Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC Meeting

Da Vinci B

9 May 2019 10:30 - 9 May 2019 13:30

INDEX

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 9th May 2019
Venue: The Colonnades, Beaconsfield Road, Hatfield AL10 8YE, Da Vinci B+C
Time: 11:00 – 13:30

Service User Story
10:30 – 11:00am

A G E N D A

	SUBJECT	BY	ACTION	ENCLOSED
1	**Welcome and Apologies for Absence:**	Chair		
2	**Declarations of Interest**	Chair	**Note/Action**	Verbal
3	**Minutes of Meeting held: 7th March 2019**	Chair	**Approve**	Attached
4	**Matters Arising Schedule** **a) Chair's Action approved at 4th April Private Board**	Chair	**Review & Update**	Attached
5	**CEO Brief**	Tom Cahill	**Receive**	Attached
QUALITY & PATIENT SAFETY				
6	**Report of the Integrated Governance Committee**	Sarah Betteley	**Receive**	Attached
7	**Care Quality Commission – initial feedback and themes**	Dr Jane Padmore	**Receive**	Attached
OPERATIONAL AND PERFORMANCE				
8	**Report of the Finance and Investment Committee**	Simon Barter	**Receive**	Attached
9	**Q4 Annual Plan 18/19**	Karen Taylor	**Receive**	Attached
10	**Annual Plan 19/20**	Karen Taylor	**Receive**	Attached
11	**Q4 Performance Report 18/19**	Ronke Akerele	**Receive**	Attached
12	**Q4 Workforce Report 18/19**	Mariejke Maciejewski	**Receive**	Attached
13	**Finance Report to end of March 18/19**	Paul Ronald	**Receive**	Attached
14	**Financial Plan 19/20**	Paul Ronald	**Receive**	Attached
15	**Gender Pay Gap**	Mariejke Maciejewski	**Receive**	Attached

as One

Our Values
Welcoming Kind Positive Respectful Professional

GOVERNANCE AND REGULATORY				
16	**Report of the Audit Committee**	Catherine Dugmore	**Receive**	Attached
17	**Audit Committee Terms of Reference**	Catherine Dugmore	**Approve**	Attached
18	**Trust Risk Register**	Jane Padmore	**Receive**	Attached
19	**NHSI – Compliance with Foundation Trust Code of Governance**	Keith Loveman	**Receive**	Attached
20	**Register of Board of Directors Interests**	Chair	**Receive**	Attached
21	**Fit and Proper Persons Declaration**	Chair	**Receive**	Attached
22	**Any Other Business**	Chair		
QUESTIONS FROM THE PUBLIC		Chair		
Date and Time of Next Public Meeting: Thursday 6th June 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 7th March 2019
Da Vinci B – Colonnades

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Christopher Lawrence | CL	Chair
Loyola Weeks | LW	Non-Executive Director
Simon Barter | SBa	Non-Executive Director
Sarah Betteley | SBe	Non-Executive Director
Tanya Barron | TBa	Non-Executive Director
Janet Paraskeva | JPa	Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Karen Taylor | KT	Director, Strategy and Integration
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	
Kathryn Wickham | KW	PA to Chairman and Company Secretary
Sandra Brookes | SBr	Deputy Director of Delivery and Service User Experience
Jacky Vincent (JV)	Deputy Director of Nursing & Quality (agenda item 6)
Charity Chitauro (CC)	Interim Modern Matron, Warren Court & 4 Bowler's Green (agenda item 6)
MEMBERS OF THE PUBLC	
Julie Meikle	Head of Hospital Inspection, Care Quality Commission
Paul Devlin	Special Advisor
APOLOGIES	
Jill Hall | JHa	Interim Company Secretary
Catherine Dugmore | CD	Non-Executive Director
Sue Darker | SD	Herts County Council

Item	Subject	Action
025/19	**Service User Presentation** CL welcomed Margaret Casey (MC) who presented to the board on the care of her son Matt who had accessed the LD Community services. MC is a member of the Carer Council. CL thanked MC for her inspiring account of being a parent to a child with Learning Difficulties.	
026/19	**Welcome and Apologies for Absence** CL welcomed all to the meeting with an extended welcome to JM and PD from the CQC. Members of the Public were also welcomed. Apologies for absence were noted.	

027/19	**Declarations of Interest** There were no items declared.	
028/19	**Minutes of the meeting held on 7th February 2019** The minutes of the meeting held on the 7th February 2019 were discussed and agreed as an accurate account of the meeting. **APPROVED** **The Minutes of the 7th February 2019 were APPROVED**	
029/19	**Matters Arising** The matters arising schedule was discussed and updates noted.	
030/19	**CEO Brief** TC presented the report to the Board. The below key headlines were discussed and noted: **Health Education England (HEE)** HEE had launched a report on staff wellbeing which set out new plans to improve staff wellbeing within the NHS. **CQC publishes 'Monitoring the Mental Health Act' report** The report was published following the CQC investigation into the quality of care for patients who had been subject to the Mental Health Act. As a Trust we would be looking at this, with TC noting he felt this had come at the right time. **NHS Long Term Plan** Dido Harding & Julian Hartley, National Executive Lead, NHS Workforce had been asked to develop an interim Workforce Implementation Plan, as part of the overall Implementation Plan for the NHS Long Term Plan (LTP). Key themes were: • Recruitment and Retention • Leadership Culture • Prioritise nursing and midwifery • New types of roles and different ways of working • National Body reviews **NHS Improvement Plan** TC updated the Board on the proposed 23 legislation changes to support the plan which would be significant. **STP** TC commented that the new Chair Paul Burstow who had now been in post since December had re-energised and provided some drive. System re-design in terms of the new ICAs and ICS' was being developed and leadership across the three CCGs being considered. **Performance** Demand continued to increase with, for example, CAMHS showing an increase of referrals since December of over 100%. In general, performance was holding	

	however for CAMHS there were pressures on access times, particularly in the east of the county. Mid Essex IAPT was progressing well with sustained improved performance. **Quality, Safety and Effectiveness** TC reported he was pleased with the safety improvements achieved from the Swarms, Huddles and Moderate Harm Panel. **Workforce** TC commented on the positive results of the Staff Survey which had maintained a positive position. **Nursing Associates** The first cohort of Nursing Associates had completed their training. JPad added that Ian Costello had been shortlisted for the Nursing Times Student Nurse, Trainee Nursing Associate of the Year award. **Finance** TC stated the reported position was good with key areas of expenditure being placements and agency. For the year end we would deliver the control total of £360k surplus; however we should not forget the £1.4m reversals of old year accruals and provisions that supported this position. **Executive Director and Non-Executive Director recruitment** TC advised the Board that a Non-Executive Director appointment had been made, subject to Governor approval, to SBa post. Further interviews would take place on the 12th March for the appointment of Michelle Maynard's post. Director of Delivery and Service User Experience – there were 4 candidates shortlisted after the 'stop-go' interviews, with interviews scheduled for the 21st March. **Awards** TC recorded recognition to: The PAIG team who were shortlisted in the Clinical Leadership Team of the Year category for the BMJ Awards 2019 Peggy Postma, Clinical Lead for the Hertfordshire Wellbeing Team who had delivered a workshop at a national conference in London who were celebrating 10 years of IAPT. Victoria Sharma, Modern Matron who had been awarded a place on an NIHR programme to foster a culture of innovation. Questions were invited: SBe queried that in terms of performance was the assessment to first treatment measured. JL responded providing reassurance that this was.	

	RECEIVED **The Board discussed and RECEIVED the CEO report**	
031/19	**Patient Safety: SafeCare Tool Presentation** JPad introduced JV and CC who provided the Board with a presentation on the SafeCare model with the below key messages: • The tool aided management of the workforce and helped with the effective rostering of staff, ensuring service requirements were met • It ensured services were run efficiently with the software mounted on the eRoster system. The SafeCare tool calculated the required staffing from service user numbers, acuity and dependency 3 times per day and provided a site-wide overview of required versus actual staffing also highlighting hotspots as well as areas that could help • The tool redeploys staff safely providing full visibility of skills and impact elsewhere to avoid unnecessary agency use • There are daily SafeCare conference calls Monday to Friday which review safe staffing levels, utilising the data which has been added onto SafeCare. In addition there is a weekly eRoster Scrutiny meeting **RECEIVED** **The Board RECEIVED the presentation**	
032/19	**Staff Survey** MM updated the Board with the results of the Staff Survey with the below highlights to note: • The Trust had received a response rate of 41% and maintained a positive overall position. • In comparison to 24 other mental health Trusts we had scored above average for safety culture, quality of care, staff engagement and quality of appraisals. • There were a number of changes to the benchmarked report this year, most notably are the 32 key findings which had been replaced by 10 themes. • Of the 10 themes we had scored above average for 4, average for 4 and below average for 2 being immediate managers and experience of violence at work The below average scores were 0.1 below the average score. • MM reported we had seen one significant positive change since last year with staff confirming the Trust values were now being discussed as part of the appraisal process. • The organisation's response to Health and Wellbeing was reported less positively than in the previous year. Areas for improvement were: • Staff making improvements at work • Health & Wellbeing • Harassment & Bullying • Time pressures	

	• Working with managers • The report would inform the Organisational Development Activity Plan for 2019/20 Members of the Board acknowledged the good results of the Staff Survey and noted the key areas for improvement with CL recording these were encouraging results and a rich source of feedback for the Trust. **RESOLVED** **The Board RECEIVED and NOTED the report**	
033/19	**Removing Dormitory Accommodation** KL presented the paper which notified the Board of the long term plans and action taken to improve the quality of inpatient environments and service user experience and the removal of all dormitory style accommodation from Trust inpatient environments (Aston ward). The programme for this was expected to be delivered by October 2019 which would see the end of using dormitories in the Trust. FIC would oversee the investment decision. **RECEIVED** **The Board discussed and RECEIVED the report**	
034/19	**Service Strategies** JL provided a presentation to the Board on the development of the Trust Service Strategies for 2019 through to 2024. Key headlines from the presentation were: • Children and young people (0 – 24) mental health Moving towards the ambition of a comprehensive service for all children and young people aged 0 to 24 that responds early to the full range of mental health needs and is led by HPFT • Adult mental health Access to psychological therapies for depression and anxiety – working as part of the primary care team – specialist recovery focused teams for people with severe problems – one hour 24/7 response to a crisis • Older people's mental health HPFT clinical staff embedded in neighbourhood teams supporting people, especially those who are frail, and their families, at home including care homes • People with a learning disability Regional lead provider of integrated community and inpatient specialist health services for people with a learning disability • Forensic services Jointly leading a regional New Care Model for community forensic and secure mental health and learning disability provision	

	RESOLVED **The Board RECEIVED and NOTED the presentation**	
035/19	**Finance Report: January 2019** KL reported to the Board on the financial summary for the period to 31st January 2019 highlighting the position was positive with a surplus of £482k for the year to date. KL noted that all figures reported were before any income from the Provider Sustainability Fund (PSF) which was expected to be £1.4m for the year to date. This reflected the control total of £1.8m had been met so far. KL reminded the Board that this did include the £1.4m release in Quarter 1. The Trust would finish the year in a good place which would support the Annual Plan priorities. **RESOLVED** **The Board RECEIVED and NOTED the report**	
036/19	**Draft Annual Plan priorities 19/20** KT summarised the paper to the Board and highlighted key messages: • The plan was in year 4 of the Trusts Good to Great Strategy (2016 – 2021) and reflected discussions held with staff, Council of Governors, service users and carers • KT referred to the Strategic Objectives and the link through to the 2019/20 priorities. The annual plan was split into seven sections with priorities identified for each Strategic Objective in 2019/20. The outcomes of these would be finalised, with measurable targets agreed; underpinned by a detailed set of milestones and outcomes by quarter for each priority. KT concluded the update reporting it would be a challenging but exciting year ahead building on the momentum and significant improvements the Trust had made during 2018/19 in our Good to Great journey. The plan would be presented to the Integrated Governance Committee and the Finance and Investment Committee and then be brought back to the Board. **RESOLVED** **The Board RECEIVED and NOTED the report**	
037/19	**Financial Plan 19/20** KL introduced the Financial Plan and Contract update for 2019/20 and provided the Board with an update focused on Hertfordshire contract:- • The Trust was expecting a 5 year contract with an opportunity for a 2 year extension. There were 3 key areas to progress: • Financial Schedule • CQUIN • Process - In terms of the process KL advised the national contract document had still not been released.	

	• Commissioners had agreed to meet the uplift tariff; however the pay award would take up a significant element of his leaving little additional support for inflationary pressures. • The Mental Health Investment Standard was expected to be met which although encouraging would not enable all desired service developments. • The estimated CRES (efficiency requirement) was expected to be circa £6.5m • KL noted the expectations from Public Health and the lack of resources to achieve these. KL asked the Board to accept the recommended action to delegate the decision on the final agreement of the Hertfordshire Services Contract to the Trust Chief Executive Officer, Trust Chair, Director of Finance and Chair of the Finance and Investment Committee. The Board approved the decision. **RESOLVED** **The Board RECEIVED and NOTED the report and APPROVED the decision to delegate the final agreement on the Contract**	
038/19	**Audit Committee Terms of Reference** CL advised the Board that as the Chair of the Audit Committee Catherine Dugmore remained off sick the terms of reference would be deferred. TC asked for consideration for a contingency plan with agreement that the Chair of the Finance and Investment Committee SBa would step in if required. **RESOLVED** **The Board noted the deferment of the Audit Committee terms of reference**	
039/19	**Any Other Business** No further business was put forward.	
	QUESTIONS FROM THE PUBLIC **CL invited questions from the public. None were put forward.**	
Date and Time of Next Public Meeting: The next Public meeting is scheduled for Thursday 9th May 2019 @ 10:30am in Da Vinci B, The Colonnades		

Close of Meeting

Hertfordshire Partnership University NHS Foundation Trust

Agenda Item 4

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 9th May 2019

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
29/11/18	**153/18**	Workforce & Organisational Development Report Quarter 2	Board Workshop to be held on Staff Engagement	It was agreed for this to be held in Quarter 1	JH	b/f	A
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 Governor	Discussion to take place as to whether we had Appointed Governors from both Healthwatch and Viewpoint	CL/JH	b/f	A

Board of Directors Public Meeting

Meeting Date:	9th May 2019	Agenda Item: 5
Subject:	CEO Brief	
Presented by:	Tom Cahill, CEO	

National update

CQC Mental Health Inspection lead to step down
Paul Lelliott, who has been deputy chief inspector and the CQC's lead for mental health inspection for five years, is set to leave the organisation at the end of summer. A former consultant psychiatrist, Dr Lelliot was appointed to the role in January 2014 when the mental health inspection programme was launched. Currently he is leading the CQC's thematic review into the use of restraint, seclusion and segregation for people with mental health, learning disabilities and/or autism.

European Elections: Pre-election Guidance from NHS Improvement
On 1 May 2019, NHS Improvement published its pre-election guidance to NHS trust, which runs from that date through to and including Thursday, 23 May 2019, the date of the European Elections. The guidance itself can be found on NHS Improvement's website:

https://improvement.nhs.uk/news-alerts/upcoming-local-elections-pre-election-guidance-2019/

In summary, the guidance states:

- The NHS has a duty to remain politically impartial at all times, but especially during pre-election periods when specific restrictions are placed on the use of public resources and the communication activities of public bodies
- NHS organisations are expected to be behave impartially, especially when it comes to any external
- In terms of media handling, NHS organisations are asked to avoid proactive media on issues that may be contentious and for social media/websites, nothing contentious should be posted
- Board meetings held in public should be confined to discussing matters that need a board decision or require board oversight; matters of future strategy should be deferred
- FT governor elections – these can continue to go ahead, but the NHS is asked to exercise caution

The Trust is in the process of bringing the guidance to the attention of its wider leadership team and it will be included in this week's Highlights e-newsletter, which is sent out to all staff by email.

Final Never Events Report for 2017/18 published
NHS Improvement published its final adjusted Never Events report for 2017/18. Never Events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented. For the year in question, no such Never Events were recorded by HPFT.

NHS England roles out Employment Coaches scheme
On 20 April 2019, NHS England announced a major expansion of a scheme designed to help tens of thousands of patients with serious mental health problems who want to work, to find employment. The voluntary scheme, known as Individual Placement and Support (IPS), is being rolled out to 28 new local NHS areas, meaning eight out of ten parts of England will have access to the programme.

Regional update

Hertfordshire and West Essex STP

Leadership
Deborah Fielding, the Executive Lead for the STP retired, as planned, during April 2019. Whilst there are plans in place to consider a joint appointment between the STP and the CCGs in due course, the STP leadership has agreed to proceed with the appointment of an interim STP Head for the period of six to nine months. Interviews are expected to take place during May.

Design
As agreed, the Chair of the STP has produced a draft paper outlining the possible future architecture for commissioning and provision in the Herts & West Essex system. This paper will come to the next board meeting, but in essence as expected, it is proposing a single Integrated Care System (ICS) for the system with responsibility for strategic commissioning, providing assurance and performance within three geographical Integrated Care Partnerships with responsibility for the health management of the population in each locality.

There is also consideration being given to the development of an Integrated Care Partnership for Specialist Mental Health. Any such proposal would require Board approval and as such, would be formally tabled at a future Board Meeting.

STP Operating Plan 2019/20
The STP operating plan for 2019/20 was submitted to NHSI on 12 April and we await formal feedback. This will form the first year of a five year plan to be developed during the first half of the financial year.

NHSI/NHSE East of England
The Regional Directors for NHSI are now operating under the leadership of Ann Radmore. The following posts have been appointed to and Catherine O'Connell, Director of Commissioning, has been identified as the main link with Herts & West Essex STP.

Elliot Howard-Jones	Director of Performance & Improvement
Simon Wood	Director of Strategy & Transformation
Lynne Wigens	Chief Nurse
Jeff Buggle	Finance Director
Sean O'Kelly	Medical Director and Chief Clinical Information Officer

We will of course work with Ann and her team to further understand the implications for HPFT and this new regulation regime.

Trust-wide Update

Performance
Our quarter-end performance results reveal an all-time record for the highest volume of referrals into SPA (16,036 referrals for Q4, 5% higher than Q3). Despite this unprecedented volume pressure we have registered the 4th highest quarter for green-rated Trust wide key performance indicators of any quarter over the last 4 years.

Clearly, we are doing more 'units' of work with the same level of resources, however there are pressure points in key service areas that require remedial action. Primarily, these pressure areas manifest as performance dips in our access targets across Adult Community, Older Persons Dementia Diagnosis and Children's services.

In response, Continuous Quality Improvement activity for CAMHS 28 day wait to assessment, EMDASS 12 week wait to diagnosis, and Adult Community 28 day wait to assessment, will allow us to optimise processes and drive efficient use of resources. However, we are alive to the risk that

addressing access pressures can move the problem deeper into our delivery system and will take a whole systems approach, problem analysis and solution design.

Within the workforce, we are seeing modest improvement across all key performance indicators and believe that the effect of recent IT system improvements with Discovery and SPIKE 2 have delivered significant improvements to mandatory training and compliance activities.

Innovation
The Innovation Hub has been open since early March, and has received positive feedback. The Hub delivers a mixture of regularly scheduled sessions as well as bespoke workshop facilitation, helping individuals and teams to understand more about Continuous Quality Improvement (CQI) in order to address the problems and realise the opportunities in delivering their services.

In March and April we continued our investment in Innovation strengthening our skills and procurement activity to train and support Continuous Quality Improvement at all levels of the Trust.

We are sharing our innovation around delivering CAHMS Tier 4 services closer to home (the Hospital at Home Model) with the New Models of Care Collaborative. As a result we are creating opportunities to explore new ways of working across the region. Extending our network in this way gives us greater capacity for ideas and innovation by borrowing ideas and analysis from our near neighbours and creates relationships and understanding to work better together in the future.

Quality & Safety
The Peer Experience Listening stakeholder group are planning work relating to feeling safe in inpatient service areas. They will work in co-production with service users to look at more proactive approaches with feeling safe and safety on the wards.

A co-produced questionnaire has been drafted to be initially piloted in Oak, Robin and Albany Lodge. The questionnaire looks at service user experiences, resources to help individuals feel calm, relaxed and reassured, how individuals feel safe on the ward and the support they need.

Safety Pods are being piloted in service areas and training provided for their use. Governance for, and evaluation of their use is overseen by the Safety Committee.

We have implemented a number of actions regarding the use of restrictive interventions – including seclusion, to focus on using the least restrictive practice in our service areas. Moving forwards these will be incorporated in to our co-produced *MOSS2gether* strategy which we are currently planning.

Quality Strategy
Our Quality Strategy has been developed through reviewing the Quality and Service Delivery Strategy and a number of consultations and sets out clear objectives under each of the three quality domains of Safe, Effective and Experience detailing what this will mean for service users, carers and staff. The final version of the draft strategy will now be presented to IGC and subsequently to the Board for ratification.

Suicide prevention
We continue to deliver the zero tolerance to suicides action plan. In collaboration with 'Spot the Signs' a new app '*Stay alive'* is being launched on 9th May. This is an excellent resource whereby service users can hold their safety plans as well as find support and guidance when in crisis.

The Trust has been part of the public health audit into suicides with Public health, and the final findings will be presented next month.

Health & Safety Executive (HSE)
The Health and Safety Executive (HSE) will be visiting the Trust for a three day inspection from 13th to 15th May 2019 in relation to the Health and Safety Act 1974.

The inspection is one of twenty inspections that are planned nationally to examine management arrangements for prevention of violence and aggression experienced by our staff and how we prevent injuries at work e.g. back injuries.

CQC
Following the CQC Inspection that concluded at the end of March, it was noted that the inspection team were very complimentary about our staff and their caring attitudes with obvious commitment to the Trust values. The Trust has now received the draft report, which is in the process of being checked for factual accuracy, and it is hoped that the final rating and report will be published later in May.

Workforce & OD
The Big Listen was held in April and proved to be the highest attended so far with nearly 100 colleagues present. The overall day was very well evaluated with the three workshops well attended. Major topics of conversation included the working environment, career progression in corporate teams and more mobile equipment to allow agile working. As with previous Big Listens the topics of discussion will be collated and responses provided to the workforce.

Our 10th Cohort of the Leadership Academy programme started in April and recruitment for our local Mary Seacole Programme is underway. We also started a series of Management Fundamentals workshops for new managers. Further developments of our learning management system launched in April include a "My Team Dashboard" which allows managers to review the compliance of their direct and indirect reports and "SME Dashboard" which allows the Subject Matter Experts to review compliance of their training areas.

Recruitment continues to be a challenge however the performance data for quarter 4 shows a drop in vacancy rate and turnover with 140 new starters through the quarter. A Buddy scheme for new starters is now in place to support the transition into a new workplace and guidance has been produced for managers to support 100 day and stay conversations as part of our retention initiatives.

Our work on improving the experience of BAME staff continues with the introduction of a BAME representative on all interview panels for Band 8a posts and above.

Financial update
For year the financial position reported was a surplus of £392k, £32k ahead of the Plan and the NHSI Control Total. This was consistent with our projections in recent months which saw after a very difficult first quarter which required £1.4m additional support, a recovery approach which delivered a continued run of favourable surplus variances and then in Q4 the decision to make £1.1m of much needed investment within the estate.

The favourable variances reflected some additional non contract income, pay and agency savings and financing costs being below Plan. The highlights have been;

1. Performance of our CAMHs T4 service which after a difficult first six months has seen the successful implementation of the vision of a community based service operating locally enabling a large reduction in the previous out of area inpatient provision.
2. Steady reduction in agency costs within services which has saw us comply with the NHSI agency ceiling; and
3. Reduction in overhead costs whilst maintaining strong support to our clinical services.

The meeting of our Control Total has provided us access to the NHSI Provider Sustainability Funding with a provisional award of £3.5m of funding which will be used for further capital investment next year.

NED Appointments
I am pleased to advise that following a formal recruitment process, we have now appointed two Non-Executive Directors. Diane Herbert commenced on 1st May and David Atkinson commenced as Associate NED on 1st May until he takes up his formal post on 1st August. Also, as a developmental

role, Sarita Dent has been appointed as Associate NED for a period of 12 months. I am pleased to welcome them all to today's meeting.

Company Secretary
Following the recent resignation of our Company Secretary Jill Hall, an advert for her replacement is currently out, with interviews scheduled for 5th June.

Executive Director People & OD
As this post is currently vacant, recruitment agency Gatenby Sanderson has been appointed to undertake an executive search of prospective candidates for this important role. I will update you as the recruitment process progresses.

Awards
Congratulations to:

National award winners
At the Advancing Healthcare Awards (AHA) for 2019 ceremony, which were held on 12 April 2019 in central London, two HPFT staff won their categories. The awards, which aim to highlight the work of allied healthcare professionals and healthcare scientists, saw adult drama therapist Amber Tibbitts announced as one of seven Rising Star award winners across the UK, along with Clare Hubbard, drama therapy lead and Marina Morgan-Gynn, drama therapist, who won the Innovation in Mental Health award for the young person's drama therapy group initiative.

Currently, HPFT has nominations submitted to a further eight different national awards, ranging from the British Medical Journal awards to the NHS Parliamentary awards. I look forward to sharing how HPFT staff have fared over the coming months.

Tom Cahill,
Chief Executive

Hertfordshire Partnership University NHS Foundation Trust

Integrated Governance Committee

Meeting Date:	9th May 2019	**Agenda Item: 6**
Subject:	Integrated Governance Committee Board Briefing- 20th March 2019	**For Publication:** Yes/No
Author:	Dr Jane Padmore, Executive Director of Quality and Safety (Chief Nurse)	**Approved by:** Sarah Betteley, Non-Executive Director
Presented by:	Dr Jane Padmore, Executive Director of Quality and Safety (Chief Nurse)	

Purpose of the report:

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

Action required

The Board are asked to note the report.

Summary and recommendations to the Committee:

An overview of the work that was undertaken is outlined in the report.
No issues were noted to be escalated to the Board but recommended:

- Deep dive into organisational development at the next meeting.

The committee also requested greater attention to policies at IGC and stronger front sheets which indicate which area of the BAF and TRR the agenda item is addressing.

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 20th March 2019. This report sets out the key matters that were discussed. The committee had one observer in attendance, Michael Thorpe, newly appointed deputy Director of performance and improvement.

1.2. No matters were identified as needing to be escalated to the Board.

1.3. The Committee requested a deep dive into organisational development at the next meeting.

1.4. It also noted that

2. Subcommittees of IGC

Workforce and Organisational Development.

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, which had positive results.

2.2. The committee requested a deep dive into organisational development at the next committee.

2.3. Recent improvements have been noted in the time to hire as a result of managers now undertaking candidate identity checks at interview. Progress was also reported on the introduction of the 100 day conversations for new staff, the Trust wide Buddy Scheme for new starters, career conversations; the establishment of Long Service Awards as well as the extension of notice periods.

2.4. The Hertfordshire Social Work Teaching Partnership has begun and is aimed at enhancing the arrangements between Health Education Institutions and employers in order to raise the quality of social work practice.

2.5. A discussion was held about the performance of this year's flu campaign and plans for next year. Discussion around strategies for the next flu campaign including having Matrons as peer vaccinators. The forthcoming flu campaign will be led by the Medical Director.

2.6. Discovery is now in place recording supervision numbers. The next stage is to utilise Discovery to record the content of supervision to support the quality of supervision.

2.7. There are 11 risks on the workforce and OD risk register.

Quality and Risk Management Committee

2.8. An update on the work of the Quality and Risk Management Committee was given. Two matters were highlighted and discussed in detail at IGC.

2.9. A number of policies were approved for ratification and the challenges in reviewing policies in a timely way were reported. IGC suggested that the Trust consider reviewing their policy format introducing a quick

reference guide for each policy. The committee discussed how to improve oversight and assurance of the policies. A standing item of policies ratified in the last quarter, with the compliance rates for review will be a standing item at future IGCs.

2.10. The committee had spent a significant period of time working on restrictive practice including long term segregation and seclusion with an update on the improvements in terms of practice and governance are being made.

3. Governance and Assurance

3.1. Board Assurance Framework: It was noted that the recommendations at the last IGC had been implemented and the BAF was now a stronger document. It was suggested that the internal and clinical audits are considered and detailed further in the BAF.

3.2. Trust Risk Register: There had not been any significant changes since the TRR was last received. A discussion was held about how we use both the BAF and TRR at IGC. Going forward, improvements will be made to the front sheet of papers, indicating what areas of the BAF and TRR are addressed by the items being discussed.

3.3. Annual Plan: The 2019/20 plan was presented and the committee discussed the priorities for the coming year.

3.4. Freedom to Speak Up policy: The committee ratified this policy.

3.5. Freedom to speak up self-assessment: The Trust has undertaken a non-mandated Freedom to Speak Up self-assessment that was developed by NHSI and the committee noted the work that had been undertaken over the last year to strengthen this role.

4. Quality and Safety

4.1. CQC Update: The committee heard about the recent CQC inspection and the informal feedback as well as the immediate actions that had been taken.

4.2. Q3 safeguarding report: The annual safeguarding plan continues to be implemented. The committee asked about the safeguarding arrangements in Buckinghamshire, Essex and Norfolk and the local arrangements were set out.

5. Quality and Effectiveness

5.1. Q3 CQUIN report: An update was given in relation to the CQUINS and highlighted some areas of risk, namely, flu vaccinations, collaboration with Primary Care and joint agency transition planning which are being addressed. Good progress has been made in relation to the reduction of sugary drinks and foods high in fat, sugar and salt available to staff, service users and visitors and tobacco screening, alcohol screening & appropriate interventions.

5.2. Quality Report: The draft quality report, with suggested indicators was presented and feedback invited. The process for auditing and approving of the report was set out.

6. Quality and Experience
   6.1. Complaints and PALs Q3: This report was discussed and areas highlighted were appointments being cancelled and what the Trust is doing to minimise this.

7. Conclusion
   7.1. The committee decided that there were no items that needed to be formally escalated to the Board.
   7.2. However, it was recommended that here is a deep dive in to Organisational development at the next meeting.
   7.3. In addition the committee asked for a greater focus on policies as well as full completion of the front sheets of papers, indicating which areas of the BAF and TRR are being addressed in each agenda item.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	9th May 2019	**Agenda Item:** 7
Subject:	CQC	**For Publication:** tbc
Author:	Dr Jane Padmore, Director of Quality and Safety	**Approved by:** Dr Jane Padmore, Director of Quality and Safety
Presented by:	Dr Jane Padmore, Director of Quality and Safety	

Purpose of the report:

To give an overview the recent CQC inspection

Action required:

For information and discussion.

Summary and recommendations:

In March 2019 the CQC conducted the annual well led inspection and core inspection of 6 service lines. The Board has previously received feedback in relation to inspection process and areas that were highlighted as positive and areas of challenge. It has also received the report relating to the embargoed draft report in the Private Board.

This report sets out the process for receiving the report and governance arrangements for ensuring the appropriate action is taken.

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

Priority one.

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

N/A

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

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

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

1. Introduction

1.1. In March 2019 the CQC conducted the annual well led inspection and core inspection of 6 service lines. The draft report has been received for factual accuracy and circulated to the Board members.

1.2. The outcome and findings in the draft report have been set out in the report that went to the Private Board meeting. That report also set out the challenges that have been put forward by the Trust. As the report is embargoed, this will not be set out in this report.

2. The inspection outcome

2.1. The factual accuracy report and supporting evidence has been received. Any challenge has to be submitted to the CQC by Tuesday 7th May 2019. The Trust has been working together to consider what has been reported and put forward any challenges that can be robustly supported with evidence.

2.2. The CQC will then make any amendments they deem appropriate prior to agreeing a release date and communication strategy with the Trust and NHSI. It is likely this will be delay due to purdah.

2.3. The intelligence from feedback during the inspection, the informal feedback letter and the draft report findings have been used to ensure swift action is taken to address any concerns.

2.4. A formal action plan is being developed which will be held at the Quality Risk Management Committee and reported through to the Integrated Governance Committee.

2.5. Given the feedback thus far it is anticipated that the Trust will receive a positive outcome.

3. Conclusion

3.1. This paper set out the next steps in relation to the CQC inspection that was undertaken in March 2019. It details how the actions will be monitored and how the Trust will receive assurance that appropriate and sustainable actions are taken.

Trust Board

Meeting Date:	9th May 2019	**Agenda Item: 8**
Subject:	Report from Finance & Investment Committee – 19 March 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 19 March 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 19 March Finance & Investment Committee meeting covered:

- Deep Dive – STP Planning
- Planning for 2019/20
  - (a) Contract Sign Off
  - (b) Draft Annual Plan 19/20
  - (b) Draft Financial Plan 19/20
- Business Development
  - (a) New Care Models
  - (b) Commercial Development Activity Other
- Strategic Investment Programme
  - Bed provision E&N Herts
  - Dormitory removal
  - Seclusion & Safe Space Programme
- Performance Report – Period to end February 2019
- Financial Summary – Period to end February 2019
- 2018/19 Final Accounts update
- Capital Plan & Expenditure Summary
- FIC Business Programme 2019

Deep Dive – STP Planning

The Director of Finance delivered a presentation outlining the current STP financial position, the headline National expectations and considering how HPFT best position services. All providers are expected to eliminate any deficit within the next two years; the deficit that sits within the three acute Trusts is in the region of £85M.

The Committee discussed the risks in system delivery, the ongoing demand on services and the longer term Mental Health investment and how to ensure that HPFT continues to work with the system

shaping the future model.

Planning for 2019/20

a) Contract Sign Off

FIC received an update on progress against the renewal of the Trust's main contracts. Most aspects of the Hertfordshire contract are agreed for a period of 5 years and are being placed into the draft contract however there are some issues that need to be resolved. Discussions with Commissioners are prioritising sustaining existing services and then addressing the Five Year Forward View requirements.

Final negations are ongoing focussing on performance targets for Access to Adult Community services and CAMHS services to ensure the thresholds are both stretching but deliverable. In terms of CAMHS, we are continuing to commit to the existing target but seeking commissioner commitment to improve the system wide CAMHS pathway to address demand on our services.

Contracts for Essex Learning Disability services and NHS England Specialist Commissioning were also discussed and noted.

b) Draft Trust Annual Plan

FIC received an update on the Trust Annual plan from the Director of Strategy and Innovation. Following feedback from the Trust Board and a workshop held with members of the Council of Governors the Annual Plan has been further refined to improve the detail related to carer experience. The outcome measures have also been streamlined.

The Annual Plan will also be presented at Integrated Governance Committee focussing on the Quality and Safety objectives.

c) Draft Financial Plan

The Deputy Director of Finance presented the draft financial plan for 2019/20 with the requirement to submit an approved financial plan to NHSI by 4th April 2019. The process for FY1920 has been developed and refined in conjunction with the Annual Plan, the contract discussions and any further requirements of NHSI.

The annual CRES requirement for FY1920 has initially been calculated at around £6.5M with ongoing programmes and new schemes being developed to achieve this.

FIC noted that the contract with Interserve is more uncertain following the business being placed into administration and whilst they are now wholly owned by RBS, the Trust will ensure exisitng contingency plans remain robust.

Business Development

a) New Models of Care

FIC received an update on the development of New Care Models (NCM) at regional and sub-regional level. Discussions have been taking place across the four main East of England NHS providers of mental health and learning disabilities about how we respond to a request to submit expressions of interest in the following services:

- Secure Adult Mental Health
- CAMHS
- Adult Eating Disorders

A collaborative approach has been agreed in principle and models are now being scoped and explored in detail. FIC heard that we have expressed a strong preference to be the lead provider for CAMHS and this has been agreed in principle. The NCM approach is no different to CAMHS Tier 4 and will be a similar process on a larger scale to work through.

FIC discussed at length the importance of governance and recommended that the approach taken to the 'Bid Board' could be replicated; noting that Board approval in relation to the governance and financial risk would be required.

b) New Commercial Development Activity

FIC received an update on the new commercial activity taking place with three particular areas for attention;

- Individual Placement Service that is consistent with the 5 Year Forward View.
- Community Forensic services which will form part of the NCM collaborative work
- Liaison and Diversion Service which is about to go out to tender.

Strategic Investment Programme

FIC considered reports from the Director of Finance in relation to progressing significant elements of the forward investment programme.

- **Bed Re-provision E&N Herts**

FIC received an update confirming the strategy for reprovision of adult acute beds for East and North Hertfordshire. A range of options are being scoped identifying potential benefits and risks with ballpark capital costs estimated as potentially up to £50M. Consideration is being given to initial soft consultation with service users and carers. FIC approved a budget of £150k to support the initial work in developing plans.

- **Dormitory Removal**

The update also set out the interim arrangements forwork being undertaken on Aston Ward to remove the dormitories as reported to the Trust Board on 7th March. The five remaining dormitory rooms on Aston ward have been moved to single accommodation only. On-going refurbishment has been allowed for in the capital plan and will progress on the basis of a 'not to be exceeded' budget of £1M.

- **Seclusion & Safe Space Programme**

Current facilities have been identified as requiring upgrade and improvement to support least restrictive operational practice and with a vision of "best in Class" high quality environments for service users. Significant work has been completed to work up designs with staff and service users and further work is now required to progress both planning and permissions FIC agreed an initial budget of £200K to support this work, requiring an update at each stage of the process.

Performance Report – Period to end February 2019

The Director of Innovation and Transformation presented the Performance report for January and the highlights for February. FIC discussed a number of areas in detail and noted that whilst there has been strong and improved performance in some areas, key areas of challenge remain in Adult 28-day wait, EMDASS 12-week to diagnosis target, CAMHS 28-day assessments and Sickness and turnover rates; focussed recovery against the targets continues.

Following discussion it was agreed that it would be helpful to see the actions being taken to improve the position and impact they are making at the next meeting.

Financial Summary – Period to end February 2019
The Deputy Director of Finance updated the Committee on the current financial position and the key highlights and risks, and the forecast of the likely financial position for the full year.

FIC noted that the February financial position had been impacted by non-recurrent estates expenditure agreed for Q4. The YTD position is strong despite at £407K, noting the £1.4m support in Q1.

The main headlines indicate progressive improvement in a number of areas, particularly secondary commissioning and agency costs. The Trust is confident that the Control Total will be achieved and will earn the available PSF income of c.£1.8m.

2018/19 Final Accounts
FIC received a presentation setting out the position in terms of the final accounts for 2018/19. The financial position was heavily supported in Q1 which has enabled the Trust to sustain improvement from Q2 onwards. The Delivering Value Programme (formerly CRES) has exceeded expectations. Success has been achieved through a reduction in PICU and CAMHs T4 placements together with a reduction in agency spend. FIC noted the report and extended tribute to the Finance Team for enabling the positive position.

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

Trust Board

Meeting Date:	9th May 2019	**Agenda Item: 9**
Subject:	Trust Annual Plan 2019-20	**For Publication:** No
Author:	Karen Taylor, Director, Strategy & Integration	**Approved by:** Karen Taylor, Director, Strategy & Integration
Presented by:	Karen Taylor, Director Strategy & Integration	

Purpose of the report:

To present the Trust's year end performance against the 2018/19 Annual Plan

Action required:

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

Summary and recommendations to the Board:

2018/19 has been a successful year, with the Trust significantly moving forward on its journey from Good to Great over the last 12 months. There have been a number of demonstrable improvements made to the care we provide, the outcomes achieved and the overall experience for our service users and their families. Importantly, this has been recognised externally as well as through our own internal validation processes. In March 2019 we were inspected by the Care Quality Commission with the Trust receiving positive feedback and, whilst the final rating is still to be released, the informal feedback we have received reflects our own assessment of our progress during the year. Some of the highlights of the year include:

- Safety has been a significant focus for us, with the introduction of a number of clinically led initiatives to transform the way we approach keeping our service users safe across the organisation. For example we have introduced the Moderate Harm Panel, SWARMs, Schwartz Rounds and our Safety Huddles. The CQC in their informal feedback to us have recognised the transformation we have made in this area
- In our national staff survey results (2018) our staff gave us the highest rating achieved nationally for our Safety Culture – reflecting the change in our approach across the Trust
- We sustained our positive ratings in our national staff survey results more broadly and the CQC inspectors told us in their informal feedback that they consistently experienced high staff morale across all teams
- During the year we put in place a number of new services for our service users improving the care we provide and offer. For example we have fully implemented a new community home treatment model within our Child and Adolescent Mental Health Services (CAMHS) allowing more young people to receive their care locally and avoid long inpatient stays.

- We were successfully awarded a new contract for Learning Disability services across the whole of Essex; allowing us to work with local GPs, the councils and the local mental health provider and community services provider to begin to put in place a new service aimed at making it easier for service users to access services and providing care locally. Continued improvements will be made during the next 12 months to fully implement the new service.

- We also introduced of a number of initiatives to support our service users achieving better physical health. For example, physical health clinics now run throughout the trust; new menus have been implemented across all our inpatient services improving service user experience and improving the nutritional menus available. New Choice and Medication leaflets are in our welcome packs to support service users to make informed choices in relation to the choice of psychotropic medication and we have also encouraged increased physical activity for our service users; including walking groups, table tennis, team games such as basketball.

- We continued to work with our partners across the health and social care system to improve services. Work included the development of a new frailty pathway across West Essex and Hertfordshire, the full implementation of a new diabetes pathway in West Hertfordshire, work with care homes and the development of our IAPT offer for patients with long term physical health conditions. We also tested new primary mental health services with General practice and secured funding to further develop and roll out the approach with GPs and the voluntary sector across Hertfordshire in 2019/20.

- Continuous Quality Improvement has become core to the way we approach the development of our services, with teams across the Trust able to point to and demonstrate improvements they have made throughout the year to improve care. The establishment of our Innovation Hub signals our commitment to this approach and further investment planned for 2019/20 will see this continue to become mainstream throughout our organisation

- An improved learning system ‘Discovery’ has overhauled our on-line learning experience across the Trust; with staff feedback very positive about the changes made. We have also seen the further development of our ‘business intelligence’ system ‘ SPIKE 2’, and further improvements made to our electronic record ‘PARIS’ – both developments supporting clinicians, practitioners and teams to deliver better care.

- The Trust delivered significant improvements to care as part of its ‘Delivering Value’ programme and despite an incredibly busy and challenging year, with demand for services reaching their highest levels, the Trust achieved its key NHSI financial targets including its financial control target and also its agency cap.

- 2018/19 also saw the Trust successfully renegotiating and renewing all of its contracts. All contracts were renewed across Buckinghamshire, Essex and Norfolk, with the Trust securing a five year contract renewal for services across Hertfordshire - securing the future of specialist mental health and learning disabilities for the foreseeable future.

Summary & recommendations to the Board

The Annual Plan comprises of seven objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the priorities for the Trust and the key actions the Trust needs to take to deliver the agreed outcomes for the year. This report providers an overall assessment of achievements and progress over the last twelve months, together with noting the specific achievements and progress during quarter 4.

The Trust Board is asked to receive the report; noting the significant progress and achievements made, together with key areas of challenge and focus moving forwards.

Relationship with the Business Plan & Assurance Framework:

Summarises Progress against Annual Plan (all objectives)

Summary of Implications for:

1. Finance – delivery of the Trust's financial plans aligned with the Annual Plan
2. IT – delivery reported within the Annual Plan report
3. Staffing – Issues reported within the Annual Plan report
4. NHS Constitution – N/A
5. Carbon Footprint – N/A
6. Legal – N/A

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

N/A

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

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

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

1 May 2019 Executive Committee

Hertfordshire Partnership University NHS Foundation Trust

TRUST ANNUAL PLAN 2018/19 – END OF YEAR REPORT

1. Introduction

The Annual Plan comprises of 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, to deliver the Trust's agreed outcomes for the year. This report provides an assessment of what was achieved during quarter 4, together with an assessment of the overall end of year position.

2. Highlights of the Year

2018/19 has been a successful year, with the Trust significantly moving forward on its journey from Good to Great over the last 12 months. There have been a number of demonstrable improvements made to the care we provide, the outcomes achieved and the overall experience for our service users and their families.

Importantly, this has been recognised externally as well as through our own internal validation processes. In March 2019 we were inspected by the Care Quality Commission with the Trust receiving positive feedback and, whilst the final rating is still to be released, the informal feedback we have received reflects our own assessment of our progress during the year. Some of the highlights of the year include:

- Safety has been a significant focus for us during the year. We introduced a number of clinically led initiatives to transform the way we approach keeping our service users safe across the organisation; for example the introduction of the Moderate Harm Panel, SWARMs, Schwartz Rounds and our Safety Huddles. The CQC, in their informal feedback to us, have recognised the transformation we have made in this area

- In our national staff survey results (2018) our staff gave us the highest rating achieved nationally for our Safety Culture – reflecting the change in our approach across the Trust

- We sustained our positive ratings in our national staff survey results more broadly and the CQC inspectors told us in their informal feedback that they consistently experienced high staff morale across all teams

- During the year we put in place a number of new services for our service users that have improved the care we provide and offer. For example we have fully implemented a new community home treatment model within our Child and Adolescent Mental Health Services (CAMHS) allowing more young people to receive their care locally and avoid long inpatient stays.

- We were successfully awarded a new contract for Learning Disability services across the whole of Essex; allowing us to work with local GPs, the councils and the local mental health provider and community services provider to begin to put in place a new service aimed at making it easier for service users to access services and providing care locally. Continued improvements will be made during the next 12 months to fully implement the new service.

- We also introduced of a number of initiatives to support our service users achieving better physical health. For example, physical health clinics are now run throughout the trust; new menus have been implemented across all our inpatient services improving service user experience and improving the nutritional menus available. New Choice and Medication leaflets are in our welcome packs to support service users to make informed choices in relation to the choice of psychotropic medication and we have also encouraged our service users to take increased physical activity through walking groups, table tennis and team games such as basketball.

- We continued to work with our partners across the health and social care system to improve services. Work included the development of a new frailty pathway across West Essex and Hertfordshire, the full implementation of a new diabetes pathway in West Hertfordshire, work with care homes and the development of our IAPT offer for patients with long term physical health conditions. We also tested new primary mental health services with General practice and secured funding to further develop and roll out the approach with GPs and the voluntary sector across Hertfordshire in 2019/20.

- Continuous Quality Improvement has become core to the way we approach the development of our services, with teams across the Trust able to point to and demonstrate improvements they have made throughout the year to improve care. The establishment of our Innovation Hub signals our commitment to this approach and further investment planned for 2019/20 will see this continue to become mainstream throughout our organisation

- An improved learning system 'Discovery' has overhauled our on-line learning experience across the Trust; with staff feedback very positive about the changes made. We have also seen the further development of our 'business intelligence' system ' SPIKE 2', and further improvements made to our electronic record 'PARIS' – both developments supporting clinicians, practitioners and teams to deliver better care.

- The Trust delivered significant improvements to care as part of its 'Delivering Value' programme and, despite an incredibly busy and challenging year with demand for services reaching their highest levels, the Trust achieved its key NHSI financial targets including its financial control target and also its agency cap.

- 2018/19 also saw the Trust successfully renegotiating and renewing all of its contracts. All contracts were renewed across Buckinghamshire, Essex and Norfolk, with the Trust securing a five year contract renewal for services across Hertfordshire - securing the future of specialist mental health and learning disabilities for the foreseeable future.

3. End of Year Summary

Overall, the year has been successful, with the key improvements and achievements summarised throughout the report. We also 'RAG' rate each objective at the end of year to summarise overall performance. For an objective to be rated green it must have achieved the majority of its end of year outcomes.

The table below shows the ratings given to each of the objectives. At the end of the year five (out of seven) objectives have been fully delivered with two rated as Amber.

Table 1 End of Year Projected RAG

Objective		End of Year Rating
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 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)	

Appendix 1 provides the commentary for each objective. The Amber objectives are as follows:

- Objective 3

  Significant work was undertaken during the year to develop and implement new pathways of care for Psychosis, Dementia and Personality Disorder pathways. The amber rating reflects the work remaining to fully implement those pathways. Also, although in progress with the University of Hertfordshire, we are yet to finalise our research strategy and model of research for the organisation.

- Objective 4

  2018/19 saw the Trust maintain its overall vacancy rate at 13% despite an increased establishment of about 70 new posts. Similarly, our turnover rate remained fairly static at 15.5% despite a national picture of shortage of staff and high turnover rates. If planned turnover (e.g. fixed term contracts and retirements and death in service/dismissal) is taken into consideration)

turnover is 11.4%. However our aspiration to reduce the vacancy rate and turnover rate to 10% was not achieved. There is also on-going targeted support for BME staff with initiatives to improve the experience for those staff.

Where plans have not been fully delivered in 2018/19 and they remain central to the delivery of our strategy 'Good to Great' they have been included in the Annual Plan for 2019/20.

5. Conclusion

2018/19 has been a successful year, with the Trust significantly moving forward on its journey from Good to Great over the last twelve months. There have been a number of demonstrable improvements made to the care we provide, the outcomes achieved and the overall experience for our service users and their families.

The majority of the outcomes identified in the Trust's Annual Plan were achieved, although challenges remain, in particular relating to the recruitment and retention of staff, which we recognise is a national issue facing mental health & learning disability organisations, and indeed the NHS at large. Increased demand for services has also caused significant challenges throughout the course of the year, with referrals into specialist mental health services significantly increasing for CAMHS and Adult mental health services.

The Trust's Good to Great strategy will see us continue to strive to improve care, experience and outcomes for our service users during 2019/20. We will continue to innovate and transform our services, working together with our service users, carers, staff and partners to coproduce and deliver the care we know our service users need and deserve; care that we would want for ourselves, our family and friends.

Appendix 1 – Annual Plan End of Year (EOY) Summary

	Objective	Exec. Dir. Lead	EOY outcomes Projection at			EOY Actual	Year End Outcomes Commentary
			Q1	Q2	Q3	Q4	
1	We will provide safe services, so that people feel safe and are protected from avoidable harm	JP					• CQC and our staff have reported an improvement in our safety culture and approach throughout the organisation • 80% service users feeling safe achieved across our adult MH inpatient units • Seclusion environments improved & safety suites programme underway • Latest published number of suicides reduced (2016). Inquests for subsequent years have not been published. Trust 2018/19 suspected suicide/unknown cause of death (56) currently above 2017/18 level. • The number of incidents of service user to staff violence recorded has remained static; service user to service user incidents have slightly increased; our MOSS2Gether (Making our Services Safety strategy) identifies the key areas of focus for the next 12-18 months.
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	JL/KL					• Service users & GPs satisfaction with primary care model piloted • 1 hour crisis response is being piloted • Reduced reliance placements, supporting individual recovery • Improved adult community services survey responses • Improved PLACE audit outcome scores to achieve national MH average in specific domains • Increased Out of Hours support from TFM provider • It remained a challenge to achieve 98% target for < 28 day access due to increased demand levels
3	We will improve the health of our service users through the delivery of effective evidence based practice	AZ					• Outcome and effectiveness measures agreed across Psychosis, Dementia and Personality Disorder pathways with on-going work to fully implement pathways • Improved employment status of service users • Improved physical health for service users (CPA, Inpatient, FEP) • On-going collaboration with University of Hertfordshire to develop new model of research for the organisation to fully align to innovation and improvement.
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	MM					• 2018/19 saw the trust maintain its overall vacancy rate at 13% • Turnover rate remained fairly static at 15.5%. If planned turnover (e.g. fixed term contracts and retirements and death in service/dismissal) is removed from consideration, unplanned turnover is 11.4%. • <30% in staff reporting work life balance as reason for leaving • 65.5% staff advising there are opportunities for flexible working • Staff engagement scores maintained and the support staff get from their

							immediate line managers increased slightly to 74.4% • Staff being to contribute to improvements at work reduced to 52.6%. • Career progression and development work on going • On-going initiatives to improve working lives for our BAME Staff
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	RA/ KL					• Efficiency plans delivered against target (£4.7m) at end of year with an improved underlying financial performance & no quality impact • SPIKE 2 provides real time information, enabling prioritisation and review of caseload, guiding supervisions and supports conversations with service about their care • Innovation Hub established, supporting staff to understand and use improvement techniques and concepts • GDPR compliance achieved • Increased use of equipment to support flexible/mobile working
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	KT					• GPs and service users reporting satisfaction with primary care model • 24/7 access for service users to Mental health expertise within A&E and acute hospital settings • Coproduced integrated model developed and commissioned across Essex • Funding secured for IAPT long term conditions for roll out 2019/20 • All physical health CQUIN indicators met in Quarter 4 • Diabetes integrated pathway fully in place (West Herts)
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	KT					• Mental Health and Learning disabilities prioritised for investment and development across STP; Mental Health Investment Standards met • Exploration of a Specialist MH/LD Integrated Care Alliance & role of MH & LD within geographical Integrated Care Alliance underway • Improved focus on dementia care - included within the STP frailty pathway • Funding for employment services successfully bid for across the STP. • Strong role across the STP and within Local Partnership Boards; All localities reporting Mental Health & Learning Disability leadership and visibility • Future locality model of care for older people's services is under development. • On-going development of HPFT Estates strategy which will reflect our integrated care ambitions and future service requirements • HPFT secured all its contracts, with a 5 year contract in place for Hertfordshire. • In Essex a fully integrated service for LD was commissioned

Appendix 2 – Annual Plan Quarter 4

Full Commentary against Milestones and Outcomes

Great Care, Great Outcomes

Priority 1 (Owner JP)	Q4 Key Actions / Milestones	Q4 Milestones Rating
We will provide safe services, so that people feel safe and are protected from avoidable harm	• Fully implement the Trust wide Mortality Review Panel to support the Trust with learning from all deaths • Complete build and implement a dedicated CAMHS Place of Safety • Focused projects based on national data, zero suicide Alliance & thematic review • Ligature work audited • Quality improvement project from the review of incidents will be implemented • Evaluation of the new module for restrictive practice training	
Key areas of focus	**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	• The Trust has fully implemented a Trust wide Mortality Review Panel that supports the review of all deaths. • The CAMHS Place of Safety is currently mid build and will be completed by the end of June 2019. • The Trust has a Suicide Prevention action plan with a number of focused projects underway and others under development, including work with the Samaritans and an internal Suicide Prevention group • Weekly ligature assessment and annual audit programme is in place. The ligature policy has been updated and these weekly assessments are being rolled out to community services. • Quality improvement project from the review of incidents has been implemented, with stage one and two in place and three and four follow. • The pilot of the new module for restrictive practice training has been evaluated. • In Q4 there were 12 unexpected deaths, of which 1 has been given a suicide verdict and 11 are still to have their inquest (9 suspected suicides and 2 unknown causes).	

Year End Summary	Key Outcomes at Year End	Year End Outcomes Rating
• CQC and our staff have reported an improvement in our safety culture and approach throughout the organisation • 80% service users feeling safe achieved across adult inpatient units • Seclusion environments improved & safety suites under development • Latest published number of suicides reduced (2016). Inquests for subsequent years have not yet published. Trust 2018/19 suspected suicide/unknown cause of death (56) currently above 2017/18 level. • Number of incidents of service user to staff violence recorded has remained static; service user to service user incidents have slightly increased.	• Reduction in the number of suspected suicides by a minimum of 10% • Increase in the % of service users reporting feeling safe across all in patient services. • Improved seclusion environments across the Trust • Reduction in number of incidents of service user to service user violence • Reduction in number of incidents of service user to staff violence • Improvements to overall safety culture/approach	

Priority 2 (Owner JL/KL)	Q4 Key Actions / Milestones	Q4 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	• Develop 'service walk through' videos to improve the accessibility of our services and reduce service user and carer anxiety • Completed and launched on website • Roll out of real-time feedback technology based on Pilot	

Key areas of focus:	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 service	• In community adult services, the primary care pilots in Stevenage, Hertford, and Watford have been evaluated and continued along, with recruitment plans and work with localities to plan a further roll-out during 19/20. This has improved links with GPs and reduced the number of Initial Assessments undertaken by the community teams. • The First Response Service has been in operation for 2 days a week from Jan and extended to 5 days a week from March, with the aim for service users to have a clear crisis plan agreed with them within the hour. • Welcome packs have been produced and are in use across adult and CAMH services. Work has started on the older people's version. • 'Service walk through' videos have been co- produced within CAMHS for 4 sites and launched on the website. The remainder (6) will be completed in line with the refurbishment of the hubs. • Six of the community hubs have IPads installed in receptions areas to collect real time feedback from service users

Year End Summary:	Key Outcomes at Year End	Year End Outcomes Rating
• There has been an overall improvement in the PLACE audit scores, particularly with regards to, 'ward food, food and hydration, maintenance and condition of environments', with improved support from TFM provider. • 'Real time' feedback through IPads being pilot in six community hubs • Out of Area placements have dramatically decreased throughout the year • 1 hour crisis response was piloted; with new crisis pathway developed and being implemented in 2019/20. • Adult community services have improved access although have not managed to reach the target due to on-going high levels of demand. The primary care mental health model is being further developed with agreed plans for roll-out. • There has been improvement in the number of carers assessments offered but further work in other areas is required	• Increased points of 'real time' feedback with increased satisfaction from service users • Adult community services 98% access within 28 days • 1 hour crisis response supporting service users and their families • Reduction out of area placements • Improved PLACE audit outcome scores • Increased Out of Hours support from TFM provider • 70% carers assessments undertaken	

Priority 3 (Owner: AZ)	Q4 Key Actions / Milestones	Q4 Milestones Projection
We will improve the health of our service users through the delivery of effective evidence based practice	• Implement new Dementia pathways across the Trust • Raise the profile of research across the organisation including organising a research capability workshop • Ensure evaluations of service & quality improvements are published	

Key areas of focus:	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	• Dementia outcomes were agreed at the clinical outcomes steering group and is now being implemented. • Research deep dive took place and a joint conference with University of Hertfordshire. • HPFT has enrolled more patients in clinical research than previous years. • Learning Disability services have begun to set up a National Benchmarking research group (RADiANT) with ten other organisations • Rehab services and adult community services are going through a two year the accreditation process. • Employment status has improved in the last year • Physical health checks of those with long term conditions have improved in the last year as reported in the CQUIN

Year End Summary	Key Outcomes at Year End	Year End Outcomes Rating
• Clinical Outcome measure has been agreed for Dementia, Personality Disorder and Psychosis. These pathways are now being implemented. • The pathways will be fully implemented in 2019/20; as such we did not see a meaningful reduction in re-admission and re-referral rates • There has been 5% reduction in DNA for the initial assessment after a new standard operating procedure was introduced • Physical health checks for service users with long term conditions & those on the PATH service have improved as reported through CQUIN • Rehabilitation and community services are going through a two year accreditation process • Number of service users enrolled into research studies has increased with focus on clinical research lead by CAMHS and LD services.	• Outcome and effectiveness measures agreed • Reduced readmission rates for service users • Reduced re-referral rates for service users • Appropriate pathway length of stays achieved • Improved employment status of service users • Improved physical health for service users • Reduced number of service users requiring transition from CAMHS to Adult services • Rehabilitation, inpatient acute and Community East team accreditation progressed • Research strategy developed • Clinical research capability increased within the organisation and higher profile of research across the organisation	

Great People

Priority 4 (Owner: MM)	Q4 Key Actions / Milestones	Q4 Milestones Rating
We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	• AfC pay refresh fully implemented • All initiatives in the NHSI retention plan implemented • Production of a detailed costed workforce plan • Long Service Awards launched • Implementation of clearer brand & marketing strategy • Launch of newly developed management and leadership programme	
Key areas of focus	**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	• All elements of the agenda for change pay refresh implemented • NHSI retention initiatives continue to be embedded including monthly health and wellbeing initiatives, the launch of career conversations for staff in February, 100 day interviews for new starters including a new toolkit to support managers, and sharing Trust vacancies with staff at the hubs. Work continues on improving the 'onboarding' experience for staff. • The new careers website has also been launched. • New roles - The first cohort of trainee nurse associates are about to graduate and 8 new Nurse Associate roles are being introduced within the Trust. • Launch of the new management fundamentals training programme and of a refreshed leadership academy training course took place in Q4 • The plan for long service awards is in place and the first long service awards will take place in Q1 19/20	

Year End Summary	Key Outcomes at Year End	Year End Outcomes Rating

• 2018/19 saw the Trust maintain its overall vacancy rate at 13%
• Turnover rate remained fairly static at 15.5%. If planned turnover (e.g. fixed term contracts/ retirements and death in service/dismissal) is removed from consideration, unplanned turnover is 11.4%.
• <30% in staff reporting work life balance as reason for leaving
• 65.5% staff advising there are opportunities for flexible working
• Staff engagement scores maintained and the support staff get from their immediate line managers increased slightly to 74.4%
• Staff being to contribute to improvements at work reduced to 52.6%.
• On-going initiatives to improve working lives for our BAME Staff
	• Clear and costed workforce plan
	• New posts identified and in place
	• Vacancy rate reduced to 10%
	• Unplanned staff turnover reduced to 10%
	• Improved staff satisfaction results in pulse and staff surveys, in particular;
	  ○ Support from line manager
	  ○ feeling able to contribute
	• WRES indicators improved for BME staff	

Great Organisation

Priority 5 (Owner: RA/KL)	Q4 Key Actions Planned / Milestones	Q4 Milestone Rating
We will improve, innovate and transform our services to provide the most effective, productive and high quality care	• Widespread use of GoToMeeting / Skype for Business • On-going expansion of devices with data SIM support; data contracts & data usage • Enable interoperability through the increasing use of MIG • iHub operational • Complete implementation of SPIKE • Put in place a single Trust wide approach to continuous improvement and deliver a quality improvement training programme to leaders	
Key areas of focus:	**Commentary:**	
• We will provide staff and teams with better access to the right information to do their jobs effectively and efficiently • We will develop more effective ways of working through the implementation of new technologies. • We will embed our approach to continuous improvement across the organisation	• Implementation of a single integrated business intelligence platform for all clinical reporting needs (SPIKE) • All 175 licences for Skype Business deployed in Q4. • Increased use of medical interoperability gateway (MIG) with East Herts MHSOP and LD teams. • Staff reporting improved functionality, improved access and ease of access to information • Improved responsiveness to deployment of equipment to support flexible/mobile working. • Established Innovation Hub within the Colonnades • Increase in staff trained in Quality Improvement (QI) methodology • CRES programme delivered (£4.7m) with no quality impact	

Year End Summary	Key Outcomes at Year End	Year End Outcomes Rating
• Efficiency plans delivering against target at end of year with an improved underlying financial performance • SPIKE 2 provides real time information, enabling prioritisation and review of caseload, guiding supervisions and supports conversations with service about their care • The Innovation Hub is supporting people to understand and use improvement techniques and concepts including generating solutions and plan rapid tests of their ideas. • GDPR compliance achieved	• Measurable increase of time - to care • 1 hour real time clinical data available • Achieve GDPR compliance • Agreed Quality Improvement (QI) methodology adopted • CRES (£4.7m) programme delivered	

Great Networks and Partnerships

Priority 6 (Owner KT /JL)	Q4 Key Actions Planned / Milestones	Q4 Milestones 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	Delivery Physical Health Strategy (Year 2)	

Key areas of focus	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	• A competency programme has been developed to support physical health skills training • The observation and escalation tool NEWS 2 (National Early Warning System) has been introduced • Physical health clinics run throughout the trust and the objective this year has been to look at best practice and the most effective and efficient use of skill mix. Standardised framework for the clinics is being piloted. • New menus have been implemented across all our inpatient services in response to service user and PLACE feedback. All the menus meet the expected national standards regarding nutritional balance. • Pharmacy team supporting service users to make informed choices in relation to the choice of psychotropic medication and side effects in relation to physical health. Choice and Medication leaflets have been introduced into welcome packs and discharge medication. • Improved physical activity service users inc. walking groups, table tennis, team games such as basketball. Wards have developed a number of initiatives to support activity and distraction. • The Trust has been implementing a number of initiatives to support smoking cessation. Service users are prepared for a smoke free admission, and supported through their admission. • LD Essex partnership in place and local plans developed

Year End Summary	Key Outcomes at Year End	Year End Outcomes Rating
• Significant progress has been made throughout the year with the key outcomes achieved. • Core 24 is in place in both Hertfordshire acute hospitals, the new Diabetes integrated pathway in place • The funding is secured for IAPT Long Term Conditions development and all Physical health CQUIN indicators met in Quarter 4. • Following successful award of the LD Essex contract services are being	• 24/7 access to Mental health expertise within A&E and acute hospital settings • Coproduced model in place across Essex • Commissioners reporting improved confidence in service delivery • LTC pathways clearly defined with ease of access for service user	

developed and this will continue during 2019/20, with commissioners reporting increased confidence	• All physical health indicators and outcomes for service users met across the Trust	

Priority 7 (Owner KT)	Q4 Key Actions / Milestones	Q4 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 • Finalise planning 2019/20	

Key areas of focus	Commentary
• Our leaders will continue to drive and support the improvement of care and outcomes across the system • We will ensure that the needs of those with a mental health illness and/or learning disability are included in the future design of services	• Identified & working with key stakeholders throughout 2018/19 to ensure the needs of those with a mental illness/learning disability are supported and met • Active participants and leaders within the Herts and West Essex STP, supporting its development and the development of the geographical Local Delivery Partnerships • Led the Mental Health & LD workstream, the Mental Health Investment standards were met across H&WE STP; successful bids were made as an STP for the development of MH & LD services. • Working with providers across the East of England to explore the development of a future Collaborative to develop New Care Models across the region • Supported the development of locality provider groups; working with GPs and other providers to develop local plans and services based on the needs of the local population; includes primary mental health models of care. • The Frailty pathway included a focus on the needs of those with dementia and those with a learning disability following work with HPFT and the STP mental health workstream

Year End Summary	Key Outcomes at Year End	Year End Outcomes Rating
• Mental Health and Learning disabilities prioritised for investment and development across STP; Mental Health Investment Standards met • Exploration of a Specialist MH/LD Integrated Care Alliance & role of MH & LD within geographical Integrated Care Alliance underway • Improved focus on dementia care - included within the STP frailty pathway • Funding for employment services successfully bid for across the STP. • Strong role across the STP and within Local Partnership Boards; All localities reporting Mental Health & Learning Disability leadership and visibility • Future locality model of care for older people's services is under development. • On-going development of HPFT Estates strategy which will reflect our integrated	• Mental Health and Learning disabilities prioritised for investment and development across the STP • HPFT Estates strategy approved • Improved focus on dementia care • Stakeholder engagement plans used throughout the organisation • New model of integrated community based care endorsed by commissioners • Clear direction for future locality model	

care ambitions and future service requirements • HPFT secured all its contracts, with a 5 year contract in place for Hertfordshire. • In Essex a fully integrated service for LD was commissioned	of care for older peoples services	

Trust Board

Meeting Date:	9 May 2019	**Agenda Item: 10**
Subject:	Trust Annual Plan 2019-20	**For Publication:** No
Author:	Karen Taylor, Director, Strategy & Integration	**Approved by:** Karen Taylor, Director, Strategy & Integration
Presented by:	Karen Taylor, Director Strategy & Integration	

Purpose of the report:

The attached paper provides an overview of our Annual Plan for 2019/20, with the full plan provided as Appendix 1 to the report. Our plan, which builds on the significant progress we have made as a Trust during 2018/19, has been developed in conjunction with our key stakeholders including our Council of Governors, commissioners and other partners. Detailed outcome trajectories and actions to be taken by quarter against each of the seven objectives are in place.

Action required:

To review and approve the Trust Annual Plan for 2019/20

Summary and recommendations to the Board:

High level summary of the 2019-20 Plan

The year ahead is exciting, building on the momentum and significant improvements we have made during 2018-19. Our relentless focus on continuously improving our services to provide high quality care will continue in 2019-20. This includes targeted work to further improve the safety of the care we provide, the experience and the outcomes for our service users. We will be focusing on releasing more time to care - more time to spend with our service users and carers to deliver the outcomes that matter to them.

We know that great care starts with a great workforce. That is why in 2019-20 staff development and staff experience remains our priority. We will be focusing on our inclusive and just culture, together with the roll out of our High Performing Team model. This together with our commitment to continuous quality improvement will support and encourage our workforce to make the changes they believe are needed to deliver great care. We also know we need to have the right number of staff with the right skills in the right place. Recruiting to our vacancies, developing new roles and retaining our existing workforce are priorities for the forthcoming year.

Externally, pace is building as our local health and social care organisations begin to move together towards a population health model of care. This, together the potential of New Models of Care for specialist services, will mean a continued focus during 2019-20 on the future development of our services – always focusing on improved outcomes for our service users and carers.

This, alongside our continued commitment to coproduction with our service users, staff and other key stakeholders means we are confident 2019-20 will see the Trust continue to make significant

strides along our journey to achieve 'Great Care, Great Outcomes'.

Overview of priorities

Strategic Objective	2019/20 priorities
We will provide safe services, so that people feel safe and are protected from avoidable harm	• We will continue our drive to reduce suspected suicides and prevent avoidable harm • We will continue to ensure our service users feel safe across our inpatient units • We will ensure seclusion and restrictive practices and environments across the Trust are in line with best practice
We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	• We will improve the timeliness and experience of accessing our services and subsequent treatment to support recovery • We will improve the quality and experience of the environment across our services for service users and staff. • We will improve the ways in which we recognise and support carers
We will improve the health of our service users & support recovery through the delivery of effective evidence based practice	• We will improve the effectiveness of our interventions to support recovery through the implementation of evidence based pathways • We will improve physical health for people with serious mental illness and learning disability • We will develop our approach to research to strengthen the relationship between practice, research and audit
We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	• We will continue to focus on and deliver key high impact recruitment and retention activities • We will develop an inclusive and just culture where all staff feel safe and valued. • We will continue to develop the collective leadership culture of the organisation where staff feel empowered and engaged
We will improve, innovate and transform our services to provide the most effective, productive and high quality care	• We will create a culture and environment where we embed continuous quality improvement approach to deliver Great Care and Great Outcomes. • We will provide staff and teams with better access to the right information to do their jobs effectively and efficiently • We will enable more effective ways of working that value service user, carer and staff time.
We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	• We will develop and deliver new models of care in our older persons services • We will implement our new model of care across Learning Disability Services in Essex • We will develop a new model of primary mental health across Hertfordshire • We will improve our physical health practices across the Trust

We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	• We will lead and drive the development of a population based model for Mental Health & LD focused on improving care & outcomes • We will actively support the development of the STP and population health, including the development of the Integrated Care System and Integrated Care Alliances. • We will support and drive the development of a new model of care for CAMHS across Hertfordshire • We will work at a region wide level to establish New Care Models

Next Steps
Once approved the Annual Plan will be published on our website. The Annual Plan priorities are cascaded via the development of Business Plans for the Strategic Business Units and Corporate Services. These, in turn, should be reflected in team plans through to individual Personal Development Plans.

At Trust Board Level, progress against milestones and outcomes will be reviewed on a quarterly basis, with a mid-year review to allow for a fuller assessment of any changes required to the plan to achieve the Trust's agreed priorities.

Recommendations
It is recommended the Trust Board approves this plan

Relationship with the Business Plan & Assurance Framework:

Annual plan outlines the key deliverables for the Trust

Summary of Implications for:

1. Finance – Delivery of the Annual Plan is aligned with the Trust's Financial Plan
2. IT – Priorities are outlined within the Plan
3. Staffing – Priorities are outlined within the Plan
4. NHS Constitution – N/A
5. Carbon Footprint – N/A
6. Legal – N/A

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

The development of the plan has been done in conjunction with a number of stakeholders

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

Delivery of the plan will support delivery of the above

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

1 May Executive Committee, Finance & Investment Committee 19 March, Integrated Governance Committee 20 March, Trust Board 4 April

Hertfordshire Partnership University NHS Foundation Trust

ANNUAL PLAN 2019-20

1. Introduction

This paper provides an overview of HPFT's Annual Plan for 2019-20. It aligns with the operating plan the Trust submitted to NHSI and with known commissioning priorities/developments at a local, regional and national level. Our plan, which builds on the significant progress we have made as a Trust during 2018/19, reflects discussions with the Council of Governors, final contracts with our Commissioners together with feedback received from NHSI.

2. Background - Good to Great

Our 'Good to Great' Strategy (2016-2021) describes how we are going to deliver our vision of 'Delivering Great Care, Achieving Great Outcomes – Together'. Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we 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 depicts the key areas of focus for the Trust in terms of its people, improving the way we do things, partnerships and quality (experience, effectiveness and safety).

3. Strategic Objectives 2016-2021

The Trust has a number of strategic objectives:

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)

4. Our Annual Plan for 2019-20

The year ahead is exciting, building on the momentum and significant improvements we have made as a Trust during 2018-19. Our relentless focus on continuously improving our services to provide high quality care will continue over the next twelve months. This includes targeted work to further improve the safety of the care we provide, the experience and the outcomes for our service users. We will be focusing on releasing more time to care - more time to spend with our service users and carers to deliver the outcomes that matter to them.

We know that great care starts with a great workforce. That is why in 2019-20 the development and experience of our staff remain our priority. We will be focusing on our inclusive and just culture, together with the roll out of our High Performing Team model. This together with our commitment to continuous quality improvement will support and encourage our workforce to make the changes they believe are needed to deliver great care. We also know we need to have the right number of staff with the right skills in the right place. Recruiting to our vacancies, developing new roles and retaining our existing workforce are priorities for the forthcoming year.

Externally, pace is building as our local health and social care organisations begin to move together towards a population health model of care. This, together with the potential of New Models of Care for specialist services, will mean a continued focus during 2019-20 on the future development of our organisation and services – always focusing on improved outcomes for our service users and carers.

This, alongside our continued commitment to coproduction with our service users, staff and other key stakeholders, means we are confident 2019-20 will see the Trust making significant strides along our journey to achieve ‘Great Care, Great Outcomes’.

5. Development of the Plan

Our 2019 plan takes into consideration and reflects national planning guidance, Herts & West Essex Sustainable Transformation Partnership (STP) priorities, local contract discussions and agreements. It

has been informed by feedback and discussions from stakeholders including our staff, our senior leadership team, the Council of Governors, our service users and carers and our commissioners.

6. 2019-20 Priorities, Actions and Outcomes

The Annual Plan is split into seven sections with priorities identified for each Strategic Objective (see Table below). The actions to be taken and outcomes are clearly defined (See Appendix 1). The Annual plan is underpinned by a detailed set of milestones and outcomes by quarter for each priority.

Strategic Objective	2019/20 priorities
We will provide safe services, so that people feel safe and are protected from avoidable harm	• We will continue our drive to reduce suspected suicides and prevent avoidable harm • We will continue to ensure our service users feel safe across our inpatient units • We will ensure seclusion and restrictive practices and environments across the Trust are in line with best practice
We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	• We will improve the timeliness and experience of accessing our services and subsequent treatment to support recovery • We will improve the quality and experience of the environment across our services for service users and staff. • We will improve the ways in which we recognise and support carers
We will improve the health of our service users & support recovery through the delivery of effective evidence based practice	• We will improve the effectiveness of our interventions to support recovery through the implementation of evidence based pathways • We will improve physical health for people with serious mental illness and learning disability • We will develop our approach to research to strengthen the relationship between practice, research and audit
We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	• We will continue to focus on and deliver key high impact recruitment and retention activities • We will develop an inclusive and just culture where all staff feel safe and valued. • We will continue to develop the collective leadership culture of the organisation where staff feel empowered and engaged
We will improve, innovate and transform our services to provide the most effective, productive and high quality care	• We will create a culture and environment where we embed continuous quality improvement approach to deliver Great Care and Great Outcomes. • We will provide staff and teams with better access to the right information to do their jobs effectively and efficiently • We will enable more effective ways of working that value service user, carer and staff time.
We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	• We will develop and deliver new models of care in our older persons services • We will implement our new model of care across Learning Disability Services in Essex • We will develop a new model of primary mental health across Hertfordshire • We will improve our physical health practices across the Trust
We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	• We will lead and drive the development of a population based model for Mental Health & LD focused on improving care & outcomes • We will actively support the development of the STP and population health, including the development of the Integrated Care System/Alliances • We will support and drive the development of a new model of care for CAMHS across Hertfordshire • We will work at a region wide level to establish New Care Models

7. Monitoring and Review

The Annual Plan priorities are cascaded via the development of Business Plans for the Strategic Business Units and Corporate Services. These, in turn, should be reflected in team plans through to individual Personal Development Plans. At Trust Board Level, progress against milestones and outcomes will be reviewed on a quarterly basis. Progress is also monitored quarterly with the Strategic Business Units.

In addition, a more extensive review will take place mid-year with the Trust Board to allow for a fuller assessment of any changes required to the plan to achieve the Trust's agreed priorities. In the event of changing factors (internal or external to the Trust) the plan may need to be adjusted/updated to ensure delivery of the required outcomes. This reflects the need to ensure the plan, although produced at the beginning of the year, remains a 'live' reflection of our work and priorities across the Trust.

8. Conclusion

2019/20 is the fourth year of our 'Good to Great' journey and our Annual Plan describes the key actions we will take to this year to further develop our services and to ensure we are able to provide the highest quality care for those individuals with a mental health illness and/or learning disability. This paper has described how we have developed our plan, the key priorities for the year ahead and how they support delivery of our Strategic Objectives. It also describes how we will monitor and track progress throughout the year, ensuring the Annual Plan outcomes are delivered.

Hertfordshire Partnership University NHS Foundation Trust

APPENDIX 1

TRUST ANNUAL PLAN

2019-20

Strategic Objective 1 - We will provide safe services, so that people feel safe and are protected from avoidable harm

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users and staff)	Measurement (how we will know)
We will continue our drive to reduce suspected suicides and prevent avoidable harm	• We will develop and deliver an **enhanced approach to supporting primary care** to identify and communicate effectively about those at risk of suicide • We will **develop a new training and education** programme for risk assessment and formulation, based on the Health Education England suicide and self-harm competency framework	• Service users will not feel that suicide is their only option and will be getting the right care, in the right place by the right people. • Reduction in the number of suspected suicides	• Reduction suspected suicides • New measure to be developed – demonstrating numbers of suicides relative to caseload numbers
We will continue to ensure our service users feel safe across our inpatient units	• We will further **embed our 'Feeling safe'** activities (e.g. peer support listening, safety huddles, red to green, safety crosses) • We will implement **The Making our Services Safer Together (MOSS 2gether);**	• Service users will feel safe when they use our services • There will be less incidents of violence and aggression on our wards • Staff will feel safe when they are working on our wards	• 85% service users report feeling safe across all adult and CAMHS inpatient units • < level of harm as consequence of violence & aggression • > staff reporting feeling safe
We will ensure seclusion and restrictive practices and environments across the Trust are in line with best practice	• We will **strengthen our Shared Decision making** with service users through implementing The Making our Services Safer Together (MOSS 2gether); using the "Safe wards" model as the underpinning • We will **build new seclusion/safe care suites** at identified service areas, configured to deliver best-in-class standards and seclusion environments approach.	• Staff, service users and carers will work together to support service users to manage their feelings and behaviour using the least restrictive practice • Improved safety and experience for service users and staff • Service users will be supported using the least restrictive practice to recover and to move out of seclusion as quickly and safely as possible	• Reduction in the length of time spent in seclusion per episode. • Safe care suites opened

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

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users or staff)	Measurement (how we will know)
We will improve the timeliness and experience of accessing our services and subsequent treatment to support recovery	• We will improve our crisis function through the roll out of a **24/7 First Response Pathway,** working with all partners across the system e.g. Drug & Alcohol, probation and police	• Service users will have better access to crisis care (within an hour) and will be able to access the service more easily than 999 and A&E	• Crisis access < 1 hour for all service users who require urgent access (100% by Q4)
	• We will improve **access to our** Children and Adolescent services, including putting in place the **CAMHS trailblazer development**	• Service users will have improved access to assessment and treatment • Service users will have improved outcomes and less reliance on crisis services • Waiting times will reduce • Service users and carers will have improved outcomes • Reduced demand for adult community secondary mental health care. • Increased GP Satisfaction • Staff will report greater ability to provide great care to service users	• CAMHS 28 day access >95% in line with contract • <wait to treatment/follow up
	• We will improve **access to our Adult Mental Health Services**, focusing particularly on establishing **primary mental health teams** across Hertfordshire		• Adult MH 28 day access >95% in line with contract • <wait to treatment/follow up
	• We will improve **access to our IAPT services**		• Improved access in line with contract
	• We will implement our **new model of care for LD** Services in Essex		• LD Transformation plan delivered
We will improve the quality and experience of the environment across our services for service users and staff	• We will complete the **refurbishment of Albany Lodge and Aston Ward** • We will progress the business case for **re-provision of adult acute beds** for E&N Herts • We will **implement 'life-cycle'** refurbishment programme of works. • We will **continue the remodelling of our community hubs**	• Staff will be able to access the clinical and office space needed to work effectively • Experience of people accessing and receiving services in our community Hubs will improve • The physical environments of our inpatient wards and Community Hubs will improve	• Delivery of the capital programme for 2019/20 • Positive feedback from staff through the pulse survey • Positive feedback from service users and carers through 'Having Your Say'
We will improve the ways in which we recognise and support carers	• We will Implement the plans outlined in our carers plan for 2019/20	• Carers reporting improved access to support and information • Carers assessments will have taken place • Carers report feeling supported	• > Carers assessments (t.b.c) • Carers report improved support and information

Strategic Objective 3 - We will improve the health of our service users through the delivery of effective evidence based practice

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users or staff)	Measurement (how we will know)

We will improve the effectiveness of our interventions through the implementation of evidence based pathways	• Fully implement **new pathways and services to support recovery** for
	  ○ Psychosis
	  ○ Dementia
	  ○ All age Personality Disorder
	  ○ Crisis care pathway
	  ○ Learning Disability services in Essex
		• Service users with psychosis, dementia and personality will experience best in class care and outcomes, aligned with NICE guidelines
		• Staff will be able to report, review and use outcome measure to support their practices, with outcome measures captured on SPIKE
		• Appropriate pathway length of stays achieved in line with recognised illness profile
			• < PD admissions
			• < admissions following CATT intervention
			• > discharge from pathways

We will improve our physical health practices across the Trust	• We will ensure all **pathways** across the Trust include physical health • We will transform **our physical health training & equipment** for our staff across the Trust • We will ensure we **develop our practices** to incorporate meeting the physical health needs of our service users • We will **work with partners and experts** in physical health to improve and develop our services, ensuring collaborative relationships are in place to meet the physical healthcare needs of people with mental illness.	• Service users will have access to support to make healthy lifestyle choices (e.g. diet, exercise and smoking) and supported to access routine age and gender appropriate physical health screening and vaccinations • Service users will be monitored for adverse physical effects of antipsychotic treatment or other poor physical health. • Staff will report having the skills and training necessary to support service users with their physical health needs • Service users will have an agreed health and wellbeing plan	• MOSS2gether implemented to support shared decision making • Service users individual recovery plans include physical health • Physical health training updated and staff training being delivered • NEWS2 implemented to support staff to identify physical deterioration
We will develop our approach to research to strengthen the relationship between practice, research and audit	• Develop **new model of research and research strategy** for the organisation, which is fully aligned to innovation and improvement. • Raise the **profile of research across** the organisation	• Staff are empowered to participate in research practice • Research strategy developed (aligned with University of Hertfordshire) • Clinical research capability increased within the organisation • Higher profile of research across the organisation	• Staff involved in research activity • New research projects started during 2019/20 are linked to practice improvements.

Strategic Objective 4 - We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our staff or service users)	Measurement (how we will know)
We will continue to focus on and deliver key high impact recruitment and retention activities	• Recruitment – we will strengthen our approach and marketing to **attract high calibre people** to join the organisation • Retention – we will continue to **focus on what our staff have said matters to them including**; their health & wellbeing; flexible working; working as part of a team; career progression and acknowledgement; access to training.	• Staff will want to join the Trust and stay working in the Trust • Staff will have more opportunities for flexible working and will be able to progress more easily through new career pathways • Staff will be able to access non-mandatory training • Staff will feel their contribution is acknowledged via long service awards • Service users will receive great care	• Minimum 10% reduction in Trust wide vacancy rate (<12%) • Minimum 10% reduction in Trust turnover rate (<14%) • Workforce for the future strategy in place • Improved staff engagement score through Pulse & staff survey
We will develop an inclusive culture where all staff feel safe and valued.	• We will work with all groups of staff with protected characteristics to further develop our **Just and Inclusive Culture** across the Trust • We will significantly **improve the experience of our BAME** staff and staff with a **disability** • We will continue our **campaign to eliminate bullying and harassment** across the Trust	• All staff will be aware of and understand what our Just and Inclusive Culture means for them and how they work with colleagues • BAME and disabled staff will have an improved staff experience • BAME staff will be on all senior recruitment panels •	• Improved staff survey results measured through Pulse survey and staff survey results • 100% senior recruitment panels (Band 8a+) have BAME representation • Reduction staff reporting bullying and harassment by a manager
We will continue to develop the collective leadership culture of the organisation where staff feel empowered and engaged	• We will implement our **High Performing Teams** model • We will **implement our CQI model** across the Trust including; putting in place training and development for staff; resourcing a CQI team • We will continue and **build on our staff engagement** activities across the Trust	• Staff will feel that they can make improvements at work • Staff will report improved support from line managers • Staff will feel more engaged and motivated to deliver great care and great outcomes to service users and carers • Improved team working with the high performing team model	• High performing team model will have been introduced across x teams • Improved staff survey results • Improved Pulse survey results

Strategic Objective 5 - We will improve, innovate and transform our services to provide the most effective, productive and high quality care

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how will we know)
We will create a culture and environment where we embed continuous quality improvement approach to deliver Great Care and Great Outcomes.	• We will **implement our CQI model** across the Trust including; putting in place training and development for staff; resourcing a CQI team • We will **create time, space and resource** to embed CQI through our first **Innovation Hub**, and further development of hubs across the Trust	• Staff will be supported to develop their continuous quality improvement skills and knowledge • Staff will be supported to generate ideas and test new improvement ideas and approaches to solving problems • Service users will experience improved safety, outcomes, effectiveness of inventions, timeliness to access service	• 320 staff CQI trained • 30% staff have utilised the improvement hub(s) • Staff reporting they are able to make improvement at work
We will provide staff and teams with better access to the right information to do their jobs effectively and efficiently	• We will finalise our **Digital Strategy** identifying key areas of development of focus for the Trust over the next 5 years • We will continue our drive to use data across the Trust to **support decision making** to improve care and outcomes. • Streamline and further **develop our Electronic Patient Record system** to support delivery of care and system interoperability.	• Staff will have improved access to different data sources to support delivery of care • Staff will have access to improved reporting through the development of SPIKE • Staff will be able to make informed decisions through triangulation of data • Staff will report improved functionality, improved access and ease of access to information	• Digital strategy in place • > staff ease of access and use of information
We will enable more effective ways of working that value service user, carer and staff time.	• We will develop and **implement plans to increase time to care** across our services • We will implement a **productivity dashboard** across the Trust	• Staff will have the equipment & technology to deliver high quality, effective care • Staff will have more time for direct service user care • Service Users will report they have more time to discuss their care • CRES programme delivered with no quality impact for service users	• All teams operating at 50% of time for direct care • Service users report improved time to discuss their care • CRES £6.5m delivered without a negative impact on quality • Corporate review CRES minimum £1m delivered

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

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how we will know)
We will develop and deliver new models of care in our older persons services	• We will develop and mobilise the Trust's response to the STP **Frailty** pathways and **locality working** • We will develop new ways of working with **care homes** • We will implement **new Dementia Pathways**	• Service users will experience more joined up care • Care home staff will have expert mental health support • Carers of service users with dementia will report improved support • Staff will feel supported and able to make improvements	• New model for Older People's community services will be in place • < reduced time to assessment • < reduced time to dementia diagnosis
We will implement our new model of care across Learning Disability Services in Essex	• Mobilise and implement **transformation of LD Services** • Potential **bed configuration** option appraisal to be completed and implemented	• Service users will experience more joined up care & have better access to services • Service users will have high quality care and better outcomes • Essex LD staff will work in joined up teams, feel supported & able to make improvements	• Local integrated teams in place • Access to service improved through new 'Way in' service • Service users reporting satisfaction with service • Bed configuration option approved
We will develop a new model of primary mental health across Hertfordshire	• Establish **primary mental health care teams** across Hertfordshire.	• Service users will have improved access to local services & improved outcomes • Service users will experience reduced waiting times to access Adult MH services and support • Staff will feel motivated and able to make improvements • Service users and GPs will report increased satisfaction	• >95% service users will be able to access services within 28 days • < reduced time to treatment and ongoing care • > Increased conversion rate from Initial Assessment to treatment
We will improve our physical health practices across the Trust	• We will **work with partners and experts** in physical health to improve and develop our services, ensuring collaborative relationships are in place to meet the physical healthcare needs of people with mental illness.	• Service users will have access to support to make healthy lifestyle choices (e.g. diet, exercise and smoking) and supported to access routine age and gender appropriate physical health screening and vaccinations	• Medical Interoperability Gateway (MIG) rolled out • Paris Connect delivered • Older people model delivered • Clear links with partner organisations

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)

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how we will know)
We will lead and drive the development of a population based model for Mental Health & LD focused on improving care & outcomes	• We will **develop a vision and approach** to the development of specialist MH&LD services and population based MH services in conjunction with partners • We will work with partners to **refocus the STP MH work** stream to focus on key transformational activities across the STP	• STP / ICA design plans will meet needs of those with specialist MH/LD • Service users will experience better outcomes • Staff will feel motivated and able to deliver great care	• STP continues to prioritise and invest in Mental Health (MH) & Learning Disabilities (LD) • Future of MH/LD specialist provision and role of MH/LD within geographical based ICAs understood and within design plans • HWE STP population health model continues to develop • Mental Health Investment Standard is met within 2019/20 • MH & LD is overtly prioritised within the STP strategy and delivery work streams
We will actively support the development of the STP and population health, including the development of the Integrated Care System and Integrated Care Alliances.	• We will ensure Board Directors and senior managers **participate and lead key work** across the STP • We will ensure HPFT staff are represented and active in **locality working groups and provider boards** • We will continue to **lead the STP mental health and LD** work stream	• Service users will experience more joined up care • Service users will receive care that meets their needs	
We will support and drive the development of a new model of care for CAMHS across Hertfordshire	• We will work across the system to fully **understand the increased demand** on CAMHS services to inform a new service model • We will work with commissioners and system partners to **reduce variation and improve experience** for children, young people and their families.	• Children & Young people (CYP) will experience better access to services • CYP will report being satisfied with the services available to support them • Staff will report being able to provide high quality services and being able to make improvements to care	• System wide agreed CAMHS transformation programme agreed and under implementation • 95% CAMHS access <28 days
We will work at a regional wide level to establish New Care Models	• Work with partners across East of England to **set up a provider collaborative** to deliver Enhanced and improved model of Secure Care, Adult Eating Disorders & CAMHS T4.	• Develop regional pathways of care to support improved quality and efficiency • Service users will have increased local choice and provision to support them at home and in their community	• East of England (EOE) Provider Collaborative established • Plans for development of services across EOE under development

Trust Board

Meeting Date:	9th May 2019	**Agenda Item:** 11
Subject:	Performance Report Q4 2018/ 2019	**For Publication: No**
Author:	Michael Thorpe, Deputy Director of Innovation and Improvement	**Approved by:** Ronke Akerele, Director of Innovation and Improvement
Presented by:	Ronke Akerele, Director of Innovation and Improvement	

Purpose of the report:

1. To inform the Trust Board on the Trust's performance against both the NHSI Single Oversight (SOF) Targets and the Trust KPIs for Q4, 2018/19
2. To assess the likely future performance projections for 2019/20 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.

Performance Summary

Overall, performance across Q4 remained balanced and holding up against pressures of a high average turnover rate of 15.5% and service demands with 6% increase in referrals into SPA of 16,036 from 15,179 in Q3.

In Q4, we have continued to build upon and maintain our performance on the following indicators:

- CAMHS CATT 4 hour A&E assessment standards: This remains above target since June 2018. This measure, although seeing a significant increase in referrals over the last six months, continues to maintain performance. In March 96.97% of the 99 service users who were seen and assessed were within the 4 hour timescales.

- CATT Gatekeeping – We have been continuing to achieve target for this measure and performing at 97.46% in March. We have met target for this measure for well over a year.

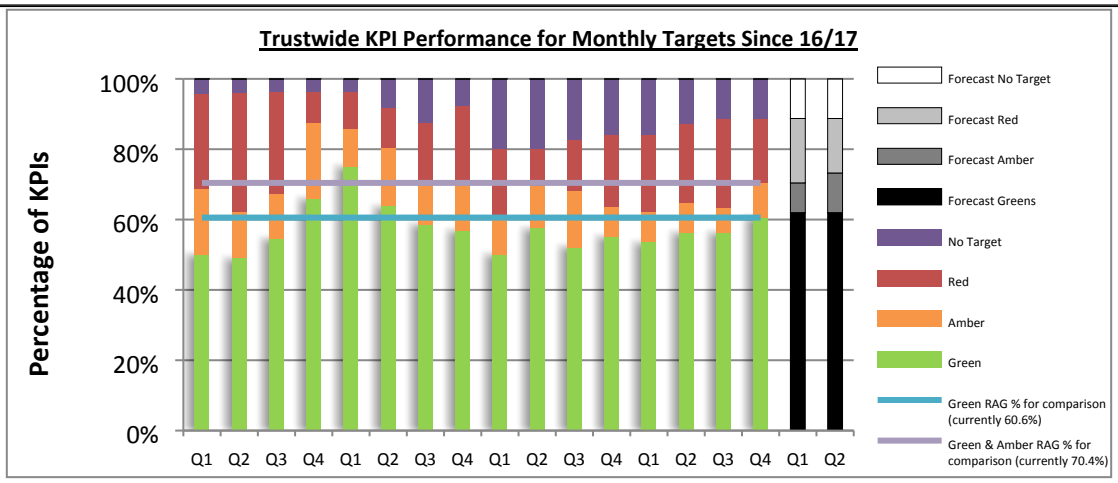
- 7 Day Follow Up – The 7 day follow up measure has been above target consistently for the last two years. This is a measure that continues to perform above target with March showing 95.83% of services receiving a follow up within 7 days.

Overall, there was a slight uplift in performance as measured by the number of Key Performance Indicators (KPI's) met. Q4 KPI metrics suggest that this quarter was the 4th highest performing quarter of the last 16 quarters (4 years) however, this positive news is balanced against deepening performance dips in Q4 for important access metrics for the

Child and Adolescent Mental Health Services (CAMHS), Early Memory Diagnosis And Support Service (EMDASS), and Adult Community Services, where we are significantly underperforming against our KPIs. There are Continuous Quality Improvement (CQI) initiatives underway in each area looking to identify:

1 - the root cause of the issues as evidenced by our performance data;
2 - near term solutions to address the issues;
3 – longer-term solutions that may include involvement of the wider system or a large scale change to working practices

This approach aims to take an evidence based approach to change and improvement where the outcomes from CQIs directly align to current operational performance.



Please note in the chart above the addition of a forecast bar for Q1 & Q2 for next financial year. The forecasts reflect a combination of trend analysis and known opportunities in the pipeline for performance improvement. We are forecasting a steady improvement in compliance based performance metrics (e.g. risk assessments, training and data capture) as a result of further embedding SPIKE 2 data into operating and governance practices. We are also forecasting improvement in access performance metrics as a result of embedding performance data metrics to underpin evidence-based improvements through CQI initiatives across the trust.

Other significant improvement and change initiatives like the Annual Plan and CQUIN are expected to be more visible in the performance metrics in Q3 & Q4 next year as they mobilise and execute in Q1 & Q2.

The key indicators to note that reflect a change in performance against targets in Q4 are as follows:

SOF

In Q4, SOF indicators were met, with the exception of FEP Cardio-metabolic assessment, which was at a provisional score of 81% against a target of 90%.

The DQMI score for Q2 (most current available) is now above the target of 95% at 95.5%. The DQMI is a CQUIN for 2019/20 and will see the addition of several data fields. Work is currently underway to assess how this will affect our compliance.

Inappropriate out of area placements increased significantly in Q4 to 105 days, from 16 in Q3. This remains within the threshold of up to 225 days set for Q4 but reflects pressure on beds across the quarter and continuing delayed transfers of care (10.74% for adult acute in Q4 and 5.97% trust-wide). This high level is not expected to continue, with indications in April that delays are reducing, thus allowing people to be brought into HPFT beds from out of area placements. All out of area placements are monitored at the Inpatient Oversight Group and the Delayed Transfer of Care call. The Trust remains in a position where it is operating within its trajectory for elimination of out of area placements by 2020/21.

Access to Services

- The adult community 28 day wait was at 84.78% for Q4, a decrease of 2.46% on the Q3 figure of 87.24% and 155 people short of the 98% target. The target has now been amended as part of the Hertfordshire contract renewal and will be 95% from April 2019 with the expectation of progressive improvement towards this over 18/19 and achievement by March 2020. Adult Community CQI has been initiated to deliver improvements by removing blockers such as inappropriate Wellbeing referrals, system barriers through cumbersome assessments and the introduction of Enhanced Primary Care Mental Health.

- CAMHS Performance decreased significantly in Q4 to 34.07% - a drop of 46.4% from the Q3 figure. As part of the Herts contract renewal, pressure on the system has been acknowledged and whilst the target remains at 95% there is commitment that continued progression toward the sustainable access of CAMH services within HPFT Tier 3 will require a system wide approach to redesigning the CAMHS pathway. CAMHS CQI has been initiated to review and re-configure the assessment process to balance HPFT demand and capacity ahead of system-wide review to strengthen Step 2 services.

- EMDASS diagnosis within 12 weeks fell slightly to 49.15% in Q4 from the Q3 level of 50.55% against a target is 80 %. The service is taking a Continuous Quality Improvement approach to performance and there is now evidence that the backlog is starting to reduce as a greater number of appointments are offered. Weekly hotspot reports are being sent to commissioners to update on progress. Contractually there is an expectation that the 80% target will be met by Q3 19/20.

- Across our 5 CCG's, we achieved our access target in 3 CCG's with Mid and West Essex not achieving respective targets. Mid Essex (218 behind target) and West Essex (431 behind target) From Q1 next year there is an agreement with the CCG to cease the practice of issuing fines associated with failure to meet this target in favour of working together to address the issue of low referral rates to the IAPT service in Mid and West Essex.

Safe and Effective Services

- CPA reviews saw a further reduction in performance from 96.86% Q3 to 92.37% in Q4 against a 95% target. The data suggests that the issues hitting this KPI are local as East and North Hertfordshire comfortably achieved the target whilst West were 7% below, Absence due to sickness was reported as a key factor although the quite sudden change from a consistently met KPI may also indicate a slip in focus during Q4.

- Delayed Transfer of Care quarter-on-quarter performance improvement has been maintained, however performance is still above target at 5.97% against 3.5% target. Against a backdrop of a significant increase in inappropriate out of area placements there is a cause to probe more deeply into occupancy to ensure that we are not witnessing an unexplained blockage in the system.

- Risk Assessments achieved 92.2% against a 95% target. All parts of the system are failing to meet target although Watford and Borehamwood are responsible for over half of the missing risk assessments for West SBU. Some anecdotal evidence of a slip in focus in Q4 in favour of addressing access issues in the system compounded with the effect of large medical caseloads in some areas are also contributing factors.

Workforce

The Pulse Survey was open from 1st January to 31 March 2019. The results were evenly spread across the 4 SBUs and highlighted similar themes to the National Staff Survey.

- 62% of staff reported they are likely to work additional hours compared to 67% in the National Staff Survey
- 84% of staff believe the Trust definitely or to some extent takes positive action on their wellbeing
- 20% of staff experiencing bullying from Service User or Carers and 39% from their managers or other Senior Manager

The turnover rate has decreased slightly to 15.49% in Q4 from 16.40% at the end of Q3.

The sickness absence rate has decreased this quarter from 4.61% in Q3 to 4.31% and is above the Trust target of 4%. There has been a decrease in the sickness absence rates across all however only corporate services has a sickness absence rate below the Trust target at 3.24% and West SBU is slightly above the Trust target at 4.02%.

The compliance rate for Statutory and Mandatory Training has increased to 90.4% from 86% over the last quarter. There is still significant work being carried out to raise the compliance rates above the target, with work continuing with Subject Matter Experts. In addition Quarterly Assurance Meetings continue to take place and action plans are in place for those topics below compliance.

Finance

- The year started with significant financial challenge, reporting a deficit for Quarter 1 of £73k only after releasing £1.4m of provisions; Quarter 2 improved with a surplus of £161k with no releases necessary; and Quarter 3 saw a further improvement to a surplus of £320k. This equated to a year to date surplus of £408k at the end of Quarter 3, it was therefore planned to spend c. £1m on Estates and Environment works during Quarter 4, and taking this into account Quarter 4 achieved a deficit of £16k giving an overall position for the year of £392k surplus.

Benchmarking Review

- In all of the following national benchmark areas HPFT are hugely outperforming against the national mean – as evidenced by the NHS Benchmarking Network Project:

  - EMDASS Waits - nationally 78% of people waited under 18 weeks for treatment. In HPFT this was 98%

- CAMHS Waits - HPFT waits are less than half (4 weeks) of the national mean (9 weeks)
- FEP 14 Day Waits – nationally 76% of people waited 14 days or less to be offered treatment. In HPFT 96% of people waited 14 days or less.
-Adult Community Waits - nationally 35% of people waited under 4 weeks for treatment. In HPFT this was 52%

Going forwards there is a move towards more standardised national benchmarking through MHSDS and other sources. HPFT should benchmark against 'best in class.' This would give a better comparator of operational performance for internal use based on data from organisations of similar maturity levels.

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

Annual Plan
SBU Business Plans
Assurance Framework

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

N/A

Equality & Diversity and Public & Patient Involvement Implications:

N/A

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

All targets

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

Performance Report
Quarter 4
2018/19

Contents

1. Summary

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- 7 Day Follow Up – The 7 day follow up measure has been above target consistently for the last two years. This is a measure that continues to perform above target with March showing 95.83% of services receiving a follow up within 7 days.

- CCATT 4 Hour – The CAMHS CATT 4 hour A&E assessment standards remain above target since June 2018. This measure, although seeing a significant increase in referrals over the last six months, continues to maintain performance. In March 96.97% of the 99 service users who were seen and assessed were within the 4 hour timescales.

Overall, there was a slight uplift in performance as measured by the number of Key Performance Indicators (KPI's) met. Q4 KPI metrics suggest that this quarter was the 4th highest performing quarter of the last 16 quarters (4 years) however, this positive news is balanced against deepening performance dips in Q4 for important access metrics for the Child and Adolescent Mental Health Services (CAMHS), Early Memory Diagnosis And Support Service (EMDASS), and Adult Community Services, where we are significantly underperforming against our KPIs. There are Continuous Quality Improvement (CQI) initiatives underway in each area looking to identify:

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This approach aims to take an evidence based approach to change and improvement where the outcomes from CQIs directly align to current operational performance.

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	84.78% against 98% target	• Review wellbeing referrals where a low percentage actually go on to treatment • Longer term investment in Primary MH Care across Hertfordshire
EMDASS referral to diagnosis – 12 week	49.15% vs 80%	• Additional & evening clinics introduced and started to address backlog • Implementation of floating clinician support planned to provide extra capacity
CAMHS 28 day referral to assessment	34.07% % against 95% target	• Successful recruitment to 5 posts, impact to be felt in Q1 • Review of referral and activity patterns to discuss joint action with commissioners
CPA	92.37% against a 95% Target	• Review sickness and resilience planning in West SBU
Risk Assessments	92.2% against a 95% target	• Use SPIKE 2 data in operational reviews sharpen focus on key issue
Delayed Transfer of Care	5.97% against 3.5% target	• Improvement trajectory to continue in Q1

2. Key Areas of Activity in 2018/19

1,346 adult acute admissions for 2018/19

29,777 new spells of care in secondary mental health services for 2018/19

3,117 people on CPA at the end of Q4

36,357 people entering treatment in Wellbeing Services for 2018/19

268,088 total secondary mental health contacts for 2018/19

29,162 discharged from secondary mental health services for 2018/19

425 inpatient beds at the end of Q4

140 Starters , 123 Leavers at the end of Q4

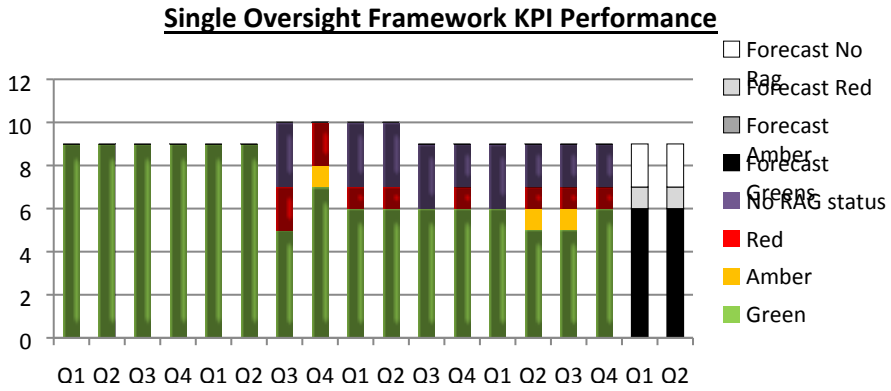
529 Starters , 516 Leavers for 2018/19

2017/18 – 2018/19 Comparisons

- Adult acute admissions remained at a very similar level (an increase of 10 in 18/19)
- Discharges fell slightly in 2018/19 (a decrease of 1.2%)
- 25 more starters but 45 more leavers
- 52 fewer inpatient beds as of end of Q4 (a reduction of 11% in 18/19)
- 7.6% more people on CPA in 18/19
- 3.3% increase in people entering treatment in Wellbeing Services
- 25% increase in secondary mental health contacts
- 4% increase in new spells of secondary care

3. Performance On SOF

Single Oversight Framework (SOF 2 – 5)



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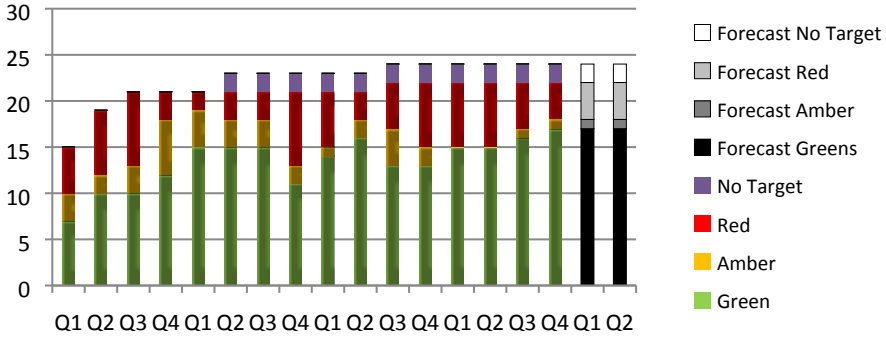
4. Performance On KPIs

Access to Services (A1 – 27)

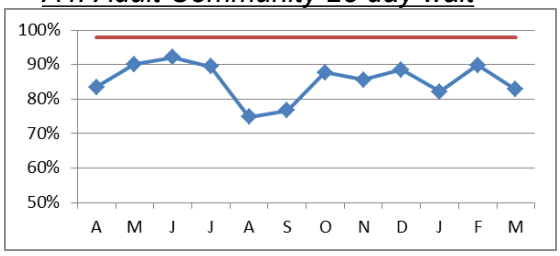
Access Indicators - Performance 2015/16 - 2018/19



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

Access KPI	Q4 Performance	Movement from Q3	Shortfall from Target
A4: Routine referrals for Adult Community Services	84.78% (997/1,176)	-2.46%	155(98%)
A11: EMDASS Diagnosis within 12 weeks	49.15% (288/586)	-1.4%	180 (80%)
A16: CAMHS Routine Waits	34.07% (138/405)	-46.37%	294 (95%)
A24: People entering IAPT Treatment – Mid-Essex	5672/5890	-	218
A25: People entering IAPT Treatment – West-Essex	4502/4933	-	431

A4: Adult Community 28 day wait



The adult community 28 day wait was at 84.78% for Q4, a decrease of 2.46% on the Q3 figure of 87.24% and 155 people short of the 98% target.

The target has now been amended as part of the Hertfordshire contract renewal and will be 95% from April 2019 with the expectation of progressive improvement towards this over 18/19 and achievement by March 2020. HPFT is currently developing an action plan that will set out the actions we will take to improve performance. This plan is expected to include:

- DNA management
- Operational performance
- Staffing
- Timeliness of appointments
- Follow-up
- Transformation and system leadership

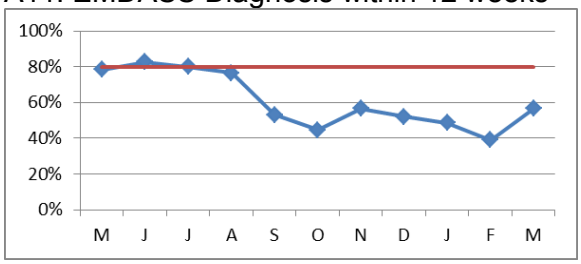
A key success measure will be the implementation of primary care mental health models across Herts and HPFT and commissioners will work together on the implementation to ensure that these are fully rolled out by April 2020.

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

Quadrant	Performance
E&SE	90.08% (118/131)
North	94.85% (92/97)
NW	84.8% (78/92)
SW	58.76% (57/97)

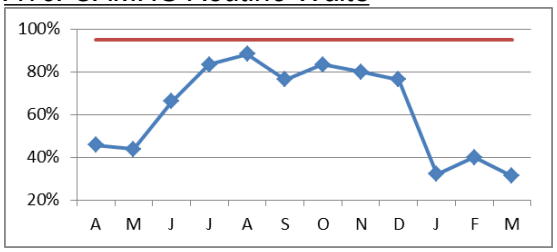
Performance on the adult community 28 day wait has remained relatively stable over Q4 with a trust-wide figure ranging between 82% - 89%. The East and South East and North quadrants have the highest performance, but are reliant on running additional clinics to maintain this level, with teams finding this increasingly challenging on a long term basis. Performance is lower in the West side of the county, particularly in the SW quadrant. This is largely due to reduced capacity caused by vacancies and some medical sickness. Borehamwood have now had successful recruitment initiatives and capacity is forecast to build over Q1 19/20 as people come into post.

A11: EMDASS Diagnosis within 12 weeks



EMDASS diagnosis within 12 weeks fell slightly to 49.15% in Q4 from the Q3 level of 50.55% against a target is 80 %. The service is taking a Continuous Quality Improvement approach to performance and there is now evidence that the backlog is being cleared, as a greater number of appointments are offered. Weekly hotspot reports are being sent to commissioners to update on progress. Contractually there is an expectation that the 80% target will be met by Q3 19/20.

A16: CAMHS Routine Waits



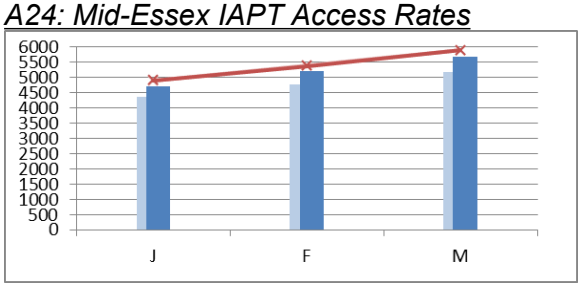
Performance decreased significantly in Q4 to 34.07% - a drop of 46.4% from the Q3 figure. Pressure on CAMHS first appointments has been building across the year, as referrals have increased and the impact of less capacity in Tiers 1 and 2 have resulted in longer waits for services and a subsequent increase in children reaching crisis levels and then accessing HPFT services via C-CATT.

As part of the Herts contract renewal, pressure on the system has been acknowledged and whilst the target remains at 95% there is commitment that continued progression toward the sustainable access of CAMH services within HPFT Tier 3 will require a system wide approach to redesigning the CAMHS pathway. This will include commissioners, HPFT and other relevant partners. A system-wide demand and capacity review will be completed by the end of Q2 2019-20 and the findings of this will enable the development of a recovery plan that enables all partners to develop an improvement trajectory that will support HPFT to achieve 95% access within 28 days by end Q4 2019-20. Commissioners will ensure that the findings of the review are used to inform the resource and delivery implications for the system to enable this target to be delivered.

At service level a number of actions are being undertaken to improve. These include:

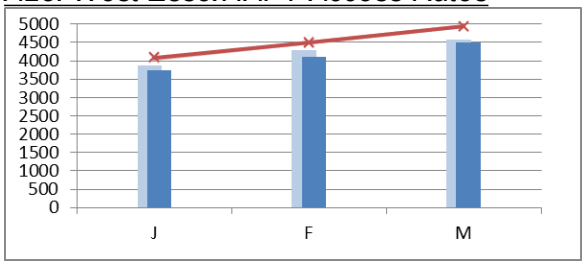
- Review of pathways and job plans
- Clear expectations of treatment given to client at the beginning of treatment
- Clinically risk assessed opt-in letters being sent to long-term waiters.
- Data cleansing of records
- Continued efforts to recruit to vacant positions, particularly in the East of the County

A24: Mid-Essex IAPT Access Rates



As forecast, Mid Essex did not meet the end of year target and were 218 people behind the cumulative access target at the end of Q4. Commissioners are currently seeking a 12 month extension to the contract, with a view to agreeing a further 24 months at the end of that period.

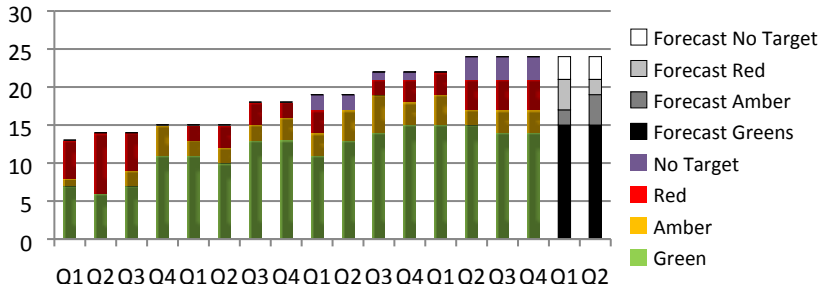
A25: West Essex IAPT Access Rates



As forecast, West Essex did not meet the end of year target and were 431 people behind their cumulative access target at the end of Q4.

Safety and Effectiveness of Services (SE1 – 21)

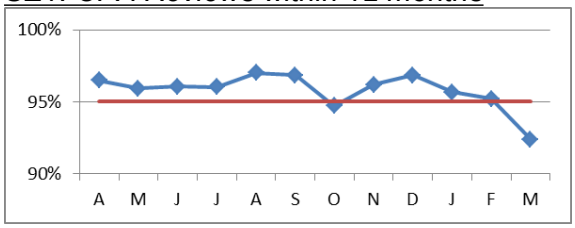
Safe and Effective Indicators 2015/16 - 2018/19



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

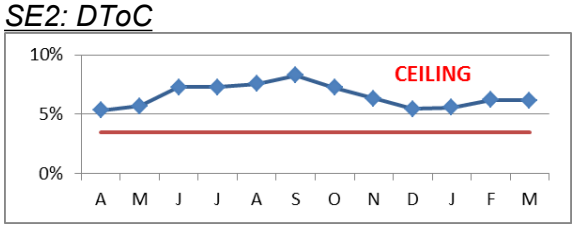
Safety and Effectiveness KPI	Q4 Performance	Movement from Q3	Shortfall from Target
SE1: CPA Reviews	92.37% (690/747)	-4.48%	20 (95%)
SE2: DToC	5.97%	- 0.62%	2.5% (3.5%)
SE5: Risk Assessments	92.22% (16,030/17,383)	-1.34%	484(95%)
SE11: Rate of acute inpatients reporting feeling safe	78.63% (92/117)	+1.58%	2 (80%)
SE 18: Cluster Reviews	87.46% (8,910/10,187)	+1.27%	768 (95%)
SE21a) Employment b) Accommodation	72.29% (11,210/15,508) 71.29% (11,055/15,508)	+13.78% +17.46%	1,972 (85%) 2,126

SE1: CPA Reviews within 12 months



CPA Reviews fell to 92.37% in Q4 from 96.85% in Q3 with a target of 95%. E&N remained above target at 95.1%, whilst West fell by 4% to 89.97%. As for the 28 day wait, the reasons for this are primarily capacity and some sickness in teams. It is not expected to signify a long-term downward trend and is forecast to recover over Q1 as vacancies are filled.

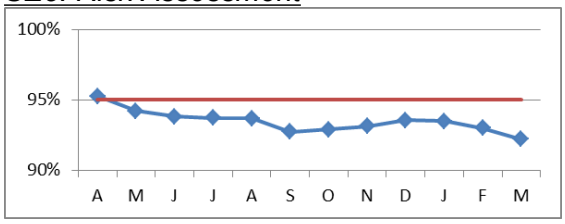
SE2: DToC



Delayed transfers saw a small reduction in Q4 from the Q3 level of 6.34% to 5.97%. The SBU breakdown is: E&N 3.86%; LD&F 3.92%; West 10.74%.

The main cause of delays is in adult acute services during the last quarter. A number of the service users in this group are awaiting specialist placements, which has contributed significantly to the delay. Escalation calls and extraordinary processes have been implemented to explore alternatives to ongoing admission.

SE5: Risk Assessment

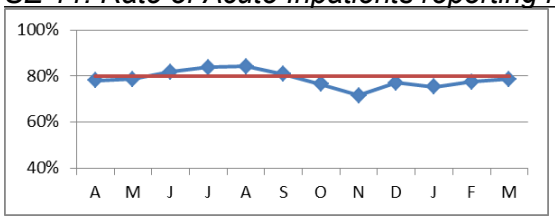


Performance for Q4 is at 92.22% against a 95% target, a 1.3% decrease on Q3 performance – 93.55%. Breakdown by SBU is:

- E&N = 92.28%
- West = 90.79%
- LD&F = 94.49%

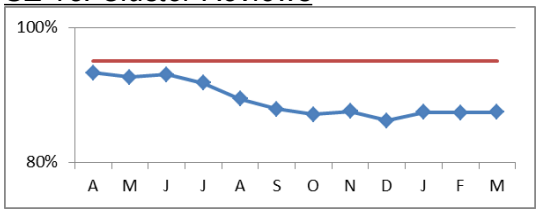
Adult Community are finding the target most challenging, with teams balancing the need to ensure timely access against regular reviews for existing service users. Large medical caseloads contribute to the issue and Service Line Leads are working with their medical colleagues to resolve this. Service users with ADHD and large medical caseloads still account for the majority of breaches in CAMHS.

SE 11: Rate of Acute Inpatients reporting feeling safe.



92/117 people reported feeling safe on acute inpatient units in Q4. The service continues to focus on working with service users to ensure a narrative in relation to feeling safe on the ward. Community meetings over the last few months have focused on the disturbance on a number of our wards and some delays in admitting to a PICU (female service users) which has contributed to people feeling unsafe at times. Themes from the community meetings do reflect that service users feel supported by staff.

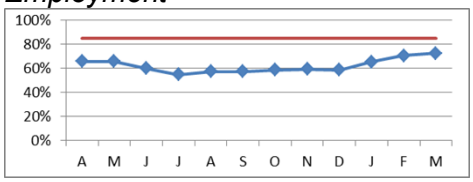
SE 18: Cluster Reviews



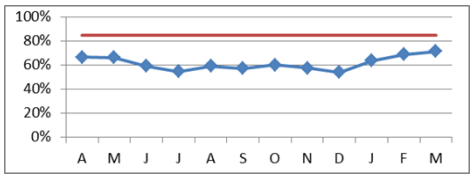
Cluster reviews have seen a small improvement from 86.2% in Q3 to 87.46% in Q4. This reflects the same issues as for risk assessments, with caseload and capacity pressures, particularly across adult community services. Services are prioritising access and risk issues above clustering, but trying to maintain and improve performance where possible.

SE21: Employment and Accommodation

Employment



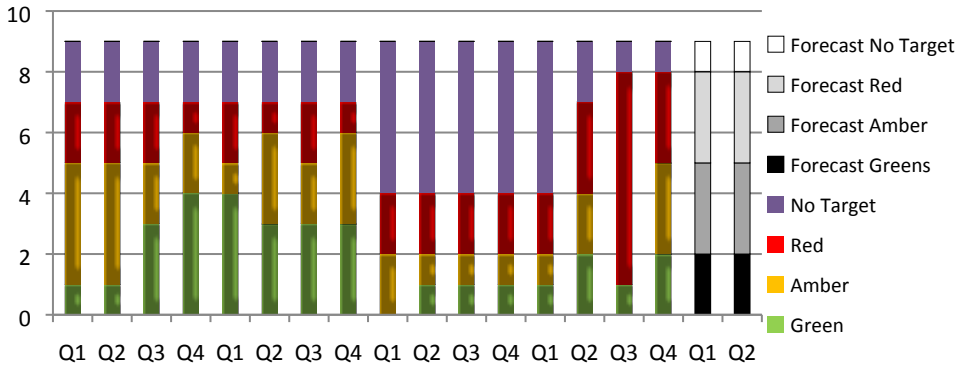
Accommodation



Employment status has improved to 72.29% from 58.51% in Q3, whilst Accommodation status also increased to 71.29% from 53.82%. This is the highest performance level since the indicators were introduced and can be attributed to the introduction of SPIKE 2 which allows individual clinicians to see gaps in their recording, with further improve expected in Q1 2019/20.

Resources – Workforce (W1 – 9)

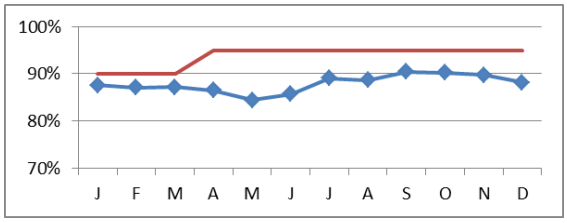
Workforce Performance 2015/16 - 2018/19



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

Workforce KPI	Q4 Performance	Movement from Q3	Shortfall from Target
W5: PDP and Appraisal	89.50% (2,456/2,744)	+1.37%	151 (95%)
W6: Mandatory Training	90.26% (26,156/28,978)	+ 4.31%	504 (92%)
W7: Sickness Rate	4.19%	+0.32%	0.19%
W8: Turnover Rate	15.49% (450.91/2,911.44)	+ 1.11%	159 (10%)

W5: PDP and Appraisal



The Trust's overall PDP rate has increased to 90% in Q4. The PDP rates for each SBU are as follows:

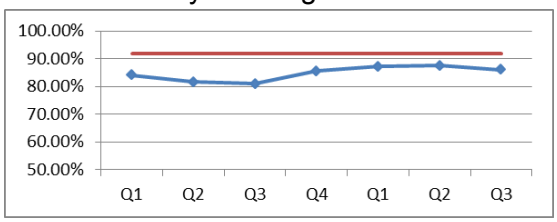
- LD&F 90%
- East & North 94%
- West 91%
- Corporate 72%

PDP rates have increased in LD & F and in East & North SBUs and remained the same in West. The corporate services PDP rate has decreased by 7% in Q4. The Business Partner Team continues to support managers in completing PDPs and managers are advised of all completion rates via monthly management reports.

LD & F SBU, PDP compliance continues to be an area of major focus with compliance across all of the service lines being monitored by the Managing Director on a monthly basis as Core Management Meetings. Norfolk Services has a 97% compliance rate, MH Rehab 97% and Herts Forensics 95%, all exceed the 95% target rate. The remainder of the service lines range

from 81% to 91%. The other two SBUs, East and North and West all discuss their PDP compliance at Core Management meetings and at Service Line Management meetings.

W6: Mandatory Training

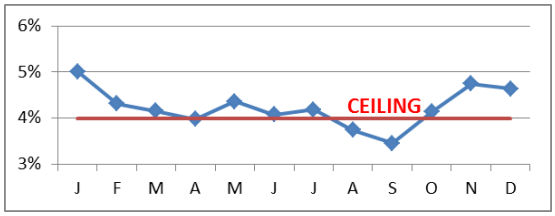


The compliance rate for Statutory and Mandatory Training has increased to 90.4% from 86% over the last quarter. The mandatory training rates by SBU are as follows:

- Corporate 87%
- LD&F 92%
- East & North 90%
- West 90%

There is still significant work being carried out to raise the compliance rates above the target, with work continuing with Subject Matter Experts. In addition Quarterly Assurance Meetings continue to take place and action plans are in place for those topics below compliance.

W7: Sickness Rate



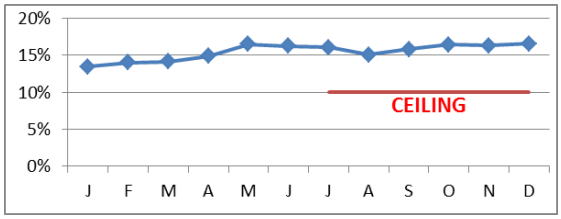
The sickness absence rate has decreased this quarter from 4.61% in Q3 to 4.31% and is above the Trust target of 4%. There has been a decrease in the sickness absence rates across all however only corporate services has a sickness absence rate below the Trust target at 3.24% and West SBU is slightly above the Trust target at 4.02%. Sickness absence rate for LD & F is at 4.57% and East and North SBU is at 4.79%.

Within West SBU particular hotspots are the Inpatient areas and Single Point of Access (9.99%). Within Learning Disabilities and Forensic Services, Norfolk LD (Broadland Clinic), LD North Essex and the Rehab Services are principally contributing to the high sickness levels. In East and North Herts SBU the Older Peoples Community services and Older Peoples Inpatient Units are primarily areas of attention. In corporate services, there have been peaks in sickness absence levels during Q4.

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 decreased slightly to 15.49% in Q4 from 16.40% at the end of Q3. The Trust's unplanned turnover rate this quarter was 11.42% from 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 developed including the retire and return process, the internal transfer process which has been expanded to include all staff, and the buddy scheme which provides new starters with additional support in their new roles in the Trust is being included as part of the recruitment process. These initiatives will be evaluated to understand their success in reducing turnover rates.

Pulse Survey Results Q4

The Pulse Survey was open from 1st January to 31 March 2019. Unfortunately there were IT issues with the distribution of the link by email and so we received 205 responses compared to 391 responses for the same quarter last year.

The results were evenly spread across the 4 SBUs and highlighted similar themes to the National Staff Survey.

- 62% of staff reported they are likely to work additional hours compared to 67% in the National Staff Survey
- 84% of staff believe the Trust definitely or to some extent takes positive action on they wellbeing
- 20% of staff experiencing bullying from Service User or Carers and 39% from their managers or other Senior Manager

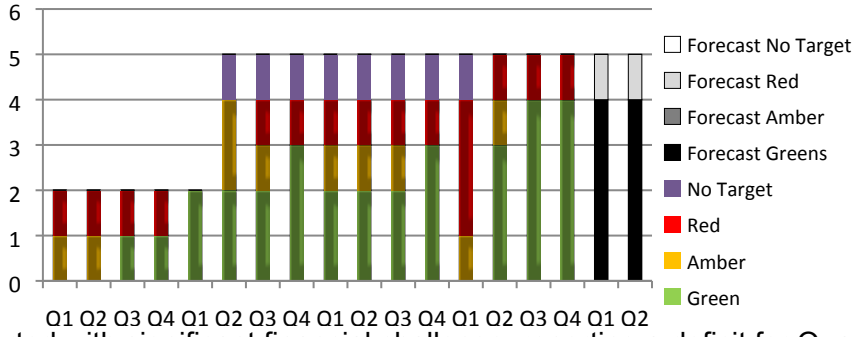
Other themes raised have been;

- Problems with their work environments including space and IT issues.
- Requests for better communication between teams, departments, SBUs and counties
- Support for career progression, training and development
- Concern over managerial workload

There are initiatives in place to respond to several of the themes mentioned above, including retention initiatives to pick up the concerns on career progression, training and development. Tackling and eliminating bullying and harassment also continue and action plans are in place to support this.

Resources – Finance (F1 – 5)

HPFT Financial Performance 2015/16 -2018/19



The year started with significant financial challenge, reporting a deficit for Quarter 1 of £73k only after releasing £1.4m of provisions; Quarter 2 improved with a surplus of £161k with no releases necessary; and Quarter 3 saw a further improvement to a surplus of £320k. This equated to a year to date surplus of £408k at the end of Quarter 3, it was therefore planned to spend c. £1m on Estates and Environment works during Quarter 4, and taking this into account Quarter 4 achieved a deficit of £16k giving an overall position for the year of £392k surplus:

2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Position for Quarter	-73	161	320	-16
Cumulative Position	-73	88	408	392

The main improvements in the position enabling the later expenditure were in Secondary Commissioning (particularly CAMHs Tier 4 New Care Models and PICU External Placements) and reducing agency costs later in the year.

All figures are reported before any income from the Provider Sustainability Fund (PSF), which is expected to be £1.8m for the year, which reflects that the Control Total has been met. The NHSI Use of Resources (UOR) Rating reports as 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)		86	-15	360	392	360	↑
Pay Overall		12,888	12,587	154,068	151,176	154,068	↔
Agency		611	533*	7,328	6,802	7,328	↑
Secondary Commissioning		2,598	2,805**	30,676	32,923**	30,676	↔

* Underlying position for ease of comparison, release of old year accruals means reported position was £319k for the month
**Underlying position, release of old year provisions and netting off CAMHs means reported position was -£1,657k for the month and 28,461k for the year

Although this is overall a positive position and the Control Total has been achieved, the following risks should be noted going into the new financial year:

a) Position for 2018/19 was achieved only with releases of £1.4m during Quarter 1.

b) Although secondary commissioning costs decreased in some areas during 2018/19 (notably CAMHs T4 NCM, PICU and Main Health Placements), other areas didn't (Social Care Placements, Personal Budgets). Additionally, there has recently been significant additional pressure from both PICU and External Acute Placements.

c) The Plan for 2019/20 assumes a further reduction in agency costs.

d) Pay costs increase significantly again from 1st April 2019, and whilst this is broadly funded, there are incremental pressures from pay points being merged.

5. Quality Account

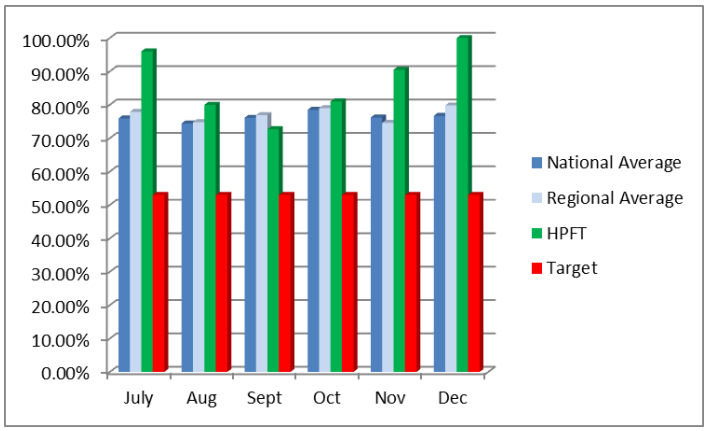
Performance for the Quality Account in 2018/19 can be found in Appendix 2. Of the 16 separate indicators 10 are rated as green, 1 as amber (Service users reporting being treated according to trust values) and 1 is rated as red (CAMHS 28 day wait); the remainder have no set target, are reported by audit or the figures are not yet available.

6. Benchmarking/National Comparative Data

FEP 14 Day Waits

Chart 1 below shows figures from NHS Digital on performance against the FEP 14 day wait indicator by National and Regional average against HPFT actual reported position. In the period from July – December (latest published data) HPFT can be seen to be above National and Regional averages, with the exception of September, when performance was marginally below.

Chart 1



CAMHS Waits

For the CAMHS benchmarking examples below, the National figure comes from the National CAMHS Benchmarking exercise for 2017/18 and may in some cases include Tier 2 services. The HPFT Sep 17 – Aug 18 data is sourced from the validated CQC PIR data and the HPFT December comparison is from validated 28 day wait data.

Chart 1

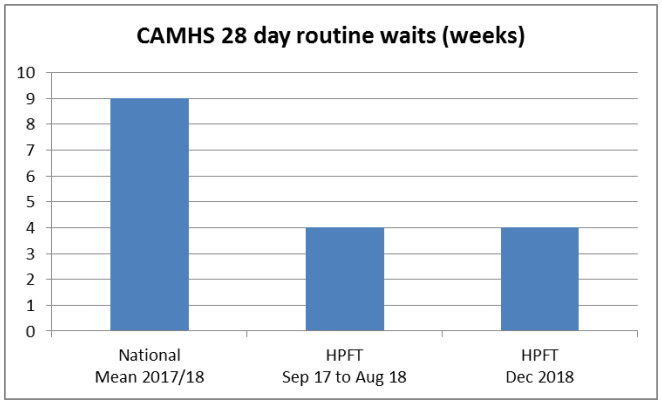


Chart 1 shows mean waits to first appointment (28 day indicator). Although the national mean may include some tier 2 services, HPFT waits in both 17/18 and in Dec 2019 are less than half (4 weeks) of the national mean (9 weeks).

Chart 2

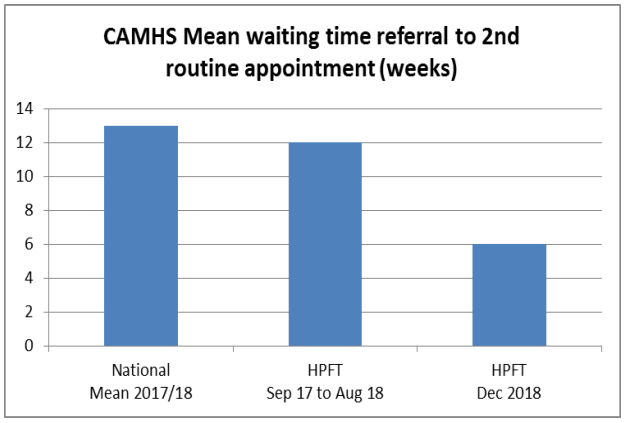


Chart 2 shows mean waits between referral and second appointments. The national mean was 13 weeks, with HPFT mean wait for Sept 17 – Aug 18 at 12 weeks and a reduction to 6 weeks in December 2018. The drop in time to second appointments in December could reflect the reported experience from the service that a greater number of CYP are coming through the C-CATT or urgent route and needing more frequent appointments.

Chart 3

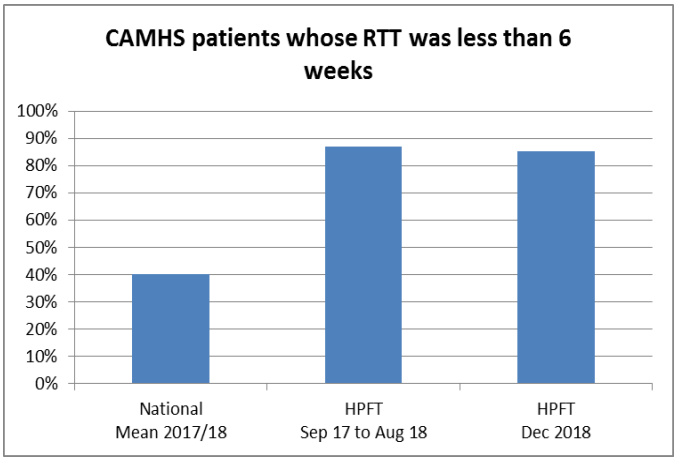


Chart 3 compares referral to treatment times and shows that nationally 40% of CYP waited less than 6 weeks for treatment. In HPFT this was 87% between Sept17– Aug 18 and had dropped slightly to 85% in December 2018.

Chart 4

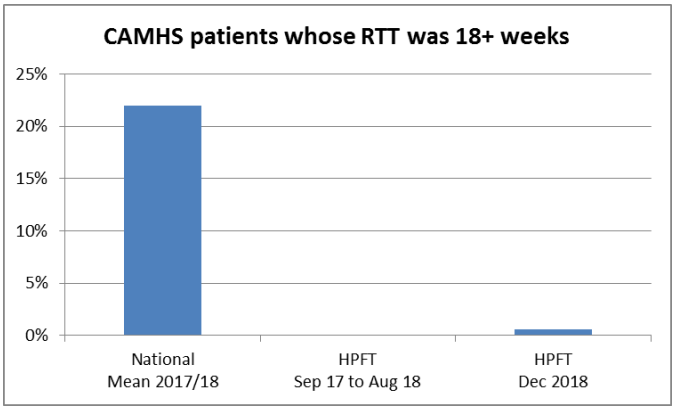


Chart 4 compares referral to treatment times and shows that nationally 22% of CYP waited over 18 weeks for treatment. In HPFT this was 0.08% between Sept17 – Aug 18 and had risen slightly to 0.61% in December 2018.

Adult Community Waits

For the Adult Community benchmarking examples below, the National figure comes from the National Adult Community Benchmarking exercise for 2017/18. The HPFT Sep 17 – Aug 18 data is sourced from the validated CQC PIR data and the HPFT December comparison is from validated 18 week wait data. The measure of referral to first and second appointment was not included in the national benchmarking exercise and therefore cannot be shown.

Chart 1

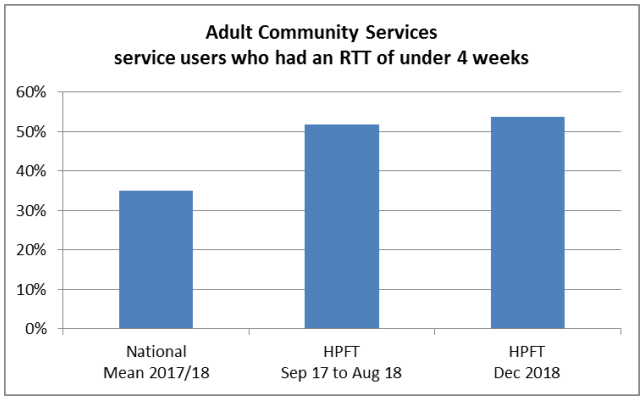


Chart 1 compares referral to treatment times and shows that nationally 35% of people waited under 4 weeks for treatment. In HPFT this was 52% between Sept 17 – Aug 18 and had risen slightly to 54% in December 2018.

Chart 2

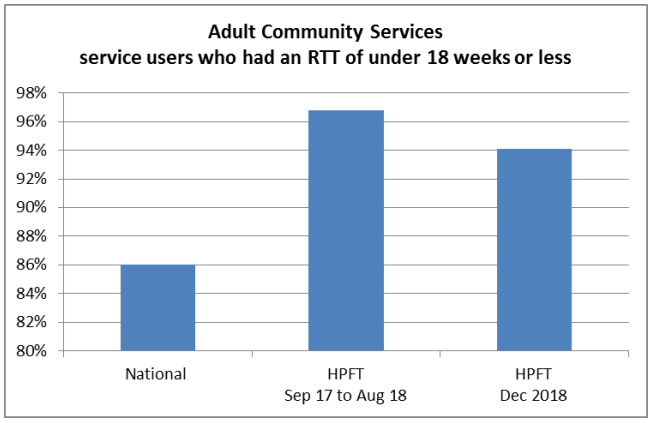


Chart 2 compares referral to treatment times and shows that nationally 78% of people waited under 18 weeks for treatment. In HPFT this was 97% between Sept 17– Aug 18 and had fallen slightly to 94% in December 2018.

EMDASS Service Waits

For the EMDASS benchmarking example below, the National figure comes from the National Adult Community Benchmarking exercise for 2017/18. The HPFT Sep 17 – Aug 18 data is sourced from the validated CQC PIR data and the HPFT December comparison is from validated 18 week wait data.

Chart 3

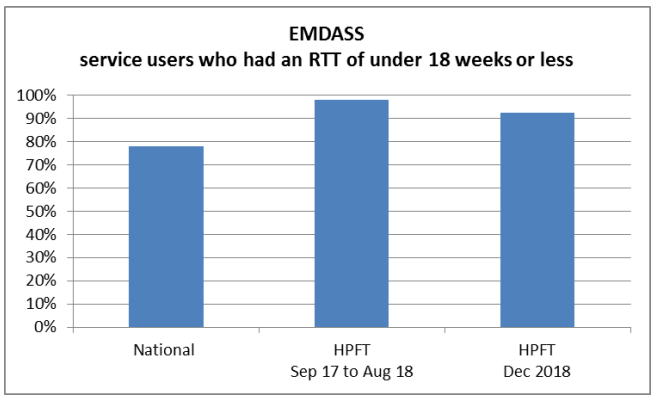


Chart 3 compares referral to treatment times and shows that nationally 78% of people waited under 18 weeks for treatment. In HPFT this was 98% between Sept17– Aug18 and had fallen slightly to 92% in December 2018.

Ref	Standard[20]	Frequency	Standard[17]	Current Period Numbers (Q4 2018/19)	Current Period (Q4 2018/19 UNLESS STATED)	Previous Period (Q3 2018/19 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1 2019/20)
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%	46/60	76.67%	89.29%	-12.62%		↔
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 27/03/19**	
	b) early intervention in psychosis services		>=90%	N/A	81.2% (Provisional)	57.3% in 17/18			↑
	c) community mental health services (people on Care Programme Approach) [23]		>=65%	N/A	Figures not available	69.8% in 17/18			
SOF3	Data Quality Maturity Index (DQMI) – MHSDS dataset score. https://digital.nhs.uk/data-quality	Quarterly in arrears	>=95%		95.5% in Q2	94.2% in Q1	1.30%	**Shown quarterly in arrears due to late availability of data.** NHS Improvement: "As this is a revised indicator, the initial focus (until April 2018) will be ensuring providers understand their current score and, where the standard is not being reached, have a clear plan for improving data quality. During 2018/19, failure to meet the standard will trigger consideration of a provider's support needs in this area."	↔
SOF4	Improving Access to Psychological Therapies (IAPT)/talking therapies • proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	Monthly	>=50%	2,016 / 3,667	54.98%	53.75%	1.22%	Data taken from Trust SPIKE report (locally reported data) on 03/04/2019. Previous period refreshed.	↔
	• waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks	Monthly	>=75%	5,640 / 7,274	77.54%	91.84%	-14.30%	Data taken from Trust SPIKE report (locally reported data) on 03/04/2019. Previous period refreshed.	↔
	- within 18 weeks	Monthly	>=95%	7,250 / 7,274	99.67%	99.88%	-0.21%	Data taken from Trust SPIKE report (locally reported data) on 03/04/2019. Previous period refreshed.	↔
SOF5	Inappropriate out-of-area placements for adult mental health services	Monthly	75 (Per month) 225 for Q4		105	16	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.

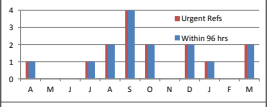
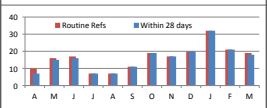
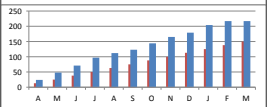
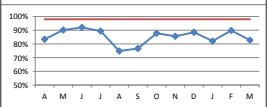
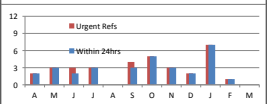
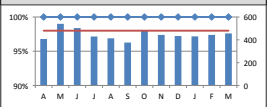
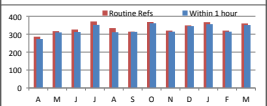
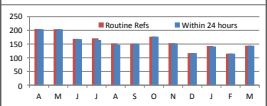
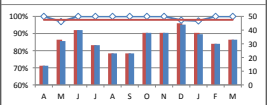
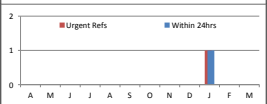
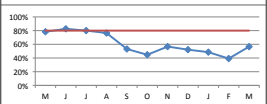
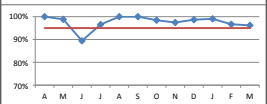
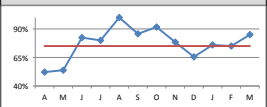
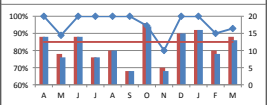
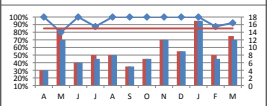
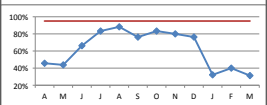
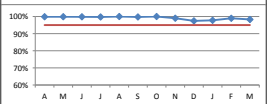
[21] In line with the recommendation of the 5YFV for mental health, providers should be working with commissioners to ensure that crisis resolution home treatment teams are delivering care in line with best practice standards (www.ucl.ac.uk/core-resource-pack/fidelity-scale).
For 2016/17, commissioners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

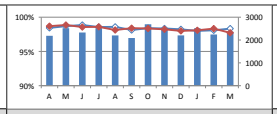
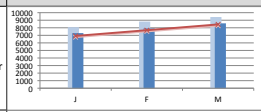
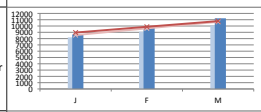
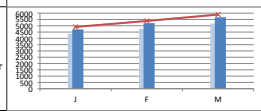
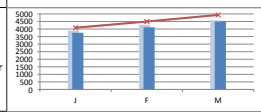
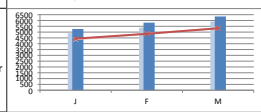
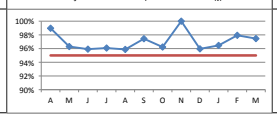
[22] This standard applies to anyone with a suspected first episode of psychosis aged 14-65.Exclusions must not be made of people aged >35 who may historically not have had access to specialist EIP services. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.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

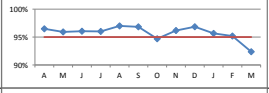
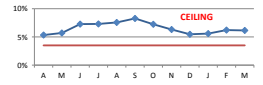
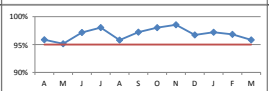
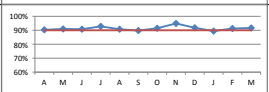
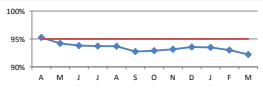
[23] Board declaration but can be triangulated with results of CQUIN audit which will be for a sample of patients in each service area). People with psychosis should receive:
> a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's records
> a record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

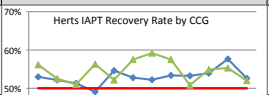
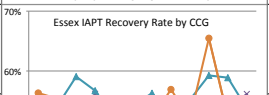
[24] Comprising: NHS number, date of birth, postcode, current gender, registered GP org code, commissioner org code

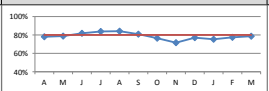
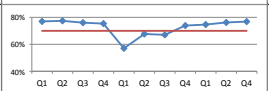
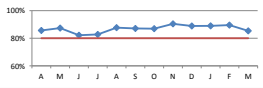
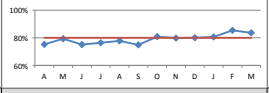
[25] For achievement by 2016/17 year-end. Comprising: ethnicity, employment status (for adults only), accommodation status (for adults only), ICD10 coding. Note: ICD10 for CYP may be supplanted by capture of a problem descriptor, rather than a formal medical diagnosis.

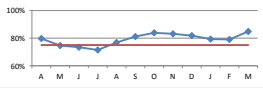
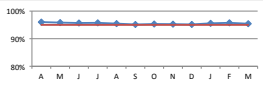
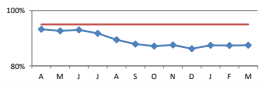
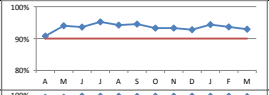
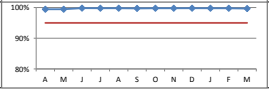
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2018/19)	Current Period Performance (Q4 2018/19)	Previous Period Performance (Q3 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1 2019/20)
A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**	>=98%		3/3	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%		71/72	98.61%	100.00%	-1.39%	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)		60	217	179	N/A	RAG rated against cumulative target. This number is likely to be adjusted downwards retrospectively, due to caseload maintenance being part of the threshold.	↔
A4	Routine referrals to community mental health team meeting 28 day wait **(Contractual)**	>=98%		998 / 1,177	84.79%	87.24%	-2.45%		↔
A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**	>=98%		8/8	100.00%	100.00%	N/A	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
Ref	**Indicator**	**Target**	**12 month Trend**	**Current Period Numbers (Q4 2018/19)**	**Current Period Performance (Q4 2018/19)**	**Previous Period Performance (Q3 2018/19)**	**Change on previous period**	**Comments and Data Quality Issues**	**Forecast for next period (Q1 2019/20)**
A6	CATT referrals meeting 4 hour wait **(Contractual)**	>=98%		1,329 / 1,329	100.00%	100.00%	0.00%		↔
A7	RAID Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A		1021 / 1047	97.52%	98.36%	-0.84%		↔
A8	RAID Response times: 24 hour wait for ward referrals (Lister & Watford combined)	N/A		400 / 402	99.50%	99.78%	-0.27%		↔
A9	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**	>=98%		100 / 101	99.01%	99.17%	-0.16%		↔
A10	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait **(Contractual)**	>=98%		1/1	100.00%	Zero	N/A	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A11	EMDASS Diagnosis within 12 weeks (Contractual)	>=80%		288 / 586	49.15%	50.55%	-1.40%		↑
A12	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**	>=95%		291 / 299	97.32%	98.16%	-0.83%	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 (Q4 2018/19)**	**Current Period Performance (Q4 2018/19)**	**Previous Period Performance (Q3 2018/19)**	**Change on previous period**	**Comments and Data Quality Issues**	**Forecast for next period (Q1 2019/20)**
A13	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**	>=75%		51/65	78.46%	77.78%	0.68%		↔
A14	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**	>=85%		38/40	95.00%	94.74%	0.26%		↔
A15	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**	>=85%		36/38	94.74%	100.00%	-5.26%		↔
A16	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**	>=95%		138 / 405	34.07%	80.45%	-46.37%		↑
A20	SPA referrals with an outcome within 14 days (Internal)	>=98%		7,058 / 7,178	98.33%	98.88%	-0.56%		↔

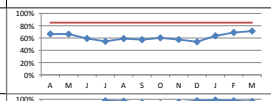
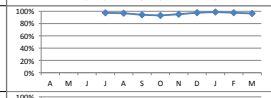
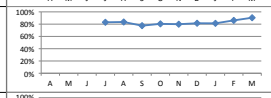
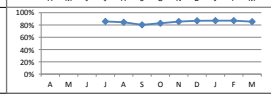
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2018/19)	Current Period Performance (Q4 2018/19)	Previous Period Performance (Q3 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1 2019/20)
A21	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services **(Contractual)**	>=98%		7,117 / 7,259	98.04%	98.21%	-0.16%		↔
A22	Number of people entering IAPT treatment (ENCCG) **(Contractual)**	8447 to end of Mar		672 (766) for March	8588 (8447)	6542 (6106)	N/A	Data taken from Trust SPIKE report (locally reported data) on 05/04/2019. Previous period is refeshed.	↔
A23	Number of people entering IAPT treatment (HVCCG) **(Contractual)**	10781 to end of Mar		1393 (900) for March	11223 (10781)	7745 (7913)	N/A		↔
A24	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**	5890 to end of Mar		465 (511) for March	5672 (5890)	4188 (4419)	N/A		↑
A25	Number of people entering IAPT treatment (West Essex) (Contractual)	4933 to end of Mar		389 (437) for March	4502 (4933)	3362 (3702)	N/A		↔
A26	Number of people entering IAPT treatment (NE Essex) (Contractual)	5327 to end of Mar		532 (476) for March	6345 (5327)	4646 (3996)	N/A		↔
A27	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	>=95%		319 / 328	97.26%	97.28%	-0.02%		↔

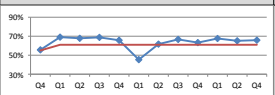
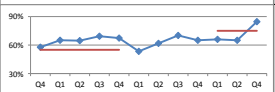
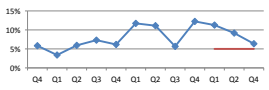
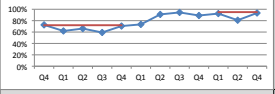
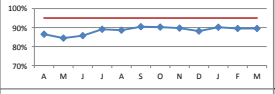
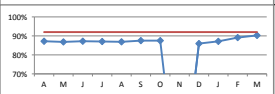
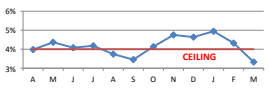
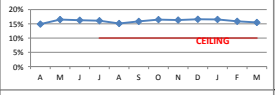
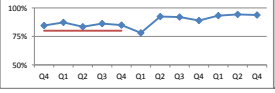
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2018/19)	Current Period Performance (Q4 2018/19)	Previous Period Performance (Q3 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1 2019/20)
SE1	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	>=95%		690 747	92.37%	96.85%	-4.48%		↑
SE2	Delayed transfers of care to the maintained at a minimal level	<=3.5%		2,113 35,368	5.97%	6.34%	-0.36%		↔
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%		399 413	96.61%	97.81%	-1.20%		↔
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		374 412	90.78%	92.70%	-1.92%	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%		16,030 17,383	92.22%	93.55%	-1.34%	Since Nov-15 this no longer matches the quality Schedule, as we have been able to separate Herts from non-Herts CCGs' data and improve the relevance of the QS.	↑

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2018/19)	Current Period Performance (Q4 2018/19)	Previous Period Performance (Q3 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1 2019/20)
SE6	IAPT % clients moving towards recovery (ENCCG)	>=50%		485 887	54.68%	52.92%	1.76%	Data taken from Trust SPIKE report (locally reported data) on 03/04/2019. Previous period refreshed.	↔
SE7	IAPT % clients moving towards recovery (HVCCG)	>=50%		647 1197	54.05%	56.29%	-2.24%	Data taken from Trust SPIKE report (locally reported data) on 03/04/2019. Previous period refreshed.	↔
SE8	IAPT % clients moving towards recovery (Mid Essex)	>=50%		358 664	53.92%	49.02%	4.89%	Data taken from Trust SPIKE report (locally reported data) on 03/04/2019. Previous period refreshed.	↔
SE9	IAPT % clients moving towards recovery (NE Essex)	>=50%		352 614	57.33%	54.74%	2.59%	Data taken from Trust SPIKE report (locally reported data) on 03/04/2019. Previous period refreshed.	↔
SE10	IAPT % of clients moving towards recovery (W Essex)	>=50%		174 305	57.05%	53.99%	3.06%	Data taken from Trust SPIKE report (locally reported data) on 03/04/2019. Previous period refreshed.	↔

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2018/19)	Current Period Performance (Q4 2018/19)	Previous Period Performance (Q3 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1 2019/20)
SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**	>=80%		92 117	78.63%	77.05%	1.58%	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%		156 203	76.85%	76.21% (Q2)	0.64%	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)		1,355 1,544	87.76%	88.63%	-0.87%		↔
SE14	Rate of service users saying they are treated in a way that reflects the Trust's values	>=80% (Since Apr 2018)		5,091 6,121	83.17%	80.32%	2.86%		↔

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q4 2018/19)	Current Period Performance (Q4 2018/19)	Previous Period Performance (Q3 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1 2019/20)
SE16	Rate of carers that feel valued by staff **(rolling 3 month basis)**	>=75%		56/66	84.85%	81.82%	3.03%		↔
SE17	Percentage of eligible service users with a PbR cluster	95%		10,061 10,543	95.43%	95.17%	0.26%		↔
SE18	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)	95%		8,910 10,187	87.46%	86.20%	1.27%	Adult Community: 83.75% Acute: 92.93% Older Peoples: 96.43% E&N SBU: 92.41% WEST SBU: 78.58% LD&F SBU (Rehab): 100%	↔
SE19	Data completeness against minimum dataset for Ethnicity (MHSDS)	90%		65,468 69,951	93.59%	93.69%	-0.10%	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. Previous period refreshed	↔
SE20	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • identifier metrics	>=95%		144,370 144,852	99.67%	99.79%	-0.12%	Previously SOF4 measure - Removed from SOF Nov-17 Data taken from last month of each quarter. Data taken from Trust SPIKE report on 06/03/19. Previous period refreshed	↔

SE21	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • Employment	>=85%		11,210 15,508	72.29%	58.51%	13.78%	Data taken from last month of each quarter. Data taken from Trust SPIKE report on 06/03/19. Previous period refreshed	↑
	• Accomodation	>=85%		11,055 15,508	71.29%	53.82%	17.46%	Data taken from last month of each quarter. Data taken from Trust SPIKE report on 06/03/19. Previous period refreshed	↑
SE22	Rate of Service Users Saying staff are welcoming and friendly (Rolling 3 months)	TBC		243 252	96.43%	97.70%	-1.27%		↔
SE23	Rate of Servie Users saying they know how to get support and advice at a time of crisis (Rolling 3 months)	TBC		227 251	90.44%	81.46%	8.98%		↔
SE24	Rate of Service Users saying they have been involved in discussions about their care (Rolling 3 months)	TBC		211 247	85.43%	86.86%	-1.43%		↔

Ref	Indicator (Monitor/Contractual/Internal)	Target	24 month Trend	Current Period Numbers (Q4 2018/19)	Current Period Performance (Q4 2018/19)	Previous Period Performance (Q3 2018/19)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q1 2019/20)
W1	Staff saying they would recommend the Trust as a place to work	>=61%		133 / 202	65.84%	65.18% (Q2)	0.66%	Pulse survey not completed for Q3, due to National Staff Survey.	
W2	Staff Wellbeing at Work	75% as of Q2 18/19		132 / 156	84.62%	65.03% (Q2)	19.59%	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		11 / 173	6.36%	9.16% (Q2)	-2.80%	Pulse survey not completed for Q3, due to National Staff Survey.	
W4	Staff skills and capability	95% as of Q2 18/19		314 / 336	93.45%	80.76% (Q2)	12.69%	Pulse survey not completed for Q3, due to National Staff Survey.	
Ref	**Indicator**	**Target**	**12 month Trend**	**Current Period Numbers (Q4 2018/19)**	**Current Period Performance (Q4 2018/19)**	**Previous Period Performance (Q3 2018/19)**	**Change on previous period**	**Comments and Data Quality Issues**	**Forecast for next period (Q1 2019/20)**
W5	Rate of staff with a current PDP and appraisal	>=95% as of Apr 2018		2,456 / 2,744	89.50%	88.13%	1.37%		↑
W6	Rate of mandatory training completed and up to date	>=92%		26,156 / 28,978	90.26%	85.95%	4.31%		↑
W7	Sickness rate	<=4%		11,032 / 263,251	4.19%	4.51%	-0.32%		↔
W8	Turnover rate	10% as of Q2 18/19		450.91 / 2,911.44	15.49%	16.60%	-1.12%		↔
W9	Living the Values at work	target under review		166 / 177	93.79%	94.30% (Q2)	-0.51%	Pulse survey not completed for Q3, due to National Staff Survey	

Ref	Financial Indicator	Target	Current Period YTD Plan (March 2018/19)	Current Period YTD Performance (March 2018/19)	Previous Period YTD Performance (February 2018/19)	Change on previous period	Comments	Forecast for next period (April 2019/20)
F1	To Achieve Surplus (amount to be confirmed) in year (not including STF)	**£0.36 million in year**	£0.36m surplus	**£385k surplus**	**£732k surplus**	**£347k reported loss**	Strategic investment in estates facilities given improved financial position	↔
F2	Use of Resources (formerly Financial Service Risk Rating)	**1**		**1**	**1**	**-**		↔
F3	To keep Agency Spend below the NHSI Agency Ceiling (£8.5 million for the year)	**£7.327 million in year**		**£6801k**	**£6,488k**	**£314k**		↔
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**		**106**	**150**		Figures as per NHSI weekly submission. Figure based on full weeks that contain days in the reporting period. March figure includes weeks commencing; 25/02/19 04/03/19 11/03/19 18/03/19 25/03/19	↔
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	Q3	Q4
1	Every discharge 7 day follow up – See Core Indicators	≥=95%	96.05%	97.81%	98.03%	
2	CAMHS 28 day wait for routine referrals	≥=95%	50.95%	80.45%	83.33%	
3	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death – See Core Indicators	-	1053* Incidents 0.66% (7)	994* Incidents 0.60% (6)		
4	Number of inappropriate out of area placements	275 (Q2)	165	9	0	
5	Cardiometabolic indicators – covered under CQUIN					
Clinical Effectiveness						
6a)	Emergency readmission within 28 days 16 + - See core indicators		4.70%	5.19%	6.29%	
6b)	Emergency readmission within 28 days 0 – 15 – See Core Indicators		0.2%	0.41%	0%	
7	First Episode Psychosis (FEP) waits 14 days (NHSI mandatory)	≥=53%	85.92%	89.29%	80.95%	
8	CATT Gatekeeping – see core indicators	≥=95%	97.1%	97.28%	96.23%	
9a)	Improving Access to Psychological Therapies (IAPT) recovery rate	≥=50%	53.32%	53.74%	55.08%	
9b)	IAPT 6 week wait	≥=75%	83.68%	91.82%	92.29%	
9c)	IAPT 18 week wait	≥=95%	99.79%	99.87%	99.88%	
Service User and Carer Experience						
10	Service users reporting their experience of Community Mental Health Services – Being treated according to trust values	≥=80%	76.55%	80.32%	80.81%	
11	Carers feeling valued by staff	≥= 75%	73.42%	81.82%	83.87%	
12	Staff Experience Friends and Family Test	≥= 70%	74.64%			
13	Service Users Friends and Family Test	≥= 80%	85.54%	85.73%	86.9%	

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

All data refreshed from Q2.

Hertfordshire Partnership University NHS Foundation Trust

TRUST BOARD

Meeting Date:	9th May 2019	**Agenda Item: 12**
Subject:	Q4 Workforce and OD Report	**For Publication:**
Author:	Maria Gregoriou, Associate Director of Workforce and Steve Graham Deputy Director of Workforce and OD	**Approved by:** Mariejke Maciejewski – Interim Director of Workforce and OD
Presented by:	Mariejke Maciejewski – Interim Director of Workforce and OD	

Purpose of the report:

To update the Trust Board on the Q4 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:

This quarter has seen an improvement in all the workforce KPIs which is positive news. The turnover rate has reduced to 15.5% and the vacancy rate has decreased to 13%. A number of changes have been made in recruitment to improve the onboarding process, reduce time to hire and improve the candidate experience. As a result we have seen a higher number of new starters this quarter with 140 new starters joining the Trust. In addition there has been the launch of several retention initiatives such as 100 day interviews and career conversations. All of which appear to be having a positive impact across the organisation.

The sickness absence rate has decreased this quarter from 4.61% in Q3 to 4.31% in Q4 which is another positive move although this is still above the Trust target of 4%. The significant work which is ongoing regarding health and well-being activities including mini health checks, mindfulness and resilience training, massages, physical health activities and Schwartz Rounds is assisting with prevention and getting staff to focus on their own health, wellbeing and resilience.

The appraisal rate has increased over the last quarter from 88.13% to 89.51%. All three SBUs have appraised 90% of their staff but further work needs to be undertaken with Corporate to improve this further. The mandatory training rate has increased to 90.26% this quarter from 85.95% at the end of Q3. The implementation and embedding of 'Discovery' the new learning management system is having a positive impact on training compliance with staff being aware of what training they need to complete and when they need to update their training.

The Trust also received the results of the national staff survey for 2018 during Q4. The results demonstrate that the Trust has maintained a positive position particularly in comparison to the last two years where we had really positive staff survey results. There were no significant differences between the 2017 and 2018 scores. In addition, the Trust achieved a national best score of 7.0 for the Safety Culture theme.

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

Hertfordshire Partnership University NHS Foundation Trust

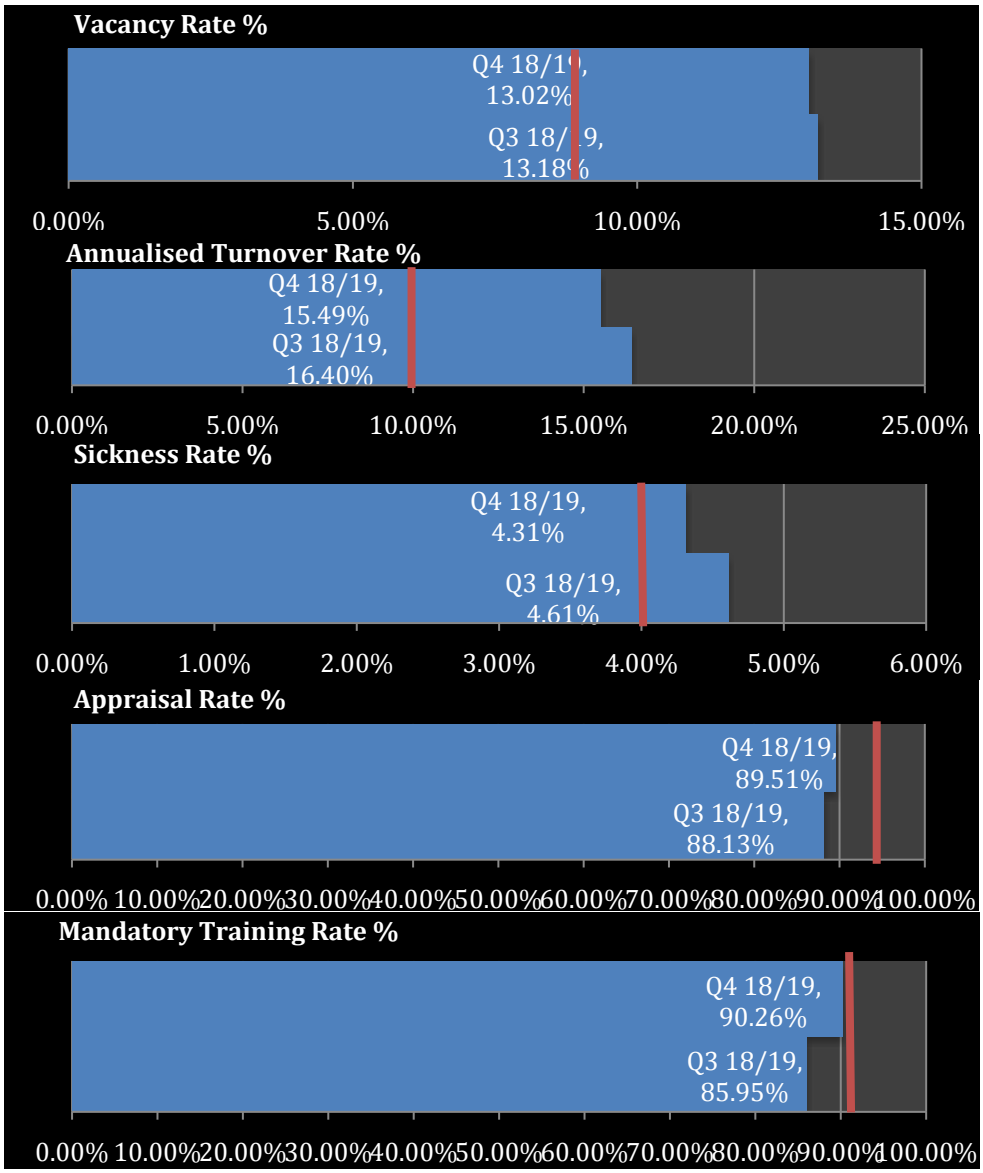
Workforce and Organisational Development Report
Quarter Four: January – March 2019

1.0 Introduction

The purpose of this report is to appraise the Trust Board on the Q4 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 Q4 summary position.

2.0 Executive Summary

Key Summary Position



This quarter has seen an improvement in all the workforce KPIs which is positive news. The turnover rate has reduced to 15.5% and the vacancy rate has decreased to 13%. A number of changes have been made in recruitment to improve the onboarding process, reduce time to hire and improve the candidate experience. As a result we have seen a higher number of new starters this quarter with 140 new starters joining the Trust. In addition there has been the launch of several retention initiatives such as 100 day interviews and career conversations. All of which appear to be having a positive impact across the organisation.

The sickness absence rate has decreased this quarter from 4.61% in Q3 to 4.31% in Q4 which is another positive move although this is still above the Trust target of 4%. The significant work which is ongoing regarding health and well-being activities including mini health checks, mindfulness and resilience training, massages, physical health activities and Schwartz Rounds is assisting with prevention and getting staff to focus on their own health, wellbeing and resilience.

The appraisal rate has increased over the last quarter from 88.13% to 89.51%. All three SBUs have appraised 90% of their staff but further work needs to be undertaken with Corporate to improve this further. The mandatory training rate has increased to 90.26% this quarter from 85.95% at the end of Q3. The implementation and embedding of 'Discovery' the new learning management system is having a positive impact on training compliance with staff being aware of what training they need to complete and when they need to update their training.

The Trust also received the results of the national staff survey for 2018 during Q4. The results demonstrate that the Trust has maintained a positive position particularly in comparison to the last two years where we had really positive staff survey results. There were no significant differences between the 2017 and 2018 scores. In addition, the Trust achieved a national best score of 7.0 for the Safety Culture theme.

3.0 Key Workforce Metrics

3.1 Establishment Data

The establishment data as at 31 March 2019 is as follows:

Funded Establishment =	**3412.81**
Staff in post =	**2968.53**
Vacant posts =	**444.28**
% Trust Vacancy rate =	**13.02**
Active Vacancies being recruited to =	**203.44**
% Total Turnover rate =	**15.49**
% Planned Turnover Rate =	**4.07**
% Unplanned Turnover Rate =	**11.42**
% Stability rate =	**87.57**

3.2 Key Recruitment Activity

At the end of Q4 the vacancy rate fell to 13% with 444.28 wte vacancies. Of these vacancies there were 203.44 posts at various stages of the recruitment process and an additional 162 posts which are out to advert.

Some significant changes were made to improve the onboarding process and streamline recruitment during Q3 and Q4. This included pre-employment checks being outsourced to TRAC and candidate identity checks being undertaken by recruiting managers at interview stage with the aim of reducing delays in the recruitment process and to improve the candidiate experience. Guidance and support is being provided to recruiting managers to enable them to carry out these checks. These changes have started to have a positive impact on time to hire which has reduced to 9 weeks from 12.5 weeks at the start of Q1.

Work continues with the aim of increasing the number of new starters each month. HRBPs work closely with managers to ensure all vacant posts are out to recruitment with currently 365 of the 444 vacancies in some part of the recruitment process.

In Q4 there were 140 new starters and 123 leavers in comparison to Q3 when there were 109 new starters and 119 leavers. There was a net gain of 17 staff this quarter which is positive news. Unfortunately there were 18 new starters and 24 leavers from nursing posts this quarter giving us a net deficit of 6. The breakdown of new starters by staff group is shown in **appendix 1, section 3, Graph 5 – starters and leavers by staff group.**

Two recruitment open days were held in Q4. Although several appointments were made, it was identified that there was a need to increase the number of focused recruitment campaigns targeting specific hard to recruit to roles in hot spot areas. Our strategy regarding bespoke recruitment events in hot spot areas and difficult to recruit to posts has been reviewed in partnership with recruiting managers and future events will be taking place locally. Area specific recruitment events are being planned for CAMHS, PATH and Norfolk to take place in Q1 followed by similar events taking place for other hot spot areas throughout the year.

Work continues with our STP colleagues and recruitment events have been planned to take place in June and October 2019. Other STP events currently being scoped include a HCA and trainee nurse associate recruitment day and an STP stand at the Health Sector Jobs recruitment fair in Dublin in October 2019.

Changes made to simplify the process of ensuring that all new starters have all their ICT equipment and network access on their first day of employment has had a positive impact. 49 of the 50 new staff members who attended the March induction all had equipment and network access in place. Work is ongoing to further streamline this process.

A welcome pack is being designed for new joiners, this will bring together information about the Trust, employee benefits and to signpost them to a range of resources they can access as a staff member. This is an important part of improving retention as well as the overall on boarding experience of new starters.

As part of ongoing work to update our recruitment processes the retire and return process has been streamlined and the Retire and Return policy has been updated to provide clearer guidance to mangers.

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

3.3 Junior Doctor Recruitment

The February rotation has taken place for Junior Doctors during Q4. The three 1st on call rotas have improved and are currently at 1:14 for Central, North and East. This has had a positive impact on all rotas and on exception reporting with no exceptions being raised this quarter. The second on call rota decreased in frequency to a 1:13 at the end of Q4.

Work has continued on the international medical recruitment scheme with interviews scheduled during April 2019 to ensure that this has a positive impact on vacancies in the August rotation. Alongside this International Trust Fellowship adverts will be placed in Q1. Specialty Doctor interviews for CAMHs have taken place with five successful job offers being made with start dates planned during Q1 and Q2.

3.4 Consultant Recruitment

In Q4 one new Consultant commenced in post in CAMHS and a Locum Consultant in our perinatal service has a start date in Q1. Advisory Appointment Committees (AAC's) took place in March and successful job offers have been made to a consultant to begin working in our General Adult services and for a consultant to begin employment in our Learning Disabilities services in May. The latter post has been covered by a long term locum and these arrangements will come to an end in Q1. It is anticipated that current consultant recruitment activity will have a positive impact on future agency spend and provide stability.

Agency spend remains a high priority for Medical Staffing with an average of 10 Agency Locums during Q4, covering both sickness and vacancies. Hot spot areas for recruitment remain as CAMHS, Old Age and General Adult Community.

3.5 Temporary Staffing

During Q4, 22,587 bank and agency shifts for registered nursing and HCA posts were requested.17,473 were filled by bank workers and 3,209 shifts were filled by agency. This is a total fill rate of 91.57%, which consists of a 77.36% bank fill rate and a 14.21% agency fill rate.

In comparison in Q3 there were 21,028 bank and agency shifts requested to be filled for registered nursing and HCA posts. 76.25% of these were filled by bank workers and 15.73% were filled by agency workers showing that agency usage continues to decrease.

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

3.6 Turnover Rate

The turnover rate has decreased slightly to 15.49% in Q4 in comparison to 16.4% at the end of Q3. This is mainly attributable to a decrease in the unplanned turnover rate from 12.44% to 11.42%. This is positive news as it shows that there has been a reduction in staff who are choosing to leave the organisation as the unplanned

turnover rate excludes those staff who leave the Trust as a result of retirement, end of fixed term contracts or dismissals. There has also been a slight increase in the planned turnover rate this quarter which was 4.07% in comparison to Q3 when it was 3.96%.

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

Guidance for the 100 day conversation process was refreshed in Q4 and now includes a toolkit which has been produced to support managers through the process. HRBP's are receiving regular reports listing staff members approaching their one hundredth day at HPFT or 2 years in post. This is being used to prompt managers to complete 100 day conversations and stay interviews for their staff.

Career conversations were launched in Q4 with the aim of supporting staff with any questions or concerns they have with their development and to discuss the retention processes and opportunities available to staff who may be thinking of leaving HPFT.

Following a review of the internal move's process, the guidance and application process is being refreshed to make the process easier and simpler for transferees as well as making this process available to all other staff groups. The internal moves process will be launched in Q1 together with an internal promotional drive to generate more interest.

The Buddy Scheme for new starters was rolled out trust wide in Q4. A buddy pack has been produced with guidance on the process. This is being sent out on a weekly basis to all hiring managers who have made offers to a candidate in the preceding week and buddies are being supported via a training session.

Progress with the Trust's retention plan continues to be a key priority; this includes evaluating the success of existing retention initiatives to review their effectiveness.

3.7 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 importantly why they stay.

During Q4 the top 4 reasons for leaving the organisation were retirement, relocation, work life balance, and other. The Business Partner Team will continue to work closely with SBU managers to have a better understanding of the reasons why staff leave HPFT and to encourage staff to openly share the reasons why they are leaving and what we could do better to improve the staff experience via completion of the exit questionnaires.

16 staff retired from the Trust during Q4. It is expected the retire and return process will provide an opportunity for those staff wishing to retire to come back and work for HPFT either immediately or at a later date so that we can keep knowledge and experience in the organisation.

Further work will be carried out in Q1 with the organisation who administer our exit questionnaires, to corrolate information gathered via the exit questionnaire, the 100 day conversations and the staff survey to corrolate data and identify themes.

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

3.8 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 rate at the end of Q4 was 87.57% in comparison to Q3 which was 86.8% A stability rate of 87.57% is outside of the target and higher than recommended but this positive variance and shows that experience and knowledge is being retained in the organisation.

3.9 Sickness Absence

The sickness absence rate has decreased this quarter from 4.61% in Q3 to 4.31% in Q4, however it is still above the Trust target of 4%. There has been a decrease in the sickness absence rates across all strategic business units. Corporate services is the only area with a sickness absence rate below the Trust target at 3.24%. West SBU is slightly above the target at 4.02%. Sickness absence rates for Learning Disabilities and Forensics services is at 4.57% and East and North SBU is 4.79%.

Within West SBU the main hotspot area is the Single Point of Access. Within Learning Disabilities and Forensic Services, Norfolk LD (Broadland Clinic), LD North Essex and the Rehab Services 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 after every period of absence is emphasised. The Management of Sickness Absence Policy has been revised. 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, resiliance and mindfulness support, mini health checks and Schwartz Rounds is well received by staff.

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

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

There are currently 128 short term sickness absence cases and 43 long term sickness absence cases being formally managed through the employee relations team as at the end of March 2019. This is an increase in short term and a decrease in long term cases compared 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 supported through occupational health, health and wellbeing initiatives, and their line managers.

The estimated costs to the Trust of sickness absence for Q4 has been calculated as over £1m with a decrease from Q3 of just under £18k.

3.10 PDP Rates

The Trust's overall PDP rate has increased by 2% to 90% in Q4. The PDP rates for each SBU are as follows:

SBU	Q1	Q2	Q3	Q4
LD&F	87 %	88%	86%	90%
East and North	89 %	91%	91%	94%
West	87 %	95%	91%	91%
Corporate	70 %	83%	79%	72%
Trust	**86 %**	**90%**	**88%**	**90%**

PDP rates have increased in LD&F and East and North SBU. Rates have remained constant in West SBU and decreased in Corporate Services. All SBUs and corporate services are provided with monthly management reports detailing completion rates and plans are in place to support managers and staff to plan and complete PDPs as part of the reporting cycle thereby further increasing completion rates.

Within the LD&F SBU, PDP compliance continues to be an area of major focus with compliance across all of the service lines being monitored by the Managing Director and scrutiny also taking place at the monthly Core Management Meetings. Norfolk Services (97%), MH Rehab (97%) and Herts Forensics (95%) all meet or exceed the 95% target rate. The remainder of the service lines are in the range of 81%-91%. Within East and North Herts SBU, PDP rates are discussed at the SBU Core Management meeting and Service Line Management meetings. West SBU review PDP completion rates at monthly unit reviews and liaise with teams around individual completion rates; for the next quarter this work will continue with the service lines and working towards the target of 95%, and maintaining rates for those teams already at 100% completion.

3.11 Statutory and Essential Training Rates

The Statutory and Essential training rates in Q4 have ended as follows:

Statutory Training = 90%
Essential Training = 89%

In comparison to Q3 statutory training showed a positive increase of 4% and essential training an increase of 6%. However, overall this is still 2% below the Trust target of 92%. The benefits of the implementation and embedding of 'Discovery', the new learning management system is starting to have a real positive impact on maintaining and improving training compliance.

There is still significant work being carried out to raise the compliance rates above the Trust target, with work continuing with Subject Matter Experts. In addition Quarterly Assurance Meetings continue to take place and action plans are in place for those areas below compliance.

March 2019:	% Compliance in Statutory Training
Corporate Services	87%
LD&F	92%
East & North Herts	90%
West Herts	90%
TRUST	**90%**

3.11.1 Discovery Update

'Discovery' the new learning management system continues to be developed. The Discovery reporting functionality has been developed and released to managers and Subject Matter Experts (SME's). A large marketing drive has taken place within the Learning and Development Service to raise the profile and simplifying the requirements for Statutory and Essential Training, making it clearer to staff what training they need to undertake and how often. A review of Statutory and Essential training requirements has been undertaken.

New developments are underway with the developers (Think Associates) to implement My Team Dashboard – this dashboard will provide managers with the functionality to run compliance reports for their teams when they wish and not rely on central reporting which is carried out on a monthly basis. It is anticipated this will be in place from mid-April 2019.

The Learning & Development Service will also implement a SME Dashboard - which will provide the SME with access to see future class lists, staff booked and the full year commissioning programme. They will also be able to run off reports for their subject areas. This will also be in place from mid-April 2019.

Moving forward the Discovery 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 to 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.

4.0 Organisational Development Activity

The Organisational Development Team is progressing delivery against the agreed Organisational Development and Learning activity plan. During Q4 work has continued on the next phase of our Good to Great journey through further development of the High Performing Team Model. The model and framework has been shared with a focus group of Team Leaders and their feedback has been used to further inform and develop the model.

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 similar to above.
- Delivery of Team development sessions for The Marlowe's and Leadership Team (similar to above leadership programme, plus some coaching).
- Supporting the development of the High Performing Team model
- Planning and confirmation of Long Service Awards
- Support to retention plan – Buddy Scheme, 100 day, stay and career interviews.
- Participation in Regional and National Leadership OD Meetings
- Team Development session for IAPT
- Developmental/personal awareness sessions for SAS doctors and student nurses.
- Holly Lodge project

4.1 Delivering Effective Leadership Capacity and Capability

The team continue to provide support to Leadership Development and activity this quarter has included the following:

- Two Senior Leaders Forums were held this quarter which focussed on CQC – well led trust and CQI in January and our staff survey results and annual plan in March.
- The first cohort of the 2 day Management Fundamentals Programme, directed at new and existing managers has been delivered. Overall the participant's feedback has been positive.

- First cohort of Coaching as a Management Style – a 2 day Programme aimed at giving managers coaching techniques to help them improve relationships with their staff/teams has been well evaluated. The Programme focusses on powerful questioning and listening techniques and will be delivered quarterly.
- The Mary Seacole Programme – this is a 6 month first line leadership programme supported by the National NHS Leadership Academy. We are currently negotiating the renewal of the license fee to enable us to deliver this Programme locally for a further 2 years throughout the STP. Some funding has been received from Health Education England to support the renewal and more funding is anticipated.
- Cohort 10 of the Leadership Academy has started – this in-house classroom based, accredited, leadership development programme is delivered in partnership with external, internal trainers and the University of Hertfordshire. The orientation morning, delivered in March 2019 to 26 participants, received positive feedback.

4.2 Maintaining and Growing Staff Engagement

Two Inspire Award presentations have taken place this quarter with 28 nominations received.

The National Staff Survey ran in Q3 with the results being published in Q4. The response rate was 41% which is slightly lower than last year and lower than the national average. There were a number of differences to the benchmark report compared to the reports used prior to the 2018 survey with Key Findings being replaced by 10 themes.

The survey results are benchmarked against 24 Mental Health/Learning Disability Trust's. The results of the national staff survey for 2018 demonstrate that the Trust has maintained a positive position particularly in comparison to the last two years where we had really positive staff survey results. There were no significant differences between the 2017 and 2018 scores. The Trust maintained the positive responses seen in previous years. In addition, the Trust achieved a national best score of 7.0 for the Safety Culture theme.

There was 1 significant positive change since last year *Values were* discussed as part of the appraisal process increased from 40.8% in 2017 to 48.6% in 2018. 1 significant negative change since last year was the organisation taking positive action on health and wellbeing which reduced from 42.8% in 2017 to 32.8% in 2018. However this score was above the national average.

The results of the national staff survey will inform activity in the OD Plan

- Embedding the culture of continuous improvement – training for staff
- Operational Activity (work pressures)
- Management and Leadership Development
- Talent Management
- Health and Wellbeing – including reducing Bullying and Harassment

The Pulse Survey was open from 1st January to 31st March 2019. The results were evenly spread across the 4 SBU's and highlighted similar themes to the national staff survey.

- 62% of staff reported they are likely to work addition hours compared to 67% in National Staff Survey
- 84% of staff believe the Trust definitely or to some extent takes positive action on their wellbeing

As with previous quarterly surveys and the national survey there is still a portion of staff who are experiencing bullying with 20% of those experiencing it from Service User or Carers and 39% from their managers or other senior managers.

There are a number of free text responses in which staff have indicated several additional issues such as:

- Problems with their work environments including space and IT issues.
- Request for better communication between teams, departments, SBU's and counties.
- Support for Career progression, Training and Development and
- Concern over manageable workloads

There are initiatives in place to respond to several of the issues mentioned above, including the retention initiatives to pick up the concerns on career progression and training and development.

Tackling and eliminating Bullying and Harassment also continues to a focus and action plans are in place to support this. These are monitored via the Workforce and OD project review process and in Q4 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 have taken place and are being further developed to take the form of "HR surgeries"

4.3 Improving Staff Health and Wellbeing

The Organisational Development team has delivered a number of health and wellbeing initiatives in accordance with the action plan over Q4. Activities delivered include:

- An 8 week mindfulness course at Colne House in the South West Quadrant.
- 1 Mindfulness and 1 Resilience session were delivered in Bucks.
- 1 Mindfulness and 1 Resilience session were delivered in Victoria Court. The overall results showed a 28% increase in mindful awareness for those attending a Mindfulness course.
- Analysis of the feedback from Schwartz Rounds delivered across the Trust. The feedback scored a rating of 10% exceptional, 55% excellent, and 18% good.
- Schwartz Steering Group meeting were set for the year and an audit was undertaken showing the spread of facilitators across the quadrants. The strategic plan for 2019-2020 has been shared with facilitators.
- Know Your Numbers (mini health checks) had 3 workshops in different locations with over 37 staff attending
- The Health hub has been presented monthly at corporate induction and Health Hub Communications have been provided via HPFT Highlights screensavers displaying health hub offerings
- 140 massages provided to staff across 6 sites
- The Working Together As One magazine; edition 23 was collated in Q4
- Health Hub Challenges took place each month including Dry January, Time To Talk Challenge, and the Nutrition and Hydration Challenge

- The Health & Wellbeing Strategy 2019 – 2021 will be updated and ratified using feedback from the National Staff Survey, pulse surveys and additional research. This will aid us to positively grow the wellbeing of our workforce.

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

The final LQAF (Library and Quality Assurance Framework) assessment was submitted to Health Education England (HEE) in August 2018 and we received the outcome in Q4 with an 88% pass rate. From 2019, a new way of assessing Libraries has been introduced by HEE 'Quality Information Standards' (QIS) and this will be used by all NHS Libraries across our region. Submission against the standards will take place in the summer of 2020.

5.1.2 Apprenticeships

During Q4 23 staff commenced on an apprenticeship programme. The programmes that commenced included:

- Lead Adult Care – Level 3
- Adult Care – Level 2
- Business Admin – Level 3
- Registered Nurse Top Up
- Project Management

A total of 74 apprenticeships commenced in HPFT during 2018/19 against a target of 70. This is really positive news and the plan is to develop the apprenticeship offering even further over the coming year. The trajectory is that during Q1 21 people will commence apprenticeship programmes across a number of clinical and non-clinical areas.

HPFT is currently an accredited center to provide a Regulated Qualification Framework (RQF) through City and Guilds and these are offered to existing staff as part of the Trust's development pathways. To maintain this accreditation the Trust has a yearly visit and review of our processes.

City and Guilds carried out a review of our accreditation in November 2018 (systems visit) where we received a positive report and during Q4 (March 2019) a portfolio review took place by the external verifier. Formal feedback has not been received and is due imminently, however initial feedback received was positive.

6.0 Recommendation

The Board is asked to note the Q4 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
April 2019

March 2019 - Based on Q4 2018/2019

HPFT Workforce Information Report Summary

WORKFORCE INFORMATION REPORT SUMMARY

Workforce Report March 2019 (Based on data for Q4 (2018/2019)

Section 1: KPI summary position

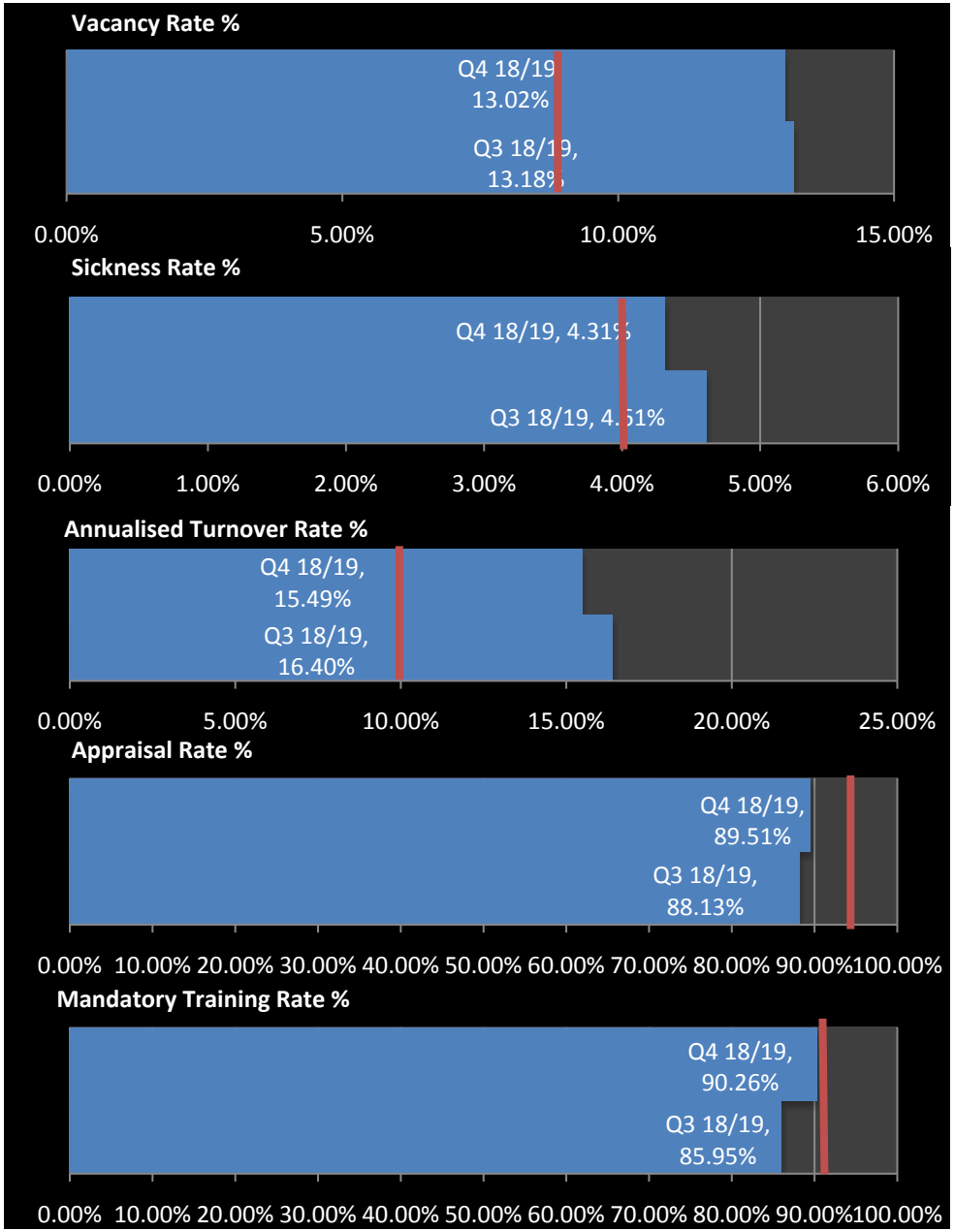


Table 1: Establishment Data

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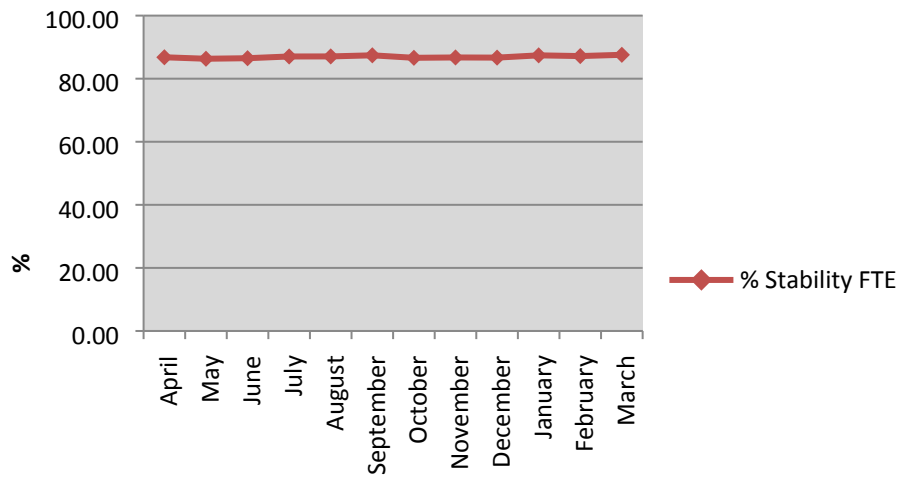
% Stability rate =	87.57

Graph 1 : % Stability



WORKFORCE INFORMATION REPORT SUMMARY

Section 2: Recruitment

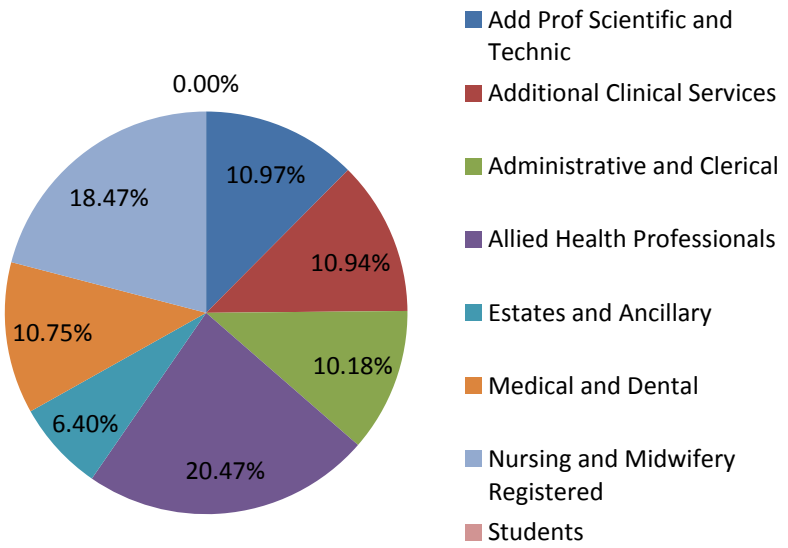
Table 2: Recruitment Summary by SBU

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Authorisation	2.6	8	10.5	14.6	35.7

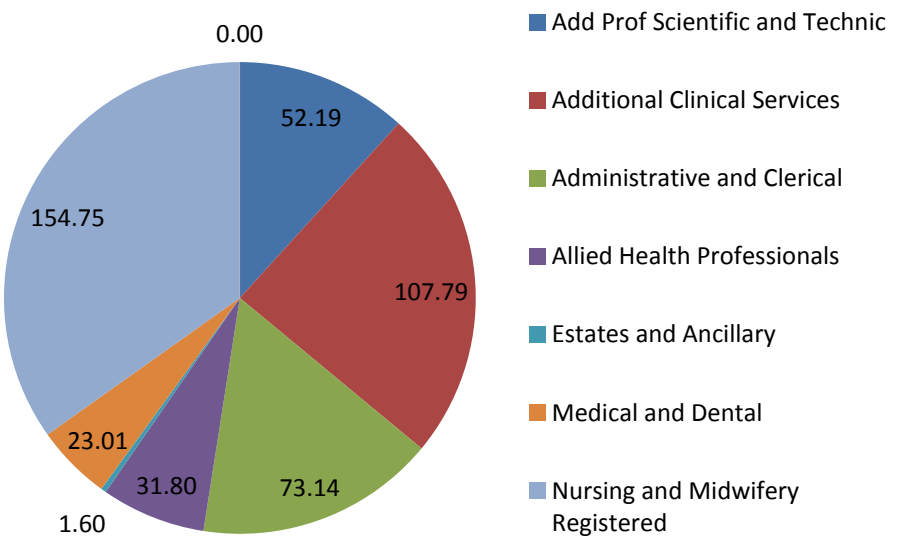
Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Longlisting	5.2	16	15.2	10.6	47
Shortlisting		18.3	21.73	19.5	59.53
Interview		16.5	17.01	20.82	54.33

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Offer	5.5	20.4	15.34	29.8	71.04
Starting	8.33	26.18	28.39	34.94	97.84

Graph 2: Vacancies (%) by Staff Group



Graph 3: Vacancies (fte) by Staff Group



Section 3: Turnover

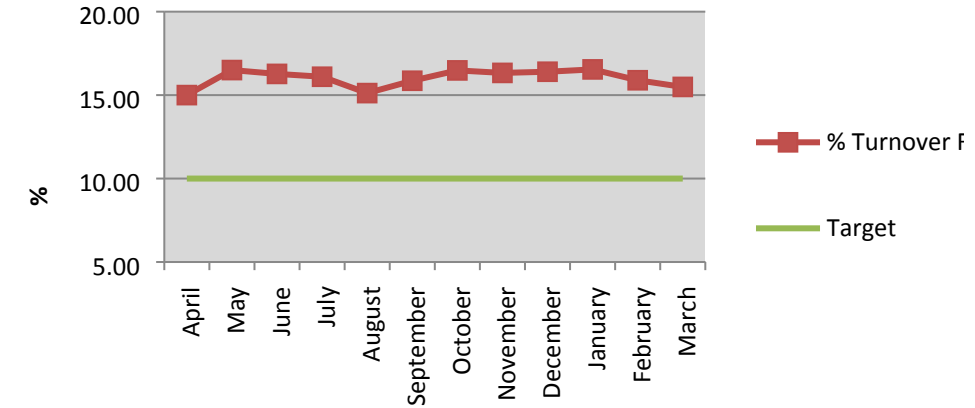
Table 3: Q4 2018-2019 Leavers by Leaving Reason

Leaving Reason	Total
Voluntary Resignation - Other/Not Known	27
Retirement Age	16
Voluntary Resignation - Relocation	15
Voluntary Resignation - Work Life Balance	10
End of Fixed Term Contract	9
Voluntary Resignation - Promotion	8
Voluntary Resignation - To undertake education or training	7
Voluntary Resignation - Health	5
Voluntary Resignation - Better Reward Package	5
Death in Service	4
Voluntary Resignation - Lack of Opportunities	3
Employee Transfer	3
End of Fixed Term Contract - Other	2
Voluntary Resignation - Child Dependants	2
Voluntary Early Retirement - with Actuarial Reduction	2
Dismissal - Capability	1
Dismissal - Some Other Substantial Reason	1
Retirement - Ill Health	1
Bank Staff not fulfilled minimum work requirement	1
Voluntary Early Retirement - no Actuarial Reduction	1
Grand Total	**123**

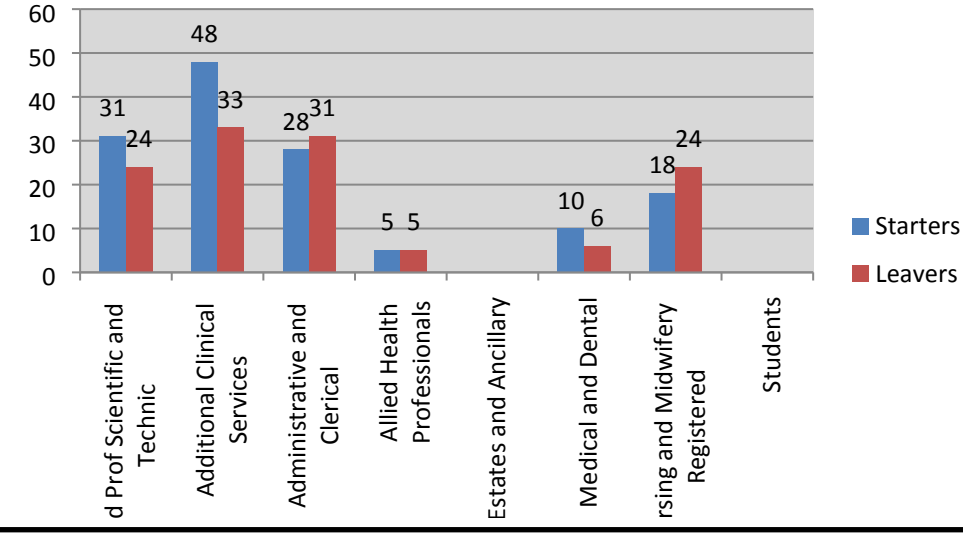
Table 4: Retirement Profile

	Age		
Retirement profile	**55-59**	**60-64**	**65+**
367 Corporate	46	19	15
367 SBU Learning Disability & Forensic	123	51	18
367 SBU MH East & North Herts	115	96	31
367 SBU MH West Herts	118	66	34
Grand Total	**402**	**232**	**98**

Graph 4 : % Turnover



Graph 5: Starters & Leavers by Staff Group Q4



Section 4: Sickness Absence

Table 5: Q4 2018-2019 Top 10 Reasons for Sickness Absence

Sickness Absence Reason	No Of Episodes
S13 Cold, Cough, Flu - Influenza	372
S98 Other known causes - not elsewhere classified	206
S25 Gastrointestinal problems	196
S99 Unknown causes / Not specified	194
S10 Anxiety/stress/depression/other psychiatric illnesses	108
S16 Headache / migraine	79
S15 Chest & respiratory problems	61
S12 Other musculoskeletal problems	56
S11 Back Problems	49
S28 Injury, fracture	40

Graph 6: % Sickness Absence by Month

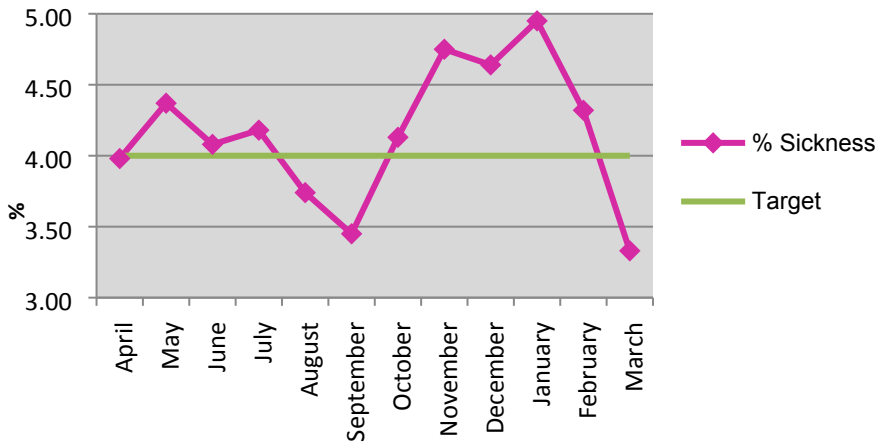
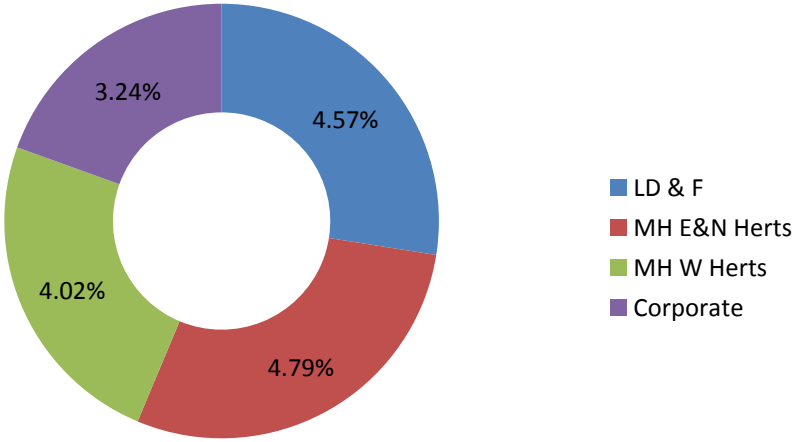


Table 6: Sickness Cost

SBU	Estimated Cost of sickness Q3
Corporate	£114,641
LD & F	£308,432
MH E&N Herts	£327,059
MH W Herts	£261,539
Trust	**£1,011,670**

Graph 7: Q4 % Sickness Absence by SBU



Section 5: Temporary Staffing

Table 7: Q4 2018-2019 Bank, Agency & Substantive Spend

2018-2019				
Total spend	**Q4**		**YTD**	
	£	**%**	**£**	**%**
Agency	1,542,269	4.03%	7,147,620	4.72%
Bank	4,056,892	10.61%	15,697,475	10.36%
Substantive	32,628,066	85.35%	128,632,562	84.92%
Total	**38,227,227**		**151,477,657**	

Graph 8: Bank & Agency Spend

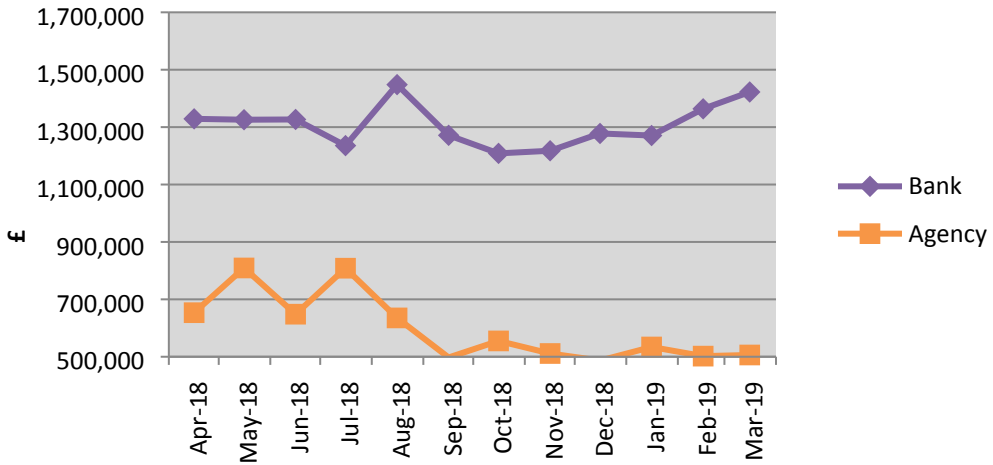
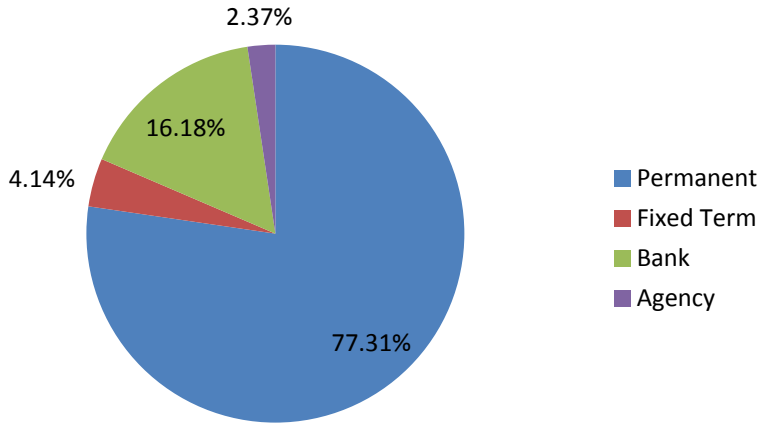


Table 8: Q4 2018-2019 Bank and Agency Usage

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	22,587	17,473	77.36%	3,209	14.21%	**91.57%**
Admin	4,421	3,847	87.02%	275	6.22%	**93.24%**
Social Workers	1,079	603	55.89%	274	25.39%	**81.28%**
OT/AHP	1,094	940	85.92%	128	11.70%	**97.62%**
Total	**29,181**	**22,863**	78.35%	**3,886**	13.32%	**91.67%**

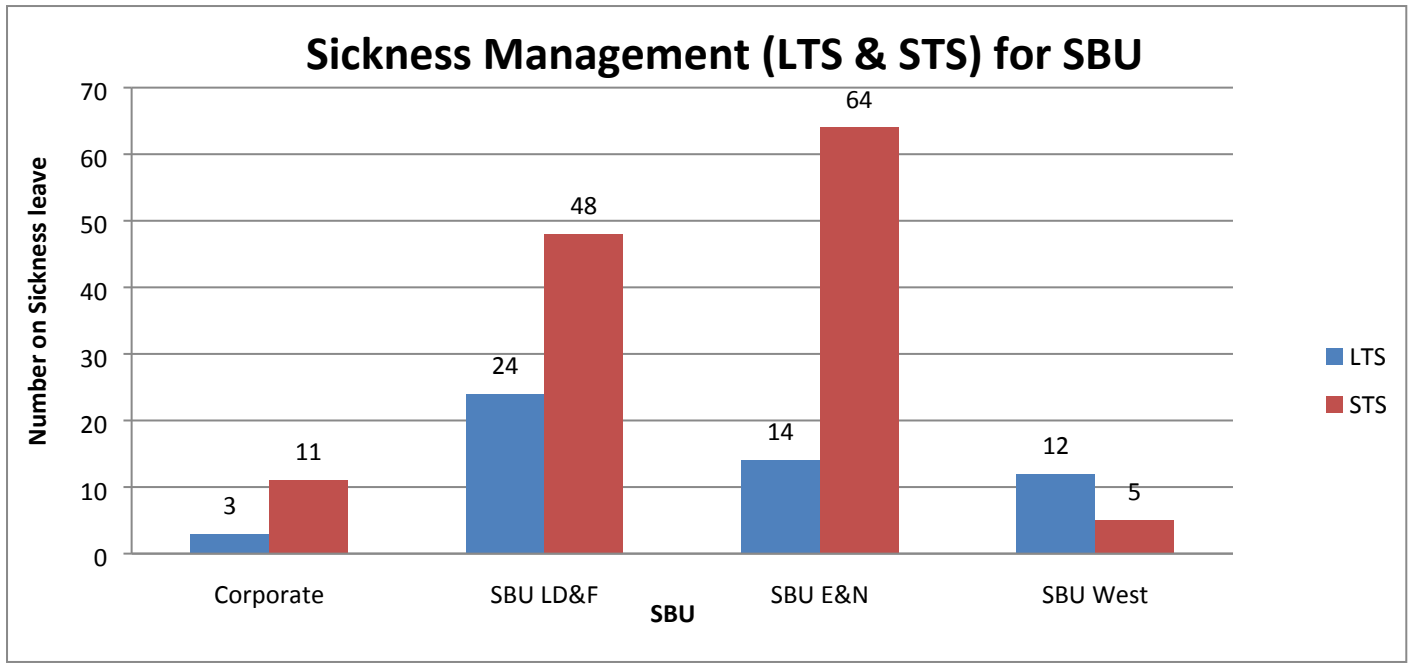
Graph 9: % FTE of Workforce by Assignment Category



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	20	2	0	0	10	**35**
Number of Grievances	1	0	5	0	0	3	**9**
Number of Capability cases	0	0	0	0	0	2	**2**
Number of Bullying & Harassment cases	0	1	1	1	0	1	**4**
Number of Whistleblowing cases	0	0	0	0	0	0	**0**
Total number of cases in progress	**4**	**21**	**8**	**1**	**0**	**16**	**50**
Number of Mediation sessions	0	0	0	0	0	0	**0**
Number of suspensions/restricted duties	1	13	0	0	0	7	**21**
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	208	289	**72%**
367 SBU Learning Disability & Forensic	743	828	**90%**
367 SBU MH East & North Herts	734	784	**94%**
367 SBU MH West Herts	771	843	**91%**
Grand Total	**2456**	**2744**	**90%**

Graph 10: % PDP Compliance

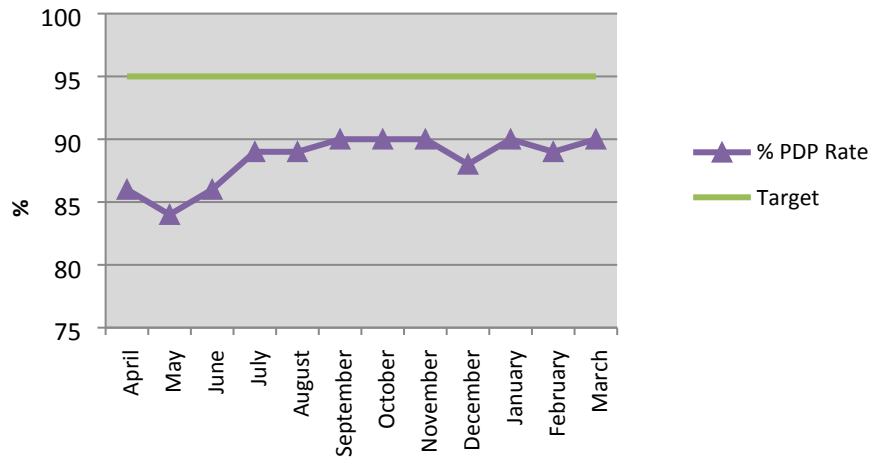
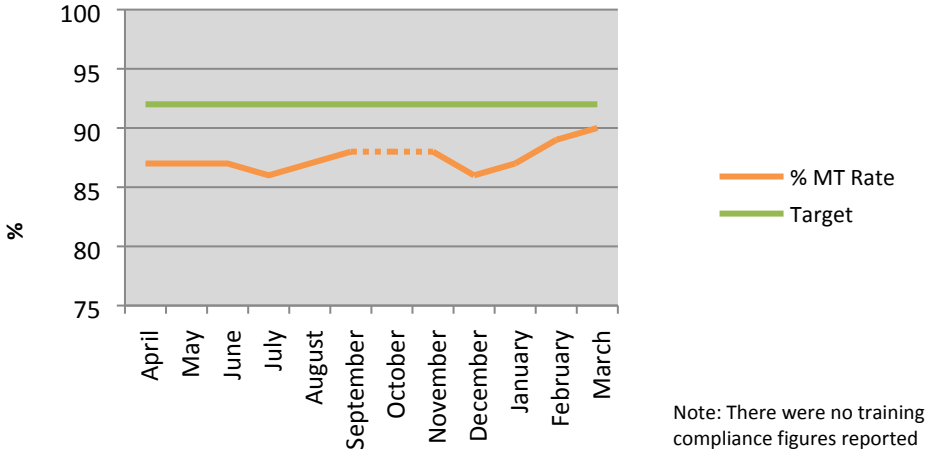


Table 11: Mandatory Training Compliance

SBU	Does not meet requirement	Meets Requirement	% Compliance
367 Corporate	385	2676	**87%**
367 SBU Learning Disability & Forensic	723	7871	**92%**
367 SBU MH East & North Herts	817	7690	**90%**
367 SBU MH West Herts	897	7919	**90%**
Grand Total	**2822**	**26156**	**90%**

Graph 11: % Mandatory Training Compliance



Note: There were no training compliance figures reported

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	16th May 2019	**Agenda Item:** 13
Subject:	Financial Summary for the Financial Year 1st April 2018 to 31st March 2019	**For Publication:** No
Author:	Sam Garrett, Head of Financial Planning & Reporting	**Approved by:** Paul Ronald, Deputy Director of Finance
Presented by:	Paul Ronald, Deputy Director of Finance	

Purpose of the report:

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

Action required:

To inform the Board of the financial position for the full year, the key highlights, the position against the NHSI requirements and early comment on the implications for the year ahead.

Summary and recommendations to the Board:

For the financial year to 31st March 2019 the reported position is a surplus of £392k, ahead of the Control Total of £360k surplus by £32k, and as forecast in recent months. The position for the month of March was a deficit of (£15k) for the month and reflects several matters specific to the end of year with the underlying position in the month sustaining most of the financial improvements that have been evidenced in recent months. All figures are reported before any income from the Provider Sustainability Fund (PSF), which is now expected to be c. £3.5m for the year, due to the Control Total has been met and exceeded and reflecting a substantial increase in allocation from NHSI. The NHSI Use of Resources (UOR) Rating is expected to report as an overall 1 pending final decision by NHSI.

UOR 1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000	Trend
Overall Surplus (Deficit)	86	-15	360	392	360	↑
Pay Overall	12,888	12,644	154,068	151,233	154,068	↔
Agency	611	533*	7,328	6,802	7,328	↑
Secondary Commissioning	2,598	2,805**	30,676	32,923**	30,676	↔

* Underlying position for ease of comparison, release of old year accruals means reported position was £319k for the month
**Underlying position, release of old year provisions and netting off CAMHs means reported position was -£1,657k for the month and 28,461k for the year

The year started with significant financial challenge, reporting a deficit for Quarter 1 of £73k only after releasing £1.4m of provisions; Quarter 2 improved with a surplus of £161k

with no releases necessary; and Quarter 3 saw a further improvement to a surplus of £320k. This equated to a year to date surplus of £408k at the end of Quarter 3, it was therefore planned to spend c. £1m on Estates and Environment works during Quarter 4, and taking this into account Quarter 4 achieved a deficit of £16k giving an overall position for the year of £392k surplus:

2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Position for Quarter	-73	161	320	-16
Cumulative Position	-73	88	408	392

The main improvements in the position enabling the later expenditure on works were in Secondary Commissioning (particularly CAMHs Tier 4 New Care Models and PICU External Placements), and reducing agency costs later in the year.

Key figures are summarised below:

1. Total Pay is reported below Plan for the year by £2.9m (1.9%). This reflects the level of vacancies, not all of which are covered, and agency levels which continue to reduce, achieving the NHSI Ceiling for the first time since it was introduced. Agency costs represent just 4.5% of the overall pay spend for the year, and just 4% of the overall pay spend for the month, the lowest level for several years.
2. Secondary commissioning is reported above Plan by £2.3m for the full year and £277k for the month of March after adjusting for netting off CAMHs T4 and release of part of the CHC provision. Significant improvements during the year included CAMHs T4 NCM (average of £359k/month Quarters 1 to 3 reducing to £232k/month Quarter 4); External Acute and PICU (average of £257k/month Quarter 1 reducing to £80k/month Quarters 2 and 3 but then increasing again to average £164k/month Quarter 4); and Main Health Placements (£576k/month Quarters 1 and 2 reducing to £504k/month Quarters 3 and 4). However there were also increases later in the year in some areas and most notably Social Care Placements hasn't reduced due to a number of step downs from health placements.
3. Income reported as worse than Plan by £2.8m however once adjusted for NHSE CAMHs T4 NCM (which has to be netted off at yearend) this figure is better than Plan by £1.1m, as forecast. There were significant positive variances for Education and Training Income (£1.4m, mainly IAPT additional income e.g. £300k expansion for North East Essex IAPT, and medical trainees income); and for Miscellaneous Other Operating Income (£1.2m, mainly income for the pay award in 2018/19). Block income was largely on Plan except where some elements were agreed to be deferred into 2019/20.
4. Overhead costs spent above Plan by c. 7% for the year, 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.

Although this is overall a positive position and the Control Total has been achieved, the following risks should be noted going into the new financial year:

a) This successful position for 2018/19 was achieved only with non-recurring releases of £1.4m during Quarter 1.

b) Although secondary commissioning costs decreased in some areas during 2018/19 (notably CAMHs T4 NCM, PICU and Main Health Placements), other areas didn't (Social Care Placements, Personal Budgets). Additionally, there has recently been significant additional pressure from both PICU and External Acute Placements.

c) Whilst the above shows a strong performance with a good exit point into 2019/20, the new year will be challenging. The Delivering Value Plan for 2019/20 is £6.5m which is a stretching target and includes a further reduction in agency costs.

d) Pay costs increase significantly again from 1st April 2019, and whilst this is broadly funded, there are incremental pressures from pay points being merged that indicate a greater level of risk.

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**

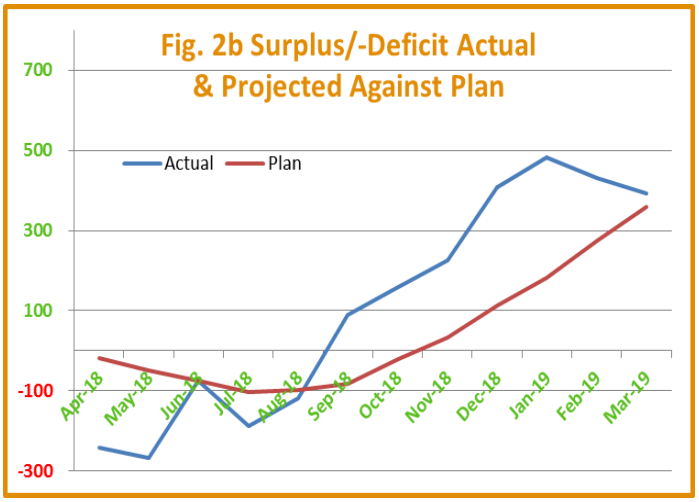
* This is before any amounts due under the Provider Sustainability Fund

2. Summary and Risk Rating

2.1 The Trust's Use of Resources (UOR) Framework rating for the year is expected to report as a 1, reflecting that most key metrics are met – strong cash position, plan position met, and agency spend fallen. The main in month movements highlighted in Fig. 2a below:

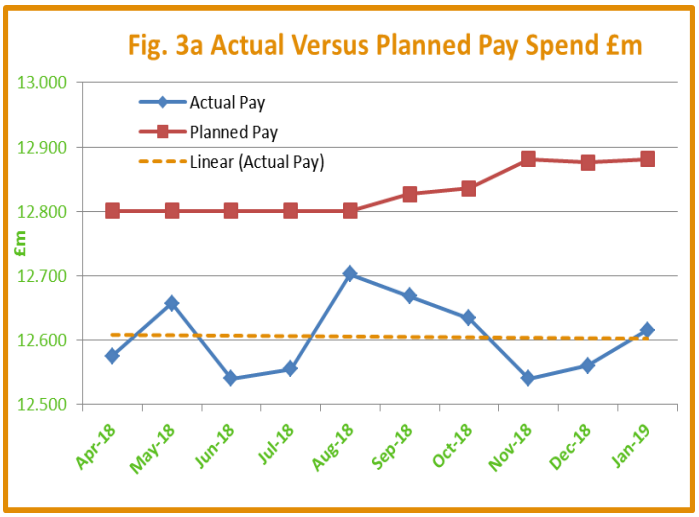
Metric	Rating	Reported Rating	Commentary
Capital Servicing Capacity	2.1 ↓	2 ↓	Slight fall in month as the loan capital repayment was made in month. NHSI sub region is confirming with regional lead that the bridging loan repayment can be excluded from the calculation.
Liquidity	1.1 →	1 →	Strong cash position of £58m supporting liquidity metric.
I&E Margin	2.1 →	2 →	Stayed the same in month.
I&E Variance	1.9 ↓	1 →	Slight fall in month due to surplus position
Agency Spend	1.8 ↑	1 →	Slight increase in rating in month due to fall in agency spend and release of agency accruals not required
UOR Overall		**1** →	

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

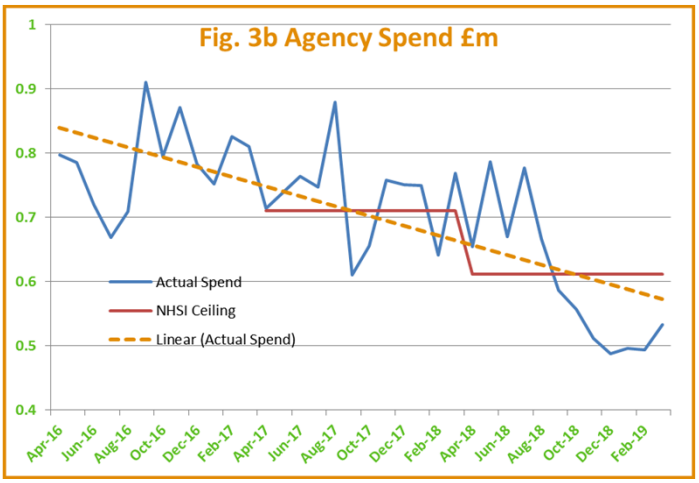


2.2 Fig. 2b shows the actual and planned surplus and deficit for the year, overall this shows the position behind Plan through to Month 4, then increasing and remaining consistently ahead of Plan, with the further reduction to come in just ahead of Plan due to expenditure on Estates in Quarter 4. In more detail, a deficit of £73k was reported for Quarter 1 only after releasing c. £1.4m of non-recurring accruals and provisions; Quarter 2 improved achieving a surplus of £161k with no releases; and Quarter 3 further improved with a surplus of £320k. Cumulatively this was a surplus of £408k at the end of Quarter 3, so with the run rate having improved to £100-200k per month surplus it was therefore agreed to spend c. £1m of Estates and Environmental works during Quarter 4. With this additional expenditure Quarter 4 reported a deficit of £16k giving an overall position of £392k surplus for the year. These figures are before the Provider Sustainability Fund (c. £3.6m expected for the year as the Control Total of £360k surplus has been met and exceeded).

3. *Trading Position*



3.1 Pay costs totalled £151.2m for the full year against a Plan of £154.1m and £12.6m in March against a Plan of £12.9m as shown in Fig. 3a. Although there have been increases and decreases during the year, in part due to the way the pay award was made, pay overall has changed very little in the last 12 months, as shown by the linear trend (dotted orange line) being fairly flat. Substantive pay spend was 85% of the total pay for the year and Bank pay was 10%.



3.2 Agency spend was reported as £6.8m for the year and £319k for the month, this is after a release of £214k old year accruals so the underlying position was £7.0m for the year (under the NHSI Ceiling) and £533k for the month. Overall this was 4.5% of the total pay expenditure for the year, the lowest level for some years. Fig. 3b shows a linear reduction

(dotted orange line) over the last several years, from average £785k / month 16/17, to average £601k / month 18/19.

3.3 SBUs maintain regular forecasts of agency spend which are combined into an overall forecast trajectory for the Trust. The final position shows that spend was £525k less than the NHSI Ceiling of £7.3m after the release of c. £350k of prior year accruals during the 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.

3.4 The NHSI Ceiling will remain at £7.3m for 2019/20 but internally the Trust has set a ceiling of £5.8m based on making some improvement to the current run rate, and this will support the Delivering Value programme. Success is dependent upon continuing focus on recruitment and retention of key staff groups, particularly inpatient staff, CAMHs Medical, and Care Co-ordinators within Adult Community and CAMHs Teams.

3.5 Year to date performance against the NHSI Ceiling in 2018/19 and the Internal Trust Ceiling for 2019/20 is illustrated in Fig. 3c below:

Fig. 3c Performance against NHSI Ceiling by SBU	Actual Full Year 2017/18	Full Year NHSI Ceiling 2018/19	Full Year Actual 2018/19	Full Year Variance 2018/19 (+adv/-fav)	Internal Trust ceiling 2019/20
	£000	£000	£000	£000	£000
E&N SBU	3,806	3,505	3,146	-359	2,800
LD&F SBU	499	423	464	42	427
Essex & IAPT SBU	419	307	272	-35	209
West SBU	3,125	2,517	2,520	3	2,138
Support Services	605	575	746	170	227
Capital & YE accounting			-346	-346	0
Total	**8,455**	**7,327**	**6,802**	**-525**	**5,800**

3.6 Secondary Commissioning reports above Plan by £2.3m for the full year and £277k for the month after adjusting for netting off CAMHs T4 and partial release of the CHC Appeals provision. Although this remains an adverse position, it did improve during the year in a number of areas, including:

3.6.1 CAMHs T4 NCM – an average of £359k/month during Quarters 1 to 3 reducing to an average of £232k/month during Quarter 4. For April 2019 the spend is expected to be around £150k if the current level of placements can be maintained;

3.6.2 External Acute and PICU – an average of £257k/month during Quarter 1 reducing to an average of £80k/month during Quarters 2 and 3, but then increasing again to an average of £164k/month during Quarter 4. For April 2019 the spend is expected to be between £225k and £300k dependent on level of funded observations and on progress made repatriating individuals;

3.6.3 Main Health Placements – an average of £576k/month during Quarters 1 and 2 reducing to an average of £504k/month during Quarters 3 and 4. For April 2019 the spend is expected to be between £450k and £500k dependent on level of funded observations.

3.7 However there were also increases later in the year, such as Acute and PICU, and spend on Social Care Placements and on Personal Budgets didn't decrease during the year. Mitigating actions include:

3.7.1 Regular review of External Acute and PICU placements and of observation levels.

3.7.2 Social care transformation project to address social care spend on both placements and personal budgets in the medium to long term.

3.7.3 Some further reductions expected on Health Placements as the result of New Sovereign House opening end April / May.

3.7.4 Discharge to Assess Pilot starting in May funded directly by commissioners, which should relive pressure to place in Social Care Placements direct from acute beds.

3.7.5 Transfer of those with Korsakoff's diagnosis to Hertfordshire County Council

Fig. 3e below shows the position by type including forecast figures for April taking into account emerging issues, and Fig. 3f shows the total number of changes in year in the main groups:

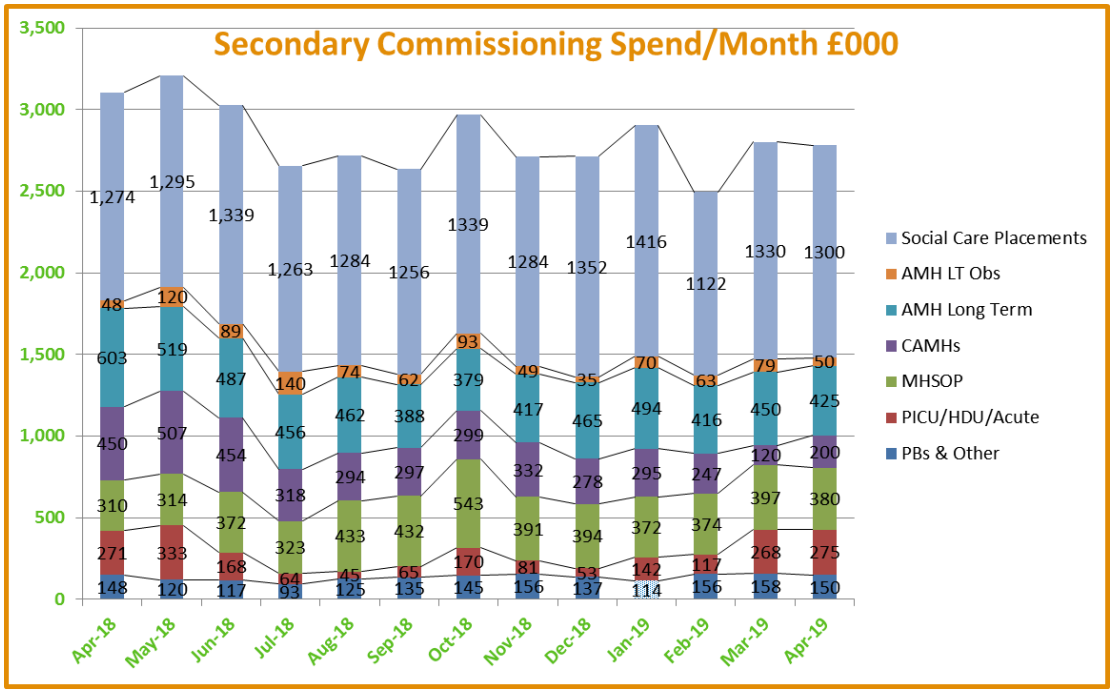


Fig. 3f	01/04/2018	Started	Ended	31/03/2019
MHSOP	72	67	63	76
Main Health	47	25	37	35
Social Care	429	127	124	432
Total	548	219	224	543

3.8 Overhead costs remain above Plan by c. 7% for the year, including in particular Consultancy, Information Technology, Estates and Project Costs, and Site Costs, with c. £1m just on Estates and Environment costs in Quarter 4. These all relate to improving environments and services across the Trust.

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 full year. Whilst this sets out a positive picture overall, it should be noted that there are risks going into the new financial year:

4.1.1 This successful position for 2018/19 was achieved only with non-recurring releases of £1.4m during Quarter 1.

4.1.2 Although secondary commissioning costs decreased in some areas during 2018/19 (notably CAMHs T4 NCM, PICU and Main Health Placements), other areas didn't (Social Care Placements, Personal Budgets). Additionally, there has recently been significant additional pressure from both PICU and External Acute Placements.

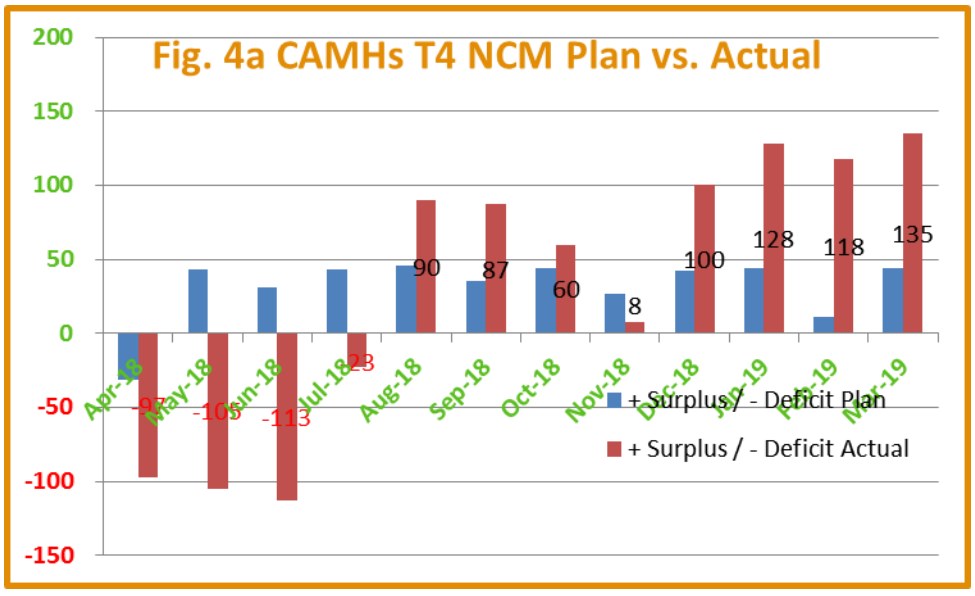
4.1.3 The Plan for 2019/20 assumes a further reduction in agency costs.

4.1.4 Pay costs increase significantly again from 1st April 2019, and whilst this is broadly funded, there are incremental pressures from pay points being merged.

4.1.5 Whilst agency has reduced significantly during 2018/19, recruitment remains a key challenge, particularly in key areas such as CAMHs, Medical, and areas that are closer to London. There has been additional investment into 2019/20 but this does need successful recruitment to function without resort to agency.

4.1.6 The extension to the Essex LD contract commenced in November and as such remains in a period of integration and embedding of the extended service. At this point costs are to Plan levels but this will continue to be tracked closely into the new year.

4.1.7 The Trust's CAMHs Tier 4 NCM service was set up on the basis that specialist community teams would 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, but it will be important to keep momentum into the new year. Fig. 5a below shows the surplus or deficit for the full year.



5. Income and Major Contracts

5.1 Total income planned for the year was adjusted to £230.9m, before PSF, including £214.8m from Main Commissioners, of which £170.9m is in respect of Hertfordshire. After adjusting for netting off CAMHs T4 with NHS England, £232.0m was received, c. £1.1m ahead of Plan.

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 included at 78.5%, a loss of c. £750k, most of which was already reported in the positon up to Month 11. The final figure is not yet known. For North Essex Learning Disability 50% was achieved for Months 1 to 5, and a similar amount has been included for the new Essex Learning Disability Contract for Months 6 onwards.

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 for the year 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.

6. Delivering Value

6.1 2018/19

6.1.1 The net Delivering Value Programme requirement for 2018/19 of £4.7m was achieved. The main elements which contributed to the programme were: Closure of Elizabeth Court, reduction in health placements, reduction in net agency spend, reduction in external acute placements, and closure of Sovereign House.

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.

6.2.2 A list of developed schemes, plans in progress, and opportunities for efficiency has been drawn up which identifies potential savings totalling between £3.2m and £5.2m.

Fig. 6a Indicative programme value range RAG rated	Worst case £000s	Best case £000s
Green	584	642
Green/ Amber	1,969	2,385
Amber	391	1,309
Red	226	854
Programme value range RAG rated total	**3,170**	**5,190**

A more detailed list is set out in the appendices with schemes listed according to the NHSI categories as Developed, Plans in Progress, and Opportunities.

6.2.3 Both the requirement and the scheme 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 estimate of the shortfall against requirement is between £2.0m and £3.0m. Immediate actions to address this include:

6.2.4.1 Developing opportunities identified into schemes.

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.

Current Trading - Income Statement for Period Ended 31-March-2019

Actual in month Mar-18	Actual YTD to 31-Mar-18	Description	2018/19 Plan	Month Mar - 19 Actual	Plan	Variance	Year to Date Mar - 19 Actual	Plan	Variance	Year to Date E&N	West	LD	Support	Other	Total
31	31	Number of Calendar Days	365	31	31		365	365							
0	0														0
13,493	167,587	Contract #1 Hertfordshire IHCCT	170,897	14,002	14,259	(257)	170,376	170,897	(521)	21	(0)	(0)	(0)	170,355	170,376
378	18,150	Contract #2 East of England	22,876	(1,807)	1,906	(3,714)	18,496	22,876	(4,380)	(0)	(0)	(0)	(0)	18,496	18,496
713	9,467	Contract #3 Essex LD	12,378	1,213	1,363	(150)	12,115	12,378	(263)	(0)	(0)	(84)	(0)	12,200	12,115
168	2,023	Contract #4 Norfolk (Astley Court)	2,166	111	181	(70)	2,095	2,166	(71)	(0)	(0)	(0)	(0)	2,095	2,095
476	6,595	Contract #5 IAPT Essex	6,579	378	548	(170)	6,604	6,579	25	(0)	(0)	136	(0)	6,467	6,604
319	3,769	Contract #6 Bucks Chiltern CCG	3,807	329	317	11	3,819	3,807	12	(0)	(0)	(0)	(0)	3,819	3,819
15,548	207,592	Contracts	218,703	14,225	18,574	(4,349)	213,504	218,703	(5,199)	21	(0)	52	(0)	213,431	213,504
61	1,123	Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	1,085	134	90	44	1,126	1,085	41	1,217	(0)	(0)	(0)	(90)	1,126
698	4,420	Education and training revenue	3,094	539	263	276	4,502	3,094	1,408	99	483	586	1,044	2,290	4,502
776	2,801	Misc. other operating revenue	4,248	507	334	173	5,490	4,248	1,241	590	553	542	1,658	2,146	5,490
411	5,154	Other - Cost & Volume Contract revenue	5,332	479	444	35	5,095	5,332	(237)	(0)	(0)	5,095	(0)	(0)	5,095
209	2,589	Other clinical income from mandatory services	1,999	186	167	20	1,965	1,999	(34)	223	377	1,303	35	27	1,965
197	528	Research and development revenue	403	79	34	45	357	403	(45)	(0)	1	5	351	(0)	357
2,789	4,322	Provider Sustainability Fund	1,775	1,967	207	1,760	3,535	1,775	1,760	(0)	(0)	(0)	(0)	3,535	3,535
(0)	(0)	Other block	(0)	(0)	(0)	(0)	(0)	(0)	(0)	54,710	53,522	63,385	22,446	(194,062)	(0)
20,690	**228,529**	**Total Operating Income**	**236,639**	**18,117**	**20,113**	**(1,996)**	**235,574**	**236,639**	**(1,065)**	**56,859**	**54,934**	**70,969**	**25,535**	**27,277**	**235,574**
(10,208)	(122,701)	Employee expenses, permanent staff	(130,293)	(10,888)	(10,900)	12	(128,679)	(130,293)	1,614	(36,257)	(37,102)	(35,267)	(15,609)	(4,444)	(128,679)
(1,448)	(15,896)	Employee expenses, bank staff	(16,447)	(1,437)	(1,378)	(59)	(15,753)	(16,447)	694	(4,279)	(5,813)	(4,789)	(813)	(58)	(15,753)
(449)	(8,454)	Employee expenses, agency staff	(7,328)	(319)	(611)	291	(6,802)	(7,328)	526	(3,146)	(2,520)	(736)	(709)	309	(6,802)
27	(362)	Clinical supplies	(269)	(28)	(22)	(5)	(394)	(269)	(125)	(184)	(90)	(86)	(38)	4	(394)
177	(27,522)	Cost of Secondary Commissioning of mandatory services	(30,676)	(591)	(2,598)	2,007	(30,709)	(30,676)	(33)	(5,241)	(2,535)	(22,103)	(0)	(829)	(30,709)
(0)	(0)	Other Contracted Services	(4,034)	(649)	(667)	18	(3,982)	(4,034)	52	(0)	(0)	(3,982)	(0)	(0)	(3,982)
(26)	(269)	GP Cover	(279)	78	(23)	101	(196)	(279)	83	(120)	(3)	(193)	(0)	119	(196)
(251)	(2,974)	Drugs	(2,646)	(242)	(221)	(21)	(3,116)	(2,646)	(470)	(1,619)	(1,319)	(241)	56	7	(3,116)
(12,178)	**(178,177)**	**Total Direct Costs**	**(191,972)**	**(14,076)**	**(16,420)**	**2,344**	**(189,630)**	**(191,972)**	**2,342**	**(50,845)**	**(49,381)**	**(67,398)**	**(17,114)**	**(4,892)**	**(189,630)**
8,512	50,352	Gross Profit	44,667	4,041	3,693		45,944	44,667		6,014	5,553	3,571	8,421	22,385	45,944
41.14%	22.03%	Gross Profit Margin	18.88%	22.31%	18.36%		19.50%	18.88%		10.58%	10.11%	5.03%	32.98%	82.07%	19.50%
		Overheads													
(309)	(957)	Consultancy expense	(628)	(21)	(51)	31	(701)	(628)	(73)	(18)	(16)	(86)	(568)	(14)	(701)
(440)	(1,242)	Education and training expense	(1,074)	(180)	(122)	(58)	(1,060)	(1,074)	14	(80)	(64)	(80)	(808)	(28)	(1,060)
(710)	(4,549)	Information & Communication Technology	(4,104)	(412)	(341)	(71)	(4,568)	(4,104)	(465)	(144)	(236)	(336)	(3,827)	(24)	(4,568)
(533)	(4,183)	Hard & Soft FM Contract	(5,144)	(475)	(428)	(47)	(5,473)	(5,144)	(329)	(4)	(0)	(3)	(0)	(5,465)	(5,473)
(1,050)	(7,267)	Misc. other Operating expenses	(6,694)	1,361	(386)	1,747	(5,934)	(6,694)	760	(801)	(1,219)	(1,703)	(1,919)	(291)	(5,934)
(808)	(6,523)	Other Contracts	(4,144)	(940)	(345)	(595)	(5,040)	(4,144)	(896)	(484)	(1,950)	(710)	(1,297)	(600)	(5,040)
(83)	(659)	Non-clinical supplies	(399)	(11)	(33)	22	(578)	(399)	(179)	(158)	(119)	(241)	(81)	21	(578)
(42)	(5,350)	Site Costs	(5,547)	(535)	(462)	(73)	(6,280)	(5,547)	(734)	(3)	0	(3)	(8)	(6,267)	(6,280)
1,000	(0)	Reserves	(1,955)	69	(159)	228	(0)	(1,955)	1,955	(0)	(0)	(0)	(0)	(0)	(0)
(424)	(3,743)	Travel, Subsistence & other Transport Services	(3,732)	(286)	(313)	27	(3,913)	(3,732)	(181)	(1,004)	(1,488)	(936)	(484)	(2)	(3,913)
(3,399)	**(34,474)**	**Total overhead expenses**	**(33,422)**	**(1,431)**	**(2,641)**	**1,210**	**(33,549)**	**(33,422)**	**(127)**	**(2,698)**	**(5,092)**	**(4,099)**	**(8,991)**	**(12,669)**	**(33,549)**
5,112	**15,879**	**EBITDA**	**11,246**	**2,610**	**1,053**	**1,557**	**12,396**	**11,246**	**1,150**	**3,316**	**461**	**(528)**	**(570)**	**9,716**	**12,396**
24.71%	6.95%	EBITDA Margin	4.75%	14.40%	5.23%		5.26%	4.75%		5.83%	0.83%	-0.74%	-2.23%	35.61%	5.26%
(424)	(4,927)	Depreciation and Amortisation	(5,025)	(432)	(419)	(13)	(4,887)	(5,025)	138	(0)	(0)	(140)	(0)	(4,747)	(4,887)
9	(382)	Other Finance Costs inc Leases	(354)	(25)	(29)	5	(317)	(354)	36	(0)	(0)	(0)	(317)	(0)	(317)
345	345	Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(32)	(0)	(32)	(0)	(0)	(0)	(0)	(32)	(32)
20	142	Interest Income	168	35	14	21	350	168	182	(0)	(0)	(0)	350	(0)	350
(123)	(3,308)	PDC dividend expense	(3,900)	(236)	(325)	90	(3,582)	(3,900)	318	(0)	(0)	(175)	(0)	(3,407)	(3,582)
4,940	**7,749**	**Net Surplus / (Deficit)**	**2,135**	**1,952**	**293**	**1,659**	**3,927**	**2,135**	**1,792**	**3,316**	**461**	**(843)**	**(537)**	**1,530**	**3,927**
23.88%	**3.39%**	**Net Surplus margin**	**0.90%**	**10.78%**	**1.46%**		**1.67%**	**0.90%**		**5.83%**	**0.84%**	**-1.19%**	**-2.10%**	**5.61%**	**1.67%**
2,151	**3,427**	**Net Surplus / (Deficit) before PSF**	**360**	**(15)**	**86**	**(101)**	**392**	**360**	**32**						

Hertfordshire Partnership University NHS Foundation Trust

Trust Board

Meeting Date:	9th May 2019	**Agenda Item: 14**
Subject:	2019-20- Financial Plan	**For Publication: No**
Author:	Paul Ronald Deputy Director of Finance	**Approved by:** Keith Loveman Executive Director - Finance
Presented by:	Paul Ronald Deputy Director of Finance	

Purpose of the report:

To inform the Board of the submission of the Trust's Financial Plan to NHSI for the new financial year.

Action required:

The Board is asked to note the submission;

- Was in accordance with previous papers and discussions on the detail and risks regarding the planned submission.
- incorporated the feedback from NHSI on the initial draft
- met the requirements of the NHSI Control Total (breakeven)
- included a Delivering Value program requirement of £6.5m which is very stretching

Summary and recommendations to the Board:

Introduction

This paper is to confirm that the Trust submitted its Annual Plan which is a mandatory submission in accordance with the National Timetable on April 4th 2019. This followed an initial draft submission made on February 12th 2019 and updated the draft to reflect any changes between the two dates. In particular the final submission was updated to reflect the final detail regarding the successful renewal of the Trust's main contracts. This saw an increase in revenue with a corresponding increase in operational cost**.**

In relation to the Financial Planning process for FY1920 then as advised previously its development and refinement has been done in conjunction with the Annual Plan, the contract discussions and any further requirements of NHSI or the STP requirement. With the objectives of ensuring;

- 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.

This paper does not provide any detailed analysis of the assumptions relating to the submission which were reported and approved previously.

In terms of the main financial elements then the Plan continues to show;

- The Control Total set by NHSI being met
- An FRR for the year of 1 (the highest rating)
- Level of Agency spend below the Agency Cap

As reported throughout **despite having a reduced Control Total break even requirement for next year; this will be financially challenging particularly given the pay increase pressure and the commissioner expectations on service development.**

The indicative annual Delivering Value requirement has been initially calculated at circa £6.5m and ongoing programmes and new schemes are being developed to achieve this. The efficiency requirement is higher than 2018-19 and whilst this is clearly a risk, the considered assessment is that with some remaining balance sheet flexibilities and the short term favourable financial impact from the "time to hire" process the Control Total can be met and on this basis the related declarations were completed as approved by the Finance & Investment Committee meeting of March 19th 2019.

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

Previous paper for which this is an update seen
Executive Team 19 December 2018
Finance & Investment Committee 22 January 2019

1. Introduction

The Purpose of this paper is to confirm the final submission of the Financial Plan for 19/20. This was based upon the full analysis provided to the Board in February and further updated and reviewed at the Finance and Investment Committee in March.

2. Background

As the first year of the NHS Ten Year Plan NHSI has made major changes to the provider sector's financial architecture particularly focussed on addressing the long term deficits across the acute sector. **Whilst the headline settlement figures and the continuing commitment to the Mental Health Investment Standards appeared encouraging the reality is different and our analysis confirmed with peer organisations is that the contract uplifts will be largely absorbed on pay with little left for delivering on service developments.**

In developing the Financial Plan we will use the central tests set to measure progress of;

- Improve productivity and efficiency
- 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.

3. Changes between the draft and final submission

The summary headlines are shown in the table below, with minimal changes from the draft to final version. The key change being with revenue which increased by £7.6m with an increase in the new contract values and in the level of deferred income from the unplanned funding received from commissioners very late in Quarter Four.

FY19-20 Key Financial Headline comparisons

	Draft	Final
Revenue	246.0	253.6
EBITDA	11.3	11.3
Surplus (before PSF)	0.0	0.0
PSF	1.9	1.9
Delivering Value	**4.8**	**6.5**
Agency	5.8	5.8
FRR	1	1
Capital Plan (net)	12.1	12.2
Closing cash	**51.6**	**51.7**

4. Planned Financial Risk Ratings for FY1920

The assessed ratings for the submission are shown below and report throughout as a 1 with a rating of 2 on capital service (due to the Loan repayments) and on the I&E margin with the continuing low margin from the block contract arrangements. The Board should note that the

rating for the year 18/19 which is currently showing as a 3 has been appealed and is expected to be adjusted to a 1.;

	Year Ending Rating	Q1 Rating	Q2 Rating	Q3 Rating	Q4 Rating	Year Ending Rating
Capital service cover	4	1	2	2	2	2
Liquidity	1	1	1	1	1	1
I&E margin	2	2	2	2	2	2
Variance From Control Total	1	1	1	1	1	1
Agency	1	1	1	1	1	1
Plan risk rating after overrides	3	1	1	1	1	1

Whilst showing as a 1 any variation from the Control Total will see the overall Rating as a 2 with the key risks identified as;

Cost Pressures/New Investment

Cost Pressures/New Investment	Mitigation
Additional Volume of activity which is unfunded	Developing new approaches to demand management working closely with primary care Reviewing staffing establishment and introduce new roles and ways of working
Inadequate staffing levels or inappropriate mix of permanent and agency staff	Detailed recruitment planning with focused recruitment drives Recruitment incentives including the cohort of potential retirees
Creation of a specialist community PD team	This is seen as priority service development and will be funded initially through deferred income
Further investments in technology to support service quality including additional functionality required within PARIS	Currently undertaking stakeholder workshops will part be capital funded and utilising available NHS project funding
Likely additional cost with Interserve on existing services	Level of increase less than first anticipated with partial mitigation through DV program
Potential increase in Microsoft licence cost	Costs lower than first expected with impact more in following year
Extension of space at Colonnades	Partial funding through NHS Workforce central income

The assessment of the CRES value is as detailed below. This assessment will continue to evolve as the impact of the new recruitment and the pay impact become clearer.

Estimate of programme requirement	£000s
Pay award	7,461
Non pay	750
Less: net uplift and demography etc.	(10,021)
	(1,810)
Service Investments	7,012
Other including capital charges	1,250
REQUIREMENT	**6,452**

5. 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. 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.

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.

Trust Board

Meeting Date:	16th May 2019	**Agenda Item:** 15
Subject:	Gender Pay Gap Report (2017/18)	**For Publication:**
Author:	Maria Gregoriou, Associate Director of Workforce	**Approved by:** Steve Graham, Interim Deputy Director of Workforce and OD
Presented by:	Mariejke Maciejewski, Interim Director of Workforce and OD	

Purpose of the report:

To provide the Trust Board with an update on the Trust's Gender Pay Gap position for the financial year 2017/18 and seek board approval prior to publication of the report on the Trust website

Action required:

The Trust Board is asked to note and discuss the contents of report and approve publication of the data on the Trust website

Summary and recommendations

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017 requires all employers with 250 or more employees to report annually on their gender pay gap. This report outlines the Regulations, sets out the data we are legally required to report on, provides an analysis and sets out our next steps as a Trust

The Trust is obliged to publish the following information on our public-facing website and report to government by the 31st March 2019:

- The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the mean gender pay gap');
- The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the median gender pay gap');
- The difference between the mean bonus pay paid to male relevant employees and that of female relevant employees ('the mean gender bonus gap');
- The difference between the median bonus pay paid to male relevant employees and that of female relevant employees ('the median gender bonus gap')

2.2 In addition there is a requirements to publish

- The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay band ('the proportion of men and women in each of four pay quartiles').

2.3 The data is based on pay rates as of 31 March 2018 and bonus payments made during the year 1

April 2017 to 31 March 2018.

3. Gender Pay Gap and Gender Bonus Gap

3.1 The following Gender pay report data is taken as the snapshot date of 31 March 2018:

1.	The mean gender pay gap for HPFT	10.67%
2.	The median gender pay gap for HPFT	2.56%
3.	The mean gender bonus* gap for HPFT	36.34%
4.	The median gender bonus* gap for HPFT	66.29%

HPFT has a mean gender pay gap 10.67%; however the gender pay gap across the Agenda for Change workforce is only 1.32%.

Analysis of the other staff groups indicates that the Trust level gender pay gap may be attributed to consultant and non-consultant roles where the gender pay gap is 7% and 7.95% respectively and VSM (Very Senior Manager) roles with a mean pay gap of 6.41%.

The gender pay gap has attracted publicity in general terms since its introduction in March 2017. It has generated interest from current employees and from the equalities networks internally at HPFT.

Work on the Gender Pay Gap 2019 will begin with stakeholders with immediate effect in order to allow HPFT to review data on an ongoing basis so that our strategy can be regularly reviewed in accordance with the action plan. Due to the way the reporting cycle works, the impact of this work will not be seen until 2020.

Relationship with the Business 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

Hertfordshire Partnership University NHS Foundation Trust
Gender Pay Gap Report

1. Introduction

1.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017 requires all employers with 250 or more employees to report annually on their gender pay gap. This report outlines the Regulations, sets out the data we are legally required to report on, provides an analysis and sets out our next steps as a Trust.

1.2 The gender pay gap is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are.

1.3 We deliver equal pay through a number of means but primarily through adopting nationally agreed terms and conditions for our workforce which are as follows:

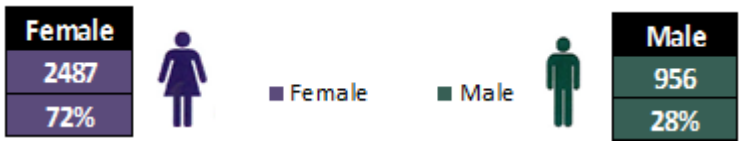
1.3.1 Agenda for Change, which is a national pay system which covers and typically applies to nursing, allied health professionals, and administration and clerical staff which make up the majority of the workforce. Where appropriate, locally agreed policies may supplement Agenda for Change arrangements such as family friendly policies.

1.3.2 Medical and Dental Terms and Conditions of service and pay arrangements are negotiated on behalf of employers by NHS Employers with NHS trade unions and apply to all consultants, medical staff and doctors in training. The Medical and Dental terms and conditions include the following:

- National Junior Doctor contract
- National Consultant contract
- Specialty and Associate Specialist contract (currently under review)

1.4 In addition, Trust contracts are used for Very Senior Managers (VSM), the Trust Chair and Non-Executive Directors (NEDs). As an NHS Foundation Trust, HPFT is free to determine its own rates of pay for its VSMs, Chair and NEDs. The VSMs include the Chief Executive, Executive Directors and other senior managers with board level responsibility.

1.5 The gender profile for HPFT is shown below:



2. Gender Pay Gap Reporting

2.1 The Trust is obliged to publish the following information on our public-facing website and report to government by the 31st March 2019:

- The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the mean gender pay gap');
- The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the median gender pay gap');
- The difference between the mean bonus pay paid to male relevant employees and that of female relevant employees ('the mean gender bonus gap');
- The difference between the median bonus pay paid to male relevant employees and that of female relevant employees ('the median gender bonus gap')

2.2 In addition there is a requirement to publish

- The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay band ('the proportion of men and women in each of four pay quartiles').

2.3 The data is based on pay rates as of 31 March 2018 and bonus payments made during the year 1 April 2017 to 31 March 2018.

3. Gender Pay Gap and Gender Bonus Gap

3.1 The following Gender pay report data is taken as the snapshot date of 31 March 2018:

1.	The mean gender pay gap for HPFT	10.67%
2.	The median gender pay gap for HPFT	2.56%
3.	The mean gender bonus* gap for HPFT	36.34%
4.	The median gender bonus* gap for HPFT	66.29%

3.1.1 For the calculation of hourly rate pay only 'Full Pay Relevant Employees' are to be included. A 'Full Pay Relevant Employee' is any employee who is employed on the snapshot date and who is paid their usual full basic pay (or pay for piecework) during the relevant pay period. This includes:

- Basic Pay
- Paid leave, including annual, sick, maternity, paternity and adoption or parental leave. The exception is where an employee is paid less than usual or is in the nil pay elements of maternity leave.
- Area and other allowances
- Shift premium pay which is defined as the difference between basic pay and any higher rate paid for work during different times of the day or night.
- Bank pay

The calculation for ordinary pay does not include any of the following;

- Remuneration referred to as overtime
- Remuneration referred to as redundancy
- Remuneration in lieu of leave

3.1.2 Within the Gender pay Gap Regulations, 'bonus pay' means any remuneration that is in the form of money relating to profit sharing, productivity, performance, incentive or commission.

3.1.3 The Clinical Excellence Awards (CEA) scheme is intended to recognise and reward those Consultants who perform 'over and above' the standard expected for their role and therefore for the purpose of Gender Pay Reporting, Clinical Excellence Awards payments are regarded as 'bonus pay'.

3.1.4 At HPFT the mean bonus gender pay gap only consist of CEA payments made to consultants. As at 31 March 2018, 28 male consultants and 22 female consultants were awarded CEAs. This equates to 59% of all male consultants and 41% of female consultants receiving a CEA.

4. Pay Quartiles by Gender

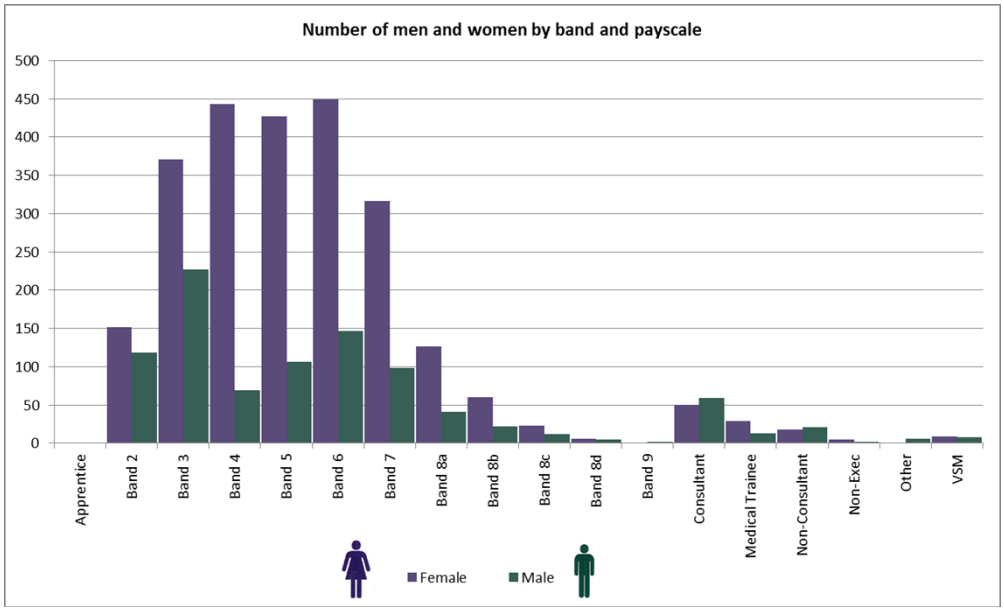
4.1 The pay quartiles shown in the table below are calculated by listing the rates of pay for every employee from lowest to highest, before splitting that list into four equal-sized groups and calculating the percentage of males and females in each.

Quartile	Female Headcount	Male Headcount	Female %	Male %	Description
1 (lowest paid)	625	235	72.67%	27.33%	Includes all employees whose standard hourly rate places them at or below the lower quartile
2	636	225	73.87%	26.13%	Includes all employees whose standard hourly rate places them above the lower quartile but at or below the median
3	651	210	75.61%	24.39%	Includes all employees whose standard hourly rate places them above the median but at or below the upper quartile
4 (highest paid)	575	286	66.78%	33.22%	Includes all employees whose standard hourly rate places them above the upper quartile

4.2 It can be seen from this table that the split between male and female employees is reasonably consistent until the 4th quartile (highest paid) where the percentage of female staff in this upper quartile reduces and the percentage of male staff in this quartile increases.

5. Overview of the distrubtion of gender by band and pay rates

5.1 The following table presents an overview of the breakdown of male and female workers in HPFT by band. This demonstrates that there are more female then male employees in all bands up to Band 8c. Posts above Band 8c have marginally more male than female staff.



5.2 This data can also be presented by gender, band and average hourly rate

Grade	Male Headcount	Female Headcount	Male Avg. Hourly Rate	Female Avg. Hourly Rate	Difference	Pay Gap %
Apprentice		1		3.84	-3.84	-100.00%
Band 2	118	152	11.63	11.95	-0.32	-2.79%
Band 3	227	371	11.99	11.29	0.69	5.79%
Band 4	69	443	11.59	11.63	-0.04	-0.33%
Band 5	106	427	15.25	14.33	0.93	6.07%
Band 6	147	449	17.97	17.69	0.29	1.59%
Band 7	98	316	20.57	19.61	0.96	4.67%
Band 8a	41	126	23.88	23.88	-0.01	-0.02%
Band 8b	22	60	28.65	28.73	-0.08	-0.30%
Band 8c	12	23	31.81	34.07	-2.25	-7.08%
Band 8d	5	6	40.97	40.86	0.11	0.27%
Band 9	2	1	46.17	51.36	-5.19	-11.24%
Consultant	59	50	46.02	42.80	3.22	7.00%
Medical Trainee	13	29	24.82	25.79	-0.98	-3.93%
Non-Consultant	21	18	32.81	30.20	2.61	7.95%
Non-Exec	2	5	7.78	8.09	-0.31	-4.00%
Other	6	1	13.75	52.41	-38.66	-281.22%
VSM	8	9	58.55	54.80	3.75	6.41%
Grand Total	**956**	**2487**	**18.57**	**16.59**	**1.98**	**10.67%**

6. Analysis of Mean Hourly Rate Gap

6.1 As shown previously, across all staff groups male staff earn on average £1.98 per hour more than female staff which leads to a mean gender pay gap of 10.67%. The median gender pay gap across all staff groups is 2.56%.

All Trust Staff – Overall Mean vs Median average hourly rate

Gender	Mean hourly rate	Median hourly rate
Male	£18.57	£14.96
Female	£16.59	£14.58
Difference	£1.98	£0.38
Pay Gap %	10.67%	2.56%

6.2 The majority of the workforce has Agenda for Change terms and conditions and the data shows us that there are mean pay gaps in favour of women at some bands and in favour of men in other bands.

6.3 When the mean pay of the agenda for change staff group is calculated alone the result is significantly smaller than the Trust's mean pay gap (see table below).

Agenda for Change Staff – Overall Mean vs Median average hourly rate

Gender	Mean hourly rate	Median hourly rate
Male	£15.89	£14.19
Female	£15.68	£14.26
Difference	£0.21	£0.07
Pay Gap %	1.32%	-0.49%

6.4 The difference in pay is reduced to twenty one pence and the mean gender pay gap is 1.32%. The median gender pay gap is in favour of women, at -0.49%.

6.5 This suggests the Trust's overall gender pay gap is impacted by non Agenda for Change staff.

6.6 There are a small number of staff employed by HPFT on what have been categorised as Trust Contracts and shown in the category "other". Typically these are substantive members of staff engaged on contracts reflecting the terms and conditions associated with TUPE transfers from non NHS organisations where staff are not on Agenda for Change pay and are paid what is known as a "spot salary" or bank workers who have been engaged on salaries which do not slot into an Agenda for Change salary range. There are 6 male staff in this category and 1 female member of staff. The gender pay gap in this category is – 281.22% a pay gap in favour of the female member of staff.

6.7 The mean gender pay gap has narrowed at VSM level. In the 31 March 2017 report there were 9 males and 8 female employees with a pay gap of 27.22% and a difference in the hourly rate of £19.82. By comparison this year there are 8 males and 9 females with an average gender pay gap of 6.41% and a difference in the hourly rate of £3.75.

6.8 In the Non-Executive group the number of male and females has remained the same for both reporting years 2017 and 2018 with 2 male and 5 female non execs with an average gender pay gap of -4% in favour of women.

6.9 The medical staff group (including non-consultants, consultants and medical trainees) has a mean gender pay gap of 11.70%, with male medical staff earning on average £4.69 an hour more than female medical staff. This due, in the main, to the process by which medics moved up the salary scale based on experience and also the historical process by which medics could negotiate their starting salary. Both of these processes have now changed to ensure equity of application.

Medical Staff – Overall Mean vs Median average hourly rate

Gender	Mean hourly rate	Median hourly rate
Male	£40.07	£41.07
Female	£35.38	£36.88
Difference	£4.69	£4.19
Pay Gap %	11.70%	10.20%

7. Analysis of Bonus Payment Gap

7.1 At HPFT the mean bonus gender pay gap only consists of clinical excellence award (CEA) payments made to consultants.

7.2 As at 31 March 2018, 28 male consultants and 22 female consultants were awarded CEAs. This equates to 59% of all male consultants and 41% of female consultants receiving a CEA.

Bonus (Clinical Excellence Awards) Mean vs Median average payment

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£11,206	£8,938
Female	£7,134	£3,013
Difference	£4,072	£5,925
Pay Gap %	36.34%	66.29%

7.3 The mean gender bonus gap is 36.34% in favour of male consultants who earn on average £4,072 more than female consultants in bonus payments. This also equates to a 66.29% median bonus pay gap which indicates most of the high awards are with male medical staff.

8. Conclusion

8.1 HPFT has a mean gender pay gap of 10.67%; however the gender pay gap across the Agenda for Change workforce is only 1.32%.

8.2 Analysis of the other staff groups indicates that the Trust level gender pay gap may be attributed to consultant and non-consultant roles where the gender pay gap is 7% and 7.95% respectively and VSM (Very Senior Manager) roles with a mean pay gap of 6.41%.

8.3 The gender pay gap has attracted publicity in general terms since its introduction in March 2017. It has generated interest from current employees and from the equalities networks internally at HPFT.

9. Next Steps

9.1 Work on the Gender Pay Gap 2019 will begin with stakeholders with immediate effect in order to allow HPFT to review data on an ongoing basis so that our strategy can be regularly reviewed in accordance with the action plan.

9.2 The use of spot salaries on the bank will be reviewed.

9.3 Family friendly and flexible working policies will be developed and implemented to increase the attractiveness of the Trust

9.4 Within the medical workforce more rigour has been introduced in the negotiations of starting salaries, and great flexibility is awarded for part time workers to progress.

9.5 With regard to Clinical Excellence Awards changes, are being introduced to policy and process to ensure more female medical staff are encouraged and do apply for awards.

9.6 Whilst the impact of this work to date with regards to the gender pay gap will not be published until 2020 regular reviews of the plans and evaluation of the impact will take place through 2019/2020.

Maria Gregoriou
Associate Director of Workforce
March 2019

Hertfordshire Partnership University NHS Foundation Trust

Trust Board

Meeting Date:	9th May 2019	**Agenda Item: 16**
Subject:	Report from the Chair of the Audit Committee – meeting held 24 April 2019	**For Publication: Yes**
Author:	Keith Loveman Executive Director - Finance	**Approved by:**
Presented by:	Catherine Dugmore Audit Committee Chair	Keith Loveman Executive Director - Finance

Purpose of the report:

This paper provides a summary report of the items discussed at the Audit Committee meeting on 24 April 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 Audit Committee met on 24 April and considered the following matters:

- Internal Audit
  - Progress and Exception report
  - Annual Report 2018/19 including Draft Head of Internal Audit Opinion
  - Plan for 2019/20
- Local Counter Fraud Service
  - Annual Report 2018/19
  - Procurement Investigation – Final Report
  - Plan for 2019/20
- External Audit 18/19 Audit Opinion Plan
- 2018/19 Accounting – Update
- Draft Annual Governance Statement 2018/19
- Annual Report/Quality Account Update
- Review of Accounting Policies
- FT Code of Governance Compliance Statement
- Use of Waivers
- Trust Risk Register
- Board Assurance Framework
- Six Monthly Reports
  - Finance and Investment Committee
  - Integrated Governance Committee
- Review of Minutes
  - Finance and Investment Committee
  - Integrated Governance Committee

Internal Audit – Progress and Exception Report

The Head of Internal Audit presented the Internal Audit Progress Report. The Internal Audit Reports finalised in the period were reviewed and the Assurance Opinion in each case noted.

- Equipment and Medical Device Maintenance – Partial Assurance. The Committee noted that this focussed on the SLA with West Herts Hospitals and that high level specialist equipment, such as within the ECT suite, was maintained by the supplier companies. The SLA covered items such as wheelchairs. It was noted that a new SLA is being finalised with an alternative provider and in the interim processes at a local level have been implemented being led by the Deputy Director of Safer Care and Standards.
- Service Line Reporting – Patient Level Costing Preparation – Reasonable Assurance. The review was to assess the Trust's readiness to provide a voluntary submission of costing data.
- Key Financial Controls – Reasonable Assurance.
- Mandatory Training – Partial Assurance. There had been a delay in mapping mandatory training to each role across the organisation. All roles have now been assigned the right level of compliance training and compliance rates for individuals are now at 90%.
- Data Security and IG Toolkit (Advisory) – Areas for action were identified and four low priority management actions have been agreed.
- Health and Safety- Service User Contact – Reasonable Assurance. This is driven by the monitoring process of the Loan Worker device. The Committee heard that a new Health and Safety Lead has been appointed and there is a forthcoming HSE Inspection planned which will focus on safety of staff.
- Data Quality – SPIKE – Reasonable Assurance – A small number of data quality issues and training provision issues were identified. Generally the data tested was complete and accurate. It was noted that SPIKE has been positively received across the Trust.
- CQC Action Plan Stage 2 (Advisory) – An initial piece of work has been undertaken assessing 5 actions. Two have been completed and the 3 are on-going.

Internal Audit - Annual Report 2018/19 including Draft Head of Internal Audit Opinion
The Head of Internal Audit Opinion was presented, based on the work performed and the overall adequacy of HPFT's risk management, controls and governance processes during the year. A positive opinion has been given; however it was noted that the Trust has received slightly more partial opinions than in previous years which is a reflection of the audit areas being reviewed. The Committee agreed to track through where there have been any changes at the meeting in September.

Internal Audit - Plan for 2019/20
The Committee considered the Internal Audit Strategy for 2019/20. Work had been undertaken with Management in relation to scope and to ensure all areas link to the annual business plan. The Internal Audit Charter remains unchanged but now includes GDPR. Following discussion, it was agreed that the Plan for 2019/20 will come back to Audit Committee in September to consider any work following the CQC and HSE inspections.

Local Counter Fraud - LCFS Annual Report 2018/19
Audit Committee received the annual report which set out:

The Self-assessment Review Tool (SRT) resulted in an amber rating indicating the Trust was assessed as partially compliant with standards. The Committee discussed in detail the key aspects and any potential impact. Concern was raised that the Trust was seen to be non-compliant however RSM explained that in part this has no impact as it relates to timings of uploading reports to the NHS system and not to dealing with actual issues. Audit Committee also noted however that Conflicts of Interest and the declaration of gifts/hospitality is a piece of work being taken forward which feeds into a number of the measured domains and also impacts across the whole organisation. Management were asked to consider whether this needs to be referenced within the Risk Register and the mitigating actions to be considered.

The Committee reviewed the referrals and investigations carried out during the year.

Local Counter Fraud - Procurement Investigation – Final Report

A one-off piece of work had been commissioned by the CEO to undertake an advisory review on procurement processes following an HR investigation by the Trust due to possible fraudulent invoicing procedures. The review identified several areas where the Trust could strengthen its processes in relation to it procurement activities;

- The Standing Financial Instruction authorisation limits.
- The application of the declaration of interest requirements from staff.
- Some areas of procurement policy particularly regarding tenders.
- Contract management of key supplier contracts.
- Business analytics to proactively support value for money/identification of fraud.

The Deputy Director of Finance advised that actions have been put in place to address the areas of weakness and to close any loopholes. Audit Committee requested that Procurement processes be the topic of a deep dive for the meeting in September.

Local Counter Fraud - Work Plan for 2019/20
Audit Committee reviewed the proposed work plan for 2019/20. The Deputy Director of Finance advised that the plan would be linked with the Finance Team and will be used as a live tool for day to day management.

External Audit – 2018/19 Audit Opinion Plan Update
KPMG presented the External Audit Opinion plan setting out the work that has been undertaken since the last meeting of Audit Committee in December.

Amendments have been made to the planned audit approach in respect of the Financial Statements Audit and KPMG highlighted additional costs that may be incurred as a result of the required changes and additional audit procedures in relation to the ESR IT control environment where weaknesses had been identified. The Committee were advised that processes had been put in place to address this and that Internal Audit had been requested to review these.

During the year a number of staff from Essex were TUPE'd to the Trust and as a result additional audit procedures will be required to ensure accuracy of the Trust's accounting treatment and disclosure.

The Quality Report indicator testing has taken place and whilst there are no concerns with the accuracy of data for Older People; EIP and 7-day follow up presented data quality issues that have since been rectified.

The VFM review raised no issues**.**

2018/19 Accounting – Update
Audit Committee received a presentation setting out the draft annual accounts position for 2018/19. The Deputy Director of Finance confirmed that the draft accounts had been submitted earlier in the day. A headline surplus of £2.9M (including PSF) was reported having achieved the Control Total however the NHSI rating remained under discussion with the NHSI team as it was perversely impacted by the in-year loan repayment.

The financial position had been difficult in Quarter 1 but the Trust had seen a sustained improvement from Quarter 2 onwards. Audit Committee noted the following;

- The Trust has delivered on the Agency Cap
- Delivered on the Delivering Value programme (CRES)
- Achieved 80% CQUIN for the year.
- Achieved a 5 year contract with Hertfordshire

Draft Annual Report 2018/19
The draft report was presented and Audit Committee was asked to note progress and the timelines for internal and external agreement before presenting to Parliament. KPMG will audit the report and in particular consider the required disclosures for compliance. Committee members were requested to give any specific comments outside of the meeting, with a separate meeting in mid-May to review the report in detail prior to Board approval.

Draft Annual Governance Statement 2018/19

The draft Annual Governance Statement was presented and Audit Committee was asked to:

- confirm that the mandatory statements made by the Accounting Officer (CEO) on behalf of the Trust Board are accurate and supported by the evidence presented; and
- confirm the accuracy of the supporting evidence.

The Committee discussed the detail of the statement covering the Head of Internal Audit Opinion, carbon reduction, information governance and how the Committee could keep sighted on pertinent issues throughout the year. It was noted that this would come back once finalised for formal review.

Draft Quality Report 2018/19

The report was presented for noting and had been separately circulated to IGC and to stakeholders for comment. KPMG had also been involved in ongoing review. The Committee welcomed the significant progress with the report.

Review of Accounting Policies

The Deputy Director of Finance reported that the main the accounting policies had been reviewed, as part of the preparation for completing the 2018/19 financial statements, to ensure their suitability.

The main identified change from the General Accounting manual is the requirement to;

1. Adopt IFRS 9, Financial Instruments, superseding IAS 39, and Financial Instruments: Recognition and Measurement.
2. Adopt IFRS 15, Revenue from Contracts with Customers, superseding IAS 18, Revenue and IAS 11, Construction Contracts.

In relation to the ongoing accounting requirements of the Trust then neither of these changes will have any material impact.

In addition it was highlighted that as commented by KPMG in their report, following the TUPE transfer of 16 employees as part of the extended contract for Learning Disability services in Essex then these staff will be part of a separate pension scheme and will be accounted for separately. There is no material impact from this.

As advised previously to the Committee, following a full revaluation in 2017/18 there will not be a full Asset revaluation in 2018/19. The Trust has engaged the District Valuer to provide impairment reviews on properties that have had significant investment and valuations on properties where it is felt there are material changes to the assumptions used in valuing specific properties. The development costs of SPIKE had been capitalised and this was drawn to the attention of the Committee given that this is a major asset (£890k) for the Trust.

Preparation work is already underway for the impact of the adoption of new standards IFRS 16 covering lease accounting, which will apply for 2019/20.

The Audit Committee noted the changes and that no further changes are proposed in relation to the preparation of the 2018/19 Annual Accounts.

FT Code of Governance Compliance Statement

The Committee considered the ‘comply or explain’ disclosures within the Code of Governance and the evidence presented to support the statement of compliance. It was agreed to recommend the statement of full compliance to the Board.

Use of Waivers – Q2 – Q4

The Committee discussed the use of waivers and particular aspects of the process including whether the Director of Finance was satisfied that the waivers were necessary. The DoF confirmed the process and that in line with an Internal Audit recommendation that more in depth analysis would be helpful, the intention was to provide a fuller report on the use of waivers each quarter.

Trust Risk Register
The Trust Risk Register was presented and discussed and it was noted that following the most recent IGC meeting an additional risk in relation to the changes to the adult physical health contract provider for west Herts, the potential impact on organisations and particularly shared services was under consideration.

Board Assurance Framework
The Board Assurance Framework was reviewed and the Committee welcomed the further update which includes a clear separation of the three lines of assurance which was seen as a significant improvement.

Clinical Audit/Effectiveness - Annual Plan
The Medical Director reported that there is a comprehensive draft plan which will be presented to Audit Committee following detailed consideration and review by IGC.

Six Monthly Reports & Review of Minutes
The 6-monthly report and the minutes from the Finance and Investment Committee and Integrated Governance Committee were received and it was noted that management and Internal Audit will consider the content of both the reports and the notes and how these might be structured to give fuller assurance.

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 University NHS Foundation Trust

Trust Board

Meeting Date:	9th May 2019	**Agenda Item: 17**
Subject:	Annual Review of Audit Committee Terms of Reference	**For Publication:**
Author:	Keith Loveman, Executive Director of Finance	**Approved by:** Keith Loveman
Presented by:	Keith Loveman, Executive Director of Finance	

Purpose of the report:

To approve the Audit Committee Terms of Reference.

Action required:

To approve the Terms of Reference of the Audit Committee

Summary and recommendations to the Board:

Annually the sub-committees 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 Board sub-committees Finance and Investment (FIC), and Integrated Governance (IGC) were approved at the 7th February 2019 Board.

Audit Committee agreed to clarify the membership of the committee and that whilst the quorum will remain as a minimum of two Non-Executive Directors, this shall be detailed as a member of the FIC and IGC in order that the responsibility of Audit Committee in receiving assurance from the two Board sub-committees is appropriately represented.

Recommendation:
For the Board of Directors to approve the Terms of Reference of the Audit Committee 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

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 : Non-Executive Directors (x5 including Chair) 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, being constituted from a member of the Integrated Governance Committee and a member of the Finance & Investment Committee.

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:

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	9th May 2019	**Agenda Item: 18**
Subject:	Trust Risk Register March 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 note any changes to the Trust Risk Register.

Summary and recommendations:

This report gives an update on the Trust's Risk Register.

There are currently 12 risks on the Trust Risk Register. This report represents the Trusts top ten risks, the full risk register has been seen at IGC.

There was one informal suggestion during the CQC well led inspection that consideration should be given to presenting how the risk ratings have changed to identity whether the risk score was increasing or decreasing over time. This change will be made to the next iteration of the Trust Risk register presented at IGC on 22nd May 2019.

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:

IGC 20.03.2019
Trust Board 09.05.2019

Trust Risk Register March 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. There are 12 risks currently on the Trust Risk Register. This report represents the top ten.

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. Risk to be considered for escalation to the Trust Risk Register

2.1 There are no risks being considered for escalation to the Trust Risk Register.

3. Risk to be considered for downgrading from Trust Risk Register

3.1 There are no risks being considered for downgrading

3.2 The Staff Survey gave the Trust the highest score achieved for a Culture of Safety. In addition to this, informal feedback has indicated that the significant work in relation to safety (Risk 978) has had a positive impact. IGC will consider downgrading this to the from the Trust Risk Register to the safety risk register.

4. Risk scores to be considered for increasing

4.1 There are no risks being considered for an increase in risk score.

5. Risk score to be considered for decreasing

5.1 There are no risk scores being considered for decreasing

6. Risk Updates

6.1 **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)**

- As at the end of February 2019 the Trust vacancy rate has reduced to 13.2% which equates to 450 vacancies of which 227 are being actively recruited to. Work is being undertaken to reduce the time to hire. From 1st January 2019 all new B5, B6 and B7 staff have a revised increased notice period. Recruitment activity and recruitment days have been planned for the calendar year. Communications have been developed to show staff where to look for Trust vacancies. An internal vacancy bulletin has been sent to Trust sites so that staff without access to PCs are aware of Trust vacancies.

6.2 **Workforce: The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657)**

- At the end of February turnover had decreased to 15.8%. Work has continued on implementing and embedding retention initiatives with a one page summary of all the incentives being sent to staff via Team Brief and via team notice boards. Our new career surgeries have successfully launched with over 20 staff taking the opportunity to attend. The new management fundamental course also launched in February.
- Weekly SitReps – internal, STP, NHSE

6.3 **Brexit: The Trust may experience continuity and/or cost of supply issues for critical goods/services. (Risk 1000)**

- Ongoing 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.

6.4 **Finance: The Trust may not have sufficient resources to ensure long term financial sustainability (Risk 1001)**

- CCG's have indicated meeting Mental Health Investment Standard (Parity of Esteem) to 2020 / 21 and HPFT CEO to independently review and sign off

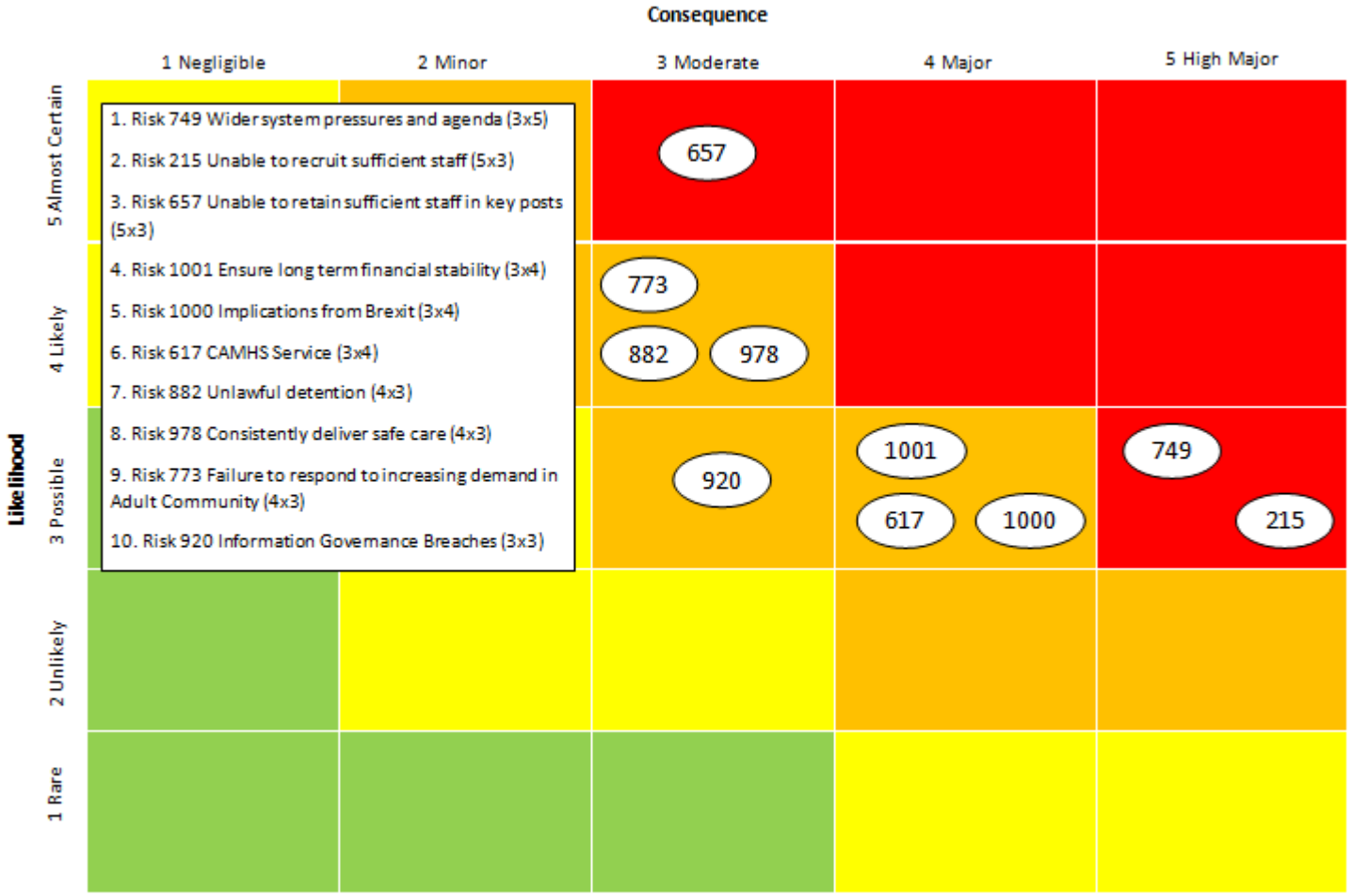
7 Conclusion

7.1 This report has detailed the suggested changes to the Trust Risk Register to be considered by the Trust Board. It has detailed the actions that have been taken and the mitigations put in place to manage the risks that have been identified.

Appendix 1 Trust Risk Register by Exec Lead and linked to Trust Strategic Objectives

	Opened	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	02.02.19	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	16.10.14	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	30.06.16	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	16.10.18	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	16.10.18	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	21.04.16	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	Sandra Brookes
7	27.12.17	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	Sandra Brookes
8	20.08.18	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	29.03.17	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	Sandra Brookes
10	01.03.18	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
March 2019

To be reviewed by:

Integrated Governance Committee: 20.03.2019

Audit Committee: tbc

Trust Board: 09.05.2019

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)	Target Rating	Early warning indicators	Current Position	Executive Lead	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	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	Karen Taylor (Director of Strategy & Integration)	14/01/2019	31/05/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
		and financial pressures across the system resulting in shifting of resources away from mental health and learning disability services						September and this will be a key focus for HPFT to secure ongoing funds and commitment to the development of services. STP events took place during June/July to consider the development of an Integrated Care System (ICS) and Integrated Care Alliance/Organisations (ICA/O) may look like in the future across W Essex and Herts. HPFT was heavily involved and specialist MH being considered in additional to the 'geographical' ICA model. Also, recognition by the STP that MH 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			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								representation Medical director & Dir. Delivery. Focus areas have been delivery of 5YFV; and development primary mental health model across STP. Clinical pathway priorities Personality Disorder, Eating Disorder. Across HVCCG and ENCCG locality based delivery models are under development (older peoples services and primary mental health model). Such care models are seeking to understand and develop how MH can be more fully integrated with GP practices, to provide more joined up care, reduce demand on specialist services, and support primary care practitioners. Recent Green paper and 'trailblazer' announcements provide opportunity to strengthen CAMHS services, linked and wrapped around schools. HPFT involved in discussion to develop service model and are likely to be the lead provider for overall CAMHS services in Hertfordshire.			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								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			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
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	Mariejke Maciejewski Interim Director of Workforce and OD	15/03/2019	15/06/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								order to create 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 users representatives to get their feedback on the careers website and on what should and should not be included. The plan is that the careers site should attract candidates to HPFT but will also assist current staff with career pathways and progression. Targeting hot spot areas such as CAMHS and Robin Ward through the recruitment and retention group. Focusing on 'on boarding' staff on their first day and / or from the time that they are recruited that we continue to keep the recruited member of staff			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								engaged with regular contacts and a welcome to HPFT pack including IT equipment required for their role when they commence in post. 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. As at the end of February 2019 the Trust vacancy rate has reduced to 13.2% which equates to 450 vacancies of which 227 are being actively recruited to. Work is being undertaken to reduce the time to hire. From 1st January 2019 all new B5, B6 and B7 staff have a revised increased notice period. Recruitment activity and recruitment days have been planned for the calendar			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								year. Communications have been developed to show staff where to look for Trust vacancies. An internal vacancy bulletin has been sent to Trust sites so that staff without access to PCs are aware of Trust vacancies.			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
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	Mariejke Maciejewski Interim Director of Workforce and OD	15/03/2019	15/06/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								succession planning - 100 day interviews - Stay interviews 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. 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			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								doing work on flexible working with managers. Plans are also in place to commence career surgeries for staff during Q4. At the end of February turnover had decreased to 15.8%. Work has continued on implementing and embedding retention initiatives with a one page summary of all the incentives being sent to staff via Team Brief and via team notice boards. Our new career surgeries have successfully launched with over 20 staff taking the opportunity to attend. The new management fundamental course also launched in February.			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
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	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	12	8	Agreed income tariff uplifts Negotiations with commissioners 3 year CRES proposals	Contract negotiations for Hertfordshire indicate potential for 5 years CCG's have indicated meeting Mental Health Investment Standard (Parity of Esteem) to 2020 / 21 and HPFT CEO to independently review and sign off 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)	15/03/2019	15/06/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
		to an increase in the risk score if these QIPP requirements materialise in the future		pilots around demand management to mitigate risk, better signposting will hopefully reduce Initial Assessment demand.							

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
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	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) 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.	Keith Loveman (Director of Finance)	15/03/2019	15/06/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
				Readiness Guidance framework for assessment of risks completed January 2019 Business continuity and incident management plans to be tested				Ongoing 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. 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. Weekly SitReps – internal, STP, NHSE			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
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	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	CAMHS Access Total referral volumes into SPA increased from 652 in September 2018 to 931 in January 2019 and of these the referrals passed on to HPFT services increase from 142 in September 2018 to 446 in January 2019. CAMHS current 28 day access performance is approx. 40% This is demonstrably the consequence of a host of system issues, compounded with local capacity within individual teams. The demand for CAMHS at SPA is >30% on last year and HCT are reporting 300 referrals per month when they are able to meet approx. 100. Capacity in the county council's services have been significantly reduced, this has resulted in considerable waiting times of 6+ months for step 2 support and counselling services. As a consequence of this we have seen an increase in referrers to SPA due to young people unable to be seen in other services deteriorating, we have also	Jess Lievesley (Director Of Service Delivery and Service User Experience)	11/01/2019	31/05/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
		OAT beds in relation to Tier 4 has not reduced in line with projection which is creating a financial risk as this does not reduce but recruitment to HTT and DBT increases.						seen a significant increase in crisis presentations via our A&E and our C-CATT services as families take their children their as due to escalating needs. As examples Step 2 are this week seeing young people referred via SPA in September and the council has closed all referrals for Counselling in North Herts as they have not replaced this service. The combination of all these factors mean that despite CAMHS offering their greatest number of assessment slots in a month of 163 during January and C-CATT seeing 109 referrals, the teams have not been able to balance demand with capacity. Actions being taken • Improving recruitment with 4 new members of staff having joined the service in the last 2 week, 2 more due in the next 2 weeks • Full leadership establishment across the quadrants and monitoring			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								this daily • Proposals being considered with National CAMHS provider who specialise in supporting assessment capacity • Work with partners and commissioners re system capacity, contract expectations and responding to demand • ADHD Pathway being challenged with commissioners as dominating available medical capacity within HPFT as GP prescribing and shared care not progressing 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. This is also noted as a separate Risk. CAMHS Leadership All CCM posts and modern matron are recruited to. Forest House team leader has been recruited to which strengthens inpatient leadership.			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								Finance 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. There are now no young people in out of area adolescent beds only PICU and Secure 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. There has been a positive turnaround in Forest House with regards to recruitment to key nursing post and additional OT support and Medical personnel for Forest House.			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
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	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	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	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 Police 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	Jess Lievesley (Director Of Service Delivery and Service User Experience)	11/01/2019	31/05/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
		assessment due to clinician availability or for lack of bed availability should an inpatient admission be required. In order to meet these timescales and manage the requirements of the changes, the Trust has to provide 24 hour clinical coverage for the Police; to ensure that the demand for Section 136 does not increase dramatically by monitoring inappropriate or unwarranted use of S136 in cases of intoxication only or presence of no mental disorder; to		the detention can be authorised - Between 9 - 5, Monday to Friday, AMHP Service prioritise Section 136 assessments in order to meet timescales - Presence of CATT staff in Kingfisher Court overnight, increasing availability for assessment - Interagency meetings and governance arrangements in place to monitor implementation of the Police and Crime Act changes to Section 136, reporting to Hertfordshire's Crisis Care Concordat Group			to move patients through	being made, and monitored via datix. There continue to be incidents of the following: - 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 dearrested 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			

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		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 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						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.			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
		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.									

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
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.	Seclusion Practice & Environment 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	Jane Padmore(Director Quality & Safety)	11/01/2019	31/05/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								review on Monday 2nd July to Thursday 5th July 2018. The Trust has received the final report. 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. Fundamentals of Care 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 Ligatures A new weekly ligature audit,			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
								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. Supervision Supervision has now gone live on Discovery. Further work is planned to enable compliance reporting and management oversight in spring 2019. Suicide and self-harm There is a deep dive on suicide and self-harm, the final report will be presented at the Trusts suicide prevention group			

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								and IGC. NHSI Collaborative – Restrictive Practice 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. NHSI Safety Collaborative 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.			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
773	Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites	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	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-	Jess Lievesley (Director Of Service Delivery and Service User Experience)	11/01/2019	31/05/2019

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
							cases pending allocation or as a % of overall community team caseloads	ordinator does not mean that individuals have no access to support from HPFT community services. 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. Some teams are using a mini team model to support individuals requiring care coordination. This is a mini team of 3 people who will work with an individual, this			

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								provides a broader group of people who will work collaboratively rather than one single identified Care Coordinator. This potentially will allow for a larger caseload across the mini team.			

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Target Rating	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
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 occuring 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	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	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.	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.	Ronke Akerele (Director Innovation and Transformation)	15/03/2019	15/06/2019

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		finances and reputation. There is a potential loss of trust in clinical and therapeutic relationships, leading to reduced quality of care and outcomes.		promotes visibility of new projects, and facilitates early input by the Data Protection Officer. This contributes to meeting the 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.			Reduction in compliance with Data Subject Rights requests (including Subject Access).	actual financial loss). Given these factors, it is reasonable to assume that the Trust will see a 'spike' in 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.			

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								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.			

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	9th May 2019	**Agenda Item:** 19
Subject:	**Compliance with NHSI's *Code of Governance* Annual Reporting Requirements-Declarations**	**For Publication:** Yes
Author:	Keith Loveman Director of Finance	**Approved by:** Keith Loveman, Director of Finance
Presented by:	Keith Loveman, Director of Finance	

Purpose of the report:

To set out for the Committee the Trust's Compliance with NHSI's *Code of Governance* in relation to the *'comply or explain'* disclosures.

Action required:

The Board is asked to note the evidence provided and approve a positive declaration of compliance with the Code of Governance (the Code) as issued by NHSI.

Summary and recommendations to the Board:

NHSI's *Foundation Trust Code of Governance* operates on a '*comply or explain'* principle and there are also specific disclosure requirements required in the Annual Report as identified in the *FT Annual Reporting Manual 2018-19.*

This paper sets out the provisions of the Code and the source of evidence to support a declaration of compliance within the Annual Report in all cases. The report was considered by the Audit Committee at its meeting of 24 April 2019.

Recommendation:

The Audit Committee recommends that the Board notes the evidence provided and approves a positive declaration of compliance with the Foundation Trust Code of Governance.

Relationship with the Business Plan & Assurance Framework (indicate which strategic goal(s) this relates to, for example Communications Strategy - 2.1):

Summary of Implications:

(a) Financial:
(b) IT:
(c) Staffing:
(d) Legal: Completion of statutory requirement
(e) Carbon Footprint:
(f) NHS Constitution:

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

N/A

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

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

Audit Committee 24 April 2019

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2018-19

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A	**LEADERSHIP**			
A.1.	**The Board of Directors** **Every NHS foundation trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS foundation trust.**			
A.1.4	The board of directors should ensure that adequate systems and processes are maintained to measure and NHSI the NHS foundations trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	Performance NHSI KPIS are set by the Trust Board to encompass all aspects of performance relating to achievement of Trust plans and priorities as well as achievement of external targets and standards including quality. Performance reports are reviewed at each of the BoD's public meeting and these are supplemented by relevant reports from external regulatory and compliance bodies such as CQC as appropriate. The Board regularly reviews its performance against regulatory requirements and receives reports from the executive outlining changes to targets/standards/guidance as they arise. Board papers are published on the Trust's website before the meeting. Performance reports are not subject to any exemptions under FOIA. The Integrated Governance and Audit Committees are responsible for testing the adequacy of the system of internal control, however, top ten scoring risks are reviewed at Trust Board level alongside the Board Assurance Framework.	• Board performance reports • Planning process • Quarterly report on performance against Annual Plan • CQUIN reports • Quality Account	√

A.1.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and in particular high risk or complex areas, independent advice, for example from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	The Trust has in place a performance dashboard where key metrics and milestones are collated and reported via performance report. The Board reviewed its committee structure and their Terms of Reference during 2018-19 to strengthen its assurance system and to allow earlier sight of performance issues and therefore more timely rectification. A programme of internal audits is agreed with RSM to focus on high risk areas.	• Performance Report • Committee's ToRs • Minutes of Board • Minutes of Committees • Meeting Schedule • Committee Key Issue Reports to Board • Internal Audit reports	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.1.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by NHS England, the CQC and NHSI. The board should record where within the structure of the organisation, consideration of clinical governance matters occur.	The Trust has a systematic approach to clinical governance which is focused on the relevant policy guidance and regulatory framework and which is supported by the Trust's Quality Strategy. The Trust's clinical governance is led by the Integrated Governance Committee which meets 6 times per year. It also receives operational clinical reports from the Quality & Risk Management Committee (QRMC) This formal assurance meeting is fed by an integrated governance framework, which permeates the organisation and facilitates the achievement of improving clinical standards through the implementation of the quality strategy. The Integrated Governance Committee scrutinizes the overall system of clinical governance and the outcomes of a programme of clinical audit as part of its audit plan. The Director of Nursing and the Head of Clinical	• Clinical Audit reports • Minutes of Quality & Risk Management Committee • Quality Work Plan • Quality & Risk Management Committee Minutes • Performance report to the Trust Board • Quality Strategy • Quality Account	√
A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHSI for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity and on issues relating to the wider responsibilities of the accounting officerfor economy, efficiency and effectiveness.	The Chief Executive is fully aware of his responsibilities as Accounting Officer and follows the procedure as set out by NHSI and the *NHS Foundation Trust Accounting Officer Memorandum.*	Signed copy of the Annual Governance Statement and procedure within the Annual Report	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.1.8	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behavior in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles)	Included in Board Standing Orders, role descriptions and code of conduct for CoG and Trust Board. Clear and transparent procedures for declaration of interests are in place and all corporate meetings require declarations to be made. The Trust's Standards of Business Conduct has detailed guidance on Gifts and Hospitality, Commercial Sponsorships, Outside Work and Conflicts of Interests The Trust's values of: Welcoming, Kind, Positive, Respectful and Professional embrace NHS values underpin the Trust's strategic objectives and the leadership approach taken by the organisation.	• Annual Fit & Proper Persons' Test • Annual Code of Conduct review Board paper • Register of Declared Interests for the Board, COG and all decision making staff • Standards of Business Conduct Policy • 'Good to Great' Strategy • Trust Values and Mission • Annual plan	√
A.1.9	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision making unless this is in conflict with the need to protect the wider interests of the public or the NHS foundation trust (including commercial in confidence matters) and make clear how potential conflicts of interest are dealt with.	The members of the Board of Directors have signed a code of conduct which is based on the spirit of the Nolan Principles. All minutes of meetings of the Board and key papers are published on the Trust's web site and only those papers which are specifically exempt under the FOIA are kept private.	• Web site – Trust Board Papers • Standards of Business Conduct Policy • Code of Conduct • Register of Declared Interests	√
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	The Trust currently has NHSLA cover and a top-up commercial policy for Directors & Officers Liability insurance.	D & O Cover policies in place and with NHSLA, Top up Policies	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.3	**The Chairperson** **The chairperson is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.**			
A.3.1	The chairperson should, on appointment by the council of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be chairperson of the same NHS foundation trust.	The Chair was appointed 1 July 2014 following agreed robust processes. On appointment, the chairman met the independence criteria and had not previously been a chief executive of the Trust. The Chairman continues to meet those independence criteria.	• Agreed CoG process for appointment of Chair • CoG's Appointment & Remuneration Committee minutes • CoG minutes • Declaration of Interest	√
A.4	**Non-Executive Directors** **As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board.**			
A.4.1	In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channel of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	The Council of Governors approved the 1st 3yr term of office of the SID at a meeting in 2017. The SID regularly attends meetings of the Council of Governors. The CoG's Policy for Engagement with the Board further defines the role of the SID in relation to the CoG escalation process, was approved in September 2017 by CoG.	• Council of Governors minutes/attendance • Constitution • Role description – SID • Council of Governors' *Policy for Engagement with Board of Directors*	√

A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson at least annually to appraise the chairperson's performance and on such other occasions as are deemed appropriate.	The Chairman has met with Non-Executive Directors without the Executives present during 2018-19.The SID and Lead Governor lead the appraisal process for the Chair annually and annually reports to the CoG's Appointment & Remuneration Committee (ARC) on the outcome. The Committee in turn reports to the full CoG.	• Appraisal of Chair procedure • ARC minutes • CoG minutes • NEDs'files and dates of 1:1 with Chair. • Approval of appraisal process	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	The Trust values embrace NHS values and underpin the Trust's strategic objectives and the leadership approach taken by the organisation. The role of the Senior Independent Director and Company Secretary in supporting and escalating concerns where appropriate is clearly defined within the Constitution and within the role descriptions. All Board members are encouraged to articulate their views in Board meetings and the minutes clearly and accurately reflect this.	• Trust Board Minutes • Exit interviews • Raising Concerns policy • Role of Company Secretary • Role of Senior Independent Director	√
A.5	**Governors** **The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed objectives and the overall strategy of the NHS foundation trust.**			
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year, Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	During 2018-19, the Council of Governors formally met on 4 occasions. The Working Groups of the Council of Governors also met at least quarterly during the year. All business as identified in the cycle of business (based on the Governors Accountability Framework) was dealt with during the year.	• CoG minutes • Meeting Schedule • Attendance List • Cycle of Business • Annual Report	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.5.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly as described in B.6.5	The CoG is deemed to be of sufficient size to discharge its duties and responsibilities and is in line with the size of other local CoGs. The Trust has a membership of just over 10,400 and has a complement of 19 public governors, 5 staff governors and seven appointed governors	• Constitution • Minutes of CoG • Membership database	√
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	The Council of Governors approved their Terms of Reference at their March meeting in December 2018. The Role of Governor is included in induction presentations given to new Governors and is included within the Council of Governors' Terms of Reference. The Council of Governors Standing Orders form part of the Trust Constitution.	• Standing Orders for CoG - Constitution • Induction Programme for Governors • ToRs	√
A.5.5	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant directors present at the meeting about the affairs of the NHS foundation trust.	The executive and non-executive directors have an open invitation to attend CoG meetings. The Chief Exec or his appointed Deputy attends all CoG meetings. The Company Secretary attends all CoG meetings and NEDs are aligned to and attend Groups of the CoG.	• CoG Minutes • CoG Groups' minutes and attendance list • CoG attendance list	√
A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance	The Council of Governors Policy for Engagement with Board of Directors is in place. The policy clearly identifies the key roles and	• CoG Minutes • Joint Meetings of CoG and Board • Role of SID	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	with the new provider licence or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director (see A.4.1).	The Council of Governors' Appointment and Remuneration Committee makes recommendation to the CoG on the appointment of the Chair and NEDs. The appointment of the SID is a joint decision between the Board and CoG as recommended by NHSI's Code of Governance. The Trust's SID was appointed in 2017.	Minutes of the ARC Minutes of the Board of Directors	
A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting of advance meeting agendas and, where possible, using clear, unambiguous language.	The CoG has a 12 month rolling cycle of business in place to allow for timely planning and to ensure it discharges its duties and responsibilities. Easy read finance reports are included in the meeting papers. Annual Plan, Quality and Performance reports/data have been regular standing items on CoG and its Groups' agendas for 2018-19 in order to keep Governors up to date. The CoG is fully aware of the boundaries between governance and management.	• CoG Easy Read Finance Summary • CoG Agendas • CoG Cycle of Business • CoG attendance list • Groups' TORs & Agendas • Training and Induction of Governors' material	√
A.5.8	The council of governors should exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	The Trust's Constitution along with the Board Standing Orders (Annexe B) details the process for removal of the Chairperson or other Non-Executive Directors.	• Constitution • Board and Council of Governors' Standing Orders	√

A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example, clinical statistical data and operational data.	The CoG receives the performance, engagement and quality reports at each meeting containing a wealth of qualitative and quantitative data and info. This is the same information as seen by the Board of Directors. There are regular presentations/Q&A sessions facilitated by various Trust depts./employees and external partners to further enhance Governors knowledge. During 2018-19 these included: • 2017-18 Annual Accounts • External Audit • Board sub-Committee Chairs • 2019-20 Annual Plan	• CoG Agendas • CoG Cycle of Business • CoG minutes • Performance Reports • Quality Reports	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		• Seeking Assurance & Holding to Account • The Audit Committee • Quality Account • Council of Governors Annual Effectiveness Review		
B	**EFFECTIVENESS**			
B.1.	**The Composition of the Board** **The board of directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.**			
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	The constitution sets out the composition of the Board of Directors. There is 1 Non-Executive Chair and 7 other non-executive directors. There are 7 executive directors including the CEO. All the NEDs are deemed to be independent.	• Annual Report • Constitution • Procedure for the appointment / reappointment of NED's • CoG Nominations Committee Minutes • CoG Minutes	√
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	The constitution prevents an individual holding office as both director and governor at the same time. That situation does not obtain in the Trust.	• Constitution • Standing Orders • Register of Interests	√
B.2	**Appointments to the Board** **There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be 'fit and proper' to meet the requirements of the general conditions for the provider licence.**			
B.2.1	The Nomination Committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The Nomination Committee should give full consideration to succession planning,	The CoG's Appointment & Remuneration Committee considers NEDs' appointments and terms & conditions. Upon identification of a vacancy, the skills requirement is considered prior to drafting a job description	• Committee ToRs • Committee minutes	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board.	and recruitment process taking place. The Board's Nominations & Remuneration Committee deals with executive appointments and terms & conditions. Upon identification of a vacancy, the skills requirement is considered prior to drafting a job description and recruitment process taking place.		
B.2.2	Directors on the board of directors and governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). In exceptional circumstances and at NHSI's discretion an exemption to this may be granted. Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations.	The 'fit and proper' persons clause is contained within the Code of Conduct for Governors and the Code of Conduct for the Directors. These are signed and filed with the Co Sec. It is included as a clause within employment contracts and engagement letters for Board members. There is an annual revalidation process in place. All directors and governors are required to sign the Code of Conduct and be subjected to the Fit and Proper Persons' Test.	• Annual revalidation process F&PPT Declaration • Register of Interests • Contracts	√

B.2.3	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	The Trust has a Board Remuneration Committee for considering executive director appointments and terms & conditions. The CoG has an Appointment & Remuneration committee for considering the appointment and terms & conditions of non-executive directors including the Chair.	• Constitution • Terms of Reference • Minutes from committees	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	experience on the board of directors, and, in light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	There is a skills audit undertaken and cognisance is taken of it when replacing NEDs or appointing new ones.	Current skills audit of NEDs	
B.2.4	The chairperson or an independent non-executive director should chair the Nominations Committee.	The Trust was Chair of the Nominations Committee during 2018-19. The ToRs were revised and approved annually and the Chairman will continue to be Chair of the Committee. The Lead Governor chairs the Appointment & Remuneration Committee of the Council of Governors	• Nominations Committee minutes • Attendance register • ToRs	√
B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the Nominations Committee should make recommendations to the council of governors.	The process for appointing a new Chair in 2014 was agreed by the Appointment & Remuneration Committee and a recommendation was made to the CoG to appoint preferred candidates. The there is a process for appointing other NEDs, and owned by both the ARC and the full CoG.	• Agreed processes • Nom Comm & Remcom minutes • ARC minutes • CoG minutes	√
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist only of a majority of governors. If only one nominations committee exists, when nominations for non-executive, including the appointment of the chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	The CoG's ARC consists entirely of Governors. The Lead Governor Chairs the ARC. It considers the appointments of NEDs including the Chair. The Trust Chair, CEO, Director of Workforce & OD and the Company Secretary are normally in attendance. The Board Remuneration committee consists entirely of NEDs and considers the appointments of Exec Directors and the Company Secretary.	• ToRs of ARC • Minutes • Remuneration ToRs • Minutes	√

B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The ARC recommends to the Council of Governors potential candidates. The Board represented by the Chair, SID and Chief Executive, Director of Workforce & OD provides input into the selection and interview process of NEDs.	• ToR • Agreed process for NED appointments • Committee Papers	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.2.8	The annual report should describe the process followed by the council of governors in relation to appointments of the chairperson and non-executive directors.	The Trust appointed a new Chair with effect from 01 July 2014. One new Non-Executive Director was appointed during 2018-19 and the process is described in the Annual Report for 2018-19.	• Annual Report • Agreed process for Chair appointment • Agreed process for appointment of NEDs	√
B.2.9	An independent external adviser should not be a member of or have a vote on the Nominations Committee(s).	The Nominations Committee's Terms of Reference allow for an independent advisor to attend meetings when engaged but make it clear that they are not a member of the CoG Nominations Committee and do not have a vote.	• ToRs • Minutes	√
B.3	**Commitment** **All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.**			
B.3.3	The board of directors should not agree to a full-time executive directors taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation.	The Declaration of Interest process requires all Directors to declare their outside interests. The *Standards of Business Conduct* policy deals with outside employment and no outside employment can be sought or engaged in without prior agreement from the Board or relevant line manager.	• Register of Interests • Standards of Business Conduct Policy • Code of Conduct	√
B.5	**Information and Support** **The board of directors and council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties**			
B.5.1	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decision they have to make. The board of	The covering sheet of both Board and CoG papers has been revised following the 2016 external governance review and now gives clarity over paper's salient points and the action required during the meeting.	• Board front Cover • CoG front cover • Cycle of Business	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	Both the BoD and CoG have annual cycles of business to ensure that all key governance information is presented in the appropriate manner at the relevant time. Further in depth information is provided to the Board's statutory and assurance committees.		
B.5.2	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The Board's Standing Orders and SFIs/SoDA and Committees' ToRs allow for the provision of professional advice where appropriate.	• Board Standing Orders / SFIs/SoD • Committee ToRs	√
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decision to appoint an external adviser	The Constitution and committees' terms of reference provide for external advice to be sought if deemed appropriate by all members.	• Constitution • Terms of Reference	√

ODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	should be the collective decision of the majority of directors. The availability of independent external sources of advice should be made clear at the time of appointment.			
B.5.4	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of governors is provided with sufficient resource to undertake its duties with such arrangements agreed in advance.	Allocated Trust secretariat resource supports the Trust Board, its assurance committees and the CoG	• Board/Sub-Committee structure	√
B.6	**Evaluation**			
B.6.3	The senior independent director should lead the performance evaluation of the chairperson within a framework agreed by the council of governors and taking into account the views of the directors and governors.	The appraisal process for the Chairman has been agreed by the Board's RemCom and CoG's ARC and is led by the SID and Lead Governor. Feedback is sought from both Board peers and Governors.	• Nominations Minutes • Appraisal procedure • CoG Minutes	√
B.6.4	The chairperson, with the assistance of the Company Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties.	During 2018-19 Board development sessions were held including the following topics: • SafeCare & Safer Staffing • Risk Appetite & Board Assurance Framework • Freedom to Speak Up	• Board Development Sessions Programme • Attendance List • NED Appraisal Reports	√

B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on: Holding the non-executive directors individually and collectively to account for the performance of the board of directors • Communicating with their member constituencies and the public and transmitting their views to the board of directors; and • Contributing to the development of forward plans of the NHS foundation trust. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.	An evaluation of CoG was undertaken with the results presented to the CoG.	• CoG minutes • Annual Report	√
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiability fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Reference is made to the removal from office of a Governor under clause 15 of the Trust Constitution and also within Annex B. The CoG approved a procedure and this is contained within the Governors Handbook.	• Constitution • CoG Minutes • Governors Handbook	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.8	**Resignation of Directors** **The board of directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its licence; its constitution; mandatory guidance issued by NHSI; relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board and directors and works with the council of governors to ensure there is appropriate**			
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	There was no agreement outside of those already agreed contractually.	• Minutes of Board Remuneration Committee • Executive Contracts	√
C	**ACCOUNTABILITY**			
C.1	**Financial, quality and operational reporting** **The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.**			
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	The Directors consider a range of risk factors and also receive assurance from the Auditors at year-end and from submissions to NHSI on a monthly and quarterly basis.	• Annual Report and Accounts • Auditors' Opinion • NHSI Declaration	√
C.1.3	At least annually and in a timely manner, the board of directors should set out clearly it's financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance. Further requirements are included in the NHS FT ARM.	All of this information is disseminated within the Annual Report.	• Annual Report • Board minutes	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
C.3	**Audit Committee & Auditors** **The board of directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors.**			
C.3.1	The board of directors should establish an audit committee composed of at least 3 members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively; including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.	The Audit Committee's Terms of Reference include all Non-Executives as members, one of whom is a qualified accountant by background. The Trust's Chair is not a member of the committee.	• ToRs of Audit • Constitution • Minutes of Audit committee	√
C.3.3	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing the external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and NHSI their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.	During 2018-19 the Audit Committee and the CoG reviewed the arrangements for the External Audit contract. SA which full market testing full market testing exercise was undertaken and	• Constitution ARC minutes • Minutes of Audit Committee • Minutes of CoG	√
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation	The External auditors were appointed for a 3 years, plus one year prior to the final one year extension.	• Constitution • CoG Handbook • Minutes of Audit Committee • ARC minutes	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	trust. The current best practice is for a three-to-five year period of appointment.		• Minutes of CoG	
C.3.7	When the council of governors ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHSI informing it of the reasons behind the decision.	Not Applicable for 2018-19 but a procedure is in place.	• Not Applicable for 2016-17	√
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	The Freedom to Speak Up policy (H&S 9.16) was reviewed by the Integrated Governance Committee and the Freedom to Speak Up Champion makes independent reports to the Trust Board.	• Freedom to Speak Up policy	√
D	**REMUNERATION**			
D.1	**The level and components of remuneration** **Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead an NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.**			

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
D.1.1	Any performance related elements of the remuneration of executive directors should be designed to align their interest with those of patients, service users and taxpayers to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: • The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public and patients. • Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group for comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. • The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for	The Executive Directors have elements of performance related pay within their current terms and condition. Any change to this would need to be presented as a proposal to the Remuneration Committee for approval.	• Remuneration Committee minutes • Contracts	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	directors close to retirement.			
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	The levels of remuneration are in line with other local Trusts and agreed by the CoG	• CoG Nomination Committee minutes • CoG minutes	√
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	The current employment contracts for Directors do not allow compensation to be reduced to reflect a departing director's obligation to mitigate loss or appropriate claw-back provisions in case of a director returning to the NHS within the period of any putative notice.		
D.2	**Procedure** **There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.**			
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for executive directors, including pension rights and any compensation payments. The committee should also recommend and NHSI the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.	The Board has delegated responsibility for setting executive directors remuneration including compensation payments and pension rights through the Remuneration Committee. This is reflected in the Committee's Terms of Reference and Scheme of Delegation	• Remuneration Committee ToRs	√
D.2.3	The council of governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at	The remuneration levels of the chairperson and non-executive directors are in line with other local Trusts, however, the Council of Governors	• Not Applicable for 2016-17	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	least once every three years and when they intend to make a material change to the remuneration of a non- executive.	via the ARC would consult with professional advisors should any material change be considered.		
E	**RELATIONS WITH STAKEHOLDERS**			
E.1	**Dialogue with members, patients and the local community**			
E.1.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g. local Healthwatch, the OSC, the League of Friends and staff groups).	During the year 2018-19 the Trust had an Engagement Strategy in place. Governorsalso have a Membership & EngagementGroup of the CoG. Service Users had several foums for giving feedback.	• Engagement Strategy • Terms of Reference	√
E.1.3	The chairperson should ensure that the view of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	The Chair of the Trust Board is also the Chair of CoG and is a great conduit for information flow between the Board and the Governors. All Non-Execs have an open invitation to attend formal open Governor meetings in order to develop an understanding of Governors' concerns. The Chair summarises the affairs of the Trust during his opening welcome at Governors meetings and presents a Key Issues Report to Board following CoG meetings.	• CoG Attendance List • CoG Minutes • Board minutes • Role of the Chair	√
E.2	**Co-operation with third parties with roles in relation to NHS foundation trusts** **The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.**			
E.2.1	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The	The Board has built relations with 3rd party bodies with which it has a duty to co-operate e.g. NHSI; CQC. Members of the Board and	• Key legal documents	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	senior leadership are the nominated contacts for these organisations. Copies of all key documents e.g. Provider Licence, Constitution are shared with members of the Board to ensure they are up to date with latest legislation requirements.		
E.2.2	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	During the year 2018-19 the Trust had an Engagement Policy in place which not only identified key stakeholders but also the level of engagement required and by whom e.g. service users; staff; commissioners.	• Stakeholder Engagement Strategy	√

Trust Board

Meeting Date:	9th May 2019	**Agenda Item: 20**
Subject:	Annual Declaration of Interests 2019/20	**For Publication:**
Author:	Chris Lawrence, Chairman	**Approved by:** n/a
Presented by:	Chris Lawrence, Chairman	

Purpose of the report:

The Purpose of the report is to inform the Board that members have completed and signed the annual Declaration of Interests form for 2019/20

Action required:

To note.

Summary and recommendations to the Board:

All members of the Board are required to complete and sign an annual Declaration of Interest form for the period 1st April 2019 – 31st March 2020. Completed forms are held centrally by the Company Secretary and are available for inspection.

Relationship with the Business Plan & Assurance Framework:

The forms are a requirement of the Code of Governance and the Trust Constitution.

Summary of Implications for:

N/A

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

N/A

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

N/A

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

N/A

Trust Board

Meeting Date:	9th May 2019	**Agenda Item: 21**
Subject:	Fit and Proper Persons Declaration 2019/20	**For Publication:**
Author:	Chris Lawrence, Chairman	**Approved by:** n/a
Presented by:	Chris Lawrence, Chairman	

Purpose of the report:

The Purpose of the report is to inform the Board that members have completed and signed the annual Fit and Proper Persons form for 2019/20

Action required:

To note.

Summary and recommendations to the Board:

All members of the Board are required to complete and sign an annual Fit and Proper Persons form for the period 1st April 2019 – 31st March 2020. Completed forms are held centrally by the Company Secretary and are available for inspection.

Relationship with the Business Plan & Assurance Framework:

The forms are a requirement of the Code of Governance and the Trust Constitution.

Summary of Implications for:

N/A

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

N/A

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

N/A

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

N/A