Hertfordshire Partnership University NHS Foundation Trust
Public Board of Directors

Da Vinci Room B, The Colonnades, Beaconsfield Road, Hatfield, AL10 8YE

29 November 2018 11:00 - 29 November 2018 13:30

INDEX

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS

A Public Meeting of the Board of Directors

Date: Thursday 29 November 2018
Venue: The Colonnades, Beaconsfield Road, Hatfield AL10 8YE, Da Vinci B+C
Time: 11:00 – 13:30

10:30 – 11:00am Presentation: New Leaf College – Andrew Nicholls

AGENDA				
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**
1	**Welcome and Apologies for Absence:**	Chair		
2	**Declarations of Interest**	Chair	**Note/Action**	Verbal
3	**Minutes of Meeting held on 27th September 2018**	Chair	**Approve**	Attached
4	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
5	**CEO Brief**	Tom Cahill	**Receive**	Attached
6	**STP Update**	Tom Cahill	**To note**	Attached
QUALITY & PATIENT SAFETY				
7	**Report of the Integrated Governance Committee – 8 November 2018**	Sarah Betteley	**Receive**	Attached
8	**Quality and Patient Safety Quarterly Report: Quarter 2**	Dr Jane Padmore	**Receive**	Attached
9	**Safer Staffing Report: Quarter 2**	Dr Jane Padmore	**Receive**	Attached
OPERATIONAL AND PERFORMANCE				
10	**Report of the Finance & Investment Committee – 13 November 2018**	Simon Barter	**Receive**	Attached
11	**Performance Report : Quarter 2 2018/19**	Ronke Akerele	**Receive**	Attached
12	**Finance Report: October 2018**	Keith Loveman	**Receive**	Attached
13	**Workforce and Organisational Development Report: Quarter 2**	Mariejke Maciejewski	**Receive**	Attached
14	**Annual Plan 2018/19: Quarter 2 update**	Karen Taylor	**Receive**	Attached
15	**Update on NHS Improvement Planning Guidance**	Keith Loveman / Karen Taylor	**Recieve**	Attached

GOVERNANCE AND REGULATORY				
16	**The Colonnades – Lease Agreement**	Keith Loveman	**To Approve**	Attached
17	**Review of the Constitution**	Jill Hall	**Receive**	Attached
18	**Board Assurance Framework**	Jill Hall	**To Note**	Attached
19	**Trust Risk Register**	Dr Jane Padmore	**To Note**	Attached
20	**Any Other Business**	Chair		
	QUESTIONS FROM THE PUBLIC	Chair		

Date and Time of Next Public Meeting:
Thursday 7th February 2019, 11.00 – 13.30, Da Vinci B/C,

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

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING
Held on Thursday September 27th, 2018
Da Vinci B – Colonnades

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Christopher Lawrence, CL	Chair
Catherine Dugmore, CD	Non-Executive Director
Sarah Betteley, SBe	Non-Executive Director
Simon Barter, SBa	Non-Executive Director
Michelle Maynard, MMay	Non-Executive Director
Loyola Weeks, LW	Non-Executive Director
Janet Paraskeva, JPa	Non-Executive Director
Tanya Barron, TB	Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill, TC	Chief Executive Officer
Mariejke Maciejewski, MMac	Interim Director, Workforce and OD
Dr Asif Zia, AZ	Director, Quality & Medical Leadership
Ronke Akerele, RA	Director, Innovation and Transformation
Jess Lievesley, JL	Director, Service Delivery & Customer Experience
Karen Taylor, KT	Director, Strategy and Integration
Keith Loveman, KL	Director, Finance
Dr Jane Padmore, JPad	Director of Quality and Safety
IN ATTENDANCE	
Jill Hall, JHa	Interim Company Secretary
Deborah Holmes, DH	PA to CEO
Deborah Fielding, DF	
Lara Harwood, LH	Service Experience Lead
Julie Hollings, JH	Deputy Director Marketing, Communications & Engagement
MEMBERS OF THE PUBLIC	
Barry Canterford	Public Governor
Tap Bali	Public Governor
APOLOGIES	
Sue Darker	Herts County Council

Item	Subject	Action
121/18	**Service User Presentation**	
122/18	**WELCOME AND APOLOGIES FOR ABSENCE** CL welcomed Janet Paraskeva new Non – Executive Director to her first public board meeting for HPFT.	
123/18	**DECLARATIONS OF INTEREST** There were none.	
124/18	**MINUTES OF THE MEETING**	

	The minutes of the meeting held on 26th July, 2018 were approved as an accurate record of the meeting.	
125/18	**MATTERS ARISING** Matters were discussed and updates noted.	
126/18	**CEO BRIEF** TC noted there are challenging pressures in the system with regards to winter pressures and STPs, Acute and Mental Health Trusts are working hard to plan for this. This week has seen the coming together of NHSE/NHSI publicised nationally and intern this leads us to think about our governance and a more formal understanding of this. TC noted the Department of Health and Social Care have communicated plans in the case of a 'no-deal scenario' for Brexit. EU citizens working within the health and care system will be invited to apply for settled status and this will be communicated to the 230 people currently working within our Trust. Meetings and workshops will be arranged for reassurance and give them the opportunity to raise any concerns. The CQC have called for national guidance to improve sexual safety on wards and plans are in place for what this means for us and what we need to do. National suicide day took place on 10 September and the Hertfordshire Suicide Prevention Partnership launched a charter for the responsible reporting of suicide in Hertfordshire. We have recently seen the biggest reduction in male suicide rates since 1981 and we are working with journalists on how they report on incidents like this and effects on vulnerable people and families. TC noted that West Herts Community Hospitals NHS Trust were unable to appoint to the post of Chief Executive. Helen Brown remains as Acting Chief Executive. Performance has remained similar but continues to be busy. Demand has increased as has staff turnover and we are continuing to work with GPs to manage this. Our main pressure point being CAMHS 28 day target which we currently behind. We are working closely with the CQC and NHSI through a safety improvement collaborative and a meeting took place last week to help us with areas that need to be focused on. TC recognised the significant improvement with regards to finance for Q1 but noted there is still a clear set of actions that we will need to meet to return the position to a recurrent surplus. The focus for September and October will be placements and agency and a revision of the CRES programme to meet the end of year plan.	
127/18	**STP UPDATE** DF provided an update on key areas for the Hertfordshire and West Essex	

	STP as below; In March 2018 the HWE STP embarked on a programme to transition to an Integrated Care System (ICS) which would be underpinned by Integrated Care Alliances (ICAs) with the ambition to be recognised as an ICS by NHSE from April 2019. As part of this programme Carnall Farrar were commissioned to facilitate this work and through a workshop based approach concluded endorsements of moving forward with being recognised as an ICS with the following recommendations; • Create a clinically-led health and care system strategy for HWE • Develop collaborative governance • Develop joint commission arrangements • Develop system leadership • Accelerate information sharing • Link the medium term financial strategy with resourcing requirements • Improve UEC performance as an exemplar of joint working On 8th August 2018 the STP had a regional review meeting. NHSE recognised there had been a lot of progress but more needed to be done for the system to work as a full collective. A key milestone of this would be the medium term financial plan for all organisations to show how we would come back to financial balance in the system. DF noted draft version of this document would be ready next week and should note we will come back into balance by 2021. Final version of this should be ready for discussions with the CEO group on 16 October 2018. DF noted this will run alongside the clinical strategy which is being progressed with the aim to have this by the end of October. This strategy has been explored by the STP CEO group and will require a set of delivery components including; • An assessment of population based needs • Population health management and place based care • Health and care prevention that is clinical and non-clinical • Wider public and voluntary sector services linkage • Urgent care, emergency care, primary care and planed care transformation The group discussed the engagement of the Board and how we benchmark the benefit for service users, mental health and learning disabilities and the importance of seeing long term conditions in both strategies. DF noted deep dives have taken place with mental health colleagues to ensure parity of esteem. **RESOLVED** **The Board RECEIVED and NOTED the report.**	
128/18	**REPORT OF THE INTERGRATED GOVERNANCE COMMITTEE = 6 SEPTEMER 2018** SB noted there were no issues that need to be escalated to the Board. It is recommended that the unlawful detention of service users following the change to the Policing and Crime Act is looked at in more detail and considered as an addition to the Trust Risk Register (TRR) along with the third line of the of the Board Assurance Framework (BAF) to be strengthened.	

	SB noted there was a theme of documentation not being completed and poor record keeping. It was noted that East and North SBU may be showing signs of concern but assurance was given that these were attended to.	
129/18	**EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE – CORE STANDARDS 2018** JL reported on the Emergency Preparedness, Resilience and Response (EPRR) Assurance process for 18/19. This has identified two core standards that are partially compliant which identifies us as 'substantial assurance' against the NHSE rating. The two core standards consist of; • Improving the governance process • Assuring dedicated resource JL noted that recruitment is underway with HCT to an EPRR Lead to ensure full compliance along with the setting up of an EPRR committee. JL noted the annual report and work programme will be presented at the Board in November along with the structure of where the EPRR committee reports to. **RESOLVED** **ACTION – JL to revisit wording on 4.2 Standard 5**	
130/18	**CARE QUALITY COMMISSION ACTION PLAN** JPad reported on the high level action plan of the must do actions identified by the CQC visit in February. This has been taken to and discussed in detail at the (Integrated Governance Committee) IGC and Audit Committee and assurance given that all actions from the CQC report are identified in the action plan. A formal response was provided to the CQC on 4th June on the regulations identified that were not being met. Following this IGC identified that a deep dive into restrictive practice and seclusion would take place and this came back without any concerns. JPad noted all actions are regularly reviewed and activity is in place to achieve full compliance. **RESOLVED** **The Board RECEIVED and NOTED the report.**	
131/18	**CQC INSIGHT REPORT** JPad reported on the CQC Insight report which is an intelligence document that the CQC use to inform inspections. This report will be updated every two months and will be shared with the executive team and through the IGC. JPad noted that we will only be able to see our Trusts report and it will give an idea of where the CQC are focussing their attention. It was agreed that that this will be brought to the back periodically to keep the Board updated. **RESOLVED**	

	The Board RECEIVED and NOTED the content within the report.	
132/18	**REPORT OF THE FINANCE AND INVESTMENT COMMITTEE** CD reported on the deep dive on innovation and improvement that took place at the last Finance and Investment Committee (FIC) and noted the request a show case of key projects going forward including some of the successful innovation fund bids. FIC received an update on the CRES programme of £4.7m savings. CD noted that there is a lot of work to be done to achieve this programme although there has been good progress on some of the key workstreams and plans are in place with regards to agency costs, social care and corporate services. **RESOLVED** **That the Board RECEIVED and NOTED the report.**	
133/18	**FINANCE REPORT MONTH 5** PR noted that for Q1 the YTD position was reported in line with the Plan this was due to the release of provisions from CHC cost that were no longer required. The causes have been identified and are being addressed and significant improvements have been made but need to be continued and further actions implemented to meet year end. PR noted that overall there has been a clear improvement and a clear set of actions that if delivered will return the position to a surplus. CL thanked PR and the Finance team for the work to bring this back in line. **RESOLVED** **That the Board RECEIVED and NOTED the report.**	
134/18	**REPORT OF THE AUDIT COMMITTEE – 13 September 2018** CD reported on the CQC deep dive that took place at the last Audit Committee. CD noted an internal audit was undertaken in two stages, the first reviewed the action plan and the internal audit gave assurance the plan was comprehensively covered all key aspects of the CQC report. This will come back again for further discussion in Q4. The committee discussed the final internal audit reports and noted disappointment that the safe management of service user property continued to be problematic. The Committee asked management to look into this area again with a view to a more practical process. CD noted the evaluation of the Audit Committee Effectiveness was positive but discussed whether this provided the assurance necessary. It was agreed that further thought be given to strengthen the self-assessment. **RESOLVED** **That the Board RECEIVED and NOTED the report.**	
135/18	**DELIVERING GOOD TO GREAT THROUGH HIGH PERFORMING TEAMS** MM reported on the Trusts ambition to deliver great care and great outcomes	

	to our service users by releasing the potential of our staff through developing high performing teams. MM noted that this has been built from the Kings Fund Model with 8 components of high performing teams. The intention is to implement this phase of organisational development with focussed resource and training. This will be shared with Senior Leaders to discuss the model and launched through the Good to Great road shows. This will turn help pull together the implementation plan. The Board are asked to endorse the introduction of the high performing team model. **RESOLVED** **That the Board RECEIVED and APPROVED the report.**	
136/18	**TRUST RISK REGISTER** JP noted this has been discussed at IGC and Audit Committee and a deep dive took place at an Executive Team meeting. JP noted there are currently 14 risks currently on the Trust Risk Register with the following recommendations; • Downgrading the risk that the Trust fails to deliver safe services at the Broadland Clinic • Reduction in the risk score that statutory and mandatory training compliance levels lead to staff being insufficiently trained to appropriate levels • Adding the risk of increase in unlawful detentions in the Place of Safety as a result of the changes to the S135//6 Policing and Crime Act • Adding the risk that BREXIT poses to staffing, supply chain and medicines management • The risk in relation to finances is revisited to consider whether the short and long term challenges are separate risks **RESOLVED** **That the Board received and agreed the recommendations to the changes on the Trust Risk Register.**	
137/18	**BOARD ASSURANCE FRAMEWORK** JH reported that the Board Assurance Framework has been received at Integrated Governance Committee and Audit Committee. JH noted the BAF has been reviewed by lead directors and work has been undertaken to ensure alignment with the Strategic Objectives in the Annual Plan 2018/19. It was agreed that the third line of assurance will be strengthened – CHECK WITH JH **RESOLVED**	
138/18	**ANY OTHER BUSINESS** LW reminded the Board of the Mental Health Act Annual Conference that is taking place on Monday 8th October in Duxford. CL confirmed his attendance at the meeting.	
139/18	**QUESTIONS FROM THE PUBLIC**	

	Question: WS raised the issue of the service user presentation and if this is something that can come to the service user council through the minutes of the Board meeting. The group discussed the options and agreed that Eni Bankole-Race would raise this presentation and the issues discussed at the next service user council meeting. It was agreed that acronyms would be shared with the Governors. **There were no further questions raised from the Public.**	
133/18	**Date and Time of Next Public Meeting:** Thursday 29th November 2018 Da Vinci B&C, The Colonnades	

Hertfordshire Partnership NHS
University NHS Foundation Trust

Agenda Item 4

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 29th November 2018

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
27/09/18	**129/18**	Emergency Preparedness	JL to revisit the wording in the EPRR on 4.2 Standard 5		JL	29 November	
22/03/18	**32/18**	Q3 Safe Staffing	JP to show the Safer Staff tool at a future Board Workshop. JP awaiting an appointment	Date to be confirmed, bring to next BOD Workshop	JP	October 25th	A
24/05/18	**Item 11**	CEO Brief	GDPR – 12 key points to achieve – bring back full report to the next Board	To go to October IGC for scrutiny and back to Board in November	RA	29 November	A
24/05/18	**Item 16**	Finance Report	Report goes to FIC end of Q1 for review. The Board to receive an update after Q1	September Board Agenda	KL	27 September	G
24/05/18	**Item 18**	STP	Sustainability and Transformation (STP) – Deborah Fielding to be invited to a future Board Meeting	Deborah Fielding will attend September Board	TC	27 September	G
26/07/18	**107/18**	Report of the Finance and Investment Committee	Finance and CRES – A number of schemes are still under development along with a challenging action plan.	September Board Agenda	KL	27 September	G

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	29th November 2018	**Agenda Item: 5**
Subject:	CEO Brief	**For Publication: Yes**
Author:	Tom Cahill, CEO	**Approved by:**
Presented by:	Tom Cahill, CEO	

Purpose of the report:

To update Board members on national, regional and Trust-wide developments.

Action required:

For the Board of Directors to note the content.

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

N/A

Summary of Financial, IT, Staffing & Legal Implications:

N/A

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

N/A

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

N/A

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

N/A

National update

The Budget

The Government's Budget included an announcement that an additional £20.5 billion over five years will be allocated to the NHS. The Government has stated that funding for mental health services will grow as a share of the overall NHS budget over the next five years and promised to extend mental health crisis services, at a cost of £250m per year by 2023/24. The NHS will also prioritise mental health services in schools. For adults, support will be expanded to help people with severe mental illness find and stay in work, with the aim of helping 55,000 people by 2023/24. The Budget also stated that the forthcoming NHS long term plan must set out how the NHS will return to financial balance.
A further budget announcement set out government plans to abolish the use of private finance initiative (PFI) deals for future capital projects.

NHS Improvement and NHS England reveal new structure

NHSE and NHSI have outlined their proposed new structure for senior national and regional management, which will affect hundreds of managers with dozens of posts being cut. Overall the two organisations are planning to reduce their costs by 15% by 2020/21.

NHS Violence Reduction Strategy

Matt Hancock, he Health and Social Care Secretary, has announced the new strategy which includes:

- the NHS working with the Police and Crown Prosecution Service to help victims give evidence and get prosecutions in the quickest and most efficient way
- the CQC scrutinising violence as part of their inspection regime and identifying trusts that need further support
- improved training for staff to deal with violence, including circumstances involving patients with dementia and mental illness
- prompt mental health support for staff who have been victims of violence

Business leaders call to make mental health a priority

Business leaders and unions have called for mental health to be given the same weight as physical health first aid in workplace legislation. An open letter urging the prime minister to prioritise manifesto pledges to act on mental health has been signed by some of Britain's biggest employers. The letter calls for an overhaul of health and safety rules to equip first aiders with early signs of mental health problems in the workplace as workplace mental health issues cost the UK economy 15.4 million working days lost to work related stress, depression or anxiety.

Local health systems to be measured on new performance metrics

A new integrated oversight framework is under development for integrated care systems and STPs to measure local health systems against the ambitions of the long-term plan and focus on health outcomes. Whilst NHS Improvement and NHS England will continue to look at trust level and CCG level data, the new framework will reflect population based approach to improving health outcomes and reducing health inequalities. The regulators said this would provide "greater focus on the performance of the local healthcare system as a whole". It has not been confirmed what the new metrics will be or when the framework will be released. However the framework will be "informed by the long-term plan" so that healthcare systems can be assessed by metrics that reflect the plan's "ambition".

Regional update

STP

A new Independent Chair has been appointed to the Herts and West Essex STP. Paul Burstow, was a former Lib Dem MP and Chair of Tavistock and Portman NHS Foundation

Trust. During his time in office he held posts as Health spokesman and Shadow Secretary of State for Health.

Five year financial plan

NHSI/E have issued the headline planning requirements for 2019/20 with more detail expected in December. It is worth noting that as previously discussed; individual organisations will submit an initial one year operational plan for 2019/20. These will be aggregated by STP alongside a local system operational plan narrative. This is to act as the baseline for the system strategic plans. System five year plans are to be developed during the first half of 2019/20 with these plans to be signed off by all organisations by summer 2019.

As a Trust we have set out our approach and milestones for the creation of the Trust Annual Plan, SBU Improvement Plans and the key Supporting Corporate Plans and this has been considered by FIC.

Winter pressures now a year-round event for the health and care system

In the last CEO Brief it was mentioned that NHS Improvement (NHSI) had published the Q1 financial and performance figures for the provider sector. The figures have prompted concerns that the health service is in a worse position heading into winter this year than 12 months ago. A key factor is the reduced amount of social care support available.
Many improvements have been put in place this year to prepare trusts and their staff for the pressures that winter will inevitably bring. But with performance against key standards in a worse position than last year, and following an exceptionally busy summer, on balance, trusts fear this coming winter will be more difficult than the last.
The British Medical Association (BMA) has since published a new analysis of NHS England performance data ahead of winter, warning that emergency care services in England are now suffering a “year-round crisis".
It finds that performance against key standards was worse during the summer of 2018 than five out of eight recent winters.
There are also high levels of vacancies which are difficult to fill and workforce remains a concern nationally. The removal of the nursing bursary has had an impact – including among mental health nurses where the student age profile is often older. A national workforce strategy is planned for later in the year. For HPFT we have been planning for winter since July and are in a robust position to manage our services as we approach the winter peaks and as in previous years we will place equal focus on ensuring that we are well placed to be responsive to the needs of the wider system during this next period of the year.

HCT

HCT have appointed Clare Hawkins as CEO. Clare has been acting Chief Executive since September 2017. Clare has been acting into the Chief Executive role since September 2017 and is well known in the system. During this time, she has brought strong leadership and direction to HCT, as well as making a significant contribution to supporting the wider health and social care system in Hertfordshire and West Essex with our partner organisations. During this time, Clare has also undertaken a national role with the nursing directorate at NHS Improvement, providing advice and expertise on community nursing services across England. We look forward to continuing our strong relationship with HCT going forward.

West Herts Hospitals

West Herts Hospitals have appointed a new Chief Executive. The Trust is moving in the right direction and has recently moved out of the CQC rating of special measures to Requires Improvement.

Trustwide update

Performance

Performance has remained relatively stable in the face of increased demand, staff turnover and notable improvements with sickness rate. We continue to sustain our performance in ensuring adults on a Care Programme Approach (CPA) have been reviewed within the last 12 months. There have been improvements across CAMHS access measures with continuous focus to improve on 28 days waits.

There continues to be high levels of demands for Adult Community Services. We anticipate that the recently implemented initiative on DNA protocols in SPA and the collaborative working with GPs on primary mental health care will help us to better support people in need of our services. There are continuous efforts to improve the rate of risk assessments completed for our service users with a focus to improve on the quality and effectiveness of the risk assessment process. Within the workforce, there have been notable improvements in our sickness rate achieving below the 4% target. We have made significant changes within our recruitment processes which will support a reduction in time to hire. There is ongoing work towards increasing the functionality of the new learning management system.

Quality and safety

Safety remains a priority for the Trust, with a focus on continuous improvement and rapidly responding to opportunities to learn and support staff. Earlier in the year, a review of the RESPECT training took place and, as a result, a number of changes have been introduced. In addition to this a group has been set up to offer the opportunity to review individual incidents and challenges as well as respond to new challenges and presentations, as they emerge.

Safety huddles are a key pillar of our work on our culture of safety. These are led by Clinical Directors and have been implemented across all inpatient areas. In addition SWARM, post incident huddles, have been introduced and are usually triggered by a patient safety incident offering the opportunity for immediate learning.

Although we have seen a reduction in unexpected deaths in recent weeks we continue to work towards zero suicides. A suicide prevention group has been established to review learning locally and nationally and ensure every opportunity is taken to ensure that no one feels that suicide is their only option.

This month has seen a focus on falls as it was National falls week. This gave us an opportunity to raise awareness as well as collaborate with partners in HCT and Age UK as well as launch our work on a new falls risk assessment tool.

CQC

The Trust has received the Routine Provider Information Request (RPIR) from CQC, with a submission date of 28th November 2018. CQC now visit annually and we know they will be returning in the New Year to inspect our services. In preparation for this, they will be holding focus groups in January 2019. This gives us a chance to present the great care that is delivered in our services and the difference our staff make for people. Teams are being supported to prepare and are working together to ensure their great work is recognised.

Financial update

October reports a small surplus and a YTD position of c. £80k, which remains ahead of plan. The current assessment for October key financial indicators is that there has been some slippage in October with regard to PICU placements and some increases in agency spend. Income overall is slightly higher with overheads being slightly lower however the margins are tight. At this point we would expect to achieve the required year end control total.

Non-Executive Director recruitment

We have begun the process of recruiting a NED to replace Michelle Maynard who resigned in September. The Appointments and Remuneration Committee met to appoint a recruitment agency to assist us in the process. Interviews will be held in the early New Year.

HPFT teams triumph in Positive Practice in Mental Health Awards

The Trust won 2 awards at the 2018 National Positive Practice in Mental Health Collaborative (PPiMH) Awards. The HPFT Wellbeing Team won the category for IAPT and our Community Perinatal Team were highly commended in the Perinatal Mental Health category.

Tom Cahill,
Chief Executive

Board of Directors

Meeting Date:	29 November 2019	**Agenda Item: 6**
Subject:	Herts and West Essex STP Update Report	**For Publication:**
Author:	Deborah Fielding, STP Leader	**Approved by:**
Presented by:	Tom Cahill, Chief Executive	Tom Cahill, Chief Executive

Purpose of the report:

The report provides an update on the STP and is will ensure that STP member organisations Boards and Governing Bodies are up to date with developments.

Action required:

The Board is asked to note the report.

Summary and recommendations

This paper provides an update from Hertfordshire and West Essex STP. In particular this report provides an update on:

- Development of a Herts and West Essex Integrated Health & Care Strategy
- Development of a Herts and West Essex Draft Medium Term Financial Plan
- Recruitment of an Independent Chair – since this paper was written Professor Paul Burstow has been appointed Independent Chair for the STP.

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

N/A

Summary of Financial, IT, Staffing & Legal Implications:

N/A

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

N/A

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

N/A

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

N/A

Hertfordshire and West Essex STP

November 2018

Title	STP Update Report
Purpose	The report provides an update on the STP and will ensure that STP member organisations Boards and Governing Bodies are up to date with developments.
Report authors	Dennis Carlton, Head of Programme Management Helen Edmondson, Associate Programme Director Jonathan Wise, Interim STP Finance lead Alison Gilbert, Director of Delivery and Partnerships STP Harper Brown, Director of Strategy Deborah Fielding, STP Leader
Short summary of the paper	The STP over the past 6-8 weeks has developed an Integrated Health and Care Strategy, engaging with clinicians and professionals across the system. In tandem a draft Medium Term Financial Plan to support future financial planning. Following a national recruitment advert the STP has interviewed for Independent Chair and hopes to make an announcement soon. NHSE in mid October provided headlines on the future approach to strategic and operational plans.

STP Update

November 2018

1. Introduction

1.1 This paper provides an update from Hertfordshire and west Essex STP to be discussed at STP member organisations Board or Governing Body meetings.

1.2 In particular this report provides an update on:

- Development of a Herts and West Essex Integrated Health & Care Strategy
- Development of a Herts and west Essex Draft Medium Term Financial Plan
- Recruitment of an Independent Chair

2. Herts and West Essex Integrated Health and Care Strategy.

2.1 Led by the clinical oversight group (COG), the Herts & West Essex STP have developed an Integrated Health and Care strategy.

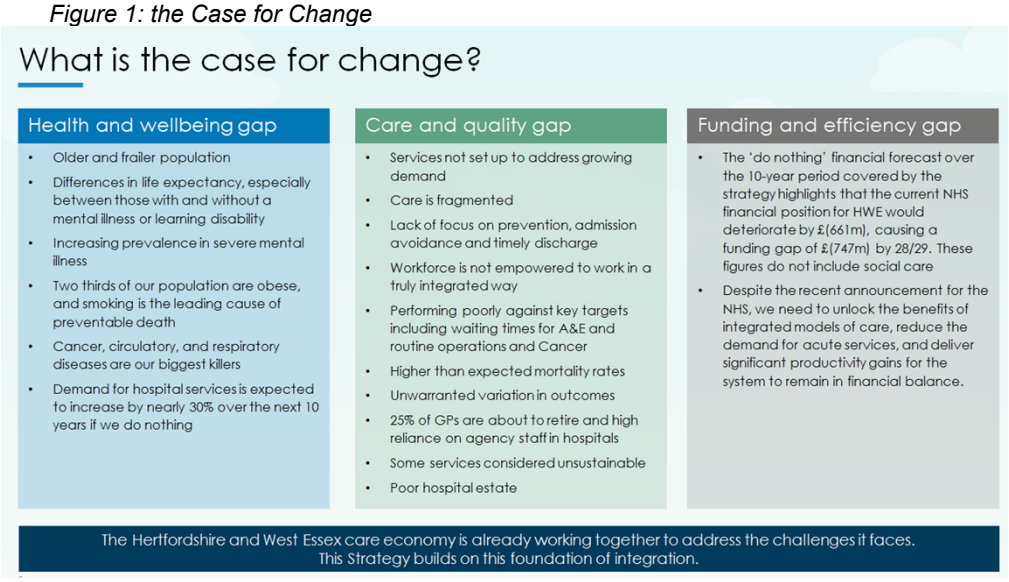
2.2 The strategy has been informed by a number of engagement events with clinical and professional colleagues from across the system.

2.3 The Integrated Health and Care Strategy sets out a blueprint for how the system will deliver a healthier future through high quality, proactive care - which is better joined up, improves outcomes, and increases value. It will act as a guiding framework for health and care organisations, professionals, service users, and our population.

2.4 At its heart is a new approach based on the principles of population health management - targeting our resources where they will have the greatest impact on health and wellbeing outcomes, care quality, and sustainability. In doing so it recognises that the population is made up of individuals who live in our local communities, and services must be wrapped around people rather than their conditions or diseases.

2.5 Figure 1 outlines the case for change. This is centred on three burning platforms of a health and wellbeing gap, a care and quality gap and a funding and efficiency gap.

Figure 1: the Case for Change



2.6 At the heart of our strategy is a population health management approach - helping to improve outcomes and reduce the cost of care – by targeting interventions at defined population cohorts through integrated models of care to prevent, reduce, or delay need before it escalates; and prevent people with complex needs from reaching crisis points in their care.

2.7 As part of this approach the population has been grouped our population into three groups (which can be further segmented by age) and designed new models of care based on their needs:

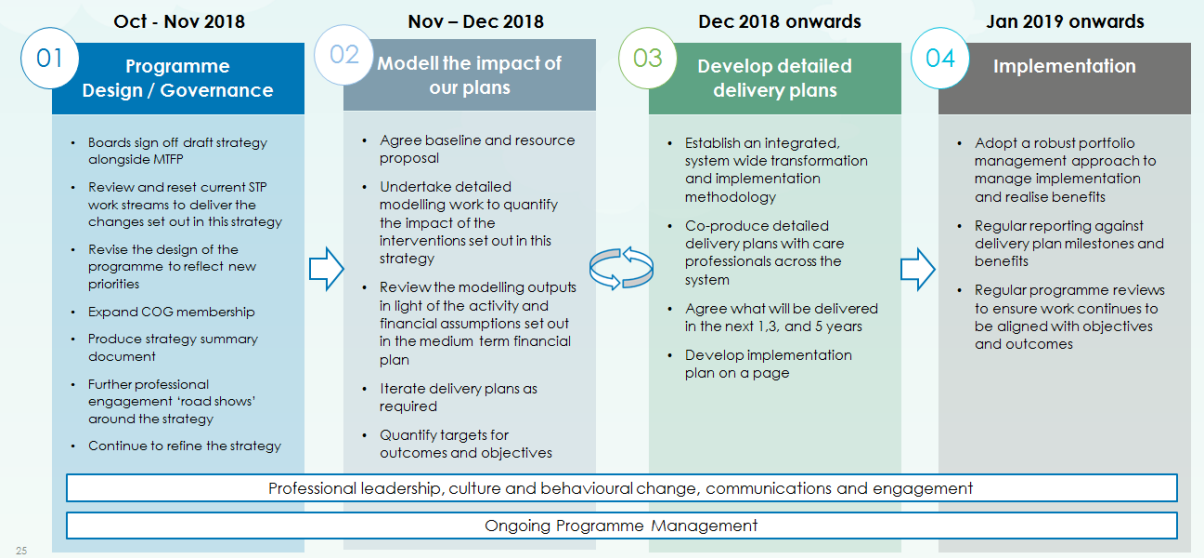
i. People with complex needs
   - For people with complex needs our goal is to prioritise the development of integrated, co-ordinated, wrap-around models of care for these groups. This will have the greatest impact on outcomes, quality, and cost.

ii. People living with a diagnosed long-term condition
   - There is an estimated 318,000 people in HWE who have a long-term condition. 16,000 of these are children. The approach to this group is early identification, a culture of self-management, enabling and empowering people to manage their own health and wellbeing, and transformed clinical pathways - which delay escalation and reduce unwarranted variation in clinical outcomes.

iii. People who are generally well
   - Two thirds of our population are generally healthy, and so the priority as a system is keeping them healthy for as long as possible and preventing them from developing long term conditions.
   - Our goal is to focus on both physical and emotional health through the development of healthier and more resilient communities, social marketing, and targeted prevention.

2.8 The draft strategy has been approved by our CEO board in its draft format. The key next steps are described in figure 2.

Figure 2: Key Next Steps



3. Herts and West Essex Draft Medium Term Financial Plan

3.1 The production of an STP wide draft Medium Term Financial Plan by October 2018 was agreed by the CEO Board in April 2018, and confirmed to NHSE/I at this time

3.2 The production of the draft plan has been led by the Finance Directors (FD) group, and has been agreed by both the FD group and the CEO Board.

3.3 All FDs have confirmed that the content of the paper represents a collective view of a draft medium term sustainability financial plan, based on the assumptions set out within this pack

3.4 The scope in terms of organisations covered, the approach taken to the modelling and the key assumptions are set out in the relevant sections of a separate paper that was submitted to the board

3.5 In summary the paper outlines three scenarios:

3.5.1 **Do nothing**
The underlying deficit position would deteriorate by £(661m) from £(86m) in 17/18 to £(747)m in 28/29. In 18/19 the position already assumed c£98m of cash support, which would materially increase in line with the deficit up to 28/29. There would be a c25-30% increase in activity, beds and workforce. The upside and downside scenarios would be a Do Nothing gap of between £(706m) (upside) to £(880m) (downside).

3.5.2 **Do something (pre-SOC)**
After the proposed interventions there is an STP wide balanced position in 20/21, which is maintained until 25/26 at which point the deficit increases to a final position of c£13m deficit in 28/29. However there remains two material deficits at organisational level. The position with the inclusion of an assumption that the current STF is allocated to Providers recurrently from

20/21 onwards has the impact of reducing the level of deficits in PAH and WHHT and increasing the surpluses in the other 3 Trusts.

3.5.3 **Do something (post SOC)**
There is an STP wide balanced position in all years from 20/21 onwards with the exception of one year (24/25) relating to the SOC capital costs. However the 2 acute trusts remain in deficit prior to an assumption that current STF is allocated to Trusts recurrently resulting in a largely breakeven (or surplus) position for all organisations.

3.6 As well as the above three scenarios, the paper describes 10 collective principles for the 19/20 planning round.

4 Recruitment of a STP Independent Chair

4.1 Following agreement from the CEO Board and Chairs Oversight Group the STP has undertaken a process to recruit an Independent Chair. The advert for the post was placed nationally via NHS jobs and NHSI facilitated the advert being made available via their established route for advertising roles.

4.2 The role will facilitate constructive relationships between STP members and help ensure that they all make an effective contribution. They will enthusiastically represent the interests of the system to national health and care bodies (such as HEE, PHE and DH) and other key stakeholders, including NHSE, NHSI and politicians. Thereby promoting and explaining the STP objectives, remit and actions and achievements.

4.3 It is proposed that the Independent Chair will also chair some of the STP CEOs Board meetings to support implementation of the STP's plan to deliver improvement and transform services, including the medium term financial plan. The independent Chair would also provide additional STP representation on the boards of the sovereign organisations within the STP.

4.4 The key functions of the role are to:

- Build and enhance relationships with a wide range of stakeholders both locally and nationally
- Ensure Oversight Board is effective in all aspects of its role,
- Promote a culture of openness and transparency, including wider engagement as appropriate.
- Facilitate constructive relationships between members of the STP and ensure they all make an effective contribution
- Promote and explain the STP's objectives, remit, actions and achievements to key stakeholders and the wider public, acting as the STP's ambassador,
- Anticipate discord and act proactively to handle the sensitivity, in the system's best interest
- Enthusiastically represent the interest of the system to national health and care bodies (such as HEE, PHE and DH) and other key stakeholders.
- Be a source of impartial and trusted guidance for the system leadership
- Promote messages of the HWE STP, including to regulators, politicians, local staff and the public

4.5 The interview and stakeholder panels were held on 17th October, with two candidates interviewed. The outcome of the day is not yet confirmed.

5. NHSE Approach to strategic and operational plans (16/10/18 Gateway 08559):

5.1 The key points for our system are;

- To secure the best outcomes from the new NHS investment NHSE is overhauling the policy framework of the NHS.
- NHSE is conducting reviews on clinical standards, new financial architecture, workforce management and physical capacity planning (access to capital)
- The letter sets out the NHSE approach to strategic & operational planning to ensure organisations can prepare to implement the new NHS Long Term Plan effectively.
- The planning timetable is set out and summarised in the HWE summary slide deck.
- NHSE is asking STP/ICS systems to clearly set out how they will run the local NHS system using the resources available.
- Proper engagement of all parts of the local system to provide robust and credible 5 year plans by spring 2019 is essential.
- Individual organisations will submit one year operational plans for 2019/20 which will be aggregated by STP/ICS and accompanied by a local system narrative.
- A revised financial framework will be set out in the NHS Long Term Plan in early December 2018.
- NHSE ask ALL organisations to have a shared open-book approach to planning.
- NHSE expects Boards and Governing Bodies to work together and oversee the development of financial and operational plans.
- Early engagement with Boards and Governing Bodies is critical to align, profile demand and capacity in order to deliver clinical and financial sustainability for each system.

5.2 The STP are working to ensure deliver against the new approach.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Integrated Governance Committee

Meeting Date:	29 November 2018	**Agenda Item: 7**
Subject:	Integrated Governance Committee	**For Publication:** Yes/No
Author:	Jill Hall, Interim Company Secretary	**Approved by:** Sarah Betteley, Non-Executive Director
Presented by:	Sarah Betteley, Non-Executive Director	

Purpose of the report:

The purpose of the report is to provide Board with an overview of the work undertaken by the Integrated Governance Committee.

Action required:

The Board are asked to note the report.

Summary and recommendations to the Committee:

An overview of the work that was undertaken is outlined in the report.

No issues were noted to be escalated to the Integrated Governance Committee however one new risk was recommended to be added to the risk register – Implications for the Trust of different scenarios arising from Brexit. Further work on the Board Assurance Framework, with a proposal on how it can be further developed to provide assurance and drive agendas.

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

Priorities 1, 2 and 3

Summary of Financial, IT, Staffing & Legal Implications:

N/A

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

N/A

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

N/A

Seen by the following committee(s) on date:

None

1. Introduction

1.1. The Integrated Governance Committee took place on 8 November 2018. This report sets out the key matters that were discussed.

1.2 No matters were identified as needing to be escalated to the Board; however one new risk was recommended to be added to the risk register – Implications for the Trust of different scenarios arising from Brexit. The committee also noted that the finance risk had been split into two separate risks to deal with the short term financial performance in the current year and ensuring long term financial sustainability.

1.3 A deep dive into restrictive practice was received. The impact of a number of initiatives implemented was described including Respect Training, Safe Care, Safety Huddles and Transforming Care. The committee felt assured that specific issues on handling restraints in Broadlands were being addressed.

1.4 The Committee received an update from the IMT & IG programme board. The committee learnt that to comply with the NHS England requirement to directly transfer discharge letters to GPs the Trust will be procuring DocMan, this system will be linked to our PARIS system. The next phase of SPIKE,_SPIKE II, was being rolled out with 120 superusers by mid-January and across the organisation in January. The Committee noted how this will revolutionise the way data is used and reported in real time. Skype for Business was discussed, in particular the savings that could be realised in terms of time and money.

2. Workforce

2.1. An update on the work of the Workforce and Organisational Development Group was given. Key areas of work that were reported were Health and Wellbeing Flu Campaign, Bank Flexible Working Pilot and Safeguarding training.

2.2. It was noted that the National Staff Survey had opened at the beginning of October, running for 8 weeks until the end of November. The Trust has opted to run a full census.

2.3. The committee noted that the Flu Campaign was on trajectory to achieve the vaccination of 75% of frontline staff by the end of February. A communications plan had been developed to meet the target.

2.4. A report on the Gender Pay Gap and the actions being taken to close the gap was received. The actions are focussed on retaining, developing and encouraging career progression and centred around parent friendly processes.

2.5. It was recognised that recruitment and retention remain on the Trust risk register.

2.6. The committee were also presented with a paper on WRES noting that there had been no significant improvement. It was noted that the National Policy Lead was coming to work with the Trust looking at improving the Trusts position.

2.7. The safe staffing report for quarter 2 particularly highlighted that the reduction in the use of agency staff during the summer had no effect on patient care and was reflected in the service users report on feeling safe.

3. Safety

3.1. The quarter two integrated safety report was received and provided assurance that the Trust is meeting its requirements and delivering safe services.

3.2. The committee noted that there is an increase in the number of serious incidents being reported. Service user to staff assaults was noted to have increased with staff reporting verbal racist abuse and physical aggression.

3.3. A rise in falls in Older Peoples Services. A falls week in September involved significant numbers of staff across the trust refocusing the importance of quality risk assessments.

3.4. The quarter two safeguarding report was presented and it was noted that the Safeguarding Improvement Plan is supporting the journey of continuous improvement in this area.

3.5. The Committee received a 6 month update report on Freedom to Speak Up (FTSP) which detailed the number, type and outcomes of cases. A communications campaign had gone out about changes to FTSP which included posters and leaflets.

3.6. The mid-year claims report provided an update on the outcome of cases and the financial cost to settle claims; in particular 85% of claims were defended successfully. The

committee heard about the successful outcome of a fraudulent claim and asked if there was any learning coming from this claim.

3.7. The annual report on Emergency Preparedness, Resilience and Response (EPRR) was received. NHS England confirmed our EPRR Core Standards Assurance rating of fully compliant

4. Effectiveness

4.1. The pharmacy and medications optimisation strategy progress report was received highlighting the CQC report reflected the significant progress working with the university. Key areas of concern were recruitment and the calibre of potential employees. Pharmacy was now more clinically focussed and about putting people in the frontline much sooner. Brexit was raised as a safety concern, software had been put in place to track the origins of drugs

4.2. An Q2 update from the Practice Audit Implementation Group (PAIG) was received. The committee noted that the majority of the audits show progress in practice and there is evidence of good practice.

4.3. An update on Q2 CQUIN performance was presented, there remained challenges. Q2 was submitted to the commissioners at the end of October and we are awaiting feedback. It was noted that a total CQUIN Value of 82% had been achieved.

4.4. The Q2 Research and Development Report was presented, the committee noted the research portfolio is a key factor in our status as a University Trust there is a small but increasing number of staff involved. The committee commented on the success in recruiting service users and the funding received for new research.

5. Experience

5.1. The Q2 complaints report highlighted that there had been a reduction in complaints and PALs concerns of 23 % in Q2.

6. Governance

6.1. The CQC high level action plan and summary report was received and discussed. Progress was noted. In particular noting the innovations to mitigate risk and the implementation of the Discovery system to centrally record supervision.

6.2. The Trust Risk Register (TRR) was received and discussed. The TRR reflects the risks that the committee in the Trust. The unlawful detention of service users as an unintended consequence of the changes to the Policing and Crime Act had been escalated from the West SBU Risk Register.

6.3. The Board Assurance Framework was received and discussed. The committee noted that improvements had been made. The committee discussed how to improve the BAF further following the recent strategic risk workshop.

7. Conclusion

7.1. The committee decided that there were no items that needed to be formally escalated to the Board.

7.2. However, it requested that further work on the Board Assurance Framework, with a proposal on how it can be further developed to provide assurance and drive agendas.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board Report

Meeting Date:	29th November 2018	**Agenda Item: 8**
Subject:	Integrated Safety Report 2018/19 (Q2)	**For Publication:** Yes
Authors:	Bela Da Costa, Legal Services Lead, Nikki Willmott, Head of Safer Care and Standards Carolyn Fowler , Deputy Director Safer Care and Standards	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety	

Purpose of the report:

To report to the Board on patient safety during Quarter 2 2018/19 and give assurance that the Trust is meeting its requirements and delivering safe services.

Action required:

To Approve: To formally agree the receipt of report
For Assurance: To appraise the Board that controls and assurances are in place.

Summary and recommendations:

This report provides the detail of the progress the Trust has made in relation to ensuring safe services are delivered and the service users remain safe whilst under our care. The moderate harm panel is now well established and has had a positive impact on ensuring the appropriateness of reporting incidents as well as sharing and embedding learning. Trust continues to report incidents and has maintained the level of reporting, particularly where no harm was sustained, but seen a decrease in the number of serious incidents reports in quarter 2. The most frequently reported incidents were related to challenges at admission, discharge and transfer, environments being damaged and restricted items being found. There has been an increase in the number of unexpected deaths that may be a suicide. The Trust continues to be actively involved in the local and National work relating to suicide prevention. The mortality governance work has identified areas that the Trust can focus work tom improve safety. These were in physical health, documentation, risk assessments and crisis plans as well as the management of service users that do not attend or cancel appointments.

This report has identified a number of areas where evidence shows safety for our service users is improving and also areas where work is required. The data informs our learning and this can be seen in the response to areas of concern and re-focus of actions.

This quarter has seen a focus on the work relating to pressure ulcer and falls. There has been a reduction in non-anchor ligature incidents, particularly in Forest House where there has been a change of approach which involves the new Home Treatment Team. Forest House has also seen significant improvements in service users reported feeling safe. This improvement in service users reporting feeling safe has also been sustained in acute services. Further work will take place to increase the response rate in older adult services. AWOL and missing persons continue to be monitored and the improvements seen previously have been sustained.

A focused look at assault from service user to service user and service user to staff has revealed further areas to focus action including the increased scrutiny of incidents and trends with support from the practice development team. The review of the RESPECT training has been completed and now modules as well as a restrictive practice group

have been developed to enable a swift response to new and challenging situations.

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

This report speaks to and provides assurance in relation to delivering safe care.

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

There are no overt financial implications.

Equality & Diversity and Public, service user and carer Involvement Implications:

No Equality and Diversity and Public & Patient Involvement Implications

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

Safety KLOE for CQC

Seen by the following committee(s) on date:

QUARTER TWO SAFETY REPORT

PART ONE: Introduction

1. Introduction

1.1. This document is the Safety report for quarter 2 of 2018/19. This is an integrated report that begins by detailing where the assurance for safety is held. The report will then cover incidents, including serious incidents, mortality governance, harm reduction work and learning. The report will begin with an overview of the key performance indicators as well as the safety related matters on the Trust risk register.

2. Assurance

2.1. The Integrated Governance Committee receives and scrutinises all aspects of safety on behalf of the Board. It conducts deep dives into areas that are identified as requiring additional focus and reports to the Board any matters that require escalation as well as recommending items for the Trust Risk Register.

Annual Plan

2.2. A number of priorities were set in relation to safety in the 2018/19 Annual Plan:
- We will continue our drive to reduce suicides and prevent avoidable harm,
- We will ensure restrictive practices across the Trust are in line with best practice,
- We will target activities to reduce violence against services users and staff.

2.3. These are reported in the Q2 Annual Plan report. This report will provide additional detail relating to how the Trust is working to deliver the objectives and achieve the outcomes.

Trust Risk register

2.4. The Trust risk register has 16 risks, a number of which relate to safety, those below have a significant impact on safety and service user harm.
- The Trust is unable to recruit staff to be able to deliver safe services due to national shortages of key staff.
- The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services.
- Implications for the Trust of differing scenarios arising from Brexit
- The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff.
- Failure to respond effectively to increasing demand resulting in a risk to safety, quality and effectiveness.

2.5. These are reported in the Q2 Trust Risk Register Report. This report will provide the Board with additional information about the work that is being undertaken to address and mitigate against these risks. A deep dive into retention took place in IGC this quarter.

Safety Dashboard

2.6. A draft safety dashboard with the relevant KPIs has been agreed. This will be hosted on SPIKE and allow real time data to be viewed at Trust, SBU and service level. This

will support identification of any hot spot areas, and be a clear method of tracking declining or improving positions.

Care Quality Commission Safety Key Lines of Enquiry (KLOE)

2.7. This section provides an overview of any safety related CQC publications that have been issued in this quarter. It will also give a brief overview on patient safety related matters raised by CQC during core and well led visits.

2.8. The CQC undertook a core inspection of inpatient services in 4 service lines within the Trust this year:

- Forensic inpatient
- Acute inpatient and Psychiatric Intensive Care Unit (PICU)
- Children and Adolescent inpatient
- Learning Disability

5 Key Lines of Enquiry (KLOEs) were considered - Safety, Responsive, Effective, Caring and Well Led. The Trust's overall rating for 'Safety' remained as 'Requires Improvement.'

2.9. The IGC received a report on the CQC action plan as well as the most recent refresh of the Insight report. The IGC requested a deep dive into safety, which took place in quarter 3. Details of this work are contained in this report.

2.10. The CQC 'Sexual Safety on mental health wards' was published in September 2018 and a group has been set up to map recommendations, assess impact and deliver any actions required.

3. Conclusion

3.1. The section of the report has set out how the IGC is receiving scrutinising and receiving assurance in relation to Safety. It seeks to demonstrate how all intelligence relating to safety is triangulated effectively through deep.

PART 2 - INCIDENTS INCLUDING SERIOUS INCIDENTS

1. Introduction

1.1. Part two of the safety report specifically considers incidents, including serious incidents. It begins by giving an overview of reporting trends.

2. Trust Incident Reporting

2.1. Patient safety incidents are defined as *'any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe*.' NHS Improvement 2017.

2.2. Datix is the information management system the Trust uses to record and analyse incidents. Training is provided for staff on using Datix which provides a forum for education to enable improvements in the consistency of the quality of incident reporting and the types of incidents that should and should not be reported on Datix.

2.3. There has been a small decrease (1%) in the total number of incidents reported on Datix this quarter when compared with the same quarter in 2017/18 (Chart 1). A trust with a positive safety culture and committed to learning expects to have a high rate of no harm and low harm incidents reported. The majority of incidents result in no harm (75%) followed by incidents that result in low harm (18%) [chart 1].

Chart 1: Number of incidents reported across all Trust services 1 July 2017 to 30 September 2018

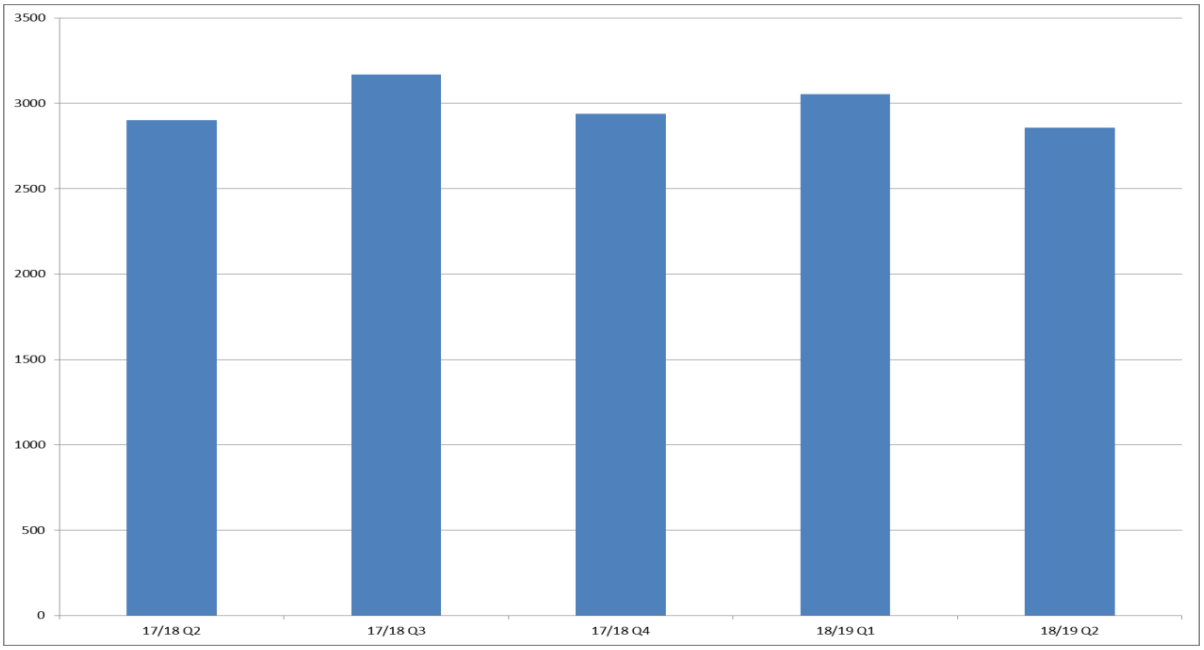
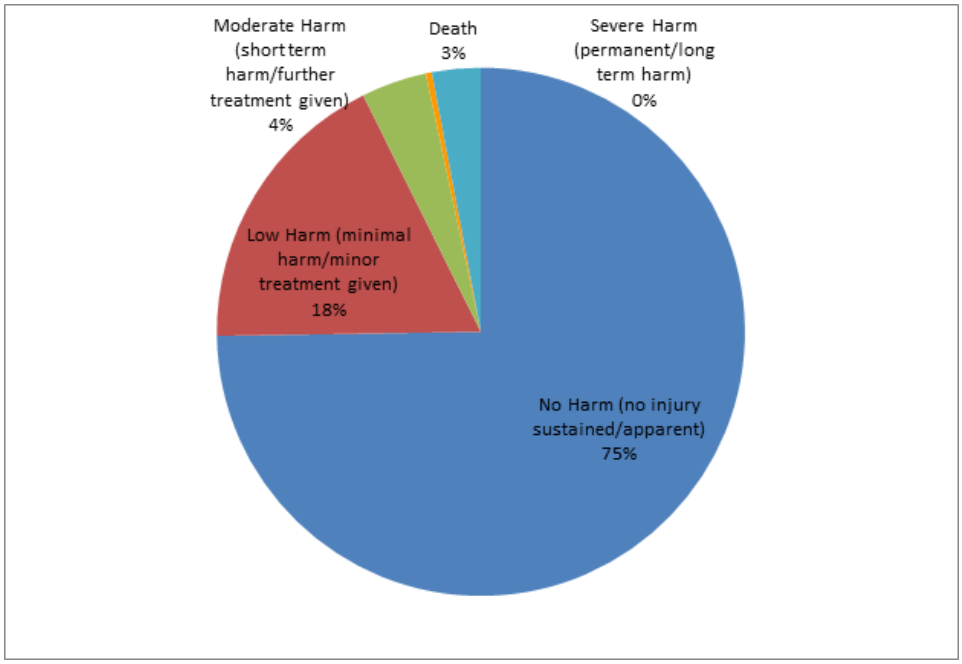


Chart 2: Incidents by Harm by Quarter 2, 2018/19



2.4. The area with the largest increase in reported incident was in the 136 Suites (60%). The summer saw exceptionally high demands on our Section 136 suites and changes in the Policing and Crime Act was one factor. Despite the positive impact of Street Triage large numbers of people were detained. However, high proportions were found to be intoxicated and did not need an acute admission. IGC received a paper relating to this change and, as a result, the risk of unlawful detention of service users in the place of safety was placed on the Trust Risk Register.

2.5. Hertfordshire Inpatients - Learning Disabilities reported 42% of the total number of incidents. The cohort of service users at Forest Lane is beginning to experience issues associated with ageing and frailty; there has been an increase in falls reported in this service which is discussed in more detail within the Slips Trips and Falls section of this report. There are also several service users displaying repetitive self-harm behaviours, and disruptive behaviour.

2.6. Incidents in Norfolk Services have decreased by 48% this quarter when compared with the same quarter in 2017/18; this is attributed to the discharge of one service user who accounted for a large number of violence & aggression incidents.

2.7. The largest increases were seen in the reporting of the following incident types:

- *Admission, discharge and transfer* issues (39%).
- Incidents reported under the category of *Environmental Safety* increased in quarter 2 2018/19 (141) when compared to the number reported in 2017/18 (103). These included the sub categories of: 'damage to NHS property requiring repair' and 'building too hot or cold'. Extremes of weather throughout the summer months account for this increase.
- *Security* (23%) There were a number of incidents related to restricted items being found in grounds/on premises. The implementation of search equipment, particularly the Pro Screen 200, a walk through metal detector to detect prohibited items with the least restrictive outcome is being planned for implementation.

It should be noted that all of the above categories have relatively low numbers of incidents overall.

3. Duty of Candour

3.1. The Trust's Duty of Candour policy sets out the requirement to meet the Statutory Duty and this is assessed through the quality schedule. It is a requirement for reviewers to attempt to make contact with the service user or the family to inform the review process.

3.2. A copy of the serious incident report is always shared in full. Where the family has engaged, they receive a copy of the report and the Trust ensures the report is shared ahead of inquests. Investigators meet with families in a number of cases but this is not always something the family wants. At inquest our representative always approaches the family to offer condolences and answer any questions the family may have. We have examples of families getting involved in suicide prevention work following the death of a service user. The Trust has been asked to draft guidance about engaging with families at inquests for the Mental Health Forum.

3.3. The Trust is committed to obtaining, listening and ensuring that feedback from bereaved families is shared with staff, included in our serious incident reports and informs local suicide prevention work streams. This feedback has highlighted the importance of gathering collateral information from families to inform the risk management plan, collaborative working and carer support.

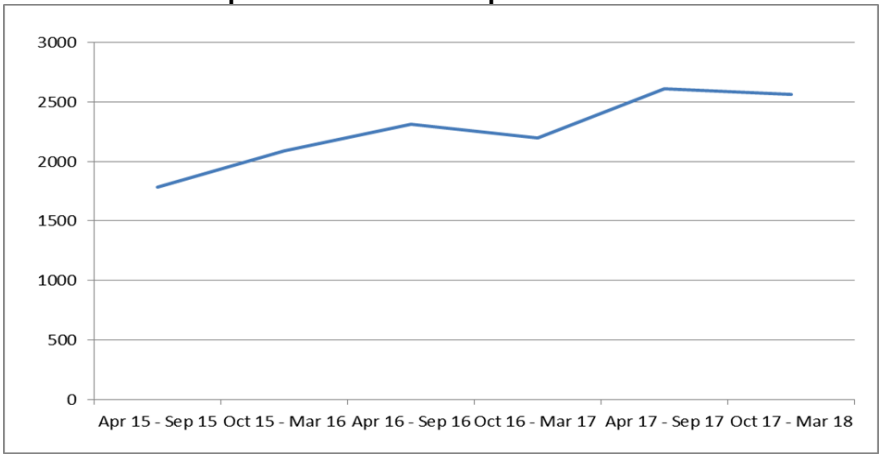
3.4. The National Quality Board for NHS Trusts, working with bereaved families and carers: Learning from Deaths (July 2018) has been benchmarked this quarter against the current Trust policies and practices.

4. National Reporting and Learning System (NRLS) Benchmarking Data

4.1. The Trust reports patient safety incidents to the National Reporting and Learning System (NRLS) in accordance with the national guidance. The latest release of the Organisational Patient Safety Incident Report data for NHS organisations was published on 26th September 2018 and provides information about incident data reported between 1t October 2017 and 31 March 2018 and comparisons with national trends [chart 3].

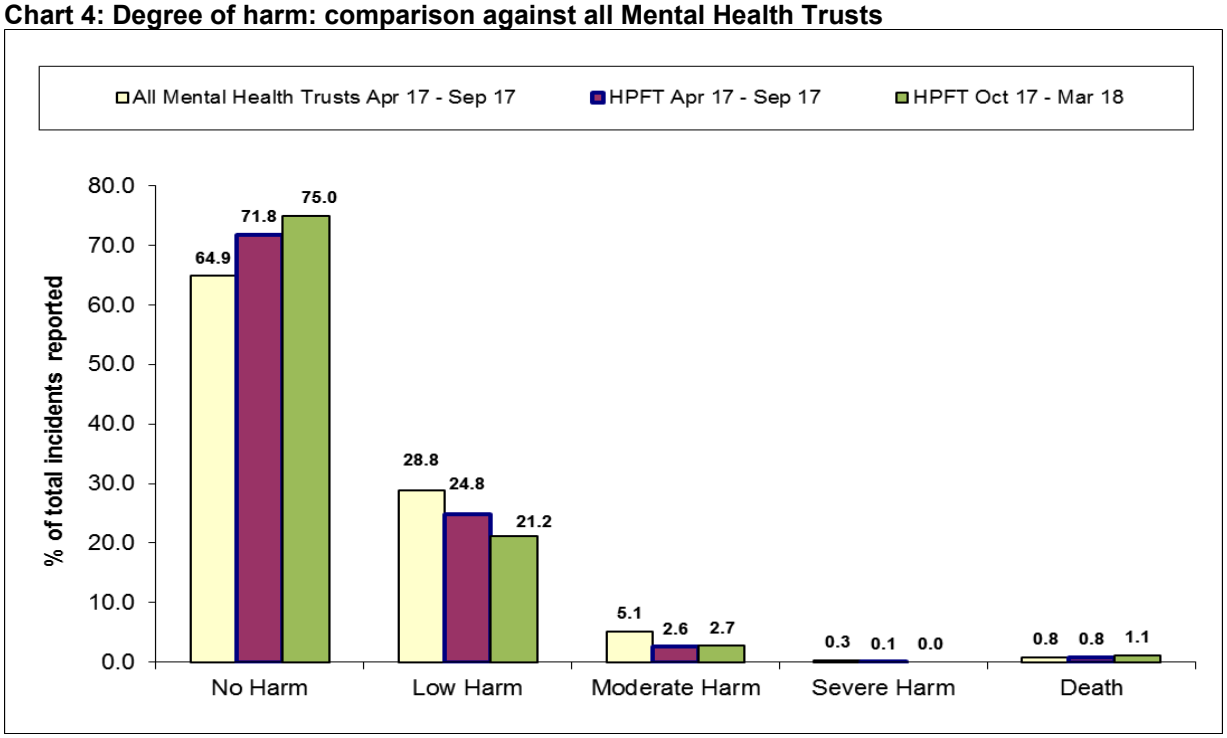
4.2. The number of incidents reported nationally to the NRLS is increasing each year, with 2.3% more incidents reported between October 2017 and March 2018 than between October 2016 and March 2017. In Mental Health, there was a 6.1% increase in the number of incidents reported in this reporting period. The continual increase in incidents reported to the NRLS over time indicates a constantly improving reporting culture.

Chart 3: Number of incidents reported to NRLS 1st April 2015 to 31st March 2018



4.3. The Trust has reported a lower level of harm between October 2017 and March 2018 compared with the previous six months [chart 4]. In comparison to all mental health Trusts, the Trust has a lower than average reporting rate of moderate harm incidents. The moderate harm panel is in place to review incidents and ensure they are reported consistently and investigated appropriately.

Chart 4: Degree of harm: comparison against all Mental Health Trusts



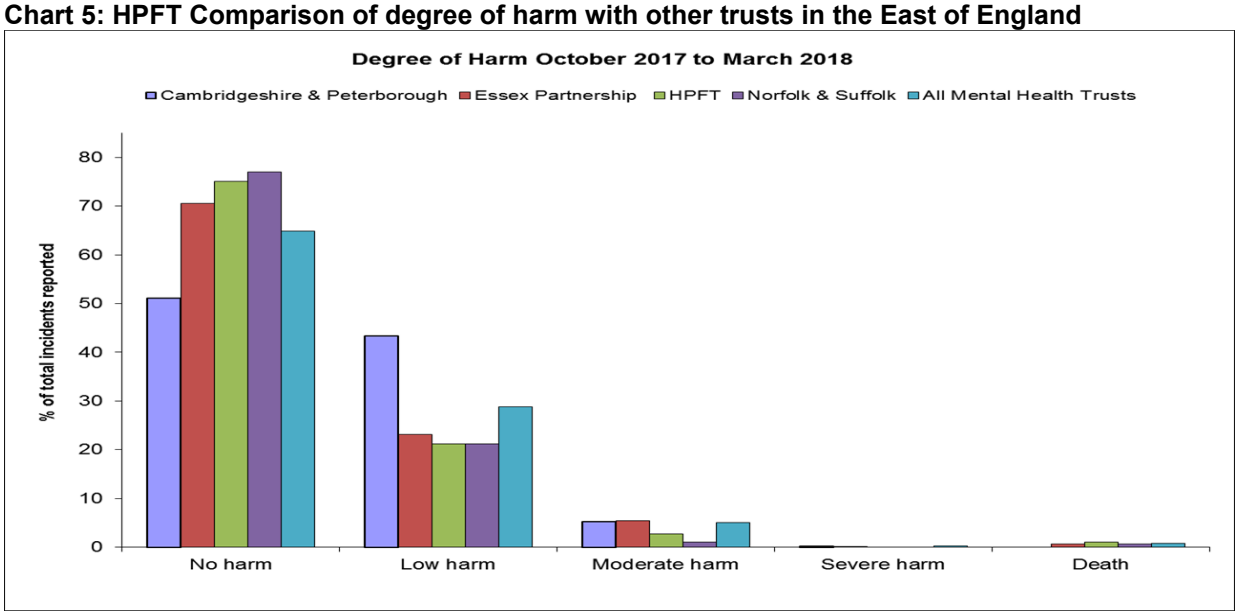
4.4. It can be seen that although reported incidents have increased in the latest 12 month reporting period (1st April 2017- 21st March 2018) to the National Reporting and Learning System (NRLS), there is a ratio of 75% of no harm compared to a benchmark against other mental health trusts of 65%.

4.5. There has been a slight decrease in the ratio of HPFT patient safety incidents resulting in severe harm to service users, (0.1% to 0%); no severe harm patient safety incidents reported to NRLS between 1st October 2017 and 31st March 2018. The proportion relating to service user deaths has risen 0.8% to 1.1%, with 9 more deaths reported in the latest reporting period.

4.6. Reported incidents are subject to a quality assurance review to ensure incidents have been appropriately graded. Then, moderate and severe harm incidents as well as unexpected deaths are discussed weekly at the Moderate Harm Panel.

4.7. When the Trust is compared with the other mental health trusts in the East of England the data demonstrates a good reporting culture in relation to reporting of no harm incidents, ensuring lessons are learnt even when there is no adverse outcome [chart 5].

Chart 5: HPFT Comparison of degree of harm with other trusts in the East of England



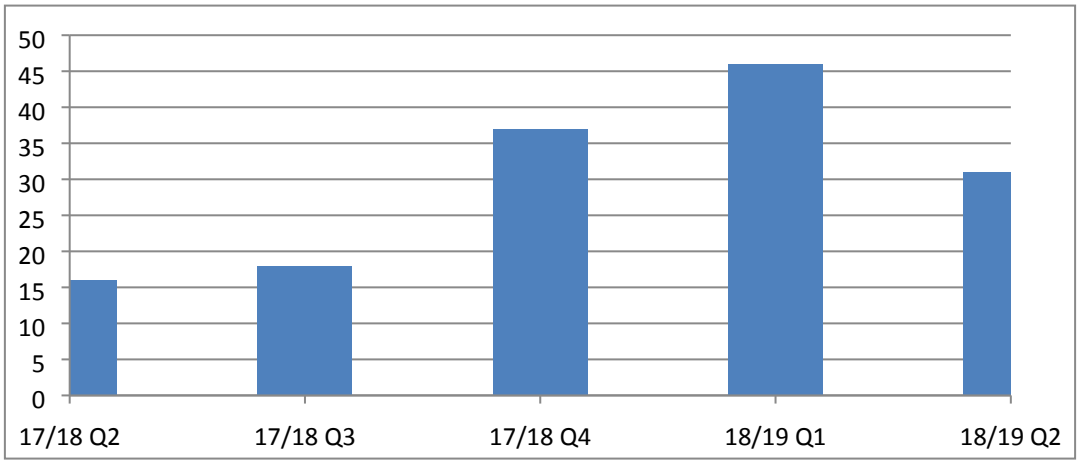
4.8. NHS Improvement is currently developing a new data collection system to replace the NRLS, and the Serious Incident reporting system (StEIS), called DPSIMS. The Safer Care Team, on behalf of the Trust, has been proactive in user engagement forums and feedback sessions, and has expressed interest in the Trust being a pilot site.

5. Serious Incident Overview

5.1. 'Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified' (*Serious Incident Framework 2015)*. The Trust awaits the publication of the updated Serious Incident Framework expected later this year following the consultation which ended in July 2018. The Board will be briefed on the outcome, implications and Trust plans for implementation at that time.

5.2. Serious Incidents are reported externally via the national Strategic Executive Information System (StEIS) and a total of 31 Serious Incidents in Quarter 2 2018/19 compared to 16 in the same Quarter in 2017/18. It is noted that there was an increase in the number of serious incidents reported in the previous three Quarters [Chart 6].

Chart 6: Serious Incidents by Reported Date, comparing 2016/17 to 2017/18



5.3. When the serious incidents are broken down by category [Table 1], apparent/actual/suspected self-inflicted harm and disruptive/aggressive/violent behaviour are the areas with the largest increases in reporting of serious incidents over the specific time period. This will be discussed in more detail later in the report.

5.4. The implementation of the Moderate Harm Review Panel considers opportunities to learn, reflect and inform clinical practice. A deep dive of self-harm and unexpected deaths reported as serious incidents in the last six months has been completed and will be reported on in the Quarter 3 Safety Report.

Table 1: Serious Incidents reported in Quarter 2 2017/18 and 2018/19 by StEIS category

Category	Q2 2017/18	Q2 2018/19
Unexpected/avoidable deaths	10	20
Apparent/actual/suspected self-inflicted harm	3	3
Disruptive/aggressive/ violent behaviour	1	3
Slip/trip/fall	1	2
Unauthorised absence	0	1
Apparent/actual/suspected homicide	0	1
Mental Health Act paperwork	0	1
Medication incident	1	0

6. Identification and Investigation Process improvements

6.1. The Serious Incident process has been developed into a Quality Improvement Project, with 3 workshops completed. Outcomes of this has been development of a reviewer checklist setting out key milestones in the serious incident reporting process with the aim of improving timeliness of the SI process.

6.2. Due to the increase in the number of serious incidents reported, the allocation of investigating leads remains a challenge. A recovery plan is in place, which is demonstrating an improved picture. Also additional Root Case Analysis investigation training was delivered in quarter 2 18/19 to increase the number of staff trained. Further training sessions are booked for December 2018 and February 2019.

6.3. A Masterclass about how to complete a 72 hour fact find report was delivered to CAMHS staff in Quarter 2 with the aim of improving quality and an improved understanding of their purpose as set out in the Serious Incident Framework.

7. Suicide Data and Suicide Prevention

7.1. The Trust is a member of the Zero Suicide Alliance and set the objective in the Annual Plan 2017/18 to reduce the number of suicides of service users open to Trust services or discharged in the last 12 months by 10%.

7.2. A 10% reduction would be no more than 32 Suicide or Open Conclusions recorded by HM Coroners in the year when compared with the previous reporting year. At the end of 2017/18 it was clear that the Trust was not going to achieve this. There remain inquests still to be heard for last financial year. At present there have been recorded 27 suicides and 1 open verdict and there are 9 still to be heard.

7.3. Q2, 2018/19 has seen an increase in the number of deaths that are suspected may receive a suicide conclusion with 20 unexpected deaths, 13 suspected to be suicide and 5 with an unknown cause of death. One of the deaths was recently been confirmed as a natural cause of death following post mortem examination, and one has received a Suicide conclusion at inquest already.

7.4. The National data 2005/6 to 2016/17 enables a longitudinal view [chart 7 and 8] from 2005 to date, considering both Suicide and Open conclusions received in deaths which were reported as Serious Incidents. All inquests have been concluded from 2005/06 to 2016/17 and therefore the final data is accurate. There remain inquests still to be heard for 2016/17 and 2017/18; therefore at the time of this report these bars do not contain a complete data set.

7.5. The data shows an upward trend in recent years for the Trust but does not show this as a ratio against the number of service users being seen in the Trust, which has risen significantly.

Chart 7: Suicide/Open Conclusions by Incident Date (April 2005 – September 2018)

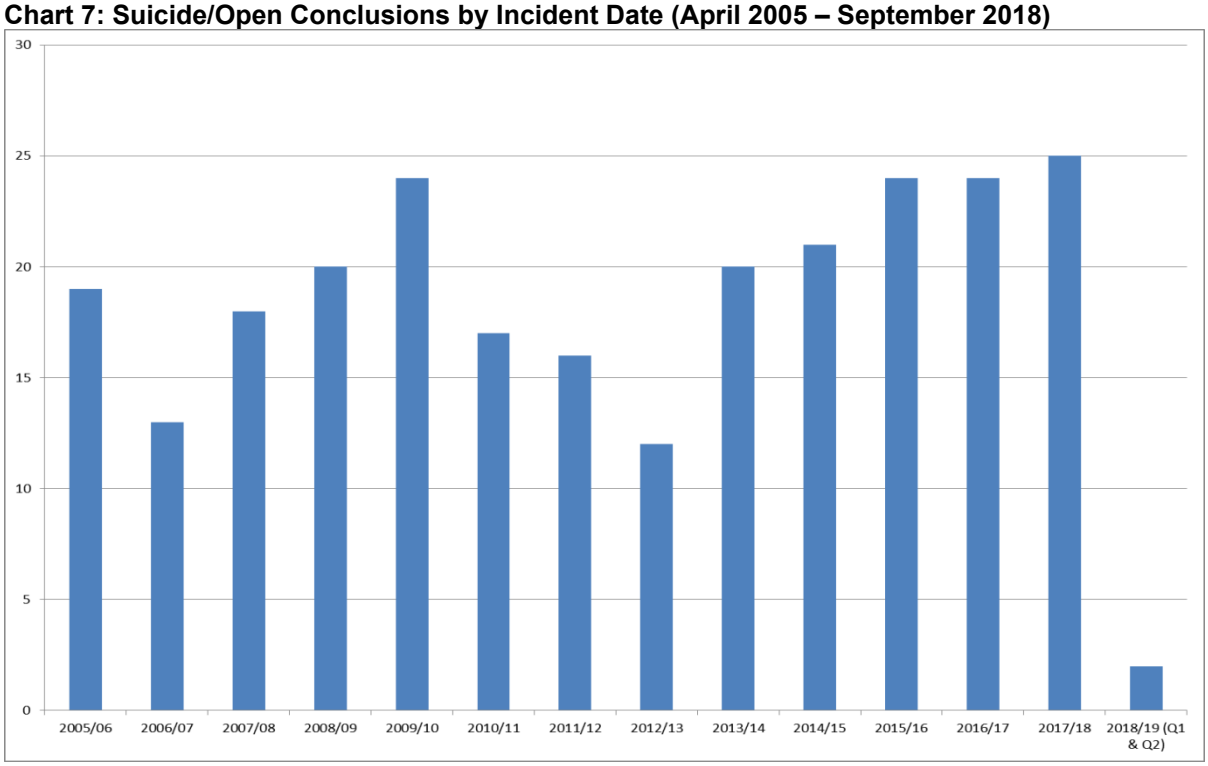
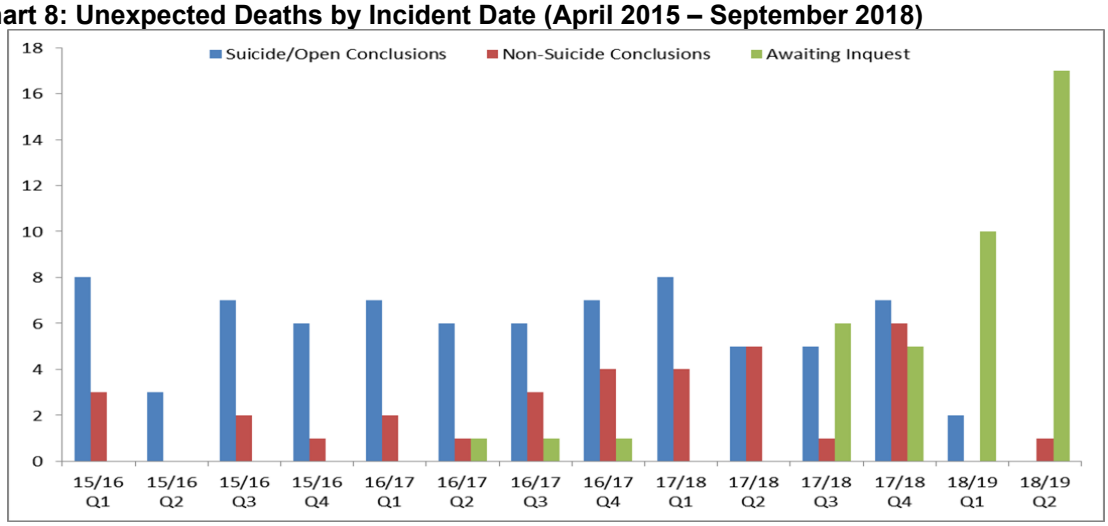


Chart 8: Unexpected Deaths by Incident Date (April 2015 – September 2018)



7.6. The Trust recognises that every suicide is one too many and the impact on the family, staff, first responders, friends and the wider community cannot be underestimated. The Trust attended the Suicide Bereavement Conference in October 2018 where those with lived experience of suicide shared their stories of the long lasting impact of suicide on those left behind. The Trust awaits the publication of the National Suicide

Bereavement Survey to inform the Task and Finish Group for the Support of the Bereaved by Suicide. The Trust remains fully engaged in the Public Health Hertfordshire Suicide Prevention Strategy with an aim that 'No-one in Hertfordshire feels that suicide is their only option'.

7.7. The Trust's internal Suicide Prevention Group continues to meet and has representation from all SBU's and primary care. On 26th October 2018 the group was presented with the key findings of a Trust wide self-harm audit, a risk assessment audit undertaken in the East & North quadrant and a deep dive of unexpected deaths and self-harm incidents reported as serious incidents between 1st January and 30th June 2018. One of the outcomes is that an education group is being set up to undertake a clinical risk assessment training needs analysis. A suicide prevention awareness week is planned.

8. Mortality governance

8.1. The Board has previously received a paper outlining the processes that have been put in place and IGC has received a detailed report about this. This report will focus on the work that has been undertaken and the resultant learning.

8.2. The Trust participated, as the only mental health Trust, in the Eastern Academic Health Science Network. This has provided a good opportunity to share learning.

8.3. The mortality governance team is involved on behalf of the Trust in a Public Health led audit of Herts Coroner's Office records to gather intelligence regarding deaths recorded as suicide in Hertfordshire to inform the Hertfordshire Suicide Prevention Strategy work streams.

8.4. The Royal College of Psychiatry's pilot of reviewing deaths through SJR has now concluded. The SJR pilot will inform National Guidance and the trust policy 'Learning from Deaths Policy' and will be updated once this guidance is available.

8.5. Structured judgment reviews (SJRs) take place when: a family member raises concerns about the care received by their loved one; or where the Mortality Governance group or other staff member feels that further clinical review is needed to due to the nature of death; or if they have a RCPsych red flag such as current or recent mental health in-patient. SJRs allow identification of both good practice as well as where improvement needs to be made. Suitably anonymised learning where appropriate may be shared with individuals or teams; including learning around themes, shared with treating and other teams across the Trust, and beyond. All learning disability deaths in HPFT continue to be reported to the LeDer programme.

8.6. An initial screening by clinicians allows for those deaths requiring further discussion or a possible structured Judgement review to have the appropriate time allocated at the Mortality Governance Meeting for a rich multi-professional discussion. All deaths are categorised.

8.7. Learning from deaths is the key purpose of the Mortality Governance process. Over quarter two the Mortality Governance Group has reviewed deaths, SJRs have taken place, LeDeR has continued and a deep dive has taken place. These have identified some areas of learning which are being taken forward in quarters 3 and 4.

9. Never Events

9.1. The revised *Never Events Framework* January 2018 defines Never Events as 'Serious Incidents that are wholly preventable because guidance or safety recommendations

that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'.

9.2. In quarter 2, 2018/19 the Trust had no incidents meeting criteria for reporting as Never Events. The Trust awaits the alignment of the revised Never Events framework and the new Serious Incident framework due to be published later in 2018 to consider any change in practice or revisions required to the Trust's Incident & Serious Incident Reporting Policy.

10. Conclusion

10.1. The moderate harm panel is now well established and has had a positive impact on ensuring the appropriateness of reporting incidents as well as sharing and embedding learning. Trust continues to report incidents and has maintained the level of reporting, particularly where no harm was sustained, but seen a decrease in the number of serious incidents reports in quarter 2. The most frequently reported incidents were related to challenges at admission, discharge and transfer, environments being damaged and restricted items being found.

10.2. There has been an increase in the number of unexpected deaths that may be a suicide. The Trust continues to be actively involved in the local and National work relating to suicide prevention. The mortality governance work has identified areas of learning that will be taken forward in quarters 3 and 4.

PART THREE- REDUCTION of HARM and LEARNING FROM INCIDENTS

1. Introduction

1.1. The Trust embraces opportunities to learn, reflect and act on intelligence from incident, serious incident, safety and mortality data. The Trust's Safety Committee oversees safety related data and existing work streams alongside the work of the Health Safety & Security Committee, the Safeguarding Strategy Committee, the Physical Health Committee and the Trust Management Group. The safety Committee reports to the Quality Risk Management Committee which reports to the Integrated Governance Committee.

1.2. This section will initially detail what learning has taken place, through the work detailed in previous section, in quarter two with specific focus on areas that have been identified as priority areas. The report will give further analysis of these areas of work and how learning has been disseminated and embedded through the organisation.

2. Areas of learning

2.1. Key themes of learning identified from serious incident reviews completed in quarter 2 were:

- Importance of considering the impact of chronic pain on mental state in the care and risk management plan
- Contact with carers as part of routine work and having a conversation with service users about the Triangle of Care
- Joined up approach from different agencies including HPFT and sharing of risk information between
- Risk assessment to be informed by gathering of collateral information
- Impact of own sexuality on a young person's mental state
- Formulating and communicating crisis/safety plans
- Involving service users, families, carers and other health professionals in risk assessment
- Joint working and communication with Drug and Alcohol agencies where there are co-morbidities

2.2. A key areas of learning from the mortality governance work in quarter 2 were

- Physical health care. Specifically the consistent use of robust nutrition and hydration as well as weight management tools, increased governance in relation to the maintenance of equipment and out of hours provision of medical care in in patient settings.
- Documentation. Decision making clearly recorded in supervision and clinical records and more emphasis on goal directed out patient care.
- Risk assessments and crisis plans. Consistently high quality risk assessments, improved joint working with partner agencies and carers, sharing risk assessments as well as the formulation and communication of crisis plans.
- Did not attend and cancellations management.

3. Embedding learning

3.1. Learning is discussed and shared at the Safety Committee and then in local Patient Safety Forums in each of the Strategic Business Units where decision are made about the appropriate method of spreading learning. Learning notes have been developed that give a quick and focused overview of learning in the Trust.

3.2. In quarter 2 a team leader in Older People's services presented a reflective learning account to the Safety Committee about learning from two Grade 3 pressure ulcers

that were reported as serious incidents and how this had informed clinical practice. This enabled learning to be shared across the trust.

3.3. Learning and reflection is further supported by Schwartz Rounds, case study presentations, and reflective learning sessions. Post Incident Huddles (SWARM) commenced in quarter 2, 2018/19 and have been held in 8 teams to aid opportunities to learn and take timely actions where required. Staff support is also offered by trained facilities to teams affected by critical or serious incidents.

3.4. Reflective learning sessions are held following completion of the serious incident investigation to share a summary of the key findings with the team and engage them in the learning. GP's and staff from other agencies are also invited to these sessions.

3.5. The Trust continues to support a bereaved family who lost their only son to suicide. The family have attended a recent suicide prevention workshop to share their lived experience and to guide thinking on the suicide prevention work streams in Hertfordshire.

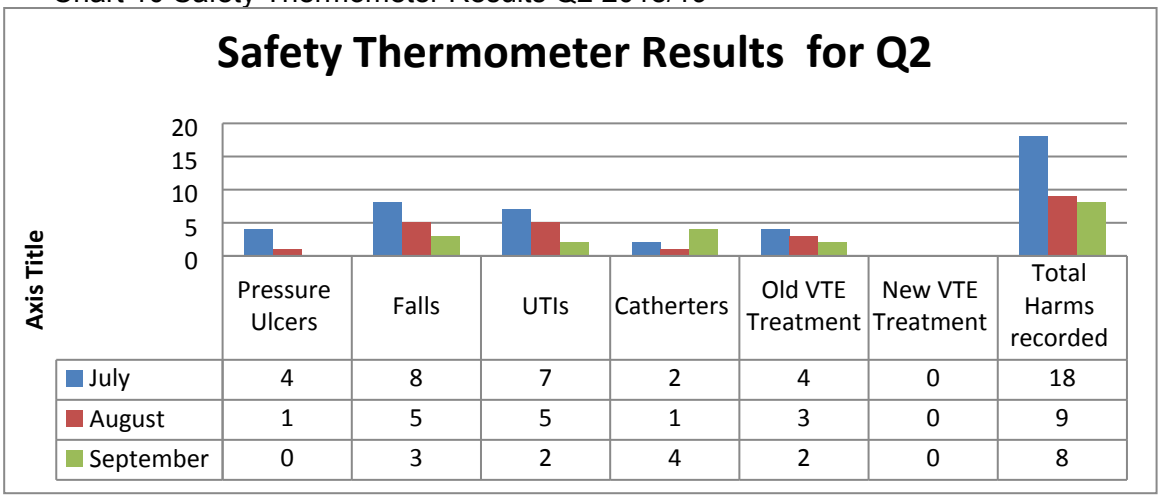
4. Safety Thermometer

4.1. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care at a single point in time. The tool measures five high-volume service user safety issues.

4.2. The Trust collects data from Older Inpatient & Community Teams and Learning Disability Inpatient & Community Teams. In Q2 there were 35 harms recorded on the day of submission [chart 10].

- Of the 6 reported pressure ulcers 2 developed 72 hours or more after admission. All 6 were reported as category 2.
- Of the falls reported these resulted in no or low harm
- Of the Urinary Tract Infections (UTI) 13 were new and 1 were old in that treatment or diagnosis was started before admission.
- There were 11 recorded incidents of service users on Treatment for Venous Thromboembolism (VTE) prophylaxis, 3 were identified as old as treatment for DVT started before admission to our Trust, 2 resulted in no VTE, 1 was identified as old as treatment for PE started before admission and the remaining 5 were recorded as 'other'.
- 7 were identified as high risk following a VTE assessment and prophylaxis was started.

Chart 10 Safety Thermometer Results Q2 2018/19



	Pressure Ulcers	Falls	UTIs	Catherters	Old VTE Treatment	New VTE Treatment	Total Harms recorded
July	4	8	7	2	4	0	18
August	1	5	5	1	3	0	9
September	0	3	2	4	2	0	8

5. Focus on pressure ulcers acquired in care

5.1. In Quarter 2 2018/2019 the Trust had two pressure ulcers acquired in our care and three service users came into the Trust with pressure ulcers. In the same Quarter last year 2017/2018, the Trust had four pressure ulcer acquired in our care and five service user came into the Trust with pressure ulcers.

5.2. In July 2018 there was one unavoidable category 2 pressure ulcer acquired in the Trust, in Older People's service (continuing care). The service user was unable to mobilise, and due to his condition, very restless, which made him at risk of a pressure ulcer, which he acquired on his large toe.

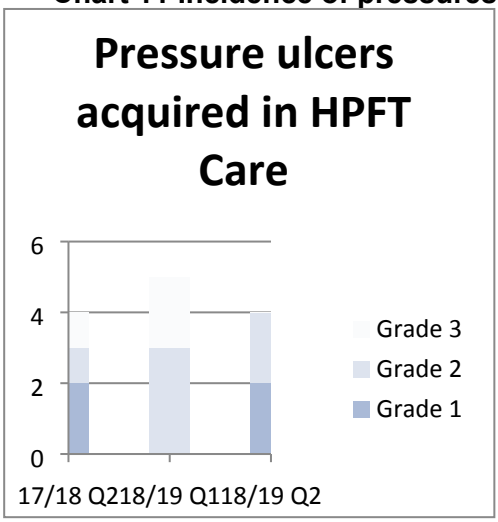
5.3. In August 2018 there were three service users with pressure ulcers that came into the Trust. Two service users from Older People's services had become acutely unwell and were admitted to general hospital. On return back to the ward the service users had category 3 pressure ulcers. Liaison took place been the Trusts Tissue Viability Nurse and the hospital Tissue Viability Team, to ensure an investigation was carried out by the hospital into causation and lack of information on discharge letters.

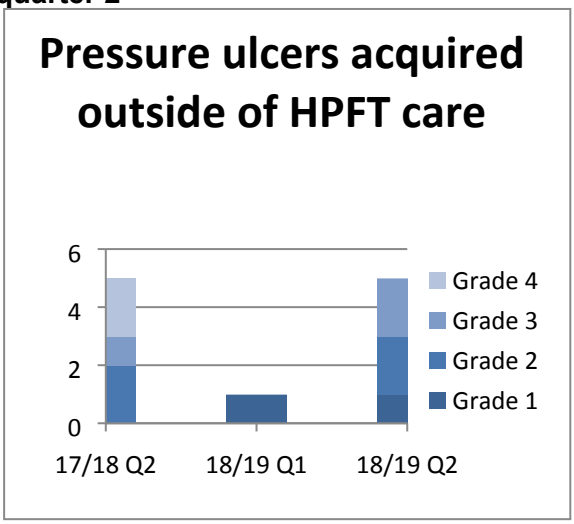
5.4. The Trust had a service user with category 2 pressure ulcer admitted from home into Older People's services for assessment and treatment. The Trust had no pressure ulcers acquired in our care during August 2018 which is noteworthy.

5.5. In September 2018 there was one category 2 pressure ulcer acquired in our care, in older people service (assessment and treatment); this was due to ill-fitting shoes. Two service users came into the Trust in 2017 with category 4 and category 2 pressure ulcers, none admitted from outside of the Trust in September 2018.

5.6. There is a theme of service users being admitted with pressure ulcers from various services. New guidance that was published in draft in June 2018, leads trusts to work together to reduce pressure ulcers, not categorising as is now 'acquired' or 'not acquired' in our services. In quarter 3 an update on the final guidance will be discussed.

Chart 11 Incidence of pressures ulcers quarter 2





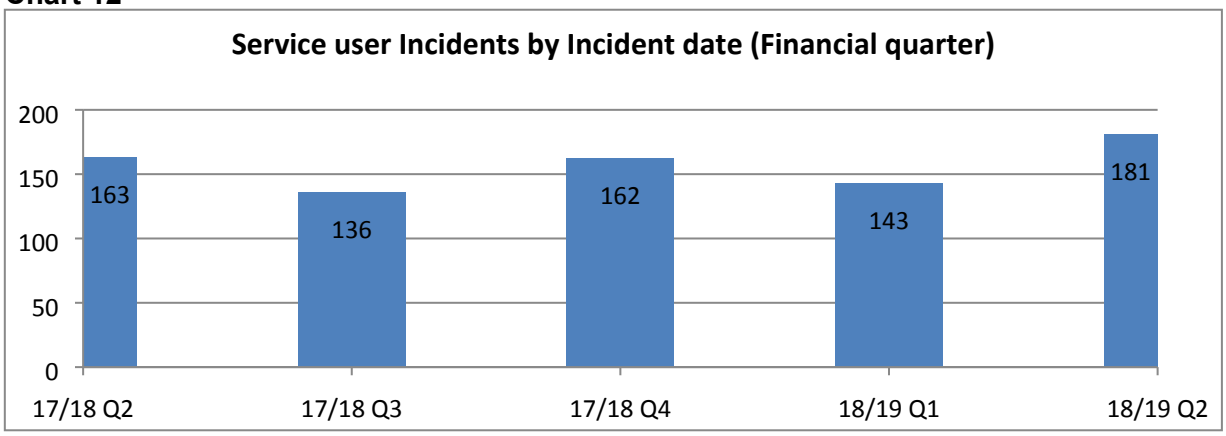
5.7. The tissue viability nurse initially provided training in pressure ulcer care and prevention only to Older People's services. This has been rolled out and continues to be delivered across all SBU's.

5.8. Whilst the number of pressure ulcers acquired in the Trust remains low; our ambition is for zero. It should be noted that when the *NHS improvement Pressure ulcers: revised definition and measurement (June 2018)* is implemented, our figures are expected to increase as all pressure ulcers will be counted together, and there will be no separation between acquired outside of our care or in our care.

6. Focus on Slips, Trips and Falls

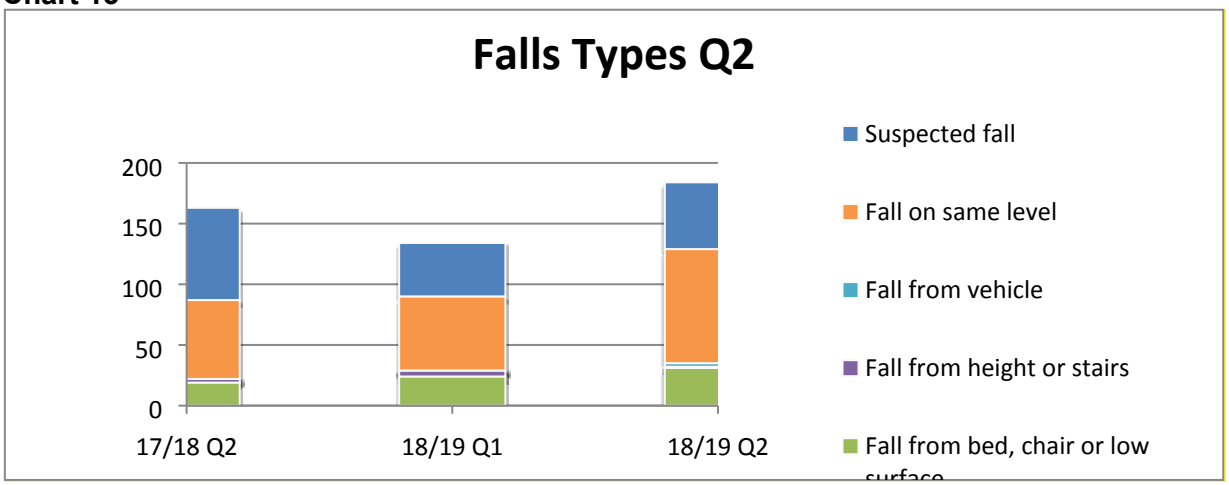
6.1. There has been an increase of 38 slips, trips and falls incidents reported in quarter 2 when compared to Quarter 1 2018/19 [chart 12]. Of the 181 service user incidents reported in quarter 2 95% resulted in no harm or low harm and 5% resulted in moderate harm.

Chart 12



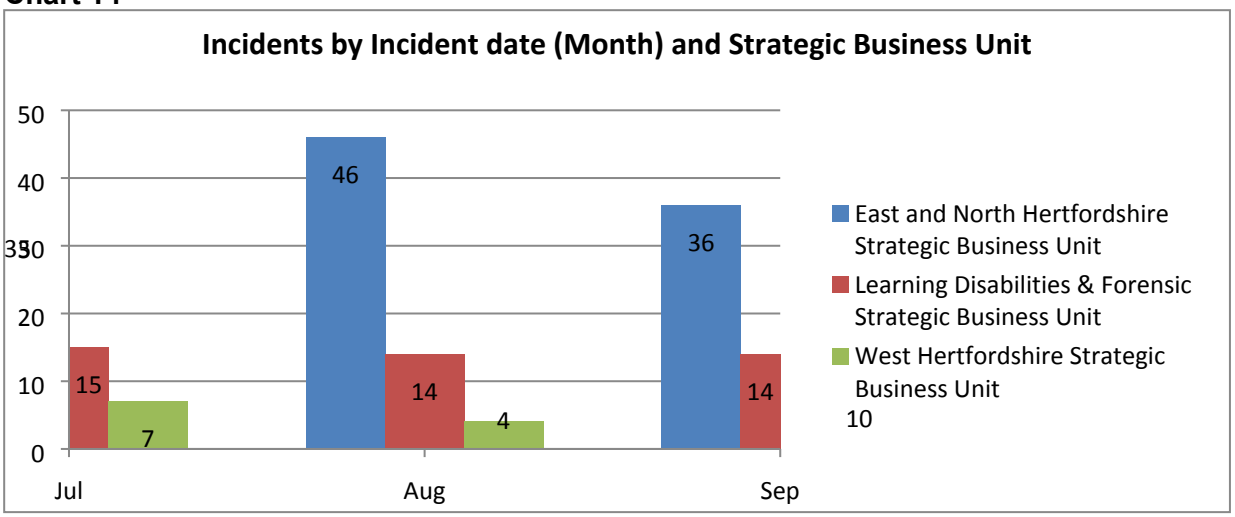
6.2. Falls on the same level (94) was the highest reported category of fall in Quarter 2 followed by suspected falls (55) and fall from bed, chair or low surface (31) [chart 13].

Chart 13



6.3. East and North SBU have Older People's Inpatient Services and are therefore highest reporters of slip trip and falls incidents in each month [chart 14] but work on falls prevention is taking place across the Trust.

Chart 14



6.4. In August 2018 the Trust Wide Inpatient Falls Audit was completed. The aim of the audit was to ensure staff in inpatient units across all SBU's are following best practice in relation to falls management and falls prevention. The audit sample was falls reported on Datix between January and June 2018. Key areas of focus arising from the audit which will inform the Falls Group work plan for 18/19 were:

- awareness of medication that increases falls risk;
- re-design of the falls risks assessment tool which will be trialled in three areas
- compliance with the post falls protocol.

6.5. As part of the ongoing incident follow up the units are asked to ensure a range of measures are put in place to help prevent further incidents from occurring. These include:

- Incident discussed at MDT
- Falls risk assessment is reviewed and updated
- Medication is reviewed
- Observation levels are reviewed and increased if necessary
- Additional environmental control measures are implemented. i.e. matting, different beds

6.6. In September 2018, the Trust held a falls week focusing on preventing falls in partnership with Hertfordshire Community Trust and Age UK, to spread key messages on how to prevent falls. Trainee nurses were able to try the frailty suit to find out what it might feel like to be frail and experience a loss of senses. A number of activities were held to raise the importance of preventing falls in all age groups, to highlight that falls can happen at all ages and the importance of supporting service users to remain active.

6.7. The team leader at Logandene spoke to staff about the work her team has been doing to improve practice by analysing causes of falls and the times falls are most likely to occur.

6.8. Falls prevention information such as clearing up spills quickly, removing any obstacles and making sure our service users are wearing sensible footwear or anti-slip socks was shared in HPFT Highlights. Training sessions were led by Occupational Therapists where the importance of keeping mobile was shared along with the latest news on equipment, medication, and nutrition.

7. Ligatures and Anchor Points

7.1. Ligatures and anchor points represent continue to be a focus for the Trust as they present an ongoing challenge faced by our clinical and front line staff.

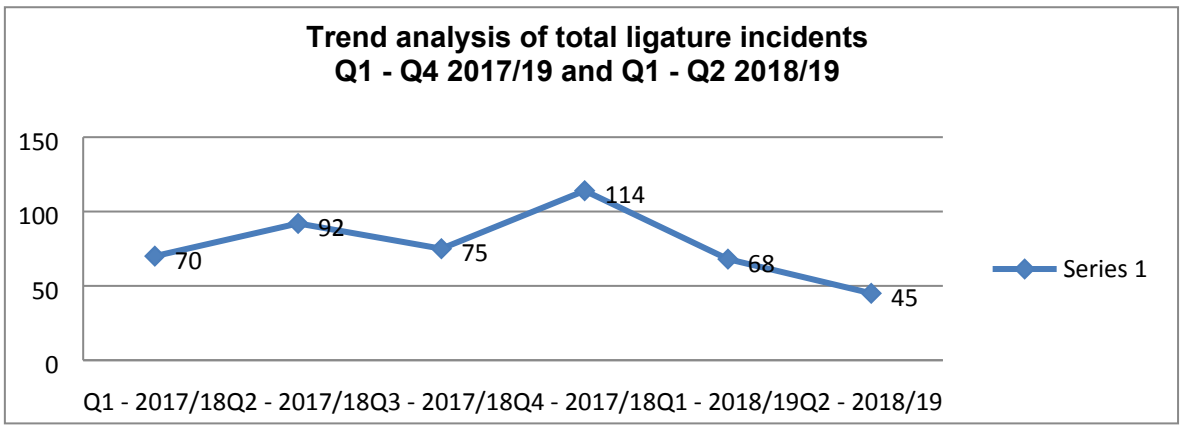
7.2. Comparing this quarter with quarter 2 in 2017/18 shows a reduction from 92 to 44 incidents (52% reduction). The highest reporting ligature type was clothing, followed by smaller items that are easier to hide on the person such as shoe laces and telephone cables [Table 4]. One possible rationale for the use of clothing may be due to a better understanding from the staff of prohibited and restricted items, and, as such these have been detected.

Table 4 provides details of the highest number of incidents in quarter 2, 2018/19.

	Bed sheets	Belt/cord	Cable	Clothing	Hair/head band	Head 'phones	Bag strap	Ribbon	Socks	Rope	Shoelace	String	Non-spec	Month
Jul	1	0	2	3	0	0	1	0	0	1	1	0	1	**10**
Aug	2	0	2	13	1	1	1	0	1	0	1	0	2	**24**
Sept	0	0	4	4	0	0	0	0	0	0	1	0	1	**10**
Total	**3**	**0**	**8**	**20**	**1**	**1**	**2**	**0**	**1**	**1**	**3**	**0**	**4**	**44**

7.3. The trends from 20178/19 (quarters 1 to 4) and into quarters 1 and 2 2018/19 [chart 15] shows total number of incidents categorised under 'ligatures' has declined after a sharp increase Q3-4.

Chart 15



7.4. Further exploration shows that 37% occurred in the evenings followed by 26% in afternoon. These findings reflect the national findings which are that incidents often in bedrooms and bathrooms and relate to high risk times, when staff maybe occupied by other activities.

7.5. The top reporting services for ligature incidents are the inpatient services at 86%, and of these, the highest were Swift, Robin and Aston wards.

7.6. Notably, there were no incidents reports in Forest House which was the highest reporter of incidents previously. Work has been focused in this service with changes to management of high risk service users who are likely to use ligatures, working alongside the introduction of the Home Treatment Team as part of the developed pathway. Conversely, there was an increased reporting of incidents in both Child and Adolescent Mental Health Services (CAMHS) Eating Disorder Clinics and Home Treatment Teams accounting for 7% of reported incidents.

7.7. A small number of service users were involved in incidents which accounted for 51% of all incidents, with the top 2 reporters being on Robin and Swift wards. These inpatient services have consistently reported higher levels of incidents, normally focused around a small numbers of complex service users.

7.8. During quarter 2, there was 1 reported anchor point incident, using a ripped towel jammed between the bedroom door and doorframe which took place on Swift ward Acute Assessment Unit. This was noted by a member of staff undertaking environmental observations. A previous learning note produced on the risks with doors was re-issued as a reminder to all service areas.

7.9. All ligature audits are being reviewed with the inclusion of photographs and maps to offer a visual check of risks and lines of sight. The use of the electronic ANT audit tool has been implemented across all inpatient service areas with an identified responsible person and identified back up person to ensure these are completed every week and submitted accordingly. All units are now receiving the weekly audit, with the initial technical issues being resolved.

8. AWOL or Missing Persons Incidents

8.1. These incidents relate to service users who leave the support of the service, resulting in a safety concerns, as follows:

- When formally detained
    - Leaving during escorted leave
    - Attempting to leave the unit
    - Absent without Leave (AWOL) (leaving the unit without agreement)
    - Failure to return from Section 17 leave
- When informal (missing person)
    - Attempting to leave
    - Not following the Managed Entry and Exit Procedure (MEEP)
    - Failing to return when informal
    - Missing from the community

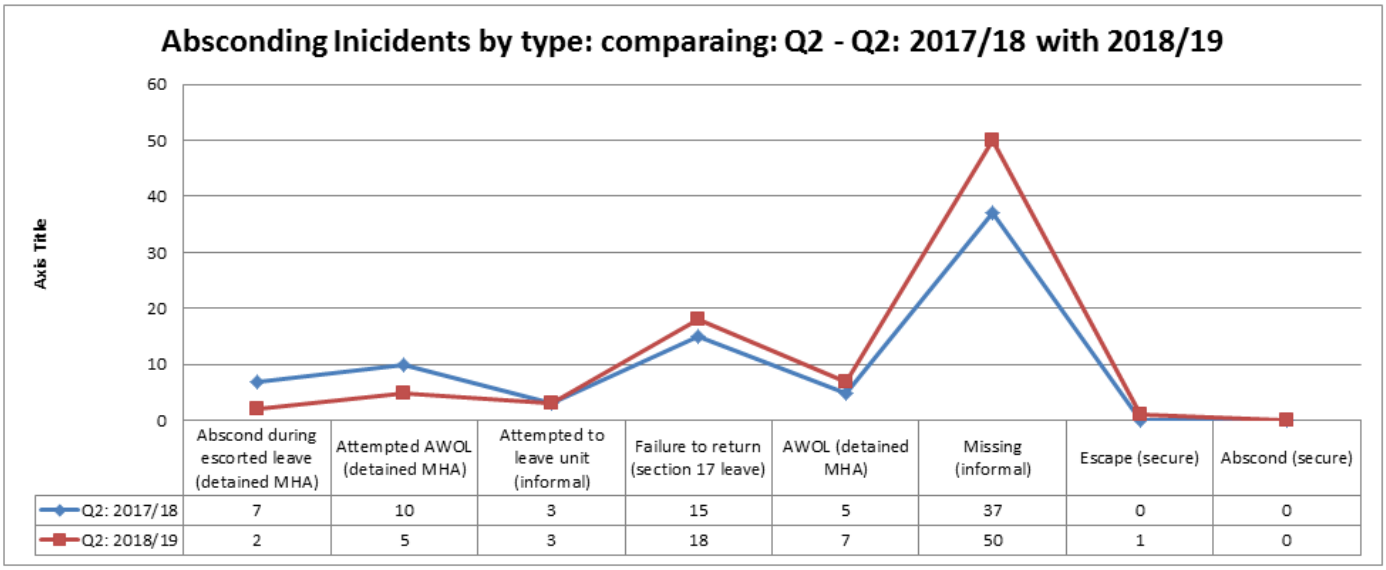
8.2. Analysis of the incident data for absconding behaviour comparing quarter 2 this year to quarter 2 last year [table 5 and chart 16] shows the overall number of incidents for all reported categories showed an increase of 9%.

8.3. Missing persons accounted for the majority increase, with community incidents accounting for the difference by 9 incidents (26%). Missing persons are always informal and are entitled to leave, unless significant concerns exist. It is important any concerns must be reported with consideration of assessment under the mental health act if there is an assessed risk.

Table 5

	Quarter 2 2017/18	Quarter 2 –2018/19
Community (missing persons)	11	20
Inpatient (missing persons)	26	30
Inpatients incidents	67	66
All incidents (9% increase)	78	87

Chart 16



	Abscond during escorted leave (detained MHA)	Attempted AWOL (detained MHA)	Attempted to leave unit (informal)	Failure to return (section 17 leave)	AWOL (detained MHA)	Missing (informal)	Escape (secure)	Abscond (secure)
Q2: 2017/18	7	10	3	15	5	37	0	0
Q2: 2018/19	2	5	3	18	7	50	1	0

8.4. This increase in the community is thought to relate to better reporting but requires further analysis to ensure that changes to service pathways, such as in CAMHS, has not had an impact. This will be reported in quarter three. To support this, guidance on reporting and recording missing persons has been issued to community services, to support decision making and recording of incidents.

8.5. The inpatient wards have shown an overall decrease by 1 incident (1.5%) when community events are removed, though reported AWOLs increased by 2 incidents in total. This related to AWOL and breech of perimeter security and damage to property. As a result, this has been reviewed with refurbishment or fixing to improve security, within the PICU Section 136 suite and Albany Lodge.

8.6. A review of the themes for (2018/19), where a safety concern was noted during one of the incidents, identified the following:

- Tailgating or breech of perimeter security = 12 (67%)
- Ground leave or issues relating to failure to return from leave = 5 (28%)
- Human error as leave status not communicated = 1 (5%)

9. <u>Violence and aggression</u>

9.1. Violence data refers to service user to service user assaults and service user to staff assaults [Tables 6 and 7]

Table 6

Service user to service user				
SBU	**East**	**West**	**LD&F**	**Total**
No Harm	19	26	13	**58**
Low Harm	16	10	8	**34**
Mod Harm	0	0	0	**0**
Sev Harm	0	0	0	**0**
Total	**35**	**36**	**21**	**92**

Table 7

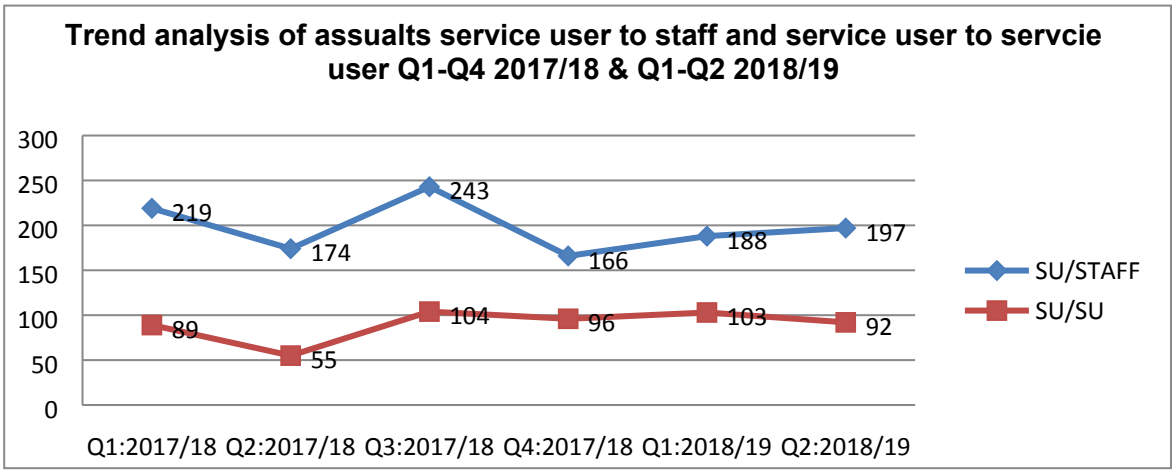
Service user to staff				
SBU	**East**	**West**	**LD&F**	**Total**
No Harm	15	36	54	**105**
Low Harm	26	11	43	**80**
Mod Harm	2	8	2	**12**
Sev Harm	0	0	0	**0**
Total	**43**	**55**	**99**	**197**

9.2. There has been an increase in service user to service user assault in both the East and North and the West SBUs, and a decrease in the Learning Disability and Forensic SBU. With regards to service user to staff assaults, again, only the learning disability and forensic SBU have a reported decrease.

9.3. Within the Learning Disability and Forensic SBU, there is a higher use of restrictive tertiary intervention such as seclusion and longer term segregation. This methodology of managing potential risks to others may impact on the overall figures regarding a reduction in both service user and staff assaults. A more detailed analysis will take place during quarter 3.

9.4. The trend shows [chart 18] over 6 quarters the total number of incidents categorised under service user to staff assaults and service user to service user assault have remained stable.

Chart 18



9.5. Further analysis was undertaken to understand what underlies this trend data in relation to the assault data. Service user to service user assault analysis shows the Q2 2017/18 with Q2 2018/19 comparison show:

- 169% increase in service user to service user data within East and North SBU
- 176% increase in West SBU
- 27% decrease in Learning Disability and Forensic SBU
- Overall increase of 67%

9.5. For the service user to staff assault, analysis shows the Q2 2017/18 with Q2 2018/19 comparison show:

- 59% increase in East and North SBU
- 37% increase in West SBU
- 7% decrease in Learning Disability and Forensic SBU
- Overall increase of 13%.

9.6. Further exploration found

- For service user to service user, 63% of reported incidents were no harm and 37% low harm.
- For service user to staff, 53% were of no harm sustained, 41% low harm and 6% moderate harm.
- There was an increase per 10 occupied bed days from 0.014 to 0.025 incidents of service user to service user assaults and 0.045 to 0.055 incidents of service user to staff assaults in quarter 2, compared to quarter 2 2017/18. There were no individual service users that contributed to any significant increase in the data. The spread was across services.
- The overall trend within quarter 2 regarding service user to service user assaults implies small increases across a larger number of units, which has led to the overall increase in the data.
- There were significant increases in service user to staff assaults in Lambourn Grove, Forest House and Robin ward which were due to individual service users, during quarter 2. This impacted on a 13% increase compared with the increase in quarter 2, 2017/18.

9.7. This has led to immediate action to ensure both our service users and our staff are safe. During quarter 3 the data considered and reviewed monthly and operational teams will be supported to develop actions that will address any areas of concern. This approach aims to be team focused with regards to increasing and expanding the skill sets, particularly around de-escalation.

9.8. Ongoing focused work on safety huddles in all inpatient services, overseen by the Clinical Directors will continue. The Practice Development and Patient Safety Team will lead on a review during quarter 3 to consider the progress made with the huddles and understand the impact and progress.

10. Feeling Safe

10.1. This quarter there has been a focus on young people feeling safe. There were 32 responses to the having your say questionnaire and 52% of young people reported feeling safe in Forest House. By comparison, this was 34% during quarter 1.

10.2. 90% of respondents in acute inpatient services indicated that they felt safe on our inpatient units against a target of 80% [table 8]. Within this group Albany Lodge (75%) and Robin ward (69%) were below the target. All other inpatient service areas were also above target with the exception of older people's services, although the number of responses was low. Work will be undertaken to increase the response rate.

Table 8 Scores for adult inpatient services

SBU	Service Line	Responses	Overall, have you felt safe on the ward?
East and North	Older Peoples' Services	3	50
Learning Disability and Forensics	Inpatient	25	88
	Forensic and Norfolk	27	96
	North Essex	1	100
West	Acute 24/7 services	164	90

11. Restrictive practice including seclusion

11.1. The actions that came from the external review that was commissioned to establish whether RESPECT provides training to meet service area needs has made progress during quarter 2. This was to develop an 'in-house' training model, developing training manuals of techniques in disengagement and teamwork skills in

consideration of the clinical challenges with the tutor group and subject matter experts.

11.2. A Task and Finish group has been established and has identified challenging situations where staff feel they do not have the confidence and/or competence to manage safely and effectively. The RESPECT training has been revised and further developed in consideration of the challenges identified by staff and also from the external review. This places an increased focus on practical scenarios relating to techniques and physical interventions as well as leadership, followership and human factors.

11.3. This revised training has been provided to Little Plumstead local trainers and sessions have been planned for October for the Oak staff team to address immediate actions and to consider future considerations.

11.4. In September 2018, key representation from the Trust attended a Senior Professional Leads meeting with NAVIGO Health and Social Care RESPECT Training Solutions regarding review and how the recommendations sit with the RESPECT approach. The feedback received was positive, with an understanding of the changing nature of health and social care services and the need to ensure training is developed to meet the complex health challenges faced. The Task and Finish Group are currently cross referencing the feedback and agreements received from NAVIGO with the listed challenging situations and to clarify any outstanding scenario's which require further consideration of management.

11.5. A briefing report is being produced to be presented to the Trust's Safety Committee to agree the future training provision with options for consideration.

11.6. At the time of the report, we are waiting for the final report for the external review of the Trust's Seclusion provision and practice, considering how as a Trust seclusion is managed across its services, being responsive to the service user, the service area and the environment.

11.7. The verbal response received noted positive feedback regarding each of the environments that were visited, the staff with whom the reviewers met and the team work. Also regarding the current techniques and content of the RESPECT, although there was a different understanding of restrictive practice across the services and some queries relating to Long Term Segregation.

11.8. Recommendations for the environment suggested consideration is made on the introduction of 'safe spaces' or 'comfort rooms'. Also to look at the introduction of a group to monitor clinical trends with the multi-disciplinary teams and ensure consistent medical reviews are held during as well as after seclusion.

11.9. Immediate action was taken in relation to the verbal feedback but once the formal report has been received these will be formalised and a paper will be presented to the Safety Committee to agree the actions for implementation.

12. <u>Safe and Supportive Observation</u>

12.1. The Safe Observation and engagement policy is in final draft and for consideration at the next Safety Committee. Key changes are personalisation of and clarity round standards for care planning. The policy identities the purpose of observations and the outcomes expected. The revised observation chart will introduce the need for more information of location of service users.

13. Conclusion

13.1. This report has identified a number of areas where evidence shows safety for our service users is improving and also areas where work is required. The data informs our learning and this can be seen in the response to areas of concern and re-focus of actions.

13.2. This quarter has seen a focus on the work relating to pressure ulcer and falls. There has been a reduction in non-anchor ligature incidents, particularly in Forest House where there has been a change of approach which involves the new Home Treatment Team. Forest House has also seen significant improvements in service users reported feeling safe. This improvement in service users reporting feeling safe has also been sustained in acute services. Further work will take place to increase the response rate in older adult services. AWOL and missing persons continue to be monitored and the improvements seen previously have been sustained.

13.3. A focused look at assault from service user to service user and service user to staff has revealed further areas to focus action including the increased scrutiny of incidents and trends with support from the practice development team. The review of the RESPECT training has been completed and now modules as well as a restrictive practice group have been developed to enable a swift response to new and challenging situations.

Appendix 1

Glossary and definitions of terms used in the report

- **Datix** – Incident reporting & safety learning system used by the Trust
- **Datix dashboards** – Real time visual representation of incident data
- **NRLS** – National Reporting & Learning System, a central database of patient safety incident reports, who analyse reported incidents to identify hazards, risks and opportunities to continuously improve the safety of patient care
- **Patient Safety Incidents (PSI)** – Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care (excluding harm caused in the community)
- **Organisational Patient Safety Incident Report** – Six-monthly statistical breakdown for NHS providers on patient safety incidents they have reported to the NRLS
- **Bed days** – The number of occupied beds as published by NHS England
- **Degree of Harm** – Severity of actual harm caused to, or impact on, patients from a particular incident (including injury, suffering, disability or death)
- **No Harm** – A patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care (near miss), or a patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care
- **Low Harm** – Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care
- **Moderate Harm** – Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care
- **Severe Harm** – Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons
- **Deaths reportable to NRLS** – Any unexpected or unintended incident that directly resulted in the death of one or more persons
- **LeDeR programme** – Learning Disabilities Mortality Review Programme delivered by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England. It requires providers of learning disabilities services to review the deaths of people with learning disabilities in their care, with the aim of making improvements to the lives of people with learning disabilities by working to ensure that potentially modifiable factors associated with a person's death are not repeated
- **StEIS** – Strategic Executive Information System, national system used by NHS Organisations to report serious incidents as defined in the National Serious Incident Framework, March 2015
- **Serious Incident** – Adverse events where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified
- **Never Events** – Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented
- **NCISH** – National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. As the UK's leading research programme in this field, the Inquiry produces a wide range of national reports, projects and papers – providing health professionals, policymakers, and service managers with the evidence and practical suggestions they need to effectively implement change.
- **ONS** – Office for National Statistics
- **Regulation 28 Prevention of Future Deaths Report** – Report issued by a Coroner on action to be taken by a named person or Organisation to prevent other deaths

Trust Board

Meeting Date:	29th November 2018	**Agenda Item: 9**
Subject:	Quarter 2 Safe Staffing Report	**For Publication:**
Author:	Jaya Hopkins, Head of Nursing, Norfolk Services Jacky Vincent, Deputy Director of Nursing and Quality	**Approved by:** Dr Jane Padmore, Executive Director, Quality & Safety/Chief Nurse
Presented by:	Dr Jane Padmore, Executive Director, Quality & Safety/Chief Nurse	

Purpose of the report:

This report provides the Board with a quarter 2 update on nurse staffing for the Trust. In addition, the report provides information that sets the context for the published data including recruitment, retention and vacancies of nursing staff and cross referenced with patient safety data.
The purpose of this report is to provide information and assurance of the governance processes for rostering and ensuring the appropriate level and skill mix of nursing staff.

Action required:

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

Summary and recommendations to the Board:

The direct care nurse staffing data was analysed according to total hours worked per ward for RN and HCA, divided into day and night time hours and includes additional duties. Quarter 2 showed adequate staffing and shift cover in response to unexpected demand and levels of acuity and dependency on the wards.
Thumbswood and Gainsford House were the only services with fill rates below 80% for RN and this was compensated with a higher HCA fill rate. There was also more actual hours than planned used for both RNs and HCAs across many services. The CHPPD analysis showed that small standalone units and wards with high acuity had high CHPPD.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

Staffing – there is a need for regular review of staffing establishment

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

n/a

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

Potentially all of the above

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

IGC 8th November 2018

1. **Introduction**

1.1. This report serves to provide the information and analysis of the quarter 2 nurse staffing data to enable the Board to have assurance in relation to the nurse staffing in the Trust's inpatient services. The report also includes data on nurse staffing in community services.

1.2. An expanded version of this report, which included PDP, Statutory and Mandatory Training and vacancy rates for each service area was received at IGC.

2. **Trust's Expectations in relation to in patient Nurse Staffing levels**

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

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

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

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

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

2.6. *SafeCare* is well embedded within all in-patient services with daily SafeCare calls held to ensure safe staffing and identifying any hotspots. This allows for effective use of our staffing resource across the Trust.

3. **Summary**

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

3.2. Care Hours Per Patient Day (CHPPD) data which became mandatory from quarter 1 is also being submitted. The details are included in **Appendix 1**.

3.3. There were two services with a fill rate below 80%; they were Thumbswood in July with a night RN fill rate of 79% and Gainsford House in August with a day RN fill rate of 79%. Both services had a higher fill rate of HCA to compensate for the shortfall in RN.

3.4. Overall, there was adequate staffing in all in-patient services and this is reflected in services users' report of 'feeling safe.' 90% of adults within acute, forensic and learning disabilities services reported as 'feeling safe'. In addition, 52% of young people also reported as 'feeling safe'.

3.5. Analysis of the CHPPD data shows that high acuity also increases CHPPD, for example Broadland Clinic in July where there were two new admissions.

3.6. Many services had used staffing above their establishment in quarter 2 to meet the clinical needs and demands of the services. For example, West SBU had high acuity levels which resulted in high levels of prescribed continuous safe and supportive observation. Their seclusion data showed a 50% increase from quarter 1 of 6 to quarter 2 of 12.

3.7. Robin and Swift wards also reported the highest number of ligature incidents for quarter 2.

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

3.9. The Trust is one of many Trusts nationally involved and contributing to the development of the Mental Health Model Hospital. The Trust has been involved in the development of key metrics for the MH model Hospital.

3.10. *SafeCare* is well embedded within all in-patient services with daily *SafeCare* call and weekly e-roster scrutiny meetings. This has also ensued effective use of the staffing resource.

3.11. As a result of this additional scrutiny, August 2018 showed a significant reduction in agency usage to compared to previous years, as detailed below:

- August 2015 1,634 shifts
- August 2016 1,735 shifts
- August 2017 1,954 shifts
- August 2018 1,160 shifts.

3.12. A significant risk remains for the Trust regarding the profile of HCA and RNs who are able to retire (total 310) (**table 1)**. Work continues to support them and explore their options to remain in the workforce.

Table 1: Nursing retirement profile

Area	**55-59**			**60-64**			**65+**		
	HCA	**RN**	**Total**	**HCA**	**RN**	**Total**	**HCA**	**RN**	**Total**
Learning Disability & Forensic SBU	41	27	68	11	12	23	4	6	10
East & North SBU	35	32	67	20	17	37	5	7	12
West SBU	23	31	54	15	15	30	5	4	9
Total	99	90	189	46	44	90	14	17	31

4. **Conclusion**

4.1. This report sets out to brief the Board in relation to the quarter 2 position for safe nurse staffing within inpatient services. The report also includes community nursing staffing and the vacancy rate.

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

4.3. *SafeCare* is embedded within all inpatient services with daily safe care call to ensure safe staffing and effective use of our staffing resources across the Trust.

4.4. The Trust continues to be involved in the development of the NHSI Mental Health Model Hospital initiative.

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

Appendix 1

Nurse Staffing fill rate data

July 2018

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	Cumulative count of s/u over the month at 23.59 each day	CHHPD RN	CHPPD HCA	Overall CHPPD
Learning Disability & Forensic SBU								
Sovereign House	100	101	100	99	168	4.4	4.4	8.8
Gainsford House	93	105	92	116	364	3.8	2.3	6.1
Hampden House	90	194	98	103	289	4.9	3.7	8.6
Warren Court	96	116	97	105	872	5.0	7.9	12.9
4 Bowlers	100	96	111	97	276	4.2	5.2	9.4
Beech	118	96	99	100	466	3.5	4.7	8.2
Dove	120	88	103	131	271	4.8	9.5	14.3
SRS	97	103	100	100	868	3.0	10.1	13.0
Lexden	104	105	97	136	140	10.8	24.6	35.4
Astley Court	93	172	101	149	230	4.6	10.2	14.8
Broadland Clinic	98	123	94	104	423	3.7	8.4	12.2
The Beacon	100	125	102	100	443	3.4	2.9	6.3
West SBU								
Swift	102	143	97	215	541	4.3	5.8	10.1
Robin	103	168	100	219	599	2.5	6.2	8.7
Owl	104	105	98	123	566	2.6	4.0	6.7
Oak	97	139	100	132	307	5.5	11.4	16.9
Thumbswood	98	102	148	79	121	7.9	11.2	19.1
Albany Lodge	107	112	103	135	741	2.5	4.2	6.7
Aston	100	169	106	169	607	2.9	6.3	9.2
East & North SBU								
Victoria Court	104	108	100	103	834	1.8	6.0	7.8
Forest House	97	136	98	251	416	3.5	9.3	12.7
Wren	100	105	100	137	458	3.2	6.1	9.3
Lambourn Grove	109	97	102	122	740	2.1	6.4	8.5
Logandene	104	101	101	113	475	3.2	7.1	10.3
Seward Lodge	97	92	99	180	472	3.0	7.2	10.3
The Stewarts	97	100	100	160	540	2.6	6.0	8.6

August 2018

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	Cumulative count of s/u over the month at 23.59 each day	CHHPD RN	CHPPD HCA	Overall CHPPD
Learning Disability & Forensic SBU								
Sovereign House	100	100	100	99.8	145	5.1	5.1	10.2
Gainsford House	79	138	94	113	365	3.5	2.6	6.1
Hampden House	96	170	98	103	320	4.6	3.2	7.8
Warren Court	88	115	100	101	874	3.4	7.1	10.5
4 Bowlers Green	97	94	103	95	279	4.1	5.0	9.1
Beech	110	97	97	103	465	3.3	4.8	8.1
Dove	109	97	103	148	286	4.3	9.4	13.7
SRS	91	102	100	100	868	2.9	10.0	12.8
Lexden	102	104	101	134	164	9.3	20.2	29.5
Astley Court	106	105	101	148	186	6.3	9.9	16.3
Broadland Clinic	94	97	88	103	419	3.6	12.0	15.6
The Beacon	101	103	100	123	438	3.4	2.8	6.2
West SBU								
Swift	98	121	96	205	504	4.5	5.6	10.1
Robin	95	202	98	245	536	2.6	7.0	9.6
Owl	101	113	97	151	565	2.6	4.6	7.2
Oak	92	120	100	106	280	6.0	10.6	16.6
Thumbswood	95	102	110	99	130	6.1	11.4	17.5
Albany Lodge	104	112	103	116	698	2.6	4.2	6.9
Aston	98	170	101	167	609	2.8	6.2	9.0
East & North SBU								
Victoria Court	95	114	100	131	840	1.7	6.7	8.4
Forest House	96	138	98	290	399	3.6	10.3	13.9
Wren	94	128	98	212	447	3.2	8.1	11.3
Lambourn Grove	127	89	103	112	744	2.3	5.8	8.1
Logandene	101	97	98	111	477	3.1	6.8	9.8
Seward Lodge	89	105	102	174	477	3.0	7.7	10.6
The Stewarts	82	100	98	153	496	2.7	6.4	9.1

September 2018

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	Cumulative count of s/u over the month at 23.59 each day	CHHPD RN	CHPPD HCA	Overall CHPPD
Learning Disability & Forensic SBU								
Sovereign House	101	101	100	100	144	5.0	5.0	10.0
Gainsford House	87	131	97	106	343	3.8	2.5	6.4
Hampden House	93	181	98	109	323	4.2	3.3	7.5
Warren Court	93	108	100	104	802	3.8	7.4	11.1
4 Bowlers	94	101	100	100	270	4.0	5.4	9.3
Beech	103	103	100	104	448	3.3	4.9	8.2
Dove	110	98	99	103	299	3.9	8.6	12.5
SRS	87	107	96	105	840	2.7	10.5	13.2
Lexden	119	107	97	153	203	7.8	17.5	25.3
Astley Court	92	141	99	149	166	6.2	12.3	18.5
Broadland Clinic	96	97	98	104	433	3.4	10.8	14.2
The Beacon	95	104	98	103	444	3.2	2.5	5.7
West SBU								
Swift	96	158	92	208	529	4.0	5.8	9.8
Robin	104	168	101	230	555	2.6	6.3	8.9
Owl	103	127	100	158	570	2.5	4.8	7.3
Oak	91	119	98	102	302	5.2	9.4	14.5
Thumbswood	109	103	103	119	104	7.7	15.2	22.9
Albany Lodge	107	120	100	114	728	2.5	4.0	6.4
Aston	102	158	98	138	607	2.8	5.4	8.2
East & North SBU								
Victoria Court	96	107	98	124	821	1.7	6.2	7.9
Forest House	110	98	99	103	375	3.1	6.8	9.9
Wren	97	107	98	159	476	2.9	5.9	8.9
Lambourn Grove	104	97	97	100	718	2.0	6.1	8.1
Logandene	94	93	98	102	429	3.2	6.9	10.1
Seward Lodge	96	99	98	181	439	3.1	7.9	11.1
The Stewarts	95	99	100	145	442	3.2	6.9	10.0

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	29th November 2018	**Agenda Item: 10**
Subject:	Report from Finance & Investment Committee – 13 November 2018	**For Publication: Yes**
Author:	Simon Barter, NED Chair - FIC	**Approved by:**
Presented by:	Simon Barter, NED Chair - FIC	

Purpose of the report:

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

Action required:

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

Summary and recommendations to the Board:

The Agenda for the 13 November Finance & Investment Committee meeting covered:

- Deep Dive – Productivity & Effectiveness
- Business Development Update
  - (a) Essex LD Contract – Commercial Close
  - (b) Commercial Development Activity
- 2019/20 Planning
- Renegotiation Herts Contract 2019/20
- Strategic Investment Programme – forward Plan
- STP – Medium Term Financial Sustainability Plan
- Performance Report - Q2 2018/19
- Financial Summary 2018/19 – Q2 and October forecast
- Capital Expenditure Summary
- The Colonnades – Lease Renewal
- Draft FIC Business Programme 2019

Deep Dive – Productivity & Effectiveness

FIC received a presentation setting out HPFT's framework for our approach to productivity and effectiveness, how this fits with the organisation's Good to Great strategy and planned next steps. The approach is to provide better health and a better experience of care at lower cost by optimising the use of our resources so that everything we do is as effective as possible and to deliver sustainable improvement in the effective use of resources to support value and quality through well organised care.

The key focus will be to "making time to care" for service users so that we;

- Maximise direct care time
- Use this time for what adds most value for service users
- Enable our staff to choose how they optimise service user value
- Make changes across the whole resource base to continually improve service user value.

In order to drive this forward the approach links clearly to the Organisational Development

Strategy and to the Carter Review and areas of work that fit with the national programme.

The simple focus will be on reducing unnecessary:-

- bureaucracy
- travel
- meetings

Next steps will introduce a set of measurable baselines and target setting. There is an expectation that service user contact will be increased by 10% across all Teams in the next year. The launch of SPIKE II will give Teams the ability to report data in real time. Productivity and efficiencies will be aligned to the Innovation and Improvement Plan.
The next phase of the Good to Great Roadshows are planned for January to November with the messaging of time to care and this will align to the work being taken forward in time for the CQC visit.

Business Development Update
FIC received a detailed update from the Deputy Director – Commercial Development on significant business development issues. Key aspects were:-

Pan-Essex LD services – FIC received a paper outlining the commercial close of the Essex LD Contract noting in particular resolution of the issues previously highlighted:

- No Fault Clause – this has since been retained and each partner has been made a Material Sub-contractor.
- Transition Costs – headroom in the contract has been negotiated
- Partnership Agreement – each party and ACE in particular queried the governance and didn't feel they could form an agreement. However, a clause has been included into the Head Contract Agreement.

FIC noted its thanks for all the hard work to close out the contract discussions and that the task is to now drive forward service delivery.

Commercial Development Activity
FIC was also updated on other activity covering:-

- CAMHS Trailblazer – disappointingly the funding for this will now be less than previously expected.
- Essex IAPT
- CAMHS Tier 2
- Employment Services

2019/2020 Planning
FIC received a paper setting out the implications of the initial planning guidance issued by NHSI/E and to make recommendations for the Trust's planning cycle for 2019/20. The paper sets out two stage approach to planning;

- Individual organisations submit an initial one year operational plan for 2019/20. These will be aggregated by STP alongside a local system operational plan narrative. This is to act as the baseline for the system strategic plans.
- System five year plans are to be developed during the first half of 2019/20 with these plans to be signed off by all organisations by Summer 2019.

FIC reviewed and accepted the following recommendations;

- The outline timetable and likely requirements of NHSI/E with regard to planning
- The two phase approach to planning for 2019/20 and beyond
- The approach and milestones for the creation of the Trust Annual Plan, SBU Improvement Plans and the key Supporting Corporate Plans.

Contract Negotiation Update
FIC noted an initial update on the renewal of the Trust's major contracts with Commissioners. The Director of Finance highlighted the nationally proposed new payment system and advised that the impact is not clear however, there could be an element of significant change.

Strategic Investment Programme – forward Plan
The Director of Finance presented a paper introducing at high level the early thinking around the developing Strategic Investment Programme and key themes which align to the Good to Great strategy. To further support this work and to help frame financial strategy and planning, the Strategic Investment Programme is being refreshed alongside other key areas of Trust development:

- Quality Strategy
- Estates Strategy including the need for a permanent solution to bed provision for east & north Hertfordshire
- Organisational Development Strategy
- Digital Strategy

It is intended that this forms the reference point for development of the investment programme with decisions being brought back to the Committee with appropriate detail for approval. FIC noted the currently estimate of broad range of £35m-72m and that this would be refined as plans were developed.

STP – Medium Term Financial Sustainability Plan

FIC received a report detailing the proposed principles and commitments expected of Boards and process/planned next steps both within STP and in terms of dialogue with NHSI/E. FIC considered the current financial position and the key elements of the forward plan and noted the;

- current financial position for the STP
- proposed collective principles for planning and future financial management
- proposed governance approach and next steps

Following a detailed discussion FIC noted that the both CCGs are committed to Mental Health Investment; further key areas for consideration were highlighted, in terms of our co-operation and financial approach.

It was agreed that active support to the system will continue as part of their collaborative work and that the Executive Team and the Chair have been effective within STP and were to be supported to maintain leadership in the local economy.

Further detailed discussion took place focussing on concerns and it was suggested that a workshop would be a useful forum to drive this forward.

FIC noted the concerns and recommended approval to the Board.

Performance Report Q2 2018/19 and October Forecast
The Director of Innovation and Transformation presented the Q2 Performance report. Overall Q2 remains balanced. However October has seen a 20% increase in demand. Areas of trending deterioration in metrics were highlighted as well as issues relating to access and clinical pressures of particular note were adult 28 day access targets.

Workforce indicators have shown a positive improvement; in particular sickness is now achieving 3.79%.

Financial Summary Q2 and October Forecast
FIC received an update on the current financial position and forecast of the likely financial position for the full year.

It is expected that October will report a small surplus to breakeven and provides the YTD position of £80K which remains ahead of plan. The assessment for October is based on a flash forecast, the key financial indicators report that there has been some slippage in October with regard to PICU placements and some increase in agency spend. Income overall is slightly higher with overheads being slightly lower however FIC were reminded that there is a caveat that one PICU placement could impact on the financial position as pressures remain around beds and complex requirements.

Capital Expenditure Summary
FIC received the Capital expenditure summary for Q2. There are no major changes since those notified in the September report.

The revised estates strategy is currently being worked on which will set out the Capital Plan for the period 2019-2024. This is much more comprehensive and will make some further amendments to 2019/20 in relation to operational capital and the seclusion room programme.

The Colonnades – Lease Renewal
FIC received a report to seek approval for the new lease offer for The Colonnades. This is an opportunity to take the lease for the whole building. From a financial point of view rent will be protected for 5 years and the new landlords are keen for HPFT to remain as tenants. This will provide an opportunity for further accommodation going forward and provides an opportunity to free up learning & development and clinical space and to rationalise back office accommodation. The lease will be for 15-years with a 10-year break clause.

FIC considered and supported the recommendations set out in the paper which will be brought forward for Board decision.

Draft FIC Business Programme 2019
The draft business programme for 2019 was agreed.

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

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

Summary of Implications for:

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

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

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

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

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	**29th November 2018**	**Agenda Item: 11**
Subject:	**Performance Report Q2 2018/ 2019**	**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 Q2, 2018/19 and early intelligence on October's performance.
2. To assess the likely future performance projections for 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 a summary of the overall performance of the organisation, capturing a range of indicators that reflect the current delivery of services and support the wider triangulation of quantitative and qualitative data to reflect the quality and effectiveness of the services we provide.

This report illustrates Q2 2018/19 performance assessed against the indicators across five elements; the NHSI Single Oversight Framework, Access to services, Safe & Effective, Workforce and Finance. It also provides an update on performance against the Q2 position of the Quality Account Priority Indicators.

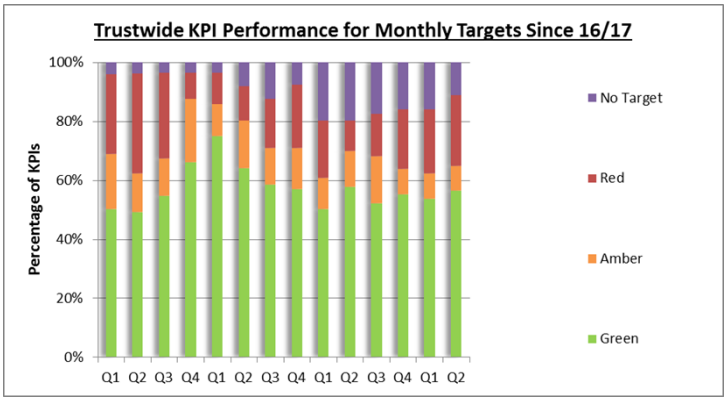
Performance Summary

Overall, performance in Q2 remains broadly balanced in the context of turnover rate of 15.8%, demands on our services with 12,705 referrals, notable improvements in our financial position with a surplus of £209k, ahead of the Plan of £34k by £173k and positive improvement with sickness rate at 3.79% achieving below target of 4%.

There are challenges ahead in achieving our desired level of performance. In October, there has been a 20% increase in demand (5601 referrals) in comparison to similar period of October 2017 (4652 referrals) and 28% increase from previous month of September 2018 (4052 referrals).

In Q2, there is good performance on SoF indicators with an emerging state of decline across access metrics. In Q2, Adult 28 day's waits had an 8% decline at 80.74% in comparison to Q1 performance; there has been a 10% improvement at 86% in October's data from September's position (76%). EMDASS 12wks diagnosis performance of 69.43% is against the 80% target, further performance exploration undertaken in October highlights error with data coding hence data is currently being re-analysed to provide accurate information on performance. In IAPT; HVCCG, Mid and West Essex are behind on cumulative targets as at Q2 and all 3 CCG's are currently above October's target.
There is improved CAMHS performance with continuous focus to achieve CAMHS 28days wait target with a notable 32% improvement at 83.2% in Q2 and a 3% increase in October's performance (79%) in comparison to September's performance (76%).

Safe and effective measures are mainly being met with CPA sustaining good performance with a risk to improving performance on specific metrics (DToC, Risk Assessment, Clustering Review, Data completeness). With the improved performance on existing workforce metrics (Sickness, PDP and Mandatory Training) recently established targets on specific metrics (Staff Wellbeing at Work, Physical violence of staff by SU, Staff Skills & Capability) are below levels.



The chart above compares the proportion of indicators rated green, red and amber since Q1 2016/17. The increased proportion of red indicators in Q2 18/19 is attributed to three newly rated workforce metrics that have set challenging thresholds for performance.

SOF

- SOF indicators were met in Q2, with the exception of FEP Cardio-metabolic assessment and DQMI.
- Cardio-metabolic assessment and treatment for people with psychosis was measured by audit in 2017/18. For 2018/19 a report for the FEP Service on SPIKE has been developed and validated to allow monitoring and reporting of this indicator. Current compliance is 84.1% against a target of 90%, with further improvement expected. This is a significant improvement on the 2017/18 compliance of 57.3%.

- The DQMI score for Q4 (most current available) is at 94.7%, below the 95% target. The score has been affected by the addition of 'primary reason for referral' to the aggregate indicators included in the MHSDS section. This is currently scoring at 35% completion and is being addressed through a programme of work to improve MHSDS recording.

Access to Services

- Routine referrals for Adult Community Services 28day waits (achieved 80.74 -988/1236 against a 98% target): This is a decline of 8% from Q1 performance. Main areas of challenge are within the SW and E&SE Quadrants, although performance in other quadrants has been described as 'fragile' and is relying on additional clinics and week-

end working that is not sustainable in the long-term. DNA protocol has been changed to include referrals in SPA which should decrease the number of assessments that DNA and reduce some of the pressure. Primary Care Pilots are being rolled at scale to across Hertfordshire and it is anticipated that this intervention will reduce referrals into secondary care. The 2 CCGs are supportive of approach around Primary Mental Health Care and an in-depth evaluation of all pilots is planned to take place in December to ascertain the impact.

- CAMHS 7days and 28days waiting times have improved significantly in Q2 in comparison to Q1 performance, 7days achieved 86.84% (26.24% increase) and 28days achieved 83.2% (32.25% increase) in Q2. The main issue remains in the East of the County where there has been a 50% vacancy rate over the quarter and locum consultants. A risk based approach is being taken to seeing CYP, prioritising assessment and then managing contact until treatment appointments. The recruitment issues in East are seen to be a long term issue and Commissioners have asked for this to be put on the agenda for the next Contract Review Meeting with a view to looking for solutions across the wider Health and Social Care Economy.

- The refined EMDASS diagnostic waits data is now captured with target achieved in Q1 at 82.48% but declined in Q2 69.43% against the 80% target. The performance in Q2 is attributed to a spike in referrals in June, July and August which has put pressure on clinic resources. Data quality have recently been identified as an issue with performance rating with assurance received from SBU that service is at target in October and this will be evidenced once quality issues have been remedied.

- Mid-Essex (300 behind target) and West Essex (489 behind target) IAPT services remain an area of concern. The Mid-Essex contract is approaching its end and a 6 month extension has been offered, with a focus on clearing the back log of people waiting. Proactive engagement is ongoing with West Essex as financial penalties were imposed, but have now been suspended. HVCCG has fallen below its access target (411 behind target) in Q2, due to a lack of referrals being received. A number of actions to increase these are in place and recovery is anticipated by the end of the year.

Safe and Effective Services

- Risk Assessments (achieved 92.74% against a 95% target): Performance against risk assessments is at steady decline for 6 consecutive months. All SBUs are below the 95% target with West at 93.96%; LD&F at 93.22% and E&N at 94.43%. Improvement actions are being implemented to improve current position across all SBUs.

- Delayed transfers of care to be maintained at a minimal level (achieved 7.25% -against 3.5% target): Performance against delayed transfers of care has risen for the seventh consecutive month. The rigorous identification and monitoring process for delays is in place across all SBUs. The main area of delay remains in adult acute services, where people with complex needs are waiting for rehabilitation placements.

Workforce

- Turnover Rate: There has been a reduction in turnover rate to 15.86% from 16.27% in Q1. The Trust is embedding a number of NHSI retention improvement initiatives that were launched in Q1, including the 'retire and return' process and internal moves process for nurses and HCAs.

- PDP (achieved 90.44% against a 95% target): PDP completion rates have increased across all SBUs with an increase of 4.7% trust-wide.

- Sickness (achieved 3.79% against 4% target): Sickness rate performance is achieving below target and there is continuous focus to ensure performance is sustained.

- Statutory and Mandatory Training (achieved 87.5% against a 92% target): Whilst the compliance rates are below the Trust target of 92%, the position has remained stable throughout Q2 and the Learning and Development Team continue to work with subject matter leads and professional leads to put action plans in place to improve the position.

Finance

For September the financial position reported was a surplus (before PSF) of £209k for the month, ahead of the Plan of £34k by £173k, and a surplus of £88k for the year to date, ahead of the Plan of £80k deficit by £168k. This was an improvement on the expected position, due in part to decreases in agency costs beyond what was forecast, and c. £108k half year additional income for Essex IAPT from Health Education England, which was previously in doubt. There remains a level of risk driven by the small surplus margin, significant demand volatility, and ongoing workforce pressures, but currently achievement of the planned full year Control Total is forecast.

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 2
2018/19

Contents

1. Summary

Overall performance in Q2 18/19 has remained generally stable from Q1, with improvement in financial performance and some of the key workforce indicators

Performance against SOF remains strong, and the FEP Cardio-metabolic indicator has been reported on for the first time this year, and shows significant improvement on 17/18 performance (84.1% against 57.3% in 17/18) with further improvement expected. DQMI is still reported on Q4 position and is rated as amber (94.7% against 95% target). This is not expected to improve until Q3, when the gap in 'primary reason for referral' field can be addressed. There is very strong performance against the indicator for inappropriate out of area placements with only 30 days against a target of 275 for Q2.

Access indicators remain relatively static, with Adult Community 28 day waits and CAMHS 28 day waits remaining the areas of concern, although significant improvement can be seen in the CAMHS 28 day performance from Q1 (32.5% increase to 83.2%). It is also of note that all other CAMHS waiting times have been met. Further detail on these can be found in the Access section of this report. IAPT access indicators remain below target in mid and West Essex and HVCCG have also now dipped below target for the year. EMDASS diagnostic waits can now be reported, and were met in Q1, but were at 69.43% in Q2, below the 80%, target due to a spike in referrals in June, July and August.

Safe and Effective Care indicators continue to largely remain steady in performance, with strong performance on IAPT recovery rates and the 3 day follow-up target. DToC rates have continued to increase (7.25%), for the second consecutive quarter, whilst performance on risk assessment and clustering reviews have deteriorated (92.7% and 87.9% respectively), reflecting the pressure on teams with focus on access targets and assessments. Employment and accommodation recording has also continued to fall (54.98% and 53.66% respectively), as annual reviews of status become due following the major push for recording completion at this time last year.

There has been an improvement in some of the key workforce indicators. Sickness has fallen below the 4% target to 3.79% in Q2. There has been a small increase in mandatory training rates to 87.5% and PDPs have increased by 4.7% to 90.44%. Some remaining recording and reporting issues mean that the actual rates are likely to be even higher. The addition of targets to some of the Pulse survey indicators that were previously not rag rated has meant the addition of 4 reds to the overall picture.

The tables below show movement in performance indicators against the five categories of: SOF; Access; Safe and Effective Care; Workforce and Finance. To give a more rounded view of performance the indicators have been rated against 3 categories of movement between Q1 2017/18 and Q2 2018/18. These are: Rag ratings; overall increase or decrease in performance and movement on what we have termed the 'Primary Indicators,' or those that are thought to be most important in that section.

For September the financial position reported was a surplus of £209k for the month, ahead of the Plan of £34k by £173k, and a surplus of £88k for the year to date, ahead of the Plan of £80k deficit by £168k. This was an improvement on the expected position, due in part to decreases in agency costs beyond what was forecast, and c. £108k half year additional income for Essex IAPT from Health Education England, which was previously in doubt. Overall there are clear and continuing improvements in Quarter 2 in comparison to Quarter 1, and a return to a surplus position has been delivered. There remains a level of risk driven by the small surplus margin, significant demand volatility, and ongoing workforce pressures, but currently achievement of the planned full year performance is forecast.

SOF: Q1– Q2 18/19

RAG Rating Movement	Overall Indicator Movement	Primary Indicator Movement
↓ 1 additional red and one additional amber indicator; one less green.	↑ 5 increases, 2 decreases.	↔ FEP 14 day wait performance maintained. Inappropriate out of area placement reduction target exceeded.

- Generally improved or maintained performance.
- DQMI moved into amber, expected to recover in Q3.

Access: Q1 - Q2 18/19

RAG Rating Movement	Overall Indicator Movement	Primary Indicator Movement
↔ No change on Q1 15 green indicators, 7 red.	↔ 10 static, 7 increases, 5 decreases.	↔ Increase in CAMHS 28 day performance of 32.25%; Decrease in adult community 28 day performance of 8%. Drop in EMDASS diagnosis rate of 13% due to temporary increase in referral rate. Expected to recover for Q3.

- General access performance remains strong, but with known issues in West, Mid and Herts IAPT services, and adult and CAMHS 28 day waits.

Safe and Effective: Q1– Q2 18/19

RAG Rating Movement	Overall Indicator Movement	Primary Indicator Movement
↔ 3 additional green indicators; static amber indicators; 2 additional red indicators	↓ 7 increases; 6 static and 9 decreases.	↓ All IAPT recovery rates achieved Risk assessment and clustering have fallen. Improved 3 day follow-up rates Increase in DToC rate

- Some downward movement in risk assessment and clustering reviews.
- Good performance on 3 day follow-up rates and IAPT recovery
- Increase in DToC rate.

Workforce: Q1– Q2 18/19

RAG Rating Movement	Overall Indicator Movement	Primary Indicator Movement
↓ 2 additional red indicators; 1 additional amber and 1 additional green. Increase in red rated indicators due to new targets being added.	↔ 4 increases; 4 decreases; 2 static	↑ Increase in PDP and appraisals and small increase in mandatory training rates. Decrease in sickness rate Small decrease in turnover rate

- Increase in PDP and appraisals
- Decrease in sickness rate to below target level
- Small increase in mandatory training rates

- Small decrease in turnover

Finance: Q1– Q2 18/19

RAG Rating Movement	Overall Indicator Movement	Primary Indicator Movement
↑ Reflects recovery of position with 3 green indicators, 1 remaining amber and 1 red indicator for agency rate cap limits.	↑ With surplus showing above plan and CRES projected to meet Target this has been a very strong quarter's performance. Risks remain to sustain throughout year.	↑ An NHSI rating of 1. Reflecting stronger surplus position a.

- Following a very poor financial position in April and May the signs of recovery in June continued throughout Q2. In particular PICU and CAMHs T4 placements and a reduction in inpatient agency spend led to a recovery to Plan. Unplanned income has resulted in a position above Plan at the half year.
- What is clear is the position remains fragile particularly in terms of unplanned specialised placements were costs are higher and can be for a lengthy period. So whilst the full year forecast is expected to be met this is not certain. PICU activity has increased in September and into October and there is a risk on the need for additional CAMHs beds due to inpatient levels within the ED service.

2. Key Areas of Activity in Q2 2018/19

312 adult acute inpatient admissions Q2

7,012 new spells of care in secondary mental health services Q2

169 Starters
126 Leavers
at the end of Q2

8,343 people entering treatment in Wellbeing Services Q2

2,797 people on CPA at the end of Q2

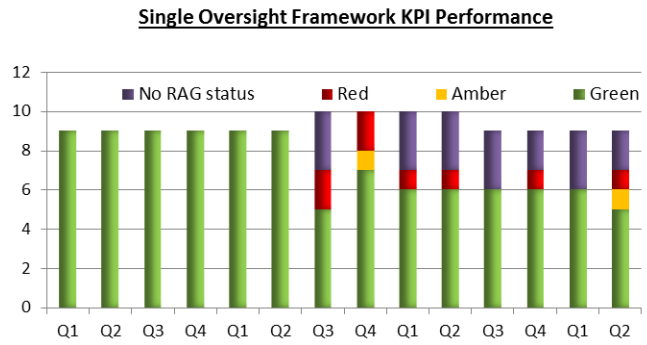
64,848 secondary mental health contacts Q2

431
inpatient beds
at the end of Q2

7,504
discharged from secondary mental health services Q2

3. Performance On SOF

Single Oversight Framework (SOF 2 – 6)



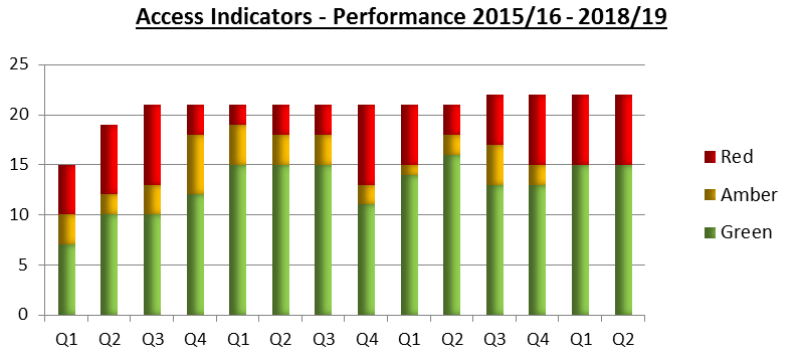
In Q2, SOF indicators were met, with the exception of FEP Cardio-metabolic assessment and Data Quality maturity Index (DQMI).

Cardio-metabolic assessment and treatment for people with psychosis was measured by audit in 2017/18. For 2018/19 a report for the FEP Service on SPIKE to allow monitoring and reporting of this indicator has been developed and validated. Current compliance is 84.1% against a target of 90%, with further improvement expected. This is a significant improvement on the 2017/18 compliance of 57.3%. A similar method of reporting is being tested and signed off for Community Services and reporting is expected from Q3. There are no current plans to develop a report for inpatient services.

The DQMI score for Q4 (most current available) is at 94.7%, below the 95% target. The score has been affected by the addition of 'primary reason for referral' to the aggregate indicators included in the MHSDS section. This is currently scoring at 35% completion and is being addressed through ongoing work to improve MHSDS recording.

4. Performance On KPIs

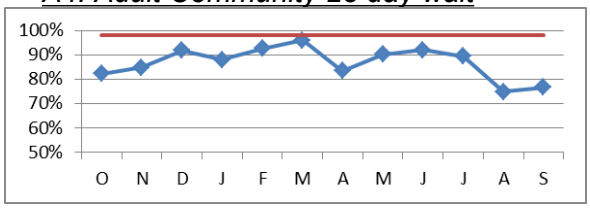
Access to Services (A1 – 24)



The table below shows Access indicators have been rated as red or amber in Q2, with movement from Q1 position and the shortfall from target.

Access KPI	Q2 Performance	Movement from Q1	Shortfall from Target
A4: Routine referrals for Adult Community Services	80.74% (998/1,236)	-8.07%	213(98%)
A5: Urgent referrals to Adult Community Services	85.71% (6/7)	-1.79%	1 (98%)
A11: EMDASS Diagnosis within 12 weeks	69.43% (318/458)	-13.04%	48
A16: CAMHS Routine Waits	83.2% (317/381)	+32.25%	45 (95%)
A23: People entering IAPT Treatment - HVCCG	4757/5168	-	411
A24: People entering IAPT Treatment – Mid-Essex	2646/2946	-	300
A25: People entering IAPT Treatment – West-Essex	1979/2468	-	489

A4: Adult Community 28 day wait



The adult community 28 day wait was at 80.74% in August, an decrease of 8% on the Q1 figure of 88.81% and 213 people short of the 98% target. The September performance figures per quadrant are: NW 92.50 (74/80); SW 43.62% (41/94) E&SE 78.07% (89/114) & North 97.53% (79/81).

Primary issues with meeting this target mainly relate to the SW and E&SE Quadrants, although performance in the other two quadrants has been described as 'fragile' and relies on additional clinics and week-end working being provided which is not thought to be sustainable in the long term.

Analysis undertaken by West SBU and the Performance Team on SW waits highlighted that approximately 60% of service users referred to adult community teams did not meet the threshold for services. This information was shared with commissioners at the Contract Review Meeting on 16th August, with a view to a joint piece of work to understand how we can meet the needs of the people who do not currently meet the threshold for Secondary Mental Health Services. The presentation was very well received and it was agreed that work would

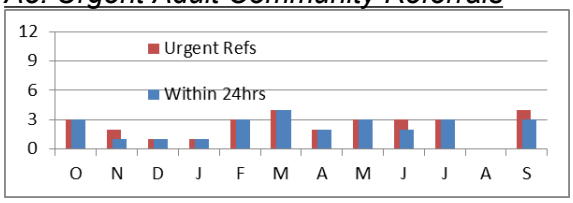
be taken forward via the STP mental health work-stream to focus on the development and agreement of a Herts Primary Care Mental Health model, building on the best practice arising out of the current Primary Care Mental Health Pilots in Watford and Hertford, supporting planned roll out countywide via the local delivery boards, aligned to PLACE based care principles. It was also recommended that the management of SPA triages be reviewed, so that if SPA telephone triage cannot be completed due to lack of response where attempts to contact an individual by telephone and letter to facilitate triage, and risk management processes have been adhered to, the individual would be discharged back to the referrer if there is no engagement, rather than passing through to the community teams for initial assessment. This proposal was agreed at the GP Leads Meeting in September 2018.

Further analysis has also shown that the DNA protocol is being applied and that the majority of service users are opting back in for a second appointment and then not attending. This means that an additional appointment slot is being wasted and putting additional pressure on teams.

Work is now underway between the West SBU and Performance Team to change the way we look at the indicator, focusing on clearing the backlog at the same time as seeing new referrals. Daily waiting list data is being collated and monitored to determine trends and understand activity at location level.

Issues in East and South East relate to the high number of vacancies, particularly at Cygnet House, where for the majority of the period there were 7.6 care co-ordinator vacancies with only 3 of these being covered by agency, and no further agency staff available. The situation has been managed on a risk basis, with those most at risk being prioritised. Holly Lodge is also very tight on staffing and will struggle to see people within 28 days as the seasonal referral rate increases. They are currently booking to breach. There have been some new starters in September, but they will take some time to hold full caseloads. The Primary Care pilot at Hertford is being extended to Cygnet House and Holly Lodge as a positive measure, with plans to extend to Roseanne House and North Herts in January 2019.

A5: Urgent Adult Community Referrals

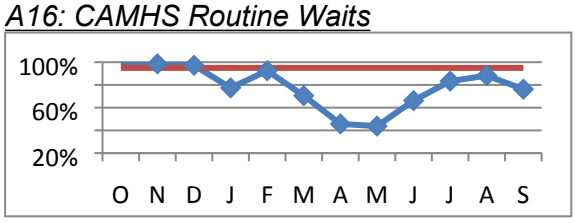


One service user was not seen within the 24 hour urgent waiting time, due to an incorrect phone number meaning that they could not be contacted. They have subsequently seen on day 5.

A11: EMDASS Diagnosis within 12 weeks

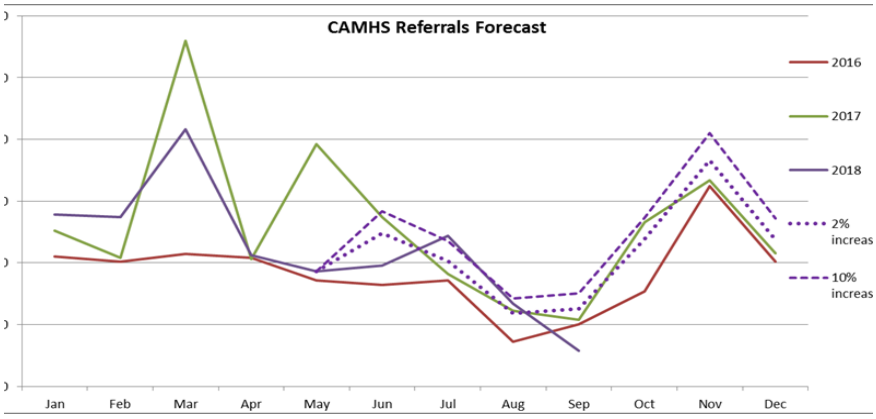
EMDASS diagnosis within 12 weeks is now reportable, and figures have been calculated for Q1 and Q2. These show a drop from 82.48% in Q1 to 69.43% in Q2. This was mainly due to a spike in referrals for 3 months over May, June and July. Referrals are now stabilising, but these 3 months have put pressure on the clinics further down the line, and has shown in the drop in performance. An improvement trajectory is being put in place in each of the quadrants.

A16: CAMHS Routine Waits

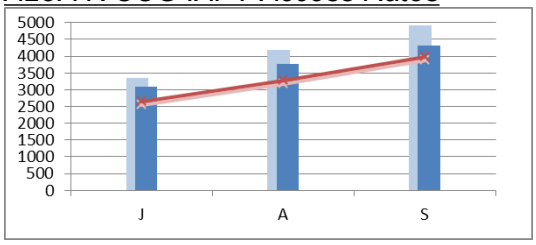


Performance has improved significantly from Q1 at 50.95% to Q2 at 83.2%. The main issue remains in the East of the County where there has been a 50% vacancy rate over the quarter and locum consultants. A risk based approach has been taken, with a focus on getting CYP seen in initial Choice appointments to assess risk and then monitoring and maintaining contact with them between Choice and the subsequent appointment for treatment. Additional Choice appointments are being offered by members of the SLT team and the team is now triaging its own referrals directly, rather than through SPA, in order to ensure only those relevant for the service threshold are passed on for Choice. There has been some recent success with recruitment of staff and interest in the Consultant position, which has not previously been the case. However, the recruitment issues in East are seen to be a long term issue and Commissioners have asked for this to be put on the agenda for the next Contract Review Meeting with a view to looking for solutions across the wider Health and Social Care Economy.

The following chart shows the pattern of referrals into CAMHS against projections of 2% and 10% increase. July and August were close to the 10% increase trajectory, and the fall seen in September referrals is expected to decrease as referrals are all passed through to services.



A25: HVCCG IAPT Access Rates

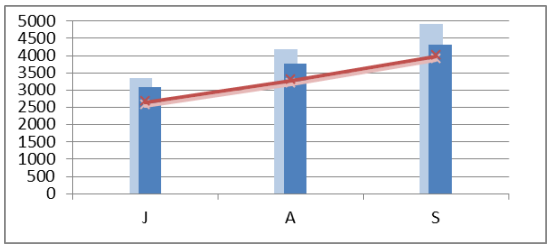


HVCCG were 411 people cumulatively behind target at the end of September (4757/5168). This is due to low referral rates into the service. A number of initiatives have been put in place to support referrals, these include:

- Weekly conference calls to monitor actions to improve access
- Monthly review of access with commissioning colleagues to agree HPFT and IHCCT actions
- IHCCT to pursue in road into Housing Provider resource and ongoing advertisement in GP surgeries
- PWPs actively promoting in GP surgeries/ shops/ local group and clubs and companies
- Beat exam stress and carers workshops; programme across Q3 2018
- Pilot of 'virtual clinics' in Q3 to increase treatment options- closely linked to access
- Increased booking clerk availability

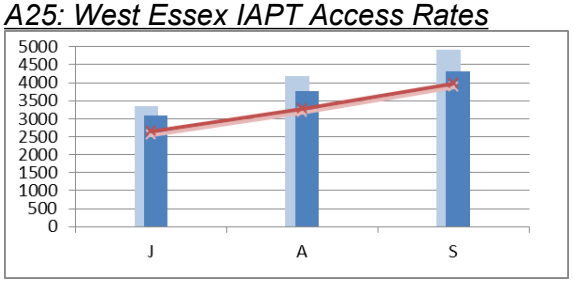
With these initiatives in place it is hoped that the access target will be back on track by year end.

A24: Mid-Essex IAPT Access Rates



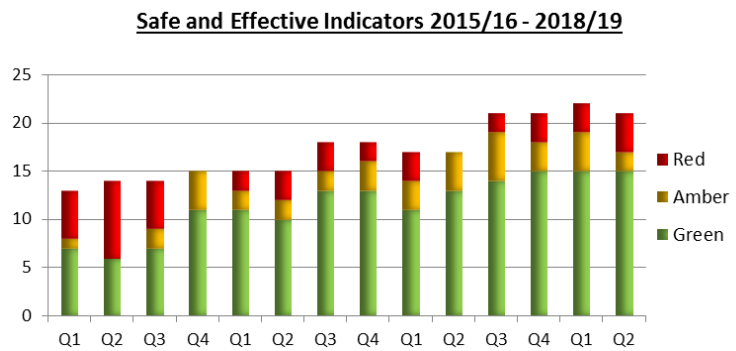
Mid Essex were 300 people behind the cumulative access target at the end of September. The Mid-Essex contract is approaching its end and commissioners have offered a 6 month extension, with a focus on clearing the back-log of waits with support from the Intensive Support Team. Options for clearing the backlog will be considered and weighed against any associated drop in service quality, for example a reduction in the number of sessions per service user. The recent Mental Health Strategies work has confirmed that both access and waiting time targets cannot be met within the current contracted staffing level. Work is now underway within HPFT to work-up a model that would allow us to continue providing a quality service and meet the Five Year Forward View access requirements. A paper will be scheduled for Trust Executive in November, outlining the options.

A25: West Essex IAPT Access Rates



West Essex was 489 people behind the cumulative access target at the end of September. The West IAPT contract still has one year left to run. Financial penalties were enforced by the CCG; so far this amounts to £43,500 for April, May and June, with a further £14,500 accrued for July. The Trust has formally written to them requesting that they stop using this contractual lever, as our ability to achieve target is also reliant on referrals being received by the service, and the CCG have a clear role in ensuring that the demand is there. We have received no further fines, but have not had a formal agreement that they will now be suspended. A joint remedial action plan is being developed with commissioners to deliver the 15% access target by the end of the year. West Essex CCG has indicated that once there is confidence in this plan and the associated trajectory they will consider suspending future fines. The plan is scheduled to be finalised by mid-October 2018.

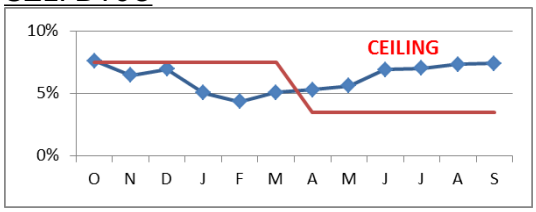
Safety and Effectiveness of Services (SE1 – 21)



The table below shows the Safety and Effectiveness monthly indicators that have been rated as red or amber in Q2, the movement from the Q1 position and the shortfall from target.

Safety and Effectiveness KPI	Q2 Performance	Movement from Q1	Shortfall from Target
SE2: DToC	7.25%	+1.32%	3.75%
SE5: Risk Assessments	92.74% (15,598/16,819)	-1.07%	380 (95%)
SE14: Rate of Service Users saying they are treated in a way that reflects trust values	76.27% (4,040/5,297)	-0.28%	247 (80%)
SE 18: Cluster Reviews	87.89% (9,321/10,605)	-5.13%	753 (95%)
SE21a) Employment b) Accommodation	54.98% (9,476/17,235) 53.66% (9,249/17,235)	-6.13% - 7.10%	5,173 (85%) 5,400

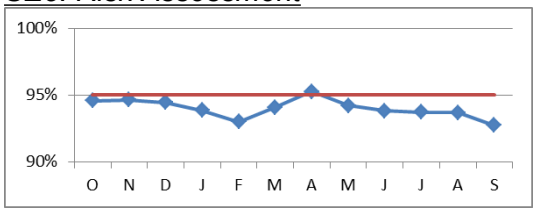
SE2: DToC



DToC is rated as red in Q2, against the nationally agreed, aspirational target of 3.5%. Overall delayed bed days have risen for the seventh consecutive month, following a downward trend during the last year. LD&F had the lowest rate of delays at 4.01% with E&N at 5.49% and West with the highest rate (adult acute) at 13.6%.

The rigorous identification and monitoring progress for delays remains in place across all SBUs. LD&F have seen a reduction to 3.18% in September, below the 3.5% target and E&N have reduced to 4.16% in September. The main area of delay remains in adult acute services, where people with complex needs are waiting for rehabilitation placements, 5 of whom are waiting for placements in HPFT services following the closure of Sovereign House, where a 5 – 6 week delay is expected.

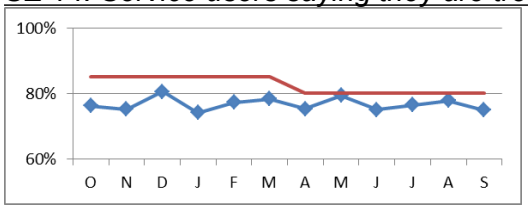
SE5: Risk Assessment



Performance for Q2 is at 92.74%, September being the sixth consecutive month that there has been a decline. April 2018 remains the only month that target has been achieved over the last 12 months. West SBU has dipped below target in Q2 at 93.96% (Q1 = 95.3%) and E&N were at 94.43%, (Q1 =92.8%). LD&F SBU have also fallen below target at 93.22% (Q1 = 95.1%). In LD&F there are issues with the system registering some of the risk assessment documents, and this is now being addressed. In E&N CAMHS services remain the most challenging in terms of risk assessment, particularly due to the large caseloads that consultants carry for ADHD, who are infrequently seen. Consultants are reviewing their caseloads with a view to safely discharging any over 18 year olds. There has also been a bid for Pharmacy prescribers, which would lessen the load on CAMHS Consultants and therefore help with capacity issues. In E& SE adult community services there is also a caseload issue, with North struggling with large consultant caseloads. Again, caseloads are being reviewed and discussions are ongoing with those with the most outstanding risk assessments. In West there is a weekly review of KPIs is ongoing within SW team. A number of overdue or not done RAs are due to individuals being in a placement outside of

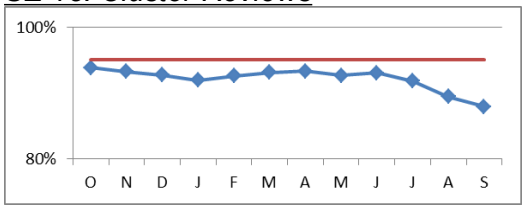
Hertfordshire. Work to address this is ongoing and a dedicated worker is responsible for this. SLL is directly communicating with team members who have not completed the RA for those who do not fall in to this category.

SE 14: Service users saying they are treated in a way that reflects Trust Values.



The score for this Having Your Say indicator has remained at a similar score in Q2 – 96.27% (-0.28% on Q1). The indicator is constructed from a number of different questions, and SBUs are getting a full breakdown of results for their services, to review and identify areas for improvement.

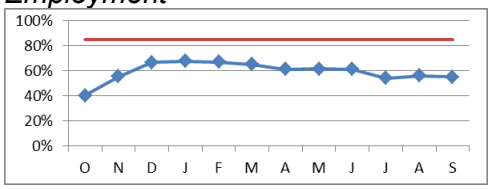
SE 18: Cluster Reviews



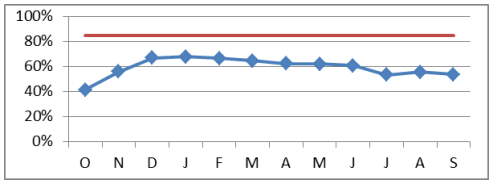
Cluster reviews have fallen over the last 3 months from 93.02% in Q1 to 87.89% in Q2, a reduction of 5.13%, and the most consistent downward increase over the last year. This reflects the same issues as for risk assessments, with caseload and capacity pressures, particularly across adult community services.

SE21: Employment and Accommodation

Employment

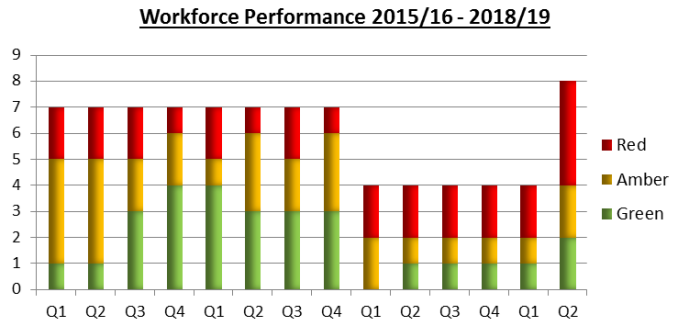


Accommodation



Employment and accommodation recording has fallen from 61.12 and 60.77% respectively in Q1 to 54.98% and 53.66% in Q2, against a target of 85%. This is a result of the focus on recording at this time in 2017, and the status not having been reviewed within the requisite 12 month period. The Adult Community Team migration is ensuring that these statuses are reviewed and updated, and a gradual improvement is therefore expected over Q3. The Data Quality Dashboard that will be introduced with SPIKE 2 will also highlight breaches in recording, by team and individual care co-ordinator, and can be used as part of the supervision process. It should be noted that the above figures refer to all service users, both seen and unseen. This definition has been queried with NHSE, as it is very rare for accommodation and employment statuses to be passed on at referral. Confirmation is awaited as to whether we can measure against 'seen only' service users, which would see compliance increase to approximately 61%.

Resources – Workforce (W1 – 9)



The table below shows Workforce monthly indicators that have been rated as red or amber in Q2, with movement from Q1 position and the shortfall from target. Turnover is not rag-rated but is included for information.

Safety and Effectiveness KPI	Q2 Performance	Movement from Q1	Shortfall from Target
W2: Staff Wellbeing at Work	65% (1058/1627)	-1%	162 (75%)
W3: Staff reporting experiencing physical violence from Service users	9.16% (45/491)	-2.11%	20 (5%)
W4: Staff Skills and Capability	80.76% (915/1133)	-11.65%	161 (95%)
W5: PDP and Appraisal	90.44% (2,430/2,687)	+4.7%	123 (95%)
W6: Mandatory Training	87.5% (23,966/27,389)	+ 0.31%	1,232 (92%)
W8: Turnover Rate	15.86% (456.67/2878.58)	-0.4%	169 (10%)

Summary of Pulse Results

The Pulse survey has been directly emailed to staff and this has been successful with 640 respondents, an increase on the 417 respondents in Q1. The results highlighted similar themes to the national staff survey.

Staff reporting working additional hours dropped from 61% to 59%,

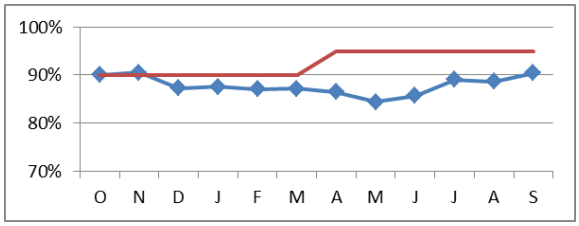
75% believe the Trust takes positive action on their wellbeing,

52% of staff report that it is easy for them to make improvements at work.

93% of staff report they have the skills and knowledge to do their job effectively and safely which is 3% down on last quarter.

As with previous quarterly surveys and the national survey there is still a portion of staff who are experiencing bullying with 23% of those experiencing it from Service User or carers and 35% from managers.

W5: PDP and Appraisal

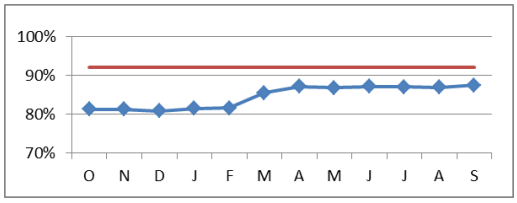


The Q2 PDP completion rates have increased across all SBUs.

East and North PDPs have increased by 2% with further work planned to upskill Band 5 and 6 managers to support with appraisals of their staff. The West SBU PDP rate increased their appraisal rate by 8% in Q2 and achieved the Trust KPI target, whilst the LD&F SBU PDP rate increased by 1% in Q2. The SBU Core Management Team are sharing best practice in order to achieve the target across all areas and the PDP completion is consistently addressed in the unit reviews on a monthly basis with a plan for achieving 100% by service each area.

In Corporate Services the PDP compliance rate increased significantly by 13% in Q2. There is a continued focus in all corporate areas to plan and complete timely PDPs.

W6: Mandatory Training



The Core Skills Statutory and Mandatory training rates in Quarter 2 have ended as follows:

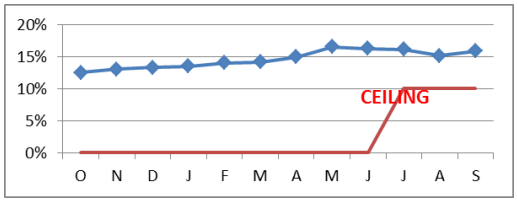
Statutory and Mandatory Training = 87%

Essential Training = 87%

Whilst the compliance rates are below the Trust target of 92%, statutory and mandatory training compliance has remained stable through Q2.

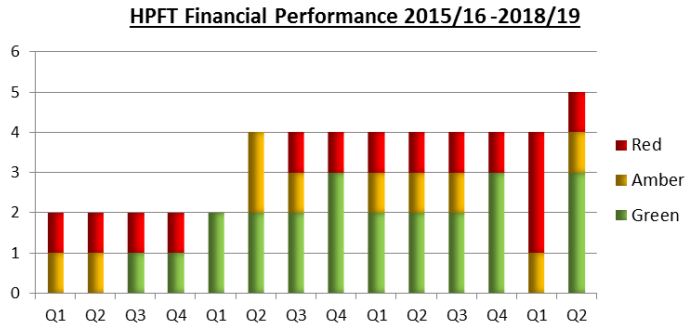
The Learning and Development Team are working with Subject Matter Experts and Professional Leads to draw up action plans to increase the compliance and map out 2019-2020 training plans. Staff will be able to access the learning platform and book onto classroom sessions, undertake on-line learning and manage their own statutory and mandatory training. Automated reminders allow for effective management to support the Trust achieve its target of a minimum compliance rate of 92%.

W8: Turnover Rate



The turnover rate has decreased in Q2 to 15.86% from 16.27% in Q1. The unplanned turnover rate remained constant at 11.79% in Q2 and the planned turnover rate dropped to 4.07%. Planned turnover includes those staff who leave the Trust as a result of retirement, end of fixed term contracts and dismissals. The Trust is embedding a number of NHSI retention improvement initiatives that were launched in Q1. This includes the Retire and Return process which aims to provide staff with a flexible approach to retirement and return to work, the internal moves process for nurses and HCAs which will make it easier for those staff to move into different roles on the same band within the Trust, and the buddy scheme which provides new starters with additional support in their new roles in the Trust.

Resources – Finance (F1 – 5)



For September the financial position reported was a surplus of £209k for the month, ahead of the Plan of £34k by £173k, and a surplus of £88k for the year to date, ahead of the Plan of £80k deficit by £168k. This was an improvement on the expected position, due in part to decreases in agency costs beyond what was forecast, and c. £108k half year additional income for Essex IAPT from Health Education England, which was previously in doubt.

All figures are reported before any income from the Provider Sustainability Fund (PSF), which is £621k for the year to date, in line with Plan. Rating for September reports as a 2. The NHSI Use of Resources (UOR) Rating is showing as 1 for the first time this year. This is however subject to NHSI confirming the treatment of the loan repayment made in year. As advised by NHSI this has been excluded until a final determination by NHSI.

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000	Trend
Overall Surplus (Deficit)		34	209	(80)	88	360	↑
Pay Overall		12,827	12,668	76,829	75,697	154,068	↔
Agency		611	586	3,053	3,937	7,327	↑
Secondary Commissioning		2,527	2,629	15,372	16,322	30,676	↑

The reported position is therefore encouraging, and ahead of both the Published Plan and the Forecast Recovery Plan. However, it is driven in part by non-recurring factors, including £1.4m reversals of old year accruals and provisions in Quarter 1; improvements will need to be sustained.

Key figures are summarised below, with the key message being the progressive improvements in recent months in a number of key areas such as secondary commissioning and agency costs:

1. Total Pay is reporting below Plan for the year to date by £1.3m (1.7%) and for the month by £159k (1.2%). This reflects the level of vacancies, not all of which are covered. Overall Pay costs will increase from October as agency pay rates increase in line with Agenda for Change rates and the Medical pay award is implemented. Agency levels reduced in the month and are below the NHSI Ceiling for the first time; though remain above it for the year to date.

2. Secondary commissioning is reported above Plan by £102k for the month and £950k for the year to date, but signals a reduction on previous months. Main adult health

placements reduced by £86k in the month to their lowest level for over a year, and social care placements also reduced by £29k, with Personal Budgets, CAMHs and MHSOP stable, and PICU/Acute increasing by £20k with recent high activity on PICU in particular. This remains a key risk going forward being high cost: low volume, albeit currently at 50% of the level seen in Q1.

3. Income reported better than Plan by £61k in the month and £248k year to date. NHSE income particularly for Medium Secure Services reported behind Plan. CQUIN estimates have been reduced reflecting a lower forecast performance in the full year (from 85% to 80% and an impact of £88k in month).

4. There remains significant immediate focus on the CRES programme, developing remaining schemes, with agency and placements starting to deliver on plans, and 2019/20 plans being put in place.

5. Whilst Overhead costs continue to spend above Plan (c. 5% year to date) this is at a reducing rate with ongoing work to reduce further this year.

Overall therefore there are clear and continuing improvements in Quarter 2 in comparison to Quarter 1, and a return to a surplus position has been delivered. There remains a level of risk driven by the small surplus margin, significant demand volatility, and ongoing workforce pressures, but currently achievement of the planned full year performance is forecast.

5. CQUIN

CQUIN results for Q2 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.

6. Quality Account

Performance for the Quality Account in 2018/19 can be found in Appendix 2. Of the 15 separate indicators 10 are rated as green, 1 is rated amber (Service users reporting being treated according to Trust values), 3 do not have targets set, one indicator, CAMHS 28 day routine waits, remains rated as red.

Ref	Standard[20]	Frequency	Standard[17]	Current Period Numbers (Q2 2018)	Current Period (Q2 2018 UNLESS STATED)	Previous Period (Q1 2018 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3)
SOF1	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]	Monthly	>=53%	54/65	83.08%	85.92%	-2.84%		↔
SOF2	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards	Annual	>=90%	N/A	Figures not available	90.9% in 17/18		**Annual figures supplied by RCP audit.** **Previous period figures shown are now confirmed by RCP (15th May 2018)** **Current period figures taken from Trust SPIKE report on 12/10/18**	
	b) early intervention in psychosis services		>=90%	N/A	84.1% YTD (Provisional)	57.3% 17/18			
	c) community mental health services (people on Care Programme Approach) [23]		>=65%	N/A	Figures not available	69.8% in 17/18			
SOF3	Data Quality Maturity Index (DQMI) – MHSDS dataset score. https://digital.nhs.uk/data-quality	Quarterly in arrears	>=95%		94.7% in Q4	95.7% in Q3	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."	
SOF4	Improving Access to Psychological Therapies (IAPT)/talking therapies • proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	Monthly	>=50%	2,157 / 4,039	53.40%	53.36%	0.05%	Data taken from Trust SPIKE report on 02/10/2018	↔
	• waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks	Monthly	>=75%	5,817 / 6,329	91.91%	83.68%	8.23%	Data taken from Trust SPIKE report on 02/10/2018	↔
	- within 18 weeks	Monthly	>=95%	6,326 / 6,329	99.95%	99.79%	0.16%	Data taken from Trust SPIKE report on 02/10/2018	↔
SOF5	Inappropriate out-of-area placements for adult mental health services	Monthly	92 (Per month) 275 for Q2	N/A	30	165	N/A		

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

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

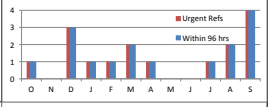
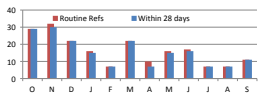
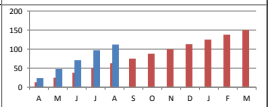
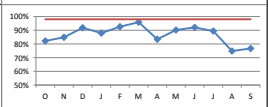
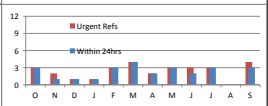
[21] In line with the recommendation of the 5YFV for mental health, providers should be working with commissioners to ensure that crisis resolution home treatment teams are delivering care in line with best practice standards (www.ucl.ac.uk/core-resource-pack/fidelity-scale).
For 2016/17, commissioners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

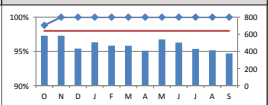
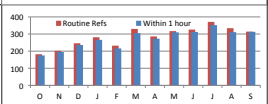
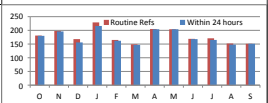
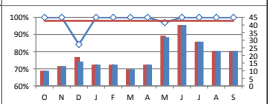
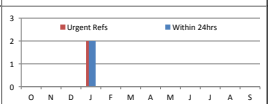
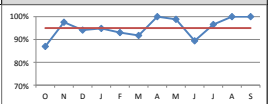
[22] This standard applies to anyone with a suspected first episode of psychosis aged 14-65.Exclusions must not be made of people aged >35 who may historically not have had access to specialist EIP services. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.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

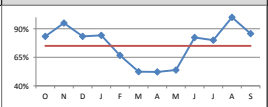
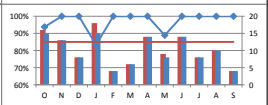
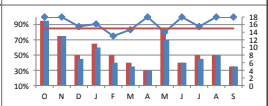
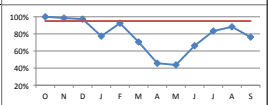
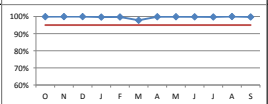
[23] Board declaration but can be triangulated with results of CQUIN audit which will be for a sample of patients in each service area). People with psychosis should receive:
> a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's records
> a record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

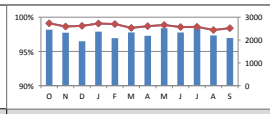
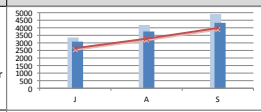
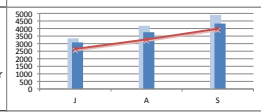
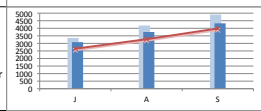
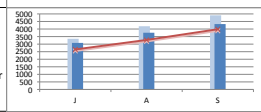
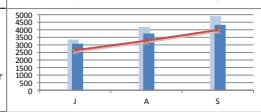
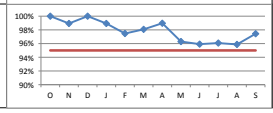
[24] Comprising: NHS number, date of birth, postcode, current gender, registered GP org code, commissioner org code

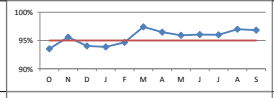
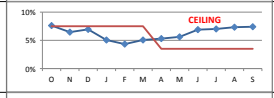
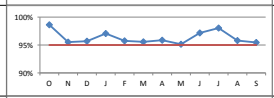
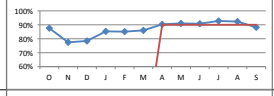
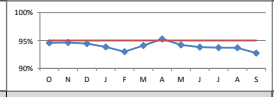
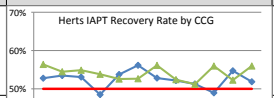
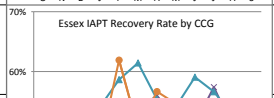
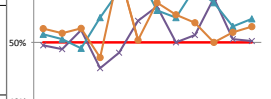
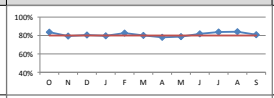
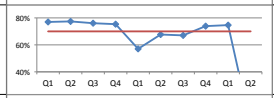
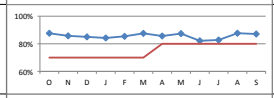
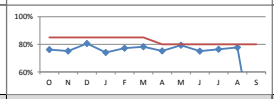
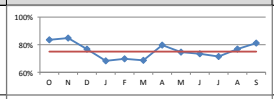
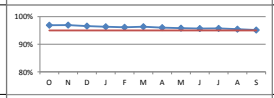
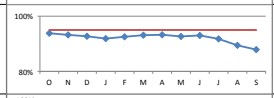
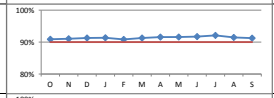
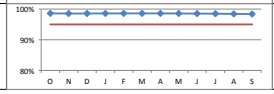
[25] For achievement by 2016/17 year-end. Comprising: ethnicity, employment status (for adults only), accommodation status (for adults only), ICD10 coding. Note: ICD10 for CYP may be supplanted by capture of a problem descriptor, rather than a formal medical diagnosis.

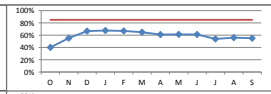
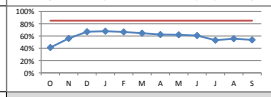
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**	>=98%		7/7	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%		25/25	100.00%	88.37%	11.63%	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)		136	136 (Cumulative)	71 (Cumulative)	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%		998 1,236	80.74%	88.81%	-8.07%		↔
A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**	>=98%		6/7	85.71%	87.50%	-1.79%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↑

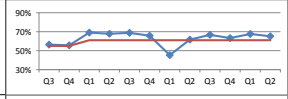
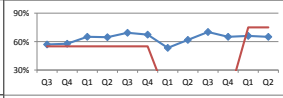
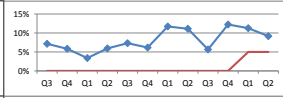
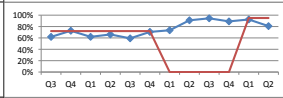
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
A6	CATT referrals meeting 4 hour wait **(Contractual)**	>=98%		1,218 1,218	100.00%	100.00%	0.00%		↔
A7	RAID Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A		976 1,019	95.78%	96.34%	-0.56%		↔
A8	RAID Response times: 24 hour wait for ward referrals (Lister & Watford combined)	N/A		464 474	97.89%	99.65%	-1.76%		↔
A9	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**	>=98%		75/75	100.00%	98.85%	1.15%		↔
A10	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait **(Contractual)**	>=98%		Zero	Zero	Zero	N/A	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A11	EMDASS Diagnosis within 12 weeks (Contractual) Reporting t.b.c	>=80%	tbc	318 458	69.43%	82.48%	-13.04%		↑
A12	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**	>=95%		164 166	98.80%	95.63%	3.16%	Note - data audit taking place on April 2018 data has delayed the availability of this KPI for reporting	↔

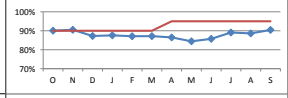
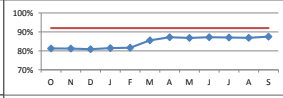
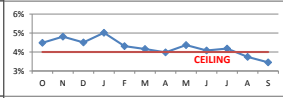
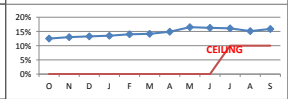
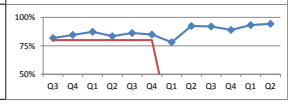
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
A13	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**	>=75%		33/38	86.84%	60.61%	26.24%		↔
A14	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**	>=85%		22/22	100.00%	97.30%	2.70%		↔
A15	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**	>=85%		20/21	95.24%	88.00%	7.24%		↔
A16	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**	>=95%		317 381	83.20%	50.95%	32.25%		↑
A20	SPA referrals with an outcome within 14 days (Internal)	>=98%		6,529 6,541	99.82%	99.85%	-0.03%		↔

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
A21	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services **(Contractual)**	>=98%		6,808 / 6,920	98.38%	98.71%	-0.33%		↔
A22	Number of people entering IAPT treatment (ENCCG) **(Contractual)**	3988 to end of September		573 (710) in September	4328 (3988) Cumulative	2094 (1989) Cumulative	n/a		↔
A23	Number of people entering IAPT treatment (HVCCG) **(Contractual)**	5168 to end of September		743 (804) in September	4757 (5168) Cumulative	2447 (2358) Cumulative	n/a		↔
A24	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**	2946 to end of September		411 (471) in September	2646 (2946) Cumulative	1340 (1473) Cumulative	n/a		↔
A25	Number of people entering IAPT treatment (West Essex) (Contractual)	2468 to end of September		350 (365) in September	1979 (2468) Cumulative	961 (1234) Cumulative	n/a		↔
A26	Number of people entering IAPT treatment (NE Essex) (Contractual)	2664 to end of September		518 (447) in September	2974 (2664) Cumulative	1506 (1332) Cumulative	n/a		↔
A27	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	>=95%		267 / 277	96.39%	97.10%	-0.71%		↔

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
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%		764 789	96.83%	96.05%	0.78%		↔
SE2	Delayed transfers of care to the maintained at a minimal level	<=3.5%		2,679 36,955	7.25%	5.93%	1.32%	Data taken from Trust SPIKE report on 03/10/2018 - previous period 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%		369 382	96.60%	96.05%	0.55%		↔
SE4	The percentage of people under adult mental illness specialties who were followed up within 72 hrs of discharge from psychiatric in-patient care	>=90% As of April 2018		346 379	91.29%	90.70%	0.60%	Target introduced April 2018	↔
SE5	Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) **Seen Only**	>=95%		15,598 16,819	92.74%	93.81%	-1.07%	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 (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
SE6	IAPT % clients moving towards recovery (ENCCG)	>=50%		534 1,028	51.95%	52.09%	-0.15%	Data taken from Trust SPIKE report on 02/10/18 (previous period refreshed)	↔
SE7	IAPT % clients moving towards recovery (HVCCG)	>=50%		762 1,389	54.86%	53.13%	1.73%	Data taken from Trust SPIKE report on 02/10/18 (previous period refreshed)	↔
SE8	IAPT % clients moving towards recovery (Mid Essex)	>=50%		415 784	52.93%	52.48%	0.45%	Data taken from Trust SPIKE report on 02/10/18 (previous period refreshed)	↔
SE9	IAPT % clients moving towards recovery (NE Essex)	>=50%		279 513	54.39%	56.26%	-1.88%	Data taken from Trust SPIKE report on 02/10/18 (previous period refreshed)	↔
SE10	IAPT % of clients moving towards recovery (W Essex)	>=50%		167 325	51.38%	55.06%	-3.67%	Data taken from Trust SPIKE report on 02/10/18 (previous period refreshed)	↔
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**	>=80%		131 162	80.86%	81.82%	-0.95%	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%		394 517	76.21%	74.65%	0.70%		↔
SE13	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=80% (Since Apr 2018)		1,394 1,626	87.10%	85.54%	1.56%		↔
SE14	Rate of service users saying they are treated in a way that reflects the Trust's values	>=80% (Since Apr 2018)		4,040 5,297	76.27%	76.55%	-0.28%		
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
SE16	Rate of carers that feel valued by staff **(rolling 3 month basis)**	>=75%		69/85	81.18%	73.42%	7.76%		↔
SE17	Percentage of eligible service users with a PbR cluster	95%		10,617 11,158	95.15%	95.69%	-0.54%		↔
SE18	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)	95%		9,321 10,605	87.89%	93.02%	-5.13%	Adult Community: 85.15% Acute: 94.93% Older Peoples: 94.40% E&N SBU: 88.25% WEST SBU: 87.09% LD&F SBU (Rehab): 100%	↔
SE19	Data completeness against minimum dataset for Ethnicity (MHSDS)	90%		72,378 79,013	91.60%	91.62%	-0.02%	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%		152,526 155,028	98.39%	98.53%	-0.15%	Previously SOF4 measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Data taken from Trust SPIKE report on 03/10/18 (previous period refreshed)	↔

SE21	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • Employment	>=85%		9,476 17,235	54.98%	61.12%	-6.13%	Data taken from last month of each quarter. Trust SPIKE report on 03/10/18	↔
	• Accomodation	>=85%		9,249 17,235	53.66%	60.77%	-7.10%	Data taken from last month of each quarter. Trust SPIKE report on 03/10/18	↔
SE22	Rate of Service Users Saying staff are welcoming and friendly (Rolling 3 months)	TBC	Trend graph not available as this is a new measure	182 193	94.30%	Figures not available	N/A		↔
SE23	Rate of Servie Users saying they know how to get support and advice at a time of crisis (Rolling 3 months)	TBC	Trend graph not available as this is a new measure	131 169	77.51%	Figures not available	N/A		↔
SE24	Rate of Service Users saying they have been involved in discussions about their care (Rolling 3 months)	TBC	Trend graph not available as this is a new measure	134 167	80.24%	Figures not available	N/A		↔

Ref	Indicator (Monitor/Contractual/Internal)	Target	24 month Trend	Current Period Numbers (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
W1	Staff saying they would recommend the Trust as a place to work	>=61%		335 514	65.2%	67.6%	-2.43%	Total responses in the quarterly Pulse survey	
W2	Staff Wellbeing at Work	75% as of Q2 18/19		1,058 1,627	65.03%	66.0%	-0.98%	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	5% as of Q2 18/19		45 491	9.16%	11.27%	-2.11%	Total responses in the quarterly Pulse survey	
W4	Staff skills and capability	95% as of Q2 18/19		915 1,133	80.76%	92.41%	-11.65%	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 (Q2 2018/19)	Current Period Performance (Q2 2018/19)	Previous Period Performance (Q1 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q3 2018/19)
W5	Rate of staff with a current PDP and appraisal	>=95% as of Apr 2018		2,430 2,687	90.44%	85.73%	4.70%		↑
W6	Rate of mandatory training completed and up to date	>=92%		23,966 27,389	87.50%	87.20%	0.31%		↑
W7	Sickness rate	<=4%		10,015 263,967	3.79%	4.14%	-0.35%		↔
W8	Turnover rate	10% as of Q2 18/19		456.67 2,.878.58	15.86%	16.27%	-0.40%		
W9	Living the Values at work	target under review		579 614	94.30%	93.23%	4.30%	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 YTD Plan (September 2018/19)	Current Period YTD Performance (September 2018/19)	Current Period YTD Performance (June 2018/19)	Change on previous period	Comments	Forecast for next period (December 2018/19)
F1	To Achieve Surplus (amount to be confirmed) in year (not including STF)	£0.36 million in year		£80k loss	**£88k surplus**	**£73k loss**	**£161k surplus**	**Position achieved through balance sheet support**	↔
F2	Use of Resources (formerly Financial Service Risk Rating)	**1**			**1**	**2**	**-**	**1 - Subject to NHSI confirming the treatment of the loan repayment made in year.**	↔
F3	To keep Agency Spend below the NHSI Agency Ceiling (£8.5 million for the year)	**£7.327 million in year**		£3664k	**£3,937k**	**£1,910k**	**£2,027k**		↔
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**				**400**			↔
F5	Projected CRES (Cash Releasing Efficiency Saving) in Financial Year	**£7327k**		**£4700k**	**£4982k**	**N/A**	**N/A**		↔

Appendix 2

Quality priority areas for 2018/19
Quarter 2

Patient (service user) Safety		Target	Q1	July	August	September	Q2
1	Every discharge 7 day follow up	≥=95%	96.05%	98.04%	95.80%	95.45%	96.6%
3	CAMHS 28 day wait for routine referrals	≥=95%	50.95%	83.33%	88.24%	76.24%	83.2%
3	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death	-	1053* Incidents 0.66% (7)				
4	Number of inappropriate out of area placements	275 (Q2)	165				30
Clinical Effectiveness							
6a)	Emergency readmission within 28 days 16 +		5.7%*	4.69%	9.21%	6.67%	6.68%
6b)	Emergency readmission within 28 days 0 - 15		0.2%*	1.56%	0%	0%	0.63%
7	First Episode Psychosis (FEP) waits 14 days (NHSI mandatory)	≥=53%	85.92%	96.15%	80.00%	70.83%	83.08%
8	CATT Gatekeeping	≥=95%	97.1%	96.08%	95.88%	97.44%	96.39%
9a)	Improving Access to Psychological Therapies (IAPT) recovery rate	≥=50%	53.42%	54.24%	52.61%	53.26%	53.4%
9b)	IAPT 6 week wait	≥=75%	83.64%	90.26%	92.73%	93.20%	91.9%
9c)	IAPT 18 week wait	≥=95%	99.77%	99.92%	100.00%	99.95%	99.95%
Service User and Carer Experience							
9	Service users reporting their experience of Community Mental Health Services – Being treated according to trust values	≥=80%	76.55%	76.4%	77.8%	74.9%	76.27%
10	Carers feeling valued by staff	≥= 75%	73.42%	71.4%	76.8%	81.2%	81.2%
11	Staff Experience Friends and Family Test	≥= 70%	74.64%				76.21%
12	Service Users Friends and Family Test	≥= 80%	85.54%	82.8%	87.7%	87.1%	85.73%

*Figures revised from Q1 Performance Report.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	29th November 2018	**Agenda Item: 12**
Subject:	Financial Summary for the period to 31st October 2018	**For Publication:** No
Author:	Sam Garrett, Head of Financial Planning & Reporting	**Approved by:** Paul Ronald, Deputy Director of Finance
Presented by:	Keith Loveman, Executive 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 Committee:

For October the financial position reported was a surplus of £72k for the month, ahead of the Plan of £60k by £12k, and a surplus of £159k for the year to date, ahead of the Plan of £20k deficit by £179k. This continues the upwards trajectory of the last few months, though the actual surplus in month was lower than the previous month, due to additional spend on secondary commissioning (£345k), of which some but not all was offset by additional income (£205k).

All figures are reported before any income from the Provider Sustainability Fund (PSF), which is £799k for the year to date, which reflects that the Control Total has been met so far. The NHSI Use of Resources (UOR) Rating is an overall 1. This is however subject to NHSI confirming the treatment of the loan repayment made in year; as advised by NHSI the repayment has been excluded from the calculation of the Capital Service metric until a final determination is made by them.

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000	Trend
Overall Surplus (Deficit)		60	72	(20)	159	360	
Pay Overall		12,836	12,634	89,666	88,131	154,068	
Agency		611	557	4,274	4,494	7,328	
Secondary Commissioni		2,598	2,974	17,970	19,296	30,676	

The reported position remains encouraging, and ahead of both the Published Plan and the Forecast Recovery Plan. However, it is driven in part by non-recurring factors, particularly the £1.4m reversals of old year accruals and provisions in Quarter 1; improvements made in recent months will need to be sustained.

Key figures are summarised below, with the key message being the progressive improvements in recent months in a number of areas, such as secondary commissioning and agency costs:

1. Total Pay is reported below Plan for the year to date by £1.5m (1.7%) and for the month by £202k (1.6%). This reflects the level of vacancies, not all of which are covered. Pay costs have increased overall during the year, in part due to pay awards made; Agenda for Change has been paid in full and backdated to April, agency rates and Medical pay have increased from October. Agency levels reduced further in the month and are below the NHSI Ceiling for the month, which is a very strong position (including absorbing the pay award referred to above), though remain above it for the year to date. Agency costs represent 4.5% of the overall pay spend, the lowest level this financial year (average 5.6% over last 12 months).

2. Secondary commissioning is reported above Plan by £376k for the month and £1.3m for the year to date, an increase of £345k in the month; it had been highlighted at Month 6 that expenditure was likely to increase. This relates to MHSOP placements (£360k of which c. £250k is due to several backdated CHC Awards); PICU (£105k due to increased activity which was highlighted in previous report); Adult MH Placements (£105k across both Health and Social Care, again as highlighted last month); Personal Budgets (£10k); General Provisions reduction (£250k as provision was made last month but not this month). This area has improved significantly during the year, however the increase this month evidences that it remains a key risk going forward.

3. Income reported better than Plan by £277k in the month and £525k year to date. There is additional income for the year to date across several areas, in particular Education and Training (c. £500k, due to additional trainee doctors than planned, income from Health Education England for IAPT training, and some deferred incomes); Miscellaneous Other Operating Income (mainly amounts of deferred income released to fund projects); partly offset by Income lower than Plan for NHSE (particularly for Medium Secure Services, c. £330k year to date); and Hertfordshire (due to CQUIN, see below). CQUIN remains reported at 80% for Hertfordshire and 100% for all other contracts. The Hertfordshire contract is behind Plan overall due to CQUIN for which the Plan was 90%, but has increased in month by £40k with several small items added to the Block. It is likely that overall Income will be over Plan at the end of the Financial Year by between £750k and £1.0m, before any impact from the new North Essex Learning Disability contract.

4. There remains significant immediate focus on the CRES programme, developing remaining schemes, with agency and placements delivering on some plans, and

2019/20 currently being worked on.

5. Whilst Overhead costs continue to spend above Plan (c. 5% year to date) this is at a reducing rate with ongoing work to reduce further this year. Costs above Plan include in particular Consultancy and Information Technology expenses for various projects to improve services within the Trust; Estates and Project costs to improve the environment for service users and staff; and Site Costs, again improving environments.

Overall therefore the Quarter 2 improvements continue into Quarter 3, with the return to surplus sustained albeit somewhat reduced, largely due to the increase in October in Secondary Commissioning spend. There remains a level of risk driven by the small surplus margin, significant demand volatility, and ongoing workforce pressures, but currently achievement of the planned full year performance is forecast.

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

Effective use of resources, in particular the organisation's continuing financial requirements.

Summary of Implications for:

Finance – achievement of the 2018/19 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 a significant surplus was achieved in 2017/18 the final position in Quarter 4 was c. £250k and was dependent upon addressing cost increases in placements and CAMHS Tier 4 NCM plans being implemented as planned. In addition there are new investments and cost increases emerging for 2018/19 as well as the ongoing issue of addressing service pressures and the operational stretch being consistently reported.

1.2 The CRES level assumed within the Plan is net £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:

Fig. 1a Plan	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	4.60%	5.10%	4.10%
Financing	9.3	8.1	9
Surplus	**0.8**	**3.4**	**0.4**

* This is before any amounts due under the Provider Sustainability Fund

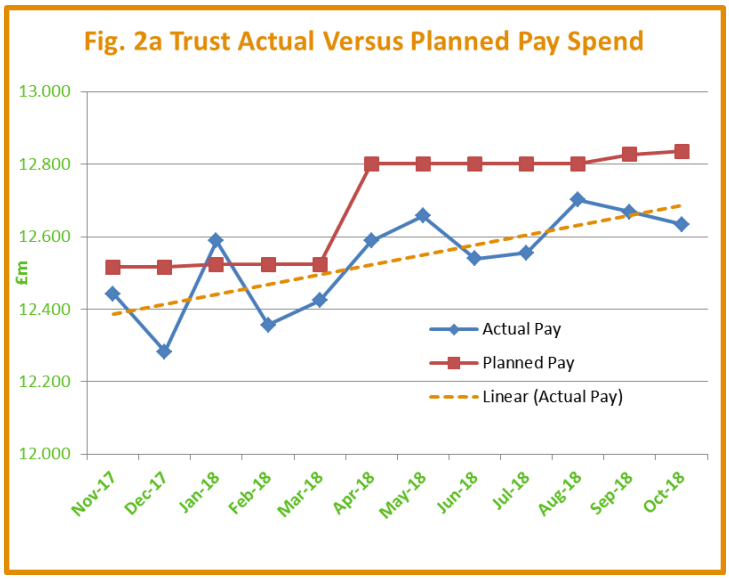
2. Key Variances and Risk Rating

2.1 The Trust's Use of Resources (UOR) Framework rating for Month 7 is a 1. The detailed calculation of the UOR is set out in the appendices, with the main in month movements highlighted in Fig. 2 below:

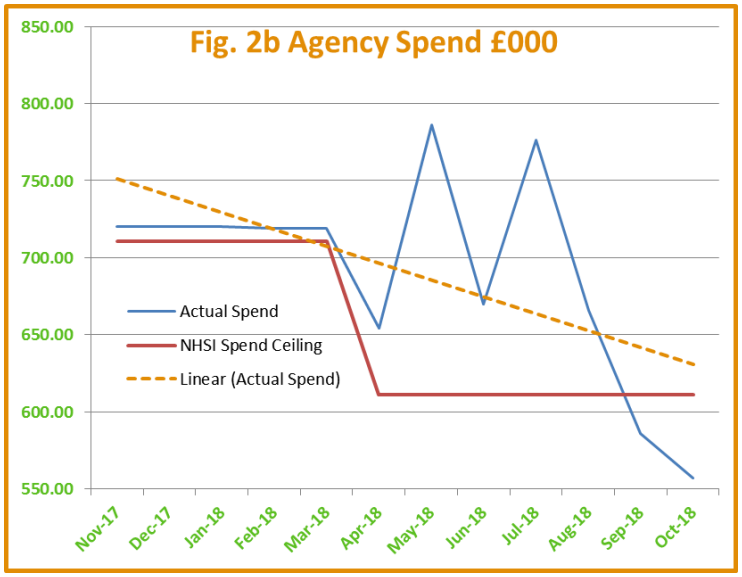
Fig. 2 UOR Summary Metric	Rating		Reported Rating		Commentary
Capital Servicing Capacity	1.9	→	1	→	Stayed the same in month. NHSI sub region is confirming with regional lead that the bridging loan repayment can be excluded from the calculation.
Liquidity	1.1	→	1	→	Strong cash position of £56.5m supporting liquidity metric.
I&E Margin	2.3	↑	2	→	Stayed the same in month.
I&E Variance	1.9	→	1	→	Stayed the same in month.
Agency Spend	2.3	→	2	→	Agency spend decreased in month below cap for this month again, but still above cap YTD
UOR Overall			**1**	→	

Green = 1, Yellow = 2, Amber = 3, Red = 4

2.2 Quarter 1 was extremely challenging and the Plan was achieved by releasing significant levels of non-recurring provisions (c. £1.4m); there were significant improvements in Quarter 2, and these have been sustained into Quarter 3, resulting in reporting ahead of Plan at £72k surplus for the month (Plan of £60k) and £159k surplus for the year to date (Plan of £20k deficit). These figures are before the Provider Sustainability Fund (£799k expected to date).

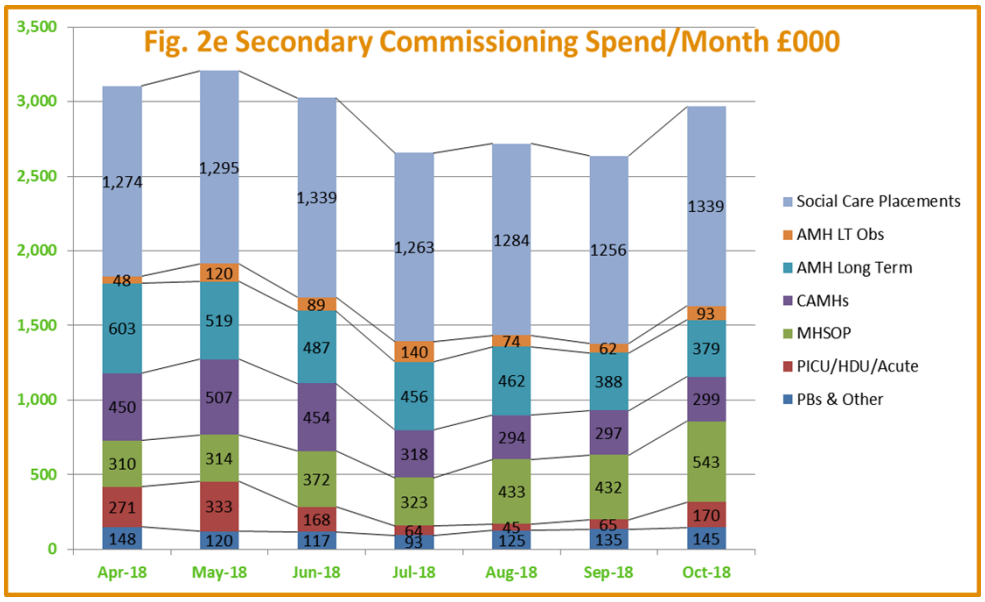


2.3 Pay Costs totalled £12.6m in October as shown in Fig. 2a. There has been a small decrease in September and October due to the backdated pay award being made in August. Overall pay has increased over the last 12 months as shown by the linear trend (dotted orange line). There was no significant change on ftes in the month. Despite this, there was an increase in Substantive Pay in the month, due in part to the Medical Pay Award (£35k) and additional Medical Trainees (£60k, supported by additional HEE income). Substantive pay spend was £10.9m or 86% of the pay cost in October; Bank was £1.2m or 9.5%.



2.4 Agency spend was £557k for the month, 4.5% of the total pay spend, the lowest percentage for Agency in the financial year to date. This represents a continued reduction, remaining below the NHSI Ceiling for the 2nd month running in October. Fig. 2b shows a linear reduction (dotted orange line) evident over the last 12 months, albeit relatively small.

2.5 Secondary Commissioning reports above Plan by £376k for the month and £1.3m for the year to date; this is a significant increase in the month, some of which had been expected due to increasing activity. The increase relates in particular to MHSOP Placements (£360k of which £250k was due to several backdated CHC Awards); PICU (£105k due to increased activity, it had been highlighted at Month 6 that this was likely); Adult MH Long Term Placements (£105k across both Health and Social Care, again it was highlighted at Month 6 that the low level was unlikely to be sustained); Personal Budgets (£10k). CAMHs T4, which also presents a risk going forward, does remain stable this month. Overall for Secondary Commissioning there have been significant improvements during the year.



3 *Mitigating Actions*

3.1 The full Statement of Comprehensive Income (SOCI) is set out as an appendix, this gives the full position and comparison to the Plan for the month and year to date. Whilst there has been improvement in Quarter 2, and this has been sustained into Quarter 3, it will be important to maintain focus on further improvements. Despite the challenging year, it is expected that the Trust's Control Total for the year will be achieved, but this will need ongoing focus including:

3.1.1 Reductions in Agency spend – these started to impact the position from month 5 and have been sustained, however meeting the NHSI Ceiling and maximising the potential saving remains challenging

3.1.2 Managing within current placement spend – this significant reduced in Quarter 2 but has slipped in some areas remaining a significant risk

3.1.3 Vacancy management processes – this has implemented more oversight of vacancies and other payroll related costs, scrutinising:

3.1.3.1 All corporate vacancies and any requested new corporate agency

3.1.3.2 Additional increment requests

3.1.3.3 Recruitment incentive requests

3.1.3.4 Requests for agency (except inpatients)

3.1.3.5 All agency bookings over 6 months, including exceptions

3.1.3.6 All posts vacant for 6 months or more

3.2 There is therefore an ongoing requirement to closely manage expenditure and potentially provide headroom against further spikes in costs in the key areas of risk.

3.3 Projections to date do not include significant further reductions from corporate services. The majority of discretionary expenditure, including project related costs, is driven through

corporate and central services, additionally benchmarking shows there could be savings achieved from Corporate Teams. The Finance Department has commenced a review of a number of discretionary expenditure areas, such as telephones and mobile phones. A review of Corporate Teams has also commenced, with assistance from an external consultant; workshops to consider the first 4 areas (Finance, IM&T, Workforce, Governance and Risk) will be run in the first week of December.

4 CRES

4.1 The net CRES Programme requirement is £4.7m. The forecast programme delivery is c. £4.9m, of which c. £500k will be non-recurrent. Individual schemes have been RAG rated in terms of the likelihood of full delivery, with further work is required to ensure that the full value is achieved in year:

Fig. 6a CRES RAG Rating	Amber	Green	Total
	£000	£000	£000
East & North SBU	918	827	**1,745**
West SBU	237	1,065	**1,302**
LD&F SBU incl. Placements	684	571	**1,255**
Corporate & Procurement	142	431	**573**
Total	**1,981**	**2,894**	**4,875**

4.2 The detailed list of schemes is set out in the appendices with an indication of the expected part year effect for 2019/20.

4.3 Schemes for 2019/20 are currently being developed with the next major step being a workshop in November for key individuals involved in the programme, to outline the schemes and the work required. The work is being informed through the findings from benchmarking work and the wider link to the NHSI support program including the Model Hospital.

5. Statement of Financial Position, Cash Flow and Treasury Management

5.1 The full Statement of Financial Position is set out in the appendices.

5.2 Receivables increased by £1.9m in the month. This is in part due to the billing of STP income which has been deferred, additional accruals for pay award income, and a delay in some payments being received.

5.3 Payables and accruals stayed the same in month.

5.4 The Statement of Cash Flows is set out as an appendix and shows cash balances have decreased by £1.3m in the month, mainly due to the delayed payment of some receivables as noted above. The main movements in month are:

- Cash inflow from operating activities (£1.2m)
- Cash outflow from investing (£200k)

- Cash outflow from financing £100k

6. Capital

6.1 The Capital Programme for the year is outlined in the appendices. The Programme comprises actual capital spend and revenue spend associated with the programme.

6.2 Cumulative net capital spend year to date for 2018/19 is £1.8m. This includes income received from the asset sale of 305 Ware Road of £1.4m.

6.3 There is a further £263k of revenue spend year to date, £50k in month. This primarily relates to the running costs for empty buildings and the dilapidation costs for Trust leased buildings.

6.4 Capital spend has decreased in month due to high levels of spend on IT infrastructure in previous months, with only fire compliance works and Forest House S136 suite extension continuing in Month 7.

6.5 There was a PDC receipt of £170k during October for Patient Wifi works, with a further £170k expected to be drawn down before the end of November.

7. Forward Look

7.1 As previously reported, October has been a key month with a return to surplus sustained through the following:

7.1.1 The implementation of the main part of the placements work stream

7.1.2 Further reductions in agency staff

7.1.3 The continuation of the vacancy management process within Corporate

7.2 Strong progress has been made and at this point it is expected that the Trust's Control Total will be met at the end of the year. However this requires a continuation of the strong focus over the next months to deliver the above as well as driving the maximum benefits from the additional expenditure planned, to support performance improvement.

Current Trading - Income Statement for Period Ended 31-October-2018

Actual in month Oct-17	Actual YTD to 31-Oct-17	Description	2018/19 Plan	Month Actual	Oct - 18 Plan	Variance	Year to Date Actual	Oct - 18 Plan	Variance	Year to Date E&N	West	LD	Support	Other	Total
31	31	Number of Calendar Days	365	31	31		214	214							
0	0														0
13,936	97,683	Contract #1 Hertfordshire IHCCT	170,897	14,210	14,259	(49)	99,462	99,604	(142)	21	(0)	(0)	(0)	99,441	99,462
1,487	10,633	Contract #2 East of England	22,876	1,830	1,906	(76)	12,921	13,344	(423)	(0)	(0)	(0)	(0)	12,921	12,921
794	5,560	Contract #3 North Essex (West Essex CCG)	9,539	801	795	6	5,576	5,564	11	(0)	(0)	(0)	(0)	5,576	5,576
175	1,179	Contract #4 Norfolk (Astley Court)	2,166	181	181	0	1,262	1,264	(2)	(0)	(0)	(0)	(0)	1,262	1,262
560	3,922	Contract #5 IAPT Essex	6,579	562	548	14	3,783	3,838	(55)	(0)	(0)	57	(0)	3,726	3,783
295	2,197	Contract #6 Bucks Chiltern CCG	3,807	317	317	0	2,221	2,221	0	(0)	(0)	(0)	(0)	2,221	2,221
17,247	121,173	Contracts	215,864	17,901	18,006	(105)	125,225	125,835	(610)	21	(0)	57	(0)	125,147	125,225
88	568	Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	1,085	177	90	86	622	633	(11)	712	(0)	(0)	(0)	(90)	622
294	2,429	Education and training revenue	3,094	456	256	200	2,342	1,806	537	57	286	159	595	1,245	2,342
155	1,319	Misc. other operating revenue	4,248	467	347	119	3,424	2,524	900	456	435	246	1,150	1,137	3,424
456	2,994	Other - Cost & Volume Contract revenue	5,332	428	444	(16)	2,924	3,110	(186)	(0)	(0)	2,924	(0)	(0)	2,924
245	1,474	Other clinical income from mandatory services	1,999	158	167	(8)	1,128	1,166	(38)	114	213	755	35	10	1,128
64	233	Research and development revenue	403	34	34	0	169	235	(66)	(0)	1	(0)	168	(0)	169
126	986	Provider Sustainability Fund	1,775	178	178	(0)	799	799	(0)	(0)	(0)	(0)	(0)	799	799
(0)	(0)	Other block	(0)	(0)	(0)	(0)	(0)	(0)	(0)	32,013	31,062	35,453	13,202	(111,731)	0
18,675	**131,175**	**Total Operating Income**	**233,800**	**19,799**	**19,522**	**277**	**136,633**	**136,108**	**525**	**33,374**	**31,998**	**39,594**	**15,150**	**16,517**	**136,633**
(10,175)	(70,887)	Employee expenses, permanent staff	(130,293)	(10,907)	(10,862)	(44)	(74,463)	(75,805)	1,342	(20,856)	(21,603)	(20,431)	(8,959)	(2,614)	(74,463)
(1,372)	(9,185)	Employee expenses, bank staff	(16,447)	(1,170)	(1,364)	193	(9,174)	(9,586)	413	(2,603)	(3,292)	(2,812)	(435)	(32)	(9,174)
(655)	(5,108)	Employee expenses, agency staff	(7,328)	(557)	(611)	53	(4,494)	(4,274)	(220)	(2,014)	(1,527)	(503)	(542)	92	(4,494)
(47)	(228)	Clinical supplies	(269)	(39)	(22)	(17)	(239)	(157)	(82)	(113)	(51)	(52)	(23)	(1)	(239)
(2,428)	(16,728)	Cost of Secondary Commissioning of mandatory services	(30,676)	(2,974)	(2,598)	(376)	(19,296)	(17,970)	(1,326)	(5,537)	(1,553)	(13,054)	(0)	849	(19,296)
(38)	(190)	GP Cover	(279)	(24)	(23)	(1)	(183)	(164)	(19)	(70)	(1)	(112)	(0)	(0)	(183)
(258)	(1,634)	Drugs	(2,646)	(282)	(221)	(62)	(1,857)	(1,544)	(314)	(914)	(762)	(130)	(59)	7	(1,857)
(14,973)	**(103,960)**	**Total Direct Costs**	**(187,938)**	**(15,954)**	**(15,700)**	**(254)**	**(109,706)**	**(109,500)**	**(206)**	**(32,108)**	**(28,790)**	**(37,092)**	**(10,017)**	**(1,699)**	**(109,706)**
3,702	27,215	Gross Profit	45,862	3,845	3,822		26,927	26,608		1,266	3,208	2,502	5,133	14,818	26,927
19.82%	20.75%	Gross Profit Margin	19.62%	19.42%	19.58%		19.71%	19.55%		3.79%	10.02%	6.32%	33.88%	89.72%	19.71%
		Overheads													
(57)	(389)	Consultancy expense	(628)	(27)	(51)	24	(576)	(372)	(204)	(16)	(15)	(34)	(488)	(23)	(576)
(63)	(535)	Education and training expense	(1,074)	(105)	(86)	(19)	(537)	(609)	71	(47)	(45)	(59)	(409)	23	(537)
(360)	(2,484)	Information & Communication Technology	(4,104)	(371)	(341)	(30)	(2,534)	(2,397)	(137)	(71)	(137)	(180)	(2,134)	(13)	(2,534)
(334)	(2,328)	Hard & Soft FM Contract	(5,144)	(457)	(428)	(29)	(3,162)	(3,002)	(159)	(4)	1	(3)	(0)	(3,155)	(3,162)
(553)	(3,869)	Misc. other Operating expenses	(6,694)	(582)	(501)	(81)	(4,445)	(4,250)	(195)	(471)	(676)	(861)	(1,155)	(1,283)	(4,445)
(551)	(3,559)	Other Contracts	(5,339)	(435)	(445)	10	(3,174)	(3,115)	(60)	(334)	(1,025)	(1,064)	(716)	(35)	(3,174)
(36)	(376)	Non-clinical supplies	(399)	(51)	(33)	(18)	(359)	(234)	(126)	(89)	(75)	(136)	(52)	(7)	(359)
(477)	(3,397)	Site Costs	(5,547)	(586)	(462)	(123)	(3,530)	(3,235)	(295)	(16)	(0)	(0)	1	(3,515)	(3,530)
(0)	(995)	Reserves	(1,955)	(0)	(166)	166	(350)	(1,133)	783	(0)	(0)	(0)	(0)	(350)	(350)
(344)	(2,049)	Travel, Subsistence & other Transport Services	(3,732)	(292)	(311)	18	(2,256)	(2,168)	(88)	(565)	(838)	(534)	(360)	41	(2,256)
(2,775)	**(19,981)**	**Total overhead expenses**	**(34,617)**	**(2,906)**	**(2,824)**	**(82)**	**(20,924)**	**(20,515)**	**(409)**	**(1,614)**	**(2,808)**	**(2,871)**	**(5,315)**	**(8,316)**	**(20,924)**
926	**7,234**	**EBITDA**	**11,246**	**939**	**998**	**(58)**	**6,003**	**6,094**	**(91)**	**(348)**	**399**	**(369)**	**(181)**	**6,503**	**6,003**
4.96%	5.51%	EBITDA Margin	4.80%	4.74%	5.10%		4.39%	4.47%		-1.04%	1.24%	-0.93%	-1.19%	39.36%	4.39%
(405)	(2,882)	Depreciation and Amortisation	(5,025)	(400)	(419)	19	(2,856)	(2,931)	75	(0)	(0)	(82)	(0)	(2,774)	(2,856)
(23)	(252)	Other Finance Costs inc Leases	(354)	(28)	(29)	1	(215)	(206)	(9)	(0)	(0)	(0)	(215)	(0)	(215)
(0)	(0)	Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(32)	(0)	(32)	(0)	(0)	(0)	(0)	(32)	(32)
7	51	Interest Income	168	33	14	19	183	98	85	(0)	(0)	(0)	183	(0)	183
(307)	(2,147)	PDC dividend expense	(3,900)	(295)	(325)	30	(2,125)	(2,275)	150	(0)	(0)	(102)	(0)	(2,023)	(2,125)
199	**2,004**	**Net Surplus / (Deficit)**	**2,135**	**249**	**238**	**10**	**958**	**779**	**178**	**(348)**	**399**	**(553)**	**(213)**	**1,673**	**958**
1.07%	**1.53%**	**Net Surplus margin**	**0.91%**	**1.26%**	**1.22%**		**0.70%**	**0.57%**		**-1.04%**	**1.25%**	**-1.40%**	**-1.41%**	**10.13%**	**0.70%**
73	**1,018**	**Net Surplus / (Deficit) before PSF**	**360**	**72**	**60**	**10**	**159**	**(20)**	**178**						

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	29th November 2018	**Agenda Item: 13**
Subject:	Workforce & OD Key Performance Indicators – Q2 Results	**For Publication: Yes**
Author:	Maria Gregoriou – Associate Director of Workforce	**Approved by: Mariejke Maciejewski**
Presented by:	Mariejke Maciejewski – Interim Director of Workforce & Organisational Development	

Purpose of the report:

To update the Trust Board on the Q2 performance against the key workforce metrics and organisational development activity agreed in the Annual Plan.

Action required:

To note the report and recommend any additional measures required.

Summary and recommendations:

There has been an improvement in all of the workforce key performance indicators during Q2. There have been significant improvements in the sickness and vacancy rate key performance indicators as well as an improvement in the appraisal rate, turnover rates and mandatory training rates.

The sickness absence rate has decreased to 3.45% this quarter from 4.40% in Q1 which is below the Trust target of 4%. This is really positive news and following a steady decrease in sickness absence rates over the last year. This is as a result of an increased focus on sickness absence through the introduction of sickness absence board meetings within the SBUs and the significant work that has been undertaken on health and well-being activities which have included the mini health checks, mindfulness and resilience training, massages, physical health activities and Schwartz Rounds which are assisting with prevention and getting staff to focus on their own health and wellbeing.

The vacancy rate has also decreased significantly in Q2 from 15.12% to 12.92%. This has been assisted by having 168 new starters this quarter and 126 leavers with a net gain of 42 new starters. The establishment control work which has been undertaken has also become embedded and the results of this work are also reflected in the vacancy rate. There will continue to be a focus on the retention of staff as well as recruiting new staff into the Trust. A number of initiatives on the NHS Improvement action plan were launched over the last two quarters and further initiatives including career clinics and the new careers website will launch in Q3. The annualised turnover rate has also reduced slightly to 15.8% but further work needs to be undertaken to reduce this further.

The mandatory training rate has improved slightly for the third quarter in a row and currently stands at 87.50%. The implementation of the learning management system, Discovery, has received positive feedback from managers and staff since its launch last quarter. The increased focus on ensuring that all staff have a PDP has led to an increase in the PDP rate to 90%.

A number of staff engagement events took place in Q2 including two senior leaders forums and chief executive breakfasts. Work has also commenced on the next phase of our Good to Great

journey though the High Performing Teams model that has been adapted from a Kings Fund model. In Q2 640 staff responded to the pulse survey, which is the highest ever number of respondent. The results highlighted similar themes to the national staff survey. There was a slight reduction in staff likely to work addition hours from 61% to 59%, 75% believes the Trust takes positive action on their wellbeing, 52% of staff reporting it is easy for them to make improvements at work. Additionally 93% of staff report they have the skills and knowledge to do their job effectively and safely.

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

Summary of Financial, IT, Staffing & Legal Implications:

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

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

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

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

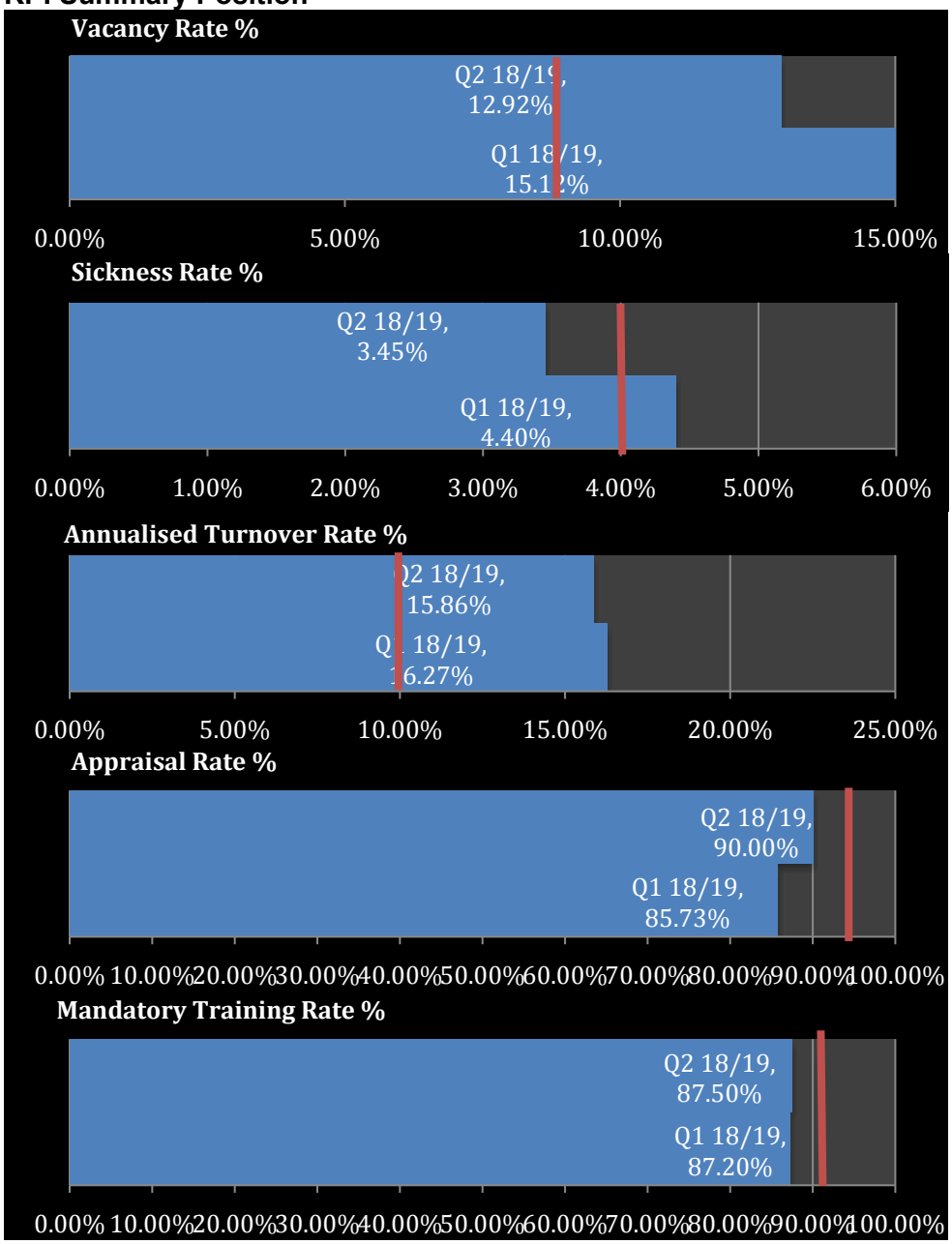
Workforce and Organisational Development Report
Quarter Two: July – September 2018

1.0 Introduction

The purpose of this report is to appraise the Trust Board on the Q2 performance of the key workforce metrics and organisational development activity as agreed in the Annual Plan. The report summarises the activities undertaken to improve performance against the agreed targets and outlines the planned activities for the next period. Detailed below is the Q2 summary position.

2.0 Executive Summary

KPI Summary Position



There has been an improvement in all of the workforce key performance indicators during Q2. There have been significant improvements in the sickness and vacancy rate key performance indicators as well as an improvement in the appraisal rate, turnover rates and mandatory training rates.

The sickness absence rate has decreased to 3.45% this quarter from 4.40% in Q1 which is below the Trust target of 4%. This is really positive news and following a steady decrease in sickness absence rates over the last year. This is as a result of an increased focus on sickness absence through the introduction of sickness absence board meetings within the SBUs and the significant work that has been undertaken on health and well-being activities which have included the mini health checks, mindfulness and resilience training, massages, physical health activities and Schwartz Rounds which are assisting with prevention and getting staff to focus on their own health and wellbeing.

The vacancy rate has also decreased significantly in Q2 from 15.12% to 12.92%. This has been assisted by having 168 new starters this quarter and 126 leavers with a net gain of 42 new starters. The establishment control work which has been undertaken has also become embedded and the results of this work are also reflected in the vacancy rate. There will continue to be a focus on the retention of staff as well as recruiting new staff into the Trust. A number of initiatives on the NHS Improvement action plan were launched over the last two quarters and further initiatives including career clinics and the new careers website will launch in Q3. The annualised turnover rate has also reduced slightly to 15.8% but further work needs to be undertaken to reduce this further.

The mandatory training rate has improved slightly for the third quarter in a row and currently stands at 87.50%. The implementation of the learning management system, Discovery, has received positive feedback from managers and staff since its launch last quarter. The increased focus on ensuring that all staff have a PDP has led to an increase in the PDP rate to 90%.

A number of staff engagement events took place in Q2 including two senior leaders forums and chief executive breakfasts. Work has also commenced on the next phase of our Good to Great journey though the High Performing Teams model that has been adapted from a Kings Fund model. In Q2 640 staff responded to the pulse survey, which is the highest ever number of respondent. The results highlighted similar themes to the national staff survey. There was a slight reduction in staff likely to work addition hours from 61% to 59%, 75% believes the Trust takes positive action on their wellbeing, 52% of staff reporting it is easy for them to make improvements at work. Additionally 93% of staff report they have the skills and knowledge to do their job effectively and safely.

3.0 Key Workforce Metrics

3.1 Establishment Data

The establishment data as at 30th September 2018 is as follows:

Funded Establishment =	**3368.02**
Staff in post =	**2932.90**
Vacant posts =	**435.12**
% Trust Vacancy rate =	**12.92**
Active Vacancies being recruited to =	**223.83**
% Total Turnover rate =	**15.86**
% Planned Turnover Rate =	**4.07**
% Unplanned Turnover Rate =	**11.79**
% Stability rate =	**87.41**

3.2 Turnover Index

The turnover rate has decreased this quarter reaching 15.86% in comparison to 16.27% in Q1. In accordance with the Trust's NHSI retention improvement plan a number of initiatives which were launched in Q1 are attracting interest from staff. This includes the retire and return process, the internal transfer process for nurses and HCAs, and the buddy scheme which provides new starters with additional support in their new roles in the Trust. In Q3 the new Career Clinics and career pathways will be launched. The success of these initiatives will be measured over the coming months.

Whilst the turnover rate in Q2 was 15.86% the unplanned turnover rate has remained stable in Q2 at 11.80% and the planned turnover rate currently stands at 4.07%. Planned turnover includes those staff who leave the Trust as a result of retirement, end of a fixed term contract, and dismissals.

3.2.1 Analysing the leavers data & understanding the reasons staff stay

In Q2 there were 168 new starters and 126 leavers in comparison to Q1 where there were 102 new starters and 118 leavers. This has led to a gain of 42 staff during Q2. There were 18 starters and 28 leavers in nursing this quarter which remains a concern.

This quarter 18 staff retired, which was one of the top 5 reasons for leaving the Trust. Other reasons include end of fixed term contracts, to undertake further education or training, promotion, and work life balance. The introduction of career clinics and the development of career pathways in Q3 should have a positive impact in this regard.

Further tables and graphs showing the turnover information can be found in Appendix 1, section 3 – Turnover.

3.3 Stability Index

This data shows the number of staff with more than one year's experience at two points in time, usually a year apart. These results are compared to give a reflection of the increase or decrease in experience in the organisation. A target of 75% - 85% represents a good balance of new ideas and organistional memory. The stability index at the end of Q2 is 87.41% which shows a slight increase from Q1 when it was 86.49%. A stability index of 87.41% is outside the target but higher than recommended which continues to be positive and shows that experience and knowledge is being retained in the organisation.

3.4 Key Recruitment Activity

There are currently 435 vacant posts this quarter showing a decrease from 513 posts in Q1. There are currently 197 posts in the recruitment pipeline and 128 posts are at offer stage with 46 new starters due to start in Q3.

Time to hire remains at 54.7 days (10.9 weeks). A number of steps are being taken during Q3 that should have a positive effect on reducing time to hire. This includes the outsourcing of pre-employment checks to Trac who run our recruitment system. In order to streamline the new starter process further and to reduce our time to hire, recruiting managers will be undertaking pre-employment and identification documentation checks at interview with support and coaching from the recruitment team.

The Workforce Team is participating in a new NHS Employers programme on career development and career planning for nursing staff and aligns to the work that is currently being undertaken on recruitment and retention. Recruitment training has taken place at various locations across the Trust and has been positively received.

Work is also underway to modernise and improve the Trust careers website so that it is easy to access and navigate. The aim is to attract potential new applicants and to make HPFT the employer of choice. The new careers website will include a function which allows interested candidates to send through their CVs to the recruitment team in order to be matched to current and future vacancies. The careers website will be launched by the end of November. Further work will be carried out to enhance the Intranet as a means of supporting our career clinics and staff engagement.

The HR Business Partner Team is working in partnership with SBU representatives to identify vacancies and recruitment hot spot areas and to support the work that the recruitment team is carrying out as well as undertaking work to implement the SBU local recruitment and retention plans.

3.5 Junior Doctor Recruitment

August rotation has taken place for Junior Doctors with the three 1st on call rotas showing an improvement overall as a 1:14 for Central, North and East. This has had a positive impact on the 2nd on call rotas as a 1:11 during August and September with 7 Specialty Doctors to support weekend cover. No exceptions reports have been raised during August and September. Links are being forged with overseas Universities and Pakistan have confirmed their interest in establishing a working relationship with Hertfordshire Partnership Foundation Trust to imbed the International Medical Fellowship scheme in readiness for February 2019 rotation vacancies at higher trainee level.

Advisory Appointment Committees (AAC's) have been held in July with 2 Consultant posts offered Perinatal (1 post) commencing April 2019 and Old Age (1 post) commencing November 2018. A further AAC took place in September 2018 and 3 posts were offered in General Adult (2) and Acute Adult Inpatient (1). 2 Specialty Doctors have commenced in CAMHS during August 2018.

Agency Doctors are reported weekly to NHSI and this has been reduced from 11 to 10 Agency Doctors between July and August 2018. Key areas for recruitment remain as CAMHS and Old Age with further interviews scheduled.

3.6 Number of starters

In Q2 there were 168 new starters and 126 leavers with a net gain of 42 new staff starting their careers at HPFT. In comparison to Q1 there were a total of 102 new starters and 118 leavers which had resulted in a net loss of 16 staff. The Recruitment Team and the HR Business Partner Team continue to support managers to advertise vacant posts in order to ensure that recruitment activity is sustained at high levels and that there is throughput in the recruitment pipeline.

The breakdown of new starters by staff group is shown in **appendix 1, section 3, Graph 5 – starters and leavers by staff group.**

3.7 Vacancy Trend

The number of vacancies has decreased in Q2 from 513.56 wte posts to 435.12 wte posts. This has resulted in a decrease in the vacancy rate to 12.92% from 15.12% in Q1. There are currently 168.74 wte registered nurse vacancies which equates to 19.90% of all vacanct posts in the Trust. This is a slight improvement on Q1 when there were 192.54 wte registered nurse vacancies equating to 22.31% of all vacant posts.

The Establishment Control Project which is validating the establishment, staff in post and vacancy data will be formally closed in Q3. This work continues to be carried out by the Business Partner Team and the Finance Business Partners to ensure that this process continues to be embedded in the Trust.

In Q2 the Trust's bank, agency and substantive spend on registered and unregistered nursing posts was 10.64%, 5.73% and 83.63% respectively.

Tables and graphs showing recruitment and vacancy information can be found in appendix 1, section 2 – Recruitment.

3.8 Temporary Staffing

During Q2 the total fill rate decreased slightly to 92.22% from 92.68%. The bank and agency fill rates are as follows; All nursing posts 91.98%, social workers 97.76%, OT/AHP 94.64% and admin 91.53%.

A total number of 27,979 shifts were requested to be filled, a drop from Q1 when this figure was 30,441 shifts. Of the total shifts requested 21,399 were filled by bank workers and 4,403 were filled by agency workers showing a bank fill rate of 76.48% and an agency fill rate of 15.74% and a total fill rate of 92.22%.

Further tables and graphs showing bank and agency information can be found in appendix 1, section 5 – Temporary Staffing

3.9 Sickness Absence

There has been a significant improvement in the sickness absence rate for the Trust which has decreased from 4.40% in Q1 to 3.45% in Q2. This is below the Trust target of 4% and is the first time that the rate has reached this level.

There has been a decrease in the sickness absence rates for LD&F and West SBUs. East and North Herts and Corporate sickness rates have increased this quarter but Corporate's sickness absence is still below 4% at 2.71%.

Sickness boards within the SBUs continue to focus on reducing the number of long term sickness absence cases by supporting staff back to work and managing short term sickness absence cases for staff with high bradford scores. In addition the work that the Trust continues to undertake with regards to health and wellbeing which includes the health hub, promoting physical activity and healthy eating, mindfulness courses, mini health checks, resiliance training, and Schwartz Rounds all seem to be having a positive impact on staff with feedback that staff feel the Trust takes an interest in their health and wellbeing.

The top reasons given for absence in the Trust are as follows:

1. Gastrointestinal problems
2. Unknown causes
3. Other known causes – not classified elsewhere
4. Cold, Cough, Flu
5. Anxiety/stress/depression/other psychiatric illnesses

The estimated costs to the Trust of sickness absence for Q2 has been calculated as just under £839k which is a reduction from Q1 at £936k. A breakdown of the sickness absence costs by SBU can be found **in appendix 1, section 4.**

There are currently 113 short term sickness absence cases and 51 long term sickness absence cases being formally managed through the employee relations team as at the end of September 2018. The number of short term sickness absence cases that are being formally managed has increased by nine since the last quarter. The Workforce Team continue to review how we support those areas with high sickness absence rates, with specific meetings / sickness boards to discuss the most appropriate support and actions to be taken, applying the Trust Absence Management procedures and ensuring staff are support through occupational health and health and wellbeing initiatives as well as their managers.

3.10 PDP Rates

The Trust's overall PDP rate has increased by 4% to 90% in Q2. The PDP rates for each SBU are as follows:

SBU	Q3	Q4	Q1	Q2
LD&F	94 %	88 %	87 %	88%
East and North	91 %	90 %	89 %	91%
West	86 %	89 %	87 %	95%
Corporate	65 %	72 %	70 %	83%
Trust	**87 %**	**87 %**	**86 %**	**90%**

PDP rates have increased across all SBUs. East and North PDPs have increased by 2% and managers are being sent monthly information detailing all staff with outstanding PDPs. Further work will be undertaken to identify and upskill Band 5 and 6 staff to support with appraisals of lower banded staff.

The West SBU PDP rate increased by 8% in Q2 and achieved the Trust KPI target of 95% which is very positive. PDP completion is consistently addressed in unit reviews on a monthly basis with a plan for 100% completion by each area.

The LD&F SBU PDP rate increased by 1% in Q2. The SBU Core Management Team are sharing best practice amongst Service Lines, using examples of teams meeting the Trust KPI, in order to plan future PDPs across all areas. In Corporate, the PDP compliance rate increased significantly by 13%. There is a continued focus in the Corporate areas to plan for and complete timely PDPs.

3.11 Statutory and Mandatory Training Rates

The Core Skills Statutory and Mandatory training rates in Q2 have ended as follows:

Statutory and Mandatory Training = 87%
Essential Training = 87%

Whilst the compliance rates are below the Trust target of 92%, statutory and mandatory training compliance has remained stable.

Quarter 2 Compliance by SBU is as follows:

	31st July		31st Aug		30-Sep-18	
Business Streams	**Mandatory**	**Essential**	**Mandatory**	**Essential**	**Mandatory**	**Essential**
Corporate Services	**84%**	**84%**	**84%**	**84%**	**85%**	**82%**
SBU Learning Disability & Forensic	**89%**	**91%**	**89%**	**91%**	**89%**	**89%**
SBU MH East & North Herts	**85%**	**88%**	**86%**	**89%**	**87%**	**86%**
SBU MH West Herts	**85%**	**90%**	**86%**	**90%**	**86%**	**87%**
Overall	**86%**	**90%**	**87%**	**90%**	**87%**	**87%**

A significant amount of work continues to take place to increase compliance rates. Currently the Learning and Development Service are working with Subject Matter Experts (SME) and Professional Leads to draw up action plans to increase the compliance and map out the 2019 – 2020 training plan. This will include the re-launch of quarterly assurance meeting with SMEs. Some of the Quality Assurance Goals include:

- ✓ Effective and Open Communication with SMEs & Learning and Development
- ✓ Improved monitoring of evaluation and actions agreed
- ✓ Better commissioning structure for courses – improved training levels within SBUs
- ✓ Improved delegate engagement
- ✓ Course attendance levels improve

The implementation of the new learning, built for entire self-service access, continues to go well. The web-based system can be used on any laptop, computer, tablet, or compatible smartphone. Staff are able to access the learning platform and book onto classroom sessions, undertake on-line learning and to manage their own statutory and mandatory compliance.

In Quarter 3 the system will be set up to provide a suite of management information and automated reminders therefore compliance can be effectivity managed to support the Trust achieve its target of a minimum compliance rate of 92%. We continue to receive positive feedback on the system and are looking at areas of improvement.

Further developments planned include:

- The promotion of non-mandatory training to be accessed and booked via Discovery
- An online Appraisal / Personal Development Planning Module will be developed to support the setting of personal objectives and an appropriate personal development plan.
- To build on the Supervision Module currently logging supervision.

4.0 Organisational Development Activity

The OD team is progressing delivery against the agreed OD and Learning activity plan. During Q2 work has commenced on embedding the next phase of our Good to Great journey through the High Performing Team Model. Our ambition at HPFT is to deliver great care and great outcomes to our service users. We want to be able to do this consistently all of the time. As an organisation we are good but our ambition is to be great. To develop a culture that delivers our ambition of going from good to great we now want to focus on releasing the potential of our staff through a focus of developing high performing teams. A paper outlining this next phase of our journey was signed off by the Trust Board in September. The model and framework has been shared with senior leaders and service user representatives for their feedback on what they would expect to see from a high performing team.

During the quarter we have also seen the of our In addition to the activity plan there are a number of interventions the OD Team have been involved with this quarter

- Delivery of two workshops at the Team Leader Development Sessions.
- East & North SBU Senior Team Development – Quarterly sessions based on the Senior Leadership Programme.
- East & North Senior Nurses – development programme similar to above.
- West SBU Senior Management Team – development programme as above and additional support for 360 feedback sessions.

- Scoping for 2 team interventions - Victoria Court following the merging of staff from Victoria and Elizabeth Courts. Hemel Team development of senior team (similar leadership programme proposed at scoping stage) and wider team session
- Coaching Network – 8 HPFT staff are now qualified at ILM (Institute of Leadership and Management) Level 5 and are registered with Coachnet (Beds and Herts Coaching Network). They are now coaching both internal and external staff.
- Supporting the development of the High Performing Team model
- Safe Care Staff Redeployment
- MBTI half day session for Wellbeing Team

4.1 Delivering Effective Leadership Capacity and Capability

Leadership Development activity this quarter has included the following:

- The Senior Leaders Forum this quarter included a Schwartz Round in July and the evaluations we received back were really positive. In September the High Performing Team model was shared for discussion and feedback.
- Our leadership offering to managers is currently under development. This will be called Management Fundamentals and is a blended approach of online and face to face offerings giving managers' training in the fundamentals required by HPFT managers to manage effectively. This will be highly recommended to both new and existing managers, with the e-learning element acting as a toolkit for future reference. It is anticipated that this will be rolled out during the coming months and would deliver on the essentials of line management.
- Cohorts 4, 5 and 6 (2018) of the Mary Seacole Local Programme are in progress with Cohort 4 just completing – results are expected by year end.
- Senior Leaders Programme – West and East & North SBU's Senior Team development. Programme based on Lencioni's 5 Dysfunctions of a Team and using MBTI and other tools to develop effective teams and strong team culture.
- Adapted version of the above Senior Leadership Programme for East & North Senior Nursing Team.
- Cohort 9 of the Leadership Academy has completed with 20 of the 21 delegates passing and gaining accreditation. This has been the most successful Leadership Academy to date. The content and delivery method for Cohort 10 is being updated. This is currently in the planning stages and anticipated to commence in February 2019.

4.2 Maintaining and Growing Staff Engagement

Two Inspire Award presentations have taken place this quarter with 31 nominations received.

This was the third quarter that the Pulse survey was emailed directly to staff. The number of respondents increased on the success of last quarter and we received our highest ever number of respondents, 640 which exceeds our target of 600.

The results highlighted similar themes to the national staff survey. There was a slight reduction in staff likely to work addition hours from 61% to 59%, 75% believes the Trust takes positive action on their wellbeing, 52% of staff reporting it is easy for them to make improvements at work. Additionally 93% of staff report they have the skills and knowledge to do their job effectively and safely which is 3% down on last quarter. As with previous quarterly surveys and the national survey there is still a portion of staff who are experiencing bullying with 23% of those experiencing it from SU/Carers and 35% from Managers.

In the qualitative responses of the staff who had experienced Bullying and Harassment there were many staff that were supported by their team/colleagues and some their manager but a high number felt unsupported from their manager and the Trust and the situation not dealt with satisfactorily. The introduction of the new manager fundamentals and effective team development work should support managers and teams in this area and reduce the number of incidents going forward.

The issue of technology and IT still seem to be a concern for many staff as is staff parking, lack of progression, career pathways and personal development are a cause of frustration for staff. Work is being undertaken to address the issues of technology and IT equipment following discussions at the Big Listen. In addition work on career surgeries and career pathways is due to launch in Q3 which should also address some the issues that have been highlighted.

4.3 Improving Staff Health and Wellbeing

Health and Wellbeing activities have continued throughout Q2. Details of the activities which have taken place are shown in the table below:

Health Hub Activity	**Staff participation numbers**
Know Your Numbers (mini health checks)	8 workshops held in different Trust locations. Over 71 staff attended
Online Tutorials - Sleep Podcasts	3 Podcasts uploaded focusing on the importance of sleep; sleep for night workers; and strategies to improve sleep
Schwartz Rounds	6 Rounds held, 98 attendees
8-week Mindfulness course	10 attendees on an 8 week course.
Working together As One	The latest issue is currently being put together
Quarterly Social	Nothing this quarter
Corporate Induction	The Health hub has been presented at each monthly corporate induction

5.0 Learning, Education and Development

5.1 Provision of Education and Delivery of the Learning and Development Agreements

5.1.1 Library and Knowledge Services

During Q2 the library generated 236 general article requests and 408 book renewals. We carried out 15 literature searches. The library currently has 1845 members enrolled to use the Library facilities. In addition 551 members are also registered Athens members. This allows users remote access to resources from outside the physical organization.

The Library and knowledge services strategy has been updated with a new implementation plan in place that is aligned with the new NHS library and knowledge services quality improvement standards. All NHS Trust libraries will now be required to complete this new standard. The Trust submitted its last assessment for the LQAF (Library Quality Assurance Framework) during Q2.

6.0 Recommendation

The Board is asked to note the Q2 position and the level of activity that is being undertaken to support delivery of the Workforce and Organisational Development metrics as well as the actions being identified to improve the position moving forward.

Maria Gregoriou
Associate Director of Workforce
September 2018

Sep 2018 - Based on Q2 2018/2019

HPFT Workforce Information Report Summary

WORKFORCE INFORMATION REPORT SUMMARY

Workforce Report Sep 2018 (Based on data for Q2 (2018/2019)

Section 1: KPI summary position

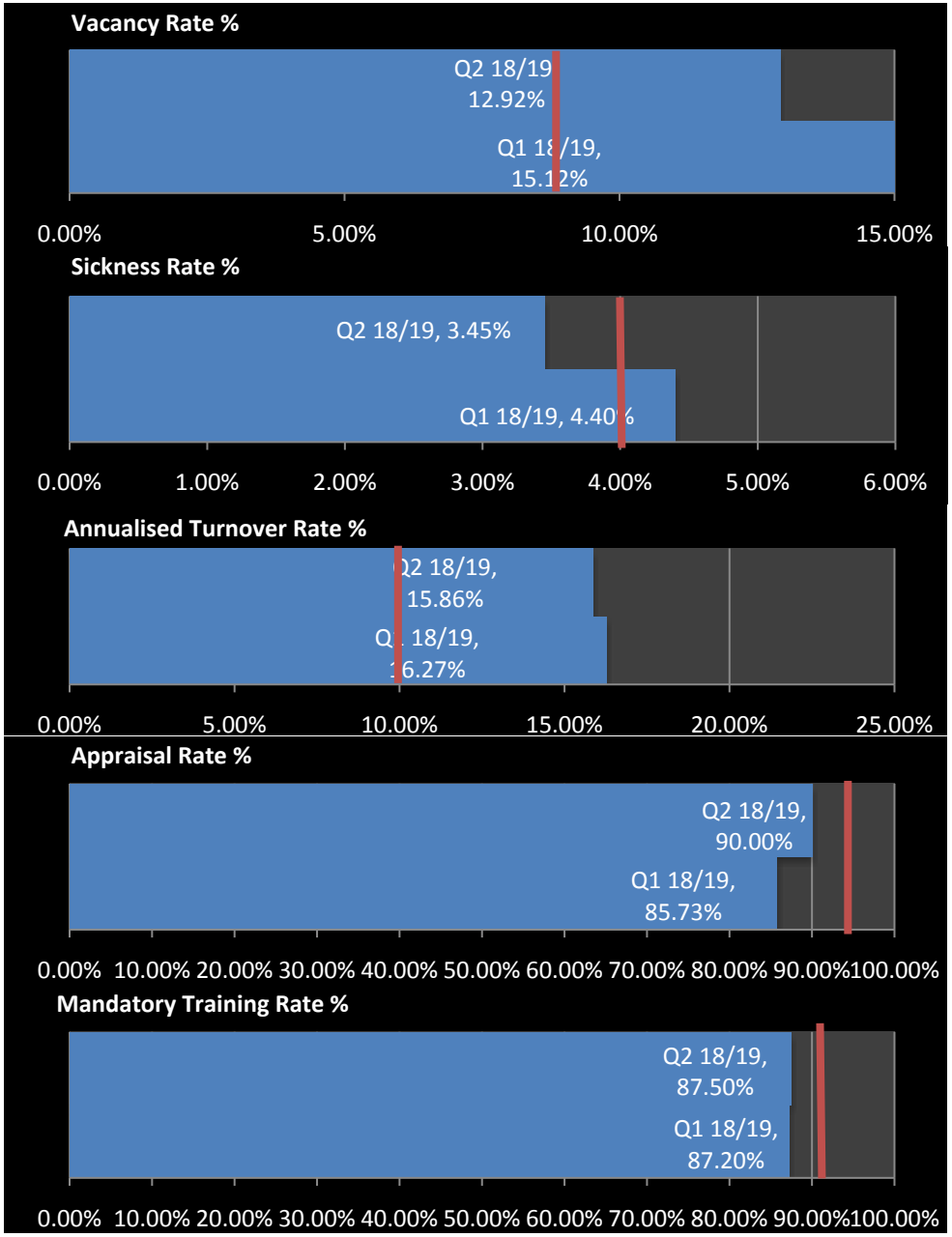
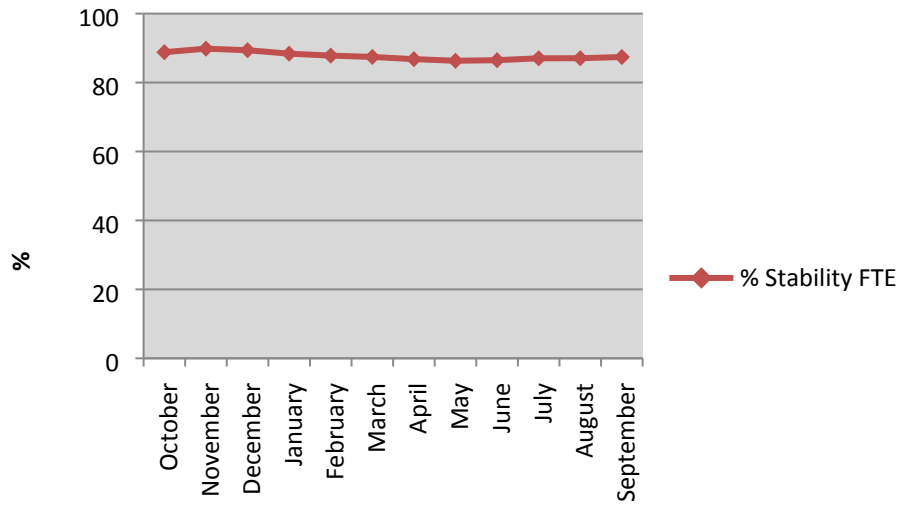


Table 1: Establishment Data

Funded Establishment =	3368.02
Staff in post =	2932.90
Vacant posts =	435.12
% Trust Vacancy rate =	12.92
Active Vacancies being recruited to =	223.83
% Total Turnover rate =	15.86
% Planned Turnover Rate =	4.07
% Unplanned Turnover Rate =	11.79
% Stability rate =	87.41

Graph 1 : % Stability



WORKFORCE INFORMATION REPORT SUMMARY

Section 2: Recruitment

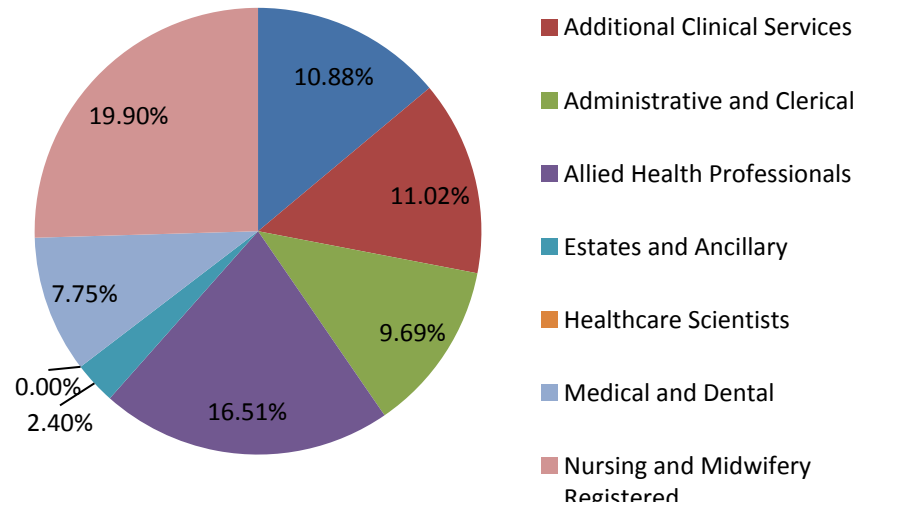
Table 2: Recruitment Summary by SBU

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Authorisation	2	15.53	18.8	23.21	59.54

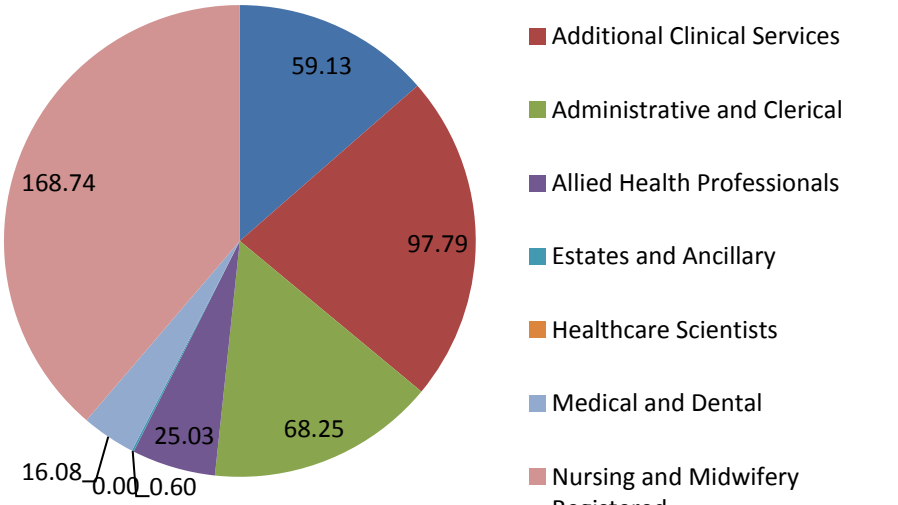
Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Longlisting	8	16	25.53	20.6	70.13
Shortlisting	2	9	13.5	8.71	33.21
Interview	3	6.35	36.3	18	63.65

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Offer	8.6	35.8	25.99	57.4	127.79
Starting	2	14	22.66	6.9	45.56

Graph 2: Vacancies (%) by Staff Group



Graph 3: Vacancies (fte) by Staff Group



Section 3: Turnover

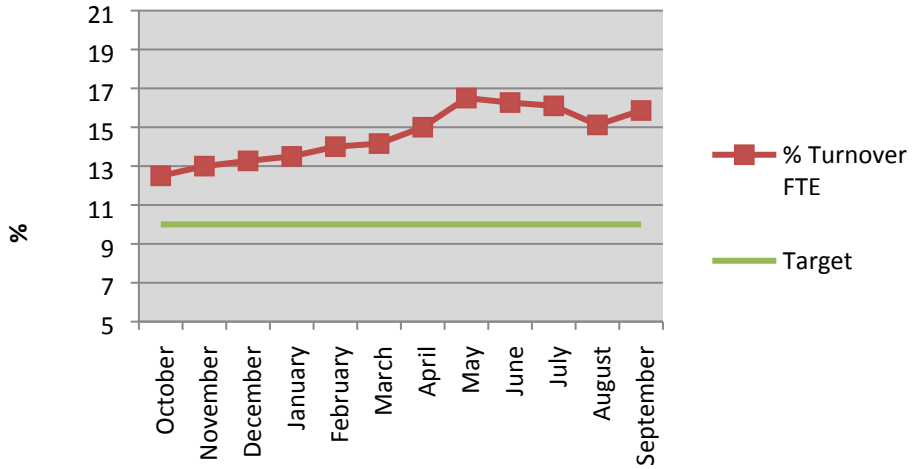
Table 3: Q2 2018-2019 Leavers by Leaving Reason

Leaving Reason	Total
Voluntary Resignation - Other/Not Known	24
Retirement Age	18
End of Fixed Term Contract	16
Voluntary Resignation - To undertake further education or training	15
Voluntary Resignation - Promotion	12
Voluntary Resignation - Work Life Balance	12
Voluntary Resignation - Relocation	12
Voluntary Resignation - Lack of Opportunities	3
Voluntary Resignation - Better Reward Package	3
Voluntary Resignation - Child Dependants	2
Voluntary Resignation - Health	2
Dismissal - Capability	1
End of Fixed Term Contract - Completion of Training Scheme	1
End of Fixed Term Contract - External Rotation	1
Mutually Agreed Resignation - Local Scheme with Repayment	1
Voluntary Early Retirement - with Actuarial Reduction	1
Death in Service	1
Voluntary Resignation - Adult Dependants	1
Grand Total	**126**

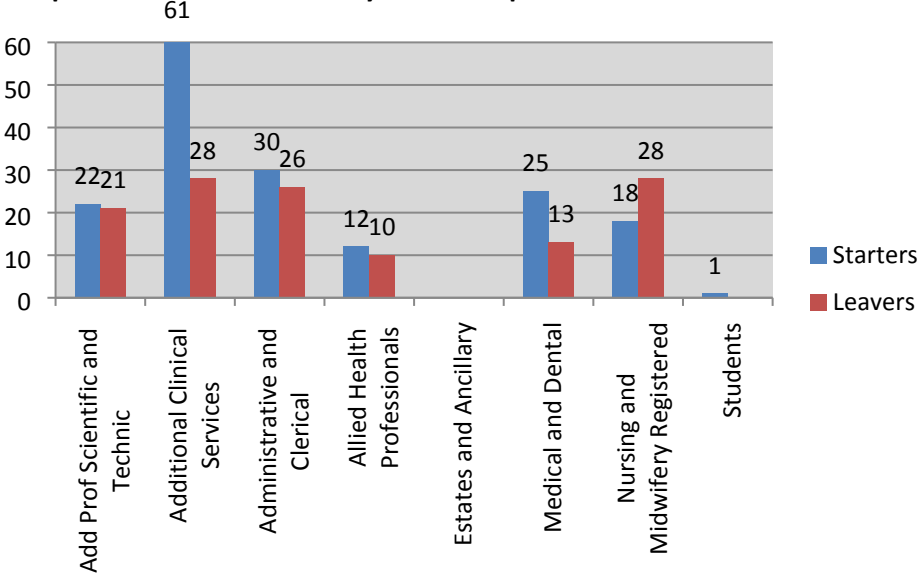
Table 4: Retirement Profile

	Age		
Retirement profile	**55-59**	**60-64**	**65+**
367 Corporate	44	20	15
367 SBU Learning Disability & Forensic	124	42	19
367 SBU MH East & North Herts	122	84	34
367 SBU MH West Herts	105	68	31
Grand Total	**395**	**214**	**99**

Graph 4 : % Turnover



Graph 5: Starters & Leavers by Staff Group Q2



Section 4: Sickness Absence

Table 5: Q2 2018-2019 Top 10 Reasons for Sickness Absence

Sickness Absence Reason	No Of Episodes
S25 Gastrointestinal problems	213
S99 Unknown causes / Not specified	196
S98 Other known causes - not elsewhere classified	178
S13 Cold, Cough, Flu - Influenza	141
S10 Anxiety/stress/depression/other psychiatric illnesses	90
S16 Headache / migraine	76
S12 Other musculoskeletal problems	61
S11 Back Problems	55
S15 Chest & respiratory problems	40
S21 Ear, nose, throat (ENT)	37

Graph 6: % Sickness Absence by Month

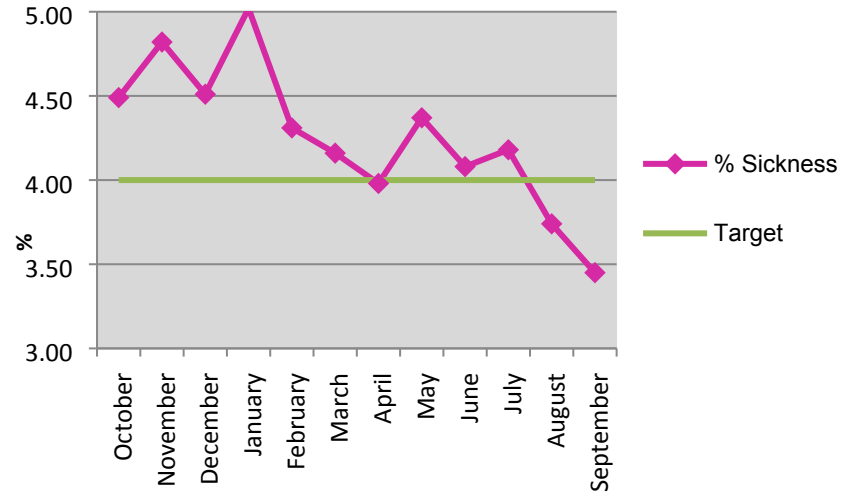
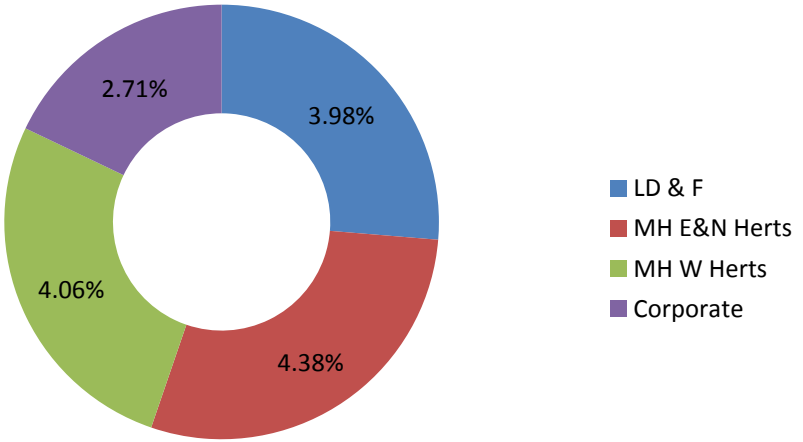


Table 6: Sickness Cost

SBU	Estimated Cost of sickness Q2
Corporate	£83,564
LD & F	£221,972
MH E&N Herts	£257,149
MH W Herts	£275,537
Trust	**£838,222**

Graph 7: Q2 % Sickness Absence by SBU



Section 5: Temporary Staffing

Table 7: Q2 2018-2019 Bank, Agency & Substantive Spend

2018-2019				
Total spend	Q2		YTD	
	£	%	£	%
Agency	1,443,760	5.73%	1,443,760	2.37%
Bank	2,683,613	10.64%	6,664,999	10.95%
Substantive	21,087,132	83.63%	52,769,119	86.68%
Total	**25,214,505**		**60,877,878**	

Graph 8: Bank & Agency Spend

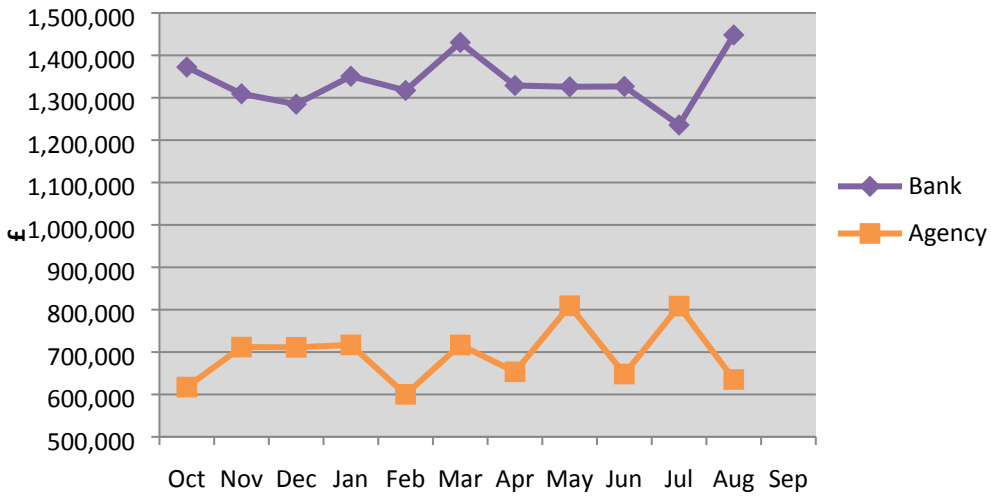
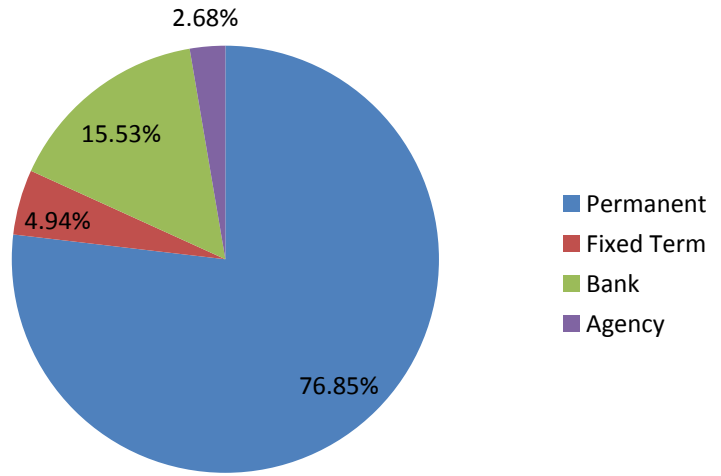


Table 8: Q2 2018-2019 Bank and Agency Usage

Staff	Number of Shifts requested minus the cancellations	Number of Bank Shifts Filled	Bank Fill Rate	Number of Agency Shifts Filled	Agency Fill Rate	Total Fill Rate
Nursing Qualified and Unqualified	21,796	16,620	76.25%	3,428	15.73%	**91.98%**
Admin	4,121	3,404	82.60%	368	8.93%	**91.53%**
Social Workers	980	448	45.71%	510	52.04%	**97.76%**
OT/AHP	1,082	927	85.67%	97	8.96%	**94.64%**
Total	**27,979**	**21,399**	**76.48%**	**4,403**	**15.74%**	**92.22%**

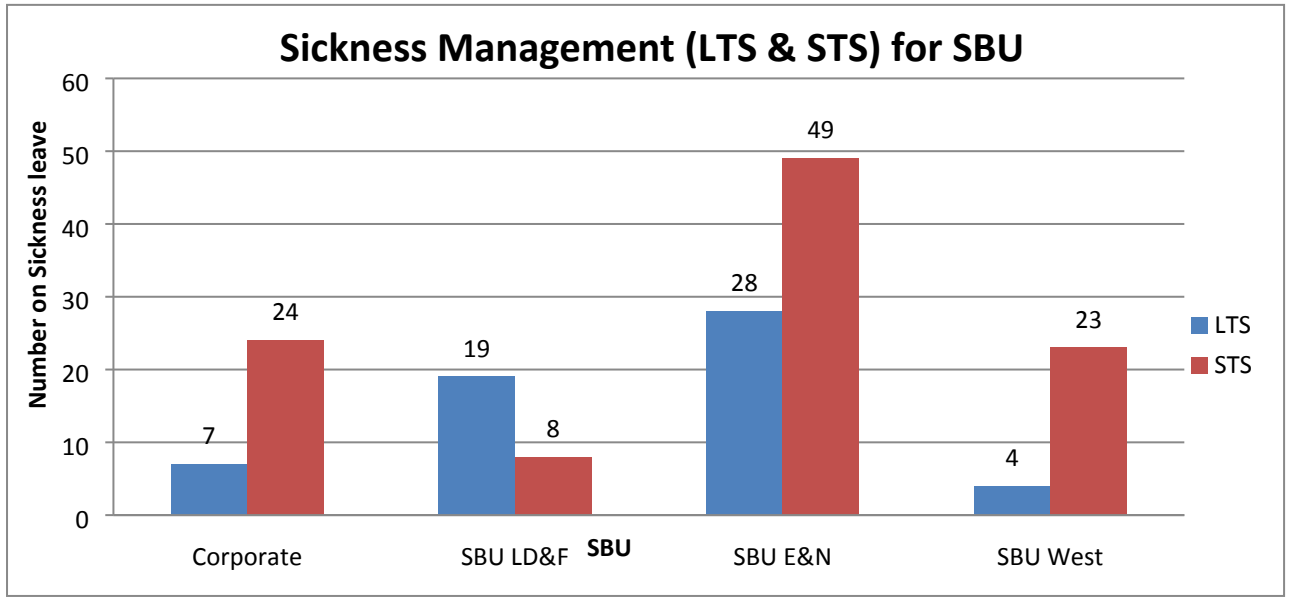
Graph 9: % FTE of Workforce by Assignment Category



Section 6: Employee Relations & Sickness Management

Live ER Cases	Add Prof Scientific and Technic	Additional Clinical Services	Admin and Clerical	Allied Health Professionals	Medical and Dental	Nursing and Midwifery Registered	Total
Number of Disciplinary Cases	1	24	1	1	0	17	**44**
Number of Grievances	2	0	2	0	0	1	**5**
Number of Capability cases	0	0	1	0	0	0	**1**
Number of Bullying & Harassment cases	0	0	0	0	0	2	**2**
Number of Whistleblowing cases	0	0	0	0	0	0	**0**
Total number of cases in progress	**3**	**24**	**4**	**1**	**0**	**20**	**52**
Number of Mediation sessions	1	1	2	0	0	0	**4**
Number of suspensions/restricted duties	1	14	0	0	0	6	**21**
Number of appeals	0	1	1	0	0	3	**5**

Table 9: Total Number of Live Employee Relations Cases in Progress by Staff Group



Section 7: Staff Development

Table 10: Appraisal Compliance

SBU	Number of completed appraisals	Number of Staff	PDP Rate %
367 Corporate	244	293	**83%**
367 SBU Learning Disability & Forensic	700	793	**88%**
367 SBU MH East & North Herts	691	762	**91%**
367 SBU MH West Herts	795	839	**95%**
Grand Total	**2430**	**2687**	**90%**

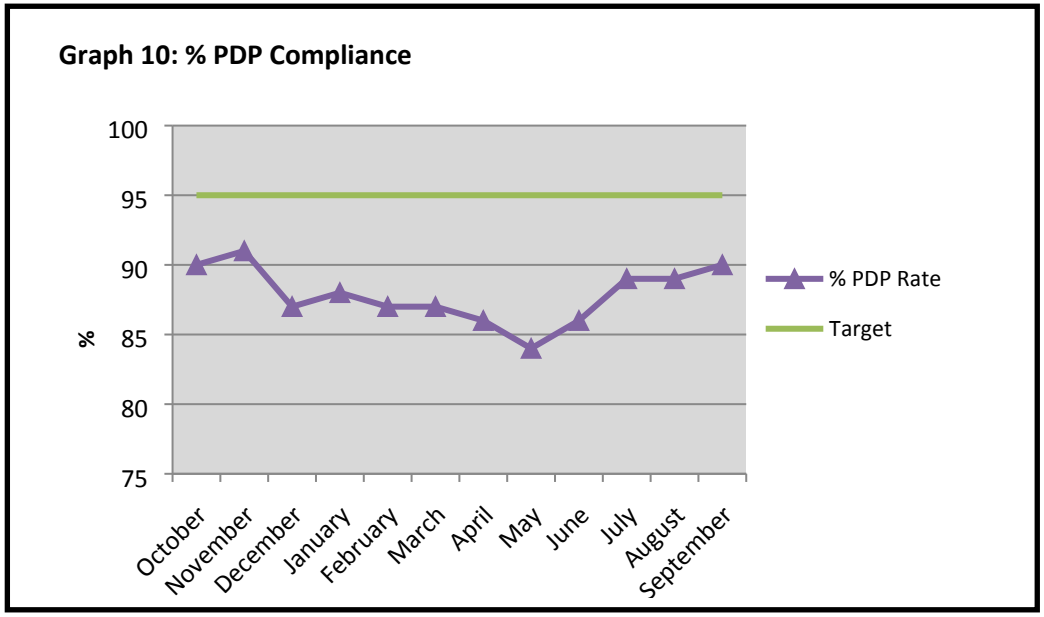
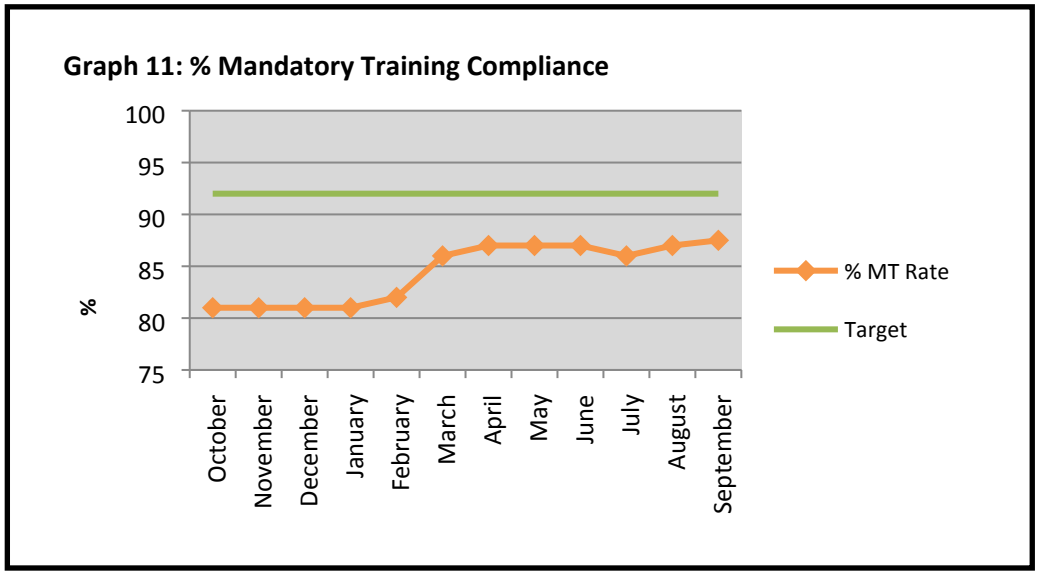


Table 11: Mandatory Training Compliance

SBU	Does not meet requirement	Meets Requirement	% Compliance
367 Corporate	380	2265	**88%**
367 SBU Learning Disability & Forensic	834	7472	**90%**
367 SBU MH East & North Herts	1047	6917	**87%**
367 SBU MH West Herts	1162	7312	**86%**
Grand Total	**3423**	**23966**	**88%**



Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS

Meeting Date:	29 November 2018	**Agenda Item: 14**
Subject:	Annual Plan 2018/19 - Quarter 2 Report (Mid-year review)	**For Publication: Yes**
Author:	Ian Love - Deputy Director Commercial Development	**Approved by:** Keith Loveman
Presented by:	Karen Taylor Executive Director – Strategy & Integrations	

Purpose of the report:

Present the Trust's performance against the Annual Plan for Quarter 2

Action required:

To:

- receive the report
- critically appraise and discuss the content and implications for Trust performance
- seek any additional information required

Summary and recommendations:

Background

The Annual Plan comprises seven 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, in order to deliver the Trust's agreed outcomes for the year. At the end of each quarter progress against priorities for the year are reviewed in relation to the planned milestones and delivery against each objective.

Summary

A considerable programme of work and activities has taken place across the Trust during Quarter 2 and positive progress continues to be made against the plan milestones as can be seen in the detail found in Appendix 1. However, there remains significant work to ensure that the plan is fully delivered in the year, including ongoing focus on the work arising from quarter 2. The following table sets out the headline progress against each objective in the quarter and the areas for continued focus:

	Objective	Q2 Progress	Areas for focus
1	We will provide safe services, so that people feel safe and are protected from avoidable harm	Good progress has continued through Q2 in putting in place those actions that will help achieve the desired outcomes. This is already bearing fruit with an increase in service users, within our inpatient services, reporting they feel safe. Key progress to note includes: • consultation for the safety strategy has been completed • new governance process for the reporting of Serious Incidents is fully embedded, incorporating the moderate harm panel & recording of decision making. • each service line has an HYS question relating to how safe they feel on the ward • new module for restrictive practice training is now in place and restrictive practice group has been set up to ensure best practice is delivered.	Suicide prevention and violent incidents remain priority areas for focus if we are to achieve the end of year outcomes. Whist we are seeing ongoing improvements in Forest House Adolescent Unit there is still work required. Further work is required to progress work in relation to fully incorporating dual diagnosis into risk assessment.
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	Positive progress continues to be made across the key milestones. Our CAHMS T4 Home Treatment Teams, now operating at 95% capacity, are helping to avoid admissions. Actions taken on catering, including facilities upgrade to enable fresh cook to Oak & Beech wards and new menus to Forest House, are showing early positive results through the PLACE audit (improvement of 5.29%). We have updated our welcome packs and provided additional training for all receptions staff. We remain on track to reduce out of area placements.	Work is ongoing with commissioners, through a range of initiatives, to improve access to our adult services and associated high DNA rates. A fully positive outcome depends on the results of these initiatives and the recalibrating of the access target threshold. Pilot schemes will be evaluated formally in December and then successful elements which are scalable, rolled out across services. The 'app' to enable real time satisfaction reporting has been developed but needs to be rolled out for general use.
3	We will improve the health of our service users through the delivery of effective evidence based practice	New processes now ensure follow through on clinical audit findings. The Clinical Outcomes framework has been developed and is in place for FEP; with work well progressed on the dementia pathway.	Further work is required to ensure positive progress across our key outcomes including implementation of outcomes for the PD pathway. Recording for physical healthcare assessments and interventions needs to be improved to ensure that the work undertaken is properly reported.
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	Q2 has seen an improvement in a number of the workforce indicators. There has been a reduction in vacancy rates to 12.9% during Q2. Against a baseline establishment in April 2018 this falls further to 12.3%. Unplanned staff turnover has remained static at 11.8% during Q2. Delivery against the key milestones has continued during Q2 with some significant pieces of work to be launched during Q3.	Launch the 'High Performing Teams' model. Launch the new Trust staff intranet and the new careers website

5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	Good progress has been made across a range of initiatives: <u>Effective ways of working</u> • Roll out of equipment to support flexible/mobile working • Management of IG including Subject Access Requests and Freedom of Information requests Business case for Digital dictation • Initial phase of corporate services review completed • Virtual meetings utilisation • <u>Better access to right information</u> • Updated Information Sharing Integration of physical health National Early Warning Score (NEWS) • <u>Embed continuous improvement and innovation</u> • High Performing Teams model for delivering team effectiveness approved by Trust Board. • Three teams identified as early adopters of continuous improvement agenda. • Innovation & Productivity strategy The financial position has been stabilised and savings plans are in place for £4.9m.	Ongoing focus will be required during the second half of the year if the agreed "Time to Care" approach is to provide measurable increases in direct contact time and the QI approach is to be embedded by the end of the year. SPIKE II is being rolled out from Q3 with implementation of a 'productivity dashboard' during Q4.
6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	A co-produced service model for learning disability in Essex has been developed and progress is now being made on its implementation. GP and service user satisfaction with the primary care model is being determined as part of its evaluation process.	Existing pilots relating to access to adult services and DNA will need to demonstrate progress when evaluated in December and further work is required on meeting key targets relating to the physical health.
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	HPFT senior leaders continue to engage with partners and stakeholders across the system as part of both STP and core service delivery priorities. The Executive Team have developed a stakeholder map and SBU senior management teams are refreshing and developing detailed mapping to reflect local relationships. Our improved relationships with district and housing partners are increasing opportunities for accommodation options. Principles for development of an integrated estates strategy have been agreed with a timeline to deliver an agreed strategy in Q4	Gaining commitment to MH & LD from commissioners continues to be a high priority with early indications of a potential 5 year contract from 2019/20 for Hertfordshire services. We maintain ongoing high visibility in the STP providing leadership and development of the MH workstream as well as leadership in a number of areas.

Conclusion

This report sets out the extensive activity undertaken during Quarter 2 to deliver the priorities outlined in the Annual Plan. Whilst significant progress has been made continued focus to overcome the known challenges and improve performance is required to enable the ambitions outlined in the Plan to be fully realised.

The attached appendix details progress against the Annual Plan. It provides a detailed commentary, by objective, against the milestones delivered during Quarter 2. It also provides commentary, by objective, against the required outcomes by objective to fully deliver the plan for the year.

The Board of Directors are asked to discuss and receive the Quarter 2 Trust Annual Plan 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

Appendix 1 – Annual Plan 2018/19 - Quarter 2

Commentary against Milestones and Outcomes

Great Care, Great Outcomes

Strategic Objective 1 (Owner JP/AZ)	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will provide safe services, so that people feel safe and are protected from avoidable harm	• Develop a new Safety Strategy 2018-21 • Embed new governance process for the reporting of Serious Incidents • Put in place an appropriate method for measuring how service users report feeling safe for CAMHS, LD, Forensic, MHOA and rehab • New module for restrictive practice training developed • Ensure the restrictive practice is delivered in line with best practice • Improve the recording of restrictive practice decision making • Develop and implement an in-house RESPECT module targeted at supporting staff to manage extremely challenging behaviour • Incorporate substance misuse into the risk assessment work and the care pathway work.	
Key Priorities	**Commentary:**	
We will continue our drive to reduce suicides and prevent avoidable harm We will ensure restrictive practices across the Trust are in line with best practice We will target activities to reduce violence against service users and staff	**Develop a new Safety Strategy 2018-21** The consultation for the safety strategy has been completed and is being incorporated into the "Quality Strategy" covering safety, effectiveness and experience which will be consulted on in Q4. **Embed new governance process for the reporting of Serious Incidents** This is fully embedded, incorporating the moderate harm panel, recording of decision making. The work has led to greater ownership of the process and decision making across the organisation and increased opportunities for learning. **Put in place an appropriate method for measuring how service users report feeling safe for CAMHS, LD, Forensic, MHOA and rehab** Each service line has a question (for the Forest House CAMHS service this tailored for this age group) relating to how safe they feel on the ward. Further work is required during Q3 and 4 to ensure we get a complete picture in our older peoples services. **New module for restrictive practice training developed** This new module is now in place. There has been a focus on current techniques and adding leadership and human factors into the revised module 4 training. A restrictive practice group has been set up and, on an ongoing basis, new and challenging situations are brought to the group to consider best practice and guidance. A number of challenging situations with case examples have been highlighted and used to enhance the training.	

	Ensure the restrictive practice is delivered in line with best practice. As above. The training in relation to restrictive practice has been developed to ensure best practice is delivered. **Improve the recording of restrictive practice decision making** The Trust has reviewed the Joint Committee on Human Rights: Inquiry into practices of restraint/segregation in CAMHS MH Settings and a monitoring template has been put in place relating to the recommendations. This will be reported through Safety committee to IGC. A 72 hour report is now completed following every seclusion outside a seclusion room and clinical records are reviewed. **Develop and implement an in-house RESPECT module targeted at supporting staff to manage extremely challenging behaviour** This is being addressed through the new training model described above. **Incorporate substance misuse into the risk assessment work and the care pathway work.** Further work is required to progress work in this area before the milestone can be considered as achieved.

Summary:	**Key Outcomes at Year End**
Good progress has continued through Q2 in putting in place those actions that will help achieve the desired outcomes. This is already bearing fruit with an increase in service users, within our inpatient services, reporting they feel safe. While we are seeing improvements in Forest House Adolescent Unit there is still work required to improve this further. Similarly to the end of Q1, suicides and violent incidents remain priority areas for focus if we are to achieve the end of year outcomes.	10% reduction in number of suspected suicides Increase % service users reporting feeling safe Reduction incidents service user to service user or service user to staff violence (10%)

Strategic Objective 2 (Owner JL/KL)	Q2 Key Actions / Milestones	Q2 milestones Rating
We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	• Fully develop and implement our new CAMHS Tier 4 services • Make improvements to crisis pathway - co locating overnight service at Kingsley Green & Test new Crisis model in SW Herts • Put in place new technology for clozapine clinics to support accessing medications immediately (2 quadrants) • Introduce initiatives to improve the food and menus and we offer • Full roll out of welcome pack and launch of welcome app	
Key Priorities	**Commentary:**	
We will improve the timeliness and experience of accessing our services and subsequent treatment We will improve the quality and experience of the environment across our services (physical estate, standard of food, cleanliness).	**CAMHS T4** Continued positive progress of T4 model for CAMHS, with recruitment into key posts enabling the home treatment team to be operating at 95% capacity by the end of Q2 enabling appropriate admission avoidance and a reduction in young people requiring out of area inpatient admission. **Crisis Services** Crisis services are now based at KFC overnight, providing county wide support for home treatments as well as on site input to the section 136 suites to ensure the effective gatekeeping and admission. **Clozapine** Successful implementation of technology to support single visit testing and dispensing of Clozapine in St Albans. Second site in Watford delayed due to need for building works to accommodate new air conditioning units, the need for which arose during the heat wave. **Access** Health placements on track against trajectory. Carers' assessments on track against trajectory at 65%. Commissioners are engaged with the discussion around 28 day access for adult community and signed up to a joint approach at the August contract review meeting, recognising that current 28 day target will require review. As the impact of the host of current schemes that are being implemented (primary MH, SPA, and DNA SOP) remains unclear they do not want to change the target threshold at this stage. However, they recognise that it will need recalibrating once the impact of the current work is known. Pilot schemes will be evaluated formally in December and then successful elements which are scalable, rolled out across services. **Welcome**	

	All reception staff have taken part in front of house training to improve welcome and service user experience across all sites. An updated and revised 'Welcome Pack' has been fully implemented for adults and for CAMHS a pack has been co-produced and in final stages of being implemented. Live service user feedback technology to be piloted in Colne house has been delayed pending final IG approval to enable GDPR compliance. Anticipated that pilot will commence in Q3 as planned. **Improving Food and menus** Extension to catering and kitchen facilities at Kingfisher Court commissioned and will allow fresh cook provision to be extended to Oak and Beech. Baseline satisfaction rates taken to allow effective monitoring of with a live feedback app being developed and due for implementation in Q2.

Summary:	**Key Outcomes at Year End**
Positive progress continues to be made across the key milestones. Our CAHMS T4 Home Treatment Teams, now operating at 95% capacity, are helping to avoid admissions. Actions taken on catering, including facilities upgrade to enable fresh cook to Oak & Beech wards and new menus to Forest House, are showing early positive results through the PLACE audit (improvement of 5.29%). We have updated our welcome packs and provided additional training for all receptions staff. We remain on track to reduce out of area placements. We will continue to work with commissioners through a range of initiatives to improve access to our adult services and associated high DNA rates.	• Improve service user experience with Adult Community Services • Adult community services access improved throughout the year (98% target) • Reduce DNA rates for initial Assessments by 20% • Reduce out of area placements • Improve service user satisfaction with food

Strategic Objective 3 (Owner AZ/JP)	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will improve the health of our service users through the delivery of effective evidence based practice	• Improve the way we implement the actions arising from clinical audits to improve effectiveness care • Implement new Psychosis pathway across the Trust • Commence work placements programme across HPFT • Continue a targeted approach to accreditation of services	

Key Priorities	Commentary:
We will improve the effectiveness of our interventions through the implementation of evidence based pathways We will develop our approach to research to strengthen the relationship between practice, research and audit	**Clinical Audits** Processes reviewed including more systematic and robust approach to audit programme and Terms of Reference for Practice Audit & Integrated Governance updated. **New Pathways** The FEP pathway is now in place. A proposal for the PD pathway is progressing through approval process given required level of investment and will be presented to TMG in Q3. **Work Placements** The Work Placement Programme is now well established with referrals being received from a wide variety of HPFT services. Further work during quarters three and four will focus on improving the brokerage of potential placements and further improving internal processes. **Service Accreditation** Targeted work continues to be progressed on accreditation of services with rehabilitation, adult community and adult inpatients services all now registered and the necessary groups established under the leadership of the Clinical Directors.

Summary	Key Outcomes at Year End
New processes now ensure follow through on clinical audit findings. The Clinical Outcomes framework has been developed and is in place for FEP; with work well progressed on the dementia pathway. However, further work is required to ensure positive progress across our key outcomes and implementation of outcomes for the PD pathway.	• Clinical Outcomes Framework developed & implemented across three clinical pathways • Actions from audits fully implemented across Trust • Key outcomes achieved (e.g. readmission rates, DNAs, employment status, physical health status) • Research strategy developed & clinical research capability increased

Great People

Strategic Objective 4 (Owner: MM)	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	• Reinvigorate talent management strategy and succession planning process • Run focus groups and commence changes to the Trust's career website • Launch internal transfer process for nursing staff • Implement career surgeries for staff • Set up a task and finish group to implement the national AfC pay refresh • Develop Team OD approach	
Key Priorities	**Commentary:**	
We will develop new roles across the organisation to ensure we have the right staff in the right place delivering the right care We will deliver the key high impact recruitment and retention activities (NHSI) We will continue to develop the culture of the organisation where staff feel empowered and engaged through collective leadership	A paper on the High Performing Team Model, which will take the Trust on its journey of going from Good to Great, was taken to the Trust Board and approval was given to implement the model. The model has been shared with the Senior Leadership Team and will also be shared with service user representatives. The model will start to be rolled out during Q3. A company has been selected to update the Trust's careers website and focus groups have been run with staff, new starters, and service user representatives to get feedback. The changes to the website are being implemented and the new career site will also launch during Q3. The internal moves process for nursing and HCA staff has been launched throughout the Trust during Q2. The buddy system for new starters has been launched, initially in high turnover areas, and 100 day interviews continue to be embedded. The guidance with regards to career clinics has been completed and career clinics for all staff are in the process of being set up. A new Trainee Nurse Associate programme specifically for Learning Disabilities has also commenced in conjunction with the University of Hertfordshire. A task and finish group has been set up with stakeholders to implement the AfC pay refresh. Staff engagement sessions continued to take place during Q2 with Chief Executive Breakfasts, Senior Leaders Forum and a Big Listen took place at the beginning of October. Talent management and succession planning training has also taken place within SBUs and is being extended throughout.	
Summary		**Key Outcomes at Year End**

Q2 has seen an improvement in a number of the workforce indicators. There has been a reduction in vacancy rates to 12.9% during Q2. Against a baseline establishment in April 2018 this falls further to 12.3%. Unplanned staff turnover has remained static at 11.8% during Q2. Delivery against the key milestones has continued during Q2 with some significant pieces of work to be launched during Q3.	• Vacancy rate reduced to 10% against baseline establishment at 1 April 2018. • Unplanned staff turnover reduced to 10% • Maintain or improve staff feeling engaged and motivated • Improved staff satisfaction results in pulse and staff surveys

Great Organisation

Strategic Objective 5 (Owner RA /KL)	Q2 Key Actions / Milestones	Q2 Milestone Rating
We will improve, innovate and transform our services to provide the most effective, productive and high quality care	• Business case for Skype-for-Business licenses (upgrade of screens / cameras) approved • Ongoing expansion of devices with data SIM support; data contracts & data usage • Introduced automated process to manage subject access request & Freedom of Information requests • To commence deployment of digital dictation (BigHand) Phase 2 • Complete corporate services review with plan in place to develop 'fit-for-future' model • Adoption of medical interoperability gateway (MIG) in specific services • Develop OD approach to building team effectiveness • Innovation & Productivity strategy and plan approved • To deliver agreed CRES plans	
Key Priorities	**Commentary**	
We will develop more effective ways of working that value service user, carer and staff time, enabled through the implementation of new technologies. We will provide staff and teams with better access to the right information to do their jobs effectively and efficiently We will embed our approach to continuous improvement and innovation across the organisation	***Effective ways of working*** • All GoToMeeting accounts (60) are active across individuals & teams with training delivered on its effective use. Utilisation is approximately 60% of planned with 130 sessions lasting a total of 115 hours. • Staff continue to be issued with laptops that have internal data SIM card capability with 66 laptops deployed in Q2, promoting culture change in the efficient use of equipment to gain productivity and care benefits underway. • Ulysses deployed for managing Subject Access Requests and Freedom of Information request, improving compliance from 53% and 28% in Q4 2017/18 to over 95% and c60% in Q2 respectively. • Business case for Digital dictation being re-evaluated to demonstrate robust benefits realisation. • Initial corporate services review completed with next phase approved with plans for initial pilot in Q3. ***Better access to right information*** • Updated Information Sharing Agreements signed for medical interoperability gateway (MIG) with East Herts MHSOP and LD teams going live in Q3. • Integration of physical health National Early Warning Score (NEWS) planned for Q3 was completed early in Q2.	

	Embed continuous improvement and innovation • High Performing Teams model for delivering team effectiveness approved by Trust Board. • Three teams identified as early adopters of adopting principles of continuous improvement agenda. • Innovation & Productivity strategy – this has been developed as two separate but interrelated streams with strategies agreed by the Executive team. Full development with underpinning plans planned to be finalised in Q3 and productivity agenda, 'Making Time to Care', forming key element of next series of Good to Great Roadshows. Whilst efficiency plans have not fully delivered against target during the quarter the underlying financial performance has improved in Q2 to bring the run rate back to plan.

Summary	**Key Outcomes at Year End**
The financial position has been stabilised and savings plans are in place for £4.9m. Ongoing focus will be required during the second half of the year if the agreed "Time to Care" approach is to provide measurable increases in direct contact time and the QI approach is to be embedded by the end of the year. SPIKE II is being rolled out from Q3 with implementation of a 'productivity dashboard' during Q4.	• Measurable increase in direct contact time • Real time access to information to improve decision making available • Quality Improvement (QI) methodology adopted, cohort of staff trained and methodology embedded • Improvement initiatives across operational and corporate services • CRES programme delivered (net £4.7m) with no quality impact based on recurrent and clinically sustainable schemes

Great Networks and Partnerships

Strategic Objective 6 (Owner: KT /JL)	Q2 Key Actions / Milestones	Q2 Milestone Rating
We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	• Strengthen our 'local' access via our Single Point of Access to improve responsiveness and link to GP neighbourhoods • Embed and extend CORE24, to meet the needs of people with acute care needs. • Older people's pilot roll out LLV • Dementia project commenced in Dacorum • Mobilise LD services in Essex • Physical Health Practitioners recruited to key service areas and support training	
Key Priorities	**Commentary:**	
We will develop and deliver new models of care to achieve improved outcomes for our service users We will mainstream our physical health practices across the Trust	Our approach to strengthening local access is under review pending the outcome of the HVCCG procurement for adult community services to reflect any interface with their Single Point of Access and any STP wide development of SPA services to support the frailty pathway. GP Satisfaction data being ascertained. Core 24 now fully operating across both acute sites 24/7 providing round the clock 1 hour response in >95% of presentations to A&E and 24 hour response to all inpatient ward settings. The dementia pilot in Lower Lea Valley has been successfully implemented and proposals are being considered to extend. The dementia project has commenced in Dacorum and a CPN has been appointed to join holistic health care team. The Managing Director has been appointed for Essex LD services (commencing Jan 20) and Essex Mobilisation on track	

Summary	Key Outcomes at Year End
A co-produced service model for learning disability in Essex has been developed and progress is now being made on its implementation. GP and service user satisfaction with the primary care model is being determined as part of the evaluation process. However, existing pilots relating to access to adult services and DNA will need to demonstrate progress when evaluated in December and further work is	• GPs & service users reporting satisfaction with primary care model • Increased conversion rate Initial Assessment to treatment • 24/7 access Core 24 - A&E and acute hospital settings • Coproduced LD model in place across Essex • Physical health indicators and outcomes for service users met • Increased number of service users reporting care is joined up • Service users report being supported to achieve weight loss

required on meeting key targets relating to the physical health	

Strategic Objective 7 (Owner KT/JL)	Q2 Key Actions / Milestones	Q2 Milestone Rating
We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	• Further develop a detailed stakeholder map and plan to support the Trust to engage and works with key stakeholders • Review our leadership into each GP locality - to ensure mental health at heart of future locality working • Continue to lead and contribute to the full range of Sustainable Transformation Partnership (STP) workstreams • Support mobilisation of the frailty pathway across the system • Develop our estates strategy in conjunction with partners to meet future service plans • Develop plans to strengthen understanding & capabilities as 'lead provider' • Design our planning processes for 2019/20 to reflect best practice and system wide approach	
Key Priorities	**Commentary:**	
We will continue to drive and support the improvement of care and outcomes across the system We will ensure the needs of those with a mental health illness and/or learning disability are included in the future design of services	The Executive Team have developed a stakeholder map and SBU senior management teams are refreshing and developing detailed mapping to reflect local relationships. HPFT senior leaders continue to engage with partners and stakeholders across the system as part of both STP and core service delivery priorities. Good engagement with district and housing partners is enabling the appropriate housing opportunities to be available for persons with a mental health or learning disability relates range of accommodation needs. STP engagement across both the Herts Valleys and E&N Hertfordshire system leadership boards as well as the individual STP workstreams is ensuring that the needs of our service users are recognised within the planning of services and that the benefits of positive mental health and wellbeing can have on the wider determinants of health and the improved outcomes for patients and service users. Principles for development of an integrated estates strategy have been agreed with a timeline to deliver an agreed strategy in Q4.	

Summary	Key Outcomes at Year End
Gaining commitment to MH & LD from commissioners continues to be a high priority with early indications of a potential 5 year contract from 2019/20 for Hertfordshire services. We maintain an ongoing high visibility in the STP,	• Mental Health & LD continues to be prioritised for investment (Parity of Esteem funding secured 2019/20) • STP leaders report engagement and delivery from HPFT • HPFT has an understood role/position within the future health and social care system • HPFT Estates strategy approved • Improved focus on dementia care across the system • MH & LD role in locality working and links in place

providing leadership and development of the MH workstream and leadership in a number of areas. Our improved relationships with district and housing partners are increasing opportunities for accommodation options.	• Accommodation, housing and employment form a key part of STP work and focus over the course of 2018/19.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	29th November 2018	**Agenda Item: 15**
Subject:	Trust Planning Cycle 2019-2020	**For Publication: No**
Author:	Ian Love, Deputy Director Commercial Development	**Approved by:** Keith Loveman
Presented by:	Karen Taylor, Director of Strategy and Integration	

Purpose of the report:

To update the Board on the implications of the initial planning guidance issued by NHS Improvement / England and make recommendations for the Trust's planning cycle for 2019-20.

Action required:

Review the paper and accept its recommendations.

Summary and recommendations to the Board:

Introduction

This paper describes the proposed approach to the Trust's Business Planning Cycle following the NHS Improvement / England (NHSE I/E) letter dated 16 October (Approach to Planning) which set out its two stage approach to planning:

- Individual organisations submit an initial one year operational plan for 2019-20. These will be aggregated by STP alongside a local system operational plan narrative. This is to act as the baseline for the system strategic plans
- System five year plans are to be developed during the first half of 2019/20 with these plans signed off by all organisations by the summer 2019.

NHS E/I Timetable

NHS I/E anticipate providing the NHS Long Term Plan along with planning guidance and submission templates in the first half of December 2018.

The following key approval and submission dates mean that documents will need to be ready for approval by the Trust Board on 7 March 2019.

Activity	Deadline
Contract Signature	21 March 2019
Organisational Board / Governing Body approval 19/20 budgets	29 March 2019
Final 19/20 Organisational Plan Submission	4 April 2019

Approach to HPFT planning needs

The Trust has a clearly established Vision, Mission and set of Values. It also has an established strategic approach, Good to Great, to moving towards its vision.

The delivery content of the Good to Great strategy sets the focus for the Trust's development activity over the short, medium and long term. The short term development activity is

summarised in the Trust's Annual Plan.

With the advent of the NHS Long Term Plan and the increasing focus on a system approach to local service provision, the Trust will need to undertake a refresh of the development activity within its Good to Great strategy. However, this will need to be informed by and inform local and national development plans and will therefore need to be undertaken in parallel with local system plan development.

It is therefore proposed, in line with the national approach, that our planning is undertaken in two phases:

- Phase One (Nov 19 - Mar 19): Establish key activities within "Good to Great" for the 19/20 Annual Plan that continue to progress the Trust towards its vision.
- Phase Two (April 19 – Sept 19): Refresh the key medium and long term activities within the Good to Great Strategy to both shape and reflect local system plans.

The Phase One planning process will build on previous years by:

- Carrying forward and updating the seven objectives found in the 2018-19 Annual Plan
- Ensuring that key activities within the 2019-20 also give consideration to the likely needs of future years
- Building shared ownership for the Annual Plan across the Trust's Senior Leadership Team
- Develop a cross functional approach to planning involving all functions throughout the planning process
- Design the delivery and governance as part of the planning process including: clear SRO leadership, milestones, outcomes and relevant performance measures.

The major milestones are summarised in the table below:

Phase 1 Planning Milestones

Milestone	**Date**
Trust Executive Identify Key Focus Areas for 2019-20	6 November 2018
SLT check challenge and confirmation Key Focus Areas	21 November 2018
Initial Draft Delivery Plans	18 January 2019
Financial alignment complete and SLT review, "check / challenge"	23 January 2019
SBU key projects confirmed by MDs and TE	4 February 2019
Key Corporate projects confirmed	4 February 2019
Annual Plan Approval by Trust Board	4 March 2019
SBU Development Plans approved by Trust Exec	20 March 2019
Key Corporate Plans approved by Trust Executive	20 March 2019

Recommendations:

The Board notes:-

- the outline timetable and likely requirements of NHS E/I with regard to planning
- the two phase approach to planning for 2019-20 and beyond
- the approach and milestones (detailed elsewhere in the paper) for the creation of the Trust Annual Plan, SBU Improvement Plans and the Key Supporting Corporate Plans

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

Process ensures the creation of the Trust's Annual Plan within the required timelines

Summary of Implications for:

1. Finance – N/A 2. IT – N/A 3. Staffing – N/A 4. NHS Constitution – N/A 5. Carbon Footprint – N/A 6. Legal – New NHS Contract, two NHS Sub contracts and a Partnership Agreement

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

N/A

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

N/A

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

Executive Team 31 October 2018 Finance & Investment Committee 13 November 2018

1.0 Introduction
With NHS England and NHS Improvement (NHS I/E) issuing an initial summary of its "Approach to Planning", this paper describes the proposed approach to the Trust's Business Planning Cycle.

2.0 Background
The government is committing to annual real terms growth in funding for the NHS of 3.4% covering the period 2019-20 to 2023-24. In return for this commitment the NHS is developing its Long Term Plan.

This will likely see an increased focus on existing trends towards service integration; new integrated organisational approaches; an erosion of the commissioner provider split; strengthening role of STPs; and a welcome prioritisation for mental health care.

The Trust has a well-established Vision, Mission and set of Values supported by its approach to realising these, through its Good to Great strategy. With the advent of the NHS Long Term Plan and a changing shape to local provision the Trust will need to formally review the content of its strategy to ensure it fully reflects the NHS Long Term Plan and a changing local landscape.

The Trust will also need to ensure it has a refreshed Annual Plan for 2019-20 to guide its activity over the short term.

This paper focuses on describing a proposed approach to developing both the Trust's Annual plan while recognising the need to also undertake a formal refresh of the content of the Trust' Good to Great strategy.

3.0 Approach to National Planning Requirements
The NHS I/E letter dated 16 October (Approach to Planning) set out a two stage approach to planning:

- Individual organisations submit an initial one year operational plan for 2019-20. These will be aggregated by STP alongside a local system operational plan narrative. This is to act as the baseline for the system strategic plans
- System five year plans are to be developed during the first half of 2019/20 with these plans signed off by all organisations by the summer 2019.

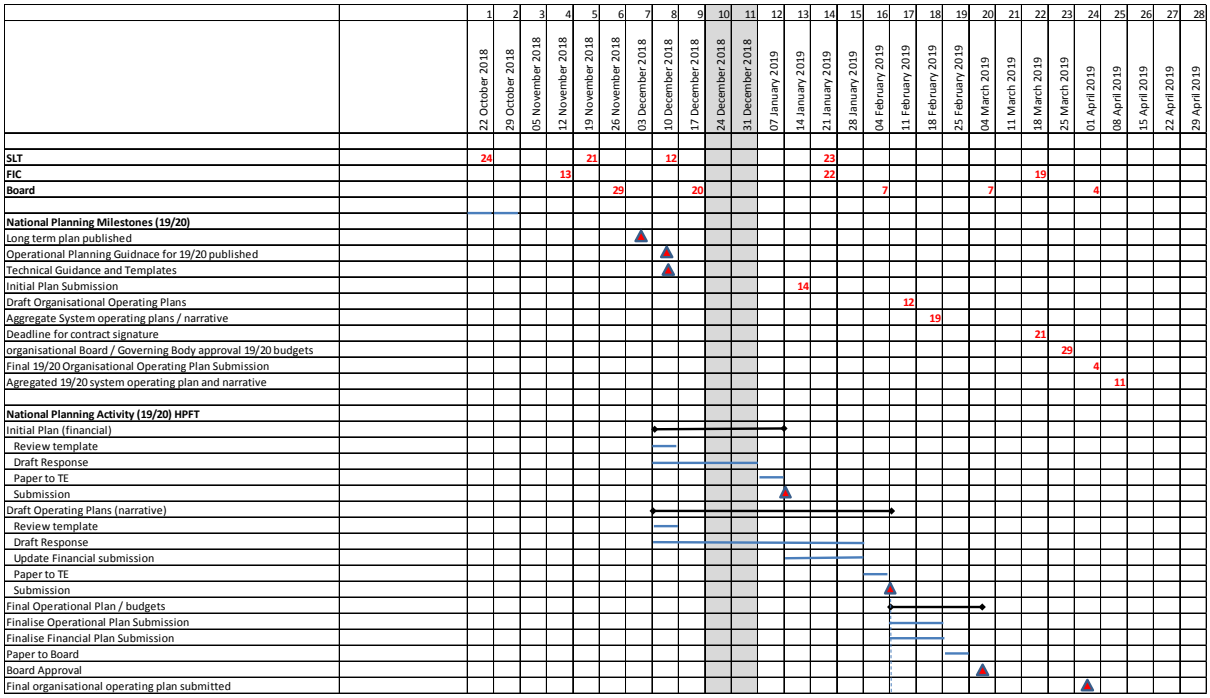
NHS I/E anticipate providing the NHS Long Term Plan along with planning guidance and submission templates in the first half of December 2018.

As with previous similar exercises we would expect two main submissions to be required:

- A Financial Plan including supporting workforce plans
- An Operational Plan narrative. It is anticipated, as on previous occasions, the requirement for this will be on providing assurance on the processes that support the Financial Plan while ensuring service quality is protected (Appendix A provides the structure of the 2017 – 19 Operational Plan narrative). While there will be some overlap, the needs of this document will be different from our own Annual Plan.

4.0 Timetable
The chart below shows the key activities and time lines for the preparation of the submissions required by NHS I/E. These are drawn from the initial timeline provided as an annex to the letter of 16 October 18.

Table 1: Timetable NHS I/E Submission Requirements



The following key approval and submission dates mean that documents will need to be ready for approval by the Trust Board on 7 March 2019.

Activity	Deadline
Contract Signature	21 March 2019
Organisational Board / Governing Body approval 19/20 budgets	29 March 2019
Final 19/20 Organisational Plan Submission	4 April 2019

While the guidance is promised in the first half of December 2018 there is work we should continue to progress in preparation for the required submissions:

- Understand and cost the impact of meeting the Five Year Forward View commitments, as currently understood, through to the end of 2019-20. This work is being progressed as part of the contracting process.
- Developing the Trust's CRES plans for 2019-20.
- Undertaking estates and capital planning
- Ensuring our budgets properly reflect the shape and growth of demand across our services

5.0 Approach to HPFT planning needs

The Trust has a clearly established Vision, Mission and set of Values. It also has an established strategic approach, Good to Great, to moving towards its vision.

The delivery content of the Good to Great strategy sets the focus for the Trust's development activity over the short, medium and long term. The short term development activity is summarised in the Trust's Annual Plan.

With the advent of the NHS Long Term Plan and the increasing focus on a system approach to local service provision, the Trust will need to undertake a refresh of the development activity within its Good to Great strategy. However, this will need to be informed by and

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It is therefore proposed, in line with the national approach, that our planning is undertaken in two phases:

- Phase One (Nov 19 - Mar 19): Establish key activities within "Good to Great" for the 19/20 Annual Plan that continue to progress the Trust towards its vision.
- Phase Two (April 19 – Sept 19): Refresh the key medium and long term activities within the Good to Great Strategy to both shape and reflect local system plans.

The focus for this paper is the approach to Phase One with the approach to Phase Two being developed in the spring of 2019, when the local system has also clarified its approach.

6.0 Phase One Planning: The Annual Plan

This phase will include the production of the Trust Annual Plan; SBU Development Plans; and key supporting corporate plans ensuring these inform and are informed by the budgeting process.

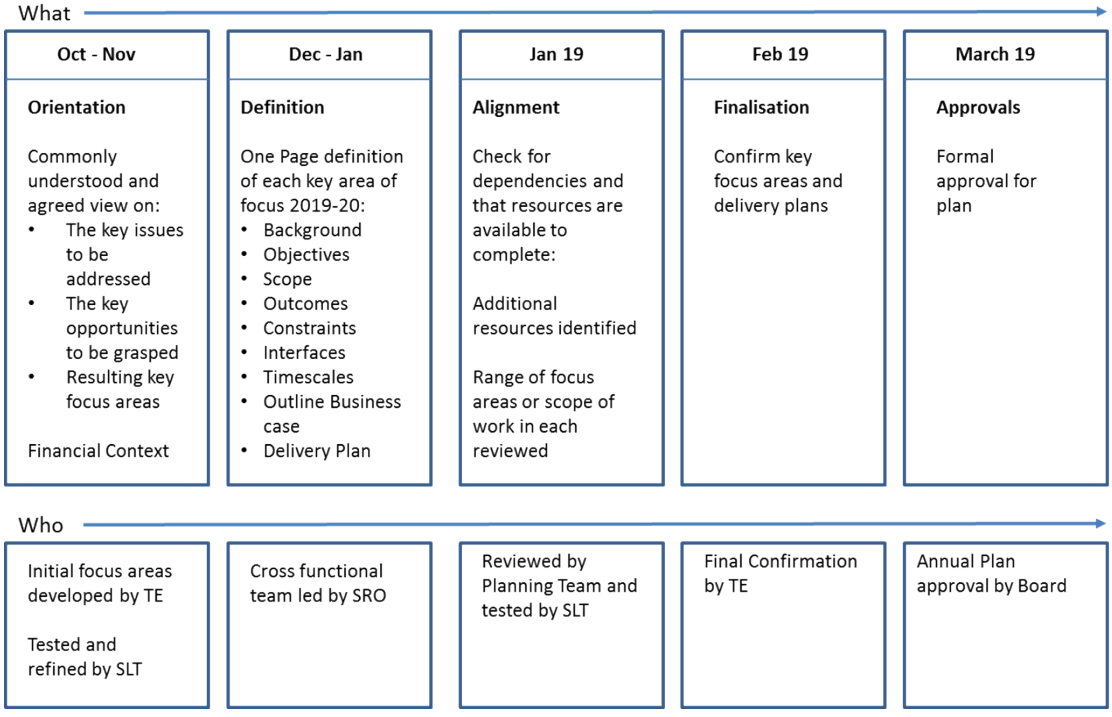
The planning process will build on previous years by:

- Carrying forward and updating the seven objectives found in the 2018-19 Annual Plan
- Ensuring that key activities within the 2019-20 also give consideration to the likely needs of future years
- Building shared ownership for the Annual Plan across the Trust's Senior Leadership Team
- Develop a cross functional approach to planning involving all functions throughout the planning process
- Design the delivery and governance as part of the planning process including: clear SRO leadership, milestones, outcomes and relevant performance measures.

<u>Approach: The annual plan</u>

The overall approach is summarised in the illustration below:

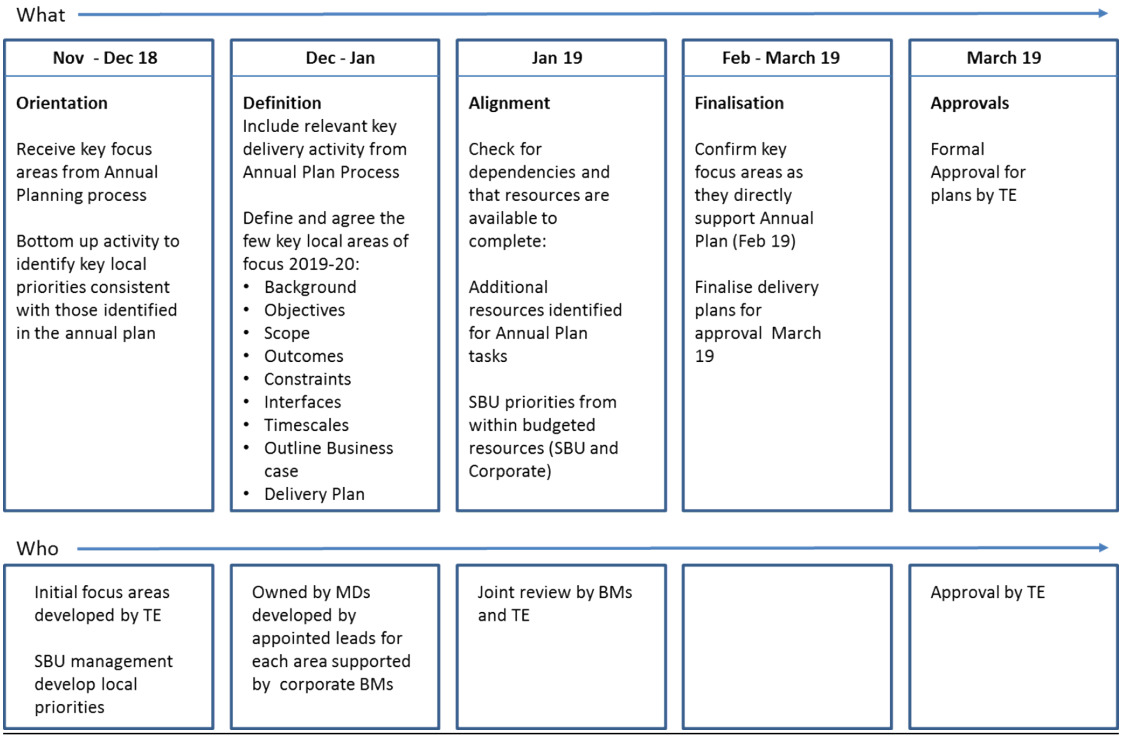
Illustration 2: Summary Development Process Annual Plan 2019/20



Approach: The SBU Development Plan

The overall approach is summarised in the illustration below:

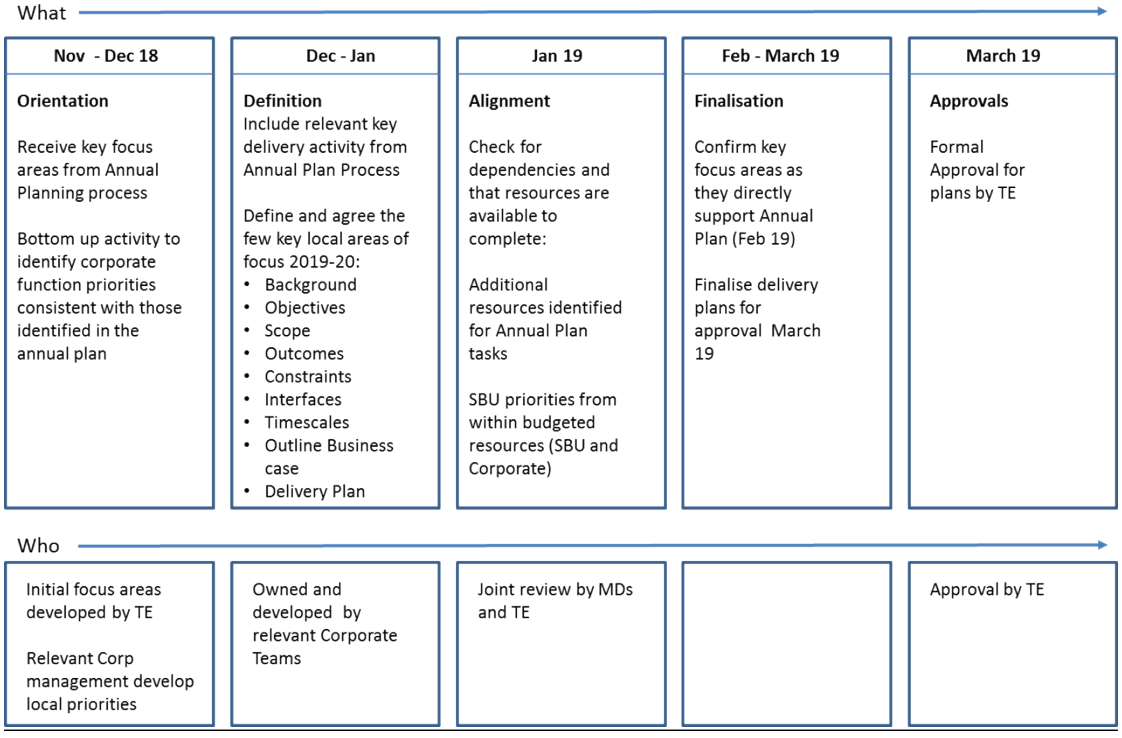
Illustration 3: Summary Development Process SBU Development Plan 2019/20



Approach: The Key Corporate Plans

The overall approach is summarised in the illustration below:

Illustration 4: Summary Development Process Key Corporate Plans 2019/20



The detailed project plan is provided in Appendix B while the major milestones are summarised in the table below:

Table 1: Phase 1 Planning Milestones

Milestone	Date
Trust Executive Identify Key Focus Areas for 2019-20	6 November 2018
SLT check challenge and confirmation Key Focus Areas	21 November 2018
Initial Draft Delivery Plans	18 January 2019
Financial alignment complete and SLT review, “check / challenge”	23 January 2019
SBU key projects confirmed by MDs and TE	4 February 2019
Key Corporate projects confirmed	4 February 2019
Annual Plan Approval by Trust Board	4 March 2019
SBU Development Plans approved by Trust Exec	20 March 2019
Key Corporate Plans approved by Trust Executive	20 March 2019

7.0 Recommendations:

The Board notes:-

- the outline timetable and likely requirements of NHS E/I with regard to planning
- the two phase approach to planning for 2019-20 and beyond
- the approach and milestones (detailed elsewhere in the paper) for the creation of the Trust Annual Plan, SBU Improvement Plans and the Key Supporting Corporate Plans

Appendix A: Likely Content of NHS I/E Operational Plan

A. Approach to Activity Planning
B. Approach to Quality Panning:
    a. Approach to Quality Improvement
    b. Summary Quality Improvement plan with a focus on Five year Forward View Commitments
    c. Quality Impact Assessments
    d. Triangulation of quality, workforce and finance
C. Approach to Workforce Planning
D. Approach to Financial Planning
E. Linkage to STP
F. Membership and elections

Appendix B: Annual Plan 2019-20 Development

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
		22 October 2018	29 October 2018	05 November 2018	12 November 2018	19 November 2018	26 November 2018	03 December 2018	10 December 2018	17 December 2018	24 December 2018	31 December 2018	07 January 2019	14 January 2019	21 January 2019	28 January 2019	04 February 2019	11 February 2019	18 February 2019	25 February 2019	04 March 2019	11 March 2019	18 March 2019	25 March 2019	01 April 2019	08 April 2019	15 April 2019	22 April 2019	29 April 2019
SLT		24				21			12						23														
FIC					13										22								19						
Board							29			20							7				7				4				
DEVELOP TRUST ANNUAL PLAN (19/20)																													
Orientation																													
Planning Process Approval	Trust Exec																												
Planning Context Development	Ian Love																												
TE Planning Session (identifying priority areas)	Trust Exec																												
Plan SLT workshop	Ian Love																												
SLT Workshop Context and key focus Areas (Check Challenge)	SLT																												
Confirm key priority areas and planing approach and milestones	Ian Love																												
Draft Annual Plan Priority Areas A - Z																													
Identify SROs	Trust Exec																												
Identify senior cross functional team	SRO																												
Develop definition	Team																												
Develop Initial project plan and any investment requirement	Taam																												
Consolidated Financial and Resource requiremsnts	Team																												
Finalise Annual Plan Priority Areas A-Z																													
Align projects with Financial Plan	Planning Group																												
Prepare Check Challenge Workshop	Planning Group																												
SLT Check Challenge Workshop	SLT																												
Develop Annual Plan																													
Develop Year One Implementation plans	Teams																												
Develop Monitoring and control structure	Trust Exec																												
Draft Annual Plan Produced	Dir Stratgy & Integration																												
Board Paper	Dir Stratgy & Integration																												
Annual Plan Approval	Board																												
DEVELOP SBU / SERVICE PLANS																													
Develop key service 12 month projects 1st draft	SBU teams																												
Review vs emerging stratgic projects 2nd draft	MDs / TE																												
Complete resource assessment	MDs / Finance																												
Finalise key 12 month projects	SBU teams																												
SBU Plan production and papers	SBU teams																												
Sign off by Trust Exec	Trust Exec																												
Corporate Plans																													
Develop Year One Implementation plans	Corp Leads																												
Develop Monitoring and control structure	Corp Leads																												
Draft Corp Plans Produced	Corp Leads																												
Corporate Plans Approval	Trust Executive																												

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	**29th November 2018**	**Agenda Item: 16**
Subject:	**The Colonnades - Lease Agreement**	**For Publication: No**
Author:	**Diane Brent, Associate Director of Estates (HPFT & HCT)**	**Approved by:**
Presented by:	**Keith Loveman**	**Keith Loveman**

Purpose of the report:

- To seek approval for the new lease offer for the Colonnades.

Summary and recommendations:

Background

The Trust entered into a lease agreement with Zurich Assurance Ltd for part of the Colonnades building in 2013 for the ground floor with a further lease agreed in 2015 for part of the first floor with the remainder of the 1st floor accommodation let to Olive Communications. These leases are coterminous and expire in 2029 with rent reviews in January 2019 and in 2024.

The Colonnades and adjacent building, Beaconsfield Court are both owned by Zurich Assurance Ltd who placed them on the market with a view to selling them both as a single lot. There were four potential purchasers who formally offered the landlord the asking price for the properties; three subsequently contacted the Trust wishing to negotiate a lease for the remainder of the first floor.

Summary

The Diamond Corporation have exchanged contracts on the Colonnades and Beaconsfield Court, both in current ownership of Zurich Assurance Ltd. There were four potential purchasers three of which had discussed leasing the whole building to HPFT. The Diamond Corporation had negotiated a potential deal with HPFT prior to the exchange of contracts.

The Trust have negotiated a favourable arrangement which will enable the Trust to acquire the additional space currently vacant on the 1st floor, obtain a lower than market value for the total space together with a one year rent free period for the additional space and remove the rent review date in January, replacing it with a review date of 2023. The details contained within the Heads of Terms are as follows:

- Surrender of both existing leases with a simultaneous new lease for the entire building comprising 28,329 sq. feet of NIA
- Lease term = 15 years
- Tenant only break clause = Year 10
- Rent = £12.50 per sq. ft. = £354,113 per annum
- Rent Review = Each 5 year anniversary to be the higher of the previous year's rent or Open Market Rent
- 12 month's rent free for the additional office space taken – I.e. 9,540 sq. feet
- All other terms to be in the form of current lease

There have also been discussions with the new landlord regarding the current condition of the building particularly in relation to the plant and mechanical and electrical systems and a £50k compensation has been included in the lease terms.

Utilisation
There is a requirement for additional office and learning & development space. Proposals (subject to due consultation) are to:-

- Relocate corporate teams from the ground floor to first floor with potential relocation of related back office functions from Lister Hospital, consolidating these functions together to provide a more streamlined and effective recruitment and deployment service. This will further enable space at Lister to be returned to E&NHT and the capital charge rent equivalent to be reduced. Estimates suggest that the combination of these space substitution opportunities would meet c.50% of the increased lease cost.
- Release training & development space by relocating teams from ground floor. This will enable teams which currently hire premises for training/away days etc due to unavailability at The Colonnades, to access HPFT space. Current year costs for additional room hire extend to £360k year to date and an element of this would easily translate to more effective utilisation of The Colonnades for training.
- Facilitate space for an 'Innovation Hub', co-located with Research & Development staff and the library resources.
- Further explore shared occupation with partner organisations including HCT, particularly with respect to shared back office and learning & development/training.

Further back office consolidation from current accommodation suitable for front facing services would be achievable within the additional area, potentially freeing up space for the integration of clinical services. This would release leased accommodation elsewhere.

Financial considerations
A brief analysis of the current market has identified the following similar available accommodation within Hatfield; however there were only 11 advertisements for office accommodation within the area most of which were significantly smaller than would be required by the Trust.

Location	Cost £ (Sq. Ft.)	Rentable Area (Sq. ft.)
The Beacons	23.50	1,738
York House	21.50	3,886
Beaconsfield Court	16.50	15,669
Mosquito Way	25.00	6,784
The Colonnades	**12.50**	**28,329**

Financial Implications

	Current Cost £ 000's	Approximate Future Costs £ 000's	Variance £ 000's
Rent - Ground Floor	184	174	**-10**
Rent - First floor	74	61	**-13**
Rent – Unoccupied First Floor		119	**119**
Service Charge	188	236	**48**
Business Rates	139	174	**35**
Depreciation	101		
PDC	38		

Total	**724**	**903**	**179**

Year one will have a reduction of £96k given the initial 12 month rent free period. The removal of the rent review due in January 2019 will also remove the increase in rent payments for a further 5 years saving in the region of an additional £47k per annum (c.£235k total). The total ten year commitment is therefore £1.7m.

All accommodation leased to other organisations including NHS partners will be charged using actual costs plus a life cycle payment.

To note:

- Capsticks have been instructed as solicitor to act on behalf of HPFT and have drawn up a lease agreement
- A full survey of the building has been undertaken
- A compensation position has been agreed with the landlord for all areas requiring investment by HPFT
- To instruct the District Valuers office to undertake a report on lease (vfm assurance)
- To develop a mobilisation plan for FM services for the building – reducing cost and improving quality.

Conclusion

Whilst the positon of HPFT acquiring the whole building at an acceptable cost is strong the requirement to rapidly secure the lease agreement will be evident as the new landlord will require this arrangement in place to complete on this sale.

This will require HPFT to approve the lease following solicitor's recommendations and progress to agreeing and signing a lease agreement.

This will secure the facility for a 15 year period with the option to break at 10. It will support the Trusts development proposals for the estate and future integration and consolidation opportunities together with acquiring a facility which provides suitable accommodation for staff and demonstrates best value within the current financial climate.

Recommendation

It is recommended that the Trust Board approve the Heads of Terms and the lease arrangements for the totality of the Colonnades.

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

Summary of Implications for:

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

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

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

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

Executive 7 November 2018 Finance & Investment Committee 13 November 2018

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	29 November 2018	**Agenda Item: 17**
Subject:	Review of the Constitution	**For Publication:**
Author:	J Hall, Company Secretary	**Approved by:**
Presented by:	J Hall, Company Secretary	J Hall, Company Secretary

Purpose of the report:

The Trusts Constitution requires a review every three years. The last review was in 2015. A full review has been carried out and changes and amendments proposed are set out in appendix 1.

Action required:

The Board of Directors is asked to agree the proposed changes to the Constitution.

Summary and recommendations

It's good practice to review the terms of the Constitution and associated Standing Orders on a regular basis to ensure that they remain fit for purpose and are compliant with relevant legislation and regulatory requirements.

A review has been undertaken and a number of updates are proposed for approval. Any changes must be approved by more than half of the members of the Board of Directors present and voting at a meeting of the Board of Directors and Council of Governors respectively.

Various amendments have been made to update the document. Only amendments resulting in substantive change are summarised in Appendix 1.

Bevan Brittan, our solicitors, have reviewed the proposed changes to ensure they are consistent and comply with the Health and Social Care Act 2006 as amended by the 2012 Act.

Following agreement of the changes by the Board of Directors the Constitution will be submitted to the Council of Governors for formal approval at its meeting on 13 December.

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

Without regularly reviewing the Constitution the Board of Directors and Council of Governors risk operating outside the scope of their powers

Summary of Financial, IT, Staffing & Legal Implications:

The Health and Social Care Act 2012 requires Foundation Trusts to have a compliant Constitution in place. The Constitution sets out how the Trust runs as an organisation, and incorporates the Standing Orders of the Board of Directors and the Council of Governors.

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

N/A

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

N/A

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

Review of the Constitution – 2018

The Constitution should be reviewed every three years. This year a full review has been carried out and the following changes and amendments are proposed:

Page No.	Section	Change
	Interpretations and Definitions:	
6	**NHS Improvement**	Now reflects the coming together of Monitor, Trust Development Authority as NHS Improvement
6	**Secretary**	Shortened description
7	**Application for membership**	Remove paragraphs 6.2 & 6.3
8	**Public Constituency**	Amend 7.1 to include 'of the trust'
8	**Staff Constituency**	Include additional paragraphs: 8.2 Academic staff 8.3 Volunteers 8.4 Staff employed by independent contractors who have worked within the Trust for 12 months of more
9	**Automatic Membership by default**	Heading removed as under GDPR staff cannot be automatically members of the trust.
9	**Membership – Restrictions, disqualifications & removal**	Include new paragraphs: 9.3.1 minimum age 9.3.2 age where parent/guardian agreement is required. 9.3.4 amendment regarding assault and violence towards others 9.3.6 additional paragraph on vexatious complainants 9.3.7 new paragraph and sub paragraph on bringing the trust into disrepute 9.4 amendment to deal with process of resolution
10	**Annual Members Meeting**	10.2 new paragraph regarding inclusion of annex 8 11.4 additional paragraph on appointed governors
11	**Council of Governors – Election of Governors**	12.5 new paragraph regarding eligibility to vote
11	**Council of Governors – Tenure**	13. amendment of wording on section 13.2 original wording removed and replaced with appointed governor can hold office for a maximum of 3 consecutive terms.
13	**Council of Governors – disqualification and removal**	14.1.1 remove paragraph 14.2.5 new paragraph - exec directors and NEDs cannot become governors. 14.2.6 governor of another trust 14.2.7 person who has been removed as a governor from another foundation trust 14.4 – 14.6 new paragraphs on governor attendance at cog meetings and disqualification
14	**Council of Governors – Meetings of Governors**	17.2 – amended to include exclusion of the press and public
16	**Board of Directors – composition**	23.8 include eligibility to be a finance director of the trust
17	**Board of Directors – Appointment of deputy**	Section 28 – appointment of a deputy chair and

	chair / Senior independent director	inclusion of provision for a Senior Independent Director
18	**Board of Directors – Disqualification**	31.1.4 – 31.1.18 changes to disqualification of directors giving clarity
21	**Registers**	37.2 – new paragraph – secretary shall compile and update registers
24	**Annual Report, Forward Plans & non-NHS work**	44.7 – approving proposals to increase by 5% or more income from activities other than the provision of goods and services for the purpose of the health service in England.
26	**Amendment of the Constitution**	48.4 – notification of amendments to the constitution to NHSI
26	**Mergers and significant transactions**	49.2- new paragraph on voting to approve entering in to a significant transaction
29	**Annex 3 composition of Council of Governors**	1. Composition – removal of tables and additional wording Inclusion of Healthwatch as a partner organisation with one appointed governor – therefore a change to the size of the CoG via increase in the number of appointed governors ***REQUIRES APPROVAL BY THE COG***
53	**Annex 5 Standing Orders of the Council of Governors**	Standing orders (SOs) of the CoG has been separated from the joint SOs
64	**Annex 6 Standing Orders of the Board of Directors**	As above
79	**Annex 7Further provisions**	New annex setting out: Indemnity Dispute Resolution Procedures Amendment to the Constitution
80	**Annex 8 Annual Members Meetings**	New annex setting out the process and procedures for the Annual Members Meeting

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	29th November 2018	**Agenda Item: 18**
Subject:	Board Assurance Framework (BAF)	**For Publication:** Yes
Author:	Jill Hall Interim Company Secretary	**Approved by:** Jane Padmore, Exec Director Quality and Safety
Presented by:	Jill Hall Interim Company Secretary	

Purpose of the report:

To enable the Board of Directors to review the effectiveness of risk management within the Board Assurance Framework (BAF) and gain assurances.

Action required:

The Board is invited to review the Board Assurance Framework and discuss how the BAF can be developed following thinking from the strategic risk workshop.

Summary and recommendations:

Introduction

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and also enable the board to gain assurance about the effectiveness of these controls.

This report provides an update on the latest iteration and controls the organisation has in place to mitigate against risks identified that could compromise the achievement of its strategic objectives.

Board Assurance Framework (BAF)

The Board of Directors identified the following Principal Risks for inclusion in the Trust's Board Assurance Framework:

1.1 Failure to deliver standards of safety
1.2 The fundamental standards of care are not delivered consistently across all our services
2.1 Service Users unable to access the right services in a timely way
3.1 Service Users will not have improved identification of physical needs
4.1 Staff do not report feeling engaged and motivated and do not recommend the Trust as a place of work
4.2 Leaders across the organisation do not receive appropriate training and support on improvement approaches and tools
4.3 Strong clinical leadership of key service changes is not evident
4.4 New roles are not created which support the clinical model
4.5 Turnover and vacancy rates are not reduced
4.6 Recruitment and retention plans are not robust and do not support increased flexible working
5.1 Staff will not have access to the right information to effectively perform their jobs
5.2 The quality and recording of data does not improve
5.3 Failure to maintain a sustainable financial position that supports investment and the continuity of services
5.4 Innovative productive ways of working are not embedded
5.5 Technology to support new ways of working is not used effectively

6.1 Service Users do not receive joined up care to meet their needs as an individual
7.1 Improving MH & LD services fails to become central to local health and social care economy plans (including within population health models)

Each Principal Risk on the BAF has been aligned to the Annual Plan and is assigned to a Lead Director who regularly reviews the risk and ensures that an appropriate mitigation plan is in place.

Assurances against each risk are updated as new information becomes available.

Board Assurance Framework development – next steps
The Board workshop on strategic risk was facilitated by Richard Mackie. The workshop looked predominately at the role of the Board in relation to strategic risk, roles and responsibilities, the purpose of the BAF, decision making, how risks are reviewed including assessment, mitigation and assurance and BAF evolution, it also asked 'How do we assure ourselves that we are delivering on our strategic objectives.'

At its meeting on the 8 November the Integrated Governance Committee reviewed the BAF and discussed how to take it forward following the discussion at the workshop. It was agreed that the Company Secretary would bring a proposal on how it can be further developed to provide assurance and drive agendas. This work will focus on reviewing and developing the BAF to ensure it meets best practice and is fit for purpose.

Relationship with the Business Plan & Assurance Framework (Risks, Controls & Assurance):
Summary of Implications for:

The BAF identifies the risks associated to the delivery of the strategic objectives annual plan.

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

N/A

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

N/A

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

This report is submitted quarterly to the IGC and Trust Board.

	BAF Risk No.	Risk Change in period
Strategic Objective1: We will provide safe services, so that people feel safe and are protected from avoidable harm		
Failure in standards of safety – Service Users do not feel safe and are not protected from avoidable harm whilst under the care of the Trust	1.1	• 3rd line assurance added – external and partner deep dives into unexpected death data and serious incidents • 3rd line of assurance added – quarterly meetings and reports from the Herts wide Local Resilience Partnership in relation to Major incidents
The fundamentals of care are not delivered consistently across all our services	1.2	
Strategic Objective 2: We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience		
Service Users unable to access the right services in a timely way	2.1	• 2nd line of assurance added – SPIKE data quality reports • Gap in assurance identified - data accuracy and data quality • Recruitment & Involvement of expert by experience policy - 1st line of assurance added - Involvement and Experience Group 6 monthly report to QRMC
Strategic Objective 3. We will improve the health of our service users through the delivery of effective evidence based practice		
Service Users will not have improved identification of physical health needs	3.1	
Strategic Objective 4. We will attract, retain and develop people with the right skill and		

values to deliver consistently great care, support and treatment		
Staff do not report feeling engaged and motivated and do not recommend the Trust as a place to work	4.1	
Leaders across the organisation do not receive appropriate training and support on improvement approaches and tools - Failure of staff to develop strong core competencies	4.2	
Strong clinical leadership of key service changes is not evident	4.3	
New roles are not created which support the clinical model.	4.4	
Turnover and vacancy rates are not reduced	4.5	
Recruitment and retention plans are not robust and do not support increased flexible working	4.6	
Strategic Objective 5. **We will improve, innovate and transform our services to provide the most effective, productive and high quality care**		
Staff will not have access to the right information to effectively perform their jobs.	5.1	
The quality and recording of data does not improve	5.2	
Failure to maintain a sustainable financial position that supports investment and the continuity of services	5.3	
Innovative productive ways of working are not embedded	5.4	
Technology to support new ways of working is not used effectively	5.5	
Strategic Objective 6. **We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners**		
Service Users do not receive joined up care to meet their needs as an individual	6.1	
Strategic Objective 7. **We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our**		

population(s)		
Improving MH & LD services fails to become central to local health and social care economy plans (including within population health models)	7.1	

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board Assurance Framework (BAF)

29 November 2018

Reviewed by:

- Integrated Governance Committee 8 November 2018

Introduction

This Board Assurance Framework brings together the principal risks potentially threatening the Trust's Strategic Objectives and outlines specific control measures that the Trust has put in place to manage the identified risks and the independent assurances relied upon by the Board to demonstrate that these are operating effectively.

Explanation of Assurance types and levels

Assurance Type **-** The identified source of assurance that the Trusts receives can be broken down into a three line model (1st, 2nd and 3rd line assurances)**. The assurance type column RAG rating records the highest level available for each control**

1st Line	2nd Line	3rd Line
Assurance from the service that performs the day to day activity E.g. Reports from the department that performs the day to day activity, Departmental Meetings, Departmental Performance Information	Assurance provided from within the Trust - Internal assurance E.g. Management Dashboards, Monthly monitoring	Assurance provided from outside the Trust - Independent assurance E.g. Internal Audit, External Audit, Peer Review, External Inspection, Independent Benchmarking

Assurance Level - For each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls

High	Medium	Low
One or more of the listed assurance sources identify that effective controls are in place and the Trust Board are satisfied that appropriate assurances are available Substantial assurance provided over the effectiveness of controls	One or more of the listed assurance sources identify that effective controls are in place but assurances are uncertain and/or possibly insufficient Some assurances in place or substantial assurance in place, but controls are still maturing so effectiveness cannot be fully assessed at this time.	The listed assurance sources identify that effective controls may not be in place and/or appropriate assurances are not available to the Board Assurance indicates poor effectiveness of controls.

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
Good to Great Strategy (Great Care, Great Outcomes) [Positive Experience, Effective, Safe]										
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	**1.1 Failure in standards of safety** – Service Users do not feel safe and are not protected from avoidable harm whilst under the care of the Trust. **Effect:** - Failure to reduce the number of suicides and prevent avoidable harm - Restrictive practice is not delivered in line with best practice. - There will be an increase in violence against service users and staff	Hertfordshire Suicide Prevention Strategy	Executive Committee IGC Trust Board		Suicide Prevention Reports included in Patient Safety Reports		High	IGC 05.07.18		Director of Quality & Safety [IGC]
		Review of all Serious Incidents Weekly Moderate Harm Panel	Executive Committee CCGs		Serious Incident Briefing Report. Weekly		High	Weekly to Exec Monthly report to Trust Board		
		Safer Care and Standards Processes Annual Freedom to Speak Up report	Mental Health Act Quality Managers Meeting. Safeguarding Strategy Group (SSG) IGC			CQC MHA Inspections	High	Bi –Annually reports to IGC 05.07.18		
			Executive Committee IGC Trust Board CCG QRM		Quarterly & Annual Patient Safety Reports	GP, CGL and other partners - deep dives into unexpected death data & serious incidents / self-harm	High	Q1 IGC TB 28.06.18 27.07.18 QRM		
			QRMC PRM IGC Trust Board		HPFT Quality Visits Quality Visit Report		Medium	TB quarterly QRMC 04.01.18		
			CCG Quality Review Meetings		Quality Assurance Visit Programme	Integrated Health and Care Commissioning Team (IHCCT)	High	QRM		
			IGC Trust Board		Freedom to Speak up – 6 monthly review Newly appointed Freedom to speak up Guardian		High	IGC 05.07.18 TB 26.07.18		
			IGC (Part of the Speak Up 6 monthly report) Trust Board		Concerns raised with the Trust via the CQC (CQC Concerns)		High	IGC 05.07.18 TB 26.07.18		
			Audit Committee	N/A			N/A	5 March 2018	Update on responding to actions required	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
			HSSC QRMC IGC		Health, Safety and Security Report (Annual / Quarterly Report)		High	IGC 5.7.18		
			IGC Trust Board		Mortality Quarterly Governance Report		High	IGC 05.07.18 TB 26.7.18		
		Quality Account Processes	Executive Committee IGC Trust Board External Audit Commissioner's Secretary of State			Quality Account 17/18 (Externally Audited) Published alongside annual report HOSC HCC	High	IGC 10.05.18 TB 24.05.18 Audit Committee 24.05.18	2018.19 process underway	
		CQUIN Processes	Executive Committee IGC Trust Board CCGQRM		CQUIN Reports – Part of quarterly Performance Report		High	IGC 5.7.18		
		Major Incident Policy	Executive Committee IGC Trust Board		Emergency preparedness, Resilience and Response Annual Report 2017 reported to Trust Board	- Emergency Planning and Business Continuity EPRR Core Standards compliance – CCG & NHSE approval - Quarterly meetings and reports from Herts wide Local Resilience Partnership	High	TB 27.09.17		
		Quality Strategy			HSCC QRMC IGC		High	IGC	Quality Strategy in development Lead: Dr Jane Padmore	
	1.2 The fundamentals of care are not delivered consistently across all our services	National Quality Board (NQB) Staffing Report	Executive Committee IGC Trust Board		Quarterly Safe Staffing Levels report CCG Contract reporting (quarterly)		High	IGC 16.07.18 TB 26.07.18 QRMC Aug 2018 QRM Q1 2018 reported to		Director of Quality and Medical Leadership [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
								CCG		
		Organisational Development Strategy	Executive Committee WODG IGC Trust Board		Workforce and OD Report Pulse Survey Report (Q) – Part of the Workforce & Organisational Development Report Good to Great Road Shows, Big Listen and Local Listen.		High	TB IGC 05.07.18		
		Quality Measures	IGC Trust Board		Trust performance KPI report on Workforce		High	TB 26.7.18		
		External Systems for Staff Feedback	Executive Committee WODG IGC Trust Board		PULSE quarterly report	National Staff Survey 2017 Report on Key Findings	High	IGC		
		Annual Programme of Clinical Audit (Practice Audit and Clinical Effectiveness) inc. NICE Guidance Policy	Executive Committee QRMC Trust Board CCG QRM		Annual Audit Programme	NICE Progress Reports	High	IGC QRMC PAIG		
		Medicines Management	QRMC Executive Committee IGC Trust Board		DTC Annual Report 6 monthly committee update		High	QRMC IGC 05.07.18		
2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	**2.1 Service Users unable to access the right services in a timely way** **Effect:** - **Service Users will not experience timely access to adult community services** - **Service Users will not experience timely access to CAMH services – CHOICE and partnership** - **Inpatient admissions for young people are not reduced**	Performance Monitoring Processes - Implementation of Accurate Clinical Information Strategy - SPIKE	Executive Committee TMG Trust Board SBU Core Management PRM Contract review meetings Internal & External Audit		Trust Performance KPI report – Access Times. Re-admission rates. Performance Review Process Live Data Performance Dashboards Performance Audit Performance against Annual Plan Internal & External Audit SPIKE live data Spike data quality reports		High	TB TB TB quarterly	Refresh of the Experience Strategy (ratification at IGC Jan 2019) Data accuracy and data quality	Director of Service Delivery and Customer Experience / Director of Finance [IGC]
		Quality Impact Assessments Procedure for CRES -	CRES PAB and Trust Executive Committee QRM – reports to		Individual Quality Impact Assessments External Commissioner scrutiny		High	QRM IGC 05.07.18		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
			Commissioners		Quality Impact Assessment reports to IGC					
		Service User Feedback	QRMC Executive Committee IGC Trust Board			Community Mental Health Annual Survey Commissioner reviews by carers in Herts and View Point	High	TB		
					Compliments, Complaints and HYS feedback Peer listening reports and feedback Friends and Family Test data Feeling Safe data		High	TB IGC		
		Outcomes Framework for Carers Pathway Development	QRMC TMG		Carer Pathway report		High	04.01.18		
		Recruitment & Involvement of Expert by Experience Policy	QRMC IGC	Involvement and Experience Group 6 monthly report to QRMC	Service User Council/Carer Council – 6 monthly report		High			
3. We will improve the health of our service users through the delivery of effective evidence based practice	**3.1 Service Users will not have improved identification of physical health needs.**	Physical Health Strategy CQUIN IAPT Adult Community FEP	TMG Trust Board Physical Health Committee QRM		CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads		High	QRM 23.01.18		Director of Service Delivery and Customer Experience / Director of Quality and Safety [IGC]
Good to Great Strategy – Great People [People have right skills and values, Leaders who involve and empower, a workplace where people grow, thrive and succeed.]										
4. We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment	**4.1 Staff do not report feeling engaged and motivated and do not recommend the Trust as a place to work** **Effect:** **Inability to develop new roles across the organisation** **Inability to recruit to vacancies and inability to retain staff** **Staff do not feel empowered or engaged leading to reduced staff motivation and**	Multi Professional Quality Improvement Performance Framework (QIPF)	IGC		QIPF Quality Performance and Review Update Paper (Action Plan)		High	08.06.17		Director of Workforce and OD [IGC]
		Workforce Health and Wellbeing Strategy Action Plan	Executive Committee WODG IGC Trust Board		Workforce and Organisational Development Report		High	TB 27.07.18 WODG		
		Health and Wellbeing CQUIN Action Plan	Executive Committee WODG IGC Trust Board		Quarterly Report		High	WODG May 2018 IGC May 2018		
		Systems for Staff Feedback	Executive		Quarterly Pulse		High	TB 28.0718		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
	satisfaction.	As defined in the Engagement & OD Strategies	Committee WODG IGC Trust Board		Survey Report– Part of the Workforce & Organisational Development Report Good to Great Road Shows, Big Listen and Local Listen.			Local Listen – July 18		
		External Systems for Staff Feedback	Executive Committee WODG IGC Trust Board			National Staff Survey 201 Report on Key Findings and action plan in place Equality review meetings with commissioners (annually)	High	IGC 05.07.18		
		Harassment and Bullying Plan (also part of the HPFT work plan for WRES)	Executive Committee WODG IGC Trust Board		Workforce and OD Report PULSE Survey Monitoring		High	TB 27.07.18	OD activity plan for year 2, bullying and harassment	
		NHSI Retention Project Quarterly OD and Workforce report	Executive Committee WODG Trust Board			Project Plan and Support Programme Monthly reporting to Workforce Board and Recruitment & Retention Deep dive in workforce challenges Deep dive into recruitment and retention	Medium	WODG Exec Team 22.08.18		
		Appraisal / PDP Reward and Recognition Processes	Executive Committee WODG IGC Trust Board		Statutory & Mandatory Training Report Monthly Inspire and annual awards Staff awards		High	TB 27/07/18 Exec Com 22.8.18	Stat Man training, PDPs and appraisals report to IGC Sept 18	
		Mandatory Training Programme			Quarterly Workforce and Organisational Development KPI Report (to services monthly) Bi-annual statutory & mandatory training report					
	4.2 Leaders across the organisation do not receive	Organisational Development Plan	Executive Committee		Workforce and Organisational		High	TB 28.06.18		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
	appropriate training and support on improvement approaches and tools - Failure of staff to develop strong core competencies		WODG IGC Trust Board		Development Report Organisational Development stock take report					Director of Workforce and OD [IGC]
		Staff Feedback systems	Executive Committee WODG IGC Trust Board		Pulse Survey Report– Part of the Workforce & Organisational Development Report		High	WODG TB 8.06.18		
			Executive Committee WODG IGC Trust Board			National Staff Survey 2017 Report on Key Findings	High	IGC 05.07.18		
	4.3 Strong clinical leadership of key service changes is not evident	Clinical Leadership Structures in place	MSC IGC Trust Board		Quality Impact Assessments		High	IGC		Director of Quality and Medical Leadership [IGC]
		External review of Trust Governance arrangements every three years	Executive Committee IGC Trust Board		Independent Well Led Review Update		High			
		Academic links in place with University of Hertfordshire Clinicians Leading Innovations Group	University of Hertfordshire strategic Management Group				Medium			
		Systems for Staff Feedback As defined in the Engagement strategy & the OD Strategy.	Executive Committee WODG IGC Trust Board		Pulse Survey Report– Part of the Workforce & Organisational Development Report		High	WODG TB		
		External Systems for Staff Feedback	Executive Committee WODG IGC Trust Board			National Staff Survey 2017 Report on Key Findings	High	IGC		
	4.4 New roles are not created which support the clinical model.	Recruitment and Retention Strategy and Policy	Executive Committee WODG IGC Trust Board		Quarterly Recruitment and Retention Report		High	WODG IGC	Quarterly reports to EMT	Director of Workforce and OD [IGC]
	4.5 Turnover and vacancy rates are not reduced	Recruitment and Retention Strategy and Policy. Ongoing Development of Workforce plans.	Executive Committee WODG IGC Trust Board		Quarterly Workforce and Organisational Development Report (to services Monthly)		High	WODG May 2018 IGC May 2018 05.07.18		
		Agency Reduction Action Plan	Executive Committee FIC Trust Board		CRES Programme Assurance Board reports		High	FIC		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
	4.6 Recruitment and retention plans are not robust and do not support increased flexible working	Recruitment and Retention Strategy and Policy	WODG Executive Committee IGC Trust Board		Recruitment and Retention Group Reports		High	WODG IGC 05.07.18	Policy to be updated to reflect current challenges	
Good to Great Strategy (Great Organisation) (Always getting fundamentals right, Always learning, innovating and improving)										
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care	**5.1 Staff will not have access to the right information to effectively perform their jobs.** **Effect:** **We will not be able to offer staff and Service Users access to innovative solutions to deliver and receive care.** **We will not be able to adopt new ways of working to improve on services we deliver.**	Implementation of a real time business intelligence reporting system (spike) Ongoing further development of PARIS functionality Opportunities for staff to develop ideas and implement through and innovation fund.	Executive Committee WODG IGC Trust Board			National Staff Survey 2017 Report on Key Findings	High	WODG IGC	Completion of a revised Digital Strategy Action Plan	Director of Innovation and Transformation [IGC]
			Executive Committee WODG IGC Trust Board		Pulse Survey Report– Part of the Workforce & Organisational Development Report		High	WODG TB		
			IM&T Programme Group Board Executive Committee IGC		PARIS/BI Development Group – progress reports IM&T Strategy External review		High	IM&T June 2018		
	5.2 The quality and recording of data does not improve	Monitor, validate and audit data quality against standards	TMG IM&T Strategy Board	Progress reports against project plan			High			
			IM&T Programme Board MSC Executive Committee	Accurate Information Group			Medium			
		Performance Monitoring Processes	Executive Committee IGC Trust Board		Quality Dashboard Performance Review Process Operational Services Report Quarterly Performance Report Trust Performance KPI report		High	TB Quarterly		
	5.3 Failure to maintain a sustainable financial position that supports investment and the continuity of services	Annual Operational & Financial Plan Strategic Investment Programme NHSI Control Total NHSI Agency Cap	Executive Committee Trust Board FIC Trust Management Group Modernising our Estate Board Executive Committee FIC		Financial summary report monitoring performance against plan including the NHSI Use of Resources Risk Rating and the Agency Cap Progress report on delivery of Strategic		High	TB 28.06.18 FIC 15.05.18 MoE 26.06.18 FIC 15.05.18		Director of Finance [FIC /Audit]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
					Investment Programme					
		External Audit Internal Audit	Trust Board Audit Committee			Annual Governance Statement Annual Financial Statements & Audit Report Head of Internal Audit Opinion	High	24.05.18 24.05.18		
		Cash Releasing Efficiency Programme CRES Programme Assurance Board	Executive Committee FIC Trust Board Trust Management Group		Part of Financial Summary Report Updates to CRES Assurance Board		High	TB monthly FIC 15.05.18 TMG 28.06.08		
		Hertfordshire and West Essex Sustainability and Transformation Plan (STP) Trust Contracts with Commissioners	Trust Board FIC Partnership Development Group		Update reports CEO Brief STP Report Contract Update Report Annual STP Plan		High	TB 28.06.18 28.08.18		
	5.4 Innovative productive ways of working are not embedded	Organisational Development Plan – High Level Deliverables	Executive Committee WODG IGC Trust Board		Quarterly Workforce and Organisational Development Report (to services Monthly)		High	WODG IGC 06.03.18 TB – 28.6.18		Director of Innovation and Transformation [FIC or IGC]
	5.5 Technology to support new ways of working is not used effectively	Productivity Monitoring Processes	Executive Committee FIC Trust Board		Financial summary report Annual Accounts Finance Reports CRES Programme Assurance Board Trust Performance KPI report		High	TB		
Good to Great Strategy (Great Networks and Partnerships) [Leading networks to deliver great joined-up care, Building great relationships and partnerships to meet whole persons needs]										
6.We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	**6.1 Service Users do not receive joined up care to meet their needs as an individual** **Effect:** **We do not work in partnership with other organisations to deliver the joined up care.** **As a consequence we do not develop or deliver new models of care to deliver new models of care for our Service Users** **We do not mainstream**	Carers Pathway	QRMC		Carer Pathway update		High	QRMC		Director of Strategy and Integration [FIC or IGC]
		Integrated Care projects and plans (e.g. primary mental health, LTC, older peoples, frailty)	Executive Committee FIC Trust Board		STP Participation Project reports		High	TB		
		Performance Monitoring Processes	FIC Exec Trust Board Exec		Performance Report		High	TB Exec -July TB	Stakeholder Plan (TBC) Stakeholder Map (TBC)	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
	physical health practices across the trust. -		TB							
		Staff training and education programme to include physical health Organisational Development Report	Executive Committee WODG IGC Trust Board		Pulse Survey Report – Part of the Workforce & Staff Feedback Mandatory training reports		High	WODG TB		
			IGC QRMC Trust Board		Having Your Say Service User Feedback		High	TB IGC QRMC 04.01.18		
		Physical Health Strategy – measures against outcomes	Physical Health Care Committee Exec Committee		Non – CQUIN Physical Health Target		Medium			
		Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	CCG QRM Exec TB			Feedback from Clinical Commissioning Group Stakeholder Map and Plan	High			
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	**7.1 Improving MH & LD services fails to become central to local health and social care economy plans (including within population health models)** **Effect:** **Our leaders are unable to influence and support improvement of care and outcomes across the system.**	Visibility and leadership by HPFT across the STP STP Leadership of MH and LD streams Locality Board membership	Executive Committee Trust Board		STP progress reports Reports to Integrated Care Development Group, Trust Management Group Local Delivery Partnership Boards		Medium			Director of Strategy and Integration
		Commercial Strategy Strong relationships with all Key Stakeholders to drive and deliver key priorities	Executive Committee Trust Board		quarterly reports Stakeholder map and plan		Medium		Quarter reports Map and Plan a being finalised	
		Annual Plan	Executive Committee Trust Board		Annual plan Quarterly reports CCG Commissioning Intentions.		Medium			

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	29th November 2018	**Agenda Item:** 19
Subject:	Trust Risk Register November 2018	**For Publication:** Yes/No
Author:	Nick Egginton, Compliance and Risk Manager	**Approved by:** Dr Jane Padmore, Director of Quality and Safety (Chief Nurse)
Presented by:	Dr Jane Padmore, Director of Quality and Safety (Chief Nurse)	

Purpose of the report:

Approve: To formally agree the report and its recommendations and updates in relation to the current Trust Risk Register (TRR)

Action required:

The Board of Directors is asked to review the Trust Risk Register and approve the escalated and new risks

Summary and recommendations:

This report gives an update on the Trust's Risk Register. It recommends changes to grading, consideration of new risks and sets out the updates in relation to the mitigations.

There are 16 risks currently on the Trust Risk Register. This paper presents the top 10 risks.

There have been no changes to existing risk scores

One risk has been split

- The finance risk has been split into two separate risks, one is that the Trust is unable to ensure short term financial performance in the current financial year; the other is that the Trust may not have sufficient resources to ensure long term financial sustainability.

One new risk has been developed and added to the Trust Risk Register

- Implications for the Trust of different scenarios arising from Brexit

One risk has been escalated from the West SBU Risk Register to the Trust Risk Register

- Unlawful detention of service users under S136 breaches beyond 24hrs.

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

Risks linked to Board Assurance Framework

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

There are no budgetary or financial implications in the TRR report, however some actions taken linked to the risks may have budgetary or financial implications.

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

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

CQC Regulation 17 Good Governance CQC Key Line of Enquiry; Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?

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

Exec Committee 31.10.2018 IGC 08.11.2018

Trust Risk Register November 2018

1. Introduction / Background

1.1. The purpose of this report is to present the Trust Risk Register (TRR) to the Board for discussion and approval. It has been discussed at the Integrated Governance Committee (IGC). Consideration should be given to the proposed changes and mitigations that have been put in place.

1.2. The TRR identifies the high level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them. There are 16 risks currently on the Trust Risk Register. This paper presents the top 10 risks although the full register was considered at IGC.

1.3. The updates to individual risks are summarised and then the TRR is set out in full with details of the controls, the early indicators and comments on the current position as well as the initial and current scores.

1.4. Each Director has reviewed the risks that they are Lead for and the Executive Team met to peer review the TRR as a whole, along with the scoring.

2. Risk Escalated to the Trust Risk Register

2.1 Unlawful detention of service users under S136 breaches beyond 24hrs.

2.1.1 From 11th December 2017, changes to Section 136 of the Mental Health Act came into force as a result of the Police and Crime Act. These changes have an impact on the Trust's responsibility to make available a qualified clinician for the Police to consult with prior to using Section 136, and for Section 136 detentions to last no longer than 24 hours (unless there are circumstances that warrant an extension of up to 12 hours). This change and the implication were presented to IGC where a decision was made to escalate this risk from the SBU risk register to the Trust risk register.

2.1.2 Since implementation of the legislation, there has been an increase in incidents of illegal detentions. Analysis of these incidents has identified the following themes as factors driving this increase:

- Delays due to AMHP availability out of hours
- The individual being too intoxicated to assess
- Complex social issues such as homelessness or vulnerability, or waiting for transfer back to home area for treatment. A particular challenge has been the presentation of children and adolescents, who are unable to return to their home. Of these, only intoxication is an accepted reason for extension of the 24 hour deadline.

2.1.3 In order to manage the risks related to failure to implement the updated Section 136 Policy, the Trust has ensured a 24 hour, 7 day a week coverage of clinicians for Police to consult with prior to detention via Street Triage and Community Assessment and Treatment Teams.

2.1.4 An updated Interagency Section 136 plan has been finalised and agreed between all parties. There is an established governance process for monitoring the use of Section 136 and informal networks in place for management of issues between parties.

2.1.5 A team leader post for section 136 suite has been recruited to, training and support from the MH Legislation Office has been delivered, with closer monitoring, requests for extensions are being made, and monitored via datix.

3. New risk developed for the Trust Risk Register

3.1 Implications for the Trust of different scenarios arising from Brexit

3.1.1 There are risk implications for the trust of different scenarios arising from Brexit, particularly a 'no deal' scenario. These relate in particular to maintaining sufficient quantity and quality of key supplies such as Medications and Equipment, impact of supply chains and contracts and implications for workforce.

3.1.2 The Department of Health and Social Care (DHSC) will write shortly to trusts and suppliers to provide further information on contingency plans to protect the supply of medical devices to the NHS in the event of a no deal Brexit. These plans result from a detailed analysis of routes to market, via NHS Supply Chain and from manufacturers, and an assessment of current stockholding, the availability of warehousing and capacity at ports.

3.1.3 DHSC has developed a self-assessment methodology for NHS Trusts to use to identify contracts that may be impacted by EU exit. DHSC will be sharing the details of this methodology with Trust Heads of Procurement. The prompt completion of this methodology is of the upmost importance.

3.1.4 The Trust will be asked to provide DHSC with a summary of those contracts deemed highly impacted, along with your Trust's planned mitigating activities, by 30 November 2018.

3.1.5 Once the Trust has completed the Self-Assessment then the known risk exposure will be clearer. Pharmacy are listing alternative prescriptions and alternative suppliers. Possible implementation of new pharmacy software to identify fraudulent medication

4. Risk to be considered for downgrading from Trust Risk Register

4.1. There are no risks being considered for downgrading

5. Risk scores to be considered for increasing

5.1There are no risks being considered for an increase in risk score

6. The risk score to be considered for decreasing

6.1. There are no risks being considered for a decrease in risk score

7. Risk Updates

7.1. The Trust is unable to ensure short term financial performance in current financial year

7.1.1. Against plan the Trust is reporting achievement of the planned position at end Q2. However, this has required support from use of non-recurrent provisions (£c.1.4m) in Q1.

7.1.2. Improved underlying run rate in Q2 through reduced PICU placements and agency spend.

7.2 The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff

7.2.1 The vacancy rate has reduced to 12.9% in Q2, from 15.1% in Q1. As of end of September the Trust has 435 WTE vacant posts of which 223.8 are actively being recruited to. 20% of these vacancies are in nursing. 7.8% are within medical. In September 2018 there were 77 new starters and 44 leavers.

7.2.2 Implementation of a new careers website has commenced and during Q2 focus groups have been run with staff, new starters, youth council and service users representatives to get their feedback on the careers website. The plan is that the careers site should attract candidates to HPFT but will also assist current staff with career pathways and progression.

7.2.3 Focusing on 'on boarding' staff from the time new staff are recruited, including regular contacts and a welcome to HPFT pack including IT equipment required for their role.

7.3 The Trust may not have sufficient resources to ensure long term financial sustainability

7.3.1 Contract negotiations for Hertfordshire indicate potential for a 5 year contract. CCG's have indicated meeting Mental Health Investment Standard (Parity of Esteem) to 2020 / 21.

7.3.2 5 year Department of Health funding agreement and we are developing Long Term Financial Model.

7.4 Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident

7.4.1 In 2017-18, the Trust received 350 reports of possible data incidents via Datix. 5 were found to be sufficiently serious to escalate to the Information Commissioner.

7.4.2 Since April 2018, (at time of writing) the Trust has received 268 reported incidents, of which 7 have been considered sufficiently serious to report to the Information Commissioner.

7.4.3 This reflects the increased awareness of data incidents within the Trust, and staff confidence in reporting issues in a timely manner when they are discovered. In addition, the change in legislation lowered the threshold for reporting to the Information Commissioner. Previously, classification hinged on the number of data subject affected, and the actual harm caused by the breach. Under GDPR, classification is determined by the reported impact on the data subject; this does not need to be a quantifiable impact.

7.4.4 The Trust has seen 4 reports of handover sheets found outside of the clinical environment, both by staff and the public.

7.4.5 The Information Rights and Compliance team is working with affected areas to review the management of handover sheets to prevent the likelihood of future losses. This includes printing sheets on coloured paper, and possible digital solutions ("e-handover sheets").

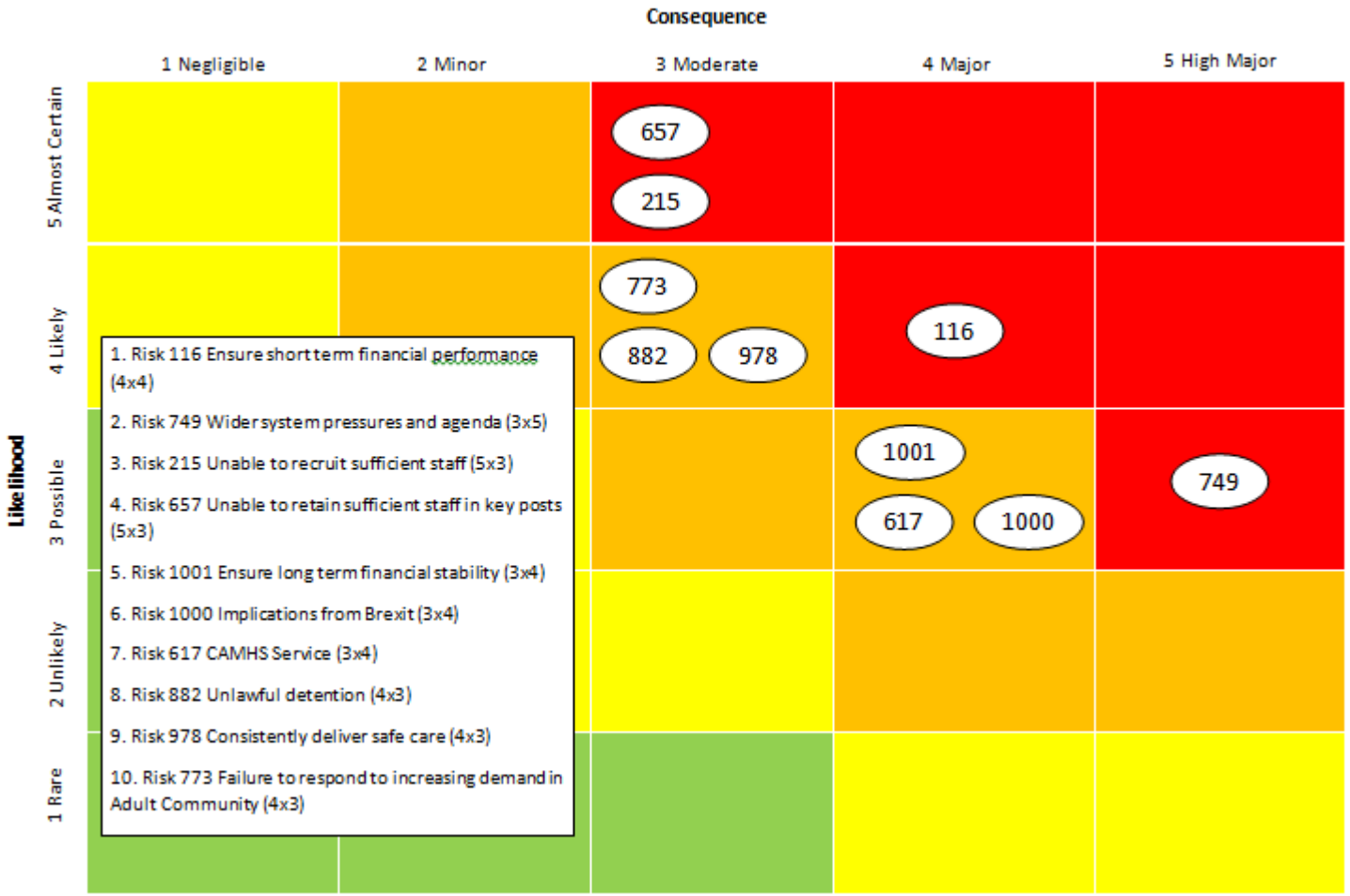
8. Conclusion

8.1. This report has detailed the suggested changes to the Trust Risk Register to be considered by the Executive Team. It has detailed the actions that have been taken and the mitigations put in place to manage the risks that have been identified. This report considers the risks detailed on the Trust risk register. The report highlights recommendations for changing risk scoring and consideration of new risk.

Appendix 1 Trust Risk Register by Exec Lead and linked to Trust Strategic Objectives

	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead	Page
1	116	The Trust is unable to ensure short term financial performance in current financial year	16	16 (4x4)	6	We will make effective use of people's time and the money we have to deliver on the outcomes that matter to those we serve	Keith Loveman	13
2	749	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and learning disability services provided by HPFT	20	15 (3x5)	10	Mental health and learning disability will be given the same emphasis as physical health in local care planning and delivery	Karen Taylor	15
3	215	The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	15	15 (5x3)	6	We will be seen as an employer of choice where people grow, thrive and succeed	Mariejke Maciejewski	18
4	657	The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	15	15 (5x3)	6	Our staff will report feeling engaged and motivated, and recommend the Trust as a place to work	Mariejke Maciejewski	20
5	1001	The Trust may not have sufficient resources to ensure long term financial sustainability	12	12 (3x4)	8	We will make effective use of people's time and the money we have to deliver on the outcomes that matter to those we serve	Keith Loveman	22
6	1000	Implications for the Trust of different scenarios arising from Brexit	12	12 (3x4)	4	Staff will report that they are able to deliver safe and effective services	Keith Loveman	24
7	617	Failure to provide an efficient and effective CAMHS service which impacts on the clinical care provided to young people.	16	12 (3x4)	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley	26
8	882	Unlawful detention of service users under S136 breaches beyond 24hrs	12	12 (4x3)	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley	28
9	978	The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff.	12	12 (4x3)	6	Staff will report that they are able to deliver safe and effective services	Jane Padmore	32
10	773	Failure to respond effectively to increasing demand resulting in a risk to safety, quality and effectiveness	12	12 (4x3)	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley	35

Appendix 2 Trust Risk Register Matrix



Trust Risk Register (Top Ten Risks)
November 2018

To be reviewed by:

Executive Team
31.10.2018

Integrated Governance Committee:
08.11.2018

Audit Committee: 04.12.2018

Trust Board: 29.11.2018

Risk Scoring Matrix (Risk = Likelihood x Consequence)

Step 1 Choose the most appropriate row for the risk issue and estimate the potential consequence

Consequence score (severity levels) and examples of descriptors					
	1	***2***	***3***	***4***	***5***
Domains	***Negligible***	***Minor***	***Moderate***	***Major***	***Catastrophic***
Impact on the safety of patients, staff or public (physical/psychological harm)	*Minimal injury requiring no/minimal intervention or treatment.* *No time off work*	*Minor injury or illness, requiring minor intervention* *Requiring time off work for >3 days* *Increase in length of hospital stay by 1-3 days*	*Moderate injury requiring professional intervention* *Requiring time off work for 4-14 days* *Increase in length of hospital stay by 4-15 days* *RIDDOR/agency reportable incident* *An event which impacts on a small number of patients*	*Major injury leading to long-term incapacity/disability* *Requiring time off work for >14 days* *Increase in length of hospital stay by >15 days* *Mismanagement of patient care with long-term effects*	*Incident leading to death* *Multiple permanent injuries or irreversible health effects* *An event which impacts on a large number of patients*
Quality/complaints/audit	*Peripheral element of treatment or service suboptimal* *Informal complaint/inquiry*	*Overall treatment or service suboptimal* *Formal complaint (stage 1)* *Local resolution* *Single failure to meet internal standards* *Minor implications for patient safety if unresolved* *Reduced performance rating if unresolved*	*Treatment or service has significantly reduced effectiveness* *Formal complaint (stage 2) complaint* *Local resolution (with potential to go to independent review)* *Repeated failure to meet internal standards* *Major patient safety implications if findings are not acted on*	*Non-compliance with national standards with significant risk to patients if unresolved* *Multiple complaints/ independent review* *Low performance rating* *Critical report*	*Totally unacceptable level or quality of treatment/service* *Gross failure of patient safety if findings not acted on* *Inquest/ombudsman inquiry* *Gross failure to meet national standards*
Human resources/ organisational development/staffing/ competence	*Short-term low staffing level that temporarily reduces service quality (< 1 day)*	*Low staffing level that reduces the service quality*	*Late delivery of key objective/ service due to lack of staff* *Unsafe staffing level or competence (>1 day)* *Low staff morale* *Poor staff attendance for mandatory/key training*	*Uncertain delivery of key objective/service due to lack of staff* *Unsafe staffing level or competence (>5 days)* *Loss of key staff* *Very low staff morale* *No staff attending mandatory/ key training*	*Non-delivery of key objective/service due to lack of staff* *Ongoing unsafe staffing levels or competence* *Loss of several key staff* *No staff attending mandatory training /key training on an ongoing basis*

Statutory duty/ inspections	*No or minimal impact or breech of guidance/ statutory duty*	*Breech of statutory legislation* *Reduced performance rating if unresolved*	*Single breech in statutory duty* *Challenging external recommendations/ improvement notice*	*Enforcement action* *Multiple breeches in statutory duty* *Improvement notices* *Low performance rating* *Critical report*	*Multiple breeches in statutory duty* *Prosecution* *Complete systems change required* *Zero performance rating* *Severely critical report*
Adverse publicity/ reputation	*Rumours* *Potential for public concern*	*Local media coverage – short-term reduction in public confidence* *Elements of public expectation not being met*	*Local media coverage – long-term reduction in public confidence*	*National media coverage with <3 days service well below reasonable public expectation*	*National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)* *Total loss of public confidence*
Business objectives/ projects	*Insignificant cost increase/ schedule slippage*	*<5 per cent over project budget* *Schedule slippage*	*5–10 per cent over project budget* *Schedule slippage*	*Non-compliance with national 10–25 per cent over project budget* *Schedule slippage* *Key objectives not met*	*Incident leading >25 per cent over project budget* *Schedule slippage* *Key objectives not met*
Finance including claims	*Small loss Risk of claim remote*	*Loss of 0.1–0.25 per cent of budget* *Claim less than £10,000*	*Loss of 0.25–0.5 per cent of budget* *Claim(s) between £10,000 and £100,000*	*Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget* *Claim(s) between £100,000 and £1 million* *Purchasers failing to pay on time*	*Non-delivery of key objective/ Loss of >1 per cent of budget* *Failure to meet specification/ slippage* *Loss of contract / payment by results* *Claim(s) >£1 million*
Service/business interruption Environmental impact	*Loss/interruption of >1 hour* *Minimal or no impact on the environment*	*Loss/interruption of >8 hours* *Minor impact on environment*	*Loss/interruption of >1 day* *Moderate impact on environment*	*Loss/interruption of >1 week* *Major impact on environment*	*Permanent loss of service or facility* *Catastrophic impact on environment*

Step 2 Estimate the likelihood

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency *Time framed descriptors*	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probably *Will it happened or not?*	<0.1 %	0.1 – 1%	1 – 10 %	10- 50%	>50%

Step 3 Complete the Risk Grading Matrix

	Consequence				
Likelihood	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Step 4 Escalation Process

Very Low Risks	**Low Risks**	**Moderate Risks**	**High Risks**
1-3	4-6	8-12	15 - 25
Local Risk Register	Service Line Risk Register	SBU Risk Register	Trust Risk Register

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
116	The Trust is unable to ensure short term financial performance in current financial year	Failure to maintain recurrent and sustainable financial performance, specifically: Failure to address immediate demand and / or cost pressures and / or to deliver required efficiency savings. Failure to achieve control total in 2018.2019 Key Issues 2018/19: Cost Pressures: - Agency expenditure and NHSI cap Demand Pressures: - Social Care Placements - External PICU Placements - Increasing referrals to community	16	Revisited and Strengthened CRES Programme Assurance Board, monthly monitoring Dedicated finance resource: Head of Finance – Efficiencies Programme Weekly monitoring of agency cap 'breaches' Raised authorisation levels for agency expenditure Vacancy Review process Implemented in-year recovery plan	16	6	Day One 'flash forecasts' for monthly outturn Weekly monitoring of key indicators - agency - placements - movement forecast Quarterly Review / Horizon Scanning Increased agency spend Increased number of placements outside HPFT CRES programme RAG rating	The Trust's overall NHS Improvement Use of Resources Risk Rating has changed from 1 to 2, since April 2018 on the basis of agency overspend and behind on surplus plan. In September this moved back to 1. The Trust continues to have a strong relationship with NHSI. Against plan the Trust is reporting achievement of the planned position at end Q2. However, this has required support from use of non-recurrent provisions (£c.1.4m) in Q1. Improved underlying run rate in Q2 through reduced PICU placements and agency spend. Cost Pressures: Agency expenditure above NHSI cap against a target of £7.3m this is mainly CAMHS and medical cover. CRES - £4.7m. Target forecast to be achieved, but c.£500k shortfall in recurrent plans CQUIN behind scheduled targets Signed contracts and financial schedules for 18.19 for	Keith Loveman (Director of Finance)	17/12/2018

		services - CAMHS Tier 4 placements						Hertfordshire Services and meeting parity of esteem. 2018/19 Control Total from NHSI, target is £360k surplus to achieve £1.8m of STP money. Trust Board have signed off 18.19 financial plan in March 2018, final submission made to NHSI.		

749	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT	The rapidly changing health and social care landscape nationally and locally creates a potential risk to the sustainability of high quality service provision for people with a mental illness or learning disability due to: • Dilution of a strong mental health and learning disability voice and presence within new models of care and systems or structures that are focused on reducing activity within general acute hospital settings • Increased sharing of risks and financial pressures across the system resulting in shifting of resources away from mental health and	20	Regular review of position by the Executive, Strategy Committee and Board Active monitoring and intervention by Council of Governors Strong leadership roles for key staff within local STP On-going regular dialogue with commissioners 5 STP Work streams including Mental Health which HPFT chairs	15	10	De-emphasis within commissioning intentions Parity of esteem agenda not honoured within contract negotiations or lack of commitment. Mental Health is represented on every locality delivery group along with commissioners; the early warning would be if Mental health is not making it onto the agenda for these meetings. Due to financial pressures the Trust does not see a demography increase and / or usual commitments aren't delivered by CCG's.	Mental Health Five Year Forward View and the recent 10 year plan announcements continue to provide the national focus and emphasis on Mental Health and learning disability. The local STP Plan outlines commitments to deliver on parity of esteem, as well as implementation of the 5YFV mental health implementation plan and transforming care agenda for people with a learning disability. The STP are developing the Clinical Strategy and medium term financial strategy. Income for 2018/19 was secured, with both CCGs meeting parity of esteem and providing demography funding. Contract discussions and planning for 2019/20 are commencing in September and this will be a key focus for HPFT to secure ongoing funds and commitment to the development of services. STP events took place during June/July to consider the development of an Integrated Care System (ICS) and Integrated Care Alliance/Organisations (ICA/O) may look like in the future across W Essex and Herts. HPFT was heavily involved and specialist MH being considered in additional to the 'geographical' ICA model. Also, recognition by the STP that MH	Karen Taylor (Director of Strategy & Integration)	17/12/2018

		learning disability services						must be incorporated into any 'population segmentation' approach to delivery – e.g. older people with complex needs, adult with complex needs, children with complex needs. STP wide Mental Health & LD working group established to provide greater emphasis and oversight of MH investment and developments across STP. Chaired by Dir. Strategy HPFT, with representation Medical director & Dir. Delivery. Focus areas have been delivery of 5YFV; and development primary mental health model across STP. Clinical pathway priorities Personality Disorder, Eating Disorder. Across HVCCG and ENCCG locality based delivery models are under development (older peoples services and primary mental health model). Such care models are seeking to understand and develop how MH can be more fully integrated with GP practices, to provide more joined up care, reduce demand on specialist services, and support primary care practitioners. Recent Green paper and 'trailblazer' announcements provide opportunity to strengthen CAMHS services, linked and wrapped around schools. HPFT involved in discussion to develop		

								service model and are likely to be the lead provider for overall CAMHS services in Hertfordshire. Commissioning intentions from the Hertfordshire CCG's are broadly in line with expectations. STP developing MTFS including principles for system control total and approach to planning. Shared in draft with organisation Boards during October.		

215	The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	Risk to Patient Safety, Quality, Staff Morale and Financial Risk. Recruitment There is a risk that the organisation is not able to recruit and select the best staff and that timely recruitment to vacancies does not occur leading to increased operational pressures and a reduction in quality of care	15	SBU review regular data – HR Performance Dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate establishment and vacancy information to be accessed at all times Recruitment and Retention Group monitors recruitment and retention activities and KPI's.	15	6	Long standing number of vacancies and hotspots Increased bank /agency costs Lack of clarity to plan recruitment campaigns Increasing turnover and a falling stability index Increasing Short Term sickness absence	Recruitment continues to be challenging due to the shortfall in skilled staff and competiveness nationally. Recruitment hotspots include the following: • Band 5 and band 6 nurses • NW & SW CATT • CAMHS – all professions • Junior doctors • Norfolk • AHPs There is a high proportion of vacancies in E&N SBU The Recruitment and Retention Group continues to meet on a monthly basis to address the issues arising from their respective areas in relation to generating ideas to deal with hot spots areas and hard to fill posts. Each SBU has developed a local recruitment and retention plan for their areas which has been reviewed and updated. The local SBU recruitment and retention plans include succession planning, putting in place career pathways in order to encourage retention, and reviewing current job descriptions in order to create some new ways of working. A further 9 Nursing Associates started May 2018 with more starting in January 2019. The vacancy rate has reduced to 12.9% in Q2, from 15.1% in Q1.	Mariejke Maciejewski, Interim Director of Workforce and OD	18/12/2018

								As of end of September have 435 WTE vacant posts of which 223.8 are actively being recruited to. 20% of these vacancies are in nursing. 7.8% are within medical. In September 2018 there were 77 new starters and 44 leavers. Implementation of a new careers website has commenced and during Q2 focus groups have been run with staff, new starters, youth council and service users representatives to get their feedback on the careers website and on what should and should not be included. The plan is that the careers site should attract candidates to HPFT but will also assist current staff with career pathways and progression. Targeting hot spot areas such as CAMHS and Robin Ward through the recruitment and retention group. Focusing on 'on boarding' staff on their first day and / or from the time that they are recruited that we continue to keep the recruited member of staff engaged with regular contacts and a welcome to HPFT pack including IT equipment required for their role when they commence in post.		

657	The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	Risk to Patient Safety, Quality, Staff Morale and Financial Risk Retention There is a risk that a higher number of existing staff choose to exit the organisation due to high workloads and a perceived lack of career pathways leading to increased and unplanned vacancies and a drain of knowledge and experience from the organisation.	15	SBU review data - HR performance dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate turnover vacancy information to be accessed at all times OD plan for Talent and succession planning Recruitment and Retention Group	15	6	Increased banks / agency costs High turnover / Reduced Stability Index Exit interview feedback Lack of quality PDPs, inconsistent and ad hoc supervision	The Trust has set a turnover target of 10% (internal target) and has a number of planned activities to address retention. The main reasons for turnover are: • Voluntary Resignation- Other /Not known • Promotion • Work life Balance This indicates that there is a need to focus efforts on workforce planning, flexible working, as well as career and succession planning. Some of these activities have been embedded into the SBU retention plans. The Trust has submitted its NHSi retention improvement plan which included a number of activities which should aid retention (NHSI turnover target is 11%). The plan has been signed off by NHSI and includes initiatives such as: - Making it easier to retire and return - Having an internal recruitment process - Marketing and branding - Talent management and succession planning - 100 day interviews - Stay interviews The Trust has launched the following initiatives; the retire and return process, internal	Mariejke Maciejewski, Interim Director of Workforce and OD	18/12/2018

								recruitment process, 100 day interviews, mindfulness and resilience training and the buddy scheme is being piloted in high turnover areas. Going through talent management and succession planning. The Trust is also planning a long service award Annualised Turnover has reduced to 15.8%. New management induction to be introduced separate to corporate induction, including training on systems and processes utilised by senior managers.		

1001	The Trust may not have sufficient resources to ensure long term financial sustainability	Failure to maintain long term financial sustainability specifically: 1) Failure to secure sufficient funding from commissioners to meet service quality and/or activity requirements 2)Failure to address underlying demand and/or cost pressures and/or to deliver required efficiency savings such that the underlying long term financial performance is not sustainable 3) Significant unidentified QIPP requirements across the STP, this could lead to an increase in the risk score if these QIPP requirements materialise in the future	12	Regular Placement Panel with cross-SBU coordination of placements pathway Provision for older peoples transformation programme in place Regular Reports are made to the Trust Board, Finance & Investment Committee, Executive Team and Trust Management Group 2018/19 Contract variations in place for health and social care contracts. Relationship management with commissioners Primary Care Mental Health pilots around demand management to mitigate risk, better signposting will hopefully	12	8	Agreed income tariff uplifts Negotiations with commissioners 3 year CRES proposals	Contract negotiations for Herefordshire indicate potential for 5 years CCG's have indicated meeting Mental Health Investment Standard (Parity of Esteem) to 2020 / 21 5 year Department of Health funding agreement Developing Long Term Financial Model - 0-3 years detailed - 4-5 years headlines - 6-10 years to be confirmed Fits in with STP medium term financial strategy	Keith Loveman (Director of Finance)	17/12/2018

				reduce Initial Assessment demand.						

1000	The Trust may experience continuity and/or cost of supply issues for critical goods/services .	There are risk implications for the trust of different scenarios arising from Brexit, particularly a 'no deal' scenario. The Trust is unable to maintain sufficient quantity and volume of key supplies and/or the unit price may rise: - Medications - Equipment - Staff	12	EU staff contacted and supported. Department of Health and Social Care (DHSC) guidance on contingency plans Self-Assessment for NHS Trusts to use to identify contracts that may be impacted by EU exit Identification of Contracts at risk to be completed by 30.11.18 Summarise highly impacted contracts and mitigating activities by 30.11.2018	12	4	Increase difficulty or delay in sourcing sufficient quantities of medication or equipment. Increased staff turnover of EU registered staff Increase in unit price	All affected EU employees (c.230 staff) to be contacted and supported in completing appropriate documentation. DHSC has written to trusts and suppliers setting out requirements for contingency in the event of a disrupted supply to the NHS arising as a consequence of Brexit arrangements. DHSC has developed a self-assessment methodology for NHS Trusts to use to identify contracts that may be impacted by EU exit. Utilising the self-assessment toolkit, the Trust is analysing spend categories and contract arrangements. This work is to be completed by 30.11.18. Once the Trust has completed the Self-Assessment then the known risk exposure will be clearer. no deal Brexit. These plans result from a detailed analysis of routes to market, via NHS Supply Chain and from manufacturers, and an assessment of current stockholding, the availability of warehousing and capacity at ports. DHSC has been working closely with Cabinet Office to implement a cross-Government approach to identifying contracts that may be impacted by potential changes to trading relations with the EU, and developing mitigating actions to	Keith Loveman (Director of Finance)	17/12/2018

								help ensure that there are suitable arrangements in place at the point of exit. The Pharmacy Department has a developed process for sourcing alternative suppliers or substitute medications. Over the last 18 months drug supplies have been volatile and the pharmacy has in place guidance on substitute prescriptions for all key medicines Progressing implementation of new pharmacy software to identify fraudulent medication Developing plans for additional pharmacy resource to carry out the above measures.		

617	Failure to provide an efficient and effective CAMHS service which impacts on the clinical care provided to young people.	Increasing level of demand on the CAMHS Service Increasing complexity of cases presenting to the CAMHS service High vacancy rates with specific teams CATT interface with Acute services CAMHS leadership cohesion needs to be strengthened to ensure clear lines of accountability and responsibility for service delivery and clinical professional standards. Reduction of young people in OAT beds in relation to Tier 4 has not reduced in line with	16	All acute admissions to go into FHAU Weekly performance reports and weekly management review HR Dashboards / HPFT Workforce Information Report Summary Service Improvement plan Deep Dive Review Access Recovery Plan including weekly trajectories and quadrant level plans for recovery	12	6	Increasing complaints Increase severity / number of incidents Increased waiting times (Choice and Partnership) Increase in staff vacancy rates / caseloads Increase in CCATT A&E response times Clinical variation in access times across quadrants Speaking Up Concerns	Recovery work from early 2018 has brought North, South and West CAMHS back within target for 28 day waiting times. Work continues with East CAMHS but this is listed as a specific risk rather than a generic all team risk Introduction of an improved referral and triage process for CAMHS East and South East. SPA will directly refer to CAMHS without triaging with the CAMHS team now undertaking this process. It is anticipated that this will lead to increased capacity with the triaging resulting in less initial appointments within CAMHS. CAMHS Psychiatry Provision There is a significant risk that consultant child and adolescent psychiatrist posts are not filled across county and that is having a significant impact on safety and team functioning. CAMHS Leadership CAMHS Senior Leadership Team requires some strengthening, 2 of the 4 CAMHS quadrants are without a permanent CAMHS Community Manager. Finance Tier 4 - Current number of young	Jess Lievesley (Director Of Service Delivery and Service User Experience)	17/12/2018

		projection which is creating a financial risk as this does not reduce but recruitment to HTT and DBT increases.						people in Out of Area/Treatment beds has reduced, thus reducing the financial risk as this is now in line with the business case and CRES plan. This needs to be maintained for an extended period of time. FHAU Staffing Staffing review completed by the Head of Nursing. Initial review by Exec has completed with further analysis requested. Staffing vacancies for both nursing and medical posts remain high resulting in significant use of bank and agency staff.		

882	Unlawful detention of service users under S136 breaches beyond 24hrs.	From 11th December 2017, changes to Section 136 of the Mental Health Act came into force as a result of the Police and Crime Act. These changes have an impact on the Trust's responsibility to make available a qualified clinician for the Police to consult with prior to using Section 136, and for Section 136 detentions to last no longer than 24 hours (unless there are circumstances that warrant an extension of up to 12 hours). Extensions are not granted for either incomplete assessment due to clinician availability or for	12	- Availability of Street Triage 9am - 4am 7 days a week, in order for Police to consult regarding anyone over 16. Crisis Assessment and Treatment Team available 4am - 9am. - Forest House Adolescent Unit to provide a clinician for consultation with Police regarding use of Section 136 at all times for anyone under 16. - Dedicated Section 136 team to monitor progress against 24 hour timeframe and co-ordinate assessing clinicians; Section 136 team to monitor and note where an extension to the detention can be authorised - Between 9 - 5, Monday to Friday,	12	6	- Lack of Street Triage involvement in Police decision to detain - Use of Section 136 by Police to manage risk as a result of intoxication, rather than use of public order offence or return to home - Lack of availability of AMHP's out of hours to undertake assessment - Numbers of people discharged from Section 136 with no evidence of mental disorder or no further action required either continues at current rate or increases - Lack of availability of S136 suites and Police waiting due to inability to move patients through	In order to manage the risks related to failure to implement the updated Section 136 Policy, the Trust has ensured a 24 hour, 7 day a week coverage of clinicians for Police to consult with prior to detention via Street Triage and Community Assessment and Treatment Teams. An updated Interagency Section 136 plan has been finalised and agreed between all parties. There is an established governance process for monitoring the use of Section 136 and informal networks in place for management of issues between parties. There have been a number of occasions since the start of 2018 when an extension to the detention could have been requested, but this has not been implemented. A team leader post for section 136 suite has been implemented and recruited to, training and support from the MH Legislation Office has been delivered, with closer monitoring, requests for extensions are being made, and monitored via datix. There continue to be incidents of the following: - Occasions where the Police have	Jess Lievesley (Director Of Service Delivery and Service User Experience)	30/11/2018

		lack of bed availability should an inpatient admission be required. In order to meet these timescales and manage the requirements of the changes, the Trust has to provide 24 hour clinical coverage for the Police; to ensure that the demand for Section 136 does not increase dramatically by monitoring inappropriate or unwarranted use of S136 in cases of intoxication only or presence of no mental disorder; to ensure availability of relevant professionals (AMHP, Section 12 approved Doctor and Crisis Assessment and Treatment Team where admission indicated) in order to assess and recommend		AMHP Service prioritise Section 136 assessments in order to meet timescales - Presence of CATT staff in Kingfisher Court overnight, increasing availability for assessment - Interagency meetings and governance arrangements in place to monitor implementation of the Police and Crime Act changes to Section 136, reporting to Hertfordshire's Crisis Care Concordat Group				not consulted with Street Triage, or approved alternative, before detaining an individual. - Underutilisation of alternatives such as Nightlight or home visits from CATT for people in crisis - Increase in number of individuals who have been de-arrested and bought in to S136 on the advice of the Forensic Medical Examiner or G4 nurse (custody nurse) who have no evidence of mental ill health - Occasions where there has been no availability of an AMHP out of hours to see an individual within 3 hours (as per local interagency policy) - Young people being brought into s136 suite by police where their family feel unable to manage their presentation of challenging behaviour, and social services are unable to identify a placement These are being monitored on a case by case basis, managed and resolved between Senior Managers within the Trust and partner organisations, and inform the agenda of interagency discussions seeking to resolve the challenges at a strategic level.		

		individuals. Since implementation of the legislation, there has been an increase in incidents of illegal detentions. Analysis of these incidents has identified the following themes as factors driving this increase: - Delays due to AMHP availability out of hours - The individual being too intoxicated to assess - Complex social issues such as homelessness or vulnerability, or waiting for transfer back to home area for treatment. A particularly challenge has been the presentation of children and adolescents, who are unable to return to their home								

		Of these, only intoxication is an accepted reason for extension of the 24 hour deadline.								

978	Failure to consistently deliver safe care across its services resulting in harm to service users, carers and staff.	The Trust is failing to delivery consistent and safe care across its services which could lead to an reduction in the quality and safety are care provided resulting in it not meeting its legal obligations in relation to the Health and Social Care Act	12	Local monitoring of supervision Ligature risk assessments in place for all units The Trusts continues to adhere to its seclusion policy Immediate improvements to seclusion environments have been made where possible Albany Lodge Service Improvement Plan	12	6	Increase of incidents to a non-seclusion room Poor Fundamental of care audit results Increase in staff saying that they are not having local supervision.	<u>Seclusion Practice & Environment</u> Mersey Care NHS Foundation Trust have been approached to undertake a review of seclusion, having been cited by the CQC as an example of good practice. This review is commissioned to establish the extent to which Hertfordshire Partnership NHS University Foundation Trust (HPFT) seclusion provision and practice complies with the Mental Health Act (MHA) Code of Practice 2015 and the National Institute for Health and Care Excellence (NICE) guidelines – Violence and aggression: short-term management in mental health, health and community settings (May 2015). This is intended to be a full review of how HPFT manages seclusion across its services, being responsive to the service user, the service area and the environment resulting in recommendations for service and provision improvements. The review will include service user, carer and staff consultation. Mersey Care completed this review on Monday 2nd July to Thursday 5th July 2018. The Trust is awaiting the final report. Dove ward where the majority of seclusions to a non-seclusion room	Jane Padmore(Director Quality & Safety)	09/11/2018

								took place have upgraded a high intensity room to a seclusion room. Final specification of new seclusion rooms has been drawn up this involves all future seclusion room environmental work which is part of the Trust Wide Seclusion Programme. Programme is awaiting sign off. <u>Fundamentals of Care</u> Fundamentals of Care Audits have been introduced to Adult MH inpatient services. These are being carried out on a weekly basis to ensure that physical health checks and appropriate care plans are in place for all service users across acute service <u>Ligatures</u> A new weekly ligature audit, via an electronic platform, Advanced New Technologies (ANT) in which teams report on any changes in environmental risks since the last audit has been rolled out. Compliance will be reported and monitored through the Safety Committee. A number of other innovations to mitigate risk have been developed including, the use of floor plans, photographs of ligature risks and blind spots and installation of mirrors. These have been completed for Swift Ward, Robin Ward and Aston Ward. Owl, Oak and Albany are in the final		

								stages of being completed. <u>Supervision</u> Supervision has now gone live on Discovery. Further work is planned to enable compliance reporting and management oversight in November. <u>Suicide and self-harm</u> There is a deep dive on suicide and self-harm, the final report will be presented at the Trusts suicide prevention group and IGC. <u>NHSI Collaborative – Restrictive Practice</u> The Trust has joined an NHSI collaborative that is addressing restrictive practice and developing definitions and KPIs for restrictive practice. We are forming collaborations with other Trusts to engage with each workstream and sharing best practice. <u>NHSI Safety Collaborative</u> The Trust is working with NHSI through a safety improvement collaborative, offered to every mental health trust that is inadequate or requires improvement for safety. The team have offered to undertake a diagnostic to ensure that the focus of our improvement work is in the right places. This will take place on Dec 11th 2018.		

773	Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness	Increased risk of being unable to respond effectively to demand in Adult Community Services and knock on effect on access times. Balancing inbound volumes of assessments with case management and treatment. Volume, acuity and complexity of caseloads is a risk leading to increased pressures on teams and potential workforce challenges.	12	Review of staff skill mix across quadrants and introduction of new roles Improved systems in SPA. Primary care projects commencing to look at work before IA referral made.	12	6	Vacancy Levels Agency spend Increase in incident reporting Number of cases pending allocation CATT caseloads Number of initial assessments Turnover of staff Increase in Complaints Performance against targets deteriorating Staff feedback/raising of concerns	Primary mental health care pilots underway in three locations (Stevenage & Watford and Hertford), this is now being rolled out across all quadrants. Agreed as part of the Did Not Attend Standard Operating Procedure, plan to improve triaging in SPA agreed with commissioners. SPA will no longer pass referrals through to adult community teams for initial appointments if the Trust has not been able to make contact the service user in SPA. This will take effect from 5th Nov. It should have a significant impact on IA slots and wider capacity. Caseload Reviews – all quadrants Identification of cases that are ready for stepdown / discharge. Regular tracking of these cases to ensure plans are being actioned.	Jess Lievesley (Director Of Service Delivery and Service User Experience)	17/12/2018