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

Membership

Public membership continued to remain over 12,000, in line with our membership strategy. New members have joined as a result of attendance at workshops and the member's day.

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

Staff membership at the end of the year breaks down as follows:

• Acute and Rehabilitation Services	502
• Community Services	860
• Learning Disability and Forensic Services	741
• Specialist Services	587
• Corporate Services	310

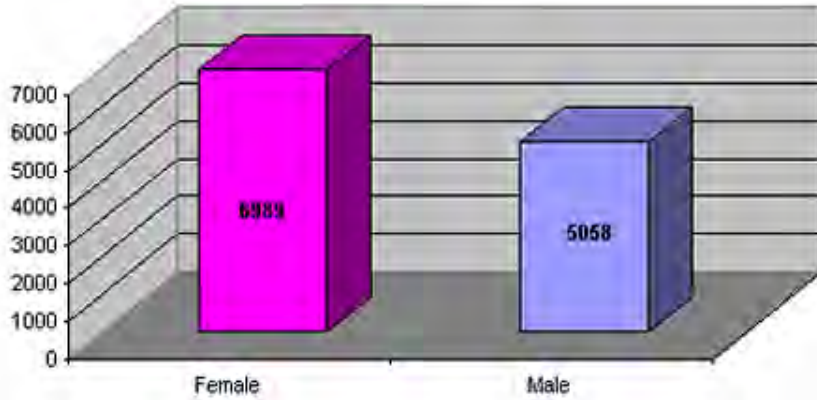
Engaging a diverse and representative membership which reflect the population and communities we serve continues to be a focus for the Trust and the Governors.

Members receive the member's magazine 'As One' three times per year, and have access to further information about the Trust and the work of the Board of Governors and Directors through the website. We are continuing with developments to highlight information of particular interest to members and enable them to take part in workshops and discussions around issues such as well being and anti-stigma campaigns.

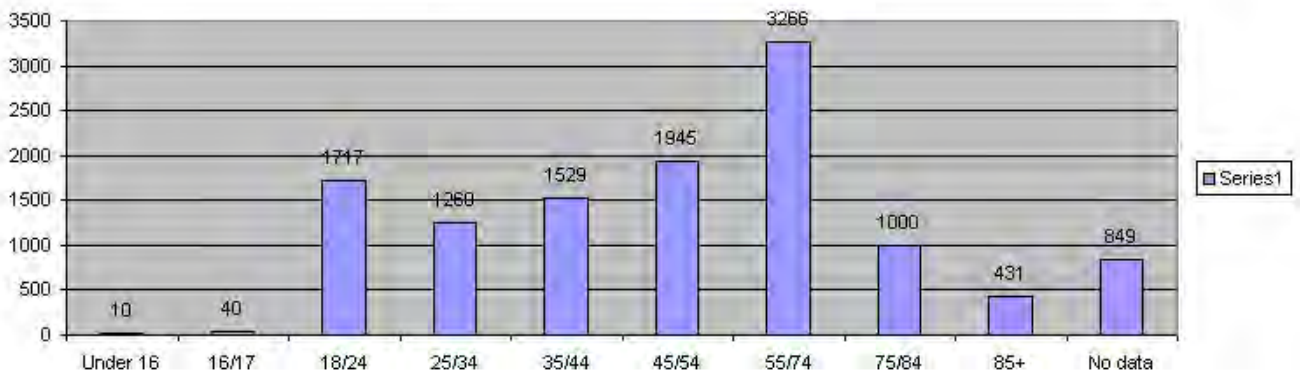
We continue to ensure that membership reflects the diversity of our communities and have worked with our Equality and Diversity lead to develop a new membership form to ensure that we make contact with hard to reach groups. We plan to remain at our standing target of 12,000 members over the coming year with a view to increase the number of members in Norfolk and North Essex by holding awareness events in these locations.

Members are encouraged through the public website and the member's magazine, to communicate with Governors via the Membership Office.

Gender



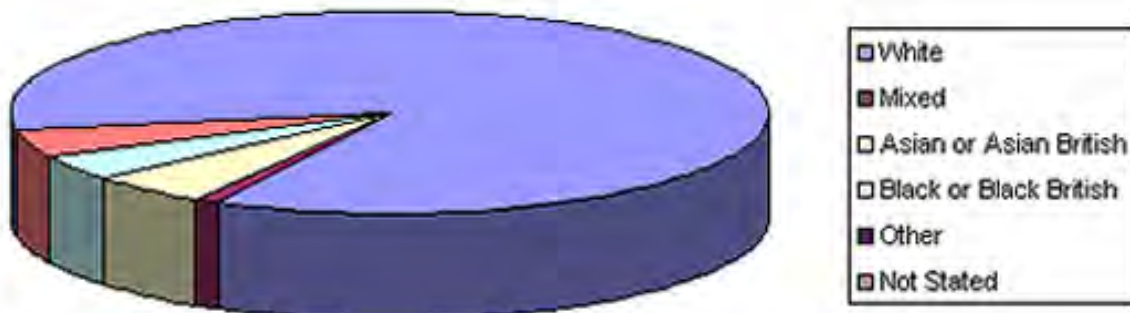
Age Group



Ethnic Group

White	10283	Black or Black British	489
Mixed	140	Other	3
Asian or Asian British	596	Not Stated	536

Ethnic Group



Public Constituency (England & Wales)	Last Year	New Year (estimated)
At Year Start (April 1)	672	680
New Members	15	20
Members Leaving	7	10
At Year End (March 31)	680	690

Public Constituency (Hertfordshire)	Last Year	New Year (estimated)
At Year Start (April 1)	11389	11367
New Members	80	120
Members Leaving	102	90
At Year End (March 31)	11367	11397

Staff Constituency	Last Year	New Year (estimated)
At Year Start (April 1)	3242	2981
New Members	241	230
Members Leaving	502	430
At Year End (March 31)	2981	2781

Quality Account

Part 1 - Statement by the Chief Executive

The Quality Account gives the Trust an excellent opportunity to describe the quality of our services over the past year to a wide audience. Through this full report - and a much shorter and simpler summary - we aim to offer a picture of how we have done that all can recognise.

In this way we can maintain our reputation for straightforward communication with all our stakeholders, and give a range of reasons why we are well placed to be the provider of choice for those who may need mental health and specialist learning disabilities services in future.

In the past year we continued to provide inpatient and community services for people with learning disabilities in Hertfordshire, Essex and Norfolk. In primary care we provided enhanced adult mental health services across Hertfordshire and began to develop them for children and young people. In secondary care we provided the full range of health and social services for adults with mental health problems. Our community drug and alcohol teams operated throughout 2011/2012 and were transferred to a private provider from 1st April 2012 after commissioners chose to put all Hertfordshire drug and alcohol services out to tender.

Our programme of service transformation (Leading by Design), which is crucial to services retaining quality at a time of ongoing disinvestment, is now being implemented. This means that last year some service users, carers and staff felt considerable uncertainty about the future of some services. The process of change has been difficult at times.

And yet the commitment to quality both within and alongside the Trust remains very much in evidence. In producing this account, many individuals and partner agencies have contributed again, arguing for particular quality priorities and putting forward new ideas for finding a better fit between what we do and what our service users require.

Within the Trust, I want to thank in particular our Performance Team, Informatics Team and Practice Governance Team for their development of better ways of measuring quality. This has meant that the staff providing services are increasingly well informed about how well they are doing. The Joint Commissioning Team, NHS Hertfordshire, the Hertfordshire Local Involvement Network and the Hertfordshire County Council Health Scrutiny Committee have continued to support our overall approach.

I would like to thank all our partners for their commitment to the highest quality standards and for all their support - as we redouble our efforts to provide the best possible care for all our service users and carers.

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 2012-2013 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 2011-2012 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 adds final comments.

Annex 1 gives the data set for performance against quality priorities in 2011-2012.

Annex 2 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
- A plain English summary will be produced and circulated widely
- 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

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

Signed:



Tom Cahill
Chief Executive
Date: 23rd May 2012

Part 2 - Priorities for Improvement in 2012-2013 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 they will be measured and reported so that where progress is not happening we can redirect our efforts.

2.1.1. Building on 2011/2012

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 2011-2012 is given in Part 3.

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

Our overall priorities for this year are Safe Services, Effective Services, The Very Best Customer Experience, Our Workforce, and Equalities.

Although the wording is different, four of these are very close to those used last year – that is, Safety, Clinical Effectiveness, Service User and Carer Experience, and Workforce. Equalities has been added as a priority area because at the consultation stage there was a strong view that minority or “protected” groups may still be receiving inferior services, and that the Trust is not always able to show what their experience is like compared to the experience of all service users and carers reported as one.

At consultation there was support for the Trust’s plan to reduce the number of quality measures, so there are 16 for 2012/2013 compared to 25 for the previous year.

The specific quality measures that are **not** carried over to this year are as follows:direction of the Trust.

Measure	Reason
7 day follow-up after inpatient care	Good performance
Rate of actual physical assaults on staff on LD (Learning Disabilities) inpatient units	Good performance
Number of falls on MHSOP (Mental Health Services for Older People) inpatient units	Good performance
Use of 'You're Welcome' standards in CAMHS (Child and Adolescent Mental Health Services) to drive up quality of clinics	Good performance – standards achieved

Rate of LD service users with HAP (Health Action Plan)	Good performance
Number of older people accessing (Improving Access to Psychological Therapies) IAPT services	Considerable progress was made (although below target each quarter)
Rate of service users finding psychological therapy helpful (working age mental health)	Good performance
Rate of service users offered advanced statements	Significant progress made. Focus will now shift to people with dementia, with progress reported to commissioners
Rate of service users who have been helped to take part fully in planning their care (national service user survey)	Good performance
Rate of service users who had enough support in getting help with any physical health need (national service user survey)	Good performance
Access to psychological therapies (working age mental health)	Good performance
Rate of service users saying they had a choice in the time and day they were seen	Good performance
Rate of service users saying they had a say in the choice of their medication	Good performance
Rate of carers saying they are sufficiently involved in discharge planning (with service user consent)	Good performance (a different carers' measure has been agreed for 2012/2013)
Rate of completion of mandatory training	Improvement made but problems exist which will remain a focus for Board

Although these measures are now excluded from the quality account list, they will still be subject to monitoring so that the Trust makes sure that progress is maintained. Performance to do with staff for example – such as rates of mandatory training, and staff sickness – will be reported regularly to Board, with the Director of Workforce and Organisational Development being held to account.

Commissioners too will ensure that the impetus is maintained with regard to areas such as the accessibility and effectiveness of IAPT (Improving Access to Psychological Therapies) in primary care. The Trust is obliged to report quarterly on progress here through the Quality Schedule that is attached to our contract.

2.1.2. Consultation

In February to March 2012 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 Health Scrutiny Committee Topic Group

The long list was taken from:

- The previous list of quality account measures
- The list of expected Commissioning for Quality and Innovation (CQUIN) measures for 2012-2013
- Measures to be used to evaluate the impact of the Trust’s service transformation programme (Leading by Design)
- The Trust’s ideas about how to measure quality improvements set out in our annual plan
- Questions in the standard service user and carer questionnaires (called Having Your Say) which are widely used
- Indicators promoted by Monitor, by the Strategic Health Authority’s Quality Observatory, and by the national NHS Indicators for Quality Improvement

Of the 46 possible indicators shown in the “long list” all but 6 received some votes. 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 the Hertfordshire Local Involvement Network (LINK) Mental Health and Learning Disabilities Sub-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 all key targets.

Key principles applied by the Board were as follows:

- The list of priorities must be consistent with those used in the annual plan 2012/2013 sections “Safe and Effective Services” and “The Very Best Customer Experience”
- The list must recognise the importance of achievement of CQUIN targets to the Trust, but should not simply repeat these targets in full
- The number of indicators should be significantly reduced from 2011/2012
- The list should adequately cover all Trust services and perspectives on quality – with recognition of social care priorities, the key relevance of workforce issues, and the equalities agenda

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 22nd March and agreed.

2.1.3. Final Priorities and Indicators

The table below shows the full list of Quality Account indicators agreed for 2012/2013, combining those that are carried over and those that are new.

The column headed "CQUIN" shows indicators which feature as Commissioning for Quality and Innovation targets set by commissioners for the coming year.

Priority area	Measure	Carried over from Quality Account 11/12	CQUIN	In Annual Plan
1. Safe Services	1.1. rate of inpatients feeling safe	yes		yes
	1.2. rate of externally reported incidents as proportion of all incidents (mandated by Monitor)	yes		yes
	1.3. rate of safeguarding adults incidents proceeding to investigation as proportion of all alerts (those under Trust care only)			yes
2. Effective Services	2.1. rate of inpatient stays with reduced (Health of the Nation Outcome Scale) HoNOS score (eg. evidence of positive clinical outcome)			yes
	2.2. rate of service users saying Trust services have helped them see a positive future for themselves	yes		yes
	2.3. rate of carers feeling valued by staff			yes
	2.4. rate of readmission within 30 days	yes		
3. The very best customer experience	3.1. rate of service users saying they would recommend Trust services to family or friends if they needed them	yes	yes	yes
	3.2. number of service users with personal budgets			
	3.3. rate of service users saying they can get advice or support when they need it (in hours and out of hours)	yes		
	3.4. rate of carers saying they can get advice or support when they need it (in hours and out of hours)			

4. Equalities	4.1. measureable improvements for service users, carers and staff across all protected groups through the Equality Delivery Scheme (EDS)			yes
	4.2. rate of service users with dementia offered advance care plans (as part of implementing NICE quality standard for people with dementia and their carers)		yes	
5. Workforce	5.1. rate of staff saying they would recommend the Trust as a place to work (mandated by Monitor)	yes		
	5.2. rate of staff saying they have a clear understanding of what is expected of them			yes
	5.3. rate of staff saying their levels of engagement and motivation have increased			yes

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 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.

Indicator 4.1.requires development of reporting systems before improvement in health outcomes for protected groups can be demonstrated.

Quarterly reports on progress will be made to the Quality and Risk Management Committee and then to Board. This will make sure that the Board continue to be closely informed about our performance as part of their quality governance duties, and they will highlight to the Executive Team where extra actions are needed to make improvements at any stage.

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.

Good News 1

In 2011 MIND published a national report "Listening to Experience" which gathered ideas from around the country on best practice in acute mental health care.

From HPFT, this featured several new initiatives including host families trained and paid to take in someone with acute mental health problems for a limited period supported by mental health staff. Also advertised were the peer support staff (people with lived experience of mental health problems trained and recruited to work for the Trust), who are helping current service users achieve their recovery goals

2.2. Statements of Assurance

2.2.1. Review of Services

During 2011/2012 the Trust provided NHS services through 154 teams in 29 locations as registered with the Care Quality Commission.

The number of teams reduced during the year down to 139, due to planned mergers of teams as part of service transformation and the transfer of Community Drug and Alcohol Teams to another provider.

The number of registered locations reduced during the year to 28 with Stamford Avenue, Royston (a unit for adults with learning disabilities) transferring as originally planned out of the Trust from 1st April 2012.

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 information available for this to be done across the whole Trust.

The income generated by the NHS services reviewed in 2011-2012 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 2011/2012, 4 sets of national clinical audits and national confidential enquiries covered NHS services that this Trust provides, as confirmed below by the Healthcare Quality Improvement Partnership (HQIP).

Name of audit		National co-ordinator	NHS area
Prescribing Observatory for Mental Health	POMH- UK	Royal College of Psychiatrists (CCQI) POMH - UK Team	Mental Health
National Audit of Psychological therapies	NAPT	Royal College of Psychiatrists (CCQI) NAPT Team	Mental Health
National Audit of Schizophrenia	NAS	Royal College of Psychiatrists (CCQI) NAS Team	Mental Health
Suicide and Homicide in Mental Health	NCISH	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Mental Health

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

Within the POMH-UK programme, we took part in all audits for which we were eligible, as confirmed below by the Prescribing Observatory for Mental Health UK.

Hertfordshire Partnership NHS Foundation Trust participation in POMH Quality Improvement Programmes (QIPs) April 2011 – March 2012

Table 1. Summary of participation by Hertfordshire Partnership NHS Foundation Trust in POMH-UK Quality Improvement Programmes April 2011 - March 2012

QIP	Date of report	Topic	Audit cycle	Number of teams	Number of patients	Trust participation in audit cycles for this topic
11a	July 2011	Prescribing antipsychotics for people with dementia	Baseline	13	361	1
6c	September 2011	Assessment of the side effects of depot antipsychotics	first supplementary audit	17	286	3
7c	January 2012	Monitoring of patients prescribed lithium	second supplementary audit	20	198	3
10b	March 2012	Use of antipsychotic medication in CAMHS	Re-audit	7	35	2

Hertfordshire Partnership NHS Foundation Trust has participated in all POMH-UK QIPs April 2011 – March 2012.

Please note:
Participation in QIPs 1f & 3f (*prescribing of high dose and combined antipsychotics*) in February 2012 will be reported in next year's summary.

The NAPT audit results showed that practice was good in many areas, but that we still struggle to provide psychological therapies that are NICE compliant for everyone with anxiety and depression who needs them. There are not enough clinical psychologists available to be able to provide these treatments in every case, especially in our services for older people with mental health problems. More non-psychologists are being trained to provide psychological treatments, but there are many other pressures on their time. This shortfall has been raised with commissioners.

The results of the National Audit of Schizophrenia were received in April 2012. The Trust level report states that we performed in the middle range on most of the key standards. We were delighted to be in the top 10% in relation to monitoring physical health and weight, but disappointed that we were below average for service users' experience of their care.

The POMH-UK audits have had a high profile this year. In view of the national concerns over the excessive prescribing of anti-psychotic drugs in the management of people with dementia, we were encouraged to see that our rate for such prescribing was 11% compared to a national average of 16%. However we recognise that improvements in practice can still be made and all old age psychiatrists are re-considering how they prescribe ahead of the re-audit later in 2012. We also continue to work closely with other agencies to address the wider factors around this important issue – such as the levels of staffing in care homes.

The POMH-UK audit on prescribing of anti-psychotic drugs for children and adolescents has also had a significant impact. We were encouraged to note that our performance was 100% in several areas – such as the reasons for the prescription being clearly recorded, and all pretreatment physical health checks being completed in every case.

The NCISH annual report to the Trust shows that overall, 14% of Hertfordshire suicides were by people (either currently or within 12 months) under this Trust's care. This compares favourably with the national figure of 26%. As the county figure has also reduced we know that our numbers are reducing in the context of a positive general pattern in Hertfordshire. However, it is also noteworthy that a higher proportion of our suicides than we would expect are by females. Frontline staff have been made aware of this trend and reflect on the possible reasons in practice governance meetings so that practice is as gender-sensitive as possible.

The reports of 92 practice audits were reviewed in the year. Each audit report has an action plan whose implementation is monitored by the audit team. Audit reports are increasingly used to drive up quality. Examples –large and small - include:

- A range of audits of practice in use of the Mental Health Act, with topics derived from the feedback from the MHA Commission (part of the Care Quality Commission)
- Audit of the new ways of supporting people with acute mental health problems in St Albans where inpatient admissions are used as rarely as possible, showing very positive results
- A range of audits of staff recording and management of records, which have also raised clinical issues (such as variable practice in clinical risk assessment and management in North Essex community teams for people with learning disabilities, now being addressed)
- Audits of the impact of the Trust's new approach to people when they are first referred, known as the Single Point of Access, highlighting how efficiencies are being made but also raising questions at the early stage of implementation about assessments (which can be addressed before the new procedures are "set in stone")
- Exploration of the provision of physical health examinations of all patients on admission to inpatient units, with previously uneven practice on units for people with learning disabilities now improved to 100%
- Examination of practice in a Crisis Assessment and Treatment Team in terms of safe prescribing (medicines reconciliation) with excellent results
- A survey of GPs' views of the Community Drug and Alcohol Teams, finding ways one team can learn from another's results county-wide in order to raise standards to a shared high level
- Audit of staff knowledge and confidence with regard to the use of the Mental Capacity Act leading to actions to make training more accessible
- A patient satisfaction survey at the Broadlands Clinic, Norfolk, with good results and clear plans for further improvement

National accreditations increasingly play a part in enabling us to improve clinical effectiveness.

As at April 2012 these units are accredited via the Royal College of Psychiatrists or other national quality networks:

- Prospect House and Edenbrook (MHSOP Inpatient Units)
- Eric Shepherd Unit and Broadlands Clinic (medium secure inpatient care (LD))
- Thumbswood (peri-natal mental health inpatient unit)
- Forest House (CAMHS inpatient unit)

2.2.3. Research

During the year 514 Trust service users were enrolled in research studies. This represents an increase on the previous two years and includes 139 participants in studies that fall within the National Institute of Health Research (NIHR) mental health research portfolio.

We were successful in attracting NIHR funding via the Research for Patient Benefit (RfPB) and Flexibility and Sustainability (FS) schemes. We have previously completed several such studies, including a trial of a recovery-focussed one-to-one personal coaching programme for people with schizophrenia, (the Whole Life approach). We are now embarking on a follow-up study of the same programme for people with personality disorder.

In collaboration with the University of Hertfordshire, we have recently been awarded further funding to work on a systematic review of strategies for managing behavioural and psychological symptoms in people with dementia. This will inform the county-wide approach to implementing the national dementia strategy including reducing, where clinically appropriate, the prescribing of anti-psychotic medication as a way of managing the behavioural symptoms.

Key findings from our research are shared with operational teams – such as the evidence on the use of the Whole Life approach with people with schizophrenia being shared with our team that develops recovery care pathways.

More applications for funding are now at submission stage. These include:

- Pharmacological and psychological interventions in obsessive-compulsive disorder
- Psychological interventions in the treatment of substance misuse in people with intellectual disabilities

2.2.4. Commissioning for Quality and Innovation (CQUIN)

A proportion of the Trust's income (1.9%) in 2011-2012 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.

For 2011-2012 – against very challenging targets – the Trust was successful in gaining the majority of available funding. The final figure is awaited.

The CQUIN over-arching goals (which were each broken down into several measures) for 2011/2012 are shown below:

- Improved access for service users
- Increased choice for service users
- To achieve the necessary service transformation to provide greater efficiency and improved quality of service
- Improving Mental Health Services for Older People
- Improved quality of Mental Health Services for Children and Adolescents
- Improving the health and wellbeing of service users and carers

The goals for 2012/2013 are:

- Improving the health and well-being of service users and carers
- Improving the quality of mental health services for children and young people
- NHS safety thermometer (the physical health of inpatients)
- Net Promoter (asking service users and carers whether they would recommend Trust services to family or friends if they needed them)

2.2.5. Statements from the Care Quality Commission (CQC)

Trust services remain fully registered with the Care Quality Commission with no conditions.

During the year six inpatient services were reviewed by CQC as part of their routine inspections. The draft reports from the visits cited one major concern and two moderate concerns at Kingsley Green units for adults with learning disabilities near Radlett and one minor concern at Shrodells (acute mental health unit), Watford. Actions to address these compliance issues were taken immediately. A review of the initial findings was undertaken by the CQC, who confirmed that the services were fully compliant with all essential standards of quality and safety at the time the final compliance report was published.

We have been very conscious of the national focus on the quality of care for adults with learning disabilities in 2011 following the Panorama programme in May 2011. As part of the CQC's National Learning Disability Review of hospitals and care homes, one Trust unit was inspected – the Broadlands Clinic in Norfolk (medium secure unit). The CQC judged that it was fully compliant with the standards assessed, which related to Care and Welfare, and Safeguarding.

We have closely monitored the national findings from the 150 visits in general, extracting the themes and continuing to check the quality of our units against these wider areas of concern.

We have also valued the monthly quality and risk profiles provided to us by CQC. These reports are promptly reviewed and each Registration Lead is advised of any red risks. Action plans to address the risks are required and all risks are reported to the Quality and Risk Management Group and the relevant sub groups. The Executive Director of Quality and Safety and the Quality and Standards Manager meet on a quarterly basis with the CQC assessors for the region and the County to discuss and identify any potential risk and update the QRP.

There was one red risk in October and November only. This referred to Outcome 14 Support to Staff. Since then staff have had more training in equalities, and steps have been taken to reduce the incidence of physical assaults on inpatient units with a focus on units for people with learning disabilities (this had been a chosen priority area for the year). There are no red risks at the end of the year.

2.2.6. Data Quality

It is recognised that if quality accounts are to have equivalent status to financial accounts continued 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 2011 leading to some recommendations and actions. In April to May 2012 we are undergoing internal audit to check the accuracy of our data. This complements the mandatory external audit of data quality that is now taking place, which scrutinises in detail a different set of quality indicators.

In the past year the Trust has taken the following actions to improve data quality:

- Extension of contracts of data quality officers working with teams to ensure accurate inputting of data onto the electronic patient record, reporting to the Performance Team manager
- Creation of a new Data Quality Steering Group which leads on all aspects of improving data quality and which reports to the Information Governance committee
- Transfer of data inputting from manual to automatic methods where possible (for example with regard to Having Your Say responses , which since April 2012 have been automatically entered analysed and reported using the Meridian system)
- Greater use of spot checks of data inputting processes by managers such as the Complaints and Customer Experience Manager
- Introduction of 100% electronic reporting of incidents using the datix system.

Despite these greater safeguards, some data inaccuracies have been identified during the year. These may relate to time lags, where a different quarterly figure for a quality indicator may be given depending on the date the data is extracted, with returns from teams occurring sometimes after the end of the quarter. Where such errors have occurred they have been declared in the next Board report. No such errors are repeated in this report.

2.2.7. NHS Number and General Medical Practice Code Validity

This year the NHS number completion rate has been at 99.8% for outpatients and 100% for inpatients.

General Medical Practice Code validity has been 100% for both outpatients and inpatients.

2.2.8. Information Governance Toolkit

We made a declaration on 31st March 2012 that we met level 2 in all areas of the Information Governance toolkit. This contains a comprehensive set of standards that enable Trusts to show that they are managing information legally and sensitively and that all staff understand their duties in this area. Our overall score on the Information Governance Assessment Report was 75% and we were graded as Green.

Our declaration was based in part on the results of three audits – independently conducted examining our practice in 29 of the 45 requirements at level 2.

This represents a considerable improvement on our position in March 2011 when we received a grading of Red. This was linked especially to low levels of training of all staff in information governance and weaknesses in our approach to clinical coding, which have now been rectified.

2.2.9. Clinical Coding Error Rate

To improve clinical coding we invested this year in an accredited coder supported by two staff who are undergoing training in coding. This has been very important as accurate diagnosis using the approved coding system is key both to the best clinical treatment and also to enable us to describe confidently the patterns of use of services. Our performance has been audited during the year by an external consultancy.

They found:

	Correct (%) (audit 2009)	Correct (%) (audit Nov 2011)
Primary Diagnosis	42.0	92.0
Secondary Diagnosis	13.4	84.3

They congratulated us for the improvement in coding over the time period.

Like all Mental Health NHS Trusts, we are not yet subject to receiving our income via Payment by Results (PbR). As we prepare for PbR, we have used the Mental Health Clustering tool as the method of assigning costs to services. Clinical coding on its own is not used to decide costs.

Good News 2

In January 2012 the Department of Health visited the CAMHS Welwyn Garden City clinic to hear how the roll out of Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) was getting on in Hertfordshire and to share thoughts on what makes an excellent CAMH Service.

The day was a huge success and feedback from Kathryn Pugh from the DoH was extremely positive:

"I really appreciated the opportunity to talk to the whole team - managers, IAPT trainees and other staff members to hear about the impact the project is making, the challenges and how you are overcoming the difficulties that are associated with being a trail blazer. I was particularly struck by the level of change within the whole CAMHS and mental health system and by the enthusiastic and positive team philosophy that standing still was not an option. As I said at the meeting, you are already streets ahead of many teams, including IAPT sites, because you are a team that is accustomed to developing new ways of working "

Part 3 Review of Quality Performance

3.1. Introduction

This section describes our performance against the priorities agreed at the start of 2011/2012. But as well as the hard numbers, wider information is also included – about significant developments, events during the year and also service user comments. We believe 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 this.

3.2. Selection of Priorities

In early 2011 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 2011.

Staff, Governors, service users, carers, commissioners, Hertfordshire County Council and Hertfordshire LINK all fed in their views and there was strong support for the four overall priorities below.

These, each with a set of indicators, were:

Service User and Carer Experience

This set of indicators covers a range of perspectives, with an emphasis on choice and access for service users, and a focus on recovery.

Safety

This focuses on aspects of inpatient care, with a combination of measures based on incident reporting and the service user experience.

Clinical Effectiveness

This set of indicators covers several major care groups – people with learning disabilities, people using primary care mental health services and children and adolescents – in turn, using different approaches to measuring clinical effectiveness.

Workforce

Three indicators are used to show progress on three essential ingredients of an effective workforce.

3.3. How Did We Do?

Note 1: please see annex 1 for detailed data set. All the figures shown together in the table in annex 1 are presented separately below in charts with some explanatory text for each.

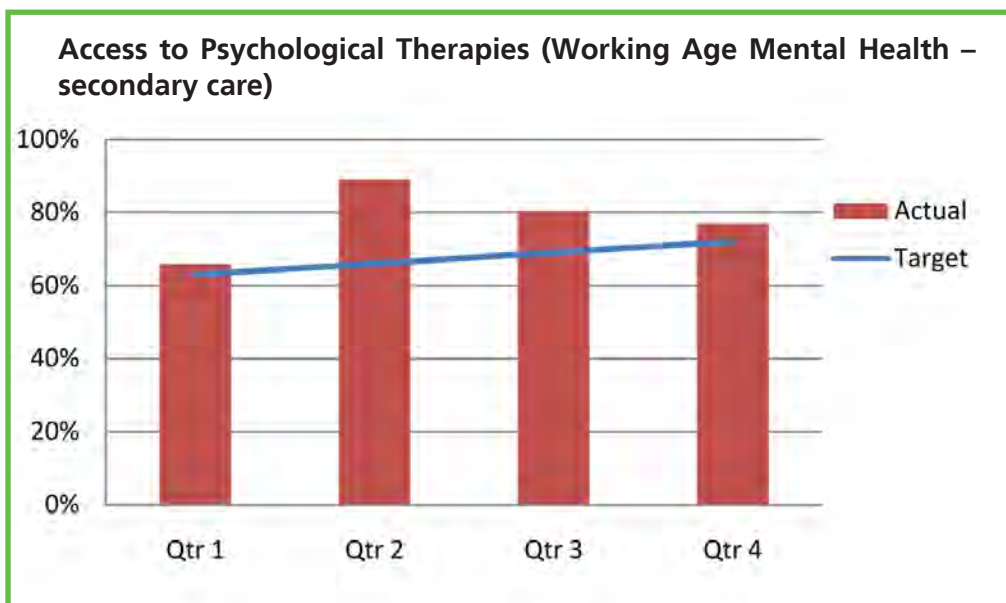
3.3.1. Service User and Carer Experience Access to Psychological Therapies (Working Age Mental Health – secondary care)

Definition: Rate of service users who said they had received psychological therapies within a reasonable time as a proportion of all those responding. It should be noted that this measure does not apply to our primary care mental health services.

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:



Target achieved. We have trained more staff in psychological therapies especially Cognitive Behavioural Therapy (CBT) and speeded up the process by which new referrals are responded to.

Other comments: In the previous year, performance was at 58.7% after quarter 1 and 64.8% after quarter 4. This year's results therefore show consistent improvement on last year's.

We know from our service users that there is room for further improvement, and also that we face different pressures around access to psychological therapies in primary care.

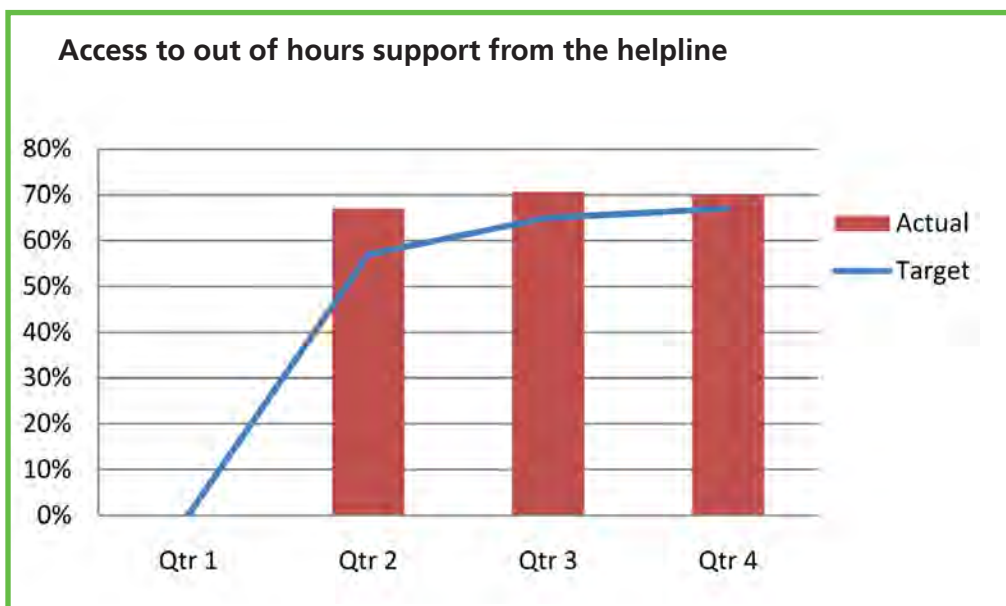
3.3.2 Access to out of hours support from the helpline

Definition: Rate of service users who said they could get help when they needed it out of hours as a proportion of all those responding.

Data source: Having Your Say.

Rationale: The Trust’s mental health out of hours helpline was known to be unable at times to deal with the demand for advice and support that exists. This was a concern to commissioners and also an area for improvement in the national service user survey.

Progress:



Target achieved. We have worked hard to improve awareness of the out of hours helpline both amongst all staff and also for service users and carers. It has become a key feature of contingency and crisis plans for mental health service users.

Other Comments: In 2012 we involved people who had used services to ask callers to the helpline how the experience had been. The “peer listeners” then helped us decide how the service could be improved in response to the feedback. We recognise that there is more to be done and provision of out of hours support including the helpline via our new Single Point of Access service will be key to this in 2012.

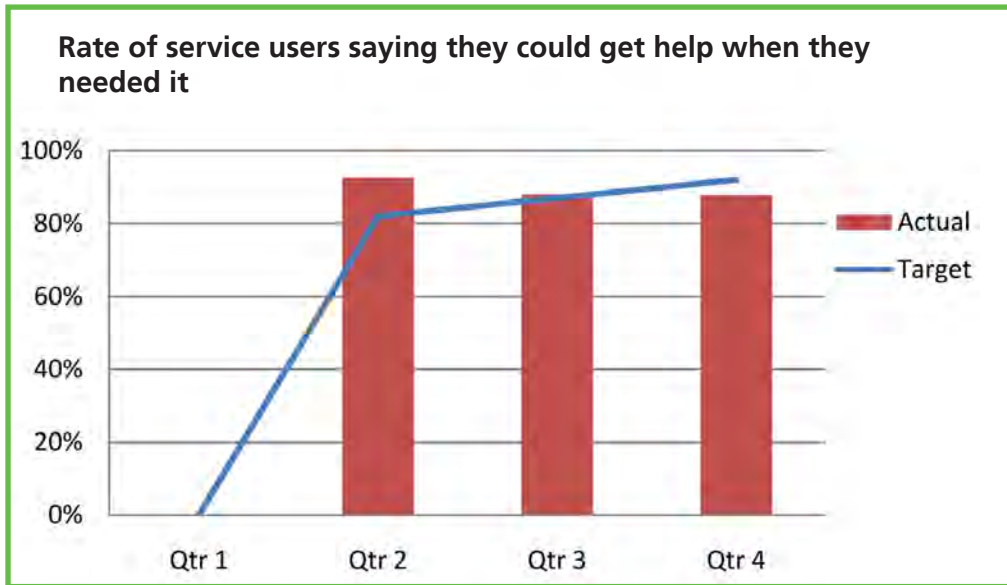
3.3.3 Rate of service users saying they could get help when they needed it

Definition: Rate of service users who said they could get help when they needed it in normal working hours as a proportion of all those responding.

Data source: Having Your Say.

Rationale: The importance of good access to Trust services had been stressed by service users, carers and GPs. Although Leading by Design has improved access as one of its principal aims, we wanted to see how much it could be improved straightaway before the service transformation was complete.

Progress:



Target partially achieved. Although in quarter 4 we dipped below the target, performance was consistently good through the year, with the 87% satisfaction rate in quarter 4 being the lowest figure. We have strict targets to reduce waiting times which are pursued vigorously through the year by operational managers, with good effect.

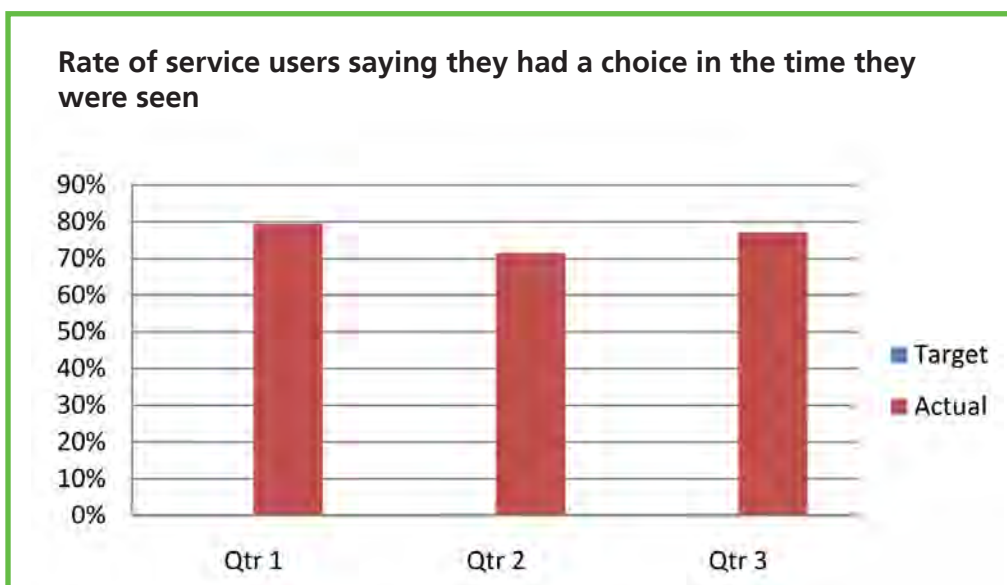
3.3.4 Rate of service users saying they had a choice in the time they were seen

Definition: Rate of service users who said they had a choice of time when they were seen for an appointment as a proportion of all those responding.

Data source: Having Your Say.

Rationale: All our stakeholders including commissioners agree that patient choice is key to a good service. It also enables us to reduce our "Did Not Attend" rates in Outpatients Clinics and run our services much more efficiently if they are convenient to use.

Progress:



Achievement of target to be confirmed. (This is because this is also a CQUIN target where achievement is still to be confirmed by commissioners).

The satisfaction rate has remained above 70% through the year. This indicates that service users have a reasonable level of choice in when they are seen, with room for improvement. We have made our administration of outpatients appointments more consistent during the year, with greater use of text messaging to remind service users of appointments, and a continued emphasis on patient choice.

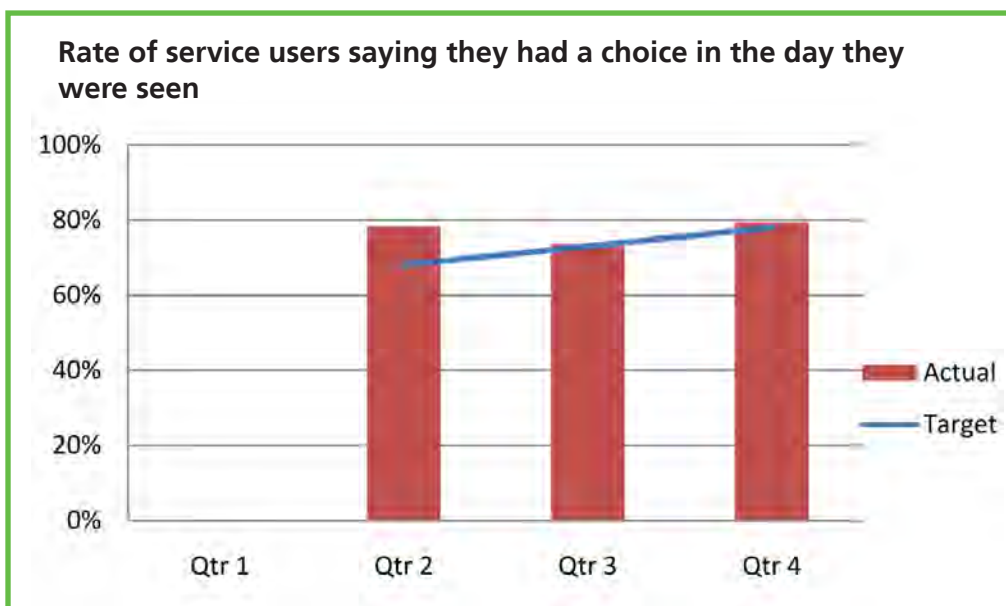
3.3.5 Rate of service users saying they had a choice in the day they were seen

Definition: Rate of service users who said they had a choice of day when they were seen for an appointment as a proportion of all those responding.

Data source: Having Your Say.

Rationale: All our stakeholders including commissioners agree that patient choice is key to a good service. It also enables us to reduce our "Did Not Attend" rates in Outpatients Clinics and run our services much more efficiently if they are convenient to use.

Progress:



Target achieved. This complements 1.4. above, but with this indicator we were free to set our own target which we are pleased to have achieved through the continued efforts of our administrative staff working closely with clinicians.

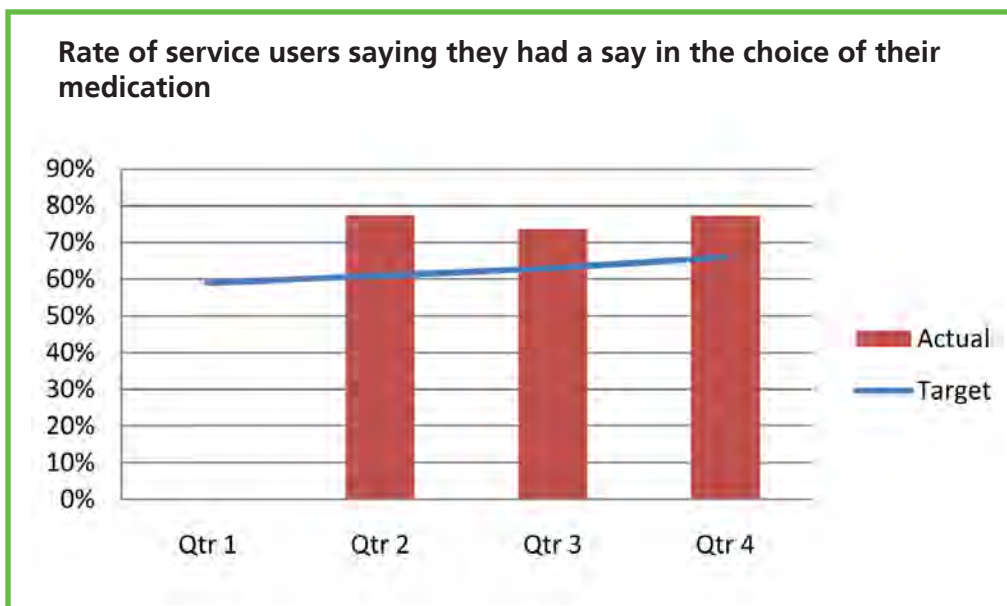
3.3.6 Rate of service users saying they had a say in the choice of their medication

Definition: Rate of service users who said they had a say in the choice of their medication as a proportion of all those responding.

Data source: Having Your Say.

Rationale: This was one of our weaker areas in the 2011 National Service User Survey. It is a key aspect of patient choice, and a powerful indicator of whether our psychiatrists and nurses are managing to work in a collaborative way with service users.

Progress:



Target achieved. Through training and better availability of patient information on wards and clinics, delivered in most cases by our pharmacy team, we have consistently hit our quarterly targets.

Other Comments: In the 2011 national survey we were in the bottom 20% for Mental health Trusts on this question. That is why we made it a priority in 2011/2012. The improvements we have made give us confidence that we will achieve our aim of being in the top 20% when the 2012 results are published this summer.

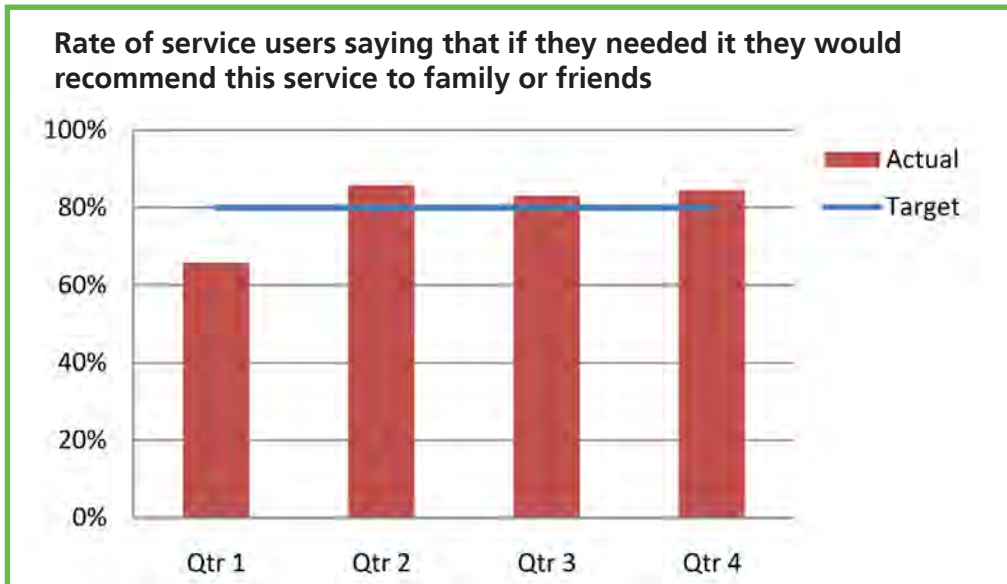
3.3.7 Rate of service users saying that if they needed it they would recommend this service to family or friends

Definition: Rate of service users who said that if they needed it they would recommend this service to family or friends as a proportion of all those responding.

Data source: Having Your Say.

Rationale: We introduced this question this year as it was beginning to be widely recommended for use in the NHS as a measure of the quality of a service. We chose the wording carefully to avoid ambiguity. There is some evidence from research that if this measure is combined with the same measure for staff (as we have), then positive results on both together offer Trust Boards and stakeholders strong assurance about quality.

Progress:



Target achieved. This significantly improved after quarter 1, with quarterly targets thereafter being clearly achieved. We have trained more staff – for example those on acute inpatient units – in customer care and establishing positive therapeutic relationships. We believe this very good performance is evidence of the training and the continued promotion of these essential values to staff beginning to bear fruit.

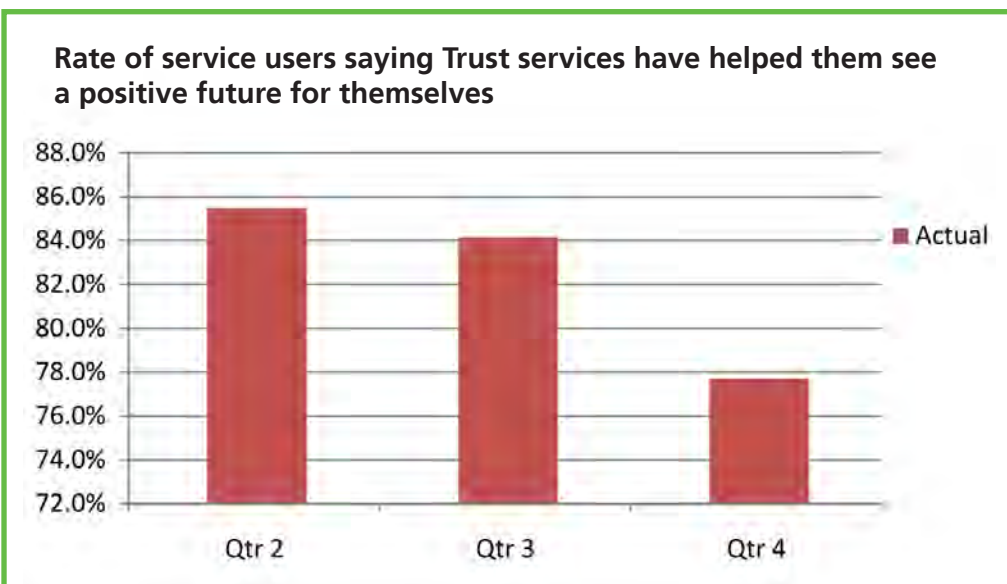
3.3.8 Rate of service users saying Trust services have helped them see a positive future for themselves

Definition: Rate of service users who said that Trust services have helped them see a positive future for themselves as a proportion of all those responding.

Data Source: Having Your Say.

Rationale: We are committed to being recovery-oriented in our practice and wanted a question that measured to what extent we were experienced in this way. After consultation the question above was adopted. It is open to interpretation, but we felt this was acceptable as each service user may want to define “a positive future” in their own way.

Progress:



Achievement of target to be confirmed. (This is because this is also a CQUIN target where achievement is still to be notified by commissioners).

Performance has varied between 78% and 85% satisfaction, which has been consistently good. Our Head of Recovery has continued to go out to individual teams to help them find ways of embedding recovery principles in their practice and the positive effects of this can be seen.

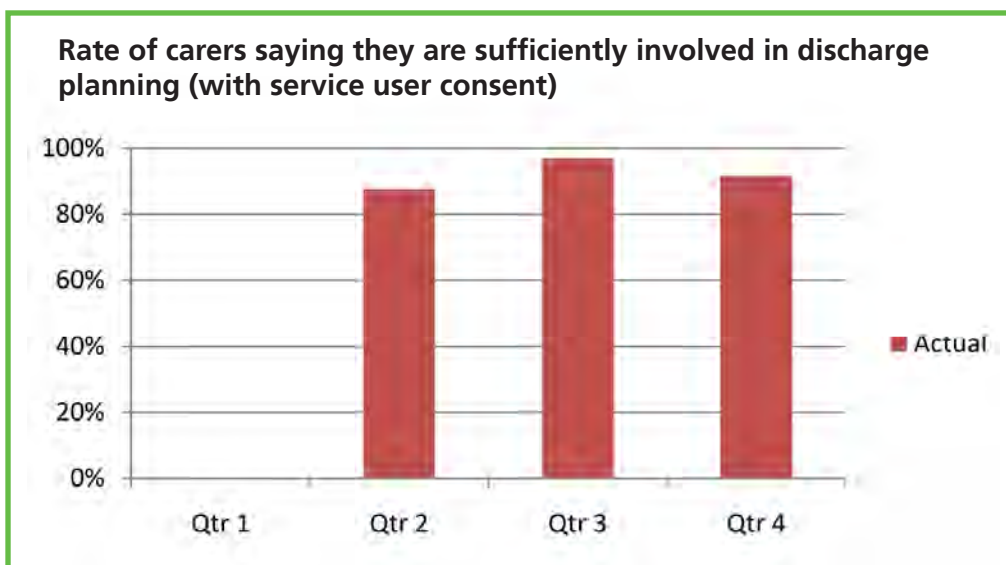
3.3.9 Rate of carers saying they are sufficiently involved in discharge planning (with service user consent)

Definition: Rate of carers who said they are sufficiently involved in discharge planning (with service user consent) as a proportion of all those responding.

Data source: Having Your Say (carers' version).

Rationale: Carers and carer representatives were asked what their priority was for the year and chose this. Planning discharge from inpatient care is a key area of practice, where carer involvement (with service user consent) can be invaluable.

Progress:



Achievement of target to be confirmed. (This is because this is also a CQUIN target where achievement is still to be notified by commissioners).

Performance has been consistently good, varying between 87% and 92% satisfaction. Transfer of service users from hospital to community services is an important and sometimes stressful process, and it is very encouraging that staff have recognised the importance of organising this in an inclusive way. This has been a focus of the practice guidance and training provided to staff on working well with carers.

3.4. Safety

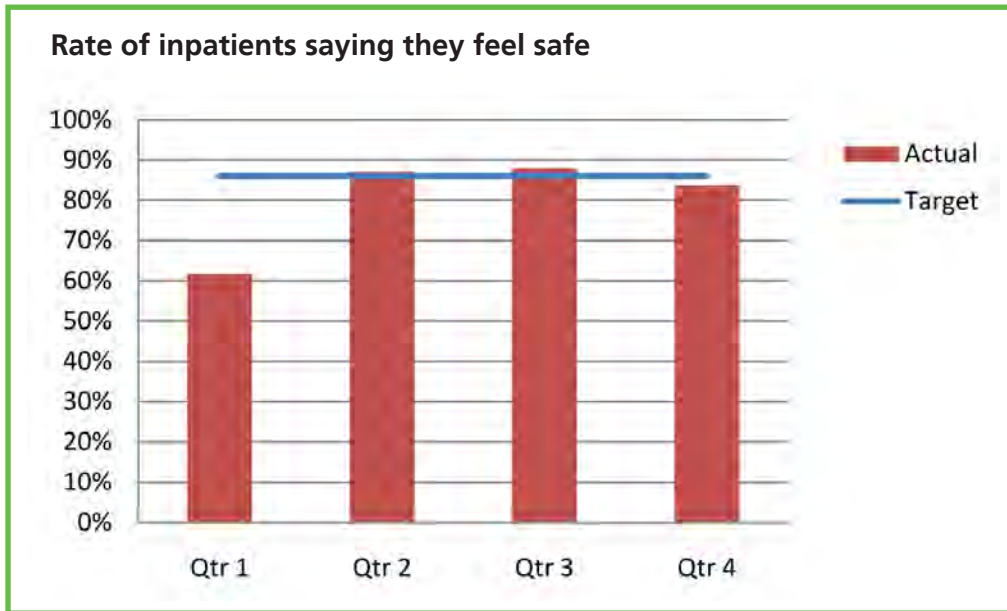
3.4.1 Rate of inpatients saying they feel safe

Definition: Rate of service users who say they feel safe as an inpatient as a proportion of all those responding.

Data source: Having Your Say (inpatient version).

Rationale: This indicator 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. It is reasonable to expect that when someone is admitted to a mental health or learning disabilities inpatient unit they will find it to be calm safe and therapeutic. It is well documented that this has not always been the case. Thus it is crucial that we continue to assess how safe inpatients feel and take actions for improvement wherever necessary.

Progress:



Target partially achieved. Performance dipped below target in quarter 4 having been very good in the two previous quarters. This year we have focussed on improving the first impressions of admission especially for those not previously admitted, and we are encouraged by satisfaction levels of 87%, 88% and 84% in the last three quarters. Our older people’s units have fared slightly less well, which reinforces the need for those with severe dementias to receive care in settings separated from those with other mental health problems of whatever age. This is the Trust’s plan which has not yet been fully implemented.

Other Comments: To support this measure, two others have been used through the year to give added assurance about inpatient safety. These have been about whether service users report sharing a room or bay during their current inpatient stay with someone from the opposite sex, and whether the Trust has formally reported to the Primary Care Trust (PCT) any clinically unjustified breaches of the Eliminating Mixed Sex Accommodation rules (EMSA).

There have been no such breaches in the year.

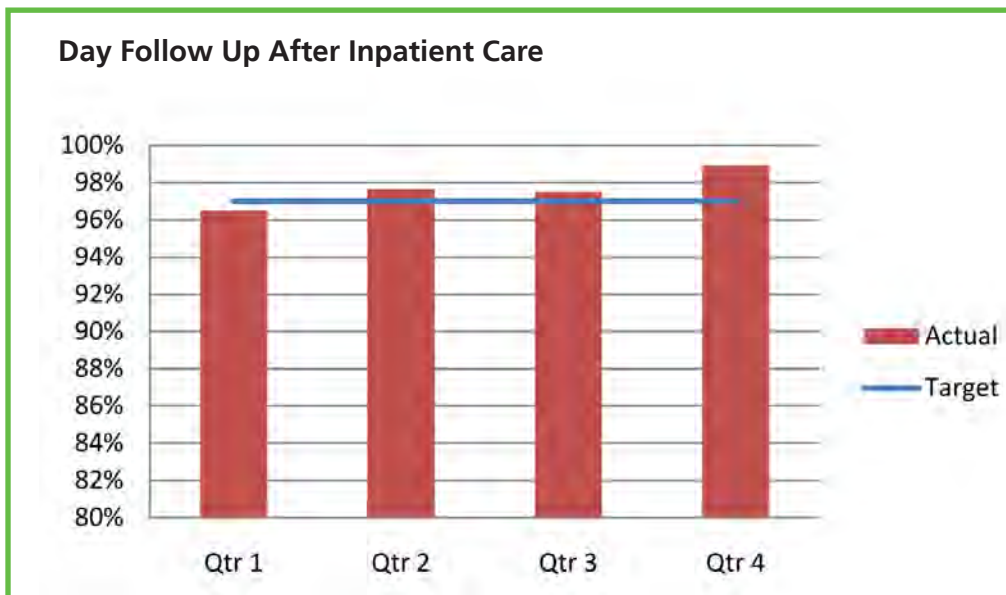
3.4.2 Day Follow Up After Inpatient Care.

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:



Figures shown are %s. eg. 0.8= 80%

Target achieved. The importance of this aspect of care is well understood by inpatient and community staff, including Crisis Assessment and Treatment Teams (CATTs). Recording is also fully accurate, with the central performance unit promptly highlighting issues that may arise with teams.

Other Comments: This indicator has been reported consistently for several years. In 2010/2011 performance was at 96.3% for quarter 1 and 97.9% for quarter 4.

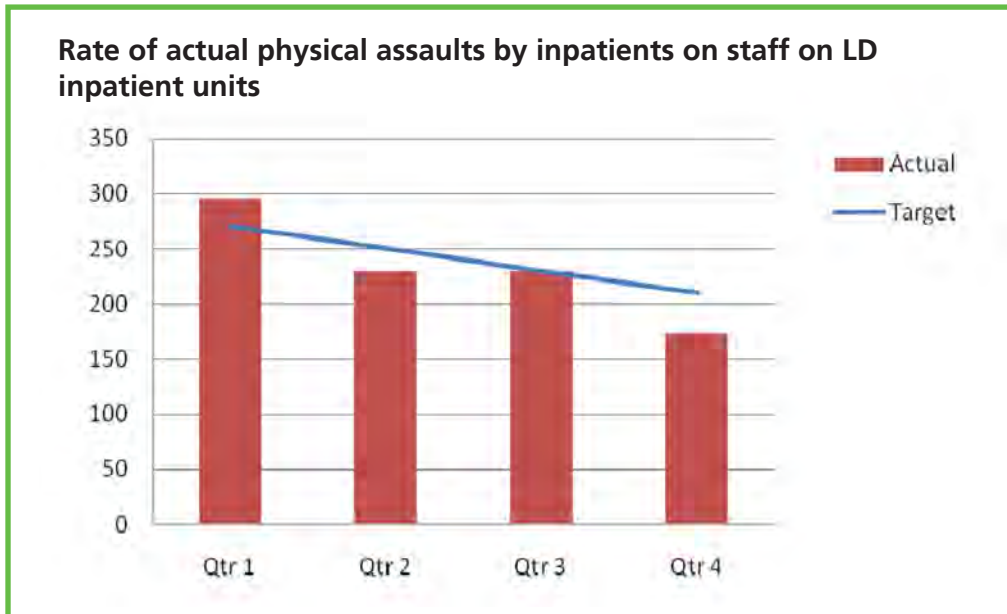
3.5 Rate of actual physical assaults by inpatients on staff on LD inpatient units

Definition: The number of reported incidents of actual physical assaults on staff by patients on inpatient units for people with learning disabilities. The aim is to reduce the numbers of incidents.

Data source: The incident reporting system (datix).

Rationale: Last year we aimed to reduce these types of incident and failed to do so. So this was carried over as a priority for this year. We provide inpatient care for adults with learning disabilities in Norfolk, North Essex and Hertfordshire and are determined that these units should be as calm and safe as possible, despite the very challenging behaviour that we manage. This has also been a specific CQUIN target for Hertfordshire patients.

Progress:



Target achieved. Numbers of such incidents have been consistently reduced during the year, with the training in the prevention and management of violence and aggression having been revised, and close attention paid to this area by senior nurses. It should be acknowledged that the number of such beds has reduced during the year which may have helped us reduce the number of incidents.

Other Comments: The number of these incidents in the second half of 2011/2012 was 367 compared to 699 in the same period in the previous year.

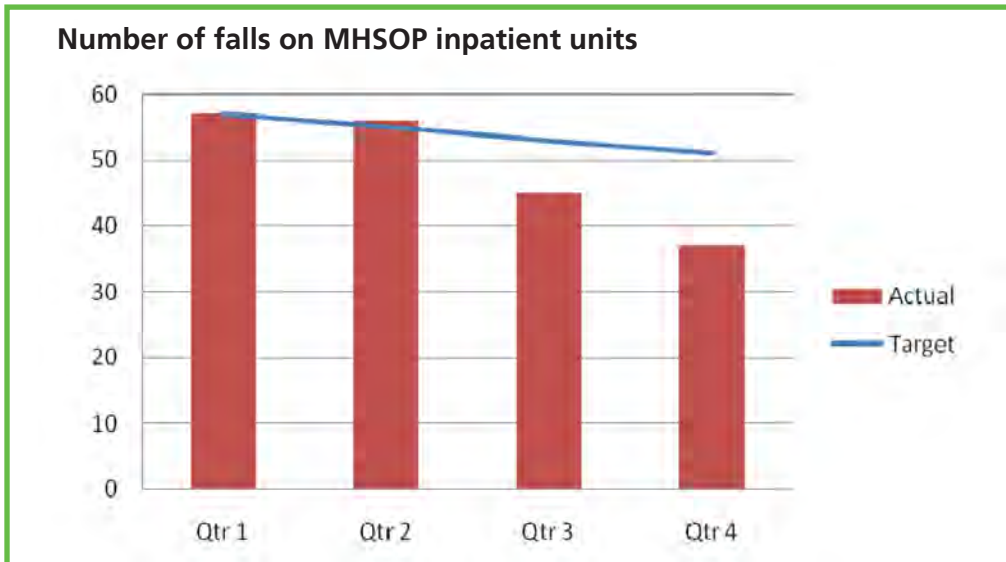
3.6 Rate of falls on MHSOP inpatient units

Definition: The number of reported incidents of actual falls on older people’s inpatient units. The aim is to reduce the numbers of incidents.

Data source: The incident reporting system (datix).

Rationale: It is crucially important in the NHS that frail elderly inpatients whether with or without dementia are safely cared for, so that they are effectively treated in every case and so that unnecessarily prolonged inpatient stays are avoided. Falls prevention is a key aspect of this. We felt we had robust levels of reporting of such incidents so that this year it was timely to aim to reduce them significantly, through adopting best practice in falls prevention implemented by the lead nurse.

Progress:



Target achieved. The numbers of such incidents has steadily reduced through the year.

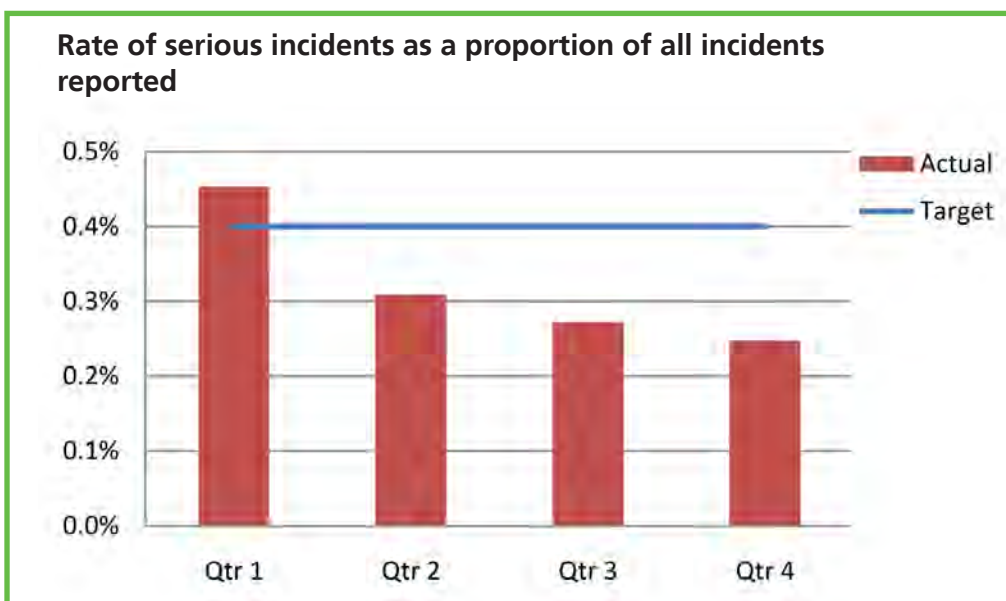
3.7 Rate of serious incidents as a proportion of all incidents reported

Definition: The number of serious incidents reported each quarter as a proportion of the total number of incidents reported. The aim is to reduce the proportion of serious incidents.

Data source: The incident reporting system (datix).

Rationale: As a Trust we expect some incidents to occur and we want them to be fully reported so that we can learn from them and monitor trends. But we also want to reduce incidents where possible, especially major incidents such as suicides. This indicator therefore measures whether we are continuing to report incidents thoroughly and at the same time reducing the numbers of major ones.

Progress:



Target achieved. There is a pattern of consistently improved performance here. Several factors may have contributed to this, including a continued focus on the role of the CATT staff in managing clinical risks including suicide risk, with training, supervision and support.

3.8 Clinical Effectiveness

3.8.1. Rate of readmission within 30 days

Definition: The rate of service users readmitted to an inpatient unit (provided by the Trust) within 30 days of being discharged from inpatient care. The aim is to reduce the rate.

Data source: The electronic patient record.

Rationale: This a familiar performance indicator for Mental Health Trusts, used to show the effectiveness of discharge planning and the levels of community support available.

Progress:



Target not achieved. Targets were achieved in two of the four quarters, but the overall trend was not downwards as it should be. There are still issues with people with personality disorders or drug and/or alcohol problems having brief repeat admissions without necessarily benefitting clinically. In the final quarter when community drug and alcohol services were transferring from the Trust to a new private provider it is likely there was more cautious management of some of these services users when they were considered for inpatient admission.

3.8.2. Use of 'You're Welcome' standards in CAMHS to drive up quality of clinics

Definition: "You're Welcome" is a set of national standards that can be used to make sure that children and young people are able to access services as easily and confidently as possible. As a CQUIN target it was agreed with commissioners that all Child and Adolescent Mental Health (CAMHS) clinics would seek external validation that they had met the majority of the standards.

This is not a numerical measure so there is no chart.

Data source: Reports provided to the approval panel and to commissioners.

Rationale: CAMHS services need to be as welcoming and engaging as possible if they are to provide a good service to all those who need them.

Progress: Target achieved. There were some delays in getting approvals from the external panel for all CAMHS clinics which were beyond our control. Commissioners have confirmed that they are satisfied we have achieved all that was required.

3.8.3 Rate of LD service users with HAP (Health Action Plans)

Definition: Evidence of completion of HAPS found by commissioners following spot checks during visits to inpatient units in Hertfordshire for people with learning disabilities.

This is not a numerical measure so there is no chart.

Data source: Report from commissioner.

Rationale: Adults with learning disabilities are at greater risk of physical ill-health (such as diabetes). They can also receive poor health care. The written health action plans make sure that all their health needs are known and communicated, with full involvement of the service user in the process.

Progress: Target achieved.

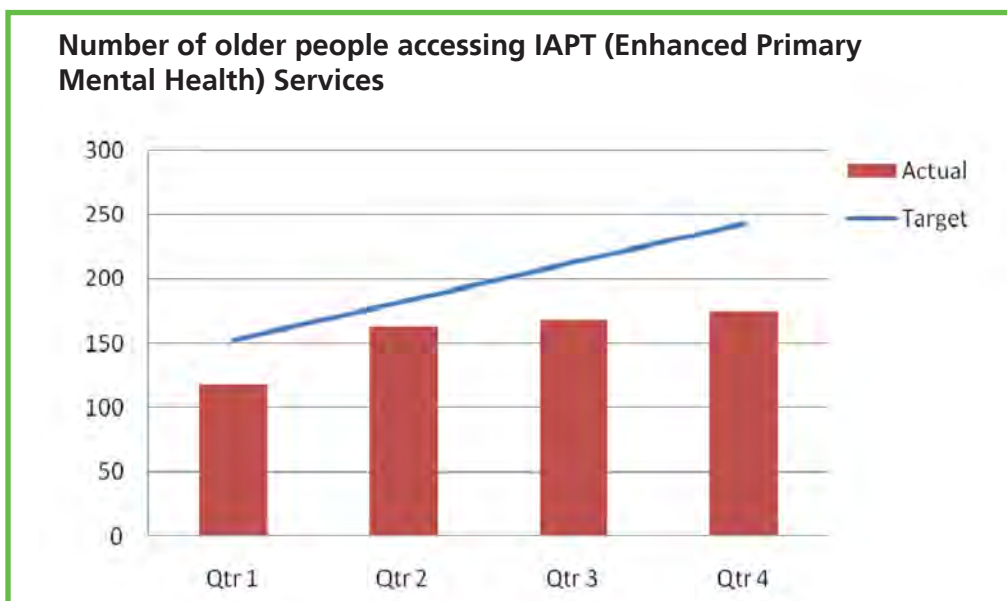
3.8.4 Number of older people accessing IAPT (Enhanced Primary Mental Health) Services

Definition: The number of people 65 and over accessing the Hertfordshire Enhanced Primary Mental Health Services provided by the Trust.

Data source: The electronic patient record.

Rationale: It is important that older people do not suffer from the view that they are less able to use psychological therapies to help them with mental health problems such as anxiety and mild to moderate depression. The Equalities Delivery Scheme demands that services are not provided in a discriminatory manner.

Progress:



Target not achieved. Considerable efforts were made to make the necessary level of progress set by commissioners. There was steady progress but not enough to achieve the target (which was one of many for the EPMHS). Now that the service is better known to older people we would expect them to continue to use it in greater numbers in 2012/2013.

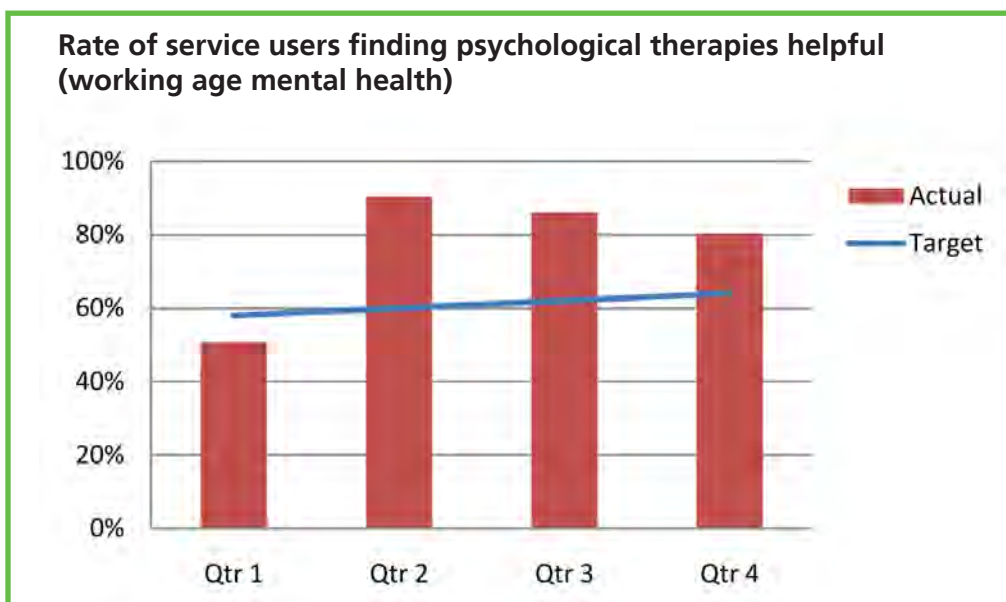
3.8.5 Rate of service users finding psychological therapies helpful (working age mental health)

Definition: The rate of service users saying they found psychological therapies helpful in the working age secondary mental health services (which excludes EPMHS), as a proportion of all those responding.

Data source: Having Your Say.

Rationale: Access to and effectiveness of psychological therapies are equally important. Steps were taken last year to improve these areas but it was felt by the Trust and stakeholders that insufficient progress had been made.

Progress:



Target achieved. Through the Head of Psychological Therapies and through the planning of new care pathways as part of Leading by Design there has been a much stronger emphasis on the correct choice of therapy – as well as positive therapeutic relationships – as the key ingredients of effective psychological treatment.

Some Comments: In the previous year performance never got above 62%; this year after quarter one it has been significantly better for the rest of the year.

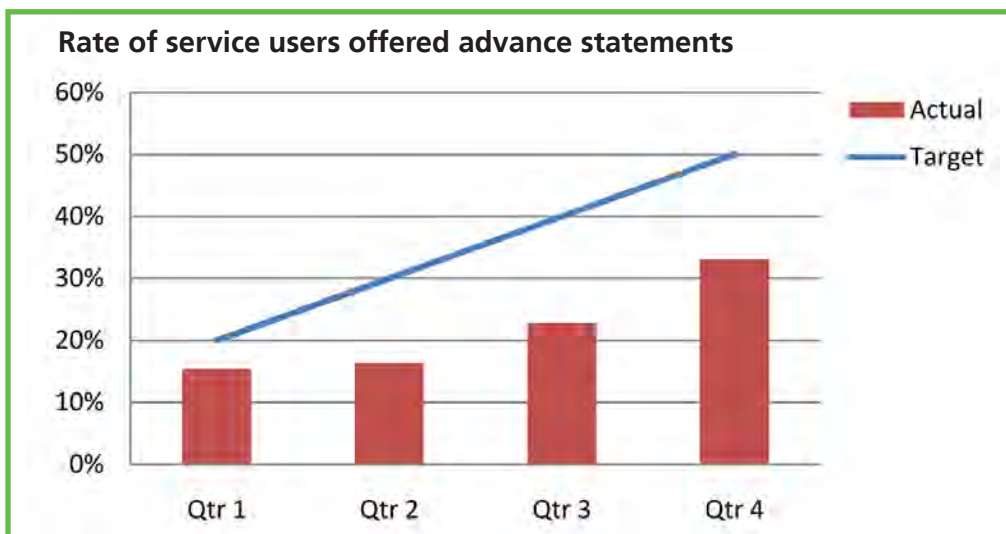
3.8.6 Rate of service users offered advance statements

Definition: The rate of service users offered advance decisions or statements or advance care plans as a proportion of all service users in adult mental health services (excluding EPMHS)

Data source: The electronic patient record.

Rationale: Advance statements offer service users a way of having more control over how they are treated if they become unwell again. Commissioners over the past two years have expected significant improvements in this area.

Progress:



Target not achieved. Considerable progress has made this year in offering advance statements, but not enough to achieve the target set by commissioners. Our work has included briefing sessions for service users hosted by Viewpoint, presentations, audit and other sorts of awareness raising in teams and integration of End of Life plans with advance care plans in Early Memory Services (EMDASS). This continues – with a particular focus on people with dementia and their carers.

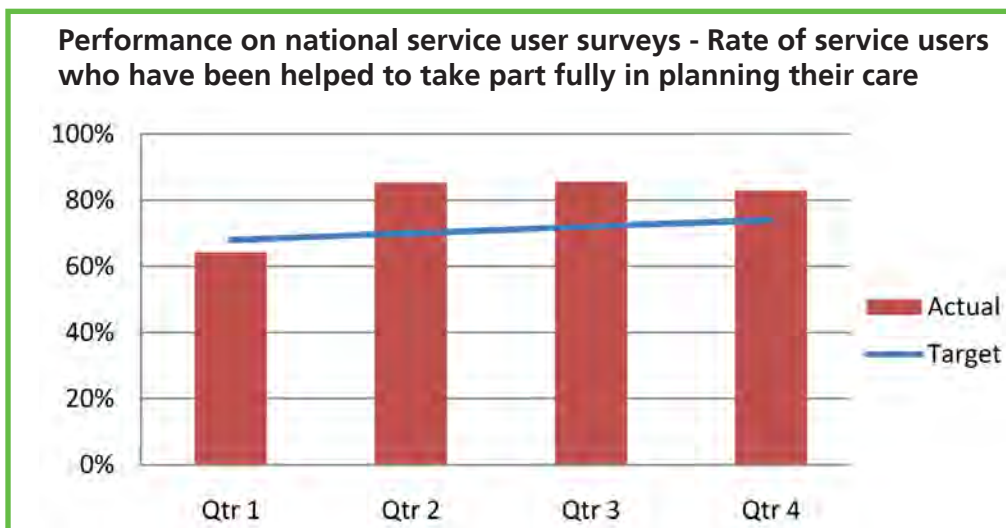
3.8.7 Rate of service users who have been helped to take part fully in planning their care (National Service User Survey)

Definition: The rate of service users who say they have been helped to take part fully in planning their care as a proportion of all those responding.

Data source: Having Your Say.

Rationale: This was an area of the National Service User survey 2011 that we wanted to improve. It is a very important indicator of how well we are working alongside service users to help them achieve their goals.

Progress:



Target achieved. Staff in all settings increasingly recognise the value in working collaboratively as far as possible with service users, with projects to promote wellness recovery action plans (WRAP) and the whole life programme.

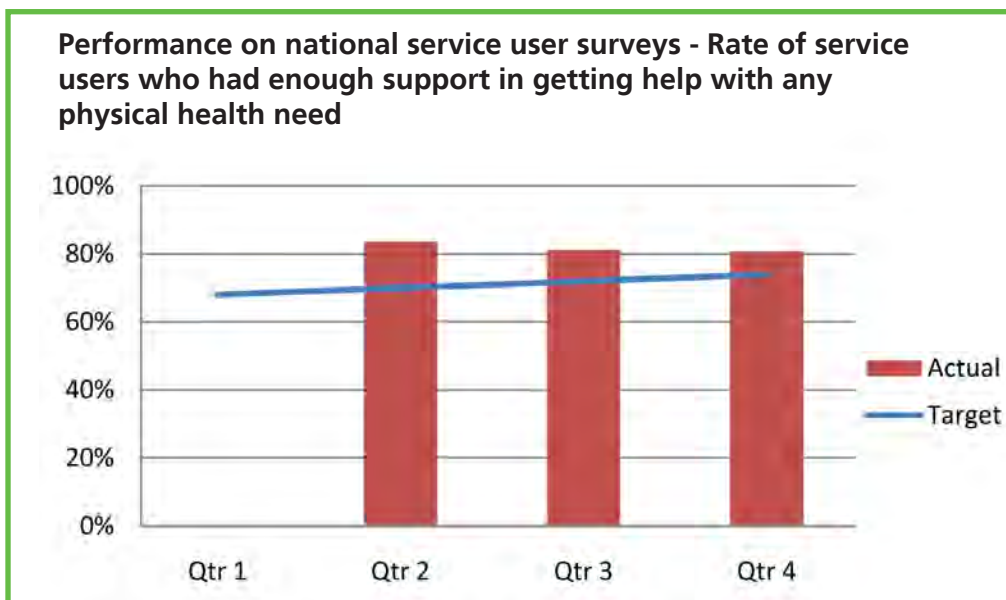
3.8.8 Rate of service users who had enough support in getting help with any physical health need (National Service User Survey)

Definition: The rate of service users who say they have had enough support in getting help with their physical health needs as a proportion of all those responding.

Data source: Having Your Say.

Rationale: This was an area of the National Service User survey 2011 that we wanted to improve. It is very important that we make every contact count in helping service users address their physical health needs as well as their mental health.

Progress:



Target achieved. There has been a focussed effort through the year led by the Associate Medical Director (Practice Governance) to improve physical health examinations on admission and reviews of physical health at least annually, supported by a programme of clinical audits, involvement of the Informatics team to ensure recording of this activity is improved and engagement with GPs so that we work more closely together.

Some Comments: In the 2011 national survey we were placed in the bottom 20% for this question nationally. We would expect to have risen to the top 20% (which is our aim) in the 2012 survey on the basis of these encouraging results during the year. 2012 survey results are expected in June.

3.9 Workforce

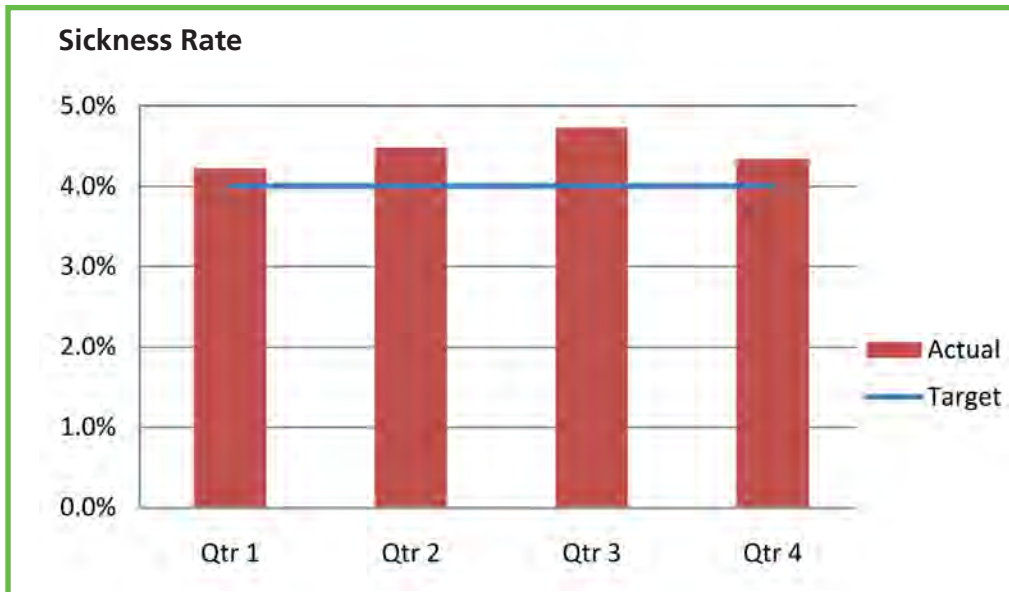
3.9.1 Sickness Rate

Definition: The number of reported days of sickness absence as a proportion of total days worked. The aim is to reduce the rate.

Data source: Human Resources Department

Rationale: Sickness data can be reported in several ways and can be a useful indicator of the morale of staff as well as their availability for work.

Progress:



Target not achieved. The Trust-wide sickness rate has remained fairly static through the year. This has kept performance slightly higher than target (when the aim is to be below it).

Figures shown are %s. eg. 0.04= 4%

Some Comments: The Trust-level figure can be difficult to change significantly. It may be more effective in future to focus on a service where the baseline rate is higher than average for the Trust (such as older people’s community teams), and set a target to reduce that.

3.9.2 Rate of completion of mandatory training

Definition: Aggregated completion rate for mandatory training by all staff (different professional groups have different sets of mandatory training to complete)

Data source: Learning and Development Unit

Rationale: The Trust has struggled in recent years to ensure all staff complete their mandatory training. Because of the known difficulties this was made a priority quality indicator for 2011/2012.

Progress:



Target not achieved. Considerable progress has been made, but not enough to achieve the target. The mandatory training programme has been modified so that it better suits the needs of particular staff groups and the reporting system is now easier and more accurate. Increasing use continues to be made of e-learning.

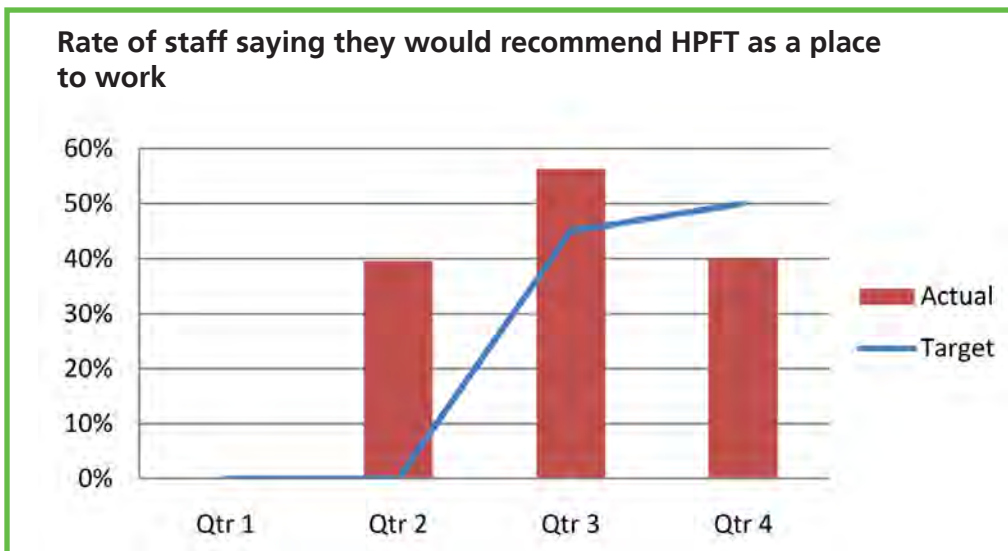
3.9.3 Rate of staff saying they would recommend HPFT as a place to work

Definition: The rate of staff saying they would recommend HPFT as a place to work as a proportion on of all responses.

Data source: Internal staff surveys (the Pulse surveys)

Rationale: We decided at the start of the year to focus in the quality account more on our workforce and their views, acknowledging that 2011/2012 would be a year of considerable change and uncertainty for many of them.

Progress:



Target not achieved. Performance on this indicator is disappointing. It should be noted that the response rate in the Pulse survey has at times been low.







3.9.4 Summary of Performance

As at 23rd April 2012, the available data shows that on the quality indicators selected for reporting in the quality account, performance over the year was as follows:

achieved	14
partially achieved	2
not achieved	6
not confirmed	3
Total	25

All Foundation Trusts are required by the NHS Operating Framework 2011/2012 to measure performance against quality, using measures defined by the Department of Health.

This year for Mental Health Foundation Trusts the mandated measures were as follows:

Indicator	Threshold	Weighting	Monitoring Period	End of Year	Rating
Care Programme Approach patients: a) Receive follow up within 7 days of discharge b) Have a formal review within 12 months	95% 95%	0.5 0.5	Quarterly	97.6% 96.6%	
Minimising delayed transfers of care	≤7.5%	1.0	Quarterly	0.4%	
Admissions to inpatient services had access to crisis resolution home treatment teams	90%	1.0	Quarterly	98.1%	
Meeting commitment to serve new psychosis cases by early intervention teams*	150 Per year	1.0	Quarterly	173	
Data completeness: identifiers	99%	0.5	Quarterly	99.3%	
Data completeness: outcomes	50%	0.5	Quarterly	60.3%	

It can be seen that we achieved all these targets mandated by Monitor for the year.

Trusts are also expected to share here their performance on complaints in the past year. The breakdown of complaints for 2011/- 2012 is as follows:

Service Stream	2011 - 2012				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Acute & Rehabilitation	14	20	10	23	67
Community	18	21	26	29	94
Learning Disabilities & Forensic	3	2	3	2	10
Specialist	16	24	17	13	70
Other	0	0	1	3	4
Totals:	57	67	57	70	245

The trend over the year is uneven, with the final quarter of the year showing the highest number of complaints. Specialist Services which included mental health services for older people have often had the highest numbers of complaints with a strong theme related to cost and accessibility of social care packages. Their numbers are declining. The relatively high numbers of complaints in community and acute mental health services may be related to the impact of changes and reductions to services carried out in the past year.

This pattern will be closely monitored as we enter another year of significant change.

Good News 3

Carers' Experience: Satisfaction Rates 2011/2012

Indicator	Q1	Q2	Q3	Q4
Valued by staff as a partner in care planning	85%	87%	91%	86%
Has participated fully in the last review meeting	N/A	85%	89%	86%
Treated with dignity and respect	94%	94%	97%	95%

3.10 Story of the Year

Introduction

This account so far has used numerical data to describe how the Trust has worked to improve the quality of its services. It is crucial to be able to present hard evidence, representing the experience of thousands of service users and carers, so that staff can see what they are helping to achieve and so that stakeholders including commissioners can see what they are getting for their money.

But both service users and staff are quick to point out that this is only one side of the story, and an account which is made up only of figures would not begin to convey what giving and receiving care in HPFT over the past year has been like.

So in this section we offer a picture of the year by summarising a range of events, achievements and challenges that have taken place, followed by a range of quotations from service users and carers about their experience. The picture given is made up of the experiences of over 20 000 individuals. Inevitably therefore it is wide-ranging and variable, highlighting some frustrations as well as many successes.

Leading by Design

As we knew it would be, 2011/2012 was a year of further significant reductions in funding for the Trust. Our four year service transformation programme “Leading by Design” represents our way of ensuring that the quality of services is maintained throughout this period, using the national and international evidence that adopting more efficient and integrated ways of working can deliver the planned financial savings without reducing quality and safety.

So this year the detailed plans for LbD were completed and tested, with the involvement of many staff, service users and other stakeholders. The radical changes to how services are delivered started in September when the Single Point of Access (our co-ordinated approach to giving easy access to services for all our service users county-wide) began to be trialled in Stevenage.

But in 2011/2012 the full effects of LbD have not been felt and several significant service reductions and changes have had to be made. There has been considerable anxiety amongst service users and carers about how this will affect them, and staff also have felt a great deal of uncertainty at times. It has not always been easy to give precise timescales about when changes will take place, and it has not always been easy to state confidently which services will be replaced in a different form by other providers and which will go for good.

Our service user and carer councils have played a significant role in getting commissioners and ourselves to “press the pause button” on some of these changes, to make them more gradually with better communication at each stage and more attention paid to offering alternatives. This has applied for example to the closures of the mental health day opportunities and community support teams provided by the Trust.

It can be seen that the quality account indicators that refer to the Trust workforce do not show all the progress through the year that we would have wanted. The workforce was made a priority because we knew that staff would be facing significant changes through the year, and our national staff survey results in early 2011 had been mixed. So during the year we put considerable effort into engaging more effectively with staff through “Big Listen” events and the weekly trustnews, and into celebrating successes more through the popular monthly Inspire awards for staff as well as the annual prizes. At the same time, we developed current and future leaders in the Trust, setting up our own local Leadership Academy as well as seconding designated staff onto regional and national leadership programmes.

The full impact of LbD will be felt in the coming year – both the challenges of supporting service users, carers and staff through massive change and the benefits to quality of care that these radical changes will bring. A committed and confident workforce is essential if these benefits are to be realised; that is why quality indicators for the coming year about staff remain critical.

Equalities

A theme of the year for the Trust is the reminder in much that we do of our responsibilities towards many of the most vulnerable people in our communities. This is echoed by our prominent role in assisting other NHS Trusts in the region develop their Equality Delivery System (EDS) plans.

An assessment panel of stakeholders (including service users and carers) in March 2012 agreed that the Trust was compliant with all necessary standards of the national EDS at an initial level, and agreed the priorities for improvement in the coming year (which are reflected in the quality account priorities shown above). Whilst the Trust has considerable evidence of improving health outcomes for many, this is often not broken down to show within it the experience of the potentially disadvantaged groups that we serve. Better reporting will be an essential building block for improved services for protected groups in the coming year.

Some Other Achievements

It is a testimony to the dedication of staff that there have been so many excellent achievements in the past year. As outlined above, the Trust has paid careful attention to the CQC's essential standards of quality and safety and has supported all teams in collecting their evidence of compliance. Despite initial concerns following visits to some units for people with learning disabilities at Kingsley Green, the CQC has at no time felt it necessary to publish reports stating major concerns nor impose any conditions on our registration.

The NHS Litigation Authority is another external body whose standards are taken extremely seriously as a badge that our systems for maintaining safe services – both clinically and corporately – are effective. We were delighted to retain level 2 status after a very thorough inspection in September 2011 and intend to move on to apply for level 3 status within 18 months.

Adults with learning disabilities can still nationally receive unacceptably poor levels of care and can lack the voice to make sure they get the quality of services they deserve. As a major provider of such services across three counties, we have made the needs of this group of service users a priority throughout the year. In Norfolk at the Broadlands clinic we have participated in the development of My Shared Pathway, a national movement to find ways of making the care plans agreed with service users in secure units more genuinely individualised and recovery-oriented.

We have taken the idea of service users as health access champions from North Essex and developed it in Hertfordshire, showing how people with learning disabilities can work effectively with us as trainers and advocates for each other when sufficiently supported. Focussing on Kingsley Green, we have used innovative ways to assure ourselves of the quality of care; these have included:

- wide involvement of carers, advocates and third sector colleagues as visitors to units and joint arbiters of quality
- considerable use of unannounced visits to promote quality, with a stronger emphasis on the good practice that is often to be found
- a focus on translating principles and written procedures for staff into actions however small that show a truly person-centred approach
- use of the "quality cycle" making sure that we come back and see that improvements suggested by visits or audits have always been made.

Both the Eric Shepherd Medium Secure Unit and its counterpart the Broadlands Clinic in Norfolk have been accredited with the forensic national quality network – a clear indication of the quality of care they provide.

Older people with dementia and their carers can also be groups in society whose needs are not well understood nor addressed. This is why we as major providers have focussed on giving them excellent care and at the same time challenging stigma.

This year we celebrated Dignity Action Day on the 1st February 2012 with a range of activities taking place across the Trust throughout Hertfordshire, Norfolk and North Essex. Older people and their carers featured prominently but not exclusively in this.

To celebrate this special day, teams from across the Trust got involved working with service users and carers facilitating a range of activities including musical events, coffee mornings, teas and lunches, baking and cake decorating, poetry, pampering and pets as therapy sessions, treasure hunt, tree planting, a balloon release and many, many more making Dignity Action Day a huge success. Many of these events were captured by video, which was shown at the East of England conference in March.

At Elizabeth Court in Stevenage, the Trust had secured funding from The King's Fund to make extensive improvements to the environment under the Enhancing the Healing Environment (EHE) programme in 2010. The newly refurbished site reopened at the end of September 2011.

The team were invited to celebrate and share their achievements by attending the 'Design Matters' national conference in January. As part of their success, the team has been asked by The King's Fund to assist them with the development of an audit tool for measuring the effect of environment on people with dementia.

In the community, Early Memory Diagnosis and Support Services (EMDASS) have developed considerably in the past year across Hertfordshire, enabling those with memory difficulties and their carers to find out at an early stage whether they have dementia and if they do putting in place the necessary support and treatments. We have set up systems that make sure carers always receive assessments of their own needs if they want them, and that they are fully informed about other sources of support and (where appropriate) options for end of life care. Occupational therapists elsewhere have driven up the quality of the group support provided to people with dementia by developing the use of cognitive stimulation therapy, which ensures that groups for older people are effective in optimising brain functioning, as well as being engaging and fun!

Acute mental health services remain a central aspect of many service users' experience of the Trust. As beds were further reduced in 2011, alternatives have been introduced where possible - such as the acute day treatment unit in Watford, and the Rapid Assessment and Discharge service in St Albans. Both have been carefully evaluated, with the research on the impact of RAD having been published. These services show that it is possible to provide effective care and treatment for many who are acutely mentally ill in ways that are less disruptive to their daily lives, less stigmatising and equally safe.

In annex 2 it can be seen that there is positive feedback from commissioners, the Hertfordshire LINK and Hertfordshire County Council about our account of quality, with areas for improvement being pointed out that the Trust fully accepts. Trust Governors also have said they support the Trust's comprehensive approach to quality under the headings used; they rightly stress service user and carer experience of services as the final arbiter of quality.

3.11 Some comments

The direct quotes below are taken from the comments in the independently administered national community mental health service user survey (May 2011). Through other means the Trust obtains similar feedback from other service users such as young people with mental health problems and people with learning disabilities. Whilst we do have these systems for teams to hear from their service users and improve quality as a result, these comments from service users are included, not as a baseline from which improvements can be measured, but simply in the spirit of providing a fuller account of what the experience of Trust services can be like.

They show powerfully that, whilst measurement of quality and its improvement are very important, that overall picture is made up of many unique transactions between Trust staff, service users and carers. These are often complex and can be fraught, with many situations where factors beyond the control of the service user and sometimes of Trust staff can lead to frustration. In these varied interactions with service users and carers, Trust staff aim to bring both their humanity and their professionalism into play, building therapeutic relationships based on optimism and hope.

A. What could be improved?

Until recently my experience with my mental healthcare has been frustrating and very unhelpful. This week I was offered some coping skills which will hopefully help.

I haven't had support from anyone. They don't listen.

I understand that you will be bringing in an agreement to the therapy sessions which will have an end date. I trust this will be negotiable. It is something I feel very frightened by as I know it can set me back because of the anxiety it creates in me.

The time taken to be referred from Dr. to mental health service was a long time. Very long time to be diagnosed.

It can be difficult to get an emergency appointment to see a psychiatrist so I feel more improvement is needed there

If I knew what can help me, I would have tried it already. Need someone to look at me as a person and to help me get my life back. I want to engage with society again, just need some genuine support.

I'm disappointed as the psychologist who dealt with me has now retired and apparently is not being replaced.

I was once referred for 'talking therapy' but it was very difficult to arrange. Took a long time to organise and make suitable appointments. Appointments were cancelled. In the end I gave up on the whole thing.

They could be more CPN Nurses to help us.

Too quick to give out tablets and don't work with the person first.

They should understand alcoholism more being professionals.

I don't always feel that I can tell him everything.

Improve access to help when seriously ill. This seems to be a real problem at my CMHT.

I only recently found out my care plan was the letter which [name removed] send to my GP. That was never clearly explained to me. I would expect lots of S.U would not be aware of that.

Whilst an inpatient more information should be provided re: medication and its side effects. The long term effect of ECT should be carefully explained.

Knowing whom to make complaint re: staff whilst an inpatient, e.g. in the case of bullying.

B. What is particularly good about your care?

Consistent, coherent and of a generally high standard, optimal.

I know the people involved now and am much more relaxed.

Welcoming reception team, availability of talking to someone if in need of anything - info/reassurance etc. Texting appointment reminding useful.

My psychiatrist and the psychologist I am seeing are extremely caring and sensitive people - I've felt very well looked after by them.

Thanks so much to the people give me support and care about me. God bless them all.

They were able to support me through school. They also were able to make appointments that fitted around school and work.

I am very happy with all the care and help and kindness shown to me by my consultant and members of his team. Including secretary and appointment clerks.

I like the staff as people I can get on with. (Particularly all the CPN's I've known over 33 years).

It gives me some support when I need it and I live with my mother and we support each other at home which helps me greatly.

I like the classes for pottery, very therapeutic.

Could do with higher rate benefits to get by a bit better but I am very grateful for what I get and having an income has helped in my stability. Great.

Overall I have nothing really that I could fault with treatment I have received.

Art psychotherapy - this has been the most useful part of my care, I am very grateful to my therapist.

My life seems to work good with the medication I am on. Improving in college and learning.

My psychiatrist is friendly and approachable. My psychiatrist sees me locally which is helpful.

I felt confident in my psychiatrist. He explained and considered my needs very clearly and carefully. He has monitored my medication and listened to my feelings regarding dosage.

Having been a patient of NHS mental health services a great deal over last 30 years, I was very impressed by the clean, light and pleasant waiting areas and friendly staff at present clinic.

I find it a peaceful calm environment which is important when mind is in turmoil.

I am very happy with my support worker she always helps me.

I go to [name removed] it is very , very good you could not wish for anything better.

The day to day support when I was at my worse around Christmas this year from the CAT team in [name removed] in Hertfordshire. A great team!

The care and support I have received in the last year has been excellent in every respect. Thank you.

The CAT team that came into see me were fantastic.

My excellent relationships with my consultant psychiatrist.

Good News 4

In February 2012 we heard that innovative ideas on improving the health of people with learning disabilities had been given the green light by the Joint Commissioning Team.

After submitting a range of innovation bids, the Trust had three of its ideas approved.

In one project, service users will use music, art and drama to explore a carer's poem about learning disability, culminating in a performance by people with learning disabilities as part of an inclusive piece of theatre .

A second project will raise awareness of the importance of annual health checks. The Trust will receive funding to hold AHC events to give people more information. In addition to this, Essex County Council will fund the filming of a video involving the North Essex Health Access Champions. This will also support the mid-Essex GP project.

Thirdly one of the health access champions and a nurse will produce together two detailed case studies as a way of generating ideas on how services should be adjusted to make them more helpful to people with learning disabilities.

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

Good News 5

In March 2012 The Trust played host to the Mayor of Watford, Dorothy Thornhill, when she took a tour of some of our key services in Watford. Dorothy was keen to find out more about mental health services in the area following the agreement of Watford and Three Rivers Health and Wellbeing Partnership to make mental health a priority during 2012.

Speaking about her visit, Dorothy said: "It was an interesting and challenging visit. I was extremely impressed with the facilities and opportunities given at Shrodells for those who were quite unwell or in crisis. More challenging, however, was the work of the community groups and nurses who are having to cope with an incredible amount of change but were all striving to do their best for their clients."

Annex 1. Quality Account Indicators 2011-2012: Data Set

Quality Account 11/12		Qtr 1	Qtr 2	Qtr 3	Qtr 4	
Customer Experience						
Access to psychological therapies (working age mental health)	Target	63%	66%	69%	72%	
	Actual	65.9%	89.1%	80.3%	76%	
Access to out of hours support from helpline	Target		57%	62%	67%	
	Actual	N/A	67.0%	70.7%	70%	
Rate of service users saying they could get help when they needed it	Target		82%	87%	92%	
	Actual	N/A	92.7%	88.0%	87%	
Rate of service users saying they had a choice in the time they were seen	Target		TBC	TBC	TBC	
	Actual	N/A	79.4%	71.5%	77%	
Rate of service users saying they had a choice in the day they were seen	Target		68%	73%	78%	
	Actual	N/A	78.3%	73.6%	79%	
Rate of service users saying they had a say in the choice of their medication	Target	59%	61%	63%	66%	
	Actual	N/A	77.4%	73.7%	77%	
Rate of service users saying that if they needed it, they would recommend this service to family and friends	Target	80%	80%	80%	80%	
	Actual	65.8%	85.8%	83.1%	85%	
Rate of service users saying Trust services have helped them see a positive future for themselves	Target		TBC	TBC	TBC	
	Actual	N/A	85.16%	83.18%	77.88%	
Rate of carers saying they are sufficiently involved in discharge planning (with service user consent)	Target		TBC	TBC	TBC	
	Actual	N/A	87.5%	97.0%	92%	
Safety						
Rate of inpatients saying they feel safe	Target	86%	86%	86%	86%	
	Actual	61.7%	87.1%	88.0%	84%	
7 day follow-up after inpatient care	Target	97%	97%	97%	97%	
	Actual	96.5%	97.7%	97.5%	98.9%	
Rate of actual physical assaults on staff on LD inpatient units	Target	<270	<250	<230	<210	
	Actual	295	230	230	137	
Number of falls on MHSOP inpatient units	Target	<76	<72	<68	<51	
	Actual	57	56	45	37	
Rate of serious incidents as a proportion of total incidents reported	Target	<0.4%	<0.4%	<0.4%	<0.4%	
	Actual	0.45%	0.3%	0.3%	0.2%	

Quality / Clinical Effectiveness						
Rate of readmission within 30 days	Target	4.75%	4.5%	4.25%	4%	
	Actual	5.7%	3.5%	3.3%	5.1%	
Use of 'You're Welcome' standards in CAMHS to drive up quality of clinics	Target	N/A	25%	50%	75%	
	Actual				Pass	
Rate of LD service users with HAP	Target	Pass	Pass	Pass	Pass	
	Actual				Pass	
Number of older people accessing IAPT services	Target	153	183	213	243	
	Actual	118	162	168	175	
Rate of service users finding psychological therapy helpful (working age mental health)	Target	58%	60%	62%	64%	
	Actual	50.9%	90.5%	86.0%	80%	
Rate of service users offered advanced statements	Target	20%	30%	40%	50%	
	Actual	7.7%	7.7%	22.8%	33.1%	
Rate of service users who have been helped to take part fully in planning their care	Target	68.0%	70.0%	72.0%	74%	
	Actual	64.2%	85.3%	85.5%	83%	
Rate of service users who had enough support in getting help with any physical health need	Target	68.0%	70.0%	72.0%	74%	
		N/A	83.7%	81.2%	81%	
Staff						
Sickness Rate	Target	4%	4%	4%	4%	
	Actual	4.2%	4.5%	4.7%	4.3%	
Rate of completion of mandatory training	Target	61%	70%	79%	88%	
	Actual	52%	51%	68%	73%	
Rate of staff saying they would recommend HPFT as a place to work	Target		TBC	45%	73%	
	Actual	N/A	39.5%	56.3%	40%	

Annex 2. Statements from Partner Agencies

1. NHS Hertfordshire

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 good performance they demonstrate in the account and recognise the commitment made by all staff to achieve this.

Commissioners also commend their strong performance against the 2010/11 Commissioning for Quality and Innovation (CQUIN) targets and welcome HPFT's onward commitment to driving up quality.

Increasing the proportion of service users offered an advance statement was a challenging target for the Trust, but commissioners note good improvements made for service users under 65 years old. We would expect this improvement to continue, along with a renewed focus on offering advance statements and end of life plans for older people, particularly those with dementia where the provision is a NICE Quality Standard. We would welcome the expansion of this offer to service users going through the new Early Memory Diagnosis and Support Service (EMDASS), as this would support the continued implementation of the National Dementia Strategy.

The rate of re-admissions to acute wards within 30 days of discharge remains at a higher rate than hoped, and the PCT would like a continued focus on this area, in light of the drug and alcohol provision moving to a new provider.

The PCT commends the work HPFT has done to become a pilot site for the Children and Young People IAPT service, and for the recent positive feedback it has received from the Department of Health.

The PCT notes the positive feedback from service users and carers as demonstrated in the responses to Having Your Say questionnaires, and would like HPFT to maintain this strong customer feedback as the Leading by Design programme takes shape, as the quality of service provided should not be compromised.

The PCT recognises the Trust's excellent performance against the Outcome Framework targets for 2011/12, and impresses that performance against the indicators on the 2012/12 outcome framework, such as the rate of the 7 day follow up for those on a Care Programme Approach who are discharged from inpatient care maintains the level of performance.


Commissioners note the work completed to increase the number of older people IAPT and would like to see the work continue. We are keen that the IAPT service continues to reach out to all parts of the community, including people with long term conditions, people from BME groups and veterans. This will be particularly important with the expectation that 15% of the estimate prevalence of people with depression or anxiety disorders should receive support under IAPT by 2015; a steep increase from the current proportion of the population receiving treatment.

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

Commissioners would ask that the Trust continues to focus on improving mandatory training rates, especially in light of the Leading by Design transformation programme.

NHS Hertfordshire endorses the Trust's priorities for quality improvement in 2012/13. 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.

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.

A handwritten signature in black ink that reads "Jane Halpin". The signature is written in a cursive, flowing style.

Dr Jane Halpin
CEO
NHS Hertfordshire

24th May 2012

2. Hertfordshire County Council



QUALITY ACCOUNTS 2011 – 2012

HERTFORDSHIRE COUNTY COUNCIL HEALTH SCRUTINY COMMITTEE

COMMENTARY

TRUST NAME: Hertfordshire Partnership Foundation Trust

DATE: 9 May 2012

SIGNATURE:

A handwritten signature in black ink that reads 'Nick.'.

Nick Hollinghurst, Vice Chair HSC

PURPOSE OF REPORT:

This commentary reflects the views (and supporting evidence, where available) of Hertfordshire County Council Hertfordshire County Council Health Scrutiny Committee (HSC) for the period April 2011 – March 2012

Quality of engagement with Hertfordshire County Council HSC

The Trust has long standing and effective engagement with HSC and its members. It has always supported the HSC's work programme and appreciates the Committee's continuing focus on mental health issues. It participates both as a mental health provider and in its role as a jointly delivered service with social care.

In addition

- there is regular exchange of information between officers to take forward the work of HSC
- site visits are welcomed
- briefings for the chair and/or other members are offered or arranged

Quality Account Engagement

The Quality Account was brought to HSC as part of the programme for involving stakeholders in the identification of priorities. Progress on the QA for 2011/12 has been monitored in year through a topic group. The Trust has followed the same process in identifying priorities for 2012/13 and a date has been set for the progress update.

HSCs attended & contribution

- 9 Feb 2012 in year finance update
- 14 Dec 2011 trust update
- 19 Oct 2011 QIPP. HSC dedicated the meeting to gaining a better understanding of QIPP. The Trust provided detailed information in response to questions distributed in advance of the meeting which members then considered in greater detail in small groups. This was the first stage in HSC's budget scrutiny. Members appreciated the efforts made by the Trust to provide accurate and timely information in lay person's language.

Topic Groups supported

- 15 Mar 2012 HSC Monitoring of Recommendations Topic Group (TG) for Quality Accounts (QAs) (2012/13)
- 6 Mar Integrated Discharge
- 23 Feb School Nursing
- 19 Jan A&E Mental Health
- 8 Dec HSC Monitoring of Recommendations TG for QAs (2010/11)
- June & Sept 2011 Mental wellbeing of military personnel & military veterans TG
- 22 Sept HSC Monitoring of Recommendations TG for Acute Inpatient Services
- 8 June HSC Monitoring of Recommendations TG for budget 2010

Visits hosted

-

HSC seminars etc supported

- 19 Oct the Trust reiterated its commitment to the HSC Concordat agreement. The Concordat clarifies relations between scrutiny and health, especially around expected engagement and consultation practice.

PRIORITY 1: Safe Services

HSC comments:

PRIORITY 2: Effective Services

HSC comments

PRIORITY 3: The very best customer experience

HSC comments

HSC commends this priority: the June meeting of HSC will receive an update from the Trust on patient satisfaction and outcomes. At its October meeting the committee will receive an update from the Trust including information on staff views and motivation/morale.

PRIORITY 4: Equalities

HSC comments

PRIORITY 5: Workforce

HSC comments

HSC commend this priority: the June meeting of HSC will receive an update from the Trust on patient satisfaction and outcomes. At its October meeting the committee will receive an update from the Trust including information on staff views and motivation/morale.

3. Hertfordshire Local Involvement Network (LINK)



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

Hertfordshire LINK supports the priorities chosen and agrees that a reduction in the quality measures will allow for a more focussed approach. Feedback from stakeholders has evidently underpinned the choice of the indicators.

LINK is pleased to see the inclusion of Equalities into the list of priorities reflecting the work being carried out through the Equality Delivery System and challenging the Trust to demonstrate how it delivers services equally to potentially disadvantaged groups.

However there is some concern that though considerable progress has been made on Improving Access to Psychological Therapies, this is still a problem for older people and needs to be monitored and enhanced.

In the coming year the Trust will want to focus on their Single Point of Access for all service users and how this will best meet their needs. The good work with the Joint Commissioning Team also needs to be carried forward to provide a seamless service and to ensure that there are no artificial barriers between mental health, health and social care. (Multidisciplinary teams need to work across not just mental health teams but also teams in health Trusts as well as social care services).

The Trust has not fully met the target on people saying they feel safe. It is crucial that this is improved. It is good to note that the Trust aspires to having units as 'calm and safe as possible' and has reduced the numbers of physical assaults by inpatients on staff on LD inpatient units. However it would be helpful to also see statistics on service users who have been assaulted either by other service users or staff to contrast and compare.

The report gives some good statistical information on how it has performed over the year against a number of quality indicators. However some of the measures are not indicative enough to show how quality improvements are moving forward for service users. The additional comments are therefore helpful to demonstrate that the Trust recognises that further improvement is required even though the set targets have been achieved.

Although the rationale behind asking service users if they would recommend HPFT's service to family or friends was explained, we are not sure of the value of asking this question when there is no alternative to using this service.

LiNK notes the Care Quality Commission (CQC) inspection report for Kingsley Green and acknowledges that the Trust has taken on board the concerns put forward by CQC and is now compliant. LiNK will need to see further evidence that the Trust is dealing effectively with the issues that CQC has raised.

It is important to LiNK that services always reflect what people need and that their needs are not forgotten when a service is commissioned to a specific contract. LiNK expects that services are constantly reviewed against this and that the service user is not made to fit what the service provides.

LiNK is encouraged by the progress that is being made by the Trust and as LiNK evolves into Healthwatch will continue constructive dialogue with the Trust and be a critical friend of the service.

A handwritten signature in black ink, appearing to read 'H Goldberg', with a decorative flourish underneath.

Henry Goldberg, Chair Hertfordshire LiNK, May 2012

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 2011 to May 2012;
 - Papers relating to Quality reported to the Board over the period April 2011 to May 2012;
 - Feedback from the commissioners received 14th May 2012
 - Feedback from governors received May 2012
 - Feedback from LINKs received 14th May 2012
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2012
 - 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 23rd May 2012

Care Quality Commission quality and risk profiles (the last received dated April 2012)

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at: www.monitor-nhsft.gov.uk/annualreportingmanual/) 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

NB: sign and date in any colour ink except black



Chair

Date 25 May 2012



Chief Executive

Date 25 May 2012

Independent Auditor's 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 Hertfordshire Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital; and
- Transfers of Care

I refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by 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 Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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

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

- Board minutes for the period April 2011 to June 2012;
- Papers relating to quality reported to the Board over the period April 2011 to April 2012;
- Feedback from the NHS Hertfordshire dated 14/05/2012;
- Feedback from Hertfordshire County Council Health Scrutiny Committee dated 9/05/2012
- Feedback from LINKs dated May 2012

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 14/05/2012;
- The latest national patient survey dated 2011;
- The latest national staff survey dated 2011;
- Care Quality Commission quality and risk profiles dated April 2011
- The Head of Internal Audit's annual opinion over the trust's control environment dated 23/05/2012; and
- Any other information included in our review.

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

I am in compliance with the applicable independence and competency requirements of the *Chartered Institute of Public Finance and Accountancy (CIPFA) Standard of Professional Practice and Ethics*. My team comprised assurance practitioners and relevant subject matter experts.

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 2012, to enable the Board of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents listed above under the respective responsibilities of the Directors and auditors.

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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

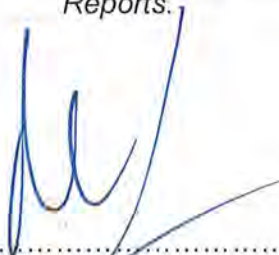
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Hertfordshire Partnership NHS Foundation Trust.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.



.....
Mark Hodgson

Officer of the Audit Commission

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

Date: 29 May 2012

Service User Care and Stakeholder Relations

Service User and Carer Involvement

Quote from a Service User, Involvement Worker and Council Member.

'Members of the Service User Council, like myself, provide an important independent voice on HPFT mental health services. I am impressed by the practical support the HPFT gives us, as well as the willingness of staff and Board members to advise us and to react positively to our suggestions and constructive criticisms. Overcoming the prejudice and ignorance of mental ill health and providing good medical and social support to those affected are battles which are yet to be won nationwide. But, I feel as a service user and as a council member that the HPFT is moving in the right direction and takes very seriously the improvement and provision of its mental health services.'

1,628 – the number of hours of involvement work with the Trust that service users have claimed payment for between 1 April 2011 and 29 February 2012. **This does not include** the service users and carers who have taken part in task groups, workshops, committees and reference groups under Leading by Design.

The Service User Council and Carer Council have continued to provide a 'critical friend' role for the Trust – and their input to discussion has been greatly valued – particularly at a time of change. Many council members are also members of other groups and forums, and can thus provide valuable links. Both councils are very keen to welcome new members. Third sector partners also regularly attend council meetings.

700+ – the number of hours of paid involvement work that service users and carers have spent in formal Trust councils, forums, committees and task groups. This does not include the substantial, and much appreciated, time that has been given on a voluntary basis by those attending meetings, workshops and public events.

A council for people with learning disabilities met on several occasions throughout the year – this forum is currently being restructured to make sure that meetings are more accessible to encourage input from as many service users as possible. Service Users with learning disabilities currently take part in a Quality Assessment Group – providing valuable input to service development and improvement. There have been many other opportunities for people with learning disabilities to be involved, and staff in learning disability services have a particularly strong commitment to involvement work.

The Involvement Development Worker for **Child and Adolescent Mental Health Services** has been in post throughout the year. She has spent her time developing links with service users and carers, clinic staff, third sector organisations and schools. 'Question of the Month', suggestion boxes and meetings with groups of young people have provided opportunities to gain feedback to share with staff in the service.

Peer Experience Listening has continued to provide significant opportunities for service users and carers to be involved in gaining feedback about services. This is now jointly funded with Herts Community Services and the listeners are engaged in various projects, including a scheme to train and involve people with learning disabilities as listeners. Peer Experience Listening has been greatly valued both for the richness and depth of the feedback it provides, and for the positive experiences of the service users and carers who have taken part – both as listeners and as part of the innovative steering committee which includes third sector partners.

20 – the number of service users and carers who have undertaken the two day training course to become Peer Experience Listeners.

99 – the number of people interviewed by Peer Experience Listeners between December and April, following this training. The feedback they provided about their experiences of mental health services has contributed to service developments in a number of different areas within the Trust.

Service user and carer input to staff inductions has been particularly valued by staff joining the Trust – they consistently remark on the impact of having the opportunity to listen to experiences of mental health problems and services. We have a group of service users who we support to share their stories with the inductees, and carer input is provided by carer trainers from Carers in Herts.

140 – the number of people who receive regular updates about involvement opportunities. These are people who have expressed an interest in contributing to and commenting on the Trust's work – and around 50% of them take part in activities on a regular basis.

We have also increased the number of service users and carers involved in staff interviews. Service users and carers have commented on this as an interesting and empowering experience – and staff have commented very favourably on the new insights that this involvement provides in the recruitment process.

252 – the number of hours that service users and carers have contributed to interviews for staff.

The future

- **The planned merger of Involvement and Equalities teams has many potential benefits.** It will encourage increased creativity in our involvement work, and will support greatly with the aim of increasing diversity in involvement.
- **Further increases to the numbers of ways that involvement workers, peer workers and volunteers can work with us.** We have been working this year to improve methods of reporting on involvement – and this has had the extra benefit of setting us a challenge to continue to expand involvement opportunities.
- **A particular focus on increasing the number of people volunteering with the Trust.** We are starting to work with both statutory and third sector partners. This will include looking at ways of ensuring that people are well supported in appropriate roles that provide added benefits for service users, carers and the volunteers themselves.

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 and to use the patient experience trackers where they are available.

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

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

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 resulting changes.

There has been an 11% increase in formal complaints during 2011/12 compared to 2010/11. This can partly be attributed to the changes in commissioned services and introduced through the extensive Leading by Design programme together with changes in direct payments causing increased anxiety. Table A shows the number and primary category for each complaint, comparing 2008/09, 2009/10, 2010/11 and 2011/12.

Table A: 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 – 31/03/11	01/04/11- 31//03/11
Assault / abuse	5	3	9	5
Clinical practice	50	67	83	79
Communication	27	39	27	40
Environment etc.	3	2	4	3
Staff attitude	7	26	28	42
Security	3	1	1	1
Systems & Procedures	42	65	60	74
Transport	0	0	1	2
Total	137	203	213	246

Of the 246 complaints received during the year 210 were responded to within 25 working days and 13 were responded to over 25 working days. Twenty complaints were still open at the time this report was prepared, three of which were overdue. Permission is sought from complainants when it is known that a complaint is likely to go overdue.

Patient Advice and Liaison Service (PALS)

PALS provides people with advice and assistance on who to contact and support if they have a concern or enquiry. The number of contacts continues to increase with a 23% increase over last year. Table B shows the number and main categories of PALS contacts, comparing 2011/12 with 2010/11, 2008/09 and 2009/10.

Table B: Number of PALS contacts and main categories

Category	01/04/08 – 31/03/09	01/04/09 – 31/03/10	01/04/10 – 31/03/11	01/04/11 – 31/03/12
Advice	42	67	109	66
Enquiry	-	-	-	40
Feedback	2	4	30	42
Issues for resolution	44	89	134	159
Other	1	5	15	3
Translation request	0	0	1	3
Not HPFT	-	-	-	19
Total	89	165	289	332

Emerging themes from the PALS issues and complaints received

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

Of the 79 complaints where clinical practice was the primary issue, 38 concerned direct care, 26 care planning, nine concerned medicines management and three concerned diagnosis. The 74 Systems and Procedures complaints fell into 26 categories, with 10 about assessment and treatment, nine about access to treatment, seven about inefficient administration and six about direct payments; and four each for service users' monies, respite care arrangements and Continuing Care Funding.

During 2011/12 we received eleven requests for files from the Parliamentary and Health Services Ombudsman (PHSO). Seven cases were returned as no further action and three were returned for further local resolution. The PHSO forwarded one file to the Local Government Ombudsman (LGO) and we are awaiting the result of that investigation. The LGO also asked the Trust to convene safeguarding procedures for an individual who was not then a service user staying in a private nursing home.

Compliments

All teams are asked to forward letters of thanks from service users, carers, advocates and visitors to the PALS and Complaints Department 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; there has been a significant increase in the number of compliments forwarded to the department.

01/04/08 – 31/03/09	317
01/04/09 – 31/03/10	308
01/04/10 – 31/03/11	432
01/04/11 – 31/03/12	674

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

Requests for Information

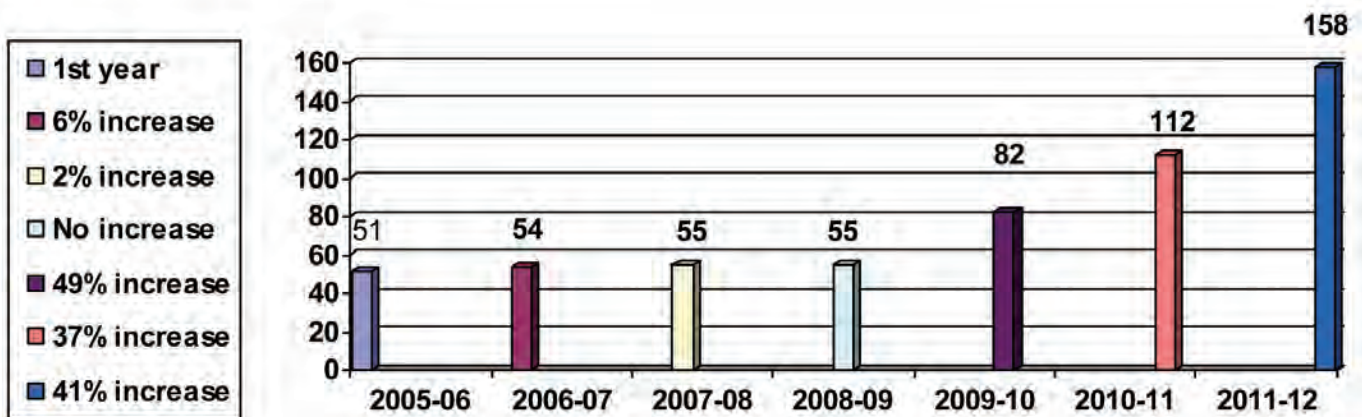
Introduction

The number of Freedom of Information Act 2000 (FOIA) requests received by the Trust during the year has again risen considerably and it seems that companies and journalists, as well as 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 the FOIA being implemented (2005-06) to 2011-12 there has been a total increase of 210% in the number of requests we have received.

For the first 3 years the number of requests was fairly stable however from 2009 onwards there has continued to be a substantial increase in the number of requests received year on year.



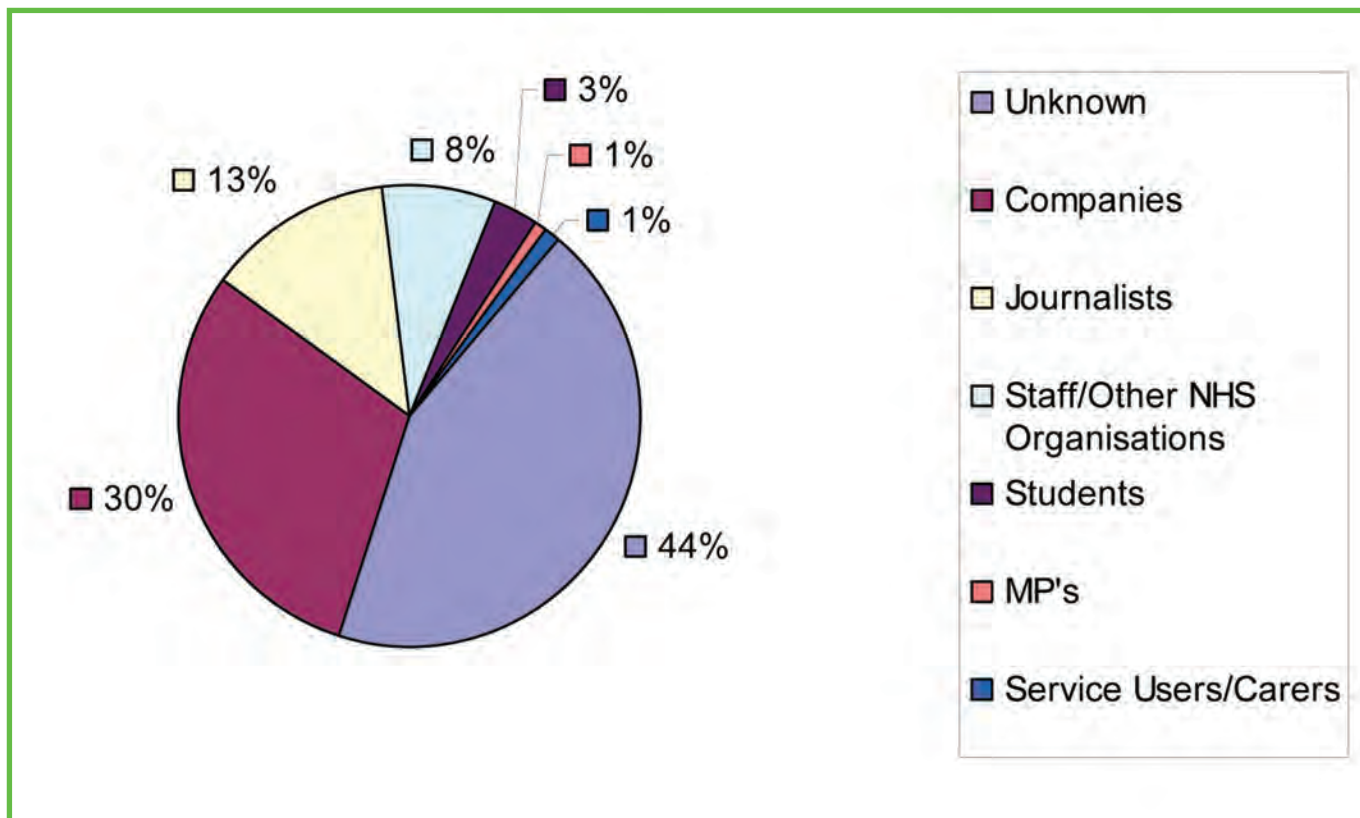
Years	Total Number of requests	Exemptions used and frequency	Number taking over 15 days to respond	%
2009-10	82	S.21 x 12 S.12 x 2 S.22 x 3 S.40 x 2	21	26%
2010-11	112	S.40 x 5 S.21 x 20 S.12 x 1 S.43 x 3 S.22 x 4 S.30 x 2	26	23%
2011-12	158	S.12 x 5 S.21 x 7 S.22 x 5 S.40 x 8 S.41 x 1 S.43 x 10	79	50%

Who has asked for information?

An applicant (requester) does not need to inform us who they are or give a reason why they want the information. All requesters are treated equally, whether they are service users, carers, journalists, local residents, public authority employees, or researchers etc.

From April 2011- March 2012 requests have been received from the following applicants (where identifiable):

Type of requester	Total number	Percentage
Unknown	70	44%
Companies	47	30%
Journalist's	20	13%
NHS Staff/Other NHS Trust's	13	8%
Students	4	3%
MP's	2	1%
Service Users/Carers	2	1%



Reporting of Personal Data Related Incidents

Loss of personal data is a risk which is nationally monitored and the table below shows incidents within 2011/12 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	9*
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	27
V	Other	1

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

Sustainability reporting

A Year of Challenge - People Places and Profit

People

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

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

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

The Trust runs special campaigns and features around specific sustainable topics on a very regular basis, which from feedback from staff, has proved very useful.

There is work to do to better communicate our successes and challenges to the wider public domain. This will be established over the next year.

Places

In 2011/2012 there have been many challenges to continue to reduce CO² emissions. There have been many successes coloured with a few disappointments but in general terms the Trust is hopeful in achieving its reduction target by the end of 2013 although we are yet to review as to whether it will be more beneficial to reset the target to 2015 to ensure compliance to our plans and those of the wider NHS commitment. The challenge has been to achieve a sustainable estate and business strategy. This is now in place and the Trust is on target to move to a Hub and Spoke system for our building location. Thus the Trust will move into an estate that delivers sustainable future in the long term thus driving down CO₂ emissions from its business and delivering efficiency savings.

The Trust is developing a ninety six bedded unit in Kingsley Green, the design of which is based on the BREEAM excellent standard. This building will deliver excellence in Sustainable design and CO² efficiency savings to match the highest quality clinical services which our service users will receive.

Profit

It is worth mentioning that over the last two years the UK has experienced the most severe winters and all the Trust teams have been focused on maintaining and delivering the highest quality services in a comfortable and safe environment. This has certainly challenged the CO² reduction figures.

Water usage is now under control as the Trust has experienced a large loss due to underground pipe vandalism at one of its major sites. This situation has now been contained and the Trust is hopeful of publishing a usage reduction next year.

Waste disposal system

The Trust is on target to achieve its target of 80% of disposals to recycling by 2015.

There has been further success on reducing waste to landfill. This has increased by a further 10% against last year's figures. The percentage reduction is as follows

General Waste

53% Waste Recycled

47% Landfill

Clinical /Incineration

3% increase on last year

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

Travel

Travel has continued to show a reduction in absolute CO² emissions this has been achieved by fewer Trust meetings, better use of Information technology, a better understanding by Staff on the need to be more fuel efficient when delivering services in their choice of transport. This has all added up to a further reduction of % against last year's figures.

It is essential that sustainability continues to be actually delivered and that it forms as a key component in our business. Therefore, to meet this challenge the Trust is on course to revisit the governance structure and will ensure Senior Management take that leadership initiative forward.

Summary of Carbon Reduction Performance

For the year 2011/12 there has been a positive decrease on the previous year's figures of 7% on CO² emissions on buildings. However, due to severe winters of the past two years this caused an overall increase of 10% on buildings.

Electricity has reduced by 8.5% on last year and against the baseline is level.

We predict this will continue to reduce.

Gas due to the severe weather has increased by 15% on the baseline, but we have decreased usage from 2010/11 by 1.2%.

We predict that there should be a continuing decrease in this section.

Water consumption has decreased against by 0.07%. Much more could have been achieved but the Kingsley Green experienced major leaks due to vandalism of the piping. This should be set in context that Kingsley Green consumes 50% of the total water usage of the Trust.

We predict that consumption will continue to show further reductions.

Waste continues to show a reduction on landfill disposal and we are optimistic that the aspiration of 80% to recycling will be achieved.

Travel

Travel has again delivered significant reductions against the baseline.

Tom Cahill, the Trust Chief Executive Officer, has pledged to travel less by car when conducting Trust business. His leadership has contributed greatly to this success story.

Investment in better IT technology has also helped staff to reduce their business mileage by 9.59% against last year's figures.

Courier services have reduced their annual mileage by 27.31% against last year's figures, by further rationalisation of activity and fleet control.

The Trust is continuing to ensure that travel delivers continuous reduction in mileages, whilst at the same time contributing accessibility to our services.

Emergency Planning

The Trust constantly reviews its Major Incident and Business Continuity plans and continues to work with Herts Environmental Forum (HEF). The Trust is an active partner in the Herts Resilience Forum taking part in relevant exercises which include flood and heat wave exercises as part of the civil contingencies requirements based on UKCIP 2009 weather projects, and linking this with our Carbon Reduction Strategy and Plan.

Area	Type	Non-Financial Information				Financial Information (£)			
		2008/9	2009/10	2010/11	2011/12	2008/9	2009/10	2010/11	2011/12
Greenhouse Gas Emissions	Scope 1 (Direct) GHG Emissions	Gas Fleet Vehicles 22,896MWh 885,204km	23,019MWh 1,682,881km	26,740MWh* 1,158,059km	26,434MWh 909,642km	803,694 136,480	805,661 152,585	935,913 176,215	639,999 148,658
	Scope 2 (Energy Indirect) Emissions	Electricity Other energy 7,151MWh 8,333kWh	7,742MWh 85,015kWh	7,871MWh* 85,015kWh*	7202MWh	607857 333	658,081 3,401	669,053 3,401	566,889 0
	Scope 3 Official Business Travel Emissions		5,768,096km	6,243,746km	5,171,420km	4,718,798km	1,236,611	1,332,355	1,132,991
Waste Minimisation and management		(a) total waste arising	919T	933T	933T	£41,510	£39,159	£43,980	£51,140
		(b) waste sent to landfill	834T	834T	459T	incineration & clinical waste	incineration & clinical waste	incineration & clinical waste	incineration & clinical waste
		(c) waste recycled/ reused	0T	0T	375T	£142,878	£185,521	£183,861	£6,365
		(d) waste incinerated	85T	99T	99T	other waste	other waste	other waste	recycling, £183,201 other waste
Finite Resources		Water (m ³) 142,798	105,032	120,299*	140,500	175,549	105,032	120,299	110,147
2013 Targets									
Include environmental criteria in specifications for third party non-emergency transport contracts 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 environment impact of travel.									
Include environmental criteria in specifications for third party non-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 arising by 2013									
To Recalibrate CO ₂ Emission target to 30% against baseline by 2015									
To reduce staff business miles by 30% by 2015									
To recalibrate waste reduction figures to a 15% reduction by 2015 and to continue to monitor reduction to landfill									

Equality and Diversity – 2011/12

2011/12 has been focused on the implementation of the NHS Equality Delivery System (EDS); the new national framework for hardwiring Equality & Human Rights principles into the work of NHS services.

HPFT has led this development in Hertfordshire as chair of the Hertfordshire NHS EDS implementation committee, including representation from NHS Trusts, third sector, county council and community members. The work of this group has included a series of high level engagement activities within Hertfordshire communities to understanding how local communities view their health services re: providing care to protected groups including age, disability, ethnicity, gender, gender reassignment, pregnancy and maternity, religion/beliefs and sexual orientation. Alongside this there has also been a significant amount of internal engagement with our service users, carers and staff.

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. Over the past year this has included advising on the implementation of the EDS as well as development of compliance reporting for the Public Sector Equality Duty (PSED) – reported in January 2012.

Some examples of application that the Trust has identified in meeting its PSED – general duty – requirements over the pas year include:

Eliminate unlawful discrimination

- **Staff Inclusivity Guides** – The Trust has developed guidance for every staff member on working in an inclusive environment covering information for protected groups.
- **Trust RESPECT campaign** – Developed as a replacement to Zero Tolerance, the RESPECT campaign is about ensuring appropriate behaviour from staff, service users and carers through a culture of mutual RESPECT.
- **Staff Support Networks** – The Trust has three staff support networks; IMPACT BME Network, Disability Staff Forum and LGBT & Straight Allies Network.

Advance equality of opportunity

- **Community Engagement Workers** – The Trust employs a team of six community engagement workers who work within the equality & diversity team and focus on the mental health needs of protected groups.
- **Trust RESPECT campaign** – This campaign (as mentioned earlier) is designed to safeguard staff, service users and carers from inappropriate behaviour.
- **Stonewall & LGBT Work** – Achieving placement in the 2012 Stonewall Workplace Equality Index for the third year running.
- **Employee Charters** – Maintaining staff charters for disability, sexual orientation, age and positivity about mental health.
- **Emotional Wellbeing Resources for BME Communities** – in 2009 the Trust produced a new DVD resource for BME communities living in Hertfordshire around their emotional wellbeing. In 2011 this was reformatted for online accessibility. <http://www.hertspartsft.nhs.uk/talkaboutit/>

Fostering Good Relations

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

- **INSPIRE development day** – focused on leadership and development for BME staff held during Black History Month.
- **Joint meetings** – In 2011 the Trust made an agreement to hold joint strategic meetings with each of the staff network groups to ensure that senior management teams are aware of the diverse range of issues that can exist for staff.
- **Equality E-learning** – In 2011 the Trust moved from a 100% face to face training programme to an new bespoke e-learning system written by the Trust Equality & Diversity team. This has shown an increase in training compliance to near 100% in 2011.
- **Members & Governors Communication** – 2011 has seen a number of articles placed on our quarterly newsletters to all members highlighting the importance of the Equality Delivery System. In addition we have included items on our work with Stonewall, the work of the spiritual care dept as well general progress on equalities.
- **Work with the Trust Board** – The Trust has an Executive and Non Executive Champion for equality. On an Annual the board receives an equality workshop looking at current issues as well as update reports on the progress on implementing the NHS Equality Delivery System.

Statistics

The Trust is required under the PSED to collect and publish diversity data for staff and those affected by its policies and processes. In addition the Trust is required to publish – from April – one or more equality objectives spanning a four year period. This has been done against the Trust annual objectives for the NHS Equality Delivery System.

All PSED compliance reporting is published through the equality & diversity section of the Trust website. However below is an overview of Trust staff, membership and service users for information as of 31st December 2011.

	Employees	Members	Service Users
Ethnic Group	Based on 3,224	Based on 12,051	Based on 19,534
White British	53%	89%	82%
White Irish	3%	1%	2%
Any other white background	6%	4%	4%
Asian - Indian	4%	1%	1%
Asian - Pakistani	<1%	<1%	<1%
Asian - Bangladeshi	<1%	<1%	<1%
Any other Asian background	4%	<1%	1%
Mixed - White & Black Caribbean	<1%	<1%	<1%
Mixed - White & Black African	<1%	1%	<1%
Mixed - White & Asian	<1%	<1%	<1%

Any other mixed background	<1%	<1%	<1%
Black Caribbean	2%	1%	<1%
Black African	7%	1%	<1%
Any other black background	<1%	<1%	<1%
Chinese	<1%	<1%	<1%
Any other ethnic group	3%	<1%	<1%
Undisclosed	15%		5%

	Employees
Age Band	Based on 3,224
16 - 20	<1%
21 - 25	3%
26 - 30	7%
31 - 35	8%
36 - 40	13%
41 - 45	16%
46 - 50	17%
51 - 55	16%
56 - 60	12%
61 - 65	5%
66 - 70	1%
71 & above	<1%

	Members
Age Band	Based on 12,051
Under 16	<1%
16/17	<1%
18/24	14%
25/34	10%
35/44	13%
45/54	16%
55/74	27%
75/84	8%
85+	4%
No data	7%

	Service Users
Age Band	Based on 19,534
Under 16	11%
16/18	4%
18/24	8%
25/34	11%
35/44	12%
45/54	13%
55/64	9%
65/74	8%
75/84	13%
85+	10%
Age Unknown	<1%

	Employees	Members	Service Users
Gender	Based on 3,224	Based on 12,051	Based on 19,534
Male	30%	42%	46%
Female	70%	58%	54%

	Employees	Members (only started in 2011)	Service Users
Religion/Belief	Based on 3,224	Based on 12,051	Based on 19,534
Atheism	3.50%	4 members	-
Buddhism	<1%	1 members	-
Christianity	17%	15 members	-
Hinduism	1%	-	-
Islam	<1%	1 members	-
Jainism	<1%	-	-
Judaism	<1%	1 members	-
Sikhism	<1%	-	-
Other	3%	5 members	-
Undisclosed	6%	57 members	-
Undefined	68%	-	-

	Employees	Members	Service Users
Disability	Based on 3,224	Based on 12,051	Based on 19,534
Yes	1%	3%	5%
No	24%	97%	2%
Undisclosed	18%	-	
Undefined	57%	-	93%

	Employees	Members (only started in 2011)	Service Users
Sexual Orientation	Based on 3,224	Based on 12,051	Based on 19,534
Lesbian	<1%	-	<1%
Gay	<1%	-	<1%
Bisexual	<1%	-	<1%
Heterosexual	27%	42 members	23%
Undisclosed	4%	44 members	3%
Undefined	68%	-	74%

Priorities and Targets

The key priority areas for equality in 2012/13 will be to focus on ensuring that the NHS Equality Delivery System (EDS) can be evidenced by all protected groups.¹










NHS Equality Delivery System Goal	2012/13 Objectives
1. Better Health Outcomes for All	The Trust ensures systems are in place that challenges discrimination against protected groups that could otherwise have a negative impact on service user recovery or other service user and carer outcomes.
2. Improved Patient Access & Experience	The Trust can show that privacy and dignity is prioritised for all service users and specific needs for protected groups identified through the trial and roll out of the new RESPECT framework for equality & dignity.
3. Engaged, empowered and well supported staff	The Trust puts in place a programme of developing role models from most protected groups to act as advisers to staff on a variety of issues relating to the workplace who feed into the Trust equality & diversity steering group.
4. Inclusive leadership at all levels	The Trust shows a demonstrable change in the ability of senior managers to affect change within their services through embedded a culture of equality and fairness based on EDS principles.
<p style="text-align: center;">Four Year Objective – As required by public sector equality duty</p> <p style="text-align: center;">The Trust shows measurable improvement in EDS scores year on year, leading to the Trust achieving 100% purple (excellence) against all 18 EDS outcomes.</p>	










¹ Protected groups are Age, Disability, Ethnicity/Race, Gender, Gender Reassignment, Marriage & Civil Partnership, Pregnancy & Maternity, Religion & Beliefs, Sexual Orientation

Assessment Progress

As the Trust has now adopted the national NHS Equality Delivery System (EDS) as it's method of assessing progress on equality and human rights, the results of the first Trust assessment process are listed below. The graded colours correspond to the following:

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

Goal	Narrative	Outcome	
1. Better Health Outcomes for All	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities	
		1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways	
		1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly	
		1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all	
		1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups	
2. Improved Patient Access & Experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds	
		2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment	
		2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised	
		2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently	

3. Engaged, empowered and well supported staff	The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades	
		3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay	
		3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately	
		3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all	
		3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.)	
		3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population	
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond	
		4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination	
		4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes	

Our Staff

Staff Engagement

The Trust is committed to staff engagement and values the input of all members of staff at all levels. There has been a rolling programme of engagement events throughout the year both with staff and with key stakeholders to ensure effective two way participation in key decision making and formation of Trust strategy. Big Listen events have now become an integral part of the mechanism for engagement along with Little Listen events in local areas. These give staff the opportunity to provide direct feedback to the Executive Team on issues which matter to them.

In addition a quarterly pulse survey enables staff to give anonymous feedback on a number of areas which matter to them, including how often they get recognition or praise. These results are monitored and tracked per service area.

The Trust has continued to ensure staff feedback is embedded into practice and shaping future services, with front line staff being an integral part of the design, trial and testing and implementation of the Leading by Design programme.

The staff survey action planning process has been progressed to enable a sharper focus on key priorities and actions for service areas. In 2011 each Business Stream took forward their priorities with a bespoke action plan, in addition to the overall action plan, to enable ownership of local issues.

Summary of performance – NHS Staff Survey 2011

	2010		2011		Trust Improvement/ Deterioration
Response rate	Trust	National Average	Trust	National Average	
	57%	54%	61%		Increase of 4%

	2010		2011		Trust's Score Increase/ Decrease
Top 4 ranking scores	Trust	National Average	Trust	National Average	
KF2 - Percentage of staff agreeing that their role makes a difference to patients	89%	90%	92%	90%	Increase of 3%
KF 9 - Percentage of Staff using flexible working options	65%	67%	71%	67%	Increase of 6%

KF21 - Percentage of staff reporting errors, near misses or incidents witnessed in the last month. (KF22 in the 2009 survey)	97%	97%	98%	97%	Decrease of 1%
KF 36 - Percentage of staff having equality and diversity training in last 12 months	31%	47%	88%	53%	Increase of 57%

	2010		2011		Trust's Score Increase/ Decrease
Bottom 4 ranking scores	Trust	National Average	Trust	National Average	
KF 20 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	29%	28%	36%	27%	Increase of 7%
KF23 - Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months.	21%	14%	20%	12%	Decrease of 1%
KF 25 - Percentage of staff experiencing harassment, bullying or abuse from patients/ relatives or the public in last 12 months	19%	18%	23%	17%	Increase of 4%
KF26 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	16%	14%	18%	13%	Increase of 2%

Largest local changes since the 2010 Survey – Key areas where staff experience has deteriorated

Question	Trust Score 2010	Trust Score 2011	Trust deterioration
KF 20 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	29%	36%	Increase of 7%
KF 29 - Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	14%	20%	Increase of 6%
KF 33 - Staff intention to leave jobs	2.51	2.66	Increase of 0.15
KF 34 - Staff recommendation of the trust as a place to work or receive treatment	3.56	3.38	Decrease of 0.18

The Trust results in relation to the National Staff Survey were mixed, with staff agreeing their role makes a difference, being motivated and being able to access development and flexible working options, however levels of staff satisfaction overall have declined.

Findings around violence and aggression have remained in the bottom 20% of mental health trusts. The Trust has commissioned an external review of the management of violence and aggression which has now concluded and will be taken forward with a specific action plan and working groups.

Specific staff survey action plans will be taken forward with the Strategic Business Units in relation to local priorities, with engagement events with staff being a key continuing part of this process.

The 2011 survey had 38 Key Findings (KF) of which 11 ranked better than average, 1 was in the top 20% and 4 were average whilst 14 were below average and 8 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. Partnership working is key to ensuring that the Trust meets its transformation agenda.

NHS Graduate Scheme

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

Staff Wellbeing

The Trust aspiration is to be an employer of choice, where employees are highly valued, well supported and rewarded. As part of this, the Trust is committed to ensuring that the health and well being of all employees is integral in the way we manage and lead our teams. As part of this commitment the Trust is working towards the 'Staying Health At Work Award', a national kite mark that recognise the dedication and commitment to health and well being. The Trust was the first organisation in the East of England region to be awarded the

Staying Healthy at Work aSHaWd Accreditation, in recognition of its strong health and wellbeing foundations it has put in place for staff A number of interventions and support packages have been implemented to support this agenda. In July 2011, the Trust launched the quarterly health and well being e- magazine – “Working Together As One”. The magazine addresses healthy eating, exercise, stress management and other issues identified by the workforce. It also has the quarterly pulse surveys which are designed to gauge staff opinion and check if the agreed interventions are making a tangible difference.

The Trust has for a number of years adopted the “Zero Tolerance” logo in relation to how promoting the Trust commitment to reducing violence and aggression towards members of staff whilst undertaking their duties. It is acknowledged, that many of our staff work in high risk services which are prone to higher rates of violence and aggression. The Trust has reviewed the approach towards this area and has launched the “Respect ”campaign. As part of this campaign, there has been a review of training and support in relation to violence and aggression, as well as improved reporting. The Trust has also signalled its commitment to eliminate harassment and bullying in the workplace through its ‘Ban Bullying’ pledge.

One of the key aims of the Trust’s health and wellbeing strategy is to support the reduction of sickness and there have been a wide range of initiatives introduced to support staff in both their physical and emotional wellbeing, including a quarterly staff health and wellbeing magazine, the RESPECT campaign and the Inspire staff awards. The Trust also has a proactive occupational health service and employee assistance scheme which supports our staff in their physical and emotional wellbeing.

Workforce and Organisational Development

Developments in the past year include:

Learning and Development

The Organisational Learning Management System (OLM) enables detailed compliance reporting for mandatory training which is closely monitored in each specialist area. Engagement with service areas by Learning and Development leads and consistency checking has been a key factor in the increase in compliance. OLM Elearning has now launched and elearning has proven to be a very successful mode of delivery for staff and has had an impact on compliance levels, most particularly with Equality and Diversity training and Information Governance.

Learning programmes are developed in conjunction with service and professional leads and are responsive to changes in organisational culture and national priorities.

Mandatory Training

Mandatory training compliance rates within the Trust have shown a consistent increase across all the business streams, the Trust has implemented a number of online learning packages that are designed to support staff achieve compliance closer to where they work

Leadership and Organisational Culture

The HPFT Leadership Academy has been successfully launched which will deliver three core programmes; Leading Yourself, Leading Others and Leading the Organisation, ensuring that the Trust continues to develop the capability of the workforce. In addition managers have been able to access a more defined area of development such as business skills and change management. Coaches are now undergoing accredited training and a group of managers have also trained in 360 degree feedback to further embed this throughout the organisation.

Leadership and management development opportunities have included input from keynote speakers covering areas such as customer focus, resilience and confident communication. A formal relationship has been developed with John Lewis PLC to promote joint opportunities between the organisation and embed a customer focused culture.

The Trust induction has been further improved to include a marketplace and one stop mandatory training option.

Sickness Absence Data - HPFT 1 April 2011 to 31 March 2012

Score together with a revised Attendance policy are proving to be useful tools for managers to support staff through their absence. Over the next 12 months, the Trust will look at further initiatives to reduce sickness absence including a review of the Occupational Health contract, investment in early intervention practices and better use of ESR data for managers.

Staff Group	FTE Days Available	FTE Days Sickness	% FTE Days Sickness
Add Prof Scientific and Technic	99338.73	4144.16	4.17
Additional Clinical Services	293784.94	22013.25	7.49
Administrative and Clerical	211142.27	8147.88	3.86
Allied Health Professionals	33323.14	818.64	2.46
Estates and Ancillary	11301.69	679.55	6.01
Healthcare Scientists	0	0	0
Medical and Dental	67151.12	858.55	1.28
Nursing and Midwifery Registered	330.618.45	18372.55	5.56
Students	1549.	87.	5.62
	1048209.33	55121.57	5.26

It is a Treasury FReM requirement that public bodies must report sickness absence data. The figures reported below relate to the calendar year 1 January to 31 December 2011.

Average FTE 2011	2,910
FTE days lost to sickness	34,163
FTE days available (average FTE 2011 x 225 days)	654,750
Average sick days per FTE	11.7
Average sickness absence % rate 2011	5.2%

Data produced by Department of Health

Staff Reward and Recognition

The Trust has refreshed the Annual Staff Awards and introduced the Customer Care Award in association with John Lewis, Welwyn. As well introducing the Chief Executive's awards in recognition for individuals who have made outstanding contribution or achievement. Following direct feedback from staff, the Trust has launched The Inspire Awards, as a mechanism for recognising staff who are enthusiastic and Innovative, provide excellent customer care and are an inspiration to others. This is a monthly award covering the business streams and corporate services. Winners of the monthly award are entered into the Annual Staff Award Ceremony.

Regulatory Ratings

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

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

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

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

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

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

The regulatory performance for Hertfordshire Partnership NHS Foundation Trust for 2011/12 is summarised as follows which also includes the previous year's ratings for comparison:

	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

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Green	Green	Green	Green

Section Two

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

1 April 2011 – 31 March 2012

FOREWORD TO THE FINANCIAL STATEMENTS

HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST

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

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

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

James Thackray
Assistant Director of Finance
Hertfordshire Partnership NHS Foundation Trust
99 Waverley Road
St Albans
Hertfordshire
AL3 5TL
Telephone number: 01727 804731



Signed

Mr Tom Cahill, Chief Executive

Date 23 May 2012

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED
31 March 2012**

		2011/12	2010/11 Restated
	note	£000	£000
Operating Income from continuing operations	4	211,684	212,204
Operating Expenses of continuing operations	5	(206,376)	(203,856)
OPERATING SURPLUS / (DEFICIT)		5,308	8,348
FINANCE COSTS			
Finance income	9	258	210
Finance expense - financial liabilities	9	(80)	(91)
Finance expense - unwinding of discount on provisions	9	(393)	(479)
PDC Dividends payable		(3,844)	(3,704)
NET FINANCE COSTS		(4,059)	(4,064)
SURPLUS / (DEFICIT) FOR THE YEAR		1,249	4,284
Other comprehensive income			
Impairments	13	(2,426)	(1,021)
Revaluations		370	4,881
Asset disposals		0	(42)
Other reserve movements		0	3,088
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		(807)	11,190

The surplus position for the financial year was £2,661k before accounting for impairments (£3,596k in 2010/11).

		2011/12	2010/11
		£000	£000
Financial performance for the year			
Surplus/(deficit) for the year		1,249	4,284
Impairments	13	1,412	92
Reversal of impairments		0	(780)
Adjusted retained surplus (deficit)		2,661	3,596

STATEMENT OF FINANCIAL POSITION
31 March 2012

	note	31 March 2012 £000	31 March 2011 Restated £000	1 April 2010 Restated £000
Non-current assets				
Intangible assets	10	158	265	372
Property, Plant and Equipment	11	136,154	138,951	131,015
Trade and other receivables	16	7,984	11,362	7,305
Total non-current assets		144,296	150,578	138,692
Current assets				
Inventories	14	15	13	12
Trade and other receivables	16	8,570	4,163	4,077
Non-current assets for sale and assets in disposal groups	15	0	491	0
Cash and cash equivalents	17	41,307	38,669	38,152
Total current assets		49,892	43,336	42,241
Current liabilities				
Trade and other payables	21	(22,199)	(21,295)	(23,105)
Borrowings	19	(156)	(156)	(156)
Provisions	20	(5,123)	(2,072)	(2,095)
Total current liabilities		(27,478)	(23,523)	(25,356)
Total assets less current liabilities		166,710	170,391	155,577
Non-current liabilities				
Borrowings	19	(654)	(729)	(795)
Provisions	20	(16,646)	(19,445)	(15,768)
Total non-current liabilities		(17,300)	(20,174)	(16,563)
Total assets employed		149,410	150,217	139,014
Financed by (taxpayers' equity)				
Public Dividend Capital	18	83,260	83,260	79,370
Revaluation reserve		47,366	50,420	47,559
Income and expenditure reserve		18,784	16,537	12,085
Total taxpayers' equity		149,410	150,217	139,014

The financial statements on pages 2 to 5, together with the notes on pages 6 to 43 were approved by the Board and signed on its behalf by:



Mr Tom Cahill, Chief Executive Date 23rd May 2012

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

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2011 (restated)	150,217	83,260	50,420	16,537
Surplus/(deficit) for the year	1,249	0	0	1,249
Transfers between reserves	0	0	(334)	334
Impairments	(2,426)	0	(2,426)	0
Revaluations - property, plant and equipment	370	0	370	0
Asset disposals	0	0	(664)	664
Public Dividend Capital received	0	0	0	0
Other reserve movements	0	0	0	0
Taxpayers' Equity at 31 March 2012	149,410	83,260	47,366	18,784

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED
31 March 2011**

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	Restated		Restated	Restated
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	139,014	79,370	47,559	12,085
Surplus/(deficit) for the year	4,284	0	0	4,284
Transfers between reserves	0	0	0	0
Impairments	(1,021)	0	(1,021)	0
Revaluations - property, plant and equipment	4,881	0	4,881	0
Asset disposals	(42)	0	(42)	0
Public Dividend Capital received	3,890	3,890	0	0
Other reserve movements	(789)	0	(957)	168
Taxpayers' Equity at 31 March 2011	150,217	83,260	50,420	16,537

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2012

	note	2011/12 £000	2010/11 £000
Net cash inflow from operating activities	23	10,063	8,909
Cash flows from investing activities			
Interest received	9.1	258	210
Purchase of Property, Plant and Equipment		(4,696)	(9,061)
Sales of Property, Plant and Equipment		1,149	220
Net cash generated from/(used in) investing activities		(3,289)	(8,631)
Cash flows from financing activities			
Public dividend capital received		0	3,890
Capital element of finance lease rental payments		(75)	(66)
Interest element of finance lease		(80)	(91)
PDC Dividend paid		(3,981)	(3,494)
Net cash generated from / (used in) financing activities		(4,136)	239
Increase/(decrease) in cash and cash equivalents	17	2,638	517
Cash and Cash equivalents at 1 April	17	38,669	38,152
Cash and Cash equivalents at 31 March		41,307	38,669

NOTES TO THE ACCOUNTS

1. Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2011/12 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Prior Period Comparatives

There has been a national exercise to restate 2010/11 final accounts for the impact of the removal of the Donated asset reserve and the Government grant reserve. Prior year comparatives have been amended to reflect the impact of this restatement.

1.3 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS FT's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of the revision and future periods, if the revision affects both current and future periods.

1.4.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below note 1.4.2) that management has made in the process of applying the NHS FT's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

True and Fair View

Foundation Trusts' financial statements should give a true and fair view of the state of affairs of the reporting body at the end of the financial year and of the results of the year. Section 393 of the Companies Act 2006 requires that Directors must not approve accounts unless they are satisfied that they give a true and fair view.

Going Concern

The Accounts have been prepared on the basis that the NHS FT is a going concern and will be in the foreseeable future.

Compliant with the NHS Foundation Trust Annual Reporting Manual

The Financial statements have been prepared in accordance with the 2011/12 Foundation Trust Annual Reporting Manual (FT ARM). The Accounting Policies contained in the FT ARM apply International Financial Reporting Standards as adapted or interpreted for an NHS Foundation Trust.

1.4.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year;

The NHS FT holds a provision for future pension liabilities of £13.9M. This amount has been set in accordance with the values provided for the schemes by the Pension Agency. These values are based upon the latest actuarial assumptions concerning the scheme provided as at 31st December 2011.

The detail of this and other provisions held can be found in note 20 to the Accounts.

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

1.5 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the NHS FT is from commissioners for health and social care services and the majority is provided under a Block Contract arrangement jointly commissioned by NHS Hertfordshire and Hertfordshire County Council.

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

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

Interest revenue is derived from balances held with the Government Banking Services and on short term deposits with commercial banks. All investments have been undertaken in accordance with the NHS FT's Treasury Management Policy.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.6 Employee Benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

Employers' pension cost contributions are charged to operating expenses as and when they become due.

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

Local Government Superannuation Scheme

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

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

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

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

1.7 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable for the goods and services received. Expenditure is recognised as an operating expense except where it results in the creation of a non current asset such as property, plant and equipment.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Measurement

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

The last full revaluation was conducted by the District Valuer, Giles Awford as at 31st March 2010. There was a subsequent desktop valuation as at 31st March 2011. Giles Awford has full membership of the Royal Institution of Chartered Surveyors (MRICS).

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

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

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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 or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
 - management are committed to a plan to sell the asset;
 - an active programme has begun to find a buyer and complete the sale;
 - the asset is being actively marketed at a reasonable price;
 - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. 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.

Donated, government grant and other grant funded assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve and a government grant creditor reserve are no longer maintained. Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Furniture and fittings with a net book value of £14k and IT equipment with a net book value of £5k are funded by Government Grant and form part of the PPE asset values recorded in note 11.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

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

1.9 Intangible Assets

Recognition

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

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the trust intends to complete the asset and sell or use it;
- the trust has the ability to sell or use the asset;

- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

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

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

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Foundation Trust as lessee

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Foundation Trust's surplus/deficit.

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS FT as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS FT's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the NHS FT's net investment outstanding in respect of the leases.

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

1.11 Inventories

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

1.12 Cash and cash equivalents

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

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

1.13 Provisions

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

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

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS FT has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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

A restructuring provision is recognised when the NHS FT has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Of the provisions totalling £14,302k (£17,456k as at 31 March 2011) for pensions and injury benefits, £8,317k (£11,929k as at 31 March 2011) of these are subject to "Back to Back" agreements with a consortium of North West London commissioners. These agreements are shown as NHS Receivables in the accounts of the NHS FT.

1.14 Clinical negligence costs

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

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

1.15 Non-clinical risk pooling

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

1.16 EU Emission Allowance Trading Scheme

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

1.17 Contingencies

Contingent assets

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

Contingent liabilities

Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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

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

Financial assets and financial liabilities held at fair value through profit and loss

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

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

Available for sale financial assets

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Fair value is determined by reference to quoted market prices where possible, otherwise at amortised cost, using the effective interest method.

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

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

1.18 Financial assets

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

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

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

1.19 Financial liabilities

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

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

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS FT's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.20 Corporation Tax

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

1.21 Value Added Tax

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

1.22 Foreign currencies

The NHS FT's functional currency and presentational currency is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

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

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS FT has no beneficial interest in them. Details of third party assets are given in Note 26 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS FT, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS FT during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.25 Losses and Special Payments

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

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses. The detail can be found in note 25.

1.26 Subsidiaries

For 2011-12 in accordance with the directed accounting policy from the Secretary of State, the NHS FT does not consolidate the NHS charitable funds for which it is the corporate Foundation Trustee.

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

1.27 Research and Development

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation

IAS 12 - Income Taxes (amendment) - subject to consultation

IAS 19 Post-employment benefits (pensions) - subject to consultation

IAS 27 Separate Financial Statements - subject to consultation

IAS 28 Investments in Associates and Joint Ventures - subject to consultation

IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13

IFRS 9 Financial Instruments - subject to consultation

IFRS 10 Consolidated Financial Statements - subject to consultation

IFRS 11 Joint Arrangements - subject to consultation

IFRS 12 Disclosure of Interests in Other Entities - subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

IPSAS 32 - Service Concession Arrangement - subject to consultation

1.29 Operating Segments

A business segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are different from those of other business segments. A geographical segment is engaged in providing products or services within a particular economic environment that is subject to risks and returns that are different from those of segments operating in other economic environments.

The NHS FT 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.

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

Notes to the Accounts - 2. Financial Risk Management

2 Financial Risk Factors

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

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

2.1 Credit risk

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

Note 16.3 shows the analysis of impaired debts and non-impaired debts which are past their due date.

2.2 Liquidity risk

The NHS FT's net operating costs are incurred under 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 internally generated resources and from any funds made available from the Government via Commissioners. The Trust is not, therefore, exposed to significant liquidity risks.

2.3 Cash flow and fair value interest-rate risk

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

Prudential Borrowing Limit (PBL)

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

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

	31 March 2012 £000	31 March 2011 £000
Long term borrowing limit set by Monitor	43,100	41,200
Working capital facility	13,000	13,000
Total Prudential Borrowing Limit	<u>56,100</u>	<u>54,200</u>

The NHS FT had no borrowings nor did it draw down any of its working capital facility in either 2011/12 or 2010/11.

The working capital facility is renewed on an annual basis and next falls due for renewal 31st July 2012.

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

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

A formal loan application has been approved by the Foundation Trust Financing Facility to part fund the likely future capital investment programme.

The NHS FT's compliance with the borrowing code ratios is as follows:-

2.5 Financial ratios

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

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

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

	Approved PBL ratios 2010/11	Actual ratio 2010/11	Headroom cover 2010/11 £000
Minimum dividend cover	>1	3.2	8,287
Minimum interest cover	>3	21.0	10,281
Minimum debt service cover	>2	18.9	10,719
Maximum debt service to revenue	<2.5%	0.3%	5,707

The NHS FT had a Tier 1 limit by Monitor, based on its 2010/11 Annual Plan submission.

3 Segmental Information

The NHS FT 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.

Notes to the Accounts - 4 Operating Income**4 Operating Income****4.1 Operating Income (by classification)**

Income is classified as "Income from Activities" when it is earned under contracts with NHS bodies and others for the provision of patient-related healthcare services. Income from non-patient-care services is classified as "Other operating income".

	2011/12 Total £000	2010/11 Total Restated £000
Income from Activities		
Cost and Volume Contract income	1,993	1,629
Block Contract income	183,987	182,074
Clinical Partnerships providing mandatory services (including S31 agreements)	907	1,777
Other clinical income from mandatory services	14,217	19,201
Total Income from Activities	201,104	204,681
Other operating income		
Research and development	223	230
Education and training	2,504	3,337
Charitable and other contributions to expenditure	5	0
Non-patient care services to other bodies	1,355	1,517
Other *	6,414	1,656
Rental revenue from operating leases	8	0
Profit on disposal of land and buildings	63	0
Reversal of impairments of Property, Plant & Equipment	0	780
Income in respect of staff costs where accounted on gross basis	8	3
Total Other operating income	10,580	7,523
Total Operating Income	211,684	212,204

* Analysis of Other Income (above)	2011/12 Total £000	2010/11 Total Restated £000
Staff accommodation rentals	60	74
Catering	1	0
Grossing up consortium arrangements	523	294
Transformation Funding	4,832	0
Other	998	1,288
Total	6,414	1,656

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

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

	2011/12 Total £000	2010/11 Total Restated £000
Income from Activities		
NHS Foundation Trusts	3	151
NHS Trusts	675	353
Strategic Health Authorities	177	158
Primary Care Trusts	26,968	26,151
Local Authorities	173,147	177,831
Bodies external to Government	134	37
Total Income from Activities	201,104	204,681

4.3 Analysis between Mandatory and Non-Mandatory Operating Income

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

	2011/12 £000	2010/11 Restated £000
Income from Activities - Mandatory Services	201,104	204,681
Other operating income - Non-Mandatory Services	10,580	7,523
	211,684	212,204

4.4 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 NHS FT's PPI cap is now set at £3,017,000 (£3,070,000 in 2010/11). No private patient income was generated in 2011/12 (none in 2010/11).

Notes to the Accounts - 4.3 Analysis between Mandatory and Non-Mandatory Income from Activities

4.5 Operating Lease Income

The NHS FT entered into a lease agreement for one of its properties (31/33 Hill End Lane) in 2011/12 under a non-cancellable operating lease agreement.

The total income from this operating leases in 2011/12 is £8k.

The future aggregate minimum lease payments due to the NHS FT under non-cancellable operating leases are as follows:

	2011/12 £000	2010/11 £000
on leases of Buildings expiring		
- not later than one year;	13	0
- later than one year and not later than five years;	52	0
- later than five years.	57	0
	<u>122</u>	<u>0</u>

Notes to the Accounts - 5 Operating Expenses**5 Operating Expenses****5.1 Operating Expenses (by type)**

	2011/12	2010/11
	£000	Restated £000
Services from NHS Foundation Trusts	726	385
Services from NHS Trusts	3,186	3,491
Services from PCTs	2,010	2,669
Purchase of healthcare from non NHS bodies	11,454	9,863
Employee Expenses - Executive directors	1,119	993
Employee Expenses - Non-executive directors	156	156
Employee Expenses - Staff	133,852	135,888
Drug costs	4,722	4,716
Supplies and services - clinical (excluding drug costs)	376	378
Supplies and services - general	5,282	4,754
Establishment	3,923	4,113
Transport	1,849	1,817
Premises	6,607	6,277
Increase / (decrease) in provision for impairment of receivables	108	(22)
Depreciation on property, plant and equipment	3,729	3,777
Amortisation on intangible assets	107	107
Impairments of property, plant and equipment	1,412	92
Audit services - statutory audit	68	68
Audit services - other services	23	18
Clinical negligence	303	366
Loss on disposal of land and buildings	5	17
Loss on disposal of assets held for sale	53	0
Legal fees	435	200
Consultancy costs	567	885
Training, courses and conferences	662	840
Patient travel	73	63
Car parking & Security	340	317
Redundancy*	3,238	321
Early retirements	827	226
Insurance	197	84
Other services, eg external payroll	4,533	5,625
Losses, ex gratia & special payments	25	37
Packages Of Social Care	14,183	14,046
Other	226	1,289
Total Operating Expenses	<u>206,376</u>	<u>203,856</u>

Notes to the Accounts - 5.2 Limitation on Auditor's Liability

5.2 Limitation on Auditor's Liability

The NHS FT'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.

5.3 Exit Packages

There were two exit packages paid to individuals in 2011/12 totalling £122k.

	*Number of compulsory redundancies	*Cost of compulsory redundancies
Exit package cost band (including any special payment element)		£000s
£25,001 - 50,000	1	38
£50,001 - £100,000	1	84
Total	2	122

Notes to the Accounts - 5.4 Salary and Pension Entitlements of Senior Managers

5.4 Salary and Pension Entitlements of Senior Managers

5.4.1 Remuneration

Name and Title	2011/12			2010/11		
	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind* (nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind* (nearest £00)
Hattie Llewelyn-Davies (Chair)	50 - 55	0	0	50 - 55	0	0
Bill Brown (Non Executive Director)	15 - 20	0	0	15 - 20	0	0
Manjeet Gill (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
Ruth Sawell (Non Executive Director)	15 - 20	0	0	15 - 20	0	0
Colin Sheppard (Non Executive Director)	15 - 20	0	0	15 - 20	0	0
Stephen Marsden (Non Executive Director)	15 - 20	0	0	15 - 20	0	0
Tom Cahill (Chief Executive)	150 - 155	0	63	150 - 155	0	60
Iain Eaves (Executive Director of Strategy & Organisational Development)	125 - 130	0	0	30 - 35	0	0
Keith Loveman (Executive Director of Finance & Performance)	110 - 115	0	42	30 - 35	0	30
Geraldine O'Sullivan (Executive Director Quality & Medical Leadership)	140 - 145	50 - 55	0	140 - 145	50 - 55	0
Stanley Riseborough (Executive Director of Service Delivery & Transformation) Retired March 2012	120 - 125	0	0	115 - 120	0	0
Karen Taylor (Chief Operating Officer) Appointed February 2012	10 - 15	0	0	115 - 120	0	33
Oliver Shanley (Executive Director of Quality & Safety)	120 - 125	0	56			
Barbara Suggitt (Company Secretary)	85 - 90	0	0	85 - 90	0	0
Anni Hartley-Walder (Director of Transformation) Appointed October 2011	45 - 50	0	0			
Harjinjer Kandola (Director of Human Resources and Workforce Development) Appointed October 2010	95 - 100	0	0	45 - 50	0	0
Band of highest paid director's total remuneration	150 - 155			150 - 155		
Median total remuneration	£28,527			£32,176		
Ratio	5.3			4.7		

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

Signed



Mr. Tom Cahill, Chief Executive 23rd May 2012

Notes to the Accounts - 5.4.2 Pension Benefits

5.4.2 Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer value at 31 March 2012	Cash Equivalent Transfer value at 31 March 2011	Real increase in Cash Equivalent Transfer value	Employer contribution to stakeholder pension in the year (nearest £000)
Tom Cahill	£000 0 - 2.5	£000 0 - 2.5	£000 65 - 70	£000 205 - 210	£000 1,153	£000 943	£000 114	£000 22
Iain Eaves	0 - 2.5	0 - 2.5	0 - 5	0	22	3	13	18
Keith Loveman	2.5 - 5	7.5 - 10	25 - 30	75 - 80	426	315	66	16
Geraldine O'Sullivan	0 - 2.5	5 - 7.5	50 - 55	160 - 165	1,073	908	84	20
Stanley Riseborough	2.5 - 5	7.5 - 10	60 - 65	190 - 195	1,316	1,138	85	17
Karen Taylor	0 - 2.5	0 - 2.5	15 - 20	55 - 60	250	153	6	2
Oliver Stanley	0 - 2.5	5 - 7.5	40 - 45	130 - 135	721	569	87	17
Barbara Suggitt	0 - 2.5	0 - 2.5	20 - 25	60 - 65	424	378	19	12
Anni Hartley-Walder	0 - 2.5	0 - 2.5	0 - 5	0	11	0	4	7
Hanjirler Kandola	0 - 2.5	5 - 7.5	25 - 30	80 - 85	429	324	62	14

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 for 23 March 2011, HM Treasury confirmed its intention to review the basis for the calculation of CETVs payable from public service schemes, including the NHS Pension Scheme. The review was undertaken and revised guidance was issued on 26 October 2011.

For the calculation of CETVs as at 31st March 2012, NHS Pensions have followed the revised guidance and have used the updated Government Actuary Department (GAD) factors in their calculations. The revised GAD factors are different to those used as at 31st March 2011 so direct comparison between financial periods is not possible.

The new factors will have differing impacts of the CETVs of the individuals concerned depending on their age and normal retirement age.

Signed



Mr. Tom Cahill Chief Executive 23rd May 2012

Notes to the Accounts - 6 Commitments under Operating Leases

6 Commitments under Operating Leases

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

The total expenditure on operating leases in 2011/12 is £2,191k comprising expenditure against minimum lease payments.

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

	31 March 2012	31 March 2011
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,844	2,163
- later than one year and not later than five years;	2,725	3,817
- later than five years.	961	1,277
Total	5,530	7,257

Notes to the Accounts - 7 Employee benefits**7 Employee benefits****7.1 The employee benefit expenses incurred during the year were as follows**

	2011/12	2010/11
	£000	£000
Salaries and wages	105,304	110,862
Social security costs	9,839	8,465
Pension cost - defined contribution plans (Employers' contributions to NHS Pensions)	13,437	12,241
Pension cost - other contributions	383	483
Termination benefits	4,065	547
Agency/contract staff	6,487	4,830
Total gross employee benefits	139,515	137,428
less income in respect of Salaries and wages where netted off expenditure	(385)	0
less income in respect of Social security costs where netted off expenditure	(34)	0
less income in respect of Pension cost where netted off expenditure - defined contribution plans Employers contributions to NHS Pensions	(60)	0
Total net employee benefits	139,036	137,428

Other pension costs relate to Hertfordshire Council's Local Government Pension Scheme. See Note 1.6.

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 liability is £795k (£958k net pension asset as at 31 March 2011). The amount chargeable to operating profit is £122k (£2,026k gain to operating profit as at 31 March 2011) and a loss of £1,995k (£5,462k gain as at 31 March 2011) recognisable in the Hertfordshire County Council Statement of Total Income and Expense.

Total employer pension contributions totalled £13,820k (£12,724k 2010/11)

7.2 Number of employees

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

	2011/12	2010/11
	FTE's	FTE's
Medical and dental	194	195
Administration and estates	613	635
Healthcare assistants and other support staff	694	749
Nursing, midwifery and health visiting staff	921	989
Scientific, therapeutic and technical staff	253	244
Social care staff	193	174
Bank and agency staff	515	507
Other	7	7
Total	3,390	3,500

Notes to the Accounts - 8 Better Payment Practice Code

7.3 Retirements due to ill-health

During 2011/12 there were 9 early retirements from the NHS FT on the grounds of ill-health with an estimated additional pension liability of £605k. In 2010/11 there were 11 early retirements on the grounds of ill-health with a liability of £654k. The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

8 Better Payment Practice Code

8.1 Better Payment Practice Code

The measure of compliance for 2011/12 has been analysed and can be found in the NHS FT's Annual Report on page 9.

8.2 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.

9 Finance Costs

9.1 Finance Income

	2011/12 £000	2010/11 £000
Interest receivable	258	210

9.2 Finance Expenses

	2011/12 £000	2010/11 £000
Finance leases	80	91
Unwinding of discount on provisions	393	479
Total	473	570

Notes to the Accounts - 10 Intangible Assets**10 Intangible Assets**

	2011/12 Software licences £000	2010/11 Software licences £000
Opening cost at 1 April	533	533
Additions - purchased	<u>0</u>	<u>0</u>
Gross cost at 31 March	<u>533</u>	<u>533</u>
Opening amortisation at 1 April	268	161
Provided during the year	<u>107</u>	<u>107</u>
Amortisation at 31 March	<u>375</u>	<u>268</u>
<u>Net book value</u>		
Purchased at 31 March (opening cost less opening amortisation)	265	372
Purchased at 31 March (gross cost less amortisation)	<u>158</u>	<u>265</u>

The economic life of these assets varies between 1 and 3 years.

£216k spend on the NHS FT's PARIS scheme is currently included as 'Additions' to Assets Under Construction (see note 11). This spend will be capitalised as an intangible asset when the asset is commissioned.

Notes to the Accounts - 11 Property, Plant and Equipment as at 31 March 2012

11 Property, Plant and Equipment

	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
11.1 Balances as at 31 March 2012								
Valuation/Gross cost at 1 April 2011	168,049	60,289	97,682	1,164	1,695	1,168	4,153	1,898
Additions - purchased	5,053	0	2,215	3	2,041	104	625	65
Impairments charged to the Revaluation Reserve	(2,426)	0	(2,426)	0	0	0	0	0
Reclassifications	0	0	958	0	(994)	36	0	0
Revaluation surpluses	370	0	370	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0
Disposals	(712)	(210)	(502)	0	0	0	0	0
Valuation/Gross cost at 31 March 2012	170,334	60,079	98,297	1,167	2,742	1,308	4,778	1,963
Accumulated depreciation & impairments at 1 April 2011	29,098	2,848	20,782	113	0	712	3,371	1,272
Depreciation provided during the year	3,729	0	3,095	35	0	112	380	107
Impairments charged to operating expenses	1,412	0	1,215	0	197	0	0	0
Disposals	(59)	0	(59)	0	0	0	0	0
Accumulated depreciation at 31 March 2012	34,180	2,848	25,033	148	197	824	3,751	1,379
Net Book Value - 31 March 2012								
Owned	135,057	57,231	72,409	1,019	2,335	484	1,027	552
Finance Lease	504	0	504	0	0	0	0	0
Donated	593	0	351	0	210	0	0	32
Net Book Value total at 31 March 2012	136,154	57,231	73,264	1,019	2,545	484	1,027	584
Protected assets	122,507	54,351	68,156	0	0	0	0	0
Unprotected assets	13,647	2,880	5,108	1,019	2,545	484	1,027	584
Total at 31 March 2012	136,154	57,231	73,264	1,019	2,545	484	1,027	584

Notes to the Accounts - Property, Plant and Equipment as at 31 March 2012

Property, Plant and Equipment

	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
11.2 Balances as at 31 March 2011								
Valuation/Gross cost at 1 April 2010	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
Transferred to disposal group as asset held for sale	4,881	1,345	3,488	48	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 & impairments at 1 April 2010	25,229	2,848	17,498	80	0	661	2,998	1,144
Depreciation 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
Disposals	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	138,377	57,441	76,326	1,051	1,695	456	782	626
Finance Lease	574	0	574	0	0	0	0	0
Donated	0	0	0	0	0	0	0	0
Net Book Value 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

Notes to the Accounts - 11.3 Disposal Of Property, Plant and Equipment**11.3 Disposal Of Property, Plant and Equipment**

	2011/12 £000	2010/11 £000
Profit on disposal of land and buildings	63	0

The Profit on disposal of land and buildings relates to the sale of The Firs, Norfolk.

	2011/12 £000	2010/11 £000
Loss on disposal of land and buildings	5	17
Loss on disposal of assets held for sale	53	0
	<u>58</u>	<u>17</u>

The Loss on disposal of land and buildings relates to the sale of 801 St Albans Road, Watford (Acorn House).

The Loss on disposal of assets held for sale relates to the sale of 35-37 Hill End Lane, St Albans (Pippin House).

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

12 Assets held under Finance Leases

	2011/12 £000	2010/11 £000
Opening cost at 1 April	<u>2,125</u>	<u>2,125</u>
Accumulated depreciation at 1 April	1,551	1,482
Provided during the year	<u>69</u>	<u>69</u>
Accumulated depreciation at 31 March	<u>1,620</u>	<u>1,551</u>
<u>Net book value</u>		
NBV total at 1 April	<u>574</u>	<u>643</u>
NBV total at 31 March	<u>505</u>	<u>574</u>

The NHS FT leases two premises under non-cancellable finance lease agreements. The leases have varying terms, escalation clauses and renewal rights. These premises are: Edinburgh House and 32 St. Peter's Street, both situated in St. Albans.

Notes to the Accounts - 13 Impairment of Assets (Property, Plant & Equipment and Intangibles)**13 Impairment of Assets (Property, Plant & Equipment and Intangibles)**

	2011/12 £000	2010/11 £000
Impairments of property, plant and equipment	1,412	92
Reversal of impairments of property, plant and equipment	0	(780)
Total impairments and reversal of impairments charged to the Statement of Comprehensive Income	1,412	(688)

Impairments of property, plant and equipment	2,426	1,021
Total impairment charged to the Revaluation Reserve	2,426	1,021

The impairment charge for 2011/12 follows an impairment review needed to re-establish the fair value of those assets where there had been significant capital expenditure due to the belief that the fair value post capital spend would be less than the book value. The total impairment was £3,838k of which £2,426k was offset against previous upward revaluations on those assets. The impairment charged to the Statement of Comprehensive Income is £1,412k.

14 Inventories

	31 March 2012 £000	31 March 2011 £000
Pharmacy stock	15	13
Total	15	13

The expense included in the Statement of Comprehensive Income for stock write off in 2011/12 is

15 Assets Held For Sale

	31 March 2012 £000	31 March 2011 £000
Net Book Value of non-current assets for sale and assets in disposal groups at 1 April	491	0
Plus assets classified as available for sale in the year	0	491
Less assets sold in year	(491)	0
Net Book Value of non-current assets for sale at 31 March	0	491

Notes to the Accounts - 16 Trade Receivables and other Receivables**16 Trade Receivables and other Receivables****16.1 Trade Receivables and other Receivables**

	31 March 2012	31 March 2011
	£000	Restated £000
Current		
NHS Receivables - Revenue	1,207	2,354
NHS Receivables - Capital	0	0
Other receivables with related parties - Revenue	3,185	844
Provision for impaired receivables	(450)	(344)
Prepayments (Non-PFI)	783	761
Accrued income	3,255	244
PDC dividend receivable	152	15
VAT receivable	262	0
Other receivables	176	289
Total current trade and other receivables	8,570	4,163
Non-Current		
NHS Receivables - Revenue	7,971	11,341
Other receivables	13	21
Total non-current trade and other receivables	7,984	11,362

NHS Receivables includes £8,317k as at 31 March 2012 (£11,929k as at 31 March 2011) relating to back to back pension provisions.

16.2 Provision for irrecoverable debts

	2011/12	2010/11
	£000	£000
At 1 April	344	430
Increase in provision	269	192
Amounts utilised	(2)	(64)
Unused amounts reversed	(161)	(214)
Balance at 31 March	450	344

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

	31 March 2012	31 March 2011
	£000	Restated £000
<u>Ageing of impaired receivables</u>		
Up to 30 days	5	44
Between 30 and 60 days	11	8
Between 60 and 90 days	2	9
Between 90 and 180 days	82	37
Over 180 days	350	246
Total	450	344
<u>Ageing of non-impaired receivables past their due date</u>		
Up to 30 days	255	862
Between 30 and 60 days	37	81
Between 60 and 90 days	44	102
Between 90 and 180 days	70	35
Over 180 days	77	467
Total	483	1,547

Notes to the Accounts - 17 Cash and cash equivalents**17 Cash and cash equivalents**

	2011/12 £000	2010/11 £000
Cash and Cash equivalents at 1 April	38,669	38,152
Net change in cash and cash equivalents	2,638	517
Cash and Cash equivalents at 31 March	41,307	38,669
Comprising:		
Cash at commercial banks and in hand	16	0
Cash with the Government Banking Service*	41,291	38,669
	41,307	38,669

*Royal Bank of Scotland and Citibank are collectively known as the Government Banking Service.

18 Public Dividend Capital

	2011/12 £000	2010/11 £000
Taxpayers' Equity at 1 April	83,260	79,370
Public Dividend Capital received	0	3,890
Taxpayers' Equity at 31 March	83,260	83,260

Public Dividend Capital received in 2010/11 related mainly to the transfer to the NHS FT of land at Kingsley Green (Harperbury).

19 Finance Lease Obligations

	31 March 2012 £000	31 March 2011 £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.	355	512
Gross lease liabilities	1,134	1,291
Less: Finance charges allocated to future periods	(324)	(406)
Net lease liabilities	810	885
Split into current and non-current borrowings on the Statement Of Financial Position:		
- current	156	156
- non current	654	729
	810	885
Expected timing of cashflows:		
- not later than one year;	87	76
- later than one year and not later than five years;	442	402
- later than five years.	281	407
	810	885

Details of Finance Leases are included in note 12.

Notes to the Accounts - 20 Provisions for liabilities and charges (held in current and non-current liabilities)

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

20.1 Provisions for liabilities and charges (held in current and non-current liabilities) 2011/12

	Total	Pensions relating to other staff	Other legal claims	Agenda for Change	Continuing care	Redundancy	Injury Claims
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2011	21,517	16,723	90	2,334	1,635	0	735
Change in the discount rate	0	0	0	0	0	0	0
Arising during the year	5,306	935	178	421	671	3,092	9
Utilised during the year	(4,091)	(3,967)	(21)	(20)	(46)	0	(37)
Reversed unused	(1,356)	(164)	(35)	(207)	(625)	0	(325)
Unwinding of discount	393	382	0	0	0	0	11
Total at 31 March 2012	21,769	13,909	212	2,528	1,635	3,092	393
Expected timing of cashflows:							
- not later than one year:	5,123	716	212	421	664	3,092	18
- later than one year and not later than five years:	6,013	2,863	0	2,107	971	0	72
- later than five years:	10,633	10,330	0	0	0	0	303
Total	21,769	13,909	212	2,528	1,635	3,092	393

The 'Pensions relating to other staff' provision is the capitalised cost of early retirements as defined by the NHS Pensions Agency. This mainly relates to early retirements of staff resulting from the closure of Hill End, Leavesden, Cell Barnes and Harperbury Hospitals.

The 'Pensions relating to other staff' and 'injury claims' provisions together total £14,302k (£17,458k as at 31 March 2011). Of this £8,317k (£11,929k as at 31 March 2011) 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 'Other legal claims' provision includes provisions in respect of the NHS FT's employer and public liabilities, the amount stated is subject to uncertainty about the outcome of legal proceedings. £3,032k (£1,918k as at 31 March 2011) is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the NHS FT.

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

The 'Continuing care' provision comprises outstanding Continuing Care appeals.

The 'Redundancy' provision is the estimated liability for redundancies.

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.

Notes to the Accounts - 20.2 Provisions for liabilities and charges (held in current and non-current liabilities) 2010/11

20.2 Provisions for liabilities and charges (held in current and non-current liabilities) 2010/11

	Total £000	Pensions relating to other staff £000	Legal and other claims £000	Agenda for Change £000	Injury Claims £000
At 1 April 2010, as restated	17,863	12,289	1,807	2,539	1,228
Arising during the year	7,933	6,684	603	628	18
Utilised during the year	(1,096)	(918)	(142)	0	(36)
Reversed unused	(3,662)	(1,791)	(543)	(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

Note in 2010/11 the 'Legal and other Claims' balances combined 'Continuing Care' and 'Other legal claims' which are disclosed separately in 2011/12.

Notes to the Accounts - 21 Trade and other payables**21 Trade and other payables**

	31 March 2012 £000	31 March 2011 Restated £000
Current		
Receipts in advance	899	1,604
NHS payables - revenue	2,051	1,915
Amounts due to other related parties - revenue	1,921	3,071
Other trade payables - capital	641	284
Social Security costs	1,338	1,313
Other taxes payable	1,486	1,518
Other payables	5,493	2,895
Accruals	8,370	8,695
Total current Trade and other payables	<u>22,199</u>	<u>21,295</u>

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

£1,576k as at 31 March 2012

£1,606k as at 31 March 2011

22 Financial assets and liabilities**22.1 Financial assets by category**

	31 March 2012 £000	31 March 2011 £000
NHS Receivables	5,447	3,442
Provision for irrecoverable debts	(450)	(344)
Other Receivables	176	289
Cash and cash equivalents (at bank and in hand) at 31 March	41,307	38,669
Total at 31 March	<u>46,480</u>	<u>42,056</u>

22.2 Financial liabilities by category

	31 March 2012 £000	31 March 2011 Restated £000
Obligations under finance leases	810	885
NHS payables	2,051	1,915
Trade and other payables	5,214	5,966
Accruals	8,370	8,695
Capital payables	641	284
Provisions under contract	4,375	4,062
Total at 31 March	<u>21,461</u>	<u>21,807</u>

Notes to the Accounts - 22.3 Fair value of financial assets**22.3 Fair value of financial assets**

	Book value £000	Fair value £000
NHS Receivables	5,447	5,447
Provision for irrecoverable debts	(450)	(450)
Other Receivables	176	176
Cash and cash equivalents (at bank and in hand) at 31 March 2012	41,307	41,307
Total at 31 March 2012	46,480	46,480
NHS Receivables	3,421	3,421
Provision for irrecoverable debts	(344)	(344)
Other Receivables	310	310
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

22.4 Fair value of financial liabilities

	Book value £000	Fair value £000
Obligations under finance leases at 31 March 2012	810	689
NHS payables	2,051	2,051
Trade and other payables	5,214	5,214
Accruals	8,370	8,370
Capital payables	641	641
Provisions under contract at 31 March 2012	4,375	4,375
Total at 31 March 2012	21,461	21,340
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

Notes to the Accounts - 23 Reconciliation of operating surplus to net cash flow from operating activities**23 Reconciliation of operating surplus to net cash flow from operating activities**

	2011/12		2010/11 Restated	
	£000	£000	£000	£000
Operating Surplus		5,308		8,348
Non cash flow movements:				
Depreciation and amortisation	3,836		3,884	
Impairments	1,412		92	
Reversals of impairments	0		(780)	
Unwinding of discount on provisions	(393)		(479)	
		4,855		2,717
Movement in Working Capital:				
(Increase) / Decrease in inventories	(2)		(1)	
(Increase) / Decrease in receivables	(893)		(3,902)	
Increase / (Decrease) in trade and other payables	547		(1,912)	
Increase / (Decrease) in other liabilities	0		(8)	
		(348)		(5,823)
Increase / (Decrease) in provisions		252		3,654
Net (gain) / loss on disposal of PPE		(4)		13
Net cash inflow from operating activities		10,063		8,909

Notes to the Accounts - 24 Related Party Transactions**24 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 NHS FT.

Remuneration of key management is disclosed in note 5.4.1

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

2011/12	Income from Related Party	Expenditure payments to Related Party	Receivables from Related Party	Payables to Related Party
	£000	£000	£000	£000
<u>Central Government</u>				
National Health Service Pension Scheme	0	0	0	1,795
National Insurance Fund	0	0	0	1,337
HMRC - other taxes & duties	0	0	0	1,502
Other Central Government	0	201	262	0
<u>NHS</u>				
Department Of Health	71	3,529	21	41
East of England Strategic Health Authority	2,452	2	0	0
NHS Barnet	527	52	1,305	0
NHS Brent	510	34	1,042	0
NHS Ealing	909	0	1,379	0
NHS Hammersmith & Fulham	0	0	679	0
NHS Hertfordshire	3,596	2,213	2,941	1,495
NHS Hillingdon	124	0	1,062	0
NHS Hounslow	872	0	896	0
NHS Norfolk	2,046	0	30	0
NHS North East Essex	7	864	12	55
NHS South East Essex	6,361	288	4	38
NHS West Essex	11,506	302	3	220
NHS Westminster	2	0	1,495	0
East & North Hertfordshire NHS Trust	82	2,141	10	156
West Hertfordshire Hospitals NHS Trust	1,195	2,264	53	104
Other NHS	5,032	2,781	1,148	504
<u>Local Government</u>				
Barnet London Borough Council	1,674	0	128	0
Hertfordshire County Council	171,627	958	2,692	650
Norfolk County Council	424	2	424	0
Westminster City Council	676	0	5	0
Other Local Government	1,251	1,114	289	197
Totals	210,944	16,745	15,880	8,094

The NHS FT 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 1.23).

Notes to the Accounts - 25 Losses and Special Payments

25 Losses and Special Payments

There were 87 cases (64 cases in 2010/11) of losses and special payments totalling £25k (£37k in 2010/11) paid during 1st April 2011 to 31 March 2012. These are the cash payments made in the year and are not calculated on an accruals basis.

26 Third Party Assets

The NHS FT held £2,383k cash at bank and in hand at 31st March 2012 (£2,336k at 31st March 2011) which relates to monies held by the NHS FT on behalf of service users. This had been excluded from the cash and cash equivalents figure reported in the accounts.

27 Post Balance Sheet Events

There are none.

28 Contingencies

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.

The contingent liability is in respect of the potential to pay excesses to the NHS Litigation Authority in respect of current and ongoing LTPS scheme claims and is per the advice received from the NHS Litigation Authority.

	31 March 2012 £000	31 March 2011 £000
Value of contingent liabilities	<u><u>(110)</u></u>	<u><u>(29)</u></u>

29 Commitments under capital expenditure contracts

	31 March 2012 £000	31 March 2011 £000
Property, Plant and Equipment	503	0
Intangible Assets	332	332
Total as at 31 March	<u><u>835</u></u>	<u><u>332</u></u>

The commitment as at 31 March 2012 relates mostly to the Kingsley Green capital development and to a contract for the new care records system (PARIS).



**Annual Governance Statement
April 2011 - March 2012**

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 2012 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 Leadership of the risk management process

As Accounting Officer, I am ultimately accountable for assuring the Board of the quality of the service provided by the Trust. This is achieved operationally through the delegation of the responsibility of executive lead for Risk Management (except for financial risk) to the Executive Director, Quality and Safety who also works with the officers responsible for ensuring, through the Risk Management Framework, that all Risk Management policies and procedures are in place and are competently used. The Trust's Risk Management Strategy approved by the Trust Board clearly defines levels of responsibility for Risk Management across the organisation and summarises the extensive tools and training available. The risk management process within the Trust is further underpinned by a robust Risk Management Policy. This policy describes the procedure for assessing, prioritising and managing all types of risk within the organisation. The Trust Risk Register forms an integral part of this and defines the process for grading and managing (or minimising) the organisations key operational and business risks. The highest level risks are reviewed regularly by the Trust Board.

3.2 Training in the management of risk

Staff are equipped to assess and manage risk through training in the use of the Risk Management Policy and Procedure which is cascaded to all staff via the Senior Managers, Professional Leads and Team Leaders and progress is monitored through the usual supervision /performance management process. Mandatory Training in Clinical Risk Management is also provided to all staff who work directly with service users, as they must be competent in recognising, assessing and managing the risks which our service users present to themselves and to others.

3.3 Learning from good practice

Analysis of 'adverse events' and sharing this intelligence through our extensive Practice Governance Framework to improve services across the Trust, is a key aspect of our approach to managing risk through service improvement. Our learning and development teams provide regular opportunities for all our staff to attend training updates and refresher programmes where these are deemed appropriate, or necessary, by line managers.

A Learning Lessons Newsletter outlining good practice and lessons learned is sent to all staff linked with the weekly distribution of HPFT News. The document is intended to prompt discussion and action within Teams.

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** and later in the year **the Chief Operating Officer** is responsible for the day to day management of risk within operational services.

A number of other senior officers assist with these responsibilities and there are a variety of systems in place to enable those responsible to identify, assess, prioritise and control hazards and all types of risks on a regular and ongoing basis, listed in the Risk Management Strategy.

4.3 Integrated Governance Risk Management is one of the building blocks of Integrated Governance and the Trust's committee structure integrates Risk Management and other forms of Governance into a single structure. The Integrated Governance Committee is the central driving force for the Risk Management Strategy and the Trust's internal control mechanisms, regularly reporting to the Trust Board on the risks being faced by the organisation and how they are being managed/controlled.

Regular discussions take place at board meetings concerning the Trust's appetite for risk, determining the strategic parameters within which decisions involving various types of risk, can then be made on a sound consistent basis.

4.4 The Board Assurance Framework and the Risk Register are the key tools to facilitate and monitor the effects of systematic action plans to control and minimise identified risks. They are central planks in the System of Internal Control.

The Board Assurance Framework (the BAF) specifically identifies potential risks to the achievement of each of the Trust's Strategic Goals and monitors the systematic controls in place to protect against them. The BAF acts as a major assurance tool by detailing the independent sources and methods of assurance used to objectively measure the effectiveness of the controls being used to minimise the risk of not achieving the Trust's strategic objectives. The Board Assurance Framework is formally reviewed 4 times a year. Two of these are full reviews reported to the Integrated Governance Committee, and to the Audit Committee which challenges the Controls and assurance processes in order to assure the Board that they are working effectively as part of the Internal Systems of Control. The other two, routine quarterly reviews, are reported solely to the Integrated Governance Committee.

The Risk Register operates at several levels within the organisation and enables local Service Managers, Senior Managers and the Executive Team on behalf of the Board, to plan and monitor mitigating actions taken to reduce risks of all types. The moderate and high risks and the overall process is monitored and reviewed by the Integrated Governance Committee with key categories of risk being a focus of relevant Sub Groups.

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

The Trust continues to monitor the risks to information, there have been no SIRI's relating to potential or actual breaches of confidentiality involving person identifiable data assessed above a level 2 (in accordance with the DOH Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents Jan 2010).

NHS Trusts are required to reach Level 2 in all areas of the Information Governance Toolkit (IGT). This is a national directive from the Department of Health and Connecting for Health. HPFT met Level 2 in all areas of the Toolkit.

The Trust has commissioned three external audits since March 2011, measuring 29 of the 45 requirements at Level 2 (or above). The 16 requirements which have not yet been audited externally have been internally assessed at Level 2. Further audits are planned during 2012-13 to provide external assurance that the Trust is fully compliant in all areas of the IGT.

4.7 The Organisations current major Risks.

The Top Three Risks on the Trust Risk Register at this time are managed and controlled via the Risk Register mechanisms described in section 4.4. They are current 'in-year' risks but in all 3 cases will continue into the future (ie. 2012-13). The risks are:

- **RISK 1 - Risk of Prosecution by the Health & Safety Executive**

Whilst the Trust accepts no liability in the matter and has entered a not guilty plea, there is a recognised risk to the Trust should an adverse judgement arise in association with a prosecution in the Crown Court, by the HSE, under the Health & Safety at Work Act 1974, in relation to a homicide in 2007.

In relation to any adverse judgement, there is potentially a high risk of adverse publicity affecting the Trust reputation and a possible sanction of a potentially unlimited fine. This could furthermore result in increased inspections, vigilance and Enforcement Actions from the HSE & CQC which will in turn affect the Trust's ability to win & retain business.

Key Mitigating Actions are: a full investigation/review of services following the incident and actions taken to implement the recommendations. Legal representation has been commissioned and indemnity agreed by NHSLA. A not guilty plea has been entered.

BAF Systems of Internal Control: there are also a number of Control Systems recorded in the BAF designed to counter the risk of being unable to grow by winning further business.

- **RISK 2 – Risk that the exceptional financial challenges facing us, cannot be managed**

There is a risk that we fail to break even due to the continued financial challenges across the next three years of the planning cycle with specific additional risks at present concerning:

- a) Possible one off transitional costs
- b) Possible loss of business as competition increases
- c) Possible failure to deliver required cash releasing efficiency savings

Key Mitigating Actions are: Ongoing negotiations with commissioners for access to transformation funds they hold. A Programme Management Office process has been introduced to assist in the management of service transformation and cash releasing efficiency savings.

BAF Systems of Internal Control: there are also a number of Control Systems recorded in the BAF designed to counter the risk of potentially not sustaining income or managing expenditure and thus failing to achieve financial targets.

- **RISK 3 – Risk that the re-provision of Acute In patient services on the Kingsley Green site will fail**

The planning and design of a new acute in patient unit on the Kingsley Green Site carries a number of risks specifically at present:

- a) Increased financial costs may be caused by delays in the building programme
- b) Risk that the poor environment in our present units significantly impacts on the quality, safety and the whole experience for service users
- c) Further delays could lead to reduced standards of care and potential loss of business
- d) Risk of not achieving Planning Permission, or it taking much longer than planned
- e) Risk that the interdependencies of all our 24 hour services are so complex that the whole service is adversely affected/de-stabilised by the re-provision and the planned improved clinical outcomes are not achieved

Key Mitigating Actions are: Specific members of the Project Team, Design Team & Clinical Groups involved in the Project, are approaching our current and future 24 hour services holistically, enhancing the current care environments in the short term as well as the new build. They are also involved in consultation exercises and learning from our current services and environments with current staff to avoid adverse events for example & improve care.

BAF Systems of Internal Control: there are also a number of Control Systems recorded in the BAF designed to counter the risk of failing to deliver recovery orientated, clinically effective, & best value services within an environment of reduced resources and new financial pressures

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.
- Communication Links between the Local & Trust Risk Register: i.e. Local Service Risk Registers can refer risks to the Trust RR at any time in a quarterly cycle. Risks can also be referred back from the TRR to the Local Service RR 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.
- The development of the new Policy Management System including Policy Website.

The successful attainment of Level 2 of the NHSLA Risk Management Standards when formally assessed in September 2011, demonstrates that the organisation has well developed and implemented policies which can now be evidenced as forming part of the Trusts Risk Management systems of internal control.

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. The Board of Governors who represent public membership also look at key risks through their Quality and Performance Groups.

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 Carbon Reduction. The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that, together with Hertfordshire County Council, this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

5.1 The key financial policies and processes

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

The effective and efficient use of resources are governed by the following key policies

- Standing Orders
- Standing 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 the Counter Fraud Service, and reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

6. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2011 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust 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:

- Provision of appropriate training to all staff including all new starters.
- Elimination where possible of manual approaches to data gathering and analysis, including investment in new systems.
- Audit of supervision to gain assurance that the process is robust in relation to data quality.
- Further development of more robust audit trails regarding decisions about data, with random checks by the Complaints and Customer Experience Manager of data reported by her team introduced in 2011.
- Incident data reporting made fully electronic from December 2011
- Extension of the contracts of data quality officers reporting to the Performance Improvement team recruited to work alongside teams to assist in full and accurate use of the electronic patient record system.

The accuracy of information for quality reports is assessed via:

- Systematic checks within the Informatics and Performance Improvement Teams themselves.
- Scrutiny of quarterly reports at Board, with any errors and/or corrections being duly noted.
- Annual internal audit.
- Annual External Audit Assurance as mandated by Monitor.

Systems and processes have been further improved with the introduction of a Data Quality Steering Group chaired by the Informatics team manager with representation from across the Trust. This group ensures the Trust is compliant with relevant information governance standards. It will ensure that the new electronic patient record (PARIS) due to be introduced in 2012/2013 facilitates accurate data inputting by frontline staff.

The quality metrics contained in quarterly Board reports are agreed before the start of the financial year by Board after a period of internal and external consultation. The quality metrics – their accuracy and relevance and progress on each – are reviews quarterly at these Board meetings. Further description of these processes is given in the quality report itself.

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.

7. Review of effectiveness

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

The process for maintaining and reviewing the effectiveness of the system of internal control involves review of all the mechanisms described particularly in section 4 of this statement (the risk and control framework).

The Trust response to any significant internal control issues or gaps in control is to assess and register the risk and develop and implement suitable mitigating actions, linking to the control mechanisms recorded in the BAF if necessary. Regular monitoring is built into the process.

The high level co-ordination and monitoring of the whole internal control system is mainly achieved through the following:

- **The Trust Board** places reliance upon the Audit Committee for assurance in respect to the soundness of the system of internal control, via regular reports concerning the Risk Register and Board Assurance Framework.
- **The Integrated Governance Committee** is responsible for ensuring that the Trust fulfils its governance and associated risk management duties. Regular reports are made to the Board on the management of the most serious risks on the Trust Risk Register and all aspects of risk management and the Board Assurance Framework.
- **The Audit Committee's** primary role is to independently oversee the governance and assurance process on behalf of the organisation and to report to the Trust Board on the soundness and effectiveness of the systems in place for risk management and internal control. In order for the Audit Committee to provide this assurance to the Board, Internal Audit undertake objective reviews of the Trust systems.

- **The Finance and Investment Committee** 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
- **The Practice Audit & Clinical Effectiveness Team** provide a variety of resources to support clinical teams to undertake practice audit in the context of the trusts strategic goals. Overseen by the Integrated Governance Committee, an Annual work programme is developed inclusive of clinical and regulatory requirements, and the outcomes are reported to the Board at year end.
- **Other assurance mechanisms** are accessed by commissioning external expertise and advice on specific areas of concern as appropriate.
- **Internal Audit** review the system of internal control during the course of the financial year and report accordingly to the Audit Committee.

The Head of Internal Audit has stated in the draft HOIA Opinion that "based on the work undertaken in 2011-2012, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk."

The weaknesses identified were specifically in the area of controls surrounding expenditure on capital schemes and additional controls have been implemented during 2011/12 to address these.

- **Monitor** monitors the Trust's Performance.

8. Conclusion

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

Signed 
 Tom Cahill, Chief Executive
Date 25 05 12



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

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

Under the NHS Act 2006, Monitor has directed the Hertfordshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Hertfordshire Partnership NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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

Signed.....
Tom Cahill, Chief Executive
Date: 23 May 2012

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 2012 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.

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. In addition, I read all the financial and non-financial 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.

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's affairs as at 31 March 2012 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 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 report to you if, in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

Certificate

I certify that I completed the audit of the accounts of 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: 29 May 2012

Mark Hodgson

Officer of the Audit Commission

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

**INDEPENDENT AUDITORS' REPORT TO HERTFORDSHIRE
PARTNERSHIP NHS FOUNDATION TRUST ON THE NHS FOUNDATION
TRUST CONSOLIDATION SCHEDULES**

I have examined the NHS foundation trust consolidation schedules (FTCs) numbered 1 to 40 of Hertfordshire Partnership NHS Foundation Trust for the year ended 31 March 2012, which have been prepared by the Executive Director – Finance and Performance Improvement and acknowledged by the Chief Executive.

This report is made solely to the Board of Hertfordshire Partnership NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. 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.

In my opinion these consolidation schedules are consistent with the statutory financial statements on which I have issued an unqualified opinion .

Date: 29 May 2012

.....
Mark Hodgson
Officer to 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 innej formie lub innym języku. Informacji w tej sprawie udziela: Patient Advice & Liaison Service:
Tel: 01727 804629, Fax: 01727 804967
(Polish)

Se avete bisogno di queste informazioni in una lingua o in un formato differente, vi preghiamo di contattare: Patient Advice & Liaison Service (Servizio relazioni e consigli per i pazienti)
Tel: 01727 804629, Fax: 01727 804967.
(Italian)

اگر آپ کو یہ کسی دوسری زبان میں یا کسی دوسرے طریقہ سے درکار ہو تو براہ مہربانی ذیل سے رابطہ کریں:

ہیڈنٹ ایڈوائس اینڈ لیاؤن 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