Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC meeting

Da Vinci B

7 February 2019 11:00 - 7 February 2019 13:30

INDEX

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS

A Public Meeting of the Board of Directors

Date: Thursday 7th February 2018
Venue: The Colonnades, Beaconsfield Road, Hatfield AL10 8YE, Da Vinci B+C
Time: 11:00 – 13:30

Service User Story:
10:30 – 11:00am

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 29th November 2018**	Chair	**Approve**	Attached
4.	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
5.	**CEO Brief**	Tom Cahill	**Receive**	Attached
6.	**Health and Social Care Strategy**	Harper Brown	**Receive**	Attached
7.	**Brexit Plan Update**	Keith Loveman	**Receive**	Attached
QUALITY & PATIENT SAFETY				
8.	**Report of the Integrated Governance Committee – 23 January 2019**	Sarah Betteley	**Receive**	Attached
9.	**Integrated Safety Report: Quarter 3**	Dr Jane Padmore	**Receive**	Attached
10.	**Safer Staffing Report: Quarter 3**	Dr Jane Padmore	**Receive**	Attached
11.	**Safe Care Tool** *(15 minutes)*	Dr Jane Padmore	**Presentation**	
OPERATIONAL AND PERFORMANCE				
12.	**Report of the Finance & Investment Committee – 22 January 2019**	Simon Barter	**Receive**	Attached
13.	**Integrated Performance Report : Quarter 3**	Ronke Akerele	**Receive**	Attached
14.	**Annual Plan 2018/19: Quarter 3**	Ronke Akerele	**Receive**	Attached
15.	**Workforce and Organisational Development Report: Quarter 3**	Mariejke Maciejewski	**Receive**	Attached

16.	**Finance Report: December 2018**	Keith Loveman	**Receive**	Attached
17.	• **Long Term Plan** • **Operating Plan 2019/20**	Keith Loveman	**Receive**	Attached
	GOVERNANCE AND REGULATORY			
18.	**Report of the Audit Committee – 4 December 2018**	Catherine Dugmore	**Receive**	Attached
19.	**Board Assurance Framework**	Jill Hall	**Receive**	Attached
20.	**Trust Risk Register**	Dr Jane Padmore	**Receive**	Attached
21.	**Risk Management Strategy**	Jill Hall	**Receive**	Attached
22.	**Board Committee Terms of Reference**	Jill Hall	**Receive**	Attached
23.	**Any Other Business**	Chair		
	QUESTIONS FROM THE PUBLIC	Chair		
Date and Time of Next Public Meeting: Thursday 7th March 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 29th November 2018
Da Vinci B – Colonnades

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Christopher Lawrence | CL	Chair
Simon Barter | SBa	Non-Executive Director
Sarah Betteley | SBe	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
Tanya Barron | TBa	Non-Executive Director
Janet Paraskeva | JPa	Non-Executive Director
Loyola Weeks | LW	Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Mariejke Maciejewski | MM	Interim Director, Workforce & Organisational Development
Dr Jane Padmore | JPad	Director, Quality and Safety
Ronke Akerele | RA	Director, Innovation and Transformation
Jess Lievesley | JL	Director, Service Delivery & Customer Experience
Keith Loveman | KL	Director, Finance
Dr Asif Zia | AZ	Director, Quality & Medical Leadership
IN ATTENDANCE	
Jill Hall | JHa	Interim Company Secretary
Kathryn Wickham | KW	PA to Chairman and Company Secretary
Andrew Nicholls | AN	Head of Recovery and Psychological Services
Dr Jo Farrow | JF	Clinical Director, West Strategic Business Unit
Julie Hollings | JH	Deputy Director, Marketing, Communications & Engagement
MEMBERS OF THE PUBLIC	
Jon Walmsley | JW	Lead Governor
Barry Canterford | BC	Public Governor
Tap Bali | TB	Public Governor
Sophie Langdale | SL	Director for Mental Health, Department of Health & Social Care
Nicola Morale | NM	Serco
APOLOGIES	
Karen Taylor | KT	Director, Strategy and Integration
Sue Darker | SD	Herts County Council

Item	Subject	Action
140/18	**Presentation – New Leaf College** A presentation on the New Leaf College was provided by Andrew Nicholls, Head of Recovery and Psychological Services.	
141/18	**Welcome and Apologies for Absence** CL welcomed all to the meeting and apologies for absence noted. A warm welcome was extended to Sophie Langdale, Director for Mental Health, Dementia and Disabilities, Department for Health and Social Care. CL advised this would be Julie Hollings last Board meeting as Julie would be leaving the Trust for a new post. CL thanked JH for her work and wished her every success for the future. CL concluded by welcoming governors, staff and a member of the public.	
142/18	**Declarations of Interest** Nothing declared.	

143/18	**Minutes of the meeting held on the 27th September 2018** The minutes of the meeting held on the 27th September 2018 were discussed and the following amendments made: Attendance: Jill Hall name to be removed as she was not in attendance Item 126/18 Fourth paragraph, the narrative corrected to: The CQC have *issued* national guidance. Item 126/18 Fifth paragraph, the narrative corrected to: We have seen an increase in rates of suicide nationally. To remove the narrative: Since 1981 Item 130/18 Amend the narrative to include: The Trust invited Mersey Care to look at restrictive practice and seclusion. To amend the narrative: this came back *with no major* concerns. Item 131/18 To remove the last sentence. The remainder of the minutes were agreed as an accurate account of the meeting and approved subject to the agreed changes. **APPROVED** **The Board APPROVED the minutes subject to the agreed changes**	
144/18	**Matters Arising** The matters arising schedule was discussed and updates noted. JPa raised a question on SU Story feedback from the previous Board. CL responded explaining that this was not necessarily something which would come back to the board. JL confirmed that a range of measures had been implemented immediately and that all issues raised had now been addressed. A short conversation took place on how, going forward, the board responded to issues made following SU presentations. It was agreed to hold a workshop at a future board. **Action: Board workshop to be scheduled to discuss SU Stories and Trust response as a Board**	
145/18	**CEO Brief** TC presented the report to the Board which was taken as read. The below key headlines were highlighted: • **Budget** The picture was positive with TC stating he was confident the money would come. Figures due to be published in December and the Improvement Plan in April 2019. Next year would be a 'transition' year for the NHS. TC noted the concern around gaps in the budget advising conversations were already underway to look at this. Unclear whether Mental Health Funding would be via the CCG or ring-fenced.	

	• **NHS Improvement and NHS England** Proposed new structure outlined – this would be good news if followed through. • **STP** Integrated Care Systems were moving forward along with an Integrated Care approach. • **Winter Pressures** TC reported on the NHSi Q2 performance report noting the poor financial and performance figures, but highlighted demand was outstripping resource. • **HCT** HCT had appointed Clare Hawkins as CEO. A bid had been submitted for community services. • **Trustwide Update** TC highlighted that demand continued to increase Concern around access for adults and young people Good progress had been made with residential beds with a drop from 44 down to 11 Quality – we continue with the Good to Great journey Safety – good progress NHSi – the Exec team would be holding a Deep Dive on the 11th December • **CQC** The Trust had completed the required RPIR document and a copy of this would be shared with the Board. Focus groups would begin in January 2019. • **Financial Update** The Trust was holding a steady ship. Key spend was agency, out of area placements and PICU. Work was underway with commissioners and a number of schemes were in place. • **Non-Executive Director recruitment** TC confirmed the process was underway. • **Trust Staff Awards** 150 staff and family members had attended the afternoon award ceremony. In the evening TC commented on Nikki Prest who won the Unsung Hero award and noted he would be sharing her story with the Board. TC concluded his update announcing that Jess Lievesley would be leaving the Trust in Spring 2019. **RECEIVED** **The Board RECEIVED the report**	
146/18	**STP UPDATE** TC introduced the paper which was taken as read and asked the Board to note the below 3 key points:	

	• **Development of a Herts and West Essex Integrated Health & Care Strategy** • **Development of a Herts and West Essex Financial Strategy** Significant amount of money with a deficit of £80m. This was broadly accrued from the three acute Trusts and we would be working together to address this. • **The future shape of the STP** Paul Burstow had been appointed as Independent Chair. Deborah Fielding would be leaving in March 2019 and recruitment for this post was underway. LW raised item 5.2 (overall page 28 of 222) from the report stating she had no sense of feeling that we had momentum to achieve the strategy. TC responded confirming there was lots of activity happening however the big ticket items had not yet been spoken about. NHSE had a new Director who would be taking this forward as part of his remit. CL concurred reporting the new appointment would see an increase in pace for the STP. TBa asked for clarification around the STP and private sector. TC advised the STP were not formal partners but were connected. Nationally there were barriers to the collaboration and no clear steer on what this would mean. **RECEIVED** **The Board RECEIVED and NOTED the report**	
147/18	**Report of the Integrated Governance Committee – 8th November 2018** SBe talked through the report to the Board which was taken as read and stated there were no issues for escalation. There was one new risk which had been recommended to be added to the Risk Register on the implications for the Trust arising from Brexit. An update had been given from WODG (Workforce and Organisational Development Group) which had highlighted there were good initiatives underway around staff retention and retire and return. The Trust 'time to hire' still required work. A pilot was running with the DoE around bank flexible working. The committee had received a report on WRES which was disappointing and showed no significant improvement. Dr Habib Naqvi, Policy Lead in the NHSE WRES team had agreed to join the working group to look at improving the experience of BME staff in the Trust. The committee had noted the benefits gained by Albany Lodge and Aston from the regular Quality meetings. Concern had been highlighted on the increased demand for the Section 136 Suite. In IM&T there had been positive progress on smarter ways of working and a steady increase for data incident reporting. A deep dive into restrictive practice had been received with a number of initiatives implemented. **RECEIVED** **The Board RECEIVED and NOTED the report**	
148/18	**Quality and Patient Safety Quarterly Report: Quarter 2**	

	JPad presented the Quality and Patient Safety Report for Quarter 2 to the Board and confirmed the report was taken as read. The below messages were detailed to the Board: Freedom to Speak Up – JPad confirmed Kevin Hallahan had been appointed as the Freedom to Speak Up lead and highlighted that a Non-Executive Director would also need to be appointed to this role now Michelle Maynard had stepped down. Following a short discussion LW agreed to undertake as the lead Non Executive for this role on an interim basis. **Key areas to note were:** An increase in the number of incidents reported in Quarter 2 and an increase in unexpected deaths. A deep dive to look at the overarching picture had been carried out with learning from this highlighting work needed to be undertaken around 'protective factors'. The regular safety huddles had provided significant impact on immediate and cultural learning and had shown improved scores on service users feeling safe; in particular to note was Forrest House. Overall there had been good progress with safety and improvement seen in each quarter. LW commended JPad on the learning and understanding. KL voiced his welcome of the Moderate Harm Panel and questioned whether there were any themes emerging from the numbers. JPad responded stating there had been an increase in service users dying from collisions with a train. To address this, work was underway with the Herts Suicide Prevention team and a specialist workstream had been set up with the Rail Network. The other theme coming into the picture was the use of ligatures in young girls and work would take place to look at this. CL referenced page 6 of the report (overall page 38 of 222) and referred to paragraph 2.4 which stated the area with the largest increase in reported incidents was the 136 suite. JL acknowledged and advised of the reasoning for this explaining it was often used by the police as a secure drying out room for intoxicated people as they had no alternative. A short discussion was held by Board members with a suggestion that this issue may be something for the Health & Wellbeing Board to address. **RESOLVED** **The Board RECEIVED and NOTED the report**	
149/18	**Safer Staffing Report: Quarter 2** JPad advised the report was taken as read with no further key messages to be highlighted to the Board. CL drew attention to the challenges around the significant risk to the Trust around the profile of HCA and RNs who are able to retire. SBa noted the challenges on the Care Hours Per Patient Day. **RESOLVED** **The Board RECEIVED and NOTED the report**	
150/18	**Report of the Finance and Investment Committee – 13th November 2018** The report was taken as read. SBa introduced the paper and thanked RA and KL for their work into the deep dive which had looked at productivity and effectiveness in the Trust. Following a brief discussion it was agreed for a realistic timeframe on the outcome of this work to be agreed and which could be worked into the annual plan. SBa noted there was a degree of uncertainty in the planning for next year.	

	Congratulations were recorded for the commercial close of the Essex LD contract. An estates strategy paper would be presented at the next FIC meeting. Performance in Quarter 2 remained balanced. Financial summary for Quarter 2 looked more stable and likely to meet the control totals. JPa raised the difficulties she had seen staff experience when being shown PARIS recently. A short discussion was held with JL and RA providing assurance the system was being reviewed and modified and a paper due to be presented at the next FIC meeting. **RESOLVED** **That the Board RECEIVED and NOTED the report**	
151/18	**Performance Report: Quarter 2** RA presented the Performance Report for Quarter 2 stating that overall performance for the quarter remained broadly balanced in the context of the turnover rate, demand on services, referrals, notable improvement to our financial position and the positive improvement with the sickness rate which was achieving below target. RA outlined the challenges ahead in achieving the desired level of performance with October seeing a 20% increase in referral demand compared to the same quarter in 2017. RA provided the below key messages from the report: There had been good performance on SoF (Single Oversight Framework) indicators for the quarter which were all met with the exception of FEP (First Episode Psychosis) cardio-metabolic assessment and DQMI (Data Quality Maturity Index) Access to services – routine referrals for adult community services had seen a decline of 8% from Quarter 1. The main areas of challenge were within the SW and E&SE quadrants. Performance in other quadrants was fragile. CAMHS – 7 and 28 day waiting times had improved significantly for the quarter. IAPT services – mid and West Essex IAPT services remain an area of concern. Safe and Effective services – risk assessments achieved 92.74% against a target of 95%. Performance against risk assessment was at a steady decline for 6 consecutive months with all SBUs below the 95% target. Delayed transfers of care achieved 7.25% against a target of 3.5%. **RESOLVED** **That the Board RECEIVED and NOTED the report**	
152/18	**Finance Report: October 2018** The report was taken as read. KL advised the board of the below main points to note: • KL reported there had been continued recovery for Quarter 2 in line with the planned trajectory • PICU placements had increased in month and were the key area of expenditure variation • Within CAMHS Tier 4, Eating Disorders were the area of key pressure – numbers of placements were small • Inpatient areas were under real pressure as reflected by near permanent 100% occupancy but the teams had continued to manage	

	well and importantly avoided external placements in adult services • Acuity was high which added an additional pressure on staff • Progress was being made around the use of agency and this was notable with c.£5m reduction since 2015 • Current forecasts are that the Trust would achieve its year-end financial target **RESOLVED** **That the Board RECEIVED and NOTED the report**	
153/18	**Workforce and Organisational Development Report: Quarter 2** The report was taken as read. MM presented the below highlights from the report: Quarter 2 had seen an improvement in workforce indicators with the vacancy rate achieving 13%. There had been more starters than leavers in the quarter and the reduction in time to hire had seen significant improvement. There had been a slight reduction in the quarter for staff turnover however October had seen an increase which would be addressed. Sickness rates were the lowest the Trust had ever seen with MM stating it was felt this was down to the introduction of staff health checks, massages and competitions which had been introduced for staff. Long term sickness staff were being given support on returning to work. Appraisal rates had increased as had Mandatory Training at 87.5%. In Quarter 2 640 staff had responded to the Pulse survey – the highest ever. There was a slight reduction in staff motivation and staff experiences. After a short discussion it was agreed to hold a Board workshop on Staff Engagement. CL raised Staff Induction with the suggestion there was a Non-Executive Director present at each of these. It was agreed for the Staff Induction dates to be circulated to the Non-Executives. **Action: Board workshop to be held on Staff Engagement** **Action: Staff Induction dates to be circulated to Non-Executives** **RESOLVED** **That the Board RECEIVED and NOTED the report**	
154/18	**Update on NHS Improvement Planning Guidance** KL reported we had not yet received the planning guidance however work on the Trust plan was already underway. Conversations with governors and stakeholders would be held for their input into the annual plan with dates being put into a planning timetable. **RESOLVED** **The Board RECEIVED the update**	
155/18	**Annual Plan 2018/19: Quarter 2** KL introduced the plan noting that page 2 of the summary outlined progress. There were 7 strategic objectives of which 5 had been rag rated green and 2 amber showing positive progress. There had been an increase in service users feeling safe and good progress with CAMHS tier 4. The workforce indicators had shown clear progress in particular with the introduction of Spike 2. Overall we were moving in a positive direction.	

	Our challenge is demand and access. The PD Pathway was in place and required implementation High Performing teams required development STP would gather pace giving a need to be 'front footed' in our leadership Looking ahead, there was a degree of confidence in the big ticket items. SBe commented stating the report was well written and easy to follow. **RESOLVED** **The Board RECEIVED the report**	
156/18	**The Colonnades Lease Agreement** KL presented the item and provided background to the report. Following discussion amongst Board members CL asked the Board for their formal approval of the new lease. All present approved **APPROVED** **The Board APPROVED the lease**	
157/18	**Review of the Constitution** JH stated the Trust was required to review the Constitution every 3 years with this last being undertaken in 2015. JH further explained it was good practice to review the terms of the Constitution and associated Standing Orders on a regular basis to ensure they remained fit for purpose and were compliant with relevant legislation and regulatory requirements. Appendix 1 of the papers set out the various amendments and updates which were proposed for approval. Bevan Brittan, the Trust solicitors had reviewed the proposed changes. Page 29 of the constitution, Annex 3, composition of the council of governors. The proposal to include Healthwatch Hertfordshire as a partner organisation was discussed with JL confirming that Viewpoint were now a subsidiary of Healthwatch. JH agreed to review this. Board members approved the Constitution subject to a copy of the final (proposed) Constitution being circulated and receiving clarification on Healthwatch Hertfordshire. **APPROVED** **The Board APPROVED the proposed Constitution**	
158/18	**Board Assurance Framework** JH reported the Board Assurance Framework (BAF) had been to the Integrated Governance Committee and now gave second and third line assurance. Ongoing work would be to ensure the use and inclusion of the BAF at Board committees. **NOTED** **The Board NOTED the report**	
159/18	**Trust Risk Register** JPad presented on the Trust Risk Register (TRR) and confirmed that the 3 requested changes had now been incorporated. There were currently 16 risks on the register. **NOTED** **The Board NOTED the report**	

160/18	**Any Other Business** CL advised that Mary Pedlow, a long standing Mental Health Act Manager would be stepping down from her role to move closer to family. As Mary had worked for many years in Health and Social Care and undertaken lots of volunteer work CL proposed we put Mary forward for an award. Mary would be a big loss to Hertfordshire and CL recorded thanks for Mary's contribution and work.	
161/18	**QUESTIONS FROM THE PUBLIC** Question: BC raised a question with regards to the sale of 305 Ware Road and the reinvestment into accommodation in Hoddesdon. BC stated he had been advised an incinerator was to be built in the area and therefore recommended there was no proposal for service user accommodation in that patch. KL thanked BC for his advice and took on board the comments. Question: BC raised a further question in relation to Lea Valley CCG GP practices and the possible move to Hoddesdon. JL responded stating the proposal was to expand the Upper Lea Valley to incorporate Lower Lea Valley. The challenge was to ensure that the service reflected local need, rather than assuming one size fits all. To that extent we will work with the locality to agree how this would be extended. TC thanked BC for his input into the two points he had highlighted. Question: JW voiced his approval of the proposed changes to the Constitution. JW asked if a copy of the CQC submission could be shared with the Governors. JPad responded advising that due to the size of the submission a summary would be prepared and shared at a future Council of Governors meeting. **Action – JPad to prepare a summary of the CQC report for a future Council of Governors meeting** **There were no further questions raised from the Public.** CL thanked SL for joining todays Board meeting with SL stating she had been extremely impressed with the high quality of papers, discussions and the transparency we hold as a Board. SL said she felt re-assured from our conversations and in particular would be taking back at a national level the dialogue around the issues with the 136 suite.	
159/18	**Date and Time of Next Public Meeting:** The next meeting is scheduled for Thursday 7th February 2019 @ 10:30am in Da Vinci B, The Colonnades	

Hertfordshire Partnership NHS
University NHS Foundation Trust

Agenda Item 4

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 7th February 2019

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
29/11/18	**144/18**	Matters Arising Schedule	Board Workshop to be held to look at SU Story feedback	Date to be confirmed for a Board Workshop	JH	b/f	A
29/11/18	**148/18**	Quality & Safety Quarterly Report Q2	Request for a NED to be appointed due to Michelle Maynard stepping down, LW would step in an interim until a formal appointment was made		CL/JH	b/f	A
29/11/18	**153/18**	Workforce & Organisational Development Report Quarter 2	Board Workshop to be held on Staff Engagement	Date to be confirmed for a Board Workshop	JH	b/f	A
29/11/18	**153/18**	Workforce & Organisational Development Report Quarter 2	Staff Induction dates to be circulated for NED attendance		KW		G
29/11/18	**157/18**	Review of the Constitution	It was agreed for a copy of the final and updated constitution to be circulated to the board for approval and recommendation to the Council		JH/KW		G
29/11/18	**157/18**	Review of the Constitution	JL noted that Viewpoint was now a subsidiary of Healthwatch Hertfordshire. CL and JH to meet and discuss whether Healthwatch Hertfordshire would still be contacted for an appointed NED		CL/JH		A
29/11/18	**160/18**	AOB	It was agreed for a summary of the CQC report to be circulated at a future Council of Governors meeting		JP		A
27/09/18	**129/18**	Emergency Preparedness	JL to revisit the wording in the EPRR on 4.2 Standard 5		JL	29 November	G
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	JP	b/f	A

				Workshop			
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	**G**
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**

Board of Directors Public Meeting

Meeting Date:	7th February 2019	**Agenda Item** 5
Subject:	CEO Brief	
Presented by:	Tom Cahill, Chief Executive Officer	

National update

NHS Long Term Plan

NHS England has published the NHS long term plan. The plan sets out ambitions for ensuring the NHS is fit for purpose and covers a 10 year window and importantly, an additional investment of £2.3bn for mental health services, including £250m earmarked for crisis services.

Mental Health features strongly in the plan with specific goals for Children and young people's mental health services, learning disability and autism, and adult mental health services. The Plan also focusses on the workforce challenges and the workforce implementation plan which will be overseen by NHS Improvement (NHSI) to ensure the delivery of its actions and to ensure the overall balance between supply and demand, for mental health, the plan promises 4000 more mental health and learning disability nurses will be trained by 2023/24.

Operating and Planning Guidance 2019/20
NHS England Operational Planning and Contracting Guidance

During January, NHS Improvement (NHSI) and NHS England (NHSE) have progressively released joint Operational Planning and Contracting Guidance, alongside its allocations to CCGs. This guidance describes their expectations for the Operational Plans they require from provider organisations and Local Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems.

These Operational Plan submissions cover a financial and related workforce submission, and an operational plan narrative outlining the providers approach to activity, quality, workforce and financial planning for 2019-20. Provider organisations are required to make a draft submission of their Operational Plan by 12 February 2019. Local STPs are required to submit a draft consolidated plan for their area by 19 February 2019. NHSI will review these plans, providing feedback that can be incorporated into final provider organisation plans that are to be submitted by 4 April 2019. Final aggregated STP / ICS Operational Plans are due for submission by 11 April 2019.

We are developing our draft plans for submission by the required deadline. This will be further refined, based on any feedback from NHSI and the final outcome of our contract discussions with our commissioners. Further details of planning requirements will be addressed on the main Board agenda.

Regional NHSIE Structure and Director Appointment

The joint directors of the new NHS England and Improvement regional teams have been confirmed by the system managers. The East of England Regional Director has been confirmed as Ann Radmore, currently Kingston Hospital Foundation Trust chief executive. The new Regional Directors will form part of a new "NHS executive group" which is set to hold its first meeting in January 2019, with the new national and regional directors expected to formally lead their integrated directorates by April 2019. We look forward to building strong relations with the new team.

An NHS Workforce for the Future
The New NHS long term plan is conspicuous by the absence of a robust workforce strategy or plan. It remains unclear as to the timetable for the development of such a national strategy. However NHS Improvement under the leadership of Dido Harding has been requested by the Secretary of State to develop a national workforce plan. The plan is expected to cover a range of themes including, future Medical and Dental workforce , future Clinical workforce, NHS best place to work, leadership and talent development and tech Skill and enablement . Further details of the plan will be reported to the Board in due course.

National WRES Report
The WRES national data report has been published for 2017/18. This shows a comparison of data for all Trusts submitted in 2018 as well as comparing it with the previous period. We remain committed to ensuring that our BME workforce has an improved and equitable experience. Nationally there has been an improvement seen between 2016 and 2018 across the range of workforce indicators. There has been an overall increase in representation of BME staff in the NHS since 2016, an increase of 10,407. HPFT continues to have a significantly higher proportion of BME staff at 33% than the NHS as a whole (19.1%).

There has been a sustained increase in BME nurses, health visitors and midwives in AfC bands 6 and above, an increase of 2,224 from 2017. In HPFT for 2018, there has been an increase in Bands 7 and 8 in nursing roles.

Regional update

Hertfordshire and West Essex STP
A new independent Chair has been appointed to the STP, Paul Burstow, formally a member of Parliament and current Chair of Tavistock and Portman MH Trust. Paul took up post on 1st December 2018. He continues to meet key partners across the system and to work with colleagues to redefine priorities for the coming year. This will take account of guidance set out in the NHS Long Term Plan. Priorities will include establishing a new Integrated Care System (ICS) by the end of 20/21 and delivering milestones set out in both the Health and Care Strategy and the medium term Financial Plan. Further work will be undertaken to understand how Commissioning Organisations can better work together and support the development of the ICS. Recruitment for a replacement of the current STP lead, who steps down in April, is under consideration.

Hertfordshire chosen as a national trailblazer in school mental health support
It was announced in late December that schoolchildren experiencing mental health difficulties in Hertfordshire would get early help from special support workers in a new initiative. https://www.healthierfuture.org.uk/news/2018/december/hertfordshire-chosen-national-trailblazer-school-mental-health-support . HPFT will play an active and leading role in the development of this service

West Herts Adult Community Services (Physical)
Following the outcome of Herts Valleys CCG's recent market testing tender process for adult community health services in West Hertfordshire it has been announced that Central London Community Healthcare NHS Trust (CLCH) will be the new provider for these services in West Hertfordshire from the Autumn, indicating that Herts Community Trust's bid was unsuccessful. CLCH have said in their press statement that this new way of working will bring physical and mental health and social and voluntary care organisations closer together so that patients can benefit from more co-ordinated care together with an opportunity to deliver an integrated model of care that builds on CLCH's experience as an established healthcare provider in Hertfordshire, where they already provide both sexual health and respiratory.

We have already made contact with colleagues at CLCH to begin conversations about how we best work together going forward. We are also in contact with colleagues from HCT to understand the impact on current joint working arrangements

Trustwide Update

Performance
Our overall performance has remained stable against the pressures of an increase in referrals and a turnover rate of 16.3%. We continue to sustain our performance in ensuring we have minimal inappropriate out of area placements and ensuring that people under adult mental illness specialties are followed up both within 72hrs and 7days of discharge from psychiatric in-patient care.

There continues to be challenges in achieving the 98% target on 28 day wait for referrals to the community mental health team. The new initiative on DNA protocol of stopping the clock following non-engagement in SPA will support in reducing some of the pressures including the roll-out of Primary Mental Health Pilots of which HVCCG have announced an additional £650k to support. 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, we continue to focus on retention initiatives with a goal to retain our current staff and also encourage staff that have retired to return to work with us again and we continue to proactively work with medical colleagues to recruit to vacant posts.

Quality & Safety
Working with the nursing leaders and Clinical Directors, an increased focus on the Safewards methodologies, safety huddles and safety crosses are examples of how staff are working more proactively to work at reducing restrictive practices in the inpatient service areas as well as promote safety in all services.

Following the deep dive into unexpected deaths, there has been a focus on the quality of risk assessments and an education group is working to ensure staff have the right skills to deliver this.

We are now in the process of planning our clinical audit programme for 2019-2020. This enables us to constantly improve our approach to clinical effectiveness in the organisation. The final plan will be approved at the QRMC.

CQC
The Trust has now been given its date for the Well Lead and Core service inspection. These will be done jointly between the 4th- 8th March and marks the beginning of a new approach by the CQC to their inspection regime. With regards the Core Services they have advised that they will be inspecting the following services:

- Adult acute and psychiatric intensive care units (PICU)
- Community adult mental health service
- Crisis services and places of safety
- Inpatient CAMHS
- Community CAMHS
- Inpatient older adults
-

They have also scheduled a 'mop up' session for any outstanding issues regarding the Well Led review on 27 & 28 March 2019.

They have already had four days of focus groups with significant numbers of staff across Hertfordshire, Essex and Norfolk.

Additionally the CQC team responsible for Mental Health Act issues, will be on site in the trust between the 5th – 7th February (based at Kingsley Green) to review seclusion practice and long term segregation. This will feed into the overall review.

The board will be reminded of the preparation underway by the Trust as presented at the last Board meeting.

Workforce & OD

Recruitment and retention remains a challenge, however there has been an improvement in the time taken to hire staff which has fallen from 12 weeks to 8.5 weeks since quarter one. Additional work to improve the on boarding process for candidates continues as well as improving the experience for new starters within the Trust. This includes the launch of the new careers website. Following negotiations and agreement with staffside we have implemented changes to notice periods for new staff joining the Trust. All newly appointed Band 5 and Band 6 staff will have an 8 week notice period and Band 7 and above a 12 week notice period. Staff engagement continues with the recent Good to Great Roadshows held across the Trust throughout December and January. The Trust expects to receive the national staff survey results on the 8th February which will be embargoed until 26th February.

Financial update

For December the financial position reported was a surplus of £182k for the month, ahead of the Plan of £78k and YTD the position is now £408k which is £295k above Plan. This continues the run of favourable surplus variances of the last few months but at a higher level. The favourable variances continue to be due to some additional non contract income, pay savings and financing costs being below Plan. The improvement is due to the continued success in managing down agency costs and in managing overhead costs. This improvement since the position in Q1 has been very encouraging and has allowed the Trust to bring forward the program of investment in our estate, improving a number of clinical and inpatient areas with a program of work to be completed in February and March.
This can be completed whilst still ensuring the achievement of the annual Plan total of £360K which is essential in order to secure £1.8m of funding for further capital investment.

Executive and NED Appointments

The Board will be aware that the Council of Governors are leading a process to recruit two new Non-Executive Directors to join our Board. These will cover the posts vacated by Michelle Maynard and Simon Barter when he finishes his term in July 2019. The recruitment process is underway and will conclude with formal interviews on 26th February.

The Board will also be aware that Jess Lievesley, Executive Director of Service Delivery and Experience, has been appointed as Director of Strategy at St Andrew's Healthcare, a charity providing specialist mental healthcare based in Northampton. The Remuneration Committee has agreed that the post should be advertised and it is expected that formal interviews should conclude in early March 2019.

Risk Management Strategy

The Risk Management Strategy has undergone a full review and has been updated and re-drafted in order to clearly set out the Trust's framework within which it leads, directs and controls the risks to its key functions. We have purposely separated the risk strategy from the risk policy to support this approach.

The Integrated Governance Committee received the Risk Management Strategy at its meeting on 23 January 2019 and agreed to recommend it to the Board of Directors for formal approval and adoption. The strategy is on the board agenda for approval.

Tom Cahill
Chief Executive

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	7th February 2019	**Agenda Item: 6**
Subject:	Herts & West Essex Integrated Health & Care Strategy	**For Publication: DRAFT**
Author:	Deborah Fielding, Chief Executive Officer, STP Harper Brown, Director of Strategy, STP Alison Gilbert, Director of Delivery and Partnerships, STP	**Approved by:** Harper Brown, Director of Strategy, STP
Presented by:	Harper Brown, Director of Strategy, STP	

Purpose of the report:

To present the HWE STP Draft Strategy to the Board for discussion and feedback.

Action required:

For the Board to provide endorsement and feedback.

Summary and recommendations:

This strategy is a blueprint for delivering a healthier future for the population of Hertfordshire and West Essex.

It is designed to guide our health and care organisations, staff, the voluntary sector and our population to work in partnership.

1) Discuss and endorse the HWE I H & C strategy.
2) Discuss and note the 4 areas of next steps including confirmation of commitment to play our role in each step.
The CEOs agreed the strategy and we have tried to make it more easy to understand and change the language to less NHS focused.
The CEOs agreed to take it through their Boards during December and January and we welcome any feedback as well as offer senior STP leads to come and present or listen to feedback.
Align this strategy with the MTFP also going through stakeholders' Boards.

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

Should influence all organisations agenda

Summary of Financial, IT, Staffing & Legal Implications:

1 Finance – this draft Strategy links to the STP MTFP
2 IT – links to STP Digital Road Map
3 Staffing – links to STP Workforce Strategy
4 NHS Constitution – none directly at this point
5 Carbon Footprint – none directly at this point
6 Legal – none directly at this point

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

Still in draft – EIA and HIA to be completed June 2019

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
Sustainability and Transformation Partnership

An Integrated Health and Care Strategy for A Healthier Future

EXECUTIVE SUMMARY

6th December 2018

Executive Summary

'Care will be high quality, proactive and joined up, to deliver a healthier future for our population and our services'

This strategy is a blueprint for delivering a healthier future for the population of Hertfordshire and west Essex.

It is designed to guide our health and care organisations, staff, the voluntary sector and our population to work in partnership.

Our approach is based on the principles of population health management. This is a way of targeting our collective resources where they will have the greatest impact, improving the quality of care through improved, affordable services. Our key priorities are:

- **Meeting people's health and social care needs in a joined-up way in their local neighbourhoods**, whenever that's in their best interests - saving time and cutting out unnecessary tests and appointments. Health and care services will support people to live as independently for as long as possible.
- Adopting a shared approach to treating people when they are ill and **prioritising those with the highest levels of need, reducing the variations in care** which currently exist.
- Placing **equal value and emphasis on people's mental and physical health and wellbeing** in all we do.
- Driving the **cultural and behavioural change** necessary to achieve the improvements we need. Care professionals, service users, families and carers will understand the role they have to play in creating a healthier future.
- Ensuring that we have the **workforce, technology, contracting and payment mechanisms** in place to support our strategy, delivering health and care support efficiently, effectively and across organisational boundaries.

All of the STP's organisations are committed to working together to implement this strategy, so that we can make rapid improvements to the health and wellbeing of our population and the sustainability of our health and care system.

How will things change?

What's wrong now?	What will be different?
We focus on what people can't do	Our staff and population will be encouraged to work together to make the most of our strengths
Resources are not targeted effectively	We will use evidence to target resources, using a population health management approach
Care is built around organisational boundaries or individual illnesses and conditions, rather than taking into account the whole person	Health and care needs will be met in a joined –up way, based on each person's needs
Too many people are treated in hospital	Care will be provided as close to home as possible. High quality specialist hospital treatment will be there when it's really needed
Care is often only provided when things go wrong	Care will be proactive and better coordinated to help people to stay healthy and independent
Mental health and the health of people with learning disabilities is not routinely prioritised	We will place equal value and emphasis on the mental and physical health of all of our population
Health and care professionals take different approaches, leading to varied care and treatment for our population.	We will develop care pathways for everyone to follow, to reduce variation in outcomes and promote best practice
Organisations and staff are not united by a common approach	Each organisation and professional will understand their role in delivering this strategy

What does the strategy cover?

Our **Integrated Health and Care Strategy** has been written for service users, patients, their families and carers and everyone who supports them. It covers the range of health and care services that our population of 1,520,500 use.

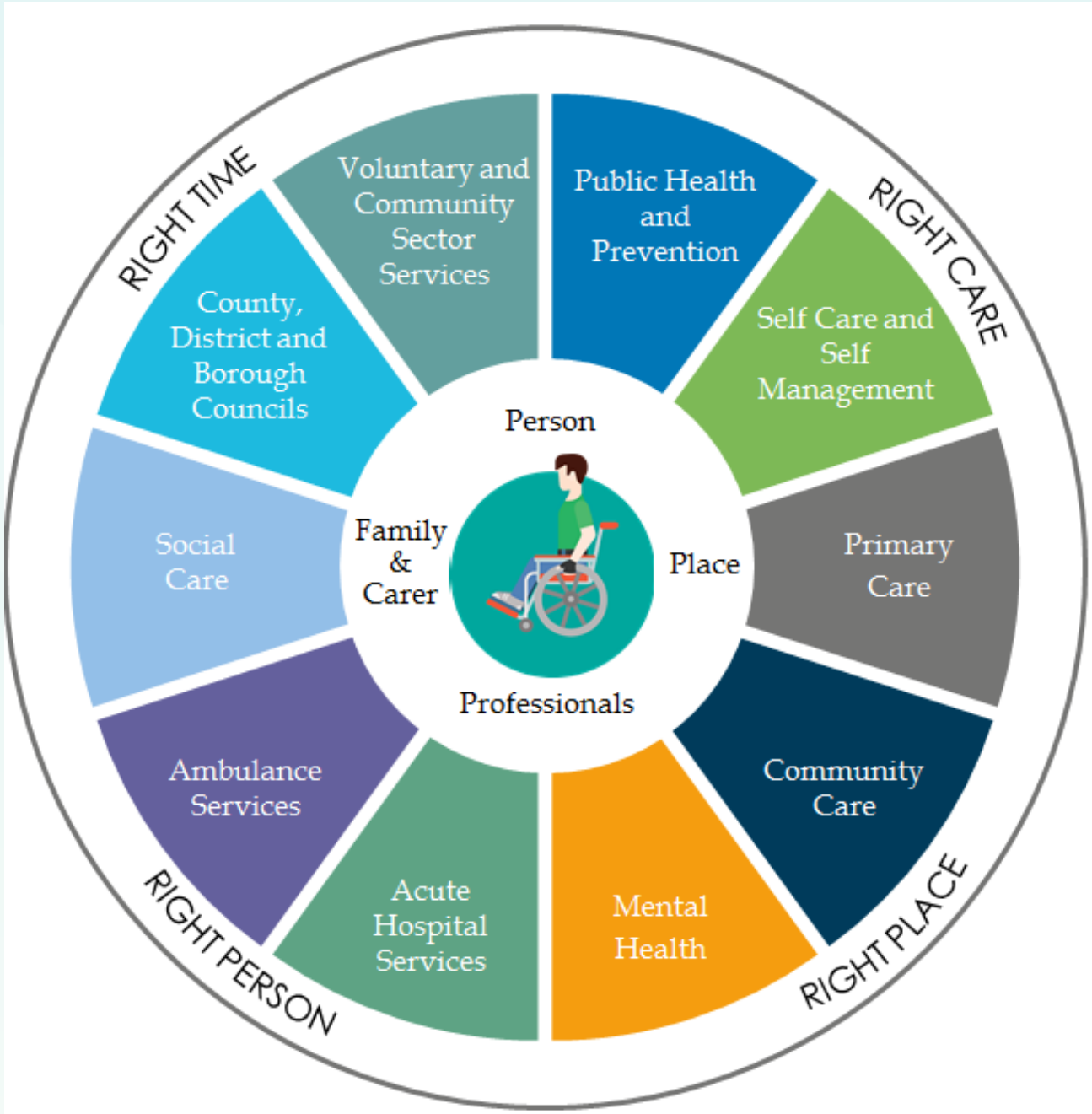
The strategy **builds on the foundation of our 'Healthier Future'** summary plan published in 2016.

It takes into account ongoing improvements to health and care services including local strategies developed by our Health and Wellbeing Boards, County and District Councils, CCGs, and Trusts.

This strategy is supported by our:

- **population health management plan**
- **medium term financial plan and our**
- **workforce strategy.**

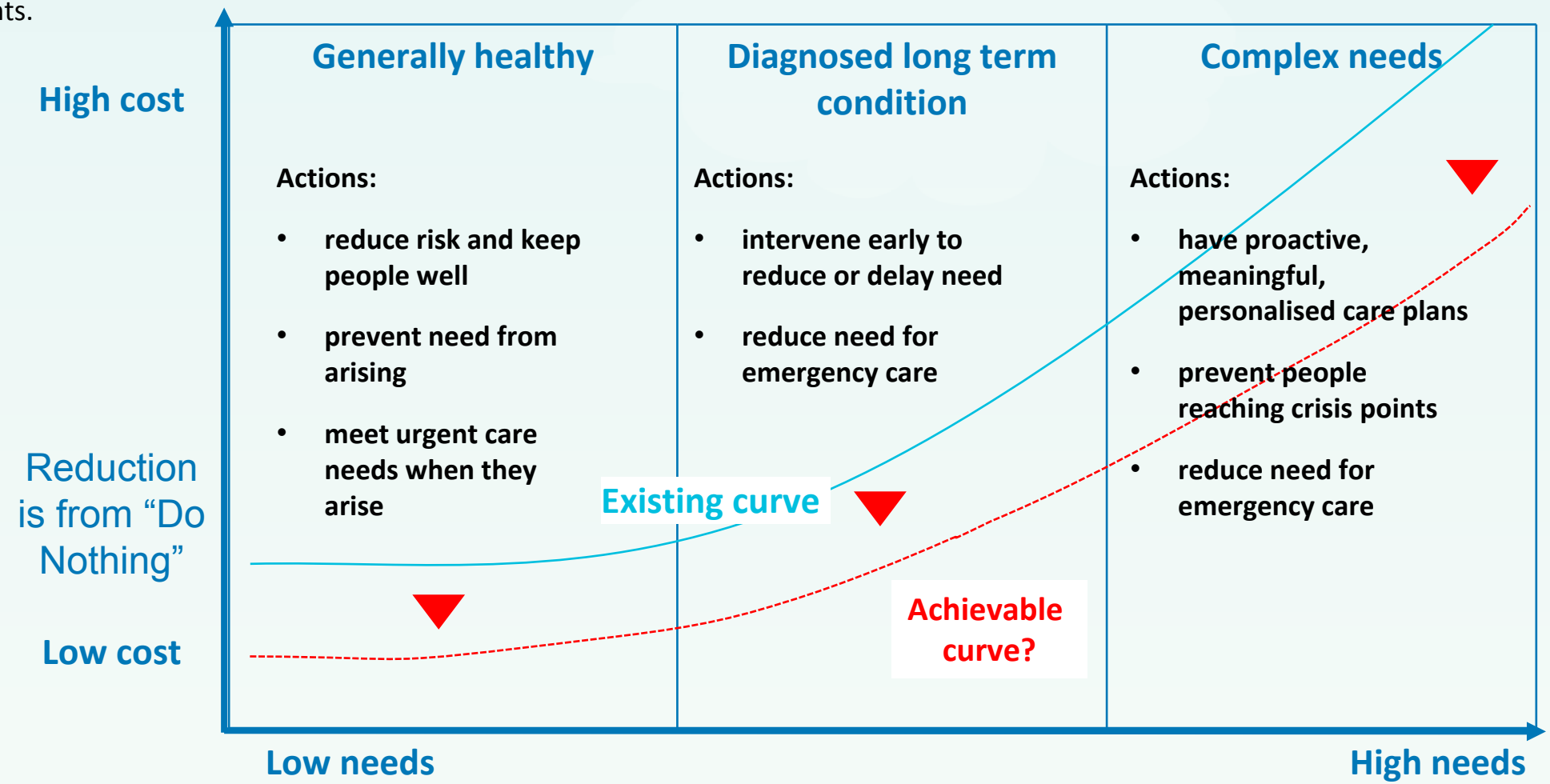
It will inform our area's neighbourhood strategies.



A population health management approach

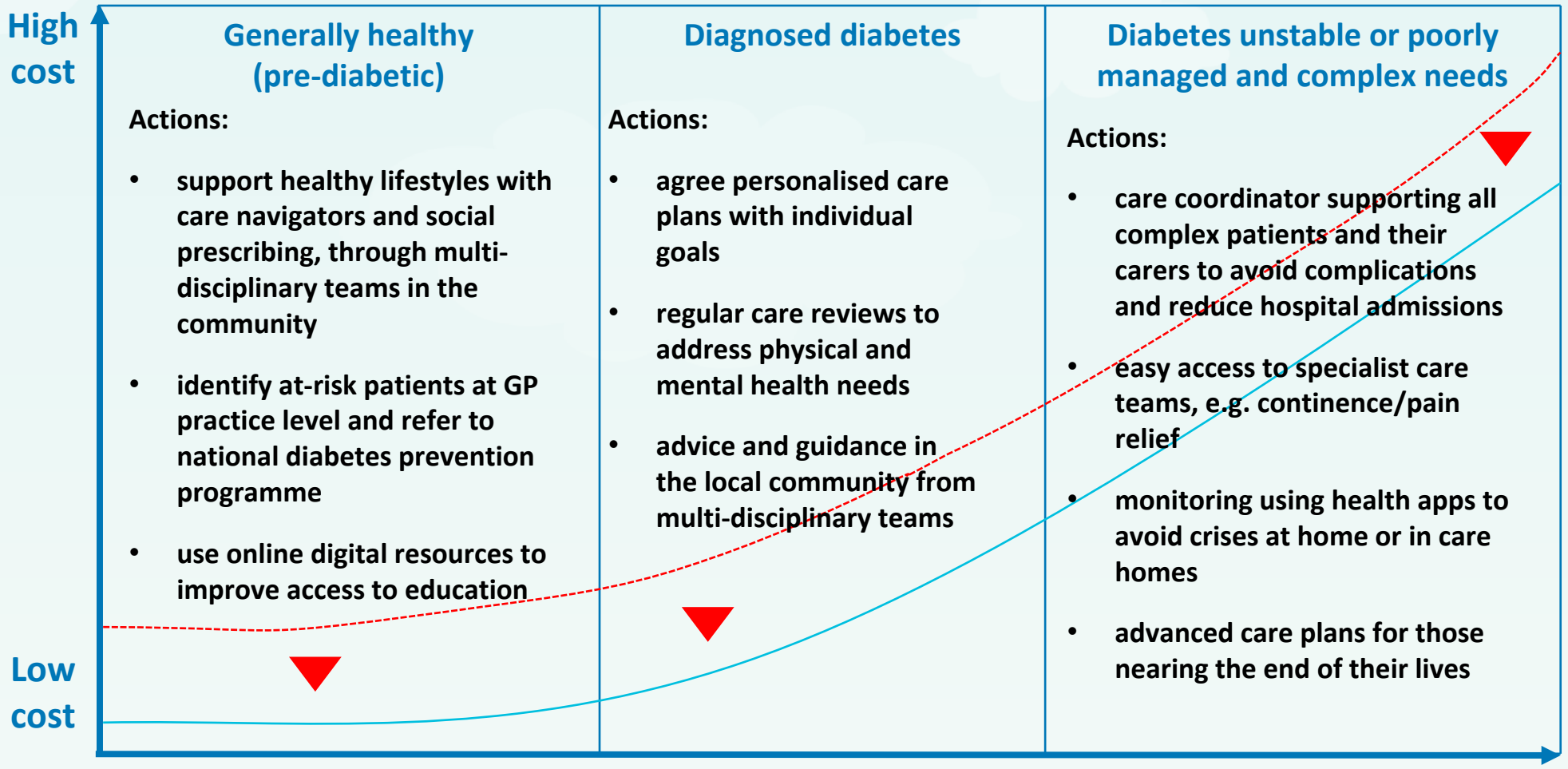
'Population health management' is an approach which will enable our STP to target our collective resources where evidence shows there is the biggest problem and that they will have the greatest impact.

Social care and health organisations, supported by the community and voluntary sector, will work closely together to deliver joined-up services to defined groups of the population. In this way, we will prevent, reduce, or delay need before it escalates; and prevent people with complex needs from reaching crisis points.



Population health management in action - diabetes

- Unless we take preventative action, 60,000 more people in our area are expected to become 'pre-diabetic' by 2023/24
- Total cost of caring for our diabetic population is currently £209.8m
- A reduction in diabetes related hospital admissions by 5% over 5 years would save £3m



10% reduction in pre-diabetic population would benefit 18,500 people and save £1.1m by 2023/24

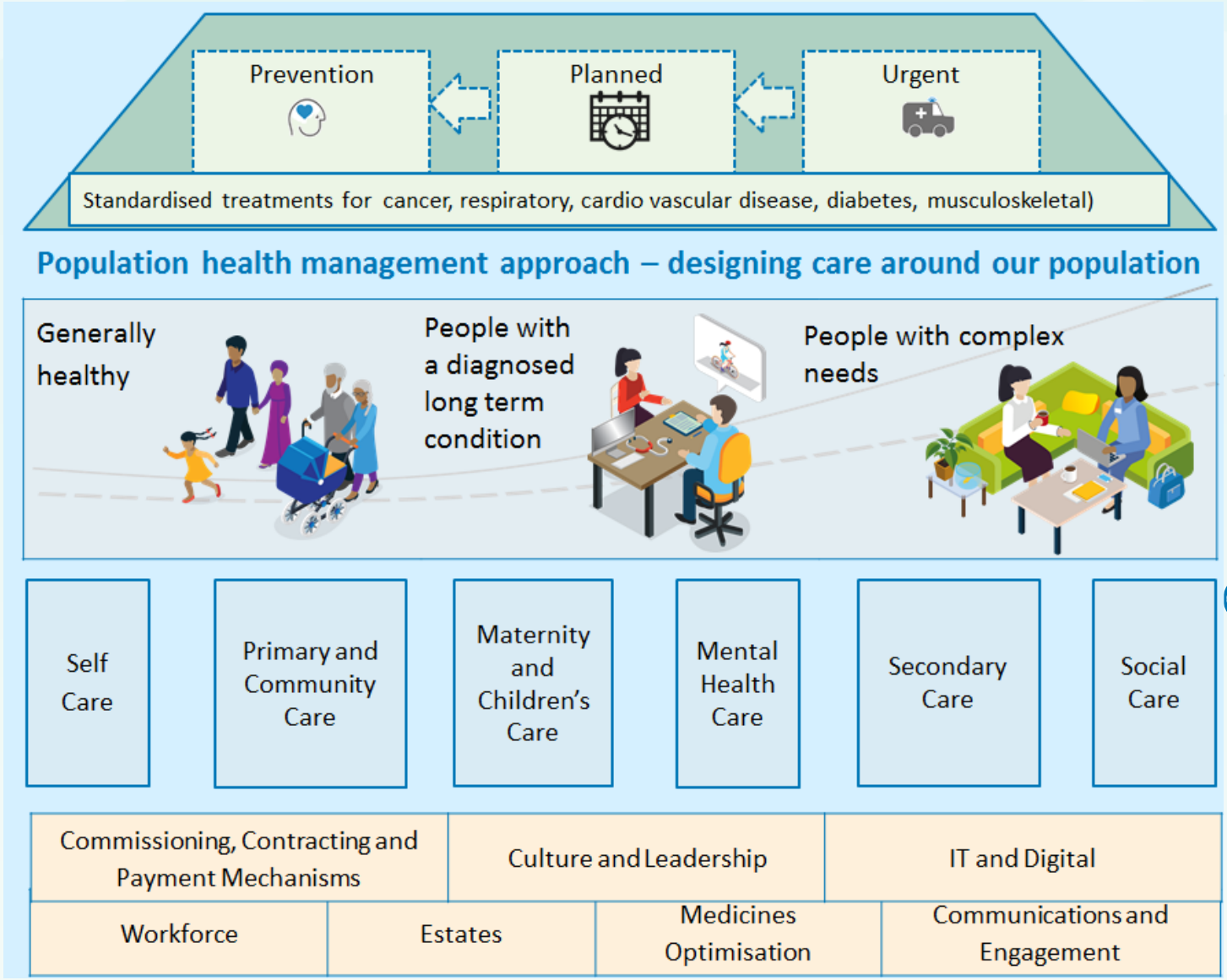
5% reduction in prevalence of T2 diabetes would benefit 3,450 people and save £5.2m by 2023/24

5% reduction in hospital admissions would represent 615 fewer admissions by 2023/24

Strategy overview

Our 'house' of integrated care

1 Develop integrated, person-centred models of care, designed to meet the needs of our population, delivered in local neighbourhoods wherever possible.



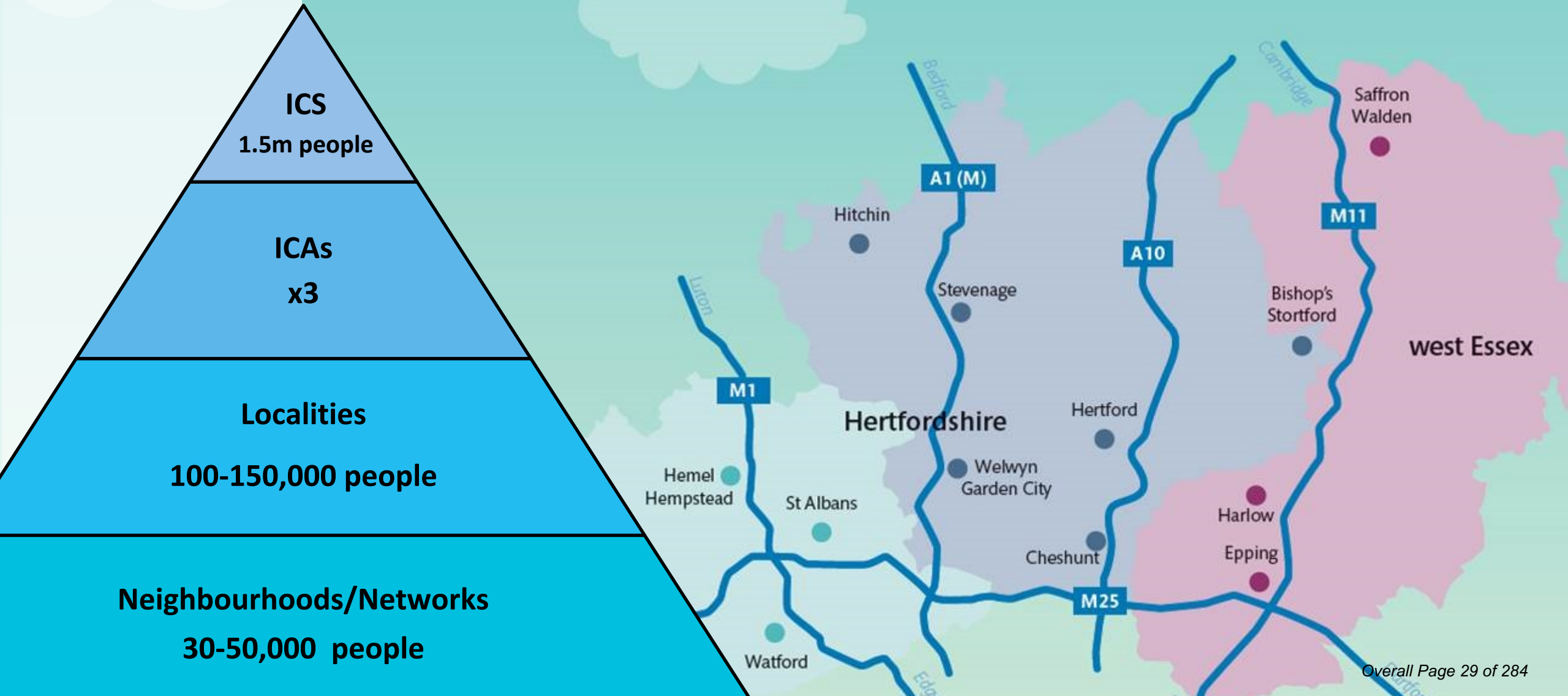
2
- Effective and efficient health and care is delivered in the right place, by the right person, at the right time.
- Shift care from reactive to proactive when possible, and standardise our approach to treatments.
- Agree the improvements we want to see and report back on their success.

3 Transform key pillars of our health and care system, to ensure they are sustainable, resilient, and deliver integrated care.

4 Put in place the staff, culture and systems we need to support the transformation we need.

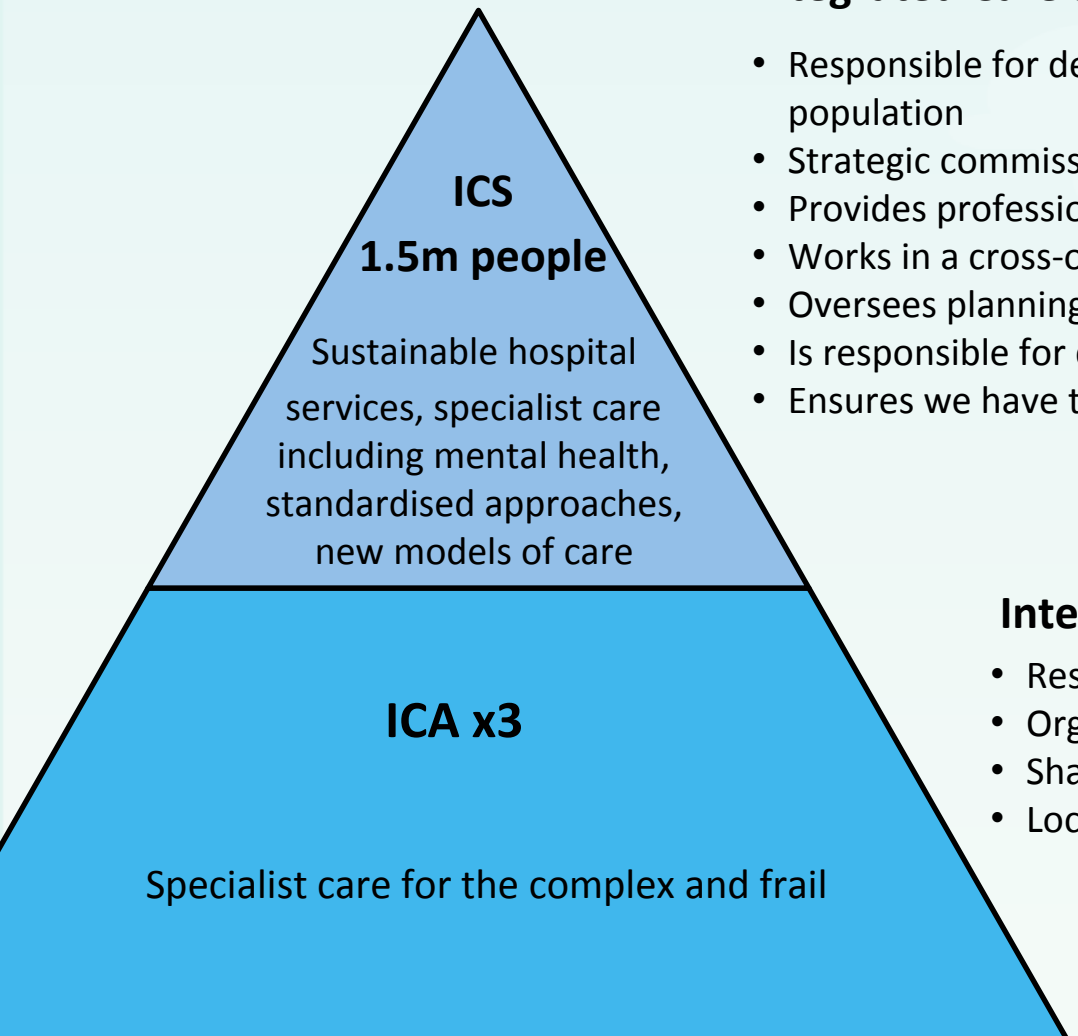
Delivering integrated care

How will health and social care be organised, commissioned and delivered in the future?



Delivering integrated care

How care will be organised, commissioned, and delivered



Integrated Care System

- Responsible for delivering the Integrated Health and Care strategy – improving the health of the population
- Strategic commissioning based on need, identified through a population health management approach
- Provides professional leadership for system
- Works in a cross-organisational way
- Oversees planning assumptions, sets financial principles and budgets
- Is responsible for delivering a sustainable system that delivers services that meet national standards
- Ensures we have the workforce, culture and systems we need to support the transformation we need.

Integrated Care Alliances

- Responsible for joint and ‘place based’ commissioning
- Organisations that provide health and care services working together collaboratively
- Shared transformation programmes to improve services
- Local risk and reward mechanisms, alignment of incentives, and new contractual forms.

Localities

Neighbourhoods

Localities

100-150,000 people

Urgent Treatment Centres, planned care in the community

Neighbourhoods

30-50,000 people

Integrated multi-disciplinary teams, GPs, opticians, pharmacies, social prescribing and support, continuing health care, nursing and care homes

- **Enabling staff across organisations to work together in an integrated way, meeting the needs of the population**
- **Development of integrated care hubs**
- **Single operating policies and procedures**

Revised leadership and governance structure

Programme governance

The programme governance structure distinguishes design from delivery.

The design programme work are accountable to the CEO Board for the design of STP wide pathways & interventions as well as the impact assessments and outcome frame works for their interventions. They will also provide resource to support delivery, knitting into the wider resource already in place and not duplicating support.

The Delivery Groups (Herts Valleys LDP, E&N Herts Chief Exec oversight group & West Essex ICP) are accountable to the CEO Board for implementation of STP interventions within their defined population as well as benefits delivery for the specific STP interventions. This line of accountability is purely for programme governance of the STP design interventions. Formal accountability for all other matters within the LDP (or equivalent) is to the CCG as system leaders and each statutory organisation.

The clinical oversite group (COG) will provide expert clinical leadership along with advice and guidance on the STP programme. The finance director group will provide expert financial leadership along with advice and guidance on the STP programme

Roles & responsibilities (summary):

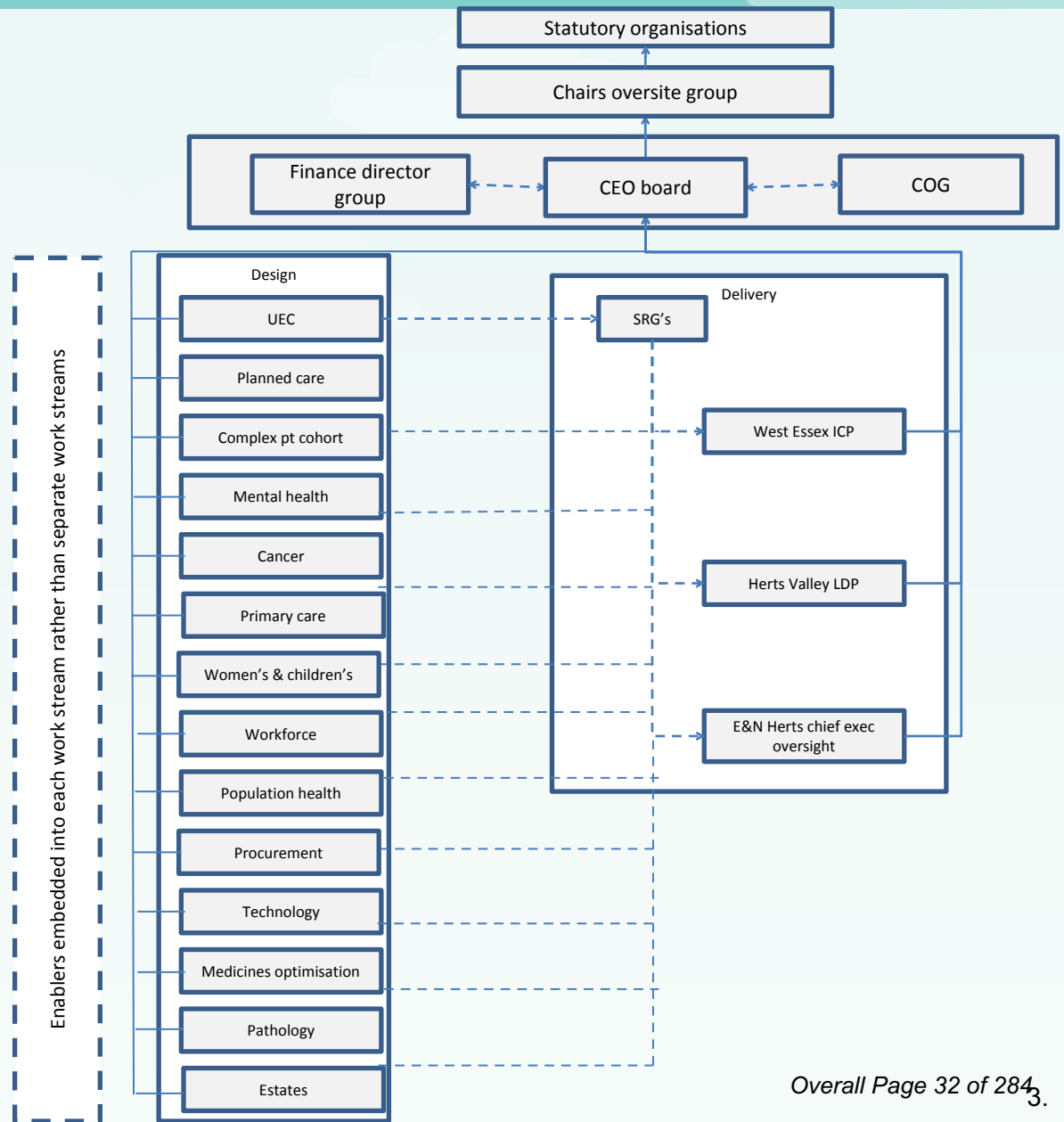
Design work streams
- Accountable for the design of system wide pathways & interventions
- Accountable for the impact assessment for their interventions
- Support each delivery unit

Delivery work streams
- Accountable for implementation of interventions within their defined population
- Accountable for benefits delivery

Key

Line of accountability

Sharing of products



What do we want to achieve?

We want to make changes that improve the quality of care and health and wellbeing outcomes for our population; and ensure we have a skilled and motivated workforce in place to deliver these changes. This will help create an effective and affordable health and care system.

Our population

Improved health and wellbeing, better quality care, closer to home

Our staff

Highly skilled and motivated staff who understand their role in delivering our strategy and are empowered to make changes

Our system

A sustainable health and care system

Next Steps

The delivery plans required to put this strategy into action will be co-produced with professionals across our health and care system

01 Programme Design / Governance

- All STP Boards to sign off draft strategy alongside medium term financial plan by end Jan 2018
- Review and reset current STP work streams to deliver the changes set out in this strategy by end Jan 2019
- Revise the design of the programme to reflect new priorities by end June 2019
- Expand membership of clinical oversight group to include wider range of professionals
- Engagement stakeholders in strategy (January – March 2019)
- Align strategy & NHS long-term plan

02 Model the impact of our plans

- Agree baseline and resource proposal by March 2019
- Undertake detailed modelling work to quantify the impact of the interventions set out in this strategy by March 2019
- Review the modelling outputs in light of the activity and financial assumptions set out in the medium term financial plan by 2019
- Set out delivery plans for each workstream by March 2019
- Quantify targets for outcomes and objectives by March 2019

03 Develop detailed delivery plans

- Establish an integrated, system wide transformation and implementation methodology by January 2019
- Co-produce detailed delivery plans with care professionals across the system
- Agree what will be delivered in the next 1,3, and 5 years by June 2019
- Develop implementation plan on a page by March 2019

04 Implementation

- Adopt a robust portfolio management approach to manage implementation and realise benefits by March 2019
- Regular reporting against delivery plan milestones and benefits by 2019/20
- Regular programme reviews to ensure work continues to be aligned with objectives and outcomes, reporting to each stakeholder by 2019/20

Professional leadership, culture and behavioural change, communications and engagement

Ongoing Programme Management

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	7th February 2019	**Agenda Item: 7**
Subject:	Preparing for a 'no Deal' scenario for BREXIT	**For Publication: No**
Author:	Keith Loveman Executive Director - Finance	**Approved by:** Keith Loveman Executive Director - Finance
Presented by:	Keith Loveman Executive Director - Finance	

Purpose of the report:

To provide an update on the planning being undertaken to mitigate where possible the risks associated with a 'no deal' Brexit scenario and to confirm the requirements of the Trust from DHSC.

Action required:

To receive and discuss the report, noting its implications for the Trust. To discuss whether the ongoing actions and appropriate mitigations are in place. To note the approach.

Summary and recommendations:

Introduction

This report provides an update on work to prepare for a possible 'no deal' Brexit scenario. The Trust has completed previously a self-assessment against major contracts and areas of potential risk which was submitted to NHS England on 28th November 2018.

The key areas of risk identified by the Trust are:

- Pharmaceuticals
- Clinical Consumables & Medical Devices
- Workforce
- Procurement

The Trust has also written to all staff with an EU passport, offering support on applying for settled status.

Update

DHSC published further guidance on 21 December, 'EU Exit Operational Readiness Guidance', developed and agreed with NHS England and Improvement, which lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal i.e. a 'no deal' exit. This is designed to ensure organisations are prepared for, and can manage, the risks in such a scenario. The guidance has been sent to all health and care providers, including adult social care providers, to ensure the health and care system as a whole is prepared.

The Trust is required to report on progress with preparations to:

- IHCCT
- Hertfordshire Local Resilience Forum (E&NHCCG Lead)

- Emergency Preparedness, Resilience and Response (EPRR) NHS England Midlands & East (Central Midlands)
- NHSI/E East EU Exit Team
- DHSC

Requirement

All providers must undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts, taking into account the instructions in national guidance. Any points of concern on specific issues are to be escalated to regional NHS EU Exit departments.

Approach

A Task & Finish 'EU Exit' Group has been formed to:

- Undertake an assessment of risks associated with EU Exit by the end of January 2019 (this has been completed), covering, but not limited to:

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

- Potential increases in demand associated with wider impacts of a 'no deal' exit.
- Locally specific risks resulting from EU Exit.
- Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.

And in pursuing this to:

- Liaise and work with wider system partners as appropriate.

Task & Finish Group Membership

SRO for EU Exit Preparation - Keith Loveman
Operational Lead - Sandra Brookes
Business Continuity and Emergency Planning - Carolyn Fowler
Chief Pharmacist - Chetan Shah
Chief Information Officer - Hakan Akozek
Interim Deputy Director of HR - Steve Graham

Recommendation

The Board is recommended to note the planning and reporting requirements placed on the Trust, the approach and EU Exit Group membership and to receive regular updates on progress.

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

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

This report has implications for finance, staffing and medicines management.

Equality & Diversity and Public & Patient Involvement Implications:

N/A

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

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

Previous reports regarding preparation for leaving the EU:
Executive Team 28 November 2018 & 16 January 2019
Audit Committee 4 December 2018

1. Purpose

1.1 The purpose of this report is to provide the Board with an update of the preparation the Trust is undertaking to mitigate the risks of a 'no deal' Brexit scenario. This remains a dynamic position and therefore whilst planning will focus on ensuring resilience, the ability to respond flexibly to emerging issues will remain a priority.

1.2 The report will detail the background to this position and the expectations of NHS England.

2. Background

2.1 In light of the ongoing uncertainty regarding the nature of the exit from the European Union, the Trust has added the exit as a risk to the Trust Risk Register. This recognises the potential impact on EU staff employed by the Trust and on risk to the continuity of supply of critical goods and services that may arise.

2.2 To provide the initial overview of current 'no deal' planning the previous paper set out a summary of the following elements:

- Pharmaceuticals
- Clinical Consumables & Medical Devices
- Workforce
- Procurement

2.3 DHSC has been working closely with Cabinet Office to implement a cross-government approach to identify agreements that may be impacted by potential changes to trading relations with the EU and developing mitigating actions to help ensure that there are suitable arrangements in place at the point of exit.

2.4 As part of this activity, DHSC developed a mandatory Self-Assessment Methodology for NHS Trusts to use to review contracts that may be impacted by a 'no deal' EU exit.

2.5 The Trust is monitoring the risks associated with a 'no deal' outcome and has responded to requirements from NHSE to assure them of rigorous planning. submitting a self-assessment document of the Trust's position on November 30th. Any requirements for business continuity arrangements as a result of the UK's departure will be coordinated as appropriate and HPFT's Emergency Planning Committee will monitor risk and mitigation.

2.6 The new NHS England Regional EU Exit Team is beginning to take shape. Once fully operational, this team will be the main point of contact and source of guidance and instructions in relation to EU Exit planning.

2.7 DHSC published further guidance on 21 December, 'EU Exit Operational Readiness Guidance', developed and agreed with NHS England and Improvement, which lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal–a 'no deal' exit. This will ensure organisations are prepared for, and can manage, the risks in such a scenario. The guidance has been sent to all health and care providers, including adult social care providers, to ensure the health and care system as a whole is prepared.

2.8 All providers must undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts, taking into account the instructions in national guidance. Any points of concern on specific issues are to be escalated to regional NHS EU Exit departments.

2.9 The actions in the guidance cover seven areas of activity in the health and care system that the Department of Health and Social Care is focussing on in its 'no deal' exit contingency planning:

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

3. Specific Actions for providers - Local EU Exit readiness preparations

3.1 Risk assessment and business continuity planning

• Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:

• The seven key areas identified nationally and detailed above.

• Potential increases in demand associated with wider impacts of a 'no deal' exit.

• Locally specific risks resulting from EU Exit.

• Continue business continuity planning in line with legal requirements under the Health and Social Care Act 2012, taking into account national guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.

• Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.

3.2 Communications and escalation

To:

• Ensure the board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.

• Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.

• Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.

• Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.

• Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams

• Note the nominated regional NHS lead for EU Exit and their contact details • Escalate any issues identified as having a potentially widespread impact immediately to your regional EU Exit team.

• Confirm the Senior Responsible Officer for EU Exit preparation which should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts.

Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.

3.3 Reporting, assurance and information

NHS providers to:

• Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.

• Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.

4. Approach

A Task & Finish 'EU Exit' Group has been formed to:

- Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:

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

- Potential increases in demand associated with wider impacts of a 'no deal' exit.
- Locally specific risks resulting from EU Exit.
- Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.
- Confirm additional cover/on-call arrangements for the immediate period following EU Exit.

And in pursuing this to:

- Liaise and work with wider system partners as appropriate.

Task & Finish Group Membership

SRO for EU Exit Preparation - Keith Loveman
Operational Lead - Sandra Brookes
Business Continuity and Emergency Planning - Carolyn Fowler
Chief Pharmacist - Chetan Shah
Chief Information Officer - Hakan Akozek
Interim Deputy Director of HR - Steve Graham

5. Recommendation

The Board is recommended to note the planning and reporting requirements placed on the Trust, the approach and EU Exit Group membership and to receive regular updates on progress.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	7th February 2019	**Agenda Item: 8**
Subject:	Integrated Governance Committee	**For Publication:** Yes/No
Author:	Jill Hall, 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 at its meeting on the 23rd January 2019.

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 Board of Directors.

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 23 January 2019. 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 three risks were considered for down grading from the Trust Risk Register – Fragility in the underlying IT infrastructure results in an IT failure; Statutory and Mandatory Training Compliance and Failure to comply with the new Data Protection Regulations (GDPR).

1.3 The Committee received an update from the IMT & IG Programme Board. The committee learnt that the DOCMAN system to securely transfer discharge letters electronically to GPs was being procured and would be implemented in the next 6 months. The benefits analysis carried out on the current cohort of Big Hand users had been reviewed by the Programme Board and they had agreed that the business case should focus on a further roll out of medical staff, whilst providing an option to roll out to wider community staff. The analysis had not been able to evidence the benefits of non-medical community staff due to the small number of users. The committee recognised the number initiatives in the pipeline.

2 Governance

2.1 The Board assurance framework was received and discussed. The committee noted that improvements had been made, particularly in the third line of assurance and suggested that the first line of assurance could be strengthened.

2.2 The Trust Risk Register (TRR) was received and discussed. The TRR reflects the risks in the Trust. There were no new risks added to the TRR, however the risk to the Trust being unable to ensure short term financial performance in current financial year was considered for downgrading to risk score of 8.

2.3 The committee received the quarterly report on the Guardian of Safer Working to September 2018 particularly noting that Guardian, Dr Ryan was on long term leave and that during this period Dr Dinal Vekaria was covering the role.

2.4 The committee received the revised Risk Management Strategy and following discussion recommended the strategy for approval by the Board

2.5 The committee reviewed its Terms of Reference and following discussion and suggestions for some minor amendments, approved the revised terms of reference.

2.6 The committee received the report on the committees annual effectiveness review. The committee noted that a review of the process and questions for all board committees was being undertaken in order to enhance the output of the effectiveness reviews.

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 Recruitment and Retention, Bank Flexible Working Pilot and Social Work Health Check.

2.2. A report on the High Performing Teams and the plan for the next phase of the journey from Good to Great and the plan to deliver great care and great outcomes through high performing teams was received.

2.3. The WODG had reviewed its Terms of Reference and made some changes. The committee approved the revised Terms of Reference

2.4. The safe staffing report for quarter 3 particularly highlighted that adequate staffing and shift cover in response to unexpected demand and levels of acuity. No service had a fill rate of below 80%. The report gave assurance that for rostering and safe staffing.

3. Safety

3.1. The quarter three 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 when compared with the previous quarter and the same quarter last year. Unexpected deaths were noted as the highest number reported in both quarter 2 and quarter three.

3.3. The committee noted the Trusts commitment to learning from incidents and that the SI process had been developed into a Continuous Quality Improvement (CQI) project, the committee noted the outcomes to date which includes improved timeliness of serious incidents reported.
3.4. Violence and aggression had increased from quarter two, with both service user to staff and service user to service user increases. The committee heard how staff were being supported and learning was being shared across operational teams.
3.5. The committee noted the increase in unexpected deaths that are recorded by the Coroner at inquest as a suicide. The Trust's Suicide Prevention Group has set up a Task and Finish Group as part of the suicide prevention work stream to take forward actions arising from the self-harm audit.

4. Effectiveness
4.1. A Q3 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.
4.2. The committee were pleased to hear that the Q4 CQUIN target for smoking would be achieved for the first time.
4.3. The committee noted the QIA report on CRES, particularly the challenges to two major schemes which relate to achieving greater efficiencies with regard to agency spend and placements, both of which carry financial and quality risks.

5. Experience
5.1. The committee noted the operational services update report particularly noting how the use of Safecare was reducing the reliance on agency staff and improved the planning to provide consistent staffing. The committee was interested to hear how this gave staff opportunities to experience working in operational areas they might not have considered.
5.2. The committee noted the East of England Health Protection Memorandum of Understanding had been signed by all partners, it set out a commitment between NHS East of England and partner agencies to ensure there were no barriers to contracts of funding in response to a health issue or emergency.
5.3. The Carers Plan 2019-2021 was presented, the committee noted it was co-produced with service users, carers, staff and other stakeholders and was based around the triangle of care.
5.4. The committee received the PLACE update report which highlighted the continued improvement across the elements, however noting that the National Averages had also increased resulting in some of the Trust scores being slightly lower than the national average and mental health averages in some key areas. Improvements were seen in Food and hydration, organisational food, ward food, maintenance and condition and Disability.

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

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	7th February 2019	**Agenda Item: 9**
Subject:	Integrated Safety Report Q3 2018/19	**For Publication:** Yes
Authors:	Nikki Willmott, Head of Safer Care and Standards	**Approved by:** Dr Jane Padmore, Executive Director of Quality and Safety
Presented by:	Dr Jane Padmore, Executive Director of Quality and Safety	

Purpose of the report:

To report to the Board on patient safety during quarter 3 2018/19 and give assurance that the Trust is meeting its requirements and delivering safe services.

Action required:

For approval: 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 during quarter 3 2018/19.

The number of reported incidents has decreased in this quarter and the majority have resulted in no or low harm. The number of serious incidents has increase when compared with the previous quarter and the same quarter last year. The number of unexpected deaths that are thought to be as a result of suicide remained at similar level to quarter 2, which does not achieve the target set in the annual plan for reduction.

The mortality governance work continues learning opportunities identified in relation to physical health monitoring, record keeping practice, risk assessment, care coordination and care of the deteriorating patient. Record keeping practice and risk assessments were also identified as the most frequently identified learning from serious incidents in the quarter and will inform the work done in quarter 4.

There has been a focus on pressure ulcers this quarter in response to an increase in prevalence, primarily pressure ulcers acquired outside the services. Positive results have been observed from continuous quality improvement initiatives in older adult's services, with a reduction in slips trips and falls. Failure to return from section 17 leave remains a challenge but should be viewed within the planned managed risk taking as a service user approaches discharge. There has been a reduction in the number of ligature incidents following continuous quality improvement initiatives on Robin Ward and Forest House Adolescent Unit.

Continuous quality improvement has been used to drive improvements in how safety is delivered within the Trust. Progress has been made in some areas but has been slower in others. Quarter 4 will see the work being developed and strengthened further.

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:

IGC 23rd January 2019

QUARTER THREE SAFETY REPORT
Part 1 - Introduction

1. Introduction

1.1. This document is the Safety Report for quarter 3 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.

1.2. The report will begin with an overview of the key performance indicators (KPI) as well as the safety related matters on the Trust's Risk Register. A summary and explanation of terms used within report is attached as Appendix 1.

2. Priorities

2.1. A number of priorities were set in relation to safety in the Trust's 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.

2.2. These are reported in the Trust's quarter 3 Annual Plan report. This report will provide additional detail relating to how the Trust is working to deliver the objectives and achieve the outcomes.

3. Governance and assurance

3.1. The Integrated Governance Committee (IGC) receives and scrutinises all aspects of safety on behalf of the Trust 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's Risk Register. In Quarter 3 the IGC undertook a deep dive into restrictive practice.

Trust Risk Register

3.2. The Trust's Risk Register has 15 risks of which a number relate specifically 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 in Adult Community resulting in a risk to safety, quality and effectiveness

3.3. These are reported in the quarter 3 Trust Risk Register Report. This report will provide the IGC with additional information about the work that is being undertaken to address and to mitigate against these risks.

Safety Dashboard

3.4. A draft safety dashboard with the relevant KPIs has been agreed. This will be hosted on 'SPIKE 2' and allow real time data to be viewed at Trust, Strategic Business Unit (SBU) and service level. This will support the identification of any hot spot areas, and be a clear method of tracking declining or improving positions and learning from this.

Care Quality Commission (CQC) Safety Key Lines of Enquiry (KLOE)

3.5. This section provides an overview of any safety related CQC publications that have been issued in the quarter. It will also give a brief overview of patient safety related matters raised by CQC during core and well led inspections, mental health act visits and other contacts with the Trust.

3.6. The CQC undertook a core inspection of inpatient services in 4 service lines within the Trust last year; these were:

- 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 in quarter 3. The IGC requested a deep dive into restrictive practice, including seclusion, which took place in quarter 3. Further details of this work are contained in this report.

2.10. The CQC 'Sexual Safety on Mental Health Wards' was published in September 2018. A task and finish group has been set up to map recommendations, assess impact and deliver any actions required. The first meeting was held on 4th January 2019 and terms of reference, membership and priorities arising from the recommendations in the report have been agreed.

4. Conclusion

4.1. This 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.

PART 2 - INCIDENTS INCLUDING SERIOUS INCIDENTS

1. Introduction

1.1. Part 2 of the safety report specifically considers incidents, including serious incidents. It begins by giving an overview of reporting trends and then goes on to explore themes and trends as well as severity of harm. How the Trust meets its Duty of Candour is detailed and then specific attention is given to mortality governance and suicide rates. It concludes with never events.

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 decrease (9%) in the total number of incidents reported on Datix this quarter, compared with the same quarter in 2017/18, as detailed in **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.

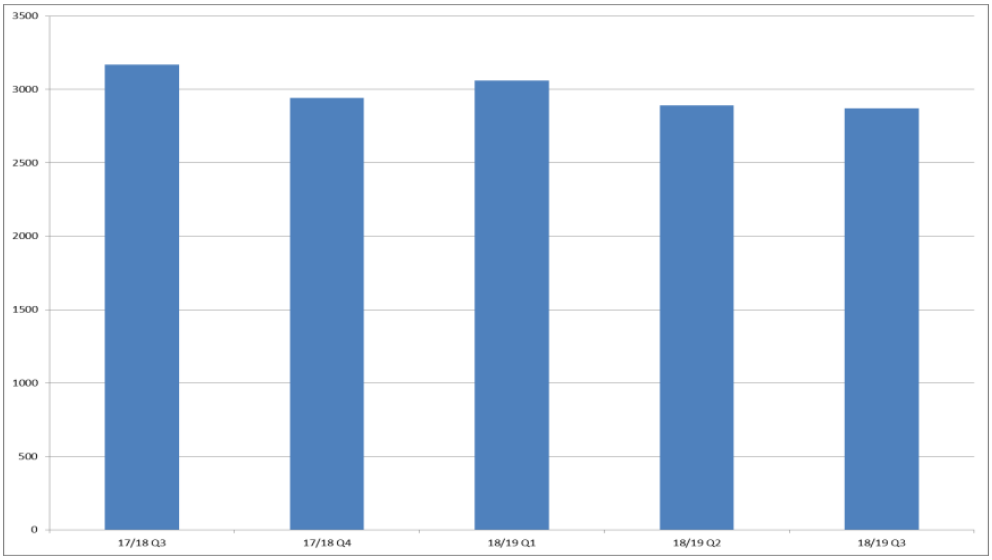


Chart 1

The majority of incidents reported resulted in no harm (76%) followed by incidents that resulted in low harm (17%), provided in **chart 2.**

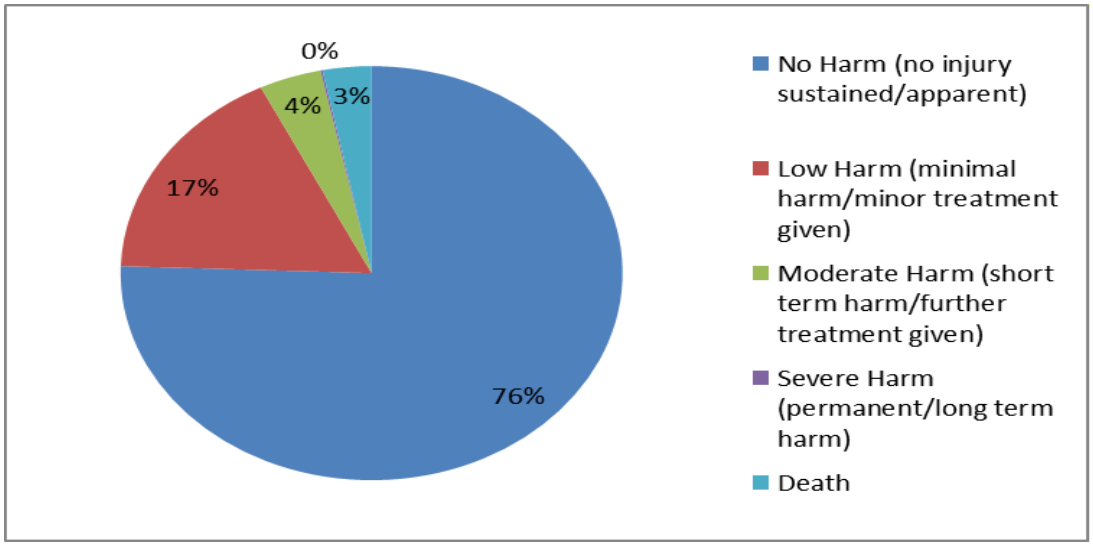


Chart 2

2.4. The area with the largest decrease in reported incidents was in North Essex inpatient services (43%). This is in part owing to the discharge of 2 service users who accounted for 57% of the incidents reported in quarter 3 of 2017/18.

2.5. Decreases were also reported in Hertfordshire Wellbeing Services, Learning Disabilities Low Secure Services, Child and Adolescent Mental Health Services (CAMHS) inpatients, acute inpatient psychiatry, Norfolk inpatient services and elderly inpatient services.

2.6. Acute inpatient psychiatry reported 17% of the total number of incidents in the quarter. 41% of all incidents reported in this area in the quarter related to violence & aggression.

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

- *Practice/Clinical Care* issues (27%) – of particular note is the decrease in the number of staff shortages reported, down by 42% when compared with the same quarter in 2017/18
- Incidents of *Self Harm* decreased in quarter 3 2018/19 (257) when compared to the number reported in 2017/18 (314)
- *Violence & Aggression* (13%) – more detail regarding this is provided later in the report.

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.

3.2. Where a service user or family has participated in the review process, a copy of the serious incident report is always shared in full. A copy of the report is also shared with HM Coroner to aid their enquiries ahead of the inquest where possible. In some cases there is no recorded next of kin in the service user record; contact is therefore made by the Safer Care Team with the Coroner's Office to obtain a name and contact details to share with the team to enable condolences to be offered and identify support needs.

3.3. A copy of the 'Help is at Hand' publication is routinely sent to families for all deaths identified as a potential suicide; for other deaths where it is unclear the Trust has a bereavement booklet which is sent instead. We have examples of families and our service users informing suicide prevention work.

3.4. 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. Staff support sessions facilitated by psychologists is also offered to teams and individuals as research shows that staff and first responders are also affected by a death by suicide.

3.5. The National Quality Board for NHS Trusts 'Working with Bereaved Families and Carers: Learning from Deaths' (July 2018) was benchmarked in the previous quarter against the current Trust policies and practices. This is informing the review of the Trust's Duty of Candour policy.

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 next release of the Organisational Patient Safety Incident Report data for NHS organisations will be published in March 2019 and will provide information about incident data and the ability to compare this with the National Trends. This will be reported on in the quarter 4 2018/19 Safety Report.

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 continues to await the publication of the updated Serious Incident Framework. The Board will be briefed on the outcome, implications and Trust plans for implementation at that time.

5.2. Serious incidents are reported via the national Strategic Executive Information System (StEIS); a total of 34 serious incidents were reported externally in quarter 3 2018/19 compared to 18 Serious Incidents reported in the same quarter in 2017/18, as detailed in **chart 3.**

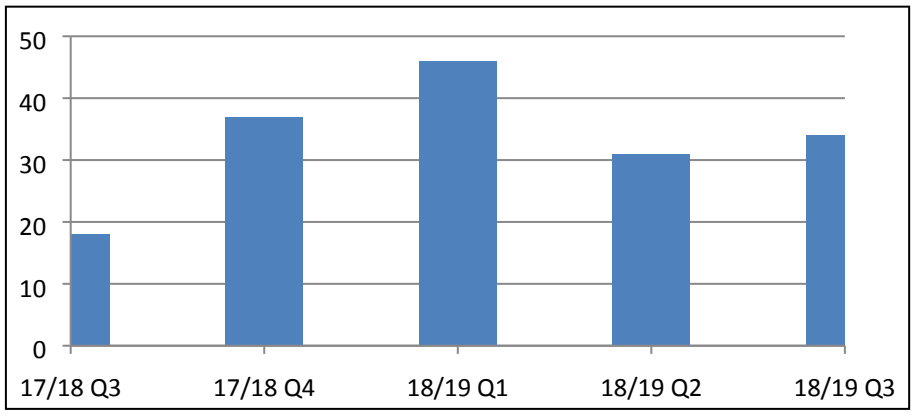


Chart 3

5.3. Serious incidents types are broken down by category in **table 1** which shows that unexpected deaths is the highest number reported across both quarters. The Trust embraces the opportunity to learn and therefore reports deaths of current service users and those discharged in the last 12 months as serious incidents where there is potential for identified learning on initial review or where the death is likely to be recorded as a suicide at the time of Inquest.

Category	Q2 2018/19	Q3 2018/19
Unexpected/avoidable deaths	20	19
Apparent/actual/suspected self-inflicted harm	3	4
Disruptive/aggressive/ violent behaviour	3	3
Slip/trip/fall	2	3
Safeguarding Adults	0	2
Unauthorised absence	1	1
Apparent/actual/suspected homicide	1	1
Medication incident	0	1
Infection Control	0	0
Data Breach	0	0
Mental Health Act paperwork	1	0
TOTAL	31	34

Table 1

5.4 The Moderate Harm Review Panel continues to meet weekly and reviews all incidents reported as moderate harm, severe harm or death (not natural causes). This provides opportunities to learn, aid reflection, inform clinical practice and safety related work streams as well as sharing of good practice across the SBU's. Initial fact find reports are requested where required to establish facts and identify learning. Serious Incidents are identified where in keeping with the Serious Incident Framework March 2015, *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.*

5.5 A deep dive of self-harm and unexpected deaths reported as serious incidents in the last six months has been completed and the findings were presented to the Trust's Suicide Prevention Group in November 2018. These were:

- Recording of risk factors data varied in consistency and quality
- Monitoring of DNAs and cancellations of appointments
- Rationale for service users not on CPA was not always recorded
- Involving service users, families, carers and other health professionals in risk assessment was not always evidenced
- Formulating/communicating crisis management plans lacked consistency and quality
- Drug and alcohol misuse, in keeping with national picture
- High prevalence of Emotionally Unstable Personality Disorder

5.6 As indicated in Part 3, Section 8.8 of the report this work is being taken forward through the Education Task & Finish Group.

6. Serious Incident Quality Improvement Project

5.4. The Serious Incident process has been developed into a Continuous Quality Improvement (CQI) Project, with 3 workshops completed to date. A showcase event is planned in quarter 4 to share learning from the CQI Project. Outcomes of this, to date, has been improved timeliness in allocating reviewers once decision has been made to report a new serious incident, terms of reference informed by the immediate learning and also introduction of a reviewer checklist, setting out key milestones in the serious incident reporting process with the aim of improved timeliness for serious incidents reported from 1st October 2018.

5.5. There has been an improved picture in quarter 3 in the allocation of investigating leads and commencing internal reviews. The Trust has a recovery plan in place, as agreed

with the two Hertfordshire CCGs, to finalise and submit the serious incident reviews in process that are outside of the 60 working day timeframe. In quarter 3, the Trust submitted a total of 29 serious incident reports against the trajectory of 33, 11 per month.

6. Suicide Data and Suicide Prevention

6.1. The Trust is a member of the Zero Suicide Alliance. An objective has been set up 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%.

6.2. 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. In quarter 3, there are 8 inquests still to be heard for deaths reported as serious incidents in the last financial year. HM Coroners have recorded 27 Suicide and 1 Open conclusions (verdicts) year to date 2017/18.

6.3. Of the 18 deaths reported in quarter 3 2018/19, 14 are felt likely to receive a suicide conclusion when the inquests are heard (**table 2**). This indicates that the increase seen in quarter 2 has remained. This indicates that the Trust will not meet the reduction that was set in the annual plan.

Q	Unexpected deaths initially considered	Confirmed Inquest Outcome				Still to be heard at inquest		
		Inquest suicides	Inquest open verdict	Confirmed open/suicide	Non suicide/Narrative at inquest/no inquest needed	Unclear awaiting histology	Suspected Substance misuse	Suspected still to hear
1	10	4	1	5	0	2	0	3
2	19	1	0	1	2	4	0	13
3	18	0	0	0	0	4	0	14
Year end	**47**	**5**	**1**	**6**	**2**	**10**	**0**	**30**

Table 2

6.4. **Charts 4 and 5** contain data from 2005/6 to 2016/17 which enables a longitudinal view of service user deaths reported as serious incidents that received a Suicide and Open conclusions. All inquests have been concluded for deaths reported as serious incidents from 2005/06 to 2016/17. There are a number of inquests still to be heard for deaths reported as serious incidents in 2016/17 and 2017/18; it should therefore be noted that the last bars in **chart 4** do not contain a complete data set at the time of this report.

6.5. 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 by Trust services, which has risen significantly.

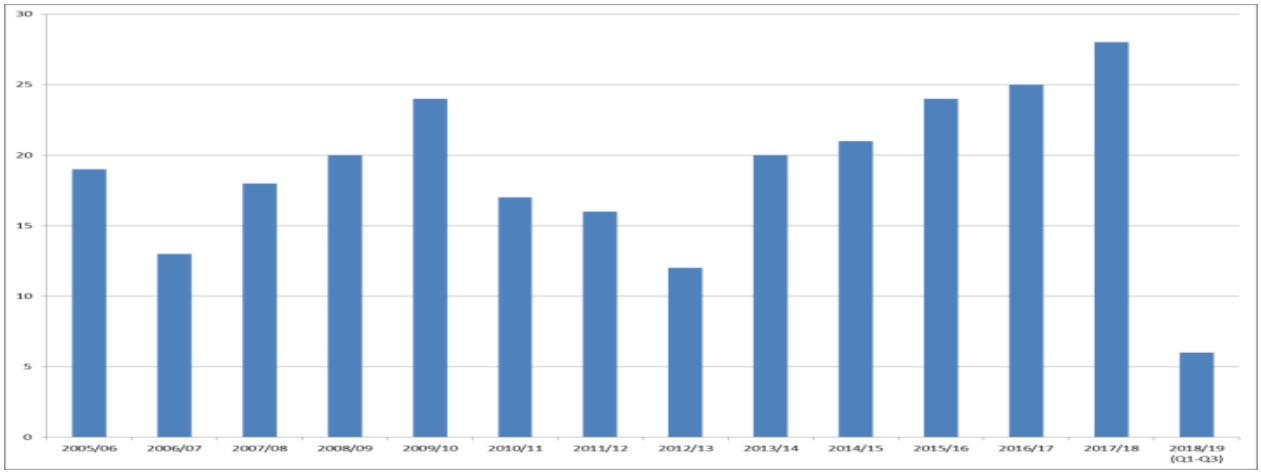


Chart 4

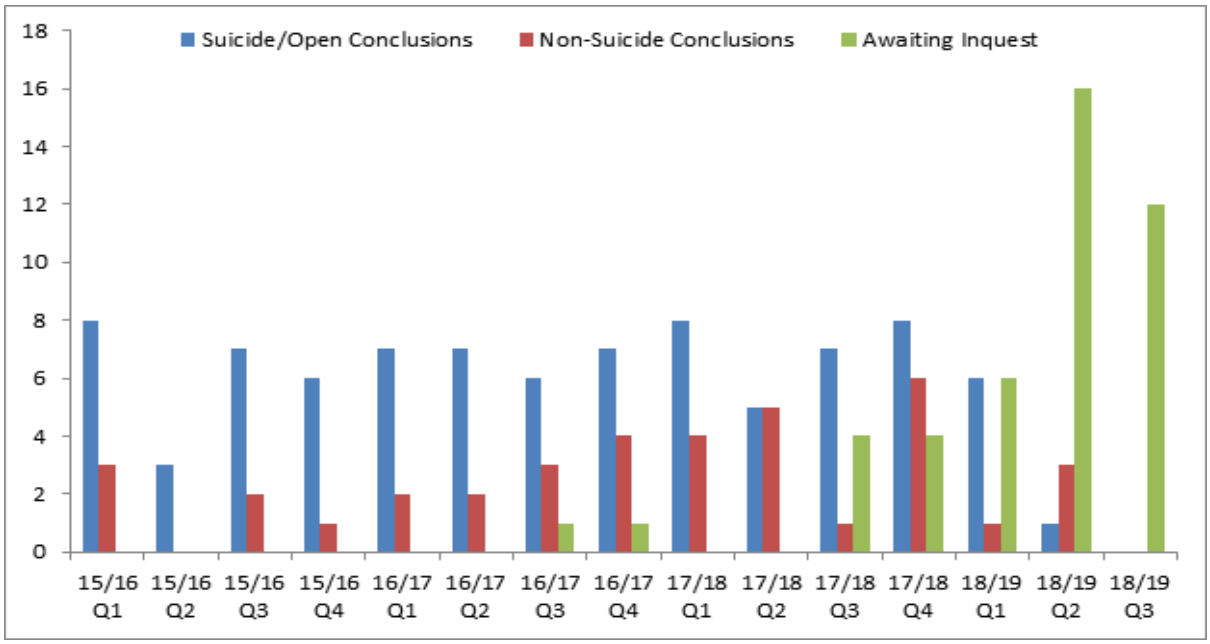


Chart 5

6.6. The Trust has a zero suicide ambition in keeping with the Hertfordshire wide ambition that 'No-one in Hertfordshire feels that suicide is their only option'. The Trust remains fully engaged in the Public Health Hertfordshire Suicide Prevention Strategy which has 8 task and finish groups with Trust representation.

6.7. The Trust is also represented on the Hertfordshire Suicide Prevention Steering Group and the Programme Board. Furthermore, the Trust is a member of the Zero Suicide Alliance and has been invited to attend a strategic planning meeting on 17th January 2019 to agree a work plan to support suicide prevention for the NHS and partner agencies.

6.8. The Trust's Suicide Prevention Group continues to meet monthly and has representation from all SBUs, Corporate Services, Primary Care and CGL Drug and Alcohol Services. An Education Task and Finish Group, as part of the Suicide Prevention work stream, is due to meet for the first time in January 2019 and will undertake training needs analysis of clinical risk training.

6.9. Learning from suicides informs the work of the Trust's internal Suicide Prevention Group and the Hertfordshire wide Suicide Prevention Steering Group and Programme Board.

7. Mortality Governance

7.1. The Trust's Mortality Governance Group continues to meet monthly to review and review and categorise all deaths reported on Datix; this enables ongoing monitoring of potential emerging themes where actions are required. The Group also monitors and shares learning to inform safety related Groups and Committees such as the Physical Health Committee, the Safety Committee and the Falls Group.

7.2. **Table 2** outlines the number of deaths of current service users or those discharged in the last 12 months by category. It should be noted that this may be subject to change as further information is obtained about causes of death.

	18/19 Q1	18/19 Q2	18/19 Q3	Total
Natural causes/ill health/accidental	71	65	88	224
Unexpected death	25	39	27	91
Total	96	104	115	315

Table 2

7.3. The learning themes from Structured Judgement Reviews completed in quarter 3 have highlighted the following areas of learning which have been discussed in the relevant teams, in Patient Safety meetings, the Mortality Governance Group and the Safety Committee:

- Physical health monitoring
- Record keeping practice
- Risk assessment
- Care coordination
- Deteriorating patient.

8. Never Events

8.1. 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'. In quarter 3 2018/19, the Trust has had no incidents meeting criteria for reporting as Never Events.

9. Violence and Aggression

9.1 This section of the report, will report on violence and aggression across the 3 Strategic Business Units (SBUs). It will report on incidents over time, reviewing levels of harm for service user to service user's assaults and service user to staff assaults. This will consider a more in depth analysis of top reporting areas and possible themes. The data sets refer to service user to service user assaults and service user to staff assaults, as shown in **tables 10 and 11.**

Service user to service user by level of harm quarter 3 2018/19				
SBU	**East**	**West**	**LD&F**	**Total**
No Harm	20	24	27	71
Low Harm	12	15	5	32
Moderate Harm	1	1	1	3
Severe Harm	0	0	0	0
Total	**33**	**40**	**33**	**106**

Table 10

Service user to staff by level of harm quarter 3 total 2018/19

SBU	East	West	LD&F	Total
No Harm	22	26	65	**113**
Low Harm	13	24	32	**69**
Moderate Harm	5	8	6	**19**
Severe Harm	0	0	0	**0**
Total	**40**	**58**	**103**	**201**

Table 11

9.2 Within quarter 3 2018/19, there has been a 15% increase in service user to service user assault across the 3 SBU's compared to quarter 2 of 2018/19. There were increases in both Learning Disability and Forensic SBU and the West SBU and a decrease in the East and North SBU. With regards to service user to staff assaults, again there was a 2% increase across the SBU's from quarter 2, only East and North have a reported decrease.

9.3 **Chart 16** shows over 7 quarters the total number of incidents categorised under service user to staff assaults and service user to service user assault have remained stable.

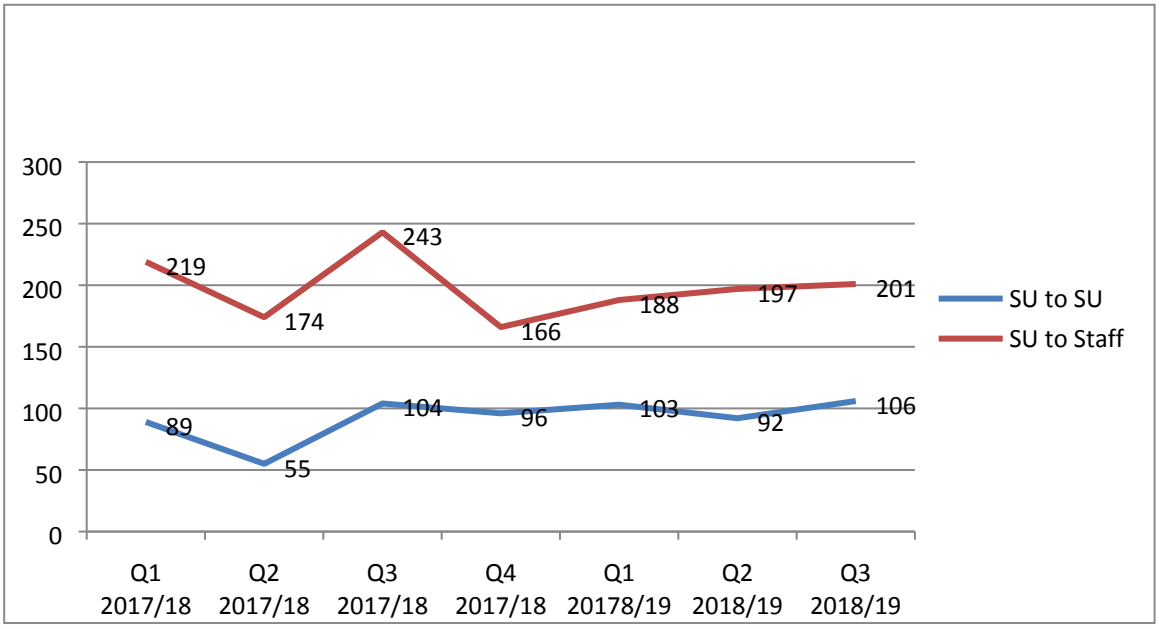


Chart 16

9.4 Quarter 2 2018/19 to quarter 3 2018/19 data service user to service user assaults across all Trust services there was an overall increase of 15%.

East and North SBU: There was a 3% decrease in service user to service user data with the top reporters in the SBU being Logandene and Victoria Court. Logandene had a slight increase in quarter 3 (3) when compared to the previous quarter. There was a 52% decrease in month 3 of quarter 3 in service user to service user assaults compared with months 1 and 2. There were a total of 33 assaults which amount to 2.75 assaults per week.

West SBU: There was an 11% increase with the top reporters in Oak, Albany Lodge and Owl. Oak had the highest increase from quarter 2 2018/19 from 2 to 13 assaults involving 12 service users. 13 assaults equates to 1.08 assaults per week in Oak There was an 8% increase in month 3 of quarter 3 compared with months 1 and 2. There were a total of 40 assaults across the SBU amounting to 3.33 per week.

Learning Disability and Forensic SBU: There was a 57% increase with the top reporters in Astley Court, 5 Warren Court and Hathor Ward. There were 7 assaults within Astley

Court which equates to 0.6 assaults per weeks. Hathor Ward had the highest increase from quarter 2 2018/19 from 0 to 4. No statistical change overall from month 3 of quarter 3 compared with months 1 and 2. There were a total 33 assaults across the SBU amounting to 2.75 assaults per week.

9.5 For the service user to staff assault, analysis shows that across the 3 SBUs there was an overall increase of 2% in quarter 3 compared to the previous quarter.

East and North SBU: There was a 7% decrease with the top reporters in Forest House Adolescent Unit, Lambourn Grove and Logandene. There were 9 assaults over the quarter which equate to 0.75 assaults per weeks in Forest House Adolescent Unit. There was a 50% decrease in month 3 of quarter 3 in assaults compared with months 1 and 2. There were a total of 40 assaults across the East and North SBU amounting to 3.33 per week.

West SBU: There was a 5% increase with the top reporters in Oak Ward, Albany Lodge and Swift Ward. Oak Ward had the highest increase in quarter 3 from 5 in quarter 2 to 19 assaults involving 12 service users, with one service user involved in 4 of the incidents. 19 assaults equates to an average of 1.6 assaults per week on Oak Ward. Robin Ward had the most significant decrease with 5 reported in quarter 3 compared to 28 in the previous quarter. There was a 48% decrease in month 3 of quarter 3 compared with months 1 and 2. There were a total of 58 assaults across the SBU amounting to an average of 4.83 per week.

Learning Disability and Forensic SBU: There was a 4% increase with top reporters in Astley Court, Dove Ward and Lexden Unit. Astley Court had the highest increase from 25 reported in quarter 2 compared to 42 assaults in the previous quarter. 42 assaults equates to 3.5 assaults per week. There was a 38% decrease in month 3 of quarter 3 compared with months 1 and 2. There were a total of 103 assaults across the SBU amounting to an average of 8.6 per week.

9.6 For service user to service user assaults 67% of reported incidents resulted in no harm 30% were low harm and 3% were moderate harm. With regards to service user to staff assaults, 56% resulted in no harm sustained, 34% were low harm and 10% were moderate harm.

9.7 The increase seen on Oak Ward led to immediate action being taken to ensure both service users and staff are safe within Oak Ward. The Practice Development and Patient Safety Team met with clinicians and management to explore the emerging themes. Further analysis through occupied bed data and incident data demonstrated that there was higher acuity within months 1 and 2 of quarter 3. The Health & Safety Lead also visited the ward to review environment and provide support to staff and the management team.

9.8 During quarter 3, the data was considered and reviewed monthly and operational teams were supported to develop actions to address any areas of concern. This approach aimed to be team focused with regards to increasing and expanding the skill sets, particularly around de-escalation.

9.9 This work will continue to progress into quarter 4 in order to identify key risk areas and develop action plans with the SBUs, supported by the Practice Development and Patient Safety Team.

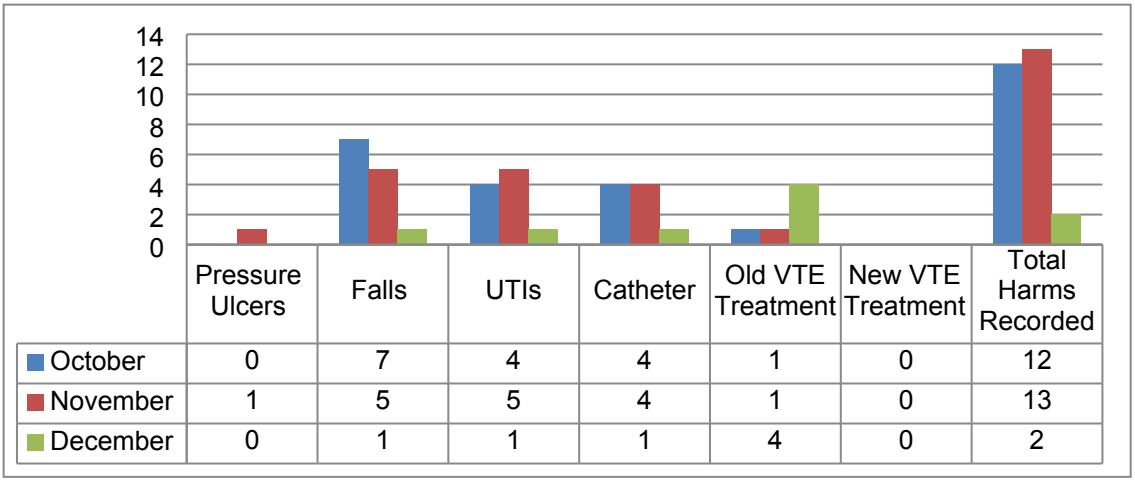
10. Safety Thermometer

10.1. The NHS Safety Thermometer is a tool used for measuring, monitoring and analysing patient harm and ‘harm free’ care at a single point in time. The tool measures 5 high-

volume service user safety issues. The Trust collects data from older age inpatient and community teams and Learning Disability inpatient and community teams. In quarter 3, there were 27 harms recorded on the day of submission, which is a 20% reduction from the previous quarter.

10.2. The category 2 pressure ulcer in **table 4** below was developed prior to admission to Trust services. There were 6 which resulted in no harm, the remaining 7 were all low harm. 8 urinary tract infections (UTI) were new and 2 were old where treatment or diagnosis was started before admission.

10.3. There were 6 recorded incidents of service users on treatment for Venous Thromboembolism (VTE) Prophylaxis; 5 were identified as old as treatment for deep vein thrombosis (DVT) started before admission to the Trust and 1 was identified as old as treatment for pulmonary embolism (PE) had started prior to admission, see **table 4.**



	Pressure Ulcers	Falls	UTIs	Catheter	Old VTE Treatment	New VTE Treatment	Total Harms Recorded
October	0	7	4	4	1	0	12
November	1	5	5	4	1	0	13
December	0	1	1	1	4	0	2

Table 4

11. Conclusion

11.1. The Moderate Harm Panel continues to have a positive impact on ensuring the appropriateness of reporting incidents as well as sharing and embedding learning. There has been good progress to date with work to complete outstanding serious incident reports and in improving compliance with nationally agreed timescales.

11.2. There has been an increase in the number of unexpected deaths that may be recorded by the Coroner at inquest as a suicide. The Trust continues to be actively involved in the local and National work relating to suicide prevention. The Education Task and Finish Group commissioned by the Trust'sSuicide Prevention Group will take forward the actions arising from the self-harm audit and the deep dive work in the East and South East quadrants, in addition to learning from our serious incidents around clinical risk assessment and management.

PART 3 - REDUCTION of HARM and LEARNING FROM INCIDENTS

1. Introduction

1.1. The Trust embraces opportunities to learn, reflect and act on intelligence from incidents, serious incidents, safety and mortality data. The Trust's Safety Committee oversees safety related data and existing work streams alongside the work of the Health, Safety and 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 IGC.

1.2. This section of the report will initially detail what learning has been identified and actioned, through the work detailed in previous section in quarter 3, with specific focus on areas that have been identified as priority areas.

1.3. The report will give further analysis of these areas of work and how learning has been disseminated and embedded through the organisation.

2. Learning Themes

2.1. Themes have been identified from serious incident reviews completed and submitted to the Clinical Commissioning Groups in quarter 3, provided in **table 3**. Themes are identified when areas of learning have been identified in 2 or more cases.

Theme	Number of Times Identified
Recording of risk information/record keeping practice	15
Risk assessment/risk management	10
Updating care plan/risk assessment documentation	9
Communication - internal/external	5
Engagement with carers/significant others to inform management plan	5
Physical health monitoring/liaison	5
CPA/ care coordination/ /care continuity	4
DNA	4
Suicide Prevention	4
Collateral information gathering	4
Safeguarding	4
Discharge/handover/transfer	4
Carer support	3
Medication management	2
Communication/joint working with CGL Drug &Alcohol Services	2
Referral to other agency	2
Bereavement support for families	2

Table 3

2.2. In response to identifying these themes, the Trust has updated the risk assessment section in the electronic patient record to include a specific section for recording of clinical risk formulation. This has been further enhanced through clinical risk refresher training held for all adult Crisis Assessment and Treatment Teams (CATT) in response to learning from a serious incident.

2.3. Two internal Safety Alerts have been disseminated around safe use of hot water on inpatient wards in response to learning from a serious incident and Paracetamol safety in response to learning from a Prevention of Future Death report issued by a Coroner to another mental health trust.

2.4. A directive about good practice relating to shift handover and the use of handover sheets has been cascaded in response to an Information Governance Breach reported as a serious incident and other incidents, reported on Datix with a focus on use of the Patient Safety at Glance (PSAG) Board on the wards rather than a reliance on the use of handwritten handover sheets.

2.5. Learning is discussed and shared at the Safety Committee and then in local Patient Safety Forums in each of the SBUs where decisions 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.

2.6. Facilitated SWARM post incident huddles continue to be held in teams across all SBUs. In addition, staff support is offered, by trained facilitators, to teams affected by critical or serious incidents.

2.7. Learning is further supported through reflective learning sessions, 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. Where relevant, external agencies such as schools, GP practices, and Local Authorities are invited to these sessions to ensure shared learning across the wider system in a supportive environment.

3. Focus on Pressure Ulcers Acquired in Care

3.1. In quarter 3, the Trust had 3 pressure ulcers acquired in our care and 1 service user came into the Trust with pressure ulcers. In the same quarter last year, the Trust had 3 pressure ulcers acquired in Trust care and 1 service user came into the Trust with pressure ulcers.

3.2. In November, there was 1 service user with 2 separate incidences of category 2 pressure ulcers in older age adult services (Continuing Care). The first pressure ulcer was on the service user's hip and was found after the service user was discovered on the floor. The second pressure ulcer occurred at a later date on the same service user's foot, caused by new ill-fitting shoes. In November 2018, there was 1 unavoidable category 3 pressure ulcer acquired in Trust care and 2 service users came into the Trust with category 1 and category 2 pressure ulcers. **Chart 6** provides detail of pressure ulcers acquired in the Trust, by sub category.

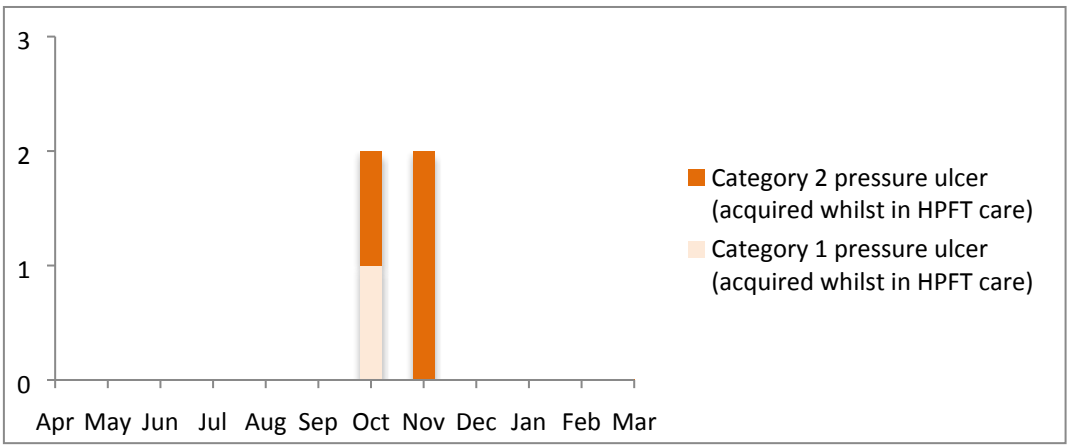


Chart 6

3.3. This quarter, pressure ulcers incidence remains low. The 3 pressure ulcers acquired in Trust care have all been in Continuing Care. The Trust aims to have no pressure ulcer acquired in its care. However for service users in Continuing Care, the risk factors, for example age, reduced mobility and co-morbidities place service users at high risk of

developing pressure damage. Staff need to continue to be vigilant reacting to risk factors including deteriorating health to prevent pressure ulcers. **Chart 7** provides detail of pressure ulcers acquired outside of Trust care, by sub category.

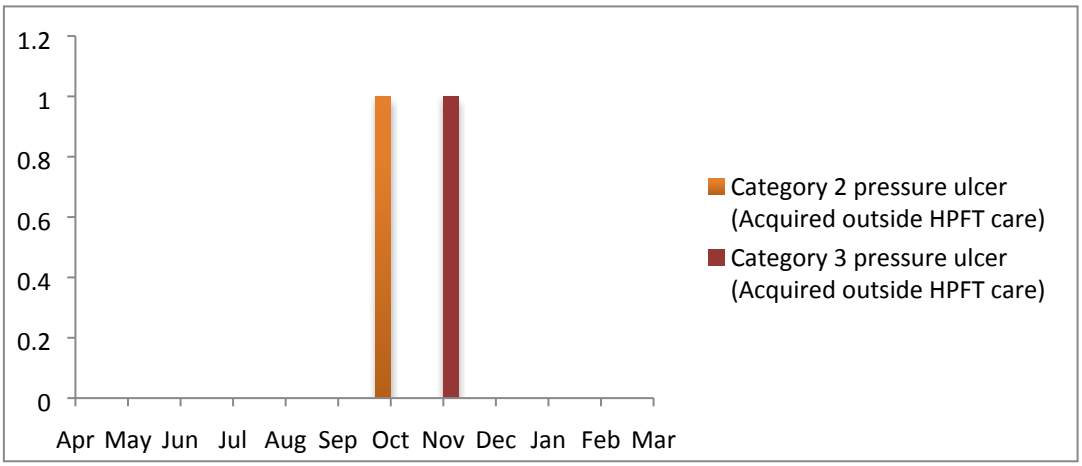


Chart 7

3.4. In response to the incidents detailed in the previous tables, the Tissue Viability Nurse trained a further 25 staff from across the Trust in pressure ulcer prevention in October 2018.

3.5. NHS Improvement (NHSI) Pressure Ulcer guidance was updated in November 2018. The changes in the guidance are:

- The term pressure ulcer to be used, rather than pressure sores, decubitus ulcers or bed sores
- Pressure ulcers should be reported by category not grade. There is no real difference between category and grade; it means category will be a universal term and we will be using a universal tool (NHSI 2018)
- The term unavoidable/ avoidable is not be used. It will no longer be possible to state a pressure ulcer is unavoidable. When investigating, the Trust will need to identify omissions in care or no omissions in care
- New categories of medical device related pressure ulcers are to be recorded, for example pressure ulcer caused by catheters, oxygen tubing etc. This is now a separate category on Datix - Device Related Pressure Ulcer category 1 to 4
- The 72 hour rule has been abandoned. If a pressure ulcer occurred within 72 hours of admission, it was deemed to have occurred in the previous Trust/organisation. Now, unless a pressure ulcer is documented on admission, it will be deemed to have occurred in the Trust's care
- The terms acquired in the Trust's care or outside of Trust care remain
- Moisture lesions are to be known as Moisture Associated Skin Damage (MASD). MASDs are to be reported on Datix in the Trust to enable national reporting.

3.6. The Tissue Viability Nurse and the Datix Lead have amended the Trust's Datix categories to reflect the NHSI changes. In quarter 3, the Tissue Viability Nurse updated the Pressure Ulcer Policy to reflect the NHSI changes and teaching programme.

4. Focus on Slips, Trips and Falls

4.1. The Trust reported a total of 156 slips, trips and falls in quarter 3, detailed in **chart 8**. This shows a decrease of 37 incidents when compared to the number reported in the

previous quarter. It should be noted that the number of falls in the same quarter in 2017/18 is comparable at 154.

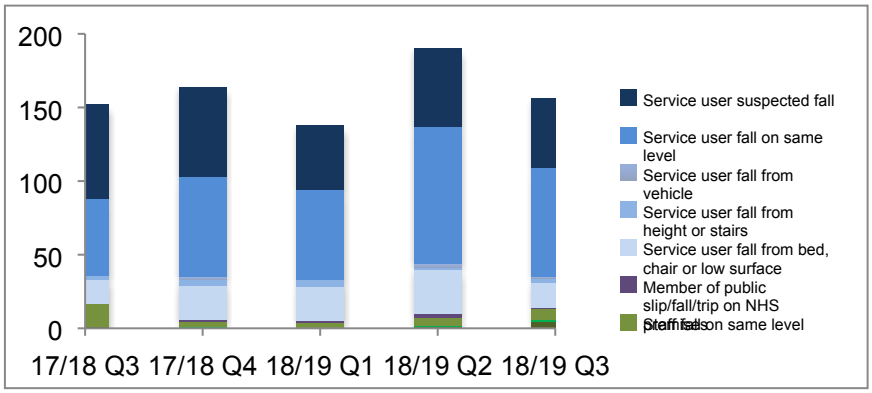


Chart 8

5.2 A total of 142 slips, trips and falls incidents reported on Datix in this quarter were attributed to service users; this is a decrease of 38 (21%) incidents when compared to the previous quarter.

5.2 The majority of slips, trips and falls incidents (96%) reported in quarter 3 were in Trust inpatient units and the highest incidence (57%) was reported in older age adult services.

5.3 There has been a decrease in falls at Logandene, Seward Lodge and The Stewarts, detailed on **chart 9.**

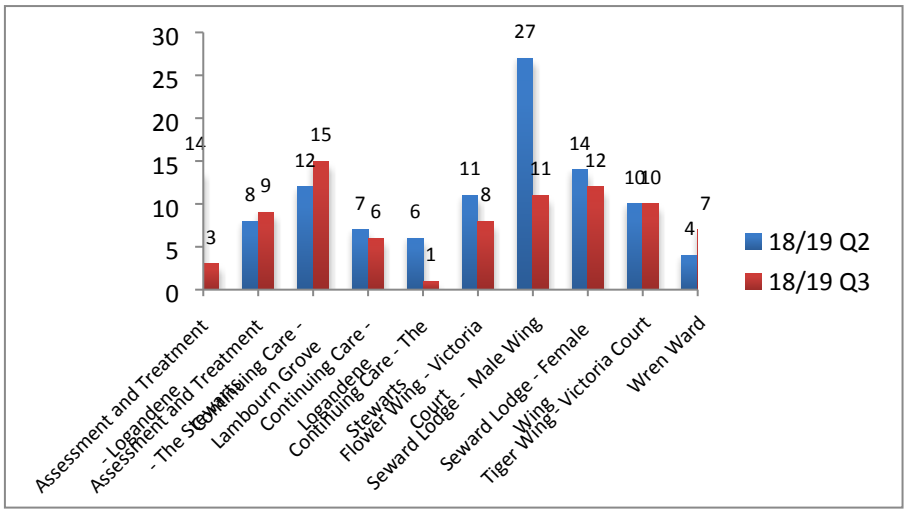


Chart 9

5.4 At Logandene, zonal observations have been piloted in quarter 3 and the unit saw a marked decrease in the number of falls and, in particular, unwitnessed (suspected) falls, detailed in **chart 9**. The only unwitnessed (suspected) falls in quarter 3 occurred at times when service users were in their own room. The unit analyses all their falls and are continuously working to reduce them - their next focus is on the unwitnessed falls when service users are in their own rooms. A similar decrease in numbers has been noted at Seward Lodge where zonal observations were introduced in December 2018, see **chart 11.**

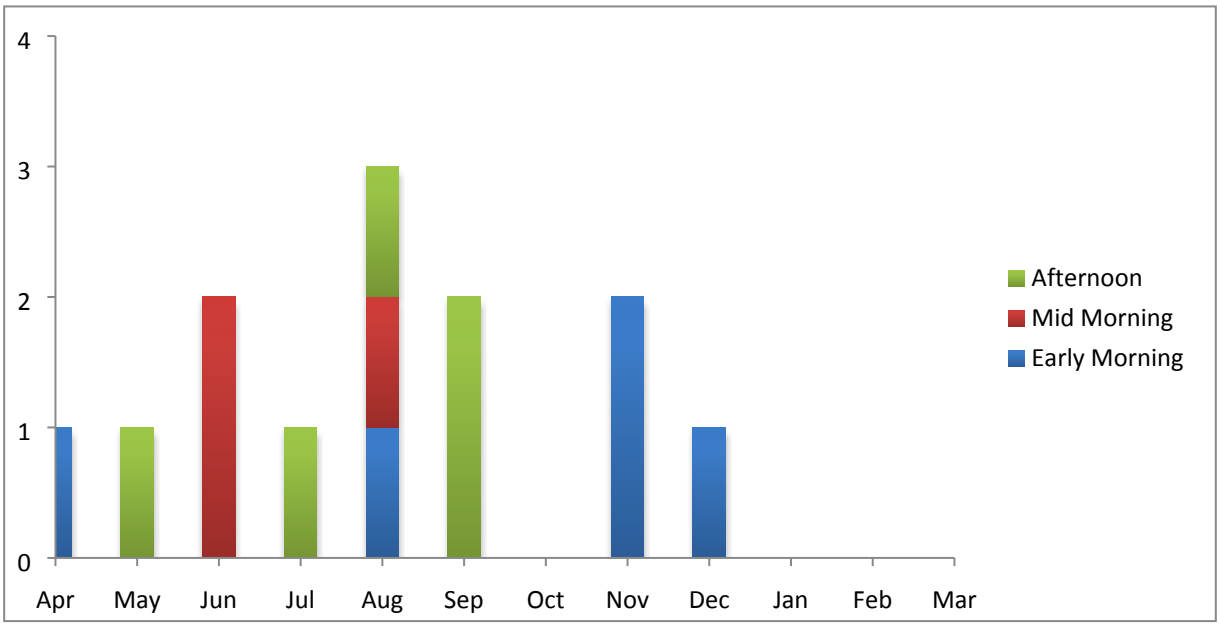


Chart 10

Table 9 Seward Lodge Suspected Service User Falls by Time band

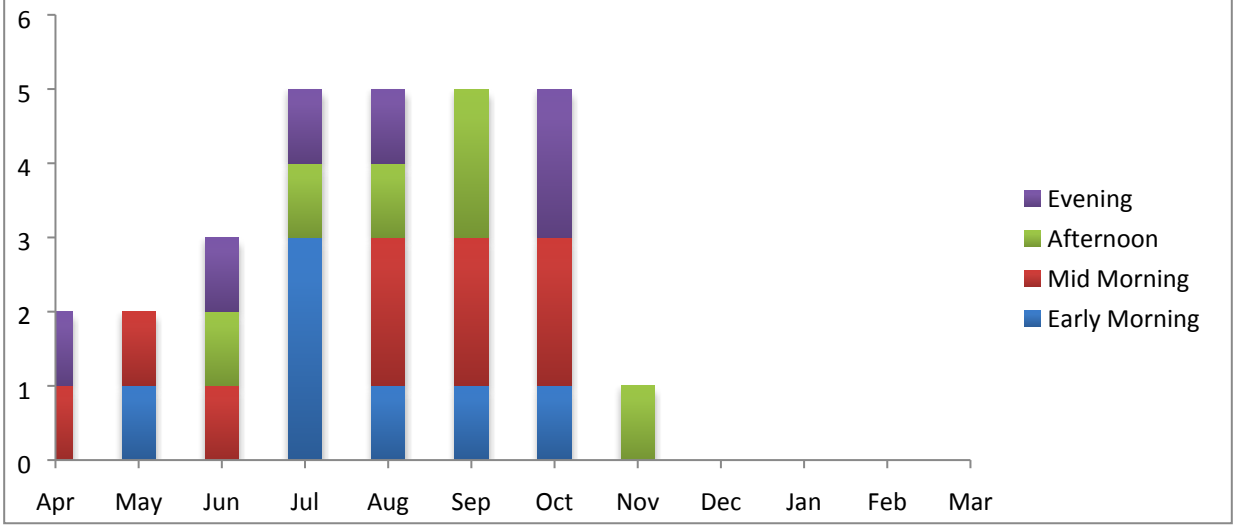


Chart 11

5.5 The Stewarts had a reduction in the number of slips, trips and falls incidents reported on Datix in quarter 3 when compared to the previous quarter; however this is attributable to the number of service users currently on the ward.

5.6 The majority of falls reported in quarter 3 were no harm or low harm (95.5%). Of the 7 slips, trips and falls incidents reported on Datix as resulting in moderate harm, 3 incidents resulting in a fracture were reported as serious incidents.

5.7 There were 13 slips, trips and falls incidents involving staff reported in quarter 3, which is an increase of 6 incidents when compared to the previous quarter. 1 of these was reported to the Health and Safety Executive under Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) regulations.

5.8 Falls data is monitored by the Falls Group which enables monitoring over time and deep dives of data where fluctuations are seen to consider actions required. Factors which may have influenced the reduction of service user falls in quarter 3 are:

- Pilot of zonal observations introduced at Logandene and Seward Lodge
- Falls Awareness Week raising awareness of ways to reduce the likelihood of falls for service users, staff and visitors
- Recruitment of a physiotherapist to support inpatient wards with falls care plans, risk assessments and equipment to manage falls risk and improve mobility
- The East & North SBU Falls Steering Group is chaired by a medical lead which has increased the focus on physical health and frailty

5.9 Further plans are in place to build on the success of this work. This includes:

- The Trust developing a new Falls Screening Tool/Risk Assessment suitable for all inpatient units with the aim of identifying the need for assessment and any required interventions, clearer for staff. Once finalised it will be added to the PARIS electronic patient record
- Use of Zonal observations being rolled out to further Inpatient units
- The Trust linking in with the Herts Sustainability and Transformation Plans (STP) to ensure that where appropriate, strategic development of falls reduction within the Trust is in line with the STP Falls and Frailty pathway. This will be monitored by the Trust wide Falls Group.

6 Focus on Absent Without Leave (AWOL) or Missing Persons Incidents

6.1 These incidents relate to service users who leave the support of the service in an unplanned way are considered AWOL or missing. Some of these will result in concerns about safety but also need to be seen within the context of positive risk taking as part of planned care and work towards discharge. The executive team is briefed on the AWOL and Missing Person incidents each week.

6.2 For consistency and to enable comparison over time the following definitions are used:

When formally detained (AWOL):

- Leaving the staff member during escorted leave
- Attempting to leave the unit
- AWOL (leaving the unit without agreement)
- Failure to return from Section 17 leave.

When informal (missing person)

- Attempting to leave the unit
- Not following the Managed Entry and Exit Procedure (MEEP)
- Failing to return from leave when informal
- Missing (lack of contact) within community services.

6.3 In the first 3 quarters of 2018 there were a total of 255 AWOL or missing person incidents reported on Datix across all services. Missing (informal) and Failure to return from section 17 leave have remained the top 2 sub categories consistently across all 3 quarters (**table 6**). Of note 95.5% of the total number of these incidents across all 3 quarters resulted in no harm, with the remaining 4.5% resulting in low harm.

	18/19 Q1	18/19 Q2	18/19 Q3	Total
Abscond during escorted leave (detained MHA)	4	2	9	15
Attempted AWOL (detained MHA)	5	6	3	14
Attempted to leave unit (informal)	1	3	2	6
Failure to return (section 17 leave)	13	19	22	54
AWOL (detained MHA)	6	9	17	32
Missing (informal)	43	50	37	130
Escape (secure)	0	1	0	1
Failure to respond to recall notice (CTO)	0	0	1	1
Failure to return (secure)	2	0	0	2
Total	74	90	91	255

Table 6 Data by sub categories of AWOL/Missing Person incidents

6.4 There has been a marginal increase (3) in the number of failure to return from section 17 leave incidents in quarter 3 when compared to the previous quarters and a decrease in the number of Missing (informal) (**table 6**).

6.5 Failure to return from section 17 leave accounted for 40% of the total number (52) of incidents reported across all 3 quarters. Albany Lodge reported the highest number of incidents across all sub-categories (19) when compared to the other units. It is of note that Albany Lodge is situated within walking distance of a town centre and is a standalone unit. Six service users were involved in AWOL or missing person incidents on two or more occasions, three male and three female. 10 of the 19 incidents on Albany Lodge (59%) occurred in the afternoon (**table 7)**.

6.6 It was identified that there were situations where service users left via a single door exit when people were gaining entry on Aston Ward and Albany Lodge.

	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)	Total
Albany Lodge	3	1	1	7	4	3	19
Hampden House	0	0	0	5	2	4	11
Owl Ward	3	0	0	3	2	2	10
Aston Ward	1	0	0	3	3	1	8
Robin Ward	0	0	0	3	1	0	4
Total	7	1	1	21	12	10	52

Table 7 Top 5 units reporting the highest number of AWOL or missing person incidents

6.6 Learning from these incidents has led to strengthening practice with staff ensuring that service users have their mobile phones with them prior to leaving the unit and that they are charged and have credit. Teams have also been reminded of the need to record the time of return in the electronic record and the reason for not adhering to leave conditions when the service user returns. Also, there is a need for staff to remain vigilant when people are entering and exiting the wards to prevent service users tailgating and attempting to leave the ward.

6.7 It is acknowledged that failure to return from section 17 leave at the expected time remains a challenge as leave is granted as part of positive risk taking and in keeping with recovery principles.

6.7 Breaches in perimeter security resulted in increased security and the pilot of a 'Belfast roll' anti–climb system on Swift Ward. This is being evaluated and considered for wider use across other units with a meeting planned for 17th January 2019 by the West SBU Management Group and Project Management teams.

7 Focus on ligatures and anchor points

7.1 Ligature incidents and anchor points continue to be a focus for the Trust, as they present an ongoing challenge faced by our clinical and front-line staff in terms of patient safety. To date, in reporting year 2018/19, there have been a total of 162 incidents involving ligatures reported in inpatient and community services. Of these incidents, 137 took place within bed based Trust services and 25 (18%) occurred outside of bed based services, and were reported by HPFT community staff members.

Bed based units and day hospitals

7.2 Over the three quarters year to date, ligature incidents have decreased by 42%. This primarily relates to fewer incidents occurring on Robin Ward and Forest House Assessment Unit which is likely to be due to changes in service delivery and how the service manages complex needs in the Child and Adolescent Mental Health Pathway.

7.3 The highest reporting ligature type was the use of clothing (45%), followed by smaller items that are easier to hide on the person. such as shoe laces and telephone cables (**chart 14).** As staff members have proactively worked to minimise the number of high risk items there has been a corresponding increase in the use of clothing. It is to be noted that clothing leads to specific challenges for staff as there are limited alternatives which would not challenge privacy and dignity.

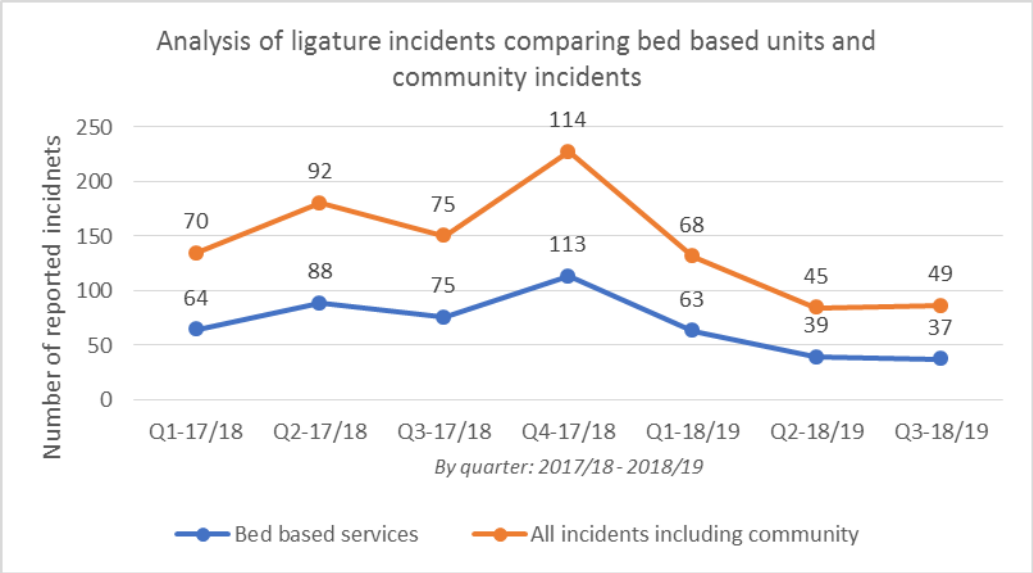
7.4 For the month of October 2018, it was noted that clothing was used as ligatures predominantly in learning disability services, particularly during seclusion and Long Term Segregation (LTS). Work is being undertaken to identify anti-tear clothing that could be used as a proportional approaches to manage combined high challenge and risks of self–harm via clothing and should include accessible items such as bedding.

	Oct-18	Nov-18	Dec-18	Total
Sheets/Bedding	2	2	1	5
Belt/dressing gown cords	1	1	2	5
Cables	2	1	2	5
Clothing	6	6	5	17
Curtains	0	0	0	0
Hair bands	0	0	0	0
Head phones	0	0	0	0
Plastic bag/ straps	0	0	1	1
Ribbon	0	1	0	1
Socks	0	1	1	2
Rope	0	2	0	2
Shoelace	2	0	0	2
Stockings / tights	0	0	0	0
String	0	0	1	1
Not Specified	5	3	1	9

Chart 14 Ligature type

7.5 The trend from Q1 2017/18 to Q3 2018/19 shows that the total number of incidents categorised under 'ligatures' (Non anchor and anchor) has declined after a significant increase quarters 3 to 4 2017/18 (**chart 15)**. Forest House Adolescent Unit and Robin Ward were identified as the highest reporters at the peak and significant work has been undertaken to understand and address this through a review of the care pathways.

Chart 15



7.6 Evenings, followed by afternoons show the highest risk times, when there is a higher demand for staff members. These findings reflect the national findings that incidents occur predominantly in bedrooms and bathrooms and relate to high risk times, when staff members are more likely to be occupied by other activities. These findings are considered in the 6 monthly review of staffing levels in services.

7.7 An alert relating to high risk ligature times, when clinical staff members are more likely to be occupied with other duties has been reissued. This focuses increased observations of the environment, for example zonal observations, practices which include increased vigilance and engagement associated with risk assessment.

7.8 During quarter 3, there were 4 reported anchor point incidents, as detailed in **table 8.**

No	Area	Anchor Point	Ligature	Action
1	Forest House	Shower chair	Shoe lace	Chair removed
2	Forest House	Hoodie cord	Soap dispenser	Dispenser checked – with anti-pic mastic
3	Forest House	Ribbon	En-suite door hinge (the service user did not weight bear)	Learning note issued to all services, advising on all risk
4	Swift Ward	Toilet door	Jumper	Increased vigilance, with regards to risks relating to doors. Risk highlighted in ligature risk assessment.

Table 8

7.9 For bed based units and Day Hospitals, annual ligature audits take place and weekly risk assessments (recorded on ANT). These are reviewed and photographs and maps are being put in place 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.

7.10 All units are now undertaking the weekly ligature risk assessment, with the initial technical issues resolved. A review of the ligature anchor point policy is taking place in Q4 and will include additional guidance and assurance of assessing environmental risk, with inclusion of risk assessment as advised in alert notice.

7.11 Following notification where magnetic curtain rails had shown to fail in other Trusts, a learning note was produced by the Trust's Health and Safety Manager. Training on fitting of rails for Estates staff and leaflets for clinical staff with advice on correct parts and fitting has been provided. During quarter 4 2018/19, an audit and replacement programme for all at risk magnetic curtain rails is to be undertaken.

Community services

7.12 Community ligature incidents are incidents which take place outside of the service area, either in the home, other agency accommodation or outside of Trust premises. Of the total ligature events reported across quarter 3 2018/19, 14 incidents fell into this category (**table 9).**

7.13 The number of community incidents represented approximately 28% of the total incidents; 1 involved an attempted suspension outside a community hub, using a tree branch as the ligature anchor point. All community services have been reminded to have accessible tuff cut scissors to use as ligature cutters.

	Community	Acute Day Treatment Unit	Community Percentage
October 2018	6	1	28%
November 2018	6		35%
December 2018	2		14%

Table 9

7.13 Bed based services and day hospitals have seen a steady decrease of ligature incidents, after a peak in incidents quarter 4, 2017/18. Quarter 3 (2018/19) combined saw a small increase in December 2018 with events attributed to community services, whilst the underlying trend for bed based units dropped. Greater focus on the environment has been introduced with the weekly walk around and actions from this. This is supported by greater awareness via the development of line of sight plans and visual prompts such as photographs.

8 Restrictive Practice

RESPECT

8.1 During quarter 3, following the external reviews of both the RESPECT training and seclusion practice, as well as the completion of the Restrictive Practice deep dive, an increased focus has been put on Safewards methodologies and other proactive practice has taken place.

8.2 Module 5 has been revised and developed for training the Forensic and Psychiatric Intensive Care Unit services which focuses on managing extreme physical aggression and to strengthen the consideration of human factors in the management of incidents. The pilot with Oak Ward staff has been positively received. Little Plumstead will commence the training in mid-February 2019.

8.3 The next stage of the review of RESPECT training, including resource requirements and local training will be taking place during quarter 4. This will also include agreement of

additional interventions, training content (increasing in practical/scenarios), equipment and assurance for key areas relating to stairs training, the use of disposable one-off lifting slings and spit hoods (as advised by Herts Police), the evaluation of soft pads for use in seclusion (pilot equipment on order) and also a discussion regarding soft cuffs. LTS is incorporated as part of the Seclusion/LTS policy with a Seclusion and LTS paper being developed onto PARIS for April 2019.

Continuous Quality Improvement

8.4 Safety Pods, which are a type of specially designed bean bag for physically supporting service user when they are demonstrating challenging behaviour, have been introduced on Oak Ward. These aim to support and assist in more comfortable and less restrictive restraint, when required.

8.5 Informed by the Feeling Safe Audit 2018, safety huddles and safety crosses have been rolled out across the SBUs, led by the Clinical Directors for each SBU.

Environment

8.6 A comprehensive programme of reviewing and improving seclusion environments across Trust inpatient services is in place and overseen by the Modernising Our Estates Group.

Long Term Segregation (LTS)

8.7 LTS data showed at the end of quarter 3 2018/19 there are 7 service users subject to the LTS framework. All of these people are within the Learning Disability and Forensic SBU, as detailed in **table 12**.

Ward	Length of time in LTS
2 Forest Lane	8 years 10 months
Lexden Recovery Unit	8 years 1 month
Dove Ward	2 months
Warren Court House 5	4 months
Warren Court House 5	6 months
Dove Ward	8 months
Dove Ward	2 weeks

Table 12

8.8 Both of the service users who have been subject to the LTS framework for over 8 years require an appropriate community placement suitable for their needs. They are subject to regular external reviews by the Care Commissioning Groups and Care Quality Commission as well as our internal reviews systems. The LTS framework has been reviewed by Mersey Care NHS Trust, as part of the aforementioned external review.

9 Conclusion

.1 This section of the report has given an overview of the work that has been undertaken. This has been specifically relating to the learning from incidents and the work that has been undertaken.

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:	7th February 2019	**Agenda Item: 10**
Subject:	Quarter 3 Safe Staffing Report	**For Publication:**
Author:	Jacky Vincent, Deputy Director of Nursing and Quality	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety	

Purpose of the report:

This report provides the Board with the data for quarter 3 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 3 showed adequate staffing and shift cover in response to unexpected demand and levels of acuity and dependency on the wards.

There was no service with a fill rate below 80%. 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 with high acuity had high CHPPD. This is reflected when comparing the Trust with the national data.

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

Integrated Governance Committee 23rd January 2019

1. Introduction

1.1 This report serves to provide the information and analysis of the quarter 3 nurse staffing data to enable the Trust Board to have assurance in relation to the nurse staffing in the Trust's inpatient services.

1.1 The report also includes data on nurse staffing in community services.

1.2 To provide further assurance, supporting data is also contained in this report in relation to vacancies, sickness, Performance Development Plan (PDP) and mandatory training rates for inpatient services.

2 Trust expectations in relation to inpatient nurse staffing levels

2.1 The Trust's expectation is that the planned number of staff to cover the ward demand and acuity level would closely match with the actual number of staff who 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.

2.4 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.

2.5 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 Bureau office or as agency.

2.6 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.

2.7 *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 of findings for quarter 3 nurse staffing data collection

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

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

Chart 1 below shows the Trust CHPPD position when compared with the national average.

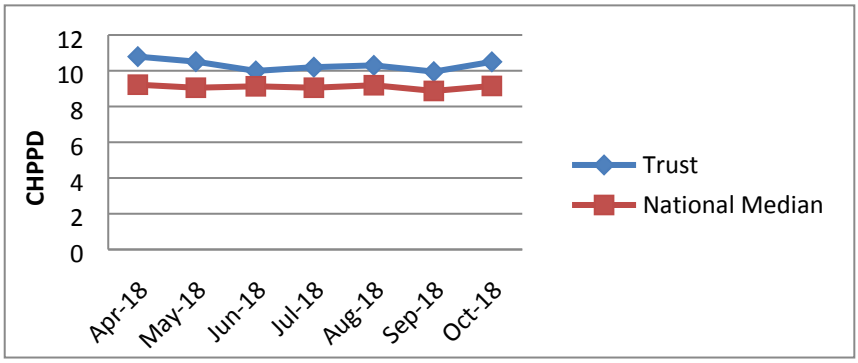


Chart 1

3.3 The Trust CHPPD is above the national median, reflecting on the increased staffing utilised in many of the services as a result of increased acuity and also the stand alone units where CHPPD is high.

3.4 There were no services with a fill rate below 80% in quarter 3.

3.5 There was adequate staffing in all in-patient services and many services have used staffing above their establishment to meet the clinical needs and demands of the services. For example, the West SBU had high acuity levels which resulted in high levels of prescribed continuous safe and supportive observation. Their seclusion data showed an increase of 15 incidents in quarter 3 compared with quarter 2.

3.6 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.

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

3.8 The Trust is one of many Trusts nationally involved and contributing to the development of the Mental Health Model Hospital. The Model Hospital is gradually being populated, providing an opportunity for us to benchmark with peers.

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

4 Vacancies

4.1 The Trust continues to have some challenges with recruitment; however a reduction in vacancy rates for RN (by 1%) whereas an increase of 3% for HCA is noted in quarter 3 as detailed in **Table 1**.

4.2 The Trust also continues to work with the local universities ensuring that student nurses feel part of the Trust family at the start of their training and meeting senior nurse leaders during their training.

4.3 In quarter 3, the Heads of Nursing and Modern Matrons met with student nurses in their service areas per placement. Shadowing opportunities were offered to students to enable a greater understanding and appreciation of the Trust, feeling welcomed and included as a member of the workforce and also to gain greater insight into potential nurse career opportunities.

4.4 The 10 trainee Nursing Associates (TNA) from Cohort 1 continue with the programme. Cohort 2 with 9 TNA started in May 2018. Cohort 3 started in September 2018 with 7 TNA. Cohort 4 with 10 TNA started on 21st December 2018.

4.5 5 Assistant Practitioners will also be starting on the flexible nursing pathway in January 2019; this is an 18 month programme with the University of Bedfordshire.

4.6 **Appendix 2** provides a breakdown of vacancies in all the in-patient services and a**ppendix 3,** a breakdown of vacancies in the community services.

Vacancy Rates				
SBU	**Sum of Position FTE**	**Sum of Actual FTE**	**Sum of FTE Variance**	**% Vacancy**
Registered Nursing				
Learning Disability & Forensic	195.27	153.58	41.69	21%
East & North	123.50	96.32	27.18	22%
West	121.06	92.03	29.03	24%
Total	439.83	341.93	97.90	22%
Unregistered Nursing				
Learning Disability & Forensic	232.52	195.66	36.86	16%
East & North SBU	208.92	168.96	39.96	19%
West	123.11	107.57	15.54	13%
Total	564.55	472.19	92.36	16%

Table 1

4.7 A significant risk remains for the Trust regarding the profile of RNs who are able to retire (308), detailed in **table 2**. Work continues to support them and explore their options to remain in the workforce.

Area	**55-59**			**60-64**			**65+**		
	HCA	**RN**	**Total**	**HCA**	**RN**	**Total**	**HCA**	**RN**	**Total**
LD&F SBU	34	19	53	11	8	19	4	4	8
E&N SBU	34	12	46	17	10	27	2	3	5
West SBU	16	15	31	9	4	13	6	2	8
Total	**84**	**46**	**130**	**37**	**22**	**59**	**12**	9	**21**

Table 2

5 Conclusion

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

5.2 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.

5.3 *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.

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

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

Appendix 1 - Nurse Staffing fill rate data

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
OCTOBER 2018								
Learning Disability & Forensic SBU								
Gainsford House	94	146	95	106	352	4.0	2.7	6.7
Hampden House	95	235	98	152	338	4.3	4.2	8.5
Warren Court	100	106	102	103	853	3.9	7.1	11.1
4 Bowlers	98	100	100	100	279	4.0	5.3	9.3
Beech	132	92	97	102	465	3.7	4.6	8.3
Dove	109	105	100	122	322	3.7	9.1	12.8
SRS	90	108	98	101	868	2.8	10.4	13.2
Lexden	106	112	100	130	187	8.3	18.9	27.1
Astley Court	92	166	102	127	155	6.9	14.2	21.1
Broadland Clinic	111	95	100	97	496	3.2	9.4	12.6
The Beacon	97	101	100	100	474	3.1	2.4	5.5
West SBU								
Swift	101	124	99	189	528	4.4	5.2	9.6
Robin	131	137	98	195	576	2.9	5.1	8.0
Owl	105	154	98	210	562	2.7	6.1	8.8
Oak	91	150	100	136	310	5.3	12.1	17.4
Thumbswood	106	104	100	105	95	8.6	16.2	24.8
Albany Lodge	110	120	102	135	726	2.7	4.4	7.2
Aston	102	136	102	130	584	3.1	5.2	8.3
East & North SBU								
Victoria Court	101	99	98	101	799	1.8	5.9	7.7
Forest House	101	129	97	204	379	3.9	9.9	13.8
Wren	101	100	100	134	468	3.2	5.7	8.9
Lambourn Grove	103	100	102	101	741	2.1	6.3	8.4
Logandene	98	89	98	103	464	3.1	6.9	10.0
Seward Lodge	100	105	93	198	364	3.9	10.5	14.4
The Stewarts	101	97	98	159	340	4.3	8.8	13.1
NOVEMBER 2018								
Learning Disability & Forensic SBU								
Gainsford House	97	115	97	107	346	4.0	2.3	6.4
Hampden House	99	164	102	97	370	3.9	2.6	6.5
Warren Court	99	108	97	102	854	5.0	7.5	12.4
4 Bowlers Green	99	100	100	100	270	4.1	5.3	9.4
Beech	123	94	98	101	431	3.7	4.8	8.5
Dove	127	111	100	139	337	3.8	9.0	12.8
SRS	83	111	98	102	840	2.6	10.5	13.1
Lexden	92	102	105	96	180	7.9	16.1	24.1
Astley Court	106	192	107	99	173	6.7	13.4	20.0
Broadland Clinic	113	99	105	103	480	3.4	9.1	12.9
The Beacon	96	104	100	106	465	3.0	2.5	5.5
West SBU								
Swift	97	155	93	227	533	4.0	5.9	10.0
Robin	102	145	100	204	567	2.5	5.1	7.7
Owl	110	148	100	170	556	2.7	5.5	8.2
Oak	92	229	100	188	327	4.9	15.6	20.5
Thumbswood	108	100	100	117	110	7.2	14.1	21.3
Albany Lodge	111	111	100	122	752	2.6	3.9	6.4
Aston	100	155	100	151	605	2.8	5.5	8.4

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
East & North SBU								
Victoria Court	100	101	93	102	780	1.8	5.9	7.7
Forest House	118	123	100	112	403	3.9	7.9	11.8
Wren	98	124	99	190	446	3.2	7.5	10.7
Lambourn Grove	104	101	100	107	716	2.1	6.5	8.5
Logandene	99	90	100	105	442	3.2	6.9	10.1
Seward Lodge	99	99	100	156	361	3.9	9.2	13.1
The Stewarts	100	100	100	105	298	4.7	6.2	10.9
DECEMBER 2018								
Learning Disability & Forensic SBU								
Gainsford House	83	135	95	113	345	3.9	2.7	6.6
Hampden House	101	184	103	132	320	4.8	3.7	8.5
Warren Court	94	111	99	107	789	5.5	8.7	14.1
4 Bowlers	98	103	97	100	279	4.0	5.5	9.5
Beech	129	93	98	107	465	3.6	4.6	8.2
Dove	125	111	98	133	375	3.5	8.4	11.9
SRS	83	110	93	101	868	2.6	10.5	13.1
Lexden	101	103	102	125	212	7.2	15.7	22.8
Astley Court	118	186	105	101	186	6.9	13.0	19.9
Broadland Clinic	109	89	94	104	496	3.1	9.3	12.4
The Beacon	98	103	100	100	444	4.0	3.1	7.1
West SBU								
Swift	98	150	101	181	516	4.4	5.7	10.2
Robin	109	157	100	211	560	2.7	5.7	8.4
Owl	104	176	106	244	677	2.3	5.9	8.2
Oak	98	196	102	172	308	5.6	15.4	21.0
Thumbswood	99	98	100	102	75	10.2	19.8	30.0
Albany Lodge	112	109	100	148	731	2.8	4.3	7.1
Aston	104	143	98	136	606	2.9	5.3	8.3
East & North SBU								
Victoria Court	96	99	100	100	824	1.8	5.7	7.5
Forest House	100	120	100	130	375	4.0	9.6	13.6
Wren	117	123	113	187	480	3.5	7.1	10.6
Lambourn Grove	99	99	97	101	320	4.6	14.6	19.2
Logandene	113	97	111	104	430	3.8	7.8	11.6
Seward Lodge	101	102	97	176	373	3.9	9.6	13.5
The Stewarts	99	122	95	101	340	3.2	4.3	7.5

Appendix 2 - Vacancies breakdown by in-patient services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Learning Disability & Forensic SBU				
4 Bowlers Green	8.00	7.00	1.00	13
Beech Ward	14.20	14.00	0.20	1
Broadland Clinic	25.20	13.13	12.07	48
Dove Ward	11.00	11.00	0.00	0
Gainsford House	10.80	8.60	2.20	20
Hampden House	10.60	8.08	2.52	24
LPH Astley Court	11.00	10.00	1.00	9
Warren Court	28.00	20.60	7.40	26
NE Inpatient Unit	12.56	12.61	-0.05	0
SRS Bungalows	18.00	10.00	8.00	44
The Beacon	11.31	9.40	1.91	17
West SBU				
Albany Lodge	13.50	11.50	2.00	15
Aston Ward	14.69	11.69	3.00	20
Oak Ward	13.00	7.00	6.00	46
Owl Ward	11.00	8.64	2.36	21
Robin Ward	11.60	8.00	3.60	31
Swift Ward	18.00	15.00	3.00	17
Thumbswood	7.67	6.53	1.14	15
East & North SBU				
Forest House	13.00	7.00	6.00	46
Lambourn Grove	11.20	7.06	4.14	37
Logandene	12.37	8.80	3.57	29
The Stewarts	11.13	8.24	2.89	26
Seward Lodge	12.00	10.80	1.20	10
Victoria Court	12.14	10.76	1.38	11
Wren	11.14	8.61	2.53	23
NON-REGISTERED NURSING				
Learning Disability & Forensic SBU				
4 Bowlers Green	10.00	10.01	-0.01	0
Beech Ward	13.00	12.00	1.00	8
Broadland Clinic	41.60	34.43	7.17	17
Dove Ward	13.89	10.89	3.00	22
Gainsford House	5.40	6.40	-1.00	-19
Hampden House	5.00	5.00	0.00	0
LPH Astley Court	12.40	10.00	2.40	19
Warren Court	35.00	29.00	6.00	17
NE Inpatient Unit	20.53	16.96	3.57	17
SRS Bungalows	58.57	46.37	12.20	21
The Beacon	7.53	7.00	0.53	7%
West SBU				
Albany Lodge	18.00	16.80	1.20	7

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Aston Ward	14.73	13.76	0.97	7
Oak Ward	16.00	14.00	2.00	13
Owl Ward	13.53	13.53	0.00	0
Robin Ward	15.20	10.00	5.20	34
Swift Ward	13.60	10.04	3.56	26
Thumbswood	9.60	7.60	2.00	21
East & North SBU				
Forest House	14.70	10.67	4.03	27
Lambourn Grove	36.86	29.33	7.53	20
Logandene	25.40	18.60	6.80	27
The Stewarts	22.69	19.39	3.30	15
Seward Lodge	22.13	18.45	3.68	17
Victoria Court	37.56	32.83	4.73	13
Wren	19.69	17.76	1.93	10

Appendix 3 - Vacancies breakdown by Community Services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	2.00	2.00	0.00	0
Continuing Care & Placement Team	10.04	8.60	1.44	14
Criminal Justice & Forensic	1.00	0.00	1.00	100
Criminal Justice Mental Health	2.00	2.00	0.00	0
LD SLDS A&T E/N Team	9.20	9.80	-0.60	-7
LD SLDS A&T West Team	10.36	6.76	3.60	35
East & North SBU				
AMHCS Centenary & Jubilee	12.63	13.43	-0.80	-6
AMHCS Cygnet House	8.60	5.19	3.41	40
AMHCS Holly Lodge	4.04	3.00	1.04	26
AMHCS Saffron Ground	4.80	4.40	0.40	8
AMHCS Oxford House	2.00	0.00	2.00	100
AMHCS Rosanne House	8.45	9.03	-0.58	-7
West SBU				
AMHCS NW Herts Dacorum	7.80	6.80	1.00	13
AMHCS NW Herts St Albans	6.40	4.60	1.80	28
AMHCS SW Herts	1.00	1.00	0.00	0
AMHCS SW Herts Borehamwood	5.00	3.00	2.00	40
AMHCS SW Herts Watford	11.40	8.27	3.13	27
NON-REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	2.00	2.00	0.00	0
Continuing Care & Placement Team	0.00	0.00	0.00	0
LD SLDS A&T E/N Team	4.00	2.00	2.00	50
LD SLDS A&T West Team	3.60	3.60	0.00	0
East & North SBU				
AMHCS Centenary & Jubilee	8.34	5.57	2.77	33
AMHCS Cygnet House	6.75	5.06	1.69	25
AMHCS Holly Lodge	2.50	2.50	0.00	0
AMHCS Saffron Ground	3.80	2.80	1.00	26
AMHCS Oxford House	2.50	1.00	1.50	60
AMHCS Rosanne House	6.00	5.00	1.00	17
West SBU				
AMHCS NW Herts Dacorum	6.29	8.29	-2.00	-32
AMHCS NW Herts St Albans	4.40	4.40	0.00	0
AMHCS SW Herts	3.51	1.20	2.31	66
AMHCS SW Herts Borehamwood	1.99	1.49	0.50	25
AMHCS SW Herts Watford	6.26	6.46	-0.20	-3

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	7th February 2019	**Agenda Item: 12**
Subject:	Report from Finance & Investment Committee – 22 January 2019	**For Publication: Yes**
Author:	Keith Loveman Executive Director - Finance	**Approved by:** Keith Loveman Executive Director - Finance
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 22 January 2019.

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 22 January Finance & Investment Committee meeting covered:

- Deep Dive – Innovation & Improvement
- Performance Report – Period to end Q3
- Financial Summary – Period to end Q3
- Key financial issues for 2019/20 year end
- Planning for 2019/20
    - (a) Planning Update
    - (b) Financial plan
- Business Development
    - (a) New Care Models
    - (b) Commercial Development Activity Other
- Contract Negotiation Update
- Strategic Investment Programme – to period ending Q3
- Forward Strategic Investment Programme
- IT Business cases
    - (a) PARIS Connect
    - (b) App Development Platform
- FIC – Review of Committee Effectiveness
- Review of TOR's
- FIC Business Programme 2019

Deep Dive – Innovation and Improvement

The Director of Innovation & Transformation presented an update on Innovation and Improvement. The Innovation Panel was established in 2016 and to date there have been 17 panels with a total investment of £213K representing 28 awarded projects across a range of services. The fund is used to pump-prime and test ideas with the potential to roll out successes and learning to other services. The discussion highlighted the following successful projects:

- Cardio Wall and Pedometers

Hertfordshire

- Digital Talking Map
- Book Beyond Words

FIC welcomed the projects and suggested that further thought was given to promoting projects such as Book Beyond Words across the wider system, charities and schools.

Performance Report – Period to end Q3
The Director of Innovation and Transformation presented the Q3 Performance report. Overall Q3 remains relatively static across the organisation but recognising ongoing increasing demand with an increase in referrals of 16% compared to the same period last year. Positive performance improvement was noted in out of area placements, First Episode Psychosis, Delayed Transfers of Care and 3 and 7 day follow-up after inpatient discharge.

Areas of trending deterioration in metrics were highlighted and include Adult 28-day wait, EDMASS referral to diagnosis, CAMHS 28-day referral to assessment and Risk Assessments. The report set out key actions focused on recovery and improvement in performance.

Workforce indicators continue to progress although the sickness absence for the month is up at 4.75%. Turnover has seen a small decrease to 16.33%; CAMHS vacancies remain a concern.

Financial Summary – Period to end Q3
FIC received a summary of the financial position to the end Q3 from the Deputy Director of Finance. The reported position remains encouraging and ahead of plan, after noting the £1.4m non-recurrent support underpinning this. Month 9 shows the second strongest surplus for the year. The NHSI rating has improved to an overall 1 in the main due to the surplus and reducing agency costs.

Overall the Q2 improvements were sustained into Q3. There remains a level of risk driven by the small surplus margin, significant demand, in particular related to secondary commissioning and ongoing workforce pressures.

Key Financial issues for 2018/19 year end
The Deputy Director of Finance presented an update outlining the key financial issues related to 2018/19 year-end. Areas with some degree of risk were highlighted:

- Likely increase in placement costs.
- Several active employment disputes with solicitors
- Some additional costs around CQC
- Delays from Interserve in notifying non contract charges
- CQUIN forecast currently 80%

The Committee discussed the potential impact on the revenue position and the Trust's refurbishment programme; noting that the Associate Director of Estates and Facilities is developing a rolling programme of life-cycle works. Consideration will be given to the way in which areas will be prioritised according to need and routinely reported to the Committee.

Operating Framework & Planning for 2019/20

a) Planning Update
FIC received an update on the recent additional planning guidance from NHS England from the Deputy Director of Commercial Development and noted the implications for internal governance processes to enable the required dates to be met. Delegation from the Trust Board will also be required in order to achieve the requirement timetable. Whilst the provision of the detailed guidance has slipped by one month, the rest of the timetable provided on 31st October 2018 remains with the first milestone of 12th February for submission of the Draft Operating Plan. Work also underway for the narrative of the Annual Plan which will be brought back to the Board.

b) Financial Plan
The Deputy Director of Finance updated the Committee on the key financial considerations and risks in relation to the Financial Planning process for the year end 2019/20. In developing and approving the

Financial Plan the following criteria are key:

- It is set in accordance with the Trusts objectives and all relevant planning guidance.
- Provides a clear assessment of the requirements and risks to financial sustainability.
- The Financial Plan remains a key tool to monitor performance.

FIC were advised that there remain a number of assumptions pending further guidance from NHSI/NHSE which may impact the plan e.g.

- The likelihood of an increase in employers pension contributions
- Changes to CQUIN flows
- Impact of pay awards

The proposed control total for 2019/20 had just been received and indicates a breakeven target with £1.8m PSF accruing for delivery. The Board will be asked to consider approval of the control total once clarity on a number of issues that may impact deliverability are received. The outcome of contract negotiations are central to this.

FIC were advised that this is the first year of the NHS Long Term Plan and is accompanied with a number of fundamental changes to the financial framework. It will be important in particular to understand the development of system wide controls. Work will continue on the plan in accordance with the national contracting and planning for submission on 12th February 2019.

Business Development

a) New Care Models

FIC received a comprehensive update from the Director of Service Delivery and Service User Experience relating to the national direction regarding New Care Models (NCM) following receipt of a letter from Specialised Commissioning NHS England and the subsequent decisions agreed by the Executive Team on potential approaches. The letter seeks expressions of interest from Mental Health provider organisations from all sectors to lead, develop and/or join arrangements for the East of England in the following areas;

- CAMHS (with the exception of Children's (<13 year-olds) Medium Secure and Deaf services
- Adult Low and Medium Secure (with the exception of High Secure, Acquired Brain Injury and Deaf Services)
- Adult Eating Disorders.

The Executive Team has agreed to respond to the letter initially to express an interest in being part of the regional NCM work in all 3 of the identified areas and that specific proposals are developed in relation to each element.

FIC also noted that that given HPFT's status as a Wave 2 CAMHS NCM site, discussions with CPFT would be taken forward on our proposed approach and to seek to lead this work in partnership with CPFT.

b) Commercial Development Activity

The Deputy Director Commercial Development updated FIC on the current activity across the organisation.

Contract Negotiation Update

FIC received an update on the renewal of the Trust's major contracts and noted the pieces of work that need to be progressed and where clarifying agreement is required.

For the main Hertfordshire contracts the objectives are:

- To set out a joint vision and approach to service development over the life of the contract
- To ensure, as a minimum, we achieve parity of esteem in the funding for our services
- We are adequately commissioned to meet the requirements of the 5-year forward view.
- The Trust is in a position to continue to play an important part in the provision of

integrated care in the local health and social care system.
- To secure a five year contract.

Strategic Investment Programme – to period ending Q3
The Director of Finance presented the Capital Plan which is reported regularly to FIC and any revisions highlighted for review and approval. There have been no updates to the current capital plan for 2018/19 however there are some points to note.

- The expected spend at Elizabeth Court and on the seclusion room program is now expected to largely occur in 2019/20.
- The £1.2m allocation for Paris development is expected to form part of the Digital Strategy referenced later in this paper.
- Spend on the Trust's Business Intelligence system is expected to be almost double that within the capital plan. This reflects a change in reporting for the staff costs experienced in implementation and expansion of the new system. This will be funded from the transformation project provisions carried within the balance sheet for the delivery of IM&T projects.

Fire Safety and Ligature work is progressing. The last piece of Fire work will be completed in the next few months and an update will be reported at the meeting in July.

The 2019/20 Capital Plan will be brought forward when signing off the budget for the new year.

Forward Strategic Investment Programme
The Director of Finance presented the Forward Strategic Investment programme which underpins delivery of our Good to Great Strategy. The Estates Strategy needs to be finalised and will be presented to FIC in March 2019. Diane Brent Associate Director of Estates & Facilities for both HPFT and HCT will be invited to attend FIC.

IT Business Cases
Hertfordshire and West Essex STP has been allocated approximately £2.65m funding for 2018/19 to use for the Health System Led Investment (HSLI). The Director of Innovation & Transformation presented two business cases following the allocation of £350K funding.

- **Paris Connect** - Approval was requested for the procurement of PARIS Connect which is a relatively simple and low risk project. FIC discussed the principles to understand how this sits within the infrastructure.
- **App Development Platform** – FIC discussed the App Development Platform to improve retrieving and capturing information by front-line and clinical staff using mobile devices.

FIC discussed both business cases in detail and endorsed the proposals, noting the match funding requirements and that these form part of the strategic investment programme moving forwards.

FIC Review of Effectiveness
As part of good governance FIC undertakes an annual self-assessment of effectiveness of the committee. The overall responses were positive and the report will be taken forward to the Board for approval.

Review of ToR's
FIC reviewed the current Terms of Reference with no particular areas of change. The Chair requested that consideration was given to whether the name of the Committee should be changed to reflect the inclusion of the review of Performance within the remit of FIC. Planning is also underway for the narrative of the Annual Plan which will be brought back to the Board.

FIC Business Programme 2019
The FIC Business programme was reviewed and forward items 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:	**7th February 2019**	**Agenda Item: 13**
Subject:	**Performance Report Q3 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 Q3, 2018/19
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.

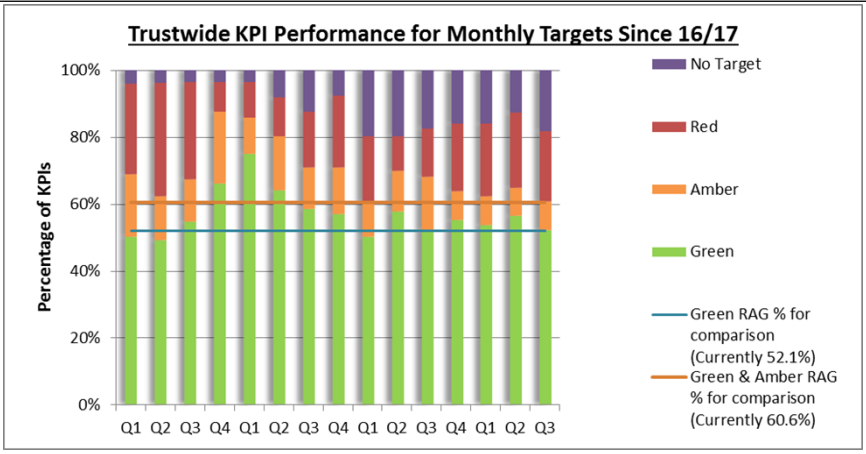
This report illustrates Q3 2018/19 performance assessed against the indicators across five elements: the NHSI Single Oversight Framework, Access to services, Safe & Effective, Workforce and Finance. It also provides an update on performance against the Q3 position of the Quality Account Priority Indicators.

Performance Summary

Overall, performance across Q3 remained balanced and holding up against pressures of increased turnover rate of 16.6% and service demands with 17% increase in referrals into SPA of 15,179 referrals in comparison to similar period in 2017 of 12,961 referrals.

In Q3, we have continued to consistently build upon and maintain our improvement on the following indicators:

- Minimal use of 'inappropriate' out of area placements (achieved 9 against a target of 250)
- First Episode Psychosis two week wait performance (achieved 89.29% against a target of 53%)
- CPA reviews (achieved 96.85% against a target of 95%)
- 3 day and 7 day follow-up after inpatient discharge at 92.7% and 97.81% respectively



The chart above compares the proportion of indicators rated green, red and amber since Q1 2016/17. The increased proportion of red indicators is attributed to performance in existing and newly established workforce metrics with challenging thresholds.

The key indicators to note that reflect a change in performance against targets in Q2 are as follows:

SOF

SOF indicators were met in Q3, 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. From internal monitoring data, current compliance is 85.4% against a target of 90%, with further improvement expected.

- The DQMI score for Q1 (most current available) is at 94.2%, 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 being addressed through a programme of work to improve MHSDS recording.

Access to Services

- Routine referrals for Adult Community Services 28day waits achieved 87.23 (1148/1316) against a 98% target. This is a 7% improvement from Q2's performance with strong performance in December of 88.5% being the highest performance since July. In particular there was very strong performance from E&SE who exceeded target at 98.23%, having cleared a previous backlog. The DNA protocol has been changed to include referrals in SPA to reduce the number of assessments and demand pressures. HVCCG have announced an additional £650k to support the Primary Mental Health Pilots, this is intended to be delivered by agreed locality plans.

- CAMHS 28days waiting times achieved 83.2% (288/358) against a 95% target; this is slight decline of 3% in comparison to Q2 performance. There are ongoing recruitment challenges in the East of the County in achieving the target. Teams are taking a risk based approach, 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.

- EMDASS Diagnosis within 12 weeks achieved 50.55% (230/455) against the 80% target; a decline of 18% in comparison to Q2 performance. Performance was affected by an increase in referrals and sickness across the teams including insufficient slots to meet demand and clear backlog. A number of recovery actions are now in place with weekly monitoring to improve performance.

- Mid-Essex (278 behind target), West Essex (345 behind target) and Herts Valley (165 behind target) IAPT services remain an area of concern. HVCCG has seen strong recovery and this will continue into Q4.There is still a forecast to recover the position by the end of Q4. West Essex access is improving following successful staff recruitment and Mid Essex are continually engaging with all stakeholders to improve performance. Both services are not predicting to achieve end of year target.

Safe and Effective Services

- Risk Assessments achieved 93.6% against a 95% target. There is slow and steady improvement across the SBUs throughout Q3 with LD & F is above target at 96%. CAMHS has seen an improvement in performance at 91.57%, up from 89.52% in Q2. Service users with ADHD and large medical caseloads account for the majority of breaches in CAMHS. 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 improved in Q3 with a decrease of 1.45% from Q2. The rigorous identification and monitoring process for delays is in place across all SBUs.

Workforce

The Pulse survey was not undertaken in Q3 as the National Staff Survey was during similar period.

- Turnover Rate: There has been an increase in turnover rate to 16.4% from 15.8% in Q2. A number of retention initiatives have been introduced which includes the retire and return process, the internal transfer process for nurses and HCAs which will be expanded to include all staff, and the buddy scheme which provides new starters with additional support in their new roles in the Trust, 100 day interviews and health and wellbeing activities.

- PDP achieved 88% against a 95% target, a decline of 2% in comparison to Q2 performance. Managers will be supported during Q4 with the data required to ensure that staff have completed PDPs in quarter 4.

- Sickness rates increased this quarter from 3.45% in Q2 to 4.61% in Q3 and is above the Trust target of 4%. 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.

- Statutory and Mandatory Training rate achieved 85.95% against a 92% target. 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 and map out the 2019/ 2020 training plan.

Finance

For December the financial position reported was a surplus of £182k for the month, ahead of the Plan of £78k by £104k, and a surplus of £408k for the year to date, ahead of the Plan of £113k by £295k, and exceeding the full year Plan of £360k. The Quarter 2 improvements were sustained into Quarter 3, with a return to surplus. There remains a level of risk driven by the small surplus margin, significant demand volatility (particularly relating to Secondary Commissioning), and ongoing workforce pressures. It is though expected that the Control Total will be exceeded for the full year.

Benchmarking Review

There is work underway on comparative analysis across local and national organisations to assess our performance against others to enable us continually learn and improve. Currently we have benchmarking insights on the following:

- CPA 7 day Follow-up: In Q2, HPFT had a total of 359/369 (97.3%) discharges that were followed up within 7 days, a good practice performance in comparison to the England average performance of 95.7%. 22 Trusts scored higher than HPFT of which only 2 Trusts (Tees, Esk and Wear Valleys and Barnet, Enfield and Haringey) had a similar or greater number of discharges. 35 trusts scored lower than HPFT.

- CATT GateKeeping: In Q2, HPFT had a total of 295/308 (95.8%) gate-kept admissions in in comparison to the England average performance of 98.4%. Of the ones that scored higher, 18 Trusts had a greater number of admissions and 39 had fewer admissions than HPFT. 4 Trusts had a lower score than HPFT.

- Adult Social Care- framework: Based on published data for 2017/18 against a comparator authority group, HPFT had the highest performance on adults in employment at 11% and adults living independently of 65%. The improvement in recording of employment and accommodation statuses over the last 2 years has contributed in reporting status and with the introduction of SPIKE 2, it is anticipated that performance for 18/19 will improve further.

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 3
2018/19

Contents

1. Summary

Overall performance has remained relatively stable across Q3 with some fluctuation for individual KPI's, but with the holistic view in the context of increasing service demand is off good performance. However, services are forecasting a difficult Q4, if referrals continue to remain at a high rate, or increase further and this could see further deterioration against 28 day access targets.

Positive performance improvement for Q3 is noted as follows:

- Significant ongoing minimal use of 'inappropriate' out of area placements (9 days vs 250 day ceiling)
- First Episode Psychosis two week wait performance (89.29% vs 53% target)
- Decreasing Delayed Transfers of Care (from 7.68% in Q2 down to 6.23% in Q3)
- 3 day and 7 day follow-up after inpatient discharge at 92.7% and 97.81% respectively

Key areas with performance issues with corresponding ongoing corrective actions are summarised as:

Performance Area	Current Performance	Actions
Adult 28 day wait for routine referrals	87.2% against 98% target	• New processes after continued non-engagement following referral • Longer term investment in Primary MH Care across Hertfordshire
EMDASS referral to diagnosis – 12 week	50.55% vs 80%	• Increased medical capacity • Additional & evening clinics introduced
CAMHS 28 day referral to assessment	80.45% against 95% target	• Triaging own referrals to reduce wait times • Successful recruitment to 5 posts, commence January to March • Review of referral and activity patterns to discuss joint action with commissioners
Risk assessment	93.55% against 95% target	• Medical leadership addressing caseloads • Remedial targeted action within under-performing areas

- PDP and Appraisal, Mandatory Training, Sickness and Turnover had all decreased and were rated as red in Q3. Pulse indicators were not reported during this period as the

survey did not take place due to the National Staff Survey being undertaken during the same period.
- Quality Account indicators were all meeting or exceeding targets, with the exception of CAMHS 28 day waits.

2. Forecast for Q4

SOF:

- No material change predicted on Q4.
- Continued strong performance on FEP 14 days
- Continued strong performance on IAPT targets.
- DQMI expected to stay marginally below target when Q2 figures are published.

Access:

- Expect to meet all waiting time indicators with the exception of CAMHS and Adult 28 days and IAPT Mid and West Essex.
- EMDASS Diagnosis within 12 weeks forecast to improve with actions in place with the aim to recover by end of March.
- Adult 28 days forecast to decline in Q4 to 80% due to known capacity issues.
- CAMHS 28 days not expected to improve above current level.
- HVCCG IAPT expected to recover by end of Q4 with Mid and West Essex IAPT not expected to reach target.

Safe and Effective:

- DToCs expected to continue to decrease over the quarter.
- Risk assessment expected to improve marginally from the current level.
- Clustering reviews expected to continue to fall slightly if access pressure remains.
- Employment and accommodation recording expected to improve with introduction of SPIKE 2.
- IAPT recovery rates expected to remain high with close monitoring required in Mid-Essex recovery rates.
- Continued good performance on 7 and 3 day follow-ups expected.
- Continue to meet CPA and CATT gatekeeping targets.

Workforce:

- Mandatory Training and PDP and Appraisal rates expected to improve, but not expected to meet target by the end of Q4.
- Sickness and turnover are expected remain reasonably static in Q4.

Finance:

- Control total expected to be met for the whole year.

3. Key Areas of Activity in Q3 2018/19

331 adult acute admissions
admissions Q3

8,380 new spells of care in secondary mental health services Q3

109 Starters
119 Leavers
at the end of Q3

9,723 people entering treatment in Wellbeing Services Q3

2,632 people on CPA at the end of Q3

66,010 secondary mental health contacts Q3

425
inpatient beds
at the end of Q3

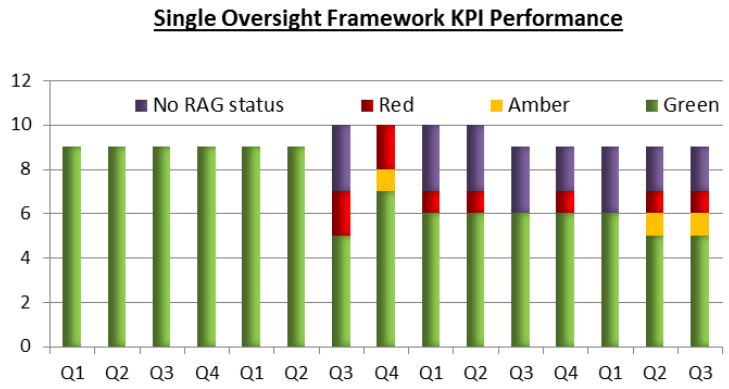
7,826
discharged from secondary mental health services Q3

Q2 – Q3 Comparisons

- 6% rise in adult acute admissions
- 60 fewer starters and 7 fewer leavers
- 6 fewer inpatient beds
- 6% fewer people on CPA
- 14% increase in people entering treatment in Wellbeing Services
- 18% increase in secondary mental health contacts

4. Performance On SOF

Single Oversight Framework (SOF 2 – 6)



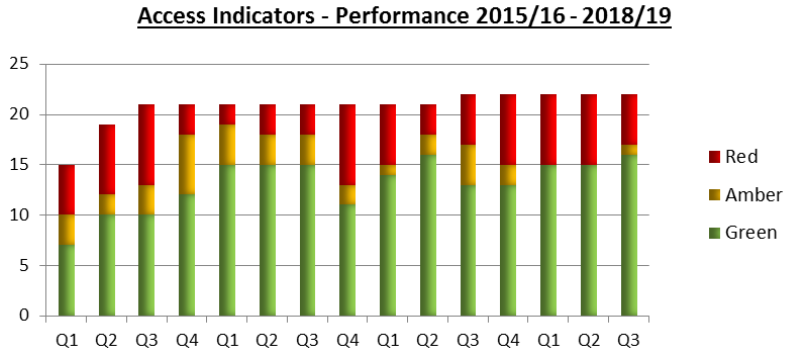
In Q3, SOF indicators were met, with the exception of FEP Cardio-metabolic assessment and Data Quality maturity Index (DQMI). There was particularly strong performance on FEP 14 day waits (89.29% against a target of 53%) and Out of Area Placements (9 days against a ceiling of 250).

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 85.4% against a target of 90%, with further improvement expected. This is a small improvement on the Q2 compliance of 83.6%.

The DQMI score for Q1 (most current available) is at 94.2%, 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. There is ongoing work to improve MHSDS recording.

5. Performance On KPIs

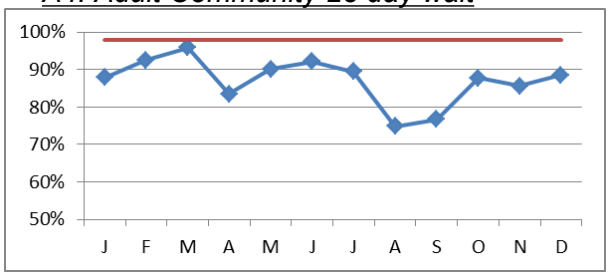
Access to Services (A1 – 27)



The table below shows Access indicators have been rated as red or amber in Q3, with movement from Q2 position and the shortfall from target.

Access KPI	Q3 Performance	Movement from Q2	Shortfall from Target
A4: Routine referrals for Adult Community Services	87.23% (1,148/1,316)	+6.49%	142(98%)
A11: EMDASS Diagnosis within 12 weeks	50.55% (230/455)	-8.79%	134 (80%)
A16: CAMHS Routine Waits	80.45% (288/358)	-1.03%	52 (95%)
A23: People entering IAPT Treatment - HVCCG	7748/7913	-	165
A24: People entering IAPT Treatment – Mid-Essex	4141/4419	-	278
A25: People entering IAPT Treatment – West-Essex	3357/3702	-	345

A4: Adult Community 28 day wait



The adult community 28 day wait was at 87.23% for Q3, a decrease of 6.49% on the Q2 figure of 80.74% and 142 people short of the 98% target.

The December performance figures per quadrant are shown in the table below:

Quadrant	Performance
E&SE	98.23% (111/113)
North	91.01% (81/89)
NW	93.81% (91/97)
SW	70.3% (71/101)

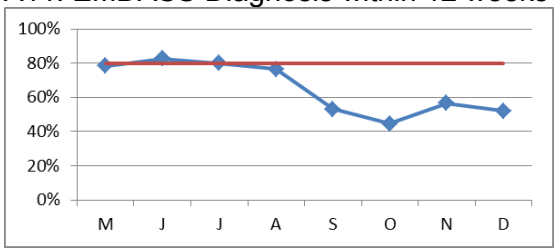
Overall performance in December was at 88.5%, the strongest performance since July 2018. In particular there was very strong performance from E&SE who exceeded target at 98.23%, having cleared a previous backlog. However, both E&SE & North predict a drop in performance for Q4 that they believe could see performance falling as low as 70%. This is due to an expected seasonal increase in referrals after the Christmas period and the inability to sustain additional clinics and week-end working within current staffing levels. SW are

currently at 70.3% and have a high vacancy rate. They are not predicting any improvement in performance within the current delivery model.

The DNA protocols that were put in place, firstly in teams, and then extended to SPA have been successful in terms of better engagement with service users and re-engagement with the service – however , early indications are that this has not had the hoped for effect of reducing people going through to initial assessment, but increased it. Similarly, early indications are that the Primary Care Pilots are welcomed by GPs and service users, with evidence of reducing IAs but in the context of increasing numbers of Initial Assessments and picking up previously unmet need.

The threshold in relation to this indicator is currently being reviewed as part of Herts contract re-negotiation as the 98% target has proved to be unachievable with the current demand and service model.

A11: EMDASS Diagnosis within 12 weeks



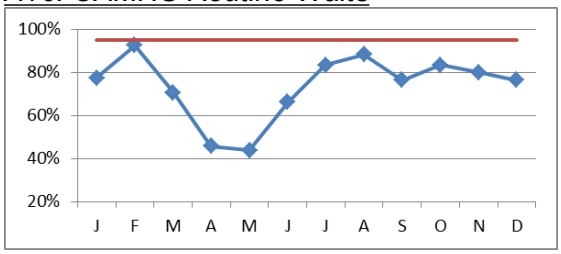
EMDASS diagnosis within 12 weeks fell to 50.55% in Q3 from the Q2 level of 69.34%, target is 80 %. Performance was affected by an increase in referrals and sickness across the teams, in particular of 2 key Consultants. There were also insufficient slots to meet demand and clear backlog. A number of remedial actions have now been put in place, which include:

- Addressing DNAs by admin contacting service users prior to appointment and providing home visits if necessary.
- Diagnosis to be made by extended range of medical staff, not just consultants.
- Additional out of hours clinics scheduled to clear back-log and those people who have been booked to breach.
- Ensuring DQ issues are addressed with recording of non-diagnoses via the supervision process, and a 'crib' sheet produced for staff.

The table below gives details of when the service is aiming to meet target.

Issue	January	February	March	Q2
At least 80% of all EMDASS service-users diagnosis within 12 weeks of referral.	Achieve **65%** diagnosis within 12 weeks	Achieve **70%** diagnosis within 12 weeks	Achieve at least **80%** diagnosis within 12 weeks	Retain performance – measured by regular reporting

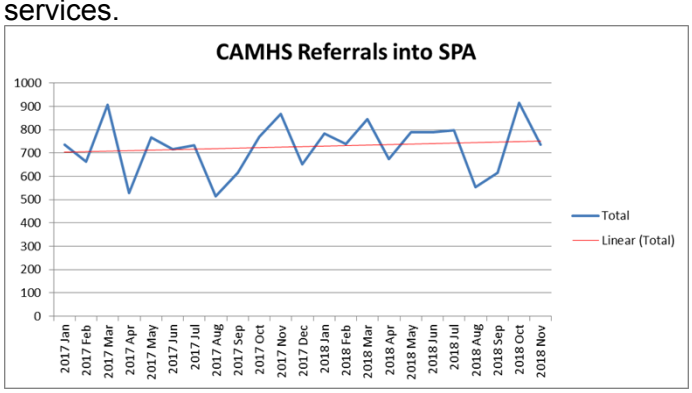
A16: CAMHS Routine Waits



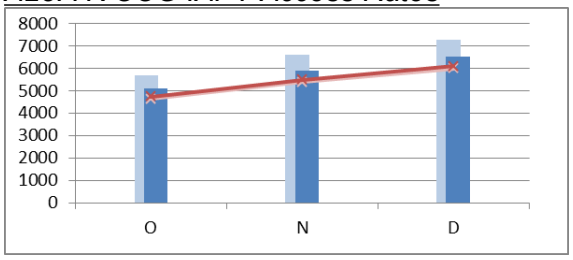
Performance has decreased by 2.76% in Q3 to 80.45%. The main challenge remains in the East of the County where there is a known long-term recruitment issue.

Teams are taking a risk based approach, 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.

The chart below shows increasing referrals into SPA for CAMHS, since January 2017. Contract discussions are focusing on how we can work together with commissioners to address how we can provide for the increasing numbers of children referred into CAMHS services.



A25: HVCCG IAPT Access Rates

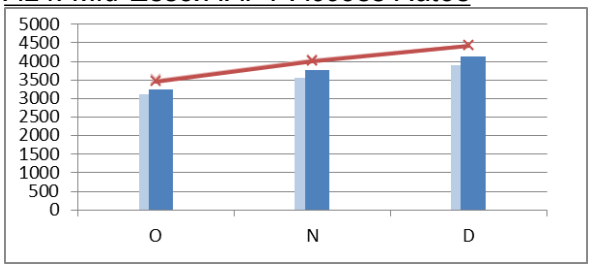


HVCCG were 165 people behind their cumulative target at the end of Q3. This is a significant improvement on the Q2 position, when the service was 411 people short of target (a claw-back of 246). The improvement has been due to the success of a range of initiatives that have been put in place, including:

- Weekly conference calls to monitor actions to improve access
- Monthly review of access with commissioning colleagues to agree HPFT and IHCCT actions
- 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

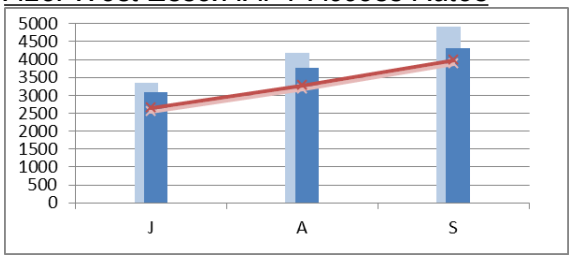
These initiatives are continuing throughout Q4, and if a similar rate of referrals is received as in Q3 the end of year target will be achieved.

A24: Mid-Essex IAPT Access Rates



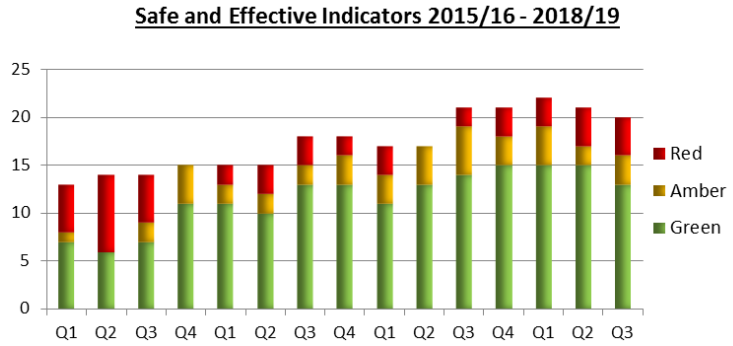
Mid Essex were 278 people behind the cumulative access target at the end of Q3. An improvement of 22 on the end of Q2 position. The service is not expecting to meet the ≥15% access target at year end, and any marked increase in referrals would increase the waiting list for treatment back over desired levels.

A25: West Essex IAPT Access Rates



West Essex was 349 people behind their cumulative access target at the end of December. As with HVCCG and Mid-Essex, this was an improvement on the position at the end of Q2, when the service was 489 people behind target (clawback of 140). Access improved following successful staff recruitment, but referrals still remain below desired levels. The service is not predicting that it will meet target at year end.

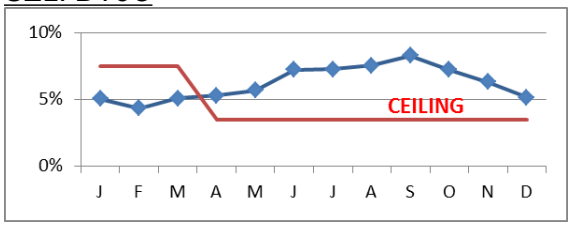
Safety and Effectiveness of Services (SE1 – 21)



The table below shows the Safety and Effectiveness monthly indicators that have been rated as red or amber in Q3, the movement from the Q2 position and the shortfall from target.

Safety and Effectiveness KPI	Q3 Performance	Movement from Q2	Shortfall from Target
SE2: DToC	6.23%	+1.45%	2.73%
SE5: Risk Assessments	93.55% (15,415/16,477)	+0.81%	238 (95%)
SE8: IAPT Recovery Mid- Essex	49.1% (328/688)	-3.65%	16
SE11: Rate of acute inpatients reporting feeling safe	77.05% (47/61)	-3.82%	2 (80%)
SE 18: Cluster Reviews	86.2% (8,582/9,956)	11.69%	876 (95%)
SE21a) Employment b) Accommodation	61.12% (9,176/15,013) 53.66% (8,544/15,013)	+3.86% - 0.38%	3,585 (85%) 4,217

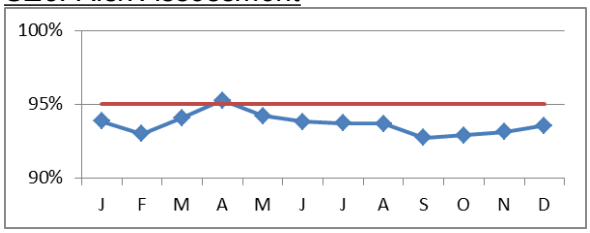
SE2: DToC



Following an increase in delayed bed days in Q1 and Q2, DToC has improved in Q3, with a decrease of 1.45% from Q2. LD&F were at 5.97% with E&N at 4.09% and West with the highest rate (adult acute) at 11.76%.

The rigorous identification and monitoring progress for delays remains in place across all SBUs. The main area of delay remains in adult acute services, where 8 people with highly complex needs are waiting for specialised placements to become available. Movement is expected by the end of January 2019. Adult Acute Services are taking a number of steps to help reduce delays, including looking at the introduction of 'stranded patient' reviews, escalating delays over 10 days directly to Service Line Leads and exploring the possibility of a hospital social worker.

SE5: Risk Assessment



Performance for Q3 is at 93.6%, with some slow but steady improvement over the quarter. Breakdown by SBU is:

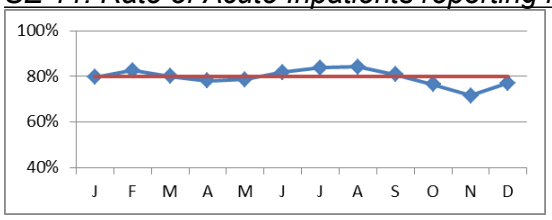
- E&N = 92.92%
- West = 92.96%
- LD&F = 96.94%

Adult Community are finding the target most challenging, with North being the closest to target at 94.7%, and E&SE the worst performing at 88.9%. SW was at 91.19% and NW at 92.13%. This reflects the capacity of teams and the focus on meeting access waiting times and in the case of E&SE clearing a significant backlog. CAMHS has seen an improvement in performance at 91.57%, up from 89.52% in Q2. Service users with ADHD and large medical caseloads still account for the majority of breaches in CAMHS.

SE8: Mid-Essex IAPT Recovery Rate

Mid-Essex recovery rate dipped below the 50% target at 49.1% in Q3. 16 people were below the threshold for recovery over the quarter. This is due to more people being booked in at Step 3, to assist waiting times. There is currently two months left to run on the current contract and we are waiting for financial details of a possible two year extension.

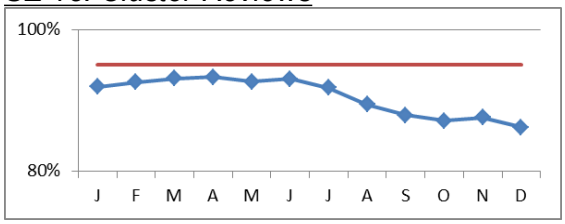
SE 11: Rate of Acute Inpatients reporting feeling safe.



47/61 people reported feeling safe on acute inpatient units in Q3. The service has been working at above 100% occupancy rates with some very complex people on the units who are waiting for placements (see DToC section). This may result in a sometimes challenging

environment that may not feel safe at times. There are ongoing community meetings in the inpatient units, and engagement with service users to see what further support can be given.

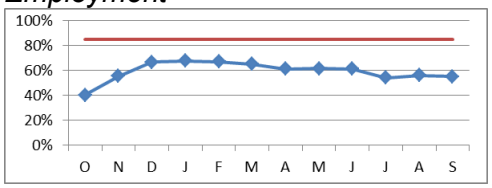
SE 18: Cluster Reviews



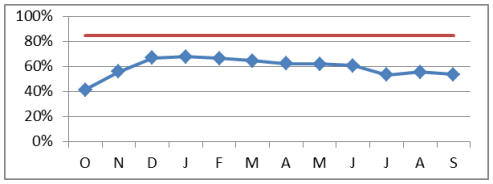
Cluster reviews have fallen from 87.89% in Q2 to 86.2% in Q3. This reflects the same issues as for risk assessments, with caseload and capacity pressures, particularly across adult community services. Services are prioritising access and risk issues above clustering, but trying to maintain performance where possible.

SE21: Employment and Accommodation

Employment

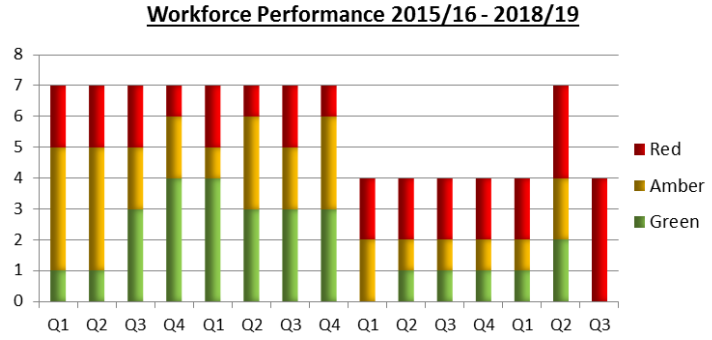


Accommodation



Employment status has improved to 61.12% from 57.26% in Q3, whilst Accommodation status had decreased slightly to 56.91% from 57.29%. The introduction of SPIKE 2 allows individual clinicians to see gaps in their recording, and is expected to improve recording of both indicators over the coming months.

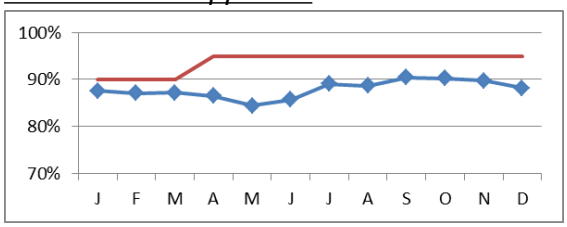
Resources – Workforce (W1 – 9)



The table below shows Workforce monthly indicators that have been rated as red or amber in Q3, with movement from Q2 position and the shortfall from target. The Pulse Survey did not run in Q3, due to the National Staff Survey being sent out in this period.

Workforce KPI	Q3 Performance	Movement from Q2	Shortfall from Target
W5: PDP and Appraisal	88.13% (2,376/2,696)	-2.3%	185 (95%)
W6: Mandatory Training	85.95% (25,782/29,996)	+ 1.55%	1,814 (92%)
W7: Sickness Rate	4.61%	- 1.16%	0.61%
W8: Turnover Rate	16.4% (479.88/2,890)	+ 0.6%	191 (10%)

W5: PDP and Appraisal



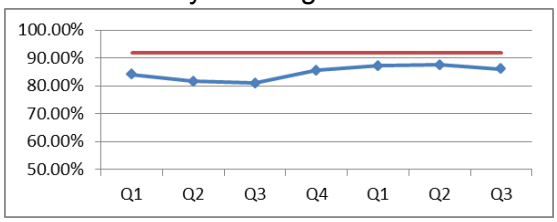
The Trust's overall PDP rate has decreased by 2% to 88% in Q3. The PDP rates for each SBU are as follows:

- LD&F 86%
- East & North 91%
- West 91%
- Corporate 79%

PDP rates have decreased in three of the SBUs and remained constant in East and North Herts. All areas receive monthly management reports detailing completion rates.

Managers will be supported during Q4 with the data required to ensure that staff have completed PDPs in Quarter 4. Within the LD&F SBU, PDP compliance is an area of major focus with scrutiny by the Managing Director and at the monthly Core Management meetings. East and North Herts are undertaking work to identify and upskill Band 5 and 6 staff to support with appraisals of lower banded staff, and management training will be provided.

W6: Mandatory Training



The compliance rate for Statutory and Mandatory Training has dropped to 86% from 87.5% over the last quarter. The mandatory training rates by SBU are as follows:

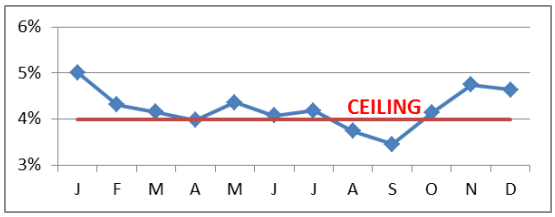
- Corporate 85%
- LD&F 90%
- East & North 86%
- West 85%

There has been a huge cleansing exercise on Discovery to ensure staff have been mapped with the correct competencies and certifications. A significant amount of work continues to take place to increase compliance rates. The Learning and Development Service are working with Subject Matter Experts (SME) and Professional Leads to increase the compliance and map out the 2019/ 2020 training plan. The training plan will ensure we commission enough training for all staff who are non-compliant, or become non-compliant, to book onto.

Discovery is now fully self-serve and 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. Discovery user guides have been launched, published and sent to main training sites and teams. An updated FAQ document is now available on the intranet for staff to access. The L&D team have worked on re-branding and updating the L&D Intranet

portal page to make this more user-friendly and documents easily accessible for staff. The reporting on Discovery has been enhanced for managers to access their staff compliance.

W7: Sickness Rate

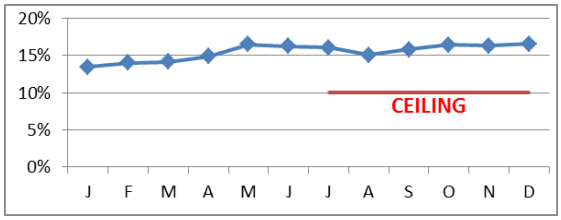


The sickness absence rate has increased this quarter from 3.45% in Q2 to 4.61% in Q3 and is above the Trust target of 4%. However, compared to the 2017/18 Q3 sickness absence rate of 4.72 % there has been an improvement.
There has been an increase in the sickness absence rates across all business units with all having sickness levels exceeding the Trust target.

Within West SBU particular hotspots are the Inpatient areas and Single Point of Access. Within Learning Disabilities and Forensic Services, North Essex LD, East and West Community LD Nursing Services and the Lexden AT&T Inpatient Unit are principally contributing to the high sickness levels. In East and North Herts SBU the Older Peoples Community services and Older People Inpatient Units are the primary areas of attention.

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. The importance of early intervention with return to work meetings is emphasised. The top reason for sickness is cough, colds and flu. 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, resilience training, and Schwartz Rounds all seems to be having a positive impact on staff.

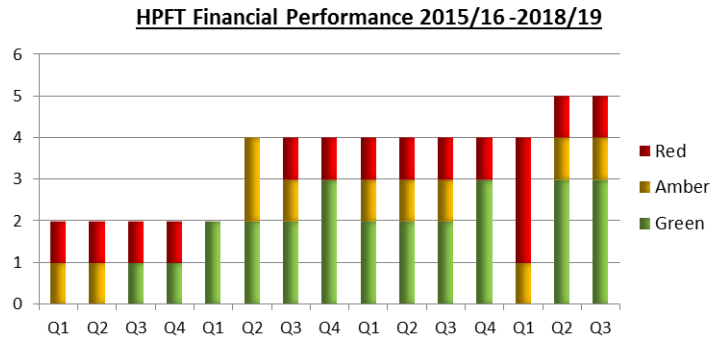
W8: Turnover Rate



The turnover rate has increased slightly to 16.4% in Q3. The Trust's unplanned turnover rate this quarter was 12.44%. Unplanned turnover excludes those staff who leave the Trust as a result of retirement, end of a fixed term contract or dismissals.

A number of retention initiatives have been introduced and are in the process of being evaluated. These processes will be reviewed if necessary. These include the retire and return process, the internal transfer process for nurses and HCAs which will be expanded to include all staff, and the buddy scheme which provides new starters with additional support in their new roles in the Trust, 100 day interviews and health and wellbeing activities. Further work in ensuring that these initiatives are communicated and fully embedded in the Trust is underway.

Resources – Finance (F1 – 5)



For December the financial position reported was a surplus of £182k for the month, ahead of the Plan of £78k by £104k, and a surplus of £408k for the year to date, ahead of the Plan of £113k by £295k, and exceeding the full year Plan of £360k. This is an improvement on the last 2 months which averaged £69k surplus each month; there were several reductions in expenditure which allowed for additional provision to be made for current Estates and Environment works to address the outcomes of PLACE audits and a full review of environments recently undertaken by the Estates & Facilities Team.

All figures are reported before any income from the Provider Sustainability Fund (PSF), which is expected to be £1.2m for the year to date, which reflects that the Control Total has been met so far. The NHSI Use of Resources (UOR) Rating has improved to an overall 1.

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000	Trend
Overall Surplus (Deficit)		78	182	113	408	360	↑
Pay Overall		12,876	12,560	115,423	113,231	154,068	↔
Agency		611	487	5,496	5,492	7,328	↑
Secondary Commissioning		2,598	2,713	23,095	24,720	30,676	↔

The reported position remains encouraging, and ahead of both the Published Plan and the Forecast Recovery Plan, though this does include £1.4m reversals of old year accruals and provisions in Quarter 1. The key message is the progressive improvements in recent months in a number of areas, such as secondary commissioning and agency costs, with the NHSI Ceiling being met year to date for the first time this month:

1. Total Pay is reported below Plan for the year to date by £2.2m (1.9%) and for the month by £316k (2.5%). This reflects the level of vacancies, not all of which are covered, and agency levels which continue to reduce, now below the NHSI Ceiling for the month and for the year to date. Agency costs represent under 4% of the overall pay spend, the lowest level for several years (average 5.2% over the last 12 months).
2. Secondary commissioning is reported above Plan by £115k for the month and £1.6m for the year to date, with no change from November despite the additional day in the month (i.e. a real reduction of c. £90k). Improvements in the month include CAMHs

(£54k reduction due to recalculation and reduction in activity); Acute and PICU (£28k due to decreased activity although January is increasing again); and Personal Budgets (£19k). These were offset by increases for Adult MH Health Placements (£34k, had been expected due to several new placements made); and Social Care Placements (£68k). It is expected that both PICU and Adult MH Health Placements will increase in January due to activity increasing again and until the New Sovereign House opens.

3. Income reported better than Plan by £18k in the month and £639k year to date, with main block contracts worse than Plan by £131k in the month and £774k year to date mainly due to reduced Herts CQUIN expected (c. £250k), reduced activity for NHSE Specialist Services (c. £500k), and reduced CQUIN for North Essex LD for Quarters 1 and 2 (£58k).
4. Overhead costs continue to spend above Plan, at c. 3.5% year to date; this is a reduction from previously stated 5% as Sub-contracts which deliver services such as within IAPT and North Essex LD have been moved to Direct Costs which reflects their nature. 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 related to improving environments.

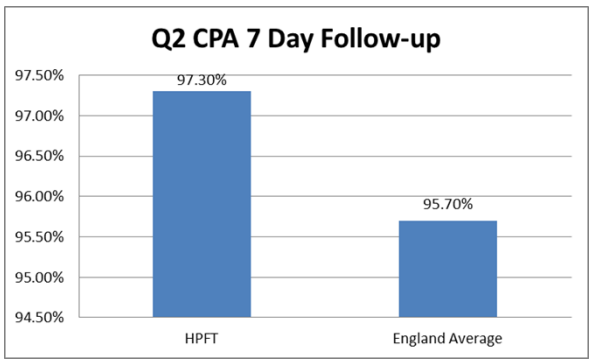
Overall therefore the Quarter 2 improvements were sustained into Quarter 3, with a return to surplus. There remains a level of risk driven by the small surplus margin, significant demand volatility (particularly relating to Secondary Commissioning), and ongoing workforce pressures. It is though expected that the Control Total will be exceeded for the full year.

6. Quality Account

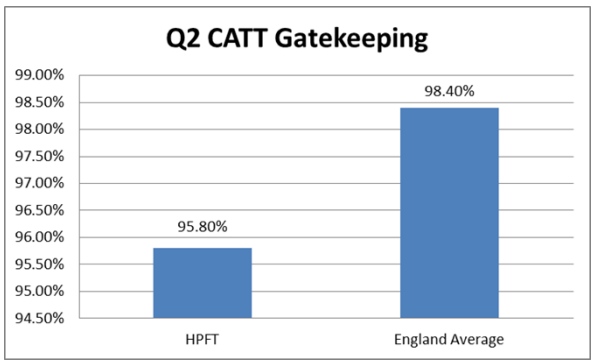
Performance for the Quality Account in 2018/19 can be found in Appendix 2. Of the 15 separate indicators 10 are rated as green, one is unreportable in Q3 (Staff FFT, which comes from the Pulse Survey), three have no set target and one indicator, CAMHS 28 day routine waits, remains rated as red.

7. Benchmarking/National Comparison Data

Mental Health Community Team Activity Q2

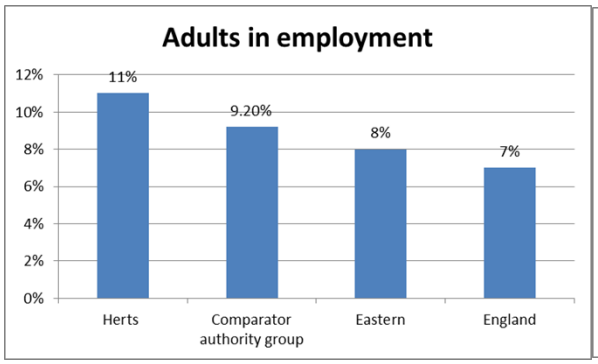


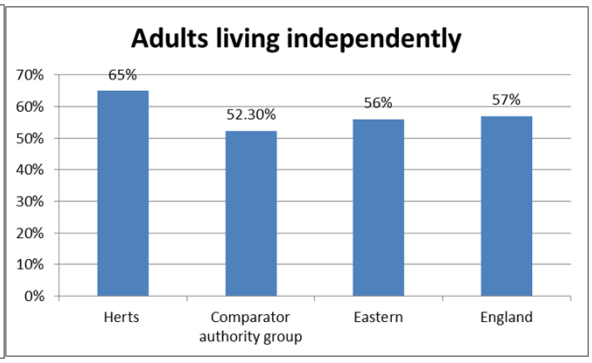
HPFT had a total of 359/369 (97.3%) discharges that were followed up within 7 days in Q2. This compared with the England Average of 16,350/17,080 (95.7%). 22 Trusts scored higher than HPFT, but of those 22 only Tees, Esk and Wear Valleys and Barnet, Enfield and Haringey had a similar or greater number of discharges. 35 trusts scored lower than HPFT.



HPFT had a total of 295/308 (95.8%) gate-kept admissions in Q2, compared to the England Average of 16,307/16,565 (98.4%). Only 4 trusts had a lower score than HPFT. Of the ones that scored higher, 39 had fewer admissions than HPFT, but the remaining 18 all scored higher and had a greater number of admissions.

Adult Social Care Framework 2017/18





The charts above show the published data for HPFT in 2017/18 against a comparator authority group, England average and the Eastern region average. In all cases HPFT had the highest performance. These results demonstrate the improvement in recording of employment and accommodation statuses over the last 2 years and reflects the hard work of operational teams and data quality officers. With the introduction of SPIKE 2, it is anticipated that performance for 18/19 will improve further.

Ref	Standard[20]	Frequency	Standard[17]	Current Period Numbers (Q3 2018)	Current Period (Q3 2018 UNLESS STATED)	Previous Period (Q2 2018 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4)
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%	50/56	89.29%	86.54%	2.75%		↔
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 10/12/18**	
	b) early intervention in psychosis services		>=90%	N/A	85.4% (Provisional)	83.6% (Provisional)			↑
	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%		94.2% in Q1	94.7% in Q4	-0.50%	**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%	1,975 / 3,675	53.74%	53.54%	0.20%	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↔
	• waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks	Monthly	>=75%	6,263 / 6,821	91.82%	91.89%	-0.07%	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↔
	- within 18 weeks	Monthly	>=95%	6,812 / 6,821	99.87%	99.95%	-0.08%	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↔
SOF5	Inappropriate out-of-area placements for adult mental health services	Monthly	83 (Per month) 250 for Q3		9	30	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.

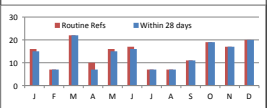
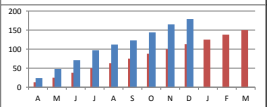
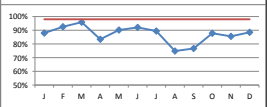
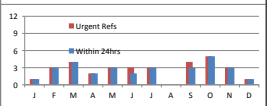
21 In line with the recommendation of the 5YFV for mental health, providers should be working with commissioners to ensure that crisis resolution home treatment teams are delivering care in line with best practice standards (www.ucl.ac.uk/core-resource-pack/fidelity-scale).
For 2016/17, commissioners 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.

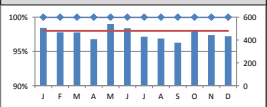
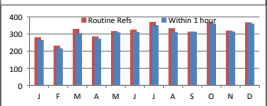
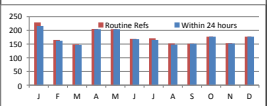
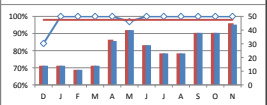
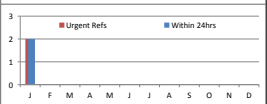
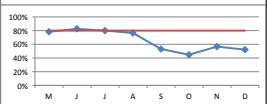
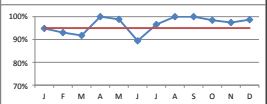
22 This standard applies to anyone with a suspected first episode of psychosis aged 14-65.Exclusions must not be made of people aged >35 who may historically not have had access to specialist EIP services. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.
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

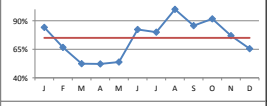
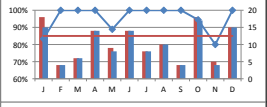
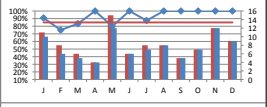
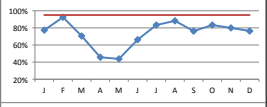
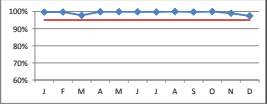
23 Board declaration but can be triangulated with results of CQUIN audit which will be for a sample of patients in each service area). People with psychosis should receive:
> a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's records
> a record 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/

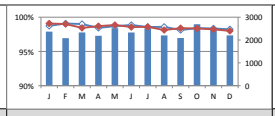
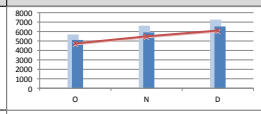
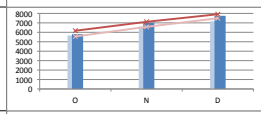
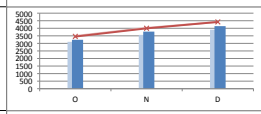
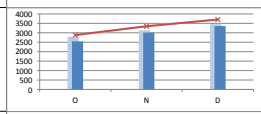
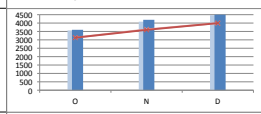
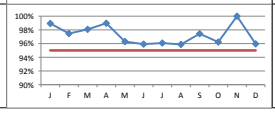
24 Comprising: NHS number, date of birth, postcode, current gender, registered GP org code, commissioner org code

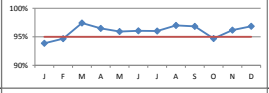
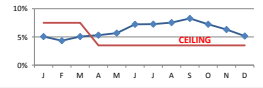
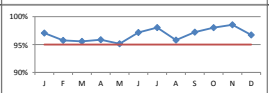
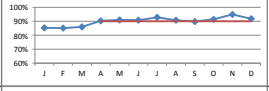
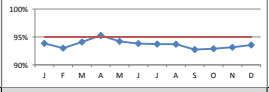
25 For achievement by 2016/17 year-end. Comprising: ethnicity, employment status (for adults only), accommodation status (for adults only), ICD10 coding. Note: ICD10 for CYP may be supplanted by capture of a problem descriptor, rather than a formal medical diagnosis.

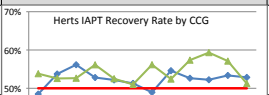
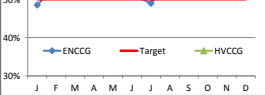
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**	>=98%		4/4	100.00%	100.00%	0.00%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A2	Routine referrals to community eating disorder services meeting 28 day wait **(Contractual)**	>=98%		56/56	100.00%	100.00%	0.00%	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)		56	179 (YTD)	123 (YTD)	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%		1,148 1,316	87.23%	80.74%	6.49%		↓
A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**	>=98%		9/9	100.00%	85.71%	14.29%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔

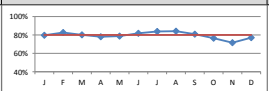
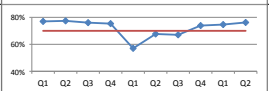
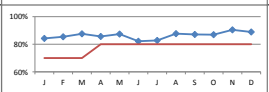
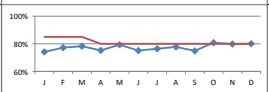
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
A6	CATT referrals meeting 4 hour wait **(Contractual)**	>=98%		1,362 1,362	100.00%	100.00%	0.00%		↔
A7	RAID Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A		1,020 1,037	98.36%	95.78%	2.58%		↔
A8	RAID Response times: 24 hour wait for ward referrals (Lister & Watford combined)	N/A		446 447	99.78%	97.89%	1.89%		↔
A9	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**	>=98%		120 121	99.17%	100.00%	-0.83%		↔
A10	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait **(Contractual)**	>=98%		N/A	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)	>=80%		230 455	50.55%	69.34%	-18.79%		↑
A12	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**	>=95%		213 217	98.16%	98.80%	-0.64%	Note - data audit taking place on April 2018 data has delayed the availability of this KPI for reporting	↔

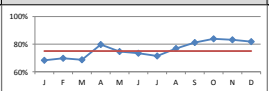
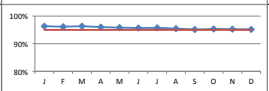
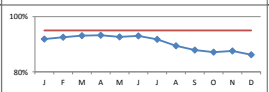
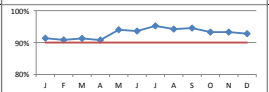
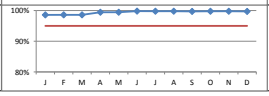
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
A13	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**	>=75%		71/92	77.17%	86.84%	-9.67%		↔
A14	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**	>=85%		36/38	94.74%	100.00%	-5.26%		↔
A15	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**	>=85%		28/28	100.00%	95.24%	4.76%		↔
A16	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**	>=95%		288 358	80.45%	83.20%	-2.76%		↓
A20	SPA referrals with an outcome within 14 days (Internal)	>=98%		6,997 7,076	98.88%	99.82%	-0.93%		↔

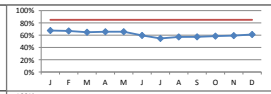
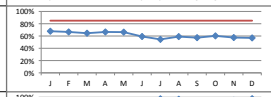
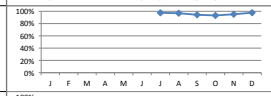
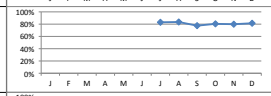
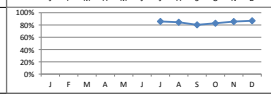
A21	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services **(Contractual)**	>=98%		7,388 7,523	98.21%	98.38%	-0.18%		↔
Ref	**Indicator**	**Target**	**12 month Trend**	**Current Period Numbers (Q3 2018/19)**	**Current Period Performance (Q3 2018/19)**	**Previous Period Performance (Q2 2018/19)**	**Change on previous period**	**Comments and Data Quality Issues**	**Forecast for next period (Q4 2018/19)**
A22	Number of people entering IAPT treatment (ENCCG) **(Contractual)**	6106 to end of Q3		623 (612) in December	6538 (6106)	4339 (3988)	N/A		↔
A23	Number of people entering IAPT treatment (HVCCG) **(Contractual)**	7913 to end of Q3		741 (800) in December	7748 (7913)	4762 (5168)	N/A		↑
A24	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**	4419 to end of Q3		362 (425) in December	4141 (4419)	2649 (2946)	N/A	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↔
A25	Number of people entering IAPT treatment (West Essex) (Contractual)	3702 to end of Q3		344 (356) in December	3357 (3702)	1981 (2468)	N/A		↔
A26	Number of people entering IAPT treatment (NE Essex) (Contractual)	3996 to end of Q3		452 (400) in December	4646 (3996)	2981 (2664)	N/A		↔
A27	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	>=95%		286 294	97.28%	96.39%	0.89%		↔

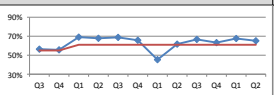
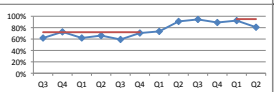
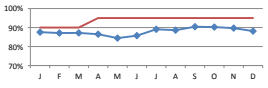
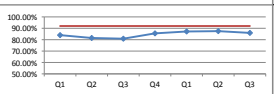
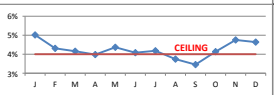
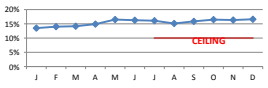
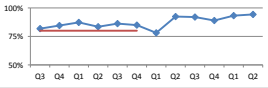
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
SE1	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	>=95%		737 761	96.85%	96.83%	0.01%		↔
SE2	Delayed transfers of care to the maintained at a minimal level	<=3.5%		2,256 36,193	6.23%	7.68%	-1.45%	Data taken from Trust SPIKE report on 17/01/2019 - 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%		402 411	97.81%	97.11%	0.70%		↔
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		381 411	92.70%	91.32%	1.38%	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%		15,415 16,477	93.55%	92.74%	0.81%	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 (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
SE6	IAPT % clients moving towards recovery (ENCCG)	>=50%		462 875	52.80%	52.15%	0.65%	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↔
SE7	IAPT % clients moving towards recovery (HVCCG)	>=50%		732 1,300	56.31%	55.39%	0.92%	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↔
SE8	IAPT % clients moving towards recovery (Mid Essex)	>=50%		328 668	49.10%	52.75%	-3.65%	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↑
SE9	IAPT % clients moving towards recovery (NE Essex)	>=50%		284 517	54.93%	54.30%	0.64%	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↔
SE10	IAPT % of clients moving towards recovery (W Essex)	>=50%		169 315	53.65%	50.76%	2.89%	Data taken from Trust SPIKE report (locally reported data) on 17/01/2019	↔

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**	>=80%		47/61	77.05%	80.86%	-3.82%	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%		N/A	N/A	76.21%	N/A	Pulse survey not completed for Q3, due to National Staff Survey.	↔
SE13	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=80% (Since Apr 2018)		1,310 1,478	88.63%	85.73%	2.90%		↔
SE14	Rate of service users saying they are treated in a way that reflects the Trust's values	>=80% (Since Apr 2018)		3,705 4,613	80.32%	76.27%	4.05%		↔

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
SE16	Rate of carers that feel valued by staff **(rolling 3 month basis)**	>=75%		81/99	81.82%	81.18%	0.64%		↔
SE17	Percentage of eligible service users with a PbR cluster	95%		9,975 10,481	95.17%	95.15%	0.02%		↔
SE18	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)	95%		8,582 9,956	86.20%	87.89%	-1.69%	Adult Community: 81.63% Acute: 92.88% Older Peoples: 96.06% E&N SBU: 86.96% WEST SBU: 84.84% LD&F SBU (Rehab): 97.56%	↔
SE19	Data completeness against minimum dataset for Ethnicity (MHSDS)	90%		64,974 69,784	93.11%	91.60%	1.50%	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%		137,782 138,174	99.72%	99.72%	0.00%	Previously SOF4 measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Data taken from Trust SPIKE report on 17/01/19	↔

SE21	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • Employment	>=85%		9,176 15,013	61.12%	57.26%	3.86%	Data taken from last month of each quarter. Data taken from Trust SPIKE report on 17/01/19	↑
	• Accomodation	>=85%		8,544 15,013	56.91%	57.29%	-0.38%	Data taken from last month of each quarter. Data taken from Trust SPIKE report on 17/01/19	↑
SE22	Rate of Service Users Saying staff are welcoming and friendly (Rolling 3 months)	TBC		170 174	97.70%	94.30%	3.40%		↔
SE23	Rate of Servie Users saying they know how to get support and advice at a time of crisis (Rolling 3 months)	TBC		145 178	81.46%	77.51%	3.95%		↔
SE24	Rate of Service Users saying they have been involved in discussions about their care (Rolling 3 months)	TBC		152 175	86.86%	80.24%	6.62%		↔

Ref	Indicator (Monitor/Contractual/Internal)	Target	24 month Trend	Current Period Numbers (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
W1	Staff saying they would recommend the Trust as a place to work	>=61%		N/A	N/A	65.2%	N/A	Pulse survey not completed for Q3, due to National Staff Survey.	
W2	Staff Wellbeing at Work	75% as of Q2 18/19		N/A	N/A	65.0%	N/A	Pulse survey not completed for Q3, due to National Staff Survey.	
W3	Rate of staff that report experiencing physical violence from service users	5% as of Q2 18/19		N/A	N/A	9.16%	N/A	Pulse survey not completed for Q3, due to National Staff Survey.	
W4	Staff skills and capability	95% as of Q2 18/19		N/A	N/A	80.8%	N/A	Pulse survey not completed for Q3, due to National Staff Survey.	
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q3 2018/19)	Current Period Performance (Q3 2018/19)	Previous Period Performance (Q2 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q4 2018/19)
W5	Rate of staff with a current PDP and appraisal	>=95% as of Apr 2018		2,376 / 2,696	88.13%	90.44%	-2.30%		↑
W6	Rate of mandatory training completed and up to date	>=92%		25,782 / 29,996	85.95%	87.50%	-1.55%		↑
W7	Sickness rate	<=4%		12,388.29 / 268,655.52	4.61%	3.79%	0.82%		↔
W8	Turnover rate	10% as of Q2 18/19		479.88 / 2,890	16.60%	15.86%	0.74%		↔
W9	Living the Values at work	target under review		N/A	N/A	94.30%	N/A	Pulse survey not completed for Q3, due to National Staff Survey	

Ref	Financial Indicator	Target	Current Period YTD Plan (December 2018/19)	Current Period YTD Performance (December 2018/19)	Previous Period YTD Performance (November 2018/19)	Change on previous period	Comments	Forecast for next period (January 2018/19)
F1	To Achieve Surplus (amount to be confirmed) in year (not including STF)	**£0.36 million in year**	£113k surplus	**£408k surplus**	**£226k surplus**	**£182k surplus**	**Position achieved through balance sheet support**	↔
F2	Use of Resources (formerly Financial Service Risk Rating)	**1**		**1**	**2**	**-**		↔
F3	To keep Agency Spend below the NHSI Agency Ceiling (£8.5 million for the year)	**£7.327 million in year**	£5,495k	**£5,492k**	**£5,005k**	**£487k**		↔
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**		**334**	**400**	**-66**		↔
F5	Projected CRES (Cash Releasing Efficiency Saving) in Financial Year	**£4,669k**	£4,875k	**Full year forecast £4,875k**	**Full year forecast £4,875k**	**£0**		↔

Quality Account: Priority Areas for 2018/19

Patient (service user) Safety		Target	Q1	Q2	Oct	Nov	Dec	Q3
1	Every discharge 7 day follow up	≥=95%	96.05%	97.11%	98.03%	98.54%	96.72%	97.81%
3	CAMHS 28 day wait for routine referrals	≥=95%	50.95%	83.2%	83.33%	80%	76.32%	80.45%
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)	1322* Incidents 1.13% (15)				994* Incidents 0.60% (6)
4	Number of inappropriate out of area placements	275 (Q2)	165	30	0	9	0	9
Clinical Effectiveness								
6a)	Emergency readmission within 28 days 16 +		4.70%	6.26%	6.29%	4.58%	3.9%	5.19%
6b)	Emergency readmission within 28 days 0 - 15		0.2%	0.42%	0%	0%	1.95%	0.41%
7	First Episode Psychosis (FEP) waits 14 days (NHSI mandatory)	≥=53%	85.92%	86.54%	80.95%	90.48%	100%	89.29%
8	CATT Gatekeeping	≥=95%	97.1%	96.39%	96.23%	100%	95.96%	97.28%
9a)	Improving Access to Psychological Therapies (IAPT) recovery rate	≥=50%	53.32%	53.54%	55.08%	53.8%	51.98%	53.74%
9b)	IAPT 6 week wait	≥=75%	83.68%	91.89%	92.29%	93.23%	89.24%	91.82%
9c)	IAPT 18 week wait	≥=95%	99.79%	99.95%	99.88%	99.88%	99.84%	99.87%
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%	76.27%	80.81%	79.8%	80.1%	80.32%
10	Carers feeling valued by staff	≥= 75%	73.42%	81.2%	83.87%	83.16%	81.8%	81.82%
11	Staff Experience Friends and Family Test	≥= 70%	74.64%	76.21%				
12	Service Users Friends and Family Test	≥= 80%	85.54%	85.73%	86.9%	90.4%	88.9%	88.63%

*figures are provisional and taken from Datix; NRLS provide 6 monthly data.
All data refreshed from Q2.

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS

Meeting Date:	7th February 2019	**Agenda Item: 14**
Subject:	Annual Plan 2018/19 - Quarter 3 Report (Mid-year review)	**For Publication: Yes**
Author:	Ian Love, Deputy Director Commercial Development	**Approved by:** Ronke Akerele, Director of Innovation and Improvement
Presented by:	Ronke Akerele, Director of Innovation and Transformation	

Purpose of the report:

To present the Trust's performance against the Annual Plan for Quarter 3

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 3 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 3. The following table sets out the headline progress against each objective in the quarter and the areas for continued focus:

	Objective	Q3 Progress	Areas for focus
1	We will provide safe services, so that people feel safe and are protected from avoidable harm	While progress continues to be made against the milestones, across a range of planned safety initiatives, our performance against the expected outcome is yet to be realised and is not on track to meet our ambitions by year end. Progress to note include: • Safety initiatives being rolled out across the Trust such as 'feeling safe' activities on inpatient services, safety crosses, safety huddles and zonal observations. • The new module of RESPECT has been developed and a pilot has been run on Oak ward. • A Suicide Prevention Group has been established.	Continued focus on activities to reduce aggression and build on the work of the recent suicide prevention deep dive on unexpected deaths to improve training and 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	Solid progress has been made against the objective during quarter 3 which includes: • The New Acute Care Model for 13-17 year olds, Home Treatment Team and 72 hour acute pathway, now in place • Ahead of plan in relation to reduction in out of area placements for adult acute • Additional works completed in major hubs to improve the look and feel and accessibility of services • Extensive training of all reception staff to improve their customer service skills carried out in quarter • Near site testing now in 4 sites across the trust in keeping with original plan.	Continue with ongoing proactive engagement with commissioners, through a range of initiatives, to improve access to our adult services and associated high DNA rates
3	We will improve the health of our service users through the delivery of effective evidence based practice	Progress continues to be made across the milestones with the Personality Disorder model, funding and implementation agreed by the Trust Management group, Executive and by the Board. A clinical outcomes framework has been developed and agreed for Dementia and First Episode of Psychosis pathway. Data on readmission rates and employment status is being captured through SPIKE 2. A deep dive into the research strategy is being presented to the executive and work has already started on benchmarking at the regional level and within Learning disability services.	Further work to be undertaken to implement the Personality Disorder pathway. Continued work to increase the number of service users able to access work based training and employment Ongoing engagement with key internal and external stakeholders to fully develop Trust's research strategy. Build on reporting to ensure readmission rates and employment status targets are met

4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	Launch of new careers website to aid in attracting more staff to the Trust. Progress on talent management and succession planning including on early deployment of the high performing team model. There has been a pilot of high performing team model with three teams and feedback is currently being evaluated. Flexible working initiatives continue to be highlighted in our recruitment process. There has been a continuing effort to reduce our time to hire and an extension of notice periods for staff bands 5.6 to 8 weeks and band 7 to 12 weeks. Staff engagement events have also continued with the Good to Great Roadshows as well as the Senior Leaders Forum and the annual staff awards and development awards.	There has been progress across various initiatives with ongoing effort in Q4 to support managers on talent management and succession planning. There will be a soft launch of high performing team model in Q4 including the recruitment of additional resources as team facilitators to support staff in embedding the model. .
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	Efficiency plans delivering against target during the quarter and the underlying financial performance has improved in Q3 to bring the run rate back to plan Good progress has been made against the quarter three deliverables: • Increase use of equipment to support flexible/mobile working. • Increased deployment of devices with no backlogs on placed orders. • Effective ways of management of Subject Access Requests and Freedom of Information requests • Better access to clinical information with SPIKE 2 implementation to super users. • Productivity stream of 'Making Time to Care' was key element of Good to Great Roadshows in Q3. • Trust Board and organisational endorsement of continuous quality improvement agenda. • The use of continuous quality improvement techniques and principles is being adopted in Holly Lodge and Swift Ward to learn and inform future diffusion across the Trust.	Continued focus will be required to sustain the momentum that has now been gathered in establishing Continuous Quality Improvement within the Trust, in particular the successful procurement of the QI capability development programme Implement 'productivity dashboard' in Q4 as part of the ongoing focus on the agreed "Time to Care" approach to provide measurable increases in direct contact time. To continue the spread the adoption of continuous quality improvement principles.

		• Commencement of works to establish Innovation Hub within the Colonnades.	
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	Good progress has been made across the quarter which includes Essex service mobilisation being on track and the approval of personality disorder business case. Physical Health equipment has been reviewed to aid standardisation across Trust; there is ongoing work to audit equipment use and physical health clinic operations.	Ongoing engagement with stakeholders to approve Dementia pathways outcomes Ongoing work to identify benefit realisation from the primary care mental health initiatives. The adoption of high quality equipment to support physical health monitoring
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	Focus has remained on consolidating engagement and influencing STP work streams and development of the refreshed Integrated Health and Care Strategy and further development of HPFT representation within locality provider delivery boards across the 10 Herts localities. Dementia pathways and system offer is under review with work in Q4 to embed learning from Dementia GPwSi pilot and confirming planning at locality level	Focus on proactive negotiation of a five year contract with Herts Commissioners alongside their commitment to the Mental Health Investment Standard shows ongoing commitment to MH and LD Continuing to develop the HPFT system offer on frailty including working with both Herts CCG's to agree offer for specific localities. Maintaining high visibility in the STP, providing leadership and development of the MH work stream and leadership in a number of areas

Conclusion

This report sets out the extensive activity undertaken during Quarter 3 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 3. 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 3 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 (extended Exec with Senior Leadership Team)18 July 2018

Appendix 1 – Annual Plan 2018/19 - Quarter 3

Commentary against Milestones and Outcomes

Great Care, Great Outcomes

Strategic Objective 1 (Owner JP/AZ)	Q3 Key Actions / Milestones	Q3 Milestones Rating
We will provide safe services, so that people feel safe and are protected from avoidable harm	• Roll out 'Feeling Safe' activities (e.g. peer support listening, safety huddles, red to green) across all inpatient units • Implement a new Safety Strategy • Put in place an 'Always Events' approach across the Trust • Quality improvement project from review of incidents • Roll out programme & implement the new module for restrictive practice training. • Quality improvement project to address % feeling safe implemented • Further develop care pathways for those who have a dual diagnosis. • Ligature report produced and actions developed	
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	<u>Feeling Safe</u> 'Feeling safe' activities, using continuous quality improvement methodology, have been rolled out across all in patient services, including, but not exclusively, safety crosses, safety huddles, red to green and zonal observations. <u>Safety Strategy & Always Events</u> The consultation on the final draft of the Quality Strategy will take place in Q4 and 'Always events' are being incorporated into this work. <u>Quality improvement</u> A continuous quality improvement approach has been taken to learning from incidents. One example, that has seen positive results, was in relation the use of non-anchor ligatures in Robin Ward and Forest House Adolescent Unit. Following the review of RESPECT, the new module has been developed and a pilot has been run on Oak ward. This will be rolled out in Q4. <u>Ligature Report</u> The ligature report has been incorporated into the integrated safety report.	

Summary:	Key Outcomes at Year End
As at Q3 the achievement of the year end outcomes looks unlikely for all metrics. On current information, we anticipate that we will not meet our year-end target for the reduction of suicides	10% reduction in number of suspected suicides

The overall improvements in the % service users reporting feeling safe, noted in previous quarters, have been sustained. Quarter 3 2018/19 has seen a 15% increase in service user to service user assault, with two SBUs seeing an increase and one seeing a decrease compared to quarter 2 of 2018/19. Over the year the number of incidents has remained at the same level. With regards to service user to staff assaults, there was a 2% increase across the SBU's from quarter 2. Over the year, the number of aggression and violence incidents of each type has remained stable, without the planned 10% reduction	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)	Q3 Key Actions / Milestones	Q3 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	• Full acute pathway for T4 CAMHS in place • Improved acute pathway in place • Physical environments in Community Hubs to improve the look, feel and accessibility of our services • Near site testing Clozapine Clinics in place fully rolled out	

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).	• Key elements of the New Acute Care Model for 13-17 year olds, Home Treatment Team and 72 hour acute pathway, now in place • Significantly ahead of plan in relation to reduction in out of area placements for adult acute • Additional works completed in major hubs to improve the look and feel and accessibility of services, including refurbishment of Saffron Ground and changes to Colne House to increase their capacity for staff and service users. • Extensive training of all reception staff to improve their customer service skills carried out in quarter • Near site testing now in 4 sites across the trust in keeping with original plan. The success of this work had led to the expansion to include all locations where Clozapine is dispensed.

Summary:	Key Outcomes at Year End
Excellent progress against the milestones in the quarter and clear improvements the experience of service users, carers and families. We remain on track to reduce out of area placements. We are continuing 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)	Q3 Key Actions / Milestones	Q3 Milestones Rating
We will improve the health of our service users through the delivery of effective evidence based practice	• Implement new All age Personality Disorder pathway across the Trust • Work with the Prince's Trust to increase the number of service users able to access work based training and employment • Develop new model of research and research strategy for the organisation, which is fully aligned to innovation and improvement.	

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	Personality Disorder model and pathway has now been agreed by the Trust Management group, Executive and by the Board. Funding has been agreed. Recruitment will now start. Clinical outcomes frame work has been developed and agreed for Dementia and First Episode of Psychosis pathway. The trust PAIG group has representation from service users and carers. Audit leads have been appointed in all the SBU to share learning from audits. Data on readmission rates and employment status is being captured through SPIKE 2. DNA data has shown only a modest improvement after change in standard operating procedure introduced for initial assessments. Further work is needed to reduce the DNA rates. Physical Health Care for those with severe mental illness is reported through the national CQUIN targets. A deep dive into the research strategy is being presented to the executive. Work has already started on benchmarking at the regional level. Learning Disability services have formed a benchmarking and research network in collaboration with other mental health trusts and research groups

Summary	Key Outcomes at Year End
A clinical outcomes framework has been developed for the three identified pathways Further work is now needed to implement the Personality Disorder pathway and work with the Prince's Trust to increase the number of service users able to access work based training and employment Further focus will be needed to build on the work done to date to ensure that the Trust's research strategy is fully developed	• 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)	Q3 Key Actions / Milestones	Q3 Milestones Rating
We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	• Roll out revised talent management strategy and succession planning process across the Trust via a talent management module on Discovery • Roll out Team OD approach • Refresh of flexible working offerings • Tender for company to assist with developing a clear brand and marketing strategy to support recruitment • Investigate workload and pressures experienced by B6 and B7 managers in selected teams	
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	<u>Talent Management</u> Roll out of talent management and succession planning on Discovery has been delayed pending further work required on reporting and the supervision module. However, talent management and succession planning continues throughout the Trust with further training being delivered to support managers <u>OD Approach</u> The high performing team model has been developed, tested with senior leaders, service users and carers and developed into a workbook for teams to use. It has been piloted with three teams and feedback is being evaluated. High performing team facilitators are being recruited to support staff through the process and further teams have been identified to be part of the soft launch in Q4. <u>Flexible Working</u> Flexible working, including the retire and return process are being shared and highlighted as part of the recruitment and retention initiatives and flexible working workshop has been piloted in Learning Disabilities and Forensics, moving forward this workshop will take place on a bi monthly basis. <u>Recruitment & Retention</u> The new careers website was launched in Q3 which should assist in attracting more staff to the Trust. The contract for the new more user friendly and easier to access intranet was also signed at the end of Q3 and an implementation plan is being developed. There is also an onboarding element that should support recruitment and retention. Alongside this there has been a continued focus on reducing the time to hire through: outsourcing pre-employment checks; asking managers to complete ID checks at interview; and expanding initiatives such as the internal moves process, the 100 day interviews and the buddy scheme. In agreement with staffside we have also amended our notice periods for new Band 5 and Band 6 staff to 8 weeks and new Band 7 staff to 12 weeks.	

	Staff engagement events have also continued with the Good to Great Roadshows as well as the Senior Leaders Forum and the annual staff awards and development awards.

Summary	**Key Outcomes at Year End**
There has been progress across various initiatives with ongoing effort in Q4 to support managers on talent management and succession planning. There will be a soft launch of high performing team model in Q4 including the recruitment of additional resources as team facilitators to support staff in embedding the model.	• 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)	Q3 Key Actions / Milestones	Q3 Milestone Rating
We will improve, innovate and transform our services to provide the most effective, productive and high quality care	<u>Business Intelligence</u> • Commence implementation of a single integrated business intelligence platform (SPIKE2) <u>Video-conferencing:</u> • Increased use of GoToMeeting • Deployment of licenses for SfB for video use & screens / cameras as per business case <u>Equipment for agile working:</u> • On-going expansion of devices with data SIM support; data contracts & data usage <u>PARIS:</u> • Integration of physical health National Early Warning Score (NEWS) <u>QI agenda:</u> • QI capability development programme procurement process completed • Establish an improvement and innovation 'hub' • Adopt the use of QI learning systems	
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	***<u>Effective ways of working</u>*** • GoToMeeting utilisation increased in Q3 with 212 sessions lasting a total of 161 hours in comparison to 130 sessions of 115 hours in Q2. • All required Skype –for Business licences and equipment was procured as per the business case. 175 licences were activated in Q3 with training/deployment dates planned for Q4. • Staff continue to be issued with laptops that have data capability with 146 equipment deployed in Q3, there are currently no backlog on device orders. • There is continued effective use of Ulysses for managing Subject Access Requests and Freedom of Information request, improving compliance from 53% and 28% in Q4 2017/18 to over 96% and c66% in Q3 respectively. • Digital Utilisation (BigHand) in Q3 across existing 9 teams was 1679 dictations and 110 hours, The business case for Phase 2 required further refinement to demonstrate robust benefits realisation, the amended business case is planned to be resubmitted to Executive team in Q4.	

	Better access to right information • SPIKE 2 implementation commenced in December 2018 with super users. • Deployment of medical interoperability gateway (MIG) with East Herts MHSOP and LD teams. • Integration of physical health National Early Warning Score (NEWS) planned for Q3 was completed early in Q2. ***Embed continuous improvement and innovation*** • Productivity stream of 'Making Time to Care' was key element of Good to Great Roadshows in Q3. • Trust Board and organisational endorsement of continuous quality improvement agenda. • Resources identified as enablers of continuous quality improvement agenda. • The use of continuous quality improvement techniques and principles is being adopted in Holly Lodge and Swift Ward to learn and inform future diffusion across the Trust. • 31 staff trained in QI foundation skills. • Commencement of works to establish Innovation Hub within the Colonnades.

Summary	**Key Outcomes at Year End**
Efficiency plans delivering against target during the quarter and the underlying financial performance has improved in Q3 to bring the run rate back to plan Spike 2 is bringing real time information and supporting improved decision making with a plan to implement 'productivity dashboard' in Q4. This is ongoing focus on the agreed "Time to Care" approach to provide measurable increases in direct contact time. The continuous quality improvement agenda is being adopted with increase in numbers of workforce trained via online QI foundation platform. A number of CQI initiatives are in place in operational services that are being supported by the core team (e.g. Holly Lodge)	• 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)	Q3 Key Actions / Milestones	Q3 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	• Review the benefits of Marlowes for service users and staff, including new ways of working and lessons learnt for future integrated working • Essex LD services mobilised • Essex LD baseline satisfaction commissioners and service users • New pathways include Physical health (Psychosis, PD, Dementia) • New approach to obesity management developed in conjunction with the University of Hertfordshire • Latest technology and equipment in place to support physical health monitoring	
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	It has not been possible to fully complete the benefits review and analysis of operating from The Marlowes in the quarter.Q4. There is on-going work to understand the benefit of CAMHS co-location (as adult-service crossover is minimal) and on reviewing delivery plans with new HV provider of community services. Essex services are on track to mobilise as planned from April 2019 as contract requires (timeline changed by commissioners) Psychosis pathway implemented and personality disorder business case approved to enable the effective implementation of the pathway Dementia pathways have been drafted and outcome measures agreed – in Q4 these will be agreed with stakeholders and signed off Physical Health equipment reviewed for the purpose of standardisation across Trust – more work needed in Q4 to audit equipment use and physical health clinic operations	
Summary	**Key Outcomes at Year End**	
The service model for learning disability in Essex is on track to go live from April 19. Implementation of the new PD and dementia pathways is progressing but taking longer than anticipated	• 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	

Primary care mental health services are being commissioned in HVCCG and discussions are progressing as part of the contract process with E&N Herts CCG Further work continues to be required on meeting key targets relating to the physical health	

Strategic Objective 7 (Owner KT/JL)	Q3 Key Actions / Milestones	Q3 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)	• Implement the stakeholder plan • Undertake 'survey monkey' to gain key stakeholder feedback • Continue to lead and develop the STP mental health & LD workstream • Deliver targeted service development and bid development activities will be targeted in line with our commercial strategy • Put in place new contract management arrangements for LD • Raise the profile of accommodation, housing and employment to ensure they form a key part of STP work • Commence structured planning 2019/20	
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 proposed stakeholder plan has not been implemented in Q3. Focus has remained on consolidating engagement and influencing STP work streams and development of the refreshed Integrated Health and Care Strategy and further development of HPFT representation within locality provider delivery boards across the 10 Herts localities. Q4 focus will prioritise clarifying the HPFT system offer on frailty, preparing to implement the STP pathways and working with both Herts CCGs in nuancing the offer according to locality Dementia pathways and system offer is under review with work in Q4 to embed learning from Dementia GPwSi pilot and confirming planning at locality level	

Summary	Key Outcomes at Year End
Current negotiation of a five year contract with Herts Commissioners alongside their commitment to the Mental Health Investment Standard shows ongoing commitment to MH and LD We continue to maintain high visibility in the STP, providing leadership and development of the MH work stream and leadership in a number of areas	• 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 • 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

Meeting Date:	7th February 2019	**Agenda Item: 15**
Subject:	Q3 Workforce and Organisational Development Report	**For Publication:**
Author:	Maria Gregoriou, Associate Director of Workforce and Steve Graham Deputy Director of Workforce and Organisational Development	**Approved by:** Mariejke Maciejewski – Interim Director of Workforce and Organisational Development
Presented by:	Mariejke Maciejewski – Interim Director of Workforce and Organisational Development	

Purpose of the report:

To update the Trust Board on the Q3 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:

The majority of the workforce key performance indicators have slightly declined this quarter. The sickness absence rate has increased from 3.45% in quarter 2 to 4.61%, which is above the Trust target of 4%. The main reason given for sickness absence is colds, coughs and flu which suggests this increase in the sickness absence rate may be seasonal. However, in comparison to Q3 last year the sickness absence rate is reduced. Work continues to be undertaken on health and well-being activities including 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, wellbeing and resilience.

The vacancy rate has increased slightly this quarter to 13.18% from 12.92%.This increase is attributable to a lower number of starters this quarter and a higher number of leavers. A significant amount of work has been undertaken to reduce time to by outsourcing pre-employment checks and asking all managers to complete ID checks at interview. In addition the new careers website has been launched in Q3 which should attract more candidates to HPFT. Agreement has also been reached with Staffside to implement changes to notice periods with effect from 1st January 2019 for new staff at Band 5 and above which will bring us in line with other Trusts. Work on implementing, embedding and communicating retention initiatives also continues.

A number of staff engagement events have taken place in Q3 including the 16th Big Listen which provided useful feedback from staff regarding innovation, ideas and suggestions to improve the Trust and their working environments. In addition the Good to Great Roadshows also commenced with a focus on making more time to care. Twenty staff graduated from the Trust's Leadership Academy with further staff participating in the Mary Seacole programme. Several team development sessions have also taken place in the East & North SBU and West SBU. This quarter also saw the Trust's annual staff awards and development awards event take place, at which it was great to hear about all the wonderful things that our staff do every day to put service users and carers at the heart of everything they do. The national staff survey also took place during quarter 3 and the results will be available in Q4.

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

Summary of Financial, IT, Staffing & Legal Implications:

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

Dec 2018 - Based on Q3 2018/2019

HPFT Workforce Information Report Summary

WORKFORCE INFORMATION REPORT SUMMARY

Workforce Report Dec 2018 (Based on data for Q3 (2018/2019)

Section 1: KPI summary position

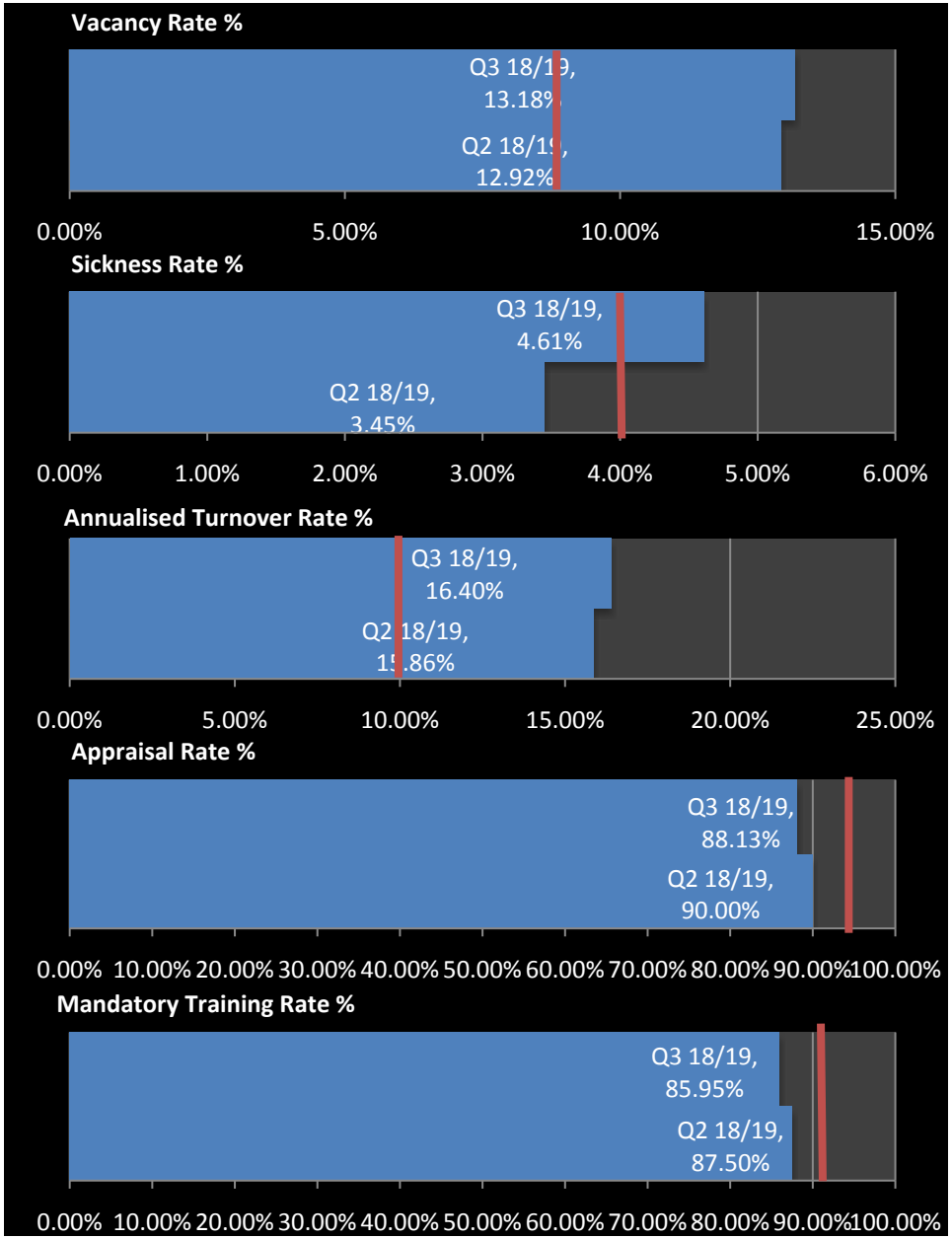
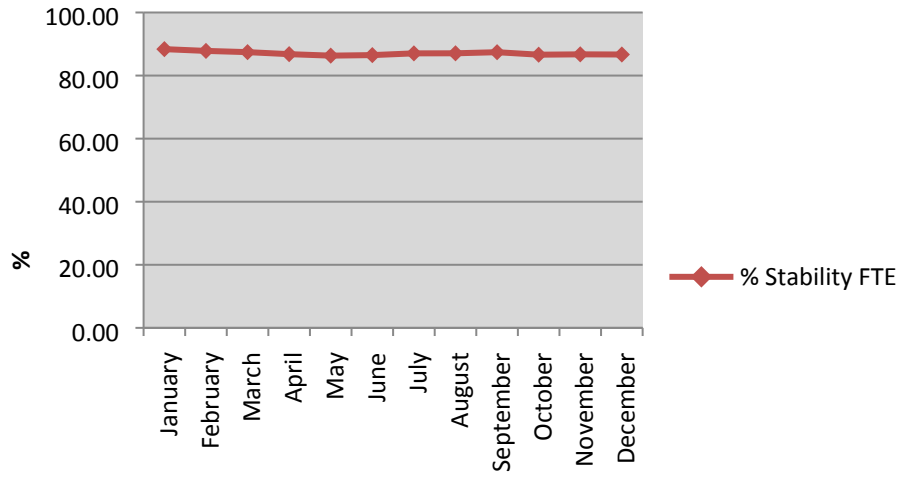


Table 1: Establishment Data

Funded Establishment =	3373.62
Staff in post =	2928.94
Vacant posts =	444.68
% Trust Vacancy rate =	13.18
Active Vacancies being recruited to =	225.99
% Total Turnover rate =	16.40
% Planned Turnover Rate =	3.96
% Unplanned Turnover Rate =	12.44
% Stability rate =	86.68

Graph 1 : % Stability



WORKFORCE INFORMATION REPORT SUMMARY

Section 2: Recruitment

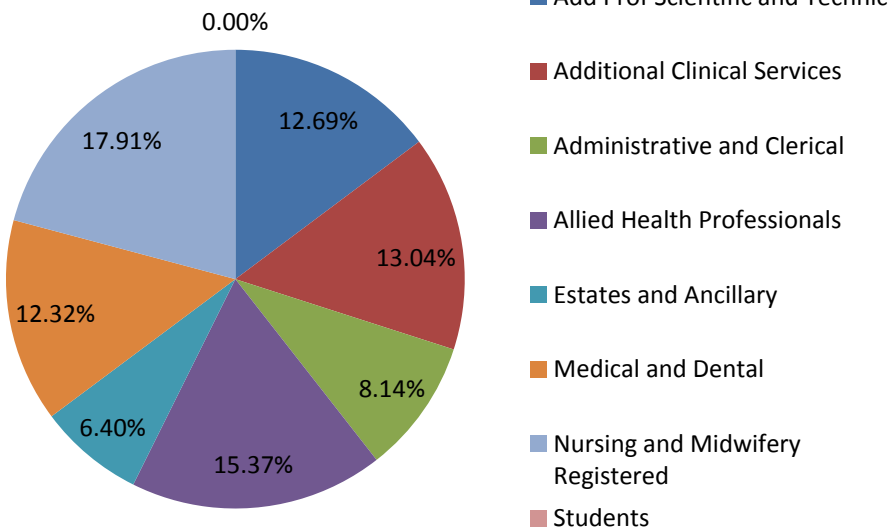
Table 2: Recruitment Summary by SBU

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Authorisation	5	4	3.74	5.6	18.34

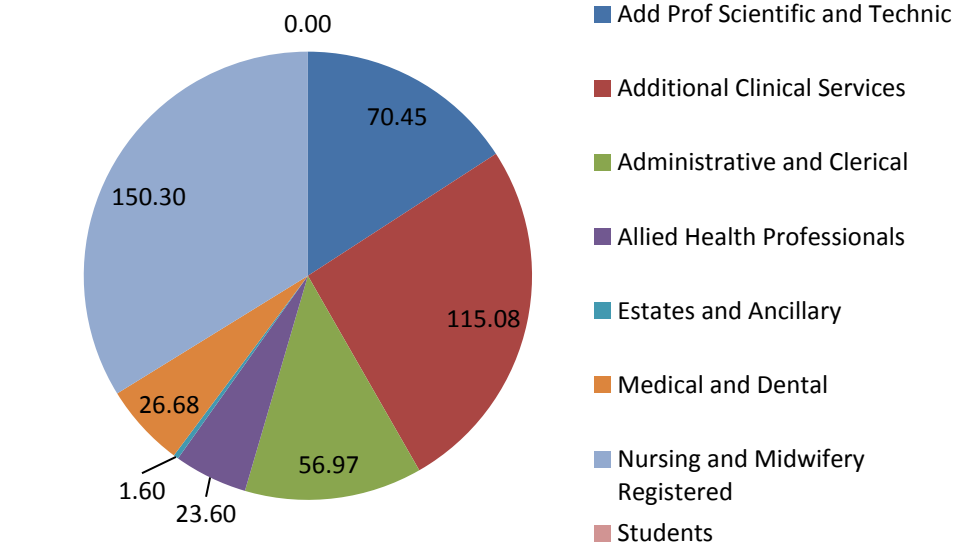
Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Longlisting	1	14	14.11	21.29	50.4
Shortlisting	4.6	4	17.05	7.7	33.35
Interview		14.1	35.92	33.87	83.89

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Offer	6.2	48.81	33.76	66.3	155.07
Starting	7	13.44	23.2	12	55.64

Graph 2: Vacancies (%) by Staff Group



Graph 3: Vacancies (fte) by Staff Group



Section 3: Turnover

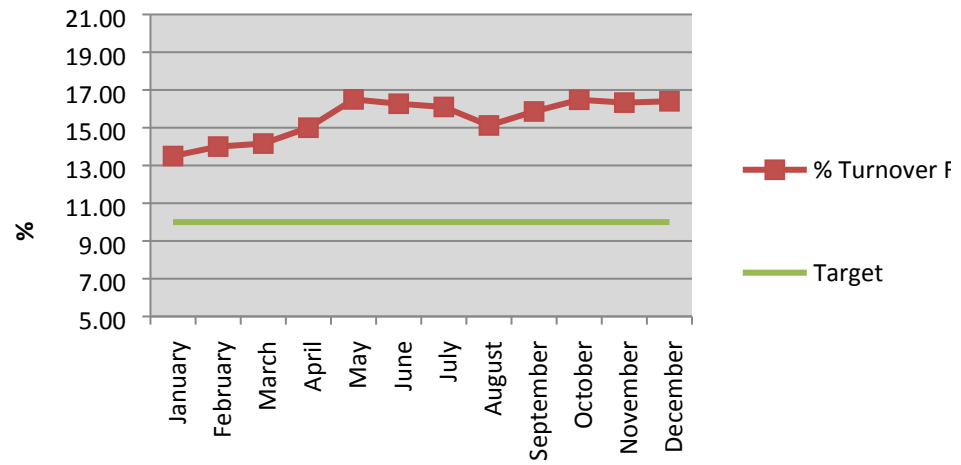
Table 3: Q3 2018-2019 Leavers by Leaving Reason

Leaving Reason	Total
Voluntary Resignation - Other/Not Known	30
Voluntary Resignation - Promotion	16
Voluntary Resignation - Work Life Balance	13
Retirement Age	12
Voluntary Resignation - Relocation	11
Voluntary Resignation - To undertake further education or training	7
Voluntary Resignation - Health	5
Voluntary Resignation - Better Reward Package	5
Voluntary Resignation - Child Dependants	4
End of Fixed Term Contract	3
Voluntary Resignation - Lack of Opportunities	3
Voluntary Early Retirement - no Actuarial Reduction	2
Dismissal - Conduct	2
Voluntary Early Retirement - with Actuarial Reduction	2
Voluntary Resignation - Incompatible Working Relationships	1
End of Fixed Term Contract - External Rotation	1
Flexi Retirement	1
Voluntary Resignation - Adult Dependants	1
Grand Total	**119**

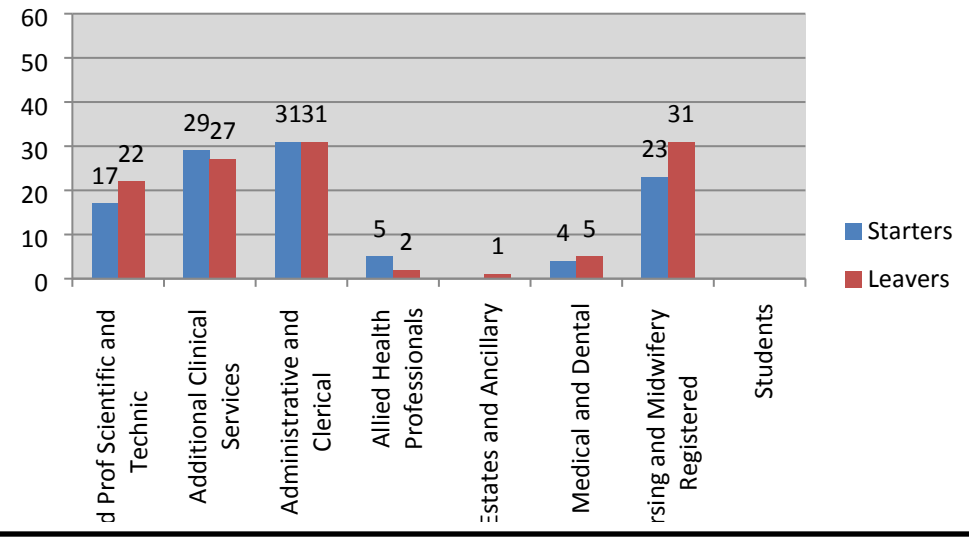
Table 4: Retirement Profile

	Age		
Retirement profile	**55-59**	**60-64**	**65+**
367 Corporate	48	19	14
367 SBU Learning Disability & Forensic	121	46	17
367 SBU MH East & North Herts	123	92	32
367 SBU MH West Herts	105	68	34
Grand Total	**397**	**225**	**97**

Graph 4 : % Turnover



Graph 5: Starters & Leavers by Staff Group Q3



Section 4: Sickness Absence

Table 5: Q3 2018-2019 Top 10 Reasons for Sickness Absence

Sickness Absence Reason	No Of Episodes
S13 Cold, Cough, Flu - Influenza	366
S99 Unknown causes / Not specified	227
S98 Other known causes - not elsewhere classified	180
S25 Gastrointestinal problems	177
S10 Anxiety/stress/depression/other psychiatric illnesses	99
S11 Back Problems	74
S16 Headache / migraine	67
S12 Other musculoskeletal problems	61
S15 Chest & respiratory problems	52
S26 Genitourinary & gynaecological disorders	47

Graph 6: % Sickness Absence by Month

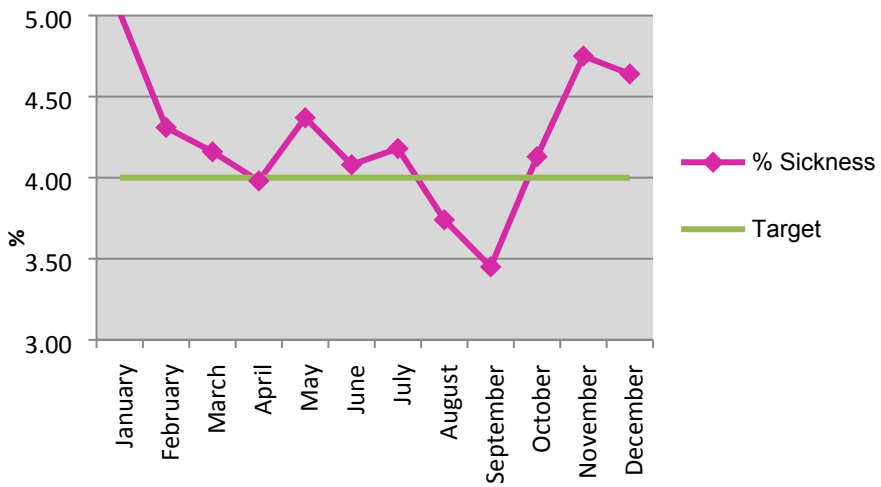
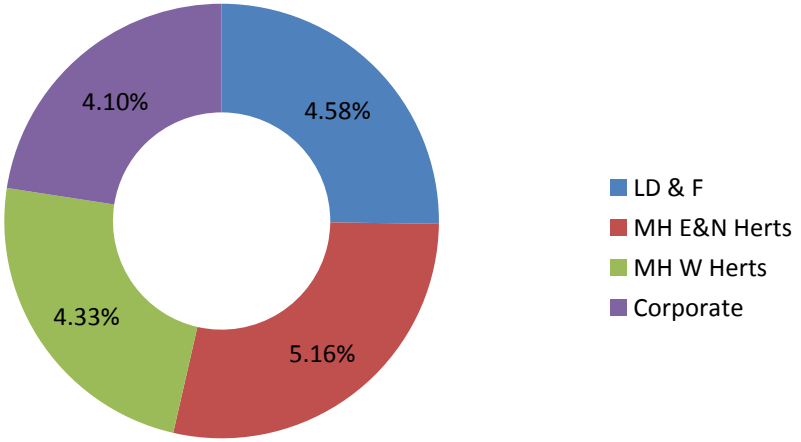


Table 6: Sickness Cost

SBU	Estimated Cost of sickness Q3
Corporate	£139,843
LD & F	£284,238
MH E&N Herts	£318,918
MH W Herts	£286,640
Trust	**£1,029,639**

Graph 7: Q3 % Sickness Absence by SBU



Section 5: Temporary Staffing

Table 7: Q3 2018-2019 Bank, Agency & Substantive Spend

2018-2019				
Total spend	**Q3**		**YTD**	
	£	**%**	**£**	**%**
Agency	1,553,070	4.12%	5,605,351	4.95%
Bank	3,704,105	9.82%	11,640,584	10.28%
Substantive	32,471,614	86.07%	96,004,496	84.77%
Total	**37,728,789**		**113,250,431**	

Graph 8: Bank & Agency Spend

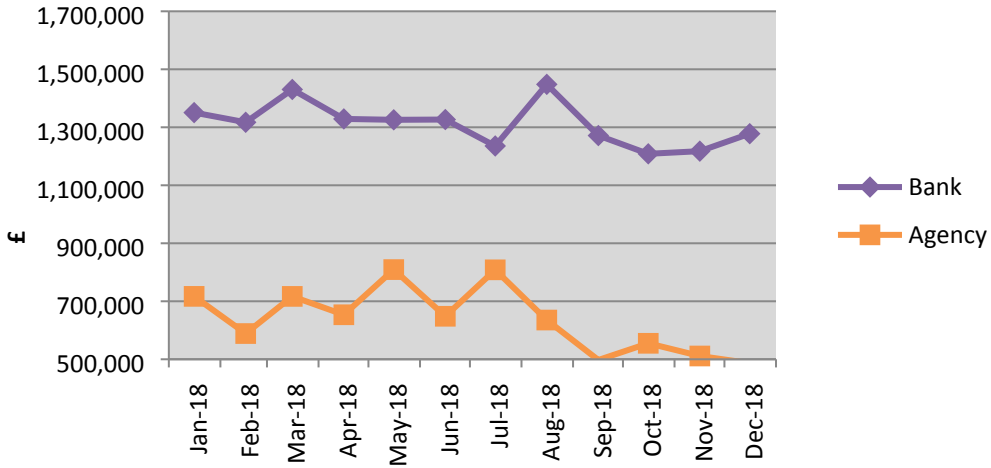
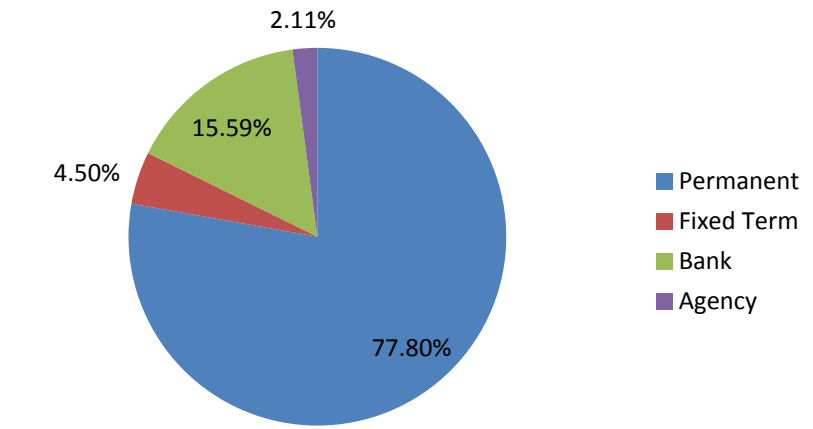


Table 8: Q3 2018-2019 Bank and Agency Usage

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	21,028	16,107	76.25%	3,458	15.73%	**91.98%**
Admin	4,116	3,700	82.60%	193	8.93%	**91.53%**
Social Workers	1,093	587	45.71%	462	52.04%	**97.76%**
OT/AHP	993	847	85.67%	113	8.96%	**94.64%**
Total	**27,230**	**21,241**	**78.01%**	**4,226**	**15.52%**	**93.53%**

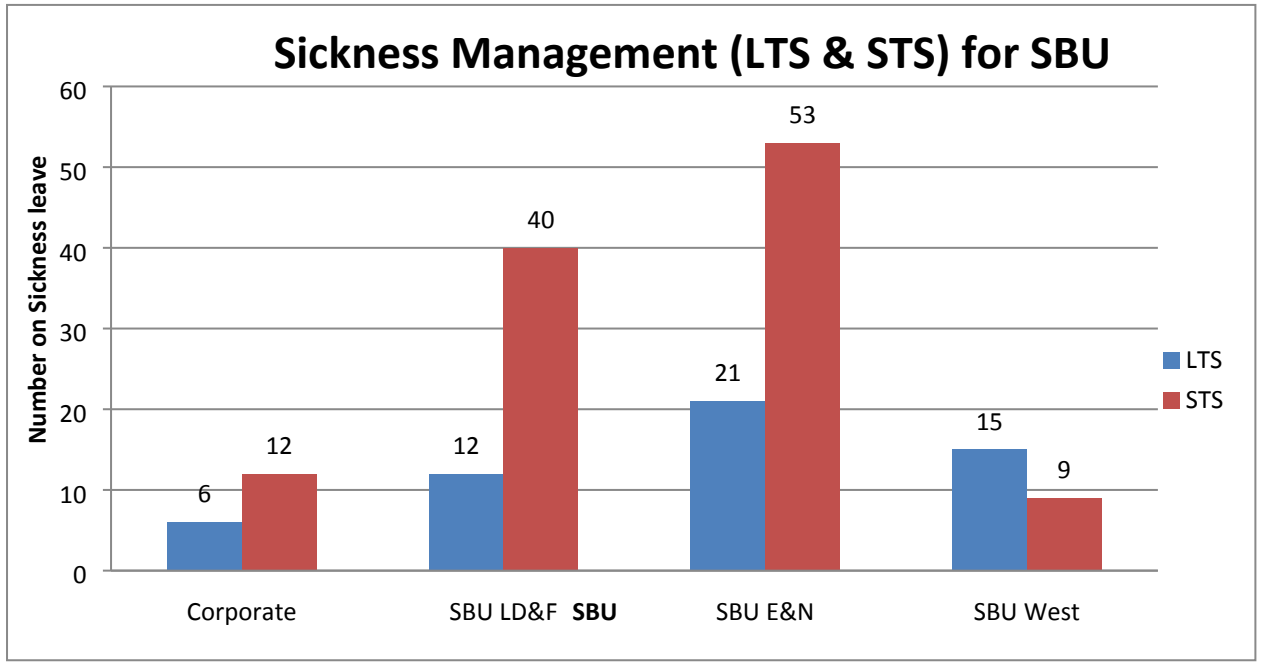
Graph 9: % FTE of Workforce by Assignment Category



Section 6: Employee Relations & Sickness Management

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

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	3	14	2	0	0	16	**35**
Number of Grievances	1	0	4	0	0	1	**6**
Number of Capability cases	0	0	0	0	0	1	**1**
Number of Bullying & Harassment cases	0	1	1	0	0	2	**4**
Number of Whistleblowing cases	0	0	0	0	0	0	**0**
Total number of cases in progress	**4**	**15**	**7**	**0**	**0**	**20**	**46**
Number of Mediation sessions	1	0	1	0	0	0	**2**
Number of suspensions/restricted duties	2	8	0	0	0	9	**19**
Number of appeals	0	2	1	0	0	4	**7**



Section 7: Staff Development

Table 10: Appraisal Compliance

SBU	Number of completed appraisals	Number of Staff	PDP Rate %
367 Corporate	224	284	**79%**
367 SBU Learning Disability & Forensic	685	797	**86%**
367 SBU MH East & North Herts	706	780	**91%**
367 SBU MH West Herts	761	835	**91%**
Grand Total	**2376**	**2696**	**88%**

Graph 10: % PDP Compliance

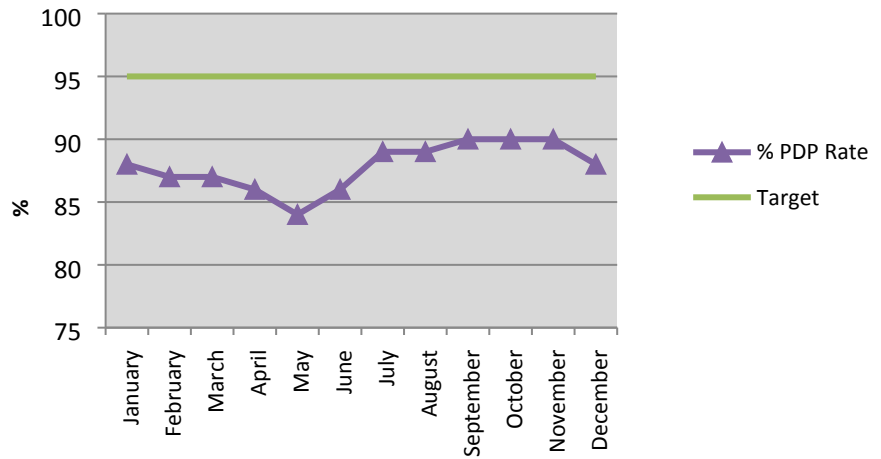
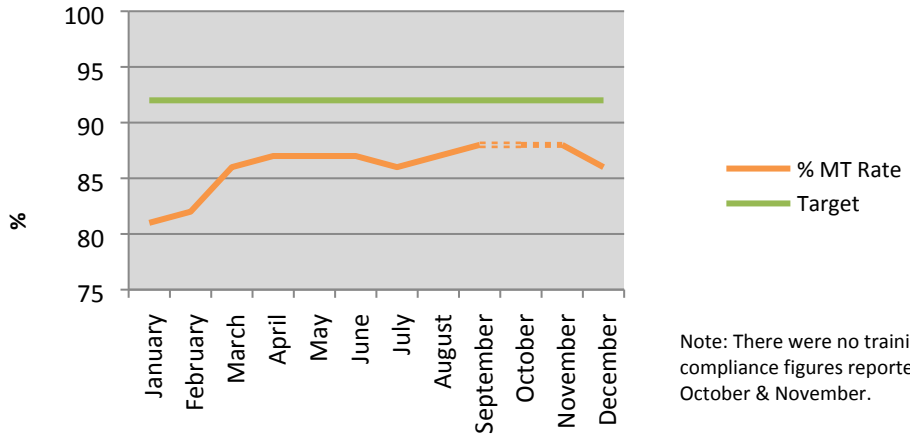


Table 11: Mandatory Training Compliance

SBU	Does not meet requirement	Meets Requirement	% Compliance
367 Corporate	617	2548	**81%**
367 SBU Learning Disability & Forensic	914	7832	**90%**
367 SBU MH East & North Herts	1236	7496	**86%**
367 SBU MH West Herts	1447	7906	**85%**
Grand Total	**4214**	**25782**	**86%**

Graph 11: % Mandatory Training Compliance



Note: There were no training compliance figures reported for October & November.

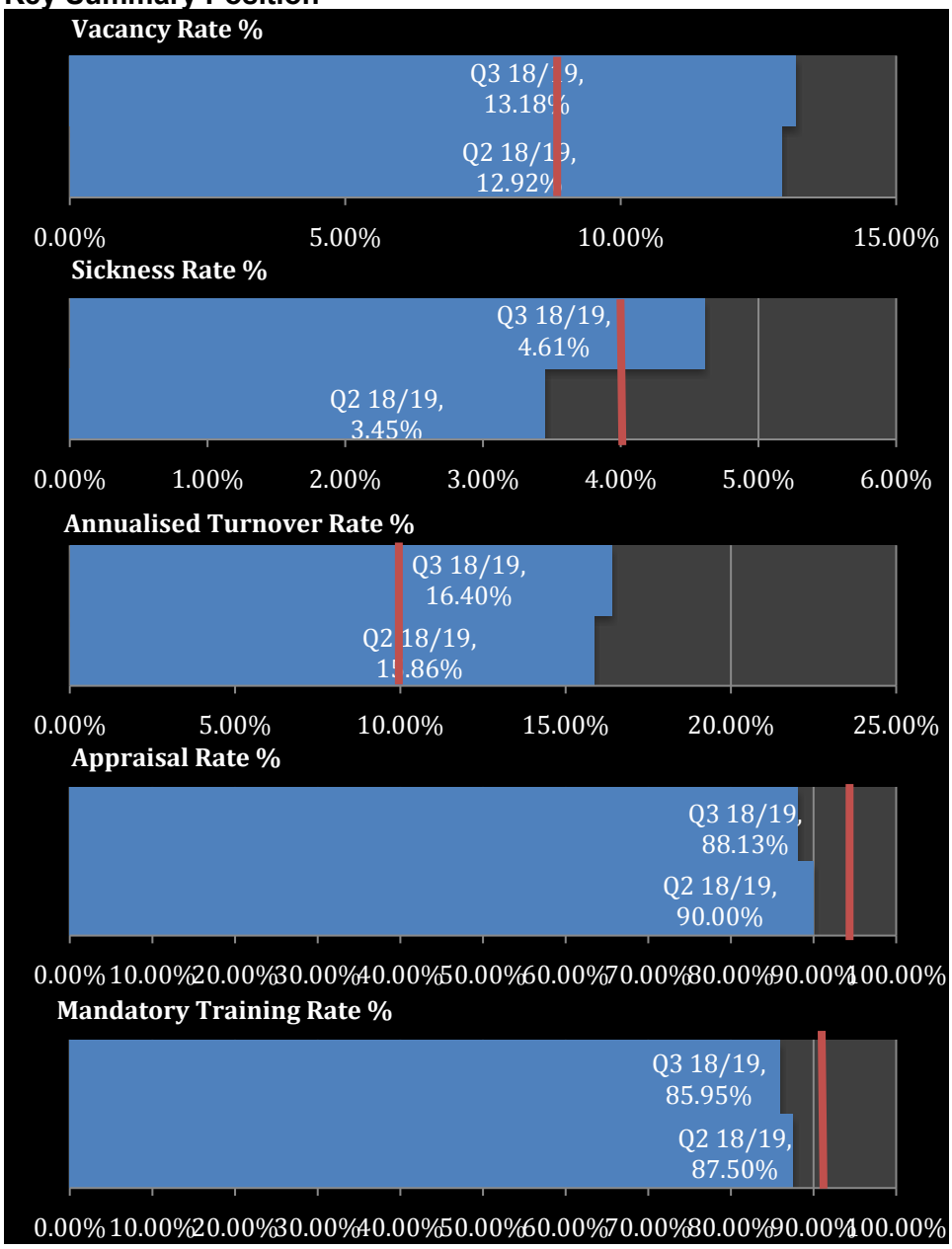
Workforce and Organisational Development Report
Quarter Three: October – December 2018

1.0 Introduction

The purpose of this report is to appraise the Trust Board on the Q3 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 Q3 summary position.

2.0 Executive Summary

Key Summary Position



The majority of the workforce key performance indicators have slightly declined this quarter. The sickness absence rate has increased from 3.45% in quarter 2 to 4.61%, which is above the Trust target of 4%. The main reason given for sickness absence is colds, coughs and flu which suggests this increase in the sickness absence rate may be seasonal. However, in comparison to Q3 last year the sickness absence rate is reduced. Work continues to be undertaken on health and well-being activities including 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, wellbeing and resilience.

The vacancy rate has increased slightly this quarter to 13.18% from 12.92%.This increase is attributable to a lower number of starters this quarter and a higher number of leavers. A significant amount of work has been undertaken to reduce time to by outsourcing pre-employment checks and asking all managers to complete ID checks at interview. In addition the new careers website has been launched in Q3 which should attract more candidates to HPFT. Agreement has also been reached with Staffside to implement changes to notice periods with effect from 1st January 2019 for new staff at Band 5 and above which will bring us in line with other Trusts. Work on implementing, embedding and communicating retention initiatives also continues.

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3.0 Key Workforce Metrics

3.1 Establishment Data

The establishment data as at 31st December 2018 is as follows:

Funded Establishment =	**3373.62**
Staff in post =	**2928.94**
Vacant posts =	**444.68**
% Trust Vacancy rate =	**13.18**
Active Vacancies being recruited to =	**225.99**
% Total Turnover rate =	**16.40**
% Planned Turnover Rate =	**3.96**
% Unplanned Turnover Rate =	**12.44**
% Stability rate =	**86.68**

3.2 Turnover Rate

The turnover rate has increased slightly to 16.4% in Q3. The Trust's unplanned turnover rate this quarter was 12.44%. Unplanned turnover excludes those staff who leave the Trust as a result of retirement, end of a fixed term contract or dismissals.

A number of retention initiative have been developed including the retire and return process, the internal transfer process for nurses and HCAs which will be expanded to include all staff, and the buddy scheme which provides new starters with additional support in their new roles in the Trust.

These processes have been included in the Recruitment and Onboarding project review process and their success in reducing the turnover rate will be evaluated.

3.2.1 Analysing the leavers data & understanding the reasons staff stay

In order to impact the turnover rate it is important to understand the data and the reason's staff leave and equally why they stay.

During Q3 one of the top 5 reasons for staff leaving the Trust was retirement. It is expected the retire and return process will provide an opportunity for those retiring staff to remain in employment with HPFT. In addition the other top five reasons for leaving included promotion, work life balance and relocation.

The Business Partner Team continue to work with operational managers to ensure reasons are provided for staff leaving and to analyse the data and identify emerging themes and patterns which can be addressed through organisational development interventions and support.

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 Q3 86.8% which is up slightly from Q2. A stability index of 86.8% is outside the target and higher than recommended but shows that experience and knowledge is being retained in the organisation and despite the high turnover a relatively stable workforce exists after 1 year of employment.

3.4 Key Recruitment Activity

At the end of Q3 there were 444.68 full time equivalent vacancies (fte). Of these vacancies there were 167.64 posts in the recruitment pipeline and 155 at offer stage with 56 new starters due to begin their careers at HPFT in Q4.

The current time to hire is 8.5 weeks which is down from over 12 weeks in Q1. The time to hire is measured from advert to the unconditional offer and excludes notice periods. These parameters are aligned to the Midlands and East Recruitment Streamlining Sector.

Important changes were made to the recruitment process in Q3 with a view to significantly reducing the time to hire. These changes included the outsourcing of

pre-employment checks and the requirement for hiring manager's to complete ID checks for all candidates at interview stage. It is expected that these changes will continue to reduce the time to hire during Q4.

As the recruitment service moves away from being a predominantly transactional function, focus is shifting to increasing candidates in the recruitment pipeline. This will be achieved through working in partnership with the SBU's in developing plans to address recruitment challenges and hotspot areas. This work began in Q2 with detailed action plans for CAMHS which were co-produced with operational managers. This will also involve reducing candidate attrition by enhancing the candidate experience throughout the process. A toolkit is being developed which will bring together an attraction strategy to support recruitment in hard to fill roles. This will be the framework used by the recruitment team to advise and support managers to consider reviewing their recruitment strategy when they are unable to recruit in to roles through the traditional methods.

Regular meetings have been established between the Recruitment and Communication Teams in order to enable more collaborative working and to support the recruitment strategy. The Recruitment Team is gathering recruitment good news stories which will form part of our communications. A number of posts on Face Book, Twitter and LinkedIn are also being planned in advance to capitalise on awareness days to generate interest in related careers at the Trust e.g. Children's Mental Health Week.

The new Careers website was launched in November and forms a key part of the Trust's attraction strategy of positioning HPFT as the employer of choice. Plans are in place to increase the visibility of the site through marketing and search engine optimisation which should result in increased traffic to the website from prospective candidates in Q4. This will be supported by a number of recruitment events which have been planned throughout the year. Following negotiations with Staff side notice periods have now been increased to 8 weeks for band's 5 to 6 and 12 weeks for Band 7 and above. This applies to all new starters beginning their career with the Trust after 1st January 2019. This change also brings the Trust in line with what other Trusts are doing.

In response to feedback from staff and to ensure staff have the right equipment to do their job on day 1, the various forms for ICT equipment and network access have been brought together in a single point of reference and managers are prompted to complete this during the recruitment process to ensure this is ready for new hires on their first day. Activity is also planned over Q4 to improve the overall recruitment and onboarding experience for new hires. This includes a more streamlined approach to ICT procurement and network access, more frequent contact with candidates ahead of joining and ensuring all new hires to the Trust are assigned a 'buddy' on joining the Trust.

Progress with the Trust's retention plan continues to be a key priority; this also includes looking back at existing retention initiatives to review effectiveness.

The internal moves process is being reviewed due to lower than expected uptake; a re-launch is planned for Q4 after making the process simpler and more accessible to other staff groups. Career Clinics are also being launched in Q4 to support staff with any queries or concerns they have with their development as well as marketing internal transfer opportunities to staff thinking of leaving their current roles.

Pre-retirement workshops took place in Q3 to promote the retire and return process to staff members approaching retirement age. This has been well received by attendees and has been re-commissioned to take place quarterly over 2019/2020.

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

3.5 Number of starters and leavers

In Q3 there were 109 new starters and 119 leavers in comparison to Q2 when there were 168 new starters and 126 leavers. There was a net deficit of 10 staff this quarter in comparison to a net gain of 42 staff in Q2. There were 23 new starters and 31 leavers from nursing posts this quarter.

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

3.6 Junior Doctor Recruitment

The December rotation has taken place for Junior Doctors with the three 1st on call rotas showing continued improvement overall with a 1:14 for Central, North and East. This has had a positive impact on all rotas during December 2018. No exceptions reports have been raised during Q3.

Discussions are underway in relation to overseas recruitment with overseas post graduate Universities. The Awalpindi Medical University, in Pakistan have confirmed their interest in establishing a working relationship with HPFT to take forward the International Medical Fellowship scheme in readiness for August – October 2019.

3.7 Consultant Recruitment

In Q3 two new Consultants commenced in post, one in Old Age Psychiatry, one in CAMHS (DBT) along with a Specialty Doctor in General Adult Services. Advisory Appointment Committees (AAC's) took place in October for CAMHS with two job offers made and accepted; two consultants are due to commence employment with the Trust in Q4. An additional start date has been confirmed for a perinatal consultant in Q1. Further AAC's are planned in Q4 for CAMHs, General Adult and Learning Disability Services.

Agency spend remains a high priority for Medical Staffing with an average of 10 Agency Locums in Q3 and adverts are live for all ten vacancies.

Hard to recruit to areas remain as CAMHS, Old Age and General Adult Community.

3.8 Temporary Staffing

In Q3, 21,028 bank and agency shifts for registered nursing and HCA posts were requested, 16,107 of these were filled by bank workers and 3,458 shifts were filled by agency. This is a total fill rate of 91.98%, 76.25% filled by bank and 15.73% filled by agency.

This continues the downward trend in requests for bank and agency shifts since Q1 when 30,441 shifts were requested and in Q2 27,979 shifts were requested to be filled

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

3.9 Sickness Absence

The sickness absence rate has increased this quarter from 3.45% in Q2 to 4.61% in Q3 and is above the Trust target of 4%. However, compared to the 2017/18 Q3 sickness absence rate of 4.72 % there has been an improvement.

There has been an increase in the sickness absence rates across all business units with all areas having sickness levels exceeding the Trust target. Within West SBU particular hotspots are the Inpatient areas and Single Point of Access. Within Learning Disabilities and Forensic Services, North Essex LD, East and West Community LD Nursing Services and the Lexden AT&T Inpatient Unit are principally contributing to the high sickness levels. In East and North Herts SBU the Older Peoples Community services and Older People Inpatient Units are the primary areas of attention.

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. The importance of early intervention with return to work meetings is emphasised. 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 seems to be having a positive impact on staff.

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

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

The estimated costs to the Trust of sickness absence for Q3 has been calculated as over £1m which is an increase from Q2 at just under £839k. A breakdown of the sickness absence costs by SBU can be found **in appendix 1, section 4.**

There are currently 114 short term sickness absence cases and 53 long term sickness absence cases being formally managed through the employee relations team as at the end of December 2018. This is similar to the previous 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, making reasonable adjustments where appropriate 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 decreased by 2% to 88% in Q3. The PDP rates for each SBU are as follows:

SBU	Q4	Q1	Q2	Q3
LD&F	88 %	87 %	88%	86%
East and North	90 %	89 %	91%	91%
West	89 %	87 %	95%	91%
Corporate	72 %	70 %	83%	79%
Trust	**87 %**	**86 %**	**90%**	**88%**

PDP rates have decreased in three SBUs and remained constant in East and North Herts. All areas receive monthly management reports detailing completion rates.

Within the LD&F SBU, PDP compliance is an area of major focus with scrutiny by the Managing Director and at the monthly Core Management meetings. East and North Herts are undertaking work to identify and upskill Band 5 and 6 staff to support with appraisals of lower banded staff, and management training will be provided.

The West SBU review PDP completion rates at monthly unit reviews as well as through ongoing liaison with individual teams. The rates for most teams had been close to 100 % and the emphasis within the SBU is on driving completion rates to achieve this target.

3.11 Statutory and Mandatory Training Rates

The Core Skills Statutory and Mandatory training rates in Q3 have ended as follows:

Statutory and Mandatory Training = 86%
Essential Training = 83%

The compliance rate for Statutory and Mandatory Training has dropped from 88% to 86% over the quarter. Essential Training has dropped from 87% to 83%. There has been an extensive cleansing exercise on Discovery to ensure staff have been mapped with the correct competencies and certifications.

Quarter 3 Compliance by SBU is as follows:

	31-Oct		30-Nov		31-Dec	
Business Streams	**Mandatory**	**Essential**	**Mandatory**	**Essential**	**Mandatory**	**Essential**
Corporate Services	**85%**	**81%**	**85%**	**55%**	**85%**	**55%**
SBU Learning Disability & Forensic	**91%**	**90%**	**90%**	**88%**	**90%**	**84%**
SBU MH East & North Herts	**87%**	**97%**	**87%**	**82%**	**86%**	**82%**
SBU MH West Herts	**86%**	**87%**	**86%**	**83%**	**85%**	**82%**
Overall	**88%**	**84%**	**87%**	**85%**	**86%**	**83%**

A significant amount of work continues to take place to increase compliance rates. The Learning and Development Service are working with Subject Matter Experts (SME) and Professional Leads to increase the compliance and map out the 2019/ 2020 training plan. The training plan will ensure we commission enough training for all staff that are non-compliant or become non-compliant to book onto.

In Q3 the Learning and Development Team held their quarterly assurance meeting with SMEs. Training Providers, Professional Leads and SME's have been sent a Quality Assurance survey to complete online. The feedback will be analysed in Q4 by the Learning and Development Service.

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

Discovery is now fully self-serve as of the 31 December 2018. 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. Discovery user guides have been launched, published and sent to main training sites and teams. An updated FAQ document is now available on the intranet for staff to access. The L&D team have worked on re-branding and updating the L&D Intranet portal page to make this more user-friendly and documents easily accessible for staff. The team has also developed the catalogue of learning available via Discovery with more offerings for staff to access. The reporting on Discovery has been enhanced for managers to access their staff compliance.

A supervision module has been commissioned to hold and record supervision and supervision records on Discovery. This development work is split into 2 phases. Supervision phase one went live in September 2018. This allows the user to record the type and date of supervision. The supervision list includes; Clinical, Professional, Managerial, Safeguarding Adult, Safeguarding Children and Education Supervision. A report function is available, which reports on the above, and also provides the users' SBU and Manager Name. The first report was produced in November 2018 and monthly reports will now be produced going forward, however these reports do not report on compliance. The Heads of Service will now be involved in the development of the necessary KPIs for supervision to ensure that the correct level of supervision is used. This will then allow the reporting of compliance. Supervision phase 2 is still under development with Think Associate. This is a top-up build on the current function, and will allow the user to upload documents onto Discovery. The functionality will allow the incorporation of supervisor and supervisee sign off. The launch date is expected to be in late January 2019 launch and a user guide will be published in line with launch.

In Quarter 4 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:

- To build on the Supervision Module. Staff can currently update the system of when this takes place, however further development will include setting up KPI's to be able to report by SBU / Corporate Services and Supervisee's will be able to upload documents.
- An online Appraisal / Personal Development Planning Module will be developed to support the setting of personal objectives and an appropriate personal development plan.

4.0 Organisational Development Activity

The Organisational Development Team is progressing delivery against the agreed Organisational Development and Learning activity plan. During Q3 work has continued on the next phase of our Good to Great journey through the High Performing Team Model. 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 and their feedback has been used to further inform and develop the model. Two teams, Swift and Holly Lodge have been selected to be 'early adopters' of the model.

The 16th Big Listen was held in October – receiving lots of useful feedback from staff regarding innovation, ideas and suggestions to improve the Trust and their working environments.

In addition to the activity plan there are a number of interventions the Organisational Development Team have been involved with this quarter

- East & North SBU Senior Team Development – Quarterly sessions based on the Senior Leadership Programme.
- East & North Senior Nurses – development programme
- West SBU Senior Management Team – development programme and additional support for 360 feedback sessions.
- Delivery of Team development sessions for Victoria Court following the merging of staff from Victoria and Elizabeth Courts and The Marlowes Leadership Team (similar to above leadership programme).
- 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
- Full day Self Awareness session for Wellbeing Team and AHP Leads
- MBTI sessions for Heads of Workforce
- Support for two Trust events – CAMHS conference and BME Event
- Planning and confirmation of Long Service Awards – to take place in Q1
- Support to retention plan – Buddy Scheme, 100 day and stay interviews.
- Participation in Regional and National Leadership OD Meetings
- Scoping meeting with Head of Nursing regarding SRS

4.1 Delivering Effective Leadership Capacity and Capability

Leadership Development activity this quarter has included the following:

- The Senior Leaders Forum which focussed on CQC and our success factors.
- The 2 day Management Fundamentals Programme, directed at new and existing managers, has been widely advertised. The first Workshop – which is planned for February, is fully booked and additional dates are planned, bi-monthly, for the rest of 2019. Initially the Programme will be delivered face to face – it is anticipated that an on-line offering will also be in place later in the

year – and will provide managers with a toolkit for immediate reference when required.

- Cohort 4 of the Mary Seacole Programme was completed with all delegates passing, and many gaining a "Good Pass". Cohort 5 and 6 (2018) are near completion and results are expected soon.
- Cohort 9 of the Leadership Academy has completed with 20 of the 21 delegates passing and gaining accreditation. The content and quality has been updated and improved upon – and costs reduced for Cohort 10. Applications are now being sought for Cohort 10 which is due to commence in March 2019.

4.2 Maintaining and Growing Staff Engagement

Three Inspire Award presentations have taken place this quarter with 35 nominations received.

The Pulse Survey did not take place this quarter due to the National Staff Survey being run during this period. The National Staff Survey ran from 8th October to 7th December. The results are expected by the end of February 2019.

4.3 Improving Staff Health and Wellbeing

The Organisational Development Team have continued to deliver Health and Wellbeing activities throughout Q3. Details of the activities which have taken place are shown below:

- The Health Hub activity has seen different events delivered across Trust locations.
- Know Your Numbers (mini health checks) had 8 workshops in different locations and over 71 members of staff attended.
- Six Schwartz rounds were held with 98 attendees. We have 2 rounds planned for Q4 and are working on a strategic plan for 2019-2020. This plan is focusing on quadrants to improve performance, wellbeing and cultural change.
- Online tutorials- Three different sleep podcasts.
- An 8 week mindfulness course was delivered with 10 attendees. There will be an 8 week course starting in February Q4 in the South West Quadrant.
- The Health hub has been presented monthly at corporate induction.
- Health Hub Communications were sent out at the end of Q3 launching the Health and Wellbeing programme for Q4, including a snapshot showing all the activities planned across our sites and four counties.

The focus for Q4 is to have a geared up approach to Health and Wellbeing for Q1-Q4 (2019-20) with targeted positive action underpinning many of the plans involving the business partners when assigning activities.

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 Q3 the Library and Knowledge Services generated 198 general article requests and 144 HPFT book renewals. We also carried out 10 literature searches. The Library currently has 1888 members enrolled to use the library facilities. In addition 560 members are also registered Athens members who use the facilities to access online facilities. This allows users remote access to resources from outside the physical organisation.

The library has 182 Knowledge Share members who receive evidence update. This is a personalised and targeted updates which focuses on the evidence that can change practice and provides links to the latest article, websites, reports and guidelines in user's chosen area.

The Trust submitted its last LQAF assessment during Q2 and we will be hearing of our results imminently in Q4.

5.1.2 Apprenticeships

The Trust has a plan to create 82 apprenticeships during 2019 in partnership with 7 different suppliers.

In Q1 and Q2 we delivered to plan, in Q3 we had 20 staff commencing an Apprenticeship programme, which is 1 apprentice short of our target for the quarter. The programmes that

commenced included:

- Business Admin
- Customer Service
- Medical Administration
- Trainee Nursing Associate

It is planned that there will 35 people commencing Apprenticeship programmes in Q4 across a number of clinical and non-clinical areas.

6.0 Policy development

Thirteen workforce policies were reviewed and ratified at JCNC in December;

7.0 Bullying and Harassment

Bullying and harassment action plans are in place and are monitored via the Workforce and OD project review process.

In Q3 work began on the following actions;

- Collaborative working between the Workforce and OD teams and staff side representatives to resolve issues at team level
- Joint "walkabouts" with staff side taken place to support staff

In Q4 work will be undertaken to;

- Develop a network of dignity at work champions/advisers to provide confidential support systems for staff to share their concerns and find effective resolutions.
- Roll out further "how to give feedback" sessions within each SBU
- Communicate mediation resources to managers and staff
- Establish a shared language with respect to dignity at work, involving staff
- WRES initiatives to act as checks and balances have been built into our Recruitment policy with all recruitment panels above 8a to consist of at least one panel member from a BME background and be gender diverse.

In addition the Disciplinary policy is be revised and will include panels to approve suspensions and fact finding investigations before they are commissioned for formal investigations.

Recommendation

The Board is asked to note the Q3 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
January 2019

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	7 February 2019	Agenda Item: 16
Subject:	Financial Summary for the period to 31st December 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 Board:

For December the financial position reported was a surplus of £182k for the month, ahead of the Plan of £78k by £104k, and a surplus of £408k for the year to date, ahead of the Plan of £113k by £295k, and exceeding the full year Plan of £360k. This is an improvement on the last 2 months which averaged £69k surplus each month; there were several reductions in expenditure which allowed for additional provision to be made for current Estates and Environment works to address the outcomes of PLACE audits and a full review of environments recently undertaken by the Estates & Facilities Team.

All figures are reported before any income from the Provider Sustainability Fund (PSF), which is expected to be £1.2m for the year to date, which reflects that the Control Total has been met so far. The NHSI Use of Resources (UOR) Rating has improved to an overall 1.

UOR 1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000	Trend
Overall Surplus (Deficit)	78	182	113	408	360	↑
Pay Overall	12,876	12,560	115,423	113,231	154,068	↔
Agency	611	487	5,496	5,492	7,328	↑
Secondary Commissioning	2,598	2,713	23,095	24,720	30,676	↔

The reported position remains encouraging, and ahead of both the Published Plan and the Forecast Recovery Plan. It does include £1.4m reversals of old year accruals and provisions in Quarter 1 with very strong improvements made in Quarters 2 and 3.

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 £2.2m (1.9%) and for the month by £316k (2.5%). This reflects the level of vacancies, not all of which are covered, and agency levels which continue to reduce, now below the NHSI Ceiling for the month and for the year to date, for the first time since the Ceiling was introduced. Agency costs represent under 4% of the overall pay spend, the lowest level for several years (average 5.2% over the last 12 months).
2. Secondary commissioning is reported above Plan by £115k for the month and £1.6m for the year to date, with no change from November despite the additional day in the month (i.e. a real reduction of c. £90k). Improvements in the month include CAMHs (£54k reduction due to recalculation and reduction in activity); Acute and PICU (£28k due to decreased activity although January is increasing again); and Personal Budgets (£19k). These were offset by increases for Adult MH Health Placements (£34k, had been expected due to several new placements made); and Social Care Placements (£68k). It is expected that both PICU and Adult MH Health Placements will increase in January due to activity increasing again and until the New Sovereign House opens.
3. Income reported better than Plan by £18k in the month and £639k year to date, with main block contracts worse than Plan by £131k in the month and £774k year to date mainly due to reduced Herts CQUIN expected (c. £250k), reduced activity for NHSE Specialist Services (c. £500k), and reduced CQUIN for North Essex LD for Quarters 1 and 2 (£58k). It is likely that overall Income will be over Plan at the end of the Financial Year by up to £1.0m.
4. Overhead costs continue to spend above Plan, at c. 3.5% year to date; this is a reduction from previously stated 5% as Sub-contracts which deliver services such as within IAPT and North Essex LD have been moved to Direct Costs which reflects their nature. 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 related to improving environments.

Overall therefore the Quarter 2 improvements were sustained into Quarter 3, with a return to surplus. There remains a level of risk driven by the small surplus margin, significant demand volatility (particularly relating to Secondary Commissioning), and ongoing workforce pressures.

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**

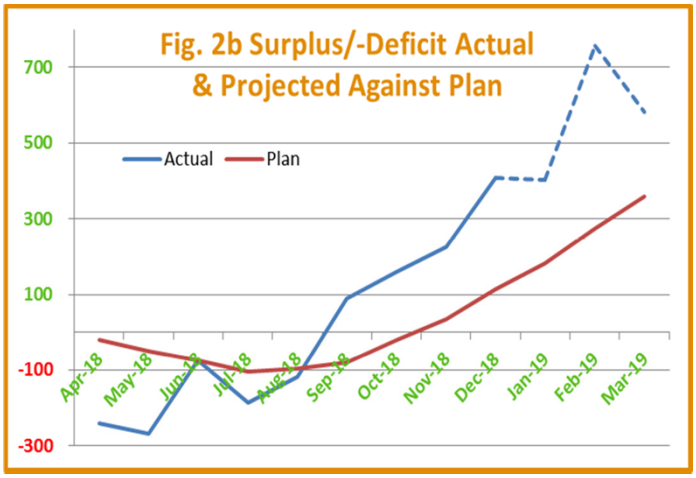
* This is before any amounts due under the Provider Sustainability Fund

2. Summary and Risk Rating

2.1 The Trust's Use of Resources (UOR) Framework rating for Month 9 is a 1, an improvement on the previously reported 2, due to the increase in surplus delivered, and the Agency Ceiling being met for the year to date. The detailed calculation of the UOR is set out in the appendices, with the main in month movements highlighted in Fig. 2a below:

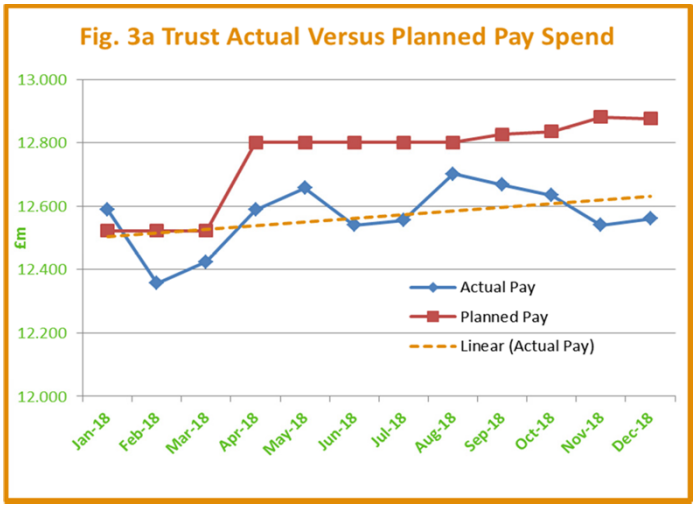
Fig. 2a Metric	Rating		Reported Rating		Commentary
Capital Servicing Capacity	1.9	↑	1	↑	Improvement in month due to surplus. NHSI still to confirm bridging loan repayment to be excluded from calculation. Rating likely to fall to 2 in March when the next loan repayment is made.
Liquidity	1.1	→	1	→	Strong cash position of £58.7m supporting liquidity metric.
I&E Margin	2.2	↑	2	→	Slight improvement in month due to increased surplus.
I&E Variance	1.9	→	1	→	Slight improvement in month due to increased surplus.
Agency Spend	1.9	↑	1	↑	Agency spend is now below Ceiling both for the month and for the year to date.
UOR Overall			1	↑	

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

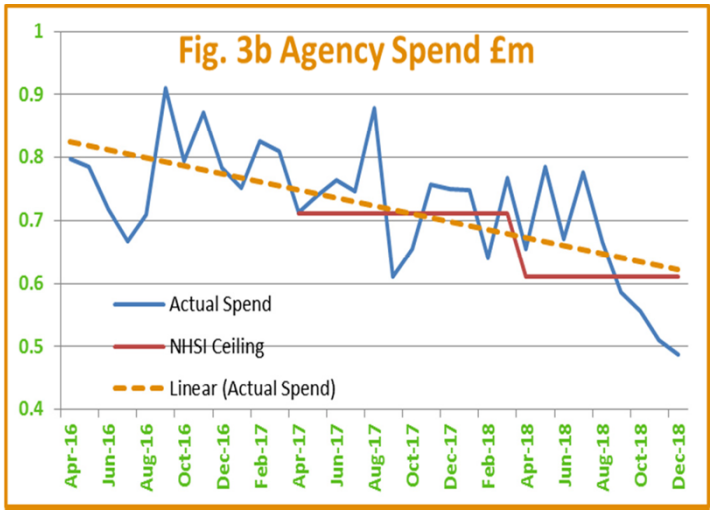


2.2 Fig. 2b shows the actual, planned and forecast surplus and deficit for the year to date, portraying the position behind Plan through to Month 4, then increasing and remaining consistently ahead of Plan to date. Overall, Quarter 1 was, as detailed previously, very challenging, and the Plan was achieved by releasing significant levels of non-recurring provisions (c. £1.4m); there were improvements in Quarter 2, and these have now been fully sustained through Quarter 3, resulting in reporting ahead of Plan at £182k surplus for the month (Plan of £78k) and £408k surplus for the year to date (Plan of £113k). These figures are before the Provider Sustainability Fund (£1.2m expected to date).

3. *Trading Position*



3.1 Pay costs totalled £12.6m in December as shown in Fig. 3a. There has been a decrease in recent months due to the backdated pay award being made in August, followed by agency reductions from September onwards. Overall pay has increased by a small amount over the last 12 months as shown by the linear trend (dotted orange line). Substantive pay spend was £10.8m in the month (86%); Bank pay was £1.3m (10%).



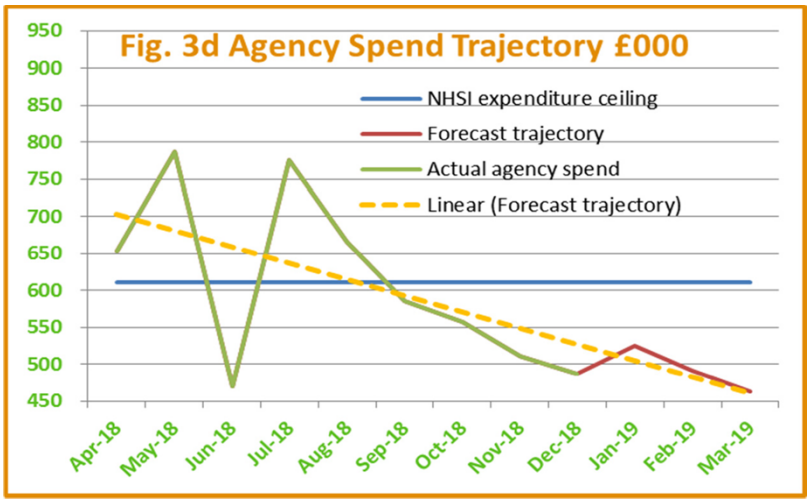
3.2 Agency spend was £487k for the month, just under 4% which is the lowest percentage for several years. This represents a continued significant reduction, below the NHSI Ceiling for the year to date for the first time since the measure was introduced. Fig. 3b shows a linear reduction (dotted orange line) over the last several years, from average £785k / month 16/17, to average £610k / month 18/19 to date.

3.3 SBUs maintain regular forecasts of agency spend which are combined into an overall forecast trajectory for the Trust. The latest figures indicate that spend will be within the NHSI Ceiling of £7.3m by the end of the financial year. The use of Safecare has resulted in better planning for staff allocation in inpatient units and the adoption of "zonal observations" has also helped to reduce the number of agency shifts booked. Keeping spend within the Ceiling for the remainder of the financial year remains dependent upon continuing focus on recruitment and retention of key staff groups, particularly CAMHs Medical Staff and Care Co-ordinators within Adult Community and CAMHs Teams.

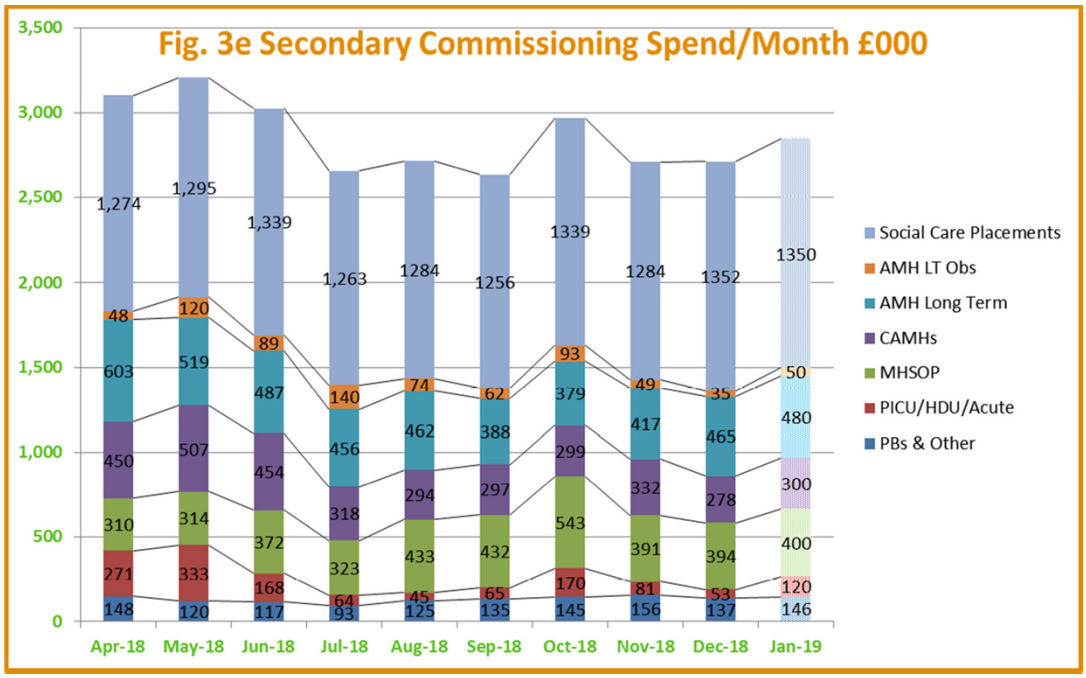
3.4 Year to date performance against the NHSI Ceiling is illustrated in Fig. 3c below:

Fig. 3c Performance against NHSI Ceiling by SBU	Actual Full Year 2017/18	Full Year NHSI Ceiling	Full Year Forecast	Full Year Forecast Variance (+adv/-fav)	Year to Date NHS Ceiling (phased evenly)	Year to Date Actual Spend (as at Month 9)	Year to Date Variance (+adv/-fav)
	£000	£000	£000	£000	£000	£000	£000
E&N SBU	3,806	3,505	3,293	-212	2,629	2,448	-181
LD&F SBU	863	730	737	7	548	598	50
West SBU	3,181	2,517	2,329	-188	1,888	1,916	28
Support Services	605	575	725	150	431	644	212
Capital & YE accounting			-113	-113	0	-113	-113
Total	8,455	7,327	6,971	-357	5,495	5,492	-3

3.5 The forecast trajectory is shown below in Fig. 3d:



3.6 Secondary Commissioning reports above Plan by £115k for the month and £1.6m for the year to date, with no change from November despite the additional day in the month (i.e. a real reduction of c. £90k). Improvements in the month included CAMHs (£54k), Acute and PICU (£28k), and Personal Budgets (£19k); partly offset by increases for Adult MH Placements (£34k) and Social Care Placements (£68k). Fig. 3e below shows reductions by type including forecast figures for January taking into account emerging issues. This shows that significant progress has been made to date but there remain risks for the coming months particularly around Adult MH Placements (until New Sovereign House opens) and PICU (where activity has increased significantly again in January):



3.7 Expenditure in all areas is being actively reviewed and monitored with several schemes to step service users down as soon as appropriate. For long term adult health placements numbers have increased to 35, but this remains a reduction of 12 in year, with 24 new placements and 36 ceased. Additionally, 50% of the cost of 5 individuals with a Korsakoffs Primary Diagnosis (which is not specified within the HPFT contract) is being transferred to Hertfordshire County Council (c. £73k saving 2018/19 and further £73k in 2019/20); there is also agreement for new cases to pass to the County Council as they are referred. Social care placements have increased by 4 overall, but given that 14 individuals have stepped down from health the social care, this remains a relatively low number. Difficulties in discharging individuals from inpatient services and lack of housing availability remain barriers to further reductions in this area.

Fig. 3f Number of Placements	01/04/2018	Started	Finished	Net Change	31/01/2019
MHSOP	72	53	53	0	72
Main Health	47	24	36	-12	35
Social Care	429	114	110	4	433
Total	548	191	199	-8	540

3.8 Overhead costs remain above Plan for the year at c. 3.5% to date, a reduction on previously stated 5% as Sub-contracts which deliver services such as within IAPT and North Essex LD have been moved to Direct Costs which reflects their nature. Costs above Plan in particular include Consultancy, Information Technology, Estates and Project Costs, and Site Costs. These all relate to improving environments and services across the Trust. It is also expected that there will be some additional expenditure resulting from the expected forthcoming CQC visit, in particular in ensuring that environments remain at a sufficiently high standard.

4. *Risks and Mitigating Actions*

4.1 The full Statement of Comprehensive Income (SOCI) is set out in the appendices, giving the detailed position and comparison to Plan for the month and year to date. Whilst improvements in Quarter 2 have been sustained through Quarter 3, it remains important to maintain focus on further improvements. It is expected that the Trust's Control Total for the year will be achieved, but this will need continued focus including:

4.1.1 Reductions in Agency spend – these started to impact the position from month 5 and have been sustained to date, with the NHSI Ceiling now being met year to date,

4.1.2 Managing within current placement spend – this significantly reduced in Quarters 2 and 3 but does remain a significant risk, with some areas increasing again recently

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

4.1.3.1 All corporate vacancies and any requested new corporate agency

4.1.3.2 Additional increment requests

4.1.3.3 Recruitment incentive requests

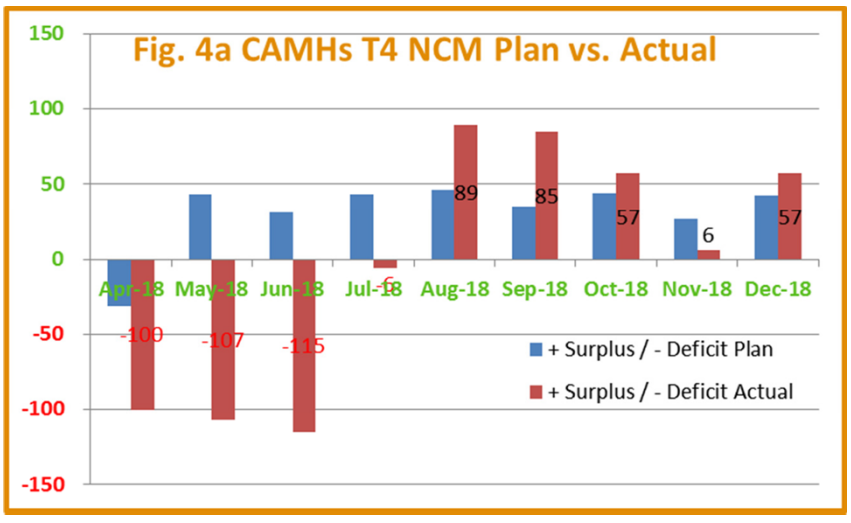
4.1.3.4 Requests for agency (except inpatients)

4.1.3.5 All agency bookings over 6 months, including exceptions

4.1.3.6 All posts vacant for 6 months or more

4.2 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. Other risks include:

4.2.1 The Trust's new CAMHs Tier 4 NCM service was set up on the basis that new, specialist community teams will enable young people to receive better quality care in the community, closer to home, and to stay out of expensive hospital placements. This is now generating a surplus of income over expenditure, though still a deficit year to date. This progress may be at risk as recruitment takes place for the new teams, and additionally it has not been possible to date to fully reconcile data with NHSE data for the financial year. Fig. 5a below shows the surplus or deficit being generated month by month, including both placements and staffing costs:



4.2.2 The extension to the Essex LD contract commenced in November and as such there will be a period of integration and embedding of the extended service. At this point costs are to Plan levels and will continue to be tracked closely in this early period.

4.2.3 The reduction in CQUIN income projected on the Essex contract will be reviewed to determine any recovery actions.

5. Income and Major Contracts

5.1 Total income planned for the year is £233.8m, including £215.9m from Main Commissioners, of which £170.9m is in respect of Hertfordshire. It is not expected that the values for current commissioners will change significantly during the year, though several additional amounts (£411k for extension of the Community Perinatal, £124k for ADHD Medical cover, £30k for the Wellbeing College) have been added.

5.2 CQUIN income is included in the position at 100% for all contracts except Hertfordshire and North Essex Learning Disability, and all including NHS England are currently on target to achieve this. For Hertfordshire, CQUIN for 2018/19 is currently projected at only 82%, with a worst case estimate of 76% and best case of 86%. This reflects the challenge to achieve targets for physical health checks and full recording. It is included in the position at 80% against a Plan of 90%, each 10% reduction equates to £351k. For North Essex Learning Disability 50% was achieved for Quarters 1 and 2, a reduction of £58k on the 100% previously expected.

5.3 NHS England income for Specialist Services has been reducing during 2018/19 due to low activity in particular for Medium Secure Services in Norfolk, with the impact to date being c. £500k. This has in part resulted from admissions being temporarily suspended earlier in the year, but the general trend has been for NHSE to seek to commission fewer beds. Some costs have been saved from reduced staffing, but due to elements of fixed/semi-fixed costs this is insufficient to cover the reduced income.

5.4 With effect from 1st November the Trust became the Lead Provider for Specialist Learning Disability Services across Essex, sub-contracting to EPUT and ACE in parts of the County. These are now included in the reported position with an increase of £560k income in month and £568k cost for sub-contracts (total part year effect £2.8m).

6. *Delivering Value*

6.1 2018/19

6.1.1 The net Delivering Value Programme requirement for 2018/19 is £4.7m. Forecast programme delivery remains unchanged at £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 required to ensure that the full value is achieved in year:

Fig. 6a Delivering Value Forecast Programme Delivery 2018/19	Amber £000	Green £000	Total £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

6.2 2019/20

6.2.1 Schemes for 2019/20 are currently being developed. The current estimate of the Delivering Value Programme requirement for 2019/20 is c. £6.5m.

Fig. 6b Indicative Delivering Value requirement 2019/20	£000s
External requirement based on 2.1% reduction in contract income value	(4,515)
HPFT cost pressures	(2,000)
Indicative Programme requirement 2019/20	(6,515)

"HPFT Cost Pressures" includes a contingency of £1.0m together with other pressures identified, including the proposed investment into a Community Personality Disorder service, and proposed investment in the Innovation Team.

6.2.2 A list of schemes and opportunities for efficiency has been drawn up which identifies potential savings totalling between £4.0m and £5.5m.

Fig. 6c Indicative schemes and opportunities RAG rated	£000s	£000s
Green	1,531	1,731
Amber	2,323	2,868
Red	151	955
Schemes and opportunities RAG rated total	4,005	5,554

A more detailed list categorised as "Schemes" and "Opportunities" is set out in the appendices.

6.2.3 Both the requirement and the schemes values will be refined over the coming weeks, along with other elements of the 2019/20 Financial Planning process, together with RAG ratings and Quality Impact Assessments.

6.2.4 The current shortfall against requirement identified is therefore between £1.0m and £2.5m. Immediate actions to address this include:

6.2.4.1 Confirming the spend reduction requirement for proposed agency savings.

6.2.4.2 Exploring the use of technology to reduce inpatient observation costs.

6.2.4.3 Development of the capital charges savings for, or income generation associated with, empty buildings.

6.2.4.4 Review of patient transport costs that the Trust currently incurs which are met by East of England Ambulance Service Trust for other providers, with a view to ensuring parity.

6.2.4.5 Exploring a number of suggestions made associated with Productivity / Time to Care, which require project or IM&T support. A Digital Strategy is being developed which can be evaluated and prioritised, this will include consideration of workstreams which can be progressed quickly.

The work to develop the programme is being informed by findings from benchmarking work and the wider link to the NHSI Support Programme.

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

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

7.2 Receivables decreased by £400k in the month. This is mainly due to payment received by Essex CCGs for £1.0m for overdue invoices. This is offset by an increase in accrued income relating to the grossing up of CAMHs Tier 4 Contract, which will increase accrued income by c. £400k until March.

7.3 Payables and accruals decreased by £500k in month. This is comprised of a decrease of £800k due to the timing of payment runs, decrease of capital accruals of £400k, increase of PDC accruals of £300k, and an increase in accruals of £200k which includes accruals for maintenance, estates and environments work noted elsewhere.

7.4 The Statement of Cash Flows is set out as an appendix and shows cash balances have increased by £200kin the month. The main movements in month are:

- Cash inflow from operating activities £1.1m
- Cash outflow from investing (£900k)

8. Capital

8.1 The Capital Programme for the year is outlined in the appendices. The Programme comprises actual capital spend and revenue spend associated with the programme. There is currently a 5 year Estates Strategy being developed which will inform the 5 year Capital Financing Plan, with a draft expected to be available later in January.

8.2 Cumulative net capital spend year to date for 2018/19 is £3.3m. This includes income received from the asset sale of 305 Ware Road of £1.4m.

8.3 There is a further £335k of revenue spend year to date, £30k in month. This primarily relates to the running costs for empty buildings and the dilapidation costs for Trust leased buildings.

8.4 Capital spend has increased from last month due to high levels of spend on IT infrastructure in month, and a correction on the reporting of the Trust's business intelligence system. The main construction projects continue to be fire compliance works and the Forest House S136 suite extension.

8.5 There is expected to be a high level of redecoration works from January until the end of March as the Trust seeks to address some backlog maintenance issues within the context of the improving financial position.

9. Forward Look

9.1 There has been a good recovery in the financial position and the year to date reported position is marginally above the Control Total. There is some pressure on placement costs showing in January (see 3.6 above), and ensuring spend is held at broadly the same level is fundamental to the financial position for the year. There is also a planned estates refurbishment program during Quarter 4 which will have an impact on the position. However it is fully expected the Trust will exceed the Control Total. Importantly this does include however the £1.4m release in Quarter 1 to meet unbudgeted placement costs in PICU and CAMHs.

9.2 Work continues to provide a degree of headroom against the expected future cost increases identified above and the impact of the planned recruitment within SBU management, IT and Estates. This focus includes:

9.2.1 Reducing the current level of agency doctors.

9.2.2 Reducing the current non contract estates spend.

9.2.3 Further reductions in corporate spend.

9.2.4 Increase in CQUIN achievement above current projection of 80%.

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

Actual in month Dec-17	Actual YTD to 31-Dec-17	Description	2018/19 Plan	Month Dec - 18 Actual	Month Dec - 18 Plan	Month Dec - 18 Variance	Year to Date Dec - 18 Actual	Year to Date Dec - 18 Plan	Year to Date Dec - 18 Variance	Year to Date E&N	West	LD	Support	Other	Total
31 0	31 0	Number of Calendar Days	365	31	31		275	275							0
14,016	125,743	Contract #1 Hertfordshire IHCCT	170,897	14,231	14,259	(27)	127,969	128,121	(153)	21	(0)	(0)	(0)	127,948	127,969
1,858	13,985	Contract #2 East of England	22,876	1,848	1,906	(58)	16,662	17,157	(495)	(0)	(0)	(0)	(0)	16,662	16,662
794	7,148	Contract #3 Essex (West Essex CCG)	12,378	1,303	1,363	(59)	8,191	8,290	(98)	(0)	(0)	(0)	(0)	8,191	8,191
168	1,518	Contract #4 Norfolk (Astley Court)	2,166	181	181	0	1,623	1,625	(2)	(0)	(0)	(0)	(0)	1,623	1,623
546	5,028	Contract #5 IAPT Essex	6,579	562	548	14	4,907	4,934	(27)	(0)	(0)	114	(0)	4,793	4,907
316	2,818	Contract #6 Bucks Chiltern CCG	3,807	317	317	0	2,856	2,855	0	(0)	(0)	(0)	(0)	2,856	2,856
17,698	156,240	Contracts	218,703	18,443	18,574	(131)	162,209	162,982	(774)	21	(0)	114	(0)	162,073	162,209
88	803	Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	1,085	114	90	24	793	814	(21)	883	(0)	(0)	(0)	(90)	793
299	3,082	Education and training revenue	3,094	320	257	63	3,069	2,318	750	74	371	268	747	1,608	3,069
191	1,839	Misc. other operating revenue	4,248	423	347	76	4,223	3,219	1,004	515	492	317	1,369	1,530	4,223
432	3,879	Other - Cost & Volume Contract revenue	5,332	450	444	6	3,794	3,999	(206)	(0)	(0)	3,794	(0)	(0)	3,794
149	1,826	Other clinical income from mandatory services	1,999	164	167	(3)	1,448	1,499	(51)	162	271	970	35	10	1,448
19	301	Research and development revenue	403	16	34	(17)	238	302	(64)	(0)	1	(0)	237	(0)	238
127	1,239	Provider Sustainability Fund	1,775	177	177	(0)	1,154	1,154	(0)	(0)	(0)	(0)	(0)	1,154	1,154
(0)	(0)	Other block	(0)	(0)	(0)	(0)	(0)	(0)	(0)	41,120	40,011	46,762	16,905	(144,798)	0
19,003	**169,210**	**Total Operating Income**	**236,639**	**20,108**	**20,090**	**18**	**176,927**	**176,288**	**639**	**42,775**	**41,146**	**52,225**	**19,294**	**21,488**	**176,927**
(10,293)	(91,604)	Employee expenses, permanent staff	(130,293)	(10,795)	(10,895)	99	(96,057)	(97,599)	1,542	(27,037)	(27,815)	(26,322)	(11,518)	(3,365)	(96,057)
(1,286)	(11,780)	Employee expenses, bank staff	(16,447)	(1,278)	(1,371)	93	(11,681)	(12,328)	646	(3,232)	(4,230)	(3,587)	(589)	(44)	(11,681)
(750)	(6,615)	Employee expenses, agency staff	(7,328)	(487)	(611)	124	(5,492)	(5,496)	3	(2,448)	(1,916)	(598)	(618)	88	(5,492)
(82)	(326)	Clinical supplies	(269)	(28)	(22)	(6)	(298)	(202)	(96)	(139)	(65)	(64)	(32)	2	(298)
(2,757)	(21,967)	Cost of Secondary Commissioning of mandatory services	(30,676)	(2,713)	(2,598)	(115)	(24,720)	(23,095)	(1,626)	(7,099)	(1,811)	(16,659)	(0)	849	(24,720)
(0)	(0)	Other Contracted Services	(4,034)	(670)	(667)	(3)	(2,013)	(2,032)	19	(0)	(0)	(2,013)	(0)	(0)	(2,013)
(24)	(188)	GP Cover	(279)	(30)	(23)	(7)	(206)	(210)	4	(90)	(3)	(142)	(0)	28	(206)
(246)	(2,146)	Drugs	(2,646)	(186)	(221)	34	(2,300)	(1,985)	(316)	(1,167)	(965)	(183)	7	7	(2,300)
(15,436)	**(134,626)**	**Total Direct Costs**	**(191,972)**	**(16,188)**	**(16,407)**	**219**	**(142,769)**	**(142,945)**	**177**	**(41,212)**	**(36,805)**	**(49,568)**	**(12,751)**	**(2,434)**	**(142,769)**
3,567	34,584	Gross Profit	44,667	3,920	3,683		34,158	33,342		1,563	4,341	2,657	6,543	19,054	34,159
18.77%	20.44%	Gross Profit Margin	18.88%	19.50%	18.33%		19.31%	18.91%		3.65%	10.55%	5.09%	33.91%	88.67%	19.31%
		Overheads													
(46)	(513)	Consultancy expense	(628)	(38)	(51)	14	(658)	(475)	(183)	(17)	(15)	(47)	(547)	(32)	(658)
(44)	(630)	Education and training expense	(1,074)	(62)	(86)	24	(719)	(780)	61	(62)	(55)	(64)	(561)	23	(719)
(340)	(3,134)	Information & Communication Technology	(4,104)	(399)	(341)	(57)	(3,344)	(3,080)	(264)	(112)	(175)	(256)	(2,772)	(28)	(3,344)
(337)	(2,989)	Hard & Soft FM Contract	(5,144)	(452)	(428)	(23)	(4,070)	(3,859)	(211)	(4)	1	(3)	(0)	(4,063)	(4,070)
(584)	(5,182)	Misc. other Operating expenses	(6,694)	(395)	(442)	47	(5,615)	(5,223)	(392)	(616)	(895)	(1,190)	(1,498)	(1,415)	(5,615)
(519)	(4,659)	Other Contracts	(4,144)	(377)	(345)	(32)	(3,168)	(3,108)	(60)	(384)	(1,288)	(505)	(950)	(42)	(3,168)
(29)	(454)	Non-clinical supplies	(399)	(64)	(33)	(31)	(473)	(300)	(173)	(116)	(93)	(183)	(70)	(10)	(473)
(472)	(4,355)	Site Costs	(5,547)	(557)	(462)	(94)	(4,646)	(4,160)	(486)	(25)	0	(1)	(2)	(4,617)	(4,646)
(0)	(1,000)	Reserves	(1,955)	(150)	(166)	16	(500)	(1,465)	965	(0)	(0)	(0)	(0)	(500)	(500)
(308)	(2,688)	Travel, Subsistence & other Transport Services	(3,732)	(366)	(313)	(53)	(2,967)	(2,794)	(174)	(741)	(1,074)	(707)	(429)	(16)	(2,967)
(2,679)	**(25,605)**	**Total overhead expenses**	**(33,422)**	**(2,859)**	**(2,668)**	**(191)**	**(26,159)**	**(25,242)**	**(917)**	**(2,077)**	**(3,594)**	**(2,957)**	**(6,831)**	**(10,701)**	**(26,159)**
889	**8,978**	**EBITDA**	**11,246**	**1,061**	**1,015**	**46**	**7,999**	**8,100**	**(101)**	**(514)**	**747**	**(299)**	**(288)**	**8,353**	**7,999**
4.68%	5.31%	EBITDA Margin	4.75%	5.27%	5.05%		4.52%	4.59%		-1.20%	1.81%	-0.57%	-1.49%	38.87%	4.52%
(405)	(3,692)	Depreciation and Amortisation	(5,025)	(400)	(419)	19	(3,656)	(3,769)	113	(0)	(0)	(105)	(0)	(3,551)	(3,656)
(36)	(323)	Other Finance Costs inc Leases	(354)	(3)	(29)	27	(245)	(265)	20	(0)	(0)	(0)	(245)	(0)	(245)
(0)	(0)	Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(32)	(0)	(32)	(0)	(0)	(0)	(0)	(32)	(32)
19	85	Interest Income	168	33	14	19	250	126	124	(0)	(0)	(0)	250	(0)	250
(259)	(2,666)	PDC dividend expense	(3,900)	(333)	(325)	(8)	(2,753)	(2,925)	173	(0)	(0)	(131)	(0)	(2,621)	(2,753)
207	**2,383**	**Net Surplus / (Deficit)**	**2,135**	**359**	**255**	**104**	**1,562**	**1,267**	**295**	**(514)**	**747**	**(536)**	**(283)**	**2,149**	**1,563**
1.09%	**1.41%**	**Net Surplus margin**	**0.90%**	**1.79%**	**1.27%**		**0.88%**	**0.72%**		**-1.20%**	**1.81%**	**-1.03%**	**-1.47%**	**10.00%**	**0.88%**
80	**1,144**	**Net Surplus / (Deficit) before PSF**	**360**	**182**	**78**	**104**	**408**	**113**	**295**						

Statement of Financial Position (Balance Sheet) as at 31/12/18

31 March 2018 £000	STATEMENT OF FINANCIAL POSITION	Previous month 8 £000	Current month 9 £000	Movement in month £000	Movement YTD £000
	Non-current assets				
212	Intangible assets	372	358	(14)	146
26,200	PPE Land	26,200	26,200	0	0
119,573	PPE Buildings & Dwellings	117,025	116,707	(318)	(2,866)
599	PPE Assets Under Construction	4,560	5,110	550	4,511
3,593	PPE Equipment	2,965	2,897	(68)	(696)
150,177	**Total non-current assets**	**151,122**	**151,272**	**150**	**1,095**
	Current assets				
38	Inventories	38	38	0	0
3,986	NHS Receivables	2,581	1,779	(802)	(2,207)
318	Non NHS Trade Receivables (related parties)	1,201	1,133	(68)	815
15,360	Other Receivables	(150)	(21)	129	(15,381)
(362)	Provision for impairment of Receivables	(362)	(362)	0	0
(9,128)	Accrued income	4,005	4,395	390	13,523
466	PDC Dividend Receivable	0	0	0	(466)
926	Prepayments	1,505	1,409	(96)	484
55,967	Cash and cash equivalents	58,535	58,702	167	2,736
2,750	Assets held for sale	1,300	1,300	0	(1,450)
70,320	**Total current assets**	**68,652**	**68,374**	**(278)**	**(1,947)**
220,497	**Total assets**	**219,775**	**219,646**	**(128)**	**(851)**
	Current liabilities				
(7,320)	Borrowings	(530)	(530)	0	6,790
(4,927)	Deferred Income	(3,633)	(3,767)	(134)	1,160
(4,196)	Provisions (see note below)	(2,226)	(2,226)	0	1,969
(2,964)	Taxes payable	(3,068)	(3,157)	(89)	(193)
0	Receipts in advance	0	0	0	0
(3,601)	Trade Payables	(962)	(937)	26	2,664
(1,003)	Other payables	(2,791)	(1,965)	826	(963)
(795)	Capital Payables	(888)	(502)	386	294
(18,781)	Accruals	(20,045)	(20,262)	(216)	(1,480)
(57)	Finance Leases	(25)	(21)	4	36
0	PDC Dividend payable	(620)	(953)	(333)	(953)
(43,643)	**Total current liabilities**	**(34,788)**	**(34,319)**	**469**	**9,324**
26,677	**Net current assets**	**33,864**	**34,055**	**191**	**7,378**
176,854	**Total assets less current liabilities**	**184,987**	**185,327**	**341**	**8,473**
	Non-current liabilities				
(10,058)	Term Loan from ITFF (2.74%)	(10,058)	(10,058)	0	(0)
(5,556)	Provisions (see note below)	(5,620)	(5,602)	18	(46)
0	Finance Leases	0	0	0	0
(15,614)	**Total non-current liabilities**	**(15,413)**	**(15,395)**	**18**	**219**
161,240	**Total assets employed**	**169,573**	**169,932**	**359**	**8,692**
	Financed by (taxpayers' equity)				
84,003	Public Dividend Capital	91,133	91,133	0	7,130
42,210	Retained earnings (I&E reserve)	43,413	43,772	359	1,562
35,028	Revaluation reserve	35,028	35,028	0	0
161,240	**Total taxpayers' equity**	**169,573**	**169,932**	**359**	**8,692**

Detailed note on Provisions

31 March 2018 £000s	Provisions summary as at month 9	Under 1 year £000s	Over 1 year £000s	Total current month 9 £000s	Movement YTD £000
(3,713)	Continuing Care appeals	(1,744)	0	**(1,744)**	1,969
(137)	LTPS	(137)	0	**(137)**	0
0	Legal claims	0	0	**0**	0
0	Redundancy	0	0	**0**	0
(2,333)	Pensions	(221)	(2,017)	**(2,238)**	95
(2,643)	Injury Benefit	(125)	(2,508)	**(2,633)**	10
(925)	Dilapidations	0	(1,076)	**(1,076)**	(151)
(9,751)	**Total provisions**	**(2,227)**	**(5,601)**	**(7,828)**	**1,923**

Use Of Resource Metrics (UOR)		Actual 31/12/2018
		£000s
Capital Service Cover: *the degree to which the organisation's generated income c overs its financing obligations*		
PDC dividend expense	*from SoCI*	(2,753)
Interest Expense on Non-commercial borrowings	*from SoCI*	(233)
Interest Expense on Finance Leases	*from SoCI*	(2)
Other Finance Costs (unwinding of discount on provisions)	*from SoCI*	(10)
Public Dividend Capital repaid	*from SoCF*	-
Repayment of bridging loans	*from SoCF*	-
Repayment of non-commercial loans	*from SoCF*	(265)
Capital element of finance lease rental payments - other	*from SoCF*	(4)
		(3,267)
SURPLUS/(DEFICIT) FOR THE YEAR TO DATE		1,562
Impairments		-
Reversal of PY Impairments		-
PDC Dividends payable		2,753
Finance expense - financial liabilities Finance lease interest		2
Finance expense - unwinding of discount on provisions		10
Finance expense - financial liabilities Loan interest		233
Profit/Loss on Sale PPE		32
Depreciation & Amortisation		3,656
Revenue available for Debt Service		8,249
Debt Service		(3,267)
Capital servicing capacity metric (Revenue / debt service)		2.52x
Capital servicing capacity rating		1
Liquidity: *days of operating costs held in cash or cash equivalent forms*		
Cash for CoS liquidity purposes	*from SoFP*	32,717
Operating Expenses within EBITDA, Total	*from SoCI*	(168,928)
Liquidity metric		52.3
Liquidity rating		1
I&E Margin:		
Surplus/(deficit) (before impairments)	*from SoCI*	1,562
Total income	*from SoCI*	176,927
I&E metric		0.88%
I&E Margin rating		2
I&E Variance:		
Actual I&E Margin	*from I&E*	0.88%
Planned I&E Margin	*from Plan*	0.70%
Variance		0.18%
Distance from financial plan rating		1
Agency spend:		
Actual agency spend	*from SoCI*	5,492
NHSI agency cap	*from Plan*	5,497
Variance		(0.10%)
Agend spend rating		1
Use Of Resource (UOR) Rating*		1

Capital Service Cover					20%
Rating	1	2	3		4
Min Score	>2.5	1.75	1.25	<	1.25
Min Surplus/(Deficit) Required £000s	1,475	(975)	(2,600)	<	(2,600)
Headroom amount £000s	(87)	(2,537)	(4,162)	<	(4,162)

Liquidity					20%
Rating	1	2	3		4
Min Score	>0	(7)	(14)	<	(14)
Min Cash for CoS liquidity required £000s	(0)	(4,300)	(8,650)	<	(8,650)
Headroom amount £000s	(32,717)	(37,017)	(41,367)	<	(41,367)

I&E Margin					20%
Rating	1	2	3		4
Min Score	>1%	0%	(1%)	<	(1%)
Min Surplus/(Deficit) Required £000s	1,769	-	(1,769)	<	(1,769)
Headroom £000s	207	(1,562)	(3,332)	<	(3,332)

Distance From Financial Plan Variance					20%
Rating	1	2	3		4
Min Score	>0%	(1%)	(2%)	<	(2%)
Min Surplus/(Deficit) Required £000s	1,230	(525)	(1,775)	<	(1,775)
Headroom £000s	(332)	(2,087)	(3,337)	<	(3,337)

Agency Spend					20%
Rating	1	2	3		4
Min Score	<0%	25%	50%	>	50%
Min Surplus/(Deficit) Required £000s	5,497	6,872	8,246	>	8,246
Headroom £000s	6	1,380	2,754	>	2,754

* Scoring a '4' on any metric will mean that the overall rating is at least a 3 (ie either a 3 or a 4), triggering a concern.

Agency Cap Performance

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
NHSI Agency Cap £000s	611	611	611	611	611	611	611	611	611
Actual Agency £000s	654	786	470	776	665	586	557	511	487

Statement of Financial Position (Balance Sheet) as at 31/12/18

31 March 2018 £000	STATEMENT OF FINANCIAL POSITION	Previous month 8 £000	Current month 9 £000	Movement in month £000	Movement YTD £000
	Non-current assets				
212	Intangible assets	372	358	(14)	146
26,200	PPE Land	26,200	26,200	0	0
119,573	PPE Buildings & Dwellings	117,025	116,707	(318)	(2,866)
599	PPE Assets Under Construction	4,560	5,110	550	4,511
3,593	PPE Equipment	2,965	2,897	(68)	(696)
150,177	**Total non-current assets**	**151,122**	**151,272**	**150**	**1,095**
	Current assets				
38	Inventories	38	38	0	0
3,986	NHS Receivables	2,581	1,779	(802)	(2,207)
318	Non NHS Trade Receivables (related parties)	1,201	1,133	(68)	815
15,360	Other Receivables	(150)	(21)	129	(15,381)
(362)	Provision for impairment of Receivables	(362)	(362)	0	0
(9,128)	Accrued income	4,005	4,395	390	13,523
466	PDC Dividend Receivable	0	0	0	(466)
926	Prepayments	1,505	1,409	(96)	484
55,967	Cash and cash equivalents	58,535	58,702	167	2,736
2,750	Assets held for sale	1,300	1,300	0	(1,450)
70,320	**Total current assets**	**68,652**	**68,374**	**(278)**	**(1,947)**
220,497	**Total assets**	**219,775**	**219,646**	**(128)**	**(851)**
	Current liabilities				
(7,320)	Borrowings	(530)	(530)	0	6,790
(4,927)	Deferred Income	(3,633)	(3,767)	(134)	1,160
(4,196)	Provisions (see note below)	(2,226)	(2,226)	0	1,969
(2,964)	Taxes payable	(3,068)	(3,157)	(89)	(193)
0	Receipts in advance	0	0	0	0
(3,601)	Trade Payables	(962)	(937)	26	2,664
(1,003)	Other payables	(2,791)	(1,965)	826	(963)
(795)	Capital Payables	(888)	(502)	386	294
(18,781)	Accruals	(20,045)	(20,262)	(216)	(1,480)
(57)	Finance Leases	(25)	(21)	4	36
0	PDC Dividend payable	(620)	(953)	(333)	(953)
(43,643)	**Total current liabilities**	**(34,788)**	**(34,319)**	**469**	**9,324**
26,677	**Net current assets**	**33,864**	**34,055**	**191**	**7,378**
176,854	**Total assets less current liabilities**	**184,987**	**185,327**	**341**	**8,473**
	Non-current liabilities				
(10,058)	Term Loan from ITFF (2.74%)	(10,058)	(10,058)	0	(0)
(5,556)	Provisions (see note below)	(5,620)	(5,602)	18	(46)
0	Finance Leases	0	0	0	0
(15,614)	**Total non-current liabilities**	**(15,413)**	**(15,395)**	**18**	**219**
161,240	**Total assets employed**	**169,573**	**169,932**	**359**	**8,692**
	Financed by (taxpayers' equity)				
84,003	Public Dividend Capital	91,133	91,133	0	7,130
42,210	Retained earnings (I&E reserve)	43,413	43,772	359	1,562
35,028	Revaluation reserve	35,028	35,028	0	0
161,240	**Total taxpayers' equity**	**169,573**	**169,932**	**359**	**8,692**

Detailed note on Provisions

31 March 2018 £000s	Provisions summary as at month 9	Under 1 year £000s	Over 1 year £000s	Total current month 9 £000s	Movement YTD £000
(3,713)	Continuing Care appeals	(1,744)	0	**(1,744)**	1,969
(137)	LTPS	(137)	0	**(137)**	0
0	Legal claims	0	0	**0**	0
0	Redundancy	0	0	**0**	0
(2,333)	Pensions	(221)	(2,017)	**(2,238)**	95
(2,643)	Injury Benefit	(125)	(2,508)	**(2,633)**	10
(925)	Dilapidations	0	(1,076)	**(1,076)**	(151)
(9,751)	**Total provisions**	**(2,227)**	**(5,601)**	**(7,828)**	**1,923**

Cashflow Statement as at **31/12/2018**

STATEMENT OF CASH FLOWS	In Month 9	YTD Year Actual
	£000	£000
Opening Balance	**58,535**	**56,018**
EBITDA	1,061	7,999
Operating cashflows before movements in working capital	**1,061**	**7,999**
Movements in Working Capital:		
(Increase) / Decrease in Inventories	0	0
(Increase) / Decrease in Receivables	740	16,774
(Increase) / Decrease in Prepayments & Accrued Income	(294)	(14,007)
Increase / (Decrease) in Payables (incl. receipts in advance)	(766)	(1,545)
Increase / (Decrease) in Accruals	216	1,480
Increase / (Decrease) in Deferred Income	134	(1,160)
Increase / (Decrease) in Provisions	0	(1,969)
Increase / (Decrease) in Working Capital	**30**	**(427)**
Increase / (Decrease) in Non Current Provisions	(18)	46
Net Cash Inflow / (Outflow) from Operating	**1,073**	**7,618**
Capital Expenditure	(550)	(4,803)
Increase / (Decrease) in Capital Creditors	(386)	(294)
(Increase) / Decrease in Assets held for sale	0	1,450
Gain / (loss) on asset disposals	0	(32)
Interest received on Cash Balances	33	250
Net Cash Inflow / (Outflow) from Investing	**(903)**	**(3,429)**
Cashflow before Financing	**170**	**4,189**
PDC Dividend Paid (actual cash excluding accruals)	0	(1,334)
PDC Received	0	7,130
Bridging Loan from ITFF (previously FTFF)	0	(265)
Loan from ITFF (previously FTFF)	0	0
Interest on loans	(24)	(233)
Unwinding discount on provisions	22	(10)
Interest Paid Finance lease	(0)	(2)
Repayment of loans and leases	0	(6,790)
Net Cash Inflow / (Outflow) from Financing	**(3)**	**(1,504)**
Net Cash Inflow / (Outflow)	**167**	**2,685**
Closing Balance	**58,703**	**58,703**

Capital and Revenue Spend to date

Service Line	Project	Plan (FIC Sept 18)	Capital Projects Management	Revenue Projects Management	Total spend
24/7 Wards	Prospect House 24/7 Refurb	50	16	1	17
	Albany Lodge Works	1000	106		106
	Elizabeth Court	2000			
Adult Community E&N	Centenary House Conversion	0	95	3	97
	Hemel Hub	0	179	18	197
Camhs	Forest House Refurb	784	546	1	547
Norfolk Learning Disabilities	Broadlands Reception	0	184		184
Fire Compliance Works	Fire Compliance Works	1650	849	1	850
Ld Hertfordshire And Bucks	Seclusion Rooms	3000	13		13
It Allocation	It Allocation	900	707		707
It Allocation	Paris Allocation	1200			
It Allocation	Business Intelligence	400	874		874
Wifi Enhancements	Wifi Enhancements	340	340		340
Dilapidations	Dilapidations	0	2	151	153
Double Running Costs	Double Running Costs	0		78	78
Operational Capital	Operational Capital	2150	838		838
Property Sales	305 Ware Rd Sale	(1,500)	(1432)		(1432)
	143/145 Harper Lane	(1,000)			
	2-4 Alexandra Road	(400)			
	Total Spend	10,574	3315	335	3650
Trustwide Maintenance	**Trustwide Maintenance**	**414**		413	413

Detailed list of schemes Delivering Value Programme 2018/19

	RAG rating	East & North SBU	West SBU	LD&F SBU	Corporate & Procurement	Total	FYE estimate 2019/20
		£000s	£000s	£000s	£000s	£000s	£000s
Adult Community							
Adult Community Demographics Monies	Green	450	450			900	
Placements & Rehab							
Health Placements	Amber			500		500	500
Social Care Placements	Amber			30		30	150
Personal Budgets	Amber	0	0			0	
External Acute Placements	Amber		175			175	
Closure of Sovereign House	Green			262		262	260
'New' Sovereign House supporting step down from Health Placements	Amber			0			260
Korsakoffs	Amber			73		73	73
MHSOP beds & community services							
MHSOP Assessment & Treatment: Closure of Prospect House/Community reconfiguration	Amber	0				0	600 to 800
MHSOP Elizabeth Court	Amber	833				833	200
MHSOP: Baldock Manor contract termination	Green	157				157	
Pay							
Net saving from agency reduction	Amber	78	136	66		280	
Medical Oncall rota implementation FYE of 17/18 scheme	Green	39	39			78	
Reduction in CDW posts FYE of 17/18 scheme	Green	32	32			64	
CAMHS	Green	59				59	
Lexden Shift patterns & Facilities FYE of 17/18 scheme	Green			122		122	
Corporate vacancies	Green				258	258	
Finance Shared Services	Amber				60	60	
Non Pay							
Estates/ Rents/ Capital Charges	Amber			15	68	83	
Photocopier contract	Green	90	115	65		270	
Telephones	Amber				68	68	
Software licenses	Amber				74	74	
Misc. other	Green & Amber	7	355	122	45	528	
Total		1,745	1,302	1,255	573	4,875	2,043

Detailed list of schemes Delivering Value Programme 2019/20

	RAG rate	2019/20 range between £000s	£000s
Schemes			
FYE MHSOP community reconfiguration (Prospect House) net saving after investing in community team	Green	600	800
FYE MHSOP saving on Elizabeth Court less increase in CHC placements	Green	200	200
FYE Health Placements	Amber	500	500
FYE Closure of Sovereign House	Green	260	260
FYE New Sovereign House supporting step down from Health Placements	Green	260	260
FYE Social Care placements	Amber	150	150
FYE Korsakoffs/ neurology	Green	73	73
Close Anglo site Bucks in 18/19 £22k FY	Green	20	20
Finance Shared Services	Green	18	18
Reduction in spend on Safecare Project	Green	75	75
Capital Charges saving from sale of 305 Ware Rd	Green	25	25
West SBU General Overheads incl. Building costs	Amber	500	500
Saving on agency premium arising from reduction in agency to £6.3m spend in 19/20	Amber	320	320
Schemes identified to date		3,001	3,201
Opportunities			
West SBU Acute Transport costs		0	350
Further reduction in agency to £5.3m spend in 19/20		96	385
Productivity/ Time To Care		0	0
Warren Court staffing	Amber	40	40
Corporate	Amber	500	1,000
General non pay workstream 5% reduction: E&NHT SLA, Interserve call outs, Parking charges	Amber	124	169
General non pay workstream 5% reduction: Phone land lines, Other SLAs, misc. GP contracts	Red	55	220
Pharmacy	Amber	23	23
Procurement	Amber	166	166
Estates - incl. Marlowes		0	0
Capital Charges reduction/ income generation from empty buildings		0	0
Opportunities identified to date		1,004	2,353
Schemes and opportunities identified to date		4,005	5,554

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	7th February 2019	**Agenda Item: 17**
Subject:	Operational Planning 2019-20 & NHS Long Term Plan	**For Publication: No**
Author:	Ian Love - Deputy Director Commercial Development Paul Ronald Deputy Director of Finance & Performance Shari Payne – Interim Improvement & Commercial Development Manager	**Approved by:** Keith Loveman Executive Director - Finance
Presented by:	Keith Loveman Executive Director - Finance	

Purpose of the report:

To brief the Board on:

- 2019/20 Operational & Financial Planning Guidance and timelines
- The NHS Long Term Plan

Action required:

The Board is asked to

- Note the planning requirements and timetable
- Critically appraise the information presented and the approach to planning
- Note the summary headlines from the NHS Long Term Plan
- Advise any additional information required
- Note the proposed approach to governance

Summary and recommendations to the Board:

Introduction

This paper brings together key joint planning guidance from NHSI & E, summarising the 2019/20 Operating Framework, including operational and financial planning and provides an initial summary of the key MH & LD elements within the NHS Long Term Plan. The operating planning and financial planning requirements and approach were considered by the Finance & Investment Committee at its 22 January meeting.

Summary

Section 1 - On the 31 October 2018 NHS England provided initial guidance on the planning cycle for 2019-20 and beyond. This indicated that they would publish, in mid-December, detailed planning guidance alongside the NHS long term plan; CCG allocations and CQUIN guidance.

On the 21 December 2018 NHE England published, in the absence of the above detailed information, updated planning guidance, "**Preparing for 2019/20 Operational Planning and**

Contracting".

The full Planning Guidance published on 18 January 2019 replaces the Preparatory Guidance and covers:

- system planning
- system control totals
- the financial settlement
- full operational plan requirements
- the process and timescales around the submission of plans.

Whilst this is a month later than intended, key milestone dates have not been moved and the turnaround times will be challenging. Appendix 1 sets out the detailed submission timelines and the relevant dates of Board and Board sub-committee meetings to achieve appropriate sign off.

It remains the intention that five year systems plans are developed by Autumn 2019. The expectation is that 2019/20 forms year one of these plans, with STP's required to produce and submit aggregated operational plans to a similar timeline as individual organisation plans for 2019/20

Section 2 - The purpose of this section is to outline the key considerations in relation to the Financial Planning process for FY1920. Its further development and refinement will be done in conjunction with the further progression of the Annual Plan, the requirements of NHSI when they are made known and any STP requirement.

In developing the Financial Plan it will be important to consider the central tests set by NHSI to measure the progress of the individual and collective Operational Plans which are;

- Improve productivity and efficiency
- Eliminate provider deficits
- Reduce unwarranted variation in the quality of care
- Improve demand management
- Better use of capital investment.
- Incentivise systems to work together to redesign patient care.

In developing and approving the Financial Plan the following criteria are fundamental;

- It is set in accordance with the Trusts objectives and all relevant Planning Guidance
- Provides a clear assessment of the requirements and risks to financial sustainability; and
- That the Financial Plan remains a key tool to monitor performance.

The starting point for FY1920 financial planning is an understanding of the FY1819 year-end forecast. The section summarises the current forecast, recurrent and non-recurrent items and the underlying run rate moving into Q4 FY1819. In summary the current forecast is shown below:

Table 1 recurrent surplus summary

	FY18/19 Plan £m	FY18/19 Forecast £m	comment
Projected reported surplus before STF	0.36	0.6	
Reversal of unused provisions/ accruals		-2.0	£1.5m in Q1
Unplanned non recurrent expenditure		1.0	Estates refurb
Underlying surplus before STF	0.36	-0.4	

Whilst the table shows for FY1819 a surplus above Plan, this is supported by a non-recurrent £1.4m provision.

We have recently received the 2019/20 Control Total offer and have asked for clarification on some of the detail. The Control Total is a breakeven requirement (detail of calculation shown in Appendix 3). Whilst this is a marginal reduction on the current year and would be met by the current underlying surplus run rate, its achievability is unknown at this time awaiting an assessment of all the various planning and contract changes that are proposed for next year.

This is the first year of the NHS Long Term Plan and is accompanied with a number of fundamental changes to the financial framework. The majority of the changes focus on the objective of eliminating the acute provider deficits but several will impact our financial future. Whilst the headlines of the financial changes appear very positive; 3.8% contract increase, 1.1% efficiency factor, the continuing priority of MH investment and the reduced Control Total, until the full detail is understood and some of the other changes such as the pension increases are clear then a full assessment cannot be made. Specifically, whilst Hertfordshire commissioners have indicated they will meet the Mental Health Investment Standard, the full impact of 2018/19 and 2019/20 pay awards will limit the funding available for new investment.

The indicative annual CRES requirement has been initially calculated at £6.5m and ongoing programmes and new schemes are being developed to achieve this.

Section 3 - The NHS Long Term Plan was published in January 2019. The Plan highlights a number of areas for improvement and investment including Mental Health and Learning Disabilities, which is welcomed, and details how services are expected to function and deliver high quality, effective and efficient care to services users and there carers over the next 10 years.

Whilst further work is required to fully understand and interpret the plan the paper sets out a brief summary of the potential implications.

Recommendations

The Board is asked to:-

- **Note the planning requirements and timetable**
- **Critically appraise the information presented and the approach to planning**
- **Note the summary headlines from the NHS Long Term Plan**
- **Advise any additional information required**
- **Note the proposed approach to governance**

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 19 December 2018 Finance & Investment Committee 22 January 2019

Section 1 - 2019/20 Operational Planning and Contracting

1.1 On the 31 October 2018 NHS England provided initial guidance on the planning cycle for 2019-20 and beyond. This indicated that they would publish, in mid-December, detailed planning guidance alongside the NHS long term plan; CCG allocations and CQUIN guidance.

1.2 On the 21 December 2018 NHE England published, in the absence of the above detailed information, updated planning guidance, "**Preparing for 2019/20 Operational Planning and Contracting"**.

1.3 This reconfirms much of what was in the letter of 31 October 18 but adds some further detail. The full Planning Guidance published on 18 January 2019 replaces the Preparatory Guidance published in December 2018 and covers system planning, the financial settlement, full operational plan requirements, and the process and timescales around the submission of plans. Whilst this is a month later than intended, key milestone dates have not been moved and the turnaround times will be challenging.

1.4 Also in December 18 NHS England placed out to consultation a wide range of changes to the NHS Standard Contract. While it has not been possible to fully review the proposed contract changes this paper does provide an overview. A more detailed assessment will follow.

1.5 This section summarises the key points and describes the initial governance approach and deadlines that flow from this recent planning update.

1.6 System Leadership and System Working

There is a continuing expectation of "collective responsibility for the delivery" of the system operating plan which will have two elements:

- an overview setting out how the system will use its financial resources to meet the needs of its population and what the system will deliver in 2019/20
- a system data aggregation (activity, workforce, finance, contracting), demonstrating how all individual organisational plans align to the system plan.

There will be an initial January Checkpoint process including the agreement by the local system on underpinning assumptions ahead of an initial submission (activity and efficiency assumptions) on 14 Jan 19.

1.7 System Control Totals

NHS E will set a system control total for each STP/ICS which will be the sum of individual organisation control totals. All STPs/ICSs will have the opportunity to propose net-neutral changes, agreed by all parties, to organisation control totals ahead of the draft and final planning submissions.

The expectation is that providers will only be in one system. However, there will be exceptions where there are significant flows from other systems.

Specialist commissioning funding flows will not be included in the control totals. However, NHS E still expect system operating plans to include agreed local specialised service priorities.

1.8 Financial Settlement

The key elements of the financial settlement are provided below:

- An uplift of 3.8%. This includes the 2018-19 pay award previously paid directly to providers.
- It "excludes the transfer into national prices of a proportion of the PSF[1] and the transfer into national and local prices of 1.25% from CQUIN and the pensions impact."
- Efficiencies are set at 1.1%. However, adjustments to the Market Forces Factor may add a further 1% (per annum for the next four years) efficiency requirement for HPFT.

There is a significant section on the ongoing need for CCGs to drive their own efficiencies so as to meet the commitment to reduce their running costs by 20%. Specifically, "NHS England will support CCGs that want to work collaboratively with their local system or with each other to make faster progress on improving our collective efficiency and effectiveness". This will add further pressure to consolidate CCGs across Hertfordshire and could act as a prompt on how to reconfigure mental health commissioning alongside a mental health ICO.

1.9 Mental Health Investment

There is a recommitment to the Mental Health Investment Standard and the associated oversight approach, which requires that spending on mental health increases by at least as much as the CCG's overall programme allocation. Additional percentage amounts must be provided for mental health funding contained within the commissioners' allocation for 19/20.

The spending must demonstrate an increased percentage of mental health spending going to frontline provision and specifically for the provision of services to Children and Young People.

The guidance emphasises the significant funding commitment and requires commissioners "achieve value for money for this investment, and so contracts must include clear deliverables supported by realistic workforce planning".

In discussions on our existing contractual commitments and any additional services we feel need funding we will need to bear this in mind.

1.10 Productivity

The guidance devotes significant space to "Productivity and Efficiency". It identifies a number of areas where it "requires transformative action" from providers in 2019-20. Of particular relevance to HPFT:

- Improve quality and productivity of services delivered in the community, across physical and mental health, by making mobile devices and digital services available to a significant proportion of staff.

[1] Provider Sustainability Fund

It also identifies areas where it wants providers to “accelerate ongoing opportunities”. Of particular relevance to HPFT:

- Focus on concrete steps to improve the availability and deployment of clinical workforce to improve productivity, including a significant increase in effective implementation of e-rostering and e-job planning standards
- Make best use of the estate including improvements to energy efficiency, clinical space utilisation in hospitals and implementation of modern operating models for community services
- Improve corporate services, including commissioners and providers working together to simplify the contracting processes (see earlier comments on current commissioning arrangements for mental health) and reducing the costs of transactional services, for example through automation.

1.11 Operational Plan Requirement

While we will need to await the technical guidance to understand the detailed requirements this guidance makes clear it will be looking for clarity on workforce planning across a range of issues which are summarised below:

- A commitment to a “bank first” temporary staffing model via improved productivity and new roles
- Demonstrate a continued downward pressure on the cost per shift
- Financial plans should show a realistic split between substantive, bank and agency
- Actions to improve staff retention
- Focus on actions to improve staff wellbeing as a mechanism to reduce bullying and harassment
- Increase diversity
- Demonstrate actions to mitigate consequences associated with the EU exit.

1.12 Timeline and HPFT Governance

While the provision of the detailed guidance slipped by about a month the rest of the timetable provided on 31 October 18 remains.

This compresses an already tight time line. The key dates have been extracted and are presented in the Appendix 1 alongside the key governance dates for HPFT.

The timing of the Trust Board, early in March, does not support the achievement of the key dates required by NHS England. The approach taken in Appendix 1 is to work within the established dates for the Trust Board, FIC and Trust Executive, rather than to add an additional Board meeting, alongside a process of formal delegation of key decisions by the Board to other groups.

This requires a delegation of key decisions from the Board and consideration is needed if this is the most appropriate approach.

1.13 NHS Standard Contract Consultation

The NHS Standard Contract is reviewed and updated following a consolation process each year. These are normally a range of technical changes; however, periodically we see a wider range of changes being proposed. This is one of these occasions. It has not yet been

possible to assess the full implications of the proposed changes but the table below provides an initial review of those most relevant to us.

Service	Change
Learning disability	Need to have regard to NHSI improvement standards and NHS England good practice guidance (not yet published)
Eating Disorders	For children and young people use all “reasonable endeavours” to maximise the number of service users who start a NICE –concordant treatment within 4 weeks for routine cases, or within one week for urgent cases
Early Intervention in Psychosis	Access target threshold to move from 53% to 56% from 1 April 2019. Additional proposal to reach Level 2 performance under the Royal College of Psychiatrists annual assessment process
Physical Healthcare for people with severe mental illness	Conversation of CQUIN into requirement within the contract
System Wide collaboration	New requirement on both commissioner and provider to contribute towards implementation of any relevant System Operating Plan. A separate contract schedule will allow each parties obligation to be captured
Staffing of clinical services	New requirements to undertake a QIA before making staffing changes and to implement a standard operating procedure for dealing with day to day staff shortfalls
NHS e-Referral Service	New requirement for “elective mental health services” to be listed on eRS by no later than 1 October 2019
Interoperability of major IT systems	New requirement to implement specific mandated Care Connect APIs by 31 March 2020

In addition to the above NHS England is running a consultation process on establishing via the contract a standard approach to Activity and Finance Reporting for all acute and mental health services. This would cover four reports:

- Aggregate Contract Monitoring
- Patient Level Contract Monitoring
- Drugs Patient Level Contract Monitoring
- Devises Patient Level Contract Monitoring

There is significant detail provided for review and Finance and Performance functions will need to review the documentation to assess if this does provide an opportunity to simplify this part of our current reporting to enable us to feed into the consultation process that closes on 1 Feb 2019.

1.14 To meet the key milestones within the HPFT governance timetable with require the Board to formally delegate a number of decisions to FIC and / or a group of key Board members. The Trust Executive reviewed this approach and confirmed it as the route forward subject to Board approval. The final formal decision point for the Board in relation to governance will be the 7 March Board meeting.

Section 2 - Financial Planning 2019/20

The purpose of this section is to outline the key elements of the Financial Planning process for 2019/20. Its further development and refinement will be done in conjunction with the further progression of the Annual Plan, the requirements of NHSI when they are made known and any STP submission required.

Background

2.1 FY19-20 is the first year of the period of the recently published NHS Long Term Plan. In agreeing the additional investment for this plan one of the key conditions set by the Government was that individual trusts, and the provider sector as a whole, returns to financial surplus as quickly as possible.

2.2 In seeking to deliver on this NHSI has made major changes to the provider sector's financial architecture based upon:

- Reflating the sector as a whole through a number of pricing related changes primarily with the 3.8% contract increase this year, the increased Emergency care funding and the abolition of the marginal rate on Emergency admissions above the threshold.
- Setting providers more realistic and achievable financial targets which is accompanied by the removal of the Commissioner Risk reserve which previously countered the shortfall on provider delivery; and
- Replacing the current special measures regime and creating a new dedicated £1bn financial recovery fund to support Trust who need further help to return to surplus

2.3 In addition there are several other key pricing/financial related changes where further examination is needed to understand the likely implications;

- Reduction in CQUIN funding from 2.5% to 1.25%
- Lower efficiency target within the contract this year
- Change to the MFF adjustments applied to contract prices
- The continuation for one year of the PSF funding which will end in 20/21 when the amount will be transferred to the Financial Recovery Fund. For MH Community and ambulance Trusts in total this will be at the same level as FY18/19 (£155m)
- Exemptions from most contract sanctions where Providers sign to the Control Total
- Changes in cash regime including the ROI on new and existing loans
- Five year indicative CCG allocations

2.4 In developing the Financial Plan it will be important to consider the central tests set by to measure the progress of the individual and collective Operational Plans which are;

- Improve productivity and efficiency
- Eliminate provider deficits
- Reduce unwarranted variation in the quality of care
- Improve demand management
- Better use of capital investment.
- Incentivise systems to work together to redesign patient care.

2.5 A second key factor in developing the Financial Plan is an understanding of this year's performance and in particular the exit position into next year. The summary details from this are shown in table 2 below with the following comments based upon the expected position for this year and its implications for the following period.

2.6 The latest estimate is a surplus of circa £0.6m against a Plan of £0.36m. The table shows that this includes some material non-recurrent impacts in Q1 and in Q4. This would show:

- An underlying position below Plan driven by increased Other Direct costs (which is placements)
- The improved position after Q1
- The additional costs in Q4 on the estate.
- There are also small savings on overheads and financing.

Table 2 FY18-19 Projection (before PSF) £m

	Q1	Q2	Q3	Q4	Total	Plan	Var
Revenue	57.8	58.5	59.6	59.9	235.8	234.9	0.9
Pay	37.6	37.9	37.7	38.0	151.2	154.0	2.8
Other Direct	10.7	9.1	10.7	10.8	41.3	37.9	-3.4
Overheads	8.8	9.2	8.8	8.3	35.1	33.2	-1.9
EBITDA	**0.7**	**2.3**	**2.4**	**2.8**	**8.2**	**9.8**	**-1.6**
Financing	2.3	2.1	2.1	2.1	8.6	9.4	0.8
Surplus	**-1.6**	**0.2**	**0.3**	**0.7**	**-0.4**	**0.4**	**-0.8**
Adjustment	**1.5**			**-0.5**	**1.0**		**1.0**
Reported Surplus	**-0.1**	**0.2**	**0.3**	**0.2**	**0.6**	**0.4**	**0.2**

2.7 The above is before the Provider Sustainability Funding (PSF) which is contingent on the achieving of the Control Total (which we will achieve). This is £1.78m and whilst there may be further amounts notified in the reallocation of any unearned amounts from other providers, none is assumed. No application was made to the recent bonus scheme offer from NHSI and it is assumed no further bonus scheme offer will be made before the year end.

2.8 The above accounts for a level of exceptional spend on Estates in Q4. It does not consider any further such expenditure, any further end of year provision movements nor does it include any impact on the SOCI from building impairments, (as this is excluded from the calculation of PSF and is not considered part of the normalised surplus position.)

2.9 Forecast position for this year and key variables

Following on from the above then compared to last year there are less areas of uncertainty Table 3 gives details of the areas of variation and provides additional comment to allow comparison to last year's position:

Table 3 FY18-19 Surplus Range

Ref	Range of surplus	High	Low
		£k	£k
	Forecast surplus	580	580
1	Change in litigation provision	-	-100E
2	Reduction in the current provision held for CHC claims	500	-
3	Claim for Interserve for contractual disputes		-100
4	Additional estates work above agreed program	-	-350
5	Review of current accruals/ deferred income		330E
	Likely reported surplus before PSF	**1080**	**360**

2.10 Brief information on the items above is:

- Last year a significant provision was released. This year there is no material existing provision. An assessment is required of the likely cost on any current or expected employment claims.
- The work on the majority of the CHC claims has been completed, whilst some are ongoing and there is still the possibility that claimants will continue to pursue claims considered closed, the remaining provision of £1.7m is at the top end of any likely estimate. £2m has been refunded to CCGs (£1m this year) and £1.5m of provision was released in year.
- Last year's dispute with Interserve is settled. The minor risk is whether there is any major difference in views on the non-contractual ad hoc works which is part of the ongoing work program.
- As in previous years the Trust can look to accelerate its routine program of estates work. There is currently a provision of circa £650k made this year to meet such costs with the actual expenditure proposals currently being finalised.
- Any shortfall in the previous items would be expected to be covered by a review of accruals and or deferred income. This would ensure the full PSF is earned.

2.11 **Initial draft assumptions for FY1920**

The detail assumptions are drawn from the guidance and from discussions within the current draft Operational Plan and are set out within appendix 2.

2.12 In addition there are some new investments and cost increases that are emerging for the next year. These items are in addition to the ongoing issue to address service pressures and operational stretch which is being consistently reported. These additional cost pressures will need formal consideration and evaluation.

Table 5 Cost Pressures/New Investment

Cost Pressures/New Investment
• Additional costs within the Innovation & Improvement area • Creation of a specialist community PD team

- Additional functionality required within PARIS
- Potential increase in Microsoft licence cost
- Likely additional cost with Interserve on existing services
- Extension of space at Colonnades
- Further investments in technology to support service quality

2.13 Likely CRES level and key components

The assessment of the CRES value was initially as detailed below. This assessment will continue to evolve over the next weeks as the contractual detail becomes clearer.

Table 6 Initial CRES assessment

	£K	Comment
External requirement based on 2.1% contract value	(4,515)	Expected to be 1.1% plus the additional sum included in the control Total
Further investment in Innovation team	(250)	Costs likely to be less as reallocation of existing staff
PD investment required in Community teams	(500)	
End of subsidy N3 phone contract (Nov 2019)	(100)	
Interserve additional costs	(500)	
- additional price pressures	(100)	
- contingency	(500)	
- Essex LD contribution	50	
- other contribution	0	
Cost pressures	(1,900)	
Vacancy factor (time to recruit)	?	This will provide offset against total. Will be assessed when clearer on recruitment requirement
Net requirement - initial assessment	**(6415)**	

2.14 Summary

This is the first year of the NHS Long Term Plan and is accompanied with a number of fundamental changes to the financial framework. Whilst the headlines of the financial changes appear very positive; 3.8% contract increase, 1.1% efficiency factor, the continuing priority of MH investment and the reduced Control Total, until the full detail is understood and some of the other changes such as the pension increases are clear then it is difficult to assess the full implications. For example the contract increase is to effectively cover two years of Pay increase (as for FY1819 a separate central allocation was provided.)

In addition it will be important to understand the evolving development of system wide control totals particularly given the clear focus on tackling provider deficits and whether this will compromise the intended investment set out above. For example for ICS organisations part of the PSF allocation is based upon the achievement of the system control total.

Work will continue on the plan in accordance with the national contracting and planning submission which requires a draft submission on February 12th with the final submission April 4th.

It is stated within the guidance that the Single Oversight Framework metrics will continue next year, but may be subject to change. Based upon the expected increase in planned income but with increased costs and a lower surplus then an FRR rating of 2 is likely with a 2 on the capital servicing capacity rating and the I&E margin rating. If there is a further Agency cap limit ratio which sees a significant fall in the spend limit then this would also likely be a 2. At this point it is expected that the recommendation will be to accept the Control Total offer but further work will be undertaken to assess the areas of uncertainty or where information is outstanding. In particular:

- Any impact of the change in the MFF adjustment
- The reduction in CQUIN to 1.25%
- The funding of the pension contribution increase
- Any push by commissioners to implement the new payment currencies in FY1920.

Section 3 - NHS Long Term Plan (10 year plan)

3.1 The NHS Long Term Plan was published in January 2019. The Plan highlights a number of areas for improvement and investment including Mental Health and Learning Disabilities and details how services are expected to function and deliver high quality, effective and efficient care to services users and there carers over the next 10 years.

3.2 Whilst further work is required to fully understand and interpret the plan, a brief summary of the possible implications of the Long Term Plan are as follows:

3.3 Primary and Community Health Services

- Expanding community teams (covering primary and secondary care providers) with an opportunity to embed mental health support.

3.4 Personalisation, Prevention and Social Prescribing

- Focussed smoking cessation programmes for new mothers and long term users in mental health and learning disabilities.
- Possible weight management programmes tied into physical health programme.
- Better access to cancer services and pathways for people with Mental Health, increasing work with acute trusts for people with mental health issues to access cancer services.
- Increased working of alcohol teams with mental health services and local authority treatment services for identification and treatment.
- Greater investment, closer working with primary and secondary care services to tackle homelessness and gambling addiction.

3.5 Children, Young People and Young Adults (MH)

- Single Point of Access: The Trust already offer a single point of access, but this needs to be supported by available assessment, community, crisis and inpatient

services that can respond appropriately in a crisis. The reality of resource allocation will be key.

- Great working with education: While the involvement of the education sector in mental health support will be welcomed, there may be questions, if not resistance, from educational establishments if they are expected to deliver from existing staff and funding resource. Complex questions of expertise and integration will need to be addressed.
- New KPIs (20% of schools and colleges to have a MH support team in place by end of 2023), investment into support teams in schools and colleges, expansion of crisis services to children and young people, increased working with local authority (children, schools and families)
- Agreeing with commissioners the increase in resource for 0-25 year olds to take account the “comprehensive offer”. Increased activity and referrals in 0-25 year olds and increased working with local authority, schools and the voluntary sector to prevent inpatient admissions and sustain people in their communities

3.6 Adult Mental Health

- Increased investment may be required into community services, working in partnership with Primary care services and social care, increased integration between primary/ secondary care services and social care, increased scrutiny on community services and how effective they are i.e. 4 week wait for Community Mental Health Teams. Continued focus on IAPT services and crisis care and alternatives to admissions.
- Expanding the availability of specialist perinatal mental health services, from preconception to two years after birth, and extending support to their partners may require partnership or further investment.
- A further expansion in the Improving Access to Psychological Therapies (IAPT) programme, particularly for people with long-term physical conditions will require continued focus and partnership working
- Testing a four-week waiting time target for community mental health teams may require investment/ restructure to deal with capacity.
- Building on the current expansion of crisis care will require investment to, “ensuring the NHS will provide a single point of access and timely, universal mental health crisis care for everyone” including nationwide use of the NHS 111 line, 24/7 community support, alternatives to admissions (such as crisis houses and sanctuaries) and improved ambulance services.
- Designing a “new Mental Health Safety Improvement Programme” to prevent suicide in inpatient units and offer support for people bereaved by suicide will require investment of time and expertise to deliver

3.7 Learning Disability and Autism

- Increased focus on Annual Health Check with the addition of those with autism, continued focus on over medication and continued funding of the Mortality Review.
- Increased focus of the highlighting of people with a Learning Disability and ensuring that reasonable adjustments have been made. Increased focus on the physical health for people with a Learning Disability

- By 2023/24 all care to meet Learning Disability Improvement Standards. This will require additional evaluation against the standards and possible investment in areas such as seclusion, long-term segregation and restraint for adults and young children.
- Reduction in the length of stay for people with a learning disability in inpatient care, meaning additional investment in out of hospital alternative care and services and community teams to support timely discharge. These will be monitored against the "12 point discharge plan".

3.8 Children and Young People (LD)

- Push for reduction in waiting lists for specialist services for autism.
- Working with education to develop packages of care for those with autism and neuro-developmental disorders incl. ADHD.
- Designated key works for those with a learning disability, autism with complex needs. This may need addition investment and recruitment.

3.9 Intensive Crisis and Community Support (LD)

- Investment in 7 day specialist multidisciplinary services and crisis care for those with a learning disability.

3.10 Workforce

- Continued work towards promoting flexibility in working arrangements and career development as well as staff wellbeing.

3.11 Funding

- Increased demand for mental health services generally, and children and young people's services specifically, mean that what appears to be a significant injection of resource may fall well short of what is needed to meet demand and deliver the changes in service design.
- Move closer to a system where mental and physical health services are paid for much more similarly and the current bias is therefore removed.
- Changes in the way health and social care is purchased and a continual push to reduce administrative costs.

3.12 Other Possible Implications

- Many of the priority areas can be seen as addressing the identified need to co-ordinate the management of acute and mental health needs pro-actively, preferably outside of hospital, in a way which reduces crisis intervention and improves the ability of those with mental illness to function and live positively in the community.
- Integration between many agencies providing physical and mental health input, social care support, education and employment input and community services will be key to the success in delivery.
- Integration will be heavily dependent on whether the resource commitments match the delivery aims.

3.13 Further analysis of the Long Term Plan will be undertaken over the next weeks to facilitate a more comprehensive discussion for the Board.

4.0 Recommendations

The Board is asked to:-

- **Note the planning requirements and timetable**
- **Critically appraise the information presented and the approach to planning**
- **Note the summary headlines from the NHS Long Term Plan**
- **Advise any additional information required**
- **Note the proposed approach to governance**

Appendix 1: Combined NHSE Planning Timetable and HPFT Governance Timetable.

Action / Deadline	Organisation	Trust Committee / Board	Comments	Date
Detailed guidance issued	NHS E	n/a	This will provide the templates, technical guidance on what is required alongside CCG allocations and CQUIN guidance	Early Jan
STP and Provider organisations agree underpinning assumptions	Trust / STP	n/a	H&WE STP has agreed to stick with the assumptions within the Medium Term Financial Plan and to use activity based on 18/19 (the majority of this is for the three acute Trusts)[2]	< 14 Jan
2019/20 Initial plan submission – activity focused	HPFT	n/a	As with all submissions the detailed requirements will not be known until detailed guidance is made available in "early January" This is identified as the "January Checkpoint" to provide evidence to NHSE of initial alignment and heads up on the starting position Submitted on approval of Director of Finance	14 Jan
Draft Operating Plan submission review / approval	HPFT	Trust Exec	Trust Executive review and approve for submission by 12 Feb	6 Feb
Submission of Draft Operating Plan	**HPFT**	**n/a**		**12 Feb**
Consolidated Draft Operating Plan	**STP**	n/a	While the HPFT financial and workforce submission is expected to be consolidated as presented, ongoing discussions with the STP will be required to ensure the "overview" properly reflects mental health and learning disability planned activity – linked with contractual commitments	**19 Feb**

[2] KL e-mail 24 Dec 18

Action / Deadline	Organisation	Trust Committee / Board	Comments	Date
2019-20 NHS Standard Contract Published	NHS E			22 Feb
Target for agreement on service contracts	CCGs / HPFT	n/a	The target date is for all principle aspects of the Main Herts contract to be agreed, subject to approvals. Key milestone if alignment with Operating plan and budgets is to be achieved. There are risks relating to our Essex LD contract and NHS E specialist contract	25 Feb
Review of key documents for FIC	HPFT	Trust Executive	Review of Budgets, services contracts, and final operating plan submission ahead of FIC on 18 March	
Approvals and delegated authority	HPFT	Trust Board	It is unlikely that all contracts, budgets and planning documents will be ready for approval in time for papers to be prepared and considered by the Trust Board. It should therefore formally delegate key decision making to FIC and/ or a group of key Trust Board members	7 March
Trust Budgets Approved	HPFT	FIC	This will allow the NHSE deadline for this of 29 March to be met	18 March
Major Trust Service Contracts approved	HPFT	FIC	Depending on delegation made by the Board, FIC may further delegate final decision making to group of key Trust Board members	18 March
Final Operating Plan Submission reviews / approved	HPFT	FIC	Depending on delegation made by the Board, FIC may further delegate final decision making to group of key Trust Board members	18 March
Deadline for contract signatures	**CCGs / HPFT**	**n/a**	We will establish contract signing dates in anticipation of approval by FIC	**21 March**
Deadline for approval of Trust Budgets		**n/a**	This will have been achieved at FIC 18 March	**29 March**
Final Trust Operating Plan Submitted	**HPFT**	**n/a**	This will be submitted following approval by FIC	**4 April**

Action / Deadline	Organisation	Trust Committee / Board	Comments	Date
			and or any further delegated approvals required	
Final Aggregated Plan Submitted	**STP**	**n/a**	Between HPFT approval of our Operating Plan and this submission date we will need to continue to work with STP to ensure the "overview" properly reflects mental health and learning disability planned activity – linked with contractual commitments	**11 April**

Appendix 2 Table 4 Assumptions& Risks

Area	Assumption	Risks
Income	Net increase in all key contract values of 2.7% with a +3.8 % inflation allowance offset by a -1.1% national efficiency requirement and a top slice applied for centralised procurement arrangements.	Proposal currently under consultation. The increase includes the Agenda for Change Pay awards for both 19/20 but also the amount funded out with the tariff in 2018/19 (which was £1.8m) No current detail on top slice other than that contribution higher for acute Trusts. Currently part of the overall contract value is funded by Cambridge CCG. The CCG is seeking to reduce this contribution. There is an option to move some of the contractual payments from a block contract to a new blended payment system. At this point there has been no discussion with commissioners on this and therefore it is unlikely to be implemented for FY1920
	For the two Hertfordshire commissioners there is an increase expected above the inflation allowance to reflect the additional CCG allocations which are: HVCCG 5.74% E&N CCG 5.72% In addition there is £1.1m of additional funding noted in aggregate for the two CCGs the purpose not currently clear	Commissioner contracts scheduled for agreement within national timetable during March. Details of how MH Investment Standard obligation will be applied by CCGs will need clarified and agreed.
	The new commitments on MH spending set out in the Guidance requires additional funding beyond the MHIS requirements; • CCGs given minimum % increase target • Increased share of MH spend to be with MH providers • Increase in children and YP spend	Whilst both CCGs have confirmed an intention to meet this there is further discussion required of the detail. Guidance provides for STP and MH lead provider to review CCG plans
	There is an update to the Market Forces Factor (MFF) which is to be implemented	Further understanding required of how MFF changes have been applied to CCG's funding and any implications for MH block arrangements

Area	Assumption	Risks
	over a five year period. This should not apply to current block contract arrangement	
	3.8% increased funding does not include the funding to be provided to fund increased pension contributions	Details of how this will be funded still awaited
	Whilst the amount of CQUIN funding provided through commissioner contracts is to be halved it is assumed that this will be replaced	Confirmation of this and details of how this will be funded still awaited
	In relation to specialised services commissioned through NHS England then it is assumed that the above will apply where applicable	Commissioner contracts scheduled for agreement within the national timetable during March. Previously the CAMHS T4 funding has been seen as outside the standard contract rules. Bed occupancy levels have been below contract levels resulting in income levels below Plan
	In relation to the remaining contracts (Essex Norfolk and Buckinghamshire) there will be no material change in the contract values other than the net tariff increase set out above with changes in service specifications expected to generate similar income levels to current	If level of bed occupancy at Astley Court is at the contract minimum of six this will reduce the current contract contribution level. There has been ongoing contract performance issues within Essex over the IAPT contracts
	In relation to HCC there will be no income reduction in FY19/20	Commissioner contracts scheduled for agreement within national timetable
	There will be a level of transformation income to be carried forward and available in 18/19 to meet the operational costs related to the continuing healthcare transformation and BI development.	

Area	Assumption	Risks
	A minimum 90% of CQUIN income will be achieved in each year on all contracts	Level of CQUIN in 18/19 likely to be at 80-85% based upon recent assessment. Further details required of changes in CQUIN proposed
	There will be no significant change in the education and training income over the period	Review of any further guidance or publications required
New Business	Full year impact of the extension of the Essex LD service	Business Plan is very small surplus during initial contract phase
Lost Business	The current Essex IAPT contracts will continue Potential changes in relation to LD residential accommodation provided at Kingsley Green, with national policy being to close these facilities.	Contract negotiations continue on Essex IAPT Early discussions on alternative care provision. Financial impact assessments will be on change options identified.
Pay costs	There will be an increase in costs in accordance with new Agenda for Change scheme introduced in July 2018. The draft tariff suggests an average 5% uplift across 18/19 & 19/20	The costs are more complex to assess during this period of transition to the new pay scales.
	There will be an increase in headcount on frontline staff to meet the additional services/expansion agreed with commissioners	This will be impacted by the recruitment and retention challenges
	There will be a review of the existing Recruitment and retention schemes	Due to be completed during Q4 FY1819
	NHSI Agency expenditure ceiling has been confirmed as £7.3m, equivalent to the 2018/19 cap	
	No planned redundancies	

Area	Assumption	Risks
Non-Pay Costs	2% included for non-pay inflation on some costs i.e. drugs, and utilities	Utility and other property related costs may be higher. Ongoing drug cost inflation may continue.
	Any cost implications of Brexit will be met through the national contingency planning	
	The costs for any exceptional continuing care claims over and above the existing provision will be met by commissioners	£2m was returned to the CCGs as part of this arrangement
	Any significant double running costs from the refurbishment of the estate will be met from transformation income c/f	There will an amount of Deferred Income c/f to meet this cost
Investment	Capital Investment Plans are currently being reviewed in particular within; Estates I.T investment	Will review capital programme in the light of affordability
	Investment interest continues to be restricted to deposits with the Government Banking system	

Appendix 3 Extract from NHSI Control Total Offer Letter

Financial control total and PSF, FRF and MRET funding for 2019/20 Financial control total	**£ million**
Rebased baseline position excluding PSF	**0.360 Surplus**
£1bn PSF transferred into urgent and emergency care prices	0.000
CNST net change in tariff income and contribution1	0.014
Other changes2	-0.725
Subtotal before efficiency	**-0.351 Deficit**
Additional efficiency requirement up to 0.5%	0.351
2019/20 control total (excluding PSF, FRF and MRET funding)	**0.000 Breakeven**
MRET central funding	0.000
Subtotal before PSF and FRF allocations	**0.000 Breakeven**
Non recurring PSF allocation	1.887
Subtotal before FRF allocation	**1.887 Surplus**
Non recurring FRF allocation	0.000
2019/20 control total (including PSF, FRF and MRET funding)	**1.887 Surplus**

Those elements highlighted. Further detail requested

Acceptance of Control Total is a condition of access to PSF funding of £1.9m. This will be payable quarterly in arrears subject only to meeting the profiled surplus requirement (based upon Plan)

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	7th February 2019	**Agenda Item: 18**
Subject:	Report from the Chair of the Audit Committee – meeting held 4th December 2018	**For Publication: Yes**
Author:	Keith Loveman Executive Director - Finance	**Approved by:** Keith Loveman Executive Director - Finance
Presented by:	Catherine Dugmore Audit Committee Chair	

Purpose of the report:

This paper provides a summary report of the items discussed at the Audit Committee meeting on the 4 December 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 Audit Committee met on 4 December and considered the following matters:

- Risk Topic Presentation – Data Quality
- Preparation for leaving the European Union
- Internal Audit Progress and Exception report
- Local Counter Fraud Progress and Exception report
- External Audit 18/19 Audit Opinion Plan
- Annual Report/Quality Account Update
- Annual Review of Terms of Reference
- Six Monthly Reports
    - Finance and Investment Committee
    - Integrated Governance Committee
- Review of Minutes
    - Finance and Investment Committee
    - Integrated Governance Committee
- Draft Annual Programme of Meetings 2019

Risk Topic Presentation – Data Quality
The Audit Committee received a presentation on Data Quality highlighting the importance of correct data being entered onto systems and setting out the approach being taken by management to improve data quality. In August 2018 the Data Quality Strategy was re-launched as the Accurate Information Strategy and reviewed the quality of data in relation to the number of service users, the number of referrals and the number of incomplete assessments which impact on reporting against key metrics.

Hertfordshire

The ongoing approach has been focussed through three key areas:

- Right First Time – entering information accurately
- PARIS (Electronic Patient Record) – the prime source and 'single version of the truth'
- SPIKEII – providing high quality user friendly business intelligence for all staff

Audit Committee noted that this is a high priority for the Trust and that SPIKE II enables real-time reporting so that data issues can be quickly resolved. A significant amount of work has been undertaken to improve data and staff will now be in a position to more easily evidence their work. Data quality has considerably improved with some 18,000 'ghost' records being closed down on the system.

The Committee welcomed the work on SPIKE II and heard that this will be rolled out across the organisation with effect from 7th January 2019. Examples of live dashboards were presented and these will link real-time data with audits and the clinical outcomes framework. SPIKE II is currently set up to report live KPI's however new metrics can be added to dashboards very quickly.

Preparation for leaving the European Union
Audit Committee received a paper setting out the planning that is in place to mitigate the possible risks associated with a "no deal" Brexit scenario. Discussions had taken place at Finance and Investment Committee, Integrated Governance Committee and Board of Directors.

The key areas of risk identified are;

- Pharmaceuticals
- Clinical Consumables and Medical Devices
- Workforce
- Procurement

NHSE requested all Trusts to complete a self-assessment of contracts for submission by 28th November. The Trust has written to all staff with an EU passport offering support on applying for settled status.

The key message for medicines management is not to stock-pile medicine and the importance of monitoring compliance in relation to this. The Trust's Chief Pharmacist has robust plans in place and has been monitoring a volatile market over the last 18-months. There is also a resource in place in Pharmacy sourcing alternative suppliers.

Audit Committee agreed that Brexit should be included on the Trust Risk Register and the recommendations that:-

- Any evidence of over prescribing or potential local stockpiling must be investigated by the Trust's Chief Pharmacist.
- Clinicians should advise patients that the UK Government has plans in place to ensure supply of medicines is maintained and as such patients should not stockpile at home.
- Human Resources and Workforce to utilise the Home Office toolkit and provide a targeted communications campaign to employees who are non-UK, EU citizens.
- A business impact analysis against the Trust in the event of a 'no deal' scenario when the UK leaves the EU.

Internal Audit – Progress and Exception Report
The Head of Internal Audit presented the Internal Audit Progress Report outlining the position of the work programme and reported that work is progressing well.

With regard to the Procurement Investigation, it was reported that a brief had been presented to the CEO.

The Internal Audit Reports finalised in the period were reviewed and the Assurance Opinion in each case noted.

- Ability to Recruit – Partial Assurance was received. Whilst the Trust has been monitoring recruitment and retention issues it is not always clear how the messages link through the organisation. There are a number of initiatives in place however the Trust was not able to formally assess the effectiveness and benefits. IGC would be asked to review and track through the action plan.
- Investigation into Overdrawn Account – Executive Summary – Whilst there is a Service User Finance Policy in place that provides guidance to staff who are handling or managing money on behalf of a service user, there does not appear to be a specific policy to be followed in the event of a service user account being overdrawn or having a negative balance and a consistent approach towards overdrawn balances has not been formalised. This would be updated.
- Doctor Revalidation – Reasonable Assurance was received. The Allocate system is utilised by the Trust to record all appraisal information used as part of the revalidation process.
- CRES Delivery – Substantial Assurance was received with evidence in place to illustrate that the Trust is on track to achieve identified savings.
- Data Quality – NHSI Metrics – the Committee heard that there has been credible improvement however further improvements to recording could be implemented to ensure the capture of information to evidence reporting. The Director of Finance confirmed he would be discussing the outcome of the audit with NHSI. The Committee felt this was a matter for escalation to the Board.

Action Tracking Status Report
Significant improvement has been seen since the last Audit Committee meeting with forty-eight recommended actions being implemented leaving 21 actions outstanding.

Local Counter Fraud – Progress and Exception Report
Audit Committee received the progress report detailing the work that is being undertaken across the Trust. Fraud Awareness month was November with key messages being publicised to staff. In addition LCFS are working with HBLICT to raise awareness about the ongoing risks associated with.

Audit Committee noted the work in respect of investigations that is underway and noted that the Fraud Policy is due to be reviewed.

External Audit – 18/19 Audit Opinion Plan
KPMG presented the External Audit progress report highlighting the work that has been undertaken together with the additional area of audit focus for 2018-19. The key areas of the report are;

- Audit opinion on the financial position
- Value for money
- Audit opinion on the Quality Report.

Annual Review of Terms of Reference
The Terms of Reference were reviewed. Whilst there is no change to the duties and responsibilities of Audit Committee it was agreed that it is not clear that the meeting is open to all Non-Executive Directors. Following discussion it was agreed that all Non- Executive Directors are members of the Audit Committee but the core members will be the Chair of Audit Committee, Finance and Investment Committee and Integrated Governance Committee.

Six Monthly Reports & Review of Minutes
The 6-monthly report and the minutes from the Finance and Investment Committee and Integrated Governance Committee were discussed. It was agreed that consideration should be given to the content of both the reports and the notes and how these might be structured to give fuller assurance.

DRAFT Annual Programme of Meetings 2019
The draft annual programme was reviewed and additional items noted.

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

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

Summary of Implications for:

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

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

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

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

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	7th February 2019	**Agenda Item: 19**
Subject:	Board Assurance Framework (BAF)	**For Publication:** Yes
Author:	Jill Hall Company Secretary	**Approved by:** Dr.Jane Padmore, Executive Director Quality and Safety
Presented by:	Jill Hall Company Secretary	

Purpose of the report:

The Board is asked to review the Board Assurance Framework (BAF) to ensure the evidence provides assurance that the principle risks have been identified and are being appropriately managed.

Action required:

The Board is invited to review and note the Board Assurance Framework.

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 the controls the organisation has in place to mitigate against the risks identified that could compromise the achievement of its strategic objectives.

The BAF was presented to the Integrated Governance Committee on 23 January 2019, Appendix 1 sets out the changes to the BAF since it was last reported to the Board in November and the changes requested by the Committee to include further first line of assurances.

The Lead Director for each risk is responsible for assessing the risks assigned to them and providing assurance on the effectiveness of risk controls.

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 to the IGC, Audit Committee and the Board of Directors

Appendix 1

	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	• Additional first line of assurances added • New risk control – Mental Health Act and DOLS guidance has been updated and is being followed
The fundamentals of care are not delivered consistently across all our services	1.2	• Additional first line of assurances added • New Risk Controls – Claims reporting Training programme Recruitment process Professional outcomes Clinical standards • Additional 1st line of assurance – Supervision taking place • Addition of 2nd line of assurance – PACE • Addition of 3rd line of assurance – POM accreditation
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	• Additional first line of assurances added
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	• Additional first line of assurances added

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	• Additional first line of assurances added • Gap in assurance/actions – Reviewing and updating the Bullying and Harassment Plans – expected April 2019 • Additional 2nd line of assurance – 6 monthly reports to Workforce and OD Group
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	• Additional first line of assurances added
Clinical leadership is not engaged with service changes	4.3	• Additional first line of assurances added • Risk description amended • Addition of 2nd line assurances • Gap in assurance/actions – Quality Strategy in development
New roles are not created which support the clinical model.	4.4	• Additional first line of assurances added • Additional 3rd line assurances • Gap in assurance/actions - Recruitment and Retention Strategy under review
Turnover and vacancy rates are not reduced	4.5	• Additional first line of assurances added • Additional 3rd line assurances • Gap in assurance/actions - Recruitment and Retention Strategy under review
Recruitment and retention plans are not robust and do not support increased flexible working	4.6	• Additional first line of assurances added • Gap in assurance/actions - Recruitment and Retention Strategy under review
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	• Additional first line of assurances added
The quality and recording of data does not improve	5.2	• Additional first line of assurances added • Addition of 3rd line of assurance
Failure to maintain a sustainable financial position that supports investment and the continuity of services	5.3	• Additional first line of assurances added
Innovative productive ways of working are not embedded	5.4	• Additional first line of assurances added • Risk Control changed to Continuous Quality Improvement Programme • Addition of 1st line of assurance – Improvement and innovation fund panel
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	• Additional first line of assurances added
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)

February 2019

Reviewed by:

- Integrated Governance Committee
- Audit Committee
- Trust Board

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]										Director of Quality & Safety [IGC]
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	Datix reports S.I reports Service audits	Suicide Prevention Reports included in Patient Safety Reports	CCG S.I reviews CQC reviews NHSI reviews Benchmarking with like organisations	High	IGC 05.07.18		
		Review of all Serious Incidents Weekly Moderate Harm Panel	Executive Committee CCGs		Serious Incident Briefing Report. Weekl Exec and Board reports and minutes of meetings		High	Weekly to Exec Monthly report to Trust Board		
		Safer Care and Standards Processes Annual Freedom to Speak Up report Mental Health Act & DOLs Act guidance is updated and followed		Service audits Service feedback from FSUG MHA service reports	MHA Committee reports	CQC MHA Inspections FSUG meetings	High	Bi –Annually reports to IGC 05.07.18 Q1 IGC TB 28.06.18 27.07.18 QRM		
			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	Trust Board July 2018		
						Internal Audits; Assurance visits from CQC, MHA	High			
			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		

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				
			IGC (Part of the Speak Up 6 monthly report) Trust Board		Concerns raised with the Trust via the CQC (CQC Concerns)	CCG quality reports	High	IGC 05.07.18 TB 26.07.18		
			Audit Committee	N/A			N/A	5 March 2018	Update on responding to actions required	
			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 Report Processes	Executive Committee IGC Trust Board External Audit Commissioner's Secretary of State	Service reports on Quality priorities	SBU, ICG and Board reports on Quality priorities and Quality Account	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	TMG Executive Committee IGC Trust Board CCGQRM	Trust Management Group update reports Service and SBU reports on CQUIN	CQUIN Reports – Part of quarterly Performance Report	CCG CQUIN reports as part of the Quality report	High	IGC 5.7.18		
		Major Incident Policy	Executive Committee IGC Trust Board	Service Business Continuity plans	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		Service and SBU objectives related to the Quality Objectives as defined in the Strategy	HSCC QRMC IGC Quality Improvement reports	CCG performance reports related to Quality Objectives	High	IGC	Quality Strategy in development Lead: Dr Jane Padmore	

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				
	1.2 The fundamentals of care are not delivered consistently across all our services	Claims Report Training Recruitment process Professional standards adhered too Clinical Outcomes	Executive Committee IGC Trust Board	Supervision Appraisals Audit of care plans and records	Quarterly Safe Staffing Levels report CCG Contract reporting (quarterly) Practice Audit Clinical Effectiveness (PACE)	POM UK Accreditation	High	IGC 16.07.18 TB 26.07.18 QRMC Aug 2018 QRM Q1 2018 reported to CCG		Director of Quality and Medical Leadership [IGC]
		Organisational Development Strategy	Executive Committee WODG IGC Trust Board	Supervision Appraisal	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.	CQC inspection	High	TB IGC 05.07.18		
		Quality Measures	IGC Trust Board		Trust performance KPI report on Workforce		High	TB 26.7.18 TB		
		External Systems for Staff Feedback	Executive Committee WODG IGC Trust Board	FSUG report	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 IGC Audit Committee Trust Board CCG QRM	Individual Clinical Audits PACE progress reports	Annual Audit Programme	NICE Progress Reports	High	IGC QRMC PAIG		
		Medicines Management	QRMC Executive Committee IGC Trust Board	Service level feedback Datix reports	DTC Annual Report 6 monthly committee update	CCG Quality report	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**	Performance Monitoring Processes - Implementation of Accurate Clinical Information Strategy - SPIKE	Service Line Leads & Modern Matrons Executive Committee TMG Trust Board SBU Core	Spike Performance Reports Service Experience team reports	Trust Performance KPI report – Access Times. Re-admission rates. Performance Review Process Live Data	Internal Audit Data accuracy and data quality report to Audit Committee Dec 18	High	TB TB TB quarterly Audit Committee	Refresh of the Experience Strategy (ratification at IGC TBC)	Director of Service Delivery and Customer Experience /

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				
	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**		Management PRM Contract review meetings Internal & External Audit	Complaints seen in real-time Datix and local reporting of incidents SBU performance reporting and local PRM service line reporting structures	Performance Dashboards Performance Audit Performance against Annual Plan Internal & External Audit SPIKE live data Spike data quality reports			Dec 18		Director of Finance [IGC]
		Quality Impact Assessments Procedure for CRES	Service Line Leads CRES PAB and Trust Executive Committee QRM – reports to Commissioners	Datix Complaints in real-time Experience reports Friends and Family results Having Your Say	Individual Quality Impact Assessments External Commissioner scrutiny Quality Impact Assessment reports to IGC		High	QRM IGC 05.07.18		
		Service User Feedback	QRMC Executive Committee IGC Trust Board	Complaints in real-time Experience reports Friends and Family results Having Your Say		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	Reporting via Experience Team Feedback from the Council of	Carer Pathway report	CQC inspection CCG reports	High	04.01.18		

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				
				Carers						
		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	IGC Sept, Nov 2018		
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	Audit of care plans and records	CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads	CQC inspection CCG reports on CQUIN	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 satisfaction.**	Multi Professional Quality Improvement Performance Framework (QIPF)	IGC	Supervision Appraisal	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	Service and SBU objectives related to Strategy	Workforce and Organisational Development Report	CQC inspection	High	TB 27.07.18 WODG Trust Board Nov 2018		
		Health and Wellbeing CQUIN Action Plan	Executive Committee WODG IGC Trust Board		Quarterly Report	CCG Quality report	High	WODG May 2018, Nov 2018 IGC May 2018		
		Systems for Staff Feedback As defined in the Engagement & OD Strategies	TMG Executive Committee WODG IGC Trust Board	Team meetings Senior Leaders Forum Staff Network Groups	Quarterly Pulse Survey Report– Part of the Workforce & Organisational Development Report Good to Great Road Shows, Big Listen and Local Listen. Use of Resources / Ability to Recruit		High	TB 28.0718 Local Listen – July 18 Big Listen Oct 18 Good to Great Roadshows – Dec/Jan 18/19 Pulse quarterly survey Sept Trust Board Nov 2018		
		External Systems for Staff Feedback	TMG Executive	OD activity plan for year 2,	Equality review meetings with	National Staff Survey 201	Medium	IGC 05.07.18	Reviewing and updating Bullying and Harassment plans to be reported via	

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				
			Committee WODG IGC Trust Board	bullying and harassment	commissioners (annually)	Report on Key Findings and action plan in place		QRMC	quarterly Workforce and OD reports to Trust Board	
		Harassment and Bullying Plan (also part of the HPFT work plan for WRES)	JCNC Executive Committee WODG IGC Trust Board	Service objectives Supervision Appraisal	Workforce and OD Report PULSE Survey Monitoring	CQC inspection	High	TB 27.07.18		
		NHSI Retention Project Quarterly OD and Workforce report	TMG Executive Committee WO 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 IGC Sept 18		
		Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee WODG Workforce Board IGC Trust Board	Performance by team/service reported monthly from Discovery system	Statutory & Mandatory Training Report Monthly Inspire and annual awards Staff awards		High	TB 27/07/18 Exec Com 22.8.18 Trust Board Nov 18	Stat Man training, PDPs and appraisals report to IGC Sept 18	
		Mandatory Training Programme	IGC (6 monthly) TMG SBU Core management SLL's	Performance by team/service reported monthly from Discovery system	Quarterly Workforce and Organisational Development KPI Report (to services monthly) Bi-annual statutory & mandatory training report Quarterly report to WODG					
	4.2 Leaders across the organisation do not receive appropriate training and support on improvement approaches and tools - Failure of staff to develop strong core competencies	Organisational Development Plan	Executive Committee WODG IGC Trust Board	Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum Team Leaders Development Programme	Workforce and Organisational Development Report Organisational Development stock take report		High	TB 28.06.18		Director of Workforce and OD [IGC]
		Staff Feedback systems	Executive	Team meetings	Pulse Survey		High	WODG		

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				
			Committee WODG IGC Trust Board	Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum	Report– Part of the Workforce & Organisational Development Report			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 Clinical leadership not engaged with service users	Clinical Leadership Structures in place	MSC IGC Trust Board	Service and SBU level meetings	Quality Impact Assessments		High	IGC		Director of Quality and Medical Leadership [IGC]
		External core and well led review of Trust Governance arrangements every three years	Executive Committee IGC Trust Board	Clinical audit	Independent Well Led Review Update	CQC inspection	High			
		Clinicians leadership within teams	Trust Management Group SLT SLF	SPIKE Audits Supervision Appraisal	Guardian of safe working report (Q) QRMC PACE report IGC Quality report Audits	Focus Group feedback to CQC	Medium		Quality Strategy in development Lead: Dr Jane Padmore	
		Systems for Staff Feedback As defined in the Engagement strategy & the OD Strategy.	TMG Executive Committee WODG IGC Trust Board	Service level meetings	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Staff survey	High	WODG TB		
		External Systems for Staff Feedback	TMG 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	reports and feedback Service level	Quarterly Recruitment and Retention Report	Use of Resources Ability to Recruit Internal Audit Action plan	Medium	WODG IGC	Recruitment and Retention Strategy being reviewed (due Q4)	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. Retention Plan	Executive Committee WODG IGC Trust Board	Regular reporting to WODG Monthly 'flash' performance KPIs	Quarterly Workforce and Organisational Development Report (to services Monthly)	Use of Resources Ability to Recruit Internal Audit Action plan	Medium	WODG May 2018 IGC May 2018 05.07.18, Nov 2018	Recruitment and Retention Strategy being reviewed (due Q4)	
		Agency Reduction Action Plan	SBU Core management TMG Executive Committee FIC	Weekly monitoring of key financial indicators Local	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				
			Trust Board	monitoring on 'post by post' basis						
	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	Supervision Appraisal	Recruitment and Retention Group Reports		High	WODG IGC 05.07.18	Recruitment and Retention Strategy being reviewed (due Q4)	
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 IGC Trust Board			National Staff Survey 2017 Report on Key Findings	High	WODG IGC Jan 2019	Completion of a revised Digital Strategy Action Plan	Director of Innovation and Transformation [IGC]
			Executive Committee IGC Trust Board	Service level reports	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Benchmarking with like organisations	High	TB		
			IM&T Programme Board Board Executive Committee IGC		PARIS/BI Development Group – progress reports IM&T Strategy External review		High	IM&T Programme Board June 2018 January 2019		
	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		Internal Audit	High			
			IM&T Programme Board MSC Executive Committee	Accurate Information Group			Medium			
		Performance Monitoring Processes	Executive Committee IGC Trust Board	Monthly 'flash' performance KPIs	Quality Dashboard Performance Review Process Operational Services Report Quarterly Performance Report Trust Performance KPI report	CCG Quality reports CQC inspection	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	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators Departmental	Financial summary report monitoring performance against plan including the NHSI Use of Resources Risk Rating and the Agency Cap	CQC reports	High	TB 29.11.18 FIC 22.01.19 MoE 25.01.19		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				
			Committee FIC	Budget Reports (monthly)	Progress report on delivery of Strategic Investment Programme			FIC 22.01.19		
		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	Delivering Value Group Monthly updates to TMG	Part of Financial Summary Report Updates to CRES Assurance Board		High	TB monthly FIC 22.01.19 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	Continuous Quality Improvement	Executive Committee WODG IGC Trust Board	Improvement & Innovation Fund	Quarterly Workforce and Organisational Development Report (to services Monthly)		High	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	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators	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**	Carers Pathway	QRMC	Carers Council Service Experience Team reporting	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	Complaints seen in real-time Performance data via SPIKE GP feedback	STP Participation Project reports		High	TB		

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				
	We do not mainstream physical health practices across the trust. -			Contract hotline via CCG						
		Performance Monitoring Processes	FIC Exec Trust Board Exec TB	Monthly 'flash' performance KPIs	Performance Report		High	TB Exec -July TB	Stakeholder Plan (TBC) Stakeholder Map (TBC)	
		Staff training and education programme to include physical health Organisational Development Report	Executive Committee WODG IGC Trust Board	Service audits on training Care plan audit	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 objectives		High	TB IGC QRMC 04.01.18		
		Physical Health Strategy – measures against outcomes	Physical Health Care Committee Exec Committee	Service and SBU objectives	Non – CQUIN Physical Health Target	Internal Audit	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	Clinical staff involved in system meetings	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			

HPFT BAF January 2019

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				

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	7th February 2019	**Agenda Item: 20**
Subject:	Trust Risk Register January 2019	**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 Trust Board is asked to consider and note the changes Trust Risk Register

- Approve the recommended changes agreed by the Integrated Governance Committee

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 15 risks currently on the Trust Risk Register.

The following report provides an update on the Trusts top ten risks.

Risk that has been closed

- Risk 387 which concerned the management of demand and capacity for those individuals pending care coordination allocation has been closed as the remaining risk is covered in risk 773 the adult community risk about failure to respond effectively to increasing demand resulting in a risk to safety, quality and effectiveness.

Risk score decreased

- Risk 116 The Trust is unable to ensure short term financial performance in current financial year; this risk remains on the Trust Risk Register but not in the top ten.

Risks downgraded from the Trust Risk Register to management on the local risk registers

- Risk 625 Fragility in the underlying IT infrastructure results in an IT failure
- Risk 862 Statutory and Mandatory Training Compliance
- Risk 942 Failure to comply with the new Data Protection Regulations (GDPR) specifically SARS & information held with external suppliers.

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 16.01.2019
IGC 23.01.2019
Trust Board 07.02.2019

Trust Risk Register January 2019

1. Introduction / Background

1.1. The purpose of this report is to present the Trust Risk Register (TRR) to the Trust Board for discussion. 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.

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 Senior Responsible Officer for. In addition the Executive Team met to peer review the TRR as a whole, along with the scoring.

2. Risks escalation to the Trust Risk Register

2.1 There are no risks being considered for escalation to the Trust Risk Register.

3. Risks downgraded from Trust Risk Register

3.1. **Information Management and Technology: Fragility in the underlying IT infrastructure results in an IT failure which prevents or reduces access to critical systems, negatively impacting quality and safety, performance and reputation. (Risk 625)**

The historical risk of having the data centres based at Waverley Road has been mitigated, data centres are now up and running based at Charter House and ARK. HBLICT have formally issued a closure certificate to the Trust as the project is formally closed. The data centre project has been formally closed for over 6 months now and the NHS.net email migration has been completed over 6 months ago. The data centre infrastructure is stable. The current score has met the risk target score. The target is the lowest acceptable (tolerated) level for the risk. The risk will remain but be downgraded to the IM&T risk register for ongoing monitoring and review.

3.2 **Workforce: Statutory and Mandatory Training Compliance (Risk 862)**

This risk was developed following a review of all statutory and mandatory training compliance which showed that recovery plans had not been as successful as anticipated following changes. These changes needed to be made to ensure that the correct level of training was being provided to the correct target audience.

A Task & Finish group was set up in November 2017 to provide focus, direction and resource in overseeing corrective action to improve statutory and mandatory training compliance by 31 March 2018. Compliance levels were reached and this group has now ceased and reporting is now business as usual.

The Trust has fully implemented the core skills training framework and are now reporting compliance against this. The statutory and mandatory training rates as at the end of December were 86%. As mandatory training rates have been improved upon and maintained over the last

year and compliance has increased and/or been maintained for individual competencies it is proposed that this risk is removed from the Trust risk register and maintained going forward on the Workforce and OD risk register. The current score has met the risk target score. The target is the lowest acceptable (tolerated) level for the risk.

3.3 **Information Management and Technology: Failure to comply with the new Data Protection Regulations (GDPR) specifically SARS & information held with external suppliers. (Risk 942)**

There are no outstanding actions against the Trust's action plan to meet the Information Commissioner's 12 Steps to GDPR compliance and the National Data Guardian's Security Standards. The Trust has received 95% of data flow mapping on information held with external suppliers from the identified 70 suppliers with 4 outstanding. We are proactively engaging with the 4 organisations to finalise this activity. The Trust has improved on compliance rates for processing SARs within one month, achieving 96% rate in December 2018, in addition FOI compliance is consistently showing steady improvement, achieving 66% of requests closed within 20 working days in December 2018. It is proposed that this risk is removed from the Trust risk register and maintained going forward on the IM&T risk register.

4. Risk scores increased

4.1 There are no risks being considered for an increase in risk score.

5. Risk scores decreased

5.1 **Finance: The Trust is unable to ensure short term financial performance in current financial year. (Risk 116)**

It is proposed that this risk is reduced to a risk score of 8 (likelihood 2 x consequence 4) on the following basis:

- Improved underlying run rate in Q2 and Q3 through reduced PICU placements and agency spend. This is in line with the planned trajectory and indicates that the full year target will be achieved.
- Agency expenditure on track to achieve NHSI cap of £7.3m
- CRES - £4.7m. Target forecast to be achieved, but c.£500k shortfall in recurrent plans

6. Risk Updates

6.1 **Quality and safety: The management of demand and capacity for those individuals pending care coordination allocation (Risk 387)**
It is proposed that this risk is closed on the Trust Risk Register as the remaining risks are covered, and have been detailed, in risk 773, the adult community risk about failure to respond effectively to increasing demand resulting in a risk to safety, quality and effectiveness.

6.2 **External landscape: The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT (Risk 749)**

- 2019/20 Operational Planning requires STP aggregated submission. Current focus is on acute Trust activity and achieving financial balance within all organisations.
- HVCCG published draft approach to develop ICA for West Hertfordshire

6.3 **Workforce: The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff (Risk 215)**

- The current vacancy rate is 13.2% which equates to 444 vacancies of which 226 are actively being recruited to.
- There have been a number of changes to the on boarding process during Q3 which has included all pre-employment checks being outsourced to TRAC and ensuring that all ID checks are undertaken by managers at the interview stage. These processes should assist

in reducing the time it takes to hire new staff. In addition the new careers site has been implemented.

6.4 **<u>Workforce:</u> The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657)**

- In December the annualised turnover was 16.4%. If planned turnover, such as retirements, end of fixed term contracts and dismissals are removed this lowers the turnover rate to 12.4%.
- A number of retention initiatives have been introduced including the retire and return process, the internal moves process, improving the on boarding process for all candidates, holding retention workshops with SBUs, and doing work on flexible working with managers. Plans are also in place to commence career surgeries for staff during Q4.

6.5 **<u>Brexit:</u> The Trust may experience continuity and/or cost of supply issues for critical goods/services. (Risk 1000)**

- 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 help ensure that there are suitable arrangements in place at the point of exit.
- DHSC has developed a self-assessment methodology for NHS Trusts to use to identify contracts that may be impacted by EU exit. The Trust has undertaken this analysis and no significant contract issues have been identified.
- Undertaking assessment of risks associated with EU Exit in line with DHSC 'Action card for providers'. Testing existing business continuity and incident management plans against EU Exit scenarios.

6.6 **<u>Information Management and Technology:</u> Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability (Risk 747)**

- Risk of cyberattack is ever present. The HBL ICT commissioned penetration test will take place from mid to end January 2019. Recommend current score is maintained.

6.7 **<u>Information Management and Technology:</u> Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident Risk 920**

- Good Practice guidance has been distributed around the information governance breaches of handover sheets and the following is being implemented in all inpatient services immediately to prevent likelihood of reoccurrence & mitigate the risk:
  - One handover sheet to be used only, written by the Nurse in Charge
  - Coloured paper to be used for the one handover sheet
  - Initials of service users & bedroom numbers to be used
  - Handover sheet to remain in the office for reference at all times throughout the shift
  - The Nurse in Charge at the end of the shift to ensure that the handover sheet is filed securely.

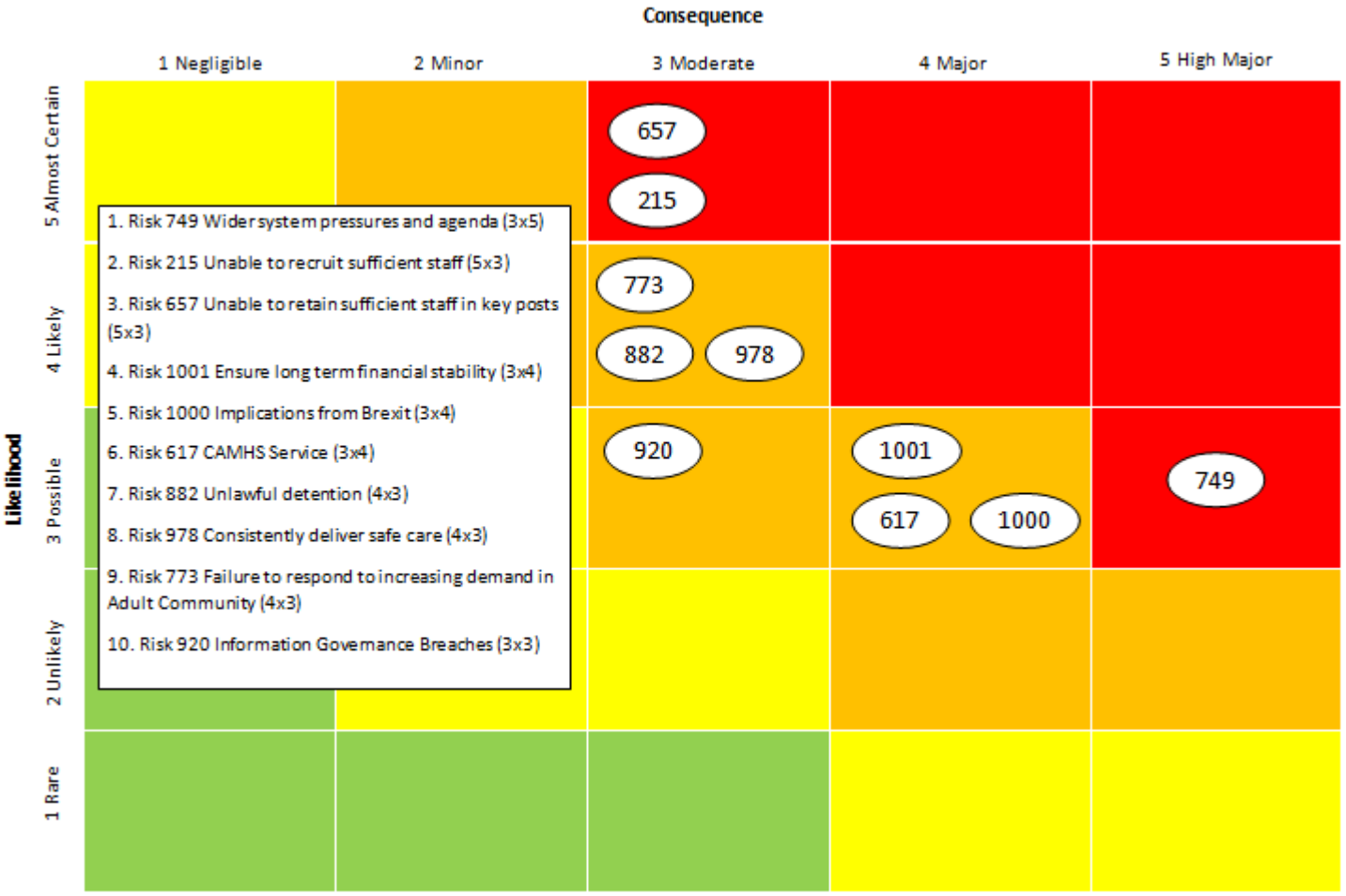
<u>7. Conclusion</u>

7.1 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
1	749	**External landscape:** 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
2	215	**Workforce:** 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
3	657	**Workforce:** 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
4	1001	**Finance:** 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
5	1000	**Brexit:** 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
6	617	**Quality and safety:** Failure to provide an efficient and effective CAMH 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
7	882	**Quality and safety:** 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
8	978	**Quality and safety:** 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
9	773	**Quality and safety:** Failure to respond effectively to increasing demand in Adult Community 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
10	920	**Information Management and Technology:** Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident	9	9 (3x3)	6	We will constantly learn, innovate and improve for the benefit of those we serve, including making the very best use of technology and information	Ronke Akerele

Appendix 2 Trust Risk Register Matrix



Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Risk Register
January 2019

To be reviewed by:

Executive Team
16.01.2019

Integrated Governance Committee:
23.01.2019

Audit Committee: 26.02.2019

Trust Board: 07.02.2019

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	Last review date	Next review date
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	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. 2019/20 Operational Planning requires STP aggregated submission. Current focus is on acute Trust activity and achieving financial balance within all organisations. The local STP Plan outlines commitments to deliver Mental Health Standard, 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	Karen Taylor (Director of Strategy & Integration)	14/01/19	14/03/19

		resources away from mental health and learning disability services						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 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 people's 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.			

								HVCCG published draft approach to develop ICA for west Hertfordshire			
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	Mariejke Maciejewski, Interim Director of Workforce and OD	14/01/19	14/03/19

								some new ways of working. A further 9 Nursing Associates started May 2018 with more starting in January 2019. Implementation of a new careers website has commenced and during Q2 focus groups have been run with staff, new starters, youth council and service user's 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. The current vacancy rate is			

								13.2% which equates to 444 vacancies of which 226 are actively being recruited to. There have been a number of changes to the onboarding process during Q3 which has included all pre-employment checks being outsourced to TRAC and ensuring that all ID checks are undertaken by managers at the interview stage. These processes should assist in reducing the time it takes to hire new staff. In addition the new careers site has been implemented.			

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	Mariejke Maciejewski, Interim Director of Workforce and OD	14/01/19	14/03/19

								The Trust has launched the following initiatives; the retire and return process, internal 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 New management induction to be introduced separate to corporate induction, including training on systems and processes utilised by senior managers. In December the annualised turnover was 16.4%. If planned turnover such as retirements, end of fixed term contracts and dismissals are removed this lowers the turnover rate to 12.4%. A number of retention initiatives have been introduced including the retire and return process, the internal moves process, improving the on boarding process for all candidates, holding retention workshops with SBUs, and doing work on flexible working with			

								managers. Plans are also in place to commence career surgeries for staff during Q4.			

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 Primary Care MH models currently being evaluated to confirm scalable benefits.	Keith Loveman (Director of Finance)	14/01/19	14/03/19

				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 Board level lead identified - DoF DHSC EU Exit Operational Readiness Guidance framework for assessment of risks be end of January 2019	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 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 help ensure that there are suitable arrangements in place at the point of exit. DHSC has developed a self-assessment methodology for NHS Trusts to use to identify contracts that may be impacted by EU exit. The Trust has undertaken this analysis and no significant contract issues have been identified. Undertaking assessment of risks associated with EU Exit in line with DHSC 'Action card for providers'. Testing existing	Keith Loveman (Director of Finance)	14/01/19	14/03/19

				Business continuity and incident management plans to be tested by end February 2019				business continuity and incident management plans against EU Exit scenarios. 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 projection which is creating a financial risk as this does not	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	Jess Lievesley (Director Of Service Delivery and Service User Experience)	11/01/19	11/03/19

		reduce but recruitment to HTT and DBT increases.						Tier 4 - Current number of young 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 lack of bed availability should an inpatient admission be	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, AMHP Service prioritise Section 136 assessments in order to meet	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:	Jess Lievesley (Director Of Service Delivery and Service User Experience)	11/01/19	11/03/19

		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 individuals. Since implementation		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				- Occasions where the Police have 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.			

		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 has received the final report.	Jane Padmore(Director Quality & Safety)	11/01/19	11/03/19

								Dove ward where the majority of seclusions to a non-seclusion room 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 spring 2019. <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.			

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. Service users pending care co-ordination allocation remains a significant risk	12	Review of staff skill mix across quadrants and introduction of new roles Primary care projects commencing to look at work before IA referral made. The number of cases pending care co-ordinator allocation in the adult community teams is tracked. Monitored weekly by the Team Leaders and service users are contacted regularly to minimise risk. Performance Monitoring of these cases is now available via SPIKE	12	6	Vacancy Levels Agency spend Increase in incident reporting Number of cases pending allocation Number of initial assessments Turnover of staff Increase in Complaints Performance against targets deteriorating Staff feedback/raising of concerns Increased length of time to be allocated a care coordinator Increase in the total amount of cases pending allocation or as a % of overall community team caseloads	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. The number of cases pending care co-ordinator allocation in the adult community teams is being tracked, although the absence of a care co-ordinator does not mean that individuals have no access to support from HPFT community services.	Jess Lievesley (Director Of Service Delivery and Service User Experience)	11/01/19	11/03/19

								Work has recently taken place within PARIS to further define the Awaiting Allocation lists within teams to support an individualised approach to those waiting for specific professional input such as psychiatry, care co-ordination and Psychology etc. Further Mitigation includes; use of duty system at times of increased or changing needs, joint working across teams to provide support i.e. Wellbeing & Psychology, increased interface where step up or down is a particular issue i.e. CATT to community, ongoing team and individual case load reviews to improve flow and group sessions offer whilst waiting. Plans are in place to introduce mini team working models across quadrants to support individuals requiring care coordination. This is based on the FEP model where there is not 1 specific care coordinator but a mini team of 3 people who will work with an individual. A broader group of people who will work collaboratively rather than one single identified Care Coordinator. This potentially will allow for a larger caseload.			

920	Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident	Failure to maintain compliance with data protection legislation creates a risk of a data incident occurring which leads to serious or catastrophic impact on data subjects (Staff or Service users). Should the Trust then fail to comply with an enforcement notice from the Information Commissioner, it would be at risk of a fine of up to £20million. Financial compensation could also be sought by affected data subjects. This would result in a serious impact on Trust finances and reputation. There is a potential loss of trust in clinical and therapeutic relationships, leading to	9	The Trust has an open and timely culture of reporting incidents that occur, which facilitates early intervention and management of incidents. This supports reporting to the relevant authorities (NHSD and ICO) within the statutory 72 hour timescale. In addition, the Trust has undertaken data flow mapping across the organisation, and maintains a detailed information asset register, with identified Information Asset Owners. A Data Protection Impact Assessment process is in place, which promotes visibility of new projects, and facilitates early input by the Data Protection Officer. This contributes to meeting the	9	6	Increase in serious data incidents reports. Increased complaints to the Information Commissioner leading to enforcement action, including audits or financial penalties. Reduction in staff compliance with mandatory training. Projects or initiatives going live without data protection or governance oversight. Failure to maintain Information Asset Register, Data flow mapping or Care record quality audit. Reduction in compliance with Data Subject Rights requests (including Subject Access).	In 2017-18, the Trust received 350 reports of possible data incidents via Datix. Five were found to be sufficiently serious to escalate to the Information Commissioner. Since April 2018, (at time of writing) the Trust has received 290 reported incidents, of which 10 have been considered sufficiently serious to report to the Information Commissioner. This is a positive trend, which 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 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 (i.e. actual financial loss). Given these factors, it is reasonable to assume that the Trust will see a 'spike' in	Ronke Akerele (Director Innovation and Transformation)	15/01/19	11/03/19

		reduced quality of care and outcomes.		statutory requirements of Article 35 of GDPR (2016). All staff are made aware of their statutory and professional responsibilities to safeguard and manage data appropriately. The quality of care record management at ward level is audited on a 24 month cycle.				reports, which will gradually reduce as the Trust addresses systemic causes of breaches (processes/practices which are unsafe). It is not possible, or desirable, to seek nil reporting. The Trust has seen 5 reports of handover sheets found outside of the clinical environment, both by staff and the public. 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"). The Information Rights and Compliance team is currently undertaking a series of clinical record audits, which will be used to target future work with high risk areas. The Trust has a well-established Data Protection Impact Assessment process, and the majority of projects seek input from the Data Protection Officer at an early stage. The Information Rights and Compliance Team offers support and advice to staff on			

								data protection by design and default. The Trust has also appointed a Data Protection Officer, and therefore complies with Article 37 GDPR.			

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	7th February 2019	**Agenda Item: 21**
Subject:	Draft Risk Management Strategy	**For Publication:**
Author:	Keith Loveman Executive Director - Finance	**Approved by:** Dr.Jane Padmore Executive Director – Quality & Safety
Presented by:	Jill Hall Company Secretary	

Purpose of the report:

To present risk Management Strategy for approval and adoption by the Board of Directors.

Action required:

To formally approve and adopt the Risk Management Strategy.

Summary and recommendations

The Integrated Governance Committee received the Risk Management Strategy at its meeting on 23 January 2019 and agreed to recommend it to the Board of Directors for formal approval and adoption.

The Risk Management Strategy has been reviewed, updated and redrafted in order to clearly set out the Trust's framework within which the Trust leads, directs and controls the risks to its key functions. To support this it purposefully seeks to separate risk management strategy from risk management policy.

Risk Management is an integral part of HPFT's management activity and is fundamental to delivering and embedding high quality, safe and sustainable services for the people we serve, to supporting good governance, is central to delivery of the Trust's Good to Great strategy and to strategic and operational management. The Risk Management Strategy sets out the vision and approach for risk management, its key goals, core framework and processes.

The aim of the strategy is to reinforce and embed a culture throughout the organisation in which risks are actively identified and managed to ensure that risk management becomes an integral part of the Trust's strategic and operational objectives, plans, practices and management systems, in an environment that promotes individual and organisational learning.

Following approval of this strategy the Risk Management Policy will be reviewed and amended to ensure it is in line with the strategic approach.

Recommendation

The Board of Directors is recommended approval and adopt the Risk Management Strategy.

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

The deliverables associated with the strategy are core to generating robust ward to board intelligence to support Board understanding of risks within the organisation. It will give high level assurance over the operation of the risk management systems and processes.

Summary of Financial, IT, Staffing & Legal Implications:

N/A

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

Executive Team 16 January 2019 Integrated Governance Committee 23 January 2019

Version	Date of Issue	Author	Status	Comment
V1	January 2019	Director of Finance	Draft	

Risk Management Strategy

1. Introduction

1.1. Good to Great

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

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

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

1.2. Strategic Objectives 2016-2021

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

1. We will provide safe services, so that people feel safe and are protected from avoidable harm

2. We will deliver a great experience of our services, so that those who need to receive our support will feel positively about their experience
3. We will improve the health of our service users through the delivery of effective, evidence based practice
4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care
6. We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

2. Background – Culture and our approach to Risk Management

2.1. Risk Management is an integral part of HPFT's management activity and is fundamental to delivering and embedding high quality, safe and sustainable services for the people we serve. As a complex organisation delivering a range of services in a challenging financial environment across a wide geography, we accept that risks are inherent to our business. Effective risk management processes are therefore central to providing assurance on the framework for clinical quality and corporate governance.

2.2. Our stated mission is to **'help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well'**. To ensure that the care provided by HPFT is safe, effective, and provides the best experience, the Trust must be founded on and supported by a strong governance structure.

2.3. The Trust is committed to a risk management strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its Good to Great strategy and underpinning strategic objectives. The Board Assurance Framework (BAF) will be used by the assuring committees and Board to identify, monitor and evaluate risks to the achievement of the strategic objectives. It will be used alongside other key management tools, such as integrated performance reports, quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

2.4. The management of risk underpins the achievement of the Trust's objectives. The Trust believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users, carers and staff, it is also significant in the financial and business planning process where investment decisions and public accountability in delivering health and social care services are required.

2.5. The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals reduce the incidence and impact of risks that they face. Risk management is therefore a fundamental part of both the strategic and

operational thinking of every part of service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks.

2.6. The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. The risk management strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, supported by effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

2.7. The Trust Board recognises that complete risk control and/or avoidance is impossible, but that risks can be managed and minimised by making sound judgments from a range of fully identified options and having a common understanding on risk appetite.

2.8. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an on-going commitment to improving the management of risk throughout the organisation through:

- **AWARENESS** - Staff will have an awareness and understanding of the risks that affect service users, carers and staff
- **COMPETANCE** - Staff will be competent at managing risk
- **MANAGEMENT** - Activities will be controlled using the risk management process and staff empowered to tackle risks
- **RISK APPETITE** - The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate.

2.9. HPFT will make a public declaration within the Annual Governance Statement of compliance against meeting risk management standards.

3. Purpose

3.1. This strategy describes a consistent and integrated approach to the management of all risk across the Trust.

3.2. The purpose of the Risk Management Strategy is to set out the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, NHS Improvement (NHSI) compliance requirements, key regulatory requirements such as Care Quality Commission standards, and its own strategic objectives.

3.3. The risk management strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

4. Goals of the Risk Management Strategy

To ensure:

- the Trust remains within its licensing authorisation as defined by NHSI and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its provider licence and/or NHS Foundation Trust Code of Governance
- compliance with NHSI requirements, Care Quality Commission registration and Health & Safety Standards
- continued development of the Board Assurance Framework (BAF) such that organisation wide strategic risks are identified dynamically
- appropriate support for further development of the organisational safety culture and its effectiveness
- open reporting of adverse events/incidents is encouraged and learning is shared throughout the organisation
- all risks, including business risks, service development risks, and project risks, are being identified through a comprehensive and informed Risk Register and risk assessment process.
- Risk Management Policies and procedures are implemented and monitored effectively
- the Trust can demonstrate compliance with the statutory Duty of Candour and that it maintains a consistent open and honest culture always involving service users and families in investigations where appropriate
- all individuals within the organisation are aware of their role, responsibilities and accountability with regard to Risk Management
- the structure and process for managing risk across the organisation is reviewed and monitored annually

5. An Open and Fair Culture

5.1. All members of staff have important roles to play in identifying, assessing and managing risk.

5.2. To support staff in this role the Trust promotes a fair, open and consistent environment and does not seek to apportion blame. In turn, this encourages a culture of openness and willingness to report mistakes.

5.3. All staff are encouraged to report any situation where things have, or could have gone wrong. However, exceptional matters may occur where an employee has acted illegally, maliciously or recklessly and in such cases appropriate action will be taken in accordance with Trust Policies.

5.4. Concerns regarding unsafe practice may be reported by staff through a confidential route under the “Freedom to Speak Up” policy.

6. Risk Appetite

6.1. The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions including the:

- nature of the risks to be assumed;
- amount of risk to be taken on; and
- desired balance of risk versus reward.

6.2. On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:

- Risk to service users
- Organisational risk
- Reputational risk
- Opportunistic risk

6.3. The statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

6.4. Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

6.5. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk.

7. Responsibility for Risk Management

7.1. The success of the risk management programme is dependent on the defined and demonstrated support and leadership offered by the Trust Board as a whole.

7.2. Day-to-day management of risk is the responsibility of everyone in the Trust at every level, and the identification and management of risks requires the active engagement and involvement of staff at all levels. Staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework.

8. Compliance & Assurance

8.1. NHS Improvement uses the information collected and received from Foundation Trusts under the *Single Oversight Framework* to assess the risk to continuity of services conditions and, for NHS foundation trust's, non-compliance with the NHS foundation trust governance conditions. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

8.2. The CQC includes risk management as part of its standards (which cover clinical and non-clinical issues). All healthcare providers, including NHS Trusts, must achieve these minimum standards.

8.3. There are different operational levels of risk governance in the Trust:

- Board of Directors
- Assurance Committees (Audit Committee, Integrated Governance Committee and Finance and Investment Committee)
- Executive Team
- SBU or Corporate Governance Meetings
- Department/speciality level
- All staff reporting risks

8.4. Risk Management by the Board is underpinned by a number of interlocking systems of control:

8.4.1. The **Board Assurance Framework** provides a structure and process that enables the organisation to focus on those risks that might compromise the achievement of its most important strategic objectives, to map out the key controls in place to manage those objectives, to confirm the Board has gained sufficient assurance about the effectiveness of these controls and to enable the Board to confirm that its responsibilities are being discharged effectively. All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The BAF brings together this evidence.

8.4.2. The Board Assurance Framework is reviewed bi-monthly, in its entirety, by the Integrated Governance Committee and Trust Board. Every risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors. An assurance committee is also identified for each principal risk to assure the Trust Board that it is being monitored, gaps in control and assurance are identified, and processes in place to minimise the risk to the organisation.

8.4.3. The Company Secretary shall work closely with the Executive Leads and appropriate senior managers to ensure that the BAF remains dynamic and is integral to the Business Planning cycle.

8.4.4. The **designated assurance committees** of the Trust Board are the Audit Committee, the Integrated Governance Committee and the Finance and Investment Committee. The Audit Committee monitors the Board Assurance Framework process overall biannually.

8.4.5. It is the responsibility of the assurance committees to report to the Trust Board, any new risks identified and gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to

the Trust's service delivery or gap in control/assurance is identified then this should be reported immediately via the Executive Directors.

8.4.6. The **Trust Risk Register** is the high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. The risk register is a dynamic process in ranking/prioritisation of risks that will change as risk mitigation and resolution takes place. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.

8.4.7. Each **Strategic Business Unit** (SBU) will maintain a comprehensive risk register, which will be formally reviewed in full at monthly intervals, with key headlines and top risks presented quarterly to the Executive Performance Review Meetings. The SBU Management Team has responsibility for ensuring that all risks within the SBU are appropriately graded and have sufficient actions in plan to mitigate/reduce the risk.

8.4.8. Each **service and department** will carry out appropriate risk assessments in accordance with the Risk Management Policy. A single framework for the assessment, rating, and management of risk is to be used throughout the Trust and this process is described in detail within the Risk Management Policy alongside how department risk registers are escalated where appropriate to the SBU risk register and to the Trust Risk Register.

8.4.9. In order to identify the risks against delivery of principal objectives and gaps in control/assurance the Trust Board must have a comprehensive Performance Management Reporting framework. The Trust Board must agree its own indicators for Performance Reports which will act as assurance on service delivery and quality. Any significant gaps in assurance or control within the Performance reports must be identified, translated onto the Board Assurance Framework and remedial action agreed.

8.4.10. If at any time performance reporting and risk management processes indicate that the Trust will not meet a current or future regulatory requirement/target then the Board will notify NHSI via an Exception Report.

9. Risk Management Policy

9.1. The purpose of the Risk Management Policy is to set out the detailed framework, process and approach to enable risks to be systematically drawn together, assessed, prioritised and managed consistently via a single approach everywhere in the organisation.

9.2. The policy will set out in detail:

- Roles, responsibilities and accountabilities for risk management

- The approach to assessing, reviewing and reporting Risk Appetite
- Processes and procedures for the identification, assessment and response to risk
- Governance Framework, processes and procedures for reviewing risk, escalation and de-escalation
- Processes and procedures for risk management performance reporting
- The approach to implementation of the risk management policy, monitoring and reviewing compliance
- Associated policies procedures and documentation

9.3. This strategy should also be read in conjunction with the following Risk Management Policies:

- Risk Management Policy
- Quality Strategy
- Clinical Risk Strategy
- Clinical Risk Assessment and Management of Individual Service Users Policy
- Incident and Serious Incident Requiring Investigation Policy
- Health Safety and Security Policy
- Information Risk Policy

10. Equality Impact Assessment

10.1. The Trust is committed to promoting equality of opportunity for all its employees and the population it serves. The trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. No detriment is intended.

11. Review

11.1. This Strategy has been developed in light of currently available information, guidance and legislation, which may be subject to change. This strategy will be reviewed every three years or sooner if circumstances dictate. Any changes will be reviewed by the Integrated Governance Committee and Audit Committee and any recommendations are submitted to the Board of Directors for formal ratification.

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS

Meeting Date:	7th February 2019	**Agenda Item: 22**
Subject:	Annual Review of Board Sub-Committee Terms of Reference	**For Publication:**
Author:	Jill Hall Company Secretary	**Approved by:** Jill Hall Company Secretary
Presented by:	Jill Hall Company Secretary	

Purpose of the report:

To approve the Board Sub-Committees Terms of Reference.

Action required:

To approve the Terms of Reference of the Board Sub-Committees.

Summary and recommendations to the Board:

Annually the sub-committee of the Board review their Terms of Reference and refer any changes to the Trust Board for approval. The Board may also review and modify a Sub-Committee Terms of Reference any time.

The Boards sub-committees, Audit, Finance and Investment (FIC), and Integrated Governance (IGC) all reviewed their Terms of Reference at their last meetings.

The FIC, following review, agreed that there were no changes required to the Terms of Reference; Audit Committee agreed to clarify the membership of the committee and that although all Non-Executive Directors were members, the core membership will be the chair of the Audit Committee, and Chairs of the FIC and IGC;
The IGC reviewed its Terms of Reference and some minor changes were agreed in relation to Membership and organisational relationships.

Recommendation:
For the Board of Directors to approve the Terms of Reference of its Sub-Committees as appended to the report.

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

It is good governance that committee's review their terms of reference annually to ensure they remain fit for purpose to ensure the organisation can discharge its statutory functions.

Summary of Financial, IT, Staffing & Legal Implications:

none

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

none

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

Evidence of robust governance review processes

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

Audit Committee – 4 December 2018 Finance and Investment Committee – 22 January 2019 Integrated Governance Committee – 23 January 2019

TERMS OF REFERENCE

Audit Committee

Status:	The Audit Committee is a non-executive sub-committee of the Trust Board.
Chair:	**Non – Executive Director**
Membership:	The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of:
Core membership:	Chairs of the: Audit Committee Integrated Governance Committee Finance and Investment Committee All Non-Executive Directors are invited to attend.
In attendance:	Director of Finance Representatives of Internal Audit Representatives of External Audit Company Secretary The Chief Executive will be invited to attend at least once per annum.
Frequency of Meetings:	5 meetings per annum
Frequency of Attendance:	Members will be expected to attend all meetings. If members miss two consecutive meetings, membership will be reconsidered by the Committee Chair (subject to exceptional circumstances).
Quorum:	A quorum shall be two Non-Executive Directors.

1. Remit

1.1 The Audit Committee is a non-executive committee of the Board and has no executive powers, other than those delegated in the Terms of Reference.

1.2 The remit of the Group is:

"To review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisations objectives."

2. Accountability

2.1 A report will be made by the Chair to the Trust Board following each committee meeting. The report will contain:

- A note of all the items discussed by the committee
- Matters for noting by the Board
- Recommendations to the Board regarding decisions to be taken by the Board on governance matters
- Matters for escalation to the Board from the committee
- Annually the committee will report on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the risk management system in the organisation and the integration of governance arrangements.
- Any other issues as agreed by the Chair & Company Secretary.

2.2 The minutes of Audit Committee meetings shall be formally recorded by the Company Secretary and submitted to the Board.

2.3 A report will be included within the annual report describing the work of the committee in how it has discharged its responsibilities. The committee chair will attend the annual general meeting at which the annual report is presented.

3. Responsibilities & Duties

The duties of the Committee can be categorised as follows:

3.1 Governance, Risk Management and Internal Control

The Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and compliance with registration requirements), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- annual review of the effectiveness of internal audit

3.3 External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- consideration and recommendation to the Board of Governors of the appointment and performance of the External Auditor.
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review all External Audit reports, including agreement of the management letter before submission to the Trust Board and Board of Governors and any work carried outside the annual audit plan, together with the appropriateness of management responses.

3.4 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Integrated Governance Committee and any Risk Management committees that are established.

In reviewing the work of the Integrated Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance

that can be gained from the clinical audit function. The Audit Committee places reliance on the work of the Integrated Governance Committee to review and assess the assurance framework and report any significant control issues. As a result the Audit Committee requires a six monthly update report from the Integrated Governance Committee on these issues (to include the Trust Risk Register).

3.5 Counter Fraud

The Audit Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

3.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

3.7 Financial Reporting

The Audit Committee shall review and scrutinise the content of the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the clarity of wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee,
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgmental areas
- significant adjustments resulting from the audit.

The Committee should also ensure that the systems for financial reporting to the Board and NHS Improvement, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board and NHS Improvement.

The Audit Committee shall be informed of the work of the Finance and Investment Committee of the Board and receive a six monthly update report for this purpose.

3.8 Quality Reporting

The Audit Committee shall review and scrutinise the content of the Quality Report and Quality Accounts prior to their submission to the Board for approval.

The Committee should also ensure that the systems for reporting to the Board and NHS Improvement are subject to review as to completeness and accuracy of the information provided to the Board and NHS Improvement.

3.8.1 Board Committees
In addition to the work of the Finance and Investment Committee and the Integrated Governance Committee, the Audit Committee shall review the work of any other

committee set up by the Board as appropriate, the period and regularity of the reporting to be determined by the Audit Committee to reflect the nature and purpose of the committee.

5. Other Matters

The Committee shall be supported administratively by the Company Secretary, whose duties in this respect will include:

- agreement of agenda with the Chair and attendees and collation of papers
- taking the minutes & keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent areas

6. Monitoring of Effectiveness

6.1 The group will review its own performance and terms of reference at least once a year to ensure it is operating at maximum effectiveness.

Terms of Reference ratified by: Audit Committee

Date of Ratification: **December 2017**

Date of Review: **December 2018**

Terms of Reference Version:

Hertfordshire Partnership NHS
University NHS Foundation Trust

TERMS OF REFERENCE

Finance and Investment Committee

Status:	The Finance & Investment Committee is a sub-committee of the Trust Board
Chair:	**Non – Executive Director**
Membership:	The Committee shall be appointed by the Board and shall consist of not less than three members including: Non-Executive Directors (x5 including committee Chair) Executive Director Finance Executive Director Quality and Safety/Executive Director Quality & Medical Leadership Executive Director Service Delivery and Customer Experience Executive Director Strategy & Commercial Development Executive Director Integration & Community Services
Frequency of Meetings:	6 meetings per annum
Frequency of Attendance:	Members will be expected to attend at least three meetings each year. If members miss two consecutive meetings, membership will be reconsidered by the Committee Chair (subject to exceptional circumstances).
Quorum:	A quorum shall be three members including at least one Executive Director and two Non-Executive Director

1. Remit

1.1 The Finance & investment Committee is a Standing Committee of the Board.

1.2 The remit of the Group is to:

> "To conduct an independent and objective review of financial and investment policy and performance issues including the assessment and monitoring of risk in respect of financial and performance issues".

2. Accountability

2.1 A report will be made by the Chair to the Trust Board following each committee meeting. The report will contain:
A note of all the items discussed by the committee
Matters for noting by the Board
Recommendations to the Board regarding decisions to be taken by the Board
Any other issues as agreed by the Chair & Company Secretary.

2.2 The minutes of the Finance & Investment Committee meetings shall be formally recorded by the Trust Secretary and submitted to the Board and Audit Committee.

2.3 A six monthly report from the Finance & Investment Committee shall be submitted to the Audit Committee.

3. Responsibilities & Duties

3.1 Financial Policy, Management and Reporting

3.1.1 To consider the Trust's financial strategy, in relation to both revenue and capital.

3.1.2 To consider the Trust's annual financial targets and performance against them.

3.1.3 To review the annual budget, before submission to the Trust Board of Directors.

3.1.4 To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets.

3.1.5 To review proposals for major business cases and their respective funding sources.

3.1.6 To commission and receive the results of in-depth reviews of key financial issues affecting the Trust.

3.1.7 To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and contractual safeguards.

3.1.8 To oversee and receive assurance on the financial plans of significant programmes.

3.1.9 To consider the Trust's tax strategy.

3.1.10 To annually review the financial and accounting policies of the Trust and make appropriate recommendations to the Board of Directors.

3.2 Investment Policy, Management and Reporting

3.2.1 To approve and keep under review, on behalf of the Board of Directors, the Trust's investment strategy and policy.

3.2.2 To maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and Monitor's requirements.

3.3 Performance Monitoring and Reporting

3.3.1 To consider the Trust's annual performance targets and performance against them.

3.3.2 To consider the Trust's performance including performance against national, local and internal targets and contractual requirements.

3.3.3 To commission and receive the results of in-depth reviews of key performance issues affecting the Trust.

3.4 Other

3.4.1 To make arrangements as necessary to ensure that all Board of Directors members maintain an appropriate level of knowledge and understanding of key financial and performance issues affecting the Trust.

3.3.2 To examine any other matter referred to the Committee by the Board of Directors.

3.3.3 To review performance indicators relevant to the remit of the Committee.

3.3.4 To monitor the risk register and other risk processes in relation to the above.

4. Other Matters

The Committee shall be supported administratively by the Company Secretary, whose duties in this respect will include:

- agreement of agenda with Chairman and attendees and collation of papers
- taking the minutes & keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent areas

5. Monitoring of Effectiveness

5.1 The group will review its own performance and terms of reference at least once a year to ensure it is operating at maximum effectiveness.

Terms of Reference ratified by: FIC
Date of Ratification: **December 2018**

Date of Review: **January 2019**

Terms of Reference Version: 6

Hertfordshire Partnership NHS
University NHS Foundation Trust

TERMS OF REFERENCE

Integrated Governance Committee (IGC)

Status: The *Integrated Governance Committee* is a locally appointed executive committee of the Trust Board and reports into the Board itself with strong relationship with the Audit Committee, a statutory committee of the Board, to which it sends reports for review and recommendations. The Executive Director Lead for the Committee is the Director of Quality & Patient Safety and the administrative lead is the Company Secretary.

1.0 Accountability

1.1 A report will be made by the Chair to the Trust Board following each committee meeting. The report will contain:

- A note of all the items discussed by the committee
- Matters for noting by the Board
- Recommendations to the Board regarding decisions to be taken by the Board on governance matters
- Matters for escalation to the Board from the committee
- Any other issues as agreed by the Chair & Company Secretary.

1.2 The minutes of the Committee's meetings shall be formally recorded by the Company Secretary and submitted to the Board and Audit Committee.

1.3 A six monthly report from the Committee shall be submitted to the Audit Committee.

Chair: **Non – Executive Director**

Membership: The Committee shall be appointed by the Board primarily from amongst the Executive Directors of the Trust and shall consist of:

Non-Executive Directors (x4 including Chair)
Executive Director Quality and Safety (or Deputy)
Director, Delivery and Service User Experience
Executive Director Quality & Medical Leadership
Executive Director Strategy & Service Improvement
Deputy Chief Executive
Executive Director, Workforce & Organisational Development
Executive Director Innovation & Transformation

In attendance:
Deputy Director Safer Care and Standards
Deputy Director of Nursing and Quality
Other nominated Directors (TBA)
Chair of Medical Staff Committee
Company Secretary

Frequency of Meetings: A minimum of six (6) meetings per annum

Frequency of Attendance: Members will be expected to attend all meetings. If members miss two consecutive meetings, membership will be reconsidered by the Committee Chair (subject to exceptional circumstances).

Quorum: A quorum shall be three members including at least one Executive Director and one Non-Executive Director plus the Chair or a NED acting for the Chair in her absence.

2.0. Remit

2.1 The IGC is an executive locally appointed committee of the Board.

2.2 The remit of the Group is to:

"To lead on the development and monitoring of quality and risk systems within the Trust and to ensure that quality, patient safety and risk management are key components of all activities of the Trust."

3.0 Organisational Relationships

3.1 Reports will be received from the Executive Director Chairs of the following Sub-Groups/Sub-committees:

- Quality & Risk Management Committee
- Workforce & Organisational Development Group
- Information, Management, Technology & Information Governance Programme Board

3.2 Key Interfaces & Relationships:
There is an interface between this Committee and the following:

- Trust Board
- Audit Committee
- Trust Management Group
- Care Quality Commission
- Hertfordshire County Council
- Others to be advised by membership

4.0 Responsibilities & Duties

4.1 To assure adherence to CQC and other relevant regulatory requirements for quality and safety and receive reports from all relevant quality and safety groups.

4.2 Receive minutes, reports, action plans and risk registers from the following standing sub-committees of the IGC:

- Quality & Risk Management Committee
- Workforce & Organisational Development
- Information, Management, Technology & Information Governance Programme Board

4.3 The following groups will also report on specific items relating to areas of regulatory compliance:

- *Operations Group*

4.4 Advise on the content and development of the Annual Governance Plan and supervise, monitor and review it and the Trust-wide Risk Register and make recommendations for improvement.

4.5 To scrutinise and provide assurance to the Trust Board through providing regular reports on governance, quality and risk issues and to escalate any risks to the BAF or concerns as appropriate where assurance is not adequate. Reports should also be sent to the Audit Committee for scrutiny and recommendations.

4.6 Set standards for the Trust Governance systems in order to meet;

- Performance targets,
- Core and developmental standards
- Risk management

4.7 To recommend to the Trust Board necessary resources needed for the IGC to undertake its work.

4.8 Advise on the production and content of the *Annual Governance Statement* and make recommendations to the Chief Executive as necessary prior to its review at Audit Committee, its approval at the Board and subsequent inclusion in the Annual Report.

4.9 Advise on the content, format and production of an *Assurance Framework* for the Trust Board and monitor its ongoing suitability and make recommendations to the Audit Committee and the Board as necessary.

4.10 Advise on the content, format and production of the annual *Quality Accounts*

4.11 Approve *Terms of Reference* and work plan of the sub-groups reporting into the Committee.

4.12 Ensure that appropriate risk management processes are in place that provide the Board with assurance that action is being taken to identify risks and manage identified risks within the Trust.

4.13 To be responsible for developing systems and processes for ensuring that the Trust implements and monitors compliance with its registration requirements of the Care Quality Commission.

4.14 To oversee the establishment of appropriate systems for ensuring that effective practice governance arrangements are in place throughout the Trust.

4.15 To ensure that the learning from inquiries carried out in respect of SIs is shared across the Trust and implemented through policies and procedures as necessary.

4.16 To ensure that services and treatments provided to service users are appropriate, reflect best practice and represent value for money.

4.17 To ensure that plans are in place to promote the patient experience.

4.18 To ensure that services are accessible and responsive to Service User needs and reflect local "nuances."

4.19 To ensure that the environments in which services are provided are appropriate and therapeutic.

4.20 To ensure that the organisation is engaged in the public health programme and this is modelled throughout the services we provide.

5.0 Other Matters

5.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- prepare, in conjunction with the Chair and the Executive Director of Quality & Patient Safety an Annual Business Cycle of Activities to ensure all of the Committee's business is captured and inform the Agenda for each meeting;
- support the Chair in ensuring that all papers to the Committee are submitted on time, of the right quality and format and distributed to members and attendees not less than seven (7) days before the meeting;
- agreement of agenda with the Chair and attendees and collation of papers
- taking the minutes & keeping a record of matters arising and issues to be carried forward;
- advising the Committee on pertinent areas of governance and the regulatory framework.

6. Monitoring of Effectiveness

6.1 The Committee will undertake an annual review of its own performance to ensure that it is operating at maximum effectiveness. The review should be sent to the Board of Directors for assurance.

Terms of Reference to be ratified by: Reviewed and approved by the IGC, ratified by the Board

Date of Ratification:

Date of Review: