NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Annual Report and Accounts 2018 – 2019

as one

Our values
Welcoming Kind Positive Respectful Professional

Hertfordshire Partnership University NHS Foundation Trust

Annual Report and Accounts 2018-2019

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

Contents

Foreword

This Report sets out how the Trust has performed over the last year, including the key risks to the achievement of our aims and aspirations and the progress we have made towards these.

The Annual Report has been prepared on the same 'group' basis as the accounts and provides a fair, balanced and understandable analysis of how the Trust performed in 2018/19. The Report provides the necessary information for patients, regulators and other stakeholders to assess the performance, business model and strategy of the Trust.

The accounts within the Report are prepared in accordance with paragraphs 24 and 25 of Schedule 7 of the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Chris Lawrence, Chair
Dated: 22 May 2019

Tom Cahill, Chief Executive
Dated: 22 May 2019

1 Performance Report

1.1 Performance Overview

1.1.1 Introduction

This Report sets out how the Trust has performed over the last year, including the key risks to the achievement of our aims and aspirations and the progress we have made towards these aims.

This report on the Trusts performance provides a fair, balanced and understandable analysis of how the Trust performed in 2018/19.

Our Trust is a provider of mental health and learning disability services and is committed to providing excellent health and social care for people with mental ill health, with physical ill health, and those with learning disabilities.

We have been an NHS Foundation Trust since our authorisation in August 2007 and continue to value the opportunities that this provides in building upon, and improving, our services. These include:

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

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

Our Vision, Mission and Good to Great strategy

Our Vision, Mission and Strategy were developed together with our service users and their carers.

Our Vision: Delivering great care and great outcomes – together

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

The Trust is now focussed on progressing its journey from ***Good to Great.***

In 2016, we launched our Good to Great strategy to service users, partners and staff. It articulates the ways we want to deliver the highest quality services and become an outstanding Trust. We are working towards this vision by focussing on four themes that will underpin our working during 2019/20.

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

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

Our Vision is underpinned by seven objectives across the four themes of the 'Good to Great' strategy:

Great Care, Great Outcomes

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

Great People

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

Great Organisation

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

Great Networks and Partnerships

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

This performance report covers the year ending 31 March 2019.

Performance Overview from Chief Executive and Chair

The 12 months to March 2019 represented the third year of our five-year Good to Great strategy, which was launched in April 2016. It puts our service users and their families at the heart of everything we do in developing services that are in line with their needs. The strategy guides our work around the key areas of great care, great people, great organisation and great partnerships. This annual report looks at how we have worked to deliver our strategy.

Every year brings with it challenges and opportunities, not least an inspection from the Care Quality Commission (CQC). Our inspectors arrived in February 2019, resulting in a final report being published in May 2019 that saw the Trust achieve an overall rating of outstanding, which included being rated as Outstanding for quality of care and being a well-led organisation.

In addition, our forensic inpatient/secure wards, child and adolescent mental health wards, wards for people with a learning disability or autism and community-based mental health services for adults of working age were all judged as being outstanding. This means that four of the 11 services inspected by the CQC are now rated as outstanding, with the remaining seven judged as being good.

Once again, the CQC recognised the commitment of all our staff in living the Trust's values and demonstrating leadership at every level. At the same time, our strong safety culture was demonstrated through this year's National NHS Staff Survey results where we achieved the top score in the country.

It is this leadership of all our dedicated and hardworking staff that has enabled us to perform well against increased demand for our services, allowing our staff to continue delivering great care and great outcomes for over 400,000 people across four counties. Examples of this work are the successful launch of several new initiatives, including a co-produced transformational learning disability model across Essex, our new Tier 4 services for children and adolescent mental health services (CAMHS) and the new psychosis pathway.

To help our staff deliver continued high-quality care to our service users and build on our outstanding rating, we received a number of recommendations from the CQC. This included staff receiving regular, good quality supervision within older people's services and ensuring all service user rooms are fitted with call bells.

2018/19 saw further improvements made to our information management systems, including the roll-out of SPIKE2 and Discovery – respectively our performance management information and learning management systems. Last year also saw the launch of the Trust's Innovation Hub, which allows staff to use specialist facilitation to look at how services can be changed or reorganised in new ways for the ultimate benefit of those who use them.

Providing great care relies on having great people and like most organisations across the NHS, we continue to face significant challenges in terms of recruiting and retaining staff. Last year, however, was our most successful ever when it comes to attracting new staff – a trend we will work to improve upon, helped in considerable measure by our outstanding CQC rating.

Not only did we recruit more staff last year, by changing and streamlining our processes we also managed to reduce the time taken between a post being advertised and someone starting their career with Hertfordshire Partnership University NHS Foundation Trust (HPFT). At the same time, we placed equal focus on retaining our staff through a wide range of initiatives from improving well-being and finding better ways to support career progression.

Initiatives such as our buddy scheme for new starters, wider access by our teams to HR surgeries and making it easier for staff to transfer between services will, between them, help us reduce our vacancy levels even further.

The Trust reports its performance to NHS Improvement through the latter's Single Oversight Framework, which was first introduced across the English NHS in October 2016. The framework seeks to identify the support that providers such as HPFT may or may not need in relation to: quality of care; finance and use of resources; operational performance; strategic change; and leadership and improvement capability. Our performance against

each of these areas is picked up in more detail in the rest of this section of the annual report, but there are a few areas that need highlighting here.

A major factor challenge is the rise in demand that our services are experiencing currently – in particular mental health. Although this reflects a trend that is happening nationally, the pressures this places on our frontline clinical teams is significant. For example between April 2018 and March 2019, there was a 25% increase in referrals to our Single Point of Access (SPA) service, with CAMHS experiencing nearly 50% more referrals over the same time period. Despite these pressures, our performance against the key performance indicators (KPIs) agreed with our commissioners - which include meeting national access standards – has remained consistent. Overall there was a net improvement in the number of KPIs where we were meeting the set standards, which is a reflection of the commitment of our staff to delivering timely, great care to our service users.

Our Board members have continued to deliver strong and responsive leadership, for which we are grateful. Our Governors, who continue to play an important role in linking with the communities we serve and ensuring that the needs of service users and the wider population are always at the heart of everything we do, are also deserving of our thanks.

We believe the effective partnerships and relationships we have continued to build upon in 2018/19 remain key to tackling the challenges that we all face. Perhaps one of the strongest indicators of that successful approach is that our commissioners in Essex and Hertfordshire have given us contracts for the next seven and five years respectively, with those for Buckinghamshire and Norfolk also renewed. This achievement provides us with a stable environment in which to plan how we can make our services even better going forward.

Part of that work will be our continuing to play a full part in the local health and social care economies, by promoting greater integration between mental and physical health and social care in the following ways:

- We work closely with commissioners across the four counties that we serve. Our largest contract, which has just been renewed for a further five years, involves working with East and North Herts CCG, Herts Valleys CCG and Hertfordshire County Council to deliver integrated health and social care services;
- Leading the development of A Healthier Future, the Sustainability and Transformation Plan (STP) for Hertfordshire and West Essex, ensuring that mental health continues to be at the heart of the STP's work as it transitions to become an Integrated Care Organisation (ICO) as set out in the NHS Long Term Plan;
- Through being a University Trust, continuing our close links with the University of Hertfordshire in strengthening our clinical research and providing excellent learning and development opportunities for staff; and
- Working with our partners to deliver integrated services to support and care for people holistically, through managing people's mental and physical health together. We are also working with our NHS partners to better deliver care closer to people's homes, and give people greater access to mental health services through GPs' surgeries.

The next 12 months will bring many challenges, not least in meeting the expectations set out in the NHS Long Term Plan, along with those of our regulators and commissioners. We expect that the CQC will return to inspect our services in early 2020, when we will face a new challenge – building on our outstanding rating. Demand for our services, especially those provided in primary and community care settings, are expected to continue to grow and we will need to find new ways of working – often in partnership – to help ensure that our service users have access to effective, high-quality support and care, when and where it is needed.

Chris Lawrence, Chair
Dated: 22 May 2019

Tom Cahill, Chief Executive
Dated: 22 May 2019

1.1.2 Key Issues and risks that could affect delivery of the Trusts objectives

The Trust has identified the key risks and issues that could affect our ability to achieve the goals set out within this strategy. The Annual Governance Statement set out in this report identifies the framework for managing these major risks to future performance. These form a core element of our quality improvement plans for 2018/19 (as set out in the Quality Report) and are summarised below:

Risk	Description	Mitigation
Management of Demand and Capacity	Volume, acuity and complexity of demand leading to inability to respond effectively.	• Developing new approaches to demand management working closely with primary care. • Reviewing staffing establishment and introduce new roles. • Improving processes and systems within our Single Point of Access. • Implementation of SPIKE 2 to provide staff with accurate accessible data.
Workforce Recruitment and Retention	Inadequate staffing levels or inappropriate mix of permanent and agency staff impacting on the quality of patient care.	• Detailed recruitment planning with focused recruitment drives. • Recruitment incentives. • Mitigating action for cohort of potential retirees. • Developing new roles and ways of working.
Ability to achieve Financial Targets	Insufficient resources to manage demand and maintain quality and ensure long term financial sustainability.	• Strengthening expenditure controls. • Robust processes to ensure efficiency. • Independent quality impact assessment assurance. • Clinically led support to identify efficiency opportunities. • Positive relationships with commissioners.
Changing external landscape and wider system pressures	Insufficient influence and resources available	• Regular review of position by the Board. • Active monitoring and intervention by the Council of Governors • Strong leadership roles for staff within local STP. • STP mental health work stream.

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

1.1.3 Going Concern Disclosure

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

Factors that might cast doubt on going concern	HPFT management response and consideration
1. Financial conditions, such as:	
a. Poor NHSI financial risk rating	The Trust has a Use of Resources Risk Rating for 2018/19 of 3. This is entirely due to the Capital Service metric and the in-year scheduled loan repayment. NHSI has acknowledged that this is an exceptional matter and would exclude this from an assessment of the Trust. Adjusting for this would give a rating of 1 and the Plan for 19/20 shows a rating of 1.
b. Necessary borrowing facilities have not been agreed	No additional loan facilities projected with current capital plans fully funded from available cash net of scheduled loan repayments. Sufficient headroom on current projections.
c. Existence of significant operating losses, historical and projected	The Trust has a surplus of £392k for the year plus PSF monies of £3.5m. The Trust has submitted its draft Plan for 2019/20 showing a breakeven position in accordance with its Control Total. This will earn further PSF of £1.8m for the year.
d. Anticipated or actual major loss of commissioner income	There has been no significant income loss overall is indicated, with the principal contract within Hertfordshire agreed for a period of five years with an option to extend for a further two.
e. Major Cash Releasing Efficiency Savings (CRES) programme with high risk of non-achievement	CRES programme for 2018/19 delivered above the planned amount. For 2019/20 the amount of CRES required is expected to be circa £5.5m to £6m which will be challenging and at the high end of what is achievable.
f. Major losses or cash flow problems which have arisen since the balance sheet date	None. Cash balances at the EoY are £58 m with further cash expected through PSF funding. No expected working capital issues.
g. Inability to repay loans when they fall due	Scheduled repayments will be fully met for the foreseeable future from available cash levels.
2. Operating conditions, such as:	
a. Loss of key management without replacement	Full senior management team with processes and track record of recruiting to vacancies that arise from time to time.
b. Loss of key staff without replacement and/or labour difficulties	Recruitment and retention remains challenging for the Trust and is a major focus. The Trust continues to believe current risk is manageable.

c. Poor CQC rating	CQC rating of Outstanding with no expectation of any deterioration in the forthcoming inspection to be carried within the next 12 to 18 months.
d. Significant failure to achieve Care Quality standards resulting in any restrictions on services provided	No concerns.
e. Fundamental changes in the market or technology to which the trust is unable to adapt adequately	Trust playing key role in STP development and continuing to extend services with all existing contracts on renewed during March. Continued investment in technology to support service delivery.
3. Other conditions, such as:	
a. Serious non-compliance with regulatory or statutory requirements	None in existence.
b. Pending legal or regulatory proceedings against the Trust that may, if successful, result in claims that are unlikely to be satisfied	Not significant, any material existing claims are covered by CNST/ NHSLA or are provided for.
c. Changes in legislation or government policy expected to adversely affect the Trust	Not significant.
d. Issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis	None in existence.

1.1.4 Summary of Performance Matters (other than those set out earlier)

Our Financial Plan for the year was set in accordance with the NHSI Control Total requirement. The actual surplus achieved was slightly above this and as a result the Trust has been provisionally awarded £3.5m Provider Sustainability funding through NHS Improvement. We will use this to support the future capital investment programme that forms a key part of to the strategy to continue to provide great care.

1.2 Performance Analysis

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

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

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

Our ambition is to become an information-led organisation. One important development has been the implementation of the first two phases of our new business intelligence system: SPIKE. This supports our service team's performance by significantly improving their access to information. The second phase of SPIKE went online in January 2019 and has built on the success of phase one. The availability of high quality operational data, updated daily, has provided new opportunities for us to fine tune how we monitor and manage our performance.

1.2.2 Detailed analysis of the development and the performance of the Trust

Regulatory performance

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

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

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

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

This new uniform approach across all provider trusts was updated again in November 2018 to reflect changes in national policy priorities and standards. The key areas of change for Mental Health Trusts were:

- A focus on eliminating Out of Area Placements (OAPs)
- A steady increase is the standard for two week referral to treatment measure – from 50% to 53%.

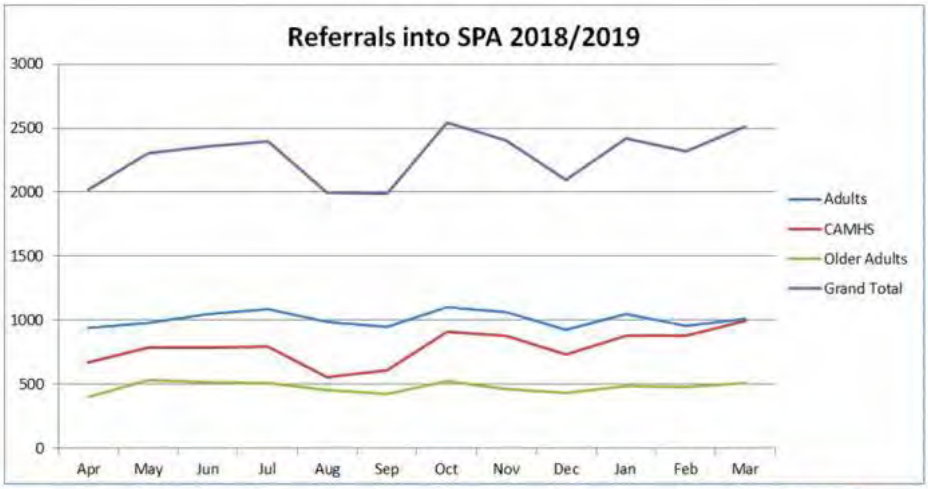
The performance framework

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

Increase in demand for our services

Throughout the year we have seen continuing growth in demand for our services and, consequently, a growth in activity.

Growth in the demand for mental health services is a national trend and the graph and table below describe how that trend manifests in HPFT.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
CAMHS	673	790	789	798	553	613	913	876	737	883	882	994
Adults	941	976	1052	1090	987	952	1101	1068	924	1047	956	1010
Older Adults	406	535	514	507	453	425	528	462	436	490	480	511
Total Referrals	**2020**	**2301**	**2355**	**2395**	**1993**	**1990**	**2542**	**2406**	**2097**	**2420**	**2318**	**2515**

There was a 25% increase in total referrals from a starting position of 2020, in April 2018 to the ending position of 2516, in March 2019. The CAMH service is experiencing almost 50% more referrals at the end of the year than at the start.

Inpatient admissions are very similar to 2017/2018 and increased by 10 across the year to 1,346. During the same period the number of beds was reduced by 52 to 425. This data reveals greater efficiency in our bed capacity.

Over the year our performance has stayed consistent, as measured by our Key Performance Indicators (KPIs), and there has been a net improvement in the number of KPI's where we are hitting target. This is testament to the resilience of our services and a tribute to the quality, professionalism and commitment of our staff in ensuring people with mental health needs or a learning disability receive the care and support they need.

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

Workforce

Recruiting and retaining staff is an NHS system-wide theme. HPFT is geographically located between commutable London, where wages are proportionately higher, and comparatively cheaper counties to the north, where housing is more affordable. As a result we lose a lot of staff who wish to earn more by going south, or get more for their money by going north. This manifests in a turnover rate of 15% and a vacancy rate of 13%.

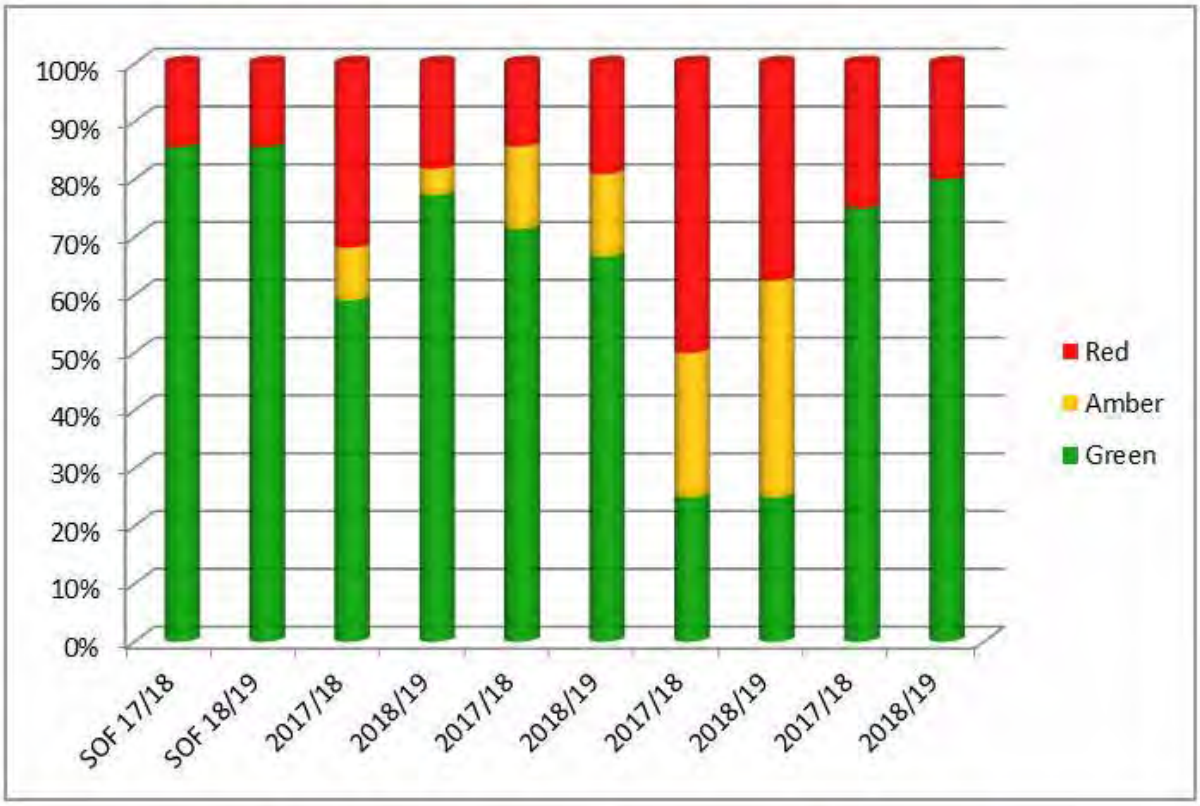
These rates have remained consistent across years and have resulted in an organisation that responds well to volume and key personnel changes. While we are ambitious to improve on this, it presents a challenge as the recent review carried out by the Centre for Mental Health on behalf of the Mental Health Network shows.

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

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

Our performance

Brief comments upon the four broad areas of performance are given below. For each metric we provide a 'RAG' (Red Amber Green) rating. These are reported quarterly to the Board. The table below shows the summary position at 31 March 2019, with the comparable figures from 2017/18.



Access		Safe and Effective		Workforce		Finance	
2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19
7	4	3	4	2	3	1	1
2	1	3	3	1	3	0	0
13	17	15	14	1	2	3	4

Overall, the strong performance of the previous year has been maintained. Most indicators – 67% in 2018/19 (it was 65% in 2016/17) were reported as Green, where Green represents a performance at or above the target (either locally or nationally set).

Access

We have had strong performance in key Access indicators across the year.

Adult eating disorder services, despite increasing numbers of referrals from Q2 onwards has hit targets.

28 day wait from referral to assessment

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Seen within 28 days	38	25	56	71
Eligible to be seen within 28 days	43	25	56	72
Performance %	**88.37%**	**100%**	**100%**	**98.61%**

The CAMHS Crisis and Treatment Team (C-CATT) four hour A&E assessment standards remain above target since June 2018. This measure, although seeing a significant increase in referrals over the last six months, continues to maintain performance. In March 96.97% of the 99 service users who were seen and assessed were within the four hour timescales.

However, we have had significant challenges in other Access targets.

Pressure on CAMHS first appointments has been building across the year, as referrals have increased and the impact of less capacity in Tiers 1 and 2 have resulted in longer waits for services and a subsequent increase in children reaching crisis levels and then accessing HPFT services via C-CATT.

A backlog built up in the first half of 2018/19 for Early Memory Diagnosis and Support Service (EMDASS) and the service needs to gain an extra 30% capacity in order to recover the position and ensure long-term sustainability. The service is taking a Continuous Quality Improvement (CQI) approach to performance and there is now evidence that the backlog is being cleared, as a greater number of appointments are offered. Weekly hotspot reports are being sent to commissioners to update on progress.

IAPT services are measured based on the number of people that are recruited into the service. The rate of referral from GPs is a key factor that affects the rate of access to this service. In areas that the referral rate is high, targets are met. In Mid and West Essex the referral rate is low. Plans are in place to market directly to potential service users as well as to work closely with GPs in the affected areas to drive up rates next year and beyond.

In common with EMDASS, demand has reached the elasticity of current capacity. In order to reach target and ensure a resilient service going forward, elements of the service require re-design. This is focusing on matching assessment acuity to need in system design, improving hit-rate between referral and take-on and removing waste in the form of bottlenecks and buffers in the system.

CAMHS – 28 day wait from referral to assessment

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Seen within 28 days	242	317	288	138
Eligible to be seen within 28 days	475	381	358	405
Performance %	50.95%	83.20%	80.45%	34.07%

EMDASS – 28 day wait from referral to assessment

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Seen within 28 days	388	337	230	288
Eligible to be seen within 28 days	479	486	455	586
Performance %	**81.00%**	**69.34%**	**50.55%**	**49.15%**

Improving Access to Psychological Therapies (IAPT) services

Mid Essex	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Recruited	1341	2650	4188	5672
Target	1473	2946	4419	5890
Performance %	**-132**	**-296**	**-231**	**-218**

West Essex	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Recruited	962	1983	3362	4502
Target	1234	2468	3702	4933
Difference	**-272**	**-485**	**-340**	**-431**

Adult community mental health services – 28 day referral to assessment

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Seen within 28 days	1040	998	1149	998
Eligible to be seen within 28 days	1171	1236	1317	1177
Performance %	88.81%	80.74%	87.24%	84.79%

Safety and effectiveness of services

The strength of our performance throughout this year is clearly illustrated by high scores in our staff and service user "Friends and Family tests." 75% of HPFT staff would recommend our services to their family and friends, whilst 87% of service users or carers would recommend us.

Crisis Assessment and Treatment Teams have continued to achieve target and were performing at 97.46% at the end of 2018/19. We have met the target for this measure for well over a year and the last time we did not reach the threshold was back in March 2017.

Over the year we have seen a rise in the acuity level of our service users. 7.6% more people were on Care Programme Approach (CPA) in 2018/19.

We have also seen a rise in the number of risk assessments falling outside review periods. At the end of Quarter 4 we were 484 risk assessments short of our key performance indicator (92.2% against a 95% target).

There is a risk that this dip in important tasks, such as risk assessments and CPA review, are a symptom of pressure building in the system and starting to affect safety and effectiveness measures. We have initiated a CQI task team to investigate this further with a view to resolving capacity issues before they impact service quality.

Resources

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

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

Analysis of financial performance

Financial overview

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

1. A £0.5m surplus (before asset impairments and Sustainability and Transformation funding). The Trust continues to meet its NHS Improvement-set financial control total at a time when the NHS is facing significant financial challenges.
2. The continuing financial support of our commissioners in delivering "parity of esteem" between physical and mental health – an ambition set out in the Five Year Forward View and contained within the requirements of the Mental Health Investment Standard.
3. Our capital investment programme which aims to maintain and improve our estate and infrastructure to support service users and clinical teams including this year the development of our in house Business Intelligence system SPIKE.
4. We have been provisionally awarded £3.5m from the £2.45 billion Provider Sustainability Fund (PSF) made available to NHS providers during 2018/19. This was linked to the achievement of the financial control total set by NHSI at the beginning of the year of £360k which we have exceeded. This funding will help the Trust continue to invest in capital programmes.

Summary of key results from the financial statements

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

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

Summary of key results from the financial Statements

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

	2018/19 £M	2017/18 £M
Income (excluding PSF)	232.0	224.2
Expenditure – pay costs	(151.2)	(146.4)
Expenditure – non-pay costs (excluding impairments)	80.3	(74.3)
Surplus for the year (excluding PSF, impairments)	0.5	3.5
Provider Sustainability Funding (PSF)	3.5	6.1
Impairment charged to expenses in the SOCI	(1.1)	(0.5)
Surplus/(Loss) for the year	**2.9**	**9.1**

	2018/19 £M	2017/18 £M
Capital spend (net of proceeds)	5.5	1.9
Loan finance liability from foundation trust financing facility	(10.1)	(17.4)
Cash flow from operations	10.9	17.7
Closing cash position	**58.0**	**56.0**

Our income is earned largely from contracts with NHS commissioners, for activities relating to the provision of health and social care services. We have six main contracts several of which are commissioned jointly and these vary in length. Most are block contracts, where the income is fixed, irrespective of changes in activity levels.

However income is linked to activity or outcomes for some services. In 2018/19 we secured additional funding for our services in Hertfordshire as commissioners increased investment in mental health and we extended our LD services across Essex.

	£M	%	£M	%
Income from activities	223.5	94.9	216.9	94.2
Other	**12.0**	**5.1**	**13.4**	**5.8**

In the financial year 2018/19 we generated income totaling £235.5m, an increase of 2.3% on the previous year overall with 3% growth in income from activities. Our income from activities arises principally from the contract we have through the Integrated Health and Care Commissioning Team acting on behalf of the Clinical Commissioning Groups of Herts Valleys CCG and East & North Hertfordshire CCG and Hertfordshire County Council. This accounts for about 80% of our total income. Our other main contracts are with NHS England (covering a number of specialist mental health and learning disability services) and NHS West Essex CCG (for learning disability services in North Essex). The contract with each of our commissioners sets out requirements that we must comply with. These include a range of performance targets. We meet with our commissioners regularly to review our performance against these targets and to discuss areas of future need.

In accordance with the National Commissioning for Quality and Innovation (CQUIN) payment framework, each year we agree a schedule of CQUIN goals with each commissioner. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of a provider income to the achievement of local quality improvement goals. We estimate that we have achieved 79% (92% last year) of the CQUIN target in our contract with Integrated Health and Care Commissioning Team and between 57% and 100% in our other contracts.

Other income includes

- regular sources of income such as national funding to support the training of medical staff.
- items such as the non-recurrent funding provided to support workforce development.
- the total £3.5m PSF funding (£6.1m last year) reported in point 4 of the Financial Overview.

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

Expenditure

In common with other trusts, our most significant area of spending is pay costs. Our total pay costs for the year are £151.2m and represent 66.0% of total Operating Expenses. The comparative figures for 2017/18 are £146.4m and 67.1%. The increase in cost is largely as a result of the new national pay scheme implemented during the year.

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

Surplus

Our financial statements show a surplus for the period of £2.9m compared to £9.1m last year. This is calculated by taking the income earned in the period and deducting the related expenditure. This calculation includes £3.5m of Provider Sustainability Funding, and non-cash accounting items (£1.1m) relating to property impairments, which are not considered by the Trust to be part of its normal activities. Adjusting for this would give a surplus for the year of £0.5m which is lower than the previous year's surplus of £3.5m after similar adjustments for items outside normal activities. This is above the Control Total set by NHSI and qualified the Trust to receive an allocation of PSF funding.

Cash flow from operations

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

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

The statement of cash flows is set out within the financial statements and shows how we continued to manage our cash balances and working capital proactively, and ended the year with a strong cash position of £58.0m – an increase in the year of £2.0m. We repaid the short-term loan of £6.9m in 2018 and repayments of £0.5m were made in accordance with the loan terms of the Capital Loan obtained in 2013 from the Independent Trust Financing facility, with the remaining loan amount being £10.1m.

Capital programme

In 2018/19 we continued investing in various service developments, focusing on service improvement and environmental quality.

Financial risk rating

We have achieved a Use of Resource metric rating of 1 at 31 March 2019 (the highest possible) reflecting the strong financial position of the Trust. See page section 2.5 for detailed and comparative data and an explanation of the regulatory rating framework.

Looking forward

2019/20 will undoubtedly be another challenging year as the Trust continues to manage the continuing financial constraints affecting the whole health and social care economy. Our contract income (our principal source of funding) has been agreed and includes a National Tariff efficiency requirement of 1.8% however we

anticipate the requirement to be circa 3% to 3.5% to cover the expected additional costs.

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

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

Other financial information

Financial investments

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

Financial statements and accounting policies

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

The Financial Statements are presented within the Accounts and Financial Statements section 5.2 and cover the following:

- Statement of Comprehensive Income (SOCI)
- Statement of Financial Position
- Statement of Changes in Taxpayers Equity
- Statement of Cash Flows

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

External audit opinion

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

KPMG LLP has been approved as the Trust's external auditors by the Council of Governors through to 2020/21 with the option to extend for a further two years. The audit is conducted in accordance with International Standards on Auditing (UK and Ireland) as adopted by the UK Auditing Practices Board (APB), the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by NHS Improvement.

Related parties

During the year none of the Board Members, Governors or members of the key management staff or parties related to them, has undertaken any material transactions with the Trust. Details of other related party disclosures are set out in the financial statements under the Accounts and Financial Statements section 5.3, note 25.

Charitable funds

As an NHS Foundation Trust we make no political or charitable donations. However, we do continue to benefit from the receipt of charitable funds arising from donations and fundraising activities and are extremely grateful to fundraisers and members of the public for this continued support. Members of the Trust Board act as Trustees, ensuring appropriate stewardship of these funds which are used for the purchase of equipment or services according to the purpose of the funds. Where funds are for 'general purpose', these are used more widely to benefit service users and staff. Further financial information on our charitable funds for the financial year 2018/19 is available on request from the Executive Director of Finance. There is no charge for the provision of this.

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

1.2.3 Information about environmental matters

Transport and travel

The transport department currently operates with 49 vehicles targeting a 10% reduction in 2019/20., We have upgraded 24 vehicles which have EURO 4 engines with the cleanest EURO 6 spec engines in line with their leasing periods. By the end of this year a further 10 vehicles will have been upgraded to the EURO 6 spec. The remaining 10 vehicles are EURO 5 engines and will be replaced at the end of their leases during 2020.

The carbon footprint is monitored every three months by our Fleetmatics tracking system and has shown a sustained fall over the period through a combination of improved routing and deployment.

Buildings

We have continued to invest significantly into replacement efficient heating systems and improvements in building infrastructure which has enabled a reduction to the carbon footprint. The substantial improvements in space utilisation enabling the disposal of surplus properties have also had a positive effect.

During 2018/19 we have completed a building efficiency audit which includes energy efficiency and reduction targets enabling a clear and accurate benchmark together with a building by building improvement plan which will support investment decisions within the 5 year capital plan.

Sustainable Care Models

We have continued to develop our integrated estates function working across both the Trust and Hertfordshire Community NHS Trust. This arrangement benefits from not only the ambition to deliver an integrated approach but also from the advantages of a significant asset portfolio and the opportunities and flexibility this could offer.

The integrated estates function has also established partnerships with other public and not for profit organisations to deliver an enhanced seamless health and social care approach.

Resource Impact

Following a review of existing exterior lighting a replacement programme across a number of sites commenced in January 2019 with the aim of replacing exterior building/garden lights, car park lighting and street access lighting to Specialist Residential Services, street access and car park lighting to Warren Court Medium Secure Unit, and lighting to staff and visitor car parks with suitable LED fittings.

The programme and forward planning takes into account the advances in LED lighting and the associated benefits, which include:

- an estimated live-expectancy of 50000hrs (or in some cases 100000hrs), based on 8hrs per day, replacement may not be required for 17 years.
- reduced on-going maintenance costs due to increased life-expectancy.
- greater energy efficiency with a higher light output, with the resulting savings of energy, emissions and running costs (£).
- uniform high quality directional lighting, resulting in less light pollution.
- more environmentally friendly, LED lights do not contain Mercury vapour or any other harmful chemicals and are therefore RoHS (Restriction of Hazardous Substances compliant), therefore cost effective for disposal.

Early indications suggest the following:

- Total estimated kWh savings comparing existing lamps against the replaced LED's will be 4919907kWh per annum.
- Total electricity costs savings in £ comparing existing lamps against the replaced LED's will be £5677 per annum.
- Total emissions savings of CO2 comparing existing lamps against the replaced LED's will be 20.7 CO2 tonnes per annum.

LED lighting will therefore help to achieve the following outcomes:

- Achieve cost savings (£).
- Meet national and local environmental sustainability targets.
- Help the trust become 'greener' and more energy efficient.

1.2.4 Information social and community

Highlights from 2018/19 included:

- Events focused on recognition of Race Equality in the workplace, LGBT+ equality within services and Carer Rights and strategy.
- Co-production of new HPFT Equality Plan 2019 – 2022.
- Co-production of new HPFT Carer Plan 2019 – 2021.
- Compliance reporting for Public Sector Equality Duty.
- Improving our approach to meeting the NHS Workforce Race Equality Standard (WRES)
- Data quality project looking at improving quality of demographic data, thereby supporting work to improve equity in outcome and experience.
- Continued work with our staff disabled network and staff mental health network in supporting preparation for the NHS Workforce Disability Equality Standard (WDES).
- Completed development of new training package for front line staff on supporting gender identity within services.
- Innovation work in relation to Spiritual Care through pilot work to deliver family sessions within inpatient services in partnership with clinical psychologist.
- Staff Windrush Walk from St Albans Community Hub to our Head Office in Hatfield to promote race equality within the NHS and remember the impact of the Windrush generation on strengthening the NHS and delivering great care.

The Trust's work around Equality and Diversity is centred on ensuring we comply with the Public Sector Equality Duty and are delivering best practice as a lead for equality and diversity as well as ensuring we use the Equality Delivery System 2 as a quality improvement tool in relation to diversity and inclusion.

Overview of activity to eliminate unlawful discrimination

- NHS Workforce Race Equality Standard (WRES) - The Trust has continued implementation of their WRES programme focusing on identifying and addressing the inequalities within Trust workplaces. This year we are pleased to have Black, Asian and Minority Ethnic (BAME) staff representatives on both the national WRES experts programme and the national WRES front line group. The WRES data can be found on the public website. We have also seen enhanced activity locally within services to proactively engage with BAME staff to understand their experiences of working in the Trust.
- New Equality Plan development – The Trust began co-production of this in 17/18 and it completed in the past year with formal launch programme beginning in early 2019 focused on the strategic priorities of the plan. As part of this piece of work the Trust has established a senior governance committee for this agenda, the Equality, Diversity and Inclusion Group (EDIG). The Equality Plan uses the person centred model for equality at its core and promotes improved awareness and understanding of intersectionality and removal of systemic barriers to inclusion.

Gender pay gap reporting

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

Our gender pay gap analysis identifies a mean gender pay gap of 10.67% and median of 2.56% (national median = 9.6%). We are confident this pay gap does not stem from paying men and women differently for the same or equivalent work. Rather it is the result of the roles in which men and women work within the organisation and the salaries that these roles attract. Whilst reporting is in its early stages, we will continue to monitor the gender pay gap and, during 2019/20, will consider the next steps we should take to reduce it. There are national historic anomalies regarding gender pay that the Trust will seek to address and resolve.

Overview of activity about advancing equality of opportunity

- Diversity Role Models - The role models programme engages staff who are BME, LGBT, Women, Carers or have a Disability in being role models and to support people from similar backgrounds. This has now been expanded to include Mental Health role models and Spiritual Care role models and is adding another layer of support for staff and helping staff identify allies in the workforce. As part of the Trust work on its Bullying and Harassment plan, the Role Models programme will be absorbed into a new 'Dignity at Work champions' programme to increase the breadth of support available to all staff, whilst retaining some focus on the needs of different protected groups.
- Stonewall Workplace Equality Index – For the second year running the Trust has seen a significant improvement in its placement in the Stonewall Workplace Equality Index. Whilst not achieving a top 100 placement in 2019, which is disappointing, the Trust climbed a further 16 places in its ranking reflecting work that has taken place over the past year ranking the Trust at 113 out of 445 entrants. We continue to focus on this area to ensure continuous improvement and demonstrate the Trust's commitment to the equality agenda.
- Staff Networks – The Trust has six staff networks that provide support and a forum for discussion for the following groups; LGBT+ staff, Women, BAME staff, Disabled Staff, Staff Carers, Staff with Mental Health Issues. Most networks continue to meet monthly and have been engaged with the design and delivery of a number of events and campaigns.
- Inclusive Revolution! – This campaign was launched in January 2019 to encourage staff to look at the demography of service users and carers they are supporting and take proactive steps to improve data quality and initiate conversations about diversity and culture.

Overview of activity to foster good relations

Our focus over the past year has been to use key events to bring a diverse range of people together to focus on a particular area of quality improvement. This has enabled both celebration of diversity and awareness around inequalities that require attention in order to remove barriers and further promote social inclusion. These have included:

- International Women's Day (IWD) Programme 2019 – This annual event brought staff together for a 'knowledge café' providing an opportunity to discuss actions for gender equality within the Trust. The event concluded with an overview presentation of the Trust gender pay gap and work taken place to narrow/eliminate this.
- LGBT History Month 2019 – As part of our annual promotion the Trust developed resources for staff and service users/carer clarifying the importance of LGBT+ rights and encouraging staff, service users and carers to have conversations with staff around sexual orientation and gender identity to improve monitoring and quality of care.
- Carers Rights Day – The Trust hosted a conference for Carers Rights Day in November 2018. This included a mixture of carers, service users and staff hearing about topics including legal support for Lasting Power of Attorney, Information about the Triangle of Care and hearing from professionals involved in Carer Inclusive Practice projects within Learning Disability Services. There were also opportunities during the day to feed views into the development of the new HPFT carer plan.
- Diversity and Leadership - In October 2018, the Trust hosted its fourth local WRES annual workforce conference focused on 'enabling change through personal growth and empowerment'. The programme included inspirational stories from staff about their own journeys as well as thought provoking presentations from NHS England about the challenges ahead in creating a fair and equal NHS.
- Hertfordshire Pride – The Trust continued its annual presence at Hertfordshire Pride this year with stalls promoting Trust employment opportunities and the Hertfordshire Wellbeing Service. As an added extra for 2018, the HPFT staff choir were invited to perform which provided a wonderful opportunity for those who would not have usually attended a pride event to be front and centre in celebrating LGBT+ equality.

Statistics

- The Trust is required under the PSED to collect and publish diversity data for staff and those affected by its policies and processes. In addition the Trust is required to publish one or more equality objectives spanning a four year period. This has been done against the Trust's annual objectives for the NHS Equality Delivery System 2.

Equality Delivery System 2

- All PSED compliance reporting is published through the Equality and Diversity section of the Trust website at http://www.hpft.nhs.uk/about-us/equality-and-diversity/our-performance/ (where a full breakdown of statistics can be found). Updated reporting takes place in April on an annual basis.
- We completed our most recent grading of the NHS Equality Delivery System 2 in March 2019. This review focused on ten of the eighteen EDS2 outcomes which were graded as below following a quality improvement exercise with our stakeholders:

EDS2 Goal	EDS2 Outcome	EDS2 grade
Better Health Outcomes	Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways.	
	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.	
	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	
Improved patient access and experience	Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds.	
	People are informed and supported to be as involved as they wish to be in decisions about their care.	
Empowered, engaged and well-supported staff	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.	
	When at work, staff are free from abuse, harassment, bullying and violence from any source.	
	Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives.	
Inclusive leadership	Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond.	
	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.	

These areas were identified for quality improvement when compared to our previous grading. The EDS3 pilot will launch in summer 2019 and the Trust will be undertaking a full regrading exercise once in place.

The grading colours for the EDS2 relate to:
Red – Undeveloped
Amber – Developing
Green – Achieving
Purple – Excelling

Launch of new rainbow project that will see the launch of staff rainbow lanyards for equality and launch of the NHS rainbow badge scheme to recognise LGBT+ equality in service provision.

Modern Slavery Act Reporting
The Modern Slavery and Human Trafficking Act 2015

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

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

Anti-fraud and Corruption including the Bribery Act 2010

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

Assurance in relation to governance and control systems is set out within the Annual Governance Statement (section 2.7).

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

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

1.2.6 Details of overseas operations

There has not been any Trust activity overseas during the period 1 April 2018 to 31 March 2019.

Accounting Officer approval of the Performance Report

Tom Cahill, Chief Executive
Dated: 22 May 2019

2 Accountability Report

2.1 Directors' Report

2.1.1 The Trust Board

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

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

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

Director's responsibility for the Annual Report and Accounts

The Directors are collectively and individually responsible for the preparation of the Annual Report and the Quality Report.

This Annual Report has been prepared on the same group basis as the accounts.

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

a. Are fair, balanced and understandable

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

Board Members

Chris Lawrence

Trust Chair and Chair of the Council of Governors

Chris joined the board of HPFT in 2012 as a Non-Executive Director. He was appointed as the Chair in 2014 and re-appointed for a second term of office in 2017.

Committed to system working, Chris is active at the heart of the Herts and West Essex STP's governance. He is a member of the Herts public sector leaders steering group. He has created Provider Chair forums in both Herts and Norfolk, collaborating closely with key stakeholders, regionally and nationally to build and strengthen partnerships for improving better wellbeing and health outcomes for patients, service users and their families.

Qualifications: BA (Hons) Leeds University.

Professional profile: Fluent in French Spanish and Portuguese, he spent 35 years working on international mergers and acquisitions with Citicorp, Rothschilds and PwC. Much of his working life has centred around leading major transformational change including a senior role in the global merger of Price Waterhouse and Coopers & Lybrand. A lifelong musician, Chris spent three years as Managing Director of the London Philharmonic in the mid 1990s. He is also Chair of the UEA staff Pension Fund and a Christian residential activity centre for young people in Norfolk.

Tom Cahill – Chief Executive

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

Tom has been recognised for his leadership, and was named HSJ Chief Executive of the Year in 2017. He has also been included in the HSJ Top 50 Chief Executives in five out of the last six years.

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

Professional profile: Tom began his NHS career as a mental health nurse in 1987 and between 1998 and 2001 held senior posts with several trusts before being appointed to Director level roles within North Essex Mental Health Partnership Trust. He moved to Hertfordshire Partnership University NHS Foundation Trust in 2005 as Executive Director of Strategy and Nursing, became Deputy Chief Executive in late 2007 and Chief Executive in April 2009. He celebrated his 10 year anniversary as Chief Executive of the Trust in April 2019.

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

Keith Loveman – Deputy Chief Executive/Director Finance

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

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

Professional Profile: Keith joined the NHS in 1990, qualifying as an accountant in 1994. He has worked in a range of NHS finance settings but predominately with organisations providing mental health and learning disability services in Hertfordshire. Previously Deputy Director of Finance and Performance Improvement with HPFT, he became Director in 2010 and Deputy Chief Executive in 2018.

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

Dr Jane Padmore – Director Quality and Safety

Jane is responsible for a diverse range of areas in HPFT including clinical and corporate risk, mental health legislation and patient safety, compliance and governance, infection control and safeguarding.

Jane is Board level lead to all clinical disciplines with the exception of medical staff and pharmacy and is the Executive Nurse. She is also the Caldicott Guardian for the Trust.

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

Professional profile: Jane has worked in mental health and learning disability services since 1990, initially as a healthcare assistant. She has experience across learning disability and adult and child mental health as well as forensic services. Jane has been involved in clinical, service development and academic work throughout her career. Jane joined the Trust in 2014 as Deputy Director of Nursing Quality and Safety and was appointed into her current role in 2016.

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

Dr Asif Zia – Director Quality and Medical Leadership

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

Qualifications: Nye Bevan NHS Leadership Academy 2017, Professor of Psychiatry (Hon) 2016, Doctor of Medicine (MD) 2012, MRCPsych 1999

Professional profile: Asif joined HPFT in 2012. He has worked as a consultant psychiatrist for learning disabilities both in the community and on acute assessment and treatment units. Asif has been involved in service development and quality improvement activities in his psychiatrist career and was appointed to his current role in 2017.

Membership of professional, national and regional bodies: Regional advisor Royal College of Psychiatrists, Council member Clinical Senate, NHS East of England.

Karen Taylor – Director Strategy and Integration

Karen is responsible for strategy development, business planning and commercial development and she also leads the development of integrated care across the Trust. She is responsible for the Trust's Physical Health Strategy and wider public health agenda, as well as the development of new models of integrated care across primary, community and specialist services working with the wider health and social care system.

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

Professional profile: Karen has worked in the NHS for over 20 years in a range of senior roles including Director of Operations of an acute trust and Deputy CEO and Director of Operations of a community trust. She joined HPFT as Chief Operating Officer in 2012 and became Executive Director, Strategy and Integration in June 2016.

Jess Lievesley –
Director of Service Delivery and Customer Experience

Jess is responsible for service delivery, customer experience and complaints.

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

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

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

Mariejke Maciejewski –
Interim Director Workforce and Organisational Development

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

Qualifications: Chartered Institute of Personnel and Development

Professional profile: Mariejke joined the Trust in 2015 as Deputy Director of Workforce and OD and has been acting in her current role since July 2018.

Membership of professional, national and regional bodies: Member of the Chartered Institute of Personnel and Development (CIPD).

Ronke Akerele – Director Innovation and Transformation

Ronke is responsible for promoting innovation, information management and technology, improving performance and leading the transformation of activities that result in improved outcomes for service users and families. She leads on developing a culture of change that promotes continuous quality improvements in clinical services and technologies, ensuring that innovative practices are a key enabler of both organisational improvement and service transformation.

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

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

Jill Hall – Company Secretary

Jill is responsible for ensuring that the Trust complies with its legal and regulatory framework and also ensures that the Council of Governors, Trust Board and its committees are properly constituted and advises on matters of regulatory issues.

Professional profile: Jill joined HPFT at the end of March 2018 as Interim Company Secretary and was appointed to the substantive post from 1 January 2019. She brings to the Trust a wealth of experience and knowledge from her previous roles in other NHS Trusts and commissioning organisations.

Loyola Weeks – Non-Executive Director

Qualifications: BSc Hons, General and Community Nurse, Midwife and Health Visitor, DPSN, NCAS trained Case Investigator

Professional profile: Loyola was appointed as Non-Executive Director in August 2014. Prior to this she was a governor at HPFT. Having undertaken numerous Leadership Mentoring and Coaching training across the NHS and private sector she continues to support aspirant Leaders and Directors. She has been a Clinical and Executive Nurse for over 40 years undertaking roles in commissioning and provider organisations.

Membership of professional, national and regional bodies:
Director O' Donovan Weeks Ltd.

Simon Barter – Non-Executive Director

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

Professional profile: Simon was appointed as Non-Executive Director in 2013. A former pharmaceutical executive with 30 years' experience in international pharmaceuticals, working in the UK, France, Belgium, The Netherlands and Sweden. He specialised in drug development and global marketing and ran the commercial merger of Astra and Zeneca Pharmaceuticals.

Catherine Dugmore – Non-Executive Director

Qualifications: Association Chartered Accountants (ACA)

Professional profile: Catherine was appointed as Non-Executive Director in August 2016. She trained with PwC in London, before specialising in financial services clients and becoming a partner in South Africa as multinationals were setting up there. When Catherine relocated to the UK in 2002 she decided to pursue a full time Non-Executive Director career in the public and voluntary sectors.

Catherine is currently a Trustee of RGB Kew and WWF-UK, as well as serving as a Non-Executive Board Member of Natural England. Prior to this, for a decade she was associated with Action for Children becoming Chair of the Audit Committee and Vice Chair of the organisation. Catherine was also Chair of Victim Support from 2014 to 2017, overseeing a significant internal transformation of the organisation and building its external profile. She has also been Chair of the Audit Committee and Vice Chair of North Middlesex University Hospital NHS Trust.

Membership of professional, national and regional bodies: Institute of Chartered Accountants of England and Wales.

Tanya Barron – Non-Executive Director

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

Professional profile: Tanya was appointed as Non-Executive Director in 2016. She has worked at Board level in an international disability organisation, has worked for the European Commission as an external manager and chaired the UNICEF NGO committee in Geneva for many years. Tanya is also the CEO of Plan International UK. In this role, Tanya leads an £80m turnover international development organisation, with a particular focus on girl's rights and gender equality.

Sarah Betteley – Non-Executive Director

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

Professional profile: Sarah was appointed as Non-Executive Director in 2014. She is a lawyer with significant non-executive experience in the NHS. For the last 10 years Sarah has worked in senior executive commercial roles across BT. Sarah has also acted in a consultant capacity supporting small businesses with strategy and growth developments.

Rt Hon Dame Janet Paraskeva – Non-Executive Director

Professional profile: Janet was appointed as Non-Executive Director in 2019. Having begun her career as a teacher, Janet went on to work in youth and community work, establishing and becoming the first Chief Executive of the National Youth Agency and creating the European Confederation of Youth Club Organisations. She set up and was the first Director of the England operation of the National Lottery Charities Board and was the Chief Executive of the Law Society from 2000 - 2006.

She has since served as First Civil Service Commissioner in Whitehall, a Non-Executive Director of the Serious and Organised Crime Agency and of the Consumer Council for water. She was Chair of the Child Maintenance and Enforcement Commission and is currently Chair of the Appointments Commission for the States of Jersey and of the Council for Licensed Conveyancers. She was made a Privy Councillor to assist in her role as a member of the Detainee Inquiry established by the Prime Minister in 2010, has been Chair of the development charity Plan UK. In 2010 she became a Dame.

Jinjer Kandola
Deputy Chief Executive/Executive Director of Workforce and Organisational Development
(left the Trust in June 2018)

Robbie Burns
Non-Executive Director
(left the Trust in July 2018)

Michelle Maynard
Non-Executive Director
(left the Trust in May 2018)

Sue Darker
Herts County Council Assistant Director for Learning Disabilities, Mental Health and Asperger's attendance at Board
(non-voting - left February 2019)

2.1.2 Board of Directors appointments and committee attendance

There were 11 Board of Directors meetings between 1 April 2018 and 31 March 2019. The Trust also holds an Annual General Meeting for members. The term of appointment and individual attendance of each Board member at Board of Director and sub-committee meetings is set out below.

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

Table 1: 1 April 2018 - 31 March 2019

Board Member	Term of Appointment	Trust Board	Nominations & Remuneration Committee	Audit Committee	Integrated Governance Committee	Finance & Investment Committee
		Attendance: actual/maximum				
Non-Executive Directors						
Chris Lawrence (Chair)	01/08/2012-31/07/2020	11/11	5/5	n/a	n/a	n/a
Simon Barter	01/08/2016-31/07/2019	8/11	3/5	2/3	n/a	6/6
Sarah Betteley	01/08/2014-31/07/2020	11/11	5/5	n/a	5/5	6/6
Robbie Burns	01/08/2015-31/07/2018 end of term	3/4	1/2	1/2	n/a	2/2
Catherine Dugmore	01/08/2016-31/07/2019	9/11	4/5	3/3	n/a	5/6
Michelle Maynard	01/06/2015-30/09/2018	5/5	3/3	n/a	0/1	0/3
Tanya Barron	01/09/2017-01/09/2020	11/11	5/5	1/3	5/5	6/6
Loyola Weeks	01/08/2014-31/07/2020	10/11	4/5	3/3	4/5	n/a
Dame Janet Paraskeva	01/09/2018-31/08/2021	7/11	3/3	n/a	n/a	n/a

Board Member	Term of Appointment	Trust Board	Nominations & Remuneration Committee	Audit Committee	Integrated Governance Committee	Finance & Investment Committee
		Attendance: actual/maximum				
Directors In Attendance						
Tom Cahill (CEO)	01/04/2009 – on-going	11/11	5/5	1/1	n/a	n/a
Jinjer Kandola	01/10/2010 – 29/06/2018	3/3	1/2	2/2	1/1	0/1
Keith Loveman	04/10/2010 – on-going	10/11	n/a	3/3	n/a	6/6
Dr Asif Zia	01/07/2017 – on-going	11/11	n/a	3/3	5/5	5/6
Jane Padmore	17/11/2016 – on-going	10/11	n/a	2/3	5/5	5/6
Karen Taylor	27/02/2012 – on-going	6/11	n/a	n/a	2/5	5/6
Jess Lievesley	27/05/2016 – 29/03/2019	10/11	n/a	n/a	2/5	6/6
Mariejke Maciejewski	01/07/2018 – on-going	8/8	4/4	1/1	4/5	4/5

Other Directors and Attendees			
Ronke Akerele	Director of Innovation and Transformation (non-voting)	04/09/2017	On-going
Sue Darker*	Herts County Council Assistant Director, Learning Disability and Mental Health		28/02/2019
Jill Hall	Interim Company Secretary		On-going

**Non-Voting*

2.1.3 Details of Company Directorship

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

The register of Directors' Interests is available from the Company Secretary at:
Hertfordshire Partnership University NHS Foundation Trust, The Colonnades, Hatfield, Hertfordshire, AL10 8YE
Tel: 01707 253866 or on opur website:
www.hpft.nhs.uk/media/3049/register-of-interests-declared-by-board-of-directors-2018-19.pdf

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

2.1.4 Statement of compliance with cost allocation and charging guidance

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

2.1.5 Details of Political Donations

There were no political donations made during the reporting period.

2.1.6 Statement of Better Payment Practice Code

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

	£000's	Number
Total non-NHS bills paid in the year	105,397	47,656
Total non-NHS bills paid within target	92,389	40,510
Percentage of bills paid within target (2017/18 percentages)	88%	85%
Percentage of bills paid within target (2016/17 percentages)	85%	78%

	£000's	Number
Total NHS bills paid in the year	14,707	953
Total NHS bills paid within target	8,680	748
Percentage of bills paid within target (2017/18 percentages)	59%	79%
Percentage of bills paid within target (2016/17 percentages)	83%	81%

2.1.7 The Well Led Framework

The Trust has in place arrangements to ensure services are well led and these have been developed to reflect NHS Improvement's "Well Led Framework". These arrangements and approach are set out in more detail in the Annual Governance Statement (section 2.7)

2.1.8 Disclosure relating to Quality Governance

2.1.8.1 How the Trust has regard to the quality Governance Framework

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

- ensuring required standards are achieved
- investigating and taking action on sub-standard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best practice and
- identifying and managing risks to quality of care

Examples of good practice linked to our Quality Governance Framework Strategy to ensure the continual provision of high quality safe services are highlighted in Table 2 below.

1. Strategy	Examples of good practice
1a: Does quality drive the Trust's strategy?	Quality is embedded in the Trust's overall strategy. • The Trust's strategy comprises a small number of ambitious trust-wide quality goals covering safety, clinical outcomes and patient experience which drive year on year improvement • Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff • Quality goals are selected to have the highest possible impact across the overall Trust • Wherever possible, quality goals are specific, measurable and time-bound • Overall trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service) • There is a clear action plan for achieving the quality goals, with designated lead and time frames • Applicants are able to demonstrate that the quality goals are effectively communicated and well-understood across the trust and the community it serves • The board regularly tracks performance relative to quality goals

1. Strategy	Examples of good practice
1b: Is the Board sufficiently aware of potential risks to quality?	The board regularly assesses and understands current and future risks to quality and is taking steps to address them The board regularly reviews quality risks in an up-to-date risk register The board risk register is supported and fed by quality issues captured in directorate/ service risk registers The risk register covers potential future external risks to quality (e.g., new techniques/ technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks There is clear evidence of action to mitigate risks to quality Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment) Initiatives with significant potential to impact quality are supported by a detailed assessment that could include: • 'Bottom-up' analysis of where waste exists in current processes and how it can be reduced without impacting quality (e.g., Lean) • Internal and external benchmarking of relevant operational efficiency metrics (of which nurse/bed ratio, average length of stay, bed occupancy, bed density and doctors/bed are examples which can be markers of quality) • Historical evidence illustrating prior experience in making operational changes without negatively impacting quality (e.g. impact of previous changes to nurse/bed ratio on patient complaints) The board is assured that initiatives have been assessed for quality All initiatives are accepted and understood by clinicians There is clear subsequent ownership (e.g. relevant clinical director) There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistle-blower policy Initiatives' impact on quality is monitored on an ongoing basis (post-implementation) Key measures of quality and early warning indicators identified for each initiative Quality measures monitored before and after implementation Mitigating action taken where necessary

2. Capabilities and culture	Examples of good practice
2a. Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	The board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review (either through participation in Audit Committee or relevant quality-focused committees and sub-committees) The capabilities required in relation to delivering good quality governance are reflected in the make-up of the board Board members are able to: • Describe the trust's top three quality-related priorities • Identify well- and poor-performing services in relation to quality, and actions the trust is taking to address them, • Explain how it uses external benchmarks to assess quality in the organisation (e.g. adherence to NICE guidelines, recognised Royal College or Faculty measures). • Understand the purpose of each metric they review, be able to interpret them and draw conclusions from them • Be clear about basic processes and structures of quality governance • Feel they have the information and confidence to challenge data • Be clear about when it is necessary to seek external assurances on quality, e.g. how and when it will access independent advice on clinical matters. Applicants are able to give specific examples of when the board has had a significant impact on improving quality performance (e.g. must provide evidence of the board's role in leading on quality) The board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained Board members have attended training sessions covering the core elements of quality governance and continuous improvement
3. Structures and processes	**Example good practice**
3a. Are there clear roles and accountabilities in relation to quality governance?	Each and every board member understand their ultimate accountability for quality There is a clear organisational structure that cascades responsibility for delivering quality performance from 'board to ward to board' (and there are specified owners in-post and actively fulfilling their responsibilities) Quality is a core part of main board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions Quality performance is discussed in more detail each month by a quality-focused board sub-committee with a stable, regularly attending membership

3. Structures and processes	Examples of good practice
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	Boards are clear about the processes for escalating quality performance issues to the board • Processes are documented • There are agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints. Robust action plans are put in place to address quality performance issues (e.g., including issues arising from serious untoward incidents and complaints). With actions having: • Designated owners and time frames • Regular follow-ups at subsequent board meetings Lessons from quality performance issues are well-documented and shared across the trust on a regular, timely basis, leading to rapid implementation at scale of good-practice There is a well-functioning, impactful clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns • Continuous rolling programme that measures and improves quality • Action plans completed from audit • Re-audits undertaken to assess improvement Both 'whistle-blower' and error reporting processes are defined and communicated to staff; and staff are prepared if necessary to "blow the whistle". There is a performance management system with clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels
3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance The board actively engages patients on quality, for example: • Patient feedback is actively solicited, made easy to give and based on validated tools • Patient views are proactively sought during the design of new pathways and processes • All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the board • The board regularly reviews and interrogates complaints and serious untoward incident data • The board uses a range of approaches to "bring patients into the boardroom" (e.g., face-to-face discussions, video diaries, ward rounds, patient shadowing)

3. Structures and processes	Example good practice
3c: Does the Board actively engage patients, staff and other key stakeholders on quality? (continued)	The board actively engages staff on quality, for example: • Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (e.g., monthly "temperature gauge" plus annual staff survey) • All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the board The board actively engages all other key stakeholders on quality, for example: • Quality performance is clearly communicated to commissioners to enable them to make educated decisions • Feedback from PALS and local Healthwatch groups is considered • For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway • The board is clear about Governors' involvement in quality governance
4. Measurement	**Example good practice**
4a: Is appropriate quality information being analysed and challenged?	The board reviews a monthly 'dashboard' of the most important metrics. Good practice dashboards include: • Key relevant national priority indicators and regulatory requirements • Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each) • Selected 'advance warning' indicators • Adverse event reports/ serious untoward incident reports/ patterns of complaints • Measures of instances of harm (e.g. Global Trigger Tool) • NHS Improvement risk ratings (with risks to future scores highlighted) • Segmentation against NHS Improvement's Single Oversight Framework • Where possible/appropriate, percentage compliance to agreed best-practice pathways • Qualitative descriptions and commentary to back up quantitative information The board is able to justify the selected metrics as being: • Linked to trust's overall strategy and priorities • Covering all of the trust's major focus areas • The best available ones to use • Useful to review

4. Measurement	Example good practice
4a: Is appropriate quality information being analysed and challenged? (continued)	The board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines Quality information is analysed and challenged at the individual consultant level The board dashboard is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the board commits time and resources to developing new metrics
4b: Is the board assured of the robustness of the quality information?	There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness • Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the board of the quality of its data • Clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents) • Electronic systems are used where possible, generating reliable reports with minimal ongoing effort • Information can be traced to source and is signed-off by owners. • There is clear evidence of action to resolve audit concerns • Action plans are completed from audit (and subject to regular follow-up reviews) • Re-audits are undertaken to assess performance improvement • There are no major concerns with coding accuracy performance
4c: Is quality information being used effectively?	Information in Quality Reports is displayed clearly and consistently Information is compared with target levels of performance (in conjunction with a R/A/G rating), historic own performance and external benchmarks (where available and helpful) Information being reviewed must be the most recent available, and recent enough to be relevant 'On demand' data is available for the highest priority metrics Information is personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate) Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance

2.1.8.2 Material inconsistencies in reporting

There are no material inconsistencies in reporting.

2.1.8.3 Summary of Service User care activities

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

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

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

2.1.8.4 Summary of stakeholder relations

Hertfordshire Partnership University NHS Foundation Trust (HPFT) maintains significant partnerships and relationships which support and facilitate the delivery of care and benefits for our service users/carers. Our strong relationships with key commissioners across Hertfordshire, Essex, Buckinghamshire and Norfolk have secured ongoing income for services, and funding for a number of developments during 2018/19 and onwards into 2019/20.

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

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

HPFT has a strong history of co-production with both external stakeholders and importantly with service users and carers. We have demonstrated this throughout 2018/19 across our services both in the development of our Trust-wide strategies and in our individual services.

2.1.9 Income Disclosures

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

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

Fees and charges (income generation)

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

2.1.10 Statement of disclosure of information to auditors (s418)

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

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

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

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

Accounting Officer approval of the Accountability Report

Tom Cahill, Chief Executive
Dated: 22 May 2019

2.2 Remuneration Report

2.2.1 Annual Statement of Remuneration

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

The following paragraphs provide information about the Remuneration Committees, the policy on remuneration and detailed information about the remuneration of the Executive and Non-Executive Directors of the Trust.

2.2.1.1 Substantial changes to senior managers' remuneration

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

2.2.1.2 Major decisions on senior managers' remuneration

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

For 2018/19 the performance targets set at the beginning of the year and actual performance against those targets is set out in the following section. The estimated resultant performance payment payable is set out in section 2.2.2 of the remuneration report. For 2018/19 any award remains subject to consideration of the performance of the Executive Team by the Nominations and Remuneration Committee.

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

Remuneration for Non-Executive Directors is set out at 2.2.3.4 of the Annual Report on Remuneration and within the Full Statutory Accounts. No additional fees are payable in the role of Non-Executive Director.

Chris Lawrence, Chair
Dated: 22 May 2019

2.2.2 Senior managers Remuneration Policy

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

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

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

The scheme has a threshold performance level which has to be achieved before the scheme becomes applicable. These include factors such as CQC requirements, quality indicators, and financial performance to ensure that basic performance is achieved before any consideration of any performance related payment can be made. There are a number of stretching objectives which focus on the advancing the Trust against both its strategic objectives and annual plan.

Where an individual Executive Director is paid more than £150,000, the Trust has taken steps to Enssure that remuneration is set at a competitive rate in relation to other similar Foundation Trusts and that this rate enables the Trust to attract, motivate and retain Executive Directors with the necessary abilities to manage and develop the Trust's activities fully for the benefit of service users.

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

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

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

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

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

2.2.2.1 Future Policy

For 2018/19 the performance targets set at the beginning of the year and the actual performance against those targets are set out in table 3. An amount has been included in the Annual Accounts to reflect the estimated amount payable. The performance related payment for 2018/19 notes the maximum estimated level payable and is included as a potential payment within the Annual Accounts. No payment has been made and the award remains subject to consideration by the Remunerations and Nominations Committee in accordance with the terms of the deferred performance pay scheme.

2.2.2.2 Service Contract Obligations

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

2.2.2.3 Policy on payment for loss of office

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

2.2.2.4 Statement of consideration of employment conditions

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

Table 3 – Executive Performance Scorecard 2018/19 (relating to section 2.2.2.1)

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

Objective	Outcome	Success Measure	Value	Threshold (50%)	Target (100%)	Q4	Final Outcome
Great Care Great Outcomes							
We will provide safe services **We will deliver a great experience of our services** **Culture of safety**	Services user kept safe Consistently positive service user experience Improved access to services Improved seclusion environments	Acute and PICU (and another service) out of needs improvement for safety	10%	CQC Good for 2 out of 3	CQC Good for 3 out of 3	CQC Good for safety in all services	10%
		Violence and aggression (our management and response to this) leading to a reduction in harm to both staff and service users	5%	5% reduction	10% reduction	5% increase and 10% increase respectively	0%
		Reduction in out of area placements	5%	83 days per month	3 PICU No acute	Out of area placements reduced	2.5%
		Reduction in suicide rates and SIs	5%	5% reduction	10% reduction	No reduction in suspected suicide rates and SIs	0%
		Improvements in follow up care	5%	7 day follow up (95%)	3 day follow up (90%)	96.6% achieved for 7 day follow up and 90.8% achieved for 3 day follow up	5%

Objective	Outcome	Success Measure	Value	Threshold (50%)	Target (100%)	Q4	Final Outcome
Great Care Great Outcomes							
We will continually learn and innovate	Quality Improvements	Access to CAMHS, Adult and IAPT and crisis services Service User Survey Physical Health Care Expanded co-creation and co-production	15%	3 out of 4 improved	4 out of 4 improved	Improvements achieved in the service user survey, physical health care and expanded co-creation and co-production	7.5%
Our People							
We will attract, retain and develop people	Reduced staff turnover / increased workforce stability Lower vacancy level Recruitment and Retention New ways of working	Unplanned Staff Turnover reduced to 10%	5%	<12%	<10%	Unplanned turnover 11.42%	2.5%
		Vacancy Rate reduced to 10% against baseline establishment as at 1 April 2018	5%	<11%	<10%	Vacancy rate against baseline establishment as at 1 April 2018 is 13.23%	0%
		Agency Shifts Achievement of the cap £ 7.3m	5%	Within 25% of the agency cap	Achieve-ment of the cap	Fully achieved the cap	5%
	Engaged and motivated workforce. Improved staff experience e.g. harassment and bullying, inclusion and diversity Leadership Development (collective) and talent management plan	% Staff reporting feeling engaged and motivated at work Baseline 66% % Staff reporting increased opportunities to progress and develop	10%	66% EOY 86%	68% EOY 90%	66% EOY 82% of staff said that the organisation acts fairly with regards to career progression	2.5%

Objective	Outcome	Success Measure	Value	Threshold (50%)	Target (100%)	Q4	Final Outcome
Great Organisation							
We will improve, innovate and transform our services to provide the most effective, productive and high quality care	Use of resources and technology	Delivery against CRES Increased productivity across a number of metrics including direct time to care, mileage usage, reduced costs, reduced reliance on agency Use of Technology Securing parity of esteem	10%	80% delivered recurrently	100% delivered recurrently	100% of CRES achieved	5%
				3 out of 4 achieved	4 out of 4 achieved	1 out of 4 achieved	0%
			5%	80% delivered	100% delivered	Introduction of SPIKE 2 Increased use of equipment to support mobile/flexible working CAMHS website and app developed New Trust intranet being implemented	2.5%
	Mental Health and Learning Disability innovations	Use of technology, apps etc. New modes of service National leaders Strategies developed in CAMHS, Dementia, IAPT etc.	5%	3 out of 4 delivered	4 out of 4 delivered	Introduction of SPIKE 2 and apps New acute care models, home treatment team and 72 hour acute pathway in place Dementia pathway and systems developed Continue to be national leaders Strategies developed in CAMHS, dementia and IAPT	5%

Objective	Outcome	Success Measure	Value	Threshold (50%)	Target (100%)	Q4	Final Outcome
Great Networks and Partnerships							
Integration	Exploring joint working options Working in partnership	Access to CAMHS, Adult and IAPT and crisis services Service User Survey Physical Health Care Expanded co-creation and co-production	5%	To be assessed by Remcom	To be assessed by Remcom	Integrated Estates function Marlowes Integrated Wellbeing hub Options for other joint working and joint appointment explored. A co-produced service model for learning disabilities in Essex being implemented GP and service user satisfaction being evaluated	2.5%
System leadership	HPFT Executive Team positioned and recognised as system leaders within Hertfordshire and West Essex STP MH and LD continue to be recognised and prioritised for investment and development	Development of robust ICA plans that include mental health and learning disabilities	5%	To be assessed by Remcom	To be assessed by Remcom	Strong influence within STP workstreams Development of integrated Health and Care Strategy HPFT representation and leadership within locality provider delivery boards	5%
Total							**55%**

2.2.3 Annual Report on Remuneration

2.2.3.1 Service Contracts

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

Table 4 – Trust Board Members for the Year Ending 31 March 2019

Name	Title	Contract Date From	Contract Date To
Non-Executive Directors			
Chris Lawrence	Trust Chair	1 July 2014	30 June 2020
Simon Barter	Non-Executive Director	1 August 2016	31 July 2019
Sarah Betteley *(Deputy Chair)*	Non-Executive Director	1 August 2014	31 July 2020
Robbie Burns	Non-Executive Director	1 August 2015	31 July 2018
Catherine Dugmore *(Senior Independent Director)*	Non-Executive Director	1 August 2016	31 July 2019
Michelle Maynard	Non-Executive Director	1 June 2015	30 September 2018
Loyola Weeks	Non-Executive Director	1 August 2014	31 July 2020
Tanya Barron	Non-Executive Director	1 August 2017	31 July 2020
Dame Janet Paraskeva	Non-Executive Director	1 September 2018	31 July 2021
Directors			
Tom Cahill	Chief Executive	1 April 2009	Current
Jinjer Kandola	Deputy CEO and Executive Director of Workforce & Organisational Development	1 October 2010	29 June 2018
Keith Loveman	Director Finance & Deputy CEO	14 October 2010	Current
Dr Asif Zia	Director of Quality & Medical Leadership	July 2017	Current
Dr Jane Padmore	Director of Quality & Safety	17 November 2016	Current
Karen Taylor	Director of Strategy & Integration	27 February 2012	Current

Name	Title	Contract Date From	Contract Date To
Directors			
Ronke Akerele*	Director of Innovation & Transformation	4 September 2017	Current
Mariejke Maciejewski	Director of Workforce & Organisational Development	01 July 2018	Current
Jess Lievesley*	Director of Delivery & Service User Experience	27 May 2016	29 March 2019
Other Directors and Attendees			
Jill Hall	Company Secretary		Current
Sue Darker*	Herts County Council Assistant Director, Learning Disability and Mental Health		28 February 2019

**Non-Voting*

2.2.3.2 Remuneration Committee

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

Nomination and Remuneration Committee

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

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

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

- Chris Lawrence (5 of 5)
- Loyola Weeks (4 of 5)
- Michelle Maynard (3 of 3)
- Robbie Burns (1 of 2)
- Sarah Betteley (5 of 5)
- Simon Barter (3 of 5)
- Catherine Dugmore (4 of 5)
- Tanya Barron (5 of 5)
- Janet Paraskeva (3 of 3)

The Company Secretary services and provides advice to the Committee.

Appointments and Remuneration Committee

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

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

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

There were 4 meetings of the committee during this financial period, and the members' attendance is shown below:

- Chris Lawrence (Chair) (4 of 4)
- Caroline Bowes-Lyon (Public Governor) (3 of 4)
- Dr Michael Shortt (Staff Governor) (2 of 4)
- Emma Paisley (Public Governor) (4 of 4)
- Jon Walmsley (Lead Governor) (4 of 4)
- Richard Pleydell-Bouverie (Public Governor) (1 of 3)

The Company Secretary services and provides advice to the Committee.

2.2.3.3 Disclosures required by the Health Social Care Act

Remuneration for senior managers is set out within section 2.2.3.4 of the Remuneration Report. For all other staff the Trust adheres to the national agenda for change guidelines for the setting of pay and notice periods.

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

	2018/19		2017/18	
	No of individuals	£	No of individuals	£
Governors	3	1,127	2	248
Non-Exec Directors	3	14,092	9	10,779
Exec Directors	8	8,378	10	13,503

Salary and Pension Entitlements of Senior Managers – Remuneration

	2018/19			
Name and Title	Salary and fees (bands of £5,000) £000	Taxable benefits* (nearest £00) £	Performance related bonuses (bands of £5,000)** £000	
Chris Lawrence (Non-Executive Director and Chair)	50 to 55			
Catherine Dugmore (Non-Executive Director)	15 to 20			
Simon Barter (Non-Executive Director)	15 to 20			
Sarah Betteley (Non-Executive Director)	15 to 20			
Loyola Weeks (Non-Executive Director)	15 to 20			
Tanya Barron (Non Executive-Director) Appointed August 2017	15 to 20			
Robert Burns (Non Executive-Director) Resigned July 2018	5 to 10			
Michelle Maynard (Non Executive-Director) Resigned September 2018	5 to 10			
Janet Paraskeva (Non Executive-Director) Appointed September 2018	5 to 10			
Manjeet Gill (Non Executive Director) Resigned August 2017				
Tom Cahill (Chief Executive)	180 to 185		15 to 20	
Asif Zia (Director of Quality & Medical Leadership) Appointed July 2017 ***	175 to 180		0 to 5	
Keith Loveman (Deputy CEO / Director of Finance) Appointed Deputy CEO December 2018	125 to 130	5.300	10 to 15	
Karen Taylor (Director of Strategy & Integration)	130 to 135		10 to 15	
Jane Padmore (Director of Quality & Safety)	130 to 135		10 to 15	
Jess Lievesley (Director of Delivery and Service User Experience)	130 to 135		10 to 15	
Aderonke Akerele (Director of Innovation and Transformation) Appointed September 2017	125 to 130		10 to 15	
Mariejke Maciejewski (Interim Director of Workforce & Organisational Development) Appointed July 2018	70 to 75			
Harjinder Kandola (Deputy CEO/ Director of Workforce & Organisational Development) Resigned June 2018	40 to 45			
Kaushik Mukhopadhaya (Director Quality & Medical Leadership) Resigned from Executive post June 2017***				
Iain Eaves (Director of Strategy & Organisational Development) Resigned April 2017				
Band of highest paid director's total remuneration	180 to 185			
Median total remuneration	£30,528			
Ratio	6.0			

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

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

	2018/19			2017/18					
	Long term Performance related bonuses (bands of £5,000) £000	Pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Salary and fees (bands of £5,000) £000	Taxable benefits* (nearest £00) £00	Performance related bonuses (bands of £5,000)** £000	Long term Performance related bonuses (bands of £5,000) £000	Pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
			50 to 55	50 to 55					50 to 55
			15 to 20	15 to 20					15 to 20
			15 to 20	15 to 20					15 to 20
			15 to 20	15 to 20					15 to 20
			15 to 20	15 to 20					15 to 20
			15 to 20	5 to 10					5 to 10
			5 to 10	15 to 20					15 to 20
			5 to 10	15 to 20					15 to 20
			5 to 10						
				5 to 10					5 to 10
			195 to 200	180 to 185		15 to 20		37.5 to 40	230 to 235
		15 to 17.5	195 to 200	130 to 135		0 to 5		152.5 to 155	285 to 290
		27.5 to 30	175 to 180	125 to 130	5.100	10 to 15		5 to 7.5	150 to 155
		35 to 37.5	180 to 185	130 to 135		10 to 15		30 to 32.5	170 to 175
		75 to 77.5	220 to 225	120 to 125		10 to 15		182.5 to 185	320 to 325
		47.5 to 50	190 to 195	125 to 130		10 to 15		77.5 to 80	215 to 220
		37.5 to 40	175 to 180	30 to 35		5 to 10		127.5 to 130	165 to 170
		60 to 62.5	135 to 140						
		200 to 202.5	240 to 245	140 to 145		10 to 15		92.5 to 95	245 to 250
				35 to 40					35 to 40
				0 to 5				0 to 2.5	5 to 10
				180 to 185					
				£31,598					
				5.7					

***The performance related bonus for 2018/19 notes the maximum estimated amount payable. No payment has been made and the award remains subject to consideration by the Remunerations and Nominations Committee in accordance with the terms of the deferred performance pay scheme. The detail of the scheme is contained within the Remuneration section of the Annual Report.*

****The salary and fees for the Director Quality & Medical Leadership includes £141k for Asif Zia in relation to their clinical role.*

Pensions Benefits

Name	Real increase in pension at pension age (bands of £2,500) £000	Real increase in lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash Equivalent Transfer value at 31 March 2019 £000	Cash Equivalent Transfer value at 31 March 2018 £000	Real increase in Cash Equivalent Transfer value £000
Tom Cahill	-2.5 to -5	-7.5 to -10	90 to 95	270 to 275	1.977	1.783	98
Harjinder Kandola	0 to 2.5	2.5 to 5	60 to 65	150 to 155	1.211	929	50
Keith Loveman	0 to 2.5	-2.5 to -5	40 to 45	110 to 115	867	752	64
Jess Lievesley	0 to 2.5	0 to - 2.5	35 to 40	90 to 95	627	508	73
Dr Jane Padmore	2.5 to 5	0 to 2.5	45 to 50	115 to 120	860	697	100
Karen Taylor	0 to 2.5	0 to - 2.5	35 to 40	80 to 85	594	488	64
Aderonke Akerele	2.5 to 5	0 to 0	5 to 10	0 to 0	103	61	28
Dr Asif Zia	0 to 2.5	-7.5 to -10	45 to 50	110 to 115	934	816	66
Mariejke Maciejewski	0 to 2.5	2.5 to 5	10 to 15	20 to 25	224	152	34

Non-Executive Directors do not receive pensionable remuneration.
**Tom Cahill has Mental Health Officer status and has reached maximum service of 40 years. There is no real increase to his pension or lump sum at age 60. His CETV has increased over the year as the calculation of this figure includes age specific factors.*

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

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

Accounting Officer approval of the Remuneration Report

Tom Cahill, Chief Executive
Dated: 22 May 2019

2.3 Staff Report

2.3.1 Analysis of staff costs

Staff Group	Permanently employed £000	Other £000	Total £000
Admin and Estates	27,883	714	28,597
Healthcare assistants and other support	27,861	745	28,606
Medical and Dental	21,166	1,293	22,459
Nursing and Midwifery	37,890	3,172	41,062
Scientific, Therapeutic and Technical	29,575	877	30,452
Grand Total	**144,375**	**6,801**	**151,176**

2.3.2 Staff numbers analysis

Staff Group	Permanently employed £000	Other £000	Total £000
Admin and Estates	738	235	973
Healthcare assistants and other support	884	333	1217
Medical and Dental	139	75	214
Nursing and Midwifery	729	129	858
Scientific, Therapeutic and Technical	634	64	698
Grand Total	**3124**	**836**	**3960**

Breakdown of the number of male and female staff

Staff Group	Female	Male	% Female	% Male	Total
Directors	4	5	44%	56%	9
Other senior managers	3	4	43%	57%	7
Medical and Dental	115	98	54%	46%	213
Employees	2752	979	74%	26%	3731
Grand Total	**2874**	**1086**	**73%**	**27%**	**3960**

Sickness absence data

The Workforce and Organisational Development (OD) Team work closely with operational managers to offer advice on the application of the sickness absence policy and procedure, providing training and one to one coaching to ensure the fair and consistent application of the policy. Throughout 2018/19 we have continued to be supportive towards staff who have been absent from work due to ill health, and have worked with our Occupational Health providers to offer advice and make reasonable adjustments in the workplace for staff returning to work after periods of absence.

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

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

- An employee assistance programme
- Cognitive Behavioural Therapy
- Physiotherapy services

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

- Mini health checks
- Massages
- Mindfulness sessions
- Hydration challenge
- Couch to 5k
- Swimming challenge
- Sports days

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

The table below shows the number of full-time equivalent days available in 2018/19 against the full-time equivalent days lost to sickness.

Staff Group	FTE Days available	FTE Days Sickness	%FTE Days sickness
Admin and Estates	237,395.81	9,832.99	4.14%
Healthcare assistants and other support	287,082.79	17,525.36	6.10%
Medical and Dental	66,615.79	1,680.87	2.52%
Nursing and Midwifery	248,416.29	11,310.04	4.55%
Scientific, Therapeutic and Technical	216,137.67	5,865.49	2.71%
Grand Total	**1,055,648.34**	**46,214.75**	**4.38%**

2.3.3 Staff policies and action applied during the financial year

We have continued to work on streamlining our policies, benchmarking where possible with other NHS Trusts and professional bodies. We aim to provide a streamlined process which is less onerous for all staff and managers. We carry out this work in partnership with our staff side colleagues. Our policies are discussed and agreed at the Trust's Policy Group before final ratification at Joint Consultative Negotiating Committee (JCNC). Our policy group is chaired by an operational manager with input and representation from operational and professional leads. This allows us to explore a variety of professional opinions and expertise when we consider how a new or amended policy will work in practice.

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

We work in partnership with full-time and local staff representatives. The Trust has both formal and informal monthly meetings with the trade unions. We discuss strategic issues at JCNC meetings which take place once every two months, while operational issues and staff concerns are raised and addressed at operational Partnership Group meetings, which also run every other month. The Trust also works in partnership with staff representatives in applying the Agenda for Change job evaluation process and to implement joint working on the roll out of the new Agenda for Change Contract Refresh. We also work in partnership on key projects and plans in relation to Bullying and Harassment action plans, Gender Pay Gap and WRES.

Anti-fraud and corruption

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

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

Staff incidents

The Trust has reported a total of 25 staff incidents to the Health and Safety Executive (HSE) under the Reporting Injuries and Dangerous Occurrences Regulations (RIDDOR) during 2018/19. This compares to 41 in 2017/18.

Twenty of the incidents were as a result of a physical assault against staff, and four of the twenty resulted from one incident during a restraint. Five incidents were as a result of a slip, trip and fall.

The Trust has issued over 831 lone working devices to those staff who undertake "High Risk" lone working duties. There have been no Red Alert activations during the year requesting the emergency services to attend to support and assist staff.

2.3.4 NHS National Staff Survey

2.3.4.1 Our approach to staff engagement

To increase organisational performance engaging with the workforce is key. The Trust has used the Holbeche & Matthews model of engagement which connects four areas between individuals and the organisation.

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

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

Engagement events included two Big Listen events held at The Colonnades, Hatfield and Local Listen events held in Buckinghamshire, Essex and Norfolk. These events are open to all staff in the organisation and provide the opportunity for the Executive Team to hear staff views on key topics and priorities, informing actions and improving employee satisfaction and wellbeing.

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

The Chief Executive holds breakfast meetings every quarter inviting different staff groups to feedback their views and experiences of working for the Trust and explore how we can improve the quality of care for service users. This year breakfast meetings were held with Medical Consultants, Staff Nurses Bands 5 and 6, Assistant Psychologists and Occupational Therapists. The main themes arising from these meetings echo the feedback from other forums and centre on workload pressures, staffing levels and IT.

The Executive Team held more face to face engagement sessions across the Trust to develop our Good to Great strategy. The roadshows were an opportunity for staff to have conversations with the Executive Team and provide feedback on the areas of interest.

We also run quarterly 'pulse' surveys to review staff satisfaction levels throughout the year. The questionnaire has a number of questions similar to the national staff survey plus extra questions relating to local evaluation or commissioner reporting. We analyse the quantitative and qualitative data and report them to Trust Board. The results inform local activity plans.

As a result of employee engagement feedback we have:

- Improved e-learning with a new online Learning Management System, Discovery
- Improved Recruitment processes with retire and return and streamlining recruitment processes so reduced length of time to hire
- Better support for new staff joining the organisation by introducing our Buddy Scheme
- Speed up access to necessary IT equipment and ordered an additional 250 laptops to reduce the backlog
- Better support for managers with our Management Fundamentals and Coaching as a management style programmes
- Greater personal development opportunities with the refreshed Leadership Academy and the Trust has trained 8 ILM Level 5 in houses coaches to support personal development

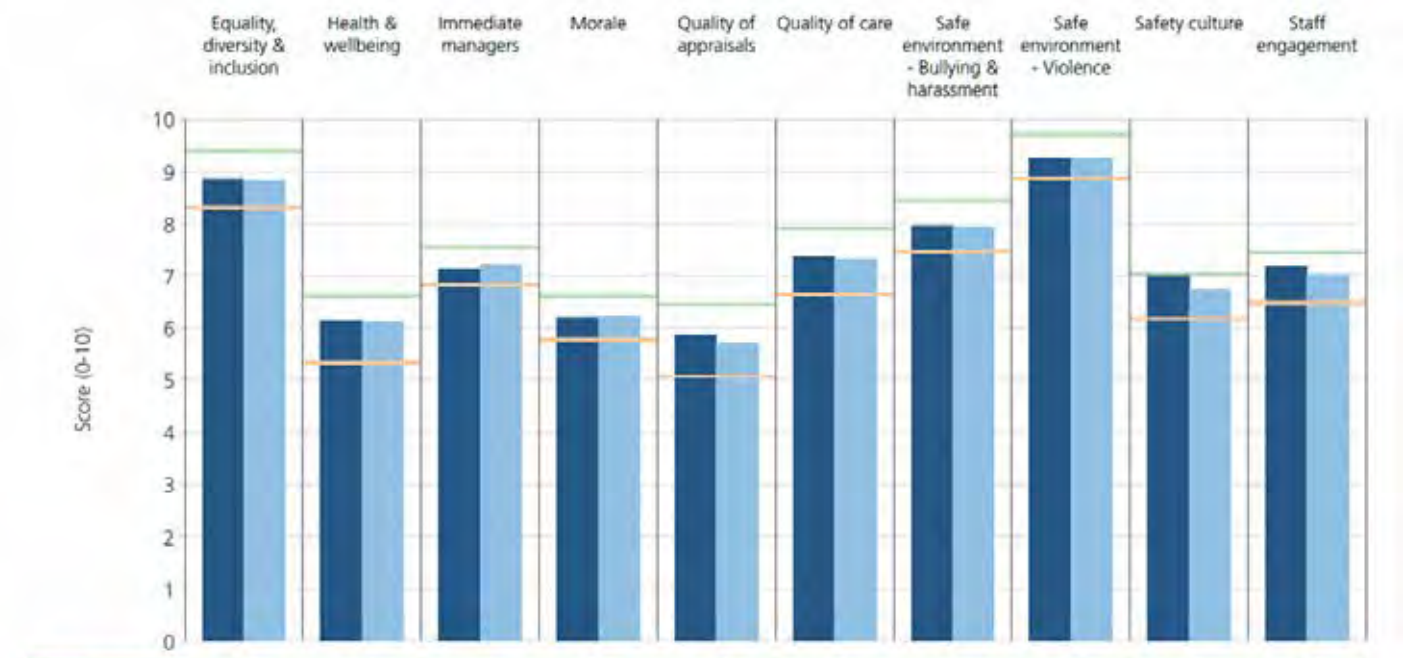
2.3.4.2 Summary of performance

Our 2018 National NHS Staff Survey results demonstrate that the Trust has maintained a positive position particularly in comparison to the last two years where we had really positive staff survey results. There were no significant differences between the 2017 and 2018 scores. The Trust achieved a 41% return rate.

There are a number of changes to the benchmarked report this year in comparison to previous years. Most notably is that the 32 key findings have been replaced by 10 themes. A theme focussing on morale has also been introduced.

- 4 themes are above average in comparison to Mental Health and Learning Disability Trusts
- 4 themes are average
- 2 themes are below average

It should be noted that both the below average scores were 0.1 away from being average.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.5	6.6	6.4	7.9	8.4	9.7	7.0	7.4
Your org	8.8	6.1	7.1	6.2	5.9	7.4	7.9	9.2	7.0	7.2
Average	8.8	6.1	7.2	6.2	5.7	7.3	7.9	9.3	6.7	7.0
Worst	8.3	5.3	6.8	5.8	5.1	6.6	7.5	8.9	6.2	6.5
No. responses	1,217	1,224	1,232	1,201	1,044	1,055	1,208	1,206	1,218	1,255

For the theme of “safety culture” the Trust achieved the national best score of 7.0 and scored above average for every question within the theme. The work that has been undertaken by staff over the last year to embed a culture of safety throughout the Trust with the use of SWARMS, safety huddles, the introduction of the moderate harm panels and zonal observations has been positively recognised in the staff survey.

Our five highest ranking scores, all of which are above the national average for Mental Health and Learning Disability Trusts are:

Top 5 scores (compared to average)	2018 Trust	2018 Mental Health Average	2017 Trust	Trust Improvement/ Deterioration
Q22b. Receive regular updates on patient/service user feedback in my directorate/department	73%	60%	72%	Improvement +1
Q19e. Appraisal/performance review: organisational values definitely discussed	48%	40%	40%	Improvement +8
Q22c. Feedback from patients/service users is used to make informed decisions within directorate/department	67%	59%	64%	Improvement +1
Q17c. Organisation takes action to ensure errors are not repeated	76%	69%	73%	Improvement +3
Q21b. Organisation acts on concerns raised by patients/service users	81%	73%	81%	No change

The Trust's bottom ranking scores are below

Bottom 5 scores (compared to average)	2018 Trust	2018 Mental Health Average	2017 Trust	Trust Improvement/ Deterioration
Q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work	70%	76%	71%	Deterioration -1
Q4d. Able to make improvements happen in my area of work	56%	61%	59%	Deterioration -3
Q13d. Last experience of harassment/ bullying/abuse reported	53%	57%	61%	Deterioration -8
Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	28%	25%	29%	Improvement +1
Q19f. Appraisal/performance review: training, learning or development needs identified	70%	71%	69%	No change

	Trust 2017	Trust 2018	Mental Health Average 2018	Trust Improvement/ Deterioration
Response Rate	47%	41%	54%	Deterioration -6%

People are our greatest asset and a focus for us was continuing to improve the experience of staff, inclusively, in the workplace. One element of this is our aspiration to eliminate any experience of bullying and harassment. We have put in place actions designed to support this aspiration which are monitored constantly and progress is evaluated on a regular basis. Our values are embedded across the organisation and the recent CQC report has confirmed this is felt by our service users. In 2019/20 we will continue to focus on demonstrating how our values translate into the workplace and develop our working relationships as a means of eliminating bullying and harassment within the Trust.

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

- Staff experiencing bullying and harassment
- Support from managers
- Health and wellbeing of staff
- Staff morale

The development of the Innovation Hub and continuous improvement initiatives will also facilitate employee engagement and feedback.

2.3.4.3 Future Priorities and Targets

Our priorities going forward are to support the delivery of the Good to Great strategy by:

- Embedding a culture of innovation and continuous improvement across the Trust
- Developing leaders by building on the Collective Leadership model.
- Introducing the High Performing Team model
- Building on the engagement activities within the Trust
- Delivering key improvements identified in our collective leadership work:
  - supporting managers to delegate and take accountability
  - ensuring workloads are manageable
  - boosting empowerment and involvement in decision making
- Continuing the development of current clinical leaders
- Supporting developments to improve the experience of all staff working for HPFT
- Developing our staff to better support service users to stay as well as possible as outlined in the Trust Quality and Service Delivery Strategy

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

2.3.5 Expenditure on Consultancy

The total expenditure on consultancy for the year is £701k. This includes the provision of specific expertise or short-term project capacity on areas such as Estates development, Service redesign, project assurance and IT consultancy where the Trust does not have the specialist expertise and/or the capacity to deliver projects and initiatives within the required timescales. The main areas of expenditure in this category for 2018/19 were £95k for IT support for the development of a new data warehouse, £25k for an independent review and advice on the development of our corporate services, £96k for support with major bid tenders, £30k for project management support to implement the Safer Care project and £50k to support the development of the longer term efficiency programme.

2.3.6 Off-payroll engagement

Table a: Off-payroll engagements as of 31 March 2019, for more than £245 per day and last for longer than six months

	Number
Total number of existing arrangements as of March 31 2019	**6**
Of which the number that have existed for;	
less than one year at time of reporting	0
between one and two years at time of reporting	0
between two and three years at time of reporting	2
between three and four years at time of reporting	3
four or more years at time of reporting	1

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

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

Table b: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	**2**
Of which;	
No. assessed as within the scope of IR35	0
No. assessed as not within the scope of IR35	2
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency/assurance purposes during the year	0
No. that saw a change to IR35 status following the consistency review	0

Table c: Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	9

2.3.7 Trade Union Facility Time

From 1 April 2017 the Trade Union (Facilities Time Publication Requirements) Regulations 2017 were introduced. At HPFT facilities time is agreed in partnership with accredited trade unions that actively support members of staff. This information is public on the Trade Union Facilities time government portal. The regulations require public sector employees to collect and publish, annually a range of data in relation to their usage and spend of trade union facilities time in respect of their employees who are trade union representatives. Facilities time is defined as the provision of paid or unpaid time off from an employee's normal role to undertake trade union duties as a trade union representative. This is a statutory entitlement to reasonable time off for undertaking union duties.

The publication requirements and our data as at 31 July 2018 was;

- HPFT had 17 employees who were relevant union officials during the relevant reporting period. This equates to 16.2 full time equivalents
- Of the 17 employees who were relevant union officials;
    - 1 spent 0% of their working hours on facilities time
    - 14 spent 1-50% of their working hours on facilities time
    - 0 spent 51-99% of their working hours on facilities time
    - 2 spent 100% of their working hours on facilities time
- The percentage of the total pay bill spent on facilities time was 0.08%
- The time spent on paid trade union activities as a percentage of the total facilities time hours was 7.54%

2.3.8 Exit Packages

There were no exit packages agreed in 2018/19 (3 in 2017/18 totalling £116k).

2.4 Code of Governance

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

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

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

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

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

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

The Board of Directors, Chair and Executive

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

Chair and Chief Executive

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

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

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

The statutory and assurance committees of the Board

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

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

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

- Internal Audits. Receiving updates on progress against actions from internal audits such as Patient Safety, Preparation of Quality Accounts and Key Financial Controls.
- Counter Fraud. Regular updates and progress on fraud issues and investigations as well as compliance with new NHSCFA standards for Providers.
- Data Quality. Relaunch of Data Quality Strategy in August 2018 as the Accurate Information Strategy to facilitate more robust date management.
- Preparations for leaving the European Union. Receiving updates and plans to mitigate against the possible risk of a “no deal” Brexit scenario with identified risks and mitigation strategies.
- General Data Protection Regulation. Preparation and action for GDPR compliance from May 2018.
- Accounting issues. Presentation of key areas of management judgement in the preparation of the annual financial statements with particular reference to:
  - The new accounting standards introduced during the year and the work carried out in relation to their adoption.
  - The level and nature of provisions for potential future costs including the continuing care obligations, which relate to claims for retrospective reimbursement of care costs met by individuals which potentially may qualify for NHS funding and the liability for dilapidations or restatement costs on the leasehold properties currently occupied.
  - The current Property Valuations and the proposal to carry out a partial valuation this year in particular focussed on the continued relevance of use of ‘Modern Equivalent Asset’ valuations for specific properties.
  - The reporting requirements that arise on the TUPE transfer of employees from Essex County Council who have chosen to remain within their existing Essex Pension Fund.
  - The capitalisation of the development costs relating to the SPIKE 2 Business Intelligence system launched during January 2019.
  - Property Valuations and the use of ‘Modern Equivalent Asset’ valuations.

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

External Audit

During 2017/18 a competitive tender exercise for future external audit services was undertaken in accordance with Trust Standing Financial Instructions following which KPMG LLP were appointed as auditors for the 2018/19 financial year end. The primary duty of our external auditors is to conduct an official inspection (audit) of the Annual Report, financial statements and quality account of the Trust and provide a level of assurance on each of these and an overall level of assurance.

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

The audit is conducted in accordance with International Standards on Auditing (UK and Ireland) as adopted by the UK Auditing Practices Board ("APB"), the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by NHS Improvement. It remains important that the external auditor's independence from management is both maintained and transparent. Therefore, any additional non-audit work carried by or contracted with KPMG LLP is reported within their annual plan and updated and reported again in their year end report. Throughout the year any non-audit work agreed between the Trust and KPMG LLP will be reported and approved by the Audit Committee prior to contracting. The cost of any non-audit work is shown separately in the accounts and in the table below. No non-audit work has been carried out or contracted in year. The KPMG external audit team do provide assurance over the Quality Report and this is included within their annual contract of work.

The total external audit fee for 2018/19 (excluding VAT) was £69k, comprising:

Audit Area	Audit Fee £k
Statutory	60
Quality	9

Anyone who may be concerned about a matter of corporate governance or probity can contact any member of the Audit Committee in confidence. The Chief Executive is invited to attend the Audit Committee at least once a year to discuss, with the committee, the process for assurance that supports the Annual Governance Statement.

Integrated Governance Committee (IGC)

The role of the Integrated Governance Committee is to:

- Assure adherence to CQC and other relevant regulatory requirements for quality and safety and receive reports from all relevant quality and safety groups.
- Receive minutes, reports, action plans and risk registers from the following standing sub-committees of the IGC:
- Quality and Risk Management Committee
- Workforce and Organisational Development
- The following groups will also report on specific items relating to areas of regulatory compliance:
    - Operations Group
    - Information Governance Group.
- Advise on the content and development of the Annual Governance Plan and supervise, monitor and review it and the Trust-wide Risk Register and make recommendations for improvement.
- Scrutinise and provide assurance to the Trust Board through regular reports on governance, quality and risk issues and to escalate any risks or concerns to the Board Assurance Framework (BAF) as appropriate where assurance is not adequate. Reports are also being sent to the Audit Committee for scrutiny and recommendations.
- Set standards for the Trust Governance systems in order to:
    - Meet performance targets
    - Meet core and developmental standards
    - Manage risks
- Recommend to the Trust Board necessary resources needed for the IGC to undertake its work.

- Advise on the production and content of the Annual Governance Statement and make recommendations to the Chief Executive as necessary prior to its review at Audit Committee, its approval at the Board and subsequent inclusion in the Annual Report.
- Advise on the content, format and production of an Assurance Framework for the Trust Board and monitor its ongoing suitability and make recommendations to the Audit Committee and the Board as necessary.
- Advise on the content, format and production of the Annual Quality Account.
- Ensure that appropriate risk management processes are in place that provide the Board with assurance that action is being taken to identify risks and manage identified risks within the Trust.
- Be responsible for developing systems and processes for ensuring that the Trust implements and monitors compliance with the Care Quality Commission's registration requirements.
- Oversee the establishment of appropriate systems for ensuring that effective practice governance arrangements are in place throughout the Trust.
- Ensure that the learning from inquiries carried out in respect of Serious Incidents is shared across the Trust and implemented through policies and procedures as necessary.
- Ensure that services and treatments provided to service users are appropriate, reflect best practice and represent value for money.
- Ensure that plans are in place to improve the service user experience.
- Ensure that services are accessible and responsive to service users' needs and reflect local "nuances".
- Ensure that the environments in which services are provided are appropriate and therapeutic.
- Ensure that the organisation is engaged in public health programmes and these are integrated throughout the services we provide.

The Finance and Investment Committee

The role of the Finance and Investment Committee:

Financial Policy, Management and Reporting

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

Investment Policy, Management and Reporting

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

Other

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

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

Council of Governors

The Trust is able to have up to 39 Governors. The Council of Governors is constituted to have 21 public governors from two constituencies, namely Hertfordshire and the Rest of England, plus 5 Staff Governors and up to 13 appointed governors, nominated by the Trust's partner organisations. Table 5 below shows the current Trust Governor profile.

Table 5 – Governors: 1 April 2018 to 31 March 2019

Name	Date Appointed	End Date	Resignation/ End Date	Number of Terms	Meetings Attended
Chris Lawrence (Chair)	01 July 2012	31 July 2020		2	4/4
Tap Bali	01 August 2012	31 July 2021	Re-elected	3	3/4
Caroline Bowes-Lyon	01 August 2011	31 July 2020	Re-elected	3	3/4
Barry Canterford	01 August 2013	01 July 2019		2	2/4
Mark Edgar	01 August 2013	31 July 2019		2	1/4
Mathew Kunyeda	01 August 2018	31 July 2021	New Appointment Term	1	0/4
Verity Masters	01 August 2016	31 July 2019		1	1/4
Kwasi Opoku	01 August 2013	31 July 2019		2	0/4
Bob Taylor	01 August 2016	31 July 2019		1	4/4
Jon Walmsley	01 August 2016	31 July 2019		1	3/4
Emma Paisley	01 August 2015	31 July 2021	Re-elected	2	4/4
Richard Pleydell-Bouverie	01 August 2013	31 July 2019	Resigned January 2019	2	2/3

Name	Date Appointed	End Date	Resignation/ End Date	Number of Terms	Meetings Attended
Ilana Rinkoff	01 August 2016	31 July 2019		1	4/4
Angelina Sclafani-Murphy	01 August 2013	31 July 2019		2	1/4
William Say	01 August 2017	31 July 2020		1	4/4
Colin Egan	01 August 2017	31 July 2020		1	0/4
Meredith Griffiths	01 Aug 2017	31 July 2020		1	2/4
Harinder Singh Pattar	01 August 2017	31 July 2020	New Appointment Term	1	0/4
Emily Burke	01 August 2018	31 July 2021	New Appointment Term	1	3/3
Catherine Adedoyin Akanbi	01 August 2018	31 July 2021	New Appointment Term	1	1/3
Eni Bankole-Race	01 August 2018	31 July 2021	New Appointment Term	1	3/3

Appointed Governors

Name	Date Appointed	End of Office	Meetings Attended
David Andrews	01 August 2013		3/4
Leslie Billy	01 August 2013	03 September 2018	1/1
Ray Gibbins	04 September 2018		3/3
Fran Deschampsneufs	01 August 2012		2/4
Rosemary Farmer	01 December 2014		1/4
Amy Wilcox-Smith	01 February 2016	28 December 2018	0/4

Staff Governors

Name	Date Appointed	End Date	Number of Terms	Meetings Attended
Herbie Nyathi	01 August 2016	31 July 2019	1	1/4
Michael Shortt	01 August 2016	31 July 2019	1	2/4
Graham Wright	01 August 2016	31 July 2019	1	2/4

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

The Council of Governors and the Board of Directors have a good working relationship. Both are chaired by the Trust Chair, and they hold five joint meetings annually, including the AGM. The Directors also have an open invitation to attend all Council of Governors meetings. The Chair and the Company Secretary act as the main links between the Board and the Council, and reports and briefings are shared by the Governors and Directors. The Trust Constitution includes a process for settling any disagreements between the Council and the Board of Directors. This process was written by the Council and the Board.

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

- Chair of Trustees, The Horstead Residential Activities Centre, Norfolk
- Lay Canon and member of the Council of Norwich Cathedral
- Liveryman, The Worshipful Company of Musicians
- Court Liveryman

The range of issues the Council of Governors has dealt with as part of their statutory duties, includes:

- Appointing the Trust's External Auditors
- Electing a Deputy Chair Governor
- The recruitment of non-executive director roles

The Governors have also been involved in:

- The Trust's Annual Members' Day and several members' workshops focusing on Trust Services
- Undertaking the Chair's performance appraisal of the Chair
- Once a year we hold a workshop with governors so they can contribute feedback, their own and the views of members, staff members and the public, to the Trust's forward plan.

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

- Engagement
- Performance
- Quality and effectiveness

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

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

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

Membership

Currently our membership stands at 9,194. The introduction of a new data management system in 2017 has significantly improved the accuracy of the data we hold. By regularly cleansing the database of individuals who have passed on or moved away and by flagging up any discrepancies, the system has enabled us to reduce the postage and manpower costs of distributing election materials and our member's magazine Partnership Matters. We are also encouraging our members to receive membership correspondence by email in a further effort to reduce costs and over the year we have noticed a definite trend towards members choosing electronic forms of communication.

We continue to look at new and innovative ways to both recruit and retain members that represent the diverse population we serve. We have encouraged people to join up by supporting governors to speak to local U3A's and other groups. Through Partnership Matters (our members magazine) and our website we have encouraged more people to join the Trust and to get involved in a wide range of ways: from standing in our Governor Elections to becoming a member of our Involvement Councils and promoting volunteering.

To be eligible for membership, people must be:

- over the age of 14 and living either within the County of Hertfordshire or the Rest of England and Wales
- or be employed by the Trust and have a permanent contract or a temporary contract lasting 12 months or more
- or, although not directly employed by the Trust, have been either employed for longer than 12 months by another organisation that is providing core services to the Trust or seconded to the Trust to provide core services

Partnership Matters, which is produced bi-annually, remains our primary medium for engaging with members and the wider community. The website is a good source of information about the work of the Council of Governors.

It is important to that we continue our efforts to recruit a diverse and representative membership. So, in the next 12 months we will increase our efforts to find new ways and creative ways to reinvigorate our membership.

Membership size and movements

Public constituency	2018/19
Year start (1 April)	10,173
New members	22
Members leaving	1,001
Year end (31 March)	9,194

Staff constituency	2018/19
Year start (1 April)	3252
New members	530
Members leaving	516
Year end (31 March)	3266

Public constituency	2018/19
Age (years)	
0 - 16	3
17 - 21	9
22+	8,525
Not specified	657

Ethnicity	2018/19
White	7,736
Mixed	434
Asian or Asian British	450
Black or Black British	7
Not specified	446

Gender analysis	2018/19
Male	3,666
Female	5,512
Not specified	16
Black or Black British	7
Not specified	446

Disclosure issues

Requests for information/ disclosure Issues

Freedom of Information Act 2000 (FOIA)

The number of Freedom of Information Act 2000 (FOIA) requests received by the Trust during this year has increased by 23%. Also, the complexity and number of questions asked has increased. The Trust received a total of 392 requests compared with 320 for 2017/18 and 242 for 2016/17.

Who has asked for information?

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

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

Type of requester	No. of requests 2018/19	No. of requests 2017/18	No. of requests 2016/17
Other/Unknown	248	188	219
Companies	10	28	61
Journalists	63	60	55
Staff/Other NHS Trusts	30	34	17
Students	36	1	3
MPs	5	9	11
Total Number	392	320	366

Timescale for responses

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

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

Information has been provided to applicants within the following timescales:

Type of requester	No. of requests 2018/19	No. of requests 2017/18
1 - 5 days	59	18
6 - 10 days	26	41
11 - 15 days	32	52
16 - 20 days	23	29
21+ days	203	145
Requests currently being processed	49	35

Exemptions

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

The following exemptions were considered and applied to all or part of a request during 2018/19:

- Section 1: Do not hold this information
- Section 12: Cost of compliance exceeds appropriate limit
- Section 14: Vexatious
- Section 21: Information available by other means
- Section 22: Information intended for future publication
- Section 31: Law enforcement
- Section 40: Personal information
- Section 41: Information provided in confidence
- Section 43: Commercial interests

Year	No of requests with exemptions applied	Exemptions used and frequency
2018/19	101	Section 1 x 16
		Section 12 x 15
		Section 14 x 3
		Section 21 x 39
		Section 22 x 1
		Section 31 x 2
		Section 40 x 16

(2017/18, 67 exemptions were applied)

Publication of information requested (disclosure log)

Requests from the previous 2 financial years are routinely published on the FOIA disclosure log on the Trust website. https://www.hpft.nhs.uk/information-and-resources/freedom-of-information-foi/information-requested/. This enables us to direct applicants to information already available and to apply exemption Section 21 (information accessible by another means) where the same/similar information has been requested. The Trust has applied this exemption for 39 requests received during the period 2018/19.

Over the course of the next year, the Trust will be identifying trends in FOIA requests to understand the key areas of interest for the public; the intention being to make this information available on our website in a clear and accessible format.

Data Protection Act 2018 (DPA)

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

Year	SARs Received	Continuing Care (CC)	SARs Processed (Excluding CC)	% Increase / Decrease Year on Year
2018/19	**583**	**24**	**559**	**25%**
2017/18	465	8	457	6%
2016/17	437	22	415	-0.2%

Please note, in addition to the above figures for 2018/19 we have received a request from the Police for a specific operation they are conducting; there were 38 requests of which we have completed 19.

Timescale for responses

DPA legislation requires the Trust to provide information within one calendar month. HPFT works to a 28 day turnaround to enable good practice. The Department of Health guidance advises that healthcare organisations should aim to respond within 21 days.

During the period 1 April 2018 – 31 March 2019, SARs were processed within the following timescales (this excludes the special project details above):

Response Time	Number of SAR requests 2018/19
Within 21 calendar days	153
Within 28 calendar days	133
Within 30 calendar days	33
30+ calendar days	13
No longer required or closed during processing	64
In progress	152

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

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

Type of requester	Total
Advocate	2
Continuing Care	24
Court Order	12
Investigatory Body	13
Other NHS Trust	23
Police	95
Relatives	43
Service User	175
Solicitors	193
Others	3
Total Number	**583**

2.5 Single Oversight Framework

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

The framework covers five themes:

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

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

Segmentation

This segmentation information shows our position as at 31 March 2019. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

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

The performance against the financial performance ratings for the Trust for 2018/19 are summarised in the table below;

2.5 Single Oversight Framework

We exceeded our planned Use of Resources ratings for Capital Servicing Capacity and those relating to the I&E Margin. This was because our surplus was above plan, our capital spends lower than planned, and capital charges were reduced. In significantly reducing our agency costs from the previous year we achieved our agency spend target of £7.3m resulting in a rating of 1. We are continuing to work collaboratively with other local NHS organisations and NHS Improvement to continue to reduce agency spend for 2019/20: NHS Improvement have maintained the expenditure cap to £7.3m for next year which reflects the strong performance achieved this year.

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

Area	Metric	2018/19				2017/18			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Financial sustainability	Capital Service Capacity Rating	2	2	1	2	1	1	1	1
	Liquidity Rating	1	1	1	1	1	1	1	1
Financial efficiency	I&E Margin Rating	2	2	2	1	1	1	1	1
Financial controls	I&E Margin Variance Rating	1	1	1	1	1	1	1	1
	Agency Rating	2	1	1	1	2	2	2	1
Overall scoring		**2**	**1**	**1**	**1**	**1**	**1**	**1**	**1**

2.6 Statement of Accounting Officer's Responsibilities

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

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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgments and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy 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/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Accounting Officer approval of the Statement of Accounting Officers responsibilities

Tom Cahill, Chief Executive
Dated: 22 May 2019

2.7 Annual Governance Statement 2018/19

2.7.1 Scope of responsibility

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

2.7.2 The purpose of the system of internal control

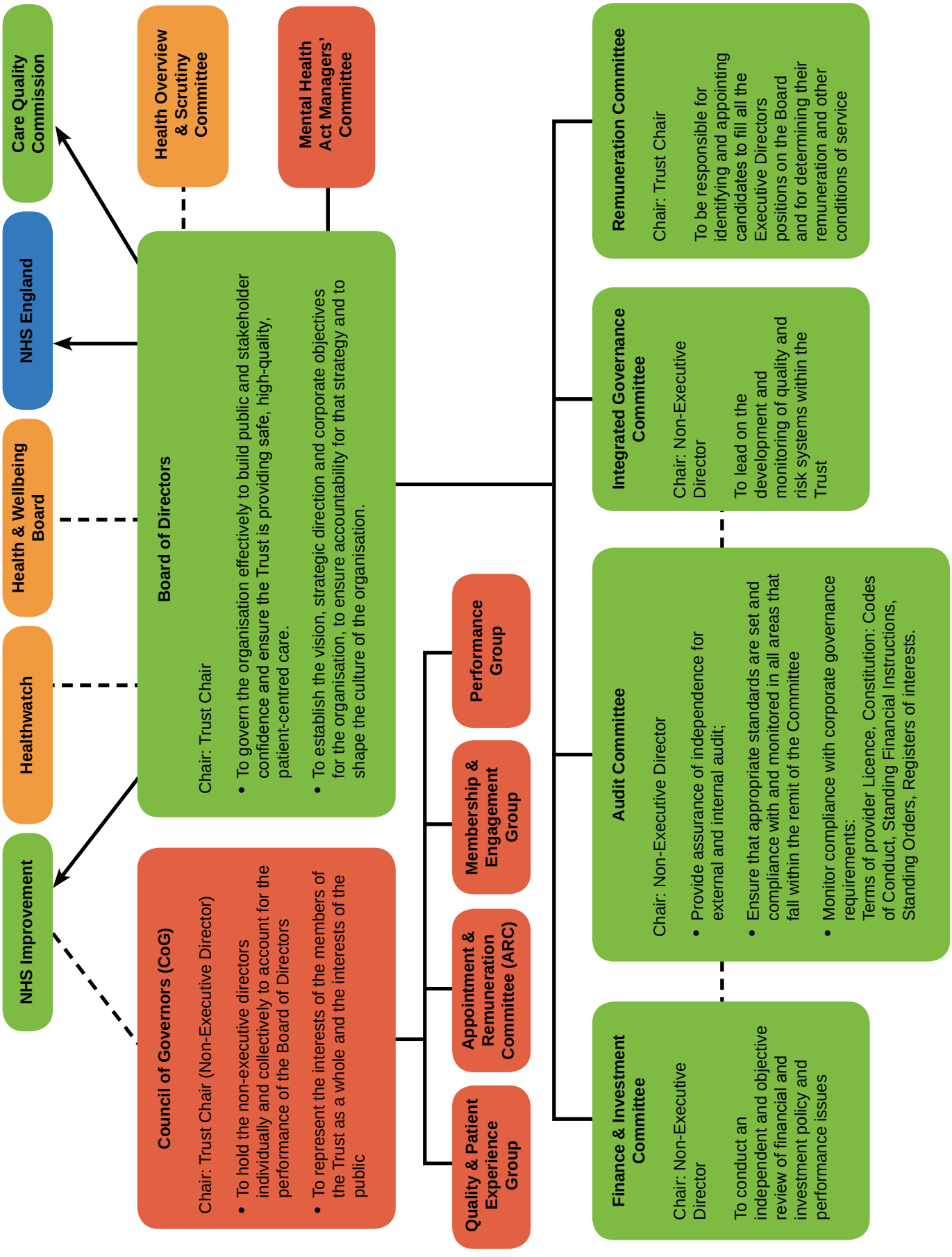
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Hertfordshire Partnership University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Hertfordshire Partnership University NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

2.7.3 Capacity to handle risk

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

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

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



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

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

Capacity and capability is developed across the Trust through training events commensurate with staff duties and responsibilities and includes risk management training for all new staff. Awareness raising sessions have also taken place for existing staff teams.

Sharing the learning through risk related issues, incidents, complaints and claims is an essential component to maintaining the risk management culture within the Trust. Learning is shared through Clinical Management Teams and Trust-wide forums such as the Quality and Risk Management Committee and Health and Safety Committee. Learning is acquired from a variety of sources which include:

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

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

In order to assist both the Board and the Audit Committee, specific risk management is overseen by two other Board Assurance Committees:

- Integrated Governance Committee (which receives reports from the Quality and Risk Management Committee and Workforce and Organisational Development Group) and has the specific purpose of delivering assurance to the Board on the management of clinical risk and operational performance against the CQC domains.
- Finance and Investment Committee, which provides assurance on management of risks relating to resources – both financial and human; and the strategic direction of the Trust.

Our Risk Management and our Risk Escalation Models are set out at **Figure 2** and **Figure 3** respectively.

2.7.4 The risk and control framework

2.7.4.1 Risk management by the Board is underpinned by four (4) interlocking systems of internal control:

- The Board Assurance Framework
- Trust Risk Register (informed by Strategic Business Units, Departments and Teams)
- Audit Committee
- Annual Governance Statement

The Risk Management Strategy and Policy which are effective guides on risk management have continued to work effectively during 2018/19. Our Risk Management system, Datix, has continued to be a source of effective risk management across all levels and a source of just-in-time reports as necessary. The risk management processes remained the same as defined within the Board Assurance and Escalation Framework. This clearly outlines the leadership, responsibility and accountability arrangements. These responsibilities are then taken forward through the Assurance Framework, the Risk Registers, Business Planning and Performance Management processes enabling the coherent and effective delivery of risk management throughout the organisation.

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

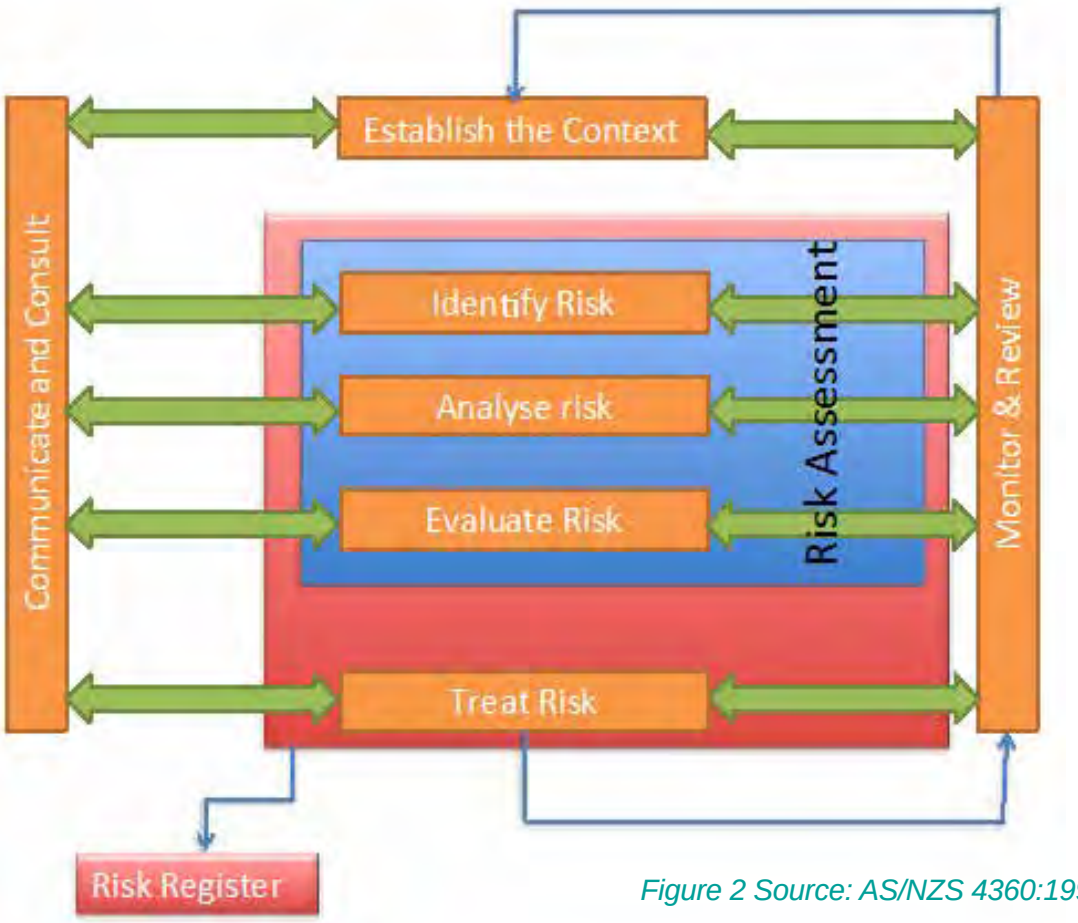


Figure 2 Source: AS/NZS 4360:1999

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

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

The Integrated Governance Committee is 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. This includes oversight of the performance and quality dashboards which show compliance with CQC registration requirements and other statutory compliance with quarterly reports being scrutinised prior to their submission to the Board.

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

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

The Trust has a strong track record in:

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

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

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

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

2.7.4.2 Board Assurance Framework (BAF)

Board assurance is a systematic method of:

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

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

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

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

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

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

It is a dynamic tool which supports the Chief Executive to complete the *Annual Governance Statement* at the end of each financial year. It is part of this wider 'Assurance and Escalation Framework' to ensure the Trust's performance

across the range of its activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for service users.

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

Risks monitored over the year included:

- Regulatory Compliance
- Quality and Safety including the 2018 CQC Action Plan
- Preparation for EU Exit
- Financial Resources including Placements
- Workforce - recruitment and retention
- Cyber security
- Data Quality and General Data Protection Regulations

The BAF has been updated during 2018/19 to reflect the Board's review of the Trust's strategic objectives and has been reviewed by the Board on a quarterly basis. The format has been revised to give greater clarity on the sources of 1st, 2nd and 3rd lines of assurance.

Leaving the European Union

As required by the Department of Health and Social Care the Trust has undertaken business continuity risk assessments to ensure any gaps in controls are addressed in preparation for an exit of the EU. An EU Exit Working Group provides the forum for risk assessment and planning and response to occurrences with oversight provided by the Emergency Planning Group, reporting to the Executive Team and Integrated Governance Committee. Tests of Business Continuity and Incident Management Plans against EU Exit risk assessment scenarios have been undertaken and Risk Assessments and Business Continuity Arrangements have been reviewed against the following preparedness areas as advised by the Department of Health and Social Care:

- supply of medicines and vaccines
- supply of medical devices and clinical consumables
- supply of non-clinical consumables, goods and services
- workforce
- reciprocal healthcare
- research and clinical trials and
- data sharing, processing and access

The Audit Committee and Board have received reports on EU Exit Preparedness and the potential risks included specifically on the Trust Risk Register.

2.7.4.3 Trust's Risk Monitoring Escalation and Assurance Process

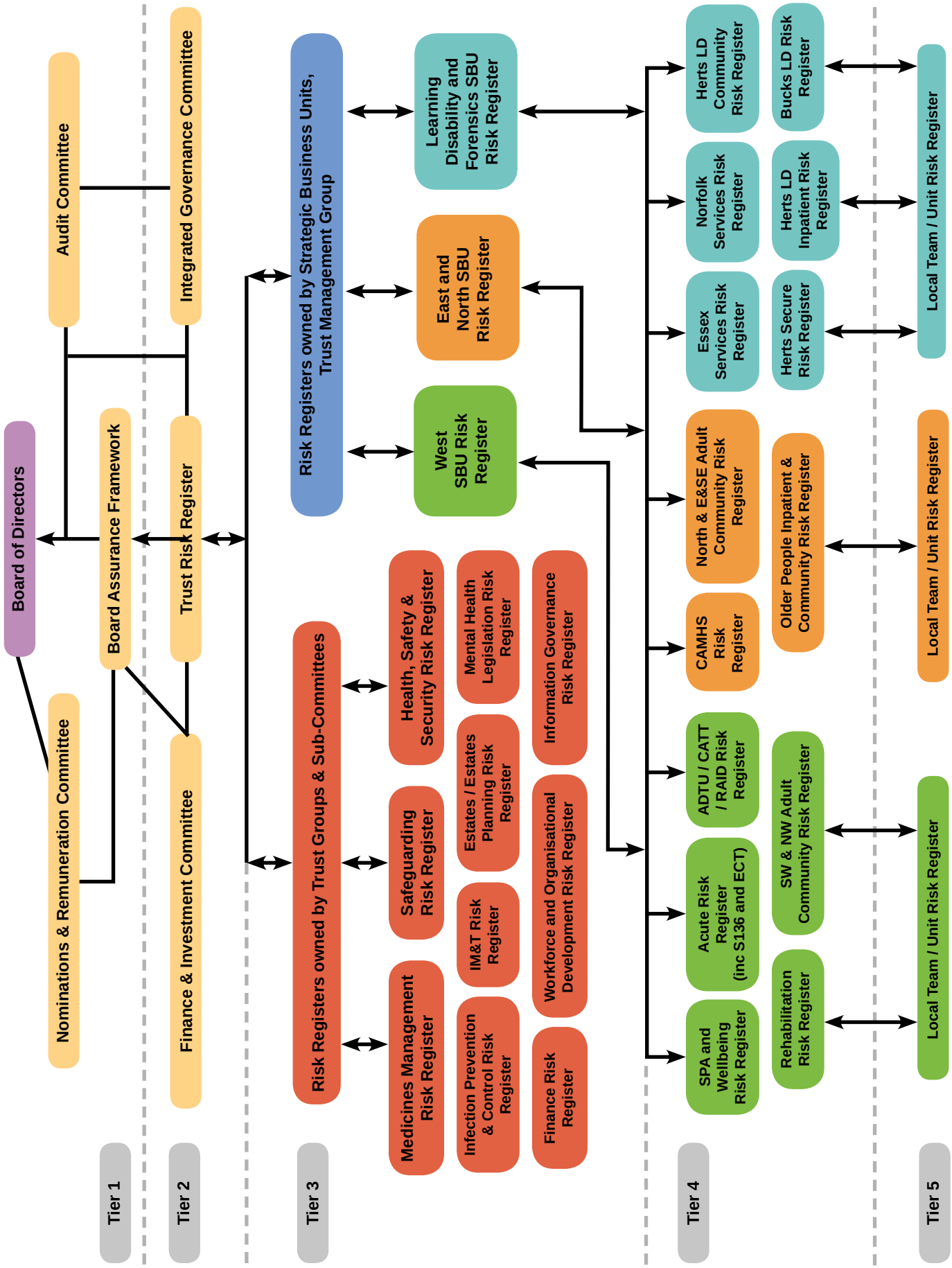
The Risk Management Strategy sets out how risk is identified and assimilated into the Risk Registers and reported, monitored and escalated throughout the directorate and corporate governance structures.

In addition to the Board Assurance Framework (BAF), the Trust operates five tiers of risk management which are all interlinked via an escalation process. The escalation of a risk is dependent upon the level of the risk, or on whether it is felt that the risk needs specialist management at a higher tier, such as the risk requiring a multi-directorate approach to its management.

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

There is a clear process for escalating high or significant risks (see **Figure 3** on page 90).
The Trust does not have a static risk appetite. The Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. In any event there must be consultation with the Board if there needs to be material altering of significant risk scores by directorates, departments or teams. The statutory and assurance committees and the Executive Team have regular oversight of all relevant risks from the Trust Risk Register.

Figure 3 – Board to Ward Risk Management and Escalation Structure



2.7.4.4 Local and Directorate Risk Registers

Each ward team or department produces a local risk register. The register is developed in response to the identification of local risks that may impact on the delivery of their immediate service. Local risk registers are recorded using the risk module in Datix.

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

All local risks are systematically reviewed within a specified time frame by the local teams to ensure that controls in place are effective, and assess whether the risk changes over time.

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

2.7.4.5 Care Quality Commission essential standards of quality

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust receives periodic unannounced CQC Mental Health Act inspections. No significant issues have arisen during 2018/19.

The Trust registered with the Care Quality Commission on 1 April 2010 and received a combined core service inspection and a well led visit in February 2019. The Trust achieved an overall rating of 'Outstanding' with four of the eleven service lines reviewed rated as 'Outstanding'. All other service lines (7) are rated as 'Good'. Overall, Trust staff are rated as 'outstanding' in the caring domain and outstanding in the well led domain.

Feedback from the CQC has been very positive including:

- Staff were very kind, caring and respectful and had a good relationship with the people they cared for, knew them well and what works for them and their carers.
- Everyone the inspectors met was open, honest and enthusiastic and made the inspection team feel welcome.
- There is exceptional leadership at all levels of the organisation.
- People throughout the organisation took personal responsibility for doing better and pushing boundaries for improvement and were fully supported to make changes.

2.7.4.6 Workforce Strategies

The Trust has a Workforce and Organisational Development Group (WODG) which oversees delivery of the workforce strategy, short medium and long term, and reports routinely to the Integrated Governance Committee. The WODG is supported in its role by a number of task oriented groups which focus on specific elements of strategy delivery and operational management including:

- Recruitment & Retention Group
- Workforce Board
- Establishment Control Group

The Annual Workforce Plan is set out within the Trust's Annual plan which is reviewed and approved by the Trust Board.

The Integrated Governance Committee and Trust Board receive periodic safe staffing reports from the Executive Director – Quality and Safety, confirming that staffing levels are safe, effective and sustainable, in line with the 'Developing Workforce Safeguards' recommendations. The Trust has a framework for ensuring real time risk based safe staffing assessment and processes, supported by SafeCare software technology as follows :

- SafeCare Census checks – three times daily and monitored by the Team Leader and Modern Matron with weekly reporting detailing the overall weekly.
- SafeCare calls – these are held daily and chaired by the Head of Nursing to manage and monitor safe staffing within their area of responsibility, ensuring consistency across the Trust on a daily basis (for the next 24 hours). This enables deployment of staff in response to acuity levels, admissions and discharges.
- eRoster Scrutiny on a weekly basis, chaired by the Head of Nursing or Service Line Lead to ensure the effective utilisation of the eRoster
- Safe Staffing Group – held on a monthly basis, chaired by the Deputy Director of Nursing and Quality, responsible for overseeing staffing regarding effective utilisation of eRostering and SafeCare, bank and agency usage, staffing skill mix and establishments.

2.7.4.7 Register of Interest

The Foundation Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

2.7.5 Pension Schemes

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

2.7.6 Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

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

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

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

We completed our most recent grading of the NHS Equality Delivery System 2 in January 2018 with an overall outcome of 'good' and this reflects ongoing progress and improvement. We are currently undertaking a similar grading with stakeholders. During 2019/20 we will be undertaking a full regrading exercise once EDS3 is in place with underpinning activity to include:

- Data quality improvement programmes with a review of equity of access to services and care outcomes.
- Initial reporting and action planning for the Workforce Disability Equality Standard.
- Launch of Gender Identity bitesize training for front line services.
- Increased activity for the NHS Accessible Information Standard.
- Launch of new online forum for staff carers.

2.7.7 Energy and Carbon Reduction

The Foundation Trust has undertaken risk assesments and has a sustainable development management plan in place which takes account of UK Cimate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

2.7.8 Internal and external stakeholders and service user and carer Involvement

The Trust has a

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

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

2018/19 was a productive and active year for service user and carer involvement. A number of members of the service user and carer councils are also elected Trust Governors and equality and diversity champions, and have supported raising awareness of disability, gender and mental health. Over the past year, the Inclusion and Engagement Team have co-produced a new Equality Plan (2019 – 2022) and Carer Plan (2019 – 2021) and continued to work with our staff disabled network and staff mental health network in supporting preparation for the NHS Workforce Disability Equality Standard (WDES).

All our Experts by Experience and volunteers undertake the same induction. This covers topics including:

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

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

At every board meeting, a service user, carer and professional from a specific service are invited to share their experiences and suggest board actions for positive change. At one meeting during 2018/19, a service user presented to the board, informing them of a lack of choice, variation and quality of meals available at our CAMHS inpatient unit. As a result we have invested in a more suitable and flexible menu with fresh cook meals and greater choice.

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

All our groups have worked relatively intensively with staff on local projects that impact service users and carers day-to-day care. It is not only the Trust that listens to, and acts on people's lived experience, our third sector partners do too, and our service users' and carers feedback contributes to local commissioning decisions.

Our focus over the past year has been to use key events to bring a diverse range of people together to focus on a particular area of quality improvement. This has enabled both celebration of diversity and awareness around inequalities that require attention in order to remove barriers and further promote social inclusion. These have included:

- International Women's Day (IWD) Programme 2019
- LGBT History Month
- Carer Rights Day
- Diversity and Leadership
- Hertfordshire Pride

2.7.9 Quality Governance Framework

The Trust's Risk Management Strategy has been updated during 2018/19 and details the relationship between the Trusts strategic goals, principal risks and the Board Assurance Framework. The Risk Management Policy outlines the process for assessing, prioritising and managing all types of risk through risk registers and includes:

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

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

The principal strategic and operational risks are outlined in the Risk Strategy which sets out how the Trust endeavours to ensure that they do not prevent the Trust from achieving its strategic objectives. The Strategy, therefore, sets out the role of the Board, its statutory and assurance committees in the identification, management and mitigation of risks. **Figure 3** on page 90 illustrates the risk escalation process.

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

The Internal Audit Plan has as part of its remit, audit of the Risk Management processes and the Board Assurance Framework. The Integrated Governance Committee, the Finance and Investment Committee and the Audit Committee scrutinise and monitor clinical and non-clinical risks where appropriate, on behalf of the Board. **Figure 1** (on page 85), our governance structure above depicts the role of Board Committees and their inter-relationship in the management of quality and risk. The whole

corporate and clinical structure is designed to ensure that the Trust has and maintains robust quality governance arrangements.

2.7.10 Information Governance

Reporting of Personal Data Related Incidents

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

On 25 May 2018, NHS Digital amended the way in which data loss/breach incidents were scored and subsequently reported to the Information Commissioners Office (ICO). Breaches are now risk assessed to establish the impact a breach could have, against the likelihood of harm occurring as a result. Breaches which result in a risk to the rights and freedoms of data subjects are reportable to the ICO. As impact levels are subjective, there has been an increase in reportable breaches as the effects will differ for each data subject.

There were 20 high level incidents requiring investigation reported to the ICO in 2018/19 as follows, compared to 5 reported in line with the previous scoring approach in 2017/18.

All 20 were formally reported as potential or actual breaches of confidentiality involving person identifiable data. The ICO has closed 18 of the 20 reported incidents. In all cases, the Commissioner has been satisfied with the steps taken by the Trust to address the incident, and no further action was required. A response from the ICO is awaited for the two remaining cases.

Themes of reportable data loss/breaches	
Theme	Total Number Reported 2018/19
SAR lost on receipt	1
Texts sent to incorrect recipient	1
Handover Sheets found	3
Personnel Files found	1
Electronic Patient Records merged	1
Letters sent to incorrect recipient	5
Records released in error	1
Malware emails	1
Documents lost/stolen	2
Unauthorised sharing of information	4

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

The key financial policies and processes

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

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

Standing Orders

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

Standing Financial Instructions (SFIs)

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

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

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

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

The SFIs are used in conjunction with:

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

Scheme of Delegated Authority

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

Anti-fraud and Corruption including the Bribery Act 2010

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

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

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

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

2.7.12 Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

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

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

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

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

The accuracy of information for Quality Reports is assessed via:

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

We continue to review our performance reporting framework, considering the increasing size and complexity of the quality measurement and reporting in the Trust. During the year our business intelligence system has been further developed and enhanced to provide additional real time information. In addition we have undertaken a full review of performance related data quality indicators by introducing a Clinical Reporting Assurance Framework (CRAF) and Information Assurance Group.

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

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

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

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

Safety

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

Effectiveness

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

Caring

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

Responsiveness

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

Well Led

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

2.7.13 Review of effectiveness

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

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

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

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

During 2018/19 we have continued to embed our programme of collective leadership throughout and at all levels of the organisation. This has included comprehensive development programmes for future and existing leaders through our Leadership Academy and partnership work with the University of Hertfordshire. The March 2019 CQC Well led inspection found organisational 'well led' to be rated as 'Outstanding' with leadership in four service lines rated as 'outstanding'.

2.7.14 Head of Internal Audit Opinion

Internal Audit review the system of internal control during the financial year and report accordingly to the Audit Committee. The Head of Internal Audit has provided an overall opinion of positive assurance based on their work during 2018/19, which gives me confidence that we have a solid foundation on which to build our improvement work. Specifically, the Head of Internal Audit has stated: *'The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'*

The Head of Internal Audit considered a range of factors and findings in coming to her overall opinion, having issued eighteen final assurance opinions and three final advisory reviews for the year. Of the 18 assurance opinions two were issued with substantial assurance, seven reasonable assurance and six partial assurance across the areas of internal audit work undertaken. The partial assurance opinions related to

- Service User Monies and Property
- Planning, Reporting and Monitoring Staff Resources
- Ability to recruit
- Equipment and Medical Device Maintenance
- Procurement
- Mandatory Training

We have addressed these issues by:

- Updating our policy in relation to service user property, strengthening the wording concerning the safe keeping of sharp objects and introducing more robust controls for access to ward safes
- Strengthening the local scrutiny of roster performance metrics relating to staff resource allocation to ensure regular timely review and action by managers in the effective planning of resources, leading to reductions in agency expenditure
- Reviewing the Recruitment and Retention Strategy, evaluating the effectiveness of incentives and working with the NHSI Retention Collaborative to improve staffing numbers
- Documenting more clearly the risks associated with recruitment and retention
- Strengthening procurement guidance, introducing additional controls and their application, with particular emphasis within the Estates and Facilities function
- Updating our medical devices policy, increasing compliance monitoring and refreshing our service level agreement
- Ensuring modules in our new mandatory training systems are mapped to changes in training programmes in a timely fashion

Accounting Officer approval of the Annual Governance Statement

Tom Cahill, Chief Executive
Dated: 22 May 2019

3 Quality Account Report

Part 1 – Statement on Quality from our Chief Executive

This Quality Account Report has been designed to report on the quality of our services. It offers you the chance to find out more about what we do and how well we are delivering on our commitments. The report's aim is to describe in a balanced and accessible way on how we provide high-quality clinical care to our service users, the various communities we serve and our commissioners. It also shows where we could perform better and what we are doing to make those improvements.

I am pleased to present this Quality Account Report in a year when the awareness of mental health has continued to be higher than ever before. Whilst this is a welcome societal change in itself, understandably this has led to many more people seeking to access our services.

Despite such challenges, May saw the Care Quality Commission (CQC) publish the outcome of its inspection of our services that took place in February and March 2019. I am delighted to report that we achieved an overall rating of outstanding, which included being rated as outstanding for the quality of care we provide and our service being well-led. In addition, our forensic inpatient/secure wards, child and adolescent mental health wards, wards for people with a learning disability or autism and community-based mental health services for adults of working age were also judged as being outstanding. This means that four of the eleven services inspected by the CQC are now rated as outstanding, with the remaining seven rated as good.

Once again, the CQC recognised the commitment of all our staff both in living the Trust values and demonstrating leadership at every level along with our strong safety culture. I believe it is this leadership of all our dedicated and hardworking staff that has enabled us to perform well against increased demand for our services, allowing our staff to continue delivering great care and great outcomes for over 400,000 people across four counties.

We are now one of just four NHS Trusts across England providing mental health and learning disability services to achieve a CQC outstanding rating and the only such service in the east of England. This comes at a time when we have launched successfully several new initiatives that you will read about in this Quality Account Report, including a co-produced transformational learning disability model across Essex, our new Tier 4 services for children and adolescent mental health services (CAMHS) and the new psychosis pathway.

Delivering great care depends on our ability to attract and retain great people and, as with many NHS organisations across the country, ensuring we have a stable workforce remains a top priority. 2018-19 saw us recruit more staff than ever before and to streamline our processes so that the time taken to fill vacancies and people to be in post was reduced. We also introduced a range of initiatives, from greater career opportunities and improving our staff experience, has helped us to retain staff. And when it comes to the latest National NHS Staff Survey, the vast majority of our scores are in line with or above the national average, but perhaps most importantly we had the highest score in the country for safety culture.

I look forward to this coming year as one where we continue to help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well. We will do this by continuing to build and maintain key relationships with our colleagues across health and social care to help us tackle collectively the challenges we face. This is because part of that journey – as set out in the NHS Long term Plan published in January 2019 – relies on great partnerships and working with other organisations to deliver integrated services that support and treat people holistically.

Declaration

Data accuracy

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

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

The Board of Directors and Executive Team have taken all reasonable steps and have exercised due diligence to ensure the accuracy of the data reported. However, we recognise that the data is subject to the limitations described above. To the best of my knowledge, the information presented to you in this document is accurate and provides a fair representation of the quality of service delivered within the organisation.

Tom Cahill, Chief Executive
Dated: 22 May 2019

Background

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

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

What is NHS Choices?

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

What the Quality Report includes

- What we plan to do next year (2019-20), what our priorities are, and how we intend to address them
- How we performed last year (2018-19), including where our services improved
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts
- Stakeholder and external assurance statements including our independent auditor's report, statements from Healthwatch Hertfordshire, Herts Valleys Clinical Commissioning Group (CCG), East and North Herts CCG and Hertfordshire County Council Health Scrutiny Committee.

Understanding the Quality Account Report

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

This is a 'What is it?' box

These explain a term or abbreviation

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

These support and illustrate the information in the report

This is a 'Comments' box

These include quotes from regulators and other governing bodies

A full list of the acronyms (abbreviations) we use are provided at the end of the Report.

Hertfordshire Partnership University NHS Foundation Trust

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

- Learning disability services in Buckinghamshire
- Improving Access to Psychological Therapies (IAPT) services in North Essex and learning disability services across Essex in partnership with as follows:
  - West Essex with Mind West Essex
  - Mid Essex with Chelmsford Counselling Foundation and Mid and North East Essex Mind
  - North East Essex with North East Essex Mind
- Forensic and learning disability service in Norfolk

Our Vision:

Delivering great care, achieving great outcomes - together

Our Mission:

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

Our principles

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

"Thank you for the excellent care that you have all given [name] whilst she was staying with you. Also we would like to thank the staff for all of the support given to us as a family from you all"

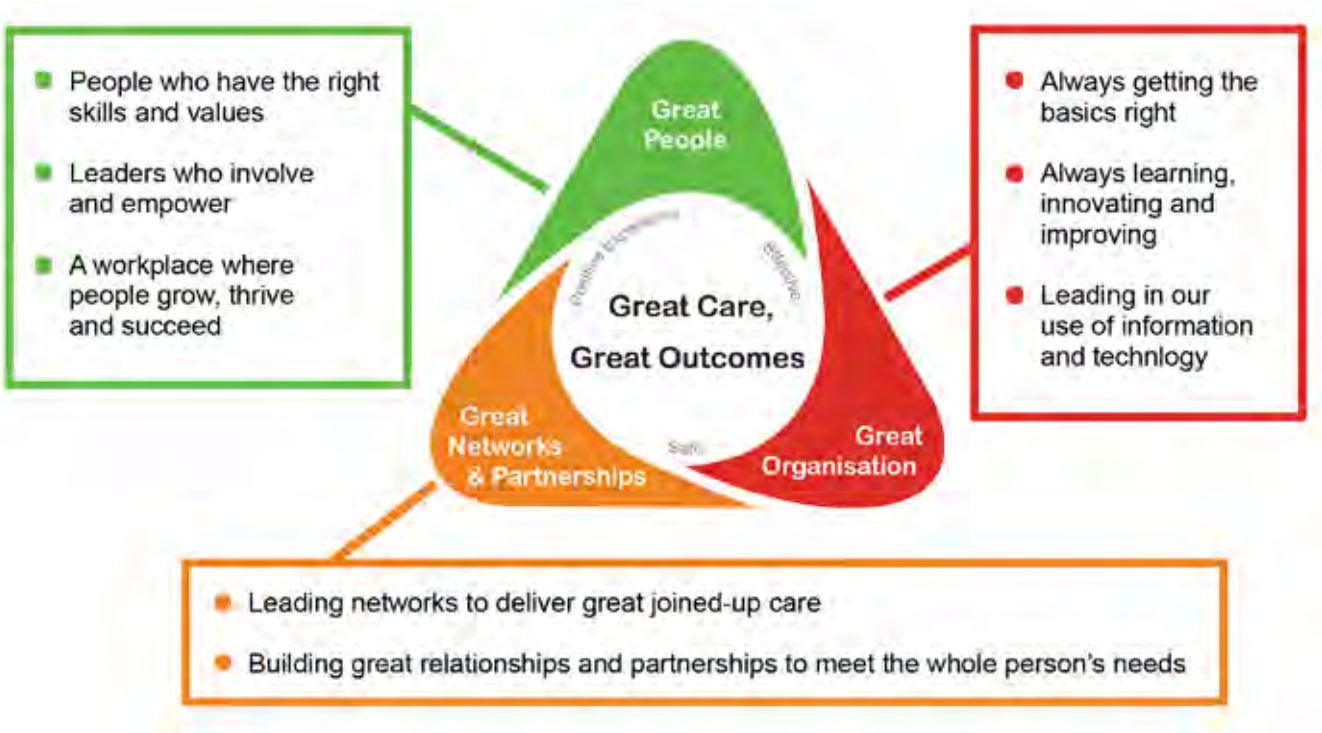
Our strategy

Our Good to Great Strategy (2016-2021) describes how we are delivering our vision of ***'Delivering Great Care, Achieving Great Outcomes – Together'.***

Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we will consistently achieve the outcomes that matter to those individuals who use our services and their families and carers, by working in partnership with them and others who support them. Furthermore, it means we keep people safe from avoidable harm, whilst ensuring our care and services are effective. That they achieve the very best clinical outcomes, support individual recovery and are of the highest quality.

Our Good to Great Strategy demonstrates the key areas of focus for the Trust, in terms of the people, the organisation and partnerships. It focuses on the three domains of service user quality – safety, effectiveness and experience. Through providing consistently high quality care that is joined up, individuals will be supported and empowered to recover and to manage their mental and physical wellbeing. This will enable us to achieve our mission – ***'We will help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well.'***

"Words cannot really express how grateful we are that you have been on our journey with us - and how your calmness and positivity has enabled us to have faith that this time to say farewell would come. All the best wishes for the future"



In 2018-19 we continued to provide:

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

Across our 89 sites, we employed approximately 3,118 permanent staff, with 147 on a fixed term/temporary contract and 682 bank staff, and budgeted to spend c. £237m on our services.

We aim to deliver great care and great outcomes and are keen to share information about the quality of our services and how we are working to improve these. This report is one of the many ways in which we share information.

Our Partnerships

Our partnership with Hertfordshire County Council helps us to develop an approach based on a holistic assessment of each service user's health and social care needs, which focuses on recovery. Working in partnership with the Council also means we can help improve integration between mental health, physical wellbeing and social care services.
We also work with other NHS partners, including Hertfordshire Community NHS Trust (HCT), as well as the following:

- MIND – Predominantly across our IAPT services, which also include Dynamic Interpersonal Therapy (DiT). They also assist with the New Leaf service taking over from Druglink 2018
- Mental Health Matters – in relation to Employment Advisors as part of the Department of Working Pensions (DWP) Initiative
- Growing People – horticultural therapy project for service users being looked after by Adult Mental Health Services at Lister Mental Health Unit in North Hertfordshire
- Reinvent Lifestyle – providing bespoke exercise to improve and maintain wellness
- Princes Trust – provision of employment and vocational support to service users with a diagnosis of First Episode Psychosis (FEP)
- Books Beyond Words – in the production of easy read booklets for learning disability services working in partnership to develop the app

We lead a new partnership with Essex Partnership University Trust and Anglia Community Enterprise to deliver a new model of specialist health services for people with a learning disability across all of Essex.

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

Our Commissioners

As a Trust, we continue to work closely with many organisations that commission and pay for our services. These include both the County Council and the CCGs.

What is a Partnership University Foundation Trust?

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

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

What is Commissioning?

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

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

As a Trust, we have services commissioned by each of the following:

- East and North Hertfordshire CCG
- Herts Valleys CCG
- Hertfordshire County Council (HCC)
- Cambridge and Peterborough CCG
- North East Essex CCG
- Mid Essex CCG
- West Essex CCG
- Basildon and Brentwood CCG
- Southend CCG
- Thurrock CCG
- Castle Point and Rochford CCG
- Norwich CCG
- South Norfolk CCG
- North Norfolk CCG
- West Norfolk CCG
- Great Yarmouth and Waveney CCG
- NHS England Midlands and East
- Barnet CCG
- London Borough Hillingdon CCG

Of the Nationally Commissioned Services that NHS England commissions, the Trust delivers on the following Specialist Services:

- Tier 4 CAMHS
- Perinatal Services
- Low Secure Mental Health
- Medium and Low Secure Learning Disabilities
- Highly Specialist Obsessive-Compulsive Disorder (OCD) and Body Dysmorphic Disorder Service.

This report

If you have any questions about anything in this report, would like to comment on it or want to know more about the Trust, contact Jacky Vincent, Deputy Director of Nursing and Quality jacky.vincent@nhs.net This Quality Account Report was signed and approved on 22 May 2019 and is available on the NHS Choices website www.nhs.uk and on our website: www.hpft.nhs.uk

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

Freedom to Speak Up

Speaking Up is when a staff member reports suspected wrongdoing at work. Officially this is called ‘making a disclosure in the public interest’. A staff member can report things that are not right, are illegal or if anyone at work is neglecting their duties, including:

- An individual’s health and safety is in danger
- Damage to the environment
- A criminal offence
- The company is not obeying the law (breach of legal obligation)
- Covering up any wrongdoing

If preferable, a concern may be raised from a distance by contacting the Freedom to Speak Up Guardian, Kevin Hallahan by:

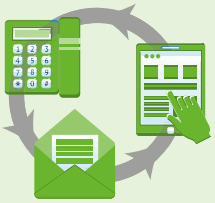
- Email - hpft.speakup@nhs.net
- Telephone - 01727 804100 on the confidential “Speak Up” Line
- In writing - to the Chief Executive or any senior person stating the concern
- The Trust’s incident reporting system (Datix)

The Trust’s nominated “Speak Up Champion” is Loyola Weeks, a Non-Executive Director on the Board.

The Trust in 2018-19

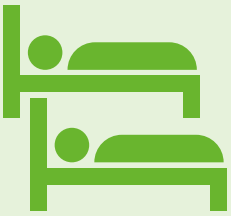
Mental Health, Community and Learning Disability Services for children and adults

407,502 **secondary care contacts**

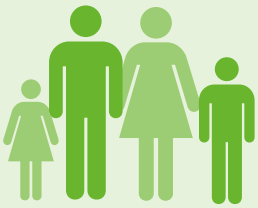


57,221 referrals through SPA

153,265 **IAPT contacts**



140,859 **occupied bed days**



87% would recommend us to friends and family

3,947 (permanent and temporary) Staff working across 89 Trust sites

What is SPA?

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

What is IAPT?

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

"I feel that the service and staff are very good, they do a good job. Very dedicated and a massive help. My CBT Therapist is a good listener and has a good way of getting me to understand and work through some problems. Very nice and very friendly, thank you to everyone and the service, very helpful to me."

Part 2 – Priorities for Improvement and Statement of Assurance from the Board

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

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

This part of the report sets out:

- The priorities we have identified for 2019-20 and how we decided on these
- Statements of assurance from our Trust Board
- How we performed in our priority areas during 2018-19

In this report we:

- Show how we performed in our priority areas during 2018-19
- Give an update on how we performed against the priority areas we identified in our 2017-18 Quality Report
- Describe our priority areas for 2019-20
- Showcase notable and innovative practices that we have introduced across our services during the past year.

What is assurance?

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

2.1 Quality priority areas for 2018-19

The table below provides an overview of our quality priority areas from last year (2017-18) and how we performed during this financial year, divided into each quarter throughout the year, and then the year end.

Patient (service user) Safety		Target	Q1	Q2	Q3	Q4	2018 / 2019
1	Every discharge 7 day follow up – see Core Indicators	≥=95%	96.05%	97.11%	97.81%	96.61%	96.88%
2	CAMHS 28 day wait for routine referrals	≥=95%	50.95%	80.45%	83.33%	34.07%	60.84%
3	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death – see core indicators	-	1053* Incidents 0.66% (7)	994* Incidents 0.60% (6)	Not yet available		
4	Number of inappropriate out of area placements	1,050	339 bed days in 2018/19 = 28.25 days – per month average				
5	Cardiometabolic indicators – covered under CQUIN						
Difference							
6a)	Emergency readmission within 28 days 16+ - see Core Indicators	N/A	4.70%	5.19%	6.29%	7.85%	6.00%
6b)	Emergency readmission within 28 days 0 – 15 – see Core Indicators	N/A	0.2%	0.41%	0%	0.68%	0.31%
7	FEP waits 14 days (NHSI mandatory)	≥=53%	85.92%	86.54%	89.29%	76.67%	84.52%
8	CATT gatekeeping – see Core Indicators	≥=95%	97.1%	97.28%	96.23%	97.26%	97.02%
9a)	IAPT recovery rate	≥=50%	53.32%	53.58%	53.75%	54.98%	53.91%
9b)	IAPT 6 week wait	≥=75%	83.68%	91.92%	91.84%	77.54%	86.06%
9c)	IAPT 18 week wait	≥=95%	99.79%	99.95%	99.88%	99.67%	99.82%
Service User and Carer Experience							
10	Service users reporting their experience of Community Mental Health Services – being treated according to Trust values	≥=80%	76.55%	76.27%	80.32%	83.1%	79.00%
11	Carers feeling valued by staff	≥= 75%	73.42%	81.18%	81.82%	84.85%	80.24%
12	Staff Experience Friends and Family Test	≥= 70%	74.64%	76.21%	N/A*	76.85%	75.81%
13	Service users Friends and Family Test	≥= 80%	85.54%	85.73%	88.63%	87.76%	86.82%

**figures are provisional and taken from Datix; NRLS provide 6 monthly data*

CAMHS 28 day wait for routine referrals

CAMHS 28 day wait performance Key Performance Indicator (KPI) is measured on 'waited' data for example, cases that have been referred and seen within 28 days. The KPI only takes account of referrals that come into the service via SPA and, as a result, excludes children and young people who have been referred via other routes, such as urgent referrals from our CAMHS Crisis Assessment and Treatment Team (CATT), Trusted Assessments and also Attention Deficit Hyperactivity Disorder (ADHD) appointments, which make up a significant proportion of the CAMHS workload. The 28 day KPI does also not take into account the full range of work offered by the service; the number of first appointments the community teams are offering has increased to manage demand although there are increased waits.

We believe there are a number of reasons for the increased wait times, including:

- An increase in the overall number of referrals into SPA
- An increase in the number of presentations via Accident and Emergency departments requiring urgent follow on appointments
- Challenges with recruitment in some teams reducing the ability to offer the number of appointments required
- Pressure in the wider Tier 2 system and the reduced early intervention offer, escalating cases directly to specialist CAMHS
- Loss of counselling services or services working at capacity and cases escalating prior to receiving an early intervention offer

"Another helpful appointment with our doctor - he listens and engages so well with my son"

We are working with partners to review the wider CAMHS system in Hertfordshire. We are also undertaking a range of different initiatives to ensure we are working to improve our wait times, including:

- Working with Continuous Quality Improvement (CQI) methodology to look at how we work and where change/improvements may be made
- Reviewing our SPA process for referrals
- Reviewing job plans for existing staff
- Developing additional CAMHS Pathways
- Reviewing all current caseloads
- Leading the management of ADHD waits with support from HELIOS (the company assisting ADHD assessments)
- Continuing the recruitment drive
- Offering additional clinics for example Saturday clinics
- Developing and implementing a 'Waiters Protocol.

Number of inappropriate out of area placements

Our out of area placements are maintained at a low threshold owing to the robust clinical and operational oversight as well as the bed management processes we have in place. We also ensure that out of area placements are subject to scrutiny at all levels in the Trust. This is subject to external audit procedures; there were no areas of concern identified.

FEP waits 14 days (NHSI mandatory)

Service Users referred to the Psychosis, Prevention, Assessment and Treatment (PATH) Early Intervention in Psychosis (EIP) Service require a specialist assessment to ascertain their needs. The PATH service is required to offer an assessment within 14 days of referral to 53% or more of service users.

Our PATH service has a diverse workforce of registered nurses, social workers, Associate Practitioners, support workers, psychologists and consultant psychiatrists, all of whom are trained in specialist assessment for First Episode in Psychosis and who work together to offer rapid assessment to service users.

PATH is able to offer a flexible approach to assessment, contacting service users and carers as soon as the referral is received, to arrange a mutually suitable time and venue, within 14 days. Our PATH service recognises that referral to the team can be a difficult time for people and works to ensure our offer of assessment is coupled with opportunities to address concerns, answer questions and ensure people feel as comfortable as possible when meeting our staff. This flexible partnership approach offers service users and carers an opportunity to work together with us around their assessment and reduces missed appointments. This is subject to external audit procedures; there were no areas of concern identified.

Service users reporting their experience of Community Mental Health Services – being treated according to Trust values

The Community Survey was reviewed during 2018-19, which resulted in a different survey during quarter 1, than for quarters 2, 3 and 4. The new survey added a question for the Trust's 'positive' value – previously no questions were counted for 'positive'. As the value score is a composite score across the Trust's five values, this change is likely to have affected the overall score for the year. However, when we reviewed the data for the year, the outlier value is 'positive', which includes questions on supporting physical health and giving opportunity an to involve people who are supporting service users.

For 2019-20, the work of our Carers Plan will engage more with service users around how we can improve on our involving carers. We have quarterly targets regarding improvements in how people feel they have been supported around their physical health and included in our Annual Plan.

2.2 Priorities for Quality Improvement 2019-20

Our Board agreed our 9 key quality priorities for 2019-20 at the Board meeting on 22 May 2019.

How we chose our Quality Priorities

We:

- consulted with stakeholders including service users, carers, staff, commissioners and others
- decided to continue to build on and monitor the work we did in 2018-19 and previous years that could potentially significantly improve our services.

What is the Trust Board?

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

What is a stakeholder?

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

The consultation process

We started by considering:

- the feedback we have received on the quality of our services in surveys, reports and other documents
- our stakeholders' (including our commissioners') priorities.

From this we developed nine potential quality priorities to focus on next year, which we discussed with our stakeholders.

We are grateful to all who have contributed to, supported and worked with us in reviewing and setting our quality plans for 2019/20, including:

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

What we heard during the consultation

Our stakeholders reported that, overall, the proposed indicators were great and considered the range of services we provide. In particular, we heard that the safety focus was important. The continued focus on carers was welcomed, including the carers' involvement with discharge planning and processes with carers from acute mental health settings.

Selection and Monitoring

NHSI provides guidance on the detailed requirements for the Quality Account Report, within which our priorities cover three indicators from each of the three areas of service user quality – Safety, Effectiveness and Experience. Six of these are mandated by NHSI as marked in the table below as (NHSI). Below details those indicators that are not mandated by NHSI and the reasons we have chosen them:

- **The percentage of service users on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.** The first few days after discharge can be a vulnerable period in an individual's life and we want to support their recovery in readjusting to life in their own community
- **Carers feeling valued by staff.** This is one of our indicators around the Triangle of Care and relates to the question "do you feel valued by staff as a partner in care planning" and sits in our internal quality dashboard as an indicator. This was also chosen by our Carer Council
- **Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family.** The Staff Friends and Family Test score is a good indicator of how staff feel about the services they provide and their level of engagement. We aim to further improve during this next year to enable an increased level of staff engagement and continue to improve the levels of care we provide to service users

The quality priority areas for 2019-20 agreed by the Trust Board are:

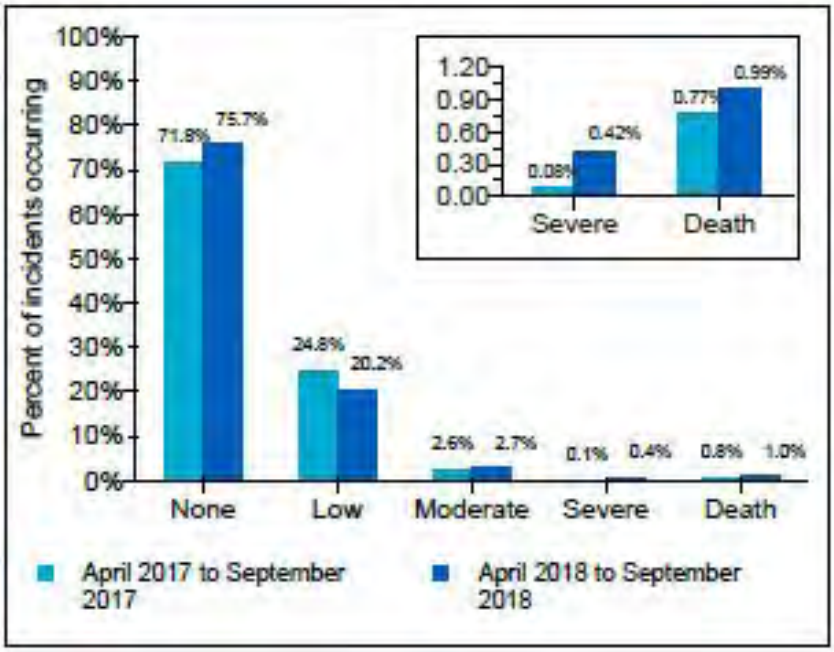
Patient (service user) Safety	
1	The percentage of service users on CPA who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period
2	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)
3	Inappropriate out-of-area placements for adult mental health services (NHSI)
Clinical Effectiveness	
4	The percentage of service users aged: (i) 0 to 14 and (ii) 15 or over Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI)
5	Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)
6	The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)
Service User and Carer Experience	
7	Carers feeling valued by staff
8	Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family
9	The Trust's 'service user experience of community mental health services' indicator score with regard to a service user's experience of contact with a health or social care worker during the reporting period (NHSI)

Detail of each priority

The Performance Team will report on all figures once a month for goals 1, 4, 5, 6 and 7; quarterly for goals 2, 3 and 8 and annually for goal 9. Data quality is important in ensuring the accuracy, validity and reliability of the KPIs. Where possible, the Performance Team will undertake work to ensure this. The Performance Team is internally and externally audited annually. Auditors check a sample of cases to ensure accuracy of the data being reported.

Name of Priority	**Patient (Service User) Safety** 1 - The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period				
Related NHS Outcomes Framework Domain and who will report on them	1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions All Trusts providing mental health services				
Data Definition	Service user is followed up either by face to face contact or by telephone within 7 days of discharge, whether the Trust contacts the service user or the service user contacts the Trust				
How this data will be collated	Data will be collated by the Performance Team and reported on a monthly basis				
Validation	Data is validated and checked by Data Quality Officers and the Performance Team				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	96.05%	97.11%	97.81%	96.61%	96.88%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**17/18**
	95.6%	96.8%	96.7%	96.01%	96.64%
Target (National)	95% rate of service users followed up after discharge from the Acute Care Pathway				

Name of Priority	**Patient (Service User) Safety** 2 – Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death
Related NHS Outcomes Framework Domain and who will report on them	Treating and caring for people in a safe environment and protecting them from avoidable harm
Data Definition	The number and rate of service user safety incidents reported within the Trust during the reporting period and the number and percentage of such service user safety incidents that resulted in severe harm or death

How this data will be collated	The Safer Care Team upload data onto the National Reporting and Learning System (NRLS) which is a central database of service user safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of service user care
Validation	This data is validated via the NRLS which is managed by NHSI
Performance in Q1 to Q4 in 2018-19	

Degree of harm, April 2018 to September 2018

None	Low	Moderate	Severe	Death
1.979	528	71	11	26

Name of Priority	**Patient (Service User) Safety** 3 – Inappropriate out-of-area placements for adult mental health services
Related NHS Outcomes Framework Domain and who will report on them	The Government has set a national ambition to eliminate inappropriate OAPs in mental health services for adults in acute inpatient care by 2020-21. The Department of Health directed NHS Digital to carry out this work.
Data Definition	Demonstrable reduction in total number of bed days service users have spent inappropriately out of area against rolling annual baseline, working towards elimination of inappropriate out of area placements by 2020/21. An out of area placement is when a service user with assessed acute mental health needs who requires non-specialised inpatient care (CCG commissioned) is admitted to a unit that does not form part of the usual local network of services

How this data will be collated	Data is collated by the Bed Management Team and submitted by the Information Team				
Validation	The data is checked and signed off on a monthly basis by the relevant Senior Service Line Lead and is audited by KPMG				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	165	30	16	105	**Mean = 26.3** days per month
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
				281	**Mean = 93.7** days per month
Target (National)	Q1 = 300; Q2 = 275; Q3 = 250; Q4 = 225				

Name of Priority	**Clinical Effectiveness** 1 – the percentage of service users aged: (i) 0 to 14 and (ii) 15 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period
Related NHS Outcomes Framework Domain and who will report on them	Helping people to recover form episodes of ill health or following injury All Trusts
Data Definition	This indicator measures the percentage of admissions of people who reside in Hertfordshire who have returned to hospital as an emergency within 28 days of discharge after an inpatient stay. It aims to measure the success of the NHS in helping people to recover effectively from illnesses. If a person does not recover well, it is more likely that they will require hospital treatment again within the 28 days following their previous admission. Thus, readmissions are widely used as an indicator of the success of healthcare in helping people to recover. This indicator is currently only reported for those residing in Hertfordshire, as required by the Hertfordshire Commissioners.
How this data will be collated	Data will be collated by the Performance Team and reported on a monthly basis
Validation	Data is validated by the Strategic Business Unit who look at all re-admissions on a monthly basis

Performance in Q1 to Q4 in 2018-19		**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	0-15	0.2%	0.42%	0.41%	0.68%	0.31%
	16+	4.70%	6.26%	5.19%	7.85%	6.00%

Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	4.51%	7.8%	7.09%	5.01%
Target (National)	No target set (National Indicator)			

Name of Priority	**Clinical Effectiveness** 2 - Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral
Related NHS Outcomes Framework Domain and who will report on them	The standard requires that more than 53% of people experiencing first episode psychosis (FEP) will commence treatment with a NICE-approved care package within two weeks of referral
Data Definition	A maximum wait time of two weeks from referral to treatment
How this data will be collated	Data will be collated by the performance team and reported on a monthly basis
Validation	Performance and service validate the data on the waiting time

Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	85.92%	86.54%	89.29%	76.67%	84.52%

Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	79.4%	66%	69.5%	64.18%
Target (National)	56% for 2019/20			

Name of Priority	**Clinical Effectiveness** 3 - The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period
Related NHS Outcomes Framework Domain and who will report on them	The proportion of inpatient admissions gate kept by the crisis resolution home treatment teams.

Data Definition	A Crisis Assessment and Treatment Team (CATT) provide intensive support for people in mental health crises in their own home. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. Teams are required to meet all of the fidelity criteria including gatekeeping all admissions to psychiatry inpatients wards and facilitate early discharge of service users. In order to prevent hospital admission and give support to informal carers CATT teams are required to gate keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate kept by a crisis resolution team if they have assessed the service user before admission and if the crisis team was involved in the decision making-process, which resulted in an admission.				
How this data will be collated	Data will be collated by the Performance Team and reported on a monthly basis				
Validation	Validated by CATT Leaders and Senior Service Line Lead				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	97.1%	96.39%	97.28%	97.26%	97.02%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	
	96%	97.8%	99.6%	98.19%	
Target (National)	95% of those admitted to an inpatient unit should have been gate kept by CATT				

Name of Priority	**Service User And Carer Experience** 1 - Carers feeling valued by staff
Data Definition	'Having your say' is offered to all carers. All questions are set against the Trust Values. One particular question asks "Do you feel valued by staff as a key partner in care planning?" The carer has the following options to choose from - Yes, No, Don't Know. Once the completed questionnaires are received they are entered onto the Membership Engagement System (MES) which is the Trust's Service Experience dashboard and reported upon by the Performance Team. Only replies that are recorded as 'Yes' are taken to be a positive answer.
How this data will be collated	Data will be collated by the performance team via MES and reported on a monthly basis
Validation	All surveys are re-checked for accuracy and 5% of the monthly inputs are re-checked by the Service Experience Lead

Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	73.42%	81.2%	80.32%	84.85%	80.24%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	
	68.7%	69.8%	71.43%	68.67%	
Target (National)	>/=75%				

Name of Priority	**Service User And Carer Experience** 2 - Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family				
Data Definition	The Friends and Family Test (FFT) is a feedback tool which allows staff to give their feedback on HPFT services. The FFT asks how likely staff are to recommend the services they work in to friends and family who may need treatment or care and also as the employer of choice. Participants respond to FFT using a response scale, ranging from “extremely unlikely” to “extremely likely”. They also have the opportunity to provide a free text comment after each of the two FFT questions. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. This question is in the Trusts Pulse survey This is also an NHS England statutory submission.				
How this data will be collated	Staff FFT data is to be collected and submitted quarterly for Q1, Q2 and Q4 after the end of each quarter. For Q3 18/19 (when the annual NHS staff survey is undertaken) the Pulse survey was not conducted				
Validation	Validated by external company MES who manage the reporting and checked by Workforce Department.				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	74.64%	76.21%	N/A	76.85%	75.81%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	
	57%	67.7%	67%	73.9%	
Target (National)	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them >=70%				

Name of Priority	**Service User And Carer Experience** 3 - The Trust's 'service user experience of community mental health services' indicator score with regard to a service user's experience of contact with a health or social care worker during the reporting period				
Data Definition	This indicator is made up of two questions in the Community Mental health Survey: • Time: for the person or people seen most recently giving enough time to discuss their needs and treatment • Understanding: for the person or people seen most recently understanding how their mental health needs affect other areas of their life.				
How this data will be collated	Data is collected via the Annual Community Mental health Survey. Responses were received from 218 people at the Trust				
Validation	Validated independently by NHS Surveys				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
					7.2%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**17/18**
					7.3%
Target (National)	Service User Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them >=80%				

How these targets will be monitored

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

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

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

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

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

What does reliable mean?

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

What does valid mean?

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

2.3 Statements of Assurances

This section of the report explains how we have provided assurance in relation to the services it provides. This is demonstrated through clinical networks, audit and our CQC inspection report. We have reviewed all the data available to us relating to the quality of care we provide in these services. Our total income from service users activities was c. £223.5m and our total income was c. £235.6m (including Provider Sustainability Fund (PSF) expected of £3.5m), thus 95%.

Clinical Audits

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

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

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

SPIKE2 is enhancing practice audit capabilities by providing increased data granularity, the ability to look further than the headline numbers and gain insights into the quality of information. It provides the function to analyse individual questions in greater details. Furthermore, SPIKE2 enables us to follow a service user's journey through our organisation and improve our ability to sample flow and pathways more effectively and efficiently.

What is a clinical audit?

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

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

National Clinical Audits

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

POMH-UK 15b Prescribing Valporate for Bipolar Disorder

A baseline audit was completed in September 2015 and a re-audit carried out in September 2017. The report was published in May 2018 and therefore the results were not able to be reported in last year's Quality Report. In total, 56 Trusts participated within the re-audit. Valporate is prescribed for almost one in four women of child-bearing age (defined as 50 years of age or younger) and this proportion has not changed since the baseline audit.

The results are detailed in the table overleaf.

Practice standard 1 – do not routinely prescribe Valporate for women of child-bearing age	2017 HPFT (n=34)	2017 TNS (n=2157)	HPFT compared to TNS	2017 National ranking out of 56 Trusts	2015 National ranking out of 55 Trusts (HPFT 2015 results)
Proportion of women of child-bearing age on Valporate	24%	25%	↔	26	41 (25%)
Practice standard 2 – patients started Valporate in past 6 months	HPFT (n=0)	TNS (n=63)			
Practice standard 3 – prior to initiating treatment with Valporate – yes fully or partially documented	HPFT (n=3)	TNS (n=199)			
BMI/Weight	100%	62%	↑	2	21 (75%)
LFTs	100%	75%	↑	2	19 (88%)
FBC	100%	75%	↑	2	18 (88%)
Practice standard 4 – patients prescribed Valproate should receive written info on Valporate for treating bipolar	HPFT (n=3)	TNS (n=138)			
Provided with suitable information	33%	33%	↔	10	8 (62%)
Practice standard 5 – early on-treatment review (within 3 months of initiation) – documented evidence	HPFT (n=1)	TNS (n=235)			
Review of therapeutic response	100%	69%	↑	2	19 (90%)
Weight gain or other common side effects	0	43%	↓	45	10 (80%)
Liver Function Tests and/or Full Blood Counts	100%	37%	↑	3	10 (50%)
Medication Adherence	0	41%	↓	39	11 (70%)
Practice standard 6 – long term monitoring (past 12 months) – documented evidence	HPFT (n=31)	TNS (n=1805)			
Body weight and/or BMI	65%	51%	↑	16	30 (45%)
Blood pressure	68%	52%	↑	14	29 (43%)
Plasma glucose	81%	55%	↑	8	31 (50%)
Plasma lipids	74%	48%	↑	8	24 (50%)

What did we do well?

- Improved in the ranking position on most standards compared to 56 mental health Trusts
- Documentation in the clinical records prior to initiating treatment of weight and/or BMI, the results of liver function tests (LFT) and a full blood count (FBC)
- Documentation in the clinical records of body weight and/ or Body Mass Index (BMI), blood pressure, plasma glucose and plasma lipids measured at least annually during continuing Valporate treatment.

What are the areas for development?

- Reduction in the proportion of women of child-bearing age on Valporate
- Documented evidence of safety issues discussed for women of child-bearing age on Valporate
- Documented evidence of protection against pregnancy for women of child-bearing age on Valporate
- Documented evidence that all patients prescribed Valporate received written information on Valporate for treating bipolar
- Documentation of the assessment of Valporate side effects and consideration of medication adherence at early on-treatment review.

During 2018-19, 8 national clinical audits covered relevant health services that we provide. During that period, we participated in 100% of national clinical audits we were eligible to participate in.

The national clinical audits that we participated in, and for which data collection was completed during 2018-19, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Audit	Trust Participation	
	Number of cases required by the terms of the audit	Number of Cases Submitted by HPFT
POMH-UK Topic 16b Rapid Tranquilisation	Information not available within HPFT	103
POMH-UK Topic 18a Use of Clozapine	Information not available within HPFT	98
POMH-UK Topic 6d Assessment of the side effects of depot antipsychotic	Information not available within HPFT	206
POMH-UK Topic 7f Monitoring of patients prescribed lithium	Information not available within HPFT	92
National Clinical Audit Anxiety and Depression – Core Audit	100	100 (100%)
National Clinical Audit Anxiety and Depression – Spotlight Audit (Psychological Therapies)	125	125 (100%)
National Clinical Audit Psychosis (NCAP) Early Intervention Psychosis (EIP) Spotlight Audit (CQUIN)	100	100 (100%)
Mental Health CQUIN Indicator 3 – Physical Health for Service Users with Serious Mental Illness	150	150 (100%)

**Not the confirmed numbers for POMH – due to be realised in July 2019*

Results from National Audits are as follows

The report of 1 national clinical audit was reviewed by the provider in 2018-19; 7 reports have not been published at the time of writing this report. The results of this published audit are summarised below along with the actions we intend to take to improve the quality of healthcare provided.

POMH-UK Topic 16b Rapid Tranquilisation involves the use of medication given via the parenteral route. It is a restrictive intervention and must only be used if de-escalation and other preventative strategies including 'Pro Re Nata' (PRN, 'as and when') oral medication have failed and there is potential for harm to the service user or other people if no action is taken.

We have worked on implementing systems to support service users and staff in managing rapid tranquilisation including revising the policy and re-drafting prescription chart templates. This report includes the re-audit results for a quality improvement programme (Topic 16b) addressing rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour.

Areas of Good Practice

- 69% of service users are offered and administered oral medication for behavioural disturbance compared to the Total National Sample (TNS) result of 43%
- Following Rapid Tranquilisation, 75% of service users had documented evidence of a debrief within 24 hours compared to the TNS of 51%
- Following an episode of rapid tranquilisation, there was documented evidence that the service user's care plan included management of future episodes of disturbed behaviour within a week in 94% of cases, compared to 53% of the TNS
- Within a week of an episode of rapid tranquilisation, there was documented evidence that the care plan acknowledged the patient's preferences should they become behaviourally disturbed again in 69% of our sample compared to 32% of the TNS.

Areas for improvement

- In 81% of our cases, there was no documented evidence of an assessment of mental and behavioural state in the hour post rapid tranquilisation being administered compared to 58% of the total national sample
- Further adherence to our Rapid Tranquilisation policy is required in particular with the documentation of physical observations (pulse, blood pressure, respiratory rate and temperature). This also includes monitoring for service users considered at risk following administration of rapid tranquilisation.

Actions

- Report to be disseminated to teams who participated in the audit
- Our Rapid Tranquilisation policy to be updated to include 72 hour timeframes for debrief to be completed
- Correspondence to be sent to staff reminding them to complete actions which were highlighted as areas for improvement within the findings.

The above actions are currently being undertaken and are being regularly monitored by the PACE team.

Local Clinical Audit

We reviewed the reports of 108 local clinical audits in 2018-19. 53 were undertaken by the PACE team as part of their annual programme and 55 were local audits registered with the PACE team by clinicians throughout the Trust. We undertook the following actions to improve the quality of healthcare provided:

- This year has seen the recruitment of Clinical Audit Lead posts in each of the Strategic Business Units. These posts are filled by consultant psychiatrists with a special interest in clinical audit. The PACE team work closely with our newly appointed Clinical Audit Leads to help influence audit activity and drive change. This is an innovative approach which we will continue to develop during the forthcoming twelve months
- This year, both carer and service user participation has now become an invaluable part of audit activity through a revised membership of the Practice Audit Implementation Group and this will continue. We are particularly proud of this work and this has been recognised by being shortlisted by the British Medical Journal for the clinical leadership award 2019
- The PACE team continue to ensure that audit findings are shared with the dedicated committees that champion that particular area of health improvement, including the Physical Health Committee, the Patient Safety Committee, the Quality and Risk Management Committees across each of our Strategic Business Units as well as our Trust-wide Quality and Risk Management Committee
- During 2019-20 we envisage roll out of our 'drivers for change' certification, this is awarded to those who demonstrate commitment to the implementation of actions following audit recommendations.

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

Where audits said we did well:

Supporting People Growing Older with Learning Disabilities (Supporting Residential Service) Audit. This baseline audit considered the newly published NICE guidance on supporting people growing older with a learning disability. The results demonstrate excellent levels of compliance across all standards. Some of the areas of great compliance are as follows;

The findings demonstrated 100% compliance in the following standards:

- A 'changing our lives'/'quality of life' action plan documented in service user records
- Evidence of physical health documentation completed
- Care plan in place which supports staff in managing any identified physical health needs
- Nutrition and dysphagia completed in the last 12 months.

There were two areas which needed slight improvement in terms of compliance. The action plan devised post the audit focussed on a falls risk assessment being completed annually for all service users and dementia baselines taken and updated in the service user records.

The service have confirmed that actions post the audit being conducted have been rolled out, with falls risk assessments being an ongoing action to assure these are embedded annually for all service users.

Safe and Supportive Observations

This audit aimed to provide assurance that observations within the adult inpatient wards are being carried out safely and in line with our policy. Some great compliance was shown in terms of staff members and their knowledge around levels of observations and the rationale behind why the service user had been placed on observation. 95% of all service users had a wellbeing plan in place.

Observation paper work and documentation was consistent across all wards. Documentation on the wards around intermittent charts being completed as the service users were being observed and continuous monitoring by staff was of a high standard.

The recommendations included conducting a qualitative study on service user experience of observations. Another recommendation was to develop training in care planning across staff in inpatient services including ensuring staff offer service users information on safe and supportive information. The PACE team continue to monitor the above recommendations and are awaiting evidence of implementation.

Gatekeeping Audit

Following concerns raised about the gatekeeping process in the last financial year, the crisis teams have been developing strategies in order to ensure that the gatekeeping takes place in a safe and secure manner by ensuring that those admitted to the inpatient services are appropriately admitted. The crisis teams developed a bespoke form on PARIS to capture this information in a clear and concise manner.

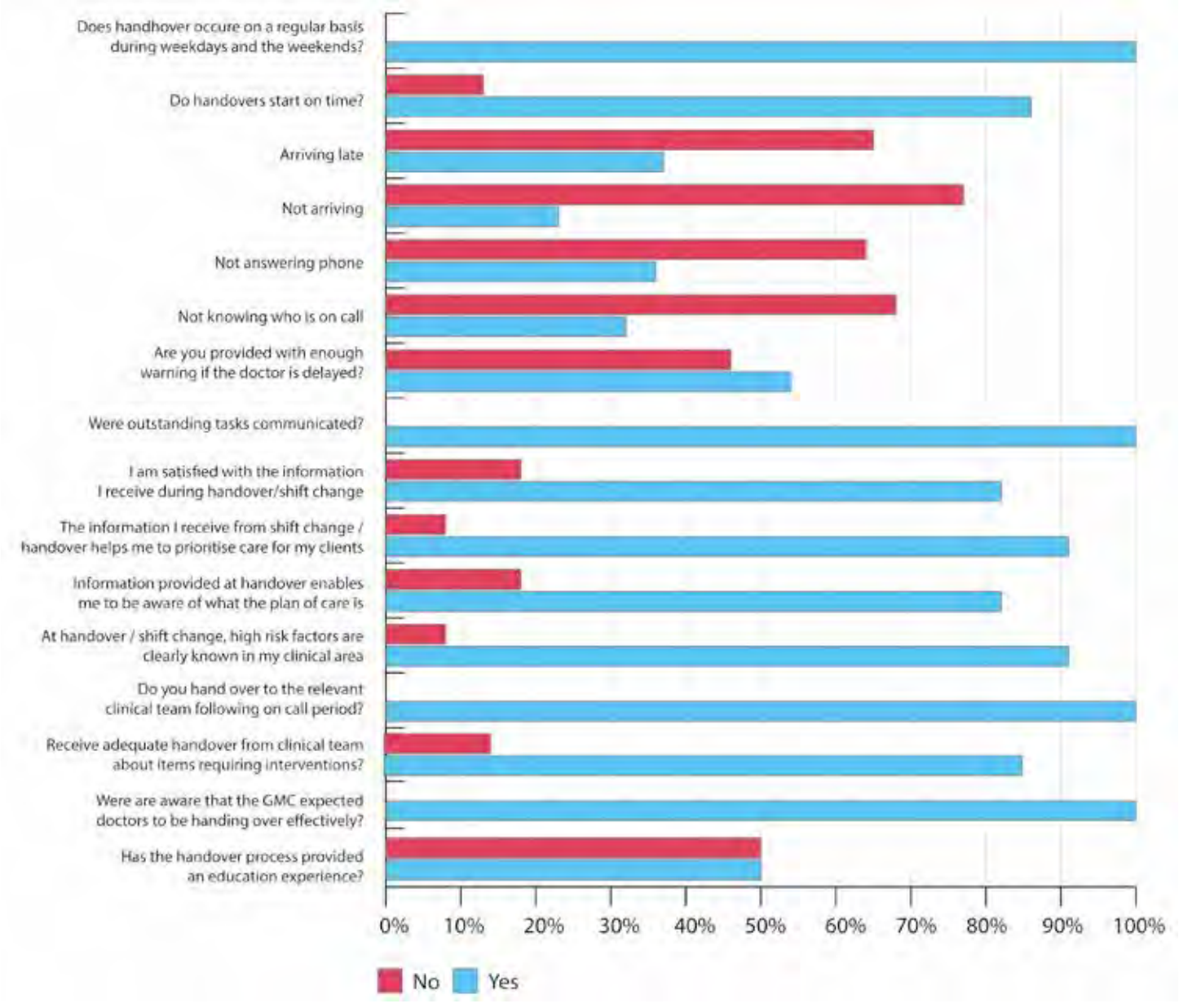
The audit aimed to analyse the quality of CATT Gatekeeping forms which were completed on PARIS, our Electronic Patient Record (EPR) system. It included a sample of service users who were gate kept between July and September 2018. As the table below shows, sufficient information was documented in 97% of cases which is of a high standard.

What is the Purpose of Admission Section		
Has this been completed on the form?	Is the information contained within this section sufficient?	If the information is not sufficient, has this area been highlighted in the casenote?
86/86 (100%)	**83/86 (97%)**	**2/3 (67%)**

Why can this not be achieved by intensive Home Treatment/Host Families/ADTU		
Has this been completed on the form?	Is the information contained within this section sufficient?	If the information is not sufficient, has this area been highlighted in the casenote?
86/86 (100%)	**85/86 (99%)**	**1/1 (100%)**

Improving the Clinical Handover Practice among the Junior Doctors

This service led evaluation was conducted by one of our junior doctors, following concerns which had been raised to them around the quality of the handover process for junior doctors when they are working on call. The service evaluation sought to attain experiences from various junior doctors via a questionnaire. Overall, the feedback from the junior doctors was very positive. It highlighted that handovers take place on a regular basis, that outstanding tasks were communicated and information is handed over to relevant clinical teams in 100% of cases.



Following the completion of this audit, a checklist has been devised and assurance measures have been put in place, to ensure that the quality of handover between junior doctors remains to a high standard.

Where audit said we need to improve:

Appointeeship Audit

Appointeeship refers to a method in which a service user's financial responsibilities are managed. Various agencies who are involved with the service user's care can be appointed as we are responsible for managing the service users' finances. For the purposes of this audit, only those service users where we are responsible have been included in the audit.

The audit looks to see if the relevant information has been included on the service user records which expressly discuss the management of their finances. This should be reviewed on a yearly basis. It is apparent from the table below that the results have declined since the previous audit cycle which was conducted in September 2017.

Cycle	Detail of the level of supervision required	Who should provide it	How it should be implemented	Capacity assessment within 12 months?	Best interest form linked to capacity assessment?	Reference to SU capacity assessment within 12 months Y?N (differs within LD)
Feb 17	12/52 (23%)	11/52 (21%)	13/52 (25%)			
Sep 17	31/53 (58%)	30/53 (57%)	31/53 (58%)			
Jun 18	**71/131 (54%)**	**66/131 (50%)**	**60/131 (50%)**	**28/118 (24%)**	**20/118 (17%)**	**28/131 (28%)**
Movement Sep 2017 – Jun 2018						
	↓ 4%	↓ 7%	↓ 8%			

Cycle	When it was assessed	Whether appointeeship / deputeeship is in place	How it should be implemented	Capacity assessment within 12 months?
Feb 17	0/52 (0%)	21/52 (40%)	22/52 (42%)	
Sep 17	25/53 (47%)	44/53 (83%)	48/53 (91%)	
Jun 18	**38/131 (29%)**	**105/131 (80%)**	**106/131 (81%)**	**53/107 (50%)**
Movement Sep 2017 – Jun 2018				
	↓ 18%	↓ 3%	↓ 10%	

While the results did not demonstrate improvement across the Trust, when looking at the breakdown, it was positive to see that our Learning Disability and Forensic SBU had demonstrated improvements of at least 71% in all measures.

Going forward from this audit, a working group has been set up with the aim of supporting staff across the Trust with managing service user finances. Since the completion of the audit, teams have been made aware of those who do not currently have an up to date CPA or capacity assessment. The group have also developed a guide on appointeeship which will provide staff with guidance on how to document these details in the electronic patient record and explain how often reviews should take place. The group also have plans to hold workshops across the community hubs to support staff when using the appropriate documents. The PACE team await evidence of implementation for the workshops to be rolled out.

'Did Not Attend' Outpatient Re-Audit

The above audit was in line with the Trust's agenda of reviewing the outpatient model with the aim of driving down Did Not Attend (DNA) rates. In addition to this the audit aimed to ensure adult clinics are compliant with our DNA policy. As this particular audit was a re-audit the findings from this audit are demonstrated below with the results from the previous cycle:

	2017 compliance (Sept 17)	**2018 compliance** (April 18)
Clinical Entry made in the case notes	25/42 60%	112/146 77% ↑
Reason for DNA recorded	6/42 14%	35/146 24% ↑
Was a reminder letter sent out to SU 7 days prior to OPA	7/42 17%	19/146 13% ↓
Was contact made on the same day as the DNA	11/42 26%	63/146 43% ↑
Is there any indication of Risk recorded on the EPR	2/42 5%	29/146 20% ↑
Has GP been notified in writing of the non-attendance	25/42 60%	80/146 55% ↓

Although some results had improved marginally, there are still some areas of concern predominantly in terms of a reminder letter being sent out to the service user 7 days prior to the appointment and documented evidence of this. The GP being notified in writing of the non-attendance of that particular outpatient appointment was also low in compliance.

Since the completion of the audit further exploration into the use of an SMS text messaging reminder service has been carried out and discussions have taken place in regards to revising our DNA policy. Discussions have also taken place around implementing virtual clinics as part of a quality improvement project. The PACE team is awaiting evidence of the sharing of information in order to raise awareness of the cost implications, for failing to attend an outpatient appointment.

Risk Assessment Audit

Clinical risk and management is a key part of our business and is fundamental to service user safety. As part of the audit, a qualitative analysis was carried out by clinical staff to analyse the quality of risk assessments conducted in adult community services. The results highlighted sections of the assessment which were deemed to be of poor quality.

Risk Assessment Audit

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	Number	%
Assessment of current situation:		
Poor	10/32	31%
Satisfactory	17/32	53%
Good	3/32	9%
No risk assessment to evaluate	2/32	6%
Formulation of risk factors:		
Poor	23/32	72%
Satisfactory	6/32	19%
Good	1/32	3%
No risk assessment to evaluate	2/32	6%

Following the concerns raised in the audit, the service focused on improving the quality of the forms on PARIS. This has been facilitated via presentations and training to staff to create awareness of the standards of risk management and enable co-production of risk assessments with service users and carers.

Discussions are also being held on considering how Peer Experience Listeners could take forward a process for obtaining service user feedback for their involvement in developing their risk assessment.

Research and Development

Our research portfolio is a key factor in our status as a University Trust and we are working to increase the number of staff involved in Research and Development. We work closely with, and receive research funding from the National Institute of Health Research (NIHR) and Clinical Research Network (CRN) Eastern to help us deliver and participate in high quality research studies. We collaborate with several academic institutions including: the University of Hertfordshire, University of East Anglia, University of Kent, and University of Southampton. In June 2018 we jointly hosted a research showcase event with the University of Hertfordshire, which was well attended. We have a research page on the Trust website, detailing the studies we are currently recruiting to, as well as some recent research publications by Trust staff.

We are pleased to announce that we have recently been successful in securing three new research grants. The first is an NIHR Research for Patient Benefit (RfPB) Award to support a new collaborative feasibility study looking at trans-cranial direct stimulation in the treatment of OCD.

The second is another NIHR RfPB award to look at what support people with Learning Disabilities need to remain living in the community after moving under the Transforming Care Programme. And thirdly, we are partnering with the University of Hertfordshire on a study funded by the Health Technology Assessment (HTA) to investigate the benefits of exercise for depression in adolescence.

There is an obligation on all NHS Trusts to support the NIHR portfolio and we have supported recruitment to 18 different research studies over the last year (an increase of 12.5% over the previous year). All research that takes place within the Trust has the appropriate level of ethical approval in place.

"Coping strategies and techniques in 9 sessions addressed 20+ years of OCD symptoms."

In 2018-19 we have recruited 302 service users into NIHR portfolio studies, which is also an increase over the previous year. We have received positive feedback from those who took part. Most of the people who completed a questionnaire about their experience of participating in the Trust research, rated their overall experience as very good or excellent. We are currently looking to recruit participants in to the following studies:

- Identifying the prevalence of antibodies to neuronal membrane targets in first episode psychosis (PPiP) – The aim of the study is to establish the prevalence of pathogenic antibodies in people with a diagnosis of psychosis and to assess the acceptability of an immunological treatment protocol for patients with psychosis and antibodies. Participants will have a blood sample taken and undergo the Positive and Negative Syndrome Scale (PANSS) assessment
- Learning about the lives of adults on the autism spectrum and their relatives – We are looking to develop a better understanding of the lives of adults on the autism spectrum and their relatives. Participants will be provided with a contact booklet to complete and return to the study team in Newcastle. Then they will be asked to complete several questionnaires which will be sent by post
- Detecting susceptibility genes for Alzheimer's disease – We are looking to recruit individuals with a diagnosis of Alzheimer's Disease (AD), and their next-of-kin. Participants with AD will be asked to provide a blood sample. They and their carers will also be interviewed using several questionnaires. These interviews will each take around 90 minutes
- Delivery of Cognitive Therapy for Young people after Trauma - This study is examining the effectiveness of cognitive therapy in young people with post-traumatic stress disorder, compared with treatment as usual
- Supporting consolidation of recent memories in Mild Cognitive Impairment - The purpose of this study is to see whether memory aids can be used to support the formation and strengthening of new memories in people with MCI and mild dementia. The total involvement time in the study is 8 weeks
- E-support for Families of individuals affected by psychosis (COP-e) - This study aims to develop and evaluate online resources providing psychological support to carers of people with psychosis and ways to promote carers' well-being
- Smartphone App-induced Habit: A treatment ingredient in HRT for OCD - This study aims to understand more about behavioural treatment called HRT and to establish how helpful it might be in treating OCD.

Please contact the Research and Development Department on 01707 253836 if you would like to find out more about any of the above studies. Or alternatively, please email hpft.research@nhs.net We will be taking on additional studies during 2019-20.

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

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

Commissioning for Quality and Innovation (CQUIN) 2018-19

The Trust's CQUIN goals are agreed with our local and specialist commissioners at the beginning of each financial year. A proportion of the Trust's income is conditional on achieving these goals. Further details of the agreed goals for 2018-19 and for the following 12 month period are available electronically in 'Trust Papers' in the 'About Us' section of the Trust's website: /www.hpft.nhs.uk/about-us/our-board-papers-and-publications/other-reports-and-plans/

What is Commissioning for Quality and Innovation (CQUIN)?

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

2.5% of the Trust's NHS contract income (£4,509k) in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and our commissioners through the CQUIN payment framework as described above.

At the end of the 2018/19, the final amount achieved was £3,649k (81% of the amount available). This compares to 2017/18 for which the Trust achieved £3,931k (89% of the amount available).

Details of the CQUIN amounts for each 2018-19 contract are set out below.

	Commissioner	Value	Achievements 18-19
1	Hertfordshire IHCCT	£3,523k	£2,767k (79%)
2	NHS England	£444k	£439k (99%)
3	Learning Disability: Mid Essex CCG, West Essex CCG and North East Essex CCG	**£130k**	**£74k (57%)**
4	Learning Disability: Basildon and Brentford CCG, Thurrock CCG, Castle Point and Rochford CCG, Southend CCG, North East Essex CCG, West Essex CCG and Mid Essex CCG	**£165k**	**£124k (75%)**
5	IAPT: North Essex CCG, Mid Essex CCG and West Essex CCG	**£140k**	**£140k (100%)**
6	North Norfolk CCG. Norwich CCG, south Norfolk CCG, West Norfolk CCG and Great Yarmouth CCG	**£49k**	**£49k (100%)**
7	Buckinghamshire CCG	**£56k**	**£56k (100%)**
Total		£4,509k	£3,649k (81%)

Hertfordshire CQUIN 2018-19 in relation to the main commissioner contract in Hertfordshire

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£423k (12%)	£176k (42%)
2	Improving physical healthcare to reduce premature mortality in people with serious mental illness	Improving the physical healthcare for people with serious mental illness in order to reduce premature mortality in this patient group	£423k (12%)	£357k (84%)
3	Improving services for people with mental health needs who present at A&E	Reducing the number of attendances at A&E for those who would benefit from mental health and psychosocial interventions	**£423k (12%)**	**£400k (95%)**
4	Transitions out Children's and Yong Peoples Mental Health Services (CAMHS)	Improvement in the experiences and outcomes for young people as they transition of out CAMHS services to other providers	**£423k (12%)**	**£130k (31%)**
5	Preventing Ill Health by Risky Behaviours	Tobacco and alcohol screening and the offer of interventions if appropriate	**£423k (12%)**	**£296k (70%)**
6	Support engagement with STPs	HPFT is required to contribute to STP transformation initiatives and demonstrate how it is supporting and engaging in these initiatives	**£705k (20%)**	**£705k (100%)**
7	Linked to the Risk Reserve	HPFT is required to achieve its financial control total in both 17/18 and 18/19	**£705k (20%)**	**£705k (100%)**
		Total	£3,523k (100%)	£2,767k (79%)

North Norfolk CCG, Norwich CCG, South Norfolk CCG, West Norfolk CCG and Great Yarmouth CCG CQUIN 2018-19

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£4k (10%)	£4k (100%)
2	Integrated Pathway	Improving the physical healthcare for people with serious mental illness in order to reduce premature mortality in this patient group.	£25k (50%)	£25k (100%)
3	Physical Health	Improving the support and care people with learning disabilities have in relation to physical health needs.	**£20k (40%)**	**£20k (100%)**
		Total	£49k (100%)	£49k (100%)

Mid Essex CCG, West Essex CCG and North East Essex CCG Learning Disability CQUIN April 2018 – October 2018

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Outcomes	Implementation of individual and service level outcome measures and their reporting.	£52k (40%)	£30k (57%)
2	Personal Health Budgets	The development of shadow/ national personal health budgets, together with the measurable outcomes they deliver.	£52k (40%)	£30k (57%)
3	Health Equality Framework	Expand use of the Learning Disability Health Equality Framework to all people known to LD Specialist Healthcare Services in a phased and manageable way.	**£26k (20%)**	**£14k (57%)**
		Total	£130k (100%)	£74k (57%)

Basildon and Brentford CCG, Thurrock CCG, Castle Point and Rochford CCG, Southend CCG, North East Essex CCG, West Essex CCG and Mid Essex CCG, Learning Disability CQUIN November 2018 – March 2019

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Place Plans	The development and agreement of the initial Place Plans that meet the local priorities of the seven Essex CCGs	£66k (40%)	£50k (75%)
2	Health Equality Framework	The development and implementation of Standard Operating Procedures to ensure a consistent approach to service delivery across Essex	£99k (60%)	£74k (75%)
		Total	£165k (100%)	£124k (75%)

North Essex CCG, Mid Essex CCG and West Essex CCG IAPT CQUIN 2018-19

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£16k (11%)	£16k (100%)
2	Carers	To promote the IAPT Services to local carers organisations through the delivery of a range of appropriately targeted initiatives	£124k (89%)	£124k (100%)
		Total	£140k (100%)	£140k (100%)

Buckinghamshire CCG CQUIN 2018-19

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Prescribing of psychotropic drugs in adults with learning disabilities/ autism or both	Implement plans to review and compliance against NICE guidelines with an aim to reduce the number of service users prescribed psychotropic drugs for challenging behaviours or a % that are now on reduction plans	£56k (100%)	£56k (100%)
		Total	£56k (100%)	£56k (100%)

NHS England CQUIN 2018-19

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Reducing Restrictive Practices within Adult Low and Medium Secure Services	The development, implementation and evaluation of a framework for the reduction of restrictive practices with adult secure services, in order to improve service user experience whilst maintaining safe services.	£222k (50%)	£219k (99%)
2	Recovery Colleges for Medium and Low Secure patients	The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services.	£222k (50%)	£220k (99%)
		Total	£444k (100%)	£439k (99%)

The CQUIN income estimated to be awarded in 2018-19 represents 1.6% of the total income generated from the provision of health services by the Trust in the year.

Clinical coding

We use clinical coding to categorise the information we gather about our service users and the services and treatments they receive from us. This information is then used to analyse the data that informs our quality indicators. As a Trust, we are not part of 'Payment by Results' (PbR) and therefore our clinical coding has not been externally audited.

The Data Security and Protection (DSP) Toolkit

The DSP Toolkit grades organisations as 'small', 'medium' and 'large'. We are a 'large' organisation and are therefore required to undertake 100 mandatory assertions on all aspects of information governance and data security.

What is the Data Security and Protection (DSP) Toolkit?

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

The Trust submitted our DSP Toolkit to NHS Digital at the end of March 2019 and we are awaiting the outcome. The Toolkit covers 140 assertions based on the National Data Guardian's 10 Data Security Standards:

- Personal Confidential Data
- Staff Responsibilities
- Training
- Managing Data Access
- Responding to Incidents
- Process Reviews
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

What is Hospital Episode Statistics (HES)?

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

We submitted records during 2018-19 to the Secondary Uses Service for inclusion in the HES which are included in the latest published data. The percentage of records in the published data which included the service users' valid NHS number was:

- 100% for admitted patient care
- 99.87% for outpatient care

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

- 98.4% for admitted patient care
- 99.7% for outpatient care.

Ethnicity April 2018 – March 2019

The percentage of records in the published data which included the service users' ethnicity was 96.1%. We plan to improve our data quality and clinical coding by:

- conducting regular audits
- supporting staff with data quality issues through reviewing KPI guides
- developing front end reports which are updated daily.

Patient Safety

This section shows how we ensure that we are providing safe care. We have continued to focus on developing a culture of safety over the last year, building safety into the heart of all we do. This has been supported through a number of safety initiatives, including:

- Safety huddles
- Safety crosses
- Improved safe and supportive observations
- A new Suicide Prevention group
- A new Risk Strategy Education group
- The development of a Moderate Harm Review Panel, reviewing harm, exploring learning and identifying Serious Incidents
- The reflective learning initiative SWARM
- A Mortality Governance framework for reviewing and learning from deaths.

The total number of incidents reported (via our live database Datix) between 1 April 2018 and 31 March 2019 was 12,067. Of these, 45 (0.37%) are recorded under the harm category as 'severe harm' and 401 (3.3%) are recorded under harm category as 'death'.

"Supportive and safe. I had the opportunity to talk through, understand, and identify what I could do to change. I felt in crisis when I started… now I feel on the start of recovery journey. Thank you SO much."

Culture of Safety

As a Trust, we have focused on developing a culture of safety over the last year. This has been delivered through approaching safety through collective ownership and leadership as well as a shared understanding and belief that safety is paramount. Some of the initiatives that have supported this approach are:

- **SWARM** enables a culture of openness, transparency and learning in a blame free environment. SWARM is a multidisciplinary forum which provides open support, guidance and feedback following serious incidents in order to learn from it and improve our services. SWARM creates an environment in which staff share information without fear of reprisal, and integrate the reporting of safety issues into daily work. It is held as soon as possible after a service user safety incident and carried out in a blame-free environment and while the incident is still fresh in everyone's mind. The meeting gives frontline staff a chance to review the facts, discuss what happened, as well as how and why it happened. This helps the team build a more accurate picture of the organisational and human factors involved, and allows staff to identify the key lessons and list actions which can be implemented immediately by the team. SWARM is identifying learning themes to be shared across the organisation, ensuring that our services are safe and we learn from our mistakes.
- **Proscreen** - as a result of learning from a serious incident, we have invested in Proscreens. These are a technology solution for detecting restricted items such as razor blades and weapons. 5 have been installed as a pilot and will be rolled out further if found to improve the quality and safety of care.
- **Itemiser** - whilst we have already had robust testing procedures in place for narcotics abuse, it was recognised that the procurement of an 'airport style' trace detection machine would provide better coverage across the range of potential narcotics within a single, rapid, non-invasive test. This is of heightened benefit in the Section 136 Suite, with the need to be particularly conscious of the potential circumstances of presentation of an individual being assessed and how the testing approach needs to be sensitive to that scenario.

  The Itemiser Enhanced are cutting edge machines in terms of narcotic trace detection and are used widely in prison and police settings, enabling the manufacturer to maintain up to date databases for new strains of drugs including synthetic cannabinoids. This has been installed in Swift Ward and 136 Suite jointly helping us with the rapid and non-invasive detection of psychoactive substances. The effectiveness will be evaluated with a view to rolling this out more widely.

Duty of Candour

We are committed to the principles of openness, honesty and transparency. We aim to learn from all incidents and engage service users and families in the review process. Our Duty of Candour policy defines the incidents to which Duty of Candour applies and sets out the duties and responsibilities of senior staff after an incident.

We have reviewed and updated the policy so that, where harm has been caused or may have been caused, staff have clear guidance on their roles and responsibilities in contacting service users and families in a way that is:

- timely
- embraces the principles of open, honest and transparent communication.

We have also included information on how we meet the Duty for moderate harm incidents.

"We considered the Trust had had significantly improved practice in [safety], reporting had improved and lessons had been learnt that would otherwise have been missed" CQC

During 2018-19 we have continued to make progress with the implementation of the Duty of Candour policy. Clinical leads are being consistent in contacting bereaved families to offer condolences and identify support needs when a death has been reported as a serious incident. We acknowledge the impact on families and friends who are bereaved by suicide or a sudden unexpected death.

When a serious incident is reported, we send a Duty of Candour letter to the person who uses our services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment affected. This is to advise on:

- our internal investigation process
- how they can contribute to establishing a factual chronology of events and help us learn from what has happened.

The person leading the investigation contacts the family and any questions or concerns the family raises are gathered, considered and included in the serious incident report. Once completed, the full report is always shared with the family and the Coroner. Trust commissioners monitor compliance with our Duty of Candour and procedures when reviewing and quality assuring serious incident reports.

National Confidential Inquiry into Suicide and Homicide (NCISH)

The NCISH is led by the University of Manchester. An annual report publishes findings and recommendations which we respond to through our internal Suicide Prevention Group and also our collaborative working across other stakeholders, including Public Health.

The NCISH process requests clinicians to complete questionnaires where a suicide is suspected or confirmed. As a Trust, we disseminate the key findings of the NCISH annual report and associated infographics via our Strategic Business Unit (SBU) governance meetings and also our Continuing Professional Development (CPD) meetings.

Learning from deaths

From April 2017, all Trusts were required to collect and publish information on deaths and serious incidents, including evidence of learning and improvements being made as a result of that information. This is part of a systematic, NHS-wide approach to reviewing and learning from deaths, being led by the Department of Health, NHS Improvement and the CQC. Guidance for Trusts was published in March 2017 to provide a consistent approach to identifying and reporting, investigating and learning from deaths, and where appropriate, sharing information with other services and organisations.

The following elements capture 'Learning from Deaths' updates as required in the quality accounts regulations:

1. The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

We capture data regarding all service users who die while they are in our services and all people who have received care in the twelve months preceding their death. During the financial year 2018/19, 443 (by date of death) of our service users died. Of the 443 deaths, 82 were identified as meeting the criteria for further review either as a Serious Incident investigation (63) or as a Structured Judgement Review (SJR) (19), as detailed in the table below.

A large number of the deaths reported are due to natural causes, ill health or accident and not related to the Trust.

Quarter 1	42	0	18	33	**93**
Quarter 2	59	0	15	30	**104**
Quarter 3	75	0	17	30	**122**
Quarter 4	72	12	16	24	**124**
Total	**248**	**12**	**66**	**117**	**443**

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 93 in the first quarter
- 104 in the second quarter
- 122 in the third quarter
- 124 in the fourth quarter.

This number is the reported deaths of all service users in the year we had contact with in the previous 12 months. The number for 2017/18 was 373. With the new Mortality Governance Framework, we have new lines of communication to enable us to 'scan' for service user deaths. The Root Cause Analysis (RCA) we complete enables us to learn and reflect.

2. The number of deaths included in item 1 which the Trust has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

19 case record reviews and 63 investigations have been carried out in relation to 443 of the deaths included in item 1.

None of the cases was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out are detailed in the table below:

	Serious Incident Investigations	Structured Judgement Reviews
Quarter 1	14	0
Quarter 2	23	6
Quarter 3	14	7
Quarter 4	12	6
Total	**63**	**19**

3. An estimate of the number of deaths during the reporting period included in item 2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

These numbers have been estimated using the Mortality Case Record Reviews (using SJR methodology) only. Serious Incident Investigation reports (RCA) do not directly address the question whether the death was more likely than not owing to problems in care.

0 representing (0%) of service user deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user.

4. A summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 3.

Not applicable as none such deaths identified.

5. A description of the actions which the Trust has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 4).

Not applicable as none such deaths identified.

6. An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.

Not applicable as none such deaths identified.

7. The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 2 in the relevant document for that previous reporting period.

0 case record reviews and 21 investigations completed in financial year 2018/19 which related to deaths which took place before the start of the reporting period.

8. An estimate of the number of deaths included in item 7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the service user, with an explanation of the methods used to assess this.

0 representing 0% of the service user deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user. This is accounting for the fact that Serious Incident Investigation reports (RCAs) not making that specific judgement.

9. A revised estimate of the number of deaths during the previous reporting period stated in item 3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 8.

0 representing 0% of the service user deaths during the previous reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user.

The Learning Disability Mortality review programme (LeDeR) has been implemented in a phased way by the local areas where we provide services. During 2018/19, 56 deaths have been reported by us to the LeDeR programme.

- 14 in the first quarter
- 11 in the second quarter
- 13 in the third quarter
- 18 in the fourth quarter

Each of the Local Authority Areas implementing the LeDeR programme have done so in a phased way with different approaches to the process. A significant number of reviews have still to be finalised and this process is overseen by the Local Authority. We have a number of reviewers trained in the LeDeR methodology to support the programme. Learning from the programme is shared via our Mortality Governance Group.

Our Mortality Governance team undertook a comprehensive audit on unexpected deaths and self-harm for January to June 2018. It addressed a number of demographics, diagnosis and explored risk factors (such as isolation/ employment/alcohol/drug use), protective factors, community, crisis plans, risk assessments and formulation. There has been considerable learning from this and an education task and finish group has been set up to look at risk assessment and risk formulation and education required. Other areas of work look at follow up with the Samaritans.

We participated in the Mortality Screening Tool Pilot study hosted by Royal College of Psychiatrists and were one of the first 14 Mental Health Trusts to pioneer this work. This has led to unifying the process of completing Structured Judgment Reviews in mental health Trusts and contribution to national guidance published by Royal College of Psychiatrists. The team were asked to do a poster presentation at the launch event of the Mortality Screening tool at the Royal College of Psychiatrists. There was considerable interest from various organisations nationally.

The Trust has been invited to present the work that we have carried out in learning from deaths at the Eastern Academic Health Science Network Learning from Deaths Forum in March 2019. A Mortality Workshop has been piloted at our Team Leader day and was well evaluated; this will now be delivered on a rolling programme for all staff.

The format of the Mortality Governance Group has be developed over the past year and ensures all learning is triangulated with the moderate harm review panel, the suicide prevention group and Safety Committee. SJRs are discussed at the safety committee, and the moderate harm panel refers cases for SJRs. Learning notes are also developed and shared across the Trust.

2.4 Reporting against our Core Indicators

This section of the Quality Account Report sets out how we performed against our 2018-19 priorities. These are the priorities we set at the beginning of the year and are published in the 2017-18 Quality Account Report. We will look at each of these in turn after considering the nationally mandated quality indicators set by the NHSI Regulation Framework.

Core Indicators

1. The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reported period

Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**
	96.05%	97.11%	97.81%	96.61%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	95.6%	96.8%	96.7%	96.01%
Target (National)	95% rate of service users followed up after discharge from the Acute Care Pathway			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Data is routinely checked and validated internally as well as by internal and external auditors. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by working to a 3 day follow-up standard in advance of the forthcoming national CQUIN.

2. The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period

Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**
	97.1%	96.39%	97.28%	97.26%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	96%	97.8%	99.6%	98.19%
Target (National)	95% of those admitted to an inpatient unit should have been gate kept by CATT			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Data is routinely validated by services as well as the Performance Team on a monthly basis. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by additional validation by clinical service line leads as well as performance with regular feedback to teams on practice and recording issues.

3. The Percentage of Patients aged i). 0 – 14 and ii). 15 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

0 - 14				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**
	0.2%	0.42%	0.41%	0.65%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	4.51%	7.8%	7.09%	5.01%
Target (National)	No target set			

15 and over				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**
	4.70%	6.26%	5.19%	7.85%
Performance in Q1 to Q4 in 2017-18	*Not collected by this category in 2017/18*			
Target (National)	No target set			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Routine report generated from the Trust's Business Intelligence System and then validated by the Performance Team on a monthly basis. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this data and so the quality of its services, by validation and reviews of reasons for readmissions by the appropriate Service Line Lead, with appropriate learning.

4. The Trust's 'Service User Experience of Community Mental Health Services' indicator score with regard to a service user's experience of contact with a health or social care worker during the reporting period.

Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
					7.2%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**17/18**
					7.3%
Target (National)	No target set (comparative data)				

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

Hertfordshire Partnership University NHS Foundation Trust considers that this data is as described for the following reasons: Forms part of an externally run national survey. Hertfordshire Partnership University NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by continuing to develop our recruitment and retention focus and actions and continuing to also focus on the Trust's value based training.

5. The number and, where available, rate of service user safety incidents reported within the Trust during the reporting period and the number and percentage of such service user safety incidents that resulted in severe harm or death.

	Q1	Q2	Q3	Q4
Performance in Q1 to Q4 in 2018-19	**1347 (44%)** Severe harm = 10 (0.7%) Death = 12 (0.9%)	**1349 (47%)** Severe harm = 2 (0.2%) Death = 20 (1.5%)	**1249 (42%)** Severe harm = 0 Death = 15 (1.2%)	**1238 (42%)** Severe harm = 2 (0.2%) Death = 6 (0.5%)

	Q1	Q2	Q3	Q4
Performance in Q1 to Q4 in 2017-18	**1330 (48%)** Severe harm = 2 (0.2%) Death = 13 (1%)	**1300 (45%)** Severe harm = 1 (0.1%) Death = 9 (0.7%)	**1310 (41%)** Severe harm =0 Death = 12 (0.9%)	**1340 (45%)** Severe harm = 0 Death = 18 (1.3%)
Target (National)	No target set			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

Hertfordshire Partnership University NHS Foundation Trust considers that this data is as described for the following reasons: Routine report generated from the Datix system. Hertfordshire Partnership University NHS Foundation Trust has taken the following actions to improve this: encouraged a high reporting culture and scrutiny on the level of harm including the weekly Moderate Harm Review panel.

Part 3 – Other Information

This part of the report gives us an opportunity to celebrate some of the notable and innovative practice that has taken place across our services in 2018-19 and to present information relevant to the quality of the health services we provide. It is not meant to be an exhaustive list, rather a sample of the many and varied initiatives our staff, service users and carers have developed and implemented to improve the quality of our services.

Local Quality Indicators

The local quality indicators for 2018-19 were set out in the Quality Account 2017-18. A brief narrative is provided on each of the indicators following the table.

	Local Indicators
	Patient (service user) Safety
1	Ensure that the cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient wards b) EIP services c) Community mental health services (people on CPA) (NHSI)
2	The use of restrictive practice, including seclusion
3	Improved response time and inclusion of Human Factors methodology in analysis of Serious Incidents
	Effectiveness
4	IAPT: • Proportion of people completing treatment who move to recovery (from IAPT dataset) • Waiting time to begin treatment (from IAPT minimum dataset): (i) Within 6 weeks of referral (ii) Within 18 weeks of referral (NHSI)
5	Inappropriate out of area placements
6	EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)

Service User Experience	
7	Admissions to adult facilities of service users under 16 years old (NHSI)
8	Improved employed rate for service users
9	Co-producing Future Plans for Carer and Family Support

1. Ensure that the cardio-metabolic assessment and treatment for people with psychosis is delivered

The aim is to ensure that service users with psychosis, including schizophrenia, receive comprehensive cardio metabolic risk assessments and have access to the necessary treatments/interventions. The results are recorded in their electronic care record (held by the secondary mental health provider) and shared appropriately with the individual service user, the treating clinical team and partners in Primary Care.

To ensure that staff have the skills and abilities to undertake such work, a physical health training programme was developed as well as pathways for interventions and signposting for all cardio-metabolic risk factors.

These included areas such as:

- Smoking cessation
- Lifestyle (including exercise, diet alcohol and drugs)
- Obesity
- Hypertension
- Diabetes
- High cholesterol.

A national audit was undertaken in February 2019 and we await the formal results. Local intelligence indicates that we performed as follows:

- Community Services: Compliance (target 75%) Trust predicted score is 81%
- Inpatient Services: Compliance (target 90%) Trust predicted score is at 82%
- PATH Services: Compliance (target 90%) Trust predicted score is at 91%.

2. The use of restrictive practice, including seclusion

An external review on our RESPECT training was commissioned by the Deputy Director of Nursing and Quality to establish whether RESPECT provides training to meet service area needs and to make recommendations, based on best practice and current evidence, specifically, to look at:

- Managing disturbed behaviour when more than one service user is an immediate threat to others
- Managing service users who use physical strength or weapons to prevent safe application of RESPECT techniques, with particular reference to the use of Personal Protective Equipment (PPE)
- Moving service users to a place of safety and to prevent the use of a prolonged restraint
- Managing service users who, through force or accident, place themselves into a prone positive
- Managing situations where staff are unable to withdraw or leave the service user
- Managing service users in challenging environmental situations, such as on the stairs.

Following the review, the recommendation to develop training manuals of techniques in disengagement and teamwork skills was agreed, in consideration of the clinical challenges. This recommendation allowed for full ownership of the training and the ability to review and add to the training in line with the changing clinical challenges presented. This 'hybrid' model aimed to meet the clinical challenges and close the skills gap, without the challenges of retraining the entire workforce. Having established a Task and Finish Group with representation from the service areas, key scenarios were identified which staff felt they did not have the confidence or competence to safely respond to and manage. Techniques were then agreed, which sit within current guidance and would be an addition to the current RESPECT training that is delivered and for identified service areas only, based on clinical need.

Members of our staff attended a meeting with Navigo (RESPECT Training Solutions) Senior Professional Leads to discuss the proposals for reviewing the current RESPECT training content. As a training organisation, Navigo understood the changing nature of services and the need to ensure training is developed to meet the complex healthcare challenges.

As an outcome of the meeting, and having considered the information provided to them, including physical descriptors and demonstrations, feedback was received in writing from Navigo on the scenarios relating to specific scenarios. The RESPECT training has been amended and trialled with the Oak team staff. Revisions to the training also include Human Factors and the principles of leadership and decision making.

There will also be a summative assessment on both theoretical and practical components of the training and an increased focus on the practical elements.

As an outcome of the external review, the Trust has now joined an external and already established Quad Group Partnership. As a result, the Trust are required to:

- Remain responsible for its own governance
- Submit lesson plans, tutor portfolios and schemes of work for review by Partnership members at the annual update/refresher
- In return, to carry out reviews of above said materials
- Submit manuals and risk assessments for scrutiny
- Perform 'teach backs' in front of each other for assessment
- Meet and follow the Professional Management of Violence and Aggression (PMVA) trainer Code of Practice and PMVA Partnership Group terms of reference.

The Partnership therefore reviews each other's syllabus to ensure working within the remits set by the various good practice guidelines including the Mental Health Act (MHA), NICE and the Department of Health, for example.

Seclusion can be a traumatic experience for individual service users. Ensuring that the Trust's seclusion facilities and practice as well as the training of staff is delivered to a high standard is essential to enable the experience to be less challenging for all involved. Through their inspections, the CQC raised concerns about our seclusion facilities and practice including documentation such as care plans, risk management plans and medical reviews as well as seclusion outside seclusion rooms.

A full review was therefore commissioned of how we manage seclusion across our services, being responsive to the service user, the service area and the environment resulting in recommendations for service and provision improvements. Mersey Care NHS Foundation Trust was approached to undertake the review, having been cited by the CQC as an example for good practice. A number of actions have since been implemented or currently being, including:

- Provision of refresher training on seclusion process and practice
- Audits of all seclusions rooms to ensure integrity of environment
- Revision of Frequently Asked Questions, flowcharts and checklists for seclusion.

Reviews of all seclusions regarding process and practice – including outside of a seclusion room, of all Long Term Segregation and the Mental Health Minimum Data Set (MHMDS). Staff will be commencing training in the HOPE Clinical Model of Care in April, aimed at reducing Long Term Segregation.

Furthermore, a programme is underway to build new seclusion and also long term segregation suites at a number of our service areas, configured to allow service users access to a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area; to also enable access to a secure outdoor area attached to the suites. The suites will also include an observation room to enable continuous observation and appropriate therapeutic interaction.

This Trust-wide programme will require seclusion suite extensions, refurbishments and/or upgrades and is aimed to deliver a standard of best-in-class seclusion specification on all sites, in consideration of the research undertaken by the Trust and Medical Architecture.

Significant work has taken place to ensure the least restrictive practice is used, focusing on proactive strategies. These will continue into the next year and include:

- Safety pods are used as part of a planned intervention and felt far safer and less restrictive on a service user. They can be used as a form of maintaining settled behaviour, as they provide a large 'snug-type' zone which has been described as "soothing and secure"

  We have purchased some safety pods to trial on Oak ward – our Psychiatric Intensive Care Unit (PICU), assessment and treatment and Medium Secure Units. The feedback from the trial will be discussed at the Safety Committee

- Safety cross is a visual representation of the hours of the day and allowed different colours to fill each hour zone to identify specific incidents. This provides a clear visual breakdown of each day so service users and staff could see at a glance whether the ward was settled. Prior to commencing the pilot, discussion took place with the clinical teams about how to complete these interventions. Each clinical area involved was provided with the equipment (charts, pens and stickers) to complete the safety crosses

- Safety huddles have been introduced in inpatient service areas and take place up to three times a day. All members of the huddle stand to enable the process to be fast and effective and ask the same three questions:

  1. Do you feel safe or do you have a concern?
  2. Which service user is unhappy with their care?
  3. What is the plan (and who is going to implement this and when)?

- **Safewards** methodologies have shown reductions in incidents and restrictive practice across acute mental health settings. Safewards includes a range of approaches by which routines and environments may be modified, flashpoints avoided, de-escalation achieved and alternatives to restrictive practice consolidated into practice. Safewards is a recommended set of evidence-based interventions, of which the principles used advocate the 10 key interventions so when there are 'flashpoints' present, they can be used to reduce potential conflict or containment, as listed below:
  - Clear mutual expectations: proving clear support on how to communicate and why – developed by staff and service users and posted on display in the clinical service areas for all to see
  - Soft words: being respectful and polite
  - Positive words: positive talk during shift handover
  - Bad news mitigation: being aware when bad news is given and received and develop approaches that may be used to support
  - Knowing each other: sharing common interests so relationships are developed
  - Mutual help meetings: thanking people, making suggestions, requests or offers, encouraging or supporting; these are run by service users
  - Calm down methods: having a box of 'calm down' equipment, such as iPods, scented towels, massage balls, herbal tea - the list is not exhaustive
  - Reassurance: being mindful of events that are occurring in the clinical service area and offering support, giving reassurance after an incident or challenging situation, checking in shift handover that all have been reassured
  - Discharge messages: service users who have been transferred or discharged from the clinical service area writing messages on postcards to offer support and hope, highlighting that went well, this can be via poster or tree murals with the messages and postcards on the branches.

3. Serious incidents response times and analysis

Following our CQC inspection in 2018, we were required to review our reporting and investigation process for Serious Incidents, which led to an increase of 50% in those we reported.

As a Trust, we are required to investigate and return completed reports to the CCG by the 60 day mandatory timescale. We have committed to a trajectory for outstanding Serious Incidents and are working towards improving our overall compliance. Furthermore, we have undertaken a quality improvement initiative to look at the overall process and improve quality.

We have implemented a Moderate Harm Panel which meets weekly and has representation across all Strategic Business Units including, safeguarding, Clinical Directors, Managing Directors, the Deputy Director of Nursing and Quality and the Deputy Director of Safer Care and Standards, also the Deputy Medical Director. The purpose of the Panel is to ensure that incidents reported on Datix as moderate harm, severe harm or death (not natural causes) are discussed and immediate learning is shared and themes identified. This supports a robust decision making approach to identifying serious incidents.

Learning is shared across the Strategic Business Units and has informed work in suicide prevention, restrictive practice, health and safety and safeguarding work streams and practice. Themes are discussed in the Safety Committee. The panel liaise with the mortality governance team, and refer cases where appropriate for structured judgment review.

A Moderate Harm section has been added to Datix to support the Panel process and decisions and actions are recorded in the incident module.

"Thank you for all your love and support through this difficult time in my life - I couldn't have done it without you. All the best."

4. IAPT

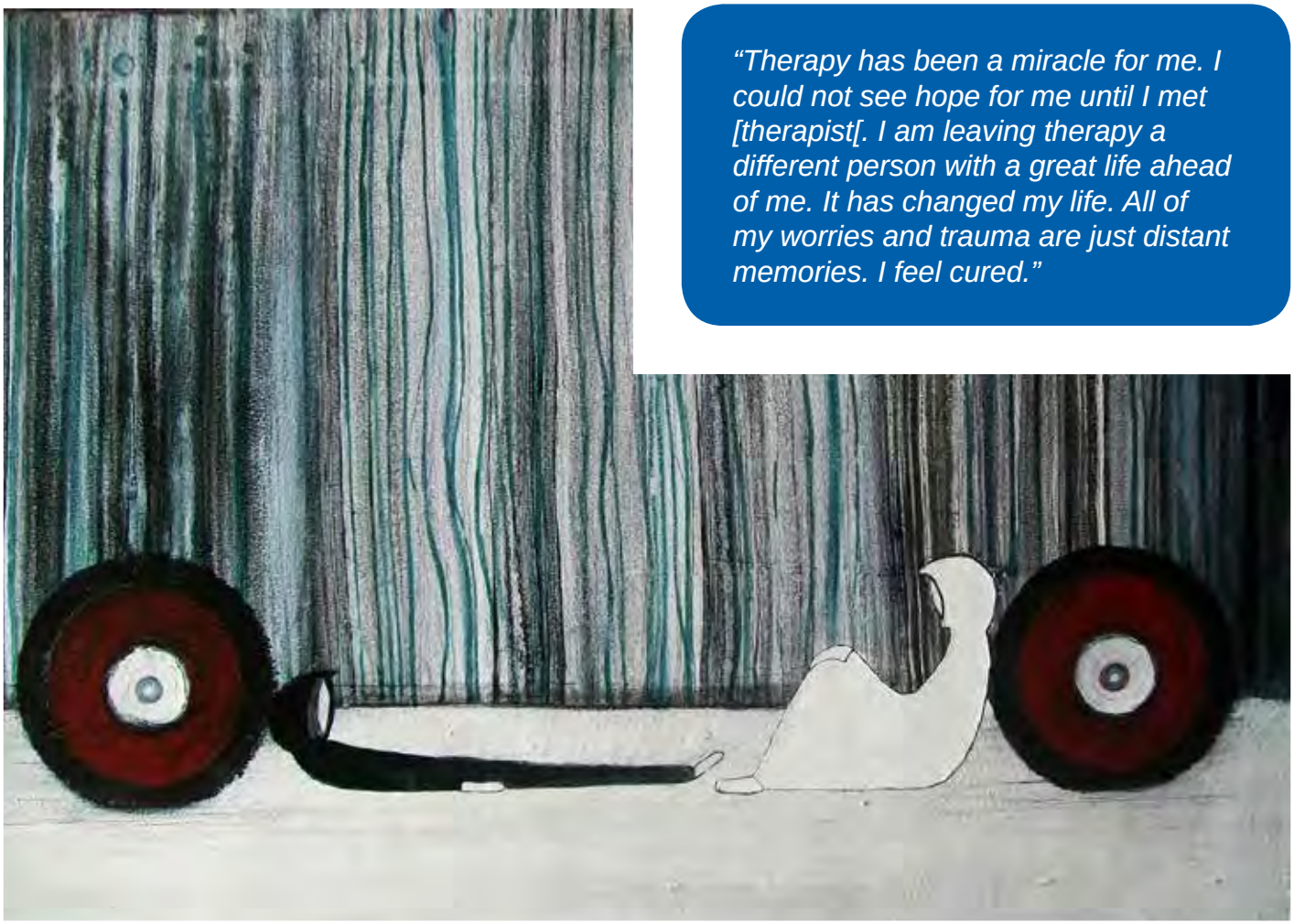
Our IAPT teams across the Trust continue to work closely with their CCGs, GPs and other local NHS providers to ensure the right people are referred in to the services and support the increasing demands for increasing access to psychological therapies. This means people from hard to reach groups, such as older people and those with long term conditions, are being supported to access the service. All teams have seen an increase in the number of people accessing their service this year.

Waiting times for the wide range of low and high intensity interventions varies depending on the type and method of treatment, such as individual, online or group interventions, and service user preferences for appointment. Wherever possible the quickest, most appropriate treatment is offered, although demand for different options can impact on how long people may have to wait.

Recruitment to all teams has been ongoing throughout the year with a cohort of trainees joining the core staff teams and ongoing continuing professional development (CPD) opportunities provided for all staff, notably to work more effectively with people with long term conditions. All teams continue to deliver higher than the national target of 50% recovery rate and good outcomes for patients are reflected in the feedback received in all areas.

"This [service] saved not only my life but also my marriage and family. It made me feel normal and not a "freak". This has been my lifeline. If it hadn`t been for my therapist, I would have lost everything. It made me understand that my reactions and thoughts were I wasn`t totally losing it."

"Therapy has been a miracle for me. I could not see hope for me until I met [therapist[. I am leaving therapy a different person with a great life ahead of me. It has changed my life. All of my worries and trauma are just distant memories. I feel cured."



5. Inappropriate out of area placements

During 2018/19, we continued to maintain inappropriate out of area placements below the trajectory set with NHS England. This has been achieved by focusing on good flow through the acute services pathway, which involves partnership working between clinicians and operational managers; by ensuring that there is always capacity to admit individuals who require a bed, the need for inappropriate admissions external to the Trust is minimised.

A weekly Inpatient Oversight Group, chaired by the Inpatient Medical Lead and supported by Senior Service Line Lead, provides early indication of individuals who are likely to experience a delay in their discharge if there is not proactive work to address social needs or accommodation; there is also clinical oversight and challenge in relation to service users with a length of stay over 25 days.

Where delays or challenges are identified, there is shared ownership across services to expedite discharge and ensure that these delays are minimised. During 2018/19, Hightown Housing Association have provided 'step down' beds at two of their services for people who are waiting for accommodation and no longer need to be in the acute pathway, this has supported inpatient services to minimise delays in the pathway.

In the last year there has been work undertaken with Crisis Teams and Mental Health Liaison, both services that undertake the gatekeeping of admissions to inpatient services, in order to introduce uniformity in gatekeeping decision making and documentation of the alternatives to admission that have been explored with the individual. Audit of the gatekeeping documents supports review of admissions with the teams and opportunity to consider whether an admission could have been avoided. Where an out of area placement is used, this is monitored between Bed Management and the Inpatient Oversight Group, with review by the Crisis Teams to facilitate early discharge and Consultant to Consultant discussion to ensure oversight of care and repatriation in a timely way. These are reviewed at least weekly.

6. EIP

Our EIP Service delivers the FEP Pathway for all people referred to and accepted into the service. The FEP pathway offers a range of evidence based interventions to service users aged 14 – 65 across 3 years. Service users are offered a rapid assessment within 14 days of referral and targeted interventions to assess and improve their physical health and lifestyle. Psychological interventions focussed on Cognitive Behavioural Therapy and Family Interventions are part of the pathway alongside Employment and Vocational interventions and regular outcome measurement.

The PATH service recently engaged with the NHSI Intensive Support team in 2018, as part of a national programme of service visits, to complete a review of the service and agree an action plan to further improve the experience and outcomes for service users and carers. The review recognised that across 2017-18, PATH has consistently offered a rapid assessment and access to the service and has made improvements to the offer of physical health assessment and intervention, to ensure over 90% of service users have access to an annual assessment and targeted health interventions for each year they are on the pathway. The service now offers dedicated Carers support programmes for carers twice a year over 10 sessions and is working to further improve access to Family Interventions for families and carers.

After the review, the PATH service formulated a detailed action plan focussed on the themes of delivering better access to psychological interventions, improving our use of data to drive improvement and recruiting to all our clinical posts, work on which is now underway and measured regularly against agreed milestones. The PATH service is subject to an annual national audit process and this year achieved a Level 2 status indicating a good level of service with excellent access rates.

"Even though we didn't have many sessions together, you helped me so much. Thank you for helping me see that I don't have to be perfect. Thank you for making me feel so comfortable that I was able to talk to you openly about my thoughts and worries. Thank you so much for everything you've done for me."

7. Admissions to adult facilities of service users under 16 years old

Young people are admitted to adult mental health wards as a last resort and when all other options have been considered; these are agreed on the basis of the individual's needs and service user safety. The decision to admit will be escalated to both a senior management and clinical level. All admissions are reported via our incident system (Datix) and will also be reportable to the CQC where the placement lasts for a continuous period of longer than 48 hours.

During November 2017 to October 2018, we reported two such cases to the CQC and there has been one further case of an admission which was for less than 48 hours and not reported. Service users are nursed on a one-to-one basis and the CAMHS multi-disciplinary team provide continued support to the adult ward, with a joint review and care plan put into place.

8. Improved employed rate for service users

Throughout 2018/19, we have been piloting a new programme which provides people using secondary community mental health services with an opportunity to undertake an 8-week work placement/internship within a Trust work place. The programme utilised Individual Placement and Support (IPS) fidelity criteria and was led by a Senior Employment and Vocational Adviser (SEVA) who worked directly with service users from across the Trust to identify suitable opportunities/ internships as a precursor to supporting people into paid employment.

Working with a full caseload, the project delivered eight outcomes for service users over an eight month period. This is in line with IPS recommendations for a SEVA to achieve one outcome per month for people on their caseload. At the year end, three people had undertaken and completed a placement across:

- Performance Team
- Horticultural Therapy
- CAMHS events administration

The following outcomes were achieved via direct work between the SEVA and prospective interns:

- 4 people referred bypassed a work placement and were supported straight into paid employment by the SEVA and remain in paid employment. This was in two full-time roles and two part-time roles
- 1 person referred for a work placement has instead been supported into full time education and began their undergraduate degree in Psychology in January 2019
- 1 person referred was supported in to full-time education and is still successfully studying for a Masters in Psychology
- 1 person who completed an Admin work placement has successfully applied and was interviewed for a Bank Admin role within the Trust.
- 1 person has successfully applied and was interviewed for Bank Healthcare Assistant role within the Trust.

The diagram below provides and overview of activity from the pilot which is currently being evaluated to be integrated into the wider Trust IPS service given the successes that have been seen in such a short space of time:

Number of referrals 35	**Number of 90 minute 1:1s 191**	**% of work time spent face to face at 1:1 23%**
Number of work placements started 3	**Average active caseload 13**	**% of appointments that were cancelled/DNA 24%**
Number of working hours spent on pilot 1230	**Number of placement locations identified 14**	**Range of different professions referring in 12***

**Self-referrals, carer referrals, Community Psychiatric Nurses (CPN), Social Workers, Occupational Therapists (OT), Support Workers, DBT Therapists, Peer Support Workers, Psychologists, Consultants, Vocational Advisers, Herts Mind Network.*

9. Co-producing Future Plans for Carer and Family Support

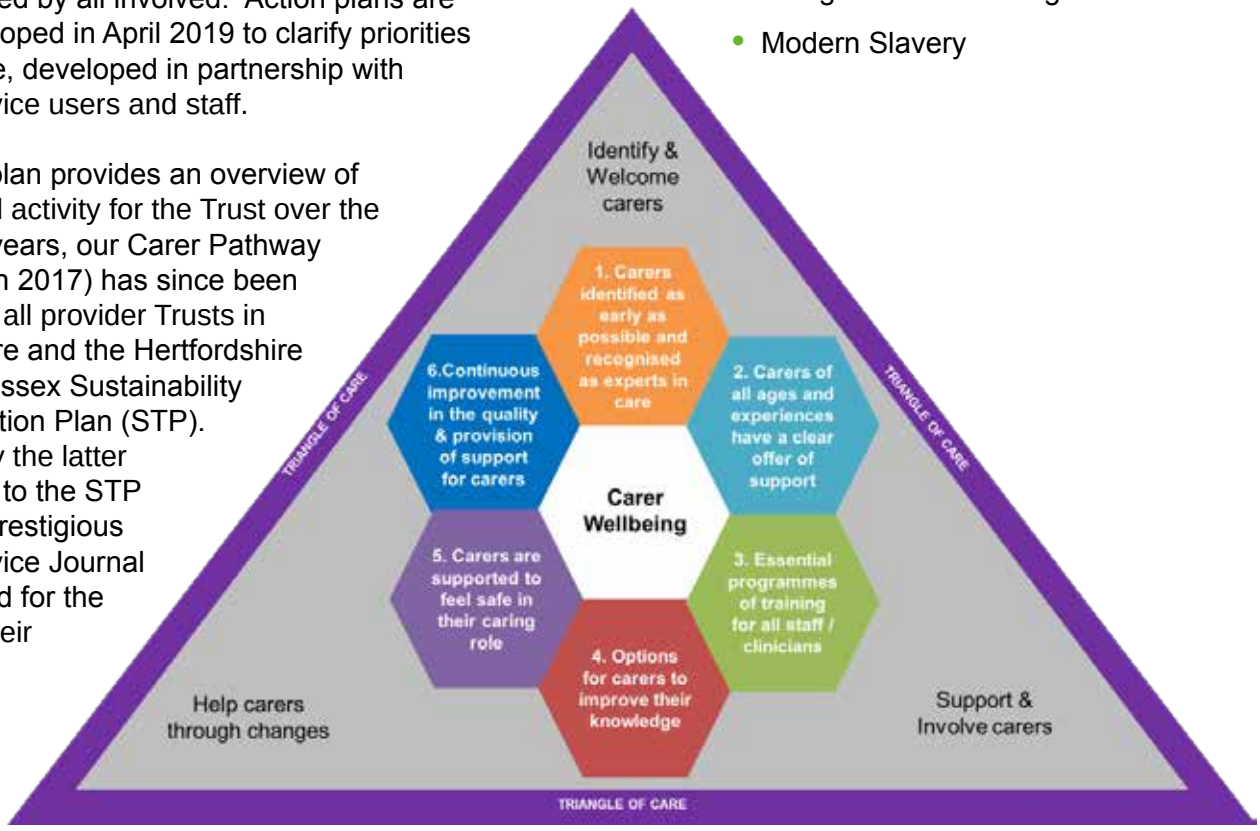
Throughout 2018/19, we have worked to co-produce a new three year plan for carer support. This involved input from carers, service users, staff and wider stakeholder groups and organisations in identifying priorities for carers against our overarching Good to Great strategy.

The plan identifies six areas of focus that are placed within the context of the national Triangle of Care model and the local Trust Carer Pathway which focuses on:

- Identifying carers
- Welcoming carers
- Supporting carers
- Involving carers
- Supporting carers through changes.

The diagram below outlines the co-produced model agreed by all involved. Action plans are being developed in April 2019 to clarify priorities for year one, developed in partnership with carers, service users and staff.

Whilst the plan provides an overview of the planned activity for the Trust over the next three years, our Carer Pathway (launched in 2017) has since been adopted by all provider Trusts in Hertfordshire and the Hertfordshire and West Essex Sustainability Transformation Plan (STP). Adoption by the latter contributed to the STP winning a prestigious Health Service Journal (HSJ) award for the quality of their systems for supporting carers in 2018.



The full Carer Plan can be viewed online at:
www.hpft.nhs.uk/carers/hpft-carer-plan-2019-2021

"So grateful for the gentle and kindly manner in which my sister is treated and well cared for."

Safeguarding adults and children at risk of abuse or neglect

In line with our Strategy of delivering 'Great care, Great Outcomes – Together', our Safeguarding Team aims to improve the quality of safeguarding practice so we can prevent harm and enable safety through:

- Vigilance
- Competence
- Personalised outcomes-focussed practice.

Over 2018-19, safeguarding activity for both adults and children have stabilised, reflecting the embedding of improvements during 2017-18. The areas where we have seen the most significant improvements are:

- Domestic abuse
- Self-neglect and hoarding
- Modern Slavery

To improve our vigilance and competence in recognising and responding to potential abuse and neglect, we:

- Co-located Independent Domestic Abuse Advisors (IDVA) from Refuge into our services
- Developed dashboards for safeguarding adults and children to improve operational oversight
- Develop safeguarding website/central depository for safeguarding information
- Improved referral quality and enhanced process for Child Protection referral
- Provided a number of learning events and practice forums on Child Safeguarding referrals, self-neglect, domestic abuse and modern slavery.

A clear vision for safeguarding to improve towards has laid the foundations for a focussed improvement in all aspects of safeguarding.

A further Safeguarding Improvement Plan has been developed for 2019-20, which will build on the achievements of 2018-19 and take us further towards our vision.

Suicide Prevention

We are a key partner in the development and launch of the Hertfordshire Suicide Prevention Strategy which has representation on the Public Health Programme Board, the Steering Group and across the Task and Finish Groups. We are also a member of the Zero Suicide Alliance. Work from these has included a *'Herts journalist's charter'* agreed across stakeholders, including the police.

We are also a key member of the Hertfordshire Suicide Prevention Network, an alliance of more than 20 organisations drawing over 80 people into eight working groups with the shared ambition of making Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. Our Trust staff input to each of the eight working groups which are:

1. **Communications –** developing relationships with media and news outputs in order that suicide is sensitively reported and the best use is made of social media. A network of news outlets recently signed a charter committing themselves to managing this issue with the mature sensitivity it deserves.
2. **Support of those bereaved by suicide –** research indicates that each suicide can touch the life of over 100 individuals, some of whom are of course deeply affected by their loss. A new Family Liaison role has been created within the Police and helpful booklets produced for families and friends.
3. **Boys and Men –** a group focusses on those most at risk of suicide, working to develop ways of reaching out to men and boys and encouraging connection when in crisis. This group has contributed to the development and launch of the Just Talk campaign which aims to normalise mental health conversations for teenage boys. At least 1 in 4 secondary schools have engaged with Just Talk and the social media campaigns on Instagram, and Facebook have been successful in reaching more than 55,000 people, 90% of whom are men.

   In addition, there have been over 9 million potential impressions on Twitter. Just Talk training was also delivered to 73 professionals in the county.
4. **Signposting and Referral –** aims to facilitate connections between those in need and those in a position to help and have enabled services to go on MiDos, the system used by the local NHS 111 service, re-established referral from custody suites to Samaritans, established a referral pathway between HertsHelp crisis service and Samaritans, and promoted pathways face-to-face with food banks, Relate, patient participant groups, interfaith organisations, local family justice board, housing associations and more
5. **Spot the Signs and Save a Life –** has been raising awareness and providing training across Hertfordshire to the public and private sectors, as well as meeting the public in everyday contexts such as the railway stations, village fairs etc. They are currently developing a smartphone app which will direct users to help and can be personalised to provide bespoke support when needed. Spot the Signs has now trained nearly 40% of GPs in Hertfordshire in Suicide Prevention methods

6. **Mental Health Transitions –** This group aims to help people move from one organisation to another through better information sharing and signposting of services available. As part of this, the group is creating a discharge pack for service users to take away when they leave a service or transition to another.

7. **Children and Young People –** focus on this most sensitive of groups and has supported the introduction of the Healthy Young Minds in Herts School Accreditation and Suicide Aware School status.

8. **Performance –** this final group does the important work of establishing the impact of the project and conducts an annual suicide audit which helps to focus the work of the other 7 groups.

In 2018, we implemented our own internal Suicide Prevention Group as part of a commitment to its zero suicide ambition. CGL Drug and Alcohol Services, a GP and a service user representative with lived experience are integral members of the group. The group commissioned a deep dive into unexpected deaths and serious self-harm for the first 6 months of 2018. An Education Task and Finish Group has been developed by the Suicide Prevention Group to take forward the actions arising from the deep dive and other Trust audits, in addition to learning from serious incidents relating to assessing and managing clinical risk.

We have supported two families and a service user affected by suicide and a suicide attempt to speak at a national learning conference and at a Hertfordshire suicide prevention event.

The Head of Safer Care and Standards chairs the Hertfordshire Support for the Bereaved by Suicide Task and Finish Group whose members have lived experience.

We are working across the system with Network Rail, attending escalation meetings for specific railway stations. We participated in a workshop in January 2019 alongside other partners from Hertfordshire Police, Public Health, Samaritans, Community Safety Partnership and the Coroner's Office which looked at a community approach to preventing suicide on the railway in Hertfordshire.

Planned work includes a collaborative approach working with the Samaritans, supporting follow ups for service users following discharge; also tackling isolation for men through activity and social interaction in social settings (i.e. pubs).

Workforce

National NHS Staff Survey results for 2018

Our 2018 National NHS Staff Survey results demonstrate that we have maintained a positive position particularly in comparison to the last two years, where we had really positive staff survey results. There were no significant differences between the 2017 and 2018 scores.

There are a number of changes to the benchmarked report this year in comparison to previous years. Most notably is that the 32 key findings have been replaced by 10 themes. A theme focussing on morale has also been introduced.

- 4 themes are above average in comparison to Mental Health and Learning Disability Trusts
- 4 themes are average
- 2 themes are below average.

It should be noted that both the below average scores were 0.1 away from being average. For the theme of safety culture, we achieved the national best score of 7.0 and scored above average for every question within the theme.

Top 5 scores (compared to average)	2018 Trust	2018 Mental Health Average	2017 Trust	Trust Improvement/ Deterioration
Q22b. Receive regular updates on patient/service user feedback in my directorate/department	73%	60%	72%	Improvement +1%
Q19e. Appraisal/performance review: organisational values definitely discussed	48%	40%	40%	Improvement + 8%
Q22c. Feedback from patients/ service users is used to make informed decisions within directorate/department	67%	59%	64%	Improvement +1%
Q17c. Organisation takes action to ensure errors are not repeated	76%	69%	73%	Improvement + 3%
Q21b. Organisation acts on concerns raised by patients/ service users	81%	73%	81%	No change

Workforce Inclusion

Our Inclusion and Engagement Team oversees the day to day work around Equality and Diversity including supporting professionals with understanding approaches they can take in ensuring inclusive workplaces for people and provision of equitable services.

Our Equality Plan was co-produced in 2018 to guide much of this work up to 2022 and includes focus on both staffing and provision of high quality services.

Additionally, to support inclusion at work, we have developed a role model programme, who are staff members from certain protected groups who are available to support and signpost other staff should they need this.

As part of our bullying and harassment action plan, there is work in progress to merge the role models programme together with a new 'dignity at work' champions' programme.

We have staff networks for the protected characteristics. The Women's Network has delivered Schwartz rounds, peer support sessions, flexible working, liaison with national women's networks. The Black, Asian and Minority Ethnic (BAME) Network is the Trust's longest running staff network and most recently has included focused work around the Workforce Race Equality Standard (WRES). The network is also instrumental in the planning of the Trust annual race equality at work event in October each year.

There has also been focus in the past year on how the network can get more engaged with reviewing outcomes of recruitment processes as a critical friend to the process.

Other areas of focus for the network include:

- How managers are relating to people
- Managers getting to know staff
- Discussion around meaningful supervision, asking "How are you" and not just going through the process
- Promoting a balanced and equitable approach across all career paths.
- Generating ideas around how the Trust could be improving approaches to recruitment to ensure equality of opportunity.
- Advocating for managers who are good role models for staff.

Specifically in relation to WRES, an open forum was advertised across the Trust to understand the reasons why staff from a BAME background are more likely to enter a formal disciplinary process and less likely to be appointed after interviewing for roles than those from other demographic groups. Across the day various staff from all backgrounds attended to give feedback on their experiences from different areas of the Trust. This was used to inform the WRES action plan.

Our WRES plan is refreshed at least annually and tracks progress across the organisation. This has been overseen, up to now, by an operational WRES management group. Over the past few months the Trust has begun to hold drop in 'surgeries' for BME staff within our business units to provide opportunity for BAME staff to meet both management and equality and diversity staff to share their experience and share ideas for improvements, as well as highlighting what works well for them.

Annually, we host an annual event for staff focused on supporting race equality across the workforce and how changes to culture can be implemented to ensure no differential, negative, experience for BAME staff.

People are our greatest asset and a focus for us was continuing to improve the experience of staff, inclusively, in the workplace. One element of this is our aspiration to eliminate any experience of bullying and harassment. We have put in place actions designed to support this aspiration which are monitored constantly and progress is evaluated on a regular basis. Our values are embedded across the organisation and the recent CQC report has confirmed this is felt by our service users. In 2019-20 we will continue to focus on demonstrating how our values translate into the workplace and develop our working relationships as a means of reducing and ultimately eliminating bullying and harassment within the Trust.

Recruitment

To overcome the recruitment challenges we face as a Trust there is an active programme of recruitment to vacancies throughout the Trust with an increased focus on hard to recruit areas. This includes recruitment campaigns, recruitment days, attendance at recruitment fairs, working with agencies, and offering students substantive roles with the Trust upon qualifying.

A significant amount of work has been undertaken to improve the on boarding process including the outsourcing of all pre-employment checks, getting all recruiting managers to undertake ID checks at interview, ensuring candidates are kept updated during the recruitment process, and ensuring all managers complete the necessary forms so that their new starter has all the equipment they need to do their job on day one. This has already helped to reduce our time to hire to 8.5 weeks.

We have recently implemented a new careers website to aid recruitment. In addition, we have changed our notice periods for new starters for band 5 and band 6 staff from 4 weeks to 8 weeks, and for Band 7 staff from 4 weeks to 12 weeks. This was effective from 1 January 2019. Our Strategic Business Units have recruitment and retention plans and are developing a welcome pack that is specific to their area of work.

We have also participated in the widening participation workshops with NHS Employers and is actively involved in the STP recruitment and attraction work stream.

Our Trust values are integral to all we do as a Trust and they are introduced early on in the recruitment process. All new recruits are screened against the Trust values at the point of application through completing a values assessment. Then interviewer packs include suggested interview questions designed to determine if candidate's values align to the trusts. All interviews must include at least one of these questions.

A values session is held at all inductions which is attended by staff, volunteers and students. We have a strongly embedded Employee Value Proposition which fosters a culture where service users, carers, staff, our partners and our referrers receive an experience that is Welcoming, Kind, Positive, Respectful and Professional. The Values and Behaviours Framework form part of all appraisals to ensure performance is measured against the Trust values.

Retention

As a Trust, we recognise the importance of retaining our staff and recognise that our retention rates are not as high as we would like. As a consequence, we have implemented a number of retention initiatives over the last year including the retire and return process, internal transfer process, piloted a buddy system for new starters which is about to be expanded, held 'Grow Don't Go' workshops within the Strategic Business Units, held flexible working workshops with managers and are embedding the 100 day interviews for new starters. Further work to be implemented includes career surgeries for staff and holding a Long Service Awards ceremony in May 2019. Communication of and embedding the schemes continue throughout the Trust. We have actively participated in the NHSI retention programme as well as the retention programme run by NHS Employers.

Our Pulse Survey

We run the survey every quarter, based on the National NHS Staff Survey questions, giving us consistent quantitative feedback from staff on their experience with the Trust. Scores indicating whether staff would recommend the Trust as a place to work or receive treatment have maintained a good level during the past few years.

The Pulse Survey questions are reviewed annually to ensure they meet the needs of the organisation and are in context with the Organisational Development Strategy.

Health and wellbeing

In 2018/19, staff were provided with an annual calendar of Health Hub events including: socials, challenges, workshops and online tutorials. Health Hub champions were supported ensuring the events had more impact.
The impact of the events has been through quantitative and qualitative data analysis. This analysis, including testimonials, has been communicated to staff via our weekly news bulletin, our staff magazine and also our Workforce reports.

The data from 2018-19, along with the National Staff Survey and Pulse Survey, will inform the areas of focus in the action plan for 2019-20 and the Staff Health and Wellbeing Strategy will be updated to reflect this.

Some of the events undertaken include:

- 140 massages to staff across sites
- Delivering mini health checks
- Schwartz Rounds in quarter 4 in our north west and our east and south east quadrants
- Mindfulness and resilience sessions in south west and Buckinghamshire.

The analysis has shown:

- Those attending a Mindfulness course had an increase of 28% mindful awareness
- Staff provided testimonials for onsite massage and mini health checks and we have quantitative information for each quarter
- Schwartz Rounds scored a feedback rating of 10% Exceptional, 55% Excellent and 18% Good.

The data from 2018/19 has provided us with the evidence-base needed to continue to evaluate the wellbeing support offered to our staff.

Staff Support

There are a number of ways in which we offer support to staff, both formally and informally. We provide Occupational Health support and an Employee Assistance programme is available to all staff 24 hours a day, 7 days a week, 365 days of the year. We have also implemented a confidential helpline which staff can contact if they have any concerns or would like to report bullying and harassment.

We have also implemented Schwartz Rounds which are a structured forum where all staff (clinical and non-clinical) come together regularly to share their personal experiences of work. The aim is not to fix problems, but to acknowledge the emotional demands of working in healthcare. Schwartz Rounds reduce feelings of stress and isolation, which make it difficult to provide compassionate care.

The benefits of Schwartz Rounds include significant improvements to staff psychological wellbeing, improved inter professional working and more compassionate care. During 2018, 16 Schwartz Rounds were held throughout the Trust with 243 participants. An evaluation of Schwartz Rounds found that 92% of participants would attend again, 95% of staff would recommend Schwartz Rounds to a colleague, 90% of staff said it would help them to work with colleagues, and 98% have a better understanding of how colleagues feel about their work.

Additional staff support also consists of workplace mediation, mindfulness courses, resilience training, stress management tutorials, and the Trust Health and Wellbeing magazine known as ‘Working Together as One’.

Where an incident has taken place, post incident support is offered on an individual as well as a team level. This is co-ordinated through the Safer Care team and continues through the serious incident investigation process to inquests and beyond.

The Spiritual Care team also contribute to staff support by offering team and individual support, particularly where a staff member or service user has died.

The importance of having support for new staff has was highlighted as needing development. As a result, a buddy scheme for new starters has been piloted in some areas of the Trust and will be rolled out over the coming months with development workshops being made available to buddies as a source of support.

Annual Staff Awards

Each year, we host our Annual Staff Awards event. The afternoon is dedicated to the development awards where we celebrate staff who have completed an academic qualification throughout the year. 164 members of staff were invited to the staff development awards with 98 members of staff attending to collect their certificates.

The evening is a black tie Staff Awards event. There are 12 Annual Staff Award categories which are as follows:

- Unsung Hero
- Council of Governors Making a Difference Award - nominations for this category are made by service users and carers
- Chief Executive's Award
- Chair's Inspire Award
- Team of the Year Award
- Outstanding Leader of the Year Award
- Rising Star Award
- Professional of the Year Award
- Innovation or Improvement of the Year Award
- Special Contribution Award
- Working in Partnership Award
- The John Lewis Customer Experience Award - Nominations for this award are made by service users, carers, their families and staff.

The last staff awards ceremony was held at Tewin Bury Farm in November 2018 and was attended by over 300 staff. Over 300 nominations for Achievement awards were received with 25 members of staff either winning an award or gaining highly commended. The awards ceremony was a wonderful opportunity to celebrate the success of our staff and all the wonderful things they do to provide great care every day to service users and carer either directly or indirectly.

Inspire Awards

The Inspire Awards are a monthly staff award to recognise and reward those staff who consistently demonstrate our values. Nominations are received, with a supporting statement, from staff, service users and carers. Anyone in the Trust can be an Inspire Award winner. Winners are invited to attend an informal presentation with the Chief Executive and members of the Executive Team where they are presented with a certificate, £50 John Lewis voucher and have a small buffet lunch. There have been 134 Inspire Award nominations with 73 winners.

Leadership

We provide a range of Leadership Development Programmes both internally and externally to meet the different requirements and learning styles of staff.

These comprise of formalised in house training programmes, covering basic management skills and leadership development, previously in our Managing Service Excellence programme, which has been reviewed and is being relaunched as the Management Fundamentals Programme and through our internal Leadership Academy, which is a level 7 accredited programme delivered in partnership with the University of Hertfordshire.

Cohort 9 of the Leadership Academy have recently graduated with 20 delegates passing and gaining accreditation. This Level 7 accredited Programme is delivered in partnership with the University of Hertfordshire and this Cohort was our most successful to date.

The Finance Team has facilitated elements of the Trust's leadership academy for some years now, writing and presenting a finance module to cover topics that leaders and future leaders need to understand in order to do their jobs effectively. For the new cohort starting in 2019, our module has expanded to 2 days and has replaced sessions which were previously covered by an external trainer, saving money for Organisational Development and providing a much more Trust-tailored training. We will also be participating in the new Management Fundamentals course again writing the material.

We are also participating in the local Mary Seacole programme within the STP, with cohort 4 recently graduating and with cohorts 5 and 6 near completion of the course. The Trust has also participated in the Bedfordshire and Hertfordshire Accelerated Directors Development Scheme (ADDS) which is a Chief Executive sponsored scheme to identify and develop leaders for Bedfordshire and Hertfordshire, who have the potential to fill key Executive Director roles. It is co-designed, owned and delivered on behalf of the Bedfordshire and Hertfordshire Talent Forum. ADDS is focused on identifying and developing high potential leaders from operational and clinical backgrounds and is a unique scheme offering automatic shortlisting for appropriate Executive Director roles, thereby linking development and job opportunities. The current Executive Director of Service Delivery and Experience, the Executive Director of Quality and Safety and the Interim Director of Workforce and Organisational Development have all been through this course. Another participant has gone on to become the Chief Nurse at the Homerton NHS Trust. In addition, 3 further participants from the Trust have just completed the last cohort.

We have also recently participated in the pilot for the Midlands and East Talent Board, with 2 candidates from the Trust being put forward. Staff have also participated in national programmes such as Nye Bevan – the current Executive Director for Quality and Medical Leadership, Mary Seacole, Aspiring Directors of Nursing programmes – the Deputy Director of Nursing and Quality and the Deputy Director of Safer Care and Standards; and the Chief Pharmacist Development programme – the Deputy Chief Pharmacist. A Senior Community Nurse Lead has been successful in her application, supported by the Trust, to join the 70@70 Senior Nurse and Midwife Research Leaders programme.

Internally, we have delivered a leadership programme for Service Line Leaders using a coaching and mentoring style, and Team Leader development days continued to run for the second year. Development days for Medical Leads have also taken place during the year and more recently for Matrons. Specific leadership development programmes are supported by additional support to managers through the coaching network and the creation of podcasts to provide 'just in time' support around key management and leadership issues. 8 members of staff have recently qualified as ILM (leadership and management) level 5 coaches and are registered with the Bedfordshire and Hertfordshire coaching network, coaching both internal and external staff.

Our 70 senior leaders meet regularly to hear from the Chief Executive about key strategic developments and to do focused thinking around strategic and operational objectives. This forum is also used for development sessions for example a session on Outward Mindset by Alec Grimsley. The national leadership framework shares the same evidence base as the collective leadership model, which we have used to inform the Organisational

Development Strategy. Succession planning also takes place within each Strategic Business Unit so that leaders of the future are identified and supported to gain the development they need.

We are also committed to increasing equality and diversity and our Unconscious Bias training is being rolled out across the organisation.

The Monthly Educational (CPD) Programme is led by senior leaders established in community teams. The programme entails teaching on risk formulation, collaborative safety planning and role play on managing difficult clinical situations. (Community Adult Mental Health Services).

Organisational Development

The Organisational Development Strategy outlines how we need to develop to deliver our strategy of going from Good to Great. It sets out a series of planned activity that develops our organisational (as well as individual) competencies. This includes embedding the desired culture, ensuring an effective workforce and developing enabling systems and processes.

In addition to leadership development and talent management and succession planning, there are a series of staff engagement programmes which take place throughout the Trust.

These include as follows:

- **Big Listen and Local Listens**

  The Executives undertake a 'Big Listen' engagement every quarter, which is open to all staff. A full day is spent meeting the Executives and discussing any issues that matter to staff. Staff are asked to put forward their comments regarding how the senior leadership team can improve both the staff and service user experience around certain themes such as WRES, bullying and harassment, recruitment and retention, for example. There is a 'Question Time' panel during the day where attendees have an opportunity to ask questions directly of the Executive Team, or anonymously should they prefer. These events receive excellent feedback and evaluation and there are actions taken from these events that are reported on at the following event to complement our 'You said, we did' approach. For example, in the October 2018 Big Listen staff complained about the backlog and length of time to get IT equipment. The Executive Team took action that day and an additional 250 laptops were ordered.

  Local listens, which follow a similar format to the Big Listen, are also held across Norfolk, Essex and Buckinghamshire to reach an even greater audience. Local Listens have also been adopted by the SBUs locally and are attended by Senior Leaders and Managers.

- **Good To Great Roadshows**

  Our Good to Great Roadshows take place every six months and provide an opportunity for our Executive Team and Senior Leadership Team to meet with staff at their work locations to discuss a certain topic. The latest Good to Great Roadshows have focussed on improvements that teams have made over the last year, making 'time to care' and the success factors to focus on. 16 roadshows were held at 15 sites with 224 members of staff attending.

- **Chief Executive Breakfasts**

  Chief Executive Breakfasts also take place throughout the year in which our Chief Executive meets with a certain staff group to understand what is going well, and what could improve their working lives. Over the last year, breakfasts have been held with 30 staff from staff groups including Medical Consultants, Matrons, Band 5 and Band 6 Registered Nurses, Assistant Psychologists and Occupational Therapists.

Statutory / Mandatory Training

A comprehensive programme of statutory and mandatory training is in place across the Trust with the requirements tailored to specific job roles. Discovery has been set up to allow the individual to know which of the statutory and mandatory training modules they are required to complete and monitor their compliance against this requirement.

Discovery now hosts all our e-learning packages which offers ease of access to staff to complete their statutory and mandatory training. For those courses which still run as face to face sessions, staff are able to book onto them directly via Discovery.

Feedback from staff has been that the system is more user-friendly and easier to navigate and as a consequence improvements in compliance rates have been seen. The functionality of the systems also allows managers to see the training compliance of their team members.

Discovery is our new learning management system accessed by staff either at work or at home. Staff can see at a glance what courses they are compliant in, what courses are about to become non-compliant and what courses are now non-compliant.

Apprenticeships

We are fully committed to utilising the Apprenticeship levy to provide alternative opportunities for the local workforce and increase our skill base. During 2018-19 we have engaged a number of apprentices across clinical and non-clinical roles. We have 82 apprentices working in the Trust through 2018-19. We have plans to provide similar opportunities during 2019-20 and are looking to potentially increase the scope of apprenticeships to include other Health Professionals and management level courses. Occupational Therapy has been identified as the next development with the University of Hertfordshire and will be accept the first students in September 2020.

Medical Education

We remain strongly committed to investing in learning and development for all our staff.

General Medical Council (GMC) Trainers and Trainees 2018 Survey.

The 2018 survey was one of our best outcomes since the GMC Training survey began, with 11 positive (green) outliers and 3 negative (red) outliers. We continue to be rated one of the best mental health trusts in terms of training in the East of England region, as in previous surveys.

Our GP trainees and Foundation Year doctors rate their placement experience with us very highly, leading to most of the positive outliers received coming from these groups of doctors.

The GP trainees rated workload, study leave and local academic teaching programme very positively, while the Foundations Year doctors gave positive responses regarding the Trust in the areas of work load, supportive environment and overall satisfaction.

The three areas which received negative outliers were amongst psychiatric trainees in the areas of work load, rota design and overall satisfaction. We identified the reasons being the recruitment challenges. This meant that there were gaps in the rota which put added pressure on trainees who sometimes had to cross-cover. The situation has improved, with the resolution of the recruitment crisis in core psychiatric posts.

We have also set up a GMC approved fellowship programme attracting overseas trained psychiatric trainees as well. Overall, the outcome of the survey was very positive with the expectation that, as the recruitment situation improves, the negative outliers will become positive. The responses of our trainers were the most positive amongst the mental health trust in the east of England region.

What is the MSc in Psychiatric Practice and Mental Health Practice?

This MSc degree programme was jointly set up and funded by the University of Hertfordshire and the Trust to provide psychiatric trainees with an academic course to help prepare them for the Royal College of Psychiatrists examinations, and to give them and other members of staff the opportunity to obtain a master's degree.

Health Education England coaching and mentoring funding 2017/18

We received funding from Health Education England of £1,500 as a one-off payment. Our Medical Education Budget has also financed a train the trainer course at which 7 of our Consultant Psychiatrists and one Organisational Development Manager attended. We plan to deliver this training in-house to our trainee medics in the future; the first workshop is arranged for 31 May 2019.

Compliments, Comments and Complaints

We place great value on the comments, compliments and complaints sent in by service users, their carers, relatives, friends and advocates. We encourage people to raise concerns with staff on the units, to use the comments, compliments and complaints leaflets available on all wards and outpatient units. Alternatively they can complete a form on the Trust website at:
www.hpft.nhs.uk/contact-us/compliments-and-complaints/online-form
email hpft.pals@nhs.net or call our dedicated phone line 01707 253916.

We also invite all service users and carers to provide ongoing feedback on their experiences by completing *'Having Your Say'* forms or Friends and Family Test (FFT) postcards, either on paper or electronically, during their recovery journey. Service Experience Volunteers visit our adult acute inpatient and rehabilitation units to provide an impartial listening ear as well as support for service users and carers providing feedback through *Having Your Say.*

What is the NHS Friends and Family Test (FFT)?

The NHS Friends and Family Test (FFT) was created to help service providers like the Trust understand whether service users are happy with the service we provide, or where we need to improve. It is a quick and anonymous way to give views after receiving care or treatment.

What we do with compliments, comments and complaints

We use information received through comments and complaints, together with the outcomes of any investigations to improve our services. We work closely with the Safer Care and Practice Governance Teams to ensure that lessons learnt are turned into action plans to change and develop practice.

Each quarter, every clinical team is required to produce a 'you said, we did' poster based on all the feedback they have received, sharing what they will do to improve the service with those who have taken the time to provide feedback.

We also feel it is important to celebrate what we do well, and all teams are encouraged to send details of compliments received to the Patient Advice and Liaison Service (PALS) and Complaints Team to make sure we capture the overall picture of service users and carers' experiences. We record all the compliments we receive and these are published in the e-magazine for staff. Satisfaction levels are monitored through Having Your Say and Friends and Family Test (FFT).

PALS

PALS provide people with advice and assistance if they have a concern or enquiry. This year we received 869 contacts – an increase of 1% on last year. The table below shows the number and main categories of PALS contacts, comparing 2018-19 with 2017-18, 2016-17 and 2015-16.

As in previous years most contacts raised issues for resolution by the PALS team or, more commonly, by the clinical teams. However, there has been an 11% increase in enquiries and a 93% increase in contacts about issues not related to our services.

We are being more rigorous about defining comments as feedback, informal complaints and issues for resolution which explains the changes to figures has meant an increase in contacts in that category compared to previous years.

Category	2015/16	2016/17	2017/18	2018/19
Advice	41	40	67	32
Enquiry	67	140	176	196
Feedback	98	100	240	156
Issues for resolution	363	446	183	272
Informal complaints	-	-	135	97
Other	0	1	0	1
Translation request	1	0	1	0
Non HPFT	36	32	59	114
Total	**606**	**759**	**861**	**869**

Formal Complaints

When we investigate complaints we aim to provide a fair, open and honest response, and to learn from them, so service users and carers can benefit from the resulting changes. The number of complaints received in 2018-19 was 284 compared to 206 received in 2017-18, which is a 38% increase. The increase is more marked owing to unusually low number of complaints in 2017-18, which was a 22% decrease on the previous year, as well as an increase in activity during 2018-19. Although it is difficult to ascertain the fluctuation over the last two years, the average of the two years together does remain comparable to the total received in previous years. The table below shows the number of complaints categorised by the main issue each complaint focused on, comparing 2018-19 with 2017-18, 2016-17 and 2015-16.

Category	2015/16	2016/17	2017/18	2018/19
Assault / abuse	11	3	3	4
Clinical practice	98	93	89	113
Communication	39	35	24	49
Environment etc.	3	2	4	7
Staff attitude	29	31	26	35
Security	3	0	6	6
Systems and Procedures	84	84	54	69
Transport	2	2	0	1
Total	**269**	**250**	**206**	**284**

Emerging themes

Some PALS ‘issues for resolution’ and ‘Informal complaints’ are transferred to the formal complaints process, either because they cannot be resolved within one working day, or because they raise serious issues. Most issues and enquiries are dealt with immediately, or very quickly, by the clinical teams and do not result in a complaint. 8 PALS contacts became formal complaints during the year.

The 113 complaints where clinical practice was the primary issue fell into 11 sub-categories. Most complaints fell into the following groups:

- Direct care (52)
- Assessment and treatment (23)
- Care planning (12)
- Diagnosis (10)

The 69 Systems and procedures complaints fell into 25 sub-categories. The highest numbers were for:

- Access to Treatment (17)
- Breach of Confidentiality (12)
- Mental Health Act detention (4)

The 4 complaints of alleged assault were:

- Alleged physical abuse to a service user by a member of staff (not upheld)
- Alleged physical abuse by another service user (this aspect of the complaint not upheld, subject to safeguarding)
- Alleged physical abuse by staff (under investigation and subject to safeguarding)
- Physical abuse by another service user (under investigation).

All allegations were considered carefully by the Multidisciplinary Team and through Safeguarding, where appropriate. One case, which resulted in a fracture, is being investigated as a Serious Incident. During 2018/19 we received 7 requests for files from the Parliamentary and Health Service Ombudsman (PHSO)/Local Government Ombudsman.

During the year we received 5 decisions:

- 2 not being investigated
- 3 not upheld

There are currently 5 complaints with the Ombudsmen.

Compliments

All teams are asked to forward letters of thanks from service users, carers, advocates and visitors to the PALS and Complaints Team so that they can be logged and reported. In line with increased numbers of other contacts there has been a 20% decrease in the number of compliments forwarded to the team.

- 2015/16 – 1622
- 2016/17 – 1915
- 2017/18 – 1981
- 2018/19 – 1571

In 2018/19, we recorded nearly 6 times as many compliments as formal complaints.

Clinical Networks

We are members of the following networks:

- Learning Disability Clinical Network
- Clinical Outcomes and Research Evaluation (CORE) CAMHS
- AIMS Accreditation Scheme (Royal College of Psychiatrists)
- East of England clinical senate
- The Trust is part of the larger Eastern Clinical Research Network (CRN). CRN Eastern is funding two consultant psychiatrist research sessions as well as one consultant psychologist research session.
- The Psychiatric Liaison Accreditation Network (PLAN)
- Quality Network for Forensic Mental health Services (Adult Forensic) Community
- Quality Networks for Community Forensic Mental Health Inpatient
- Quality Networks for Early Intervention Psychosis
- Quality Networks for Child and Adolescent Eating Disorder Community
- Quality Networks for Child and Adolescent Inpatient
- Quality Networks for Child and Adolescent Community
- Quality Networks Inpatients Child and Adolescent Inpatient
- Quality Networks for Perinatal inpatients
- Quality Networks for Perinatal community
- Quality Networks for Rehabilitation services Inpatient
- National Association of Psychiatric Intensive Care Units (NAPICU)

"Absolutely fantastic people. Everyone I met was so kind. My experience with the crisis team was a fundamental part of my recovery. I could not have done it without their kindness and support. It meant so much to me! Thank you from the bottom of my heart."

We continue to:

- contribute to the regional and national transforming care programme through regional expert reference groups
- work with Health Education England on the development of competency frameworks to create and sustain models of good practice in community learning disability and forensic teams
- support NHS England in the development of service specifications and quality commissioning products through our membership of the regional senate and national clinical reference groups.

What is a clinical network?

These networks are dedicated to providing assurance and sharing good practice so we can improve the health service for all those who work in and use it.

We also participated in the following accreditation schemes:

Service Accreditation Programme and Quality Improvement Network			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
	Early Memory Diagnosis and Support Services – South West Hertfordshire	Accredited	
	Early Memory Diagnosis and Support Services – North West Hertfordshire	Accredited	
Perinatal	Hertfordshire Partnership University NHS Foundation Trust	Member	51
	Thumbswood Mother and Baby Unit	Accredited	
Psychiatric Liaison Accreditation Network	Lister RAID (The Lister Hospital and Queen Elizabeth II Hospital)	Accredited	81
	Watford RAID Team (Watford General Hospital)	Accredited	
Quality Network for Community CAMHS	CAMHS Eating Disorders	Participating but not yet undergoing accreditation	42
Quality Network for Forensic Mental Health Services	Beech Ward (Kingsley Green)	Accreditation not offered by this Network	83
	Eric Shepherd Unit	Accreditation not offered by this Network	
	Broadland Clinic	Accreditation not offered by this Network	

Service Accreditation Programme and Quality Improvement Network			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
Quality Network for Inpatient CAMHS	Forest House Adolescent Unit	Accredited	131
Quality Network for Inpatient Learning Disability Services	Assessment and Treatment Unit, Lexden	Accredited	41
	Dove Ward	Accredited	
	Astley Court	Accredited	
Quality Network for Older Adults Mental Health Services	Prospect House	Participating	87
Psychiatric Intensive Care Units	Oak Ward	Accredited	38
Prison Mental health Service	HMP The Mount	Accreditation not offered by this Network	40

CQC

As a Trust, we were registered with the CQC on 1 April 2010 to carry out the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

We were inspected by the CQC between 23 January – 9 February 2018, which included an unannounced inspection of services and a well led inspection. The Trust's report was published in April 2018.

The Trust achieved an overall rating of 'Good'. The report focused on 5 different domains of quality:

- Safe
- Effective
- Caring
- Responsive
- Well led

The CQC's overall rating of the Trust stayed the same, it was rated as 'Good' because:

- Staff showed caring, compassionate attitudes, were proud to work for the Trust, and were dedicated to their roles
- Staff managed medicines safely in most services. The Trust had made improvements in medicines management since the last inspection
- Staff completed comprehensive and robust risk assessments and documentation showed clear service user involvement and inclusion
- Staff included service users in service improvement, using their feedback to change practice
- Safeguarding and incident reporting were transparent locally and thorough; review and evaluation of this was proactive. Teams shared lessons learnt effectively and in some services shared this learning with service users
- Local leadership across the majority of services was strong, visible and effective
- Local governance meetings discussed ward issues, such as incidents, safeguarding, staffing concerns, and identified and shared learning from incidents
- Quality improvement initiatives had begun to make a difference
- A system called SPIKE gave staff access to monitor performance and leaders saw this as a way to assist data collection and analysis and reduced time on administration tasks
- The CQC were provided with a good description of the way in which the Trust implemented Duty of Candour, highlighting that it is in the terms of reference for the investigation of each serious incident that the duty of candour is complied with; service users are contacted before, as part of, and at the conclusion of each investigation.

The Trust devised an action plan with a list of 'Must do' and 'Should do' recommendations to address areas identified by the CQC of which its implementation was overseen by the Integrated Governance Committee and the Board. At the time of this report we have completed the following actions:

- **Ensure that all ligature points and blind spots are identified and risks are mitigated**

  All Acute and the psychiatric intensive care unit (PICU) ligature risk assessments were reviewed and updated at the time of the inspection

  Further work to combine ligature risks, blind spots, lines of sight and floor plans into one risk assessment was initiated. Weekly environmental assessments and walk rounds take place across the Trust, with a new system provided by Advanced New Technologies (ANT)

- **Ensure that all service users receive a physical health assessment on admission and that identified health care needs are met**

  Processes are in place and the Fundamentals of Care audits are taking place to ensure and monitor physical health assessments are being completed, progress is monitored via the local Practice Governance meetings

- **Ensure adherence to the Mental Health Act Code of Practice in regards to recording of seclusion practices and the seclusion environment**

  Immediate work completed on the PICU seclusion room. Work also completed on upgrading a high intensity room to a seclusion room on Dove ward. The refurbishment of seclusion rooms programme is underway with work commenced. Furthermore, an external review by Mersey Care of seclusion practice and environments was completed in July 2018, with a final report and recommendations received

- **Ensure the proper and safe management of medicines**

  Updated expiry date Standard Operating Procedure (SOP) has been shared with nursing staff by our Chief Pharmacist. The SOP has been amended to re-enforce the importance of documenting the "date of opening" on specific medications

- **Ensure staff are supervised in line with their policy and that this is monitored**

  All supervision trees are up to date and with the Service Line Leads; supervision trackers are in place on all units and being reported on monthly. The Discovery supervision module became operational from July 2018.

This allows the recording and will enable the monitoring of supervision against our policy. Compliance of this will be audited monthly, and compliance will be monitored through this system.

At this inspection, the CQC rated two core services as 'Outstanding', one core service as 'Good' and one as 'Requires Improvement'. Therefore, two of our 11 services are rated as 'Outstanding', 8 as 'Good' and 1 as 'Requires Improvement'.

As part of the CQC's annual approach to inspections, the Trust was inspected week commencing 4 March 2019. The inspection included a core services and well led inspection.

The following core services were inspected:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based Mental Health services for adults of working age
- Child and adolescent mental health wards
- Specialist community mental health services for children and young people
- Mental health crisis services and health based places of safety
- Wards for older people with Mental Health problems.

The CQC published our inspection report in May 2019 and rated us as Outstanding. We are now one of just five mental health and learning disabilities NHS Trusts in the country to be rated as outstanding – and the only one in the east of England.

Of the eleven services that have now been inspected by the CQC, seven are good and four are rated as being outstanding.

"Staff showed caring, compassionate attitudes, were proud to work for the Trust, and were dedicated to their roles."

From Norfolk to Buckinghamshire and Hertfordshire to Essex, this has been achieved by brilliant, dedicated staff who are committed to our service users and carers by delivering great care and achieving great outcomes together.

The CQC inspectors were particularly impressed with the strength and depth of our leadership and that staff felt respected, supported and valued, with staff morale across all teams consistently high. Furthermore, they were full of practice for staff, saying that they had found examples of outstanding practice in all the core services they visited.

"Throughout the Trust, staff treated patients with kindness, dignity and respect. Consistently, staff attitudes were helpful, understanding and staff used kind and supportive language patients would understand."

The report noted our clear proactive approach to seek out and embed new and more sustainable models of care, citing the introduction of a series of new care pathways on our CAMHS ward, where we have reduced the average length of stay from 80 days to just 15.

Areas of outstanding practice also highlighted by the inspectors include our commitment as a Trust to supporting staff and learning from incidents to improve service user safety including the safety huddles, Swarms, Schwarz Rounds and Moderate Harm Review panels, as noted in this Quality Account Report.

The report also noted our service user groups' involvement in re-designing key resources including simplified care plans and information leaflets for new service users and their loved ones.

Also a Young Person's Council which had helped service users get involved in staff recruitment and met with senior management to discuss changes to our CAMHS.

Our community mental health services for adults were noted with specialists working in multi-disciplinary teams, established to meet the needs of service users.

Our journey of good to great continues and we will build on this outstanding achievement together.

"Managers ensured staff had caseload sizes depending on their level of experience, other duties and seniority."

"Achieving this highest rating is a real testament to the hard work of all the Trust's staff and its leadership."

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ May 2019	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good ↑ May 2019
Long-stay or rehabilitation mental health wards for working age adults	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015
Forensic inpatient or secure wards	Good →← Apr 2018	Good →← Apr 2018	Outstanding →← Apr 2018	Good →← Apr 2018	Outstanding →← Apr 2018	Outstanding →← Apr 2018
Child and adolescent mental health wards	Good ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019
Wards for older people with mental health problems	Good →← May 2019	Requires improvement ↓ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Wards for people with a learning disability or autism	Good →← Apr 2018	Good →← Apr 2018	Outstanding →← Apr 2018	Good →← Apr 2018	Outstanding →← Apr 2018	Outstanding →← Apr 2018
Community-based mental health services for adults of working age	Good →← May 2019	Good ↑ May 2019	Outstanding ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019
Mental health crisis services and health-based places of safety	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Specialist community mental health services for children and young people	Good →← May 2019	Good →← May 2019	Outstanding ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Community-based mental health services for older people	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015
Community mental health services for people with a learning disability or autism	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015
Overall	Good ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

CQC inspectors did identify a number of areas for improvement and said we needed to take immediate action to rectify a minor breach of legal requirements by ensuring staff on wards for older people with mental health problems received regular, good quality supervision.

You can the CQC reports at:
www.cqc.org.uk/provider/RWR

Our Sustainability and Transformation Plan (STP)

Hertfordshire and West Essex has developed and agreed an STP-wide Integrated Health and Care Strategy which is very much in line with the NHS Long Term Plan and has agreed a Medium Term Financial Plan (MTFP). The Hertfordshire and West Essex STP Integrated Health and Care Strategy is a blueprint for delivering a healthier future for the population of Hertfordshire and West Essex. It is designed to guide our health and care organisations, staff, the voluntary sector and our population to work in partnership.

The approach is based on the principles of population health management. This is a way of targeting collective resources where they will have the greatest impact, improving the quality of care through improved, affordable services.

What is an STP?

Across England, NHS and Social care organisations have been encouraged to work together more closely to deliver more effective, joined up and affordable services. The country has been divided into 44 'Sustainability and Transformation Partnerships' or 'STP' areas by the national organisation, NHS England. Hertfordshire and West Essex is one of these 44 STP areas.

The Hertfordshire and West Essex key priorities are:

- Meeting people's health and social care needs in a joined-up way in their local neighbourhoods, whenever that is in their best interests - saving time and cutting out unnecessary tests and appointments. Health and care services will support people to live as independently for as long as possible. We will provide care and support to keep people healthy, rather than reacting when they are in crisis
- Adopting a shared approach to treating people when they are ill and prioritising those with the highest levels of need, reducing the variations in care which currently exist. Support and treatment will be delivered compassionately, effectively and efficiently, in partnership with people and their families and carers
- Placing equal value and emphasis on people's mental and physical health and wellbeing in all we do. Improved mental health care and support for people with disabilities is a core pillar of our strategy and people's psychological and emotional wellbeing will be supported while their physical health and social care needs are being met
- Driving the cultural and behavioural change necessary to achieve the improvements we need. Care professionals, service users, families and carers will understand the role they have to play in creating a healthier future.

  Staff will be empowered to drive change throughout the system. We will all be supported and encouraged to take greater responsibility for our own health and wellbeing
- Ensuring that we have the workforce, technology, contracting and payment mechanisms in place to support our strategy, delivering health and care support efficiently, effectively and across organisational boundaries.

The STP has shared work underway on the following clinical priorities:

- Urgent and Emergency Care
- Planned Care
- Complex patients (service users)
- Mental health and learning disability
- Cancer
- Primary care
- Women and Children

All of the STPs' organisations, including our Trust, are committed to working together to implement this strategy, so that we can make rapid improvements to the health and wellbeing of our population and the sustainability of our health and care system.

Continuous Quality Improvement

The Executive Director of Transformation and Innovation leads the Trust's organisation-wide approach to Continuous Quality Improvement. Over the past 12 months, we have continued to evolve and develop our approaches to and our culture of Quality Improvement that enables us to continuously improve the safety, timeliness, effectiveness, efficiency, equity and person centredness of our services and the experience of using them.

We have continued to make improvements to our services using the tools, techniques and thinking of Quality Improvement with some examples being:

Safe

- Establishing the Moderate Harm Panel to review opportunities for learning from incidents other than Serious Incidents
- Developed approaches to post incident huddles (SWARM) that focus on team learning and improvement to prevent further harm
- Conducted restrictive practice reviews with a focus on reducing instances
- Continued to eliminate hazards and create safe environments

Effective

- Piloted new approaches to an Initial Response to people in crisis – enabling crisis to be self-defined
- Developed and implemented new models of care for rehabilitation, CAMHS and dementia services
- Delivering recovery focused care and outcomes

Experience

- Created new and responsive services; CAMHS crisis and treatment team and adult primary mental health
- Progressed an ethos of co-production within service delivery and service improvement and embedded shared decision making.

Our colleagues continue to generate innovative ideas and use our Innovation and Improvement Fund to help access the financial and project development support available to progress their ideas. This year the Fund has supported ideas including:

- Pro Screen Safety and Security Screening - increasing safety through the use of a non-invasive ferrous metal screening device
- Books Beyond Words App – a collaboration with the Books Beyond Words company team to develop an app to support staff to communicate with service users about the care they receive, the challenges they face and to help them identify their own solutions
- Peer Support in PATH - improving recovery outcomes and experience of the PATH service through the provision of Peer Support

Our small central support resource have worked with individuals and teams across the year to encourage and support improvement opportunities. They have commenced some focussed work with one of our community mental health teams and an inpatient ward, to start to build the capacity within those teams to make improvement a daily habit. The work is at an early stage and the teams are taking forward ideas that will improve their efficiency and effectiveness, using technology as an enabler, as well as opportunities that will improve outcomes for people who use our services.

In December 2018, we agreed the enabling elements that we would put in place to further develop our culture of Continuous Quality Improvement and innovation. These include:

- A programme of development for 320 leaders – both formal and some self-identified 'improvement enthusiasts' – in leading quality improvement
- The additional resources required to establish a central Continuous Quality Improvement Team that will be able to support colleagues across the organisation in delivering their improvement ambitions
- An Innovation Hub – a facilitated workspace unlike people's usual work environments that will be equipped to enable 'thinking differently' and working creatively and collaboratively to solve problems and generate innovative solutions.

These exciting developments will start to be put in place through the early part of 2019 and will build upon our current capability and capacity allowing us to improve more parts of the organisation and do this in increasingly sustainable ways.

Service User and Carer Involvement

Our service user involvement programme exists to provide us with assurance that processes and services are co-produced. The programme is also closely linked to individual recovery journeys and provides opportunities to build skills, confidence, hope for the future and opportunities.

During 2018/19, our service users and carers (Experts by Experience - EbE) contributed their expertise and time to interview panels, forums, working groups and helped us design and deliver our services. In total, people with experience of our services participated in 2806 hours of involvement activity across the activities below:

Activity	Hours
Specialist participation in Trust meetings and forums	824
Service User Council	459
Carer Council	339
Interview Panel	290
Direct participation in a workshop or seminar	277
Councils Together	207
Peer Experience Listening	132
PLACE Audit	120
Youth Council	65
Support at events	22
Sharing Story (E.g. filming, audio etc.)	13
Trust staff induction	11
Art Panel	11
Stakeholder workshop events	10
Public Speaking	9
SBU meeting	9
Equality Events	8
Crisis Care Pathway Training	5

In October 2017, we began a co-produced review of involvement work to ensure the involvement opportunities we offer are recovery-focused, beneficial to the Trust and – most importantly – provide development for EbEs to move on from involvement programmes to other activities. This completed in December 2018 with the launch of new policy and rewards structure for people providing their time and expertise toward Trust improvements.

Service users and carers continue to share their stories, personal accounts and suggestions with our Board and Council of Governors and through media projects within the Trust. We also continue to focus on reviewing feedback from service users and carers and working in partnership with them to develop improvements to local services. Over the coming year, we will be putting in place a new plan for service user and carer involvement/experience strategic plan that will guide local services in improvement approaches that can be taking at a local level. This will support the experience dimension of the our Quality Strategy and include a set of core priorities for involvement and experience across Trust services.

The **Peer Experience Listening** programme trains people with lived experience in semi structured interview listening techniques. This is then used to gather feedback from people currently using services.

Following a number years of delivering projects across topics such as the Mental Health Act assessment, safety on inpatient wards, carer experience, experience of dementia services, street triage and Community Mental Health Services. The programme underwent a review throughout December 2018 and will shortly relaunch using strengthened Quality Improvement methodology and research techniques to further enhance the effectiveness of information collated. This will enable front line services to continue to use this information to plan key changes to services.

As a Trust we are a member of the Triangle of Care scheme and have been awarded two stars. These are awarded when the Trust has demonstrated a commitment to becoming more carer inclusive, has shown honesty about where they are now and planned where they need to be to ensure carers are better identified and supported.

Our Carer Pathway frames the approach that services take to carer support built around five principles of:

1. Identifying carers
2. Welcoming carers
3. Supporting carers
4. Involvement carers
5. Helping carers through changes.

More recently, we have co-produced a new Carer Plan up to 2021 which details a range of outcomes we are working towards in supporting carers.

Carer Council

The Carer Council is a group of carers (primarily with lived experience of caring for people with mental health issues) who meet 6 weekly to discuss Trust business and provide feedback on quality and areas of concern and good practice. The Council has a chair and deputy (both carers) and agrees an annual work-plan of issues important for carers.

This year has included carers plan, Carers safety, CQC Report and 'From Good to Excellent', FEP pilot and the MHA Review. The agenda is agreed by both the Council and the Trust, enabling both partners to ensure issues of importance to them are raised as part of the business cycle. Agenda planning meetings are held with chairs and deputies prior to meetings to review actions and agree agenda for future meetings.

Recovery

In October, nestled around World Mental Health Day, we once again put on a series of local events in Hertfordshire, Buckinghamshire and Norfolk, managing to gather together the largest group of service users, carers, staff and other people into our annual celebration of Recovery yet. In total, 250 people attended events in Aylesbury, Stevenage, Watford, Hatfield, Ware and Norfolk and heard numerous rich voices of lived experience talk about Hope and Opportunity.

We were really pleased to have attracted lots of people with lived experience to the events – around 41% of attendees described themselves in this way – more than we have managed previously, and 95% of people who completed a feedback form rated the events as 'good' or 'excellent'. As always, the events were co-produced from beginning to end and supported financially by the Trust.

"Really wonderful to hear people talk openly about their struggles and achievements"

"I was inspired by the stories I heard and feel more confident myself that I can overcome my issues"

New Leaf: The Hertfordshire Wellbeing College

New Leaf Wellbeing College is based on the Recovery College model. The recovery approach is based on the principles of individual strength, co-production, recovery and self-management. Co-production makes sure people with lived experience are equal partners alongside a range of other stakeholders, recognising they have experience and therefore knowledge, which is used to develop services or in this case free educational courses.

The Trust is the lead in partnership with Herts Mind Network (HMN). As a Trust, we provide operational and strategic management, including co-production of courses and workshops, and HMN the peer elements, which offer students and opportunity to engage in the peer pathway and develop confidence and skills that support them into Peer Tutor roles. We also support the student council and students to develop their learning goals.

All courses are developed in the spirit of co-production, always including people with lived experience. The role of the Curriculum Board is to oversee and ratify course and curriculum development. Membership of the Board includes third sector, public services and students. All courses are presented in Board meetings, which ensures they have been co-produced with up to date evidence, and will only ratify if these assurances are met. It also offers another level of co-production ensuring the content is not discriminatory in any way, and is focused on self-management.

To date, the college has 2,194 registered students. In the Autumn Term, the college saw a rise in in students booking onto courses (975), with an average of 12+ students per session, with 16 courses out of 47 running, having 15+ student attendances; booking rates for many courses have been as high as 20+. The college has co-produced a portfolio of 18 courses, with four more being developed during the Spring Term (2019). 85% of students report the courses to be good/very good and 97% would recommend the college to friends.

Student wellbeing was measured using the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). Of the 303 students with two completed questionnaires, 151 (50%) have shown an improvement of at least one point. By contrast, 107 (35%) have decreased by at least a point, and 45 (15%) have remained on the same score. Our data would suggest that more women access the college, with more targeted communication and marketing taking place to attract men. The number of people reporting to have a disability, including mental and physical health challenges as steadily risen, with 55% of new enrolments stating they have a disability.

The college launched a new Peer Involvement pathway in the Spring Term, which proved successful with 3 students going on to become volunteers within the college, 2 expressing an interest in becoming Peer Tutors or Peer Mentors, both paid positions.

> *"It really was special and amazing and that came from the ability, I believe, ton our true authentic selves, which came from a place of trust and respect. This trust and respect was facilitated by you both, to whom I am grateful."*

Marketing initiatives to attract students from the east of Hertfordshire and male members will include promotional material on a local bus route from Ware, Bishop Stortford and Waltham Cross and also a feature in a football club.

The summer term has been launched with the first course 'Understanding Depression' fully booked within 2 weeks of going live.

Student stories

"I joined New Leaf Wellbeing College in March 2018. I joined late in my recovery story; I'd long suffered from depression, and in recent years, I had noticed an increasing issue with Seasonal Affective Disorder. I had managed to independently find information and ideas to help me cope with my issues and to begin a process of recovery, and by the time I joined the college, I had managed to make significant improvements to my situation. Joining the college gave me the opportunity to continue learning about the conditions affecting me, to learn new ideas and strategies to assist me in my continuing recovery. I've been able to learn from and exchange ideas with students who have suffered from similar issues to myself, and to learn from tutors with expert knowledge and experience. To date, I have attended two courses, with more to come.

I am not only learning for myself; I have several friends who have suffered from anxiety and depression, and I hope that the knowledge gained by attending the college will help me to assist them, to either help them to look for help or to make adjustments to that could help them begin their own journey to recovery. I have already noticed that I often have a clearer picture of what I am seeing in situations with my friends, rather than just an idea or notion that I recognise from my own past experiences. Since joining the college, I have found that I am feeling increasingly more upbeat about my own personal circumstances. My journey has not been easy, but it certainly feels to me that learning with and contributing to the college can only help in my on-going journey".

Physical Healthcare

We have made progress over the past year with regards to physical healthcare. This includes, but not exclusively:

- The further development of clinics, enabling more access to our service users for physical health checks
- The implementation of the Shared Care Agreement in Hertfordshire with our GPs, improving communication and continuity for our service users
- The continuation of work to reduce falls and pressure ulcers
- The introduction of zonal observations, aimed at decreasing the number of falls in our older peoples services; we led a Falls Week in September in partnership with HCT and HCC
- The development of a Physical Health Education Framework for all clinical staff, to be launched early in 2019/20

We have also continued to develop initiatives to improve the physical health and wellbeing of service users, including increased gym sessions and outdoor activities, such as a walking group and table tennis for older people service users.

Frailty Pathway

We play an active role in ensuring that a holistic approach to health and wellbeing is taken. As a Trust, we are committed to the delivery of care in its broadest sense, and recognise the opportunities for people in providing care that is fully joined up across physical health, mental health and social needs. This aligns with the mission statement 'We help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well'.

We have agreed to implement a new frailty strategy and work with partners across the system to deliver integrated care pathways for some of the most complex members of our population and our goals include:

1. Consider if frailty is an issue in every patient encounter
2. Support people to remain in their usual place of residence
3. Reduce inappropriate attendance at the Emergency Department (ED)/secondary care
4. Work as a system
5. Delivery high quality safe care for our frail population
6. Support people living with frailty to achieve their personal goals
7. Achieve frailty outcomes.

The main components of the delivery plan include the introduction of common frailty pathways and training and Improving physical health pathways and interventions. To support this we will also need to introduce a Frailty Minimum Dataset and IT capability.

Integrated Care

We continue to be committed to bringing care together across physical and mental health and across health and social care, removing the barriers to integrated care that can sometimes develop. Our priorities for 2019-20 include:

- Making sure more mental health practitioners are embedded within community Integrated Care Teams working with people with frailty and complex long term conditions - with plans to introduce more frailty hubs across the county and easier way for making referrals for support and care for frail service users
- More support and expert mental health knowledge being shared with staff working in care homes to support better care for people and help to manage complex behaviours
- Learning from what has been working well in primary care mental health and dementia diagnosis pilots with a view to seeing what can be scaled up and shared.

Primary Care

Innovative Primary Care Mental Health Pilot projects have been running in three areas of Hertfordshire and have had evaluations supporting their continuation and extension. The pilots are in Stevenage, Hertford and Watford. In Hertford and Watford, a mental health practitioner has been embedded in a number of practices to triage referrals to secondary care and signpost as appropriate, provide advice to primary care workers regarding care or passing the referral on to secondary care.

In Stevenage, a model has been piloted which has provided a stand-alone drop in clinic for GPs to refer to for triage and signposting as appropriate. Part of the pilot work across all areas has included strengthening of the relationship between designated Consultants and local GPs in order to help build and maintain relationship with GPs.

There has been a reduction in the number of initial assessments required by the community mental health teams (CMHT) as a result. GPs and service users have provided very positive feedback. Service design principles have been agreed to support the extension of the pilot engaging local systems in developing the service. The pilot service is being extended across further localities county-wide. In Stevenage, an alternative model has been piloted which has provided a drop in clinic for GPs to refer to. This has resulted in a significant reduction in demand going into the CMHT but also positive feedback from both service users and GPs particularly in terms of responsiveness. This model is being reviewed to see how it could be replicated elsewhere.

To support this their GPs have designated Consultants in order to help build and maintain relationship with GPs. Delivering physical health checks for mental health patients in collaboration with primary care. Service users are invited to GP surgery for physical health checks where they are assessed jointly by the primary and mental health clinicians.

This integrated delivery of physical health checks is enhancing patient and staff engagement in improving physical health outcomes, improving communication between secondary and primary care, enhancing primary care clinicians' knowledge and expertise in mental health problems and ensuring delivery of physical health interventions.

Pressure Ulcers – zero tolerance

We continue with a zero tolerance approach to avoidable pressure ulcers. We have recruited a Tissue Viability Nurse (TVN) to ensure a robust care pathway in place to manage pressure damage and wound care. There has been a slight decrease in the number of incidents in 2018-19.

We have:

- a robust system in place for providing medical devices, including pressure relieving mattresses, cushions and boots
- reviewed the Service Level Agreement for pressure relieving mattresses and cushions have and further improved the quality of the product that will be provided to our service users
- made a dressing formulary available on each inpatient ward
- local Pressure Ulcer champions monitoring progress, who are having a positive impact promoting efficiency and evidence-based practice across our services
- continued to support the 'Heel Alert' campaign: evidence suggests that heels are the second most common site for pressure ulcers, and that these are becoming more common
- run our annual 'Stop the Pressure Ulcer' awareness on 15 November 2018 across our Older People Services
- displayed 'React to red' screensavers and posters and worked with the Bedfordshire and Hertfordshire Tissue Viability forum to send these out to GP surgeries across Hertfordshire, Bedfordshire and Essex
- continued to monitor pressure ulcers and to report our findings to our Safety Committee.

The procurement team and Head of Nursing for East and North Strategic Business Unit continues to monitor the purchase and use of pressure relieving mattresses and cushions, and staff continue to receive training in how to prevent and treat pressure ulcers and care for wounds.

Our audits suggest staff feel more confident and competent in preventing and managing pressure ulcers. This is predominantly due to the ongoing support from the TVN and discussions with other senior nurses.

Nutrition

Nutrition and Dysphagia Steering Group

Our Dysphagia and Nutrition Steering Group leads work across the organisation to make sure inpatient service users' nutritional needs are met. We use the CQC nutritional and hydration standards to guide our work.

Our work and future plans

Menus

We introduced new menus to our services at the beginning of 2018; these were designed to better meet the tastes and requirements of our different service user groups. We have collected instant feedback from service users at the time of eating and have collected more detailed feedback. The new menus and new dishes have been well received by service users. We continue to collate and respond to feedback.

For example, we invested in new equipment to increase capacity of the kitchens at Kingsley Green in order to include Oak and Beech wards in our fresh cook menu service, we are working with Lexden Assessment and Treatment Centre to increase flexibility of menu options to improve our person centred menus.

Service user experience of mealtimes

We have started work on looking at our service users' experience of mealtimes, how it feels to be in the dining area at mealtimes and how we can make mealtimes an enjoyable part of the day. Service users on our units have helped us identify what is important for them and we have started to implement changes

Safe and effective screening

We have added our Dysphagia and Nutrition screening tool to our EPR system. This has made it easier for staff to complete the form, monitor the outcomes, manage reviews and evaluate compliance with standards.

Supporting staff

We are continuing to develop our resources for staff to use on their teams during handovers and at local inductions. These are designed to increase staff skills and knowledge of dysphagia and nutrition.

Nutrition and Hydration week

This year we focussed on the positive messages about what we can eat and how nutrition and hydration impacts on our health, with 'eating for health' messages rather than 'healthy eating'. We concentrated our activities on snacks which are good for our health. We combined this with information for staff, service users and carers on snacks you could eat if on a modified texture diet, linking in our work on the new international descriptors.

Increasing Physical Activity in Older People

Following a two week trial of a table tennis prototype on Seward Lodge, we introduced two specialist table tennis tables (as designed by the BAT foundation in conjunction with Kings College London) on two of our older adult wards: Seward Lodge and Wren Ward. An Occupational Therapist and Physiotherapist work collaboratively on collecting baseline and post-intervention outcomes covering: mood, function, and physical abilities to measure the impact of the table tennis as an intervention for promoting the maintenance of physical and mental and well-being. This was funded through the Trust and the BAT foundation sourced a sponsor who match funded the second table.

Lifestyle Matters

Lifestyle matters Occupational Therapy for Older People group is an evidence based intervention that adds to the promotion of the Nice guidelines Mental wellbeing in over 65s: occupational therapy and physical activity interventions (NICE 2008).

This group focus is for individuals who struggle to engage in meaningful activity and are at risk of further decline in their physical and mental wellbeing For example anxiety, low mood, reduced confidence isolated and poor mobility. The aim of the 12 week group sessions is for the occupational therapist to provide

education and strategies to the attendees. To enable attendees to develop skills to make lasting changes to improve their health and wellbeing post group. Therefore minimising the risk of relapse to continue living and engaging in the community safely and independently. Feedback from the group attendees was positive they felt the support and skills gained from attending gave them the skills and confidence to join community groups and stay safe living in their home/community.

All group members reported feeling a sense of support and a safe place to share and help each other in problem solving issues that arose.

Pimp my Zimmer

The Pimp My Zimmer project in Watford was initiated through the Watford locality group. PMZ has been adopted across the country and has been proven to reduce falls as people can recognise their own, correctly adjusted walking frames. A GP from the GP Federation, a mental health OT and support worker, care home staff and a local schools joined forces to run 3 intergenerational, interagency sessions to 'pimp' 9 care home residents' zimmer frames. The team pulled in the concepts of reminiscence and life story work and measured the residents' wellbeing before and after the sessions.

The outcomes were that:

- 50% reduction in referrals to the Trust (depression)
- 86% improvement in resident wellbeing validated scores
- 66% increase in zimmer frame usage
- 50% improved mobility, 33% mobility remained constant despite deteriorating health (due to frame usage)
- 17% stable.

Digital Technology

Art Therapists have been developing art therapy programs using digital media, such as iPads, to increase the opportunities for service users who find traditional art materials too messy or unpredictable, such as those with Autism. Digital media is also available for those with limited physical abilities this might include someone who is not able to hold a pen but could use

their finger to draw on the screen. Younger clients engage with digital media on a daily basis but applying the uses of digital media in a therapeutic context has helped to foster the therapeutic relationship through a shared appreciation. It has been used in creating simple to sophisticated animations. The team have developed guidelines that consider the clinical, ethical and legal implications involved when offered in therapy and the sufficient skill and competence in using the software and digital device to ensure safe and effective use.

Pets as Therapy (PAT) Dogs

PAT dogs are engaged in many of our services. At Kingsley Green, a walking group is run once a week for service users to attend. This encourages physical activity and supports time away from the unit. Our team at Seward Lodge has facilitated the use of Pet therapy with PAT dogs that come to the unit every Thursday. This has resulted in therapeutic engagement for service users with some individuals becoming more settled.

Psychology and Spiritual care Pilot

The Spiritual Care service is working collaboratively (as second professional) with psychology on an 8 month pilot to explore the effectiveness of offering family support as a key part of inpatient care. Up to three sessions are offered to inpatients and families/ carers they identify as being significant to assess whether a systemic approach (rather than a solely service user focus) offers enhanced care.
This is an innovation fund project and is being assessed against a series of outcome measures with a view to offering it on other acute adult inpatient units. Meetings are open to all service users admitted to Albany Lodge, although are not accessed by all, for a variety of reasons. Questionnaires are administered pre and post meetings. Key data is also collated, including average lengths of stay and readmission rates is collated and will be compared to data prior to the pilot to test effectiveness.

Zonal Observations and Engagement

Zonal observations and engagement is an approach our older adult wards are taking to enhance the observation of a particular group of service users within a specified ward or clinical area. The Zonal Engagement and Observation approach ensures appropriate observation of individual service users without the need to assign a particular nurse to be in close proximity to the service user for long periods. Identified staff are responsible for observing and engaging with all service users within a particular zone (area) of the Ward. This will entail checking on people in rooms within the zone, assisting a person to find their way about within the zone and intervening when necessary to maintain safety of those in the zone. Calling for help from other staff as needed.

Host Families

The Host Families scheme was the first of its kind in the UK and is based on evidence that people with mental ill health recover better if they are out in the community, in a supportive family setting, taking part in a daily routine. It is an alternative to hospital admission or can be used following a period of inpatient care to facilitate early discharge.

A host family provides a caring family environment for a service user (guests) where this type of treatment will help to restore dignity, develop relationships and autonomy, and lead to their social or professional reintegration. Host family placements will be in a traditional family unit deemed appropriate for that particular patient at that particular time.

Access to a host family is through our CATT, with both the hosts and guests receiving intensive support through CATT. The length of stay is usually for about three to six weeks with a maximum of eight weeks.

At the time of this report, there are 8 ‘active’ host families available across Hertfordshire, with 4 extra rooms enabling a total of 11 beds. Recruitment is ongoing – with local events and at public places proving to be the best method for expressions of interest.

Street Triage

The Street Triage service provides an immediate joint assessment by a police officer and a mental health professional, and support, to residents within Hertfordshire who may be experiencing a mental health crisis in a public place, and who may be subject to detention under Section 136 of the MHA (Place of Safety).

The Street Triage service function is also to provide opportunities and potential for both police officers and mental health service staff to reduce demand on limited resources, an opportunity to benefit from cross over training, developing a greater understanding of early warning signs of crisis and provide an opportunity to develop a better understanding of the challenges faced by each agency.

Street Triage has now been operating for over two years and is achieving good outcomes. The Street Triage team works with a paramedic on one of the shifts. By working together, we have been able to support and treat people in the community, which means they can avoid attending ED and being detained under Section 136.

Between October and December 2018 street triage attended 364 incidents, their input resulted in only

9.6% service users being detained on a Section 136 and 5.9% attended ED, with 80.6% diverted into appropriate health services

The feedback from the Police is overwhelmingly positive, they:

1. Value the access to mental health expertise
2. Say that Street Triage saves many hours of police time and ensures that people who need access to mental health services are supported to get it in a timely and efficient way
3. Feel that working with the Street Triage team has increased their knowledge and understanding of mental health.

111 Pilot

The HUC 111 Mental Health Pilot comprises of a Mental Health Clinician from the Crisis Team. Their working hours are Saturday and Sunday 0900-1700. The clinician sits within the call centre and is able to offer support/ give advice to both clinicians and Health Advisors when needed. It is evident from the outcomes shown within the data that by having an expert Mental Health Clinician available that many of the high acuity mental health conditions are receiving the help and support needed without the need to arrange an ambulance or direct the patient to Emergency Department.

First Response

A First Response model was successfully trialled in 2018 with agreement to start in February 2019. This service will progress to a 24 hour/7 day a week response, offering swift access to mental health, which is:

- more readily available than emergency services or ED
- offering intervention in a timely way which reduces demand on secondary care mental health services
- reduces inappropriate demand on services such as Section 136, Acute Admissions Unit and RAID and,
- which offers a more satisfactory experience and outcome for service users.

The first response service seeks to resolve or minimise the impact of every mental health crisis and can facilitate a rapid direct intervention for the most serious situations. The service will have a plan in place for all crises within one hour.

The service will work with partners to ensure people are signposted to services that can most appropriately meet their needs to either minimise the current crisis or help prevent future ones.

Rehabilitation

The new Rehabilitation pathway (EROS) has been co-produced with an outcomes framework specifically for rehabilitation, including an outcomes tracking database across the range of patient (service user) rated outcome measures (PROMS), patient (service user) rated experience measures (PREMS), carer rated outcome measures (CROMS) and carer rated experience measures (CREMS) for every service user. A comprehensive Rehabilitation Handbook has been developed for the Rehabilitation staff teams that advises on Recovery, Goal setting use of outcome measures, how systems work, Care planning and risk assessment management plans, as well as how to have conversations about resilience.

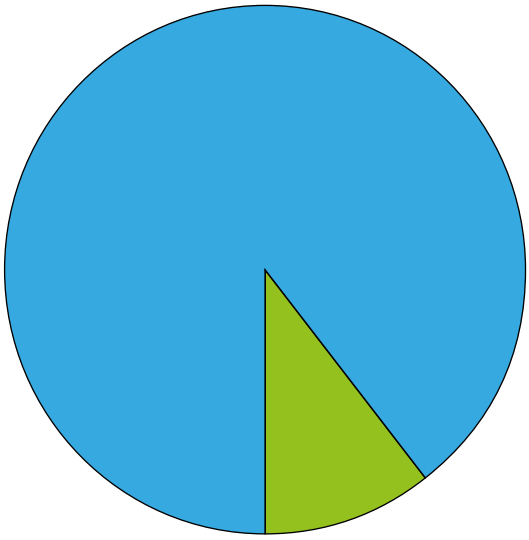
Introduction of one stop clozapine clinics

Point of Care Testing and One Stop Supply Clozapine Clinics were introduced at Waverley Road, Colne House and Roseanne House. Prior to the new clinic format, service users attended the Clozapine clinic on a Monday to have their bloods taken, the blood samples were then sent via courier to pathology and service users could collect their medication from the hospital outpatient Pharmacy on a Thursday, if results were within range.

Since the introduction of the new clinic format, blood samples are analysed in the clinic immediately service users are able to collect their tablets from the clinic at the same time providing their blood results are within range.

The service user feedback survey at Colne House on the introduction of the new clinic format was overwhelmingly positive, as detailed in the graph below:

How do you think the clinic compares to the previous system, now that you can get your blood results and medications on the same day (n = 29)?



Response %

- *It is much better than before (89.66%)*
- *Is is slightly better than before (10.34%)*
- *Is is the same as before (0%)*
- *Is is worse than before (0%)*

CAMHS

A transformation plan specific to CAMHS has been developed and is monitored via the Trust Management Group. The Children's Home Treatment Team (HTT), set up during 2018, works intensively with young people to avoid inpatient admissions. Working in a DBT informed way to cater for young people has led to successfully stepping down individuals from low secure units into the community.

The work of the team has also lead to a significant number of young people (reduced from 45 to approximately 10) being treated in the county since the service transferred from NHSE in January 2018, whereas previously they had been treated throughout the country, significantly improving the quality of the experience for young people and families. The team work closely with the Eating Disorders Team who offer intensive community work with young people and the family and carers.

These numbers refer to the number of Hertfordshire young people that were placed out of county in a number of different placements, for example Psychiatric Intensive Care Units (PICU), low secure, medium secure, general adolescent, Eating Disorders and learning disability children's units (under 13s) before we commenced the New Care Models Work.

CAMHS Place of Safety Development

Our young people at Forest House have been involved in the design and kept up to date with the development of the new Place of Safety, Section136 suite being built at Forest House. Our young people's participation lead gathered questions and concerns from the young people and took these to one of the stakeholder meetings. The answers were fed back through the lead to the young people. The project managers and Service Line Lead then attended one of the Forest House council meetings in December, to give the young people more information on who they are and why they are building the development. They gave them an update on how far the work had progressed and what was left to do.

They then asked if they had anything they wanted to discuss. As part of the development, young people were invited to paint cladding boards so they would not have to look out of the unit windows at metal and wooden boards. The young people decorated the boards with motivational quotes and pictures.

CAMHS Website and Welcome Pack

The Young People's Council has been involved in the design and development of our new CAMHS website www.hpftcamhs.nhs.uk. The young people fed back that our previous website was not very helpful and user friendly.

They gave extensive feedback on what features they think it should include such as colourful banners

and scroll bars to help navigate the information. They also thought of and co-produced many of its innovative and interactive features such as our who's who tool, our jargon buster and our POD walks of CAMHS clinics. The website launched in December and will continue to be co-productively updated.

Alongside our website update we have also been working on designing and developing our welcome pack, as part of the overall improved welcome to services project. The lead met with a group of our young people on two occasions to ask them what they wanted it to include and what design they wanted it to take.

The inclusion of note sheets, doodle pages and puzzles came from feedback that when young people are feeling anxious before or during an appointment all these tools can help. This feedback was taken on board and contributed to the final design. Additionally it was fed back that there were too many bits of paper and leaflets given out. All the essential information that we need to give as a trust and that young people and their parents and carers feel they need was incorporated into the design and development of two new leaflets. One leaflet is for young people and the other is for their parent or carer. These leaflets contain information on what to expect from appointments, support and confidentiality, as well as containing helpful numbers for our clinics and frequently asked questions that young people and their parents and carers have. This pack launched at the same time as the webpage and again we will continue to develop new puzzles and leaflets that can be slotted in as and when needed for more specialist information.

PATH

What is the Psychosis, Prevention, Assessment and Treatment (PATH)?

This is a specialist team who work specifically with individuals who are experiencing psychosis for the first time, referred to as a 'first episode of psychosis'.

The aim of this service includes:

- Early detection, assessment and treatment of symptoms
- Optimistic views about recovery focused interventions
- Provide a wide range of psycho-social interventions and support
- Provide support and interventions for family and carers
- Work in partnership with a range of statutory and non-statutory services.

What is an Associate Practitioner (AP)?

This group of staff have gained a Psychology Degree and form part of the PATH workforce. They work alongside our qualified social workers, nurses and psychologists to provide specialist care, including the delivery of carers' programmes and family interventions.

What is a Support Time and Recovery (STaR) worker?

STaR workers also work with the PATH workforce, providing practical support for service users and carers.

"I found the service very helpful. Knowing I am not alone in my feelings and anxieties was quite a relief. As I completed each section of the CBT course, I felt much more positive and can refer back if I need to. I feel as though a weight has been lifted and can continue my life in a more positive and assured manner."

SafeCare and eRostering update

Through the use of SafeCare, we have been able to redeploy staff safely and with their full visibility of skills, helping to reduce agency usage. We have also been able to request bank (and agency) cover if needed and track any red flags identifying potential staffing issues.

Service user acuity census data is recorded three times a day during a handover of each shift in all inpatient service areas. We also hold daily SafeCare conference call (Mondays to Fridays) to review safe staffing levels, utilising the data inputted onto SafeCare. Furthermore, weekly eRoster Scrutiny meetings are held to proactively review all observations, staffing and acuity levels in each inpatient service area, before agreeing the required staffing levels for the upcoming shifts.

As a result of the above, we have seen positive impacts in our service areas, particularly a reduction in our use of agency, including at peak holiday periods. This has had a positive impact including an improvement in staff morale, an improvement in the service user experience, an increase in the skill mix for staff and also cross working and learning.

What is eRostering?

The use of eRostering aids the management of our workforce, including service user demand, establishment management, staff working preferences, absence management, rostering, time and attendance as well as payroll integration. It also helps with the effective rostering of staff, ensuring that service requirements are met. Furthermore, it ensures that services run in a fair and efficient way, reducing errors in timesheets and ensuring staff are aware of their off duty in a timely manner.

What is SafeCare?

SafeCare is mounted onto eRoster and calculates the required staffing from service user numbers, acuity and dependency, three times a day. It provides as site-wide overview of required versus actual staffing, highlighting hotspots as well as areas that could help.

SafeCare enables the viewing of staffing status across many dimensions, including hours short/excess, missing skills, missing service user census, Care Hours Per Patient Day (CHPPD) and the cost of a shift. It also enables the tracking of attendance and sickness of all rostered staff.

Spotlight on Nurse Education

Trainee Nursing Associates

As a Trust, we lead for the Hertfordshire and West Essex STP Nursing Associate programme. The first cohort are due to register in May 2019. This programme was developed to give the trainees a broad range of experience across all branches of nursing and therefore strengthen the current workforce across the whole STP range of services. As every Nursing Associate will have had experience in adult, learning disability, mental health and children's nursing, the newly qualified Nursing Associates will enhance the care received by service users and not be used to replace registered nurses.

We have recognised the significant impact in quality of care the role of Nursing Associate can have and so used the apprenticeship levy in partnership with the University of Hertfordshire to train 34 Nursing Associates. The first cohort will qualify in May and start employment in the Trust in a number of our inpatient and community teams. The second cohort will qualify later in the year and additional cohorts are in place for future years.

We see this as a transformational role to support new ways of delivering care. Our Trainee Nursing Associates have a high profile nationally and we have supported individuals to write articles, present at conferences, tweet and sit on advisory groups.

New Nursing and Midwifery Council (NMC) Standards

We have been preparing for the introduction of the new NMC standards in September 2019. This includes the development of nurses and allied health professionals as supervisors and assessors, and a move away from the previous mentorship role.

SPIKE2

Building on the success of SPIKE, our reporting and business intelligence tool, in January we released an enhanced version of the tool – SPIKE2. SPIKE2 provides clinical data to help support informed decision making and improved outcomes for service users and is built on an open source platform with different dashboards available. A couple of examples of these dashboards include:

- **Service user dashboard**
  For the first time, key information from the three separate electronic patient (service user) records systems are available 'under one roof'. This helps staff to review historical information such as teams involved in service user care, contacts and assessments and when they are due for review. This gives staff access to all of the information they need to make clinical decisions and helps with improving the workflow of staff, reducing administration time and the duplication of locating clinical information.
- **Staff and Team Dashboard**
  At a glance, staff and Team Leaders are able to view their caseloads and review them, reducing the time spent on searching and gathering information.

Since its launch, SPIKE2 has had a big impact on the electronic data capture/recording by clinical and front line staff, providing accurate clinical data helping to support informed decision making and improved outcomes for service users.

Modernising Our Estate

Improving and modernising our facilities

We have a number of initiatives underway to improve our community sites at Saffron Ground, Colne House, The Colonnades and Rosanne House. This includes internal refurbishment and remodelling the working areas.

A range of life-cycle decorating and minor works requirements have also been identified across 28 key sites, arising from our Patient Led Assessment of the Clinical Environment (PLACE), Senior Leaders and Big Listen feedback and also Estate led site surveys.

A full programme estimated at £2.2m has been prioritised based on need with future requirements being formalised within a rolling refurbishment programme. We have also invested in our Facilities Management contract and refreshed our Estates and Facilities in-house team to improve Estates' response time, improve response prioritisation from our outsourced supplier and focus on seclusion and Section 136 ongoing repairs and maintenance to ensure any decommissioning of critical areas is minimal

Furthermore, we have set out a significant investment programme to our seclusion facilities including refurbishment, new build and an increase in capacity to ensure we can always keep people safe during such interventions.

Norfolk Services

Quality Improvement project: developing outcome measures for people with intellectual disability, that are determined by service users and families.

There are few nationally accepted benchmarks for PROMS, PREMS, CROMS and CREMS within specialist in-patient services for people with an intellectual disability. This Quality Improvement project was initiated to identify at least one tool within each of these areas for use within our forensic and non-forensic inpatient services for people with intellectual disability.

The project has undertaken a systematic review of 60 identified outcome studies and has identified four domains within service user and carer rated outcomes and experiences – quality of life, therapeutic environment, involvement and satisfaction.

Four externally facilitated focus groups involving service users, family members and clinicians have been held, and have identified further key themes - earlier access to meaningful work or activity and level of support post discharge.

Based on these, four outcome measures have been identified and will be piloted within the inpatient forensic intellectual disability services for a 3-month period and assessed for ease of use and acceptance. They will also be compared with existing rating tools including clinical tools and the Friends and Family test. If the pilot is deemed successful, then these new measures will be incorporated into routine clinical practice.

PENNA

In November 2018, the nominations for the Patient Experience Network National Awards opened and services were invited to submit nominations in a number of categories. The Patient Experience Network (PEN) are an independent "not for profit" network looking to provide a valuable resource/ service for NHS and other organisations wishing to improve patient experience and staff experience.

The annual National Awards allow services to celebrate good practice and share what we do to improve patient and staff experience. Broadland Clinic Forensic Service entered a video of our Carers Day on 1 December, showcasing the work we do to support carers. This particular Carers Day, we captured the carers talking about the new Trus Carers Plan and feeding back their ideas for local service improvements, carers enjoying a shared lunch with their loved ones, and presentations to carers from service users on their experiences within the clinic. The video also captured how the Clinic worked with a carer with limited mobility to help her access the event and spend time with her son. In March 2019, Broadland Clinic were awarded Runner up in the Support for caregivers, Friends and Family category and finalist in the Using Insight for Improvement (Accessibility) category at the PENNA ceremony in Birmingham.

Broadland Clinic - Services to carers

The following is a quote from the Quality Network Peer Review visit that we received in September 2018.

"The service has excelled in carer engagement and involvement. The team's social worker plays a key role in this by making an initial home visit to a carer's home to give them appropriate information on what they can expect from the service for their loved ones. Following this, a carer contact care plan is jointly produced with a patient's named nurse and the social worker, and ensures regular contact is made with carers. A carer's charter is provided to all carers, detailing what they can expect from the team and how the team will support them. The team also hold quarterly carer's days allowing feedback sessions to take place, which have been very well attended and enjoyed."

The Enhanced Assessment and Treatment Service (Community Outreach service from Astley Court)

The EATS team received 1st prize at the Eastern Division Conference with its award-winning poster. The service has been in operation from September 2016; the poster was about how the service has been effective at avoiding unnecessary admission to hospital for service users with learning disabilities and/or autism and mental health problems.

Broadland Clinic- Recovery Conference

In 2018, the 2nd local Recovery Conference was held and was even more successful than the first, with more staff and service users from an increasing number of local services presenting and participating. Feedback from the conference was excellent with lots of ideas generated for 2019! Here is just some of the feedback we received.

What did you like about the conference?

Buckinghamshire Services

The Buckinghamshire Community Learning Disability Team continues to evolve and embrace good practice from our Hertfordshire services. In 2018, the service introduced a Specialist Learning Disability Dietitian to complement the established Dysphagia Pathway, noting a positive impact on service users' care.

Following the success of the Positive Partnerships Team within Hertfordshire, we have introduced the same model in Buckinghamshire, based on Positive Behaviour Support principles and aiming to work with service users on a longer term basis to skill up providers to help recognise and reduce the triggers which may cause behaviours which challenge. This team has enabled a reduction in the caseloads of the Intensive Support nurses, allowing them to focus on hospital admission avoidance. The admission rate and length of stay for service users from Buckinghamshire to Dove Ward in Hertfordshire has reduced significantly and the Buckinghamshire team have fully embraced the Adaptive Mentalisation-Based Integrative Therapy (AMBIT) approach; using this both with service users and as a team approach.

In 2019-20, the team will focus on the integration with social care, starting with the co-location of the Buckinghamshire Social Care team from Buckinghamshire County Council to our Midshires site in Aylesbury in May.

It is envisaged this will lead to improved working relations, more joint working and less duplication for service users, resulting in improved service user experience as well as efficiency savings.

Essex Services

As a Trust, we are leading on the transformation of learning disability services across Essex, in partnership with Anglian Community Enterprise (ACE) and Essex Partnership University Trust (EPUT) through the Essex Learning Disability Partnership (ELDP).

For our service users, this means:

- **Way in –** one point of entry and a Personalised Assessment Process (PAP) based on individual need not diagnostic threshold. Also a single care plan co-produced and owned by the individual/named contact at all times.
- **Enhanced Support and Early Intervention –** advice and support available 24/7, breaking down barriers through a shift to new flexible roles and shared competencies. Community Rehabilitation and Engagement Workers, working jointly with key system partners. Also admission avoidance initiatives – for example support respite and crisis accommodation.
- **Inpatient Assessment and Treatment Services -** improved continuity of care through a responsive staffing model; integrated multi-disciplinary team working and advocacy services.
- **Community Forensic Services –** highly specialist support, individual and group offence specific interventions. Liaison and joint working as well as advice, support and training.
- **Community link service –** new community link roles for 'neighbourhoods' and acute hospitals. Named case workers offering guided support and movement between mainstream and specialist services. Health promotion and facilitation, training and consultancy to support community resilience. Extending care pathways into the other community services, for example voluntary and charity sector.
- **Community Specialist Health –** Locality based model for each CCG/Case management and crisis prevention. Also evidence-based clinical pathways.

What is AMBIT?

This is part of the development of the Personality Disorder pathway within our Learning Disability services, led by psychology. AMBIT is a mentalisation based team approach for teams working with young people with severe and multiple needs, who do not tend to access mainstream services run by the Anna Freud Centre. The plan is to train members of the Learning Disability community teams in Hertfordshire, Buckinghamshire and Essex as trainers. It will be involving all members of the team, including psychology, Allied Health Professionals, nursing and psychiatry.

Annexe 1 – Statements from Partners

Healthwatch Hertfordshire's Response to Hertfordshire Partnership University NHS Foundation Trust (HPFT) Quality Report 2019

Healthwatch Hertfordshire welcomes the opportunity to comment on HPFT's Quality Account. We would like to make the following comments:

- There are many positives within the Quality Account but worthy of particular note is that the Trust seems to be continuously reviewing and working on various initiatives, programmes and pilots including for example a programme to build seclusion suites and a pilot for a new programme to provide work placement opportunities. All of the many initiatives described could offer significant benefit to services users, carers and staff and we look forward to hearing about the outcomes from those accordingly
- The Quality Account clearly demonstrates how the quality priorities have been chosen and that consideration was given to the feedback generated from the consultation around the priorities. Measures to monitor progress of the priorities are robust though we assume that quality priority 9 (the Trust's service user experience of community mental health services' indicator) will be reviewed throughout the year before the annual report is produced
- Overall the report appears to cover most elements and facets of the service in detail and includes reports on achievements and comparisons to previous years / periods which for the most part seem to indicate improvements. However, information, reports and achievements in terms of care in the community including crisis care seem to be rather light as is any detail, reports or information on relapse and return to hospital care outside of the current 28 day measure, which could help to review success or otherwise for care in the community
- We are pleased to be working in partnership with HPFT, Viewpoint and Carers in Herts to investigate carer involvement in discharge planning and processes from acute mental health settings to improve services through the patient voice and welcome the positive approach taken by HPFT.

Healthwatch would like to thank the Trust for welcoming us at Board, committee and group meetings and for being so responsive to any questions that we raise. We look forward to working with HPFT in the coming year to continue to improve patient experience and outcomes.

Steve Palmer, Chair Healthwatch Hertfordshire, April 2019

NHS
East and North Hertfordshire
Clinical Commissioning Group

NHS
Herts Valleys
Clinical Commissioning Group

Hertfordshire Partnership University Foundation NHS Trust Quality Account Statement from Herts Valleys Clinical Commissioning Group and East and North Herts Clinical Commissioning Group

The information provided within this Quality Account presents a balanced report of the quality of healthcare services that HPFT provides and is, to the best of our knowledge, accurate and fairly interpreted. The Quality Account clearly evidences the improvements made and importantly where improvements are still required.

Commissioners have been working closely with HPFT during the year; gaining assurance on quality of care ensuring it is safe, effective and delivers a positive patient experience. In line with the NHS (Quality Accounts) Regulations 2011 and the Amended Regulations 2017, commissioners have reviewed the information contained within the HPFT annual account and checked this against data sources, where this is available to us as part of our existing monitoring discussions and confirm this to be accurate and fairly interpreted to the best of our knowledge.

At the end of March 2019 we agreed a new five year contract with Hertfordshire Partnership University NHS Foundation Trust (HPFT) for the provision of mental health and specialist learning disability services in Hertfordshire. This reflects our view that HPFT is an organisation that we can work with to deliver, transformed and improved outcomes for people in Hertfordshire which is open, transparent and provides high quality patient focused services.

As with last year's Quality Account our most significant area of concern has been around staffing – both recruitment of new staff and retention of high calibre staff to enable HPFT to deliver good quality, and safe, services across the range of geographical and services areas that they provide. We know that the Trust shares these concerns and has significant focus not only on recruitment but also on retaining and supporting existing staff. For example in Learning Disabilities (LD) we know that many LD nurses are nearing retirement and the numbers of LD nurses graduating are falling. This is similar to what is being seen in other areas nationally and support HPFT in the work they are doing to encourage applicants e.g. working with the University of Hertfordshire to ensure that nurses in training locally remain in Hertfordshire once they qualify

Our second most significant area of concern has been HPFT's ability to see people waiting for a routine assessment of their needs within 28 days, both in adults and in Child and Adolescent Mental Health Services (CAMHS). We have worked with the Trust on a number of approaches to mitigating these issues. These have included primary care mental health pilots in adult services and increasing capacity in early intervention services for children and young people. Alongside this the Trust has been working on reducing the number of people who Do Not Attend (DNA) appointments. Improving performance here will continue to be important for us collectively in 2019/20 as we need to response to the increasing demand for services. We are very pleased to have been successful in our bid to become a trailblazer area for the development of mental health support teams linked to schools and will be collaborating with the Trust to roll these out in the two pilot areas during the coming year.

NHS
East and North Hertfordshire
Clinical Commissioning Group

NHS
Herts Valleys
Clinical Commissioning Group

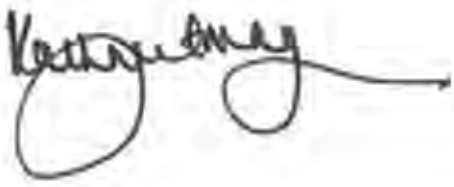
In terms of specialist LD services both the inpatient (Dove ward) and Community Assessment Treatment service (CATs) are continuing to respond effectively to the rising acuity of mental health, behavioural and forensic support needs of people with learning disabilities residing in Hertfordshire. Commissioners are particularly impressed by Dove ward's approach to managing acuity and behaviours that challenge. CATs are being out under additional pressure by the numbers and complex needs of people being placed out of area into social care provision in Hertfordshire who are requiring their specialist learning disability services.

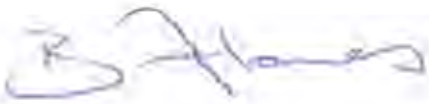
Working with HPFT has allowed us to embed expanded psychiatric liaison services in both Watford General and Lister Hospitals over the past year. These services are now operating 24 hours a day, 7 days a week and so meet the Core 24 standard. The evaluation undertaken during the year evidenced that these teams are vital to supporting urgent and emergency care staff in Accident and Emergency and on inpatient wards to identify, manage and support people with mental health needs.

The Trust moved to a new and more robust training programme for safeguarding children. This will improve training and bring benefits in the longer term, but caused short term training challenges. They have been open and transparent and worked closely with the Designated Team and commissioners through this transition.

We have worked with HPFT during the year to consider the closure of Prospect House, an assessment and treatment unit for people with dementia. This proposal has been considered by Hertfordshire County Council's Health Scrutiny Committee.

Over the coming year we look forward to working with HPFT to improve the response to crisis in both adults and children and young people, to developing community mental health services linked to primary care and considering the potential to extend CAMHS services up to age 25.





Kathryn Magson
Chief Executive
Herts Valleys CCG

Beverley Flowers
Chief Executive
East & North Herts CCG

Hertfordshire Partnership University Foundation NHS Trust Quality Report Statement from Seamus Quilty, Chairman Hertfordshire Health Scrutiny Committee

There has been regular communication between the Health Scrutiny Committee, Scrutiny Officers and the Trust over the last 12 months. The Trust has supported the scrutiny process when approached and the Committee look forward to working with the Trust in the future. The Committee were pleased and reassured to learn that CQC had rated the Trust outstanding following the recent CQC inspection. Councillors are pleased and reassured that Hertfordshire residents are receiving quality mental health and learning disability services from the Trust.

Annexe 2 – Statement of Directors' responsibilities for the Quality Report

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

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality 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 2018/19 and supporting guidance Detailed Requirements for Quality Reports 2018/19
- 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 2018 to March 2019
  - Papers relating to quality reported to the Board over the period April 2018 to March 2019
  - Feedback from commissioners dated May 2019
  - Feedback from governors May 2019
  - Feedback from local Healthwatch organisations dated May 2019
  - Feedback from Overview and Scrutiny Committee dated May 2019
  - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
  - The 2018 national patient survey October 2018
  - The 2018 national staff survey February 2019
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated May 2019
  - CQC inspection report dated May 2019.
- 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 NHS Improvement's Annual Reporting Manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

Chris Lawrence, Chair
Dated: 22nd May 2019

Tom Cahill, Chief Executive
Dated: 22nd May 2019

Annexe 3 – External Audit Opinion

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Hertfordshire Partnership University NHS Foundation Trust to perform an independent assurance engagement in respect of Hertfordshire Partnership University NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral; and
- inappropriate out-of-area placements for adult mental health services.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated May 2019;
- feedback from governors, dated May 2019;
- feedback from local Healthwatch organisations, dated May 2019;
- feedback from Overview and Scrutiny Committee, dated May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2018 national patient survey, dated October 2018;

- the 2018 national staff survey, dated February 2019;
- Care Quality Commission Inspection, dated 15 May 2019;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Hertfordshire Partnership University NHS Foundation Trust as a body, to assist the Council of Governors in reporting the Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Hertfordshire Partnership University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change

over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Hertfordshire Partnership University NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; 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 Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

24 May 2019

Glossary

ACE	Anglian Community Enterprises
ADDS	Accelerated Directors Development Scheme
ADHD	Attention Deficit Hyperactivity Disorder
ADTU	Acute Day Treatment Unit
A&E	Accident and Emergency
AIMS	Accreditation for Inpatient Mental Health Services
AMBIT	A metallisation based team approach for teams working with young people
ANT	Advance New Technologies
APPTS	Accreditation Programme for Psychological Therapies Service
ASYE	Assessed and Supported Year in Employment
AWOL	Absent Without Leave
BAME	Black, Asian & Minority Ethnicity
BMI	Body Mass Index
BMJ	British Medical Journal
BNF	British National Formulary
CAMHS	Child and Adolescent Mental Health Services
CASC	Clinical Assessment of Skills and Competencies
CATT	Crisis Assessment and Treatment Team
C-CATT	Children's Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCQI	Royal College of Psychiatrists' College Centre for Quality Improvement
CEDS	Community Eating Disorders Service
CGL	Change, Grow, Live – health
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CORE	Clinical Outcomes and Research Evaluation
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPT	Community Perinatal Team
CQC	Care Quality Commission
CQI	Continuous Quality Improvement
CQUIN	Commissioning for Quality and Innovation
CREMS	Carer Rated Experience Measures
CRN	Clinical Research Network
CROMS	Carer Rated Outcome Measures
CTR	Care and Treatment Review
CYP	Children and Young People
Datix	Trust incident reporting tool
DBT	Dialectical Behaviour Therapy
DiT	Dynamic Interpersonal Therapy
DOLS	Deprivation of Liberty Safeguards
DNA	Did Not Attend
DSP	Data Security and Protection
DToC	Delayed Transfer of Care
DWP	Department of Working Pensions
EbE	Experts by Experience
ED	Emergency Department
EDS	Equalities Delivery Scheme
EIP	Early Intervention Psychosis
EIPN	Early Intervention in Psychosis Network
ELDP	Essex Learning Disability Partnership
EMDASS	Early Memory Diagnosis and Support Services
EPMHS	Enhanced Primary Mental Health Services (IAPT)
EPR	Electronic Patient Record

EPUT	Essex Partnership University Trust
EROS	The new Rehabilitation pathway
EWS	Early Warning Score
FBC	Full Blood Count
FEP	First Episode Psychosis
FFT	Friends and Family Test
GMC	General Medical Council
HoNOS	Health of the Nation Outcome Scales
HCC	Hertfordshire County Council
HCT	Hertfordshire Community NHS Trust
HDAT	High Does Antipsychotic Therapy
HEE	Health Education England
HES	Hospital Episode Statistics
HMN	Herts Mind Network
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HQUIP	Healthcare Quality Improvement Partnership
HSCA (RA)	Health and Social Care Act Regulated Activities
HSCIC	Health and Social Care Information Centre
HSJ	Health Service Journal
HYS	Having Your Say
HSC	Hertfordshire Health Scrutiny Committee
HTA	Health Technology Assessment
HTT	Home Treatment Team
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Abuse Advisors
IG	Information Governance
IHCCT	Integrated Health and Care Commissioning Team
IPS	Individual Placement and Support
KPI	Key Performance Indicators
LeDeR	Learning Disability Mortality Review Programme
LFT	Liver Function Test
LQAF	Library Quality Assurance Framework
MES	Member Engagement System
MH	Mental Health
MHA	Mental Health Act
MHMDS	Mental Health Minimum Data Set
MOSS	Making Our Services Safer
MSNAP	Memory Services National Accreditation Programme
MTFP	Medium Term Financial Plan
NCISH	National Confidential Inquiry into Suicide and Homicide
NHSI	NHS Improvement
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NRLS	National Reporting and Learning System
OCD	Obsessive Compulsive Disorder
OSC	Overview and Scrutiny Committee
OT	Occupational Therapy
PACE	Practice Audit and Clinical Effectiveness
PALS	Patient Advice and Liaison Service
PAIG	Practice Audit Implementation Group
PANSS	Positive and Negative Syndrome Scale
PAP	Personalised Assessment Process
PARIS	Electronic Patient Record system
PATH	Psychosis, Prevention, Assessment and Treatment
PC-MIS	IAPT information recording system
PbR	Payment by Results
PBS	Positive Behavioural Support
PDS	Post Diagnostic Support
PELS	Peer Experience Listening Service
PEN	Patient Experience Network
PHSO	Parliamentary and Health Services Ombudsman

PICU	Psychiatric Intensive Care Unit
PLACE	Patient Led Assessment of the Clinical Environment
PLAN	Psychiatric Liaison Accreditation Network
PMVA	Management of Violence and Aggression
POMH UK	Prescribing Observatory for Mental Health – UK
PoS	Place of Safety
PPE	Personal Protective Equipment
PREMS	Patient (service user) Rated Experience Measures
PRN	Pro Re NATA (“when required”) medicine
	Hertfordshire Community NHS Trust
PROMS	Patient (service user) Rated Outcome Measures
PSF	Provider Sustainability Fund
QNCC	Quality Network for Community Services
QNCC-ED	Quality Network for Community Services Eating Disorders
QNFMHS	Quality Network for Forensic Mental Health Services
QNIC	Quality Network for Inpatient Services
QNLD	Quality Network for Learning Disability Services
QNOAMHS	Quality Network for Older Adults Mental Health Services
QNPICU	Quality Network for Psychiatric Intensive Care Units
QNPMHS	Quality Network for Prison Mental Health Service
R and D	Research and Development
RAID	Rapid Assessment Interface and Discharge (now known as Mental Health Liaison)
RCA	Root Cause Analysis
RfPB	Research for Patient Benefit
SBU	Strategic Business Unit
SCM	Structured Clinical Management
SEVA	Senior Employment Education Advisor
SI	Serious Incident
SJR	Structured Judgement Review
SOF	Single Oversight Framework
SOP	Standard Operating Procedure
SPA	Single Point of Access
SPIKE	Reporting tool for the Trust
SSRI	Selective Serotonin Reuptake Inhibitor (a type of anti-depressant medication)
STaR	Support Time and Recovery
STP	Sustainability and Transformation Partnerships
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale
TNS	Total National Sampling
TVN	Tissue Viability Nurse
UK CRN	UK Clinical Research Network
WRES	Workforce Race Equality Standard

Accounts and Financial Statements

FOREWORD TO THE FINANCIAL STATEMENTS

HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2019, have been prepared by Hertfordshire Partnership University NHS Foundation Trust ('the NHS FT') in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

If you require any further information on these Annual Financial Statements please contact:

Matthew Hooper
Head of Financial Services
Hertfordshire Partnership University NHS Foundation Trust
99 Waverley Road
St Albans
Hertfordshire
AL3 5TL
Telephone number: 01727 804 764

Signed TJ Cahill

Mr Tom Cahill, Chief Executive Date 22 May 2019

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2019

	note	2018/19 £000	2017/18 £000
Operating income from patient care activities	4	223,531	216,892
Other operating income	4	12,044	13,417
Operating expenses	5	(229,133)	(218,128)
OPERATING SURPLUS		**6,442**	**12,181**
FINANCE COSTS			
Finance income	9.0	350	142
Finance expense - financial liabilities	9.1	(304)	(377)
Finance expense - unwinding of discount on provisions	9.1	(14)	(5)
PDC dividend charge		(3,582)	(3,218)
NET FINANCE COSTS		(3,550)	(3,458)
(Losses)/Gains of disposal of assets	11.3	(32)	345
SURPLUS FOR THE YEAR		**2,860**	**9,068**
SURPLUS FOR THE YEAR			
Other comprehensive income will not be reclassified to income and expenditure:			
Impairments	13	(1,060)	(3,290)
Revaluations	11	2,326	8,907
Remeasurements of net defined benefit pension scheme	26	(57)	(28)
Will not be reclassified to income and expenditure:		**1,209**	**5,589**
TOTAL COMPREHENSIVE INCOME/EXPENSE FOR THE YEAR		**4,069**	**14,657**

Whilst the surplus for the financial year was £2,860k (£9,068k in 2017/18) as reported above, this includes a small number of items which are unusual in nature and not considered by the NHS FT to be part of its normal activities, and are therefore adjusted for to show the comparative financial performance against the NHSI control total of £360k for 2018/19 (£786k for 2017/18)

		2018/19	2017/18
Financial performance for the year:		£000	£000
SURPLUS FOR THE YEAR (as above)		2,860	9,068
less Provider Sustainability Funding (PSF)	1.3	(3,535)	(6,103)
add back Net Impairments charged to the SOCI	13	1,124	580
remove Non-cash element of on-SOFP pension costs	26	(57)	(28)
Adjusted financial performance against the NHSI Control Total		**392**	**3,517**

STATEMENT OF FINANCIAL POSITION
31 March 2019

	note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	10	1,343	212
Property, plant and equipment	11	150,741	149,964
Total non-current assets		**152,084**	**150,176**
Current assets			
Inventories	14	50	38
Receivables	16	7,812	11,591
Assets held for sale	15	1,592	2,750
Cash and Cash Equivalents	17	58,023	56,018
Total current assets		**67,477**	**70,397**
Current liabilities			
Trade and other payables	21	(22,682)	(27,219)
Borrowings	19	(551)	(7,377)
Provisions	20	(2,301)	(4,195)
Other liabilities	22	(6,724)	(4,927)
Total current liabilities		**(32,258)**	**(43,718)**
Total assets less current liabilities		**187,303**	**176,855**
Non-current liabilities			
Borrowings	19	(9,528)	(10,058)
Provisions	20	(5,324)	(5,556)
Total non-current liabilities		**(14,852)**	**(15,614)**
Total assets employed		**172,451**	**161,241**
Financed by (taxpayers' equity)			
Public Dividend Capital		91,144	84,003
Revaluation Reserve		36,035	35,056
Other reserves		(85)	(28)
Income and expenditure reserve		45,357	42,210
Total taxpayers' and others' equity		**172,451**	**161,241**

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 22 May 2019

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED
31 March 2019

	note	Total	Public Dividend Capital	Revaluation reserve	Other Reserves	Income and expenditure reserve
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 01 April 2018 - brought forward		**161,241**	**84,003**	**35,056**	**(28)**	**42,210**
Surplus for the year	SOCI	2,660	0	0	0	2,660
Net impairments	13	(1,060)	0	(1,060)	0	0
Revaluations - property, plant and equipment	11	2,326	0	2,326	0	0
Transfer to retained earnings on disposal of assets		0	0	(287)	0	287
Remeasurements of defined net benefit pension scheme liability / asset	26	(57)	0	0	(57)	0
Public dividend capital received	18	7,141	7,141	0	0	0
Taxpayers' Equity at 31 March 2019		**172,451**	**91,144**	**36,035**	**(85)**	**45,357**

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued by the Department of Health and Social Care. In 2018 three amounts were received as Public Dividend Capital the principal amount being a receipt of £6.8m to fund the repayment of a capital loan. A charge, reflecting the cost of capital utilised by the NHSFT, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential. There was no revaluation reserve held against the asset sold in 2017/18 and therefore no transfer to retained earnings on the disposal of an asset.

Other reserves
The Other reserves relate to accounting for the Local Government Pension Scheme as a defined benefit scheme, see note 26 for further details.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHSFT.

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED
31 March 2018

	note	Total	Public Dividend Capital	Revaluation reserve	Other Reserves	Income and expenditure reserve
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 01 April 2017 - brought forward		**145,643**	**83,063**	**29,439**	**0**	**33,141**
Surplus for the year	SOCI	9,068	0	0	0	9,068
Transfers between reserves		0	0	(1)	0	1
Net impairments	13	(3,290)	0	(3,290)	0	0
Revaluations - property, plant and equipment	11	8,907	0	8,907	0	0
Remeasurements of defined net benefit pension scheme liability / asset	26	(28)	0	0	(28)	0
Public dividend capital received	18	940	940	0	0	0
Other reserve movements		1	0	1	0	0
Taxpayers' Equity at 31 March 2018		**161,241**	**84,003**	**35,056**	**(28)**	**42,210**

There was no revaluation reserve held against the asset sold in 2017/18 and therefore no transfer to retained earnings on the disposal of an asset.
The 'Remeasurements of defined net benefit pension scheme liability / asset' relates to accounting for the Local Government Pension Scheme as a defined benefit scheme, see note 26 for further details.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2019

	note	2018/19 £000	2017/18 £000
Net cash inflow from operating activities	24	**10,897**	**17,711**
Cash flows used in investing activities			
Interest received	9	342	127
Purchase of intangible assets	10	(1,268)	(25)
Purchase of property, plant and equipment	11	(5,696)	(6,555)
Proceeds from sales of property, plant and equipment	11	1,417	4,711
Net cash flows used in investing activities		**(5,205)**	**(1,742)**
Net cash generated used in financing activities			
Public dividend capital received		7,141	940
Movement in loans from the Department of Health and Social Care		(7,320)	(530)
Capital element of finance lease rental payments		(45)	(45)
Interest on loans		(323)	(372)
Interest element of finance lease		(6)	(6)
PDC dividend paid		(3,134)	(3,499)
Net cash generated used in financing activities		**(3,687)**	**(3,512)**
INCREASE IN CASH AND CASH EQUIVALENTS	17	2,005	12,457
Cash and Cash equivalents at 1 April	17	**56,018**	**43,561**
Cash and Cash equivalents at 31 March		**58,023**	**56,018**

The Statement of Cash Flows reports transactions purely on a cash basis and not on an accruals basis as used in the other Financial Statements. For this reason some figures may appear different to the figures reported elsewhere. An example of this is 'PDC dividend paid' being £3,134k in the statement above, compared to £3,582k on the Statement of Comprehensive Income. Cash and cash equivalents are recorded at current value.

The 'Proceeds from sales of property, plant and equipment' in 2018/19 consisted of the sales proceeds realised on the sale of 305 Ware Road. For 2017/18 it consisted of the sale proceeds for the Old Laundry on the Kingsley Green site and The Meadows sold on 31st March 2017 but cash received in the 2017/18 accounting year.

Notes to the Accounts

1. Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the NHS FT shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS FT for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to 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 Critical accounting judgements and key sources of estimation uncertainty

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

1.2.1 Critical judgements in applying accounting policies

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

True and Fair View

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

Going Concern

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

1.2.2 Key sources of estimation uncertainty

There are no key assumptions concerning the future, or other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Estimates of the amount to provide for in Pensions provisions, with a carrying amount liability of £2,114k, and Injury Benefit provisions , with a carrying amount liability of £2,628k, are based on the latest estimates of life expectancy tables provided by the Government Actuary's Department (GAD).

Estimates of the amount to provide for in Continuing Health Care provisions, with a carrying amount liability of £1,268k, are based on the number of claims received with an average value for the claim (based on recent actual settlements) and related costs calculated.

Valuation assumptions for Property, Plant and Equipment, with carrying assets of £150,741k are based on valuations provided by the District Valuer, Giles Awford, as at 31 March 2019 in line with note 1.6.

Legal claims provisions, with a carrying amount liability of £485k, are based on the best estimate received from Solicitors involved in the case, and estimates of probability of as provided by the NHS Litigation Authority.
Estimates of the amount to provide for dilapidation costs, with a carrying amount liability of £1,130k, reflect the requirements obligated within individual lease agreements and estimated in value by the Associate Director of Estates.
Estimates for the Hertfordshire Local Government Pension Scheme (LGPS) are based provided by Hymans Robertson LLP.

1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).
Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/ services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.
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 East & North Hertfordshire Clinical Commissioning Group, NHS Herts Valleys Clinical Commissioning Group and Hertfordshire County Council. A performance obligation relating to the delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.
Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty. The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes.
The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.
The NHS FT has an agreement with NHS England that income for the New Care Models (NCM) CAMHs Tier 4 service is shown net of the cost of inpatient beds commissioned by NHS England on behalf of the NHS FT for this service.
A £2.45bn Provider Sustainability Fund (PSF), previously referred to as the Sustainability and Transformation Fund (STF), has been made available again to NHS providers during 2018-19, linked to the achievement of financial control total and performance targets. Of this the NHS FT has been provisionally awarded a total of £3,535k comprising £1,775k in relation to its achievement of its control total, £30k in relation to its achievement in excess of its control total, £949k in relation to incentive PSF general distribution and £781k in relation to a bonus amount awarded. This is a reduction on the £6,103k received in 2017/18.

1.3.1 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.4 Employee Benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.
The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.
The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure 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. These assets are held by the Hertfordshire County Council.

Some current employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. Previously this was treated as a defined contribution scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the NHS FT's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

In 2018/19 a small number of staff who have transferred under TUPE from Essex County Council remain members of the Essex Pension Fund. The NHS FT is not yet an admitted fully funded member of the pension scheme so has not accounted for such in 2018/19, but expects to become a member in 2019/20.

1.5 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable for the goods and services received. Expenditure is recognised as an operating expense, except where it results in the creation of a noncurrent asset such as property, plant and equipment and is therefore capitalised (see 1.6 below).

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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 lives.

Measurement

Valuation

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period.
Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.
An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.
A revaluation of selected assets was conducted by the District Valuer, Giles Awford, as at 31st March 2019 and those values have been included. The selected assets represented those that had either undergone material investment or the circumstances directing the modern equivalent valuation had materially changed. Giles Awford has full membership of the Royal Institution of Chartered Surveyors (MRICS). The NHS FT undertook a full estate valuation in 2017/18.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is either: probable that additional future economic benefits, or; service potential deriving from the cost incurred to replace a component of such item, will flow to the NHS FT and the cost of the item can be determined reliably.
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 lives in a manner consistent with the consumption of economic or service delivery benefits.
Depreciation is provided at rates calculated to write off the cost of non-current assets, less their estimated residual value, over the expected useful lives on the following basis:

	Years
Plant & machinery	5 - 15
Set up costs in new buildings	10
Furniture & Fittings	1 0
Information Technology	3

Buildings held under finance lease agreements are depreciated over the term of the lease.

Freehold land is considered to have an infinite life and is therefore not depreciated.
Refurbishment of leased buildings is depreciated over the term of lease.
Property, plant and equipment which has been reclassified as 'Held for Sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the NHS FT.

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

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.
An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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

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

1.7 Intangible Assets

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

Internally generated goodwill, brands, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the NHS FT intends to complete the asset and sell or use it;
- the NHS FT has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the NHS FT to complete the development and sell or use the asset; and
- the NHS FT can measure reliably the expenses attributable to the asset throughout its remaining development.

Software
Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset and amortised over the useful life of the asset which is generally 5 to 10 years.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.
Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.
Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. This is expected to be between 5 and 10 years.

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

The NHS FT as lessee
Property, plant and equipment held under finance leases are initially recognised at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor.
Lease payments are apportioned between finance charges and a reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged as an expense within the Statement of Comprehensive Income.
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases and accounted for accordingly.

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

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

1.9 Inventories

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

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.
Cash, bank and overdraft balances are recorded at current values.

1.11 Provisions

The NHS FT recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.
A restructuring provision is recognised when the NHS FT has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditure arising from the restructuring, which are those amounts that are necessarily entailed by the restructuring and not associated with the ongoing activities of the NHS FT.

1.12 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 20 but is not recognised in the Trust's accounts.

1.13 Non-clinical risk pooling

The NHS FT participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution 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.

1.14 Contingencies

Contingent assets

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

Contingent liabilities

Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

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

1.15 Financial assets and financial liabilities

1.15.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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

1.15.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability. Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Contract receivables are distinguished between local government, salary overpayments and other as appropriate groupings of shared credit risk. Historical loss rates are obtained for these groupings and applied to the current levels of contract receivables. It is not expected that credit losses would be recognised in relation to other NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.15.3 De-recognition

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

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

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

1.18 Foreign currencies
The NHS FT's functional currency and presentational currency is sterling. There are no material foreign currency transactions in the year.

1.19 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS FT has no beneficial interest in them. Details of third party assets are given in Note 28 to the accounts.

1.20 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.
At any time, the Secretary of State can issue PDC to, and require PDC repayments from, the Trust. PDC is recorded at the value received.
A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year.
Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii)
average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.
The average relevant net assets is calculated as a simple average of the opening and closing relevant net assets.
The PDC dividend calculation is based upon the NHS FT's group accounts, but excluding charitable funds.

1.21 Losses and Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover, had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).
The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses. The detail can be found in note 27.

1.22 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Subsidiaries

The NHS FT is the corporate trustee to Hertfordshire Partnership NHS Foundation Trust Charity. The NHS FT has assessed its relationship to the charitable fund and determined it to be a subsidiary because the NHS FT is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.
The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.
The NHS FT has chosen not to consolidate the Charitable Funds into these Financial Statements as the amounts of the Charitable Funds are not material and would not provide additional value to the reader of the NHS FT's Financial Statements.

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

The DH GAM does not require the following Standards and Interpretations to be applied in 2018/19.

- IFRS 14 Regulatory Deferral Accounts - Not yet EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2. Financial Risk Factors

The NHS FT's activities expose it to a variety of financial risks: credit risk, liquidity risk, cash flow risk and fair value interest-rate risk. The NHS FT's overall risk management programmes focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the NHS FT's financial performance. Risk management is carried out centrally under policies approved by the Board of Directors.

2.1 Credit risk

Over 90% of the NHS FT's income is from contracted arrangements with commissioners. As such, any material credit risk is limited to administrative and contractual disputes. Where a dispute arises, provision will be made on the basis of the age of the debt and the likelihood of a resolution being achieved.

2.2 Liquidity risk

The NHS FT's net operating costs are incurred under contract agreements principally with NHS Clinical Commissioning Groups and Hertfordshire County Council, which are financed from resources voted annually by Parliament. The NHS FT also finances its capital expenditure from internally generated resources, from funds made available by commissioners and from loan agreements with the National Loan Fund. The NHS FT is not, therefore, exposed to significant liquidity risks.

2.3 Cash flow and fair value interest-rate risk

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

2.4 Borrowings

As an NHS Foundation Trust the NHS FT has the authority to finance capital expenditure through borrowing.
Up until 2012/13 the NHS FT had financed its capital programme from existing cash balances. Two loan applications were approved by both Monitor and the Independent Trust Financing Facility to part fund the future capital investment programme up to a value of £38.8m. £19.2m was drawn down in previous years (£10.2m in 2014/15, £9m in 2013/14). No further drawdown against this facility is permitted. Any future requirements would require agreement of a new facility. In 2018/19 the £6.8m bridging loan was repaid in full.

3 Segmental Information

Under IFRS 8, an Operating Segment is a component of an entity:

- that engages in activities that may attract income and incur expenses (including income and expenses incurred internally)
- whose operating results are regularly reviewed the NHS FT's 'Chief Operating Decision Maker' to make decisions about resources allocated to that segment and assess performance
- for which discrete financial information is available

A separate segment must only be reported if it exceeds one of the quantitative thresholds: 10% of revenue, profit/loss or assets; unless this would result in 75% of the NHS FT's revenue being included in reportable segments, in which case additional reportable segments are identified such that the 75% threshold is reached or exceeded.

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 the assets are managed as one central pool.

Notes to the Accounts - 4 Operating Income from continuing operations

4 Operating Income from continuing operations

4.1 Operating Income (by classification)

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

	2018/19 Total	2017/18 Total
	£000	£000
Income from activities		
Cost and volume contract income	5,095	5,154
Block contract income	213,504	207,806
Clinical partnerships providing mandatory services (including S75 agreements)	1,126	1,123
Other clinical income from mandatory services	1,966	2,809
AfC pay award central funding	1,840	0
Total income from activities	**223,531**	**216,892**
Other operating income		
Research and development	358	529
Education and training	4,503	4,420
Non-patient care services to other bodies	126	448
Provider sustainability fund (PSF)	3,535	6,103
Other	3,331	1,796
Rental revenue from operating leases	191	121
Total other operating income	**12,044**	**13,417**
Total operating Income	**235,575**	**230,309**

The NHS Staff Council reached agreement in 2018 on reform of the NHS Terms and Conditions of Service (Agenda for Change), resulting in a three-year pay deal, as well as reform of the pay structure and changes to terms and conditions. For 2018/19 an element of funding was received direct from the Department of Health and Social Care, shown as above 'AfC pay award central funding'. For 2019/20 onwards funding will be included within 'Block contract income' with commissioners.

A £2.45bn Provider Sustainability Fund (PSF), previously referred to as the Sustainability and Transformation Fund (STF), has been made available again to NHS providers during 2018-19, linked to the achievement of financial control total and performance targets. Of this the NHS FT has been provisionally awarded a total of £3,535k comprising £1,775k in relation to its achievement of its control total, £30k in relation to its achievement in excess of its control total, £949k in relation to incentive PSF general distribution and £781k in relation to a bonus amount awarded. These values are indicative draft allocations subject to further adjustment. This is a reduction on the £6,103k received in 2017/18.

Notes to the Accounts - 4 Operating Income from continuing operations

4.2 Income from Activities (by source)

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

	2018/19 Total	2017/18 Total
	£000	£000
Income from Activities		
Local authorities	176,065	173,546
Clinical commissioning groups	26,640	24,512
NHS England	18,473	18,364
Department of Health and Social Care	1,840	0
NHS Trusts	456	456
NHS Foundation Trusts	57	0
NHS other (including Public Health England)	0	14
Total Income from Activities	**223,531**	**216,892**

The NHS FT's main source of income (79%) is included in 'Income from Local Authorities' and is principally from the joint commissioning arrangement between East and North Hertfordshire Clinical Commissioning Group, Herts Valleys Clinical Commissioning Group and Hertfordshire County Council.

4.3 Analysis between Commissioner Requested Services and non-Commissioner Requested Services

Under the NHS FT's Provider Licence, the NHS FT is required to provide commissioner requested health and social services. The allocation of income from activities between Commissioner Requested Services and other services is shown below.

	2018/19	2017/18
	£000	£000
Income from Commissioner Requested Services	223,531	216,892
Income from non-Commissioner Requested Services	12,044	13,417
	235,575	**230,309**

4.4 Operating Lease Income

The NHS FT leases one of its properties (31/33 Hill End Lane) under a non-cancellable operating lease agreement with VMH Support Ltd and a portion of the Marlowes Health & Wellbeing Centre under an operating lease agreement with Hertfordshire Community NHS Trust.

The total annual income from these operating leases in 2018/19 is £191k (£13k in 2017/18).

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

	2018/19 £000	2017/18 £000
on leases of Buildings expiring:		
- not later than one year;	191	13
- later than one year and not later than five years;	942	52
- later than five years.	890	0
	2,023	**65**

Notes to the Accounts - 5 Operating Expenses of continuing operations

5 Operating Expenses of continuing operations

5.1 Operating Expenses (by type)

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	444	1,799
Purchase of healthcare from non-NHS and non-DHSC bodies	13,338	10,358
Purchase of social care	17,339	16,760
Staff and executive directors costs	151,176	146,438
Non-executive directors	161	170
Supplies and services – clinical (excluding drugs costs)	542	525
Supplies and services - general	7,874	7,192
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	3,115	2,974
Inventories written down (net including drugs)	1	3
Consultancy	701	957
Establishment	2,500	2,903
Premises - business rates collected by local authorities	1,532	1,074
Premises - other	2,351	2,126
Transport (business travel only)	2,003	2,019
Transport - other (including patient travel)	1,599	1,450
Depreciation	4,752	4,838
Amortisation	137	87
Impairments net of (reversals)	1,124	580
Movement in credit loss allowance: contract receivables/assets	(12)	0
Movement in credit loss allowance: all other receivables & investments	0	109
Provisions arising / released in year	(1,900)	(2,447)
Audit services - statutory audit (inc. VAT)	73	69
Other auditor remuneration (payable to external auditor only and inc. VAT)	11	9
Internal audit - non-staff	102	110
Clinical negligence - amounts payable to NHS Resolution (premium)	480	569
Legal fees	227	176
Insurance	302	334
Research and development - staff costs	0	298
Education and training - staff costs	1,001	1,242
Education and training - non-staff	59	0
Operating lease expenditure (net)	2,582	2,481
Redundancy costs - staff costs	0	116
Car parking and security	704	989
Hospitality	100	71
Other services (e.g. external payroll)	11,112	8,380
Other	3,603	3,369
Total Operating Expenses	**229,133**	**218,128**

Notes to the Accounts - 5 Operating Expenses of continuing operations

5.2 Limitation on Auditor's Liability

The contract signed on 26th July 2018, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1m, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

5.3 Exit Packages

Reporting of other compensation schemes - exit packages **2018/19**

There were 0 exit packages agreed in 2018/19 totalling £0k.

Reporting of other compensation schemes - exit packages **2017/18**

There were 3 exit packages agreed in 2017/18 totalling £116k.

Exit package cost band (including any special payment element)	Number of exit packages	Cost of exit packages
	Number	£000s
£25,001 - £50,000	3	116
Total	**3**	**116**

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 NHS FT has reviewed the nature of rental agreements across the Trust in preparation for IFRS 16 changes during 2019/20. This has identified a number of rental arrangements that are being formalised into lease agreements and has materially increased the future minimum lease payments expected as shown within the total below.

Analysis of operating lease expenditure 2018/19

	Total £000	Buildings £000	Other £000
Minimum lease payments	2,582	2,289	293
Total	**2,582**	**2,289**	**293**

Analysis of operating lease expenditure 2017/18

	Total £000	Buildings £000	Other £000
Minimum lease payments	2,481	2,200	281
Total	**2,481**	**2,200**	**281**

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

Arrangements containing an operating lease 2018/19

	Total £000	Buildings £000	Other £000
Future minimum lease payments due:			
- not later than one year;	2,800	2,638	162
- later than one year and not later than five years;	8,862	8,628	234
- later than five years.	10,237	10,237	0
	21,899	**21,503**	**396**

Arrangements containing an operating lease 2017/18

	Total £000	Buildings £000	Other £000
Future minimum lease payments due:			
- not later than one year;	1,632	1,503	129
- later than one year and not later than five years;	5,176	5,004	172
- later than five years.	8,961	8,961	0
Total	**15,769**	**15,468**	**301**

Notes to the Accounts - 7 Employee expenses

7 Employee expenses

7.1 The employee expenses incurred during the year were as follows

	2018/19	2017/18
	£000	£000
Salaries and wages	118,424	113,747
Social security costs	12,098	11,643
Apprenticeship levy	569	547
Pension cost - employer contributions to NHS pension scheme	14,215	13,671
Pension cost - other	70	32
Temporary staff - agency/contract staff	6,801	8,454
Total Gross Staff Costs	**152,177**	**148,094**
Employee expenses - staff & executive directors	151,176	146,438
Education and training	1,001	1,242
Research & development	0	298
Redundancy	0	116
Total Employee benefits excl. capitalised costs	**152,177**	**148,094**

Notes to the Accounts - 7 Employee expenses

7.2 Retirements due to ill-health

During 2018/19 there was 1 (5 in 2017/18) early retirement from the NHS FT on the grounds of ill-health with an estimated additional pension liability of £50k (£347k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

8 Better Payment Practice Code

The measure of compliance for 2018/19 has been analysed and can be found in the NHS FT's Annual Report.

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

There are no material amounts included within Finance Expenses (note 9.1) arising from claims made under this legislation.

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

9 Finance Income

	2018/19 £000	2017/18 £000
Interest receivable on bank deposits	350	142

Interest received as stated in the Statement of Cash Flows is the actual cash received by the NHS FT in year (£342k relating to 2018/19 and £127k relating to 2017/18), whereas the figure above comprises the £342k received relating to 2018/19 and also includes £28k closing interest receivable less £20k opening interest receivable. Increases in the national interest rates and higher cash balance resulted in increased interest receivable income.

9.1 Finance Expenses

	2018/19 £000	2017/18 £000
Interest on loans from the Department of Health and Social Care:	301	372
Interest on finance lease obligations	3	5
Unwinding of discount on provisions	14	5
Total	**318**	**382**

Following the repayment of a bridging loan in June 2018, this resulted in lower total interest payments for the year 2018/19 compared to the previous year.

Notes to the Accounts - 10 Intangible Assets

10 Intangible Assets

	2018/19 Software licences £000	2017/18 Software licences £000
Opening cost at 1 April	796	771
Additions - purchased	1,268	25
Disposals	0	0
Gross cost at 31 March	**2,064**	**796**
Opening amortisation at 1 April	584	497
Provided during the year	137	87
Disposals	0	0
Amortisation at 31 March	**721**	**584**
Net book value		
At 1 April	212	274
At 31 March	**1,343**	**212**

The 2018/19 intangible asset additions relate to both the purchase of Microsoft software licences and to the capitalisation of the development costs of the Business Intelligence system developed by the NHSFT which has been named SPIKE.
The 2017/18 intangible asset addition relates to the purchase of staff appraisal software licences.

11 **Property, Plant and Equipment as at 31 March 2019**

11.1 Balances as at 31 March 2019	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**152,064**	26,200	119,609	230	599	756	1,540	3,130
Additions - purchased (including capital lifecycle additions)	**5,679**	0	3,795	0	388	0	1,495	1
Impairments charged to operating expenses	**(1,133)**	(340)	(572)	0	(221)	0	0	0
Impairments charged to the revaluation reserve	**(1,060)**	(100)	(960)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**11**	0	11	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	**0**	0	0	0	0	0	0	0
Reclassifications	**0**	0	217	0	(217)	0	0	0
Revaluations	**2,131**	445	1,686	0	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	**(292)**	(99)	(193)	0	0	0	0	0
Disposals/derecognition	**(288)**	0	0	0	0	0	(288)	0
Valuation/gross cost at 31 March 2019	**157,112**	**26,106**	**123,593**	**230**	**549**	**756**	**2,747**	**3,131**
Accumulated depreciation at 1 April 2018 - brought forward	**2,100**	0	266	0	0	308	369	1,157
Provided during the year	**4,752**	0	3,850	5	0	71	556	270
Impairments charged to operating expenses	**2**	0	2	0	0	0	0	0
Revaluations	**(195)**	0	(195)	0	0	0	0	0
Disposals/derecognition	**(288)**	0	0	0	0	0	(288)	0
Accumulated depreciation at 1 April 2018 - brought forward	**6,371**	**0**	**3,923**	**5**	**0**	**379**	**637**	**1,427**
Net book value at 31 March 2018								
Owned	**150,724**	26,106	119,653	225	549	377	2,110	1,704
Finance Leased	**17**	0	17	0	0	0	0	0
NBV Total at 31 March 2019	**150,741**	**26,106**	**119,670**	**225**	**549**	**377**	**2,110**	**1,704**

The NHS FT's land and buildings underwent a partial valuation at 31 March 2019 to carry out an impairment review on Forest House construction spend and reviewing the details behind buildings valued on a modern equivalent asset basis.

Included within 'additions - purchased' are the following material items:
Classified as 'Buildings, excluding dwellings':
- Forest House Section 136 seclusion room extension - £1,255k which was completed in Q4 2018/19
- Trust wide fire prevention works - £1,093k which was completed in Q4 2018/19
- The Marlowes Health and Wellbeing Centre - £251k of additional works which was completed in Q4 2018/19
- Broadlands refurbishment - £185k which was completed in Q4 2018/19

Classified as 'Information technology':
- £938k to replace computers at the end of their economic life
- £429k to upgrade mobile and Wi-Fi reception signal

See note 13 for details of Impairments.

Included within 'reclassifications' are the following items, previously held as 'Assets under Construction':
- Forest House extension - £197k which was completed and brought in to use in Q4 2018/19

See note 11.3 for details of property disposals.

Notes to the Accounts - 11 Property, Plant and Equipment

Property, Plant and Equipment as at 31 March 2018

11.2 Balances as at 31 March 2018	Total	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction	Plant & machinery	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**152,934**	27,442	117,471	195	311	803	3,718	2,994
Additions - purchased (including capital lifecycle additions)	**6,903**	0	5,200	0	549	0	803	351
Impairments charged to operating expenses	**(2,506)**	(569)	(1,911)	0	(7)	0	(7)	(12)
Impairments charged to the revaluation reserve	**(3,290)**	(1,383)	(1,907)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**1,940**	0	1,940	0	0	0	0	0
Reclassifications	**0**	0	254	0	(254)	0	0	0
Revaluations	**1,513**	1,671	(193)	35	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	**(1,450)**	(887)	(563)	0	0	0	0	0
Disposals/derecognition	**(3,980)**	(74)	(682)	0	0	(47)	(2,974)	(203)
Valuation/gross cost at 31 March 2018	**152,064**	**26,200**	**119,609**	**230**	**599**	**756**	**1,540**	**3,130**
Accumulated depreciation at 1 April 2017 - brought forward	**7,904**	0	4,010	5	0	284	2,536	1,069
Provided during the year	**4,838**	0	3,664	5	0	71	807	291
Impairments charged to operating expenses	**14**	0	14	0	0	0	0	0
Revaluations	**(7,394)**	0	(7,384)	(10)	0	0	0	0
Disposals/derecognition	**(3,262)**	0	(38)	0	0	(47)	(2,974)	(203)
Accumulated depreciation at 31 March 2018	**2,100**	**0**	**266**	**0**	**0**	**308**	**369**	**1,157**
Net Book Value at 31 March 2017								
Owned	**149,933**	26,200	119,312	230	599	448	1,171	1,973
Finance Leased	**31**	0	31	0	0	0	0	0
Net Book Value at 31 March 2017	**149,964**	**26,200**	**119,343**	**230**	**599**	**448**	**1,171**	**1,973**

The NHS FT's land and buildings underwent a full valuation at 31 March 2018.

Included within 'additions - purchased' are the following items:
Classified as 'Buildings, excluding dwellings';
- Centenary House refurbishment - £735k which was completed in Q4 2017/18
- The Marlowes Health and Wellbeing Centre - £2,433k which was completed in Q4 2017/18
- Broadlands Reception extension - £218k which was completed in Q3 2017/18
- Trust wide fire prevention works - £876k which was completed in Q4 2017/18
- Forest Lane Bungalows refurbishment - £264k which was completed in Q4 2017/18

Classified as 'Information technology';
- £777k to replace computers at the end of their economic life and improve cyber security

See note 13 for details of impairments.

Included within 'reclassifications' are the following items, previously held as 'Assets under Construction':
- The Marlowes Health and Wellbeing Centre - £208k which was completed and brought in to use in Q4 2017/18
- Centenary House refurbishment - £45k which was completed and brought in to use in Q4 2017/18

See note 11.3 for details of property disposals.

There were a number of items within Plant & Machinery, Furniture & Fittings and IT that have been de-recognised within the year due to them reaching the end of their economic life and having no carrying value

The NHS FT's land and buildings underwent a full valuation at 31 March 2018.

Notes to the Accounts - 11 Property, Plant and Equipment

11.3 Disposal Of Property, Plant and Equipment

	2018/19 £000	2017/18 £000
Gains on disposal of property, plant and equipment	0	345
Losses on disposal of assets held for sale	(32)	0
Total gain/loss on disposal recorded in the Statement of Comprehensive Income	**(32)**	**345**

The asset disposed in 2018/19 was the sale of 305 Ware Road, Hailey.

The asset disposed in 2017/18 consisted of the sale of the Old Laundry on the Kingsley Green site.

12 Assets held under Finance Leases

	2018/19	2017/18
Opening cost at 1 April	**2,125**	**2,125**
Accumulated depreciation at 1 April	2,094	2,070
Provided during the year	14	24
Accumulated depreciation at 31 March	**2,108**	**2,094**
Net book value		
NBV total at 1 April	31	55
NBV total at 31 March	**17**	**31**

The NHS FT leases one premises under a finance lease agreement.
The premises is 32 St. Peter's Street, St. Albans.

Notes to the Accounts - 13 Impairment of Assets (Property, Plant & Equipment and Intangibles)

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

	2018/19 £000	2017/18 £000
Impairments of Property, Plant and Equipment charged to operating expenses due to changes in market price	914	2,505
Impairments of Property, Plant and Equipment charged to operating expenses due to unforeseen obsolescence	0	15
Impairments of Property, Plant and Equipment charged to operating expenses due to other reasons	221	0
Reversal of prior year impairments of Property, Plant and Equipment credited to operating income	(111)	(1,940)
Total impairments and reversal of impairments charged to the Statement of Comprehensive Income	**1,124**	**580**

Total Net Impairments of Property, Plant and Equipment charged to the Revaluation Reserve	1,060	3,290
Total impairment charged to the Revaluation Reserve	**1,060**	**3,290**

The impairment adjustments for 2018/19 follow a partial revaluation and impairment review conducted by the District Valuer. The assets impaired to operating expenses largely related to decreases in the value of buildings held by the NHS FT following significant investment (£546k). Other impairments charged to the revaluation reserve were incurred as a result of consideration being taken of the modern equivalent asset value of some specialised assets, mainly Prospect House.

The 'impairments due to other reasons' in 2018/19 primarily related to write downs for Prospect House and Victoria Court where the assets are to be used for a lower specification purpose than originally intended.

The 'reversal of impairments credited to operating income' in 2017/18 are impairments incurred in prior years and the assets have since been revalued upwards. These largely relate to Broadlands Clinic, Little Plumstead (£406K), Albany Lodge (£270k), Waverley Road (£253k), Seward Lodge (£217k), Astley Court (£148k).

14 Inventories

	2018/19 £000	2017/18 £000
Carrying Value at 1 April	38	27
Additions	604	531
Inventories recognised in expenses	(591)	(517)
Write-down of inventories recognised as an expense	(1)	(3)
Carrying Value at 31 March	**50**	**38**

15 Assets Held For Sale

	31 March 2019 £000	31 March 2018 £000
Net Book Value of assets held for sale at 1 April	2,750	1,300
Plus assets classified as available for sale in the year	292	1,450
Less assets sold in year	(1,450)	0
Net Book Value of assets held for sale at 31 March	**1,592**	**2,750**

Assets held for sale at March 31st 2019 comprise the properties at 143 and 145 Harper Lane, Radlett and Alexandra Road, Hemel Hempstead.

Assets held for sale at March 31st 2017 comprise the properties of 143 and 145 Harper Lane, Radlett and 305 Ware Road, Hailey, which has now been sold.

Notes to the Accounts - 16 Receivables

16 Receivables

16.1 Trade and other Receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables	3,938	3,948
Accrued income	2,280	6,236
Allowance for impaired contract receivables	(102)	(362)
Prepayments	733	885
Interest receivable	28	20
PDC dividend receivable	19	467
VAT receivable	859	334
Other receivables	57	63
Total current trade and other receivables	**7,812**	**11,591**
Of which receivable from NHS and DHSC group bodies	**5,273**	**5,826**

The reduction of 'Contract receivable not yet invoiced' relates principally to PSF funding awarded for 2017/18 and paid by the Department of Health and Social Care in 2018/19.

16.2 Allowance for impaired contract receivables

	2018/19	2017/18
	£000	£000
At 1 April	362	258
Increase in provision	4	145
Amounts utilised	(248)	(5)
Unused Amounts reversed	(16)	(36)
Balance at 31 March	**102**	**362**

As part of the implementation of IFRS 9 an expected credit loss model for impaired contract receivables was introduced, which had no material impact on the allowance. The majority of the utilisation of the allowance in 2018/19 related to charges for historic out of area placements dating back to 2015 and 2016 which were deemed unrecoverable.

Notes to the Accounts - 17 Cash and cash equivalents

17 Cash and cash equivalents

	2018/19 £000	2017/18 £000
Cash and cash equivalents at 1 April	56,018	43,561
Net change in cash and cash equivalents	2,005	12,457
Cash and cash equivalents at 31 March	**58,023**	**56,018**
Comprising:		
Cash at commercial banks and in hand	77	77
Cash with the Government Banking Service	9,246	55,941
Deposits with the National Loan Fund	48,700	0
	58,023	**56,018**

The NHS FT's cash reserves have increased in year primarily due to the PSF funding received from NHS Improvement and the level of surplus achieved.

18 Public Dividend Capital

	2018/19 £000	2017/18 £000
Taxpayers' Equity at 1 April	84,003	83,063
Public Dividend Capital receipts	7,141	940
Taxpayers' Equity at 31 March	**91,144**	**84,003**

PDC receipts during 2018/19 were related to the Department of Health and Social Care sale of a portion of the Kingsley Green site and subsequent contribution to the Trust to fund relocation works (£6,790k) and capital projects relating to patient Wi-Fi improvements (£340k) and pharmacy software improvements (£11.5k).

19 Borrowings

19.1 Borrowings: Loans and Finance Leases

	31 March 2019 £000	31 March 2018 £000
Current		
Capital loans	542	7,320
Obligations under finance leases	9	57
Total current borrowings	**551**	**7,377**
Non-current		
Capital loans	9,528	10,058
Total non-current borrowings	**9,528**	**10,058**
Total borrowings	**10,079**	**17,435**

The NHS FT has a loan arrangement with the Department of Health and Social Care (see note 2.4). The reduction of £6.8m within current capital loans reflects the repayment of a £6.8m bridging loan following the PDC receipt (see note 18). This follows the sale of Kingsley Green land by the Department of Health and Social Care.

Notes to the Accounts - 19 Borrowings

19.2 Finance Lease borrowings

	31 March 2019 £000	31 March 2018 Restated £000
Payable:		
- not later than one year;	12	60
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Gross lease liabilities	**12**	**60**
Less: Finance charges/(income) allocated to future periods	(3)	(3)
Net lease liabilities	**9**	**57**
Split into current and non-current borrowings on the Statement Of Financial Position:		
- current	9	57
- non current	0	0
	9	**57**
Expected timing of cashflows:		
- not later than one year;	9	57
- later than one year and not later than five years;	0	0
- later than five years.	0	0
	9	**57**

Details of Finance Leases are included in note 12.

Notes to the Accounts - 20 Provisions for liabilities and charges

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) 2018/19

2018/19	Total	Pensions relating to other staff	Pension - Injury benefits	Other legal claims	Continuing Health Care	Dilapidations
	£000	£000	£000	£000	£000	£000
At 1 April 2018 - brought forward	9,751	2,333	2,644	137	3,713	924
Arising during the year	885	131	104	444	0	206
Utilised during the year - accruals	(240)	(208)	(32)	0	0	0
Utilised during the year - cash	(288)	5	(96)	0	0	(197)
Reversed unused	(2,497)	(153)	0	(96)	(2,445)	197
Unwinding of discount rate	14	6	8	0	0	0
Total at 31 March 2019	**7,625**	**2,114**	**2,628**	**485**	**1,268**	**1,130**
Expected timing of cashflows:						
- not later than one year (current)	2,301	210	128	485	1,268	210
- later than one year and not later than five years (non current)	1,606	840	514	0	0	252
- later than five years (non current)	3,718	1,064	1,986	0	0	668
Total	**7,625**	**2,114**	**2,628**	**485**	**1,268**	**1,130**

The 'Pensions relating to other staff' provision is the capitalised cost of early retirements as defined by the NHS Pensions Agency. This mainly relates to early retirements of staff resulting from the closure of long stay institutions, namely, Hill End, Leavesden, Cell Barnes and Harperbury Hospitals. Early retirement provisions are discounted using the HM Treasury's pension discount rate of 0.29% in real terms.

The 'Pension - Injury benefit' provision is the capitalised cost of injury benefits as defined by the NHS Pension scheme, for scheme members who have claimed that they are permanently incapable of fulfilling their duties effectively through injury. Injury Benefit provisions are discounted using the HM Treasury's pension discount rate of 0.29% in real terms.

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. £27,114k (£26,603k as at 31 March 2018) is included in the provisions of NHS Resolution at 31 March 2019 in respect of clinical negligence liabilities of the NHS FT.

The 'Continuing Health Care' provision comprises the potential liability for claims to the NHS FT for the reimbursement of the costs of Continuing Health Care incurred by the claimant where the claimant considers the costs should have been met by the NHS FT. In 2018/19 £1m was reimbursed to Herts Valley CCG

The 'Dilapidations' provision relates to the cost to return leased buildings back to their original condition upon exit.

The very nature of these provisions means that there are uncertainties regarding timing and amount of settlement, though the amount provided is judged sufficient to meet these liabilities. See note 1.2.2 for details of the uncertainties about the amount and timing of outflows.

Notes to the Accounts - 20 Provisions for liabilities and charges

20.2

Provisions for liabilities and charges (held in current and non-current liabilities) 2017/18

2017/18	Total	Pensions relating to other staff	Pension - Injury benefits	Other legal claims	Continuing Health Care	Redundancy	Dilapidations
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017 - as previously stated	13,966	2,544	2,717	1,463	6,489	121	632
Arising during the year	410	36	48	33	0	0	293
Utilised during the year - accruals	(86)	(55)	(31)	0	0	0	0
Utilised during the year - cash	(1,165)	(152)	(93)	0	(920)	0	0
Reversed unused	(3,379)	(42)	0	(1,859)	(1,857)	(121)	0
Unwinding of discount rate	5	2	3	0	0	0	0
Total at 31 March 2018	**9,751**	**2,333**	**2,644**	**137**	**3,712**	**0**	**925**
Expected timing of cashflows:							
- not later than one year (current)	4,195	221	125	137	3,712	0	0
- later than one year and not later than five years (non current)	2,307	883	499	0	0	0	925
- later than five years (non current)	3,249	1,229	2,020	0	0	0	0
Total	**9,751**	**2,333**	**2,644**	**137**	**3,712**	**0**	**925**

The 'Pensions relating to other staff' provision is the capitalised cost of early retirements as defined by the NHS Pensions Agency. This mainly relates to early retirements of staff resulting from the closure of long stay institutions, namely, Hill End, Leavesden, Cell Barnes and Harperbury Hospitals. Early retirement provisions are discounted using the HM Treasury's pension discount rate of 0.1% in real terms.

The 'Pension - Injury benefit' provision is the capitalised cost of injury benefits as defined by the NHS Pension scheme, for scheme members who have claimed that they are permanently incapable of fulfilling their duties effectively through injury. Injury Benefit provisions are discounted using the HM Treasury's pension discount rate of 0.29% in real terms.

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. £26,603k (£20,713k as at 31 March 2017) is included in the provisions of NHS Resolution at 31 March 2018 in respect of clinical negligence liabilities of the NHS FT.

The 'Continuing Health Care' provision comprises the potential liability for claims to the NHS FT for the reimbursement of the costs of Continuing Health Care incurred by the claimant where the claimant considers the costs should have been met by the NHS FT.

The 'Redundancy' provision is the estimated liability for the costs directly related to the formal restructuring plan announced.

The 'Dilapidations' provision relates to the cost to return leased buildings back to their original condition upon exit.

The very nature of these provisions means that there are uncertainties regarding timing and amount of settlement, though the amount provided is judged sufficient to meet these liabilities. See note 1.2.2 for details of the uncertainties about the amount and timing of outflows.

Notes to the Accounts - 21 Trade and other payables

21 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	963	2,775
Capital payables (including capital accruals)	778	795
Accruals (revenue costs only)	15,734	18,743
Social security costs	1,713	1,621
VAT payables	19	15
Other taxes payable	1,442	1,349
Accrued interest on DHSC loans	0	33
Other payables	2,033	1,888
Total Trade and other payables	**22,682**	**27,219**

Accruals are the charges from suppliers for goods or services that have not been paid as at 31 March.

22 Other liabilities

	31 March 2019	31 March 2018
Current		
Deferred income	6,724	4,927
Total Other liabilities	**6,724**	**4,927**

Other liabilities largely comprise income received from commissioners for a specific activity that will be delivered in a future period. As such, this income has been deferred and therefore not included in the Statement of Comprehensive Income in this reporting period.

Notes to the Accounts - 23 Financial assets and liabilities

23 Financial assets and liabilities

23.1 Financial assets by category

	31 March 2019 £000	31 March 2018 £000
Receivables (excluding non financial assets) - with DHSC group bodies	5,238	5,264
Receivables (excluding non financial assets) - with other bodies	963	4,641
Cash and cash equivalents	58,023	56,018
Total	**64,224**	**65,923**

23.2 Financial liabilities by category

	31 March 2019 £000	31 March 2018 £000
DHSC loans	10,070	17,378
Obligations under finance leases	9	57
Trade and other payables excluding non financial liabilities	19,451	27,219
Provisions	6,358	6,039
Total	**35,888**	**50,693**

Notes to the Accounts - 24 Reconciliation of operating surplus to net cash flow from operating activities

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

	2018/19		2017/18	
	£000	£000	£000	£000
Operating Surplus		6,442		12,181
Non cash flow movements:				
Depreciation and amortisation	4,889		4,925	
Impairments and reversals	1,124		580	
		6,013		5,505
Movement in Working Capital:				
Decrease / (Increase) in trade and other receivables	3,341		(1,377)	
on SOFP Pension liability - employer contributions paid less net charge to the SOCI	(57)		(28)	
Increase in inventories	(12)		(11)	
(Decrease) / increase in trade and other payables	(4,487)		5,357	
Increase in other liabilities	1,797		304	
		582		4,245
Decrease in provisions		(2,140)		(4,220)
Net cash inflow from operating activities		**10,897**		**17,711**

Notes to the Accounts - 25 Related Party Transactions

25 Related Party Transactions

25.1 Related Party Transactions 2018/19

The NHS FT is a body corporate established by the Secretary of State for Health and Social Care. The Department of Health and Social Care is regarded as a related party as it exerts influence over a number of transactions and operating policies of the Trust. During the year ended 31 March 2019 the NHS FT had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department of those entities.

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

The NHS FT also has a linked charity, The HPFT Charity registered with the Charity Commission under registered charity number 1053767, which the transactions for which are not consolidated within these statements.

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

2018/19	Income from Related Party	Expenditure payments to Related Party	Receivables from Related Party	Payables to Related Party
	£000	£000	£000	£000
Central Government				
National Heath Service Pension Scheme	0	14,215	0	2,111
HMRC - VAT	0	0	859	19
HMRC - other taxes & duties	0	12,667	0	3,155
National Loans Fund	0	0	48,700	0
Other Central Government	0	6	0	12
NHS				
Department Of Health	2,061	0	38	368
NHS England - Core	3,365	0	1,820	0
Foundation Trusts				
Camden and Islington NHS Foundation Trust	0	104	0	40
East Suffolk and North Essex NHS Foundation Trust	0	114	0	16
Essex Partnership University NHS Foundation Trust	5	2,051	0	501
Norfolk and Norwich University Hospitals NHS Foundati	151	94	68	34
Salford Royal NHS Foundation Trust	0	412	0	53
South London and Maudsley NHS Foundation Trust	0	179	0	38

Clinical Commissioning Groups				
NHS Basildon and Brentwood CCG	835	0	20	0
NHS Bedfordshire CCG	126	0	65	0
NHS Buckingham CCG	3,834	0	45	0
NHS Camden CCG	230	0	99	0
NHS Ealing CCG	363	0	76	0
NHS East and North Hertfordshire CCG	695	2,312	90	150
NHS Great Yarmouth and Waveney CCG	477	0	46	0
NHS Hounslow CCG	322	0	28	0
NHS Herts Valleys CCG	135	35	3	0
NHS Hounslow CCG	322	0	28	0
NHS Mid Essex CCG	5,109	0	150	15
NHS North East Essex CCG	7,699	0	30	398
NHS North Norfolk CCG	644	0	2	0
NHS Norwich CCG	248	0	0	0
NHS South Norfolk CCG	721	0	0	44
NHS Southend CCG	576	0	5	0
NHS Thurrock CCG	314	0	4	0
NHS West Essex CCG	4,537	104	98	117
NHS West Norfolk CCG	155	0	1	0
NHS Trusts				
East and North Hertfordshire NHS Trust	175	1,456	97	1,129
Hertfordshire Community NHS Trust	929	486	378	240
The Princess Alexandra Hospital NHS Trust	0	115	24	24
West Hertfordshire Hospitals NHS Trust	752	1,064	155	352
NHS Other				
Health Education England	3,809	6	252	2,905
East of England Specialised Commissioning hub	18,826	0	821	0
NHS Resolution (formerly NHS Litigation Authority)	0	680	0	69
Other NHS	1,073	421	810	346
Local Government				
Barnet London Borough Council	1,341	0	0	0
Hertfordshire County Council	173,241	146	690	2,558
Hammersmith and Fulham London Borough Council	457	0	14	0
Norfolk County Council	898	0	0	0
Other Local Government	872	899	252	403
Totals	**235,297**	**37,566**	**55,768**	**15,097**

Notes to the Accounts - 25 Related Party Transactions (continued)

25 Related Party Transactions (continued)

25.2 Related Party Transactions (continued) 2017/18

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.

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

2017/18	Income from Related Party	Expenditure payments to Related Party	Receivables from Related Party	Payables to Related Party
	£000	£000	£000	£000
Central Government				
National Heath Service Pension Scheme	0	13,542	0	1,822
HMRC - VAT	0	0	229	0
HMRC - other taxes & duties	0	11,385	0	2,877
National Loans Fund	0	0	37,500	0
Other Central Government	2	9	0	5
NHS				
Department Of Health	875	0	108	436
NHS England - Core	6,688	0	5,713	0
Foundation Trusts				
Central and North West London NHS FT	2	174	0	69
Colchester Hospital University NHS Foundation Trust	0	51	0	4
Norfolk and Norwich University Hospitals NHS FT	73	133	11	45
South London and Maudsley NHS FT	0	167	0	43
Clinical Commissioning Groups				
NHS Camden CCG	231	0	1	0
NHS Chiltern CCG	2,337	0	17	9
NHS Ealing CCG	326	0	27	0
NHS East and North Hertfordshire CCG	685	2,249	41	54
NHS Great Yarmouth and Waveney CCG	400	0	1	0
NHS Harrow CCG	133	0	97	0
NHS Herts Valleys CCG	18	15	0	410
NHS Hounslow CCG	327	0	28	0
NHS Mid Essex CCG	4,544	0	11	0
NHS North East Essex CCG	7,340	0	70	0
NHS North Norfolk CCG	603	0	0	0
NHS Norwich CCG	262	0	0	0
NHS South Norfolk CCG	672	0	0	0
NHS West Essex CCG	4,083	0	205	183
NHS West Norfolk CCG	239	0	0	0

NHS Trusts				
East and North Hertfordshire NHS Trust	103	1,427	116	1,101
Hertfordshire Community NHS Trust	634	262	294	982
West Hertfordshire Hospitals NHS Trust	814	1,032	175	623
NHS Other				
Health Education England	2,631	3	247	65
East of England Specialised Commissioning hub	18,831	0	0	0
NHS Litigation Authority	0	751	0	302
Other NHS	703	156	6,257	615
Local Government				
Barnet London Borough Council	1,339	0	111	0
Hertfordshire County Council	167,466	199	977	2,617
Hammersmith and Fulham London Borough Council	455	0	0	0
Norfolk County Council	867	0	0	0
Other Local Government	946	230	149	179
Totals	**224,629**	**31,785**	**52,385**	**12,441**

Income received from Hertfordshire County Council includes all income received from the Integrated Health and Care Commissioning Team which includes the two Hertfordshire Clinical Commissioning Groups.

Notes to the Accounts - 26 Pension

26 Pension

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 NHS FT has reviewed the accounting treatment and is now accounted for from 2017/18 as a defined benefit scheme. The scheme is in an asset position that cannot be realised by the NHS FT, so the asset ceiling is restricted to the value of the scheme liabilities. This has had no material impact on the NHS FT's SOCI or SOFP positions.

	2018/19 £000	2017/18 £000
Present value of the defined benefit obligation at 1 April	**(25,389)**	**(25,936)**
Current service cost	(91)	(97)
Interest cost	(650)	(638)
Contribution by plan participants	(14)	(14)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains)/losses	(1,197)	391
Benefits paid	842	905
Present value of the defined benefit obligation at 31 March	**(26,499)**	**(25,389)**

Plan assets at fair value at 1 April	**25,389**	**25,936**
Interest income	759	723
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets (excludes any amounts already included in interest income above)	1,450	379
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling (excluding amounts included in interest income/expense)	(310)	(798)
Contributions by the employer	39	40
Contributions by the plan participants	14	14
Benefits paid	(842)	(905)
Plan assets at fair value at 31 March	**26,499**	**25,389**
Plan surplus/(deficit) at 31 March	**0**	**0**

Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised on the SoFP

	2018/19 £000	2017/18 £000
Present value of the defined benefit obligation	(26,499)	(25,389)
Plan assets at fair value	26,499	25,389
Total net (liability)/asset after the impact of reimbursement rights as at 31 March	0	0

Amounts recognised in the SoCI	2018/19 £000	2017/18 £000
Current service cost	(91)	(97)
Net interest income	109	85
Total net gain / (charge) recognised in SoCI	18	(12)

Notes to the Accounts - 27 Losses and Special Payments

27 Losses and Special Payments

There were 20 cases (33 cases in 2017/18) of losses and special payments totalling £4k (£14k in 2017/18) during 1 April 2018 to 31 March 2019. These are reported on an accruals basis but exclude provisions for future losses.

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000's	Number	£000's
Losses				
Losses of cash due to:				
- theft, fraud	0	0	0	0
- other causes	7	0	4	0
Fruitless payments and constructive losses	0	0	0	0
Bad debts and claims abandoned	0	0	1	6
Damage to buildings, property etc. (including stores losses) due to:				
- theft, fraud etc.	0	0	0	0
- stores losses	0	0	0	0
- other	5	2	1	3
Total losses	**12**	**2**	**6**	**9**
Special Payments				
Compensation under legal obligation	0	0	0	0
Ex gratia payments in respect of:				
- loss of personal effects	8	2	26	4
- other negligence and injury	0	0	1	1
- other	0	0	0	0
Total Special Payments	**8**	**2**	**27**	**5**
Total losses and special payments	**20**	**4**	**33**	**14**

Notes to the Accounts - 28 Third Party Assets

28 Third Party Assets

The NHS FT held £4119k cash at bank and in hand at 31 March 2019 (£3829k at 31 March 2018) which relates to monies held by the NHS FT on behalf of service users.

This has been excluded from the cash and cash equivalents figure reported in the accounts.

29 Post Balance Sheet Events

There are no such events to be reported.

30 Contingencies

There are no contingent assets (recoverable values from third parties).

Contingent liabilities are a possible obligation depending on whether some uncertain future event occurs, or a present obligation but payment is not probable or the amount cannot be measured reliably.

The contingent liability for 2018/19 is in respect of the potential to pay excesses to NHS Resolution in respect of current and ongoing LTPS scheme claims and is per the advice received from the NHS Resolution. In 2017/18 it also included a legal claims where there is a possible obligation, which became a probable obligation in 2018/19 and is shown within legal provisions.

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities	**93**	**212**

31 Commitments under capital expenditure contracts

	31 March 2019 £000	31 March 2018 £000
Property, Plant and Equipment	778	795
Total	**778**	**795**

The capital commitments as at 31 March 2019 relate to the agreement of the final account on a number of projects. The Marlowes Health and Wellbeing Centre and Centenary House refurbishments have completed and are awaiting final account confirmations. Albany Lodge, Forest House and Trust wide fire prevention works account for the majority of the remaining commitments along with retention payments against a number of completed projects.

The capital commitments as at 31 March 2018 relate to the agreement of the final account on a number of projects. The Marlowes Health and Wellbeing Centre and Centenary House refurbishments have completed and are awaiting final account confirmations. Albany Lodge, Forest House and Trust-wide fire prevention works account for the majority of the remaining commitments along with retention payments against a number of completed projects.

Notes to the Accounts - 32 New Accounting Standards

32 New Accounting Standards

32.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £33k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £3k decrease in the carrying value of receivables.

32.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

KPMG

Independent auditor's report

to the Council of Governors of Hertfordshire Partnership University NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Hertfordshire Partnership University NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2019 and the Department of Health and Social Care Group Accounting Manual 2019.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: financial statements as a whole	£4.4m 2% of total revenue
Risks of material misstatement	
	Valuation of land and buildings assets
	Valuation and existence of income and receivables (including revenue recognition)
	Accrued expenditure and provisions recognition

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Land and Buildings (£145.8 million; 2018: £145.5m) *Refer to page 10 (Audit Committee Report), Note 1.6 (accounting policy) and Note 11 (financial disclosures)*	**Subjective valuation** Assets held for their service potential and are in use should be measured at their current value in existing use. In accordance with the adaptation of IAS16 this is interpreted as market value for non-specialised assets and as market value in existing use for specialised assets. Market value in existing use is interpreted as the modern equivalent asset value, being the cost of constructing an equivalent asset at today's cost. Trusts may determine that an equivalent asset would be constructed at a different site or make assumptions about the amount of space required. These should be realistic assumptions about the location and size of site required. Hertfordshire Partnership University NHS Foundation Trust adopts an alternative site valuation methodology for some of its estate. It is necessary to consider whether there is any indication of impairment. Impairment could occur as a result of loss of market value due to conditions in the market or due to deterioration in the value in use of the asset, either because of its condition or because of obsolescence. Valuations are inherently judgemental, therefore our work is focused on whether the valuers methodology, assumptions and the underlying data used to arrived at those, are appropriate and correctly applied during the valuation exercise Hertfordshire Partnership University NHS Foundation Trust undertook an impairment assessment and identified five land and building assets for a desktop valuation at the 31 March 2019.	Our procedures included: - **Assessing valuer's credentials:** We assessed the independence, objectivity and capability of the valuer and considered the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the Department of Health and Social Care Group Accounting Manual; - **Test of detail:** We considered the accuracy of the underlying data provided by the Trust and used by the valuer as the basis of their valuation. We reconciled the data to that used in the prior year and investigated the cause for any changes; - **Benchmarking assumptions:** We assessed the reasonableness of the assumptions adopted during the valuation exercise particularly regarding GIA data and use of the building. Through inquiries with management we identified buildings for which the primary use of the building had changed during the financial year (specialised, non-specialised, surplus) and ensured these changes have been considered during the valuation exercise; - **Methodology choice:** We considered the impairment assessment completed by management regarding assets not selected for external revaluation and considered its reasonableness. In doing so we drew on national benchmarks; - **Our sector expertise:** We considered the revaluation basis and benchmarks used by the valuer. We engaged our valuation expert to undertake an assessment of the revaluation; and - **Application of the valuation:** We considered the appropriateness of the accounting treatment applied by the Trust when recognising revaluation gains or losses on individual assets. **Our findings** We found the resulting valuation of land and buildings to be balanced.

	The risk	Our response
Total Operating Income and Receivables (£235.6 million; 2018: £230.3 million) Total receivables (£7.8 million; 2018: £11.6 million) *Refer to page 11 (Audit Committee Report), Note 1.3 (accounting policy) and Notes 4 and 16 (financial disclosures).*	**Subjective estimate** Of the Trust's reported total income, £202.7m (2017/18 £198.1m) came from commissioners and local authorities. CCGs and local authorities make up 86% of the Trust's income. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPI's then commissioners and its local authorities are able to impose fines, reducing the level of income achievement. This results in estimates being required at the year end. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. Discrepancies between the submitted balances from each party can result in adjustments being made to yearend balances. The recognised £3.5 million of income from the Provider and Sustainability Fund. Receipt of this income is contingent on achievement of quarterly financial targets agreed with NHS Improvement. The availability of these funds can act as an incentive for management to make adjusts to its position to ensure these targets are met. There may therefore be an incentive to accrue income and reduce provisions relating to doubtful debts in order to achieve the control total agreed with NHS Improvement.	Our procedures included: **Control operation:** We undertook the following tests to assess whether controls had operated during the period: — We agreed a sample of commissioner and local authority income balances to signed agreements. We assessed contract variations identified and sought explanations as to the cause of these variances; and — We considered the extent to which the Trust had agreed the income and receivable balances it was entitled to for 2018-19 through its participation in the Agreement of Balances exercise. **Tests of detail:** We undertook the following tests of detail: — We inspected supporting documentation for variances over £220,000 arising from the Agreement of Balances exercise to critically assess the Trust's accounting for disputed income and its yearend receivable balance; — For income and receivables not included within the Agreement of Balances exercise we inspected supporting evidence, including invoices and receipt of cash on bank statements, for a sample of transactions recorded during the year; — We assessed the Trust's calculation of performance against the financial and operational targets used in determining receipt of Provider Sustainability Funding to determine the amount the Trust qualified to receive. We agreed the amounts recorded in the accounts to our calculation; — We considered the basis upon which provisions for non-NHS debt have been made. We tested the assumptions taking into account both past performance and circumstances specific to the financial year end; and — We tested income transactions that spanned the financial year end to assess whether the income had been recognised in the correct financial period. **Our findings** We found the resulting estimates made by the Trust in relation to income and receivables to be balanced.

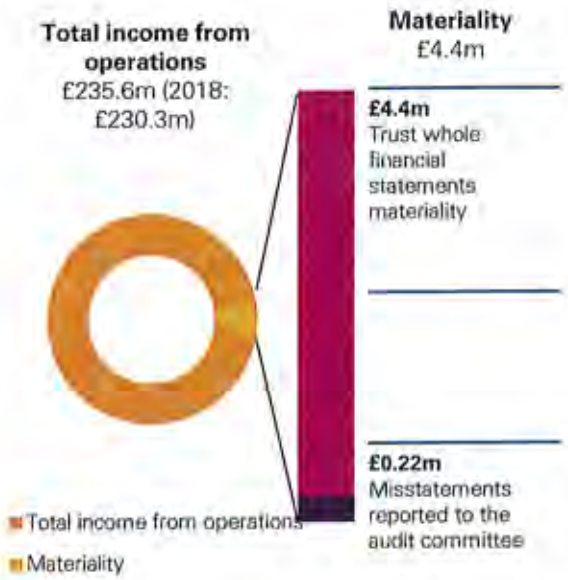
	The risk	Our response
Accrued expenditure and provisions recognition **NHS and Non-NHS Accruals** (£15.7 million; 2018: £18.7m) *Refer to page 12 (Audit Committee Report), Note 1.2 (accounting policy) and Note 21 (financial disclosures).* **Total Provisions** (£7.6 million; 2018: £9.8m) *Refer to page 12 (Audit Committee Report), Note 1.11 (accounting policy) and Note 20 (financial disclosures).* **Provision for doubtful debts** (£0.1 million; 2018: £0.4) *Refer to page 12 (Audit Committee Report), Note 1.11 (accounting policy) and Note 16 (financial disclosures).*	**Effects of irregularities** In the public sector auditors consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay expenditure at year-end, as well as the completeness of the recognition of provisions or the inappropriate release of existing provisions The Trust agrees a target for its financial performance with NHS Improvement for 2018-19, achievement of which entitled it to Provider Sustainability Funding. There may therefore be an incentive to defer expenditure, or recognise commitments at a reduced value in order to achieve the control total agreed with NHS Improvement.	Our procedures included: – **Test of detail:** We tested expenditure transactions that spanned the financial year end to assess whether the expenditure had been recognised in the correct financial period; – **Test of detail:** For a sample of accruals recognised at the financial yearend we assessed the appropriateness of the existence of the accrual and the reasonableness of the accrual valuation; – **Test of detail:** We confirmed the basis upon which the provision for doubtful debt had been made. We tested the assumptions taking into account both past performance and any circumstances specific to the year ended 31 March 2019; and – **Test of detail:** For a sample of year-end provisions we assessed the appropriateness of the recognition of the provision balance and assessed the assumptions used by management in valuing the provision. **Our findings** We found the estimates used in calculating the expenditure balances in relation to yearend accruals and provisions to be reasonable.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4.4 million, determined with reference to a benchmark of total income from operations (of which it represents approximately 2%). We consider total income to be more stable than a surplus or deficit related benchmark.

We agreed to report to the Audit Committee corrected and uncorrected identified misstatements exceeding £0.22 million, in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's premises in St. Albans, Hertfordshire.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement on pages 90-91 to the annual report on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on pages 90-91 the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006; or
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017 as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

Our risk assessment did not identify any significant risks

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Hertfordshire Partnership University NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Neil Hewitson
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
15 Canada Square, London
E14 5GL
24 May 2019

KPMG

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated TAC02 to TAC29 for tables outlined in red, excluding TAC05A and TAC23 of Hertfordshire Partnership University NHS Foundation Trust for the year ended 31 March 2019, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Hertfordshire Partnership University NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.2 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also included in the audited financial statements.

Auditors are required to report on any differences over £300,000 between the audited financial statements and the consolidation schedules.

Unqualified audit opinion on the audited financial statements; no differences identified

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Neil Hewitson
Director
KPMG LLP
Chartered Accountants
15 Canda Square
London
E14 5GL

24 May 2018

www.hpft.nhs.uk
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