NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Annual Report and Accounts 2020/21

as One

Our Values
Welcoming Kind Positive Respectful Professional

Hertfordshire Partnership University NHS Foundation Trust Annual Report and Accounts 2020/21

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

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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 with a reflection on the impact of the coronavirus pandemic and the significant future changes.

The Annual Report has been prepared on the same basis as the Annual accounts and provides a fair, balanced and understandable analysis of how the Trust performed in 2020/21. The Report provides the necessary information for service users, 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.

Sarah Betteley, Chair
Dated: 11 June 2021

Tom Cahill, Chief Executive
Dated: 11 June 2021

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 Trust's performance provides a fair, balanced and understandable analysis of how the Trust performed in 2020/21.

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.

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 and North Herts Clinical Commissioning Group (CCG), Herts Valleys CCG and Hertfordshire County Council. Our income is largely paid as a fixed sum which is subject to the national annual adjustment to reflect inflation and the efficiency expectation. Additional income sums are also negotiated annually with commissioners for new services or variations in existing service agreements. This is largely secured through commissioners complying with the Mental Health Investment Standard requirement to ensure that the investment in mental health services as a minimum grows each year in line with the growth in the commissioner funding allocation.

For 2020/21 the existing routine financial arrangements were altered to support NHS organisations responding to the COVID-19 pandemic. This is described in section 1.1.5 below.

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 continuing 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 remain an outstanding Trust. We are working towards this vision by focussing on four themes that will underpin our working during 2021/22.

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.

The 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).

The Trust is committed to ensuring there is equality of access to services for all our service users. During this period the Trust undertook a partial regrading of (Equality Delivery System 2) EDS2 in the absence of EDS3 being published and the results of which are published on our website https://www.hpft.nhs.uk/about-us/equality-and-diversity/our-performance/

This report covers the year ending 31 March 2021.

1.1.2 Performance Overview from Chief Executive and Chair

The past year has been one of the most challenging and difficult periods we have ever faced in our country's peacetime history. The COVID-19 pandemic has touched everyone and changed our way of life in a manner that many of us have not experienced in our lifetime. The pandemic's effects on daily life, working arrangements and personal wellbeing have had an immense impact on our service users, their carers and families and on our staff and teams. Despite these challenges, our staff have responded magnificently, rapidly embracing different ways of working and new technologies to help provide our service users with the care and support they need, even when face to face meetings have not been possible and 'going the extra mile' at every call. All our services have remained open and we established processes to ensure that anyone in mental health crisis could come directly to us rather than needing to attend a local Accident and Emergency department.

Very sadly, we lost a number of service users and two colleagues to the virus. Each one is an individual tragedy and leaves families and friends grieving. We paid our own collective tributes on the National Day of Reflection on 23 March and were pleased to join with people in an opportunity to pause and reflect.

Working with our system partners in Hertfordshire, Buckinghamshire, Essex and Norfolk we delivered the majority of our priorities, making considerable progress across all seven of our strategic objectives and targeted outcomes for the year. We fully delivered our planned outcomes for four out of seven objectives:

- **We will provide safe services**, so that people feel safe and are protected from avoidable harm.
- **We will improve the health of our service users** through the delivery of effective evidence-based practice.
- **We will improve, innovate and transform our services** to provide the most effective, productive and high quality care.
- **We will shape and influence the future development and delivery of health and social care** to achieve better outcomes for our populations.

For the remaining three objectives, we still delivered more than half of the individual key milestones, have made good progress and will continue to focus on them. Our performance was impacted both by the response to the COVID-19 pandemic and increased demand, especially for our crisis services:

- **We will deliver a great experience of our services**, so that those who need to receive our support feel positively about their experience.
- **We will attract, retain and develop people** with the right skills and values to deliver consistently great care, support and treatment.
- **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.

Overall, our response to COVID-19 gave us the opportunity to make bold changes to the way we work with service users and collaborate with partners. As a result:

- We have had more contact more often with service users and in more ways than ever before.
- We have developed our approaches to risk and our physical health capabilities.
- We have become accustomed to overcoming problems and facing new challenges.
- We have become better integrated by working across disciplines and organisational boundaries.
- We have developed our capabilities and strengths so that we are ready to continue our focus on delivering great care and great outcomes in the coming year.

The unexpected yet extraordinary achievement from 2020/21 was receiving the prestigious Health Service Journal (HSJ) Mental Health Trust of the Year award. This is a real testament to the tremendous hard work of our staff and their commitment to making a difference to the lives of our service users and carers, not just over the past year but over many years. The award judges said they were “blown away” by how the Trust always puts service users at the heart of everything, as well as our commitment to continuous innovation and partnership working to improve care and outcomes, even throughout the pandemic. They were also highly impressed with our culture of keeping everyone safe from harm, which is at the core of the organisation. The sense of achievement has been felt by everyone in HPFT and we have encouraged our teams to reflect and feel proud of their contributions.

The NHS's annual staff survey is a key opportunity for our people to tell us about their experiences of working at HPFT. Their feedback is a valuable tool in helping us make the Trust a great place to work. In the results of the 2020 survey, we scored above the national average in comparison to the other 51 mental health and learning disability trusts in England for seven of the ten survey themes. In particular:

- 76 per cent of staff would recommend HPFT as a place to work – second highest score.
- 88 per cent of staff say that care of service users is HPFT's top priority – second highest score.
- 92 per cent of staff say they know their role makes a positive difference to our service users – third highest score.
- 76 per cent of staff would recommend HPFT as a place to receive treatment and care – seventh highest score.

There were three areas where we scored below the average in comparison to our peer trusts:

- Bullying and harassment, especially from service users, relatives and the public.
- Violence from service users, relatives and the public.
- Equality, diversity and inclusion, especially in relation to fairness in career progression and promotion, and also discrimination on the basis of ethnicity from service users, relatives and the public.

We are very clear that any form of bullying, harassment or violence or discrimination from whatever source, is unacceptable. We will focus on plans to tackle these issues during the coming year.

Over the past year, keeping our staff up to date and helping them feel informed and well cared for has been more important than ever. With more people working remotely, we have adapted our internal communications channels and introduced more online and virtual briefings and events. These include a fortnightly online *Catch up with the Execs* session which is open to all staff and gives people the chance to hear from members of the executive team and to ask questions. Teams tell us they feel more connected with the organisation and better informed, especially those based outside Hertfordshire. In December, we held our annual Staff Awards ceremony via a webcast. It was heartening to see teams and individual colleagues taking part and sharing in each other's successes, albeit virtually. Over the coming year we will review the effectiveness of our internal communications with our teams and will continue with some of the online and virtual channels which have worked so well over the past year.

Working with our consultant psychiatrists, we introduced specific emotional help and support for staff around the personal and professional impact of COVID-19 and this was very much welcomed. Working with our system partners in Hertfordshire and Essex, we introduced our *Here for You* emotional wellbeing and support service alongside Essex Partnership University NHS Foundation Trust (EPUT). The service provides 24/7 confidential support for anyone working in health and social care, voluntary and not-for-profit organisations in Hertfordshire and Essex, including staff whose work base is further afield. Our staff can still access our own occupational health and employee assistance programmes for support.

Despite the challenges of the past year, we continued to introduce innovative new services to help support people with mental health needs and learning disabilities. Highlights include:

- **Our Blue Box project which supports physical healthcare in a mental health setting** – our Older People's Service introduced remote physical health monitoring for a pilot group of 60 service users. The Blue Box contains Bluetooth-enabled devices to measure vital observations including blood pressure, blood oxygen and glucose levels which are automatically uploaded to the service user's clinical record.
- **Our new Criminal Justice Liaison and Diversion Team's screening and assessment service for vulnerable individuals involved in the criminal justice system in Hertfordshire** – a team including psychologists, nursing practitioners, social workers, support, time and recovery (STAR) workers and administrators provide assessments, services and advice, working alongside the police, courts, probation services, prison in-reach services and other organisations. The team helps ensure the criminal justice process is safe, fair and takes people's vulnerabilities into account.
- **Our Improving Access to Psychological Therapies (IAPT) service's innovative online webinar series to support people in dealing with grief and loss** - the four-part series offers ways to learn more about living with grief and loss, dealing with difficult conversations, thoughts and beliefs about grief and moving on. The series is facilitated by two trained and experienced therapists. Additional pre-recorded webinars cover other topics, including mindfulness, worry and sleep.
- **Our free webchat service** – available from 7am to 7pm Monday to Friday, the service is open to all Hertfordshire residents experiencing mental health problems but who would prefer to talk to a member of our team online rather than by phone. The service helped over 1,100 people in its first two months and continues to be popular.

As well as being awarded the HSJ's Mental Health Trust of the Year, we were successful in other award schemes during the year:

- **Health in Mind, our North East Essex IAPT service, and North East Essex Diabetes Services (NEEDS) won the Mind and Body Together category of the 2020 Quality in Care (QiC) Diabetes Awards** for their innovative diabetes pathway. This offers access to a specialist wellbeing and diabetes course, co-located clinics and individually tailored therapy sessions delivered by a therapist with additional knowledge about diabetes.
- **Psychiatrists from HPFT's North Essex Learning Disability services won first and second prizes in a prestigious annual poster competition run by the Royal College of Psychiatrists' Faculty of Intellectual Disability** - first prize was awarded to the team for their poster on improving physical health outcomes in an enhanced clinic, with second prize for a poster describing a survey into the impact of COVID-19 on the mental wellbeing of patients with intellectual disability.
- **We were shortlisted for three of the Royal College of Psychiatrists awards in 2020 -** Dr Dilini Jayalath, consultant working with service users with dementia, was shortlisted for the Speciality Doctor/Associate of the Year award; our CAMHS Dialectical Behaviour Therapy (DBT) Service was shortlisted for the Psychiatric Team of the year (Children and Adolescent) award and our Buckinghamshire Community Learning Disability Team was shortlisted for the Psychiatric Team of the year (Intellectual Disability) award.
- **Our CAMHS Dialectical Behaviour Therapy (DBT) Service was shortlisted** for both the Team of the Year and the Nursing in Mental Health categories **in the 2020 Nursing Times Awards.**
- **We were shortlisted in two categories of the Health Service Journal Patient Safety Awards** – our safety culture approach was shortlisted for the Changing Culture Award and our medicines optimisation clinic was shortlisted for the Improving Safety in Medicines Management Initiative category.

Although it has been a positive year for the Trust we recognise that the experience for some service users and staff is not always as good as we would want it to be. We are determined to continuously improve and learn from feedback we receive.

Looking forward to 2021/22 we have a significant transformation programme to improve outcomes and the experience for service users. We will continue to improve our services including meeting our Long-Term Plan commitments for our Early Intervention in Psychosis; Individual Placement, Community Perinatal, IAPT and community mental health services. We recognize the important role carers play in the support and outcomes for our service users and this coming year will see us further improve our engagement and support for them.

Our capital programme includes schemes that will improve the environments for service users and staff and ensure we are best placed to provide high quality services in the years to come and also support the continued rollout of the Trust's digital strategy and our adoption of a continuous quality improvement approach. The pandemic has brought increased focus on our work to improve the physical health care of those suffering a mental health need or with a learning disability and the coming year will see us stepping up our existing improvement work in this area.

Increasingly we have been working collaboratively with other organisations to improve care. We will continue to work with others trusts to develop a joined-up approach to mental health care; across the East of England to transform specialist mental health care and services for those with Learning Disabilities, and in Essex, where in partnership with

Essex Partnership University Trust we are working to transform learning disability services.

We see this collaborative approach accelerating during the coming year. In Hertfordshire we will, together with others, complete the work to establish a Collaborative focused on improving outcomes for those with mental health needs and/or learning disability. In Norfolk, together with other local providers and the local commissioner we will be setting out a plan to provide improved and integrated learning disability services.

Throughout the year, our Board and our Governors have continued to provide valuable support, helping us to engage with our services users, staff and communities. In December, we said a fond farewell to our former Chair, Chris Lawrence, who had led the Board for over six years. Chris oversaw significant developments for HPFT, including introducing services in Essex, Norfolk and Buckinghamshire, our Good to Great strategy and receiving an overall rating of *Outstanding* from the Care Quality Commission. To mark Chris' contribution to the Trust, we have named our innovation hub at the Colonnades building in Hatfield after him. We will miss Chris a great deal and wish him all the best for the future.

During the year, we also said goodbye to three other non-executive directors - Loyola Weeks, Tanya Barron and Janet Paraskeva – all of whom have made significant contributions to the organisation. With their departures, we have welcomed three new non-executive directors to our Board – Anne Barnard, Tim Bryson and Patrick Vernon - and an associate non-executive director, Kush Kanodia, to replace Sarita Dent who also left the Trust in 2020. Looking forward, we welcome John Walmsley to the Board as a non-executive director. Jon has served as a Trust governor for many years and most recently as the Lead Governor, he will bring a further source of experience and expertise. We have also welcomed Barry Canterford as our new Lead Governor.

We have never been more proud of our colleagues and teams and of the care they provide to our communities, supporting people when they and their families and loved ones need it most. The challenges posed by the COVID-19 pandemic will continue into the coming year, but we are confident our teams will continue to meet them.

Signature  Sarah Betteley, Chair Dated 11 June 2021	Signature  Tom Cahill, Chief Executive Dated 11 June 2021

1.1.3 Key Issues and risks that could affect delivery of the Trust's objectives, its future success and sustainability

The Trust has identified the key risks, issues, opportunities that could affect our ability to achieve the goals set out within our 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 2021/22 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 and utilising digital technology. • Reviewing staffing establishment and introduce new roles. • Improving processes and systems within our Single Point of Access. • Utilisation of trust's internal information system (SPIKE2) 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 workforce 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.	• Reseting key expenditure controls. • Use of internal and external performance metrics to identify opportunities for improvement. • Independent quality impact assessment assurance. • Clinically led support to identify efficiency opportunities.

		• Routine use of Continuous Quality Improvement processes to identify and implement opportunities for improvement. • Adoption of digital innovations where this improves value for money. • Working with partner organisations to provide more effective pathways and economies of scale.
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 ICS. • Development of Mental Health and Learning Disability Collaborative.

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 ill health or a learning disability. Our Board reviews this regularly, and the Trust provides strong leadership within the local Integrated Care System (ICS) and maintains good relationships with commissioners, local providers and other key stakeholders.

1.1.4 Going Concern Disclosure

The accounts have been prepared on the basis that the Trust continues to operate as a 'going concern', reflecting the ongoing nature of the services provided. The 2020/21 DHSC Group Accounting Manual now states that the anticipated continued provision of services is a sufficient basis for the application of going concern in the preparation of its Annual Accounts. After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. This is based upon consideration of the rollover of the previous year's funding arrangements with commissioners and the discussions over the variations in service investments to be made in the next financial year 2021/22. The Trust has also prepared detailed cash flows which demonstrate the Trust has sufficient cash reserves to meet its key operations over the next 12 months from the date of signing this report. For these reasons, we continue to adopt the going concern basis in preparing the accounts. In making these enquires the directors have made full consideration of any risk relating to the impact of COVID-19.

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

The financial framework was revised by NHSI/E for 2020/21 to support the response to the national COVID-19 pandemic. Initially a number of changes were made for the first four months of the financial year which were then extended to 30 September 2020. These arrangements were then amended and the revised financial framework continued throughout the second half of the year.

The key features of the revised arrangements were;

- A suspension of the normal contract arrangements with the income allocations between commissioners and providers set by NHSI/E based upon values in M8-10 of 2019/20 adjusted by a top up amount to cover any movement in costs.
- The reimbursement of the additional costs incurred by organisations related to the response to COVID-19. For the second half of the year this was amended to being a fixed sum based upon the additional costs of COVID-19 reimbursed to organisations during the first three months of 20/21.
- Further adjustments were then made to the block payment arrangements by NHSI/E to reflect matters such as the application of a de minimis value for transactions between NHS organisations. This either resulted in additional funding or a reduction.
- As an extension of the arrangements that applied to NHS Trusts each ICS was provided a Capital Resource Limit which set the aggregate amount of capital that could be spent within the ICS for the year. This total sum was then allocated amongst all individual ICS organisations and this was regularly monitored and reported within the ICS. Whilst as an FT the Trust had no statutory duty to comply with this requirement, the Trust worked to this limit recognising its role to support the wider ICS policies and objectives.
- Suspension of both CQUIN arrangements and any application of contract penalties.

The above arrangements ensured that all NHS organisations achieved a break even position in the first half of the year and NHSI/E set financial plans accordingly for each organisation. Trusts were required to set a financial plan for the second part of the year as part of an ICS wide return.

The initial Financial Plan was set for months 7 to 12 with a £1.2m deficit. This reflected the level of risk in moving to a fixed sum allocation being provided to meet the additional costs relating to COVID 19 and from the additional demand and workforce pressures that were anticipated in the second half of the year. The Trust has reported a financial performance better than forecast with an adjusted financial surplus (before impairments and other items excluded by NHSI/E in assessing financial performance) of £6k. This reflects additional unplanned income from NHSI/E, lower pay costs and a reduction in the Public Dividend Capital dividend paid this year arising from the higher cash balance that the Trust held.

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 and reflect the domains of the NHS Oversight Framework (para 1.2.2). The reporting of these includes the trends in performance as well as deep dives into specific issues requested by the Board and its sub-committees.
- Regulatory requirements from NHS Improvement and others.
- The contractual measures reported regularly to commissioners and other partner organisations.
- Progress on the Trust Annual Plan and the achievement of the related objectives.

Our ambition to become an information-led organisation has resulted in the continued development of our business intelligence system: SPIKE2 and we are implementing a Modelling for Improvement Tool which helps us track a service user's journey through our service. This helps support our teams' performance by improving their access to high quality, real time information that enables them to manage and develop their services in a way that provides the best quality care.

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 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.

During this period the Trust continued to be placed by NHS Improvement in segment 1 with no enforcement action taken by the NHS Improvement.

The performance framework

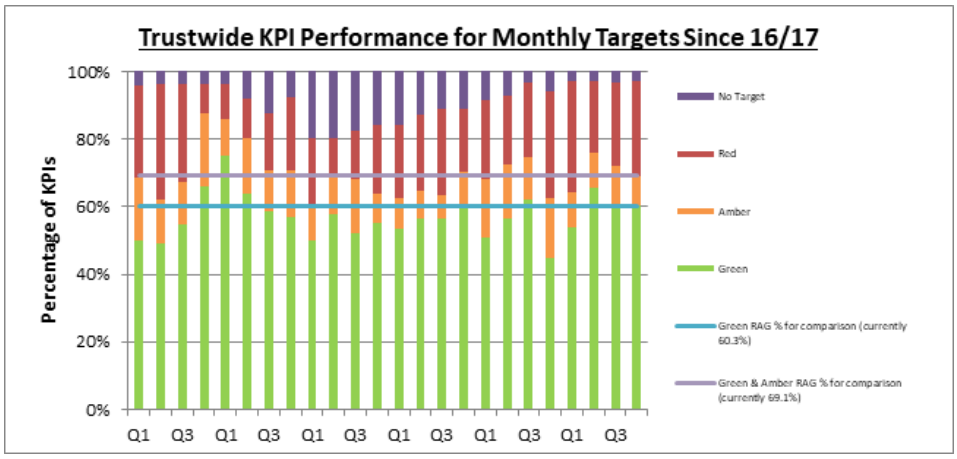
Our Performance Framework is grouped under 5 different areas, with a total of 67 KPIs, reported monthly and/or quarterly.

- NHS Oversight Framework SOF (6)
- Access (24)
- Safe and Effective (25)
- Workforce (7)
- Finance (5)

The Trust's Performance remained strong despite the COVID 19 pandemic. We maintained our access times for services and improved upon some key areas of performance, such as physical health checks.

Our Inpatient Services showed unfaltering resilience in a year of unprecedented challenge, facing a sickness rate of circa 26% during points of the pandemic and at its peak over 50% of our wards with at least one COVID-19 positive patient. Infection rates remained remarkably low as a result of infection control measures and the design of our estate.

Overall we did see an improvement in the areas of sickness and turnover. We successfully responded to the fluctuations in demand throughout the year, due to factors such as the periods of 'lockdown' and subsequent impact of suppressed demand.

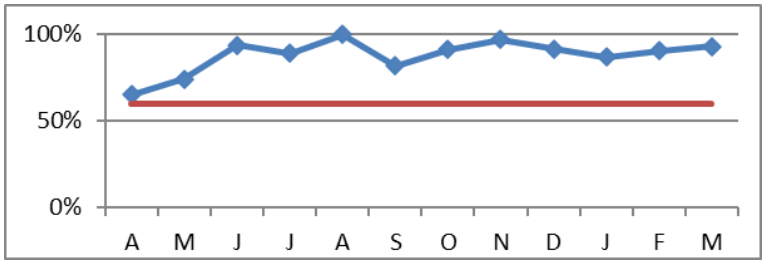


NHS Oversight Framework

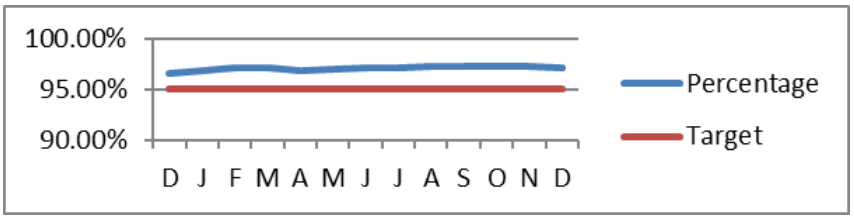
There are six Key Performance Indicators (KPIs) under this domain. Over the year we consistently met five out of six KPIs. The exception is the number of people referred to out of area beds which has been high in the first and latter part of the year. We are now seeing improvements in this area, however the local and national picture reveals that all secondary care services are challenged, particularly when it comes to finding beds in the South East of England.

The charts below show how we performed over the year against each of our six indicators.

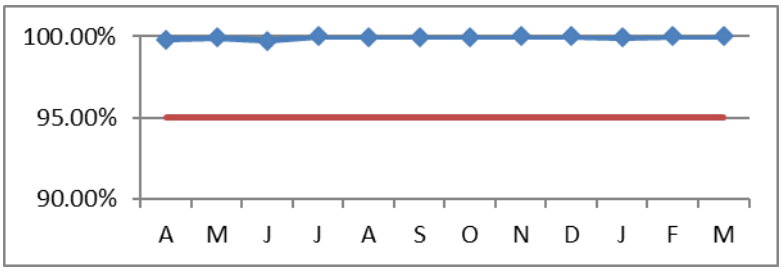
- People with First Episode Psychosis receive treatment within two weeks of referral



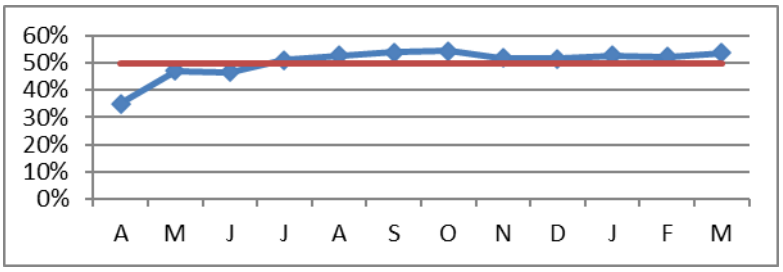
- Data Quality Maturity Index (reported three months in arrears)



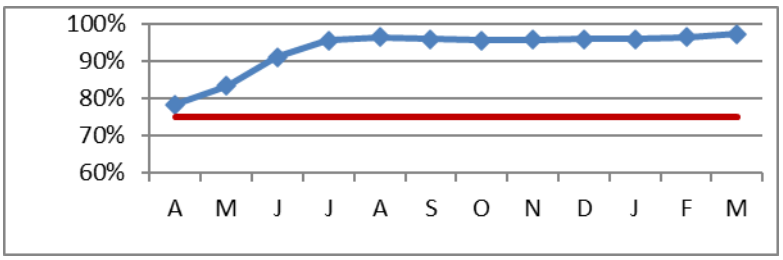
- Improving Access to Psychological Therapies (IAPT) (18 week access)



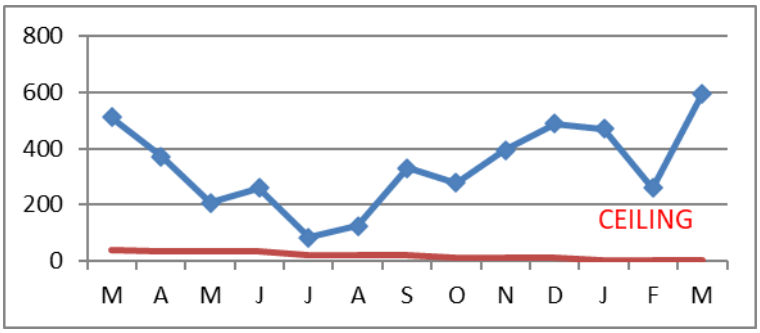
- Improving Access to Psychological Therapies (IAPT) recovery (Target 50%)



- IAPT waiting time to receive treatment (within six weeks)



- Inappropriate Out of Area Placements

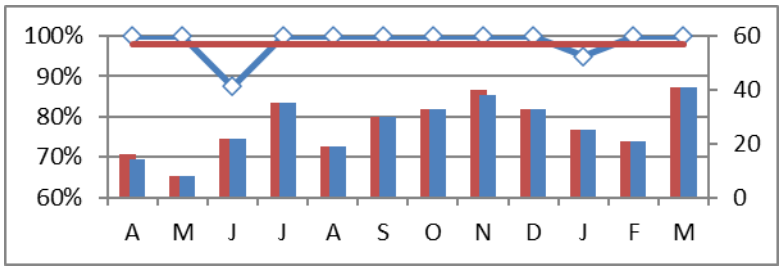


Access

Throughout the year we have almost met or exceeded our internal target of 98% of all people to be treated within 18 weeks of referral to us and on average we met or exceeded 15 out of our 24 access indicators.

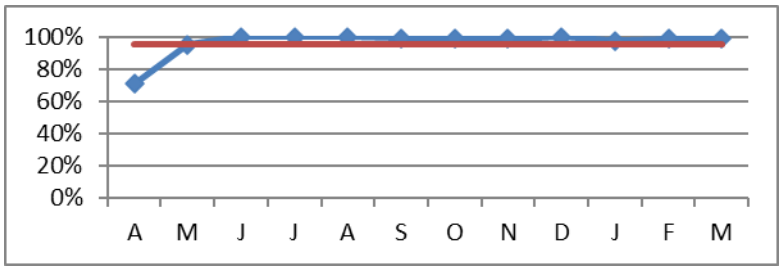
Despite challenges from COVID-19, we maintained last year's improved performance against waiting times for Adult Services, Children's Services and Older People's Services. Charts setting out performance against these key indicators are shown below.

- 28 Day Waiting Time for People with Learning Disabilities

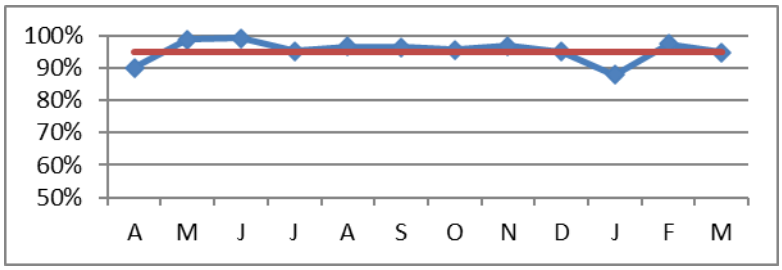


Bars show numbers accessing the service

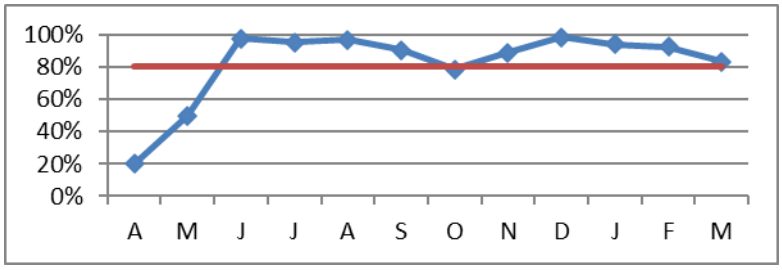
- CAMHS 28 Day Waiting Time



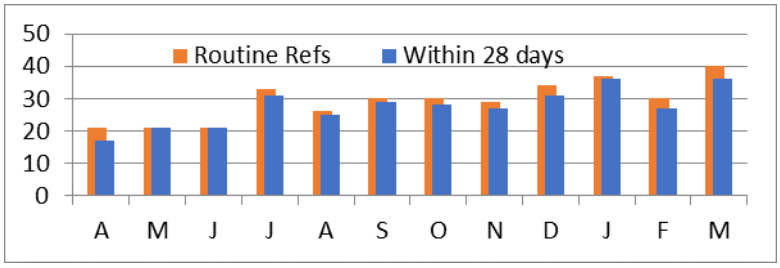
- 28 Day Waiting Time for Adult Community Mental Health Services



- Early Memory Diagnosis Assessment (within 12 weeks)



Some areas of challenge for access were routine waits for Adult Eating Disorder Services, where we saw an increased level of referrals. We are currently working with looking with our commissioners at how this new level of demand can be met.



Access across all of our five Wellbeing Services was below target, due to a lack of referrals during the COVID-19 pandemic. We are expecting levels to rise, as COVID-19 restrictions are lifted.

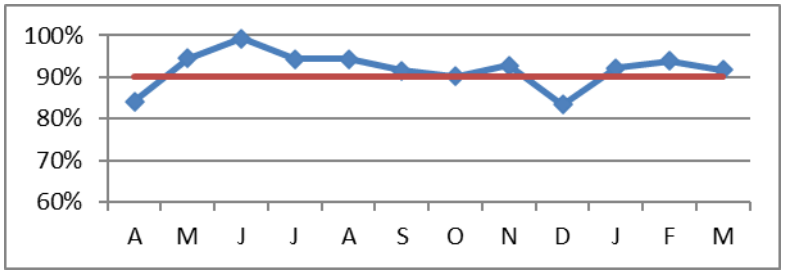
"The understanding care and support was life changing. The regular reviews made us feel that someone cared and supported us. If we had any problems we had someone to talk to face to face who helped and understood my condition".
Carer Older People's Services

Safe and Effective
There are 25 Safety and Effectiveness Key Performance Indicators which describe our performance in terms of safety, experience, quality and data. On average, fourteen were fully met, four were almost met, and seven where we have been focussing improvement activities over the year.

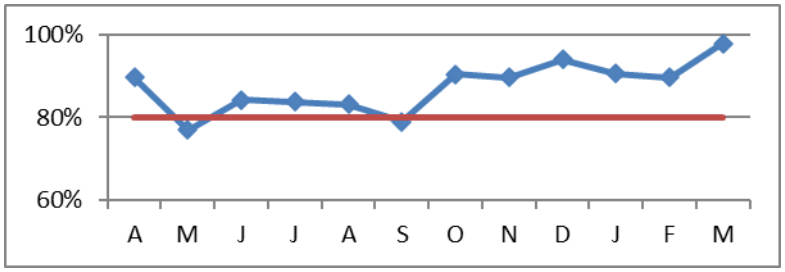
Areas in which we have performed particularly strongly are service users recommending our services to friends and family if they needed them, service users saying that they know how to get advice and support in a time of crisis and the number of people discharged from inpatient units who are followed up within 72 hours.

Charts showing performance against some of our key safe and effective indicators are shown below:

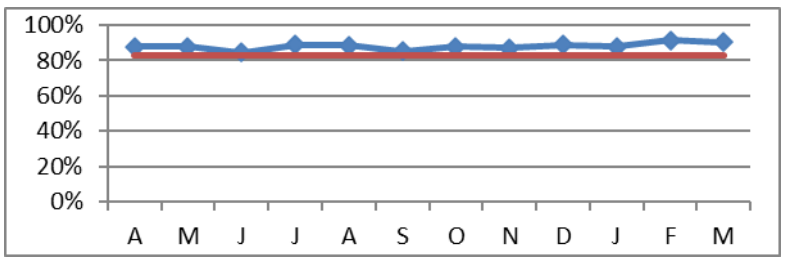
- People followed up within 72 hours of discharge from an inpatient unit



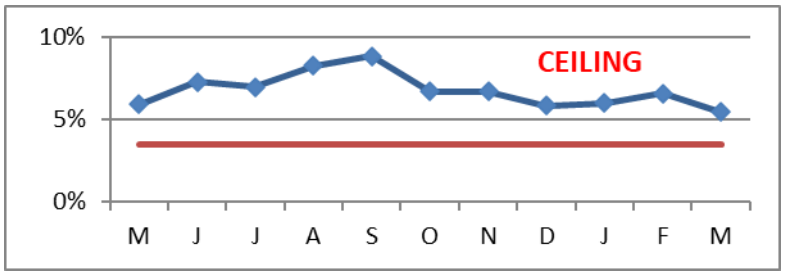
- Service Users Recommending our Services to Family and Friends if they need it



- Service Users who know how to access support and advice in a crisis

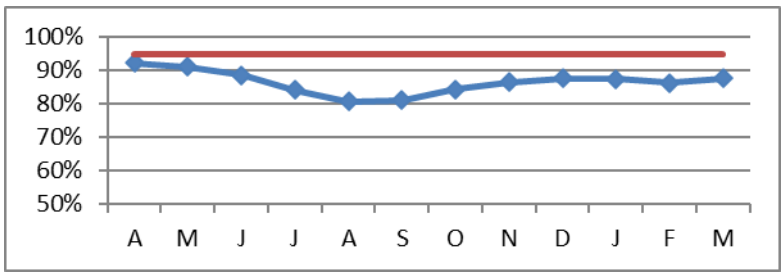


- Delayed Transfers of Care



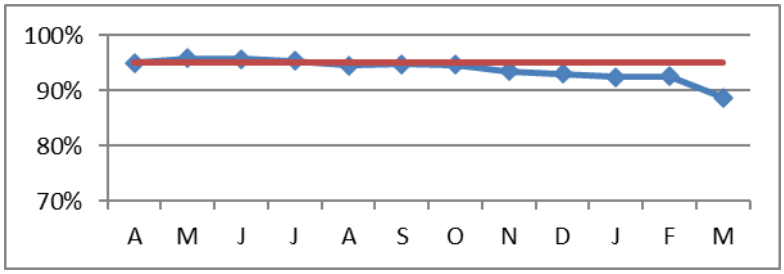
Indicators that have not been met in the year were largely due to the pressure of COVID-19 and have trajectories for recovery now in place. Delays in transferring people from our care to other resources did see an increase due to COVID-19, but has now fallen to a similar level to pre-COVID performance. Maintaining 95% of annual reviews for people on the Care Programme Approach during COVID restrictions was also a challenge. The position is improving and is expected to be met by the end of the first quarter of 2021/22.

- Annual reviews for people on the Care Programme Approach.



Maintaining 95% of people having a formal, annual risk assessment review, again affected by COVID-19. A co-produced piece of work is currently underway to improve the risk assessment process for our service users.

- Formal, annual risk assessment review

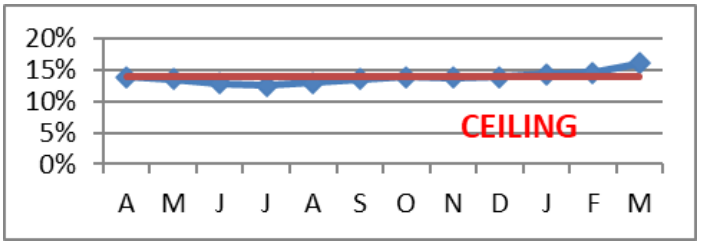


Workforce

Across 2020/21 we have made significant progress in attracting and retaining staff particularly during the pandemic. We have met our targets for the year and strive to make our organisation a great place to work for everyone. We received very positive feedback from the national staff survey, section 2.3 (Staff Report) provides more detail. We have developed new ways of recruiting to address staff turnover in particular areas and services

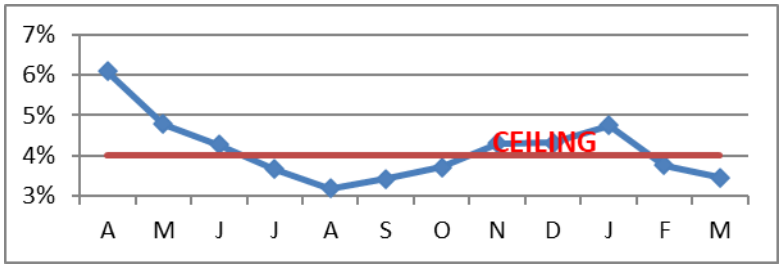
and continue to work hard to retain our experienced and committed staff members as well as attracting new talent to our services. Staff turnover has been consistently on target over 2020/21 as summarised in the chart below.

- Staff Turnover Rate



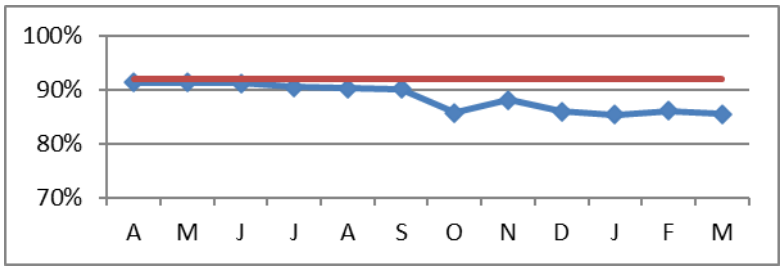
Seasonal illnesses have meant that our consistently low sickness rate rises to just under 5% in the winter months and during the peak of the pandemic. An increased focus on inoculating staff against flu and COVID-19 has had a positive impact on our sickness absence rates this year and in particular over the winter. The wide range of wellbeing activities and services offered across the Trust help maintain physical and mental wellbeing in our workforce. The chart below shows staff sickness rates over 2020/21. It is worth noting that the increase in sickness in April 2020 is a result of COVID-19 which, at one stage, meant that 26% of our workforce was absent. Fortunately this position had recovered by the beginning of May and whilst absence is high by normal standards the peaks and troughs reflects the seasonal patterns along with the impact of the COVID-19 pandemic.

- Staff Sickness Rate



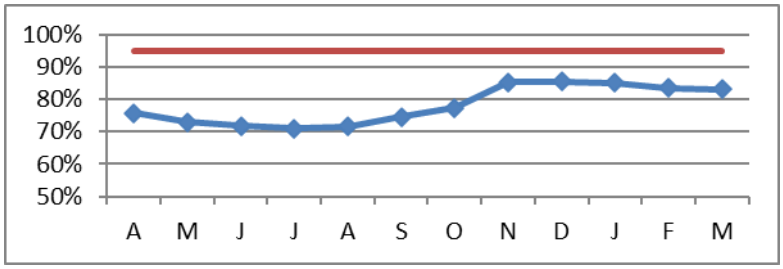
Areas of challenge in the year were, meeting our 92% target for mandatory training, due to the inability to hold face to face training during the pandemic. Improvements are now being seen, with face to face training recommencing.

- Mandatory Training



PDP and Appraisal rates remained below the 95% target throughout the year, due to staffing pressures during the pandemic. A revised, more user friendly, appraisal format is being launched and improvements are expected for Quarter 1 2021/22.

- PDP and Appraisals



Digital

Despite having to reprioritise our resources to respond to the pandemic, we made significant progress in the implementation of our digital strategy. In 2020/21, we developed a chatbot with artificial intelligence that will help our IAPT service users and carers to access self-help resources and support them with engaging our service. We also procured and started implementing a digital solution that will enable our service users and carers to report their clinical outcomes online more regularly, should they wish to do so. This will help us better understand and improve outcomes for our service users and carers.

Significant progress on interoperability across our systems was made, which will also pave the way to safely and securely sharing information with other NHS organisations where appropriate. We also selected and started implementing an electronic prescribing and medicines administration system that will improve the safety and quality of our services across the Trust. To help improve cyber security and also to help reduce the administrative burden to staff we started to implement the single sign-on system.

Analysis of Financial Performance and Financial Overview

Our track record of solid financial performance continues this year and we have again been able to invest in improvement at the same time as maintaining strong financial control. Draft accounts for the financial year 2020/21 were completed and submitted to NHSI/E and the external audit completed in line with national timetable. The Trust has reported a normalised surplus of £6k for the year against a planned deficit of £1,200k.

As noted above the intended financial framework was suspended throughout the year and amended arrangements made. This saw all NHS organisations being provided with additional COVID-19 related revenue either through the reimbursement of specific costs incurred or from financial sums assessed and awarded by NHSI/E. This amounted in 2020/21 to £10.7m and was used to meet the additional costs in responding to the pandemic which included; additional pay costs to cover both staff absence and the additional inpatient staffing required, the additional infection prevention and control costs, and the costs of supporting staff to work remotely.

The Trust invested £17.2m in capital assets in the year and had capital disposal proceeds of £0.5m. The capital spend included £4.6m on the design and build of four new safety suites (to be completed in early 2021) £8.2m on building and site developments to improve patient and staff facilities and £1.2m of digital investment. This investment was funded from additional PDC of £2.7m and remainder from internal cash and working capital.

The Trust has continued to provide for future liabilities. These are, in line with the previous year, including pensions, injury benefit, CHC building dilapidations and future service changes expected.

Important events since the end of the financial year affecting the Trust
Throughout the year the Trust has responded to the COVID-19 pandemic, this has seen our Trust implement its Business Continuity Plans, adapt our services and ensure our staff are supported to provide great care to our services users. The pandemic will continue to have an impact on both demand levels and acuity. It will also have an impact on staff and their wellbeing. The Trust has and will continue to work consistently and innovatively to meet the needs of its existing and new service users.

We will work with partners, staff and service users to support recovery, adopting good practice and learning from our response to the pandemic. We will work hard to ensure we continue our strong financial performance against what will be a challenging environment.

The NHS White Paper is due to become legislation in 2021/22 and the impact on Foundation Trusts is emerging. During the year ahead the Trust will 'go live' with the East of England Provider Collaborative and there is likely to be further development of other Collaboratives in the system including one for Mental Health and Learning Disabilities.

Conclusion and looking ahead
Our performance has stayed strong during the year in the key areas of access to services, safety and also the recruitment and retention of our people. Strong financial performance has continued to allow us to invest where necessary to keep service standards high against increases to demand.

Over the next year we are going to see much greater levels of collaboration with partners and commissioners and we expect our organisation to evolve and adapt to these challenges. Our Annual Plan and Good to Great Strategy stand us in good shape to make necessary changes and as the organisation develops we monitor performance carefully to make sure that standards maintain and improve whilst the system develops towards Integrated Care System working.

Tom Cahill, Chief Executive
Dated: 11 June 2021

1.3 COVID-19

1.3.1 Introduction and Background

This section of the Annual Report sets out how the Trust specifically responded to the COVID-19 Virus. It provides details of our approach to supporting service users, carers and staff whilst ensuring sound governance and robust systems of internal control. Other sections of the Annual Report also recognise the impact of COVID-19 and how the Trust responded to the pandemic.

On 31 December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China. On 12 January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. The identified virus became referred to as Coronavirus (COVID-19). WHO declared this is a public health emergency of international concern.

Further cases were identified in the UK in early February and this prompted the Secretary of State for Health and Social Care to introduce the Health Protection (Coronavirus) Regulations 2020 statutory instrument: Guidance on infection prevention and control, how to detect and diagnose COVID-19. The Chief Medical Adviser to the UK Government, Chris Whitty set out a four-pronged strategy to tackle the outbreak: contain, delay, research and mitigate.

On 11 March 2020 WHO declared the outbreak a pandemic. On 12 March, the UK risk level was raised from moderate to high and the UK declared a Level 4 incident, which meant:

- An incident that requires NHS England National Command and control to support the NHS response
- NHS England to co-ordinate the NHS response in collaboration with local commissioners at the tactical level.

In late March 2020 measures were put in place to contain and then delay the virus including school, pub and restaurant closures, and further measures on social distancing and advised people against "non-essential" travel and contact with others. The population was also categorised into: those at high risk and asked to self-isolate for 12 weeks; those at increased risk and the general population.

From March 2020 the Trust started to see its first cases amongst service users and staff.

1.3.2 Our response

In response to the identification of the increased risk linked to the pandemic the Trust developed a framework for managing and planning the incident. This was in parallel with the emergency planning and response (EPRR) protocol for managing a major incident. The Executive Director Quality and Safety was identified is the Board Lead for COVID-19 working alongside the Executive Director of Service Delivery and Service User Experience who is the Senior Responsible Officer for Emergency Planning.

To support the response an incident management structure was put in place 24 hours a day, 7 days a week:

- Strategic Management Team (SMT) [formally known as Gold Command].
- Tactical Control Team (TCT) [formally known as Silver Command].
- Local Incident Response Team (LIRT) [formally known as Bronze Command].
- COVID-19 Incident Support Team (loggists and admin coordination with SPOC inbox management, incident action oversight and sitrep submission)

The incident management structure was supported by a nurse on call system and additional on call support from the Infection Prevention and Control team.

The Trust identified the priorities with regard to managing the incident as ensuring:

- We have contingency plans to maintain core service at all times, ensuring staff available, redeploying staff and indeed closing some services.
- We have plans in place to support service users who are at most risk either mentally or physically.
- We are able to manage any outbreaks of the Virus in our services and maintain safe services.
- We are supporting staff well-being and ensuring they have the skills and support to manage the incident as it progresses. This will include but not be limited to training, leadership, prevention, annual leave, pay.
- We are supporting Partners, Emergency Departments, Children's services, Adult Services and Older peoples services
- We have the infrastructure, technology to support home working and have the necessary supplies.
- Leadership capacity and capability, ensuring availability of appropriate leadership capacity at all levels including appropriate on call rotas at all levels.

"I was pleasantly surprised how quick I was seen. I expected a delay with Covid and this wasn't the case at all. Really helped as waiting can make me anxious".

Service User Herts IAPT

1.3.3 Business continuity

The Trust implemented its Business continuity plan at different stages to manage the incident. During the first wave: March 2020 to July 2020 the Trust made some changes to the services, focusing on the front door and crisis services, sustaining inpatient care and providing community services based on assessed need.

In particular the SPA service continued as normal and was further strengthened with IAPT staff, the 24/7 Mental Health Help Line was developed; diversion hubs were established to release pressure on Acute hospitals and urgent Community and Crisis services remained open. In inpatient services, service users were subject to additional screening re: COVID-19 in relation to admission, transfer, and discharge. Services were maintained in specialist units and PICU but elsewhere there was focus on patient flow through tighter gatekeeping and discharge to community teams. The teams worked to reduce bed occupancy through alternatives to admission where possible.

In community services all service users were risk assessed (RAG) based on both physical health (COVID-19 risk) and mental health needs. Those service users in the Green cohort had their appointments postponed for a period of 12 weeks and in these instances were provided with information on how they could access services if they felt their mental health was deteriorating. Service users in Amber Cohort saw some changes to the way their care is delivered – e.g. reduced face to face contact where possible and those in the red Cohort – those most at risk and needing greatest support saw very little change to the way care was delivered. During this period all service users could step up and down as needed over the duration of the 12 weeks.

During the second and third waves of the pandemic we made very limited changes to service delivery, with all services staying open to referrals and offering appointments. There were fluctuations in demand with some services e.g. dementia diagnosis seeing a drop in contact and CAMHS and eating disorders seeing significant increase in demand.

Responding to COVID-19 provided opportunities to make bold changes to the way we work with service users and collaborate with partners. We were in contact more often with service users and in more ways; we developed our approaches to risk and developed our physical health capabilities; we became accustomed to overcoming problems and facing new challenges; and became better integrated by working across disciplines and organisational boundaries. We have emerged from 2020/21 having delivered the vast majority of commitments we made to our service users, their carers, our partners and our people. We have at the same time developed our capabilities and strengths ready to continue our focus on delivering great care and great outcomes in the forthcoming year.

Overall, our performance has remained relatively strong as reflected across the principal KPIs. We maintained our access standards into services against a backdrop of challenging circumstances. Section 1.2 of the Annual Report provides more detail the Trust's performance during the year and the table below provides a summary of the end of year position.

Table 1 details end of year performance against Annual Plan 2020/21 Objectives

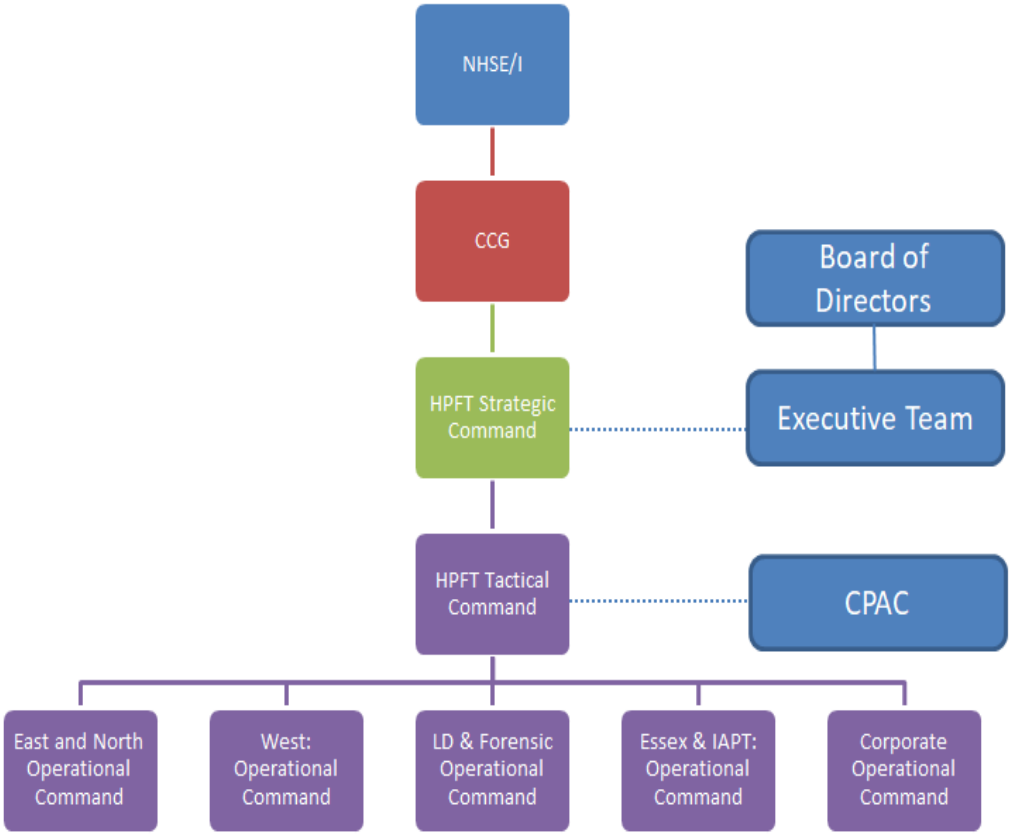
Objective		**Q4 RAG rating**
1	We will provide safe services, so that people feel safe and are protected from avoidable harm	6/6 (100%)
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	5/8 (63%)
3	We will improve the health of our service users through the delivery of effective evidence based practice	5/6 (83%)
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	3/6 (50%)
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	5/6 (83%)
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	5/8 (63%)
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	7/8 (88%)

Note: milestones refers to how many of the *activities* that we said we would do for the quarter have been completed

1.3.4 Governance Structure

The Trust operated its Business Continuity policy for a Major Incident but, in line with guidance from NHSI/E, this was not formally declared. In consequence, the Trust operated a command and control structure alongside its established corporate governance framework. Diagram 1 describes the Major Incident command structure in place in the Trust.

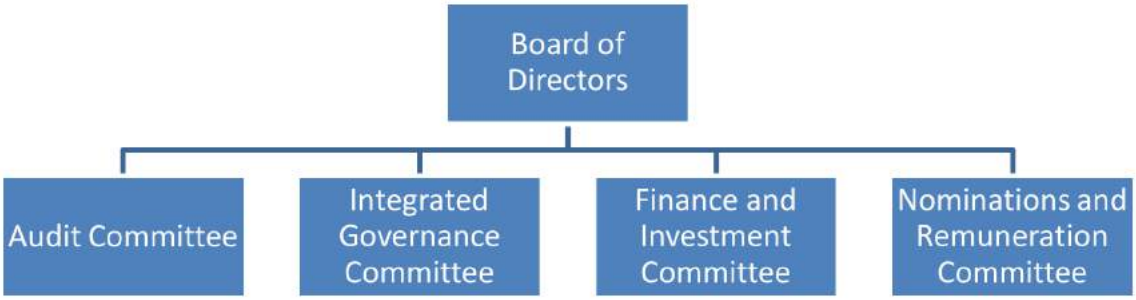
Diagram 1: HPFT Major Incident Command Structure



The Clinical & Professional Advisory Committee (CPAC) was established to offer expert guidance and advice relating to the clinical and practice issues in relation to COVID-19, this included but was not limited to ethical issues, Mental Health Act, DoLS, Restraint, Admissions and physical environments. The Committee agreed Terms of Reference with the membership of Clinical Directors, Deputy Medical Director, Consultants, Heads of Professions, Junior Doctor representative, service user, carer and NED.

In line with the well-established corporate governance structure that ensured robust systems of internal control. For the year the Board of Directors remained as the ultimate corporate decision making body, collectively responsible for the performance of the Trust and ensured the Trust functioned effectively, efficiently and economically (The NHS Foundation Trust Code of Governance). It was supported in this role by sub committees, a constitution, scheme of delegation and standing orders (diagram 2).

Diagram 2: The established Board governance framework:



As well as the framework detailed above and to enable the leadership team to ensure that staff keep service users safe and well and that our staff were supported whilst working through this challenging time interim corporate governance arrangements were implemented for the period 1 March 2020 to 31 July 2020. The arrangements ensured that the decisions made by the Executive Team and CEO were clearly reported, scrutinised and recorded and that the Board was provided with appropriate assurance.

The interim corporate Governance arrangements saw the establishment of a new Board Sub-Committee; Board Assurance Sub Committee COVID-19 that provided the Board of Directors with assurance with regard to safety, quality, risk, financial and contract arrangements during this time. The membership of Committee included members of the Integrated Governance Committee (IGC) and Finance and Investment Committees (FIC).

During this period the Audit Committee continued to meet and provide the Board of Directors with assurance with regard to Trust's systems of internal control, reporting directly to the Board of Directors. It was agreed that the IGC and FIC meetings be deferred until end of July 2020. The Nomination and Remuneration Committee was in place but was only used for urgent matters.

To provide assurance to the Trust two advisory audits were commissioned from our internal auditors RSM. One review was to assess whether the actions taken to establish an effective governance framework and associated processes were robust and comprehensive and could provide assurance to the Board and Committees.

The second review specifically focused on the changes in relation to financial governance which have been implemented nationally. It looked to provide assurance that the Trust had responded appropriately, ensuring decisions to commit resources in response to COVID-19 whilst being supportive and flexible continued to be robust and ensure that the high standards required from publicly funded bodies remained.

The two reports provided positive assurance and the detailed findings are noted below.

COVID-19 Governance (Interim Arrangements)
As this was an advisory review, we have not provided a formal assurance opinion. Overall, we found robust controls in place for the interim governance arrangements at the Trust. We were able to evidence approved Terms of Reference for both the Board Assurance Sub Committee COVID-19 (Board) and CPAC. We confirmed that the new committees were COVID focused but included elements of governance, risk, performance and quality reporting. We also confirmed that during the pandemic, a COVID-19 risk register has been set up and was being continually reported to the Board and Board Assurance Sub-Committee: COVID-19. Through review of the minutes from the Board and Board Assurance, we confirmed that quality and performance of services was discussed, this included services undergoing a Quality Impact Assessment and deterioration of performance highlighted on the COVID risk register. In addition, we evidenced that the Trust had considered staff welfare and support and also how they could help partner organisations. We found weaknesses leading to two low and one medium priority management actions being agreed.

Financial Governance
Our review confirmed that controls were generally well designed and complied with in relation to financial governance and financial controls. We found that controls with respect to additional costs as a result of COVID-19, monthly reporting to NHSI/E, payments to suppliers and cashflow forecasting and monitoring were evidently in place and working. We also evidenced adequate reporting to the Executive Team, Integrated Governance Committee and Board.
However, we noted further areas of control enhancement, agreed with the Trust. More specifically, we found insufficient evidence to confirm whether there was appropriate review and approval of COVID-19 spend and budgets had not yet adjusted to reflect the effects of COVID-19. We also noted that whilst a Business Continuity Plan was in place and skills gaps as a result of staff illness had been identified, it hadn't been made clear in advance how these gaps would be filled, though they were in fact effectively covered.

During this period the risk escalation process was enhanced through a COVID-19 specific risk register, this was reviewed daily at Tactical Command in relation to appropriate mitigating actions. The review was informed by the Operational Command incorporating SBU and corporate functions as well as CPAC with key risks and concerns escalated to Strategic Command on a daily basis. The full COVID-19 risk register was then reviewed by the executive team on a weekly basis and considered by the Board Assurance Sub-Committee: COVID-19 and Board. As the year progressed the risks in the COVID-19 risk register were integrated into the Trust Risk Register.

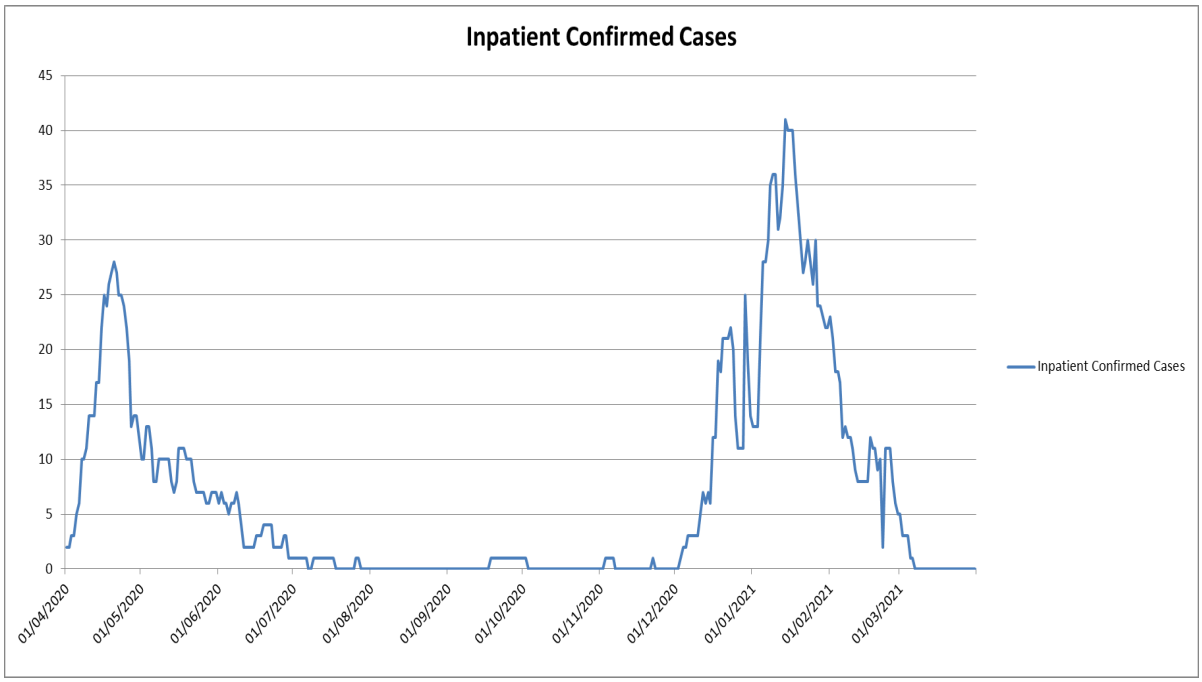
During this period the Trust established an Infection Prevention and Control Board Assurance Framework (IPC BAF), in line with national best practice. The IPC BAF set out the risks, controls and assurance in place to manage IPC during the year. The IPC BAF was reviewed by CQC who gave a positive opinion. The Trust also commissioned an external review to provide assurance and identify areas for improvement. The IPC BAF and external review were reported to the Integrated Governance Committee.

1.3.5 Impact

Very sadly during the year we have a significant number of our services users who have died due to COVID-19, 15 of whom were reportable by the Trust. We also had two members of the Trust family who sadly passed away during the year due to COVID-19.

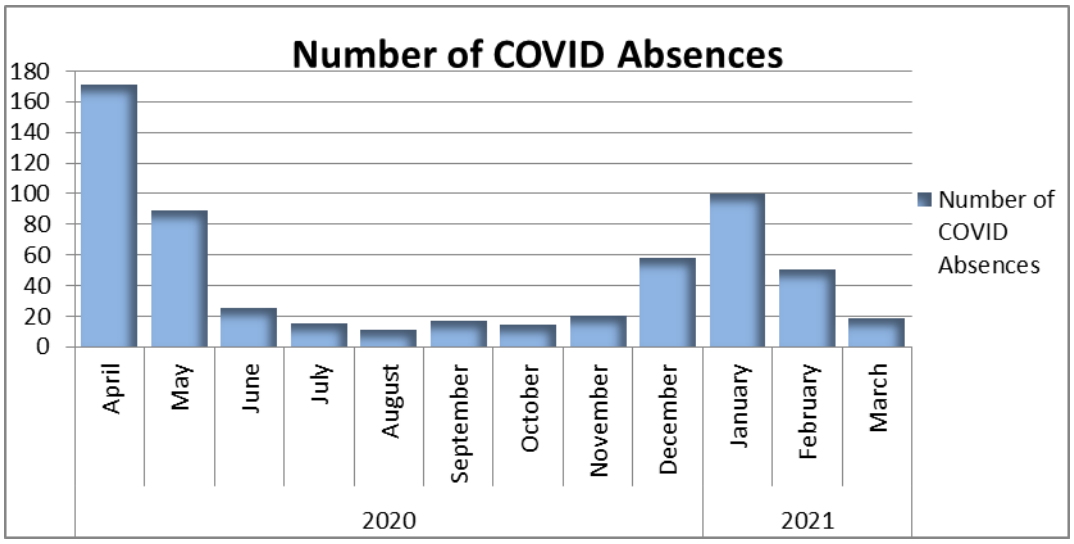
Also during this time the Trust saw a number of positive cases amongst inpatients.

Graph 1: Confirmed inpatient cases



The Trust also saw peaks in absence staff absence due to COVID-19.

Graph 2: Number of Staff absences for 2020/21



1.3.6 Quality

Throughout the year the Trust was focused on the key quality and safety considerations related to continuing to provide safe and effective services. This was at a time when there was an impact on staff availability and there was the presence of a virus that was causing higher mortality rates and was having a long term impact to people's health.

Evidence continued to emerge throughout the year regarding those in the population who were most at risk and how the virus was transmitted. It also became clear that the virus was having a significant impact on people's mental health, including those who were not previously known to services. The impact of the 'lock down' and closure of schools was particularly highlighted with the expectation that the impact would continue over several years to come.

Service Users

Risk Assessment

Supporting and caring for our service users continued to be a priority for the Trust. To enable us to provide high quality, safe and effective care at a time when the pressure on the availability of staff resource was high the Trust implemented a programme of ensuring all service users on our case load were risk assessed and given a RAG rating. The achievement of this was managed and monitored through CPAC and reported through tactical command. This approach enabled us to have a clear picture of service users and the input they needed from services.

"Because all the staff made me feel at ease, were honest and treated me fairly and like a human being".

Service User during COVID-19: Section 136 Suite

Guidance

CPAC had an important role in providing guidance on a constantly evolving picture. They considered all the relevant national guidance and its application to Trust services users and staff, making recommendations for implementation. During the year CPAC considered 241 different guidance documents. The success of CPAC following its establishment means that it will be continuing to meet and provide guidance.

Digital

The pandemic has seen the Trust move swiftly to providing care and support using virtual platforms supported by digital technology, in particular we have:

- Deployed appropriate video consultation solutions so that we can continue to support our service users and carers whilst minimising the risk to them.
- Provided over 1,500 pieces of mobile equipment to our staff, updated wi-fi across all our buildings and enhanced our remote access technologies to enable our staff to work more flexibly so that we can continue to comply with changing infection control and prevention requirements whilst supporting our service users and carers.
- Made several changes to our electronic patient record, corporate record and business intelligences systems so that we can understand, monitor and manage

the risk posed by the pandemic to our service users, carers and staff, and continue to keep them well and safe.
- Developed and implemented new ways of working, such as remote monitoring, to keep supporting our service users and carers in their place of residence.

Learning Disabilities

People with Learning Disabilities are recognised as being at increased vulnerability due to COVID-19. They are at increased risk of becoming more seriously ill and dying from COVID-19 due to the high prevalence of underlying health conditions. They are also at increased risk of worsening mental health symptoms, which may also be exacerbated by anxiety, changes to routine and reduced or no face to face contact with family, friends or staff. At the start of COVID-19 an HPFT Team of clinicians, experts by experience and Academics from RADiANT developed the first guidance for COVID-19, care planning and treatment escalation in people with Learning Disabilities. This was implemented in all HPFT teams. The guidance has been widely circulated nationally and internationally and informed the RCPSYCH guidance. Further guidance on advance care plans for people with Intellectual Disabilities during COVID-19 has also been produced and published through RADiANT.

All inpatient service teams produced a COVID-19 care plan and a treatment escalation plan to ensure that people with Learning Disabilities received the same care should they develop a COVID-19 or non COVID-19 related acute deterioration of their physical health during the pandemic.

The community HPFT teams produced a RAG rating for service users to guide the frequency of contact based on physical and mental health vulnerabilities and liaised constantly with service users, carers, primary care and general hospitals to safeguard provision of all health needs. Physical health care needs were prioritised and facilitated and at times directly provided to ensure that the person was safe and well.

During the COVID-19 pandemic, our inpatients with Learning Disabilities were supported to maintain contact with their family and friends through virtual platforms and, where government guidance has permitted, carefully risk assessed visits, often in outdoor spaces. Staff worked with service users to adapt individualised activity plans in light of COVID-19 restrictions and infection control guidance. Virtual Care and Treatment Reviews and Tribunals have been supported to ensure ongoing care and service users, family and carers have been supported to take full part in these as well as other meetings around service user care. In order to protect our community service users, our community teams adapted quickly to virtual consultations at the beginning of the pandemic.

We developed an easy read guide for patients for virtual Tribunal hearings in collaboration with Royal College of Psychiatrists and Tribunal service. The guide has been put on the gov UK website https://www.gov.uk/government/publications/what-to-expect-at-a-mental-health-tribunal-virtual-hearing-easyread-guide

In order to understand the impact this had on service users, family and carers a virtual consultation survey was undertaken via phone and paper survey; over 150 surveys were completed with detailed feedback on what worked and what could be improved around remote consultations. This information was used to create a face to face versus remote consultation decision making tool for staff, with service user and carer choice at the centre. Throughout the pandemic, staff have continued to provide face to face visits where the risk to the service user required this. Additionally, HPFT

staff have provided increased support to the community, including stepping in to help staff a care home where the majority of the staff and service users contracted COVID-19.

A survey was carried out to review the impact of COVID-19 on the mental well-being of patients with intellectual disabilities, their families and carers. An easy read questionnaire was developed and sent to 250 service users; it was designed to capture some of the thoughts, feelings, social interactions and medical support required. The survey demonstrated that people with intellectual disabilities coped remarkably well with the sudden changes that 'lockdown' brought. The extreme changes in their routine and structure did not have the initial impact suspected and the quiet and calm of society, with reduced pressure to fit in to 'social norms' appeared to be positive for many at the start of the pandemic.

As vaccines were introduced, HPFT was at the forefront of prioritising people with Learning Disabilities for early uptake of the vaccine. All inpatient service users with Learning Disability have been offered a vaccine, with a very high uptake on our units. Community staff have supported the roll out of the vaccine to community service users in Hertfordshire and Buckinghamshire.

Prior to COVID-19 Trust teams were already learning from The Learning Disability Mortality Review (LeDeR) reviews and had already made changes within their care pathways. During the pandemic these efforts and links have been strengthened within the strategic partnerships and networks to ensure that their future model of care works in the most person centred and effective way to further reduce inequity and improve the quality of life and health for this vulnerable group. Nationally we contributed to an observational descriptive case series looking at deaths because of COVID-19 in people with intellectual disability.

Mental Health Act Assessments

The Trust, through the Mental Health Legislation Department (MHLD) has continued to have robust governance, an audit programme, and policies and procedures around the use of Mental Health Legislation which has been recognised by the Care Quality Commission (CQC). The CQC continue to monitor our compliance via video links and 'phone calls.

Over the last year, although the number of service users subject to mental health legislation continued to rise, the Trust has been proactive in its response to COVID-19 and ensuring that all government guidelines have been adhered to. Trust guidelines have been issued to ensure that service users were able to access alternative means of communicating with their family and friends by use of iPads, laptops etc when visitor access was reduced. Leave has been facilitated which complies with government guidelines without restricting service users' ability to leave the hospital. There have been no blanket restrictions imposed due to COVID-19. The MHLD have been available for advice with regard to legislation that can be used with regard to testing and isolating patients due to COVID-19.

There was a robust contingency plan put in place for the MHA Office during the pandemic, ensuring that staff were able to continue to deal with statutory duties on behalf on the MHA Managers effectively and safely even though short staffed due to isolation, COVID-19 sickness and other absences.

In December 2020 there were changes to the MHA regulations which allowed statutory papers to be served electronically. There was also the "Devon Judgment" which clarified that, regardless of the pandemic, all examinations and assessments

for detention, renewal and extension of MHA sections must be face to face. The MHLD has updated its scrutiny process to ensure that there has been no remote component to the assessment process.

Since the lockdown, MHA Manager (MHAM) Hearings and First Tier Tribunal (FTT) hearings have continued throughout the Trust, initially as paper reviews and via the phone, however these have been replaced by video hearings which allows service users and their legal representatives to be seen and heard. Where there are connectivity issues a member of IM&T has been identified to support staff and liaise with the Tribunal Service.

During the last year there has also been a White Paper for the reform of the Mental Health Act (MHA) issued, the Trust has provided a response to this; it is anticipated that the changes will come into effect during 2023. The Trust has robust plans in place with partner agencies to move forward with the introduction of Liberty Protection Safeguards by April 2022.

Physical health needs

The pandemic meant that the Trust needed to consider how it would provide care to service users to meet physical health needs associated with the virus. The Trust worked closely with other partners and rapidly established a physical health response team and identified a site that could be used to cohort services users. This saw the Trust identifying and training a team to be able to manage service users' physical health needs. This team also directly supported wards with service users' physical health needs. The impact of this was that we were able to manage, where appropriate service users without them being referred to acute hospitals. It also saw the upskilling of staff and increased awareness of the wide physical health needs for mental health and learning disability service users.

The Trust took the early decision to ensure that service users with Severe Mental Illness were prioritised to receive their vaccine. We ensured the services users on our wards received the vaccine and worked with the Primary Care Networks to support services users in the community.

Staffing levels

It was clear from early in the pandemic that it could have an impact on availability of staff due to sickness or them having to work from home. The Trust continued its robust approach to Safe Staffing levels with 3 times a day census check calls, redeploying staff across services and Team Leaders and Matrons working alongside their colleagues on shift. In April the Trust agreed a plan to mitigate for any potential increase in absence across our services. This plan detailed that the minimum staff levels have been reviewed alongside the way nursing is delivered on the inpatient units. The agreed proposed minimum staffing levels were temporary and were reviewed weekly throughout the time COVID-19 was impacting on staffing levels. It is worth noting that at no point through the year did the Trust need to implement the agreed minimum staffing levels.

Staff

During the year staff have responded magnificently and completely in line with Trust values, looking out for and caring for our services users and also for their colleagues. The Trust recognised early on the extraordinary lengths that staff were going to ensure safe and high quality care was being provided. The Trust did a number of things to support staff and ensure their wellbeing was being looked after.

Risk Assessments

All staff had an individual risk assessment. The assessment considered a number of factors such as likely exposure to the virus, personal health risks and demographic data to generate a risk score. Each assessment was discussed with their line manager and any mitigating actions considered and implemented. They were also subject to regular review dependent on the risk score.

Engagement

Through all waves of the pandemic the Trust has had a number of staff that needed to 'shield' based on their individual health issues. The Trust enabled staff, where appropriate to work from home while shielding. We also regularly reached out to all shielding staff to keep them engaged with the Trust and ensure they were being supported. This work was supported by the continued work of the staff networks, which moved onto virtual platforms. The BAME network was particularly active during this year, supporting staff who were identified at higher risk and affected by the Black Lives Movement.

Wellbeing

The Trust implemented a significant programme of support for staff, including a number of wellbeing initiatives, such as access to meals, hotel accommodation and a simplified remuneration process for additional hours. This was supported by a recovery strategy, launched towards the end of 2020/21 is based on three themes of Organisation, Great Care and Great Outcomes and has five key pillars to the strategy:

- Paying witness to what's happened.
- Rest and recuperation.
- Reward and recognition.
- Health and well-being.
- Keeping our people.

To support the first pillar on 23 March 2021 the Trust held a remembrance service for staff, service users and carers, to remember all those who had lost their lives to COVID-19. The strategy will continue to be implemented in 2021/22.

The Trust also established a 24/7 helpline for health and social care staff in Hertfordshire, which our staff were able to access whenever they wanted. We increased our engagement with staff, with regular Q & A sessions with the Exec Team, as well as CEO videos and Big Listen events.

"Given the numerous people whose mental health is suffering, including myself, because of COVID, I was surprised how little time past between the initial contact with my GP to having my first contact with the Wellbeing team. Well done and thank you".

Service user Herts IAPT

Infection Prevention and Control

During the year there has been a significant focus on Infection Prevention and Control (IPC) and its role in ensuring the Trust provided high quality, safe and effective care. Detailed below are the key strands to this work and what the Trust did.

Outbreak Management

There were a total of 17 confirmed outbreaks of COVID-19 reported during 2020/21. All were fully investigated and monitored through daily Outbreak Control Team (OCT) Meetings. There were good working relationships between HPFT and external organisations including PHE, CCG and NHSI/E who attended the OCT meetings on a regular basis. A learning note was produced following the outbreaks/incidents after the first wave of the pandemic and all SBUs are in the process completing a fact finding report from the outbreaks that occurred in quarter 4. The findings will be supported by a CQI approach to embed learning.

IPC practices and procedures were implemented in line with the PHE guidance which was regularly reviewed. This included implementing isolation/co-horting practices, nasopharyngeal swabbing and adhering to standard and transmission based precautions. Root cause analysis reports and risk assessments were developed and implemented for staff and service users who were identified as being COVID 19 positive.

Testing

Twice weekly lateral flow tests (LFT) for staff were introduced and the uptake monitored. Managers continuously encouraged staff to carry out this regular testing

Vaccination

Staff were encouraged to have the COVID-19 vaccination and the figures at the end of April were reported at 85.2% for the first vaccine and 32.4% for the second dose.

Weekly flu meetings continued to be implemented throughout the duration of the flu campaign. The flu vaccination season finished at the end of February 2021 and the number of frontline staff vaccinated was recorded at 72.38%, as detailed in the table below. The SBU teams monitored the administration of the vaccine at a local level and feedback sessions will be implemented to learn to support the aim to improve the overall compliance for 2021/22 flu campaign.

	2018/19	2019/20	2020/21
Frontline staff, flu vaccinations	51.9%	63.9%	72.38%

Cleaning

It was a challenging year with many changes to "normal operating" and service delivery. Aside from the COVID-19 pandemic and the changes to safe working practices across Trust services, all Hard, Soft Facilities Management and waste services have been put out to tender with a more robust specification to improve services for service users and staff. Three contracts were awarded after rigorous checking and evaluation and approval from the Trust Board, which came into effect from 1 April 2021. Waste collection and disposal services were also reviewed and are now provided by two specialist companies audited by the Trust Estates Facilities Management team. The Estates team negotiated and initiated 24/7 rapid response cleaning services for Section 136 and all safety suites at Kingsley Green, which will continue as part of the new contract service.

During the year the Trust worked closely with the cleaning service provider. The Trust also used specialist trained cleaning teams to conduct all COVID-19 related cleaning, separate to regular site cleaning teams with all cleaning conducted in line with PHE guidance. Enhanced cleaning of high touch points/usage areas initiated within site cleaning schedules across the Trust's estate. A COVID-19 waste standard operating procedure (SOP) was also developed in compliance with national NHSI/E guidance. Jointly developed internal COVID-19 cleaning procedures for all sites to follow were developed which were in conjunction with PHE guidance. Overall cleaning audit scores remain high throughout the year with an improvement from the previous year, as detailed in **tables below**.

Year	**Inpatient**	**Increase**	**Overall**	**Increase**
2019-20	96.77%		95.53%	
2020-21	97.17%	+ 0.4%	96.53%	+ 1.01%

Training

All Trust staff were required to be compliant with either level 1 or level 2 training. At the end of quarter 4, the training compliance was reported at:

- Level 1 – 85%; a decrease from quarter 3 which was reported at 93%
- Level 2 – 94%; the same that was reported in quarter 3.

The reduction is believed to be due to the challenges of COVID-19 and the senior nursing team have followed up the non-compliant staff. IPC link practitioners are also offered additional training and development.

'Donning' and 'doffing' training has been provided for multi-professional staff and competencies developed. PPE guidance has been developed and updated in line with national PHE guidance. PPE supplies were monitored on a weekly basis to ensure that staff had sufficient supplies available.

An introduction to Antimicrobial Resistance training was agreed to be essential training for staff and, at the end of quarter 4, the training figures were recorded as 86% compliant which is an increase from quarter 3 (76%).

Throughout the year we continued to undertake surveillance and management with regard to alert organisms such as MRSA, E-coli bacteraemia and Clostridium difficile.

1.3.7 System Working

One of the positive developments from managing the COVID-19 pandemic was the enhanced collaboration between health and social care partners. In response to the first wave the Trust established, at short notice two A&E Diversion hubs, one in Watford and the other in Stevenage. They provided an alternative care setting for people presenting to A&E with mental health needs and transferred them from the clinical hospital environment to reduce likelihood of transmission of the virus but also 'free up' capacity in the A&E department for them to care for patients with physical health needs. Children's crisis services were also enhanced during the pandemic and a business case secured to enable a sustainable model of 24/7 support into the two Hertfordshire acute trusts.

The Trust actively participated in system work, providing mutual aid. We did this to support colleagues with access to PPE and the roll out of the vaccination programme. We particularly provided advice and support to the system for people with a Learning Disability. At short notice we led the work to support the transfer of a number of residents from the Beau Sejour home. The team worked directly with residents ensuring they were cared for and the transition to their new home was undertaken sensitively and with compassion. The Trust has proactively advocated for people with a mental illness and or a learning disability to be able to access COVID-19 Vaccinations.

1.3.8 Learning

We are committed to continually improve our services and experience for service users and carers. We have embedded CQI methodology and have used it to support the process to evaluate the changes we have made in response to the pandemic. In particular:

- New model for EMDASS (Early Memory Diagnosis and Assessment)
- Community model (all age) and alignment with primary care, and new model of care for those service users who would have traditionally received care through an outpatient model

- Enhanced Crisis pathway (also part of wider system work within the Hertfordshire Mental Health & Learning Disability Integrated Care Partnership – MHLD ICP)
- LD transformation across the Trust
- CAMHS (also part of wider system work within the Herts MH & LD ICP)
- Use of digital and virtual platforms to provide care
- Support for physical health needs of service users

The changes and innovative practice are being taken forward as part of the Transformation programme.

1.3.9 Restoration phase

Following the first wave of the pandemic, the incident management arrangements remained in place but were scaled down. The Trust moved to the next phase of managing the COVID-19 pandemic and a framework was developed which manages it in 4 stages.

From the beginning of August 2020 the Trust reverted to the corporate governance arrangements described in diagram 2.

1.3.10 Ongoing impact

The COVID-19 virus is likely to be present for several years to come and providing care to service users and supporting carers against this background will see the changes brought in continuing as business as usual. The robust IPC practice will continue to be vital and key to reducing transmission and managing any outbreaks. We will work with staff to identify how great IPC practice can work alongside provision of care and safe working environments. This will also be considered as part of our capital programme.

Staff have been fantastic during the year but they are tired and they need time to rest, reflect and remember. We will continue to support staff and help them pay witness to the service users and staff we have lost. We have a comprehensive wellbeing programme, based on co production and in line with the five pillars of the recovery strategy. We will support future vaccination programmes, including Flu and COVID-19.

It is expected that future years will see an increase in demand for mental health services and the Trust will work with partners to plan for this, ensuring we continue to provide safe, effective care

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 NHS Foundation Trust 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.

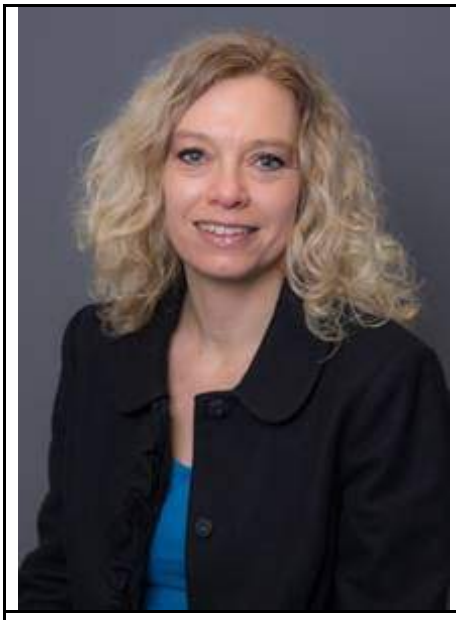
The NHS Foundation Trust Code of Governance specifies that Non-Executive Directors, including the Chairman, should be subject to re-appointment at intervals of no more than three years, following formal performance evaluation. Any term beyond six years should be subject to rigorous review and take into 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.

This Annual Report has been prepared on the same 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 and Annual Accounts:

a: Are fair, balanced and understandable
b: Provide the necessary information for service users, regulators and other stakeholders to assess the performance, business model and strategy of the Foundation Trust.

Board Members



Sarah Betteley, Chair

Sarah joined HPFT as a non-executive director in 2014. She became Deputy Chair in 2019 and was appointed as Chair in December 2020.

Sarah is a lawyer with significant non-executive experience in the NHS. She held a number of senior executive commercial roles at BT and has also acted in a consultant capacity with small businesses supporting them on strategy and growth development.

Tom Cahill - Chief Executive

Tom joined HPFT in 2005 as Executive Director of Nursing and Practice Governance. He became Deputy Chief Executive in late 2007 and then Chief Executive in April 2009. He is the accounting officer for the Trust and carries full responsibility for the Trust's strategic direction, performance, planning, business management and development.

Tom began his career as a mental health nurse and held several senior posts before joining HPFT. At HPFT, he has overseen the development of new models of care, new facilities and the Trust's culture. Under his leadership, HPFT was rated as 'Outstanding' by the Care Quality Commission in 2019.

Tom also led the Sustainability Transformation Plan (STP) for Hertfordshire and West Essex in 2016 and 2017. He is one of the Health Service Journal's Top 50 NHS Chief Executives and received the prestigious HSJ Chief Executive of the Year Award in 2017.

Keith Loveman, Executive Director Strategic Finance

Keith has been with HPFT since its inception. He became Director of Finance, Performance and Improvement in 2010 and was appointed Deputy Chief Executive in 2019, a role he held until March 2021 when he then became Director of Strategic Finance. Keith is responsible for performance improvement, information management and technology (IM&T) and strategic finance.

Keith joined the NHS in 1990, qualifying as an accountant in 1994. He has worked in a range of NHS finance role, predominately with organisations providing mental health and learning disability services in Hertfordshire. Keith is a Fellow of the Chartered Institute of Public Finance and Accountancy and holds an Institute of Directors Certificate in Company Direction.

Dr Jane Padmore, Director Quality and Safety

Jane joined HPFT in 2014 as Deputy Director of Nursing, Quality and Safety and became Executive Director of Quality and Safety in 2016. Jane is responsible for clinical and corporate risk, patient safety, compliance and governance, infection control and safeguarding. She is the Caldicott Guardian for the Trust, the Board level lead for all clinical disciplines (except for medical and pharmaceutical staff) and the Executive Nurse. Jane is involved at a national and regional level in a number of safety and quality initiatives and sits on the NHS Confederation's Mental Health Board.

Jane has worked in mental health and learning disability services since 1990, initially as a healthcare assistant before qualifying as a registered mental health nurse in 1994. She has experience in mental health services for both adults and children, as well as in learning disability and forensic services. Jane has been involved in clinical, service development and academic work throughout her career.

Prof Asif Zia, Executive Director Quality and Medical Leadership

Asif joined HPFT in 2013 as Clinical Director for Learning Disability and Forensic services. He was appointed as Executive Director of Quality and Medical Leadership in 2017. Asif is responsible for the clinical elements of the Trust's quality management approach, as well as medicines management, research and development and medical appraisals and revalidation for doctors. He is also the professional head of HPFT's medical staff and is responsible for medical teaching and training.

Asif began his career in the UK in 1994 and held several senior posts before joining HPFT. At HPFT, he has overseen the transformation of learning disability services, developed the Trust's research strategy and led on improving the safety and quality of services.

Asif is a regional advisor to the Royal College of Psychiatrists and a Council member of the NHS England East of England Clinical Senate, where he sits on independent clinical review panels. He is also an author of book chapters and academic papers on epilepsy and service evaluations for peer reviewed journals.

Karen Taylor, Deputy Chief Executive, Director Strategy and Integration

Karen joined HPFT in 2012 as Chief Operating Officer, becoming Executive Director of Community Services and Integration in January 2014 and then Executive Director of Strategy and Integration in 2017. She was appointed Deputy Chief Executive in March 2021. Karen is responsible for strategy development, business planning and development and leads the development of integrated care across the Trust, working with partners across the wider health and social care system. She is also the Senior Responsible Officer for the Mental Health and Learning Disabilities Programme across the Hertfordshire and West Essex Integrated Care System.

Karen began her career in 1998 on the NHS Management Training Scheme and has a breadth of experience across the NHS, holding a number of senior roles including Director of Operations of an acute hospital trust and Chief Operating Officer/Deputy Chief Executive of a community services trust.

Sandra Brookes, Director of Service Delivery and Service User Experience

Sandra joined HPFT in 2014 as Managing Director for services in West Hertfordshire. She then led services in East and North Hertfordshire before becoming Executive Director of Service Delivery and Service User Experience in 2019. Sandra is responsible for service delivery and service user involvement and experience.

Sandra has worked in the NHS since 1986 and is an occupational therapist by background. She has worked in a range of mental health services including acute, rehabilitation, primary care, community and older people's services and has held a number of operational roles in other mental health and learning disability trusts.

Ann Corbyn, Executive Director of People and Organisational Development

Ann joined HPFT in 2020. She leads on developing of innovative People, Culture and Organisational Development strategies that support the Trust's aims of providing great care and great outcomes for our service users and which enable our people by developing a work place where people grow, thrive and succeed.

Ann has nearly 20 years' experience of working at a strategic level in human resources and organisational development. She began her human resources career at Tesco and has worked in both public and private sectors, with leadership roles in police forces, social housing, social care, consumer goods and business support services. Ann is a Fellow of the Chartered Institute of Personnel and Development (CIPD) and holds a Postgraduate Diploma in HR Management.

Paul Ronald, Director of Operational Finance

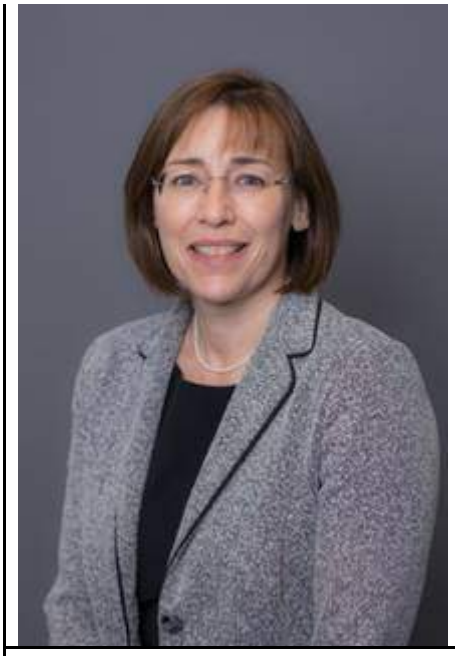
Paul joined HPFT in 2012 as Deputy Director of Finance. He is responsible for the operational aspects of financial performance, procurement, capital projects, estates and facilities.

Prior to joining the NHS in 2001, Paul worked in the commercial sector and was a director of a large UK transport group before running his own business. Since joining the NHS Paul has worked with a number of different organisations both within commissioning and service provision. Paul was awarded the HFMA Deputy Director of the Year award in 2013. He regularly presents Chartered Institute of Management Accountants (CIMA) masterclass training courses to NHS finance students. He is also the Chair of MIND in Mid Herts.

Helen Edmondson, Head of Corporate Affairs and Company Secretary

Helen joined HPFT in 2019. She is responsible for advising the Board and the organisation on all aspects of governance, ensuring the Board and its sub committees act fairly and with integrity. She manages the Trust's Corporate Office, is the primary point of contact and advice for the Non-Executive Directors and Trust Governors and is also the Trust's Counter Fraud Champion.

Helen has worked in the NHS for nearly 30 years in a range of managerial roles, including as Director of Corporate Affairs and HR in an ambulance Trust and Associate Director of Governance in a large clinical commissioning group. She has worked in the Hertfordshire health and care system for over 10 years in both commissioning and strategic planning organisations, most recently in the Hertfordshire and West Essex Integrated Care System.



Catherine Dugmore, Non-Executive Director, Senior Independent Director

Catherine joined HPFT as a non-executive director in 2016. She trained with PwC, specialising in multinational financial services clients setting up operations in South Africa. She relocated to the UK in 2002 and has since had a full time career as a non-executive director.

Catherine had a ten-year association with Action for Children, becoming Chair of the Audit Committee and Vice Chair of the organisation. She has also been Chair of Victim Support and Chair of the Audit Committee and Vice Chair of North Middlesex University Hospital NHS Trust.

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 was the CEO of Plan International UK. In this role, Tanya led a £80m turnover international development organisation, with a particular focus on girl's rights and gender equality. She is currently the Chair of a national provider of services to people with a learning disability.

David Atkinson, Non-Executive Director

David joined HPFT as a non-executive director in 2019. He is a former banker with 26 years' experience, working in London, Tokyo and Hong Kong. He specialised in finance and risk management, with region-wide responsibilities in Europe and Asia Pacific.

David is a member of the Institute of Chartered Accountants in England and Wales (ACA) and a Board trustee for The Papworth Trust, an East of England disability charity.

	**Diane Herbert, Non-Executive Director** Diane joined HPFT as a non-executive director in 2019. She is an HR professional by background and was previously HR Director at Channel 4. Alongside this and her other non-executive roles, Diane also works as an executive coach and consultant, specialising in helping to build and develop cultures that support creativity, innovation and change.
	**Anne Barnard, Non-Executive Director** Anne joined HPFT as a non-executive director in 2021. She has more than 30 years' experience in general and financial management in both the public and private sector. She was Managing Director of BBC World News, the BBC's commercial international news channel. Anne has held a variety of non-executive roles, including as Vice Chair of Central London Community Healthcare NHS Trust and Dimensions, one of the largest not-for-profit providers of support to people with learning disabilities. She is a Member of the Institute of Chartered Accountants in England and Wales (ACA).
	**Tim Bryson, Non-Executive Director** Tim joined HPFT as a non-executive director in 2021. He is a qualified mental health nurse with a broad range of clinical and managerial experience in commissioning and service delivery. Tim was Executive Director of Nursing at Cambridgeshire and Peterborough NHS Foundation Trust for ten years from 2002 to 2012. Tim now works as an independent healthcare consultant on a wide range of projects, most recently for the London Cavendish Square Group on safety improvement and Health Education England on learning disability nursing. In 2010, he co-founded the Blue Smile children's charity in Cambridgeshire and was Chair of Trustees for eight years. Tim is a member of the National Mental Health Nurse Directors Network and also a member of Cam MIND, COPE and Rethink in Cambridgeshire.

Patrick Vernon OBE, Non-Executive Director

Patrick joined HPFT as a non-executive director in 2021. He is Associate Director for Connected Communities for the Centre for Ageing Better and has over 20 years of senior experience working across mental health, public health, heritage and race equality and is well known in health, local government and the voluntary sector. Patrick is a Clore and Winston Churchill Fellow, Fellow of Goodenough College, Fellow at Imperial War Museum, Fellow of Royal Historical Society and former associate fellow for the Department of History of Medicine at Warwick University.

Patrick was awarded an OBE in 2012 for his work in tackling health inequalities for ethnic minority communities in Britain, and in 2018 he received an honorary PhD by Wolverhampton University for his work on migration history and equalities.

Kush Kanodia, Associate Non-Executive Director

Kush joined HPFT as an associate non-executive director in 2021. Originally an investment banker, he is currently Chief Disability Officer for the Kaleidoscope Group of Companies and is known as a social entrepreneur, systems leader and a champion for equality and inclusion. Kush holds a number of board and trustee roles, including with Health Data Research UK, the Global Disability Innovation Hub and the Centre for Access to Football in Europe.

Kush has been cited as one of the top ten most influential BAME leaders in technology and was second in the 2019 Disability Power 100 list of the most influential disabled people in the UK.

Note: The individuals listed below held Board positions in year but are not in post at 31 March 2021.

Chris Lawrence	Chairman, left the Trust 31 December 2020
Janet Paraskeva	Non-Executive Director, left the Trust 30 September 2020
Loyola Weeks	Non-Executive Director, left the Trust 31 December 2020
Sarita Dent	Associate Non-Executive Director, left the Trust 31 July 2020

2.1.2 Board of Directors appointments and committee attendance

There were 11 Board of Directors meetings between 1 April 2020 and 31 March 2021. 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 of which they are members is set out below.

Table 1- Appointments and attendance at Board of Directors meetings and statutory and assurance committees April 2020 - 31 March 2021

Board Member	Term of Appointment	Trust Board	Nominations and Remuneration committee	Audit Committee	Integrated Governance Committee	Finance and Investment Committee	Board Assurance Committee - COVID-19
Attendance/actual/maximum							
Non-Executive Directors							
Chris Lawrence (Chair)	01/08/2012-31/07/2020*	7/8	3/3	NA	N/A	NA	2/3
Sarah Betteley	01/08/2014-31/07/2020* (NED) 1/01/21-31/12/24 (Chair)	11/11	6/6	NA	3/3	2/2	3/3
David Atkinson	01/08/2019-31/07/2022	11/11	5/6	5/5	1/1	4/4	3/3
Anne Barnard	01/01/21-31/12/24	3/3	3/3	1/1	2/2	2/2	N/A
Tanya Barron	01/09/2020-31/08/23	9/11	5/6	NA	4/5	1/4	3/3
Tim Bryson	01/01/21-31/12/24	3/3	2/3	1/1	2/2	NA	N/A
Sarita Dent	01/05/2019-31/07.2021	3/4	1/2	1/2	NA	NA	2/3
Catherine Dugmore	01/08/2016-31/07/2019	11/11	3/6	5/5	1/1	3/4	2/3
Diane Herbert	01/05/2019-30/04/2022	11/11	6/6	5/5	4/4	NA	0/3
Dame Janet Paraskeva	01/09/18–30/9/20	4/5	2/2	NA	2/2	NA	1/3
Kush Kanodia	1/3/21-28/2/2022	1/1	1/1	NA	1/1	1/1	NA
Patrick Vernon	01/01/21-31/12/24	3/3	3/3	1/1	1/2	1/1	N/A
Loyola Weeks	01/08/2014-31/07/2020*	8/8	3/3	4/4	3/3	NA	3/3
Directors In Attendance							
Tom Cahill (CEO)	01/04/2009 – ongoing	11/11	6/6	1/1	NA	NA	NA
Keith Loveman	04/10/2010 – 30/06/21	10/11	N/A	5/5	3/4	4/4	3/3

Board Member	Term of Appointment	Trust Board	Nominations and Remuneration committee	Audit Committee	Integrated Governance Committee	Finance and Investment Committee	Board Assurance Committee - COVID-19
Dr Asif Zia	01/07/2017-ongoing	11/11	N/A	4/5	5/5	2/4	1/3
Dr Jane Padmore	17/11/2016-ongoing	10/11	N/A	5/5	5/5	4/4	3/3
Sandra Brookes	01/04/2019 - ongoing	10/11	N/A	2/5	4/5	4/4	2/3
Karen Taylor	27/02/2012-ongoing	11/11	N/A	NA	2/2	4/4	2/3
Ann Corbyn	01/02/2020 - ongoing	8/11	4/6	3/5	4/5	2/4	3/3
Paul Ronald	01/04/20 – ongoing	10/11	N/A	5/5	NA	4/4	3/3
Other Directors and Attendees							
Helen Edmondson*	Head of Corporate Affairs and Company Secretary		02/09/2019		Ongoing		

*Chair and two NEDs terms of office were extended for six months to provide continuity and enable the Trust to concentrate on managing its response to the COVID-19 pandemic. The extension was recommended by the Appointments and Remuneration Committee and approved by the Council of Governors.

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 Head of Corporate Affairs and Company Secretary.

The register of Directors' Interests is available from the Company Secretary or on our website at: Hertfordshire Partnership University NHS Foundation Trust, The Colonnades, Hatfield, Hertfordshire AL10 8YE Tel: 01707 253866 or https://www.hpft.nhs.uk/about-us/our-staff/ 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

The NHS Foundation Trust has complied with the cost allocation and charging requirements set out by HM Treasury.

2.1.5 Details of Political Donations

There were no political donations made during the reporting period.

2.1.6 Liability to pay Interest

The Trust did not pay any interest as the result of failing to pay invoices within the 30-day credit periods so agreed.

2.1.7 Statement of Better Payment Practice Code

The NHS Foundation Trust has adopted the Better Payment Practice Code, formerly known as the CBI policy on prompt payment. This 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 performance against this target in the year was as follows;

Non NHS	£000's	Number
Total bills paid in the year	133,792	44,326
Total bills paid within target	123,648	40,738
Percentage of bills paid within target 2020/21	92%	92%
Percentage of bills paid within target 2019/20	92%	91%

NHS	£000's	Number
Total bills paid in the year	14,117	800
Total bills paid within target	9,050	664
Percentage of bills paid within target 2020/21	64%	83%
Percentage of bills paid within target 2019/20	81%	80%

2.1.8 The NHS Improvement's Well-Led Framework

The Trust has in place arrangements to ensure services are well-led and these have been developed to reflect NHS Improvement's "Well-Led Framework". During the year the Trust commissioned an external well-led development review in line with best practice. The review confirmed that the Trust has strong leadership at Board level that supports the development and delivery of a clear vision and strategy. Also that there are robust governance systems supporting the Board, Sub-Committees and Council of Governors that ensure risks are managed appropriately. High quality information is available to inform decision making and working within our values we ensure we engage and include others in our strategy development and delivery. It also concurred with the CQC inspection that the Trust was outstanding with regard to the well led domain. There is additional information on these arrangements and approach in the Annual Governance Statement (section 2.7).

"Well looked after and staff encouraging me to think positive and to move forward".

Service User Forensic Services

2.1.9 Disclosure relating to Quality Governance

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 and maintained
- investigating and taking action on any sub-standard performance
- planning and driving continuous quality improvement
- identifying, sharing and ensuring the 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.

Table 3 - Quality Governance Framework – examples of good practice

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 of a small number of ambitious Trust-wide quality goals covering safety, clinical outcomes and service user experience which drive year on year improvement • Quality goals reflect local as well as national priorities, reflecting what is relevant to service user 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 Business Units/services (which will be tailored to the specific service) • There is a clear action plan for achieving the quality goals, with designated lead and timeframes • Applicants 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.
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 Trust Risk Register. The Trust Risk Register is supported and fed by quality issues captured in Business Unit/service Risk Registers. This is also supported by a regularly updated Board Assurance Framework, which the Board reviews at least quarterly. 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 from the Trust, of actions in place 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). *Table continued overleaf*

	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 service user 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 Freedom to Speak Up policy Initiatives' impact on quality is monitored on an ongoing basis (post-implementation). Key measures of quality and early warning indicators are 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 *Table continued overleaf*

	• 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 Board members are able to give specific examples of when the Board has had a significant impact on improving quality performance. The Board conducts regular self-assessments to test its and capabilities; and has a succession plan to ensure they are maintained.
3. Structures and processes	**Examples of 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 every other month by a quality-focused Board sub-committee with a stable, regularly attending membership.
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	The Board is 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. *Table continued overleaf*

	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 'whistleblower' (Freedom to Speak Up) and error reporting processes are defined and communicated to staff; and staff are prepared if necessary to speak up. 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 service users on quality, for example: • Service user feedback is actively solicited, made easy to give and based on validated tools • Service user views are proactively sought during the design of new pathways and processes • All service user 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 Incident data • The Board uses a range of approaches to "bring service users into the Board room" (e.g. face-to-face discussions, video diaries, ward rounds, service user shadowing) The Board actively engages staff on quality, for example: • Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (e.g. monthly "temperature gauge" plus annual staff survey; regular 'Big Listen' events) • 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 *Table continued overleaf*

	• The Board is clear about Governors' involvement in quality governance
4. Measurement	**Examples of 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 service user experience (at least three each) • Selected 'advance warning' indicators • Adverse event reports/ Serious 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. The 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 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 Business Unit/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. *Table continued overleaf*

	• 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 • Trust internal audit plan also includes audits linked to the review of the quality of data and information.
4b: Is quality information being used effectively?	Information in Quality Reports is displayed clearly and consistently. Information is compared with target levels of performance (in conjunction with a 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.

2.1.10 Material inconsistencies in reporting

There are no material inconsistencies in reporting.

2.1.11 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.

"This service has scraped me off the floor from a place I didn't know existed. The kindness, non judgemental professionalism offered a safe place to heal. The care and support has been incredible. This service has given me myself back, meant that my husband is no long worrying about what I might do and allowed me to fall in love with my little girl and finally bond with her. I will be externally grateful. Thank you"

Services user PATH service

2.1.12 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 2020/21 and onwards into 2021/22.

HPFT operates within the Hertfordshire and West Essex ICS, 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 ICS wide mental health and learning disability work streams and has let the work to establish a Mental Health and Learning Disabilities Collaborative for Hertfordshire. We have also been at the forefront of the New Care Models collaborative that see us working closely with other specialist providers to develop pathways for CAMHS and Learning Disability services. This is an exciting opportunity that will 'go live' in 2021/22.

Within each geographical footprint (Hertfordshire, Essex, Buckinghamshire, 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. HPFT is part of the Integrated Care Partnerships for West Hertfordshire and East and North 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 2020/21 across our services both in the development of our Trust-wide strategies and in our individual services. We also have a strong relationship with the University of Hertfordshire, an important partner supporting workforce development.

2.1.13 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. The NHS Foundation Trust met this requirement.

In accordance with Section 43(3A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) the NHS Foundation Trust confirms it has several income sources that are not directly linked to patient care of which the main sources are training and education funding and research grants. 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 NHS Foundation Trust has no fees and charges where the full cost exceeds £1 million or the service is otherwise material to the accounts.

2.1.14 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 and 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
	11 June 2021

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 manager's remuneration

A review of the senior managers' remuneration policy if required is provided to the Nominations and Remuneration Committee by a pay specialist, during 2020/21 no advice external to the Trust was received. 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.

2.2.1.2 Major decisions on senior managers' remuneration

Following discussion in 2019, the Nominations and Remuneration Committee commissioned work to benchmark Executive Director remuneration. A report was presented to the Committee in March 2020 which detailed director remuneration packages and standard benchmark data for the NHS.

It was considered that whilst the overall composition of remuneration was competitive, the performance related pay element was no longer effective for recruitment or retention of Directors. Additionally, the system of PRP was considered to be out of line with current approaches to remuneration in the NHS. During the accounting period the Remuneration Committee agreed that the performance element of Directors pay be consolidated into basic pay meaning that for 2020/21 there is no longer a performance element to their remuneration. The amount consolidated was 67% of the total available.

The full remuneration report of salary, allowances and benefits of senior managers are set out in section 2.2.3.7 of the Annual Report on Remuneration.

Remuneration for Non-Executive Directors is set out at 2.2.3.7 of the Annual Report on Remuneration and within the Full Statutory Accounts. No additional fees are payable in the role of Non-Executive Director.

Sarah Betteley, Chair
Date: 11 June 2021

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.

Where an individual Executive Director is paid more than £150,000, the Trust has taken steps to ensure 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 benefits of service users

Future Policy Table.

Executive Director annual salaries are inclusive.
Other payments such as overtime, long hours, on-call and stand by do not feature in Executive Directors' remuneration.
Executive Medical Director's salary is in accordance with national terms and conditions of the Service Consultant Contract 2003.
Deputy CEO receives an additional salary payment for the responsibilities associated with the role above those within their Executive Director role
For Executive Director and Very Senior Manager (VSM) positions, the Trust does not currently implement a performance-related pay policy.
Cost-of-living increases or notice periods/loss of office for Executive Directors are linked to the Agenda for Change terms and conditions of employment, which apply to all staff.

2.2.1.3 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.

2.2.1.4 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.

2.2.1.5 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. Following discussion in 2019, the Nominations and Remuneration Committee commissioned work to benchmark Executive Director remuneration. A report was presented to the Committee in March 2020 which detailed director remuneration packages and standard benchmark data for the NHS. Any annual cost-of-living increases for Executive Directors are linked to the Agenda for Change terms and

conditions of employment, which apply to all staff. No Board Director is involved in setting their own remuneration.

2.2.2 Annual Report on Remuneration

2.2.2.1 ***Service Contracts***

All directors are subject to a six months' notice period. Table 3 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 2021

Name	Title	Contract Date From	Contract Date To
Non-Executive Directors			
Chris Lawrence	Trust Chair	1 July 2014	31 December 2020
Sarah Betteley	Non-Executive Director Chair	1 August 2014 1 January 2021	31 December 2020 31 December 2024
Catherine Dugmore (*Senior Independent Director)*	Non-Executive Director	1 August 2016	31 July 2022
David Atkinson	Associate Non-Executive Director Non-Executive Director	1 May 2019 1 August 2019	31 July 2019 31 July 2022
Anne Barnard	Non-Executive Director	1 January 2021	31 December 2023
Tanya Barron	Non-Executive Director	1 August 2020	31 July 2023
Tim Bryson	Non-Executive Director	1 January 2021	31 December 2023
Sarita Dent*	Non-Executive Director	1 May 2019	13 July 2020
Diane Herbert	Non-Executive Director	1 September 2018	31 August 2021
Kush Kanodia *	Associate Non-Executive Director	1 March 2021	28 February 2022
Dame Janet Paraskeva	Non-Executive Director	1 September 2018	31 July 2021
Patrick Vernon	Non-Executive Director	1 January 2021	31 December 2023
Loyola Weeks	Non-Executive Director	1 August 2014	31 December 2020
Directors			
Tom Cahill	Chief Executive	1 April 2009	Current
Keith Loveman	Director Finance and Deputy CEO (until 28 February 2021)	14 October 2010	Current
Karen Taylor	Director of Strategy and	27 February 2012	Current

	Integration and Deputy CEO (from 1 March 2021)		
Sandra Brookes	Director Delivery and Service User Experience	1 April 2019	Current
Ann Corbyn	Director of People and OD	2 February 2020	Current
Dr Jane Padmore	Director Quality and Safety	17 November 2016	Current
Paul Ronald*	Director of Operational Finance	1 April 2020	Current
Dr Asif Zia	Director of Quality and Medical Leadership	July 2017	Current
Other Directors and Attendees			
Helen Edmondson	Head of Corporate Affairs and Company Secretary	2 September 2019	Current

***Non-Voting**

Note:

1. *In April 2020 Chair, Chris Lawrence and Non-Executive Directors Sarah Betteley and Loyola Weeks tenures were extended for a maximum of six months due to COVID-19. They were in fact in post until end of December 2020.*
2. *There was no identified Deputy Chair from 1 January 2210 to 31 March 2021.*

2.2.2.2 ***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.

2.2.3.3 ***Nominations and Remuneration Committee***

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

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

There were six meetings of the committee during the financial period and the members' attendance is shown in section 2.1.2 in table 1.

The Executive Director of People and Organisational Development and the Head of Corporate Affairs and Company Secretary serves and provides advice to the Committee. No advice external to the Trust was received in relation to the Remuneration Committee in 2020/21.

2.2.3.4 ***Policy on diversity and inclusion used by Nominations and Remuneration Committee***

The Nomination and Remuneration Committee follows the Trust policy on Equal Opportunities and ensures all decisions made are in line with the principles laid out in the policy to:

- Eliminate discrimination of all kinds

- Promote equality of opportunity
- Work to maintain relationships between different groups of staff
- Advocate for fairness in the workplace

This is part of Strategic Objective 4 for the Trust that we will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment.

2.2.3.5 ***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 enabling a range of representative views. The Chair, Head of Corporate Affairs and Company Secretary, Executive Director of People and Organisational Development and the Chief Executive are normally in attendance. The committee is chaired by the Lead Governor.

Appointments and Remuneration Committee (period 1 April 20 – 31 March 21)

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

- Chris Lawrence – Chair (3/3)
- Sarah Betteley – Chair (2/2)
- Caroline Bowes Lyon (5/5)
- Ilana Rinkoff (1/2)
- Ray Gibbins (4/5)
- Vanessa Cowle (5/5)
- Barry Canterford (5/5)
- Eni Bankole Race (5/5)
- Jon Walmsley (0/4)*
- Michael Shapiro (3/4)
- Helen Edmondson (4/5)
- Tom Cahill (4/5)
- Ann Corbyn (3/5)

**Note: Jon Walmsley was not able to attend meetings as he had a conflict of interest.*

The Executive Director of People and Organisational Development and the Head of Corporate Affairs and Company Secretary services and provides advice to the Committee.
The appointing of the Chair and Non-Executive Directors in 2020/21 was supported by an external search agency and included open advertising.

2.2.3.6 ***Disclosures required by the Health Social Care Act***

Remuneration for senior managers is set out within section 2.2.3.7 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 may claim travel expenses at the rate of 45p per mile as well as other reasonable expenses incurred on Trust business. Non-Executive Directors may claim in line with the Trust's expenses policy and 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:

	2019/20		2020/21		
	No of individuals claimed	**£**	**No of individuals claimed**	**£**	**No of individuals in post**
Governors	4	345	0	0	29
Non-Exec Directors	4	12,209	1	474	13
Exec Directors	9	10,346	4	1,001	8

2.2.3.7 **Senior Managers' remuneration**

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2020/21 was £200k-£205k (2019/20, £180-185k). This was 6.3 times (2019/20, 6.4 times) the median remuneration of the workforce, which was £32,237 (2019/20, £31,574). The increase in the highest paid director salary relates to performance related bonuses which for 2020/21 are no longer applicable and are included within the basic salary.

Remuneration ranged from £7,500 to £204,284, (2019/20, £7,410 to £201,745). The main reason for the slight increase in the median pay figure, and therefore the reduction in the ratio, is due to the agenda for change contract refresh.

In 2020/21, (0) 2019/20 (0) employees received remuneration in excess of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Senior Managers remuneration details and pension benefits for 2020/21 are set out in the tables below. These are subject to audit. During the accounting period no payments were made to past senior managers and no payments were made for loss of office.

Salary and Pension entitlements

Remuneration

Name and Title	2020/21						2019/20					
	Salary and fees (bands of £5,000)	Taxable benefits * (nearest £00)	Performance related bonuses (bands of £5,000)**	Long term Performance related bonuses (bands of £5,000)	Pension related benefits (bands of £2,500)***	Total (bands of £5,000)	Salary and fees (bands of £5,000)	Taxable benefits * (nearest £00)	Performance related bonuses (bands of £5,000)**	Long term Performance related bonuses (bands of £5,000)	Pension related benefits (bands of £2,500)***	Total (bands of £5,000)
	£000	£	£000	£000	£000	£000	£000	£	£000	£000	£000	£000
Christopher Lawrence (Non Executive Director and Chair) Resigned December 2020	35 to 40					35 to 40	50 to 55					50 to 55
Sarah Betteley (Non Executive Director and Chair) Appointed Chair January 2021	20 to 25					20 to 25	15 to 20					15 to 20
Catherine Dugmore (Non Executive Director)	15 to 20					15 to 20	15 to 20					15 to 20
Loyola Weeks (Non Executive Director) Resigned December 2020	10 to 15					10 to 15	15 to 20					15 to 20
Tanya Barron (Non Executive Director)	10 to 15					10 to 15	15 to 20					15 to 20
Diane Herbert (Non Executive Director) Appointed May 2019	10 to 15					10 to 15	10 to 15					10 to 15
David Atkinson (Non Executive Director) Associate from May to July 2019, Appointed August 2019	10 to 15					10 to 15	10 to 15					10 to 15
Janet Paraskeva (Non Executive Director) Resigned September 2020	5 to 10					5 to 10	15 to 20					15 to 20
Sarita Dent (Associate Non Executive Director) Appointed May 2019, Resigned July 2020	0 to 5					0 to 5	5 to 10					5 to 10
Timothy Bryson (Associate Non Executive Director) Appointed January 2021	0 to 5					0 to 5						
Anne Barnard (Associate Non Executive Director) Appointed January 2021	0 to 5					0 to 5						
Patrick Vernon (Associate Non Executive Director) Appointed January 2021	0 to 5					0 to 5						
Kush Kanodia (Associate Non Executive Director) Appointed March 2021	0 to 5					0 to 5						
Simon Barter (Non Executive Director) Resigned July 2019							5 to 10					5 to 10
Tom Cahill (Chief Executive)	200 to 205				487.5 to 490	690 to 695	180 to 185		15 to 20			200 to 205
Asif Zia (Director of Quality & Medical Leadership) ****	185 to 190				75 to 77.5	260 to 265	180 to 185		0 to 5		70 to 72.5	255 to 260
Keith Loveman (Deputy CEO/Director of Finance) Appointed Deputy CEO December 2018	155 to 160	6,000			132.5 to 135	295 to 300	140 to 145	6,000	10 to 15		130 to 132.5	290 to 295
Karen Taylor (Director of Strategy & Integration)	145 to 150				117.5 to 120	265 to 270	130 to 135		10 to 15		47.5 to 50	190 to 195
Jane Padmore (Director of Quality & Safety)	145 to 150				155 to 157.5	305 to 310	130 to 135		10 to 15		50 to 52.5	195 to 200
Sandra Brookes (Director of Delivery and Service User Experience) Appointed April 2019	145 to 150				192.5 to 195	340 to 345	125 to 130		10 to 15		182.5 to 185	320 to 325
Ann Corbyn (Director of Workforce & Organisational Development) Appointed February 2020	130 to 135				30 to 32.5	160 to 165	15 to 20		0 to 5		2.5 to 5	25 to 30
Paul Ronald (Director of Finance) Appointed April 2020	130 to 135				87.5 to 90	215 to 220						
Susan Young (Interim Director of Workforce & Organisational Development) Appointed October 2019, Resigned March 2020	0 to 5					0 to 5	65 to 70					65 to 70
Aderonke Akerele (Director of Innovation and Transformation) Resigned September 2019							85 to 90				20 to 22.5	105 to 110
Mariejke Maciejewski (Interim Director of Workforce & Organisational Development) Resigned September 2019							50 to 55				17.5 to 20	70 to 75
Jess Lievesley (Director of Delivery and Service User Experience) Resigned March 2019							0 to 5					0 to 5

Band of highest paid director's total remuneration	200 to 205	180 to 185
Median total remuneration	£32,237	£31,574
Ratio	6.3	6.4

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

** The performance related bonus for 2019/20 noted the maximum estimated amount payable. For 2020/21 there is no longer a performance related pay system with payments included within the basic salary.

*** The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

**** The salary & fees for the Director Quality & Medical Leadership includes £140k for Asif Zia in relation to their clinical role.

Pensions benefits

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer value at 31 March 2021	Cash Equivalent Transfer value at 31 March 2020	Real increase in Cash Equivalent Transfer value
	£000	£000	£000	£000	£000	£000	£000
Tom Cahill*	20 to 22.5	62.5 to 65	110 to 115	335 to 340	2,586	1,977	409
Asif Zia	2.5 to 5	0 to 2.5	55 to 60	115 to 120	1,126	1,026	61
Keith Loveman	5 to 7.5	10 to 12.5	55 to 60	135 to 140	1,181	1,020	104
Karen Taylor	5 to 7.5	7.5 to 10	45 to 50	90 to 95	763	649	74
Jane Padmore	7.5 to 10	12.5 to 15	55 to 60	135 to 140	1,088	927	105
Sandra Brookes	7.5 to 10	17.5 to 20	55 to 60	130 to 135	1,136	923	141
Ann Corbyn	0 to 2.5	0 to 0	0 to 5	0 to 0	41	5	25
Paul Ronald	2.5 to 5	12.5 to 15	25 to 30	85 to 90	734	605	85

Non-Executive Directors do not receive pensionable remuneration.

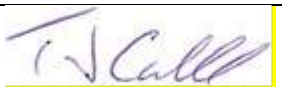
* Tom Cahill has Mental Health Officer status and has reached maximum service of 40 years. There is no real increase to his pension or lump sum at age 60. His CETV has not increased as he has now opted out of the pension scheme.

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
	11 June 2021

2.3 Staff report

2.3.1 Analysis of staff costs

Staff Group	Permanently Employed £'000	Other £'000	Total £'000
Admin and estates	21,268	256	21,524
Healthcare assistants and other support staff	54,980	1,164	56,144
Medical and Dental	25,647	898	26,545
Nursing and midwifery	49,614	3,678	53,292
Scientific, therapeutic and technical staff	35,667	889	36,556
Grand Total	**187,176**	**6,885**	**194,061**

2.3.2 Staff numbers analysis

Staff Group	Permanently employed	Other	Total
Admin and Estates	839	191	1030
Healthcare assistants and other support	1022	455	1477
Medical and Dental	149	89	238
Nursing and Midwifery	778	145	923
Scientific, Therapeutic and Technical	798	71	869
Grand Total	**3586**	**951**	**4537**

Breakdown of the number of male and female staff

Staff Group	Female	Male	% Female	% Male	Total
Directors	5	4	56%	44%	9
Other Senior Managers	5	6	45%	55%	11
Medical and Dental	125	112	53%	47%	237
Employees	3194	1086	75%	25%	4280
Grand Total	**3329**	**1208**	**73%**	**27%**	**4537**

Sickness absence data
The People 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 2020/21 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. This link is to information published by NHS Digital https://digital.nhs.uk/data-and-information/publications/statistics/nhs-sickness-absence-rates

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. Over the last 12 months we have seen a significant increase in the usage of our Occupational Health service and continue to receive positive feedback about the support and service provided.

We offer a range of support services to our staff through a variety of benefits partners:

- Employee assistance programme
- Here for You
- Physiotherapy services

We continue to implement our Health and Wellbeing Strategy; we have:

- Begun recruiting Health and Wellbeing Champions across the Trust;
- Identified a Workforce Wellbeing Guardian at Board level;
- Expanded our Winter Wellbeing Programme to become a regular offer;
- Introduced Mental Health First Aid Training;
- Launched our project to become a Menopause Friendly Workplace;
- Delivered our new Management Fundamentals: Supporting Wellbeing Session;
- Continued to support staff with Reasonable Adjustments and accessing support;
- Worked with our EAP, OH and Here for You providers to enhance support pathways and establish regular benefit provider roundtables.

Employee Assistance Programme Data

- Over the last year 79 employees have utilised the telephone support from the EAP
- 200 staff have accessed the EAP website, this has recently been relaunched and an App Service will follow

The table below shows the number of full time equivalent days available in 2020/21 against full time equivalent days lost to sickness.

Staff Group	FTE Days available	FTE Days Sickness	%FTE Days sickness
Admin and Estates	259,579	7,572	2.92%
Healthcare assistants and other support	358,110	19,470	5.44%
Medical and Dental	74,131	1,974	2.66%
Nursing and Midwifery	261,839	12,321	4.71%
Scientific, Therapeutic and Technical	240,806	6,821	2.83%
Grand total	**1,194,465**	**48,158**	**4.03%**

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 workplace. Local and regional 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.

We work in partnership with local and regional 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, and monthly meetings take place with local representatives 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 introduction and roll out of the Just Culture. We also work in partnership on key projects and plans in relation to the Gender Pay Gap, WRES and WDES.

Our workforce race equality scheme (WRES) and workforce disability equality scheme (WDES) data is published on our website at: NHS Workforce Race Equality Standard (WRES) (hpft.nhs.uk) and NHS Workforce Disability Equality Standard (WDES) (hpft.nhs.uk). This data shows a positive trend compared to previous years and compared to the national data. Significant work was undertaken during the year to promote equality, diversity and inclusion, with Schwartz rounds to talk about race,

support directly from the Executive Team, refreshing our induction in relation to equality, diversity and inclusion, relaunching our BAME staff network with an Executive level sponsor and inviting white staff to join the BAME staff network as allies. This work appears to have made a positive impact in reducing experience of discrimination at work. In the past year, we have also introduced reverse mentoring for our Executive and Senior Leadership Team. We have continued our implementation of the first decision making panel in disciplinary matters to significantly reduce the likelihood of BAME staff entering the disciplinary process, so that the gap in experience is now 0.03. We have continued to ensure that there is a BAME staff representative at all senior level selection panels, which has reduced the difference in likelihood of appointment between BAME and white staff to 0.22. We have also introduced an Associate Non-Executive Director post on the Board specifically to address the profile of the Board. Finally, we refreshed our appraisal approach to include equality, diversity and inclusion as part of the appraisal conversation.

Our 2020 annual staff survey identifies that whilst our WRES indicators show a positive trend compared to the national data and the previous year, there remain some gaps in experience between our white and our BAME staff, in particular in relation to the proportion of BAME staff employed at senior levels compared to the overall Trust workforce, perceived fairness of promotion/career progression and experience of discrimination from our service users, relatives and the public. Our action plans for 2021/22 therefore focus on improving performance in these areas.

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 new 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 29 staff incidents to the Health and Safety Executive (HSE) under the Reporting Injuries and Dangerous Occurrences Regulations (RIDDOR) during 2020/21. This compares to 32 incidents in 2019/20.

Three incidents were specified injuries and all others resulted in staff being absent for seven or more days,

Twenty-five of the incidents were as a result of a physical assault against staff, two were a result of manual handling incidents and one incident each of a slip, trip and fall and contact with object.

The Trust has issued over 1000 lone working devices to those staff who undertake high risk lone working duties. There were no Red Alert activations during the year requesting the emergency services to attend to support and assist staff, however this is in the context of a reduction in face to face appointments during the COVID-19 pandemic. The Trust Lone Worker devices received a major improvement this year,

as the Trust moved to a new provider, following a pilot that received very positive feedback.

The Trust operates an Equal Opportunities Policy, which sets out that we will give full and fair consideration to applications for employment made by disabled persons. The policy also cites the Trust's 'Managers Guide for Supporting Staff with a Disability', which describes the Trust's approach to ensuring support for staff who have become disabled, as well as our approach to applicants and existing disabled staff. The Equal Opportunities Policy and Management Guidance are complemented by the Trust's Absence Management Policy and our Recruitment and Selection Policy. The Trust is a Disability Confident employer. As part of our Disability Confident commitment, our Recruitment and Selection Policy states that all applicants with a disability who meet the minimum shortlisting requirements for a position will be shortlisted for the post and guaranteed an interview and we have robust systems for monitoring this.

Occupational Health
The Trust has an external Occupational Health Service, which assesses new staff prior to employment to ensure that any risks in relation to their own or others' health and safety are identified and actions taken to mitigate these and recommend reasonable adjustments for disabled staff. In addition, the Occupational Health Service assesses existing staff to assess their fitness for work and advise how we can support our people, including making reasonable adjustments for disabled staff. During 2019/20, the Trust worked with the organisations that make up the Hertfordshire and West Essex ICS in relation to the sharing of Occupational Health Services. As a result of this work, the Trust entered into an arrangement with a neighbouring trust that secured a new Occupational Health Service from April 2020. This arrangement fully complies with the need to ensure value for money, procurement rules and all relevant standards for Occupational health Services, such as SEQOHS (Safe Effective Quality Occupational Health Service standard). Section 2.3.3 details incident information for 2020/21.

"Friendly, happy, helpful staff. The group in WGC where my mum attended really made her feel welcome and brought her out of herself. Tracey, Kerry and Shirley really welcomed her and myself. This group only lasted 1.5 hours a week but this was just about enough for my mum and others like her. Shame it is over. (CST Group)"

Carer Older People's Services

2.3.4 NHS National staff survey

2.3.4.1 ***Summary of Performance***
The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2020/21 survey among trust staff was 52% (2019/20: 57 %). The actual number of responses we received, however was greater this year (1803 compared to 1786 in 2019). Scores for each indicator together with that of the survey benchmarking group (Mental Health & Learning Disability and Mental Health, Learning Disability& Community Trusts) are presented below.

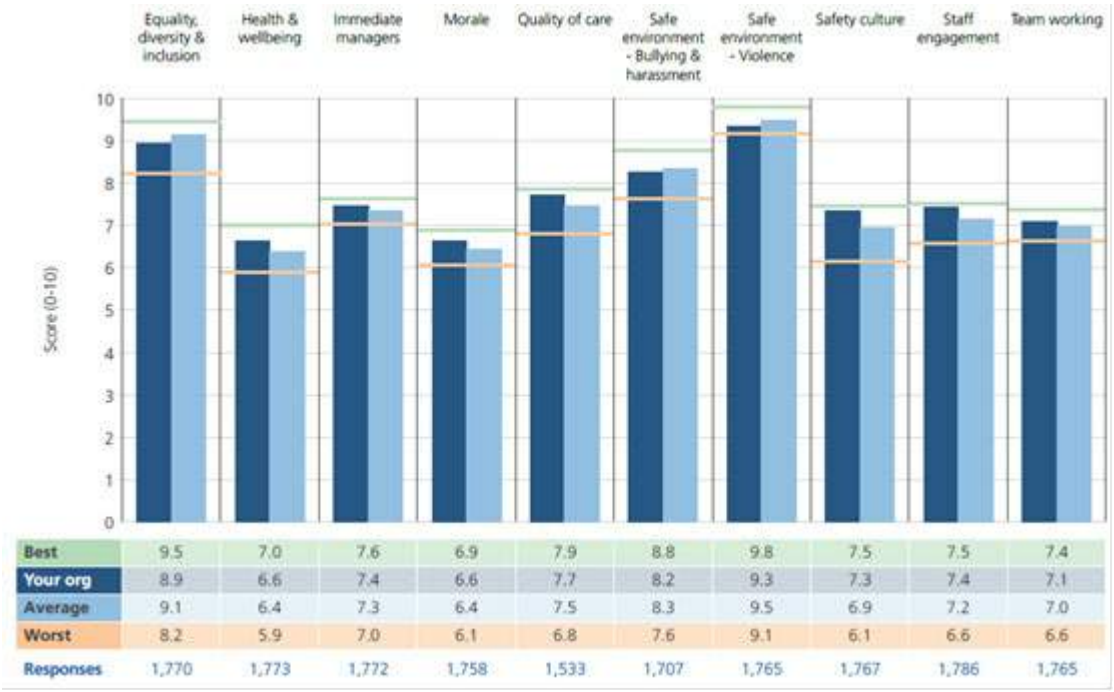
	2018/19		2019/20		2020/21	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	8.9	9.0	8.9	9.1	8.9	9.1
Health and wellbeing	6.1	6.1	6.3	6.1	6.6	6.4
Immediate managers	7.1	7.2	7.4	7.3	7.4	7.3
Morale	6.2	6.2	6.5	6.3	6.6	6.4
Quality of care	7.4	7.3	7.7	7.4	7.7	7.5
Safe environment – bullying and harassment	8.0	8.2	8.1	8.2	8.2	8.3
Safe environment – violence	9.3	9.4	9.3	9.4	9.3	9.5
Safety culture	7.0	6.8	7.2	6.8	7.3	6.9
Staff engagement	7.2	7.0	7.4	7.1	7.4	7.2
Team Working	6.8	6.9	7.1	6.9	7.1	7.0

Note: Staff Survey for 2020 did not include question regarding quality of appraisals

The results of the 2020 staff survey were overwhelmingly positive and we have maintained a good overall result demonstrating the value of current organisational development, wellbeing initiatives and a range of staff engagement events. The key highlights are as follows:

- We scored higher than average on 7 of the 10 themes and 58 of the78 questions asked also scored above average compared to our comparator group.
- Staff ratings of Health and Wellbeing showed a statistically significant improvement compared to 2019 and our score was higher than the national average.
- 76% recommend HPFT as a place to work to friends & family (2nd highest score in country)
- 76% happy with standard care for their own friends & family (7th highest in country)
- 92% say they know their role makes a positive difference to our SUs (3rd highest in country)
- 88% say care of service users is HPFT's top priority (2nd highest in country)

Each of the 10 themes are compared against the national average scores, below:



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	8.9	6.6	7.4	6.6	7.7	8.2	9.3	7.3	7.4	7.1
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	1,770	1,773	1,772	1,758	1,533	1,707	1,765	1,767	1,786	1,765

There was one significant difference across the 10 themes compared to last year which is the result for Health and Wellbeing:

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.9**	1757	**8.9**	1770	Not significant
Health & wellbeing	**6.3**	1766	**6.6**	1773	↑
Immediate managers †	**7.4**	1765	**7.4**	1772	Not significant
Morale	**6.5**	1734	**6.6**	1758	Not significant
Quality of care	**7.7**	1533	**7.7**	1533	Not significant
Safe environment - Bullying & harassment	**8.1**	1748	**8.2**	1707	Not significant
Safe environment - Violence	**9.3**	1752	**9.3**	1765	Not significant
Safety culture	**7.2**	1755	**7.3**	1767	Not significant
Staff engagement	**7.4**	1776	**7.4**	1786	Not significant
Team working	**7.1**	1756	**7.1**	1765	Not significant

The 3 areas where we scored lower than the national average, will be our key areas of focus:

- Bullying & harassment - In particular from service users/relatives/public.
- Violence - In particular from service users/relatives/public.
- Equality, diversity & inclusion - In particular relating to fairness of career progression/promotion, as there is an 18% difference in BAME and White staff's experience on this; and Discrimination on the basis of ethnicity from service users/relatives/public is a particular issue.

Based on this feedback from staff the Trust is introducing a positive response to bullying, harassment and poor behaviour to enable staff to reach respectful resolution

together. We are building on our Values which are well embedded into our culture, and providing a Respectful Resolution programme to all our staff. This will include e-learning modules on how to give feedback and being able to speak up safely as giving and receiving feedback are the heart of a safe organisation.

Our strategic aim is to develop a Just and Learning Culture and we are committed to creating a culture where staff feel supported, valued and respected for what they do. Traditionally there has been an emphasis on policies, procedures and training as the cornerstone of tackling bullying. Research is clear that enabling individuals to better raise their concerns can be effective to reduce the overall levels of bullying. As an approach, Just and Learning Culture can be proactive and preventative. Our people are our greatest asset and the focus for us is to continue to improve the experience of staff in the workplace.

Our priorities going forward to build on our Good to Great strategy will be:

- Continued rollout of the Great Teams Approach
- Introduce Respectful Resolution
- Build on the engagement activities within the Trust
- Develop a Just and Learning culture
- Further build on our culture of innovation and continuous improvement across the Trust
- Develop leaders at all levels building on the Collective Leadership model.
- Developing our staff to better support service users to stay as well as possible.

The People 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 2020/21.

2.3.4.2 ***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 an 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 have developed a number of ways of supporting managers prior to and during the COVID-19 pandemic. Our staff had to adapt and adopt new ways of working which led to managers having to manage teams differently. We developed a virtual half day ‘Working Differently’ workshop for all managers to support them through the

transition and how to adopt new practices and skills for managing their teams. We adapted our management fundamentals workshop from a 2-day face to face workshop to a virtual modular approach. This enabled access to training as and when needed enabling a more responsive approach to manager and team needs.

We value the input of all members of staff at all levels and are committed to staff engagement. A regular programme of Live MS Teams events was run throughout the year delivered by the Executive Team. It was an opportunity for staff to receive regular updates in a quickly changing environment and also to ask questions, share suggestions, connect with colleagues and ensure effective two-way communication.

We redesigned and adapted our large engagement event, the Big Listen events, which are usually a face to face all day event held at The Colonnades, Hatfield, to a week-long virtual event. Listening events were held daily throughout the week and open to staff in the organisation. They provide the opportunity for the Executive Team to hear staff views directly on key topics and priorities, informing actions and improving employee satisfaction and wellbeing.

The Senior Leaders Forum brings together the top 100 leaders from across the organisation on a regular basis throughout the year for joint problem solving and development activities. This continued during this year in a virtual format and received positive feedback and engagement from our leaders.

We continued to run our Inspire Awards (monthly recognition) throughout the year using a blended approach of virtual and socially distanced award ceremonies.

A number of virtual 'coffee mornings' were held for our staff, particularly those shielding, to support their wellbeing and to enable colleagues to keep connected with their work and the organisation. In addition, a wide variety of health and wellbeing virtual sessions have taken place and we launched a new newsletter called 'Supporting You' which sets out all the support on offer to our staff.

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.

Really supportive and gave me the skills and ability to put my problems into perspective and implement positive action to get them sorted.

Service User Herts IAPT

2.3.4.3 ***Future Priorities and Targets***

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

- Support our people to 'pay witness' to the pandemic, to rest and recuperate.
- Continue to develop and provide a broad range of wellbeing activities & approaches across the organisation.
- Increase opportunities for reward & recognition across the Trust.

- Work with our staff networks to continue to address differences in employee experience.
- Refresh our Equality Diversity and Inclusion Plans, focusing on our just and learning cultural programme.
- Develop our approach to talent and promotion to ensure fairness of promotion opportunities across all groups including BAME.
- Continue our campaign to eliminate bullying and harassment across the Trust.
- Improve our recruitment approaches to attract high calibre people reflecting local communities.
- Ensure we have the right people with the right skills through more effective workforce planning.
- Support teams to develop through fully implementing our Great Teams model.
- Further develop our staff engagement activities across the Trust.

The People 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 2021/22.

2.3.4 Expenditure on Consultancy

The total expenditure on consultancy for the year is £199k. 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 2020/21 were £58k for IT support for the Trust's digital strategy implementation, £51k to assist with the Trust's post COVID-19 strategy, and £32k for the provision of a well led review.

2.3.6 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 March 2021 was:

- HPFT had 15 employees who were relevant union officials during the relevant reporting period. This equates to 13.79 full-time equivalents
- Of the 15 employees who were relevant union officials;
-

0% working hours on facilities time	1-50% of their working hours on facilities time	51-99% of their working hours on facilities time	100% of their working hours on facilities time
3	10	2	0

- The percentage of the total pay bill spent on facilities time was 0.02%
- The time spent on paid trade union activities as a percentage of the total facilities time hours was 3.06%

2.3.7 Exit Packages

There were no exit packages agreed in 2020/21 (0 in 2019/20).

2.3.8 Off-payroll engagement

Table 4: Off-payroll engagements as of 31 March 2021, for more than £245 per day and last for longer than six months

	Number
Total number of existing arrangements as of 31 March 2021	**1**
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	0
between three and four years at time of reporting	0
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 5: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, 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 2019 and 31 March 2020	0
Of which;	
No. assessed as within the scope of IR35	0
No. assessed as not within the scope of IR35	0
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 6: Off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

	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.	8

2.3.9 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.

As at 31 March 2020 our gender pay gap analysis identifies a mean gender pay gap of 10.10% and median of 4.11%. 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 2021/22, will consider the next steps we should take to reduce it. Please see the link to further details on our Trust website. **https://www.hpft.nhs.uk/about-us/gender-pay-gap-reporting/**

2.3.10 Equality, Diversity and Human Rights

Control measures are in place to ensure that all the HPFT'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 May 2019 with an overall outcome of 'good' and we also self-assessed in May 2020 as part of our COVID-19 quality impact assessment. Our overall 'good' reflects ongoing progress and areas for improvement. During 2021/22 we will be undertaking a full regrading exercise once EDS3 is in place with underpinning activity to include:

- Monitoring and recording our data as part of an improvement programme - with a review of equity of access to services and care outcomes.
- Leading a programme of work that is focused on identifying and removing systemic barriers that can lead to inequity.
- Reviewing our experience feedback for staff, service users and carers.
- Working at SBU level to promote and engage staff on the EDI agenda.
- Increased activity for the NHS Accessible Information Standard (communication and language needs).

2.3.11. 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

"Thank you for helping me open up and providing me with the help I need".

Service user CAMHS

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 Audit Committee and

Board received a report providing detail of compliance. 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 (2019) demonstrated. During this period the Trust also undertook an external developmental Well Led Review in line with the KLOEs in the framework. The report was positive and the review concurred with the CQC's assessment of the Trust as 'Outstanding' with regard to the well led domain. The review identified a number of recommendations for which an action plan has been developed and will be monitored going forward.

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. It also sets out the interim governance arrangements in place for 2020/21 including the assurance role undertaken by the Board Assurance Sub-committee: COVID-19. 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 assures itself of the review of accounting policies and draft annual accounts prior to submission to the Board of Directors.

The 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:

- **COVID-19 Pandemic:** in particular, the Trust's response and the handling of the risks the pandemic brought in terms of safety, finance, effectiveness and experience. The Committee was supported by the work of the Board Assurance sub-Committee – COVID-19; Integrated Governance Committee and Finance and Investment Committee. The financial governance to support the COVID-19 Pandemic including the main accounting/audit issues relating to the year such as PPE stocks, building valuations and income recognition.
- **Information Governance:** In response to internal audit report the Committee approved new policy on Standards of Business Conduct and received assurance on its implementation. Regular compliance reports will be considered by the Committee.
- **Cyber Security:** Details of the systems in place to manage Cyber Security and Fraud were considered. The discussion also enabled both Internal Audit and Counter Fraud Services to confirm that the work being undertaken covered all the appropriate areas.
- **Capital Allocation:** The increasing role of the ICS in terms resource allocation and the application of an annual capital limit.

The Committee also considered:

- Internal Audits. Receiving updates on progress against actions from internal audits such as Safeguarding, Violence and Aggression and Risk Management.
- Counter Fraud. Regular updates and progress on fraud issues and investigations as well as compliance with NHSCFA standards for Providers.
- Accounting issues. Presentation of key areas of management judgement in the preparation of the annual financial statements with particular reference to:
- The level and nature of provisions for potential future costs for example continuing care obligations the liability for dilapidations or restatement costs on the leasehold properties currently occupied, potential employment claims and the costs of providing alternative care arrangements whilst a major refurbishment is undertaken.

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

During the year the committee undertook a thorough self-assessment. The self-assessment was positive and the committee agreed actions to improve on a small number of areas.

External Audit

KPMG is the appointed auditor for the Trust. The primary duty of our external auditors is to conduct an official inspection (audit) of the Annual Report, financial statements 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 yearend 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 are contracted to provide assurance over the Quality Report and audit Quality Accounts. The Annual Reporting Manual 2020/21 removed the requirements of an external audit of the Quality Report and Quality Account and therefore the work was no longer required.

The total external audit fee for 2020/21 (excluding VAT) was £70k, comprising:

Audit Area	Audit Fee £k
Statutory	70
Quality	0

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.
    - People and Organisational Development.
    - The following groups will also report on specific items relating to areas of regulatory compliance:
        - Operations Group.
        - Information Governance Group.
- Supervise, monitor and review Trust governance systems and processes 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 Accounts.
- Ensure that appropriate risk management processes are in place that they 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 (CQC) 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.
- Provide assurance with regard to the workforce and organisational development work of the Trust.

"The team are amazing and so easy to get on with and which makes recovery easier in the long run. They really have done such a great job I was sad to say goodbye".

Service user Eating Disorder Service

The Finance and Investment Committee

The role of the Finance and Investment Committee in regard to Financial Policy, Management and Reporting and is to:

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

Investment Policy, Management and Reporting

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

Other

- 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.
- Examine any other matter referred to the Committee by the Board of Directors.
- Review performance indicators relevant to the remit of the Committee.

During the year the Integrated Governance committee and Finance and Investment Committee undertook thorough self-assessments. The self-assessments were positive and the committees agreed actions to improve on some areas.

The Board Assurance Sub Committee COVID-19

The role of the Board Assurance Sub-Committee COVID-19 was to provide the Board of Directors assurance with regard to monitoring of safety, quality, risk, financial and contract arrangements during planning and response to COVID-19 pandemic in particular to:

- Assure adherence to CQC and other relevant regulatory requirements for quality and safety and receive reports from all relevant quality and safety groups during the COVID-19 pandemic.
- Scrutinise and provide assurance to the Trust Board through providing regular reports on governance, quality and risk issues and to escalate any risks to the BAF or concerns as appropriate where assurance is not adequate, during the COVID-19 pandemic

- Ensure that appropriate risk management processes are in place which provide the Board with assurance that action is being taken to identify risks and manage identified risks within the Trust during the COVID-19 pandemic.
- Be responsible for developing systems and processes for ensuring that the Trust implements and monitors compliance with its registration requirements of the Care Quality Commission during the COVID-19 pandemic.
- Ensure that the learning from inquiries carried out in respect of SIs is shared across the Trust and implemented through policies and procedures as necessary.
- Consider Trust's service, financial and contractual performance during the COVID-19 pandemic.
- Ensure that services and treatments provided to service users are appropriate, reflect best practice and represent value for money during the COVID-19 pandemic.
- Ensure that services are accessible and responsive to Service User needs and reflect local "nuances" during the COVID-19 pandemic.
- Ensure that the environments in which services are provided are appropriate and therapeutic.

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 40 Governors. The Council of Governors is constituted to have 21 public governors from two constituencies, namely Hertfordshire and the Rest of England and Wales, plus 5 Staff Governors and up to 11 appointed governors, nominated by the Trust's partner organisations. **Table 4** below shows the current Trust Governor profiles.

Table 7:. Governors: 1 April 2020 to 31 March 2021

Name	Date Appointed	End Date	Resignation / End Date	Number of Terms	Meetings Attended
Tap Bali	01 August 2012	31 July 2021		3	4/5
Caroline Bowes-Lyon	01 August 2011	31 July 2020		3	5/5
Barry Canterford	01 August 2013	31 July 2022		3	5/5
Mathew Kunyeda	01 August 2018	31 July 2021		1	0/5
Bob Taylor	01 August 2016	31 July 2022		2	5/5
Jon Walmsley Lead Governor	01 August 2016	31 July 2022		2	4/5
Ilana Rinkoff	01 August 2016	31 July 2022	October 2020	2	2/2
William Say	01 August 2017	31 July 2020		1	4/5

Name	Date Appointed	End Date	Resignation / End Date	Number of Terms	Meetings Attended
Colin Egan	01 August 2017	31 July 2020		1	1/5
Meredith Bradford	01 August 2017	31 July 2020	October 2020	1	1/2
Harinder Singh-Pattar	01 August 2017	31 July 2020		1	0/5
Emily Burke	01 August 2018	31 July 2021		1	5/5
Catherine Adedoyin Akanbi	01 August 2018	31 July 2021		1	3/5
Eni Bankole Race	01 August 2018	31 July 2021		1	4/5
Maria Watkins	01 August 2019	31 July 2022		1	2/5
George Ashcroft	01 August 2019	31 July 2022		1	5/5
Louis Sanford	01 August 2019	31 July 2022		1	3/5
Michael Shapiro	01 August 2019	31 July 2022		1	4/5
Michelle Maddison	01 August 2019	31 July 2022		1	0/5
Cynthia Price	04 November 2019	03 September 2020		1	3/5
Appointed Governors					
	Date of Appointment	**End of Office**			
David Andrews	01 August 2013	31 July 2022			3/5
Ray Gibbins	04 September 2018	03 September 2021			3/5
Fran Deschampsneufs	01 August 2012	31 July 2021			4/5
Rosemary Farmer	01 December 2014	30 November 2023			5/5
Eve Atkins	07 January 2017	06 January 2023			1/5
Staff Governors					
Herbie Nyathi	01 August 2016	31 July 2022		2	2/5
Sue Nolan	01 August 2019	31 July 2022		1	2/5

Francis Bernard	01 August 2019	31 July 2022	1	2/5
MJ Cruz	01 August 2019	31 July 2022	1	3/5
Vanessa Cowle	01 August 2019	31 July 2022	1	3/5

We thank all our governors for their valuable contribution to the Trust. In particular those who left the Trust during the year 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 Head of Corporate Affairs 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 Head of Corporate Affairs and Company Secretary. The significant commitments declared by the Chair are:

Sarah Betteley

- Director DEVA Medical Electronics Ltd.

Chris Lawrence

- Chair, University of East Anglia Staff Superannuation Scheme.
- Director, Lambeth Conference Company.
- Chair of Trustees, The Horstead Residential Activities Centre, Norfolk.

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

- Recruitment of Chair.
- The recruitment of non-executive director roles.
- Recruitment of Lead Governor.

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.
- Input into Trust's Annual 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:

- Membership and 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 Head of Corporate Affairs 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.

"I am so much better than I was before I started this course. Several methods of learning to cope with anxiety & stress has certainly helped me. Thank you so much for allowing this course for me".

Service user Adult Mental Health Services

Membership
Currently our membership stands at 8,813. The Trust has a data management system to ensure it has accurate membership data. We are 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 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 members 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

Our website remains our primary medium for engaging with members and the wider community and is a good source of information about the work of the Trust including the Council of Governors.

It is important 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	2019/20	2020/21
Year start (01 April)	9,194	8,916
New members	10	2
Members leaving	289	105
Year end (31 March)	8,916	8,813
Staff constituency	**2019/20**	**2020/21**
Year start (01 April)	3,354	3,478
New members	617	605
Members leaving	493	524
Year end (31 March)	3478	3,559

Public constituency	2019/20	2020/21
Age (years0		
0 - 16	3	3
17 - 21	4	4
22+	8,286	8,188
Not specified	623	618

Ethnicity	2019/20	2020/21
White	7,500	7,407
Mixed	415	408
Asian or Asian British	440	439
Black or Black British	118	118
Other	7	7
Not specified	436	434

Gender analysis	2019/20	2020/21
Male	3,547	3,508
Female	5,353	5,289
Not specified	16	16

Disclosure Issues

Requests for Information

Freedom of Information Act 2000 (FOIA)
The number of Freedom of Information Act 2000 (FOIA) requests received by the Trust during this year has decreased, however the complexity and number of questions asked continue to increase. The Trust received a total of 311 requests compared with 373 in 2019/20, 392 in 2018/19 and 320 for 2017/18.

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 requestor	Number of requests 2020/21	Number of requests 2019/20	Number of requests 2018/19
Other/Unknown	206	245	248
Companies	17	10	10
Journalists	37	51	63
Staff/Other NHS Trusts	21	30	30
Students/Research	25	30	36
MPs	5	7	5
Total Number	**311**	**373**	**392**

Timescales for responses
FOIA legislation requires public authorities to provide a response to requests for information within 20 working days. Whilst every effort is made to complete all requests within this timescale, it is not always achievable due to the 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.

In Q1, the Trust made the difficult decision to suspend work on FOI, to support the front line response to COVID-19. Requests were accepted, but requesters were advised that the response would be delayed. Whilst necessary, this decision has generated a significant backlog of work, which is impacting on timeliness.

Information has been provided to applicants within the following timescales:

Response Time (in working days)	Number of Requests 2020/21	Number of requests 2019/20
1 - 5 days	39	5
6 - 10 days	12	26
11 - 15 days	11	40
16 - 20 days	5	33
21+ days	163	187
Other	6	
Requests currently being processed	75	82

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 2020/21:

- 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
2020/21	82 exemptions were applied (2019/20, 136 exemptions were applied)	Section 1 x 24
		Section 12 x 4
		Section 14 x 1
		Section 21 x 33
		Section 22 x 1
		Section 31 x 3
		Section 40 x 8
		Section 41 x 0
		Section 43 x 3

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. 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 33 requests received during the period 2020/21.

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	SARs Processed (Excluding CC)	% Change Year on Year (received)	Continuing Care (CC)	Access to Deceased Record	Enquiries
2020/21	789	716	-4%	54	21	48
2019/20	821	807	+ 44%	14		
2018/19	583	559	+ 25%	24		

Please note, in addition to the above figures for 2020/21 we have received requests from the Police for two operations they are conducting.

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

During the period 1 April 2020 – 31 March 2021, SARs were processed within the following timescales (this excludes the special project details above):

Response Time	Number of SAR requests 2020/21
Within 21 calendar days	236
Within 28 calendar days	50
Within 30 calendar days	30
30+ calendar days	267
No longer required or closed during processing	133
In progress	73

The Trust will endeavor 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 requestor	Total
Advocate	1
CCG	10
Continuing Care	5
Court Order	58
Doctor/Research	1
Investigatory Body	22
Other NHS Trust	10
Other Public Authorities	13
Police	148
Probation Service	1
Relatives	41
Service User	208
Solicitor	265
Staff Members	2
University	1
Others	3
Total	**789**

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 on the form and on the basis required by those Directors. 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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, 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 and disclose any material uncertainties over going concern

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 them 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.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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
	11 June 2021

2.7 Annual Governance Statement 2020/21

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.

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 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

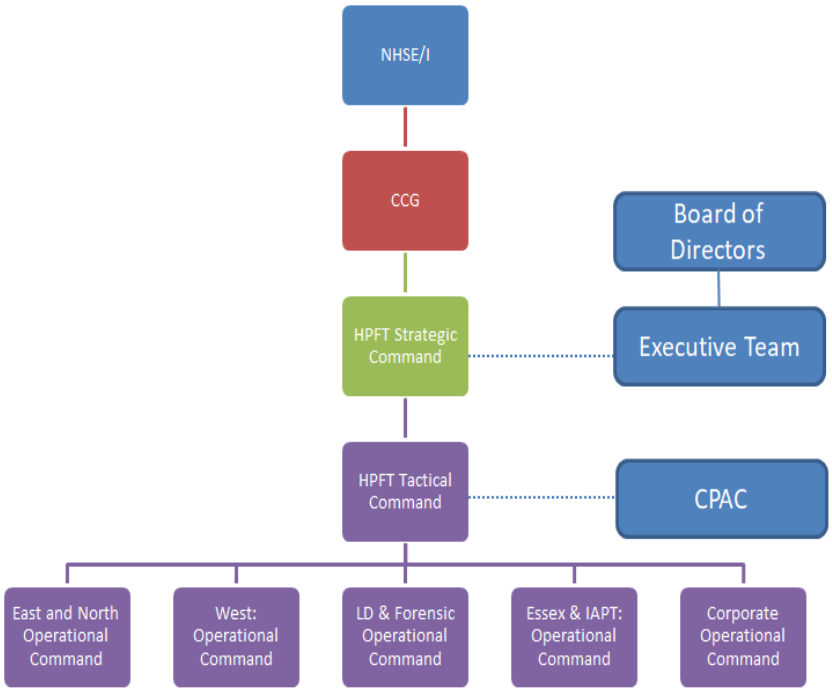
Overall Risk Management	Executive Director of Quality & Safety (Caldicott Guardian)
Clinical Governance	Executive Director of Quality & Safety
Clinical Risk & Medical Leadership	Executive Director of Quality & Medical Leadership
Corporate Governance	Head of Corporate Affairs and Company Secretary
Board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

Figure 2 below illustrates the robustness and effectiveness of our risk management and performance processes via our governance structure.

During 2020/21, in response to the COVID-19 global pandemic and in line with guidance from the NHSI/E (Reducing the Burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic) the trust agreed and implemented interim governance arrangements for the period April to end of July 2020.

In order to respond appropriately to the pandemic in 2020/21 the Trust implemented its Business Continuity policy for a Major Incident. As a consequence, for the majority of the period the Trust operated a command and control structure alongside its established corporate Governance framework. **Diagram 1** describes the Major Incident command structure in place in the Trust.

Diagram 3: HPFT Major Incident Command Structure



Governance arrangements were reviewed in relation to the COVID-19 pandemic. Throughout the period of the pandemic, interim governance arrangements were put in place to respond to the specific circumstances:-

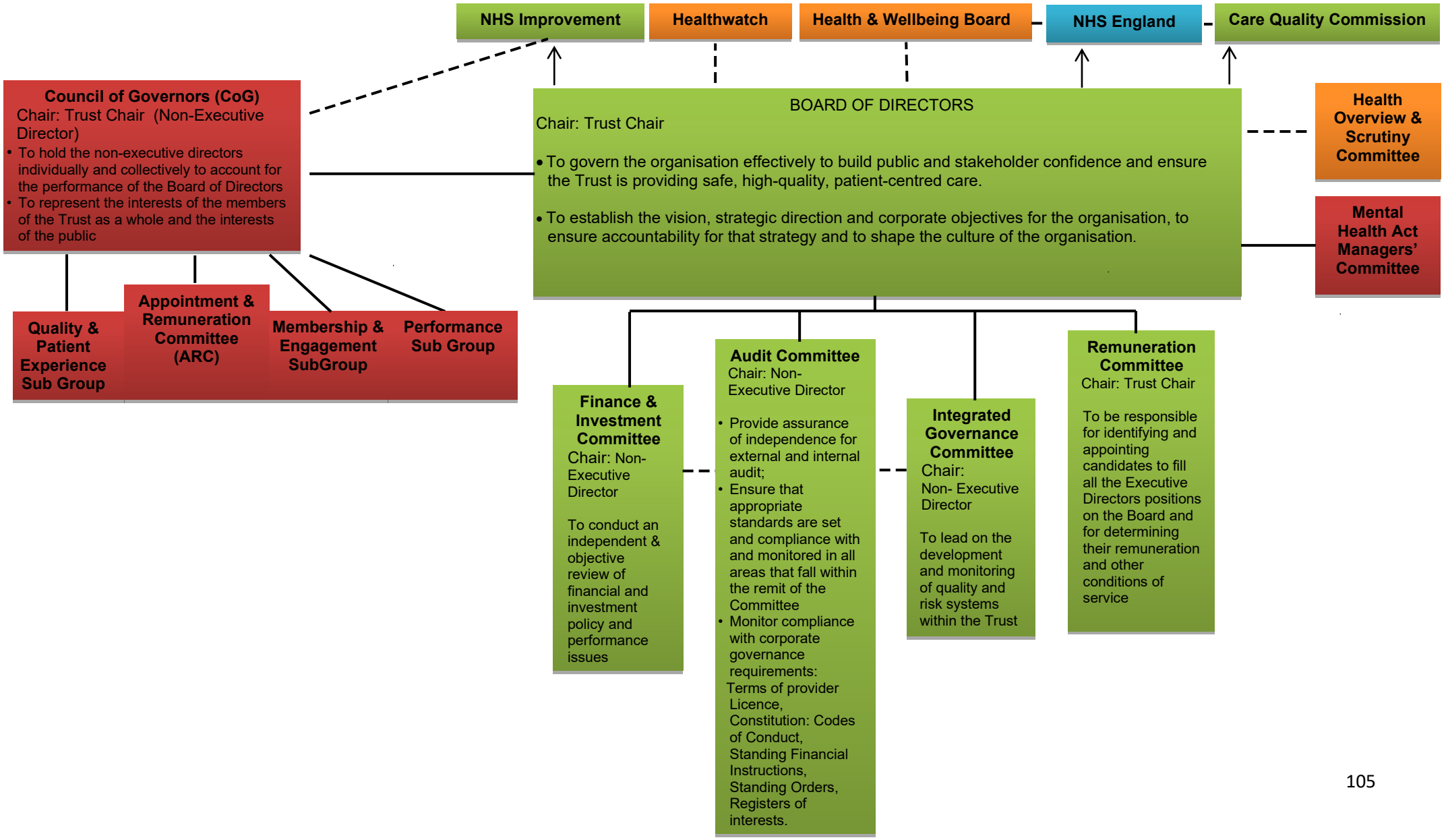
- The Board of Directors remained the ultimate corporate decision making body, collectively responsible for the performance of the Trust ensuring the Trust functioned effectively, efficiently and economically (The NHS Foundation Trust Code of Governance). The Board was supported in its work by sub committees, a constitution, standing orders and a scheme of delegation.
- The Audit Committee continued to provide the Board of Directors with assurance with regard to Trust's systems of internal control, reporting directly to the Board of Directors.

- The Integrated Governance Committee and Finance and Investment Committee were stood down for a limited period and a Board Assurance Committee – COVID-19 established.
- The Board Assurance Committee – COVID-19, provided the Board of Directors with assurance with regard to safety, quality, risk, financial and contract arrangements during this period. Supported with the membership of Committee all members of the Integrated Governance and Finance and Investment Committee.
- The Major Incident command structure oversaw the operational, tactical and strategic management of the incident drawing appropriate support and resources as necessary.
- The Clinical & Professional Advisory Committee (CPAC) was established to offer expert guidance and advice relating to the clinical and practice issues in relation to COVID-19, this includes but is not limited to ethical issues, Mental Health Act, DoLS Restraint, Admissions and physical environments.

All of the interim arrangements were subject to a trust commissioned review by internal audit, which found that robust controls were in place for interim governance arrangements.

Figure 1

HPFT GOVERNANCE STRUCTURE



In addition, the Director of Delivery and Experience/Chief Operating Officer is responsible for the day-to-day management of risk and performance within operational services and there is a designated role of Deputy Director of Nursing, Quality, Safer Care and Standards 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.

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 & Risk Management Committee and People & 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, service performance 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.

The risk and control framework

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 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 illustrates the risk escalation process.
It also emphasises the role of the Board Assurance Framework and Risk Register in the management of strategic and operational risks respectively.

The Trust's Risk Management Strategy details the relationship between the Trust's strategic goals, principle risks and the Board Assurance Framework and thereby provides the quality governance framework for the Trust. It is also enhanced by Practice Governance Framework and the Quality Strategy.

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 Policy has continued to work effectively during 2020/21. 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, accountability and responsibility arrangements.

These responsibilities are then taken forward through the Board 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 3** below illustrates risk management and how it 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:

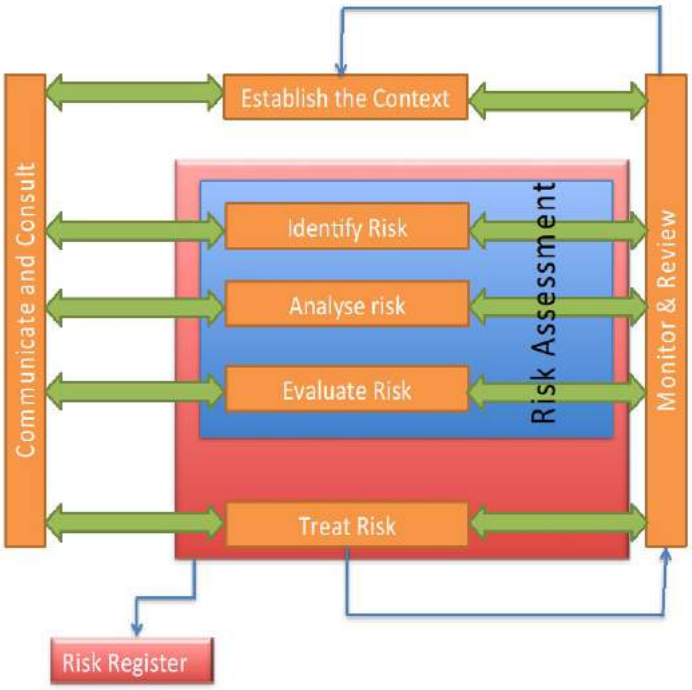


Figure 2 Source: AS/NZS 4360:1999

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 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, Board Assurance Sub-Committee COVID-19 and the Audit Committee scrutinise and monitor clinical and non-clinical risks where appropriate, on behalf of the Board. Figure 1 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.

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 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. It is supported in this role by the Integrated Governance Statement and Finance and Investment Committee.

The Integrated Governance Committee is the important part of 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 and are then embedded in practice.

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. We have also in 2020/21 provided a new means of engagement for staff with the introduction of regular live Q&A sessions with the Executive Team. These sessions enable any member of staff to attend and put questions or raise issues directly with the Executive Team.

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.

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 2020/21 *Annual Governance Statement*. In particular the principal risks of the Trust have been updated to ensure complete alignment with the Trust's Strategic Objectives. During 2020/21 the BAF has been considered and reviewed by the Integrated Governance Committee, Audit Committee and Board and has been updated in line with feedback following an internal audit.

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 Head of Corporate Affairs and 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
- Response to COVID-19 pandemic
- Recovery following COVID-19 pandemic waves
- Infection Prevention and Control
- Long term impact of COVID-19 on demand
- Transition following EU Exit
- Financial Resources
- Staff – including wellbeing
- Cyber security
- Data Quality and General Data Protection Regulations.
- Changes to system architecture

- Acuity and complexity of needs and impact on operational services

During this period the Trust had an Infection Prevention and Control Board Assurance Framework (IPC BAF) in line with national best practice. The IPC BAF set out the risks, controls and assurance in place to manage IPC during the COVID-19 pandemic. The IPC BAF was reviewed by CQC who gave a positive opinion. The Trust also commissioned an external review to provide assurance and identify areas for improvement. The IPC BAF and external review were reported to the Integrated Governance Committee.

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.

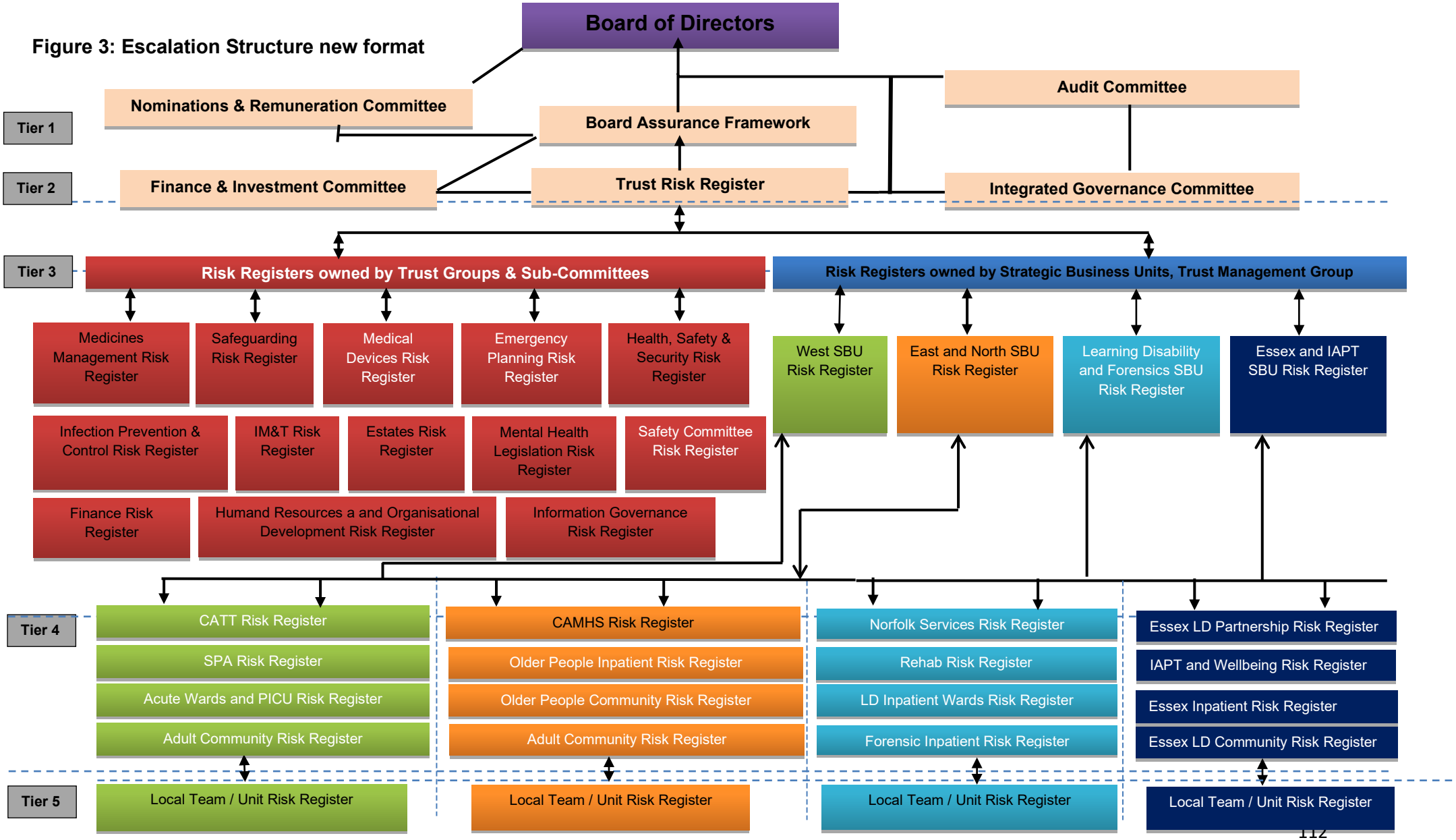
There is a clear process for escalating high or significant risks (see **Figure 4** below). The Trust does not have a static risk appetite. The Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. In any event there must be consultation with the 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.

During this period the risk escalation process has been enhanced through a COVID-19 specific risk register, reviewed daily at Tactical Command in relation to appropriate mitigating actions. The review is informed by the Operational Command incorporating SBU and corporate functions as well as CPAC with key risks and concerns escalated to Strategic Command on a daily basis. The full COVID-19 risk register is then reviewed by the executive team on a weekly basis and considered by the Board Assurance Sub-Committee: COVID-19 and Board.

All risks that are entered onto Datix (anyone can alert the organisation to a risk through Datix) are reviewed by the Risk and Governance Team and these are fed into the relevant risk register, including the COVID-19 risk register.

To support this approach to risk management the Trust has a Freedom to Speak Up Guardian, with a dedicated email address and Datix whistleblowing facility. The Board has also identified a Non-Executive Director for Freedom to Speak Up, to support the Guardian in their role. Also, CQC inform the Trust of any concerns that they are alerted to. All of these are fed into the COVID-19 or Trust risk register.

Figure 3: Escalation Structure new format



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 & 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.

Care Quality Commission essential standards of quality
The Trust is fully compliant with the registration requirements of the Care Quality Commission under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During 2020/2021 and the height of the coronavirus pandemic the CQC made changes to the way that it undertook its regulatory role by using a transitional approach to monitoring Trusts and services specifically using a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so that they could continually monitor risk in a Trust and target inspection activity where they identified concerns, rather than continuing the cyclical comprehensive inspections of Trusts.

The Transitional Monitoring Approach (TMA) uses intelligence and Key lines of Enquiry (KLOE) questions to assist in gaining an understanding of the risk level of the Trust and if any regulatory action is required.

The Trust participated in the TMA commencing November 2020 which required a KLOE document to be completed and submitted along with evidence. Through the document, the CQC were seeking overall Trust information but also wanted to focus on Seward Lodge, where their intelligence - complaints and Serious Incidents (SI) - had been highlighted as an area of possible concern. This was provided in a separate document.

There was a scheduled TMA interview with the Executive Director of Quality and Safety (Chief Nurse) and the Deputy Director of Nursing and Quality (DIPC) on 21 January 2021, to complete the TMA process. This was undertaken virtually and the outcome was shared at the meeting. There will not be a published report at the end of the process nor a written report that will be provided.

At the end of the interview, CQC indicated that they were satisfied and, for the Trust, the TMA has concluded. Ongoing monitoring will continue in the form of MHA inspection visits and quarterly engagement meetings.
The CQC have recently held a consultation on their Strategy for the next five years.

Other External Reviews
During the year the Board commissioned an independent 'well-led' review, this was in line with best practice as there is an expectation that the review is undertaken every three to five years. The report gives a positive assessment of the leadership of the organisation and supports the CQC outstanding award for leadership. The final report was considered by the Board and Council of Governors in the first quarter of 2021/22.

Also during this period the external auditor undertook a Value for Money review in line with requirements for 2020/21 to provide a public commentary on the arrangements in place for ensuring Value for Money is achieved at the Trust. The report is very positive with no significant risks identified across any of the domains with three recommendations identified.

Leaving the European Union
During the year the Trust has undertaken business continuity risk assessments to ensure any gaps in controls are addressed in preparation for exiting from the EU. The Trust continued to consider the risk assessments and that appropriate business continuity plans are in place. Oversight was provided by the Emergency Planning Group, reporting to the Executive Team and Integrated Governance Committee.

Tests of Business Continuity and Incident Management Plans 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. The Audit Committee and Board have also received reports on EU Exit Transition including the contingency plans in place to minimise any possible disruption and the potential risks included specifically on the Trust Risk Register. Specific support has been put in place for staff who may be impacted by the requirement to apply for 'settled status'.

Workforce Strategies
The Trust has a People and Organisational Development Group (PODG) which oversees delivery of the workforce strategy, short medium and long term, and reports routinely to the Integrated Governance Committee. The PODG 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 and Retention Group
- Safer Staffing Meeting
- Medical Educators Forum
- Joint Consultative and Negotiating Committee

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 regular safe staffing reports from the Executive Director – Quality & 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 & 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 Leader to ensure the effective utilisation of the eRoster.
- **Safer Staffing Group –**held on a monthly basis, chaired by the Deputy Director of Nursing & Quality, responsible for overseeing staffing regarding effective utilisation of eRostering and SafeCare, bank & agency usage, staffing skill mix & establishments.

In response to the COVID-19 pandemic and in order to manage the increase in staff absence from work whilst ensuring safe staffing levels, the staffing levels were reviewed and minimum staffing levels were proposed and agreed as a temporary measure if required. The staffing levels were reviewed daily and weekly throughout the pandemic. At no time did the minimum levels have to be implemented.

Register of Interests
HPFT has published on its website an up to date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the "Managing Conflicts of Interest in the NHS guidance.

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.

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 partial re-grading of the NHS Equality Delivery System 2 in May 2019 with an overall outcome of 'good' and this reflects ongoing progress and improvement. We are currently waiting for NHS England and NHS

Improvement to release the new EDS3 and once this comes into effect we will undertake a full regrading EDS3; activity will include:

- Data quality improvement programmes with a review of equity of access to services and care outcomes.
- Reporting and action planning for the Workforce Equality Standards (WRES, WDES).
- Increased activity for the Information Standards (AIS, SOIS).
- Launch of Gender Identity bitesize training for front line services.
- Revise the action planning framework following unconscious Bias Training
- Gender Pay Gap reporting

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.

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 Council.
- Forest House Council (CAMHS Inpatient).
- 'Making Services Better' Group for people with Learning Disabilities.

All of our councils and groups ensure that stakeholder views are embedded in the ways we work.

Service User and Carer Groups/Councils have been a significant presence in the Trust for over 15 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.

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 Feeling safe in acute and Improving the responsiveness of community services.

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.
- Wellbeing and Mindfulness (self-care)

2020/21 has been characterised by the impact of COVID-19 which has affected the way we have been able to interact with our service users and carers. There was a need to rethink the way we engaged in the new environment. Having adopted our approaches we devised an active virtual involvement programme for our service users and carers. Elections were held for new chairs of the Councils. A number of members of the service user and carer councils are also elected Trust Governors. An inclusion and equality working group is also being formed.

Over the past year, the Inclusion & Engagement Team have lead on the priorities in our Equality Plan (2019 – 2022) and Carer Plan (2019 – 2021). Our staff disabled network (Diversability) and our staff mental health network have been instrumental in supporting our work around the NHS Workforce Disability Equality Standard (WDES) which we are now monitored on as part of our standard NHS contract.

Our BAME staff network has led on an extensive consultation programme with staff that has resulted improvements such as; COVID-19 risk assessment for all trust staff, informing the development of the Trust people plan and the development and implementation of a BAME staff support line that has since been up scaled across the ICS. The efforts of the network over the last year can also be seen through the improvements in outcomes as measured through the NHS Workforce Race Equality Standard (WRES).

At every Board meeting, a service user, carer or professional from a specific service are invited to share their experiences (their story) and suggest actions for positive change.

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.

As Trust we also aim to have an Expert by Experience on every recruitment panel, this is an important element to ensuring people recruited to the Trust are in tune with our values.

All our groups have worked relatively intensively with staff on local projects that impact service users and carer's day-to-day care including CQI projects virtually – an example is engaging in a design sprint. We also work with our other stakeholders to listen and act on people's lived experience. Our third sector partners have been vital in carers' feedback contributing to local commissioning decisions.

Our focus over the past year has been to introduce key programmes and 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:

- LGBT History Month
- Black History Month
- International Womens Day
- Time to talk and Blue Monday
- Carers week and Carer Rights Day
- Diversity & Leadership
- Equality, Diversity and Human Rights Week
- Schwartz Rounds for Inclusion
- Race equality programme
- Introduction of equality ambassadors programme
- Introduction of equality champions programme
- Relaunching staff network virtually
- Flu vaccine engagement programme

It is notable from the WDES, WRES and NHS Staff Survey results that our equality and diversity programmes have made a contribution to improving the performance of the Trust and the Trust becoming Mental Health Trust of the year 2020.

Data quality and governance

The Trust has an Information Governance Policy in place. The four key interlinked strands to the information governance policy are:

- Information security;
- Legal compliance;
- Openness; and
- Quality assurance.

The policy contains duties and responsibilities for information governance and highlights the reporting structure, with reference to the Information Management and Governance Sub-Committee as a key forum for discussion, challenge and oversight.

The Trust has a policy framework, which outlines the statutory requirements for the Trust and the limitations for personal data processing. Policies within the framework also detail the responsible owners for Personal Confidential Data and Personal Identifiable Data.

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 and managing data.
- Where possible, we eliminate manual approaches to data gathering and analysis. This includes investing in new systems.
- We audit the electronic patient record to gain assurances that our clinical record-keeping and data quality processes are robust.

The accuracy of information for Quality Reports is assessed via:

- Systematic checks within the Data Quality team.
- Board scrutiny of the quarterly reports, ensuring that any errors and/or corrections are noted.

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.

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.

During this period the Trust increasingly used its internal information repository – SPIKE to support the management of services during the pandemic and to support our wellbeing offer to staff.

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.

Data 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.

The following table details every data incident notified to the Information Compliance team in 2020/21.

Themes of reportable data loss/breaches	
Theme (Historic HSCIC SIRI Classifications)	**Total Number Reported 2020/21**
A Corruption or inability to recover historic data	**2**
B Disclosed in error	**225**
C Lost in transit	**6**
D Lost or stolen hardware	**4**
E Lost or stolen paperwork	**4**
F Non-secure disposal - Hardware	**0**
G Non-secure disposal – Paperwork	**1**
H Uploaded to website in error	**2**
I Technical security failing (inc Hacking)	**2**
J Unauthorised access/disclosure	**12**
K Other and rejected	**61**
Total	**319**

There were seven incidents requiring investigation which were reported to the ICO in 2020/21, compared to seven reported in 2019/20. All seven were formally reported as potential or actual breaches of confidentiality involving person identifiable data. The ICO has closed five of the seven reported incidents, two remain open. In all closed cases, the Commissioner has been satisfied with the steps taken by the Trust to address the incident, and no

further action was.

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 rigour of decision-making processes aligns with the strategic priorities of the Trust and supports implementation of best practice.

Anti-fraud and Corruption including the Bribery Act 2010
The Bribery Act which came into force in April 2011 makes it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery could lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This helps ensure that the taking or receiving of bribes is less likely, and improve the integrity and transparency of the Trust's transactions and decisions.

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

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

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

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 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 to each 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 and the Board Assurance Framework quarterly.
- 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 Resolution and the CQC.

In this period the Trust has also undertaken an external development review of leadership and Governance using the well-led framework. The review provided a positive view and is a valuable source of external assurance with regard to the governance of the Trust.

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 2020/21, 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 seven final assurance opinions and three final advisory reviews for the year.

Of the seven assurance opinions, five reasonable assurances and two partial assurances and zero no assurance opinions across the areas of internal audit work undertaken. The partial assurance opinions related to:

- Workforce Planning
- Safeguarding monitoring processes

We have addressed these issues by:

- Procuring expertise to support the development of a more robust framework for workforce planning processes.
- Implementing stronger processes for the management of bank staff shifts and for documenting monitoring meetings
- Ensuring more consistent documentation of safeguarding outcomes supported by training and the use of digital systems to ensure comprehensive reporting.

The Trust also commissioned three advisory reviews in relation to COVID-19 Governance (Interim Arrangements), Data Protection by Design and Data Security Protection Toolkit and Rostering and SaferCare. The reviews were positive but did identify some areas that could be strengthened further with regard to data protection impact assessments and tracking of completion of the DSPT toolkit.

1. Conclusion

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

Tom Cahill
Chief Executive

Date: 11 June 2021

3. Accounts and Financial Statements

FOREWORD TO THE FINANCIAL STATEMENTS

HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2021, 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
Head Office, The Colonnades
Beaconsfield Road
Hertfordshire
AL10 8YE
Telephone number: 07971 639542

Signed 

Mr Tom Cahill, Chief Executive Date 14 June 2021

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2021

	note	2020/21 £000	2019/20 £000
Operating income from patient care activities	4	273,695	254,168
Other operating income	4	21,293	10,331
Operating expenses	5	(294,930)	(259,150)
OPERATING SURPLUS		**57**	**5,349**
FINANCE COSTS			
Finance income	9.0	0	396
Finance expense - financial liabilities	9.1	(258)	(272)
Finance expense - unwinding of discount on provisions	9.1	43	24
PDC dividend charge		(2,904)	(3,886)
NET FINANCE COSTS		(3,119)	(3,738)
Gains of disposal of assets	11.3	178	0
(DEFICIT)/SURPLUS FOR THE YEAR		**(2,884)**	**1,611**
Other comprehensive income will not be reclassified to income and expenditure:			
Impairments	13	(9,565)	(2,080)
Revaluations	11	2,945	2,477
Remeasurements of net defined benefit pension scheme	26	(402)	(41)
Will not be reclassified to income and expenditure:		**(7,022)**	**356**
TOTAL COMPREHENSIVE INCOME/EXPENSE FOR THE YEAR		**(9,906)**	**1,967**

Whilst the deficit for the financial year was £2,884k (£1,611k surplus in 2019/20) 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 break-even for 2020/21 (break even for 2019/20)

		2020/21	2019/20
Financial performance for the year:		£000	£000
(as above)		(2,884)	1,611
less Provider Sustainability Funding (PSF)	1.3	0	(2,330)
less central MH funding provided in March 2020	1.3	0	(1,371)
add back Net Impairments charged to the SOCI	13	3,105	1,677
remove Non-cash element of on-SOFP pension costs	26	(38)	(41)
less gain on disposal of assets	11.3	(178)	0
COVID-19 eligibility adjustment- in FY20-21 the additional holiday pay accrual for untaken staff holidays was matched with additional income in the PY this was not the case		0	507
Adjusted financial performance against the NHSI Control Total		**5**	**53**

STATEMENT OF FINANCIAL POSITION
31 March 2021

	note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	10	815	1,035
Property, plant and equipment	11	152,990	153,780
Total non-current assets		**153,805**	**154,815**
Current assets			
Inventories	14	59	56
Receivables	16	8,127	16,551
Assets held for sale	15	3,054	1,592
Cash and Cash Equivalents	17	78,891	55,260
Total current assets		**90,131**	**73,459**
Current liabilities			
Trade and other payables	21	(40,750)	(26,021)
Borrowings	19	(541)	(540)
Provisions	20	(4,347)	(3,334)
Other liabilities	22	(15,481)	(8,391)
Total current liabilities		**(61,119)**	**(38,286)**
Total assets less current liabilities		**182,817**	**189,988**
Non-current liabilities			
Borrowings	19	(8,469)	(8,998)
Provisions	20	(5,932)	(5,780)
Other liabilities	22	(364)	0
Total non-current liabilities		**(14,765)**	**(14,778)**
Total assets employed		**168,052**	**175,210**
Financed by (taxpayers' equity)			
Public Dividend Capital		94,684	91,936
Revaluation Reserve		28,830	36,432
Other reserves		(528)	(126)
Income and expenditure reserve		45,066	46,968
Total taxpayers' and others' equity		**168,052**	**175,210**

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 14 June 2021

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 March 2021

	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 2019 - brought forward		**175,210**	**91,936**	**36,432**	**(126)**	**46,968**
Surplus for the year	SOCI	(2,884)	0	0	0	(2,884)
Net impairments	13	(9,565)	0	(9,565)	0	0
Revaluations - property, plant and equipment	11	2,945	0	2,945	0	0
Transfer to income and expenditure reserve on disposal of assets		0	0	(982)	0	982
Remeasurements of defined net benefit pension scheme liability / asset	26	(402)	0	0	(402)	0
Public dividend capital received	18	2,748	2,748	0	0	0
Taxpayers' Equity at 31 March 2020		**168,052**	**94,684**	**28,830**	**(528)**	**45,066**

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 2020/21 £1,000k was issued to fund capital investment on estates and technology which otherwise could not have been funded; £1m to relocate theplant room on the Litte Plumsted Hospital site, £882k to support the implementation of an electronic prescibing system, £579k for COVID capital claims, and £286k to fund additional remote working support . 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.
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 2020

	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		**172,451**	**91,144**	**36,035**	**(85)**	**45,357**
Surplus for the year	SOCI	1,611	0	0	0	1,611
Net impairments	13	(2,080)	0	(2,080)	0	0
Revaluations - property, plant and equipment	11	2,477	0	2,477	0	0
Remeasurements of defined net benefit pension scheme liability / asset	26	(41)	0	0	(41)	0
Public dividend capital received	18	792	792	0	0	0
Taxpayers' Equity at 31 March 2019		**175,210**	**91,936**	**36,432**	**(126)**	**46,968**

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 2019/20 £792k was received for cyber sercurity and digital strategy funding. 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.
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 CASH FLOWS FOR THE YEAR ENDED 31 March 2021

	note	2020/21 £000	2019/20 £000
Net cash inflow from operating activities	24	**37,737**	**8,686**
Cash flows used in investing activities			
Interest received	9	0	409
Purchase of property, plant and equipment	11	(12,692)	(7,922)
Proceeds from sales of property, plant and equipment	11	504	0
Net cash flows used in investing activities		**(12,188)**	**(7,513)**
Net cash generated used in financing activities			
Public dividend capital received		2,748	792
Movement in loans from the Department of Health and Social Care		(530)	(530)
Capital element of finance lease rental payments		0	(9)
Interest on loans		(256)	(273)
PDC dividend paid		(3,880)	(3,916)
Net cash generated used in financing activities		**(1,918)**	**(3,936)**
INCREASE IN CASH AND CASH EQUIVALENTS	17	23,631	(2,763)
Cash and Cash equivalents at 1 April	17	**55,260**	**58,023**
Cash and Cash equivalents at 31 March		**78,891**	**55,260**

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 £3,880k in the statement above, compared to £2,935k 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 2020/21 consisted of the sales proceeds realised on the sale of Alexandra Road and a small plot of land on the Little Plumsted Hospital site.

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 2020/21 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 and fair view as described above.

Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

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.
Valuation assumptions for Property, Plant and Equipment, with carrying assets of £147,063k are based on valuations provided by the District Valuer, Giles Awford, as at 31 March 2021 in line with note 1.6. The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, the valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

Estimates for the Hertfordshire Local Government Pension Scheme (LGPS) are based on actuarial reports as provided by Hymans Robertson LLP, and for the Essex Pension Fund by Barnett Waddingham, see note 1.5 for further details. In response to the UK Government's 2019 announcement to make changes to the Retail Prices Index (RPI) from 2030, a change in methodology has been applied to the calculation of the CPI rate underpinning the valuation of the Hertfordshire pension scheme liabilities. The impact of this change in methodology is not considered to have a material impact on the valuation of the Trust's total pension liability balance and the scheme would continue to remain in surplus under both calculation methodologies."

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

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).

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.
To maintain the NHS FT's cashflow position, then in this year the normal contract arrangments were set aside with block payment arrangements applied, performance obligations are assumed to have been met by the elapsing of time. Non-block contract performance obligations require payment 30 days from the date of request for payment. Block contract income accounts for circa 95% of the NHS FT's income in this year.

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. For 20/21 additional income has been provided by CCGs to meet the additional costs related to the provision of services during the COVID 19 pandemic. These arrangements which were nationally applied included Top Up income, amounts to meet the specific costs in responding to COVID 19 and also further income allocated by Hertfordshire and West Essex ICS

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. During 2020/21 this was accounted for on a gross basis due to the income receipt as part of the cash block payments.

For 2020/21 there is no Provider Sustainability Fund (PSF) available to NHS providers. In 2019/20 there was £1.25bn avaialble to NHS Providers based upon thier performance against the Provider Control Total set with the NHS FT being awarded a total of £1,887k in relation to its achievement of its control total and £443k in relation to a further amount awarded in relation to 2018/19. Income earned from the fund was accounted for as a variable consideration.

For 2020/21, contracting was paused and block cash payments were made by CCG's. This also resulted in a top up payment being received by the NHS FT to account for items that would have naturally been resolved during the contracting process.

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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

1.4 Other forms of income

Grants and Donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once the conditions attached to the grant have been met. Donations are treated in the same way as government grants. During 20/21 the NHS FT received £1,579k of donated Covid consumables from the Department of Health and Social Care.

Apprenticeship Service Income

The value of the benefit received when accessing funds from the Governments apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trusts Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition of the benefit

1.5 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. During the year 2020/21 the level of untaken leave carried forward has been higher than previous years due to COVID-19 with more staff unable to take leave in the period to March 2021. income has been provided by NHSE to meet this additional cost

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 and Social Care 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.

Changes to the rate of employers NHS Pension contribution have not been reflected in funding provided to individual Trusts during 2020/21. For this reason, the addition 6.3% liability was paid centrally by the Department of Health and Social Care . The amount is £7,464k in 2020/21 and £6,640k in 2019/20.

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:

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:

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

1.5 Employee Benefits (continued)

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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. 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 5 staff, with a further 3 staff in 2019/20, who had transferred under TUPE from Essex County Council remained members of the Essex Pension Fund. The NHS FT is now an admitted fully funded member of the pension scheme so has been accounted for such in 2020/21.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable for the goods and services received. Expenditure is recognised as an operating expense, except where it results in the creation of a non-current asset such as property, plant and equipment and is therefore capitalised (see 1.7 below).

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

1.7 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

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.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie 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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements-.

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 desktop revaluation of all assets was conducted by the District Valuer, Giles Awford, as at 31st March 2021 and those values have been included. Giles Awford has full membership of the Royal Institution of Chartered Surveyors (MRICS). The NHS FT last undertook a full estate valuation in 2017/18.

The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, the valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

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

1.7 Property, plant and equipment (continued)

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	10
Information Technology	3

Buildings held under finance lease agreements are depreciated over the term of the lease.

Freehold land is considered to have an infinite life and is therefore not depreciated.

Refurbishment of leased buildings is depreciated over the term of lease.

Property, plant and equipment which has been reclassified as 'Held for Sale' 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 expenditure.

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.

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

1.7 Property, plant and equipment (continued)

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met: The sale must be highly probable and the asset available for immediate sale in its present condition.

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 de-recognised when scrapping or demolition occurs.

Of the properties listed in the 2019/20 accounts as Assets Held For Sale, one, Alexandra Road, was disposed of as expected, and one asset, Harper Lane, was not disposed of within 2020/21 as intended due to COVID. The sale is considered highly probable in 2021/22 and remains as held for sale. In addition a further asset, The Stewarts, has now been classified as held for sale.

1.8 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 capitaised when it meets the requirements set out in IAS 38.

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.

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

1.8 Intangible Assets (continued)

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 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.

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.

1.9 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 on the Statement of Financial Position 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.

1.10 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. In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.11 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.

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

1.12 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 HM Treasury's discount rates effective for 31 March 2021.

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.

1.13 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.

1.14 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.

1.15 Contingencies

Contingent assets

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

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

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.

1.16 Financial assets and financial liabilities

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 Office for National Statistics.

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.

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).

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

Impairment of financial assets (continued)

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.

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.

1.17 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.

1.18 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.

1.19 Foreign currencies

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

1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However they are disclosed in Note 28 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.21 Public Dividend Capital (PDC) and PDC dividend

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

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 and grant 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 any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health and Social Care (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 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.

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

1.22 Losses and Special Payments

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses. The detail can be found in note 27.

1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 Subsidiaries

The 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.

1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

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

1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Notes to the Accounts - 2. Financial Risk Factors

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 , £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. Refer to note 23.2 for the current liabilities shown.

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”.

	2020/21 Total	2019/20 Total
	£000	£000
Income from activities		
Cost and volume contract income		
Block contract income	261,487	243,415
Clinical partnerships providing mandatory services (including S75 agreements)	1,066	981
Other clinical income from mandatory services	2,306	2,179
Additional pension contribution central funding	7,464	6,640
Other clinical income	1,373	953
Total income from activities	**273,695**	**254,168**
Other operating income		
Research and development	342	320
Education and training	5,562	4,277
Reimbursement and top up funding	10,735	0
Education and training - notional income from apprenticeship fund	195	214
Consumables donated from DHSC group bodies for COVID response	1,579	0
Provider sustainability fund (PSF) (see note 1.3)	0	2,330
Other	2,258	2,499
Rental revenue from operating leases	622	691
Total other operating income	**21,293**	**10,331**
Total operating Income	**294,988**	**264,499**

Changes to the rate of employers NHS Pension contribution have not been reflected in funding provided to individual Trusts during either 2019/20 or 2020/21. For this reason, the addition 6.3% liability was paid centrally by the Department of Health and Social Care and the NHS FT has subsequently recognised the income and expenditure in the note above and Note 5.1. The amount is £7,464k in 2020/21 and £6,640k in 2019/20.

Other Operating Income includes amounts of income provided by NHS England to meet the additional costs incurred by the NHS FT in relation to COVID-19. These are shown as reimbursement and top up funding.

PPE consumables were provided to the NHS FT at no charge. The cost of these consumables is shown within operating expenses and the equivalent amount is shown as income above

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.

	2020/21 Total	2019/20 Total
	£000	£000
Income from Activities		
NHS Trusts	391	531
NHS England	33,133	27,942
Local authorities	25,307	189,338
NHS Foundation Trusts	920	78
Clinical commissioning groups	213,943	35,289
Non NHS: other	0	990
Total Income from Activities	**273,695**	**254,168**

During 2020/21 NHS England directed income to be paid directly from Commissioners to the NHS FT. Previously the CCGs had transferred funding through to the Local Authority who managed the contractual arrangement on their behalf with the NHSFT. This has accounted for the large movement in the relative amounts of income shown in the two years between Clinical Commissioning Groups and Local Authorities.

The large increase in Foundation Trust income relates to one specific contract with East London NHS Foundation Trust that had previously been funded by NHS England

NHS England income has increased with the CAMHS Specialised Commissioning contract being accounted on a gross basis following a change in payment arrangements in 2020/21.

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.

	2020/21	2019/20
	£000	£000
Income from Commissioner Requested Services	273,695	254,168
Income from non-Commissioner Requested Services	21,293	10,331
	294,988	**264,499**

The increase in Income from non-Commissioner requested services relates to the Covid reimbursement income received, totalling £10,735.

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. In 2020/21 the Trust also leased the sites Albany Lodge to Hertfordshire Community NHS Trust, Forest House Annex to Hertfordshire County Council, Sovereign House to New Directions and Spring House land to NHS Property Services.

The total annual income from these operating leases in 2020/21 is £622k (£691k in 2019/20).

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

	2020/21 £000	2019/20 £000
on leases of Buildings expiring:		
- not later than one year;	621	590
- later than one year and not later than five years;	1,687	1,948
- later than five years.	1,343	1,607
	3,651	**4,145**

Notes to the Accounts - 5 Operating Expenses of continuing operations

5 Operating Expenses of continuing operations

5.1 Operating Expenses (by type)

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,450	5,355
Purchase of healthcare from non-NHS and non-DHSC bodies	23,303	18,101
Purchase of social care	18,315	17,726
Staff and executive directors costs	193,322	169,237
Non-executive directors	168	180
Supplies and services – clinical (excluding drugs costs)	1,125	820
Supplies and services – clinical: utilisation of consumables donated from DHSC	1,579	0
Supplies and services - general	8,842	7,237
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	3,415	3,307
Consultancy	199	271
Establishment	2,900	2,325
Premises - business rates collected by local authorities	1,687	1,697
Premises - other	2,519	2,488
Transport (business travel only)	558	2,211
Transport - other (including patient travel)	1,823	1,440
Depreciation	6,483	5,224
Amortisation	220	308
Impairments net of (reversals)	3,105	1,677
Movement in credit loss allowance: contract receivables/assets	330	45
Provisions arising / released in year	1,344	1,538
Audit services - statutory audit*	85	73
Other auditor remuneration (payable to external auditor only)*	0	6
Internal audit - non-staff	90	92
Clinical negligence - amounts payable to NHS Resolution (premium)	525	448
Legal fees	389	217
Insurance	376	318
Education and training - staff costs	1,364	1,212
Education and training - non-staff	175	121
Education and training - notional expenditure funded from apprenticeship fund	195	214
Operating lease expenditure (net)	3,478	3,156
Car parking and security	1,019	673
Hospitality	92	112
Other services (e.g. external payroll)	6,345	5,270
Other	4,110	6,051
Total Operating Expenses	**294,930**	**259,150**

* Audit services and remuneration figures are quoted inclusive of VAT

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
There were 0 exit packages agreed in 2020/21 totalling £0k.

Reporting of other compensation schemes - exit packages
There were 0 exit packages agreed in 2019/20 totalling £0k.

Notes to the Accounts - 6 Commitments under Operating Leases

6 Commitments under Operating Leases

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

Analysis of operating lease expenditure 2020/21

	Total £000	Buildings £000	Other £000
Minimum lease payments	3,478	3,160	318
Total	**3,478**	**3,160**	**318**

Analysis of operating lease expenditure 2019/20

	Total £000	Buildings £000	Other £000
Minimum lease payments	3,156	2,838	318
Total	**3,156**	**2,838**	**318**

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

Arrangements containing an operating lease 2020/21

	Total £000	Buildings £000	Other £000
Future minimum lease payments due:			
- not later than one year;	3,744	3,430	314
- later than one year and not later than five years;	13,197	12,810	387
- later than five years.	9,607	9,607	0
	26,548	**25,847**	**701**

Arrangements containing an operating lease 2019/20

	Total £000	Buildings £000	Other £000
Future minimum lease payments due:			
- not later than one year;	2,620	2,482	138
- later than one year and not later than five years;	8,024	7,910	114
- later than five years.	8,054	8,054	0
Total	**18,698**	**18,446**	**252**

Notes to the Accounts - 7 Employee expenses

7 Employee expenses

7.1 The employee expenses incurred during the year were as follows

	2020/21	2019/20
	£000	£000
Salaries and wages	147,724	128,538
Social security costs	14,829	12,994
Apprenticeship levy	696	612
Pension cost - employer contributions to NHS pension scheme	17,058	15,235
Pension cost - employer contribution amount paid directly by NHSE	7,464	6,640
Pension cost - other*	101	106
Temporary staff - agency/contract staff	6,885	6,703
Total Gross Staff Costs	**194,757**	**170,828**
Employee expenses - staff & executive directors	193,322	169,237
Education and training	1,364	1,212
Total Employee benefits excl. capitalised costs	**194,686**	**170,449**

Changes to the rate of employers NHS Pension contribution have not been reflected in funding provided to individual Trusts during 2020/21. For this reason, the additional 6.3% liability was paid centrally by the Department of Health and Social Care . The amount is £7,464k in 2020/21 and £6,640k in 2019/20.

Notes to the Accounts - 7 Employee expenses

7.2 Retirements due to ill-health

During 2020/21 there was 1 (0 in 2019/20) early retirements from the NHS FT on the grounds of ill-health with an estimated additional pension liability of £36k (£0k in 2019/20).

Where incurred the cost of any ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

8 Better Payment Practice Code

The measure of compliance for 2020/21 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

	2020/21 £000	2019/20 £000
Interest receivable on bank deposits	0	396

Interest rates reduced in the final month of 2019/20 and no interest income was received in 2020/21.

9.1 Finance Expenses

	2020/21 £000	2019/20 £000
Interest on loans from the Department of Health and Social Care:	258	272
Unwinding of discount on provisions	(43)	(24)
Total	**215**	**248**

Notes to the Accounts - 10 Intangible Assets

10 Intangible Assets

	2020/21 Software licences £000	2019/20 Software licences £000
Opening cost at 1 April	1,567	2,064
Disposals/Derecognition	0	(497)
Gross cost at 31 March	**1,567**	**1,567**
Opening amortisation at 1 April	532	721
Provided during the year	220	308
Disposals/Derecognition	0	(497)
Amortisation at 31 March	**752**	**532**
Net book value		
At 1 April	1,035	1,343
At 31 March	**815**	**1,035**

The 2019/20 intangible asset disposals/derecognition relates to the derecognition of fully depreciated assets previously capitalised.

Notes to the Accounts - 11 Property, Plant and Equipment

11 **Property, Plant and Equipment as at 31 March 2021**

11.1 Balances as at 31 March 2021	**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 2020 - brought forward	**163,594**	25,419	125,101	230	2,304	1,467	5,942	3,131
Additions - purchased	**17,204**	0	4,357	0	10,275	1,185	1,254	133
Impairments charged to operating expenses	**(4,410)**	(825)	(3,585)	0	0	0	0	0
Impairments charged to the revaluation reserve	**(9,565)**	(2,329)	(7,236)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**1,305**	522	783	0	0	0	0	0
Reclassifications	**0**	0	883	0	(883)	0	0	0
Revaluations	**(7,053)**	507	(7,580)	20	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	**(1,942)**	(450)	(1,492)	0	0	0	0	0
Disposals/derecognition	**(6)**	(6)	0	0	0	0	0	0
Valuation/gross cost at 31 March 2021	**159,127**	**22,838**	**111,231**	**250**	**11,696**	**2,652**	**7,196**	**3,264**
Accumulated depreciation at 1 April 2020 - brought forward	**9,814**	0	6,169	10	5	450	1,483	1,697
Provided during the year	**6,483**	0	4,113	6	0	183	1,898	283
Impairments charged to operating expenses	**0**	0	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	**0**	0	0	0	0	0	0	0
Revaluations	**(9,998)**	0	(9,982)	(16)	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	**(162)**	0	(162)	0	0	0	0	0
Disposals/derecognition	**0**	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2021	**6,137**	**0**	**138**	**0**	**5**	**633**	**3,381**	**1,980**
Net book value at 31 March 2021								
Owned	**152,990**	22,838	111,093	250	11,691	2,019	3,815	1,284
NBV Total at 31 March 2021	**152,990**	**22,838**	**111,093**	**250**	**11,691**	**2,019**	**3,815**	**1,284**

The NHS FT's land and buildings underwent a full valuation at 31 March 2021

Included within 'additions - purchased' are the following material items:
Classified as 'Buildings, excluding dwellings';
- 6 Facet Survey Fire Compliance works - £1,008k which were completed at Lister Hospital, Lexden Hospital, Astley Court and Victoria Court over the year 2020/21
- Forest House refurb phase 1 infection control and security- £275k which was completed in Q4 2020/21
- Kingsley Green overflow carpark - £561k which was completed in Q4 2020/21
- Colonnades 1st floor conversion- £461k which was completed in Q2 2020/21
- Harper House refurb - £260k which was completed in Q3 2020/21

Classified as 'Information technology';
- £804k to replace computers at the end of their economic life
- £441k development of digital sign on and digital dication, part of the Trust's broader Digital Strategy

A further £4,590k 'additions - purchased' spend is included under 'Assets Under Construction' for the Trust's Safety Suites

See note 13 for details of Impairments.

Included within 'reclassifications' are the following material items, previously held as 'Assets under Construction':
- Colonnades 1st floor conversion- £727k, completed in Q2 2020/21

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 2020

11.2 Balances as at 31 March 2020	**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 2019 - brought forward	**157,112**	26,106	123,593	230	549	756	2,747	3,131
Additions - purchased (including capital lifecycle additions)	**9,543**	0	3,765	0	1,872	711	3,195	0
Impairments charged to operating expenses	**(2,237)**	(1,403)	(834)	0	0	0	0	0
Impairments charged to the revaluation reserve	**(2,080)**	(845)	(1,235)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**339**	425	(86)	0	0	0	0	0
Reclassifications	**0**	0	117	0	(117)	0	0	0
Revaluations	**917**	1,136	(219)	0	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	**0**	0	0	0	0	0	0	0
Disposals/derecognition	**0**	0	0	0	0	0	0	0
Valuation/gross cost at 31 March 2019	**163,594**	**25,419**	**125,101**	**230**	**2,304**	**1,467**	**5,942**	**3,131**
Accumulated depreciation at 1 April 2019 - brought forward	**6,371**	0	3,923	5	0	379	637	1,427
Provided during the year	**5,224**	0	4,032	5	0	71	846	270
Impairments charged to operating expenses	**5**	0	0	0	5	0	0	0
Reversal of impairments credited to operating expenses	**(226)**	0	(226)	0	0	0	0	0
Revaluations	**(1,560)**	0	(1,560)	0	0	0	0	0
Disposals/derecognition	**0**	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2020	**9,814**	**0**	**6,169**	**10**	**5**	**450**	**1,483**	**1,697**
Net Book Value at 31 March 2020								
Owned	**153,780**	25,419	118,932	220	2,299	1,017	4,459	1,434
Net Book Value at 31 March 2020	**153,780**	**25,419**	**118,932**	**220**	**2,299**	**1,017**	**4,459**	**1,434**

The NHS FT's land and buildings underwent a partial valuation at 31 March 2020 to carry out an impairment review on Saffron Ground and Lister MHU refurbishment 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';
- Saffron Ground - £422k which was completed in Q4 2019/20
- Albany Lodge works - £626k which was completed in Q4 2019/20
- Aston Ward Lister MHU - £921k which was completed in Q4 2019/20
- Safety Suites - £1,219k which is still an 'Asset Under Construction'
- Colonnades - £727k which is still an 'Asset Under Construction'

Classified as 'Information technology';
- £2,123k to replace computers at the end of their economic life
- £462k to upgrade the NHS FT's Electronic Patient Record System
- £425k to improve the NHS FT's Cyber Security software protection

See note 13 for details of Impairments.

Included within 'reclassifications' are the following items, previously held as 'Assets under Construction':
- Apportioned project management costs - £56k

See note 11.3 for details of property disposals.

Notes to the Accounts - 11 Property, Plant and Equipment

11.3 Disposal Of Property, Plant and Equipment

	2020/21 £000	2019/20 £000
Gains on disposal of property, plant and equipment	178	0
Total gain/loss on disposal recorded in the Statement of Comprehensive Income	**178**	**0**

The assets disposed of in 2020/21 were: Alexandra Road (previously categorised as an Asset Held For Sale (see note 15.) and; a small area of land at the Little Plumstead site.

12 Assets held under Finance Leases

	2020/21	2019/20
Opening cost at 1 April	**2,125**	**2,125**
Accumulated depreciation at 1 April	2,125	2,108
Provided during the year	0	17
Accumulated depreciation at 31 March	**2,125**	**2,125**
Net book value		
NBV total at 1 April	0	17
NBV total at 31 March	**0**	**0**

The NHS FT leased one premises under a finance lease agreement. The premises was 32 St. Peter's Street, St. Albans and was vacated at the beginning of 2020/21.

Notes to the Accounts - 13 Impairment of Assets (Property, Plant & Equipment and Intangibles)

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

	2020/21 £000	2019/20 £000
Impairments of Property, Plant and Equipment charged to operating expenses due to changes in market price	4,410	2,237
Impairments of Property, Plant and Equipment charged to operating expenses due to other reasons	0	5
Reversal of prior year impairments of Property, Plant and Equipment credited to operating income	(1,305)	(565)
Total impairments and reversal of impairments charged to the Statement of Comprehensive Income	**3,105**	**1,677**

Total Net Impairments of Property, Plant and Equipment charged to the Revaluation Reserve	9,565	2,080
Total impairment charged to the Revaluation Reserve	**9,565**	**2,080**

The impairment adjustments for 2020/21 follows a full revaluation and impairment review conducted by the District Valuer. The asset impairments related to a combination of (i) decreases in the value of land and buildings held by the NHS FT following a review of the Modern Equivalent Asset valuation method and (ii) buildings that had received significant investment and had been revalued lower than the investment.

The 'reversal of impairments credited to operating income' in 2020/21 are impairments incurred in prior years and the assets have since been revalued upwards. These largely relate to Elizabeth Court and Albany Lodge land (£520k), Colne House (£305k) and Seward Lodge (£225k).

14 Inventories

	2020/21 £000	2019/20 £000
Carrying Value at 1 April	56	50
Additions	483	479
Additions (donated) - from DHSC	1,579	0
Inventories recognised in expenses	(2,059)	(473)
Carrying Value at 31 March	**59**	**56**

15 Assets Held For Sale

	31 March 2021 £000	31 March 2020 £000
Net Book Value of assets held for sale at 1 April	1,592	1,592
Plus assets classified as available for sale in the year	1,780	0
Less assets sold in year	(318)	0
Net Book Value of assets held for sale at 31 March	**3,054**	**1,592**

Assets held for sale at March 31st 2020, comprised the properties at 143 and 145 Harper Lane, Radlett and Alexandra Road, Hemel Hempstead. Alexandra Road was sold early in 2020/21. The Harper Lane properties sale was delayed due to COVID reasons. An additional asset, the Stewarts was re-categorised as an Asset Held For Sale in 2020/21.

Notes to the Accounts - 16 Receivables

16 Receivables

16.1 Trade and other Receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	4,048	8,699
Accrued income	1,705	6,304
Allowance for impaired contract receivables	(472)	(147)
Prepayments	1,452	1,341
PDC dividend receivable	1,025	50
VAT receivable	309	159
Other receivables	60	145
Total current trade and other receivables	**8,127**	**16,551**
Of which receivable from NHS and DHSC group bodies	**5,342**	**6,855**

The decrease in Contract Receivables relates to additional block income invoices that were paid in early 20/21.

The decrease in Accrued Income relates to 2019/20 accruals for Covid costs reimbursement £1m, additional Mental Health distribution funding of £1.4m and £2.2m under the New Care Model contract with NHS England for the provision of CAMHS Tier 4 services where NHS England process the expenditure, and remaining balance is due based upon a reconciliation at year end. These had all been paid in 2020/21.

The increase in the PDC receivable in 2020/21 relates to the timing of block contract receipts for 2020/21 where funding was received one month in advance. This lead to a higher average cash balance and at the time of the submission of expected PDC values for the year was not confirmed if there would be a PDC adjustment for this. This was subsequently confirmed and the Trust is holding a £1,025k PDC receivable which will be offset against the cash PDC payable in 2021/22.

16.2 Allowance for impaired contract receivables

	2020/21	2019/20
	£000	£000
At 1 April	147	102
Increase in provision	363	51
Amounts utilised	(5)	(6)
Unused Amounts reversed	(33)	0
Balance at 31 March	**472**	**147**

As part of the implementation of IFRS 9 an expected credit loss model for impaired contract receivables was applied. This has had no material impact on the allowance in the period.

Notes to the Accounts - 17 Cash and cash equivalents

17 Cash and cash equivalents

	2020/21 £000	2019/20 £000
Cash and cash equivalents at 1 April	55,260	58,023
Net change in cash and cash equivalents	23,631	(2,763)
Cash and cash equivalents at 31 March	**78,891**	**55,260**
Comprising:		
Cash at commercial banks and in hand	127	241
Cash with the Government Banking Service	78,764	55,019
	78,891	**55,260**

The NHS FT's cash reserves have increased in year primarily due to level of receivables at March 31st 2020. The majority of this amount was received in April. Block contract payments were received in advance during 20/21 and therefore ensured similar balances were not outstanding.

18 Public Dividend Capital

	2020/21 £000	2019/20 £000
Taxpayers' Equity at 1 April	91,936	91,144
Public Dividend Capital receipts	2,748	792
Taxpayers' Equity at 31 March	**94,684**	**91,936**

In 2020/21 £1,000k was received for critical infrastructure funding to relocate a plant room on the Litte Plumsted Hospital site, £882k to support the implementation of an electronic prescibing system, £579k for COVID capital claims, and £286k to fund additional remote working support .

PDC receipts in 2019/20 of £792k were received for cyber security and digital strategy funding.

19 Borrowings

19.1 Borrowings: Loans and Finance Leases

	31 March 2021 £000	31 March 2020 £000
Current		
Capital loans	541	540
Total current borrowings	**541**	**540**
Non-current		
Capital loans	8,469	8,998
Total non-current borrowings	**8,469**	**8,998**
Total borrowings	**9,010**	**9,538**

The NHS FT has a loan arrangement with the Department of Health and Social Care (see note 2.4).

Notes to the Accounts - 19 Borrowings

19.2 Finance Lease borrowings

	31 March 2021 £000	31 March 2020 £000
Payable:		
- not later than one year;	0	0
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Gross lease liabilities	**0**	**0**
Less: Finance charges/(income) allocated to future periods	0	0
Net lease liabilities	**0**	**0**
Split into current and non-current borrowings on the Statement Of Financial Position:		
- current	0	0
- non current	0	0
	0	**0**
Expected timing of cashflows:		
- not later than one year;	0	0
- later than one year and not later than five years;	0	0
- later than five years.	0	0
	0	**0**

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) 2020/21

2020/21	Total	Pensions relating to other staff	Pension - Injury benefits	Other legal claims	Restructuring	Continuing Health Care	Other
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2020 - brought forward	9,114	2,008	2,679	600	169	1,268	2,390
Arising during the year	2,190	125	102	310	26	0	1,627
Utilised during the year - accruals	(87)	(53)	(34)	0	0	0	0
Utilised during the year - cash	(564)	(165)	(93)	(179)	0	(229)	102
Reversed unused	(331)	0	0	(306)	(16)	(60)	51
Unwinding of discount rate	(43)	(18)	(25)	0	0	0	0
Total at 31 March 2021	**10,279**	**1,897**	**2,629**	**425**	**179**	**979**	**4,170**
Expected timing of cashflows:							
- not later than one year (current)	4,347	213	134	425	43	979	2,553
- later than one year and not later than five years (non current)	2,038	853	534	0	136	0	515
- later than five years (non current)	3,894	831	1,961	0	0	0	1,102
Total	**10,279**	**1,897**	**2,629**	**425**	**179**	**979**	**4,170**

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 -0.95% 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 -0.95% 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. £27,934k (£24,819k as at 31 March 2020) is included in the provisions of NHS Resolution at 31 March 2021 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.

Other provisions includes a dilapidations provision which relates to the cost to return leased buildings back to their original condition upon exit. It also includes a provision for the refurbishment of a psychiatric intensive care unit that will require additional operational costs to be incurred during the period of refurbishment, and a provision for the future legacy costs of COVID-19.

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) 2019/20

2019/20	Total	Pensions relating to other staff	Pension - Injury benefits	Other legal claims	Restructuring	Continuing Health Care	Other
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2019 - brought forward	7,625	2,114	2,628	485	0	1,268	1,130
Arising during the year	2,237	109	196	214	169	0	1,549
Utilised during the year - accruals	(86)	(54)	(32)	0	0	0	0
Utilised during the year - cash	(499)	(151)	(99)	(20)	0	(229)	0
Reversed unused	(139)	0	0	(79)	0	(60)	0
Unwinding of discount rate	(24)	(10)	(14)	0	0	0	0
Total at 31 March 2020	**9,114**	**2,008**	**2,679**	**600**	**169**	**979**	**2,679**
Expected timing of cashflows:							
- not later than one year (current)	3,334	214	132	600	44	979	1,365
- later than one year and not later than five years (non current)	1,915	856	526	0	125	0	408
- later than five years (non current)	3,865	938	2,021	0	0	0	906
Total	**9,114**	**2,008**	**2,679**	**600**	**169**	**979**	**2,679**

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 -0.5% 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 -0.5% 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. £24,819k (£27,114k as at 31 March 2019) is included in the provisions of NHS Resolution at 31 March 2020 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.

Other provisions includes a dilapidations provision which relates to the cost to return leased buildings back to their original condition upon exit. It also includes a provision for the refurbishment of a psychiatric intensive care unit that will require additional operational costs to be incurred during the period of refurbishment

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 2021 £000	31 March 2020 £000
Current		
Trade payables	3,346	413
Capital payables (including capital accruals)	6,911	2,399
Accruals (revenue costs only)	21,806	16,641
Annual leave accrual	2,170	823
Social security costs	2,180	1,894
VAT payables	19	19
Other taxes payable	1,855	1,508
PDC dividend payable	0	1
Other payables	2,463	2,323
Total Trade and other payables	**40,750**	**26,021**

Accruals are the charges from suppliers for goods or services that have not been paid as at 31 March.

22 Other liabilities

	31 March 2021	31 March 2020
Current		
Deferred income	15,481	8,391
Net defined benefit pension scheme liability	364	0
Total Other liabilities	**15,845**	**8,391**

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.

The net defined pension scheme liability relates to the Essex Pension Fund which has been accounted for in 2020/21 as a defined benefit pension scheme. As at 31st March 2021 the actuary reports show the scheme is in a £364k deficit (£150k in 2019/20) and the potential pension liability is shown here.

Notes to the Accounts - 23 Financial assets and liabilities

23 Financial assets and liabilities

23.1 Financial assets by category

	31 March 2021 £000	31 March 2020 £000
Receivables (excluding non financial assets) - with DHSC group bodies	4,297	6,799
Receivables (excluding non financial assets) - with other bodies	1,044	8,202
Cash and cash equivalents	78,891	55,260
Total	**84,232**	**70,261**

23.2 Financial liabilities by category

	31 March 2021 £000	31 March 2020 £000
DHSC loans	9,010	9,538
Trade and other payables excluding non financial liabilities	36,605	22,599
Provisions	6,771	6,901
Total	**52,386**	**39,038**

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

	2020/21		2019/20	
	£000	£000	£000	£000
Operating Surplus		57		5,349
Non cash flow movements:				
Depreciation and amortisation	6,703		5,532	
Impairments and reversals	3,105		1,677	
		9,808		7,209
Movement in Working Capital:				
(Increase) / Decrease in trade and other receivables	9,397		(8,722)	
on SOFP Pension liability - employer contributions paid less net charge to the SOCI	(38)		(41)	
Increase in inventories	(3)		(6)	
Increase in trade and other payables	10,218		1,717	
Increase in other liabilities	7,090		1,667	
		26,664		(5,385)
Increase in provisions		1,208		1,513
Net cash inflow from operating activities		**37,737**		**8,686**

Notes to the Accounts - 25 Related Party Transactions

25 Related Party Transactions

25.1 Related Party Transactions 2020/21

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 2020 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.

2020/21	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	24,522	0	0
HMRC - VAT	0	0	309	19
HMRC - other taxes & duties	0	15,525	0	4,035
National Loans Fund	0	0	0	0
Other Central Government	0	13	0	0
NHS				
Department Of Health	185	0	0	338
NHS England - Core	12,789	0	1,976	154
Foundation Trusts				
Camden and Islington NHS Foundation Trust	0	1	0	8
Cambridgeshire and Peterborough NHS Foundation Tr	0	224	0	484
East London NHS Foundation Trust	918	0	91	0
Essex Partnership University NHS Foundation Trust	10	5,267	10	0
Norfolk and Norwich University Hospitals NHS Foundat	54	48	0	122
Salford Royal NHS Foundation Trust	0	207	0	223
Clinical Commissioning Groups				
NHS Basildon and Brentwood CCG	2,099	0	0	0
NHS Bedfordshire CCG	(2)	0	0	0
NHS Buckinghamshire CCG	4,033	0	13	0
NHS Cambridgeshire and Peterborough CCG	0	0	81	0
NHS Castle Point and Rochford CCG	768	0	0	0
NHS Ealing CCG	173	0	0	1
NHS East and North Hertfordshire CCG	86,819	2,759	478	113
NHS Herts Valleys CCG	86,615	2	0	5
NHS Hounslow CCG	171	0	0	0
NHS Mid Essex CCG	6,378	0	0	76
NHS North East Essex CCG	9,816	0	(283)	137
NHS Norfolk & Waveney CCG	2,523	0	0	3
NHS North Central London CCG	157	0	100	26
NHS Southend CCG	1,457	0	0	0
NHS Thurrock CCG	784	0	0	0
NHS West Essex CCG	12,235	127	281	3
NHS Trusts				
East and North Hertfordshire NHS Trust	259	1,097	116	124
Hertfordshire Community NHS Trust	887	151	137	127
The Princess Alexandra Hospital NHS Trust	22	0	17	26
West Hertfordshire Hospitals NHS Trust	783	704	172	447
NHS Other				
Health Education England	5,170	4	688	5,936
East of England Specialised Commissioning hub	23,853	0	163	0
NHS Resolution (formerly NHS Litigation Authority)	0	715	0	0
Other NHS	342	261	276	137
Local Government				
Barnet London Borough Council	1,398	0	350	0
Dacorum Borough Council	0	453	9	0
Hertfordshire County Council	22,691	79	551	7,589
Hertsmere Borough Council	0	249	0	0
Hammersmith and Fulham London Borough Council	0	0	119	0
Hillingdon London Borough Council	232	0	82	0
Islington London Borough Council	135	0	(84)	84
Norfolk County Council	867	2	144	0
Westminster City Council	168	0	306	0
Other Local Government	176	96	50	384
Totals	**284,966**	**52,506**	**6,152**	**20,601**

Notes to the Accounts - 25 Related Party Transactions

25 Related Party Transactions

25.1 Related Party Transactions 2019/20

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 2020 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.

2019/20	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	21,875	0	53
HMRC - VAT	0	0	159	19
HMRC - other taxes & duties	0	13,606	0	3,402
National Loans Fund	0	0	0	0
Other Central Government	0	7	0	0
NHS				
Department Of Health	275	0	0	305
NHS England - Core	2,600	142	1,707	23
Foundation Trusts				
Camden and Islington NHS Foundation Trust	0	45	0	0
East Suffolk and North Essex NHS Foundation Trust	0	114	0	16
Essex Partnership University NHS Foundation Trust	0	5,157	0	683
Norfolk and Norwich University Hospitals NHS Foundat	117	163	59	82
Salford Royal NHS Foundation Trust	0	254	0	73
South London and Maudsley NHS Foundation Trust	0	2	0	0
Clinical Commissioning Groups				
NHS Basildon and Brentwood CCG	2,054	0	16	0
NHS Bedfordshire CCG	94	0	44	0
NHS Buckinghamshire CCG	3,995	0	17	0
NHS Camden CCG	237	0	97	0
NHS Cambridgeshire and Peterborough CCG	51	0	78	0
NHS Castle Point and Rochford CCG	746	0	0	0
NHS Ealing CCG	336	0	59	0
NHS East and North Hertfordshire CCG	498	2,656	95	99
NHS Great Yarmouth and Waveney CCG	592	0	16	0
NHS Greenwich CCG	160	0	0	0
NHS Herts Valleys CCG	1,461	36	1,382	3
NHS Hounslow CCG	334	0	30	0
NHS Mid Essex CCG	5,938	0	35	0
NHS North East Essex CCG	9,975	0	25	0
NHS North Norfolk CCG	683	0	39	0
NHS Norwich CCG	276	0	39	0
NHS South Norfolk CCG	789	0	6	0
NHS Southend CCG	1,416	0	0	0
NHS Thurrock CCG	762	0	0	0
NHS West Essex CCG	4,812	213	140	13
NHS West Norfolk CCG	154	0	(2)	0
NHS Trusts				
East and North Hertfordshire NHS Trust	198	692	19	278
Hertfordshire Community NHS Trust	1,169	268	451	359
The Princess Alexandra Hospital NHS Trust	0	1	0	27
West Hertfordshire Hospitals NHS Trust	800	1,080	479	500
NHS Other				
Health Education England	4,192	3	19	2,868
East of England Specialised Commissioning hub	20,196	(8)	1,540	93
NHS Resolution (formerly NHS Litigation Authority)	0	627	2	78
Other NHS	1,969	260	414	116
Local Government				
Barnet London Borough Council	1,267	0	230	0
Dacorum Borough Council	0	394	0	0
Hertfordshire County Council	185,999	67	5,297	4,475
Hertsmere Borough Council	0	251	0	0
Hammersmith and Fulham London Borough Council	391	0	119	0
Hillingdon London Borough Council	230	0	88	0
Islington London Borough Council	230	0	10	0
Norfolk County Council	965	0	700	0
Westminster City Council	331	0	138	0
Other Local Government	119	116	64	451
Totals	**256,411**	**48,021**	**13,611**	**14,016**

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. In 2018/19 5 staff, with a further 3 staff in 2019/20, who had transferred under TUPE from Essex County Council remained members of the Essex Pension Fund. The NHS FT is now an admitted fully funded member of the pension scheme so has been accounted for such in 2020/21. The scheme is in a net deficit postion which is shown in the following table and within other liabilities in note 22.

	2020/21 £000	2019/20 £000
Present value of the defined benefit obligation at 1 April	**(23,924)**	**(26,499)**
Current service cost	(95)	(110)
Interest cost	(551)	(627)
Contribution by plan participants	(22)	(15)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains)/losses	(4,656)	2,319
Benefits paid	878	1,008
Past service costs	(16)	0
Present value of the defined benefit obligation at 31 March	**(28,386)**	**(23,924)**

Plan assets at fair value at 1 April	**23,924**	**26,499**
Interest income	681	735
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets (excludes any amounts already included in interest income above)	5,474	(1,022)
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling (excluding amounts included in interest income/expense)	(1,220)	(1,338)
Contributions by the employer	19	43
Contributions by the plan participants	22	15
Benefits paid	(878)	(1,008)
Plan assets at fair value at 31 March	**28,022**	**23,924**
Plan surplus/(deficit) at 31 March	**(364)**	**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

	2020/21 £000	2019/20 £000
Present value of the defined benefit obligation	(28,386)	(23,924)
Plan assets at fair value	28,022	23,924
Total net (liability)/asset after the impact of reimbursement rights as at 31 March	(364)	0

Amounts recognised in the SoCI

	2020/21 £000	2019/20 £000
Current service cost	(95)	(110)
Net interest income	130	108
Past Service Cost	(16)	0
Total net gain / (charge) recognised in SoCI	19	(2)

Notes to the Accounts - 27 Losses and Special Payments

27 Losses and Special Payments

There were 24 cases (22 cases in 2019/20) of losses and special payments totalling £5k (£9k in 2019/20) during 1 April 2020 to 31 March 2021. These are reported on an accruals basis but exclude provisions for future losses.

	2020/21		2019/20	
	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:				
- other causes	4	0	1	0
Damage to buildings, property etc. (including stores losses) due to:				
- theft, fraud etc.	0	0	1	0
- other	0	0	7	2
Total losses	**4**	**0**	**9**	**2**
Special Payments				
Ex gratia payments in respect of:				
- loss of personal effects	13	3	7	1
- other negligence and injury	0	0	1	1
- other	7	2	4	5
- maladministration, no financial loss	0	0	1	0
Total Special Payments	**20**	**5**	**13**	**7**
Total losses and special payments	**24**	**5**	**22**	**9**

Notes to the Accounts - 28 Third Party Assets

28 Third Party Assets

The NHS FT held £4,477k cash at bank and in hand at 31 March 2021 (£4,406k at 31 March 2020) 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 2020/21 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.

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities	**44**	**53**

31 Commitments under capital expenditure contracts

	31 March 2021 £000	31 March 2020 £000
Property, Plant and Equipment	6,911	2,399
Total	**6,911**	**2,399**

The capital commitments as at 31 March 2021 relate to the agreement of the final account on a number of projects: 6 Facet Survey, Kingsley Green overflow carpark, 15 Forest Lane decant and Holly Lodge modular building have completed and are awaiting final account confirmations. The NHS FT's Safety Suite program, Oak Ward, Forest House HDU and Albany Lodge schemes, general IT Investment and Backlog maintenance 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 2020 relate to the agreement of the final account on a number of projects. Saffron Ground and Aston Ward, Lister refurbishments have completed and are awaiting final account confirmations. The NHS FT's Safety Suite program, Cyber Security investment, general IT Investment and Backlog maintenance works account for the majority of the remaining commitments along with retention payments against a number of completed projects.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Hertfordshire Partnership University NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers 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 2021 and of its income and expenditure for the year then ended; and
- 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 and the Department of Health and Social Care Group Accounting Manual 2020/21.

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.

Going concern

The Directors have 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 have also concluded that there are no material uncertainties that could have cast significant doubt over its 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").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

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.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve control totals delegated to the Trust by NHS Improvement.
- Reading the minutes of Board, Audit Committee and other sub-committees of Board.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls, the risk of fraudulent revenue recognition, in particular the risks that additional funding was claimed inappropriately through the extra resources made available as a result of Covid-19, revenue from NHS sources is recorded in the wrong period, or that revenue has been inappropriately manipulated through year end adjustments, and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals and prepayments.

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation and testing of the operating effectiveness of Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals with unusual account combinations, and journals posted after the ledger close which amended the Trust's reported income and expenditure balance.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Sample testing of customer and supplier invoices cleared and cash received and paid in the period 01 March 2021 to 31 May 2021 to determine whether income and expenditure was recognised in the correct accounting period, in accordance with the amounts billed to the corresponding parties.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors (as required by auditing standards), and discussed with the directors the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

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; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 98, 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 its 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

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its 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 paragraph 1(d) of Schedule 10 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 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.

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 for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Dean Gibbs
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

15 June 2021