Hertfordshire Partnership University NHS Foundation Trust
Board of Directors Public Board Meeting

Colonnades Beaconsfield Road AL10 8YE

22 March 2018 10:15 - 22 March 2018 13:00

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BOARD OF DIRECTORS

Thursday 22nd March 2018

The Colonnades, Beaconsfield Road, Hatfield AL10 8YE
Da Vinci A&B
Public Session of Trust Board 10.45hrs to 13.00hrs
to commence with
Service User Presentation 10.15 to 10:45

A G E N D A

PUBLIC				
ITEM	**SUBJECT**	**BY**	**ACTION**	
1.	Welcome and Apologies for Absence: Tom Cahill	Chair		
2.	Declaration of Interests	Chair	Note/Action	Verbal
3.	Minutes of Meeting dated 25th January 2018	Chair	Approve	Attached
4.	Matters Arising Schedule	Chair	Review	Attached
5.	CEO Brief	Jinjer Kandola	Receive	Attached
	QUALITY & PATIENT SAFETY			
6.	Report from Integrated Governance Committee	Sarah Betteley	Receive	Attached
7.	Safe staffing Q3	Jane Padmore	Receive	Attached
8.	Staff Survey Results	Jinjer Kandola	Receive	Attached
9.	CQC Update	Jane Padmore	Receive	Attached
	Questions from the Public			
	OPERATIONAL AND PERFORMANCE			
10.	Report from Finance & Investment Committee	Simon Barter	Receive	Attached
11.	Performance Report (Jan 2018)	Ronke Akerele	Receive	Attached
12.	Q3 Service User Experience	Jess Lievesley	Receive	Attached
13.	Finance Report to end of February 2018	Keith Loveman	Receive	Attached
14.	Annual Plan 18/19	Karen Taylor	Receive	Attached
15.	Finance Plan 18/19	Keith Loveman	Receive	Attached

Questions from the Public				
GOVERNANCE AND REGULATORY				
16.	**Report from Audit Committee**	**Catherine Dugmore**	**Receive**	**Attached**
17.	**Adoption of Going Concern Statement**	**Keith Loveman**	**Receive**	**Attached**
18.	**Public Sector Equality Duty and EDS2 compliance report**	**Jane Padmore**	**Receive**	**Attached**
19.	**Gender Pay Gap**	**Jinjer Kandola**	**Receive**	**Attached**
20.	**Board Assurance Framework**	**Jane Padmore**	**Receive**	**Attached**
21.	**Trust Risk Register**	**Jane Padmore**	**Receive**	**Attached**
Questions from the Public				
22.	**Any Other Business**	**Chair**		
23.	**Date and Time of Next Public Meeting: 24th May 2018 11:00 – 14:00hrs in Da Vinci A&B**			

ACTIONS REQUIRED

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action
Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approving it
Note: For the intelligence of the Board without the in-depth discussion as above
For Assurance: To apprise the Board that controls and assurances are in place
For Information: Literally, to inform the Board

Chair: Chris Lawrence

Hertfordshire Partnership NHS
University NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING
Held on Thursday January 25th, 2018
Da Vinci B – Colonnades

PRESENT:

NON-EXECUTIVE DIRECTORS	
Christopher Lawrence	Chair
Catherine Dugmore	Non-Executive Director
Sarah Betteley	Non-Executive Director
Simon Barter	Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill	Chief Executive
Jinjer Kandola	Deputy CEO & Director Workforce & Organisational Development
Asif Zia	Director Quality & Medical Leadership
Jane Padmore	Director Quality and Safety
Ronke Akerele	Director of Innovation and Transformation
Jess Lievesley	Director Service Delivery & Customer Experience
Karen Taylor	Director Strategy and Integration
Keith Loveman	Director Finance
IN ATTENDANCE	
Jonathan Elwood	Company Secretary, Head of Corporate Affairs
Allison Lerner	Board Secretary PA to Company Secretary (Minute Taker)
Gill Stevens	Executive Assistant
Sultan Muhamad	Corporate Office Apprentice
MEMBERS OF THE PUBLIC	
Jon Walmsley	Lead Governor
Ilana Rinkoff	Public Governor
Barry Canterford	Public Governor
Tap Bali	Public Governor
William Say	Public Governor
Grahame Wright	Staff Governor
APOLOGIES	
Michelle Maynard	Non-Executive Director
Robbie Burns	Non-Executive Director
Loyola Weeks	Non-Executive Director
Tanya Barron	Non-Executive Director
Sue Darker	Director, Adults with Disabilities, MH and Autism Herts County Council

Item	Subject	Action
01/18	**Welcome and Apologies for Absence** The Chair welcomed all present to the meeting including the six Governors.	
02/18	**SERVICE USER PRESENTATION** The Chair welcomed Alex, who outlined his personal journey from Oak Ward, Albany Lodge and on to The Beacon Centre, where he currently resides. It was noted that the team have helped and supported him to a point where he now works for MIND as a Grounds Keeper, working at various HPFT sites. The Chair thanked Alex for his story, and following a question from TC as to how the Trust could further support Alex, he advised that the use of a landline to call his family and friends would be helpful and that during the transfer process from Albany Lodge to The Beacon, more clarity and explanation would have benefited him.	

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03/18	**Declarations of Interest** None declared	
04/18	**Minutes of Meeting dated 29th November 2017** The Minutes were noted, and with minor drafting changes were approved as an accurate record. • For clarification in future minutes, Sarah Betteley to be referred to as *SBe* and Simon Barter as *SBa*. • Catherine Pelley to be added as 'In attendance'.	
05/18	**Matters Arising:** 'Evalu8' software issues need to be rectified and Board Survey to be completed online. CL informed the group of Baroness Dido Harding's visit on January 10th to King Fisher Court and Thumbswood, it was an excellent visit where she met both patients and staff. They also visited Forest House, and although they were not expected there, it was a very positive visit. Baroness Harding tweeted about her visit to HPFT and enquired about additional site visits. CL acknowledged his thanks to Jackie Newitt and her team. **No further matters arising.**	
06/18	**CEO BRIEF – Tom Cahill** TC presented his brief and advised that all services planned for and performed extremely effectively through the winter period, with all those who required inpatient care across the services able to access the support they needed. Other highlights from the briefing included: **PERFORMANCE** - The principal challenges remain within access for 28 days adult community in SW quadrant, access to Mid- Essex IAPT and the number of service users with up-to date risk assessments. **CQC** - The CQC unannounced Inspection has completed day two with positive feedback and no significant issues highlighted. Feedback report is expected late March. Routine assessments are anticipated twice a year going forward, the Well Led inspection will commence on Monday 5th February. **CARILLION** – There are no formal contracts with HPFT, Interserve has a working relationship with Carillion but this is not expected to affect the Trust. TC assured the Board that the Trust works with Interserve directly and is working on a contingency plan for soft management and support in preparation. **CQC CHIEF EXECUTIVE** – Sir David Behan has announced his intention to step down as Chief Executive of the CQC in the summer and a process will commence in due course to find his successor. **STP** – As TC has now stepped down from his role, Deborah Fielding, CEO of West Essex Clinical Commissioning Group has been appointed and commenced in post from 16th January. **The CEO Brief was noted.**	
07/18	**PATIENT SAFETY Q3 REPORTS** JP advised the Board that the number of incidents reported has increased, but the severity of harm has decreased. There has been an increased in non-anchor ligatures events which is reflected nationally and we will be joining a learning event between CQC and DONs about how to address this. In addition to this the clinicians that are working on the personality disorder care pathway, are incorporating work on	

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	these types of incidents into the pathway. There have been no 'Never Events' in the Quarter or year to date. Referring to Duty of Candour, JP advised that this is included in each SI's Terms of Reference, and that every investigator is reminded of their responsibilities. The Duty of Candour policy has been reviewed externally and deemed fit for purpose. Future patient safety reports will make explicit reference to Duty of Candour. Following a question from TC regarding trends, and whether incident reporting is up or down, JP confirmed that actual reporting of incidents at all levels is going up, reporting of external reporting of SIs is going up but suicides are going down year on year. SBe confirmed that IGC receive SIs at their meeting and are assured that people feel comfortable to report incidents. KL requested that Information Governance issues within the report be reported into Audit Committee. **SAFEGUARDING** JP advised the Board of the increase in reporting and level of safeguarding activity for both adults and children. In Q2 it was identified that that HPFT were not on course to achieve mandatory training compliance of 90% by March 2018. A review of all safeguarding training was undertaken and a new e-learning package purchased. This would be delivered to staff as an alternative to face to face training enabling a projected achievement of 90% compliance by March 2018. Following the successful implementation and improvements in practice, Safeguarding has now been removed from serious concerns and a number of Dip audits have been undertaken to ensure the lessons have been learnt. The CCGs have conducted both adult and child (section 11) reviews of the Trust's safeguarding practice providing assurance that in relation to safeguarding practices. Some areas for improvement were detailed and these are being addressed. **SBe advised that this report had been through IGC where they had commented on a very strong report. The Board agreed, and JP agreed to take these positive comments back to the team.**	**JP**
08/18	**REPORT FROM INTEGRATED GOVERNANCE COMMITTEE** SBe advised that written reports would be attached going forward; however the IGC had only taken place on 14th January and therefore there had not been time to completed this. A Deep Dive on lone working devices occurred and use of devices took place and showed that the system was effective but operational services needed to use them more consistently. **SBe agreed to ensure the draft IGC minutes are circulated to the Board going forward.**	**SBe**
09/18	**PLACE AUDIT OUTCOMES 2017 REPORT** KL informed the Board that overall audit outcomes show a significant improvement, in particular relating to Disability Access, dementia environments and privacy & dignity scores. Catering and Maintenance scores were however disappointing, with improvement required from our FM contractor, Interserve. KL advised that improvement in these domains would require some additional investment and tight contract management. It would be the appropriate approach and had been discussed at Finance & Investment Committee. The focus would be on menus, which need to be less generic across the Trust in order to offer a wider range of varied and appropriate menus, in particular for older adults and younger adult services, and KL expects to see a rapid turnaround. The Board agreed that the menus need to reflect a good variety of nutritious food which is presented well. It was noted that service	

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	users would be involved in the menu planning going forward. TC noted that significant commitment needs to be given in order to tidy up environments and maintain the standard expected. KL confirmed that additional operational capital (c.£200k) had been set against the necessary environment improvements noted within the PLACE audit outcomes. **The Board received the PLACE AUDIT report**	
10/18	**SERVICE USER EXPERIENCE** **Q3 Reports** - JL put into context that the Trust receives approximately 10 recorded compliments to each complaint. Friends and Family scores have remained at an unchanged yet strong position. Following a question from TC relating to the trends year on year JL indicated that complaints are slightly increasing whilst overall satisfaction rates remain consistently high. Focus of all teams is to work with individuals to bring about a positive outcome for the individual raising a complaint or a concern in as timely and effective way possible and not seeing feedback and complaints as a process led response. Wherever possible team leaders are engaging directly to resolve issues locally. **Community Services Plan** - JL Presented the plan that was developed in response to the 2017 Care Quality Commission annual community adult survey results for the trust. Cares in Herts and Viewpoint as 3rd sector partners have been directly commissioned by the trust to support our evaluation of the effectiveness of our response to the survey as well as providing further intelligence about the experience of those accessing the service **The Board received the report and CL acknowledged the notable progress that has been made and the hard work involved to make this happen.**	
11/18	**LEARNING FROM DEATHS DASHBOARD** AZ informed the Board that information about Deaths is collected through Datix, SPA System and National Spine and then reported to the Board after analysis by the HPFT Mortality Review Panel. He added that further National Guidance is awaited on what is known as a 'preventable death' or an unexpected or unnatural death. Trust has put in internal system to review all deaths and look at the 'Preventable Deaths'. During Q3 there were 87 deaths reported on Datix. Each one had been investigated by the Mortality Governance Group. No national benchmarking is currently available which makes it difficult to make comparisons across the trusts. KT advised that further breakdown would be helpful to pick up trends. AZ advised that as the dashboard evolves; reporting would be undertaken in a different way. HPFT is working with other mental health trusts to further develop the Dash Board TC highlighted the importance of; • The number of deaths • What the review states • What remains outstanding • What does the Board need to know and as a Trust, is everything that should be, being done. **The report was noted. CL advised that he looked forward to a breakdown when available.**	**AZ**

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12/18	**QUESTIONS FROM THE PUBLIC** • Jon Walmsley enquired about the fill rate on wards, and JK agreed to look into this. • William Say commented on the PLACE Audit and the marked difference between fresh and reheated food. He advised that he would like to commend Gary Inman and his audit team for working under some difficult conditions. KL agreed to take his comment about the team back and confirmed that over the next 15 months a new meal specification would be undertaken and would be going out to tender in due course.	**JK**
13/18	**ANNUAL PLAN REPORT (Q3) 2017/18** KT advised the Board that at the end of Q3 good progress had been made, with the assessment of the Annual Plan outcomes showing that seven out of the ten objectives were RAG rated Green and on track to fully deliver the planned end of year outcomes. Two objectives were rated Amber; ***Objective 2*** *- Deliver better access to our services*. The amber rating reflects that although access to adult community services had improved and commissioners agreed the new DNA policy, the access target would not be achieved due to both the level of demand and the resources available for initial appointments. ***Objective 8*** *– Innovate, improve and become more productive*. There has been considerable evidence of innovation and improvements being made throughout the Trust, however the Amber rating relates to being able to demonstrate the improved use of resources. One objective rated Red; ***Objective 6*** *- To reduce vacancy levels and reliance on temporary staffing*. The stretch targets of 10% vacancy and 10% turnover rates are unlikely to be achieved by the end of 18/19, due in part to an increase in establishment of 80 WTE in year, but also due to the challenging recruitment environment. SBa questioned why the Workforce report shows the staff turnover target as 11% and within this report it shows as 10%. JK advised that the NHSI target is 11% but we had set ourselves a stretch target of 10%. The stretch target is 10%, however NHSI acknowledge that this isn't going to be achieved. **The Board received the report, discussing the content implications for Trust performance.**	
14/18	**WORKFORCE AND OD Q3 REPORT** JK presented the Q3 Workforce and OD report to the Board and highlighted the following: Recruitment and retention remains a key focus for the Trust. An annual recruitment activity plan for the next financial year is being produced as well as undertaking activity to aid retention of staff. The Trust has continued to be involved in work on recruitment and retention on a national basis with NHS Employers and NHS Improvement during the quarter. Delivery against the activity in the OD Strategy has continued in Q3. A significant amount of engagement activity continued in Q3 including the Big Listen, Local Listens, Senior Leaders Forums, the annual staff awards and a number of health and wellbeing initiatives. Q3 saw the continuation of the flu campaign which is	

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	encouraging all staff to have the flu vaccine. The national staff survey took place during Q3 with 46% of all staff responding to the survey. Feedback from the Q3 pulse survey saw an improvement or maintenance in the friends and family test scores, with 67% of staff recommending the Trust as a place to receive care, and 67% saying they would recommend the Trust as a place to work. Although the safer staffing report is not due until the next Board, JK advised that there are robust and comprehensive safer staffing tools and dashboards that look at staff shift cover and give a good picture of areas with good staff cover, enabling bank and agency staff to be sent to where they are most needed. SBe questioned whether bank staff have felt fully integrated and whether there is scope to re-categorise them in order to be considered as part of the permanent workforce. JK advised that legal advice is currently being sought to move them onto the workforce whilst still on bank. JK also noted that mental health nurses are able to retire on full pension at age 55, yet some still want to work as and when they are able to, and these need to be classified within the workforce in a different way. **The Board noted report and acknowledged the additional measures that are being introduced.**	
15/18	**REPORT FROM FINANCE & INVESTMENT COMMITTEE (FIC)** SBa Informed the Board that at the last FIC the members undertook a deep dive into the development of service line reporting, noting that it was progressing well. Performance was discussed noting a strong performance during the winter months as well as employing Trust staff to support acute Trust colleagues. The financial position continues to look strong in terms of year to date with the key issues remaining unchanged relating to medical agency spend, placement costs and a current shortfall against original CRES with additional work being undertaken to address this. Going forward the efficiency programme for 18/19 and the new general ledger system were discussed. **The Board noted the report from FIC.**	
16/18	**FINANCE Q3 REPORT** KL advised that a monthly surplus continues; with the overall Trust position reported in December of £80k, better than the Plan of £14k by £66k (before STF). The overall Trust position year to date (before STF) is a surplus of £1.145m, which is ahead of the Plan of £563k by £581k. What remains evident is the tightening position, and moving into 2018/19 the real focus would be on the run rate and ensuring robust efficiencies. The Trust is expected to achieve all financial targets other than the agency cap, which would not be met. Focus has been on medical agency, both locally and nationally, and KL advised that AZ attended the CRES PAB in order to discuss progress on all medical agency issues. KL advised that he fully expected the Trust's control total to be met at the end of the year, however the following risks should be noted; • Pay remains underspent but has increased year to date. • Secondary commissioning for long-term health placements, social care placements, and social care packages, have not achieved the savings planned for in year. • External PICU and Acute placements have also not yet fully achieved planned savings. Additional expenditure has been planned for later in the year, in order to drive	

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	performance improvement and data quality and to further develop IT. KL confirmed that JP and AZ have overall responsibility for QIAs and that currently there are 36 in total. These consist of 13 that have been fully signed off, 18 that do not require QIA sign off due to a number of reasons and four schemes that have not proceeded. SBe confirmed that QIAs are received and discussed at the IGC. **The Board discussed and noted the content of the Finance report.**	
17/18	**QUESTIONS FROM THE PUBLIC** • Barry Canterford queried how many HPFT staff have contracted flu. JK advised that although the data is not yet available, and large numbers haven't been identified, the top reason for absence relates to colds, coughs and flu. • Barry Canterford also commended the commitment of staff across the Trust for getting in to work during the adverse winter weather.	
18/18	**REPORT FROM AUDIT COMMITTEE** CD reported on the key items of business from the Audit Committee of 6th December, This included of note a comprehensive presentation from the Head of Information Governance with a 'deep dive' focus into the key issues and risks faced by the Trust and the mitigation actions in place. Internal Audits were received which covered Recruitment, Patient Safety: Responding to Medical Emergencies (Resuscitation) and Safeguarding – Delegated Responsibilities. Partial assurance had been received for the three audits and the Audit Committee spent significant time considering the detail. Clear action plans were discussed in relation to addressing the findings from each audit including a follow up unannounced audit of medical equipment. Counter Fraud work continues, and it was noted that a session on Counter Fraud and Bribery now takes place at staff induction, ensuring all new staff receive this information first hand. Deloitte's are in their final contracted year as the Trust's external audit advisors, and the tendering process is well under way. Audit Committee had also reviewed the Trust Risk Register and Board Assurance Framework. **The Board received the report, noting that audits are not just linked to finance but are also have a clinical focus.**	
19/18	**BOARD ASSURANCE FRAMEWORK (BAF)** JE indicated that the Trust objectives are within the BAF and are updated regularly to reflect the new objectives. In terms of risk and compliance, the BAF goes to the Integrated Governance Committee and Audit Committee meetings regularly and reviewed together with the Trust Risk Register (TRR). JE added that he holds regular meetings with all Directors to ensure accuracy of the BAF. CL quoted a question from the CQC mock interviews relating to where assurance would be found, and JE confirmed that this would be through the BAF. JE also confirmed that the CQC would be requesting sight of the BAF and TRR during the Well-Led Review. **The Board received the BAF and noted that the document has improved and was more 'user friendly' and helpful**.	

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20/18	**TRUST RISK REGISTER (TRR)** JP advised that the TRR is a live document, reviewed monthly at the Executive Team Meeting in addition to directors reviewing their individual SRO risks. The TRR listed the top 11 risks and this last came to the Board meeting in December, since that time progress has been made in relation to the actions taken, but scores remain unchanged. TC acknowledged that it is always useful to identify the top 5 risks and be aware of how these are being actioned. **The TRR was discussed and it was noted that the next iteration would be at the March Public Board.**	**JE**
21/18	**SUB-COMMITTEE TERMS OF REFERENCE ANNUAL REVIEW** JE informed the Board that each Sub-Committee is required annually to review its Terms of Reference (ToR) and refer any changes to the Trust Board for approval. He acknowledged that the Finance & Investment Committee ToR are now due and that the Integrated Governance Committee ToR are due for review in April 2018, It was also noted that the Remuneration Committee ToR would be reviewed at a future Audit Committee and brought back to Board for approval. KL noted that in item 3.3 of the FIC ToR, whereby it notes the responsibility of FIC to receive the performance report and the further reporting surrounding this, that it is new, and therefore needs to also be amended within the Audit Committee ToR. **The minor amendments within the Audit Committee and FIC Terms of Reference were reviewed and approved and it was noted that in order to streamline the review process in future, all Sub-Committee ToR would be brought for review and approval to the same Board meeting each year.**	**JE**
22/18	**Any Other Business** No further business was noted	
23/18	**Date and Time of Next Public Meeting:** Thursday 22nd March 2018 9.30 – 13.30 Da Vinci B&C, Colonnades	
24/18	**Resolution to hold remainder of meeting in private** CL noted the resolution and the approval by the Board.	

There being no further business, the meeting was adjourned.

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Agenda Item 4

PRIVATE BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 22nd March 2018

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
25/01/2018	**07/18**	Patient Safety Q3 Reports - Safeguarding	SBe advised that this report had been through IGC where they had commented on a very strong report. The Board agreed, and JP agreed to take these positive comments back to the team.		JP	Completed	G
25/01/2018	**08/18**	Report from IGC	SBe agreed to ensure the draft IGC minutes are circulated to the Board.		SBe	After IGC on 6/3	A
25/01/2018	**12/18**	Questions from the Public	Jon Walmsley enquired about the fill rate on wards, and JP agreed to look into this.		JP	Completed	G
25/01/2018	**12/18**	Questions from the Public	William Say commented on the PLACE Audit and the marked difference between fresh and reheated food. He advised that he would like to commend Gary Inman and his audit team for working under some difficult conditions. KL agreed to take his comment about the team back and confirmed that over the next 15 months a new meal specification would be undertaken and would be going out to tender in due course.		KL	Completed	G
25/01/2018	**20/18**	Trust Risk Register	The TRR was discussed and it was noted that the next iteration would be at the March Public Board.		Company Secretary	22nd March	G
25/01/2018	**21/18**	Sub-Committee Terms of Reference Annual Review	The minor amendments within the Audit Committee and FIC Terms of Reference were reviewed and approved and it was noted that in order to streamline the review process in future, all Sub-Committee ToR would be presented at the same Board Meeting.	Added to Board Meeting Cycle	Company Secretary	January 2019 Meeting	G

Hertfordshire Partnership NHS
University NHS Foundation Trust

PUBLIC BOARD MEETING

Meeting Date:	22nd March, 2018	**Agenda Item: 5**
Subject:	CEO Brief	**For Publication:** Yes
Author:	Julie Hollings, Deputy Director | Marketing, Communications & Engagement |	**Approved by:** Jinjer Kandola, Deputy CEO & Director of Workforce and Organisational Development
Presented by:	Jinjer Kandola, Deputy CEO & Director of Workforce and Organisational Development	

National update

February shown as the most pressurised month for NHS performance

Figures show that A&E departments treated 76.9% of patients within the four-hour target. These are the lowest figures since records began and are below the 95% target covering urgent and emergency care. They have been ascribed to winter weather coupled with high numbers of flu and norovirus cases.

NHS pay deal

Reports have suggested that health unions are close to negotiating a pay deal for NHS staff above the cap imposed by ministers in recent years. Any outline agreement between the two sides will need final approval from ministers.

CQC publishes 'Are we listening?' – national review of CAMHS

The phase one report from the CQC's review of CAMHS, published this month, found "widespread issues with accessibility" of specialist services and variation in waiting times across England. The report states that mental health care is funded, commissioned and provided by many different organisations that do not always work together in a joined-up way.

Where care has been identified as 'good, the CQC ascribed this to collaboration between different organisations and services. They also found examples of creative approaches that help some services provide good or outstanding examples of person-centred care. Hertfordshire was one of 10 places that the CQC visited as part of the national review, cited as an example where partnership working is in place to develop and implement the mental health and wellbeing transformation plan for children and young people in Hertfordshire. The report features the work of HPFT's CAMHS Community Eating Disorders Team and our Community Perinatal Team.

The next phase of the review will look at what could be done to make it easier to improve access and quality. The CQC will make full recommendations when they publish their thematic review later in March.

The report is available at: http://www.cqc.org.uk/publications/themed-work/review-children-young-peoples-mental-health-services-phase-one-report.

Regional update

Herts Valley CCG

Herts Valleys CCG has confirmed its intention to tender Adult Community Services. A market engagement event was held on 28 February. A PPQ and ITT tender process will take place in April – June with a view to recommend an award in September.

Nascot Lawn

At the end of February, the High Court in London announced its conclusion following a judicial review brought by three parents who opposed the decision by Herts Valleys CCG to stop funding the respite service at Nascot Lawn.

The case was presented on six grounds and the judge's ruling agreed with the families on one of those grounds. Herts Valley CCG must now consult with Hertfordshire County Council, before making a new decision. The CCG will make the decision in the early part of May.

Trust-wide update

Performance

- Our overall position remains generally strong in the face of unprecedented increased demands on our services during the busy winter period. This demand is in line with the national picture with referral rates growing to 15% compared to previous years.
- However, we have built upon and sustained our performance within SPA and CAMHS. Furthermore, we have improved our performance in routine LD waits within 28 days and cardio-metabolic assessment and treatment for people with psychosis on CPA. The most significant challenges remain: access to routine 28-day adult community services, C-CATT 4 hour wait, CAMHS routine waits and Essex IAPT. We are working with commissioners on a range of initiatives to improve performance.

Operational services

- February has continued to be very busy, with referral rates continuing to grow significantly particularly in adult and children's services.
- Although we continue to use far fewer out of area acute beds than we did at this time last year, our inpatient teams are managing high levels of complexity and acuity. With a national expectation that all out of area placements will be eradicated by 2021, we will continue to work to further strengthen our 24/7 crisis services.
- We have also seen good early progress with the mobilisation of our CAMHS Tier 4 (Beds) Service. The number of young people being placed out of county is beginning to reduce already and the service continues to develop.
- Finally, it is worth acknowledging the work with primary care to develop improved pathways for mental health care. We have two projects currently in pilot phase and both are showing encouraging early results.

Quality

- We have seen an increase in the number of incidents reported by the Trust following work with staff to encourage openness and transparency. This has been coupled with a decrease in the harm sustained as a result of incidents.
- Our Workforce Race Equality Standard (WRES) data has shown that BME staff being appointed following shortlisting has improved. However, the proportion of BME staff entering the disciplinary process has worsened. The coming year will see more focus on leadership for inclusion including how we ensure processes are fairly applied across the Trust. The Trust Equality Strategy (2018 – 2022) is currently out to public consultation.

CQC inspections

We have had both our core CQC inspections (22 – 26 Jan) and well led inspection (5 – 8 February) and have received informal feedback which highlighted many positives that they found during their visit, including:

- The Trust values being embraced and modelled across the organisation at all levels.
- Leadership being demonstrated at all levels of the organisation. Leaders are visible and approachable.
- Working effectively across a diverse geography
- Staff supporting one another.
- Engagement that is well embedded, involving staff, service users and partners.
- IT systems – in particular Safe Care and Spike were held up as good IT solutions.
- Patient care - with a focus on patient care, safe care and quality that is clearly thought out.
- Quality improvement - evidence that this is starting to make a difference.

The CQC also identified some areas that required attention:

- Seclusion practices and documentation.
- Serious incident recording and reporting
- Pace and responsiveness in relation to lessons learnt
- Recruitment of a Freedom to Speak Up guardian
- Responsiveness to concerns - ensuring that we respond to early signals.

We are awaiting the formal report, which is due at the end of March.

HPFT National NHS Staff Survey results

We have now received our National Staff Survey results for 2017. Overall the results show staff experience of working in HPFT continues to be a positive one. Despite increased demand, just over 90% of our scores are in line with or above the national average. Once again we have scored highly for staff engagement and staff continue to tell us that they feel motivated at work. This year there are five key areas where HPFT staff scored higher than the national average:

- Staff agree that they feel motivated in their jobs
- Staff agree that the Trust uses patient and service user feedback effectively
- Staff would recommend the Trust as a place to work or receive treatment
- Staff feel that the Trust provides high quality appraisals, non-mandatory training, and learning and development
- Staff feel confident and secure in reporting unsafe clinical practice. This is a result of teams holding reflective sessions on the wards and an increase in people taking part in regular supervision sessions with their managers. This is very positive and something we strongly encourage.

There are a number of areas for improvement. In particular, the number of staff who have attended work in the last three months despite feeling unwell has risen and people continue to work extra hours. This reflects trends in the national results where staff are feeling that they are working under greater pressure.
A full report is on the Board agenda.

The Marlowes Health & Wellbeing Centre, Hemel Hempstead

March has seen services beginning to move into the Marlowes Health & Wellbeing Centre in Hemel Hempstead. Bringing mental and physical health services (from HPFT and HCT) together is part of our approach to delivering integrated care. Providing services under one roof will help us ensure that service users, carers and families receive joined-up care with healthcare professionals able to share expertise with each other

The newly refurbished centre is located in central Hemel Hempstead, near the Marlowes Shopping Centre. Community dental, CAMHS, LD and adult services clinics will start from mid-March. The centre will be formally opened on Friday 11 May by Mike Penning MP.

Finance

Our position in January showed a small deficit of £3k, which is slightly behind the plan of £6k surplus (before STF). The overall Trust position year to date (before STF) shows a surplus of £1.142m, which is ahead of the plan by £572k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating (the UOR) reports as a 1, the highest rating. This reflects the financial position reported previously. There is a full report on the Board agenda.

Adverse weather

I would like to thank all our staff who worked hard to cope with the snow in early March. There were numerous examples of people finding different ways to get to work. This included staff trudging through the snow by foot to get to work or staying overnight to ensure they were able to work the next day. Some staff across Herts, Essex and Norfolk who came in on their days off used their own 4x4 vehicles to take colleagues to community appointments in hard to reach areas. Staff within our Transport Department relocated temporarily to Norfolk in order to take staff to and from their shifts during the week, including night shifts.

International Women's Day 2018

A successful staff event was held to recognise International Women's Day on 8 March, compered by Jinjer Kandola and Tulika Jha, new chair of the HPFT Women's Network. Women across the Trust heard Yinglen Butt talk about her experiences as a chief nurse working at a national level.

National Nutrition and Hydration Week

During the week beginning 12 March**,** our allied health professionals promoted this important work through a programme of events as well as a social media campaign (#foodmemories) which focussed on the importance of food and impact of the social aspects of eating on our mental wellbeing

Trust CEO in HSJ's Top 15 NHS Trust Chief Executives 2018

I am proud to tell you that I have been recognised in the HSJ's Top 15 NHS Trust Chief Executives 2018.

Tom Cahill,
Chief Executive

Hertfordshire Partnership University NHS Foundation Trust

BOARD OF DIRECTORS

Meeting Date:	**22.03.18**	**Agenda Item: 6**
Subject:	**IGC report to Board**	**For Publication: Yes**
Author:	**Carolyn Fowler** **Deputy Director of Safer Care and Standards**	**Approved by:** **Sarah Betteley**
Presented by:	**Sarah Betteley – Non Executive Director**	

Purpose of the report:

To confirm to the Board that the Integrated Governance Committee has carried out the duties delegated to it and provide assurance in relation to the matters considered.

Action required:

For assurance

Summary and recommendations:

The IGC met on 6th March 2018. The report identifies the items considered and highlights any matters considered relevant for escalation to the Board.

Relationship with the Strategy (objective no.), Business Plan (priority) & Assurance Framework (Risks, Controls & Assurance):

Summary of Financial, Staffing, and IT & Legal Implications (please show £/No's associated):

Equality & Diversity and Public & Patient Involvement Implications:

Evidence for Registration; CNST/RPST; Information Governance Standards, other key targets/standards:

N/A

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/Board/Audit

N/A

Report from Integrated Governance Committees held on 6th March 2018

The following items were considered by the Committee:

Reports from Subgroups:

Quality and Risk Management Committee (QRMC)
Workforce & OD Group. (WODG)

Quality and Patient Safety

Operational Services Update – Winter Performance
CQC Update
Quality Account
Q3 Safe Staffing report
Q3 CQUIN progress report
PACE Annual Programme Report
HPFT Equality Plan Consultation Document 2010-2022
Public Sector Equality Duty (PSED) compliance report
Never Events Briefing

Regulatory and Governance

Trust Risk Register

Items of Note: The committee agreed that a number of themes were apparent during the meeting and presentation of reports which required assurance that intelligence was being triangulated and risks identified.

1. **Seclusion**
   The committee discussed the recent concerns raised by CQC in relation to seclusion in Dove Ward. Concerns relate to the Trust ensuring best practice that aligns to its own policy with robust documentation, care planning and risk assessment for assurance of best practice. An external review is to be commissioned to reflect the assurance required, evaluating the Trusts practice and rationale for seclusion. The risk assessments have been revised and a safe guarding referral expected when seclusion happens outside a seclusion room.
   It was agreed that seclusion should be on the individual SBUs risk register rather than the Trust register as it has not been identified as a trust wide concern. However it was noted that assurance should be sought regarding practice in other Trust services.

   It was agreed that the Safety Strategy would be brought to IGC in July.

2. **Safe Staffing**
   The safe staffing paper will be reported at board, the committee recognised that safe staffing at Thumbswood was referred to in more than one report. Assurance was given that the ward had safe staffing but this had been achieved by an increase in registered nursing to fill unregistered nursing shifts. It was agreed this required further scrutiny and plans are in place using Safe Care to look at wards working together to ensure safe and efficient use of staffing.

3. **PACE**
   A discussion was had regarding the quantity and quality of audits and the necessity to deliver the high number identified for 2018. There was also discussions as to whether some issues could be explored in a slightly lighter touch/deep dive way rather than a full audit. It was agreed this challenge would be taken back to the Audit Committee for further consideration.

4. **CAMHS and Forest House**
   Forest House continues to be discussed in relation to safe care, particularly leadership and continuous improvement. It was noted a lot of work has been done but that a deep dive into CAMHS and Forest House with updates to the next committee would be requested and that the increased scrutiny needs to continue.

5. **DNA pathway and Stevenage pilot**
   An update was given regarding the new access clinics in GP surgeries in Stevenage. The very early indications so far show decreased DNAs, timely actions relating to adjusting medications and improved service user satisfaction with services.

6. **Never Events**
   The revised Never Events list for 2018 has been published, eleven relate to Mental Health. Services have been asked to review the risks, identify mitigation and required actions. The committee agreed the leads and the process for the gap analysis.
   It was agreed that assurance was also required in relation to the Trusts commissioned NHS funded care.

7. **Trust Risk Register**
   The committee was in agreement that the risk register was now more robust and was a live document updated and discussed by the executive regularly. Two risks were considered and agreed for downgrading, Risk ID 66 'The demand growth within the SPA service', and ID 366 'To ensure sufficient AMHP cover'. Seclusion was also discussed as above.

8. **CQC update**
   The moderate harm incidents were discussed in relation to concerns raised of consistent levels of harm identified and serious incidents being recognised. Assurance had been requested with a full review of 36 moderate harm cases, all incidents have been reviewed with a request for further information on some. A new process for reviewing moderate harm would be in place ongoing, with the Deputy Directors of Nursing and Medicine reviewing all against the proposed guidance and template.

   A separate paper will be presented to the board relating to concerns raised by CQC.

9. **Equality Strategy and PSED compliance**

   The strategy and PSED compliance documents were presented to the committee, there was a good discussion and it was agreed a further report would be brought back to the May IGC.

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Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	22nd March 2018	**Agenda Item: 7**
Subject:	Quarter 3 Safe Staffing Report	**For Publication:**
Author:	Jaya Hopkins, Head of Nursing Learning Disability & Forensic Jacky Vincent, Deputy Director of Nursing and Quality	**Approved by:** Dr Jane Padmore, Executive Director of Quality & Safety/Chief Nurse
Presented by:	Dr Jane Padmore, Executive Director of Quality & Safety/Chief Nurse	

Purpose of the report:

This report provides the Board with a quarterly update on nurse staffing for the Trust for quarter 3. In addition, the report provides information that sets the context for the published data including recruitment, retention and vacancies of nursing staff. The purpose of this report is to provide information and assurance of the governance processes for rostering and ensuring the appropriate level and skill mix of nursing staff.

Action required:

The Board is asked to consider and note the contents of the report and discuss any point of clarification. To also receive assurance of the governance process for rostering.

Summary and recommendations to the Board:

The direct care nurse staffing data was analysed according to total hours worked per ward for RN and HCA, divided into day and night time hours and includes additional duties. Quarter 3 showed adequate staffing and shift cover in response to unexpected demand and levels of acuity and dependency on the wards. SRS and Thumbswood both had a fill rate below 80%, There was also more actual hours than planned used for both RNs and HCAs across many services.

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):

Adequacy of a balanced skill mix for nursing workforce has an impact on clinical outcomes, patient safety and experience.

Summary of Implications for:

1	Finance	n/a
2	IT	n/a
3	Staffing	there is a need for regular review of staffing establishment.
4	NHS Constitution	n/a
5	Carbon Footprint	n/a
6	Legal	n/a

Equality & Diversity (has an Equality Impact Assessment been completed?) and Public & Patient Involvement Implications:

n/a

Evidence for Essential Standards of Quality and Safety; NHSLA Standards; Information Governance Standards, Social Care PAF:

Potentially all of the above

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

IGC 6th March 2018

1. Introduction

1.1. This report serves to provide the information and analysis of the quarter 3 nurse staffing data to enable the Trust Board to have assurance in relation to the nurse staffing in Hertfordshire Partnership NHS University Foundation Trust's (the Trust) inpatient services. The report also includes data on nurse staffing in community services.

2. Trust expectations in relation to inpatient nurse staffing levels

2.1. The Trust's expectation is that the planned number of staff to cover the ward demand and acuity level would closely match with the actual number of staff who are working, as this should reflect the complexity of the needs of the service users.

2.2. Where the skill mix and the numbers of staff who actually work is lower than planned, this may indicate a safety concern. There is an agreed escalation process for reporting any safety concerns associated with nurse staffing, as detailed in previous Board reports.

2.3. In the event that a shift remained unfilled, this is reported to the Heads of Nursing and recorded as a safety incident on Datix, again as detailed in previous reports. Staffing cover is often mitigated by an increase of staff from a different band, cross cover from co-located services and by the Team Leaders and Matrons.

2.4. Although all efforts are made to ensure the right skill mix, staff sometimes prefer to work with a regular Healthcare Assistant (HCA) to ensure continuity of care rather than seek a Registered Nurse (RN) through the Bank office or Agency.

2.5. Outliers (wards with fill rates below 80% and in excess of 120%) continue to be discussed at the Safe Staffing meeting and also the Strategic Business Unit's (SBU) governance meetings.

3. Summary of findings for quarter 3 nurse staffing data collection

3.1. The analysis from the safe staffing returns has been broken down by month to provide detailed information about the services; detailed analysis is provided on services with fill rate under 80% in red and those over 120% in purple.

3.2. There was one service with a fill rate below 80% in October 2017; this was Thumbswood, with a HCA day fill rate of 68%, and this was compensated with a higher RN day fill rate of 171%. Thumbswood was also the only service with a fill rate below 80% in December 2017. This was for HCA day at 78% and night at 72% and both were compensated with a higher RN fill rate of 145%.

3.3. There were two services with a fill rate below 80% in November 2017. One was SRS with an RN day fill rate of 77% resulting in the Team Leader, Matron and Clinical Nurse Lead providing support. In addition, there was cross working across Dove ward and SRS to support each other as well as *SafeCare* implementation regarding redeployment of staff. The other service was

Thumbswood with a day HCA fill rate of 79% which was compensated with a day RN fill rate of 283%.

3.4. Many services had used staffing above their establishment to meet the clinical needs and demands of the services. For example, Aston ward had high acuity levels and Victoria Court had used extra HCAs due to refurbishment work and to maintain a safe environment. They also had service users prescribed continuous safe and supportive observation.

3.5. Nurses in charge of the shifts and the Team Leaders continue to review their nurse staffing level daily, on a shift by shift basis, in response to the changing clinical needs of services, following the clear process for escalation when staffing falls below the minimum safe level.

3.6. **Appendix 1** provides detailed data for each inpatient service for quarter 3.

3.7. The Trust is preparing to ensure it is ready for the submission of Care Hours Per Patient Day (CHPPD) from April 2018. CHPPD is a simple calculation by dividing the number of actual nursing (both registered and unregistered) hours by the number of service users. It therefore represents the number of nursing hours that are available to each service user.

3.8. CHPPD is a way of representing staffing data that puts the hours in the context of the service user activity, in an easy to understand figure. Using CHPPD has a number of advantages over other methods of representing this data:

- It provides a single figure that represents both staffing levels and service user requirements, unlike actual hours alone, and
- It allows for comparisons between the units. As CHPPD has been divided by the number of service users, the value does not increase owing to the size of the unit – allowing comparisons between different units of different sizes.

4 Vacancies

4.1 The Trust continues to have some challenges with recruitment with 24.9% RN vacancies and HCAs at 19.4%, as detailed in **Table 1** overleaf.

4.2 The Trust continues to work with the local universities ensuring that student nurses feel part of the Trust family at the start of their training and meet senior nurse leaders during their training. The 17 newly registered nurses (Cohort September 2014) have started in their respective services and are undergoing their preceptorship.

4.3 The 10 trainee Nursing Associates continue with the programme. A celebratory event is being planned for the end of their first year. Plans are in place for further cohorts during 2018.

4.4 The Trust and the University of Hertfordshire are involved in the Health Education England (HEE) pilot to undertake a 2 year MSc programme for mental health nursing. Of the 10 in the cohort which started in September, 4 were seconded HCAs from the Trust.

4.5 The first overseas nurse, who arrived on 10th November 2017, is actively preparing for his OSCE which is booked for 15th February 2018.

Table 1: Vacancy Rates

Registered Nursing – inpatient services				
SBU	**Sum of Position FTE**	**Sum of Actual FTE**	**Sum of FTE Variance**	**% Vacancy**
Learning Disability & Forensic	168.31	133.97	34.33	20.4
East and North SBU	95.55	66.98	28.56	29.9
West SBU	91.07	65.65	25.41	27.9
Total	354.93	266.61	88.31	24.9
Unregistered Nursing				
SBU	**Sum of Position FTE**	**Sum of Actual FTE**	**Sum of FTE Variance**	**% Vacancy**
Learning Disability & Forensic	232.82	204.56	28.25	12.1
East & North SBU	214.65	154.76	59.89	27.9
West SBU	97.6	80.16	17.44	17.9
Total	545.07	439.48	105.58	19.4

4.6 A significant risk remains for the Trust regarding the profile of nursing workforce who are able to retire (281), detailed in **table 2** below. Work continues to support them and explore their options to remain in the workforce.

Table 2: RN retirement profile

Area	55-59	60-64	65+
LD & F	69	22	4
East and North	53	40	13
West	43	32	5
Trust	**165**	**94**	**22**

5 NHSI 90 Day Carter Review

5.1 The Trust is one of 24 Trusts which engaged in the Carter Review process with NHS Improvement (NHSI), focussing on improving efficiency and productivity of e-rostering. Achievements have been made regarding 12 weekly rosters in all inpatient services as well as a focus on improving the unused hours and additional costs. E-Rostering is currently being implemented across all community services.

5.2 A review of the reporting structure, governance and escalation processes is underway to enable ERoster, *SafeCare,* Bed Management and the Bank Bureau to work together more effectively and efficiently.

5.3 The Trust's Safer Staffing Group meeting has been revised requiring all Team Leaders and Matrons to attend and report on their ERoster Key Performance Indicators, reports derived from *SafeCare* and their bank and agency usage, with remedial actions plans.

This is by use of a standardised report template and is to ensure local accountability is held with regards to management of safe staffing.

5.4 The Trust has given a presentation to NHSI Carter Review Collaborative on 18th January 2018 on its implementation, challenges and achievements to date. Involvement in this review has benefitted the Trust with the following outcomes realised:

- Positive impact on use of temporary staffing
- Improved staff morale with 12 weeks roster in place
- Financial impact from unused hours (c£10K as a one off)
- Closer localised monitoring of rosters with greater understanding and ownership and scrutiny
- Assessment of staffing levels and acuity at least daily as a minimum
- Effective use of staffing resources with staff moved according to need
- Good understanding of Key Performance Indicators and remedial action.

6 Conclusion

6.1 This report sets out to brief the Board in relation to the quarter 3 position for safe nurse staffing within inpatient services. The report also includes community nursing staffing and the vacancy rate.

6.2 In addition, the report details the work the Trust is currently undertaking in order to run safe and effective services whilst being compliant with the safer staffing requirements, to ensure the Trust has the right staff, in the right place, with the right skills, at the right time.

6.3 *SafeCare* is embedded within all inpatient services and this is being implemented across the community services.

6.4 The Board is asked to note this report and discuss any point of clarification.

Appendix 1

Nurse Staffing fill rate data

October 2017

Services	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Learning Disability & Forensic SBU				
SRS	81	91	100	100
Dove	103	96	100	139
Sovereign House	100	100	100	100
Gainsford House	112	137	108	103
Hampden House	109	98	100	100
The Beacon	98	100	100	100
Warren Court	99	105	117	95
Beech	98	100	97	114
Lexden	93	113	105	129
Astley Court	109	129	100	128
Broadland Clinic	83	106	98	122
4 Bowlers Green	100	99	100	100
East and North SBU				
Elizabeth Court	107	107	95	133
Victoria Court	102	130	100	226
Seward Lodge	102	176	98	140
The Stewarts	113	97	110	240
Logandene	102	97	98	103
Wren	100	187	100	144
Lambourn Grove	113	96	110	240
Forest House	92	138	95	310
West SBU				
Swift	96	129	100	187
Robin	97	114	100	168
Owl	104	124	100	181
Albany Lodge	97	158	100	186
Aston	98	221	100	242
Thumbswood	171	68	119	92
Oak	106	113	100	136

November 2017

Services	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Learning Disability & Forensic SBU				
SRS	77	93	100	100
Dove	127	90	104	142
Sovereign House	105	100	100	100
Gainsford House	114	127	117	104
Hampden House	107	107	100	100
The Beacon	99	99	100	100
Warren Court	118	124	101	140
Beech	98	100	90	131
Lexden	100	95	100	101
Astley Court	97	138	100	132
Broadland Clinic	113	101	83	102
4 Bowlers Green	98	92	100	100
East and North SBU				
Elizabeth Court	95	143	103	208
Victoria Court	118	124	101	141
The Stewarts	103	85	102	167
Seward Lodge	98	157	100	195
Logandene	106	96	100.	102
Wren	97	127	100	123
Lambourn Grove	109	116	108	117
Forest House	92	127	98	157
West SBU				
Swift	103	130	100	192
Robin	100	123	100	122
Owl	98	136	100	167
Albany Lodge	99	135	100	144
Aston	96	189	100	123
Thumbswood	283	79	127	85
Oak	92	172	100	183

December 2017

Services	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Learning Disability & Forensic SBU				
SRS	86	104	100	101
Dove	144	96	110	140
Sovereign House	102	100	100	100
Gainsford House	108	121	103	106
Hampden House	100	118	100	103
The Beacon	99	99	100	100
Warren Court	94	104	105	105
Beech	110	103	92	97
Lexden	85	113	98	124
Astley Court	96	143	100	128
Broadland Clinic	96	90	105	97
4 Bowlers Green	97	100	100	100
East and North SBU				
Elizabeth Court	100	109	90	143
Victoria Court	94	137	98	199
The Stewarts	102	257	98	287
Seward Lodge	90	197	102	168
Logandene	107	102	108	130
Wren	115	226	113	231
Lambourn Grove	109	91	110	234
Forest House	89	95	97	127
West SBU				
Swift	110	106	96	190
Robin	98	118	98	176
Owl	93	127	95	160
Albany Lodge	98	117	100	165
Aston	95	201	100	189
Thumbswood	145	78	145	72
Oak	92	169	102	201

Hertfordshire Partnership NHS
University NHS Foundation Trust

PUBLIC BOARD

Meeting Date:	22nd March 2018	**Agenda Item: 8**
Subject:	Staff Survey Report 2017	**For Publication:** Yes
Author:	Sandy Hastilow – Organisational Development Manager & Lindsey Holman – Interim Associate Director of Organisational Development	**Approved by:** Jinjer Kandola, Deputy Chief Executive Officer & Director of Workforce and Organisational Development
Presented by:	Jinjer Kandola – Deputy Chief Executive / Director of Workforce and Organisational Development	

Purpose of the report:

To present to the Board the results and analysis of the national staff survey 2017 and recommended actions and next steps

Action required:

For noting and feedback on recommendations

Summary and recommendations to the Committee:

The national staff survey results represent a good position for the Trust with 13 key findings above average for other mental health and learning disability trusts, 16 average and only 2 below average. Compared to last year there is only one significant change in the position of the key findings (a downward trend for the number of staff coming into work when ill feeling under pressure). It is notable that the Trust has maintained a good position when last year was the best results since 2011 in a climate of continuing demand on services.

It is recognised that the organisation cannot be complacent about the results and that other mental health trusts are also improving in terms of their satisfaction levels. There are also key findings where although we rate above average, we aspire to higher results in the delivery of Good to Great.

The category of 'the organisation' was consistently average or above average with more staff recommending HPFT as a place to work and have treatment compared to last year and other Mental Health Trusts. Our staff also tell us that they remain motivated at work.

The results show that the Trust needs to continue to focus on reducing bullying and harassment and the activities within the WRES plan to ensure equity in staff experience and satisfaction. It also highlights that the fundamentals of management and team effectiveness should be taken forward as a priority for improvement.

The SBUs, professional leads and other heads of department are all reviewing the data and a collated action plan will be presented to WODG in May. The findings will inform the OD activity plan for 2018 - 19.

Within the OD activity plan there are a number of activities which continue to invest in the development of workplace culture were staff feel valued and motivated to deliver at their best

- Continued roll-out of unconscious bias training as part of the equality diversity and inclusion plan
- On-going implementation of Health and Wellbeing strategy including resilience and mindfulness to reduce work related pressures
- Collective leadership

There will also be a new focus on reviewing and developing teams (people, process and structure) developing a consistent operating model across the organisation.

Relationship with the Assurance Framework

Recruitment and retention, annual plan, OD Plan, National Staff Survey

Summary of Financial, IT, Staffing & Legal Implications:

Supports Staff Retention and Employee Satisfaction

Evidence for S4BH; NHSLA Standards; Information Governance Standards, Social Care PAF:

CQC Well led domain

Seen by the following committee(s) on date:

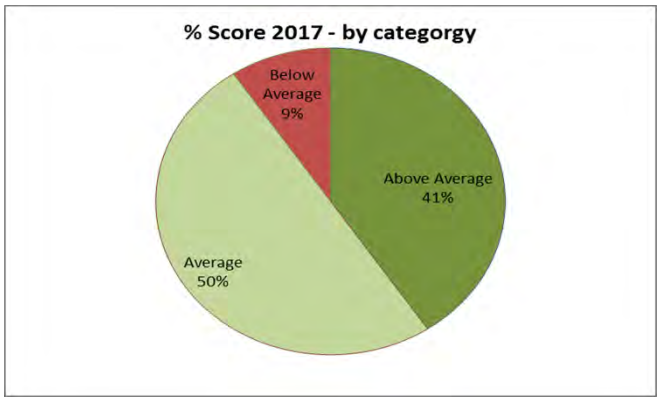
Summary presentation to Executive Team and WODG March 2018

1. Introduction and Summary

1.1 The results of the National Staff Survey 2017 demonstrate a continuing positive position for the Trust. Last years' results were the best set of results in six years, and we have maintained our position in 2017. This year, 91% of the scores within the Trust are above the national average or at average (when compared to other mental health and learning disability Trusts). Diagram 1.

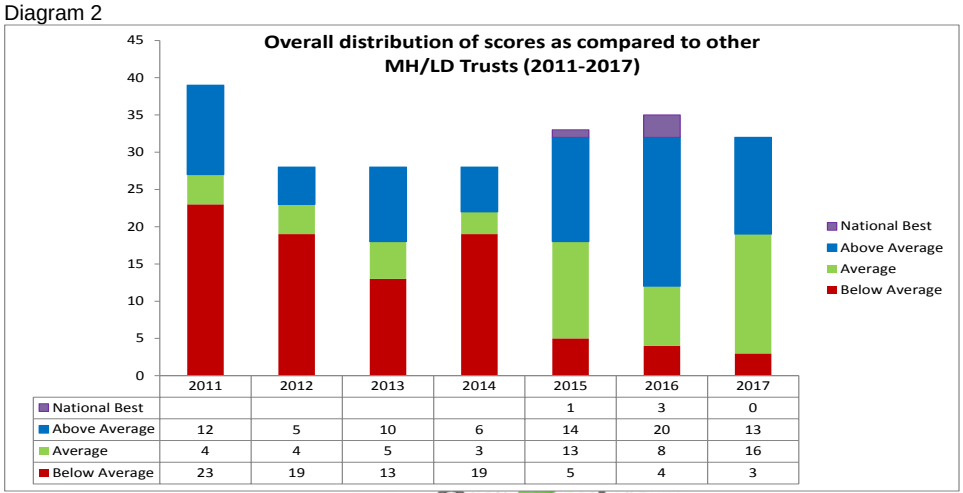
1.2 The survey measures and reports 32 key findings these results are categorised as above average, average and below average. Our results when compared to other mental health trusts were 13 above average, 16 average and 3 below average.

Diagram 1



1.3 The diagram 2, below shows the distribution of scores compared to other mental health trusts since 2011. Whilst, this year produced the lowest number of below average scores, disappointing, there were no overall national best scores.

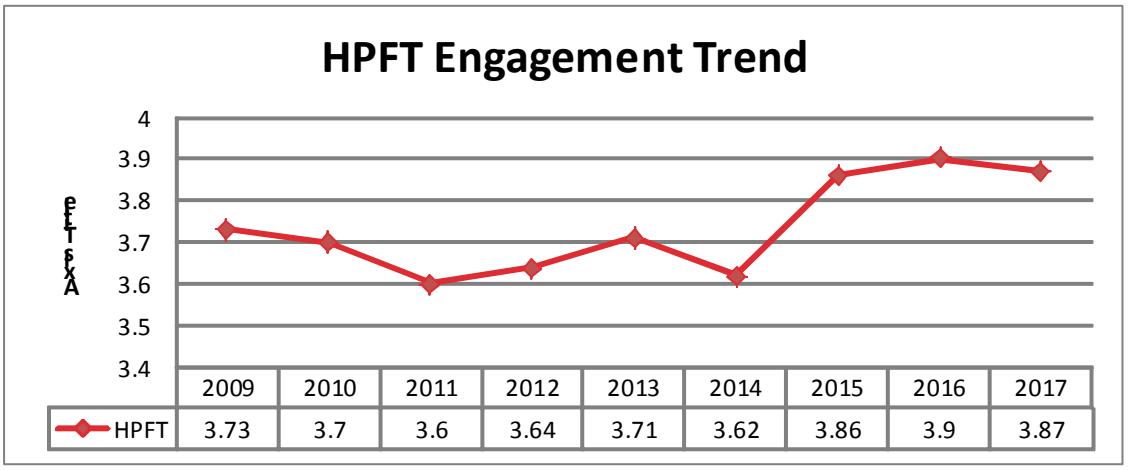
Diagram 2



	2011	2012	2013	2014	2015	2016	2017
National Best					1	3	0
Above Average	12	5	10	6	14	20	13
Average	4	4	5	3	13	8	16
Below Average	23	19	13	19	5	4	3

1.4 The overall engagement score remains above average compared to other mental health trusts, and static since the increase in 2014. This score is made up of 3 key findings Staff recommendation of the trust as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work. The area of requiring more focus remains, staff ability to contribute towards improvements.

Diagram 3



1.5 When we undertake a detailed analysis, in comparison to last year, there is only one significant change, with the remaining results seeing no change of statistical significance. The significant change is the percentage of staff reporting that they 'attended work in the last three months despite feeling unwell' because they felt under pressure.

2. Background and Key Findings

2.1 The Staff Survey was sent to all 2917 eligible staff, during September to December 2016. The response rate was 46.9%, which was higher than the 42% received back in 2016.

2.2 The operating context for the Trust during 2017 was one of high demand for services and pressure on staffing, with recruitment and retention remaining a challenge. Although there were a number of service developments and increasing responsibility for physical health; there have been no major transformation programmes. However, we have seen the growth of new services, the Trust successfully bid for and mobilised CAMHS Tier 4, as well as the development of Hemel Hub an integrated physical and mental health facility.

2.3 The key findings are structured thematically around nine themes. The nine themes are:-

- Appraisals and support for development
- Equality and diversity
- Errors and incidents

- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying

3. Summary of Key Findings.

3.1 The top 5 ranking scores for the Trust were

- Effective use of patient/service user feedback
- Quality of non-mandatory training, learning or development
- Staff motivation at work
- Staff confidence and security in reporting unsafe clinical practice
- Staff recommendation of the organisation as a place to work or receive treatment

3.2 The bottom 5 ranking scores were

- Percentage of staff working extra hours
- Percentage of staff experiencing physical violence from staff in last 12 months
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- Support from immediate managers
- Percentage of staff experiencing discrimination at work in the last 12 months.

3.3 The key findings are divided into nine themes and the summary of the score in these themes are detailed below

3.4 **Appraisals and Support for Development** – This has 3 key findings

- Percentage of staff appraised in last 12 months has stayed static at 88%, and is rated average. A large portion of our localities have higher than average and also higher than national best (95%) in particular both LD&F Management and West Herts Management both achieving 100% and a significant increase for Essex IAPTs who have improved from 79% in 2016 to 97% in 2017. Whilst Quality & Safety, Finance and Quality & Medical Leadership are significantly below the national average, 67%, 69% and 65% respectively.
- Quality of appraisals scored 3.29 was higher than the national average of 3.22. The majority of our localities scored above the national average and 6 localities scoring above the national best score, the Chief Executive Officer rated highest 4.33.
- Quality of non-mandatory training, learning & development scored 4.14, which is above the national average but a slight drop on 2016 but not a statistical significance.

3.5 **Equality and Diversity (E&D)** – This theme has 2 key findings

- Staff experiencing discrimination at work in the last 12 months scored 17% higher than the national average 14% and 1% higher than 2016. This still remains a priority, so is a disappointing result.
- Believe the organisation provides equal opportunities for career progression/promotion was the national average of 85% and a decrease of 3% from 2016. The WRES data shows that white staff continues to report better experience than BME staff for both of the E&D key findings for example experienced discrimination against 17% BME staff compared to 6% white staff.

3.6 **Errors and Incidents** – this theme has 4 key findings

- Witnessing potentially harmful errors, near misses or incidents in the last month, this scored 27% the same as the national average score and a significant improvement on 2016 score of 32%. 5 localities scored lower than the national best score of 17% but of those only Essex IAPT is not a corporate/support function. 9 localities scored higher than the national average and Norfolk Services and Acute 24/7 scored significantly higher, 46% and 43% respectively.
- Reporting errors, near misses or incidents witnessed in last month scored 94% slightly better than the national average 93% and an improvement of 3% on 2016 score. Most scores reported are 90% or above except for Older People Community 82% and East & North Adult Community 89%.
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents the Trust scored 3.82 a significant increase on 2016 (3.77) and higher than national average 3.75. 13 localities scored higher than the Trust average and 1 scored higher than the national average. CAMHS and SPA both scored lower than the national average, 3.33 and 3.23 respectively.
- Staff confidence and security in reporting unsafe clinical practice remained the same as 2016 scoring 3.80 significantly higher than the national average of 3.71. Over half of the localities scored higher than the national average whilst CAMHS 3.44 and Quality & Medical Leadership 3.50 scored significantly below the national average.

3.7 **Health and Wellbeing** – this theme has 3 key findings

- Staff feeling unwell due to work related stress in last 12 months scored 40% an increase of 3% compared to 2016 however better than the national average of 42%. 10 localities scored worse than the Trust score in particular Norfolk Services and SPA both scoring 58%.
- Staff attending work in last 3 months despite feeling unwell because they felt pressure scored 54%, 1% above the national average and a significant increase of 7% compared to 2016. 9 localities scored significantly higher than the Trust score in particular SPA who scored 92% and Norfolk Services 67%.
- Organisation and management interested in and action on health and wellbeing reported a significant improvement on 2016 score of 3.76 rising to 3.83 also significantly higher than the national average 3.77

and the majority of localities scored higher than the national average. CAMHS 3.24 and SPA 3.36 both scored lower than the national average.

3.8 **Working Patterns** – this theme has 2 key findings

- Staff satisfied with the opportunities for flexible working patterns scored 64% the same as 2016 and significantly higher than the national average 60%. The majority of localities scored above the national average however these were mainly management and corporate functions. Norfolk Services and SPA both scored significantly lower than the national average, 45% and 33% respectively.
- Staff working extra hours scored 76% a decrease of 3% compared to 2016 however still significantly higher than the national average 72%. 12 localities scored higher than the national average in particular West Herts Management 93% and Older People 24/7 Trustwide 92%.

3.9 **Job Satisfaction** – this theme has 6 key findings

- Staff recommendation of the organisation as a place to work or receive treatment scored 3.85 a slight increase on 2016 and significantly higher than the national average 3.67. The majority of localities scored higher than the national average, whilst at the other end of the scale CAMHS and SPA scored 3.40 and 3.36 respectively.
- Staff motivation at work decreased significantly from 4.05 in 2016 to 3.97 in 2017 however this was still above the national average 3.91. Corporate Area were the only Area to score lower than the national average with 3.85 and the lowest locality score was SPA at 3.00.
- Able to contribute towards improvements, again a slight decrease from 76% in 2016 to 74% in 2017 but this is still slightly higher than the national average at 73%. East and North SBU scored lower than the national average 70%,
- Satisfaction with level of responsibility and involvement the Trust scored the national average of 3.88.
- Effective Team Working score 3.83 is just lower than the national average 3.84 and lower than 2016. The lowest scores are Norfolk Services 3.53 and SPA 3.31.
- Satisfaction with resourcing and support score is 3.35 the same as the national average but lower than 2016 3.40. West Herts SBU and East & North Herts SBU scored 3.30 and 3.31 respectively and the lowest localities were CAMHS 2.92 and SPA 2.83.

3.10 **Managers** – this theme has 3 key findings

- Recognition and value of staff by managers and the organisation scored 3.59 the same as the national average. East & North Herts SBU scored lowest 3.56 and once again SPA, CAMHS and Norfolk Services all scored significantly lower than the Trust average.
- Staff reporting good communication between senior management and staff scored 40% which is significantly higher than the national average 36%. LD&F Management and Chief Executive Officer scored the highest, 92% and 93% respectively but 13 localities scored the same or

lower than the Trust average score and the lowest scoring occupational group was admin/clerical at 33%.

- Support from immediate managers scored 3.89 significantly lower than the national average 3.95. East & North Herts SBU scored the lower 3.83 and again CAMHS, SPA and Norfolk Services are the bottom 3 ranking scores.

3.11 **Patient Care & Experience** – this theme has 3 key findings

- Satisfaction with the quality of work and care they able to deliver scored 3.89 higher than the national average but lower than the Trust 2016 score of 3.98. Learning Disabilities & Forensic SBU and Corporate SBU scored below the trust average and Norfolk Services, CAMHS and Quality and Medical Leadership were the lowest localities scoring 3.32, 3.50 and 3.52 respectively.
- Agree their role makes a difference to patients/service users the Trust achieved the national average 88%. Not surprisingly Corporate SBU scored lowest at 79% and the lowest localities are Norfolk Services 73% and Quality & Medical Leadership 71%. However 8 localities scored above the national best score of 90%
- Effective use of patient/service user feedback the Trust scored 3.88 significantly higher than the national average 3.72 and an increase on 2016 (3.78). 4 localities scored significantly higher than the national best (3.89), Hertfordshire Forensic Services, 4.01 LD Herts & Bucks and Quality and Safety both scored 4.05 and LD&F management 4.33

3.12 **Violence, harassment and bullying** - this theme has 6 key findings

- Experiencing physical violence from patients, relatives or the public in last 12 months scored 22% the same as the national average. 2 localities in particular have significantly high scores Norfolk Services 63% and Older people 24/7 Trust wide 61%
- Experiencing physical violence from staff in last 12 months scored 3% the national average but 1% higher than 2016. Hertfordshire Forensic Services scored particularly high 15%. There are also several localities that score 5-8%.
- Reporting most recent experience of violence the Trust scored 95% higher than the national average of 93%. East and North SBU scored lowest 87% and Older People Community the lowest locality 83%. Both Norfolk Services and Hertfordshire Forensic Services scored 100%.
- Experiencing, harassment, bullying or abuse from patients, relatives or the public in last 12 months scored 30% lower than the national average 32% and a significant improvement on 2016 (35%). West Herts SBU scored 40% and Norfolk Services and SPA scored 57% and 50% respectively. The score for BME staff is 35% compared to 28% for white staff.
- Experiencing harassment, bullying or abuse from staff in last 12 months scored 24%, 1% higher than 2016 and significantly higher than the national average 21%. Again this score is higher for BME staff 28% compared to 22%. Only LD&F management scored 0% and SPA scored highest 50%.

- Reporting most recent experience of harassment, bullying or abuse scored 61% the same as the national average. Corporate SBU scored the lowest 47% and LDF SBU the highest 66%.

4. Conclusions and Actions

4.1 This is a positive survey for HPFT having maintained 29 findings average or above average compared to other mental health trusts. There was also a higher response rate than previous year, which is encouraging that staff value giving their feedback. It is recognised that although there has been only 1 significant change since last year, that many of the findings are on a slight downward trend, (although of no statistical significance) so it is essential that the Trust does not become complacent and continues to identify central and local action plans to improve the environment for staff (and service user) satisfaction

4..2 The Trust has maintained a good overall staff engagement score demonstrating the value of current organisational development, learning and development and wellbeing initiatives and a range of staff engagement events. Engagement activity will continue in line with the Engagement Strategy including local Good to Great roadshow events, The Big Listen and Local Listens. The question within this category that is average (the other two are above average) is the staff ability to contribute towards improvements at work. The organisation is investing in the development of staff in continuous improvement approaches and specifically how managers of teams can enable and encourage steps change improvements and ideas to improve the services provided. To further support this ability to facilitate change, further investment has been allocated to deliver coaching training to leaders at band 7 and above. Improving coaching skills will further embed collective leadership where managers share ownership and encourage engagement and participation of their teams in delivering their work.

4.3 It is acknowledged that staff are experiencing continuing work demands and are working across complex systems and with an increasing number of staff reporting coming into work and working extra hours. This will be a focus of the health and wellbeing activities for next year and although the vacancy levels and difficulties in recruiting some professional groups are representative of the national picture, the recruitment and retention group will be focusing on future models of workforce for the future, increasing apprenticeship opportunities and advanced practitioner roles. Staffing and rostering is also monitored to ensure safe staffing levels are maintained

4.5 The response to the staff survey findings is based upon building on the areas of strength and addressing those areas of concern - support from managers and staff experiencing physical violence and/or bullying and harassment along with quality appraisals indicate that there are opportunities to re-focus management training and support to get the fundamentals right

4.6 This report will inform the OD Activity Plan for 2018 – 19. Specifically:

- Strengthening a safety culture

- Embedding the culture of continuous improvement
- Management and Leadership Development
- Talent Management
- Engagement activities
- Health and Wellbeing plan
- Development of Teams

4.7 Within the OD activity plan there are a number of activities which continue to invest in the development of workplace culture were staff feel valued and motivated to deliver at their best

- Continued roll-out of unconscious bias training as part of the equality diversity and inclusion plan
- On-going implementation of Health and Wellbeing strategy including resilience and mindfulness to reduce work related pressures
- Collective leadership

There will also be a new focus on reviewing and developing teams (people, process and structure) developing a consistent operating model across the organisation.

4.8 There is more that we need to do to address some of the perceived inequalities across different groups, including how we can further support our Workforce Race Equality Standard programme as a priority. The HPFT Equality plan 2018 – 22 is in the final stages of consultation and will highlight priority areas of investment to continue to promote and embed inclusivity and act on discrimination

4.9 The survey data enables us to drill down into locality results for questions where there were enough respondents for them to remain anonymous. This will be invaluable for the SBU's to focus and prioritise their activity and to feedback to staff and have further open dialogue discussions about improving their experience. The data has been made available to SBU Senior Leaders, Professional Leads and HR Business Partners and plans will be developed and implemented to support those targeted areas. A number the hotspots highlighted in the survey results are already being addressed through team development (in particular CAMHS and Norfolk Services). If the negative outliers continue to be addressed it will significantly improve the Trust scores. A collated plan will be presented to the Workforce and Organisational Development Group in May 2018

4.10 The Trust continues to be in a strong position compared to other Mental Health Trusts and will promote this as part of the employer brand and offering. As mentioned, the organisation must not and is not standing still and the prioritised actions aim to maintain and improve across all areas of the staff survey next year. In going from 'Good to Great' there are key findings scores that although are above average are still not where the Trust would want them to be. (For example: 45% don't have the resources to do their job and 25% of the workforce report a negative experience of their line manager) these target improvements will also drive the activity for next year and will be improved by focusing on team effectiveness and collective leadership.

4.11 The quarterly Pulse Surveys will provide an on-going measure of improvements and feedback as will evaluation of the OD strategy, engagement plan and making our services safe activities. The Trust will also re-introduce the cultural index monitoring when sufficient quarterly returns are received. The Culture index provides early warnings of downward trends in areas that are identified as impacting on safety.

SBU activity will be monitored through performance review meetings. The WODG will receive regular updates of the delivery of workforce and OD activity and the Equality Strategy. Staff survey action plans are also monitored by commissioners through quality review meetings.

Hertfordshire Partnership University NHS Foundation Trust

Key Findings (KF)	2010	2011	2012	2013	2014	2015	2016	2017	2017 National Average	Difference Trust/Nat Avg	Compared to other trusts	Best Result Higher or Lower
Overall Staff Engagement (KF22, KF24, KF25)	3.71	3.61	3.64	3.71	3.62	3.86	3.90	**3.87**	3.79	0.13	Above Average	Higher = better
Response Rate	57.4%	61%	54%	51%	54%	40.1%	42.0%	**47.0%**				
Appraisals & Support for Development												
KF 11 - % Staff appraised in last 12 months	82%	85%	88%	90%	86%	88%	88%	**88%**	89%	1%	Above Average	Higher = better
KF 12 - Quality of appraisals						3.20	3.42	**3.29**	3.22	0.07	Above Average	Higher = better
KF 13 - Quality of non-mandatory training, learning or development						4.11	4.18	**4.14**	4.06	0.08	Above Average	Higher = better
Equality & Diversity												
KF 20 - Percentage of staff experiencing discrimination at work in last 12 months	18%	19%	17%	14%	17%	14%	16%	**17%**	14%	3%	Below Average	Lower = Better
KF 21 - % Believing Trust provides equal opportunities for career progression or promotion	87%	86%	83%	87%	79%	84%	88%	**85%**	85%	0%	Average	Higher = better
Errors & Incidents												
KF 28 - % witnessing potentially harmful errors, near misses or incidents in the last month	29%	36%	31%	27%	32%	24%	31%	**27%**	27%	0%	Average	Lower = Better
KF 29 - % Staff reporting errors, near misses or incidents witnessed in the last month	99%	98%	94%	95%	95%	91%	91%	**94%**	93%	1%	Above Average	Higher = better
KF 30 - Fairness and effectiveness of procedures for reporting errors, near misses and incidents						3.74	3.77	**3.82**	3.75	0.07	Above Average	Higher = better
KF 31 - Staff confidence and security in reporting unsafe clinical practice					3.66	3.76	3.80	**3.80**	3.71	0.09	Above Average	Higher = better
Health & Wellbeing												
KF 17 - % Staff suffering work-related stress in last 12 months	36%	34%	41%	43%	49%	40%	37%	**40%**	42%	2%	Above Average	Lower = Better
KF 18 - Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell					59%	57%	48%	**54%**	53%	1%	Above Average	Lower = Better
KF 19 - Organisation and management interest in, and action on, health and wellbeing						3.62	3.76	**3.83**	3.77	0.06	Above Average	Higher = better
Working Patterns												
KF 15 - %age of staff satisfied with the opportunities for flexible working						59%	64%	**64%**	60%	4%	Above Average	Higher = better
KF 16 - % Staff working extra hours	73%	70%	72%	77%	78%	77%	79%	**76%**	72%	4%	Below Average	Lower = Better
Job Satisfaction												
KF 1 - Staff recommendation of the Trust as a place to work or receive treatment	3.56	3.38	3.48	3.52	3.43	3.75	3.84	**3.85**	3.67	0.18	Above Average	Higher = better
KF 4 - Staff motivation at work	3.92	3.84	3.84	3.91	3.86	4.02	4.04	**3.97**	3.91	0.06	Above Average	Higher = better
KF 7 - % Staff able to contribute towards improvements at work	68%	67%	65%	70%	64%	70%	76%	**74%**	73%	1%	Average	Higher = better
KF 8 - Staff Satisfaction with the level of responsibility and involvement					3.71	3.88	3.89	**3.88**	3.88	0.00	Average	Higher = better
KF 9 - Effective team working						3.85	3.90	**3.83**	3.84	0.01	Average	Higher = better
KF 14 - Saff Satisfaction with resourcing and support						3.34	3.41	**3.35**	3.35	0.00	Average	Higher = better
Managers												
KF 5 - Recognition and value of staff by managers and the organisation						3.53	3.61	**3.59**	3.59	0.00	Average	Higher = better
KF 6 - % Staff reporting good communication between senior management and staff	30%	25%	28%	33%	29%	43%	42%	**40%**	36%	4%	Above Average	Higher = better
KF 10 - Support from immediate managers	3.78	3.74	3.68	3.75	3.72	3.84	3.87	**3.89**	3.95	0.06	Below Average	Higher = better
Patient Care & Experience												
KF 2 - Staff satisfaction with the quality of work and patient care they are able to deliver						3.97	3.98	**3.89**	3.83	0.06	Above Average	Higher = better
KF 3 - % Of staff agreeing that their role makes a difference to patients/service users						91%	91%	**88%**	88%	0%	Average	Higher = better
KF 32 - Effective Use of patient/service user feedback is used to make informed desisions in their directorate/department					3.52	3.80	3.77	**3.88**	3.72	0.16	Above Average	Higher = better
Violence, Harassment & Bullying												
KF 22 - % Staff experiencing physical violence from patients, relatives or the public in the last 12 months	21%	20%	31%	24%	19%	18%	24%	**22%**	22%	0%	Average	Lower = Better
KF 23 - % Staff experiencing physical violence from staff in last 12 months	2%	1%	8%	4%	4%	1%	2%	**3%**	3%	0%	Average	Lower = Better
KF 24 - %age of staff/colleagues reporting most recent experience of violence					87%	80%	94%	**95%**	93%	2%	Above Average	Higher = better
KF 25 - % Staff experiencing harassment, bullying or abuse from patients/relatives or the public in last 12 months	19%	23%	37%	36%	33%	34%	35%	**30%**	32%	2%	Above Average	Lower = Better
KF 26 - % Staff experiencing harassment, bullying or abuse from staff in last 12 months	16%	18%	26%	24%	29%	28%	23%	**24%**	21%	3%	Below Average	Lower = Better
KF 27 - %age of staff/colleagues reporting most recent experience of bullying, harassment or abuse					52%	42%	60%	**61%**	61%	0%	Average	Higher = better

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22.03.2018	**Agenda Item:** 9
Subject:	Update re CQC	**For Publication:** Yes
Author:	Dr Jane Padmore, Director of Quality and Safety	**Approved by:** Dr Jane Padmore, Director of Quality and Safety
Presented by:	Dr Jane Padmore, Director of Quality and Safety	

Purpose of the report:

To brief the Board in relation to the immediate actions that have been taken following the recent Core and Well Led Inspections.

Action required:

For information and discussion.

Summary and recommendations:

The paper outlines the immediate actions that have taken place following the informal feedback received by CQC from the core and well led inspections.

Relationship with the Strategy (objective no.), Business Plan (priority) & Assurance Framework (Risks, Controls & Assurance):

Priority one

Summary of Financial, Staffing, and IT & Legal Implications (please show £/No's associated):

N/A

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

Evidence for Registration; CNST/RPST; Information Governance Standards, other key targets/standards:

CQC action plan

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/Board/Audit

None

1. Introduction

1.1. In February 2018 the CQC conducted the annual well led inspection and core inspection of 4 service lines. The informal feedback letters have been circulated and were presented at the last Board. This paper serves to inform the Board of the actions that have been taken since these were received.

1.2. The Trust's immediate actions in response to the letters were taken to the Executive Team Meeting. Following this, a comprehensive report was presented to IGC on 6th March and the action plan was presented to the executive team on 14th March 2018.

1.3. The key responses to the areas that needed attention are set out. These are not an end; rather the beginnings of the work that will develop and then be added to once the final reports are received. The action plans will be monitored through the Quality Risk Management Committee through to the Integrated Governance Committee.

1.4. This report gives a brief overview of the core and well led inspections followed by the key themes that were identified in the informal feedback and the action taken.

2. The inspections

2.1. Both inspections were facilitated by an HPFT CQC project team who ensured were

- responsive to any requests or concerns
- offered support to staff
- validated data and documents prior to them being submitted
- collated soft intelligence from the visits

2.2. 4 service lines were inspected as part of the core inspection:

- Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units
- Forensic Inpatients wards
- Wards for People with Learning Disabilities or Autism
- Child and Adolescent Mental Health Wards

Every service in each service line were visited by an inspection team.

2.3. During the well led inspection, the inspection team interviewed directors and non-executive directors as well as a wide range of leaders and senior staff from HPFT as well as representative from the police and ambulance service. They also attended the Council of Governors meeting.

3. Since the inspection

3.1. Following the core and the well led inspection the Trust received informal verbal feedback which was followed up with two informal feedback letters. The letters detailed areas of good practice as well as areas that required attention.

3.2. The Trust took immediate action to address all the concerns raised and developed an action plan which is being held at QRMC and reporting to IGC. Key areas of work that are being undertaken are:

- **Ligatures**

Acute and PICU ligature audit and risk assessments have been updated and the wards and service areas have copies of these documents. A pilot electronic template has been developed and has been set up on the Health & Safety Audits system (called ANT). The pilot will begin shortly and if successful will be rolled out in the next financial year.

The current audits will be uploaded by the end of March and this will be pulled into the Ligature Policy which will be completed for April. Weekly ligature audits will then take place and be reported using the new system, noting any changes from previous audit. This new process will be coupled with a review of the governance relating to this.

- **Restrictive practices**

It has been communicated to all services that all service users at risk of being secluded in a bedroom should have this detailed in their risk assessment and care plans to ensure that this is managed safely. Where this is not predicted and occurs in response to an immediate safety concern, the reasons for this would be clearly documented in their clinical record and care plan. In addition, a review of each seclusion incident that takes place outside a seclusion room is now carried out retrospectively to ensure the risk assessment and care plan is in place and any learning is identified.

Mersey Care NHS Foundation Trust are being approached to ask them to undertake an independent review of the seclusion practices in the Trust. CQC recently published a report on restrictive practices and they were one of five Trusts used as examples of good practice.

One seclusion room was decommissioned immediately and the issues raised were addressed during the inspection. CQC have clarified that the seclusion room of Oak was the other room that they found was not compliant with the guidelines. The practice development team have undertaken an assessment of the unit and identified some areas that require attention and this work has been requisition.

The feedback from the CQC is being considered alongside the Making Our Services Safer (MOSS) Strategy, which has come to the end of its term, in addition to Seni's law. This is due before the parliamentary committee on 14th March 2018 and, if passed into law, makes provision for the oversight and management of the appropriate use of force in relation to people in mental health units and similar institutions. A task and finish group is being set up, reporting to QRMC through to IGC, consider these areas of work. It will review the use of restrictive practices in the Trust, the relevant policies and develop the new Safety Strategy for the Trust.

- **Supervision**

Acute services and PICU have reported that although there is no single central record of supervision, supervision is taking place locally. All teams are now ensuring that this is happening within the policy timescales. The SBU management team have strengthened their assurance process so that senior managers are able to validate supervision on a two monthly basis. A new automated system for recording supervision will also be going live shortly and bring with it the ability to centrally monitor the records of supervision.

- **Serious Incident Grading**

A retrospective look at the moderate harm incidents is currently underway by the Deputy Medical Director, Deputy Director of Nursing and Quality and Deputy Director of Safer Care and Standards, reviewing each case. 36 incidents have been identified. So far, one has been reported as an SI (this was the one identified by CQC). Each incident has been reviewed twice and further information is being sought to clarity prior to the final decision making in partnership with the Deputy Medical Director.

- **Freedom to speak up**

The Freedom To Speak Up National Office has just published a new job description for the role. This will be used to open the role to expressions of interest where a new guardian will be appointed.

- **Pace of responsiveness when things go wrong**

Discussions have taken place with the senior leaders, the Quality and Safety team meeting and in QRMC to consider how we increase the pace of responsiveness and strengthen the clinical voice. It is proposed that the work to address this will involve complementary work streams that will involve both processes and culture.

  - The Organisational Development Strategy implementation plan is incorporating the work to improve how we triangulate information and increase our responsiveness.

- A safety culture audit has been completed and is currently being written up. This will form the baseline for the organisational development piece of work that is being developed in relation to safety/learning culture.
- The Head of Psychological Therapies and Recovery is leading a piece of work that assists teams to reflect and learn from incidents, complementing the process actions with ones that tackle hearts and minds and share learning across the organisation.
- The Trust Safety Strategy work described above will encompass both how we learn and respond to lessons learnt. This will be coupled with a review of the meetings that feed into QRMC and their TOR.

4. Conclusion

4.1. This paper sets out the key work that is underway in response to the informal feedback that was received by letter from the CQC in relation to the core and the well led inspections.

4.2. These actions will be strengthened over time and then built upon once the formal reports are received. The governance of these actions will be held at QRMC and reported to IGC.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22 March 2018	**Agenda Item: 10**
Subject:	Report from Finance & Investment Committee – 13 March 2018	**For Publication: Yes**
Author:	Simon Barter, NED Chair - FIC	**Approved by:** Simon Barter
Presented by:	Simon Barter, NED Chair - FIC	

Purpose of the report:

This paper provides a summary report of the items discussed at the Finance & Investment Committee meeting on 13 March 2018.

Action required:

To note the report and seek any additional information, clarification or direct further action as required.

Summary and recommendations to the Board:

The Agenda for the meeting covered:

- **Business Development Update**
- **Performance Report – January 2018 and February headlines**
- **Financial Summary to end January 2018 and February headlines**
- **Presentation on Final Accounts 2017/18**
- **2018/19 Draft Annual Plan and draft NHSI Operational Plan**
- **2018/19 Draft Financial Plan**
- **2018/19 Efficiencies Programme Update**
- **Strategic Investment Programme**
- **Forest House Place of Safety**
- **Development of PARIS (Electronic Patient Record)**
- **Estate Transformation Programme – Progress Update**
- **FIC Business Programme 2018**

Business Development Update
FIC received a detailed update on the significant business development from the Director of Strategy and Integration. Key aspects were:-

- Pan-Essex LD services – detailed modelling work is progressing well and the partners are sharing details of current and future costs. Commissioners have been positive in their feedback regarding the proposed transformational service model
- Tier 2 CAMHS (Hertfordshire) – a bid was submitted in response to the procurement exercise by Hertfordshire commissioners and feedback is awaited
- Substance Misuse Services, Hertfordshire – no specific detail available as yet but the Trust has proactively appointed a Clinical Advisor to support the development of the bid
- Community Perinatal Mental Health - Hertfordshire CCG's have both verbally given support for progressing this bid.
- Forensic Outreach and Liaison Service –The Trust is considering application to wave 2 at the end of this financial year.
- CAMHS Tier 4 Inpatient Services –NHSE have informed providers of their intention to enter a formal procurement exercise for services. The Trust and the wider STP are responding formally as this appears counter to the current transfer of responsibilities to the Trust.

- Community Services, west Herts – FIC were updated on the HVCCG procurement for Adult Community services. There is a tight deadline for bid submissions:

FIC discussed in detail the resources required to drive forward the work to pre-bid stage and run the procurement process, including both internal capacity and the need to work with the right partners on such a significant and complex bid. FIC endorsed the proposed budget for the next stage of the bid development and recognised that there would be a significant financial commitment to progress through the whole process. The Bid Board would be responsible for tightly managing the process and resources.

Performance Report
The Director of Innovation & Transformation presented the January performance report including early indicators for February. The majority of KPIs remain strong and FIC focussed on areas of challenge:-

- High levels of referrals into adult community services through Primary Care
- Access to services Adult 28-day target –January performance is 87% and is likely to achieve 90% by the end of the year.
- CAMHS 28-day target - declined in January and has improved through February with full recovery forecast for March.
- CPA Reviews – Priority is being given to ensuring risk assessments are in place and CPA reviews are being carried out in planned and robust manner. On-going work with the Accurate Information Strategy is expected to positively affect the performance going forward.
- Mid Essex IAPT – there is a comprehensive campaign to increase self-referral.
- Workforce indicators – particularly sickness and statutory mandatory training

The committee discussed the full report in detail and the need to ensure the associated action plans recognise any 'warning signs' and that these are fully addressed.

Financial Summary to end January 2018 and February headlines
The Committee received the financial summary for the period to the end of January. The Director of Finance reported that the position continues to look strong in terms of year to date with the key issues remaining unchanged relating to growing pay spend and placement costs. It was noted that the Q4 run rate however indicates a relatively small margin moving into 2018/19.

Presentation on Final Accounts 2017/18
FIC received a presentation on the key issues for closure of the accounts from the Deputy Director of Finance. These are very much in line with the areas previously discussed aby the Committee:-

- The successful transfer to a new General Ledger and Financial Shared Services
- Full property valuation
- Continuing Healthcare Provision
- Local Government Pension Scheme accounting
- Finalisation of the transaction with DH for Kingsley green reprovision

FIC noted that pay costs have seen a steady increase and that a more detailed review of pay cost is being undertaken.

FIC noted the content of the presentation.

2018/19 Draft Annual Plan
The Committee received an update on the development of the Annual Plan for 2018/19. The plan sets out high level objectives and will be brought together with the detail form the NHSI Operational plan following finalisation of the Annual Plan by the Trust Board. The Committee noted the six strategic objectives which have been further refined and the work to include a further objective related to system influence and leadership following comment on the draft plan.

FIC noted the report.

2018/19 Draft NHSI Operational Plan
FIC received the refreshed draft NHSI Operational Plan. A 2-year operating plan had been submitted to NHSI in March 2017 covering the period 2017-2019 which details areas of focus for the Trust for the 2-year period. The plan has been refreshed to reflect the activity and achievements made during the first year and to provide further detail in relations to plans for 2018/19. This draft had been submitted to NHSI in line with the 8 March timeline. A final plan will be submitted to NHSI by 30th April 2018.

FIC noted the NHSI Operational Plan.

Financial Planning for 2018-19
The Committee reviewed a further update of the financial plan 2018/19 for approval and recommendation to the Board.

Headlines for the 2018/19 financial plan covered:-

- Run rate moving into next financial year
- Estimated CRES requirement
- Forecast cost pressures
- Likely areas for investment, including environments, commercial development and innovation
- Contract negotiations
- NHSI Control Total and Agency Expenditure cap
- Areas of risk and mitigation
- Capital programme

Following discussion, FIC approved the 2018/19 financial plan for recommendation to the Trust Board.

Efficiencies Programme Update
FIC received a progress with the 2018/19 CRES programme and noted that the requirement of £4.7m had a current gap of £750k. The approach, based on service improvement to deliver productivity and efficiency gains was welcomed, recognising the development of a clinically based sustainable programme. FIC noted that regular updates will be provided and emphasised the importance of ensuring plans are progressed quickly and with appropriate support to ensure the programme is fully delivered. It was noted also that Quality Impact Assessments had to be in place and that these were reviewed by IGC.

Strategic Investment Programme Overview
Two key changes to the Capital Plan in the period since the last meeting were highlighted relating to inclusion of:-
An allowance for significant work on seclusion facilities across the Trust
An allowance for development of the EPR, PARIS development. It was noted that the final position for 2017/18 would affect the level of STF achieved and that this would potentially enable flexing of the programme later in the year.

The committee were advised that Diane Brent has been appointed to the post of joint Head of Estates for HPFT/HCT and that work to start drafting a strategy for estates for the next 5-10 years had been commenced.

FIC noted the report.

Forest House Place of Safety
The Committee considered and approved the proposal set out for the provision of a Place of Safety for adolescents at Forest House and an additional budget allowance of £149K to progress the work.

Development of PARIS
The Director of Innovation and Transformation introduced a paper outlining the requirement to contract for new licences over a five year period on the same basis as the current provision. Progress had also been made on exploring future electronic patient record (EPR) system functionalities on PARIS and considering the hosting arrangements for the system. The Committee discussed the proposal and wider issues in significant detail including the negotiations with the incumbent supplier CIVICA and how these had been progressed.

Following full consideration of the issues, FIC approved the proposal for recommendation to the Trust Board.

Estate Transformation Programme – Progress Update
The Committee received an update on the progress with the programme. The works to Marlowes Health & Wellbeing Centre, Hemel Hempstead and Centenary House, Hitchin have reached practical completion. An opening event for Marlowes is planned for 11th May 2018and FIC acknowledged all the hard work undertaken by the Project Team to deliver the programme.

It was also noted that the Anti-ligature work programme and Fire Safety Phase I had been completed.

FIC Business Programme 2018
The business programme was considered and forward items agreed.

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):

Summary of Implications for:

1 Finance
2 IT
3 Staffing
4 NHS Constitution
5 Carbon Footprint
6 Legal

Equality & Diversity (has an Equality Impact Assessment been completed?) and Public & Patient Involvement Implications:

Evidence for Essential Standards of Quality and Safety; NHSLA Standards; Information Governance Standards, Social Care PAF:

N/A

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

N/A

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	**22nd March 2018**	**Agenda Item: 11**
Subject:	**Performance Report January 2018**	**For Publication: No**
Author:	**Performance Improvement Team**	**Approved by: Ronke Akerele, Director of Innovation and Improvement**
Presented by:	**Ronke Akerele, Director of Innovation and Improvement**	

Purpose of the report:

1. To inform the Trust Board on the Trust's performance against both the NHSI Single Oversight (SOF) Targets and the Trust KPIs for January 2018
2. To assess the likely future performance projections based upon a review of current trends, management actions and any variations in future targets (as shown in forecast column of dashboard – Appendix 1)

Action required:

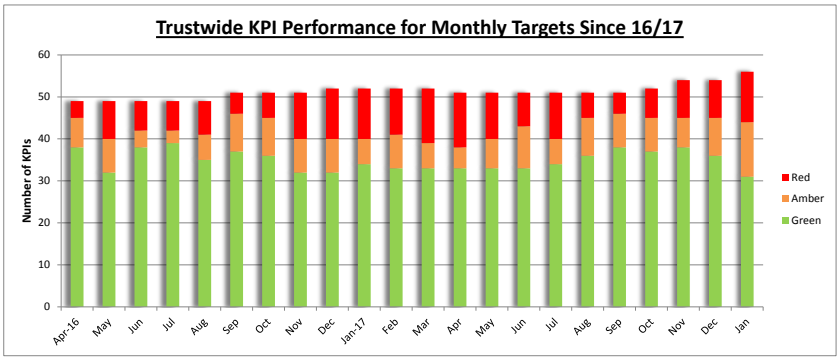
1. Review and assess the Trust's Performance against the NHSI targets and the published KPIs (Full Dashboards can be found in Appendix 1).
2. To consider whether any further information is required to further assess the performance reported and the likely future projections.

Summary and Recommendations:

Summary at a glance

This report provides an overview of January 2018 performance, assessed against National, contractual and Trust targets.

The chart below reflects performance against Trust-wide KPIs since April 2016.



During the winter months of 17/18, we are experiencing a similar pattern of a dip in performance as for 16/17. January performance reflects increased demands on the system during the busy winter period with particular pressure on maintaining access and safe and effective measures. This is further illustrated through graphs in the relevant sections of the main report.

Areas of strong or improved performance in January are:

- IAPT waiting times – 91% (2120/2327) six week wait and 99.87% (2324/2327) 18 week wait
- CATT 4 hour waits – 100% (506 seen)
- SPA referrals with an outcome within 14 days – 99.67% (2083 seen with seven not seen)
- CATT Gatekeeping – 98.94% (93 met target with 1 not)
- Delayed Transfers of Care – improved to 5.9%(786 delayed days of 13,326 occupied days) from 7.3%
- Strong IAPT recovery rates in HVCCG – 53.95% (246/456) and NE Essex – 53.85% (84/156)
- Service users recommending trust services – 84.2% (598/710) in line with last month.
- Service users looking to the future more positively has the highest score in the last year at 79.3% (260/328, rolling 3 months)

- An increase in staff recommending the trust as a place to work – 66.7% (60/90)
- Continued strong financial performance with £1,142k surplus at month 10 (plan 569k surplus) and highest use of resources rating of 1.

The following indicators moved from red or amber in December to green rated in January:

- Cardio-metabolic assessment and treatment for people with psychosis on CPA
- Routine LD waits within 28 days at 100% (14/14) compared to 84.2% in December (16/19)
- IAPT Clients moving to recovery (NE Essex), 53.85% (84/156); 49.01% in December (74/151)

The key indicators to note that reflect under performance against targets in January are detailed below:

SOF – *An overall increase of one green indicator and one red indicator*

- **Cardio-metabolic assessment and treatment for people with EIP:** 61% achieved for early intervention in psychosis services (FEP) against a target of 90% = 25% funding achieved (approx. £16,828). To be confirmed by RCP audit in April.

Access to Services – *A decrease of two green indicators, increase of two amber indicators and no change in red indicators.*

- **Routine referrals for Adult Community Services** 87% (420/489, would have required 480/489 to meet 98% target): In January the main areas of challenge were the North and SW quadrants. Recovery in month shows 86% waiting within 28 days for North and 90% for SW Quadrants. Pre-validated figures for February are 88.19% (298/338).
- **EMDASS 6 week wait** 82.5% (217/263**,** would have required 237/263 to meet 90% target): This is as expected with the introduction of the one stop diagnosis clinics. The Indicator will be revised for the new contract in April.
- **C-CATT 4 hour wait** 94.8% (92/97, This missed the target by one case with 93/97 required to meet 95% target): Target was narrowly missed due to high demand for the service (an increase of 36% in referrals in January 2018 compared with January 2017) coupled with ongoing recruitment challenges to meet such demand.
- **CAMHS Targeted 14 day wait** 83.3% (15/18, performance is one case below target with 16/18 required to meet 85% target): Numbers of referrals are relatively low with the three breaches of the 14 day wait, being two due to capacity issues and one a re-opened case.
- **CAMHS Routine waits** 77.4% **(**113/146 –performance of 132/146 required to meet 95% target): CAMHS 28 day performance fell due to short term sickness and patient choice-recovery measure were put in place, resulting in a positive recovery and a February pre-validated figure of 130/146 – 89.04% - 9 short of the 95% target. Full recovery is expected for March.
- **People entering IAPT treatment (Herts Valleys, West Essex; Mid-Essex):** HVCCG 8,136 entered to end of January (420 short of the 8,556 cumulative targets) - A significant amount of work is taking place to increase referrals into Herts Valleys therefore increase access rates. Service capacity is sufficient to deal with these referrals if they are made. Mid Essex 4,358 entered to end of January (537 short of the 4,895 cumulative target) - Following the review with Mental Health Strategies a joint action plan with the CCG Primary Care Team is now in place which combined with a new interim CCG lead being appointed is providing improved engagement. West Essex 3,858 entered to end of January (199 short of the 4,057cumulative target) - The CCG are reinvesting £10k in communications and marketing. January figures had improved, with 28 referrals above the target level set.

Safe and Effective Services –*A decrease of four green indicators, increase of two amber indicators and two red indicators.*

- **CPA Reviews/Risk Assessment/Clustering:** Priority is being given to ensuring risk assessments (93.8%, or 16,466/17,546; 203 short of 95% target based on caseload size: February (92.99% 16,460/17,700; 355 short of the 16,815 needed to reach 95%) are in place and that CPA reviews (93.9%, or 780/831; 10 short of the 790 needed to reach 95% target February (87.28% 844/967 pre-validation but predicted to be 95.35% based on the minimum increase seen post-validation) are carried out in a way that recognises the feedback from the adult community service user review, this requires pre planning and ensuring the service users and carers are well prepared for their reviews- this can impact on the overall target levels if meetings are missed or need to be rescheduled. Ongoing work with the Accurate Information Strategy is expected to positively affect performance, with strong progress being made in the closure of cases with no activity. Cluster reviews are at 91.9%, (10,255/11,161;

348 short of the 10,603 needed to reach 95% target. February 92.54%: 10,283/11,112; 274 short of the 10,557 needed to reach 95%).

- **IAPT Recovery: (E&NCCG; Mid Essex; West Essex:** The volume of referrals into the service have affected the recovery rate in E&NCCG (48.49%, or 177/365; 6 short of the 183 needed to reach the 50% target), increasing waiting times and people entering into treatment at a more severe stage. Mid Essex (48.68%, or 92/189; 3 short of the 95 needed to reach the 50% target) narrowly missed target and cases are being reviewed to establish any themes. West Essex (47.47%, or 75/158; 4 short of the 79 needed to reach the 50% target) missed target for the first time since April 16. No clinical reasons or patterns have been identified for this and not expected to continue into February.
- **Inpatients feeling safe** (79.7% rolling 3 month target, or 188/236; just 1 short of reaching the 80% target with very consistent performance within the 3 month rolling period)**:** Inpatient services are using the feedback from the Having Your Say questionnaire to triangulate the data regarding people feeling safe with the feedback at Mutual Expectations Meetings. Work continues with service users how to make them feel more assured when an inpatient.
- **Carers feeling valued by staff** (68.3% rolling 3 month target, or 56/82; 62 required to reach the 75% target)**:** The carers' indicator was adversely affected by a higher than average rate of return in January, with a high amount of negative comment. This will be monitored to see if it reflects the start of a trend or is a one-off occurrence but is likely to affect the figure until April as it is measured on a 3 month rolling basis.
- **Employment** (11,096/16,157) **and Accommodation** (11,055/16,157)**:** Progress continues but has slowed significantly with a respective 1.37% and 1.24% rise in January and reflects the issue of new referrals into the trust not routinely coming with this information. An increase of a further 2% for employment and 2.7% for accommodation is anticipated from closing down the 500 inactive cases on Paris as part of the Accurate Information work. 14,541 complete data items required to meet the 90% mark based on current volumes, an increase of circa 3,500 completed data items.

Workforce – All indicators red or amber – remain static.

- **Sickness:** An increase in sickness rates to 5.02%, mainly due to seasonal illnesses – coughs, colds and flu. This represents 904 sick days above the 4% target across the trust. Flu vaccination rate of front-line staff at 56% as of 21st Feb.
- **Turnover Rate:** An increase to 13.5% from 13.27%for the year to December. NHSI retention plan to reduce turnover to 11% over the next 12 months has been submitted and approved, which equates to approximately 60 jobs retained.
- **PDP and Appraisal:** An increase of 1% in January to 88%, a further 65 would need to be completed to reach the 90% target. February a slight reduction in performance 87.11% 2,298/2,638 Improvement in Corporate and West SBU but a decrease in East and North and LD&F.
- **Statutory and Mandatory Training:** Rate remained static at 81%. In process of transition from old competencies to new which align with the core skills training framework. Compliance against new competencies is currently at 70% but reflects a higher level of training and has risen by 9% since December.

Finance – *Indicator rag ratings remain static.*

- The overall Trust position reported in January is a deficit of £4k, which is worse than the Plan of £6k surplus by £9k (before STF). The overall Trust position year to date (before STF) is a surplus of £1.142m, which is ahead of the Plan of £569k by £572k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 1, the highest rating.

Relationship with the Strategy (objective no.), Business Plan (priority) & Assurance Framework (Risks, Controls & Assurance):

Annual Plan
SBU Business Plans
Assurance Framework

Summary of Financial, Staffing, and IT & Legal Implications (please show £/No's associated):

N/A

Equality & Diversity and Public & Patient Involvement Implications:

N/A

Evidence for Registration; CNST/RPST; Information Governance Standards, other key targets/standards:

All targets

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/Board/Audit

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Appendix 1 - Performance against SOF Indicators

Appendix 2 - KPI Dashboards

Summary

The overall performance in January has seen a reduction in green indicators from 55% for the month which compares to 64% at the end of December and 67% (adjusted) at the September Quarter. The summary detail of this is shown in the table below;

KPI indicator	January	Q3	Q2	Change from Q3	Change from Q2
Green	32	37	39	-5	-7
Amber	14	11	10	+3	+4
Red	12	10	9	+2	+3
Total	**58**	**58**	**58**		

The drivers to the overall change are within the ratings for Access Indicators which show 13 ratings as green against 15 last month and 17 at September and within the Safe & Effective Indicators where nine indicators were reported green against 13 in both of the previous periods. Further detail on the individual indicators is given below and within the main report focusing on the key operational themes and challenges. Several of the indicators with small patient cohorts are impacted by small activity variations which are expected to recover in future periods.

SOF: The overall rag rating for green indicators has improved by one to seven , with one red rated indicator Cardio-metabolic assessment and treatment for people with EIP which is reported at 61% achieved for early intervention in psychosis services (FEP) against a target of 90%. Further detail below

Access: Performance on access is a significant challenge facing our services impacted by additional demand and the workforce challenges. The three key areas of focus are;

- Adult services 28 day; This has been a challenge throughout the year with discussions continuing with commissioners to
  Realign the target. Operationally the focus has been working with primary care to manage demand as well as addressing the particular issues within the SW and North teams.
- CAMHS 28 day; this had fallen back from December and followed a sustained strong period of performance. This is expected to recover during the Quarter.
- IAPT; There is a mixed performance across the five service areas with activity levels in both Mid and West Essex continually below the national targets. There are shared action plans in place which is likely to see the recovery of Mid Essex by March.

Safe & Effective: This is the sector that has changed most on the previous Quarter;

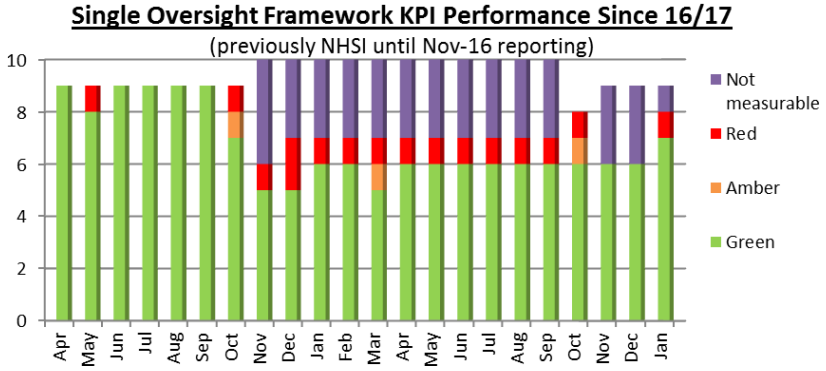
- The main change is within the IAPT recovery performance which saw three service areas fall in the month and one
  showing an improvement. Of these Mid Essex were 3 short of the target and West Essex 4 short No clinical reasons or patterns have been identified for this and not expected to continue into February.
- The carers' indicator has fallen to its lowest level this year and is the second month of decline. A review has shown a higher than average rate of return in January, with a high amount of negative comment. This will be monitored to see if it reflects the start of a trend or is a one-off occurrence but is likely to affect the figure until April as it is measured on a 3 month rolling basis.

Resources: In relation to:

Workforce; sickness and, mandatory training remain red. There is some marginal improvement in mandatory training and appraisal levels. Whilst several actions being taken to support the required improvement the current workforce challenges make these a significant challenge

Finance; the position continues to hold above Plan but with continuing pressures principally within bed capacity and on the recruitment & retention. This is reflective of the breach of the Agency cap.

Performance Highlights



The chart above and SOF dashboard in Appendix 1 reflect the changes to the SOF indicators which came into effect with the November update of the Operational Performance Metrics.

The indicators now included are:

- FEP 14 day wait (now calculated on a 3 month rolling basis)
- Cardio-metabolic indicators for people with psychosis (no change)
- Data Quality Maturity Index (New)
- IAPT waits and recovery rates (now calculated on a 3 month rolling basis)
- Inappropriate out of area placements (New)

The former SOF indicators for Identifiers, accommodation and employment have been moved to Safe and Effective Care and the CATT Gatekeeping indicator has moved to the Access section of the report.

The current position shows 7 green indicators, one red indicator (Cardio-metabolic assessment for FEP) and one indicator that is not reportable (OAPs, which does not yet have a target set). The 3 indicators are the CQUIN cardio-metabolic indicators for FEP which will be measured by audit, the new DQMI measure and out of area placements.

FEP 14 day waits

FEP referrals engaged with a care co-ordinator within 14 days saw a 12% drop from December to January at 54.55% or 12/22 (11/22 needed to achieve target). This is attributable to patient choice, which is not excluded for this indicator and inability to contact service users over the holiday period, despite repeated attempts. One breach was also due to a complex case that needed joint management.

Efforts continue to match the Unify reporting with MHSDS and a meeting has been held in February with NHS England to help to understand the reasons for discrepancy. The gap in reporting is now only 3 people for January figures and there is an understanding of what changes need to be made to ensure that figures fully match before reporting moves entirely to MHSDS from April 2018. NHS England have requested a full mapping of the fields that HPFT is using for assurance processes and this will be completed by the end of February.

This indicator will be subject to external audit as part of the Quality Account validation for 17/18.

Cardio-metabolic indicators for people with psychosis

HPFT are undertaking two National audits on the management of psychosis. The first audit will review physical health monitoring for a defined cohort of those people on CPA, the submission to the Royal College of Psychiatrists was made at the end of November and in total 300 questionnaires were submitted. The PACE Team then conducted an exercise to assess compliance with the SOF indicators and the key predictions are shown below. Compliance will not be confirmed until we receive final results from the RCP in April 2018.

- 73% achieved for the Community CPA cohort against a target of 65% = 100% funding achieved (approx. £67,296)
- 95% achieved for the Inpatient cohort against a target of 90% = 100% funding achieved (approx. £100,944
- 61% achieved for early intervention in psychosis services (FEP) against a target of 90% = 25%

funding achieved (approx. £16,828).

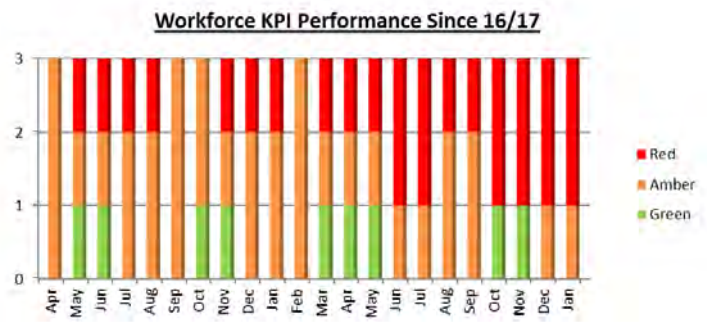
Data Quality Maturity Index (DQMI)
This is a new indicator that replaces the previous MHSDS priority and identifier metrics. The DQMI is a quarterly publication intended to raise the profile and significance of data quality in the MHSDS. It combines data submitted via MHSDS and SUS returns to derive a 'score'. The target set is ≥ 95%. Data has now been published for Q2 and HPFT remains at a combined DQMI of 96.1%.

Actions for improvement are already underway. Performance against the DQMI will form part of the Accurate Information Strategy and will be managed by the Data Quality Team (including the Information Officers). Only 10 of the 25 DQMI metrics currently have targets and the Information Team are investigating this further with NHS Digital. In the absence of further targets we plan to take the highest score Nationally and aim for this, to ensure that we improve our ranking. A DQMI dashboard is also in development, similar to the current one that has proved successful in improving our MHSDS scores and this will be made available on SPIKE.

IAPT Recovery Rate; 6 Week and 18 week waits
Combined recovery rate target of 50% has been met at 50.91%, although a drop on December performance of 2.18%. High performance on waiting time indicators continues - achieving 91.1% for 6 week wait (target 75%) and 99.87% for 18 week wait (target 95%).

Inappropriate Out of Area Placements
This is a new SOF indicator that is reportable on a monthly basis. It informs the government's national ambition to eliminate inappropriate out of area placements (OAPs) in mental health services for adults in acute inpatient care by 2020 – 2021. The indicator measures the total number of bed days patients have spent out of area in the last quarter. Trajectories for improvement will be agreed at both STP and provider level. The January 2018 submission will be taken as an agreed baseline position – this was 70 bed days, a reduction of 25 on the December figure. A governance process with operational sign-off to ensure accurate submission has now been agreed.
This indicator will be subject to external audit as part of the Quality Account validation for 17/18.

Resources – Workforce



Staff Sickness
The sickness absence rate for the month of January was 5.02% which is an increase from the December rate of 4.51% and above the Trust target of 4%. This represents a total of 4,465 sick days in January, which is 904 sick days above the 4% target across the trust. There has been an increase in the sickness absence rates across all SBUs and Corporate with the exception of LD&F where there has been a slight improvement. The main reasons for sickness were cough, colds and flu during the month of January with over 200 episodes. In particular there has been an increase in sickness absence within the West SBU and Corporate, although Corporate still remains under the Trust target of 4%. Sickness hotspot areas within the SBUs are being addressed through the newly established sickness absence boards. 185 sickness absence cases are being managed by the Employee Relations Team of which there are 61 long term sickness cases and 123 short term sickness cases. The HR Business Partners will be undertaking spot checks to ensure that quality return to work interviews are being undertaken consistently and a review of the sickness absence policy is also underway. Health and wellbeing initiatives continue to be promoted and staff are encouraged to actively take part. The flu vaccination rate for frontline staff as at 21st February was 56%.

Staff Turnover

The turnover rate increased this month to 13.5% in January compared to 13.3% in the year to December, effectively showing an increase in turnover in Jan-18 compared to Jan-17. Each SBU is focusing on delivering against their reviewed their local recruitment and retention plans. The NHSI retention plan which aims to reduce turnover to 11% over the next 12 months has been submitted and approved. Actions are in the process of being scoped up and implemented which should have a positive impact on the Trust's turnover rates in the coming months. This includes marketing and branding of what we have to offer as a Trust, making it easier to return to the Trust once you have retired, making it easier to move roles within the Trust, reviewing the flexible working offer and making the Trust a place that staff are proud to work for. The Trust's recruitment activity plan has been populated with local and national campaigns. During January a recruitment event was held at Brent Cross Shopping Centre for 7 days to promote the Trust as a place to work. In addition the Trust also attended a recruitment fair at the University of West London with all students who expressed an interest in the Trust being followed up. During January there were 51 new starters and 37 leavers.

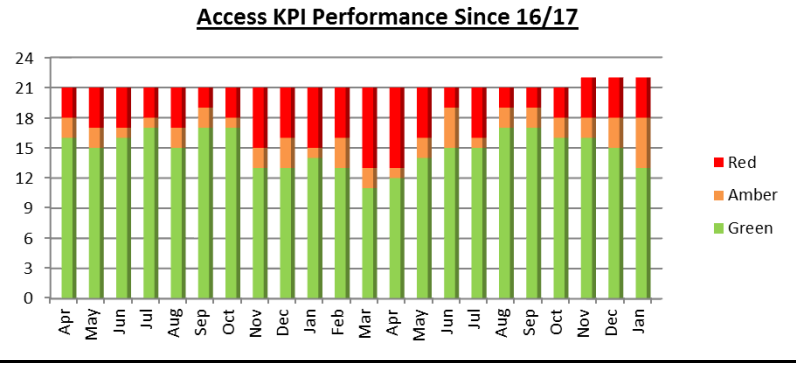
Staff PDPs

Staff with a current PDP has increased from 87% in December to 88% in January, with a net 65 more PDPs required to hit the 90% target. There has been an improvement in the PDP rates in Corporate and the West SBU but a slight decline in East and North SBU and LD&F. The service lines within LD&F are all above 93% with the exception of Norfolk and North Essex LD. The West SBU have been tasked with reaching 95% compliance by the end of March 2018 and East and North SBU managers have been tasked with completing all outstanding PDPs by the end of March with regular time being allocated to complete this work.

Statutory and Mandatory Training

The statutory and mandatory training rate in January remained at 81% which was the same as December. The Trust is currently in a transition period of transferring all staff onto new training competencies that align with the core skills training framework. Compliance rates against the old competencies stands at 81% whilst compliance rates against the new competencies is 70% as at the end of January 2018. This does not mean that staff are not trained – they are being trained to a higher level of competency. There has been an overall increase in compliance of 9% from the end of December 2017 to the end of January 2018 in the new competencies. A task and finish group meets on a weekly basis to monitor compliance against the recovery plans that have been put in place for safeguarding training, WRAP/Prevent, Infection Prevention and Control, Moving and Handling and Resuscitation. There have been improvements in resuscitation and moving and handling but additional focus will be taking place on Safeguarding, WRAP and Infection Prevention and Control during February and March. Monitoring of the trajectories continues to take place on a weekly basis and any deviation against the plan is mitigated against. The Learning and Development Team continue to work with the subject matter experts to remind staff that they need to attend training and ensuring there is enough capacity available. A new learning management system has been procured by the Trust during January and will be implemented during quarter one of the new financial year.

Access to services



The following waiting time indicators have been rated as red or amber in January. Figures in brackets relate to change from December performance except for IAPT indicators which are based on YTD performance.

- Routine referrals to Community Eating Disorder Services – 93.75% (-6.25%)
- Routine referrals for Adult Community Services – 87.93% (-3.88%)
- EMDASS 6 week wait – 82.51% (-3.51%)
- C-CATT 4 hour wait – 94.85% (+ 0.73%)
- CAMHS Targeted 14 day wait (-16.67%)
- CAMHS Routine waits (-19.82%)

- People entering IAPT treatment – Herts Valleys – 8136/8556 (-420)
- People entering IAPT treatment – Mid Essex – 4358/4895 (-537)
- People entering IAPT treatment – West Essex – 3858/4057 (-199)

Routine referrals to Community Eating Disorder Service
The numbers for the Eating Disorder service are low (15/16 within 28 days, but 98% target on these volumes is effectively a 100% target), however, the complexity of presentation and the number of clinicians involved in managing each case has increased, which has meant that one service user was not seen within the 28 day target, but was seen on day 30. Work continues to look at the demand on the ED service and its capacity to manage this within existing resource.

Adult Community 28 day wait
Adult 28 day performance remains below target 87% (420/489, would have required another 60 (total 480) to meet 98% target). In January the main areas of challenge were the North and SW quadrants. Recovery in month shows 86% waiting within 28 days for North and 90% for SW Quadrants. This gives an overall waiting position mid – Feb of 88.53% and no one is being booked into breach appointments. Waited performance is at 87.04%. With these two areas addressed overall waiting performance will be at 90% by the end of February. Waited position is expected to have recovered by the end of Q4 to over 90%.

EMDASS 6 week wait
EMDASS remains below 90% target for appointments within 6 weeks (82.5% or 217/263**,** would have required another 20 of the waiting list to be below 28 days to meet the 90% target). This is as expected with introduction of one stop diagnosis clinics and supported by commissioners. Increasingly expectation from the commissioners in this regard is that our priority should be the time to achieve a dementia diagnosis and increasing the % improvement towards their target of 67% being diagnosed within 6 weeks. The 6 week wait to appointment offered indicator is therefore being reviewed by commissioners.

C-CATT 4 hour wait
C-CATT target was narrowly missed (92/97; one more required to meet 95% target) due to high demand for the service (an increase of 36% in referrals in January 2018 compared with January 2017) coupled with ongoing recruitment challenges to meet such demand.

CAMHS targeted 14 day wait
Numbers of referrals are relatively low and the target was also narrowly missed (15/18; one more required to meet 85% target) due to three breaches of the 14 day wait. Two were due to capacity owing to staff leave and the other was a case that was not originally accepted, but was subsequently re-opened and will be seen within 14 days of this date.

CAMHS Routine Waits
CAMHS 28 day performance fell sharply to 77.4% (113/146; 20 more required to meet 95% target) due to short term sickness and patient choice- this position was identified immediately and recovery measures put in place, resulting in a positive recovery and a current performance Mid-February of 89% waiting and 90.4% waited. This indicates that performance of 95% waited should be recovered fully by the end of March.

Herts Valley IAPT Access Rates
HVCCG is 420 below the YTD access target (8,556), with 8,136 at the end of January.
A significant amount of work is taking place to increase referrals into the service and therefore access rates for HVCCG. Service capacity is sufficient to deal with these referrals if they are made. Initiatives include the following:

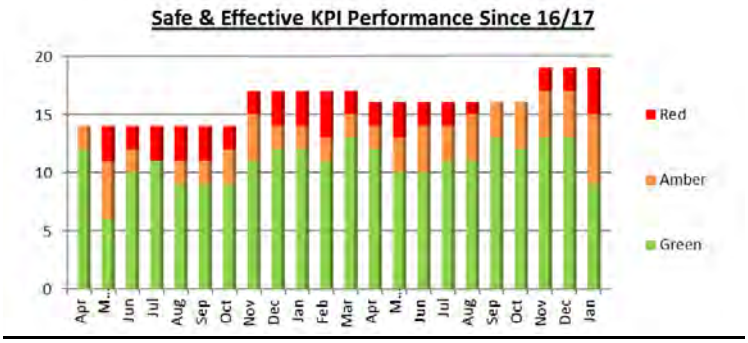
- Initiatives with schools and pharmacies to increase understanding of treatment options and referral process into IAPT.
- Increased access of therapists at University of Hertfordshire.
- Liaison with respiratory and cardiology services in WHHT.
- Radio advertising for the service
- Leaflet drops to the highest and lowest referring GP geographical catchment areas.
- Review and refresh of information in GP surgeries IAPT.
- Promotion on social media.
- Dedicated assessment week in March 2018.

The access manager for the service will closely monitor the success of these initiatives to determine the most effective ways of increasing referrals.

Mid-Essex IAPT Access Rates
Mid-Essex was 537 behind the YTD target (4,895), with 4,358 at the end of January.
Following the review with Mental Health Strategies a joint action plan with the CCG Primary Care Team is now in place. Initially the service experienced limited engagement from the CCG and there was no associated improvement in referrals. However, a new interim CCG lead has now been appointed and better engagement is now being seen.

West Essex IAPT Access Rates
West Essex was 199 behind target for YTD access (4,057), with 3,858 at the end of January. The remedial action plan remains in place and some new actions have been added. The CCG are reinvesting £10k in communications and marketing. January figures had improved, with 28 referrals above the target level set.

Safety and effectiveness of services



The following indicators were rated red or amber in January, with performance relative to December shown in brackets:

- CPA Reviews – 93.9% (-0.17%)
- Risk assessments – 93.8% (-0.6%)
- IAPT Recovery – E&NCCG - 48.49% (-4.58%)
- IAPT Recovery – Mid-Essex – 48.68% (-3.10%)
- IAPT Recovery – West Essex – 47.47% (-5.24%)
- Inpatients feeling safe – 79.66% (-0.89%)
- Carers feeling valued by staff – 68.3% (-8.49%)
- PBR Cluster Reviews – 91.9% (-0.84%)
- Employment – 68.68% (+ 1.37%)
- Accommodation – 68.42% (+ 1.24%)

CPA Reviews/Risk Assessment/Clustering
A number of indicators continue to be consistently below target. Priority is being given to ensuring risk assessments (93.8%, or 16,466/17,546; 203 short of the 16,669 needed to reach 95% target based on caseload size) are in place and that CPA reviews (93.9%, or 780/831; 10 short of the 790 needed to reach 95% target) are carried out in a way that recognises the feedback from the adult community service user review, this requires pre planning and ensuring the service users and carers are well prepared for their reviews- this can impact on the overall target levels if meetings are missed or need to be rescheduled.

The Accurate Information work stream is currently underway and in the process of closing approximately 500 cases on Paris. As of the end of January it was estimated that this would improve risk assessment by +4.79%; cluster reviews by +2.34% and CPA reviews by +7.02%. Cluster reviews are at 91.9%, (10,255/11,161; 348 short of the 10,603 needed to reach 95% target). These estimates were given at a fixed point and do not take into account movement on and off of the cohort being measured, so will vary to some extent in practice.

IAPT Recovery – ENCCG,Mid Essex and West Essex
E&NCCG fell below the recovery target in January at 48.49% (177/365; 6 short of the 183 needed to reach the

50% target). Consistent and continued high referral (Access) rate in E/SE IAPT team has led to increased wait times for entering into treatment and is affecting the recovery rate as service users are entering treatment later. The access target is consistently above target levels but no additional resource has been made available to counteract increased access rate and associated implications on the recovery rate. Issue has been highlighted in ongoing discussions with commissioners regarding resourcing of E/SE team in particular.

IAPT recovery for Mid-Essex was below the 50% target in January at 48.68% (92/189; 3 short of the 95 needed to reach target). These cases are currently being reviewed to see if there are any themes or patterns emerging.

West Essex recovery was at 47.47% (75/158; 4 short of the 79 needed to reach the 50% target) in January. This is the first time that the recovery target has been missed since April 16. All of the cases concerned have been clinically reviewed and there are no concerns or reason to believe that this will continue and at mid-February performance was in excess of 67%.

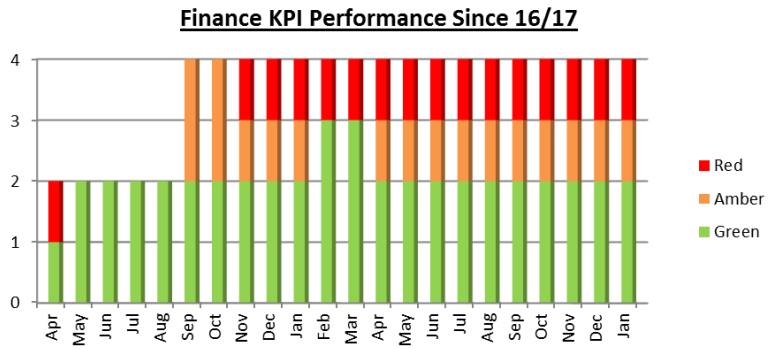
Inpatients Feeling Safe
Inpatient services narrowly missed their target (79.7% rolling 3 month target, or 188/236; 1 short of reaching the 80% target with very consistent performance within the 3 month rolling period) and are using the feedback from the Having Your Say questionnaire to

triangulate the data regarding people feeling safe with the feedback at Mutual Expectations Meetings. Areas are exploring with service users how to make them feel more assured at these times. The acute service line is also exploring peer volunteers to support completion of the survey, as well as someone for service users to talk to about their experiences.

Rate of Carers feeling valued by staff
The carers' indicator was adversely affected (68.3% rolling 3 month target, or 56/82 with 62/82 required to reach the 75% target) by a higher than average rate of return in January (46 respondents compared to only 36 in November and December combined), with a high amount of negative comment (29/46 – 63% saying that they felt valued in the care planning process). This will be monitored to see if it reflects the start of a trend or is a one-off occurrence but is likely to affect the figure until April as it is measured on a 3 month rolling basis.

Employment (11,096/16,157) *and Accommodation* (11,055/16,157)
These specific indicators no longer form part of the SOF in their own right, but continue to contribute to the overall DQMI score. They have been included in the Safe and Effective section as they are important social care indicators and when data is completed it can serve as a proxy outcome measure, showing progress with getting people into paid work, and settled accommodation. Progress continues but has slowed significantly with a respective 1.37% and 1.24% rise in January. This is due to the 'quick wins' now being recorded via the Accurate Information work and reflects the issue of new referrals into the trust not routinely coming with this information. 14,541 complete data items required to meet the 90% mark based on current volumes, an increase of circa 3,500 completed data items, but to mitigate that, an increase of a further 2% for employment and 2.7% for accommodation is anticipated from closing down the 500 inactive cases on Paris as mentioned for CPA/Risk/Clustering, above.

Resources – Finance



The overall Trust position reported in January is a deficit of £4k, which is worse than the Plan of £6k surplus by £9k (before STF). The overall Trust position year to date (before STF) is a surplus of £1.142m, which is ahead of the Plan of £569k by £572k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 1, the highest rating. Key figures are summarised below:

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000
Surplus (Deficit) excluding STF		6	-3	569	1,142
Total Pay (including Agency)		12,523	12,589	124,981	122,589
Agency		710*	749	7,104*	7,364
Secondary Commissioning		2,165	2,929**	21,382	24,896**

*NHSI Ceiling (breaching HPFT recovery plan by £234k year to date)
** Secondary Commissioning spend is higher this due to CAMHs Tier 4 NCM (see below) not reflected in original Plan

The adverse position in the month is caused by:

- Pay costs continuing to rise significantly, now £66k above Plan in the month and increased by £k from December. Substantive pay costs in particular have increased, and also bank, with no compensating reduction in agency costs. Around £50k of the increase in January relates to a previous undercharge for junior doctors, there is also an increase in Acute 24/7 which has recruited for an extended RAID service, the remainder is small amounts across a number of service lines. Pay remains under Plan for the year to date, by £2.4m, but have risen steadily during the year. Agency is significantly above both the NHSI Plan and the internal Recovery Plan.

- Secondary commissioning costs also continuing to rise, now adverse to Plan by £764k in month, an increase of £172k from December. However this is part relates to the new CAMHs Tier 4 NCM (New Care Models) contract which started in December. The cost of this in January was £454k including an adjustment of £33k for December; taking out this effect other spend still increased by £54k, mainly on Older People's placements due to backdated CHC costs.

This position remains a favourable one year to date, however it presents an actual deficit for the first time in the year, which is not unexpected given that pay and secondary commissioning costs have continued to rise with insufficient income or reductions in spend to offset them. Some additional spend is also still planned e.g. to drive performance improvement and data quality initiatives, and on Information Technology to support staff.

This position is stated before income from the Sustainability and Transformation Fund (STF); £1.4m for the year to date.

KPI Key Action Update

KPI	Action Agreed	Update
Adult Community 28 day wait	• Trajectory for improvement to be agreed and monitored weekly for SW. To reach 90% by end of November. • Trajectory for SW amended to 85% at end of January. • SW data cleansing issues with data not being recorded properly have been identified and data will be cleansed by end of December. • Commissioners have agreed a DNA Standard	• In place with ongoing weekly monitoring. Backlog not cleared – extended into December. 90% not reached. • 85% not reached in SW at end of Jan but achieved across the service SW have achieved 90% by week 2 of Feb. • Data qualities improved, but cleanse not yet completed- likely to be mid March

	operating procedure. Preparation for Implementation will commence during January ahead of a full go live on 1 Feb.	• DNA procedure went live on 1st Feb. Implementation being monitored.
IAPT Access West Essex	• Meetings with GP localities to improve referral rate.	• Meetings undertaken with GP localities. • CCG investing £10k for communications and marketing.
IAPT Access Mid Essex	• Regular meetings with Senior Commissioner/Exec in CCG	• Joint action plan in place with CCG Primary Care Team • Supported links with Primary Care in place. • A lot of engagement with GPs taking place, requests from commissioners to adapt service models to increase waiting times between 1st and second appointment not deemed to be safe by HPFT
IAPT Access HVCCG	• Access weeks in month 10 and 11 and management oversight of numbers of referrals on a weekly basis.	• On track
CPA Reviews	• Adult Community committed to recover target performance by the end of Q3 – not achieved. Amended to mid Feb.	• CPA reviews fallen back marginally in Jan- some areas plans show significant improvement delivered in feb. Recovery actions combined with data quality are anticipated to maintain an improved level of performance during the remainder of Q4 however unclear if this will achieve 95% as number of variables
Risk Assessments	• Predicted to achieve by mid-month 11	• Adult and MHSOP at 94% as of 21st; CAMHS 89.9%; LD&F 96%

Trust Board

Meeting Date:	**March 22nd 2018**	**Agenda Item: 11a**
Subject:	**Performance Report Q3 2017/18**	**For Publication: Yes**
Author:	**Performance Improvement Team**	**Approved by: Ronke Akerele, Director of Innovation and Transformation**
Presented by:	**Ronke Akerele, Director of Innovation and Transformation**	

Purpose of the report:

1. To inform the Trust Board on the Trust's performance against both the NHSI (Single Oversight Framework) Targets and Trust KPIs for Q3, 2017/18
2. To assess the likely future performance projections for Q4, 2017/18 based upon a review of current trends, management actions and any variations in future targets.

Action required:

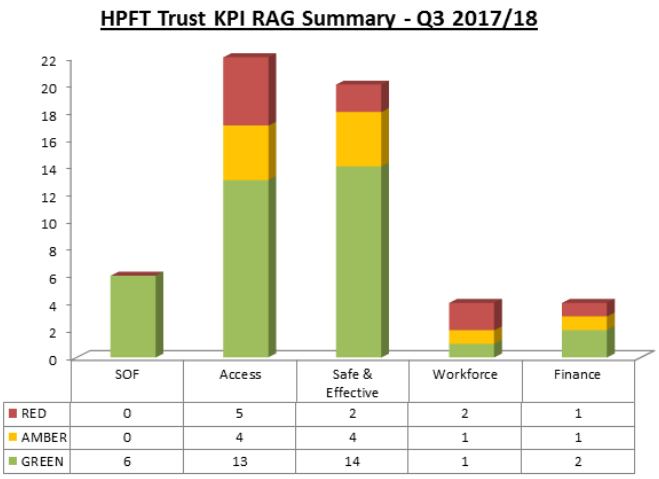
1. Review and assess the Trust's Performance against the NHSI targets, the published KPIs and the other selected quality measures provided.
2. To consider whether any further information is required to adequately assess the performance reported and recommend any improvement actions.

Summary and recommendations:

Summary at a glance

This report provides an overview of Q3 2017/18 performance, assessed against contractual targets across the five elements of Single Oversight Framework, Access to services, Safe & Effective, Workforce and Finance.

Overall Trust performance in key areas is summarised in the graph below and detailed analysis is set out in the main report.



	SOF	Access	Safe & Effective	Workforce	Finance
RED	0	5	2	2	1
AMBER	0	4	4	1	1
GREEN	6	13	14	1	2

With increased demands on the system during our busy winter period, our overall performance remains generally strong, but with ongoing pressure on services particularly in relation to access targets.

Demand for mental health services for children and adults nationally is increasing

significantly and locally we have seen considerable growth in demand year on year, with referral rates for Children having increased by over 25% in the last year and in some parts of the county adult services have seen referrals rates grow by in excess of 10%.
This is clearly demonstrated through the growth in referrals into our single point of access since its inception in 2013 - with approaching 5,000 referrals received into HPFT in January 2018 alone it is clear that working with partners, particularly in primary care is critical to the effective delivery of services.

All Referrals	2013	2014	2015	2016	2017	2018
Jan	1471	3653	3647	4089	4206	4844
Feb	1487	3228	3809	4209	4009	

We have however, continued to consistently build upon and maintain our improvement within SPA and CAMHS.

The financial position remains strong and this continues to provide the basis for services to look for ways to strengthen service performance through implementing and rolling out best practice.

Workforce remains a key challenge with the important metrics of staff turnover and staff sickness falling back slightly in the period. There are a series of initiatives to support workforce development and retention and whilst this has reflected in very encouraging staff survey results for the second year, the Trust continues to maintain a turnover rate at circa 13%.

Since the last performance report to the Board in November 2017, the following key performance indicators moved from 'red and amber' to 'green' rated.

- Cardio-metabolic assessment and treatment for people with psychosis
- Delayed transfers of care to be maintained at a minimal level

The key indicators to note that reflect underperformance against targets in Q3 are:

Access to Services

- **Routine (28 day) referrals to community mental health team**: There is ongoing work across community services to improve waiting times, the implementation of a DNA protocol and work with GPs will assist in improving the clinical decision making regarding those individuals who do not engage with our services for an initial assessment in a timely way. However, demand management work with partners will need to impact referral rates in order to sustain performance in waiting times.
- **Eating disorder services** – With the complexity of presentation on referrals to the service, and the number Work is underway to look at the demand and its capacity to manage this within existing resource of clinicians involved in managing the workload
- **CAMHS Crisis** (C-CATT 4 hour wait) - The demand on the C-CATT teams has been high and limited availability of staff during the Christmas period was a contributor. We have experienced an improvement in January performance.
- **Number of People entering IAPT treatment** (West Essex & Mid Essex) - Regular meetings taking place with senior commissioner in the CCG to explore options on improving the number of referrals from GPs, with links to GP forums now facilitated by Primary Care Clinical Leads. West Essex CCG are reinvesting £10k in communication and marketing.

Safe and Effective

- **CPA Reviews within last 12 months** - All people with an outstanding CPA review or due in Q4 have a date in place for completion. A mini team to

oversee all placements is in the process of being recruited and expected to be in place by the end of Q4.

- **Risk Assessments** – Clinical Director in East and North SBU is currently reviewing risk assessments on medical caseloads and engaging with appropriate clinicians to complete outstanding clinical assessments.
- **Employment and Accommodation Status** - There has been a marked improvement in the recording of employment and accommodation status, moving from the mid-thirty % region in Q2 to high sixties in Q3. This improvement has been a result of the Accurate Information work-stream focussing on data quality, supported through the continuous improvement approach.

Workforce

- **Current PDP and appraisal** – There is a focus at SBU team performance and core management meetings to attain compliance rates.
- **Mandatory training** – The Trust are currently in a transition of moving to new competencies to align with the core skills training framework. A significant amount of activity to improve performance has taken place with a review of how training is delivered, the competency levels required by staff, ensuring there is enough training capacity for each course and there are enough resources to deliver against the plans. This is overseen by a task & finish group.
- **Sickness rate** - Focused work continues to take place to manage sickness absence with the HR Business Partners and Employee Relations Team working with managers and new sickness absence continues.
- **Turnover rate** - Work on retention is being undertaken on a national basis with NHS Employers and NHS Improvement and the Trust submitted its retention improvement plan to NHSI during Q3.

Planned improvement actions on the indicators highlighted above are illustrated in the main report with additional information in relation to specific targets.

A further area of focus is on information systems and data quality and whilst the Trust reports green against the new SOF measure it is recognised that there is further work required to become “information led”. The report below summarises actions against the two key work streams underway.

Relationship with the Strategy (objective no.), Business Plan (priority) & Assurance Framework (Risks, Controls & Assurance):

Annual Plan
SBU Business Plans
Assurance Framework

Summary of Financial, Staffing, and IT & Legal Implications (please show £/No’s associated):

N/A

Equality & Diversity and Public & Patient Involvement Implications:

N/A

Evidence for Registration; CNST/RPST; Information Governance Standards, other key targets/standards:

All targets

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/Board/Audit

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1. Summary

The overall performance in Q3 has seen a reduction in green indicators from 72% in Q2 to 64% in Q3. Amber indicators have risen from 15% in Q2 to 18% in Q3 and reds have gone from 13% to 18%. The main cause for the decrease is due to lower performance ratings for Access Indicators, albeit that some of these represent a small number of breaches which then adversely affect measure.

SOF: The SOF indicators have changed in Q3 with the effect of strengthening the performance within this national framework of measures. Further detail is given in the SOF section below. The overall rag rating for green indicators has remained the same, with the red rated indicators for employment and accommodation replaced with a composite data quality measure (which is reported green) The previous measures will continue to be reported moving to the Safe and Effective Care section.

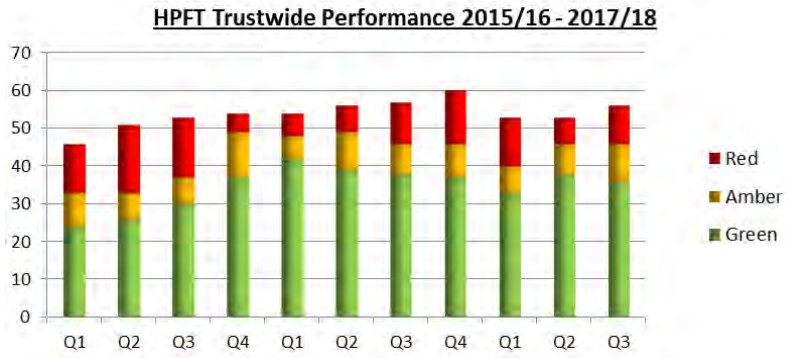
Access: Performance on access has remained the most significant challenge facing our services during the period, perhaps reflected by the Calendar year of 2017 representing the busiest period of demand that HPFT has faced. Recovery plans have been in place for a number of services with strong performance noted in SPA and CAMHS. Adult services have struggled to maintain their planned performance improvement trajectories and a range of primary care initiatives will come into place in q4 which are anticipated will further improve the performance of this service. In two of the remaining Access indicators, the numbers of individuals referred within the quarter were small and therefore single digit changes negatively affected the overall performance metric. CATT Gatekeeping – a green rated indicator has moved from the SOF section to the Access section due its removal from the national SOF requirements.

Safe & Effective: This area has remained stable in Q3. There has been an increase in the number of indicators in this section, with three indicators formerly in SOF moved to Safe and Effective care. These are MHSDS identifiers, employment and accommodation statuses; the latter two account for the two red indicators- albeit the performance improvement in there two areas during the quarter has been considerable given the number of individual records that needed to be updated.

Resources: In relation to Workforce, of the measures reported the Pulse indicators have maintained or improved in performance. Sickness, turnover, mandatory training and PDP and appraisal have all decreased from the Q2 level.

In relation to finance then the position continues to hold above Plan but with continuing pressures principally within bed capacity and on the recruitment & retention. This is reflective of the breach of the Agency cap in the quarter.

Chart 1



2. Activity in Q3

4,084 new spells of secondary care

477 inpatient beds at end of Q3

81,487 face to face contacts in secondary services

4,131 discharges from adult secondary care

2,965 people on CPA at the end of Q3

8,410 people entering treatment in Wellbeing Services

104 Starters

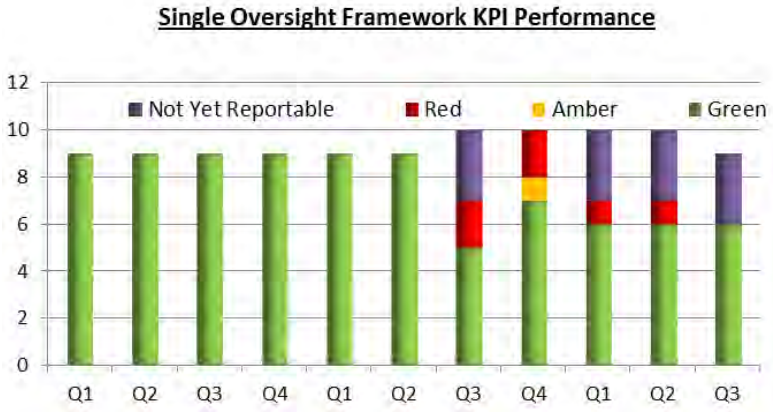
100 Leavers

3. Performance against Single Oversight Framework Targets

The chart below and SOF dashboard in Appendix 1 reflect the changes to the SOF indicators which came into effect with the November update of the Operational Performance Metrics.

Chart 2 shows the performance against the SOF targets.

Chart 2



The indicators now included are:

- FEP 14 day wait (now calculated on a 3 month rolling basis)
- Cardio-metabolic indicators for people with psychosis (no change)
- Data Quality Maturity Index (New)

- IAPT waits (now calculated on a 3 month rolling basis)
- Inappropriate out of area placements (New)

The former SOF indicators for Identifiers, accommodation and employment have been moved to Safe and Effective Care and the CATT Gatekeeping indicator has moved to the Access section of the report.

FEP 14 day wait

69.49% (41/59) people began treatment within 2 weeks of referral in Q3. This was a 3.5% increase on the Q2 performance. Work is ongoing with NHS England to ensure that the MHSDS data matches the manual reporting that is continuing via Unify.

Cardio-metabolic indicators for people with psychosis

HPFT are undertaking two National audits on the management of psychosis. The first audit will review physical health monitoring for a defined cohort of those people on CPA, the submission to the Royal College of Psychiatrists was made at the end of November and in total 300 questionnaires were submitted. The PACE Team then conducted an exercise to assess compliance with the SOF indicators and the key predictions are shown below. Compliance will not be confirmed until we receive the final results from the RCP in April 2018.

- 73% achieved for the Community CPA cohort against a target of 65% = 100% funding achieved (approx. £67,296)
- 95% achieved for the Inpatient cohort against a target of 90% = 100% funding achieved (approx. £100,944)

The third part of the indicator is for FEP Services (approximately 400 service users). The timeframe for this audit is 31st October 2017 – 30th January 2018. PACE will then undertake a similar process to determine compliance. National results will not be released until June 2018 but internal results are anticipated by February 2018. It is likely that performance in this area may be more challenged and closer to 50%.

Data Quality Maturity Index (DQMI)

This is a new indicator that replaces the previous MHSDS priority and identifier metrics. The DQMI is a quarterly publication intended to raise the profile and significance of data quality in the MHSDS. It combines data submitted via MHSDS and SUS returns to derive a 'score'. The target set is ≥ 95%. The latest published data is for Q1 2017/18 and HPFT had a combined DQMI of 96.1%.

IAPT waits

Performance remains strong on all IAPT services.

Inappropriate Out of Area Placements

This is a new SOF indicator that is reportable on a monthly basis. It informs the government's national ambition to eliminate inappropriate out of area placements (OAPs) in mental health services for adults in acute inpatient care by 2020 – 2021. The indicator measures the total number of

bed days patients have spent out of area in the last quarter. Trajectories for improvement will be agreed at both STP and provider level. Initial figures show total bed days as submitted to the national Unify2 upload system, to establish a baseline before inappropriate beds days are deducted. A governance process with operational sign-off to ensure accurate submission has now been agreed.

4. Performance against Trust KPIs

The Trust monitors and reports on performance at an individual KPI level. This is summarised below against three broad areas.

- Access Indicators
- Safe and Effective Care Indicators
- Resource Indicators- the Resource indicator section is split between those focused on workforce and finance. The Trust-wide dashboards can be found in Appendix 3.

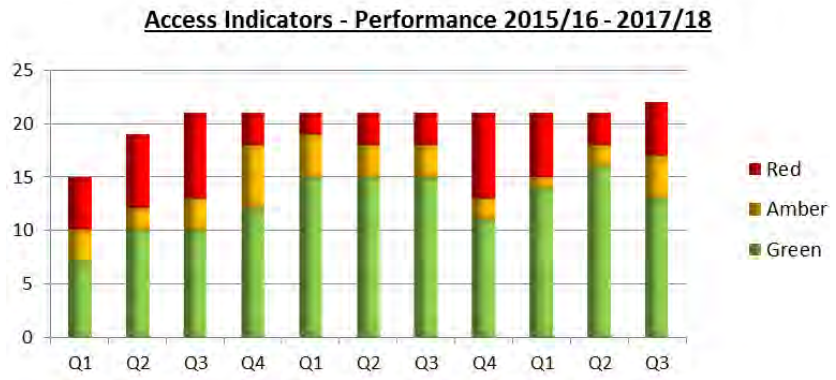
A) Access Indicators

This is the category which has shown the most variation by quarter. This is illustrated within Chart 3 below with a broad trend of a relatively stronger position in earlier quarters then a fall before a recovery, the driver of this variation most notably being within the SPA performance. After a very strong access performance within Q2 which saw the completion of the action plans within CAMHS and SPA there have been sustained challenges in some areas during the quarter, particularly in 28 day routine referrals in adult services largely as a result of prolonged and significant demand from primary care- this has been most evident in the SW quadrant who had anticipated achieving a 90% performance rate by the end of the quarter, however this has not proved possible due to the high number of persons not attending their initial assessment as well as continued peak levels of referral rates from primary care.
CAMHS 28 day waits has maintained its positive improvement through the quarter.

Other changes are summarised below:

- Urgent adult referrals moving from green to red (but only relates to one breach, due to low numbers);
- Routine LD waits, saw 3 persons within the quarter not offered an appointment within 28 days and the issues that led to this booking oversight have now been resolved; C-CATT demand, particularly via A&E remained very high for the quarter and in a small number of instances this led to young people and their families waiting longer than we would like.
- IAPT access for HVCCG and West Essex CCG- referral numbers in both these areas were not as high as required and HPFT staffs are taking proactive steps to increase those accessing the service.
- Within the EMDASS service, the 6 week waits performance has fallen back but is attributed to an agreed positive service change.

Chart 3



Red/Amber Rated Indicators:

Routine Referrals to Community Eating Disorder Services

The numbers for the Eating Disorder service are low (30/32), however, the complexity of presentation and the number of clinicians involved in managing each case has increased, which has meant that in November two service users were not seen within the 28 day target. Both were seen by day 36. Work is underway to look at the demand on the ED service and its capacity to manage this within existing resource. The service achieved 100% seen within 28 days again in December.

Routine Referrals to Community Mental Health Teams

Performance against this indicator fell by 2% in Q3 to 85.2% against a 98% target. East and North SBU achieved 94.47% and West SBU 76.52%. In December West had risen to 81.77%, as opposed to 69.59% at the beginning of the quarter, whilst East and North achieved the 98% target in December. There is ongoing work across community services to improve waiting times, including having focused Initial Assessment workers within the SW Community Team and scrutiny of potential 28 day waiting breaches across both clinical and operational leads to accelerate decision making on actions to address. Current waiting time performance as of 1st week month 10 is 80% for SW Community Services with 23 ongoing breaches from mid-October to the beginning of December, who have not yet been assessed, have had multiple breaches and have not yet exited the system. Referral numbers continue to increase with 111 referrals through month 9. Ongoing work is progressing with SPA to reduce the pass on rates of individual clinical assessors. Forecast numbers are for SW Community to achieve 85% compliance at end of month 10.

The implementation of a DNA protocol and work with GPs will assist in improving the clinical decision making regarding those individuals who do not engage with our services for an initial assessment and this will also impact on improving the capacity within our teams to see individuals in a timely way. This new way of working is scheduled to begin from February 2018.

Urgent Referrals to Community Mental Health Team

There was one breach in November, when the person was subsequently seen on Day 5. December is back to 100% compliance.

Routine Referrals to Specialist Community Learning Disability Services

Performance for the quarter was 95.12% (39/42) Of the three individuals who did not access treatment within 28 days; one was due to difficulty in contacting the service user which resulted in them being seen 2 days over target, the second was as a result of several attempts to contact the service user failing and management not being made aware that a breach was likely, and the third one was allocated to a doctor on day 1 however no face to face was recorded until the 31st day. The process issues highlighted within these cases have all been addressed appropriately

CAMHS Crisis 4 hour waits

The demand on the C-CATT teams has been high and so when multiple assessments are required there is a high risk of delays. These limitations are now being captured accurately following the CRAF audit which highlighted that the previously reported 100% performance was not always reflective of practice. This change in the pathway and consequential impact on the target is known by the commissioners who support the trailing of this improved diagnostic pathway.

IAPT Access – Mid and West Essex; Herts Valleys CCG

West Essex*:* Performance for the quarter was 3452 against a target of 3700. A remedial action plan is in place and some additional actions have been added. The CCG are reinvesting £10k in communication and marketing.

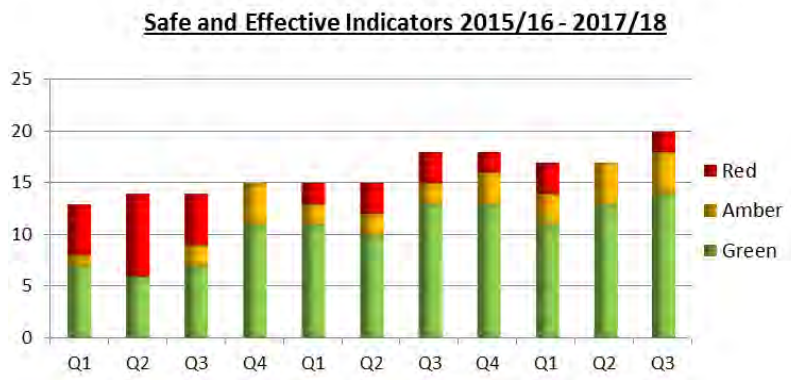
Mid-Essex: Performance for the quarter was 3907 against a target of 4419. Regular meetings taking place with senior commissioner/Exec in the CCG to engage their support to ensure appropriate number of referrals from GPs, with links to GP forums now facilitated by Primary Care Clinical Leads. The remedial action plan is currently under review as there has been a slight increase in referrals.

Herts Valleys: HVCCG wellbeing access has been behind the target throughout Q3, and currently is 317 behind target year to date at the end of month 9 (7170/7487). Primarily this has been due to reduced referral numbers into the service over the last quarter. A significant marketing campaign has been undertaken across Q3 directly targeting households in postcode areas where there has been a reduction in referral numbers, working with GPs and pharmacies across HVCCG and targeting carers within the HV localities. Referral numbers have started to increase in month10, and an access week is planned in both month 10 and month 11 to recover the current access position. Weekly oversight of referral and access numbers across HV Wellbeing Teams is in place.

B) Safe and Effective Services Indicators

There has been an increase in the number of indicators in this section, with three indicators formerly in SOF moved to Safe and Effective care. These are MHSDS identifiers, employment and accommodation statuses; the latter two account for the two red indicators.

Chart 4



Red/Amber Rated Indicators:

CPA Reviews within last 12 months

Improvement has been made in all community services, with the exception of the SW Community Quadrant, particularly in relation to external placements. East and North SBU is above target at 96.03%. West SBU was at 92.27%.Teams are expected to exceed 95% target and sustain by mid-month 11. SW Community Quadrant has made steady improvement to 91% but remains behind target, with an increasing number of CPA reviews due in Q4. All people with an outstanding CPA review or due in Q4 have a date in place for completion. A mini team to oversee all placements is in the process of being recruited and expected to be in place by the end of Q4. Ongoing focussed work is taking place with SW Community Services, including oversight and scrutiny of individual and team caseloads, clarity of purpose and processes and weekly actions to improve and sustain the position for those who are overdue or require CPA review, Risk Assessment and Cluster review through Q4.

Risk Assessments

East and North SBU are at 93.67% at the end of Q3; West at 94.94% and LD&F at 96.5%. In East and North SBU there are a number of risk assessments not being completed that are on the medical caseloads. This has been highlighted to the Clinical Director who is currently

reviewing medical caseloads and resolving this situation with the clinicians concerned.
In West, improvement has been made in all community services in addressing risk assessment compliance, with teams expected to exceed 95% target and sustain by mid-month 11. SW Community Quadrant has made steady improvement to 93.07% but remains behind target, with an increasing number of risk assessment reviews due in Q4.

Clustering Reviews

East and North SBU are at 93.05% at the end of Q3 and West SBU is at 92.08%. The importance of this data continues to be reiterated as although it is not directly applicable to the individuals' clinical care it is helpful for the planning and development of our services.

Staff Friends and Family Test

Commentary on this indicator is included within the Workforce commentary in Section C) of the report.

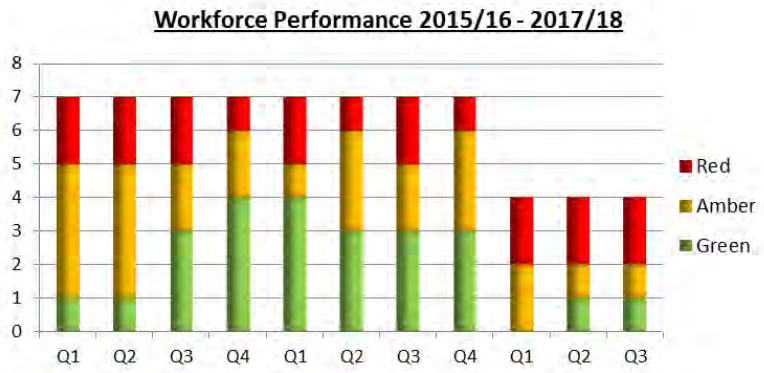
Employment and Accommodation Status

There has been a marked improvement in the recording of employment and accommodation statuses, moving from the mid-thirty %t region in Q2 to high sixties in Q3. This improvement has been a result of the accurate information work-stream. However, the 85% target that was set previously for SOF will continue to prove difficult whilst there is ambiguity from NHS digital about the need for HPFT to capture the status of persons that have not yet been seen.

C) Resource Indicators

Workforce:

Chart 5

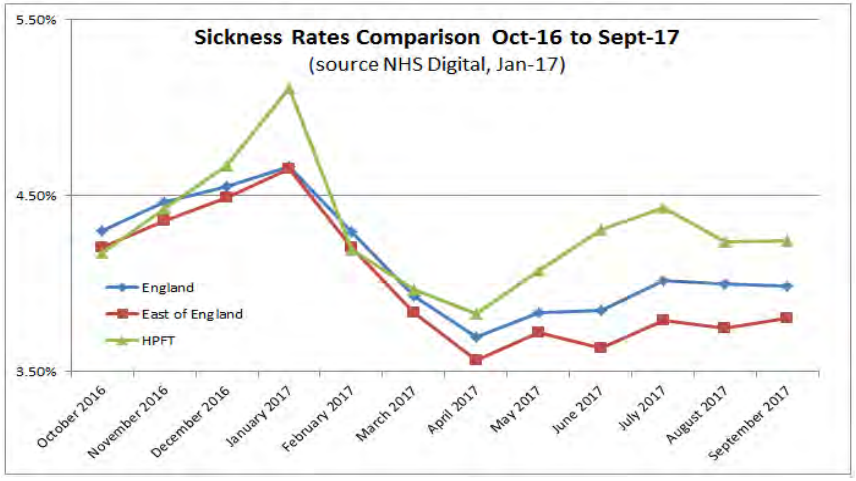


Quarter 3 has seen a maintenance or improvement in the pulse survey scores, 67% of staff recommending the Trust as a place to receive care, and 68% saying they would recommend the Trust as a place to work. Additionally, 92% of staff say they are mindful about living the Trust Values always or often. The findings from the survey, both qualitative and quantitative suggest that staff have high levels of confidence in their skills and abilities. This is reflected in that 94% of respondents said they had the skills and knowledge to do their job effectively an increase of 4% on quarter two. There continues to be a positive improvement in staff who believe the Trust takes positive action on their wellbeing with results increasing by 4% to 81% for quarter three. Additionally 88% of staff said that they did not experience bullying and harassment at work, a positive improvement of 11% on quarter two and 92% did not experience violence which is another positive increase of 4% on the previous quarter. One of the largest thematic areas of concern last quarter was workload management but there have been some improvements this quarter. 28% of staff said they did not work additional unpaid hours, an increase of 4% and 56% felt their workload was manageable compared to 46% in Quarter Two. There was a decrease of 2% in staff who said that Trust processes help them to be effective (Q2 34%) and an increase of 7% to 57% of staff who say they are able to make improvements easily at work. In the qualitative responses staff reflected that improved IT and data systems and more access to developmental training and CPD would enable staff to progress and be more effective.

The sickness absence rate in Q3 has increased from 4.3% in Q2 to 4.7% which is above the Trust target of 4%. There are currently 72 short term sickness absence cases and 54 long term sickness absence cases being formally managed through the employee relations team. The number of short term sickness absence cases that are being formally managed has remained constant since the last quarter. The number of long term sickness cases being managed has decreased by 9 at the end of Q3. Focused work continues to take place to manage sickness absence with the HR Business Partners and Employee Relations Team working with managers and new sickness absence boards continue. Further health and wellbeing initiatives have taken place during Q3 and 51.5% of frontline staff have had their free flu vaccine to date during the flu campaign. It is recognised that work needs to be undertaken with occupational health and the OD team to support some the hotspot areas to assist in improving sickness absence rates. Published NHS sickness rates for the 12 months up to September 2017 have just released in January (Chart 6, source: NHS Digital), showing that HPFT is tracking marginally above the national average, but remains in line with seasonal variation, given the relative smaller sample size of one trust against national

and regional averages.

Chart 6



The turnover rate has increased this quarter to 13.27%. Nursing saw more leavers than starters during the quarter. Each SBU has reviewed their local recruitment and retention plan which should aid retention. Work on retention is also being undertaken on a national basis with NHS Employers and NHS Improvement and the Trust submitted its retention improvement plan to NHSI during Q3.

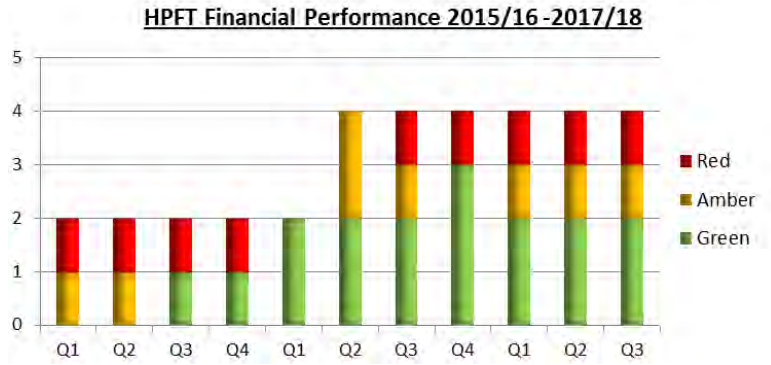
Staff with a current PDP has decreased from 89% in Q2 to 87% in Q3. There has been a decline in PDP rates in all SBUs with the exception of LD&F. LD&F has the highest compliance rates with all of their service lines above 90% except Mental Health Rehabilitation Services. Hertfordshire Forensics and Essex IAPT are above the Trust target of 95%. Compliance rates in East and North SBU have remained relatively stable at 91% and there is a focus at team performance meetings and core management meetings to keep the momentum to reaching compliance. Older People's Inpatients and Adult Community have achieved 95 %. There has been a decrease in compliance in the West SBU and the Managing Director has written to the managers in the poor performing areas to request that all outstanding PDPs are completed by the end of January. The PDP rate in Corporate has dropped to 65% and managers will be tasked with having a concerted effort to addressing this.

The mandatory training rate has decreased from 82% in Q2 to 81% in Q3. A deep dive to identify why compliance was falling has taken place. The Trust are currently in a transition of moving to new competencies to align with the core skills training framework. A significant amount of activity to improve performance has taken place with a review of how training is delivered, the competency levels required by staff, ensuring there is enough training capacity for each course and there are enough resources to deliver against the plans. A statutory and mandatory training matrix has been produced which will assist staff in understanding what training they need to undertake and e learning packages have been purchased and implemented for safeguarding level 2 training. Trajectories to achieve the 92% Trust target by the end of March have been put in place for

safeguarding, WRAP, resuscitation, infection prevention and control, and moving and handling. These are being monitored on a weekly basis at a task and finish group.

D) Resource Indicators:

Finance: Chart 7



The overall Trust position reported in December is a surplus of £80k, which is better than the Plan of £14k by £66k (before STF). The overall Trust position year to date (before STF) is a surplus of £1.145m, which is ahead of the Plan of £563k by £581k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 1, the highest rating. Key figures are summarised below:

There are four main variances within this position:

- Pay overall is better than Plan by £233k in the month (1.9%), and £2.9m year to date (2.5%). Substantive pay decreased by c. £130k, however month 8 was particularly high and the upward trend remains. Both Bank and Agency pay also decreased, by £24k and £8k respectively. Agency despite reducing in September and October remains adverse to the NHSI Plan and to the Recovery Plan, both in the month and year to date.
- Income is better than Plan by £400k, increasing by £29k overall, however there was £360k of new income for CAMHs Tier 4 NCM (New Care Models) which went live on 4th December. Taking out the effect of this new income, income actually reduced in the month by £330k, however like Pay month 8 was particularly high, and there were no particularly large reductions, just a combination of small ones. This position assumes 100% CQUIN for all contracts except Hertfordshire at 90%; for Hertfordshire this figure presents some risk, but there is a recovery plan in place, and to date projections do reach 90%.
- Secondary commissioning adverse to Plan by £520k, an increase of £274k from November, however as with income this includes new expenditure for CAMHs Tier 4 NCM, this was £326k, taking out this effect spend decreased by £52k. Observation costs in December were c.

£63k; Rehab placements and Acute/PICU placements were stable; Older Peoples placements decreased having been high in November; and social care increased by c. £60k.

- Other Direct Costs, Overheads and Financing were adverse to Plan by c. £47k, and decreased in the month by c. £210k, comprising a number of variances.

This position remains a favourable one, albeit with several risks, which will be monitored carefully in the final quarter of the year:

- In recent months there have been general increases in spend which though not large in themselves cumulatively have started to become significant. This has not impacted upon the surplus in earlier months with additional (backdated) Hertfordshire income offsetting this.
- Although pay remains underspent, and has reduced this month, a pronounced upward trend remains (see graph at 3a), with recruitment ongoing, so it will not remain underspent to this degree. The Pay underspend of £2.9m year to date, represents c. 100 posts, based on an average.
- Additional spend is planned e.g. to drive performance improvement and data quality initiatives; spend on Information Technology to support staff.

This position is stated before income from the Sustainability and Transformation Fund (STF); £1.2m for the year to date.

5 Clinical Reporting Assurance Framework (CRAF)

Background and Objectives:

CRAF has been developed in response to a need for assurance on KPIs following issues identified with the accuracy of reporting on Gatekeeping and Delayed Transfer indicators. This is an element of the 'Good to Great' strategy, with an increasing importance and scrutiny given to performance data both within and outside of the Trust based on findings from internal and external audits regarding the need to improve data quality.

The objectives for the project are as follows:

- Provide a detailed description of each of our reported indicators (statutory, National or contractual)
- Check the reporting methodology is accurate (automated or manual) and document the process
- Provide a process map of the clinical recording process
- Provide training tools
- Audit the quality of data
- Highlight any risks or areas of concern to a designated forum for remedial action

The success of the project relies on good clinical engagement to understand the processes around recording of KPIs and ensure that these are followed consistently. The CRAF Team have engaged with a range of staff from clinical teams during two hour fact finding sessions. The resulting documents include a process map of the current way of working, recording on PARIS and issues and ideas for improvement raised by staff. This approach was reviewed by Beautiful Information and thought to be both robust and ambitious.

Project Plan Progress:
The project was initially split into three phases, with the KPIs identified as being most at risk in the first cohort, followed by Phase two and three. SPA and CAMHS, although originally within the scope of Phase 1 were subsequently delayed due to implementation of changes in clinical process in these services. CAMHS KPIs were audited by Data Quality staff to provide interim assurance and will form part of Phase 3 of the project.

Two additional elements to the project are also now being progressed. The addition of these elements has extended the finish date from January to the end of March 2018.
1) Review of the Care Review document on Paris, which will simplify the clinical review process and also align reporting requirements.
2) Transformation of reporting and data collection tools for RAID, CATT and C-CATT which will move data collection and reporting to Paris, instead of current manual method.
Phase 2 is now complete with successful clinical engagement. This was in line with the deadline of the 31st December 2017. Approximately 100 staff members have been consulted in the process so far.

Key Findings:
A range of issues, in both operational and reporting/recording processes have been identified. Some of the emerging themes have been:
- Lack of standardisation in operational and clinical processes across services.
- Recording on Paris not always intuitive or straightforward.
- Lack of understanding of KPIs and why they are being measured.
- Duplication of processes of recording key clinical and KPI information on PARIS and various manual trackers.

These issues are being tackled by the Project Team working with services to hold 'to be' workshops to ensure standardised processes, ease of recording and training materials in place for staff.

Some examples and solutions that are being implemented are listed below:

Issue	Solution
Gatekeeping: Non standardised way of recording Gatekeeping on PARIS. Extensive validation currently required.	Bespoke form commissioned and in development for CATT team to record gatekeeping accurately. Will reduce need for manual validation and ensure timely, accurately recording. Policy document and SOP in development.
Manual data collection and reporting methods for RAID, C-CATT and CATT teams. Data on spreadsheets does not always correlate with what is recorded on Paris.	Transformation process underway to bring reporting onto Paris and SPIKE. Data will be available to teams in real-time and will ensure accuracy of recording. PARIS UDF (form) will be created to capture key clinical and KPI requirements.
Open referrals to AMHPs and On-Call Doctors are skewing the accuracy of reporting on KPIs – for example risk assessment.	Agreed new process for managing AMHP referrals and on-call doctors' referrals are being eliminated by ensuring access to the right teams – see below in Accurate Information Work-stream.

Multiple places to record employment and accommodation status – confusion over where to record. Current Care Coordination Review form needs improvement	Review of the care review document in Paris to ensure easy recording of these indicators and other social care requirements as well as meeting the needs for an effective CPA review.

6 Accurate Information Work-stream

The accurate information work-stream forms part of the Trust's 'Good to Great' Strategy and directly contributes to Objective 7 in the Annual Plan 17/18 *'We will provide staff and teams with better access to the right information and tools to do their jobs effectively and efficiently'.*

The work-stream has been introduced to improve data quality across the trust which will improve the quality of information that is generated and allow informed decisions to be made when planning for future services. The Data Quality Team has been expanded to provide a dedicated Information Officer for every service and regular meetings are being established between them. A data quality dashboard has also been provided on SPIKE that highlights, amongst other things, incomplete forms, months since last activity was recorded, unrecorded deaths and Paris users in each team. Data quality issues that were initially identified and addressed were:

Issue	Solution
AMHP and on-call doctors' referrals being left open and skewing the data for KPIs and activity data for MHSDS	Standalone on call doctors' team removed from Paris and all on-call doctors given access to all inpatient teams on Paris. 4500+ referrals closed.
Deaths not accurately recorded on Paris	3240+ deaths accurately added to Paris by information officers.
Accommodation and employment statuses not routinely recorded.	10,500+ service user details updated by information officers with accommodation and employment statuses.
Inpatient referrals left open once the service user was discharged	743 inpatient referrals closed.

The next phase of work will be tackling:

- Team caseload validation (going through 4000+ referrals)
- PARIS Teams – cleansing start and end dates and closing referrals.
- Pathway cleansing (105+ records on PARIS – need cleansing due to bug)
- On-call doctors stage 2 – (closing of 700+ records and incomplete forms)
- NELD – data cleansing to allow move from discipline to team based reporting.

7 CQUIN

CQUIN results for Q3 were not yet available at the time of writing the report. Results will be reported directly to Trust Executive and Board when they are validated.

8 Quality Account

Performance on the Quality Account at the end of Q3 has improved on the Q2 position, with 8 of the 10 indicators with targets agreed rated as green. Detail can be found in Appendix 2. The amber rated indicators were CPA reviews within 12 months, Delayed Transfers and Staff Friends and Family Test. Further detail on these indicators is documented in Section B) covering Safe and Effective indicators and C) Workforce indicators.

9 Additional Key Quality Considerations

The purpose of this section of the report is to provide the Board with a summary of the key areas of quality reviewed within the wider Trust governance processes. The aspects of quality covered in this section include:

- Safeguarding
- Infection Prevention and Control
- Health and Safety
- PALS and complaints
- Quality Visits

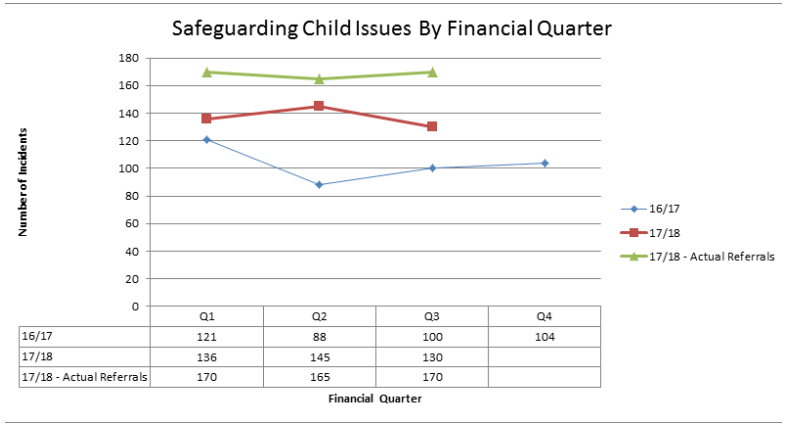
Safeguarding

Over 2017/18 there has been an increased level of safeguarding activity for both adults and children. This is in response to the increased awareness through training, practice development and improvement in reporting. During quarter 3 referrals have stabilized indicating the embedding of improved practice and consistency of reporting

Referrals for safeguarding children

Chart 8 shows that the number of referrals has remained stable over the 2017/18 period to date, when the improvement initiatives commenced. This shows a significant increase in referrals from the same periods in 2016/17, demonstrating increased radar for safeguarding issues.

Chart 8 - Child Safeguarding Incidents by financial quarter

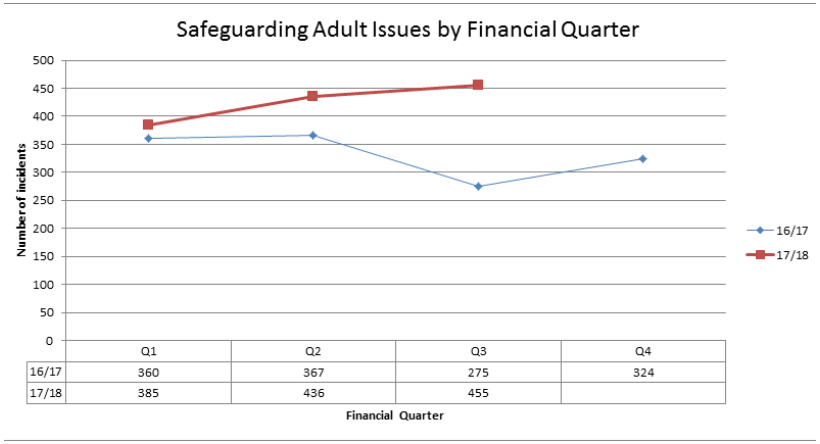


	Q1	Q2	Q3	Q4
16/17	121	88	100	104
17/18	136	145	130	
17/18 - Actual Referrals	170	165	170	

Safeguarding Activity for Adult

Chart 9 shows that in Quarter 3 there were 455 incidents, 66% increase, reported relating to adult safeguarding. This was a significant increase on the same period last year when 275 incidents were reported and is attributable to the increased awareness of safeguarding.

Chart 9 - Adult Safeguarding Incidents by financial quarter

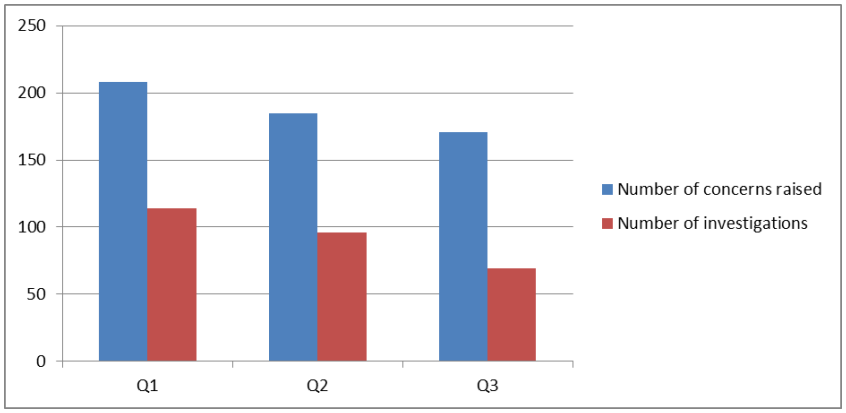


	Q1	Q2	Q3	Q4
16/17	360	367	275	324
17/18	385	436	455	

Statutory Safeguarding Adults in Hertfordshire

Statutory safeguarding relates to the cohort of service users for whom HPFT have additional statutory safeguarding responsibilities (Adult Safeguarding for people with functional mental illness residing or placed with Hertfordshire). Safeguarding activity has decreased over the three quarters. It is important to note that quarter 1 saw the instigation of the Serious Concerns process which involved reviewing open Safeguarding cases and also reopening some closed cases in order to undertake fresh enquiries. This reflects the higher number of concerns and enquiries during the first two quarters of the year. It is expected that there will be a stabilisation of these figure going forward.

Chart 10 – Statutory safeguarding adults concerns and enquiries



Serious Concerns Process

In May 2017 the Trust was placed under the serious concerns by Hertfordshire County Council (HCC) when it was identified that safeguarding referrals to Borehamwood team had no evidence of progress made against each referral. As a result of the serious concerns the Trust took action to remedy the issues and undertook a significant programme of review of safeguarding practice across the whole county.

In September 2017, HCC and the CCG were assured that safeguarding practice had improved and HPFT were taken out of Serious Concerns.

As part of the Trust internal audit plan, RSM were commissioned to audit the delegated safeguarding case work that had taken place following the closure of the serious concerns process. This took place shortly after the serious concerns were concluded. The RSM audit gave partial assurance as the improvements had not been embedded. It highlighted:-

- HPFT safeguarding policy was not compliant with HSAB safeguarding policy
- The new monthly audit tool was ambiguous in some areas, not sufficiently defining standards.
- There continued to be delays in decision making in safeguarding cases.

The following actions have been taken to

address the priority recommendations:-

- The Trust audit tool has been amended in line with all recommendations.
- A communication was sent out re-enforcing timeframes for decision making and practice standards.
- A spot check audit has been carried in October and we achieved 100% compliance with in time decision making. This will be carried bi-monthly going forward.
- The HPFT Safeguarding Policy is currently being re-written and will be completed by end of January.

During quarter three the Trust has been involved in three serious case reviews in the period with no significant practice concerns regarding HPFT raised through these. The learning that has occurred across the partnerships will be taken from these reviews and integrated into the safeguarding improvement plans and disseminated throughout the organisation.

Annual external assurance visits took place during quarter three and we demonstrated safe and effective safeguarding practice for both adults and children to the satisfaction of the CCGs. The reviews supported our identification of areas of good practice and opportunities for continuous improvement. The recommendations will be developed into an action plan and form part of the safeguarding improvement plan 2018/19.

In quarter 2 it was identified that we were not on course to achieve our mandatory training compliance of 90% by March 2018. A review of all safeguarding training was undertaken and a new e-learning package has been purchased from Skills for Health. This will be delivered to staff as an alternative to face to face training enabling us to achieve 90% compliance by March 2018. Prevent Level three training will also be delivered through a new NHS England e-learning package released in December 2017. This will provide an alternative to the current face to face (WRAP) training and is accessible to staff from January 2018.

Infection Prevention and Control

Infection prevention and control incidents reported in quarter 3 was recorded at 25 (Q1 = 23, Q2=16). This includes 1 *Norovirus* outbreak and 5 periods of increase in incidence of infections. There were also 7 incidents relating to accidental inoculation injuries including 2 needle-stick injuries involving clean needles. A further 12 incidents were reported involving communicable diseases, poor compliance with infection prevention and control guidance, infestations, large spillages of blood or body fluids or concerns regarding Interserve.

There have been no reported cases of MRSA, MSSA or E-coli bacteraemia.

There have been no reported cases of *Clostridium difficile.*

Infection prevention and control training (IPC) programmes continue to be implemented. In April 2017, the IPC training was updated to comply with the East of England streamlining programme. Consequently, all Trust staff are now required to implement either level 1 or level 2 IPC training. During this transition period, the training levels have dropped. An action plan has been developed and the compliance rates are being monitored on a weekly basis, with a trajectory to meet 100% compliance by the end of quarter 4.

Health and Safety

The Trust has recorded a total of 134 slips, trips or fall incidents in this quarter. Data is showing this is a decrease of 29 incidents from Quarter 2 July - September 2017/18 and a decrease by 22 incidents compared to the same period last year October – December 2016/17. The level of harm from most falls is low to no harm. However the Trust recognises the need to ensure that work on falls with harm continues which will be led by the Falls Group.

The Trust has reported a total of 11 staff incidents to the Health and Safety Executive (HSE) under the Reporting Injuries and Dangerous Occurrences Regulations (RIDDOR) during October – December 2017/18.

7 of these incidents were as a result of a physical assault against staff, 1 incident was as a result of a member of staff being struck by an object (Door) and 3 incidents as a result of a slip trip or fall incident. 10 of these incidents resulted in staff being absent from work for 7 days or more. There was 1 “specified” injury as a result of a member of staff breaking a bone in their elbow following a slip, trip and fall incident. The data compared to the same period last year shows a decrease in the total number of RIDDOR incidents being reported to the HSE. The Trust reported a total of 12 staff incidents to the HSE in the same period last year.

There were a total of 71 ligature incidents reported in this quarter which is a decrease of 13 incidents reported in the previous quarter July-September 2017/18.

The Trust has issued over 800 lone working devices to those who staff who undertake “High Risk” lone worker duties. There have been no RED Alert activations during October - December 2017/18 requesting the police to attend to support and assist staff.

PALS and Complaints

62 complaints were received in Q3 (35 West, 23 E&N, 4 LDF) a 27% increase on Q2 2017/18. 94% of complaints were acknowledged within the 3 working day target required by the regulations, compared to 98% in Q1.

There were 190 Patient Advice and Liaison Service (PALS) contacts, compared to 219 in Q2. 59 were forwarded to the PALS and Complaints Team by operational services, an increase of 22%. There were almost 10 times more compliments than complaints received during the quarter. The primary issues for the majority of complaints was about clinical practice (31), systems and procedures (16), staff attitude (8), Communication (4) (although poor communication remains an aspect of most of the complaints) and security of patient belongings (2).

The Parliamentary and Health Services Ombudsman (PHSO) / Local Government Ombudsman made 0 requests for records and returned 2 decisions, not upheld, with no further action.

Quality Visits

There were nine quality visits in Quarter 3:

- SRS Forest Lane 1 – 75% Good, 12% Requires Improvement; actions include further work on MOSS, staff knowledge on DOLS and supervision records
- The Beacon – 65% Good, 22% Requires Improvement; actions include learning from incidents, understanding of local risk register and achievement of monthly physical health reviews
- Hampden House – 76% Good, 8% Requires Improvement; actions include better dissemination of information within the team including the risk register and promotion of positive risk taking.
- Wellbeing NW – 36% Outstanding, 44% Good
- CATT Cygnet House – 33% Outstanding , 57% Good
- CATT NW – 46% Good, 32% Requires Improvement. Actions were around risk assessments being completed in a timely manner and risk management in the care plans
- ADTU Glaxo – 75% Good, 16% Requires Improvement. Actions were around recording handover notes on Paris, staff awareness of risks register and staff training on the share drive
- STT NW – 69% Good, 18% Requires Improvement. Actions were around allergy information on drug charts, evidence of wellbeing in care plans, supervision, and access to current PDP rates.

Appendix 1 – Trust Performance SOF

Ref	Standard[20]	Frequency	Standard[17]	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4)
SOF2	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)[22]	Quarterly	>=50%	41/59	69.49%	66.02%	3.47%		↔
SOF3	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards	Annual	>=90%	21/22	95.45%	86% in 16/17		**Provisional figures shown** HPFT will not receive confirmed performance from the RCP until April 2018. The NCAP team will now begin the process of data cleaning and will contact HPFT with regards to any data queries by mid-January. We will have until 2 February 2018 to respond after which data analysis will begin.	
	b) early intervention in psychosis services		>=90%		Q3 data not yet available	96% in 16/17			
	c) community mental health services (people on Care Programme Approach) [23]		>=65%	103/141	73.05%	48% in 16/17			
SOF4	Data Quality Maturity Index (DQMI) – MHSDS dataset score	Quarterly	>=95%		Q2 data not yet available	96.1% in Q1	n/a	**Shown quarterly in arrears due to late availability of data.** NHS Improvement: "As this is a revised indicator, the initial focus (until April 2018) will be ensuring providers understand their current score and, where the standard is not being reached, have a clear plan for improving data quality. During 2018/19, failure to meet the standard will trigger consideration of a provider's support needs in this area."	
SOF5	Improving Access to Psychological Therapies (IAPT)/talking therapies • proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	Quarterly	>=50%	2015 3805	52.96%	54.00%	-1.04%	Data taken from Trust SPIKE report on 15/01/2018 - Q2 figure refreshed	↔
	• waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks	Quarterly	>=75%	6069 6404	94.77%	94.82%	-0.05%	Data taken from Trust SPIKE report on 1501/2018 - Q2 figure refreshed	↔
	- within 18 weeks	Quarterly	>=95%	6404 6404	100.00%	100.00%	0.00%	Data taken from Trust SPIKE report on 15/01/2018 - Q2 figure refreshed	↔
SOF6	Inappropriate out-of-area placements for adult mental health services	Monthly	Total number of bed days patients have spent out of area in last quarter	**Q3 Bed days by month:** **Oct- 84** **Nov-78** **Dec-102**	264	321	57	**Shows total OBDs in each period. No current way to remove appropropriate OAPs from this total.** NHS Improvement: "Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021". Source:http://content.digital.nhs.uk/oaps Further information: www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care	

Appendix 2 - Quality Account

Quality priority areas for 2017/18

Quarter 1 & 2:

Patient (service user) Safety		Target	April	May	June	Q1	July	Aug	Sep	Q2
1	Every discharge 7 day follow up (NHSI mandatory)	95%	98.2%	93.9%	95.1%	95.6%	95.5%	98.5%	96.4%	96.8%
2	CPA Reviews within 12 months	95%	95.8%	94.5%	96.0%	96.0%	96.4%	93.6%	93.5%	94.5%
3	Service users receiving a physical health check within 24 hours of admission	90%	100%	100%	95.9%	98.6%	93.3%	95.3%	90.1%	93.1%
4	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI mandatory)	-	388 Incidents 1.03% (4)	432 Incidents 1.62% (7)	421 Incidents 0.71% (3)	1241* Incidents 1.13% (14)	381 Incidents 0.78% (3)	490 Incidents 0.61% (3)	413 Incidents 0.96% (4)	1284* Incidents 0.78% (10)
Clinical Effectiveness										
5	*Delayed Transfer of Care (DToC)	7.5%	8.49%	8.04%	7.3%	7.94%	8.3%	7.9%	6.5%	7.6%**
6	Emergency readmission within 28 days (NHSI mandatory)	<=7.5%	3.4%	2.8%	7.1%	4.5%	10.1%	5.9%	7.2%	7.8%
7	Improving Access to Psychological Therapies (IAPT) recovery rate	50%	54.1%	52.3%	54.3%	53.4%	51.7%	53.2%	57.2%	54.1%
8	First Episode Psychosis (FEP) waits 14 days (NHSI mandatory)	50%	80.0%	83.3%	73.7%	79.4%	60.6%	73.5%	63.9%	66.0%
Service User and Carer Experience										
9	Service users reporting their experience of Community Mental Health Services (NHSI mandatory)					92.3%				94.7%
10	Carers feeling valued by staff	≥= 75%				85.3%				80.7%
11	Staff Experience Friends and Family Test	≥= 70%				57.0%				67.7%
12	Service Users Friends and Family Test	≥= 70%	88.8%	87.9%	86.7%	87.7%	89.2%	89.3%	85.8%	88.0%

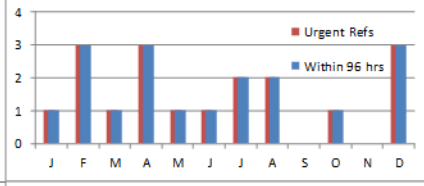
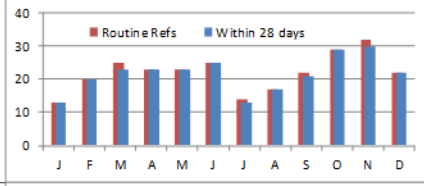
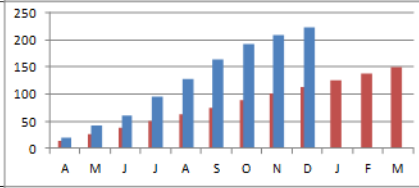
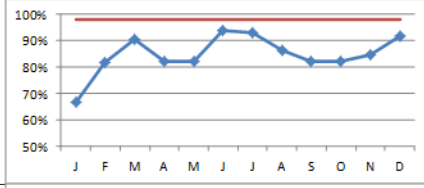
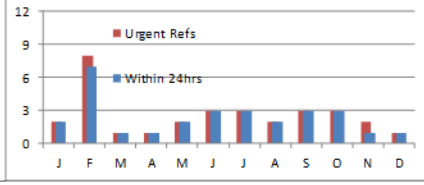
**Quarterly rate (combined figures for July, August, September reported for QA. Performance dashboard shows figure at end of September)

Quarter 3 & 4:

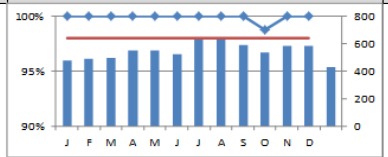
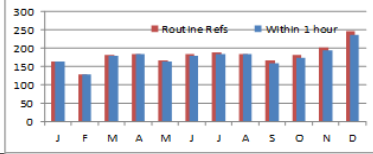
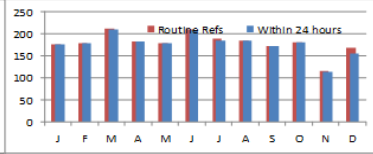
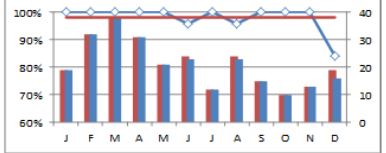
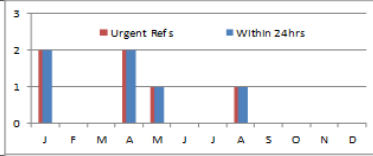
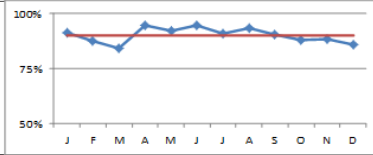
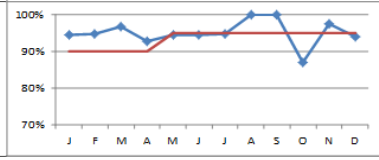
Patient (service user) Safety		Target	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
1	Every discharge 7 day follow up (NHSI mandatory)	95%	98.62%	95.52%	95.68%	96.7%				
2	CPA Reviews within 12 months	95%	93.53%	95.59%	94.03%	94.4%				
3	Service users receiving a physical health check within 24 hours of admission	90%	92.66%	93.27%	94.38%	93.38%				
4	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI mandatory)	-	484 Incidents 0.415% (2)	403 Incidents 0.99% (4)	402 0.76% (3)	1289** Incidents 0.69% (9)				
Clinical Effectiveness										
5	*Delayed Transfer of Care (DToC)	7.5%	7.48%	6.25%	6.76%	6.83%				
6	Emergency readmission within 28 days (NHSI mandatory)	<=7.5%	3.70%	8.51%	5.30%	7.09%				
7	Improving Access to Psychological Therapies (IAPT) recovery rate	50%	53.3%	52.7%	52.9	53.0%				
8	First Episode Psychosis (FEP) waits 14 days (NHSI mandatory)	50%	64.29%	81.25%	66.67%	69.5%				
Service User and Carer Experience										
9	Service users reporting their experience of Community Mental Health Services (NHSI mandatory)					93.2%				
10	Carers feeling valued by staff	≥= 75%				82.2%				
11	Staff Experience Friends and Family Test	≥= 70%				67.0%				
12	Service Users Friends and Family Test	≥= 70%	87.6%	85.8%	85.0%	86.3%				

**As the incident data is subject to a quality assurance review at local level and also by the Safer Care Team prior to uploading to NRLS incident data provided for each Quarter may be subject to change in future reports

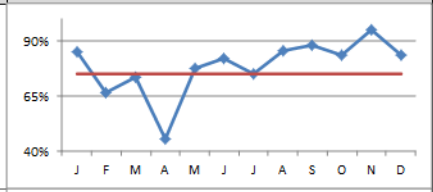
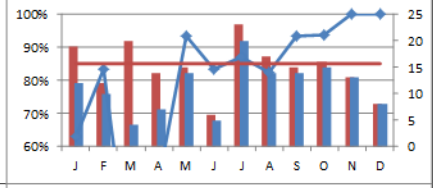
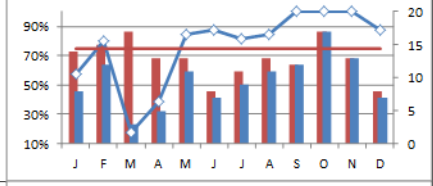
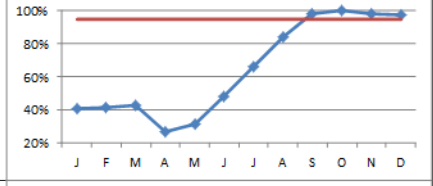
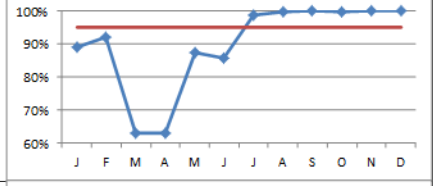
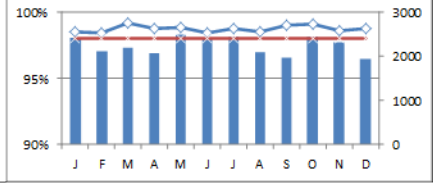
Appendix 3 – Trust Performance KPIs – Access

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**	>=98%		4/4	100.00%	100.00%	0.00%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A2	Routine referrals to community eating disorder services meeting 28 day wait **(Contractual)**	>=98%		81/83	97.59%	96.23%	1.36%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↑
A3	Number of new cases of psychosis **(Contractual)** *Shows, from Apr-16, the number of First Episode of Psychosis (FEP) engaged with Care Co-ordinator for year to date*	150 in year (stay above cumulative threshold of 12.5 per month)		59 in Q3	223 to end Q3 (threshold 113)	164 to end Q2 (threshold 75)	n/a	RAG rated against cumulative target. This number is likely to be adjusted downwards retrospectively, due to caseload maintenance being part of the threshold.	↔
A4	Routine referrals to community mental health team meeting 28 day wait **(Contractual)**	>=98%		1151 1351	85.20%	87.26%	-2.06%		↑
A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**	>=98%		5/6	83.33%	100.00%	-16.67%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↑

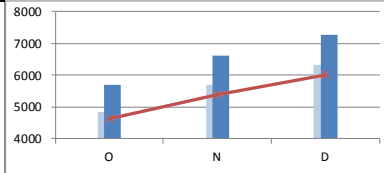
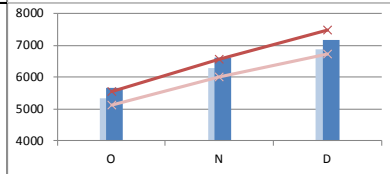
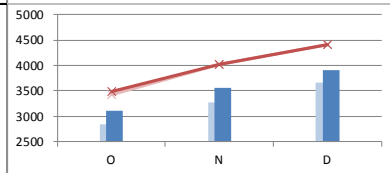
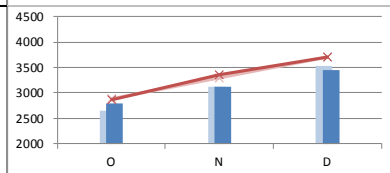
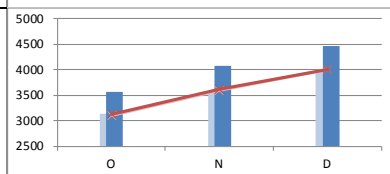
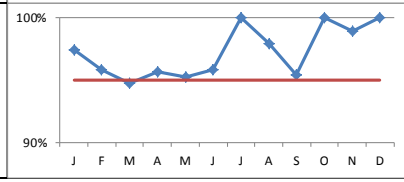
Appendix 3 – Trust Performance KPIs – Access

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
A6	CATT referrals meeting 4 hour wait **(Contractual)**	>=98%		1599 1606	99.56%	100.00%	-0.44%		↔
A7	RAID Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A		606/630	96.19%	97.60%	-1.41%		↔
A8	RAID Response times: 24 hour wait for ward referrals (Lister & Watford combined)	N/A		449/464	96.77%	98.91%	-2.14%		↔
A9	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**	>=98%		39/42	92.86%	98.04%	-5.18%		↑
A10	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait **(Contractual)**	>=98%		Zero	Zero	100.00%	n/a	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A11	EMDASS Referrals meeting 6 week wait **(Contractual)** **(Shows waiting list** as opposed to completed waits)	>=90%		238/277	85.92%	90.73%	-4.81%		↔
A12	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**	>=95%		224/242	92.56%	98.11%	-5.55%	Note - target updated from 90% to 95% in commissioning contract in April 2017	↑

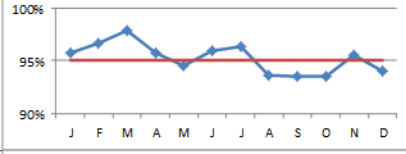
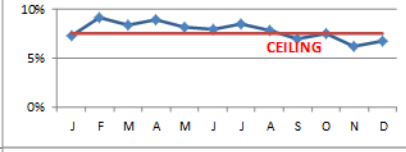
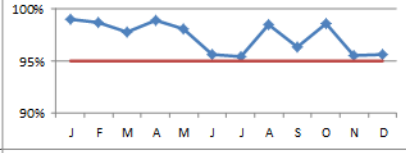
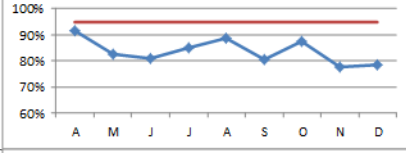
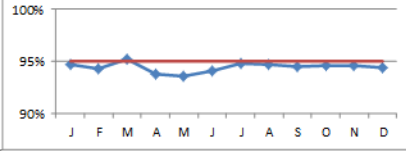
Appendix 3 – Trust Performance KPIs – Access

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
A13	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**	>=75%		39/44	88.64%	83.33%	5.30%		↔
A14	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**	>=85%		36/37	97.30%	87.27%	10.02%		↔
A15	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**	>=85%		37/38	97.37%	88.89%	8.48%		↔
A16	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**	>=95%		363/368	98.64%	79.54%	19.11%		↔
A17	SPA referrals with an outcome within 14 days **(Internal)**	>=95%		6419 / 6423	99.94%	99.52%	0.42%		↔
A18	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services **(Contractual)**	>=98%		6718 / 6797	98.84%	98.76%	0.08%		↔

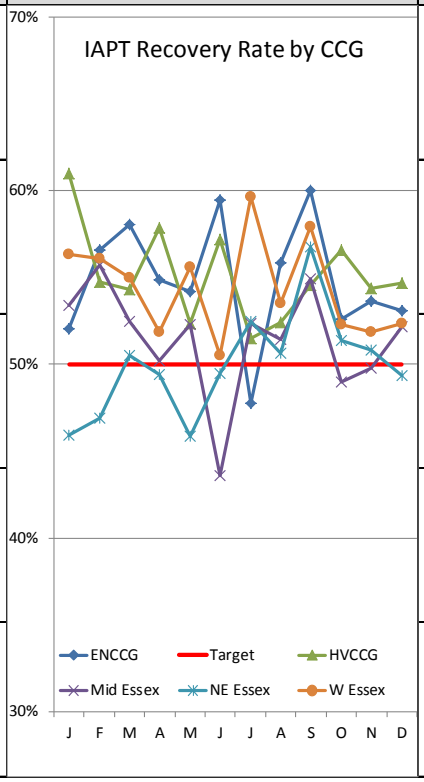
Appendix 3 – Trust Performance KPIs – Access

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Data Quality Issues	Comments	Forecast for next period (Q4)
A19	Number of people entering IAPT treatment (ENCCG) **(Contractual)**	5996 to end of Q3		**2353 (Q3)**	**7,259 (Cumulative)**	**4,906 (Cumulative)**	**n/a**	NOTE: **Data shown is taken from Trust internal reporting system (SPIKE) and does not represent a final monthly position, as national submissions of cleansed data are reported after the production of this report.** RAG Status for IAPT to shows their Year to Date position against monthly cumulative plans (see target column) which is more relevant to performance than their monthly position. GRAPH INTERPRETATION: Dark red lines show the seasonally adjusted plan to meet the Herts and 15% (Essex) Targets. Light red lines show the flat line performance to meet target. Dark Blue bars show 16/17 performance Light blue bars show equivalent performance from last year. Shown one quarter at a time for clearer viewing. A dark blue bar higher than a light blue bar shows improved cumulative performance compared to last FY		↔
A20	Number of people entering IAPT treatment (HVCCG) **(Contractual)**	7487 to end of Q3		**2409 (Q3)**	**7,168 (Cumulative)**	**4,759 (Cumulative)**	**n/a**			↔
A21	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**	4419 to end of Q3		**1206 (Q3)**	**3,907 (Cumulative)**	**2,701 (Cumulative)**	**n/a**			↔
A22	Number of people entering IAPT treatment (West Essex) (Contractual)	3700 to end of Q3		**1,054 (Q3)**	**3,452 (Cumulative)**	**2,398 (Cumulative)**	**n/a**			↔
A23	Number of people entering IAPT treatment (NE Essex) (Contractual)	3996 to end of Q3		**1451 (Q3)**	**4,469 (Cumulative)**	**3,018 (Cumulative)**	**n/a**			↔
A24	Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards (UNIFY2 and MHSDS)[21]	>=95%		**269/270**	**99.63%**	**97.84%**	**1.79%**		Previously SOF1 measure - Removed from SOF from Nov-17	↔

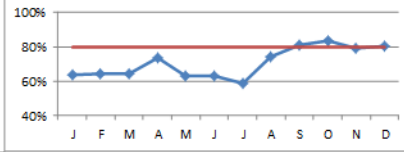
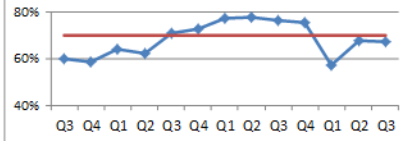
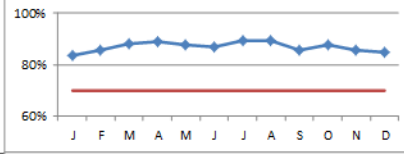
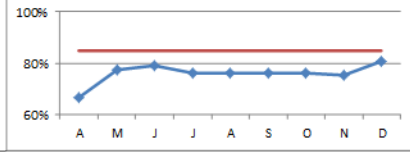
Appendix 3– Trust Performance KPIs – Safe & Effective

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
SE1	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	>=95%		709/754	94.0%	93.5%	0.51%		↑
SE2	Delayed transfers of care to the maintained at a minimal level	<=7.5%		N/A	6.8%	7.8%	-0.94%	Data taken from Trust SPIKE report on 15/01/2018 - Q2 figures refreshed, and have changed from green to amber with retrospective data	↔
SE3	Care Programme Approach (CPA): The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	>=95%		404/418	96.7%	96.8%	-0.12%		↔
SE4	The percentage of people under adult mental illness specialties who were followed up within 72 hrs of discharge from psychiatric in-patient care	t.b.a		339/417	81.29%	84.6%	-3.28%		↔
SE5	Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) **Seen Only**	>=95%		16,447 / 17,415	94.4%	94.5%	-0.03%	Since Nov-15 this no longer matches the quality Schedule, as we have been able to separate Herts from non-Herts CCGs' data and improve the relevance of the QS.	↑

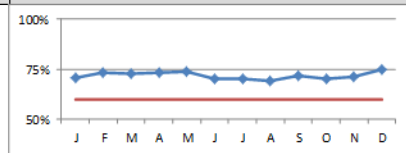
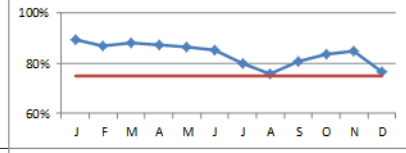
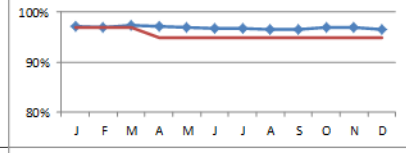
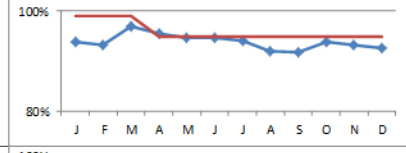
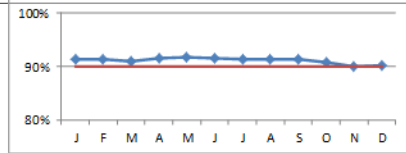
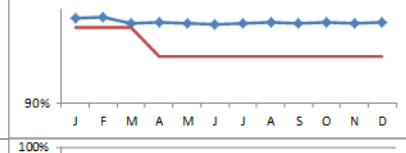
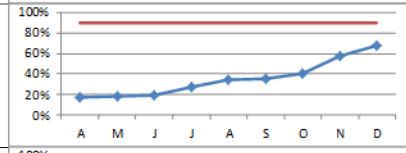
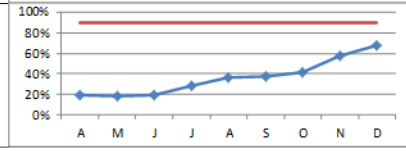
Appendix 3 – Trust Performance KPIs – Safe & Effective

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
SE6	IAPT % clients moving towards recovery (ENCCG)	>=50%		520/979	53.12%	54.85%	-1.74%	Data taken from Trust SPIKE report on xx/01/2018 - Q2 figures refreshed	↔
SE7	IAPT % clients moving towards recovery (HVCCG)	>=50%		729/1320	55.23%	52.95%	2.28%	Data taken from Trust SPIKE report on xx/01/2018 - Q2 figures refreshed	↔
SE8	IAPT % clients moving towards recovery (Mid Essex)	>=50%		281/561	50.09%	52.84%	-2.75%	Data taken from Trust SPIKE report on xx/01/2018 - Q2 figures refreshed	↔
SE9	IAPT % clients moving towards recovery (NE Essex)	>=50%		243/481	50.52%	53.15%	-2.64%	Data taken from Trust SPIKE report on xx/01/2018 - Q2 figures refreshed	↔
SE10	IAPT % of clients moving towards recovery (W Essex)	>=50%		242/462	52.16%	57.08%	-4.93%	Data taken from Trust SPIKE report on xx/01/2018 - Q2 figures refreshed	↔

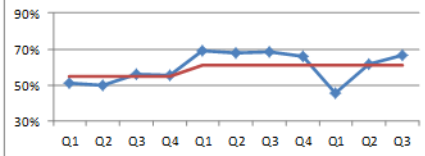
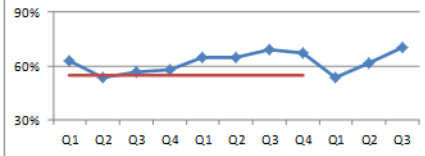
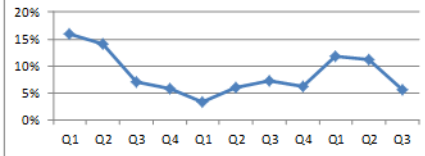
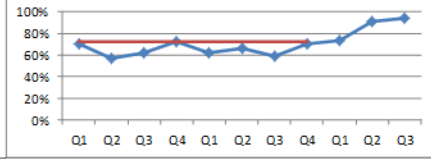
Appendix 3 – Trust Performance KPIs – Safe & Effective

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**	>=80%		174/216	80.6%	80.8%	-0.27%	Service users in Acute HPFT units responding "yes" to the question: "Is the unit a safe environment?" ("sometimes" currently counts as negative)	↔
SE12	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	>=70%		61/91	67.03%	67.7%	-0.63%	Since Nov-16 data, this no longer matches the Quality Schedule, as Herts and non-Herts CCGs' data has been separated to improve the relevance of the QS.	
SE13	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=70%		1341 1554	86.3%	88.0%	-1.74%		↔
SE14	Rate of service users saying they are treated in a way that reflects the Trust's values ***HYS Questions changed in Q1***	Target under review		4845 6315	76.7%	76.1%	0.64%	RAG rating not possible as target not yet agreed	

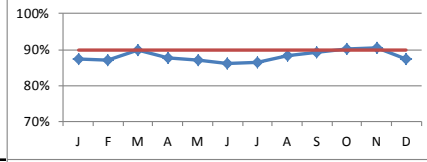
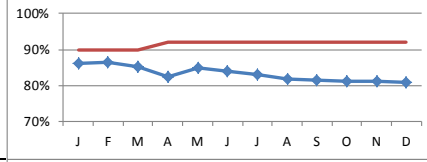
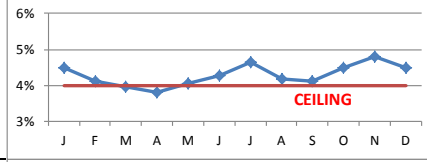
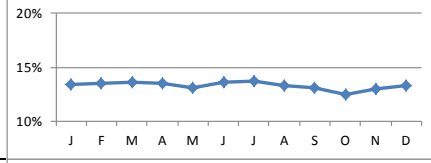
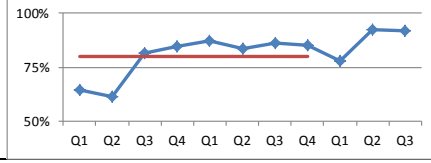
Appendix 3 – Trust Performance KPIs – Safe & Effective

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
SE15	Rate of Community service users saying the services they receive have helped them look to the future more confidently **(rolling 3 month basis)**	>=60%		210/281	74.7%	72.0%	2.74%	Note - reposnses taken from the following Community and LD questions respectively: Has the service you have used been helpful to you? Do the services you receive help you to feel more hopeful about the future?	↔
SE16	Rate of carers that feel valued by staff **(rolling 3 month basis)**	>=75%		43/56	76.8%	80.7%	-3.94%		↔
SE17	Percentage of eligible service users with a PbR cluster	95%		10,920 11,307	96.6%	96.6%	0.01%		↔
SE18	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)	95%		10,360 11,173	92.7%	91.8%	0.92%	Adult Community: 90.61% Acute & Rehab: 93.92% Older Peoples: 97.15% E&N SBU: 93.05% West SBU: 92.08%	↑
SE19	Data completeness against minimum dataset for Ethnicity (MHSDS)	90%		21,920 24,305	90.19%	91.31%	-1.12%	Data taken from last month of each quarter. Trust SPIKE report on 15/01/2018 - Q2 figures refreshed	↔
SE20	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • identifier metrics	>=95%			98.64%	98.55%	0.09%	Previously SOF4 measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Trust SPIKE report on 15/01/2018 - Q2 figures refreshed	↔
SE21	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • Employment	>=85%		10,745 15,796	68.02%	35.04%	32.98%	Previously part of SOF4 MHSDS priority measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Trust SPIKE report on 15/01/2018 - Q2 figures refreshed	↑
	• Accomodation	>=85%		10,675 15,796	67.58%	37.37%	30.21%	Previously part of SOF4 MHSDS priority measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Trust SPIKE report on 15/01/2018 - Q2 figures refreshed	↑

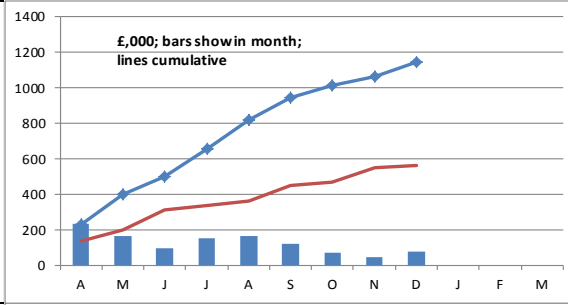
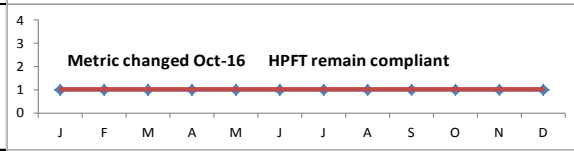
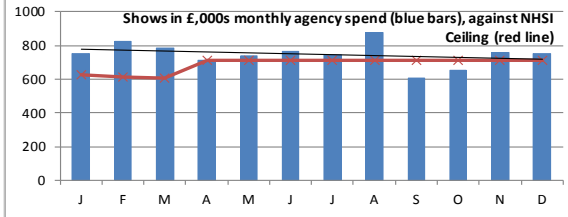
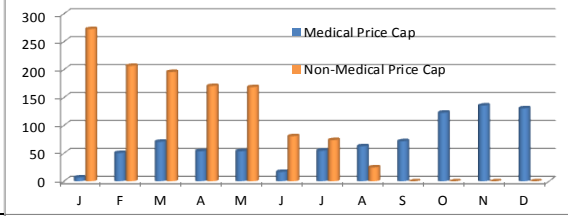
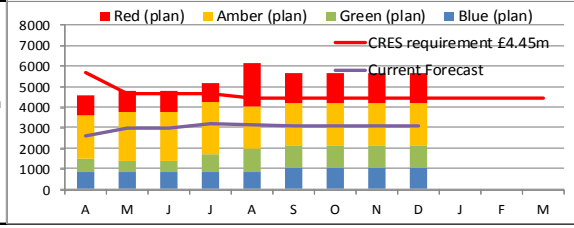
Appendix 3 – Trust Performance KPIs – Resources – Workforce

Ref	Indicator (Monitor/Contractual/Internal)	Target	24 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
W1	Staff saying they would recommend the Trust as a place to work	>=61%		60/90	66.7%	61.7%	4.99%	Total responses in the quarterly Pulse survey	
W2	Staff Wellbeing at Work (Change of measure in Q1)	target under review		195/278	70.14%	61.8%	8.35%	Total responses in the quarterly Pulse survey Comparison not available due to new Pulse questions used in Q1	
W3	Rate of staff that report experiencing physical violence from service users	N/A		6/106	5.66%	11.1%	-5.45%	Total responses in the quarterly Pulse survey	
W4	Staff skills and capability (Measure of changed in Q1)	target under review		85/90	94.44%	91.0%	3.48%	Total responses in the quarterly Pulse survey Comparison not available due to new Pulse questions used in Q1	

Appendix 3 – Trust Performance KPIs – Resources – Workforce

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
W5	Rate of staff with a current PDP and appraisal	>=90%		2298 2634	87.2%	89.3%	-2.02%		↑
W6	Rate of mandatory training completed and up to date	>=92%		18,043 22,310	80.9%	81.5%	-0.63%		↔
W7	Sickness rate	<=4%		12,077 262,641	4.6%	4.3%	0.27%		↔
W8	Turnover rate	N/A		352.43 2655.75	13.3%	13.1%	0.16%		
W9	Living the Values at work (Change of measure in Q1)	target under review		92/100	92.0%	92.4%	-0.42%	Total responses in the quarterly Pulse survey Comparison not available due to new Pulse questions used in Q1	

Appendix 3 – Trust Performance KPIs – Resources – Finance

Financial Indicator	Target	12 month Trend	Current Period Numbers (Q3)	Current Period YTD Performance (Q3)	Previous Period YTD Performance (Q2)	Change on previous period	Comments	Forecast for next period (Q3)
To Achieve Surplus (amount to be confirmed) in year (not including STF)	tbc		£200k surplus in Q3 (Plan £110k in Q3)	**£1145k surplus at Q3** **(Plan £563k surplus at Q3)**	**£945k surplus at Q2** **(Plan £453k surplus at Q2)**	**n/a**	**Chart:** Red line = Cumulative plan surplus 2017/18 Blue bars - in month surplus/deficit Blue line = cumulative surplus/deficit	↔
Use of Resources (formerly Financial Service Risk Rating)	**1**		**1**	**1**	**1**	**n/a**		↔
To keep Agency Spend below the NHSI Agency Ceiling (£8.5 million for the year)	**£8.5 million in year**		£2.162m agency spend in Q3	**£6.614m Spend in year at Q3** **(Ceiling £6.395m Spend in year)**	**£4.452m Spend in year at Q2** **(Ceiling £4.265m Spend in year)**	**decrease in spend £73k relative to Q2**	**Chart:** Red line = NHSI ceiling Blue bars - in month agency spend Black line = linear spend trend line	↔
NHSI Agency Price Caps: (*wage caps no longer reported to NHSI) - monthly number of shifts breaching price caps reported weekly to NHSI in period	**Reduce to Zero**		**390 Price Caps in Q3** *(all Medical)*	**1225 Price Cap breaches YTD at Q3** (of which 705 are Medical and 520 Non Medical)	**835 Price Cap breaches YTD at Q2** *(of which 315 are Medical and 520 Non Medical)*	**Increase of 101 price caps in Q3 compared to Q2 (decrease of 99 Non Medical and increase of 200 Medical)**	**Chart:** Blue bars - in month medical price caps Amber bars = in month Non Medical price caps	↔
Projected CRES (Cash Releasing Efficiency Saving) in Financial Year	**£4.45 million in year**			**Forecast £3.097m at Q3; £1.353m shortfall against £4.45m requirement. (Plans total £5.652m)**	**Forecast £3.097m at Q2; £1.353m shortfall against £4.45m requirement. (Plans total £5.652m)**	**No change in forecast**	**Chart:** Shows indicative forecast against requirememt. Also shows progression of Red and Amber Plans into Blue and Green Plans over time.	↔

Ref	Standard[20]	Frequency	Standard[17]	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Feb-18)
SOF2	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)[22]	Quarterly	>=50%	**12/22**	**54.55%**	**66.67%**	**-12.12%**		↔
SOF3	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards	Annual	>=90%	**21/22**	**95.5% 17/18 Provisional**	**86% in 16/17**		**Shows ANNUAL data - Provisional figures shown** HPFT will not receive confirmed performance from the RCP until April 2018. The NCAP team will now begin the process of data cleaning and will contact HPFT with regards to any data queries by mid-January. We will have until 2 February 2018 to respond after which data analysis will begin.	
	b) early intervention in psychosis services		>=90%	**133/217**	**61% 17/18 Provisional**	**96% in 16/17**			
	c) community mental health services (people on Care Programme Approach) [23]		>=65%	**103/141**	**73.0% 17/18 Provisional**	**48% in 16/17**			
SOF4	Data Quality Maturity Index (DQMI) – MHSDS dataset score	Quarterly	>=95%		**96.1% in Q2**	**96.1% in Q1**	**0.0%**	**Shown quarterly in arrears due to late availability of data.** NHS Improvement: "As this is a revised indicator, the initial focus (until April 2018) will be ensuring providers understand their current score and, where the standard is not being reached, have a clear plan for improving data quality. During 2018/19, failure to meet the standard will trigger consideration of a provider's support needs in this area."	
SOF5	Improving Access to Psychological Therapies (IAPT)/talking therapies • proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	Quarterly	>=50%	**674 / 1,324**	**50.91%**	**53.08%**	**-2.18%**	Data taken from Trust SPIKE report on 08/02/2018 - December figure refreshed	↔
	• waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks	Quarterly	>=75%	**2,120 / 2,327**	**91.10%**	**94.68%**	**-3.58%**	Data taken from Trust SPIKE report on 08/02/2018 - December figure refreshed	↔
	- within 18 weeks	Quarterly	>=95%	**2,324 / 2,327**	**99.87%**	**99.94%**	**-0.07%**	Data taken from Trust SPIKE report on 08/02/2018 - December figure refreshed	↔
SOF6	Inappropriate out-of-area placements for adult mental health services	Monthly	Total number of bed days patients have spent out of area in the period		**70**	**105**	**-25**	**Shows total OBDs in each period. No current way to remove appropropriate OAPs from this total.** NHS Improvement: "Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021". Source:http://content.digital.nhs.uk/oaps Further information: www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care	

[17] Minimum % of patients for whom standard must be met

[20] In addition to the MH indicators, NHS Improvement is following the development of metrics to assess: (i) access and waiting times for children and young people eating disorder services in line with evidence-based treatment guidelines (ii) providers' collection of data on waiting times for acute care (decision to admit to time of admission, decision to home-treat to time of home-treatment start), delayed transfers of care and out of area placements (OAPS) and (iii) systems to measure, analyse and improve response times for urgent and emergency mental health care for people of all ages. These may be incorporated in future iterations of this framework.

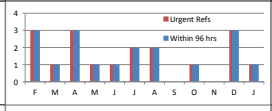
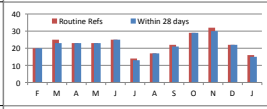
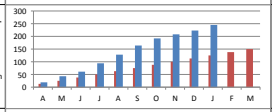
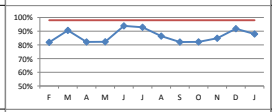
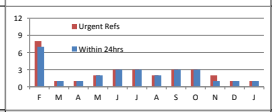
[21] In line with the recommendation of the 5YFV for mental health, providers should be working with commissioners to ensure that crisis resolution home treatment teams are delivering care in line with best practice standards (www.ucl.ac.uk/core-resource-pack/fidelity-scale).
For 2016/17, commissioners have been asked to focus on the following key components of CRHTT care:
> rapid response to new referrals
> provision of a 24/7 gatekeeping function, assessing all people face-to-face within four hours of referral
> adequate staffing with caseloads in line with recommended practice
> provision of intensive home treatment in line with recommended practice (For example, by routinely visiting people at least twice a day for the first three days of home treatment, providing twice daily visits when required thereafter, and routinely offering visits that allow enough time to prioritise therapeutic relationships and help with social and practical problems)
> routine collection and monitoring of clinician and patient reported outcomes, as well as feedback from people who use the service.
These are reflected in NHS England's CCG Improvement and Assessment Framework mental health indicators.

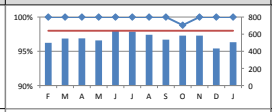
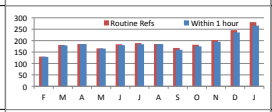
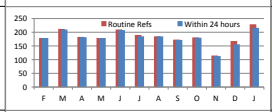
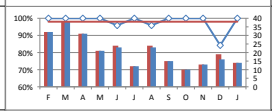
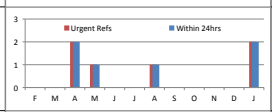
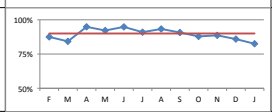
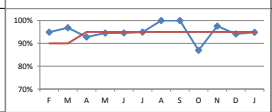
[22] This standard applies to anyone with a suspected first episode of psychosis aged 14-65.Exclusions must not be made of people aged >35 who may historically not have had access to specialist EIP services. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.
Provider boards must be fully assured that RTT data submitted is complete, accurate and in line with published guidance. Both 'strands' of the standard must be delivered.
> performance against the RTT waiting time element of the standard is being measured via MHSDS and UNIFY2 data submissions.
> performance against the NICE concordance element of the standard is to be measured via:
- a quality assessment and improvement network being hosted by CCQI at the Royal College of Psychiatrists. All providers will be expected to take part in this network and submit self-assessment data which will be validated and performance scored on a 4-point scale at the end of the year. This assessment will provide a baseline of performance and will be used to inform the development of performance expectations for 17/18 and beyond.
- submission of intervention and outcomes data using SNOMED-CT codes in line with published guidance. Provider boards must be fully assured that intervention and outcomes data submitted are complete and accurate.
Further information can be found in the implementation guidance published by NHS England here: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf

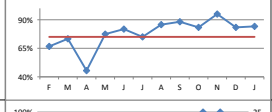
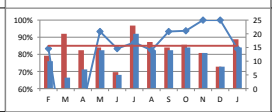
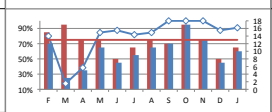
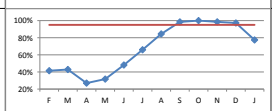
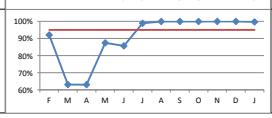
[23] Board declaration but can be triangulated with results of CQUIN audit which will be for a sample of patients in each service area). People with psychosis should receive:
> a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's records
> a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool.
The cardio metabolic parameters based on the Lester Tool are as follows:
> smoking status
> lifestyle (including exercise, diet, alcohol and drug use)
> body mass index
> blood pressure
> glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
> blood lipids.
Information on the Lester Tool and the recommended key interventions and treatments can be found at: www.england.nhs.uk/2014/06/lester-tool/
This indicator aligns with the national CQUIN scheme for 2016/17: www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/

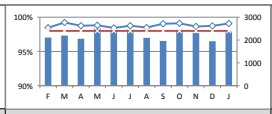
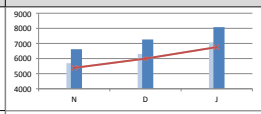
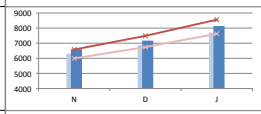
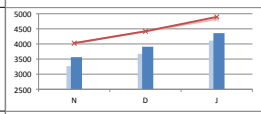
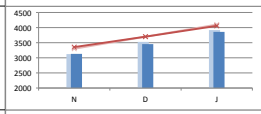
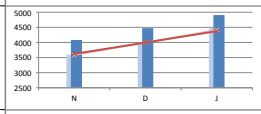
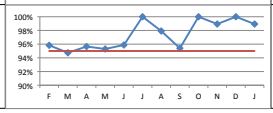
[24] Comprising: NHS number, date of birth, postcode, current gender, registered GP org code, commissioner org code

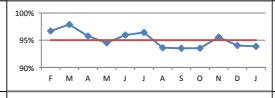
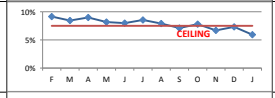
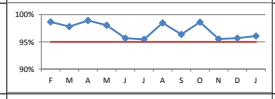
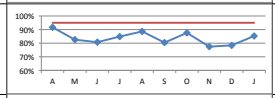
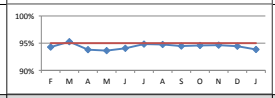
[25] For achievement by 2016/17 year-end. Comprising: ethnicity, employment status (for adults only), accommodation status (for adults only), ICD10 coding. Note: ICD10 for CYP may be supplanted by capture of a problem descriptor, rather than a formal medical diagnosis.

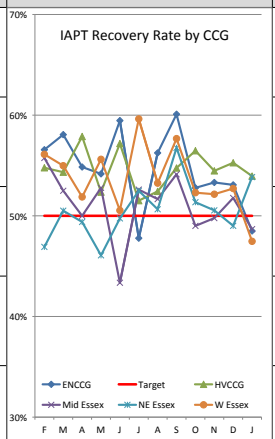
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**	>=98%		1/1	100.00%	100.00%	0.00%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A2	Routine referrals to community eating disorder services meeting 28 day wait **(Contractual)**	>=98%		15/16	93.75%	100.00%	-6.25%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↑
A3	Number of new cases of psychosis **(Contractual)** *Shows, from Apr-16, the number of First Episode of Psychosis (FEP) engaged with Care Co-ordinator for year to date*	150 in year (stay above cumulative threshold of 12.5 per month)		22 in Jan	245 to end of January (threshold 125)	223 to end of December (threshold 113)	n/a	RAG rated against cumulative target. This number is likely to be adjusted downwards retrospectively, due to caseload maintenance being part of the threshold.	↔
A4	Routine referrals to community mental health team meeting 28 day wait **(Contractual)**	>=98%		430 / 489	87.93%	91.81%	-3.88%		↑
A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**	>=98%		1/1	100.00%	100.00%	0.00%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔

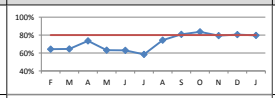
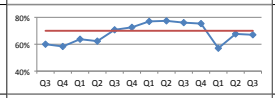
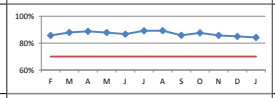
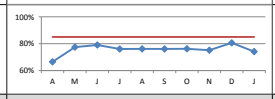
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
A6	CATT referrals meeting 4 hour wait **(Contractual)**	>=98%		506 / 506	100.00%	100.00%	0.00%		↔
A7	RAID Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A		266 / 281	94.66%	95.93%	-1.27%		↔
A8	RAID Response times: 24 hour wait for ward referrals (Lister & Watford combined)	N/A		216 / 229	94.32%	92.86%	1.47%		↔
A9	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**	>=98%		14/14	100.00%	84.21%	15.79%		↔
A10	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait **(Contractual)**	>=98%		2/2	100.00%	Zero	n/a	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A11	EMDASS Referrals meeting 6 week wait **(Contractual)** **(Shows waiting list** as opposed to completed waits**)**	>=90%		217 / 263	82.51%	85.92%	-3.41%		↑
A12	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**	>=95%		92/97	94.85%	94.12%	0.73%	Note - target updated from 90% to 95% in commissioning contract in April 2017	↑

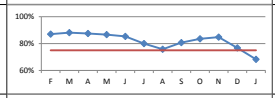
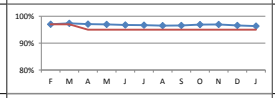
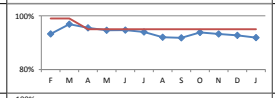
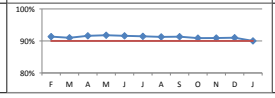
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
A13	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**	>=75%		16/19	84.21%	83.33%	0.88%		↔
A14	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**	>=85%		15/18	83.33%	100.00%	-16.67%		↑
A15	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**	>=85%		10/11	90.91%	87.50%	3.41%		↔
A16	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**	>=95%		113 / 146	77.40%	97.22%	-19.82%		↑
A17	SPA referrals with an outcome within 14 days **(Internal)**	>=95%		2,083 / 2,090	99.67%	99.95%	-0.29%		↔

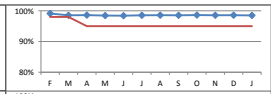
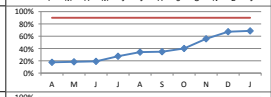
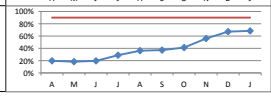
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
A18	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services **(Contractual)**	>=98%		2,368 2,390	99.08%	98.73%	0.35%		↔
A19	Number of people entering IAPT treatment (ENCCG) **(Contractual)**	6757 to end of Jan		814 (January)	8,077 (Cumulative)	7,263 (Cumulative)	n/a		↔
A20	Number of people entering IAPT treatment (HVCCG) **(Contractual)**	8556 to end of Jan		966 (January)	8,136 (Cumulative)	7,170 (Cumulative)	n/a		↔
A21	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**	4895 to end of Jan		450 (January)	4,358 (Cumulative)	3,908 (Cumulative)	n/a	Data taken from Trust SPIKE report on 08/02/2018 - December figures refreshed	↔
A22	Number of people entering IAPT treatment (West Essex) (Contractual)	4057 to end of Jan		405 (January)	3,858 (Cumulative)	3,453 (Cumulative)	n/a		↔
A23	Number of people entering IAPT treatment (NE Essex) (Contractual)	4372 to end of Jan		433 (January)	4,906 (Cumulative)	4,473 (Cumulative)	n/a		↔
A24	Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards (UNIFY2 and MHSDS)[21]	>=95%		93/94	98.94%	100.00%	-1.06%	Previously SOF1 measure - Removed from SOF from Nov-17	↔

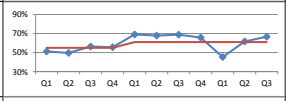
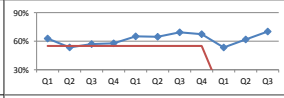
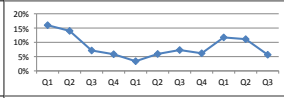
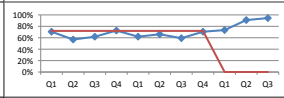
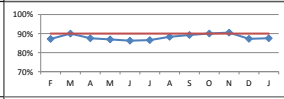
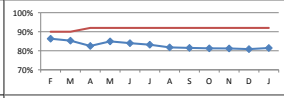
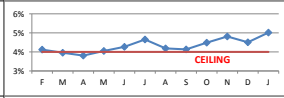
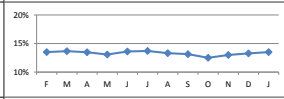
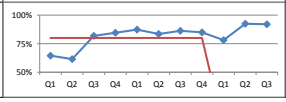
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
SE1	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	>=95%		780 831	93.9%	94.0%	-0.17%		↑
SE2	Delayed transfers of care to the maintained at a minimal level	<=7.5%		786 13,326	5.9%	7.3%	-1.42%	Data taken from Trust SPIKE report on 08/02/2018 - December figures refreshed	↔
SE3	Care Programme Approach (CPA): The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	>=95%		98 102	96.1%	95.7%	0.39%		↔
SE4	The percentage of people under adult mental illness specialties who were followed up within 72 hrs of discharge from psychiatric in-patient care	t.b.a		87 102	85.29%	78.4%	6.88%		↔
SE5	Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) **Seen Only**	>=95%		16,466 17,546	93.8%	94.4%	-0.60%	Since Nov-15 this no longer matches the quality Schedule, as we have been able to separate Herts from non-Herts CCGs' data and improve the relevance of the QS.	↑

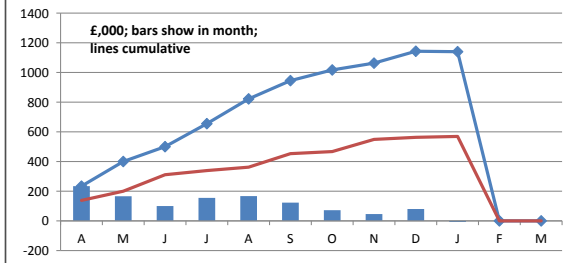
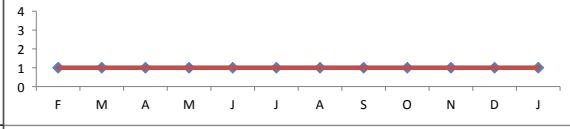
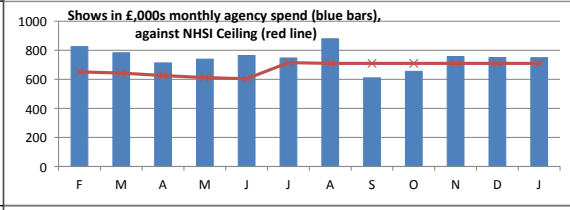
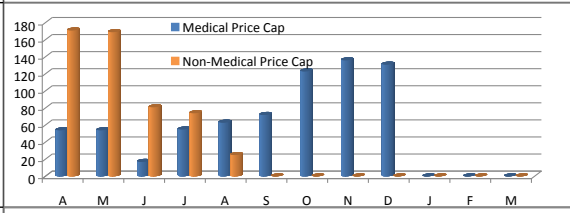
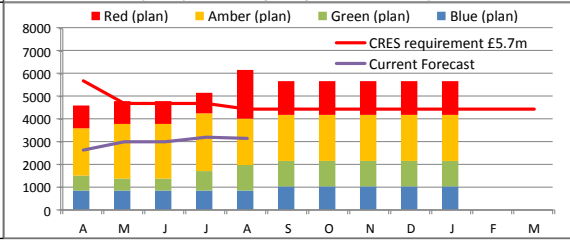
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
SE6	IAPT % clients moving towards recovery (ENCCG)	>=50%		177 365	48.49%	53.07%	-4.58%	Data taken from Trust SPIKE report on 08/02/2018 - December figures refreshed	↑
SE7	IAPT % clients moving towards recovery (HVCCG)	>=50%		246 456	53.95%	55.27%	-1.32%	Data taken from Trust SPIKE report on 08/02/2018 - December figures refreshed	↔
SE8	IAPT % clients moving towards recovery (Mid Essex)	>=50%		92 189	48.68%	51.77%	-3.10%	Data taken from Trust SPIKE report on 08/02/2018 - December figures refreshed	↑
SE9	IAPT % clients moving towards recovery (NE Essex)	>=50%		84 156	53.85%	49.01%	4.84%	Data taken from Trust SPIKE report on 08/02/2018 - December figures refreshed	↔
SE10	IAPT % of clients moving towards recovery (W Essex)	>=50%		75 158	47.47%	52.71%	-5.24%	Data taken from Trust SPIKE report on 08/02/2018 - December figures refreshed	↑

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**	>=80%		188 236	79.66%	80.56%	-0.89%	Service users in Acute MPFT units responding "yes" to the question: "Is the unit a safe environment?" ("sometimes" currently counts as negative)	↑
SE12	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	>=70%		61/91 (Q3)	67.03% (Q3)	67.66% (Q2)	-0.63	Since Nov-16 data, this no longer matches the Quality Schedule, as Herts and non-Herts CCGs' data has been separated to improve the relevance of the QS.	
SE13	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=70%		598 710	84.2%	85.0%	-0.79%		↔
SE14	Rate of service users saying they are treated in a way that reflects the Trust's values ***HYS Questions changed in Q1***	Target under review		2,828 3,816	74.1%	80.6%	-6.50%	RAG rating not possible as target not yet agreed	

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
SE15	Rate of Community service users saying the services they receive have helped them look to the future more confidently **(rolling 3 month basis)**	>=60%		260/328	79.3%	74.7%	4.54%	Note - reposnses taken from the following Community and LD questions respectively: Has the service you have used been helpful to you? Do the services you receive help you to feel more hopeful about the future?	↔
SE16	Rate of carers that feel valued by staff **(rolling 3 month basis)**	>=75%		56/82	68.3%	76.8%	-8.49%		↑
SE17	Percentage of eligible service users with a PbR cluster	95%		11,161 11,585	96.3%	96.6%	-0.24%		↔
SE18	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)	95%		10,255 11,161	91.9%	92.7%	-0.84%	Adult Community: 89.70% Acute & Rehab: 93.47% Older Peoples: 96.82% E&N SBU: 91.18% West SBU: 93.24%	↑
SE19	Data completeness against minimum dataset for Ethnicity (MHSDS)	90%		22,430 24,919	90.0%	91.0%	-1.00%	Data taken from Trust SPIKE report on 15/02/2018 - December figures refreshed	↔

SE20	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • identifier metrics	>=95%		147,289 149,544	98.49%	98.57%	-0.08%	Previously SOF4 measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Trust SPIKE report on 09/02/2018 - December figures refreshed	↔
SE21	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • Employment	>=85%		11,096 16,157	68.68%	67.30%	1.37%	Previously part of SOF4 MHSDS priority measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Trust SPIKE report on 09/02/2018 - December figures refreshed	↑
	• Accomodation	>=85%		11,055 16,157	68.42%	67.18%	1.24%	Previously part of SOF4 MHSDS priority measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Trust SPIKE report on 09/02/2018 - December figures refreshed	↑

Ref	Indicator (Monitor/Contractual/Internal)	Target	24 month Trend	Current Period Numbers (Q3 2017/18)	Current Period Performance (Q3 2017/18)	Previous Period Performance (Q2 2017/18)	Change on previous period	Comments	Forecast for next period (Q4)
W1	Staff saying they would recommend the Trust as a place to work	>=61%		60/90	66.7%	61.7%	4.99%	Total responses in the quarterly Pulse survey	
W2	Staff Wellbeing at Work (Change of measure in Q1)	target under review		195 278	70.14%	61.8%	8.35%	Total responses in the quarterly Pulse survey Comparison not available due to new Pulse questions used in Q1	
W3	Rate of staff that report experiencing physical violence from service users	N/A		6 106	5.66%	11.1%	-5.45%	Total responses in the quarterly Pulse survey	
W4	Staff skills and capability (Measure of changed in Q1)	target under review		85/90	94.44%	91.0%	3.48%	Total responses in the quarterly Pulse survey Comparison not available due to new Pulse questions used in Q1	
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period Performance (Jan-18)	Previous Period Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
W5	Rate of staff with a current PDP and appraisal	>=90%		2,317 2,646	87.6%	87.2%	0.32%		↑
W6	Rate of mandatory training completed and up to date	>=92%		17,299 21,238	81.5%	80.9%	0.58%		↔
W7	Sickness rate	<=4%		4,464 89,029	5.0%	4.5%	0.51%	Percentages based on WTE time available and lost	↔
W8	Turnover rate	N/A		362.27 2,683.46	13.5%	13.3%	0.23%		
W9	Living the Values at work (Change of measure in Q1)	target under review		92 100 (Q3)	92.00% (Q3)	92.42% (Q2)	-0.42%	Total responses in the quarterly Pulse survey Comparison not available due to new Pulse questions used in Q1	

Ref	Financial Indicator	Target	12 month Trend	Current Period Numbers (Jan-18)	Current Period YTD Performance (Jan-18)	Previous Period YTD Performance (Dec-17)	Change on previous period	Comments	Forecast for next period (Feb-18)
F1	To Achieve Surplus (amount to be confirmed) in year (not including STF)	tbc		£3k defecit in Jan (Plan £6k surplus in Jan)	**£1142k surplus at Month 10** **(Plan £569k surplus at M10)**	**£1145k surplus at Month 9** **(Plan £563k surplus at M9)**	**n/a**	**Chart:** Red line = Cumulative plan surplus 2017/18 Blue bars - in month surplus/deficit Blue line = cumulative surplus/deficit	↔
F2	Use of Resources (formerly Financial Service Risk Rating)	**1**		**1**	**1**	**1**	**n/a**		↔
F3	To keep Agency Spend below the NHSI Agency Ceiling (£8.5 million for the year)	**£8.5 million in year**		£749k agency spend in month	**£7.363m Spend in year at M10** **(Ceiling £7.105m Spend in year)**	**£6.614m Spend in year at M9** **(Ceiling £6.395m Spend in year)**	**decrease in spend £1k relative to M9**	**Chart:** Red line = NHSI ceiling Blue bars - in month agency spend	↔
F4	NHSI Agency Price Caps: (*wage caps no longer reported to NHSI) - monthly number of shifts breaching price caps reported weekly to NHSI in period	**Reduce to Zero**		**Data not yet avaialbe for Price Caps in month** *(all Medical)*	**TBC Price Cap breaches YTD at M10** (of which TBC are Medical and 520 Non Medical)	**1226 Price Cap breaches YTD at M9** (of which 705 are Medical and 520 Non Medical)		**Chart:** Blue bars - in month medical price caps Amber bars = in month Non Medical price caps	↔
F5	Projected CRES (Cash Releasing Efficiency Saving) in Financial Year	**£4.45 million in year**			**Forecast £3.097m at M10; £1.353m shortfall against £4.45m requirement. (Plans total £5.652m)**	**Forecast £3.097m at M9; £1.353m shortfall against £4.45m requirement. (Plans total £5.652m)**	**No change in forecast**	**Chart:** Shows indicative forecast against requirememt. Also shows progression of Red and Amber Plans into Blue and Green Plans over time.	↔

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	**22nd March 2018**	**Agenda Item: 12**
Subject:	**Service Experience Report Q3 2017-18**	**For Publication: Yes**
Author:	**Mary Stephenson, Complaints and Service Experience Manager**	**Approved by: Jess Lievesley, Director –Service Delivery and Customer Experience**
Presented by:	**Jess Lievesley, Director – Service Delivery and Customer Experience**	

Purpose of the report:

This report provides information on compliments, PALS contacts, complaints and responses to patient experience questionnaires, especially Having Your Say questionnaires, received during Quarter 3 2017/18.
It provides assurance about how the Trust learns from complaints and other service experience information.

Action required:

- To note progress.
- To advise on areas for improvement.

Summary and recommendations:

This report provides an overview of the qualitative and quantitative service experience measures for Quarter 3 2017/18. Information is provided over time to help identify themes, trends and learning for the Trust. The report contains more detailed information on complaints received as well as elements of learning that the Trust has undertaken in response to the complaints and other feedback.

This paper was received and considered by the Integrated Governance Committee in January 2017.

The report highlights the continued benefit to services on receiving feedback on the care they provide as we as providing a summary and the themes of the issues that are being raised in both compliments and complaints.

The quarter has seen the maintenance of the Trust's strong overall position with regard to the experience and satisfaction rates, reported by service users and carers, with HPFT remaining in the upper range for comparator trusts in relation to Friends & Family.

The strategic business units continue to examine the themes and issues arising from both compliments and complaints to inform their wider practice and the central support functions ensure that issues and themes are shared on an organisational basis.

The report highlights those areas where increases or decreases have been noted within quarter – with East & North SBU showing the biggest variance in quarter and the Managing and Clinical Directors are currently reviewing the themes and findings to establish if there are any systemic issues that require action over and above the investigation and response to the immediate concerns or complaints raised.

Board are asked to note.

Relationship with the Strategy (objective no.), Business Plan (priority) & Assurance Framework (Risks, Controls & Assurance):

The report related to the following strategic objectives:

1. Deliver safe and effective services
2. Service users, carers, referrers and commissioners will have a positive experience of our services

Summary of Financial, Staffing, and IT & Legal Implications (please show £/No's associated):

Equality & Diversity /Service User & Carer Involvement implications:

The report concerns feedback and complaints from service users and carers and the information and as a result is monitored closely by Engagement and Inclusion Team

Evidence for Registration; CNST/RPST; Information Governance Standards, other key targets/standards:

CQC Key Lines of Enquiry
Responsive R4 How are people's concerns and complaints listened and responded to and used to improve the quality of care?

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/Board/Audit

Inclusion and Engagement Group
Integrated Governance Committee

*On receipt, complaints are risk assessed against a 5x5 matrix, as low, medium and high risk. The rating is reviewed and adjusted, if necessary, once the investigation is complete. High and moderate risk complaints are itemised in this report

Service User & Carer Experience Report

Quarter 3 - 2017 / 2018

1. Introduction

This report provides an overview of the qualitative and quantitative service experience measures for Quarter 3 2017/18. Information is provided over time to help identify themes, trends and learning for the Trust. The report contains more detailed information on complaints received as well as elements of learning that the Trust has undertaken in response to the complaints and other feedback.

2. Compliments & Trust Values

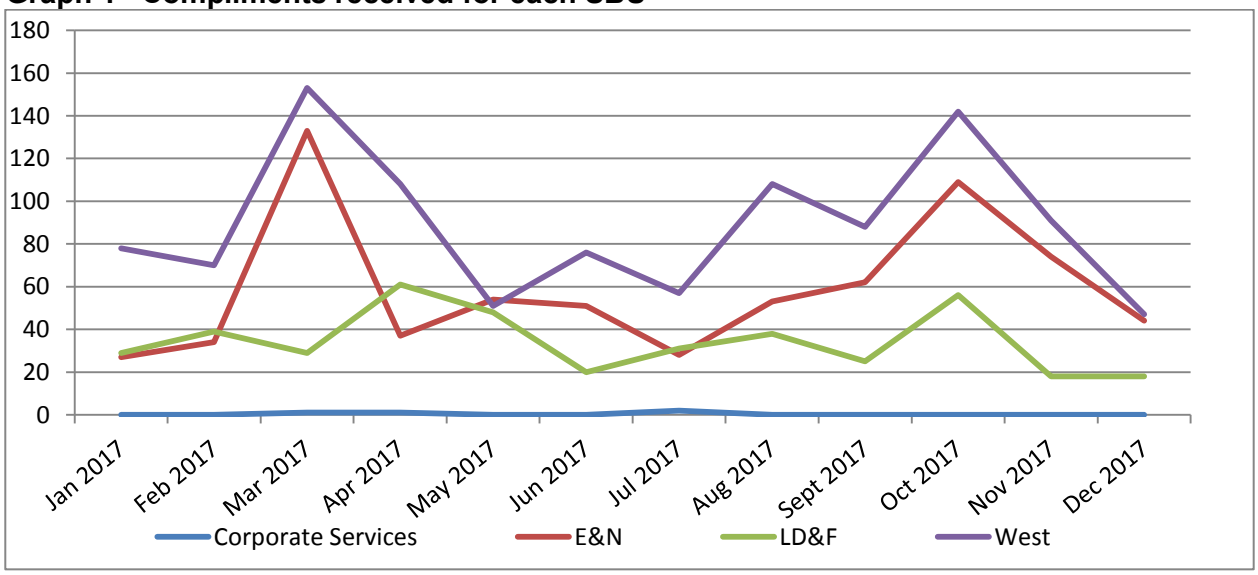
Table 1 shows the number of compliments received each quarter over the last 12 months.

Table 1 Compliments received over the last 12 months (rolling year)

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	TOTAL 2017/18
Compliments received	593	507	492	599	1598

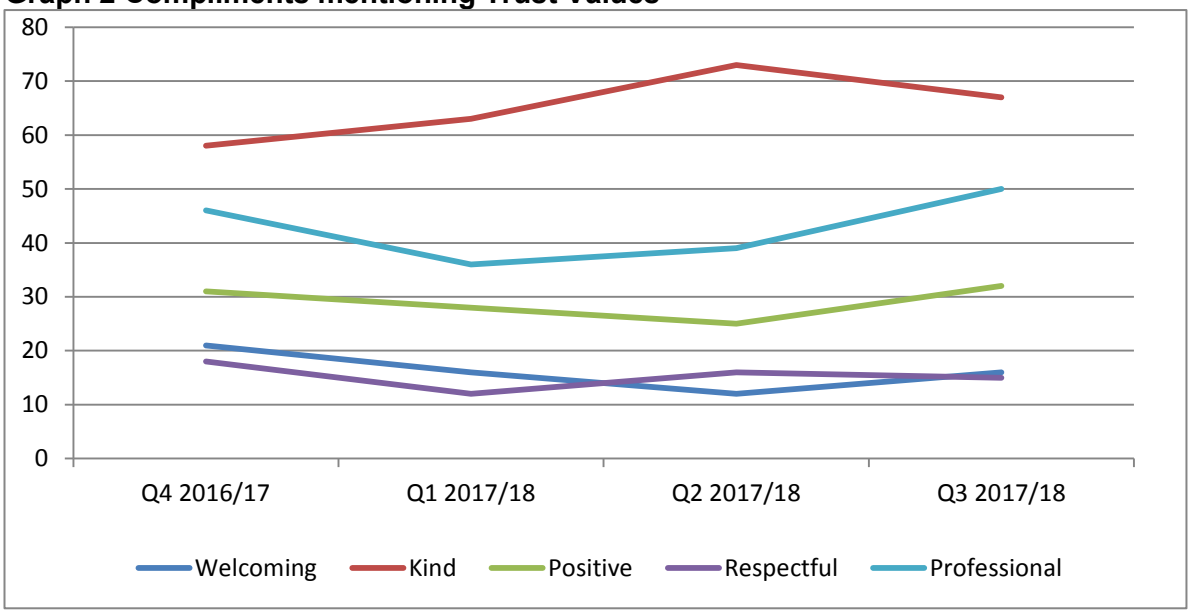
In the Q3 89% of compliments came from service users, 8% from carers/relatives and 2% from professionals outside the organisation. Three compliments were posted on NHS Choices. Consistently the Trust receives more compliments than complaints about the services it provides. During Quarter 3 the Trust received almost 10 times more compliments than complaints.

Graph 1 Compliments received for each SBU



Most compliments generally refer to good or excellent care. During Q3 310 compliments mentioned that staff were helpful or helped them and 124 that staff were caring. All compliments received by the PALS team are recorded and assessed for reference to the Trust Values. Graph 2 shows the number of references to the Values. Consistently staff are being complimented on being kind and professional. A selection of comments is also provided below.

Graph 2 Compliments mentioning Trust Values



They are very positive about helping me. I'm happy I have people who care. *(Forest House Adolescent Unit)*

> Everyone is always polite, the building has a great atmosphere, and coming here has helped me a lot more than other places I've been to. *(Dacorum Wellbeing)*

I have had excellent care throughout my time with the community services. Staff were very considerate, attentive and helpful. I am so truly grateful to the team at Waverley Road for all their kind help. At a time where I felt incredibly vulnerable, CP and JG gave me security, support and hope for my future. I will be forever grateful for their kind, considerate, and friendly manners *(NW Support and Treatment Team St Albans).*

> Thank you all so much for all the help and support I have received from all you at ADTU. I started here with a new journey not knowing what was happening but I leave here with a new outlook on life and many new experiences. There are no words which will ever say thank you enough for all you have done for myself and my family, as you have given them their daughter, wife, sister and mother back do an amazing job. Thank you. *(ADTU West)*

3. Having Your Say and Trust Values

All Having Your Say (HYS) surveys have the questions broken down into sections by Trust values. Based on the results of each question a satisfaction score is calculated for each Trust value.

Table 2: % satisfaction scores for Trust values

Value	Q4 16/17	Q1 17/18	Q2 2017-18	Q3 2017-18	Total
Respectful	86%	88%	91%	92%	**92%**
Welcoming	89%	89%	90%	92%	**91%**
Professional	79%	76%	76%	78%	**78%**
Kind	81%	77%	81%	82%	**79%**
Positive	95%	91%	89%	95%	**91%**

Examples of positive comments referring to Trust values, made by service users are shown below: -

"Teresa's interaction with mum was supportive, caring and very respectful."
"Staff were very helpful and welcoming."
"All the staff in Aston Ward were very professional and caring…"
"This service has been so helpful with my daughter; they are very kind and compassionate."
"I found the experience very helpful and positive and not too difficult to cope with…"

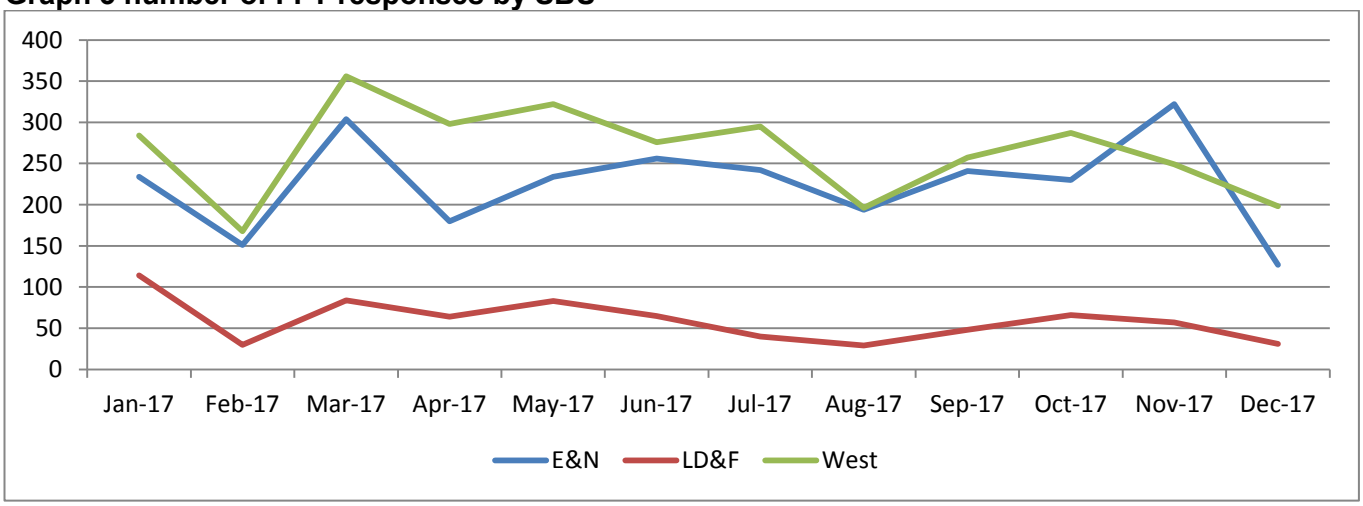
Friends & Family Test (FFT)

Table 3: FFT scores for each quarter

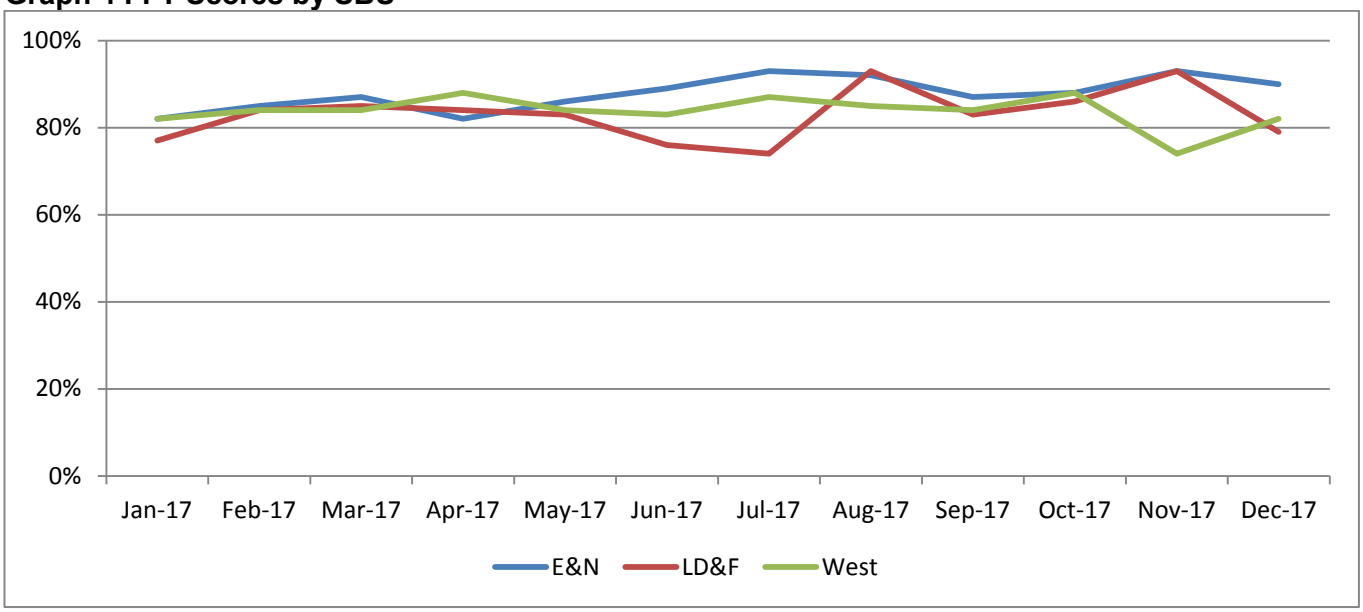
	Q4 2016-17	Q1 2017/18	Q2 2017-18	Q3 2017-18	Total
FFT would recommend	86%	85%	88%	86%	**88%**
FFT would not recommend	7%	6%	5%	5%	**5%**

The Friends & Family Test satisfaction score for the quarter was 86%. Service users who said they would not recommend our services scored 5%.

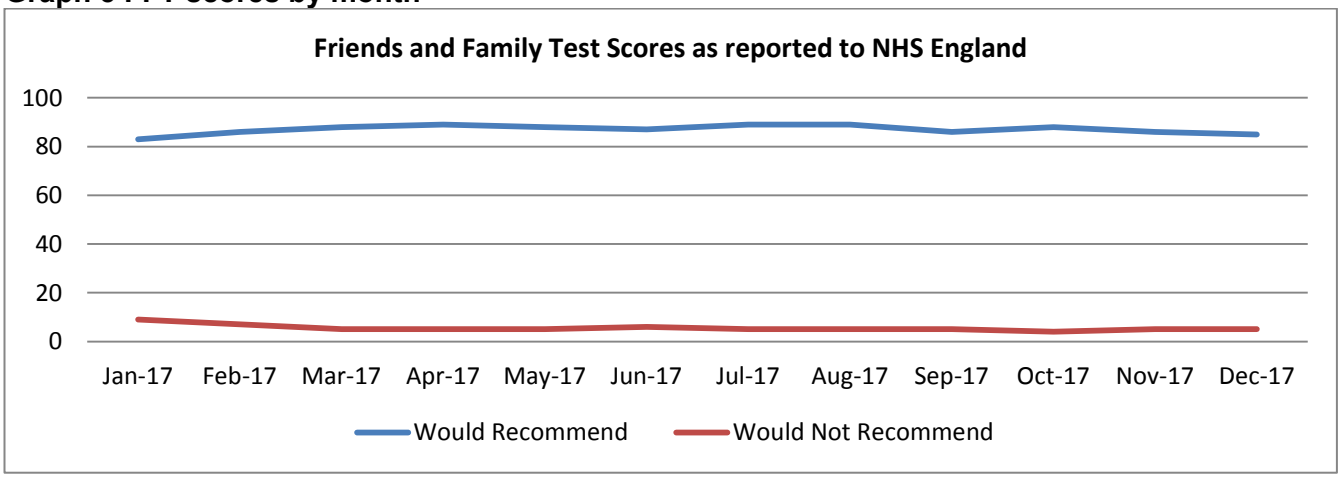
Graph 3 number of FFT responses by SBU



Graph 4 FFT Scores by SBU



Graph 5 FFT scores by month



4. Stories to the Trust Board

The purpose of the presentations is to ensure that the Board and Governors have a chance to hear the service user and/or carer experience of services first hand and also to learn more about the issues and practice from the services themselves, as this enables the Board and Council to triangulate this information with the reports and data they receive at meetings.

They have helped the Board members, particularly the Non-executive Directors, to gain a real understanding of the services we deliver and the impact we have on people's lives.

Following the presentations the Chair sends a letter to the individual involved, which references any action agreed at the meeting and how this will be reviewed. A quarterly update on the Board Stories and outcomes is given to the Inclusion and Experience Group and reported onwards to the Quality and Risk Management Committee. This reporting structure exists to ensure that service user and carer involvement is happening effectively across the organisation and that the Trust understands service user and carer experience, both in terms of strategic development and delivery of operational services in order to ensure a continual improvement in quality.

Date & Service	Issues raised by service user/carer	Outcomes
19-10-17 CAMHS	• Confusing "tiers" and "steps" in CAMHS service, unhelpful to families. • More collaborative – joined up working between services.	• Agreement from Board that terminology can be confusing, to be reviewed. In process
16-11-17 Wellbeing Service	• No option for face to face initial assessment. • Electronic literature was not preferred style • The out of hours helpline was not particularly helpful. • The effects of retirement on your mental health – could HPFT provide more support?	• Service user agreed to join the SPA Reference Group to give advice about the helpline. • HPFT to consider re-starting "Keeping Well in Retirement" workshops.
29-11-17 Older Peoples' Services	• GPs need better understanding about mental health and the need for early referral. • Involving specialists at an early stage. • Supporting carers.	• Exec talked about working with primary care and providing more information for GPs about mental health.

5. Having Your Say

The Trust received 1,567 pieces of feedback under the "Having Your Say" umbrella during Quarter 3 2017/18 showing an increase of 2% compared to the previous quarter.

Table 5: Overview of data received in Q3 compared to previous three quarters

	Q4 2016-17	Q1 2017/18	Q2 2017-18	Q3 2017-18	Total 2017/18
Service User Feedback Surveys completed	1458	1406	1175	1247	**5286**
Carer Feedback Surveys completed	297	358	367	320	**1342**

This quarter the Service Experience Team began a review of the HYS community survey, following the success of last year's inpatient review, a process that is fully co-produced. The new survey will be used from 1 April 2018.

The team has also been shortlisted for a Patient Experience Network National Award (PENNA) for the inpatient review.

6.1 Trends

This quarter we are able to see increases in the satisfaction scores for 8 teams. Having provided actions based on HYS results in Q1 we can track progress of feedback through HYS with the results seen below. These actions are displayed on the Quality Improvement website and in the SBU Sharing Good Practice newsletters. The table below lists actions showing a significant increase in satisfaction in Q2 compared to Q1.

Table 6 Summary of actions taken in response to HYS feedback showing significant increase in satisfaction

Team	*Q2 Scores*	*Q3 We Did…*	*Increase in Satisfaction*
Robin Ward	89% Kind and caring	**1. Review the activities on the ward and base it on needs.** A new activity plan has been put in place by the recreational worker and there are increased activities provided by the Occupational Therapist. **2. We will ensure that your physical health needs are met.** The team continues to do weekly observations in addition to the junior doctors observations. **3. Staff will plan 1:1 sessions with you.** There are now more 1:1 sessions happening on the ward. The team leader is also discussing feedback at team meetings to see what further improvements can be made..	**12%**
Stevenage CAMHS Clinic	70% FFT	**1. Aim to improve your experience by making CAMHS feel more welcoming.** • The team leader spoke to the manager of the homeless shelter next door as young people had told us they felt intimidated by people hanging around the entrance. • Email circulated to staff about not smoking on site as people were congregating around the entrance for cigarette breaks. • We are being more flexible when offering appointments. **2. Aim to make changes based on what you tell us including improving ventilation in the waiting room during the summer months.** Unfortunately we will not be able to install air conditioning but the team leader is exploring the options of purchasing fans.	**17%**

6.2 **Comments from HYS and FFT**

In Quarter 3, 2017-18 we received over 1,300 comments. Teams use these free text comments together with the quantitative data to produce their "you said, we did" action posters.

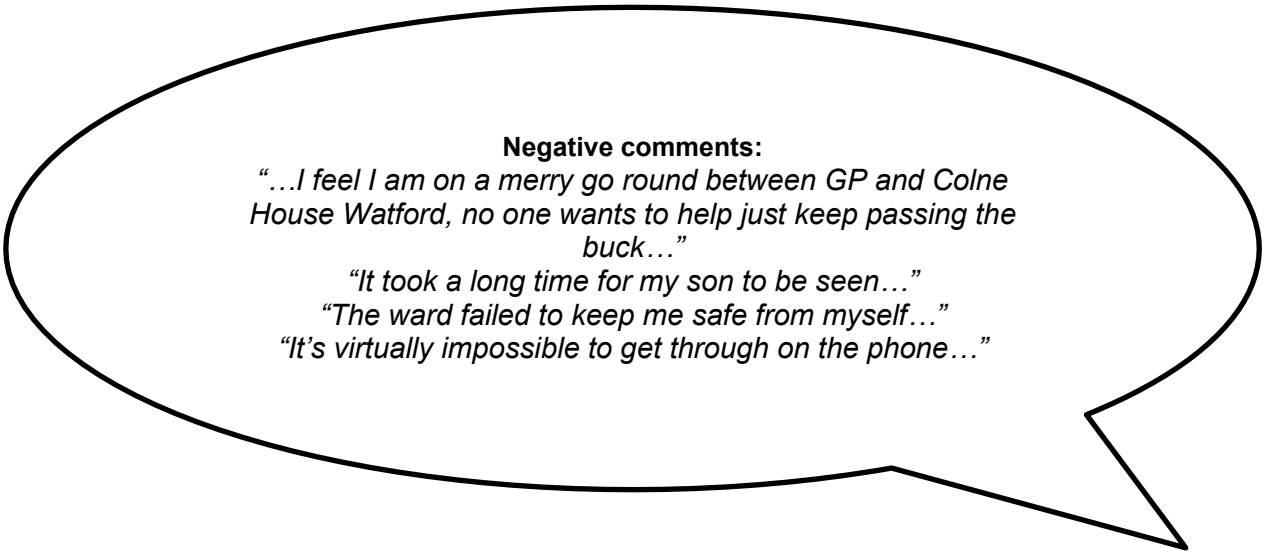
Positive comments:

"The lady who came to visit me really took time to evaluate my condition. She was very helpful."

"Excellent, timely care."

"I visited Kingsley Green to see a friend, WOW sure has changed for the better."

"A team of excellent, kind people, kind people that care about ill people."



6.3 Wellbeing patient experience questionnaire (PEQ) report

255 Patient Experience Questionnaires (PEQs) were returned. Compared to the last quarter, the PEQ return rate has increased in the West (Q2 - 10%, Q3 - 12%) and reduced in the NE (Q2 - 10%, Q3 - 7%), leading to a consistent return rate across the county (Q2 - 10%, Q3 - 10%).

Client satisfaction remains high within the Wellbeing Service. This is in line with previous PEQ results from 2016/17. During Q3, satisfaction was highest for client perception of the listening skills of their therapist (95% responding that they felt staff listened to them and treated their concerns seriously "at all times"). Satisfaction was higher for understanding of the patients' difficulties than in Q2 (69% responding that they felt the service helped them to better understand and address their difficulties "at all times"). Across the 5 questions the "rarely" and "never" response was used only 6 times (2%). However, data and learning statements should be interpreted with caution given the low return rates for the PEQ.

7. PALS (including contact through NHS Choices and HPFT App)

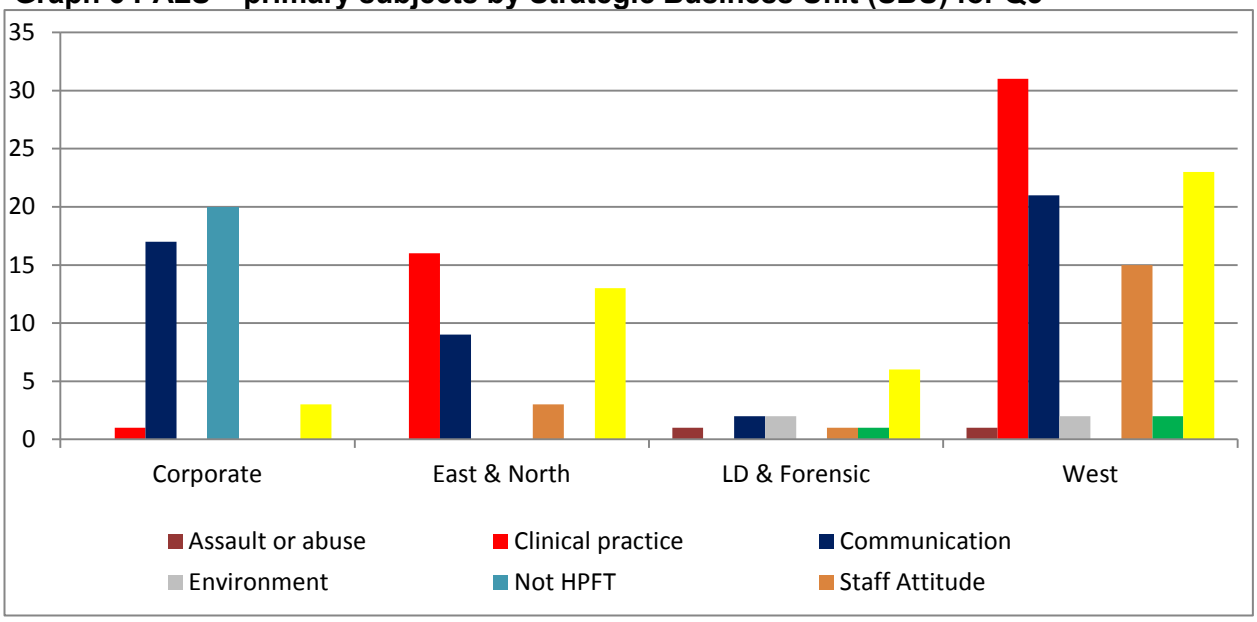
Table 7: PALS contacts received in the last 12 months

	Q4 2016/17	Q1 2016/17	Q2 2017/18	Q3 2017/18	Total 2017/18
PALS contacts received	214	217	219	190	**626**

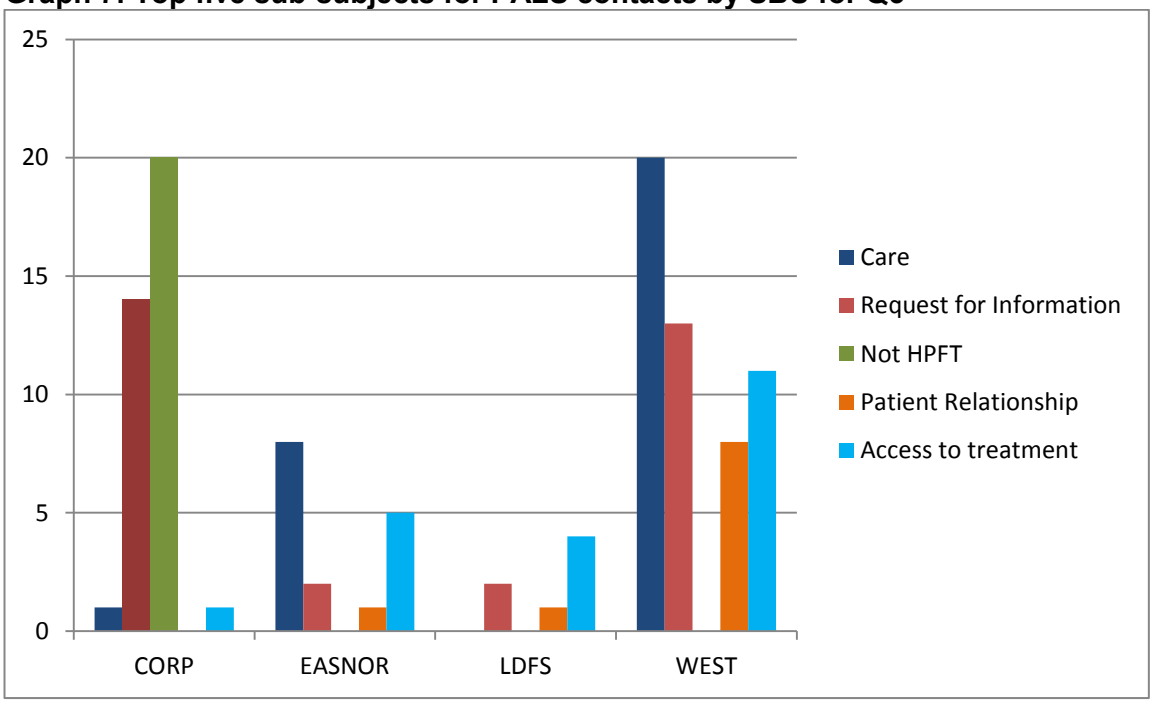
There were 190 Patient Advice and Liaison Service (PALS) contacts during the quarter, a 13% drop compared to Q2. These include contacts direct to the Trust through the PALS and Complaints team, Having Your Say forms, NHS Choices and external organisations.

The issues raised are shown in graph 6. 20 contacts were not about HPFT services and were referred on to the correct organisation. 63 contacts were informal complaints, 16 were issues for resolution, 34 provided feedback on services, 40 were enquiries and 15 requested advice/information, there was 1 request for access to records and 1 from a staff member which was referred to HR.

Graph 6 PALS – primary subjects by Strategic Business Unit (SBU) for Q3



Graph 7: Top five sub-subjects for PALS contacts by SBU for Q3



The top five sub-subjects were requests for information (31 contacts), care (29 contacts), access to treatment (21 contacts) Non-HPFT (20 contacts) and service user relationship (10 contacts). Any queries or issues related to HPFT services, are passed to the relevant team leader (copied to the managing director and service line lead) to provide the necessary information or to try to resolve concerns locally.

Negative feedback received through NHS Choices and Care Opinion is recorded as PALS contacts because it is anonymous. There were 8 negative postings; 4 were about South West Wellbeing Services (and 1 each were about Community Services at St Pauls Community Services, Waverley Road and Cygnet House and 1 was about the Mental Health Helpline. When NHS Choices posts a comment about the Trust, the comment is forwarded to the relevant Managing Director and Service Line Lead so appropriate action can be taken and, if the person can be identified, contact is made with the individual. Otherwise we respond by advising the individual to contact the PALS and Complaints team to enable the Trust to investigate the matter further.

6. Complaints

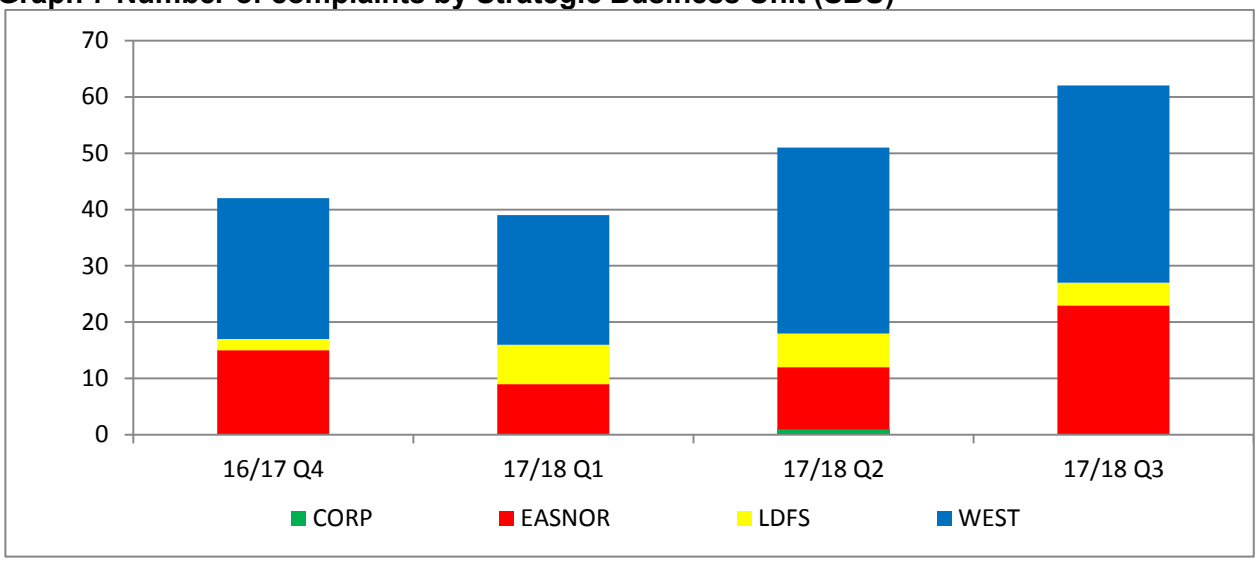
The Trust received 62 complaints in Q3 compared to 49 in Q2. E&N Herts SBU saw the biggest increase across the trust and of these a number related to E&SE community services. The reasons and themes within these complaints is subject to a review by the business unit.

Acknowledgement within 3 days, as required by the Regulations, was 94% in Q3 compared to 98% for Q2. The Trust ambition is for 100% of all complaints to be acknowledged within 3 days throughout the year. The first response rate figures will be available after 5 February 2018.

Table 8: Complaints and acknowledgement and response rates for 2016/17

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Total 2017/18
Complaints received	42	39	49	62	**194**
% of complaints acknowledged within 3 working days	98%	100%	98%	94%	**97%**
% of complaints with a first response within 25 working days (90% target)	89%	83%	86%	85% - Awaiting Validation	**Awaiting Validation**

Graph 7 Number of complaints by Strategic Business Unit (SBU)



East & North SBU received 23 complaints in Q3 compared to 11 in Q2. 14 of the complaints related to East and South East adult community mental health services; 1 complaint was about older people's community services, and CAMHS had 8 complaints during Q3. One complaint was graded moderate* (see appendix for more information)

LD & Forensic SBU received 4 complaints during the quarter compared to 6 complaints received in Q2. 1 was about Hertfordshire LD Forensic Services, 1 about Hertfordshire Community Assessment and Treatment Service and 2 about Essex IAPT Services.

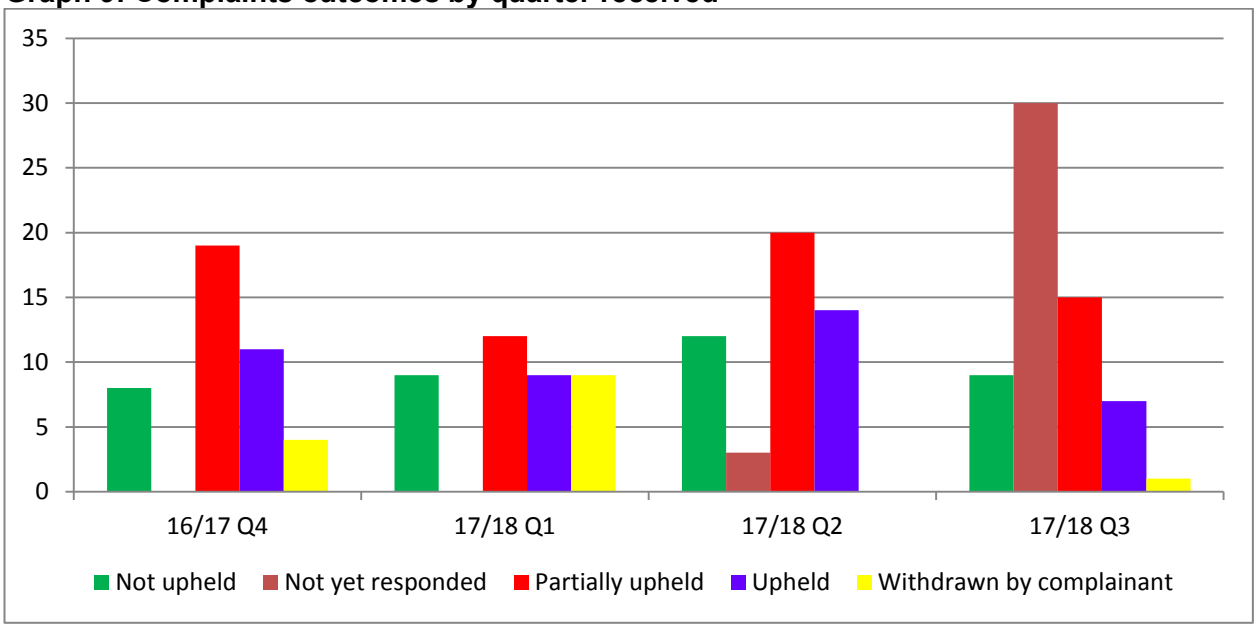
West SBU received 35 complaints this quarter compared to 32 complaints in Q2. 12 of the complaints were about inpatient services with 6 about Swift ward, 3 about Albany Lodge, 2 about Aston ward and one about Robin ward. There were 2 complaints about RAID, 1 complaint about CATT and 1 about ADTU. There were 16 complaints about adult community services with 9 complaints about South West Community Services and 7 about North West Community Services. There was 1 complaint about the Adult Community Eating Disorder Service and 2 complaints about Hertfordshire Wellbeing Services. Complaints are discussed at the relevant Quality and Risk and Practice Governance meetings where they are reviewed to identify trends and to determine what specific actions may be required. Three complaints were graded as moderate* (see appendix for more detail)

Corporate
There were no complaints about corporate services in Q3.

Main themes
The primary issue for 31 complaints was clinical practice (16 about care, 4 about assessment and treatment, 4 about diagnosis, 3 about care planning, 2 about failure to act, and 1 each about administration of drugs and failure to follow procedures).
There were 16 complaints about systems and procedures (6 about access to treatment, 3 about breaches of confidentiality, 2 about discharge and 1 each Mental Health Act detention, record keeping, non-referral and continuity of care).

Outcomes
Graph 9 shows the outcome of complaints for Q2 compared to the previous 3 quarters. The majority of complaints are fully or partly upheld. 11 complaints are awaiting a final response.

Graph 9: Complaints outcomes by quarter received



8.1 Learning from Feedback through PALS, Complaints and HYS
The following learning has taken place, or is planned to take place, in relation to complaints received this quarter.

Most of the complaints that were upheld or partially upheld related to individual service users and individual members of staff, with no clear pattern related to a particular service.

Volunteers in Community Hubs
As part of our commitment to improving the responsiveness of our services, we are introducing volunteers to all of our hubs to support with meeting and greeting of services uses, as well as helping to gather feedback from service users and carers. This has been piloted in St Albans and shown a significant increase in the quality of feedback. We will be introducing volunteers to our largest hubs by end of January 2018 (Saffron, Colne, Rosanne, Waverley, and St Paul's). Other hubs will follow in the coming months.

Reception and front of house staff
Over the last year we have been working with staff, service users and carers to identify how we can enhance the experience of working and visiting the community hubs.

Short term:

- Inconsistency of reading matter within the reception areas: A magazine subscription scheme has been introduced which delivers a variety of magazines to appeal to a wide range of tastes.
- Reception ambiance: At the suggestion of service user and carer groups, fish tanks have been installed in the bigger hubs to create a calmer and more relaxed environment. These have generated significant positive feedback.
- Call handling: As a pilot we have introduced a dedicated telephonist to pick up all the calls for one of the busiest adult teams in order to provide a consistent and more positive experience for callers. This will be reviewed in the spring.

Medium term

- Receptionist uniforms: A suggestion by some front of house staff. Uniforms that properly reflect this important role are being introduced with a positive response from both staff and visitors.
- Refurbishment of Saffron Ground reception: Following comments about the poor seating arrangements and general ambiance of the area, a better layout has been designed. Work should begin in the spring.

Long term

- WiFi in reception areas: At the request of service users we are working with the combined IT team to implement WiFi access, with the hope that there will be progress by the spring.
- Information in the television loops in reception: Request for information to be relevant to the local area as well as useful information about wellbeing. Slots should be paced so they can be read and be varied enough to engage and interest whilst waiting for appointments. This will be looked at further in 2018.

Service user property on wards

Following a number of complaints about property going missing on the ward, a number of changes have been made to the way property is recorded. On Swift ward property is being photographed as well as being recorded on the property / valuables lists to enable better identification of items should they go missing. Staff on all wards have been reminded to ensure that property is properly recorded both into and out of the wards to ensure that it is tracked appropriately. This is especially important when a service user moves between wards. Service users are encouraged to bring as few valuables, such as jewellery, electronic goods, expensive clothing, as possible.

A barcoding system for service user property is also going through procurement to further strengthen the logging and identification of service user property.

7. Ombudsmen requests

9.1 Files requested

The Trust received no for complaints files from the Parliamentary and Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) or the Ombudsmen's Joint Working Team (JWT).

9.2 PHSO/LGO decisions returned

The Trust received 2 Ombudsmen's decisions in Q3.

Table 10: summary of decisions returned by the Ombudsmen

Service	Background and detail of learning	Ombudsman decision
CAMHS community Services C2863	The mother of a service user complained about the level of care and support provided. The Trust responded to the ongoing complaints but was unable to resolve them to the complainant's satisfaction. The Ombudsmen's Joint Working Team (JWT) decided to investigate the complaints which were about 5 different organisations in the hope that this would bring closure to all involved.	**Not upheld** No further action for the Trust
Adult Community Services C2754	The mother of a service user complained about the care and treatment she and her daughter had received from the Trust during the service user's admission to a specialist out of county unit. She complained of poor communication, that her request for a change of coordinator for her daughter was not addressed and the Trust failed to offer her a carer's assessment	**Not upheld** No further action for the Trust because whilst it was clear that the Trust's action had caused the family distress, the ombudsman was satisfied that following the complaint the Trust took appropriate action to put things right.

8. Complaints Training

At the end of Quarter 3 93% of staff had completed their mandatory complaints E-learning. This is the same as for Q2. During the quarter a half day training session on investigating and responding to complaints was provided to 6 members of staff.

Benchmarking

The Trust seeks feedback from complainants using an electronic survey within the HYS feedback umbrella. Where we have an email address we send the invitation and link by email, otherwise we send an invitation by post with the link. We also inform complainants that we can send them a questionnaire by post if they prefer.

In Quarter 3 no questionnaires were returned

The Trust continues to work with the Patient's Association to review its procedures and determine what changes we need to make in order to improve service user/carer experience of the complaints process with training due to take place in Q4.

Appendix 1

Overview of complaints received
During quarter 2 a total of 62 complaints were received, 60 of which were about Hertfordshire services.

6 complaints were graded as moderate risk with more detail provided in the table below.

Adult community services
30 complaints: 22 were about the Support and Treatment Teams (12 for West and 10 about East & North SBUs). 2 were graded as moderate.

The primary issue for 12 complaints was clinical practice, with 5 about systems and procedures, 4 about staff attitude and 1 about poor communication. 2 complaints were upheld, 6 partially upheld, 2 not upheld, 1 was withdrawn by the complainant and 11 are under investigation

4 were about Targeted Treatment Teams (3 about West and 1 about East & North SBU).

The primary issue for 3 complaints was clinical practice, with 1 about systems and procedures. 2 complaints were not upheld, and 2 are under investigation.

4 complaints were about Initial Assessment Teams (1 about West SBU and 3 about East & North SBU. The primary subject for 3 was clinical practice and the fourth was systems and procedures. 2 were partially upheld, 1 was not upheld and 1 is under investigation

Adult Community Eating Disorder Service
2 complaints:
- The parents of a service user complained that she was not being admitted for treatment. **Not upheld**
- A service user's mother complained about the attitude of two members of staff. **Not upheld**

Acute Adult Inpatient Services
12 complaints with 3 about Albany Lodge, 2 about Aston ward, 1 about Robin ward, 6 about Swift ward.
- Albany Lodge 1 – complaint about missing belongings. **Under investigation**
- Albany Lodge 2 – complaint about the way the service user was discharged from the ward and their subsequent care. **Under investigation**
- Albany Lodge 3 – Complaint about the care and treatment on the ward. **Under investigation**
- Aston ward 1 – A service user complained about staff attitude and care. **Under investigation**
- Aston ward 2 – A service user's mother complained about care on the ward. **Under investigation**
- Robin ward 1 – A service user's relative raised concerns about her care and access to physical health services. **Not upheld**
- Swift ward 1 – a service user complained about being detained under the Mental Health Act. **Under investigation**
- Swift ward 2 – A service user's relative complained about a service user's care on Swift and Aston wards and in the community. **Under investigation**
- Swift ward 3 – a service user's relatives complained about poor discharge planning and lack of appropriate support on discharge. **Upheld**
- Swift ward 4 – a service user's belongings were mislaid. **Upheld**
- Swift ward 5 – a service user's mother complained that he was discharged prematurely. Graded Moderate (see below). **Under investigation**
- Swift ward 6 – A service user's father complained about her overall care and discharge. Closed for consent. **Under investigation**

Crisis Services
There were 4 complaints about Crisis Services, 2 about RAID, 1 about CATT and 1 about ADTU

- ADTU – Breach of confidentiality. Complaint suspended as service user very unwell. **Not yet responded**
- CATT – A service user's partner complained about the lack of support from CATT. **Upheld**
- RAID 1 – A service user's son complained about diagnosis, care and lack of communication. **Partially upheld**
- RAID 2 – A service user's mother complained about the way a consultant spoke to the service user and stopped her involvement in a therapy group she was attending. **Under investigation**

Single Point of Access (SPA)/Mental Health Helpline
No complaints during Q3

Wellbeing
2 complaints.
- 1 - Poor communication while staff member was off. **Upheld**
- 2 – Parent of service user with special needs complained about lack of access to treatment. **Upheld**

Older Peoples Services
1 complaint about Older people's community services following death of service user – Mortality Group review undertaken Primary subject: Clinical Practice. **Partially upheld** due to poor communication with family members. Meeting being arranged with complainant.

CAMHS
Eight complaints
- CAMHS S 1 – a service user's parent complained about the attitude of the clinician towards the service user. **Under investigation**
- CAMHS S 2 - Joint complaint about three organisations. Primary subject for HPFT was Clinical practice. **Not upheld**
- CAMHS East 1 – A service user's mother complained that the service user is not getting the help or diagnosis she needs. **Under investigation**
- CAMHS East 2 – Mother of service user unhappy that she had been discharged and referred to another service. **Not upheld**
- CAMHS North – The parents of a young person complained about poor communication between professionals from different organisations. **Not upheld**
- CAMHS North West - Continuity of care. **Partially upheld**
- CAMHS CATT - Communication breakdown with relatives
- Forest House – A service user complained about a staff member's attitude **Not upheld**

Learning Disability and Forensic Services
1 complaint about medium secure services – The primary subject was clinical practice. **Under investigation and graded as moderate** (see below)
1 complaint about the Community Assessment and Treatment Service. The primary subject was about clinical practice. **Partially upheld**
2 complaints about Essex IAPT services. Primary subjects in each case were access to treatment. **Both partially upheld**

Moderate graded complaints

Table 10: Summary of High and Moderate* Risk complaints for Q2 2017/18

Service	Description	Outcome
Moderate		
Adult Community Services C3176	A service user's ex-partner complained that Complaint about Sus death having been left by staff attending his property after finding out he had taken an overdose	**Under investigation** Serious incident investigation owned by Ambulance Service – HPFT has been involved in the investigation. Mortality Governance Group review undertaken
Adult Community Services C3191	A service user's mother complained about the care and support being provided to her son who has autism.	**Under investigation** Safeguarding involved
Acute Inpatient Services C3179	A service user's mother complained that her son was discharged despite her explaining to the consultant that her son called her to say he intended to take his life when he is discharged and that he will be homeless. Mother was very concerned as her son was missing.	**Not yet responded** Under investigation (service user is currently under the care of Kent MH services)
Acute Inpatient Services C3147	A service user's mother complained about her daughter's care / failed suicide attempt / 1:1 nursing care whilst at L&D Hospital and service user's bed on Aston Ward being given to another patient.	**Not yet responded** Under investigation
Medium Secure Services C3184	A service user's mother complained about the service user's welfare, in particular that he was being threatened and beaten up by other service users on the unit.	**Under investigation** Safeguarding involved
Older People's Community Services C3161	A service user's son raised concerns about his mother's care. She did not take her medication, was not able to prepare food for herself, was unable to use toilet facilities unassisted and was unable to look after herself or her home properly. It was recommended that she be taken into care but a consultant decided this was not necessary as she appeared to be taking her medication and allowing carer to attend to her needs.	**This incident was subject to a desk top review by the Mortality Governance Group.** **Complaint partially upheld** Multi-agency involvement and decision making was appropriate. However, it was felt that if communication with the family had been better they would have understood the rationale behind the decision not to admit at that time. Service user death has been attributed to a stroke.

*On receipt, complaints are risk assessed against a 5x5 matrix, as low, medium and high risk. The rating is reviewed and adjusted, if necessary, once the investigation is complete. High and moderate risk complaints are itemised in this report

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22nd February 2018	**Agenda Item: 13**
Subject:	Finance Report for the period to 28th February 2018	**For Publication:** No
Author:	Sam Garrett, Head of Financial Planning & Reporting	**Approved by:** Paul Ronald, Deputy Director of Finance and Performance Improvement
Presented by:	Keith Loveman, Director of Finance	

Purpose of the report:

To inform the Board of the current financial position the key highlights and risks and the forecast of the likely financial position for the full year.

Action required:

To review the financial position set out in this report, consider whether any additional action is necessary, or any further information or clarification is required.

Summary and recommendations to the Board:

The overall Trust position reported in February is a surplus of £136k, which is behind Plan by £75k (before STF). The overall Trust position year to date (before STF) is a surplus of £1.277m, which is ahead of the Plan by £497k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 1, the highest rating. Key figures are summarised below:

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000
Surplus (Deficit) excluding STF		211	136	780	1,277
Total Pay (including Agency)		12,523	12,357	137,504	134,946
Agency		710*	641	7,815*	8,005
Secondary Commissioning		1,961	2,802**	23,343	27,698**

*NHSI Ceiling (breaching HPFT reduction plan by £234k year to date)
** Secondary Commissioning spend is higher this month due to CAMHs Tier 4 NCM (see below) not reflected in original Plan

There are four main variances within this position:

1. Pay overall is better than Plan by £166k in the month (1.3%), and remains better than Plan for the year to date by £2.6m year to date (1.9%). Agency remains adverse to the NHSI Plan and to the internal reduction plan for the year to date. Further details on pay are provided in the body of the report.
2. Income is better than Plan by £582k, decreasing by c. £200k overall against January; this was expected and was signposted in the last report because January was unusually high due to several backdated amounts. The difference against Plan is partly due to

new income for CAMHs Tier 4 NCM (New Care Models), £391k in February (£1.14m year to date). The main change in the month was a reduction in Education and Training income of c. £140k due to a revised schedule from Health Education England. The position assumes 100% CQUIN for all contracts except Hertfordshire at 90%; for Hertfordshire this figure presents some risk because current projections equate to 86%.

3. Secondary commissioning is adverse to Plan by £841k, a decrease of £127k from January, largely due to the reduced number of days in February. As with income this includes new expenditure for CAMHs Tier 4 NCM, which did not form part of the original Plan, being part year. For February this was £339k (£1.13m year to date). CAMHs NCM has made a deficit of c. £50k, however this is lower than was expected; further details are provided in the body of the report.
4. Other Direct Costs, Overheads and Financing were better than Plan by c. £20k, with very little change from February.

This position remains a favourable one, and it is fully expected that a yearend surplus will be reported and the NHSI control total achieved. However the position remains of concern in terms of the ongoing run rate, due to the following factors:

1. Throughout 2017/18 there have been general increases in spend which though not large in themselves cumulatively have become significant.
2. Although pay remains underspent year to date, there is a pronounced upward trend (see graph at 4a), with recruitment ongoing, and agency costs not sufficiently decreasing (with a reduced NHSI Ceiling from April).
3. Secondary commissioning costs continue to increase with no net CRES achievement in this area due to increasing demand.
4. Risk from the CAMHS Tier 4 NCM service particularly if sufficient staff cannot be recruited to run the revised model and prevent further costly placements.
5. Additional spend is still needed e.g. to drive performance improvement and data quality initiatives, and on Information Technology to support staff.

This position is stated before income from the Sustainability and Transformation Fund (STF); £1.2m for the year to date.

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):

Effective use of resources, in particular to meet the continuing financial requirements of the organisation.

Summary of Implications for:

Finance – achievement of the 2017/18 planned surplus and Use of Resources Rating.

Seen by the following committee(s) on date: Finance & Investment / Integrated Governance / Executive / Remuneration / Board / Audit

1. Background to Financial Plan 2017/18

1.1 The Financial Plan reflects the early settlement of all key contracts. There is a net uplift of 0.1% comprising inflation of 2.1% and efficiencies of 2.0%. Additionally, there has been a £750k reduction in the Hertfordshire Social Care contract. Although there is an overall increase in income, this is in respect of new services, rather than growth for existing ones, with demography from only East and North Hertfordshire CCG of £659k; Herts Valleys have not provided demography in 2017/18. The Trust has to meet the growing pressures both in the level and nature of the demand for services, the challenges in recruiting and retaining staff, and the growing impact of wider systems issues. The national background to this year is one of continued and increasing concern across provider organisations and the system as a whole.

1.2 The CRES level assumed within the Plan is £5.7m, and the NHSI Agency Ceiling is £8.5m, which is c. £1.0m below last year's actual spend. The Plan is summarised in Fig. 1a below:

Fig. 1a Description	2016/17 Plan	2016/17 Actual	2017/18 Plan*
Income	211.4	218.1	221.7
Pay	-136.1	-138	-147.8
Other Direct Costs	-27.8	-31.1	-28.2
Overhead Costs	-36.9	-34.9	-35.6
EBITDA	**10.6**	**14.1**	**10.1**
EBITDA Margin	5.01%	6.44%	4.56%
Financing	-10.0	-9.9	-9.4
Impairment	0.0	-1.6	0.0
Surplus	**0.6**	**2.6**	**0.8**

* This is before any amounts due under the Sustainability and Transformation Fund

2. Performance Summary and Risk Rating

2.1 The overall Trust position reported for February is a surplus of £136k, which is worse than the Plan of £211k surplus by £75k; year to date the position is a surplus of £1.277m, which is ahead of the Plan of £780k by £497k. This position does not include income from the STF (Sustainability and Transformation Fund).

2.2 Whilst this remains a favourable position year to date, and the yearend Plan will be achieved, there has been a deterioration in performance which is of concern in terms of the coming financial year 2018/19. Broadly this is because substantive pay costs have been increasing without agency costs reducing, and secondary commissioning spend continues to increase.

2.3 The four main variances within this position are:

2.3.1 Pay overall better than Plan by £166k

2.3.2 Income better than Plan by £582k (but see further detail re CAMHs NCM)

2.3.3 Secondary commissioning adverse to Plan by £841k (but see further detail re CAMHs NCM)

2.3.4 Other Direct Costs, Overheads and Financing better than Plan by £20k

2.4 Performance against budgets for each section of HPFT is reported below:

E&N	West	LD&F	Support Services	Other	Total
(827)	224	603	297	982	1,277

"Other" relates to Central items which are not part of an SBU or Support Services, such as reserves, depreciation, and PDC.

2.5 The Trust's overall Use of Resources Framework Rating, the UOR, reports as a 1 in the month, the highest level.

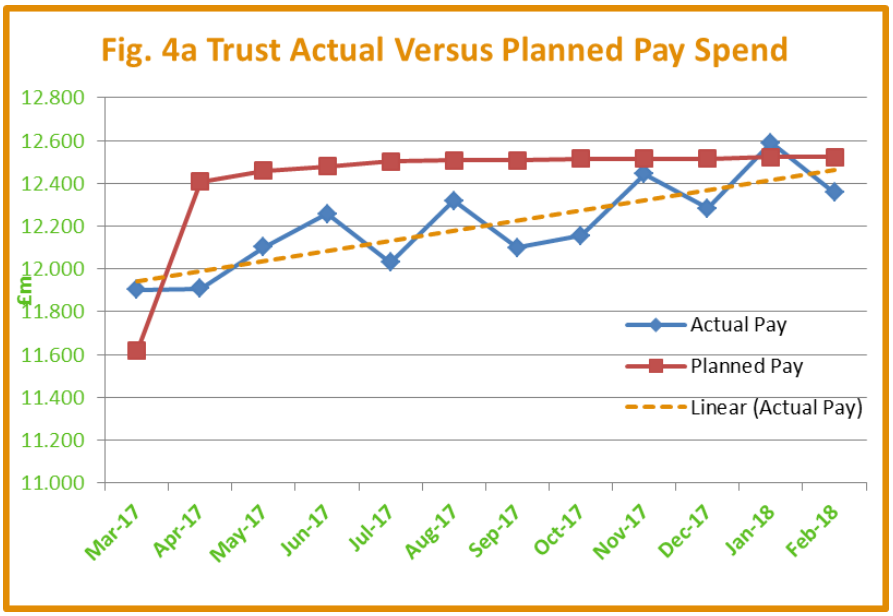
3 Key Financial Risks

3.1 The Finance Team has assessed the current key financial risks for the Trust as follows:

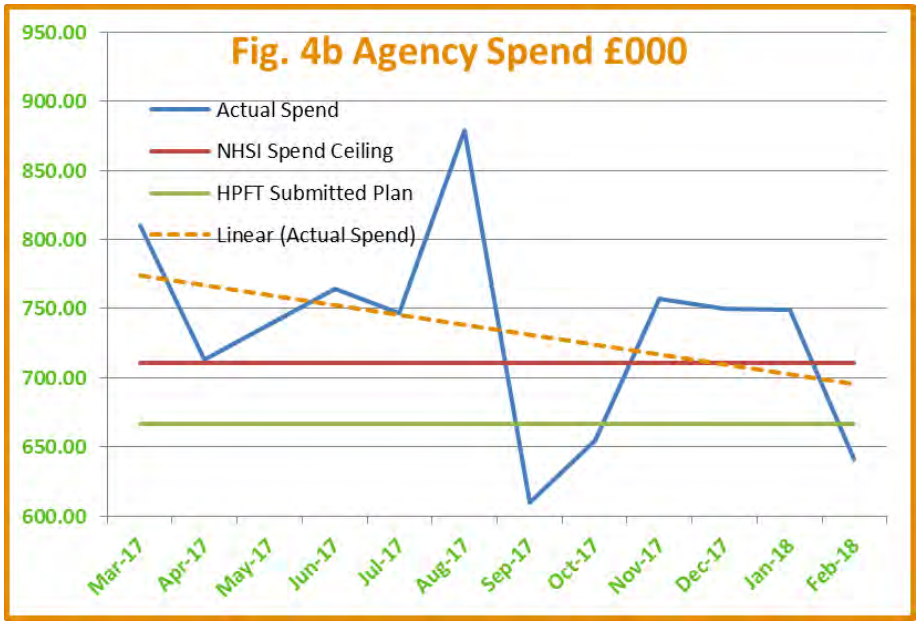
3.1.1 The Trust's new CAMHs Tier 4 NCM service has been set up on the basis that new, specialist community teams will enable young people to stay out of expensive hospital placements. If young people continue to be placed at the same rates, and funding is also spent on the new teams, there could be a shortfall of income over expenditure. For the two months of service to date, income is expected of £1.14m (not taking into account set-up income), and accrued expenditure is £1.23m; this is a shortfall of c. £90k, however at this point a significantly higher shortfall had been planned for. Lower expenditure is though in part due to delays in recruitment, rather than simply a reduction in placements made, so risks do remain.

3.1.2 Work is ongoing in finalising the 2018/19 CRES, however currently there is a shortfall in plans of c.£750k.

4 Trading Position



4.1 Fig. 4a shows the actual against planned pay spend over the last 12 months. Pay Costs totalled £12.4m in February, £166k better than Plan. The dotted trend line shows that overall pay has increased steadily over the 12 months.



4.2 Of the overall total spend in the month, £10.4m (84%) was on Substantive Staff, £641k (5%) on Agency, and £1.3m (11%) on Bank. Fig. 4b shows Agency spend for the last 12 months, alongside the NHSI Spend Ceiling and Agency Reduction Plan. The trend line illustrates that overall there has been some reduction in spend over the last 12 months, though not sufficient to meet the year to date NHSI Ceiling or Internal Plan, which is of particular concern given that there is a further target reduction of c.£1.3m in 2018/19.

4.3 The most significant area of non-pay spend above Plan is Secondary Commissioning, which reports for the month at £2.8m against a Plan of £2.0m; however as stated above £339k was against the new CAMHs Tier 4 NCM contract. This was a reduction in spend from January but this was largely due to the reduced number of days in February. The main increase in spend in month was due to backdated MHSOP CHC placements.

5 Forward Look

5.1 At this point it is fully expected that the Trust's control total will be met at the end of the year. However it should be noted that there are some risks moving forwards:

5.1.1 Pay remains underspent but has increased year to date with the trend is rising.

5.1.2 Secondary commissioning for long-term health placements, social care placements, and social care packages, have not achieved the savings planned for in year.

5.1.3 External PICU and Acute placements have also not yet fully achieved planned savings and activity has increased again during January and February.

5.1.4 There is additional expenditure planned, for instance to drive performance improvement and data quality; develop Information Technology to support staff and to improve catering and cleaning for environments.

5.2 An End of Year forecast has been presented to the FIC setting out the range and expected position including the key areas of uncertainty and related actions.

Current Trading - Income Statement for Period Ended 28-February-2018

APPENDIX F2

Actual in month Feb-17	Actual YTD to 27-Feb-17	Description	2017/18 Plan	Month Feb - 18 Actual	Month Feb - 18 Plan	Month Feb - 18 Variance	Year to Date Feb - 18 Actual	Year to Date Feb - 18 Plan	Year to Date Feb - 18 Variance
28 0	28 0	Number of Calendar Days	365	28	28		334	334	
13,511	150,124	Contract #1 Hertfordshire IHCCT	167,275	14,180	13,940	240	154,095	153,336	759
1,546	17,041	Contract #2 East Anglia LAT	18,377	1,877	1,531	346	17,772	16,846	926
764	8,397	Contract #3 North Essex (West Essex CCG)	9,530	812	794	18	8,754	8,735	19
172	1,781	Contract #4 Norfolk (Astley Court)	2,022	168	169	(0)	1,855	1,854	1
543	6,025	Contract #5 IAPT Essex	6,717	560	560	0	6,119	6,157	(38)
296	1,774	Contract #6 Bucks Chiltern CCG	3,814	316	318	(2)	3,450	3,496	(46)
16,832	185,141	Contracts	207,735	17,914	17,311	602	192,044	190,424	1,621
57	1,060	Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	1,085	105	90	15	1,062	994	67
230	2,417	Education and training revenue	2,610	250	217	33	3,722	2,392	1,330
515	4,166	Misc. other operating revenue	2,658	125	222	(97)	2,024	2,437	(413)
409	4,873	Other - Cost & Volume Contract revenue	5,322	402	444	(42)	4,742	4,879	(137)
119	1,280	Other clinical income from mandatory services	1,736	254	145	110	2,380	1,591	789
78	436	Research and development revenue	572	9	48	(39)	332	525	(193)
(0)	(0)	STF	1,262	147	147	(0)	1,533	1,113	420
(0)	(0)	Other block	(0)	(0)	(0)	(0)	(0)	(0)	(0)
18,241	**199,374**	**Total Operating Income**	**222,980**	**19,206**	**18,624**	**582**	**207,839**	**204,355**	**3,484**
(9,916)	(104,295)	Employee expenses, permanent staff	(127,502)	(10,399)	(10,646)	247	(112,493)	(116,856)	4,364
(1,193)	(13,461)	Employee expenses, bank staff	(14,000)	(1,316)	(1,167)	(150)	(14,448)	(12,833)	(1,615)
(825)	(8,613)	Employee expenses, agency staff	(8,525)	(641)	(710)	69	(8,005)	(7,815)	(190)
(26)	(374)	Clinical supplies	(300)	(20)	(25)	5	(389)	(275)	(113)
(2,233)	(24,927)	Cost of Secondary Commissioning of mandatory services	(25,508)	(2,802)	(1,961)	(841)	(27,698)	(23,343)	(4,356)
(244)	(2,258)	Drugs	(2,378)	(266)	(198)	(68)	(2,723)	(2,180)	(543)
(14,438)	**(153,928)**	**Total Direct Costs**	**(178,214)**	**(15,446)**	**(14,707)**	**(739)**	**(165,756)**	**(163,302)**	**(2,454)**
3,803	45,446	Gross Profit	44,766	3,760	3,916		42,083	41,053	
20.85%	22.79%	Gross Profit Margin	20.08%	19.58%	21.03%		20.25%	20.09%	
		Overheads							
(72)	(751)	Consultancy expense	(15)	(83)	(1)	(82)	(648)	(14)	(634)
(79)	(668)	Education and training expense	(928)	(0)	(77)	77	(32)	(850)	818
(408)	(4,207)	Information & Communication Technology	(4,351)	(431)	(363)	(69)	(4,424)	(3,989)	(435)
(351)	(3,722)	Hard & Soft FM Contract	(3,862)	(326)	(322)	(4)	(3,650)	(3,540)	(110)
(675)	(7,137)	Misc. other Operating expenses	(7,268)	(1,288)	(606)	(682)	(14,737)	(6,662)	(8,075)
(579)	(6,654)	Other Contracts	(6,621)	(30)	(549)	519	(243)	(6,071)	5,828
(55)	(594)	Non-clinical supplies	(495)	(64)	(41)	(23)	(577)	(454)	(123)
(245)	(2,586)	Rents	(2,891)	(259)	(241)	(18)	(2,686)	(2,650)	(36)
245	(4,020)	Reserves	(3,546)	(0)	(295)	295	(1,000)	(3,250)	2,250
(271)	(3,150)	Travel, Subsistence & other Transport Services	(3,359)	(316)	(281)	(35)	(3,319)	(3,079)	(241)
(2,491)	**(33,489)**	**Total overhead expenses**	**(33,335)**	**(2,797)**	**(2,776)**	**(21)**	**(31,316)**	**(30,559)**	**(757)**
1,312	**11,957**	**EBITDA**	**11,431**	**963**	**1,140**	**(177)**	**10,767**	**10,494**	**273**
7.19%	6.00%	EBITDA Margin	5.12%	5.01%	6.11%		5.18%	5.13%	
(436)	(4,767)	Depreciation and Amortisation	(5,475)	(405)	(456)	51	(4,503)	(5,019)	516
(31)	(373)	Other Finance Costs inc Leases	(469)	(33)	(39)	6	(391)	(430)	39
(0)	(0)	Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(0)	(0)	(0)
6	96	Interest Income	105	18	9	9	122	96	26
(348)	(3,832)	PDC dividend expense	(3,544)	(260)	(295)	36	(3,185)	(3,249)	63
503	**3,081**	**Net Surplus / (Deficit)**	**2,048**	**283**	**358**	**(75)**	**2,810**	**1,893**	**917**
2.76%	**1.55%**	**Net Surplus margin**	**0.92%**	**1.47%**	**1.92%**		**1.35%**	**0.93%**	
		Net Surplus / (Deficit) before STF	**786**	**136**	**211**	**(75)**	**1,277**	**780**	**497**

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22 March 2018	**Agenda Item: 14**
Subject:	Annual Plan 2018-19	**For Publication:** No
Author:	Karen Taylor – Executive Director Integration & Strategy	**Approved by:** Karen Taylor – Executive Director Integration & Strategy
Presented by:	Karen Taylor – Executive Director Integration & Strategy	

Purpose of the report:

To update the Trust Board on the development of the Annual Plan for 2018/19

Action required:

Review and discuss the contents of this paper and approve the Annual Plan priorities.

Summary and recommendations

This is the third year of our 'Good to Great' journey. Our Annual Plan priorities reflect the national 'must do's', the ambitions of the Sustainable Transformation partnership(s) in which we operate, local commissioning intentions, together with our own ambitions and priorities agreed through the development of our Good to Great Strategy with our staff, service users and other stakeholders.

Our annual plan reflects the priorities identified within our draft NHSI operating plan. The final operating plan including the financial and activity plan will be approved by the Board prior to submission. Our final Annual Plan therefore will contain detailed actions and outcomes which will reflect;

- The conclusion of contract negotiations
- Any feedback from NHSI on our draft operating plan
- Our final CRES plans
- Our Quality account priorities
- Together with other priorities from key implementation plans (e.g. Workforce & OD plan; Physical Health plan; Quality & Service Development plan for 2018/19)

The priorities have been reviewed and informed by discussions with our Council of Governors; and their feedback will also be reflected in the detailed actions beneath those priorities. At the same time, corporate department and Strategic Business Unit annual plans are under development and will be reviewed through our 'PRM' – Performance Review Meetings – scheduled for April.

The Trust Board is asked to approve the Annual Plan priorities.

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):

The Annual Plan describes the activities the Trust will deliver in 2018/19 and is aligned with both the Trust's Good to Great Strategy and its Commercial Strategy

Summary of Financial, IT, Staffing & Legal Implications:

Financial, IT, staffing implications are all taken into consideration during the planning cycle and form the basis of the financial, workforce and IT plans for the year.

Equality & Diversity (has an Equality Impact Assessment been completed?) and Public & Patient Involvement Implications:

n/a

Evidence for S4BH; NHSLA Standards; Information Governance Standards, Social Care PAF:

n/a

Seen by the following committee(s) on date: Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

Executive Committee on 14 Feb and 14 March, Finance & Investment committee 13 March

DRAFT ANNUAL PLAN 2018-19

1. Background - Good to Great

Our 'Good to Great' Strategy (2016-2021) describes how we are going to deliver our vision of " Delivering Great Care, Achieving Great Outcomes – Together'. Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we will consistently achieve the outcomes that matter to those individuals who use our services, their families and carers by working in partnership with them and others who support them. It also means we keep people safe from avoidable harm, whilst ensuring our care and services are effective, achieve the very best clinical outcomes and support individual recovery outcomes.

Our 'Good to Great' triangle below demonstrates the key areas of focus for the Trust in terms of its people, organisation, partnerships and focus on the three domains of quality – experience, effectiveness and safety.

Through providing consistently high quality, joined up care, support and treatment that empowers individuals to manage their mental and physical wellbeing we will achieve our mission - 'We help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well'.

2. Strategic Objectives 2016-2021

The Trust has a number of strategic objectives. These are as follows:

1. We will provide safe services, so that 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 will feel positively about their experience
3. We will improve the health of our service users through the delivery of effective, evidence based practice
4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care
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)

3. Our Annual Plan for 2018-19

Each year we describe the key actions we will take to further develop our services and to ensure we are able to provide the highest quality care for those individuals with a mental health illness and/or learning disability.

This relentless focus on quality will continue in 2018-19, and includes targeted work to further improve the safety and effectiveness of the care we provide together with improving the overall experience of that care.

We will be doing this through the adoption of best practice, putting in place new models of care, and ensuring we use available technology to support how we work, the way we deliver services and the experience of care. We will be focusing on how we can release more time to care - more time to spend with our service users and carers to deliver the outcomes that matter to them.

We know that great care starts with a great workforce. That is why in 2018-19 our focus will continue to be on supporting our staff, using our collective leadership model to encourage and enable our workforce to make the changes they believe are needed to deliver great care. We also know we need to have the right number of staff with the right skills in the right place. Recruiting to our vacancies, developing new roles and retaining our existing workforce are priorities for the forthcoming year.

This together with our continued commitment to coproduction with our service users, staff and other key stakeholders means we are confident 2018-19 will see the Trust moving forward along its journey to achieve ‘Great Care, Great Outcomes’.

4. Development of the Plan

The 2018/19 plan takes into consideration and reflects:

- The national planning guidance (released on 9 February)
- Local contract discussions and agreements
- Feedback from stakeholders including the Council of Governors, our service users and carers and our commissioners.
- Feedback and discussions with our staff and Senior Leadership Teams
- Sustainable Transformation Partnership (STP) priorities and system changes

5. 2018-19 Priorities

The table below provides an overview of the proposed priorities for 2018-19 mapped against the Strategic Objectives.

Strategic Objective	2018/19 priorities
We will provide safe services, so that people feel safe and are protected from avoidable harm	• We will continue our drive to reduce suicides and prevent avoidable harm • We will ensure our restrictive practices across the Trust are in line with best practice • We will target activities to reduce violence against service users and staff
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 improve the timeliness and experience of accessing our services and subsequent treatment • We will improve the quality and experience of the environment across our services (physical estate, standard of food, cleanliness).
We will improve the health of our service users through the delivery of effective evidence based practice	• We will improve the effectiveness of our interventions through the implementation of evidence based pathways (e.g. psychosis, Personality Disorder, Dementia) • We will develop our organisational approach to research to ensure practice drives research and research drives practice
We will attract, retain and develop people with the right skills and values to deliver consistently great care,	• We will develop new roles across the organisation to ensure we have the right staff in the right place delivering the right care • We will deliver the key high impact recruitment and retention activities (NHSI)

support and treatment	• We will continue to embed our collective leadership approach throughout the organisation
We will improve, innovate and transform our services to provide the most effective, productive and high quality care	• We will improve the use of information and implement new technologies to improve the care we provide and develop the most effective working practices • We will embed our approach to continuous improvement across the organisation
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	• We will develop and deliver new models of care to achieve improved outcomes for our service users • We will mainstream our physical health practices across the Trust
We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	• Our leaders will continue to drive and support the improvement of care and outcomes across the system • We will work across our geographical areas to deliver system wide priorities • We will ensure that mental health and learning disabilities are fully included in the future design of services, including the 'population based' delivery model.

6. Next Steps

A draft operating plan was submitted to NHSI on 8 March. This included our proposed financial and activity plan and key priorities for 2018/19 (reflecting the content of this Annual Plan). The Annual Plan and final operating plan will be approved by the Board prior to final submission (submission due on 30 April 2018).

Against each priority the following are being finalised by the relevant SRO(s)

- What we are going to do (the actions we will take)
- How we are going to do it (the key milestones)
- When we will achieve it by (the timelines)
- The outcomes we will achieve (SMART)

The Annual Plan is cascaded through the organization through the development of Strategic Business Unit Plans and corporate department plans; which are in turn reflected in team plans through to individual PDPs.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22 March 2018	**Agenda Item: 15**
Subject:	Financial Plan for Financial Year 2018/19	**For Publication: No**
Author:	Keith Loveman Director of Finance	**Approved by:** **Keith Loveman**
Presented by:	Keith Loveman	

Purpose of the report:

1. This report sets out for consideration the proposed Financial Plan for the next year. The report follows on from reports presented previously to the Executive Team (20/12/17 & 7/3/18) and Finance & Investment Committee FIC (16/1/18 & 14/3/18) which outlined the key assumptions which were proposed to form the basis of the Plan and the NHSI submission, contract discussions and the further work planned to validate and refine those assumptions.
2. The Financial Plan reflects the draft submission to NHS Improvement as detailed in the financial planning guidance.
3. Following approval, detailed budgets will be distributed to Trust budget managers.

Action required:

- To fully consider the proposed 2017/18 Plan, consider the reasonableness of the assumptions made and whether all relevant matters and related risks are adequately considered and that the responses are appropriate and reasonable.

Summary and recommendations to the Board:

Recommendation

The Board is recommended to:-

- **approve acceptance of the 2018/19 NHSI control total of £2.135 surplus**
- **approve the 2018/19 Financial Plan and distribution of detailed budgets**

The purpose of this paper is to set out for approval the key elements of the Financial Plan for 2018/19.

Whilst NHSI have not required a full planning submission for 2018-19 relying instead on the input from last year's two year plan, it remains important that a new Financial Plan is produced and approved in order to ensure that the Plan:

- remains relevant to the Trusts objectives,
- provides a clear assessment of the key requirements and risks to financial sustainability; and
- remains a key tool to monitor performance.

The starting point for 18/19 financial planning is an understanding of the 17/18 year end forecast. The paper sets out the detail of the forecast, recurrent and non-recurrent items and the underlying

run rate for Q4 17/18. In summary the current forecast for 2017/18 is:

	FY1718 Plan £m	FY1718 Forecast Range £m	Variance from plan £m
Surplus	**0.8**	**1.2**	**0.4**
Reversal of unused provisions/ accruals		2.4 - 3.4	2.4 - 3.4
Unplanned STF expenditure		-1.0	-1.0
Headline surplus before property disposals	**0.8**	**2.6 - 3.6**	**1.8 - 2.8**
Non-recurrent property benefit		7.1	7.1
Likely surplus before STF	**0.8**	**9.7 - 10.7**	**8.9 - 9.9**

At this stage there are a few variables which may impact the 17/18 position and these are set out at 3.3.

2018/19

As advised above whilst FY1718 will see a significant surplus the underlying position before exceptional items will be circa £2.2m of which circa £2m was achieved in the first 6 months.

Therefore the expected normalised position for the current year is:

Description	£m
Forecast surplus	1.2
Add back non recurrent STP contribution in FY1718	1.0
Normalised surplus Forecast	2.2

However, the exit position in Q4 is likely to be circa £0.2 - £0.25m and this will be dependent upon addressing the cost increase in placement costs and the T4 CAMHS plans being implemented as timetabled. **i.e. the Q4 run rate indicates no better than £1m surplus fye and this should be recognised as the true underlying position moving into 2018/19**.

In relation to Regulator targets then for the Plan period:

- The NHSI Control Total target has been set at £360K which is £426K below the 2017/18 figure.
- The Agency spend target has been set at a reduced value of £7.327m compared to this year's Target of £8.525m. The expected spend in 2017/18 is already above this and is forecast at c.£8.8m for the full year.

The indicative CRES requirement has been calculated at £4.7m although this will be subject to change following completion of contract negotiations and actual Q4 underlying performance.

Given the Q4 run rate, the continuing cost increases for pay and placements and the known investment requirements in FY1819 the delivery of the Control Total surplus of £0.36m cannot be automatically assumed and will require a significant reduction against the current level of expenditure, eliminating non-recurrent costs as planned.

The summary financial planning timetable is set out below and will need to support and dovetail with the Annual Planning cycle.

Month	Financial Plan
March	- 8 March Draft submission to NHSI - 13 March Draft to FIC - 22 March Final for sign off at March Board
April	- 30 April Final submission to NHSI

Should feedback from NHSI in relation to the draft paln submission indicate any material changes are required to the financial plan prior to final submission on 30 April, this will be brought back to the Board for consideration.

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):

Detailed on Risk Register, Actual performance compared to plan routinely

Summary of Implications for:

1 Finance- NHSI Risk Ratings, threat to proposed investment programme 2 IT- future investment capacity 3 Staffing- staffing levels, Agenda for change 4 NHS Constitution 5 Carbon Footprint 6 Legal

Equality & Diversity (has an Equality Impact Assessment been completed?) and Public & Patient Involvement Implications:

N/A

Evidence for Essential Standards of Quality and Safety; NHSLA Standards; Information Governance Standards, Social Care PAF:

N/A

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

Executive Team 20 December 2017 Finance & Investment Committee 16 January 2018 Executive Team 7 March 2018 Finance & Investment Committee 13 March 2018

1. Introduction

1.1. The purpose of this paper is to set out for approval the key elements of the Financial Plan for 2018/19.

1.2. Whilst NHSI have not required a full planning submission for 2018-19 relying instead on the input from last year's two year plan, updated guidance was published in mid-February setting out detail for 'Refreshing NHS Plans for 2018/19'. This included additional guidance on new funding announced in the Autumn Statement and revised guidance on control totals and Sustainability & Transformation Funding (STF).

1.3. The revised guidance has required additional detailed financial modelling prior to submission.

1.4. The key internal milestones and NHSI submission dates are:-

Month	Financial Plan
March	- 8 March Draft submission to NHSI - 13 March Draft to FIC - 22 March Final for sign off at March Board
April	- 30 April Final submission to NHSI

2. Background

The financial surplus for the current year will be above the Plan level of £786K (before any adjustment for STF funding). This reflects a combination of the following factors:-

- Income levels have increased over the last two years and are above Plan in 17/18
- Whilst agency costs are above the NHSI Agency target there has been an ongoing reduction in agency costs against last year (c.£0.6m) arising from lower usage and reduced rates.
- There is an ongoing level of vacancies which arise from both the lead time in recruiting to newly created posts and the time in replacing leavers. Whilst the Trust has seen incremental growth in overall payroll, vacancies have tracked at circa 13% for most of the year. Whilst this is partly covered by Bank shifts and agency usage it does not cover all vacancies.
- Bed placement costs have increased overall against 2016/17 levels despite the CRES work in this area and arise from increases in activity and limited access to general needs housing to enable individuals to move on or step down.
- The level of overheads has remained broadly flat and not increased in line with the revenue growth. However, as noted below, this is an area that is likely to see some pressure in 2018/19.
- Financing costs have reduced through tighter fiscal management and the reduced capital programme.

3. 2017/18 Outturn

3.1. The starting point for 18/19 financial planning is an understanding of the 17/18 year end forecast. This section sets out the detail of the forecast, recurrent and non-recurrent items and the underlying run rate during Q4 17/18. In summary the current forecast for 2017/18 is:-

	FY1718 Plan £m	FY1718 Forecast Range £m	Variance from plan £m
Surplus	**0.8**	**1.2**	**0.4**
Reversal of unused provisions/ accruals		2.4 - 3.4	2.4 - 3.4
Unplanned STF expenditure		-1.0	-1.0
Headline surplus before property disposals	**0.8**	**2.6 - 3.6**	**1.8 - 2.8**
Non-recurrent property benefit*		7.1	7.1
Likely surplus before STF	**0.8**	**9.7 - 10.7**	**8.9 - 9.9**

**accounting treatment for this transaction remains subject to discussion with DH & NHSI*

3.2. This likely level of surplus has the advantage of attracting additional STF funding. Realistically however, it can support capital expenditure only.

3.3. ***Key variables***

The main variables at this point which will require attention are:-

- ***Managing the cost base -*** costs have been steadily increasing in recent months both within Pay and placement costs. In month 11 there are further increases in both. Managing placements costs in particular will be an important determinant in the final outturn.
- ***Detailed Plans for the use of the current deferred income -*** the amount at month11 is £3.7m of which £1.4m is historic transformation funding, mainly for MHSOP and £0.9m is historic workforce development funding. The majority of this goes back over 3 years plus so very clear spending plans are required to carry this forward to 2018/19. The only known commitment currently is the recent approved spend on our business intelligence system, SPIKE £0.2m. A number of other significant investments have been proposed in order to deliver against the key strands of our 'Good to Great' strategy and business cases for these are awaited.
- ***Implementation of CAMHS T4 Operating Plan -*** The new CAMHs T4 service commenced in M9. At commencement the service will operate at a planned loss with the investment in a new community team. This cost will be recovered through reducing the current level of external placements.

3.4. Given the above detail where any expenditure plans can be brought forward into the current year then these will accelerate the benefit of the investment, bringing down the surplus in the current year but help the position for next year.

- Ideas identified through the feedback from the recent staff engagement events.
- Replacement of current on line mandatory training system
- Replacement of intranet site
- Bring forward of future PARIS developments
- Bring forward any planned work with Mental Health strategies
- Programme management support for key projects
- Training programme for staff to support innovation/performance improvement work stream
- Organisational Development – Continuous Improvement
- Commercial development – Structure & Bid support
- Innovation & Transformation – capacity
- Operational Services – various non-recurrent schemes and pump-priming

3.5. FY18-19 is the second year of the two year Financial Plan submission made to NHSI. As previously reported, the expected normalised position for the FY17-18 is an underlying surplus of c.£2.2m. As reported above this surplus position is largely achieved in the first half of the year.

Description	£m
Forecast surplus	1.2
Add back non recurrent STP contribution in FY1718	1.0
Normalised surplus Forecast FY1718	2.2

4. Tariff

The national tariff for 2017/18 and 2018/19 was set (excluding HRG specific CNST adjustments) as:

Uplift factors	Weighted average estimate (uplift x weighting)	
	2017/18	2018/19
Pay costs	1.3%	1.3%
Drugs costs	0.2%	0.2%
Other operating costs	0.4%	0.4%
Unallocated CNST	0.0%	0.0%
Capital costs	0.2%	0.2%
Total	**2.1%**	**2.1%**

The efficiency factor for both years is set at 2.0%, resulting in a net 0.1% uplift to prices.

5. 2018/19 Planning Guidance

Key elements of 2018/19 planning are set out in the recent NHSE/I publication 'Refreshing NHS Plans for 2018/19' which restates **'universal adherence to the Mental Health Investment Standard'**.

The headline elements of the guidance in relation to financial planning are summarised as:-

National

An additional £1.4bn, principally to fund emergency activity:

- £600m additional CCG allocations
- Removal of CCG 0.5% 'surplus' requirement for 18/19 = £370m
- Commissioner Sustainability Fund (CSF) = £400m
- CCGs expected to plan against financial control totals - minimum of financial balance with zero deficits
- CQUIN 0.5% risk reserve removed and added to engagement CQUIN, now 1%
- Proposed joint provider/commissioner CQUIN returns

Provider Sustainability Fund (PSF)

- Renamed from STF – transformation 'dropped'
- Additional £650m to PSF, increasing to £2.45bn

Control Totals

- Must improve provider bottom line by £650m – control totals to be revised
- Boards are expected to accept revised control totals or, 'action' under SoF
- Accepting control total means exempt from range of contractual performance sanctions and considered for discretionary capital – little impact on HPFT

Other

- £354m 'extra' capital but not to be assumed in plans
- STP capital contingent on integrated plans
- Two-year National Tariff remains
- Local systems to continue to implement priority efficiencies maximising productivity:
- Model Hospital, GIRFT, procurement, corporate services, workforce, estates
- Digital & technological systems and innovations
- No further detail on lifting of the pay cap

Local

HVCCG – to receive an additional 0.82% allocation uplift = £6.363m. This indicates a further c.£609k available to meet the MH Investment Standard (c.£2.7m potential growth in total (3.71%).

E&NCCG – to receive an additional 0.82% allocation uplift = £5.964m; This indicates a further c.£607k available to meet the MH Investment Standard (c.£2.6m potential growth in total (3.65%).

It should be noted that the MH Investment Standard is across the totality of CCG MH priorities and expenditure and therefore it cannot be assumed that the full allocation uplift would be contracted with the Trust.

6. Control Total

For 2018/19 planning two key financial elements have been revised in line with the expectation that organisations operate within the funding available:

- Control Total
- Agency ceiling

The NHSI control total for the Trust has been set as:

	£m
Original 2018/19 Control Total (including STF)	2.240
Net CNST impact	0.089
Risk Reserve	-0.515
Control Total flexibility	-0.192
Additional PSF	0.513
Revised Control Total (including PSF)	**2.135**
Being:	**£m**
Total PSF	1.775
Surplus (excluding PSF)	0.360
Revised Control Total (including PSF)	**2.135**

The key element to note here is that the target surplus to achieve full PSF allocation has reduced from £978k to £360k. The 2017/18 requirement was £786k.

7. Planning for FY1819

7.1. As advised above whilst FY1718 will see a significant surplus the underlying position before exceptionals will be circa £2.2m of which circa £2m was achieved in the first 6 months. However, the exit position in Q4 is likely to be circa £0.25m and this will be dependent upon addressing the cost increase in placement costs and the T4 CAMHS plans being implemented as timetabled. **i.e. the Q4 run rate indicates no better than £1m surplus fye and this should be recognised as the true underlying position moving into 2018/19**.

7.2. In addition there are some new investments and cost increases that are emerging for 2018/19. These items are in addition to the ongoing issue to address service pressures and operational stretch which is being consistently reported. These additional cost pressures will need formal consideration and evaluation. There is the potential for some of the items below to be b/f to FY1718:

- Additional business development resource for major tenders
- Additional management costs within Innovation & Improvement
- Renewal of PARIS licences with Civica including a level of new functionality
- Substantial increase in Microsoft licence cost
- Likely additional cost with Interserve on existing services
- Additional SBU based staff within data quality/performance
- Operating costs of Hemel hub

7.3. To be clear therefore given the Q4 run rate, the continuing cost creep and the known investment requirements in FY1819 the delivery of the Control Total surplus of £0.36m is not certain and will require a significant reduction against the current level of overall expenditure.

8. Key Assumptions

The following are highlighted:

Area	Assumption	Risks/Mitigations
Income	Net increase in all key contract values of 0.1% with a -2.0% national efficiency requirement and a +2.1 % inflation allowance.	
	For the two Hertfordshire commissioners there is an increase expected above the inflation allowance to reflect the additional CCG allocations which are: HVCCG 3.71% E&N CCG 3.65%	National variation signed but contract value for 18/19 to be finalised. Whilst both CCGs have confirmed an intention to meet this there is further discussion required of the detail.
	In relation to specialised services commissioned through NHS England then there are no specific adjustments to MSU/LSU or perinatal services applied other than the net inflator. CAMHS Tier 4	National variation signed but contract value for 18/19 to be finalised. NHSE have indicated potential reductions to CAMHS T4 funding. The detail of these still needs to be worked

Area	Assumption	Risks/Mitigations
		through.
	In relation to the remaining contracts (Essex Norfolk and Buckinghamshire) there will be no material change in the contract values other than the net tariff increase set out above with changes in service specifications expected to generate similar income levels to current	If level of bed occupancy at Astley Court is at the contract minimum of six this will reduce the current contract contribution level. This is considered low risk. There has been ongoing contract performance issues within Essex over the IAPT contracts
	In relation to HCC there will be no significant income reduction	At this stage HCC have notified the Trust of a £0.3m income reduction in line with the FYE of 17/18 £1m requirement.
	There will be a level of transformation income to be carried forward and available in 18/19 to meet the operational costs related to the continuing healthcare transformation and BI development.	
	A minimum 90% of CQUIN income will be achieved in each year on all contracts	Level of CQUIN in 17/18 likely to be at 85-90% based upon recent assessment. Important that robust monitoring applied in 18/19
	There will be no significant change in the education and training income over the period	Review of any further guidance or publications
New Business	No amounts included	
Lost Business	Potential changes in relation to LD residential accommodation provided at Kingsley Green, with national policy being to close these facilities.	
Pay costs	Average 1.5% increase to all pay points from 1 April 2018.	Costs are provided for at the assumed level
	No planned redundancies	
Non-Pay Costs	2% included for non-pay inflation on some costs i.e. drugs, and utilities	Utility and other property related costs may be higher. Ongoing drug cost inflation may continue.
	The costs for any exceptional continuing care claims over and above the existing provision will be met by commissioners	Current provision considered robust
	Any significant double running costs from the refurbishment of the estate will be met from transformation income c/f	Would be impacted by delays to the transformation programme
Investment	Capital Investment Plans have been updated to reflect addition of seclusion rooms programme	Will review capital programme in the light of affordability
	Investment interest continues to be restricted to deposits with the Government Banking system	

9. Key Risks

9.1. Given the current financial and performance challenges across the NHS and the position within the STP footprint then there is clearly a level of risk to all organisations both providers and commissioners. Setting aside this broader level of systemic risk then at an organisational level the risk within the Financial Plan at this point is considered slightly higher than in 2017/18. In particular:

9.1.1. There is no significant new business growth assumed.
9.1.2. Contract values have not been signed but are principally agreed with all commissioners
9.1.3. The net level of CRES assumed in the Plan of £4.7m is less than previous years targets.
9.1.4. The need for additional investment in environments, facilities services, organisational development and technology is recognised.
9.1.5. The prevailing financial run rate is c.0.5% surplus.

9.2. To this extent the level of operational risk remains high with the following of greatest significance:-

9.2.1. There is a level of uncertainty with any contract income and in particular the current position with Herts Valley CCG which in 2017/18 saw a lower contract sum than originally expected and the need for more robust demand management.
9.2.2. CQUIN income is assumed again at 90% for Hertfordshire and 100% elsewhere and whilst this has been achieved in each of the last years it remains a risk. This is worth circa £3.5m in total.
9.2.3. Recruitment of staff and staff turnover remain a key operational risk. In financial terms then the risk that Pay costs will exceed Plan is more limited currently because of the lack of available staff. Combination of the organisational Agency Cap Limit and the squeeze on agency pay rates mean that the use of agency staff is more limited and any vacancies cannot be assumed to be filled. The level of Bank fill is broadly flat and therefore the most likely pay risk in the short term is through pay inflation arising indirectly through initiatives such as the retention premiums.
9.2.4. The biggest area of cost risk is in relation to placement costs both directly through the continuing increases in the level of referrals and acuity and also the workforce pressures referred to above which directly impact upon the ability to support service users in the community.
9.2.5. Overhead costs have remained relatively stable over the last few years with the revenue growth absorbed within the current infrastructure. There is however emerging risks most clearly within the ability to attract and retain staff. A particular area of recruitment difficulties this year have been both within H.R and within I.T but this is becoming more widespread.
9.2.6. The PARIS contract is being renegotiated and new elements will be implemented during the financial year and will provide the start point for a significant shift in the use of technology and in information which will have to be supported by additional investment in staff capacity and in new skills.

9.2.7. In each of the last few years there has been significant unplanned expenditure such as additional CHC claims, employment cases, building works. The Trust has a contingency fund of 0.5% of turnover to mitigate any such cost but this is at the low end of previous levels of cost.

9.2.8. Demand continues to rise above demographics. Particular focus is on increasing care coordination capacity through more effective demand management, reduced bureaucracy and ensuring activity is appropriately allocated. Key to this development is to work in partnership with primary care to identify new and innovative ways of working that can get the right care to individuals in an increasingly timely manner. Three pilots are planned to test this in Watford, Hertford and Stevenage with a view to considering wider roll out after evaluation.

10. Likely Cash Releasing Efficiency Programme (CRES) level and key components

10.1. The key mitigation to the above risks is the successful delivery of the CRES programme which is focussed on service improvement through changes in operational practice. The detailed criteria to best assess the CRES value required is set out in Appendix 1 and is summarised below. This assessment will continue to evolve over the next few weeks and will continue to be calibrated throughout.

	£m	variation	
Contract reductions applied by commissioners	3.8		Assumed at 2.0% will be confirmed by contract process
Change in Control Total	(0.4)		Based upon assessment that current surplus run rate of £250k per quarter is broadly in line with 18/19 control total
New business surplus	(0.4)		Used CAMHS T4 business case. Assumed that Essex LD and other new business will be cost neutral
Net Cost Pressures & New developments	1.7		Covers both new developments plus inflationary pressures above any contract inflation
Contingency	0.4		Set centrally to meet unexpected cost movements. Final level to be approved by DoF
Gross requirement	5.1		
Vacancy factor	(0.4)		This reflects the favourable cost impact of vacancies either not covered by bank/agency. Again this is a broad estimate of circa 20 posts
Net Requirement	**4.7**		

10.2. The variation column represents the degree of potential change in the amount assessed and shows that the most likely areas of variation are in relation to the new investment, excess cost inflation and the impact of continuing vacancies.

11. Current Capital Programme

The capital programme for 2018/19 has been updated to include the following key changes:-

- Prospect House refurbishment has moved to 2018/19
- Victoria Court project has seen funds moved to 2018/19
- An initial allocation of £3m for the development of 'best in class' seclusion facilities across inpatient MH and LD services
- An initial allocation of £1.2m for PARIS development & software enhancements
- An additional £133k has been added to the Forest House place of safety project funding slipped to 2018/19 to match expenditure profiles
- Phase II fire safety funding has been provided for in 2018/19.
- The removal of St Pauls sale from the current 5 year plan, with it expected to be within 2019/20 plans moving forward

The current capital programme indicates a net spend of £15.9m as set out below:

Schemes	Outline Plan 2018/19
	£000s
24/7 refurbishment	15,255
Community Schemes	0
Learning Disabilities Schemes	0
Informatics	1,200
CAMHS	133
Rehabilitation	0
Operational capital	4,300
TOTAL CAPITAL EXPENDITURE	**20,888**
Asset sale proceeds / income	(4,980)
Net total	**15,908**

11.1. Priorities and affordability will be reviewed throughout the year and considered by the Finance & Investment Committee. In particular the final STF position for 2017/18 will potentially enable the timing and extent of the programme to be reviewed. As noted above there will be a net capital spend in the year. This will be met from the available cash balances with no requirement to seek additional borrowing expected. The detailed plan is set out at appendix 3.

11.2. The impact of the above is that the liquidity ratio will potentially fall. Cashflow implications have been worked through as part of the planning submission and the position will continue to be reviewed throughout the financial year.

11.3. The main risk is inflationary pressures generally within the construction industry which can lead to increased capital spend. This is likely to be offset by the payment of the current provisions later than the date set within the plan.

12. **NHSI Single Oversight Framework – Use of Resource**
The achievement of a surplus of £2.135m (including £1.775m STF) combined with the proposed capital programme will provide an overall NHSI Use of Resource metric of 1, the strongest position. The ratings from the draft NHSI submission are summarised below. There is a risk that particularly in relation to the Agency cap this falls to a rating of 2 if exceeded by over 25% (c.1.8m), which would trigger a rating of 2 overall and this will require ongoing close focus:

Plan Risk Ratings	Year Ending Rating
Capital Service Cover rating	2
Liquidity rating	1
I&E Margin rating	2
Variance From Control total rating	1
Agency rating	1

The draft SOCI which summarises the budget to deliver this target is set out at appendix 2.

Conclusions and Recommendations

13. The Trust is expected to be able to deliver the control total (circa 0.4%) for FY18/19 based upon the above assumptions and the completion of the actions of those factors listed above. The key risks are the need to continue the work to reduce the pressure on placement costs, improve staff recruitment and retention, delivery of the CRES programme and implement and embed measures to manage demand.

14. The Board is therefore asked to note the contents of this report as set out as the basis for the annual financial plan and final NHSI plan submissions. In particular the Board is asked to note the following:
    14.1. Planned surplus of £360k achieves the control total (before STF) set by NHS Improvement
    14.2. The plan seeks to achieve a Use of Resource metric of 1, the strongest position.

The Board is recommended to:-

- **approve acceptance of the 2018/19 NHSI control total of £2.135 surplus**
- **approve the 2018/19 Financial Plan and distribution of detailed budgets**

Appendix 1 - Calculation of CRES Value

		2018/19
	£000s	£000s
External requirement based on 2.1% contract value		(3,800)
Change in annual surplus		360
Trust specific requirements (cost pressures)		
- new investments incl. PARIS upgrade	(400)	
- increase in Corporate costs	(344)	
- PY funding for EROS team (* Rehab Strategy)	(364)	
- PY funding for new CHC team (** MHSOP)	(341)	
- additional price pressures	(400)	
- contingency	(470)	
- less CAMHS T4 new business contribution	400	
- Reduction in NHSLA requirement	104	
- FYE Reduction in WHHT rent	26	
- increase in rent Lister site	60	
- reduction in spend on Safecare Project	100	
sub total cost pressures		(1,629)
Vacancy factor (time to recruit)		400
Net requirement - initial assessment		**(4,669)**

Appendix 2 – Draft SOCI

SOCISum	SOCI2	Sum of Total Gross Costs
1Income	Contract #1 Hertfordshire IHCCT	-167,599,000
	Contract #2 East of England	-18,194,000
	Contract #2 East of England Tier4	-2,264,000
	Contract #3 North Essex (West Essex CCG)	-9,549,000
	Contract #4 Norfolk (Astley Court)	-2,024,000
	Contract #5 IAPT Essex	-6,723,000
	Contract #6 Bucks Chiltern CCG	-3,818,000
	Education and training revenue	-3,047,611
	Research and development revenue	-402,612
	Other clinical income from mandatory services	-1,875,211
	Other - Cost & Volume Contract revenue	-5,332,194
	Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	-477,812
	Misc. other operating revenue	-2,281,224
	Sustainability and Transformation Funding	-1,775,000
2Direct	Employee expenses, permanent staff	135,047,437
	Employee expenses, bank staff	4,687,406
	Employee expenses, agency staff	7,327,000
	Cost of Secondary Commissioning of mandatory services	30,743,167
	Drugs	2,646,107
	Clinical supplies	269,097
	Savings/cost pressures	-3,976,654
3Overhea	Consultancy expense	15,000
	Education and training expense	1,029,149
	Hard & Soft FM Contract	5,227,020
	Information & Communication Technology	4,590,356
	Misc. other Operating expenses	8,542,375
	Non-clinical supplies	279,128
	Other Contracts	6,712,915
	Rents	2,683,699
	Reserves	4,159,264
	Travel, Subsistence & other Transport Services	3,745,598
4Other	Depreciation and Amortisation - owned assets	5,615,000
	Interest Income	-168,000
	Other Finance Costs	47,000
	PDC dividend expense	3,719,000
	Interest Expense on Non-commercial borrowings	286,600
Grand Total		**-2,135,000**

Appendix 3 – Capital Plan

Capital Programme 2018/19	
March FIC	
Schemes	**Outline Plan 2018/19 £000s**
24/7 refurbishment	
24/7 - East Herts Beds	4,491
24/7 - Prospect House, Watford	1,776
24/7 - Albany Lodge	1,000
24/7 - Elizabeth Court, Stevenage	2,000
24/7 - Victoria Court, Stevenage	2,988
Seclusion rooms	3,000
24/7 refurbishment Total	**15,255**
Schemes	**Outline Plan 2018/19 £000s**
Informatics (Infrastructure & People cost)	
EPR Implementation (Care Records System) PARIS	1,200
Agile Working / Technology Refesh	
Informatics (Infrastructure & People cost) Total	**1,200**
CAMHS Inpatients	
Forest House place of safety	133
CAMHS Inpatients Total	**133**
Rehabilitation services Total	**0**
Operational capital	
IT Allocation	500
Other Capital	1,000
Fire Safety	1,650
Backlog Maintenance	900
General Contingency	250
Operational capital Total	**4,300**
TOTAL CAPITAL EXPENDITURE	**20,888**
Schemes	**Outline Plan 2018/19 £000s**
Asset sale proceeds / income	
2-4 Alexandra Rd	(400)
MHSOP - Stewarts	(1,780)
145/3 Harper Lane	(1,300)
305 Ware Road	(1,500)
Asset sale proceeds / income Total	**(4,980)**
Total	**15,908**

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22 March 2018	**Agenda Item: 16**
Subject:	Report from the Chair of the Audit Committee – meeting held 1st February 2018	**For Publication: Yes**
Author:	Catherine Dugmore	**Approved by:**
Presented by:	Catherine Dugmore Audit Committee Chair	

Purpose of the report:

To:

- Report key matters from Audit Committee to the Board

Action required:

To:

- Note the report
- Seek any additional information, clarification or assurance as appropriate
- Direct Audit Committee concerning any further action required

Summary and recommendations to the Board:

The Audit Committee met on 1 February 2018. Unfortunately due to illness the meeting was not quorate. However, following consideration by the Company Secretary it was determined that the committee would discuss the business on the agenda and that any items for formal approval would be addressed either outside the meeting or if appropriate carried forward in accordance with the Committee's Terms of Reference. The Committee considered the following matters:

- Internal Audit progress report and draft 2018/19 Annual Plan
- 2017/18 Annual Report update
- 2017/18 Accounting issues
- External Audit Update
- 2017/18 Accounting Issues
- 2017/18 Review of Accounting Policies
- Evaluation of:
  - Audit Committee Effectiveness
  - External Audit Effectiveness
- Use of Waivers Q3
- Audit Committee Business Programme 2018
- Minutes from Finance & Investment Committee and Integrated Governance Committee

Internal Audit – progress report
RSM presented the progress report on the audits within the 2017/18 plan and gave a good overview. The audit completed in the period related to Information Governance was an advisory audit with two medium and four low risk actions to undertake prior to finalisation of the IG Toolkit compliance declaration for the financial year. The committee also discussed the forthcoming work on Key Financial Controls, Data Quality and the Risk management & Assurance Framework.

Internal Audit – draft plan 2018/19
The draft Internal Audit Plan for 2018/19, developed in conjunction with RSM was presented. The plan had been discussed by the Executive Team and areas for focus highlighted. RSM have been asked to add a review on wider stakeholder relationships especially across the STP in light of the moving landscape externally.

The plan has wider scope than previously and therefore there is a requirement for a small increase in audit days and fees. Audit Committee agreed the increase in fees in principle, with formal agreement required at the next meeting, but approval for the work programme to continue.

2017/18 Annual Report Update
The Company secretary informed Audit Committee of progress on the Annual Report. Work is underway with weekly meetings in place; section authors have been identified and timelines shared. The Committee discussed the timeline and requirements in detail. The report will be shared with members of the Audit Committee prior to the meeting on 17th April 2018 for formal discussion. External Audit advised that the NHSI are likely to change the Quality Account indicators and whilst a list is available these have not yet been confirmed

Presentation on Final Accounts 2017/18
Audit Committee received a presentation on the key issues for closure of the accounts from the Deputy Director of Finance. These are very much in line with the areas previously discussed by the Committee:-

- The successful transfer to a new General Ledger and Financial Shared Services
- Full property valuation
- Continuing Healthcare Provision
- Local Government Pension Scheme accounting
- Level of provisions
- Disclosure notes on Losses & Special Payments
- Finalisation of the transaction with DH for Kingsley Green reprovision

The forecast for 2017/18 was discussed covering;

- Sustainability & Transformation Funding
- Discussions with Commissioners
- Q4 spending
- Discussions with our Total Facilities Management supplier, Interserve

External Audit
External Audit updated Audit Committee on activity related to the External Audit Plan. In addition a Benchmarking report is being prepared which will be shared with the Audit Committee at the next meeting. The report had not identified any risks against

Going Concern and Value for Money and advised that HPFT is in the top quartile of the customer base and in the middle of the pack in terms of STF funding.

2017/18 Going Concern Statement
Audit Committee were asked to recommend to the Board approval of the preparation of the financial statements for the year ending 31st March 2018 on a going concern basis. The report was reviewed and the key factors for consideration highlighted. highlighted;

The management view is that the report should be adopted. Because the meeting was not quorate, the Audit Committee Chair requested that the report be circulated to members of the Committee for approval prior to recommendation to the Board of Directors.

2017/18 Review of Accounting Policies
The Director of Finance reported that the Trust accounting policies had now been reviewed and the highlighted presentational adjustments to the cash flow statement which will further clarify disclosures. Audit Committee also noted the work which has been undertaken with Herts County Council (HCC) to confirm the basis of membership of the Local Government Pension Scheme relating to staff who TUPE'd from HCC to HPFT in 2004/05. The report was noted by the Committee.

Q3 - Use of Waivers
Audit Committee noted the report.

Evaluation of:

a) **Audit Committee Effectiveness**
b) **External Audit Effectiveness**

Due to software issues, the exercise will run again.

Audit Committee Business Programme 2017/18
The annual business programme was reviewed.

Six monthly reports and Committee minutes
Audit Committee noted the minutes from Finance and Investment Committee and Integrated Governance Committee.

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):

Controls & Assurance – reporting key matters considered by the Audit Committee to the Trust Board.

Summary of Implications for:

1 Finance
2 IT
3 Staffing
4 NHS Constitution
5 Carbon Footprint
6 Legal

Equality & Diversity (has an Equality Impact Assessment been completed?) and Public & Patient Involvement Implications:

Evidence for Essential Standards of Quality and Safety; NHSLA Standards; Information Governance Standards, Social Care PAF:

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	22 March 2018	**Agenda Item: 17**
Subject:	GOING CONCERN STATEMENT	**For Publication: Yes**
Author:	Matthew Hooper Head of Financial Services	**Approved by:** Paul Ronald Deputy Director of Finance
Presented by:	Keith Loveman Director of Finance	Director of Finance & Performance Improvement

Purpose of the report:

To recommend to the Board approval of the preparation of the financial statements for the year ending 31st March 2018, on a going concern basis.

Action required:

The Board of Directors should consider the specific factors (Financial, Operational and Other) that individually or collectively, might cast significant doubt on the going concern assumption.

Summary and recommendations to the Board:

Summary

The Audit Committee has considered the detail provided below and other relevant information that has been made available to them and has approved the recommendation set out below for the Trust Board to confirm at the Board meeting set of 22 March 2018.

1. **Recommendation**

The Board is recommended to adopt the going concern basis for the preparation of the Trust's financial statements for the year to 31st March 2018.

2. **Introduction**

There is no presumption of going concern status for NHS Foundation Trusts. IAS 1 requires management to assess, as part of the accounts preparation process, the NHS foundation trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

The HM Treasury Financial Reporting Manual (FReM) emphasises that:
"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern." (FReM table 6.2)

The Board of Directors should consider the specific factors (Financial, Operational and Other) that individually or collectively, might cast significant doubt on the going concern assumption. These are set out in the table below for consideration.

3. Assessment

FACTORS THAT MIGHT CAST SIGNIFICANT DOUBT ON GOING CONCERN

FACTORS THAT MIGHT CAST SIGNIFICANT DOUBT ON GOING CONCERN	HPFT MANAGEMENT RESPONSE & CONSIDERATION
1. Financial conditions, such as:	
a. poor NHSI financial risk rating	The Trust currently has a Use of Resources Risk Rating for 2017/18 at Q3 of 1 (highest) and a forecast EoY rating of 1 fort March 31st 2018.
b. necessary borrowing facilities have not been agreed	No additional loan facilities projected with current capital plans fully funded from available cash net of scheduled loan repayments. Sufficient headroom on current projections
c. existence of significant operating losses, historical and projected	At quarter 3 the Trust is recording a surplus of £1.145m with a forecast surplus of c.£2.0m - £2.5m at year end plus STF monies (excluding any technical impact of impairments linked to Property, Plant and Equipment revaluations,). The Trust is has a planned surplus of £0.9m for 2018/19.
d. anticipated or actual major loss of commissioner income	All major contracts signed with generally one year to run. No significant income loss overall is indicated.
e. major CRES programme with high risk of non-achievement	Currently CRES plans are not sufficiently developed to provide confidence of delivery of proposed plans. Series of remedial actions will be taken if required to ensure financial plan delivered.
f. major losses or cash flow problems which have arisen since the balance sheet date	None. Cash balances at Q3 were £55.6m with further cash expected through STF funding and reimbursement of costs incurred on Kingsley Green. Receivables remain liquid with no material payment issues.
g. inability to repay loans when they fall due.	Strong Capital Servicing Capacity rating performance of 1 with NHSI , additional surplus, the agreed cost reimbursement for Kingsley Green site costs and the unplanned STF funding will provide significant headroom
2. Operating conditions, such as:	

a. loss of key management without replacement	All posts within the senior management team have been substantively filled for the majority of the year and the Executive Team at full complement from September 2017.
b. loss of key staff without replacement and/or labour difficulties	Recruitment and retention remains challenging for the Trust and is a major focus. Trust believes current risk is manageable
c. poor NHSI governance risk rating	GREEN governance since 2007 and CQC rating of Good
d. significant failure to achieve Care Quality standards resulting in any restrictions on services provided	CQC inspection rating of 'Good' September 2015. Inspection w/c 22 January 2018, (S29 Broadland Clinic November 2017, now lifted). Well Led inspection w/c 5 February 2018. No significant issues expected.
e. fundamental changes in the market or technology to which the trust is unable to adapt adequately	Potential changes in relation to west Herts community services. Developing lead provider role pan-Essex LD. Trust playing key role in STP working.

3. <u>Other conditions, such as</u>:	
a. serious non-compliance with regulatory or statutory requirements	None in existence
b. pending legal or regulatory proceedings against the trust that may, if successful, result in claims that are unlikely to be satisfied	Not significant. Any major claims are covered by CNST/NHSLA. Retrospective continuing healthcare claims provided for.
c. changes in legislation or government policy expected to adversely affect the Trust	Not significant
d. issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis.	None in existence

Furthermore, the existence of a framework of good financial governance in the Trust, with accurate, up to date and reliable information routinely reported to the Board and other Committees is evidenced through the following specific considerations:

- Forecast and budgets
- Borrowing/cash flows
- Financial and operational risk management
- Audit reports and action plans

It is therefore intended that the Trust will prepare financial statements for the year to 31st March 2018 on a going concern basis, based on its assessment and analysis of its

financial standing, the annual plan and compliance framework submissions.

4. Adoption of Going Concern Basis

After making enquiries the Directors have a reasonable expectation that the Hertfordshire Partnership University NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future and there are no material uncertainties that may cast significant doubt upon the Trust's ability to continue as a going concern.

For this reason, they continue to adopt the going concern basis in preparing the accounts.

Relationship with the Business Plan & Assurance Framework (indicate which strategic goal(s) this relates to, for example Communications Strategy - 2.1):

N/A

Summary of Implications:

(a) Financial: Inability to confirm going concern might mean qualified audit opinion
(b) IT:)
(c) Staffing:)
(d) Legal:) N/A
(e) Carbon Footprint:)
(f) NHS Constitution:)

Equality & Diversity (has an Equality Impact Assessment been completed?) and Public & Patient Involvement Implications:

N/A

Evidence for CQC; NHSLA Standards; Information Governance Standards, Social Care PAF:

Internal Control/Financial Management & Governance

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

Audit Committee 1 February 2018 – recommendation to Board approved outside meeting

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22nd March 2018	**Agenda Item: 18**
Subject:	Public Sector Equality Duty (PSED) compliance report and outcome of Equality Delivery System Grading – 2017/18	**For Publication: Yes**
Author:	Samantha Slaytor, Equality & Diversity Lead	**Approved by:** Dr Jane Padmore, Director Quality and Safety
Presented by:	Dr Jane Padmore, Director Quality and Safety	

Purpose of the report:

The Trust is required to comply with both the general duties and the specific duties of the PSED and is mandated to publish the results of exercises in relation to the EDS2. The purpose of this report is

- To brief the Board on the Public Sector Equality Duty (PSED) between1st January– 31st December 2017.
- To note the outcome of a partial grading exercise in relation to the NHS Equality Delivery System 2 (EDS2) which was completed in January 2018.
- To approve the compliance report for publication.

Action required:

The Board is asked to approve the annual compliance as required by the PSED.

Summary and recommendations:

This report sets out the Trust's assessment, through consultation with stakeholders, of compliance with the general duties under EDS2. The EDS2 reporting is given in the form of grades in comparison to previous grading. It is required that the EDS2 grading is completed by Trust stakeholders (rather than self–assessed) based on evidence supplied.

The purpose of this report is to provide details of how the Trust is compliant with the Public Sector Equality Duty (PSED). The period assessed is 1st January– 31st December 2017. The report also gives the outcome of the partial grading exercise in relation to the NHS Equality Delivery System 2 (EDS2) which was completed in January 2018.

In addition to overseeing ongoing EDS2 compliance, the focus over the past year has included

- Further development of the NHS Workforce Race Equality Standard (WRES).
- Preparing for the NHS Workforce Disability Equality Standard (WDES)
- Preparation for the Sexual Orientation Information Standard (SOIS).
- Further work on the implementation of the Accessible Information Standard.
- Review of training needs within specific service areas.
- Review of the Trust wide mandatory Equality training programme.

The report has been presented and discussed at IGC, QRMC and the executive meeting. It is envisaged that a reassessment will take place early in the new financial year, following the ratification of the Equality Strategy.

Relationship with the Strategy (objective no.), Business Plan (priority) & Assurance Framework (Risks, Controls & Assurance):

The programme of work supporting compliance with the PSED and EDS2 links to the following annual plan priorities for 2017/18:
Great Care, Great Outcomes
We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy
Great People
We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership
We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base
Great Networks and Partnerships
We will be recognised as system leaders having successfully driven and delivered on key system priorities.

Summary of Financial, Staffing, and IT & Legal Implications (please show £/No's associated):

In the standard NHS contract, Equality Delivery System 2 and the NHS WRES remain mandated for all provider organisations. This report indicates Trust compliance in implementing these two areas, it acknowledges that this may now mean additional scrutiny through its relationships with commissioners.

Equality & Diversity /Service User & Carer Involvement implications.:

This paper shows compliance with the PSED and the EDS2 which both contribute to meeting legal responsibilities under the Equality Act 2010. Service user and carer representatives were involved in the re-grade of the EDS2 alongside a range of other stakeholders.

Evidence for Registration; CNST/RPST; Information Governance Standards, other key targets/standards:

Compliance with key legal and contractual components re: equalities not form part of over compliance with CQC KLOE.

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/Board/Audit

QRMC – 26th February 2018. Report agreed with minor corrections which have been made.
IGC – 6th March 2018.

Public Sector Equality Duty (PSED) compliance report and outcome of Equality Delivery System 2 Grading – 2017/18

1. Introduction/Executive Summary

1.1 The purpose of this report is to provide assurance of compliance with the Public Sector Equality Duty (PSED) between 1st January – 31st December 2017 for Hertfordshire Partnership University NHS Foundation Trust (the Trust). The PSED requires the Trust to ensure that **ALL** of its functions are carried out in a way that does not disadvantage anyone from a protected group. This is part of the Trust's overall compliance with the Equality Act 2010.

1.2 Additionally, the report provides the outcome of the Trust's EDS2 partial regrading which took place between November 2017 – January 2018.

1.3 The Trust is required to comply with both the general duties and the specific duties of the PSED given the size of the organisation. The EDS2 is a mandated part of the NHS standard contract for providers.

1.4 A summary of past year's activities include:

- Further implementation of organisational values
- Evaluating the bullying & harassment pledge
- Development and implementation of Sexual Orientation and Gender Identity guides for CAMHS services
- Further implementation of mandatory staff training programme for equalities
- Coproduction of Equality, Diversity and Inclusion plan for 2018 - 2022
- Equality Delivery System 2 (EDS2) involvement with local stakeholders in 2017
- Review of Trust diversity role models programme
- Further implementation of contractual obligations regarding EDS2 and WRES
- Full implementation of recommendations made to support our six staff networks, strengthening role of executive sponsors
- Implementing new policy and launching new strategy regarding Spiritual Care Services.
- Partial regrading of EDS2 and beginning review of four year objectives set in 2016.

1.5 Challenges from the past year have included:

- Identifying resources to improve metrics of the WRES and prepare for the introduction of WDES and SOIS
- Reducing the gaps in equality monitoring data for staff, service users and carers.
- The need for a more systematic approach to storing and cataloguing EDS2 evidence for stakeholders.

1.6 Compliance with the general duty is given in the form of some narrative regarding key pieces of project work, as detailed in this report). Following this, data has been published on workforce as part of Trust compliance with the specific duties.

1.7 Compliance with the EDS2 is given in the form of a partial regrading shown in comparison the Trust previous grading.

1.8 Appendix 2 provides an overview of the Trust's requirements in relation to the Public Sector Equality Duty and requirements under the EDS2.

2. PSED - Summary of Key Performance Areas regarding General Duties

The general duty of the PSED requires the Trust, in relation to all protected groups[1], to ensure it is working to:

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it
- **Foster good relations** between people who share a protected characteristic and people who do not share it.

2.1 Overview/narrative to eliminate unlawful discrimination

2.1.1 *The Trust's organisational Values.* The Trust has continued to embed its values in the organisation. All staff receive an annual values based appraisal to ensure staff reflect on their behaviours, identifying areas for improvement in themselves and others. The past year has seen 91% of values based appraisals completed. The Trust has focused on more promotion of the values, through promotional campaigns.. One of these was around the flu jab and staff from across our geographical areas was part of the Trust wide video which included staff who are members of Trust staff networks and also members of staff that are Trust diversity role models increasing the visibility of our demography.

2.1.2 *Anti-Bullying & Harassment Pledge*. The Trust launched an Anti-Bullying and Harassment Pledge in October 2016. On reflection of staff survey results, including NHS and Internal surveys around bullying and harassment, the pledge has had some impact but evidence suggest this is not breaking down systemic barriers within the organisation as had been hoped. To support this, the Trust has now included a message from each Diversity Role model about supporting someone who is experiencing bullying and harassment. In addition, our Freedom to Speak Up guardian has been offering open sessions encouraging staff to talk about their experiences and to approach for support.

2.1.3 *NHS WRES*. The Trust has implemented a WRES action plan focusing on identifying and address the inequalities within the Trust. The WRES data can be found on the public website.[2] The 2017 data showed a significant improvement between BME and non-BME staff in relation to recruitment and targeted work, narrowing the gap in relation to staff appointed following shortlisting. The 2017 figures indicate an improvement in the past year. The Trust is now performing above the national average. Work will be needed to recognise the barriers around the disciplinary process, as this is an area identified for the Trust for further improvement.

There remains some challenge for the Trust with WRES which has resulted in refreshing its annual work-plan to ensure that this is focused on making measurable improvements. The Trust's WRES data and work plan can be found online at http://www.hpft.nhs.uk/about-us/equality-and-diversity/nhs-workforce-race-equality-standard/

2.1.4 *New Equality Plan development.* The Trust has coproduced a draft of the new Trust Equality, Diversity and Inclusion plan, aiming for the final document to be ratified in April 2018 and for the action plan to follow clearly setting out the Trust's Equality objectives. At the time of publishing this report, the draft plan was open for public consultation.

[1] Age, Disability, Gender identity/reassignment, Pregnancy and maternity (employment only), Race/Ethnicity, Religion/Beliefs, Sex (gender), Sexual orientation, Marriage & Civil Partnership (employment only)

[2] http://www.hpft.nhs.uk/about-us/equality-and-diversity/wres/

2.1.5 *Reviewing the Equality Impact Assessment process to be more inclusive of staff, carers and service users*. Identifying the positive and negative implications to changing service provision and developing a stronger quality.

2.2 Overview/narrative to advancing equality of opportunity

2.2.1 *Diversity Role Models*. The Trust's Diversity Role Models launched in February 2016 and was internally reviewed in July 2017. The recommendation was to enhance the programme and advance the opportunity for staff to be involved and engaged. The programme engages staff who are BME, LGBT, Women, Carers or have a Disability in being role models and to support people from similar backgrounds. This has now been expanded to include Mental Health role models and Spiritual care role models and is adding another layer of support for staff and helping staff identify allies[3] in the workforce.

2.2.2 *Stonewall Diversity Champions*. The Trust continues as a member of the Stonewall Diversity Champions programme and is passionate about focusing on the needs of LGBT staff, service users and carers. In relation to this, throughout 2016 the Trust was listed as one of the Stonewall top 100 employers in England for LGBT staff. The Trust did not achieve a top 100 placement for the 2018 index (launched January 2018) however a vast improvement has been noted on the Trust's placing since 2017, climbing 82 places in the index. Over the next year, the Trust will invest time in focusing on LGBT community engagement and aiming for a top 100 placement in the index for 2019.

2.2.3 *Staff Networks*. There has been improvement of the Trust's staff networks to incorporate its Vision for what it wants to achieve "Delivering Great Care, Achieving Great Outcomes - Together". The six staff networks supporting staff from a range of backgrounds.[4] are expected to set annual objectives based around the Trust's *Good to Great* strategy.

2.2.4 *Implementation of Sexual Orientation and Gender Identity CAMHS guide*. This piece of work focused on developing a new guidance for clinicians in relation to talking about sexual orientation and gender identity. It was developed in partnership with Anna Freud Centre[5] and CYP IAPT Collaborative and had an official launch in May 2017, the Trust's annual International Day Against Homophobia, Biphobia & Transphobia (IDAHOBIT) conference. Further work is being undertaken with CAMHS staff to continue to utilise this resource. The resource is available to view online at https://cypiapt.com/2017/04/03/so-and-gi-guide/

2.3 Overview/narrative to foster good relations

2.3.1 *International Women's Day (IWD) Programme*. In March 2017, the Trust hosted its annual IWD conference and focused on the given theme Be Bold for Change; Good to Great - Realising Your Full Potential. There were a range of professionals that spoke about their personal journeys as well as a variety of workshops focusing on self-development or signposting. The whole programme was rated as either great or good by attendees, with the recommendation to focus on intersectionality for IWD 2018. This means to explore the relationship between the protected characteristics and the multiple impact that they can have. Since the event, the Trust has two male allies that have become members of the network to foster good relations and highlight shared experiences.

2.3.2 *International Day Against Homophobia, Biphobia & Transphobia (IDAHOBIT)*. The Trust delivered its annual event in May 2017. The theme chosen was Families and "The voice of parents".

[3] Allies are broadly defined as people from a different background to a group they are speaking on behalf of. E.g. male allies supporting work around equality for women.
[4] BME Network, Outlook (LGBT), Women's Network, Disability Network, Carers Network, MH Network
[5] National Centre for Children and Families

The Trust worked in collaboration with the University of Hertfordshire and delivered a workshop full of rich experiences highlighting some of the key issues for anyone that is grappling with their sexual orientation and/or gender identity and available support that is available locally. This was also evidenced by research and a tool kit was launched to aid professional development, including hearing from inspiring community champions highlighting their personal experiences. The keynote speaker is fostering good relations with the Trust and HCC and third sector providers to highlight the experiences of families and the voice of parents.

2.3.3 *Equality diversity and human rights week*. The Trust held several events and had staff networks and diversity role models involved in highlighting the programme. Two of these events focused on dementia and were promoted through the Trust's library service, with attendees from other NHS providers, the Clinical Commissioning Groups (CCG), University of Hertfordshire, HCC and third sector partners. The event was well attended with lots of speakers and workshops. The evaluation showed that attendees really enjoyed the different programmes and got the chance to build relationships and network whilst highlighting pertinent issues.

2.3.4 *Carer Week Conference & Carer Rights Day.* The Trust hosted their annual conference for Carers Week in June 2017 as well as 'An event for carers' in November 2017 for Carers rights day. Both events were extremely popular with carers and professionals. For carers, there was an opportunity to hear speakers followed by a range of alternative therapies for carers. Important points from the day included carer'' ongoing need to be engaged fully in the Trust and ensuring more support is offered to be able to continue with Caring responsibilities. Further work needs to be done to help substantive staff talk about also being a Carer and to understand the choices available to them.

2.3.5 In October 2017, the Trust hosted its third local WRES annual workforce conference with Unison and NHS England focused on 'Diversity & Leadership - Why it matters to you?' which emphasised on ways the Trust can improve its approach to race equality and the retention and promotion of BME staff. The event was well attended with a number of Service Line Leads and Executive Directors who pledged to undertake more work around the WRES in their Strategic Business Unit (SBU).

3. PSED - Specific Duties

3.1 Overview of requirements

3.1.1 The Trust is required to comply with the specific duties in the following ways:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of the workforce
- Publish data on those affected by Trust policies and procedures
- Publish one or more equality objectives.

3.1.2 Publish information to demonstrate compliance with the general duty – this report has been written and published to ensure compliance with this element of the duty.

3.1.3 Publish data on the make-up of the workforce – this is provided in Appendix 1

3.1.4 Publish data on those affected by Trust policies and procedures – this is provided in Appendix 1 (service user and carers)

3.1.5 Publish one or more equality objectives spanning a four year period – The Trust's Equality Objectives were published in June 2016 as part of our EDS2 compliance reporting and are detailed in section 4.

3.2 Observations against our data

Appendix 1 details data for employment and for service provision by protected group. The following observations have been made from this along with our WRES data – available at http://www.hpft.nhs.uk/about-us/equality-and-diversity/nhs-workforce-race-equality-standard/

3.2.1 The Trust has a good quality of data across ethnicity, gender and age. However there remain some gaps in data across sexual orientation, disability and religion/belief with larger numbers of people declining to given this information. This is already and area of action for the Trust and improvements are beginning to be seen – particularly in relation to employee data.

3.2.2 The Trust's WRES data shows improvements have been in the experience of BME applicants being appointed following shortlisting. As detailed earlier in this report the Trust is focusing additional action on how to see the same improvement where disciplinaries are concerned.

3.2.3 Over 25% of our carers are aged over 65. Supporting an ageing population for carers is an area of focus for the Trust and development of contingency planning processes continues to ensure risk is minimised for carer and service user.

3.2.4 6% of applicants disclose a disability, yet only 3% of the appointed workforce have disclosed a disability (for the latter, there is a large number (18%) of staff who choose not to disclose). The Trust disability network is reviewing actions for addressing this as part of the Trust Disabled Confident Employer membership.

3.2.5 34% of employees are from an ethnic minority background (where those who did not state their ethnicity are removed from figures). This is not currently reflected evenly across the workforce which is a key evidence base for the WRES having been implemented. However over the past year, the Trust has begun to see some movement in band 5 BME staff moving into band 6 roles (in line with national trends since the WRES was implemented).

4. EDS2 – partial regrading of activity

4.1 The EDS2 requires providers to select one or more EDS2 outcomes to re-assess on an annual basis.

4.2 EDS2 grades should be agreed by the Trust's 'local interests' (stakeholders) through the provision of range of evidence showing the Trust current position.

4.3 The EDS2 has four grading options:

- Red – Under-developed (I.e. no evidence of activity for protected groups)
- Amber – Developing (I.e. evidence of activity (often good) but not for all protected groups)
- Green – Developed (I.e. good evidence of activity for most protected groups)
- Purple – Excelling (I.e. good evidence of activity for all protected groups).

4.4 The Trust chose to re-grade six outcomes graded as either 'developing' or 'excelling' in the previous grading exercise. One 'excelling' outcome was not re-graded as this relates to topics that are actively being discussed by the Trust staff mental health and disability networks (outcome 3.5) and therefore it was felt that assessment of this outcome should be linked to this work.

4.5 Table 1 overleaf shows the results of those EDS2 objectives that were regraded against the previous grading.

Goal	Outcome	June 2016	January 2018
1. Better health outcomes	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities.		
	1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways		
	1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.		
	1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.		
	1.5 Screening, vaccination and other health promotion services reach and benefit all local communities.	Not Graded	
2. Improved patient access and experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds		
	2.2 People are informed and supported to be as involved as they wish to be in decisions about their care.		
	2.3 People report positive experiences of the NHS.		
	2.4 People's complaints about services are handled respectfully and efficiently.		
3. Empowered, engaged and well-supported staff	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.		
	3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.	Not Graded	
	3.3 Training and development opportunities are taken up and positively evaluated by all staff.		
	3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.		
	3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives.		
	3.6 Staff report positive experiences of their membership of the workforce.		
4. Inclusive leadership	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond		
	4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed.		
	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.		

Table 1: HPFT EDS2 partial re-grading outcome (2018)

4.6 Observations from re-grading

- Outcome 1.2 has declined in quality but still rated as 'good'. This indicates we are lacking evidence that shows how we are achieving this for all service user and carer groups. There are some challenges in ensuring that we have a full data set of demography for people using our services which already forms part of our equality objectives set during our last grading.
- Outcome 1.3 has maintained a position of developing – this is consistent with the current Trust position around transitions between services, however there is currently a more targeted approach in the Trust to addressing issues around transition
- Outcome 2.3 has maintained its position based on feedback we receive though our Having Your Say and Friends & Family Test feedback
- Outcome 3.1 has improved – largely in response to changes that have been made to the Trust recruitment process over the past 18 months and improve reporting of equalities data
- Outcome 3.4 has not improved its position which is consistent with feedback from staff through the Trust staff survey
- Outcome 4.3 shows that further improvement is needed re: skilling up middle managers to work in cultural competent ways
- Outcome 3.2 relates to equal pay and was not graded as the Trust is due to publish details of its gender pay gap by April 2018 (in line with national requirements). Therefore this piece of work will take place later in 2018.

It should be noted that the Trust has considerably improved its data quality around a number of equalities areas over the past 18 months therefore more accurate reporting may be providing a truer picture of the Trust position. It is also important to note that an amber grade implies that good work is happening, but that this does not yet have enough breadth to be considered as a high performing area.

4.7 EDS2 objectives

The PSED (and EDS2) encourage organisations to publish one or more equality objectives covering a four year period. These were last revised in June 2016 and are currently being reviewed in the context of new Trust Equality Plan (currently out to public consultation to 16th March 2018). Our objectives currently set are:

- Project focused on improvement in the quality of data that more clearly shows information on care planning by protected groups
- Improve the data quality dashboard for patient safety to ensure that demography is scrutinised in relation to service users response to the question 'is the service a safe environment'
- Equity audit carried out which looks at initial access to services through SPA (or other routes) that maps different groups against each other Having Your Say data is scrutinised on a quarterly basis to identify any patterns or trends in relation to the demography of respondents and what they are saying about Trust services (and included in SBU reports)
- A targeted action plan for the Workforce Race Equality Standard works to proactively decrease the negative experiences of BME staff when compared to white staff in relation to aspects such as recruitment, disciplinary procedures and bullying and harassment
- Unconscious bias training is rolled out to the entire Trust workforce to ensure some scrutiny of individual behaviours, actions and a general awareness of how to reduce inequality
- A project takes place to scrutinise the impact of abuse from service users and relatives toward staff as this features high in the staff survey, and understand which (if any) groups may receive disproportionate abuse
- The senior board champions for Equality are visible in speaking about equalities and challenging inequality within the Trust and local health economy
- The Trust's collective leadership programme includes core components of equality & diversity that support in developing culture change in the way people work.

5. Challenges & Opportunities for the coming year

5.1 As the equality programme increases in size, there is an ongoing pressure to ensure that every part of the service is contributing to take necessary action to prevent, reduce and eliminate inequalities. As a mental health and learning disability service provider, the Trust are aware there is an ongoing need to improve its approaches around intersectionality[6] to ensure that it identifies the needs of the whole person so that agreement can be made together with individuals the best possible course of action/opportunity for them – whether that be in relation to service provision or employment.

5.2 The WRES has also presented some challenges in the past year. Whilst an improvement in figures is noted, the gap to show less disproportionality between BME and White staff in relation to staff disciplinary, the same cannot be said for staff who are appointed following shortlisting. For 2018, there will be further analytical work to look at shortlisting and to build robust evidence around this to ensure the Trust can make the changes needed to make the process fairer and promote equality of opportunity.

5.3 Information and Equality Standards - April 2018 will see the reporting of the standards for SOIS, WDES. In addition, the publication of reporting on any Gender Pay Gap. In relation to these we need to look at effective work plans to implement and delivery targets on the above with being aware of the limitations to resources.

5.4 In relation to service provision our ongoing challenge is around monitoring of demographic data. The Trust sees significant gaps in data regarding sexual orientation and disability. Therefore this is an area of focus over the coming year. We also see this for employment data and actions will be set to address this. With regards to service provision, the Trust is developing a new reporting mechanism to allow teams to see, in real time, data that may be missing from service user records so local action can be agreed.

5.5 Whilst the Trust has reviewed both our equality training package, the next year will see additional training being rolled out across the Trust through an unconscious bias train the trainer programme and will evaluate its effectiveness.

6. Conclusion

6.1 This report has provided a summary overview of progress against key parts of the Public Sector Equality Duty whilst recognising areas for development and challenges for the organisation. Additionally this has included a partial review of the EDS2 in line with contractual requirements.

6.2 Whilst there have been a number of areas of good practice to celebrate, there remains an improvement needed around some of the more simple structures of the organisation in relation to equality monitoring, initial recruitment and also retention as well as increasing understand the voices of staff, service users and carers in relation to different protected groups.

6.3 The EDS2 re-grading has shown that there is still action to be taken in order to get more traction in areas of service accessibility and transitions between different services. In relation to staffing it is expected that programmes of work such as WRES, Disability Confident and Stonewall Diversity Champions will begin to see a positive change in the experiences of staff from protected groups.

6.4 In producing this report, and the activities detailed within, it is felt there are no substantial areas where the Trust is failing in its duty to comply within the Equality Act 2010, whilst acknowledging that there are areas for improvement in raising the standard of equity for some protected groups. In April 2018 the Trust will publish a new Equality, Diversity & Inclusion Plan for the next four years. At this time, this report will be refreshed to ensure that PSED reporting is brought in line with reporting on the overall Trust's Equality plan as well as reviewing EDS2 objectives.

[6] The interconnected nature of social categorisations such as race, sexuality, and gender as they apply to a given individual or group. Also termed dual or multiple identity.

7. Contact

Any further information needed on the contents of this report can be obtained from the Trust Equality & Diversity Department within the Inclusion & Engagement Team on equality@hpft.nhs.uk.

Appendix 1 – Workforce & Service User/Carer Data

Data tables for staff and service user equalities data, 01/01/17 – 31/12/17. The % listed in the tables relates the following numbers:

Applicants	7,326
Staff in Post	3,662
Leavers	514
Service Users/Carers (open referrals during year)	46,792

AGE

	Applicants	Employed staff	Leavers	% of Professional Development Plans completed
17-19	1.09%	0.73%	1%	100%
20 - 24	21.12%	5.6%	11.5%	85.7%
25 - 29	20.79%	8.21%	12.6%	91.9%
30 - 34	14.51%	9.2%	7.1%	86.5%
35 - 39	10.44%	11.2%	11.3%	88.3%
40 - 44	9.08%	13.8%	8.7%	90.4%
45 - 49	8.68%	14.58%	8.5%	90.8%
50 - 54	7.63%	14.61%	13.6%	91%
55 - 59	4.79%	11.25%	11.4%	91.6%
60-64	1.54%	7.15%	9.4%	91.3%
65-70	0.19%	2.67%	4.1%	89.5%
71-75		1%	0.8%	92.85%
76-80		-	-	-
81-85		-	-	-

	Service Users	Carers
Under 16	14%	0.5%
16/18	5%	0.1%
18/24	13%	2.3%
25/34	15%	7.3%
35/44	12%	12%
45/54	11%	24.4%
55/64	8%	26.9%
65/74	6%	15.9%
75/84	9%	5.9%
85+	8%	1.1%
Age Unknown	0%	4.1 %

GENDER

	Applicants	Employed staff	Leavers	% of Professional Development Plans completed	Service users	Carers
Male	21.74%	27.65%	25.49%	92.2%	45.9%	66.8%
Female	77.6%	72.35%	74.51%	89.3%	54%	30.4%
Unknown	0.66%	-	-	-	5.12%	2.7%

ETHNICITY

	Applicants	Employed staff	Leavers	% of Professional Development Plans completed	Service users	Carers
White - British	47.55%	50.46%	52.5%	90.4%	64.5%	31.2%
White - Irish	1.67%	2.67%	2.7%	86.4%	1.2%	1.1%
White - Any Other White Background	10.64%	7.21%	9.1%	90.4%	3.3%	1.6%
Asian Or Asian British - Indian	7.87%	4.55%	4.7%	84.1%	0.78%	0.9%
Asian Or Asian British - Pakistani	3.08%	1.4%	1.5%	82%	0.52%	0.4%
Asian Or Asian British - Bangladeshi	1.44%	0.39%	0.77%	100%	0.2%	0.5%
Asian Or Asian British - Any Other Asian Background	2.86%	4.64%	4.07%	94%	1.14%	0.8%
Mixed - White & Black Caribbean	0.87%	0.46%	0.99%	77%	0.65%	0.2%
Mixed - White & Black African	0.46%	0.32%	0.77%	75%	0.26%	0%
Mixed - White & Asian	0.94%	0.9%	0.39%	74%	0.42%	0.2%
Mixed - Any Other Mixed Background	1.83%	0.73%	0.97%	94.7%	0.87%	0.3%
Black Or Black British - Caribbean	2.57%	2.43%	1.94%	86.5%	0.48%	0.2%
Black Or Black British - African	12.05%	10.86%	9.5%	88%	0.59%	0.6%
Black Or Black British - Any Other Black Background	0.69%	2.32%	1.36%	88%	0.83%	1.3%
Other Ethnic Group - Chinese	0.76%	0.62%	0.19%	100%	0.17%	0.2%
Other Ethnic Group - Any Other Ethnic Group	1.95%	2.43%	2.14%	92%	0.72%	0.8%
Undisclosed	2.77%	7.61%	6.42%	95%	22.86%	59.8%

SEXUAL ORIENTATION

	Applicants	Employed staff	Leavers	% of Professional Development Plans completed	Service users	Carers
Lesbian	0.23%	0.33%	0.58%	100%	0.18%	0.3%
Gay Man	0.9%	0.46%	0.99%	100%	0.25%	0.3%
Bisexual	4.9%	0.95%	1.3%	89%	0.26%	0.3%
Heterosexual	87.8%	68.74%	69.2%	89%	28.05%	22%
Refused	6%	24.8%	25%	92.7%	0.67%	-
Other	-	-	-	-	0.18%	0.1%
Unknown	0.17%	4.72%	2.93%	88%	67%	77%

DISABILITY

	Applicants	Employed staff	Leavers	% of Professional Development Plans completed	Service users	Carers
Yes	6.11%	3.11%	2.91%	95.45%	0.18%	0.6%
No	92.13%	69.93%	66.7%	88.77%	0.25%	0.4%
Not Defined	0.28%	18.86%	21.78%	93.2%	99.31%	99%
Undisclosed	1.48%	8.1%	8.56%	91.2%	0.26%	-

Disability Category	Service Users	Carers
None	0.25%	0.4%
Learning Disability	0.1%	0.1%
Long-term Health Condition	0.18%	0.2%
Mental Health Condition	0.2%	0.2%
Physical Impairment	0.1%	0.1%
Sensory Impairment	0.08%	0.1%
Not defined or recorded	99.31%	99%

RELIGION & BELIEF

	Applicants	Employed staff	Leavers	% of Professional Development Plans completed	Service Users	Carers
Atheism	18.56%	10.67%	11.6%	88.3%	1.4%	2.2%
Buddhism	1.4%	0.84%	0.77%	85%	0.02%	0.5%
Christianity	46.35%	44.2%	41.8%	89.2%	39%	8.2%
Hinduism	3.89%	3%	3.89%	86.2%	0.4%	0.5%
Islam	6.3%	4.15%	4.28%	94%	0.87%	1.2%
Jainism	0.13%	0.05%	0.19%	100%	0.07%	0.1%
Judaism	1.26%	0.9%	0.77%	95.2%	0.4%	0.8%
Sikhism	1.59%	0.68%	0.19%	76.9%	0.06%	0.13%
Other	10%	6.3%	7.97%	91.2%	5.4%	2.47%
Rather not say	10.19%	24.33%	25.4%	92.2%	0.68%	-
Undisclosed	0.17%	4.75%	2.91%	88 %	51%	83.2%

MARRIAGE & CIVIL PARTNERSHIP

	Applicants	Employed staff	Leavers	% of Professional Development Plans completed
Civil Partnership	1.66%	1%	0.39%	100%
Divorced	5%	6.77%	6.15%	89.6%
Legally Separated	1%	1.28%	1.58%	92.8%
Married	33.1%	53.1%	47.2%	89.4%
Single	54%	33.47%	37.89%	90.6%
Unknown	3.6%	3.22%	4.76%	92.7%
Widowed	0.75%	1.04%	1.1%	82.6%
Other	0.55%	-	-	-

NB Service user and carer data has not been included for this area as, in the context of the Equality Act 2010, this protected characteristic relates to employment.

Appendix 2 – Overview of Trust requirements re: Public Sector Equality Duty

In October 2010, the Equality Act 2010 came into effect. Prior to this time there had been over 100 pieces of legislation covering equalities protections and – with them – three associated public duties for race, gender and disability.

The Equality Act 2010 has brought with it a new – legal – public sector equality duty (PSED) requiring public bodies to declare their compliance with the duty on an annual basis. This means that HPFT must show compliance with both the general and specific duties of the PSED. This includes:

For the general duty showing how we have due regard to the need to:

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it
- **Foster good relations** between people who share a protected characteristic and people who do not share it.

Protected characteristics – in the context of the PSED – are defined as:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race – this includes ethnic or national origins, colour or nationality
- Religion or belief – this includes lack of belief
- Sex (gender)
- Sexual orientation

It also applies to marriage and civil partnership in respect of the requirement to have due regard to the need to eliminate discrimination.

For the specific duty HPFT must:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of the workforce
- Publish data on those affected by HPFT policies and procedures
- Publish one or more equality objectives.

This document outlines how HPFT is currently complying with the PSED and working at maintaining a level of excellence in equality & diversity. Much of our evidence of PSED compliance is detailed through Trust Equality Delivery System 2 (EDS2) approached.

The PSED is a legal framework which requires the Trust to be compliant across **ALL** functions in meeting the needs of those with a protected characteristic.

Hertfordshire Partnership NHS
University NHS Foundation Trust

TRUST BOARD MEETING

Meeting Date:	22nd March 2018	**Agenda Item: 19**
Subject:	Gender Pay Gap	**For Publication:** yes
Author:	Maria Gregoriou – Associate Director of Workforce	**Approved by:** Mariejke Maciejewski – Deputy Director of Workforce and OD
Presented by:	Jinjer Kandola – Deputy Chief Executive, Director of Workforce and Organisational Development	

Purpose of the report:

To request agreement from the Trust Board on the report to be approved for the publication of the gender pay gap information in order to fulfil statutory requirements.

Action required:

Approval required by the Trust Board for the report of the gender pay gap information for publication on the HPFT website by 31 March 2018.

Summary and recommendations to Board Members:

Following government consultation, it became mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG).

The new requirements

Employers with 250 employees and over are required to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This will include those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations should be made relating to the pay period in which the snapshot day falls. For the first year, this will be the pay period including 31 March 2017. The specific requirements for public authorities such as armed forces, local authorities, NHS bodies, publically funded schools etc. The regulations apply if such public bodies have 250 or more employees on 4 April 2018 and each year thereafter

Employers will need to:

- Calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls calculate the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees
- Calculate the difference between the mean (and median) bonus pay paid to male and female employees
- Calculate the proportions of male and female employees who were paid bonus pay
- calculate the proportions of male and female employees in the lower, lower middle, upper

middle and upper quartile pay bands by number of employees rather than rate of pay .

Ordinary pay includes basic pay, paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave) area and other allowances shift premium pay, defined as the difference between basic pay and any higher rate paid for work during different times of the day or night pay for piecework.

It does not include:

- Remuneration referable to overtime.
- Remuneration referable to redundancy or termination of employment
- Remuneration in lieu of leave
- Remuneration provided otherwise than in money.

Bonus pay relates to performance, productivity, incentive, commission or profit-sharing, but excludes: remuneration referable to overtime, redundancy, and termination of employment.

A key item of note is that the figures produced should be published by the public authority on its own website in a way which is accessible to both employees and the public. The results must stay on our website for three years. The same information must also be uploaded onto the a government viewing website and all organisations must register with the government viewing website before they can upload their reports.

Organisations must provide an aggregated gender pay report of all their employees. This includes all employees with a contract of employment, workers and agency workers that form part of an organisations head count and are paid directly from our payroll. The calculations must show:-

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median gender pay gap
- The proportion of males and females receiving a bonus payment
- The proportion of males and females in each quartile band

The attached report is the report which we would like to publish on our website which sets out the legal requirements and the data which the Trust is legally obligated to publish.

Comparator information is not yet fully available, which will be available post publication date. Once this is available we will benchmark the Trust and ensure that we are addressing any of the themes that emerge. In conclusion, we will continue to monitor the gender pay gap and consider what interventions if any need to take place to ensure that the gap is closed where appropriate.

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):

The gender pay gap data and action taken to make improvements will link to business plans and should impact staff survey results.

Summary of Financial, IT, Staffing & Legal Implications:

1 Finance
2 IT
3 Staffing
4 NHS Constitution
5 Carbon Footprint
6 Legal

Equality & Diversity (has an Equality Impact Assessment been completed?) and Public & Patient Involvement Implications:

Evidence for S4BH; NHSLA Standards; Information Governance Standards, Social Care PAF:

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

Hertfordshire Partnership University NHS Foundation Trust
Gender Pay Gap Report

1.0 Background to the Trust

Hertfordshire Partnership University NHS Foundation Trust (HPFT) provides health and social care to over 400,000 people with mental ill health, physical ill health and learning disabilities across Hertfordshire, Buckinghamshire, Norfolk and North Essex. We employ 3,000 staff who deliver these services within the community as well as inpatient settings.

HPFT is committed to being an equal opportunities employer and to building equality, diversity and inclusion into everything that it does.

2.0 Gender Pay Gap Reporting

Legislation has made it statutory for organisations with 250 or more employees to report annually on their gender pay gap. Government departments are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017. These regulations underpin the Public Sector Equality Duty and require the relevant organisations to publish their gender pay gap data by 30 March 2018 (and then annually), including mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The gender pay gap is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

HPFT supports the fair treatment and reward of all staff irrespective of gender.

This report sets out:

- the reporting requirements for HPFT
- provides additional data where appropriate
- provides some analysis to identify the gender pay gap
- possible reasons for the gender pay gap, and
- what we are doing to close the gender pay gap in the organisation.

3.0 Definitions and scope

The gender pay gap is defined as the difference between the mean or median hourly rate of pay that male and female colleagues receive.

The mean pay gap is the difference between average hourly earnings of men and women, i.e. The hourly gap divided by the average for men equates to the mean gender pay gap.

The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women. It takes all salaries in the sample, lines them up in order from lowest to highest, and picks the middle-most salary.

The report is based on rates of pay as at 31 March 2017 and bonuses paid in the year 1 April 2016 – 31 March 2017. It includes all workers in scope at 31 March 2017.

4.0 Gender Pay Gap

The following Gender pay report data is taken as the snapshot date of 31 March 2017:

1.	The mean gender pay gap for HPFT	7.68%
2.	The median gender pay gap for HPFT	2.92%
3.	The mean gender bonus* gap for HPFT	1.59%
4.	The median gender bonus* gap for HPFT	56.45%

* Please see comments later in this report explaining what constitutes a bonus

5.0 Pay Quartiles by Gender

Quartile	Female Headcount	Male Headcount	Female %	Male %	Description
1 (lowest paid)	607	218	73.58%	26.42%	Includes all employees whose standard hourly rate places them at or below the lower quartile
2	594	231	72%	28%	Includes all employees whose standard hourly rate places them above the lower quartile but at or below the median
3	610	215	73.94%	73.94%	Includes all employees whose standard hourly rate places them above the median but at or below the upper quartile
4 (highest paid)	563	262	68.24%	31.76%	Includes all employees whose standard hourly rate places them above the upper quartile

6.0 What do we do to ensure equal pay?

As noted earlier in this report, gender pay is different to equal pay.

Legisalation requires that men and women must receive equal pay for:

- the same or broadly similar work;
- work rated as equivalent under a job evaluation scheme; or
- work of equal value.

HPFT is 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/maternity, sexual orientation, gender reassignment or disability. It has 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:

National NHS Agenda for Change Terms and Conditions of Service (AfC).

AfC is negotiated nationally by the NHS Staff Council, led by NHS Employers. The national NHS Staff Council has overall responsibility for the AfC pay system and has representatives from both employers and trade unions. AfC provides the framework for pay arrangements which are in place at HPFT.

Typically, AfC terms and conditions apply to nursing, allied health professionals and administration and clerical staff, which are the majority of the workforce.

Where appropriate, locally agreed policies may supplement AfC arrangements, such as:

- Family friendly policies
- Evaluating job roles and pay grades as necessary to ensure a fair structure starting salaries policy

Medical and Dental Staff are employed on national Terms and Conditions of Service (TCS) and pay arrangements.

These pay arrangements are negotiated nationally on behalf of employers by NHS Employers with the NHS trade unions. These terms and conditions include all Consultants, Medical and Dental staff and Doctors and Dentists in Training.

Very Senior Managers (VSMs) and Chairs and Non-Executive Directors (NEDs).

As a NHS Foundation Trust, HPFT is free to determine its own rates of pay for its VSMs and Chairs and NEDs. VSMs include Chief Executives, Executive Directors and other senior managers with board level responsibility who report directly to the Chief Executive.

7.0 The Gender Pay Gap at HPFT – further data

HPFT is confident that its gender pay gap does not stem from paying men and women differently for the same or equivalent work. Rather its gender pay gap is the result of the roles in which men and women work within the organisation and the salaries that these roles attract.

It is perhaps helpful to review the staffing profile within HPFT. Below is a table which reflects the pay bands in operation. The bands referred to in the table are the AfC pay bands and range from band 1 (the lowest pay band) through to band 9 (the highest pay band).

Medical and dental roles are categorised by 'Non Consultant Medical' and 'Consultant'. There is a line for Executive Directors and Non-Executive Directors (NEDs).

There are a small number of staff employed by HPFT on what have been categorised as Trust Contracts. Typically these are substantive members of staff engaged on contracts reflecting the terms and conditions associated with TUPE transfer from other organisations. These are shown in the category marked as "other" in the table below showing a figure of -25.17%, a pay gap in favour of females.

The information contained within the table is sourced from the same data which provided the gender pay gap figures, i.e. The staffing position as at 31 March 2017.

The final colum within the table reflects the gender pay gap position, based on the staff contained within the respective pay categories. Where there is a negative figure, it suggests that the pay gap is in favour of females. Where it is a positive figure, it reflects a gender pay gap in favour of males.

Grade	Male Headcount	Female Headcount	Male Avg. Hourly Rate	Female Avg. Hourly Rate	Difference	Pay Gap %
Apprentice		4		3.83	-3.83	-100.00
Band 2	115	159	11.35	11.61	-0.25	-2.24
Band 3	240	363	11.86	11.33	0.53	4.49
Band 4	53	414	11.55	11.44	0.11	0.98
Band 5	111	403	15.27	14.44	0.83	5.46
Band 6	139	431	17.85	17.45	0.40	2.22
Band 7	105	305	20.07	19.42	0.65	3.24
Band 8a	37	108	23.63	23.71	-0.07	-0.31
Band 8b	20	51	28.03	28.17	-0.15	-0.52
Band 8c	8	18	31.99	31.46	1.26	3.62
Band 8d	3	6	42.72	40.23	2.50	5.84
Band 9	3	1	48.13	51.70	-3.57	-7.42
Consultant	47	45	32.92	30.45	2.47	7.50
Medical Trainee	9	32	19.55	19.70	-0.16	-0.81
Non-Consultant	20	19	22.26	19.22	3.04	13.67
Non-Exec	2	5	7.78	8.09	-0.31	-4.00
Other	5	2	15.23	19.07	-3.83	-25.17
VSM	9	8	72.84	53.01	19.82	27.22
Grand Total	**926**	**2374**	**17.20**	**15.88**	**1.32**	**7.68**

** Negative figures in the column 'Gender Pay Gap by Pay Band' indicate a gender pay gap in favour of females.*

7.1 What is the data telling us?

There is a relatively small gender pay gap within AfC pay bands 3 to 7 hence the overall gender pay gap of 7.68% for HPFT. It is important to remember that this is about the gender pay gap not equal pay gap.

On face value, the staff group/banding analysis is reassuring in resepect of pay. However, analysis suggests that the gender pay gap may be attributed to the medical roles, typically the highest earning roles within the HPFT.

7.2 What is the Gender Bonus Gap?

Within the Gender pay Gap Regulations, 'bonus pay' means any remuneration that is the form of money relating to profit sharing, productivity, performance, incentive or commission.

It is clear within the regulations that bonus pay does not include ordinary pay, overtime pay, redundancy pay or termination payments.

For the purpose of Gender Pay Reporting, Clinical Excellence Awards payments are regarded as 'bonus pay'. The Clinical Excellence Awards (CEA) scheme is intended to recognise and reward those Consultants who perform 'over and above' the standard expected for their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions towards the delivery of safe and
high quality care to patients and to the continuous improvement of NHS services.
There are 12 Levels of award with monetary value. Levels 1-9 are awarded locally (employer based awards) and Levels 10-12 (Silver, Gold and Platinum hereafter) are awarded nationally in accordance with an assessment criteria and application.

Consultants with an existing distinction award or discretionary points keep them, subject to existing review provisions, and are eligible to apply for awards under the new scheme in the normal way.

Accordingly, the legacy of the CEA scheme means that there will continue to be a gender pay gap because there are more male consultants than female consultants and the gender balance is only likely to improve over time (see above).

8.0 Conclusion

In conclusion, HPFT will continue to monitor the gender pay gap and consider next steps to reduce the gap where applicable.

Maria Gregoriou
Associate Director of Workforce
March 2018

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22.03.2018	**Agenda Item: 20**
Subject:	Board Assurance Framework (BAF)	**For Publication:**
Author:	Nick Egginton, Compliance and Risk Manager	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety	

Purpose of the report:

For discussion of the latest iteration of the BAF and to provide timescales for introduction of the revised Trust Risk Strategy and underlying Policies.

Action required:

Please receive the BAF and proposed revision of the risk process and associated documentation.

Summary and recommendations to the Audit Committee:

1. Introduction

As reported at the Trust Board on 25th January 2018, the BAF has undergone a series of updates to ensure that as a method of setting out the most important risks facing the organisation. The BAF identifies the control framework used to manage them, shows any gaps in control and details the assurances that the Trust uses to satisfy itself that the controls are working as intended.

Each Risk, Control and Assurance line was reviewed by the Lead Director and peer reviewed in an Executive session prior to the 25th January 2018 board report to ensure that the information provided in the BAF is sufficient to provide the Board with the necessary assurance. The following updated BAF has had a concise table top review.

The Trust is continuing to review the overarching Risk Strategy and Policy Documents to ensure we maintain a comprehensive, pro-active and dynamic risk management framework. The Board Assurance Framework (BAF) sits alongside the Trust Risk Register and is the principle method of setting out the most important risks facing the organisation. It sets out the control framework used to manage them, any gaps in control and how the organisation satisfies itself that the controls are working as intended.

The BAF is intended to provide Trust Board with a clear and comprehensive understanding of the most important risks faced by the organisation and sets out how those risks are managed, how assurance on the operation of those controls is obtained, and enables timely consideration of assurance outcomes. The controls and assurances listed will be reviewed as part of the risk management process and assurance sources will continue to be reviewed at Board and its sub-committees.

The overarching Risk Strategy and its and its underlying policies are due for review and renewal. The Strategy is currently being re-written and will be completed alongside the main Trust Strategy to ensure that it fits with the Trusts vision, values and incorporates the latest objectives. The policies and operational documents will be reviewed in light of the updated Risk Strategy.

2. BAF Risk Control Updates

Suicide Prevention Strategy

The Trust continues to be active partners in the implementation of the Hertfordshire Suicide Prevention

Strategy, in addition to this the Trust is a member of the Zero Suicide Alliance and attend the launch in Q3, in Q4 an action plan will be developed from learning from across the membership of the alliance.

CQC MHA Inspections

During the period 1st October 2017 – 31st December 2017 there have been 4 MHA CQC visits to wards within HPFT. All 4 Provider Action Statements from these visits have been submitted by the CQC. The table below shows the wards visited. All Trust responses were submitted within the required timeframe.

- Cymbeline Lodge (Lexden)
- Aston Ward
- Swift Ward
- Logandene

Since January 2018 the following CQC MHA visits have taken place

- Gainsford House (Provider action plan submitted)
- Forest House Adolescent Unit (Provider action plan submitted)
- Assessment and Treatment, Lexden (awaiting report and action plan development)
- Victoria Court (Provider action plan submitted)

Integrated Health and Care Commissioning Team (IHCCT) Quality Assurance Visit Programme

The following visits have taken place recently undertaken by IHCCT:

- Holly Lodge on 28th October 2017;
- SPA on 19th December 2017
- Colne House on 11th January 2018.

These are fed back and reviewed at the QRM. The action plans have been developed and are monitored internally and by the CCGs.

HPFT Quality Assurance Visits

The Deputy Director Quality and Nursing has recently taken over leading the HPFT Quality Assurance Visits and is reviewing the process with the SBU leadership team with the aim of strengthening the process and assurance.

Emergency Planning

Annual updates are provided on Emergency planning. We have, in 2017/18, provided training to the executive, silver and bronze command. We have established bronze command in each SBU. This was tested when we declared a Major Incident when PARIS went down in January 2018. We have responded to all EPRR requests in relation to winter and in particular during the periods of heavy snow. We are leading on the planning of an LHRP wide event on post incident psychological support.

Making Our Services Safer (MOSS) Strategy

The MOSS strategy has come to an end of its life. Consideration was given to developing a safety strategy and renewing the MOSS strategy. The Deputy Director of Quality and Nursing and the Deputy Director of Safer Care and Standards are working together to develop a strategy that develops the MOSS principles and wider approach to safety. This will be presented at IGC in July.

NICE Guidance

NICE Guidance compliance reporting takes place at Practice Audit Implementation Group, through to the Quality Risk Management Committee and the Integrated Governance Committee. In addition the NICE compliance has also been reported to the Quality Review Meetings with commissioners.

National Community Survey

A progress report was provided to the Board in January 2018. The results were publically released November 2017. Work to date has included improving care review literature, welcome packs, review of having your say community survey and reviewing service user and carer experience.

Physical Health Targets (Non CQUIN)

The Physical Health Committee oversees progress on the Physical Health Targets. The current report describes progress against a range of non CQUIN targets. While progress is being made against a range of actions, there remain some outstanding actions that continue to require additional focus.

NHSI Retention Support Programme / Retention Improvement Plan

NHS Improvement has developed a three year national programme for improving retention across the health service. The objective is to stabilise and subsequently reduce the leaver rates. HPFT has been identified as a Mental Health Trust with high leaver rates and therefore has been asked to participate in the first cohort of this programme. The Trust submitted its Retention Improvement Plan to NHSI at the end of the Quarter 3 following positive meeting with NHSI. NHSI feel the project structure is in place, that the risks have been considered but the mitigation to those risks needs to be outlined, that the initiatives are data driven and there is further staff engagement to ensure the turnover reduction is achieved. Further to submitting our retention plan a project plan has been produced.

Productivity Monitoring Processes

The Annual Plan objective to support and empower staff to improve innovate and become more productive is reported in the Q3 annual plan report as an 'amber' projection for the year which reflects the use of core productivity metrics. We are involved in the NHSI model hospital initiative and some work streams have not yet come to a conclusion and cannot yet demonstrate improved use of resources.

Recommendation:

Board are asked to receive the BAF and note the work in relation to reviewing and renewing the Risk Management documents

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):
Summary of Implications for:

N/A

Equality & Diversity (has an Equality Impact Assessment been completed?) and Public & Patient Involvement Implications:

No

Evidence for Essential Standards of Quality and Safety; NHSLA Standards; Information Governance Standards, Social Care PAF:

Yes

Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

Trust Board 22.03.2018

Board Assurance Framework (BAF)

14th March 2018

To be reviewed by:

- Trust Board 22nd March 2018

Introduction

This Board Assurance Framework brings together the principal risks potentially threatening the Trust's Strategic Objectives and outlines specific control measures that the Trust has put in place to manage the identified risks and the independent assurances relied upon by the Board to demonstrate that these are operating effectively.

Explanation of Assurance types and levels

Assurance Type **-** The identified source of assurance that the Trusts receives can be broken down into a three line model (1st, 2nd and 3rd line assurances)**. The assurance type column RAG rating records the highest level available for each control**

1st Line	2nd Line	3rd Line
Assurance from the service that performs the day to day activity E.g. Reports from the department that performs the day to day activity, Departmental Meetings, Departmental Performance Information	Assurance provided from within the Trust - Internal assurance E.g. Management Dashboards, Monthly monitoring	Assurance provided from outside the Trust - Independent assurance E.g. Internal Audit, External Audit, Peer Review, External Inspection, Independent Benchmarking

Assurance Level - For each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls

High	Medium	Low
One or more of the listed assurance sources identify that effective controls are in place and the Trust Board are satisfied that appropriate assurances are available Substantial assurance provided over the effectiveness of controls	One or more of the listed assurance sources identify that effective controls are in place but assurances are uncertain and/or possibly insufficient Some assurances in place, or substantial assurance in place, but controls are still maturing so effectiveness cannot be fully assessed at this time.	The listed assurance sources identify that effective controls may not be in place and/or appropriate assurances are not available to the Board Assurance indicates poor effectiveness of controls.

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
What the Trust aims to deliver on the next phase of the Good to Great journey	**Principal risks are** those that threaten the achievement of the Trusts strategic objectives. There is a risk that…	The Trust should ensure that **key controls are** in place which is designed to manage the principal risks.	What sources of assurance are there? **[It is essential that minutes of Board and Sub-committees that review assurances, contain a clear reference to the quality and level of assurance received.]**	It is essential that Board and Board sub committees receive regular reports about the assurances on the management of their principal risks and are proactive in addressing issues that arise.	The assurances that the Trust receives can be broken down into a three line model	Each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls	The date of the assurance	There is a lack of assurance about the effectiveness of one or more of the key controls. This may be as a result of lack of relevant reviews, concerns about scope, depth of reviews that take place or the length of time since the last review.	The Executive Director Responsible for managing the Risk [& the Principle Board Sub-Committee]
Good to Great Strategy (Great Care, Great Outcomes) [Positive Experience, Effective, Safe]									
1. The safety of our services will improve so that more people feel safe and are protected from avoidable harm	**Service users are not able to progress positively through our services, feel safe and be protected from avoidable harm** - **Service users on acute wards do not report feeling safe** - **Failure to reduce the number of**	Suicide Prevention Strategy	Suicide Prevention Reports included in Patient Safety Reports	Executive Committee IGC Trust Board	2nd Line	High	IGC 18.01.18		Director of Quality & Safety [IGC]
		Review of all Serious Incidents	Serious Incident Briefing Report. Weekly	Executive Committee CCGs	2nd Line	High	Weekly to Exec		
		Safer Care and Standards Processes	CQC MHA Inspections	Mental Health Act Quality Managers Meeting.	3rd Line	High	Bi – Annually report planned		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
	suicides			Safeguarding Strategy Group (SSG) IGC			for IGC		
			Quarterly & Annual Patient Safety Reports	Executive Committee IGC Trust Board CCG QRM	2nd Line	High	Q3 IGC 18.01.18 TB 25.01.18 QRM 23.01.18		
			HPFT Quality Visits Quality Visit Report (Part of Performance Report)	QRMC PRM IGC Trust Board	2nd Line	Medium	TB 29.11.17 QRMC 04.01.18	Gaps identified in robustness of visits / review process and action plan follow up	
			Integrated Health and Care Commissioning Team (IHCCT) Quality Assurance Visit Programme	CCG Quality Review Meetings	3rd Line	High	QRM 24.11.17		
			Freedom to Speak up – 6 monthly review	IGC Trust Board	2nd Line	High	29.11.17		
			Concerns raised with the Trust via the CQC (CQC Concerns)	IGC (Part of the Speak Up 6 monthly report) Trust Board	2nd Line	High	IGC 14.12.17		
			Externally Commissioned McCallion Report on SI processes	Executive Committee IGC Trust Board CCG QRM	3rd Line	High	08.06.17 24.07.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
			Internal Audit Reviews Risk Management and Assurance Framework	Audit Committee	N/A	N/A	Planned 5 March 2018		
			Health, Safety and Security Report (Annual / Quarterly Report)	HSSC QRMC IGC	2nd Line	High	IGC 04.01.18		
		Quality Account Processes	Quality Account 16 - 17 (Externally Audited) Published alongside annual report	Executive Committee IGC Trust Board External Audit	3rd Line	High	18.04.17 24.05.17 24.05.17		
		CQUIN Processes	CQUIN Reports – Part of quarterly Performance Report	Executive Committee IGC Trust Board CCGQRM	2st Line	High	IGC 06.03.18 QRM 23.01.18		
		Emergency Planning	Emergency Planning and Business Continuity EPRR Core Standards compliance – CCG & NHSE approval Emergency preparedness, Resilience and Response Annual Report	Executive Committee IGC Trust Board	2nd Line	High	TB 27.09.17		
		MOSS Strategy	Annual Report	HSCC QRMC IGC	2nd Line	High	IGC 14.12.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
	The fundamentals of care are not delivered consistently across all our services	National Quality Board (NQB) Staffing Report	Quarterly Safe Staffing Levels report	Executive Committee IGC Trust Board	2nd Line	High	IGC 13.09.17 TB 29.11.17 QRMC 26.02.18 IGC 06.03.18 QRM 24.11.17		Director of Quality and Medical Leadership [IGC]
		HR Processes	Trust performance KPI report on Workforce Workforce and OD Report Pulse Survey Report (Q) – Part of the Workforce & Organisational Development Report Good to Great Road Shows, Big Listen and Local Listen.	Executive Committee WODG IGC Trust Board	2nd Line	High	TB 29.11.17 25.01.18 IGC 06.03.18		
		External Systems for Staff Feedback	National Staff Survey 2017 Report on Key Findings	Executive Committee WODG IGC Trust Board	3rd Line	High	IGC 18.01.18		
		Annual Programme of Clinical Audit (Practice Audit and Clinical Effectiveness) inc NICE	Annual Audit Programme	Executive Committee IGC Trust Board CCG QRM	2nd Line	High	IGC 06.03.18		
		Medicines Management	DTC Annual Report	QRMC Executive	2nd Line	High	QRMC 08.09.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
			6 monthly committee update	Committee IGC Trust Board			04.01.18		
		NICE Guidance Policy	NICE Progress Reports	PAIG QRM	2nd Line	High	PAIG 24.01.18 QRM 23.01.18		
2. The Quality and Service Development Strategy will deliver a better experience of services and improved outcomes	**Service users unable to access the right services in a timely way** - **Service users will not experience timely access to adult community services** - **Service users will not experience timely access to CAMH services – CHOICE and partnership** - **Inpatient admissions for young people are not reduced**	Performance Monitoring Processes	Trust Performance KPI report – Access Times. Re-admission rates. Performance Review Process Live Data Performance Dashboards Performance Audit Performance against Annual Plan Internal & External Audit	Executive Committee TMG Trust Board SBU Core Management PRM Contract review meetings Internal & External Audit	2nd Line	High	TB 29.11.17 TB 25.02.18		Director of Service Delivery and Customer Experience [IGC]
		Quality Impact Assessments Procedure for CRES	Individual Quality Impact Assessments	CRES PAB and Trust Executive Committee QRM	2nd Line	High	QRM 23.01.18		
		Service User Feedback	Community Mental Health Survey (Progress reports)	QRMC Executive Committee IGC Trust Board	3rd Line	High	TB 25.01.18		
			Compliments, Complaints and HYS feedback Peer listening reports and feedback		2nd Line	High	TB 29.11.17 / 25.01.18 IGC 18.01.17		
		Carers Pathway Development	Carer Pathway report	QRMC	2nd Line	High	04.01.18		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
3. Better health monitoring and support to address health risk factors is delivered and the wellbeing and physical health of service users will improve	- **Service users will not report physical health care needs being met**	Physical Health Strategy CQUIN	CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads	TMG Trust Board Physical Health Committee QRM	2st Line	High	QRM 23.01.18		Director of Service Delivery and Customer Experience [IGC]
		Physical Health Strategy – measures against outcomes	Non – CQUIN Physical Health Targets	Physical Health Care Committee	2nd Line	Medium	19.01.18		
Good to Great Strategy – Great People [People have right skills and values, Leaders who involve and empower, a workplace where people grow, thrive and succeed.]									
4. A culture of collective leadership is developed and a more empowered and engaged workforce is created	**Staff do not report feeling engaged and motivated and do not recommend the Trust as a place to work** - **Staff do not report improved satisfaction with level of responsibility and involvement** - **Staff do not report increased support from immediate managers** - **Staff do not report an increase in recognition and value by managers and the organisation**	Multi Professional Quality Improvement Performance Framework (QIPF)	QIPF Quality Performance and Review Update Paper (Action Plan)	IGC	2nd Line	High	08.06.17		Director of Workforce and OD [IGC]
		Workforce Health and Wellbeing Strategy Action Plan	Workforce and Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	TB 29.11.17 25.01.18		
		Health and Wellbeing CQUIN Action Plan	Quarterly Report	Executive Committee WODG IGC Trust Board	2nd Line	High	WODG 15.01.18 12.03.18 IGC 06.03.18		
		Systems for Staff Feedback As defined in the Engagement & OD Strategies	Pulse Survey Report– Part of the Workforce & Organisational Development Report Good to Great Road Shows, Big Listen and	Executive Committee WODG IGC Trust Board	2nd Line	High	TB 25.01.18		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
			Local Listen.						
		External Systems for Staff Feedback	National Staff Survey 2017 Report on Key Findings	Executive Committee WODG IGC Trust Board	3rd Line	High	IGC 15.01.18		
		Harassment and Bullying Plan (also part of the HPFT work plan for WRES)	Workforce and OD Report	Executive Committee WODG IGC Trust Board	2nd Line	High	WODG 12.03.18		
		NHSI Retention Project	Project Plan and Support Programme	WODG	3rd Line	Medium	WODG 12.03.18		
		Appraisal / PDP Reward and Recognition Processes	Statutory & Mandatory Training Report Monthly Inspire and annual awards	Executive Committee WODG IGC Trust Board	2nd Line	High	TB 25.01.18		
		Mandatory Training Programme	Quarterly Workforce and Organisational Development KPI Report (to services monthly)						
5. Our leadership base is developed and the capabilities and capacity required to deliver our plans is strengthened	**Leaders across the organisation do not receive appropriate training and support on improvement approaches and tools** - **Failure of staff to develop strong core competencies**	Organisational Development Plan	Workforce and Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	TB 25.01.18		Director of Workforce and OD [IGC]
		Staff Feedback systems	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	WODG 13.11.17 TB 25.01.18		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
			National Staff Survey 2017 Report on Key Findings	Executive Committee WODG IGC Trust Board	3rd Line	High	IGC 18.01.18		
	Strong clinical leadership of key service changes is not evident	Clinical Leadership Structures in place	Quality Impact Assessments	MSC IGC Trust Board	2nd Line	High	IGC 14.12.17		Director of Quality and Medical Leadership [IGC]
		External review of Trust Governance arrangements every three years	Independent Well Led Review Update	Executive Committee IGC Trust Board	2nd Line	High	08.06.17		
		Academic links in place with University of Hertfordshire Clinicians Leading Innovations Group		University of Hertfordshire strategic Management Group	2nd Line	Medium	10.11.17		
		Systems for Staff Feedback As defined in the Engagement strategy & the OD Strategy.	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	WODG 13.11.17 TB 25.01.18		
		External Systems for Staff Feedback	National Staff Survey 2017 Report on Key Findings	Executive Committee WODG IGC Trust Board	3rd Line	High	IGC 18.01.18		
6. New roles are developed, staff turnover reduces and there is a reduction in	**New roles are not created which support the clinical model.**	Recruitment and Retention Strategy and Policy	Quarterly Recruitment and Retention Report	Executive Committee WODG IGC	2nd Line	High	WODG 15.01.18 IGC		Director of Workforce

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
reliance on temporary staffing				Trust Board			06.03.18		and OD
	Turnover and vacancy rates are not reduced	Recruitment and Retention Strategy and Policy. Ongoing Development of Workforce plans.	Quarterly Workforce and Organisational Development Report (to services Monthly)	Executive Committee WODG IGC Trust Board	2nd Line	High	WODG 15.01.18 IGC 06.03.18		[IGC]
		Agency Reduction Action Plan	CRES Programme Assurance Board reports	Executive Committee FIC Trust Board	2nd Line	High	FIC 13.03.18		
	Recruitment and retention plans are not robust and do not support increased flexible working	Recruitment and Retention Strategy and Policy	Recruitment and Retention Group Reports	WODG Executive Committee IGC Trust Board	2nd Line	High	WODG 15.01.18 IGC 06.03.18		
Good to Great Strategy (Great Organisation) [Always getting fundamentals right, Always learning, innovating and improving.]									
7. Staff and teams will have better access to the right information and tools to do their jobs effectively and efficiently	**Staff will not have an improved experience of our EPR and Business Intelligence systems**	Digital Strategy Action Plan	National Staff Survey 2017 Report on Key Findings	Executive Committee WODG IGC Trust Board	3rd Line	High	WODG 15.01.18 IGC 06.03.18		Director of Innovation and Transformation [IGC]
			Pulse Survey Report– Part of the Workforce & Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	WODG 13.11.17 TB 25.01.18		
			PARIS/BI Development Group – progress reports IM&T Strategy External review	IM&T Strategy Board Executive Committee IGC	2nd Line	High	IM&T 17.11.17		
		Strategic Investment Programme	Report from Finance & Investment	FIC Trust Board	2nd Line	High	FIC 13.03.18		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
	The quality and recording of data does not improve	Clinical Recording Assessment Framework	Progress reports against project plan	IM&T Strategy Board	1st Line	High	27.11.17		
		Monitor, validate and audit data quality against standards	Accurate Information Group	IM&T Strategy Board MSC Executive Committee	1st Line	Medium	Sept 2017		
		Performance Monitoring Processes	Quality Dashboard Performance Review Process Operational Services Report Quarterly Performance Report Trust Performance KPI report	Executive Committee IGC Trust Board	2nd Line	High	TB 29.11.17 TB 25.02.18		
	Failure to maintain a sustainable financial position that supports investment and the continuity of services	Annual Operational & Financial Plan Strategic Investment Programme	Financial summary report monitoring performance against plan including Overall NHSI Use of Resources Risk Rating Progress report on delivery of Strategic Investment Programme	Executive Committee Trust Board FIC Audit Committee Modernising our Estate Board Executive Committee FIC	2nd Line	High	TB 25.01.18 MoE 27.02.18		Director of Finance [FIC or Audit]
		External Audit	Annual Governance Statement Annual Financial Statements	Trust Board Audit Committee	3rd Line	High	27.05.17 27.05.17		
		Cash Releasing Efficiency Programme	Part of Financial Summary Report CRES Programme Assurance Board	Executive Team FIC Trust Board Trust	2nd Line	High	TB 25.01.18		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				Management Group					
		Hertfordshire and West Essex Sustainability and Transformation Plan (STP) Trust Contracts	Update reports CEO Brief STP Report Contract Update Report Annual Plan	Trust Board FIC	2nd Line	High	TB 25.01.18		
8. Staff will be supported and empowered to improve, innovate and become more productive in delivering great care	**Innovative productive ways of working are not embedded**	Organisational Development Plan – High Level Deliverables	Quarterly Workforce and Organisational Development Report (to services Monthly)	Executive Committee WODG IGC Trust Board	2nd Line	High	WODG 15.01.18 IGC 06.03.18		Director of Innovation and Transformation [FIC or IGC]
		Single Oversight Framework Requirements	Use of Resources Metrics	Executive Committee FIC Trust Board	2nd Line	High	TB 25.01.18		
	Technology to support new ways of working is not used effectively	Productivity Monitoring Processes	Financial summary report Annual Accounts Finance Reports CRES Programme Assurance Board Trust Performance KPI report	Executive Committee FIC Trust Board	2nd Line	High	TB 25.01.18		
	The Safe Care tool is not successfully rolled out across services such that resource utilisation is not enhanced	National Quality Board (NQB) Processes	Quarterly Safe Staffing Levels report	Executive Committee IGC Trust Board	2nd Line	High	IGC 13.09.17 TB 29.11.17 QRMC 26.02.18 IGC 06.03.18 QRM		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
							24.11.17		
		Productivity Monitoring Processes	Annual Plan Reporting	Trust Board	2nd Line	Medium	TB 25.01.18		
Good to Great Strategy (Great Networks & Partnerships) [Leading networks to deliver great joined-up care, Building great relationships and partnerships to meet whole persons needs]									
9. We will deliver more joined up services across mental health, physical health and primary care.	**Failure to work in partnership to deliver support and treatment that is joined up across mental health, physical health and social care services** - **Key integration projects will not be delivered** - **Failure to work jointly with GPs and GP Federations** - **Service users and staff unable to report improved experience of referral and discharge pathways**	Carers Pathway	Carer Pathway update	QRMC	2nd Line	High	QRMC 04.01.18		Director of Strategy and Integration [FIC or IGC]
		5 Year FV Delivery Plan	STP Participation Provider Collaborative Individual Strategy Groups Integrated Care development Group	Executive Committee FIC Trust Board	2nd Line	High	TB 25.01.18		
		Performance Monitoring Processes	Performance Report	FIC Trust Board	2nd Line	High	TB 29.11.17 TB 25.02.18		
		Staff Feedback	Pulse Survey Report – Part of the Workforce & Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	WODG 13.11.17 TB 25.01.18		
		Service User Feedback	Having Your Say	IGC QRMC Trust Board	2nd Line	High	TB 29.11.17 / 25.01.18 IGC 18.01.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
							QRMC 04.01.18		
		Physical Health Strategy – measures against outcomes	Non – CQUIN Physical Health Targets	Physical Health Care Committee	2nd Line	Medium	19.01.18		
		Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	Clinical Commissioning Group	CCG QRM	3rd Line	High	23.01.18		
		Engagement Policy	Service User Council/Carer Council – 6 monthly report	QRMC	2nd Line	High	26.02.18		
10. We will be recognised as system leaders having successfully driven and delivered on key system priorities.	**Improving MH & LD services fails to become central to local health and social care economy plans**	STP Leadership of MH and LD streams Locality Board membership	STP progress reports Reports to Integrated Care Development Group, Trust Management Group	Trust Strategy Group Executive Committee Trust Board	2nd Line	Medium	14.12.17		Director of Strategy and Integration
	HPFT/HCT Strategic Alliance fails to drive and deliver key system priorities	Commercial Strategy action plan Strong relationships with all Key Stakeholders to drive and deliver key priorities	Relationship progress reports	Trust Strategy Group Executive Committee Trust Board	2nd Line	Medium	14.12.17		
		CCG Commissioning Intentions. Annual Plan	Quarterly reports	Executive Committee Trust Board	2nd Line	Medium	Annual 25.01.18		

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Public Board

Meeting Date:	22.03.2018	**Agenda Item:** 21
Subject:	Trust Risk Register February 2018	**For Publication:** yes
Author:	Nick Egginton, Compliance & Risk Manager	**Approved by:** Dr Jane Padmore, Director of Quality and Safety
Presented by:	Dr Jane Padmore, Director of Quality and Safety	

Purpose of the report:

The current Trust Risk Register (TRR)

Action required:

For information

Summary and recommendations:

1. Introduction / Background

The Trust Risk Register (TRR) outlines the high level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them. The following report identifies the top 10 risks on the Trust Risk Register

The full iteration of the Trust risk register was reviewed at Exec on 28.02.2018 and IGC on the 06.03.2018

2. Escalated Risks to Trust Risk Register to be considered

None

3. Risks downgraded from Trust Risk Register

Risk ID 666 The demand growth within the SPA service has the potential to impact on the infrastructure resulting in a performance, reputational and clinical risk to the Trust.

It was agreed at IGC that the following risk will be downgraded from the Trust Risk Register on the basis that SPA performance has improved and been sustained over 2 quarters and we have seen the successful implementation of our new IT and telephony platform. The risk to SPA that remains is the impact that IT failure has on SPA performance, which is linked to the risk 625 about the fragility of the underlying IT infrastructure. The risk will remain on the West SBU risk register.

Risk ID 366 To ensure sufficient AMHP coverage is in place to meet county requirements

There has significant improvement in the HPFT AMHP coverage on a regular basis, there still remains some inconsistent service provision across 24/7 period due to different levels of service between HPFT and HCC (OOH). IGC approved the recommendation that the risk score is

reduced from 12 (Likely 4 x Moderate 3) to a 9 (Possible 3 x Moderate 3) and the risk is downgraded from the Trust Risk Register, it will remain on the East and North SBU risk register.

4. Risk scores increased
None

5. Risk scores decreased or to be considered for decreasing
None

6. Updates
Risk ID 666 The demand growth within the SPA service has the potential to impact on the infrastructure resulting in a performance, reputational and clinical risk to the Trust

- Ceased using faxes from Dec 2018 - all referrals are now received from emails or calls.
- Phase 2 outbound work is linked to NHS.net migration likely to take place March 2018.
- One vacancy at present - the operational team leader role which is out to recruitment.
- IVR system is in place which supports initial callers to access the correct advisor.
- Weekly performance calls continue with CAMHS.
- Concerns remain around the impact that IT failure has on SPA performance, for example the fault with the phone lines at Waverley Road on 15.02.2018 meant staff worked Saturday to resolve any backlog.

Risk ID 387 Management of demand and capacity for those individuals pending care coordination allocation
The Service Line Lead provided an update on a specific risk for SW Adult Community for unannounced cases (Risk 550)

- 100 approx. cases pending allocation,
- The high number of pending cases is linked to volume, demand and turnover.
- One individual is working through these cases and RAG rating them.
- These service users need a care coordinator as they might have been discharged by CATT or have been discharged from inpatient units.

Risk ID 625 Fragility in the underlying IT infrastructure results in an IT failure which prevents or reduces access to critical systems, negatively impacting quality and safety, performance and reputation.
This risk was reviewed:

- Decommissioning Waverley Road Server Room.
- National PARIS problem mid-January - Silver command set up - Business Continuity in place to minimise impact.
- Risk to remain on the Trust Risk Register.

Risk ID 749 The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT
This risk was reviewed with the Deputy Director of Commercial Development and Strategy:

- Continued financial pressure on acute and HVCCH married with shared STP control totals which could see funding move away from mental health.
- The Trusts ability to keep parity of esteem in these circumstances is going to remain challenging.

Risk ID 215 The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff
This risk was reviewed with the Deputy Director of Workforce and OD:

- Introduction of a recruitment and retention Premia (RRP) has improved the Trust's ability to recruit to nursing vacancies at Broadland Clinic and Astley Court (Norfolk).
- The Trust has 9 staff who are currently undertaking the Nursing Associate programme with a further cohort being planned to commence in April 2018.
- A seven day recruitment event took place at Brent Cross shopping centre w/c 22nd January 2018. This generated 245 expressions of interest which the recruitment team are following up. One of the overseas nurses from the Philippines started with the Trust in November 2018 and is in the process of completing his OSCE. A further 2 candidates are awaiting visa clearances.
- The vacancy rate has reduced by 0.42% from 13.42% in December to 13% at the end of January.

Risk ID 657 The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services

This risk was reviewed with the Deputy Director of Workforce and OD:

- The Trust submitted its NHSi retention improvement plan during Q3 which includes a number of activities which should aid retention such as focusing on an internal recruitment process, making it easier for staff to return following retirement and developing career pathways
- Delivery against the activity in the OD Strategy has continued in Q3. A significant amount of engagement activity continued in Q3 including the Big Listen, Local Listens, Senior Leaders Forums, Staff Awards, Staff Development Awards and a number of health and wellbeing initiatives.
- There were 100 leavers during Q3 which is lower (by 30) than Q2. This is the third quarter where nursing & midwifery staff had more leavers than starters. In January 2018 there were 51 new starters and 37 leavers.
- Work continues to be undertaken to address turnover and all SBU's have localised retention plans. The Trust is also working with NHSI with regards to retention and submitted its NHSI retention improvement plan during Q3 which outlines the activity the Trust is undertaking to improve retention.
- The turnover rate has increased slightly in January to 13.5%.

Risk ID 862 Statutory and Mandatory Training Compliance

The following update to the risk has been provided by the Deputy Director of Workforce and OD

- There has been an overall increase in compliance of 9% from the end of December 2017 to the end of January 2018 in the new competencies.
- A weekly statutory and mandatory task and finish group has been established with the objective of reaching 92% compliance in statutory and mandatory training by the end of March 2018.
- Trajectories have been set for each training course and progress against these are being monitored each week. Where progress is not being achieved or is behind trajectory the subject matter experts and learning and development team are being asked what action is being taken to mitigate against this.

Risk ID 801 The Trust's statutory safeguarding delegated responsibilities not consistently and effectively undertaken placing service users at risk

- Further PACE audits have demonstrated that adherence to HSAB standards of practice regarding timely decision making and strategy meetings has improved and 90% of decisions to proceed are made in timely manner.
- The Safeguarding committee is being presented with the next set of dip audit results on 27.02.2018; these will subsequently be reported to IGC.

Further actions have been taken

- A practice note has been disseminated affirming to Investigating Managers that minutes need to be recorded on service users EPR and distributed in a timely manner
- A system for monitoring compliance with timescale for documentation has been instigated with performance team
- TMG, on 23rd February 2018, agreed to the development of a new structure for delivering the delegated safeguarding responsibilities that add additional assurance and expertise to what is offered within the Trust.

It is envisaged that this risk will be downgraded from the Trust risk register once satisfactory audit results have been presented to the audit committee.

Risk ID 861 The Trust fails to deliver safe services at the Broadland Clinic

The following progress has been made:

- The completion of a number of actions from the Broadland Clinic action plan within the agreed timescale
- The sustained reduction in the number of incidents and safeguarding referrals reported.
- Recruitment of staff and safe staffing levels maintained.
- Informal feedback from the CQC that the warning notice will be removed.

The actions that remain outstanding are within the agreed timescale and relate to building the safety suite and full implementation of the findings of the RESPECT review. The CQC continue to be provided with weekly updates on the action plan along with data on staffing, safeguarding and incidents.

Relationship with the Strategy (objective no.), Business Plan (priority) & Assurance Framework (Risks, Controls & Assurance):

Risks linked to Board Assurance Framework

Summary of Financial, Staffing, and IT & Legal Implications (please show £/No's associated):

There are no budgetary or financial implications in the TRR report, however some actions taken linked to the risks may have budgetary or financial implications.

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

Evidence for Registration; CNST/RPST; Information Governance Standards, other key targets/standards:

CQC Regulation 17 Good Governance
CQC Key Line of Enquiry; Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?

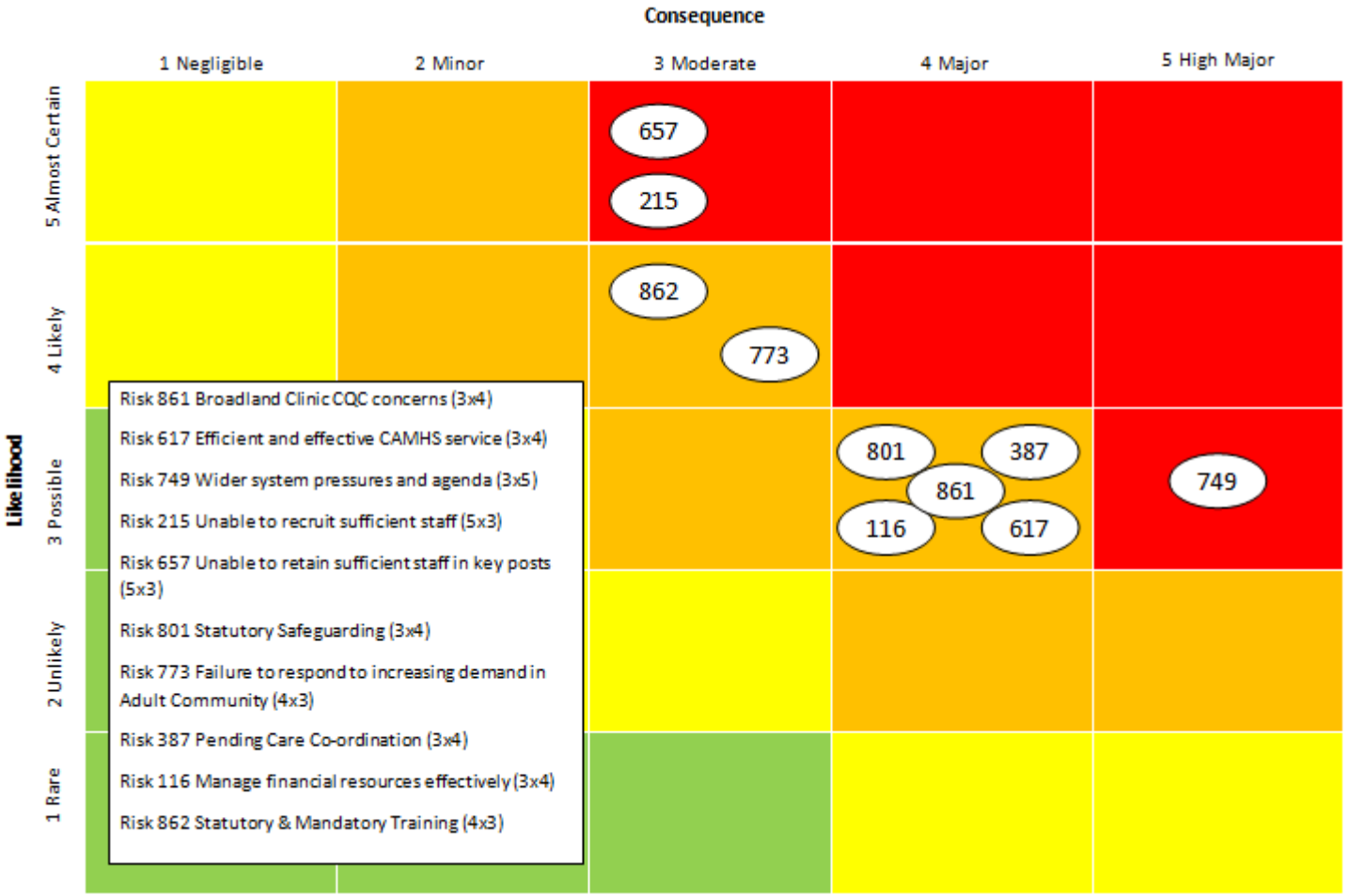
Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/Board/Audit

Exec 28.02.2018
IGC 06.03.2018

Appendix 1 Trust Risk Register by Exec Lead and linked to Trust Strategic Objectives

	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead
1	749	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT	20	15	10	Mental health and learning disability will be given the same emphasis as physical health in local care planning and delivery	Karen Taylor
2	215	The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	15	15	6	We will be seen as an employer of choice where people grow, thrive and succeed	Jinjer Kandola
3	657	The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	15	15	6	Our staff will report feeling engaged and motivated, and recommend the Trust as a place to work	Jinjer Kandola
4	861	The Trust fails to deliver safe services at the Broadland Clinic	20	12	8	Staff will report that they are able to deliver safe and effective services	Jane Padmore
5	617	Failure to provide an efficient and effective CAMHS service which impacts on the clinical care provided to young people	16	12	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley
6	801	The Trust's statutory safeguarding delegated responsibilities not consistently and effectively undertaken placing service users at risk	16	12	6	Staff will report that they are able to deliver safe and effective services	Jane Padmore
7	773	Failure to respond effectively to increasing demand resulting in a risk to safety, quality and effectiveness (Adult Community)	12	12	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley
8	387	Management of demand and capacity for those individuals pending care coordination allocation	16	12	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley
9	116	The Trust may not have sufficient resources to ensure short term and long term financial stability	16	12	6	We will make effective use of people's time and the money we have to deliver on the outcomes that matter to those we serve	Keith Loveman
10	862	Statutory and Mandatory Training Compliance	12	12	6	Staff will report that they are able to deliver safe and effective services	Jinjer Kandola

Appendix 2 Trust Risk Register Matrix



Trust Risk Register
February 2018

To be reviewed by:

Executive Team
28.02.2018

Integrated Governance Committee:
06.03.2018

Trust Board: 23.03.2018

Audit Committee: 17.04.2018

Risk Scoring Matrix (Risk = Likelihood x Consequence)

Step 1 Choose the most appropriate row for the risk issue and estimate the potential consequence

Consequence score (severity levels) and examples of descriptors					
	1	***2***	***3***	***4***	***5***
Domains	***Negligible***	***Minor***	***Moderate***	***Major***	***Catastrophic***
Impact on the safety of patients, staff or public (physical/psychological harm)	*Minimal injury requiring no/minimal intervention or treatment.* *No time off work*	*Minor injury or illness, requiring minor intervention* *Requiring time off work for >3 days* *Increase in length of hospital stay by 1-3 days*	*Moderate injury requiring professional intervention* *Requiring time off work for 4-14 days* *Increase in length of hospital stay by 4-15 days* *RIDDOR/agency reportable incident* *An event which impacts on a small number of patients*	*Major injury leading to long-term incapacity/disability* *Requiring time off work for >14 days* *Increase in length of hospital stay by >15 days* *Mismanagement of patient care with long-term effects*	*Incident leading to death* *Multiple permanent injuries or irreversible health effects* *An event which impacts on a large number of patients*
Quality/complaints/audit	*Peripheral element of treatment or service suboptimal* *Informal complaint/inquiry*	*Overall treatment or service suboptimal* *Formal complaint (stage 1)* *Local resolution* *Single failure to meet internal standards* *Minor implications for patient safety if unresolved* *Reduced performance rating if unresolved*	*Treatment or service has significantly reduced effectiveness* *Formal complaint (stage 2) complaint* *Local resolution (with potential to go to independent review)* *Repeated failure to meet internal standards* *Major patient safety implications if findings are not acted on*	*Non-compliance with national standards with significant risk to patients if unresolved* *Multiple complaints/ independent review* *Low performance rating* *Critical report*	*Totally unacceptable level or quality of treatment/service* *Gross failure of patient safety if findings not acted on* *Inquest/ombudsman inquiry* *Gross failure to meet national standards*
Human resources/ organisational development/staffing/ competence	*Short-term low staffing level that temporarily reduces service quality (< 1 day)*	*Low staffing level that reduces the service quality*	*Late delivery of key objective/ service due to lack of staff* *Unsafe staffing level or competence (>1 day)* *Low staff morale* *Poor staff attendance for mandatory/key training*	*Uncertain delivery of key objective/service due to lack of staff* *Unsafe staffing level or competence (>5 days)* *Loss of key staff* *Very low staff morale* *No staff attending mandatory/ key training*	*Non-delivery of key objective/service due to lack of staff* *Ongoing unsafe staffing levels or competence* *Loss of several key staff* *No staff attending mandatory training /key training on an ongoing basis*

Statutory duty/ inspections	*No or minimal impact or breech of guidance/ statutory duty*	*Breech of statutory legislation* *Reduced performance rating if unresolved*	*Single breech in statutory duty* *Challenging external recommendations/ improvement notice*	*Enforcement action* *Multiple breeches in statutory duty* *Improvement notices* *Low performance rating* *Critical report*	*Multiple breeches in statutory duty* *Prosecution* *Complete systems change required* *Zero performance rating* *Severely critical report*
Adverse publicity/ reputation	*Rumours* *Potential for public concern*	*Local media coverage – short-term reduction in public confidence* *Elements of public expectation not being met*	*Local media coverage – long-term reduction in public confidence*	*National media coverage with <3 days service well below reasonable public expectation*	*National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)* *Total loss of public confidence*
Business objectives/ projects	*Insignificant cost increase/ schedule slippage*	*<5 per cent over project budget* *Schedule slippage*	*5–10 per cent over project budget* *Schedule slippage*	*Non-compliance with national 10–25 per cent over project budget* *Schedule slippage* *Key objectives not met*	*Incident leading >25 per cent over project budget* *Schedule slippage* *Key objectives not met*
Finance including claims	*Small loss Risk of claim remote*	*Loss of 0.1–0.25 per cent of budget* *Claim less than £10,000*	*Loss of 0.25–0.5 per cent of budget* *Claim(s) between £10,000 and £100,000*	*Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget* *Claim(s) between £100,000 and £1 million* *Purchasers failing to pay on time*	*Non-delivery of key objective/ Loss of >1 per cent of budget* *Failure to meet specification/ slippage* *Loss of contract / payment by results* *Claim(s) >£1 million*
Service/business interruption Environmental impact	*Loss/interruption of >1 hour* *Minimal or no impact on the environment*	*Loss/interruption of >8 hours* *Minor impact on environment*	*Loss/interruption of >1 day* *Moderate impact on environment*	*Loss/interruption of >1 week* *Major impact on environment*	*Permanent loss of service or facility* *Catastrophic impact on environment*

Step 2 Estimate the likelihood

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency *Time framed descriptors*	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probably *Will it happened or not?*	<0.1 %	0.1 – 1%	1 – 10 %	10- 50%	>50%

Step 3 Complete the Risk Grading Matrix

	Consequence				
Likelihood	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Step 4 Escalation Process

Very Low Risks	Low Risks	Moderate Risks	High Risks
1-3	4-6	8-12	15 - 25
Local Risk Register	Service Line Risk Register	SBU Risk Register	Trust Risk Register

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
749	02/02/2017	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT	The rapidly changing health and social care landscape nationally and locally creates a potential risk to the sustainability of high quality service provision for people with a mental illness or learning disability due to: • Dilution of a strong mental health and learning disability voice and presence within new models of care and systems or structures that are focused on reducing activity within general acute hospital settings • Increased sharing of risks and financial pressures across the system resulting in shifting of resources away	20	Regular review of position by the Executive, Strategy Committee and Board Active monitoring and intervention by Council of Governors Strong leadership roles for key staff within local STP On-going regular dialogue with commissioners 5 Work streams with STP including Mental Health which HPFT chairs Member of the West Herts Provider Collaborative – all providers in Herts Valleys working together on key pathways/development of new models in West Herts	15	10	De-emphasis within commissioning intentions Parity of esteem agenda not honoured within contract negotiations or lack of commitment. Mental Health is represented on every locality delivery group along with commissioners, the early warning would be if Mental health is not making it onto the agenda for these meetings. Due to financial pressures the Trust does not see a demography increase and / or usual commitments aren't delivered by CCG's by Dec 2017.	The local STP includes a commitment to delivering on parity of esteem, as well as implementation of the 5YFV mental health implementation plan and transforming care agenda for people with a learning disability The most recent contract negotiations with our main commissioners has concluded with East & North CCG fully honouring its parity of esteem funding commitment , but Herts Valley CCG financial position remains challenging with the CCG revisiting its commitments within all providers across the local health economy (including RAID and FEP services). It is anticipated that this situation remains the same as we enter contract discussions for 2018-19. Mental health and learning disability issues continue to have a strong profile nationally as well as locally through the work of HPFT leaders and partners within the STP and the Alliance with HCT. STP wide Mental Health & LD working group established to provide greater emphasis and oversight of MH investment and developments across STP. Chaired by Dir. Strategy HPFT, with representation Medical director & Dir. Delivery Meetings planned with all GP Localities and Federations started during August and September with CEO/ Director of Strategy, will continue during the remainder of the year.	Karen Taylor (Director of Strategy & Integration)	22/05/2018

			from mental health and learning disability services								

215	16/10/2014	The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	Risk to Patient Safety, Quality, Staff Morale and Financial Risk. Recruitment There is a risk that the organisation is not able to recruit and select the best staff and that timely recruitment to vacancies does not occur leading to increased operational pressures and a reduction in quality of care	15	SBU review regular data – HR Performance Dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate establishment and vacancy information to be accessed at all times Recruitment and Retention Group	15	6	Long standing number of vacancies and hotspots Increased bank /agency costs Lack of clarity to plan recruitment campaigns Increasing turnover and a falling stability index Increasing Short Term sickness absence	Recruitment continues to be challenging due to the shortfall in skilled staff and competiveness nationally. Recruitment hotspots include the following: • Band 5 and band 6 nurses • CAMHS – all professions • Junior doctors • Norfolk • AHPs The Recruitment and Retention Group continues to meet on a monthly basis to address the issues arising from their respective areas in relation to generating ideas to deal with hot spots areas and hard to fill posts. Each SBU has developed a local recruitment and retention plan for their areas which has been reviewed and updated. The local SBU recruitment and retention plans include succession planning, putting in place career pathways in order to encourage retention, and reviewing current job descriptions in order to create some new ways of working. The annual recruitment activity plan has been reviewed adding forth coming events and recruitment days in January 2018, March 2018, June 2018 and September 2018. The Trust has received funding from Health Education England for the MSC Nurse Training for Mental Health. 4 internal staff have been seconded to undertake this nurse training with a further 6 students from the University of Hertfordshire who will undertake their placement with a view of securing employment with the Trust at the end of their two year MSC nurse training programme. The programme commenced on the 18 September 2017. In addition the Trust has 9 staff who are currently undertaking the Nursing Associate programme with a further cohort being planned to commence in April 2018. A seven day recruitment event took place at Brent Cross shopping centre w/c 22nd January 2018. This generated 245 expressions of interest which the recruitment team are following up. One of the overseas nurses from the Philippines started with the Trust in November 2018 and is in the process of completing his OSCE. A further 2 candidates are awaiting visa clearances. A task and finish group has been set up to focus on the junior doctor gap for 2018. This has recently been reduced	Jinjer Kandola (Director of Workforce & Organisational Development, Deputy CE)	05/05/2018

									from 24 to 3. Social media advertising is being trialled including advertising on various social media platforms, job boards and targeted advertising as well as regular posting on the Trust Facebook , twitter accounts, Linked in and the Trust Career site. The vacancy rate has reduced by 0.42% from 13.42% in December to 13% at the end of January.		

657	30/06/2016	The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	Risk to Patient Safety, Quality, Staff Morale and Financial Risk Retention There is a risk that a higher number of existing staff choose to exit the organisation due to high workloads and a perceived lack of career pathways leading to increased and unplanned vacancies and a drain of knowledge and experience from the organisation.	15	SBU review data - HR performance dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate turnover vacancy information to be accessed at all times OD plan for Talent and succession planning Recruitment and Retention Group	15	6	Increased banks / agency costs High turnover / Reduced Stability Index Exit interview feedback Lack of quality PDPs, inconsistent and ad hoc supervision	The Trust has set a turnover target of 10% and has a number of planned activities to address retention. The main reasons for turnover are: • Relocation • Promotion • Retirement • Worklife Balance This indicates that there is a need to focus efforts on workforce planning, flexible working, as well as career and succession planning. Some of these activities have been embedded into the SBU retention plans. The Trust submitted its NHSi retention improvement plan during Q3 which includes a number of activities which should aid retention. The plan has been signed off by NHSI and includes initiatives such as: • Making it easier to retire and return • Having an internal recruitment process • Marketing and branding • Talent management and succession planning • 100 day interviews • Stay interviews Delivery against the activity in the OD Strategy has continued in Q3. A significant amount of engagement activity took place in Q3 including the Big Listen, Local Listens, Senior Leaders Forums, Staff Awards, Staff Development Awards and a number of health and wellbeing initiatives. New Coaching Skills for Leaders Development Programme - Proposal that the trust invests in a programme of workforce development targeted at Tier 2 and Tier 3 leaders initially, but rolled out across all people managers over time. The tender process for this programme is currently underway. There were 100 leavers during Q3 which is lower (by 30) than Q2. This is the third quarter where nursing & midwifery staff had more leavers than starters. In January 2018 there were 51 new starters and 37 leavers. The turnover rate has increased slightly in January to 13.5%.	Jinjer Kandola (Director of Workforce & Organisational Development, Deputy CE)	05/05/2018

861	06/11/2017	The Trust fails to deliver safe services at the Broadland Clinic.	The risks are: - The seclusion environment will enable the safe provision of seclusion practice - The Restraint Practice will not be delivered in line with the policy and best practice - Risk Assessments are not updated regularly and using an appropriate tool, leading the risks not being managed effectively. - Ligature points management are not managed effectively and environmental risks are not managed in a way that keep service users and staff safe - Staffing are not receiving regular Supervision that supports safe practice	20	Care plans monitored weekly in relation to the management of violence and aggression Ongoing presence of Clinical Team Leaders and Charge Nurses in handovers with Modern Matron and Service Line Lead presence on a regular basis within handovers The Head of Nursing to spend the day at the Broadland Clinic on at least a monthly basis Enhanced review of all RIDDOR reportable incidents relating to violence and aggression Medication care plans in place for those on Clozapine Broadland Clinic closed to new admissions Refresher training in relation to undertaking seclusion following requirements of the MH Act. Review of safe staffing data to be undertaken weekly An increase in RNs per shift has been put in place. Internal quality assurance visits	12	8	Increase in the following: - unfilled shifts for RN's, HCA's and other registered professional - safeguarding incidents - staff injuries/RIDDORS - number of incidents involving physical restraint by ward	The Trust was issued with a possible section 31 urgent enforcement letter of intent to which the Trust responded to with an action plan that addressed the issues raised in the letter. On the 1st November the CQC issued the Trust with a formal warning notice (section 29a) in relation to the quality of care provided at the Broadland Clinic requiring significant improvement by 31st January 2018. The action plan which was in place for the possible section 31 has been reviewed against the actions required in the section 29a letter. It is reviewed weekly by the Exec team and submitted to the CQC on a weekly basis. Progress against the action plan includes: - Plans to build a new seclusion room (Capital funding has been identified) - Lighting and heating improvements to be included in the refurbishment works planned to be completed by Jan 2018. - Commissioning of an independent review of restraint techniques - Implementation of a short term assessment of Risk and Treatability, a concise clinical guide to the assessment of short term risk for violence and treatability. - Refurbishment of the area beyond the airlock to address any significant ligature issues. - Scoped and costed CCTV installation - Strengthened registered nurse presence - Strengthened supervision and leadership arrangements There is regular contact between the CQC relationship manager and the Executive Director of Quality and Safety in relation to progress against the action plan. The CQC have said they are pleased with the progress being made, the openness of the Trust and do not have any concerns in relation to progress.	Jane Padmore(Director Quality & Safety)	25/05/2018

617	21/04/2016	Failure to provide an efficient and effective CAMHS service which impacts on the clinical care provided to young people.	Increasing level of demand on the CAMHS Service Increasing complexity of cases presenting to the CAMHS service High vacancy rates with specific teams CATT interface with Acute services CAMHS leadership cohesion needs to be strengthened to ensure clear lines of accountability and responsibility for service delivery and clinical professional standards.	16	Weekly performance reports and weekly management review HR Dashboards / HPFT Workforce Information Report Summary CAMHS leadership support team in place which includes CAMHS Consultant Lead, Interim Head of Recovery and Psychological Services, Deputy Head of Nursing and Quality and Interim Service Lead. Service Improvement plan Access Recovery Plan including weekly trajectories and quadrant level plans for recovery	12	6	Increasing complaints Increase severity / number of incidents Increased waiting times (Choice and Partnership) Increase in staff vacancy rates / caseloads Increase in CCATT A&E response times Clinical variation in access times across quadrants	Performance Choice waits are back on target above 95% since September. Weekly performance calls with SPA team continue and close working relationship now in place. Service Model Work on the CAMHS service model was completed by service wide QLT, clinical groups are being piloted and will be reviewed by the end of quarter 4 2017/2018. Tier 4 mobilisation project plan in place, recruitment for DBT and HTT in progress. All out of area T4 placements are being reviewed, weekly conference call with NHS England case manager taking place in preparation of handover date 4 Dec. Accommodation for HTT confirmed as Forest House and DBT team clinical and team accommodation still under discussion. Leadership CAMHS SLT OD sessions with Sandy Haslow nearing completion final session Jan 18 and established service wide QLT bringing together all 4 Quadrant teams as one now meeting bi-monthly. CAMHS Transformation lead appointed to commence early 2018 Recruitment All budgets reviewed, cost pressures accounted for in Quadrant teams and all vacant posts out to advert. Number of overall vacancies have reduced with newly recruited staff either in post or coming into post and some agency staff converted to permanent. High Risk Pathway Successfully recruited to the Watford Post. Lister post out to advert for the second time. FHAU Environment / Ligatures There has been an increase in attempted non-anchor ligatures. Forest House have reviewed the prohibited items and added earphones to this list, which reduced the number for a period of time, needs to be sustained.	Jess Lievesley (Director Of Service Delivery and Service User Experience)	12/03/2018

801	16/06/2017	Statutory safeguarding delegated responsibilities are not consistently and effectively undertaken placing service users at risk	Patient safety risk: Risk to the identified 'person at risk' and other adults at risk. Safeguarding referrals raised about abuse and neglect have not been consistently been followed up or there is a lack of evidence to support actions taken to mitigate risk and safeguard the individual. Wider risks to other people have not consistently been considered or appropriately followed up. Serious Concerns process has commenced in relation to Hertsmere Community Mental Health Service (Borehamwood Adult Community Team) Contractual Risk: The Trust is in breach of its S113	16	Continued implementation of Serious Concerns action plan, sits in addition to the Safeguarding Improvement plan Serious Concerns Oversight Group, chaired by Exec Director Quality and Safety. Report to Partnership Operations Group (POG) and HCC chaired Serious concerns panel. SPIKE provides a management system for oversight of open safeguarding cases. Case by case review and RAG rating of all open safeguarding referrals, taking remedial action where necessary and appropriate. These are being done in conjunction with HCC and held centrally by corporate safeguarding to provide consistent and objective assurance. Case by case review of all cases closed within the last 12 months, ensuring the person at risk is safe and re-opening if there is an identified risk. Immediate Practice Development sessions for S113 managers. Appointing fixed term Consultant Social	12	6	SPIKE flagging system Results from monthly and quarterly case audits Safeguarding live tracking via Datix	8th February 2018 • Further PACE audits have demonstrated that adherence to HSAB standards of practice regarding timely decision making and strategy meetings has improved and 90% of decisions to proceed are made in timely manner • PACE audit does evidence that minutes of meeting and documentation is not completed in a timely manner as required by HSAB policy • Further dip audits have evidenced similar practice improvement in timescales and safeguarding practice decision making, however cases are being closed without minutes attached. The following actions have been taken • Administrators in operational quadrants have had access to Safeguarding Minute taking training through HCC • A practice note has been disseminated affirming to Investigating Managers that minutes need to be recorded on service users EPR and distributed in a timely manner • A system for monitoring compliance with timescale for documentation has been instigated with performance team • This issue will be reviewed and reported to POG	Jane Padmore(Director Quality & Safety)	25/05/2018

			agreement with Hertfordshire County Council (HCC) with the potential for a contact review / notice and withdrawal of safeguarding functions via termination of the agreement.		Worker for statutory safeguarding functions to ensure consistency and pace of improvements						

773	29/03/2017	Failure to respond effectively to demand in Adult Community resulting in a risk to safety, quality and effectiveness	Increased risk of being unable to respond effectively to demand in Adult Community Services and knock on effect on access times. Balancing inbound volumes of assessments with case management and treatment. Volume, acuity and complexity of caseloads is a risk leading to increased pressures on teams and potential workforce challenges.	12	Review of staff skill mix across quadrants and introduction of new roles Improved systems in SPA. Primary care projects commencing to look at work before IA referral made.	12	6	Vacancy Levels Agency spend Increase in incident reporting Number of cases pending allocation CATT caseloads Number of initial assessments Turnover of staff Increase in Complaints Performance against targets deteriorating staff feedback/raising of concerns	Agreement and implementation of recruitment & retention incentives has resulted in improved recruitment and good retention of staff supporting agency reduction. Launch of a new Signposting Directory on the staff intranet. The directory provides up to date contact details for local community and voluntary sector resources in each quadrant. The directory is being regularly updated by the MIND workers in the Wellbeing teams, and is now easily accessible to SPA and all other HPFT teams. Overall implementation of GP guidance and building referral form into System One to standardise referral process into SPA – SPA Project leading on this piece of work. Non Medical Prescribing will: a)Release care co-ordinator capacity – SUs who are very stable on depot can manage within the structured support of the clinic b)Release medic capacity – the Non Medical Prescribers will review stable service users every 6 months, with supervision from a consultant psychiatrist. The responsible psychiatrist will review all SUs open to the NMP clinics at least once every two years Low Intensity Treatment Teams The two clinic pilots are the first phase of a longer term ambition to move towards a Low Intensity Treatment Team model. The aim of this model, which is based on a similar model already operating in South London and Maudsley (SLAM), is to provide a less intensive service to SUs on Standard care, encouraging independence from services and firmly rooted in the recovery approach. It is anticipated that managing very stable SUs in this way will further embed recovery thinking across adult community. There is scope to create additional capacity on care co-ordinator caseloads – the caseload reviews are identifying SUs who are stable and who don't need intensive care co-ordination. The NMP / Low Intensity Team approach also has the potential to release capacity in outpatients, with stable SUs having their medication reviewed by NMPs rather than consultants. Pre discharge group being piloted at Holly Lodge Support for SUs moving on from services. Up to 10 per group.	Jess Lievesley (Director Of Service Delivery and Service User Experience)	25/05/2018

									Primary mental health care pilots underway in two locations (Stevenage & Watford) Caseload Reviews – all quadrants Identification of cases that are ready for stepdown / discharge. Regular tracking of these cases to ensure plans are being actioned. Piloting a 'whole system' approach at Cygnet House Tighter MDT management and oversight of cases coming into the team and those being discharged. Better use of CPA levels and clustering to inform practice; testing 'zoning' as a system for managing the work of the team STR worker posts converted to PB posts in E&SE Increased capacity for Band 5/6 CPNs and SWs as these workers will be doing PB reviews. Ongoing monitoring of caseloads and activity to ensure maximum efficiency and improved staff retention Consistency around caseloads in all quadrants and improved caseload monitoring system via Spike. Introducing 3rd sector roles work along side our teams (e.g MIND) DNA Standard Operating Protocol has been agreed with QRMC, TMG and Commissioners and live from 1st Feb 2018.		

387	23/07/2015	Management of demand and capacity for those individuals pending care coordination allocation	Service users pending care co-ordination allocation remains a significant risk for the service area.	16	The number of cases pending care co-ordinator allocation in the adult community teams is tracked. Monitored weekly by the Team Leaders and service users are contacted regularly to minimise risk. Performance Monitoring of these cases is now available via SPIKE	12	6	Serious Incidents linked to cases pending allocation. Increased number of complaints from GPs, carers and SUs regarding cases pending allocation. Increased length of time to be allocated a care coordinator Increase in the total amount of cases pending allocation or as a % of overall community team caseloads	The number of cases pending care co-ordinator allocation in the adult community teams is being tracked, although the absence of a care co-ordinator does not mean that individuals have no access to support from HPFT community services. Quadrants are implementing a number of changes around Demand and Capacity, and the number of cases pending care co-ordinator allocation needs to be understood within this context. These changes include: i)reducing the number of agency staff in the teams ii)achieving consistency in caseload numbers and ensuring reasonable caseload numbers as part of measures to retain staff iii)responding to increasing demand for assessments from primary care iv)a detailed caseload review with the aim of discharging or 'stepping down' service users who are no longer in need of care co-ordination v)improving systems at team level for categorising unallocated work vi)improving MDT oversight of 'flow' through the system, including new work coming into the teams and cases that are ready to be discharged Actions cross referenced with 773 as both risks are linked to ensure we have improved capacity in our community teams balance inbound assessments and existing treatment of persons on our caseload.	Jess Lievesley (Director Of Service Delivery and Service User Experience)	30/03/2018

116	05/10/2009	The Trust does not have sufficient resources to ensure short term and long term financial stability	Failure to maintain recurrent and sustainable financial performance, specifically: (1) Failure to secure sufficient funding from commissioners to meet service quality and/or activity requirements (2) Failure to address underlying demand and/or cost pressures and/or to deliver required efficiency savings such that the underlying financial performance is not sustainable Cost Pressures: •Agency expenditure and NHSI cap •Double running costs for transformation of older people inpatient services Demand Pressures:	16	Strengthened CRES Programme Assurance Board, monthly monitoring Dedicated finance resource: Head of Finance – Efficiencies Programme Weekly monitoring of agency cap 'breaches' Raised authorisation levels for agency expenditure Regular Placement Panel with cross-SBU coordination of placements pathway Provision for older peoples transformation programme in place Regular Reports are made to the Trust Board, Finance & Investment Committee, Executive Team and Trust Management Group. 2017/18 Contract variations in place for health and social care contracts. Relationship management with commissioners HPFT have started to work formally with HCT on some areas of service integration and development of consolidation opportunities for 'Back Office'. Estates and	12	6	Day One 'flash forecasts' for monthly outturn Quarterly Review / Horizon Scanning Agreed income tariff uplifts Increased agency spend Increased number of placements outside HPFT CRES programme RAG rating Negotiations with commissioners	The Trust's overall NHS Improvement Use of Resources Risk Rating is 1, the highest performance, although agency spend only achieves a rating of 2 under the Single Oversight Framework model. The Trust has a strong relationship with NHSI 2016/17 surplus £8.9m and on-going strong balance sheet with provisions against recognised potential material liabilities Cost Pressures: Agency expenditure above NHSI cap (forecast £9.5m versus £8.5m), this is mainly out of hours and medical cover. Short term delays to older peoples transformation programme due to shortage of beds in independent sector 2017/18: No demographic uplift for West Herts (£600k) from Herts Valley CCG and no additional resources for demand pressures. CRES - shortfall in robust schemes c£0.5m HVCCG commitment to develop demand management approach (work still to get real traction) Active discussions with commissioners particularly HVCCG, concerning funding streams Risk linked to SBU LD&F risk on the Essex LD Procurement for which the Trust has already appointed a project lead and the risk around the transforming care agenda and the potential impact on bed based service income. Carter Review work - involved in cohort	Keith Loveman (Director of Finance)	Being reviewed, next review date to be set

			- Social Care Placements - External PICU Placements Key Issues 2017/18: •No Demographic uplift for west Herts •4.4% social care savings requirement •CRES requirement £5.7m •HVCCG c.£38m unidentified QIPP requirement.		Facilities consultation being developed.						

862	06/11/2017	Statutory and mandatory training compliance levels lead to staff being insufficiently trained to appropriate levels	A review of all statutory and mandatory training compliance has shown that the recovery plans have not been as successful as anticipated following changes which needed to be made to ensure that the correct level of training was being provided to the correct target audience. This could result in not enough staff trained to deliver safe and effective care. Specifically in relation to Moving and Handling, Safeguarding, Infection Control, Intermediate and Basic Life Support mandatory training.	12	Task and Finish Group to drive necessary recovery with Executive Director SRO. Monitoring of compliance rates at Exec and WODG	12	6	Current compliance rates	Compliance in all of the recovery plans is expected by end of March 2018, decisions and immediate issues to resolve have been allocated. Actions Taken to Increase Compliance Rates: •Over the first few months of the new framework we did not see the pace with the transition. •Trajectory modelling showed that this would not improve without a change in approach. •Needed to balance operational service risks and needs with releasing staff to undertake face to face training for those packages that required face to face training •Safeguarding and moving and handling team experienced staffing challenges (sickness and individuals being promoted) which impacted on the ability to deliver training. •The training delivery model was reviewed and an executive director was put in place as SRO to ensure improvements. •Combined Safeguarding Adult Level 2 and Safeguarding Children Level 2 face to face training incorporating WRAP •Safeguarding Adult and Children level 2 e-learning package purchased from Skills for Health (approx 500 staff have undertaken the e learning training since implemented in January 18). •Use of GoTo webinar to enable people to access face to face training remotely piloted and roll out has begun. •Introduction of NHSE WRAP e-learning package. •Communication strategy developed to ensure that staff and managers are clear on training to be undertaken and the priority of this. •Saturday training sessions have been available •New one page statutory and mandatory training matrix has been produced and put on Trust intranet for staff to access and all staff communication sent out. This enables managers to have a greater oversight of their teams training compliance •Weekly monitoring through statutory and mandatory training task and finish group led by the SRO and Deputy Director of Workforce and OD. A weekly statutory and mandatory task and finish group has been established with the objective of reaching 92% compliance in statutory and mandatory training by the end of March 2018. Trajectories have been set for each training course and progress against these are being monitored each week. Where progress is not being achieved or is behind trajectory the subject matter experts and learning and development team are being asked what	Jinjer Kandola (Director of Workforce & Organisational Development, Deputy CE)	04/05/2018

									action is being taken to mitigate against this.		