Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC Meeting

Da Vinci B Chair: Chris Lawrence

27 February 2020 10:30 - 27 February 2020 13:30

INDEX

Hertfordshire Partnership University NHS Foundation Trust

BOARD OF DIRECTORS
Meeting Held in Public

Date: Thursday 27 February 2020
Venue: The Colonnades, Beaconsfield Road, Hatfield AL10 8YE
Time: 10:30 – 13:30pm

SERVICE USER STORY				
A G E N D A				
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**
1.	**Welcome and Apologies for Absence:**	Chair		
2.	**Declarations of Interest**	Chair	**Note/Action**	Attached
3.	**Minutes of Meeting held on: 30 January 2020**	Chair	**Approve**	Attached
4.	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
5.	**CEO Brief**	Tom Cahill	**Receive**	Attached
QUALITY & PATIENT SAFETY				
6.	**Quarter 3 Integrated Safety Report**	Jane Padmore	**Receive**	Attached
7.	**Quarter 3 Safe Staffing Report**	Jane Padmore	**Receive**	Attached
8.	**Quarter 3 Guardian of Safe Working**	Asif Zia	**Receive**	Attached
9.	**Coronavirus Update**	Jane Padmore	**Receive**	Attached
OPERATIONAL AND PERFORMANCE				
10.	**Community Survey**	Sandra Brookes	**Receive**	Attached
11.	**Staff Survey**	Susan Young	**Receive**	Attached
12.	**Quarter 3 Performance Report**	Karen Taylor	**Receive**	Attached
13.	**Quarter 3 Annual Plan 2019/20**	Karen Taylor	**Receive**	Attached
14.	**Finance Report**	Paul Ronald	**Receive**	Attached
15.	**Gender Pay Gap**	Susan Young	**Receive**	Attached
STRATEGY				
16.	**Operating Planning Guidance 20/21**	Karen Taylor	**Receive**	Attached
17.	**STP Update**	Tom Cahill	**Receive**	Attached
GOVERNANCE AND REGULATORY				

18.	**Report of the Audit Committee: 13 February 2020**	Catherine Dugmore	**Receive**	Attached
19.	**Trust Risk Register**	Jane Padmore	**Receive**	Attached
20.	**Review of Board Effectiveness**	H Edmondson	**Receive**	Attached
21.	**Six monthly report from Nominations & Remuneration Committee**	Chair	**Receive**	Attached
22.	**Board Planner 20/21**	H Edmondson	**To Approve**	Attached
23.	**Any Other Business**	Chair		
	QUESTIONS FROM THE PUBLIC	Chair		

Date and Time of Next Public Meeting:
Thursday 30 April 2020, 10.30 – 13.30, Colonnades

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

Declarations of Interest Register

Trust Board of Directors

27th February 2020

Members	Title	Declaration of Interest
Chris Lawrence	Chairman	None
Tanya Barron	Non-Executive Director	Chair of Affinity Trust
Sarah Betteley	Non-Executive Director/Deputy Chair	Director DEVA Medical Electronics Ltd
Diane Herbert	Non-Executive Director	NED HRMC Shareholder in own coaching/leadership business
Janet Paraskeva	Non-Executive Director	None
Loyola Weeks	Non-Executive Director	Director O'Donovan Weeks Ltd
Catherine Dugmore	Non-Executive Director	None
David Atkinson	Non-Executive Director	Goldman Sachs Group Inc equity share owner Trustee of Papworth Trust Trustee of Varrier-Jones Foundation Independent NED Mizuho Trustee Eternal Forest Trust
Tom Cahill	Chief Executive Officer	None
Ann Corbyn	Director, People & Organisational Development	None
Asif Zia	Director, Quality & Medical Leadership	None
Keith Loveman	Director of Finance/Deputy CEO	Member Congregational Giving Team, St Albans Cathedral

Jane Padmore	Director, Quality & Safety	None
In Attendance	**Title**	**Declaration of Interest**
Sandra Brookes	Director, Service Delivery & Service User Experience	None
Karen Taylor	Director, Strategy & Integration	None
Sarita Dent	Associate Non-Executive Director	Treasurer of Bipolar UK
Helen Edmondson	Head of Corporate Affairs & Company Secretary	None
Susan Young	Interim Director, People & Organisational Development	Director of consultancy business PSCA Consulting Ltd (owner) Incorporation of Company

Hertfordshire Partnership University NHS Foundation Trust

Agenda Item: 4

Minutes of the PUBLIC Board of Directors Meeting
Held on Thursday 30th January 2020
Da Vinci B – Colonnades

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Christopher Lawrence | CL	Chair
David Atkinson | DA	Non-Executive Director (items 0-08)
Sarah Betteley | SBe	Non-Executive Director
Tanya Barron | TBa	Non-Executive Director
Janet Paraskeva | JPa	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Susan Young | SY	Director of People & Organisational Development
Dr Jane Padmore | JPad	Director, Quality and Safety
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Keith Loveman | KL	Director, Finance
Dr Asif Zia | AZ	Director, Quality & Medical Leadership
IN ATTENDANCE	
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Kathryn Wickham | KW	PA to Chairman and Company Secretary
Sarita Dent | SD	Associate Non-Executive Director
Jon Walmsley | JW	Lead Governor
Paul Ronald | PR	Deputy Director of Finance
Alicia O'Donnell-Smith | AOS	Interim Deputy Director of Communications and Engagement
APOLOGIES	
Loyola Weeks | LW	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
Karen Taylor | KT	Director, Strategy and Integration

Item	Subject	Action
000/20	**Service User Presentation** CL welcomed Rosie who presented to the Board on her experience of receiving mental health services from HPFT. Rosie explained about her struggle with anxiety, receiving CBT treatment and working with support workers and her therapist Loraine. Loraine McSherry was in attendance to support Rosie along with Lara Harwood, Service Experience Lead. CL thanked Rosie for her insightful presentation.	
001/20	**Welcome and Apologies for Absence** CL welcomed all to the meeting and apologies for absence were noted.	
002/20	**Declarations of Interest** The Declarations of Interest Log was reviewed and noted.	
003/20	**Minutes of the meeting held on 5th December 2019** The minutes of the meeting held on the 5th December 2019 were reviewed with the below amendment requested. ***Page 9***	

	Bullying and Harassment ***A Deep Dive would also be undertaken in the New Year to not only look at compliance but also the quality of staff appraisals with their line manager*** The minutes were agreed as an accurate account of the meeting subject to the amendment. **APPROVED** **The Minutes of the 5th December 2019 were APPROVED subject to the requested amendment**	
004/20	**Matters Arising** The matters arising schedule was reviewed and updates noted.	
005/20	**CEO Report** TC presented to the Board. Key headlines were discussed and noted as follows: **National Update** **EU Exit** TC advised that all EU Exit preparations had formally been stood down. **National Performance** TC reported that nationally the NHS was under significant pressure with demand greater than ever with very little headroom. **Sustainable Transformation Partnership (STP)** The pace of change across the Hertfordshire and West Essex STP was accelerating. Recruitment to the joint Accountable Officer role for the ICS and three Clinical Commissioning Groups (CCGs) had taken place with an announcement to take place shortly. **New Care Models (NCM)** The Collaborative continues to develop the Business Case with significant conversations around risk. Submission is due mid-April 2020. **Planning 2020/21** Planning for 2020/21 is underway, however of note to the Board was that the NHS Operating Framework and Planning Guidance had not yet been received, and therefore changes to current planning may be required depending on the guidance's content. of the direction of travel. **Trust-wide Update** **Performance** TC commented on the strong performance for Quarter 3 with Adult Community, CAMHS and Older Peoples services seeing the full recovery to meet access targets, however was keen to note it was not known if this was sustainable. **Flu Campaign** To date uptake was 62% against a target of 85%. The Trust would need to give focus to plans for next year to increase the uptake. **Quality**	

	Following the outcome of the Annual Assessment 2019/20 by NHS England, the Trust had been placed in the category of Routine Surveillance. **Coronavirus** The Trust were working to increase awareness with staff and service users and were in daily communication with Public Health and NHSE. **People** **Staff Survey** TC highlighted the Staff Survey response rate of 57.4%. This was well above average and a huge increase to the previous year. The results were embargoed until the 18th February 2020. **Good to Great Roadshows (G2G)** The Good to Great Roadshows were being rolled out with the Executive Team currently getting out and about across the organisation. **Senior Leadership Team** TC advised the Board that Ann Corbyn, Director of People and Organisational Development would be starting with the Trust on Monday 3rd February 2020. **RECEIVED** **The Board discussed and RECEIVED the CEO report**	
006/20	**Report of the Finance & Investment Committee held 16th January 2020** DA provided the Board with a verbal update on the work undertaken by the Finance and Investment committee at its most recent meeting held 16th January 2020. Of note to the Board were: • The committee had received a Deep Dive presentation by Michael Thorpe on CQI work, providing some early examples of where it had been used and outlining some of the future plans. • In terms of performance, overall the Trust continued to do well against increased demand. It was noted that Access was a strong area of performance for adult, CAMHs and older people with the key being whether the Trust was able to sustain this improvement. Areas for improvement were noted as out of areas placements and delayed transfers of care. • The committee had received an update on the expected financial position for December including a detailed discussion on the current provisions and future risks. • An update was provided on the Capital Investment Plan which was generally progressing well with the full year forecast expected spend at £10.85 which was £3.89m below plan. The committee discussed the lower spend for backlog maintenance and noted the two planned estate disposals with expected proceeds of £1.3m. • The committee received an update on the Delivering Value programme for 2020/21 which had a target set at £6.2m with a contingency gap of 20%. • The committee had reviewed the results of the self-assessment undertaken in December 2019 which was felt to be a very worthwhile	

	exercise with overall positive results. Areas for improvement related to clarifying the role of Audit and FIC with regard to financial policies volume and appropriate use of summary papers that provide analysis. • The committee had been advised that for year to date the Trust had secured income of £10.4m and were currently engaged in bids and negotiations to retain and grow business worth £16.2m. • The committee had noted the decision for the PARIS contract extension to enter into an early extension of the contract with Civica for the Electronic Patient Record (PARIS). • The committee had noted that engagement with SU and stakeholders had started for the East and North Herts bed provision Business Case with SBr appointed as chair of the project board. • The committee had reviewed and considered its Terms of Reference in light of the self -assessment. A few changes had been made and these would be presented to the Board for approval. HE confirmed that the FIC terms of reference being considered later on the agenda had been updated in light of the feedback from the self-assessment. **RECEIVED** **The Board RECEIVED the verbal report**	
007/20	**Finance Report** PR provided the Board with the monthly summary which outlined the financial performance for the month, Year to Date (YTD) and the Full Year Outturn (FOT). Of note to the Board were the following headlines: Overall the Trust remained confident in the delivery to meet its control total for this year whilst continuing to maintain a balanced position in terms of its provisions. The current financial position had the following headlines: • There has been good improvement in operational cost control from July onwards which had largely held. • There was a continuing level of vacancies arising from this year's new investment and there had been a level of net recruitment in Q3 indicating the vacancy gap was reducing. • There was some additional income likely to be received in the final months principally relating to the NHS Long Term and was in addition to income held back in the first two quarters to match future recruitment. • As noted by KPMG, our external auditors, the Trust held a sensibly balanced position at March 31st 2019 on its accruals and provisions. • There is the ongoing risk particularly with winter system pressures that bed use could increase in the remaining months as shown in early January. This is the one major area of cost risk currently with the other area of focus being medical staff sickness cover. When taken together the above factors show that the surplus is expected to be marginally ahead of Plan (and the Control Total) for the year. The latest	

	forecast shows a surplus of £39k for the full year against a planned breakeven. In addition the Board are asked to note the following as the key financial themes relevant to other discussions and decision areas:- • This year has seen a greater degree of variation in additional bed costs which indicates a greater level of risk than previous. At particular times bed numbers have escalated rapidly and taken time to reduce back down. • Significant demand and activity pressures have been experienced in community services across adult, older peoples and CAMH services resulting in the need for short term investment to support the reversal of adverse performance and to protect service quality. • The recruitment to the new service teams is still ongoing in several areas indicating a very long timeline in some more difficult areas of recruitment. Understanding these causes in more detail will support future planning • The CRES program has not met its full recurrent target in year with limited progress in Q1 and Q2. This had led to key changes in approach and is also expected to now accelerate with the operational management team now recruited to. • The agreement of income levels with commissioners had been more fragmented and prolonged this year. • Within the capital and estates program some items have had lengthy implementation periods and again a review of the reasons will support future planning A discussion was held amongst Board members in relation to 2020/21 and the significant increase in the proposed Control Total to £1.4m. The discussion acknowledged that this year's position had been favourably impacted by some one-off income and from non-recurrent savings from the time to recruit to new teams. Whilst there was some additional income expected in 2020/21 this was for specific service investments and related to the delivery of the Mental Health Standard. TC concluded the discussion stating that he did not feel the Trust could continue to deliver high quality services to meet the new investment requirements, address the underlying financial shortfall and provide an additional £1.4m surplus. TC also felt that there was risk with the £1.4m being retained by the STP that this investment would be directed away from mental health and was counter to the specific policy intentions of extra funding. All in attendance supported this view and the proposed position that the Trust would not be able to support the proposed Control Total as the additional savings required would likely have a material detrimental impact on services and on staffing. **RECEIVED** **The Board RECEIVED the report**	
008/20	**EU Exit** KL reported to the Board advising that the briefing note set out the current position in relation to preparations for the EU Exit which was due to become law on the 31 January 2020. Between now and December 2020 would be a transitional period. The contingency plans for a 'no deal' had now formally been stepped down	

	nationally, however it was expected this would be ramped up again around September 2020 depending on the negotiations with the EU. KL reported that previously the Trust had contacted all EU staff to offer support and would continue to do this. Staff had also been encouraged to support EU colleagues throughout this period. A further communication regarding settled status was being prepared. It was noted that we were not seeing a significant exodus of staff but would expect inflow to be affected. In response to a question KL reported that there had been volatility of pharmacy costs but not clear if related to EU exit. **NOTED** **The Board NOTED the report** *David Atkinson left the meeting*	
009/20	**Report of the Integrated Governance Committee held 15th January 2020** SBe provided the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting held on the 15 January 2020. There were no items for escalation to the Board. Highlights for the Board to note were: • The meeting had noted that the Quality Assurance visits for safeguarding for adults and children by the Care Quality Commission (CQC) had been rated as good. • The Committee had received an updated version of the Board Assurance Framework (BAF) with a full BAF being presented to the meeting in March 2020. • The Committee had also considered and approved the Trust Risk Register (TRR) which had an enhanced look and provided a greater level of understanding the Trust risks. • The Committee had received a report which provided an update on the significant work undertaken to support the Emergency Preparedness Resilience and Response (EPRR). Following an assessment by NHSE/I the Trust were now compliant with one area of partial compliance relating to on-call training. The next review was expected in July 2020. • The Committee had considered the Quarter 3 policy report which had seen a big improvement. The Trust now had 90% of policies within review date against a target of 90%. • The Committee had reviewed the results from the outcome report of the self-assessment undertaken in December 2019, which had been generally positive but with scope for improvement. • A Deep Dive had been undertaken to look at appraisals with a good discussion held among committee members. • The Committee had considered and approved the MOSStogether Strategy and workplan.	**JPad**

	• The Committee had received an operational update which had summarised the key operational issues for the Trust with plans for the refurbishment of Forrest House and the sustainability of CAMHS access being discussed. SBe concluded the update advising that JPad had agreed to undertake a self-assessment on behalf of the Board on Freedom to Speak Up. The results would be presented to the Board at a future meeting. **RECEIVED** **The Board RECEIVED the report**	
010/20	**Workforce & Organisational Development Report: Quarter 3** SY introduced the report and provided the Board with the headlines on activity undertaken during Quarter 3. • SY reported there had been strong performance for the quarter. The Staff Survey Result had shown a response rate of 57.4% being 16% higher than in 2018. The survey results are published on the 18th February 2020 with a formal update being submitted to the Board. • The Quarter had a continued focus to staff engagement with the Big Listen and Good to Great Roadshows. • The Great Teams initiative had been launched which would help teams in their journey to become great teams. • SY noted the level of activity which had taken place to support the delivery of the People and Organisational Development metrics. SY further noted that the revised approach to recruitment had seen a positive impact and as a consequence Quarter 3 had seen the vacancy rate drop below the target of 12.2% ending the quarter slightly above target but 2% lower than in Quarter 2. In addition, the retention initiatives were having an impact seeing 3 consecutive months of a dropping rate which equated to a 1% drop in the turnover rate and ending the quarter below target. Statutory and Mandatory training continued to meet the Trust target. **RECEIVED** **The Board RECEIVED the report**	
011/20	**Community Survey** SBr presented the results of the Community Survey advising the Board that the paper provided an overview of the management report following the publication of the National Community Mental Health Survey results for 2019, and the actions being taken forward. SBr briefed the Board on the background outlining that the 2019 Community Mental Health Survey was part of the NHS Patient Survey Programme in line with the NHS Outcome Framework. The survey had been undertaken between February and June of 2019 with the overall results showing no significant change compared to the results received in 2018 which was very disappointing. Responses to five questions fell into the bottom 20% range and responses to two questions in the top 20% category in comparison to other Trusts.	

	The focus now was on the 5 key areas noted below to impact on future survey results: • Implementation of new place-based community mental health framework in line with the NHS Long Term Plan, to replace the Care Programme Approach (CPA) • Review communication sent to service users to ensure they receive clearer details of reviews and more regular up to date information of changes in care coordinators and Consultants • Continue with the implementation of Shared Clinical Decision making • Continue to implement the Individual Placement Support (IPS) scheme • Further expansion of peer support workers During February and March 2020 a series of focus groups would be held with the aim to listen, validate and pull together a Service Improvement Plan. This would be done in conjunction with CQI methods and in co-production with Service Users and Carers. TC acknowledged SBr update stating that the results were not where we wanted to be. CL requested that an update was provided to the Board at a future meeting. ***Action Point: SBr to provide the Board with an update on the work following the Community Survey Results at a future meeting*** **RECEIVED** **The Board RECEIVED the report**	**SBr**
012/20	**Report of the Audit Committee – 3 December 2019** CD reported to the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 3 December 2019. . Of note to the Board: • The Committee had received a presentation from Susan Young regarding Strategic Objective 4: HR and OD and its attached risks as identified in the Board Assurance Framework (BAF) which had been very helpful. • The Committee had received a report which had provided the initial areas of management focus in relation to work on the 2019-20 Annual Accounts due for sign off in May 2020. The new accounting standard on leases IFRS16, which comes in 2020/21, was discussed. • The Committee had received the RSM Internal Audit Progress report with two rated as partial assurance, these were: o Patient Monies – the Committee had held a good and full discussion noting that a Task and Finish group would be set up and a report provided to the Audit Committee at its next meeting. o Health and Safety – the audit had covered a wide subject base noting that there had been control weakness highlighted during the audit. A lead member of the Estates team had been present at the meeting and was able to provide assurance that a robust process, supported by a database had been implemented.	

	• The Committee had received the Audit Action Tracker which had highlighted the overdue actions with agreement that the management team would look at a system to ensure robust chasing of outstanding actions. • The Committee Terms of Reference had been reviewed which had been agreed subject to two amendments: - accurately they describe required NED attendance - amend wording regarding financial reporting • The annual review of the Committee effectiveness proposal was considered and would be discussed at the Audit committee meeting in February 2020. CD concluded the update advising that the Committee had received a report detailing the outcome of the evaluation of the effectiveness of Internal Audit and Local Counter Fraud with the survey highlighting scores of 82% for effectiveness for Internal Audit and 78% effectiveness for Local Counter Fraud. Following discussion with Committee members, the Audit Committee approved the contract for RSM to be extended for two years. The Board noted and supported the Committee's decision to extend the Internal Audit and Counter Fraud Contract. **RECEIVED** **The Board RECEIVED the report**	
013/20	**Well Led Review** HE updated the Board with regard to the selection of a preferred provider to work in partnership with the Trust to deliver the Well-Led framework. HE further updated advising that the Chair, Chief Executive, Deputy Chief Executive and Head of Corporate Affairs & Company Secretary had met with Deloitte, the preferred provider on the 14 January 2020 with agreement to award them the contract in line with the SBS Framework. An initial engagement meeting had been held with Deloitte with work now underway to plan in detail the self-assessment and external review process. The final report was expected at the end of May 2020. The Board were asked to approve the appointment of Deloitte as the provider of the external support for the Well-Led review, noting that it was a direct award which was in line with relevant guidance and legislation. All in attendance approved. **APPROVED** **The Board APPROVED the report**	
014/20	**Terms of Reference** **a) Audit Committee** CD advised the Board that Annually the Audit Committee reviewed their Terms of Reference and referred any changes to the Trust Board for approval. The Audit committee reviewed its Terms of Reference at its meeting of the 3rd December 2019 with the significant amendments being: • Clarification of which Non-Executive Directors are required to attend. • Updating of requirements under financial reporting	

	• Clarification of Committee's role with regard to assurance for policy review. The Board was asked to approve the Terms of Reference of the Audit Committee. All in attendance approved. **b) Finance & Investment Committee** PR advised that annually the Finance and Investment Committee reviewed their Terms of Reference and referred any changes to the Trust Board for approval. The Finance and Investment Committee reviewed its Terms of Reference at its meeting on 16 January 2020 with the significant amendments being: • Clarification of which Non-Executive Directors are required to attend. • Clarification of Committee's role with regard reviewing of all aspects of performance including quality and workforce The Board was asked to approve the Terms of Reference of the Finance and Investment Committee. TC queried its role with regard to financial policies. CD agreed to re-look at the wording with HE. Subject to wording changes all in attendance approved. **APPROVED** **The Board APPROVED the revised Terms of Reference for the Audit committee and Finance & Investment committee**	
015/20	**Planning 2020/21** **a) Annual Plan 2020/21** KL presented the report that provided the Board with an update on the considerations relating to the 2020/21 Annual l Plan, including the timetable and process for its completion. It was noted that this was being written in the absence of the detailed Planning Guidance from NHSI/E, which was still not published. KL referenced an announcement by Julian Kelly the previous week which had noted 3 key areas: • Mental Health Investment Standard • Primary Care and Community Services investment • Outcomes & care commitments for LD & autism services The planning focus for 2021 would be the delivery of the mental health performance standards with a system wide approach which dove tailed with the STP planning. KL referred to page 5 of the report (overall page 91 of 105) which set out the Trusts strategic objectives on its Good to Great journey. A draft of the report would be presented to the February Board with a governor engagement event scheduled for the 3rd February 2020. KL invited the Board for comment. Comments should be with KL by CoP Thursday 13th February 2020. ***Action Point: Board members to provide comments to KL on the Annual***	**All**

	Plan **b) Financial Plan** PR presented the paper reiterating that the Plan was being written in the absence of the detailed Planning Guidance from NHSE/I. It was anticipated that 2020/21 would show continuing revenue growth however the Board should note the continuing increase in service demand, recruitment and pay pressures would mean this remained a very challenging period financially. PR also noted the Capital Spend plan currently being developed which would see an increase on the £10m submitted within the STP plan. The effective roll out of CQI methods and the Digital Strategy were noted in terms of risk and mitigating actions. PR concluded advising the Board that the Finance & Investment Committee would be updated further at their meeting in March 2020 with any items required for escalation reported to the Board. **RECEIVED** **The Board RECEIVED the report**	
016/20	**STP Update** TC presented the paper which provided an update to the Board on the current activities, issues and planned work across the Hertfordshire & West Essex (HWE) Sustainable Transformation Partnership. TC referred to overall page 104 of the pack which outlined the key headline areas which covered the development of the ICS, Leadership, ICPs, Herts MH and LD ICP, governance, workstreams and the system operating plan. TC also talked about the role of the Non-Executive and Lay Members with a meeting scheduled to look at the development of a SNED group. An update on this would be provided at a future Board on the alignment of NEDs to identified areas ***Action Point: An update on this would be provided at a future Board on the alignment of NEDs to identified areas*** **RECEIVED** **The Board RECEIVED the report**	**TC**
017/20	**Any Other Business** AZ reported that the outcome of the Clinical Excellence Awards process would be reported to the Board in March/April 2020. No further business was put forward.	
019/20	**Questions from the Public** No questions were received.	
Date and Time of Next Public Meeting: The next meeting is scheduled for Thursday 27th February 2020 @ 10:30am Da Vinci B, The Colonnades		

Close of Meeting

Agenda Item 4

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 27th February 2020

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
30/01/20	**016/20**	STP Update	Alignment of NEDs to identified areas		HE	27/2/20	A
30/01/20	**015/20**	Annual Plan 2020/21	Board members to provide comments to KL by the 13th February 2020		ALL	13/02/19	A
30/01/20	**011/20**	Community Survey	Update to be provided to the Board regarding Community Survey Improvement Plan		SBr	27/2/20	G
05/12/19	**144/19**	Workforce & Organisational Development Report – Quarter 2	Board session to be scheduled on the Just and Learning Culture		HE	March 2020	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	July 2020	G
29/11/18	**153/18**	Workforce & Organisational Development Report Quarter 2	Board Workshop to be held on Staff Engagement	Schedule of Board workshops to be agreed at meeting 27.2.20	SY	March 2020	G

Trust Public Board

Meeting Date:	27 February 2020	**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.

NHS Bill

The Queen's Speech outlined the government's commitment to enshrining in law the NHS Funding Bill as outlined in the NHS Long Term Plan (LTP). The bill places a duty on the Secretary of State to ensure the sums paid to NHS England for revenue spending do not fall below the amounts specified in the LTP Funding Settlement for the remaining financial years of that settlement, up to and including the financial year 2023/24.

While the additional funding committed by government to deliver the long term plan is welcome, there is concern that the settlement as it stands will not be sufficient to enable the NHS to deliver the aspirations set out within the plan. A number of sectors are not covered by this bill, notably social care, public health, capital investment and education and training.

Care Quality Commission's 'Monitoring the Mental Health Act in 2018/19'

The CQC has published 'Monitoring the Mental Health Act in 2018/19', key points from within the paper include;

- Identification of the use of human rights principles and frameworks as a key area of concern. CQC state services must apply human rights principles and frameworks, and their impact on people should be continuously reviewed to make sure people are protected and respected.
- CQC MHA monitoring visits suggest that since 2015 the number of services meeting the basic expectations of the MHA code of practice have improved.
- CQC has concluded it is difficult for patients, families, professionals and carers to navigate the complex laws around mental health and mental capacity.

Operating Guidance 2020/21

NHS England and NHS Improvement (NHSE/I) published the operational planning and contracting guidance for 2020/21 on 30 January. This overarching document sets the delivery task for both NHS providers and commissioners for the coming financial year, covering system planning, finances, operational performance, and workforce. It details what the service will be expected to deliver in the second year of the long term plan period, including moving towards financial balance and improving access to services.

https://www.nhsconfed.org/-/media/Confederation/Files/Publications/NHS-Operational-Planning-and-Contracting-Guidance-2020_21.pdf?dl=1

The timetable sees first submission of draft operational plan by 5 March 2020. A more detailed paper is on the agenda for discussion.

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.

Sustainable Transformation Partnership (STP)
The pace of change across the STP continues in line with national and regional timetables and development plans. A full update is on the Public Board agenda.

New Care Model – East of England Provider Collaborative
From 1 May 31 October 2020 Tracy Dowling of Cambridge & Peterborough FT will be the lead CEO, taking over from Sally Morris of EPUT. From 1 November through to end of April 2021 Tom Cahill will assume leadership of the collaborative. In addition, the new commissioning hub will be hosted by Cambridgeshire and Peterborough NHS Foundation Trust, enabling a seamless transition of staff into the new working arrangements

Trust-wide update

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

Finance update
The financial position for January highlights a deficit in month of £36k against Plan of £0k, and a surplus year to date of £259k against Plan of £0k (excluding PSF.) The in-month position was in line with expectations and the forecast out-turn remains a marginal surplus which will mean the Trust has met its Control Total for the year and triggers the earning of the full amount of the Provider Sustainability Funding (PSF) of £1.9m. In relation to 2020/21 proposed control total, we have now written to the STP Finance Director advising that we cannot accept this figure, which includes an additional 0.5% efficiency above the national tariff, as it would significantly impact our ability to meet the requirements of the MH Implementation Plan and the MH Investment Standard.

Performance
Overall, our performance as a Trust has continued to be strong throughout January and into February. Access standards for community services (across all age groups and for people with learning disabilities) have been met and exceeded and we have improved our performance in a number of key areas including the time it takes from referral to dementia diagnosis, our delayed transfers of care have reduced slightly, and we have improved our IAPT recovery rates. Whilst staff sickness has increased (reflecting a seasonal trend we see each year) it remains at a relatively low level, and importantly we have continued to reduce the number of vacancies across the Trust and have seen our rate of staff turnover reach its lowest level in the last 12 months. This reflects the ongoing emphasis and focus we place on improving our staff's experience of working at HPFT.

There remain a number of challenges across our services, with our inpatient units under considerable pressure, reflecting both national and regional levels of demand. In common with other providers we have seen an increase in the number of service users we have needed to place out of area to ensure they received the inpatient care they needed when we have not had a bed available. We are working hard to ensure we minimise the times this needs to happen. Improving Access to Psychological Therapies also continues to be a key focus for us during Quarter 4, with challenging targets to achieve by the end of the year.

NE Essex IAPT
The Trust has been informed about the outcome of the recent procurement exercise undertaken by North East Essex Clinical Commissioning Group. Disappointingly the Trust has not been awarded the contract. We have raised a number of issues of clarification with the bid authority and are awaiting further feedback.

Quality
The risk level of Coronavirus in the UK remains moderate; to date there have been eight confirmed cases of Novel Coronavirus (2019-n CoV), in the UK. The NHS is therefore putting in place appropriate measures to ensure business as usual. It has been advised that we start identifying designated isolation rooms within all our buildings across the Trust, so that we can safely manage the situation, in the event we have an individual who self-presents at any of our sites.

The CQI team has been working with our safer care team to improve our Serious Incident root cause analysis, the CQI methodology has enabled us to identify areas of development and we are starting to see the positive change in our RCAs of Serious Incidents. We are pleased to announce that we have our first 50 CQI graduates, who will be working on various CQI projects across the organisation.

The Care Quality Commission (CQC) has published Monitoring the Mental Health Act in 2018/19, under its statutory duty to provide Parliament with an annual review of how health services in England apply the Mental Health Act (MHA).

The report's key findings relate to concerns around;

- adherence to human rights principles
- Improvements required in the involvement of service users.
- Access to appropriate services, including availability of health-based places of safety and the number of people in long-term segregation.
- difficulty for patients, families, professionals and carers to navigate the complex laws around mental health and mental capacity.
- issues with the availability and quality of community care and people being placed far from home
- staffing levels and availability

We have a focus group co-ordinating a programme of events throughout the year to celebrate the Nurse and Midwife; our approach is on recruitment and retention.

Flu

This year's Flu vaccination campaign has focused around protecting family from flu. Whilst there are still areas for improvement this has been the Trust's best ever result. To date 64% of the trusts frontline staff (direct care workers) have had flu vaccination as compared to 53% of staff last year. It is worth noting that the target for next year has been increased to 90% and we will take the learning from this year and approaches from other Trusts into next year's campaign, with a learning event organised for the end of March.

PLACE Outcomes 2019

The results of the 2019 Patient Led Assessment of the Care Environment (PLACE) for 2019 have been published. These assessments are undertaken by Service Users, Carers and Healthwatch, who provide an independent assessment across 6 domains – cleanliness, food overall (food across the organisation, food for inpatients), privacy, dignity and wellbeing, condition, appearance and maintenance, dementia, disability. The outcomes are the best ever for the Trust with scores well above both the national and MH average in every domain. This is positive testament to the Estates & Facilities Team, the improved partnership working with Interserve and reflective of the additional investment into these areas made by the Board. A fuller report will be taken to the next IGC meeting.

Measurement	Cleanliness	Food Overall	Food Organisation	Ward Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
National Avg	98.6	92.2			86.1	96.4	80.7	82.6
MH National Avg	98.5	92.1	90.6	94.0	92.4	95.7	90.6	87.5
HPFT Result	**99.42**	**96.74**	**96.33**	**96.80**	**93.8**	**98.99**	**93.57**	**91.15**

Operations

It is a credit to our adult community teams in East and North Herts as five out of the six teams have been successful in achieving the Royal College accreditation: The successful teams at Rosanne House, Saffron Ground, Holly Lodge, Cygnet House and Oxford House have achieved the accreditation. Centenary House are working had to be accredited which is hoped will take place in the near future.

Community service workshops – we are holding a series of workshops during February and March with Service Users, Carers and staff and will be working together to co-produce a complete Service Improvement Plan..

Our People

Staff Survey

The National Staff Survey has been in place since 2003 and is the biggest external metric of staff experiences that is used by CQC and future employees. Eleven themes were provided as a high level overview and scored on a 0 - 10 scale. Results are presented in the context of the best, average and worst results for similar organisations, bench-marked against 23 Mental Health and Learning Disability Trusts. The outcome shows positive improvement across 73 out of 91 questions with some areas for further focus.

Full detail will be provided in the report later on the agenda.

Good to Great Roadshows

Nine 'Good to Great' roadshows have taken place so far, with others planned. Amongst the feedback we have received from staff we know that what would improve their working life is if there could be improved IT and Wi-Fi, localised inductions, agile working opportunities, further development opportunities, healthy working environments and mini health checks.

EU Exit

Although the UK left the European Union on 31 January 2020, nothing will change between now and 31st December 2020 whilst the UK and EU negotiate how the new relationship will work, especially around buying and selling goods.

We are very proud at HPFT to be enriched by having staff from diverse backgrounds and cultures and this very much includes our colleagues from the EU who are very important to our HPFT family. As a Trust we will ensure that we do to everything we can to support our EU colleagues during this uncertain time.

Senior Leadership Team

I am pleased to advise that Ann Corbyn commenced with us on 3 February as the new Director of People and OD. Susan Young, as interim, is undertaking a thorough handover with Ann and will continue to support a number of projects before she moves on from the Trust.

Independent Well Led Review

The Board have started the self–assessment process which will culminate in a workshop to finalise the Board's self-assessment, scheduled for mid-March. Planning is well underway for the external review phase which will include survey, interviews, focus groups and desk top review.

Tom Cahill
Chief Executive

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 6
Subject:	Quarter 3 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:** Keith Loveman Director of Finance & Deputy Chief Executive
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:

To:-

- Review the Integrated Safety Report
- Critically appraise the information presented including any risks identified and mitigations in place
- Consider the robustness of the assurances provided
- Advise any further action required

Summary and recommendations:

Integrated Safety Report Quarter 3 2019/20

1. Introduction

1.1 The Integrated Safety Report provides Board members with an overview of incidents and serious incidents reported during Quarter 3, 2019. Previously the Board 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:

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

1.4 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.

1.6 Datix is a live data base and therefore is subject to change. Data in this report was taken on 14th January 2020

Summary

This quarter has seen good progress against the majority of the annual plan priorities relating to safety, but further attention in Q4 will be required to ensure these are met in full.

Recommendation

The Board is recommended to:

- Review the Integrated Safety Report
- Critically appraise the information presented including any risks identified and mitigations in place
- Consider the robustness of the assurances provided
- Advise any further action required

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

Trust Strategy & Board Assurance Framework

Objective One is that *we will provide safe services, so that people feel safe and are protected from avoidable harm.* The Integrated Safety Report is a key line of assurance in relation to risks associated with delivery of this objective

Annual Plan

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.*

The priorities are also supported by the safety domain of the Quality Strategy which was launched in this Q3.

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.

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 3 2019/20 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

Elements that form the integrated report have been reviewed by IGC and the Quality and Risk Management Committee during the quarter.

Executive Summary

The Integrated Governance Committee (IGC) receives and scrutinises all aspects of safety on behalf of the Trust Board conducting deep dives into areas that are identified as requiring additional focus. The Integrated Safety Report provides Board members with an overview of incidents and serious incidents reported during Quarter 3, 2019 and assurances arising from the work of the Integrated Governance Committee.

Progress against Annual Plan Priorities
This quarter has seen good progress against the majority of the annual plan priorities relating to safety, but further attention in Q4 will be required to ensure these are met in full.

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 the same period last year
- a decrease in violence and aggression from service users to staff
- an increase in the use of seclusion.

In this quarter there has been:

- a significant decrease in service user to service user assaults
- an increase in Service user to staff assault which has been the trend over the last six quarters following a period of lower reported incidents, and up to a similar level to 24 months ago.

Feeling Safe
A multifaceted approach has been taken to improving how service users, visitors and staff feel safe, whilst in services and in work, 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 task and finish groups developing training and education about clinical risk formulation and sexual safety.

There continue to be challenges in completing serious incident investigations to time. 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. Restrictive practice data continues to be discussed and triangulated through the Restrictive Practice Committee and local review of data.

Safeguarding
During Q3 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 the embedding of Think Family.

The appointment to the Named Doctor for Safeguarding Children role has provided a further opportunity to further develop and enhance practice in this area. The Corporate Safeguarding Team continues to work in partnership across agency boundaries and in all areas of the Trust.

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 A Trust Risk Register Report was presented to the Integrated Governance Committee on 15th January 2020 which provided additional information about the work that is being undertaken to address and to mitigate against these risks. Safety specific updates related to:

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

- CAMHS: Unable to provide consistent timely access to CAMHS Community Services (Risk 1150)
- 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)
- Workforce: The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657)
- Adult Community: Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites (Risk 773)

4 Safety Dashboard

4.1 It was anticipated that the safety dashboard with relevant Key Performance Indicators (KPI) would be in place in Q3 2019/20 but further work was needed during the development stage. Phase 1 KPI's will be those reported nationally and those included in the Trust Annual Plan will be in use in Q4:

- *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 An updated assurance report on progress with the Trust's CQC action plan will be presented to the QRMC in April 2020 and then report to IGC.

6 Health and Safety Executive

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 and deep dive into violence and aggression were considered by IGC during the quarter 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.

7 STP Zero Suicide Plan

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.

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 continues to be monitored by the Trust's Suicide Prevention Group, which reports to the Safety Committee. Updates are included in the Integrated Safety Report. Although the requirement was to develop a plan that aimed at zero suicides in the inpatient services the Trust decided to take the Action Plan further and incorporate actions being taken to aim to reduce suicides in the community services.

8 Conclusion

8.1 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.

1.2. The MOSStogether Strategy, which was ratified in Q3 IGC, sets the direction for providing safe and effective services, enabling a positive experience for those who receive our services. It supports and builds upon the Trust's Making our Services Safer (MOSS) Strategy. The strategy sets out an approach which aims to ensure that safety is at the heart of everything we do. It ensures that safe services are provided, so that people feel safe whilst receiving our services.

1.3. The MOSStogether Strategy identifies key priorities. It provides a 'menu' for staff to follow in both community and inpatient services as a means of proactive approaches that can be used to achieve the priorities. The implementation of the Strategy is supported by a work plan which is overseen by the Trust's Restrictive Practice Committee. The Strategy has been developed in light of currently available information, guidance and legislation and will be reviewed annually along with the actions in the work plan.

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. Chart 1 below shows that there was a decrease of 7% in the total number of incidents reported on Datix in Quarter 3 2019/20 when compared to the previous quarter; when comparing the data over time variances can be expected.

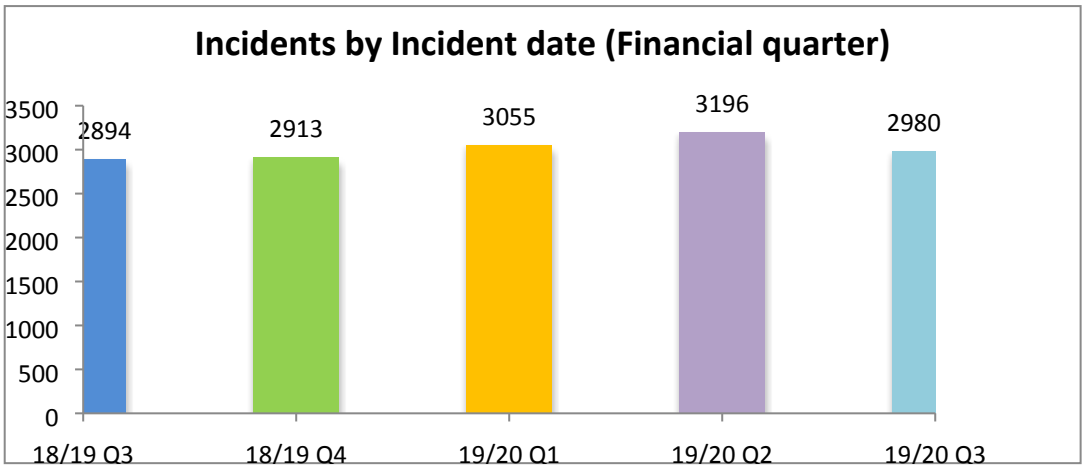


Chart 1 Total Trust Incidents Q3 2018/19 to Q3 2019/20

2.5 In Q3, 76.4% of the total number of incidents resulted in no harm, 17% low harm, 2.8% moderate harm, 0.3% severe harm, and 3.5% death.

3. National Reporting and Learning System (NRLS)

3.1 The Trust reports patient safety incidents to the National Reporting and Learning System (NRLS) in accordance with the national guidance. The next release of the Organisational Patient Safety Incident Report data for NHS organisations is due to be published in March 2020, and will provide data relating to patient safety incidents occurring between April 2019 and September 2019. This will be reported on in the annual integrated safety report at year end.

4. Safety Alerts

4.1 There were a total of 52 MHRA Central Alerting System (CAS) Alerts received between 1st October 2019 and 31st December 2019 which have been reviewed and policy and practice updated as necessary. These have been across the following areas:

- 1 Estates and Facilities Alerts
- 4 Patient Safety Alerts
- 14 Medical Device Alerts
- 1 Field Safety Notices
- 31 Medication / Drug Alerts (including supply disruption)
- 0 Other External Alert
- 1 HPFT Internal Alert was issued

5. EMSA

5.1 There were no mixed sex accommodation breaches in Q3, 2019/20.

6. Serious Incident Overview

6.1 *'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.

6.2 The Trust reported a total of 29 Serious Incidents in Q3 2019/20 (table 3) when compared to 34 in the same period in 2018/19.

StEIS Category	Q3 2018/19	Q3 2019/20
Unexpected/avoidable deaths	19	16
Apparent/actual/suspected self-inflicted harm	4	7
Disruptive/aggressive/ violent behaviour	3	2
Slip/trip/fall	3	2
Safeguarding Adults	2	0
Apparent/actual/suspected homicide	1	0
Medication incident	1	1
Unauthorised absence	1	0
Commissioning Incident meeting SI Criteria	0	1
TOTAL	34	29

Table 1 Serious Incidents reported Q3 2018/19 and Q3 2019/20 by StEIS category

6.3 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 weekly Moderate Harm Panel. Unexpected deaths (16) and self-harm incidents (7) were the top two categories reported in this quarter.

6.4 There has been a decrease in the number of unexpected deaths reported as serious incidents in Q3 2019/20 when compared to the same quarter in 2018/19; this category includes substance misuse related deaths, deaths of an unknown cause and suspected suicides.

6.5 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. Whilst efforts are made to do so, it is not always possible to obtain a cause of death for every case if for example; it is not clear where the person died.

7. Duty of Candour

7.1 The Trust continues to involved service users and carers in the reviews into serious incidents. In keeping with this 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.

7.2 Phase 2 of the Safety Dashboard will include a KPI on duty of candour compliance in terms of timescales. This improvement was identified in a recent internal audit; this will enable reporting in future Integrated Safety Reports. Work will continue in Q4 to ensure that Duty of Candour process is embedded across all areas of the Trust.

8. Serious Incident Process improvements

8.1 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.

8.2 The Trust completed and submitted 38 serious incident reports during Q3 and work is continuing to seek assurance that learning from these cases has been embedded across SBU's. This is detailed later in the report.

8.3 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.

8.4 Additional resource has been identified to support the Trust in completing cases in process that are outside of nationally defined timeframes by the end of March 2020. This recovery work is being supported by the Managing Director of Learning Disability & Forensics SBU on behalf of the Executive Team. This includes a weekly call between each SBU and a member of the Safer Care Team to identify where each case is in process, to ensure that any challenges in keeping to timeframe are identified and appropriate actions to be taken.

8.5 Timeliness of completing investigations is improving for the serious incidents reported although this requires more pace. There are continuing challenges to allocated reviewers ensuring the Trust keeps within the 60 working day national timeframe and to ensure consistent quality of the serious incident reports. A test for change pilot of the revised serious incident process which involves a serious incident investigator from the safer care team working alongside a clinician from the services, regular check ins and presentation of the report to a panel for sign off will commence in Q4 and will continue into Q1 2020/21. Key KPIs for the new process will be measureable on Spike 2 going forward.

8.6 The root and branch review of the incident management process using continuous improvement methodology, led by the Deputy Director of Nursing and Quality is due to be reported in Q4. The report outlining the key findings made and recommendations will be taken forward through to implementation by 1st April 2020.

9. Suicide Data and Suicide Prevention

9.1 The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2019 was published in January 2020 and reports on deaths for the period 207-2017. The timeframe for this report means it is not used to compare the Trust data over recent years but key clinical messages can be considered.

9.2 Key clinical messages from the report include:

- Inpatient and post-discharge care remain times of high risk for suicide.
- Alcohol and drugs are common antecedents of suicide.
- The importance of safer prescribing in primary and secondary care with particular attention on opiates/opioids prescribed to people with long-term physical illness
- Working with local authorities to reduce risk at frequently used locations
- Ensuring clinical staff are aware of suicide methods associated with internet use, as a result of information available online or by online purchases.

9.3 The Trust's Zero Aspiration Action Plan is in keeping with the NCI's "10 ways to improve safety" in mental health services is an important component of the NHS England and NHS Improvement suicide prevention programme. Progress is overseen by the Trust's Suicide Prevention Group. The group's aim, as set out in the Suicide Prevention Group's refreshed terms of reference, is to develop and share best practice in relation to clinical risk, self-harm and suicide prevention and to drive the national profile of the Trust around leading the way in suicide prevention initiatives and good practice.

9.4 The Trust continues to be 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. It is recognised that suicide prevention is complex and a joined up approach with other partner agencies, including Public Health, is vital in this ambition. The Trust is a member of the Zero Suicide Alliance and will be represented at the annual conference in January 2020. The Trust also participates in the East of England Collaborative action learning sets, which enables sharing of innovation and best practice and is represented on the Suicide Prevention Boards across our entire STP footprint.

9.5 Suicide and Open conclusions that were reported for deaths reported as Serious Incidents between 2005 and 2019, where the inquest has been concluded (chart 2), 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.

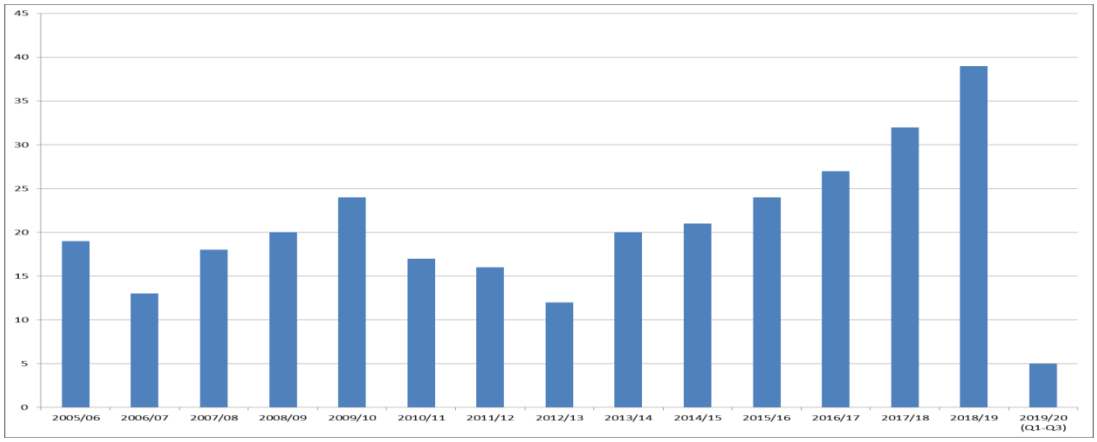


Chart 2: Suicide/Open Conclusions by Incident Date (April 2005 – September 2019)

9.6 At the time of this report there are remaining inquests still to be heard for 2016/17, 2017/18 and 2018/19; therefore at the time of this report chart two does not contain information on all deaths, as outcomes have not been concluded. Chart 3 shows an overview of deaths and where they are in process, providing information on expected outcomes. Work is ongoing to enable the Trust to strengthen this area of reporting in 2019/20.

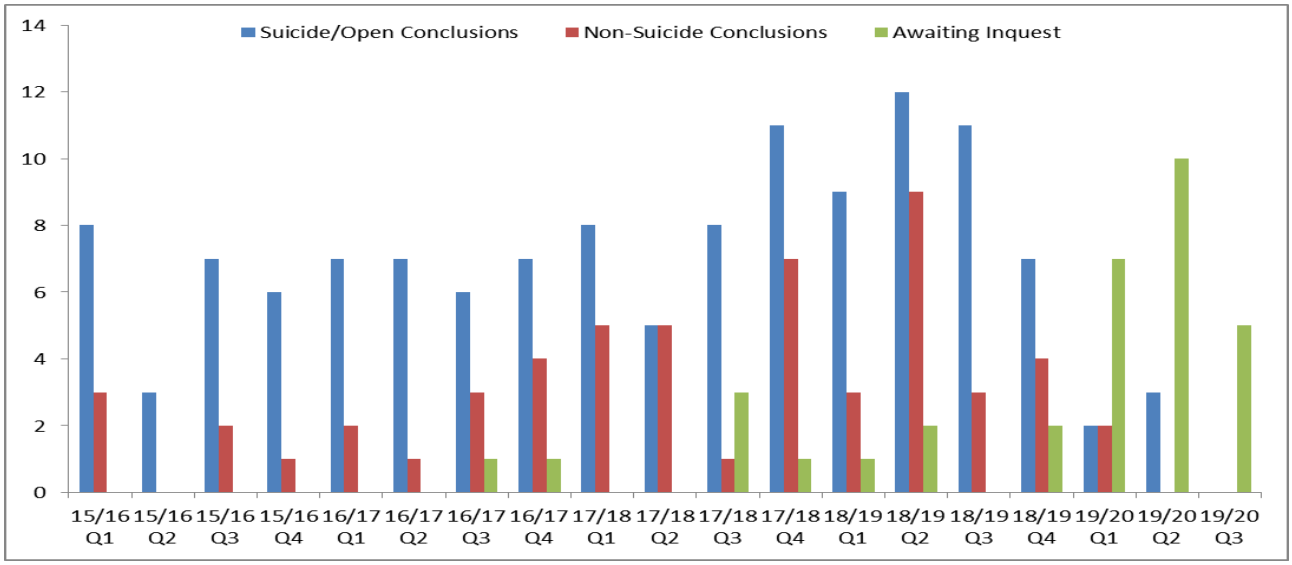


Chart 3 Unexpected Deaths by Incident Date (April 2015 – September 2019)

9.7 The annual plan sets out a minimum of 10% decrease in deaths that are suspected suicides. At the end of Quarter 3, table 2, demonstrates, when compared to 2018/19 the Trust has seen a decrease of more than 10% cumulatively. These figures are subject to change as the Trust is notified of deaths and the outcome of inquests are reported. For example, at the beginning of the year, the number of unexpected deaths in 2018/19 was 52.

Chart 2: Unexpected deaths that may be as a result of suicide

	2018/19		2019/20	
	Number	Cumulative	Number	Cumulative
Q1	11	11	8	8
Q2	18	29	13	21
Q3	12	41	11	32
Q4	9	50	TBC	TBC

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

10.1 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.

10.2 The Safety Thermometer data was collected on the single points in time:

- Wednesday 16th October 2019
- Wednesday 13th November 2019
- Wednesday 18th December 2019

10.3 The Safety Thermometer data was collected from the following locations:

- 1-7 Forest Lane (SRS)
- Dove Ward
- Astley Court
- Lexden
- Victoria Court
- Wren Ward
- Lambourn Grove

- Logandene
- Seward Lodge

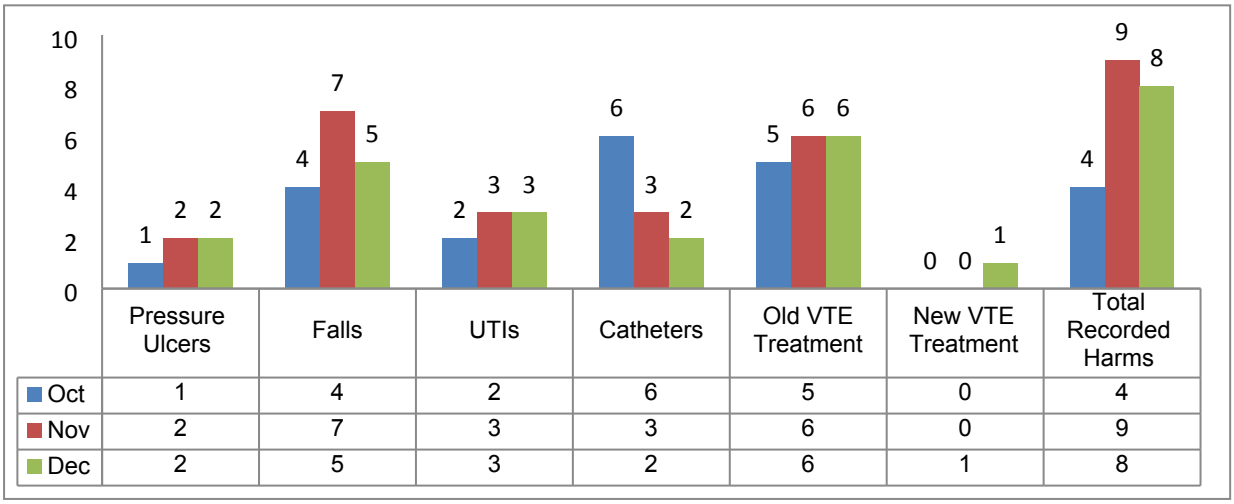
10.4 Harm free care' is calculated on the number of service users receiving harm free care and the number of service users who have had the following harms:

- A pressure ulcer of any category 2,3 or 4 acquired anywhere
- A fall which resulted in any degree of harm within the previous 72 hours
- A new VTE of any type acquired under our care
- Treatment for a UTI with a urethral urinary catheter

10.5 There were a total of 21 harms that occurred in Q3. Harm free care for HPFT was reported as the following for 'all harms' during Q3:

- October - 98%
- November - 95.4%
- December – 96.9%

10.6 Chart 4 below shows the type of harm by month in this reporting period.



	Pressure Ulcers	Falls	UTIs	Catheters	Old VTE Treatment	New VTE Treatment	Total Recorded Harms
Oct	1	4	2	6	5	0	4
Nov	2	7	3	3	6	0	9
Dec	2	5	3	2	6	1	8

Chart 4 Safety Thermometer Results Q3 2019/20

11 Pressure Ulcers

11.1 In Quarter 3 there were 5 pressure ulcers (acquired whilst in HPFT care) reported on Datix which were acquired in our care; all were in the Older People's Inpatient Services. This compares to 8 reported in Q2.

	06/10/19	03/11/19	08/12/19	29/12/19	Total
Category 1 pressure ulcer	1	0	0	0	1
Category 2 pressure ulcer	0	1	1	1	3
Category 3 pressure ulcer	0	0	0	1	1
Total	1	1	1	2	5

Chart 5 Categories of Pressure Ulcers Acquired In HPFT Care in Q3

11.2 Of the 5 pressure ulcers reported in Q3, one pressure ulcer was sacral, one was on the side of the foot, one was on a hip and two were on heels. Category 2 pressure

ulcers have 'mini' root cause analysis reviews completed by ward staff to aid learning and identify areas of good practice.

11.3 3 day fact find reports are completed for Category 3 or 4 pressure ulcers and presented to the weekly moderate harm panel to consider whether it may meet criteria for reporting as a serious incident or require further actions. One Category 3 pressure ulcer was reported as a serious incident in Q3 and the review is in process.

11.4 Emerging themes in this reporting period have been 'ill fitting' shoes and non-compliance with treatment plan due to mental state.

11.5 During Q3 the Tissue Viability Nurse (TVN) trained 29 staff from across the trust in pressure ulcer prevention and wound care. The TVN also took part in Frailty Week, with a 'drop in' for staff and delivered a session on pressure ulcer prevention as part of the Physical Health conference.

11.6 The TVN had a stall at the Colonnades for international Stop the Pressure day in November, which was well attended. The TVN continues to visit and support service users and staff across all Trust services.

11.7 A pilot of use of a SEM scanner on Lambourn Grove has been completed in Q3 and the evaluation is in process. Of note only one pressure ulcer was identified on a service user who could not be scanned during the pilot.

12 Falls

12.1 64% of falls in Q3 occurred in the Trust's Older People's Services. Chart 6 shows that in Q3 there were a total of 96 falls recorded on Datix across Older People's inpatient services. This was a decrease of 29 falls (125 =23%) from the previous quarter.

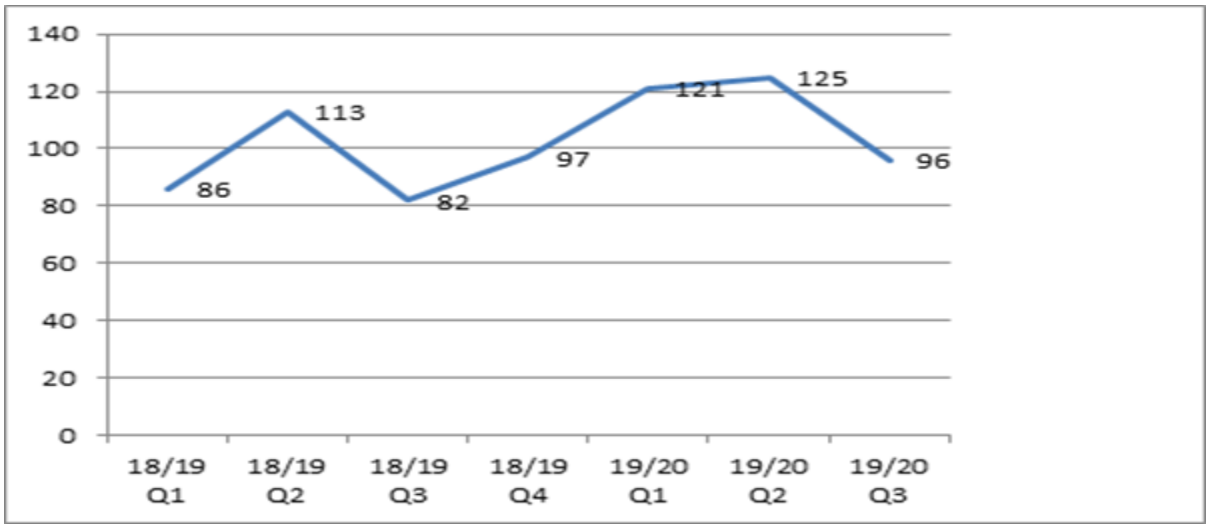


Chart 6 Falls reported Q1 18/19 to Q3 19/20 in Older People's services

12.2 The top 3 reporters in Older peoples services were Lambourn Grove (34), Seward Lodge (25) and Victoria Court (16). Some service users had more than one fall. An analysis of the falls data is undertaken at a local level to identify any actions needed. Service user fall on the same level (44) and service user suspected fall (35) were the top two types of fall reported.

12.3 A review of all the completed Falls RCA's reported as serious incidents in the last 12 months was undertaken and the findings disseminated Trust-wide by way of a learning note in Q3. The themes were as follows:

- Review of Falls Care Plan & Multifactorial Falls Risk Assessment
- Post Falls Protocol recording of actions taken
- Medication including pain relief
- Physical health History
- Postural hypertension
- Use of SBARD (Situational Background Assessment Recommendation Decision) as a communication tool
- Food & Fluid intake

12.4 A CQI project in relation to community falls supported by an Advanced Physiotherapist is in process. A second CQI project on implementing the Frailty pathway and the multi factorial risk assessment is ongoing.

12.5 As a result of four falls in Specialist Residential services it was identified that the needs of the service users on SRS are changing and they are an ageing population. The Modern Matron is supporting work on falls prevention in SRS.A CQI Falls Project is in process.

13. Never Events

13.1 Never Events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented. What is defined as a Never Event is provided by NHSE/I. The Trust reported no Never Events in Q3, 2019/20.

14. Mortality Governance including LeDeR

14.1 The Mortality Governance team ensure there is a system for reviewing and learning from deaths. In Q3, 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 Q3 2019/20 (Chart 7. Deaths reported in Q3 2019/20 (129) increased when compared to the previous quarter (104). It should be noted that deaths can be reported retrospectively and therefore these numbers will vary over time.

	East & North SBU	Essex & IAPT SBU	LD&F SBU	West Hertfordshire SBU	Total
18/19 Q3	75	0	18	32	125
18/19 Q4	76	13	17	25	131
19/20 Q1	54	6	9	24	93
19/20 Q2	65	14	5	20	104
19/20 Q3	73	11	25	20	129

Chart 7 Deaths by SBU reported on Datix in Q3

14.2 The Trust reported 29 deaths to the LeDeR programme in Quarter 3. The Mortality Governance Team screen deaths and identify cases, and Structured Judgement Reviews (SJR) are completed for any meeting 'red flag' criteria. These are concerns about the care raised by family, carers or staff, diagnosis of psychosis or eating disorder at the last episode of care, psychiatric inpatient at the time of death or discharged from inpatient care within the last month, under Crisis Resolution & Home

Treatment Team at the time of death, other locally determined criteria for review or case selected at random.

14.3 In Q3 2019/20, the Mortality Governance Team completed a total of 21 SJR's. A variety of approaches such as SWARMs and reflective discussions are used to aid reflection with the team involved.

15. Prevention of Future Deaths Reports (PFDs)

15.1 In Q3, the Trust received no Regulation 28 Prevention of Future Death (PFD) reports from HM Coroners. All PFDs that are reported nationally are reviewed and provide us with an opportunity to discuss and review our own processes and systems with a view to reflect and learn. PFD's are also presented to the Safety Committee and key learning points are disseminated for the purposes of wider learning. The key areas of reflection for the Trust in this quarter arising from PFD's were responsibilities of mental health services when a service user is absent without leave to return them to the ward when located by police; risk assessment and information sharing within prison healthcare, and crisis response and engagement of families.

16. Independent review of gross negligence, manslaughter and culpable homicide

16.1 In 2018 the General Medical Council commissioned an independent review to consider how the laws of gross negligence manslaughter and culpable homicide are applied to medical practice, following the sad and unexpected death of a patient. This was part of a wider programme of work to support profession to deliver good care.

16.2 The report was published in this quarter and seven recommendations were made. The importance of a just and learning culture and the need to learn, not apportion blame when things go wrong was noted. The report provided a summary of criminal law and medical regulation applied in practice and how this can also support a just and learning culture.

16.3 Quality of record keeping and the need for a comprehensive investigation undertaken by staff who are trained and understand the focus on reflection and learning. Support for staff attending Coroners courts and early contact with families when things go wrong are also highlighted as key areas of focus.

16.4 The recommendations from this report are reflected in the Trust Quality Strategy but a full gap analysis of the report will be taken to the Safety committee, with the plans for addressing any gaps, in Q4.

17 Service Users Experience of Feeling Safe

17.1 The question "Overall, have you felt safe on the ward?" is asked on our Having Your Say Inpatient surveys. The question enables us to understand how safe service users feel whilst in inpatient care. This information is used to understand key areas of feeling safe, enhance physical support, privacy, dignity and respect, quality of treatment and care and equity which enables us to continuously improve.

17.2 The feeling safe score Trust-wide decreased slightly to 78% in Q3 from 79% in Q2.

17.3 The feeling safe score for CAMHS rose in Q3 to 67% compared to 46% in Q2. Young people in Forest House were involved in co-producing changes to the survey moving the "safe" question to the beginning of the survey and reducing the number of

questions, this change has had a significant impact on the satisfaction scores across the survey. The Young Peoples' Participation Lead has also been explaining the purpose of this question to the young people during the Forest House Council meetings.

17.4 The score for Acute 24/7 services in Q3 remained unchanged at 76%, compared to Q2. There was a 1% decrease in responses received to the inpatient survey feedback. Both Owl and Oak Ward scored 100% but Robin Ward scored 69%, Swift Ward 81%, Thumbswood 100%, Albany Lodge 44% and Aston Ward 25%. Aston Ward only had 4 respondents. Owl ward had a 15% increase in service users feeling safe in Q3 which followed actions to ensure service users had 1:1 time every day.

17.5 There were 27 responses to the feeling safe question in Q3 in LD&F services, the score was 88%. Astley Court had a 10% increase in service users feeling safe compared to Q2, the team have been working hard to ensure service users have fun activities on a regular basis. Warren Court had a 57% increase, the team have been encouraging service users to report concerns to the named nurse, staff have also been encouraging interactions with other peers to ensure service users feel included and suppported. Hampden House had a 26% increase in feeling safe.

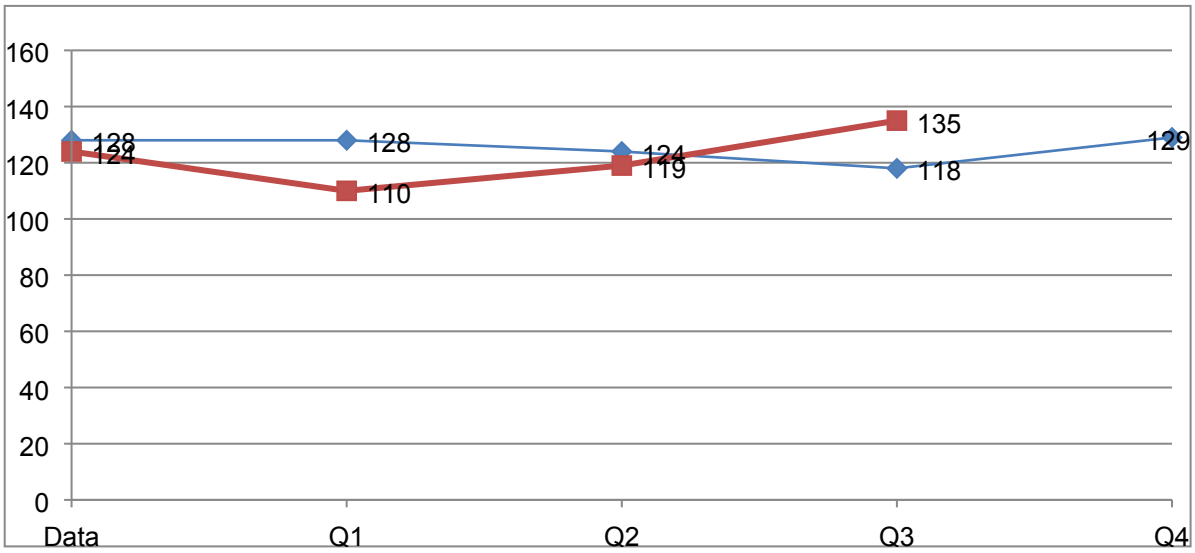
17.6 The recommendations from the Peer Experience Listening Safety on Wards Project that was undertaken in Q2, 2019/20 were co-produced and a draft report produced in Q3, 2019/20. The recommendations are waiting to be agreed by West SBU at which point the finalised report and recommendations can be distributed trust wide. Recommended actions will be implemented and monitored for improvements.

18. Safeguarding

18.1 HPFT has responsibilities for Safeguarding Adults and Children in all geographical areas that services are provided. Additionally, in Hertfordshire, the Trust has responsibilities, in partnership with Hertfordshire County Council (HCC), for undertaking Safeguarding Adult enquiries and decision making for adult mental health cohort and their carers. These were formally part of the delegated responsibility but now form part of a section113 Agreement whereby HPFT staff undertake Reserved Safeguarding Functions under new governance arrangements.

Safeguarding Activity for Children

18.2 Chart 8 shows that in Q3 there has been a 13% increase in safeguarding children concerns, which has continued from the upturn seen in quarter two. This is a result of a change in HPFT policy, in line with the introduction of the Hertfordshire Children's Services portal. The policy now requires that all safeguarding referrals are made on the portal and that a Datix is completed regardless of the level of risk. Historically the policy stated only Child Protection referrals required a Datix.



. *Chart 8 - Child Safeguarding Incidents by financial quarter*

Red- 2019/ 20 Blue- 2018/ 19

18.3 Chart 9 shows Safeguarding Children alerts by category of abuse. This quarter there has been a 31% increase in the number of emotional abuse cases reported. This is also attributed to the recent policy change as emotional abuse is more likely to be reported at a sub-child protection level, thus many referrals have not previously been reported as they did not meet this threshold.

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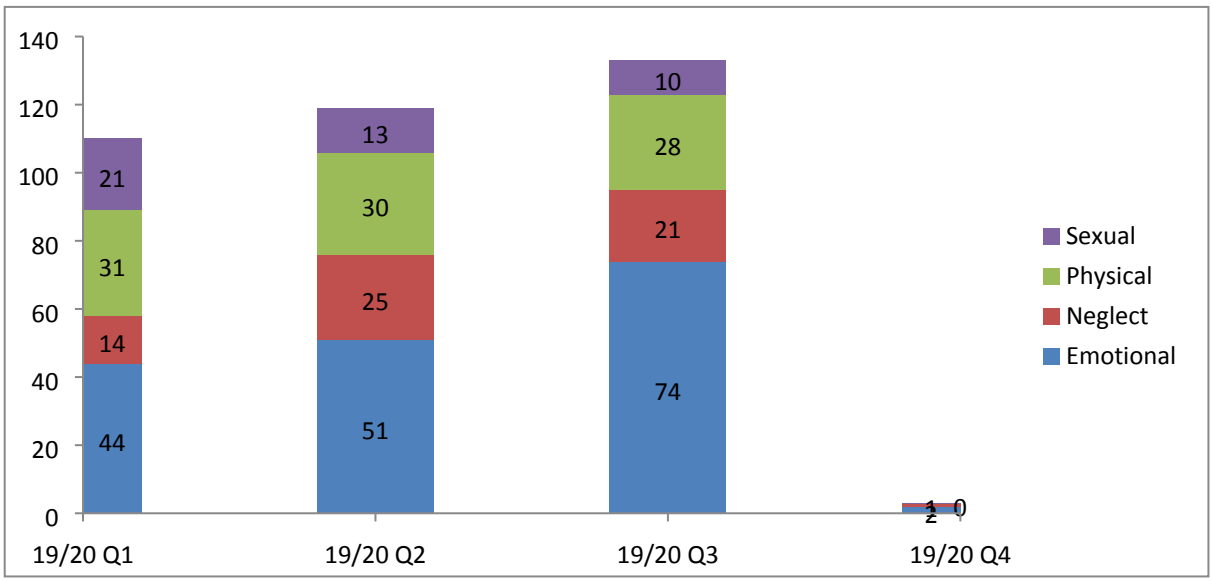


Chart 9 – Child Safeguarding by Category of abuse

Safeguarding Children Practice Development

18.4 A system has now been developed to embed a safeguarding tab in the staff caseload tool on SPIKE. This enables alerts to pull through which can be drilled down to case detail and provides a one view mechanism for individual caseload oversight for

supervisors and managers. To ensure that we embed a "Think Family" approach the safeguarding adult information will also be added to this.

18.5 A Named doctor for Safeguarding Children has now been appointed and will commence her role in January 2020. Dr Tamari has significant experience in the Named Doctor role within Hertfordshire and her knowledge, experience and existing networks will be an asset to safeguarding in the Trust.

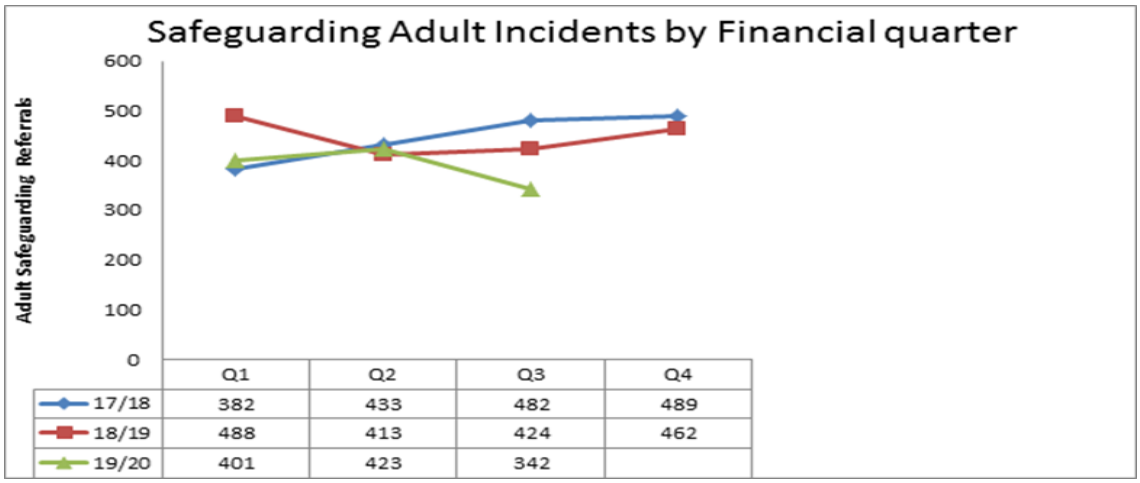
18.6 Safeguarding supervision compliance data is now reportable from Discovery. A majority of teams are reporting 100% compliance. In areas where we have not yet achieved full compliance we have been assured that safeguarding is discussed and recorded in MDT and in team meetings, in addition to informal supervision. A plan is now in place to improve supervision recording and the frequency of structured one to one supervision within these teams.

18.7 In order to further embed "Think Family", the safeguarding team are focusing on learning from cases where both adult and child needs and risks have been identified, within a family context. In quarter three learning was disseminated following an incident where adult community mental health services were working with a woman who was pregnant and who also had complex mental health needs. Missed opportunities were identified in the areas of multi-agency working and management oversight that may have prevented a social and emotional crisis at the time of delivery.

Safeguarding Activity for Adult

18.8 Chart 10 below shows that there has been a significant drop (34%) in Safeguarding Adults incidents reported in quarter three (342) in comparison to quarter two (423).

18.9 After reviewing other data sources an issue with recording and reporting has been identified. This is currently been investigated further and once addressed it is anticipated that there will be a sharp increase in reported activity.



	Q1	Q2	Q3	Q4
17/18	382	433	482	489
18/19	488	413	424	462
19/20	401	423	342	

Chart 10 – Safeguarding Adult incidents by financial quarter

18.10 Chart 11 shows that 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 is service user to service user physical or verbal abuse

within our inpatient services. Improvement work in this area is being led by the Prevention and Management or Violence and Aggression Leads as outlined in this report.

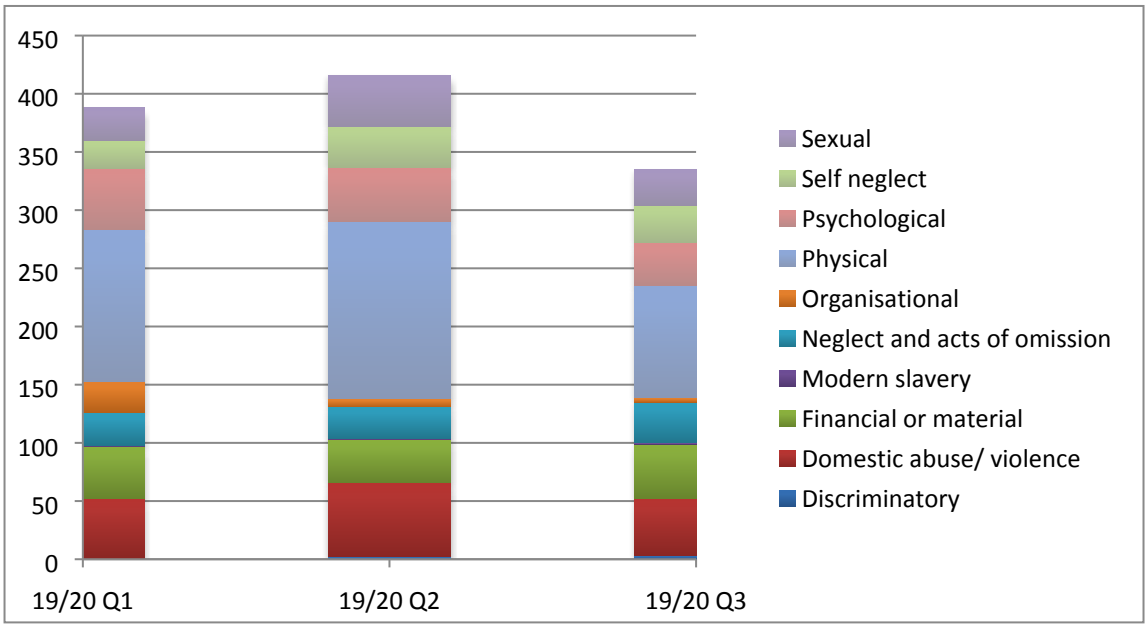


Chart 11 Safeguarding types of abuse by quarter

18.11 There has been an increase in the reporting of financial abuse in this quarter. This could either be a result of increased awareness following a recent HSAB campaign or an increase in actual incidents. The Hertfordshire Fraud Strategy 2019-22 reported that people with mental illness or learning disabilities are significantly more likely to be a victim of financial abuse.

18.12 In 2020/21 financial and material abuse, including online/telephone scamming will be HSAB areas of focus and will be incorporated into the HPFT Safeguarding Improvement Plan 2020/21.

18.13 Although the identification of Domestic Abuse has improved across HPFT, reporting remains very low within our Mental Health Services for Older People (MHSOP). This is an area where we would anticipate higher levels of abuse against Carers which is commonly associated with Dementia. The Consultant Social Worker and Named Doctor for Adult Safeguarding have delivered a presentation to MHSOP to highlight the key risks and vulnerabilities for this group, the support available for people experiencing domestic abuse, including the Multi-agency Risk Assessment Committee (MARAC).

18.14 During Q3 HPFT referred 29 cases to the Independent Domestic Abuse Advisors (IDVA) 4 of which were referred onto MARAC as high risk victims for enhanced risk management

Safeguarding Adult Practice Development

18.15 The new Hertfordshire Safeguarding Adults team was launched within Hertfordshire County Council in Q1 2019/20 and provides a central response to all Safeguarding Adult concerns in Hertfordshire. At present HPFT will continue to respond to Safeguarding concerns for people within the scope of mental health services

however the plan is for HPFT to integrate into this team through the colocation of staff in 2020.

18.16 A majority of the posts for the centralised team have now been recruited to and the staff are currently undertaking an extended induction in HPFT to develop knowledge, expertise and networks. A migration plan is currently being developed to transfer responsibility to the Centralised Safeguarding Team.

Sexual Safety Collaborative

18.17 HPFT 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 mixed sex communal environments.

18.18 The project team are currently in the process of gathering baseline data, including that obtained from staff and service user surveys. Survey results indicate that a majority of staff and service users feel sexually safe (90%) on wards however areas for further area for improvement have been identified as follows:-

- Improve reporting of sexual safety incidents
- Enhance the sexual safety of LGBTQ service users

18.19 Actions will be identified after the first Collaborative Action Learning set in January 2020, which will be attended by the Team Leader from Swift Ward, Consultant Social Worker and a service user representative. Wider learning from other partners in the Sexual Safety Collaborative will be brought into the HPFT Sexual Safety Group for consideration and implementation as appropriate.

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).

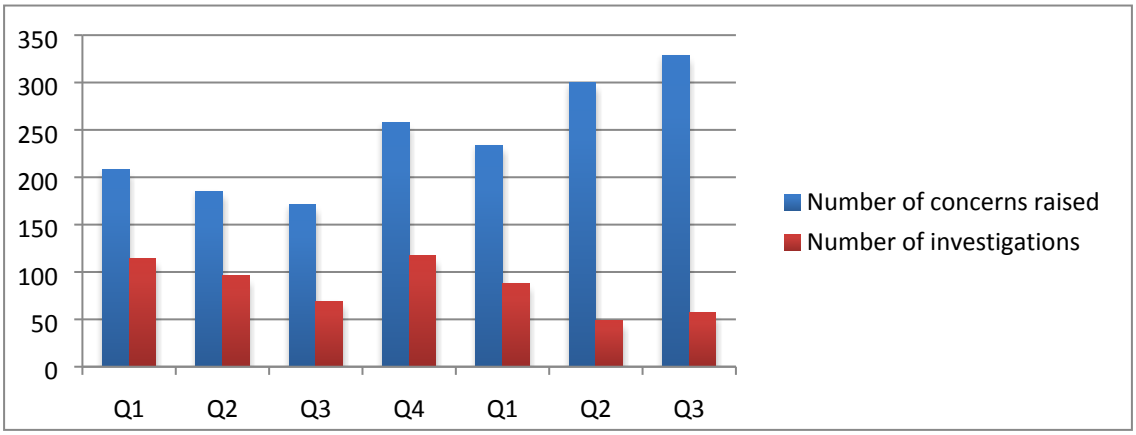


Chart 12 – Statutory safeguarding adults concerns and enquiries

18.22 Despite the increase in concerns the conversion rate has decreased from 34.2% in Q1 to 17.5% in Q3. This is significantly below the variation seen across 2018/19 and also below the conversion rate across other service user groups in Hertfordshire which is approximately 50%. A PACE audit has been completed which provided assurance regarding safeguarding adult practice; however significant issues in recording were identified which have impacted on the conversion rate. An action plan is now in place to address these issues.

18.23 Live reporting is now available in SPIKE2 which will enhance management oversight and enable accurate reporting. This follows a period were live reporting was not available due to issues brought about by the with SPIKE upgrade, which have now been resolved.

Prevent and Channel Panel

18.24 HPFT did not make any referrals to Prevent in quarter three however we continue 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 Consultant Social Worker for Safeguarding Adults attends Channel Panel and will facilitate 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.

18.25 In response to a decrease in referrals the Consultant Social Worker is undertaking a programme of visits to teams and practice governance forums to raise awareness of the vulnerabilities of people with mental illness being radicalised.

Audits

18.26 During Q3 Safeguarding Adult Practice audit was completed: The purpose of this audit is to provide assurance that the safeguarding adult process is being adhered to and that Trust policy is being followed to ensure that the process of safeguarding is being applied consistently

18.27 *Areas of Good Practice*

- 80% of the cases that progressed to enquiry had approved minutes distributed within 10 working days.
- 100% of cases where a safeguarding form was identified, the form was completed comprehensively.
- 100% cases that progressed to case conference, the conferences occurred within 3 months. **(100%)**

18.28 *Areas for Improvement*

- 26% of safeguarding concerns raised did not have completed safeguarding documents on EPR.
- The statutory eligibility criteria or is not being appropriately applied in decision making in relation to whether cases progress to enquiry.

18.29 Overall the audit provided high levels or assurance and the areas for improvements have been developed into an action plan which will be reviewed at the Safeguarding Strategy Committee.

18.30 Appendix A of this report provides an overview of high profile safeguarding cases. High profile cases relate to people who have suffered death or serious injury through suspected abuse or neglect.

19. Ligature Incidents

19.1 In Q3 2019/20, there were a total of 149 ligature incidents reported across all Trust inpatient services, which is an increase of 56 in comparison to the 93 reported in the previous quarter and a continual increase over the past 4 quarters.

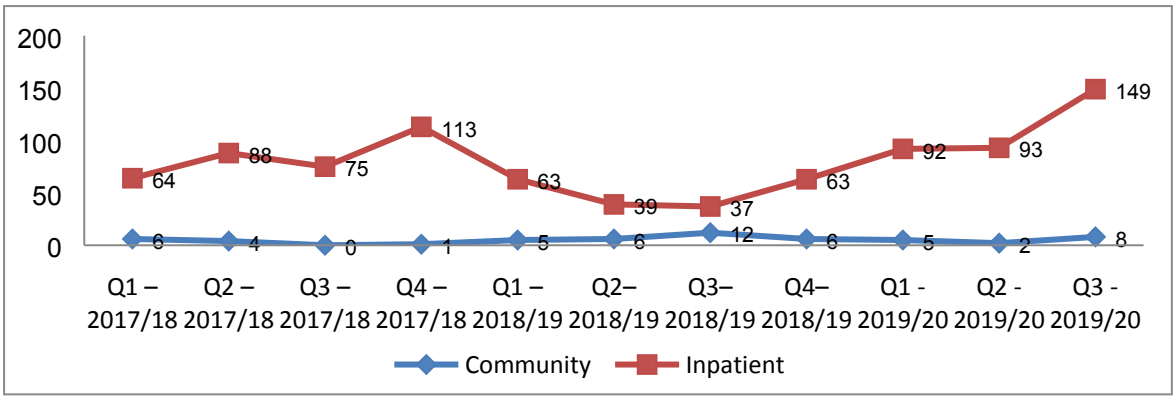


Chart 12 ligature incidents during Q3 2018/19 to Q3 2019/20

19.2 Robin ward accounted for the majority of incidents with 89 (60%) in the quarter. Most other incidents occurred on Albany Lodge with 39 (26%) and Forest House Assessment Unit 8 (5%). Four individual service users on Robin ward were involved in all the incidents there. They all have a diagnosis of Emotionally Unstable Personality Disorder.

19.3 In response to the increase in self-injurious behaviour over the quarters, in this quarter, Robin ward introduced a new search procedure and use of a Pro-Screen metal detector as part of an ongoing Continuous Quality Improvement (CQI) project. This has led to strengthened process in search which has helped to screen for prohibited items that may be used to self-harm.

19.4 Whilst this has led to a decrease in self-injurious behaviours involving sharp objects, the aforementioned four individual service users have subsequently used items to self-ligature. Focused work was undertaken to understand and manage a clinical challenge where small numbers of service user's account for high numbers of incidents and this has resulted in the method of self-harm changing. The newly developed EUPD pathway forms the strategy for addressing this.

19.5 Ligature incidents using clothing remains the category with the highest number of incidents of this type on the inpatient units. Staff continue to remain vigilant around potential risk in this area and an internal safety alert has been disseminated.

19.6 There were 5 ligature incidents involving anchor points during quarter 3, 3 of which involved the same service user on Albany Lodge and all 5 five anchor points involved the use of doors. Although door are antiligature doors, new risks have been identified and options included assisted technology or door sensors with conected alarms are being investigated.

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

20.1 This incident type relates to service users who leave the support of the service in an unplanned way and consider:

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

20.2 Incidents can indicate concerns about safety, it is also important to consider them in the context of positive risk taking as part of planned care, recovery principles and work towards discharge. During Q3, there was a significant decrease in the number of reported AWOL and missing person incidents (28) when compared to the previous quarter (57) (chart 13).

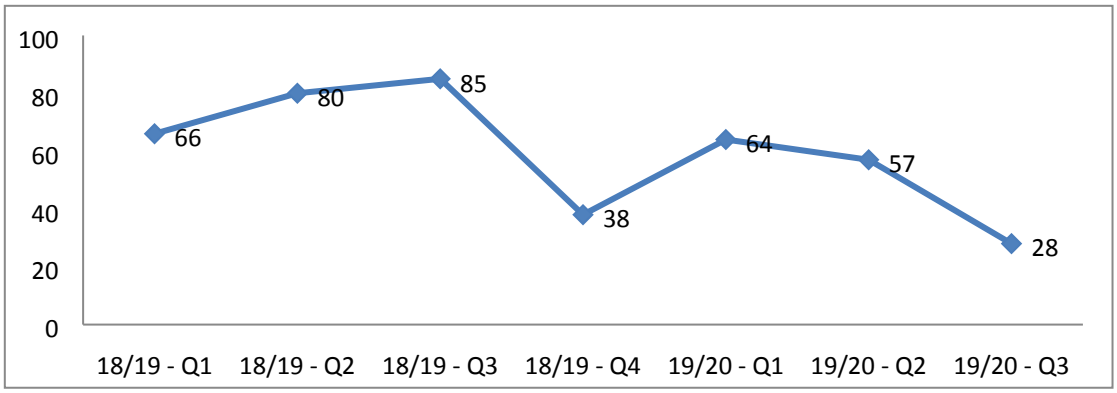


Chart 13 AWOL and Missing Person incidents Q1 18/19 to Q3 19/20

20.3 Beacon had 10 (36%), Robin Ward 6 (21%) and Albany Lodge 4 (14%) were the top three reporters of AWOL and Missing Person incidents with the highest reported sub-category of incident being Missing Informal (36%) followed by Failure to Return section 17 leave (32%).

21. Violence and Aggression

21.1 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 by the Practice Development and Patient Safety Team working with the Strategic Business Units. Each category shows a trend analysis for the past two years to give context to the reporting in terms of emerging trends and identify actions required.

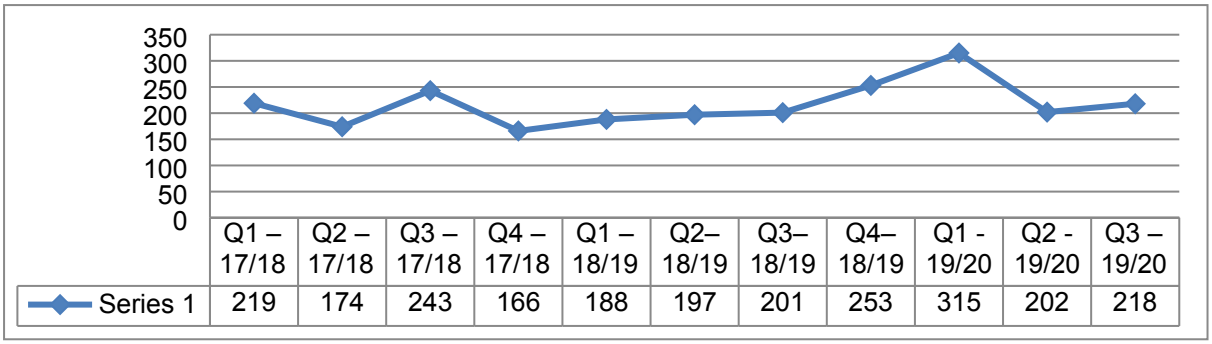
21.2 The CQI project into aggression on Oak Ward using the Broset Violence Checklist is continuing into Q4 to allow staff to better predict when people are at risk of becoming aggressive and provide earlier intervention.

Service User to Staff Assaults

21.3 The top 3 reporters in Q3 are Logandene, Aston Ward and Broadland Clinic. There are two CQI projects within the mental health inpatient services for older age adults; the first is to increase incident reporting and the second to understand the issues relating to meeting personal care needs and the risk of violence and aggression towards staff.

21.4 The reductions in violence to staff principally relates to a small number of service users, who present with a range of behaviours such as ligature use, cutting and self-harming, combined with assaultive behaviour and therefore pose significant challenge. The incident trend on analysis also shows there is a greater risk of staff assault when restraint is used as a response to challenging behaviour.

21.5 Service user to staff assault data (chart 14) shows a steady increase over six quarters (Q4 2017/18 – Q1 2019/20). It should also be noted that in Q2 2019/20, there has been a 36% decrease in this incident type and a small (16) increase from Q2 2019/20 to Q3 2019/20. When the trend is looked as a whole over this two year period the number of incidents has not changed.



	Q1 – 17/18	Q2 – 17/18	Q3 – 17/18	Q4 – 17/18	Q1 – 18/19	Q2– 18/19	Q3– 18/19	Q4– 18/19	Q1 - 19/20	Q2 - 19/20	Q3 – 19/20
Series 1	219	174	243	166	188	197	201	253	315	202	218

Chart 14 Service user to staff assault data Q1 17/18 to Q3 19/20

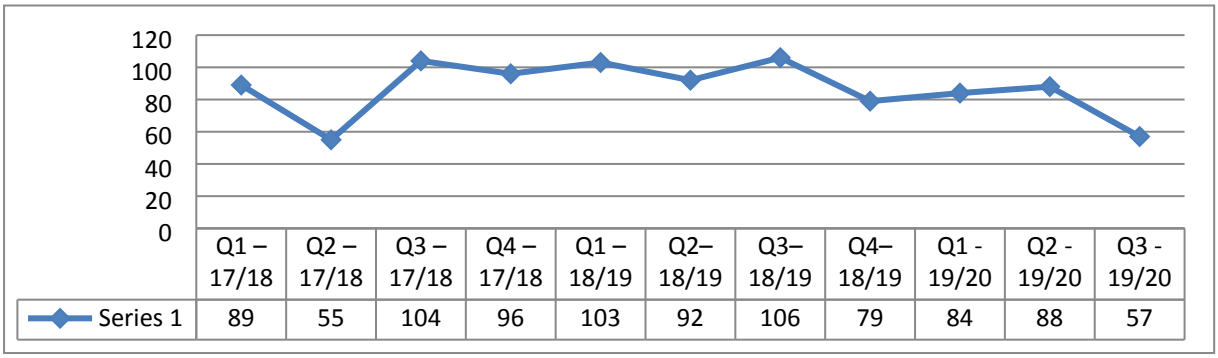
21.6 On the Lexden Assessment and Treatment Unit, 1 service user accounted for the majority of the assaults which was part of the assessment phase and where levels of challenge are anticipated. Support is offered to staff using the TriM model.

21.7 On review of harm as a result of service user on staff assaults, 112 (52%) resulted in no harm, 99 (45%) resulted in low harm, 7 (3%) resulted in moderate harm and no severe harm. There were 218 incidents of violence and aggression reported in Q3 with the top 3 reporters were Lambourn Grove (12%), Astley Court (11%) & Dove ward (11%).

21.8 Under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) the Health and 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 7 consecutive days as the result of their injury. In Q3, the Trust made 4 RIDDOR reports to the HSE, 3 of which were attributed to violence and aggression resulting in staff being on sick leave for 7 days or more. Support was put in place for those staff.

Service User to Service User Assaults

21.9 In Q3, there has been a significant decrease (46%) in service user to service user assaults.



	Q1 – 17/18	Q2 – 17/18	Q3 – 17/18	Q4 – 17/18	Q1 – 18/19	Q2– 18/19	Q3– 18/19	Q4– 18/19	Q1 - 19/20	Q2 - 19/20	Q3 - 19/20
Series 1	89	55	104	96	103	92	106	79	84	88	57

Chart 15 Service user to service user assaults Q1 17/18 to Q3 19/20

21.10 69% of service user to service user assaults resulted in no harm, 26% in low harm, 5% in moderate harm and 0% in severe harm. All 4 SBUs reported reductions in service user to service user actual assaults, with the breakdown as follows: East and North SBU 32%, West SBU 29%, Learning Disability and Forensic SBU 41% and Essex SBU 50%.

21.11 The top two reporters of service user to service user assaults in Q3 were Logandene (9) and Dove Ward (9); 4 of the incidents on Logandene involved the same service user.

21.12 The Community Violence and Aggression Task and Finish Group will continue with its work into Q4, with a focus on the training of lone workers and safety of staff working in the community. A communications plan is being launched with a poster campaign setting out the organisations approach to personal safety.

22. Self – harm – Head banging

22.1 Head banging can be complex to manage which may involve a higher risk of restrictive practices and potential conflict. There is a larger number of incidents in learning disabilities and forensic services but, in recent times the Trust has seen an increase in head banging outside of these services particularly by individuals diagnosed with a Personality Disorder or a psychosis.

22.2 Outcomes from head banging can range from mild and less damaging injuries, to severe and potentially life threatening. It is important that regular review of such self-injurious behaviours considers the severity and the potential risk to life, and with protection plans in place to manage the risk of immediate and future harm. Additional outcomes of head banging can relate to cuts, bleeding, infection, retinal detachment and blindness, bruising with possible permanent injury to ears, hearing and speech. This can lead to Traumatic Brain Injury with an increased risk via repeated blows to the head.

22.3 In Q3, a guidance note was issued around staff response, physical health monitoring and red flag symptoms. Into Q4 staff are being supported to both manage this behaviour and its consequences.

23. Restrictive Practices

23.1 Over the past two years, there has been a consistent level of use of restraint up to Q2 2018/19, followed by an increase from Q3 2018/19 to Q1 2019/20. In Q3 2019/20, there has been a decrease in overall use of restraints by 18% since Q1 2019/20 but this has not reduced to the level previously seen.

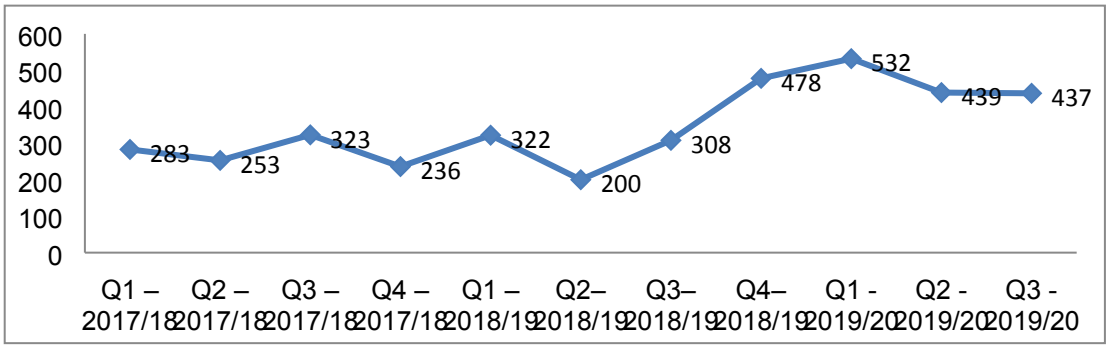


Chart 16 Restraint Q1 2017/18 to Q3 19/20

23.2 Robin ward reported 109 incidents which amounted to 25% of the total restraints for the Trust. Significantly, many of these incidents were attributed to self-harm behaviours such as the use of ligatures. Of the 109 incidents within Robin ward, 3 service users accounted for 98 of the incidents (service user A 39 incidents, service user B 38 incidents and service user C 21 incidents). The next highest use of

restraints was within Forest House (64) with the 3 young people accounting for 39 of the incidents.

Prone Restraint

23.3 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.

23.4 In Q3, there were no prone restraints reported. Overall, there are a low numbers of prone restraint incidents.

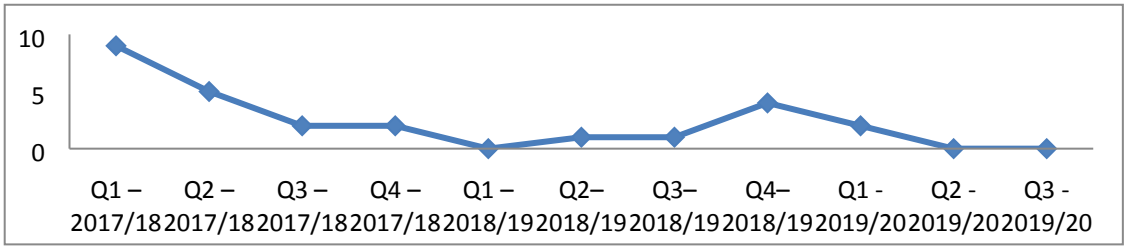


Chart 17 Prone restraint Q1 17/18 to Q3 2019/20

Long Term Segregation (LTS)

23.5 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 the report, 4 individuals were in long term segregation (LTS).

23.6 Service users in LTS are subject to daily medical reviews and a weekly MDT reviews to ensure that service users are kept in LTS for the shortest time possible. Actions being taken in each service area where a service user is in LTS are discussed at the Restrictive Practice Committee which enables robust challenge and learning being shared across SBU's.

Unit	Section	Start Date
2 Forest Lane	3	18 02 2010
Dove Ward	3	18 04 2018
House 5 Warren Court	3	17 08 2018
Dove Ward	3	20 12 2018

Table 18 LTS by unit, detention status and start date Q3 19/20

Seclusion

23.7 The use of seclusion peaked in use for Q3 2018/19 (chart 19), which related to Astley Court (57 incidents), Broadland Clinic (30) and Dove ward (30). Q3 saw an 18% reduction in the overall use of seclusion when compared to Q2 and a downward trend from the peak in Q3 2018/19.

23.8 From Q4 each SBU will be presenting a report of their restrictive practice data which include use of seclusion and actions taken. This will be reported on in further detail in Q4.

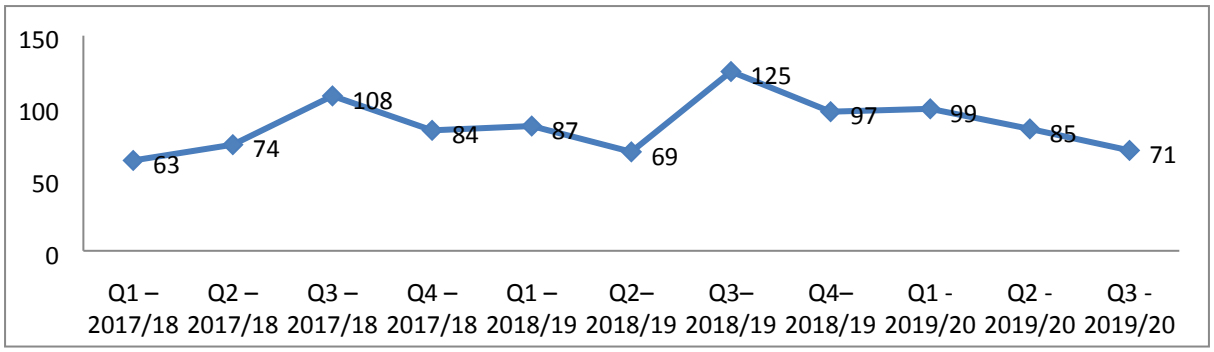


Chart 19 Seclusion data Q1 17/18 to Q3 19/20

23.9 Seclusion was used within 3 of the 4 SBUs- Learning Disabilities and Forensic (57), West (12) and Essex and IAPT (2). Whilst Learning Disability and Forensic SBU had more seclusion incidents, the average time spent in seclusion was lower when compared to West SBU.

Rapid Tranquillisation

23.10 Rapid Tranquilisation is the use of psychotropic medication to address disturbed behaviour. There has been a decrease in use of rapid tranquilisation since Q2 2019/20 (chart 20), the majority of these incidents occurred within the West SBU.

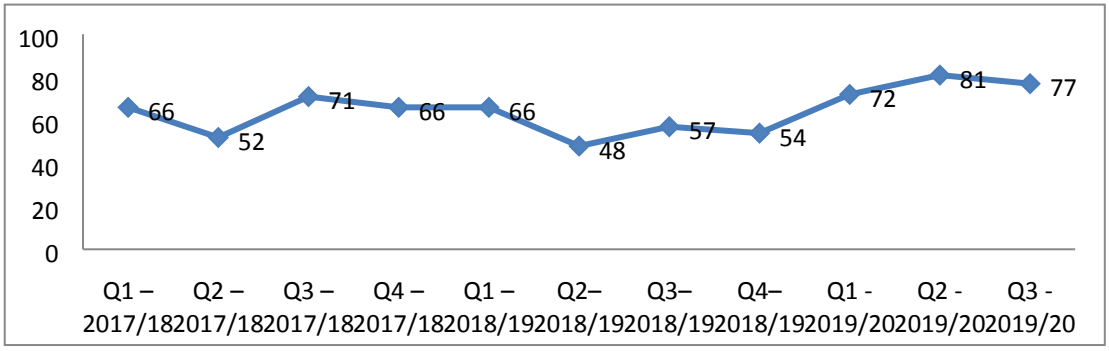


Chart 20 Rapid tranquilisation data Q1 17/18 to Q3 19/20

24. Conclusion

24.1 Section B of this report has given an overview of the incidents and serious incidents that have occurred in Q3 2019/20. Section C will detail learning and action that has taken place.

24.2 During Q3 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 the embedding of Think Family. Additionally the appointment to the Named Doctor for Safeguarding Children role has provided a further opportunity to further develop and enhance practice in this area.

25.4 The Corporate Safeguarding Team will continue 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."*

25.4 In March 2020 the Corporate Safeguarding Team will develop the 2020/21 Improvement Plan which will incorporate recommendations from our assurance visits, areas of improvement identified through SI or serious case reviews, HSAB and HSPC areas of focus and any other improvement work or opportunities that are carried over from 2019/20. This will be presented in the Q4 Integrated Safety report

25.5 Restrictive practice data is considered in conjunction with the violence and aggression, seclusion and restraint incident data to ensure triangulation.

25.6 Self – harm by head banging continues to be a concern for the Trust. In Q3, a guidance note was issued around staff response, physical health monitoring and red flag symptoms. Work will continue into Q4 to support staff to manage this risk.

25.7 In Q3, there has been a significant decrease (46%) in service user to service user assaults. Work is continuing as part of the Trusts commitment in its annual plan to reduce harm from violence and aggression incidents.

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 Q3 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. These are a way of ensuring that discussions about safety of the ward are taking place at each handover and also when staff or the teams have concerns about potential safety issues. Huddles are now well embedded across Trust services.

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 Ensuring that support for those affected or bereaved by suicide is a continued focus for the Trust; this includes service users, carers, families, staff, first responders and the wider community. The Trust and other key partners involved in the development and implementation of the Hertfordshire Suicide Prevention Strategy attended the Scrutiny Advisory Committee in October 2019 to provide assurance around partnership working. Three recommendations were made and a response setting out actions to be taken was provided by HPFT and Public Health. Implementation and impact of the recommendations will be considered by (ISAC) on 5th March 2020. The Head of Safer Care & Standards will be jointly facilitating a Bereavement workshop at the Hertfordshire Suicide Network Event on 31st January 2020 which will include a benefits mapping exercise. The Integrated Health and Care Commissioning Team are leading on a proposal for consultancy work to carry out a project to support Hertfordshire Adult Mental Health Services' stated aims and aspirations to ensure that adults bereaved by suicide are well met by access to appropriate bereavement support; to identify levels of need, current service provision and capacity and need for further service support and development.

2.5 Continued implementation of the Personality Disorder pathway remains a key priority for the Trust.

2.6 Work is continuing on falls prevention priorities and implementation of the STP frailty pathway through CQI methodologies.

2.7 There are a number of CQI safety related projects in process which include observation, search, falls and frailty and reducing violence and aggression during personal care.

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 from incidents. There is also a direct link to safety related learning that arises from discussions at the weekly Moderate Harm Panel where incidents graded as moderate harm and above are reviewed in detail.

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.

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

- A CQI project around search in response to self–harm and contraband items being brought onto the ward on Robin Ward.
- The Trust's Physical Health Consultant Nurse is supporting a CQI project on Specialist Residential Services around falls and frailty
- Safe and supportive observations CQI project led by the Head of Nursing in LD&F SBU.

4. Restrictive Practice

4.1 Robin ward reported 109 incidents which amounted to 25% of the total restraints for the Trust. Significantly, many of these incidents were attributed to self-harm behaviours such as the use of ligatures. Of the 109 incidents within Robin ward, 3 service users accounted for 98 of the incidents. The next highest use of restraints was within Forest House (64) with the 3 young people accounting for 39 of the incidents. Challenges relating to this risk behaviour is managed by the clinical teams with support of the Patient Safety and Practice Development Team where required. Data is overseen by the trust's Restrictive Practice Committee.

4.2 The MOSStogether Strategy sets the direction for providing safe and effective services, enabling a positive experience for those who receive our services. It supports and builds upon the Trust's Making our Services Safer (MOSS) Strategy. It ensures that safe services are provided, so that people feel safe whilst receiving our services. The Strategy identifies key priorities to support its implementation. It provides a 'menu' for staff to follow in both community and inpatient services as a means of proactive approaches that can be used to achieve the priorities. The implementation of the Strategy is supported by a work plan which is overseen by the Trust's Restrictive Practice Committee. The Strategy has been developed in light of currently available information, guidance and legislation and will be reviewed annually along with the actions in the work plan.

5. Sexual Safety

5.1 HPFT is part of the Sexual Safety Collaborative which is hosted and facilitated by the National Collaborating Centre for Mental Health. The pilot on Swift Ward which provides mixed sex communal environments will commence once the project team gathers baseline data obtained from staff and service user surveys. Survey results indicate that a majority of staff and service users feel sexually safe (90%) on wards however areas for further

improvement include reporting of sexual safety incidents and enhancing the sexual safety of LGBTQ service users. Actions will be identified following the first Collaborative Action Learning set in January 2020. Wider learning from other partners in the Sexual Safety Collaborative will be brought into the HPFT Sexual Safety Group for consideration and implementation as appropriate.

6. Pressure ulcers

6.1 Emerging themes in this reporting period have been 'ill fitting' shoes and non-compliance with treatment plan due to mental state.

6.2 During Q3 the Tissue Viability Nurse (TVN) trained 29 staff from across the trust in pressure ulcer prevention and wound care. The TVN also took part in Frailty Week, with a 'drop in' for staff and a formal session as part of the Physical Health conference on pressure ulcer prevention. The TVN had a stall at the Colonnades for international Stop the Pressure day in November, which was well attended. The TVN continues to visit and support service users and staff across all Trust services.

6.3 A pilot of use of a SEM scanner on Lambourn Grove has been completed in Q3 and the evaluation will be reported on in Q4.

7. Falls

7.1 A review of the completed Falls RCA's reported as serious incidents in the last 12 months was undertaken and was disseminated Trust-wide by way of a learning note in Q3.

7.2 The Trust's Advanced Physiotherapist is making links with the London Falls Prevention Network and the in Essex Partnership University Trust Falls Practitioner.

7.4 A Falls CQI project is being undertaken at Logandene.

7.5 The Advanced Physiotherapist regularly visits the wards to support work on assessing and managing falls risk, and is also supporting work streams including a falls awareness presentation and stall at the Physical Health conference, a falls champion training workshop, a review and refresh of the Falls policy and Falls RCA template and is also involved in the community falls pathway CQI project.

7.6 The E&N SBU Falls group meetings are taking place monthly and are facilitated by the Physiotherapist and chaired by a Modern Matron. Meetings are held at different locations each month to encourage attendance and input from all areas. Each team has a nominated falls champion who attends the meetings on the team's behalf.

7.7 Work in continuing into Q4 to embed the use of safety crosses in the Older People's wards to provide information on where the falls took place, time, location and any injuries sustained.

7.8 The Advanced Physiotherapist is supporting teams to complete quarterly reports and to take forward any recommendations.

7.9 Following the positive outcome of the trial of a mobility checklist poster in service user's bedrooms at Logandene as a visual check list/reminder of the aids that the service user requires at the start of each day, this will implemented on other wards during Q4.

8. Specialist Residential Services (SRS)

8.1 A Falls CQI project is in process in SRS which is reviewing themes and frequency of falls, environment, reducing harm from falls, equipment, staff skills around managing frailty including moving and handling, impact of nutrition and hydration on falls and completion of multifactorial falls assessments, care plans to manage falls risk and use the Rockwood Frailty Scale.

9. Ligatures

9.1 In Q3 2019/20, Robin ward introduced a new search procedure and use of a Pro-Screen metal detector as part of an ongoing Continuous Quality Improvement (CQI) project. Whilst this has led to a decrease in self-injurious behaviours involving sharp objects, the aforementioned four individual service users subsequently used items to self-ligature. This may indicate that when focused work is undertaken to understand and manage a clinical challenge where small numbers of service users account for high numbers of incidents, that the method of self-harm may change.

9.2 This requires ongoing monitoring at local level and more detailed analysis over time; during Q4, local standard operating procedures will be developed which will outline standards of search for individual wards with auditable criteria to measure quality improvement.

9.3 Ligature incidents using clothing remains the category with the highest number of incidents of this type on the inpatient units. Staff continue to remain vigilant around potential risk in this area and an internal safety alert will be disseminated in Q4.

9.4 There were 5 ligature incidents involving anchor points during quarter 3 2019/20, 3 of which involved the same service user on Albany Lodge and all 5 five anchor points involved the use of doors. A paper is to be presented to the Trust's Safety Committee to consider actions required around future management of this potential risk, such as assisted technology or door sensors with conected alarms.

10. Service user on staff assaults

10.1 Work is continuing on a poster campaign looking at how the Organisation supports staff around the impact of violence and aggression; this will be rolled out in Q4. A community violence and aggression focus group led by the Health & Safety Lead/Local Security Management Specialist and will continue into Q4. Work on personal safety and reducing harm from violence and aggression in the community is being supported by Hertfordshire University. Work is being overseen by the Health, Safety & Security Committee.

11. Safeguarding children

11.1 A system has now been developed to embed a safeguarding tab in the staff caseload tool on SPIKE (appendix 1). This enables alerts to pull through which can be drilled down to case detail and provides a one view mechanism for individual caseload oversight for supervisors and managers. To ensure that we embed a "Think Family" approach the safeguarding adult information will also be added to this.

11.2 A Named doctor for Safeguarding Children has now been appointed and will commence her role in January 2020. Dr Tamari has significant experience in the Named Doctor role within Hertfordshire and her knowledge, experience and existing networks will be an asset to safeguarding in the Trust.

11.3 Safeguarding supervision compliance data is now reportable from Discovery. A majority of teams are reporting 100% compliance. In areas where we have not yet achieved full compliance we have been assured that safeguarding is discussed and recorded in MDT and in team meetings, in addition to informal supervision. A plan is now in place to improve supervision recording and the frequency of structured one to one supervision within these teams.

11.4 In order to further embed "Think Family", the safeguarding team are focusing on learning from cases where both adult and child needs and risks have been identified, within a family context. In quarter three learning was disseminated following an incident where adult community mental health services were working with a woman who was pregnant and who also had complex mental health needs. Missed opportunities were identified in the areas of multi-agency working and management oversight that may have prevented a social and emotional crisis at the time of delivery.

12. Education and Training

12.1 Sepsis training was delivered on Lambourn Grove by the Physical Health Consultant Nurse in Q3.

12.2 A falls refresher session was delivered to SRS staff in response to learning from a serious incident.

12.3 Three Root Cause Analysis training sessions have been arranged for Q4 to boost the number of staff trained to undertake serious incident investigations. This will also ensure there is a focus on learning and improvement.

12.4 Clinical risk assessment and management is part of the Trust's overall risk management strategy and is fundamental to patient safety. The Trust employs the Department of Health's best practice around 'basic ideas in risk management' and 'individual practice and team working'. In Q3 funding was secured to develop a simulation training facility in HPFT. In Q4 a working group led by the Clinical Director in East & North SBU will meet to take forward development of a strategy for a simulation facility in HPFT for multidisciplinary staff.

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 Q4. In addition to this, these have been built on, from the learning in Q1, Q2 and Q3.

Annual Plan

i. Reducing suicides by 10%
ii. Feeling safe
iii. Reducing harm in relation to violence and aggression
iv. Seclusion environments and practice.

Strategy

v. Quality Strategy
vi. Making our Services Safer Together (MOSS 2gether)

Governance

vii. Safety Dashboard on Spike2 with KPI safety indicators will be completed and in use in Q4
viii. The root and branch review of the incident and serious incident process led by the Deputy Director of Nursing and Quality using CQI methodology was completed in Q3. A report will be presented to the Integrated Governance Committee in Q4 and recommendations will be taken forward and overseen by the Safety Committee.
ix. Some additional resource has been identified to support the Trust in its commitment to complete all serious incidents that are outside of nationally defined timeframes by the end of March 2020.

Learning from incidents

- Referral forms and on line self-referral portal for the Trust's Wellbeing Services were amended to include contact details of next of kin/relative/friends.
- The Safer Care Team have a learning summary section on the Trust's Hive intranet page to enable easy access to learning from serious incidents to aid discussion within team meetings and at local governance meetings. In East and North SBU a Cascade Bulletin is used to share learning from serious incidents.
- Medication concordance has been added as a prompt in the Paris Risk Assessment.
- Medication Compliance has been added into the Fundamentals of Care audit which is completed two weekly in the Crisis Assessment & Treatment Teams
- The Service Line Lead met with the local council to discuss and clarify pathway and referral process for those who require specialist mental health support. They clarified procedures around referrals.
- The Adult Community Mental Health Services Manager attends the monthly Watford Borough Council strategic homelessness forums meetings.
- The Service Line Lead for Adult Crisis Services and CATT Service Managers reviewed the risk assessment process within the CATT as outlined in the Crisis Assessment and Treatment Teams Operational Policy. Audit of risk assessment undertaken to seek assurance that changes had been implemented into clinical practice.
- Mental Health Helpline Protocol updated to provide further clarity on the process for when follow up actions are required following contact with the Mental Health Helpline; to include responsibilities and expectations of staff, and the service.

- Process devised, through co-production, by the Manager and Service Line Lead and written into the operational policy to ensure that telephone contact is made, where appropriate, with service users' who attend the Emergency Department and are assessed by the Mental Health Liaison Team for the first time where the outcome of the assessment is to refer them back to the GP.

Policy and Practice

x. The Wellbeing Operational policy was updated in May 2019 to include a specific section on discharge from Wellbeing services and a reference to the Trust's Did Not Attend / Not Brought in Policy.
xi. Falls CQI project has commenced on Logandene and will continue into Q4.
xii. The three month pilot of a SEM scanner used for detecting changes in sub-epidermal moisture (SEM) to show pressure-induced tissue damage was completed in Q3. Evaluation of the pilot will be completed and reported on in Q4.
xiii. NEWS 2 Training is being delivered weekly from March 2020
xiv. Physical Health training is being delivered in East & North SBU in Q4, in Essex Learning Disability Services in March 2020 and to preceptorship nurses in in March & April 2020
xv. Care of physically ill patient with learning disabilities conference is arranged for May 2020
xvi. Care of physically ill patient with serious mental illness conference is arranged for September 2020
xvii. Care of older people with mental illness arranged for October 2020

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item: 7**
Subject:	Quarter 3 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 3, 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 are asked to consider and note the contents of the report and discuss any point of clarification. To also receive assurance of the governance process for rostering and safe staffing.

Summary and recommendations to the Board:

The direct care nurse staffing data was analysed according to total hours worked per ward for RN and HCA, divided into day and night time hours and includes additional duties. Quarter 3 showed adequate staffing and shift cover in response to unexpected demand and levels of acuity and dependency on the wards.
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.
Increased focus on agency usage continued during the quarter with targeted plans for the SBUs.
The Trust's involvement in a number of programmes including the Student Nurse Associate, the Health and Care Academy and learning disability nurse apprenticeship are aimed to continue in the focus to recruit and retain nursing staff.

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:

None

Finance & Investment/Integrated Governance/Executive/Remuneration/ Board/Audit

None

Quarter 3 Safer Staffing Report 2019/20

1. Introduction

1.1 This report serves to provide the information and analysis of the quarter 3 nurse staffing data to enable the Board 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 Board reports.

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

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

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

2.6 *SafeCare* 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 3 nurse staffing data collection

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

3.2 Care Hours Per Patient Day (CHPPD) data 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. **Appendix 1**

provides detailed data for each inpatient or quarter 3. From quarter 4, this data will include in a separate column the data relating to the Registered Nurse Associates (RNA).

North Essex and IAPT SBU

3.3 There was no agency used during October at Lexden. During November there was only one agency shift booked, which was the same for December. However, the CHPPD hours remained high in comparison to other service areas which relates to agreed higher staffing levels owing to it being a stand-alone unit.

3.5 Opportunities have been provided to staff to have the opportunity to work alongside colleagues in both Community Nursing and Enhanced Support, gaining community experience.

East and North SBU

3.6 There has been a decrease in agency in October, in comparison to month 6 and a further decrease in bank usage across the SBU. However, this was followed by an increase in both bank and agency owing to an increase in reported sickness levels, an increase in prescribed safe and supportive observations and also some late cancellations of shifts by temporary staff.

3.7 Seward Lodge has continued to have high levels of safe and supportive observations as well as concerns regarding sickness levels and also vacancies. Challenges have further been exacerbated by HR processes.

3.8 Forest House Assessment Unit has also had challenges regarding vacancies and also the acuity with prescribed levels of safe and supportive observations. The Child and Adolescent Mental Health Services (CAMHS) Section 136 Place of Safety Suite opening was delayed owing to the number of vacancies and challenges to ensure it is safely staffed – options for which are being explored. However, the team have recruited to four Health Care Assistants (HCAs) and a second Team Leader; a recruitment day is planned for quarter 4.

West SBU

3.9 Staffing levels in October were higher than the staffing establishment across all of the inpatient service areas in the SBU as a result of high levels of acuity and also a subsequent increase in prescribed safe and supportive observation levels. Aston ward also required additional staffing in relation to environmental works. The use of enhanced observations as a key intervention remains a key area for review in the West SBU.

3.10 Improvements have been made in the Key Performance Indicators (KPIs) for all of the inpatient service areas during the quarter, however there have also been increases in the reporting of staffing incidents on Datix as well as issues with the completion of the SafeCare census. The SBU are therefore focusing on more targeted work in a number of areas including the review and management of therapeutic engagement and observation levels on the wards,

the use of alternative interventions including SafeWards methodologies, eRoster management of bank bookings, annual leave and ensuring staff are working to contracted hours whilst ensuring fairness to staff.

3.11 Further work is also required to ensure that all registered staff are conversant with the dependency levels in utilising the SafeCare census as well as the Team Leaders and Matrons increasing their awareness and understanding of budgets and spending on additional shifts with the provision of training sessions from the SBU's Finance Business Partner.

Learning Disability and Forensic SBU

3.12 Agency spend in Little Plumstead has continued to reduce during the quarter, however, it remains the highest spend within the SBU, with excessive hours shown at night at the Broadland Clinic. Consideration of working with NHSP remains ongoing.

3.13 There have been reported incidents on Datix of staff shortages on SRS owing to sickness as well as an increase in observation levels.

4. Bank and Agency

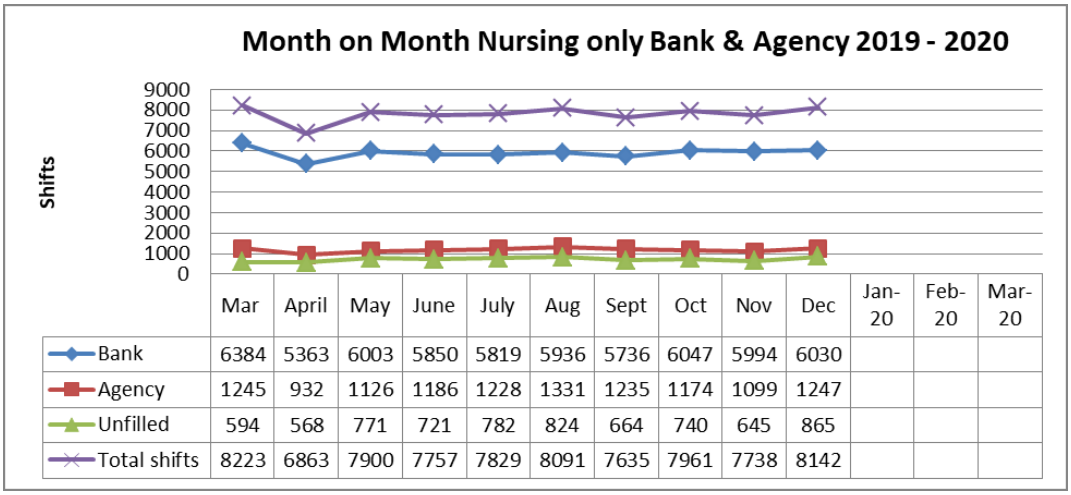
4.1 The overall bank and agency usage for quarter 3 is provided as a total number of shifts, over a 5 year period as shown in **table 1. Table 2** highlights the comparisons with the previous quarter of this year. Furthermore, **graph 1** shows the bank and agency use month on month for this financial year.

		October	November	December
2015	**Bank**	5763	5511	5200
	Agency	1334	1255	1515
2016	**Bank**	5388	5320	5081
	Agency	2017	2144	1894
2017	**Bank**	5702	5502	5645
	Agency	1742	1659	1545
2018	**Bank**	5448	5325	5334
	Agency	1174	1204	1080
2019	**Bank**	6047	5994	6030
	Agency	1174	1099	1247

Table 1

Q2 2019/20	July	August	September
Bank	5819	5936	5736
Agency	1228	1331	1235

Table 2



	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-20	Feb-20	Mar-20
Bank	6384	5363	6003	5850	5819	5936	5736	6047	5994	6030			
Agency	1245	932	1126	1186	1228	1331	1235	1174	1099	1247			
Unfilled	594	568	771	721	782	824	664	740	645	865			
Total shifts	8223	6863	7900	7757	7829	8091	7635	7961	7738	8142			

Graph 1

4.2 Although there has been an increase in agency use in month 3 of the quarter, overall there continues to be less agency usage in comparison to the previous years. Shifts covered by bank and agency have remained almost static during the course of this financial year, continuing into quarter 3, which is closely monitored by the SBUs and the monthly Safer Staffing Group.

4.3 As detailed in the quarter 2 report, the SBUs continue to work with their detailed plan trajectories, quantifying how they would keep agency expenditure wo within the agreed total with regular monitoring of actual spend against these trajectories. This is based on the successful reduction in agency spend in the last half of 2018/19, at the start of 2019/20 and the internal ceiling set of £5,800k spend to support the Trust's Delivering Value savings programme and the NHSI agency spend ceiling for 2019/20 of £7,327k.

4.4 In consideration of this, there are significant assumptions about reducing agency spend from month 10 onwards, in particular in the West SBU, which will be monitored closely.

4.5 The actions previously discussed at the Safer Staffing Group meetings therefore continued, including:

- 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.

4.6 During quarter 3, the Trust commenced its participation in a self-rostering pilot initiative to implement a team-based rostering system for nursing staff. Aimed at increasing nurses' input into their working patterns and improving work-life balance in the Trust and provide the nursing team with autonomy and permission to negotiate the eroster, in the context of being open and transparent. Inpatient services from each of the SBUs are participating in the pilot.

5. Vacancies

5.1 The Trust continues to have challenges with recruitment in quarter 3 as detailed in **Table 3**, which remains a focused priority with the SBUs and the corporate nursing services.

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex and IAPT	12.00	11.17	0.83	7
Learning Disability & Forensic	173.71	130.86	42.85	25
East and North	122.36	105.96	20.54	16
West	126.5	105.96	20.54	16
Total	**434.57**	**343.13**	**91.44**	**21**
Unregistered Nursing				
Essex and IAPT	15.00	16.43	-1.43	-10
Learning Disability & Forensic	215.71	173.46	42.25	20
East & North	197.73	167.48	30.25	15
West	130.77	105.93	24.84	19
Total	**559.21**	**463.30**	**96.91**	**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. The Deputy Director of Nursing and Quality/DIPC meets monthly with the University of Hertfordshire's Head of Nursing, Health and Wellbeing to build on the work with the students' placements, ensuring regular contact as their future employee and enabling a more smooth transition from student to registered nurse with the Trust being their employment area of choice.

5.3 Six monthly meetings with all learning disability and mental health student nurses continue with the Deputy Director of Nursing and Quality/DIPC and the Heads of Nursing to maintain contact with them, discuss their opportunities and also ensure they feel welcomed and part of the Trust.

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

5.5 A significant risk remains for the Trust regarding the profile of RNs who are able to retire, detailed in **Table 4**. Work continues to support them and explore their options to remain in the workforce.

5.6 During quarter 3, the Trust agreed to participating as a Health and Care Academy, working with Health Education England (HEE). Led by the Deputy Director of Nursing and Quality/DIPC, this is aimed at supporting and

developing young people and encouraging them into health-related careers, supporting the pipeline of individuals joining the NHS.

Area	55-59			60-64			65+		
	HCA	RN	Total	HCA	RN	Total	HCA	RN	Total
Essex and IAPT	2	3	5	2	0	2	0	0	0
LD and F SBU	33	18	51	10	9	19	5	0	5
E and N SBU	33	10	43	16	12	28	5	2	7
West SBU	19	12	31	13	6	19	3	4	7
Total	**87**	**43**	**130**	**41**	**27**	**68**	**13**	**6**	**19**

Table 4

5.7 The Academy concept allows the Trust to 'grow its own staff', linking with colleges and schools to recruit local people/students who may not have previously considered careers in healthcare. A Lead has been appointed to oversee the development of an interactive programme to support development into careers such as nursing as well as broaden knowledge and understanding of the NHS.

5.8 Working with the Talent Academy, plans are being finalised during quarter 4 to pilot two programmes starting as a summer school with 20-25 students for 5 days, with lesson plans focusing on mental health and learning disability.

5.9 The Trust has continued to lead on the Student Nursing Associate working group on behalf of the STP. The next cohort commences in quarter 4, and plans to externally recruit into a 'pool' across the STP are being processed ahead of quarter 1 2020/21 moving forwards.

5.10 Recruitment to undergraduate learning disability nursing is a challenge, with trainee numbers reducing nationally – especially over the last two years. The Trust has therefore participated in the recruitment of learning disability registered nursing degree apprenticeships (RNDA) tapping in to a pool of experienced health care workers.

5.11 HEE and the Capital Nurse Programme (CNP) aim to establish a London-wide learning disability RNDA cohort based on successful schemes elsewhere in the country and Hertfordshire University was selected as the preferred partner. The Trust has agreed to participate in this new pilot apprenticeship programme, working with other NHS Trusts and the University of Hertfordshire. At the time of reporting, the Trust was looking to enrol 7 of its staff.

6. Conclusion

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

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 continues for quarter 4 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 Trust's involvement in the SNA programme, the learning disability nursing RNDA and the Health and Care Academy are all aimed to improve recruitment and retention.

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

Appendix 1 - Nurse Staffing fill rate data

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	CHHPD RN	CHPPD HCA	Overall CHPPD
October 2019							
Learning Disability and Forensic SBU							
Gainsford House	102	124	102	103	4.2	2.3	6.5
Hampden House	103	115	100	99	5.0	2.6	7.6
Warren Court	100	100	100	100	5.2	7.3	12.9
4 Bowlers	110	93	100	100	4.3	5.0	9.4
Beech	109	102	102	126	3.4	5.3	8.7
Dove	94	118	100	130	3.2	9.7	12.4
SRS	98	107	100	102	3.0	10.3	13.4
Astley Court	68	186	102	186	1.9	5.2	7.2
Broadland Clinic	104	94	98	102	2.4	8.0	10.7
The Beacon	100	104	101	106	3.4	2.7	6.2
Essex & IAPT SBU							
Lexden	92.8	100	106.6	98.3	11.4	15.8	28.0
West SBU							
Swift	111	174	95.7	265	4.4	6.5	11.0
Robin	152	178	112	313	3.2	7.2	10.7
Owl	121	195	99.6	246	2.9	7.4	10.3
Oak	85.4	141	101	132	3.5	9.8	14.3
Thumbswood	179	115	106	119	8.1	11.6	20.7
Albany Lodge	108	148	100	208	2.4	5.3	7.7
Aston	103	139	99.7	133	3.9	6.8	10.8
East and North SBU							
Victoria Court	98.4	97.2	99.9	103.2	1.8	5.6	7.4
Forest House	101.0	135.3	95.2	187.2	3.2	12.2	15.4
Wren	103.2	90.6	100.0	100.0	3.1	6.4	9.4
Lambourn Grove	104.8	118.3	103.1	150.2	2.1	7.6	10.0
Logandene	103.8	93.5	98.3	102.1	3.2	7.2	10.8
Seward Lodge	82.8	96.3	95.1	100	2.8	7.1	9.9
November 2019							
Learning Disability and Forensic SBU							
Gainsford House	102	94	100	170	4.2	2.7	7.0
Hampden House	101	113	102	106	4.9	2.7	7.5
Warren Court	103	93	99	97	3.7	5.9	10.1
4 Bowlers Green	103	100	100	100	4.2	5.4	9.6
Beech	93	100	93	115	3.0	5.1	8.1
Dove	90	109	103	129	3.3	9.6	13.0
SRS	95	107	100	101	2.9	10.3	13.3
Astley Court	68	182	103	104	6.0	10.4	29.4
Broadland Clinic	126	94	91	105	2.8	8.0	10.9
The Beacon	95	103	93	120	3.5	2.9	6.5
Essex & IAPT SBU							
Lexden	99.3	100.8	99.7	99.8	18.2	22.4	40.5
West SBU							
Swift	110	166	97.7	283	4.4	5.8	10.4

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	CHHPD RN	CHPPD HCA	Overall CHPPD
Robin	143	213	100	103	3.0	7.2	10.4
Owl	121	191	100	200	2.9	7.5	10.4
Oak	102	165	100	145	4.8	11	15.8
Thumbswood	175	84.3	106	137	7.9	9.8	18.8
Albany Lodge	106	135	100	183	2.3	4.9	7.3
Aston	129	148	100	101	4.6	7.7	12.5
East and North SBU							
Victoria Court	94.2	103.2	99.9	111.1	1.8	5.9	7.6
Forest House	92.8	128.0	96.7	170.8	3.2	11.9	15.1
Wren	116.0	93.3	99.9	99.0	3.4	6.8	10.2
Lambourn Grove	99.3	100.8	99.7	99.8	2.2	7.8	10.5
Logandene	96.6	96.8	98.3	101.2	4.3	8.8	13.4
Seward Lodge	92.5	100.0	94.9	102.2	3.8	9.1	12.9
December 2019							
Learning Disability & Forensic SBU							
Gainsford House	102	119	100	123	4.0	2.3	6.3
Hampden House	100	99	98	103	5.1	2.6	7.7
Warren Court	97	107	99	99	3.7	6.4	10.5
4 Bowlers	102	103	103	99	4.1	5.4	9.5
Beech	102	103	103	99	2.5	3.2	5.6
Dove	94	105	110	105	3.2	7.7	10.9
SRS	103	106	97	107	3.1	10.4	13.6
Astley Court	67	184	102	99	4.6	12.6	17.2
Broadland Clinic	126	96	101	100	2.9	7.6	10.9
The Beacon	100	119	100	154	3.7	3.4	7.7
Essex & IAPT SBU							
Lexden	96.9	100	99.9	96.5	12.8	17.5	31.3
West SBU							
Swift	107	175	98.9	270	4.4	6.4	10.9
Robin	139	167	103	251	2.9	6.0	9
Owl	136	202	95.2	265	3.1	8.0	11.1
Oak	93.9	160	98.8	135	4.5	10.3	14.9
Thumbswood	155	83.5	100	120	8.4	11.7	20.1
Albany Lodge	104	117	101	160	2.5	4.7	7.2
Aston	125	163	100	182	4.3	8.1	12.5
East and North SBU							
Victoria Court	92.2	105.5	96.8	99.0	1.7	5.8	7.5
Forest House	102.6	127.4	112.9	176.4	3.5	11.9	15.5
Wren	115.0	94.5	104.7	108.5	3.3	6.7	9.9
Lambourn Grove	125.7	98.8	109.6	139.5	2.4	6.4	9.0
Logandene	106.8	96.0	108.0	114.6	3.7	7.8	11.8
Seward Lodge	96.3	93.0	95.3	98.8	3.7	8.1	12.0

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	11.17	0.83	7
Total	**12.00**	**11.17**	**0.83**	**7**
Learning Disability and Forensic SBU				
4 Bowlers Green	9.00	8.00	1.00	11
Beech Ward	14.20	10.00	4.20	30
Broadland Clinic	26.20	15.80	10.40	40
Dove Ward	12.00	8.13	3.87	32
Gainsford House	10.80	10.40	0.40	4
Hampden House	10.60	9.28	1.32	12
Astley Court	12.00	8.00	4.00	33
Warren Court	28.00	24.00	4.00	14
SRS Bungalows	16.00	11.00	5.00	31
The Beacon	11.31	8.28	3.03	27
Total	**150.11**	**112.90**	**37.21**	**25**
West SBU				
Albany Lodge	13.50	10.50	3.00	22
Aston Ward	15.00	13.82	1.18	8
Oak Ward	13.00	11.00	2.00	15
Owl Ward	11.00	9.64	1.36	12
Robin Ward	11.60	11.60	0.00	0
Swift Ward	18.00	17.00	1.00	6
Thumbswood	7.67	7.53	0.14	2
Total	**89.77**	**81.10**	**8.67**	**10**
East & North SBU				
Forest House	14.00	6.80	7.20	51
Lambourn Grove	11.04	9.77	1.27	11
Logandene	12.01	10.76	1.25	10
Seward Lodge	12.00	9.80	2.20	18
Victoria Court	12.64	8.96	3.68	29
Wren	11.14	10.61	0.53	5
Total	**72.83**	**56.70**	**16.13**	**22**
Overall Total				
NON-REGISTERED NURSING				
Essex and IAPT SBU				
Lexden	15.00	16.43	-1.43	-10
Total	**15.00**	**16.43**	**-1.43**	**-10**
Learning Disability & Forensic SBU				
4 Bowlers Green	11.02	9.01	2.01	18
Beech Ward	14.00	12.00	2.00	14

Broadland Clinic	42.60	32.59	10.01	23
Dove Ward	13.89	12.89	1.00	7
Gainsford House	5.40	4.40	1.00	19
Hampden House	5.00	4.00	1.00	19
Astley Court	11.40	10.00	1.40	12
Warren Court	37.00	30.00	7.00	19
SRS Bungalows	57.00	44.37	12.63	22
The Beacon	8.00	7.00	1.00	13
Total	**205.31**	**166.26**	**39.05**	**19**
West SBU				
Albany Lodge	20.80	16.40	4.40	21
Aston Ward	13.76	14.60	-0.84	-6
Oak Ward	17.00	10.64	6.36	37
Owl Ward	15.53	12.53	3.00	19
Robin Ward	17.20	12.53	4.67	27
Swift Ward	15.90	12.04	3.86	24
Thumbswood	9.60	7.00	2.60	27
Total	**109.79**	**85.75**	**24.04**	**22**
East & North SBU				
Forest House	25.70	10.00	15.70	61
Lambourn Grove	32.62	30.03	2.59	8
Logandene	31.72	26.19	5.53	17
Seward Lodge	22.13	18.77	3.36	15
Victoria Court	34.90	32.15	2.75	8
Wren	18.80	18.80	0.00	0
Total	**165.87**	**135.94**	**29.93**	**18**
Overall Total	**495.97**	**404.38**	**91.59**	**18**

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	0.00	0
Continuing Care & Placement Team	3.60	2.40	1.00	28
Criminal Justice & Forensic	1.00	0.00	1.00	100
Criminal Justice Mental Health	2.00	2.00	0.00	0
LD SLDS A&T E/N Team	8.00	6.36	1.64	21
LD SLDS A&T West Team	9.00	7.00	2.00	22
Total	**23.60**	**17.96**	**5.64**	**24**
East & North SBU				
AMHCS Centenary & Jubilee	14.60	10.31	4.29	29
AMHCS Cygnet House	8.59	5.90	2.69	31
AMHCS Holly Lodge	5.00	4.00	1.00	20
AMHCS Saffron Ground	9.34	7.20	2.14	23
AMHCS Oxford House	2.00	1.00	1.00	50
AMHCS Rosanne House	10.00	10.03	-0.03	0
Total	**49.53**	**38.44**	**11.09**	**22**
West SBU				
AMHCS NW Herts Dacorum	8.20	5.33	2.87	35
AMHCS NW Herts St Albans	7.33	3.73	3.60	49
AMHCS SW Herts	1.00	2.00	-1.00	-100
AMHCS SW Herts Borehamwood	7.20	6.60	0.60	8
AMHCS SW Herts Watford	13.00	7.20	5.80	45
Total	**36.73**	**24.87**	**11.86**	**32**
Overall Total	**109.86**	**81.27**	**28.59**	**26**
NON-REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	0.00	0.00	0.00	0
Continuing Care & Placement Team	0.00	0.00	0.00	0
Criminal Justice & Forensic	0.80	0.00	0.80	100
LD SLDS A&T E/N Team	4.00	1.00	3.00	75
LD SLDS A&T West Team	5.60	6.20	-0.60	-11
Total	**10.40**	**7.20**	**3.20**	**31**
East & North SBU				
AMHCS Centenary & Jubilee	7.14	7.23	-0.09	-1
AMHCS Cygnet House	6.90	5.06	1.84	27
AMHCS Holly Lodge	2.50	4.50	-2.00	-80
AMHCS Saffron Ground	4.97	5.40	-0.43	-9
AMHCS Oxford House	2.35	2.35	0.00	0

AMHCS Rosanne House	8.00	7.00	1.00	13
Total	**31.86**	**31.54**	**0.32**	**1**
West SBU				
AMHCS NW Herts Dacorum	5.89	6.89	-1.00	-17
AMHCS NW Herts St Albans	4.40	4.40	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	5.40	0.80	13
Total	**20.98**	**20.18**	**0.80**	**4**
Overall Total	**63.24**	**58.92**	**4.32**	**7**

Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 8
Subject:	Guardian of Safe Working Report	**For Publication:**
Authors:	Dr Dinal Vakeria (interim Guardian of Safe Working)/ Dr Asif Zia	**Approved by:** Dr Asif Zia Executive Director for Quality and Medical Leadership
Presented by:	Dr Asif Zia, Executive Director for Quality and Medical Leadership	

Purpose of the report:

To update the Board on the mandatory assurance report from the Guardian of Safe Working for Junior Doctors

Action required:

To apprise the Board that controls and assurances are in place

Summary and recommendations:

i) As part of Junior Doctor Contract review process, in 2016, DoH and BMA agreed that junior doctors who are asked to work outside their work schedule (e.g. Work carried out after working hours) and or when asked to cover additional work (e.g. cover for sickness or rota gaps) would be able to raise an Exception report. A secure electronic portal system was set up for the reporting purposes and role of Guardian of Safe Working was established to monitor and report to the trust Board on number of exception reports being raised.

ii) This is the Quarterly Guardian of Safe Working Report, covering period between Octobers to December 2019. Since October, 2019 the Trust has not received any exception reports.

iii) The main reasons for the reduction in exception reports in this quarter are;

1) reduction in junior doctor WTE vacancies

2) increase in bank/ agency locum bookings to cover gaps on the on-call rota

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

Quality and safety: The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff.

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

3. We will improve the health of our service users & support recovery through the delivery of **effective** evidence based practice

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

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 exception report being raised but the gaps in the junior doctor on-call rota are covered by locum and agency cover which has cost implications for the trust.

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:

IGC in March 20020

Hertfordshire Partnership University NHS Foundation Trust

Guardian of Safe Working Hours Quarterly Report
October 2019 – December 2019

1) Executive Summary

- This is the quarterly Guardian of Safe Working Report covering the period between October to December 2019
- Since October 2019, the Trust has not received any exception reports
- The main reasons for the reduction in exception reports in this quarter are:
  - reduction in junior doctor WTE vacancies
  - Increase in bank/agency locum bookings to cover gaps on the on-call rota
- The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of the exception reporting process

2) Time allocation for Guardian of Safe Working Role

- Amount of time available in job plan for guardian to do the role: **2 PAs**
- Admin support provided to the Guardian (if any) **Medical Staffing**
- Amount of job-planned time for clinical supervisors **0.25 PAs per trainee**

3) High level data for Junior Doctor post

- Data below gives the number of trainees of different grade working for the organisation. There are separate arrangements between HPFT and local trusts around core trainees rotating through psychiatric posts in Buckinghamshire, Norfolk and Essex.
- All training posts (junior doctor posts) except trust doctor posts are part funded by the Deanery and the Regional Post Graduate Dean, Health Education East of England has oversight of their training and education.
- There are currently 82 doctors of different grades in training in the trust. Most of the trainee posts are in Hertfordshire. Although included in the training post, Trust Doctors posts have been recruited from overseas against posts that were left vacant after national recruitment.
- The time that each grade spends within the trust varies considerably. Core psychiatric trainees and Specialist trainees are training grades for psychiatrist and spend between 3-6 years respectively completing their psychiatrist training. Other grades work for up to 4 months in psychiatry and then rotate between different hospitals/ specialties and primary care.
- Number of doctors in training on 2016 TCS (total):

- October – December 2019 82 trainee doctors (including LTFT/Trust doctors)

Number of Junior Doctors and their grade (October- December 2019)

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	26	1	0	0	27
Specialist Registrars	7	2	0	0	8
FY2 trainees	7	0	0		7
FY2 (WAST)	1	0	0	0	1
FY1 trainees	8	0	0	0	8
GPST	14	0	0	0	14
Innovative GPST	2	0	0	0	2
Trust Doctor (including IMF/MTI/LAS)	14	0	1	0	15
Total	**79**	**0**	**0**	**0**	**82**

4) Number of vacancies across the rotation

- The number of vacancies across the junior doctor tier has remained low. However, a number of specialist trainee posts are being filled by a junior doctor of a lower training grade due to difficulties in national recruitment to this grade. This has an impact on clinical care and on the on-call cover. These vacancies are filled by a locum doctor on short term basis where possible.

- The current vacancies for all grades are as follows:

  October 2019 4.4 WTE (inclusive of 2 doctors on maternity leave)

  November 2019 4.4 WTE (inclusive of 2 doctors on maternity leave)

  December 2019 4.4 WTE (inclusive of 2 doctors on maternity leave)

5) Exception Reports (with regard to working hours)

- As part of Junior Doctor Contract review process, in 2016, DoH and BMA agreed that junior doctors who are asked to work outside their work schedule (e.g. Work carried out after working hours) and or when asked to cover additional work (e.g. cover for sickness or rota gaps) would be able to raise an Exception report. A secure electronic portal system was set up for the reporting purposes and role of Guardian of Safe Working was established to monitor and report to the trust Board on number of exception reports being raised.

- In Q3 there were no exceptional reports raised by the junior doctors. Out of a total of gaps in the rota, 91 gaps were successfully covered by using bank & agency locums, 12 were covered by cross covering with other on-call doctors.

- There are currently 9 exception reports from previous quarters that are going through a review by the Guardian of Safe Working. Most of the exceptional reports are raised by the core psychiatric trainees in previous quarters.

- The main reason for exception reports are; Junior Doctors cross covering on-call rota as a result of short term sickness/ absence; gaps in rota due to long term sickness and restricted duties.

- As number of junior doctor vacancies has decreased the cross cover arrangements have improved.

- HPFT has one of the lowest numbers of exception reports in the region.

6) Work Schedule Reviews

- During this quarter there were no recorded requests for work schedule reviews by either trainees or clinical supervisors.

7) Fines

- No fines were issued during this quarter.

8) Locum work by HPFT doctors for other NHS Trusts

- Did HPFT doctors do locum shifts for other organisations?

  There were no other shifts that we are aware of declared at different organisations.

Summary

- This quarterly report provides data on the safe working hours for junior doctors.

- The recruitment to vacant junior doctor posts has improved between the period October-December 2019. In September 2019 there were 5.7 WTE vacancies which improved to 4.4 WTE between October - December 2019. This has resulted in better cover for the on-call rota.

- Gaps in the rota remain the main reason for exception report being raised.
- Although the recruitment to junior doctor posts has improved, there are 2 full time vacant posts on the on-call rota due to long term sickness and one doctor requiring restricted duties.

- It is anticipated that the second on call rota will improve further from February 2020 as a result of trainees returning from maternity leave.

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 9
Subject:	COVID 19 Update	**For Publication:**
Author:	Debbie Pinkney, Infection Prevention and Control Consultant Nurse 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:

To provide the Board with a brief update on COVID 19

Action required:

This is for information; the Board are asked to note the update.

Summary and recommendations to the Board:

On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China. On 12th January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus is now referred to as Coronavirus (COVID 19). Based on the WHO's declaration that this is a public health emergency of international concern, the UK Chief Medical Officers have raised the risk to the public from low to moderate.

- The Trust is receiving information and guidance on a daily basis from Public Health England (PHE) along with requests for submissions. The Director of Infection Prevention and Control (DIPC) is overseeing and ensuring all the guidance is followed and submissions responded to
- Trust staff have been issued with the PHE flowchart regarding the management of a suspected individual with Novel Coronavirus whether they be staff or service user and posters developed by PHE have been cascaded and are displayed at the entrance to the units/sites
- A page on the HIVE has been developed, dedicated to information about coronavirus and its management. This is updated as new information and guidance is received
- The importance of implementing standard infection prevention and control precautions within the local governance structures. PPE has been ordered to ensure that staff are able to assess a service user whilst they are in isolation
- Fit test training have been scheduled
- Trust managers are establishing any staff who have or are going to travel to China or any of the other specified high risk areas used to risk assess and manage staffing levels
- If a service user is thought to be infected and is an inpatient, they will be isolated in their room until advice has been sought from the Infection Control Doctor or from NHS 111
- For any self-referrals (self-presenters) from individuals entering the community hubs/reception areas, specific isolation pods are currently being identified.

In the event of any identified incident the Trust will liaise closely with PHE and act in line with their guidance.

Relationship with the Business Plan & Assurance Framework:

Summary of Implications for:

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

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

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

1. Introduction

1.1 On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

1.2 On 12th January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus is now referred to as Coronavirus (COVID 19).

1.3 Based on the World Health Organisation's declaration that this is a public health emergency of international concern, the UK Chief Medical Officers have raised the risk to the public from low to moderate.

1.4 As of 18th February 2020, 72,436 cases and 1,868 fatalities have been officially reported by the Chinese National Health Commission from mainland China. Some health care workers have been reported to be infected.

1.5 According to the Chinese National Health Commission, cases are now reported across all provinces in China; as of 17th February 2020, 83% of cases were in Hubei Province. The Hubei Provincial Health Committee reported that, as of 17th February 2020, 71% of the confirmed cases in Hubei Province were from Wuhan City.

1.6 In addition, as of 18th February 2020, 897 cases have been diagnosed in 28 other countries or areas and 2 international conveyances. Five fatalities outside of China have been reported. As of 19th February 2020, 5216 people have been tested of which 5207 were confirmed negative and 9 cases have been positive.

1.7 This paper sets out how the Trust is reacting to the emerging situation and preparing should the situation in the UK worsen.

2. Management

Oversight

2.1 The Trust is receiving information and guidance on a daily basis from Public Health England along with requests for submissions. The Director of Infection Prevention and Control is overseeing and ensuring all the guidance is followed and submissions responded to.

2.2 To support this, and to ensure that vital information is communicated through the Trust, a daily conference call takes place with key individuals present such as the Infection Prevention and Control Consultant Nurse, Heads of Nursing, Deputy Medical Director, Communications Team representative, Health, Safety and Security Lead, EPRR Manager, Estates Lead and the Chief Pharmacist.

Preparedness

2.3 The Trust staff have been issued with the updated Public Health England (PHE) flowchart regarding the management of a suspected individual with Novel Coronavirus (COVID 19) whether they be staff or service user.

2.4 Posters developed by PHE have been cascaded to the senior nursing staff and are displayed at the entrance to the units/sites.

2.5 A page on the HIVE has been developed, dedicated to information about coronavirus and its management. This is updated as new information and guidance is received.

2.6 Senior nursing staff and Clinical Directors have reminded the staff of the importance of implementing standard infection prevention and control precautions within the local governance structures.

2.7 PPE has been ordered to ensure that staff are able to assess a service user whilst they are in isolation. One equipment pact will be held at:

- Kingfisher Court
- Lexden
- Norfolk
- North Essex community
- Buckinghamshire community
- The Lister

2.8 Three sessions of fit test training have been scheduled – two sessions on 21st February and one on session on 5th March 2020. Multi-professional staff (senior nursing, medical staff, Infection Prevention and Control and Health and Safety) have all been identified to attend the training. To date there are 26 staff enrolled onto the training.

2.9 Trust managers are establishing any staff who have or are going to travel to China or any of the other specified high risk areas. This will be used to risk assess and manage staffing levels. In addition, staff have also been provided with the PHE advice regarding health care workers travelling.

2.10 The Trust will be responsible for correctly cleaning the room in the event the person is advised for admission; Interserve will support the cleaning process. Staff implementing the clean will need to wear the appropriate Personal Protective Equipment (PPE) as identified within the PHE guidance.

Management of a suspected case

2.11 If a service user is thought to be infected and is an inpatient, they will be isolated in their room until advice has been sought from the Infection Control Doctor or from NHS 111.

2.12 For any self-referrals (self-presenters) from individuals entering the community hubs/reception areas, specific isolation pods are currently being identified. The isolation pods are isolated rooms, within Trust buildings, which can be used to test people with symptoms indicative of infection and will ensure they receive a quick assessment without disruption of other services within the building.

These rooms will be close to the entrance of the building and will have clear signposting measures to ensure people go directly to the room and don't enter other services.

2.13 The purpose of the isolation pods is to support acute Trusts with the increased pressure of managing self-presenters walking into their Emergency Departments. Once inside the isolation pod, the person will be expected to dial NHS 111 using the set up land line and will be assessed over the phone. In the event the person is advised of admission NHS 111 will need to arrange appropriate transportation.

2.14 In the event of any identified incident the Trust will liaise closely with PHE and act in line with their guidance.

3. Conclusion

3.1 Based on the WHO's declaration that this is a public health emergency of international concern, the UK Chief medical Officers have raised the risk to the public from low to medium. This permits the government to plan for all eventualities. The risk to individuals remains low.

3.2 As of 19th February 2020, a total of 5,216 people have been tested in the UK of which 5,207 were confirmed negative and 9 positive.

3.3 This paper provides details of the oversight, preparedness and management for COVID 19. In the event of any identified incident the Trust will liaise closely with PHE and act in line with their guidance.

Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 10
Subject:	National Community Mental Health Survey 2019 - Actions update	**For Publication: No**
Author:	Sandra Brookes, Executive Director of Service Delivery & Service Experience	**Approved by:** Sandra Brookes, Executive Director of Service Delivery & Service Experience
Presented by:	Sandra Brookes, Executive Director of Service Delivery & Service Experience	

Purpose of the report:

To provide the Board with an update on the actions being taken forward to improve the experience of service users and carers, receiving care from Adult community services.

Action required:

To note the actions being taken following analysis of the 2019 community survey results.

Summary and recommendations:

The 2019 Community Mental Health Survey is part of the NHS Patient Survey Programme in line with the NHS Outcome Framework and is a major source of data for the CQC under the inspection regime, via intelligent monitoring. The survey is co-ordinated by the Patient Survey Co-ordination Centre, based at the Picker Institute Europe, on behalf of the Care Quality Commission (CQC).

A number of recommendations to improve the survey results, but more importantly continue to improve community services and respond appropriately to service user and carer feedback have been identified, however as some of these will take some time to realise the impact, 5 key areas have been identified for immediate focus;

- CPA reviews
- Ensuring service users and carers are aware of how to access crisis services
- Ensuring service users are aware of who is leading their care and how to contact them and are informed of changes to care coordinators
- Ensuring service users are supported to, maintain or seek employment and carry out meaningful activities
- Increasing feedback from service users

A small task and finish group has been established to lead on the communications plan to support the areas of focus. Key headline messages have been agreed and shared with staff across all 5 areas. In addition there will be a weekly focus on each area, highlighting key messages for staff and service users. A range of communication methods will be used to share the messages including; screen savers, media screens in hubs, information on Hive, displays in the hubs.

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

Links to Strategic Objectives 2 We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience.
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care.

Links to Risk register: Quality and safety**:** Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness

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

N/A

Equality & Diversity /Service User & Carer Involvement implications:

The national survey includes a sample of service users from adult and older peoples community mental health services who used services between 1 Sept – 30 Nov 2018.

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

The Trust is required to participate in the national community mental health survey, the basic sample of which is covered under Section 251 of the NHS Act 2006.

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

Executive – 12th February 2020

National Community Mental Health Survey 2019

1. Background

The 2019 Community Mental Health Survey is part of the NHS Patient Survey Programme and is co-ordinated by the Patient Survey Co-ordination Centre, based at the Picker Institute Europe, on behalf of the Care Quality Commission (CQC).

The survey of people who use community mental health services involves 52 providers in England (mental health trusts and community interest companies with mental health functions).

People aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition, and had been seen by the Trust between 1 September and 30 November 2018.

2. Results

Following analysis of the results the areas that required improvement are summarised as:

- Taking into account a person' personal circumstances, for example; employment status and their physical health at the point of assessments and reviews
- Ensuring service users feel they are fully involved in their care and decisions made about their care
- Service users being clear who is leading their care and how to contact that person
- Service users being clear who to contact in a crisis
- Encouraging feedback from service users

3. Actions

A number of recommendations to improve the survey results, but more importantly continue to improve community services and respond appropriately to service user and carer feedback have been identified, however as some of these will take some time to realise the impact, 5 key areas have been identified for immediate focus;

- CPA reviews
- Ensuring service users and carers are aware of how to access crisis services
- Ensuring service users are aware of who is leading their care and how to contact them and are informed of changes to care coordinators
- Ensuring service users are supported to, maintain or seek employment and carry out meaningful activities
- Increasing feedback from service users

A small task and finish group has been established to lead on the communications plan to support the areas of focus. Key headline messages have been agreed and shared with staff across all 5 areas. In addition there will be a weekly focus on each area, highlighting key messages for staff and service users. A range of communication methods will be used to share the messages including; screen savers, media screens in hubs, information on Hive.

These actions will be monitored by the Trust Management Group.

4. Conclusion

A number of actions have been identified including the expansion of the Individual Placement Scheme, further training in Shared Decision-making and improved use of digital methods of obtaining feedback from service users to support improving the experience of service users and carers under the care of the adult community services.
However as these are longer-term plans and in response to feedback the report summarises key areas of focus for immediate action.

Appendix 1 – Full question breakdown with comparison against 2018 and national findings

↔ - equal to or within 1% either side
↓ - more than a % point lower
↑ - more than a % point higher
N/A – new question for 2019

	Compared to HPFT 2018	Compared to National 2019
Your Care & Treatment		
3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	↔	↔
Your Health & Social Care Worker		
4. Were you given enough time to discuss your needs and treatment?	↔	↔
5. Did the person or people you saw understand how your mental health needs affect other areas of your life?	↔	↓
Organising Your Care		
6. Did the person or people you saw appear to be aware of your treatment history?	N/A	↓
7. Have you been told who is in charge of organising your care and services?	↓	↓
9. Do you know how to contact this person [in charge of care] if you have a concern about your care?	↓	↓
10. How well does this person organise the care and services you need?	↓	↓
Planning Your Care		
11. Have you agreed with someone from NHS mental health services what care you will receive?	↓	↔
12. Were you involved as much as you wanted to be in agreeing what care you will receive?	↑	↑
13. Does this agreement on what care you will receive take your personal circumstances into account?	↓	↔
Reviewing Your Care		
14. In the last 12 months, have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?	↓	↓
15. Did you feel that decisions were made together by you and the person you saw during this discussion?	↓	↓
Crisis Care		
16. Do you know who to contact out of office hours if you have a crisis?	↔	↑
17. In the last 12 months, did you get the help you needed when you tried contacting this person or team?	↓	↓
Medicines		
19. Were you involved as much as you wanted to be in decisions about which medicines you receive?	↔	↓
20. Has the purpose of your medication ever been discussed with you?	N/A	↑
21. Have the possible side effects of your medicines ever been discussed with you?	N/A	↔
24. In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines?	↓	↔
NHS Therapies		
26. Were these NHS therapies explained to you in a way you could understand?	↓	↓
27. Were you involved as much as you wanted to be in deciding what NHS therapies to use?	↓	↓
Support & Wellbeing		
29. In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs?	↓	↓
30. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	↔	↔

	Compared to HPFT 2018	Compared to National 2019

Results are shown from the longitudinal data to ensure accurate comparison against 2018 results.

Appendix 2 – HYS comparison with national survey 2019 (1 Sept – 30 Nov 2018)

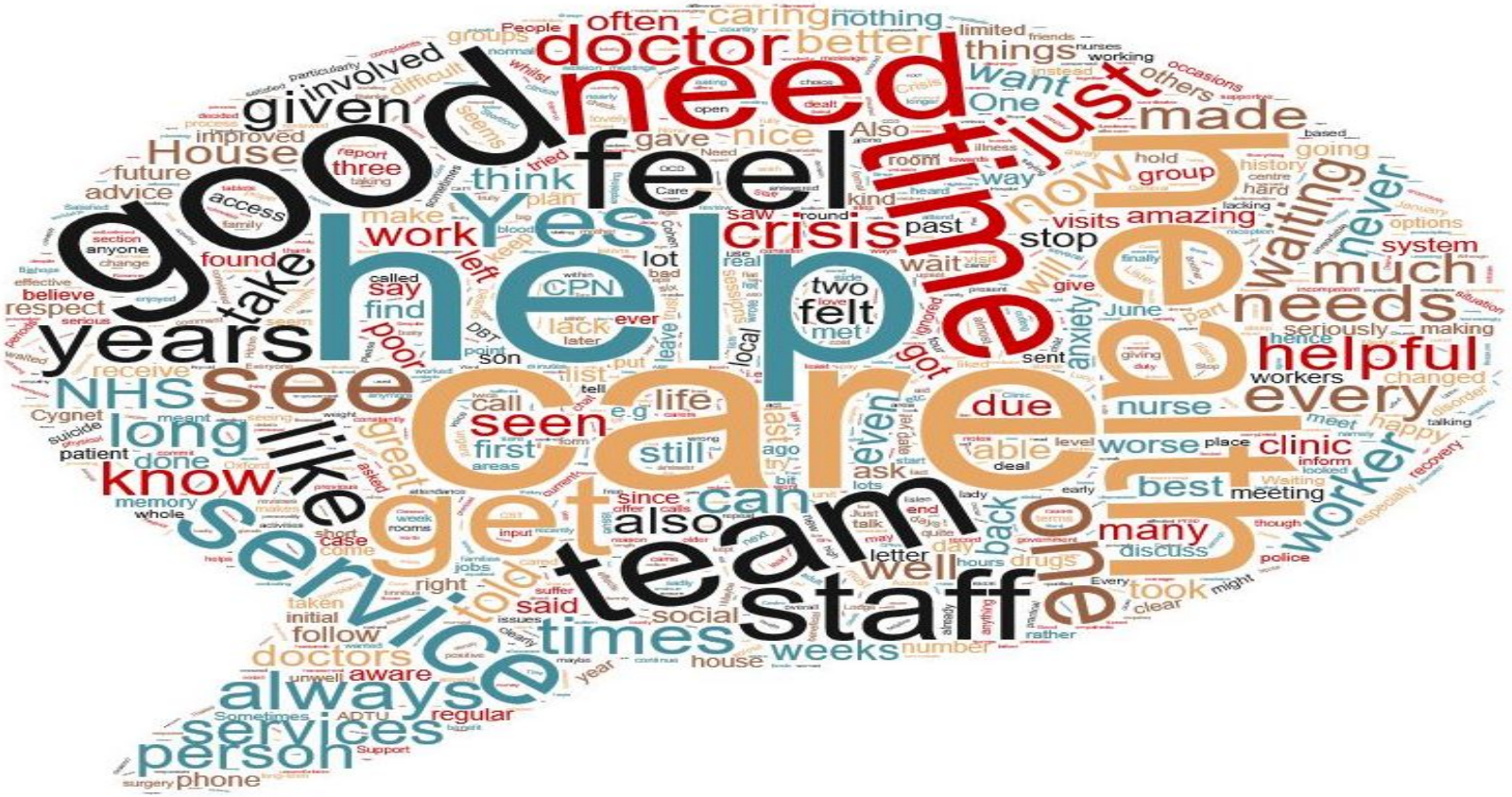
National Survey Question	%	Responses	Having Your Say Question	%	Responses
Do you know how to contact this person if you have a concern about your care? ***Yes***	94	221	Do you know who to contact for support? ***Yes***	81	182
Did the person you saw understand how your mental health needs affect other areas of your life? ***Yes, definitely***	50	493	Do you think the service understands how your mental health affects your life? ***Yes***	75	182
Were you involved as much as you wanted to be in agreeing what care you will receive? ***Yes, definitely***	41	502	Have you been involved as much as you want to be in discussions about your care? **Yes**	86	179
Do you know who to contact out of hours if you have a crisis? ***Yes***	73	440	Do you know how to get support and advice at a time of crisis? ***Yes***	80	182
Has the purpose of your medicines ever been discussed with you? ***Yes, definitely*** Have the possible side effects of your medicines ever been discussed with you? ***Yes, definitely***	60 41	410 406	Were you given information about medications and any side effects in a way you could understand? ***Yes***	62	152
In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs? ***Yes, definitely***	24	240	Did we talk about any support you may need that would help with your physical health? ***Yes***	65	179
Have NHS mental health services involved a member of your family or someone else close to you as much as you would like? ***Yes, definitely***	52	307	Have we given an opportunity to those supporting you to be involved in your care? ***Yes***	77	177
Overall, how was your experience (scale 1-10) ***(Result shown as scored by Quality Health)***	68	489	Friends and Family Test score.	84	182
Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services? ***Yes always***	69	500	Respect value score. (Combination of questions under the Respect value). ***Yes***	85	1091 (multiple responses)

(Please note these results are taken from the compositional data and show "Yes" only results to maintain comparability to HYS)

Appendix 3

Word Cloud

The words given in comments are shown below, the larger the word, the more frequently it has been mentioned.



Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 11
Subject:	National Staff Survey	**For Publication:**
Author:	Sandy Hastilow – Acting Head of Organisational Development	**Approved by:** Ann Corbyn – Director of People and OD
Presented by:	Tbc	

Purpose of the report:

To present the findings and proposed responses to the survey

Action required:

Members are asked to note the contents of the report

Summary and recommendations to the Board:

The Staff Survey is a really important tool for the Trust – it allows us to hear directly from our people about their experience of working for HPFT. It helps us understand if our people feel that they have the right tools to their jobs to the highest of standards for our service users; it helps us to understand how they feel about coming to work and whether they feel supported, valued and encouraged. Our return rate improved this year and this means that we heard directly from nearly 1,800 of our people.

The 2019 results are showing continued improvement on previous years' results. The Trust has improved in 73 questions and 57 are above the national average compared to similar Mental Health / Learning Disability Trusts. The Trust has also performed well against the national key results provided by NHS Providers.

The Trust scored above average on 9 of the 11 themes and continued to improve on the safety culture result, with a national best score for the second year running.

The overall staff engagement score has remained above average compared to other Mental Health and Learning Disability Trusts with a score of 7.4, marginally below the national best score of 7.5. This theme focuses on staff motivation at work, being able to make improvements at work and the 2 Friends and Family Test questions (FFT), recommending the Trust as a place to work and to receive treatment. These 2 questions had a positive significant increase - 73.7% of our staff would recommend HPFT as a place to work compared to 66.1% in 2018, whilst 75.6% of our staff would recommend HPFT as a place to receive treatment compared to 68.7% in 2018.

There are a number of areas that the Trust needs to improve upon and these have already been recognised by the People and OD Directorate and are outlined in the proposed responses.

Relationship with the Business Plan & Assurance Framework:

Strategic Objective 4: We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment
Relevant BAF risk: Low staff morale and staff engagement will affect experience for staff

Summary of Implications for:

N/A

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

The report compares the experiences of staff that identify as BAME compared to staff that identify as white.

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

CQC monitor staff survey results as part of the Well Led domain

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

Senior Leadership Team Meeting (19/02/2020)

2019 NATIONAL STAFF SURVEY RESULTS

1.0 Introduction

The national staff survey has been in place since 2003. It is the most important metric of staff experience that is used by the CQC, potential employees and current & future partners and stakeholders to understand our culture and our approach to our people. The results deepen our understanding of staff experiences and focus where to drive improvements. The results of the national staff survey for 2019 have improved significantly across all themes, building on the positive results the Trust received in the past 2 years. The Trust is benchmarked against 23 Mental Health and Learning Disabilities Trusts.

The survey was sent to all eligible Trust staff, between September and December 2019; with 1786 staff responding, a response rate of 57%. This was a substantially higher response rate than 2018 (41.3%) and above the national average of 54.5% for Mental Health and Learning Disability Trusts.

The survey results are presented in two different formats.

- ✓ Trust Overview - 54 of the questions are themed into 11 key areas. Each theme is scored on a scale of 0-10 where a higher score is more positive

- ✓ Detailed Results – All 91 questions are themed into 5 key areas. Each question is percentage scored

The first format is used to show the key highlights and to give an ‘at a glance’ overview of the survey and the second format is used for the main report to ensure a full and robust analysis of the survey data.

2.0 Key Highlights from the National Staff Survey

When compared to other Mental Health and Learning Disability Trusts we scored as follows in each of the 11 themes:

<u>Above Average</u>:

- ✓ Health & Wellbeing
- ✓ Immediate Managers
- ✓ Morale
- ✓ Quality of Appraisals
- ✓ Quality of Care

- ✓ Safe Environment – Bullying & Harassment
- ✓ Safety Culture
- ✓ Staff Engagement
- ✓ Team Working

Average:

- ✓ Safe Environment - Violence

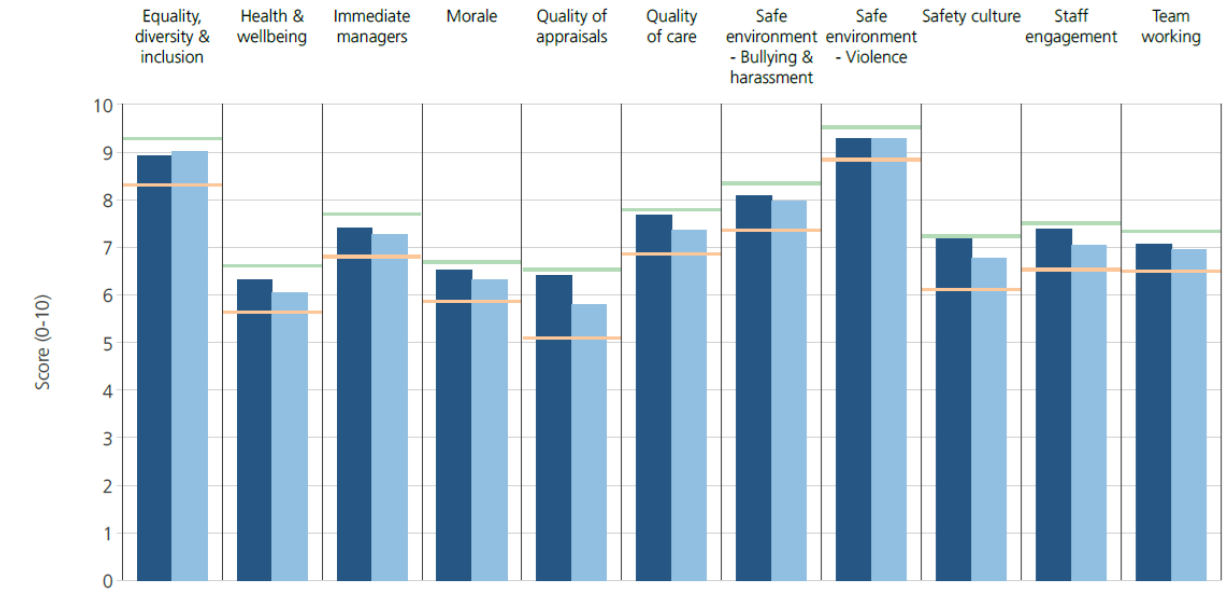
Below Average:

- ✓ Equality, Diversity & Inclusion*

*please note that the score was only 0.1 below average.

Graph 1 below shows how HPFT has performed in comparison to other Mental Health and Learning Disability Trusts with regards to the 11 themed results.

Graph 1 - Overview of Themed Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.3	6.6	7.7	6.7	6.5	7.8	8.3	9.5	7.2	7.5	7.3
Your org	8.9	6.3	7.4	6.5	6.4	7.7	8.1	9.3	7.2	7.4	7.1
Average	9.0	6.0	7.3	6.3	5.8	7.4	8.0	9.3	6.8	7.0	7.0
Worst	8.3	5.6	6.8	5.9	5.1	6.9	7.4	8.8	6.1	6.5	6.5
Responses	1,757	1,766	1,765	1,734	1,450	1,533	1,748	1,752	1,755	1,776	1,756

For the theme of safety culture the Trust achieved a national best score of 7.2.

The overall staff engagement score has remained above average compared to other Mental Health and Learning Disability Trusts, with a score of 7.4, which is marginally below the national best score of 7.5. This theme focuses on staff motivation at work, being able to make improvements at work and the 2 FFT questions recommending the Trust as a place to work and to receive treatment. These 2 questions had a positive significant increase - 73.7% of our staff would recommend HPFT as a place to work compared to 66.1% in 2018 and 75.6% of staff would recommend HPFT as a place to receive treatment compared to 68.7% in 2018.

The greatest positive significant increase was in the Equality, Diversity and Inclusion theme - 79.9% of our staff reported adequate adjustments to enable them to carry out their work had been made compared to 70.5% in 2018.

3.0 Theme Results

Top 5 Ranking Scores for the Trust

- ✓ Recommend organisation if friend / relative needed treatment
- ✓ Would recommend organisation as place to work
- ✓ Appraisal / Review: organisational values definitely discussed
- ✓ Feedback from patients / service users is used to make informed decisions within directorate / department
- ✓ Organisation acts on concerns raised by patients / service users

Bottom 5 Ranking Scores for the Trust

- ✓ Appraisal / Review: training, learning or development needs identified
- ✓ Satisfied with level of pay
- ✓ Don't work any additional paid hours per week
- ✓ Don't work any additional unpaid hours per week
- ✓ Had appraisal / KSF review in last 12 months

The 91 question results are divided into 5 themes, summarised below

3.1 Your Job – This theme has 31 questions - 22 scored above average and 3 below average - the highlights of this theme are below

- ✓ 71.9% staff say they are able to deliver the care they aspire to - a significant positive increase of 6% on 2018
- ✓ 85.3% of staff say they are satisfied with the care they give - a significant positive increase of 5% on 2018
- ✓ The extent to which the organisation values my work has continued an upward trend over the 5 years and now stands at 58.8%, which is 9% above the average

- ✓ Our staff reporting that they have adequate materials and equipment to do their work had the largest significant increase from 52.8% in 2018 to 62.9% in 2019
- ✓ 48.5% of our staff report that they are able to meet all conflicting demands on their time, which is a positive increase on 2018 but also demonstrates that over half of the organisation is struggling to do this
- ✓ 91.2% of our staff feel trusted to do their job, which is the highest score we have received over a 5 year period and which is above the national average
- ✓ Staff reporting that they experience unrealistic time pressures has improved on 2018 results but is marginally below average

3.2 Your Managers – This theme has 11 questions - 10 questions scored above average and 1 below average.

- ✓ My immediate manager takes a positive interest in my health and wellbeing has significantly increased to 77.3% from 72.3% in 2018
- ✓ Senior Managers acting on staff feedback has increased to 46.3% from 40.2% in 2018
- ✓ Senior managers try to involve staff in important decisions has shown an upward trend over the last 3 years achieving 46.6% - 10% above the average
- ✓ Staff knowing who their senior managers are reduced by 2% to 88.6%

3.3 Health & Wellbeing – This theme has 30 questions - 22 questions scored above average and 5 below average

- ✓ 38.9% of staff have felt unwell as a result of work related stress, which is a positive 3% decrease on 2018 and better than average
- ✓ 89.6% of staff put themselves under pressure to come to work when unwell which is a 3 % improvement on 2018 and shows a positive decreasing trend
- ✓ Recognising that the organisation is taking positive action on health and wellbeing improved from 32.8% in 2018 to 37.4% in 2019 and scored 9% above the national average
- ✓ Personally experiencing physical violence at work from managers positively decreased to 0.1% compared to 0.9% in 2018 and was equal to the best national score
- ✓ Bullying and Harassment from Service Users, the Public, Managers and Colleagues scores have all improved on 2018 and are similar to the national average, except Service Users / Public which was a positive 4% lower than national average
- ✓ However, 59.1% of our staff are reporting bullying and harassment which is a significant increase on 2018
- ✓ Does the organisation act fairly with regard to career progression / promotion has significantly improved from 81.9% in 2018 to 86.5% in 2019

- ✓ Staff experiencing discrimination from service users / the public and managers / colleagues are both higher than the national average on the grounds of ethnic background which at 57.9% is markedly higher than the national average of 41.1%

3.4 Personal Development – This theme has 8 questions - 5 questions scored above average and 3 below average

- ✓ Appraisal / Review helped me to improve how I do my job improved by 3% compared to 2018 to 31.4% and was 6% above national average
- ✓ Appraisal / Review helped me agree clear objectives improved by 7% on 2018 to 43.9% and is 6% above national average
- ✓ Appraisal / Review left me feeling my work is valued by my organisation improved by 6% compared to 2018 to 40.5% and is 5% above the national average
- ✓ Appraisal / Review our values were discussed as part of the process achieved a national best score of 54.6% which is a 6% improvement on 2018 and is 14% above the national average
- ✓ 70.2% of staff received non-mandatory training and development, which is a 2% decrease on 2018 and is below the national average.

3.5 Your Organisation – This theme has 11 questions and all scored above the national average

- ✓ Care of service users is my organisation's top priority achieved a national best score of 85.8% and is also a 5% improvement on our 2018 score
- ✓ Recommend the organisation as a place to work continued its upward trend and showed a significant 7% improvement on 2018, achieving 73.7%
- ✓ Recommend to a friend / relative if they needed treatment scored 75.6% which is significantly higher than 2018 (68.7%) and 13% above national average
- ✓ 70.4% of staff use feedback from Service Users to make informed decisions – this is a 3% increase on 2018 and 9% above national average
- ✓ 52.5% of staff are not considering leaving their current job which is a positive increase of 6% compared to 2018.

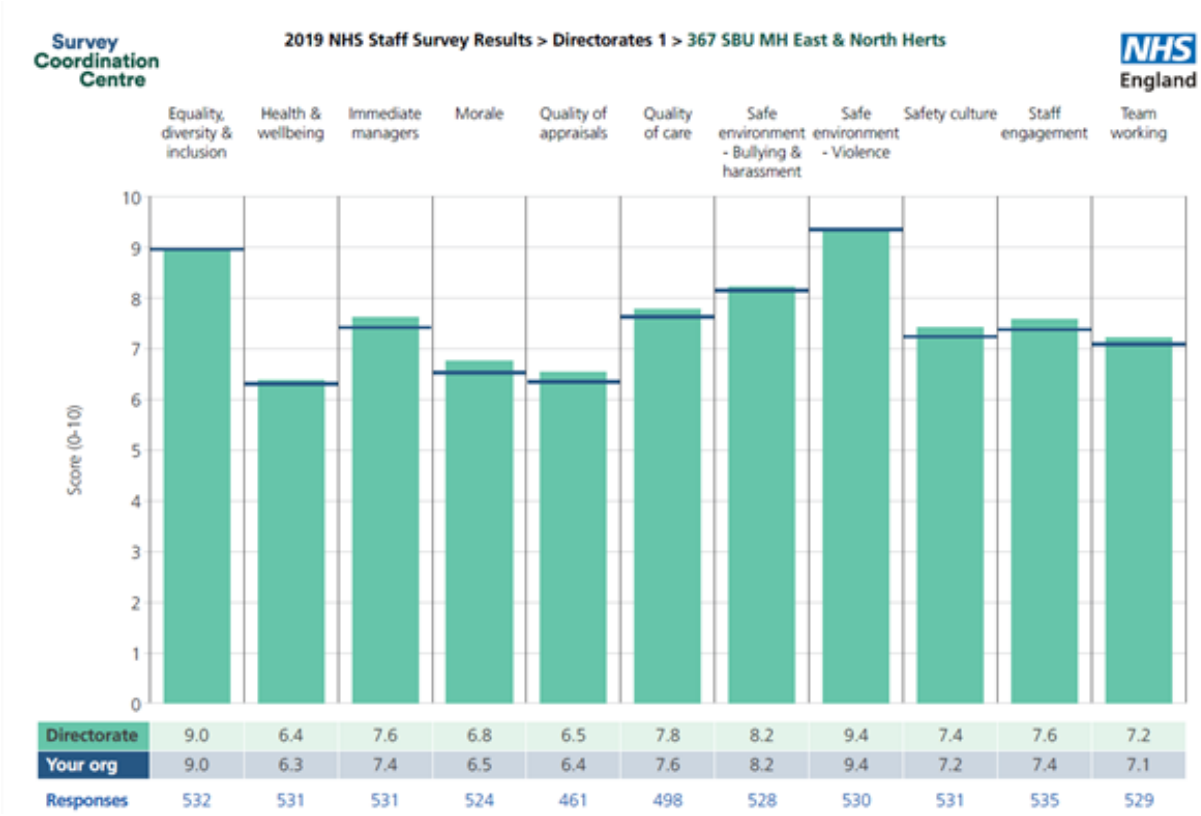
The full results of the survey can be found on the NHS Staff Survey website at:
http://www.nhsstaffsurveyresults.com/homepage/benchmark-directorate-reports-2019/

If members would like a paper copy of the results, please contact Pauline Corbett at pauline.corbett1@nhs.net

4.0 SBU Results

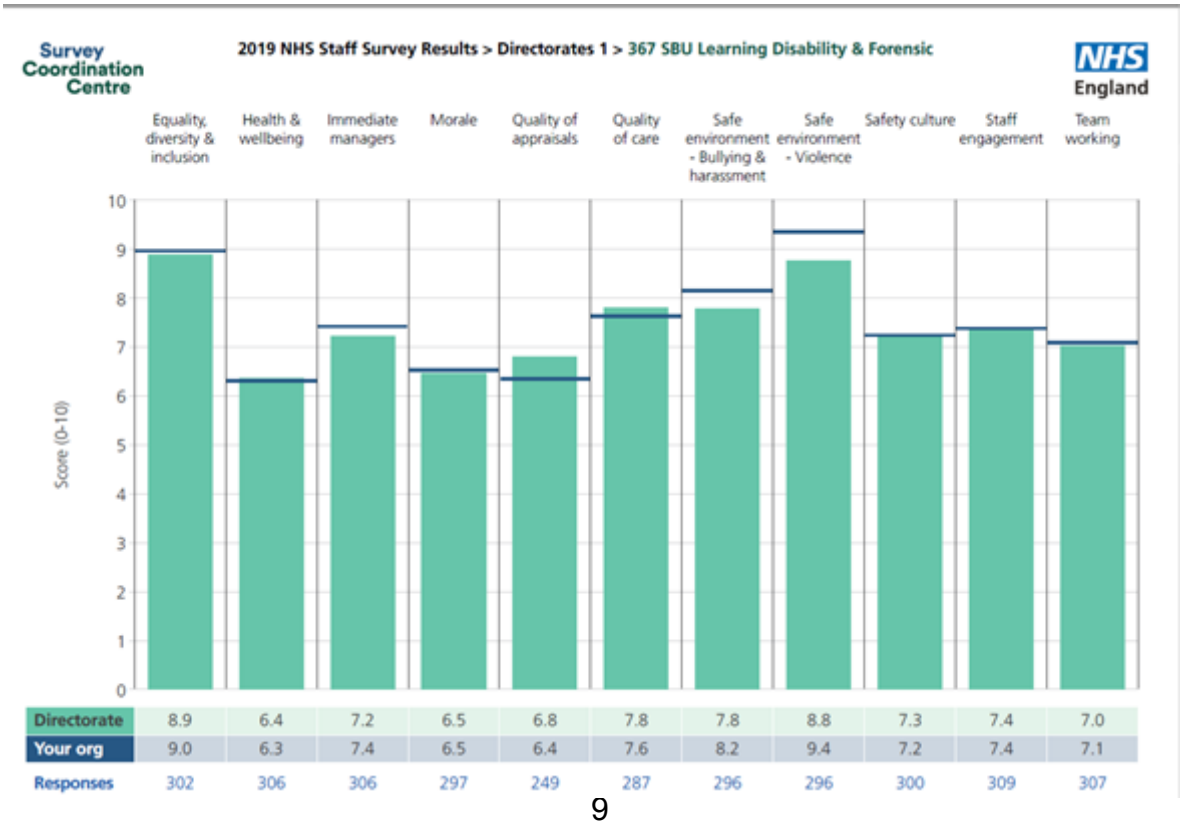
Below is the high level themed data for each SBU, which show how the SBU performed compared to the organisation as a whole. More detailed analysis will be undertaken by the SBU Senior Leadership Teams and Human Resources Business Partners. This will inform and drive the workforce elements of the SBU plans for the next year where areas may need targeted support and input, but also allows the sharing of good practice and learning support and input. The overview graphs for each SBU are included below.

Graph 2. E&N -SBU



Graph 3. – West SBU

Graph 4 – LD&F SBU



Graph 5 – Essex & IAPT

Corporate was reported differently this year compared to previous years. The Corporate SBU was divided into 6 Directorates of:

- ✓ Quality & Medical Leadership
- ✓ Quality & Safety
- ✓ Finance
- ✓ Strategy & Improvement
- ✓ Workforce & Organisational Development
- ✓ Chief Executive Officer

The overview graphs for each directorate and service lines can be found on the NHS Staff Survey website at:

http://www.nhsstaffsurveyresults.com/homepage/benchmark-directorate-reports-2019/

Again, if members would like a paper copy of these results, please contact Pauline Corbett at pauline.corbett1@nhs.net

5.0 National Comparison

NHS Providers summarises the key points at a national level, reflecting on the positive trends for providers in quality of management, staff recognition, pay, engagement between staff and senior leaders, as well as any concerning findings regarding bullying, harassment and incidents of violence & discrimination at work. Below is how HPFT compares to the national picture and not just similar Trusts.

- ✓ **63.3%** of staff would recommend their organisation as a place to work – a 2% increase from 2018 **(HPFT 73.7%)**
- ✓ **38%** of staff are satisfied with their pay – a 2% increase and the highest level in past five years **(HPFT 36.7%)**
- ✓ There has been no significant decrease in the proportion of staff reporting bullying and harassment from colleagues **(19.1%) (HPFT 15.8%)**, or their immediate manager **(12.3%) (HPFT 11.7%)**
- ✓ Too many staff **(14.9%) (HPFT 15.6%)** still experience violence and discrimination from patients and service users – with a small increase on last year's findings
- ✓ There remains a disparity between white staff and BME staff in feelings of receiving equal opportunity, with BME staff **16% (HPFT 13%)** less likely to feel they are offered an equal shot at career progression or promotions
- ✓ **59.5% (HPFT 65.1%)** of staff look forward to going to work, and **74.5% (HPFT 77%)** are often or always enthusiastic about their jobs – both show small increases from 2018
- ✓ Only **22.9% (HPFT 22.8%)** of staff never or rarely suffer from unrealistic time pressures at work.

6.0 Conclusion and Actions

The 2019 staff survey results show further improvements on the results achieved in recent years. There have been significant improvements in all themes against a backdrop of increased demand, increased acuity, increased pressure on staffing, with remaining challenges regarding recruitment and retention. Of the 91 questions asked, 73 show improvement from last year and 57 are better than the national average.

The Trust has continued to improve on the safety culture results and achieved a national best score for the second year running. This is likely to be a result of the introduction of SWARM's, huddles and continued improvements in reporting.

The Trust has improved on its staff engagement score and is higher than the national average, demonstrating the value and range of current staff engagement events. Engagement activity will continue in line with the existing

events such as local Good to Great roadshow events, The Big Listen and Local Listens and the recently introduced Long Service Awards.

The introduction of 2 programmes for managers ‘management fundamentals’ and ‘coaching as a management style’ (both of which have had good attendance and feedback) have developed the skills of our managers and this is evident in the results in the Manager theme.

The positive increases in the ‘Your Organisation’ theme could be due to a number of factors including those mentioned above but the Trust receiving Outstanding rating from CQC must also be considered as a contributing factor.

One of our main areas of focus in the Trust’s Annual Plan for 2020 / 2021 is our People and the staff survey provides a number of areas for us to concentrate on.

Personal development is the one area that the Trust scored below the national average on 2 questions and also one lower than 2018. Both of these relate to having an appraisal and learning or development needs being identified. This is an area that the People and OD Directorate have already identified for increased focus and we are putting initiatives and processes in place to improve both the uptake and quality of appraisals. The process will be reviewed and the use of technology is to be explored. In addition, training focused on ‘quality and confident conversations’ will be provided for all of our people that manage or supervise staff.

There have been some improvements in the Bullying and Harassment results but further work is needed to reduce this. The plan is to further embed the Trust Values through conflict resolution, civility and a Just & Learning Culture approach. The People and OD Directorate have already started work to support this area and we will involve members of our BAME community in identifying the issues and commissioning the solutions to ensure that we make effective and sustainable change for our people in their working environment.

The OD team will continue to support managers with their development through the management fundamentals and coaching as a management style programmes. There is also an opportunity to support newly promoted first time managers and new managers to the Trust and plans are being developed for a manager orientation programme which will have a coaching focus.

It is also acknowledged that staff are experiencing continually increasing work demands and are working across complex systems – we have an increasing number of staff reporting coming into work when unwell and working extra hours. The new health and wellbeing strategy has been written and focuses

on the 5 pillars of Wellbeing (Mental, Physical, Financial, Environmental and Nutritional). The priorities for Q4 2019/20 and Q1 2020/21 are Mental Health First Aiders (MHFA), Menopause, HALT and financial education and support. The Trust will continue to raise the profile of Health and Wellbeing, creating a supportive environment so staff have a sense of belonging, being cared for and feeling valued.

The Great Teams model has been developed to support Teams to identify areas for development or further improvement which in turn will impact positively on how our people feel about their work, particularly in respect of collaborative working and which will then show a positive impact on future staff survey results.

There is more that we need to do to address the inequalities across different groups, in particular for those staff from a BAME background. We need to support the activity in the Workforce Race Equality Standard programme as a priority and work with the staff networks to address areas of concern and continue to promote and embed inclusivity and act on discrimination. We will do this through effective listening and engagement with our BAME colleagues.

Although recruitment and retention remains challenging and is representative of the national picture, we continue to focus on reducing time to hire, increasing apprenticeship opportunities, implementing and embedding new ways of working and career development opportunities for all our people.

The Trust continues to be in a strong position compared to other Mental Health and Learning Disability Trusts and the NHS nationally and we will promote this as part of the employer brand and offering.

This has been a positive staff survey for the Trust but it is essential that we do not become complacent. We will continue to identify central and local action plans to improve staff (and service user) satisfaction. The quarterly Pulse Surveys will provide an on-going measure of improvements and feedback. SBU activity will be monitored through performance review meetings. The WODG will receive regular updates of the delivery of People and OD activity, which in turn will be driven by the Trust's People and OD Strategy.

Sandy Hastilow
Acting Head of Organisational Development
27/02/2020

Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 12
Subject:	Performance Report: Quarter 3 2019/20	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director, Improvement and Innovation, Karen Taylor, Executive Director, Strategy & Integration	**Approved by:** Karen Taylor, Executive Director, Strategy and Integration
Presented by:	Karen Taylor, Executive Director, Strategy and Integration	

Purpose of the report:

1. To inform the Trust Board about the Trust's performance including performance against both the NHS Oversight Framework (NHSOF) targets and the Trust Key Performance Indicators (KPIs) for Quarter 3 2019/20

2. To inform the Trust Board of likely future performance projections for 2019/20 based upon a review of current trends, management actions and any variations in future targets

Action required:

To receive the report, discussing performance and projections for the end of Quarter 4.

Summary and Recommendations:

Quarter 3 Performance Summary

Overall, Trust wide performance continues to do well against a backdrop of continued increased demand for services. 75% (47 out of the 63 performance indicators monitored in Quarter 3) are exceeding, meeting or very nearly achieving the performance level required. Please note that Pulse Indicators are not included this quarter due to the National Staff Survey taking place.

This report provides a summary of the overall performance of the organisation during Quarter 3 against 63 national, regional and local indicators across five key groupings:

- NHS Oversight Framework (NHSOF)
- Access to Services
- Safety and Effectiveness of Services
- Workforce indicators
- Financial indicators

Please note that Pulse Survey Indicators are not included this quarter due to the National Staff Survey taking place.

Of the 63 performance indicators currently monitored overall performance is as follows:

- 39 (62%) are meeting or exceeding target performance levels (on target)
- 8 (13%) are almost meeting target performance levels (close to target)
- 14 (22%) are not meeting our performance standards (underperforming)
- 2 (3%) performance is monitored (No formal target)

Areas of Strong Performance

Quarter 3 has seen continued strong performance in a number of areas. Of particular note are the following areas:

- Workforce - Our rate of staff turnover has reached its lowest level over the last 12 months (14.15%) and our staff are also being supported to complete their Mandatory Training (92.93%)
- Access to services - The majority (97.7%) of adults accessing our community services are being seen within the 28 day standard and people of all ages are being seen within the 18 week referral to treat standard for all services (98.8%). 100% people referred to us with an eating disorder are able to access care within the specified 96 hours (4 days). People admitted to Specialist Community Learning Disability Services continue to be seen within the 28 day waiting standard (100%)
- Safety - Our specialist crisis resolution/ home treatment team has assessed (96.8%) service users prior to their admission to our in-patient service and people discharged from adult mental illness specialty services are contacted within 72 hrs of discharge from inpatient services (93%). Service users who are cared for using a Care Plan Approach have at least annual reviews (96.57%)
- Carers – have reported feeling valued by staff (assessed by survey on a rolling 3 month basis) 80.26% (based on survey 76 carers)
- Financial position - At the end of Quarter 3 the Trust reported a surplus of 295k YTD (against Plan of breakeven)

We have also seen a number of key areas of improvement from the Quarter 2 reported position which includes:

- Children and Adolescent Mental Health Services 28 day waiting standard –– target achieved in December (97% improved from 16%).

- EMDASS referral to diagnosis 12 week standard – target achieved in November and December (84% improved from 68%)

- Delayed transfers of care (6.85% reduced from 7.5%)

- Improving Access to Psychological Therapies - Recovery Rates improved during December

- Employment and Accommodation recording (75% improved from 66%)

- Cardio-metabolic assessments (52% improved from 42%)

Areas of Focus

Quarter 4 will see a continued focus on those remaining indicators that are below our performance standards which are either Improving, Holding (i.e. no change) or Worsening. Of particular focus are the following key areas (detail found within the report)

- Access to IAPT Services – People accessing and enrolling into Improving Access to Psychological Therapies services in Mid, West and North East Essex remains a challenge. Although anticipated to recover in Hertfordshire, access for East & North Herts remains under trajectory at the end of Quarter 3
- IAPT Recovery – All services achieved the target 50% recovery rate in December; however the overall trend for the year remains downwards and further work is being undertaken to understand and address this to ensure recovery targets are now sustained.
- Completion of Risk Assessments remains a key priority for Quarter 4; with targeted work underway within specific Strategic Business Units to improve this position.
- Sickness amongst our staff has increased in line with usual seasonal trends and this remains a key focus for us to ensure staff are supported during Quarter 4.
- The number of service users placed in Inappropriate Out of Area Placements has increased reflecting both the national trend and increased local demand.
- Service users reporting they are feeling safe is a key focus for us in Quarter 4 with work underway to further support service users whilst they admitted.
- The number of staff due for a PDP and appraisal review has seen a slight downward trend over several months. Immediate action to address this is being taken, with a longer term plan to provide managers with an automated system to support recording and better quality conversations to take place.

Conclusion & Recommendation

Overall, Trust wide performance continues to do well against a backdrop of continued increased demand for services. 75% (47 out of the 63 performance indicators monitored in Quarter 3) are exceeding, meeting or very nearly achieving the performance level required. This report highlights a number of areas that require continued focus to achieve the expected performance standards, all of which are subject to focused areas of improvement work in Quarter 4 with some improvements in performance already being achieved.

The Trust Board is asked to:

- Receive the Report
- Discuss the overall Trust's performance including the areas of strong performance, areas for improvement and the key actions being taken to address.

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

Performance Report reflects the delivery requirements of the Annual Plan and SBU Business Plans; and provides assurance against the outcomes identified to be achieved during 2019/20

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

N/A

Equality & Diversity and Public & Patient Involvement Implications:

N/A

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

All targets

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

Executive Committee Date 5th Feb 2019

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Performance Report
Quarter 3
2019/20

1. Summary

1.1 Introduction

This report provides a summary of the overall performance of the organisation during Quarter 3 against 63 national, regional and local indicators across five key groupings:

- NHS Oversight Framework - NHS Improvement
- Access to Services
- Safety and Effectiveness of Services
- Workforce indicators
- Financial indicators

See Appendix 1 for the full breakdown of all 63 indicators. Please note that Pulse Survey Indicators are not included this quarter due to the National Staff Survey taking place.

1.2 Performance Overview – Quarter 3

Overall, Trust wide performance continues to do well against a backdrop of continued increased demand for services. 75% (47 out of the 63 performance indicators monitored in Quarter 3) are exceeding, meeting or very nearly achieving the performance level required. Please note that Pulse Indicators are not included this quarter due to the National Staff Survey taking place.

Of the 63 performance indicators currently monitored overall performance is as follows:

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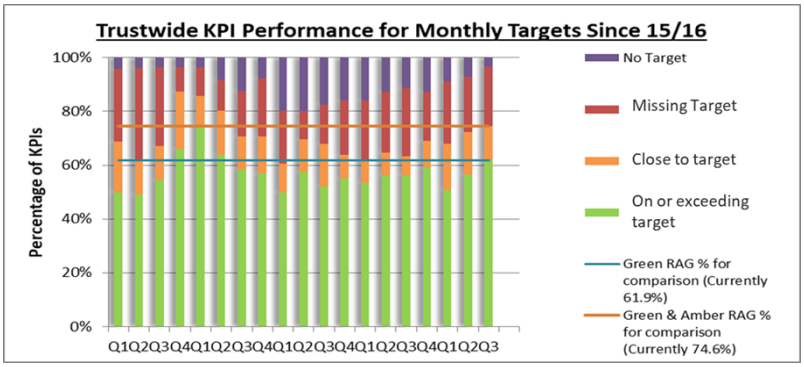

1.3 Areas of Strong Performance

Quarter 3 has seen continued strong performance in a number of areas. Of particular note are the following areas:

- Workforce - Our rate of staff turnover has reached its lowest level over the last 12 months (14.15%) and our staff are also being supported to complete their Mandatory Training (92.93%)
- Access to services - The majority (97.7%) of adults accessing our community services are being seen within the 28 day standard and people of all ages are being seen within the 18 week referral to treat standard for all services (98.8%). 100% people referred to us with an eating disorder are able to access care within the specified 96 hours (4 days). People admitted to Specialist Community Learning Disability Services continue to be seen within the 28 day waiting standard (100%)
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- Carers – have reported feeling valued by staff (assessed by survey on a rolling 3 month basis) 80.26% (based on survey 76 carers)

1.4 Areas of Improvement

The Trust has also seen a number of key areas of improvement from the Quarter 2 reported position which includes:

- Children and Adolescent Mental Health Services 28 day waiting standard –– target achieved in December (97% improved from 16%).

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- Improving Access to Psychological Therapies - Recovery Rates improved during December

- Employment and Accommodation recording (75% improved from 66%)

- Cardio-metabolic assessments (52% improved from 42%)

1.5 Areas of Focus

Quarter 4 will see a continued focus on those remaining indicators that are below our performance standards which are either Improving, Holding (i.e. no change) or Worsening. Of particular focus are the following key areas (detail found within the report)

- Access to IAPT Services – People accessing and enrolling into Improving Access to Psychological Therapies services in Mid, West and North East Essex remains a challenge. Although anticipated to recover in Hertfordshire, access for East & North Herts remains under trajectory at the end of Quarter 3
- IAPT Recovery – All services achieved the target 50% recovery rate in December; however the overall trend for the year remains downwards and further work is being undertaken to understand and address this to ensure recovery targets are now sustained.
- Completion of Risk Assessments remains a key priority for Quarter 4; with targeted work underway within specific Strategic Business Units to improve this position.
- Sickness amongst our staff has increased in line with usual seasonal trends and this remains a key focus for us to ensure staff are supported during Quarter 4.
- The number of service users placed in Inappropriate Out of Area Placements has increased reflecting both the national trend and increased local demand.
- Service users reporting they are feeling safe is a key focus for us in Quarter 4 with work underway to further support service users whilst they admitted.
- The number of staff due for a PDP and appraisal review has seen a slight downward trend over several months. Immediate action to address this is being taken, with a longer term plan to provide managers with an automated system to support recording and better quality conversations to take place.

1.6 Activity Summary

The table below provides a summary of some of the key areas of activity across the Trust during Quarter 3 providing a sense of the volume of work across the Trust. Of note are the referrals into our Single Point of Access (SPA) that are up 7% from the same quarter in 2018/19 and 9% on Year to Date figures. Also of note is a significant increase in the number of people joining our organisation (new starters) in the quarter.

A Summary of the Activity across the Trust during Quarter 3

280 adult acute admissions in Q3

6,689 new spells of care in secondary mental health services in Q3

2,977 people on CPA in Q3

9,366 people entering treatment in Wellbeing Services in Q3

65,207 individual secondary mental health contacts in Q3

6,831 discharged from secondary mental health services in Q3

404 inpatient beds in Q3

156 Starters, 96 Leavers at the end of Q3

The remainder of the paper provides an overview of performance using the five main reporting categories for the Trust:

2 NHS Oversight Framework

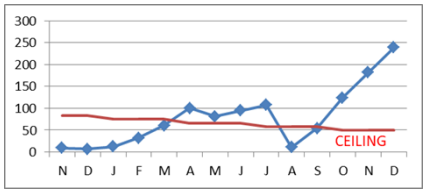
2.1 Summary of Position

There are six Key Performance Indicators (KPIs) under this domain.

- First Episode Psychosis receive treatment within 2 weeks of referral
- Data Quality Maturity Index
- Improving Access to Psychological Therapies (18 week access)
- Improving Access to Psychological Therapies (IAPT) recovery (Target 50%)
- IAPT waiting time to receive treatment (within 6 weeks)
- Inappropriate Out of Area Placements

All of the above have been met with the exception of Out of Area Placements (detail below) which also reflects the regional and national picture of demand for acute services. IAPT waiting times (18 weeks) have improved over the quarter, although IAPT access more broadly in terms of numbers of people accessing the service continues to be a continued focus for the Trust. (See section 3.)

<u>Out of Area Placements</u>

KPI	Trend	Q3 Status
Inappropriate out-of-area placements (OAPs) for adult mental health services. (Target max 50 bed days per month)		**Current performance:** **Q3:** 545 (against target 150) Increased demand has resulted in an increase of out of area placements, which also reflects the national trend. Work to address this is ongoing with a 'task and finish group' established to oversee progress.

3 Access to Services

3.1 Summary Position

In Quarter 3 the Trust consistently met 16 out of our 24 access indicators. Access has been a key area of focus during 2019/20, with significant improvements seen across a range of services, including CAMHS, EMDASS and Adult Mental Health Community services.

3.2 Strong/Improved Performance

- All Child & Adolescent Mental Health Service (CAMHS) access targets were met in Quarter 3 with the exception of the 28 day target which is significantly improved to 86.36% for the quarter and exceeded target in December at 97.83%, the highest level of performance in the last 2 years.

- 97.71% of people referred on a routine wait to adult mental health services were seen within 28 days.

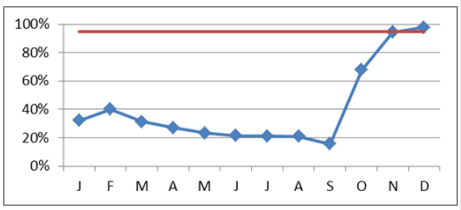
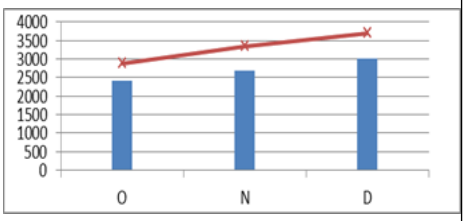
- 78.6% of all EMDASS referrals were diagnosed within 12 weeks for Quarter 3, meeting the 80% target in November and 85% in December.

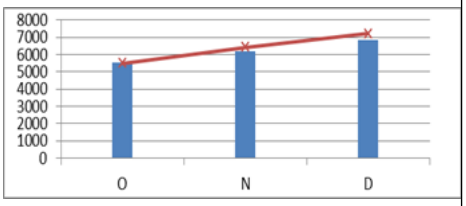
- 100% of Learning Disabilities routine referrals were seen within 28 days.

- 98.58% of people received treatment within 18 weeks in Quarter 3.

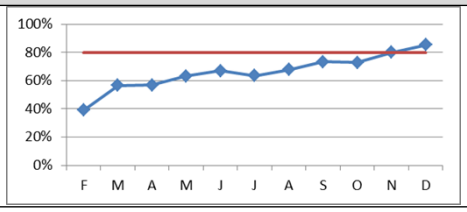
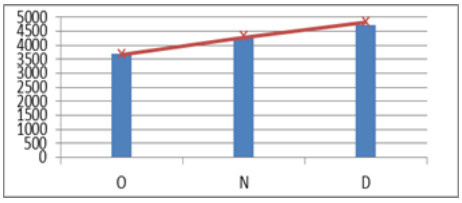
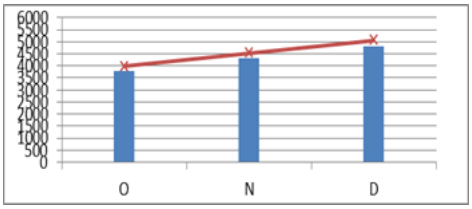
3.3 Access Indicators currently underperforming

Below is an exception summary for those KPIs that have not been met:

KPI	Trend	Q3 Status
CAMHS referrals meeting assessment waiting time standards – 28 days		**Current performance – 86.36%** Althought the target was not achieved during the Quarter, there was a stepped improvement in line with the planned trajectory and the target was exceeded in December at 97.83%.
Number of people entering IAPT treatment - West Essex (Target 3702)		**Current performance - 675 below target (Cumulative)** Targeted work is underway to imporve this position including GP referrals, targeting more self referrals. It remains very challenging to meet the set target by the end of Q4.

Number of people entering IAPT treatment (ENCCG) (Target 7207)		**Current performance – 364 below target** Slower than anticipated recruitment has impacted on performance, which was also related to the national training programme for trainees. It is anticipated the target will be achieved by the end of Q4.

3.3.1 Access Indicators - Almost Met

KPI	Trend	Q3 Status
EMDASS diagnosis within 12 weeks (Target 80%)		**Q3 Performance – 78.64%** Target achieved in November and exceeded in December. Expected to maintain performance.
Number of people entering IAPT treatment - Mid Essex (Target 4727)		**Current performance – 88 behind target** The service is slightly behind target, which coincided with a period of staff turnover. This is expected to recover by end of Q4.
Number of people entering IAPT treatment - NE Essex (Target 5061)		**Current performance – 233 below target** Recruitment to vacancies is ongoing, and plans are in place to achieve this target by the end of Q4, however this remains challenging to achieve.

4 Safety and Effectiveness of Services

4.1 Summary Position

There are 24 Safety & Effectiveness Key Performance Indicators of which 14 have been fully met, 4 are almost met, and 6 where further improvement is required. (See Appendix 1 for the full list). Indicators that have not been met in Quarter 3 have seen month on month improvement in the majority of cases across the quarter. In particular, IAPT recovery rates have seen significant improvement and are expected to be met in Quarter 4.

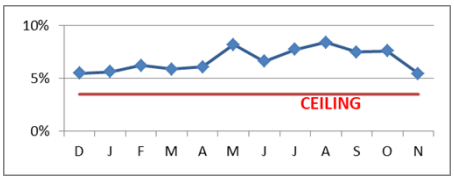
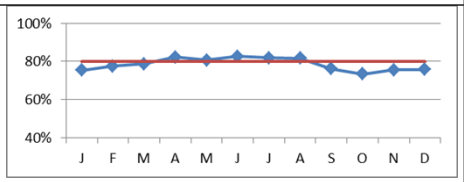
4.2 Areas of Strong/Improved Performance

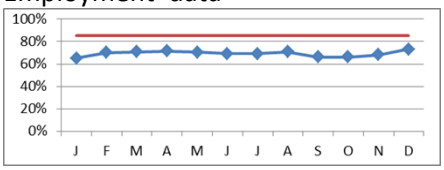
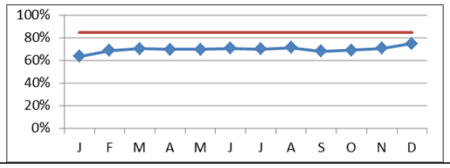
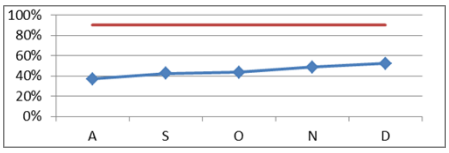
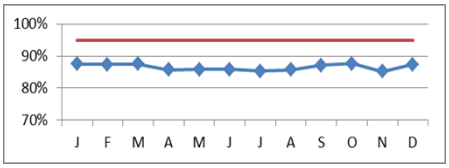
- 96.57% of people receiving a CPA review within the last 12 months.
- The percentage of adults followed up post discharge from our inpatient units within 3 days has exceeded target at 93.48% and within 7 days at 97.83%.
- The majority of service user experience indicators from Having Your Say have been positive measured against our targets, with the exception of acute inpatients feeling safe (see below)

4.3 Underperforming Indicators

There are six KPIs that have not been met during Quarter 3:

- Delayed Transfers of Care
- Acute inpatients feeling safe
- Gathering Employment data
- Gathering Accommodation Data
- Cardio-metabolic checks
- Cluster reviews
-

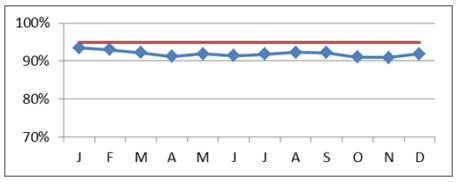
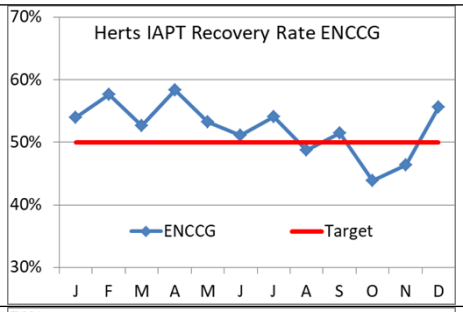
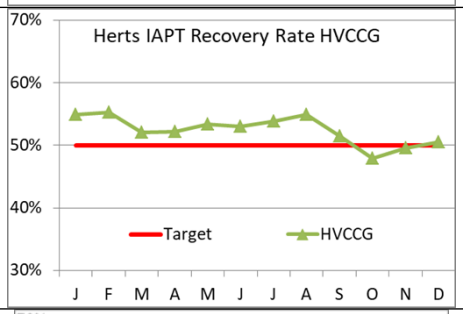
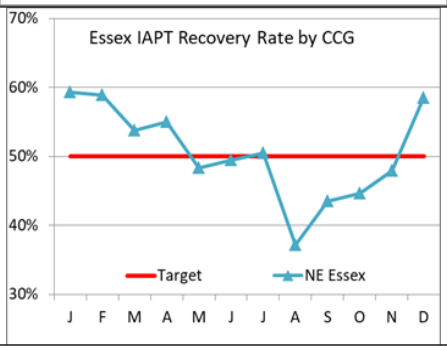
KPI	Trend	Q3 Status
Delayed Transfers of Care (DTCs) (Target 3.5%)		**Q3 Performance: 6.85%** A new Standard Operating Protocol to improve all discharges from inpatient services to our community services has been developed. However, a number of the DTCs involve complex care packages between health & social care, all of which are being tracked with work ongoing to actively resolve.
Rate of acute inpatients reporting feeling safe		**Q3 Performance: 75.78%** In line with the Quality Strategy there is a significant focus on experience of our service users on acute inpatient units. During Q4 new service user 'safety huddles' are being introduced to support our service users to feedback in real time about their experience and feeling is of feeling safe on the unit, and for action to be able to taken to support them.

Mental Health Services Data Set submissions to NHS Digital Employment Accommodation (Target 85%)	Employment data  Accommodation data  	**Q3 mean performance: 74%** Recording of employment & accommodation has continued to improve throughout Q3. HPFT Benchmarks extremely well against other trusts for these indicators. On the current trend the targets should be met for both these standards by the end of Quarter 4.
Cardio-metabolic checks for people with psychosis (Target 90% FEP 65.5%; Community CPA 43.5%)	 	**Q3 aggregate performance: 52.17%** There has been a slow but steady improvement overall. Underperformance in part has been caused by inconsistent recording. The Physical Health Care Group is actively monitoring this, with a target for full delivery by the end of Quarter 1 2020/21.
Completed cluster reviews (Target 95%)	 	**Q3 Performance: 87.36%** The trend for the year overall is flat. The new care pathways include cluster data as part of the quality metrics; which will see increased reporting during 2020/21.

4.3.1 Safety & Effectiveness - Almost Met KPIs

There are a further four KPIs which are close to being met:

- Up to date risk assessment
- Improving Access to Psychological Therapy (IAPT) East & North Herts CCG Recovery Rate
- Improving Access to Psychological Therapy (IAPT) Hertfordshire Valley CCG
- Recovery Rate Improving Access to Psychological Therapy (IAPT) NE Essex CCG Recovery Rate

KPI	Trend	Q3 Status
Rate of service users with a completed up to date Risk Assessment (Target 95%)		**Q3 performance: 91.95%** This has remained relatively stable all year, targeted work is being undertaken during Q4 to increase the number of service users with up to date risk assessments. This work is mainly targeted within E&N SBU, and has commenced during Q4.
IAPT % clients moving towards recovery (E&N H CCG) (Target 50%)		**Q3 Performance: 48.47%** Performance has recovered in December following a review of practice early in Q3. There is ongoing work to fully understand the root cause to ensure the recovery position is maintained.
IAPT % clients moving towards recovery (HVCCG) (Target 50%)		**Q3 Performance: 49.25%** Performance has recovered in December following a review of practice early in Q3. There is ongoing work to fully understand the root cause to ensure the recovery position is maintained.
IAPT % clients moving towards recovery (NE Essex) (Target 50%)		**Q3 performance: 49.57%** As previously reported, a focus on increasing the number of service users entering treatment and a number of staff vacancies contributed to this position. There is ongoing work to fully understand the root cause to ensure the recovery position is maintained.

5 Workforce

5.1 Summary position

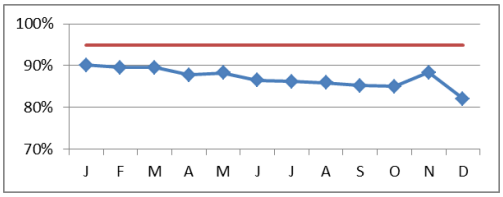
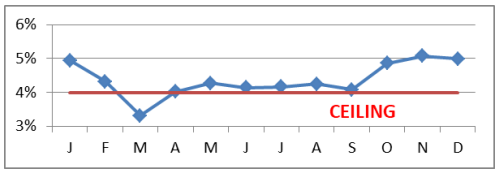
There are four KPIs monitored in Quarter 3. Two have been fully met, and two require further improvement. Mandatory Training has been achieved for the third consecutive month and Turnover has met the 2019/20 staggered quarterly target for the first time. Sickness increased in the quarter, an expected seasonal trend. PDPs and appraisal rates have fallen in December.

5.2 Areas of Strong Performance

Turnover has fallen below the staggered target of 14.3% for Quarter 3. This is the first time that target has been met since thresholds were introduced in July 2018. Mandatory training remains above the 92% target for the second consecutive quarter. The widespread adoption of the Discovery platform is a large factor in this success.

5.3 Under Performing Indicators

There are two KPIs that have not been met during November. These are; Staff with a Personal Development Plan (PDP) and the Trust sickness rate.

KPI	Trend	Status
Rate of staff with a current PDP and appraisal (Target 95%)		**Current performance: 82.07%** Activity is underway to encourage completion and recording of appraisal and PDP during Quarter 4. An online appraisal system is being considered to help simplify the process of capturing appraisal and PDP activity in the medium term.
Sickness Rate (Target <4%)		**Current performance: 4.99%** Our sickness rate was steady at just above 4% for over 6 months, and we have seen a typical seasonal trend of increased sickness over the Autumn and winter period – which reflects historic trends for the Trust and the national picture.

6. Financial Resources

6.1 Finance Overview

At the end of Quarter 3 the Trust reported a surplus of 295k YTD (against Plan of breakeven), key figures are given in the table below.

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000	Trend
Overall Surplus (Deficit)		-50	10	nil	295	0	⟷
Pay Overall inc agency		13,461	13,503	121,283	119,818	161,660	↑
Agency		483	534	4,343	4,877	5,800	↑
Secondary Commissioning		2,633	2,903	23,787	25,450	31,528	⟷

The key variances are:

- Income is above Plan YTD (£588k to date). Both the YTD and outturn income being above Plan reflects the additional Herts income now agreed particularly for CAMHS and the additional Essex IAPT income.
- Pay is for the first time above Plan in December and whilst in part reflecting the recruitment linked to the additional income it is also signalling that overall staffing levels (payroll and bank are getting close to Plan levels.) This reflects the successes in both higher levels of recruitment and the improved retention rates.
- Agency costs (net of the short term CAMHs agency agreed to support recovery of the access waiting time) are in line with Plan and for the full year should be in line with Plan and well below the National Cap.
- Secondary commissioning is tracking circa £270k worse than plan in month, which is 10% above Plan. YTD spend is £1.7m or 7% above Plan; significant pressure remains.

All figures are reported before income from the Performance Sustainability Fund (PSF). PSF income is £1.8m for the year should the Trust meet the Control Total set. Subject to the current level of external beds numbers being managed back down through the series of actions underway, then, it is expected that this will be achieved. On this basis it is also expected that the Trust will report the Use of Resource rating of 1 for the full year.

7. Quality Account – Priority Areas

Quality Account indicators were met in Quarter 3 with the exception of Inappropriate Out of Area Placements, of which there were 545 in the quarter against a target of no more than 150. This has previously been discussed in Section 2.

A table showing performance against the Priority Areas can be found in Appendix 2.

8. Conclusion

This report has evidenced the continued strong performance of the Trust during Quarter 3 2019/20. Overall, Trust wide performance continues to do well against a backdrop of continued increased demand for services. 75% (47 out of the 63 performance indicators monitored in Quarter 3) are exceeding, meeting or very nearly achieving the performance level required.

The report has highlighted a number of areas that require continued focus to achieve the expected performance standards, all of which are subject to focused areas of improvement work in Quarter 4 with some improvements in performance already being achieved.

Appendix 1 - Trustwide Dashboard

The following pages show the complete summary of KPIs, broken down by:

-Single Oversight Framework (SOF)
- Access
- Safe and Effective
- Resources

SOF

Ref	Standard	Standard	Current Period (Q3 2019/20 UNLESS STATED)	Previous Period (Q2 2019/20 UNLESS STATED)
SOF1	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)[22]	>=56% as of April 2019	70.77%	79.41%
SOF3	Data Quality Maturity Index (DQMI) – MHSDS dataset score.	>=95%	95.2% in September	93% in June
SOF4	Improving Access to Psychological Therapies (IAPT)/talking therapies • proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	>=50%	50.05%	51.17%
	• waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks (3-Month Rolling)	>=75%	84.36%	75.20%
	- within 18 weeks	>=95%	99.91%	99.62%
SOF5	Inappropriate out-of-area placements for adult mental health services	<= 150 for Q3 2019/20	545 (150)	172 (175)

Access

Ref	Indicator	Target	Current Period Performance (Q3 2019/20)	Previous Period Performance (Q2 2019/20)
A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**	>=98%	100.00%	100.00%
A2	Data Quality Maturity Index (DQMI) – MHSDS dataset score.	>=98%	100.00%	98.61%
A3	Number of new cases of psychosis **(Contractual)**	150 in year (stay above cumulative threshold of 12.5 per month)	208 (Cumulative)	143 (Cumulative)
A4	Routine referrals to community mental health team meeting 28 day wait **(Contractual)**	>=95%	97.71%	92.65%
A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**	>=98%	100.00%	66.67%
A6	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	>=95%	96.80%	96.98%
A7	CATT referrals meeting 4 hour wait **(Contractual)**	>=98%	100.00%	100.00%
A10	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**	>=98%	100%	98.82%
A11	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait **(Contractual)**	>=98%	Zero	Zero
A12	EMDASS Diagnosis within 12 weeks (Contractual)	>=80%	78.64%	68.03%
A13	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**	>=95%	95.81%	98.68%
A14	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**	>=75%	79.73%	77.08%
A15	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**	>=85%	87.50%	96.15%
A16	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**	>=85%	91.30%	100.00%
A17	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**	>=95%	86.36%	19.23%
A21	SPA referrals with an outcome within 14 days (Internal)	>=95%	97.72%	99.76%
A22	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services (Contractual)	>=98%	98.58%	96.78%
A23	Number of people entering IAPT treatment (ENCCG) **(Contractual)**	7207 to end of December	6843 (7207)	6209 (6428)
A24	Number of people entering IAPT treatment (HVCCG) **(Contractual)**	8866 to end of December	9046 (8866)	8226 (8120)
A25	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**	4815 to end of December	4727 (4815)	4275 (4290)
A26	Number of people entering IAPT treatment (West Essex) (Contractual)	3702 to end of December	3027 (3702)	2701 (3346)
A27	Number of people entering IAPT treatment (NE Essex) (Contractual)	5061 to end of December	4828 (5061)	4316 (4535)

Safe and Effective

Ref	Indicator	Target	Current Period Performance (Q3 2019/20)	Previous Period Performance (Q2 2019/20)
SE1	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	>=95%	96.57%	94.87%
SE2	Data Quality Maturity Index (DQMI) – MHSDS dataset score.	<=3.5%	6.85%	7.57%
SE3	Care Programme Approach (CPA): The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	>=95%	97.83%	96.99%
SE4	The percentage of people under adult mental illness specialties who were followed up within 72 hrs of discharge from psychiatric in-patient care	>=90%	93.48%	91.60%
SE5	Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) **Seen Only**	>=95%	91.95%	92.17%
SE6	IAPT % clients moving towards recovery (ENCCG)	>=50%	48.47%	51.51%
SE7	IAPT % clients moving towards recovery (HVCCG)	>=50%	49.25%	53.34%
SE8	IAPT % clients moving towards recovery (Mid Essex)	>=50%	53.76%	52.98%
SE9	IAPT % clients moving towards recovery (NE Essex)	>=50%	49.57%	43.79%
SE10	IAPT % of clients moving towards recovery (W Essex)	>=50%	51.67%	52.14%
SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**	>=80%	75.78%	76.16%
SE12	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=80%	83.53%	86.23%
SE13	Rate of service users saying they are treated in a way that reflects the Trust's values	>=80%	82.38%	80.99%
SE14	Rate of Service Users Saying staff are welcoming and friendly (Rolling 3 months)	>= 95%	97.65%	95.95%
SE15	Rate of Service Users saying they know how to get support and advice at a time of crisis (Rolling 3 months)	>= 83%	84.12%	88.84%
SE16	Rate of Service Users saying they have been involved in discussions about their care (Rolling 3 months)	>= 85%	87.28%	88.31%
SE17	Rate of carers that feel valued by staff **(rolling 3 month basis)**	>=75%	80.26%	82.89%
SE18	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	>=70%	N/A	81.01% Q2
SE15	Rate of Community service users saying the services they receive have helped them look to the future more confidently **(rolling 3 month basis)**	>=60%		
SE19	Percentage of eligible service users with a PbR cluster	95%	95.60%	94.58%
SE20	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)	95%	87.36%	87.15%
SE21	Data completeness against minimum dataset for Ethnicity (MHSDS)	90%	92.37%	94.63%
SE22	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: identifier metrics	>=95%	99.71%	99.76%
SE23.a	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • Employment	>=85%	72.98%	66.17%
SE23.b	• Accomodation	>=85%	74.97%	67.98%
SE24	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards, early intervention in psychosis services and community mental health services (people on Care Programme Approach) 23	>=90%	52.17%	42.56%

Workforce

Ref	Indicator (Monitor/Contractual/Internal)	Target	Current Period Performance (Q3 2019/20)	Previous Period Performance (Q2 2019/20)
W1	Staff saying they would recommend the Trust as a place to work	>=61%	N/A	85.69%
W2	Data Quality Maturity Index (DQMI) – MHSDS dataset score.	75%	N/A	72.09%
W3	Rate of staff that report experiencing physical violence from service users	5%	N/A	10.10%
W6	Rate of staff with a current PDP and appraisal	>=95%	82.07%	85.24%
W7	Rate of mandatory training completed and up to date	>=92%	92.93%	92.84%
W8	Sickness rate	<=4%	4.97%	4.17%
W9	Turnover rate (Rolling 12 months)	14.3%	14.15%	15.30%

Appendix 2: Quality Account: Priority Areas for 2019/20

Patient (service user) Safety		Target	Q1	Q2	Q3	Q4	2019/20
1	The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	≥=95%	98.41%	96.99%*	97.83%		
2	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)	N/A	Reported Annually				
3	Inappropriate out-of-area placements for adult mental health services (NHSI)	150	276*	172	545		
Clinical Effectiveness							
4i)	Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI) The percentage of service users aged: **0 to 14**	≤=7.5%	0%	0%	0%		
4ii)	**15 or over**	≤=7.5%	7.4%	7.03%	7.4%		
5	Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)	≥=56%	78.67%	79.41%*	70.77%		
6	The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)	≥=95%	96.92%	96.98%	96.80%		
Service User and Carer Experience							
7	Carers feeling valued by staff	≥=75%	76.00%*	82.89%*	80.26%		
8	Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family	≥= 70%	83.33%*	81.01%*	**N/A**		
9	The Trust's 'service user experience of community mental health services' indicator score with regard to a service user's experience of contact with a health or social care worker during the reporting period (NHSI)		Reported Annually				

* Figure amended from previous report.

Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item: 13**
Subject:	Annual Plan 2019/20 - Quarter 3 - Report	**For Publication: Yes**
Author:	Michael Thorpe, Deputy Director of Improvement and Innovation & Karen Taylor, Executive Director Strategy & Integration	**Approved by:** Karen Taylor, Executive Director, Strategy & Integration
Presented by:	Karen Taylor, Executive Director, Strategy & Integration	

Purpose of the report:

To present the Trust's performance against the Annual Plan for Quarter 3 of 2019/20

Action required:

To receive the report, discussing the content and implications for Trust performance

Summary and recommendations:

The Annual Plan comprises of seven objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust needs to take and the milestones to be reached, by quarter, in order to deliver the Trust's agreed outcomes for the year. At the end of each quarter each objective receives two RAG ratings which provide:

- An assessment of whether the Trust is on track to achieve the stated outcome(s) by the end of the year
- An assessment of whether the milestones/actions planned for that quarter were achieved.

Year End Outcomes

We measure the success of our Annual Plan against the outcomes we achieve for our service users, their carers, our staff and our services. At the beginning of the year we identified 50 main outcomes to be achieved across our seven strategic objectives. The significant work that has taken place during Quarter 3 means the Trust is in a strong position with 82% of the year end outcomes (41/50) on track to be fully delivered, with work ongoing to further improve this position during Quarter 4.

At this stage of the year however, there are three outcomes that are unlikely to be fully delivered by the end of 19/20. One of these outcomes relates to Objective 1 (safety) reflecting what our service users are telling us about their experience of 'feeling safe' on our inpatient units. Two of the outcomes relate to Objective 2 (experience). Firstly, we are unlikely to fully achieve our access targets for Improving Access to Psychological Therapies and secondly, the work we anticipated taking forward to improve the experience for our carers has not progressed as quickly as we had originally planned. Overall, this means that at the end of

Quarter 3 five (out of seven) objectives are on track to fully deliver the planned end of year outcomes (RAG rated Green).

Conclusion

This report has demonstrated the extensive activity undertaken during Quarter 3 to deliver the priorities outlined in the Annual Plan. Significant progress has been made with the vast majority of milestones delivered and outcomes on track to be delivered. The majority of end of year outcomes are on track to be delivered (82%) and work is ongoing to further improve this position during Quarter 4.

The attached paper summarises progress against the Annual Plan and provides a detailed commentary, by objective, against the milestones delivered during Quarter 3. It also provides a detailed commentary, by objective, against the required outcomes and a projected end of year position.

Summary & Recommendation

The Trust Board is asked to;

- Receive the Quarter 3 Annual Plan report noting the significant progress that has been made
- Note the projected year end position, including the overall delivery against the Annual Plan outcomes

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

Summarises progress against Annual Plan (all objectives)

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

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

Equality & Diversity and Public & Patient Involvement Implications:

None noted

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

Provides evidence across range of areas

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

Executive Committee Date 5th Feb 2020

Hertfordshire Partnership University NHS Foundation Trust

TRUST ANNUAL PLAN 2019/20

QUARTER 3 REPORT

1. Summary

The Annual plan comprises of seven strategic objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust will take and the milestones to be reached, by quarter, to deliver the Trust's agreed outcomes for the year. At the end of each quarter each objective receives two RAG ratings providing:

- An assessment of whether the Trust is on track to achieve the stated outcome(s) by the end of the year

- An assessment of whether the milestones/actions planned for that quarter were achieved.

2. Progress against End of Year Outcomes

We measure the success of our Annual Plan against the outcomes we achieve for our service users, their carers, our staff and our services. At the beginning of the year we identified 50 main outcomes we wanted to achieve across our seven strategic objectives.

The significant work that has taken place during the first three quarters of the year means the Trust is in a strong position with 82% of the year end outcomes (41/50) on track to be fully delivered, with work ongoing to further improve this position during Quarter 4. Appendix 2 provides a detailed overview of the activities that have taken place and the milestones achieved during Quarter 3 itself.

18% of the outcomes (9) are currently rated as partially delivered, with only three of those nine outcomes currently assessed as unlikely to be fully achieved by the end

of the year. When reviewing the outcomes across the seven strategic objectives at the end of Quarter 3, this means five (out of seven) objectives have been assessed as on track to fully deliver the planned end of year outcomes

Table 1 below provides a summary of the projected Year end RAG ratings by objective.

Table 1 End of Year projected RAG projection

Objective		**End of Year Projection**
1	We will provide safe services, so that people feel safe and are protected from avoidable harm	6 out of 7 outcomes
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	6 out of 8 outcomes
3	We will improve the health of our service users through the delivery of effective evidence based practice	6/6 outcomes
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	5/5 outcomes
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	6/6 Outcomes
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	9/9 Outcomes
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	9/9 outcomes

The Amber rated objectives are as follows:

Objective 1 – Safety

The amber rating reflects the percentage of our service users reporting feeling safe in our inpatient acute services. Work is ongoing with the implementation of our 'Making our Services Safer – Together' strategy and Quarter 4 will see further targeted work in this area including the introduction of service user safety huddles.

Objective 2 – Experience

The Amber rating reflects our performance for Improving Access to Psychological Therapies (IAPT) which is behind trajectory and also slower than anticipated progress in regards to improving carers experience.

3. Performance against Milestones

At the end of Quarter 3, five (out of seven) objectives delivered fully against the milestones set for the quarter. (RAG rated Green). Two objectives have been RAG rated Amber reflecting the current performance and achievement against key milestones.

Table 2 – Q3 milestones RAG rating

Objective		Q3 RAG rating
1	We will provide safe services, so that people feel safe and are protected from avoidable harm	
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	
3	We will improve the health of our service users through the delivery of effective evidence based practice	
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	
6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	

Objective 2 – Experience

This objective was rated Amber due to the slower than anticipated progress made to deliver the work related to carers. This work is being taken forward during Quarter 4.

Objective 6 – Joined up Care

This objective has been rated Amber due to falling behind against planned milestones for the community transformation. However, the pre-work that has taken place in Quarter 3 provides the platform for the milestones to be delivered during Quarter 4.

4. Conclusion

This report has demonstrated the extensive activity undertaken during Quarter 3 to deliver the priorities outlined in the Annual Plan. Significant progress has been

made with the vast majority of milestones delivered and outcomes on track to be delivered. The majority of end of year outcomes are also on track to be delivered (82%). Work is ongoing to further improve this position during Quarter 4.

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

	Objective	EOY Projection at			EOY Actual	Year End Outcomes Commentary
		Q1	Q2	Q3	Q4	
1	We will provide safe services, so that people feel safe and are protected from avoidable harm					Good progress has been made against the key milestones during Quarter 3, with a positive impact on outcomes including a reduction in suspected suicides. The year-end outcome remains Amber, reflecting the 'feeling safe' experience of service users on our inpatient units. Quarter 4 will see further targeted work in this area including the introduction of service user safety huddles.
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience					Positive progress made during the quarter with really good progress around Pathways. However the carer work remains challenged and performance in IAPT is not currently on track to deliver the end of year access target.
3	We will improve the health of our service users through the delivery of effective evidence based practice					Most Q3 milestones were met, with strong progress made in regards to progressing the development pathways consistently across HPFT. Evidence that research is being embedded in the trust is behind projection but plans in place mean we expect to recover in Q4.
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment					Good progress made in Q3 with a new approach to recruitment including targeted recruitment events. Vacancy and turnover rates continue to drop across the Trust's and the recruitment pipeline is strong. We have growing confidence that we are optimising our approach to recruitment and retention
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care					All key enabler actions have been delivered during this quarter. CQI and Digital activities are progressing well. CRES targets will be achieved; although this is supported in part by non-recurrent schemes, which are being targeted to identify recurrent schemes on an ongoing basis.
6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners					Good progress has been made in Quarter 3 with Pathways developed. However, bed configuration proposals for LD and Essex are behind trajectory, though it is anticipated the options appraisal will be concluded by the end of the year.
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)					HPFT has led discussions regarding the future model of MH & LD within the new system architecture, with agreement to develop a Hertfordshire Integrated Care Partnership for LD & MH. Quarter 3 has seen further progress against all the key milestones, with the East of England (EOE) Collaborative moving forward to its next stage of development.

Appendix 2 – Annual Plan 2019/20 - Quarter 3

Commentary against Milestones and Outcomes

Great Care, Great Outcomes

Strategic Objective 1 (Owner JP)	Q3 Key Actions / Milestones	Q3 Milestones Rating
We will provide safe services, so that people feel safe and are protected from avoidable harm **Key Priorities** We will continue our drive to reduce suicides and prevent avoidable harm We will continue to ensure our service users feel safe across our inpatient units We will ensure seclusion and restrictive practices and environments across the Trust are in line with best practice	• Implement discharge support programme • Facilitate suicide prevention conference in collaboration with external stakeholders • Review signposting and resources for those in crisis • Launch of MOSS 2gether strategy and its work plan • Each inpatient unit to implement a minimum of a further 2 x SafeWard methodologies, working with the EbEs • Each inpatient unit evaluate the implementation of the safety huddles & safety crosses • Revised RESPECT training provision and resource planned to include local trainers • HOPE(S) model of care training to all service areas • Develop a process to improve debriefing (staff & Service users) following the use of restrictive practice to ensure critical learning takes place & appropriate support	
	Commentary:	
	• Discharge follow ups and supports are fully implemented, closely monitored and delivering consistently and above target • Suicide and Crisis collaboration and resourcing work is progressing well and meeting all milestones • MOSS2Gether, SafeWard and Safety Crosses are well socialised and forming part of normal practice in the trust. Vigilance is needed to support momentum. • The HOPE model and RESPECT training are making steady progress but are both behind target. With focus the trajectory is recoverable for Q4.	

Summary:	Key Outcomes at Year End	Year End projection
Good progress has been made against the key milestones during Quarter 3, with a positive impact on outcomes including a reduction in suspected suicides. The year-end outcome remains Amber, reflecting performance regarding service users feeling safe in inpatient wards.	• 10% reduction suspected suicides (12 per quarter) • Suicides relative to total contacts with HPFT. (Baseline 5.07^{-4}) • 85% service users report feeling safe across adult & CAMHS inpatients • < moderate - severe harm as consequence violence & aggression (<54) • < Moderate - severe harm as % of violence & aggression (baseline 13%) • > % staff reporting feeling safe (82% baseline) • Reduction in the length of time spent in seclusion per episode • Safety Suites opened (deferred to Q1 2020/21)	

Strategic Objective 2 (Owner SB)	Q3 Key Actions / Milestones	Q3 milestones Rating
We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience **Key Priorities** We will improve the timeliness and experience of accessing our services and subsequent treatment We will improve the quality and experience of the environment across our services (physical estate, standard of food, cleanliness). We will improve the ways in which we recognise and support carers	• Evaluate FRS & CATT to develop 24hr First Response & Home Treatment models • Implement trailblazer pathways and new model CAMHS Community service • Evaluate primary care provision & scope expansion • IAPT - scope physical health improvements • Commence refurbishment of Forest Lane, Phase II colonnades commenced • Refurbishment of Aston Ward incl. dormitory areas complete, Thumbswood extension completed • Review of passport referrals • Routine referral in place via Paris for carers between Acute & Community Services • Learning event re: social care practice with carers • IAPT – digital strategy and plans to be implemented • Refurbishment of Oak Ward s136 room completed • Launch updated carer literature for promoting support offer for carers • Evaluate and scale up 'induction groups' • Evaluation of HPFT Carer Pathway & launch new staff carer awareness training program	
	Commentary:	
	• Crisis response and pathways well developed with good evidence of adoptions • Refurbishment work completed or well underway • Mixed success in IAPT with good progress in physical health improvements balanced against slow progress in digital plans for IAPT. The digital plans for IAPT are a key pillar of IAPT capacity work and needs to be recovered in Q4 to avoid missing key performance outcomes for year end. • Slow progress into Q3 around meeting project milestones for carers. Carer assessments in Quarter 3 remain static, and recovery in Q4 will require significant focus to deliver.	

Summary:	Key Outcomes at Year End	Year End Projection
Positive progress made during the quarter with really good progress around Pathways. However the carer work remains challenged and mixed performance in IAPT means the end of year outcomes are unlikely to be fully achieved	• Improved crisis access (service users have a crisis plan in place within an hour) • >95% access standard achieved in both CAMHS and Adult MHS • CAMHS trailblazer in place. • CAMHS reduction in wait to treatment time • > access to our IAPT services – in line with contract standards for all 4 CCGs • Refurbishment of Albany Lodge and Aston Ward • Business case for re-provision of adult acute beds for E&N Herts • Remodelling community hubs leading to improvements in experience metrics • Implement the plans outlined in our carers plan for 2019/20	

Strategic Objective 3 (Owner AZ)	Q3 Key Actions / Milestones	Q3 Milestones Rating
We will improve the health of our service users through the delivery of effective evidence based practice **Key Priorities** We will improve the effectiveness of our interventions through the implementation of evidence based pathways We will improve our physical health practices across the Trust We will develop our approach to research to strengthen the relationship between practice, research and audit	• Audit length of time service users remain under CATT pathway/under CATT care • Pilot equipment for physical health monitoring for recording physical health • Clozapine point of care testing to be available in all the clozapine clinics • Roll out of PH priority training (phase 2) • Roll out phase 2 NEWS2 in community • PD pathway - clinical outcome measure available on SPIKE	
	Commentary:	
	• Measures have been agreed for pathways however training and progress in developing the measures in SPIKE has been slow. Milestones are recoverable in Q4 and recovery plans are in place to get back on track. • Physical health and clozapine testing equipment have been installed and are in use. Teething problems with IT have hampered adoption but these will be ironed out in Q4. • NEWS2 rollout progress has been good and will continue to throughout the rest of the year and until it forms part of business as usual activities for the Trust • Evidence that research profile is being raised across the trust is behind projection. Events in Q4 have been organised to address this and the Q4 audit of application for CLARCH and NIHR is expected to show improvements.	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection

Most Q3 milestones were met, with strong progress made in regards to progression the development pathways consistently across HPFT. Research strategy & profile is behind projections but plans in place to move forward during Q4. Consistency of pathways and outcomes are a key focus for Quarter 4.	• Fully implement new pathways and services to support recovery for
	  ▪ Psychosis; Dementia; All age Personality Disorder (PD)
	  ▪ Crisis care pathway; Learning Disability (LD) services in Essex
	• All pathways across the Trust include physical health
	• Physical health training & equipment for our staff across the Trust
	• Work with partners and experts in physical health to improve services
	• New model of research and research strategy – aligned to service & innovation
	• Profile of research raised across the organisation.
		

<table>
<tr><th>Strategic Objective 4
(Owner SY)</th><th>Q3 Key Actions / Milestones</th><th>Q3 Milestones Rating</th></tr>
<tr><td rowspan="2">We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment

Key Priorities
We will continue to focus on and deliver key high impact recruitment and retention activities

We will develop an inclusive culture where all staff feels safe and valued.

We will continue to develop the collective leadership culture of the organisation where staff feel empowered and engaged</td><td>• Workforce of future strategy approved
• Expansion of career conversations
• Run disability awareness training
• HR surgeries with a focus improving the experience for BAME staff to be held throughout Q3
• Third set of teams commence on high performing teams framework
• Implement increased functionality of Trust Intranet
• Succession plans in place across the Trust</td><td></td></tr>
<tr><td colspan="2">Commentary:
• Workforce of the future is being taken forward under the national workforce planning initiative. This is a positive move and shows workforce planning at the STP level as well as locally.
• Vacancy and turnover rates continue to drop across the trust and recruitment pipeline is very healthy
• Talent mapping continuing in SBUs, however succession plans not complete.
• Milestones have been met for focussed work around BAME and disability awareness and we expect this to show progress in our results at the end of the year.
• Infrastructure and training around the intranet and Great Teams (formerly High Performing Teams) continues to meet milestones and business impact from these is expected by the end of next quarter.</td></tr>
<tr><th colspan="2">Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes</th></tr>
<tr><td colspan="2">Good progress made in Q3 with a new approach to recruitment including targeted recruitment events. Vacancy and turnover rates continue to drop across the Trust's and the recruitment pipeline is healthy. We have growing confidence that we are optimising our approach to recruitment and retention. There is a continued need to focus on supporting evidence of significant improvement in the experience of our BAME staff and staff living with disabilities.</td><td>• Recruitment – Target of <12% vacancy rate by year end
• Retention – Target of <14.7% turnover rate by year end
• Develop our Just and Inclusive Culture across the Trust
• Significant improvement in the experience of our BAME staff and staff with a disability
• High Performing Teams (Great Teams) Model implemented</td><td></td></tr>
</table>

Strategic Objective 5 (Owner KL/JP)	Q3 Key Actions / Milestones	Q3 Milestones Rating
We will improve, innovate and transform our services to provide the most effective, productive and high quality care • We will create a culture and environment where we embed continuous quality improvement approach to deliver Great Care and Great Outcomes. • We will provide staff and teams with better access to the right information to do their jobs effectively and efficiently • We will enable more effective ways of working that value service user, carer and staff time.	• 2nd cohort of senior leaders trained in CQI skills and expertise • Gather evidence on staff accessing the iHub being able to generate ideas and test new approaches to solving problems • Business case developed for Skype Video full roll-out (subject to positive evaluation) • Business case developed for Single Sign On • Business case approved for Single Service User View System • All PCs migrated to Windows 10 and upgraded to current specification • All mobile phones in scope migrated to EE contract with enterprise data • Productivity reporting included within performance monitoring • Productivity Dashboard Live in SPIKE • Big Hand productivity gains incorporated into Delivering Value programme targets	
	Commentary:	
	• CQI continues to meet its milestones and there is an increased sense that the movement towards CQI being 'the way we do things round here' has made a strong start. • The recovery of key access measures using CQI is building confidence in our approach and training. • Enabling IT projects have met milestones and are making it easier for our staff to collaborate and use our systems. • Good progress has been made with productivity dashboards and performance monitoring but targets have been narrowly missed for the Quarter.	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
All key enabler actions have been delivered during this quarter. CQI and Digital activities are progressing well. CRES targets are reporting a trajectory to meet target by year end, focus in Quarter 4 will be to ensure remaining non-recurrent schemes translated to recurrent savings.	• CQI model implemented with 1000 staff utilising CQI training & facilities • Digital Strategy finalised – focus for the next 5 years • Improve time to care to 50% for all staff • Streamline and further develop our Electronic Patient Record system to support delivery of care and system interoperability. • CRES £6.5m delivered without a negative impact on quality • £1m corporate CRES delivered	

Strategic Objective 6 (Owner KT/SB)	Q3 Key Actions / Milestones	Q3 Milestones Rating
We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners **Key Priorities** We will develop and deliver new models of care in our older persons services We will implement our new model of care across Learning Disability Services in Essex We will develop a new model of primary mental health across Hertfordshire	• HV community frailty hub mobilised • Delivery of level 2 frailty and dementia training to 60 MHSOP staff • Phased approach commences to MHSOP locality mobilisation in some localities • Locality plans agreed for 2020/21 • Stakeholder engagement plan for new service agreed • Review of transformation to be undertaken • Evaluate primary care provision & scope expansion for 2020/21	
	Commentary:	
	• HPFT has played an active role in working with colleagues shaping new community frailty pathways for both CCGs • More than 60 community and inpatient older people services staff trained in frailty awareness during Q3. • Community Teams have mapped their caseloads and staffing numbers against primary care networks and early adopter activity is mobilising well in the community. • Stakeholder engagement has slipped into Q4 in part due to the level of involvement and engagement in Q3. This engagement is tied to review of transformation and the evaluation of plans for primary care provision and expansion. The investment in time in Q3 and Q4 will help ensure success in the longer term. • New community transformation programme in place; in line with the national programme – recruitment to project manager undertaken.	

Summary:	Key Outcomes at Year End	Year End Outcomes
Good progress has been made in Quarter 3 with frailty pathway making good progress. However, bed configuration proposals for LD and Essex is behind trajectory, although it is anticipated the options appraisal will be concluded by the end of the year.	• We will develop and mobilise our response to Frailty, Primary Mental Health Care Teams and Dementia pathways • New model for Older People's community services will be in place • We will develop new ways of working with care homes • < reduced time to dementia assessment and diagnosis • Mobilise and implement transformation of LD Services • Access to service improved through new 'Way in' service • LD Essex - bed configuration option approved • Adult >95% service users will be able to access services within 28 days • Adult < reduced time to treatment and ongoing care	

Strategic Objective 7 (Owner KT)	Q3 Key Actions / Milestones	Q3 Milestones Rating
We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s) **Priorities** We will lead and drive the development of a population based model for Mental Health & LD focused on improving care & outcomes We will actively support the development of the STP and population health, including the development of the Integrated Care System and Integrated Care Alliances. We will support and drive the development of a new model of care for CAMHS across Hertfordshire We will work at a regional wide level to establish New Care Models	• Stakeholder review and approval of MH/LD 'Manifesto' for the system • Review HPFT engagement with locality provider boards following start-up of primary care networks • CAMHS system change business case complete and approved by stake holders, with continued design of clinical model • Continued contribution all STP work streams • Business Plan for CAMHS T4 developed and submitted to NHSE, supported submission of Forensic and ED business cases	
	Commentary: • Mental Health & Learning Disability Partnership has been agreed for Hertfordshire and is now in its early stages of development, with a Partnership Board in place (met twice). Broader stakeholder event being planned for April. • HPFT senior leadership team is engaged with the emergent geographical ICPs. • Improvement initiatives are making good progress; many are taking place under CQI projects. (e.g. CAMHS, Older people). • EOE Collaborative – business case due be submitted in March, activity and financial information has now been released by NHSE. CAMHS submission has met milestones and position the Trust well for ongoing development and integration work.	

Summary	Key Outcomes at Year End	Year End Outcomes Projection
HPFT has led discussions locally, regionally and nationally regarding the future model of MH & LD within new system architecture. The Herts & West Essex STP has agreed the development of an ICP MH & LD for Hertfordshire. Quarter 3 has seen further progress against all the key milestones, with the EOE Collaborative moving forward to its next stage of development. The HWE STP Long Term Plan and operating plan identify and prioritise funding for MH & LD.	• STP continues to prioritise & invest in MH & Learning Disabilities • Clear manifesto agreed for MH & LD future model • HWE STP population health model continues to develop • Mental Health Investment Standard is met within 2019/20 • MH & LD overtly prioritised within STP strategy & workstreams • System wide CAMHS transformation programme agreed & in place • CAMHS <28 day access achieved • East of England (EOE) Provider Collaborative established • Plans for development of services across EOE under development	

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 14
Subject:	Financial Summary to 31st January 2020	**For Publication:**
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 forecast financial position for the full year and the key considerations in relation to the End of Year position.

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 January, which is a deficit in month of £36k against Plan of £0k, and a surplus year to date of £259k against Plan of £0k (excluding PSF.) The report explains that the in-month position was in line with expectations and that the forecast out-turn remains a marginal surplus which will mean the Trust has met its Control Total for the year and triggers the earning of the full amount of the Provider Sustainability Funding (PSF) of £1.9m.

The position in month is broadly as forecast:

- Income has held at the higher level reflecting the release of income in line with new services being recruited too, as noted in section five below there remains a level of income that has still to be finalised and released by commissioners. This will be where appropriate carried forward into the next year.
- There has been good progress on CQUIN targets within Hertfordshire albeit the position remains behind Plan.
- Linked to the above is the additional pay cost this month reflecting an increase in Payroll headcount with the last months seeing a sustained net recruitment. Agency costs have seen some increase in month mainly within medical posts.
- Overall additional short term external bed costs held slightly above recent levels which was encouraging but costs are still above Plan and this remains the key area of cost risk.
- 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 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 Board that given the low margin level, the growth in activity and its volatility means there is a continuing risk to the position which is most significant with:

- The strong success in which means pay costs are back towards Plan levels
- The internal demand on beds with the potential further impact of winter bed pressures within the acute sector.

Work continues on the 2020/21 Plan and the significant savings requirement given the underlying gap and the continuing growth in demand.

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 January there is a deficit of £36k reported against a Plan of £0k, and for the year to date a surplus of £259k against a Plan of £0k. The position has therefore remained ahead of Plan for the year to date, but spend has increased in January leading to a deficit in month as expected. This position is driven by income staying broadly in line with Month 9, including £114k to pay for CQI training; reduced overhead and financing costs; offset by increasing pay costs and other direct costs such as drugs. There was a net increase in fte of 55.29, and external bed costs remain high (though not increased).

2.2. A summary of key figures is reported below:

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000	Trend
Overall Surplus (Deficit)		0	-36	0	259	0	
Pay Overall		13,461	13,590	134,744	133,409	161,660	
Agency		483	505	4,825	5,383*	5,800	
Secondary Commissioning		2,633	2,924	26,420	28,375	31,528	

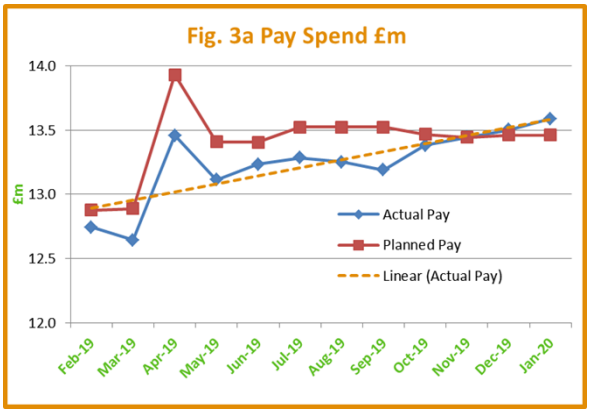
* NB without spend on CAMHS 28 Day Project, which commissioners will separately fund, this would be on Plan for the year to date

2.3. The Trust's Use of Resources (UOR) framework rating for January remains as a 1, the highest rating, with the Trust's surplus position slightly ahead of the Plan year to date. The detailed calculation of the UOR is shown as an Appendix with the main in month movements highlighted below:

Metric	Rating	Reported Rating	Commentary
Capital Servicing Capacity	1.8	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 £58.1m supporting liquidity metric.
I&E Margin	2.2	2	Stayed the same in month
I&E Variance	1.9	1	Stayed the same in month
Agency Spend	1.4	1	Stayed the same in month, overall spend is still under the NHSI agency cap.
UOR Overall		1	

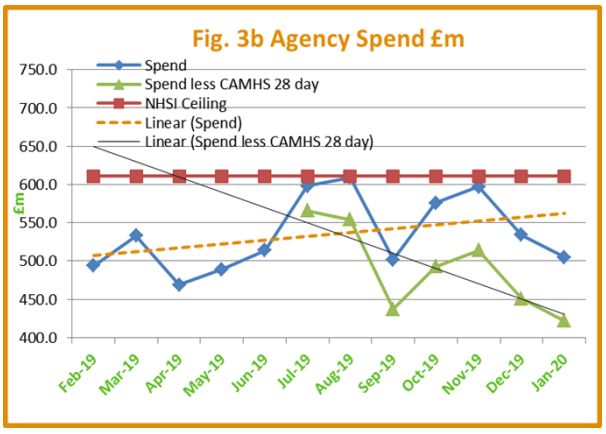
2.4. All figures are reported before any income from the Provider Sustainability Fund (PSF) which is expected to be £220k for the month and £1.5m for the year to date, assuming the Control Total is met. Additionally, incentive PSF for 2018/19 of £443k is shown in the year to date position (but is similarly not part of the Control Total).

3. *Trading Position*



3.1. Pay costs totalled £13.6m for the month against the Plan of £13.5m, and £133.4m for the year to date against a Plan of £134.7m. 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 through to January 2020. Total Pay being above Plan in month reflects the fact that additional unplanned income has been secured mainly around CAMHs

3.2. As noted elsewhere there has been a marked increase in net recruitment in recent months with ftes increasing by 55 in January which amongst the highest net monthly changes this year.



3.3. Agency spend was £505k for the month and £5.4m for the year to date, still just within the NHSI Ceiling but above the Internal Trust Plan year to date. Fig. 3b shows the overall spend and indicates a small increase through the last 12 months, however it should be noted that £484k to date relates to exceptional expenditure on the CAMHS, which will be separately funded by commissioners (income is estimated and included within this position); without this spend has decreased. However, in month 10 there was a backdated adjustment on CAMHS for revised activity, without this the overall agency spend would have increased in January, which is of concern. Largely the issues remain in inpatient areas, medical, and some adult community areas.

3.4. Work is ongoing to further improve 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 the forecast spend is £5.7m, which is an increase on previous months, mainly due to continued pressure in inpatient units and for medical agency covering vacancies, sickness, and maternity leave.

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 10)	Year to Date Actual Spend (as at Month 10)	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	2,364	2,347	-17	2,765
CAMHS 28 day etc.	0	0	0	487	487	659
LD&F SBU	464	424	354	204	-149	247
Essex & IAPT SBU	272	213	178	139	-38	139
West SBU	2,520	2,100	1,750	2,029	279	2,385
Support Services incl. Medical Trainees	746	227	189	169	-20	184
Capital & YE accounting	-346	0	0	4	4	4
Total	**6,802**	**5,801**	**4,834**	**5,379**	**545**	**6,382**
less: CAMHS 28 day target agency				-487		-659
Total (excl. CAMHS 28 day)			**4,834**	**4,892**	**58**	**5,724**

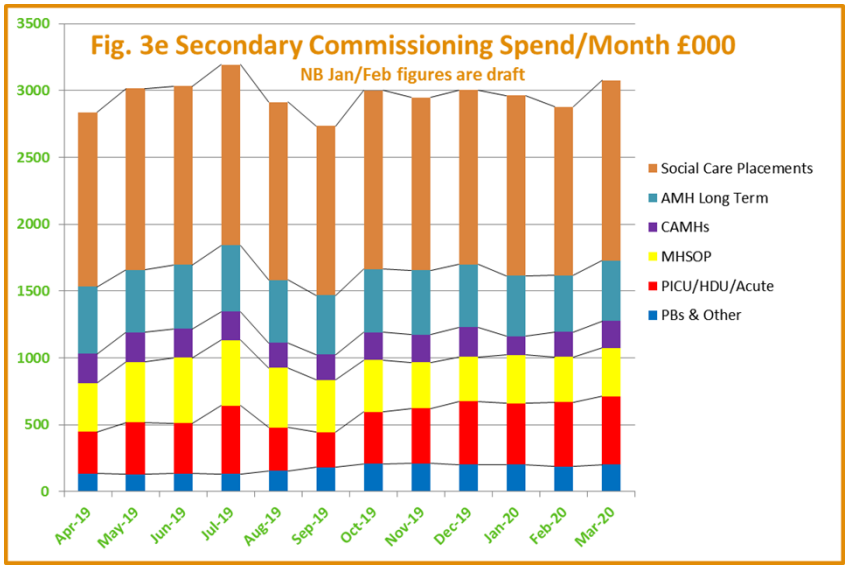
Performance against NHSI Ceiling	Actual Full Year 2018/19	Full Year NHSI Ceiling 2019/20	Year to Date NHSI ceiling	Year to Date Actual Spend (as at Month 10)	Year to Date Variance (+adv/-fav)	Forecast spend for the year 2019/20
Total	6,802	7,327	6,106	5,379	-727	6,382

3.5. Secondary commissioning reports at c. £2.9m in the month and at £28.4m for the year to date, above Plan by c. £292k in month and £2.0m for the year to date. There was a small increase overall in January, comprised of increases for MHSOP (£30k), Acute out of area (£39k) and Social Care Placements (£45k); offset by reductions for Main Health (£18k), PICU backdated reductions (£50k), and CAMHS backdated reductions due to improved data (£82k).

3.6. In general, savings have been made in some areas (notably CAMHS and also Main Adult Health Placements, more recently MHSOP), but not all. In particular, year to date spend has increased for Acute and PICU External Placements, and not decreased for Social Care Placements. 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. £940k year to date).

3.7. Regular review takes place of all areas under Secondary Commissioning to push these savings forward, and there are Delivering Value plans for a number of areas including MHSOP.

3.8. Fig. 3e below shows spend by category from April 2019 with forecast figures for February and March 2020.



3.9. Overhead costs have averaged £2.95m per month during 2019/20 and are just over at £3.0m for January, including accruing for CQI training at £114k (covered by transformation income). In month the key movements are Interserve old year adhoc costs, a change in the provision of waste collection services, additional IT costs, for CQI training, and for various items of equipment. In general overhead costs are holding well and the areas of increase are in targeted areas to support staff and service improvement.

3.10. 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 is reducing 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 complex to model.

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 favourable to Plan by £754k for the year to date, and £167k favourable in month, this has reversed the position of earlier months due to releasing deferred income to cover increasing pay costs (as planned) and additional income from Herts commissioners particularly in respect of CAMHS 28 Day. 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, and again from month 9.

5.3. Notification has been received regarding Hertfordshire CQUIN for 2018/19 with achievement as planned.

5.4. For 2019/20, CQUIN for Hertfordshire is included at 90%; for all other contracts CQUIN are included at 100% and this is expected to be achieved, with the possible exception of a 4% reduction for NHS England (not yet confirmed).

5.5. There have been penalties accrued totalling £22k for Essex IAPTs.

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

5.6.1. Items to be added to the IHCCT contract such as CAMHS Trailblazers, CAMHS Eating Disorders, and Individual Placement Support, totalling c. £400k

5.6.2. Key NHSE Bids such as Community and Crisis transformation bids, totalling nearly £3.0m for the year

5.6.3. CAMHS 28 day Recovery Plan – agreement in principle subject to actual costs – expected c. £500k to date

5.7. Income is included within this position if it is expected and is being spent. In most cases this income is agreed, commissioners need to find a formal mechanism to transfer the funds. This is being actively worked on with commissioners and invoices will be raised by end of February. A "Recruitment at Risk" process has been put in place to ensure that recruitment is not delayed but that 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 was 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 £4.3m and £5.2m. These are listed in the appendix.

6.3 The current 'gap' between programme requirement and schemes has reduced to circa £1.7m, before considering the vacancy factor. Whilst it is likely that there will be a degree of non-recurrent savings this year

relating to new vacancies, work will be needed to develop the longer term transformational work streams that will address the recurrent financial position into 2020/21.

Fig. 6b Programme value range RAG rated	Worst case £000s	Best case £000s	average £000s
Green	1,714	1,794	1,754
Green/ Amber	1,921	2,221	2,071
Amber	612	993	802
Red	10	190	100
Programme value range RAG rated total	**4,257**	**5,198**	**4,727**

6.4 As part of the planning for FY20/21 and to accelerate the building of the next DV program the first of a series of workshops was held in December. A number of schemes were identified with indicative values which are currently being reviewed.

6.5 An initial assessment has been made of each of the elements of the program which are expressed in the table below in terms of the following levels of maturity:

- Developed schemes: a well-developed scheme with a clear plan. A number of these are the FYE of schemes partially impacting in 2019/20
- Proposals: a clearly understood concept which needs working up to give confidence around the £ values identified and the timescales
- Identified Opportunities: an idea which may be developed into a plan/ or a savings requirement which will need to be addressed

Level of maturity	£000s	Indicative value £000s
Developed schemes	657	
Proposals	4,044	**4,701**
Identified Opportunities		1,108
Current program 20/21 total		**5,809**

7. Statement of Financial Position

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

7.2 Receivables increased by £600k in month. Further detail on the debtor's position is below in 7.6.

7.3 Payables and accruals increased by £100k in month.

7.4 The pension and injury benefit provisions were reviewed in month and updated to the latest unwinding discount rates as released by HM Treasury.

7.5 The Statement of Cash Flows is set out as an appendix and shows cash balances have decreased by £500k in the month. The main movements in month are:

- Cash inflow from operating activities £200k
- Cash outflow from investing (£700k)

7.6 As at 31st January 2020 the Trust had £3.8m outstanding with NHS organisations and £1.5m with non-NHS debtors. Of the £1.5m of non-NHS, £1.2m was with other government bodies. This was a total increase from the previous month which primarily relates to the late payment of the block contract with NHS England for Specialist Services, £1.5m.

7.7 Items under query or with a dispute include:

7.7.1 £149k with NHS Property Services due to a dispute with their reciprocal invoices

7.7.2 £447k with West Herts Hospitals NHS Trust who have delayed payment

7.7.3 £599k with Norfolk County Council due to a dispute over part of the amount regarding the uplift in contract, Finance and Business Manager are working to resolve

7.7.4 £76k to date with Hammersmith & Fulham Council regarding SRS invoices, Finance and Operations are working to resolve

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 £7.2m, £700k in month.

8.3. There is a further £386k of revenue spend year to date, £24k in month. This primarily relates to the running costs for empty buildings and the dilapidation costs for Trust leased buildings.

8.4. Capital spend is forecast to remain relatively stable at just over £1.0m per month for the remainder of the year as further spend is made at Albany Lodge, Oak Ward, Safe Care Suites and the Colonnades. There is the potential for additional accelerated IT spend which may increase this value for the last two months.

9. Forecast for the Full Year

9.1. The full year position is expected to be in line with the Control Total, likely to be slightly ahead with a surplus of around £50k.

9.2. Quarter Four remains a key period with the recruitment of new teams; spend is expected to increase by c. £100k/month on pay. Bed pressures also remain crucial to the financial position, both in terms of agency to manage activity and acuity, and in terms of additional out of area beds.

9.3. PDC and Depreciation are not expected to alter materially during the year, subject to any valuation of our assets and impairment reviews but this is not expected to have a material net impact.

9.4. A surplus property in Hemel Hempstead, 2-4 Alexandra Road, is being prepared for sale with the expectation that it will deliver a gain on disposal of between £50-200k. This would not form part of the calculation to determine the achievement of the Control Total.

9.5. A summary of the expected position is:

	£k	Comment
Position at M10	850	Includes £600k non recurrent in year
Current run rate	100	£50k per month average (mainly Feb)
Further recruitment	(200)	Assumed further 20 net posts (10 per month) plus two project manager posts
Non Pay spend	(150)	Areas such as replacing defibliators, additional in patient screens
Additional provisions	(550)	These could include matters such as: Operational costs relating to Oak Ward refurbishment, additional pension liability, costs related to service redesign for SRS
Expected position	**50**	

Use Of Resource Metrics (UOR)		Actual 31/01/2020
		£000s
Capital Service Cover: *the degree to which the organisation's generated income covers its financing obligations*		
PDC dividend expense	*from SoCI*	(3,280)
Interest Expense on Non-commercial borrowings	*from SoCI*	(229)
Interest Expense on Finance Leases	*from SoCI*	-
Other Finance Costs (unwinding of discount on provisions)	*from SoCI*	20
Public Dividend Capital repaid	*from SoCF*	-
Repayment of bridging loans	*from SoCF*	(265)
Repayment of non-commercial loans	*from SoCF*	-
Capital element of finance lease rental payments - other	*from SoCF*	(4)
		(3,758)
SURPLUS/(DEFICIT) FOR THE YEAR TO DATE		2,148
Impairments		-
Reversal of PY Impairments		-
PDC Dividends payable		3,280
Finance expense - unwinding of discount on provisions		(20)
Finance expense - financial liabilities Loan interest		229
Depreciation & Amortisation		4,444
Revenue available for Debt Service		10,082
Debt Service		(3,758)
Capital servicing capacity metric (Revenue / debt service)		2.68x
Capital servicing capacity rating		1
Liquidity: *days of operating costs held in cash or cash equivalent forms*		
Cash for CoS liquidity purposes	*from SoFP*	32,979
Operating Expenses within EBITDA, Total	*from SoCI*	(202,596)
Liquidity metric		48.8
Liquidity rating		1
I&E Margin:		
Surplus/(deficit) (before impairments)	*from SoCI*	1,705
Total income	*from SoCI*	211,885
I&E metric		0.80%
I&E Margin rating		2
I&E Variance:		
Actual I&E Margin	*from I&E*	0.80%
Planned I&E Margin	*from Plan*	0.70%
Variance		0.10%
Distance from financial plan rating		1
Agency spend:		
Actual agency spend	*from SoCI*	5,383
NHSI agency cap	*from Plan*	6,109
Variance		(11.89%)
Agend spend rating		1
Use Of Resource (UOR) Rating*		1

Capital Service Cover					20%
Rating	1	2	3		4
Min Score	>2.5	1.75	1.25	<	1.25
Min Surplus/(Deficit) Required £000s	170	(365)	(715)	<	(715)
Headroom amount £000s	(1,978)	(2,513)	(2,863)	<	(2,863)

Liquidity					20%
Rating	1	2	3		4
Min Score	>0	(7)	(14)	<	(14)
Min Cash for CoS liquidity required £000s	(0)	(4,700)	(9,450)	<	(9,450)
Headroom amount £000s	(32,979)	(37,679)	(42,429)	<	(42,429)

I&E Margin					20%
Rating	1	2	3		4
Min Score	>1%	0%	(1%)	<	(1%)
Min Surplus/(Deficit) Required £000s	2,119	-	(2,119)	<	(2,119)
Headroom £000s	414	(1,705)	(3,824)	<	(3,824)

Distance From Financial Plan Variance					20%
Rating	1	2	3		4
Min Score	>0%	(1%)	(2%)	<	(2%)
Min Surplus/(Deficit) Required £000s	380	(40)	(465)	<	(465)
Headroom £000s	(1,325)	(1,745)	(2,170)	<	(2,170)

Agency Spend					20%
Rating	1	2	3		4
Min Score	<0%	25%	50%	>	50%
Min Surplus/(Deficit) Required £000s	6,109	7,637	9,164	>	9,164
Headroom £000s	726	2,253	3,781	>	3,781

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

Agency Cap Performance

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
NHSI Agency Cap £000s	611	611	611	611	611	611	611	611	611	611			6,109
Actual Agency £000s	459	489	479	633	609	502	576	597	534	505			5,383

Current Trading - Income Statement for Period Ended 31-January-2020

Actual in month Jan-19	Actual YTD to 31-Jan-19	Description	2019/20 Plan	Month Jan - 20			Year to Date Jan - 20			Year to Date						
				Actual	Plan	Variance	Actual	Plan	Variance	E&N	West	LD	Essex & IAPT	Support	Other	Total
31	31	Number of Calendar Days	365	31	31		671	671								
0	0															0
14,185	142,080	Contract #1 Hertfordshire IHCCT	182,441	15,420	15,233	188	152,282	151,976	306	34	(0)	(0)	(0)	(0)	152,248	152,282
1,828	18,520	Contract #2 East of England	22,635	1,890	1,886	4	18,893	18,863	30	(0)	(0)	(0)	(0)	(0)	18,893	18,893
1,355	9,591	Contract #3 Essex LD	16,769	1,397	1,397	(0)	13,942	13,974	(32)	(0)	(0)	(0)	(0)	(0)	13,942	13,942
181	1,803	Contract #4 Norfolk (Astley Court)	2,223	185	185	(0)	1,852	1,853	(1)	(0)	(0)	(0)	(0)	(0)	1,852	1,852
659	5,567	Contract #5 IAPT Essex	8,281	699	690	9	7,406	6,901	505	(0)	(0)	(0)	(0)	(0)	7,406	7,406
317	3,173	Contract #6 Bucks Chiltern CCG	3,918	311	327	(16)	3,186	3,265	(79)	(0)	(0)	(0)	(0)	(0)	3,186	3,186
18,526	180,734	Contracts	236,268	19,903	19,718	185	197,560	196,831	728	34	(0)	(0)	(0)	(0)	197,526	197,560
122	914	Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	1,026	132	85	47	846	855	(9)	838	(0)	(0)	(0)	(0)	8	846
496	3,565	Education and training revenue	4,338	401	483	(82)	3,093	3,372	(279)	70	0	2	13	3,008	(0)	3,093
342	4,565	Misc. other operating revenue	3,259	292	359	(67)	2,387	2,540	(152)	238	343	214	107	842	644	2,387
419	4,212	Other - Cost & Volume Contract revenue	4,742	467	395	72	4,522	3,951	571	10	(0)	4,512	(0)	(0)	(0)	4,522
144	1,592	Other clinical income from mandatory services	2,193	184	183	1	1,754	1,827	(74)	167	345	1,242	(0)	(0)	(0)	1,754
20	259	Research and development revenue	369	42	31	11	277	308	(31)	(0)	(0)	(0)	(0)	277	(0)	277
207	1,361	Provider Sustainability Fund	1,887	220	220	(0)	1,889	1,446	443	(0)	(0)	(0)	(0)	(0)	1,889	1,889
20,275	**197,202**	**Total Operating Income**	**254,081**	**21,641**	**21,475**	**166**	**212,328**	**211,131**	**1,197**	**49,348**	**41,545**	**45,925**	**27,394**	**26,177**	**21,940**	**212,328**
(10,849)	(106,906)	Employee expenses, permanent staff	(139,680)	(11,665)	(11,626)	(39)	(114,069)	(116,434)	2,365	(32,019)	(27,204)	(20,844)	(15,819)	(18,103)	(79)	(114,069)
(1,270)	(12,951)	Employee expenses, bank staff	(16,190)	(1,420)	(1,352)	(68)	(13,957)	(13,485)	(472)	(3,719)	(5,305)	(3,838)	(481)	(616)	2	(13,957)
(496)	(5,988)	Employee expenses, agency staff	(5,790)	(505)	(483)	(23)	(5,383)	(4,825)	(558)	(2,834)	(2,032)	(204)	(139)	(169)	(4)	(5,383)
(36)	(334)	Clinical supplies	(294)	(28)	(25)	(3)	(292)	(245)	(47)	(159)	(61)	(52)	(3)	(18)	(0)	(292)
(2,477)	(22,804)	Cost of Secondary Commissioning of mandatory services	(31,528)	(2,924)	(2,633)	(292)	(28,375)	(26,420)	(1,955)	(6,926)	(3,899)	(17,967)	(1)	(0)	418	(28,375)
(465)	(5,227)	Other Contracted Services	(10,020)	(867)	(834)	(33)	(8,368)	(8,352)	(17)	(252)	(146)	(230)	(7,617)	(123)	(0)	(8,368)
(266)	(2,566)	Drugs	(3,133)	(315)	(261)	(54)	(2,695)	(2,611)	(84)	(1,438)	(1,058)	(180)	(18)	(7)	7	(2,695)
(15,859)	**(156,777)**	**Total Direct Costs**	**(206,635)**	**(17,724)**	**(17,213)**	**(511)**	**(173,138)**	**(172,372)**	**(766)**	**(47,347)**	**(39,705)**	**(43,315)**	**(24,079)**	**(19,036)**	**343**	**(173,138)**
4,417	40,425	Gross Profit	47,445	3,918	4,262		39,190	38,759		2,001	1,840	2,610	3,315	7,141	22,283	39,190
21.78%	20.50%	Gross Profit Margin	18.67%	18.10%	19.85%		18.46%	18.36%		4.06%	4.43%	5.68%	12.10%	27.28%	101.56%	18.46%
		Overheads														
(28)	(686)	Consultancy expense	(828)	(18)	(68)	49	(142)	(693)	551	(6)	(0)	3	(22)	(98)	(19)	(142)
(62)	(781)	Education and training expense	(1,226)	(199)	(103)	(96)	(1,000)	(1,021)	21	(65)	(52)	(89)	(39)	(755)	1	(1,000)
(387)	(3,731)	Information & Communication Technology	(4,700)	(389)	(392)	3	(3,947)	(3,917)	(30)	(107)	(94)	(64)	(214)	(3,406)	(63)	(3,947)
(475)	(4,545)	Hard & Soft FM Contract	(6,406)	(527)	(534)	7	(5,303)	(5,338)	36	(257)	(258)	(263)	(11)	(0)	(4,515)	(5,303)
(757)	(6,209)	Misc. other Operating expenses	(8,324)	(641)	(937)	296	(6,395)	(6,287)	(108)	(666)	(956)	(988)	(698)	(1,925)	(1,162)	(6,395)
(1,052)	(6,233)	Other Contracts	(1,921)	(125)	(160)	35	(1,779)	(1,601)	(178)	(48)	(530)	(49)	(25)	(1,043)	(84)	(1,779)
(48)	(522)	Non-clinical supplies	(419)	(60)	(35)	(26)	(518)	(350)	(168)	(115)	(93)	(179)	(34)	(84)	(13)	(518)
(549)	(5,195)	Site Costs	(6,672)	(587)	(556)	(31)	(5,856)	(5,560)	(296)	(10)	(0)	(7)	(3)	(2)	(5,834)	(5,856)
220	(280)	Reserves	(1,537)	(35)	(131)	96	(800)	(1,275)	475	(0)	(0)	(0)	(0)	(0)	(800)	(800)
(310)	(3,277)	Travel, Subsistence & other Transport Services	(4,070)	(421)	(339)	(82)	(3,717)	(3,392)	(326)	(966)	(1,488)	(537)	(438)	(285)	(4)	(3,717)
(3,448)	**(31,458)**	**Total overhead expenses**	**(36,105)**	**(3,004)**	**(3,254)**	**250**	**(29,457)**	**(29,434)**	**(23)**	**(2,239)**	**(3,472)**	**(2,171)**	**(1,485)**	**(7,598)**	**(12,493)**	**(29,457)**
969	**8,968**	**EBITDA**	**11,341**	**914**	**1,008**	**(94)**	**9,732**	**9,325**	**408**	**(238)**	**(1,632)**	**440**	**1,830**	**(457)**	**9,790**	**9,732**
4.78%	4.55%	EBITDA Margin	4.46%	4.22%	4.69%		4.58%	4.41%		-0.48%	-3.92%	0.95%	6.67%	-1.74%	44.62%	4.58%
(400)	(4,056)	Depreciation and Amortisation	(5,531)	(443)	(461)	18	(4,444)	(4,609)	165	(0)	(0)	(0)	(117)	(0)	(4,327)	(4,444)
(24)	(269)	Other Finance Costs inc Leases	(354)	7	(29)	36	(209)	(295)	85	(0)	(0)	(0)	(0)	(209)	(0)	(209)
(0)	(0)	Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
34	284	Interest Income	366	34	31	3	349	305	44	(0)	(0)	(0)	(0)	349	(0)	349
(299)	(3,052)	PDC dividend expense	(3,935)	(328)	(328)	(0)	(3,280)	(3,279)	(1)	(0)	(0)	(0)	(146)	(0)	(3,134)	(3,280)
281	**1,875**	**Net Surplus / (Deficit)**	**1,887**	**184**	**220**	**(36)**	**2,148**	**1,447**	**701**	**(238)**	**(1,632)**	**440**	**1,567**	**(17)**	**2,028**	**2,148**
1.38%	**0.95%**	**Net Surplus margin**	**0.74%**	**0.85%**	**1.03%**		**1.01%**	**0.69%**		**-0.48%**	**-3.93%**	**0.96%**	**5.72%**	**-0.06%**	**9.24%**	**1.01%**
74	**514**	**Net Surplus / (Deficit) before PSF**	**0**	**(36)**	**0**	**(36)**	**259**	**0**	**259**							

Statement of Financial Position (Balance Sheet) as at **31/01/20**

31 March 2019 £000	STATEMENT OF FINANCIAL POSITION	Previous month 9 £000	Current month 10 £000	Movement in month £000	Movement YTD £000
	Non-current assets				
1,343	Intangible assets	1,112	1,086	(26)	(257)
26,106	PPE Land	26,106	26,106	0	0
119,897	PPE Buildings & Dwellings	116,879	116,546	(333)	(3,351)
549	PPE Assets Under Construction	7,065	7,766	701	7,217
4,498	PPE Equipment	3,438	3,354	(84)	(1,144)
152,393	**Total non-current assets**	**154,599**	**154,858**	**258**	**2,465**
	Current assets				
50	Inventories	50	50	0	0
3,138	NHS Receivables	2,493	3,837	1,344	698
1,820	Non NHS Trade Receivables (related parties)	1,217	1,171	(47)	(649)
57	Other Receivables	434	599	165	542
(102)	Provision for impairment of Receivables	(102)	(102)	0	0
2,078	Accrued income	2,844	1,544	(1,300)	(533)
18	PDC Dividend Receivable	18	0	(18)	(18)
468	Prepayments	1,027	1,497	471	1,030
57,958	Cash and cash equivalents	58,646	58,098	(548)	139
1,592	Assets held for sale	1,592	1,592	0	0
67,077	**Total current assets**	**68,219**	**68,286**	**67**	**1,209**
219,470	**Total assets**	**222,818**	**223,144**	**325**	**3,674**
	Current liabilities				
(542)	Borrowings	(609)	(631)	(23)	(89)
(6,724)	Deferred Income	(6,621)	(6,399)	223	326
(2,301)	Provisions (see note below)	(2,217)	(2,208)	9	93
(3,154)	Taxes payable	(3,723)	(3,355)	368	(201)
0	Receipts in advance	0	0	0	0
(963)	Trade Payables	(830)	(846)	(15)	118
(1,963)	Other payables	(1,312)	(1,974)	(662)	(11)
(778)	Capital Payables	(858)	(783)	75	(5)
(15,734)	Accruals	(16,360)	(16,154)	206	(421)
(9)	Finance Leases	(2)	(1)	1	7
0	PDC Dividend payable	(1,003)	(1,313)	(310)	(1,313)
(32,168)	**Total current liabilities**	**(33,537)**	**(33,665)**	**(128)**	**(1,496)**
34,909	**Net current assets**	**34,682**	**34,621**	**(61)**	**(287)**
187,301	**Total assets less current liabilities**	**189,281**	**189,479**	**198**	**2,178**
	Non-current liabilities				
(10,058)	Term Loan from ITFF (2.74%)	530	530	0	10,588
(5,323)	Provisions (see note below)	(5,354)	(5,367)	(14)	(44)
0	Finance Leases	0	0	0	0
(14,851)	**Total non-current liabilities**	**(14,617)**	**(14,631)**	**(14)**	**221**
172,450	**Total assets employed**	**174,664**	**174,848**	**184**	**2,398**
	Financed by (taxpayers' equity)				
91,144	Public Dividend Capital	91,394	91,394	0	250
45,383	Retained earnings (I&E reserve)	47,347	47,531	184	2,148
35,924	Revaluation reserve	35,924	35,924	0	0
172,450	**Total taxpayers' equity**	**174,664**	**174,848**	**184**	**2,398**

Detailed note on Provisions

31 March 2019 £000s	Provisions summary as at month 10	Under 1 year £000s	Over 1 year £000s	Total current month 10 £000s	Movement YTD £000
(1,268)	Continuing Care appeals	(1,234)	0	**(1,234)**	33
(485)	LTPS & Legal Claims	(425)	0	**(425)**	60
(2,114)	Pensions	(210)	(1,678)	**(1,888)**	225
(2,627)	Injury Benefit	(128)	(2,520)	**(2,648)**	(21)
(1,131)	Dilapidations	(210)	(1,170)	**(1,380)**	(249)
(7,624)	**Total provisions**	**(2,208)**	**(5,368)**	**(7,576)**	**48**

Cashflow Statement as at **31/01/2020**

STATEMENT OF CASH FLOWS	In Month 10 £000	YTD Year Actual £000
Opening Balance	**58,644**	**58,023**
EBITDA	914	9,732
Operating cashflows before movements in working capital	**914**	**9,732**
Movements in Working Capital:		
(Increase) / Decrease in Inventories	0	0
(Increase) / Decrease in Receivables	(1,492)	(591)
(Increase) / Decrease in Prepayments & Accrued Income	859	(496)
Increase / (Decrease) in Payables (incl. receipts in advance)	309	72
Increase / (Decrease) in Accruals	(206)	421
Increase / (Decrease) in Deferred Income	(223)	(326)
Increase / (Decrease) in Provisions	(9)	(93)
Increase / (Decrease) in Working Capital	**(762)**	**(1,013)**
Increase / (Decrease) in Non Current Provisions	14	44
Net Cash Inflow / (Outflow) from Operating	**165**	**8,763**
Capital Expenditure	(701)	(6,960)
Increase / (Decrease) in Capital Creditors	(75)	5
(Increase) / Decrease in Assets held for sale	0	0
Gain / (loss) on asset disposals	0	0
Interest received on Cash Balances	34	349
Net Cash Inflow / (Outflow) from Investing	**(743)**	**(6,606)**
Cashflow before Financing	**(578)**	**2,157**
PDC Dividend Paid (actual cash excluding accruals)	0	(1,949)
PDC Received	0	250
Bridging Loan from ITFF (previously FTFF)	0	10,323
Loan from ITFF (previously FTFF)	0	0
Interest on loans	(23)	(229)
Unwinding discount on provisions	30	20
Interest Paid Finance lease	0	0
Repayment of loans and leases	23	(10,499)
Net Cash Inflow / (Outflow) from Financing	**30**	**(2,084)**
Net Cash Inflow / (Outflow)	**(548)**	**73**
Closing Balance	**58,096**	**58,096**

Project	Internal HPFT Plan	Capital Projects Management	Revenue Projects Management	Total spend	Forecast 19/20 Spend
	£'000s	£'000s	£'000s	£'000s	£'000s
Inpatient Projects					
Albany Lodge Works	**1,500**	631		631	978
Oak Ward	**500**	151			553
Aston Ward Refurb	**1000**	820	(2)	818	1,000
Hamden Antiligature	**700**	53		53	53
Gainsford Antiligature	**700**	53		53	53
Forest House Annexe	**250**				0
Forest House Refurb		(49)		(49)	0
Broadlands Reception		9		9	9
Safe Care Suites	**5,220**	808	3	812	1,500
Stevenage New Inpatient Unit		10	14	24	50
Community Projects					
Centenary House Conversion		(1)		(1)	0
Hemel Hub		18	1	19	18
Colonnades	**1,000**	122		122	1,000
Trustwide Projects					
6 Facet Survey works		804	2	803	983
Backlog Maintenance	**1,500**	211		211	1,100
Dilapidations			249	249	
Double Running Costs			6	6	
IT Projects					
Business Intelligence		363	23	386	450
Wifi Enhancements		13		13	13
App Development	**100**				100
It Allocation	**1,680**	1770		1770	1,780
Paris Upgrade	**690**	462	20	482	462
Reactive Operational Capital					
Operational Capital	**1,200**	959	69	1027	1,200
PLACE Works		8	1	9	
Harper Lane Sales	**(1,000)**	2		2	
Alexandra Road Sale	**(300)**	2		2	(300)
Total Spend	**14,740**	**7218**	**386**	**7600**	**11,002**
Trustwide Maintenance	**500**	(0)	417	417	500

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item: 15**
Subject:	Gender Pay Gap Reporting	**For Publication:**
Author:	Maria Gregoriou – Associate Director of Workforce	**Approved by:** Ann Corbyn, Director of People and OD
Presented by:	tbc	

Purpose of the report:

To present the Statutory Gender Pay Gap Snapshot Report, the Gender Pay Report for the Board and the Gender Pay Gap Action Plan for 2020/21

Action required:

To note the contents of the 2 Reports and the action plan prior to publication on the Trust's website

Summary and recommendations to the Board:

The Gender Pay Report sets out for the Board the information that the Trust is required to publish and some further information that has shaped our current action planning. These actions are summarised as next steps at the end of the report and are included in further detail in the accompanying action plan.

The Statutory Gender Pay Gap Snapshot Report will be submitted to the required Government website (www.gov.uk/report-gender-pay-gap-data) by the required date of 31st March 2020.

The Trust will continue to build on the progress it is making in promoting diversity and equality within the workforce and living our values of welcoming, kind, positive, respectful and professional.

Relationship with the Business Plan & Assurance Framework:

Aligns with Strategic Objective Four

Summary of Implications for:

N/A

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

This report will help inform our overall Equality and Diversity Strategy

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

Well Led Standard

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

Executive 12th February 2020

Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board

Gender Pay Gap Report
For the period ending 31st March 2019

1. Introduction

This is the third Gender Pay Gap report for Hertfordshire Partnership University NHS Foundation Trust, and it is used as a welcome addition to the workforce data that the Trust uses to monitor diversity and informs our decision making regarding workforce inequalities.

The workforce at HPFT is predominantly female, which is in common with the wider NHS and our Trust has a good track record of promoting diversity within the workforce. The Trust uses this data to recognise that inequalities continue to exist and drive the actions that we take to address those inequalities.

Legislation has made it statutory for organisations with 250 or more employees to report their gender pay gap annually. Government departments are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into force on 31st March 2017. These regulations underpin the Public Sector Equality Duty and require the relevant organisations to publish their gender pay gap annually by 31st March, as at 31st March the previous year.

2. Purpose of this report

This report sets out the information that the Trust is required to publish and some further information that has shaped our current action planning. These actions are included as next steps at the end of this report. The Trust will continue to build on the progress it is making in promoting diversity and equality within the workforce and living our values of welcoming, kind, positive, respectful and professional.

3. Background to Gender Pay Gap Reporting

3.1 Since the 31st March 2017, it has been a legal requirement for public sector organisations with more than 260 employees to report annually on their gender pay gap.

3.2 The first report was published in 2018, and was informed by 'snapshot data' as at 30th March 2017. The second report was published in 2019, and was informed by 'snapshot data' as at 30th March 2018. This year's report will be published in March 2020 and is informed by 'snapshot data' as at 30th March 2019.

3.3 The report must include:

- ✓ The mean and median gender pay gaps
- ✓ The mean and median gender bonus gaps
- ✓ The proportion of men and women who received bonuses
- ✓ The proportions of male and female employees in each pay quartile

3.4 The definitions set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and NHS Employers guidance on the definitions of ordinary and bonus pay have been followed in preparing this report.

3.5 The gender pay gap shows the difference in the average pay between all men and women in the workforce. The gender pay gap is different to equal pay. Equal pay deals with pay differences between men and women who carry out the same, or similar, jobs or for work of equal value. It is unlawful to pay people unequally on the basis of gender. It is possible to have pay equality but still have a significant gender pay gap.

3.6 The Gender Pay Reporting regulations were specifically introduced to facilitate a national shift towards greater equality in the average hourly earnings of men and women. This is influenced by a range of factors, including:

- ✓ Women historically working in lower-paid occupations and sectors and occupying less senior roles
- ✓ Women taking time out and / or working part-time due to unequal sharing of caring responsibilities
- ✓ Historical stereotyping and workplace cultures that were unsupportive

3.7 Across the UK in 2019, The Office for National Statistics reported that the mean gender pay gap for full time employees was 8.9%, whilst for all employees it was 17.3%. The ONS reported that the median pay gap was 11.9%. For age groups under 40, the gender pay gap for full time employees is reported as close to zero, whilst the gender pay gap is over 15% amongst 50 to 59 year olds and is not declining strongly over time. (Source – The Office for National Statistics, October 2019)

3.8 The Trust is committed to the principle of equal opportunities and equal treatment for all employees regardless of sex, race, religion or belief, age, marriage or civil partnership, pregnancy / maternity, sexual orientation, gender reassignment or disability. On this basis, the Trust has a clear policy of paying employees equally for the same or equivalent work, regardless of their sex (or any other characteristic set out above), The Agenda for Change pay framework is designed to support NHS Trusts in ensuring NHS employees are paid equally and this is fully embedded within the Trust.

3.9 The Trust has a largely female workforce, like many other NHS organisations, with 72% of the workforce being female, and 28% male.

4. Definitions and Scope

4.1 There are six measures that must be included in a gender pay gap report – these are:

- ✓ The mean gender pay gap
- ✓ The median gender pay gap
- ✓ The mean gender bonus gap

- ✓ The median gender bonus gap
- ✓ The proportions of men and women who received a bonus
- ✓ The proportions of men and women in each quartile pay bands

4.2 The gender pay gap is defined as the gap between the mean or median hourly rate of pay that male and female colleagues receive.

4.3 The mean pay gap is the difference between the average hourly earnings of men and women – i.e. the hourly gap divided by the average for men equates to the mean gender pay gap.

4.4 The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women – it takes all salaries in the sample, lines them up in order from lowest to highest and picks the middle-most salary.

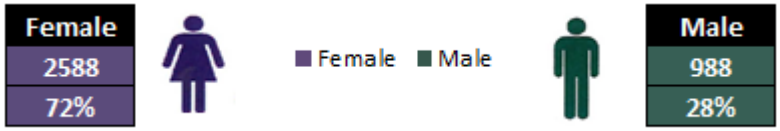
4.5 This report is based on rates of pay as at 31st March 2019 and bonuses paid in the year 1st April 2018 to 31st March 2019. It includes all workers in scope as at 31st March 2019. In scope means all staff employed under a contract of employment including those under Agenda for Change terms and conditions, Medical and Dental terms and conditions and Trust contracts for very senior manager roles (VSM).

4.6 As a Foundation Trust, HPFT is empowered to determine the rates of pay for VSMs. The VSM roles in the Trust include the Chief Executive, Executive Directors and other senior managers with Board level responsibilities.

4.7 Only staff employed by the Trust at the snapshot date of 31st March 2019 are included in this report. This includes the Trust's bank staff. All data is taken from the Electronic Staff Record system (ESR).

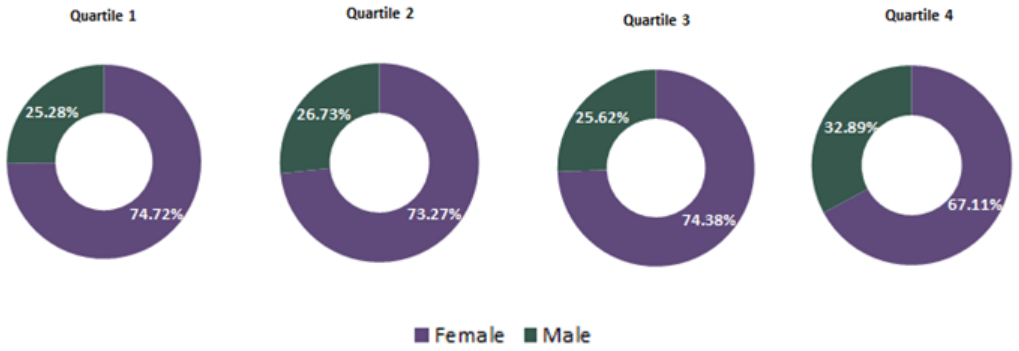
5 HPFT Gender Pay Gap and Pay Quartiles by Gender

5.1 The Trust's Gender Profile



5.2 The Trust's Mean Gender Pay Gap and Median Gender Pay Gap
Our Mean Gender Pay Gap and Median Gender Pay Gap are illustrated by the graphic on the following page.

5.3 The Trust's Staff by Earning Quartiles
This diagram illustrates the proportions of men and women in each quartile of the Trust's pay bands. For clarity, Quartile 1 is our lowest pay band quartile and quartile 4 is our highest pay band quartile.



5.4 The calculation of hourly rate of pay includes 'Full Pay Relevant Employees'. This means any employee who was employed on the snapshot date of 31st March 2019 and who was paid their usual full basic pay. That full basic pay includes;

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

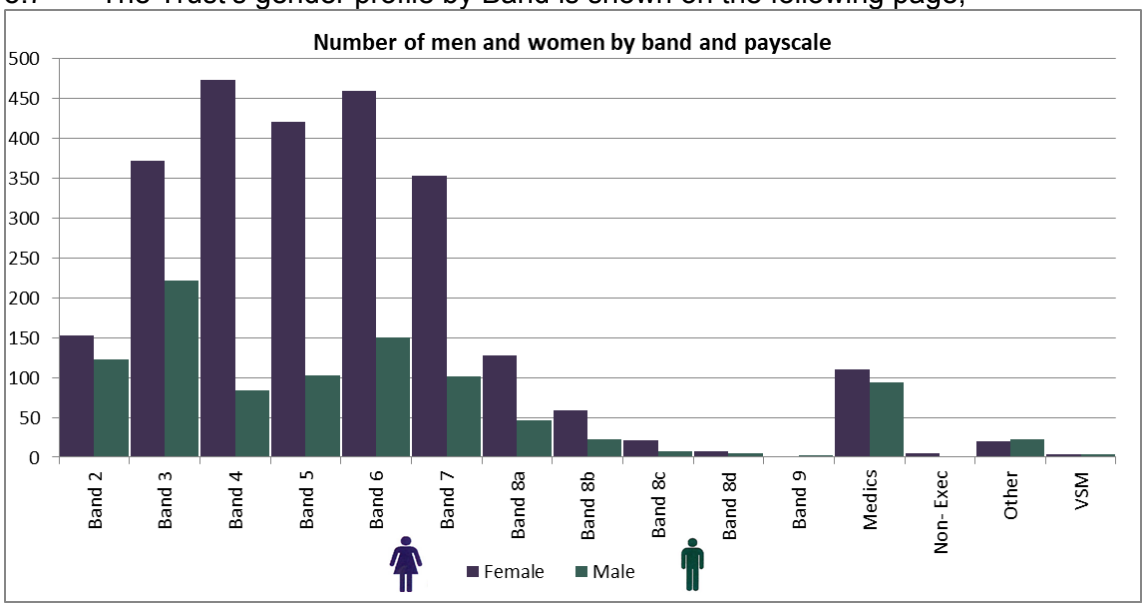
5.5 It does not include any of the following elements:

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

5.6 At HPFT, there is a mean gender pay gap of 11.55% and a median pay gap of 4.66%. The staff earnings by quartiles helps explain this gap further as it

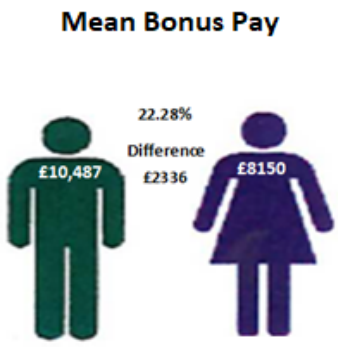
highlights that in the first three categories, the workforce genders at HPFT are broadly representative of the overall workforce profile. However, in the 4th category, women are underrepresented by approximately 5% against the overall workforce profile position, whilst still being the larger group within the category. Historically, there is higher male representation at a senior level in the NHS overall. It is also worth noting that the Trust employs more women than men in every category, including the 4th quartile group, which is where our highest earners are grouped.

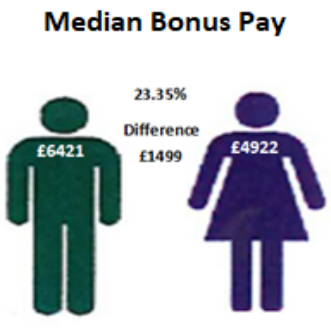
5.7 The Trust's gender profile by Band is shown on the following page,



6 Bonus Pay and Gender Pay Gap Bonus Pay

6.1 The Trust's Mean Bonus Gender Pay Gap and Median Bonus Gender Pay Gap





6.2 The proportion of men and women who received a bonus

Gender	Number paid a bonus	Total Employees	% receiving a bonus
Female	25	2588	0.97%
Male	35	988	3.54%

6.3 Within the Gender Pay Gap Regulations 'bonus pay' means any remuneration that is in the form of money relating to productivity, performance or incentive – within the Trust our Consultants can be nominated for Clinical Excellence Awards (CEA payments, which recognise and reward those Consultants who perform over and above the standard expected for their role). The Trust also has a performance related pay scheme (applicable to a small group of VSM contract holders) and a 'refer a friend' incentive scheme.

6.4 The regulations set out that bonus pay does not include ordinary pay, overtime pay, redundancy payments or termination payments.

6.5 For bonus pay, all staff are included that were employed at the snapshot date of 31st March 2019. 29 male Consultants and 20 female Consultants were awarded CEA payments. 4 male and 4 female VSM contract holders were awarded performance related pay. 2 males and 1 female received a refer a friend incentive.

6.6 The mean gender bonus pay gap is 22.28% in favour of males, who earn on average £2,336 more than their female colleagues. This equates to a median bonus pay gap of 23.35% The Trust's position is improving in comparison to the March 2018 equivalent report where the mean gender bonus pay gap was 34.72% in favour of males who earned on average £3,809 more in bonus payments than their female colleagues. This meant that the median bonus gender pay gap was 66.29% for March 2018.

7 Conclusion and Next Steps

7.1 HPFT has a mean gender pay gap of 11.55% and a median pay gap across all staff groups of 4.66%.

7.2 HPFT has a mean gender bonus pay gap of 22.28% and a median gender bonus pay gap of 23.35%.

7.3 In March 2018, the Trust's snapshot data revealed a mean gender pay gap of 10.67% and a median gender pay gap of 2.56%. In respect of the mean bonus, the Trust reported a gap of 36.34% and a median bonus gap of 66.29%

7.4 The positive change to the Trust's gender bonus gap can, in part, be attributed to the actions taken as a result of the March 2018 data, which resulted in an action plan for the Trust – which focused attention on:

- ✓ Ensuring female medical staff are encouraged to apply for the CEA awards

- ✓ The implementation of family friendly processes and flexible working practices to encourage female returners and to better support those with caring responsibilities in the workplace

- ✓ Increased rigour in the negotiation of starting salaries within the medical workforce combined with greater flexibility in awarding progression points for part time staff

7.5 The Trust recognises that it has further work to do in positively impacting the gender pay gap position and has developed a draft revised action plan to support this ongoing work. The draft revised action plan will be submitted to IGC for further scrutiny to ensure that we focus on those things that our data and insight are telling us need attention. In this coming year, we intend to focus on:

- ✓ Improving the recruitment of flexible workers and those with protected characteristics and improving their experience of employment within HPFT

- ✓ Continue to encourage and support applications from the female and BAME Consultant workforce

- ✓ Developing a 'return to work programme' to provide better support for carers, maternity returners and others to aid the retention of skills within our workforce and encourage talent to stay and progress

- ✓ Use our internal Leadership Academy (LA) to positively encourage applications from female and BAME staff and develop a network of mentors from previous LA alumni to better support those who are in the LA programme

- ✓ Developing a health and wellbeing strategy to ensure that our people feel supported to bring their 'whole self' to work regardless of protected characteristic, and can therefore provide the best service to our service users

Maria Gregoriou
Associate Director of Workforce
February 2020

Appendix 1

Gender Pay Gap Draft Action Plan 2020/21

Area and Objective	Action	Lead	Timescale	Resources	Outcome and Impact
Recruitment					
Recruitment processes – to improve access to training for recruiting managers	Review recruitment training offered to managers and undertake interview training	Head of Recruitment	April 2020	Data and information Internal communications	Well trained recruitment managers.
Spot Salaries	Review the process for spot check salaries for new staff	Associate Director of People	April 2020	Data	Implement a new process to agree spot salaries.
Recruitment	Review of adverts across all roles within the Trust to ensure that those with protected characteristics and returners to the workforce are welcomed to apply	Head of Resourcing	April 2020	Data	Increase the number of applicants from BAME, and those with protected characteristics, returners to the workforce
Recruitment	Monitor workforce data in relation to protected characteristics and: Applications Shortlisting New starters Promotion/career progression Flexible working	Associate Director of People	June 2020	Data	Metrics to be included in quarterly board reports.
Organisational Development					
Business Partnering Employee Relations	Continue to develop a just and learning culture, where civility and kindness are the norm. Understand what this	Deputy Director of People and OD	June 2020	Internal communications	Change in culture though out the organisation

Area and Objective	Action	Lead	Timescale	Resources	Outcome and Impact
	means to all of our people and support our leaders to understand how to drive this culture throughout the Trust				
Business Partnering	Develop a “return to work” programme of support for maternity, paternity returners and staff who have been absent from work for long periods of time	Associate Director of People	July 2020	Internal Communications	Positive impact on staff Returning to work. Positive impact on staff survey results.
Organisational Development Team	Develop a HPFT mentoring network linked to Leadership Academy alumni	Head of OD/Associate Director of People	July 2020	Internal Communications	Positive Impact on staff development Positive impact on the staff survey
Health and Wellbeing					
Health and Wellbeing	Develop a Health and Well Being Strategy and ensure that gender specific needs of staff are met	Head of OD/Associate Director of People	July 2020	Internal Communication	Positive impact on staff survey results Staff feel that their physical, mental, and psychological needs are met regardless of gender.
Learning and Development					
Learning and Development	Review and develop programmes to check inclusion and that staff are not disadvantaged due to their gender:	Head of Learning and Development	August 2020	Data Internal Communications	Staff have access to all learning and development opportunities.

Area and Objective	Action	Lead	Timescale	Resources	Outcome and Impact
	Access to venues Access to learning and development opportunities Monitor the take up of learning and Development Opportunities by protected characteristics.	Head of Learning and Development	August 2020	Data	Staff have access to all learning and development opportunities.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Hertfordshire Partnership University NHS Foundation Trust

Gender Pay Gap Data for Statutory Reporting for the year to 31st March 2019

1. Introduction

1.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 came into force on 30 March 2017 and require all employers with 250 or more employees to report annually on their gender pay gap.

1.2 This report sets out the data which we are required to report to government via the gender pay gap reporting service for the year to 31st March 2019.

2. Data required for Reporting

2.1 The data required for reporting includes the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportion of male and female employees in each pay quartile.

2.2 Employers must also publish their gender pay gap data and a written statement on their public facing website. This report sets out the data we are legally required to report on.

2.3 The following Gender Pay Report data is taken at the snapshot date of 31 March 2019:

1.	The mean gender pay gap for HPFT	11.55%
2.	The median gender pay gap for HPFT	4.66%
3.	The mean gender bonus gap for HPFT	22.28%
4.	The median gender bonus gap for HPFT	23.35%

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

Quartile	Female Headcount	Male Headcount	Female %	Male %	Description
1 (lowest paid)	668	226	74.72%	25,28%	Includes all employees whose standard hourly rate places them at or below the lower quartile
2	655	239	73.27%	26.73%	Includes all employees whose standard hourly rate places them above the lower quartile but at or below the median
3	665	229	74.38%	25.62%	Includes all employees whose standard hourly rate places them above the median but at or below the upper quartile
4 (highest paid)	600	294	67.11%	32.89%	Includes all employees whose standard hourly rate places them above the upper quartile

2.5 Further to the requirement to report on the mean bonus pay gap and the median bonus pay gap, the Trust is also required to report the percentage of male and female staff who received bonus pay. This is set out in the table below.

Gender	% of employees who received bonus pay
Female	0.97%
Male	3.54%

3. **Next Steps**

3.1 The data set out above will be reported on or before 30 March 2020 as required.

3.2 This statutory report is supplemented by a Gender Pay Gap Report that is submitted to the Trust's Board and is then published on the Trust's website.

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 16
Subject:	NHS Operational Planning and Contracting Guidance 2020-21	**For Publication: YES**
Author:	Ian Love, Deputy Director Commercial Development and Paul Ronald, Deputy Director Finance	**Approved by:** Karen Taylor, Executive Director, Strategy and Integration
Presented by:	Karen Taylor, Executive Director, Strategy and Integration	

Purpose of the report:

To update the Trust Board on the main elements of the NHS England and NHS Improvement NHS Operational Planning and Contracting Guidance for 2020-21 and the associated implications for the Trust.

Action required:

To Receive and note the contents of the paper.

Summary and recommendations to the Board:

Introduction

NHS Operational Planning and Contracting Guidance 2020-21[1] was issued on 30 Jan 2020. This guidance was further supported by twelve additional annexes over the following weeks.

The guidance, as a whole, is largely technical in nature and supports the completion of the processes and submissions required by the organisations across the local system. However, it also sets expectations for Sustainability and Transformation Partnerships / Integrated Care Systems (STP/ICS) as they submit their operational plans for 2020-21, these being the first year of the strategic (Long Term Plan) plans already submitted to NHS England / Improvement.

This paper highlights some key elements and their implications for the Trust that are found in the guidance.

System Planning

To support the more effective integration of care provision the contents of the Operational Planning Guidance sees the acceleration of accountability and decision making moving from Trusts and Foundation Trusts to that of the "local system" in the shape of the Integrated Care System (ICS).

Operational Requirements – Mental Health

The Trust, working with its commissioners, is already well placed in meeting the expectations of the Mental Health Long Term Plan. Looking forward into 2020/21 there is a significant requirement to develop community mental health services, CAMHS and anticipate new access standards.

[1] www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/

Operational Requirements – Learning Disability
The national priorities for improving the care of those with a learning disability are well established and continue into 2020/21. The opportunity is to seek further improvement in community services.

Other
Expectations are increasing across People, Digital and our approach to addressing the Green agenda. The priorities and approach to meeting these expectations are more and more being set for systems (and providers within those systems) to follow.

Financial Settlement
The contract pricing changes are currently subject to consultation and are in line with the expectations previously trailed. What is most of note is the greater link of finances to the performance of the local system. This is shown in the fact that a minimum of 50% of Trust Financial Recovery Funding (FRF) is linked to the system meeting the overall trajectory and in both new service investment and capital funding allocations being contingent on system tests being met.

Conclusions
The Operational Planning Guidance builds on that previously issued relating both to changes in the governance of local systems and in particular on the future service requirements for mental health and learning disability. So, while there are some areas for additional attention there are no major new initiatives or requirements. More generally, for us a Foundation Trust, it establishes a greater level of guidance and more detailed expectations from the local system and NHS E/I and linked to this a greater level of interdependency between organisational and system performance.

Recommendations

The Trust Board is asked to

- Receive and note the contents of this paper
- Discuss the key implications for HPFT and for mental health & learning disabilities more broadly

Relationship with the Business Plan & Assurance Framework:

NHS England and NHS Improvement's Operational Planning and Contracting Guidance for 2020-21 sets expectations on how the NHS Long Term Plan will be progressed during 2020-21.It establishes how the Trust through its Business Plan will directly and through supporting the local system deliver on these expectations.

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

Operational guidance is reviewed as part of the Trust's annual planning cycle; financial, staffing, IT implications are all considered as part of this process.

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

Guidance discussed at Executive Committee – 12 February 2020

Hertfordshire Partnership University NHS Foundation Trust

NHS Operational Planning and Contracting Guidance 2020-21

Overview and Key Implications for HPFT

1.0 Introduction

NHS Operational Planning and Contracting Guidance 2020-21[1] was issued on 30 Jan 2020. This guidance was further supported by twelve additional annexes over the following weeks.

The guidance is largely technical in nature and supports the completion of the processes and submissions required by the organisations across the local system. However, it also sets expectations for Sustainability and Transformation Partnerships / Integrated Care Systems (STP/ICSs) as they submit their operational plans for 2020-21, these being the first year of the strategic plans (Long Term Plan) already submitted to NHS England / Improvement.

This paper highlights some key elements and their implications for the Trust that are found in the guidance that go beyond the submissions and processes with particular note being;

- The much more significant input of systems leaders in the agreement of individual organisations plans.
- the degree by which individual organisations funding is dependent upon the performance of the system

This change in emphasis is being described as 'system by default' at a national level.

2.0 System Planning

To support the more effective integration of care provision the contents of the Operational Planning Guidance sees the acceleration of accountability and decision making moving from Trusts and Foundation Trusts to that of the "local system" in the shape of the Integrated Care System (ICS).

Some key features of local system development that are driving this are:

- Individual provider and commissioner plans being agreed by "System Leaders" to ensure they consistent with the system plans agreed with NHS England / Improvement (NHS E/I). Nationally, NHSE/I has described the two functions of the ICS as 'transformation' and 'collective management of system performance'. Nationally, with typically one CCG per system, the CCG is likely to become overtime the executive arm of the ICS.
- Capital & Estates Planning at the system level will become the main basis for capital planning, including technology

[1] www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/

- A clearer view of the systems capability requirements and the related need to agree its level of resourcing
- System based financial control totals which remain based upon the initial STP Plan submissions 2020-2024.
- A Single Oversight Framework is being developed for commissioners and providers
- The Financial Recovery Fund award will now be as dependent on the overall system performance (50%) as on that of the Trust (50%)
- There is now a contractual requirement to enter into a System Collaboration and Financial Management Agreement, this will:
    - Describe the behaviors expected of a collaborative health system
    - Set principles for open book accounting and transparency
    - Describe how a consensus view of the use of financial and other resources will be reached
    - Set out a mechanism for financial management and risk sharing to support delivery of the system improvement trajectory

Alongside these sits the Mental Health Investment Standard that establishes the minimum investment required in Mental Health. Ensuring this continues to be met, thus sustaining and improving local provision of mental health services, may come into conflict with the system approaches above.

The Trust has an important role through sustaining a high profile within the local system to directly and via the developing Mental Health and Learning Disability Integrated Care Partnership, to continue the advocacy for those who need these services and to ensure, to our best ability, that investment and funding continues to be made in mental health and learning disability services.

In view of the changing emphasis on 'system by default' and in common with other Foundation Trusts we are likely to see the progressive erosion of the freedoms we have previously had as an organisation (such as capital planning and investment) and will see this being sought to be undertaken increasingly at system level.

3.0 Operational Requirements – Mental Health

The Trust, working with its commissioners, is already well placed in meeting the expectations of the Mental Health Long Term Implementation Plan[2]. Looking forward into 2020/21 there is a significant requirement to develop community mental health services and anticipate new access standards.

The Planning Guidance references The Mental Health Implementation Plan which sets out the required deliverables for mental health up to 2023-24, these build on and overlap with the Five-Year Forward View for Mental Health[3].

These requirements are well understood and, working with our local commissioners, we have supported the local system to meet these requirements. Building on this continues as part of our current contract discussions with a focus on: further expanding access to our Improving Access to Psychological Therapy (IAPT) services; enhancing our services for a First Episode of Psychosis; and expanding the access to our Community Perinatal services.

[2] www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

[3] www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

However, there are some elements of the guidance that are worth noting.

3.1 Reducing inequalities

There is a requirement for the operational plan to address mental health inequalities. This will require the Trust to continue working with others on the determinants of mental health and to better understand those that access our services and those who do not and take steps to ensure we are reaching all who need them. HPFT has a key role in supporting the emerging West of Herts Integrated Care Partnership and the E&N Herts Integrated Care Partnership to put in place plans to address mental health inequalities in their local populations. The Hertfordshire wide Mental Health & LD Integrated Care Partnership will also see organisations across Hertfordshire coming together to address mental health inequalities.

3.2 Provider Collaboratives

There is a need to ensure that the specialist mental health services being covered by the emerging Provider Collaboratives link into local pathways of care. This requirement is well understood by the Trust, both through its existing work in Hertfordshire on the provision of Tier Four Child and Adolescent Mental Health Services (CAMHS) and as part of the East of England (EOE) Provider Collaborative. The EOE Provider Collaborative is currently developing new care models for CAMHS, Adult and LD secure services and Eating Disorders; with the expectation that, subject to business case approval by all Trust Boards and NHSE, the Collaborative will 'go live' in Autumn 2020.

3.3 Community Mental Health

Arrangements are to be in place with Primary Care Networks (PCNs) by March 2020-21 to organise and begin delivering integrated services. This is further supported by contractual requirements to work with PCNs on their obligations to provide two new services: Anticipatory Care and Enhanced Health Care in Homes.

Work should also begin to align community mental health services with the Community Mental Health Framework

The Trust's existing primary care mental health services and the Transforming Community Health pilots in Lower Lea Valley and Watford, together with our collaborative work with system partners on the Frailty pathway, make us well placed to meet this set of expectations.

The three main priorities for PCN development support in 2020/21 are:

i. Supporting workforce redesign and team development,
ii. Improving patient access and practice waiting times
iii. Building operational relationships with community providers (including pharmacies) to support integrated care.

Successful implementation of these objectives will support community MH provision. That said, it is worth noting the full community transformation is a considerable ask, and already forms a significant plank of our planned service transformation during the course of 2020/21.

3.4 Access Standards

A clinically led review of NHS Access standards is currently testing new standards in 70 trusts across the country which will inform final recommendation in the Spring of 2020. The Interim Report from the NHS National Medical Director[4] covers four possible access standards for mental health:

- Emergency assessment "within hours", Urgent assessment within 24 hours in community mental health services
- Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments
- Children and Young People access to treatment within four weeks for specialist mental health services
- Adult community access within four weeks "to an assessment and start of treatment or plan".

The major shift is looking at the time to treatment within four weeks, rather than to assessment. While the outcomes from the national pilot sites will help inform the organisational and resource implications in meeting these standards the Trust is already starting to look at what these would mean for our services, with treatment waits already a key area of focus for us as a Trust during 2020/21.

4.0 Operational Requirements – Learning Disability

The national priorities for improving the care of those with a learning disability are well established and continue into 2020/21. As a Trust our work around Transforming Care in terms of reducing reliance on inpatient provision continues, with the further opportunity outlined in the operating plan to seek opportunities to further improve community services and the use of Personal Health Budgets.

The Mental Health Long-Term Plan Implementation Framework says that systems should identify what community provision is in place for intensive crisis and forensic community support, this includes seven-day specialist multidisciplinary services and crisis care for children and young people. Targeted funding for pilot work will be made available from 2020-21 with funding available to support the roll out of these services in 2023/24. The Operational Planning Guidance re-emphasises this.

The Trust will look for opportunities across Essex, Norfolk, Hertfordshire and Buckinghamshire to pilot such approaches, in line with our existing service geography, and will work with partners to achieve this

5.0 Other

Expectations are increasing across People, Digital and our approach to addressing the Green agenda. The priorities and approach to meeting these expectations are more and more being set for systems and providers to follow.

5.1 People

The guidance reflects the draft NHS People Plan with the final plan dependent on the budget which is now scheduled for 11 March 2020, but may be subject to further delay following the resignation of the Chancellor. The Plan is built around the following ambitions;

- Grow the future workforce, supported by reforms to education and training
- Make the NHS the best place to work and improve retention

[4] www.england.nhs.uk/wp-content/uploads/2019/03/CRS-Interim-Report.pdf

- Improve the leadership culture
- Release time for care
- Redesign workforce models, including changes in skill mix

Within the draft contract it is proposed to include a new requirement on providers to develop a plan to implement in full the NHS People Offer (that is, the core standards in relation to the work environment and experience of work for staff working in NHS services) to be published in conjunction with the final NHS People Plan.

The Department of Health and Social care is also "considering making flu vaccination mandatory for NHS staff". They will issue guidance in due course. There is also a requirement for providers should work towards the full implementation and effective use of e-rostering and e-job planning against a meaningful level of standards.

The Trust will need to continue to focus on making itself an attractive and rewarding place to work, building a stable workforce increasingly able to provide great care and deliver great outcomes. The way it sets about achieving this may be increasingly framed by national requirements.

5.2 Environment

All systems should have a Green Plan (also known as the Sustainable Development Management Plan). The draft contract[5] requires Green Plans that must set out the provider's detailed plans and actions for 2020/21 in pursuit of NHS Long Term Plan commitments on:

- Reducing air pollution by moving to low and ultra-low emission vehicles
- Cutting carbon emissions from provider premises
- Reducing the use of single use plastics
- Reducing levels of waste and waste water

The Trust will need develop a Green Plan with a focus on its current plans across its fleet of vehicles and its approach to Facilities Management to ensure progress is made against these focus areas. The retendering of the Interserve facilities contract in 2021 provides the opportunity to align these new requirements within the contract provision.

5.3 Digital

NHSX (a relatively new organisation to "improve health and social care by giving people the technology they need" [6]) will set expectations of "what good looks like" for a digitized health and care system. Systems and providers will be expected to set out clear plans to work towards the agreed ambitions by 2024. Expectations will be embedded in the CQC inspection framework and the single oversight framework.

The Digital Strategy recently adopted by the Trust puts the Trust in a good place to meet the expectations as they embed in the CQC inspection framework.

6.0 Financial Settlement

While the proposed increase in the national tariff and the impact of the Mental Health Investment standard provide positive headline funding growth, this is set against increasing service commitments in the Mental Health Implementation Plan and increasing pay costs.

[5] www.england.nhs.uk/wp-content/uploads/2019/12/8-contract-technical-guidance-20-21.pdf
[6] www.nhsx.nhs.uk

There will, therefore need to be a continued focus for the Trust on identifying and realising further efficiencies.

The financial sustainability of the Trust will be increasingly tied to that of the local system's financial performance.

6.1 Mental Health Investment Standard

Clinical Commissioning Groups must continue to increase investment in line with The Mental Health Investment Standard (MHIS). For 2020-21 this requires every CCG to increase spend by at least their overall programme allocation growth plus additional funding included in CCG allocations.

This should be prioritised to deliver the commitments in the mental Health Implementation Plan.

6.2 Tariff and Efficiency

The statutory consultation for the national tariff[7] proposes for 2020/21 a tariff cost uplift of 2.5% and efficiency factor at 1.1%. Whilst this net uplift is higher than in most previous years it reflects the impact of the recently implemented national pay settlement.

Additionally, the extra funding paid by the Department of Health to meet the additional pay costs of services provided to Local Authorities and County Councils will not continue into 2020/21.

The Trust will therefore need to find ways of delivering additional efficiencies. These Cost Improvement Plans need to be fully developed before the start of the financial year and agreed between commissioners and providers. System leaders are also required to confirm that activity, finance, performance and workforce assumptions are consistent.

NHS E/I will continue to provide tools, information and support to help systems working together to support to aid systems to deliver provider cost improvement plans, commissioners savings plans and to reduce unwarranted variation. It will be important for the Trust to fully engage with these initiatives.

6.3 New Investment Funding

New investment funding for 2020/21 will be aggregated at system level and released to local systems on the basis the following is in place.

- Agreed and signed off system-wide strategic plan is in place.
- There are appropriate system arrangements for decision making which include all partners in the system.
- There is appropriate system level oversight and reporting to track expenditure and measure outcomes.
- There is agreement that system plans are acceptable from a finance perspective.

Specifically, in relation to mental health investment in 2020/21, CCGs will have ~£135m of NHS Long Term Plan baseline funding for community mental health provision for adults and older adults, with, all CCGs required to increase investment and staffing in core and

[7] https://improvement.nhs.uk/resources/national-tariff-2021-consultation/

dedicated (for eating disorders, mental health rehabilitation and “personality disorder”) community mental health services, in line with the recently published Community Mental Health Framework.

7.0 Process and Timetable

The development of system operational plans (financial, activity and workforce) are to be produced in partnership working across the Sustainability and Transformation Partnership (STP) / Integrated Care System (ICS). These should build on the Strategic Plans already produced highlighting and explaining differences between the two.

Supporting system “narrative plans” are also to be produced.

The Trust will work with local system partners to achieve this within the timetable set out below:

Milestone	Date
First submission of draft operational plans	5 March 2020
First submission of system led narrative plans	5 March 2020
2020/21 STP/ICS led contract/plan alignment submission	12 March 2020
Deadline for 2020/21 contract signature	27 March 2020
2020-21 STP/ICS led contract/plan interim alignment submission	8 April 2020
Parties entering arbitration to present themselves to NHS !/E	6 April – 10 April 2020
Submission of appropriate arbitration documentation	15 April 2020
Final submission of operational plans	29 April 2020
Final submission of system-led narrative plans	29 April 2020
Publication of the People Plan and national implementation plan fro the NHS Long Term Plan	March ? April 2020
Arbitration Panel and or hearing	16 April – 1 May 2020
2020-21 STP/ICS led contract/plan final alignment submission	6 May 2020
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	7 May 2020

8.0 Conclusions

The Operational Planning Guidance builds on that previously issued relating both to changes in the governance of local systems and in particular on the future service requirements for mental health and learning disabilities. So, while there are some areas for additional attention there are no major new initiatives or requirements.

More generally, for us a Foundation Trust, it establishes a greater level of guidance and more detailed expectations from the local system and NHS E/I.

9.0 Recommendations

The Trust Board are asked to review and note the contents of this paper.

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 17
Subject:	Herts & West Essex Sustainable Transformation Partnership (STP) Update	**For Publication:**
Author:	Karen Taylor, Executive Director, Strategy & Integration	**Approved by:** Karen Taylor, Executive Director, Strategy & Integration
Presented by:	Tom Cahill, Chief Executive Officer	

Purpose of the report:

To update the Trust Board on the current activities, issues and planned work across the Hertfordshire & West Essex (HWE) Sustainable Transformation Partnership.

Action required:

To Receive the report and note the update provided

Summary and recommendations to the Board:

The paper gives a brief summary of the national position, together with an overview of the key focus and activities across the STP since the last report provided to the Trust Board in January.

Nationally, the recently published NHSE/I Operating Guidance reinforced expectations for all systems to move to become Integrated Care System across England, with a clear shift signalled towards system accountability. The approach is being described as a "System by Default" operating model whereby the ICS will become the future default mechanism for oversight of system transformation and system performance. Further to the publication of the planning guidance last week, the STP has begun the process of detailed planning to ensure that it is in a position to meet the national submission timetable in respect of the system narrative, workforce, finance and activity elements. The Operating Guidance, its implications and timetable is subject to a separate Board Paper.

As a HWE system, the focus over the last month has continued to be on developing the appropriate governance and finance and contracting mechanisms. Putting the 'System by Default' operating model into practice will be the subject of discussion across the STP during March, taking into consideration work undertaken to date. Service transformation continues through the existing STP clinical workstreams, and this work is anticipated to continue into 2020/21 to support delivery of the STP's Operating Plan.

Recruitment to the joint Accountable Officer role for the ICS and the three Clinical Commissioning Groups (CCGs) has taken place and is now subject to the national due process required to appoint

to an Accountable Officer post.

As previously reported, the emerging system architecture includes the development of three Integrated Care Partnerships across the STP footprint together with agreement to develop a Hertfordshire Mental Health and Learning Disability Integrated Care Partnership. All four Integrated Care Partnerships have Partnership Boards/Groups and are exploring together ways of working, agreeing priorities and developing their plans for the next 12 months to support each ICP to move into a more formal arrangement.

The MH & LD ICP Partnership Board met for the second time in January with positive exploration and discussion by partners about the principles and shared ambitions for mental health & learning disabilities across the population of Hertfordshire. These principles, together with an emerging 'way of working together' also discussed at the meeting in January, will begin to form the basis on which the Partnership will take shape over the next few months. The next Partnership Board is taking place at the end of February and a key focus for this meeting will be discussion about priorities and also planning a broader stakeholder event in April.

The voluntary sector, including charities, are recognised by the STP to have a key role to play as partners across the Integrated Care System. A series of meetings and workshops have begun to take place to explore together with the voluntary sector how best this relationship will work at the Integrated Care System level, and also within the Integrated Care Partnerships and Primary Care Network level.

Summary & Recommendations

The pace of change across the Sustainable Transformation Partnership continues in line with national and regional timetables and development plans.

The Trust Board is asked to

- Receive the paper, noting the national focus, pace and implications for the development of the HWE STP/ ICS
- Note the continued development of the Hertfordshire MHLD ICP and the three place based Integrated Care Partnerships across the STP

Relationship with the Business Plan & Assurance Framework:

Strategic Objective 7 – Partnerships & Networks and Strategic Objective 6 – Joined up care

Summary of Implications for:

The development of the new system architecture has a number of potential implications for HPFT, including considerations in the following areas;

- Finance & Contracts
- Service Models and Delivery
- Strategic Partnerships and Relationships
- Governance
- Performance accountability
- Estates, digital and workforce

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

STP discussed and updates provided on a weekly basis to Executive Committee

Hertfordshire Partnership University NHS Foundation Trust

Hertfordshire & West Essex
Sustainable Transformation Partnership (STP) Update
27 February 2020

1. Purpose

To update the Trust Board on the current activities, issues and planned work across the Hertfordshire & West Essex (HWE) Sustainable Transformation Partnership.

2. National Position

Momentum and pace continues to build with the recently published NHSE/I Operating Guidance reinforcing expectations for all systems to move to become Integrated Care System across England. The Guidance signals a clear shift towards system accountability with the approach described as a "System by Default" operating model whereby the ICS will become the future default mechanism for oversight of system transformation and system performance.

3. Development of the HWE Integrated Care System

As a HWE system, the focus over the last 2-3 months has been on developing the appropriate governance and finance and contracting mechanisms. Although the official NHSE accelerator status has now expired, some resource will continue to be provided from the centre around Population Health Management, governance and finance and contracting over the next three months. Putting the 'System by Default' operating model into practice will be the subject of discussion across the STP during March, taking into account the governance work already considered by the STP's Governance Task and Finish Group. Service transformation also continues through the existing STP clinical workstreams, and this work is anticipated to continue into 2020/21 to support delivery of the STP's Operating Plan.

4. Leadership & CCG Joint Management & Governance

Recruitment to the joint Accountable Officer role for the ICS and the three Clinical Commissioning Groups (CCGs) has taken place and an appointment made, subject to the national due process required to appoint to an Accountable Officer post. A joint management structure for the ICS and CCGs is under development; and this will be confirmed in due course.

5. Integrated Care Partnerships

As previously reported, the emerging system architecture includes the development of three Integrated Care Partnerships across the STP footprint together with agreement to develop a Hertfordshire Mental Health and Learning Disability Integrated Care Partnership. All four Integrated Care Partnerships have Partnership Boards/Groups and are exploring together ways of working, agreeing priorities and developing their plans for the next 12 months to support each ICP to move into a more formal arrangement.

6. Hertfordshire Mental Health & Learning Disabilities ICP

The MH & LD ICP Partnership Board met for the second time in January with positive exploration and discussion by partners about the principles and shared ambitions for mental health & learning disabilities across the population of Hertfordshire. These principles, together

with an emerging 'way of working together' also discussed at the meeting in January, will begin to form the basis on which the Partnership will take shape over the next few months.

Of note is a recent publication by the Centre for Mental Health[1] which has highlighted how essential it is for emerging integrated care systems to pay attention to mental health needs within their local populations. It highlights that mental health and emotional wellbeing are important in and of themselves and they are also critical to good physical health and quality of life. The Hertfordshire approach, in developing a dedicated MHLD ICP, is aiming to ensure that equal priority is afforded to mental and physical health, and through a focus on prevention and early intervention, working as partners and with communities, it is aiming to bring about significant and lasting improvements in the health of the people of Hertfordshire

A small working group has been established reporting to the Partnership Board to focus on a number of key areas including future commissioning arrangements, governance, stakeholder engagement and involvement, service user and carer involvement and to develop an overall programme of work for consideration by the Partnership Board. The next Partnership Board is taking place at the end of February and a key focus for this meeting will be discussion about priorities and also planning a broader stakeholder event in April.

7. STP Relationship with the Voluntary Sector

The voluntary sector, including charities, is recognised by the STP to have a key role to play as partners across the Integrated Care System. A series of meetings and workshops have begun to take place to explore together with the voluntary sector how best this relationship will work at the Integrated Care System level, and also within the Integrated Care Partnerships and Primary Care Network level.

8. 2020/21 System Operating Plan

Further to the publication of the planning guidance last week, the STP has begun the process of detailed planning to ensure that it is in a position to meet the national submission timetable in respect of the system narrative, workforce, finance and activity elements. The Operating Guidance, its implications and timetable is subject to a separate Board Paper.

9. Summary & Recommendations

The pace of change across the Sustainable Transformation Partnership continues in line with national and regional timetables and development plans. HPFT is active across the STP, including supporting the development of the ICS and the ICPs. As an organisation, we have also been advocating strongly for and driving the development of the Mental Health and Learning Disability ICP, and will continue to do this with partners across the system.

The Trust Board is asked to;

- Receive the paper, noting the national pace, focus and implications for the development of the HWE STP/ ICS
- Note the continued development of the Hertfordshire MHLD ICP and the three place based Integrated Care Partnerships across the STP

[1] https://www.centreformentalhealth.org.uk/integrated-care-systems

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 18
Subject:	Report from the Chair of the Audit Committee – meeting held 3 December 2019	**For Publication: Yes**
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Catherine Dugmore Audit Committee Chair
Presented by:	Catherine Dugmore Audit Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 13 February 2020.

Action required:

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

Summary and recommendations to the Board:

An overview of the work undertaken is outlined in the body of the report.

The Board are asked to note that the Committee agreed the 20/21 plans for Internal Audit and Counter Fraud.

There were no formal matters for escalation to the Board.

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

List specific risks on BAF – 1.1, 1.2, 2.1, 5.3

Summary of Implications for:

None

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

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

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

Not applicable

1. Introduction

The Audit Committee was held on the 13 February 2020 in accordance with its terms of reference and was quorate.

2. Minutes from Other Committees

2.1 **Finance and Investment Committee (FIC) held on 19 November 2019.** Following presentation of the minutes the Committee noted that FIC had received a deep dive on the different benchmarking tools available to the Trust, for example the Model Hospital and how these are being used. The Committee discussed the value of such programmes to help identify areas that may require transformation and may give opportunity for productivity gains. It was agreed that the Committee would receive an update in six months' time on this work. The Committee also discussed the financial performance for the YTD and the expected outturn for the year, with the key risks and mitigations set out. An update was provided on the capital investment programmes and the Committee received the draft of the Strategic Outline Business Case for East and North Herts bed provision. FIC received an update on planning for 20/21 whilst noting that formal guidance had not been published at that time.

2.2 **Integrated Governance Committee (IGC) held on 20 November 2019:** Following presentation of the minutes of the meeting the Committee noted that IGC had covered a variety of subjects that included workforce, safety, effectiveness and governance. The Committee looked in detail at the BAF and the Trust Risk Register. IGC had received an update on the work to reduce the incidences of Violence and Aggression to staff and service users and also considered the bi-annual reports for Speaking Up, Infection Control, Claims and Caldicott.

3. Risk Topic Presentation

3.1 Risk Topic Presentation – Internal Audit Plan 2020/21

A summary presentation and discussion was given on the process for the agreement of and subsequent management of the annual work program carried out by internal audit. The presentation confirmed that the program was working well and supporting the Committee in its role and also helped identify some opportunities to strengthen the process further in terms of the scope of the individual audits and in the assessment of the findings and their wider relevance to the Trusts governance and assurance processes.

4. Risk/Governance Matters

4.1 Update on Quality Accounts Report 2019/20

The latest position with regard to the drafting of the Quality Accounts was presented to the Committee. It was noted that the guidance for 2019/20 Quality Accounts had been very recently received but initial assessment had not identified any significant changes from 2018/19 guidance. The Committee were informed that Deputy Director of Nursing was lead the process of developing the Accounts and was working very closely with KPMG.

The Committee were informed of the work underway to identify the priority and local indicators for 2020/21.

4.2 **Update on 2019/20 Accounts i. Going Concern Review. ii. Asset Re-valuation Exercise iii. IFRS16 iv. Other Matters CQC Registration**

The Audit Committee were informed of the good progress of the comprehensive plan in relation to the Annual Accounts. Areas of risk and additional complexity have been identified and are been given additional focus. The Committee discussed the identified areas of uncertainty, which currently relate to the level of deferred income and to the nature and amount of provisions. An update was provided on the work on IFRS 16 which was currently progressing as required. It was noted that work on the Annual Accounts is supported by a detailed work plan on the annual report and quality accounts. The Committee were informed that KPMG, external auditors will be undertaking their interim visit in February and this will further confirm progress and highlight any matters that require further focus.

The Committee was provided with management's assessment of the evidence to support the application of the Going Concern assumption in preparing the Annual Accounts and the Committee agreed that this was a reasonable assessment at this time. The Committee would continue to assess this and make a final recommendation at the date of reviewing the Annual Accounts.

The Committee was presented with and approved the increase in the bad debt provision as recommended by management.

4.3 **Update on Annual Report 2019/20**

The Committee received an update with regard to drafting of the Annual Report for 19/20. It was noted that the Annual Reporting Manual guidance had been received in January and the small number of changes were discussed. It was reported that the changes were not expected to create any issues for the Trust. The Committee noted the timetable for preparation and presentation of Annual Report, Annual Accounts and Quality Accounts.

4.4 **Phishing Email Test**

Following up on a previous Committee discussion details of a simulated phishing campaign that took place 16-30 September were presented. It was noted against a benchmark standard HPFT performed better than this standard, however the risk assessment is still; 'Requires Improvement' due to the level of staff who did seek to progress the email. The Committee agreed the recommendations made which included: undertaking a training and communication campaign focusing on cyber security and awareness; a further phishing campaign is undertaken in 6 months

4.5 Use of Waivers Quarter 2 and 3

The Audit Committee received a reporting detailing the Waivers for quarters 2 and 3. They were informed that in quarter 2 there were 6 waivers totalling £384k for the Trust, the same number compared to the same period last year; however the value has approximately tripled. Four out the six waivers were requested by Estates.

In quarter three there were 9 waivers totalling £173k for the Trust, a slightly higher number compared to the same period last year, when 7 were approved, but the total value was approximately the same. Details of the reasons for the waivers and the department of origin were presented and discussed and revisions to future reports were agreed to make the detail clearer.

5. External Reports

5.1 Internal Audit Progress Report

The Committee received the Internal Audit Progress report and noted that three final audits were included, all three rated as reasonable assurance; Purchasing Controls, Risk Management and Board Assurance Framework and Clinical Audit.

Two internal audits are due to be completed in 2019/20: Conflicts of Interest Part 2 and Delivering Value. These will be completed in time to be included in Head of Internal Audit Opinion. It was noted that within 2019/20 the Trust had received three reports of partial assurance: patient monies, health & safety and appraisals

5.2 Internal Audit Action Tracker Exception Report

The Committee received the Audit Action Tracker Exception Report which detailed the progress made on this and it was noted that there had been a significant improvement in the completion of the actions.

5.3 Internal Audit Plan 20/21

This followed on from earlier presentation and discussion and the draft program was agreed subject to there being further consideration of including an item on the governance processes in relation to the partnership arrangements now operating in Essex in relation to Learning Disability services.

5.4 Counter Fraud Progress Report

A report outlining Counter Fraud work undertaken since the last Audit Committee held on 3 December 2019 was received. Four referrals for 2019/20 and there are no ongoing cases requiring active investigation.

Since the December 2019 meeting the CFS successfully received the completed health checklist for pre-employment checks in relation to standard 3.4 which was rated as red (non-compliant). The contents of this checklist suggest that the Trust rates themselves as compliant with 56 of the requirements and that three were not applicable. No areas have been rated as non-compliant.

It was noted that a new counter fraud manager will be joining the team to provide support.

5.5 Counter Fraud Plan 20/21

The counter fraud Plan for next year was presented and approved. It was noted that this continued to be Risk based with a focus on cyber security and with specific content to support the current work on conflicts of interest. The Committee were also advised that whilst the overall program days would remain as this year consideration was being given to changing the plan detail to increase the days allocated to awareness

5.6 External Audit: Progress Report

The Committee received the External Audit progress report and noted the actions taken since the meeting held on 3 December 2019, namely: commenced working with the Trust regarding the production of the year end Quality Report; commenced the 2019/20 interim audit; presented at the December 2019 Council of Governors meeting and assisted in the selection of the Local Indicator for Quality Report audit.

Next steps were identified as: debrief management on the results of Interim Audit; complete 2019/20 interim audit, the Committee were informed that KPMG's findings form this work would be reported on an exceptions basis.

Other Matters

5.7 Annual Self-Assessment of Committee Effectiveness

The Committee considered the report on the outcome of the committee self-assessment undertaken in December 2019. It was agreed that the feedback was helpful and would be useful for the Committee to consider. Overall the feedback was very positive and the areas for improvement, which related to the role of Audit Committee with regard to review of annual financial and accounting policies; how the committee uses external reports to undertake its responsibilities; the Committee's role in reviewing the work of IGC and FIC; and the level of analysis versus detail provided in the reports were discussed and agreed. It was noted that the role of FIC and Audit Committee with regard to financial policies had been clarified.

6. Matters of Escalation

The Board are asked to note that the Committee agreed the 20/21 plans for Internal Audit and Counter Fraud.

There following matters are for formal escalation to the Board;

- The Committee recommends that the going concern concept is applied to the preparation of the Annual Accounts. (this will be confirmed again prior to submission of the draft and the final Annual Accounts)
- The Committee approved the increase in the bad debt provision from £101,850 to £110,600.

Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 19
Subject:	Trust Risk Register January 2020	**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 Trust Board on the current and emerging risks in the Trust Risk Register (TRR).

Action required:

Approve: To note the Trust Risk Register and the changes approved by the Integrated Governance Committee.

Summary and recommendations:

This report provides the current Trust Risk Register, top ten risks.

The Integrated Governance Committee approved the following changes to the risk scores on the 15th January 2020.

Risk score increased

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

- This risk has been increased in score to 16 reflecting the additional efficiency requirement and potential that this cannot be achieved without compromising service quality. The likelihood of the risk has increased from possible (3) to likely (4).

Risk scores decreased

Changing External Landscape: The changing external landscape and wider system pressures/agenda leads to a shift of influence and resources away from mental health & Learning Disability services and from HPFT (Risk 749)

- The risk score has been downgraded from a 15 to a 12, the consequence of the risk has been downgraded from catastrophic (5) to major (4)

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

- The risk score has been downgraded from a 16 to a 12, the likelihood of the risk has been downgraded from likely (4) to possible (3)

Finance: The Trust is unable to ensure short term financial performance in the current year (Risk 116)

- The risk score has been downgraded from a 12 to 8; the likelihood of the risk has been downgraded from possible (3) to unlikely (2) as the Trust is confident of achieving full year target. This risk is no longer included with the top ten risks on the Trust Risk Register.

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

- The risk score has been downgraded from a 15 to 9; the likelihood of the risk has been

downgraded from almost certain (5) to possible (3) as the CAMHS access targets are being achieved. Alongside the additional funding from the CCG there have been changes in the way the teams are working to ensure that access is sustained which will mitigate the risk when the additional resource cease. This risk will continue to be tracked to ensure assurance around sustainability.

These changes have been made to the Trust Risk Register following approval by IGC.

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

IGC 20.02.2020 Audit Committee: 13.02.2020 Trust Board: 27.02.2020

Hertfordshire Partnership University NHS Foundation Trust

Trust Risk Register January 2020

1. Introduction

1.1. The purpose of this report is to present the Trust Risk Register (TRR) to the Trust Board for discussion. Consideration should be given to the proposed changes and mitigations that have been put in place. The TRR identifies the high level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them. There are currently 12 risks on the Trust Risk Register, all of which have been presented to the Integrated Governance Committee. For the purpose of this report the top 10 are reported.

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 score increased

2.1 **Finance: 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 reflecting the East of England 0.5% contingency requirement. Current planning suggests the additional 0.5% is not achievable.
- Work to manage demand has demonstrated improved performance across adult, CAMHS and Older Peoples services.

This risk is being considered for an increase in score to 16 reflecting the additional efficiency requirement and potential that this cannot be achieved without compromising service quality. The likelihood of the risk has increased from possible (3) to likely (4).

3. Risk scores decreased

3.1 **Changing External Landscape: The changing external landscape and wider system pressures/agenda leads to a shift of influence and resources away from mental health & Learning Disability services and from HPFT (Risk 749)**

- Herts ICP for MH & LD now agreed and now moving to mobilise
- STP LTP includes MH&LD national commitments – provides a roadmap for future investment
- Risk re system QUIPP and pull on transformation underspends
- EOE Collaborative development and through first gateway

The proposal is that this risk is downgraded from a 15 to a 12, the consequence of the risk has been downgraded from catastrophic (5) to major (4)

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

- Parliament has confirmed the Withdrawal Agreement Bill (WAB) and EU Exit will take place on 31 January 2020.
- A 'no deal' exit is therefore no longer expected.
- NHS England has stood down daily monitoring requirements in relation to EU Exit preparedness

- The Trust has continued with weekly preparation meetings for the EU Exit Group in order to maintain readiness for any unexpected consequences.

The proposal is that this risk is downgraded from a 16 to a 12, the likelihood of the risk has been downgraded from likely (4) to possible (3)

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

- The Trust has been successful in securing additional funding for CAMHS from Hertfordshire Commissioners, providing more capacity to meet growing demand.
- Service has achieved 94% on the 28 day KPI.

The proposal is that this risk is downgraded from a 15 to 9; the likelihood of the risk has been downgraded from almost certain (5) to possible (3) as the CAMHS access is being achieved.

4. Risks Updates

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

- If the current level of recruitment activity continues the next iteration may consider dropping the likelihood
- October and November both saw a reduction in vacancy rate to 12.53% in November. The Trust had 51 starters against 25 leavers (headcount) in November.
- The Target Vacancy rate for the trust for Q2 was 12.7% and for Q3 will be 12.2%. The trust is currently on trajectory against the target vacancy rate.
- The Time to Hire (T2H) was 53.4 days in September but has dropped to 50 days in October and November. 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. This change in approach has brought in significant numbers of new staff. 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 continues over January, February and March which is projected to maintain the current level of candidates for the next quarter and increase the staff in post and reduce the vacancy rate.

4.2 **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 due to low morale and staff engagement is “extremely likely” which is how the likelihood of this risk is currently scored.
- The turnover rate in October and November dropped to 14.93% and 14.59% respectively.
- The Target Turnover rate for the trust for Q3 is 14.3%. Whilst the turnover rate is tracking just above target it is on a downward trend.
- Staff recognise the value of the retention initiatives which have been introduced and the drop in turnover rate for consecutive months may well as a consequence of them.
- Increase of exit interview return rates to 50%, these are now being managed by Realworld Consulting Ltd
- Staff survey response was 57% showing high levels of engagement

4.3 **Adult Community: 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. At the end of November the trust was achieving 92.6%.

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

- No change to current controls. Updated current position.
- Three incidents have been reported to the Information Commissioner in Q1.
- Two incidents were reported to the Information Commissioner in Q2.
- The Trust has reported two data breaches to the Information Commissioner in Q3.
- There remain 2 on-going investigations awaiting an outcome from the commissioner.
- The most common theme across Q3 for all data incidents has been 'information disclosed in error. Q3 has seen a reoccurrence of handover sheets being lost or discarded in unsecure locations. This has been escalated to the SBU leadership teams for the affected ward and the Information Rights and Compliance team will revisit the work that was done in 2018 to reinforce best practice.

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

- 68 people exceeded the 24hr period of detention in the audit period. This accounts for 34% of detentions in the audit period. This compares with 24% in April-June 2019 audit. 33 people exceeded the maximum time of 36hrs (compared to 22 in April-June 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.
- System wide Section 136 CQI session planned.

4.6 **Flu: The Trust may not be able to sustain service user safety during a flu outbreak (Risk 1147)**

- The flu campaign is currently in stage 3.
- Stage 3: January to February: Final push, using the information we have collected, to focus on any specific teams, professional groups etc. where take up has been low.
- The team are continuing to use available data to target teams and staff groups with low compliance this is being done through targeted walk round by peer vaccinators. The Team now have flu compliance data broken down by SBU, team and also by professional groups.
- Alongside this the performance team are reviewing the guidance for reporting to NHSE to ensure accurate report.
- Flu compliance as at 09.01.2020 is
  - Front line staff 42.98%
  - All staff 44.46%

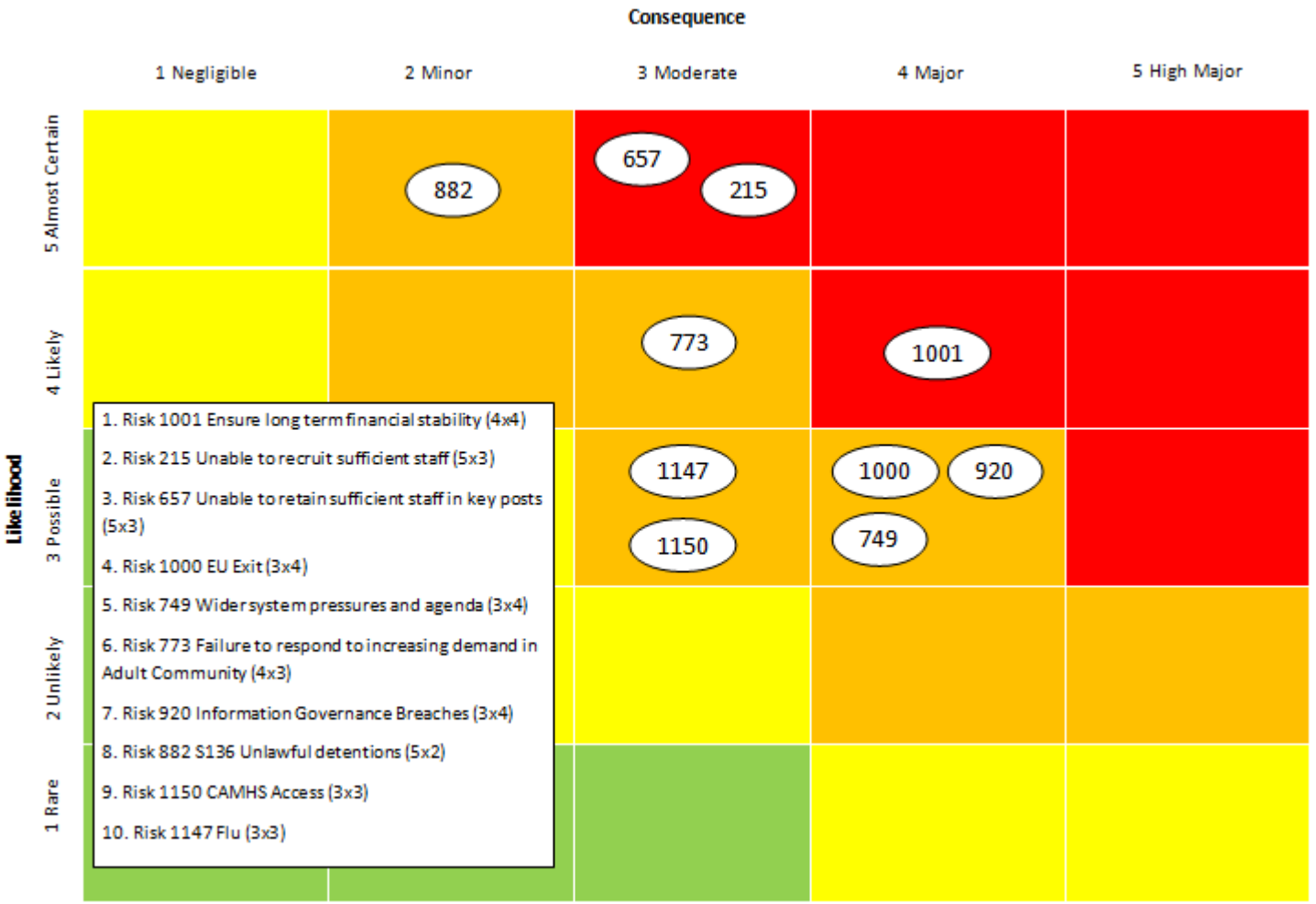
5 Conclusion

5.5 This report has detailed the changes approved by IGC. It has detailed the actions that have been taken and the mitigations put in place to manage the risks that have been identified.

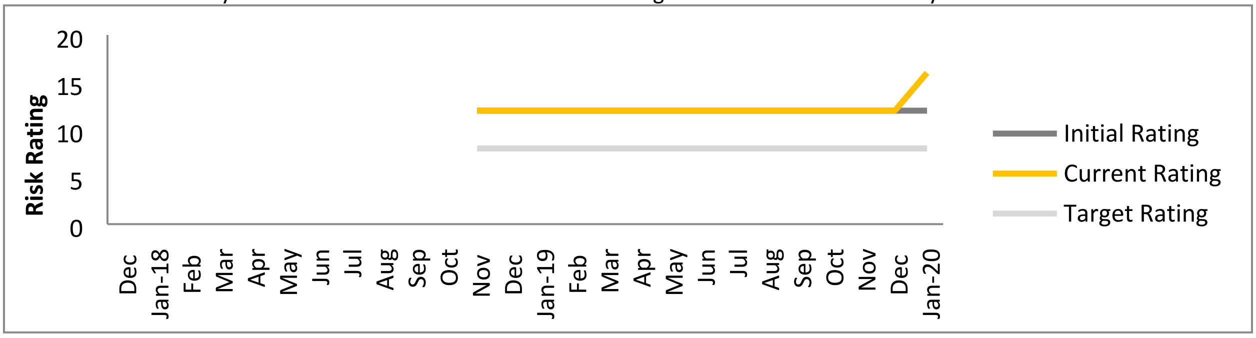
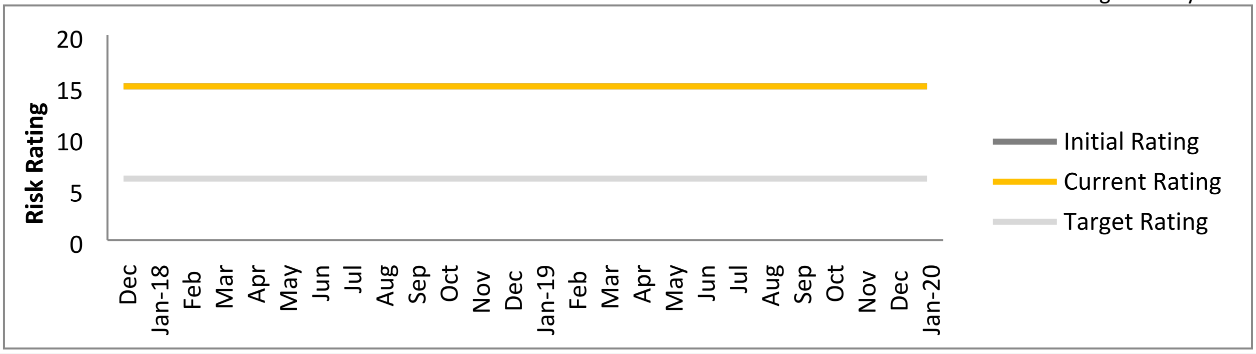
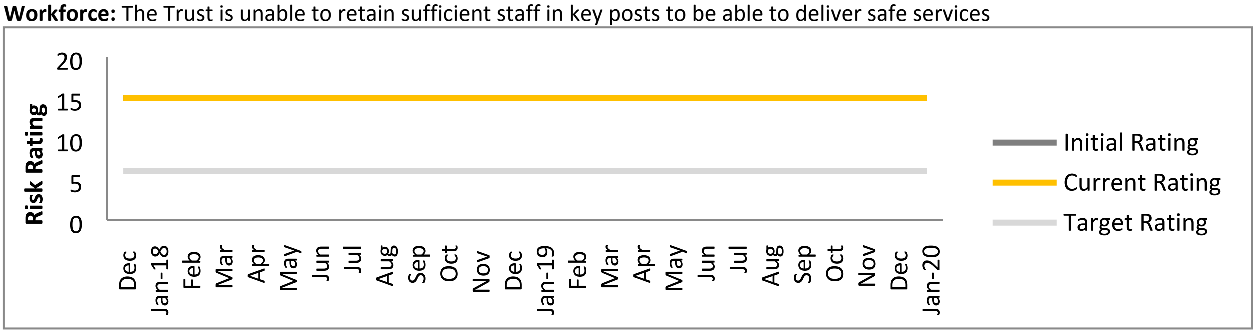
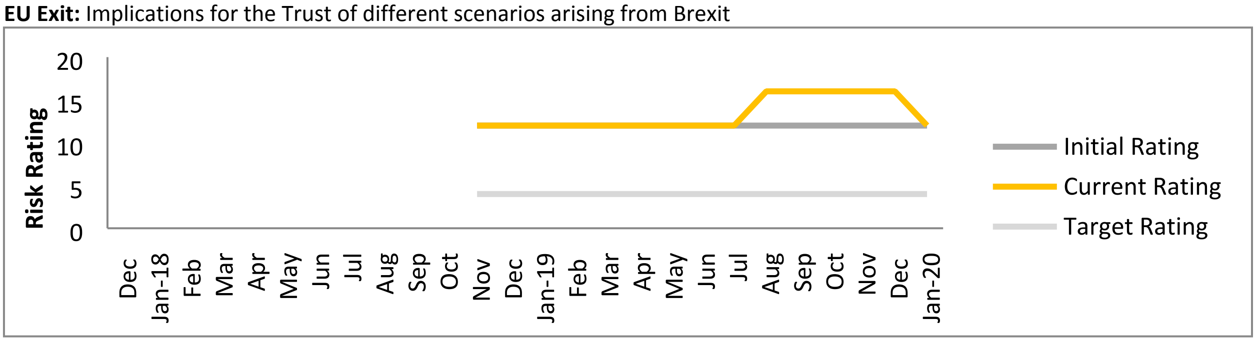
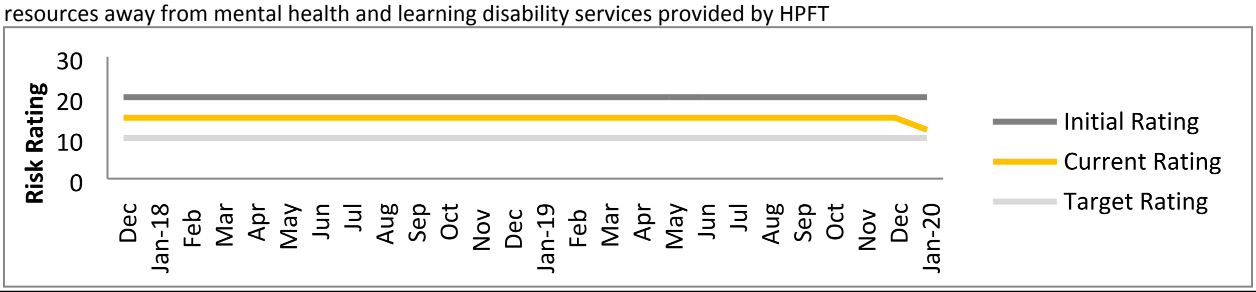
Appendix 1 Trust Risk Register by Exec Lead and linked to Trust Strategic Objectives

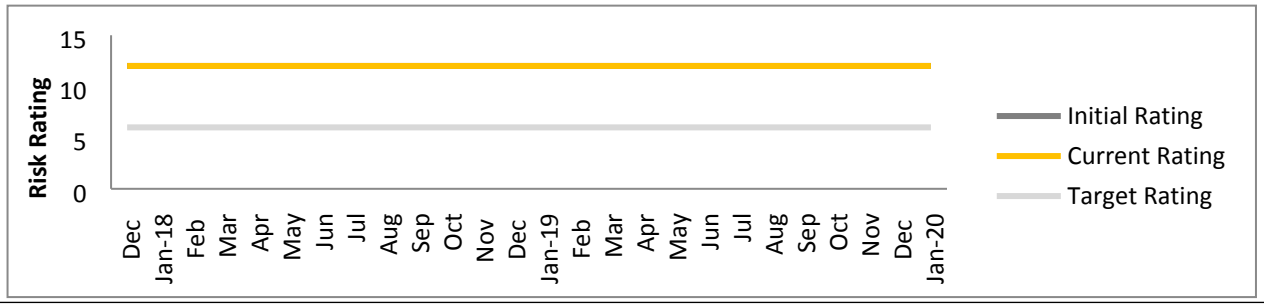
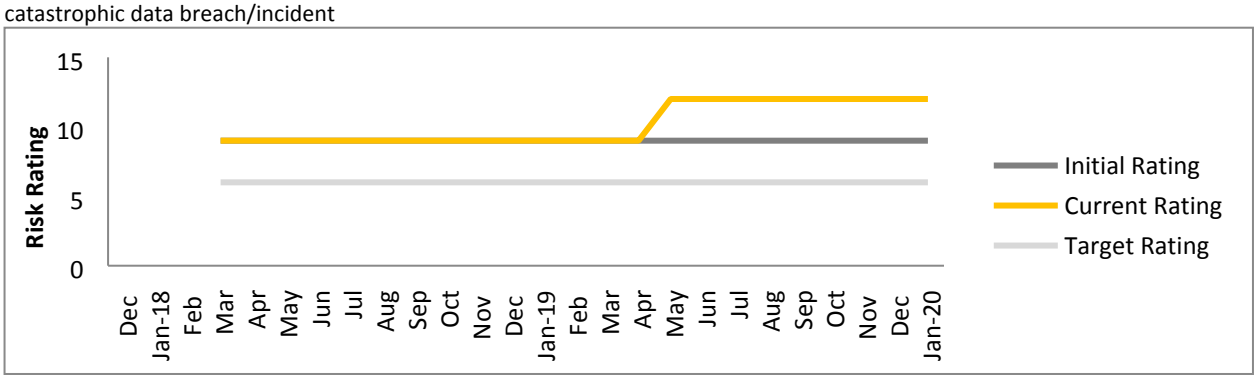
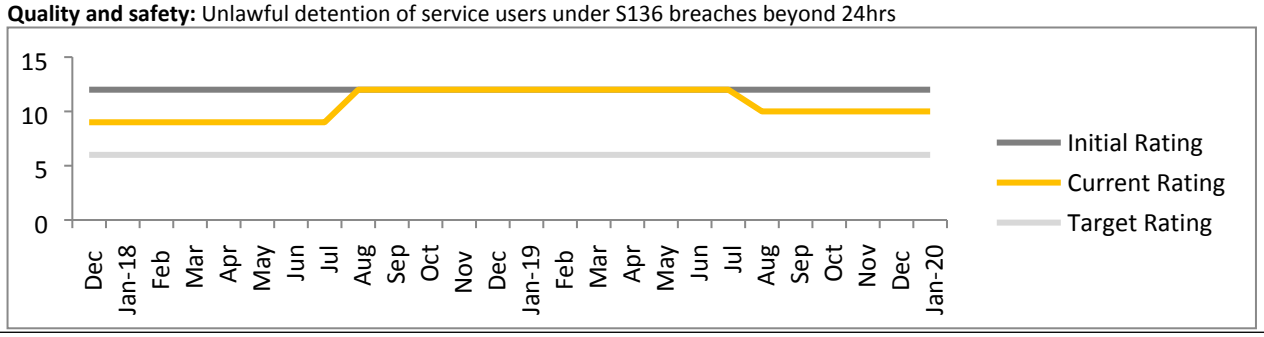
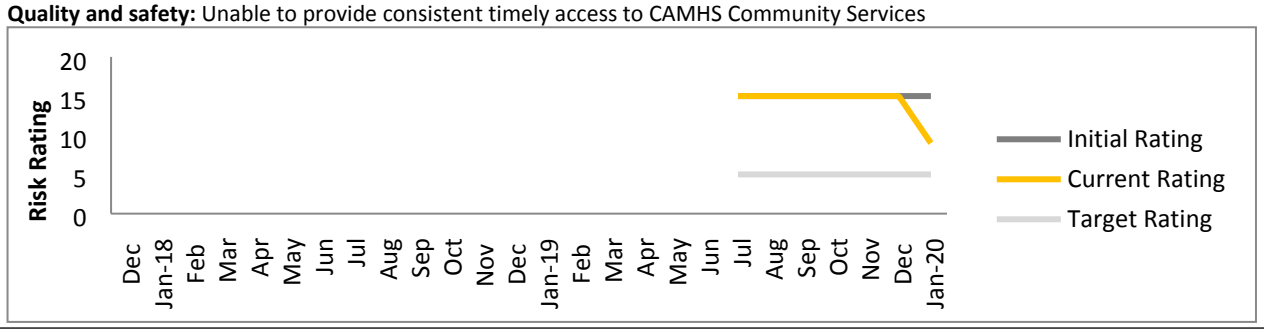
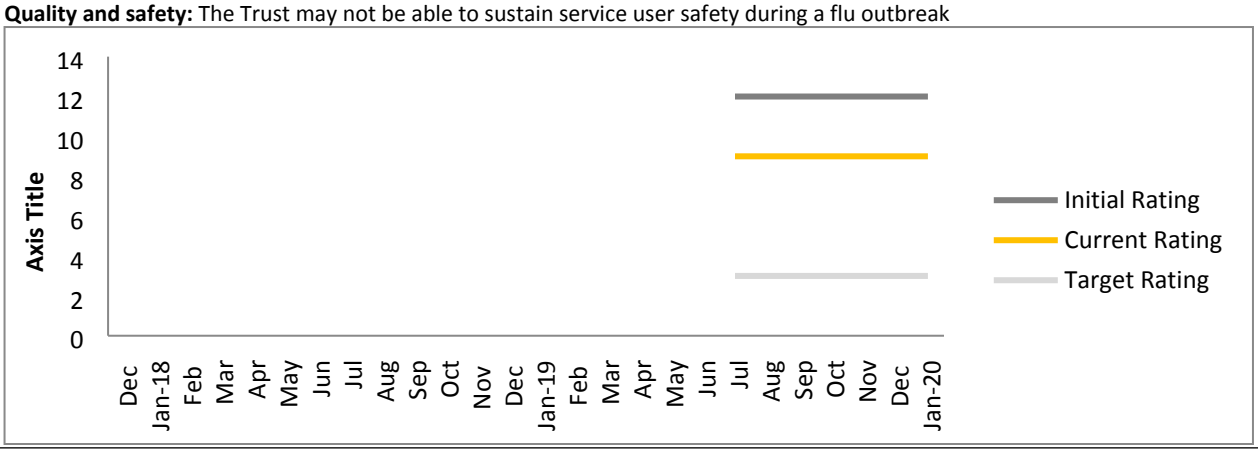
	Opened	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead
1	16.10.18	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability	12	16 (4x4)	8	We will make effective use of people's time and the money we have to deliver on the outcomes that matter to those we serve	Keith Loveman
2	16.10.14	215	**Workforce:** The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	15	15 (5x3)	6	We will be seen as an employer of choice where people grow, thrive and succeed	Susan Young
3	30.06.16	657	**Workforce:** The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	15	15 (5x3)	6	Our staff will report feeling engaged and motivated, and recommend the Trust as a place to work	Susan Young
4	16.10.18	1000	**EU Exit:** Implications for the Trust of different scenarios arising from Brexit	12	12 (3x4)	4	Staff will report that they are able to deliver safe and effective services	Keith Loveman
5	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	12 (3x4)	10	Mental health and learning disability will be given the same emphasis as physical health in local care planning and delivery	Karen Taylor
6	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
7	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
8	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
9	15.08.19	1150	**Quality and safety:** Unable to provide consistent timely access to CAMHS Community Services	15	9 (3x3)	5	People will able to access the right service in a timely way	Sandra Brookes
10	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

Appendix 2 Trust Risk Register Matrix



Appendix 3 Trend Analysis – 24months

No	Risk	24 month trend analysis
1	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability 
2	215	**Workforce:** The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff 
3	657	**Workforce:** The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services 
4	1000	**EU Exit:** Implications for the Trust of different scenarios arising from Brexit 
5	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 

6	773	**Quality and safety:** Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness 
7	920	**Information Management and Technology:** Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident 
8	882	**Quality and safety:** Unlawful detention of service users under S136 breaches beyond 24hrs 
9	1150	**Quality and safety:** Unable to provide consistent timely access to CAMHS Community Services 
10	1147	**Quality and safety:** The Trust may not be able to sustain service user safety during a flu outbreak 

Hertfordshire Partnership University NHS Foundation Trust

Appendix 4

Trust Risk Register
January 2020

To be reviewed by:

Integrated Governance Committee: 22.01.2020

Audit Committee: 13.02.2020

Trust Board: 27.02.2020

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
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	16	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 Work to manage demand have demonstrated improved performance across adult, CAMHS and	Keith Loveman (Director of Finance)	09/01/2020	09/03/2020

				demand.				Older Peoples services. 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 reflecting the East of England 0.5% contingency requirement. Current planning suggests the additional 0.5% is not achievable.			

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 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	If the current level of recruitment activity continues the next iteration may consider dropping the likelihood October and November both saw a reduction in vacancy rate to 12.53% in November. The Trust had 51 starters against 25 leavers (headcount) in November. The Target Vacancy rate for the trust for Q2 was 12.7% and for Q3 will be 12.2%. The trust is currently on trajectory against the target vacancy rate. The Time to Hire (T2H) was 53.4 days in September but has dropped to 50 days in October and November. 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	Susan Young Interim Director of Workforce and OD	07/01/2020	07/03/2020

								areas / roles. This change in approach has brought in significant numbers of new staff. 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 continues over January, February and March which is projected to maintain the current level of candidates for the next quarter and increase the staff in post and reduce the vacancy rate.			

657	The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	Risk to Staff Morale and Financial Risk Retention There is a risk that a higher number of existing staff choose to exit the organisation due to high workloads and a perceived lack of career pathways leading to increased and unplanned vacancies and a drain of knowledge and experience from the organisation.	15	SBU review data - HR performance dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate turnover vacancy information to be accessed at all times OD plan for Talent and succession planning Recruitment and Retention Group	15	6	Increased banks / agency costs High turnover / Reduced Stability Index Exit interview feedback Lack of quality PDPs, inconsistent and ad hoc supervision	The 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 due to low morale and staff engagement is “extremely likely” which is how the likelihood of this risk is currently scored. The turnover rate in October and November dropped to 14.93% and 14.59% respectively. The Target Turnover rate for the trust for Q3 is 14.3%. Whilst the turnover rate is tracking just above target it is on a downward trend. Staff recognise the value of the retention initiatives which have been introduced and the drop in turnover rate for consecutive months may well as a consequence of them. Increase of exit interview return	Susan Young Interim Director of Workforce and OD	07/01/2020	07/03/2020

								rates to 50%, these are now being managed by Realworld Consulting Ltd Staff survey response was 57% showing high levels of engagement			

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 Highly impacted contracts and mitigating activities completed Board level lead identified - DoF DHSC EU Exit Operational Readiness Guidance framework for assessment of risks completed January 2019 Business continuity and incident management plans tested	12	4	Increase difficulty or delay in sourcing sufficient quantities of medication or equipment. Increased staff turnover of EU registered staff Increase in unit price	Parliament has confirmed the Withdrawal Agreement Bill (WAB) and EU Exit will take place on 31 January 2020. A 'no deal' exit is therefore no longer expected. NHS England has stood down daily monitoring requirements in relation to EU Exit preparedness The Trust has continued with weekly preparation meetings for the EU Exit Group in order to maintain readiness for any unexpected consequences. 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	Sandra Brookes (Director Of Service Delivery and Service User Experience)	09/01/2020	09/03/2020

								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. 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 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 ment	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	Active engagement with the system about MH & LD by HPFT leaders; together with leading the development of a Herts MH & LD ICP for the future 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 STP Mental Health & LD workstream chaired by HPFT National LTP commitments for MH documented within STP LTP	12	10	Commissioning intentions demonstrate reduced funding/intention Parity of esteem agenda not honoured within contract negotiations or lack of commitment Lack of discussion about Mental Health & LD priorities across STP, within developing geographical ICPs and in Local Delivery Boards No demography increase and / or usual commitments aren't delivered by CCG's.	MH Long Term Plan provides a roadmap for further investment and priorities and is reflected within the STP LTP submission Herts MH & LD ICP agreed by STP CEO's. Partnership Board established and governance arrangements at early stage of development. Next Partnership Board scheduled for 23 Jan; HCC engagement taking place in Jan which includes discussions about LD & CAMHS. Broader partnership workshop being arranged for March. STP will move to 'shadow' ICS from April 2020 and HPFT supporting and shaping development; Directors involved in key STP decision making forums and groups. ICP MH & LD to align with 'go live' of ICS in April 2021 E&N ICP and West Herts ICP developing at pace; with HPFT well represented and supporting/shaping	Karen Taylor (Director of Strategy & Integration)	09/01/2020	09/03/2020

								development, including MH & LD priorities within the ICPs. NHSE transformation funding secured – community (Adult & older people) and crisis and service design commenced 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 There remains on-going issue of QIPP for MH & LD; and also system use of non-recurrent MH underspend (e.g. transformation funding)			

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 requiring MHAA and admission.	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. At the end of November the trust was achieving 92.6%. 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.	Sandra Brookes (Director Of Service Delivery and Service User Experience)	09/01/2020	28/02/2020

		allocation remains a risk					High CATT caseloads as unable to pass on to community teams.	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 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			

920	Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident	Failure to maintain compliance with data protection legislation creates a risk of a data incident occurring which leads to serious or catastrophic impact on data subjects (Staff or Service users). Should the Trust then fail to comply with an enforcement notice from the Information Commissioner, it would be at risk of a fine of up to €20million. Financial compensation will 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% compared 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	Keith Loveman (Director of Finance)	03/01/2020	03/03/2020

				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.				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). Three incidents have been reported to the Information Commissioner in Q1. Two incidents were reported to the Information Commissioner in Q2. The Trust has reported two data breaches to the Information Commissioner in Q3. There remain 2 on-going investigations awaiting an outcome from the commissioner. 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'. The most common theme across Q3 for all data incidents has been 'information disclosed in error. Q3 has seen a reoccurrence of handover sheets			

								being lost or discarded in unsecure locations. This has been escalated to the SBU leadership teams for the affected ward and the Information Rights and Compliance team will revisit the work that was done in 2018 to reinforce best practice.			

882	Unlawful detention of Service Users under S136 i.e. 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. The risk, therefore, is in relation to	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. Section 136 suite dedicated to YP opens October 2019 - 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	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 - Lack of availability of S12 approved Dr's to support AMHP if detention necessary - 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 - Lack of bed capacity in HPFT, as identified through OPEL status of 3/4 - Bed closure due to damage or fault, impacting on capacity	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. 68 people exceeded the 24hr period of detention in the audit period. This accounts for 34% of detentions in the audit period. This compares with 24% in April-June 2019 audit. 33 people exceeded the maximum time of 36hrs (compared to 22 in April-June 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	Sandra Brookes (Director Of Service Delivery and Service User Experience)	11/12/2019	09/03/2020

		availability of a bed to admit someone into, should this be the outcome of the S136 assessment; or the lack of availability of clinicians to carry out triage and assessment in a timely way i.e. discharge from S136 within 24 hours. In order to meet these timescales and manage the requirements of the changes, the Trust has to provide 24 hour clinical coverage for the Police; to ensure that the demand for Section 136 does not increase dramatically by monitoring inappropriate or unwarranted use of S136 in cases of intoxication only or presence of no mental disorder; to ensure availability of relevant professionals (AMHP, Section 12 approved Doctor and Crisis Assessment and		- Presence of CATT staff in Kingfisher Court overnight, increasing availability for assessment - Interagency meetings and governance arrangements in place to monitor implementation of the Police and Crime Act changes to Section 136, reporting to Hertfordshire's Crisis Care Concordat Group				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. This is in place for high use Service Users identified. Paper has gone in requesting additional resource for clinical review of top 40 frequent users of services to look for trends and make recommendations in relation to treatment pathways which should resolve repeated attendance at 136.			

		Treatment Team where admission indicated) in order to assess and recommend individuals. Since implementation of the legislation, there has been an increase in incidents of illegal detentions. Analysis of these incidents has identified the following themes as factors driving this increase: - Delays due to AMHP 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						System wide Section 136 CQI session planned.			

		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. From January 2019, there was an upward trajectory in numbers of people being detained under Section 136, which combined with growing pressure on the acute mental health pathway led to an increase in the numbers of people who were subsequently detained over 24 hours. Although there has been no legal recourse from any service users to date, this does remain a risk.									

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	9	5	CAMHS 28 day KPI/performance Number of referrals Re-referral rates DNA rates WTE Vacancies Use of agency staff Complaints	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 backlog of over 500 has been reduced down to 6 and CAMHS are now booking into 28 day choice appointments. Service has achieved 94% on the 28 day KPI. Risk of sustaining performance remains and impact on partnership waits. Additional funding has been given for 6 CAMHS practitioners spread across the	Sandra Brookes (Director Of Service Delivery and Service User Experience)	11/12/2019	28/02/2020

				clinics and early evening appointments.				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.			

1147	The Trust may not be able to sustain service user safety during a flu outbreak	There is a risk that the Trust is unable to vaccinate enough front line staff against flu prior to the winter of 2019-20 which if during a flu outbreak might lead to a shortage of staff and a risk that the Trust is unable to provide sufficient staff to safely care for service users. The risk in 2019 - 20 could potentially increase due to the following: - Occupational Health have informed the Trust that there would be a delay in the supply of the vaccine, with the first batch arriving in October rather than September. - Link between flu trends in Australia and the UK. The flu season in Australia typically peaks in August, but laboratory-confirmed cases of influenza have been higher than usual so far this year.	12	Learning from the themes from the 2018-19 campaign. Flu Plan Steering Group	9	3	International / Global Flu trends	The flu campaign is currently in stage 3. Stage 3: January to February: Final push, using the information we have collected, to focus on any specific teams, professional groups etc. where take up has been low. The team are continuing to use available data to target teams and staff groups with low compliance this is being done through targeted walk round by peer vaccinators. The Team now have flu compliance data broken down by SBU, team and also by professional groups. Alongside this the performance team are reviewing the guidance for reporting to NHSE to ensure accurate report. Flu compliance as at 09.01.2020 is - Front line staff 42.98% - All staff 44.46%	Asif Zia (Medical Director)	08/01/2020	08/03/2020

End of Report

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item: 20**
Subject:	Board Self-Assessment 2019	**For Publication: No**
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Chris Lawrence, Chair
Presented by:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	

Purpose of the report:

To report the outcome of the self-assessment undertaken by the Board of Directors in December 2019

Action required:

To critically evaluate the feedback provided through the questionnaire in order to consider any improvements or learning for the Board of Directors to consider.

Summary and recommendations to the Board:

1. Background

As part of good governance members and attendees of the Board of Directors undertook an annual self-assessment of its effectiveness. An online questionnaire was distributed and responses collated during December 2019 - January 2020.

2. Evaluation Findings

The survey attracted a response rate of 100% across an evaluation of 20 questions, with a lot of useful feedback and comments provided. The scoring was a standard 1 – 5 rating with 1 or 2 representing a red score, 3 an amber and 4 – 5 a green score. Appendix 1 provides a summary of the scores for each question.

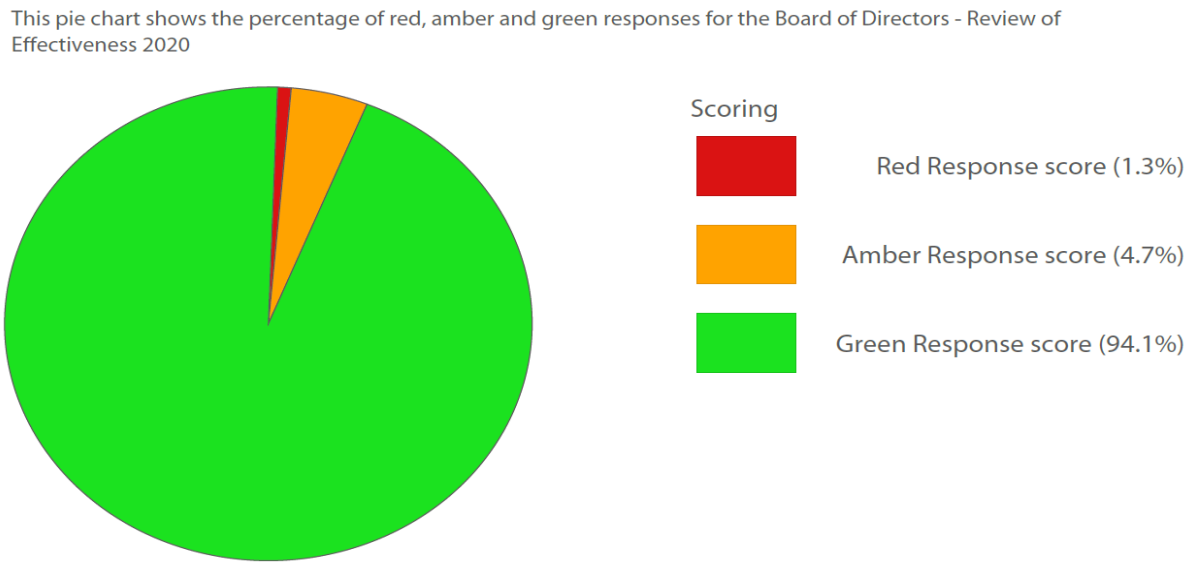
The feedback provided is detailed and is incredibly helpful in providing assurance and identifying areas for improvement

The overall score was 89%, the summary of the scores is set out in table 1 and diagram 1 and they detail the percentages red, amber or green scores.

Table 1.

					Overall Score	% Score 2020
Board of Directors - Review of Effectiveness 2020	4 [1.3%]	15 [4.7%]	301 [94.1%]	0	1417/1600	89%

Diagram 1



2.1 The highest scoring questions were:

Question 6: Does the Board ensure the Trust Risk Register is regularly reviewed and up to date? Score of 92%

Question 13: Is there effective leadership of the Board? Score of 94%

Question 17: Is the meeting conducted in a manner that means all members can contribute in meetings? Score of 92%

2.2 The lowest scoring questions were:

Question 11. Does the Board effectively review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. For example: reviews by Department of Health Arm's Length Bodies? Score of 80%

Question 15: Does the Board run effectively, i.e. reports received in a timely manner with right format and content and effectively chaired? Score of 75%

Question 16: Does the Board set its agenda and workload in a sufficiently flexible way to ensure it manages items that will support delivery of Trust objectives? Score of 80%

All other question scored over 84%

2.3 **Comments**

The people who provided the comments have obviously given the areas close consideration and taken a significant amount of time to provide some incisive and helpful feedback.

The main themes from the comments are:

a) Board does spend time discussing strategic issues but with the changing external environment the time spent may benefit from being increased.
b) The Board does hold the Executive to account for delivery of priorities and the Annual Plan. This could be enhanced further with comparative information from other Outstanding Trusts.
c) Positive response regarding the Board's role in reviewing the effectiveness of assurance processes, including the use of Board Assurance Framework and the Risk Register. It was noted that there was appropriate escalation from sub-committees.
d) Clear confirmation that the Board scrutinises the Quality Report, Quality Account, Annual Report and Annual Accounts.
e) Reported that some external assurance reports are considered but some queries that this could be done more.
f) Majority view that Board effectively reviews work of sub committees but also one view that there is some overlap between the committees.
g) There is effective leadership of the Board and the Board shapes the positive culture for Trust leadership.
h) Improvements required with regard to analysis and level of detail provided in papers.
i) Agenda is well structured, with perhaps too many items. The agenda is flexible enough to respond to emerging issues.
j) Participants feeling they can contribute and Board follows up on previous actions.
k) Board has skills and experience need to facilitate delivery of objectives.

3. Areas of Development

It is worth noting that the scores provide a very positive view of the effectiveness of the Board of Directors, and the areas of development identified are made in the spirit of improving on an already strong position.

a) Ensure agendas for formal Board and workshops provided sufficient time to consider the strategic issues facing the Trust.
b) Consider the use of external benchmarking information and external reports when providing analysis to the Board.
c) Review volume and appropriate use of summary papers to assist working and discussion as at the Committee, noting broader piece of work underway reviewing flow of papers between Board and committees.

4. Summary and Recommendations

a) Critically review and evaluate the findings.
b) Discuss and agree identified areas of development.
c) Update the Council of Governors regarding the outcomes of the assessment and any next steps.

Relationship with the Business Plan & Assurance Framework:

Assessing the effectiveness of the Board of Directors is essential to ensuring that the Trust is well led, meetings is objectives as set out in the Annual Plan and continues to deliver high quality care to service users.

Summary of Implications for:

None identified

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

None identified

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

Evidence to support the NHSI/CQC Well Led Standard.

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

n/a

This summary report shows total scores, total percentage scores and a breakdown of responses by statement category and by individual statement.

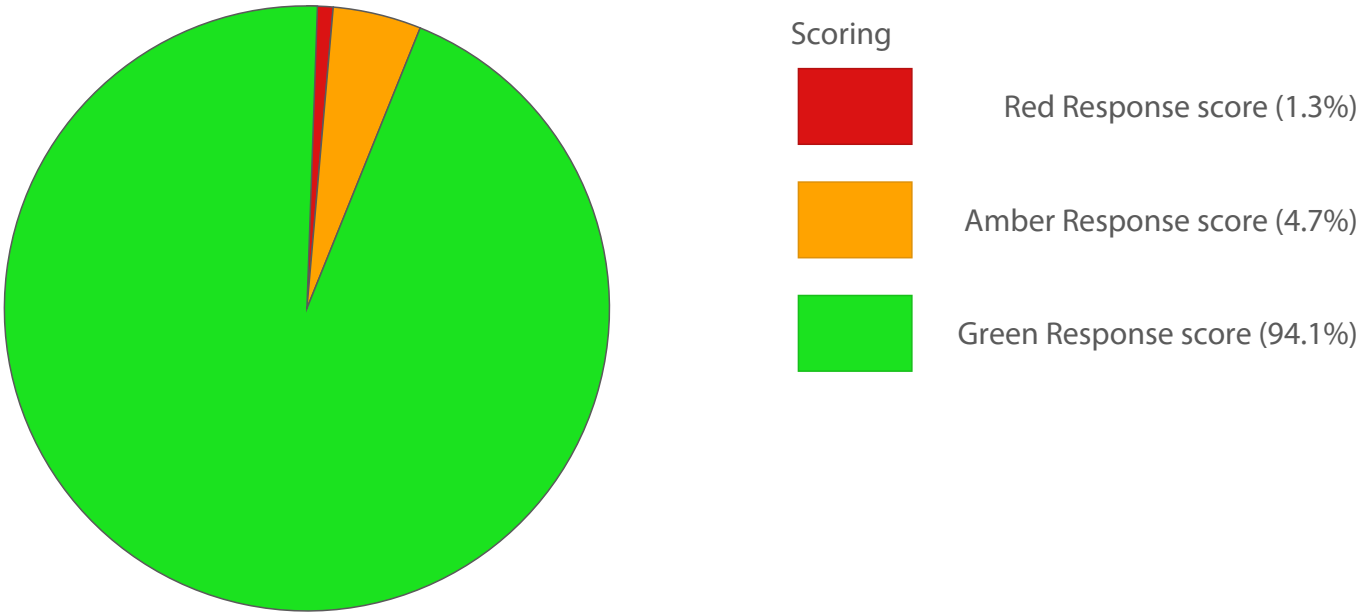
Board of Directors - Review of Effectiveness 2020

Number of respondents: 16

Number of statements: 20

					Overall Score	% Score 2020
Board of Directors - Review of Effectiveness 2020	4 [1.3%]	15 [4.7%]	301 [94.1%]	0	1417/1600	89%

This pie chart shows the percentage of red, amber and green responses for the Board of Directors - Review of Effectiveness 2020



Key:


Red indicates the number of responses in the strongly disagree or disagree categories and scores either 1 or 2.


Amber indicates the number of responses in the undecided category and scores 3.


Green indicates the number of responses in the strongly agree or agree categories and scores either 4 or 5


Grey indicates the number of n/a responses and scores zero.

Breakdown of responses by category/competency.

Board of Directors - Review of Effectiveness 2020					Overall Score	% Score
Assessment and Review	4	15	301	0	1417/1600	89%

Key:

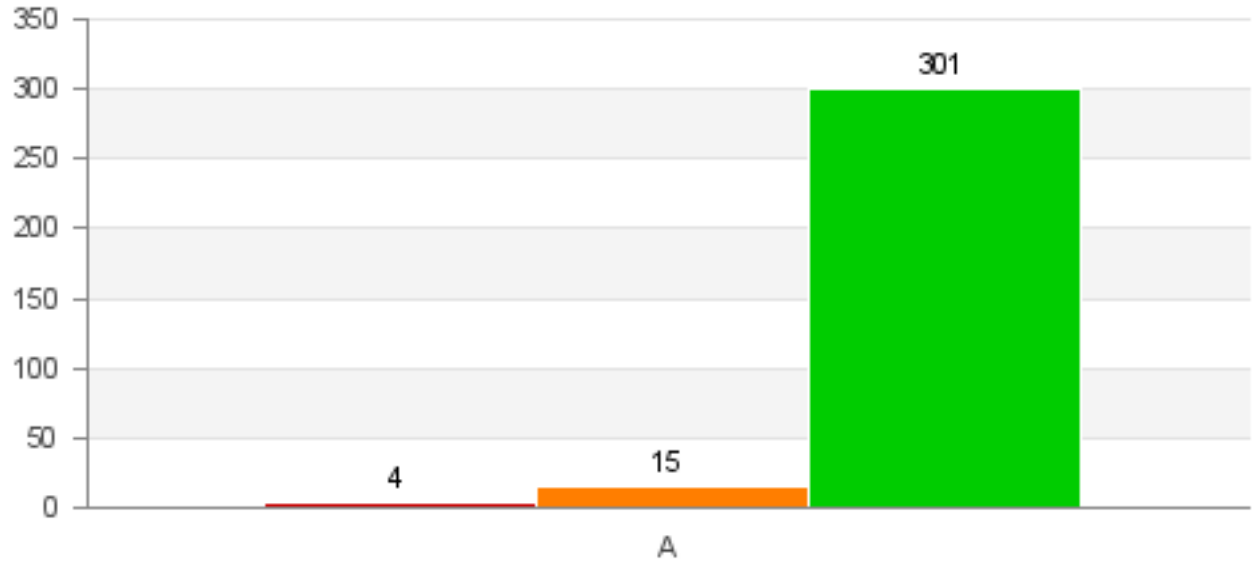

Red indicates the number of responses in the strongly disagree or disagree categories and scores either 1 or 2.


Amber indicates the number of responses in the undecided category and scores 3.


Green indicates the number of responses in the strongly agree or agree categories and scores either 4 or 5


Grey indicates the number of n/a responses and scores zero.

Graph of number of red, amber and green responses by statement categories for the Board of Directors - Review of Effectiveness 2020 appraisal.



Statement Categories
A - Assessment and Review

Key:

Red indicates the number of responses in the strongly disagree or disagree categories and scores either 1 or 2.

Amber indicates the number of responses in the undecided category and scores 3.

Green indicates the number of responses in the strongly agree or agree categories and scores either 4 or 5

Grey indicates the number of n/a responses and scores zero.

Breakdown of report by individual statements

Board of Directors - Review of Effectiveness 2020						Score	%age
Assessment and Review							
1	Does the Board effectively consider the key strategic issues facing the Trust?	0	1	15	0	73/80	92%
2	Does the Board hold the Executive to account for the delivery of the strategy, its objectives and the associated priorities?	0	1	15	0	71/80	89%
3	Does the Board assure itself that the Trust' Annual Plan is developed from feedback and analysis and is focused on Trust's objectives?	0	1	15	0	71/80	89%
4	Does the Board, through seeking assurance ensure that systems of control are robust and reliable?	0	2	14	0	71/80	89%
5	Does the Board effectively review the robustness of the underlying assurance processes that indicate the effectiveness of the management of the principal risks, in line with the Board Assurance Framework?	0	0	16	0	70/80	88%
6	Does the Board ensure the Trust Risk Register is regularly reviewed and up to date?	0	0	16	0	74/80	93%
7	Do the sub-committees escalate any risks to the BAF or concerns as appropriate where assurance is not adequate?	0	0	16	0	72/80	90%
8	Does the Board seek reports and evidence based assurances from directors and managers as appropriate?	0	2	14	0	70/80	88%
9	Does the Board review and scrutinise the content of the Quality Report and Quality Accounts prior to their submission?	0	0	16	0	73/80	92%
10	Does the Board review the content of the Annual Report and Financial Statements before sign off?	0	1	15	0	74/80	93%

Key:


Red indicates the number of responses in the strongly disagree or disagree categories and scores either 1 or 2.


Amber indicates the number of responses in the undecided category and scores 3.


Green indicates the number of responses in the strongly agree or agree categories and scores either 4 or 5


Grey indicates the number of n/a responses and scores zero.

11	Does the Board effectively review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. For example: reviews by Department of Health Arm's Length Bodies?	0	3	13	0	67/80	84%
12	Does the Board effectively review the work of its sub-committees by assuring itself that the committees have appropriate terms of reference, membership and are considering relevant matters and are reporting effectively to the Board?	1	1	14	0	70/80	88%
13	Is there effective leadership of the Board?	0	0	16	0	75/80	94%
14	Does the Board shape a positive culture for Trust leadership and the organisation as a whole?	0	0	16	0	73/80	92%
15	Does the Board run effectively, i.e. reports received in a timely manner with right format and content and effectively chaired?	2	1	13	0	61/80	77%
16	Does the Board set its agenda and workload in a sufficiently flexible way to ensure it manages items that will support delivery of Trust objectives?	1	1	14	0	64/80	80%
17	Is the meeting conducted in a manner that means all members can contribute in meetings?	0	0	16	0	74/80	93%
18	Does the Board conduct its meetings both public and private in an open and transparent manner enabling appropriate scrutiny?	0	0	16	0	73/80	92%
19	Does the Board have an up to date log of actions and decisions and is satisfied that they have been actioned and outcomes reviewed?	0	0	16	0	73/80	92%
20	Does the composition, skills and experience of the Board facilitate appropriate delivery of its objectives?	0	1	15	0	68/80	85%

Key:


Red indicates the number of responses in the strongly disagree or disagree categories and scores either 1 or 2.


Amber indicates the number of responses in the undecided category and scores 3.


Green indicates the number of responses in the strongly agree or agree categories and scores either 4 or 5


Grey indicates the number of n/a responses and scores zero.

Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item:** 21
Subject:	Six monthly report from Nominations and Remuneration Committee: covering the period June to December 2019.	**For Publication: Yes**
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Chris Lawrence, Chair
Presented by:	Chris Lawrence, Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Nominations and Remuneration Committee in the period June to December 2019.

The report is required by the Committee's Terms of Reference.

Action required:

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

Summary and recommendations to the Board:

An overview of the work undertaken is outlined in the body of the report.

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

List specific risks on BAF – 2.1, 4.1, 7.1

Summary of Implications for:

None

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

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

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

Not applicable

1. Introduction

1.1 The Nominations and Remuneration Committee is a Committee of the Trust Board of Directors and is responsible for:

- Reviewing and making recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board. It recommends to the Board of Directors the appointment of Executive Directors.

- Setting the remuneration policy for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

- Approving contracts of employment for the Chief Executive, Executive Directors, and non-voting Directors and other senior managers reporting directly to the Chief Executive.

- Agreeing arrangements for termination of contracts, including severance payments paid to the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2. Meetings from June 2019 to December 2019.

2.1 Since June 2019 the meeting has met six times:

- 6 June 2019
- 4 July 2019
- 5 September 2019
- 26 September 2019
- 7 November 2019
- 16 December 2019

2.2 Each meeting was quorate as outlined in the Committee's Terms of Reference. Please note that the Trust's Annual Report will detail the attendance for each Committee member for 2019/20.

2.3 At the beginning of each meeting any conflicts of interests were reviewed and mitigating action taken as appropriate.

2.4 The Committee forms part of the overall governance framework for the Trust which supports the assurances and controls detailed in the Board Assurance Framework.

2.5 During the past six months a range of topics were discussed in line with the Committee's responsibilities, namely:

- Changes to the Executive team and structure
- Recruitment to the Executive Team, including skills required, remuneration and terms & conditions
- Update on relevant employee relations cases
- Executive Team objectives: setting and performance against
- Succession planning for the Executive Team

3. Committee Effectiveness

3.1 Each meeting in the past six months has been minuted and matters arising logged and followed up.

3.2 The Committee's agendas have been in line with the Terms of reference and papers distributed in advance of the meeting.

3.3 The Terms of Reference for the Committee are scheduled to be reviewed in January 2020 and will be brought to Trust Board for ratification.

3.4 Committee members and attendees undertook an effectiveness self- assessment questionnaire in December 2019 which will be reported to the Committee in March 2020.

4. Next Steps

4.1 The Committee will review the outcome of the self- assessment, identifying and agreeing any actions as required.

4.2 The Committee will consider and agree its annual work place to ensure it complies fully with its terms of reference and consider all required areas e.g. gender pay; Fit and Proper Person and remuneration policy.

Trust Public Board

Meeting Date:	27 February 2020	**Agenda Item: 22**
Subject:	Board Planner 2020/21	**For Publication:**
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** N/A
Presented by:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	

Purpose of the report:

The Board Planner provides the Board with a forward view of topics to be covered throughout 2020/21 and will be reviewed every few months.

Action required:

For the Board to approve.

Summary and recommendations to the Board:

Relationship with the Business Plan & Assurance Framework:

Summary of Implications for:

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

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

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

Trust Board Annual Cycle of Business 2020/21															2021	

Meeting Planning	Frequency	Lead	Feb	Mar	Apr	May	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Date of meeting			27	26	30	21	28	25	30		24	22	26	17	28	25	25
Note each public meeting is preceded by private Board meeting			Public	Workshop	Public	Public For Annual Report and Accounts	Public	Workshop	Public	No Mtg	Public	Public	Public	Workshop	Public	Public	Workshop
Service User Story	M	Director of Service Delivery &Customer Experience	X		X		X		X		X	X	X		X	X	
Opening Business																	
Welcome and Apologies for Absence	M	Chair	X		X	X	X		X		X	X	X		X	X	
Declarations of Interest	M	Chair	X		X	X	X		X		X	X	X		X	X	
Approval of Minutes from the Last Meeting	M	Chair	X		X	X	X		X		X	X	X		X	X	
Matter Arising Schedule	M	Chair	X		X	X	X		X		X	X	X		X	X	
Chair's Report	M	Chair	X		X		X		X		X	X	X		X	X	
Chief Executive's Brief	M	Chief Executive	X		X		X		X		X	X	X		X	X	
Quality																	
Report of the Integrated Governance Committee	Bi-monthly	Chair of IGC			X		X		X		X		X		X		
Integrated Safety Quaterly Report/Annual Integrated Safety Report	Q&A	Director of Quality & Safety	Q3				Q4&A		Q1				Q2			Q3	
Safe Staffing Report	Q&A	Director of Quality & Safety	Q3				Q4&A		Q1				Q2			Q3	
Infection Prevention and Control Annual Report	A	Director of Quality &Safety					A										
Safeguarding Annual Report	A	Director of Quality & Safety					A										
Health Safety& Security Annual Report	A	Director of Quality & Safety									A						
Medical Appraisal & Revalidation of Doctors Annual Report	A	Director of Quality & Medical Leadership							A								
Emergency Preparedness Resilience & Response-Core Standards	A	Director of Service Delivery &Customer Experience									A						
Service User Experience Annual Report	A	Director of Service Delivery &Customer Experience					A										
Service User Outcomes from Stories to Board	A	Director of Service Delivery &Customer Experience											A				
Equality and Diversity Annual Report	A	Director of Quality & Safety					A										
Public Sector Equality Duty Compliance Report& Outcome of Equality Delivery System Grading	A	Director of Quality & Safety					A										
Staff Annual Survey Report	A	Director of Workforce & Organisational Development	A														
Operational and Performance																	
Annual Planning		Director of Strategy & Integration	A														
Annual Plan Approval		Director of Strategy & Integration			A												
Annual Plan Quaterly Updates	Q	Director of Strategy & Integration	Q3				Q4		Q1				Q2			Q3	
Performance Report	Q	Director of Strategy & Integration	Q3				Q4				Q1		Q2			Q3	
Financial Planning		Finance Director	A													A	
Financial Report	M	Deputy Finance Director	X		X	X	X		X		X		X		X	X	
Report from the Finance and Investment Committee	Bi-monthly	Chair of the Finance & Investment Committee			X		X				X		X		X		
Workforce & OD Quaterly Report	Q	Director of Workforce & Organisational Development					Q4				Q1		Q2		Q3		
Community Survey	6 monthly	Director of Service Delivery &Customer Experience	X								X						
Annual Clinical Excellence Awards	A	Director of Quality and Medical Leadership			A												
Governance and Regulatory																	
Audit Committee Report	Q	Chair of the Audit Committee	X				X						X		X		
Freedom to Speak Up	6 Monthly	Director of Quality & Safety					A						X				
Trust Risk Register	Q	Director of Quality & Safety	Q3				Q4				Q1		Q2			Q3	
Board Assurance Framework quaterly review	Q	Company Secretary			Q3		Q4				Q1		Q2			Q3	
Review of Board Committee Terms of Reference	A	Company Secretary	Q3		Q						Q						
Review of Board Effectiveness	A	Chair/Company Secretary	A						X							A	
Board Business Cycle	A	Company Secretary									A						
Board Planner	A	Company Secretary	A									A					
Fit and Proper Person Compliance	A	Chair/Company Secretary			A												
Register of Board of Directors' Interests	A	Company Secretary			A												
Annual Accounts	A	Deputy Finance Director				A											
Internal Audit Annual Report (including Head of Internal Audit Opinion)	A	Head of Internal Audit				A											
External Audit - Annual Governance Report	A	External Auditors				A											
Annual Report including Annual Governance Statement and Quality Accounts	A	Finance Director				A											
Audit Committee Annual Report	A	Audit committee Chair				A											
Use of the Trust Seal	A	Company Secretary				A											
Use of Waivers	A	Finance Director				A											
Lossess and Compensation Payments	A	Deputy Finance Director				A											
Compliance with NHSI Licence	A	Company Secretary			A												
Well Led Framework Self- Assessment	A	Company Secretary			A												
Integrated Governance Committee Annual Report	A	IGC Chair/Company Secretary			A												
Gender Pay	A	Director of People and OD	A													A	
Finance & Investment Committee Annual Report	A	FIC Chair / Company Secretary			A										A		
Trust Regulatory Documents Annual Review																	
Standing Orders	A	Company Secretary			A												
Standing Financial Instructions	A	Finance Director			A												
Matters Reserved to the Board & Scheme of Delegation	A	Finance Director			A												
Charitable Funds Annual Accounts Sign off	A	Finance Director									A						
Trust Constitution	A	Company Secretary							A								
Metal Health Act Manager's Annual Report	A	Committee Chair							A								
Strategy																	
Sustainability & Transformation Partnerships	M	Director of Strategy & Integration	X		X	X	X		X		X	X	X		X	X	
Strategy Development	6 Monthly	Director of Strategy & Integration			X							X					
OD Strategy	A	Director of People and OD									X						
Estates Strategy	A	Director of Finance															