Hertfordshire Partnership University NHS Foundation Trust
Public Board of Directors

Da Vinci A and B

24 May 2018 11:00 - 24 May 2018 13:00

INDEX

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS MEETING

A Public meeting of the Board of Directors
Thursday 24 May 2018 – 11.00 am – 13.00
VENUE: The Colonnades, Beaconsfield Road, Hatfield AL10 8YE, Da Vinci B+C

A G E N D A

	SUBJECT	BY	ACTION	ENCLOSED
1	**Welcome and Apologies for Absence:**	Chair		
2	**Declarations of Interest**	Chair	**Note/Action**	Verbal
3	**Minutes of Meeting dated 22 March 2018**	Chair	**Approve**	Attached
4	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
TO APPROVE THE ANNUAL REPORT AND ACCOUNTS				
5*	**Annual Accounts 2017-18:**			
5a	**Draft Annual Accounts**	Paul Ronald	**Approve**	Attached
5b	**Internal Audit Annual Report including:** • **Head of Internal Audit Opinion** • **Final Progress Report**	Head of Internal Audit	**Approve**	Attached
5c	**External Audit – Annual Governance Report**	External Audit	**Approve**	Attached
5d	**Draft Annual Report including Annual Governance Statement**	Jinjer Kandola	**Approve**	Attached
5e	**Draft Quality Account (included in Annual Report)**	Asif Zia	**Approve**	Attached
5f	**Annual Report of the Audit Committee**	Catherine Dugmore	**Approve**	Attached
6 *	**NHSI Declarations:** • **Compliance with Provider License**	Jill Hall	**Approve**	Attached
7*	**Use of Waivers – 2017 - 18**	Paul Ronald	**Approve**	Attached
8*	**Use of the Corporate Seal**	Jill Hall	**Approve**	Attached
9*	**Losses and Compensation Report 2017-18**	Paul Ronald	**Approve**	Attached
10*	**Treasury Management Report 2017-18**	Paul Ronald	**Approve**	Attached
QUALITY & PATIENT SAFETY				
11	**CEO Brief**	Tom Cahill	**Receive**	Attached
12	**Report of the Integrated Governance Committee – 10 May 2018**	Sarah Betteley	**Receive**	Attached
13	**Care Quality Commission Report**	Jane Padmore	**Receive**	Attached

OPERATIONAL AND PERFORMANCE				
14	**Report of the Finance & Investment Committee**	Simon Barter	**Receive**	*To follow*
15	**Performance Report : Quarter 4 2017/18**	Ronke Akerele	**Receive**	Attached
16	**Finance Report: Revenue Summary to 30 April 2018**	Keith Loveman	**Receive**	Attached
17	**Annual Plan 2018-19**	Karen Taylor	**Approve**	Attached
18	**Sustainability and Transformation Plan**	Tom Cahill	**Receive**	Attached
GOVERNANCE AND REGULATORY				
19	**Hertfordshire Health Concordat**	Jill Hall	**Agree**	Attached
20	**Any Other Business**	Chair	**N/A**	
21	**QUESTIONS FROM THE PUBLIC**	Chair		
22	**Date and Time of Next Public Meeting:** **26 July 2018, 09.30 – 13.30, Da Vinci A+B** **Annual General Meeting – 19 July 2018 from 5pm**			

*These items are in your Audit Committee pack. Please bring your pack with you.

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

Agenda Item: 3

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING
Held on Thursday March 22nd, 2018
Da Vinci B – Colonnades

PRESENT:

NON-EXECUTIVE DIRECTORS	
Christopher Lawrence	Chair
Catherine Dugmore	Non-Executive Director
Sarah Betteley	Non-Executive Director
Michelle Maynard	Non-Executive Director
Robbie Burns	Non-Executive Director
Loyola Weeks	Non-Executive Director
Tanya Barron	Non-Executive Director
Simon Barter	Non-Executive Director
EXECUTIVE DIRECTORS	
Jinjer Kandola	Deputy CEO & Director Workforce & Organisational Development
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	
Allison Lerner	Board Secretary PA to Company Secretary (Minute Taker)
Gill Stevens	Executive Assistant
Dr Billy Boland	Deputy Medical Director
Carolyn Fowler	Deputy Director of Safer Care and Standards
MEMBERS OF THE PUBLIC	
Barry Canterford	Public Governor
Tap Bali	Public Governor
Bob Taylor	Public Governor
Graeme Wright	Staff Governor
Julie Hollings	Deputy Director Marketing, Communications & Engagement
APOLOGIES	
Tom Cahill	Chief Executive Officer
Asif Zia	Director Quality & Medical Leadership
Sue Darker	Herts County Council

Item	Subject	Action
	WELCOME AND APOLOGIES FOR ABSENCE Chris Lawrence welcomed all present to the meeting. Apologies were received from CEO Tom Cahill, and it was noted that Deputy CEO Jinjer Kandola would present the CEO Brief on his behalf. Apologies also received from Executive Director of Quality & Medical Leadership Dr Asif Zia, and it was noted that Deputy Medical Director Dr Billy Boland would be in attendance. Apologies also received from Sue Darker, Herts County Council. CL welcomed the Governors that attended the meeting.	
	SERVICE USER PRESENTATION The Chair welcomed Sarah, together with members of the Perinatal Services team. Sarah outlined her personal experiences, both positive and negative, within the CATT team and Thumbswood Perinatal Service following the birth of her first child,	

	and advised that she had found the Thumbswood Perinatal Service equally supportive leading up to the birth of her second child. The members of the Board found Sarah's story fascinating and CL thanked her and the Perinatal Team for coming along with Sarah's youngest child to advise the Board of her experiences with the Trust's services.	
27/18	**DECLARATIONS OF INTEREST** None declared.	
28/18	**MINUTES OF THE MEETING DATED** The Minutes of the meeting held on 25th January 2018 were approved as an accurate record, with minor drafting changes to page 9, targets, whereby the wording needs a slight amendment.	
29/18	**MATTERS ARISING** There were no further matters arising.	
30/18	**CEO BRIEF** Jinjer Kandola presented the CEO brief and expanded on the following points: Nationally the NHS is still under significant pressure; A&E and Care of the Elderly are the most demanding services and February was the most pressurised month. ***NHS Pay Deal*** - The NHS pay deal had been approved by the Government and she expressed how welcoming this news was. ***Performance*** - The overall position remains strong against a backdrop of increasing demand and managing the demand in out of areas beds. This demand is in line with the national picture with referral rates up by 15% compared to previous years. ***Staff Survey*** – The results of the National Staff Survey 2017 have been received and overall results show staff experience in HPFT remains positive. Despite increased demand, staff remain patient focussed. There were 5 key areas where HPFT staff scored higher than the national average. 1. Staff agrees they feel motivated in their jobs 2. Staff agrees the Trust uses patient and service user feedback effectively 3. Staff would recommend the Trust as a place to work 4. Staff feel the Trust provides high quality appraisals and training 5. Staff feel confident and secure in reporting unsafe clinical practise. JK expressed her thanks to staff for going above and beyond especially during adverse weather conditions and following a question from MM relating to whether staff have been recognised for their dedication, JL assured her that the Executive Team have relayed their thanks to all of the staff and some have been referred for inspire awards. JK also announced that Tom Cahill was now at position 12 in the HSJ CEOs table from number 15 and all attendees extend their congratulations to TC. **The CEO Brief was noted.**	
	REPORT FROM INTEGRATED GOVERNANCE COMMITTEE CHAIR SBe informed the Board that there were a number of issues relating to seclusion however, assurance was received that although there are on-going concerns, they are being monitored via the SBU Risk Register. This item would also be going back to the IGC in July. Thumbswood was referred to in more than one safe staffing report, however assurance had been given that the ward had safe staffing but this had been achieved by an increase in registered nursing to fill unregistered nursing shifts. Other items discussed at the meeting included PACE, CAMHS, Trust Risk Register and CQC.	

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	In relation to CAMHS, JK advised that the CAMHS team had been receiving enhanced support and that all plans relating to transformation and place of safety have received closer scrutiny by the Executive Team. SBe also informed that Board that Forest House menus have been changed and improved, and JL confirmed that he is scheduled to have lunch there to test this. **The Board reviewed the report for assurance.**	
	QUARTER THREE SAFE STAFFING REPORT JP advised that 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 included 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. **JP elaborated on the safer staff tool, which enables the safer staff team to move staff around where they are better utilised, and JP agreed to show the safer staff tool at a future Board workshop.** **The Board discussed and noted this report.**	**JP**
	2017 STAFF SURVEY RESULTS JK advised the Board that the staff survey results were the best for the Trust in six years, with 91% key findings above the national average. Appraisals support and job satisfaction were above average as was staff engagement and the Trust should not underestimate the achievement in maintaining its position. The area that requires more focus relates to violence and aggression and in particular harassment and bullying. Following a comment relating to comments within the report on SPA, and how first time managers in SPA could be better supported, JL advised that work has been undertaken with leadership in SPA and a new structure which also has the benefit of an ex-111 call centre manager, who better understand the needs associated within SPA. With this in mind, he would be keen to see the results on SPA within next year's staff survey results. **The Board noted the report and fed back on recommendations, and the Chair offered his congratulations on the improved staff survey results.**	
	CQC UPDATE JP presented the CQC high level summary paper that is underpinned by the action plan which is held within Quality & Risk Management Committee. Highlights from the report included; ***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. The pilot will begin shortly and if successful will be rolled out in the next financial year. ***Restrictive Practices*** - 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	

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	the unit and identified some areas that require attention and this work has been requisitioned. JP also confirmed that the Freedom to Speak Up Guardian advert will be going out requesting expressions of interest. **JP agreed to share the Job Description with the Board.** JP advised that once the final report has been received within the next week, the action plans would be monitored through QRMC and reported to IGC. **CL thanked JP and her team as well as all that had been involved in the process.**	**JP**
	QUESTIONS FROM THE PUBLIC No questions were forthcoming.	
	REPORT FROM FINANCE AND INVESTMENT COMMITTEE SBa advised that a business development update had been received, and that CAMHS T4 had 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. Annual Plan, Operation Plan and Efficiency Plan were also discussed. Diane Brent had been appointed to the post of joint Head of Estates for HPFT/HCT. CL encouraged all to visit The Marlows opening on 11th May as it is a testament to joint working. **The Board noted the report from the FIC.**	
	PERFORMANCE REPORT RA advised the Board that overall performance is very strong and referrals have been increasing. Key challenge lies with sickness rates and JL indicated the challenge of managing the demand, which is 25% growth year on year. Other areas of note included; **Sickness:** An increase in sickness rates to 5.02%, mainly due to seasonal 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 at 21st February. **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. **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. **The Board discussed and noted the report.**	
	Q3 SERVICE USER EXPERIENCE JL advised the Board that the paper was received and considered by the Integrated Governance Committee in January 2017 and highlights from the report included; • The continued benefit to services on receiving feedback on the care they provide and the themes of the issues that are being raised in both	

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	compliments and complaints. • Maintenance of the Trust's strong overall position with regard to the experience and satisfaction rates, reported by service users and carers. • 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. Following a question from MM relating to paper based feedback, JL advised that apps are being researched to provide feedback as well as digital welcome packs, which offer a virtual video walk through. **The Board received the report and JL agreed to take further report to IGC then back to Board in Q4.**	**JL**
	FINANCE REPORT TO END OF FEBRUARY 2018 KL advised that 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 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%. 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.Other Direct Costs, Overheads and Financing were better than Plan by c. £20k, with very little change from February. KL advised that This position remains a favourable one, and it is fully expected that a year-end surplus would be reported and the NHSI control total achieved. **The Finance Report was agreed and noted.**	
	ANNUAL PLAN 2018-19 KT outlined the high level annual plan, and advised that she would be bringing back the final version to the next Board Meeting. The annual plan reflects the priorities identified within the draft NHSI operating plan. The final operating plan including the financial and activity plan will be approved by the Board prior to submission and would therefore contain detailed actions and outcomes which will reflect the following; • 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 and OD plan; Physical Health plan; Quality & Service Development plan for 2018/19)	

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	The Board received the report and noted that KT would bring the final report to the next Board of Directors meeting.	
	FINANCE PLAN 2018/19 KL advised the Board that 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 and Transformation Funding (STF). The revised guidance had required additional detailed financial modelling prior to submission. KL advised that the Trust is expected to be able to deliver the control total (circa .4%) for FY18/19. 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 and noted that planned surplus of £360k achieves the control total (before STF) set by NHS Improvement and the plan seeked to achieve a Use of Resource metric of 1, the strongest position. **The Board discussed and noted the report and approved their acceptance of the 2018/19 NHSI control total of £2.135 surplus and the 2018/19 Financial Plan and distribution of detailed budgets.**	
	REPORT FROM AUDIT COMMITTEE CD advised the Board that Audit Committee had met on 1 February 2018 however due to illness the meeting was not quorate. 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. CD advised that 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 which 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 Report from Audit committee was noted.**	
	ADOPTION OF GOING CONCERN STATEMENT KL advised that it is a requirement of the Board to consider whether the Trust is a going concern and the accounts for the year should be prepared on this basis. He advised that it had been through Audit Committee who had recommended approval to the Board. **The Board agreed to adopt the going concern basis for the preparation of the Trust's financial statements for the year to 31st March 2018.**	
	Public Sector Equality Duty (PSED) Compliance report JP advised the Board that the PDED 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. She added that it is a requirement that the EDS2 grading is completed by Trust stakeholders rather than self–assessed based on evidence supplied.	

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	The purpose of the 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 **The Board discussed, received and approved the annual compliance as required by the PSED, to publish this on the Trust's website.**	
	GENDER PAY GAP JK advised that 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 annually by 30 March 2018. JK advised that 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. **Overall, the Board was very pleased with the legislation, as it reflects the gender equality agenda of the Trust. The Board received and approved the submission of this report.**	
	BOARD ASSURANCE FRAMEWORK JP informed The Board that there had been no recent changes within the BAF and it would be refreshed over the coming year. **The Board received and noted the Board Assurance Framework.**	
	TRUST RISK REGISTER JP advised the Board that there had been no escalated risks, however two riskes had been downgraded; ***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 together with the successful implementation the 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 relating to the fragility of the underlying IT infrastructure. The risk would however 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 to a 9 and the risk is downgraded from the Trust Risk Register, it would however remain on the East and North SBU risk register. **The Board agreed and approved the Trust Risk Register acknowledging that it is a true reflection of the Trust's risks.**	

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	QUESTIONS FROM THE PUBLIC There were no questions raised from the Public.	
	Any Other Business No further business was noted	
	Date and Time of Next Public Meeting: Thursday 24th May 2018 11:00 – 13.30 Da Vinci B&C, Colonnades	
	Resolution to hold remainder of meeting in private was approved by the Board.	

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Agenda Item 4

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

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
22/03/18	**32/18**	Q3 Safe Staffing	JP to show the Safer Staff tool at a future Board Workshop	Scheduled for June workshop	JP	June 26	A
22/03/18	**40/18**	Annual Plan	KT to bring the final report to the next Board meeting	On Agenda for approval	KT	May 24th	G
22/03/18	**44/18**	Public Sector Equality Duty (PSED) Compliance Report	Report to be published on the Trust's Website	This has been published on the Trust Website	JP	April 26	G

Hertfordshire Partnership NHS
University NHS Foundation Trust

PUBLIC BOARD MEETING

Meeting Date:	24 May, 2018	**Agenda Item: 11**
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:	Tom Cahill, CEO	

National update

Government to consider NHS multi-year funding plan

The Prime Minister indicated that the Government may put in place a "multi-year" funding plan for the NHS in England when she appeared before the Commons Liaison Committee. NHS national bodies have broadly welcomed the announcement of a long term approach while emphasising the importance of ensuring that social care is supported.

Government MHA review to call for more investment

- Prof Sir Simon Wessely has said that his independent review of the Mental Health Act could have “significant” implications for NHS funding, as it calls for more investment for the sector. The independent review panel published its interim findings earlier in May. It said that some areas requiring attention had “potentially significant financial implications”. The review was commissioned by the Prime Minister in 2017 with a remit to investigate the rising number of people detained under the act; the disproportionate use of the act on black, Asian and minority ethnic groups; and processes that were “out of step” with a modern health system.The report can be found at www.gov.uk/government/publications/independent-review-of-the-mental-health-act-interim-report

Select Committees report on CAMHS green paper

The Health and Social Care Committee and the Education Committee have published their report on the government’s mental health green paper, titled *The government's green paper on mental health: failing a generation*. The Committees claim that the green paper is "unambitious". The NSPCC issued a press statement based on a FOI request into the numbers of referrals from schools and education providers – claiming that in the East of England, referrals are up by a third over the last three years, and a third of those referred in that three year period have been judged to be ineligible for treatment. The statement has received widespread media coverage.

NHSI and NHSE to work more closely

NHS England (NHSE) and NHS Improvement (NHSI) have announced that they are to work more closely together. This will include creating seven single integrated regional teams to replace the five existing regional patches. The exact areas are still to be decided but will include the current London, South West and South East patches. The East patch will be one of those that will be split in two. Each organisation will retain its own chair and CEO with some national teams and direct roles merged. Further details will follow. The changes will take effect from September 2018.

NHS England announces Wave 2 of community perinatal funding

NHSE has announced £23m of funding to expand specialist perinatal community services to every part of the UK by April 2019. This funding forms part of a package of measures, worth a total of £325m by 2021, to transform specialist perinatal care. HPFT has been included in the wave 2 funding. Our community perinatal service was included as a case study of good practice in the publicity supporting the announcement.

New CEO for CQC

Ian Trenholm has been appointed as CQC's new Chief Executive. He will take over the role from Sir David Behan when he leaves in July. Ian has been Chief Executive of NHS Blood and Transplant since 2014. His previous roles include COO at the Department of Environment Food and Rural Affairs (Defra) and CEO of the Royal Borough of Windsor and Maidenhead.

NMC chief steps down

Jackie Smith has announced her decision to step down as Chief Executive and Registrar of the Nursing and Midwifery Council (NMC) after six years in the role. The regulator has been criticised by the Professional Standards Authority for taking too long to act over midwives fitness to practice at Morecambe Bay which attracted widespread media attention.

Regional update

STP CEOs commission review

Senior leaders of all of the STP organisations have agreed to work together, with the help of independent advisors Carnall Farrar, to make our organisations more integrated and fit for the challenges of the future. Carnall Farrar staff have started to work with all of the STP organisations. They will gather information and suggestions from a range of staff across all the trusts within the STP. The recommendations are expected in the summer.

Change of CEOs at two Hertfordshire Trusts

David Law, Chief Executive of Hertfordshire Community NHS Trust, has resigned. He left the Trust at the end of April. Clare Hawkins has been Acting Chief Executive and will continue in this role.

Katie Fisher, Chief Executive of West Herts Hospitals NHS Trust is leaving to become Chief Executive at St Andrews Healthcare, a healthcare charity based in Northampton. Ms Fisher will leave her role at the trust at the end of June. Her deputy, Helen Brown, will take up the role from July until a new chief executive is appointed.

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Trustwide update

Trust rated 'Good' by CQC

We have now received our final report from the CQC. The Trust has received an overall rating of 'Good'. Two core services – forensic inpatient services and wards for people with a learning disability – have been rated 'Outstanding.' In the Key Lines of Enquiry we have received 'Good' for Effective, Caring and Responsive but 'Requires Improvement' for Safe. The CQC highlighted many strengths as well as areas for improvement. A report is included in the Board agenda and you can see the full CQC report here http://www.cqc.org.uk/provider/RWR/reports

Quality and safety

As part of our on-going focus on quality and safety, we are reviewing the way in which we identify serious incidents and the quality of investigations. This includes responding to a national consultation on 'The future of NHS patient safety investigation', launched by NHS Improvement. We are also reviewing our seclusion arrangements as well as further developing our Safety Strategy.

Performance

Many of our teams ended the year very strongly indeed in the face of increased demand. Our CAMHS service is under particular pressure at the moment through a combination of system pressures, high demand and national staffing shortages. However, despite this, the wait to treatment following assessment has improved significantly to under 8 weeks. To manage the on-going demand for our services we are working with primary care colleagues, including testing new models of service provision to change the way people can access the services and reduce overall pressure on our teams. Over the next few months we will continue to develop these further along with improved short-term access and support for our service users and carers in crisis.

Finance

The overall Trust position year to date (before STF) shows a surplus of £1.277m, which is ahead of our plan by £497k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating (the UOR) remains as a 1, the highest rating. We will also receive non-recurrent STF funding of c £6m which will support our capital programme moving forward. The underlying position remains very tight, however, as most of our surplus was achieved in the first six months of the year with the run rate in Q4 being at or below plan. Moving into 2018/19, delivering the control total of £360k remains a challenge.

The Marlowes Health & Wellbeing Centre opens in Hemel Hempstead

The state of the art health and wellbeing centre developed by HPFT and Hertfordshire Community Trust (HCT) in central Hemel Hempstead was opened by Sir Mike Penning, MP, on Friday 11 May. The centre will be home to community mental and physical health services for adults and children on dedicated floors.

Recruitment of a non-executive director (NED)

We have begun the process of recruiting a NED to replace Robbie Burns whose tenure expires on 31 July. Interviews have been arranged for late July.

Jinjer Kandola appointed to CEO role

Jinjer Kandola, Deputy CEO & Director of Workforce & OD, has been appointed to the role of Chief Executive for Barnet, Enfield & Haringey (BEH) Mental Health NHS Trust. She will leave HPFT on 29 June. Our arrangements for recruiting her replacement will be publicised in due course.

Trust theatre group wins award

"May Contain Nuts", a theatre company created by HPFT drama therapist Gerald Maiello has won the Guardian Award for Innovation in Mental Health Services at the 2018 Advancing Healthcare Awards (AHA). The company is made up of service users who have completed their therapy provided by HPFT. Both Three Counties Radio and Bob FM broadcast interviews with the service users about the award in May.

Tom Cahill,
Chief Executive

Hertfordshire Partnership University NHS Foundation Trust

BOARD OF DIRECTORS

Meeting Date:	**24 May 2018**	**Agenda Item: 12**
Subject:	**IGC report to Board**	**For Publication: Yes**
Author:	**Jill Hall Interim Company Secretary**	**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 10 May 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 10th May 2018

The following items were considered by the Committee:

Reports from Subgroups:

Quality and Risk Management Committee (QRMC)
Workforce & OD Group. (WODG)
Health Safety and Security Committee (HSSC)
Information Management and Technology (IM&T) & Information Governance Board

Quality and Patient Safety

CAMHS Deep Dive

The Committee received a CAMHS deep dive report into Forest House Adolescent Unit noting that five key impact changes had been identified:

- Development of practice across CAMH services
- Recruitment and retention
- Strengthening leadership
- Estates development
- 7 day modelling

Benchmarking information was being used to learn and improve.

CQC update and action plan

The many areas of good and outstanding practice were highlighted as well as those areas that require improvement particularly in safety and effectiveness. An action plan was now being developed to reflect the final report and would be reported through QRMC to IGC and Board.

Annual Quality Account

The final version with the External Auditors comments had been received and would now be edited to reflect comments, once this is completed it would be circulated to IGC for a final view.

Nutrition and Hydration – Board Assurance Survey

NHS Improvement had carried out a survey at the end of 2017, 63 trusts, of which only 3 were mental health trusts, had responded to the survey. The trust had met two of the six highlighted best practice indicators for governance including having a Director lead for nutrition and hydration, as a non-executive director champion was needed, Loyola Weeks, NED, volunteered to be the champion. The committee noted changes to menus and that nutritional information was being made clearer.

HPFT Equality Plan 2018-2022

The Committee discussed and approved the plan for forward submission to the Board. This was co-produced and set the tone for the next four years for a person centred equality, diversity and inclusion plan.

Quarter 4 Position Statements

The committee received position statements which highlighted key data for the quarter. The Q4 reports and Annual reports would be submitted to the IGC in July.

Regulatory and Governance

Trust Risk Register

The Committee questioned if bullying and harassment was a risk to be added to the risk register. It was noted that the organisations reported rate for bullying and harassment equalled the national average and feedback from the Big Listen backed this up. However data from operational service surveys highlighted bullying and harassment was an issue for further discussions by the Executive.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	24 May 2018	**Agenda Item: 13**
Subject:	CQC summary report	**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 show an initial comparison with the outcome of the 2015 CQC report.
To brief the executive on the contents of the CQC final report.

Action required:

For information and discussion.

Summary and recommendations:

The paper outlines the high level comparisons with the 2015 report and the key findings and messages in the report which were presented verbally in the April public Board.

6 KLOEs have improved since 2015, one by two bands. 13 have stayed the same and one has gone down. Overall, one service line has gone down, one has stayed the same, two have improved, with one of these improving by two bandings.

Many areas of good and outstanding practice were highlighted in the report as well as areas that require improvement. Improvements are needed primarily in safety and effectiveness.

A sample of the actions taken is included followed by the governance arrangements for the action plan.

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

IGC 10th May 2018

1. Introduction

1.1. In February 2018 the CQC conducted the annual well led inspection and core inspection of 4 service lines. The final report has been received and circulated to the executive team.

1.2. This report sets out the high level comparisons between the 2015 and 2018 inspection reports followed by the high level messages from the report. The initial actions that were taken have been shared at the executive team, IGC and Board. These are now being developed into an action plan that reflects the final report. This will continue to be developed and report through QRMC to IGC to Board.

1.3. The full report can be found at

https://www.cqc.org.uk/sites/default/files/new_reports/AAAH0791.pdf

2. Comparison with 2015

2.1. Although the overall rating has not changed there is an improved picture which is demonstrated in table 1.

Table 1

Tartan rug		individual boxes exc overall boxes	Service lines over all	trust overall
position	up	6*	2***	0
	same	13	1	6
	down	1**	1****	0

* Forensic in patient-safe (Good), caring (Outstanding), well led (outstanding); LD Safe (Good), Effective (Outstanding), Well led (Outstanding).
** Acute and PICU-effective (Requires improvement).
***LD (Outstanding) and Forensic (outstanding)
****Acute and PICU (requires improvement)

2.2. In 2015, the report detailed 10 must dos and 33 should dos whereas the 2018 report has 6 must and 25 should dos (table 2).

Table 2

	Should do	Must do
2015	33	10
2018	25	6

2.3. In the 2018 report we have been issued with 2 regulatory notices, one in relation to staffing and one in relation to safe care and treatment. This is comparison to 9 across 4 regulations in 2015.

Table 3

Regulatory notices	9- person centred care	18- staffing	15- safe premises	12- safe care and treatment	Total
2015	3	2	2	2	9
2018	0	1	0	1	2

3. Overview of the findings

3.1. The report details many areas of good and outstanding practice that the inspectors found when they visited our services and reviewed the information we submitted. Primarily these were in relation to:

- Culture and Values
- Care (e.g. co-production, responsiveness to service user needs, safeguarding, risk assessments)
- Outcomes (e.g. recovery)
- People (e.g. collective leadership, investment in developing leaders)
- Organisation (e.g. IMT and bed management, continuous and quality improvement)
- Partnerships (e.g. internal and external joint working as well as with service users)

3.2. The report also highlights areas that we need to improve which resulted in receiving two regulatory notices:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
  - *Acute and PICU*- this was in relation to (1) the identification and mitigation of ligature points and blind spots, (2) service users receiving a physical health assessment on admission and that identified health care needs are met, (4) adherence to the Mental Health Act code of practice in regards to recording of seclusion practices and the seclusion environment and (5) medication management.
  - *CAMHS*- this was in relation to identification, management and mitigation of ligatures.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
  - *Acute and PICU*- this was in relation to the supervision of staff.

3.3. In addition the areas of focus for improvement are the must and should dos (must in bold):

- Adult and PICU
  - **Ligature points and blind spots identified and risks mitigated.**
  - **Physical health needs assessed and managed.**
  - **Seclusion practices and environment.**
  - **Medication management.**
  - **Supervision**
  - Reduce restrictive practices
  - Service users involved in their care plans and record they have a copy.
- CAMHS
  - **Ligature risks identified mitigated and managed.**
  - Staffing- appropriate skills, competence, qualifications and experience.
  - Access to a dietician.
  - Young people able to make private phone calls.

- Quality of food monitored and poor food addressed.
- Alternations to the environment to ensure privacy and dignity are maintained.
- Restrictive practice reduced.
- 7 days a week therapeutic activity.

- Learning Disability
  - Staffing at SRS.
  - Ligature assessments.
  - Astley Court and SRS care plans more holistic and recovery focused.
  - Seclusion outside a seclusion room recorded appropriately.
- Forensic
  - Cleaning on the ward.
  - Furniture and furnishings maintained.
  - Curtains in bedrooms.
  - Decommission seclusion rooms when they do not meet the requirements of the MHA code of Practice.
  - Hand wash available in bathrooms.
  - Adequate medical cover out of hours.
- Trust wide
  - NEDs who have unsupervised access to service user have enhanced DBS.
  - Supervision compliance monitoring system.
  - Timely action to review environments in response to acuity.
  - Comply with the serious incident rating framework.
  - Long term conditions audited and deliver care for these.
  - Joined up oversight between clinical and non-clinical audits.

4. Response

4.1. Since the inspection and since receiving the draft report for factual accuracy, the Trust has taken action to address the concerns that were highlighted. The full action plan, aligning with the final report, is in development but this has not delayed the work to address the areas requiring improvement.

4.2. A sample of actions taken in response to the concerns raised by CQC are detailed below. This is a small sample rather than a comprehensive overview. The action plan will be reported through QRMC to IGC to Board.

Safety

A new safety strategy is being co-produced and is in the development stage with a target date of July IGC for completion of the first draft for consideration. In addition:

- **Responsiveness-** Work has begun on a team based approach to quality improvement throughout the organisation. This approach aims at local ownership and will strengthen the clinical voice and culture of safety.
- **Ligatures**- The Trust is updating the annual Health & Safety Audit adding the ligature audit. Audits can now be distributed and stored as a central e-audit. Alongside this a new process is being put in place with weekly reminders which include two questions
  - has the ligature risk audit has changed,
  - if Yes, it will generate an exception report asking to state the change with the risk and action.

  The weekly audits will allow a display of performance in a dashboard style format aim and therefore a real time response and management of environmental needs and assessment, rather than relying on the annual cycle.

The first stage of implementation is on the wards with the highest risks (P1), allowing quarterly reports from Qtr 1.

- **Seclusion-** Merseycare NHS Foundation Trust has been commissioned and have begun to undertake the review of seclusion practice and environments. In the meantime additional scrutiny has been put in place to monitor and ensure seclusion is used safely and effectively.
- **Restrictive practice-** Regular review of all restrictive practice including restrictive items is in place. In addition a task and finish group is in place and are overseeing the implementation of the RESPECT review.
- **Albany Lodge-** A specific action plan, attending to leadership, safety and fundamentals of care has been specifically developed and is progressing.

Staffing

- **Supervision-** Local monitoring has been put in place. Longer term a new IT system will be in place, by the end of Q2. This will enable centralised monitoring of supervision.
- **Skill mix-** Nursing staffing levels have been reviewed. Skill mix within the multidisciplinary team is under review.

5. Governance

5.1. As described governance of the actions taken is held at IGC, on behalf of the Board, operationally overseen through QRMC.

5.2. The internal auditors, RSM, will conduct an audit of the response to CQC which will consider:

- The development of the Action Plan to deliver the improvements identified within the original CQC inspection, including review and approval by the Board;
- They will reconcile the actions with the plan to the original CQC inspection report and ensure all actions have been captured, and that actions are SMART and outcomes based;
- How the Trust has communicated the actions through the organisation. This will include whether SBU's have been made aware of the actions, there significance and the expectations of the Trust in terms of delivery;
- They will select a sample of actions from the Plan that the Trust has identified as progressing or completed and provide an opinion on whether these have been actioned and robust evidence is in place to illustrate delivery;
- For those completed, they will provide an opinion on whether the actions have been fully embedded, and what the Trust is doing to ensure the actions have been embedded and not just marked as complete;
- They will review the plan against the actions taken and assess whether at a local level, actions have been implemented and embedded as expected; and
- They will review the governance forums in place to monitor and report on delivery of the actions.

5.3. As part of this review, they will meet with operational staff within wards and departments to determine both whether the actions have been implemented, but also whether staff are aware of why the actions are required.

6. Conclusion

6.1. This paper sets out the initial comparisons between to 2015 report and the draft report that we have received for factual accuracy. The high level findings of the report was then detailed followed by details of the action plan that is in place to address the areas that require improvement.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	**24th May 2018**	**Agenda Item: 15**
Subject:	**Performance Report Q4 2017/ 2018**	**For Publication: Yes**
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 Q4, 2017/18
2. To assess the likely future performance projections for Q1 18/19 based upon a review of current trends, management actions and any variations in future targets.

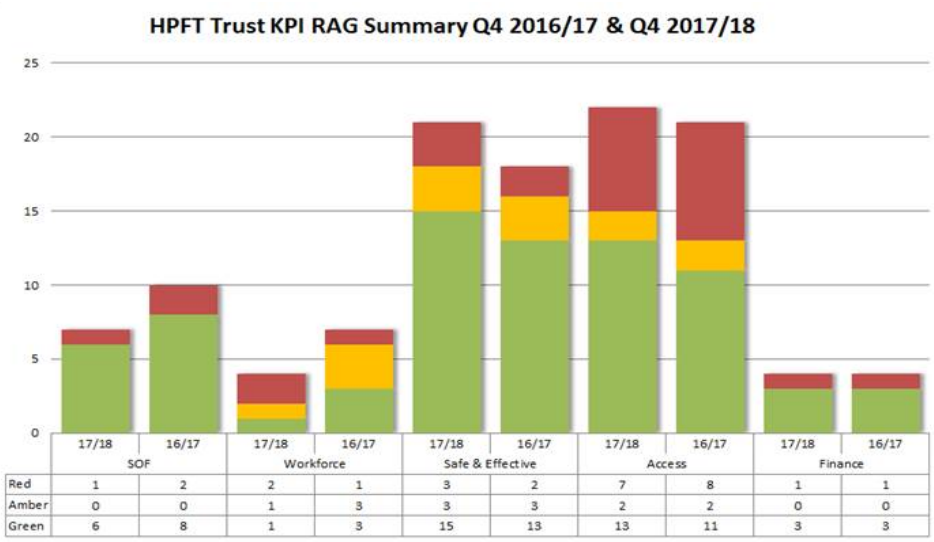
Action required:

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 further assess the performance reported and the opportunities for further improvement.

Summary and Recommendations:

This report provides an overview of Q4 2017/18 performance, assessed against the indicators across five elements; the NHSI 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. Within the graph the comparative figures for the previous year are also provided.



All Referrals	2014	2015	2016	2017	2018
Jan	3653	3647	4089	4206	4844
Feb	3228	3809	4209	4009	4549
Mar	3333	4391	4092	4878	4823

The increased demands into our services was quite evident in Q4, we had 14,216 referrals into our services which is an increase of 8.5% in comparison to the 13,093 figures last year. With the ongoing workforce challenges (shown by the 14% turnover rate and the level of vacancies), the overall performance has held up well with many areas above target and in line with or above earlier periods.

We have continued to consistently build upon and maintain our improvement within SPA which against the measure of an outcome in 14 days has been above the 95% target since July often being at 98% plus.

In terms of the service performance in Q4, 5 indicators moved to achieving green – Urgent referrals to Community Teams, Routine Referrals to Community LD teams, CPA reviews and on our Staff recommending Trust services to family and friends if they need them.

The key challenge on service performance is within the Access measures mainly on:

- IAPT access performance (3 measures from 5 reported as red) - This has remained the same for a number of months within Mid and West Essex. To support with improving performance, a detailed review has been commissioned to evaluate impact of proposed improvement initiatives. In Herts valley there was a strong performance in the first half of the year before a fall in the later period.

IAPT access in both East&North and NE Essex has sustained their strong position in achieving target.

- CAMHs access performance (2 measures reported as red and 1 as amber from 5). – There has been a decline in performance after a very strong performance in Q3 across all CAMHs services. Increases in urgent referrals, delays in SPA and staff vacancies are identified as the key issues and work in underway to address these areas.

In other areas across Access measures, performance is good with a number of services showing improvement including CATT referrals which achieved 100% throughout the quarter. Whilst Adult Community 28 day wait did not meet the target for the quarter, there

has been improved performance in March at 95.9% with several quadrants now meeting the 95% threshold.

For Safe and Effective services, the reported position has continued to hold well with 71% targets green. There have been improvements in:

- CPA review (12 months) performance which in March was 97.4% the highest in the year.
- DTOC rates has made good strides throughout the year from 9% to 7% in Q3, ending Q4 at 4.7%.
- Staff recommending services to Friends and family at 73.9% which is 7% above previous quarters.
- IAPT recovery rates across 4 CCG's achieved above target of 50% with the exception of Mid Essex slight missing target at 49.6%

Of those reported red, Carers feedback on feeling valued by staff has fallen back from 82% to 69% in the quarter, an action plan is is being developed to improve performance. The other two areas are the data completeness on employment and accommodation. This showed notable improvements from circa 20% to 60% plus in earlier quarters and will be prioritised for further improvement in the next quarter.
All other key performance indicators across Safe and Effective services are maintaining good performance including the rate of acute inpatients reporting feeling safe in our Trust.

On Workforce, 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.
The overall performance of the key performance indicators are:

- Sickness absence rate reduced slightly to 4.5% in Q4 with a reduction to 4.2% in March.
- There was positive improvement in mandatory training in Q4, it ended at 85.5% which is a 5% increase on the Q3 position of 80%.
- Appraisal levels have remained the same in Q4 at 87% with 75 further appraisals needed to meet the 90% target.
- The turnover rate increased from 13.3% in Q3 to 14.2% in Q4.

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 financial position remains strong and this continues to provide the basis for services to look for ways to strengthen service performance through investment and the implementation of best practice. The achievement of additional STF funding from the national scheme provides the opportunity for targeted capital investment to achieve this. In part the financial position is derived from pay costs being below plan which as highlighted throughout the report is a key pressure within several services notably CAMHS and several of the community teams

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

Performance Report
Quarter 4
2017/18

Contents

1. Summary

The overall performance at Q4 has seen an increase in green indicators to 66% at the Quarter end which compares to 64% at Q3 and 62% when compared to February. Balanced against this is the increase in red indicators particularly when compared to the December position where there has been a shift from amber to Red.
This is shown in the table below with further detail provided below;

KPI indicator	Mar	Feb	Jan	Dec	Change Prev. M	Change Prev Q
Green	38	35	31	37	+3	+1
Amber	6	8	13	11	-2	-5
Red	14	13	12	10	+1	+4
Total	**58**	**56**	**56**	**58**	**+2**	**0**

In relation to the four scorecard elements the strongest position remains within Finance and Safe & Effectiveness and the most challenged areas are against the Workforce and Access metrics, this position has remained largely consistent across the year. Against the Single Oversight framework (which is a broad range of measures) then the performance remains relatively strong with one indicator showing red following the audit conducted on the Cardio-metabolic assessments for people with psychosis carried out within the FEP service during Q3.

Areas of strong or improved performance:
Continuing Strong

- FEP 14 day wait—64.2% (43/67) against a target of 50% with an average of 70.9% over the year.
- New FEP cases for the year were 290 against a target of 150 (93% above)
- 100% CQUIN funding achieved on two of the three Cardio-metabolic indicators reported within the SOF
- Data quality Maturity Index remaining at 96.1% on the latest data with further improvement anticipated in the remaining quarters.
- Overall IAPT waiting times – for the year showing 93.6% six week wait against a target of 75% and 99.9% 18 week wait against a target of 95%. Out of a total number of 26,306 service users only 15 were not seen within 18 weeks and 2,238 not seen in 6 weeks.
- IAPT recovery rate – At March was 55% (674/1,241) aggregate with all services above the 50% target. The average for the year was 53.4% with the strongest monthly performance in March.
- CATT referrals meeting the 4 hour wait was 100% throughout the quarter (1439 cases)
- Gatekeeping assessments were completed 98.2% (272 cases from 277)
- Delayed transfer of cares from inpatient has fallen throughout the year from 9% to 4.8% (second lowest monthly figure in march)

- Service users with PbR cluster remained above the 95% target throughout the year.
- The service users that would recommend services to friends and family was above the 70% target throughout the year averaging 86.9%.
- Continued strong financial performance with an YTD surplus position well ahead of Plan achieving £6.1m STF earned for the year.

Significant changes in the month

- Routine adult community wait – 95.9% in month the highest by some way achieved in the year (349/364) against 98% target.
- CPA reviews at 97.4% in March (792/813)
- IAPT recovery rate in Mid Essex was 55.5%, 7.5% above the February figure achieving above the 50% target
- Staff Friends and family test figure was 73.9% for the quarter above the 70% target for the first time this year.
- CAMHS Urgent P1 referrals fell to 65.6% in March (11/21) against 84.2% January and 66.7% in February. Target being 75%
- CAMHs 28 day referrals have fallen back after Februarys improvement to 70.5% (91/129) a fall of 22%.

Indicators moving from the previous Quarter from red/amber to green:

- Urgent referrals to Community Teams returned to 1005 (8/8) from 83% the last quarter.
- Routine referrals to Community Learning Disability teams returned to 100% (39/39) from 93%.
- Proportion on CPA with 12 month review has continued upward trajectory and is 97.4% (792/813) for quarter from 94% (amber)
- The staff Friends and Family measure has improved from 67% (Amber) to 73.9% (218/295)and is above the 70% target for the first time this year (measured quarterly)

Indicators moving from the previous quarter from green to red

- CAMHS Urgent (P1) waits is Red at 67.2% (39/58) from 88.7%. Target 75%
- CAMHS 28 day waits is red at 80.5% (339/421) from 98.6%. Target 95%
- Carers feeling valued by staff which is 68.7% (57/83) from 76.8%. Target 70%

SOF:

- Performance remained stable in the period. Very strong performance against IAPT indicators.

Access:

- 13 green indicators – which is consistent throughout the quarter and the previous quarter end. There has been shift within this with a fall in two CAMHs indicators from Green to Red including routine 28day waits, with an offsetting improvement in urgent community waits and routine community Learning Disability access.
- Significant Improvement in Adult 28 day waits to above 95% in March.
- In CAMHS two of the 5 indicators reported Green for the quarter.
- In IAPT, both East & North and NE Essex sustained there position and exceeded the target HVCCG (5% below) Mid Essex (12% below) and West Essex (7% below) as forecast did not achieve full year requirement.

Safe & Effective:

- This shows continuing improvement throughout the Quarter with further increase in green indicators in March from 13 to 15. 2 indicators improved from Amber to Green and 1 (Carers feeling valued by staff) moved from Green to red in the period.
- IAPT recovery rates continued to show strong position with 4 areas well above the 50% threshold and in Mid Essex there was 3 cases short of the 50% at 49.6%
- Risk Assessment completion and Clustering reviews overall were below the 95% target at 94% and 93% respectively.

Workforce:
The overall performance of the reported indicators has remained the same. There was a positive movement in mandatory training with a 5% improvement over the quarter to 86% and there was a fall in sickness to 4.5% for the quarter with a favourable movement in March which was at 4.2%. PDP appraisal remained at 87% with 75 further appraisals needed to meet the requirement.

Finance:

The EoY position was above Plan in part due to the favourable movement in two provisions made in previous years. Importantly the continuing cost pressures principally with placement costs impacted upon the early year savings. The continuing rise in placement costs combined with the planned increase in support costs will mean that next year's financial position is likely to be very challenging.

2. Key Areas of Activity in 2017/18

1,336 adult acute inpatient admissions YTD

28,668 new spells of care in secondary mental health services YTD

504 Starters
471 Leavers

35,185 people entering treatment in Wellbeing Services YTD

2,897 people on CPA at the end of Q4

335,516 individual secondary care contacts YTD

477
inpatient beds
at the end of Q4

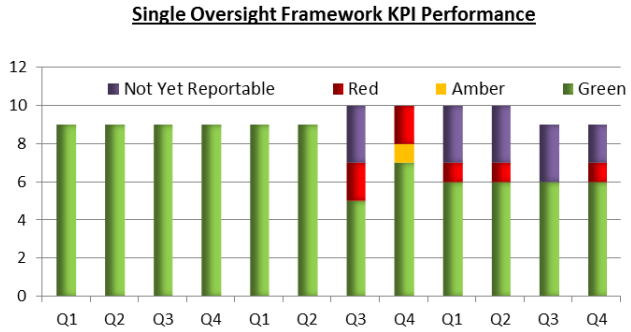
29,505 spells of care discharged from secondary mental health services YTD

Key highlights against previous year (where data available) include;

- 9% increase in new referrals from 26.2k last year.
- Community contacts marginally below last year's 335.5k
- Slight fall in numbers on CPA being 3.1k at the same point last year
- New starters similar to last year (if TUPE from Buckinghamshire excluded) leavers 24 increase (circa 5% more)

3. Performance On SOF

Single Oversight Framework (SOF 2 – 6)



In Q4, six indicators were rated as green, one was provisionally red (FEP cardio-metabolic assessment rates) and two were not reportable due to data not yet being released for the quarter.

SOF 2: FEP 14 day waits

FEP referrals engaged with a care co-ordinator within 14 days was at 64.18% against a 50% target for the quarter (43/67). Two meetings have been held with NHS England to better understand how to ensure that MHSDS matches the Unify return which ended in March. Discrepancies are now greatly reduced and the March return is expected to match.

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

SOF 3: Cardio-metabolic indicators for people with psychosis

HPFT are undertaking two National audits on the management of psychosis. The PACE Team 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 due at the end of April 2018.

- 73% achieved for the Community CPA cohort against a target of 65% = 100% funding achieved (approx. £67k)
- 95% achieved for the Inpatient cohort against a target of 90% = 100% funding achieved (£101k)
- 61% achieved for early intervention in psychosis services (FEP) against a target of 90% = 25% funding achieved (approx. £17k).

SOF4: Data Quality Maturity Index (DQMI)

The latest published data is for Quarter 2 which shows a DQMI of 96.1% (same as previous quarter) which is above the national 95% target. The current focus on data quality with the extended data quality team is expected to see this improve further throughout the year. Analysis of the data set shows our data quality is most complete within Outpatient and MHMDS and is below 95% in IAPT and within Inpatients. Of the 49 data items measured in 42 cases our completeness is above the national average with the following fields being those that are below in the last available data.

	Data field	score	Nat. aver	diff
IP	SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	59.7	96.8	-37.1
IP	PRIMARY DIAGNOSIS (ICD)	54.2	87.7	-33.5
IP	ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	65.2	98	-32.8
IAPT	SOURCE OF REFERRAL FOR MENTAL HEALTH	92	99.5	-7.5
IAPT	ETHNIC CATEGORY	81	86.9	-5.9
IAPT	PERSON GENDER CODE CURRENT	95	96.6	-1.6
IAPT	NHS NUMBER	94	94.3	-0.3

A set of actions for further improvement is underway as part of the Accurate Information Strategy and will be managed by the Data Quality Team. 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 with quarter 3.

SOF 5: IAPT Recovery Rate; 6 Week and 18 week waits

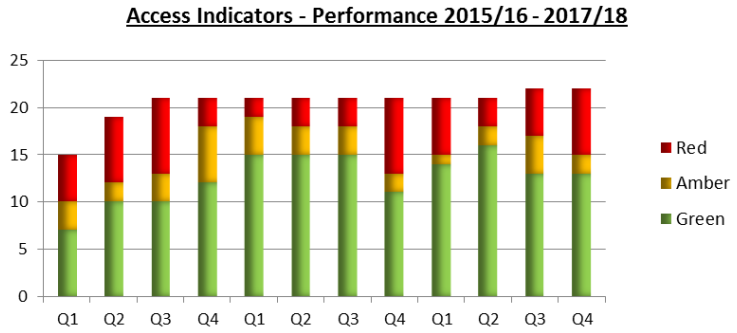
Combined recovery rate target of 50% has been exceeded at 53.12%, an increase of 0.21% on Q3 figures. High performance on waiting time indicators continues - achieving 92.53% for 6 week wait (target 75%) and 99.96% for 18 week wait (target 95%).

SOF 6: Inappropriate Out of Area Placements

This indicator measures the total number of bed days patients have spent out of area in the last quarter and trajectories will be set at both STP and provider level to drive an overall improvement in national performance.
Whilst the final figures are awaited for
This indicator is subject to external audit for Q4 data as part of the Quality Account validation for 17/18.

4. Performance On KPIs

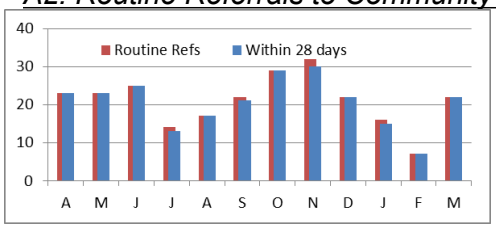
Access to Services (A1 – 24)



The table below shows Access indicators have been rated as red or amber in Q4, with movement from Q3 position and the shortfall from target.

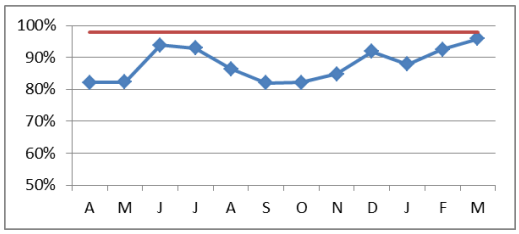
Access KPI	Q4 Performance	Movement from Q3	Shortfall from Target
A2: Routine referrals to community eating disorder services	97.78% (44/45)	+0.19%	1 (98%)
A4: Routine referrals for Adult Community Services	91.67% (1090/1189)	+5.6%	70 (98%)
A11: EMDASS 6 week wait ⊘ KPI Ended as of 31/03/18	76.5% (267/327)	-9.42%	26 (90%)
A12: C-CATT 4 hour wait	93.28% (250/268)	+0.72%%	5 (95%)
A13: CAMHS P1 7 day wait	67.24% (39/58)	-21.39%	5 (75%)
A16: CAMHS Routine Waits	80.52% (339/421)	-18.12%	61 (95%)
A20: People entering IAPT Treatment - HVCCG	10,092/10,663	-	571
A21: People entering IAPT Treatment – Mid-Essex	5,174/5,892	-	718
A22: People entering IAPT Treatment – West-Essex	4,577/4,933	-	356

A2: Routine Referrals to Community Eating Disorder Services



Performance for Q4 was at 97.78% (44/45). The complexity of presentation and the number of clinicians involved in managing each case has increased, which meant that one service user was not seen within the 28 day target in January, 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.

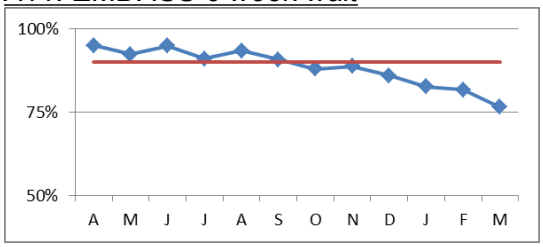
A4: Adult Community 28 day wait



Performance in March on the 28 day wait was at its strongest point in the last year at 95.8%. Overall performance for the quarter is at 91.67% which is a 5.6% improvement on Q3 performance.

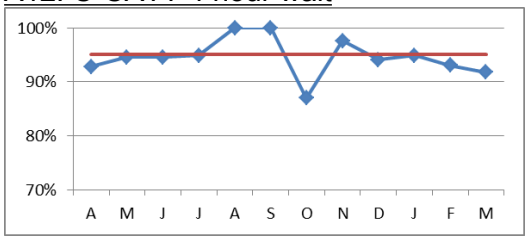
The new DNA Protocol has now been fully implemented across Adult Community Services. This provides a robust pathway for clinical decision making on those who do not attend appointments and should result in an increase in slots available for first appointments. Analysis on the first three months of data is underway, with a report due to commissioners at the end of April. The improvement in performance also reflects ongoing work across community services to improve waiting times, including focused initial assessment workers, scrutiny of potential 28 day waiting breaches and Saturday clinics in some areas.

A11: EMDASS 6 week wait



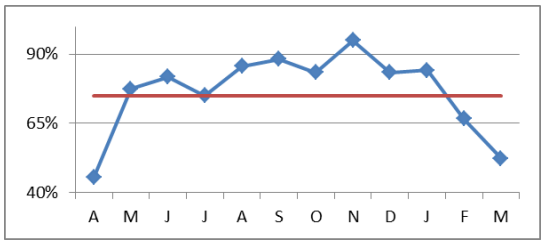
With the introduction of the new One Stop Shop diagnosis clinics the <6 week assessment waiting target (90%) is now invalid and will be superseded from April by the new 80% of referrals to diagnostic appointment within 12 weeks target. The specific detail of the target remains to be agreed with the key point being the current wait times on the initial screening appointment at the acute Trust.

A12: C-CATT 4 hour wait



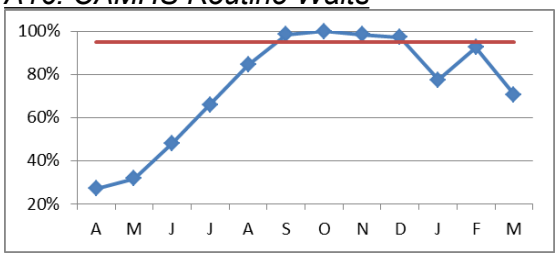
Q4 performance was at 93.28% (250/268).
Under performance due to high number of referrals into CCATT at both A&E departments and staffing being stretched due to vacancies. Delays are monitored daily and staff moved between the acute trusts as appropriate.
Six cases went over target and all can be attributed to days in A&E where there were high numbers of referrals to be assessed e.g. 4, 5 or 6 young people at a time. Recruitment is underway.

A13: CAMHS Urgent 7 day waits (P1)



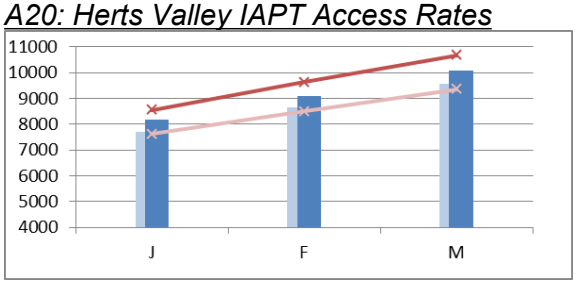
Q4 performance was at 67.24% - a reduction of 21.39% on Q3. Performance over the last quarter has been adversely affected by an increase in referrals, particularly P1s and urgent appointments. The service is currently auditing the P1 referrals received to try to better understand the impact. Demand is currently outstripping staffing levels.

A16: CAMHS Routine Waits



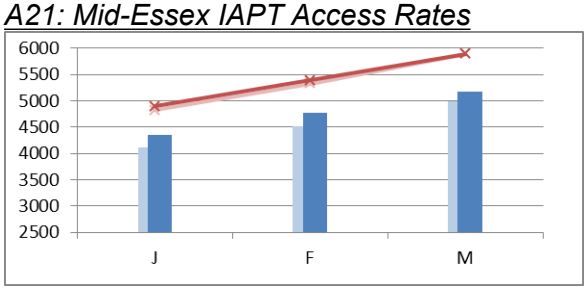
Performance in Q4 fell by 18.12% to 80.52%. This was due to a combination of reasons which includes delays in SPA passing on referrals to CAMHS – in some cases on day 14 rather than day 5. Large numbers of referrals into SPA also resulted in quality issues for triages. Capacity issues in Step2/Tier2 services also saw delays in passing any cases on to Tier 3. An inability to recruit good quality agency staff to temporarily fill vacancies has also impacted on performance.

A20: Herts Valley IAPT Access Rates



At the end of Q4 HVCCG IAPT service was 600 short of the required number of people entering treatment (9024/9624). A significant amount of work took place across February and March in an attempt to recover the position including; assessment weeks, job centre and schools recruitment, SPA AQP process review but all with only limited success. 18/19 access workshop undertaken to identify HPFT & IHCCT activities to improve position

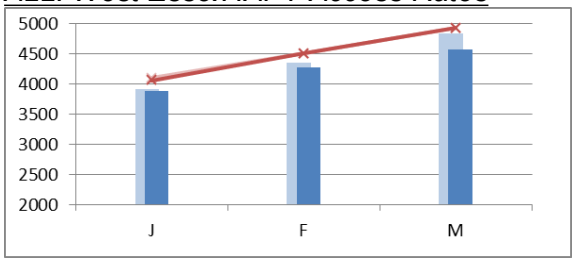
A21: Mid-Essex IAPT Access Rates



As predicted the access target was not met this financial year, as the gap in referrals and current access levels was too large to recover (5,174/5,892. Key issues are:

- A lack of GP referrals – no change in pattern from last year despite variety of engagement strategies
- CCG have not provided any indication of additional funding following the findings of the Mental Health Strategies report that indicated current funding would be insufficient to meet target if referrals were being made.
- Commissioned activity remains at 15% for 18/19

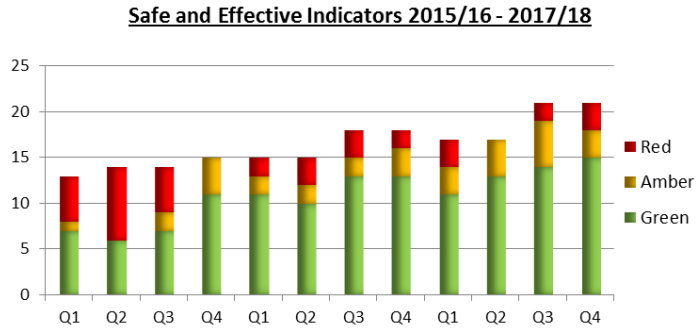
A22: West Essex IAPT Access Rates



As for Mid-Essex, the access target was not met in West Essex this financial year, as the gap in referrals and current access levels was too large to recover (4,577/4,933). Key issues are:

- lack of referrals from GPs
- Current pressure on workforce has been reviewed and alternative options to support the team are being explored, given recruitment and agency support has not proved successful.
- agreed to review Communications and Marketing strategy with CCG (could be Essex/STP wide)
- Negotiations for this year's trajectory are ongoing as are finances (back stop is current contract 15% for the year, although additional funding is likely to be agreed.)
- There were no further actions identified from the recent Mental Health Strategies review.

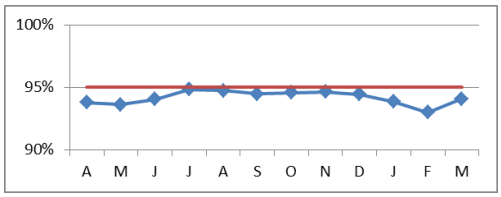
Safety and Effectiveness of Services (SE1 – 21)



The table below shows the Safety and Effectiveness monthly indicators that have been rated as red or amber in Q4, the movement from the Q3 position and the shortfall from target.

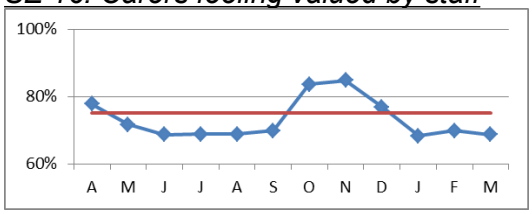
Safety and Effectiveness KPI	Q4 Performance	Movement from Q3	Shortfall from Target
SE5: Risk Assessments	94.1% (16,460/17,700)	-0.34%	158 (95%)
SW8: Mid-Essex IAPT Recovery Rate	49.6% (292/589)	- 0.25%	3 (50%)
SE16: Carers feeling valued by staff	69.8% (57/83)	-8.11%	5 (75%)
SE 18: Cluster Reviews	93.1% (10,296/11,057)	-0.39%	209 (95%)
SE21a) Employment b) Accommodation	65.52% (10,742/16,396) 67.08% (10,642/16,396)	-1.13% - 2.07%	3,195 (85%) 3,295

SE5: Risk Assessment



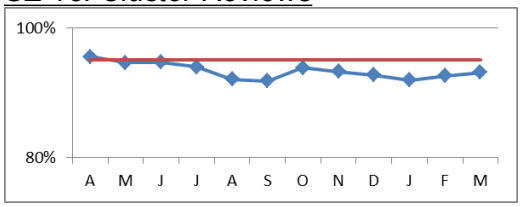
Performance for Q4 is at 94.1%, a 0.34% decrease on Q3.
It should be noted that March performance saw an improvement on that of January and February, as shown in the chart above. Adult Community Services, the largest service in terms of caseload, achieved the 95% target at the end of March. LD&F remained compliant at 95.69%. MHSOP were at 93.47% and CAMHS were the lowest performing service on this indicator at 90.41%. This is due to the large caseloads that some the CAMHS clinicians are currently managing. There is an ongoing process of caseload review to manage caseload sizes more effectively and a renewed focus on data quality to ensure that all completed reviews are correctly signed off and therefore counted.

SE 16: Carers feeling valued by staff



This indicator comes from Having Your Say and is reported on a 3 month rolling basis, due to relatively small numbers of returns. In Q4 performance was at 68.7% (57/83). Performance is being discussed with senior leaders and teams to ensure that staff understand and uphold the triangle of care with carers.

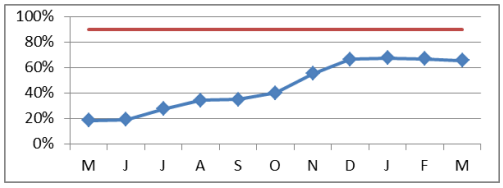
SE 18: Cluster Reviews



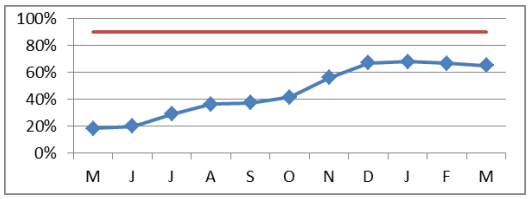
Performance in Q4 was at 93.1% (10,296/11,057) and an improvement of 0.39% on Q3. Adult Community were at 91.58%, with a particular issue identified in the North of the County, where changes in consultants had left caseloads sitting with trainees. These cases are now being moved back under consultants and they are being informed where cases need to be reviewed. MHSOP are above target at 96.99% and Acute and Rehab are at 93.85%.

SE21: Employment and Accommodation

Employment



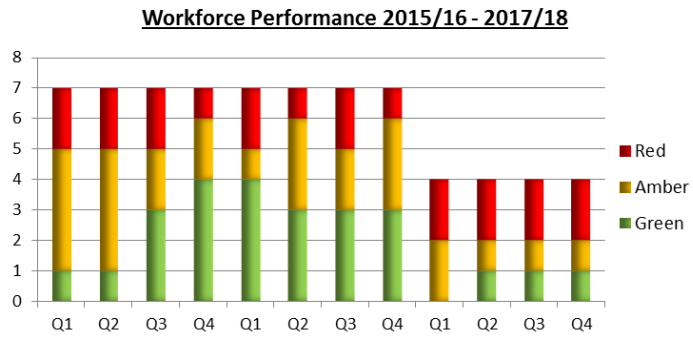
Accommodation



There has been a small fall in recording of employment and accommodation in February and March, which had been due to the shift of focus of the Data Quality Officers onto other areas such as risk assessments, CPA reviews and clustering. From April these indicators will

become part of routine monitoring and the cohort of service users without employment and accommodation statuses will be targeted for completion.

Resources – Workforce (W1 – 9)



The table below shows Workforce monthly indicators that have been rated as red or amber in Q4, with movement from Q3 position and the shortfall from target. Turnover is not rag-rated but is included for information.

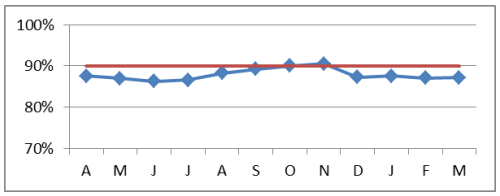
Safety and Effectiveness KPI	Q4 Performance	Movement from Q3	Shortfall from Target
W5: PDP and Appraisal	87.2% (2,298/2,638)	-0.08%	75 (90%)
W6: Mandatory Training	85.5% (22,657/26,485)	+ 4.67%	1,710 (92%)
W7: Sickness Rate	4.5%	+0.1%	- (4%)

	(11,610/257,945)		
W8: Turnover Rate	14.2% (375.77/2,683.52)	+0.89%	-

Summary of Pulse Results

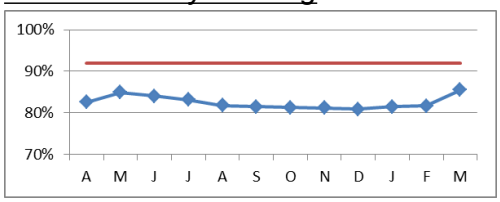
Quarter 4 has seen maintenance or improvement in the pulse survey scores, 75% of staff recommending the Trust as a place to receive care, and 64% saying they would recommend the Trust as a place to work. This is 4% down on Q3 results. Additionally, 92% of staff say they are mindful about living the Trust 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 further reflected in that 90% of respondents who said they had the skills and knowledge to do their job effectively a decrease of 4% on quarter three, with only 61% reporting that had the opportunity to develop new skills. There has been a slight decrease in the number of staff that believe HPFT takes positive action on their health and wellbeing this quarter to 79% a decrease of 2% in Q3. Additionally 85% of staff said that they did not experience bullying and harassment at work, this is slightly down from 88% in Q3 and 88% did not experience violence which shows a decrease 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. Staff reported that they worked additional unpaid hours has increased by 6% to 59% and 47% felt their workload was manageable which was a 9% decrease on Q3. There was a positive increase of 7% in staff who said that Trust processes help them to be effective (Q3 34%) and a decrease of 4% to 53% of staff who said 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.

W5: PDP and Appraisal



Staff with a current PDP remains the same at 87% at the end of Q4. East & North has the highest compliance rates with all of their service lines above 85% except for CAMHS. West Herts Single Point of Access Team and West Herts Management Team are at 100%. Compliance rates in East and North SBU have remained relatively stable at 90% and there is a focus at team performance meetings and core management meetings to keep the momentum to reaching compliance. LD&F Mental Health Rehab services have achieved 96 %. The PDP rate in Corporate has increased to 72% an increase of 7%.

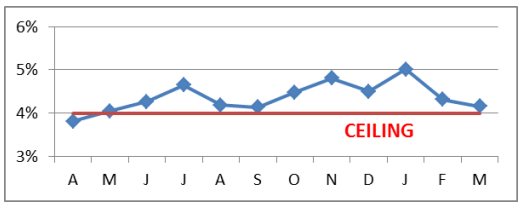
W6: Mandatory Training



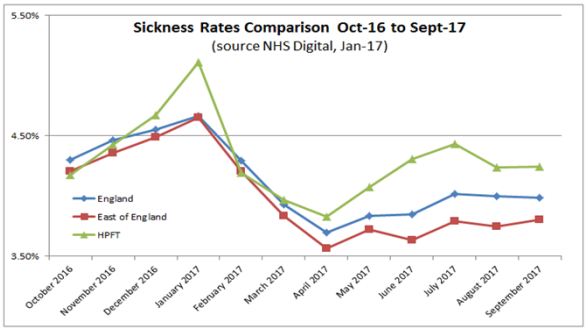
The mandatory training rate has increased from 81% in Q3 to 85% in Q4. The Trust is currently in a transition of moving to new competencies to align with the core skills training framework. A significant amount of activity to improve performance has taken place with a review of how training is delivered, 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 were put in place for safeguarding, WRAP, resuscitation, infection prevention and control, and moving and handling. At the end of Q4 these reached an overall compliance of 86%. Monitoring continues on a weekly basis at a task and finish group.

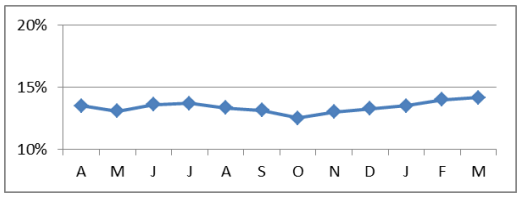
W7: Sickness Rate



The sickness absence rate in Q4 has decreased slightly to 4.1% a decrease of 0.2% but remains slightly above the Trust target of 4%. There are currently 123 short term sickness absence cases and 61 long term sickness absence cases being managed through the employee relations team. The number of short term sickness absence cases that are being managed has increased by 51 since the last quarter. The number of long term sickness cases being managed has also increased by 7 at the end of Q4. 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. The introduction of sickness absence dip audits in the SBUs will further support managers. Further health and wellbeing initiatives have taken place during Q4 and 57.9% of frontline staff have had their free flu vaccine at the end of the 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 (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.



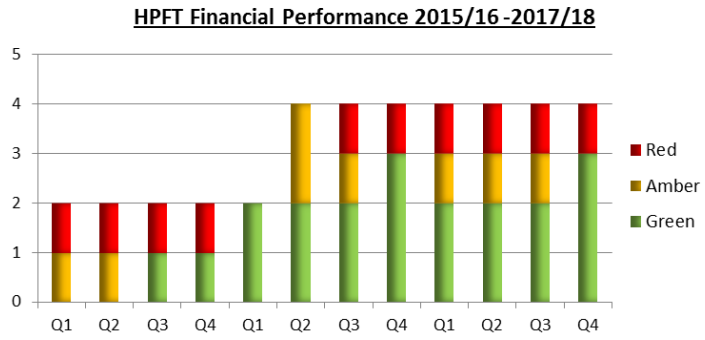
W8: Turnover Rate



The turnover rate has increased in Q4 to 14.16% from 13.27% in Q3. 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. Work continues in this area.

Resources – Finance (F1 – 5)



The overall Trust position for the full year is a surplus of £3.4m, before STF and Impairments, which is better than the Plan of £0.8m by £2.6m. The NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 1, the highest rating.

£m	1718 Plan	1718 Forecast	1718 Actual	Variance from Forecast
Surplus	**0.8**	**1.2**	**1.2**	**0.0**
Reversal of unused Provisions / Accruals	**0.0**	**3.2**	**3.6**	**0.4**
STP Expenditure	**0.0**	**-1.0**	**-1.0**	**0.0**
Other Unplanned Expenditure	**0.0**	**0.0**	**-0.4**	**-0.4**
Headline Surplus	**0.8**	**3.4**	**3.4**	**0.0**
STF	**1.2**	**4.3**	**4.3**	**0.0**
Impairments	**0.0**	**-0.6**	**-0.6**	**0.0**
Revised Likely Surplus	**2.0**	**7.2**	**7.2**	**0.0**

This position results from a surplus of £1.2m in the first half of the year, after which the run rate reduced to little more than break even most months; additional expenditure of £1.0m towards the STP, utilising STF; release of £3.6m of provisions and old year accruals, including £0.9m previously provided for CHC Appeals, £1.3m previously provided for a legal appeal, and £0.7m in respect of other pay items, most of which was planned; with c. £400k of additional yearend expenditure which had been reported as expected in recent forecasts.

Although the surplus for the full year was as forecast, it should be noted that within this there was additional expenditure supported by additional old year releases. The run rate going forward is extremely challenging with substantive pay increasing, bank and agency not having reduced as planned, secondary commissioning not having reduced as planned. It will be important to monitor this through the first months of the year

5. Clinical Assurance Recording Framework

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:

CRAF work is now complete with successful clinical engagement with over 150 staff across services. Assurance has been obtained for all KPIs that the team have reviewed that none are in a situation similar to the Gatekeeping scenario identified by the Deloitte audit.

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 separately by Data Quality staff to provide interim assurance.

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.

CRAF findings and issues are currently being reviewed and addressed as part of the Business Change and Transformation work with the RAID and CATT teams (to ensure standardised processes, ease of recording and training materials in place for staff). This

approach is working very successfully and has been welcomed and supported by the teams concerned.

Having reviewed our approach with senior managers it has been agreed that continuing with a Service-led Transformation work will be most effective in addressing the issues identified, and improving processes and recording.

6. CQUIN

CQUIN results for Q4 were not yet available at the time of writing this report. Results will be reported directly to Trust Executive and the Trust Board once they are validated.

7. Quality Account

Performance for the Quality Account in 2017/18 can be found in Appendix 2. Of the 12 indicators at year end all

But one indicator was rated as green. This was Carers Feeling Valued by Staff which was at 68.7% at the end of Q4 against a target of 75%.

8. Additional Key Quality Considerations

Infection Prevention and Control

There were 26 Infection Prevention and Control incidents reported in Quarter 4 2017/18(Q1 = 23, Q2=16, Q3 =25). This includes 1 *Norovirus* outbreak and 2 periods of infections relating to gastro intestinal illness. There were 8 incidents relating to accidental inoculation injuries involving bites, scratches and splashes. A further 15 incidents were reported involving communicable diseases, poor compliance with infection prevention and control guidance, large spillages of blood or body fluids or concerns regarding Interserve. There were no needle-stick injuries reported.

There have been no reported cases of MRSA, MSSA or E-coli bacteraemia. There has been 1 reported case of MRSA colonisation/infection. This was investigated and the necessary treatment/procedures implemented.

There has been 1 reported case of *Clostridium difficile* and 1 reported case of Pulmonary Tuberculosis, both incidents were fully investigated and any follow up care implemented.

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 initially dropped. The current training compliance rates are as follows:-

Level 1 – 83%

Level 2 – 82%

An action plan has been developed and the compliance rates have been monitored on a weekly basis.

Health and Safety

The Trust has recorded a total of 169 Slips, Trips and Falls (ST&F) in Quarter 4 2017/18. This shows an increase of 15 incidents from Quarter 3 2017/18. In comparison with the same period in 2016/17 there has been a 7% reduction in falls reported in Q4 2017/18.

The Trust has reported a total of 10 staff incidents to the Health and Safety Executive (HSE) under the Reporting Injuries and Dangerous Occurrences Regulations (RIDDOR) during January - March 2017/18.

9 of these incidents were as a result of a physical assault against staff and1 incident was as a result of a member of staff trapping a finger in a door. All of these incidents resulted in staff being absent from work for 7 days or more. The data compared to the same period last year shows an increase of 3 incidents in the total number of RIDDOR incidents being reported to the HSE.

There were a total of 114 ligature incidents reported in this quarter which is an increase of 43 incidents reported in the previous quarter October – December 2017/18. The increase was seen on the Adolescent Unit.

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 January - March 2017/18 requesting the police to attend to support and assist staff. Usage remains low, but a revised process and action plan is being instigated in Q1 2018/19.

Quality Visits

There was 1 quality visit in Quarter 4:
Improved Access to Psychological Therapy (IAPT) - North East Essex – 16% Outstanding, 61% Good; clear communication around incidents, inclusion of staff when planning and developing services and improved environment.

There was a decrease in the amount of quality visits undertaken in Q4, this was as a direct impact of the CQC unannounced and Well Led Inspections that took place in January and February of 2018. The Quality Visit process is currently being reviewed by the Deputy Director of Nursing & Quality, Clinical Directors for each SBU and the Compliance & Risk Team and the new changes will be in effect from Quarter 1 2018/19.

PALS and Complaints

56 complaints were received in Q4 (36 West, 13 E&N, 4 LDF a decrease of 10%) on Q3 2017/18. 93% of complaints were acknowledged within the 3 working day target required by the regulations, compared to 94% in Q1.

There were 226 Patient Advice and Liaison Service (PALS) contacts, compared to 190 in Q3, an increase of 19%. 381 compliments were forwarded to the PALS and Complaints Team by operational services, a decrease of 22%. There were almost 7 times more compliments than complaints received during the quarter. The majority of complaints involved clinical practice (22), systems and procedures (18), staff attitude (6), 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 (LGO) made 2 requests for records and returned 1 decision (not upheld, with no further action). The PHSO informed the Trust that one complaint referred to them would not be investigated as the complaint was out of time.

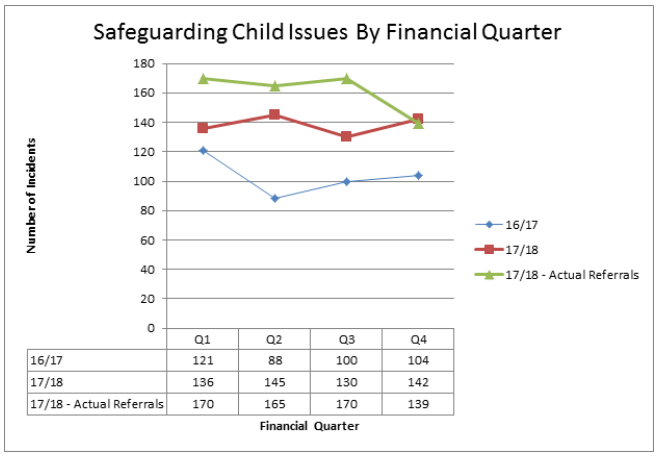
Safeguarding Activity for Children

Referrals for safeguarding children:

Chart 1 shows that the number of referrals has decreased significantly (23%) in quarter four after remaining stable over 2017/18. This is due to practice development in referral threshold to ensure that Safeguarding referrals are based on risk of "significant harm" and do not include general service requests for children in need for family support etc. These are referred through single service request process.

Recording issues identified in Quarter 3 have now been addressed and there is now a close correlation between Safeguarding Child incidents reported on Datix and Child Safeguarding referrals made to local authorities. This demonstrates that concerns are now being recorded on the incident reporting system (Datix).

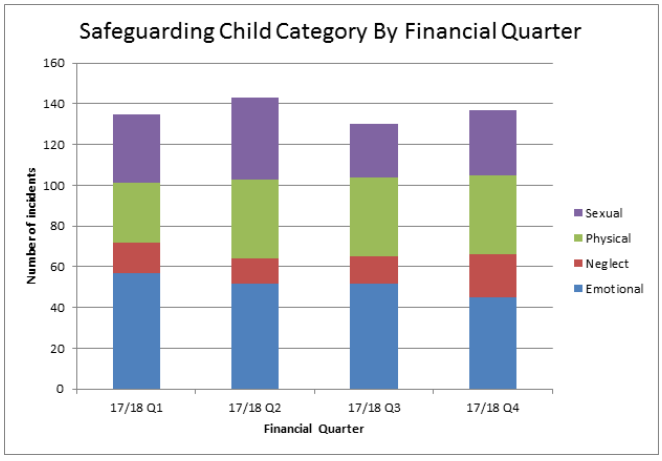
Chart 1 - Child Safeguarding Incidents by quarter



	Q1	Q2	Q3	Q4
16/17	121	88	100	104
17/18	136	145	130	142
17/18 - Actual Referrals	170	165	170	139

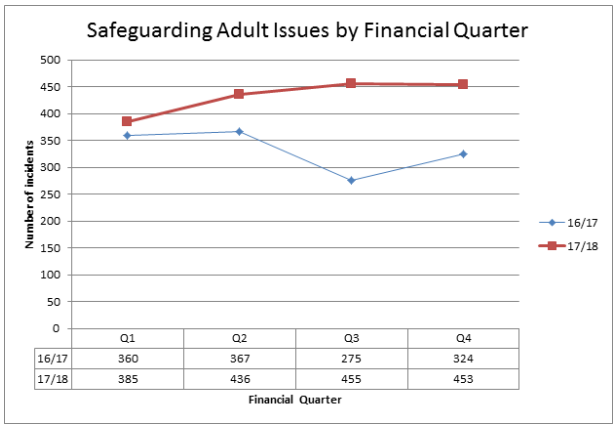
The emotional and physical abuse categories remain the highest reported categories in Quarter 4 2017/18 and across the whole of the 2017/18 period. This is consistent with the national report of child abuse with sexual abuse being consistently under reported and most often reported as neglect. Chart 2 breaks down this data.

Chart 2 – Child Safeguarding by Category of abuse



Safeguarding Activity for Adult

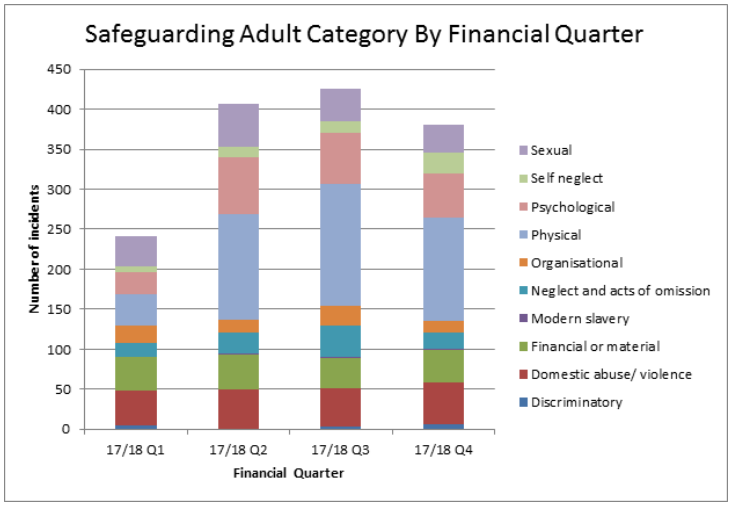
Chart 3 shows that safeguarding adults concerns have remained stable in quarter 3 and 4 after an increase in quarter 1 and 2 when practice issues were addressed following serious concerns



	Q1	Q2	Q3	Q4
16/17	360	367	275	324
17/18	385	436	455	453

Chart 4 shows that there has been consistency in the types of adult abuse identified with the highest proportion being physical abuse within our in-patient services

Chart 4 – Safeguarding Adult by category of abuse

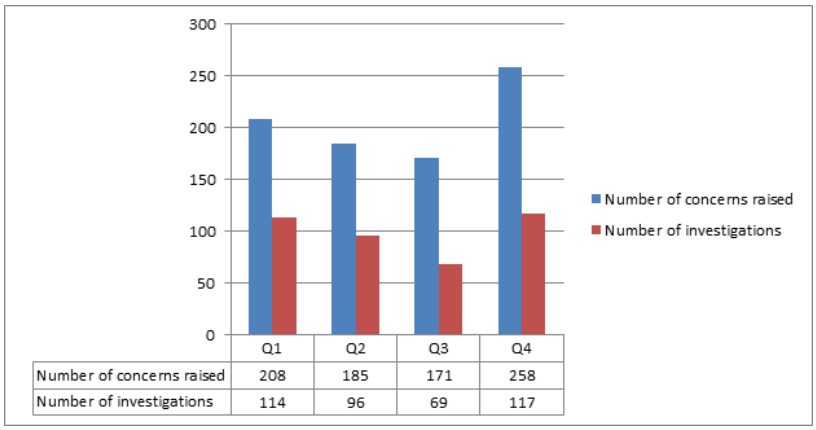


Statutory Safeguarding Adults in Hertfordshire

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).

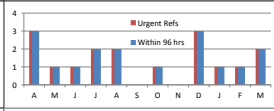
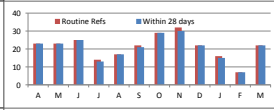
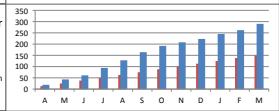
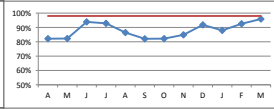
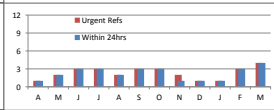
There has been a significant increase in safeguarding activity in quarter 4 which is a result of increased identification of safeguarding referrals in Single Point of Access (SPA). These concerns were previously being triaged out of the service and signposted however these are now being passed through to the community teams for decision making in line with our statutory responsibilities. Practice guidance for SPA when dealing with referrals has been developed alongside Hertfordshire County Council Safeguarding Lead.

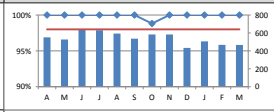
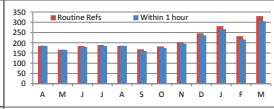
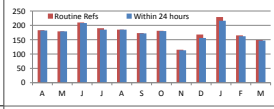
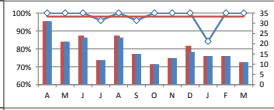
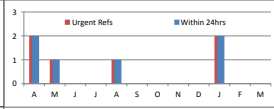
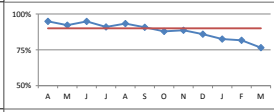
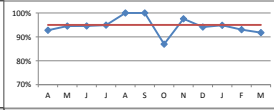
Chart 5 – Statutory safeguarding adults concerns and enquiries

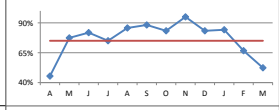
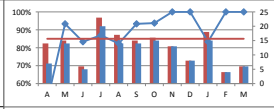
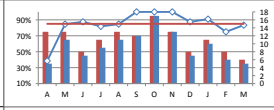
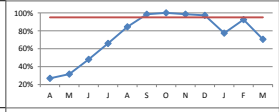
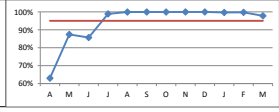


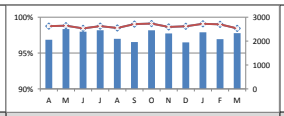
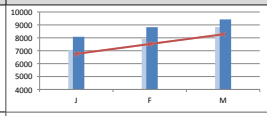
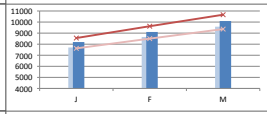
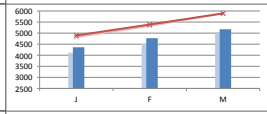
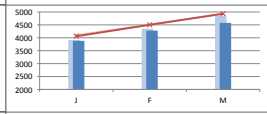
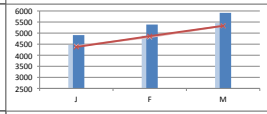
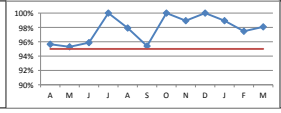
	Q1	Q2	Q3	Q4
Number of concerns raised	208	185	171	258
Number of investigations	114	96	69	117

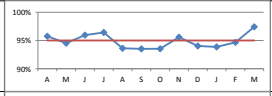
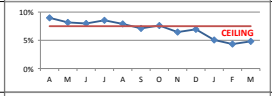
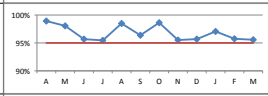
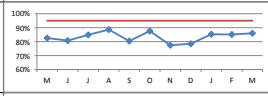
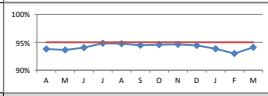
Ref	Standard[20]	Frequency	Standard[17]	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1)
SOF2	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)[22]	Quarterly	>=50%	**43/67**	**64.18%**	**69.49%**	**-5.31%**		↔
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**		HPFT has not yet received confirmed performance from the RCP .	
	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 https://digital.nhs.uk/data-quality	Quarterly in arrears	>=95%		**Q3 data not yet available**	**96.1% in Q2**	**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%	**2036 / 3833**	**53.12%**	**52.90%**	**0.21%**	Data taken from Trust SPIKE report on 16/04/2018 - Q3 figure refreshed	↔
	• waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks	Quarterly	>=75%	**6189 / 6689**	**92.53%**	**94.67%**	**-2.14%**	Data taken from Trust SPIKE report on 16/04/2018 - Q3 figure refreshed	↔
	- within 18 weeks	Quarterly	>=95%	**6686 / 6689**	**99.96%**	**99.92%**	**0.03%**	Data taken from Trust SPIKE report on 16/04/2018 - Q3 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	**Q4 Bed days by month:** **Jan-18** **Feb-18** **Mar-18**	**TBC**	**264**		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	

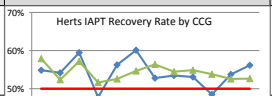
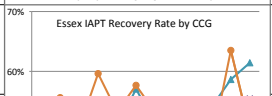
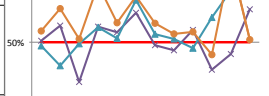
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**	>=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%		44/45	97.78%	97.59%	0.19%	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)		290	290 to end Q4 (threshold 150)	223 to end Q3 (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%		1090/1189	91.67%	86.08%	5.60%		↑
A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**	>=98%		8/8	100.00%	83.33%	16.67%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔

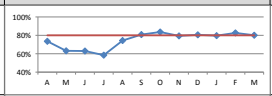
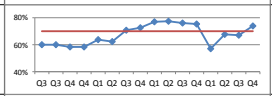
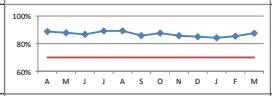
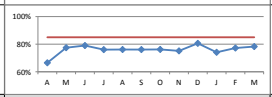
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
A6	CATT referrals meeting 4 hour wait **(Contractual)**	>=98%		1439/1439	100.00%	99.56%	0.44%		↔
A7	RAID Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A		787/843	93.36%	96.19%	-2.83%		↔
A8	RAID Response times: 24 hour wait for ward referrals (Lister & Watford combined)	N/A		525/543	96.69%	96.77%	-0.08%		↔
A9	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**	>=98%		39/39	100.00%	92.86%	7.14%		↔
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%		319/417	76.50%	85.92%	-9.42%	Target shows waiting list and will be superceded with a diagnostic target more appropriate to new one-stop-shop method of service delivery in 2018-19	KPI Ending
A12	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**	>=95%		250/268	93.28%	92.56%	0.72%	Note - target updated from 90% to 95% in commissioning contract in April 2017	↑

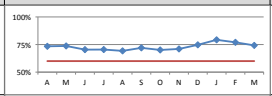
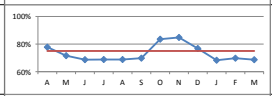
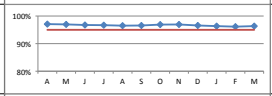
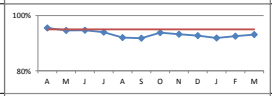
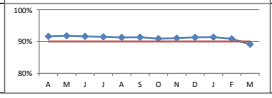
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
A13	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**	>=75%		39/58	67.24%	88.64%	-21.39%		↑
A14	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**	>=85%		25/28	89.29%	97.30%	-8.01%		↔
A15	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**	>=85%		22/25	88.00%	97.37%	-9.37%		↔
A16	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**	>=95%		339/421	80.52%	98.64%	-18.12%		↑
A17	SPA referrals with an outcome within 14 days **(Internal)**	>=95%		6658/6725	99.00%	99.94%	-0.93%		↔

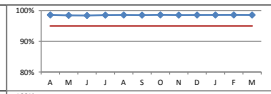
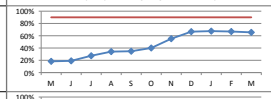
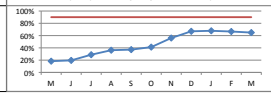
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
A18	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services **(Contractual)**	>=98%		6781 6861	98.83%	98.84%	0.00%		↔
A19	Number of people entering IAPT treatment (ENCCG) **(Contractual)**	8271 to end of Q4		2,162 (Q4)	9,426 (Cumulative)	7,264 (Cumulative)	n/a		↔
A20	Number of people entering IAPT treatment (HVCCG) **(Contractual)**	10663 to end of Q4		2,925 (Q4)	10,092 (Cumulative)	7,167 (Cumulative)	n/a		↔
A21	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**	5892 to end of Q4		1,265 (Q4)	5,174 (Cumulative)	3,909 (Cumulative)	n/a		↔
A22	Number of people entering IAPT treatment (West Essex) (Contractual)	4933 to end of Q4		1,123 (Q4)	4,577 (Cumulative)	3,454 (Cumulative)	n/a		↔
A23	Number of people entering IAPT treatment (NE Essex) (Contractual)	5328 to end of Q4		1,142 (Q4)	5,915 (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%		272/277	98.19%	99.63%	-1.43%		↔

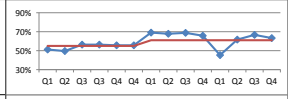
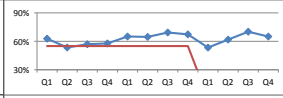
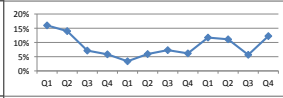
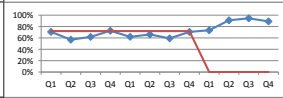
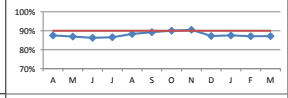
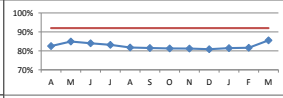
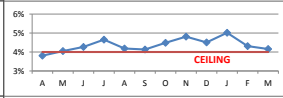
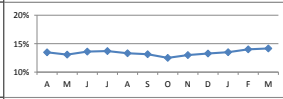
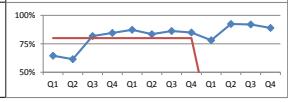
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
SE1	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	>=95%		792 813	97.4%	94.0%	3.39%		↔
SE2	Delayed transfers of care to the maintained at a minimal level	<=7.5%		1820 38,338	4.7%	7.0%	-2.26%	Data taken from Trust SPIKE report on 17/04/2018 - Q3 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%		385 401	96.0%	96.7%	-0.64%		↔
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		342 400	85.50%	81.29%	4.21%		↔
SE5	Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) **Seen Only**	>=95%		16,488 17,522	94.1%	94.4%	-0.34%	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.	↔

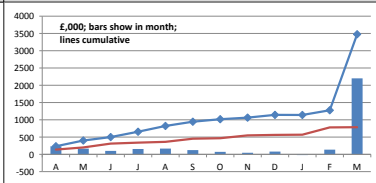
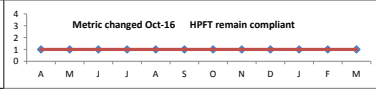
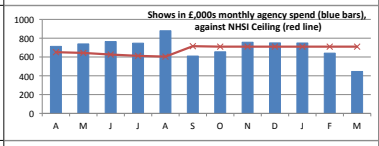
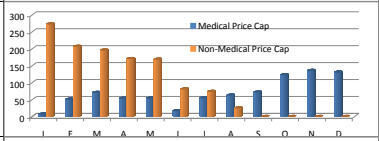
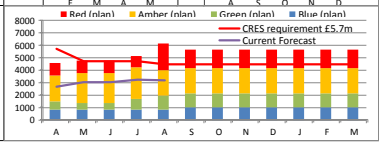
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
SE6	IAPT % clients moving towards recovery (ENCCG)	>=50%		581 1100	52.8%	53.1%	-0.30%	Data taken from Trust SPIKE report on xx/04/2018 - Q3 figures refreshed	↔
SE7	IAPT % clients moving towards recovery (HVCCG)	>=50%		691 1303	53.0%	55.3%	-2.22%	Data taken from Trust SPIKE report on xx/04/2018 - Q3 figures refreshed	↔
SE8	IAPT % clients moving towards recovery (Mid Essex)	>=50%		292 589	49.6%	49.8%	-0.25%	Data taken from Trust SPIKE report on xx/04/2018 - Q3 figures refreshed	↑
SE9	IAPT % clients moving towards recovery (NE Essex)	>=50%		257 443	58.0%	50.3%	7.70%	Data taken from Trust SPIKE report on xx/04/2018 - Q3 figures refreshed	↔
SE10	IAPT % of clients moving towards recovery (W Essex)	>=50%		215 398	54.0%	52.2%	1.87%	Data taken from Trust SPIKE report on xx/04/2018 - Q3 figures refreshed	↔

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**	>=80%		145 181	80.1%	80.6%	-0.45%	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%		218 295	73.9%	67.03%	6.87%	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%		1505 1761	85.5%	86.3%	-0.83%		↔
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		6256 8235	76.0%	76.7%	-0.75%	RAG rating not possible as target not yet agreed. Performance against previous target shown in chart.	

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
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%		288 388	74.2%	74.7%	-0.51%	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%		57/83	68.7%	76.8%	-8.11%		↑
SE17	Percentage of eligible service users with a PbR cluster	95%		11,065 11,484	96.4%	96.6%	-0.23%		↔
SE18	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)	95%		10296 11057	93.1%	92.7%	0.39%	Adult Community: 91.58% Acute & Rehab: 93.85% Older Peoples: 96.39% E&N SBU: 93.72% West SBU: 91.99%	↔
SE19	Data completeness against minimum dataset for Ethnicity (MHSDS)	90%		22,650 24,935	90.8%	91.3%	-0.45%	Note: data is reported **one month in arrears** due to the MHSDS refresh (one month in arrears) being a much more accurate figure than the primary. Quarterly reports show latest refresh month against last month of previous quarter	↔

SE20	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • identifier metrics	>=95%		150,686 152,874	98.6%	98.6%	0.00%	Previously SOF4 measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Trust SPIKE report on 17/04/2018 - Q3 figures refreshed	↔
SE21	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • Employment	>=85%		10,742 16,396	65.52%	66.65%	-1.13%	Data taken from last month of each quarter. Trust SPIKE report on 16/04/2018 - Q3 figures refreshed	↑
	• Accomodation	>=85%		10,642 16,396	64.91%	66.98%	-2.07%	Data taken from last month of each quarter. Trust SPIKE report on 16/04/2018 - Q3 figures refreshed	↑

Ref	Indicator (Monitor/Contractual/Internal)	Target	24 month Trend	Current Period Numbers (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
W1	Staff saying they would recommend the Trust as a place to work	>=61%		186 294	63.3%	66.7%	-3.40%	Total responses in the quarterly Pulse survey	
W2	Staff Wellbeing at Work (Change of measure in Q1)	target under review		629 967	65.0%	70.14%	-5.10%	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		35/286	12.24%	5.66%	6.58%	Total responses in the quarterly Pulse survey	
W4	Staff skills and capability (Measure of changed in Q1)	target under review		593 666	89.04%	94.44%	-5.41%	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 (Q4 2017/18)	Current Period Performance (Q4 2017/18)	Previous Period Performance (Q3 2017/18)	Change on previous period	Comments	Forecast for next period (Q1)
W5	Rate of staff with a current PDP and appraisal	>=90%		2289 2626	87.2%	87.2%	-0.08%		↑
W6	Rate of mandatory training completed and up to date	>=92%		22,657 26,485	85.5%	80.9%	4.67%		↑
W7	Sickness rate	<=4%		11,610 257,945	4.5%	4.6%	-0.10%		↑
W8	Turnover rate	N/A		378.1 2670.2	14.2%	13.3%	0.89%		
W9	Living the Values at work (Change of measure in Q1)	target under review		330 371	88.9%	92.0%	-3.05%	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 (Q4)	Current Period YTD Performance (Q4)	Current Period YTD Performance (Q3)	Change on previous period	Comments	Forecast for next period (Q4)
F1	To Achieve Surplus (amount to be confirmed) in year (not including STF)	tbc		£2333k surplus in Q4 (Plan £223k in Q4)	£3476k surplus at Q4 (Plan £786k surplus at Q4)	£1145k surplus at Q3 (Plan £563k surplus at Q3)	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		£1.836m agency spend in Q4	£8.450m Spend in year at Q4 (Ceiling £8.525m Spend in year)	£6.614m Spend in year at Q3 (Ceiling £6.395m Spend in year)	decrease in spend £326k relative to Q3	**Chart:** Red line = NHSI ceiling Blue bars - in month agency spend Black line = linear spend trend line	↔
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		TBC	TBC	**1225 Price Cap breaches YTD at Q3** (of which 705 are Medical and 520 Non Medical)	TBC	**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 Q4; £1.353m shortfall against £4.45m requirement. (Plans total £5.652m)	Forecast £3.097m at Q3; £1.353m shortfall against £4.45m requirement. (Plans total £5.652m)	No change in forecast	**Chart:** Shows indicative forecast against requirement. Also shows progression of Red and Amber Plans into Blue and Green Plans over time.	↔

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	24th May 2018	**Agenda Item:**
Subject:	Finance Report for the period to April 30th 2018	**For Publication:** No
Author:	Paul Ronald, Deputy Director of Finance and Performance Improvement	**Approved by:** Keith Loveman, Director of Finance
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:

For April the financial position has been challenging, with an overall Trust position reported in April being a deficit of (£240k), which is behind Plan by (£222k) (before STF). The STF available for meeting the Control Total is £89k for the month and £1775k for the full year. This will only be paid where the surplus position recovers to Plan. The overall NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 2. Key figures are summarised below and show adverse variances in the main cost areas :

UOR 1	In Month Actual £000	In Month Plan £000	YTD Plan £000	YTD Actual £000	FY Plan £000
Surplus (Deficit) excluding STF	(240)	(19)	(240)	(19)	360
Total Pay (including Agency)	12,590	12,472	12,590	12,472	149,703
Agency	654	611	654	611	7,327
Secondary Commissioning	3,107	2,550	3,107	2,550	30,955

In relation to the above and the wider financial performance:

1. Total Pay is reported above Plan by 118k in the month (0.9%), partly due to agency which is £42k above the cap requirement and the current shortfall on the CRES program (which is currently assumed to be Pay.) Further details on pay are provided in

the body of the report.

2. Secondary commissioning is significantly adverse to Plan by £557k (21%) with spend above Plan across all areas particularly within CAMHs Tier 4 NCM, and PICU placements where external bed requirements have increased from earlier months.

3. The immediate areas of focus are in relation to the CRES program where a number of schemes are still in development and in addressing the additional level of bed pressures in the areas identified above.

This position is clearly concerning and reflects the level of financial risk from such a small surplus margin in the current environment of increased demand and areas of significant demand volatility. Whereas in previous years there was some degree of offset within Pay budgets this has reduced. This general level of risk has been further impacted by the phasing of saving schemes and some seasonal spikes in activity pressures. In addition we have continued to make additional spend to support performance improvement and data quality initiatives, and on Information Technology to support staff.

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 2018/19

1.1. Whilst FY1718 saw a significant surplus the exit position in Q4 was circa £0.25m and was dependent upon addressing the cost increase in placement costs and the T4 CAMHS plans being implemented as timetabled. In addition there are new investments and cost increases emerging for 2018/19 in addition to the ongoing issue to address service pressures and operational stretch which is being consistently reported. These additional cost pressures include:

- 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

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.

1.1 The CRES level assumed within the Plan is £4.7m, and the NHSI Agency Ceiling is £7.3m, which is c. £1.4m below last year's actual spending. The Plan is summarised in Fig. 1a below:

Description	2017/18 Plan	2017/18 Actual	2018/19 Plan
Income	221.7	225.6	229.8
Pay	147.8	147.1	149.8
Other Direct Costs	28.2	32.2	33.9
Overheads	35.6	34.8	36.7
EBITDA	10.1	11.5	9.4
EBITDA margin	4.6%	5.1%	4.1%
Financing	9.3	8.1	9.0
Surplus	**0.8**	**3.4**	**0.4**

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

2. Performance Summary and Risk Rating

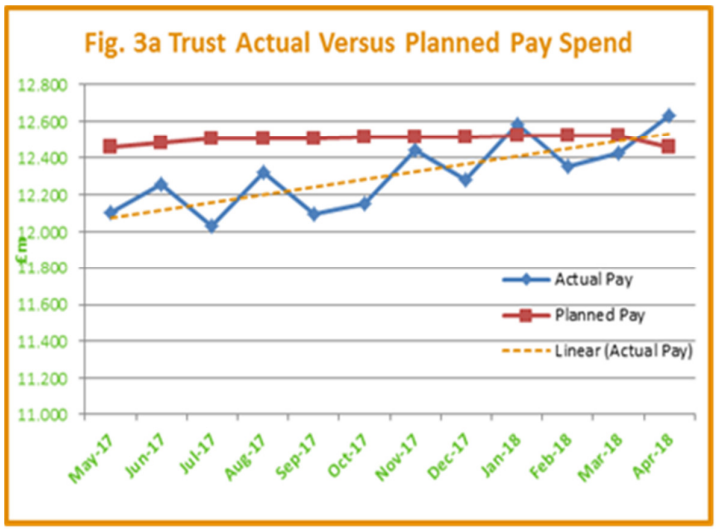
2.1 For April the financial position has been challenging, with an overall Trust position reported in April being a deficit of (£240k), which is behind Plan by (£222k) (before STF). The STF available for meeting the Control Total is £89k for the month and £1775k for the full year. Whilst this position does not include income from the STF (Sustainability and Transformation Fund) this will only be paid where the surplus position recovers to Plan.

2.2 Whilst this is the first month and some of the additional cost is through short term demand pressures on high cost external beds as identified in section 1 above the achievement of the control total will be very challenging. We have seen the trend in recent months of substantive pay costs increasing above any agency costs reduction and secondary commissioning spend continues to increase.

2.3 The four main variances within this position are:

2.3.1 Income on Plan but with contract income circa £0.1m below

2.3.2 Pay costs £0.1m above which is £76k substantive and £43k agency. Historically this is where a key element of savings has been made. There has been an increasing trend in pay costs over the period as shown in the graph below;



2.3.3 Secondary commissioning adverse to Plan by £0.6m

2.3.4 Other Direct Costs, Overheads and Financing better than Plan by £0.5m which is in part due to reserve allocations to be made.

2.4 The Trust's overall Use of Resources Framework Rating, the UOR, reports as a 2 in the month, due to the surplus margin being below Plan and the agency cap not being met.

3 Trading Position

3.1 In relation to the current trading position then the key is the implementation of the CRES program.

3.2 Following feedback from NHSI in relation to CRES proposals within the draft 2018/19 plan submission, the net CRES requirement for the year, estimated at £4.7m, is now reported gross being an additional £1.1m. Further, a 'stretch' element has been introduced to reflect plans to invest in further innovation and improvement on a 'spend to save' basis. This additional £1.5m will be delivered through a revised vacancy management process including review of all recruitment activity, vacancy analysis and utilisation of agency. This funding will be made available for non-recurrent investment and therefore neutral in impact as follows.

	£'000	£'000
Net requirement - initial assessment		-4,669
Gross up:		
- CAMHS T4 contribution	-400	
- Vacancy factor	-400	
- Rent reductions	-86	
- Safecare benefits	-100	
- Insurance reductions	-104	-1,090
- Facilitate Innovation		-1,500
Gross Requirement (Final Plan)		**-7,259**

3.3 In terms of deliverability of this then there is clearly more work required to be confident of this. In particular;

- Whilst there has been some initial good progress with a number of schemes mainly focussed around bed requirements (both number and type) progress in several areas appears to have slowed.
- In relation to the Agency cap more detailed plans are required.
- Further work is required in relation to Social Care and Corporate services.

Overall, key enablers to support the CRES and Continuous Improvement Programmes include:

- Developing the reporting capability of Safecare and e-roster systems
- Aligning e-roster, Safecare, Bed Management and Bank Bureau functions and optimising performance
- Investment of time and resource in the development of the Trust's Accurate Information Strategy.
- Evaluation of suggested actions arising from national benchmarking returns
- Roll out of Service Line Reporting to enable costing of pathways/ services and support internal benchmarking and analysis of effectiveness, productivity, profit or loss.

4 Forward Look

4.1 At this point it is fully expected that the Trust's control total will be met at the end of the year. However this needs significant focus over the next months:

4.1.1 Reduction in agency costs and review of current processes particularly in relation to non-clinical posts.

4.1.2 Secondary commissioning and ensuring the most effective arrangements for long-term health placements, social care placements, and social care packages.

4.1.3 Management of short term External PICU and Acute placements and the position on CAMHs T4.

4.1.4 Driving the maximum benefits from the additional expenditure planned, to support performance improvement and data quality and bid management.

4.2 End of Year forecasts will be presented regularly 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 30-April-2018

APPENDIX F2

Actual in month Apr-17	Actual YTD to 30-Apr-17	Description	2018/19 Plan	Month Apr - 18 Actual	Plan	Variance	Year to Date Apr - 18 Actual	Plan	Variance
30	30	Number of Calendar Days	365	30	30		30	30	
0	0								
13,890	13,890	Contract #1 Hertfordshire IHCCT	170,486	14,207	14,207	(0)	14,207	14,207	(0)
1,531	1,531	Contract #2 East of England	22,876	1,843	1,906	(64)	1,843	1,906	(64)
794	794	Contract #3 North Essex (West Essex CCG)	9,539	796	795	1	796	795	1
169	169	Contract #4 Norfolk (Astley Court)	2,166	181	181	0	181	181	0
546	546	Contract #5 IAPT Essex	6,579	534	548	(14)	534	548	(14)
317	317	Contract #6 Bucks Chiltern CCG	3,807	317	317	0	317	317	0
17,247	17,247	Contracts	215,453	17,877	17,954	(77)	17,877	17,954	(77)
93	93	Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	1,085	78	90	(12)	78	90	(12)
221	221	Education and training revenue	3,096	315	257	58	315	257	58
176	176	Misc. other operating revenue	2,453	332	204	128	332	204	128
428	428	Other - Cost & Volume Contract revenue	5,332	409	444	(35)	409	444	(35)
180	180	Other clinical income from mandatory services	1,975	141	165	(24)	141	165	(24)
13	13	Research and development revenue	403	15	34	(19)	15	34	(19)
63	63	Sustainability and Transformation Funding	1,775	89	89	(0)	89	89	(0)
18,422	**18,422**	**Total Operating Income**	**231,572**	**19,256**	**19,238**	**18**	**19,256**	**19,238**	**18**
(10,065)	(10,065)	Employee expenses, permanent staff	(126,428)	(10,605)	(10,529)	(76)	(10,605)	(10,529)	(76)
(1,174)	(1,174)	Employee expenses, bank staff	(15,948)	(1,331)	(1,332)	1	(1,331)	(1,332)	1
(713)	(713)	Employee expenses, agency staff	(7,327)	(654)	(611)	(43)	(654)	(611)	(43)
(30)	(30)	Clinical supplies	(279)	(39)	(23)	(16)	(39)	(23)	(16)
(2,204)	(2,204)	Cost of Secondary Commissioning of mandatory services	(30,667)	(3,107)	(2,526)	(580)	(3,107)	(2,526)	(580)
(20)	(20)	GP Cover	(288)	(27)	(24)	(3)	(27)	(24)	(3)
(212)	(212)	Drugs	(2,646)	(249)	(221)	(28)	(249)	(221)	(28)
(14,418)	**(14,418)**	**Total Direct Costs**	**(183,583)**	**(16,010)**	**(15,265)**	**(745)**	**(16,010)**	**(15,265)**	**(745)**
4,004	4,004	Gross Profit	47,990	3,246	3,973		3,246	3,973	
21.73%	21.73%	Gross Profit Margin	20.72%	16.86%	20.65%		16.86%	20.65%	
		Overheads							
(67)	(67)	Consultancy expense	(615)	(19)	(51)	33	(19)	(51)	33
(46)	(46)	Education and training expense	(1,029)	(73)	(83)	10	(73)	(83)	10
(334)	(334)	Information & Communication Technology	(4,080)	(326)	(340)	14	(326)	(340)	14
(334)	(334)	Hard & Soft FM Contract	(5,238)	(457)	(437)	(20)	(457)	(437)	(20)
(397)	(397)	Misc. other Operating expenses	(8,273)	(442)	(773)	331	(442)	(773)	331
(495)	(495)	Other Contracts	(5,778)	(473)	(481)	8	(473)	(481)	8
(50)	(50)	Non-clinical supplies	(279)	(47)	(23)	(23)	(47)	(23)	(23)
(469)	(469)	Site Costs	(5,546)	(401)	(462)	61	(401)	(462)	61
(468)	(468)	Reserves	(2,205)	(100)	(184)	84	(100)	(184)	84
(297)	(297)	Travel, Subsistence & other Transport Services	(3,700)	(325)	(308)	(17)	(325)	(308)	(17)
(2,957)	**(2,957)**	**Total overhead expenses**	**(36,744)**	**(2,663)**	**(3,143)**	**481**	**(2,663)**	**(3,143)**	**481**
1,047	**1,047**	**EBITDA**	**11,246**	**583**	**830**	**(246)**	**583**	**830**	**(246)**
5.68%	5.68%	EBITDA Margin	4.85%	3.02%	4.31%		3.02%	4.31%	
(419)	(419)	Depreciation and Amortisation	(5,025)	(416)	(419)	3	(416)	(419)	3
(36)	(36)	Other Finance Costs inc Leases	(354)	(34)	(29)	(4)	(34)	(29)	(4)
(0)	(0)	Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(0)	(0)	(0)
11	11	Interest Income	168	40	14	26	40	14	26
(307)	(307)	PDC dividend expense	(3,900)	(325)	(325)	0	(325)	(325)	0
296	**296**	**Net Surplus / (Deficit)**	**2,135**	**(152)**	**70**	**(222)**	**(151)**	**70**	**(222)**
1.61%	**1.61%**	**Net Surplus margin**	**0.92%**	**-0.79%**	**0.37%**		**-0.78%**	**0.37%**	
233	**233**	**Net Surplus / (Deficit) before STF**	**360**	**(240)**	**(19)**	**(222)**	**(240)**	**(19)**	**(222)**

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board Meeting

Meeting Date:	24 May 2018	**Agenda Item:**
Subject:	2017/18 Annual Plan - End of Year Report	**For Publication: Yes**
Author:	Karen Taylor, Executive Director Strategy & Integration	**Approved by:** Karen Taylor Executive Director Strategy & Integration
Presented by:	Karen Taylor, Executive Director, Strategy & Integration	

Purpose of the report:

Present the Trust's year end performance against the 2017/18 Annual Plan.

Action required:

To receive the report, discussing the content and end of year performance.

Summary and recommendations:

The Annual Plan comprises of ten objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust needs to take and the milestones to be reached, by quarter, to deliver the Trust's agreed outcomes for the year. This report provides both an assessment of what was achieved during quarter 4, together with an overall end of year position.

Highlights of the Year

2017/18 has been a busy and successful year with demonstrable improvements made to the care we provide, the outcomes achieved and the overall experience for our service users and their families.

In January 2018 we were inspected by the Care Quality Commission (CQC) as part of their standard inspection routine. Overall, the Trust received a rating of Good and of the four services reviewed, two services were rated Outstanding. We are very proud of this result - it reflects the incredible work our staff do on a daily basis. The CQC also highlighted some areas where we need to further improve and we have taken immediate action to resolve these issues reflecting the importance we place on safety and getting things right first time, and every time for our service users.

Our 2017 national staff survey results were our best results since 2010. In 32 key findings the Trust had 91% of scores at average or above average with an increased number of staff reporting they would recommend HPFT as a place to work.

During the year we have seen the introduction of a new models of care including the Perinatal Mental Health Service and our new CAMHS (Child and Adolescent Mental Health Services) Tier 4 service which sees the development of a new enhanced community home treatment model. We have also improved our Single Point of Access and waiting times in both our adult community services and our CAMHS services. That said, demand continues to rise which places our services under considerable pressure and access to services will remain a significant challenge and focus for us in 2018/19.

Throughout the year our service users and carers have provided feedback about our services which we use to inform how we can further improve. This has identified areas we need to do more work (such as feedback from the adult community service user survey) and work is underway to address this. There has also been some very positive feedback with overall 85% of service users (who responded) reporting they would recommend us in the friends and family test (placing us in the upper quartile of comparator trusts). On our acute inpatient units we have also seen a marked improvement in the feedback we have received with over 80% of service users overall telling us they feel safe and some units now achieving 100%.

We have also continued our focus on ensuring the care we provide is joined up and meeting the needs of our service users. In 2017/18 more of our service users have told us that their physical health care needs have been supported and met because of this approach. We have also continued throughout the year to work across the health and social care system to ensure mental health and learning disability services are visible, prioritised for investment and considered in any future development of services.

Finally, the Trust ended the year in a positive financial position achieving its key NHSI financial targets; both the control target and the agency cap. This resulted in additional Sustainability and Transformation Funding. However, the underlying position for the Trust represents a relatively small surplus of £1m and in the context of increased demand and acuity our financial performance will continue to be a key focus in 2018/9

Annual Plan – End of Year Summary

At the end of the year good progress has been made, with nine (out of ten) objectives RAG rated Green or Amber and are on track to fully deliver, or deliver the majority of planned end of year outcomes. The three objectives are rated Amber and one Red are as follows:

- Objective 1 – Improve the safety of our services. The amber rating is due to the higher number of deaths which are suspected to be a result of suicide. Although subject to the outcome of coroners inquests it is expected the final number will remain higher than the reduction sought at the beginning of the year.

- Objective 2 - Deliver better access to our services. The amber rating reflects that

although access to adult community services has improved, the access target was not achieved – a reflection of both the level of demand and the resources available for initial appointments.

- Objective 8 – Innovate, improve and become more productive. There is 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.

- Objective 6 - Reduce vacancy levels and reliance on temporary staffing. The red rating is because the stretch target 10% vacancy and 10% turnover have not been achieved. This is in part due to an increase in establishment of 125 WTE in year, but also due to the challenging recruitment environment. Work with NHSI has demonstrated the Trust has adopted all nationally cited best practice, although work continues on the development of new roles and a new marketing campaign.

Conclusion and Recommendation

2017/18 was a successful year for the Trust as demonstrated through our feedback from the Care Quality Commission, our staff, our service users and carers. We have seen good progress made against the objectives in our Annual Plan with the majority of outcomes delivered. Overall 90% of the objectives are RAG rated Green or Amber (9/10).

The Trust Board are asked to receive and review the 2017/18 Annual Plan - End of Year report.

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

Summarises Progress against Annual Plan (all objectives)

Summary of Financial, Staffing, and IT & Legal Implications:

Financial & staffing implications of the annual plan have previously been considered; actions to support delivery of the Trusts financial, staffing, IT plans are contained within the Annual Plan

Equality & Diversity and Public & Patient Involvement Implications:

None noted

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

Delivery of the Annual plan supports delivery of key targets and standards across the Trust

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

Executive Committee 9 May 2018

TRUST ANNUAL PLAN 2017/18 – END OF YEAR REPORT

1. Introduction

The Annual Plan comprises of ten objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust needs to take and the milestones to be reached, by quarter, to deliver the Trust's agreed outcomes for the year. This report provides both an assessment of what was achieved during quarter 4, together with an overall end of year position.

2. Highlights of the Year

2017/18 has been a busy and successful year with demonstrable improvements made to the care we provide, the outcomes achieved and the overall experience for our service users and their families.

In January 2018 we were inspected by the Care Quality Commission (CQC) as part of their standard inspection routine. Overall, the Trust received a rating of Good and of the four services reviewed, two services were rated Outstanding. We are very proud of this result - it reflects the incredible work our staff do on a daily basis. The CQC also highlighted some areas where we need to further improve and we have taken immediate action to resolve these issues reflecting the importance we place on safety and getting things right first time, and every time for our service users.

Our 2017 national staff survey results were our best results since 2010. In 32 key findings the Trust had 91% of scores at average or above average with an increased number of staff reporting they would recommend HPFT as a place to work.

During the year we have seen the introduction of a new models of care including the Perinatal Mental Health Service and our new CAMHS (Child and Adolescent Mental Health Services) Tier 4 service which sees the development of a new enhanced community home treatment model. We have also improved our Single Point of Access and waiting times in both our adult community services and our CAMHS services. That said, demand continues to rise which places our services under considerable pressure and access to services will remain a significant challenge and focus for us in 2018/19.

Throughout the year our service users and carers have provided feedback about our services which we use to further improve and shape our services. This has identified areas where we need to do more work (such as feedback from the adult community service user survey) and work is underway to address this. There has also been some very positive feedback with 85% of service users (who responded) reporting

they would recommend us in the friends and family test (placing us in the upper quartile of comparator trusts). On our acute inpatient units we have also seen a marked improvement in the feedback we have received with over 80% of service users overall telling us they feel safe and some units now achieving 100%.

We have also continued our focus on ensuring the care we provide is joined up and meeting the needs of our service users. In 2017/18 more of our service users have told us that their physical health care needs have been supported and met because of this approach. We have also continued throughout the year to work across the health and social care system to ensure mental health and learning disability services are visible, prioritised for investment and considered in any future development of services.

Finally, the Trust ended the year in a positive financial position achieving its key NHSI financial targets; both the control target and the agency cap. This resulted in additional Sustainability and Transformation Funding. However, the underlying position for the Trust represents a relatively small surplus of £1m and in the context of increased demand and acuity our financial performance will continue to be a key focus in 2018/9.

3. End of Year Summary

At the end of Quarter 4 six (out of ten) objectives have been fully delivered. Three objectives are rated Amber and one Red.

Table 1 End of Year RAG

Objective		End of Year Rating
1	We will improve the safety of our services so that more people feel safe and are protected from avoidable harm	
2	We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy	
3	We will improve the wellbeing and physical health of service users through better health monitoring and support to address health risk factors	
4	We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership	
5	We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base	
6	We will reduce vacancy levels and reliance on temporary staffing by developing new roles and reducing staff turnover	
7	We will provide staff and teams with better access to the right information and tools to do their jobs effectively and efficiently	
8	We will support and empower staff to improve, innovate and become more productive in delivering great care	
9	We will deliver more joined up services across mental health, physical health and primary care	
10	We will be recognised as system leaders having successfully driven and delivered on key system priorities	

Appendix 1 provides a commentary for each objective. The Amber or Red objectives are as follows:

- Objective 1 – Improve the safety of our services. The amber rating is due to the higher number of deaths suspected to be a result of suicide. Although subject to the outcome of coroners inquests it is expected the final number will remain higher than the reduction sought at the beginning of the year.

- Objective 2 - Deliver better access to our services. The amber rating reflects that although access to adult community services has improved, the access target was not achieved – a reflection of both the level of demand and the resources available for initial appointments.

- Objective 8 – Innovate, improve and become more productive. There is 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.

- Objective 6 - Reduce vacancy levels and reliance on temporary staffing. The red rating is because the stretch target 10% vacancy and 10% turnover have not been achieved. This is in part due to an increase in establishment of 125 WTE in year, but also due to the challenging recruitment environment. Work with NHSI has demonstrated the Trust has adopted all nationally cited best practice, although work continues on the development of new roles and a new marketing campaign.

4. Areas to be carried forward into the 2018/19 Annual Plan

During 2018/19 we will continue our journey of 'Good to Great'. This will include targeting those areas that were not fully delivered in the 2017/18 plan for delivery next year and these include:

- Safety – suicide prevention, ensuring restrictive practice are in line national best practice and the continuation of our anti-ligature work
- Collective leadership and Quality Improvement – development of our team based developmental approach
- Quality and Service Development Strategy – further roll out and development of pathways
- Access – sustaining and achieving access waiting times on an ongoing basis
- Workforce –improving retention and recruitment throughout the organisation

5. Progress against Quarter 4 Milestones

The assessment of progress against the quarterly annual plan milestones provides a greater level of detail about the considerable programme of work and activities taking place across the Trust. This detail is provided in Appendix 2.

6. Conclusion

2017/18 was a busy and successful year for the Trust as demonstrated through our feedback from the Care Quality Commission, our staff, our service users and carers. We have seen good progress made against the objectives in our Annual Plan with the majority of outcomes delivered. Overall 90% of the objectives are RAG rated Green or Amber (9 out of 10 objectives).

Appendix 1 – Annual Plan End of Year Summary

	Objective	Exec. Dir. Lead	EOY Projection at			EOY	Year End Outcomes Commentary
			Q1	Q2	Q3	Q4	
1	We will improve the safety of our services so that more people feel safe and are protected from avoidable harm	JP					• Service users reporting they 'feel safe' has improved considerably through the year on our acute wards – from a baseline of 65% to all wards exceeding 80%. • Quarter 4 has seen an increase in the number of deaths that are suspected to be suicide and the reduction in suicides by 10% by year end will not be achieved. • Key areas identified by the CQC inspection are already subject to improvement and plans – seclusion, anti-ligature practice, supervision.
2	We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy	JL					• SPA improvements maintained and Q4 performance strong • CAMHS CHOICE access times have continued to perform strongly during the quarter • Amber rating reflects improved position for Adult Community Services but remain under 98% target. Partnership waits in CAMHS remain above 6 weeks. Although Tier 4 CAMHS mobilisation has commenced, the full service will not be in place until end of Quarter 1 due to recruitment challenges. • Psychosis pathway competed and approved. Implementation plans now being progressed
3	We will improve the wellbeing and physical health of service users through better health monitoring and support to address health risk factors	JP/KT					• Physical Health Plan 2017/18 – majority of actions delivered, and year two plan coproduced with staff, services users and stakeholders • Improved physical health screening, interventions and advice being delivered e.g. community physical health clinics and inpatient admissions • 88% acute inpatient service users report that their physical health needs were met
4	We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership	JK					• Inspire Awards, Annual Awards and local recognition pilots (Albany Lodge, Robin & HR department) continue to build recognition & value of staff • Engagement activities have also continued with an increased focus on health & wellbeing activities (e.g. flu campaign and Schwartz rounds) • Leadership Academy, Mary Seacole Programme, and Team Leaders Away day continue • Staff feedback from the staff survey and 'pulse survey' suggests outcomes being delivered with regards to engagement

5	We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base	JK					• Leaders have received improvement training through the leadership academy and via ad hoc sessions and training programmes. • QI training sessions & Systems leadership provided to Senior Leaders • Innovation and continuous improvement programme for all staff will commence Q2 2018/19 • Innovation & Improvement website provides a range of practical resources and 'how to' improvement project guidance accessible to all staff
6	We will reduce vacancy levels and reliance on temporary staffing by developing new roles and reducing staff turnover	JK					• Vacancy rate as at the end of March 2018 was 13.71% (Target 10%). 125 WTE additional posts in 2017/18 has elevated the Trust's vacancy position, at the same time the recruitment market has remained difficult. • Turnover rate was 14.16%. (Target 10%). • NHSI national recommended actions have been implemented. • Development of new roles is building momentum - nursing associate programme, mental health accelerated nurse programme and apprentices in place
7	We will provide staff and teams with better access to the right information and tools to do their jobs effectively and efficiently	KL/ RA					• New Electronic Patient Record (EPR) contract in place and strategic development programme drafted and being progressed. • Business Intelligence (BI) solution well developed with second phase agreed and in progress. • Programme for improved data quality in place and being actioned.
8	We will support and empower staff to improve, innovate and become more productive in delivering great care	KL/ JL/RA					• Growing number of quality improvement / innovation projects being delivered Areas of innovation and better use of technology piloted, but not yet evaluated and rolled out across Trust. • Availability of equipment significantly enhanced. • SafeCare tool implemented successfully across all inpatient areas. • Productivity metrics yet to be fully established.
9	We will deliver more joined up services across mental health, physical health and primary care	KT					• Hemel Hub (between HCT & HPFT) completed • Stort Valley & Villages Integrated team (Older people) is in place • Primary Mental Health Care pilots commenced • 85% service users in adult community have reported feeling their physical health needs are being met (Having your say)
10	We will be recognised as system leaders having successfully driven and delivered on key system priorities	KT					• MH&LD is one of the named priorities across the STP • HPFT Executive Team, together with senior clinicians and managers actively participate in the STP - providing leadership across broad range of STP programmes of work (e.g. workforce, Finance, Mental Health & LD, Place Based Care, AHP working group)

Appendix 2 – Annual Plan Quarter 4

Full Commentary against Milestones and Outcomes

Great Care, Great Outcomes

Priority 1 (Owner JP)	Q4 Key Actions / Milestones	Q4 Milestones Rating
We will improve the safety of our services so that more people feel safe and are protected from avoidable harm	First phase of plan delivered including pilot sites beginning new initiatives.	

Key areas of focus	Commentary:
• Reducing suicide rates - in particular through sign off and delivery against suicide prevention strategy • Improving safety on our inpatient wards – in particular through delivery on our MOSS strategy • Delivering consistently on the fundamentals of care across all of our services	Feeling safe – in Quarter 4 all acute wards continued to report increased numbers of service users reporting positively to the question 'overall, have you felt safe on the ward'. Aston ward achieved 100% and Owl ward 95% with Albany, Robin and Swift reporting 83%, 86% and 85% respectively. This exceeded the target set at the beginning of the year to move from a baseline of 60% to 80%. Reducing Suicide Rates The number of deaths that are suspected to be a suicide in Quarter 4 increased. A full report will come to the Integrated Governance Committee. The 10% reduction in suicides has not been achieved, with the number of suicides likely to be in the range of 34 – 42 (depending on the outcome of inquests as they are heard). CQC Inspection 2018 The CQC reviewed our services in Q4 and overall rated the Trust 'Good'. Within this, safety remain 'requires improvement'. Seclusion practice and facilities, anti-ligature practices and supervision were all highlighted by the CQC. The Trust has already taken action to address and has plans in place which will be fully implemented in 2018/19.

Summary and Actions Being Taken	Key Outcomes at Year End	End of Year Position
Service users reporting they 'feel safe' has improved considerably through the year on our acute wards – from a baseline of 65% to all wards exceeding 80%. Quarter 4 has seen an increase in the number of deaths that are suspected to be suicide and the reduction in suicides by 10% by year end will not be achieved. Key areas identified by the CQC inspection are already subject to improvement and plans – seclusion, anti-ligature practice, supervision.	• Reduction in suicides by 10% (Maximum 32 - 8 per quarter) • More service users on acute wards will report feeling safe (moving from baseline of 65% to 80% by end of Q4)	

Priority 2 (Owner JL)	Q4 Key Actions / Milestones	Q4 milestones Rating
Priority 2 **We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy (QSDS)**	**Q4** New Crisis and Personality Disorder pathways implemented Forest House place of safety & redevelopment - FHAU **Outstanding from Q3** CAMHS DBT community team established (subject to commissioner approval)	
Key areas of focus:	**Commentary:**	
• Delivering consistent timely access to services through design and implementation of a more robust access pathway • Deliver consistent access to all CAMHS services • Other Quality and Service Development Strategy priorities as confirmed during Q1	• During Quarter 4 performance improved or remained stable across the majority of services, despite increased demand during January and February. Access to community services has improved, with over 90% of adults receiving assessment within 28 days, however it remains below the 98% commissioned target. SPA and crisis access performance has been strong throughout the quarter, however CAMHS access has been significantly impacted on during Q4 as a consequence of high demand and recruitment challenges. CAMHS treatment (partnership) waits during the same period have improved and are meeting the target across all four quadrants. • Some progress has been achieved in the recruitment to the new Tier 4 CAMHS service, however challenges remain to recruitment and the full implementation of this service. This is a key focus for 2018/19. • Although the Trust has approved the development of the Place of safety and associate capital funds (together with the NHSE investment received) delays to the development have arisen due to complex ground works that came to light. The suite will now be operational by the end of Quarter 3 in 2018/19.	

Summary:	Key Outcomes at Year End	End of Year Position
Access to community services has improved, but remains a challenge due to the demand facing the service. CAMHS Partnership waits have improved, however access to Choice appointments are under significant pressure. The Psychosis pathway has been developed and the supporting technology is now being developed to support the implementation during 2018/19 as part of QSDS. Throughout the year our service users and carers have provided feedback on our services, rating us in the upper quartile of comparator trusts at >85% in the friends and family test with <5% of feedback not recommending the trust. Our adult community service user survey carried out by the CQC remained static and identified a number of areas of focus for the Trust which we have taken action to improve during Q4 (Experience of annual reviews, contacting services in a crisis and feeling involved in own care planning)	• Timely access to adult community services • QSDS Outcomes to be agreed and pathway pilot to be completed • Timely access to CAMHS services – CHOICE & partnership • Reduced inpatient admissions for Young People	

Priority 3 (Owner: KT / JP)	Q4 Key Actions / Milestones	Q4 Milestones Projection
We will improve the wellbeing and physical health of service users through better health monitoring and support to address health risk factors	Healthy food options implemented trust wide Delivery against prevention and wellbeing plan Development staff competency framework for physical health	

Key areas of focus:	Commentary:
• Development of and delivery against prevention & wellbeing priority within the Quality and Service Development Strategy • Improved physical care of service users through delivery against our physical health strategy and action plan	• There has been further work in the final quarter to continue the implementation of the physical health priorities. The development of a physical health competencies framework for staff for physical health has been a larger and more complex piece of work than was originally anticipated. The delivery of this framework remains outstanding; it will be a key focus in 2018/19 as the framework will lead to a more rigorous approach to embedding physical health practice • The co-produced development of a series of plans and deliverables for Year 2 of the Physical Health Strategy has been completed this quarter. There are now plans and deliverables for Year 2 (2018/19) developed, and agreed with staff, service users and carers, and signed off by our Service User Council and Physical Health Committee. This is a key element in our movement forward with the priorities of physical health and delivering joined up care. • The work on prevention and well-being has been delivered through focusing on three work streams- prevention, well-being and recovery. Key areas of progress include a. The development of the well-being plan on the EPR and Nutrition and Hydration week activities b. The annual recovery event took place and the CQC reported that our care plans are recovery focused. c. Spot the signs engaged with just over 3000 young people regarding mental health through workshops, stalls, focus groups and school assemblies. The children and young people's Spot the Signs programme was promoted at 38 professional events. Funding was secured for continuation of the programme. d. 88% acute inpatient service users report that their physical health needs were met

Summary	Key Outcomes at Year End	End of Year Position
The work on prevention and well-being has been delivered through focusing on three work streams- prevention, well-being and recovery with progress made against each, although not to the extent envisaged at the beginning of the year. The majority of actions outlined in our physical health plan for 2018/19 were delivered. There is a need to continue to mainstream physical health practices across the Trust and this will be a key focus in 2018/19.	• Screening, assessment & interventions / advice being delivered to support improved physical health • Increased number of service users reporting their physical health needs being met • Specific prevention and wellbeing targets to be confirmed as part of plan developed in Q1.	

Great People

Priority 4 (Owner: JK)	Q4 Key Actions / Milestones	Q4 Milestones Rating
We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership	Delivery of key programmes to support managers	

Key areas of focus	Commentary:
• Developing more empowered clinical leaders through delivering on our Collective Leadership agenda • Continued improved engagement of our workforce through a systematic approach to delivery against the Trust's engagement model	Collective Leadership The review of the current leadership offerings and redesign has been completed, together with a new Leadership Competency Framework. The Leadership Programmes are being reviewed so that they reflect the changes. A 'Coaching for Managers' Development programme also went out to tender during Q4 however there was only one tender received and the procurement of the development programme is now being reviewed. Clinical Leaders Programme for Key Staff Groups The Team Leaders Development Programme continued during Q4. Another Senior Leaders Forum took place in Q4 and the new Senior Leadership Team (SLT) forum which takes place on a monthly basis continued, with an away day for the SLT also taking place during Q4. A development programme for medical leaders also took place in Q4. Other Activities to Achieve Year End Outcomes A number of other engagement and health & wellbeing activities have taken place during Q4 which include the flu campaign and Schwartz rounds. The Leadership Academy and the Mary Seacole Programmes continue to run. Staff survey results continued to demonstrate that we continued to have an engaged and motivated workforce but there is more work to do around immediate support from line managers.

Summary	Key Outcomes at Year End	End of Year Position
The Trust continued to maintain a strong position in the National Staff Survey, with 91% of the Key Findings at above average or average. Engagement and satisfaction levels as measured by the National Staff Survey and Pulse survey remain strong and positive. A number of key engagement events have been held and the Trust continues to deliver OD interventions to support the culture change required for Good to Great.	• Improved satisfaction with level of responsibility and involvement. • Increase support from immediate managers. • Increase in recognition & value of staff by managers and organisation.	

Priority 5 (Owner: JK)	Q4 Key Actions Planned / Milestones	Q4 Milestone Rating
We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base	Continue delivery of cultural change programme sessions	

Key areas of focus:	Commentary:
Developing our leadership base with a particular focus on: • System leadership • Continuous improvement and innovation mind set and approaches • Clinical leaders	The Trust continues to deliver cultural change programmes to support continuous improvement within the organisation, through a number of OD interventions. In Quarter 4 an STP system 'leadership lab' session was hosted by HPFT bringing together a number of leaders to share learning and development. The decision to delay the procurement process of an overarching cultural change programme reflects the decision to firstly develop and align our approach with team development and collective leadership approach throughout the organisation. During Quarter 4 the Trust's 'Team OD' framework has been developed, which builds on the Kings Fund best practice Team OD model and work already being undertaken within the Trust. Pilots of this approach begun in quarter 4 and will continue during 2018/19.

Summary	Key Outcomes at Year End	End of Year Position
Throughout the year leaders have been supported with developing their improvement thinking and skills in 'hands on' ways through the work of the continuous improvement team. Additionally our leaders have benefited from receiving development and support on improvement through a range of formal and informal learning opportunities including the Managing Service Excellence programme, Team Leaders Development programme, Leadership Academy and Senior Leaders Forum. The Innovation & Improvement (internal) website outlines our improvement approaches and, amongst a range of resources, provides a simple 'how to' improvement guide, outlining the steps to delivering successful improvement projects. Whilst we have not procured and delivered a formal programme of development at the pace and scale that we envisaged at the beginning of 2017/18, significant progress has been made and we envisage this work will be rolled forward for delivery in 2018/19.	Leaders across the organisation have received training and support on improvement approaches and tools	

Priority 6 (Owner JK)	Q4 Key Actions Planned / Milestones	Q4 Milestones Rating
We will reduce vacancy levels and reliance on temporary staffing by developing new roles and reducing staff turnover	Delivery of the agreed recruitment & retention plan	

Key areas of focus	Commentary:
• Creation of new roles and use of apprenticeship model • Robust local recruitment and retention plans supporting greater flexible working	<u>Development of Apprenticeships and New Roles</u> • Nursing Associate Programme - progress continues with 10 staff seconded onto the nursing associate programme with plans for a further two cohorts during 2018/19 (becoming an apprenticeship programme). • Mental health accelerated nurse programme - continues to progress with 10 individuals on the programme • Physician Associates programme with the University of Hertfordshire - development continues and placements with HPFT will take place in June 2018. • The Trust currently has 32 apprentices in place and more staff continue to be identified to start on the apprenticeship programme. This will be assisted by the introduction of the nurse associate apprenticeship from May 2018 and the proposal to recruit the majority of Band 2 HCAs on an apprenticeship so that we can meet our levy moving forward. • Planning has commenced to ensure these staff are employed into substantive roles when they complete their training programmes. Job descriptions are being completed and workforce planning is being progressed. <u>Local Recruitment and Retention Plans:</u> Local recruitment and retention plans are in place for each SBU. Progress continues to be monitored through the recruitment and retention group. The Trust is also implementing the actions and activities from the NHSI Retention Improvement Plan which includes a streamlined internal recruitment process, an internal transfer process and health and wellbeing initiatives. Activity will be monitored through WODG and IGC.

Summary	Key Outcomes at Year End	End of Year Position
Activities from the NHSI retention plan are being implemented, with local recruitment and retention plans in place. New roles continue to be developed and the focus in 2018/19 will be to expand the scale of new roles and ensure roles are embedded and utilised. Recruitment activity continues to take place and in 2018/19 there needs to be an increased focus on retention. It is worthy of note that the Trust achieved its agency cap in 2017/18. The headline vacancy rate as at the end of March 2018 was 13.71% (this was due to a further increase of 40 WTE to the establishment in Q4) and the turnover rate is 14.16%. The underlying vacancy position against the March 2017 WTE establishment is 9.7%.	• Reduced staff turnover (10%) • Lower vacancy levels (10%)	

Great Organisation

Priority 7 (Owner RA /KL)	Q4 Key Actions / Milestones	Q4 Milestone Rating
We will provide staff and teams with better access to the right information and tools to do their jobs effectively and efficiently	**Carried over from Q3 -** New Electronic Patient Record (EPR) contract in place aligned to agreed strategic development programme **Q4** – Plans to develop Business Intelligence system progressed	

Key areas of focus	Commentary
• Development of our EPR and business intelligence systems • Improved data quality and recording	• Five year EPR contract agreed with discussions now focussed on future developments and ensuring these fully reflect organisational priorities • PARIS development has continued throughout Q4 including the release of new forms, enhancements to the Quick View feature and release of new letter templates which allow the letters to be pre-populated with data, saving time and reducing the risk of errors. • SPIKE phase I fully implemented and Phase II Business Intelligence (BI) development agreed and on track • Information Assurance Group now a standing committee overseeing delivery of data quality improvements with Clinical Reporting Assurance Framework (CRAF) progressed and data quality improvements made and embedded

Summary	Key Outcomes at Year End	End of Year Position
PARIS development continues as per agreed priorities and continues to make a positive impact to accessing information more effectively. New EPR contract in place and strategic development programme drafted and being progressed. BI solution well developed with second phase agreed and in progress. Programme for improved data quality in place and being actioned.	Improved experience of Paris and business intelligence systems Improved data quality evidenced through internal & external audit programmes	

Priority 8 - Owner RA/KL/ JL/JK	Q4 Key Actions / Milestones	Q4 Milestone Rating
We will support and empower staff to improve, innovate and become more productive in delivering great care	**Q3** – outstanding actions for agile working programme rolled out **Q4 -** Hemel hub go live with technologies successfully supporting new ways of working	

Key areas of focus	Commentary:
• Successfully embedding innovative and more productive ways of working e.g. agile working, back office, valuing service user time • Using technology more effectively to support new ways of working e.g. Hemel hub, agile working • Roll out of Safe Care tool across services to better align staff to meet acuity levels across inpatient settings	• Elements of agile programme are in place including wider use of video conferencing, access to laptops and mobile phones significantly enhanced and all Trust sites upgraded to provide staff access to wifi. However, this is yet to translate to significant reductions in travel and increases to time available for direct care. • Digital Dictation & Voice Recognition – the BigHand system now live (c.100 staff using) • Hemel Hub opened with enhanced technology available and organisational development programme to support new ways of working. Evaluation will take place once the hub has been opened and operating for six months. • Safe Care fully launched across all inpatient units and implemented as 'business as usual' with routine daily census check at each handover (3 times daily) with a Trust wide conference call to enable alignment of staff to acuity levels • Core productivity metrics developed but not across all services and still to be rolled out.

Summary	Key Outcomes at Year End	End of Year Position
Quality improvement projects are being delivered across the Trust, with the Innovation Board continuing to review and approve a number of schemes and projects developed by teams. Availability of equipment has been greatly enhanced and the SafeCare tool implemented successfully across all inpatient areas. However, that use of innovation and better use of technology, although piloted, has not yet been evaluated or subsequently rolled out across the Trust. Productivity metrics yet to be fully established As such it is difficult to demonstrate measurable impact and improvement, or to demonstrate improvements in the overall use of Trust resources.	• Evidence of a growing number of quality improvement / innovation projects being delivered across the Trust • Measurable improvements in the Trust's use of resources	

Great Networks and Partnerships

Priority 9 - Owner: KT / JL	Q4 Key Actions / Milestones	Q4 Milestone Rating
We will deliver more joined up services across mental health, physical health and primary care	Hemel hub opening Neurodevelopmental service implemented with HCT & ENHT (CAMHS transformation funding dependent)	

Key areas of focus	Commentary:
• Successful delivery of key 'integration projects' through HPFT / HCT Alliance • Improved joint work with GPs and GP federations resulting in improved referral and discharge pathways	• Hemel Hub successfully completed at the end of March, with all teams moved into the new building as planned. Operational, estates and workforce teams worked extremely hard to make the move as smooth as possible. The Hub will be formally opened on 11 May. Ongoing organisational development work continues to support the teams to develop together; this will be subject to further support in 2018/19 • An integrated neurodevelopmental service was not commissioned. Work is ongoing with commissioners. • Considerable work has taken place to develop relationships and working with GP Federations and GPs. This includes the development of the Stort Valley and Villages (SVV) integrated team which has seen improved integrated working wrapped around the needs of the person; the piloting of a new primary mental health models in both Herts Valleys and E&N Herts. Early indications from the Stevenage pilot are very positive with GPs and service users reporting increased satisfaction with the service.

Summary	Key Outcomes at Year End	End of Year Position
The key project between HPFT & HCT was delivered successfully, with work now taking place to further develop ways of working and practices within the Hemel Hub. Considerable progress has been made during 2017/18 with a number of projects/schemes developed with primary care. However, this has been relatively small scale and 2018/19 will need to see a considerable 'scaling' of projects and approach.	• Delivery of Hemel, Stort Valley & Villages and CAMHS/Children's services projects • Increased rate of 'appropriate' referrals and improved flow • Improved service user and staff experience	

Priority 10 - Owner: KT	Q4 Key Actions / Milestones	Q4 Milestone Rating
We will be recognised as system leaders having successfully driven and delivered on key system priorities	STP Mental Health work stream successfully focussing and supporting delivery of MH 5YFV across the STP footprint.	

Key areas of focus	Commentary:
• HPFT/HCT Strategic Alliance recognised as driving and delivering on key system priorities • HPFT recognised for continued leadership of key system functions and programmes	• The Marlowes Hub has opened successfully, which was the main focus between HCT and HPFT for 2017/18. Benefits realisation review to be undertaken during 2018/19. • STP mental health workstream is fully operational; with a clear programme of work and deliverables. Successes for 2017/18 include; STP wide primary mental health learning event which led to the establishment of primary mental health pilots across the STP; support Wave 2 NHSE funding applications for perinatal MH (Herts) & Core 24 (w.Essex), and Wave 1 IPS service (w.Essex); built clinical leadership across the STP with appointment STP MH Clinical Lead; MH included in main delivery workstreams – primary care, frailty and place based care • Parity of Esteem funding secured for 2018/19 • Place Based Care workstream in HVCCG realigned to include commissioners and providers – core to new system approach to delivery • HPFT Directors and Senior managers continue to lead/drive key STP workstreams/projects

Summary	Key Outcomes at Year End	End of Year Position
HPFT presence across the STP is visible and recognised, with HPFT able to contribute to and influence at a range of levels and across workstreams. The MH & LD workstream has developed its work programme; with some successes in 2017/18 which need to be broadened in 2018/19. System leadership and delivery will be an ongoing focus for HPFT to ensure the improvement of MH & LD continues to be central to future health and social care developments.	HPFT system leadership valued and sought by local partners Improving mental health and learning disability services is central to local health and social care economy plans	

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	24th May 2018	**Agenda Item: 18**
Subject:	**STP Update & Systems Partners Update**	**For Publication:**
Author:	Tom Cahill, CEO	**Approved by:**
Presented by:	Tom Cahill, CEO	

Purpose of the resolution:

The purpose of this report is to update the Trust Board in respect to recent and on-going developments with the H&WESTP In the context of system architecture, development of Integrated Care Systems (ICS) and its approach to population based health provision.

Action required:

Board members are asked to note the update on recent developments on the Hertfordshire and West Essex Sustainability and Transformation Partnership.

Summary and recommendations:

The attached update outlines recent developments in relation to the Hertfordshire and West Essex Sustainability and Transformation Partnership.

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):

N/A

Equality & Diversity /Service User & Carer Involvement implications:

N/A

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

Introduction

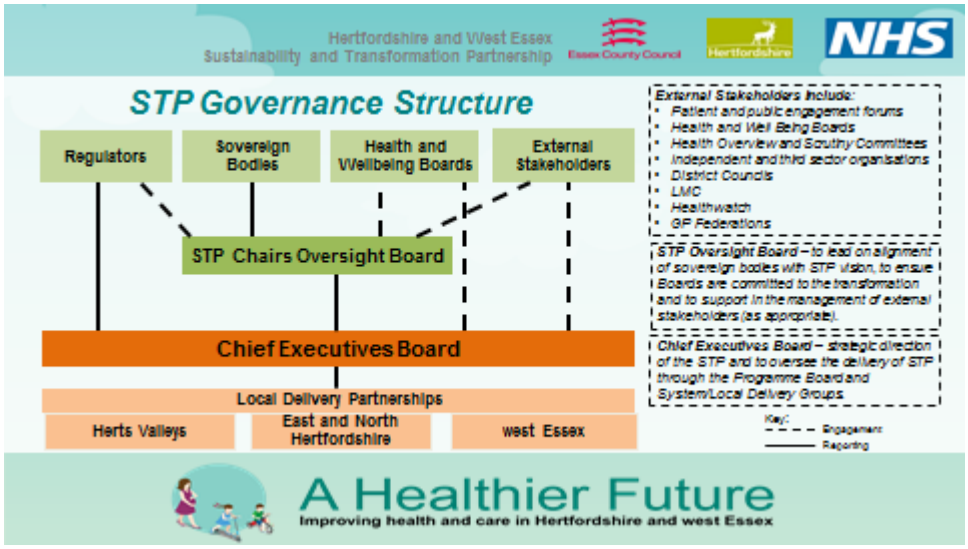
The Hertfordshire and West Essex STP (H&WESTP) which includes all the health providers and social care, have now been working together for over two years.

The aim of the H&WSTP is threefold;

- To improve the health and wellbeing of the population
- To improve the quality of services provided
- To ensure that the services are affordable and sustainable

As previously reported to the Board the STP is over seen by the Chairs Oversight Group and the Chief Executive Steering Group and activities are delivered through a number of core work streams which include mental health, urgent and primary care. Figure 1 illustrates the governance structure.

Figure 1.



Recent Developments

Some noticeable recent developments since the last report to the Board include the appointment of a full time officer to lead the H&WESTP. The H&WESTP has identified a number of priorities going forward which include developing a sustainable financial framework for the STP, developing a coherent estates strategy, developing a coherent workforce strategy, developing a technology and digital strategy. This is in addition to developing an integrated care system that supports population based health commissioning and population based health and social care provision.

Integrated Care Systems and Integrated Care Partnerships

In recent months the Chief Executives Steering Group together with the Chairs Oversight Group commissioned an external consultant Carnall Farrah to support the design and development of an integrated care structure within H&WESTP. The system is designed to enhance the opportunities for further integrated working to achieve the three outcomes for the STP.

Figure 2

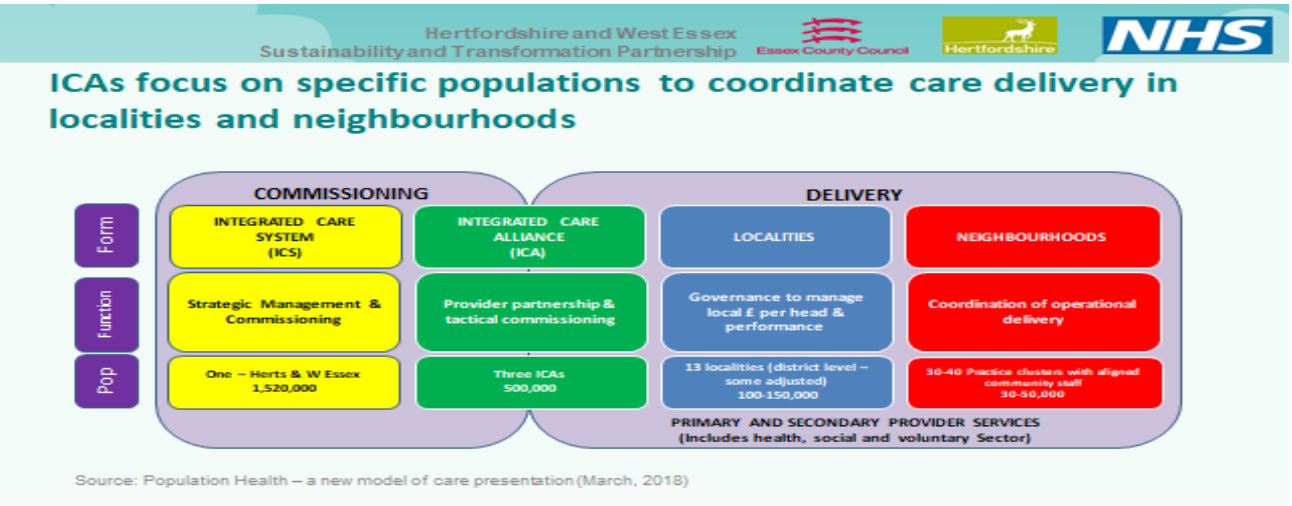


Figure 2 above, illustrates in broad terms the H&WESTP aspirations for the provision of health and social care within the H&WESTP going forward.

In line with national policies that assume the H&WESTP will have one integrated care system (ICS) whose core responsibility is to provide integrated services for the population. Play a role in providing assurance in performance management of activity and ensure that the key health and social care outcomes are delivered. The H&WESTP will peruse the development of three integrated care alliances (ICA) across our system loosely based in West Hertfordshire, West Essex and one in East and North Hertfordshire. These integrated care alliances will encompass existing organisations working together to meet the local needs of that population. With the delivery of health and social care at locality and neighbourhood level, it is anticipated we will have 13 localities which will be defined broadly at district boundaries each serving a population 100-150k. With 30-40 practice clusters each serving a population cluster of 30-50k. These are initial thoughts and the work of the ICA group will further develop and refine the final function and form.

Progress so Far

To support this ambition there are two steams of work the stream a) define the ambition and purpose of the ICS b) define the population needs and interventions required to meet the needs and the options for the organisations within the ICA.

Two meetings of the ICS have been held which have focused on case for change, ambition for the future, functions of the ICS and the role of the ICAs. The ICA group have initial met focusing on population based health needs, best practice care models to which will support the ambition set above.

Implications for the Trust

We are currently well represented both within the H&WESTP and in the development of this new system architecture. It is quite clear that there is commitment across the system to integrate Mental and Physical Health in each of the sub systems and localities whilst at the same time recognising that there is a need for provision for a specialist Mental Health service. We are currently working with system leaders across the H&WESTP and Carnall Farrah to explore what options are available for us to ensure that we organise ourselves in a

way that provides maximum out comes for our service users, for people with a Mental Health and a Learning Disability.

It is expected that this work will continue throughout June and July and of course an updated report will be presented at the next Board meeting which will describe in more detail the possible impact on the way Mental Health and Learning Disability services are currently provided across the H&WESTP.

Meeting Date:	24th May 2017	**Agenda Item: 19**
Subject:	Hertfordshire Health Concordat	**For Publication:**
Author:	Jill Hall, Interim Company Secretary	**Approved by:** Jill Hall, Interim Company Secretary
Presented by:	Jill Hall, Interim Company Secretary	

Purpose of the report:

To inform the Board of the arrangements for a formal Concordat agreement between Hertfordshire County Council and health bodies within Hertfordshire.

Action required:

To **review** and **agree** the Healthcare Concordat

Summary and recommendations to the Board:

The Concordat is a commitment of all partners involved in the Strategic and Transformation Partnership (STP) to follow the Concordat principles for all service changes arising from the STP work plan. This would also include any future developments including the creation of an Accountable Care System or Organisation.

The Committee is asked to:

a) **review** and **agree the principles described in the report; and,**
b) **give authority that the Chief Executive sign the Concordat on behalf of HPFT.**

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

Summary of Financial, IT, Staffing & Legal Implications:

NONE

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:

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

NONE

Introduction

The Concordat applies to relations between the Health Scrutiny Committee (HSC) and the health bodies serving the population of Hertfordshire. It also covers consultations and engagement carried out by any of the NHS Bodies, where Hertfordshire County Council is among those formally consulted. The principles outlined below in appendix 1 apply not only to extensive formal public consultations required by legislation, but also to developments which will affect smaller numbers of patients, smaller geographical areas or particular services only. The Concordat covers changes resulting from commissioning decisions or service changes.

The following health bodies within Hertfordshire are being asked to sign up to the principles of the Concordat:

1. Hertfordshire County Council (HCC) which will act through its Health Scrutiny Committee (HSC)
2. The Hertfordshire Partnership University NHS Foundation Trust (HPFT)
3. East & North Hertfordshire NHS Trust (ENHT)
4. West Hertfordshire Hospitals NHS Trust (WHHT)
5. East of England Ambulance Service NHS Trust (EEAST)
6. Hertfordshire Community NHS Trust (HCT)
7. Herts Valleys Clinical Commissioning Group (HVCCG)
8. NHS East & North Hertfordshire Clinical Commissioning Group (ENHCCG)
9. Cambridge & Peterborough Clinical Commissioning Group (C&PCCG)
10. Princess Alexandra Hospital, Harlow (PAH)
11. Healthwatch Hertfordshire (HWH)

Recommendation

The Committee is asked to review and authorise the Chief Executive to sign the Concordat on behalf of HPFT.

Hertfordshire Health Concordat

between

Hertfordshire County Council

and

Local NHS Organisations

and

HealthWatch Hertfordshire

Dated October 2017

This Concordat is agreed between the following bodies:

1. Hertfordshire County Council (HCC) which will act through its Health Scrutiny Committee (HSC)
2. The Hertfordshire Partnership University NHS Foundation Trust (HPFT)
3. East & North Hertfordshire NHS Trust (ENHT)
4. West Hertfordshire Hospitals NHS Trust (WHHT)
5. East of England Ambulance Service NHS Trust (EEAST)
6. Hertfordshire Community NHS Trust (HCT)
7. Herts Valleys Clinical Commissioning Group (HVCCG)
8. NHS East & North Hertfordshire Clinical Commissioning Group (ENHCCG)
9. Cambridge & Peterborough Clinical Commissioning Group (C&PCCG)
10. Princess Alexandra Hospital, Harlow (PAH)
11. Healthwatch Hertfordshire (HWH)

The signatories attached in Appendix 5 reflect the commitment of all partners involved in the Strategic and Transformation Partnership (STP) to follow the Concordat principles for all service changes arising from the STP work plan. This would also include any future developments including the creation of an Accountable Care System or Organisation.

Supporting documents
Appendix 1 Background to NHS consultation & HSC Concordat
Appendix 2 Consultation Principles 2016
Appendix 3 Substantial Variation
Appendix 4 Checklist
Appendix 5 Signatories
NHS England guidance April 2017

HERTFORDSHIRE HEALTH CONCORDAT

Executive Summary

The Concordat applies to relations between the Health Scrutiny Committee (HSC) and the health bodies serving the population of Hertfordshire. It also covers consultations and engagement carried out by any of the NHS Bodies, where HCC is among those formally consulted. The principles outlined below apply not only to extensive formal public consultations of the kind required by legislation, but also to developments which will affect smaller numbers of patients, smaller geographical areas or particular services only. The Concordat covers changes resulting from commissioning decisions or service changes.

The principles that the Concordat are built on underpin the whole relationship between scrutiny and health. The NHS Five Year Froward View states that 'we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services'

Given the financial and service landscape it is accepted that changes will have to be made but that they are done so for the best interest of the population of Hertfordshire and the Hertfordshire and West Essex health and social care system. There is also recognition of the aim to balance timely, well informed decision-making with the use of public monies.

The advent of the Sustainability Transformation Partnership (STP) requires local government and health bodies to work together and that discussions around service changes held in the STP forum will be fed back to HSC.

The Concordat facilitates discussion between HSC and partners so that a culture of 'no surprises' is engendered and maintained through regular contact with Head of Scrutiny and the Chairman of the Committee, to develop engagement into agreed approaches to identify substantial variation and more formally structured consultation.

When consultations take place the Concordat highlights the need to consult the relevant stakeholders in the right way using 'digital by default' as per Central Government consultation principles guidance 2016. While digital contact through social media and webpages should be at the forefront of any consultation, this does not preclude the use of alternative methods to reach all stakeholders. All communications need to have accessible language so that it is clear and allows for responses to be captured resulting in effective reporting, which in turn informs effective decision making.

Ongoing engagement with the population is necessary to create transparency and awareness of the direction of travel for services. To further this goal it is anticipated that engagement will be ongoing; and all consultations should allow everyone to see the use of stakeholder feedback in formulating any final strategy.

PRINCIPLES

1. What is consultation?

1.1 Consultation within the Concordat covers commissioning decisions or service changes with stakeholders to communicate any proposals as well as to gain feedback. All proposed changes require informal liaison with Head of Scrutiny and Chairman of HSC at an early stage and prior to a final decision on consultation being taken by the relevant organisation. At this first meeting the proposals will be shared and agreement sought for the required programme of consultation, which will be dependent on the likely impact of the proposals to residents and/or partner organisations.

2. Consulting the HSC on "substantial variations"

2.1 Legislation requires that scrutiny committees must be consulted in the event of a substantial development or variation. A substantial variation is dependent on local circumstances. **The final definition of what constitutes a substantial variation is determined by the HSC.** The Concordat assumes that a substantial variation is defined as a change or augmentation to a service or provisions that will impact on the health of the local or wider population (see App 3). The relevant NHS body must discuss this with the Head of Scrutiny. If it is agreed that the proposed changes are substantial, HSC will require the NHS to undertake a formal consultation process.

2.2 Consultation on substantial variations will extend to an appropriately wide group of stakeholders in addition to the HSC and will conform to the principles outlined in this Concordat. Proposals for substantial variations in NHS services will be the subject of a formal public consultation. It is anticipated that consultation will be undertaken for a proportionate period. This may mean 12 weeks and the Head of Scrutiny must be consulted before any reduction in this timeframe is considered. HSC may decide not to scrutinize the proposal or consultation as detailed at Appendix 3 and agree to a consultation period shorter than 12 weeks.

2.3 It is not the function of HSC to manage the NHS; therefore scrutiny will not consider managerial decisions

2.4 Where there is a national consultation from NHS England, NHS Improvement or other national body, it is agreed that local commissioners

and/or providers will share any national consultations that they are aware of with Head of Scrutiny and Chairman when relevant to Hertfordshire. At this time it should be made clear whether the consultation is taking place nationally or locally. If it is nationally there is an understanding that local commissioners and/or providers will share such information with the Committee. This may then mean that local consultation is undertaken in addition to national consultation.

3. No surprises

3.1 **A principle of "no surprises" will operate** i.e. Scrutiny officers and the HSC chairman meet regularly with health bodies providing opportunities for informal discussion of upcoming issues.

3.2 The Government has replaced previous consultation guidance by issuing the Consultation Principles 2016. The key Consultation Principles are:

- departments [*here health bodies*] will follow a proportionate timescale dependent on the expected impact of the decisions or proposals;
- departments [*here health bodies*] will need to give more thought to how they engage with and consult with those who are affected;
- consultation should be 'digital by default', but other forms should be used where these are needed to reach the groups affected by a policy and are seldom heard;
- that the consultation should provide sufficient information to consultees so that they can provide informed responses;
- that consultation should state how responses have been received and how they have informed policy.

3.3 The work of HSC will reflect the Consultation Principles and follow agreed ways of working

- advance notification to HSC of the proposed work programmes
- formal consultation is preceded by extensive discussions and engagement with a wide range of stakeholders and those likely to be affected
- detailed informal pre consultation activity takes place to develop proposals
- formal proposals in consultation documents should come as no surprise to many of those consulted
- the level of consultation should be proportionate to the change and those affected.

3.4. The NHS should look to provide as much evidence as possible to the extent and effectiveness of its engagement processes and formal consultation. The Chairman, on behalf of the HSC will take this into account when discussing the expected timescales for consultation or to include matters in its work programme for scrutiny. Evidence that NHS bodies have a culture of engagement and consultation embedded in their day-to-day activities will include

- board papers or other strategy and action planning documents indicating a rich and ongoing process of engaging/consulting service users and potential service users
- evidence that this process is part of a circle of dialogue and feedback that influences service planning and delivery
- feedback and updates to HSC from relevant health bodies and HWH over the course of the planning and delivery cycle about the level, extent, inclusiveness and influence of patient and public consultation and involvement.

3.5 Where urgent action is required because of concerns about risks to the safety, or welfare of patients and staff or the viability of a service to safeguard public safety and the financial stability of a health body HSC would expect to be engaged and informed of any actions as soon as is possible.

3.6 Where the provider or commissioner is operating regionally, information affecting the region is shared with Head of Scrutiny and Chairman, especially when a regional change could affect Hertfordshire.

4. Consulting the right people

4.1 It is anticipated that consultation will be underpinned by the NHS Constitution, principles of good practice accepted nationally and the Secretary of State's 4 Tests (updated 2015)

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from commissioners.

4.2 Consultation processes will attempt to gather the views of a representative cross-section and a geographical spread of the relevant population. The NHS consulting body, including Foundations Trusts, will be able to show how it has encouraged a wide range of people to give their views and how

it has enabled the voices of seldom heard people and minorities as well as the majority to be heard.

4.3 Those consulted (key stakeholders, groups and individuals with an interest and those likely to be affected by any proposed changes) will all be given an opportunity to provide an informed view. HCC, the Health & Wellbeing Board, Healthwatch, District/Borough Councils in Hertfordshire and HSC, will be consulted separately as will elected representatives (including MPs) and stakeholders, as appropriate. Consultation with the HSC will not be used as a substitute for consultation with HCC's executive (and vice versa). The organisation will need to consult the executive as HCC's decision-making body and with the executives or other decision-making bodies of the Hertfordshire District/Borough Councils, where appropriate, all of whom may have different perspectives from HSC.

5. Being clear about proposals and options

5.1 It will be clear that it is a **consultation** not a vote or referendum.

5.2 Consultations will have clear stated objectives. It will be made clear to those being consulted what is being proposed. Options will be put forward in good faith, i.e. it will be made clear which options the consulting body considers to be viable ones, what, if any, its current preferences are among these options and what consultees can still change or influence. If certain options have been excluded as being completely unviable, this will be made clear and the constraints spelled out. If the pre consultation engagement has been extensive and the NHS body is able to provide substantial evidence of engagement and how this activity has shaped proposals, the NHS body may consult on one proposal only. It is anticipated that this will be the exception.

5.3 The consulting body will also make clear that it will give due regard to new alternative options or aspects of options proposed by consultees during the consultation process. Consultees will be specifically asked for their views on options which they do not favour as an understanding of the advantages and disadvantages of all options from the public perspective may be helpful to decision makers.

5.4 Where possible an assessment of the likely effects of proposals on other services and of the groups of people most likely to be affected will be given, including an assessment of the impact of making no change. This should also include the likely impact on other organisations that interact with this service. Short and long-term impacts, knock-on effects, equalities

impacts, sustainability and opportunity costs of options will be outlined with an assessment of the likely impact on transport and local site issues.

6. Consulting in the right way

6.1 Consultation will take many forms, both formal and informal, proportionate to the issue and population being effected. Consultation documents will be made available widely and public consultation events will be well publicised using 'digital by default', but also make sure that a range of suitable media communication is used and events are held at times and venues that will suit as many people as possible to be fully inclusive and allow informed decisions to be made. Materials will state clearly how consultees should respond. They will include a contact point for any consultee who wishes to complain about the consultation process. The numbers responding and their submissions to consultation documents or at consultation events will be recorded and reported in a final summary. Questionnaires will be objective, appropriate and fair and the methodology for analysing them will be indicated in the final report of a consultation.

6.2 HSC recognises that public meetings and questionnaires are not always the most appropriate method of consulting people. Where appropriate smaller scale engagement with specific groups can be a more effective means of capturing the views of defined users of particular services and of people whose views are seldom heard, and therefore its use is encouraged.

7. Using accessible language

7.1 The language of consultation documents and at consultation events will be accessible, user-friendly and jargon free. Publicity for consultation events and documents will make clear what the overall implications of proposed changes are likely to be (e.g. a proposal to "reconfigure" services that may result in a closure of a hospital or facility will say so and **not** simply use vague terms such as "Come to a meeting about NHS changes" or "new ways of providing health services").

8. Effective reporting

8.1 Responses to consultations will be analysed using methods that can be shown to be fair and objective and will, where possible, give a demographic breakdown of those responding, including a geographic breakdown.

8.2 NHS boards, HSC, HWB, HWH and the public will have access to full reports of consultations. Access for this purpose may include publication of consultation reports to boards as posted with board papers on health body websites. All signatories to this Concordat shall also comply with their obligations under the Freedom of Information Act 2000 and shall also disclose such information as may be requested under that Act unless they can clearly demonstrate that exemption from disclosure under the Act applies. However, this is likely to be exceptional in the case of information relating to a public consultation exercise.

9. Objective decision-making and feedback

9.1. Decisions made by boards will give due weight and attention to the full range of consultation formats used, including oral and written responses in formal and informal settings. In general, reports of decisions on issues where consultation has taken place will make clear how the pre consultation informal engagement and consultation process has influenced the decision. It is also necessary to include in the report how feedback from stakeholders has been used in the decision making process.

9.2. Health bodies need to ensure that sufficient consideration has been given to any issues raised during the consultation concerning the impact of the proposals on clinical quality and outcomes

9.3. Wherever possible, direct feedback will be given to groups and individuals who have responded to a consultation, indicating where their views have influenced a decision. Where a decision goes against a large body of opinion of those consulted, or against the view of those who will be most affected, reasons will be given for this.

10. Lessons learned

10.1 In their overall consultation strategies, NHS bodies will show how they have evaluated previous consultations and put into practice the lessons they have learned about how to improve consultation.

10.2 This Concordat will be reviewed and its effectiveness tested with both signatories and other stakeholders including HWH, on a four year basis unless other factors suggest an earlier revision is necessary.

11. Implementation of an agreed strategy

11.1. The implementation of a strategy does not require further scrutiny, unless it is a substantial variation to the agreed strategy. This is especially important if implementation of all or part(s) of the strategy will not take place for a considerable period of time. To enable HSC to monitor implementation it has been agreed that health bodies will undertake a full range of activities as requested by HSC in relation to specific strategy implement. This will include

- regular, short, written updates
- assurance that reconfiguration/service changes is in line with the agreed strategy
- reassurance of substantial engagement with users and the community to inform service changes
- hosting site visits for HSC members, where appropriate

The Concordat will be reviewed every four years

Appendix 1

HERTFORDSHIRE COUNTY COUNCIL (HCC)
HEALTH SCRUTINY COMMITTEE (HSC)

BACKGROUND TO NHS CONSULTATION & HCC CONCORDAT

1. INTRODUCTION

1.1. It is the role of HCC to hold the local NHS to local democratic account. However, the relationship between HCC's Health Scrutiny Committee (HSC) and its health partners is only one of the many that operate at different levels across the two sectors. The Health & Wellbeing Board (HWB) will influence the strategic direction for commissioning services that relate to the health and wellbeing of the population. HCC and health staff work closely together to ensure that their commissioning strategies are aligned and that patients' experience of moving between health and social care services are as seamless as possible.

2. Legislative background

2.1. The law gives powers to local authorities (other than districts in two-tier areas) to consider issues affecting the health of local people and to call the NHS and private providers whose services are funded by the NHS to account on behalf of local communities.[1] The primary aims of health overview and scrutiny is to ensure that:

- health services reflect the views and aspirations of local communities
- all sections of local communities have equal access to services
- all sections of local communities have an equal chance of a successful outcome from services.[2]

2.2. The regulations specifically require NHS bodies to consult on any proposals for "substantial variations or developments" of health services. HSC does not have powers to enforce any of the recommendations it makes to the NHS or private providers, either as a result of carrying out a scrutiny review, or in responding to a consultation. It can only hope to influence decisions by the evidence it brings forward and to ensure that

[1] Health and Social Care Act 2001, National Health Service Act 2006 (section 244) **as amended by Health and Social Care Act 2012; Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013**
[2] Centre for Public Scrutiny, *Substantial Variations and Developments of Health Services: a Guide*, 2005.

consultation by the NHS has been of a high quality. The final decision on how NHS services are run and developed remains with NHS Boards. In Hertfordshire HSC and NHS bodies have agreed an approach to monitoring the implementation of recommendations through the OSC Review of Recommendations Topic Group.

2.3. In addition to the creation of duties relating to local authority scrutiny, legislation requires the NHS to involve and consult the public widely on what it does.[3] Clinical Commissioning Groups (CCGs), NHS Trusts and NHS Foundation Trusts must involve and consult people who receive or who may receive health services on:

- the planning of the provision of those services,
- the development and consideration of proposals for changes in the way
  those services are provided, and
- decisions affecting the operation of those services

3. Hertfordshire County Council Health Scrutiny Committee (HSC)

3.1 HSC has been carrying out its scrutiny powers since 2002. The statutory health scrutiny powers, following changes made by the Health and Social Care Act 2012, now rest with HCC, but they will continue to be exercised on behalf of HCC by HSC. HSC includes representation from all the districts/boroughs in Hertfordshire. All districts/boroughs, and HCC's executive , continue to provide an executive response to NHS consultation proposals and service developments.

3.2 HSC is aware that the NHS in Hertfordshire has also been developing the ways it involves and consults patients and the public and HSC wishes to encourage these developments, at the same time recognising the finite resources available. HSC aims to ensure that it has a comprehensive overview of NHS developments and an opportunity to contribute to improving the health of the people of Hertfordshire. It wishes to support new developments designed to improve health services, as long as it is assured that good and comprehensive involvement and consultation with patients and the public is happening. HSC believes that the best way for it to scrutinise the activities of the NHS locally is to act as a challenging critical friend.

[3] National Health Service Act 2006 (section 242) as amended by the Health and Social Care Act 2012.

3.3 HSC expects to be informed of proposed substantial variations in services, as is required by law. However, HSC would not wish – and indeed would not have the capacity - to carry out detailed scrutiny in relation to the content of all new NHS proposals or existing services. This does not preclude HSC from undertaking scrutiny on specific issues it deems necessary. It is very important, therefore, that HSC can be satisfied that adequate, appropriate and effective consultation and involvement of patients and the public has takes place as a matter of course.

3.4 HSC understands that consultations are not referenda and that NHS Boards must weigh up a number of factors in making decisions about changes in services. HSC and the NHS signatories to this Concordat agree that the views of patients and the local population are an important factor which must play and be seen to play a role in those decisions.

4. The Concordat between Health & HCC

4.1. HCC, acting through HSC, and the NHS signatories of this Concordat have agreed to develop a Concordat on the way in which patients and the public in Hertfordshire are informed, consulted and involved in decision-making by the NHS. The purpose of this Concordat is:

- to create an explicit consensus between HSC and the NHS in Hertfordshire about the principles that should underlie good consultation of patients and the public
- to enable HSC to prioritise its scrutiny activity and to maintain the role of critical friend referred to above
- to assist patients and the public, including HealthWatch Hertfordshire (HWH), to understand the principles on which consultation with them is carried out by the NHS.

4.2. The guiding assumption is that, only where there is clear evidence that a consultation process has failed to comply with the principles of the Concordat in a way which has materially affected the process or outcome will there be a need for detailed and formal scrutiny review by HSC. Such principles and assessment of compliance with them could never be wholly scientific, since they require a degree of judgement about whether their spirit has been fulfilled, and an understanding of local circumstances. However, it is hoped that they will provide a public benchmark to assist patients, the public, and NHS bodies themselves as well as HSC to plan patient and public involvement and consultation and to evaluate the adequacy and effectiveness of consultations.

4.3. It is accepted that both providers and commissioners have a statutory duty to “involve and consult”; however, the lead organisation in respect of public consultation is the commissioning body. This body is expected to lead the contact with HSC.

4.4. Each signatory shall notify HCC’s Scrutiny Officer of the name and contact details for a lead officer within their organisation who shall act as the principle point of contact for all matters in relation to this concordat. Any amendments to the name, role or contact details of a lead officer shall also be notifed accordingly.

5. Status of the Concordat, Amendments, Withdrawal and Successor Bodies

5.1. The Concordat is not a legally binding contract or agreement. However, the signatory organisations voluntarily subscribe to its provisions. Agreeing the Concordat shall be approved by each organisation in accordance with its Constitutional requirements. HCC’s Head of Scrutiny shall maintain a definitive current version of the Concordat.

5.2. Significant amendments which impact on the substance of the Concordat or any of its provisions will continue to be revised and agreed by health and HSC. Amendment will only be made with the agreement of all signatories. Minor amendments (including e.g. changes of organisation name or post titles) shall not require agreement.

5.3. Any signatory may withdraw from the Concordat by giving three months notice in writing to HCC’s Head of Scrutiny. Withdrawal from the Concordat does not exempt an organisation from the fulfilment of its statutory duties in respect of consultation.

5.4. An organisation shall automatically cease to be a signatory to this concordat in the event of it ceasing to exist as a statutory body. The Concordat does not bind successor organisations but any successor organisation shall be invited and encouraged to become a signatory. Notification in writing to HCC’s Head of Scrutinyl shall constitute an organisation becoming a signatory for this purpose, subject to their having complied with paragraph 12.1 above.

5.5. The establishment of HWH requires inclusion within any Concordat arrangements. Where a member of the public, a representative organisation of the HWH or a member of HSC believes that consultation has not been carried out according to the spirit of the principles in the Concordat they may submit evidence to HSC as to why they consider the

Concordat has not been complied with. In such instances HSC will either as a whole, or appoint a sub-group of it members to assess the process of consultation against the principles in the Concordat and decide, on this basis, whether further scrutiny is necessary. Appendix 4 to the Concordat provides a checklist of questions to assist any assessment of whether consultations have followed the principles of the Concordat.

5.6. The Concordat draws on the relevant legislation (referred to in footnotes) and the experience of HSC and the NHS in developing and overseeing good practice on consultation and involvement at a practical level. In addition, the Concordat has drawn on principles outlined in the following documents:

- *Hertfordshire County Council's Have Your Say principles for consultation*
- *Consultation Principles 2016*
- *The Independent Reconfiguration Panel's best practice guidance.*
- *NHS Constitution*
- *Health & Social Care Act 2012*
- *Care Act 2014*

Appendix 2

Consultation Principles 2016

A. Consultations should be clear and concise

Use plain English and avoid acronyms. Be clear what questions you are asking and limit the number of questions to those that are necessary. Make them easy to understand and easy to answer. Avoid lengthy documents when possible and consider merging those on related topics.

B. Consultations should have a purpose

Do not consult for the sake of it. Ask departmental lawyers whether you have a legal duty to consult. Take consultation responses into account when taking policy forward. Consult about policies or implementation plans when the development of the policies or plans is at a formative stage. Do not ask questions about issues on which you already have a final view.

C. Consultations should be informative

Give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated assessments of the costs and benefits of the options being considered when possible; this might be required where proposals have an impact on business or the voluntary sector.

D. Consultations are only part of a process of engagement

Consider whether informal iterative consultation is appropriate, using new digital tools and open, collaborative approaches. Consultation is not just about formal documents and responses. It is an on-going process.

E. Consultations should last for a proportionate amount of time

Judge the length of the consultation on the basis of legal advice and taking into account the nature and impact of the proposal. Consulting for too long will unnecessarily delay policy development. Consulting too

quickly will not give enough time for consideration and will reduce the quality of responses.

F. Consultations should be targeted

Consider the full range of people, business and voluntary bodies affected by the policy, and whether representative groups exist. Consider targeting specific groups if appropriate. Ensure they are aware of the consultation and can access it. Consider how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

G. Consultations should take account of the groups being consulted

Consult stakeholders in a way that suits them. Charities may need more time to respond than businesses, for example. When the consultation spans all or part of a holiday period, consider how this may affect consultation and take appropriate mitigating action.

H. Consultations should be agreed before publication

Seek collective agreement before publishing a written consultation, particularly when consulting on new policy proposals. Consultations should be published on gov.uk.

I. Consultation should facilitate scrutiny

Publish any response on the same page on gov.uk as the original consultation, and ensure it is clear when the government has responded to the consultation. Explain the responses that have been received from consultees and how these have informed the policy. State how many responses have been received.

J. Government responses to consultations should be published in a timely fashion

Publish responses within 12 weeks of the consultation or provide an explanation why this is not possible. Where consultation concerns a statutory instrument publish responses before or at the same time as the

instrument is laid, except in exceptional circumstances. Allow appropriate time between closing the consultation and implementing policy or legislation.

K. Consultation exercises should not generally be launched during local or national election periods.

If exceptional circumstances make a consultation absolutely essential (for example, for safeguarding public health), departments should seek advice from the Propriety and Ethics team in the Cabinet Office.

This document does not have legal force and is subject to statutory and other legal requirements.

Appendix 3

HSC Substantial variation guidance

1. Department of Health guidance (2014), good practice as recorded by the Centre for Public Scrutiny (CfPS 2005) and Section 10.6.3 of Local Authority Scrutiny regulations recommend that the following are taken into account when considering whether a development, proposed change or variation is 'substantial':
    - Changes in accessibility of services
    - The impact of the proposal on the wider community and other services (including economic impact, transport and regeneration)
    - The degree to which patients are affected
    - Changes to service models and methods of service delivery NHS e.g. moving a particular service into a community setting from an acute hospital setting

2. Section 242 of the NHS Act places a statutory duty on the NHS to engage and involve the public and service users in:
    - Planning the provision of services
    - The development and consideration of proposals to change the provision of those services
    - Decisions affecting the operation of services.

To assist in transparency a template for detailing service changes that can be shared with HSC is in Appendix 3a.

Appendix 3a:

Service Changes

Organisation	
Lead manager & contact details	
Description of service variation	
Reasons for service variation i.e. Case for Change	
Impact on the Wider Community *(e.g. transport, accessibility)*	
Number of Patients/Carers Affected	
Changes in Methods of Service Delivery	
Impact on other Services (e.g. health, social care, voluntary sector)	
Impact on different communities *(e.g. age, gender, locality)*	
Date due at Health & Wellbeing Board or relevant Commissioner	
Proposed Engagement	

Appendix 4

Checklist to ascertain if consultations have followed the Concordat, Consultation Principles, NHS Constitution & best practice

Reflecting the 4 Tests, cconsultation should provide evidence of

- clarity on the clinical evidence base underpinning the proposals
- support of GP commissioners i.e. CCGs
- that it promotes choice for patients
- genuine engagement with the public, patients and local authorities

1. What efforts has the health body made from an early stage to inform relevant stakeholders that a proposal is being formulated?

2. What evidence is there of patient and public involvement and/or consultation in the development of the proposal?

3. If the proposal is clearly a substantial variation in services and not subject to formal public consultation, how will the health body ensure stakeholder input?

4. If there is doubt about whether the proposal constitutes a substantial variation have the Head of Scrutiny and the Health Scrutiny Committee (HSC) been asked for their views?

5. In the case of proposals that will not lead to substantial variations in services, is the timescale for consultation realistic and acceptable?

6. Have those being consulted been made aware of the objectives of the consultation? Have options been put forward in good faith? Has it been made clear which options are still “on the table” and which have been ruled out and the reasons given in sufficient depth to justify their exclusion?

7. Have the right people been consulted: key stakeholders, users (current and past) groups and individuals with an interest and those likely to be affected? Has consultation sought to elicit responses from a representative cross-section and a geographical spread (where appropriate) of views? Has the health consulting body encouraged people to give their views and enabled the voices of seldom-heard people and minorities to be heard?

8. Has consultation taken the right forms appropriate to the subject matter and to those being consulted? Have responses to consultation been captured,

recorded and reported appropriately? Have consultees been made aware of how they can complain about the consultation process, if they wish?

9. Is the language of any consultation documents and events accessible, user-friendly and jargon free? Has any publicity made clear what the overall implications of any proposed changes will be?

10. Has analysis of consultation responses used fair and objective methods? Has the methodology for analysing consultation responses been recorded in any report of consultation, where appropriate? Where possible, has a demographic and geographic breakdown of responses been provided in any final report? Is any final report available to relevant Boards, HSC and the public and is anonymised raw data from consultation available on request?

11. Have any decisions made after a consultation period given due weight and attention to consultation responses and made it clear how they have influenced the decision(s)? How will feedback be given, where possible, to those consulted? Where a decision goes against a large body of opinion of those consulted, or against the view of those who will be most affected, have reasons been given for this?

APPENDIX 5

Signatories

The signatories below have signed on behalf of their organisation and have done so in agreement with the principles outlined in the Concordat 2017.

1. Signed…… Date…….
   Print Name and Post Title…….....
   (*Hertfordshire County Council which will act through its Health Scrutiny Committee*)

2. Signed…… Date…….
   Print Name and Post Title…….....
   (*Hertfordshire Partnership University NHS Foundation Trust*)

3. Signed…… Date…….
   Print Name and Post Title…….....
   (*East & North Hertfordshire NHS Trust*)

4. Signed…… Date…….
   Print Name and Post Title…….....
   (*West Hertfordshire Hospitals NHS Trust*)

5. Signed…… Date…….
   Print Name and Post Title…….....
   (*East of England Ambulance Service NHS Trust*)

6. Signed…… Date…….
   Print Name and Post Title…….....
   (*Hertfordshire Community NHS Trust*)

7. Signed…… Date…….
   Print Name and Post Title…….....
   (*Herts Valleys Clinical Commissioning Group*)

8. Signed…… Date…….
   Print Name and Post Title…….....
   (*East & North Herts Clinical Commissioning Group*)

9. Signed…… Date…….
   Print Name and Post Title…….....
   (*Cambridge & Peterborough Clinical Commissioning Group*)

10. Signed…… Date…….
    Print Name and Post Title…….....
    (*Princess Alexandra Hospital, Harlow*)

11. Signed…… Date…….
    Print Name and Post Title…….....
    (*Healthwatch Hertfordshire*)