Hertfordshire Partnership University NHS Foundation Trust Board of Directors PUBLIC Meeting v

Da Vinci B

5 December 2019 10:30 - 5 December 2019 13:30

INDEX

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS PRIVATE / PUBLIC MEETING

SCHEDULE OF THE DAY

Thursday 5th December 2019

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

Timing	Subject	Venue
09:00 – 10:15	Private Board	Da Vinci B
10:15 – 10:30	COMFORT BREAK	
10:30 – 11:00	Service User Story	Da Vinci B
11:00 – 13:30	Public Board Meeting	Da Vinci B
13:30 – 14:30	Board Christmas Lunch	Beales Hotel

as One

Our Values
Welcoming Kind Positive Respectful Professional

Hertfordshire Partnership University NHS Foundation Trust

BOARD OF DIRECTORS

A Public Meeting of the Board of Directors

Date: Thursday 5th December 2019
Venue: The Colonnades, Beaconsfield Road, Hatfield AL10 8YE, Da Vinci B+C
Time: 10.30 – 13:30

AGENDA				
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**
1.	**Welcome and Apologies for Absence:**	Chair		
2.	**Declarations of Interest**	Chair	**Note/Action**	Verbal
3.	**Minutes of Meeting held on 7 November 2019**	Chair	**Approve**	Attached
4.	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
5.	**CEO Brief**	Tom Cahill	**Receive**	Attached
QUALITY & PATIENT SAFETY				
6.	**Report of the Integrated Governance Committee – 20 November 2019**	Sarah Betteley	**Receive**	Attached
7.	**Quality and Patient Safety Quarterly Report: Quarter 2**	Dr Jane Padmore	**Receive**	Attached
8.	**Safer Staffing Report: Quarter 2**	Dr Jane Padmore	**Receive**	Attached
OPERATIONAL AND PERFORMANCE				
9.	**Report of the Finance & Investment Committee – 19 November 2019**	David Atkinson	**Receive**	Attached
10.	**Finance Report**	Paul Ronald	**Receive**	Attached
11.	**Workforce and Organisational Development Report: Quarter 2**	Susan Young	**Receive**	Attached
GOVERNANCE AND REGULATORY				
12.	**Board Assurance Framework**	Helen Edmondson	**To Note**	Attached
13.	**Trust Risk Register**	Dr Jane Padmore	**To Note**	Attached
14.	**Well Led Review**	Helen Edmondson	**To Note**	Attached
STRATEGY				
15.	**Chairs Action**	Loyola Weeks	**Approve**	Attached
16.	**Any Other Business**	Chair		

	QUESTIONS FROM THE PUBLIC	Chair		

Date and Time of Next Public Meeting:
Thursday 30 January 2020, 10.30 – 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

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Minutes of the PUBLIC Board of Directors Meeting
Held on Thursday 7th November 2019
Da Vinci B – Colonnades

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Chris Lawrence | CL	Chairman
Tanya Barron | TB	Non-Executive Director
Sarah Betteley | SBe	Deputy Chair and Non-Executive Director
Loyola Weeks | LW	Non-Executive Director
David Atkinson | DA	Non-Executive Director
Janet Paraskeva | JPa	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Karen Taylor | KT	Director, Strategy and Integration
Susan Young | SY	Interim Director Workforce & Organisational Development
Dr Jane Padmore | JPad	Director Quality and Safety
Sandra Brookes | SBr	Director Service Delivery & Customer Experience
Keith Loveman | KL	Director Finance & Deputy CEO
Dr Asif Zia | AZ	Director Quality & Medical Leadership
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chairman and Company Secretary | Minute Taker
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Sarita Dent | SD	Associate Non-Executive Director
Paul Ronald | PR	Deputy Director of Finance
Hakan Akozek | HA	Chief Information Officer (item 128/19)
MEMBERS OF THE PUBLC	
Barry Canterford | BC	Public Governor and Trust Engagement Champion
Jon Walmsley | JW	Lead Governor
Ann Corbyn | AC	Member of the Public
Alicia O'Donnell-Smith | AO'DS	Interim Deputy Director of Communications & Engagement
APOLOGIES	

Item	Subject	Action
111/19	**Service User Presentation** CL welcomed JG the father of a young person with Learning Disabilities who presented to the Board on his experiences. James was supported by Lara Harwood, Service Experience Lead. CL thanked JG for his presentation to the Board.	
112/19	**Welcome and Apologies for Absence** CL welcomed all to the meeting with an extended welcome to Susan Young, Interim Director for People and Organisational Development. Members of the public were also welcomed. There were no apologies to note.	

113/19	**Declarations of Interest** There were no items declared.	
114/19	**Minutes of the meeting held 5th September 2019** The minutes of the meeting held on the 5th September 2019 were discussed with one amendment to item 096/19 which should read: Although there were a number of indicators showing as red, the majority of these were moving in the right direction. The remainder of the minutes were agreed as an accurate account of the meeting. **APPROVED** **The Minutes (subject to amendment of item 096/19) of the meeting held 5th September 2019 were APPROVED**	
115/19	**Matters Arising** The matters arising schedule was discussed and updates noted.	
116/19	**CEO Brief** TC presented the report to the Board which was taken as read. The below key headlines were discussed and noted: **National Update** TC confirmed the Trust was in a period of Purdah in the run up to the election on the 12th December 2019. It was noted that the election was likely to have a huge impact on the NHS and its direction of travel. He reported that preparations for the EU Exit had been stepped down. • CQC State of Care Report 2018/19: The report described that overall care was improving however access and pressure on beds remained. • Children and Young Peoples Well-Being: TC advised Board members of the recently published State of the National Children and Young People's well-being report. The report promised extra funding, it was commented that it was not clear if it would be sufficient funding. • HSJ Awards 2019: TC advised the Board of HPFT's CAMHS Home Treatment Team win of the award for their category. The other two finalists for HPFT were Care Home Support Service by MHSOP and the Business Intelligence & Data warehouse team for SPIKE2. **Regional Update** • Adult Community Services in West Hertfordshire: TC updated the Board stating that Central London Community Healthcare NHS Trust (CLCH) were now the provider of adult community services in West Hertfordshire. HPFT formally welcomed them as future partners. • Capital: £2.8bn had recently been announced nationally and two local Acute Trusts would benefit. In support of this the Prime Minister Boris Johnson	

	had visited Watford General Hospital with TC confirming he and HPFT staff had joined this visit and had held a very interesting 20 minute conversation with the Prime Minister. **Trust-wide Update** • Overall progress was going well in terms of quality with the CQI starting to become embedded. In terms of performance the Trust was doing pretty well, with teams working hard however noting the pressure Community teams were under and the considerable demand on beds. • CAMHS Additional Funding: The Trust had been successful in securing additional funding for Children and Young People from Hertfordshire commissioners, providing more capacity to meet the growing demand. • Black History Month: October was Black History month and in support of this the Trust had held a Race Equality Action Day on the 18th October 2019. The event was very positively received and well attended and would be used as a platform for Trust inclusion work. • Recognition of our Staff: The Positive Practice in Mental Health Awards saw 3 teams receive highly commended for their work. • Appointments: Director of People & Organisational Development – final interviews would be taking place on the 12th November 2019. The Board would be kept briefed of the outcome. Following a national recruitment process, Sarah Damms had been appointed as Managing Director for West Herts SBU, starting at the beginning of December 2019. Recruitment of the Essex and IAPT Managing Director role was underway. Interim arrangements would continue whilst an advert was placed for the substantive role. • Well Led Review: HE would lead on this piece of work. We were currently in the tendering process and the Board would be kept appraised of developments. Questions were invited with none put forward. **RECEIVED** **The Board discussed and RECEIVED the CEO report**	
117/19	**Report of the Integrated Governance Committee – 18th September 2019** SBe presented the Integrated Governance Committee report to the Board which was taken as read. The following key messages were provided: • Two members of the CQC inspection team were in attendance of the meeting as observers and were welcomed • The Committee received feedback from the following committees and work areas: a) QRMC (Quality and Risk Management Committee): There were no items	

	to escalate to the Board b) WODG (Workforce & Organisational Development Group): There were no items to escalate to the Board. The Committee had noted the reduction in agency spend work and were provided with assurance in terms of safety. c) IM&T (Information Management & Technology Group): The Committee had received an update on the performance of HBLICT services and had noted the improvements made to waiting times. A number of projects were highlighted which included windows 10 upgrade, Skype and the PARIS infrastructure refresh. d) The Board Assurance Framework (BAF) and Trust Risk Register (TRR) had been discussed and considered, with the Committee noting good progress. CL asked the Committee to consider when next reviewing the BAF if it reflected the external environment appropriately. e) The Quarter 1 Workforce and Organisational Development report was presented. The Committee had noted the focus of the work on the Just and Learning Culture. f) The Quarter 1 Pulse Survey results were received which reported significant improvement in responses. g) The Health & Safety Executive Submission action plan was presented to the Committee and approved. h) The Committee was advised that Statutory and Mandatory training compliance was at 91% for Quarter 1. The Committee highlighted that they were interested to see the improvements reported through SPIKE2 at their next meeting. The Committee had welcomed feedback from the CQC observers in regards to how the Trust could receive feedback on the quality of supervision provided. i) Guardian of Safe Working Quarter 1 had been presented with the Committee noting an increase in the number of exception reports, however it was noted that the Trust still had the lowest number of forms completed by a Mental Health Trust in the East of England. The Committee also discussed junior doctor sickness and possible solutions. **RECEIVED** **The Board RECEIVED the report**	**SBe**
118/19	**Business Continuity and Preparedness** **<u>Flu</u>** AZ updated the Board on the 2019/20 Flu Vaccination for staff campaign which was being led by Sally Judges, Head of Allied Health Professionals and Healthy Lifestyles. The CQUIN target for 2019/20 was 80% of frontline staff. The campaign had been delayed slightly due to a delay in the delivery of the vaccine being	

	available. The target for 2018/19 was 75% of frontline staff of which the Trust achieved 53% for Hertfordshire based staff. The Board noted the paper included the assurance checklist to be submitted to NHSE/I. To date the Trust had achieved 18.30% of frontline staff being vaccinated. Board members held a short discussion on the flu clinics and their experiences with a suggestion for all Board members to achieve 100%. **Emergency Preparedness, Resilience and Response (EPRR)** SBr provided the Board with a summary of the Emergency Preparedness, Resilience and Response (EPRR) Annual Report advising that the report provided assurance against the Core Standards for 2019/20. **EPRR** Following an assurance meeting with NHSE/I there were 3 areas identified as partially compliant: • On call staff trained • Strategic and tactical responder training • Use of Filtering Face pieces The above standards had action plans in place to achieve full compliance by the end of Quarter 4 2019/20. SBr further advised that a Table Top exercise had been undertaken to test the Major Incident Plan for a Flu pandemic which had gone well and identified areas of learning. **Winter** SBr stated there was concern around demand for mental health, Flu and the Norovirus. A number of measures had been put in place: A Band 6 Mental Health practitioner had been appointed and would be based at the Herts Urgent Care office to respond to mental health calls and triage; Twilight AMHP shift, prioritising S136 suite and extension to hours of AMHP rota; Discharge to Access – both actual and virtual beds in place across Herts and A Band 6 Frailty Discharge to Assess nurse post to support D2A from Princess Alexandra Hospital **NOTE** **The Board NOTED the reports including the Flu Assurance checklist**	
119/19	**Service User Outcomes: Stories to the Board** SBr presented the Service User Outcomes: Stories to the Board report advising that the purpose of the report was to review the outcomes of the board stories provided at the Trust Board and Council of Governor meetings and to reflect on the stories heard over the previous year. SBr highlighted that the report made a number of recommendations. The Board highlighted the value of the Stories to Board and approved the recommendations in the report. It was recognised that closely linking the	

	agendas with service user and staff availability was challenging. CL formally acknowledged the work of Lara Harwood and her team. **APPROVE** **The Board APPROVED the report**	
120/19	**Mental Health Act Use of Force Act** JPad informed the Board that the report provided an update in reference to the Use of Force Act and the next stages regarding implementation and compliance. The report was taken as read. JPad advised the Board that due to Purdah the consultation on guidelines for the Act had moved to January 2020. The report set out how the Trust was preparing for the implementation of the Act which made provision for the oversight and management of appropriate force in relation to people in mental health units. There was a requirement for each mental health unit to appoint a Responsible Person who was required to publish a policy regarding the use of force by staff which includes the steps taken to reduce the use of force by staff in the Trust. HPFT sits on the Expert Reference Group which is chaired by the Care Quality Commission (CQC) and the Department of Health and Social Care (DoH) and was making preparations for this in a timely manner. JPad advised that the Board were asked to approve the following • Responsible Officer: Dr Jane Padmore • Operational Lead: Jacky Vincent • Governance Structure: Integrated Governance Committee up to Board JPad noted to the Board the recommendations which had been agreed by the Executive team and asked the Board to approve. All in attendance approved. **APPROVE** **The Board APPROVED the report and its recommendations**	
121/19	**Report of the Finance & Investment Committee – 17th September 2019** DA presented the Finance & Investment Committee report to the Board following the meeting held 17th September 2019. Key highlights from the meeting for the Board to note were: • The committee had undertaken a Deep Dive on Delivering Value with DA highlighting this year's CRES target of £6.5m. The Deep Dive had set out measures to close the gap for the target. • KT had provided the Committee with an overview of the progress and development on the East of England Provider Collaborative which showed good progress. The Committee was advised of the key areas of focus and	

	the risk share arrangements which would be discussed in detail at the Strategy Group. • KT also updated the Committee on the implementation of the Long Term Plan 2023/24 and the risks in respect of its delivery. • An update was provided on the Trusts Annual Plan for 2020/21 which was due to be signed off by the Board in March 2020. • The Committee received an update on the Strategic Investment Programme which highlighted the proposed inpatient development in the East and North of the County with further detail being provided to the Finance & Investment committee at future meetings. The development of the Digital Strategy was also discussed. • The Committee discussed and approved the disposal of 2-4 Alexandra Road which was now surplus to requirement. • A summary of Performance for Quarter 1 was provided with an update on the Trusts performance for targets and KPIs. Overall performance was good with 63% of the indicators meeting or exceeding the required standard. • A financial summary was provided for the period to end 31st August 2019 which showed a pleasing turnaround for the Quarter in particular with reduced bed and agency costs. The Committee was advised that the Quarter 2 Control Total was now expected to be met. CL thanked DA for the update and formally recorded recognition of the efforts in reducing the agency spend and out of area placements. **RESOLVED** **The Board RECEIVED the report**	
122/19	**Annual Plan 2019/20 – Quarter 2** KT updated the Board on the Trusts performance against the Annual Plan for Quarter 2 advising this had been a hugely positive Quarter and gave credit to the teams. There were two objectives behind track: • **Objective 2 – Experience** KT advised this would be back on track within Quarter 3 & 4. • **Objective 5 – Innovation & productivity** Plans were being put in place to achieve the required CRES (Cash Releasing Efficiency Savings). The significant work undertaken during Quarter 2 had put the Trust in a favourable position for year-end outcomes, however it was noted that Safety was one area we may not achieve. The target when set was ambitious, and this was	

	recognised with a need to take stock and adjust. KT advised the objective would be kept at Amber for the remainder of the year. The revised timeline for the delivery of the Safety Suites was noted. SY confirmed that the NHSI metrics to measure performance against the targets for inclusion and High Performing Teams. CL thanked KT for the report stating it was a very informative document. **RESOLVED** **The Board RECEIVED the report**	
123/19	**Performance Report – Quarter 2** KT updated the Board on the Performance Report for Quarter 2 which provided a summary of the overall performance of the Trust against 69 national, regional and local indicators across five key groupings. Overall the Trust continued to do well against the demand and this reflected the work on the ground by our teams. 50 out of the 69 performance indicators (72.4%) were exceeding, meeting or very nearly achieving the performance level required. Areas which were worsening in their performance for the Quarter were: • CAMHS Access • 18 week wait • IAPT Access for West Essex • North East Essex Recovery Rates • Delayed Transfer of Care (DTC) • Service Users' Feeling Safe • Personal Development Plans (PDP) Overall, in the context of demand and pressure the trust was performing well and a detailed action plan was in place for each of the areas shown above which were under performing. LW raised Delayed Transfer of Care performance, it was noted that a Deep Dive would be scheduled for the Integrated Governance Committee. ***Action Point: A Deep Dive on Delayed Transfer of Care to be scheduled for the Integrated Governance Committee*** **RESOLVED** **The Board RECEIVED the report**	
124/19	**Finance Report: Quarter 2** The report was presented by PR who informed the Board on the current financial position, key highlights and risks, and the projected financial forecast for the full year. Key highlights for the Board to note were: • September's position confirmed that there had been a strong improvement in the position and this had been sustained into November with the control total	

met for the Quarter.

- The Trusts Use of Resources (UOR) framework rating for Quarter 2 remained as 1, the highest rating.
- Flash Forecast for October noted a small surplus which continued the strong performance, part of this impact was from vacancies.
- The Trust was well placed for the year end control total, however needed to be mindful of the need for beds which could create a financial impact.

TC commented that the Annual Plan, Performance and Money were all doing well, however we would only sustain this if our staff worked at their absolute peak and asked the Board to be mindful of this.

RESOLVED
The Board RECEIVED the report

125/19 **Financial Planning 2020/21**

PR presented the report which set out the early considerations in relation to the 2020/21 Annual Financial Plan, the timetable and process for its completion.

Headlines for the Board to note were:

The Trust was expecting to fully meet the Control Total for the current year.

Point 11 (overall page 98 of 132) outlined the additional funding shown below:

Mental Health	**(1,316)**	**(1,421)**	**(4,110)**	**(8,268)**	**(11,1**
Children and Young People	**(64)**	**(69)**	**(1,260)**	**(1,952)**	**(3,22**
Adult and older adult CRHTTs and Crisis Alternatives	**(1,252)**	**(1,352)**	**(587)**	**(787)**	**(1,02**
SMI	**0**	**0**	**(2,264)**	**(5,530)**	**(6,86**

Table 2 summary annual LTP funding available to STP estimate

Table 4 (overall page 99 of 132) showed the high level impact analysis of revenue growth on headcount:

	19/20	20/21	21/22	22/23	23/4
Income less OI	244,933	251,554	261,728	272,569	281,576
Growth %		2.7%	4.0%	4.1%	3.3%
Growth £		**6,621**	**10,174**	**10,841**	**9,007**
inflation					
Pay %		2.9%	2.8%	2.1%	2.1%
Pay inflation £		**-4,669**	**-4,611**	**-3,640**	**-3,776**
non pay %		1.8%	1.9%	2.0%	2.0%
Non pay inflation £		**-1,583**	**-1,702**	**-1,815**	**-1,882**
available		369	3,860	5,386	3,349
estimated headcount		**7**	**69**	**96**	**60**
CIP at 2%		70	71	73	74

	Net -63 -2 23 -14 Point 18 (overall page 100 of 132) laid out the risks and mitigating actions which would be discussed and taken through the Finance & Investment Committee. **RESOLVED** **The Board RECEIVED the report**	
126/19	**Strategic Investment Plan 2019/20** KL introduced the item which provided the Board with an update on the forward Strategic Investment Programme which supported the Trusts Good to Great Strategy. The report summarised high level estimates which had previously been discussed at the Finance & Investment Committee. Of note to the Board were: The potential areas of strategy development likely to require investment including: • Estates Strategy • Organisational Development Strategy • Digital Strategy For the Estates Strategy the key areas to note were: • Provision of Beds • Bed Numbers • Safety Suites • Refurbishment of Oak Ward • Significant work to Forrest House Appendix 1 (overall page 104 of 132) provided a draft of the 5 year Strategic Investment Programme, to the value of £85m. In response to a question KL reported that capital expenditure in the last five years had been in the region of £110m. It was noted that as areas in the plan were worked up in more detail they would be taken to the Finance & Investment Committee and the Board as appropriate. **RESOLVED** **The Board NOTED the report**	
127/19	**Report from the Audit Committee – 10th September 2019** CD provided the Board with a summary of the work undertaken by the Audit Committee at its meeting held 10th September 2019. The report was taken as read with no items for escalation to the Board. Key points to note were: • Clinical Audit programme: The committee noted improvements were starting to be seen. Three audits had been escalated to the Quality & Risk Management committee (QRMC).	

	• CQC: The Committee had been informed that all the relevant data and evidence had been submitted in regards to the regulatory notice with a further update to be provided at the December 2019 meeting. • Health & Safety Executive (HSE): The Committee noted that the Trust had submitted the required information to HSE to evidence its compliance. • Trust Risk Register (TRR) and Board Assurance Framework (BAF): The Committee discussed and reviewed the TRR and BAF and noted the good progress. • Internal Audit Reports: The Committee noted the two areas of partial assurance; Appraisals and Procurement advising this would be discussed within the Integrated Governance Committee and an action plan developed. • Duty of Candour: The Committee would be receiving a report at their December meeting on the outstanding actions from the 2017/18 Duty of Candour audit. • Counter Fraud Progress Report: The committee received the report. • Charitable Funds: The Charitable Funds Annual Report and Annual Accounts were presented to the Committee for approval. It was noted that a meeting of the Trustees should be scheduled following a Board meeting. ***Action Point: A meeting of the Board of Trustees to be scheduled*** **RESOLVED** **The Board RECEIVED the report**	**HE**
128/19	**Digital Strategy** KL advised the Board that the Trust Digital Strategy set out the strategic framework and key objectives to make our organisation 'systematically' and 'instinctively' digital in delivering great care and great outcomes, together supporting our 'Good to Great' strategy. It was noted that the strategy was 'nimble' and would continuously be reviewed. The meeting welcomed the strategy and the strategic priorities which 'anchor' the activities of the Trust. In response to CL question KL confirmed that the proposed expenditure was a mixture of new and incremental. HA detailed that the Trust was participating in the interoperability work locally and regionally. Hakan Akozek, Chief Information officer presented to the Board on the Digital Strategy (attached) in support of the strategy included in the papers. **APPROVED** **The Board APPROVED the Digital Strategy.**	Digital Strategy Board Presenta
129/19	**New Care Models - East of England Mental Health Collaborative** KT presented a report prepared by Andy Graham, Interim Managing Director of	

	the East of England New Care Models Collaborative on progress to date in forming the provider collaborative. The paper was taken as read and the following points highlighted to the Board: • The paper was to be presented to all Collaborative Provider Boards in November 2019. • Following a selection process by NHS England the collaborative of 6 Trusts had been approved to proceed to the next stage to develop a full business case by March/April 2020. • It was proposed the New Care Provider Collaborative model would 'go live' in September/October 2020. • The leads for the development and design of the CAMHS pathway were Dr Linda Zirinsky, Consultant Child and Adolescent Psychiatrist and Shari Payne, Interim Head of New Care Models. • KT confirmed that a more detailed discussion had been held in the Private Board. **RESOLVED** **The Board RECEIVED the report**	
130/19	**Hertfordshire and West Essex STP Update** TC updated the Board on the Hertfordshire and West Essex STP advising that the partnership continued to move at pace, with the next 6 months a critical period as the system sought to become a shadow Integrated Care System from the 1st April 2020. A joint Accountable Officer across the three CCGs was being recruited to and was key for the development of the system moving forward. The STP had submitted its draft Long Term Plan at the end of October 2019. Feedback from NHSE regional team had been predominately positive and a final submission was required to be made in November 2019. This submission would expand on how the STP would address the health inequalities. TC advised that the development of a dedicated Integrated Care Partnership for Mental Health and Learning Disability (in addition to the three geographical ICPs) had, in principle, been agreed and we would need to see what this would look like. TC confirmed that the Board would be kept appraised as work developed and invited questions. SBe raised the outcome of the interviews to be held 14th November for the Joint Accountable officer role with TC stating he did not know who would have the final call, however gave assurance that it had a varied stakeholder panel including Providers, Commissioners and NHSE/I. KL asked if the enforcement of Purdah would cause a delay in the development of ICS and ICPs, and the appointment of the one CCG Accountable Officer. TC	

	advised that he did not think so. **RESOLVED** **The Board RECEIVED the report**	
131/19	**Any Other Business** No further business was put forward.	
132/19	**QUESTIONS FROM THE PUBLIC** CL invited questions from the public. JW stated that he was encouraged by the overall performance of the Trust however asked about the Trusts internal capacity to deliver on the Digital Strategy. KT responded advising that Hakan Akozek, Chief Information Officer was developing a detailed implementation plan, which would be presented to the Executive team. No further questions were put forward.	
Date and Time of Next Public Meeting: The next Public meeting is scheduled for Thursday 5th December 2019 @ 10:30am in Da Vinci B, The Colonnades		

Close of Meeting

Agenda Item 4

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 5th December 2019

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
07/11/19	**127/19**	Report from the Audit Committee	A meeting of the Board of Trustees to be scheduled to agree the charitable funds		KL		A
07/11/19	**123/19**	Performance Report Quarter 2	Deep Dive to be scheduled on Delayed Transfer of Care for the Integrated Governance Committee		HE		A
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 2 7th November It was agreed for Susan Young to take this forward.	SY	b/f	A

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item:** 5
Subject:	CEO Briefing	
Presented by:	Tom Cahill, CEO	

National update

In this section of my briefing, I set out a number of recent national announcements and reports that will help shape and provide context to the work being undertaken by HPFT in providing consistent, high-quality care to service users and their carers.

General Election
The NHS is high in the domestic priorities of all the political parties and continues to feature in the campaigns. One impact of the General Election is that the date of the Comprehensive Spending Review for next year is yet to be confirmed. The period of Purdah is in place and the Board are reminded to avoid any actions that will either distract from or influence election campaigns.

Implementation of Mental Health Long Term Plan
A national framework to support the local delivery of LTP commitments has been developed, underpinned by nationally allocated funding in the region of £2.3bn. The majority of funding allocated nationally is targeted towards the development of community-based mental health services. Indicative workforce numbers estimate an additional 27,500 staff will be required nationally to deliver the plan. Funding has already begun to be released nationally to test new delivery models with HPFT one of a few Trusts who have been funded to develop, test and pilot new models of community based care for adults (all age), adults with eating disorders and a new model for crisis care. The New Care Models programme also continues to develop nationally, with NHS-led provider Collaboratives forming to both commission and provide new care models for specialist CAMHS, Adult & Learning Disability Secure services and Eating Disorder services.

Learning Disabilities and Autism
Nationally, there is a continued focus on Learning Disabilities and Autism, which follows on from the feedback from the CQC State of Health report for 2018/19. In particular there is a:

- CQC thematic review of restraint, segregation and seclusion for people with a learning disability or autism (interim report)
- Joint committee on human rights report on detention of young people with learning disabilities or autism
- CQC inspection focus on identifying and responding to closed cultures, CQC action in response to Whorlton Hall
- 3rd annual learning from deaths report (LEDER)
- National autism strategy

National Performance
The NHS nationally continues to be struggling to achieve the constitution performance targets. For example: more A&E attendances than September 2018; RTT waiting list is 4.41 million – an increase of 35,500 since the previous month; Missing key cancer targets including the 2 week urgent GP referral (90%) and 62 day wait (76.7%)

There is significant demand for mental health services, with national acuity reported as:

- 1,389,109 adults in contact with NHS funded secondary mental health, learning disabilities and autism services on 31st July 2019
- 338,333 new referrals (10.4% increase) into NHS funded secondary NH, LD & autism services in the past year
- 472,025 children & young people in contact with NHS funded primary and secondary MH services on 31st July 2019
- 49,988 detentions under the MHA in 2018/19, an increase of 2% on the previous year

Clinical Standards Review
Work is underway to review the Clinical Standards for the NHS, in particular the standards described in the NHS Constitution. The review is due to report in March 2020 and is expected to be subject to public consultation. There are Trust pilot sites for new A&E, RTT, mental health and cancer standards and NHS England is commissioning an independent evaluation of the pilots. Their work is overseen by Clinical Standards Oversight Group chaired by Professor Stephen Powis. Healthwatch is also undertaking research into public perceptions. Information from the mental health pilot sites is starting to be shared, but it is early on in the pilots and they have only started to collect data.

NED and Chair competency and remuneration framework
NHSI/E has published a competency and remuneration framework for NEDs and Chairs. The framework has been developed with providers and sets out the competencies expected for those working as NEDs and Chairs. It also recommends remuneration for NEDs and Chairs for Trusts and Foundation Trusts. The main change is that the remuneration for Trust NEDs and Chairs has been moved to be in line with that for Foundation Trusts. Chris Lawrence, HPFT Chair has been actively involved in working with NHSE/I in developing the framework. The Trust is reviewing the framework and the Appointments and Remuneration Committee will be considering the framework and identifying any relevant next steps.

Royal College Report
In early November the Royal College of Psychiatrists published a report asking for action to reduce out of area placements. The report states that more NHS mental health beds are needed urgently in England to help end the “shameful” practice of sending severely ill patients far from home for treatment. The report clarified that the findings do not relate to highly specialist care. The Royal College of Psychiatrists report states that cuts to NHS mental health hospital beds have gone too far in some areas. Earlier in the year the Trust had a high rate of out of area placements but as a result of concerted work by the team this has reduced over recent months, although the situation does remain volatile.

NHS Pensions
Pensions and the impact of changes to tax laws continue to be an area of focus nationally. Within the Trust there is currently limited impact being experienced but it has been agreed that additional information sessions will be provided for all staff to enable them to better understand the issues and decide the best course of action. Recently Simon Stevens, Chief Executive of the NHS and Amanda Pritchard, COO for the NHS wrote to Trusts outlining an approach to resolving concerns about the impact of clinical staff exceeding NHS pension annual allowances. The Trust is working to consider implementation of the approach.

Regional and System update

This section of the briefing reviews significant developments at a regional and STP level in which HPFT is involved or has impact on the Trust’s services.

STP Update
The Board at its meeting in November 2019 received a detailed update on the STP. Developments since the meeting include:

- Long Term Plan – the STP has submitted its final version of the draft implementation plan, although the General Election will have an impact on the review of this and it may be that a fuller submission will be required in 2020.
- Recruitment underway for a single Accountable Officer for the three CCGs in the STP footprint.
- Continued development of Primary Care Networks (PCNs).
- The continued development of Integrated Care Partnerships for West Herts, East and North Herts and West Essex
- The way in which the future system will be able to best meet the needs of those with severe and ensuring Mental Health & Learning Disabilities, together with meeting the broader mental health needs and support for those the wider population, continue to be explored. There is agreement that this remains a priority for the system.

Regulators: NHSE/I
NHSE/I continue to be in a time of transition, senior teams are in place and going through a process to recruit to the whole team. It is complex piece of organisational design in the current legislative framework. Keith Loveman, Deputy Chief Executive and Helen Edmondson, Head of Corporate Affairs and Company Secretary have had an initial meeting with Victoria Woodhatch, Director of Performance for East and England and Director link for Hertfordshire and West Essex STP. The meeting was helpful and an opportunity for her to visit the Trust and its services is being organised. It is expected that over the next couple of months that assurance and support meetings will start to be programmed on a quarterly basis. The Trust welcomes these as it is an important opportunity to keep NHSE/I updated on matters at the Trust and to reach out for support as required.

Trust-wide update

Finally in this section, an overview of the Trust's most recent performance, along with other important information, is provided.

Winter
Preparations for Winter Resilience Plans are well developed and subject to assurance from NHSE/I. The Trust will be holding weekly conference calls from beginning of December and over the Christmas/New Year period. The Plan's covers to staffing across all the teams, including on call and operational management.

A number of schemes have been funded as part of the system winter resilience plans:
- CATT worker is based at HUC office to triage and respond to mental health calls where A&E disposition or Ambulance dispatch is indicted.
- The Twilight AMHP shift.
- Step-down service (6 beds) at Hightown Pretorian Housing Association to support discharge from hospital.
- Discharge to Assess (D2A) – both actual and virtual beds in place across Herts.
- Frailty Discharge to Assess nurse post to support D2A from Princess Alexandra Hospital.

The Trust's flu vaccination programme is well underway as the teams look to encourage staff to have the vaccine, for their own health and well-being as well as that of colleagues and service users.

Quality
The Trust held its quarterly engagement meeting with CQC on 28 November 2019. The meeting was a helpful opportunity to provide an update on work to meet the requirements of the action plan developed in response to the 2018 inspection report and work underway at the Trust. The Trust has

not yet received a Provider Information Request and whilst we do not know when the next inspection visit will be, we continue to focus on key quality objectives.

The Royal College of Psychiatrics has accredited Oak Ward as part of the Quality Network for Psychiatric Intensive Units. The accreditation is for three years and recognises a significant amount of work undertaken by the team.

The Trust were informed by Elysium Health care on 22 November 2019 regarding a number of allegations that have been made against their Potters Bar Clinic believed to date from April 2019, that BBC London were due to broadcast on 22 November 2019. The Trust has two adult and one CAMHS service users at the clinic and they were reviewed on Monday 25 November 2019 and the Trust is assuring itself there are no concerns.

Performance
The Trust has continued to see increased demand into our services (over 10% year on year). Services continue to be under significant pressure whilst performance continues to be generally strong overall. Access to services continues to improve, including CAMHS and EMDASS, whilst adult community services access remains strong. Nationally, pressure on beds continues, and we see this trend continuing within HPFT; with out of area placements and delayed transfers of care remaining an area of focus for us.

Community Survey
The Trust has received initial indications of the result of the National Community Mental Health Service User Survey Results undertaken earlier in 2019 and is awaiting formal publication by CQC. Five focus areas have been identified to further improve service user experience:

- Implementation of new place-based community mental health model in line with the NHS Long Term Plan, the Care Programme Approach (CPA) model
- Review communication to service users to ensure clearer details of reviews and provide more regular up to date information of changes in care coordinators, Consultants
- Continue with the implementation of Structured Clinical Decision making
- Continue to implement the Individual Placement Support (IPS) scheme
- Further expansion of peer support workers.

Finance
For the month of October there is a surplus reported of £30k against a Plan of £75k deficit, and for the year to date there is a surplus reported of £243k against a Plan of £125k surplus. The position has therefore remained ahead of Plan for October and for the year to date. This position is driven by increased income in the month, offset by the related increases in pay costs with a sizeable net headcount increase in the month and higher external bed costs.

It should be noted however that indications for November show some deterioration with increases for agency inpatient, community and medical and increased numbers in Acute beds. We remain relatively confident that the target control total for the year will be met.

The Trust has received planning permission for the development of Safety Suites which will provide high quality environments for LTS and seclusion when recovering. This is a significant programme with a 12 month timeline.

Well led
The Trust is working to start the independent Well Led Review process in 2020. The Board have been briefed on the process underway.

Success Areas

To enable the continued improvement of the care that the Trust provides and how the Trust is experienced as a place of work the Trust has identified key success factors and areas for focus. They are themed around care plans; safety; workforce; practice and leadership. Each theme has a number of specific areas identified against them.

Our People
Our staff continue to provide excellent care to our service users and this is recognised locally and nationally. Looking forwards we will focus on supporting staff through our Organisational Development Strategy focusing on supporting Great Teams, developing a just, fait and learning culture, diversity and inclusion, staff health and well-being and our Values.

Awards
In recognition for the transformation of services the CAMHS home treatment team were awarded the prestigious national HSJ award in the category for Acute or Specialist Service Redesign Initiative category - London and the south.

The Trust held its 14th Annual Staff Awards Ceremony on 27 November 2019 with twelve categories. It was a fantastic opportunity for staff to be recognised for the amazing contribution they make to providing excellent care.

Two Trust social workers have been nominated for Social Worker of the Year Award and will be attending the ceremony on 29 November 2019, supported by Jane Padmore, Director of Quality and Safety.

New Appointments
Following a national recruitment process an offer has been made for the post of Director of People and OD. The final elements of the HR process are being completed and it is hoped that the new Director will start in early February 2020. Ethel Changa has been appointed as the Deputy Director of Safe Care and Standards following a national recruitment process. She is due to start in the post within a month.

The Trust has also exceeded its target for the number of year one trainee nurses for mental health and learning disabilities who started with the Trust in November 2019.

Staff Survey
As of Thursday 28 November 2019 the Trust response rate was 53.2%, the highest ever achieved for the Trust. The average rate for mental health trusts at 25 November stood at 50.6% with the best performing at 61.4%. This is an improvement for the Trust and the work has already started to identify how the Trust can improve on this in 2020.

Tom Cahill,
Chief Executive

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item:** 6
Subject:	Integrated Governance Committee Report 20th November 2019	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Sarah Betteley, Non-Executive Director, Committee Chair
Presented by:	Sarah Betteley, Non-Executive Director, Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting held on the 20 November 2019.

Action required:

The Board is asked to receive and note the report.

Summary and recommendations to the Board:

An overview of the work undertaken is outlined in the body of the report. No issues were noted to be escalated to the Board.

Recommendation:
To receive and note the report and note that there were no issues that needed to be escalated to the Board.

Relationship with the Business Plan & Assurance Framework:

Strategic Priorities 1, 2, 3, 4 and 5. and associated Board Assurance Framework risks 1.1, 1.2, 2.1, 3.1, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6 and 5.1.

Summary of Financial, IT, Staffing and Legal Implications:

None.

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

The Committee regularly receives updates from the Equality, Diversity and Inclusion Group and a summary of their most recent meeting on the 10 September 2019 was received.

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

Evidence of robust governance review process for the Well Led standard.

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

None.

1. **Introduction**

The Integrated Governance Committee (IGC) was held on the 20 November 2019 in accordance with its terms of reference and was quorate.

2. **Reports were received from the IGC Sub Committees**

2.1 QRMC meeting held on 14 November 2019. The IGC noted the focus at QRMC on the West SBU and performance against the CQUIN targets for 2019/20. It was noted that the Personality Disorder Pathway had been launched and that recruitment to the team was well underway. The QRMC received assurance the policy compliance remained high and discussed the clinical audit escalated to Group. There were no matters for escalation to IGC.

2.2 Workforce and Organisational Development Group held on 5 November 2019. The IGC noted that the meeting had received an update on Recruitment and Retention; the Committee were informed that there were over 200 people currently in the recruitment pipeline. In response to a question it was confirmed that the time to hire was lower than 2018 but had increased earlier in 2019. It was reported that this was due to volume of recruitment underway and slippage in processing of pre-employment checks. The Committee heard that the team were looking to resource this differently to reduce the time it was taking.

2.2.1 The Group discussed training and skills support being offered to assist managers and supervisors with having conversations with people. The aim being to empower people to seek resolution rather than the formal route to gain resolution. Quarter 2 Pulse survey was received. One change from quarter 1 related to bullying and harassment experienced by staff as there were new questions which provided greater information

2.2.2 Work is continuing to encourage staff to complete their staff survey, including communications to emphasise that survey is not just for unhappy staff and helping with accessibility for staff that do not regularly access their email. It was noted there were no items for escalation to IGC.

2.3 Information Management and Technology and Information Governance Programme Group held on 21 October 2019. The meeting discussed performance against targets for FOIs and Subject Access Requests. It has been agreed to use temporary resource to clear backlog by end of quarter 4. The Group received feedback from a recent phishing campaign by HBLICT with a formal report due to go to Audit Committee.

2.3.1 In addition IGC received an update regarding performance of HBLICT services with regard to handling of contacts. The Committee noted the improvement in waiting times and reduction in number of contacts and that the Group continue to monitor performance and use of different contact points. There were not matters for escalation to IGC.

2.4 Equality, Diversity and Inclusion Group meeting held on the 10 September 2019. The Committee discussed the Equality and Diversity at Work Audit Results and the NHSI Learning Disability Quality Standards survey results. The Committee welcomed the Operational Policy for Gender Identity within

HPFT services and it was confirmed that it would apply to Governors as well as staff.

3. Governance and Regulation

3.1 Board Assurance Framework

The updated Board Assurance Framework (BAF) was reviewed and approved. The Committee noted the progress made and agreed that the strength of the framework lay in the clarity of the assurances. The Committee noted that work had been undertaken to update assurances with Lead Directors. This meant it included the most recent evidence and the principle risks for Strategic Objective 4 had been updated. It was agreed for next iteration to consider how to best capture any risks associated with ICS and changing external landscape.

3.2 Trust Risk Register

3.2.1 IGC considered and approved the Trust Risk Register for November 2019. The Committee discussed the process of each Executive Director reviewing the risks as SRO as well as the Executive team undertaking peer review of the Risk Register as a whole.

3.2.2 The Committee reviewed the risks that had been updated and considered the proposals for one risk from West SBU be escalated to the Trust Risk Register. It was agreed for the West SBU risk to remain on the SBU register as it was specific to that SBU and it was agreed that particular attention would be given to it in the quarter 3 Integrated Safety Report.

3.3 Bi-Annual Caldecott Report

The Committee considered the Bi-Annual report. It was noted that there had been a slight increase in the number of queries seeking advice and the most significant issues related to information sharing with partners. One incident had fallen outside the time parameters due to the need to get clarification from the requester.

3.4 IGC Annual Business Cycle 2020/21

The Committee received and approved the business cycle for 2020/21. It was agreed to amend the cycle to describe the purpose of the paper coming to IGC and look to consolidate papers where appropriate.

3.4 Integrated Governance Committee Self-Assessment 2019

The Committee considered a proposal with regard to the self-assessment of its effectiveness. A proposal for an on line questionnaire was considered and subject to the amendment of one question was agreed. It was noted that the results of the self-assessment would be considered at the Committee's meeting in January 2020.

4. Deep Dive – Violence and Aggression

4.1 The Committee received a deep dive into violence and aggression across inpatient units over 10 quarters. It was noted that 95% of assaults reported resulted in no or low harm with 4.4% at moderate harm level. Service user assaults had shown little variation in the trend, although hot spots were seen as a high challenge for assaults and use of restrictive practice. With regard to

restrictive practice, there was a reported increase from quarter 4 2018/19 to quarter 1 2019/20, in both the use of restraint and intramuscular medication.

4.2 During the discussion it was noted that individual service users' specific conditions need to be considered as they can 'skew' the data. Also that the incidents of violence and aggression in the community have a different profile and are relatively few in number. Staff reports of experience are triangulated across the different independent data. The Committee were updated on the actions undertaken already and noted the newly established Restrictive Practice Committee and agreed the proposal of the quarter 3 Integrated Safety report would include focus on community violence.

5. **Workforce**

5.1 **Quarter 2 Workforce and Organisational Development Report**

5.1.1 An update was received on the activity of the workforce and OD directorate. The meeting heard that during quarter two the focus had continued with regard to the experience of the people working at HPFT. The Committee considered the report that provided detail on the quarter 2 pulse survey and key workforce metrics.

5.1.2 It was noted that the vacancy rate and establishment numbers had increased. It was confirmed that if the new roles that had been added to the establishment were removed then the vacancy rate would have reduced. The Committee discussed the figures of staff who self-declared as having a disability asking the workforce team to consider the details of this further.

5.2 **Statutory and Mandatory Training Update Report**

5.2.1 The progress made in quarter two with regard to Statutory and Essential training compliance was discussed. The Committee noted that at the end of quarter two statutory compliance was at 93% and essential at 88%, both against the minimum compliance level of 92%.

5.2.2 It was noted that the drop in essential compliance was due to the introduction of Safeguarding Adults Level course 3. The Committee were assured that with regard to this Safeguarding training that the Trust was on trajectory to be compliant by March 2020.

5.3 **Guardian of Safe Working Quarter 2**

5.3.1 The Committee noted that there had been a spike in exception forms in July, with August and September seeing a significant improvement. The issues raised in the exception reports were discussed and it was noted that the sickness rates among Junior Doctors had improved. The Committee were informed that a new system of reporting sickness had been implemented in August. It was noted that work continued to improve the experience for junior doctors while on call.

5.4 **Bi Annual Freedom to Speak Up Report**

5.4.1 The Committee noted the Bi-annual report that detailed the number of cases raised and the emerging themes. The main theme related to Bullying and Harassment and Learning Disabilities and Forensics emerged as an area that had raised the most concerns. It was confirmed through questioning that the themes from the Trust were consistent with other mental health trusts.

5.4.2 The Committee were informed that NHSI had published a self-review document. It was agreed that the first draft of the Trust's self-assessment would be presented for discussion to the January 2020 Committee meeting.

5.5 **Quarter 2 Safer Staffing Report**
The detailed report was received and it was noted that quarter 2 saw adequate staffing and shift cover. It was noted that Safe Care continues to be embedded within inpatient services with daily Safe Care calls. The Committee were updated with regard to targeted work in SBUs for quarter three.

6. **Quality Safety**

6.1 Restrictive Practice Update
The report was noted as the item had been covered under the deep dive.

6.2 Quarter 2 Integrated Safety Report

6.2.1 The Committee discussed and approved the quarter two report. It was noted that development of the safety dashboard was underway and scheduled to be in place in quarter three. The Committee were updated on the work underway to provide assurance on Safeguarding for Adults and Children

6.2.2 The national suicide data for 2017 was discussed as it has recently been published; the data described a local increase that was in line with a national one. The Committee were informed that themes from the learning from death work were around older people and some practice issues.

6.3 Bi-Annual Infection Control Report
The Bi-Annual report highlighted key progress over the past six months in maintaining low incidence, improvements in training compliance, cleaning, waste disposal and reporting systems. The next period will focus on infection control in the community and continue the focus on cleaning and ensuring modern matrons are involved in the visits.

7. **Quality Effectiveness**

7.1 **Quarter 2 CQUIN Report**
The report provided IGC with update on performance against CQUIN goals for quarters one and two and forecast for last two quarters of the year. It was reported that the CAMHs measure was now green and Flu was forecast not to be met. Overall the position at this point was better than this point last year.

7.2 **Quarter 2 Continuous Quality Improvement Report**
The Committee noted that quarter two objectives for CQI had been met and good progress was being made with embedding CQI in performance improvement and project delivery. Two risks were identified regarding diversity and continued momentum.

7.3 Quarter 2 Practice Audit Implementation Report
The report provided an update on progress of clinical audit programme for quarters two and three. The Committee were updated with regard to the one audit escalated to QRMC relating to section 136 detentions. The Committee received an update on the audits not approved by Practice Audit Implementation Group.

7.4 Bi Annual Quality Impact Assessment Report
The report identified that in line with the requirement that identified schemes require a Quality Impact Assessment, this had been achieved. The continued work on long standing proposals as well as new proposals was noted.

7.5 Bi-Annual Claims Report
The Committee noted the report that detailed the claims received from April to September 2019, those that had been settled and learning identified. It was reported that 89% of claims are defended successfully and that work was continuing to triangulate with incident and complaint information.

8. **Quality Experience**

8.1 **Quarter 2 Service User and Carer Experience Update**
The Committee noted there has been a reduction in complaints and PALS and an increase in compliments and Having Your Say surveys received in quarter two in comparison to quarter 1. It was confirmed that feedback from Users Councils was captured through the inclusion team

9. **Innovation and Transformation**.

9.1 **Quarter 2: Information Governance Report**
The report detailed the work of the Information Rights and Compliance team, including FOI, Subject Access Request, and data incidents. In this period two data breaches had been escalated to the ICO, it was noted that automation as detailed in the digital strategy would help reduce data breaches. There were no matters of escalation to the Committee.

10. **Recommendations**

The Board is requested to receive and note the report and to note that there were no items that needed to be formally escalated.

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item:** 7
Subject:	Quarter 2 2019/20 Integrated Safety Report	**For Publication: Yes**
Authors:	Nikki Willmott Head of Safer Care & Standards and Andrew Cashmore Practice Development and Patient Safety Lead	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety, Chief Nurse
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety, Chief Nurse	

Purpose of the report:

This paper is presented to the Board of Directors to provide assurance on actions taken in response to safety related incidents, themes, learning in keeping with the Quality Strategy, CQC regulations, and the commitments that are set out in the Annual Plan.

Action required:

Receive: To discuss in depth the Patient Safety report and its implications for the Trust.

Summary and recommendations:

This report provides an overview of the incidents reported in the Trust and progress made in relation to ensuring safe services are delivered and that service users remain safe whilst under our care in the second quarter of 2019/20. It includes a review of mortality data and serious incidents reported and investigated by the Trust. The report seeks to provide assurance on actions taken in response to safety related incidents, serious incidents, mortality data and associated learning. This is the first quarter where safeguarding is included in the integrated safety report, rather than a separate report.

Work has taken a multi-faceted approach using a combination of planned continuous quality improvement initiative and immediate response to identified or emerging needs, a sample of which are detailed in the report. The annual plan priorities in relation to safety are to reduce the number of suicides and decrease the number of violence and aggression incidents by service users. At this point in the year the Trust has seen a decrease in the number of unexpected deaths, when compared to last year and a decrease in violence and aggression from service users to staff. The service user to service user violence and aggression has not changed. There has been a significant increase in the number of responses to the Having You Say questionnaire, but this has revealed that more work is needed to ensure that service users feel safe whilst in our services.

The safety dashboard, with relevant Key Performance Indicators (KPI), which will be hosted on Spike 2, is scheduled to be in place in Q3 2019/20. Phase1 KPI's will be those reported nationally and those included in the Trust Annual Plan. The report provides a review of trends, themes and identified learning in this reporting period.

Safeguarding both children and adults continues to be a priority for the Trust and progress has been made against the Safeguarding Improvement Plan, particularly in relation to strengthening governance through supervision and audit, implementing the updated intercollegiate document with the appropriate strengthening of training and the work on sexual safety in our services.

The Integrated Governance Committee is asked to receive and discuss in depth the Patient Safety report and its implications for the Trust.

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

Relation to the Trust Risk Register:

The Trust's Risk Register has a number of risks that relate specifically to safety which are reported in the quarterly Trust Risk Register Reports. Those below have a significant impact on safety and service user harm:

- The Trust is unable to recruit staff to be able to deliver safe services due to national shortages of key staff
- The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services
- Implications for the Trust of differing scenarios arising from EU Exit
- Unable to provide consistent timely access to CAMHS Community Services
- Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness.
- CAMHS: Unable to provide consistent timely access to CAMHS Community Services (Risk 1150)
- Flu: The Trust may not be able to sustain service user safety during a flu outbreak (Risk 1147)
- EU Exit: The Trust may experience continuity and/or cost of supply issues for critical goods/services. (Risk 1000)

Relation to the BAF:

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 & support recovery through the delivery of **effective** evidence based practice

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

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

There are no current financial, staffing, IT or legal implications arising from this report.

Equality & Diversity and Public, Service User and Carer Involvement Implications:

There are no implications arising from this report.

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

This report sets out actions taken in Quarter 2 2019/20 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

This report has been presented to QRMC 14/11/19 and IGC on 20th November 2019

Executive Summary

The Integrated Governance Committee (IGC) receives and scrutinises all aspects of safety on behalf of the Trust Board. It conducts deep dives into areas that are identified as requiring additional focus and, alongside this report the committee is receiving a deep dive into violence and aggression towards staff. The Trust continues with its work on ensuring safety and quality is at the heart of what we do. There remains a commitment to improving and embedding the safety and just culture, as set out in the Quality Strategy, to improve the experience and safe care of our service users.

The annual plan priorities in relation to safety are to reduce the number of suicides and decrease the number of violence and aggression incidents by service users. At this point in the year the Trust has seen a decrease in the number of unexpected deaths, when compared to last year and a decrease in violence and aggression from service users to staff but this is correlated with an increase in the use of seclusion. The service user to service user violence and aggression has not changed. There has been a significant increase in the number of responses to the Having You Say questionnaire, but this has revealed that more work is needed to ensure that service users feel safe whilst in our services. The level of harm sustained as a result of violent incidents has reduced and remains lower that the national average. Plans have been drawn up and planning permission has now been granted for the safety suites which include seclusion rooms, long term segregation rooms and low stimulus rooms.

A multifaceted approach has been taken to improving how service users, visitors and staff feel safe, whilst in services and in work, has been adopted, with oversight from both the safety committee and the newly formed restrictive practice committee. Work also continues internally and as part of the wider system in relation to prevention and this has included the launch of the Stay Alive app as well as a task and finish group developing training and education about clinical risk formulation and sexual safety. There continue to be challenges in completing root cause analysis reports of serious incidents. The CQI methodology was applied but did not have the impact that was hoped for and so the second round of the cycle has begun, building on the previous work. This cycle will include further embedding of the just culture and safety culture work.

The Safeguarding team has continued to work through the Safeguarding Improvement Plan 2019/20. Significant progress has been made across a range of outcomes, including improvement of systems for oversight and reporting for safeguarding children, partnership working and pathways in relation to historic child abuse and the development of new safeguarding adult level three and domestic abuse training. The Trust has joined the NHSE Sexual Safety Collaborative with the aim of enhancing sexual safety for service users and staff. Work continues in partnership across agency boundaries in all areas of the Trust to improve the safety and wellbeing of service users and their families towards our vision of “preventing harm and enabling safety through vigilance, competence and personalised outcomes focused practice.”

This quarter has seen good progress against some of the annual plan objectives with the others receiving further attention in Q3 to ensure all are met. The exception is the building of the safety suites, which were delayed, due to the planning position.

Integrated Safety Report Quarter 2 2019/20

1. Introduction

1.1 The Patient Safety Report provides members with an overview of incidents and serious incidents reported on Hertfordshire Partnership NHS University Foundation NHS Trust's (the Trust) Datix incident reporting system during Quarter 2, 2019. Previously the committee has seen a quarterly integrated safety report, a safeguarding report and a mortality governance report. These latter two reports have now been integrated into the Integrated Safety Report to enable members to triangulate the data and identify themes more easily.

1.2 The report is divided into the following sections:

- Part A Governance and Assurance
- Part B Analysis of Incidents
- Part C Learning and Changing Practice

1.3 The Trust's Annual Plan objective for safety is that *we will provide safe services, so that people feel safe and are protected from avoidable harm.*

The key priorities to support this are:

- *We will continue our drive to reduce suicides and prevent avoidable harm*
- *We will ensure restrictive practices are in line with best practice*
- *We will target activities to reduce violence against service users and staff.*

1.4 Datix is a live data base and therefore is subject to change. All data in this report was taken on 2nd October 2019. The report provides a review of trends, themes and identified learning in this reporting period. The report gives an overview of Trust incident data, with comparison against 2018/19, including serious incidents, falls, pressure ulcers, ligature risk, absent without leave, restrictive practice, feeling safe and violence & aggression.

1.5 Key areas of learning and actions taken are discussed in the report with an outline of the education and training the Trust delivers to support safe care.

Part A- GOVERNANCE AND ASSURANCE

1. Introduction

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

1.2. The Quality and Risk Management Committee (QRMC) reports to IGC on the work of QRMC and its subcommittees. The Safety Committee oversees work relating to safety in the Trust and holds the safety risk register. The Mortality Governance Group, the Moderate Harm panel, the Restrictive Practice Group, the Sexual Safety group, the Falls Group, the Suicide Prevention Group, and the Physical Health Committee play a significant role in the work and governance relating to safety.

2. Priorities

2.1. A number of priorities were set in relation to safety in the Trust's 2019/20 Annual Plan:

- *We will continue our drive to reduce suicides and prevent avoidable harm*
- *We will ensure restrictive practices across the Trust are in line with best practice*
- *We will target activities to reduce violence against services users and staff.*

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

2.3. The priorities are also supported by the safety domain of the Quality Strategy which was launched in this quarter. The principles of just culture, learning and the service user as partner in their own care and treatment as well as service development through Continuous Quality Improvement are fundamental to this approach.

3 Trust Risk Register

3.1 The Trust's risk register is reviewed regularly and has a number of risks that relate specifically to safety; those below have a significant impact on safety and service user harm:

- The Trust is unable to recruit staff to be able to deliver safe services due to national shortages of key staff
- The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services
- Implications for the Trust of differing scenarios arising from EU Exit
- Unable to provide consistent timely access to CAMHS Community Services
- Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness.

3.2 In this Quarter the Trust Board agreed to two risks being escalated to the Trust Risk Register:

- CAMHS: Unable to provide consistent timely access to CAMHS Community Services (Risk 1150)
- Flu: The Trust may not be able to sustain service user safety during a flu outbreak (Risk 1147)

3.3 One risk was downgraded from the Trust Risk Register to the local risk register:

- CAMHS: Failure to provide an efficient and effective CAMHS service which impacts on the clinical care provided to young people (Risk 617).

3.4 Risk scores increased for two risks:

- EU Exit: The Trust may experience continuity and/or cost of supply issues for critical goods/services. (Risk 1000)
- Finance: The Trust is unable to ensure short term financial performance in the current year (Risk 116)

3.5 One risk score has been decreased and amended

- S136: Unlawful detention of service users under S136 breaches beyond 24hrs (Risk 882)

3.6 These are reported in the quarterly Trust Risk Register Report. This report provides the IGC with additional information about the work that is being undertaken to address and to mitigate against these risks.

4 Safety Dashboard

4.1 The safety dashboard with relevant Key Performance Indicators (KPI) is scheduled to be in place in Q3 2019/20. Phase 1 KPI's will be those reported nationally and those included in the Trust Annual Plan:

- *We will continue our drive to reduce suicides and prevent avoidable harm*
- *We will ensure restrictive practices across the Trust are in line with best practice*
- *We will target activities to reduce violence against services users and staff.*

4.2 The safety dashboard will be hosted on 'SPIKE 2' and allow real time data to be viewed at Trust, Strategic Business Unit (SBU) and service level. This will support the timely identification of hot spot areas, and be a clear method of tracking declining or improving positions and learning from this.

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

5.1 The CQC published its report on the 15th May 2019 following its core service and well led inspection which took place week commencing 4th March 2019. The CQC inspected the following services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems

5.2 The Trust has 1 'Must Do' action and 24 'Should Do' actions. The Trust agreed to undertake a number of actions and to report back to the CQC by 31st August 2019 in relation to the following regulation breach 'The trust must ensure all staff receives regular, good quality supervision, in accordance with trust policy' in relation to Wards for Older people with mental health problems'.

5.3 The Trust has confirmed that these actions have been completed but that we continue to seek to strengthen the practice in this area and throughout the Trust. PACE undertook a supervision audit that was completed in August 2019, which was previously reported to IGC.

5.4 A number of the 'should do' actions have been completed, others remain ongoing. A more detailed report will be brought to the January 2020 IGC.

6 HSE Visit and Outcome

6.1 The Health and Safety Executive inspected the Trust from 13th to 15th May 2019. The inspection was one of twenty inspections that are planned nationally to examine the management arrangements for violence and aggression (V&A) and musculoskeletal disorders (MSDs) at care providers in the public sector.

6.2 In Q2 2019/20 the Trust provided a formal response to the HSE on work undertaken around the Notice of Contravention (NOC) and four improvement notices received following the HSE visit:

- Violence & aggression against staff and need to improve processes, plans, learning and risk assessment
- Risk Assessment for violence and aggression to employees and those not in our employment from or by service users
- Arrangements to get all slings under a thorough scheme of examination
- Arrangements to review and update all moving and handling risk assessments for service users.

6.3 A full report was brought to the last IGC and the Health, Safety and Security Committee continues to have oversight of the action plan put in place following the HSE visit and reports through to the Integrated Governance Committee. The Q2 Health and Safety Report will be presented to IGC in January 2020.

7 STP Zero Suicide Pan

7.1 As part of the Mental Health Delivery Plan 2019/20, Clinical Commissioning Groups and STPs were asked to refresh or fully establish a Strategic Transformation Partnership (STP)-wide, multi-agency suicide prevention plan bringing together local authority action plans (in line with national guidance) and wider Mental Health transformation. This was to ensure robust links across, at a minimum, the core defined partners in public health, primary care and secondary care (and wider agencies). This included plans for reducing inpatient suicides to zero in line with Secretary of State for Health and Social Care's Zero suicide ambition. In quarter 2 this was approved by the Trust Board and recommended to the STP.

7.2 The Trust has in place a Zero Suicide Plan that was developed to support the Government's ambition of zero suicides in mental health inpatient settings and the commitment to reduce suicide by 10% by 2020/21. Progress with the plan will be monitored by the Trust's Suicide Prevention Group, which reports to the Safety Committee. Updates will be included in the quarterly Integrated Safety Report. Although the requirement was to develop a plan that aimed at zero suicides in the in-patient services the Trust decided to take Action Plan further and incorporate actions being taken to aim to reduce suicides in the community services.

8 Parliamentary and Health Service Ombudsman (PHSO)

8.1 In June 2019, the Parliamentary and Health Service Ombudsman (PHSO) published its report on its investigations into the deaths of two inpatient service users who died under the care of Essex Partnership University NHS Foundation Trust (formerly North Essex Partnership University NHS Trust), in two separate incidents in 2008 and 2012. The report was titled 'Missed Opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust'.

8.2 A paper was presented to the Safety Committee in September 2019 to share the key findings and learning amongst Trust services. An assurance statement will be requested from each SBU around actions taken in response to the three key points above.

9 Conclusion

9.1 This section of the report has set out how the IGC is receiving assurance in relation to safety. It seeks to demonstrate how all intelligence relating to safety is triangulated effectively.

Part B- INCIDENTS INCLUDING SERIOUS INCIDENTS

1. **Introduction**

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

2. **Trust Incident Reporting**

2.1. Patient safety incidents are defined by NHS Improvement (NHSI) as *'any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare'*. Reporting incidents supports the Trust to learn and improve which, in turn helps the Trust to keep service users safe. A Trust with a positive safety culture and committed to learning expects to have a reporting culture that encourages staff to report incidents and near misses, but where harm remains low.

2.2. Datix is the incident management system the Trust uses for staff to report incidents. Training is provided for staff and managers on the use of Datix. There is local monitoring and oversight of data by each SBU and additional quality assurance checks undertaken by the Safer Care Team on incidents which are moderate harm and above.

2.3. Clinical Directors, Team Leaders and Matrons have access to incident dashboards on Datix to enable the use of incident reporting for team reflection and learning. During 2018/19, work commenced on a Safety Dashboard on Spike 2, with a set of agreed safety KPIs. This is in addition to generic and bespoke dashboards available on Datix for subject matter experts, Team Leaders and SBU management teams. The Datix Lead provides a rolling programme of training for staff and managers.

2.4. The number of incidents reported in Quarter 2 2019/20 (chart 1) has marginally increased compared to the previous quarter and the overall trend is of a gradual increase quarter on quarter over time. It can be seen that incidents resulting in categories of low harm and moderate harm have all fallen in Quarter 2 2019/20 when compared to the previous quarter (chart 2).

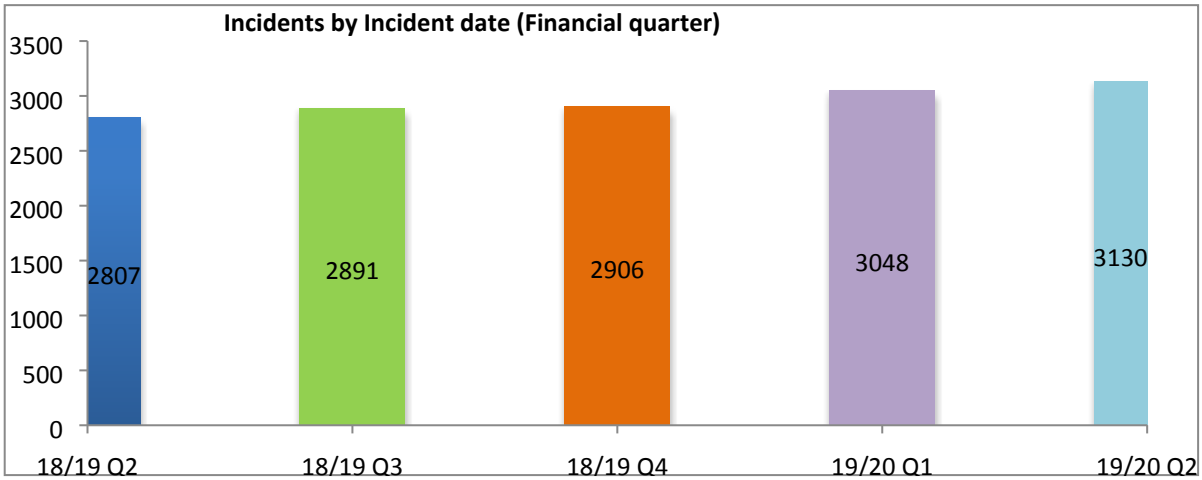
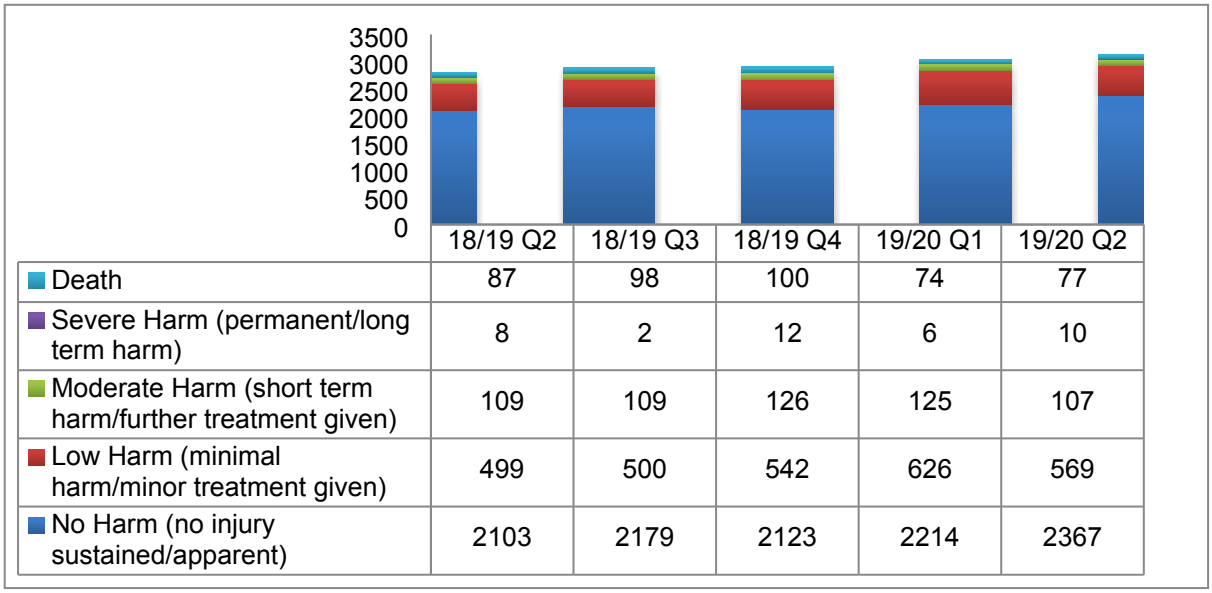


Chart 1 Total Trust Incidents Q2 2018/19 to Q2 2019/20



	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Death	87	98	100	74	77
Severe Harm (permanent/long term harm)	8	2	12	6	10
Moderate Harm (short term harm/further treatment given)	109	109	126	125	107
Low Harm (minimal harm/minor treatment given)	499	500	542	626	569
No Harm (no injury sustained/apparent)	2103	2179	2123	2214	2367

Chart 2 Total Trust Incidents by Harm by Quarter Q1 2018/19 to Q1 2019/20

3. **National Reporting and Learning System (NRLS) Benchmarking Data**

3.1. The Trust reports patient safety incidents to the National Reporting and Learning System (NRLS) in accordance with the national guidance. The latest release of the Organisational Patient Safety Incident Report data for NHS organisations was published in September 2019, and provides data relating to patient safety incidents occurring between October 2018 and March 2019.

3.2. The published data shows that our rate of patient safety incidents per 1,000 bed days fell from 36.3 in the previous published report to 34.11 (2,615 incidents reported to NRLS between April 2018 and September 2018, down to 2,349 incidents reported between October 2018 and March 2019). However, the published data demonstrates that there is no evidence for potential under-reporting by the Trust (chart 3) below (the larger blue circle represents the Trust's reporting rate in comparison with all Mental Health Trusts nationally).

Chart 3 Overall reporting rate compared with all Mental Health NHS Trusts

3.3. Incidents are subject to a quality assurance check by the Safer Care Team prior to submission to the NRLS to ensure accurate reporting.

3.4. A new prompt has been added to Datix to enable the reporter to identify patient safety related incidents which will assist the Safer Care Team to more easily identify those incidents that meet NRLS reporting criteria.

4. **Serious Incident Overview**

4.1. *'Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential*

for learning is so great, that a heightened level of response is justified' (Serious Incident Framework 2015). The Trust awaits the publication of the updated Serious Incident Framework expected in 2019/20, following the consultation which ended in July 2018. The Trust Board will be briefed on the outcome, implications and Trust plans for implementation at that time.

4.2. The Trust welcomed the publication of the NHS Patient Safety Strategy in July 2019 and will continue to embrace the principles of a just culture, continuous improvement, collaborative working with service users around patient safety, learning from excellence and responding appropriately when things have gone wrong. The principles have been incorporated into the Quality Strategy and will be implemented through the delivery plan.

4.3. The Trust reported a total of 30 Serious Incidents in Q2 2019/20 (table 1) when compared to 46 in the same period in 2018/19.

Category	Q2 2018/19	Q2 2019/20
Unexpected/avoidable deaths	20	14
Apparent/actual/suspected self-inflicted harm	3	7
Disruptive/aggressive/ violent behaviour	3	2
Slip/trip/fall	2	3
Apparent/actual/suspected homicide	1	1
Abuse/alleged abuse of adult patient by staff	0	0
Medication incident	0	0
Unauthorised absence	1	0
Pressure Ulcer meeting SI criteria	0	0
Confidential information leak/information governance breach	0	0
Commissioning Incident meeting SI Criteria	0	3
Diagnostic incident including delay meeting SI criteria	0	1
HCA Infection Control Incident meeting SI Criteria	0	1
Mental Health Act Paperwork	1	0
Abuse/alleged abuse of adult patient by third party	0	0
Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare services	0	0
Adverse media coverage or public concern about the organisation or the wider NHS	0	0
TOTAL	31	32

Table 1: Serious Incidents reported Q1 2018/19 to Q1 2019/20 by StEIS category

4.4. The Trust continues to embrace opportunities for learning and is reporting different types of serious incidents in each quarter following discussion and agreement at the Moderate Harm Panel. Unexpected deaths (14) and self-harm (7) incidents were the top two categories reported in Q2 2019/20.

4.5. There has been a decrease in the number of unexpected deaths reported as serious incidents in Q2 when compared to the same quarter in 2018/19; this category includes substance misuse related deaths, deaths of an unknown cause and suspected suicides.

4.6. For deaths reported to the Coroner, the inquest will not have been held and it is therefore not possible, in the majority of cases, to record the cause of death at the time of reporting on Datix. The Trust has a process for following up on causes of death by the Safer Care Team and the Mortality Governance Lead. It is not always possible to obtain a cause of death for every case if, for example, it is not clear where a service user died.

5. **Duty of Candour**

5.1. The Trust's Duty of Candour policy was updated in Q2 2019/20 following the recommendations made by internal audit. These changes included

- To more clearly define the 10-day regulatory requirement of fulfilling Duty of Candour for all moderate harm and above incidents
- To reflect the Safety Committee being the current governance and reporting arrangements.
- A flowchart has been added to provide clarity on roles and responsibilities for team managers around implementation and assurance around the duty of candour process.

The policy was presented to the Safety Committee for ratification in October 2019.

5.2. Phase 2 of the Safety Dashboard will include a KPI on duty of candour compliance to enable reporting in future Integrated Safety Reports. Work will continue in quarters 3 and 4 to ensure that Duty of Candour process is embedded across all areas of the Trust.

5.3. In keeping with a commitment to being open and transparent on completion of the review, a copy of the serious incident report is shared in full with the service user or family with an offer to meet to go through the findings. A copy of the report is also sent to HM Coroner where appropriate.

6. **Serious Incident Process improvements**

6.1. The increased reporting of serious incidents from April 2018 led to a backlog of cases that were not being completed and submitted to the relevant Commissioner within the national timeframe of 60 working days. To address this, the Serious Incident process was developed into a Continuous Quality Improvement Project with an aim to improve the quality of the learning and efficiency of the process, leading to improved compliance with reporting timeframes and timelier sharing of the reports with families and sharing of the learning with clinical teams. This CQI project did not have the impact to the extent that it was needed.

6.2. The Trust completed and submitted 32 serious incident reports during Q2 and work is continuing to seek assurance that learning has been embedded across SBU's. Weekly reporting to the Executive Director Quality & Safety, the Executive Medical Director and the Executive Director of Service Delivery and Service User Involvement continues to enable monitoring and identify where actions or additional focus is needed.

6.3. Timeliness is improving for serious incidents reported although it requires more pace and the Trust is still challenged to keep within the 60 day timeframe. A pilot of a revised serious incident process is due to commence in Q3.

6.4. To further strengthen this work the Trust is attending a workshop in November 2019 for an early adopter site of the Patient Safety Incident Response Framework to inform the work of the Trust to implement the changes going forward. NHS England

have advised that implementation of the changes outlined in the PSIRF will be rolled out over the next two years.

6.5. A root and branch review of the incident management process commenced in Q2, led by the Director of Nursing and Quality. The review panel includes representation from safer care, medical leadership, operations, commissioners, carers and service users.

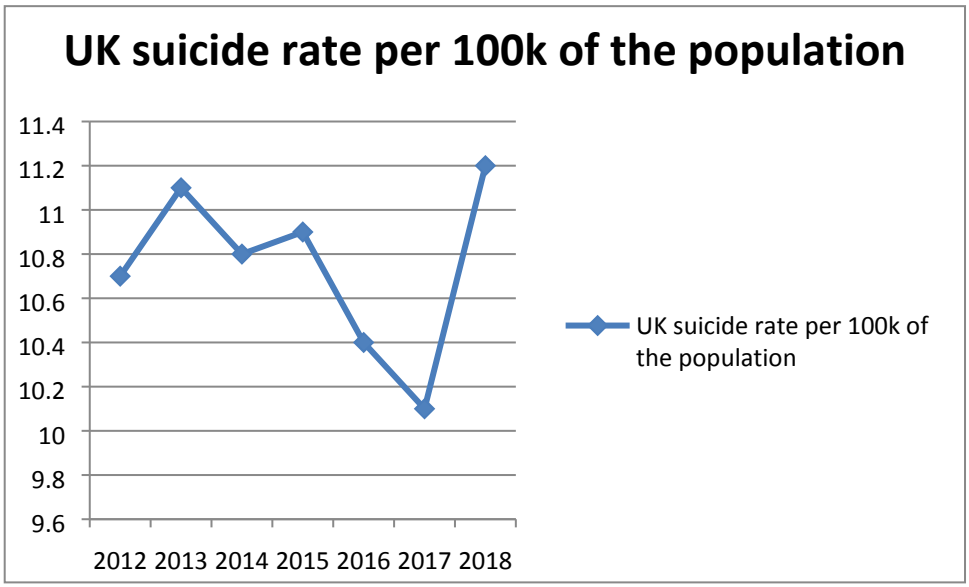
6.6. The objective of the review is to improve safety by ensuring we systematically learn from incidents. This review is part of the Quality Strategy which is driven by CQI and aims to develop a learning, safe and just culture.

6.7. The review includes communication and involvement with families, commissioners and regulators as well as internal stakeholders, timeliness of reporting and investigation, willingness of staff to be involved and seeing beyond it being a process, timeliness of learning being implemented, demonstrated by closing down of action plans and reduction in the repeated themes from serious incidents, use of Datix to record progress and outcomes by the owners and others, KPI review and systems for monitoring, quality of reports and actions recommended, consistency and ownership.

6.8. The review is due to be completed by 1st January 2020 and will detail recommendations that will be taken forward through to implementation 1st April 2020.

7. Suicide Data and Suicide Prevention

7.1. There has been a downward trend in suicide rates within England (and East of England), albeit with several statistically significant peaks' until last year when there was a spike nationally (Graph one). The Trust also so an increase in 2018 but not to the extent that was seen nationally and Hertfordshire remains one of the lowest reporters of suicide in the country.



Graph one

7.2. It is recognised that the death of someone by suicide can have a profound effect on families, friends, colleagues, first responders, staff, the wider community and beyond. It has been estimated that around 135 people may be affected by each

person dying by suicide. There is also a considerable economic cost estimated at around £1.7 million per death. Whilst Hertfordshire continues to have lower rates of suicide than the national and regional levels, in 2018, inquests were concluded by the Coroner on 95 deaths attributable to suicide.

7.3. In July 2018, the standard of proof used by Coroners in England and Wales to determine whether a death was caused by suicide was lowered from the criminal standard (beyond all reasonable doubt) to the civil standard (on the balance of probabilities). The lowering of the standard of proof is expected to result in an increased number of deaths recorded as suicide going forward.

7.4. The Trust is committed to an aspiration of zero suicides in keeping with the Hertfordshire Suicide Prevention Strategy. The Trust set an aspiration, through its annual plan, to reduce the number of confirmed suicides by 10% in 2019/20. An indication in relation to the position at any one time is only an estimate as it is not possible to pre-empt the outcome of the inquest.

7.5. Suicide and Open conclusions that were reported for deaths reported as Serious Incidents between 2005 and 2019, where the inquest has been concluded (chart 4), shows an upward trend. It should be noted that all inquests have been concluded from 2005/06 to 2015/16 and therefore the data within this specific reporting period will not change in future reports.

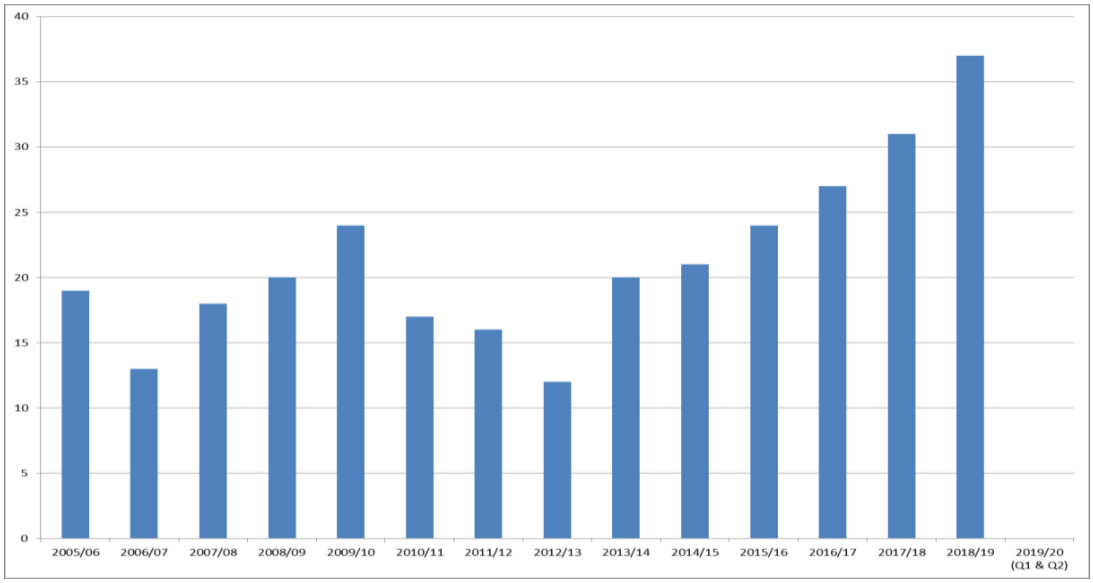


Chart 4: Suicide/Open Conclusions by Incident Date (April 2005 – September 2019)

7.6. There are remaining inquests still to be heard for 2016/17, 2017/18 and 2018/19; therefore at the time of this report these graphs do not contain information on all deaths, as outcomes have not been concluded. Chart 5 below shows an overview of deaths and where they are in process, providing information on expected outcomes. Work is ongoing to enable to Trust to strengthen this area of reporting in 2019/20.

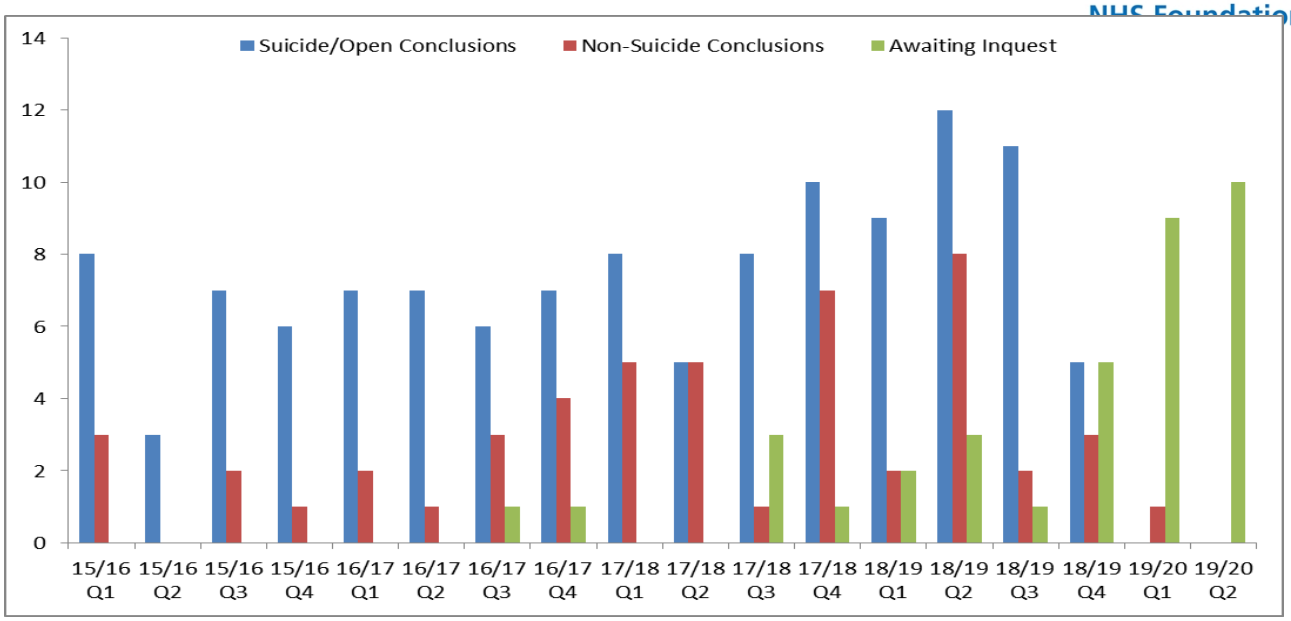


Chart 5 Unexpected Deaths by Incident Date (April 2015 – September 2019)

7.7. The Public Health Suicide Prevention Audit was published in September 2019 and will be presented by the Public Health Lead at the Trust's Suicide Prevention Group in October 2019 to inform the Trust's ongoing work plan. The audit reported on 95 deaths that occurred in Hertfordshire between 1st January and 31st December 2018, an increase from 74 in the 2017 audit. Due to the time delay between deaths occurring and the inquest taking place, the majority of deaths occurred in 2017. Key findings were:

- Men aged 30-49 years old made up the highest proportion of people dying by suicide, a slightly younger profile than nationally and the previous 2017 audit.
- Mental health issues were the most common risk factor mentioned in the Coroner's files.
- Over a quarter of people included in the audit were known to a mental health service at the time of death and/or had discussed mental health issues with a member of their GP practice in the four weeks leading up to their death. This is in keeping with national findings that on average ¾ of people who die by suicide are not known to mental health services.
- Over a third of people who died by suicide were known to have made a previous suicide attempt.
- Almost one in ten suicides took place on the railway, higher than nationally.

7.8. A gap analysis, following publication of the NICE guideline on Preventing Suicide in Community and Custodial settings, highlighted good evidence of collaborative working to identify and manage risk between health and police in custodial settings and a well-embedded Multi Agency Safeguarding Hub (MASH) approach. There was also good evidence of joint working as part of the Hertfordshire Suicide Prevention Strategy and commitment to ensure that Hertfordshire is a county where no one feels that suicide is their only option.

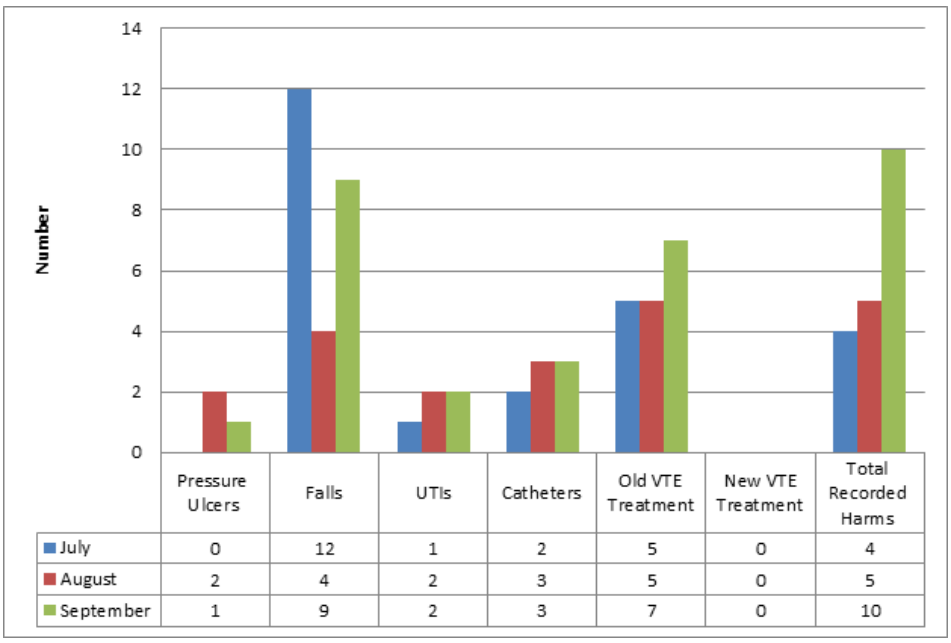
7.9. The Mount prison has its own suicide prevention strategy and approach to manage the risk of suicide, as part of the National Offender Management Service. The Trust has an Inreach Team based at the prison that provides support and advice for prisoners with mental health needs and assessed at risk of suicide. An Assessment Care in Custody and Teamwork (ACCT) document is used where risk is identified. The NICE guideline was also discussed at the Hertfordshire Programme Board.

8. **Safety Thermometer and associated types of harm**

8.1. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care at a single point in time. The tool measures five high-volume service user safety issues. Safety Thermometer Results for Q2 2019/20 were as follows:

8.2. Harm free care for HPFT was reported as the following for 'all harms':

- July 97.9%
- August 97.3%
- September – 94.6 % (chart 6)



	Pressure Ulcers	Falls	UTIs	Catheters	Old VTE Treatment	New VTE Treatment	Total Recorded Harms
July	0	12	1	2	5	0	4
August	2	4	2	3	5	0	5
September	1	9	2	3	7	0	10

Chart 6 Safety Thermometer Data

8.3. The Trust collects data from Older Inpatient and Learning Disability Inpatient Teams. There were 19 harms in Q2.

Pressure Ulcers

8.4. Of the 3 reported pressure ulcers 2 category 2's were reported as new, that they developed under our care, or developed 72hrs (3 days) or more hours after admission to HPFT, they were both on Logandene. The 3rd pressure ulcer was reported as a category 3 on Logandene but reported as an old pressure ulcer which is defined as being a pressure ulcer that was present when the patient came in. Overall, for the whole Trust, in Q2 2019/2020 8 pressure ulcers acquired in our care were reported (Chart 7). Seven pressure ulcers were sacral and the remaining one was a heel.

8.5. In Q2, the pressure ulcers have all occurred in Older People's services. A concise root cause analysis report is completed by ward staff for all Category 2 pressure ulcers with oversight from the Tissue Viability Nurse. The emerging theme in this quarter was service users presenting with agitated behaviour and being non-compliant with treatment plans due to their mental health. Examples of this are service users removing dressings, not sitting on pressure relieving cushions or mattresses and in some cases not going to bed.

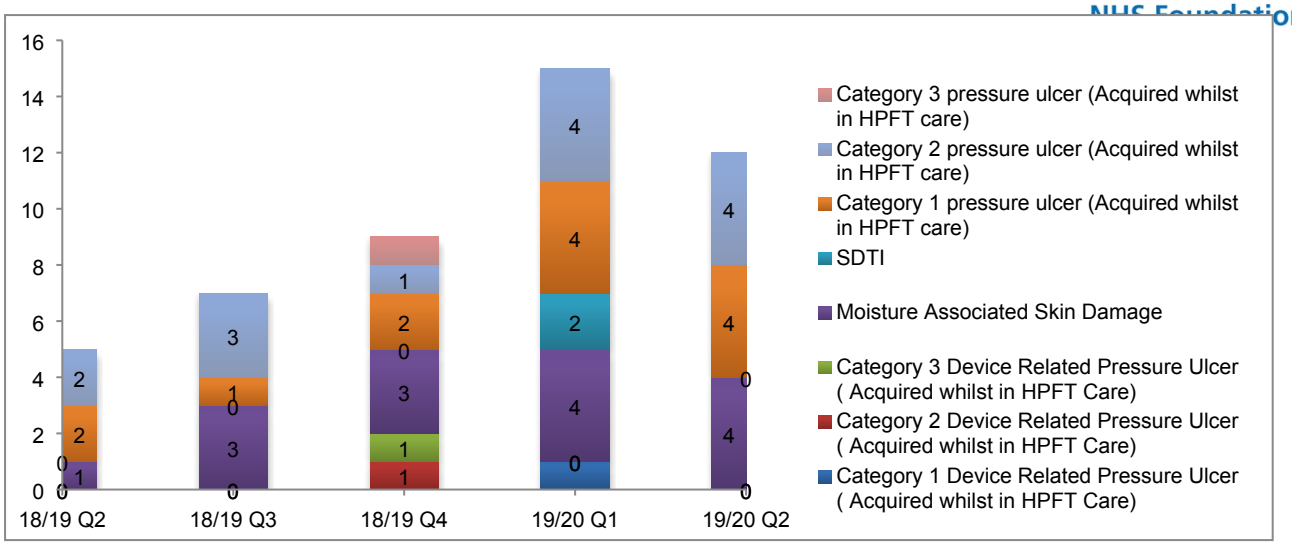


Chart 7 Pressure Ulcers reported in Q2 2019/20 by Quarter and Category

Falls

8.6. Of the 25 falls reported there were 14 which resulted in no harm, 11 recorded as low harm and of the Urinary Tract Infections (UTI) 5 were new, there were x2 on Lambourn Grove and 1 each on Logandene, Victoria Court and Wren Ward.

8.7. The Trust Falls Group meets quarterly to review falls data and has oversight of embedding best practice around falls prevention. The Group has representation across all SBU's. There is a Falls CQI project in Older People's Services continuing into Q3 which is implementing the Sustainability and Transformation Partnership (STP) frailty pathway and innovation around falls prevention for service users in the community. 125 falls incidents were reported in Older People's services with Seward Lodge being the top reporter followed by Victoria Court and Lambourn Grove (table 2).

	July 2019	August 2019	September 2019	Total
Lambourn Grove	5	2	19	27
Seward Lodge	19	6	18	43
Logandene	7	9	6	22
Victoria Court	6	12	12	30
Kingfisher Court	1	2	1	4
Total	38	31	56	125

Table 2 Falls reported by Unit and Quarter in Older Peoples Services in Q2 2019/20

8.8. Service user falls on the same level was the highest category of falls reported in Older People's Services in Q2 2019/20 (72) followed by suspected fall (34). Mid-morning and evening were the times when most falls occurred in Older Peoples Services in Q2. There was one fall resulting in a fracture and one unwitnessed but suspected fall resulting a fracture in the Learning Disability Specialist Residential services in Q2.

Catheters

8.9. The number of catheters in place at any point in the last 72hrs is recorded and the number of days it has been in place. There were 8 catheters recorded, of the 8, 2 were in place for between 1 - 28 days, 6 were 28 days or more.

Venous thromboembolism (VTE)

8.10. There were 17 cases identified as old VTE treatment as treatment started before admission to HPFT, 1 of these was for DVT the other cases were recorded as 'other'. All of these cases were on Lambourn Grove. There were no new VTE cases.

9. Never Events

9.1. Never Events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented. The Trust reported no Never Events in Q2, 2019/20.

10. Mortality Governance including LeDeR

10.1. The Mortality Governance team ensure there is a system for reviewing and learning from deaths. In Q2 2019/20, a module on Datix has been constructed for the screening of deaths and is used to record screening outcomes. East & North SBU, which includes Older Peoples' Services, is the highest reporter in Q2 2019/20 (table 3). Deaths reported in Q2 2019/20 (94) increased when compared to the previous quarter (91). It should be noted that deaths are sometimes reported retrospectively and therefore these numbers may change slightly over time.

	East and North SBU	Essex & IAPT SBU	LD&F SBU	West Hertfordshire SBU	Total
18/19 Q2	59	0	15	30	104
18/19 Q3	75	0	18	30	123
18/19 Q4	73	13	17	22	125
19/20 Q1	52	6	9	24	91
19/20 Q2	58	14	5	17	94

Table 3 Number of deaths by incident date by Strategic Business Unit Q 2 18/19 – Q2, 19/20

10.2. The Trust reported 10 deaths to the LeDeR programme in Quarter 2 2019/20. Work has taken place in this quarter to strengthen the Trust's learning disability mortality screening process. The Trust Learning Disability Services have agreed a template for reviewing deaths of service users open to services or who have been open to services in the 12 months prior to death. Work is ongoing to make this template live on Datix in Quarter 3, 2019/20 to enable monitoring of learning from deaths and identification and sharing of good practice.

10.3. The Mortality Governance Group meets bi-monthly to review mortality data and discuss and disseminate learning trends and themes from Structured Judgement Reviews. An End of Life Care Group is in place and there is representation from the Mortality Governance Team so that learning can be shared and implemented into policy and practice.

10.4. The Mortality Governance Team screen deaths and identify cases, through the 'red flag' criteria, that require a Structured Judgement Review (SJR) to be completed. In Q2 2019/20, the Mortality Governance Team completed a total of 10 SJRs. A variety of approaches such as SWARMs and reflective discussions are employed on completion of a SJR to aid reflection with the team involved.

10.5. Of the SJRs completed in this quarter, one case identified an excellent standard of documentation of care, including medical admission clerking, palliative care, coordination between HPFT community, liaison mental health and inpatient teams, an acute Trust and the Mental Health Act Directorate Office. Other cases

highlighted lifesaving intervention by Trust staff, following a choking incident on an inpatient ward, risk assessment documentation of a high standard, and timely and focused care by a community mental health team.

10.6. The learning themes included responding to previous and underestimating risks appropriately, strengthening practice relating to delayed transfer of care, fluid and food intake, lithium blood testing and the need to review the risks and benefits of an anti-psychotic medication in the presence of dysphagia not of expected practice. In addition to this, delays in action being taken following a relapse in mental state were identified and likely delirium in the community not being immediately identified were highlighted.

10.7. A deep dive into the deaths that occurred in the first six months of 2018 in the North Herts Adult Community Mental Health Services to better understand the lead up to unexpected deaths, to learn from the case notes and risk assessment documentation to aid reflection and inform practice. The review highlighted areas of good practice around timely updating of risk assessments when risks changed, regular follow up and contact including medical reviews, comprehensive risk assessment documentation, comprehensive record keeping and liaison with Drug & Alcohol services.

10.8. The learning identified the role of family where they had been identified as protective factors without understanding the relationships, the role of Mental Health Helpline in risk assessment, use of welfare checks, updating risk assessment documentation, clinical risk formulation in response to changes, improvements in safety planning, service users with a history of alcohol misuse problems, self-harm being an indicator for suicide and the need to incorporate hope into risk assessments, and how IT systems, including PARIS risk module, could be further developed to support clinical staff.

11. Prevention of Future Deaths (PFDs)

11.1. In Q2 2019/20, the Trust received no Regulation 28 Prevention of Future Death reports from HM Coroners. PFD's issued to other Trusts are presented to the Safety Committee and disseminated for the purposes of wider learning.

12. Ligature Incidents

12.1. In Q2 2019/20 shows that there were a total of 93 ligature incidents across all Trust services compared to the previous quarter when there were 92 reported (chart 8).

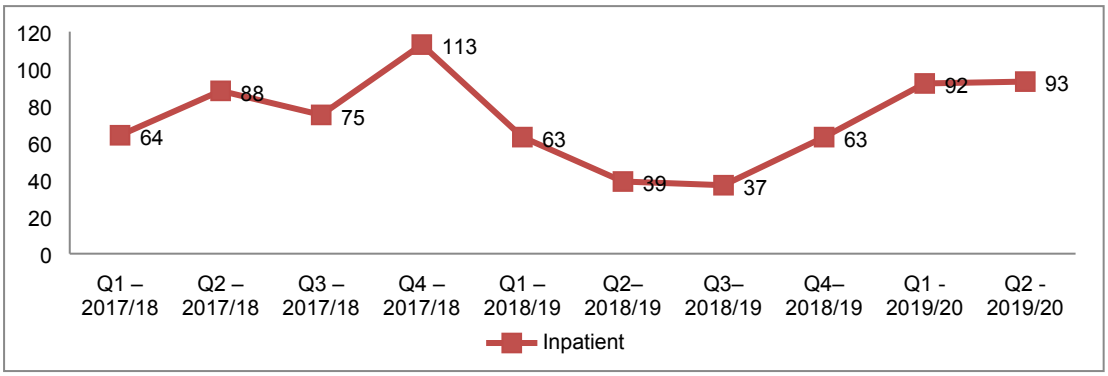


Chart 8 Ligature incidents reported Q2 2018/19 – Q2 2019/20

12.2. The ward reporting the highest number of ligature incidents in this quarter was Robin ward, 93 (62%) (chart 9) but the number has decreased from last quarter, whereas Albany Lodge has seen a significant increase. Service users on this ward tended to be involved in two or more self harm incidents involving ligatures and the increase on Albany relates to service users moving from Robin Ward to Albany Lodge.

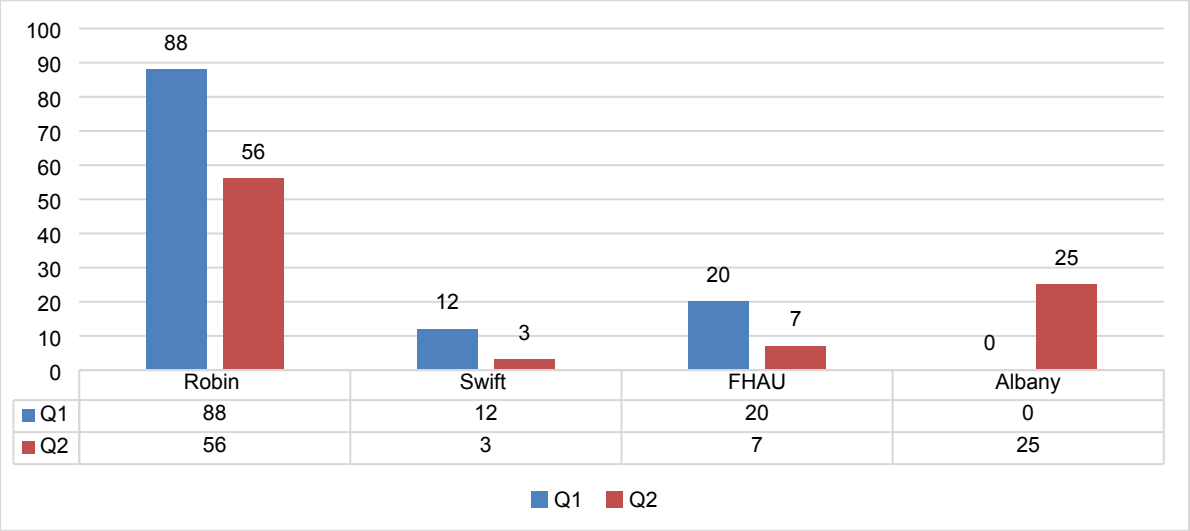


Chart 89Top Reporters of Ligature Incidents Q1 and Q2 2019/20

12.3. There were 9 ligature incidents involving anchor points in Q2, 2019/20, eight of which involved the same service user on Robin Ward. It is of note that these were not exisiting anchor points but as a result of damage caused to building structure and removal of bathroom panels by the service user. This has presented the staff with a change in risk that they have had to develop their management plans to address both in terms of the environment and individual service user plans. An Internal Safety Alert was circulated in response to this.

12.4. Ligature incidents, using clothing, remains the category with the highest number of incidents of this type on inpatient units.

12.5. The ANT weekly review used in inpatients is now being developed as a monthly process for community environmental risk assessment. Alongside the annual community ligature audits, the first phase of this process began in Q1, 2019/20 and will continue into Q3, 2019/20. This will be used as a pilot to agree the methodology and risk assessment process, inclusive of the proposed App. This will include Annual Audits in 20 community hubs with an aim to complete this cycle in Q3, 2019/20 in the remaining community hubs.

13. Absent Without Authorised Leave (AWOL) and Missing Persons

13.1. This incident type relates to service users who leave the support of the service in an unplanned way and are therefore considered:

- AWOL (formally detained under the Mental Health Act (MHA) 1983)
- Missing (informal status and are admitted voluntarily).

13.2. Incidents can result in concerns about safety but also need to be seen within the context of positive risk taking as part of planned care, recovery principles and work towards discharge. There was a decrease in the number of AWOL and missing person incidents reported in Q2 2019/20 (57) when compared to the previous quarter (64) (Chart 10).

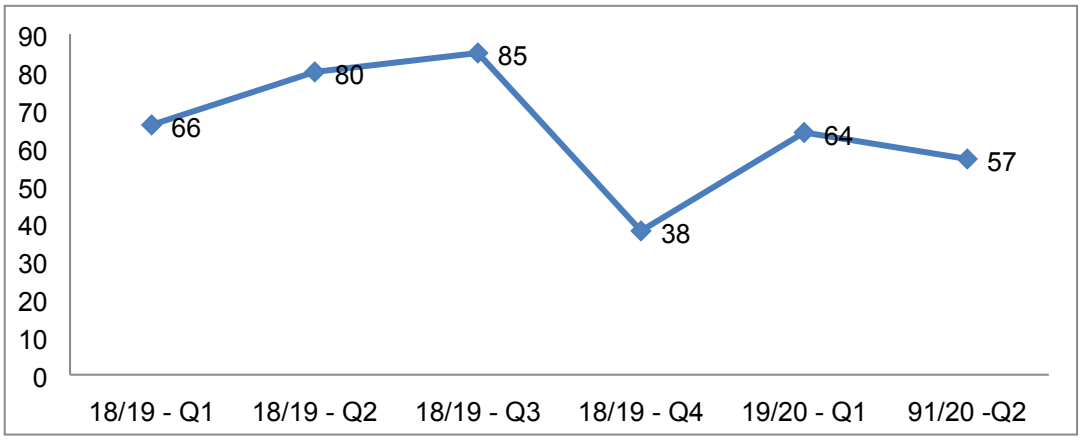


Chart 10 AWOL or Missing Person Incidents reported Q2 2018/19 – Q2 2019/20

13.3. Albany Lodge 13 (8%), Robin Ward 12 (7%) and The Beacon 12 (7%) were the top three reporters of AWOL and Missing Person Incidents in Q2, 2019/20. The highest reported sub-category of incident was Failure to return from Section 17 leave (31.5%). This is a consistent theme reported across previous quarters.

14. Violence and Aggression

14.1. This month IGC receives a deep dive into Violence and Aggression towards staff and therefore detail contained in that paper complements this paper. Incidents are reported on the Trust's Datix incident reporting system by two categories, service user to staff assaults and service user to service user assaults. Data is subject to local analysis and further in depth analysis as part of the quarterly reporting cycle. Each category shows a trend analysis for the past two years to give context to the reporting in terms of emerging trends.

14.2. There is currently a pilot study into aggression on wards using Broset Violence Checklist. This is a short risk assessment of six behaviours that allow staff to better predict when people are at risk of becoming aggressive and provide earlier intervention.

Service User to Staff Assaults

14.3. Learning Disability SBU experienced a decrease in service user to staff assaults (18%) in Q2, when compared to the previous quarter. East & North SBU also saw a decrease (29%) when compared to the previous quarter. Essex & IAPT SBU showed the most significant decrease (83%) which related to the discharge of one service user. West SBU showed an increase (18%) with Oak ward, Robin ward and Swift ward seeing the most.

14.4. The reductions in violence to staff principally relates to a small number of service users, who pose significant challenge who present with a range of behaviours such as ligature use, cutting and self-harming, combined with assaultive behaviour. Generally, incident trends show there is a greater risk of staff assault when restraint is used as a response to challenging behaviour (chart 11).

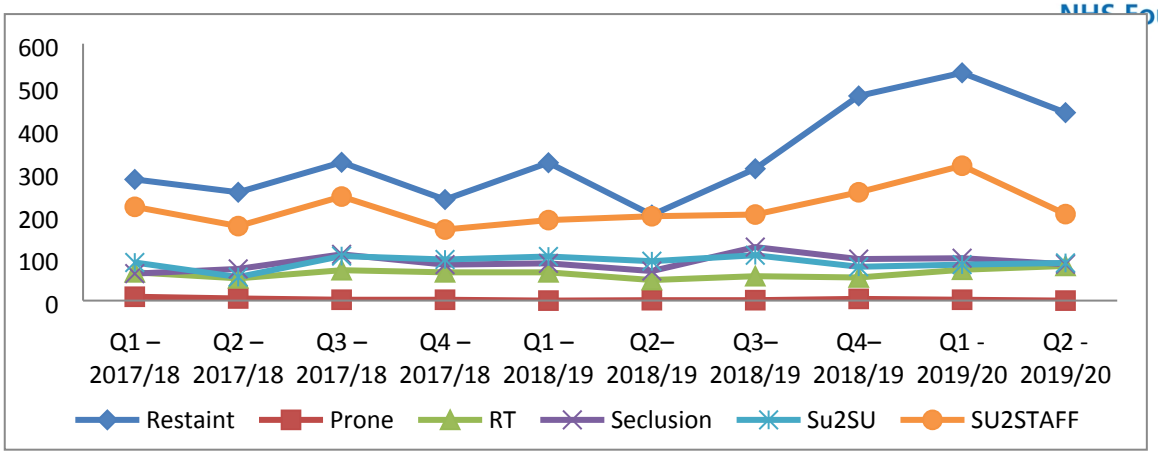


Chart 11: Service User and Staff Assaults combined with the use of Restrictive Practices

14.5. Of note, as different from the usual picture were, two seclusions on Swift ward relating to violence and aggression incidents. The Swift ward Team Leader highlighted that smoking continued as an ongoing challenge increasing the risk of flash points and potential conflict and containment events. Swift ward has also seen an on-going challenge relating to tying of ligatures and cutting. The ward is using Pro-screen and, in addition to this, learning from the CQI work that has been developed on Robin Ward.

14.6. Service user to staff assault data (chart 12) shows a steady increase over six quarters (Q4 2017/18 – Q1 2019/20) making this significant and a trend. It should be noted however that in Q2, 2019/20 there has been a 36% decrease in this incident type. Analysis of the possible reasons for this reduction has identified that this was, in the main, due to the discharge of one service user within Essex SBU inpatient services.

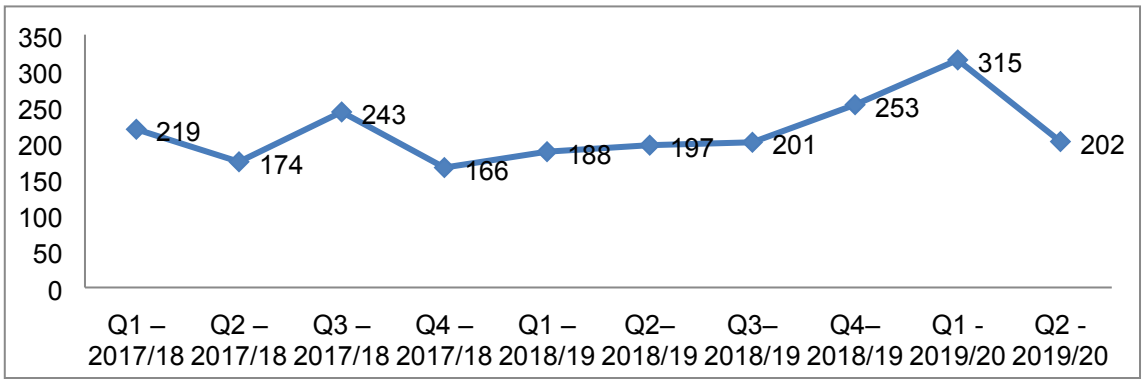


Chart 12 Service User to Staff Assaults Q1 2017/18 – Q2 2019/20

14.7. On review of harm as a result of service user on staff assaults 103 (51%) resulted in no harm, 84 (41.5%) resulted in low harm, 14 (7%) resulted in moderate harm and 1 (0.5%) resulted in severe harm. The severe incident was discussed at the Moderate Harm panel and was reported as a serious incident and the terms of reference were shared with Staff Side, learning from the recommendations from the Health and Safety Executive.

14.8. Of the total number of violence and aggression incidents reported in Q2 (202) the top 3 reporters were Lambourn Grove (14%), Dove ward (12%) and Oak Ward (11%).

14.9. Under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) the Health & Safety Executive (HSE) requires organisations to report accidents resulting in an employee being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury. In Q2, the Trust made 17 RIDDOR reports to the HSE. Further detail relating to this will be in the Q2 Health and Safety report.

Service User to Service User Assaults

14.10. In Q2 there has been a relatively stable picture without statistical relevance over time other than the aim of having a decrease (Chart 13). A peak was seen in Q3, 2018/19 and then a drop in Q4 2018/19. In this Quarter 2 2019/20 has seen an overall increase of incidents by 4 (5%) when compared to the previous quarter but not reaching the level seen from Q3 2017/18 to Q3 2018/19.

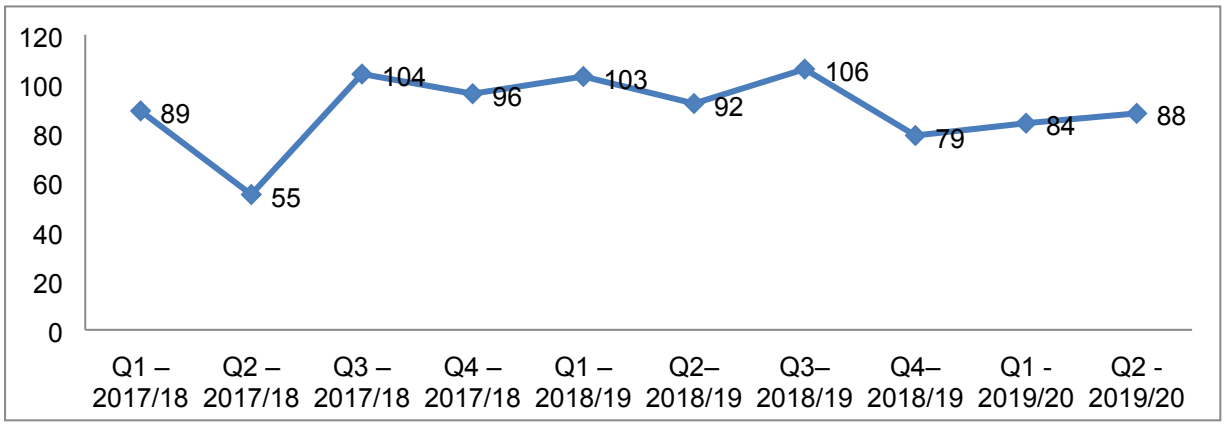


Chart 13 Service User to Service User Q1 2017/18 – Q2 2019/20

14.11. 65% of service user to service user assaults resulted in no harm, 32% in low harm, 3% in moderate harm and 0% in severe harm.

14.12. Learning from these events has shown that it is important to recognise that a clear safety plan must be in place to recognise and manage escalating behaviour including safeguarding and immediate protection for vulnerable service users. In Older Peoples services it was found that service users may wander, without purpose into rooms or areas where other service users are, resulting in a violence and aggression incident.

15. **Restrictive Practices**

15.1. Over the past two years (chart 14), there has been a consistent level of use of restraint up to Q2 2018/19 followed by an increase from Q3 18/19 to Q1 2019/20 and then in, Q2 2019/20, there has been a decrease in overall use of restraints by 17%.

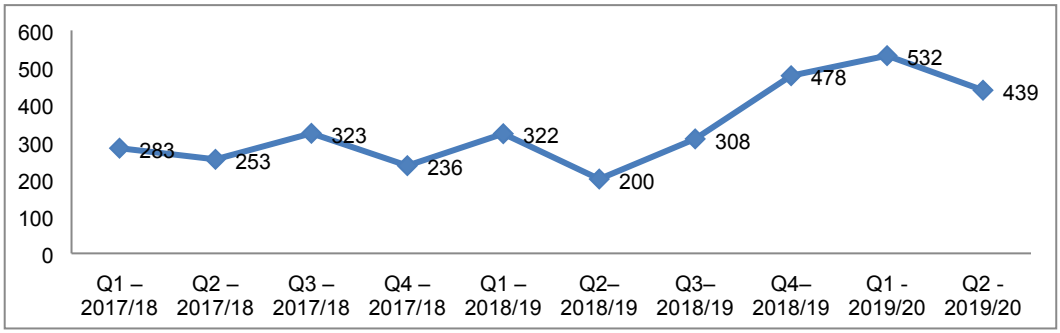


Chart 14 Physical Interventions (Restraint): Q1 (2017/18) – Q2 (2019/20)

15.2. There were challenges within Forest House (91) and Robin Ward (70). Of the 91 incidents within Forest House three service users accounted for 75 of the incidents and within Robin Ward two service users accounted for 49 of the incidents.

Prone Restraint

15.3. In this quarter, there were no prone restraints reported on the Trust's incident reporting system. Prone restraint is a type of physical restraint where a person is held chest down, whether the service user placed themselves in this position or not. Each case is subject to a comprehensive review, by a subject matter expert, at the time of reporting. Overall, there are a low numbers of prone restraint incidents (Chart 15) primarily taking place in West SBU and Learning Disability & Forensic SBU.

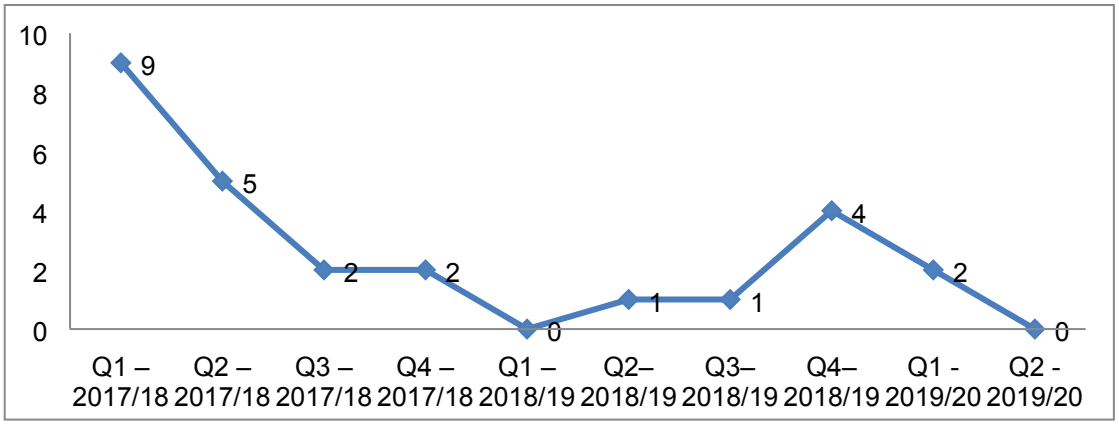


Chart 15 Prone Physical Interventions (Restraint): Q1 2017/18 – Q2 2018/19

Rapid Tranquillisation

15.4. Rapid Tranquilisation (IMI) is the use of psychotropic medication to address disturbed behaviour. There has been an increase in use of rapid tranquilisation since the lowest level in Q2 2018/19 (Chart 16). The majority of these incidents occurred within West SBU. This data is considered in conjunction with the violence and aggression, seclusion and restraint. The Trust will continue to be monitored to enable identification of actions to be taken in a timely fashion.

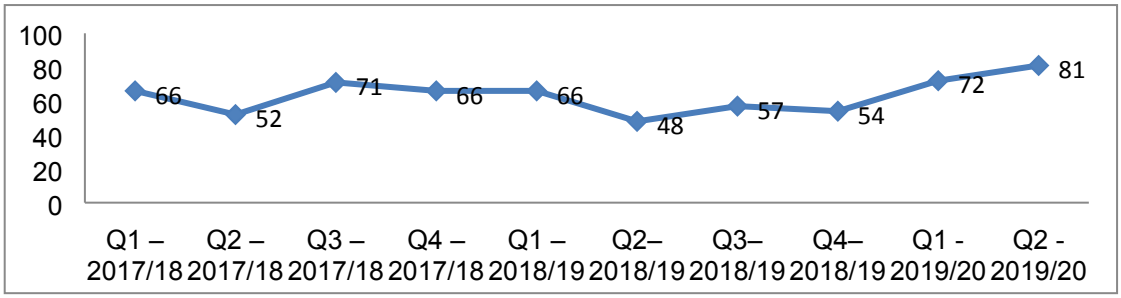


Chart 16 Rapid Tranquilisation: Q1 2017/18 – Q2 2018/19

Seclusion

15.5. The use of seclusion peaked in use for Q3 2018/19 (Chart 17) which related to Astley Court (57 incidents), Broadland Clinic (30), and Dove ward (30). There was a 14% reduction in the overall use of seclusion in Q2 2019/20 compared to Q1 and a downward trend from the peak in Q3 2018/19.

15.6. Seclusion was used within three of the four SBU's, Learning Disabilities and Forensic (67), West SBU (13) and Essex and IAPT SBU (1). Whilst Learning

Disability and Forensic SBU had more seclusions, the average time spent in seclusion was lower when compared to West SBU.

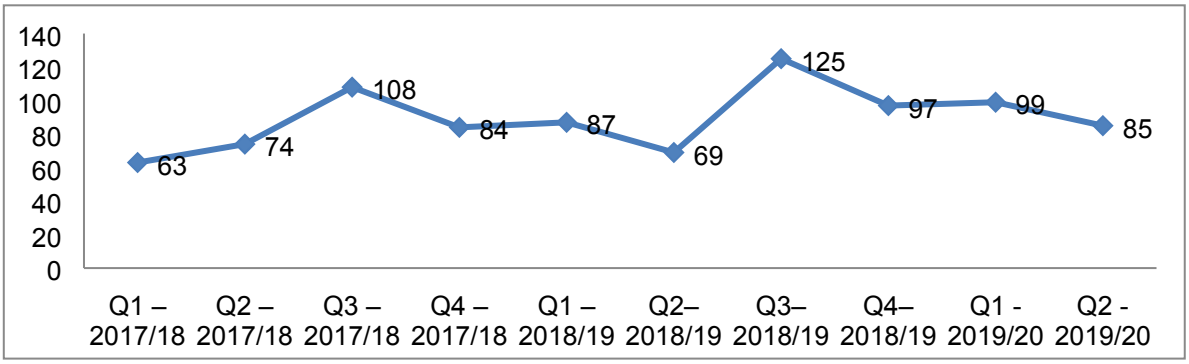


Chart 17 seclusion Q1 (2017/18) - Q1 (2018/19)

Long Term Segregation (LTS)

15.7. Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the service user to others, which is a constant feature of their presentation, a service user is cared for separated from others. At the time of this report the areas in table 4 have long term segregation (LTS) in place (table 4).

16. Unit	Section	Start Date	End Date
2 Forest Lane	3	18 02 2010	
Dove Ward	3	18 04 2018	
Hse 5 Warren Court	37	06 06 2018	
Hse 5 Warren Court	3	17 08 2018	
Dove Ward	3	16 10 2018	16 09 2019
Dove Ward	3	20 12 2018	
Oak Ward	3	26 07 2019	23 09 2019
Beech Ward	47/49	31 07 2019	20 08 2019

Table 4 LTS by Unit, Section of the Mental Health Act and Start Date

16.1. There were two new applications authorised during Q2, 2019/20 on Beech and Oak Wards and three were discontinued on Beech, Oak, and Dove Wards.

17. **Feeling Safe**

17.1. The Trust values feedback from service users to enable the Trust to continuously improve. 'Feeling Safe' is a ward based project which is developed through the collection of qualitative and quantitative data from service users to enable reporting on how safe they feel whilst in our inpatient services. This information is used to understand key areas of feeling safe, enhanced physical support, privacy, dignity and respect, quality of treatment and care and equity.

17.2. The feeling safe score Trust-wide decreased from 80% in Q1, 2019/20 to 71% in Q2 2019/20. The score for Acute 24/7 services decreased to 76% in Q2 compared to 83% in Q1. However, there was a 73% increase in responses received to the inpatient survey feedback. An increase in feedback will generally result in lower satisfaction scores.

17.3. In Acute inpatient services feeling safe scores for Albany Lodge were 100%, Aston Ward were 88% and Owl Ward were 85%, which achieved or exceeded the

Trust's target. There were low numbers of responses for Albany Lodge and Aston Ward. Oak Unit scores were 74, Robin Ward were 73%, Swift Ward were 69% and Thumbswood were 62%, which were all below the target.

17.4. Beech Unit and Dove Ward had an 11% increase of service users feeling safe on the unit compared to Q1. Astley Court, Hampden House and The Beacon saw decreases in satisfaction for their service users feeling safe.

17.5. During Q2, 2019/20 the Safety on the Wards Project (West SBU Peer Experience Listeners) continued and the initial interviews from Q1, 2019/20 were used as a baseline. Further interviews were undertaken on Albany Lodge, Oak Ward, Owl Ward and Robin Ward.

17.6. The Safety on the Wards Project (West SBU Peer Experience Listeners) continued and the initial interviews from Q1, 2019/20 were used as a baseline. Further interviews were undertaken on Albany Lodge, Oak Ward, Owl Ward and Robin Ward. Final recommendations to support co-produced actions within each SBU will be agreed and reported on in Q3.

18. Safeguarding

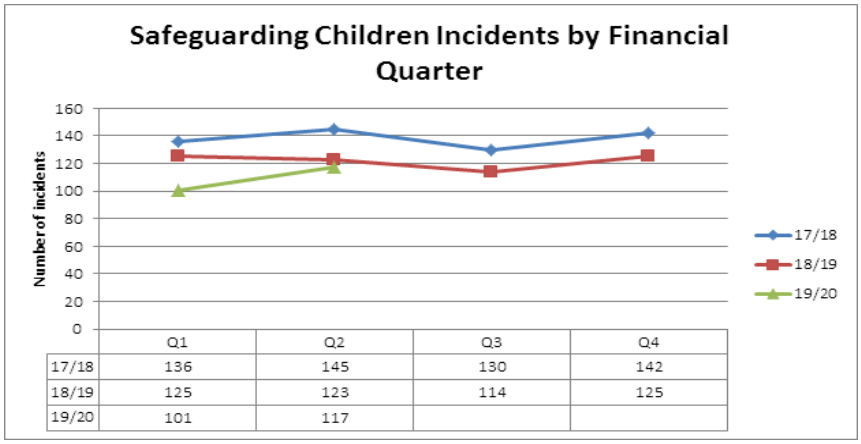
18.1. During Q2 2019/20, the Safeguarding team has continued to work through the Safeguarding Improvement Plan 2019/20. Significant progress has been made across a range of outcomes, including improvement of systems for oversight and reporting for safeguarding children, partnership working and pathways in relation to historic child abuse and the development of new safeguarding adult level three and domestic abuse training. The Trust continues to work in partnership across agency boundaries in all areas of the Trust to improve the safety and wellbeing of service users and their families towards our vision of "preventing harm and enabling safety through vigilance, competence and personalised outcomes focused practice."

18.2. Hertfordshire has introduced new safeguarding arrangements and the Trust has responded to these and continues to participate in learning from incidents relating to people who have suffered death or serious injury through suspected abuse or neglect are detailed. The IGC received details of each of these cases. There are five main categories of

- serious case review for adults (Serious Adults Review),
- children (Serious Case Review)
- domestic homicide (Domestic Homicide Review).
- Multi-agency case review
- Partnership case reviews (PCR)
- Local Reviews (for cases that do not meet the threshold for SCR but would benefit from a review)

Safeguarding Children

18.3. There has been a 17% increase in safeguarding children concerns this quarter (Chart 18). This increase followed a marked decrease in Q1, 2019/20 (19%), thus safeguarding concerns are back within the variation that we have seen since 2017. The safeguarding team have undertaken dip audits following this phenomenon but no practice concerns where identified.



	Q1	Q2	Q3	Q4
17/18	136	145	130	142
18/19	125	123	114	125
19/20	101	117		

Chart 18 - Child Safeguarding Incidents by financial quarter

18.4. Across the wider system safeguarding children concerns have increased steadily over recent years and other health providers are reporting a marked increase the number of concerns identified. However, within The Trust , concerns have remained stable over the last two years therefore we are undertaking work to understand this and ensure that concerns are raised appropriately in accordance with the Continuum of Care thresholds.

18.5. There has been an increase in the number of neglect cases reported however there have not been any other significant changes in categories of abuse from those seen in Q1 (Chart 19).

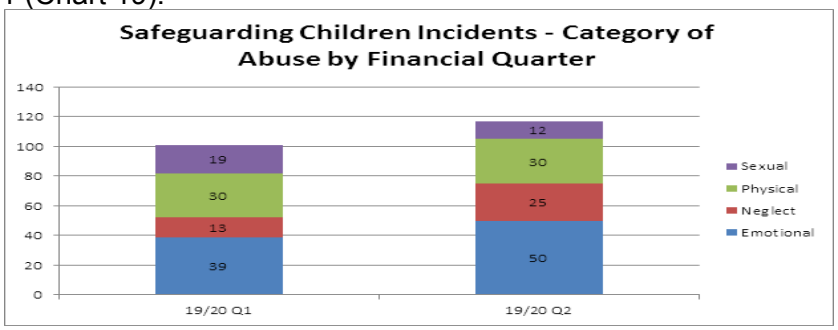
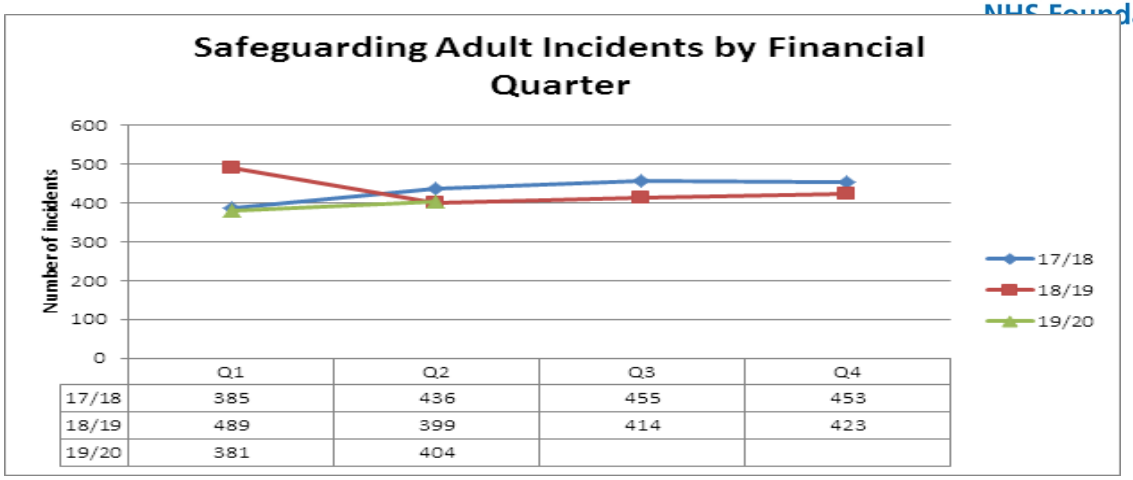


Chart 19 – Child Safeguarding by Category of abuse Q2 2019/20

18.6. During Q2 2019/20 there was one referral from the Community Perinatal Team for Female Genital Mutilation (FGM). This involved young two girls who were identified as “at risk” following a disclosure from their mother that she had undergone FGM as a child. The mandatory reporting duty for FGM requires a dataset to be completed and shared with NHS England. This was completed.

Safeguarding Adults

18.7. The number of safeguarding adult concerns raised has continued to remain stable which provides assurance that staff are continuing to recognise and respond to risks of abuse or neglect (chart 20).



	Q1	Q2	Q3	Q4
17/18	385	436	455	453
18/19	489	399	414	423
19/20	381	404		

Chart 20 – Safeguarding Adult incidents by financial quarter

18.8. There has continued to be consistency in the types of adult abuse identified with the highest proportion being physical abuse, the most significant proportion of this being service user to service user physical/verbal abuse within our in-patient services (chart 21).

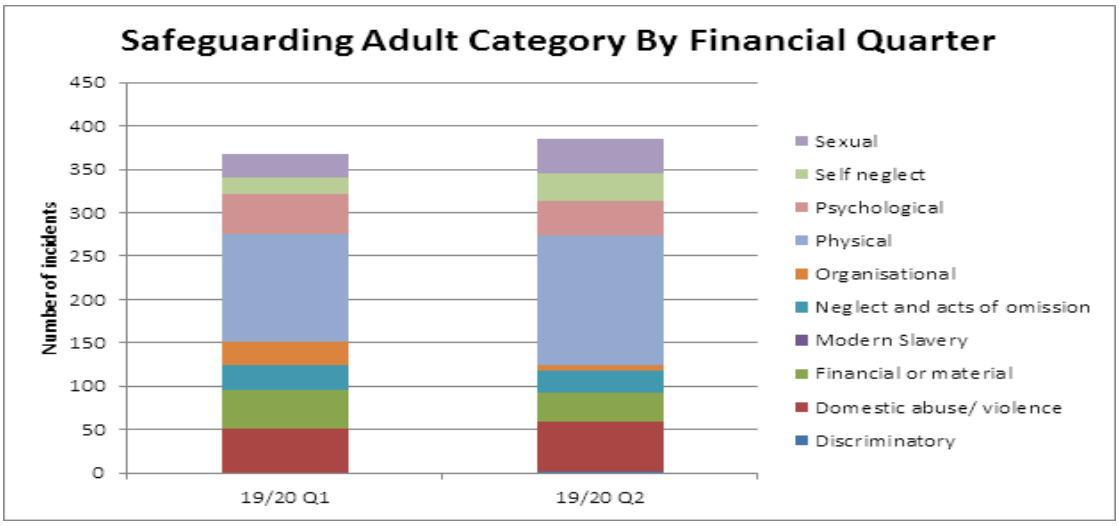


Chart 21 – Safeguarding Adult by category of abuse 2019/20

18.9. Analysis of these incidents demonstrates that they are most often linked to a small number of patients who present particular challenges in terms of managing aggression. There is a system of oversight where hot spots can be identified by the Senior Professional Lead and staff can be supported appropriately to manage incidents.

18.10. Domestic Abuse is the second most prevalent category of abuse. Women are significantly more likely to be identified as at risk of this type of abuse which is estimated to affect 8.2% women and 4% men in the general population. People with disabilities, including those related to mental health, are also more likely to be both victims and perpetrators of domestic abuse (SafeLives “Safe and Well: Mental Health and Domestic Abuse” May 2019).

18.11. An in depth analysis of our data will be undertaken during Q4 2019/20 to identify domestic abuse incidents by age, gender, ethnicity and district. This information will then be compared to the Hertfordshire dataset to identify and understand any variation within these groups.

Hertfordshire Centralised Safeguarding Adult Team

18.12. The new Hertfordshire Safeguarding Adults team was launched within HCC in Q1 2019/20 and provides a central response to all Safeguarding Adult concerns in Hertfordshire. At present, the Trust will continue to respond to Safeguarding concerns for people within the scope of mental health services; however the plan is for the Trust to integrate into this team through the co-location of staff in 2020. Four posts are currently being recruited to and following this a migration plan will be developed to transfer responsibility to the Centralised Safeguarding Team.

Safeguarding Adult Training

18.13. A new Safeguarding Adult Intercollegiate document was published in August 2018 which sets out the training and competency requirements for all registered health and social care staff in relation to safeguarding adults. A new requirement for all staff involved in the assessment and care planning for adults who may be at risk has been set for 2020.

18.14. Level three safeguarding adult training has now been developed in house and was launched in July 2019. Current compliance is 65% and we are ahead of trajectory for full compliance of 95% for March 2020.

18.15. Hertfordshire CCG's have also required that staff are trained specifically on domestic abuse and the Trust has taken a decision to train staff on sexual safety, following the recommendation made in the CQC report on Sexual Safety on in-patient units and the NHSE Sexual Safety Strategy. This has been incorporated into our existing Level three training to ensure that enhancing staff knowledge whilst ensuring staff have time to care.

Sexual Safety including Mixed Sex Accommodation

18.16. The Sexual Safety task and finish group was established in Q4 2018/19 to embed the recommendations of the CQC report on sexual safety in in-patient settings and the NHS Sexual Safety strategy. A number of actions have been taken by this group:

- The development of co-produced a co-produced leaflet "Sexual Safety on Wards" for in-patients which re-enforces a person's right to be safe on the ward and provides advice where to get help if they have concerns about their sexual safety or experience a sexual assault.
- The development of guidance for staff on responding to disclosures and raising concerns about their own sexual safety
- The development of a flowchart on how to report concerns and pathways to support.

18.17. The recommendations are being embedded and progress as well as effectiveness will be reported to the Safeguarding Strategic Committee and become business as usual.

18.18. The Trust has been successful in a bid to join the Sexual Safety Collaborative which is hosted and facilitated by the National Collaborating Centre for Mental Health. Swift Ward will be the pilot as it provides a mixed sex communal environment. A small project team has been set up which will meet regularly and report into the Safeguarding Strategy Committee. Members include ward staff and team leaders, service users, the Head of Nursing and the Consultant Social Worker for Safeguarding. The project sponsor is the Head of Social Work and Safeguarding.

This work will also be supported by a CQI lead from the Mental Health Collaborative and will be shared through the Life QI platform.

18.19. In September 2019, a revised national policy, delivering Same Sex Accommodation was published. Reporting to the national Mixed Sex Accommodation (MSA) return will reflect these updates from January 2020 data onwards but Q2 the Trust did not breach the guidelines.

Scams Steering Group

18.20. HPFT is a core member of the Hertfordshire-wide Scams Steering Group which is led by the Fire & Rescue service. This is a multiagency panel which includes Trading Standards, the Police and Nationwide Bank. The group have produced a Scams Strategy document for Hertfordshire and there will now be workshops to develop an action plan.

Statutory Safeguarding Adults in Hertfordshire

18.21. Statutory safeguarding relates to the cohort of service users for whom HPFT have additional statutory safeguarding responsibilities (Adult Safeguarding for people with functional mental illness residing or placed within Hertfordshire). Safeguarding Adults concerns have increased by 20% from Q1 (240) to Q2 (300) (Chart 22).

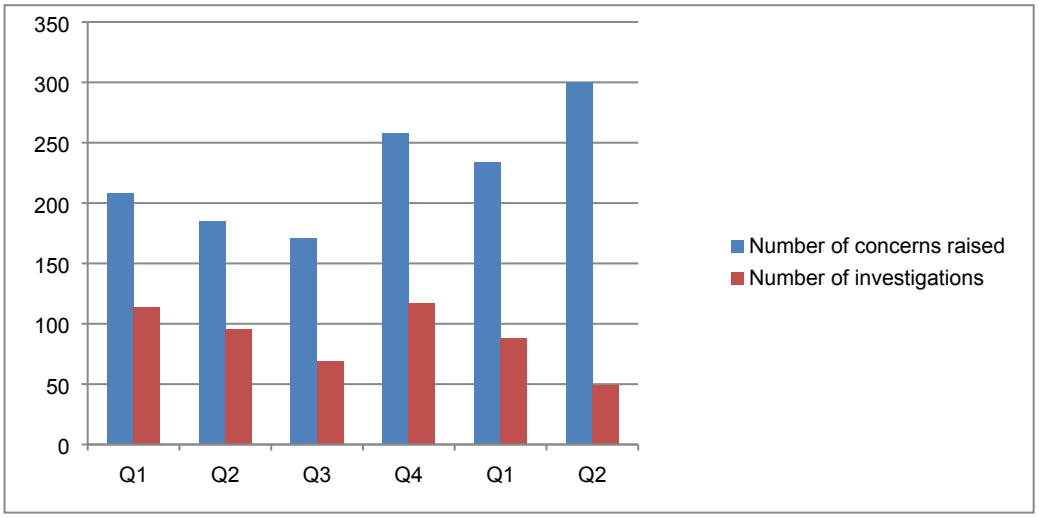


Chart 22 – Statutory safeguarding adults concerns and enquiries

18.22. Despite the increase in concerns the conversion rate has decreased from 34.2% in Q1 to 17.5% in Q2. Concerns had been raised that the Trust tended to over refer to safeguarding and, as a result, there was a low conversion. The conversion rate across other service user groups in Hertfordshire which is approximately 50%.

18.23. Dip samples and discussions with the Investigating managers have indicated that there are practice issues with the reporting of safeguarding adults concerns. Whilst actions are be taken in relation to protecting people from any abuse or neglect, these have not been taken within the formal safeguarding adult process. This issue occurred following the implementation of the new forms in Q2 2018 and was addressed however practice has not reverted back to the previous position.

18.24. The following actions are being undertaken to address the practice issues:

- Safeguarding Adults Decision Making Audit in quarter three.
- Communication and reinforcement about safeguarding process and eligibility criteria with investigating managers.
- Developed training for staff around 'processes' and will deliver this to investigating teams face to face.

18.25. In Q1 2019/20, 57% of all enquires were "other" enquiries however this has decreased in Q2 2019/20 to 42% (Chart 22). Other enquiries are relevant for people do not meet the eligibility criteria for a s42 enquiry but would still benefit from this in order to prevent future harm and/or their needs increasing. This is in the context of an overall significant decrease in enquiries. This will be investigated during quarter three, alongside the underreporting of statutory enquiries and any practice issues address through further guidance and training.

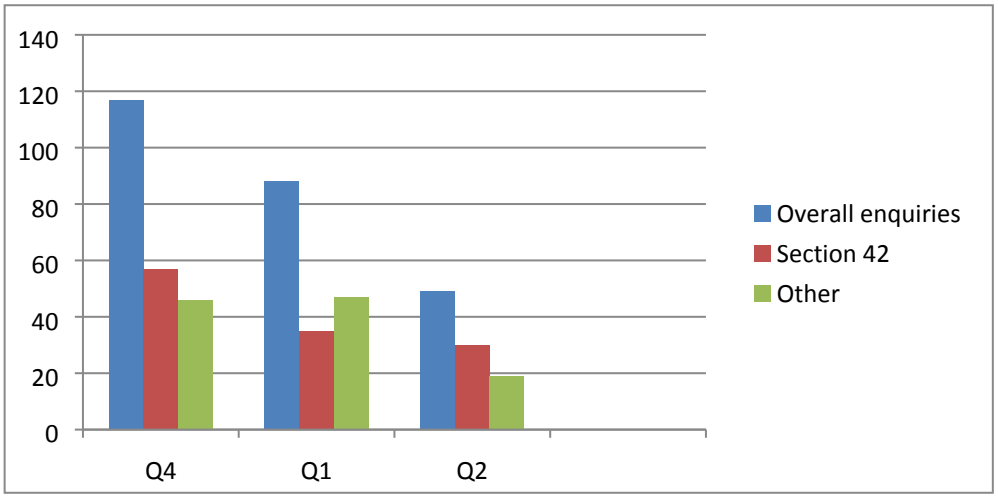


Chart 23 – Breakdown of S42 enquiries and "other" enquiries

Prevent and Channel Panel

18.26. No referrals to Prevent in quarter two however there the Trust continues to be a key partner in terms of the Prevent response as a number of individuals who are referred are known to our services. The Trust is represented at the Channel Panel and facilitates communication between Prevent and our teams to ensure that actions are carried out for these individuals who are deemed at high risk of radicalisation or of being drawn into criminality.

18.27. During Q2 2019/20, in response to a decrease in referrals, targeted meetings have taken place to raise awareness around the vulnerabilities of young people with mental health problems of being radicalised. A plan is in place to set up forums across the Trust to raise awareness of Radicalisation.

Domestic Abuse

18.28. A review of Safeguarding referrals from the Mental Health Liaison Team (MHLT) for assurance around their knowledge of recognising and responding to Domestic Abuse was undertaken. A number of actions have taken place following a specific incident in 2018/19 where a service user was subjected to a serious assault and it was identified that opportunities to intervene were missed (DHR MM).

18.29. The audit showed an improvement in practice within MHLT; however actual numbers remain low. Further work will be undertaken in Q4 to compare Domestic

Abuse in Emergency Department referral data with East and North and West Herts Hospital Trust and to identify any further learning and opportunities in this area.

Audits

18.30. CAMHS Not Brought In (NBI) Audit was completed. The purpose of this audit was to ensure that communication is being made with other professional's, such as G.P.'s and Children's Services, who are involved in the young person's care following the person not being brought in to an outpatient appointment.

18.31. Areas of Good Practice were identified including:

- Clinician recorded that child was not brought in within 2 days in 100% cases
- Clinician contacted the service user/parent/carer following NBI in 100% cases
- Good evidence of actions being carried out following NBI

18.32. In addition, areas for Improvement were also identified:

- Consideration of any risks to the child following NBI being identified on PARIS
- Evidence of communication to the GP with 5 days only found in 44% cases*
- Evidence that children's services were contacted within 3 working days only found in 69% cases.

18.33. The Trust DNA/ NBI policy does not require every NBI episode to be notified to the GP. Therefore, the professional lead for CAMHS reviewed the sample cases and made a judgement that only 9 out of the 27 cases should have been reported to the GP. The GP was informed of 4/9 NBI episode. The areas for improvement have been developed into an action plan which will be reviewed at the Safeguarding Strategy Committee.

19. **Conclusion**

19.1. Section B of this report has given an overview of the incidents and serious incidents that have occurred in Q2 2019/20. Section C will detail learning and action that has taken place.

PART C LEARNING FROM INCIDENTS AND CHANGING PRACTICE

1. Introduction

1.1. Learning from incidents, serious incidents, complaints, feedback, safety processes, including safeguarding, and mortality reviews, is integral to the Trust's safety culture. The Trust has various ways in which to share learning including, reflective learning sessions, local and Trust patient safety meetings, SBU Quality Risk Meetings, case study presentations and learning notes.

1.2. Learning themes and actions taken in response to these are included in the quarterly Integrated Patient Safety reports to Board. This part of the report will highlight some, but not all, of the initiatives that have taken place in Q2 2019/20. This section of the report will build on the findings in Part B of the report and demonstrate how learning is being taken forward. This is not an exhaustive list.

2. Building on previous quarters

2.1. Safety Huddles continue to take place and are being co-ordinated across the trust, led by the Clinical Directors. Each area has developed their own methodology, responding to the unique needs of their service users.

2.2. Safety Pods have been introduced in Broadlands, Oak ward, and Lexden Unit, with a planned wider roll out, once additional Module 5 training, has taken place. The aim by Q4 2019/20 is to introduce Safety Pods in all Acute Services.

2.3. Support for those affected or bereaved by suicide (families, first responders and staff), engagement with families in learning lessons, suicide prevention in middle aged men, mental health transitions, self-harm in young people, joint working with Drug & Alcohol services and continued implementation of the Personality Disorder pathway remain key priorities for the Trust.

3. Improvement initiatives

3.1. The Safety Committee oversees the work in relation to safety in the Trust and spends time discussing significant issues so that a robust and mutual understanding of the issues is reached. Topics discussed in this quarter included safety concerns, learning from incidents, Prevention of Future Death reports, external reports such as the PHSO are discussed and cascaded through the services by various means including use of learning notes, email, handover, issuing of guidance, supervision and Safety Alerts. Policies are updated as a result of the learning.

3.2. Learning and reflection is further supported by the delivery of Schwartz Rounds, case study presentations, Staff Support, SWARM sessions, reflective learning sessions, representation on multi agency reviews and Task and Finish groups.

3.3. As a result of these discussions some service specific improvement initiatives have begun including:

- SBARD methodology as a handover communication tool, trialled at Logandene.
- The CQI project around search in response to self–harm and contraband items being brought onto the ward on Robin Ward.
- A Physical Health conference with a focus on frailty planned for Q3.
- The Trust has appointed to a Physical Health Consultant Nurse post.
- Safe and supportive observations CQI project led by the Head of Nursing in LD&F SBU.
- CQI initiative around discharge planning in the Acute pathway.

4. Restrictive Practice

4.1 A consultation on the MOSS*together* Strategy was completed during quarter 2, with service users, carers and staff. The outcome from this consultation are being included into the final version of the Strategy with a work plan for during quarter 3. The strapline for the Strategy is that *restrictive practice starts with a conversation*, with an overall aim to use the least restrictive practice in all service areas. More proactive approaches are within the workplan to enable and support staff to achieve this aim, which includes the continuation – and more consistent – implementation of the Safeward methodologies. Furthermore, to use Shared Decision Making when working in co-production with service users regarding the methodologies and strategies to work with when managing violent and aggressive behaviour.

4.2 MerseyCare Trust have been approached to provide clinical training on the HOPE model to be introduced for staff to support individuals when in Long Term Segregation (LTS). Also, the recommendations identified in last year's external review of the RESPECT training have been implemented with revisions made to the content; ongoing review and development of the training continues in response to the learning from incidents and challenging situations.

4.3 The Restrictive Practice Committee was established in quarter 2, chaired by the Deputy Director of Nursing and Quality. The Committee's membership includes the Heads of Professions, Clinical Directors, the Practice Development and Patient Safety Team and will receive a more detailed analysis and narrative from the Strategic Business Units and the Practice Development and Patient Safety Team on all incidents relating to violence and aggression as well as the use of restrictive practice. This enables the identification of themes, lessons learned, sharing good practice and considering areas for development and training.

5. Sexual Safety

5.1. The Sexual Safety Task and Finish Group which was convened to respond to the recommendations made by the Care Quality Commission in the Sexual Safety on Mental Health Wards publication in 2018 consists of representatives from a range of agencies including the Safeguarding Team, police, the Sexual Assault Referral Centre and sexual health services. The aim of the group is to ensure an effective organisational and partnership response to Sexual Safety and Sexual Abuse.

5.2. Work undertaken by the Sexual Safety Group has included the development of a multi-agency pathway for sexual abuse to include a flowchart and guidance for staff responding to allegations made by adult service users, a co-produced leaflet outlining the key principles of sexual safety including service user rights and what support to expect from staff in responding to allegations and general tips on staying safe in the community which will be disseminated in Q3.

5.3. Work has also been undertaken on Forest House in consultation with young people in strengthening the induction pack to allow for one to one conversations with any new admission which is tailored to the young person's needs and understanding, encompassing acceptable behaviour, young people's rights and sexual boundaries.

6. Pressure ulcers

6.1. A learning note has been distributed across the trust following completion of an investigation of a category 3 pressure ulcer reported as a serious incident in the previous quarter. The learning note identified ways in which staff can avoid pressure ulcers developing such as completing nutrition assessments, Waterlow score and SSkin bundles, repositioning to avoid skin damage and use of emollients to maintain

skin integrity, using mattress cushions and heel protectors and ensuring risks are communicated and discussed at shift handover and at huddles.

6.2. The Trust has renewed its contract with Linet for dynamic cushions and mattresses and the new models have been rolled out across the trust.

6.3. he Tissue Viability Nurse trained a further 27 staff from across the trust in pressure ulcer prevention and wound care. This included the unit where the serious incident occurred.

7. Falls

7.1. Falls risk awareness and frailty of the SRS service user group was identified as an area that required improvement. A bespoke training session was arranged for the SRS staff and a carer's session on awareness on falls risk was held during Falls Awareness week. Analysis of falls data in the Learning Disability Service will be included in future reports.

7.2. The Trust held a Falls Awareness week in September 2019 and information for staff, service users and carers was shared across the Trust. There were various activities across inpatient units and community teams across Trust services including a sensory story about Humpty Dumpty developed for service users in our Specialist Residential Services by Speech and Language Therapists. The Public Health England 'Get Up and Go' booklet was shared, with quizzes and posters to raise awareness around falls risk.

7.3. Safety crosses that pay attention to falls risks have been introduced in all Older People's inpatient services. Safety huddles are being piloted on Seward Lodge, Victoria Court and Wren ward specifically as part of identifying and managing falls risk. Safety huddles are also used post fall to discuss what happened and collectively agree the best way to minimise the risk of further falls. Each unit has a falls champion.

7.4. Teams refer newly admitted service users to the Physiotherapist in Older Peoples' Services or when a presentation changes. The physiotherapist provides advice and support to staff regarding falls prevention including use of walking aids. There were 51 referrals made in Q2, all of which were completed within three days of the referral being made. These included back pain, reduced mobility, posture and seating, walking aid assessments and falls.

7.5. The physiotherapist has led on education around footwear and falls risk, with families encouraged to bring in appropriate footwear for service users including outdoor footwear for the garden. Older Peoples' inpatient wards are providing 'gummy socks' for service users on an individual basis as appropriate. Training was also delivered about physical activity by Occupational Therapy staff.

7.6. Logandene has been trialling individual service user mobility checklists. Posters have been placed in every service user's bedroom as a visual checklist of the aids they need at the start of each day; this includes glasses, hearing aids, walking frames, well-fitting slippers or shoes or slipper socks. It has been well received by staff and will be implemented across other units in Q3.

8. Ligatures

8.1. A CQI project initiated on Robin Ward relating to search is underway and will continue into Q3. As part of this project data relating to self-harm in the last two quarters has shown a total of 258 reported incidents; this is of significance as over the last three years, in total, there were 255 self–harm incidents reported on this ward. These

incidents often took place whilst service users were under observations. Additional support has been put in place for staff.

8.2. A new process for the procurement and maintenance ligature cutters was agreed and this includes additional training materials and training to improve competence in the management of emergency situations.

8.3. An internal Safety Alert was issued in Q2 to highlight learning from a near miss incident and risk relating to a potential window ligature risk through use of a thin specific to Kingfisher Court.

9. AWOL

9.1. In response to learning from incidents and serious incidents the AWOL (MEEP) policy has been updated in Q2 2019/20, to include further clarity around response times to the levels of AWOL risk. Additional guidance has been added outlining the roles and responsibility of managing the Signing In and Signing Out book.

9.2. The Police Grab bag template that can be updated to reflect changes on the PARIS electronic patient record has been approved for development onto the PARIS system. This was based on learning from a Prevention Future of Death report, external to the Trust, where the Police Grab bag was not completed appropriately.

10. Assaults

10.1. The Mental Health (Use of Force) Act which makes provisions "about the oversight and management of the appropriate use of force in relation to people in mental health units; which makes provision about the use of body cameras by police officers in the course of duties in relation to people in mental health units; and for connected purposes. Royal assent was received on 1st November 2018. The implications for this and plans were presented to Board in September 2019.

10.2. Work commenced on a poster campaign looking at how the Organisation supports staff around the impact of violence and aggression, this will be rolled out in Q3.

10.3. A Trust Security & Police Liaison Group commenced in July 2019 to monitor the effectiveness of the processes in place for risk identification, elimination and reduction in relation to any Crime, Disorder and the joint Memorandum of Understanding in place between the Police and Health. The Group will monitor processes in place to take forward prosecutions where appropriate where violence and aggression incidents have occurred on Trust premises. There have been three recent prosecutions of service users following assaults on Trust premises.

10.4. The work to review RESPECT training is underway with a focus on strategies and approaches to manage challenging behaviour during personal care, leadership and human factors. This will be completed by Q3 2019/20.

10.5. The Violence & Aggression and the Incident & Serious Incident Reporting Policies were reviewed and strengthened in light of the HSE Improvement Notice relating to investigation of violence and aggression incidents and staff support. A poster was also produced for standalone units outlining actions to take when a violence & aggressions has occurred. The 3 day report template used by the Trust has also been updated, to include staff support offered post incident and level of harm.

10.6. A CQI project is underway on Oak ward introducing the Brøset Violence Checklist. This is used to assess violence, record through the use of safety crosses

and develop action plans for proactive of violence and aggression as part of the ongoing assessment process. Oak Ward has had a higher number of reported incidents of violence and aggression incidents. This primarily related to one service user who required both seclusion and Long Term Segregation.

11. **Safeguarding children**

11.1. A system has been developed for CAMHS teams to report compliance data for safeguarding children supervision. This provides internal and external assurance that all clinical staff who are involved in assessing and supporting children at risk of abuse or neglect have access to appropriate safeguarding supervision and will be reported quarterly as part of the Safeguarding Children's Dashboard.

11.2. The historic child abuse guidance and flowcharts have been updated and communicated in collaboration within Hertfordshire and Essex Police. This includes changes to the management of historic concerns of sexual abuse that have occurred abroad.

12. **Education and Training**

12.1. The Trust continues to develop and offer a number of training opportunities to cover all aspects of safety. Training content is updated and refreshed in light of learning from incidents. SME's ensure training is accessible to all staff in all areas of the Trust.

12.2. Additional Root Cause Analysis training is being sourced to enable additional staff to be trained in investigation methodology to undertake high quality serious incident investigations with a focus on learning.

13. **Conclusion**

13.1. The Trust remains committed to improving and embedding of the safety and just culture as set out in the Quality Strategy to improve the experience and safe care of our service users.

13.2. There is evidence to show significant improvement in a number of areas but there continue to be challenges in others and these require further development and scrutiny. These include timeliness of root cause analysis of serious incidents, the quality of reports. In addition the just and learning culture requires further work to embed across the Trust in a meaningful way in relation to safety. Work will continue in relation to service users reporting feeling safe, seclusion practice and the management of ligature risks.

13.3. The continuing commitment to safety is reflected in the annual objectives for 2019/20, the continuing drive to reduce the number of suicides and harm from violence and aggression incidents through updating of the Violence & Aggression policies, Incident Reporting policies, learning from incident investigation, our response to the HSE visit, and embedding of the MOSStogether and Quality Strategies.

14. **Priorities**

14.1. Priorities were set at the beginning of year and continue into Q3 and Q4. In addition to this, these have been built on, from the learning in Q1 and Q2.

14.2. *Annual Plan*

- Reducing suicides by 10%
- Feeling safe
- Reducing harm in relation to violence and aggression
- Seclusion environments and practice.

14.3. *Strategy*

- Quality Strategy
- Making our Services Safer Together (MOSS 2gether)

14.4. *Governance*

- Safety Dashboard on Spike2 with KPI safety indicators
- Strengthening of the SI process to ensure compliance with nationally defined timeframes, quality and learning

14.5. *Learning from incidents*

- Learning from the key findings of the deep dive into unexpected deaths and serious self-harm incidents which occurred between 1st January and 30th June 2018 was undertaken by the Mortality Governance Team and informed the work of the Trust's Suicide Prevention Group; the deep dive will be repeated in Q3 2019/20 and will be reported on in Q4 2019/20.
- Work will continue into Q3 2019/20 on raising awareness with Trust staff about encouraging the use by services users and families of the Stay Alive App, a collaborative working approach with the Samaritans to offer support to service users post discharge and between outpatient appointments, and implementation of a 48 hour follow up post discharge.
- The Trust's Suicide Prevention Group will review its membership, terms of reference and the work plan for 2019/20 in light of these findings and keeping with Trust's commitment to reduce suicide by 10% in 2019/20 as set out in the Annual Plan and the Trust's Zero Suicide Action Plan.
- An algorithm to enable the West Community Assessment & Treatment Service to develop a robust plan to respond to service users who find involvement with the team difficult or who are not attending appointments
- Domestic abuse safeguarding training delivered to the Watford Mental Health Liaison Team
- Domestic Violence Leads in place in the Mental Health Liaison Teams

14.6. *Policy and Practice*

- Lambourn Grove will be commencing a three month pilot of a SEM scanner used for detecting changes in sub-epidermal moisture (SEM) to show pressure-induced tissue damage, which can become a pressure ulcer.
- Update of Duty of Candour policy following recommendations from internal audit
- Update of the AWOL policy following learning from a serious incident
- Teaching sessions delivered on post-partum psychosis
- Updates of CATT, Mental Health Liaison and Adult Community Mental Health Services operational policies in response to learning from serious incidents.
- Implementation, through CQI methodology of Trauma Risk Management (TRiM) in Essex & IAPT services, to support wellbeing and resilience of staff affected by a potentially traumatic incident and REACT which is an approach to facilitate conversations about difficulties at work and effect on mental wellbeing.
- CQI to produce an easy read guide to the MOSStogether strategy.
- A restricted items list has been developed for West SBU Acute Wards.
- Norfolk services raining for staff on Mental Health First Aid and Resilience to be delivered by Thriving workplaces.
- A CQI project on Dove ward around seclusion is continuing.
- Work commenced in Q2 and will be continuing in Q3 with a working group to refresh the Falls RCA report template.

- Falls CQI project has commenced on Logandene and will continue.
- A learning note on learning themes from falls and guidance will be disseminated across all Trust services.
- An evaluation of six months pre and post introduction of zonal observations is being undertaken.
- A review of the Ligature Awareness e-learning package to include the use of ligature cutters and specific advice for community services will be completed by Q3, 2019/20.

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item: 8**
Subject:	Quarter 2 Safer Staffing Report	**For Publication:**
Authors:	Jacky Vincent, Deputy Director of Nursing and Quality/DIPC	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety/Chief Nurse
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety/Chief Nurse	

Purpose of the report:

This report provides the Board with the data for quarter 2, 2019/20 on nurse staffing for the Trust. In addition, the report provides information that sets the context for the published data including recruitment, retention and vacancies of nursing staff and cross referenced with patient safety data. The purpose of this report is to provide information and assurance of the governance processes for rostering and ensuring the appropriate level and skill mix of nursing staff.

Action required:

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

Summary and recommendations to the Board:

The direct care nurse staffing data was analysed according to total hours worked per ward for RN and HCA, divided into day and night time hours and includes additional duties. Quarter 2 showed adequate staffing and shift cover in response to unexpected demand and levels of acuity and dependency on the wards.

Astley Court had a fill rate below 80% on two occasions, and there were also more actual hours than planned used for both RNs and HCAs across many services. The CHPPD analysis showed that small standalone units with high acuity had high CHPPD. This is reflected when comparing the Trust with the national data.

Relationship with the Business Plan & Assurance Framework:

Relation to the Trust Risk Register:

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

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)

Relation to the BAF:

1. We will provide safe services, so that people feel safe and are protected from avoidable harm.
4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment

Summary of Implications for:

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

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

N/A

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

Potentially all of the above

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

IGC- 20th November 2019

Quarter 2 Safer Staffing Report 2019/20

1. Introduction

1.1 This report serves to provide the information and analysis of the quarter 2 nurse staffing data to enable the Integrated Governance Committee (IGC) to have assurance in relation to the nurse staffing in the Trust's inpatient services.

1.2 This report also provides supporting data in relation to vacancies.

2 Trust expectations in relation to inpatient nurse staffing levels

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

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

2.3 In the event that a shift remained unfilled, this is reported to the Heads of Nursing and recorded as a safety incident on Datix, again as detailed in previous reports.

2.4 Staffing cover is often mitigated by an increase of staff from a different band, cross cover from co-located services and by the Team Leaders and Matrons.

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

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

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

3 Summary of findings for quarter 2 nurse staffing data collection

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

3.2 Care Hours Per Patient Day (CHPPD) data submitted by the Trust, reflects the increased staffing utilised in many of the services as a result of increased acuity and also the stand alone units where CHPPD is high.

North Essex and IAPT SBU

3.3 Staffing levels for Lexden were reduced 6th July 2019. However, following a service user incident resulting in two Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) on 27th July, staffing levels were increased again. During July, there were two service users with complex needs, requiring continuous safe and supportive observations.

3.4 The overall CHPPD remained high in July - although a slight decrease from June – which predominantly relates to the night shifts where the budget is set for 5 staff at night. This is in consideration of the unit being a standalone unit and also with one individual service user with high acuity needs.

3.5 There has been a significant decrease in agency usage during July, attributed to the discharge of a service user requiring 4:1 support. A further reduction in agency in August and September was also reported. Plans to convert a band 5 Staff Nurse vacancy to a Charge Nurse post were agreed to strengthen the leadership within the inpatient service.

East and North SBU

3.6 With regards to the East and North SBU, the Business case for Forest House has been agreed and, as a result, the number of nursing vacancies has increased.

3.7 An increase in the number of bank and agency usage across the SBU's inpatient services has been noted, predominantly due to the level of observations.

West SBU

3.8 In the West SBU, the use of enhanced safe and supportive observations as a key intervention remains a critical area for review. Some of the previously reported issues impacting on high staffing levels remain – for example on Swift ward.

3.9 There has also been a challenge in the West SBU with regards to service users who are medically cleared at acute hospitals and are subsequently assessed as physically unwell when arriving for admission to the Trust's units, requiring 1-2 staff members to escort the individuals back to the hospital. Robin ward have also continued to manage high levels of challenging self-harming behaviour.

3.10 Agency use in some community teams has been high owing to ongoing vacancies, and limited availability of bank staff that are able to fulfil these posts.

Learning Disability and Forensic SBU

3.11 Bank and agency usage across the Learning Disability and Forensic SBU has increased, predominantly agency use in Norfolk services owing to high levels of staff sickness and ongoing vacancies. Options are being explored regarding external bank and agency to support the services in Norfolk.

3.12 The SBU has continued to utilise SafeCare effectively and redeploy staff across the service areas which has demonstrated positive outcomes in consideration of both sharing as well as acquiring new of skills and experience.

3.13 The use of eRostering and SafeCare have been key enablers in ensuring that services are run safely and staff utilised as efficiently as possible. The information from both of these has also proven to be invaluable in the planning and enabling of swift action to be taken where pressures have emerged, relating to both quality and finance.

3.14 As data is extracted relating to shifts being utilised on a weekly basis and used to inform decision-making, a reminder was sent to the Matrons and Team Leaders for eRosters to be updated on a weekly basis - including both bank and agency shifts loaded onto the system and finalised, and a review of lost contracted hours. The aim is to ensure that eRosters are kept up to date to enable the extraction of information every week.

3.15 The Heads of Nursing with the Deputy Director of Nursing and Quality completed a peer review of the skill mix and establishment of all inpatient services, including the consideration of increasing the number of safe and supportive observations absorbed in the numbers to reduce the need for late bank and/or agency shifts for support. These are currently for discussion within each of the SBU's core management for agreement before being brought to the safer staffing Group.

4. Bank and Agency

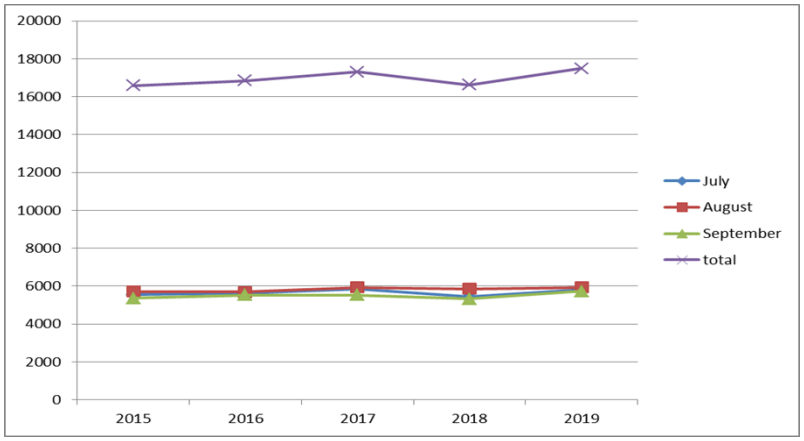
4.1 The overall bank and agency usage for quarter 2 is provided as a total number of shifts, over a 5 year period are shown in **table 1. Tables 2** highlight the comparisons with the previous quarter of this year. Furthermore, **graphs 1** and **2** shows the bank and agency use for quarter 2 over 5 years respectively.

		July	August	September
2015	**Bank**	5540	5702	5351
	Agency	1711	1634	1359
2016	**Bank**	5622	5699	5520
	Agency	1510	1735	2341
2017	**Bank**	5846	5933	5530
	Agency	1834	1954	1733
2018	**Bank**	5435	5864	5321
	Agency	1796	1160	1089
2019	**Bank**	5819	5936	5736
	Agency	1228	1331	1235

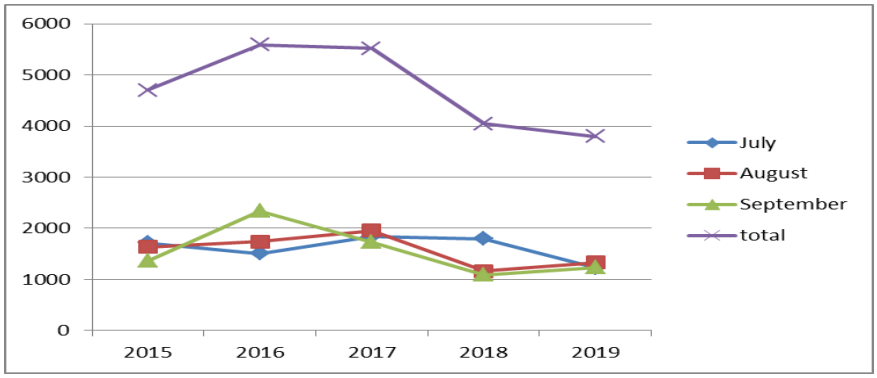
Table 1

Q1 2019/20	April	May	June
Bank	5363	6003	5850
Agency	935	1126	1186

Table 2



Graph 1



Graph 1

4.2 Although there has been an increase in agency use during the quarter, overall there continues to be less agency usage in comparison to the previous years. Shifts covered by bank at month 3 of quarter 2 have decreased by 200 shifts overall and shifts covered by agency has also decreased by 96.

4.3 Based on the successful reduction in agency spend in the last half of 2018/19, at the start of 2019/20 the Trust set an internal ceiling of £5,800k spend to support the Trust's Delivering Value savings programme. Each SBU has drawn up detailed plan trajectories to quantify how they would keep agency expenditure to within the agreed total with regular monitoring of actual spend against these trajectories.

4.4 Remedial action has been discussed at the Safer Staffing Group meetings and include:

- Keeping agency use to an absolute minimum and ensuring that all agency use goes through the correct authorisation process
- Ensuring all agency shifts are confirmed on a weekly basis to ensure clear sight of usage
- Reviewing processes to ensure that the potential to convert agency to permanent staff is maximised.

4.5 **Appendix 1** provides detailed data for each inpatient service for quarter 2.

5. Vacancies

5.1 The Trust continues to have challenges with recruitment in quarter 2 as detailed in **Table 3**.

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex and IAPT	12.00	10.17	1.83	15
Learning Disability & Forensic	173.47	126.91	46.56	27
East and North	125.72	87.69	38.03	30
West	126.10	89.83	36.27	29
Total	**437.29**	**314.60**	**122.69**	**28**
Unregistered Nursing				
Essex and IAPT	15.00	15.43	-0/43	-3
Learning Disability & Forensic	223.91	182.85	41.06	18
East & North	197.00	165.78	31.22	16
West	132.57	105.73	26.84	20
Total	**568.48**	**469.78**	**98.7**	**17**

Table 3

5.2 The Trust continues to work with the local universities ensuring that student nurses feel part of the Trust family at the start of their training and meeting senior nurse leaders during their training. Work is underway with Hertfordshire University to agree final placements with the students' employment area of choice to enable a more smooth transition form student to registered nurse and also increase the likelihood of recruiting the nurse.

5.3 Furthermore, a flowchart with agreed dates for every learning disability and mental health student nurse to meet with the Deputy Director of Nursing and the Heads of Nursing every six months on a formal basis to maintain contact with them, discuss their opportunities and also ensure they feel welcomed and part of the Trust.

5.4 In quarter 2, 35 learning disability and mental health student nurses secured employment within the Trust from the 2016 cohort.

5.5 The Nursing Associates from cohort 1 have settled into their new posts with some exploring options to further their career within the Trust.

5.6 A change in approach to recruiting to specific areas rather than Trust wide recruitment days is proving to be more effective. A recruitment campaign for West SBU resulted in an open day that attracted 50 attendees and 30 offers were made. Similar events continue to be planned, including targeted social media campaigns.

5.7 **Appendices 2** and **3** provide a breakdown of vacancies in the inpatient and community services respectively.

5.8 A significant risk remains for the Trust regarding the profile of RNs who are able to retire (212), detailed in **Table 4**. Work continues to support them and explore their options to remain in the workforce. Particular concern remains within the SRS and the Learning Disability and Forensic SBU are looking at strategies to mitigate and manage this risk.

Area	55-59			60-64			65+		
	HCA	RN	Total	HCA	RN	Total	HCA	RN	Total
Essex and IAPT	2	1	3	2	0	2	0	0	0
LD and F SBU	32	19	51	13	7	20	4	0	4
E and N SBU	31	10	41	16	11	27	6	2	8
West SBU	19	13	32	11	5	16	3	4	7
Total	**84**	**43**	**127**	**42**	**23**	**65**	**13**	**6**	**19**

Table 4

6. Conclusion

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

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

6.3 SafeCare continues to be embedded within all inpatient services with daily SafeCare calls to ensure safe staffing and effective use of our staffing resources across the Trust.

6.4 Targeted work in the SBUs for quarter 3 includes:

- Ensuring best practice is applied in the review and management of therapeutic engagement and observation levels on the wards (for example, reviewing in each shift to ensure the level of observation is in line with the level of risk presented by the service user
- Use of alternative interventions including SafeWards to be relaunched and refreshed in all inpatient wards – as part of the MOSS*together* Strategy
- eRoster management of bank bookings, management of annual leave and ensuring staff working to contracted hours and ensuring fairness
- Ensuring all Registered Nurses are conversant with the dependency levels in utilising SafeCare census
- Team Leaders and Matrons aware of budgets and spending on additional shifts (and attending the training sessions on offer from Finance)
- Ensuring unutilised hours are addressed.

6.5 The IGC is asked to note this report and discuss any point of clarification.

Appendix 1 - Nurse Staffing fill rate data

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	CHHPD RN	CHPPD HCA	Overall CHPPD
JULY 2019							
Learning Disability and Forensic SBU							
Gainsford House	106.8	109.6	100	100	4.7	2.4	7.1
Hampden House	98.8	97.3	100.2	100	5.7	2.8	8.5
Warren Court	100.8	110.5	99.5	100.2	4.8	7.1	12.0
4 Bowlers	98.6	100.1	100	97.9	4.1	5.2	9.3
Beech	114.9	107.4	101.7	124	3.4	5.4	8.8
Dove	92	102.7	129	125.2	2.8	7.0	9.8
SRS	95.7	108	100	103.5	3.0	10.4	13,4
Astley Court	79	171.3	103.7	99.9	4.5	10.8	15.3
Broadland Clinic	101	86.8	90.8	106.4	2.4	7.5	9.9
The Beacon	100.2	106.2	101.6	119.3	3.6	3.0	6.6
Essex & IAPT SBU							
Lexden	90.7	100.4	100	107	11.1	18.5	29.5
West SBU							
Swift	103.2	149	101.1	262.6	4.1	6.0	10.1
Robin	120.1	163.7	99.7	270.6	2.8	6.9	9.6
Owl	104.8	162.6	101.6	246.8	2.7	6.7	9.4
Oak	95.5	252.1	104.8	197.9	4.9	15.5	20.4
Thumbswood	132.2	105.4	122.7	114	6.9	10.9	17.8
Albany Lodge	114.3	92.1	98.3	112.7	2.7	4.3	7.0
Aston	113.2	110	98.4	141.5	2.7	4.3	7.0
East and North SBU							
Victoria Court	96.9	112.1	98.3	100.4	1.7	6.1	7.8
Forest House	99.1	145.0	100	121	3.4	9.1	12.6
Wren	94.6	96.9	100	115.9	3.0	6.2	9.2
Lambourn Grove	120.6	122	110.4	135	2.4	7.9	10.2
Logandene	114.3	92.1	98.3	112.7	3.5	7.6	11.1
Seward Lodge	95	101.8	98.3	145	2.9	7.6	10.6
AUGUST 2019							
Learning Disability and Forensic SBU							
Gainsford House	107.2	193.5	100	100	4.6	3.2	7.9
Hampden House	99.9	99.9	99.9	99.9	5.1	2.7	7.8
Warren Court	94.8	103	98.9	99.3	3.5	6.4	9.9
4 Bowlers Green	103.1	99.7	99.6	99.8	4.1	5.1	9.2
Beech	116.9	93.6	103.9	104.7	3.6	4.8	8.4
Dove	88.6	94.6	96.8	101.3	2.5	6.3	8.9
SRS	92.3	108.5	98.4	107	2.9	10.6	13.5
Astley Court	75.7	179.5	103.4	100.4	4.4	11.1	15.5
Broadland Clinic	95.5	91.9	92	104.3	2.4	7.8	10.4
The Beacon	112	526.8	108.9	146.1	4.3	3.5	7.9
Essex & IAPT SBU							
Lexden	96.0	96.8	98.4	99.9	11.3	16.7	28.0
West SBU							
Swift	104.7	175.7	98.8	247.9	4.4	6.3	10.9

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	CHHPD RN	CHPPD HCA	Overall CHPPD
Robin	110.9	181.4	99.9	256.1	2.6	6.7	9.6
Owl	115.3	189.2	100.9	252.4	2.7	7.3	10.0
Oak	87.9	249.4	100	200.7	4.3	15.0	19.3
Thumbswood	157.2	100.6	116.1	138.6	8.1	13.5	21.6
Albany Lodge	108.7	114.1	101.6	147.8	2.6	4.4	7.0
Aston	96.7	120.8	101.6	114.2	3.8	5.8	9.6
East and North SBU							
Victoria Court	94.7	109.4	98.0	99.1	1.7	6.0	7.7
Forest House	90.6	174.6	98.4	170.2	3.3	11.8	15.1
Wren	94.7	99.6	100	116.2	3.1	7.3	10.3
Lambourn Grove	114.5	114.4	112.7	123.7	2.3	7.2	9.6
Logandene	110.6	99.8	104.8	114.4	3.5	7.5	11.0
Seward Lodge	97.2	99.1	106.5	128.7	3.3	7.7	11.0
SEPTEMBER 2019							
Learning Disability & Forensic SBU							
Gainsford House	96.9	198.4	101.7	96.6	4.5	3.3	7.7
Hampden House	96.4	115.9	101.6	96.6	4.9	2.6	7.4
Warren Court	96.4	122.6	99.6	106	5.0	7.7	12.0
4 Bowlers	111.1	90	100.1	99.9	4.5	5.1	9.6
Beech	106	98.4	98.3	99.1	3.6	5.2	8.8
Dove	94.9	98.6	101.7	106.7	2.9	7.1	10.0
SRS	96.7	112.4	100	103	3.1	10.9	14.1
Lexden	106.6	112.2	108.6	118.2	11.2	14.5	26.7
Astley Court	69.1	183.9	101.3	95.5	6.6	17.3	24.0
Broadland Clinic	98.5	95.4	102.8	97.9	2.6	7.8	11.0
The Beacon	99.6	103.9	102.3	114.1	3.7	2.6	6.3
West SBU							
Swift	103.1	177.8	97.7	247.2	4.6	6.5	11.2
Robin	114.7	177.8	97.7	247.2	2.7	8.9	11.6
Owl	116	185	101.7	216.4	2.9	7.0	9.9
Oak	89.7	179.7	103	155	4.8	12.7	17.5
Thumbswood	152.4	102.4	106.6	131.7	8.6	13.0	23.0
Albany Lodge	113.8	114.1	108.5	155.6	2.8	4.7	7.5
Aston	95.8	125	100	114.4	3.8	6.0	10.0
East and North SBU							
Victoria Court	96	113.1	95.4	110	1.8	6.5	8.3
Forest House	93.7	151.4	100	156.7	3.2	11.0	14.2
Wren	103.7	95.5	100	123.7	3.2	7.2	10.3
Lambourn Grove	106.6	112.2	108.6	118.2	2.2	7.0	9.4
Logandene	97.9	99.3	98.2	99.8	3.1	6.9	10.4
Seward Lodge	90.4	91.8	100	114.7	2.9	6.4	9.4

Appendix 2 - Vacancies breakdown by in-patient services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Essex and IAPT SBU				
Lexden	12.00	10.17	1.83	15
Total	**12.00**	**10.17**	**1.83**	**15**
Learning Disability and Forensic SBU				
4 Bowlers Green	9.00	7.00	2.00	22
Beech Ward	14.20	11.00	3.20	23
Broadland Clinic	26.20	13.40	12.80	49
Dove Ward	12.00	9.13	2.87	24
Gainsford House	10.80	9.60	1.20	11
Hampden House	10.60	8.28	2.32	22
Astley Court	12.00	8.00	4.00	33
Warren Court	26.00	24.00	2.00	8
SRS Bungalows	16.00	8.00	8.00	50
The Beacon	11.31	8.95	2.36	21
Total	**148.11**	**107.36**	**40.75**	**28**
West SBU				
Albany Lodge	13.50	10.50	3.00	22
Aston Ward	15.00	8.82	6.18	41
Oak Ward	13.00	9.00	4.00	31
Owl Ward	11.00	8.64	2.36	21
Robin Ward	11.60	9.00	2.60	22
Swift Ward	18.00	17.00	1.00	6
Thumbswood	7.67	7.00	0.67	9
Total	**89.77**	**69.96**	**19.81**	**22**
East & North SBU				
Forest House	14.00	6.80	7.20	51
Lambourn Grove	11.04	8.60	2.44	22
Logandene	12.37	9.44	2.93	24
Seward Lodge	12.00	9.12	2.88	24
Victoria Court	12.64	8.96	3.68	29
Wren	11.14	10.61	0.53	5
Total	**73.19**	**53.53**	**19.66**	**27**
Overall Total				
NON-REGISTERED NURSING				
Essex and IAPT SBU				
Lexden	15.00	15.43	-0.43	-3
Total	**15.00**	**15.43**	**-0.43**	**-3**
Learning Disability & Forensic SBU				
4 Bowlers Green	11.02	10.01	1.01	9
Beech Ward	16.00	14.00	2.00	13

Broadland Clinic	44.60	38.02	6.58	15
Dove Ward	14.89	12.89	2.00	13
Gainsford House	5.40	4.40	1.00	19
Hampden House	5.00	4.00	1.00	20
Astley Court	11.40	9.00	2.40	21
Warren Court	36.00	28.00	8.00	22
SRS Bungalows	62.00	47.17	14.83	24
The Beacon	8.00	7.00	1.00	13
Total	**214.31**	**174.49**	**39.82**	**19**
West SBU				
Albany Lodge	22.00	15.60	6.40	29
Aston Ward	13.76	14.33	-0.57	-4
Oak Ward	17.00	10.64	6.36	37
Owl Ward	15.53	13.53	2.00	13
Robin Ward	17.20	12.00	5.20	30
Swift Ward	15.90	12.04	3.86	24
Thumbswood	9.60	7.00	2.60	27
Total	**110.99**	**85.15**	**25.84**	**23**
East & North SBU				
Forest House	25.70	11.00	14.70	57
Lambourn Grove	32.62	30.84	1.78	5
Logandene	28.30	26.55	1.75	6
Seward Lodge	22.13	17.77	4.36	20
Victoria Court	34.40	31.67	2.73	8
Wren	20.69	20.80	-0.11	-1
Total	**163.84**	**138.62**	**25.22**	**15**
Overall Total				

Appendix 3 - Vacancies breakdown by Community Services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	0.00		0.00	0
Continuing Care & Placement Team	3.60	2.60	1.00	28
Criminal Justice & Forensic	1.00		1.00	100
Criminal Justice Mental Health	2.00	1.00	1.00	50
LD SLDS A&T E/N Team	9.00	8.20	0.80	9
LD SLDS A&T West Team	9.76	7.75	2.01	21
Total	**25.36**	**19.55**	**5.81**	**23**
East & North SBU				
AMHCS Centenary & Jubilee	14.60	10.43	4.17	29
AMHCS Cygnet House	9.59	3.90	5.69	59
AMHCS Holly Lodge	5.00	4.00	1.00	20
AMHCS Saffron Ground	10.34	5.80	4.54	44
AMHCS Oxford House	2.00	1.00	1.00	50
AMHCS Rosanne House	11.00	9.03	1.97	18
Total	**52.53**	**34.16**	**18.37**	**35**
West SBU				
AMHCS NW Herts Dacorum	8.20	3.33	4.87	59
AMHCS NW Herts St Albans	6.33	3.73	2.60	41
AMHCS SW Herts	1.00	1.00	0.00	0
AMHCS SW Herts Borehamwood	7.20	5.60	1.60	22
AMHCS SW Herts Watford	7.20	5.60	1.60	22
Total	**36.33**	**19.87**	**16.46**	**45**
Overall Total	**114.22**	**73.57**	**40.65**	**36**
NON-REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	0.00		0.00	0
Continuing Care & Placement Team	0.00		0.00	0
LD SLDS A&T E/N Team	4.00	2.76	1.24	31
LD SLDS A&T West Team	5.60	5.60	0.00	0
Total	**9.60**	**8.36**	**1.24**	**13**
East & North SBU				
AMHCS Centenary & Jubilee	8.14	6.24	1.90	23
AMHCS Cygnet House	6.90	5.66	1.24	18
AMHCS Holly Lodge	2.50	2.50	0.00	0
AMHCS Saffron Ground	5.27	3.40	1.87	35
AMHCS Oxford House	2.32	2.35	0.00	0
AMHCS Rosanne House	8.00	7.00	1.00	13

Total	**33.16**	**27.15**	**6.01**	**18**
West SBU				
AMHCS NW Herts Dacorum	5.89	5.89	0.00	0
AMHCS NW Herts St Albans	5.00	5.00	0.00	0
AMHCS SW Herts	3,00	2.00	1.00	33
AMHCS SW Herts Borehamwood	1.49	1.49	0.00	0
AMHCS SW Herts Watford	6.20	6.20	0.00	0
Total	**21.58**	**20.58**	**1.00**	**5**
Overall Total	**64.34**	**56.09**	**8.25**	**13**

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item:** 9
Subject:	Report from Finance & Investment Committee – November 19th 2019	**For Publication:** Yes
Author:	Paul Ronald, Deputy Director of Finance	**Approved by:**
Presented by:	David Atkinson, Non-Executive Director Chair – Finance & Investment Committee	

Purpose of the report:

This paper provides a summary report of the items discussed at the Finance & Investment Committee meeting on 19th November 2019.

Action required:

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

Summary and recommendations:

Deep Dive – Benchmarking

The deep dive was within the context of the Delivering Value program currently being short of the target value of £6.5M. The Deputy Director of Finance and Head of the Efficiencies gave a joint presentation setting out the current benchmarking workstreams being undertaken to support the provision of a strong evidence base to the development of our annual Delivering Value Program. These workstreams included the early work on using the Model Mental Health Hospital portal site and the next steps in promoting its use within service lines and the work within the annual National Benchmarking Program. Whilst the latter is a more developed program of work the Committee recognised the breadth of the Model Hospital site and the sophistication of the analysis tools and was encouraged by the early participation in its rollout and the steps to promote and extend its use.

The presentation also covered the Trusts participation in the annual Corporate Services benchmarking and how this had been used internally and some work that the Trust had initiated with a group of local peer trusts on specific areas. The Committee noted how this work was limited by the challenges in producing comparable data sets and could see how as the Model Hospital site develops further that this peer to peer review will be more easily conducted. In the final part of the presentation the early steps in developing a benchmarking facility within SPIKE was discussed and how this would build upon and enhance what is available within the Model Hospital providing the data at team level and allowing further drill down to source data.

The Committee were encouraged by the work being undertaken and requested an update to be given of progress in six months' time.

Annual Plan

The Committee received a report detailing the Trust's performance against the seven Annual Plan objectives and noted that good progress has been made at the end of Q2 with 5 out of 7 objectives assessed as meeting the milestones. Objective 2 (Experience) has been rated Amber due to the carer related milestones being slower to progress and on Objective 5 (Innovation and productivity) is also rated Amber as plans have not yet been fully identified to achieve the required Delivering Value requirement.

Performance Report Q2
The Committee received the Performance Report for Q2 and noted that the trust wide performance continues to do well against a backdrop of continued increased demand for services. 72.4% of indicators are exceeding, meeting or very nearly achieving the performance level required.

FIC noted the areas of strong performance and focussed on those areas where there has been a decline in the quarter and the actions being taken in each of these areas. In particular the Committee noted progress on the CAMHS Access through the Task and Finish Group overseeing the recovery.

Finance Report M7
The Committee received the Financial report for October and noted that the position continues to be slightly ahead of plan and the continuing confidence that the end of year control total will be met. The Committee were presented with the key highlights in the period and advised there has been an increase in reported monthly revenues as the income for several new service developments is now being reported as more of these new services become established. This has seen an increase in Pay costs. It was noted that as these teams are progressively recruited to then this will put pressure on the underlying position where there remains a gap in the requirement to achieve a recurrent surplus.

The Committee noted that the Trust continues to have an n NHSI Finance rating of 1 which is the highest level with one individual metric reporting a 2.

The Committee then discussed the level of risk likely within the New Care Models development and were advised that these discussions remained very live currently and as the discussions and arrangements progressed this would be considered fully within the Committee. The Committee noted the learning from the CAMHS Tier 4 transfer and the successful management of this risk.

Capital Expenditure
The Committee was provided the regular update to the Capital Plan and also advised of the work being done on the new 5-year Strategic Investment Plan. The Plan will see additional spend on both estates and additional IT infrastructure. FIC noted that NHSI have asked for Trusts to make outline proposals to accelerate their Capital spend in the current year and that the Trust had proposed an additional IM&T spend of circa £1.5m was possible provided approval provided early.

In relation to the current year Plan the spend YTD was noted and further clarification was requested at the next meeting on the expected full year spend. The Committee were supportive of bringing the planned spend forward where this was possible.

Committee Self-Assessment
The Committee received and agreed to undertake a self-assessment process for 2019.

Business Development
a) New Care Models
The Committee noted the report which from the Interim Managing Director of the East of England New Care Models Collaborative on the progress in forming a provider collaborative to deliver New Care Models for specialist mental health services in the East of England and the next steps. This was to be discussed in greater detail at the Strategy Committee later the same day.

The Committee were supportive of the principles outlined in the paper and would look to develop these further;

- Putting Service Users at the heart of all decisions.
- A genuine commitment from all parties to make this work.
- Open dialogue, honesty and information sharing.
- Sharing risks as well as benefits

Strategic Investment Programme Update
The Director of Finance updated FIC on the key investment considerations, being the Digital Strategy, with a likely level of investment over the period of £15m-£20m and the proposed inpatient development in the East and North of the County part funded by related asset disposals. There was a discussion on the financing options being explored in the context of the recent systems wide capital developments. It was noted that external borrowing is likely to be required to meet elements of the forward programme and informal discussions regarding future plans and potential funding requirements have commenced

Strategic Outline Case: East and North Herts Bed Provision
The Estates Strategy development for Adult Inpatient Beds was presented with an update on the current position regarding the preparation of the Strategic Outline Case. The business case is developed over 3 stages;

- Strategic Outline Case (SOC)
- Outline Business Case (OBC)
- Full Business Case (FBC)

The draft SOC for the project is well developed with the only outstanding issue being the receipt of the capital cost estimates with an estimated capital cost of £55M assumed currently. Once the capital cost estimates are received the Financial Case of the draft SOC can be finalised and the SOC completed.

The two main areas for consideration discussed were;

- Further stakeholder engagement.
- An independent review had been commissioned of RSM confirm compliance with the NHS Green Book and best practice.

The Committee were advised that the final SOC document is brought back for approval in January 2020 with the next steps in order to progress the Project being;

- Establish a Project Steering Group (with an Executive Director lead).
- Confirm the program for the Project from the business case phases to the commissioning of the new facility.
- Commission a Health Needs Assessment to be included in the OBC.

Place of Safety capital Program next phase
The Committee received an update on progress with the capital investment in the place of safety provision and approval was given to progress this to the next stage. It was noted that at this point the cost of the scheme was still under review and that no overall commitment had yet been made to the financial quantum.

Financial Planning Requirements
The committee received an update on the Financial Planning requirements for 20/21 and the implications of the extended planning obligations of each STP. Of particular note was the 0.5% contingency funding being required within the region and its effect on the proposed Control Total which would increase to circa. £1.4m annually for the next four years. It was highlighted that, the mechanics of how this will be progressed and any adverse impact on MH investment is unclear at this point.

In relation to the Trusts own plans then these would be developed over the next months in accordance with national guidance, discussions with commissioners and the Trusts own internal strategy development. It was noted that whilst there would be an increase in income in 20/21 the indication is that this would largely be absorbed with inflationary pressures and that any development would needed to be funded from additional efficiencies.

It was noted that the figures included within the STP plans were estimates at a point in time and that

the Trusts own plans would further refine this. One significant area not included for example was any projections for the New care Model development discussed earlier.

Financial Control Total
As noted above it was very unclear how this would work in practice and the trust continued to make enquiries from the region on this. At this point the Trust continued to support it but a final decision would be when the Trusts plans were submitted in march/ April.

Any Other Business
The Committee noted that;

- HFMA the health accountancy body had raised concerns over the implementation of PLICS reference cost submissions in July 2020 as being too soon.
- There was discussions within East & North Hertfordshire to move away from the current PbR payment currency with its acute Provider
- The decision on the North Essex IAPT tender was delayed with the election.
- The Trust was continuing to provide a service to the Mount Prison as the recent tender had not provided a successful candidate.

FIC Business Programme 2019
The FIC Business programme was reviewed and potential forward items discussed.

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 Financial, IT, Staffing & Legal Implications:

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

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

Trust Board

Meeting Date:	5th December 2019	**Agenda Item:** 10
Subject:	Financial Summary to 31st October 2019	**For Publication:** Yes
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 forecast of the likely financial position for the full year.

Action required:

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

Summary and recommendations:

This report sets out the financial position for October Year To Date against Plan including an assessment of the likely outturn, it shows a year to date position continuing slightly ahead of Plan and a strengthening confidence that the End of Year Control Total will be met.

The key highlights are:

- There has been an increase in reported monthly revenues as the income several of the new service developments commissioned is now being reported as more of these new services become established. This is having a favourable impact on the surplus position as in most cases the recruitment is still ongoing.
- Linked to the above is the additional pay cost this month reflecting an increase in Payroll headcount of 42 which is the highest monthly increase. The full impact of this increase is not seen in October so will increase further in November.
- Whilst agency costs are higher in month this is largely driven by the work within the discrete time limited work within CAMHS. Of note is within the core workforce areas of agency and community agency costs re reducing and the target reduction of 10% below Q1 is being met in many areas. The area of risk currently is within medical posts.
- Overhead costs continue to be largely held with a focus on the areas of travel estates and several of the outsourced services.
- As reported below there is a gap in the recurrent position, this is showing a level of progress, with further improvement towards recurrent financial balance being contingent upon the full implementation of the main service developments.

- It is important in this analysis to remind the Committee that given the low margin level, the growth in activity and its volatility there are continuing risks to the position which whilst increasingly are likely to be absorbed in the position do present ongoing challenges:

- There is an increase in headcount in October of circa 40 staff; further work is ongoing to profile the likely recruitment timeline to new posts and to address this recruitment gap.

- As well as the internal demand pressures on beds there is the anticipated impact of the expected winter bed pressures within the acute sector

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

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

Summary of Financial, IT, Staffing & Legal Implications:

Finance – achievement of the 2019/20 planned surplus and Use of Resources Rating.

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

Background to Financial Plan 2019/20

1.1. The Control Total for 2018/19 was met, with a strong turnaround in financial performance in the second half of the year. Whilst this provides a good entry position into the new year, 2019/20 will be a very challenging year, in particular due to:

1.1.1. The continued growth in referral numbers whilst operating within a fixed revenue budget.

1.1.2. The pressures around pay costs with the second year of the new Agenda for Change pay award.

1.1.3. The level of non-pay inflation in areas such as third party bed provision and within estates costs.

1.1.4. The number of structural changes to NHS financial systems which have been focused on reducing large acute sector deficits.

1.2. The Plan is summarised in Fig. 1a below, stated prior to any amounts due under the Provider Sustainability Fund (PSF):

Fig 1a Plan	2017/18 Actual	2018/19 Actual	2019/20 Plan
Income	224.2	232.0	252.0
Pay	147.6	151.6	163.4
Other Direct Costs	32.2	36.8	43.7
Overheads	32.5	34.7	35.4
EBITDA	**11.9**	**8.9**	**9.5**
EBITDA margin	5.3%	3.8%	3.8%
Financing	8.4	8.5	9.5
Surplus	**3.5**	**0.4**	**0.0**

2. Summary and Risk Rating

2.1. For the month of October there is a surplus reported of £30k against a Plan of £75k deficit, and for the year to date there is a surplus reported of £243k against a Plan of £125k surplus. The position has therefore remained ahead of Plan for October and for the year to date. This position is driven by increased income in the month, now above Plan as the full contract value is released; offset by the related increases in pay costs with a sizeable net headcount increase in the month (still below Plan to date but starting to increase) and higher external bed costs.

UOR	1	In Month Plan £000	In Month Actual	YTD Plan £000	YTD Actual	Full Year Plan £000	Trend

2.2. A summary of key figures is reported below:

		£000		£000		
Overall Surplus (Deficit)	**-75**	**30**	**243**	**125**	**0**	
Pay Overall	**13,444**	**13,382**	**94,378**	**92,871**	**161,660**	
Agency	**483**	**576**	**3,378**	**3,747**	**5,800**	
Secondary Commissioning	**2,633**	**2,901**	**18,600**	**19,696**	**31,528**	

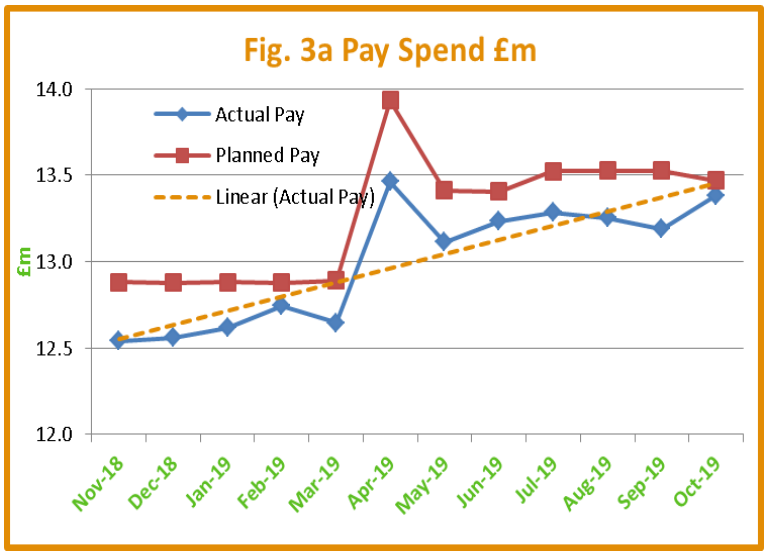
2.3. The Trust's Use of Resources (UOR) framework rating for October and for Quarter 2 remains as a 1, the highest rating. The detailed calculation of the UOR is shown as an Appendix, with the main in month movements outlined below. The main risk area is the Capital Servicing Capacity could fall below a 2 in month 12 dependent on the Trusts surplus position:

Metric	Rating	Reported Rating	Commentary
Capital Servicing Capacity	1.9	1	Rating maintained in month. Likely slight increase in rating in future months until M12 when the next loan repayment will be made
Liquidity	1.1	1	Strong cash position of £56.3m supporting liquidity metric.
I&E Margin	2.3	2	Stayed the same in month
I&E Variance	1.9	1	Stayed the same in month
Agency Spend	1.4	1	Slight fall in month, although agency spend increased in month this was mainly due to CAMHS 28 day recovery posts which are seperately funded, and overall spend is still under the NHSI agency cap.
UOR Overall		1	

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

2.4. All figures are reported before any income from the Provider Sustainability Fund (PSF) which is expected to be £189k for the month and £849k for the year to date, assuming the Control Total is met. Additionally, incentive PSF for 2018/19 of £443k is shown in the year to date position (but is not part of the Control Total).

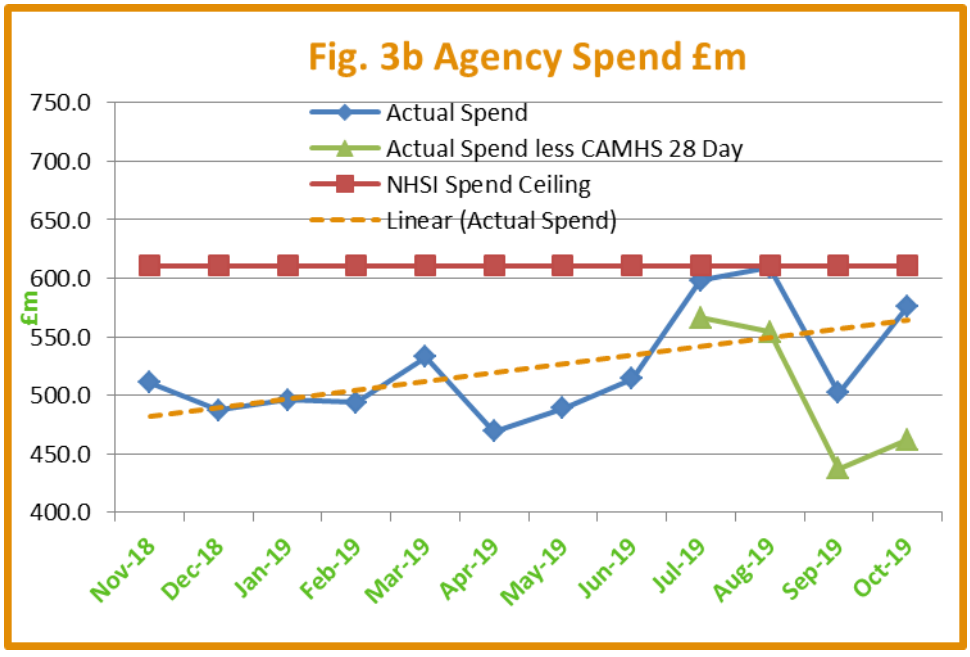
3. Trading Position



3.1. Pay costs totalled £13.4m for the month against a Plan of £13.4m, and £92.9m for the year to date against a Plan of £94.4m. Pay overall is shown for a rolling 12 month period in Fig. 3a. This includes the significant increase in Plan for 2019/20 relating both to new investments and to the pay award, and the increase in April for the £420k 1.1% non-consolidated pay award in April only, reducing back down and then most months increasing slightly with a more marked increase in October.

3.2. With a relatively high investment to recruit against through the remainder of the year across a range of new and expanded services, recruitment remains a challenge. However payroll ftes did increase by 42 in October and there was additional pay cost, with an expectation of further cost from November onwards.

3.3. There are signs of an increased risk in medical recruitment with a number of doctors leaving or taking maternity leave which may prove challenging to recruit to. Medical pay awards have been agreed and have now been paid; there remains some provision for the remaining pay settlements outstanding.



3.4. Agency spend was £576k for the month and £3.7m for the year to date, still just within the NHSI Ceiling but above the Internal Trust Plan year to date. Fig. 3b shows there has been an increase overall through the last 12 months, however it should be noted though that £266k to date relates to exceptional expenditure on the CAMHS 28 Day Recovery Plan, which will be separately funded by commissioners (income is estimated and included within this position).

3.5. Work is ongoing to recover the agency position with plans for a 10% reduction for every area on their Quarter 1 spend, which will result in a revised ceiling of £5.4m. Without the exceptional expenditure noted above this target is broadly being achieved, which is a significant improvement to the general agency spend. Continued focus and monitoring will continue to ensure this is maintained, progress to date is shown below.

Fig. 3c Performance against Trust Ceiling by SBU	Actual Full Year 2018/19	Full Year Trust Ceiling 2019/20	Year to Date Trust Ceiling (as at Month 7)	Year to Date Actual Spend (as at Month 7)	Year to Date Variance (+adv/-fav)	Forecast spend for the year 2019/20
	£000	£000	£000	£000	£000	£000
E&N SBU (excl. CAMHS 28 day)	3,146	2,837	1,655	1,447	-208	2,647
CAMHS 28 day	0	0	0	267	267	423
LD&F SBU	464	424	247	150	-97	280
Essex & IAPT SBU	272	213	124	104	-20	134
West SBU	2,520	2,100	1,225	1,375	150	2,247
Support Services incl. Medical Trainees	746	227	132	136	4	180
Capital & YE accounting	-346	0	0	0	0	0
Total	**6,802**	**5,801**	**3,384**	**3,480**	**96**	**5,911**
less: CAMHS 28 day target agency				-267		-423
Total (excl. CAMHS 28 day)				**3,213**		**5,488**

Performance against NHSI Ceiling	Actual Full Year 2018/19	Full Year NHSI Ceiling 2019/20	Year to Date NHSI ceiling	Year to Date Actual Spend (as at Month 7)	Year to Date Variance (+adv/-fav)	Forecast spend for the year 2019/20
Total	6,802	7,327	4,274	3,480	-794	5,911

3.6. Secondary commissioning reports at c. £2.9m in the month and at £19.7m for the year to date, above Plan by c. £269k in month and £1.1m for the year to date. This is an increase in expenditure for October; however September was particularly low with some backdated reductions in observation costs included. Of the increase in month, £90k related to the extra day in October compared to September, £110k to Acute and PICU External Beds, and £27k to Social Care Placements.

3.7. In general, savings have been made in some areas (notably CAMHS and also Main Adult Health Placements), but not all. In particular, year to date spend has increased for MHSOP Placements, and significantly for Acute and PICU External Placements, though MHSOP has decreased again in recent months. The short term costs of bed provision whilst the estates work is completed at Aston Ward was

provided for in 2018/19 and is not therefore included in this year's cost (c. £700k year to date).

3.8. Regular review takes place of all areas under Secondary Commissioning and current activity is as follows:

3.8.1. MHSOP Continuing Health Care Placements – all are being reviewed to ensure that they continue to meet criteria for fully-funded NHS Care and to transfer to Social Care funding (via Hertfordshire County Council) if not, and to ensure that appeals are dealt with promptly. A planned trajectory has been worked up for this and the target was achieved for the first month.

3.8.2. External PICU and Acute Placements – monitored by West SBU and as part of weekly Financial Health Check, there have been significant reductions in year. New PD team will also support in avoiding admissions. Fig. 3c shows average number of placements in month based on bed days utilised for last 12 months:

Fig. 3d average no of placements	PICU	Acute	Total
Nov 2018	**3**	**0**	**3**
Dec 2018	**1**	**0**	**1**
Jan 2019	**3**	**0**	**3**
Feb 2019	**4**	**1**	**5**
March 2019	**6**	**9**	**15**
April 2019	**6**	**10**	**16**
May 2019	**8**	**9**	**17**
June 2019	**10**	**8**	**18**
July 2019	**8**	**14**	**22**
Aug 2019	**5**	**8**	**13**
Sept 2019	**6**	**7**	**13**
Oct 2019	**7**	**9**	**16**
Current number	**6**	**12**	**18**

NB: the position from March includes 5 acute beds whilst the estates building work is done

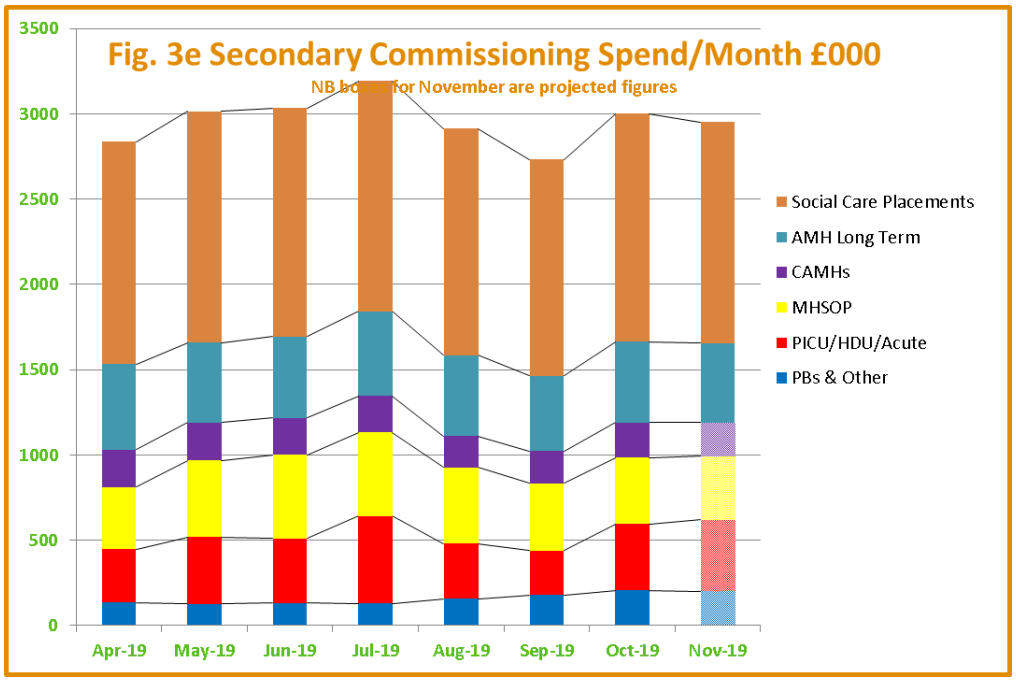
3.8.3. CAMHS Tier 4 – reviewed weekly by CAMHS clinicians and as part of weekly Financial Health Check. New DBT Team are supporting more individuals in the community, and 3 day admissions have been piloted reducing bed days overall. Activity increased slightly mid-year is now down to 6 with 0 General Acute.

3.8.4. Social Care (Placements and Personal Budgets) – plans being developed as part of Social Care Transformation project.

3.8.5. Main Adult Long-term – monitored via Financial Health Check and weekly meetings between Placement Service, Senior Service Line Leader and Finance. Progress has slowed as expected for this point of the year, and is further challenged by step-downs from secure services and difficulties in stepping up to Secure. A further reduction of 3 individuals is likely when the New Sovereign House opens mid-November (c. £200-300k full year, c. £50-100k in year 2019/20).

3.8.6. Discharge to Assess has started in East and North Herts which should also speed discharges and avoid unnecessary placements.

3.9. Fig. 3e below shows spend by category from April 2019 with draft figures for October 2019, which shows the reductions from July's peak but increasing again from October.



3.10. Overhead costs have averaged £2.95m per month during 2019/20 and are just over at £3.0m for October. Additional provision is being made for Interserve old year adhoc costs, and for a change in the provision of waste collection services and for additional IT costs.

3.11. The Trust has received 3 invoices to date totalling £100k from NHS Pensions, which relate to final pay control charges. A final pay control charge appears to apply where a NHS Pension Scheme Officer or Practice Staff member with 1995 Section membership (including 1995/2015 transition members) has a pensionable pay increase which exceeds an allowable amount resulting in disproportionate NHS pension benefits. The Trust has successfully disputed 1 of the invoices for £14k and is continuing to investigate the remaining 2. The likelihood of any further charges being received is also being explored.

4. Risks and Mitigating Actions

4.1. The full Statement of Comprehensive Income for Month is set out as an Appendix, giving the full detailed position and comparison to Plan. It should be noted that there are risks some of which may not be immediately evident:

4.1.1. The pay cost underspend will significantly reduce as new services are recruited to. This could also increase agency whilst the planned recruitment takes place. Operational, HR and Finance staff are working up the expected profiling in this area.

4.1.2. This is the second year of the new Agenda for Change pay award, some step points advance people quite rapidly and the overall impact is not yet fully determined.

4.1.3. Secondary commissioning continues to overspend and although some planned reductions have taken place (notably CAMHS) others remain at or above Plan levels.

4.1.4. There is a risk from the change in commissioning of Secure Services regionally under New Care Models, as any reduction in beds could result in pathways no longer being available or being more difficult to access.

4.1.5. Extension of Essex Learning Disability services commenced in November and remains within a period of integration and transition, at this point costs are to Plan but will be tracked closely.

5. Income and Major Contracts

5.1. Total income planned for the year is £252.2m, before PSF, including £235.9m from main commissioners, of which £182.5m is in respect of Hertfordshire. PSF is expected to be £1.9m for the year with an additional £443k in respect of 2018/19 received this year.

5.2. Income is reported adverse to Plan by £156k for the year to date, this relates largely to deferred income not yet released as planned due to delays in recruitment. In October this income has started to be released at c. £200k/month, it is expected that this will bring some favourable impact as pay costs are unlikely to increase by as much. There was also under-activity on the NHSE Specialist services contract earlier in the year, but this has now increased and additional Cost and Volume Income was received in respect of Astley Court for months 4 and 5.

5.3. A number of areas of additional income are expected but not yet all agreed, as follows:

5.3.1. Items to be added to the IHCCT contract such as CAMHS Trailblazers, CAMHS Eating Disorders, and Individual Placement Support

5.3.2. Key NHSE Bids such as Community and Crisis transformation bids

5.3.3. CAMHS 28 day Recovery Plan – agreement in principle subject to actual costs

Income is included within this position if it is expected and is being spent. In most cases this income has technically been agreed, commissioners need to find a formal mechanism to transfer the funds. A “Recruitment at Risk” process has been put in place to ensure that recruitment is not delayed but there is oversight of posts being agreed.

6. Delivering Value CRES Programme

6.1 The target of the Delivering Value Programme for 2019/20 was c. £6.5m, which is relatively high compared to previous years and at the top end of the likely level required to meet this year’s Control Total. It is however viewed as a prudent assessment.

6.2 The list of developed schemes plans in progress and opportunities for efficiency identifies potential savings totalling between £4.7m and £5.5m. These are listed in the appendix.

6.3 Non-recurring schemes have largely been identified in respect of the ‘gap’ between programme requirement and schemes.

6.4 As part of the planning for FY20-21 and to accelerate the building of the next DV program there is the first of a series of workshops to be held at in December.

7. Statement of Financial Position

7.1 The full Statement of Financial Position is set out as an appendix.

7.2 Receivables increased by £1.4m in month. This mainly related to some quarterly invoices being raised.

7.3 Payables and accruals were similar to Month 6. There was a fall of £0.7m in accruals and payables that was offset by a £0.7m increase in deferred income relating to LDA funding where the relevant expenditure has not started yet.

7.4 The Statement of Cash Flows is set out as an appendix and shows cash balances have decreased by £1.3m in the month. The main movements in month are:

- Cash outflow from operating activities (£600k)
- Cash outflow from investing (£900k)
- Cash inflow from financing £200k

8. Capital

8.1. The Capital Programme for the year is outlined in the appendices. The Programme comprises actual capital spend and revenue spend associated with the programme. The plan was updated for the September Finance and Investment Committee. There is currently a 5 year estates strategy being developed which will inform the 5 year capital financial plan.

8.2. Cumulative net capital spend year to date for 2019/20 is £5.2m, £900k in month.

8.3. There is a further £277k of revenue spend year to date, £34k in month. This primarily relates to the running costs for empty buildings and the dilapidation costs for Trust leased buildings.

8.4. Capital spend has been high in the first three months of the financial year. This is predominantly from high levels of IT equipment spending, Fire compliance works being completed and Albany Lodge structural works. There was a significant drop in spend in month 4 due to IT spend levels reducing whilst roll out is achieved and major construction projects coming to a conclusion before other projects start. Spending has increased again in months 6 and 7 due to Paris Connect works, Albany Lodge structural works and Aston Ward refurbishment, gathering momentum.

9. Forecast for the Full Year

9.1. The full year position is expected to be in line with the Control Total. The position is currently above Plan, which is very positive, with reduced agency costs and a reduction in bed costs from the quarter 2 peek.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item:** 11
Subject:	People and OD Q2 update	**For Publication:**
Authors:	Steve Graham, Interim Deputy Director of Workforce and OD	**Approved by:** Susan Young, Interim Director of People and OD
Presented by:	Susan Young, Interim Director of Workforce and OD	

Purpose of the report:

For Information and to brief the Board on the work and activity of the People and OD directorate during Q2 of 2019/20.

Action required:

The Board is asked to receive the report and discuss in depth, noting its implications for the Trust without needing to formally approve it.

Summary and recommendations:

This report provides the Board with an update on the workforce data and activity across the People and OD directorate during Q2.

The report is laid out in a way that describes the key activity in the teams within the Directorate and the impact of the work. The report also shows the key workforce data across the Trust for the quarter.

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

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

Relation to the Trust Risk Register: This work relates to Risks 215 Workforce the Trust is unable to recruit sufficient staff to deliver safe services due to national shortages of key staff and 657 The Trust is unable to retain sufficient staff in key roles to be able to deliver safe services

Relation to the BAF: (Strategic objectives, only leave those that apply)

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

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

as One

Our Values
Welcoming Kind Positive Respectful Professional

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

Equality & Diversity and Public, Service User and Carer Involvement Implications:

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

Seen by the following committee(s) on date:

Workforce and Organisational Development Report
Quarter Two: July – September 2019

1.0 Introduction

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

2.0 Executive Summary

A continued focus in Q2 has been on enhancing our people's experience across the Trust and introducing changes to the way we do things to provide a better experience.

Our approach to enhancing the staff experience is the development of an inclusive Just and Learning Culture which is informed by the experiences highlighted in the results of the NHS national and local Pulse surveys plus the annual WRES and Gender Pay Gap data.

The amendment we made to the Disciplinary Policy and Process in Q1 to include representatives from the BAME network to ensure objectivity in decision making appear to be having a significant positive impact on the number of allegations progressing to formal investigation and therefore having a positive impact on the experience of our people.

Our meetings with the TCM group (an external consultancy who design conflict resolution and mediation services) have led to the development of a proposal to support and develop all staff with the ability to hold confident and facilitated conversations. This is an important part of the development of the just culture and will provide manager's with tools to address issues at the local level, an area of concern that has been identified by the decision making groups in the disciplinary process.

This process will go through various discussions and iterations in Q2 to ensure it meets the needs and is properly co-produced.

A Recruitment, Retention and Reward Strategy is in development which addresses our significant challenges around recruitment and retention and lays out our commitment to our people, their development and working lives in HPFT. The strategy includes a number of retention initiatives which have already been implemented and have been evaluated well.

During Q2 interviews were held for the roles of High Performing Team Facilitators, these colleagues are expected to start during Q3 and pick up the role of working with teams. In the meantime HR Business Partners and Organisational Development Team members have initiated the self-assessment with a number of teams across the Trust.

Leadership Development activity this quarter has included running the Management Fundamentals Programme, Coaching as a Management Style workshop, the Mary Seacole Programme and Cohort 10 of the Leadership Academy.

The Q2 pulse survey was run through September 2019 and we received 538 responses which is 13% of Trust staff and is a 2% increase in responses from Q1.
Other key findings;
• 70% were female
• 41% were aged between 50-64 and 40% aged between 30-49
• 21% were identified as having a disability
• 28% described their ethnicity in terms other than 'White British'
• Respondents made almost 1700 comments throughout the survey
• SBU responses E&N 24%, LD&F 22%, Corporate 20%, West 19%, Essex & IAPT 15%

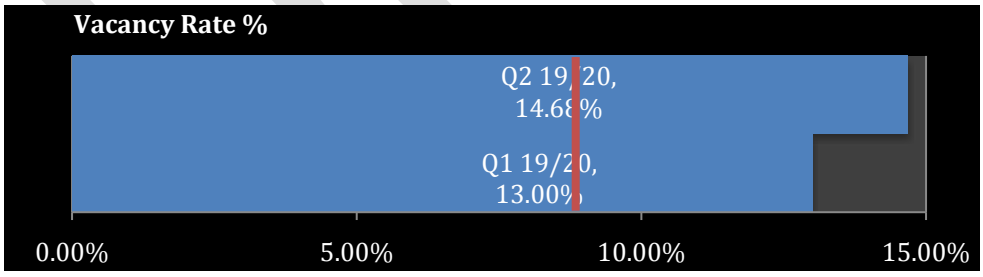
The Q2 responses were very similar to those received in Q1 with very little movement either way on the majority of indicators.

There was one change to the pulse survey this quarter. The survey now includes a follow up question with 9 options staff can select to identify the type of bullying and harassment they are experiencing. This additional data will enable us to better understand and investigate the occurrences of bullying and harassment experienced by staff.

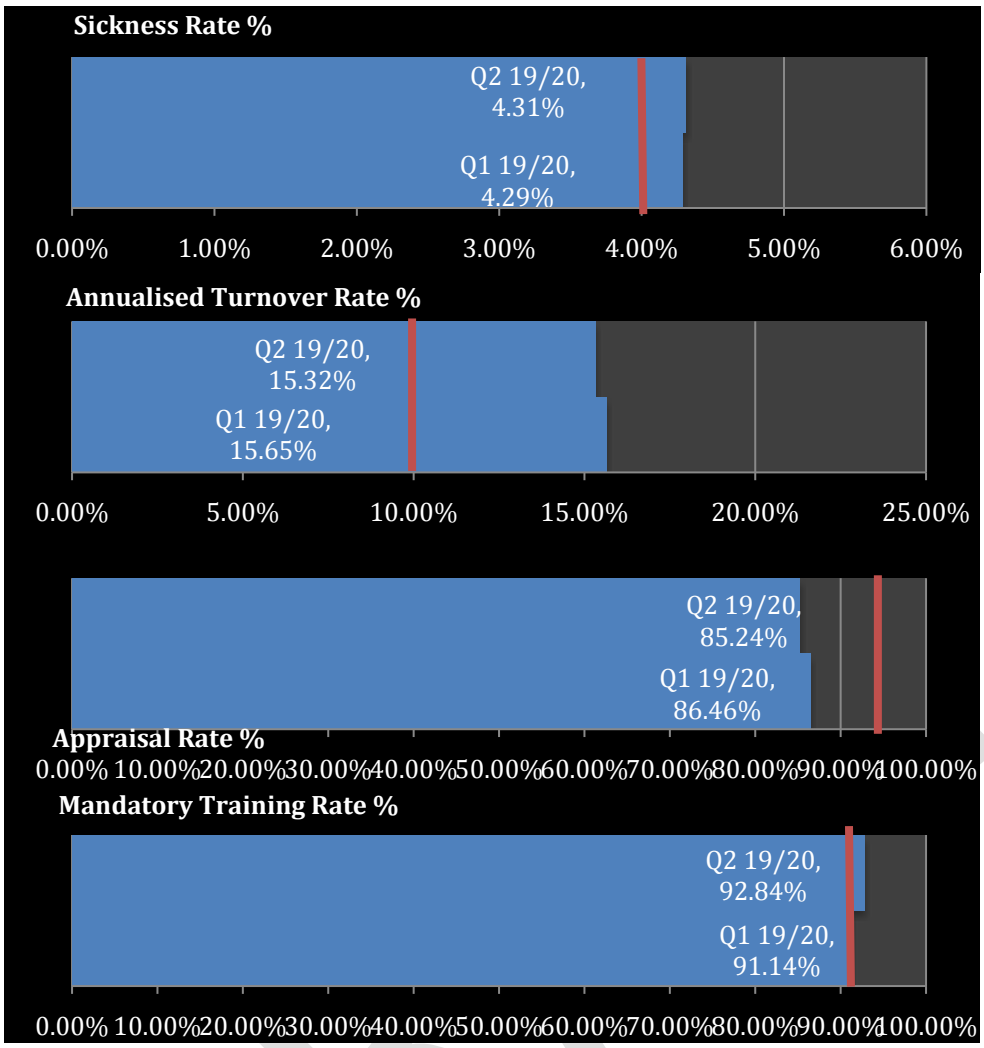
The following graphics show the summary position of the key workforce metrics in Q2.

The addition of the newly commissioned transformation posts to the establishment has had a significant negative impact on the vacancy rate.

At the end of Q1 the Trust had a funded establishment of 3409 FTE with 2966 FTE in post and 443 vacancies, at the end of Q2 the funded establishment had increased to 3483 FTE with 2972 staff in post and 511 vacancies.



For the remaining key metrics, whilst the sickness absence rate and appraisal rate have remained reasonably stable between quarters, there has been positive movement on both the mandatory rate (which is at target levels) and the turnover rate, which has dropped slightly.



A Health and Well Being strategy has been drafted and is going through the final stages of ratification, however significant work across the Trust regarding health and well-being continues with activities including mini health checks, mindfulness and resilience training, massages, physical health activities and Schwartz Rounds. These activities are all designed to assist with prevention and getting staff to focus on their own health, wellbeing and resilience.

3.0 Enhancing Staff Experience

A continued focus in Q2 has been on enhancing our people's experience across the Trust and introducing changes to the way we do things to provide a better experience.

Our approach to enhancing the staff experience is the development of an inclusive Just and Learning Culture which is informed by the experiences highlighted in the results of the NHS national and local Pulse surveys plus the annual WRES and Gender Pay Gap data.

The amendment we made to the Disciplinary Policy and Process in Q1 to include representatives from the BAME network to ensure objectivity in decision making appear to having a significant positive impact on the number of allegations progressing to formal investigation and therefore having a positive impact on the experience of our people.

Our meetings with the TCM group have led to the development of a proposal to support and develop all staff with the ability to hold confident and facilitated conversations. This is an important part of the development of the just culture and will provide manager's with tools to address issues at the local level, an area of concern that has been identified by the decision making groups in the disciplinary process.

This proposal will go through various discussions and iterations in Q2 to ensure it meets the needs and is properly co-produced.

4.0 Organisational Development Activity

The Organisational Development Team continued to progress delivery against the agreed Organisational Development and Learning activity plan.

4.1 Delivering Effective Leadership Capacity and Capability

- Continuation of Cohort 10 with participants presenting their leadership learning to a panel on September 17th.
- Continuation of Cohort 7 of the Mary Seacole Programme
- Senior Leadership Form
- 360 feedback facilitation coaching

4.2 Maintaining and Growing Staff Engagement

- Q2 pulse survey, results described in detail later in this report (4.2.1)
- Preparation for the launch of the National NHS survey on the 7th October took place during Q2.
- Inspire awards and Executive Breakfasts have also been held during Q2.

4.2.1 Staff Feedback

There have been no significant changes in the scoring of the majority of responses between Q1 and Q2 surveys. However, the additional questions posed in relation to Bullying and Harassment provided very useful insight into the experiences being reported as Bullying and Harassment.

In the last 3 months, 13% of staff who completed the survey (60 people) reported experiencing Bullying and Harassment which is a 3% negative increase on last quarter.

When asked the question who they had experienced bullying from those staff reported

- 11% (6 people) was from SU/Carers/public,
- 89% (54 people) was from HPFT staff broken down as follows
    - my manager 29% (17 people),
    - my team 29% (17 people),
    - other senior manager 23% (14 people) and
    - other colleague (6 people) %.

In West and LD&F SBU's staff were experiencing bullying and harassment from team members or managers equally (25% and 33% respectively), Essex & IAPT SBU it

was team members (43%), East & North SBU it was managers (61%) and Corporate it was team members or other senior managers equally (32%)
The type of bullying and harassment staff were experiencing was broken down as follows

- 16.13% reported receiving criticism not supported by evidence or given without the necessary constructive support
- 14.84% reported being shouted at/raised voice
- 14.19% reported being micro managed, overbearing supervision or other misuse of power and position
- 12.90% reporting being made to feel isolated or deliberately excluded
- 12.26% reported a lack of cooperation or deliberately holding back information
- 10.32 reported malicious rumours inappropriate jokes questions or comments
- 7.74% reported being made fun of humiliated or hurtful remarks
- 6.45% reported being singled out to receive an unmanageable workload or unachievable deadlines
- 5.16% reported being unfairly denied training or promotional opportunities

The type of bullying and harassment staff are experiencing in the SBU's is similar to the overall Trust with the exception of West where the highest response rate was for lack of cooperation or deliberately holding back information.

Work will now be undertaken to gain further information from this data by reviewing the responses by SBU to identify it there are any specific areas of concern.

4.3 Improving Staff Health and Wellbeing

The Organisational Development team has delivered several health and wellbeing initiatives detail including

- Mindfulness programmes
- Schwartz rounds
- Health Hub challenges
- Mini massage events
- An evaluation of the Mindfulness programme has been undertaken. This has shown that whilst there is quite a low uptake of this programme delegates who have been on it report a positive impact in assisting staff to lower stress levels, in some cases reporting a 50% reduction in stress..

  A review of how the programme is managed will take place to ensure there is opportunity for all employees across the Trust.

  Work is underway across the STP to replace the current Occupational Health provider and EAP service when the contract ends in March 2020.

5.0 Key Workforce Metrics

5.1 Establishment Data

The establishment data as at 30 September 2019 is as follows as Q2, this is shown in comparison to the data for the end of Q1:

	Q1	Q2
Funded Establishment =	3409.47	3483.78
Staff in post =	2966.35	2972.50
Vacant posts =	443.12	511.28
% Trust Vacancy rate =	13.00	14.68
Active Vacancies being recruited to =	254.69	292.47
% Total Turnover rate =	15.65	15.32
% Planned Turnover Rate =	4.62	3.84
% Unplanned Turnover Rate =	11.03	11.48
% Stability rate =	87.04	85.71

5.2 Key Recruitment Activity

There has been an addition of 74 wte newly commissioned transformation posts to the establishment which has had a significant negative impact on the vacancy numbers and vacancy rate.

At the end of Q2 the vacancy rate was 14.68% with 511.28 WTE vacancies. Of these 177 wte vacancies were registered nursing vacancies and 145 wte were additional clinical vacancies.

Within these vacancies 444 wte posts are being actively recruited to compared with 255 wte in Q1. Of these 196.31 WTE candidates were in post offer stage. Work continues with the aim of increasing the number of new starters each month. This includes increasing the number of recruitment campaigns to fill hard to recruit roles.

The following four focused and targeted recruitment events were held during Q2,

- In July, an Open Day event for SPA clinical advisors at Waverley Road (filled all their posts on the day)
- In July, an assessment centres for HCAs in West SBU for HCAs (9 posts filled)
- In August, an Open day for CAMHS in Forest House (no appointments)
- In September, an Open Day for West SBU Nursing and HCA candidates at the Colonnades (21 HCAs and 9 Nursing staff offered roles)

This model of utilising social media for a focussed locality and/or staff group will be continued through Q3 and Q4.

The time to hire increased through Q2 to just over 10 weeks, this is still lower then this time last year, but the increase is a cause for concern. The increase is predominantly due to an increase in time to issue the conditional offer letter and relates to candidates not providing all the correct documentation at interview. A review of the process and communication will take place to ensure the most efficient and effective processes are in place.

Despite the work with our IM&T colleagues to simplify the process for new starters to have network and IT equipment access on day 1 of joining HPFT there are still reports of long delays. The CQI work on this issue continued throughout Q2 to enable implementation and access to mandatory training for new starters prior to starting at HPFT.

In Q2 there were 159 new starters and 138 leavers which is a net gain of 21 staff compared with the next loss of 13 staff in Q1.The breakdown of new starters by staff group is shown in **appendix 1, section 3, Graph 5 – starters and leavers by staff group.**

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

5.3 Temporary Staffing

During Q2, 23,760 bank and agency shifts for registered nursing and HCA posts were requested across the Trust. 17,696 shifts were filled by bank workers and 3,794 were filled by agency workers. This is a total fill rate of 90.45%, which consists of a 74.48% bank fill rate and a 15.97% agency fill rate.

This is a slight increase in the number requested in Q1 with a slighlty higher proportion of agency shifts used. Work continues to recruit to the bank, with specific focus on Norfolk

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

5.4 Turnover Rate

The turnover rate has decreased slightly in Q2, which may be due to decrease in the planned turnover rate in this quarter. The planned turnover rate includes those staff who leave the Trust as a result of retirement, end of fixed term contracts or dismissals. Promsinigly we had more leavers than starters this quarter which reflects the increased and focussed recruitmnet activity during the quarter.

It is anticipated that the retention initiatives that have been launched are now embedded and will start taking effect during Q3 and Q4.

Future project work planned for implementation in Q3 are Alumni events for leavers thanking them for their contribution to our CQC rating and encouraging them to keep in touch with regards to future opportunities. Manager's guidance will be produced to support managers when carrying out an exit questionnaire which should increase the quality of information obtained through this process. It is proposed that a refer a friend scheme will extended to those who have been offered a new post at HPFT but not yet started with us.

5.5 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 Q2 we have worked with our exit survey provider to revise the survey and its method of delivery. This has resulted in a 55% response rate for exit interviews during Q2 which is a significant increase on previous response rates.

The data shows that a third of leavers are leaving to do a similar job and around 20% are leaving for a more senior job or for better career progression.

This insight will continue to infrom the work we are doing on career maps, career development and talent mapping.

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

5.6 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 Q2 was 85.71% which shows that experience and knowledge is being retained in the organisation.

5.7 Sickness Absence

The sickness absence rate is 4.08 % in Q2 which is the lowest rate since April 2019 but is still fractionally above the Trust target of 4%.

There has been a decrease in the sickness absence rates in Q2 in all the SBUs except East and North Herts, which has risen slightly.

The sickness absence percentages for each of the SBUs is as follows: Corporate Services 2.54 %, Essex and IAPT SBU 4.54 %, Learning Disabilities and Forensic Services SBU 5.04 %, East and North Herts SBU 4.14 % and West SBU 4.59 %.

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 and reminds employees of the ongoing monitoring of absence, to ensure that standards are consistently maintained. 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. Gastrointestinal problems

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

The estimated costs to the Trust of sickness absence for Q2 has been calculated as just over £1m which is same as Q1 and a decrease from Q4 of just over £3k. A breakdown of the sickness absence costs by SBU can be found **in appendix 1, section 4.**

5.8 PDP Rates

The Trust's overall PDP rate has decreased slightly by 1% to 85% in Q2. The PDP rates for each SBU are as follows:

SBU	Q2 (2018/19)	Q3	Q4	Q1 (2019/20)	Q2 (2019/20)
LD&F	88%	86%	90%	93%	89%
Essex & IAPTS				80%	82%
East and North	91%	91%	94%	89%	91%
West	95%	91%	91%	90%	87%
Corporate	83%	79%	72%	69%	65%
Trust	**90%**	**88%**	**90%**	**86%**	**85%**

All areas receive monthly management reports detailing completion rates. All managers should be able to access their teams PDP compliance rates on SPIKE which is updated on a regular basis.

Within the LD&F SBU, PDP compliance continues to be scrutinised at the monthly Core Management Meetings and Team reviews. Within East and North Herts SBU the issue of PDP completion has been raised with the Managing Director; also PDP training will be delivered with the aim of improving the quality of the PDP. The West SBU Managing Director has emphasised the importance of PDP completion and PDPs are reviewed at monthly unit reviews. Corporate services will have greater scrutiny and support regarding completion rates as the position is declining.

5.9 Statutory and Essential Training Rates

The Statutory and Essential training rates in Q2 have ended as follows:

Statutory Training = 93%
Essential Training = 92%

Both have hit the Trust target and the expectation is that they will remain there.

5.10 Discovery Update

During Q2 we launched the supervision recording function on Discovery this was supported by a Trust wide campaign advising managers and staff. We also designed the KPI to report compliance.

There has been a steady but slow uptake of recording, so the message on recording supervision will continue. We have also received feedback from those who have

used it which we will use to enhance the product and simplify the experience of recording supervision.

6.0 Learning, Education and Development

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

6.1.1 Apprenticeships

During Q2 we have continued to progress with applications for the Trainee Nurse Associate with the next cohort due to start in Q3.

We have also reviewed our apprenticeship offers with the intention of increasing the breadth of apprenticeships available. This work is expected to be completed during Q3.

The Talent for Care Agenda continues and the Education Manager is heavily involved in Career fairs and events which have taken place in schools and colleges around Hertfordshire. The common theme coming from these events are work experience days in Mental Health and Learning Disability areas. The Trust is looking at how we can support students who are under 18 years of age with work experience. In addition to the visits, there has been interest in working for the Trust and starting an Apprenticeship from pupils at some of the local schools which have been followed up on.

7.0 Conclusion

We have continued on focus on our people during Q2 with work designed to enhance staff experience across the Trust.

We have also revised our approach to recruitment, which appears to have had significant impact, to support the recruitment challenges we face.

Underpinning all of this work will be the continued wellbeing, staff engagement and culture developments already started in 2018/19 which will reflect on HPFT being a great place to work.

With our focus on people and the workplace in 2019/20 our organisational development work will continue to provide tools to ensure individuals and teams operate in an effective manner, but there will also be a very strong focus on supporting the creation of a culture of inclusivity and incivility making HPFT an outstanding place to work.

8.0 Recommendation

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

Steve Graham

Interim Deputy Director of Workforce and OD
November 2019

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item:** 12
Subject:	Board Assurance Framework	**For Publication: Yes**
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To provide assurance that the Trust's principal risks have been identified and are being appropriately managed.

Action required:

The Board is asked to review and approve the Board Assurance Framework (BAF) to ensure the evidence provides assurance that the principal risks have been identified and are being appropriately managed.

Summary and recommendations to the Committee:

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

This report provides an update on the latest iteration that has been reviewed and updated by each Lead Director since it was discussed at Board on the 5 September 2019 and IGC on 18 September 2019. This iteration includes updated controls and lines of assurance together with the most recent dates for the assurance evidence.

This version of the BAF was reviewed and approved at the Integrated Governance Committee meeting held on 20 November 2019. The Committee asked the Lead Directors to consider where best to identify the specific issues relating to the emerging ICS, this will be reviewed and included the next iteration of the BAF.

Appendix 1 details the changes to the BAF since it was reviewed at IGC on 18 September 2019 and Board on 5 September 2019. Appendix 2 is the full BAF, please note that the BAF has been amended to include up to date meeting and assurance dates.

Recommendation:

1. For Board to note the latest iteration of the BAF.
2. For Board to review and approve updated BAF.

Relationship with the Business Plan & Assurance Framework:

The BAF identifies the risks associated with the strategic objectives as set out in the Annual Plan.

Summary of Financial, IT, Staffing and Legal Implications:

None outlined in the summary report.

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 process for the NHSI/CQC Well Led Standard.

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

Reviewed and approved by IGC on 20 November 2019

Please note the BAF has been updated to include the most relevant dates for Board, Committees and other groups

Appendix 1

Principal Risks and Lead Director/s	BAF Risk No.	Risk Change in period
Strategic Objective 1: **We will provide safe services, so that people feel safe and are protected from avoidable harm**		
Failure in standards of safety – service users do not feel safe and are not protected from avoidable harm whilst under the care of the Trust, Effect: - Failure to reduce the number of suicides and prevent avoidable harm - Restrictive practice is not delivered in line with best practice. - There will be an increase in violence against service users and staff (Director of Quality and Safety)	1.1	**New 3rd Line of Assurance:** • Herts Health Scrutiny Report • Annual ONS data on suicides • Duty of Candour audit. • Adults and Children's Quality Assurance Visit **Updated/New Actions** Review of incidents including serious incidents and moderate harm reviews. **New 2nd Line of Assurance** • MossTogether Strategy • Use of Force Act and Restrictive Practice Committee • EPRR Table top exercise • Launch of Quality Strategy
Strategic Objective 3. **We will improve the health of our service users through the delivery of effective evidence based practice**		
If we do not improve the identification of physical health needs we will fail to improve the health of our service users resulting in increased incidents and poorer health outcomes (Director of Service Delivery and Customer Experience/Director of Quality and Safety)	3.1	**Additional Risk Control** Dedicated nurse consultant for physical health **Change to Senior Responsible Officer for Physical Health** to Director of Quality and Medical Leadership

Strategic Objective 4. **We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment**		
The trust will be unable to recruit the right numbers of people with the right skills due to insufficient supply of staff nationally and locally Effect: Inability to recruit to vacancies leading to high use of agency staff, with adverse financial impact and lack of continuity for service users. (Director of Workforce and Organisational Development)	4.1	**Description of Principal Risk** Change to wording of principal risk
Low staff morale and staff engagement will affect experience for staff Effect: High turnover and high vacancy rates (Director of Workforce and Organisational Development)	4.2	**Description of Principal Risk** Change to wording of principal risk
The trust is unable to provide adequate learning, development and training to enable staff to be skilled to the right levels, both clinically and in relation to leadership/managerial skills Effect: Poor quality services for users and low staff engagement (Director of Workforce and Organisational Development)	4.4	**Description of Principal Risk** Change to wording of principal risk
Strategic Objective 5. **We will improve, innovate and transform our services to provide the most effective, productive and high quality care**		
Staff will not have access to the right information to effectively perform their jobs.	5.1	**Assurance Date** TB approved digital strategy 7.11.19

Effect: - We will not be able to offer staff and service users access to innovative solutions to deliver and receive care. - We will not be able to adopt new ways of working to improve on services we deliver. (Director of Finance)		
The quality and recording of data does not improve. Effect: - We will not have accurate records of care provided and activity undertaken. (Director of Finance)	5.2	**Updated/New Actions:** Data Quality Maturity Index dashboard has been developed and added to BI reporting at team level. Starting to see improvement in October 2019 Updated effect of principal risk
Failure to maintain a sustainable financial position that supports investment and the continuity of services Effect - Risk that appropriate funds not be available to support delivery of high quality care. (Director of Finance)	5.3	Updated effect of principal risk

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)**		
The changing external landscape and wider system pressures and priorities lead to a shift of influence and resources away from mental health and learning disabilities (Director of Strategy and Integration)	7.1	**Description of Principal Risk** Change to wording of principal risk **Additional Risk Controls** ICP Board ICP Transition Group Developing relationships with PCNs Emerging system strategy for MH and LD New Care Models Collaborative **New 1st Line of Assurance:** • Partnership Advisory Board for

		STP MH and LD **New 2nd Line of Assurance:** • New Care Collaborative Directors group **New 3rd Line of Assurance:** • ICP Local Delivery Boards • ICP transition groups for East & North Herts and West Herts • STP CEO Board • New Care Models Collaborative CEO Group

Hertfordshire Partnership University
NHS Foundation Trust

Board Assurance Framework (BAF)

December 2019

Reviewed by:

- Integrated Governance Committee
- Audit Committee
- TB

as one

Our Values
Welcoming Kind Positive Respectful Professional

Introduction

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

Explanation of Assurance types and levels

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

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

Assurance Level - For each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls

High	Medium	Low
One or more of the listed assurance sources identify that effective controls are in place and the TB are satisfied that appropriate assurances are available Substantial assurance provided over the effectiveness of controls	One or more of the listed assurance sources identify that effective controls are in place but assurances are uncertain and/or possibly insufficient Some assurances in place, or substantial assurance in place, but controls are still maturing so effectiveness cannot be fully assessed at this time.	The listed assurance sources identify that effective controls may not be in place and/or appropriate assurances are not available to the Board Assurance indicates poor effectiveness of controls.

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
Good to Great Strategy (Great Care, Great Outcomes) [Positive Experience, Effective, Safe]										
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	**1.1 Failure in standards of safety** Service users do not feel safe and are not protected from avoidable harm whilst under the care of the Trust. **Effect:** - Failure to reduce the number of suicides and prevent avoidable harm - Restrictive practice is not delivered in line with best practice. - There will be an increase in violence against service users and staff	Hertfordshire Suicide Prevention Strategy	Executive Committee IGC TB CCG QRM	Datix reports S.I reports Service audits Deep dive into unexpected death in North Quadrant	Suicide Prevention Reports in Quarterly Integrated Safety Reports	CCG S.I reviews CQC reviews NHSI reviews including deep dive into safety. (Dec 2018) Member of Zero Suicide Alliance (supporting suicide prevention in NHS & partner agencies) CQC Inspection Report Annual Report 2018/19 – Quality Account Report HSC Scrutiny Report ONS data	High	IGC 22.05.19 IGC 17.07.19 IGC 18.9.19 IGC 23.01.19 May 2019 May 2019 Oct 2019	Hertfordshire Suicide Prevention Strategy, led by Public Health Hertfordshire is in place. This is currently under review for completion end Q3 2019/2020. Awaiting results of South London & Maudsley review into the unexpected deaths in South East Quadrant.	Director of Quality & Safety [IGC]
		Briefing of all Serious and potential serious Incidents Moderate Harm Panel	Executive Committee Board CCGs QRMs Safety committee reporting into QRMC	Moderate harm panel/ datix notes	Serious Incident Briefing Report. Weekly to exec and Board Exec and Board reports and minutes of meetings	CCG SI reviews Independent Authors from selected SI investigations CQC Whistleblowing	High	Weekly SI report to Exec and monthly report to TB Weekly moderate harm panel		
		Freedom to Speak Up Practice and Processes	Integrated Governance Committee Quality and Risk Management Committee CCG QRM	Service audits Service feedback from FSUG	Freedom to Speak up – 6 monthly review & Annual Report	CQC MHA Inspections Freedom to speak up Guardian Concerns raised with the Trust via the CQC (CQC Concerns) Duty of Candour Audit	High	F2SU 6 Monthly Review to IGC 18.11.19 F2SU Annual Report to IGC 22.05.19 & TB 06.06.19 CCG QRM September 2019	Review of SI and Moderate harm process.	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	**1.1 Failure in standards of safety** Service users do not feel safe and are not protected from avoidable harm whilst under the care of the Trust. **Effect:** - Failure to reduce the number of suicides and prevent avoidable harm - Restrictive practice is not delivered in line with best practice. - There will be an increase in violence against service users and staff	Making Our Services Safer Strategy	QRMC Executive Committee IGC TB CCG QRM	Peer review (SBU to SBU) of seclusion practice.	Quarterly & Annual Integrated Safety Reports MOSS Together strategy Use of Force Act and Restrictive Practice Committee		High	Q4 & Annual Integrated Safety Report to IGC 22.05.19 & TTB 06.06.19 Q1 to IGC 17.07.19 & TB 6.9.19		Director of Quality & Safety [IGC] & TB
						Independent reviews of Respect (Jan 2018) and Seclusion July 2018)		Respect & Inclusion Reviews reported to IGC in 2018.		
						Assurance visits from CQC & CQC, MHA team.				
						Ongoing involvement in Restrictive Practice Peer Review Collaborative.		Start Sep 19 & ongoing. Unannounced & announced		
				Internal Clinical Audits	Practice Audit Implementation Group Quarterly & Annual Reports			Annual Report to IGC 22.05.19 IGC 18.9.19		
					PACE Annual Clinical Audit Programme			To IGC 22.05.19		
						NHSI/CQC Safety Collaborative Involvement Expert – involvement in Task & Finish Group & targeted work.				
					Audit of Seclusion			July 2019		
					Minimum mental health data set			Monthly submissions		
		Mental Health Act & DoLs Act Guidance is updated and followed.	CCG QRM IGC TB QRMC Safeguarding Strategic Committee	Internal audits	HPFT Quality Visits & CCG Quality Visit reports.	Assurance visits from CQC and CQC MHA team – Provider Action Statements	Medium	TB quarterly Executive Team QRMC		
						Herts-wide assurance group				
1. We will provide safe	**1.1 Failure in standards of safety**				Deprivation of Liberty using MHA			Safeguarding Strategy		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
services, so that people feel safe and are protected from avoidable harm	Service users do not feel safe and are not protected from avoidable harm whilst under the care of the Trust. **Effect:** - Failure to reduce the number of suicides and prevent avoidable harm - Restrictive practice is not delivered in line with best practice. - There will be an increase in violence against service users and staff				& DoLS Quarterly Report			Group 20.05.19		Director of Quality & Safety [IGC] & TB
					Mental Health Legislation Quarterly Update from MH Legislation Quality and Policy Group (attended by CCGs)			QRMC 10.05.19 IGC 22.05.19		
					Mental Health Act Managers Annual Report 2017/18			QRMC 10.05.19	2018/19 report scheduled for Board 05.09.19.	
				MHA Quarterly Newsletter (themes & actions)				Quarterly		
		Safe Care Standards processes and policies	CCG QRM	Internal audits	Quality Assurance Visit Programme Quarterly & Annual Integrated Safety Reports	Integrated Health and Care Commissioning Team (IHCCT) Volvina annual audit programme (ligatures)	High	CCG QRM 18.06.19		
			Health Safety and Security Committee Audit Committee		Health, Safety and Security Report (Annual / Quarterly Report) Health & Safety Annual Report	Health & Safety Executive Inspection Report May 2019 & Action Plan Internal Audit Report – H&S Service User Contact		HSE Inspection Report to IGC 17.07.19 & TB 04.07.19 & 05.09.19 Feb 2019 TB 05.09.19	Health & Safety Audit with HCT underway.	
			Quality and Risk Management Committee		Quarterly Safety Reports Policy Compliance Report CQC Action Plan	CQC Insight Reports		01.08.19		
1. We will provide safe	**1.1 Failure in standards of safety**		Safeguarding Strategic Committee		Safeguarding Reports (Annual and quarterly)	Section 11 safeguarding assessment Annual CCG safeguarding assurance assessment Adults and Childrens Quality Assurance Visit		27.9.19 31.10.19		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
services, so that people feel safe and are protected from avoidable harm	Service users do not feel safe and are not protected from avoidable harm whilst under the care of the Trust. **Effect:** - Failure to reduce the number of suicides and prevent avoidable harm - Restrictive practice is not delivered in line with best practice. - There will be an increase in violence against service users and staff		IGC		Reporting Quarterly Integrated Safety Report	Internal Audit Reports - CQC Action Plan		Audit Committee April, July and Sept 2019 IGC 22.05.19 17.07.19 18.9.19		
			Infection Prevention & Control Committee	Quarterly reports to IPCC IPC audits	Annual Infection Prevention & Control Report			IPCC reports 29/04/19 & 19/07/19 IGC 22.05.19 TB 06.06.19		
		Mortality Governance processes	IGC TB		Mortality Governance Reporting Quarterly Integrated Safety Report	Externally reporting		IGC 22.05.19 17.07.19		
		Quality Report Processes	Executive Committee IGC TB External Audit Commissioner's Secretary of State	Service reports on Quality priorities	SBU, ICG and Board reports on Quality priorities and Quality Account	Quality Account 18/19 (Externally Audited) Published alongside annual report	High	IGC 22.05.19 TB 23.06.19 Audit Committee 23.05.19 TB 23.05.19 AGM 17.07.2019	2019/20 process underway	
		CQUIN Processes	TMG Executive Committee IGC TB CCG QRM	Trust Management Group update reports Service and SBU reports on CQUIN	CQUIN Reports – Part of quarterly Performance Report	CCG CQUIN reports as part of the Quality report	High	IGC 17.07.19		
1. **2. We will provide safe**		Major Incident Policy	Executive Committee IGC TB	Service Business Continuity plans Core standards compliance	Emergency preparedness, Resilience and Response Annual Report 2018 reported to TB Table top exercise	- Emergency Planning and Business Continuity EPRR Core Standards compliance – CCG & NHSE approval - Quarterly meetings and reports from Herts wide Local Resilience Partnership	High	Compliance Report to TB 27.09.18 Report to TB 7.11.19 11.10.19	Emergency Preparedness, Resilience and Response (EPRR) annual assurance process scheduled for submission at end of September 2019.	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
services, so that people feel safe and are protected from avoidable harm		Quality Strategy	QRMC IGC Board	Service and SBU objectives related to the Quality Objectives as defined in the Strategy	HSCC QRMC IGC Quality Improvement reports Quality Strategy launched	CCG performance reports related to Quality Objectives	High	IGC 22.05.19 TB 06.05.19 18.9.19		
	1.2 The fundamentals of care are not delivered consistently across all our services **Effect** - Resulting in poor quality of care for service users	Training Recruitment process Professional standards adhered to Clinical Outcomes	Executive Committee IGC TB QRM	Quarterly Safe Staffing Levels report CCG Contract reporting (quarterly) Supervision Appraisals			High	IGC 17.07.19, 18.9.19 QRM 1.8.19		Director of Quality and Medical Leadership [IGC]
		Organisational Development Strategy	Executive Committee WODG IGC TB	Supervision Appraisal	Workforce and OD Report Pulse Survey Report (Q) – Part of the Workforce & Organisational Development Report Good to Great Road Shows, Big Listen and Local Listen.	CQC inspection	High	Workforce Quarterly Report -TB 5.9.19		
					Annual Report on Workforce & OD			IGC 17.07.19		
					Annual Report on Revalidation and Appraisal of Doctors	Internal Audit – Doctor Revalidation		Audit – Dec 2018 Annual Report TB 05.09.19 IGC report 18.9.19		
		Quality Measures including Quality Strategy	IGC TB CCG QRM		Trust performance KPI report on Workforce Quality Strategy review & approval	POM UK Accreditation	High	IGC 22.05.19 TB 06.06.19		
						Quarterly CCG Quality Review Meeting/Reports		08.06.19		
					Quarterly Claims Reports Briefing & Annual Claim Report			IGC 22.05.19		
						POM UK Accreditation				
1. We will provide safe		External Systems for Staff Feedback	Executive Committee WODG IGC TB	FSUG report	PULSE quarterly report		High	Staff survey WODG 04.19 and 5.11.19 IGC 22.05.19TB		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
services, so that people feel safe and are protected from avoidable harm	**1.2 The fundamentals of care are not delivered consistently across all our services** **Effect:** **Resulting in poor quality of care for service users**							07.03.19 WODR to TB – Pulse & National Staff Survey 09.05.2019		
		Annual Programme of Clinical Audit (Practice Audit and Clinical Effectiveness) inc NICE Guidance Policy	Executive Committee QRMC IGC Audit Committee TB CCG QRM	Individual Clinical Audits Audit of Care Plans & records	Annual Audit Programme Practice Audit Clinical Effectiveness Progress Reports (PACE) PACE Annual Report	NICE Progress Reports	High	Annual Audit Programme to IGC 22.05.19 IGC 17.7.19 IGC 22.05.19		
		Medicines Management	QRMC Executive Committee IGC TB	Service level feedback Datix reports	DTC Annual Report 6 monthly committee update Pharmacy & Medicines Optimisation Annual Report	CCG Quality report Internal Audit Report – Medicines Mgt.	High	QRMC IGC 17.07.19 IGC 17.07.19 Audit Committee 13.09.18		
2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	**2.1 If our service users are unable to access the right services in a timely way (including adult community services, CAMHs, CHOICE & partnership, they will not feel positive about their experience resulting in poor service user feedback.**	Performance Monitoring Processes - Implementation of Accurate Clinical Information Strategy - SPIKE	Service Line Leads & Modern Matrons Executive Committee TMG TB SBU Core Management PRM Contract review meetings Internal & External Audit FIC	Spike Performance Reports Service Experience team reports Complaints seen in real-time Datix and local reporting of incidents SBU performance reporting and local PRM service line reporting structures	Trust Performance KPI report – Access Times. Re-admission rates. SBU Quarterly Performance Reviews Live Data Performance Dashboards Performance Audit Performance against Annual Plan Internal & External Audit SPIKE live data Spike data quality reports	Internal Audit Data accuracy and data quality report to Audit Committee Dec 18 Quality Account 18/19 (Externally Audited) Published alongside annual report	High	09.05.19 Q4 Performance To TB 05.09.19 Q1 Performance to TB FIC 09.07.19, 17.9.19 TB 09.05.19 TB 05.09.19 IGC 22.05.19 TB 23.06.19 Audit Committee 23.05.19 TB 23.05.19 AGM 17.07.2019		Director of Service Delivery and Customer Experience / Director of Finance [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	**2.1 If our service users are unable to access the right services in a timely way (including adult community services, CAMHs, CHOICE & partnership), they will not feel positive about their experience resulting in poor service user feedback.**	Quality Impact Assessments Procedure for CRES	Service Line Leads CRES PAB and Trust Executive Committee QRM – reports to Commissioners	Datix Complaints in real-time Experience reports Friends and Family results Having Your Say	Individual Quality Impact Assessments External Commissioner scrutiny Quality Impact Assessment reports to IGC		High	QRM IGC 22.05.19		
		Service User Feedback	QRMC Executive Committee IGC TB	Complaints in real-time Experience reports Friends and Family results Having Your Say		Community Mental Health Annual Survey Commissioner reviews by carers in Herts and View Point	High			
					Complaints & Service User Experience Annual Report 2018/19 Peer listening reports and feedback Friends and Family Test data Feeling Safe data		High	TB 06.06.19 IGC 18.09.19		
		Outcomes Framework for Carers Pathway Development	QRMC TMG	Reporting via Experience Team Feedback from the Council of Carers	Carer Pathway report	CQC inspection CCG reports	High	May 2019		
		Recruitment & Involvement of Expert by Experience Policy	QRMC IGC	Involvement and Experience Group 6 monthly report to QRMC	Service User Council/Carer Council – 6 monthly report		High	IGC Sept, Nov 2018		
3. We will improve the health of our service users through the delivery of effective evidence based practice	**3.1 If we do not improve the identification of physical health needs we will fail to improve the health of our service users resulting in increased incidents and poorer health outcomes.**	Physical Health Strategy CQUIN IAPT Adult Community FEP Dedicated consultant for physical health	TMG TB Physical Health Committee IGC QRM QRMC	Audit of care plans and records	CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads Annual Physical Health Strategy Report	CQC inspection CCG reports on CQUIN	High	Bi-monthly CQUIN reports to IGC 20.03.19 22.05.19 17.07.19 18.9.19 IGC 17.07.19		Director of Quality and Medical Leadership / Director of Quality and Safety [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
Good to Great Strategy – Great People [People have right skills and values, Leaders who involve and empower, a workplace where people grow, thrive and succeed.]										
4. We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment	**4.1 The trust will be unable to recruit the right numbers of people with the right skills due to insufficient supply of staff nationally and locally** **Effect: Inability to recruit to vacancies leading to high use of agency staff, with adverse financial impact and lack of continuity for service users.**	NHSI Retention Project Quarterly OD and Workforce report	TMG Executive Committee WODG TB Recruitment & Retention Group	Recruitment & Retention Task & Finish Group	Project Plan and Support Programme Monthly reporting to Workforce Board and Recruitment & Retention Deep dive in workforce challenges Deep dive into recruitment and retention Quarterly Workforce & OD Report	Ability to recruit internal audit	Medium	WODG 08.03.19 May 2019 TB 29.11.18 07.02.19 Recruitment and Retention: 19.2.19 19.03.19 21.05.19 24.6.19	A number of retention initiatives have been actioned – the impact of which will be evaluated and reported in due course. - Retire and Return Scheme - 100 Day Interviews/New Starters - Buddy Scheme - Internal Moves Process (under evaluation) - HR Surgeries. - Focus of Health and Wellbeing Programme	Director of Workforce and OD [IGC]
		Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee WODG Workforce Board IGC TB	Performance by team/service reported monthly from Discovery system	Quarterly WODG reports to IGC Monthly Inspire and annual awards Staff awards Long Service Recognition Awards		High	WODG to IGC: 20.03.19 22.05.19 17.9.19 Quarterly Reports to Board: 09.05.19 6.9.19 Exec Committee: 01.05.19		
		Recruitment and Retention Strategy	Executive Committee WODG IGC Audit Committee TB	Recruitment & Retention Task & Finish Group Reports and feedback Service level	WODG Quarterly Recruitment and Retention Report Recruitment & Retention Strategy & Policy Approval	Use of Resources Ability to Recruit Internal Audit Action plan	Medium	Audit Committee 04.12.18 22.05.19 July 2019 WODG	Recruitment and Retention Strategy plans roll out – Q3 2019. Review of Recruitment and retention schemes	
		Recruitment and Retention Strategy. Ongoing Development of Workforce plans including Retention Plan	Executive Committee WODG IGC TB	Recruitment & Retention Task & Finish Group Regular reporting to WODG Monthly 'flash' performance KPIs	WODG Quarterly Workforce and Organisational Development Report (to services Monthly)	Use of Resources Ability to Recruit Internal Audit Action plan	Medium	WODG 8/3/19 WODG to IGC: 20.03.19 22.05.19 18.9.19 Quarterly Reports to Board: 09.05.19 7.9.19	A number of retention initiatives have been actioned – the impact of which will be evaluated and reported in due course. - Retire and Return Scheme - 100 Day Interviews/New Starters - Buddy Scheme - Internal Moves Process (under evaluation) - HR Surgeries. - Focus of Health and Wellbeing Programme	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
								Exec Committee: 01.05.19 12.06.19		
		Agency Reduction Action Plan	SBU Core management TMG Executive Committee FIC TB	Weekly monitoring of key financial indicators Local monitoring on 'post by post' basis	FIC Finance Reports Bi-monthly Finance Board Reports Quarterly Performance Board Reports		High	FIC : 19.03.19 21.05.19 09.07.19 17.9.19 Finance – Board Reports: 07.02.19 07.03.19 09.05.19 06.06.19 6.9.19 7.11.19 Performance – Board: 07.02.19 09.05.19 6.9.19 7.11.19		
		Recruitment and Retention Strategy.	Recruitment & Retention Task & Finish Group Regular reporting to WODG	Supervision Appraisal discussions	WODG Quarterly Workforce and Organisational Development Report Recruitment and Retention Group Reports	National Staff Survey 2018 Report on Key Findings	High	WODG 11/1/19 8/3/19 IGC 23.01.19 TB 07.02.19		
4. We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment	**4.2 Low staff morale and staff engagement will affect experience for staff** **Effect: High turnover and high vacancy rates**	Multi Professional Quality Improvement Performance Framework (QIPF)	IGC	Supervision Appraisal	QIPF Quality Performance and Review Update Paper (Action Plan)		High	WODG: May 2019. IGC 18.9.19		Director of Workforce and OD [IGC]
		Workforce Health and Wellbeing Strategy Action Plan	Executive Committee WODG IGC TB	Service and SBU objectives related to Strategy	Workforce and Organisational Development Report	CQC inspection	High	WODG May 2019	Health and Wellbeing Strategy under review with deadline for completion end Q2 2019/20.	
		Health and Wellbeing CQUIN Action Plan	Executive Committee WODG IGC		Quarterly Report	CCG Quality report	High	17.07.19		
		Systems for Staff Feedback As defined in the Engagement & OD Strategies	TMG Executive Committee	Team meetings Senior Leaders Forum	Quarterly Pulse Survey Report– Part of the Workforce &		High	WODG May 2019 July 2019		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
			WOD IGC TB	Staff Network Groups	Organisational Development Report Good to Great Road Shows, Big Listen and Local Listen. Use of Resources / Ability to Recruit			IGC 22.05.19 18.9.19 TB 06.06.19 6.9.19 Big Listen April & October 2019 Good to Great Roadshows – 19/20 Pulse quarterly survey Sept TB Nov 2019		
		External Systems for Staff Feedback	TMG Executive Committee WODG IGC TB	OD activity plan for year 2, bullying and harassment	Equality review meetings with commissioners (annually)	National Staff Survey 2018 Report on Key Findings and action plan in place	High	TB 07.02.19 07.03.19 WODG 08.03.19 Exec 06.03.19		
		Harassment and Bullying Plan (also part of the HPFT work plan for WRES)	JCNC Executive Committee WODG IGC TB	Service objectives Supervision Appraisal	Workforce and OD Report PULSE Survey Monitoring	CQC inspection	High	TB 17.02.19 05.09.19 6.9.19	Reviewing and updating Bullying and Harassment plans to be reported via quarterly Workforce and OD reports to TB	
		Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee WODG Workforce Board IGC TB	Performance by team/service reported monthly from Discovery system	Quarterly WODG reports to IGC Monthly Inspire and annual awards Staff awards Long Service Recognition Awards		High	WODG to IGC: 20.03.19 22.05.19 18.9.19 Quarterly Reports to Board: 09.05.19 6.9.19 Exec Committee: 01.05.19		
		Staff Feedback systems		Team meetings Local Listens Good to Great Roadshows (October 2019) Big Listen (April & October 2019)	Pulse Survey Report– Part of the Workforce & Organisational Development Report		High	WODG 08.03.19 WODG to IGC: 20.03.19 22.05.19 18.9.19		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
				Senior Leaders Forum				Quarterly Reports to Board: 09.05.19 6.9.19 Exec Committee: 01.05.19 12.06.19 WODG 08.03.19		
		Implementation of Discovery Learning Management System (easier access to e-learning and training compliance)	WODG IGC FIC	Training Compliance to WODG Twice Yearly Training Compliance to IGC			High	Training Compliance to WODG – July 2019 FIC 17.9.19	Twice Yearly Training Compliance Report to IGC due Q2.	
4. We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment	**4.3 Clinical leadership not engaged with service users** **Effect:** - **Inconsistent delivery of care and clinical risk to service users.**	Clinical Leadership Structures in place	MSC IGC TB	Service and SBU level meetings	Quality Impact Assessments		High	IGC		Director of Quality and Medical Leadership [IGC]
		External core and well led review of Trust Governance arrangements every three years	Executive Committee IGC TB	Clinical audit	Independent Well Led Review Update	CQC inspection Report May 2019	High	May 2019		
		Clinical leadership within teams – clinical & management leadership aligned in teams including nurse leadership & modern matrons.	Trust Management Group Senior Leadership Team Senior Leadership Forum	SPIKE Audits Supervision Appraisal	Guardian of safe working report (Q) QRMC PACE report IGC Quality report Audits	Focus Group feedback to CQC	High	Guardian of Safe Working Quarterly to ICG - 22.05.19 18.9.19		
		Systems for Staff Feedback As defined in the Engagement strategy & the OD Strategy.	TMG Executive Committee WODG IGC TB	Service level meetings	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Staff survey 2018 Report on key findings	High	TB 07.03.19 (National Staff Survey) WODG to TB – Pulse & National Staff Survey 09.05.2019		
		External Systems for Staff Feedback	TMG Executive Committee WODG IGC TB			National Staff Survey 2018 Report on Key Findings	High	TB 07.03.19		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
		Quality Strategy	TB IGC Executive Committee		Approval of Quality Strategy		High	IGC 22.05.19 TB 06.05.19		
4. We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment	**4.4 The trust is unable to provide adequate learning, development and training to enable staff to be skilled to the right levels, both clinically and in relation to leadership/managerial skills** **Effect: Poor quality services for users and low staff engagement**	Mandatory Training Programme Statutory & Essential Training Policy	IGC (6 monthly) TMG SBU Core management SLL's	Performance by team/service reported monthly from Discovery system	Quarterly Workforce and Organisational Development KPI Report (to services monthly) Bi-annual statutory & mandatory training report Quarterly report to WODG & TB Statutory & Essential Training Policy Ratification		High	WODG to IGC: 22.05.19 18.9.19 Quarterly Reports to Board: 07.01.19 09.05.19 6.9.19 Exec Committee: 01.05.19 JCNC 27.06.19		Director of Workforce and OD [IGC]
		Implementation of Discovery Learning Management System (easier access to e-learning and training compliance)	WODG IGC FIC	Training Compliance to WODG Twice Yearly Training Compliance to IGC			High	Training Compliance to WODG – July 2019 IGC 18.9.19 FIC 17.9.19	Twice Yearly Training Compliance Report to IGC due Q2.	
		Organisational Development Plan Continuous Quality Improvement Implementation	Executive Committee WODG IGC TB	Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum Team Leaders Development Programme OD Deep Dive to ICG Exec. Committee Update	Workforce and Organisational Development Report Organisational Development stock take report IGC Update	Mandatory Training Internal Audit	High	WODG to IGC: 20.03.19 22.05.19 18.9.19 Quarterly Reports to Board: 09.05.19 6.9.19 Exec Committee: 01.05.19 WODG 08.03.19 IGC 22.05.19 29.05.19	Q2 2019/20 launch of high performing team framework within a number of teams across the Trust.	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
								CQI to Exec Committee 06.02.19 29.05.19 CQI to IGC 17.07.19 Internal Audit – Audit Committee Dec 2018		
		Agency Reduction Action Plan	SBU Core management TMG Executive Committee FIC TB	Weekly monitoring of key financial indicators Local monitoring on 'post by post' basis	FIC Finance Reports Bi-monthly Finance Board Reports Quarterly Performance Board Reports		High	FIC : 19.03.19 21.05.19 09.07.19 17.9.19 Finance – Board Reports: 07.02.19 07.03.19 09.05.19 06.06.19 6.9.19 7.11.19 Performance – Board: 07.02.19 09.05.19		
Good to Great Strategy (Great Organisation) (Always getting fundamentals right, Always learning, innovating and improving)										
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care	**5.1 Staff will not have access to the right information to effectively perform their jobs.** **Effect:** **We will not be able to offer staff and service users access to innovative solutions to deliver and receive care.** **We will not be able to adopt new ways of working to improve on services we deliver.**	Implementation of a real time business intelligence reporting system (spike) Ongoing further development of PARIS functionality Opportunities for staff to develop ideas and implement through and innovation fund. Development and Implementation of Digital Strategy	Executive Committee IGC TB			National Staff Survey 2018 Report on Key Findings	High	TB 07.03.19		Director of Finance [IGC]
			Executive Committee IGC TB	Service level reports	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Benchmarking with like organisations	High	TB 07.01.19 09.05.19		
			IM&T Programme Board Board Executive Committee IGC		PARIS/BI Development Group – progress reports IM&T Strategy External review		High	IM&T Programme Board updates to IGC: 22.05.19 17.7.19 18.9.19		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care								TB approved digital strategy 7.11.19		
	5.2 The quality and recording of data does not improve **Effect:** - **We will not have accurate records of care provided and activity undertaken.**	Monitor, validate and audit data quality against standards	TMG IM&T Strategy Board	Progress reports against project plan		Internal Audit Data accuracy and data quality report to Audit Committee Dec 18	High	December 2018		Director of Finance [IGC]
			IM&T Programme Board MSC Executive Committee	Accurate Information Group		Quality Account 18/19 (Externally Audited) Published alongside annual report	Medium	IGC 22.05.19 TB 23.06.19 Audit Committee 23.05.19 TB 23.05.19 AGM 17.07.2019 Executive Committee March 2019	Data Quality Maturity Index dashboard has been developed and added to BI reporting at team level. Seen an improvement in October 2019.	
		Performance Monitoring Processes	Executive Committee IGC FIC TB	Monthly 'flash' performance KPIs	Quality Dashboard Performance Review Process Operational Services Report Quarterly Performance Report Trust Performance KPI report	CCG Quality reports CQC inspection	High	Executive Committee March 2019 Performance to FIC: 19.03.19 21.05.19 09.07.19 17.9.19 Performance – Board: 07.02.19 09.05.19 5.9.19 7.11.19		
	5.3 Failure to maintain a sustainable financial position that supports investment and the continuity of services **Effect** - **Risk that appropriate funds not be available to support delivery of high quality care.** **5.3 Failure to maintain a**	Annual Operational & Financial Plan Strategic Investment Programme NHSI Control Total NHSI Agency Cap	Executive Committee TB FIC Trust Management Group Modernising our Estate Board Executive Committee FIC Audit Committee	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators Departmental Budget Reports (monthly)	Financial summary report monitoring performance against plan including the NHSI Use of Resources Risk Rating and the Agency Cap Progress report on Delivery of Strategic Investment	CQC reports Internal Audit Reports – CRES Planning & Delivery Internal Audit Report – Key Financial Controls Internal Audit Service Line	High	MoE 25.01.19 FIC : 19.03.19 21.05.19 09.07.19 17.9.19 Finance – Board Reports: 07.02.19		Director of Finance [FIC /Audit]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care	**sustainable financial position that supports investment and the continuity of services** **Effect** - **Risk that appropriate funds not be available to support delivery of high quality care.**			Bi-monthly FIC reports. Board Finance Reports	Programme	Reporting – Patient Level Costing Preparation		07.03.19 09.05.19 06.06.19 Audit Committee – Internal Audit – CRES Planning – Sep 2018, CRES delivery Dec 2018 Key Financial Controls & Service Line Reporting April 2019.		
		External Audit Internal Audit	TB Audit Committee			Annual Governance Statement Annual Financial Statements & Audit Report Head of Internal Audit Opinion	High	Trust audit committee 23.05.19 TB 23.05.19 Annual Report at AGM 17.07.19		
		Cash Releasing Efficiency Programme CRES Programme Assurance Board	Executive Committee FIC TB Trust Management Group	Delivering Value Group Monthly updates to TMG	Part of Financial Summary Report Updates to CRES Assurance Board		High	TMG Monthly FIC : 19.03.19 21.05.19 09.07.19 17.9.19 Finance – Board Reports: 07.02.19 07.03.19 09.05.19 06.06.19 5.9.19 7.11.19	£2m short in identified schemes for CRES programme at July 2019. Plans monitored by the Executive Team and FIC	
		Hertfordshire and West Essex Sustainability and Transformation Plan (STP) Trust Contracts with Commissioners	TB FIC Partnership Development Group		STP Update reports Appended to CEO Brief Contract Update Reports	STP Design Brief STP Estates Strategy 5 Year contract signed with commissioners	High	TB STP Updates 07.03.19 06.06.19 5.9.19 7.11.19 09.05.19 FIC 17.05.19 FIC 19.03.19 March 2019		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care	**5.4 Innovative productive ways of working are not embedded** **5.4 Innovative productive ways of working are not embedded**	Continuous Quality Improvement	Executive Committee WODG IGC FIC TB	Improvement & Innovation Fund Updates Transformation Update	CQI Update Reports		High	CQI to Exec Committee 06.02.19 29.05.19 CQI to IGC 17.07.19 Innovation fund to FIC 22.01.19 Transform-ation update to Exec 08.05.19 October 2019		Director Quality and Safety
	5.5 Technology to support new ways of working is not used effectively	Productivity Monitoring Processes	Executive Committee FIC IGC IM&T Programme Board TB	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators ICT Service Improvement Update	Financial summary report Annual Accounts Finance Reports CRES Programme Assurance Board Trust Performance KPI report		High	IGC Jan 2019 TB 07.03.19	Productivity Dashboard being developed – implementation for end Q3 2019.	Director of Finance
Good to Great Strategy (Great Networks and Partnerships) [Leading networks to deliver great joined-up care, Building great relationships and partnerships to meet whole persons needs]										
6.We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	**6.1 If we do not work in partnership with other organisations to deliver joined up care.** **Effect:** - **We will not develop or deliver new models of care for our service users** - **Service users will not receive joined up care to meet their needs as an individual** - **We will not mainstream physical health practices across the trust.**	Carers Pathway	QRMC	Carers Council Service Experience Team reporting	Carer Pathway update		High	QRMC		Director of Strategy and Integration [FIC or IGC]
		Integrated Care projects and plans (e.g. primary mental health, LTC, older peoples, frailty)	Executive Committee FIC TB	Complaints seen in real-time Performance data via SPIKE GP feedback Contract hotline via CCG Integrated care Systems Board Workshop	STP Participation Project reports	STP Updates to Trust Board in CEOs Briefing	High	07.03.19 06.06.19 5.9.19 7.11.19 04.07.19		
		Performance Monitoring Processes	FIC Exec TB	Monthly 'flash' performance KPIs	Performance Report		High	FIC: 19.03.19 21.05.19		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
					Monitoring of Annual Plan – Reports to TB			09.07.19 17.9.19 TB: Performance Report: 07.02.19 09.05.19 5.9.19 7.11.19 Annual Plan Reports to TB: 07.02.19 07.03.19 09.05.19 7.11.19		
		Staff training and education programme to include physical health Organisational Development Report	Executive Committee WODG IGC TB	Service audits on training Care plan audit	Pulse Survey Report – Part of the Workforce & Staff Feedback Mandatory training reports		High	TB 07.01.19 09.05.19 WODG to IGC: 22.05.19 19.9.19 Quarterly Reports to Board: 07.01.19 09.05.19 Exec Committee: 01.05.19		
			IGC QRMC TB		Having Your Say Service User Feedback Objectives		High	Report to IGC 18.9.19		
6.We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	**6.1 If we do not work in partnership with other organisations to deliver joined up care.** **Effect:** - **We will not develop or deliver new models of care for our service users** - **Service users will not receive joined up care**	Physical Health Strategy – measures against outcomes	Physical Health Care Committee Exec Committee	Service and SBU objectives	Non – CQUIN Physical Health Target	Internal Audit	Medium		Director of Quality and Medical Leadership	
		Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	CCG QRM Exec TB			Bi-monthly Joint Delivery Boards (Hertfordshire) Feedback from Clinical Commissioning Group Minutes (Reviews)	High			

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				1st line	2nd line	3rd line				
	to meet their needs as an individual - **We will not mainstream physical health practices across the trust.**	Stakeholder Map and plans	Exec Committee	Intelligence sharing via EC		Feedback from Commissioners	Medium		Stakeholder plans to be updated given changing external landscape	
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	**7.1 The changing external landscape and wider system pressures and priorities lead to a shift of influence and resources away from mental health and learning disabilities**	Visibility and leadership by HPFT across the STP STP Leadership of MH and LD streams ICP Board ICP Transition Group Locality Board membership across Herts	Executive Committee FIC Trust Strategy Group TB	Clinical staff involved in system meetings Executive Committee Minutes	Updates to TB Update to Strategy Group	Local Delivery Partnership Boards ICP local delivery group ICP Transition Groups for East & North Herts and West Herts	Medium	Weekly to Executive Committee TB 7.11.19 October		Director of Strategy and Integration
		Relationships with all Key Stakeholders to drive and deliver key priorities	Executive Committee Strategy Group	Update to Strategy Group	Weekly reports Stakeholder map and plan		Medium	Weekly to Executive Committee	Stakeholder plans to be updated given changing external landscape end Q3	
		Annual Plan Emerging system strategy for MH and LD New Care Model Collaborative (leadership role for CAMHS)	Executive Committee TB Executive Committee FIC Trust Strategy Group TB	 Partnership Advisory Board for STP MH and LD	Annual plan Quarterly reports CCG Commissioning Intentions. New Care Model Collaborative Directors Group	 STP CEO Board New Care Model Collaborative CEO Group	High	Annual Plan Reports to TB: 07.02.19 07.03.19 09.05.19 7.11.19 2.12.19 Exec: 30.10.19 TB 7.11.19		

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item:** 13
Subject:	Trust Risk Register November 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:

To brief the Board on the current and emerging risks in the Trust Risk Register (TRR).

Action required:

Approve: To formally agree the Trust Risk Register and approve the recommended changes.

Summary and recommendations:

This report provides the current Trust's Risk Register. There are currently 12 risks on the Trust Risk Register. The full register was presented and discussed at IGC, the Board is presented with the top 10. The allocation of risks to Executive Leads have been reviewed and updated to reflect current portfolios. There are no changes to the existing risk ratings.

IGC considered one risk for escalation to the Trust Risk Register

- The West SBU have put the following risk forward for escalation to the Trust Risk Register: Risk 966: Ligatures, Non-anchor ligatures and self-harm in inpatient settings. The full risk is listed in appendix 5.

The committee considered this risk, along with the information in the patient safety report and ratified the risk remaining on the West SBU risk register. The committee requested that the Q3 integrated safety reports considers this risk specifically. The rationale for the risk remaining on the local register is that the risk is isolated to a small number of service users and, after two quarters where an increase was seen, Q2 has not seen a further increase.

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

Relation to the BAF: (the following Strategic Objectives link to individual risks on the Trust Risk Register)

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
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)

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

There are no budgetary or financial implications in the Trust Risk Register 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:

Health and Social Care Act 2008 (Regulated Activities) Regulations

Regulation 12: Safe care and treatment

- Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible. They should review methods and measures and amended them to address changing practice.

Regulation 17: Good Governance

- Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.
- Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.
- Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.
- Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.
- Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

Care Quality Commission Key Line of Enquiry; Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions

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

Exec Meeting 16.10.2019
IGC 20.11.2019

Hertfordshire Partnership University NHS Foundation Trust

Trust Risk Register November 2019

1. Introduction / Background

1.1. The purpose of this report is to present the Trust Risk Register (TRR) to the Trust Board of Director for discussion. Consideration should be given to the proposed changes and mitigations that have been put in place. 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. The Integrated Governance Committee considered all 12 risks and the top 10 are presented here.

1.2. 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. Each Director has reviewed the risks that they are Senior Responsible Officer for. In addition, the Executive Team met to peer review the TRR as a whole, along with the scoring.

2. Risks Updates

2.1 **EU Exit: Implications for the Trust of different scenarios arising from Brexit. (Risk 1000)**

- All c.230 have been written to again regarding applying for settled status however the response has been limited.
- The Trust was represented at the Regional EU Exit workshop held on the 16th September 2019.
- Recent Emergency Planning table top exercise held 11th October 2019. Testing Gold, Silver and Bronze command.
- NHS England EU Exit preparedness – Daily Sit reps (as of 31.10.2019 these have been stood down)
- The nature and timing of the EU exit remains uncertain.

2.2 **Changing External Landscape: The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT (Risk 749)**

- Long Term Plan MH has strengthened national focus and provides a roadmap for further investment and priorities.
- STP LTP submission includes MH&LD; with dedicated section and also a section on the future governance of MH&LD within the system
- STP will move to 'shadow' ICS from April 2021 and HPFT supporting and shaping development; Directors involved in key STP decision making forums and groups
- E&N ICP and West Herts ICP developing at pace; with HPFT well represented and supporting/shaping development; ensuring voice for MH&LD & HPFT
- MH & LD ICP 'Case for Change' agreed in principle by STP CEO group; next steps agreed to further explore clinical model and alliance approach.
- Regional events held to develop approach for MH&LD across the region; now gaining pace as other systems commence discussions and positioning of MH&LD
- NHSE transformation funding secured – community (Adult & older people) and crisis

- EOE Provider Collaborative successfully moved through the NHSE first gateway; clinical models and business case under development. HPFT a 'founding partner' leading development of the approach with CPFT and EPUT.
- STP wide MH & LD group in place, overseeing MH investment and developments across the STP – chaired by Dir. Strategy

2.3 **CAMHS: Unable to provide consistent timely access to CAMHS Community Services (Risk 1150)**

- The backlog of over 500 has been reduced down to 6 and CAMHS are now booking into 28 day choice appointments.
- Risk of sustaining performance remains and impact on partnership waits.
- Additional funding has been given for 6 CAMHS practitioners spread across the quadrants to support choice and partnership up to March 2020.
- Further funding to develop an assessment and brief intervention team in SPA until March 2020 to support triage of Tier 3 and 4 cases who might need limited interventions rather than being added to the waiting lists.

2.4 **Workforce: The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff (Risk 215)**

- The risk has remained the same in terms of its current rating although consideration in the next iteration needs to be given to whether the likelihood of staff shortages and its impact on our ability to provide safe services is 'almost certain' which is how the likelihood of this risk is currently scored.
- In the next iteration consideration also needs to be given to the risk title if indeed the risk about the risk of delivering safe services or the inability to recruit to establishment.
- Q2 average / cumulative vacancy rate was 14.14% which equates to 488.62 staff. The Trust had 161 starters against 138 leavers (headcount).
- The Target Vacancy rate for the trust for Q2 was 12.7%. The trust is currently above the target vacancy rate by 1.98%.
- The Time to Hire (T2H) was 53.4 days in September up 7.7 working days from August. Time taken to issue conditional offers increased substantially in September, up 5.8 days from August. These metrics are crucial for HPFT to be the first organisation to make an offer to staff who might have alternative employment opportunities
- There has been a change in approach to recruitment campaigns with them focusing on specific areas / roles. A recruitment campaign for West SBU resulted in an open day that attracted over 50 attendees. 30 offers were made on the day with 9 of these being too hard to fill qualified roles. There was also a successful campaign in Norfolk where 9 staff were made offers.
- Increased recruitment activity over October and November is projected to increase the number of candidates in the pipeline over the coming months in effort to keep pace with turnover and the anticipated growth of establishment due to new services.

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

- The risk has remained the same in terms of its current rating although consideration in the next iteration needs to be given to whether the risk likelihood of being unable to retain staff and the impact to deliver safe services is 'almost certain' which is how the likelihood of this risk is currently scored.
- The turnover rate in September was 15.32% and so remained similar to the previous month.
- The Target Turnover rate for the trust for Q2 14.7%. The trust is currently above the target turnover rate by 1.02%.
- Staff recognise the value of the retention initiatives which have been introduced however there has been a limited impact.
- Increase of exit interview return rates to 50%, these are now being managed by Realworld Consulting Ltd.

2.6 **<u>Finance:</u> The Trust is unable to ensure short term financial performance in the current year (Risk 116)**

- At end M6, there remains a £1.5m - £2m gap in established delivery plans.
- Demand pressure continues to grow across a range of services, both community and inpatients. This has resulted in performance reduction and additional resource has been required to support corrective action in CAMHS community. This additional funding for CAMHS agency staff is now being funded by the CCG to enable the Trust to achieve its waiting time targets. This additional funding will become recurrent funding from next year.
- Significant additional bed placements have been required during Q1, this has reduced in Q2 with more responsive remedial action being taken to reduce the length of the placements.

2.7 **<u>Adult Community</u>: Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites (Risk 773)**

- Adult Mental Health Services are tasked with achieving and sustaining 95% of service users receiving an initial Assessment within 28 days by 31st March 2020. In September 2019 the 95% target was achieved – this needs to be maintained (risk around sustainability)

2.8 **<u>Finance:</u> The Trust may not have sufficient resources to ensure long term financial sustainability (Risk 1001)**

- The Trust has been given its control totals up to 2024, this will enable longer term financial planning, however these control totals are higher than anticipated requiring a surplus of £1.5m each year rather than break even.

2.9 **<u>Data Protection:</u> Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident (Risk 920)**

- 91 data incidents were reported through Datix to date in Q2 2019/20. Misdirected correspondence remains the most common cause of data incidents. Two incidents were reported to the Information Commissioner in Q2.
- One of the core roles of the Information Rights and Compliance team is to manage and reduce the occurrence of preventable data breaches. This is currently done through:
  - Investigation of every incident
  - Challenging practices that lead to breaches – duplicate letters, breakdown of role based access controls.
  - Publishing a monthly information governance newsletter
  - Care Records Quality Audit; information governance practice is reviewed with managers and administrators on every ward and community team at least once a year.

  Data Protection Impact Assessments – this process enables the IR&C team to get involved at the design stage of projects and new initiatives, to build in 'data protection by design'.

2.10 **<u>S136</u>: Unlawful detention of service users under S136 breaches beyond 24hrs (Risk 882)**

- When the CQC inspected - Between Oct - Dec 2018 8% (19 out of 231) detentions exceeded 24hrs.
- 59 people exceeded the 24hr period of detention in the audit period (Apr – Jun). This accounts for 24% of detentions in the audit period. This compares with 14% in Jan-March 2019 audit.
- 22 people exceeded the maximum time of 36hrs (compared to 5 in Jan-March 2019).
- The contributing factors of intoxication and unavailability of inpatient beds remains
- The Trust is continuing to work with CGL and has reinstated interagency meetings to look at the commissioned services and also to provide training for S136 staff.
- Frequent attenders project in development which will look at reducing the attendance by the top 40 frequent attenders.

- Exploration of the adoption of the Serenity Integrated Mentoring (SIM) which is an innovative mental health workforce model that brings together the police and community mental health services in order to better support people with complex mental health needs.

3 Risks considered for escalation to the Trust risk register by IGC

There was one proposed risk for escalation to the Trust Risk Register that was considered by IGC. The West SBU put the following risk forward for escalation to the Trust Risk Register:

3.1 **Self harm: Ligatures, Non-anchor ligatures and self-harm in inpatient settings (Risk 966)**
Full details pertaining to this risk are in the Q2 Integrated Safety report. The risk is isolated to a small number of service users and, after two quarters where an increase was seen, Q2 has not seen a further increase. IGC approved the risk remaining on the local risk register and requested that the Q3 integrated safety report considers this risk specifically, reporting on whether the trend has changed and the mitigation that is in place is effective.

4 Conclusion

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

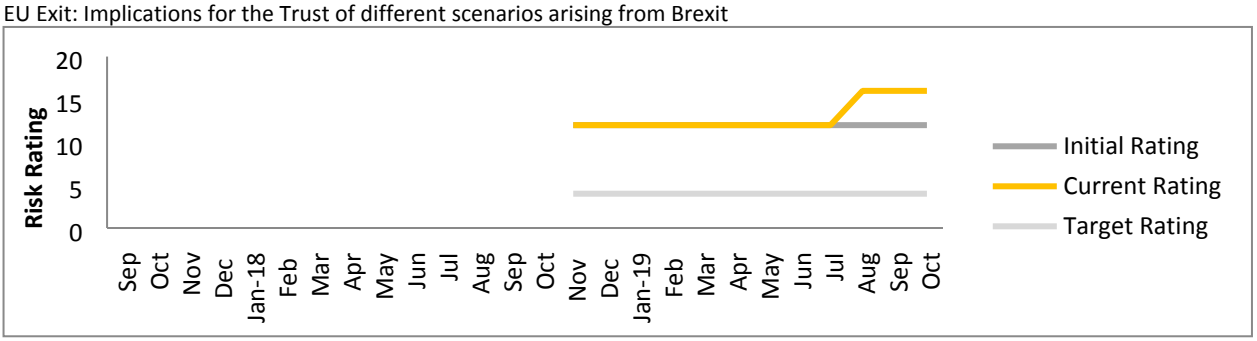
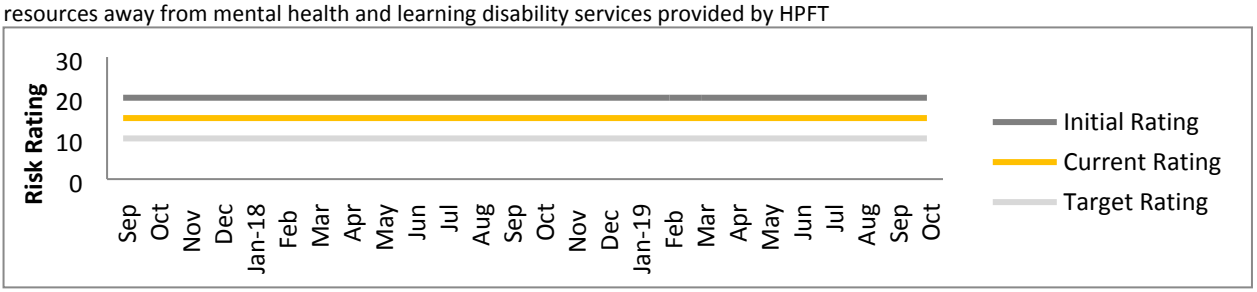
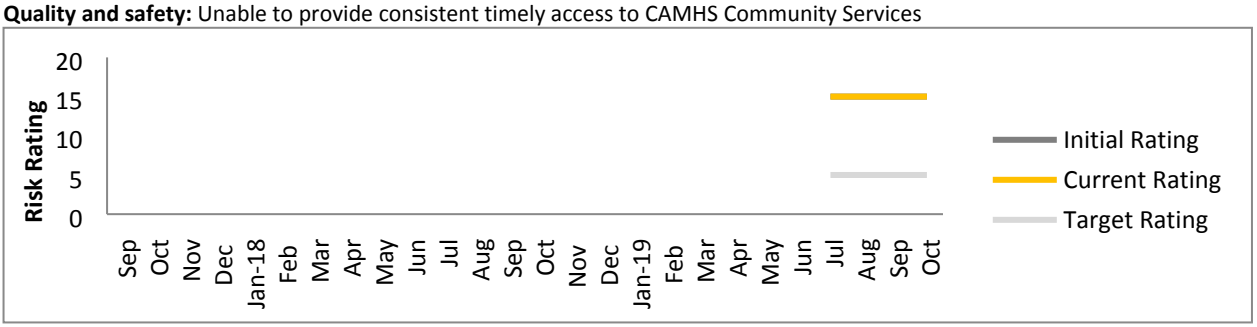
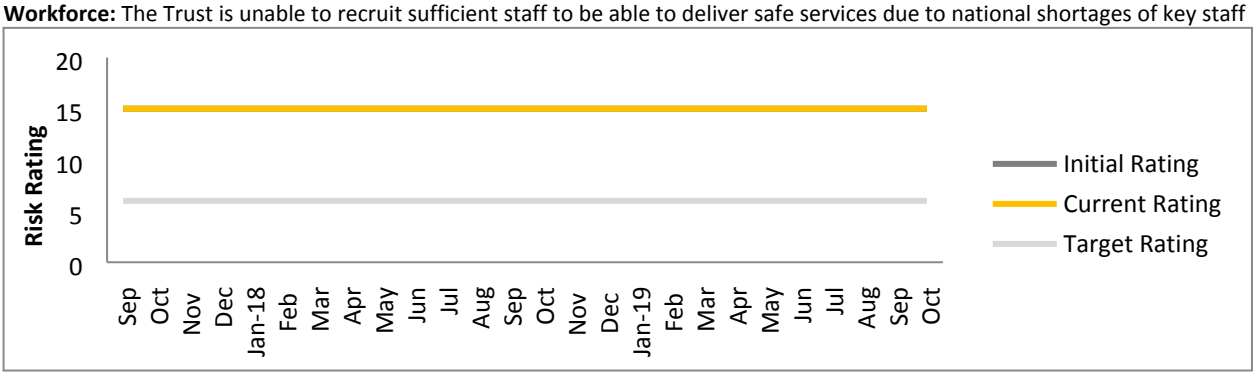
The proposed escalation risk, by West SBU, of risk of self harm and anchor and non-anchor ligature events in the acute services, was considered by IGC. It was agreed that this remains on the West SBU risk register but particular attention is given to the risk in the Q3 Integrated Safety Report.

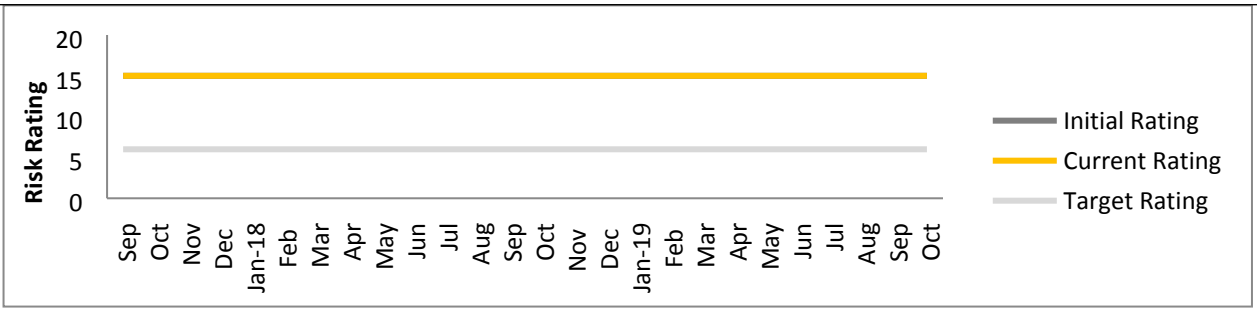
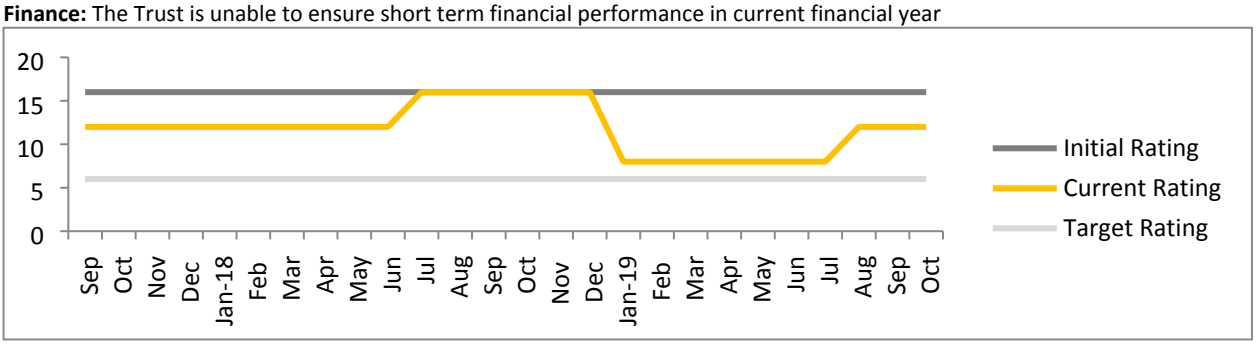
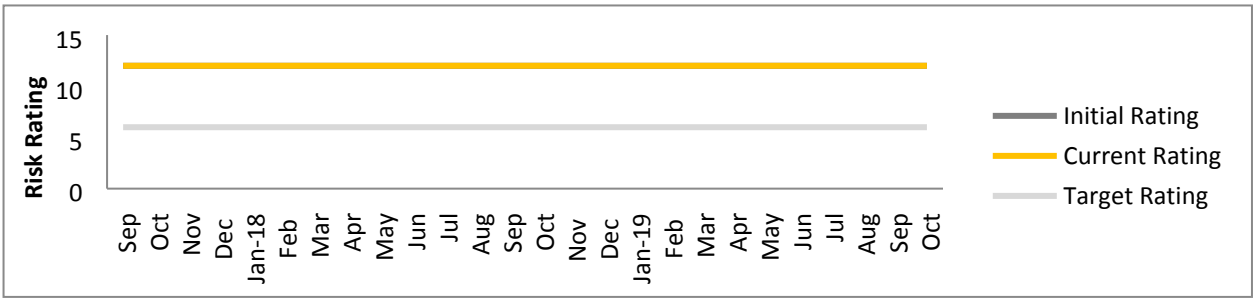
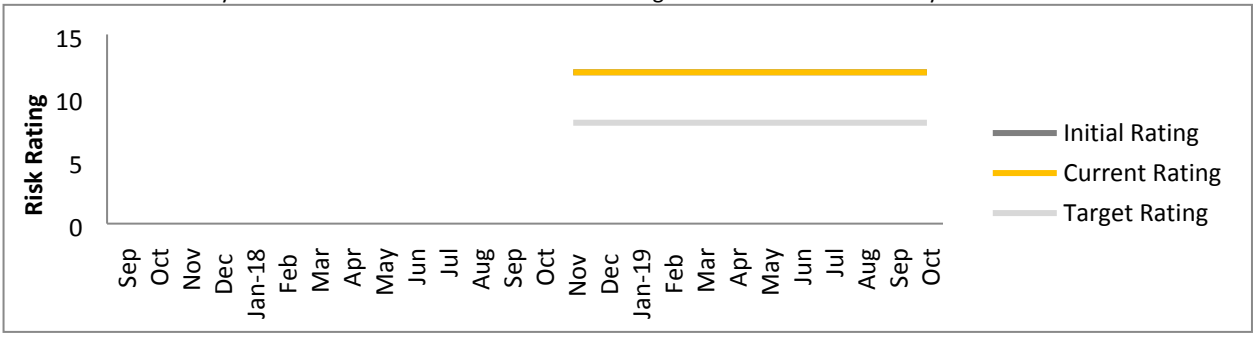
Appendix 1 Trust Risk Register by Exec Lead and linked to Trust Strategic Objectives

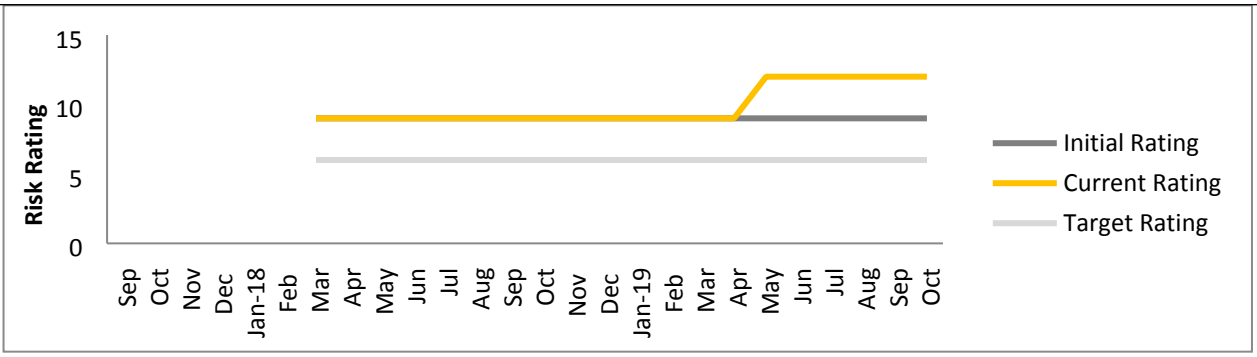
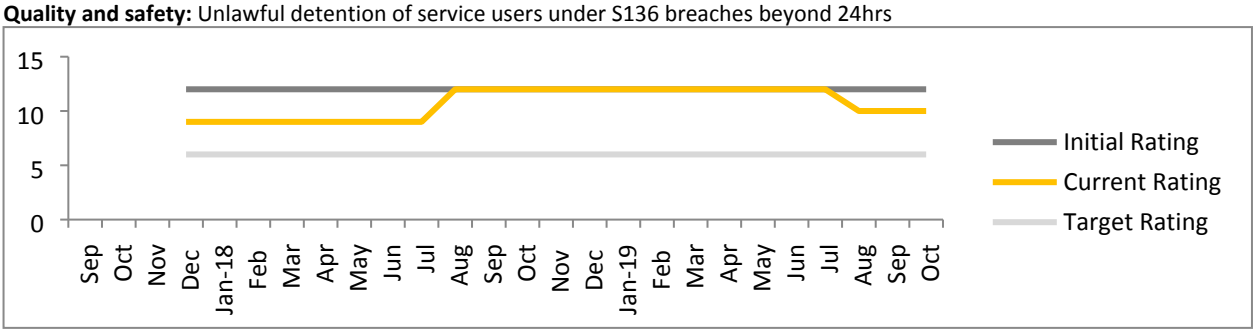
	Opened	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead
1	16.10.18	1000	**EU Exit:** Implications for the Trust of different scenarios arising from Brexit	12	16 (4x4)	4	Staff will report that they are able to deliver safe and effective services	Keith Loveman
2	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
3	15.08.19	1150	**Quality and safety:** Unable to provide consistent timely access to CAMHS Community Services	15	15 (5x3)	5	People will able to access the right service in a timely way	Sandra Brookes
4	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	Susan Young
5	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	Susan Young
6	05.10.09	116	**Finance:** The Trust is unable to ensure short term financial performance in current financial year	16	12 (3x4)	6	We will make effective use of people's time and the money we have to deliver on the outcomes that matter to those we serve	Keith Loveman
7	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
8	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
9	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	12 (3x4)	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	Keith Loveman
10	27.12.17	882	**Quality and safety:** Unlawful detention of service users under S136 breaches beyond 24hrs	12	10 (5x2)	6	Staff will report that they are able to deliver safe and effective services	Sandra Brookes
11	09.08.19	1147	**Quality and safety:** The Trust may not be able to sustain service user safety during a flu outbreak	12	9 (3x3)	3	Staff will report that they are able to deliver safe and effective services	Asif Zia
12	30.01.17	747	**Information Management and Technology** : Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	12	8 (2x4)	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	Keith Loveman

Appendix 2 Trust Risk Register Matrix

Appendix 3 Trend Analysis – 24months

No	Risk	24 month trend analysis
1	1000	EU Exit: Implications for the Trust of different scenarios arising from Brexit  Risk Opened 16.10.2018, the current risk rating increased in August 2019
2	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  Risk opened on 02/02/2017 initially as failure to respond to changing health and social care landscape and then wider system pressures and agenda leading to a shift of influence and resources away from HPFT.
3	1150	**Quality and safety:** Unable to provide consistent timely access to CAMHS Community Services  New risk opened August 2019
4	215	**Workforce:** The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff  Risk opened on 16.10.2014, there has been no change in the risk score in the last 24 months and the current score is the same as the initial score.
5	657	**Workforce:** The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services

		 Risk opened on 30.06.2016, there has been no change in the risk score in the last 24 months and the current score is the same as the initial score.
6	116	**Finance:** The Trust is unable to ensure short term financial performance in current financial year  Risk opened 05.10.2009 as financial challenges, in Feb 2017 this changed to specify short term and long term financial stability, in Oct 2018 the risk was made to be specifically for short term financial stability.
7	773	**Quality and safety:** Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness  Risk opened on 29.03.2017 initially as a risk for East and South East Quadrant and then for all of Adult Community from June 2018. The current risk rating remains the same as the initial risk rating.
8	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability  Risk Opened 16.10.2018, it was created as a decision to separate out short term and long term finance risks, the current rating and initial rating are the same.
9	920	**Information Management and Technology:** Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident

		 Risk opened on 01.03.2018, initially as failure to keep patient information safe, it was managed on the IM&T/IG risk register and escalated to the Trust risk register in May 2018 following an increase in level 2 IG breaches reported to the Information Commissioner Office (ICO).
10	882	**Quality and safety:** Unlawful detention of service users under S136 breaches beyond 24hrs  Risk opened on 27.12.2017 and was managed on the West SBU risk register; in Oct 2018 it was escalated to the Trust Risk Register.

Hertfordshire Partnership University NHS Foundation Trust

Appendix 4

Trust Risk Register
November 2019

To be reviewed by:

Integrated Governance Committee: 20.11.2019

Audit Committee: tbc

Trust Board: tbc

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)	TRR Rating (Aggregated)	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
1000	Implications for the Trust of different scenarios arising from Brexit	There are risk implications for the trust of different scenarios arising from Brexit, particularly a 'no deal' scenario. The Trust is unable to maintain sufficient quantity and volume of key supplies and/or the unit price may rise: - Medications - Equipment - Staff	12	EU staff contacted and supported. Department of Health and Social Care (DHSC) guidance on contingency plans Self Assessment for NHS Trusts to use to identify contracts that may be impacted by EU exit Identification of Contracts at risk to be completed by 30.11.18 Summarise highly impacted contracts and mitigating activities by 30.11.2018 Board level lead identified - DoF DHSC EU Exit Operational Readiness Guidance framework for assessment of risks completed January 2019 Business continuity and incident	16	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. All c.230 have been written to again regarding applying for settled status however the response has been limited. 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)	24/10/2019	24/12/2019

				management plans 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. Recent Emergency Planning table top exercise held 11th October 2019. Testing Gold, Silver and Bronze command. Risks around Medicines are being managed centrally by DH with clear instructions for pharmacies. The Pharmacy Department has taken local actions as follows: Added in an additional reputable wholesaler onto our list of suppliers so that we have additional procurement options Signed an East of England MOU that allows trusts to sell medicines to each other Developed a page on our Pharmacy intranet that lists all out of stock medication which is updated monthly Developed guidance for clinicians on a case by case basis on alternatives when medicines are out of stock The nature and timing of the EU exit remains uncertain. NHS England has reinstated monitoring requirements in relation to EU Exit preparedness – Daily Sit reps (As of 31.10.2019 these have			

							been stood down) The Trust has reinstated (from August 2019) weekly preparation meetings for the EU Exit Group. The Trust was represented at the Regional EU Exit workshop held on the 16th September 2019.				

749	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT	The rapidly changing health and social care landscape nationally and locally creates a potential risk to the sustainability of high quality service provision for people with a mental illness or learning disability due to: • Dilution of a strong mental health and learning disability voice and presence within new models of care and systems or structures that are focused on reducing activity within general acute hospital settings • Increased sharing of risks and financial pressures across the system resulting in shifting of resources away from mental health and learning disability services	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 Active engagement of the system about MH & LD by HPFT leaders; together with leading the development of proposals for MH & LD for the future	15	10	De-emphasis within commissioning intentions Parity of esteem agenda not honoured within contract negotiations or lack of commitment. Lack of discussion about Mental Health & LD priorities across STP and in Local Delivery Boards No demography increase and / or usual commitments aren't delivered by CCG's.	Long Term Plan MH has strengthened national focus and provides a roadmap for further investment and priorities. STP LTP submission includes MH&LD; with dedicated section and also a section on the future governance of MH&LD within the system STP will move to 'shadow' ICS from April 2021 and HPFT supporting and shaping development; Directors involved in key STP decision making forums and groups E&N ICP and West Herts ICP developing at pace; with HPFT well represented and supporting/shaping development; ensuring voice for MH&LD & HPFT MH & LD ICP 'Case for Change' agreed in principle by STP CEO group; next steps agreed to further explore clinical model and alliance approach. Regional events held to develop approach for MH&LD across the region; now gaining pace as other systems commence discussions and positioning of MH&LD NHSE transformation funding secured – community (Adult & older people) and crisis	Karen Taylor (Director of Strategy & Integration)	24/10/2019	24/12/2019

								EOE Provider Collaborative successfully moved through the NHSE first gateway; clinical models and business case under development. HPFT a 'founding partner' leading development of the approach with CPFT and EPUT. STP wide MH & LD group in place, overseeing MH investment and developments across the STP – chaired by Dir. Strategy			

1150	Unable to provide consistent timely access to CAMHS Community Services	Increasing level of demand on CAMHS Community Services resulting in an increased length of time for service users to access CAMHS community services, which impacts on the clinical care and treatment provided to young people. Long waits for other parts of the CAMH system resulting in deterioration of young people and referrals from these services being sent to Tier 3. (For Example Tier 2, ASD). Lack of clear pathways for ASD 16-18 year olds and subsequent referrals to Tier 3. Limited early intervention offers within the system to support young people and their carers. Despite previous recovery plans, performance is not sustained.	15	CAMHS CQI initiative has commenced A weekly task and finish group is in place Chaired by the Executive Director of Service Delivery and Service User Experience to oversee the recovery plan. Weekly reporting to commissioners. An agency team continues to support both SPA Triage and the community quadrant teams. Intensive work is on going with the performance team to ensure data is being reported in the best possible way, to reflect the work taking place and to support our KPI requirements. Quadrant Teams continue to offer a high number of first appointments. In addition to allocated quotas, teams are offering additional slots including Saturday	15	5	CAMHS 28 day KPI/performance Number of referrals Re-referral rates DNA rates WTE Vacancies Use of agency staff Complaints	A weekly task and finish group is in place Chaired by the Executive Director of Service Delivery and Service User Experience to oversee the recovery plan. This includes looking at referrals from the point of entry, reviewing data and implementing options to reduce the current backlog. The service has a detailed recovery plan in place (reported weekly to Commissioners) outlining the current plan to recover the position for the 28 day wait KPI. This has now transformed into a CAMHS Improvement Group to ensure sustainability is maintained. There is a dedicated team to focus on the children waiting over 28 days, who had no appointment booked. All children offered telephone triage assessment. The process of clearing the current backlog will take 4 months (mid July – mid October). Additional resources brought in will increase capacity and will allow the teams to clear other waiters within 7 weeks (end of September). The backlog of over 500 has been reduced down to 6 and CAMHS are now booking into 28 day choice appointments.	Sandra Brookes (Director Of Service Delivery and Service User Experience)	07/11/2019	07/02/2020

				clinics and early evening appointments.				Risk of sustaining performance remains and impact on partnership waits. Additional funding has been given for 6 CAMHS practitioners spread across the quadrants to support choice and partnership up to March 2020. Further funding to develop an assessment and brief intervention team in SPA until March 2020 to support triage of Tier 3 and 4 cases who might need limited interventions rather than being added to the waiting lists.			

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	Q2 average / cumulative vacancy rate was 14.14% which equates to 488.62 staff. The Trust had 161 starters against 138 leavers (headcount). The Target Vacancy rate for the trust for Q2 was 12.7%. The trust is currently above the target vacancy rate by 1.98%. The Time to Hire (T2H) was 53.4 days in September up 7.7 working days from August. Time taken to issue conditional offers increased substantially in September, up 5.8 days from August. These metrics are crucial for HPFT to be the first organisation to make an offer to staff who might have alternative employment opportunities There has been a change in approach to recruitment campaigns with them focusing on specific areas / roles. A recruitment campaign for West SBU resulted in an open day that attracted over 50 attendees. 30 offers were made on the day with 9 of these being too hard to fill qualified roles. There was also a successful campaign in Norfolk where 9 staff were made offers. Increased recruitment activity over October and November is projected to	Susan Young Interim Director of Workforce and OD	04/11/2019	04/02/2020

								increase the number of candidates in the pipeline over the coming months in effort to keep pace with turnover and the anticipated growth of establishment due to new services.			

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	A number of retention initiatives have been introduced which include: - the buddy scheme - the retire and return process - the career conversations - HR surgeries - 100 day conversations - internal moves process These retention initiatives have been reviewed and presented at WODG. Staff recognise the value of the retention initiatives which have been introduced however there has been a limited impact. The turnover rate in September was 15.32% and so remained similar to the previous month. The Target Turnover rate for the trust for Q2 14.7%. The trust is currently above the target turnover rate by 1.02%. Increase of exit interview return rates to 50%, these are now being managed by Realworld Consulting Ltd.	Susan Young Interim Director of Workforce and OD	04/11/2019	04/02/2020

116	The Trust is unable to ensure short term financial performance in current financial year	Failure to maintain recurrent and sustainable financial performance, specifically: Failure to address immediate demand and / or cost pressures and / or to deliver required efficiency savings. Failure to achieve control total in 2018.2019 Key Issues 2018/19: Cost Pressures: - Agency expenditure and NHSI cap Demand Pressures: - Social Care Placements - External PICU Placements - Increasing referrals to community services - CAMHS Tier 4 placements	16	Revisited and Strengthened CRES Programme Assurance Board, monthly monitoring Dedicated finance resource: Head of Finance – Efficiencies Programme Weekly monitoring of key financial indicators associated with areas of volatile spend eg placements Raised authorisation levels for agency expenditure Vacancy Review process Implemented in-year recovery plan	12	6	Day One 'flash forecasts' for monthly outturn Weekly monitoring of key indicators - agency - placements - movement forecast Quarterly Review / Horizon Scanning Increased agency spend Increased number of placements outside HPFT CRES programme RAG rating	The Trust's overall NHS Improvement Use of Resources Risk Rating remains a 1. The Trust continues to have a strong relationship with NHSI. The Trust met its control total for 18.19 albeit the position in Q1 was supported by the use of provisions. 2019/20 Control Total from NHSI, target is to break even. The Delivering Value Plan for 2019/20 is £6.5m which is a stretching target and includes a further reduction in agency costs. At end M6, there remains a £1.5m - £2m gap in established delivery plans. Demand pressure continues to grow across a range of services, both community and inpatients. This has resulted in performance reduction and additional resource has been required to support corrective action in CAMHS community. This additional funding for CAMHS agency staff is now being funded by the CCG to enable the Trust to achieve its waiting time targets. This additional funding will become recurrent funding from next year. Significant additional bed placements have been	Keith Loveman (Director of Finance)	24/10/2019	24/01/2020

								required during Q1, this has reduced in Q2 with more responsive remedial action being taken to reduce the length of the placements. The resulting cost pressures have been broadly balanced by vacancies, but this is only a short term position as recruitment continues.			

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 providing access in a timely way. Ongoing challenge in balancing, inbound volumes of assessments with effective case management and treatment of ongoing caseload. This can result in high demand of MHAA and admissions for known service users. Limited use of social care packages to prevent crisis or support discharge. 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	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 and 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. Monthly reporting of position against target including detailed action plan to improve performance across all quadrants.	12	6	Vacancy Levels Agency spend Increase in incident reporting Number of cases pending allocation Number of initial assessments Turnover of staff Increase in Complaints Performance against targets deteriorating Staff feedback/raising of concerns Increased length of time to be allocated a care coordinator Increase in the total amount of cases pending allocation or as a % of overall community team caseloads Increase in readmission rates. % rise in service users known to community services	Adult Mental Health Services are tasked with achieving and sustaining 95% of service users receiving an initial Assessment within 28 days by 31st March 2020. In September 2019 the 95% target was achieved – this needs to be maintained (risk around sustainability) Continuous quality improvement (CQI) projects are in place across Adult Community Services Innovative Primary Care Mental Health Pilot projects have been running in three areas of Hertfordshire and have had evaluations supporting their continuation and extension. The pilots are in Stevenage, Hertford and Watford. In Hertford and Watford a mental health practitioner has been embedded in a number of practices to triage referrals to secondary care and signpost as appropriate, provide advice to primary care workers regarding care or passing the referral on to secondary care. There has been a reduction in the number of initial assessments required by the CMHTs as a result. The pilot service is being extended across further localities county-wide. In Stevenage, an alternative model has been piloted which has provided a drop in clinic for GPs to refer	Sandra Brookes (Director Of Service Delivery and Service User Experience)	07/11/2019	07/02/2020

		allocation remains a risk					requiring MHAA and admission. High CATT caseloads as unable to pass on to community teams.	to. This has resulted in a significant reduction in demand. SW Adult Community Team are working on proportionate assessment, defining this and developing new systems and processes to support this new approach in the teams. The Teams are currently refining the concept of a case review, whereby initial assessment will be offered to the right service users. The group is developing the tools to support implementation. The tools to support new ways of working are in development and will be ready for operation in September 2019 Letter to service user and GP – this is being developed by the Adult Community Team in the North to ensure a succinct letter is being sent which includes what we've agreed to provide (co-agreed with service user) with clear time scale. It is anticipated that this will reduce administrative time and make the process of written communication more efficient. •ADHD/ASD diagnosis – the process for addressing these referrals is being redesigned and will be ready for implementation in Q2. •Increase in weekend initial			

								assessment slots (Herts Valleys community teams) •NW continues to undertake re-triage locally; this has enabled direct contact with GP's with advice and support and facilitated a reduction in initial assessments undertaken. •A self-service questionnaire is in development which will be completed by service user prior to attending an initial assessment. This will support the person's involvement and engagement in the assessment process; this may reduce the length of the assessment too. •Robust implementation of DNA policy. Automated texting system using CQI methodology is being explored at Oxford House. •Improved use of cancellation slots •Work underway across STP to implement community transformation plans in line with Long-Term Plan to remodel services to support SMI more effectively in primary care			

1001	The Trust may not have sufficient resources to ensure long term financial sustainability	Failure to maintain long term financial sustainability specifically: 1) Failure to secure sufficient funding from commissioners to meet service quality and/or activity requirements 2)Failure to address underlying demand and/or cost pressures and/or to deliver required efficiency savings such that the underlying long term financial performance is not sustainable 3) Significant unidentified QIPP requirements across the STP, this could lead to an increase in the risk score if these QIPP requirements materialise in the future	12	Regular Placement Panel with cross-SBU coordination of placements pathway Provision for older peoples transformation programme in place Regular Reports are made to the Trust Board, Finance & Investment Committee, Executive Team and Trust Management Group 2018/19 Contract variations in place for health and social care contracts. Relationship management with commissioners Primary Care Mental Health pilots around demand management to mitigate risk, better signposting will hopefully reduce Initial Assessment demand.	12	8	Agreed income tariff uplifts Negotiations with commissioners 3 year CRES proposals	Hertfordshire - A five year contract with an option to extend for a further two years has been signed. Included in the contract are agreements in relation to access target thresholds for CAMHS and Adult services. Additionally, funding meets the Mental Health Investment Standard and allows us to meet the commitments made within the Five Year Forward View for Mental Health. 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 The Trust has been given its control totals up to 2024, this will enable longer term financial planning, however these control totals are higher than anticipated requiring a surplus of £1.5m each year rather than break even.	Keith Loveman (Director of Finance)	24/10/2019	24/01/2020

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 finances and reputation. There is a potential loss of trust in clinical and therapeutic relationships, leading to reduced quality of care and outcomes.	9	The Trust has an open and timely culture of reporting incidents that occur, which facilitates early intervention and management of incidents. This supports reporting to the relevant authorities (NHSD and ICO) within the statutory 72 hour timescale. In addition, the Trust has undertaken data flow mapping across the organisation, and maintains a detailed information asset register, with identified Information Asset Owners. A Data Protection Impact Assessment process is in place, which promotes visibility of new projects, and facilitates early input by the Data Protection Officer. This contributes to meeting the statutory requirements of Article 35 of GDPR (2016).	12	6	Increase in serious data incidents reports. Increased complaints to the Information Commissioner leading to enforcement action, including audits or financial penalties. Reduction in staff compliance with mandatory training. Projects or initiatives going live without data protection or governance oversight. Failure to maintain Information Asset Register, Data flow mapping or Care record quality audit. Reduction in compliance with Data Subject Rights requests (including Subject Access).	In 2018-19, a total of 502 data breach incidents were reported, an increase of 34% comparted to 375 in 2017-18. The Trust is continuously raising awareness about the value of information governance and the importance of reporting incidents; regardless of how insignificant they may feel. This may have been a contributing factor to the rise in reported incidents. These incidents are investigated on a case by case basis. Where there is wider learning, it is communicated to staff throughout the Trust. NHS Digital uses a risk matrix to score each data incident to determine whether it should be reported to the Information Commissioners Office (ICO). 20 incidents were scored as high level incidents and were reported to the ICO in 2018-19, compared to 5 reported in line with the previous scoring style in 2017-18 In May 2019 in light of the reporting threshold to the (Information Commissioners Office) ICO changing and the increased consequence of reporting more data breaches to the ICO this risk has increased in consequence to Major (4). 74 data incidents were reported on Datix in Q1	Keith Loveman (Director of Finance)	24/10/2019	24/01/2020

				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.				2019/20, 43 (58%) of these were due to misdirected correspondence (Letters and email). Three incidents have been reported to the Information Commissioner in Q1. 91 data incidents were reported through Datix to date in Q2 2019/20. Misdirected correspondence remains the most common cause of data incidents. Two incidents were reported to the Information Commissioner in Q2. One of the core roles of the Information Rights and Compliance team is to manage and reduce the occurrence of preventable data breaches. This is currently done through: - Investigation of every incident - Challenging practices that lead to breaches – duplicate letters, breakdown of role based access controls. - Publishing a monthly information governance newsletter - Care Records Quality Audit; information governance practice is reviewed with managers and administrators on every ward and community team at least once a year. - Data Protection Impact Assessments – this process			

							enables the IR&C team to get involved at the design stage of projects and new initiatives, to build in 'data protection by design'				

882	Unlawful detention of service users under S136 breaches beyond 24hrs.	From 11th December 2017, changes to Section 136 of the Mental Health Act came into force as a result of the Police and Crime Act. These changes have an impact on the Trust's responsibility to make available a qualified clinician for the Police to consult with prior to using Section 136, and for Section 136 detentions to last no longer than 24 hours (unless there are circumstances that warrant an extension of up to 12 hours). Extensions are not granted for either incomplete assessment due to clinician availability or for lack of bed availability should an inpatient admission be required. In order to meet these timescales and manage the requirements of	12	- Availability of Street Triage 9am - 4am 7 days a week, in order for Police to consult regarding anyone over 16. Crisis Assessment and Treatment Team available 4am - 9am. - Forest House Adolescent Unit to provide a clinician for consultation with Police regarding use of Section 136 at all times for anyone under 16. - Dedicated Section 136 team to monitor progress against 24 hour timeframe and co-ordinate assessing clinicians; Section 136 team to monitor and note where an extension to the detention can be authorised - Between 9 - 5, Monday to Friday, AMHP Service prioritise Section 136 assessments in order to meet timescales - Presence of CATT staff in Kingfisher Court overnight, increasing availability for	10	6	- Lack of Street Triage involvement in Police decision to detain - Use of Section 136 by Police to manage risk as a result of intoxication, rather than use of public order offence or return to home - Lack of availability of AMHP's out of hours to undertake assessment - Numbers of people discharged from Section 136 with no evidence of mental disorder or no further action required either continues at current rate or increases - Lack of availability of S136 suites and Police waiting due to inability to move patients through	In order to manage the risks related to failure to implement the updated Section 136 Policy, the Trust has ensured a 24 hour, 7 day a week coverage of clinicians for Police to consult with prior to detention via Street Triage and Community Assessment and Treatment Teams. When the CQC inspected - Between Oct - Dec 2018 8% (19 out of 231) detentions exceeded 24hrs. 59 people exceeded the 24hr period of detention in the audit period (Apr – Jun). This accounts for 24% of detentions in the audit period. This compares with 14% in Jan-March 2019 audit. 22 people exceeded the maximum time of 36hrs (compared to 5 in Jan-March 2019). The contributing factors of intoxication and unavailability of inpatient beds remains The Trust is continuing to work with CGL and has reinstated interagency meetings to look at the commissioned services and also to provide training for S136 staff. Frequent attenders project in development which will look	Sandra Brookes (Director Of Service Delivery and Service User Experience)	07/11/2019	07/02/2020

		the changes, the Trust has to provide 24 hour clinical coverage for the Police; to ensure that the demand for Section 136 does not increase dramatically by monitoring inappropriate or unwarranted use of S136 in cases of intoxication only or presence of no mental disorder; to ensure availability of relevant professionals (AMHP, Section 12 approved Doctor and Crisis Assessment and Treatment Team where admission indicated) in order to assess and recommend individuals. Since implementation 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:		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				at reducing the attendance by the top 40 frequent attenders. Exploration of the adoption of the Serenity Integrated Mentoring (SIM) which is an innovative mental health workforce model that brings together the police and community mental health services in order to better support people with complex mental health needs.			

		- Delays due to AMHP availability out of hours - The individual being too intoxicated to assess - Complex social issues such as homelessness or vulnerability, or waiting for transfer back to home area for treatment. A particularly challenge has been the presentation of children and adolescents, who are unable to return to their home Of these, only intoxication is an accepted reason for extension of the 24 hour deadline. The risk is unlawful deprivation of liberty for which the legal proceedings could be brought against the Trust by an individual.									

Board of Directors

Meeting Date:	5th December 2019	**Agenda Item:** 14
Subject:	Development Review of Leadership & Governance Using the Well-Led Framework	**For Publication:** No
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To update the Board with regard to the process underway to deliver the developmental review of leadership and governance using the Well-Led framework in accordance with the requirements of the NHS Foundation Trust Code of Governance.

Action required:

To note and consider the process involved, the proposal is that the review starts in January 2020, with final report to Board on 30 April 2020.

Summary and recommendations to the Board:

Summary

At the Private Board meeting on 5 September 2019 it was agreed to start the process of planning for the undertaking of a developmental review of the leadership and governance using the Well-Led framework in accordance with the requirements of the NHS Foundation Trust Code of Governance. The Board agreed to undertake a process whereby the organisation commissioned to undertake the independent part of the process provides input into the design of the self-assessment part of the process.

A specification for the services to be commissioned has been agreed with the Chair and Chief Executive. The Head of Corporate Affairs and Company Secretary has worked with procurement to agree a process for directly awarding the contract under the SBS framework. A meeting is taking place on 18 December 2019, with the preferred supplier to ensure they are the 'right fit' for what the Trust wants to achieve by undertaking the review.

Throughout the design and prior to the, self-assessment and independent review the Board will be updated on the process. The Board is asked to note that the well led review process will involve all board members, governors and other relevant stakeholders.

Recommendation

It is recommended that the Board:

- Note the work underway to secure preferred provider.
- Note the agreed specification
- Note the proposed timeline of final report to Board in April 2020

Relationship with the Business Plan & Assurance Framework:

Reviews provide a tool to facilitate continuous improvement to develop and improve capacity and capability in the organisation. This in turn enables Boards to demonstrate that their organisations are providing high quality, sustainable care.

Summary of Financial, IT, Staffing and Legal Implications:

There will be a financial implication in relation to the cost of the independent review.

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

Governors have a key role in the Well Led Key Line of Enquiry No. 7: "Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?" The independent reviews usually include interviews and focus groups with Governors and other key stakeholders.

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

The independent review provides assurance for the CQC Well Led standard.

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

Executive Team Business Meetings on the 9 October 2019.

Hertfordshire Partnership University NHS Foundation Trust

Trust Board

Meeting Date:	5th December 2019	**Agenda Item:** 15
Subject:	Chair's Action	**For Publication:**
Author:	Chris Lawrence, Chair	**Approved by:** n/a
Presented by:	Loyola Weeks, Non-Executive Director	

Purpose of the report:

To inform and seek agreement for Chairs action to be carried out for Errol John to become an MHA Manager.

Action required:

To approve the Chair's action.

Summary and recommendations to the Board:

Mental Health Act Manager – Errol John

Errol has successfully completed the required 3 hearing sessions to become a MHA Manager.

The Board is asked to **approve** the Chairs action for appointing Errol John as an MHA Manager.

Relationship with the Business Plan & Assurance Framework:

N/A

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