Hertfordshire Partnership University NHS Foundation Trust
PUBLIC Board of Directors

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26 May 2022 10:30 - 26 May 2022 13:30

INDEX

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors Meeting
Date: Thursday 26 May 2022

Venue: The Colonnades
Time: 10:30 – 13:30pm

AGENDA					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
1.	**Welcome and Apologies for Absence**	**Chair**			10:30
2.	**Declarations of Interest**	**Chair**	**Note**	**Attached**	
	Shared Experience – Staff				10:30
4.	**Minutes of the meeting held: 27 April 2022**	**Chair**	**Approve**	**Attached**	11:00
5.	**Matters Arising Schedule**	**Helen Edmondson**	**Review & Update**	**Attached**	
6.	**CEO Brief**	**Karen Taylor**	**Receive**	**Attached**	11:05
7.	**Chairs Report**	**Chair**	**Receive**	**Verbal**	11:15
	QUALITY & PATIENT SAFETY				
8.	**COVID-19 Update**	**Jacky Vincent**	**Receive**	**Attached**	11:25
9.	**Report of the Integrated Governance Committee held: 12 May 2022** **a) Integrated Safety Report Q4 and End of Year** **b) Safe Staffing Report Q4 and End of Year** **c) Service User Experience Report Q4** **d) Guardian of Safe Working**	**Diane Herbert** **Jacky Vincent** **Jacky Vincent** **Helen Edmondson** **Asif Zia**	**Receive** **Receive** **Receive** **Receive** **Receive**	**Attached** **Attached** **Attached** **Attached** **Attached**	11:30
	PEOPLE				
10.	**People and OD Report Q4 and End of Year**	**Janet Lynch**	**Receive**	**Attached**	12:05
	STRATEGY				
11.	**Annual Plan 22/23**	**David Evans**	**Approve**	**Attached**	12:15
12.	**Social Care Reform**	**Jacky Vincent**	**Receive**	**Attached**	12:30
	PERFORMANCE				
13.	**Report from Finance and Investment Committee held on 10 May 2022** **a) Performance report Q4** **b) Annual Plan 21/22**	**David Atkinson** **Hakan Akozek** **David Evans**	**Receive** **Receive** **Receive**	**Attached** **Attached** **Attached**	12:40
14.	**Finance Report – Month one**	**Maria Wheeler**	**Receive**	**Attached**	12:55

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Our Values
Welcoming Kind Positive Respectful Professional

GOVERNANCE AND REGULATORY					
15.	**Annual Freedom to Speak Up report**	**Jacky Vincent**	**Receive**	**Attached**	13:00
16.	**Well Led Review – Update**	**Helen Edmondson**	**Receive**	**Attached**	13:10
17.	**Appointment of Chairs of Audit Committee and Finance and Investment Committee**	**Sarah Betteley**	**Approve**	**Attached**	13:15
18.	**Any Other Business**	**Chair**			13:20
	QUESTIONS FROM THE PUBLIC	**Chair**			
Date and Time of Next PUBLIC Meeting: Thursday 28 July 2022 Thursday 9 June 2022 (Annual Accounts and Annual Report)					

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: Sarah Betteley

Declarations of Interest Register

Board of Directors

May 2022

Members	Title	Declaration of Interest
Hakan Akozek	Director, Innovation and Digital Transformation	Shareholder in Go2Healthcare Limited Wife is an Executive Partner in South Street Surgery, Bishop's Stortford
David Atkinson	Non-Executive Director	Goldman Sachs Group Inc equity share owner Trustee of Papworth Trust Independent NED Mizuho Trustee Eternal Forest Trust Accredited Humanist funeral celebrant RNLI crew member
Anne Barnard	Non-Executive Director	Share Portfolio managed by a private client stockbroker Independent member of the Audit & Risk Committee of the Department of Health & Social Care Director and minority shareholder in Qube Information Systems Ltd Independent member of Audit & Risk Committee Latymer Foundation of Hammersmith (2 x schools) Independent member of Queen Mary University of London Finance & Investment Committee

Sarah Betteley	Chair	Director DEVA Medical Electronics Ltd
Sandra Brookes	Director, Service Delivery & Service User Experience	Nil Return
Tim Bryson	Non-Executive Director	Director of Tim Bryson Consultancy Services Ltd Chair of Family Psychology Mutual CIC
Catherine Dugmore	Non-Executive Director	WWFUK Trustee Natural England Board Member Aldwickbury School Trust Limited Housing 21 Board Member NED at Cambridge Community Services NHS Trust NED designate for Herts & West Essex ICB
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
David Evans	Director Strategy & Partnerships	Nil Return
Diane Herbert	Non-Executive Director	Nil Return
Kush Kanodia	Associate Non-Executive Director	Intersectional Advisory Board – Inclusion London Advisory Board – Global Disability Hub Ambassador – Disability Rights UK Trustee & Director – Centre for Access Football in Europe Trustee & Director - AbilityNet
Janet Lynch	Interim Director People & OD	Harpenden MacMillan Fundraising Committee Member
Karen Taylor	Chief Executive Officer	Nil Return

Jacky Vincent	Director Quality & Safety (Chief Nurse)	Member Director of Nursing Forum, National Mental Health & Learning Disability Honorary Fellow at University of Hertfordshire
Jon Walmsley	Non-Executive Director	Independent Board Member of Ravensbourne University, London | Would recuse from any relevant discussions. Trustee on Board of homelessness charity: 'Accumulate' (1170009) | Would recuse from any relevant discussions Member of Green Angel Syndicate
Maria Wheeler	Director, Finance, Performance & Improvement	Nil Return
Asif Zia	Director, Quality & Medical Leadership	Nil Return

Minutes of the: PUBLIC Board of Directors
Date: 27 April 2022
Venue: The Colonnades and Virtual

MINUTES	
NON-EXECUTIVE DIRECTORS	**DESIGNATION**
Sarah Betteley | SBe	Chair
Jon Walmsley | JW	Non-Executive Director (virtual attendance)
Tim Bryson | TB	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
David Atkinson | DA	Non-Executive Director (virtual attendance)
Diane Herbert | DH	Non-Executive Director
DIRECTORS	
Karen Taylor | KT	Chief Executive Officer
Paul Ronald | PR	Director of Performance Improvement
Jacky Vincent | JV	Director, Quality and Safety & Chief Nurse
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Prof Asif Zia | AZ	Director, Quality & Medical Leadership
Janet Lynch | JL	Interim Director People and OD
Maria Wheeler | MW	Director Finance and Estates
Hakan Akozek | HA	Director
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chair & Company Secretary (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Barry Canterford | BC	Lead Governor & Engagement Champion
Mark Graver | MG	Deputy Director Communications (virtual attendance)
David Evans | DE	Herts Valleys Clinical Commissioning Group
APOLOGIES	
Catherine Dugmore | CD	Non-Executive Director
Kush Kanodia | KK	Associate Non-Executive Director

Item	Subject	Action
047/22	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. Apologies for absence were received from Catherine Dugmore and Kush Kanodia.	
048/22	**Declarations of Interest** The Declarations of Interest Register was noted. **NOTED**	
049/22	**Service User Story** Service User Amelie shared her story of the Exposure and Response Prevention (ERP) work she has been doing with CAMHS and how it has helped her OCD.	
050/22	**Minutes of Meeting held 31 March 2022** The minutes were reviewed and approved as an accurate record of the meeting. **APPROVE**	

	The Board APPROVED the minutes	
051/22	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
052/22	**CEO Brief** KT presented the CEO Brief to the Board which was taken as read. Headline messages of note to the Board were: Nationally, the NHS remained on level 4 however the number of COVID cases was reducing. Further Infection Prevention and Control guidance had been published and seeing a return to pre-pandemic restrictions. Processes were now in place to enable NHS staff to order Lateral Flow Devices free of charge. The government had published a paper and consultation for the development of the New Mental Health and Wellbeing 10 Year Plan with KT stating this was pivotal for setting the direction. Further updates would be presented to the Board as this developed. KT noted the cost-of-living crisis to the Board and that as a Trust we were agreeing a number of support measures including a temporary uplift to mileage of 10p per mile. The Ockenden Report was published in April following a national enquiry. As a Trust we would be taking forward the learning. The Trust would continue to monitor progress of the independent EPUT Inquiry for immediate learning. Ann Radmore, Regional Director for NHS England had retired, with Sean O'Kelly, Medical Director NHSEI stepping in to provide cover until the substantive post was appointed to. The Hertfordshire & West Essex Integrated Care System (ICS) continue to develop with the appointment of Executive Directors now complete and a final team in place. The go live date for the Integrated Care Board (ICB) was still expected to be 1 July 2022 with Hertfordshire and West Essex recently assessed as 'green' in terms of readiness. It was noted that the next stage for the ICB was the recruitment to the partner member roles. The Hertfordshire Mental Health, Learning Disability and Autism (MHLDA) Collaborative had agreed its transformation priorities for the next 18 months. The East of England (EOE) Provider Collaborative continued to make progress with some movement in the plans for CAMHS. As a Trust, the number of active COVID outbreaks and levels of staff absence were reducing. Operational services remain under pressure with high levels of demand and acuity, however the easter and bank holiday period did not see the expected scale of pressure, with KT paying tribute to the good work of the teams. Demand in our adult acute inpatients continued with KT noting a clear plan	

	was in place to address the backlog along with added resource for our community teams. Nationally, the Safe and Wellbeing reviews had been carried out showing good practice but also areas for us to have focus on, in particular our Specialist Residential Services (SRS). Forest House continued to robustly monitor progress against the Service Improvement Action Plan with KT acknowledging the improvement of communication on the unit. Key challenges for our workforce were turnover and vacancy rates however this had stabilised since December. We continued to provide a robust health and wellbeing offer to our staff. Our annual staff results had now been received formally with KT noting the positive results. Financially it had been a difficult and challenging period with KT reporting we were still in negotiations with commissioners. The Trust had delivered a breakeven financial position at 31 March 2022, in line with the revised Financial Plan. The recruitment process for the Executive Director of People and OD (Chief People Officer) was underway with Alumni Global selected as the search agency. Interviews were scheduled for July. David Evans, Director of Strategy & Partnerships will commence his post next week. **RECEIVED** **The Board RECEIVED the CEO Brief**	
053/22	**Chairs Report** SBe provided Board members with a verbal update on the work undertaken since the last Board meeting. SBe reported on her recent site visit to Essex, commenting on the positive, committed and compassionate nature of the staff. SBe had attended the Staff Network Chairs meeting on the 12 April stating it had been useful to hear from the various network groups. Lead Governor, Barry Canterford had recently attended an NHS Providers governor event which had highlighted new guidance for governors to be involved in the ICS. SBe would be following this up in a conversation with Paul Burstow. At the Appointments & Remuneration (ARC) meeting held on the 12 April the Committee had approved the process for the NED recruitment and a meeting was scheduled for Friday to appoint a search agency. Final interviews for the NED roles are expected to be held in July. SBe reported that she continued with the Governor appraisals which had provided her with useful feedback. Governor sub-groups were restarting in May which was positive. At the EoE NHS CEO &, Chair Event which SBe had attended with KT,	

	SBe commented that we had been the best represented in the room. SBe concluded the update advising that she had a useful conversation with Ellen Schroder around pressures in the system. No questions were put forward. **RECEIVE** **The Board RECEIVED the verbal update**	
	QUALITY & PATIENT SAFETY	
054/22	**COVID-19 Update** SBr presented the report which updated the Board on the work overseen through Incident Command regarding the COVID-19 pandemic, and on actions being taken to address surge in community transmission of COVID-19, and Trust-wide activity and acuity. The report was taken as read. Of note to the Board were the below points: SBr provided assurance that as a Trust, our Incident Command structure continued to be managed at level 4. It was unclear as to when level 4 would be stepped down. As previously mentioned by KT, we continued to see a reduction in cases and outbreaks and this was monitored daily. A key focus for living with COVID was the continuation of LFT testing. Questions were invited. In response to AB question about vaccination, JL confirmed that with staff vaccination not being mandatory we were only able to encourage staff that had not yet received it. AZ confirmed that the Trust was still offering servicers users vaccination. **RECEIVE** **The Board RECEIVED the report**	
055/22	**CQC Forest House Update report** JV introduced the report which provided the Board with an update on the outcome of the CQC's focussed inspection of Forest House Adolescent Unit along with details of the action the Trust had taken and improvements made in the areas identified by the CQC. The report was taken as read. Points drawn out for attention were noted as: JV provided background advising that at the end of 2021, the Care Quality Commission (CQC) had carried out a focused inspection process at Forest House Adolescent Unit (FHAU). On 30 March 2022, the final inspection process report was published which identified 'must do' and 'should do' actions detailed in point 3.4 and 3.6 of the report. As a consequence of their findings the service was rated as Inadequate.	

	A detailed Service Improvement Action Plan (building on a plan implemented in September 2021) had been put in place and included the key areas of improvements identified by the CQC. There were robust processes in place to both monitor and track progress. Appendix 1 set out an assessment of the status of the improvements with the majority of actions now complete. JV reported that following the inspection report, we had met with young people and their families/carers to talk through any remaining concerns, the actions the Trust had taken and any further action the Trust may need to take. We had also further strengthened leadership on the unit and recruited. Forest House remained open to admissions. Currently there were six young people on the unit with a clear trajectory to safely increase bed capacity over the next 3 months. It was anticipated the CQC would reinspect the unit as part of their inspection process as an unannounced visit. The Trust was required, under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to inform the CQC in writing when it had taken the actions in the report and how the Trust considers that it is now meeting the standards. This is to be submitted to the CQC by 26 April 2022 with JV confirming this had taken place. SBr reported that supporting and developing the leadership for CAMHS services that will include national recruitment. **RECEIVE** **The Board RECEIVED the two reports**	
OPERATIONAL AND PERFORMANCE		
056/22	**Finance Report** MW presented the report which set out a summary of financial performance for the year-ended 2021/22. The report was taken as read with the below points drawn out for attention. The Trust submitted its draft, unaudited accounts to NHSE on the 26 April 2022. These would then be presented to the Board on the 9 June. It was noted that KPMG had completed the interim audit and had started the full audit. The Trust had delivered a break-even plan with a small surplus position. The Trust had also delivered on its Delivering Value programme. The Trust's Capital target had been met recording a small underspend of £9k against its capital expenditure limit. The Trust Audit Committee had received a detailed breakdown of the Trust's Draft Accounts for 2021/22 at its meeting on 21 April. MW reported that the Government Accounting Manual (GAM) required all NHS Organisations to formally consider the application of a Going Concern basis for the production of Annual Accounts. This had been considered by	

	the Audit Committee at its meeting on 21 April and no such exceptional circumstances were identified and was put forward for Board approval. All in attendance provided approval. MW concluded the update commenting the Trust had finished the year in a strong position. SBr added that how the effective use of capital made a significant difference to services. KT commented that whilst recognising the Trust year end position the coming year would be more challenging and as a Board, we needed to plan for the next 5 years. **RECEIVE** **The Board RECEIVED the report**	
057/22	**People & OD Report** JL introduced the report which provided the Board with updates on two items since the last Board meeting. The report was taken as read with the below points highlighted. The vacancy and turnover rate had stabilised since December with a slight slippage in the vacancy rates, noting 611 new staff members had commenced with the Trust this month. The on-boarding process had reduced from 54 to 44 days. Sickness absence reduced to 5.08% in March and was consistent with system level. There had also been a continued reduction in mental ill health related absence during the quarter and reduced levels of absence related to colds and flu. Focus had been given to Appraisal rates with a clear plan in place which was seeing better compliance. The results of the 2021 annual staff survey had been released which put us as 4th overall in the country for Mental Health. The results had been overwhelmingly positive with the key themes laid out in the body of the report. There were some key areas for the Trust to focus on and the Senior Leadership Team were working with our staff to co-produce a meaningful action plan. The report set out the key areas of focus. A final plan would be brought to the People & OD group then into the Integrated Governance Committee. JL concluded the update reporting that the Quarter 4 update would be presented to the May board. Questions were invited. In response to AB question about having more granular detail with comparison to other Mental Health Trusts, JL reported that data was available by department. She also agreed to clarify an anomaly with the figure in the report. It was agreed that IGC would consider information on service hotspots at the July meeting.	**JL**

	RECEIVE **The Board RECEIVED the report**	
	GOVERNANCE AND REGULATORY	
058/22	**Compliance with NHSI License** HE reported to the Board advising that the NHSI's Foundation Trust Code of Governance operated on a 'comply or explain' principle with specific disclosure requirements required in the Annual Report as identified in the FT Annual Reporting Manual 2021-22. This paper set out the provisions of the Code and the source of evidence to support a declaration of compliance within the Annual Report in all cases. At its most recent meeting the Audit Committee had reviewed and recommended approval to the Board. HE invited comments. SBe noted a couple of typos however subject to these changes the Board noted the evidence provided and approved a positive declaration of compliance with the Code of Governance. **APPROVE** **The Board APPROVED the report**	
059/22	**Report of the Audit Committee meeting held:** **21 April 2022** DA presented the report which provided the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 21 April 2022. Points highlighted in particular from the report were: The Committee approved the Internal Audit Plan for 22/23, the Counter Fraud Plan for 22/23 and the Fraud Risk Register. The Committee recommended for Board approval when it considered the accounts the Losses and Special Payments and Provision of Irrecoverable Debts. The Committee recommended for Board approval at its meeting held 21 April 2022, the NHSI Compliance Declaration and the Scheme of Reservation and Delegation. **RECEIVED** **The Board RECEIVED the report**	
060/22	**Audit Committee Annual Report** DA presented the Audit Committee Annual report which outlined how the Audit Committee had complied during the financial year 2021/22 with the duties delegated to it by the Trust Board through the Committee's terms of reference. Detail was contained within the body of the report with the below points drawn out. During 2021/22 Catherine Dugmore had continued as a Non-Executive	

	Director and Chair of the Audit Committee. In February 2022 the Terms of Reference were reviewed and updated and approved by the Board in March 2022. Five meetings per annum were required and in 2021/22 six meetings were held and the meetings were quorate. An annual review of effectiveness was carried out in December 2021 which had provided a positive review and identifying a small number of areas for improvement. The Committee led the process to procure internal audit and counter fraud services via a new contract and undertook an assessment of the effectiveness of the External Audit services, making a recommendation to the Council of Governors to extend the contract with KPMG for one year. The Committee received regular updates on the Trust financial position and key risks and issues. The Committee reviews, at least six monthly the Board Assurance Framework and the Trust Risk Register. The Charitable Fund accounts and annual report for 2020/21 were presented in December 2021. The Committee approved the application of the Going Concern assumption and the review of Accounting Policies. In April 2021 the Committee approved the position with regard to Provision for Irrecoverable Debts and the loses and compensations register 2020/21. During the year members of the Committee undertook appropriate mandatory training and received a number of deep dives. Committee members also received regular briefing documents from internal and external audit keeping them abreast of regulatory updates and issues. SBe recorded a formal thank you to CD for her work as Chair of the Audit Committee. **RECEIVE** **The Board RECEIVED the report**	
061/22	**Integrated Governance Committee Annual Report** DH presented the report which provided the Board with the annual report from the Integrated Governance Committee (IGC) for 2021/22. The report was taken as read. DH commented on the balance between the volume of work and size of papers and acknowledged the work of HE and those that presented to IGC. DH reported that the Committee had revised timings of the agenda so Deep Dives were now presented at the start of meetings thus allowing a fuller discussion.	

	Focus for the Committee continued on Safety, Effectiveness, Experience and Quality. DH noted the work of the committee with regard to monitoring outcome of unannounced CQC visits. She noted that the increased focus on people and Free to Speak up had been beneficial. DH thanked HE and Committee members for their contribution. **RECEIVE** **The Board RECEIVED the report**	
062/22	**Finance & Investment Committee Annual Report** DA introduced the report which furnished the Board with the annual report from the Finance and Investment Committee for 2021/22. The report was taken as read. The below points were highlighted to the Committee. During 2021/22 David Atkinson continued as a Non-Executive Director and Chair of the Finance and Investment Committee. During this period the FIC met a total of seven times including one extraordinary meeting. The Committee had considered and approved the Trust's Green Plan, recommending it to the Board. DA recoded sincere thanks to Paul Ronald and the FIC Committee members. SBe added her thanks as Chair to all the Committee for the vital work they do and to recognised the important assurance role they have. **RECEIVE** **The Board RECEIVED the report**	
063/22	**Matters Reserved to the Board & Scheme of Delegation** HE presented the report which provided the Board with the updated and revised Scheme of Reservation and Delegation (SoRD) for the Trust. HE highlighted the importance of the document for us as an organisation advising the current SoRD was due to be reviewed and the revised SoRD presented today was based on best practice. The document was made up of four tables as set out in the paper. The revised version had been informally shared with Internal Audit who confirmed it was in line with what you would expect to see in a Foundation Trust's SoRD. Of particular note was that for items of value greater than £1,000,00 would continue to need Board approval. The Audit Committee at its meeting on 21 April considered the revised	

	SoRD and recommended it for approval by the Board. Subject to some typos and amendments Board members provided their approval. **APPROVE** **The Board APPROVED the report**	
064/22	**Any Other Business** SBe made acknowledgement this was PR's last Board meeting. Board members wished PR a very happy retirement and thanked him for his commitment, hard work and contribution. No further business was put forward.	
065/22	**Questions from the Public** In response to BC's question about the increase in CAMHS referrals during this period, SBr advised that trends did show this time of year as busy noting the Mental Health support teams in schools would be monitoring this. No further questions were put forward.	
Date of Next Meeting Thursday 26 May 2022 Thursday 9 June 2022 (Annual Accounts and Annual Reporting)		

Close of Meeting

NHS
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Committee Meeting: PUBLIC Board of Directors
MATTERS ARISING SCHEDULE

May 2022

Matters Arising from meeting held on: 27 April 2022					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
6	**CEO Brief**	**HE**	HE to share details of the appointment process for partner members for the ICB with the Board	Not yet available	**A**
11	**People & OD Report**	**JL**	JL to clarify detail on data provided in Figure 6	May 2022	**G**
11	**People & OD Report**	**JL**	JL to provide an update on hotspots from the staff survey to IGC	July 2022	**A**
13	**Compliance with NHSI License**	**HE**	HE to amend and finalise based on comments from April Board meeting	May 2022	**G**
18	**Matters Reserved to the Board & Scheme of Delegation**	**HE**	HE to amend and finalise based on comments from the April Board meeting	May 2022	**G**

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Our Values
Welcoming Kind Positive Respectful Professional

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	26 May 2022	Agenda Item: 6
Subject:	CEO Briefing	
Presented by:	Karen Taylor, Chief Executive Officer	

National update

The national activity is summarised below:

COVID -19

On 19 May NHS England / Improvement reclassified the national incident level from Level 4 (National) to a Level 3 (Regional) Incident. Amanda Pritchard, NHS Chief Executive reinforced the importance of the NHS remaining vigilant, and local systems need to ensure their resilience and capability to re-establish full incident responses if required. As the NHS moves away from managing COVID the focus of trusts is on recovery. In particular the recovery of elective waiting lists and outpatients and also the recovery of urgent and emergency services.

Queens Speech

On Tuesday 10 May 2022 HRH the Prince of Wales outlined the government's priorities for the year ahead, highlighting laws that the government intends to pass in the coming year. Growing and strengthening the economy, easing the cost of living for families, and levelling up the UK was at the heart of this Queen's Speech. It also included information on funding for the NHS to clear the COVID-19 backlogs.

There were a number of announcements relevant to health and social care including women's health strategy; health and social care funding; social care and integration; Social Housing Regulation Bill; Data Reform Bill and Conversion Therapy Bill. One of the announcements included the draft Mental Health Act Reform Bill, which is expected to be published in the summer 2022. The purpose of the draft Mental Health Act Reform Bill is to ensure service users experiencing mental health conditions have greater control over their treatment and receive the dignity and respect they deserve.

National Funding

The financial environment across the NHS will be challenging in 2022/23 as it continues its recover from the COVID Pandemic. The financial pressures result from rising demands for services, the reduction in COVID funding assistance and rising inflationary pressures. NHS England in recognition of these inflationary pressures has announced additional £1.5bn funding.

Dementia Strategy

On 17 May the Health and Social Care Secretary Sajid Javid announced that a new 10-year plan for dementia will be published later this year. It was announced that the 10-year plan will focus on how new medicines and emerging science and technology can be harnessed to improve outcomes for dementia patients across the country. The plan will also focus on supporting people with their specific health and care needs while living with dementia.

The Health and Care Bill

On 28 April 2022 the Health and Care Bill received Royal Assent, becoming the Health and Care Act 2022 and is a significant change to health legislation. The main provisions of the Act are: establishment of statutory Integrated Care Systems (ICS); new duties for the Care Quality Commission (CQC); changes to capital regime for NHS Foundation Trusts; Secretary of State powers around local reconfigurations; establishment of Health Services Safety Investigations Body (HSSIB) on a statutory footing and provisions made to increase transparency on mental health spending.

Regional and System update

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

New Regional Director

On 10 May 20022 NHS England and NHS Improvement announced the appointment of Clare Panniker as the new Regional Director for the East of England. A former nurse who has spent over 30 years working in the NHS, Clare will join the regional team from Mid and South Essex NHS Foundation Trust, where she has been Chief Executive since the Trust formed in April 2020.

Hertfordshire & West Essex (HWE) Integrated Care System (ICS)

In line with the Health & Care Act the HWE ICS will become a statutory body from 1 July 2022. The approved Integrated Care Board (ICB) constitution clearly sets out that one of the Board's partner members shall have specific knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental health. The next stage of nominating and appointing partner members of the ICB has commenced.

Hertfordshire Mental Health, Learning Disability and Autism (MHLDA) Collaborative

The collaborative continues to develop at pace and is currently focussing on delivering outcomes and priorities for the year ahead. At its meeting in May 2022, the Collaborative will review the business case for Attention Deficit Hyperactive Disorder (ADHD) backlog and ongoing work to ensure a consistent and sustainable model to address neurodiversity across the life-course is being taken forward by the Collaborative.

The Collaborative has initiated an acute workstream in response to sustained system pressure and the specific increase in s136 activity. This is focussing on developing alternatives to A&E, integrated front door triage and options to divert at this point, increasing the available options to support out of hospital care. In addition, the Collaborative is working with Public Health to improve support and pathways of care for those people with substance misuse/dual diagnosis of Mental Health, LD and Autism.

Hertfordshire Health Care Partnerships

Development of the three place-based partnerships, South and West Herts HCP, East and North Herts HCP, and One Health Care Partnership in west Essex continues. The main areas of focus over the past month have been on developing an operating model between the HCPs and the ICB. Discussions have yet to conclude, but there is a current view that the delegation of functions from ICB to place will begin in 2023/24.

East of England (EOE) Provider Collaborative

The Collaborative continues to develop. In particular it is working to support the proposal to align the of commissioning of Forensic CAMHS (FCAMHS) and mainstream CAMH which

will be achieved by the devolution of the commissioning of FCAMHS to the Provider Collaboratives. The national team suggest that this could come to provider collaboratives in September 2022. The Collaborative is also continuing to resolve issues relating to funding for extraordinary packages of care (EPC).

NHSEI has approved 'medium term funding' for CAMH beds in BLMK prior to the collaborative going live. Eight beds are due to open in September 2022 as an interim measure with a final provision of 12 General Adolescent Unit (GAU) and 6 Psychiatric Intensive Care Unit (PICU) beds in phase 2 of the project. This will have a significant impact on the current waiting list for CAMH beds. Work is also under to pursue a commissioning model where specialised Mother and Baby Unit (MBU) commissioning sits within the collaborative portfolio.

Trust-wide update

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

COVID-19

The Trust continues to have a robust and appropriate covid incident response in place, with the ability to scale up a response quickly is required. Currently, daily SITREP reporting is continuing. The Trust currently has no outbreaks and we can be proud of how we have managed the risk of infection and kept our service users and staff safe. The Trust recently updated its Infection Prevention and Control advice regarding wearing of marks in non-clinical areas.

Operational update

Whilst demand has remained high throughout the last month, we have seen improved flow through inpatient beds and a subsequent reduction in out of area placements. There are a number of discharges planned from our Learning Disability wards but further work is required to work with partners to improve this position.

We are continuing to work with Hertfordshire County Council and commissioners, as part of the Service Improvement Process on a number of actions to improve the care in Specialist Residential Services. This is particularly focused on increasing access to activities and ensuring personalised care as the transition to a new service model continues.

Older people's services have been working with voluntary sector partners in the Watford to provide a new series of support events at the local Dementia Support Centre for carers and people with Dementia. These have been well attended and the team have received very positive feedback.

Adult community services are continuing to receive a high number of referrals. The recovery plan has been implemented to manage the backlog and increased demand levels although progress is slow due to challenges to recruit additional staff.

We are working with our acute and voluntary sector partners on a number of areas to improve the care of people with mental health needs in the acute hospitals; diversion from A&E, front-door triage, improved environment, additional crisis options.

Forest House Assessment Unit

The Trust continues to robustly monitor progress against the Service Improvement Action Plan, which incorporates improvements to be made against the CQC Key Lines of Enquiry

(safe, effective, Caring, Responsive, well-led). It also incorporates the actions necessary to address the issues raised by the CQC in their inspection report. Particular areas of note are the improvement in mandatory training and supervision compliance, strong compliance of the requirements with regard to the clinic room, successful recruitment to psychology roles and continuing weekly audits of risk assessment and Fundamentals of care.

Our People

Our vacancy rate in April was 14.26% and has remained at a similar level since December. We continue our high levels of recruitment activity and campaigns, in particular for harder to recruit to areas and for nurses, healthcare support workers and allied health professionals. Our unplanned turnover remained consistent for the fifth month in a row at 13% in April.

Our appraisal rates have recovered further to 76%, following the impact of pressures relating to the COVID-19 pandemic and Winter. We continue our work to ensure that strengths-based appraisal conversations are taking place annually as part of our retention plans to ensure our people are supported to thrive and further develop their careers with us. We are also concentrating on increasing mandatory training compliance, which has increased to 89.75%.

As part of our retention work, we continue to provide a robust health and wellbeing offer to our staff. We saw sickness absence reduce further to 4.92% in April and there has been a continuing reduction in mental ill health related absence and reduced levels of absence related to colds and flu. April was stress awareness month and therefore our wellbeing offer focussed on stress related staff support to help our people to manage and alleviate stress. We also expanded our financial wellbeing offer to staff as part of our response to increases in the cost of living.

In April, we were excited to launch our new Inclusion Ambassador scheme, which was developed in partnership with the BAME Staff Network. We have trained 21 Inclusion Ambassadors who will participate in recruitment panels for Band 8a and above posts. The scheme is part of the Trust's commitment to ensuring fair, equitable and unbiased recruitment decisions, providing greater confidence to BAME applicants and helping us achieve greater diversity at senior levels of the Trust.

The Inclusion Ambassadors will bring a particular focus on equality and inclusion and provide valuable guidance and advice to recruitment panels.

Planning 2022/23

Contracting negotiations have continued across all the major contracts. For Hertfordshire negotiations continue to finalise the financial aspects of the contract. Once this aspect is completed, we will be able to sign the 22/23 contract.

Contract negotiations continue for Norfolk and Buckinghamshire Learning Disability services with the aim of finalising these by the end of May. Likewise, the Mid Essex IAPT contract is also expected to be completed at the end of May for a new 5 year contract. The Essex Learning Disability contract negotiations have been delayed due to sad death of the lead commissioner which has led to a temporary pause whilst commissioning colleagues reset their responsibilities.

The Trust's Annual Plan has been finalised will be discussed in detail later on the agenda. A comprehensive communications plan for the 'launch' of the plan is being developed which will include engagement with the staff, services users, carers and stakeholders. We have

also contributed to ICS planning submissions for finance, workforce and performance to the required deadlines.

Executive and Non-Executive Director update

The recruitment process for the Executive Director of People and OD (Chief People Officer) is well underway with the search agency providing weekly updates on progress. The interview day is scheduled for early July 2022.

The recruitment process for Non-Executive Director posts has also commenced, under the oversight of the Appointments and Remuneration Committee. The aim is for final interviews to take place in July 2022.

Karen Taylor

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 8
Subject:	Incident Command	**For Publication:** Yes
Author:	Sam Garrett, Financial Controller	**Approved by:** Sandra Brookes, Director for Service Delivery and Experience
Presented by:	Jacky Vincent, Director Quality & Safety (Chief Nurse)	

Purpose of the report:

To update the Board on the work overseen through Incident Command regarding the COVID-19 pandemic, and on actions being taken to address surge in community transmission of Covid-19, and Trust-wide activity and acuity.

Action required:

The Board is asked to receive and note this report.

Summary and recommendations to the Board:

Summary and Current Arrangements

This report will update the Trust Board on the actions in place to ensure that Covid-19 infections and suspected or confirmed cases are managed effectively over 7 days a week.

Until week commencing 9th May Incident Command continued 7 days a week 08:00 – 20:00, and this has ensured that the incident has remained well-managed. However, it has become clear over recent weeks that activity has significantly reduced in terms of a role for Incident Command, with all outbreaks now closed and low numbers of positive staff and service users. The Executive Team therefore made the decision to step down further as of 12th May, and rely instead primarily on Business as Usual, including on-call arrangements.

A small Incident Command function has been retained for the time being with inbox cover in place Monday through Friday 09:00-17:00 and Weekends 09:00-13:00 (previously 08:00-20:00 daily), to manage SitReps, other returns, and any incoming communications; all meetings have ceased with immediate effect except one short weekly meeting involving the EPPR Lead, inbox cover, and Senior Lead, to ensure a structure is in place to review progress over the transition period. A Senior Nurse will remain on call over the weekend but for reduced hours, and named commanders remain in place as part of a shadow consolidated rota to facilitate easy communication, and action if necessary.

This structure along with the on-call system is sufficient to manage the current activity well, and to monitor any resurgence of the Pandemic (or other incidents), as well as to enable any response should this be needed.

Update on the Incident

As at 18th May all outbreaks remain closed and no other cases have arisen which would amount to an outbreak. Only 1 positive inpatient service user case remains at the present time, and at total of 15 positive staff members, 5 from inpatient areas. Absence including annual leave all sickness & non-working isolation remains relatively low at 11%, well within the “green” zone for levels of

unavailability (assumes 3,500 establishment). Sickness & non-working self-isolation including Covid and non-Covid is just over 4% (also assumes 3,500 establishment). These numbers have all been either reducing or stable for some weeks.

The wider system has continued to experience pressures but in the main these relate to general bed pressures rather than being directly attributable to Covid-19.

Latest IPC guidance nationally has continued to be discussed within HPFT and it has been agreed that staff in non-clinical areas can now be seated at desks and in meeting rooms without masks; masks remain in all clinical areas and for moving around all other areas.

Next Steps
Progress on the Incident will continue to be reviewed to determine if any escalation is necessary, or conversely whether arrangements can be stepped back further.

Focus now moves to assessing this period of Incident Management, and to ensuring that the learning from this is embedded into arrangements in future, for both this and potential other incidents. Two de-brief session have taken place, one with the members of Tactical Command and another with those who have provided admin support as loggists and note-takers over the course of the incident. The Trust's EPPR lead is ensuring that this information is disseminated appropriately.

Additionally, there is a system-wide focus on training, ensuring that all potential commanders have the appropriate and up to date skills to carry out their roles; the EPPR lead is ensuring that training places are available and taken up accordingly, including a plan for local induction and "buddying" for new commanders.

Recommendation
The Trust Board is recommended to note the update provided within this report.

Relationship with the Annual Plan & Assurance Framework:

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

Summary of Implications for Finance, Staffing, IT and Legal

The staffing, financial, IT and legal risks are identified within the risk register part of this paper; Actions taken to medicate risks may have budgetary or financial implications.

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

Individual risk assessments of BAME staff

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

None

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

Executive Team 18th May

Incident Command Update

As at Week Commencing 16th May 2022

1. Introduction

1.1 This report will focus on the management of Incident Command and the actions the Trust has taken to address and manage staff shortages, Covid-19 outbreaks, the issues that have arisen a result of the most recent surge of Covid-19, and the impact on the Trust.

2. Current Status of Incident

2.1 The NHS response to Covid-19 continues to be managed as a Level 4 incident nationally, however incident related activity for HPFT as well as numbers of positive cases or outbreaks have reduced progressively and significantly over recent months and weeks. The Executive Team therefore decided to step back Incident Command considerably with effect from 12th May, and rely on a reduced function along with Business-as-Usual arrangements, including on-call for out of hours.

2.2 Latest IPC guidance nationally has continued to be discussed within HPFT and this week it was agreed that staff could be seated at desks and in meeting rooms without masks, in non-clinical areas only; masks remain in all clinical areas and for moving around all other areas

3. Trust Incident Response Structures

3.1 With immediate effect Incident Command has been stepped back with a small function remaining on reduced hours to manage any activity and the transition period. This includes inbox cover in place Monday through Friday 09:00-17:00 and weekends 09:00-13:00 (previously 08:00-20:00 daily); all meetings cancelled except one short weekly meeting for the EPPR Lead and Senior lead to manage the transition period; and a remaining "shadow" consolidated rota to give a structure for communications or for any necessity for stepping back up.

3.2 Cover now in place is summarised below:

	Mon-Fri 9-5	Mon-Fri out of hours	Weekends / Bank hols
Covid inbox cover	√	x	9-1
Ops Commanders	√	x	x
Tactical Commander	√	x	x
Senior Nurse on call	√	x	9-5
OOH Clinical Leads	x	√	√
Director on call	√	√	√

3.3 This structure is sufficient to manage the current activity well, and to monitor any resurgence of the Pandemic (or other incidents), as well as to enable any response should this be needed. Other activity moves back to Business as Usual during working hours, and the on-call system for out of hours.

3.4 Incident Command over the last fortnight has focused on these changes as well as the update in requirements for mask wearing.

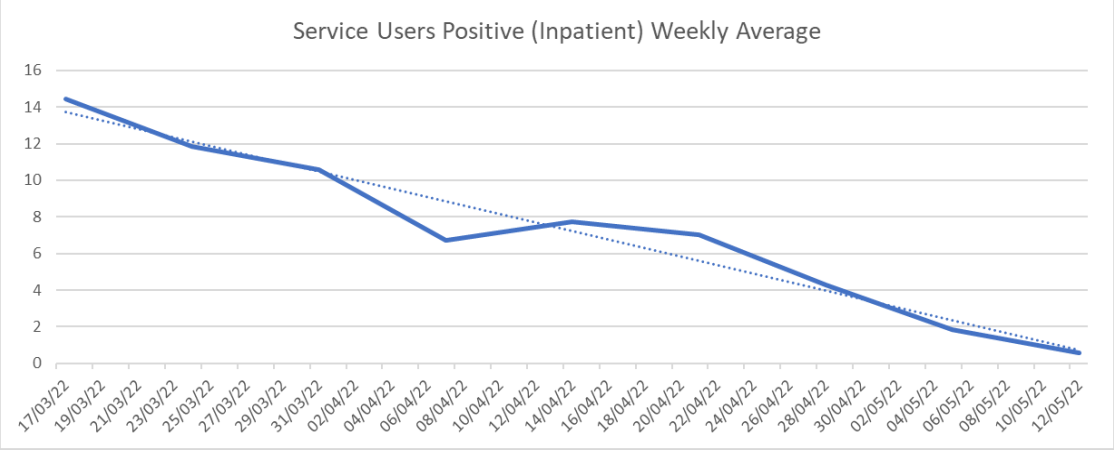
3.5 Focus now moves to review of this period of Incident Management, and ensuring that any learning from this is embedded into dealing with this incident going forward, and potential future incidents. Two de-brief session have taken place, one with the members of Tactical Command and another with those who have provided admin support as loggists and note-takers over the course of the incident. The Trust's EPPR lead is ensuring that this information is disseminated appropriately.

3.6 Additionally, there is a system-wide focus on training, ensuring that all potential commanders have the appropriate and up to date skills to carry out their roles; the EPPR lead is ensuring that training places are available and taken up accordingly, including a plan for local induction and "buddying" for new commanders.

4. Covid-19

4.1 On 12th May Covid-19 positive service users within inpatient settings remained at 1.

Figure 1 Positive service user inpatient cases



4.2 All outbreaks are now closed and there have been no new cases which would constitute an outbreak. All positive cases are still carefully monitored by the Trust's IPC lead and change to this will be acted on appropriately.

4.3 In the last month there have been 2 further Covid-19 related service user deaths notified, bringing the total to 228.

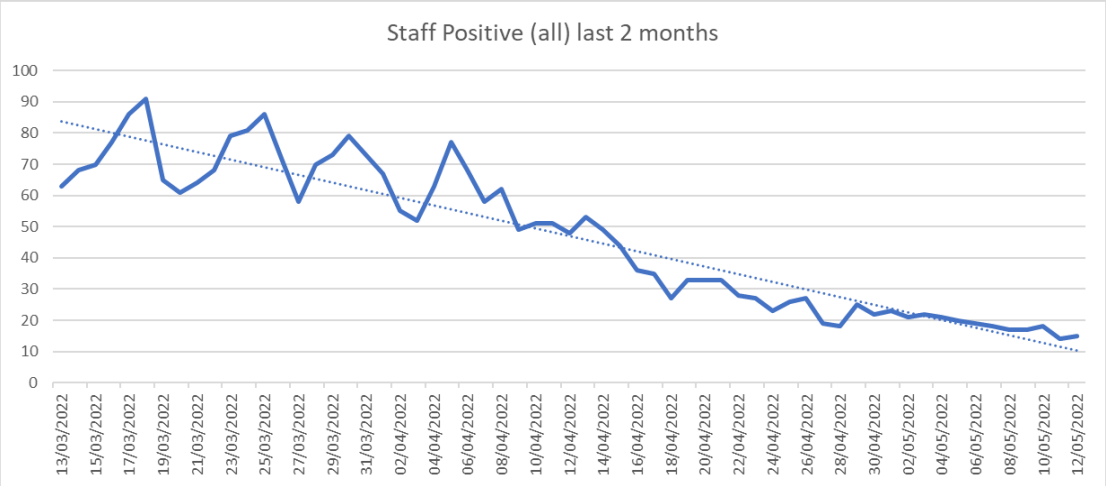
4.3.1 The first was notified to the Wellbeing Team by family on 20th April; C had died in hospital that morning, she had informed the team previously that she had Covid-19, and confirmation of the cause of death was to be sought from the hospital.

4.3.2 The second was notified to EMDASS East by a care home on 28th April; 89-year-old "E" had died there on 14th March due to Lung Cancer with Covid-19 complications. He had been referred to EMDASS by his GP due to cognitive impairment and had had an initial assessment with a plan to repeat memory tests once hearing aids had been fitted.

5. Safe and Effective and Timely Care Delivery

5.1 Staff positive cases are at 15 this week (20 last week).

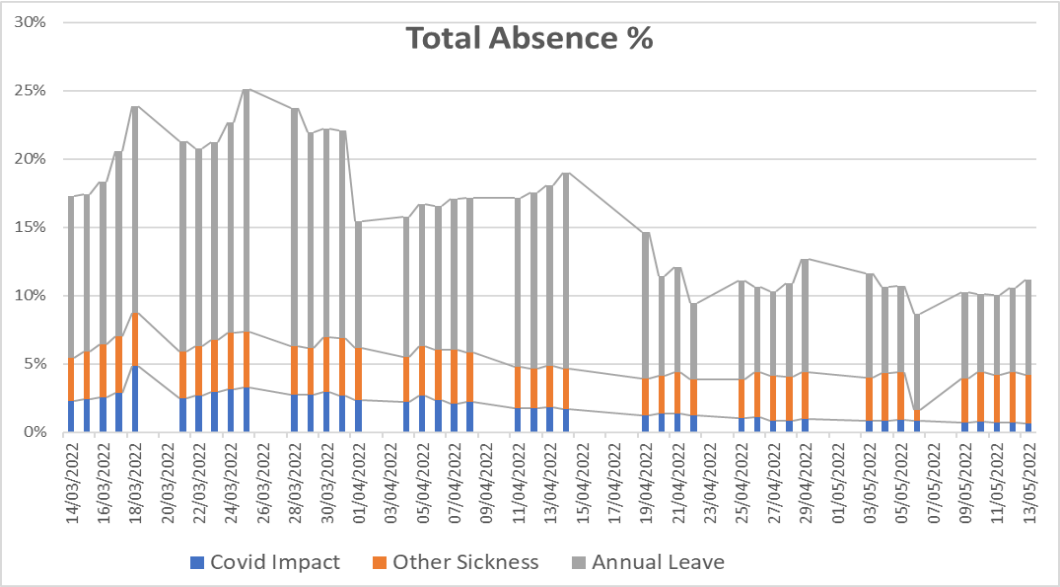
Figure 2 staff positive cases



5.4 Staffing levels remaining challenging in a number of areas, however in the vast majority of cases this is not now directly related to Covid-19, and is being managed via Business as Usual. All absence including annual leave all sickness & non-working isolation is 11%, with low levels of annual leave, and absence excluding annual leave is 4%; these are both within the Green categories.

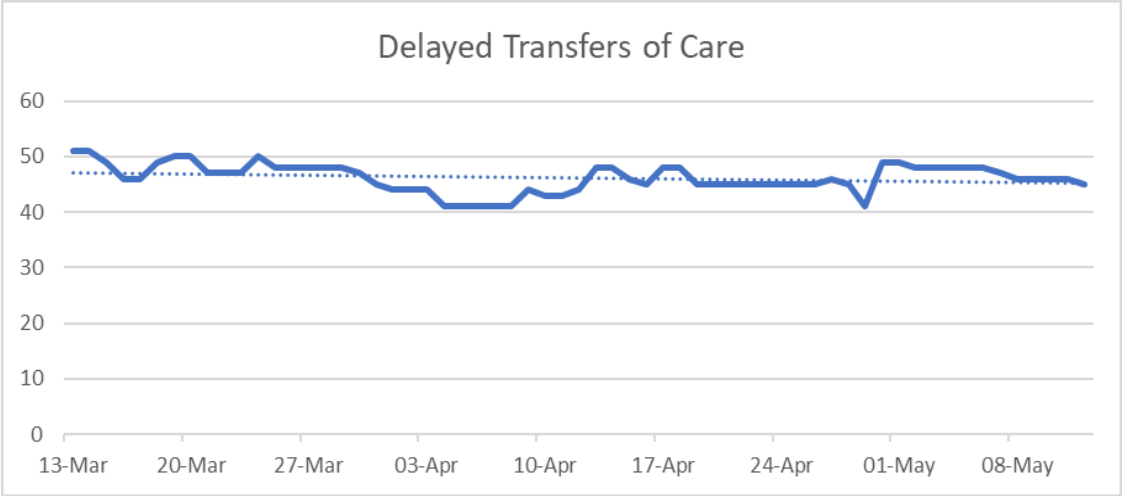
5.5 The impact of all absence tracked over the last 2 months is shown in the graph below split by Annual Leave, non-Covid sickness, and Covid impact (including confirmed and suspected Covid, Long Covid, and self-isolation).

Figure 3 Absence



5.6 Delayed Transfers of care are being tracked daily to ensure timely escalations are actioned, and are currently recorded at 48.

Figure 4 Delayed Transfers of Care



6. People

6.1 LFD Testing continues to fluctuate with latest frontline staff averaging under 30% reported compliance, despite much higher numbers of staff reporting having tested.

Figure 5 staff tested twice SBU percentage

SBU	% Compliance
367 Corporate Support Services	**22.1%**
367 SBU Essex and IAPTS	**40.9%**
367 SBU Learning Disability and Forensic	**33.0%**
367 SBU MH East and North Herts	**30.2%**
367 SBU MH West Herts	**16.6%**
Trust Total – 27.0%	

7. Infrastructure and Enablers

7.1 No significant matters currently.

8. System and Partnership

8.1 Pressures do continue but are largely not directly related to Covid-19.

8.2 HPFT is working with the wider system to access training for Incident Commanders, including Media Training.

9. Communications

9.1 Communication this week have focused on the changes to incident command arrangements, and to mask wearing in non-clinical areas.

10. Reflection on Key Risks

10.1 Key risks currently relate to any significant upturn in outbreaks or staff sickness levels. Neither risk is considered high at this time, though absence will continue to be monitored closely through to the Jubilee bank holiday weekend in June.

10.2 It has been agreed last week to reduce the level of the current Covid-19 risk on the Trust's Risk Register.

11. Recommendation

11.1 The Trust Board is recommended to note the update provided within this report.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 9
Subject:	Integrated Governance Committee Report: 20 January 2022	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Diane Herbert, Non-Executive Director, Committee Chair
Presented by:	Diane Herbert, Non-Executive Director, Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting held on 12 May 2022.

Action required:

The Board is asked to receive and note the report.

Summary and recommendations to the Board:

Summary

An overview of the work undertaken at the meeting held on 12 May 2022 is outlined in the body of the report.

Recommendation:

To receive and note the report.

To note that the Trust Infection Prevention and Control Work Plan for 2022/23 was approved by the Committee.

Relationship with the Business Plan & Assurance Framework:

Strategic Priorities 1, 2, 3, 4 and 5. and associated Board Assurance Framework principal risks

Summary of Financial, IT, Staffing and Legal Implications:

None.

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

The Committee regularly receives updates regarding Equality, Diversity and Inclusion.

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

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

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

None.

1. Introduction

The latest Integrated Governance Committee (IGC) was held on 12 May 2022. In accordance with its terms of reference and was quorate.

2. Deep Dive – Complaints CQI Project

The Committee received a detailed presentation on the recent CQI project on complaints. The presentation updated the Committee on the improvements made to the complaints process over the past two years. These included the move to digital records, updating training for investigating managers, availability of standards reports, and weekly monitoring information to SBUs.

The Committee were updated on the current number of active cases and how the Trust performs against the relevant metrics. It was noted that the Annual Plan for 2022/23 includes an objective to improve the average response time for complaints.

The Committee were updated on the CQI process undertaken and the themes and outcomes it identified. It was noted that Experts by Experience had been involved, and their input had been invaluable. The process had been supported by two independent facilitators and had good levels of involvement from operational services.

The presentation outlined that the Trust had undertaken a self assessment against the proposed new complaints standards from the PHSO. The self assessment had identified the same areas of improvement as the CQI project, which has meant that one action plan has been developed in response to both. The Committee were updated on the progress of the actions.

In response to Anne Barnard's question, Helen Edmondson confirmed that the team were seeking to improve the use of early resolution and using the information in tandem with other data to identify possible service areas that need support.

3. Quality and Safety

3.1 <u>CQC Update- Forest House</u>

The Committee considered a report that provided an update on the outcome of the CQC's focused inspection of Forest House Adolescent Unit and the details of the action the Trust has taken to make improvements.

The Committee noted that on 30 March 2022, the final inspection process report was published by the CQC. Within the report, the CQC has identified actions that the Trust *must* take to comply with its legal obligations and actions that the Trust *should* take to improve the services. As a consequence of their findings, the service line (Child and Adolescent Mental Health Wards - CAMHS) was rated at the inspection as *Inadequate*. This followed two unannounced visits to the unit.

The Committee was updated on the detailed Service Improvement Action Plan (which builds on a plan implemented in September 2021, prior to the inspection for FHAU) that includes the key areas of improvements identified by the CQC as identified in their inspection process report. It was reported

that a significant amount of progress had been made, and it continues to be embedded to sustain the improvements.

It was noted that in line with the CQC process, the Trust submitted the actions it has taken within the required timeline. It was noted that the progress would be followed up in the engagement meeting with the CQC and that this meeting would also cover progress at Warren Court. The Committee agreed to have an update on Warren Court at its next meeting.

In response to Tim Bryson's question, it was confirmed that the independent external input had fed back that it was her observation that the improvements are embedded.

3.2 Incident Command Update

The Committee considered a report that provided a summary of the management of the incident, noting that the Incident Command structures remain in place but had recently been reviewed and changes implemented. It was noted that the NHS remained at level 4 alert status.

The Committee were updated that the Trust currently has no outbreaks, staff absence is down, and that updated Infection Prevention and Control Guidance has been implemented for non-clinical areas.

It was noted that the next phase would be to undertake a review and evaluation of the Trust's response to the pandemic, which will form part of the Trust's EPRR self assessment that will be reported in July 2022.

3.3 Annual Integrated Safety Report incorporating Quarter four: 2021/22

The Committee considered the Annual report that provided detailed information on safety, including trends, themes and actions taken in response to identified learning for quarter three.

The Committee considered the information provided concerning Serious Incidents, deaths and never events. It was noted that there had been an increase in the number of incidents reported in the year compared to the previous year but a reduction in incidents resulting in moderate or severe harm. Suicide or open conclusions continue to show a downward trend. It was noted that there had been no Never Events and no Prevention of Future Death reports issued by HM Coroners to the Trust. All Serious Incident investigations had been completed within the expected timescales.

During the year, there had been no breaches of Eliminating Mixed Sex Accommodation (EMSA). There had been an increase in the number of restraints, rapid tranquillisation, service user on staff assaults and an increase in the number of RIDDORs During the year, four new safety suites had been completed and launched. A further four further safety suites across the Trust had been commenced. CCTV was installed in communal areas in Albany Lodge and Warren Court. And all bedroom windows were replaced at Kingfisher Court with next-generation windows with an external sliding pane, eliminating the identified ligature risk. The Patient Safety Dashboard was rolled out across the Trust following a successful pilot allowing managers to scrutinise and review incidents effectively. It was agreed that a demonstration for Committee members would be organised.

The Committee noted the priorities for 2022/23. In response to Tim Bryson's question, Jacky Vincent confirmed that Trust was adopting a trauma-informed

approach. Jacky Vincent also clarified the role of Serious Incident investigation and Structured Judgement Reviews.

The Committee were updated on the introduction of the Use of Forces Act and how the Trust is ensuring it meets the requirements of the Act. It was agreed that the July Committee meeting would receive a full report on the Act.

3.4 Quarter Four Safer Staffing Report

The report provided an update on the fourth quarter. It outlined the staffing levels achieved against the safe staffing levels set for each patient unit for nursing staff. It was noted that they had never gone below safe staffing levels.

It was noted that there had been an increase in staffing levels across services, owing to levels of acuity and complexity of service users and an increase in safe and supportive observations. During this quarter, there was clear evidence of scrutiny and escalation process of staffing across SBUs.

4. Quality – Effectiveness

4.1 PAIG Report

The Committee received an update on the PAIG meetings held in quarter four. It was noted that 14 audits had been approved at the meetings. It was reported that when an audit is impact-rated red, it indicates the frequency within which the audit needs to be repeated and is not a sign of significant clinical risk.

The Committee were updated on the audits relating to the involvement of service users and carers in care planning and recording of epilepsy care plans.

In response to Anne Barnard's question, Asif Zia confirmed that the recording of medical capacity to treatment was subject to a 'short audit' to ensure the immediate issue of the recording of this information was remedied.

4.2 Annual Infection Prevention and Control Report

The Committee noted the Annual Report. The Committee noted and approved the Infection Prevention and Control Programme for 2022/23.

5. People

5.1 People and OD Report

The Committee considered a report on the Trust's performance against the key people and organisational development metrics and activity set out in the Annual Plan for quarter four and the full year.

The Committee considered the information on the detailed workforce metrics, including vacancy rates, recognising the professions which are areas of particular concern. The Committee also discussed the unplanned turnover rates, noting the top reasons for leaving and the stabilisation of the figures over the last three months. It was noted that the Trust had .recurited over 671 new staff in the year, there had been 450 internal promotions, and the time to hire had reduced by a fifth.

The current focus in quarter one of 2022/23 on appraisals and mandatory training was welcomed. It was noted that the future format of the report would be aligned with the Annual Plan to give clarity on how the metrics linked with the Plan for the year.

5.2 Workforce Planning Update

The Committee considered a report that provided an update on the Trust workforce plan. It was noted that the plan sets out: the current workforce picture, noting the areas of current challenge in relation to our vacancies and workforce profile; how services are likely to change over time; the workforce the Trust will need in the future; key workforce risks and pressures associated with the level of growth required over the next five years; and the actions that will be taken to secure future workforce

The Committee were also updated on the Trust's draft workforce submission for the 2022/23 planning round. It was noted that the submission would be triangulated with other data before being finalised.

In response to Anne Barnard's question, Janet Lynch confirmed that the recruitment plan was ambitious but that it was needed to support the Trust's Annual Plan. Jacky Vincent confirmed that a competency framework was used to assess progress between band 2 staff.

5.3 Annual Freedom to Speak up Guardian Report

The Committee considered the data on the number of concerns received in 2021/22, noting that the number had increased from the previous year. It was noted that as a proportion, the number which were anonymous was less than ten per cent.

The Committee considered the report that set out the concerns received in the year and that a number remained open and were being actively managed. The Committee was updated on the recruitment of FtSU Champions.

The Committee discussed the need to continue encouraging staff to raise concerns and supporting managers to respond to and resolve the concerns raised. It was agreed to have a deep dive into Freedom to Speak Up later in the year. In response to Jon Walmsley's question, it was confirmed that the Trust would look to compare data with other trusts to help with benchmarking.

5.4 Quarter Four Guardian of Safe Working

The Committee considered the report for quarter four. It was reported that during the quarter, there were two exception reports raised by Trust Junior Doctors, both of which had been resolved. Overall, there had been an increase in bank locum spend since the previous report as a direct result of doctors having to self-isolate and sickness absence

The Committee discussed the need to ensure Junior Doctors continued to feel able to raise exception reports. The Guardian reported that they deliver a presentation at each junior doctor induction to ensure that the trainees are aware of the exception reporting process and hold monthly junior doctor forums to discuss any concerns.

6. Experience

6.1 Quarter Four and Annual Experience Report

The Committee considered the report for quarter four and the full year. It was noted that overall the amount of feedback had increased due to the implementation of a digital option to complete the Friend and Family Test questionnaire. There had also been an increase in complaints from previous years.

It was reported that the use of volunteers would be stepped up across services, and this includes using them to support involvement, engagement and seeking feedback. The Committee noted that significant work was taking place at SBUs to involve service users and carers.

The Committee noted that in quarter four, the Trust had received the outcome of a PHSO investigation and that two other case files were requested in the quarter and were being considered under their early resolution process. The Committee were updated on the action in place to address the issues raised by the investigation.

The Committee welcomed the increased use of digital solutions to encourage feedback. In response to Jon Walmsley's question, Sandra Brookes confirmed that services were offering a choice to service users of either virtual or face to face. Hakan Akozek confirmed the Trust had moved to Teams for consultation following positive feedback. In response to Anne Barnard's question, Helen Edmondson reported that the complaints team were reviewing the categories used for data collection.

6.2 Inclusion Update 2021/22

The Committee considered a report that set out the work of the Trust's inclusion and involvement functions. This included recruiting to the team, which was now fully staffed.

The Committee noted the key priorities for 2022/23 as launching an Inclusion strategy/culture change programme; developing a work plan that captures the activities in each portfolio, and builds towards the achievement of key objectives from the Trust's Annual Plan and indicated by assessments, e.g. WRES and WDES; reinstatement of governance and Executive sponsorship arrangements for involvement and inclusion and engagement with staff, service users and carers on the new configuration of the team.

7. Governance

7.1 Draft Annual Governance Statement

The draft Annual Governance Statement was reviewed. The Committee noted that is a key part of the Trust's Annual Report. The Statement serves an important purpose in allowing the Trust to reflect and report publicly on the extent to which it complies with its code of governance. It should include how the organisation has monitored and evaluated the effectiveness of governance arrangements in the year and any planned changes in the coming period.

It was noted that the statement would be updated following receipt of the external audit report and the Head of Internal Audit Opinion. Subject to those

amendments, the Statement was approved and recommended for inclusion in the Annual Report for 2021/22.

7.2 Annual Mental Health Legislation Report

The Committee considered a report that provided an overview of the use of Mental Health (MH) legislation across Trust services, noting the areas of increased activity. The report outlined the progress and the achievements and challenges in relation to auditing the requirements of MH legislation and implementing changes to practice due to COVID-19, as well as updates to forthcoming changes in legislation.

The report set out how the Hertfordshire Partnership University NHS Foundation Trust (the Trust) managed the requirements of Mental Health (MH) Legislation in 2021/22. The report set out compliance under the Care Quality Commission (CQC) notification requirements for the use of Deprivation of Liberty Safeguards (DoLS) and our Mental Health Act (MHA) CQC action statements.

It was noted that there has been a decrease in the use of Section 136, whereas the number nationally is increasing.

The report set out that there had been six unannounced and one announced MHA CQC visits during the year. All action plans for issues raised were returned to the CQC within the required time scales. The report set out how the Trust has robust governance, audit programme, policies and procedures around the use of MH legislation which has been recognised by the Care Quality Commission (CQC). It was noted that legislation audits would continue, and effective methods of distribution and follow up with Practice Governance Leads will be maintained.

In response to Tim Bryson's question, Sandra Brookes reported on the work underway with partners to reduce the use of Section 136 and ensure the lengths of detentions are as low as possible. It was agreed that the July Committee would receive a report on Section 136.

7.3 Quality Accounts Indicators

The Committee considered a report that, following a three-month consultation across the SBUs, Carer/SU Council, the Council of Governors, and the Executive, the final priority indicators have been chosen for 2022/23 and were detailed in the report.

It was reported that each of the priority indicators for 2022/2023 will be subject to quarterly reporting. And that no mandatory priority indicators have been set by NHSE this year, and the priority indicator forms part of the Quality Schedule measures (our contractual agreement).

7.4 Annual Caldicott Report

The Committee received the Annual Report of the work of the Caldicott Guardian for 2021/22.

8. Items to Note

The Committee received the following reports to note. All papers were distributed in the pack, and questions were invited from Committee members.

8.1 Quality, Risk Management Committee (QRMC)
The Committee received a report from the QRMC, which met on 3 May 2022. There were no matters for escalation to the IGC.

8.2 People and OD Group
The meeting noted the report from the People and OD Group meeting held on 8 April 2022. There were no matters for escalation to the IGC.

8.3 Information Management and Governance Subcommittee (IMGS)
The Committee noted a report from the Information Management and Governance Sub-committee, which held its last meeting on 3 May 2022. There were no matters for escalation to the IGC.

8.4 Quarter Four and Annual Information Governance Report.
The Committee noted in the quarter four report there were no matters for escalation to the IGC.

8.5 Quarter Four and Annual Safeguarding Report
The Committee noted in the quarter four report, there were no matters for escalation to the IGC.

8.6 Quarter Four and Annual Claims Report
The Committee noted in the quarter four report, there were no matters for escalation to the IGC.

8.7 Follow up of Committee Development Areas
The Committee noted in the quarter four report, there were no matters for escalation to the IGC.

8.8 Committee Planner
The Committee noted the updated planner. It was noted that items for Deep Dive would be discussed in the Committee debrief meeting.

9. Items for Escalation

It was noted that there were no formal items for escalation to the Board.

NHS
Hertfordshire
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NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 9a
Subject:	Annual Integrated Safety Report incorporating Quarter 4 2021/22	**For Publication:** Yes
Authors:	Nikki Willmott Head of Safer Care & Standards | John Fanning, Head of Safety | Lara Harwood, Experience Manager	**Approved by:** Bina Jumnoodoo Deputy Director of Nursing and Quality
Presented by:	Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse)	

Purpose of the report:

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

Action required:

Receive: To discuss the Integrated Safety Report and its implications for the Trust.

Summary and recommendations:

The Board is asked to receive and discuss the Annual Integrated Safety report incorporating quarter 4 and its implications. The COVID-19 pandemic has had an impact on the Trust responding swiftly to risks that emerged in relation to higher acuity on inpatient wards and increases in physical health needs.

The past year saw:

- A reduction in deaths overall from 764 in 2020/21 to 544 in 2021/22
- 75 deaths reported to the LeDeR programme in 2021/22
- An increase of incidents reported externally as Serious Incidents from 124 to 137
- The number of incidents increased; a reduction in incidents resulting in moderate or severe harm or death
- An increase in unexpected deaths or avoidable deaths declared Serious Incidents
- Suicide or open conclusions continue to show a downward trend
- A 12% increase in incidents reported to the National Reporting and Learning System (NRLS)
- All Serious Incident investigations completed within the expected timescales.
- The majority of actions resulting from Serious Incident investigations closed and clarifications agreed in real time
- An increase in ligature incidents and reduction in ligature incidents involving anchor points in inpatient services.
- Improved compliance with weekly ligature audits
- No Prevention of Future Death Notices issued to the Trust and no Never Events
- No breaches of Eliminating Mixed Sex Accommodation (EMSA)
- An increase in the number of restraints
- An increase in rapid tranquilisation
- An increase in the number of service user on staff assaults
- An increase in the number of RIDDORs
- The completion and launch of four new safety suites and the commencement of four further safety suites across the Trust
- An increase in reported AWOLs
- CCTV installed in communal areas in Albany Lodge and Warren Court

- All bedroom windows replaced at Kingfisher Court with next generation windows with external sliding pane which eliminates the identified ligature risk.
- Refresher training sessions on incident reporting delivered to teams across the Trust. A training video on reporting incidents also been produced and uploaded to the Trust YouTube channel
- The Patient Safety Dashboard rolled out across the Trust, following a successful pilot allowing managers to effectively scrutinise and review incidents.
- Reduction in service user to service user actual assaults involving moderate harm
- No category 3 or category 4 pressure ulcers acquired whilst receiving Trust care
- An increase in falls, however the falls in older adults are 15% lower
- No reported cases of VTE related in-patient service user deaths
- Launch of Patient Safety Syllabus Modules 1 and 2 on Discovery
- Having Your Say responses for inpatient wards increased
- A Clinical seconded to Mersey Care for three years as a Specialist Practitioner to roll out the HOPE(s) model in the Trust and other Trusts in the region, to support the reduction of Long-Term Segregation
- Compliance with Natasha's Law with the Trusts catering contractor regarding detailing their allergens list for all fresh produce that is then packaged and sold on
- All Environment Heath Officer (EHO) visits to inpatient units rated at 5* for food hygiene
- An Independent Health and Safety assurance audit conducted by Empathy Environmental Consultants Ltd on the Soft FM service provisions, which was most favourable and stated Mitie have provided excellent assurance and only minor recommendations were made to support best practise
- The launch of the Simulation Hub that places staff in an environment accurate to scenarios they would face in real life, teaching staff practical skills such as risk assessment and management, core psychiatry and physical health skills, whilst also coaching to work better and communicate more effectively together.

The priorities for 2022/23

- Keep service users, staff and carers, physically and mentally safe, reducing the harm they experience
- Proactively identify and implement the best evidence-based approaches to managing violence and aggression, and restrictive practice using a CQI approach
- Strengthen our partnership working with system partners to reduce incident of violence and aggression
- To use digital technology to enhance safety across the organisation including CCTV, ligature app, electronic PSAG boards
- Eliminate the racial discrimination our staff experience during their deliver of care
- Introduce a trauma informed approach to care across the organisation
- Review RESPECT training package
- Review MossTogether approaches adopted across services
- Roll out the of the HOPE(S) Model across the Trust
- Four further safety suites to go live in Lexden, Astley Ct, Oak and Beech
- Two High Dependency bedrooms in Forest House to be completed and operational
- CCTV to be installed in Victoria Court, 4 Bowlers Green, Astley Court, Oak and Beech as part of phase two of the CCTV project
- Full Compliance with Mental Health Units (Use of Force Act) 2018
- Launch of new Ligature audit app.
- Preparation for a systems-based approach of patient safety incidents investigation and transition to Patient Safety Incident Response Framework (PSIRF) in Spring 2022 and learn

from patient safety events (LFPSE) service in quarter 4 to replace NRLS and STEiS reporting of safety incidents
- Full compliance with Patient Safety Syllabus Modules 1 and 2
- Introduce the Trauma Risk Management Mode (TRiM) across the Trust including a peer support system, to support and offer timely interventions post events
- Continue to work with system partners to reduce suicides, improve access to bereavement support and develop the use of Real Time Surveillance
- Implementation of the Matrons Handbook across all services.

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

Relation to the Trust Risk Register:

The Trust's Risk Register has a number of risks that relate specifically to safety which are reported in the quarterly Trust Risk Register Reports. Those below have a significant impact on safety and service user harm:
Quality and Safety: The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 outbreak.
Workforce: The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with increased demand now and during the recovery phase.
Quality and safety: S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience.
Quality and safety: The Trust may not be able to sustain service user safety due to risks of COVID, flu outbreak and other winter pressures.
Workforce: Insufficient workforce to meet predicted increased demand and deliver commitments in Long Term Plan

Relation to the BAF:
1. We will provide **safe** services, so that people feel safe and are protected from avoidable harm.

2. We will deliver a great **experience** of our services, so that those who need to receive our support feel positively about their experience

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

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

6. We will deliver **joined up care** to meet the needs of our service users across mental, physical and social care services in conjunction with our partners

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

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

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

There are no implications arising from this report.

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

This report sets out actions taken in Quarter 4 2021/22 and during 2021/22 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

IGC 12 May 2022

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 throughout the year. It conducts deep dives into areas that are identified as requiring additional focus and reports to the Board any matters that require escalation, as well as recommending items for the Trust's Risk Register.

1.2. The Quality and Risk Management Committee (QRMC) reports to IGC on the work of QRMC and its subcommittees. The Safety Committee oversees all the work relating to safety and holds the safety risk register and reports into QRMC. Medicines safety, safe staffing, safeguarding, including sexual safety in Trust inpatient services, infection prevention and control are addressed in other annual reports and so will not be addressed here. They are important and should be considered in conjunction with this report.

2. Annual Plan Priorities

2.1. A number of priorities were set in relation to safety in the Trust's 2021/22 Annual Plan:

- *We will continue to work with system partners to prevent suicides*
- *We will keep service users and staff physically and mentally safe, reducing the avoidable harm they experience*
- *We will ensure the least restrictive practice is appropriately used to support service user recovery.*

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.

3. Quality Strategy

3.1. The Quality Strategy 2019-2024 has safety as one of the three areas of focus. The safety objectives in the strategy are

- Providing safe care in top quality environments
- Fostering a learning and just culture
- Fostering a culture of safety.

3.2. Keeping service users, carers, and staff safe is a key priority for the Trust. The Trust will consistently deliver high quality care in **top quality environments** and this will be achieved through prioritising:

- The development and implementation of the Making Our Services Safer Together Strategy (MOSS together), with clear work streams, actions and outcomes
- Introducing the Hope (or similar) Model and rolling this out which will result in the least restrictive practice being used
- Reducing the level of harm that is sustained as a result of incidents.

Through this objective, safe and compassionate care will be delivered in top quality environments through staff, service users and carers working together.

3.3. A **learning and just culture** will be fostered by:

- Ensuring timely investigations into Serious Incidents that enables learning to be embedded swiftly
- Innovative ways, such as SWARMs, will be embedded across the Trust to ensure swift learning from incidents

- The Trust will have a Just Culture that will support consistent, constructive and fair evaluation of the actions of staff involved in service user safety incidents. This will result in swift learning when something goes wrong, where everyone's experience is valued and action is taken to prevent it happening again.

3.4. A **culture of safety** will be fostered through:

- Shared beliefs, perceptions and values in relation to the risks within the Trust
- The High Performing Teams initiative is rolled out with safety as one of the areas for teams to work on together
- Strengthened communication in relation to safety, sharing of learning from multiple sources including national reports and prevention of future death reports, advances in the evidence and incidents that occur in the Trust.

This will ensure safety is a priority for all, with shared decision making that includes positive risk taking.

4. MOSStogether Strategy

4.1. The Trust's MOSStogether Strategy underpins the Quality Strategy and supports and builds on the Trust's Making Our Services Safer (MOSS) Strategy and sets the direction for providing safe and effective services, enabling a positive experience for those who receive our services. The launch of the strategy and its implementation action plan were postponed due to the pandemic but will be taken forward into next year.

4.2. The priorities of the MOSStogether Strategy are

- To use the least restrictive practices and as a last resort and safety intervention, considering alternative approaches to ensure support safe practice.
- To understand the impact of restrictive practices for all involved, through values-based practice, on-going surveillance of incidents and timely de-brief, aligning it with the principles of Recovery and Shared Decision Making, considering best practice and evidence.

4.3. The MOSStogether Strategy focuses on shared decision making and a just culture, with an aim to reduce the level of harm that is sustained as a result of incidents.

5. Trust Risk Register

5.1. The Trust's Risk Register has been reviewed regularly throughout the year and has a number of risks that relate specifically to safety; most recently the Trust Risk Register has been reviewed and updated by the Executive Team on 2 March 2022 and presented at the Integrated Governance Committee on 17 March 2022. All the risks have been reviewed and updated.

5.2. Those below have a significant impact on safety and service user harm:

- **People:** We won't have sufficient number of staff with the right skills, due to high levels of turnover, insufficient recruitment, and limited supply of workforce. Which will impact on our ability to provide safe responsive care, avoid harm and unexpected deaths, which will also have an impact on staff's wellbeing
- **Demand and acuity:** Increase in demand for services and increase in complexity of needs of service users. Which will see a reduction in the quality of care, lengthening of waiting times and have an impact on our ability to provide safe responsive care, avoid harm and unexpected deaths
- **Insufficient beds:** We don't have access to sufficient number of inpatient beds. Which sees an increases in use of out of area placements, an increased number of services users in the community waiting for admission and causes a financial pressure. Will also have an impact on quality of care and staff wellbeing

- **Quality of care:** We won't be able to provide high quality care at Forest House, Warren Court, SRS and northwest adult community services, due to a number of factors including workforce, significant increases in demand and availability of beds.

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

6. Care Quality Commission (CQC)

6.1 Throughout the pandemic the CQC have kept their regulatory approach under review. This is in recognition of the changing pressures health and social care services find themselves working under. Throughout 2021/22 CQC have undertaken inspections where there has been evidence that people are at risk of harm. Alongside their risk-based activity, CQC have recommenced the undertaking of ongoing monitoring of services. This helps to identify where CQC may need to take further action to ensure people are receiving safe care and offer support to providers.

6.2 With regards to the Trust, the CQC carried out an unannounced focused inspection at Warren Court in September 2021 following a number of whistleblows raised regarding concerns about the safety and quality of the services. The inspection was risk focused and the CQC did therefore not look at all Key Lines of Enquiry. The service was also not rated at this inspection.

6.3 The CQC provided a full and detailed report, following their inspection process, outlining their findings, which included 7 'must dos' and 1 'should do' actions. As a result of the judgements made in the CQC's inspection report, actions have been set which the Trust have shared and have taken forward.

6.4 The CQC also carried out an unannounced focused inspection at Forest House Adolescent Unit in November and December 2021, following a number of whistleblows which raised concerns regarding the safety and quality of the services provided. Prior to the inspection, the Trust already had a Service Improvement Action Plan in place. On 30 March 2022 the CQC published its report which included five enforcement actions, four requirement actions and two 'should do' actions. The CQC rated the Forest House Adolescent Unit as 'inadequate'. Actions identified during the visit are being taken forward and the action plan has been shared with the CQC.

7. Staff Survey

7.1 NHS Staff Survey are now measured against the seven People Promise elements. The annual NHS staff survey results for 2021 revealed that the Trust score for the We are Safe and Healthy element remain above average. The score for Health and Safety Climate theme was above average. All five questions that contribute to safety climate remain above average:

1. My organisation acts on concern raised by patients / service users
2. I would feel secure raising concerns about unsafe clinical practice
3. I am confident that my organisation would address my concern
4. I feel safe to speak up about anything that concerns me in this organisation
5. If I spoke up about something that concerned me, I am confident my organisation would address my concern

7.2 For the question '*In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relative?*' there has been a slight improvement since last years survey from 18.3% to 18.2%, however the Trust still remain above average compared to other organisations.

8. Central Alert System (CAS) Safety Alerts

8.1 The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

8.2 There were 105 Safety Alerts received in 2021/2022, as detailed below:

- 0 Estate and Facilities Alerts
- 11 Patient Safety Alerts
- 3 Medical Device Alerts
- 0 Field Safety Notices
- 78 Medication / Drug Alerts (including supply disruption)
- 10 Other External Alerts
- 19 HPFT Internal Alerts were issued by the Trust.

8.3 Those alerts which were applicable were actioned and closed.

8.4 The Trust issued the following internal safety alerts, the majority linked to ligature risks or self-harm risks:

- HPFT/2021/006: Clinell Universal Wipes and Spray, allergy risk
- HPFT/2021/008: Non-Fixed Ligature Incident – Stitched on Paper Bags
- HPFT/2021/009: HMRC Scam
- HPFT/2021/010: Seclusion Observations and Monitoring
- HPFT/2021/012: Safer Needle Device
- HPFT/2021/014: Wipes Plastic Packaging Risk
- HPFT/2021/013: Sanitary bin non collapsible ligature risk
- HPFT/2021/016: Memantine
- HPFT/2021/015: Fridge Shelf – Possible self-harm risk
- HPFT/2021/018: Internal Safety Alert Plastic Bags (reminder)
- HPFT/2021/017: Potentially Dangerous Persons (PDP) process
- HPFT/2021/019: Rope made from newspaper
- HPFT/2021/020: Valproate in women of bearing potential
- HPFT/2021/021: Inpatient Toilet Roll Dispenser Ligature Risk
- HPFT/2021/022: Falls from Chairs
- HPFT/2021/023: Alcohol Based Hand Sanitisers
- HPFT/2021/024: Bracelets for Breaking Glass
- HPFT/2022/001: Confirming bank and agency staff identity

9. Conclusion

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

Part B- INCIDENTS INCLUDING SERIOUS INCIDENTS

1. Introduction

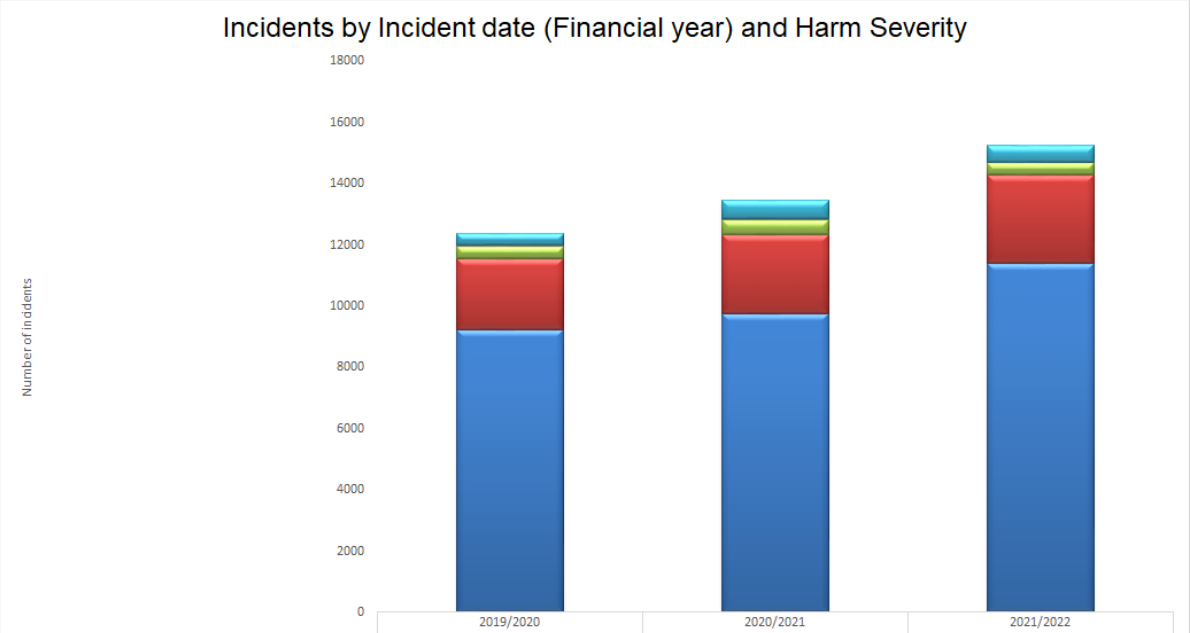
1.1. Part B of the safety report specifically considers incidents, including serious incidents. It begins by giving an overview of reporting trends and then goes on to explore themes and trends as well as severity of harm. How the Trust meets its Duty of Candour is detailed and then specific attention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

2. Incidents profile

2.1. All incidents are reported internally on Datix, the Trust's incident reporting system. Work has been undertaken this year on increasing the number of managers and clinical leads who have access to incident dashboards on Datix to enable oversight of incident trends. The Trust reports patient safety incidents to the National Reporting and Learning System (NRLS) in accordance with the national guidance. Not all incidents are reportable to NRLS for example safeguarding incidents and staff incidents.

2.2. In keeping with the principles of the NHS Patient Safety Strategy to continuously improve patient safety, the Trust actively encourages a positive reporting culture where staff are confident to report safety related incidents and near misses so the Trust can learn from where things go well as well as where things could be improved.

2.3. The number of incidents reported on our incident reporting system during 2021/22 increased (Chart 1). There has been continued work in 2021/22 on improving the quality of our incident reporting with a renewed focus on the operational teams reviewing and closing incidents. This work is supported by the Safer Care Team through advice, oversight and training for staff and managers.



	2019/2020	2020/2021	2021/2022
Death	394	623	546
Severe Harm (permanent/long term harm)	25	38	17
Moderate Harm (short term harm/further treatment given)	404	495	394
Low Harm (minimal harm/minor treatment given)	2339	2568	2907
No Harm (no injury sustained/apparent)	9229	9751	11392

Chart 1 Total Trust Incidents by Harm 2019/20 – 2021/22

2.4. The number of incidents resulting in moderate or severe harm and death combined decreased from 1156 to 957 in 2021/22. The proportion of incidents resulting in moderate or severe harm has decreased from 3.96% to 2.69%.

2.5. The latest Organisational Patient Safety Incident Report data for NHS organisations (September 2021) indicated that, in the period April 2020 to March 2021 the Trust reported 39.2 incidents per 1000 bed days, an increase from the previous reporting period (35.5). The CQC Insight report for the NRLS reporting period July 2020-July 2021 had suspended indicators on NRLS reporting. Additional resource for the team has improved the timeliness of NRLS reporting with incidents being uploaded on a monthly basis. Incidents reported to NRLS has increased from 4,947 in 2020/21 to 5,566 in 2021/22 an increase of 12%.

2.6. 1412 incidents were reported to NRLS, an increase of 2.46% from quarter 3.

2.7. Work has continued on delivering incident reporting training for staff and managers to raise awareness of the link between incident reporting and safety. Working in different ways has provided an opportunity to take forward into 2022/23 further development of eLearning packages; monthly virtual Datix training for staff is now available on the Discovery platform along with bespoke training for managers. Refresher training sessions has been delivered to teams across the Trust and in particular to East and North and West SBUs. A training video on reporting incidents also been produced and uploaded to the Trust YouTube channel with plans to record an upcoming training session for reviewers.

3. Serious Incidents

3.1. 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)*.

3.2. The NHS Never Events policy and framework was first published in January 2018 and is relevant to all NHS funded care; the latest update was published in February 2021. The Trust reported no Never Events during 2021/22.

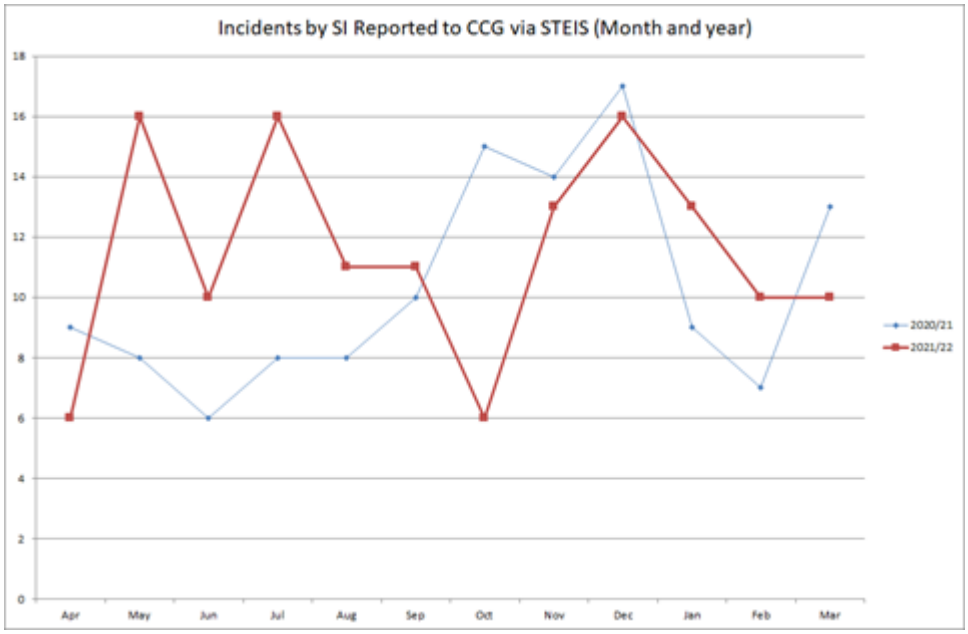
3.3. The NHS Patient Safety Strategy was published in July 2019; the latest update was published in February 2021 outlining the expansion of the patient safety specialist network, publication of the patient safety partner's framework and roll out of the new patient safety incident management system. The introduction of the new Patient Safety Incident Response Framework (PSIRF) has been delayed by NHSE and is now expected to go live in quarter 2 2022/23.

3.4. Organisations are also expected to establish effective systems, processes and behaviours that enable recovery from the effects of an incident and where learning and improvement are more likely to happen. The strategy provides guidance on how to respond to patient safety incidents with a focus on a just culture, openness and candour, engagement of families in learning from our incidents, support for staff and trained investigators. These principles are in evidence within existing Trust processes and will be built on further in 2022/23. The Trust appointed a substantive Patient Safety Specialist/Head of Safety from 1st April 2021 following the introduction of an interim post in December 2021.

3.5. During 2021/22, the Trust has been preparing for the implementation of the national Patient Safety Incident Response Framework (PSIRF), which will replace the Serious

Incident Framework in 2022/23, through attendance at patient safety network meetings, and discussion with early adopter Trusts. PSIRF will support the NHS to operate systems, underpinned by behaviours, decisions, and actions, that assist learning and improvement, and allow organisations to examine incidents openly without fear of inappropriate sanction, support those affected and improve services. These principles are already in evidence in the Trust's Serious Incident Process.

3.6. The weekly Moderate Harm Panel provides a robust assurance process for the oversight of moderate harm incidents and above reported on Datix. It provides a decision-making process, identifying cases where a SWARM is needed or additional support is needed for a team, sharing of learning across the SBUs and identify timely actions to be taken where there are emerging trends and themes.



Graph 1: Serious Incidents by Reported Month comparing 2020/21 to 2021/22

3.7. The Trust remains committed to reduce the occurrence of avoidable harm. All incidents meeting the threshold of a Serious Incident are investigated and reviewed according to principles set out in the current Serious Incident Framework. The purpose of an investigation is to ensure that lessons can be learnt to prevent similar incidents recurring.

3.8. In the quarter, the Trust reported 29 Serious Incidents external to the Trust. Of these, ten were unexpected deaths, nine were self–inflicted harm, two were disruptive, violent or aggressive behaviour, three were slips, trips or falls, two were alleged homicides, one were medication incident, one was related to practice, and one was unauthorised absence.

3.9. The Trust reported 137 Serious Incidents in 2021/22 (Graph 1) compared to 124 in 2020/21. This should be seen within the context of the continued work undertaken to encourage a positive reporting culture, and an ongoing commitment to learning and continuous quality improvement.

3.10. The Serious Incident reports consistently demonstrate engagement with service users and families as part of the review process, to ensure that views on care provided are heard and acted upon; this has helped us to inform work streams that will continue in 2022/23 in relation to bereavement support, reducing violence and aggression in our

inpatient settings, falls prevention, carer support, acting on concerns, physical health monitoring, dual diagnosis, safety planning, harm minimisation, and suicide prevention.

3.11. Table 1 shows that unexpected death continues to be the highest reported Serious Incident category and has increased 34% from 47 in 2020/21 to 683 in 2021/22. The number of disruptive, aggressive or violent behaviour incidents reported as Serious Incidents in 2021/22 has decreased.

Category	**2020/21**	**2021/22**
Unexpected or avoidable deaths	47	68
Disruptive, aggressive or violent behaviour	15	13
Apparent, actual or suspected self-inflicted harm	35	36
Slip, trip or fall	12	7
Abuse or alleged abuse of adult patient by staff	0	1
Abuse or alleged abuse of adult patient by a third party	2	6
Abuse or alleged abuse by adult patient of a third party	0	1
Medication incident	2	0
Unauthorised absence	2	0
Sub-optimal care of deteriorating patient	0	2
Confidential information leak/information governance breach	1	0
Health care associated infection or infection control	2	0
Apparent, actual or suspected homicide	2	2
Commissioning incident meeting SI criteria	0	1
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1	0
Treatment delay meeting SI criteria	1	0
Medical equipment	1	0
Allergy incident on ward	1	0
TOTAL	**124**	**137**

Table 1 Serious Incidents reported in 2019/20 and 2020/21 by StEIS category

4 Incident investigations

4.1 Serious Incidents are investigated using Root Cause Analysis (RCA) and all have been investigated within the mandated 60 working day time frame. Weekly update meetings with the SBUs and the Safer Care Team are in place, along with circulation of cases with upcoming deadlines each week.

4.2 The Trust's Duty of Candour policy sets out the requirement to meet the Statutory Duty and this is assessed through the Quality Schedule. The Datix incident reporting system records when Duty of Candour has been met. A copy of the Serious Incident report is shared in full, with the service user or the family and also with HM Coroner.

4.3 The Trust is engaged in work being led by Public Health on improving bereavement support in Hertfordshire. There is a Support for the Bereaved by Suicide Group as part of the Suicide Prevention strategy. Signposting to suicide bereavement support and resources is included in the Duty of Candour letter sent to families, with a Help is at Hand booklet. Funding has been agreed for a Bereavement Support Officer to work across the ICS supporting those bereaved by suicide.

4.4 The Trust has received feedback from families who have been engaged in the incident investigation. This has included positive feedback relating to the support offered post incident, but there have also been areas where improvements could have been made. This has led to the Trust strengthening its processes to ensure families are given every opportunity to inform the review and affect change. This learning also informs the wider Public Health suicide prevention work through presentations and discussions.

5. Mortality Governance

5.1 All deaths are considered in the mortality governance process and are screened to identify whether a Structured Judgement Review (SJR) should be undertaken. A SJR is completed on any death meeting red flag criteria, with data analysis used to inform improvements in care.

5.2 There is SBU level oversight of the SJRs and these are cascaded down to the relevant teams through the practice governance structures. The Mortality Governance team has not found any deaths in the quarter where care concerns are thought to have contributed to the outcome for the service users.

5.3 All deaths that are reported continue to be screened each week. There continues to be a higher-than-average number of deaths in the quarter with 68 deaths in March. 66 (40%) deaths in the quarter have not been screened at the time of this report. 15 SJRs were completed in the quarter and it should be noted that there is a data lag in the reports and the figures may change in later reports.

5.4 SPIKE is aiding timely recording of deaths on the EPR and screening of deaths which includes deaths reported on the national spine and has improved the timeliness of screening of deaths and updating of Trust systems to show a person as deceased and not open to services.

5.5 The numbers of deaths increased during the third wave of the Covid-19 pandemic around October 2021 in line with the national picture (Table 1). Cause of death for all deaths were not available at the time of reporting to provide a breakdown, however, the majority of the deaths screened were in the Expected Natural (EN1) category. Indications are that March 2022 was the peak month for deaths for the financial year 2021/22 with 68 deaths.

5.6 During the financial year 2021/22, 544 (by date of death) service users died, of which 128 were identified as meeting the criteria for further review either as a Serious Incident investigation (65) or as a SJR (63). A large number of the deaths reported are due to natural causes, ill health or accident and not related to the Trust; natural cause deaths include deaths from COVID-19.

	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
East and North Hertfordshire Strategic Business Unit	72	85	104	94	355
Essex & IAPT SBU	12	13	14	17	56
Learning Disabilities & Forensic Strategic Business Unit	8	7	17	14	46
West Hertfordshire Strategic Business Unit	18	19	24	26	87
Total	110	124	159	151	544

Table 1: Deaths by SBU and Quarter reported on Datix. Note this does not include 2 homicide incidents with a harm severity of death which are included in the overall incident 'death' harm severity in section 1.

5.7 27 Covid 19 deaths were reported in 2021/22, of which three were reported externally to the Covid-19 Patient Notification System (CPNS) during the COVID-19 pandemic in 2021/22. Three were in Learning Disability services, 21 from older people's services and three from adult community teams

5.8 All deaths of people with a learning disability are referred to the Learning Disabilities Mortality Review (LeDeR) programme. LeDeR has undergone a policy review and the local Integrated Care Systems (ICSs) are responsible for ensuring reviews are undertaken and actions are implemented. The Trust will continue to notify deaths through a new web-based platform. The reviews will be undertaken by a central pool of reviewers.

5.9 The primary representative for the LeDeR steering group is the Deputy Director of Nursing and Partnerships, who leads on physical health for the trust. The recommendations from reviews will be taken forward through the physical health outcomes group in the Learning Disability and Forensic SBU and the Physical Health Committee.

5.10 The Trust reported 75 deaths to the LeDeR programme in 2021/22, which will each be reviewed by external professionals under the LeDeR programme. The national review of this data will be reported on once published.

5.11 There were areas of good practice evident from the completed SJRs. Learning also learning included:

- Life threatening poor nutrition: inadequate evaluation and no urgent escalation
- Lack of involvement of service user with prescribing decisions and verifying mental capacity to participate in treatment

- Mental health monitoring whilst in general hospital under S17 MHA
- Medication monitoring
- Lack of discharge summary
- Yellow Card Scheme (MHRA) – no report submission.

5.12 The Trust continues to be committed to an ambition of zero suicides, in keeping with the Hertfordshire Suicide Prevention Strategy. The Trust Annual Plan priority was to reduce the number of confirmed suicides by 10% in 2020/21.

5.13 To support this work the Trust works with Public Health and sits on the Suicide Prevention Boards in Hertfordshire and Essex. It is a member of the Zero Suicide Alliance participates in the East of England Collaborative action learning sets, which enables sharing of innovation and best practice.

5.14 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. The data for 2019/20 is currently showing a downward trend, with four inquests yet to be heard. Data for the reporting years 2017/18, 2019/20, 2020/21 and 2021/22 is incomplete as not all inquests have been concluded. The Trust is aware of delays in inquests being heard in Hertfordshire.

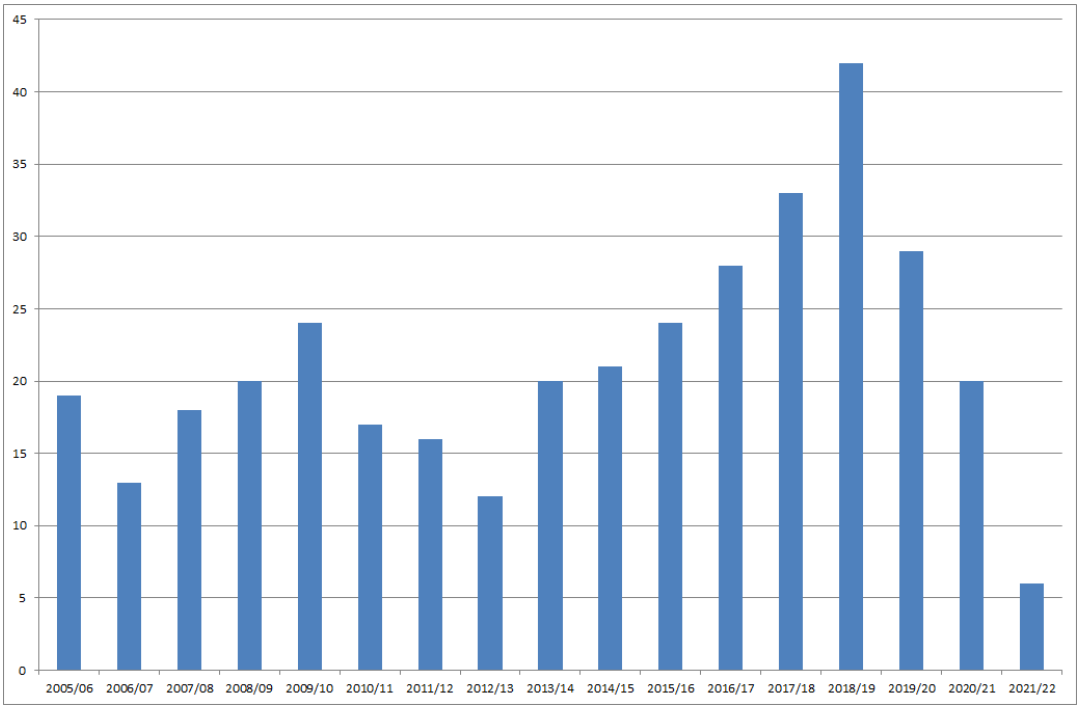


Chart 2: Suicide/Open Conclusions by Incident Date (April 2005 – March 2022)

5.15 The Trust will classify a death as suspected suicide until the outcome of the inquest is known and included in the data set, reported as Serious Incidents and subject to investigation; they are followed through inquest to the outcome (Chart 3).

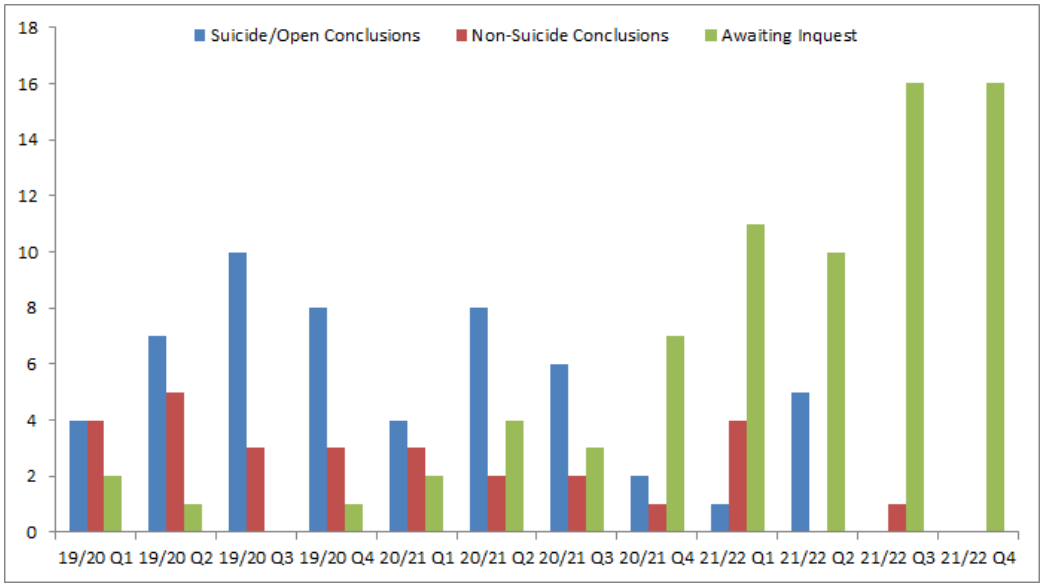


Chart 3 Unexpected Deaths by Incident Date (April 2015 – March 2022)

5.16 The Annual Plan sets out a minimum of 10% decrease in deaths suspected suicides as part of an ongoing commitment to suicide prevention. At the beginning of the year, the number of deaths that were thought to be as a result of suicide in 2020/21 was 44. A 10% reduction would mean no more than 40 at year end. At the time of this report, it is thought that 36 service users had possibly died by suicide in 2020/21, with 12 inquests still to be heard.

5.17 Coroners have a statutory duty to issue a Prevention of Future Death (PFD) report to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths. The report is sent to whoever the coroner believes has the power to take such action and the recipient then has 56 days to respond. In 2021/22, the Trust received no Regulation 28 Prevention of Future Death reports from HM Coroners.

5.18 Whilst it is acknowledged that PFD reports only provide a snapshot of evidence heard at an inquest, and therefore have some limitations, these reports provide an opportunity to review practice, processes and systems and to identify where actions may be needed. PFD reports are shared with Subject Matter Experts, Heads of Service, policy authors, suicide prevention leads, and the Corporate Safeguarding Team.

5.19 A CPD session for medical staff included a session on PFDs and associated learning. PFD reports are also shared with SBU Clinical Directors and Managing Directors for discussion at local governance meetings for further dissemination of the learning to teams trust wide. Leaning is also shared at the monthly learning events and is presented and discussed at the Safety Committee.

5.20 Key learning themes disseminated from published PFD reports in 2021/22 were:

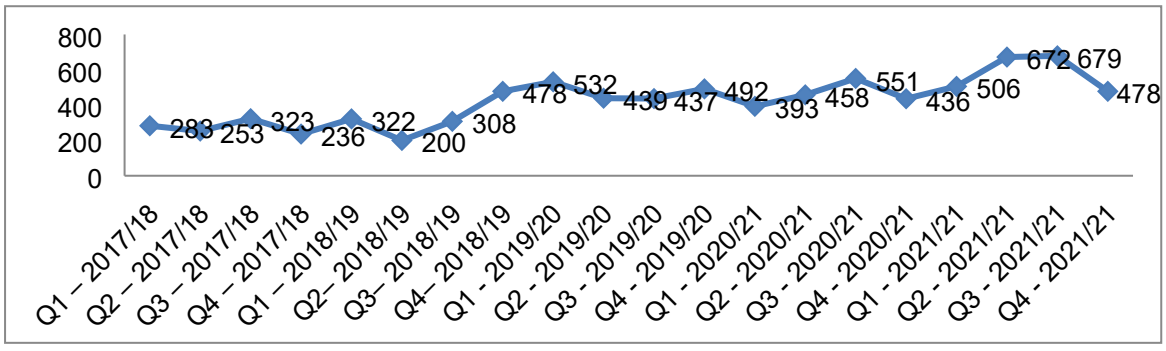
- Involving families and primary care contact
- Autism awareness as a barrier to a proper understanding mental health needs
- Findings and learning from the internal investigations being shared in a meaningful and timely manner with all grades of clinical staff
- Increased risk factors of obesity, immobility, and risperidone medication in DVT

- Accurate and up to date medication/prescribing information not routinely obtained by clinicians in advance of reviews of patients, due to inability to readily access information held by GP practices
- Failure to keep proper and adequate records by staff
- Triaging the acuity of a referral and expedite a clinical assessment where necessary
- Need for staff to demonstrate professional curiosity and enquire about suicidal thoughts and plans
- Formal mental capacity assessments to be made and properly recorded.
- Appropriate contacts to be made with the GP whilst the patient was an in-patient to obtain relevant clinical information
- Lack of communication between inpatient and community team and between mental health and primary care
- Long waiting list for Psychology
- A lack of inclusion of support workers in regular meetings
- Need for S12 doctor assessment as well AMHP assessment prior to discharge from S136.

6 Least restrictive care

6.1 The last four years have seen an increase in the use of restraint year on year except for 2020/21. There has been an increase from 1,838 incidents in 2020/21 to 2,335 in 2021/22.

6.2 Graph 2 shows an increase about the upper quartile, followed by a significant decrease in quarter 4, some of which can be attributed to a small number of service users with highly complex needs within Lexden, Astley Court, Robin ward and Forest House. These increases have been further exacerbated through the lack of specialised services being available nationally. One service user was discharged in quarter 3 significantly reducing the need for restraint within Lexden Assessment and Treatment Unit from 252 in October / November.



Graph 2 Q1 2017/18 to Q4 2021/22 Use of Restraint

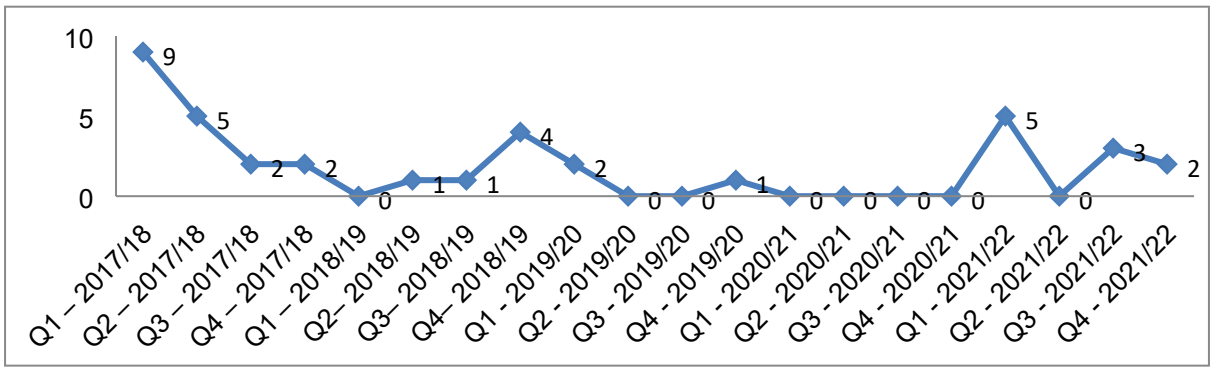
6.3 The data should be read in conjunction with the violence and aggression data later in the report. The pattern of higher number of restraints is in the same period where there has been a decrease in service user to service user violence but an increase in service user to staff violence, thought to relate to challenges associated with COVID 19 and the potential for higher isolation and reduced activity.

6.4 The Trust has developed a recovery RESPECT training plan within 2021/22 which continues to be implemented. A further six inhouse trainers successfully completed a train the trainer course.

6.5 Prone restraint is not taught as part of the restraint teaching methodology. Despite this, prone restraint can happen occasionally. As part of ongoing assurance, each case is subject to a comprehensive review, by a subject matter expert.

6.6 There has been a downward trend over the three years prior to 2021/22. However in line with full disclosure of all prone incidents including the use by the police and incidental incidents whereby the service user rolled themselves prone, there has been an increase of ten (Graph 3).

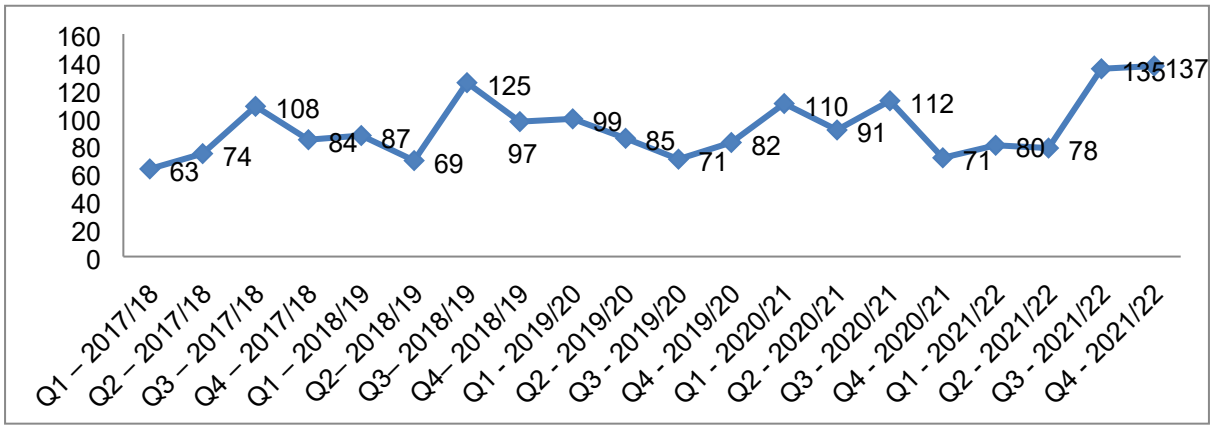
6.7 The Trust's training approach is benchmarked against the current national guidance and standards, evidence-based practices and have been accredited to the BILD Association of Certified Training during 2021/22.



Graph 3: Prone restraint Q1 2017/18 to Q4 2021/22

6.8 The use of seclusion is reviewed daily and audited monthly, being reported both internally and externally through the NHS Digital and the Restraint Reduction Group – reflected in the SBU Flash Reports. This is further reviewed and audited on an annual basis in line with the MHA CoP 2015 by the Practice Development and Patient Safety Team and findings are disseminated in the Trust.

6.9 An increase in seclusion has been reported in this reporting year (384 to 430); some of this increase may have been attributed to the Covid-19 pandemic and the challenges involving meeting the cohorting of service users leading to an escalation in their behaviour towards others. The number of seclusions has increased within quarters 3 and 4 to (Graph 4) which mirrors the finding of the use of restraint data, whereby it is a small number of service users who impact on the figures due to their high-risk presentation towards others and the lack of specialised beds nationally.



Graph 4: seclusions: Q1 17/18 to Q4 21/22

6.10 An increase in seclusion has been reported within the quarter of two incidents (135 to 137 - Graph 4), 107 of the incidents (78%) where attributed to the Learning Disability and Forensic services. The mean average time spent in seclusion is 1,993 minutes (33 hours 13 minutes), a 109% increase on 954 (15 hours 54 minutes) the previous year. However, a service user at the time of this report remains in seclusion from March 2022, awaiting a judicial review and has accounted for 14 seclusions totalling 219,795 minutes over the previous year.

6.11 All long term segregation (LTS) reviews take place in line with the Mental Health Act Code of Practice (2015) including daily medical reviews, weekly MDT reviews, independent clinician reviews, and external hospital reviews as part of agreed procedural safeguards, that uphold Human Rights. As part of the national approach to monitoring the use of LTS within Trust's, each of the service users has a regular external Independent Care and Treatment Review.

6.12 Within the year 2021/22, there were 14 service users' subject to LTS over the period with nine service users' still remaining subject to LTS at the years end (Table 3).

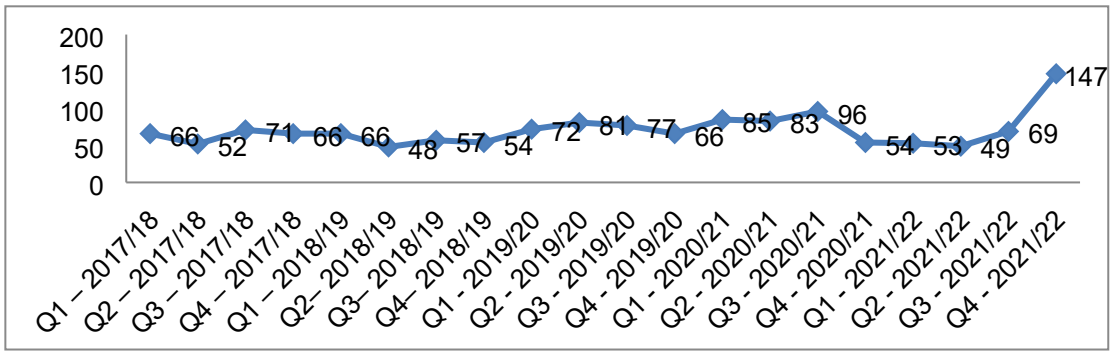
6.13 Two service users were subject to LTS prior to this period; a service user within 2 Forest Lane with long term Learning Disability specialised care and a service user transferred from Oak to Beech Ward***, however this service user has been subject to LTS on three separate occasions during 2021/22, due to his high risk of violence towards other, this service user is currently awaiting a secure service.

6.14 There were two further service users who had two periods of LTS; one following transfer from Forest House to Robin ward* and one in Lambourne Grove**. Additional use of the Barriers for Change Check has been used, as part of the HOPE(s) model, and the focus has been on positive and proactive approaches to reduce this level of restrictive practice.

Unit	Section	Start Date	End Date
2 Forest Lane	3	18 02 2010	
A&T Lexden	3	18 06 2021	
5 Warren Court	37/41	30 09 2021	
Lambourne Grove**	3	09 11 2021	
Beech Ward***	3	25 01 2022	
Forest House	3	26 01 2022	
Robin Ward*	3	17 02 2022	
Astley Court	3	23 02 2022	
Hathor Ward	3	03 03 2022	
Forest House	3	21 02 2022	28 03 2022
Forest House*	3	01 04 2021	03 06 2021
Hathor Ward	3	21 05 2021	23 02 2022
Lambourne Grove**	3	15 06 2021	22 09 2021
Beech Ward***	3	05 10 2021	17 11 2021
Oak Ward***	3	12 02 2021	05 10 2021
Forest House	3	21 02 2022	28 03 2022
Dove Ward	3	18 08 2020	06 06 2021
Forest House	3	31 12 2021	11 01 2022

Table 3 LTS Applications by Start Date / End Date.

6.15 The use of Rapid Tranquilisation has increased in quarter 4 (Graph 5), with the majority in acute mental health services.



Graph 5 – Rapid Tranquillisation: Q1 17/18 to Q4 21/22

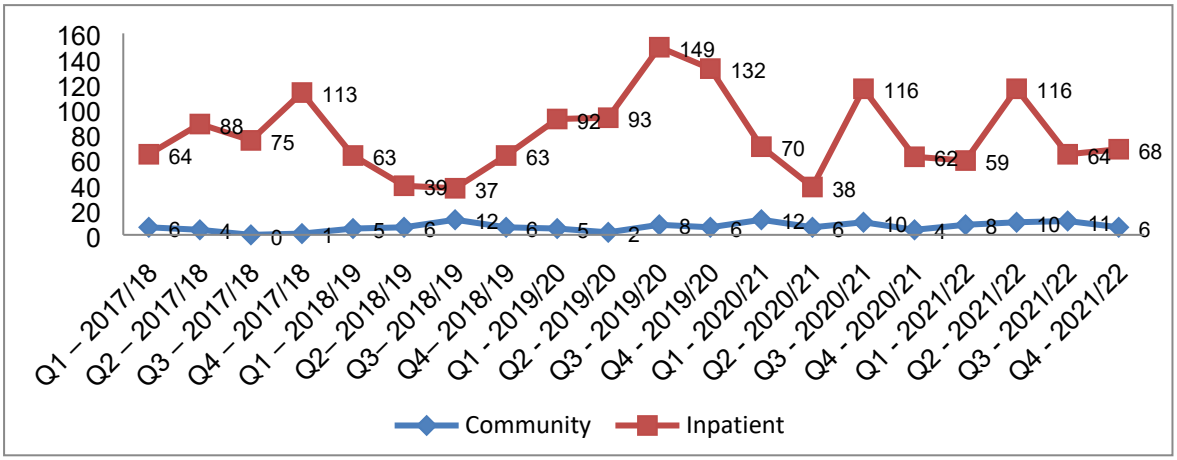
6.16 All efforts are taken to proactively manage events, so they are proportional least restrictive and in the best interests of the service user. Associated work relating to the introduction of NEWS2 and the use of soft measures has supported post incident review after Rapid Tranquilisation.

6.17 152/216 incidents which occurred in quarters 3 and 4 were within SBU West, with 94 (61%) of these incidents relating to an individual service user within Aston ward who is awaiting external specialised placement.

6.18 As part of the ongoing governance procedures, all clinical areas receive a clinical visit from a pharmacist who monitor Rapid Tranquilisation prescriptions as part of their routine work. Rapid Tranquilisation is included in the POMH-UK audit cycle and was also the subject of a PAIG audit.

7 Harm free mental health care

7.1 Ligature incidents can be anchor or non-anchor and take place in the community or in our services. This part of the report focusses on anchor and non-anchor ligature events in the in-patient services. In this reporting year, there were 307 ligature incidents, a slight increase on the previous year of 286 (7%) (Graph 6).



Graph 6: Ligature incidents during Q1 2017/18 to Q4 2021/21

7.2 There were 13 ligature incidents involving anchor points (Table 4) across the year, which is a decrease of five from the previous year. There have been two uses of an anchor point in the quarter within the inpatient services,one use of a plug cord from the

Cardiowall and the other use of electrical cables following damage by the service user to the wall of their bedroom.

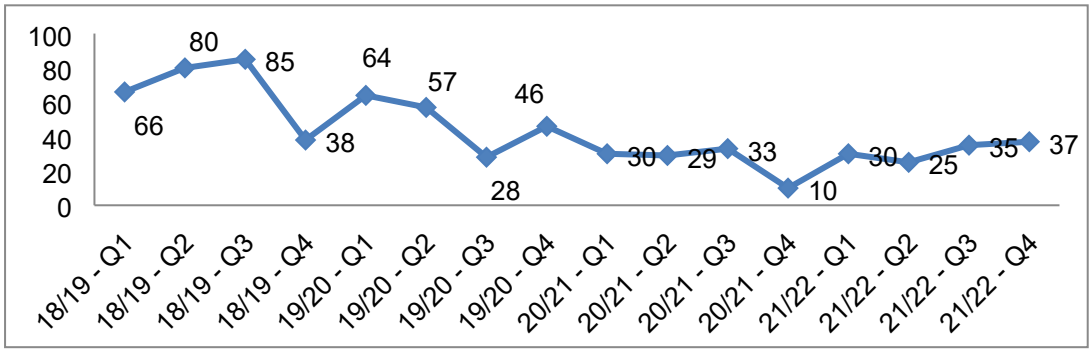
7.3 Weekly ligature audits take placed on the inpatient wards, and these are monitored by the ANT system. Improved monitoring and scrutiny has seen compliance increase above 95%.

Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
2	5	4	2

Table 4 – Ligature incidents involving anchor points 2019/20.

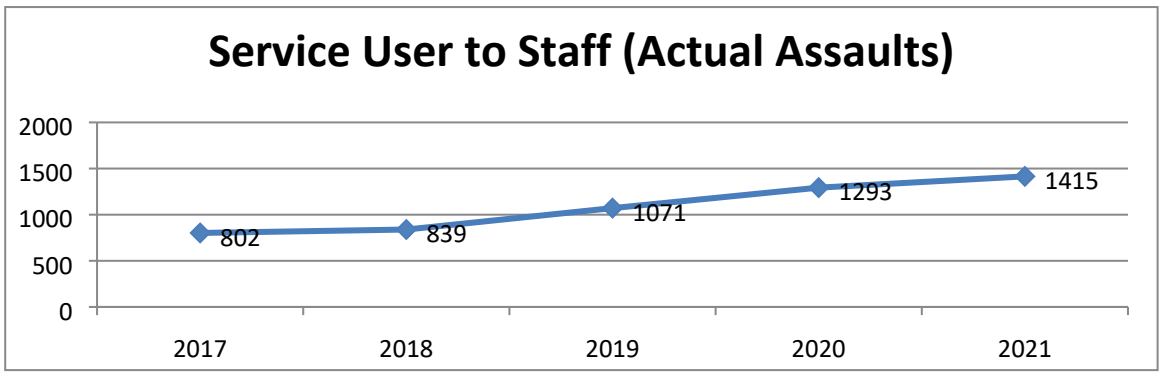
7.4 Ligature incidents using clothing remains the category with the highest number of incidents of this type on the inpatient units. Staff continues to remain vigilant around potential risk in this area and an internal safety alert has been disseminated. A review of the Ligature Awareness Training has taken place, which includes additional advice of the use of ligature cutters. The Trust has also received a new supply of ligature cutters which include cordage cutters, wire cutters and cutters for sheets.

7.5 There has been an increase from 35 to 37 incidents in quarter 4 relating to AWOL and Missing Person (Graph 7).



Graph 7 AWOLs by quarter

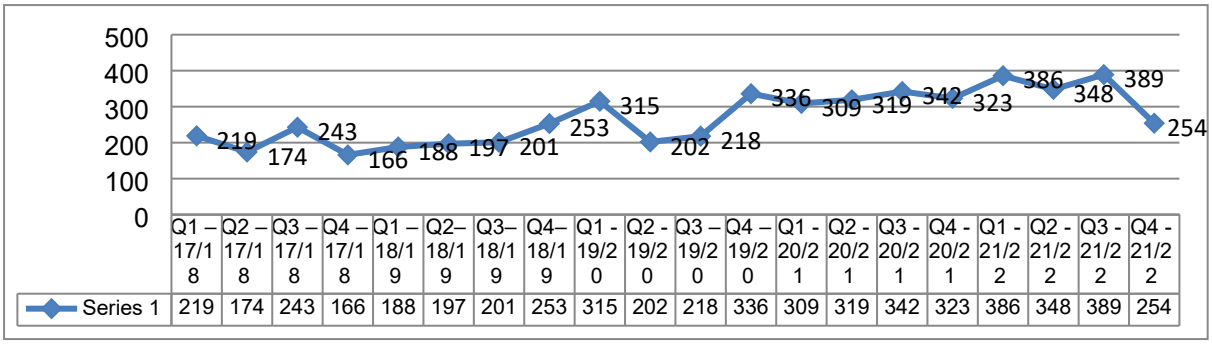
7.6 Service user to staff assault incidents reported have increased this reporting year (graph 8). The Annual Plan set a target for reducing those that resulted in moderate or severe harm so that people would not be discouraged from reporting.



Graph 8: Service user to staff assault data: 2017/18 to 2021/22

7.7 In addition to the increase in reporting (graph 8), the breakdown, quarter on quarter (graph 9), shows a correlation with restrictive practice data and a limited number of

individuals involved in multiple incidents within inpatient services. Of note Lexden accounted for 310 (22%) of the total assaults on staff, which has a separate plan to address the level of challenge and conflict.



	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	Q4 – 19/20	Q1 - 20/21	Q2 - 20/21	Q3 - 20/21	Q4 - 20/21	Q1 - 21/22	Q2 - 21/22	Q3 - 21/22	Q4 - 21/22
Series 1	219	174	243	166	188	197	201	253	315	202	218	336	309	319	342	323	386	348	389	254

Graph 9: Inpatient Units - Service user to staff assault data: Q1 – 17/18 to Q4 21/22

7.8 Within 2021/22, 49% of service user to staff actual assault incidents resulted in no harm. The Annual Plan set a target for reducing service user on staff assaults that resulted in moderate or severe harm, rather than reducing overall, so that staff would not be discouraged from reporting.

7.9 Compared to the previous year's data, there has been an 9% increase in the overall number of incidents with no incident resulting in severe harm. Consequently, incidents resulting in moderate harm increased from 31 in 2021/22 to 45 in 2020/21 (32% increase). 97% of service user on staff assaults resulted in no harm or low harm, 3% in moderate harm. (Table 5).

	Total	**%**
No Harm	**688**	**49**
Low Harm	**682**	**48**
Mod Harm	**45**	**3**
Severe Harm	**0**	**0**
Total	**1415**	100

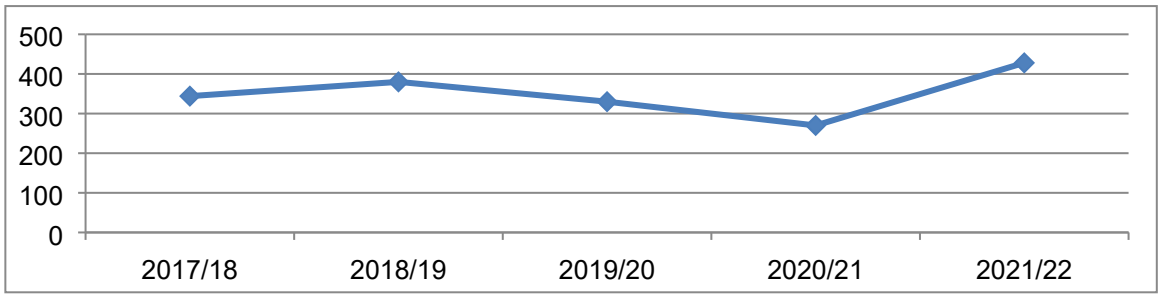
Table 5 – Service User to Staff Actual Assaults by Harm 2020/21

7.10 The moderate/severe harm incidents as a percentage of total incidents per annum has increased from 2.6% in 2020/21 to 3.5% in 2021/22 giving an increase of 35% in moderate/severe harm incidents staff have experienced. (Table 6 - Service User to Staff Actual Assaults by Harm 2020/21 – 2021/22).

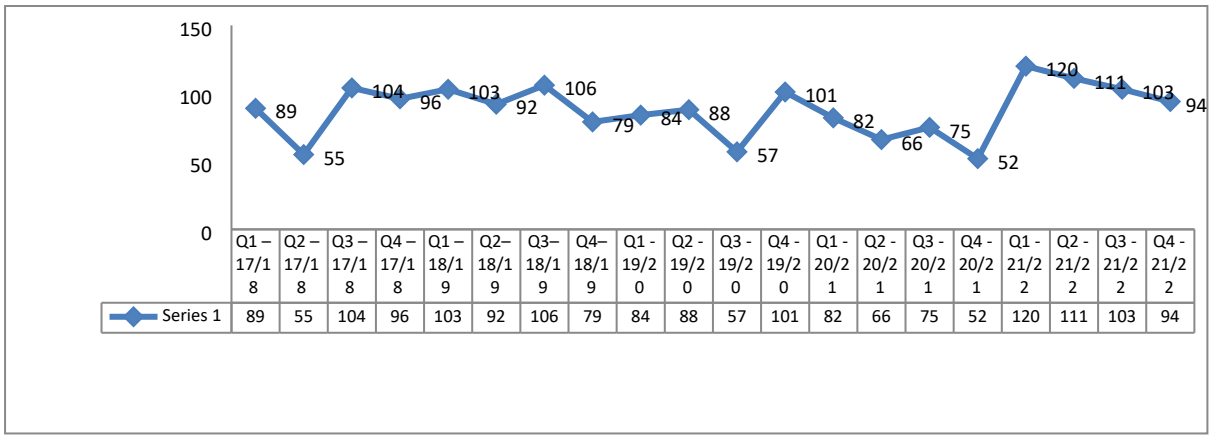
	2020/22	**2021/22**
Mod/Sev Harm	**32**	**45**
Incidents	**1269**	**1415**
% of incidents	**2.6%**	**3.5%**
Overall Reduction		**35%**

Table 6 – Service User to Staff Actual Assaults by Harm 2019/20 - 2020/21

7.11 Following the number of service user to service user assaults continuing to reduce year on year from 2018 to 2020/21, there has been an increase to 428 in 2021/22 (graph 10 and broken down by quarter in graph 11).



Graph 10: Service User to Service user Assaults 2017 – 2021.



Graph 11 Service user to service user assaults: Q1 17/18 to Q4 21/22.

7.12 The Annual Plan sets a target for reducing those that resulted in moderate or severe harm so that people would not be discouraged from reporting. Overall, 2.1% of service user to service user actual assaults involved moderate / severe harm. Overall, there was an increase of four to nine incidents from 2020/21 to 2021/22. (Table 7).

Trust Wide	**2020/21**	**2021/22**
No Harm	177	270
Low Harm	94	149
Moderate Harm	**4**	**8**
Severe Harm	**0**	**1**
Total	**275**	**428**

Table 7: Service User to Service User Actual Assaults by Harm 2019 to 2020

7.13 Compared to the previous year's data there has been a 62% decrease in moderate harm incidents involving service user on service users assaults with no severe harm incidents compared to 2019/20).

	2020/21	**2021/22**
Mod/Sev Harm	**4**	**9**
Incidents	**275**	**428**
% of incidents	**1.5%**	**2.1%**
Overall Increase		**40%**

Table 8 – Service User to Staff Actual Assaults by Harm 2020/21 - 2021/22

8 Harm free physical healthcare

8.1 The Safety Thermometer data analysis shows:

- Pressure Ulcers - There were 17 recorded pressure ulcers, all category 2, the majority were recorded as old pressure ulcers, defined as being a pressure ulcer that was present when the service user came into our care, or developed within 72 hours of admission, there were 4 recorded new pressure ulcer developed 72 hours (3 days) or more after admission
- Falls – There were 42 recorded falls, the majority of which were no or low harm, 4 were recorded as moderate harm
- Urinary Tract Infections (UTIs) - there were 11 UTIs.
- Catheters – there were 19 recorded cases where a urinary catheter was in place during the last 72 hours (3 days)
- Venous Thromboembolism (VTE) – there were 22 recorded cases of service users being treated with VTE prophylaxis for old pulmonary embolisms or deep vein thrombosis 13 of these cases were new.

8.2 The Trust continues to have a zero-tolerance approach to avoidable pressure ulcers. There have been no category 3 or 4 pressure ulcers acquired whilst in Trust care in 2021/22.

8.3 Category 1 pressure ulcers are non-blanching discoloration of intact skin. The number of category 1 pressure ulcers acquired whilst in Trust care has risen from five in 2020/21 to 11 in 2021/22. This demonstrates early identification and action to prevent further damage.

8.4 The number of category 2 pressure ulcers acquired whilst in Trust care has stayed the same at 10 in 2020/21 and 2021/22. The reporting of these pressure ulcers has changed, potentially erroneously, with the majority now described as device related in 2021/22 but without evidence of the device responsible in the narrative. This is being investigated as both a training and a reporting issue. It is reflective of the absence of a trust tissue viability nurse to review each case and update the relevant documentation.

8.5 Despite several recruitment campaigns the Tissue Viability Nurse has been vacant for the financial year. Further recruitment is planned with the role now funded full time. Service users reported to have pressure ulcers have been reviewed by the tissue viability support worker and advice given on care. Training for preceptorship nurses has been continued by the physical health nurse, supported by the safer care team.

	2020/21	2021/22
Category 1 Device Related Pressure Ulcer (Acquired whilst in HPFT Care)	3	6
Category 1 Device Related Pressure Ulcer (Acquired outside in HPFT Care)		1
Category 2 Device Related Pressure Ulcer (Acquired outside HPFT Care)	0	4
Category 2 Device Related Pressure Ulcer (Acquired whilst in HPFT Care)		9

Category 1 pressure ulcer (Acquired outside HPFT care)	0	0
Category 1 pressure ulcer (Acquired whilst in HPFT care)	2	1
Category 2 pressure ulcer (Acquired outside HPFT care)	3	1
Category 2 pressure ulcer (Acquired whilst in HPFT care)	10	1
Category 3 pressure ulcer (Acquired outside HPFT care)	1	1
Category 3 pressure ulcer (Acquired whilst in HPFT care)	0	0
Total	19	24

Table 9: Pressure ulcers by category

8.6 The falls in older adults are 15% lower compared with 2019/20, as detailed in Table 10. Table 11 provides details of the sub categories.

Table 10: Falls by year by SBU

Service User Falls	2019/2020	2020/2021	2021/2022	Total	3 year average
East and North Hertfordshire Strategic Business Unit	455	269	383	1107	369
Essex & IAPT SBU	8	7	6	21	7
Learning Disabilities & Forensic Strategic Business Unit	103	99	126	328	109
West Hertfordshire Strategic Business Unit	51	61	87	199	66
Total	617	436	602	1655	551

Service user falls by sub category	2019/ 2020	2020/ 2021	2021/ 2022	Total	3 year average
Service user fall from bed, chair or low surface	116	60	95	271	90
Service user fall from height or stairs	13	7	12	32	10
Service user fall from vehicle	1	1	1	3	1
Service user fall on same level	315	238	356	909	303
Service user suspected fall	172	130	138	440	146
Total	617	436	602	1655	551

Table 11: Falls by sub-category

8.7 There have been no reported cases of VTE related in-patient service user deaths. The planned systematic review of service user admissions to acute hospitals will identify preventable cases of VTE and subsequent learning.

8.8 The safety thermometer identified 11 cases of UTI and 19 recorded cases where a urinary catheter was in place during the preceding 72 hours (three days). The physical health team is linking with the ICS wide working party to reduce UTIs and resultant gram-negative blood stream infections.

9 Service Users Experience of Feeling Safe

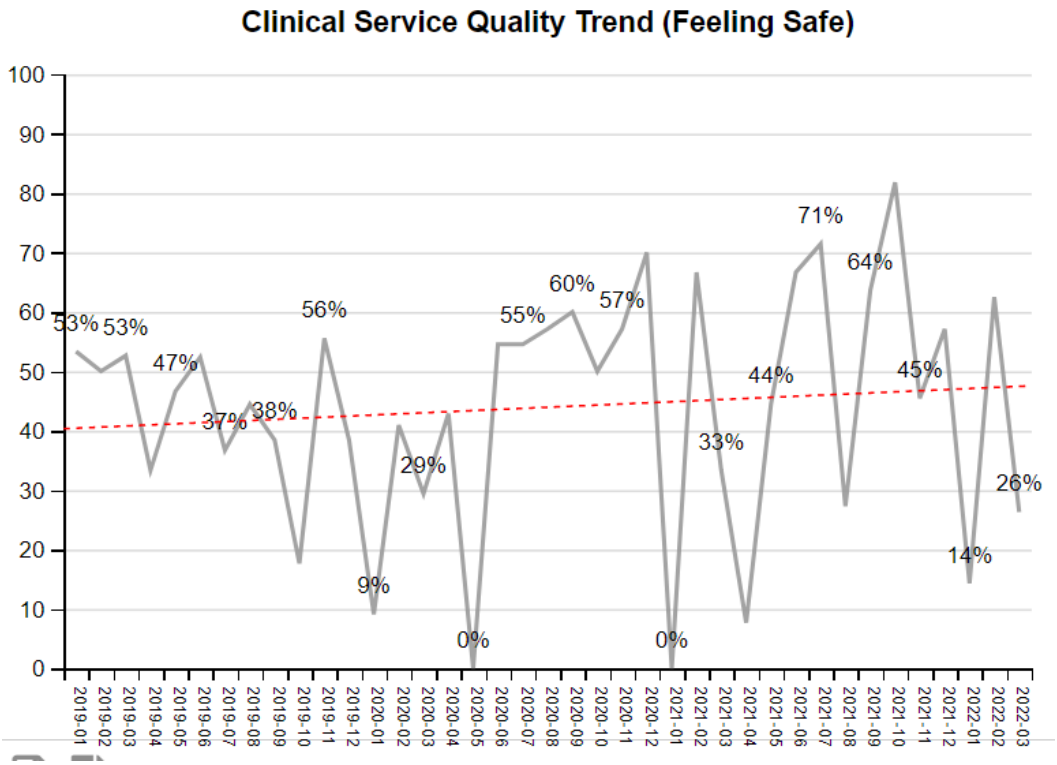
9.1 The feeling safe score Trust-wide was 77% compared to 85% in quarter 3 and the number of responses dropped to 93 compared to 150 in quarter 3. The feeling safe score Trust-wide was 83% (450 responses) in the year April 2021 – March 2022 compared to 77% (361 responses) in the previous year.

9.2 There was one survey received from Forest House in quarter 4, although the individual did not give feedback about feeling safe. The CAMHS Involvement Lead is now visiting the unit weekly and is encouraging young people to complete the surveys.

9.3 The feeling safe score for Acute 24/7 services was 76% (74 responses) compared to 86% (110 responses) in the previous quarter. Of particular note, Robin ward returned 62 surveys in quarter 3 and scored 77% for feeling safe. The Experience Team will continue to encourage staff to seek feedback from service users and carers on our wards.

9.4 There were 20 responses to the feeling safe question in the learning disability and forensic services compared to 40 in the previous quarter, with a score of 84% compared to 83%. Broadland Clinic and Warren Court scored 100% for feeling safe. Gainsford House scored 67% (3 responses), Hampden House 75% (5 responses) and The Beacon scored 0% (1 response).

9.5 The chart below shows the thematic emotional analysis for all comments given for Having Your Say and compliments for the last three years. Any comment given related to “safety” are mapped as a positive or negative comment.



9.6 There were 492 compliments received Trust wide compared to 439 in quarter 3; 19 compliments mentioned the word “safe”.

9.7 Nine complaints (compared to six in quarter 3) had the description of the concerns contained the word “safe”, “unsafe” or “safety”, of which seven were for the East and North SBU. In the last year, 25 complaints were received where the words “safe”, “unsafe”, or “safety” were used, compared to 12 in the previous year.

9.8 There were four PALS enquiries recorded (compared to 5 in quarter 3) relating to “safe”, “unsafe” or “safety” and 16 PALS enquiries where the words “safe”, “unsafe”, or “safety” were used, compared to 12 in the previous year.

9.9 The Experience and Involvement Teams have been recruiting more Experts by Experience and planning the Peer Experience Listening “Post Incident Support” project for Medium Secure Services. The team is also working with older peoples’ services on the Peer Observation Project, looking at the actions proposed from Phase 1 and ensuring those have been completed before moving to phase 2. This project is understanding how safe people feel in older inpatient units, particularly those service users who have dementia and may not be able to communicate their feedback.

10 Health, Safety and Security

10.1 The Memorandum of Understanding with the police has been updated by a working group of Trust and Hertfordshire Constabulary staff and is now called the Joint Working Protocol. This has been approved and is ready to be relaunched in quarter one.

10.2 It was felt the previous Respect poster regarding abuse towards staff did not give a strong enough message. A range of new posters have been developed and distributed for display in inpatients and community hubs. Police have provided their own version of the poster that can be used in any setting.

10.3 Kingfisher Court alarm pagers have been decentralised and are now based on the wards. This is audited monthly to ensure the alarms are being used correctly. Changes were made to the crash response system to reduce false ‘crash’ calls and this has worked well. Estates and Health and Safety Team are currently reviewing the contract with the supplier (Stanley) as it is due for renewal this year.

10.4 The use of CCTV has been approved and provided in both inpatients areas and community hubs covering communal areas. Phase one now almost complete which included Warren Court and Albany Lodge. Phase 2 will commence in Quarter 1 covering Victoria Court, Astley Court, Dove Ward, Beech Ward and 4 Bowlers Green.

10.5 From 1 April 2021 to 31 March 2022, the Trust received 12 new claims with Health and Safety implications, an increase from nine new related claims received in the previous financial year. Nine of the new claims related to assaults by service users on staff, and three related to personal accidents in which staff members/contractors were injured. Liability has been denied in nine of these claims, admissions have been made in one and the remaining two are under investigation.

10.6 11 Health and Safety related claims were settled between 1 April 2020 and 31 March 2021 at a cost of £73,070. This was an increase from the previous year of £21,129. The Trust successfully defended seven of these claims.

10.7 All claims are scrutinised to ensure any learning can be taken forward. In this reporting period, the Trust's Health and Safety Team have developed investigation template forms for managers to complete following slip/trip/fall incidents and violence and aggression incidents; these forms will further strengthen the incident review process and assist with the investigation of claims at an early stage.

10.8 Human Resources and the Legal Services Lead have begun meeting regularly to discuss Employment Tribunal claims and Staff claims which may overlap, in order to share information, ensure a consistent approach, and settle claims more efficiently under one process (where applicable). This collaborative approach has led to the Trust defending a claim for personal injury brought by a staff member who had been dismissed from the Trust due to fraud.

10.9 59 incidents have been reported under the RIDDOR regulations during 2021/22, an increase from 28 RIDDOR reported in 2020/21. Improved scrutiny of incidents and awareness of RIDDOR reporting has contributed to this increase. There have been four incidents involving two staff members being injured requiring reporting under RIDDOR.

10.10 51 RIDDOR incidents have been as a result of violence and aggression towards staff. Five incidents have been as a result of a slip, trip or fall and three occurred during Physical Intervention training, as detailed in chart 5.

	E&N SBU	Essex & IAPT SBU	LD&F SBU	Corporate Services	WSBU	Total
21/22 Q1	4	5	2	0	1	12
21/22 Q2	0	6	7	0	2	15
21/22 Q3	4	2	7	2	4	19
21/22 Q4	2	0	10	0	1	13
Total	10	13	26	2	8	59

Chart 5 RIDDOR reports by Financial quarter and SBU

10.11 12 RIDDORs reported within inpatient services, with 11 related to incidents of violence and aggression, nine of which occurred in Learning Disability and Forensic. There were three specified injuries, two involved concussion/bleed to brain and one was a fractured wrist following a slip on a recently mopped floor, this is being followed up by Estates and Facilities with Mitie.

10.12 An investigation form was introduced to assist staff in reviewing all RIDDOR incidents and services are gradually engaging and using the new form.

10.13 There have been 104 personal accidents to staff in 2021/22 of which 26 have been in this quarter.

	Moving and handling	Needle stick injury	Slip fall or trip	Total
21/22 Q1	2	3	8	25
21/22 Q2	6	3	4	27
21/22 Q3	1	3	10	26
21/22 Q4	1	2	12	26
Total	10	11	34	104

10.14 There have been ten incidents in relation to moving and handing for the year 2021/22, one in quarter 4 involving the moving and handling of a service user in Inpatient services. The Moving and Handling Advisor follows up all moving and handling incidents.

10.15 The Trust recorded 34 staff and visitor slips, trips and fall incidents in 2021/22

10.16 12 incidents were reported, 11 in inpatient services. The majority occurred on the same level. One incident has been reported under RIDDOR. This involved a staff member slipping on a recently mopped floor, Estates and Facilities are currently investigating this incident in conjunction with Mitie.

10.17 The slips and trips in 2021/22 occurred due to various reasons ranging from poor lit areas, trips over furniture and open drawers, uneven ground and wet floors. There have been five incidents whereby staff have slipped on floors that have just been mopped, this has been discussed with Estates and Facilities who have indicated there are issues with using the trolley system in some areas either because of safety or size of the area being cleaned, meaning that a 50 /50 mopping regime cannot be completed.

10.18 Security incidents are monitored by the Trust so that appropriate action can be taken. The most reported themes in 2021/22 were bringing in inappropriate items and a breach of security, as was seen in previous quarters.

	Discovery of inappropriate item/object on a ward/unit	Inappropriate item brought onto ward by member of public	Inappropriate item brought onto ward by service user		Inappropriate use/access to keys	Item lost/stolen from NHS property	Total
21/22 Q1	11	2	6	3		4	26
21/22 Q2	24	1	8	7		7	47
21/22 Q3	17	3	11	5		2	38
21/22 Q4	11	2	5	3		3	24
Total	63	8	30	18		16	135

10.19 Covid 19 impacted on all face-to-face training due to reduced class sizes. ECG continues to provide Moving and Handling training. The Moving and Handling advisor to start training and six other internal trainers to be pooled in to support training but yet to be utilised due to service pressures.

10.20 The Trust has implemented a Respect Training Recovery plan. Two trainers were seconded from services and funding has been secured for a further 6 full time RESPECT trainers through NMET. A 'Train the Trainer' course was successfully undertaken in Q3 and 5 trainers from services are now trained and are released from their role for an agreed number of hours each month.

10.21 3,195 (74.4%) people have completed their DSE training. 3,080 (71.7%) their risk assessment and of these 487 have been rated as high risk. Staff work with their managers to mitigate any risk assessment rated as high and a reminder to review the risk assessment is now sent to staff after three months. A significant number of staff are working from home and so the Trust has an agile working policy that allows managers

to assist staff at home with provision of workstation related furniture and equipment. Follow up emails are sent to individuals every fortnight to encourage them to complete all aspects of Cardinus Healthy Working training.

10.22 In March, chairs of SBU Health and Safety have been sent a list of staff compliance and asked to follow this up with their SLL and Teams. Refresher training and repeat of the risk assessment has been set at 2 yearly intervals, the first refreshers are due in May 2022.

10.23 The Trust has in place a new three-year contract for the supply and management of lone working devices with Peoplesafe which commenced in November 2020. This is a more advanced solution with a pendant device alongside with a mobile app. The contract has continued smoothly with a marked improvement in usage.

10.24 NHS England provides to the Trust an external Fit tester and have fit tested over 2.4k, 83% of staff the new range of masks, with a 77% pass rate. There remains a percentage of staff that have not passed on any mask and the Health and Safety team in process of getting reusable mask approved to be used in the Trust.

10.25 DHSC developed a set of resilience principles and performance measures that Trusts are asked to consider and implement to ensure FFP3 resilience. Tactical have made the decision to test and pass staff in inpatient settings on at least two masks.

10.26 Health and Safety Audits were piloted and launched in inpatient areas which are risk assessment based and are undertaken annually. The Health and Safety Team have worked with Team Leaders on an individual basis.

10.27 All Trust sites have up to date Fire Risk Assessments, held on individual sites as well as centrally within the Estates Department. The Trust's appointed Authorising Engineer for Fire will complete the annual audit and provide a detailed fire safety compliance report.

10.28 Full maintenance contracts covers all the Fire Engineering requirements for the Trust and is reported as to the agreed SLAs with the contractors. Fire evacuation reporting is captured centrally via the raising of a Datix, the form sent to Fire Safety Manager and filed in the Site Fire Log book. Managed by the Site Managers or the Service Line Lead for the buildings. Those logged are reported to the HS&SC.

10.29 An Asbestos Risk Register is in place, along with systems for the safe management of asbestos risk through the Trust's Asbestos Policy. Prior to the start of any new works or refurbishment projects, Registers are consulted, and Refurbishment and Demolition Surveys are completed if required. No issues have arisen from asbestos management surveys in the last quarter.

10.30 In order to prevent and control the risk of legionella, flushing of little used outlets (LOUs) is undertaken three times a week. Estates and Facilities have a tracker in place and all services complete returns and send them to Estates. This tracker is used as a report in both the IPCC and HS&SC meetings.

10.31 NHSE have further updated the COVID-19 waste management standard operating procedure to version 6, released in November 2021. It draws on the key principles of HTM 07-01 (Safe Management of Healthcare Waste) to ensure that systems are in place for waste to be managed in a safe manner and that critical waste disposal resources are not exhausted during the COVID-19 emergency response. The Trust is compliant with HTM-07-01 and continue to revise services where required to cater for the increase in demand for waste disposal.

10.32 External waste collection services have continued to be managed well with minimal disruptions due to the national HGV driver shortage issues. No escalation has been necessary to seek collection support from the national contingency hub.

10.33 The Trust's internal Food Safety audits are up to date and are conducted compliantly on a monthly and quarterly basis. The Trust also remains Commissioning for Quality and Innovation (CQUIN) compliant with its café and vending facilities, selling only CQUIN compliant products such as zero sugar carbonated drinks.

10.34 The Trust's menus have been reviewed and revised following the feedback from the initial role out, surveys and food safety groups. Unpopular dishes have been removed and new dishes have been introduced. There have been various supply issues throughout the year due to the pandemic, driver shortages and national production downturn which has been managed effectively by the Trust. Minor tweaks to fresh cook menus and packaging shortages of condiments, cereals and pasta have been communicated to all affected areas and suitable alternatives provided when required.

10.35 Natasha's Law came into force in October 2021 which the Trusts catering contractor is compliant with by detailing their allergens list for all fresh produce that is then packaged and sold on. All Environment Heath Officer (EHO) visits to inpatient units have been rated at 5* for Food Hygiene.

10.36 An Independent Health & Safety assurance audit was conducted in Q3 by Empathy Environmental Consultants Ltd on the Soft FM service provisions. Mitie were well prepared and provided lots of evidence to back up their answers to the audit questions. The consultant's report was most favourable and stated Mitie have provided excellent assurance and only minor recommendations were made to support best practise.

11 Conclusion

11.1 This section of the report has given an overview of 2021/22. It has considered incidents management and the types of incidents reported. This was followed by further detail relating to mortality, restrictive practice and harm free care both in mental health and physical health, health and safety and service users feeling safe.

PART C LEARNING FROM INCIDENTS AND CHANGING PRACTICE

1 Introduction

1.1 Learning from incidents, Serious Incidents, complaints, feedback 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 Improvements are made based of intelligence from many sources, including:

1. Incidents
2. Complaints
3. Claims
4. Freedom to speak up
5. National publications, such as prevention of future death reports, research, Clinical Alert System (CAS) alerts multiagency reviews and guidance.

1.3 The primary approach to improving safety is through continuous quality improvement and fostering a culture of safety. The processes and policies that are in place underpin and support this but are not meant to stifle individual action to make improvements when they are needed. This part of the report will therefore summarise some, but not all of the initiatives that have taken place in the year.

1.4 This section will detail the developments, in year, in terms of strategy and then consider each of the annual plan priorities in turn.

2 Strategy

2.1 The Trust's MOSStogether strategy enables us to deliver on the strategic objective - "we will provide safe services, so that people feel safe and are protected from avoidable harm". It aims to support this objective by ensuring the least restrictive practices are used, setting out how service users will feel safe across our services, and as a partner in their own care and treatment, enabling a positive experience. It also aims to support in the reduction of violence and aggression to both staff and services users, across all of our services.

2.2 The priorities of the MOSStogether Strategy are:

- To introduce the HOPE(s) Model, resulting in the least restrictive practice being used.
- To use the least restrictive practices, as a last resort, and as a safety intervention, considering alternative approaches to ensure safe care.
- To reduce the negative impact on service users and staff when restrictive practice is used.
- To involve service users in their recovery and care through shared decision making.
- To ensure this at practice is responsive to the changing needs of service users and services as well as best practice and the evidence base.

2.3 The strategy is monitored by the Restrictive Practice Committee. The implementation of the Restrictive Practice Committee has led to greater oversight and responsiveness, with representation from each of the Strategic Business Units (SBU). The Committee supports the actions detailed in the Annual Plan, including aiming to reduce both violence and aggression and ensuring the use of the least restrictive practice.

2.4 Notable Achievements this year are:

- The building of the first four safety suites in the Trust was completed and are in use and a further four are under construction. These much larger spaces enable the Human Rights of service users requiring seclusion or Long-Term Segregation to be upheld and include access to outside space and meaningful activities. The suites include separate living and sleeping areas and shower facilities, radio and TV and adjustable mood lighting
- In order to support increased compliance with the Trusts RESPECT training in prevention and management of violence and aggression, three full time trainers were seconded and five further staff from clinical services became RESPECT trainers and are released a set number of days per month to deliver training. Additional community venues are being utilised for the delivery of training to enable multiple sessions to be delivered concurrently. A further 6 RESPECT Trainer posts have been approved and are currently being recruited to, to further improve compliance with training
- AMatron from the Trusts learning disability services was seconded to the role of HOPE(s) National Model Specialist Practitioner to lead a system change to reduce long term segregation for people with a learning disability and autistic people across the region. The HOPE(S) model is an ambitious human rights-based approach to working with people in long term segregation, developed from research and clinical practice. In partnership with Mersey Care NHS Foundation Trust, NHS England and NHS Improvement are funding the model through the NHS-led Provider Collaboratives across England
- The DASA (Dynamic Appraisal of Situational Aggression), a structured violence risk assessment was introduced in Oak Ward and the Broadland Clinic to identify acute risk of patient aggression within 24 hours of the assessment
- Availability of live data to the service areas via a Patient Safety Dashboard, following the development of SPIKE 2, including the ability to monitor seclusions as they are reported through PARIS
- Refresh of the joint working protocol with Hertfordshire Police which supports a just culture between healthcare and the police for dealing with concerns around potential criminality in mental health settings.

2.5 The Trust has focused on developing a culture of safety over the last year. This has been delivered through approaching safety through collective ownership and leadership as well as a shared understanding and belief that safety is paramount. Some of the initiatives that have supported this approach are:

- The Trust appointed to the substantive post of Head of Safety and Patient Safety Specialist as per the requirements of the Patient Safety Strategy
- The Patient Safety Specialist provides dynamic, senior leadership and visibility whilst supporting the development of a patient safety culture, safety systems and improvement activity and networking with other Patient Safety Specialists. The post is also key in embedding learning from incidents into the clinical areas and in practice
- Over 50 members of staff have been trained in a systems-based approach of patient safety incidents investigation ahead of the transition to Patient Safety Incident Response Framework (PSIRF) in Summer 2022.

2.6 *Modules 1 and 2 of the Patient Safety Syllabus went live on Discovery* to support a transformation in patient safety. The syllabus is designed for all NHS staff and provides an understanding of safety and the approaches that will build safety for patients, reduce the risks created by systems and practices and develop a genuine culture of patient safety.

2.7 There was a significant reduction (over ¼) in incidents categorised as moderate/severe harm when compared to the previous year.

2.8 ANT technology continues to be used in ligature audits that ensure that risk in relation to ligature anchor points in ward environments is mitigated.
Action during quarter 3 and 4 to improve the use and ensure compliance of the Applied New Technologies (ANT) system for recording weekly ligature audits and to ensure audits are consistently completed in the weekly cycle.

2.9 SWARM enables a culture of openness, transparency and learning in a blame free environment. SWARM is a multidisciplinary forum which provides open support, guidance and feedback following serious incidents in order to learn from it and improve our service. SWARM creates an environment in which staff share information without fear of reprisal and integrate the reporting of safety issues into daily work.

2.10 Over the past year SWARMS have become embedded across the Trust. It is held as soon as possible after a service user safety incident and carried out in a blame-free environment and while the incident is still fresh in everyone's mind. The meeting gives frontline staff a chance to review the facts, discuss what happened, as well as how and why it happened. This helps the team build a more accurate picture of the organisational and human factors involved and allows staff to identify the key lessons and list actions which can be implemented immediately by the team. SWARM is identifying learning themes to be shared across the organisation, ensuring that our services are safe, and we learn from incidents. A rolling programme of SWARM facilitator training ensures that the Trust are able to be responsive and embed any learning soon after an incident occurs.

2.11 The use of Datix, the information technology system for managing incidents, has been developed in response to changing needs, for example COVID-19, and feedback, to strengthen its usefulness. In particular Datix Dashboards are more accessible at team level and recording of Prevention of Future Death reports are captured and the dissemination and actions are captured.

2.12 A comprehensive virtual monthly training programme has been developed s well as a Datix Training video which is on the Trust YouTube site. Following a successful pilot, the Patient Safety Dashboard on Spike has been rolled out across the Trust to enable managers to see at a glance, incidents within their teams and take and record appropriate actions in a timely manner.

2.13 As part of the Mental Health Delivery Plan 2019/20, CCGs were asked to fully establish a multi-agency suicide prevention plan bringing together local authority action plans and wider mental health transformation. This included an ambition for reducing inpatient suicides to zero. The Trust took the decision to include a commitment to reducing suicides by community service users and a Preventing Suicide within Mental Health Inpatient Settings and Community Services Action Plan was developed which continues to be implemented.

2.14 The Trust continues to work alongside key partners including Public Health, Samaritans, British Transport Police, Network Rail Hertfordshire Constabulary, HM Coroner for Hertfordshire, CGL, service user council and carers council and Spot the Signs to collaborate on reducing suicides in the population. The Trust has been part of three suspected suicide cluster responses this year working with partners to support local communities and prevent future suicides.

2.15 The joint partnership between Samaritans and the Trust for service users who may have recently left hospital, or those who are assessed as not requiring further follow up, but who may be in emotional distress will go live in Quarter 1 2022/23. Benefits include contact with someone who is prepared to listen and provide emotional support with no time constraints and a safe and confidential place to discuss feelings and explore support options, 365 days per year. This partnership will be complementary to our existing services and will provide an additional support option.

2.16 Key partners are invited to our Reflective Learning sessions to aid system wide learning In the past year this has included the Ambulance Service, the Fire Service, CCG colleagues, acute Trusts and other local Mental Health Trusts. Feedback on these sessions has been overwhelmingly positive.

2.17 The Trust is a key partner in implementation of Real Time Surveillance with system partners in Hertfordshire. The first phase was in place from quarter 4 2021/22 with further work being taken forward into 2022/23. This will enable early identification of a suspected suicide, and potential clusters where timely action can be taken, timely signposting to suicide bereavement support and monitoring and reporting of suicide data.

2.18 Dual Diagnosis protocol has been refreshed with CGL and work is being undertaken as part of community transformation around harm minimisation and improving joint working and communication.

2.19 The Trust's Simulation Hub has been developed to offer an interactive approach replicating real life situations to develop staff skills in risk assessment and risk management, Case scenarios have been co-produced to increase staff confidence in complex decision making. It's envisaged this facility will be made available to partner agencies going forward.

2.20 The Trust is working closely with colleagues on the Gold Coast, Australia to learn from their work around a zero-suicide ambition in tandem with embedding a just and learning culture.

2.21 Risk formulation refresher sessions have been delivered to teams Trust wide.

2.22 GPs are asked to provide summaries of contacts and medications to inform Serious Incident reviews. A copy of the serious incident reports are shared with GPs to support system wide learning and suicide prevention.

2.23 The management of high-risk service users is being reviewed and changes are being made to ensure that service users are identified and given the support needed. Risk formulation meetings occur in teams on a weekly basis.

2.24 The reduction in avoidable harm can be seen in terms of mental health and physical health, as set out in Part C. This year the focus has been on:

- Self-injurious behaviour- Work has continued with our services to reduce self-injurious behaviours. Search training has been delivered, however, on occasion service users have managed to bring items onto the ward which they have then used to self-harm. A pilot has been arranged for a new metal detector wand used during search that will show an image of the metal item that has been detected. Following an incident where a service user was able to tie a ligature to an internal sliding window pane in Kingfisher Court, immediate action was

taken to mitigate this risk. All windows at Kingfisher Court have now been replaced with newer model external sliding panes to mitigate this risk. The Trust are working with Surrey & Borders Trust to develop a cost-effective app to assess environmental risk regarding ligatures. The Trust are working with a neighbouring Trust to learn from a prosecution by the HSE following the deaths of service users in their inpatient services. A regional ligature forum has been established to share learning and innovation to reduce ligature risks. Headbanging continues to increase in both CAMHS, adult and learning disability services. This is mirrored in other Trusts and the Trust are part of national forum focusing on headbanging behaviour to look at how to manage this. Significant work was undertaken to ensure staff were able to manage the mental health and physical health implications of this

- Lone working Lone working devices received a major improvement this year as the Trust moved from the established supplier to the current industry leader Peoplesafe. This has been rolled out across the Trusts and currently 1100 staff have devices. Since the change compliance has improved and feedback from managers and staff has been positive however we are not complacent and continue to look at how we can increase compliance further. Usage is constantly monitored and as teams grow or new teams come on board, we ensure we have sufficient pendants for staff and new orders are placed if needed. Whilst staff await delivery of devices, they are able to use the Peoplesafe App on their phones
- Physical healthcare - There has been a strong focus on physical healthcare over the past year which will continue into next year. NEWS2 training continues to be rolled out and all substantive nurses have undertaken PEWS training. A task and finish group was set up to address the risks associated with Clozapine, particularly the risk of constipation following learning from serious incidents. Despite several recruitment campaigns the tissue viability nurse band 7 post has been vacant for the entire financial year. Further recruitment is planned with the role now funded full time. Training for preceptorship nurses has been continued by the physical health nurse, supported by the safer care team. Following a successful pilot of the Blue Box project which enables remote monitoring of service users vital sign which automatically uploads onto the service user's electronic patient record in older peoples community teams, this is being extended to older peoples and learning disability care homes. A smoking cessation team has been appointed which commences in quarter one to further develop smoking cessation for those within the Trusts inpatient services and those open to community teams
- Risk formulation- Simulation training programme on suicide risk commenced in quarter 3 2021/22 following pilot delivered monthly to front line teams by the Simulation faculty with a focus on risk formulation and safety planning. Lived experience in the development of case scenarios and through use of trained facilitators is integral to ensuring there is a carer and service user perspective in the delivery of our training. Learning from our serious incidents, SWARMs and SJRs is also integral to the development and delivery of the training programme.

2.25 The Restrictive Practice Committee has led to greater oversight and responsiveness in the aim of reducing both violence and aggression and the use of the least restrictive practice. The Committee is responsible for overseeing the implementation of the MOSStogether Strategy and supported implementation plan and monitors the reported incident data and practice regarding restrictive interventions.

2.26 Using the least restrictive practice is a complex and multi-faceted issue where progress in one area can have unintended consequences in another. The different types of

restrictive practice are considered together when understanding the outcome of any initiative in this area.

2.27 This year, the emphasis has been on implementing the MOSSTogether strategy and ensuring that shared decision making is a key factor in any practice and CQI projects that emerge. Key areas of work this year have been:

- The Eastern Academic Health Science Network CQI project focused on reducing restrictive practices at Astley Ct and all data collected is uploaded to Life QI. All sessions with other Trusts in thre region have been virtual up until now but a face to face session focusing on the project has been arranged in quarter 1
- Safety huddles- Safety Huddles are co-ordinated across the trust and owned within the service lines. In 2022/23 these will be fully embedded, and there will be a focus on service user safety huddles
- SafeWards- Each area has developed their own methodology, responding to the unique needs of their service users. For example, some have opted not to use safety crosses as this information can cause conflict or potential flash points, when service users read this information. This will be further monitored via the review of incident forms which now include the 10 Safewards Interventions. An audit of Safewards effectiveness is currently being undertaken by the PACE team
- Seclusion- Work has been undertaken in improving standards relating to seclusion practice. This has resulted in support, weekly seclusion audits and reviews in the PICU. An overarching seclusion audit has also been undertaken which highlights significant improvements in both policy and practice as a result of this work. The Trust, as part of its learning from seclusion audits, has incorporated the recording / monitoring of seclusion within the electronic patients record (PARIS). Four safety suites were opened in 2021. These state-of-the-art suites enable service users who require seclusion or long-term segregation a more positive experience in a calm spacious environment whilst ensuring their human rights are met. Four further safety suites will be operational in quarter 2 2022/23
- Use of Force In December 2021 the government released final guidance regarding the Mental Health Units (Use of Force Act) 2018. The act came into force on 31st March 2022 and applies to England only. The act sets out measures which are needed to both reduce the use of force and ensure accountability and transparency about the use of force in mental health units. A task and finish group was commissioned by the Restrictive Practice Committee and actions have been taken to ensure the Trust are compliant with the act.

3 We will target activities to reduce violence against services users and staff

3.1 Work is continuing as part of the Trusts commitment in its annual plan to reduce harm from violence and aggression incidents.

3.2 The Police Liaison Safety and Security Committee has been refreshed and the memorandum of understanding between healthcare and the police for dealing with concerns around potential criminality in mental health settings has been rewritten and will undergo a join launch with police in quarter 1.

3.3 Following the decision by the police to remove the PCSO attached to Kingsley Green in 2021, the police have now reinstated this post to assist in the prevention of criminal activity, improve crime reporting and support to staff and service users who have been victims of criminal activity going through court procedures.

3.4 The Sexual Safety group reformed this year to oversee all work related to sexual safety of services users and staff in Trust services. This is covered in the Annual Safeguarding Report.

3.5 CCTV has been installed in communal areas in Albany Lodge and Warren Ct this year and phase 2 will continue in 2022/23 with the introduction of CCTV in Elizabeth Ct, Oak and Beech Ward, 4 Bowlers Green Low Secure Unit, Broadlands's clinic. This will assist in keeping both staff and service users' safety.

3.6 The primary work in relation to the violence and aggression is part of the work detailed in the restrictive practice section. In addition to this the Trust has a range of posters was launched for display in inpatient and community staff giving a strong message that we do not accept physical, racial, or verbal abuse of staff and reminding everyone we are a values-based organisation.

3.7 The Patient Safety Syllabus Module 1 including Just Culture training from HEE went live on Dicovery and is mandatory for all staff. Compliance reporting by learning and development commences in quarter 1.

3.8 Work has been undertaken in response to the learning from previous quarters with particular focus on racial abuse, violence and aggression, sexual safety, and restrictive practice.

3.9 There has been a focus in improving sexual safety within our inpatient units this quarter with regular meetings and development of a sexual safety work plan.

3.10 Work has taken place with commissioners and the Provider Collaborative to ensure that people admitted for assessment and treatment appropriately and discharge pathways agreed on admission.

3.11 The Enhanced Risk Assessment (ERA) and Enhanced Risk Assessment Team went live, An ERA is a framework to capture and formulate risk to enable a management plan to be developed. A minority of service users may pose a risk to others. The ERA Team helps the Trust to understand and manage potential risks at the earliest opportunity and so increase the safety of service users, their families, friends and carers, wider society, and colleagues.

3.12 Changes were made to the case note section of the Trusts Electronic Patient Record to allow clinicians to view and immediately note actions related to changes in risk without having to open a new Risk Assessment care document. This change was made to make service users safer by enabling visibility of risk assessment / management in the case note view. It has helped clinicians to continuously assess, evaluate and record management of risk as part of routine work, rather than as an additional, separate task.

4 Conclusion

4.1 The Trust is committed to improving the safety culture going into 2022/23 as well as the experience and safe care of our service users.

4.2 Continuous quality improvement methodology has been used to address areas of concern that are highlighted by incidents and complaints. This section has highlighted a small selection of these initiatives.

PART D- Conclusion and Priorities for 2022/23

1. Conclusion

1.1. This report has given an overview of the governance and assurance in relation to safety. It then gave an account of the incidents and position in relation to delivering harm free care in both mental health and physical health. The report concludes with some of the key areas of work that have been taken forward in the year.

1.2. This year progress has been made in learning from incidents , risk formulation and reducing the deaths that are thought to have been through suicide. The mortality governance processes have been strengthened and, as a result, additional learning and action has been taken to strengthen how the Trust delivers physical healthcare.

2. Priorities for 2022/23

2.1. Building on the work this year a number of priorities have been set. These have taken into account national and local drivers, including learning from incidents. In summary these are:

- **Annual Plan**
  - Continue our drive to prevent suicides
  - Reduce avoidable harm experienced by service users and staff
  - Ensure our service users and staff feel safe
  - Ensure the least restrictive practice is appropriately used to support service user recovery
- **Strategy**
  - Continue with the priorities set out in the Quality Strategy and Making our Services Safer Together (MOSS 2gether) as detailed in Part A of this report with its focus on Just and learning culture, safety culture and providing safe care in top quality environments
  - CQI methodology is embedded in the Trust when considering safety.
- **Governance**
  - Further improvements and embedding of the Patient Safety Dashboard on Spike 2
  - Improve the timeliness of completing investigations and reporting on action plans
  - Move from RCA approach towards a systems-based approach to patient safety incidents investigation in quarter 2
  - Transition from STEiS and NRLS recording of safety incidents to LFPSE (Learn from patient safety events service) by quarter 4 to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment
  - Systematically join up and build on learning from serious incidents, triangulating with other intelligence such as complaints, freedom to speak up and national safety notices.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 9b
Subject:	Quarter 4 Safer Staffing Report	**For Publication:** Yes
Author:	Jinu Joseph, eRoster SafeCare Lead	**Approved by** Bina Jumnoodoo, Deputy Director of Quality and Safety
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

This paper is presented to the Board of Directors to give assurance in relation to Safer staffing requirements for 2021/22

Action required:

For Assurance: To appraise the Committee that controls, and assurances are in place.

Summary and recommendations to the Committee:

This report informs the Board of Directors with a quarter 4 2021/22 update on the safe staffing across all SBUs within the Trust.
There has been a significant increase in staffing levels across services, owing to the increased acuity and complexity and the number of prescribed safe and supportive observations. During this quarter, there was some evidence of scrutiny and escalation process of staffing across SBUs.
The avoidable costs have seen an increase in all the SBUs. Management of unused contracted hours are reasonably well across the services, with exception of Forest House and SRS. An increase of staff unavailability has been observed across SBUs and inpatients units recorded more than 40% on total unavailability.
The audit on Additional duties shows the most frequently used Additional Duty Reason which have been reviewed and reduced the number of additional duty reasons to 8 from 28.

This quarter has also seen an increase of bank and agency shifts and reported a total vacancy of Registered of 226.66WTE and Healthcare Assistants are 107.88 WTE.

Relationship with the Business Plan & Assurance Framework:

Relation to the Trust Risk Register:
Workforce: The Trust is unable to retain enough staff in key posts to be able to deliver safe services (Risk 657).
Workforce: The Trust is unable to recruit enough 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.
2. 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:

This report is primarily about staffing but also incorporate the financial implications

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

There are no implications arising from this report.

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
IGC 12 May 2022

Quarter 4 Safer Staffing Report

1. Introduction

1.1 This report provides assurance that Hertfordshire Partnership NHS University Foundation NHS Trust (the Trust) had safe nurse staffing levels across all inpatient services and appropriate systems in place to manage the demand. This report covers the reporting period for quarter 4 (January 2022 – March 2022)

1.2 This report serves to provide an analysis of safe staffing, financial ramifications and forecasting against bank and agency usage and e-rostering across the Trust.

1.3 The Trust is required to consider staffing capacity and capability and to meet the National Quality Board (NQB) guidance, *'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing (2016)'*. The 2016 guidance provides a set of expectations for nursing and midwifery care staff, and an expectation that Trusts measure and improve patient outcomes, people productivity and financial sustainability.

2. Trust's expectation

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

2.2 Where the skill-mix and the number of staff who 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. If a shift remained unfilled, this is reported to the Heads of Nursing (HoN) and recorded as a safety incident on DATIX.

2.3 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 Clinical Matrons.

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

3. Summary of findings for nurse staffing data collection

3.1 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 the standalone units where CHPPD is high.

3.2 There are some inpatient services where the CHPPD is more than 120% for the period, both for Registered Nurses (RN) and for Healthcare Assistants (HCA), owing to the increase in service user acuity and prescribed safe and supportive observations.

3.3 There have been occasions where the CHPPD hours for the RNs have been below 80% and above 120%, as detailed in the data below. The HoNs are continuing to focus their weekly scrutiny meetings on ensuring close monitoring and management of the skill mix and staffing levels.

4. Safer staffing across the SBUs

4.1 West SBU.

During the quarter, there were reported challenges with ensuring staffing levels met the demand and acuity, considering prescribed safe and supportive observations, requiring Team Leaders, Clinical Matrons, and management to support.

There have been 72 reported incidents of staff shortages in the quarter, which is an increase of 21 incidents from the previous quarter.

Inpatient staffing levels are monitored and reviewed in the daily SBU Safe Staffing meetings and weekly Roster Scrutiny meetings.

Areas of concern:

- Acuity continues to be a challenge with increased numbers of staffing on every shift in some service areas
- Complex cases in some service areas have resulted in longer stay and challenges with reducing staff numbers
- Delayed discharges have increased owing issues including housing, difficulties and securing appropriate placements
- Incidents of aggression on staff are high
- Staff under HR process.

Priorities for the next quarter:

- Increasing lateral flow devise (LFD) testing
- Staff wellbeing considering the incidents of aggression and acuity
- Sickness/absence management
- Scrutiny and focus on the eroster Key Performance Indicators (KPI) and the management of unfilled shifts
- Timely production of rosters
- Daily review of prescribed safe and supportive observations
- Reduction in incidents of aggression Continue focus on supervision and appraisals for all staff
- Recruitment of international nurses and targeted recruitment of graduate nurses.

4.2 East and North (E&N) SBU

There has been sustained high levels of acuity across all inpatient services. Violence and aggression remain a challenge and continual support was provided for an individual cared for under the Long-Term Segregation (LTS) framework.

The challenges at Forest House have remained a focus for the SBU, exacerbated by the staffing establishment with high levels of bank and agency staff.

Challenges with vacancies and ongoing HR investigations has also impacted on the MDT and leadership of the unit. Consequently, there remains an increased reliance on the use of bank and agency across all services to maintain quality and safety in the unit.

Victoria Court has experienced significant challenges with staffing owing to acuity levels and staffing sickness and is reflected on their Risk Register.

Work continues to pilot a rotational scheme across all services with support from the senior nurses and operational managers.

Areas of concern:

- Forest House and Victoria Court, with complexity and acuity
- Increase in violence and aggression
- Mandatory training – Level 5 Respect at Forest House

- Increase in bank and agency
- Level of vacancies and sickness.

Priorities:

- Forest House improvement and development
- Reduction in violence and aggression, particularly during personal care
- Engagement, ownership, and knowledge of Team Leaders regarding their budgets
- Staff supervision and appraisals
- RN recruitment.

4.3 Essex and IAPT

Acuity levels within the inpatient services and challenges with recruitment of RNs.
Levels of prescribed safe and supportive observations and staff sickness exacerbated challenges.
Senior nurses continue to meet three times a week to review the staffing across the services.
Bank and agency usage increased and reflected in the avoidable costs, attributed to high acuity and the inpatient service area reporting a COVID-19 outbreak.

Areas of concern:

- Recruitment to band 5 RNs
- Bank and Agency usage
- Violence and aggression – although reduced significantly from the previous quarter, a slight increase has been reported in months 2 and 3.

Priorities:

- RN international recruitment
- Partnership working with Social Care and Commissioners to ensure timely discharges
- Three times weekly review of staffing, with aim to safely reduce staffing numbers on shift
- Increase access to Student Nurse Associate (SNA) and attend the course
- Develop local NHS Programme in Essex in collaboration with partners to engage with future HCAs and RNs
- Develop local induction Learning Disability programme to support newly RNs in mental health
- Ongoing Recruitment Advertising and Quarterly Recruitment Events for 2022/23.

4.4 Learning Disability and Forensic (LD&F) SBU

- Ongoing challenges with acuity and recruitment of RNs, particularly in Norfolk.
- Increase to MSU staffing establishment paper has been approved by Exec. Recruitment to these posts is out and request for e-roster to be updated.
- An increase in agency usage across the SBU with staffing shortages due to number of enhanced observations and covid outbreaks.
- High levels of prescribed safe and supportive observations and acuity in the inpatient service areas and an increased need for Team Leaders and Clinical Matrons stepping into the numbers.
- Exceptional support throughout the SBU remains with regular redeployment via daily SafeCare call
- Additional duties across the SBU remain high. Hotspots are Broadland Clinic, Dove and The Beacon.
- The Beacon 3 bedded house has been unused for some time now due to the success of EROS and stepdown is not indicated as a need. In order to support the acute pathway, we

are trialling the house reopening for a month which will now be staffed 24/7 and will require an additional HCA at night. Although pilot has ended the house remains being staffed 24/7 so will need to review establishment. This is due to come to CMM in April

- SBU CQI project focusing on violence and aggression, restrictive practice and enhanced observations to commence Q1 with initial focus on Dove.
- We have sadly lost a service user from SRS in the beginning of April so we are working with commissioners and official solicitor with consideration of consolidating the bungalows to enable more effective management of staffing resources and therefore improve the care provided.

Areas of concern:

- Safe and supportive observation levels and additional duties
- Provision of face-to-face training
- Level of reported incidents:
- High fill rates in the inpatient service areas.

Priorities:

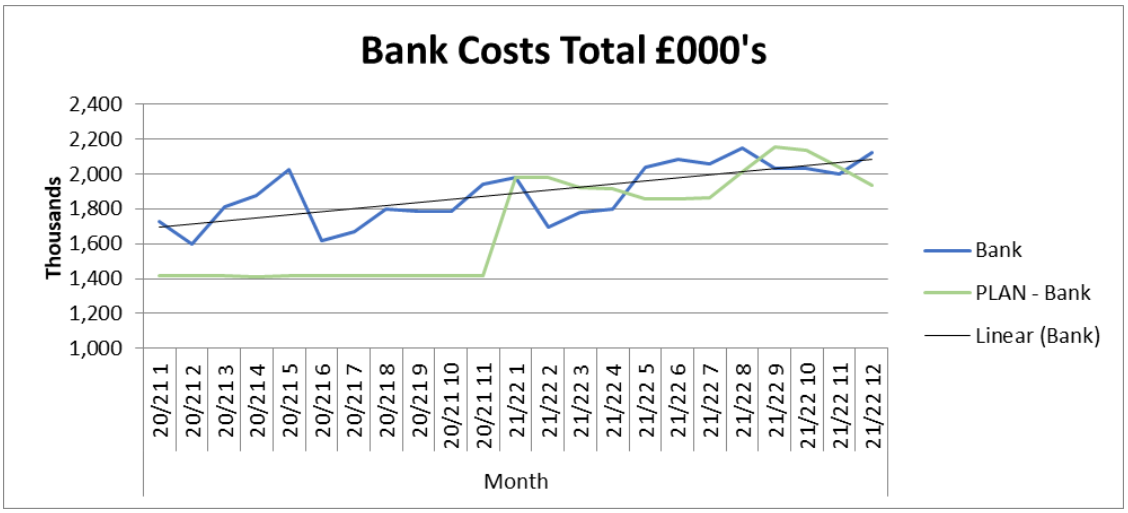
- Compliance with Safecare Census
- Recruitment of RNs
- Productivity of the SBU's monthly Safer Staffing meeting
- Safer staffing and vacancies
- Retainment of Learning Disability student nurses on qualifying.
  O

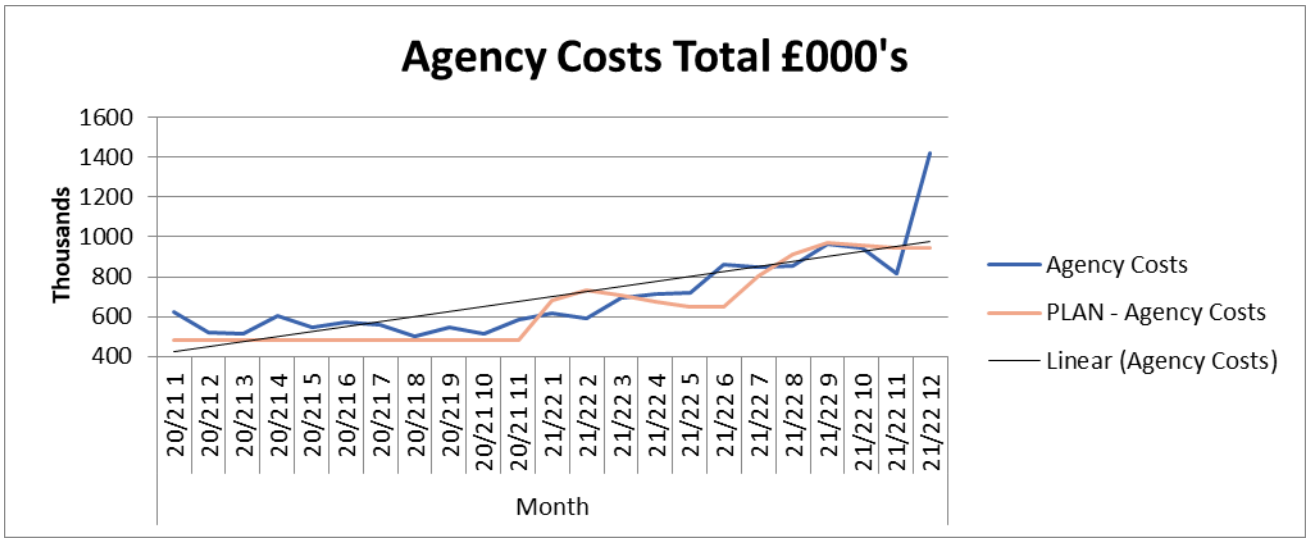
5. Finance

5.1 Pay spend has averaged at c. £16.5m per month following the pay award and represents 65-75% of the Trust's total monthly expenditure. There has been, and continues to be, substantial investment into new and expanded services within the Trust.

5.2 Over the last 24 months' pay spend has steadily increased. Both bank and agency usage has increased owing to the increasing demand and acuity. Work continues to ensure that this usage of temporary staffing represents the most efficient use of resources.

5.3 The graphs below provide a comparison between planned changes in temporary staffing and actuals over the previous 24 months.





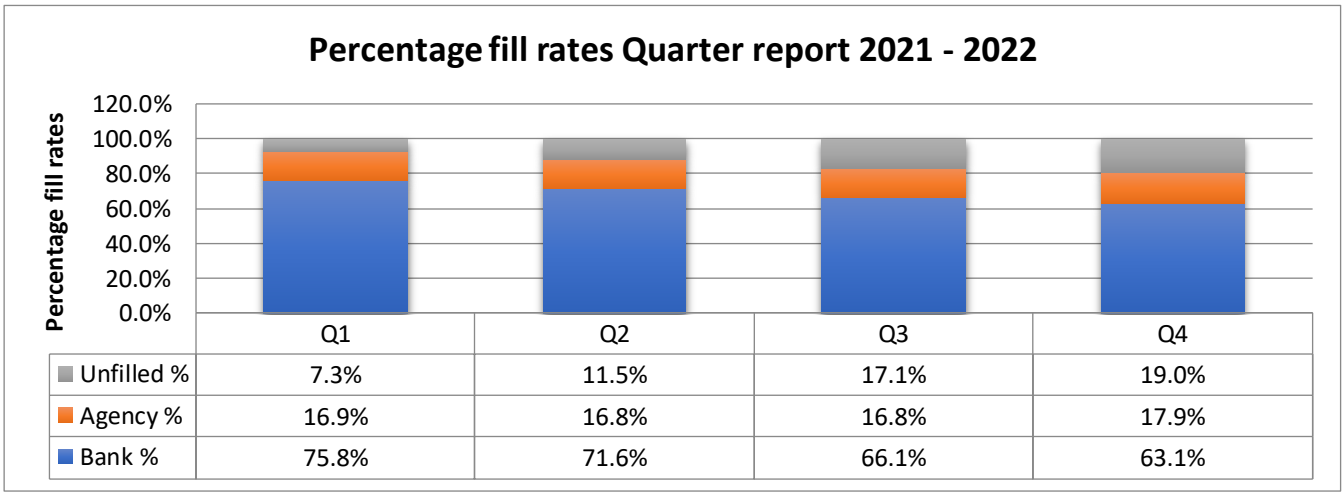
5.4 Quarter 1 2022/23 focus:

- Scrutiny of e-roster shift patterns and the number of staff on shift being appropriate for the acuity of service users to continually be challenged through the weekly scrutiny meetings
- Reporting of hotspot areas of bank and agency usage to individual SBU Safer Staffing meetings
- Ensuring all substantive staff have their hours allocated before any bank or agency use
- Ensuring any owed hours by substantive staff are used before any bank or agency use
- Annual leave planned and covered within substantive staff before any bank or agency usage
- Agreed levels of observations are covered within the approved establishment before bank and agency usage
- All recruitment translates to reductions in bank and agency, including the cancellation of future rostered bank and agency shifts following recruitment
- Budget levels for inpatient wards reviewed to ensure appropriate levels and this will be reflected in the 2022/23 budgets.

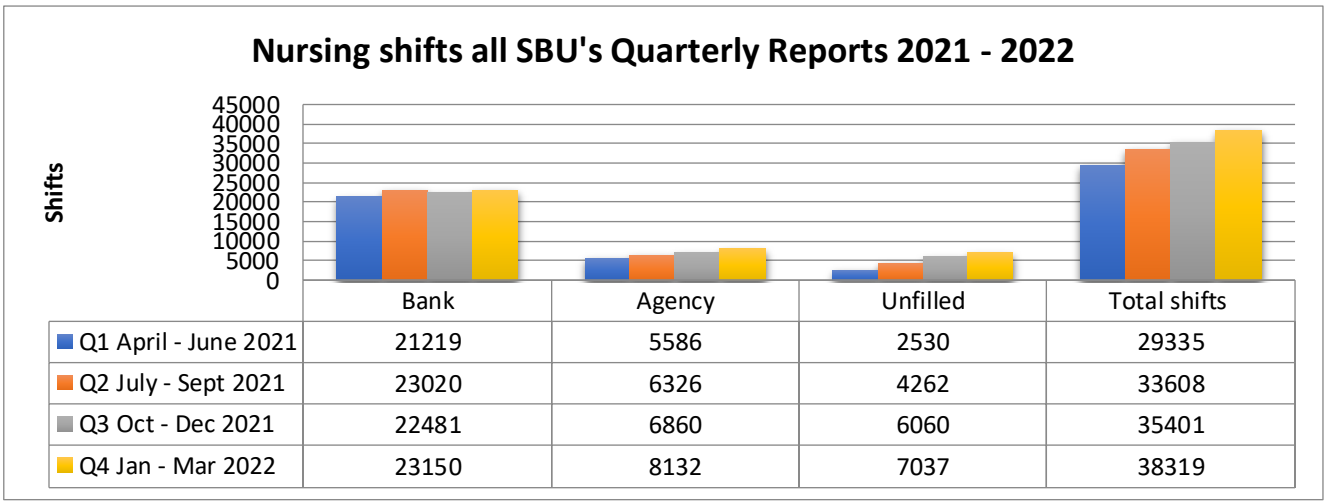
5.5 Future recruitment, and its relationship with current bank and agency usage, needs to be clearly aligned. The development of reporting requirements at individual SBU Safer Staffing will continue to progress to identify the most appropriate and accessible information. This will look to inform hotspot areas for future focus and the reasons listed for the bank and agency use. Using e-Roster as an enabler for a number of Delivering Value schemes and to be able to report on the efficient deployment of staff will need to be a key focus during 2022/23.

6. Bank and agency

6.1 The graphs below show the percentage fill rates for all requested shifts and the nursing shifts respectively.



	Q1	Q2	Q3	Q4
Unfilled %	7.3%	11.5%	17.1%	19.0%
Agency %	16.9%	16.8%	16.8%	17.9%
Bank %	75.8%	71.6%	66.1%	63.1%



	Bank	Agency	Unfilled	Total shifts
Q1 April - June 2021	21219	5586	2530	29335
Q2 July - Sept 2021	23020	6326	4262	33608
Q3 Oct - Dec 2021	22481	6860	6060	35401
Q4 Jan - Mar 2022	23150	8132	7037	38319

6.2 Bank shifts for all nursing areas have increased by 669 shifts overall, and agency by 1,272 shifts. Unfilled or not authorised to go to agency has increased by 977 shifts. Bank nursing hours over the last quarter were 216,351.81, which equates to 1,331.39 WTE; agency nursing hours were 84,879.66, equating to 522.33 WTE.

6.3 Lost contracted hours are checked weekly, monitoring any staff booked for bank shifts if they have not met their contractual hours and agency approvals made once all staff are assigned their hours. There were 14 shifts reported where temporary staff failed to attend for the booked shifts. All DNAs are reported, recorded, and monitored and action taken with individuals not returning if they have DNA for three consecutive shifts.

7. Recruitment and retention

7.1 The HoNs, HR business Partner, Service Line Lead, Finance Business Partner, and support from the eroster and SafeCare lead have continued to review the inpatient establishment to ascertain if the existing establishment meet the needs of the service delivery and review skills mix rather than recruiting like for like.

7.2 A focus on recruiting all newly qualified RNs has progressed and changes to the placement management to be held by the Trust in place of the University will help to ensure a smooth transition for individuals form student nursing to a RN in the Trust.

7.3 To support retention, career progression pathways have been developed for bands 2 to 3 and bands 5 to 6. Plans are in place to recruit to new Nurse Consultants, which will further enhance the career progression for clinical nursing roles.

8. Future planning

8.1 All SBUs will continue providing assurance to the committee on safer staffing through the weekly, monthly, and quarterly reporting system.

8.2 There are key actions as a focus in the next quarter, in consideration of the key headlines provided in this report:

- All SBUs to participate in CQI project of Safer Wards and the management of violence and aggression
- The process of reviewing the eRostering processes to review the staff onboarding process
- An increased focus on establishment reviews and further analysis of CHPPD hours
- To implement the Team based rostering across all inpatient services.

APPENDIX 1

Jan 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	99%	121%	-	-	98%	130%	-	-
	Hampden House	95%	114%	-	-	98%	113%	-	-
	Astley Court	61%	161%	-	-	95%	121%	-	-
	Warren Court	91%	86%	-	100%	87%	106%	100%	-
	4 Bowlers Green	80%	87%	-	-	100%	101%	-	-
	Beech	114%	95%	-	-	101%	107%	-	-
	Dove	90%	127%	-	-	71%	179%	-	-
	The Beacon	100%	152%	100%	-	100%	308%	100%	-
	Broadland Clinic	103%	108%	100%	-	110%	144%	100%	-
	SRS	95%	83%	100%	100%	102%	98%	100%	100%
West	Albany Lodge	107%	173%	-	100%	120%	174%	-	100%
	Aston	106%	301%	100%	-	102%	269%	100%	-
	Swift	103%	163%	100%	-	96%	261%	100%	-
	Robin	201%	174%	-	-	118%	239%	-	-
	Owl	95%	143%	100%	100%	102%	168%	-	-
	Oak	81%	233%	-	-	83%	222%	-	-
	Thumbswood	151%	150%	-	-	137%	161%	-	-
Essex & IAPT	Lexden	94%	155%	100%	-	103%	123%	-	100%
East & North	Logandene	104%	115%	100%	-	84%	196%	100%	-
	Wren	86%	94%	-	-	88%	157%	-	-
	Lambourn Grove	108%	88%	100%	100%	97%	127%	100%	100%
	Seward Lodge	87%	98%	-	-	84%	155%	100%	-
	Forest House	138%	128%	-	100%	134%	193%	-	-
	Victoria Court	79%	100%	-	-	82%	111%	-	-

Feb 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	97%	102%	-	-	99%	100%	-	-
	Hampden House	98%	114%	-	-	96%	125%	-	-
	Astley Court	60%	137%	-	-	96%	110%	-	-
	Warren Court	95%	88%	100%	100%	79%	125%	100%	100%
	4 Bowlers Green	89%	84%	-	-	96%	98%	-	-
	Beech	111%	90%	-	-	101%	124%	-	-
	Dove	83%	135%	-	-	80%	168%	-	-
	The Beacon	102%	157%	-	100%	98%	301%	-	-
	Broadland Clinic	106%	105%	100%	100%	121%	144%	100%	-
	SRS	88%	91%	100%	100%	100%	105%	-	-
West	Albany Lodge	105%	171%	-	-	123%	153%	100%	100%
	Aston	97%	251%	100%	-	102%	254%	-	-
	Swift	113%	202%	100%	100%	93%	296%	-	-
	Robin	191%	222%	-	-	120%	297%	-	-
	Owl	104%	122%	100%	-	94%	137%	100%	-
	Oak	78%	203%	-	-	88%	219%	-	-
	Thumbswood	145%	87%	-	-	111%	149%	-	-
Essex & IAPT	Lexden	96%	173%	100%	-	98%	139%	-	100%
East & North	Logandene	96%	106%	100%	100%	95%	162%	100%	-
	Wren	87%	98%	-	-	99%	169%	-	-
	Lambourn Grove	108%	91%	100%	100%	100%	128%	100%	-
	Seward Lodge	87%	102%	100%	-	95%	151%	-	-
	Forest House	135%	167%	-	-	142%	247%	100%	-
	Victoria Court	97%	102%	-	-	88%	121%	-	-

Mar 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	100%	100%	-	-	100%	100%	-	-
	Hampden House	97%	111%	-	-	100%	100%	-	-
	Astley Court	52%	152%	-	-	98%	108%	-	-
	Warren Court	84%	97%	100%	100%	94%	127%	100%	100%
	4 Bowlers Green	80%	89%	-	-	100%	97%	-	-
	Beech	97%	83%	-	-	97%	126%	-	-
	Dove	89%	122%	-	-	89%	184%	-	-
	The Beacon	91%	157%	100%	-	95%	313%	100%	-
	Broadland Clinic	95%	96%	100%	100%	106%	144%	-	-
	SRS	93%	91%	100%	-	100%	100%	-	100%
West	Albany Lodge	124%	157%	-	100%	125%	207%	-	100%
	Aston	106%	247%	100%	-	110%	220%	-	-
	Swift	106%	157%	100%	-	96%	253%	-	-
	Robin	163%	256%	-	-	145%	279%	-	-
	Owl	95%	120%	100%	-	98%	150%	-	-
	Oak	84%	222%	-	-	96%	238%	-	-
	Thumbswood	154%	98%	-	-	100%	133%	-	-
Essex & IAPT	Lexden	94%	188%	100%	-	100%	154%	-	-
East & North	Logandene	85%	95%	100%	-	95%	134%	-	-
	Wren	97%	99%	-	-	95%	154%	-	-
	Lambourn Grove	106%	86%	-	-	95%	127%	100%	-
	Seward Lodge	97%	97%	-	-	97%	139%	-	-
	Forest House	150%	214%	-	100%	140%	274%	-	-
	Victoria Court	98%	102%	100%	-	97%	137%	100%	-

APPENDIX 2

January 2022

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex & IAPT	71.41	47.47	23.94	33.53%
Learning Disability & Forensic	212.01	162.8	49.21	23.21%
East & North	310.85	239.71	71.14	22.89%
West	310.75	235.58	75.17	24.19%
Total	938.05	712.36	225.69	24.06%
Unregistered Nursing				
Essex & IAPT	31.36	35.59	-4.23	-13.48%
Learning Disability & Forensic	193.23	158.69	34.54	17.88%
East & North SBU	244.74	187.76	56.98	23.28%
West SBU	173.35	138.55	34.8	20.07%
Total	644.68	521.59	123.09	19.09%

February 2022

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex & IAPT	72.41	49.85	22.56	31.15%
Learning Disability & Forensic	209.87	161.23	48.64	23.18%
East & North	312.05	240.11	71.94	23.05%
West	310.79	234.92	75.87	24.41%
Total	936.15	713.51	222.64	23.78%
Unregistered Nursing				
Essex & IAPT	33.36	34.41	-1.05	-3.16%
Learning Disability & Forensic	193.23	164.02	29.21	15.12%
East & North SBU	245.74	189.02	56.72	23.08%
West SBU	173.35	142.02	31.33	18.07%
Total	647.68	530.48	117.20	18.10%

March 2022

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex & IAPT	72.41	47.60	24.81	34.27%
Learning Disability & Forensic	209.87	161.26	48.61	23.16%
East & North	314.05	239.22	74.83	23.83%
West	310.49	232.08	78.41	25.25%
Total	937.85	709.96	227.89	24.30%
Unregistered Nursing				
Essex & IAPT	33.36	35.21	-1.85	-5.56%
Learning Disability & Forensic	193.23	165.05	28.18	14.58%
East & North SBU	246.74	196.05	50.69	20.54%
West SBU	173.35	142.49	30.86	17.80%
Total	647.68	539.80	107.88	16.66%

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 9c
Subject:	Experience of Care Report: Quarter 4	**For Publication:** Yes
Authors:	Lara Harwood, Experience Manager	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

This summary report provides the Board with information on feedback received from service users and carers, i.e. compliments, PALS contacts, complaints, Having Your Say and other local surveys including the Friends and Family Test, and other experience feedback during Quarter 4, 2021-22 and the period April 2021 to March 2022.

The report also provides information about the actions and learning from teams following feedback.

It provides assurance about how the Trust learns from feedback and uses this information to continuously improve services.

Action required:

The Board is requested to RECEIVE the report and note progress.

Summary and recommendations:

Summary

This report is bringing all feedback together with more information about learning and actions.

This summary report provides an overview of feedback: local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during quarter four 2021-22. Information is provided over time to help identify themes, trends and learning for the Trust. The report highlights the importance of services receiving feedback on the care and services they provide.

Overall, 12% of the HPFT caseload, service users and carers in our care in quarter four provided some form of feedback.

There was an increase in the number of compliments received in quarter four, 492 compared to 439 in quarter three, the majority of compliments received were for the Herts IAPT service.

1,254 local surveys were received in quarter four, an increase compared to quarter three (783) which was due to the introduction of SMS texting for the FFT question. The main theme of qualitative thematic analysis across the surveys was “emotional and physical support”. There was an increase in negative comments this quarter relating to “emotional and physical support”, “listening”, “waiting” and “feeling safe”.

During quarter four there was an increase in the number of complaints received (100 to 128) and there was an increase in the number of PALS (292 to 304) enquiries. During quarter four the Trust

received 128 formal complaints. The main themes of complaints remained unchanged as “care” and “assessment and treatment”.

Over the last year, April 2021 to March 2022 there were 2,060 compliments received, 3,296 FFT responses, 1,212 PALS contacts and 459 complaints.

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

Relation to the Trust Risk Register:

617 **CAMHS** – Failure to provide an efficient and effective CAMHS service which impacts on clinical care provided to you people.
773 **Adult Community –** Failure to respond effectively to demand in Adult Community impacting safety, quality and effectiveness – all sites
978 **Quality & 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:

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, innovate and transform** our services to provide the most effective, productive and high quality care

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

Financial implications with financial remedy recommended to acknowledge distress and inconvenience caused by failings in service delivery and complaints handling. Also claims for property that is lost while in the safe-keeping of the Trust.

Mandatory Friends and Family Test monthly submission to NHS England

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

The Trust must continue to learn from the lived experiences of those using HPFT services (NHS England Five Year Forward for Mental Health 2016), by working collaboratively with stakeholders, staff, service users and carers to ensure that we consistently deliver services that are representative of the people using services.

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

CQC Key Lines of Enquiry
Responsive R4 How are people’s concerns and complaints listened and responded to and used to improve the quality of care?

Seen by the following committee(s) on date:

Integrated Governance Committee 12 May 2022

Experience of Care Report – Annual Report and Quarter Four, 2021-22

1. Headlines for quarter four, 2021-22 and the year 2021-22

In quarter four we received:
492 compliments (439 in quarter three)
1,254 surveys (HYS, FFT, Attend Anywhere) - (783 in quarter three)
88% FFT Score (91% in quarter three)
304 PALS contacts (292 in quarter three)
128 complaints (100 in quarter three)
12% of the HPFT caseload provided feedback in quarter four

HPFT services had a caseload of 34,266 during Quarter 4

In 2021-22 we received:
2,060 compliments (1,321 in 2020-21)
3,296 surveys (2,442 in 2020-21)
1,212 PALS enquiries (932 in 2020-21)
459 complaints (342 in 2020-21 and 418 in 2019-2020)

She's the first person to actually listen to me, the first person who has made me feel heard and is the best care coordinator. She is friendly and understanding. She's a good listener and is fighting for me…

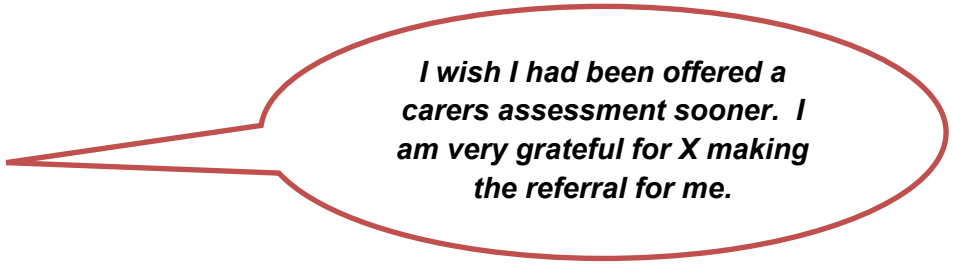
2. Key Performance Indicators and Strategic Objectives (Appendices 2 and 3)

77% service users feeling safe on adult and CYP inpatient units in quarter four – compared to 86% in quarter three
82% service users know how to get support and advice at a time of crisis in quarter four – compared to 87% in quarter three

91% service users have been involved as much as they want to be in discussions about their care in quarter four – compared to 87% in quarter three.
80% of carers feel valued by staff as a key partner in care planning in quarter four – compared to 68% in quarter three.
71% of service users and carers saying they were treated with trust values in quarter four
29 working days was the average number of days for a complaint response for those complaints received and responded to in quarter four (37 in quarter three).

What are the most significant changes when compared with the previous quarter or year?

- The number of surveys increased giving the highest percentage compared to caseload.
- The FFT score remained above target at 88%.
- An increase in service users who have been involved in discussions about their care.
- An increase in carers feeling valued as a key partner in care planning
- A 56% increase in compliments compared to the previous year.

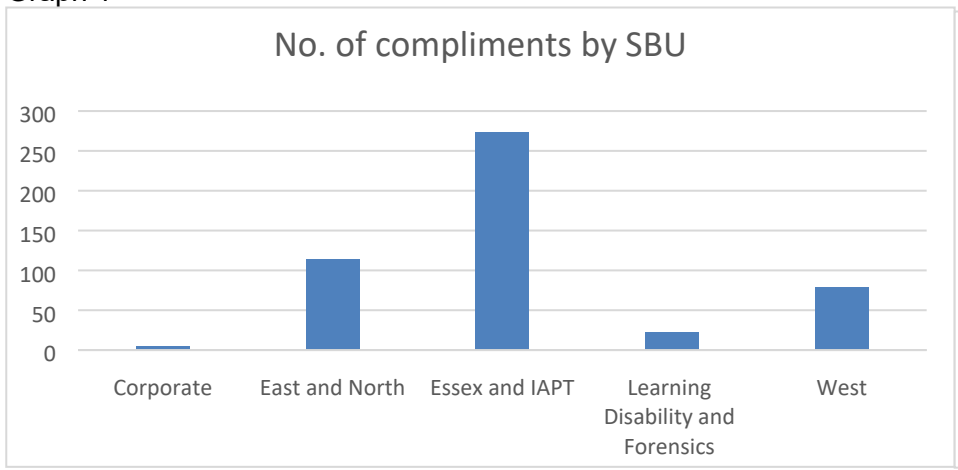


- The number of formal complaints increased.
- A 34% increase in complaints compared to the previous year (10% compared to 2019-20).
- Decrease in service users feeling safe on inpatient units.
- Decline in the number of surveys received from carers.

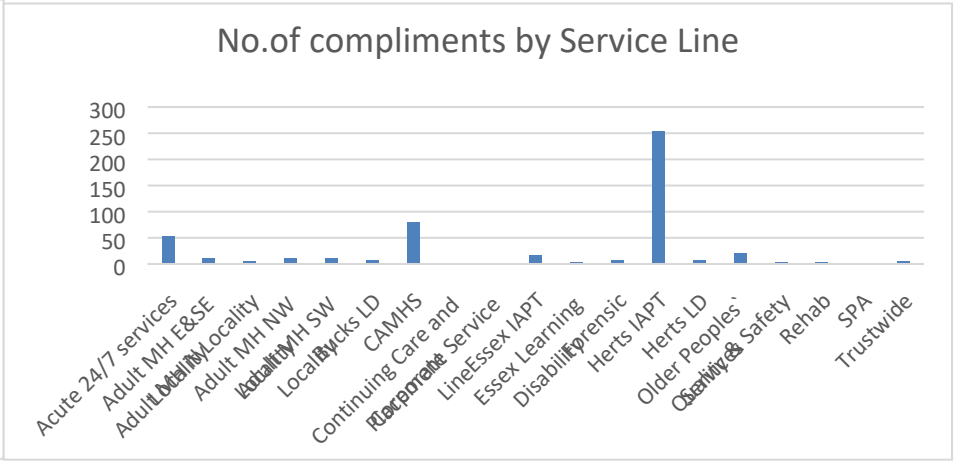
2. Compliments

In quarter four, 2021-22 we received a total of 492 compliments compared to 439 in quarter three, 2021-22. The majority of compliments were received for the Herts IAPT teams with a total of 253 compliments, 250 being received by the East and South East Team. (The total number of compliments received by services is shown in Appendix 1). Compliments are shared with staff through The Hive and “compliment of the week” in the staff bulletin. 74% of the compliments were received from service users, 22% from carers and 3% from external professionals.

Graph 1



Graph 2



Compliment Themes

"Comfortable" "supportive", "kindness" and "amazing" were words used in compliments in quarter four.

Thank you again for your swift actions in the matter pointed out to you today. You were amazing!

…she has shown herself to be the most compassionate and supportive doctor. Nothing is ever too much; no query or fear is ever belittled…

I wanted to send a personal note thank you for the kindness and care you always showed to X …

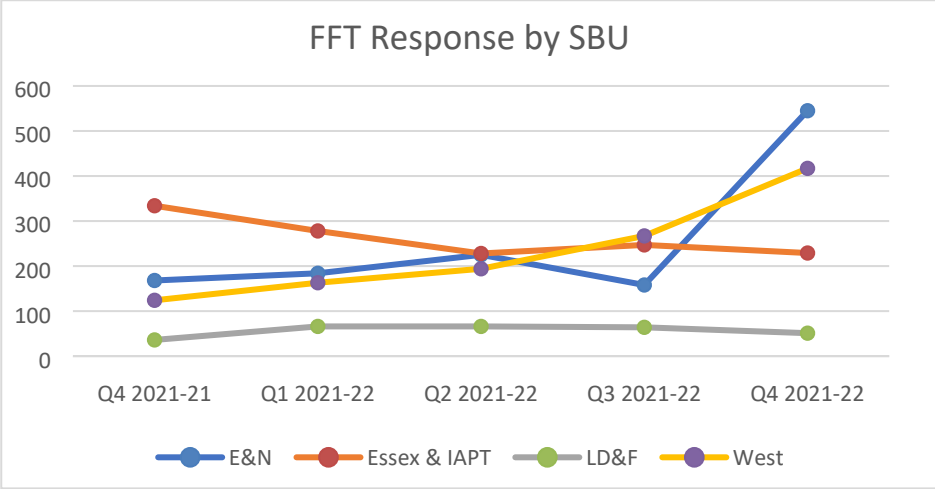
3. Surveys

3.1 Local Surveys

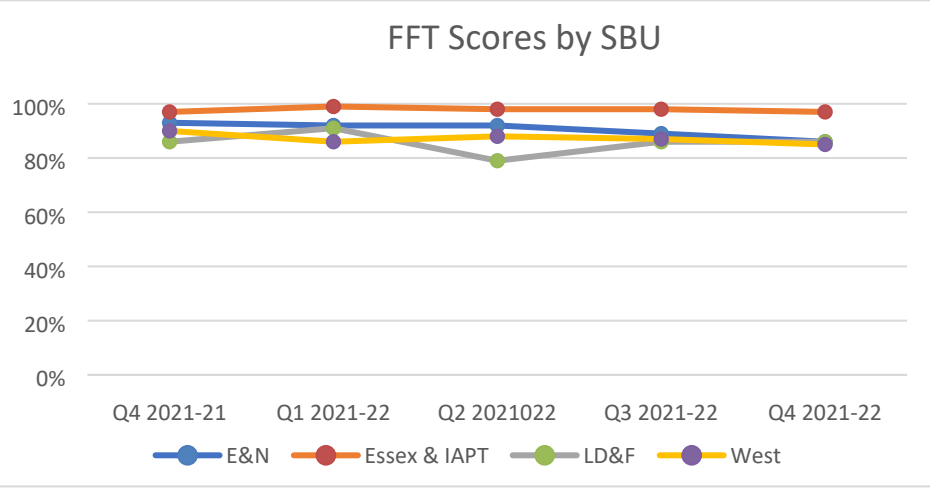
During quarter four we received 1,254 survey responses compared to 783 in quarter three. The introduction in March 2022 of SMS texting for the FFT question for adult community and older peoples' community services has seen a 60% increase in the survey responses compared to the previous quarter. Despite the increase in responses the FFT score has remained relatively unchanged at 88% which is above the Trust's target of 85%.

The increase in FFT surveys is very encouraging, however we are still seeing very low numbers of HYS surveys being returned. HYS surveys have many more questions some of which are KPIs, so it is important to note that the performance from these should be treated with caution against the low number of responses. A review of the HYS surveys is a project for 2022-23 for the Experience Team to better understand how people want to feedback their experiences.

Graph 3



Graph 4



Local Survey Themes

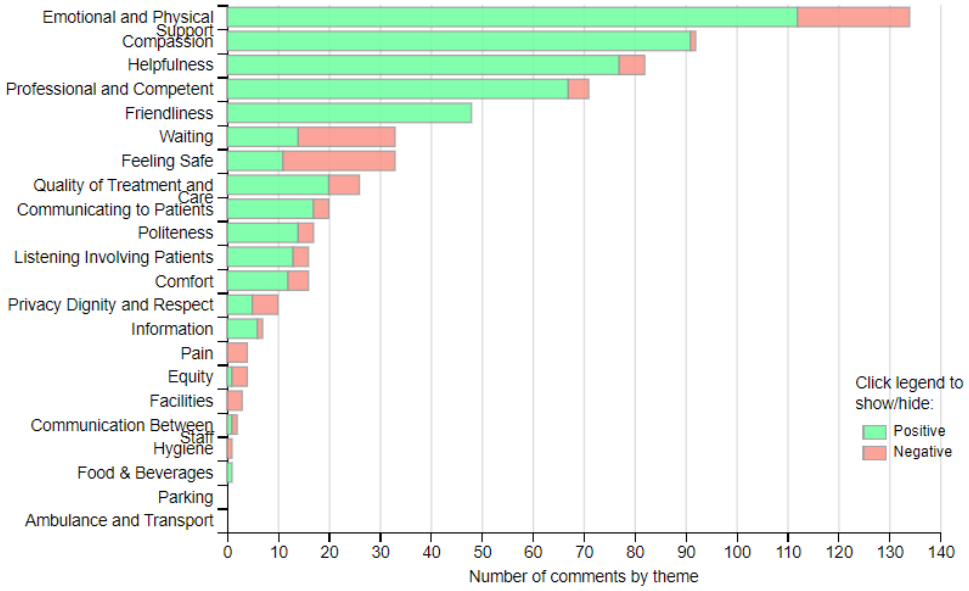
The majority of comments given through local surveys were positive and were categorised under the theme “Emotional and Physical Support”. The words “excellent”, “friendly” and “amazing” were mentioned frequently. “Emotional and Physical Support” also showed the highest number of negative comments alongside the theme of “Waiting”. Negative comments given mentioned the words “rude”, “uncaring” and “negligence”.

Extremely helpful and encouraging, he really understood my perspective on my struggles and experiences.

Wrong medication, missed medication, unresponsive staff, unapproachable….

Below are graphs and word clouds showing the thematic emotional analysis of the qualitative feedback given on local surveys.

Graph 5 - all survey data

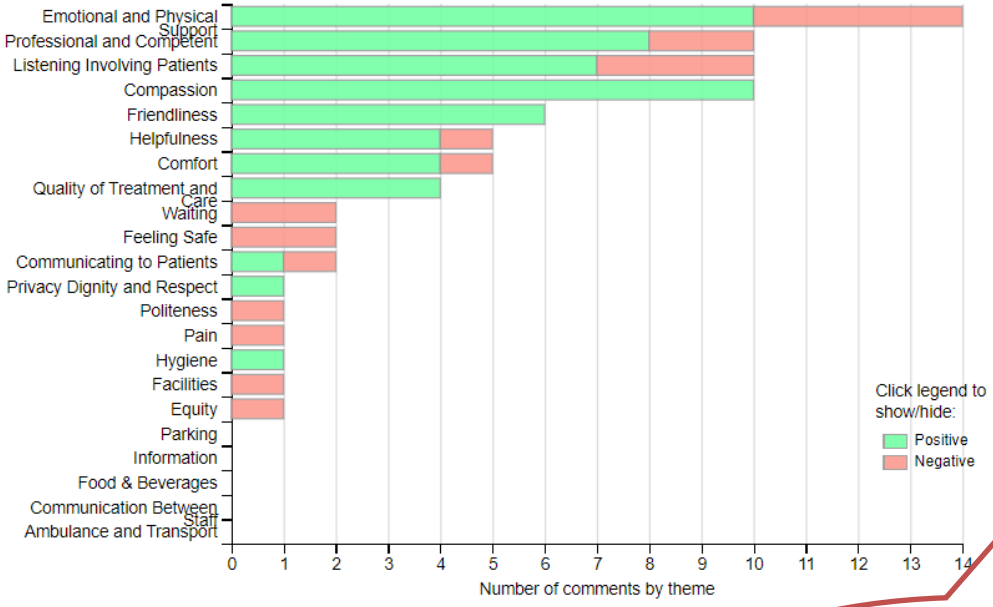


Graphic 1 Word Cloud

Below is the emotional thematic analysis for CAMHS. Please note that the amount of feedback is considerably less for CAMHS services, however there was an increase compared to the previous quarter and 124 surveys were completed. The FFT score for CAMHS was 88%.

The majority of positive comments related to the theme of “Compassion” with words such as “comfortable” and “friendly” being used. There was an increase in negative comments this quarter relating to “emotional and physical support”, “listening”, “waiting” and “feeling safe”.

Graph 6: CAMHS comments



Graphic 2 Word Cloud

The sessions felt calm and controlled which allowed me to feel comfortable with my thoughts and feelings.

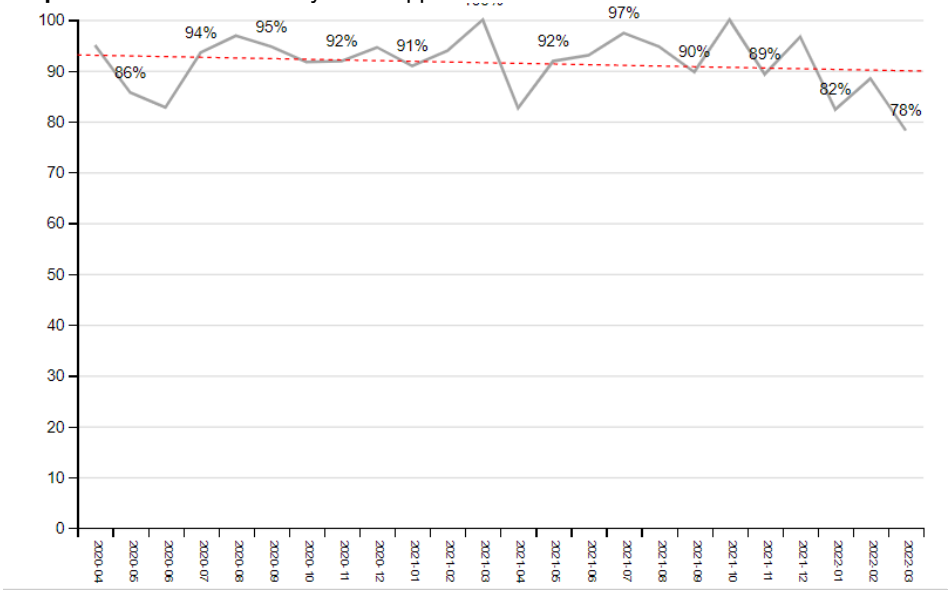
They don’t treat patients, they deteriorate and are eventually discharged, many return, no therapy, no consistent treatment.

Everyone has been friendly, and I have received the best care I think possible.

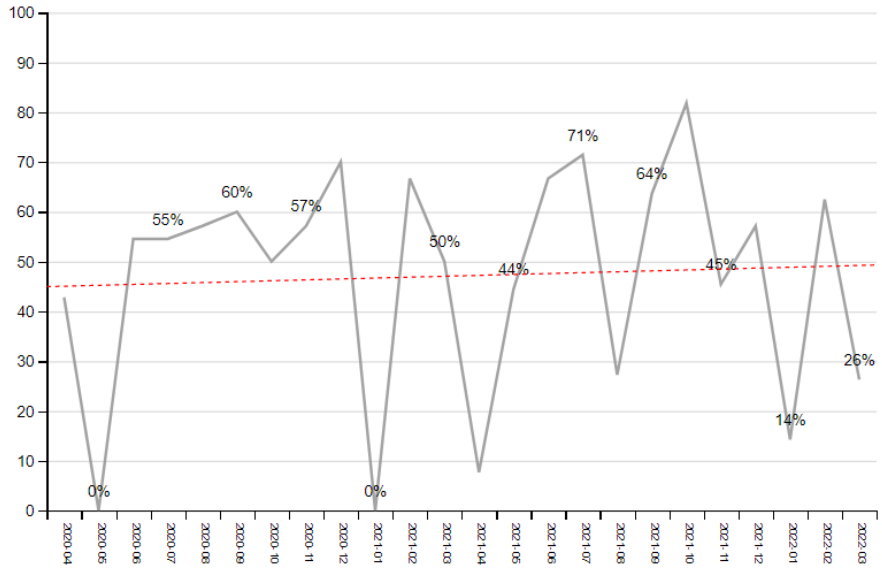
3.2 Trends

Graph 7 shows the trend for “Emotional and Physical Support” which is consistently high although it is seeing a downward trend in recent months. Graph 8 shows the trend for the thematic category of feeling safe which is seeing a slight upward trend.

Graph 7 – Emotional and Physical Support Trend



Graph 8 – Feeling Safe Trend



3.3 Digital Initiatives

In quarter four, 2021-22 164 Attend Anywhere consultation surveys were received compared to 166 in quarter three. Attend Anywhere surveys are being replaced for virtual consultations by MS Teams and a survey has been set up to replicate the one currently being used on Attend Anywhere.

In March 2022, the new SMS texting for the Friends and Family Test was launched. Service users in adult community and older peoples’ community teams are now sent a text with the Friends and Family Test survey link following a face to face or virtual appointment. Service users will only receive one text every 30 days regardless of the number of appointments attended to avoid survey fatigue. Service users can opt out of receiving texts if they wish to. Since the introduction of this method we have seen an increase of 60% in survey responses.

Work is ongoing with the IT team to add an Experience dashboard page to SPIKE so that teams can see their response rates and scores for feedback from one dashboard.

3.5 National Community Survey

The 2022 National Community Mental Health survey is currently in the middle of field work, meaning that service users are being requested to complete a survey. The Communications Team are encouraging completion of the survey by weekly tweets and teams are being reminded of the importance of encouraging service users, if they receive a survey, to complete it.

Following the results from the 2021 surveys work continues to improve the experience and a steering group meeting will start to meet in Q1 to discuss the actions and monitor the improvement work.

4 Stories

Some experiences are harder to listen to, particularly where we have not provided the best level of care, but we learn from that to improve so the value is high.

4.1 Stories to the Board

There was one story shared in quarter four at a Board meeting on 31st March.
The story shared at Board was from a service user who has been under the care of the Crisis Resolution and Home Treatment Team (CRHTT) on several occasions over the last 5 years. The service user had been incorrectly diagnosed with Emotionally Unstable Personality Disorder (EUPD) as a teenager and her story explored how an incorrect diagnosis led to difficulty with treatment. She reflected on how much she had learnt from the experience and how much knowledge it had given her.

The Stories to the Board programme will continue in quarter one with one staff experience story each quarter arranged by the Organisational Development Team.

In the last year there have been ten stories, seven were service user and carers and three were from staff members. Feedback from Board members is that the stories are incredibly valuable and ensure that the Board remain focused on the Quality and experience for our services users.

Keep these stories coming at all costs. They are an essential direct link between the Board and the reality of service-user experience.

Each year we ask our governors and executive team members for feedback about the stories they have heard over the last year. We received 8 surveys, and all were extremely positive about the “stories” programme over the last year saying how impactful the experiences had been for them and a good learning experience. There were questions asked about support for the individuals after sharing their story and the Experience team can offer reassurance that a debrief and support after

the board meeting is always offered. The team also ask the individual if they are happy to share their story more widely for use in the Shared Experience Library.

4.2 Shared Experience Library

The Library Steering Group met on 1st February and are currently recruiting two new EbE members. Communications are continuing to support the team with promotional work to improve the uptake of the use of stories in the Trust. However, uptake is continuing to be slow and in Q1 the group will be looking at ways of encouraging the use of stories.

A video story from an EbE has now been added to the Complaints Investigation Training.

5 Complaints and PALS

In quarter four, 2021-22 we received 128 complaints compared to 100 in Quarter three. Included in this figure are 25 MP enquiries and six professional to professional complaints.

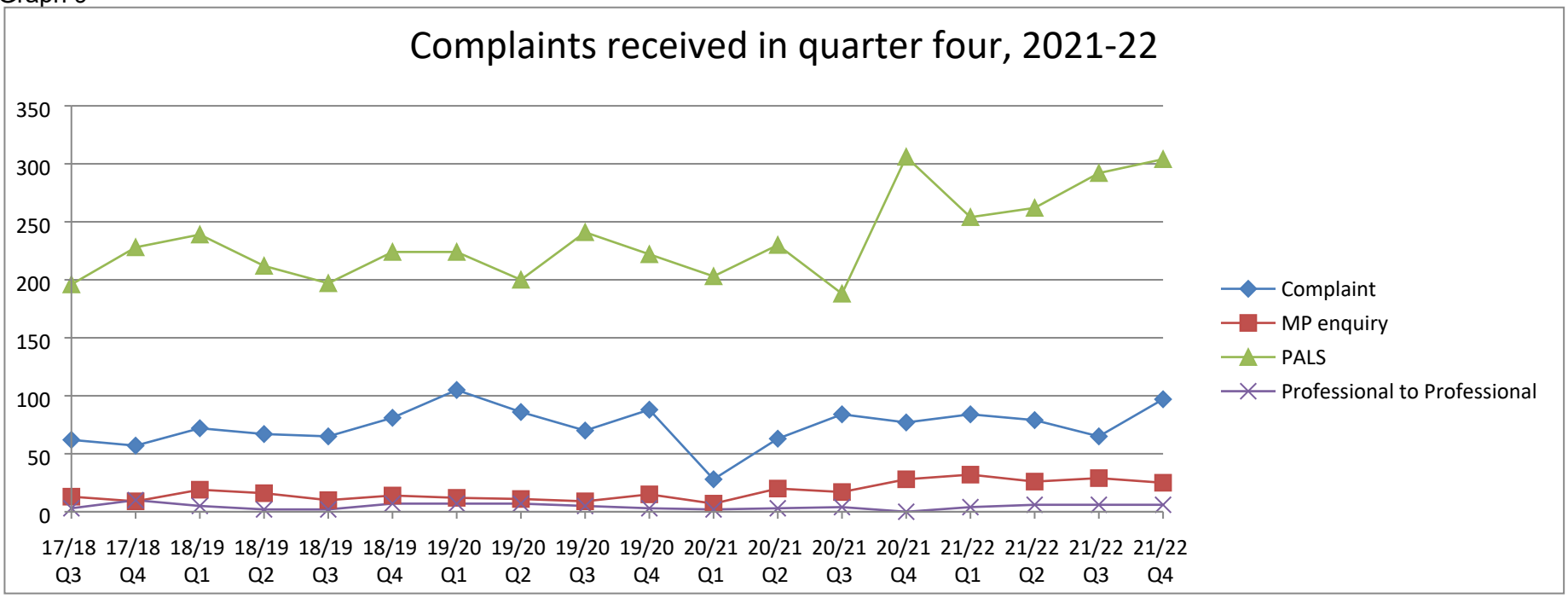
There were 304 PALS enquiries in Quarter 4 compared to 292 in Quarter 3, in particular, we have seen an increase in enquiries related to other organisations such as E&N Herts and West Herts Hospitals Trusts. There continues to be an increase in PALS enquiries which has impacted on the ability of the team to respond, this has been recognised capacity in the team,

There were 91 complaints closed in quarter four compared to 108 in quarter three; 12 were upheld, 37 partially upheld, 32 were not upheld, 7 were withdrawn, 1 was closed because consent was not received. 2 complaints were closed as the concerns did not fall within the remit of HPFT Complaints Procedure. (Please note that complaints closed during quarter four were not necessarily received in the same quarter).

The upheld complaints are categorised by service and type as follows:
3 x SPA (2 x Systems and Procedures, 1 x Staff Attitude)
2 x Forest House (Communication and Systems and Procedures)
1 x CAMHS AABIT (Systems and Procedures)
1 x NW ACMHS Dacorum (Systems and Procedures)
1 x SW ACMHS Borehamwood (Systems and Procedures)
1 x SW ACMHS Watford (Clinical Practice)
1 x Adult Eating Disorder (Communication)
1 x Swift Ward (Systems and Procedures)
1 x 136 Suite (Systems and Procedures)

In the year April 2021 to March 2022 we received 459 complaints, including 112 MP enquiries and 22 professional to professional complaints.

Graph 9



Appendix 5 shows the complaint subjects and sub-subjects, the majority of complaints came under the themes of “care” and “assessment and treatment”.

The average number of days taken to acknowledge complaints in quarter four was 1 working day, in quarter three it was 2 working days.

The average number of days taken to respond to a complaint in the last year was 42 working days, this is above the target of 25 working days. This figure is calculated by looking at all complaints closed over the last year (it should be noted that those complaints where consent is required will have caused a delay to the complaint response, the team are looking at a way to calculate this to reflect the cases where consent was a factor).

A new phone system was installed for the PALS and Complaints Team in March 2022. This system operates through the team's laptops and for the first time we are able to report on statistics for calls taken.

In March there were 220 calls made to the PALS and Complaints phone line, 99 of these were handled immediately. This means that voicemails may have been left and if this was the case, the team will have returned the call within 3 working days. The average time taken to answer a call was 12 seconds. The average duration of call was 5 minutes, however the longest call taken was 26 minutes.

5.1 Demography

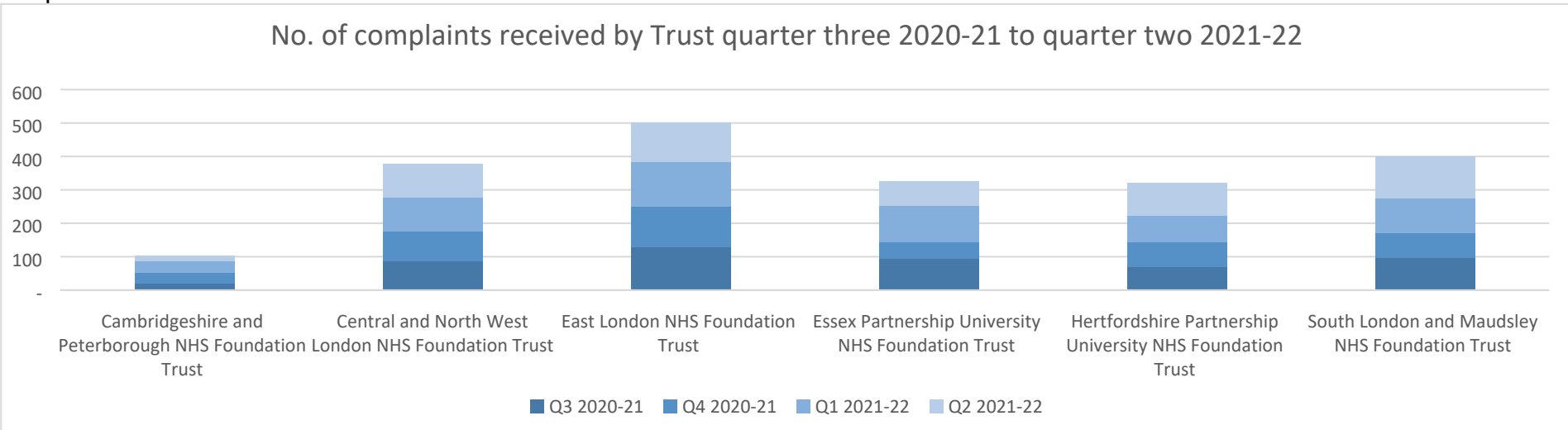
Equality monitoring data is requested from complainants when registering a complaint. As requested by the Information Rights team, the information collected is no longer held on the Datix system but is held separately to maintain the individual's confidentiality. Of the 128 complaints received in quarter four, we received 6 completed equality monitoring forms:

100% were heterosexual
67% stated their religion to be Christian
50% of complaints were made by relatives/carers
50% were from people from a White British background

5.2 Benchmarking Data

Complaints data provided by NHS Digital for quarter three, 2020-21 to quarter two 2021-22 showing a comparison of complaints received.

Graph 10



5.3 Complaints Evaluation

There were 10 complaints evaluation surveys received in quarter four which was the same number as were received in the previous quarter. The team send evaluation surveys to all complainants electronically or by post 5 weeks after the final response letter.

67% of respondents were complaining about someone else's care.
67% felt the quality of care would reduce if they complained.
40% felt they wanted to take their complaint further but felt too stressed or ill to do so
75% felt their complaint was handled poorly
57% said the timescale for a response was not discussed at the beginning of the process.
83% felt they were poorly informed about the progress of their complaint.
100% felt the process was very stressful.
100% did not feel the response to their complaint was truthful.

No update, communication poor. Details of what was going to change opposite to what was actually happening in practice.

5.5 External Requests

In quarter four 2021-22 the Parliamentary and Health Service Ombudsmen requested the case files for 2 complaints and received the outcome of one investigation.

The completed investigation report for case C3883 as partially upheld and a letter of apology has been sent to the complainant. The main findings were that they found fault in the mental health and social care of the SU, which the Trust had already identified and provided an apology for. The PHSO did not find fault with the Trust's mental health assessment of the service user or the Trust's complaint handling. An action plan has been drafted which has been sent to the complainant and PHSO in line with the PHSO's recommendations. Details of the action plan are noted below.

- Communication with the family was not consistent with confidentiality guidelines which increased the families concerns. The Adult Community operational policy has been updated to reflect that staff should liaise and communicate with family members without breaching confidentiality. This has been shared through governance meetings and changes highlighted to staff. Staff will also receive carer training in line with NICE Guidance.
- A member of staff was not in receipt of regular clinical supervision and team leaders had been reminded of the importance of compliance in this area with supervision trackers reported to Core Management meetings. Ongoing compliance is monitored, and the implementation of a new Supervision App is supporting with this.
- Cover arrangements when staff are taking unplanned leave – the Adult Community operational policy has been updated to clarify the process.
- Care plans – the Adult Community operational policy has been updated to ensure responsibilities about having care plans in place are clear. Team leaders and Service Line Leads will monitor compliance with this. The launch of the new Carer and Support Plan in 2022 will be an opportunity for all parties to focus on the importance of a co-produced holistic care plan.
- Missed appointments – The Adult community operational policy has been updated and staff made aware of the process for contacting service users in the case of missed appointments. In addition, there is also a "Did Not Attend" policy for easy reference.

Case C26846, was returned from the PHSO suggesting Level 3 compensation. This is currently being reviewed before a decision is made by the Trust.

Case C3675 was suggested by the PHSO for their new Early Dispute Resolution (EDR), this process involves a mediator from the PHSO arranging a meeting with the Trust and the complainant to understand the issues and try to resolve them informally. The meeting is due to take place in July.

5.3 Complaints Continuous Quality Improvement (CQI) and New National Framework

An action plan has been written by the Experience team following the CQI project and self-assessment work completed in 2021. This plan sets out the work needing to be done in 2022-23.

6 Involvement

The Involvement program is operating under a hybrid approach with involvement activities being conducted virtually and face-to-face. Experts by Experience continue to be supported with activities by the involvement leads and coordinators.

Quarter four has seen three Carer Essential Virtual training sessions delivered. The Carer Essential Training has been part of a NICE Audit intending to train 300 adult community staff. We have been able to train 119 staff and will carry over this target as it's important for staff to build on their understanding of how to work with carers and identify support when needed. The carer council endorses this training and would like all staff to complete the carer's essential training.

During quarter four two Carer Council meetings have taken place, the Carer Council has been focusing on reviewing their terms of reference and working with Senior leads to increase the diversity of HPFT experiences of Carer Council members and put in place smarter working processes that evaluate the impact of the council. The Carers Council is yet to agree to their new Terms of Reference as they are waiting for the trust to agree on the resourcing of the sub-group structure.

Three Service User Council meetings were held, whereby the Service User Council continue to review their work plan and priority working areas for the year to come.

The CAMHS Young People's Council has had three meetings during quarter two, and the Young People's Council continues to grow. During December, the Young Person Involvement Lead has been meeting with young people and staff at Forest House, to support some challenging feedback received. The young people and staff have enjoyed having an additional communication method in place via the young person's Involvement Lead and the aim is for them to continue spending time on the unit weekly.

During quarter four, 356 hours of involvement, activity has taken place, this is a decrease from quarter three 585. The total number of hours on the interview panel conducted with an Expert by Experience was 38 hours, a continued decrease from 76 interviews in quarter three. There have been 216 hours of specialist participation in trust meetings and forums that have taken place in quarter four, compared to the 208 hours in quarter three. 139 other involvement activity types.

Recommendations

- Ensure an Expert by Experience is part of every recruitment panel - as stated in the recruitment policy.
- To continue working alongside experts to develop services.
- For staff to actively involve experts by experience to ensure tokenistic involvement doesn't happen

We continue to work alongside our experts to meaningfully engage in service development and delivery that influences the overall experience for stakeholders.

7 Actions and Learning from Feedback

Teams are required to take local action based on the feedback received. "You said, we did" posters are being reintroduced and teams are expected to take local ownership of their actions.

7.1 Quarterly Feedback Group (QFG)

The aim of this group is to ensure that feedback received across the Trust is triangulated, key themes identified and learning and action take place. The meeting took place in February and Practice Governance colleagues shared information about feedback received in their service areas and project work taking place. The continuation of sharing across SBUs is found to be particularly helpful and an opportunity for the Experience Team to update colleagues on projects, ongoing experience work plans and offer support.

7.2 Experience Projects

The Post Incident Support Project with Medium Secure Forensic units is underway with recruitment of Experts by Experience (EbEs) and training will be commence in Q1. The project will run throughout 2022-23 to understand the experience of service users who witness an incident.

The Peer Observation Project which was completed in 2020 will review the proposed actions from the report to ensure they have been completed. Once this work has been done the project will move to phase 2, of further visits by EbEs to the units to understand how safe service users on our older peoples' units feel.

A review of the Having Your Say surveys will be conducted in 2022-23 and a request for EbEs and staff to participate in the project has been sent out. The review will look at the ways people want to give feedback and the questions we need to ask to ensure a comprehensive picture of the experience of care.

8 SBU Updates

8.1 East & North SBU

CAMHS Inpatient (FHAU) Forest House have daily meetings with the young people and the Young Persons Involvement Lead is present on the unit at least twice a week to support young people and receive and respond to any feedback they may have; including on the quality of care provided at Forest House. On an individual basis young people are involved in planning for their care in advance of the ward reviews. The young person is encouraged to think about the questions they would like to raise by being provided

with a written information sheet. The unit provides regular contact during the week with families. The multi-disciplinary team at Forest House hold twice weekly ward reviews which families are encouraged to attend. If this is not possible, the young person's allocated lead worker liaises with the family to provide an update and discuss the plans. Paper Having Your Say forms and a confidential post box have been reintroduced on the unit following the updated IPC guidelines. QR codes, for direct access to the Having Your Say forms electronically, are displayed in the reception/waiting room areas for feedback to be given. A welcome pack has been produced for admissions to the unit and it is planned that feedback on this will be obtained from newly admitted young people.

MHSOP Assessment and Treatment team at Seward Lodge have been arranging monthly meetings but unfortunately attendance at the meeting has been very low; with no carers/family members attending the most recent meeting. The unit CPA coordinator is arranging the meetings which are being chaired by the unit RN's.

The MHSOP Continuing Care Units, Lambourn Grove and Victoria Court, are continuing to hold their carers/relatives/family meetings monthly. The meetings continue to be held virtually as a large room would be required to facilitate 1 metre distancing in accordance with IPC guidelines and families seem happy with the MS Teams virtual meetings currently in place.

Lambourn Grove have a relatives 'Whatsapp' group and the items discussed are shared by one of the relatives to those that are unable to attend. Some topics of discussion include, summer house and garden, visiting in bedrooms, continuing care correspondence.

Victoria Court's most recent carers meeting was held at the end of April. The meeting was attended by staff and three carers. Topics discussed include, laundry system, communication regarding meetings, carers needs and confidentiality.

Wren Ward, HPFT's Frail Functional unit have reinstated carers meetings and the most recent meeting was attended by three carers/family members. The meeting was chaired by the team leader and the topics discussed included confidentiality, discussion of life on the ward, treatment process, escalation of concerns and further meetings are being planned going forward.

8.2 Essex & IAPT SBU

IAPT and Wellbeing Patient Experience qualitative data continues to be collated, reviewed and shared with the teams on a monthly basis for discussion at their local meetings. This is providing the opportunity for teams to follow up with people where they have indicated that they were unhappy with their treatment or where they have disclosed that they remain unwell. Some teams are also incorporating the feedback into a monthly bulletin and where feedback indicates improvement is required, this is translated into an action-based approach. Supervision is also used as a place to discuss comments further should this be felt appropriate.

SBU are continuing to develop the Essex Learning Disability Partnership website and now have page reader videos on the majority of key pages on the site. These support with the accessibility of the site with staff and people with learning disabilities talking through the information that is available on the page to aid user understanding.

Service users have been working with the SBU to develop principles that will underpin the new design for the new inpatient unit within the SBU.

During quarter four we also attempted contact with over 20 service users by telephone who had recently transitioned into our learning disability services in order to obtain feedback on their experience. The aim of this was to guide our work in the development of a new transition pathway. We also held a virtual stakeholder event which was attended by a number of local agencies and transition teams alongside families and carers with lived experience. In terms of feedback from the telephone surveys, the main issues were around: earlier intervention, better interagency working and the need for clearer communication and pathways. Positive comments included a good experience of the dietician input, staff taking time to get to know the family and listen to their concerns, good communication about future care and good communication between LD services and the care home.

All of the feedback from the survey and the stakeholder event is now being consolidated as part of the CQI project and will continue to be taken forward.

The Patient Experience Questionnaire (PEQ) offers the opportunity for service users to provide both quantitative and qualitative feedback on their experience. 712 service users completed the PEQ during quarter four which accounts for 18% of service users who completed treatment and the quantitative responses can be found in appendix 1. During the quarter four reporting period 659 comments were received within the Patient Experience Questionnaires. Of these, 574 were positive and 85 were negative **or** provided feedback with ideas on how the services could be improved. Within the positive comments there were 339 comments which included specific therapist related feedback.

Feedback for further consideration included: dissatisfaction with the therapist, dissatisfaction with discharge, dissatisfaction with session structure, length of session, content or delivery method and waiting times.

(See Appendix 1 for question analysis)

8.3 LD&F SBU
Peer evaluation Project:

NHS England have devised a peer evaluation methodology using learning disability experts by experience to run focus groups with service users in inpatient Learning Disability units to get their views on their environment and care. The peer evaluators are trained, allocated a supporter, run group and individual sessions with service users and interview frontline staff, and produce a report and action plan. NHS England have agreed to

provide training to, and sharing resources with, Health Access Champions/Experts by Experience/advocates working within HPFT to allow us to replicate this model of peer evaluation in our inpatient units within our services as part of our internal quality assurance and improvement processes. We have agreed to run a pilot with 4 units over the next few months, working with Opening Doors Advocacy group in Norfolk and the Health Access Champions in Herts and Bucks. In quarter two, the Health Access Champions and Practice Governance Facilitators in Herts completed their training and in Quarter 3 have been working together to build resources and plans to start the initial focus groups. In Norfolk, the focus groups have been added to our contract with Opening Doors and training has taken place in Quarter 3 with initial focus groups at Broadland Clinic in December 2021 and continuing into Quarter 4. We have a trainee clinical psychologist who is completing a research project on the evaluation of the pilot at Broadland Clinic. She has received the go ahead from the NHS Ethics Committee and HPFT have approved this piece of work. We hope that this model will add an additional dimension to Quality Visits to inpatient units and that we will be able to facilitate at least one visit a year to all our units.

Making Services Better:
The experts by experience group continue to meet monthly via Microsoft Teams due to COVID restrictions. This quarter, the group has extended the meeting to an hour and a half each month as everyone is now much more used to using Microsoft Teams. This has allowed for more time for feedback from members about their involvement with services and service users. The group has also spent some time reviewing the easy read information about the No Force First Act with came into law on 31st March 2022. From this date, it is expected that all inpatients of mental health wards will be given written information on the Act and the Trust's response to this. The group have also reviewed an easy read leaflet from Viewpoint, a charity supporting people with mental health or drug and alcohol issues. The group have also spent time with the external facilitator involved in the Service User and Carer Engagement project below to start putting together a questionnaire for service users.

Service User and Carer Engagement Event:
As part of the SBU's ongoing commitment to involving service users and their carers in their care, and engaging with them about service developments and change, the SBU has commissioned Inclusion Unlimited, and external advocacy group, to run a focus group involving service users and carers so we can hear from them how we can improve and facilitate meaningful involvement and engagement. The initial proposals for this project were taken to staff groups in Quarter 3 for their input into the best way of engaging service users and carers in this project. Three focus groups were then scheduled spanning learning disability inpatients and community, forensic services and rehabilitation services. The first two sessions ran in Quarter 3 for staff and carers in Rehabilitation and Forensic Services. A further focus group will run in January for staff and carers of inpatient and community Learning Disabilities services. The facilitator has requested help from the Health Access Champions to plan this. Health Access Champions will also be working with the external facilitator to design questionnaires for service users and carers. The questionnaires will be delivered via existing service user and carer forums, post and phone calls. The findings from these groups will inform the SBU's ongoing strategy for improved service user and carer engagement. This has been slightly delayed in Quarter 4 due to unavailability of the external facilitator but is back on track with the findings being shared with the SBU extended management team in May 2022.

CQI Training
The Health Access Champions have also been helping to develop accessible CQI training for those with a learning disability. This will mean the Health Access Champions and other experts by experience with a learning disability will be able to access this training and be better equipped to work with the SBU on CQI projects. The session to develop this concluded in Quarter 3. Three sessions to go through the training slide by slide were arranged with two facilitated before the CQI lead was seconded to a different role. The project has been reallocated within the CQI team and is recommencing with one further session to go through the training slides. A session with staff from LD&F and Essex SBU has been arranged to review how the Health Access Champions and other trained experts by experience will be supported to work with teams on CQI projects and this will then be reviewed by the Making Services Better group.

Equine Therapy
Equine therapy was proposed by a patient at Warren Court Medium Secure Service, who then worked with his Responsible Clinician and the assistant psychologist to put together a funding bid. Three local equine therapy organisations were interviewed, and the partner organisation 'Strength in Horses' was selected based on their therapists being qualified Clinical Psychologists, plus the organisation having experience of running equine therapy within a prison. The team successfully obtained funding from the HPFT Innovation Fund for two blocks of therapy. Horses and 'Strength in Horses' therapists came into Warren Court one day per week for eight weeks (during each day, two groups and up to three individual sessions were run). Therapy sessions were supported by the Warren Court psychology team.

Feedback from service users:

- All service users enjoyed the project.
- Comments on realising they were more patient than they realised and 'able to be trusted'.
- It felt that the horses were able to give people the 'courage' to do try new things, for people to feel they 'weren't really in the unit' and a sense of 'freedom'.
- Encouraged people to get out of bed in the mornings.
- Team building and using each others' strengths to achieve things.
- Being able to be a good leader – skill not often used in the unit.
- "People are always under pressure in this place, horses bring fun'.

A second block started in March 2022 with patients who took part in Block 1 acting as mentors to patients new to the project. The unit are working with the University of Hertfordshire to evaluate the project.

Experts by Experience involvement with Service Development
There are a number of exciting new service developments within the SBU and experts by experience have helped to shape these. The EROS+ project is looking to expand the rehabilitation community outreach programme and a number of carers have been integral to the design of this project through the steering group for this project. The Norfolk Community Learning Disability Forensic Team has been enhanced and is launching new pathways this April 2022. Opening Doors, the local Learning Disabilities advocacy charity has agreed to provide service user feedback

sessions and peer support within this team. The Herts Secure Service has been putting together a proposal for a Women's Forensic Service and has reached out to women currently in forensic services to hear their views which have been used to inform the proposal.

A Focus on Physical Health
The SBU have been looking at ways to promote healthy weight for inpatients as weight gain as an inpatient is common for a variety of reasons including medication, less physical activity and poor diet. On Dove Ward and Rehabilitation units an external company, Psychesoma, have been coming into the units to provide additional activity sessions including those that promote physical activity. Warren Court and Rehabilitation units are working with Watford Football Club to run Shape Up programs for those with a high BMI. At Broadland Clinic, service users are participating in an adapted healthy eating programme for people with learning disabilities called CALMPOD which encourages mindful eating; this is run by members of the multi-disciplinary team.

8.4 West SBU
Inpatient Feedback

Swift Ward have a new 72hour Meeting involving Crisis and Community Teams, this meeting is designed to help reduce Length of Stay. The meeting was a 'Pilot' until the end of February but has now been rolled out to all wards.

Mutual Help meetings continue to take place on our inpatient Wards, this gives our Service Users the opportunity to feedback in a timely way on issues relating to the Ward and their care. Aston Ward started a Group making sensory boxes, the service users found this amazing and really helpful with ongoing feelings of anxiety.

With the increase of 1.6 Assistant Therapy Practitioners (0.4 externally funded and 1.2 funded via Bank) the Occupational Therapy service across the acute inpatient wards has been able to offer meaningful Occupational Therapy intervention and assessments to an extra 23 people across the month, and an additional 223 contacts.

By increasing the Occupational Therapy Practitioners on the acute inpatient wards, the overall activity levels on the wards have increased. The ATP's offer psychoeducational work (supported by the OT), alongside therapeutic activity work, both within a group and one to one setting.

Their role also includes completing assessments such as the Occupational Therapy screenings, the Needs and Feelings document, and the Interest Checklists to help identify peoples' interests, likes and what motivates them. This information informs the Occupational Therapists in shaping their intervention plan, can help identify those people who have occupational needs and identifies the potential barriers to discharge, early in the admissions process.

This extra ATP time enables the qualified OTs to be able to focus on developing and taking forward quality improvements to support the wider Trust agendas, as well as be able to focus on assessing for and facilitating discharges from the wards.

The Acute Pathway Improvement Project

Working in co-production with our service users and carers, we will ensure every service user will receive a clear, purposeful admission within our inpatient setting. Developing improved multi-agency collaboration for all service users, with the aim that all inpatient bed days will be of value to their recovery.

Work continues on the development of the pathway on the Trust template. Some good progress on the Treatment protocols with Psychosis, EUPD and Depression developing well.

The Acute Pathway Improvement Project is focused on looking at the pathway through the inpatient services and the integration between inpatient and community services. The desired outcomes are to;

- Reduce the delays in the transfers of care and out of area placements.
- Standardise the processes across the acute pathway and to remodel the bed management system.

The Treatment work stream forms part of this project. This workstream examined the activity levels on the wards in July across all disciplines (see previous report).
Two Task and Finish groups were held with relevant stakeholders. Service user feedback was gathered and audits were completed to guide the inpatient activities and interventions offered.

Abuse on the Ward

Following a successful session with staff on Aston Ward, a second session was held to discuss any improvements and how staff have felt the Ward is managing with current challenges. Staff took part in an open and honest discussion about what it feels like to work on a ward where they face challenging behaviour on a daily basis and how this makes them feel. The next step is to spend some time on the Wards talking to service users about what it is like for them to see and hear some of the incidents that occur and why frustration and anxiety are manifested into abuse to both staff and other service users.

Quality and Risk Meeting

We said thank you goodbye to Our Service User - Expert by Experience, who has left the West SBU Quality and Risk meeting after 3 years, his experience and feedback has been really helpful. He was often the first one to start the meeting and listened to us very patiently, before challenging the Team and bringing up subjects and topics for us to think about and feedback on. We wanted to say a huge thank you to him and we really appreciate his input. We look forward to continuing working with him on the Stevenage New Build Project and this Project will benefit from his comments and contributions going forward.

We will be welcoming our new Experts by Experience to our May meeting. Both our new Carer and Service User EbE will bring a different perspective and new ideas.

Community Mental Health Transformation Programme – Experts by experience (service users and carers) have been involved in all aspects of the programme including key projects and workstreams. They are members of the internal project board and the Hertfordshire commissioning programme board.

Evidence Based Care (Depression Pathway) – Service users and carers are members of the core project group. The pathway was co-developed with experts by experience and a service user co-chairs the meetings. They also co-developed the service user and carer surveys and had led in presenting this to the service users and carers council.

Outpatient Model – The outpatient model was co-developed with our experts by experience. They are currently supporting the mobilisation process and have leveraged their lived experience in steering the plan and engagement with stakeholders.

Personalised Care and Support Plan – Experts by experience have been instrumental in the development of the personalised care and support plan. Ensuring the plan developed is service user and carer centric with an holistic approach to assessing and providing support to address wider determinants of mental health.

Advancing Equalities in Mental Health – Experts by experience supported the establishment of the reference group and are also involved in the review of population health data in order to support identification of key areas of focus. Development of targeted offers for underserved communities will be driven by stakeholders with lived experience in the reference group.

PD Pathway – The pathway was co-developed with service users who are also core members of the implementation group. They have been involved in engagement to socialise the pathway and have presented at number of forums including regional forums.

ARMS Service (At Risk Mental State)
A workshop took place at the Colonnades to updated the ARMS Project. is now underway and being led with project Manager and with the inclusion of service users and carers and Experts by Experience for the development of the ARMS Service. The aim of the ARMS Service is to help prevent or delay the development of a first episode of psychosis, and support people with all aspects of their lives including mental wellbeing, social functioning, employment and general quality of life. - we are using the Care Quality Improvement (CQI) framework to support this work. Work has started on the Operational Policy and a working group will look at the Pathway Service Users will take. A successful Recruitment Event take place in Quarter 3 to fill vacant posts for the ARMS Service and remaining posts will go out to advert. Our Expert by Experience has kindly offered to ask for service user representation at the Service User Council and the Viewpoint Facilitators team meeting to join the steering meeting and workstreams for workforce & training and also to input on seeing Service Users for assessments.

Appendix 1 – Compliments received by Service

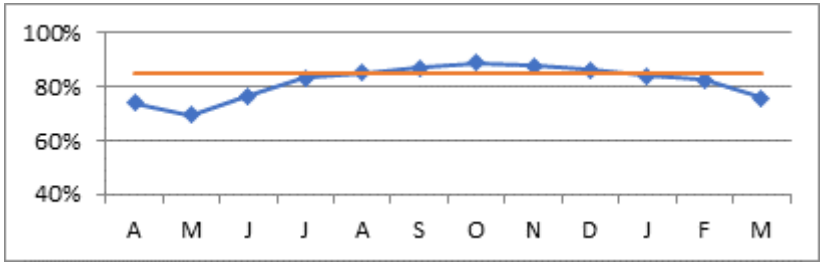
Service	No. of compliments
Acute 24/7 services	53
Adult MH E&SE Locality	11
Adult MH N Locality	4
Adult MH NW Locality	11
Adult MH SW Locality	10
Bucks LD	7
CAMHS	79
Continuing Care and Placement	1
Corporate Service Line	1
Essex IAPT	17
Essex Learning Disability	3
Forensic	6
Herts IAPT	253
Herts LD	6
Older Peoples` Services	20
Quality & Safety	3
Rehab	2
SPA	1
Trustwide	4
Total	**492**

Appendix 2 – Trust Values – information taken from Having Your Say surveys

SBU	FFT Scores	Kind	Positive	Professional	Respectful	Welcoming
East and North	78.83%	87.72%	77.27%	64.71%	78.57%	96.97%
Essex and IAPT	94.17%	100.00%	100.00%	100.00%	100.00%	100.00%
Learning Disability and Forensics	82.35%	92.31%	87.72%	82.42%	90.35%	100.00%
West	78.61%	83.76%	64.33%	82.19%	85.14%	88.75%
Trust Overall	81.53%	85.50%	71.53%	81.06%	85.05%	90.79%

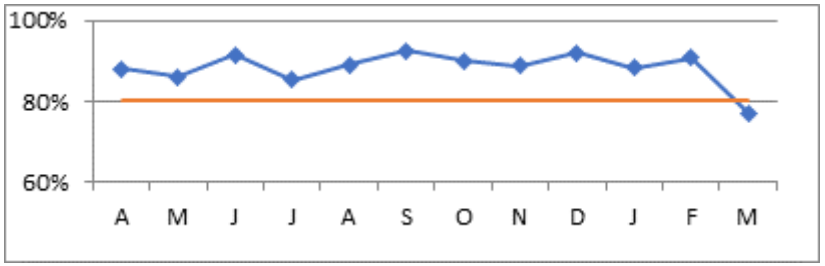
Appendix 3 Trend Graphs for Having Your Say Key Performance Indicators – as reported in the Performance Dashboard
(please note that the 3 month rolling figures are an average of the results over 3 months)

Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**

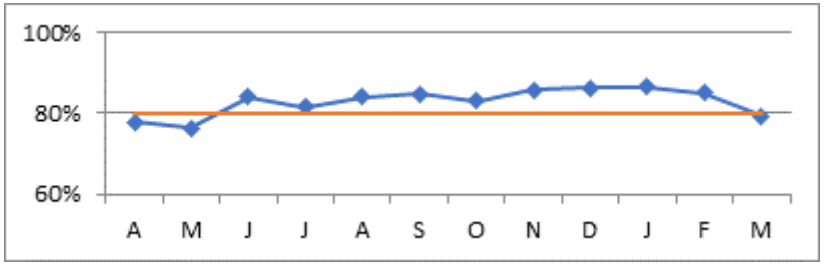


Rate of service users that would recommend the Trust's services to friends and family if

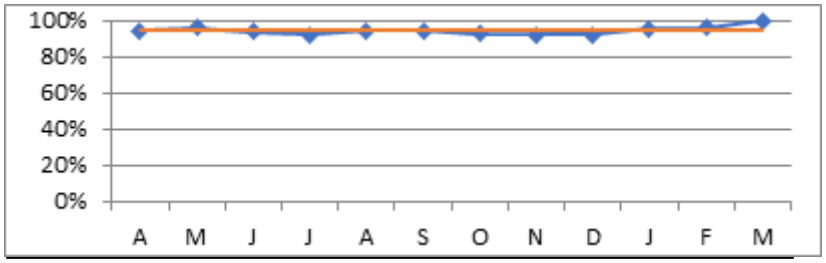
they needed them



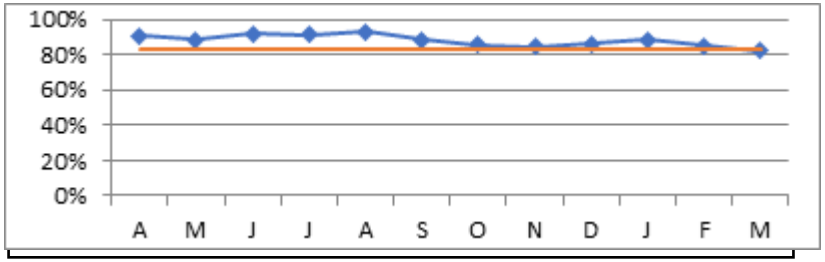
Rate of service users saying they are treated in a way that reflects the Trust's values



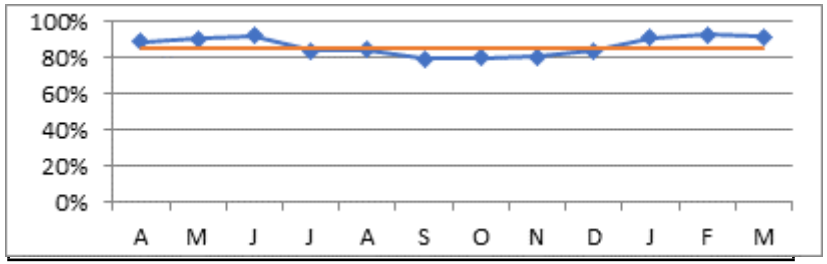
Rate of Service Users saying staff are Welcoming and Friendly
(Rolling 3 months)



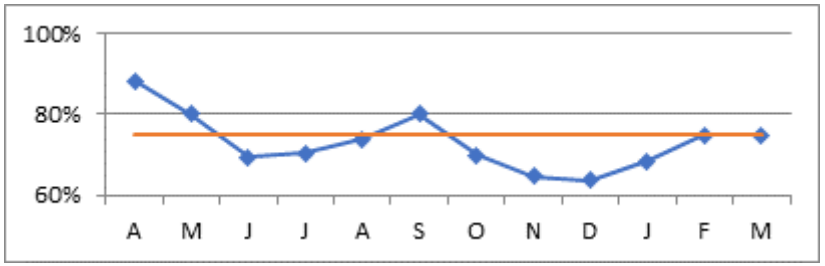
Rate of Service Users saying they know how to get support and advice at a time of crisis
(Rolling 3 months)



Have you been involved as much as you want to be in discussions about your care (Rolling 3 months)



Rate of carers that feel valued by staff **(rolling 3 month basis)**



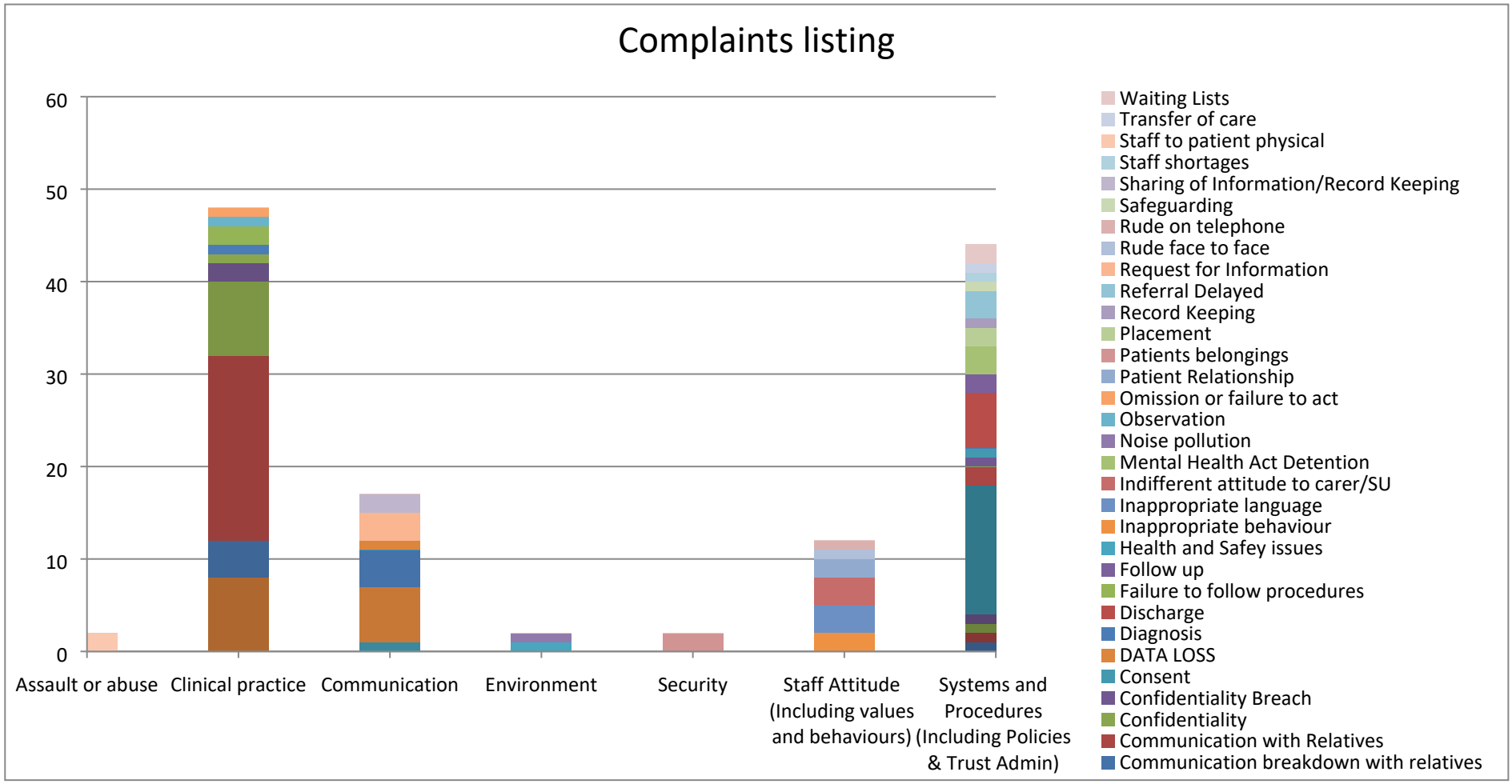
Appendix 4 - Understanding feedback by service area

Complaints, MP enquiries and PALS by service – Quarter 4

	Complaint	MP enquiry	PALS	Professional to Professional	Total
Enhanced Primary Care Mental Health Service	0	0	1	0	1
Integrated Flow Service	0	0	2	0	2
Liaison Diversion Team	1	0	0	0	1
136 Suite	1	0	2	0	3
Acute Inpatient Psychiatry	14	1	10	0	25
Adult Community Services (East and South East)	9	2	17	0	28
Adult Community Services (North West)	11	5	20	0	36
Adult Community Services (North)	5	1	9	2	17
Adult Community Services (South West)	7	2	16	0	25
Buckinghamshire Community Learning Disability Services	0	0	0	2	2
CAMHS Community Child and Family Services	15	7	18	0	40
CAMHS Crisis Assessment & Treatment team	0	0	2	0	2
CAMHS Eating Disorders Service	1	0	1	0	2
CAMHS Inpatient Services	3	0	0	0	3
Community Assessment and Treatment Service (LD)	2	1	2	0	5
Community Eating Disorders Services	2	0	1	0	3
Community Forensic Mental Health Service	0	0	1	0	1
Crisis Resolution Home Treatment Team	2	3	3	0	8
ECT Suite - Trustwide	0	0	1	0	1
Elderly Inpatient Services	2	0	4	1	7
Essex IAPT Services	2	0	2	0	4
Hertfordshire Inpatients	1	0	1	0	2
Low Secure Services (Learning Disabilities)	1	0	1	0	2

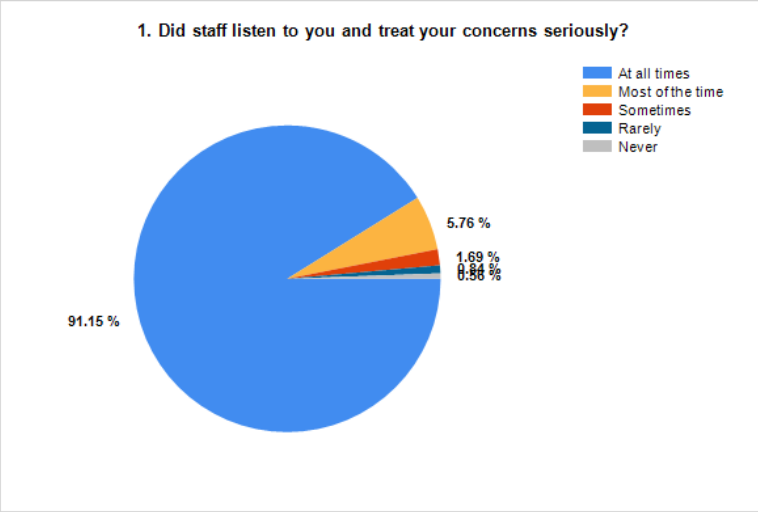
Medium Secure Services (Herts)	1	0	2	0	3
MHSOP Community Services East	2	0	2	0	4
MHSOP Community Services North	0	0	1	0	1
MHSOP Community Services North West	1	0	2	0	3
MHSOP Community Services South West	3	0	4	0	7
Norfolk Services	3	0	0	0	3
North Essex Community Learning Disability Services	0	0	1	0	1
Obsessive Compulsive Disorder Service	0	0	2	0	2
PATH Countywide Service	1	0	4	0	5
Quality & Medical Leadership	0	0	2	0	2
Quality & Patient Safety	0	0	0	0	0
Mental Health Liaison	1	1	2	0	4
Rehabilitation	0	0	1	0	1
Single Point of Access	2	2	17	1	22
Specialist Mother and Baby Services	2	0	1	0	3
The Wellbeing Service	2	0	16	0	18
Workforce Strategy & Organisational Development	0	0	5	0	5
Non HPFT Service	0	0	128	0	128
Total	97	25	304	6	432

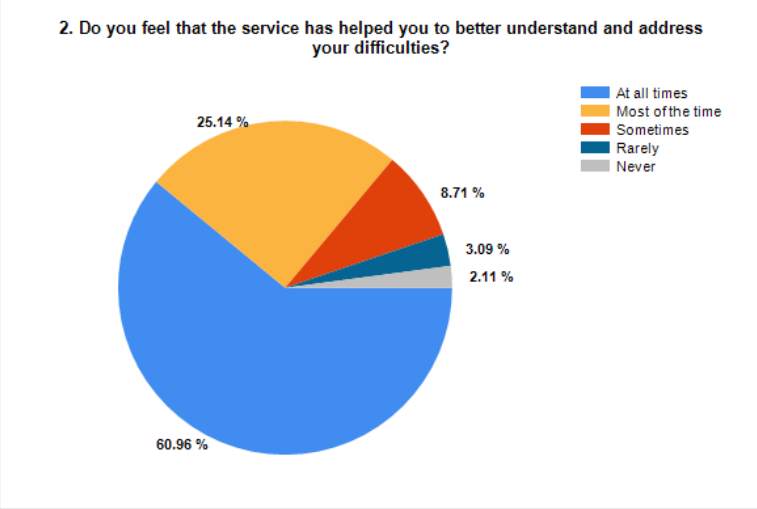
Appendix 5 – Complaints Themes

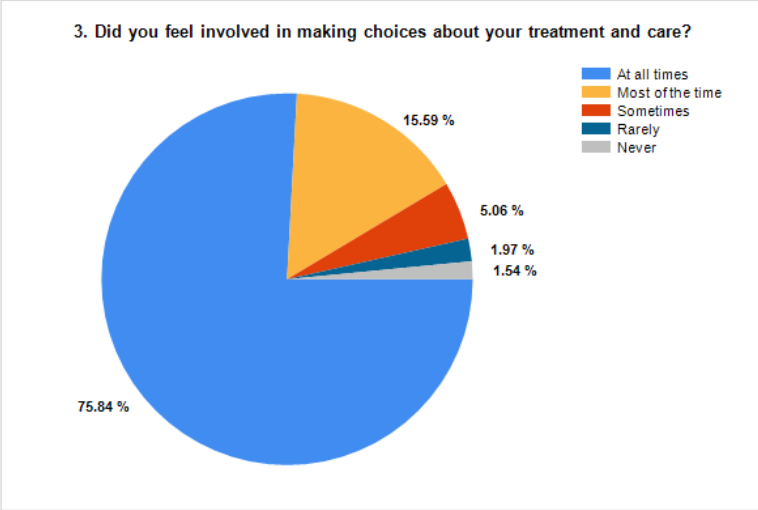


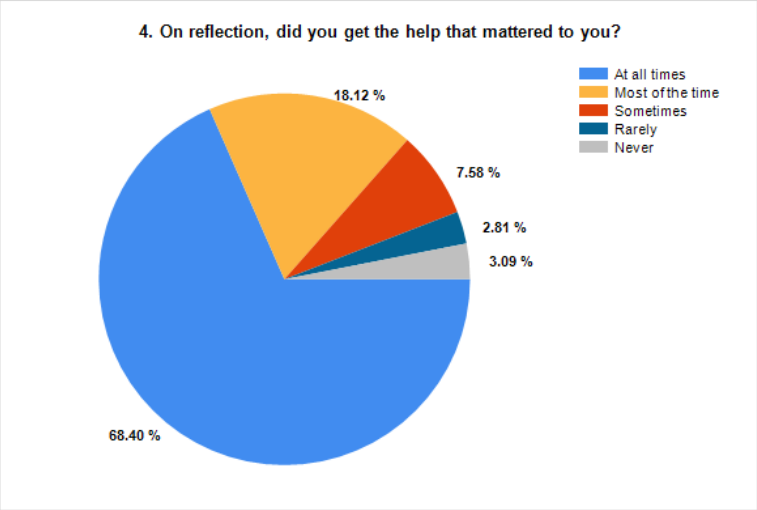
Appendix 6 PEQ Data

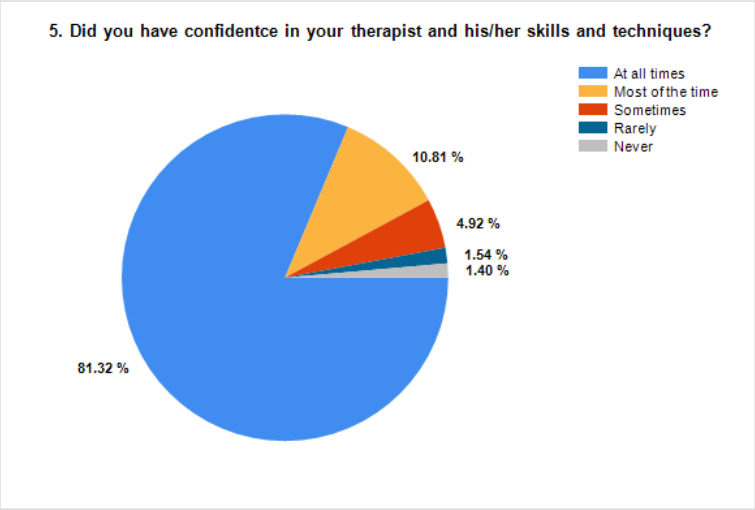
	East & North Herts	Mid Essex	West Herts	Total
Total Number Completed Treatment	1390	958	1606	3954
Total Number Completed Treatment And Completed PEQ Treatment	239	193	280	712
Return Rates for PEQ Treatment	17.19%	20.15%	17.43%	18.01%

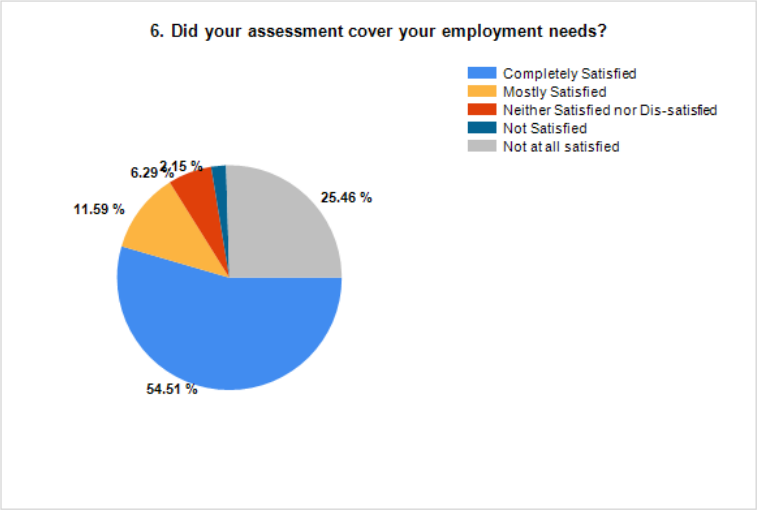





3. Did you feel involved in making choices about your treatment and care?
At all times
Most of the time
Sometimes
Rarely
Never
15.59 %
5.06 %
1.97 %
1.54 %
75.84 %


4. On reflection, did you get the help that mattered to you?
At all times
Most of the time
Sometimes
Rarely
Never
18.12 %
7.58 %
2.81 %
3.09 %
68.40 %


5. Did you have confidentce in your therapist and his/her skills and techniques?
At all times
Most of the time
Sometimes
Rarely
Never
10.81 %
4.92 %
1.54 %
1.40 %
81.32 %


6. Did your assessment cover your employment needs?
Completely Satisfied
Mostly Satisfied
Neither Satisfied nor Dis-satisfied
Not Satisfied
Not at all satisfied
6.29 %
2.15 %
11.59 %
25.46 %
54.51 %

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 9d
Subject:	Guardian of Safe Working Hours Quarterly Report (Q4) January- March 2022	**For Publication:** Yes
Author:	Dr Dinal Vekaria, Consultant Psychiatrist - Oxford House Community Mental Health Team and Guardian of Safe Working	**Approved by:** Prof. Asif Zia Director of Quality and Medical Leadership
Presented by:	Prof. Asif Zia Director of Quality and Medical Leadership	

Purpose of the report:

To share with the Board of Directors the Guardian of Safe Working Hours Quarterly Report (Q4) January- March 2022

Action required:

To RECEIVE the report.

Summary and recommendations to the Board:

This is the Quarterly Guardian Report, covering January- March 2022.

During this quarter there were 2 exception report raised by our Junior Doctors through a national portal. These exceptional reports are still very low as compared to other trusts in the region.

Overall, there has been an increase in bank locum spend since the previous report. This is a direct result of doctors having to self-isolate and both ad hoc and long-term sickness absence as well as doctors stepping down from the on-call rota for health-related reasons and vacancies.

The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process. All junior doctors including Trust doctors can submit an exception report.

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

IGC 12 May 2022

Guardian of Safe Working Hours Quarterly Report (Q4) January- March 2022

1) Executive summary

- This is the Quarterly Guardian Report, covering January- March 2022.
- During this quarter there were 2 exception report raised by our Junior Doctors. These exceptional reports are still very low as compared to other trusts in the region.
- Overall, there has been an increase in bank locum spend since the previous report. This is a direct result of doctors having to self-isolate and both ad hoc and long-term sickness absence as well as doctors stepping down from the on-call rota for health-related reasons and vacancies.
- The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process. All junior doctors including Trust doctors can submit an exception report.

2) Time allocation for Guardian of Safe Working Role

- Amount of time available in job plan for guardian to do the role: 2 PA's
- 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 posts

- 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 93 doctors of different grades in training in the trust. Most of the trainee posts are in Hertfordshire. Trust Doctors posts have been recruited from overseas against posts that were left vacant after national recruitment, however the number of Trust doctors have reduced due to increase in trainee doctors.

- 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.

January 2022

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	29	1	0	0	30
Specialist Registrars	20	0	0	1	21
FY2 trainees	9	0	0	0	9
FY1 trainees	8	0	0	0	8
GPST	15	0	0	0	15
Innovative GPST	2	0	0	0	2
Integrated GPST	4	0	0	0	4
Trust	4	1	1	1	7
Total	**91**	**2**	**1**	**2**	**96**

February 2022

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	28	2	0	0	30
Specialist Registrars	20	0	0	1	21
FY2 trainees	9	0	0	0	9
FY1 trainees	8	0	0	0	8
GPST	15	0	0	0	15
Innovative GPST	2	0	0	0	2
Integrated GPST	4	0	0	0	4
Trust	3	0	0	1	4
Total	**89**	**2**	**0**	**2**	**93**

March 2022

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	28	2	0	0	30
Specialist Registrars	20	0	0	1	21
FY2 trainees	9	0	0	0	9
FY1 trainees	8	0	0	0	8
GPST	15	0	0	0	15
Innovative GPST	2	0	0	0	2
Integrated GPST	4	0	0	0	4
Trust	3	0	0	1	4
Total	**89**	**2**	**0**	**2**	**93**

Number of doctors in training on 2016 TCS (total):

January 2022 – 96 Junior doctors (including Trainees/ LTFT/ Trust doctors)

February 2022- 93 Junior doctors (including Trainees/ LTFT/ Trust doctors)

March 2022 - 93 Junior doctors (including Trainees/LTFT/ Trust doctors)

4) Vacancies

- Junior Doctor vacancy stats are as follows:

- **January 2022**
- 1 Specialty Trainee (Saffron Ground)
- 1 Specialty Trainee (Colne House)
- 1 Specialty Trainee (Buckinghamshire)
- 1 Trust Doctor- (Norfolk)
- 1 GPST (Seward Lodge)

- **February 2022**
- 1 Specialty Trainee (Saffron Ground)
- 1 Specialty Trainee (Colne House)
- 2 Specialty Trainee (Buckinghamshire)
- 1 Trust Doctor- (Norfolk)

- **March 2022**
- 1 Specialty Trainee (Saffron Ground)
- 1 Specialty Trainee (Colne House)
- 2 Specialty Trainee (Buckinghamshire)

- 1 Trust Doctor- (Norfolk)

5) Exception reports (in 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.

- Of note there were 2 exception report raised by the junior doctors in this Quarter. Below tables provide the breakdown by department and grade of junior doctors.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General adult psychiatry	0	2	2	0
Learning disability and forensic	0	0	0	0
Old age psychiatry	0	0	0	0
Child and adolescent psychiatry	0	0	0	0
Total	**0**	**2**	**2**	**0**

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1/F2	0	0	0	0
GPST	0	0	0	0
CT1-3	0	2	2	0
ST4-6	0	0	0	0
Trust	0	0	0	0

- The main themes for the above exception reports were due to staff shortages on ward and natural breaks.

- All exception reports from previous quarters have been reviewed by the Guardian of Safe Working.

- 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. The clinical supervisors were advised to consider a work schedule review in response to one series of exception reports.

7) Fines

- No fines were issued during this period.

8) Locums spend

- During this quarter the total cost for bank & agency locums for the 1st on call rota was £37,338 and £10,867 for the 2nd on-call rota.
- There was an increase of £7,591 on the cost of locum spend for the 1st and 2nd on call rota (combined) since last report.
- There were 18 cases of self-isolating/ positive COVID results within this quarter as well as 12 ad hoc sickness absence cases.
- Self-isolating/ positive COVID cases have increased by 10 since the last report.
- There were 4 long term absences across the 1st on call rota due to long term sickness OH restrictions and vacancies on the rota resulting in on call vacancies requiring cover. In addition, 2 trainees left the Trust in February 2022 which resulted in an additional 2 vacancies on the 1st on call rota. There was also a further instance of compassionate/ extended leave on the 2nd on call rota between January and February 2022.
- Out of a total of 153 gaps on the rota, 100 were successfully covered by using locum bank & 1 Agency locum, 50 were covered by cross covering with other on-call doctors and there were 2 instances where step down was required.

- Rota gaps increased from previous quarter to this quarter which is reflected in the increase in locum Gaps since the last quarterly report.

- All doctors doing locums completed the 48-hour opting out declarations.

9) Locum work by HPFT doctors for other NHS Trusts

(Did any 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 1st on call rotas frequencies were all 1 in 12 and 1 in 13.

- The 2nd on call rota was 1 in 13 with 4 SAS underpinning.

- There has been 2 exception report in this quarter which have been resolved.

- In relation to sickness absence Medical staffing have a robust system in place to ensure accurate reporting as well as return to work interviews are taking place. Covid19 risk assessments are also being completed to ensure junior doctors are supported.

- Most of the gaps have been covered by Bank locums/ cross cover.

- The Guardian of Safer working co-chairs a monthly Junior doctor forum that is run virtually. In addition, there is also a weekly meeting held with Junior Doctor Reps, Guardian of Safe working, DME's and Medical Staffing in order for any concerns or questions to be raised and resolved in a timely manner.

Dr Dinal Vekaria

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 10
Subject:	Month 12 and Quarter 4 People & OD Report – March 2022	**For Publication:** Yes
Author:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Janet Lynch, Interim Executive Director, People and OD
Presented by:	Janet Lynch, Interim Executive Director, People and OD	

Purpose of the report:

To update the Board on progress against the People and OD KPIs for March 2022 and Quarter 4.

Action required:

To receive the report.

Summary and recommendations to the Executive Team:

The attached report sets out the Trust's March and Quarter 4 performance in relation to key People and OD metrics that support our annual plan and the NHS People Plan. Also set out are the actions being taken to address the three key areas of focus:

- Recruitment
- Retention
- Wellbeing

These remain our areas of focus due to the continuing data trends and direct feedback from staff, as follows:

1. Vacancy rates
    - Our vacancy rates remained around the same for the fourth month in a row, at 14.14% in March (559.4 WTE vacancies), a reduction from 14.51% at the end of Quarter 3 (566.86 WTE vacancies). Our registered nurse vacancy rate increased slightly to 24.4% and our AHP vacancy rate reduced again to 21.87%.
    - Our establishment increased again in March, with a total establishment increase this year of 171 WTE.
    - Recruitment activity remains particularly high, increasing our staff in post despite the increase in establishment and unplanned turnover levels.

2. Retention
    - Our unplanned turnover remained stable for the fourth month in a row at 12.82% in March, compared to 12.82% in February, albeit significantly above our target of 9%.
    - Several retention projects are in progress and described in more detail in the report, in particular:
        a) Our HCSW recruitment and retention programme.
        b) Participation in the ICS Retention Pathfinder project, which is helping us to develop an action plan for ICS level actions where it may be beneficial to collaborate.
        c) Participation in the national mental health workforce retention group
        d) Our Trust Flex for the Future programme, supported by NHSE/I.

e) Exploring talent pools for Band 5 nursing staff to develop into Band 6 roles and also for some AHP roles.
f) Implementing a career map for nursing staff from non-registered through to Executive Director level.
g) Focusing on equality and inclusion in recruitment and promotion practices, making this an integral part of our planned talent pools and introducing our new Inclusion Ambassador programme in Q1 of 2022/3.

- We are focussing on improving our appraisal rates as an integral part of retention, quality and safety and have seen a slight increase in compliance in March, although this remains significantly below target.

3. Wellbeing
   - Wellbeing and morale are also integral to retention and our comprehensive offer continues. Sickness absence has reduced once more from 5.25% in February to 5.08% in March. Mental ill health related absence has continued to reduce.

The report highlights some key achievements during the 2021/22 financial year:

- Welcomed 667 new staff to HPFT
- Recruited 450 staff internally
- Reduced time to hire to 44 days
- Increased recruitment capacity to 600+ recruitment episodes per month
- Engaged with 1793 staff via the annual staff survey
- Filled 144,462 bank/agency shifts
- Supported over 400 staff via the Here for You Service and Employee Assistance Programme
- Engaged with 1496 staff through our monthly health and wellbeing offer
- Engaged with c.2000 staff through the Summer and Winter wellbeing festivals
- Celebrated the contribution of 63 Inspire Award winners
- Ranked in the top 10 MH & LD trusts by staff for our health and wellbeing support
- Increased apprenticeships by 39%
- 26 people have participated in the local Mary Seacole Programme and Leadership Academy
- 385 people have attended our bite-sized leadership development sessions.

In summary, recruitment, retention (which includes having high quality appraisals) and wellbeing remain of particular concern, albeit that unplanned turnover and vacancy rates are stabilising (despite the continued increase in establishment) and absence, particularly mental ill health related absence, is reducing.

The Board is asked to receive this report.

Relationship with the Business Plan & Assurance Framework:

Links to Strategic Objective 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:

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

Equality, diversity and inclusion plays a major role in our plans to recruit and retain staff and improve wellbeing and morale.

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

IGC 12 May 2022

Hertfordshire Partnership University NHS Foundation Trust

People and Organisational Development Report
Month 12 and Quarter 4 Report (2021/2022)

1. Introduction

The purpose of this report is to update the Committee on performance against the key people and organisational development (OD) metrics and activity as set out in the Annual Plan. The report sets out the position for March 2022 and Quarter 4 and summarises the activities undertaken to improve performance against the agreed targets and outlines the planned activities for the next period.

2. Context

Our Annual Plan states under Strategic Objective 4:

We will attract, retain and develop all our people with the right skills and values to deliver consistently great care, support and treatment	• Improve the employment experience of all of our people, including support to improve their health & wellbeing and to help them to rest & recover post COVID19 • Ensure all our people feel valued, included and able to fulfil their potential through the development of our just & inclusive culture • Develop our collective leadership culture through the implementation of 'Great Teams' to support our staff to feel empowered & engaged

Our HPFT People and OD Plan sets out the detailed actions to support this objective. Our People and OD Plan flows from the following strategies:

- Our Good to Great Strategy: Great Care, Great Outcomes - great people, great organisation, great networks and partnerships, safe, effective, positive experience
- Our OD Plan: Great teams, just & learning culture, diversity & inclusion, health & wellbeing, values (welcoming, kind, positive, respectful, professional), underpinned by engagement
- Our Recruitment and Retention Strategy
- We Are The NHS: People Plan 2020/21 - action for us all

The NHS People Plan comprises the following four key themes:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on the discrimination that some staff face
- **New ways of working** – capturing innovation, much of it led by our NHS people
- **Growing for the future** – how we recruit, train and keep our people, and welcome back colleagues who want to return

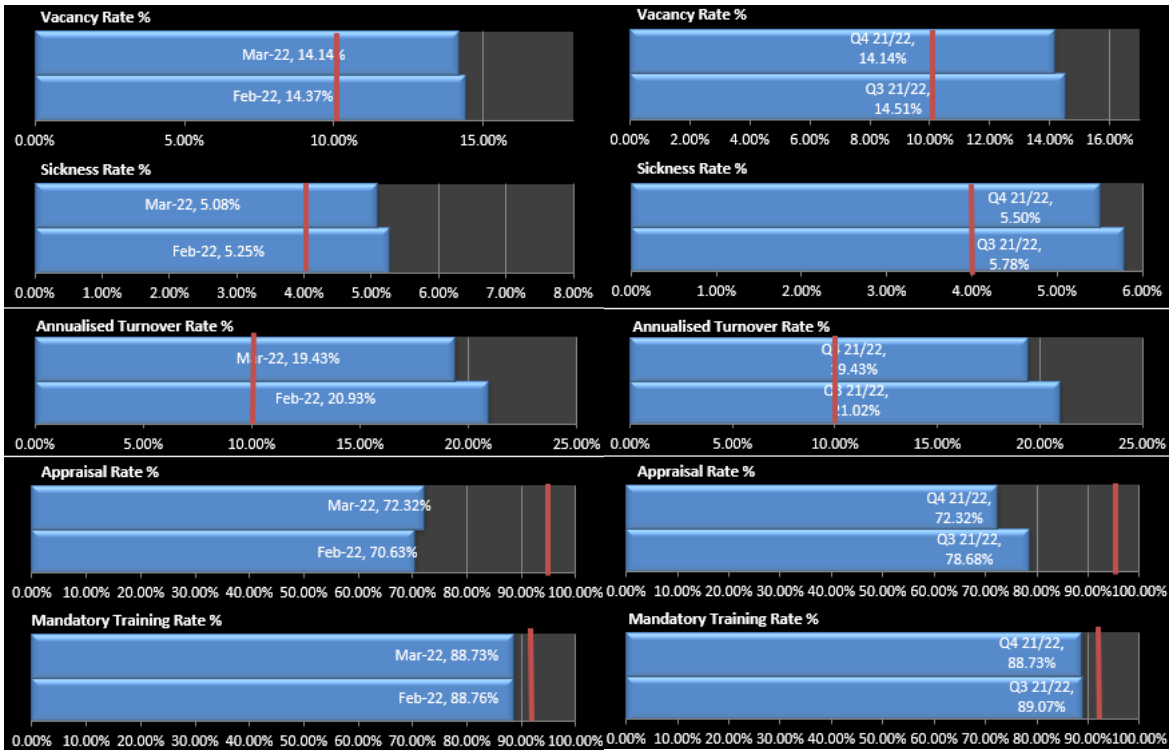
The Plan also encompasses the NHS People Promise, which was refreshed nationally in July 2021:

This report summarises our performance in relation to the key people performance indicators and the activity that supports delivery against the annual plan.

3. March 2022 and Quarter 4 Summary Position

A detailed report with regards the Quarter 4 performance is attached at Appendix 1. Below is the summary position for both March 2022 and Quarter 4:

March 2022 **Quarter 4**



3.1 Vacancies

3.1.1 Vacancy rates remained around the same for the fourth month in a row, at 14.14% in March (559.4 WTE vacancies), a reduction from 14.51% at the end of Quarter 3 (566.86 WTE vacancies).

3.1.2 Our registered nurse and Allied Health Professionals (AHPs) vacancy rates remain of particular concern. In March:

- Our registered nurse vacancy rates increased slightly to 24.4% (227.89 WTE) from 23.74% (222.24 WTE) in February. This is an increase compared to the vacancy rate of 22.87% (212.84 WTE) at the end of Quarter 3, however, the nursing establishment has also increased by 8 WTE since the end of Quarter 3.
- Our AHP vacancy rates reduced again to 21.87% (41.83 WTE) from 22.05% (42.03 WTE) in February. This is also a decrease compared to the end of Quarter 3 vacancy rate of 25.68% (48.6 WTE), whilst the establishment has increased by 2 WTE since Quarter 3.

3.1.3 Our overall establishment continued to increase each month during Quarter 4, totaling a 171 WTE increase in our establishment this financial year and thus further compounding our vacancy challenge. This has meant that whilst we have 27 WTE more staff in post, we have 111 WTE more vacancies than at the start of the year.

3.1.4 Our recruitment activity against vacancies is shown below by staff group and by SBU. The impact of our recruitment activity against AHP and nursing vacancies and turnover is shown at Appendix 2:

Staff Group	Vacancies	Pre-interview Pipeline	Post-interview Pipeline
Professional, Scientific & Technical	50.59	83.4	36.1
Clinical Support Services	183.01	69.5	49.67
Administrative & Clerical	39.79	39.3	30.48
Allied Health Professionals	41.83	22.9	12.86
Medical and Dental	12.09	42.2	10
Registered Nursing and Midwifery	227.89	83.3	37.96
Total	**555.2**	**340.6**	**177.07**

SBU	Vacancies	Pre-interview Pipeline	Post-interview Pipeline
Corporate	36.33	30.8	17.9
Essex & IAPT SBU	42.3	38.6	30.99
Learning Disability & Forensic SBU	124.41	61.9	32.35
East & North SBU	193.12	130.9	51.23
West SBU	163.23	78.3	43.6
Total*	**559.39**	**340.5**	**176.07**

*NB: there is slight variation between the two tables as a small amount of recruitment activity in the SBUs does not fall within the main staff groups specified in the first table and vice versa.

3.1.5 In addition to the external post-interview pipeline of 177.07 WTE new staff, we also have 88.8 WTE internal candidates currently in the post-interview pipeline, making a total 606.47 WTE recruitment episodes being managed as at the end of March 2022.

3.1.6 During March, we experienced a net negative recruitment position in relation to actual numbers of people leaving (headcount), as we had 68 leavers and 44 new starters. However, a significant number of the leavers were due to fixed term contracts, rather than voluntary reasons. Our actual staff in post increased by 12.08 WTE and our vacancies reduced by 8.64 WTE, producing a net positive position in whole time equivalents.

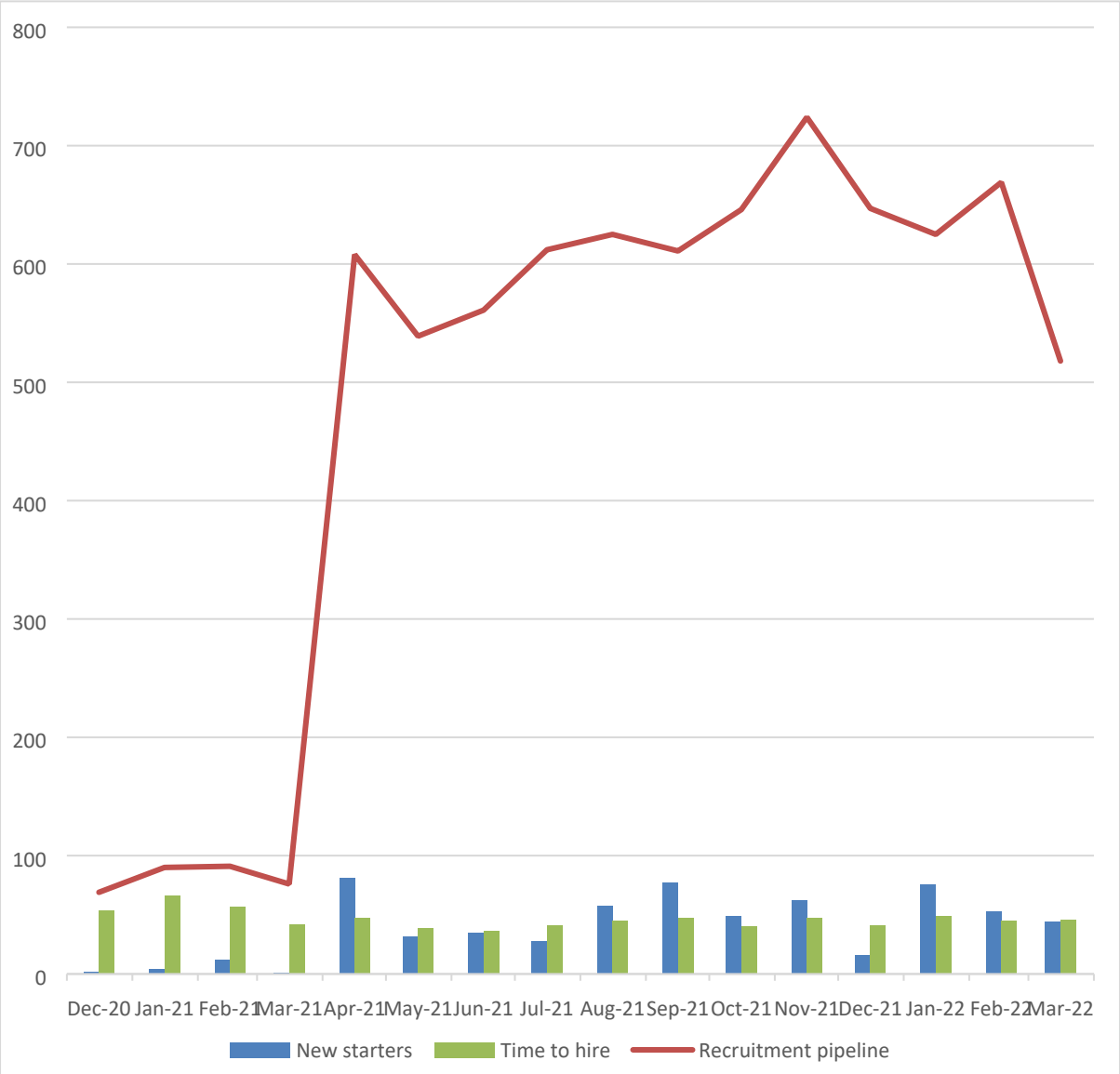
3.1.7 During 2021/22, we recruited a total of 667 new staff to the Trust. We also recruited around 450 staff internally.

3.1.8 Although our recruitment activity remains high, our time to hire remained low in March at 45.6 days (compared to 45.1 days in February).

3.1.9 Prior to 2021/22, the recruitment activity for the Trust had been fairly low. As shown in the chart overleaf, prior to April 2021, we were welcoming on average 4 or 5 new external staff per month, our time to hire was around 54 days and our recruitment

pipeline activity from authorisation through to appointment was around 82 WTE each month.

3.1.10 Since August 2021, we have temporarily increased the capacity of our recruitment team in order to meet the significantly increased recruitment demand. As shown in the chart overleaf, we have consistently seen an average recruitment pipeline of over 600 WTE, achieved an increased number of external staff starting with us (on average around 58 staff joining us each month) and an average time to hire of 44 days.



3.1.11 A CQI project took place during Q2 and Q3 involving MDs and SBU management teams and the Recruitment and Retention Group members. The project provided feedback with regards SBU recruitment support needs and examined how we might be able to learn from other trusts' practices.

3.1.12 As a result, a proposal has been agreed to increase the capacity of the recruitment team in the longer term and to better meet SBU recruitment needs. A recruitment partner model is now being adopted for each SBU, in order to:

- Increase capacity to develop more bespoke, targeted recruitment campaigns both reactively for hot spot areas and in a planned way throughout the year, capitalising on social media and other advertising media appropriate to the vacancies.
- Better enable horizon scanning to identify opportunities for recruitment, such as careers fairs and events both locally and nationally.
- Proactively identify individual posts that are being re-advertised and are hard to fill, exploring alternative strategies to improve the chances of successful recruitment to the post or an amended post.
- Proactively manage the recruitment pipeline to identify and remedy posts that are taking too long at any stage of the process, supporting managers to project manage recruitment episodes in a planned and efficient way.
- Identify blockages in the pipeline and specific parts of the pipeline where the activity is taking longer than the KPI and increasing time to hire, providing proactive recruitment reports to the SBU and HRBP.
- Evaluate and report on the efficacy of the various recruitment initiatives undertaken and keep up to date with emerging and creative practices to ensure continuous improvement in recruitment practice.
- Ensure that adverts and job descriptions (JDs) are written in an attractive and appealing way, tailored to the target staff group.
- Manage talent pools for mass recruitment activities.
- Maintain an up to date JD library in liaison with services and heads of professions.
- Work closely between the transactional recruitment team, HRBPs, L&D and the SBU management team to ensure all recruitment needs of the services are met and that candidate onboarding experience is outstanding and in line with our values.

3.1.13 Our medical staffing position as at the end of March is as follows:

- There are 20 vacancies across the Trust at present. (some have the potential of being filled with International Medical Fellows)
- There was an AAC held in February, which was successful in appointing a candidate to our Norfolk Learning Disabilities service. The successful candidate will commence work in early June 2022.
- The AAC that took place in January also led to a successful appointment, with the successful candidate starting in May 2022.
- There AAC for the Community Consultant roles in West SBU will be rescheduled as both candidates withdrew.
- There is an AAC planned for May 2022 for the position of a Consultant on Wren Ward.
- We are using eight locums due to vacancies, extra support and sickness.
- Two Specialty Doctors commenced work in CAMHS in February, one in Forest House Adolescent Unit and one in the Eating Disorders Service and are settling into their new roles well.
- As part of the medical retention plan, the £6k Welcome Payment was included in job adverts in March.
- The International Medical Fellow (IMF) programme has reopened with a significant response – This is a two-year programme for overseas doctors. We have appointed 6 candidates. who join at CT3 equivalent (junior doctor level). They will rotate every 6 months and will get exposure to different sub-specialties in Psychiatry. In addition, we will sponsor their GMC registration and give them the same opportunities as our trainee doctors. We are working through the pre-employment checks for each candidate.
- 36 new junior doctors commenced work with us in April 2022, with a streamlined onboarding process, ensuring that all the new doctors have all relevant IT access, ID Badges, scrubs and laptops on their first day. Each trainee has a peer mentor assigned to them and they all received their work schedules 8 weeks ahead of them commencing work in post as per the code of practice timeline.

3.1.14 The most recent developments in relation to recruitment campaigns at scale are as follows:

i. *Newly qualified nurses*
   - We have been working on our 2022 intake of newly qualified nurses. A small task and finish group was set up to ensure that the 134 final year students are given firm offers before the University Easter break, with a support and onboarding package for each individual. A virtual meeting was held in the last week of February to showcase the Trust's offer to newly qualified nurses and was well attended.
   - To date we have received 75 applications of which 50 have received offers and the remainder are in the process of being matched to suitable teams. We will continue to promote our offer to this cohort of new nurses to keep increasing the number who will join us in Q2.

ii. *HCSWs*
   - Our HCSW recruitment campaign continues, with the aim of achieving zero vacancies. As at the end of March, our vacancies stood at 107.88 WTE (16.7%), with 26.23 WTE in the post interview pipeline and 41.5 WTE in the pre-interview pipeline.

iii. *Campaigns* –

- West SBU
  - In February and March, we concluded our campaigns for the Eating Disorder Team, there were 13 vacancies that we ran paid adverts for, and nine offers were made, which meant we filled two of our four clinical psychology vacancies. The Eating Disorder Team were able to benefit from the Welcome Payment. A landing page was designed for them and their adverts were placed on different social media sites.
  - In addition, we conducted campaigns for PATH and ARMS. Their landing page was updated, with the adverts on external publications and social media running until 28 May. Two offers have already been made.
  - For the months of April and May, we are running a campaign on the Mental Health Practitioner post in Watford, and this will be part of the Recruitment Event on 28 April.

- LD&F SBU
  - We are particularly focusing on Dove Ward and Little Plumstead vacancies. Both are running separate campaigns with focus on their Band 5 and 6 posts and also Health Care Support Worker posts.
  - Dove Ward will be part of the Trust Virtual Recruitment Event on 28 April.
  - Little Plumstead will hold a face to face event, also on 28 April.

- East & North
  - We continue to focus on Forest House. Following our February recruitment event, three offers were made for one Charge Nurse, one Staff Nurse and one HCSW. There is a further HCSW interview that will be taking place on 22 April 2022.
  - Forest House is featured as part of our recruitment event on 28 April.
  - Our campaigns are all paid for external campaigns, using various social media, Indeed UK and the Nursing Times.

- Essex & IAPT
  - We concluded our Paid Campaign for the Essex Learning Disability on 28 March. There was a paid for campaign on eight adverts and seven offers were made.
  - In March, there was a recruitment event on 28 March, which focused on nursing vacancies only. Two Charge Nurses were appointed at Band 6 level, one Registered Nurse was also offered a post and one Student Nurse was given a confirmed offer.

iv. *International Recruitment*

- We have expanded our international nurse recruitment ambitions from 10 to 50 nurses by the end of this calendar year. Currently, we have made 16 offers to overseas nurses with one candidate cleared and planned to arrive in late May.
- In addition, we continue to provide NMC registration support to our 12 overseas registered nurses who already work with us as HCSWs.
- Finally, it has recently been agreed to expand our international recruitment campaign to AHP staff, with the aim of recruiting up to 10 international AHPs this year.

3.1.15 We continue to promote the relocation payment and, whilst the welcome payment for eligible posts has now ceased, we are now seeing eligible new starters amongst our new starters and noting the positive impact. The impact is being monitored via the Recruitment and Retention Group and will be more fully analysed at the end of Quarter 1 of 2022/23 and reported to the People and OD Group.

3.1.16 We are sourcing a marketing and attraction partner to assist in ensuring all our recruitment materials and internet presence are attractive and that our roles have a visible presence on social media platforms and internet searches. Proposals from five organisations will be received in the week of 25 April and a decision made to appoint a partner will be made in early May 2022.

3.1.10 The key recruitment areas being focussed on currently are:

- International recruitment
  - To recruit 50 international nurses by the end of the calendar year;
  - To recruit up to 10 international AHPs this year.
- Marketing and attraction
  - Carrying out targeted campaigns, in particular for hotspot areas;
  - Updating our marketing materials and staff benefits offer .

3.2 Turnover

3.2.1 Our unplanned turnover remained stable for the fourth month in a row at 12.82% in March, compared to 12.82% in February, albeit significantly above our target of 9%.

3.2.2 Our top reasons for leaving (retirement, relocation, work-life balance and promotion) are echoed across the ICS. We have joined a national mental health workforce retention task and finish group, which met for the first time in March and aims to identify national synergies in our retention challenges and areas on which we can collaborate to address these.

3.2.3 We have continued our work as part of the Trust Flex for the Future programme, supported by NHSE/I. A working group was set up with wide representation across the Trust to take forward this work. During January and February, significant engagement took place across the Trust, including with members of our seven staff networks. Our engagement and workforce data has been used to design our action

plan, which was received by the People and OD Group in April 2022. The plan focuses on the following key pillars of the NHS Flex for the Future Framework:

- Leadership and culture
- Flexible working policy and processes
- Manager capability and support
- Employer brand and talent acquisition
- Inclusive career paths and progression

3.2.4 We continue to concentrate on how we can further support staff with regards promotion and career development within the Trust. In particular, we:

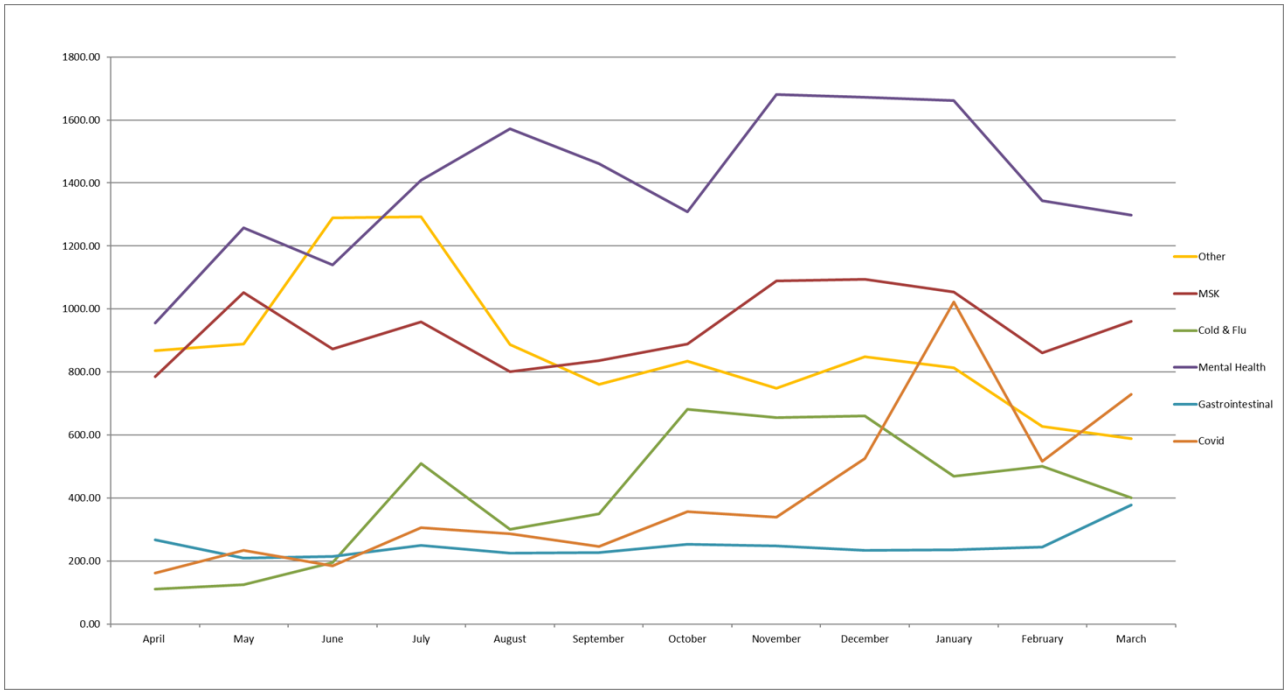
- Have agreed to establish all Band 2 HCSW posts as Band 3 posts to enable career progression upon demonstration of core competencies, with a supportive development framework in place. This is to tackle our 20% turnover rate amongst Band 2 HCSWs and the fact that almost half have been employed with us for over four years and there is a disproportionate over-representation of BAME staff in this, our lowest paid, group of staff.
- Are exploring converting all new Band 2 HCSW posts to apprenticeships to further support development and automatic progression to Band 3 level.
- Are exploring developing talent pools for Band 5 nursing staff to develop into Band 6 roles and also for some AHP roles.
- Are launching a career map for nursing staff from non-registered through to Executive Director level to use as part of our attraction campaigns and to help promote the options available to existing staff in order to retain them and develop their careers within HPFT.
- Are focusing on equality and inclusion in recruitment and promotion practices, making this an integral part of our planned talent pools and introducing our new Inclusion Ambassador programme in Q1 of 2022/3, now that we have 21 people from across our BAME Staff Network who are participating in the scheme and have been fully trained.

3.3 Sickness Absence

3.3.1 Sickness absence has reduced further from 5.25% in February to 5.08% in March.

3.3.2 Whilst staff continue to report a positive experience of working at HPFT, there are signs that our highly dedicated staff have been working long hours and feel exhausted. Service user acuity, caseloads and vacancy levels are reported anecdotally as feeding into this experience and together with the impact of the continuing pandemic and Winter pressures, these factors may be driving presenteeism and mental ill health. In addition, Covid-19 related absence peaked in both January and March.

3.3.3 However, as shown in the chart overleaf, mental ill health related absence reduced in both February and March and is significantly improved since Quarter 3, although remaining higher than at the beginning of the year.



3.3.4 Our comprehensive programme of health and wellbeing work is detailed later in this report and aims to ensure our people are fully supported and to reduce absence levels. The package of wellbeing support continues to be highly rated by staff in our surveys.

3.4 Appraisals

3.4.1 Appraisal compliance has been decreasing since the Summer. Compliance had increased significantly in Q1 and previously it had increased most significantly in Quarter 3 of 2020/21, when our new strengths-based appraisal conversation launched. This means that there was a large volume of people falling out of compliance at this time of the year, which in turn impacted on compliance. In addition, compliance was impacted by staffing challenges due to Winter pressures and the Covid-19 pandemic.

3.4.2 Our drive to increase compliance launched during March as part of a combined campaign to drive up compliance in appraisals, mandatory training and supervision as part of retention and quality. The campaign is focussing on the value of appraisal as a key retention tool and that high-quality appraisals are linked to better care and outcomes for service users, thus the campaign focusses on making time to make a difference.

3.4.3 Thus far, we have experienced a small increase in appraisal compliance from 70.6% in February to 72.3% at the end of March. The aim is to have reach compliance by the end of May.

3.5 Mandatory Training

3.5.1 Mandatory training compliance has increased slightly from 89% in February to 89.4% in March, which remains slightly below our target of 92%. Compliance has held at a similar level for the majority of the year.

3.5.2 We have launched a push to achieve full compliance on all eLearning by mid-April. The majority of our mandatory training is available as eLearning and in total there were 3,500 modules outstanding at the end of February. SBU senior leadership have been given discretion to MD discretion to offer staff the ability to complete their

eLearning via the Bank pay of up to 30 minutes per module to catch up by 10 April if they are on E-Roster and cannot undertake training in core hours due to operational pressures. Managers of all other staff have been required to ensure they enable completion during working hours by mid-April.

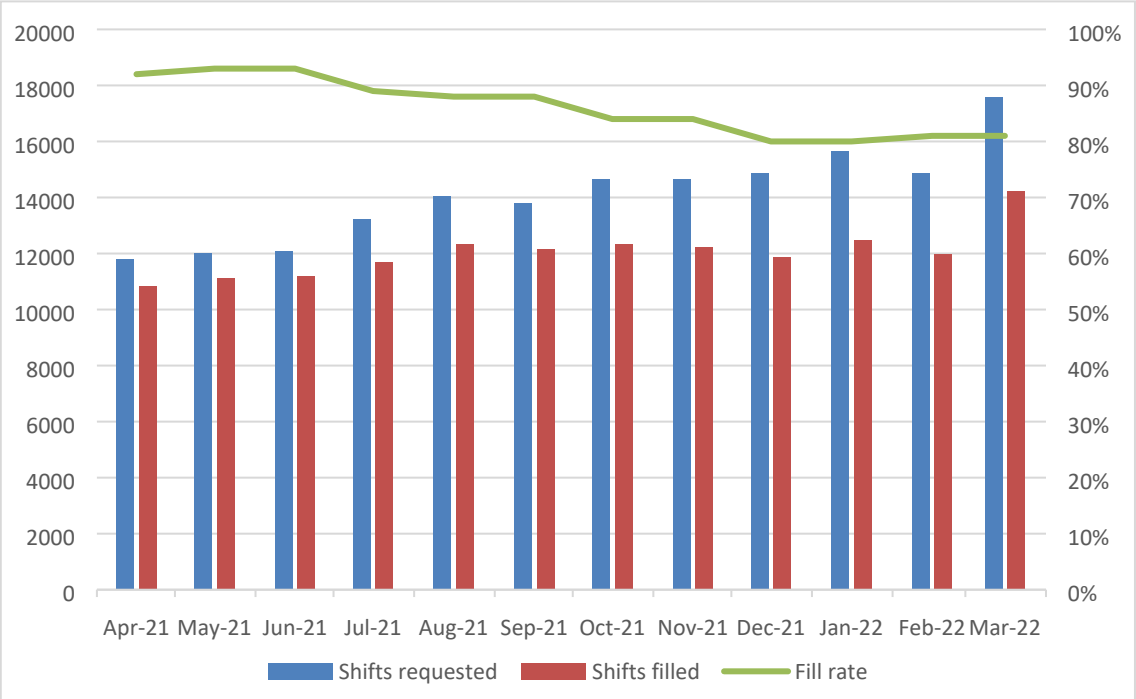
3.5.3 Thus far, we have seen eleven out of the 24 eLearning courses achieve compliance with a further four just under compliance at 90% or 91%. However, the remaining nine are between 72% and 89% compliance and therefore our campaign will continue.

3.5.4 An expanded number of face to face courses are now offered, as we continue to expand the pool of trained trainers and use of weekends for respect, moving and handling and ILS/BLS training to enable full recovery of mandatory training. Although changes to social distancing will increase capacity, one training venue which currently acts as a venue for a significant number of course is planned to be used for operational purposes and training courses undertaken at that venue will be rescheduled. We are pursuing external training company venues and support for moving and handling and ILS/BLS training. We are also recruiting six further Respect trainers full time from outside the Trust, who we will train up so that they can deliver training from Q3.

3.6 Temporary Staffing

3.6.1 During March, Bank and agency shifts for registered nursing and HCA posts shift requests increased significantly from 11,654 in February to 14,177 in March, with an overall fill rate of 81.3% (down from 83.5% in February).

3.6.2 Demand for Bank and agency shifts rose significantly over the year, as a result of vacancy cover, cover to address additional workload and increased observation duties as a result of increased service user acuity. The chart below shows the month on month increase in shift requests, number of shifts filled by the Bank Bureau team and the fill rate. In total, during the year, 169,157 Bank/agency shifts were requested, 144,462 shifts were filled and the average fill rate was 85%.



3.6.3 Over the Easter period, the Bank incentive scheme was extended once more to cover inpatient services during April and staff were paid at their substantive grade in order to maintain shift fill rates and safe staffing levels up to the end of April. The over-booking of shifts to create roving Bank teams at key sites was also stepped up to ensure that safe staffing is maintained despite anticipated absence levels over Easter.

3.6.4 Bank staff spend remained at a similar high level (around £2m) as in February, which is a similar level to that experienced each month since (and including) August 2021. Agency spend, however, increased significantly from £810.4k in February to £1.28 million, which is the highest it has been this year.

3.6.5 Medical locum use has increased by one since February to eight posts, which are being covered by agency locums due to vacancies, extra support and sickness.

3.5 Employee Relations Cases

3.5.1 The number of live investigations for non-medical staff remain at 7 for March the same as in February. The average length of time has reduced to 14 weeks (slightly above our 12-week target), as one long-standing case has concluded, one case which was delayed due to sickness absence remains live and one new case has been added.

3.5.2 All seven cases are disciplinary cases. There are no long-standing formal grievance or bullying cases, as these have all been resolved. All other potential cases have reached informal resolution, which is a reflection on the energy invested to achieve satisfactory informal resolution for all parties, wherever possible.

3.5.3 The number of suspensions have increased by one, bringing the total to six. These are being proactively managed to resolve them as swiftly as possible.

3.5.4 For medical staff, there are two MHPS investigations underway and three grievances which we are actively working to resolve as quickly as possible.

4 Other People and OD Activity

The following items represent some of the key People and OD activities over the last quarter.

4.1 Health and Wellbeing

4.1.1 A significant amount of wellbeing support continues to be provided. Our regular health and wellbeing programme of activities and events include more flexible timings of day and evening sessions and cover topics such as pilates, mindfulness, hypnorelaxation, art and craft sessions, with themes in line with national awareness campaigns. During 2021/22, 1496 staff attended one of our regular monthly sessions and around 2000 staff attended the Summer and Winter Wellbeing Festivals, which were very well received.

4.1.2 Our eight-week mindfulness course remains open to all staff to help people learn how to reduce the physical and psychological symptoms of stress, reduce anxiety, improve mood and concentration. The IAPT service and New Leaf Wellbeing and Recovery College also open up their webinars to all staff and have run a number of sessions, including, for example, on coping with stress, sleeping better, relaxation skills, mindfulness, self-compassion, women's health and moving forward with long-covid.

4.1.3 Our HPFT menopause support group was launched in January and is bi-monthly to enable a supportive space where staff can ask questions, share experiences and share information about perimenopause and menopause. These continue to to be well attended.

4.1.4 A new six-week mindful approach for Menopause course has been developed and will be introduced in April for HPFT women who are experiencing the perimenopause and menopause.

4.1.5 Menopause Advocacy training has launched with the first of two training cohorts in February and the next taking place in May. HPFT staff that attend the awareness training will be attending the support forum and all our staff networks to share learning. They will also be attending relevant management meetings and running further awareness sessions. The advocacy training is part of the continued project work with the ICS to enable HPFT to work towards the menopause friendly employer accreditation.

4.1.6 During March, the Here for You service has provided direct support to people affected by the situation in Ukraine, including reflective sessions for those affected by the situation in Ukraine and for staff experiencing Burnout.

4.1.7 Between January 2021 and February 2022,our Here for You service has seen 126 HPFT staff. 154 HPFT staff have also accessed the regular outreach webinars. 41 of our staff had a specialist Rapid Clinical Assessment, which equates to roughly 3,690 clinical hours of assessment time delivered by a clinical lead psychologist and psychological therapist specialists

4.1.8 In the same period, 122 staff accessed the Employee Assistance Programme provided by Vita Health. The most accessed service was in relation to emotional support followed by musculoskeletal support.

4.2 Leadership Development

4.2.1 We continue to support leadership development, through a number of channels. Our Seniors Leaders Forum met in February to discuss the key themes for the coming year and to shape the content and focus of future forums, as a consequence of which, we now have a plan for this year which addresses our leaders' needs.

4.2.2 The East of England Leadership Academy has resumed its offer of leadership development courses and career development support, which has been promoted across the Trust, alongside the HPFT offer, including our bite-sized training on 'coaching as a management style', 'management fundamentals' , "compassionate leadership" and "listening skills" development sessions.

4.2.3 In addition, Cohort 12 of the local Mary Seacole Programme which started in October 2021 continues. Cohort 13 has now received over 30 applications, which are currently under consideration.

4.2.4 We also continue to provide team development support, coaching, and healthcare leadership model 360 appraisal feedback. Particular support has been provided to the Forest House team and the team at Warren Court.

4.2.5 During 2021/22, 385 people have accessed our in-house bite-sized leadership development sessions and 26 people have participated in the local Mary Seacole Programme and Leadership Academy.

4.3 Apprenticeships

4.3.1 Following our relaunch of apprenticeships and the work during National Apprenticeship week, there are now 88 apprentices in the Trust, an increase of 21 and 39% increase compared to the start of the 2021/22.

4.3.2 Our apprenticeships are currently mostly in nursing, with 26 staff on the nurse associate programme and 30 undertaking registered nurse programmes. In addition, we have 11 Occupational Therapy apprentices, nine six PWPs, three adult care apprentices, one pharmacy apprentice and the remainder undertaking non-clinical apprentices such as business administration, finance and customer service.

4.3.3 We have an apprenticeship levy pot of £1.5 million and expect to received £810k this year. In the last year, we have spent £407k. With our current number of apprentices, we would spend £501k this year and expect to lose £57k from our levy pot each month.

4.3.4 However, we expect to continue our expansion of apprenticeships through advertising apprenticeships as a career development option in our recruitment adverts. In addition, by the end of Q1, we will start to convert all our Band 2 HCA posts to apprenticeships as part of our HCSW recruitment and retention plans and to increase our use of the apprenticeship levy.

4.3.5 We will continue to monitor the impact of our relaunch of apprenticeships quarterly at the People and OD Group.

4.4 Engagement

4.4.1 During Quarter 4, we held four Inspire Award ceremonies, where we recognised the contribution of our 23 worthy winners who had been nominated by colleagues and service users for their inspirational contribution. During 2021/22, we have recognised the contribution of 63 Inspire Award winners.

4.4.2 During March, we celebrated International Women's Day, with a programme of inspirational speakers from within and outside the Trust.

4.4.3 Currently all Executive team members and some Senior Leadership Team (SLT) members have a BAME reverse mentor, who is a junior member of staff who shares their experiences and gains insights into aspects of the Trust's leadership and management. In order to expand the programme so that every member of the SLT has the benefit of a BAME reverse mentor, expressions of interest opened in March to attract more BAME staff to become reverse mentors.

4.4.3 23 March 2022 marked the second Covid-19 National Day of Reflection. Our Chief Executive and our Spiritual Care Manager led a 30-minute time of reflection, where we heard thoughts and hopes from colleagues across the Trust as we looked back over the last year and forward into what is to come.

4.4.4 We have been listening to feedback from our people about the impact of cost of living increases. As a result, we have:

- We are introducing a temporary increase to mileage payments (an extra 10p per mile) to help with fuel costs for all staff who need to travel as part of their roles. This will be payable for all mileage claimed between 1 April and 30 June, pending a national announcement about NHS mileage payments.
- We will pay public holiday rates for everyone who is rostered to work on 3 June, which is the additional Platinum Jubilee bank holiday this year

- We have compiled a comprehensive list of discounts, offers and financial support services for our staff, including a range of charities specifically for NHS staff, who offer financial support and hardship funds.
- We have reviewed our current benefits offer and are expanding this, focussing particularly on financial support.

4.4.5 1793 staff (50%) participated in the annual staff survey in 2021. During April, we are talking to all our people about our annual staff survey results which show that our people are proud to work for the Trust, recommend us as a place to work, are proud of the standard of care we provide, are clear that service users are our top priority. The survey results tell us that our people are highly engaged, motivated and emotionally invested in their work, that we have a strongly compassionate culture and that staff feel supported and looked after through the support for health and wellbeing, work-life balance and flexible working, development and high quality appraisals and that people feel confident to raise concerns and know that if they do so, their concerns will be addressed.

4.4.6 Our staff survey results indicate that the areas we should focus on to keep improving the experience of all our people include reducing violence and aggression, continuing to improve belonging and inclusion, helping our people to achieve better levels of self-care and embracing feedback as an opportunity to grow and improve.

4.4.7 We are engaging with all our people to discuss our survey results and to co-produce an action plan to continue to make the Trust the best place to work. Conversations are taking place across the Trust, within teams and at our seven staff networks. We are capturing everyone's feedback and inviting everyone to contribute their ideas, suggestions and feedback via an online notice board, where all suggestions are anonymous and staff can see other people's ideas and vote for them. During May, we will collate al the feedback to create our co-produced plan.

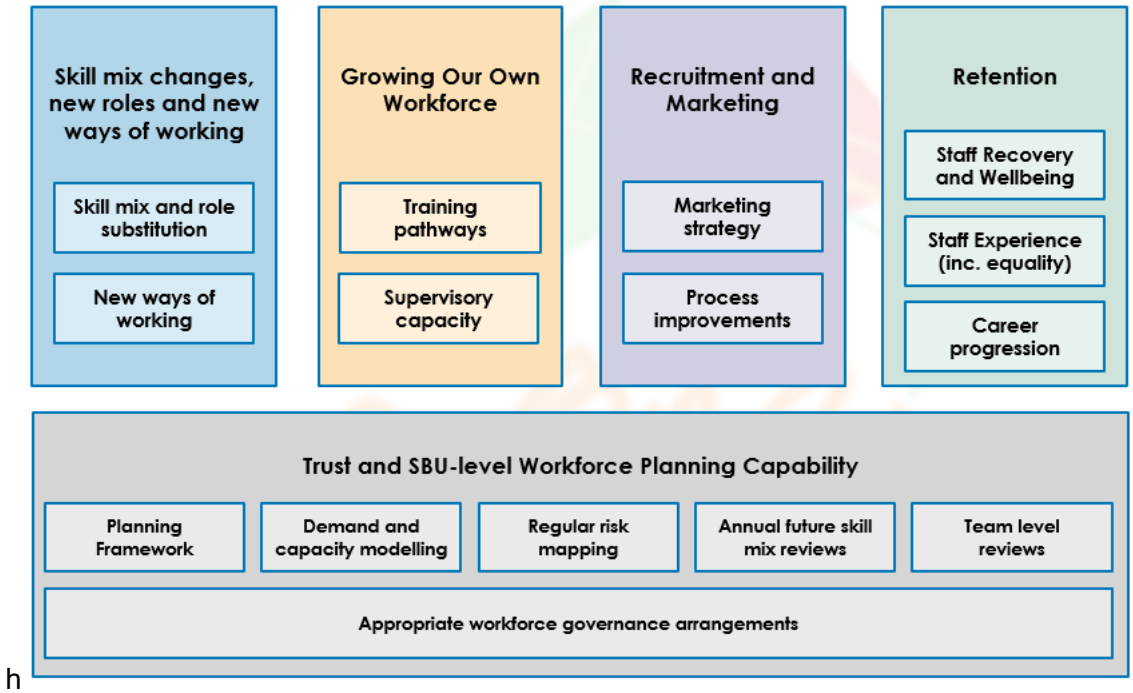
4.4.8 At our meeting of the People and OD Group in May, we are discussing plans for this year's Big and Little Listen so that we continue to engage with all our people about what is most important to them and keep making HPFT the best place to work.

4.5 Workforce Planning

4.5.1 Our annual planning submission for workforce is due on 28 April 2022. The submission was developed through discussion and scrutiny of the Workforce Planning and Development Group. Our submission predicts increases of staff in post as a result of our recruitment and retention work and an equal reduction in temporary staffing. We expect growth in establishments due to new funding and service expansion as well as increased activity and demand. The predicated establishment increase is by 300 WTE, with a staff in post increase predicted as 492 WTE.

4.5.2 The Trust workforce plan which was created in Q1 of 2021/22 and predicted that our workforce would need to grow by 650 WTE over a period of five years. As expected, our demand and activity have increased considerably. We have seen a growth in establishment of 171 WTE in the last year and predict a growth of 300 WTE in the next year.

4.5.3 An overview of the workforce plan is summarised below with progress against each of the four pillars detailed.



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4.5.4 Skill Mix

In relation to skill mix, new roles and new ways of working, we have introduced a number of new roles to adapt skill mix, including, for example, clinical associate psychologists, pharmacist technicians, assistant practitioners, trainee nurse associates, HCSWs and physician associates. However, there is a need to scale up this work and undertake a more far-reaching establishment and skill mix review in order to meet the challenge of our predicted increase in activity and enable us to create novel recruitment pipelines (including volunteers) to avoid over-reliance on traditional roles for which there is insufficient supply. The Deputy COO, Deputy Director of Nursing and Deputy Director of People and OD are currently scoping this work. In addition, our digital strategy will enable further transformation in new ways of working.

4.5.5 Growing Our Own

We have been successful in growing our own staff in that 42% of our appointments this year have been internal candidates, who we have successfully developed to take their next step and continue their career at HPFT. Our staff ranked us third in the country out of all mental health and learning disability trusts in relation to our career development offer. However, we continue to see people leave us in order to progress elsewhere and our BAME staff report a difference in experience in relation to progression. One objective of the establishment and skill mix review work which is currently being scoped is expected to bring about improved training pathways to better enable us to grow our own supply of staff as well as retain our people. We also plan to further expand our apprenticeship routes into the Trust at HCA level to better enable us to grow our own supply of HCSWs. We are also concentrating on the experience of our students who work with us on placement during their studies and ensuring that we provide an attractive offer to join us a registered professionals.

4.5.6 Recruitment and Marketing

As set out earlier in this report, recruitment capacity and marketing approaches have been significantly improved to enable us to recruit higher numbers of external candidates. Our workforce plan predicted that we would need to recruit between 860-920 staff to be at full establishment by March 22, or 520 - 580 staff to retain our current vacancy levels. We have recruited in excess of the status quo figure, however, our unplanned turnover increased so that the recruitment challenge was

greater. Whilst we have experience success in expanding our recruitment capacity and and external pipeline ourselves, we are intending to partner with an external organisation to further develop our marketing and attraction.

4.5.7 Retention

We implemented our co-produced people recovery plan and staff survey action plan during 2021/22. Our people report an overall positive experience of working at HPFT and we were ranked joint fourth in the country in relation to staff recommending us as a place to work and our health and wellbeing support ranked in the top ten. However, as noted above, people continue to leave due to career progression and our BAME staff, who make up more than a third of the Trust, do not have such a consistently positive experience. We are therefore strengthening our talent management offer, in particular for BAME staff. In addition, we are concentrating on reducing violence and aggression, including racial abuse, against our staff. Further detail on staff reasons for leaving and our retention plans are set out earlier in this report.

4.5.8 Workforce Planning Capability

In Quarter 2 of this year, we established the Workforce Planning and Development Group, which consists of SBU leadership, heads of professions, finance representatives, Staffside, business and performance, strategy and partnerships and people and OD colleagues. The group has overseen the delivery of the H2 and 2022/23 workforce submissions, as well as a workforce planning framework and SBU plans. We continue to strengthen workforce planning capability within the Trust and are providing development sessions for key members of the workforce planning and development group, as well as establishing further templates and frameworks to forecast recruitment activity.

4.6 Inclusion Ambassadors

4.6.1 21 Inclusion Ambassadors have now been fully trained and the scheme will launch at the end of April.

4.6.2 Each time that a Band 8a+ post is advertised, an Inclusion Ambassador will be assigned and added to the recruitment panel. They will have a role equal to all other panel members in preparing for the interview/assessment and participating in the interview. Their name and role will be included in the interview invitation letter and details about the scheme will appear in adverts.

4.6.3 The standard recruitment packs are being updated to include the Inclusion Ambassador scheme and the standard equality and inclusion questions which have been adopted by all trusts in the ICS. Our launch will include messaging via Trac to all recruiting managers, HPFT News, the Senior Leaders Forum and the Trust Management Group.

4.6.4 A community of practice is being set up for the Inclusion Ambassadors and they will discuss with the BAME staff network their feedback, issues and themes arising from their work. Key measures of the schemes success include the results from our quarterly pulse survey, our annual staff survey, feedback from the Inclusion Ambassadors, appointment rates for BAME staff in 8a+ posts and the percentage of BAME staff in 8a+ posts. These will be formally reported to and monitored by the People and OD Group quarterly with effect from September.

5. Conclusions

5.1 Recruitment, retention and wellbeing remain of particular concern, albeit that unplanned turnover and vacancy rates are stabilising (despite the continued increase

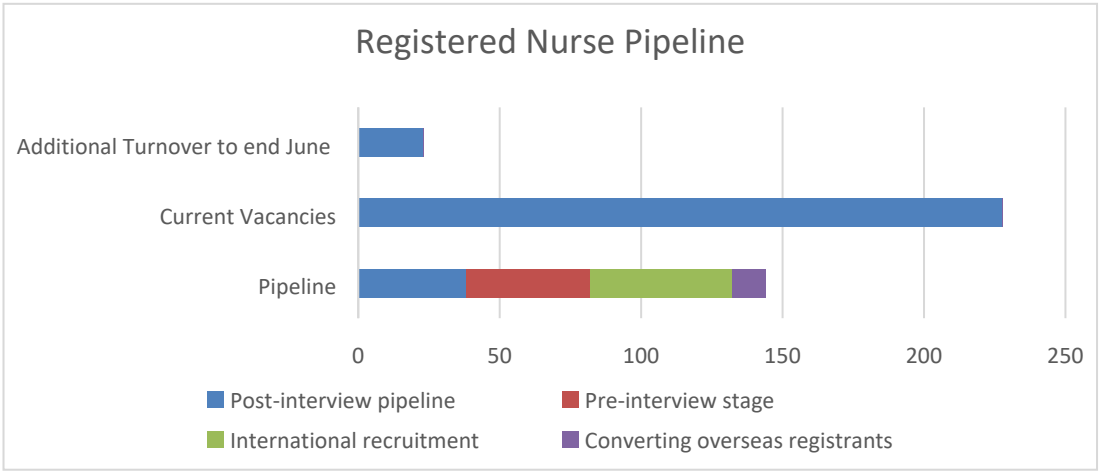
in establishment) and absence, in particular mental ill health related absence, is reducing. These will remain our areas of focus into 2022/3.

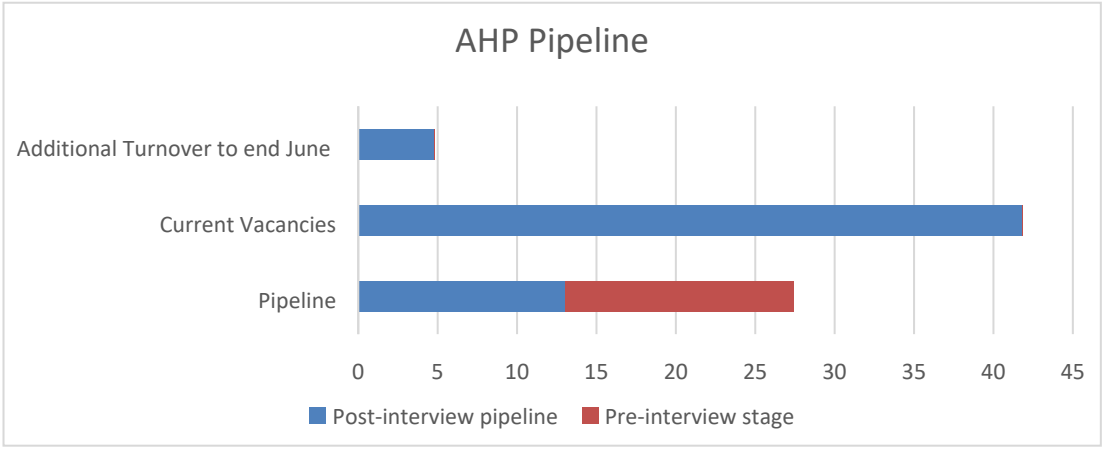
6. Recommendation

6.1 The Committee is asked to note the current position and the work that is being undertaken to support delivery against the annual plan and the NHS People Plan, as well as the actions being taken to improve the position moving forward.

Appendix 2: Impact of Recruitment Pipeline on Vacancies

The following charts assume 53% of nursing adverts will be filled externally and 63% of AHP adverts will be filled externally, based on current external fill trends.





PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 11
Subject:	Annual Plan 2022/23	**For Publication:** Yes
Author:	Simon Pattison, Deputy Director of Strategy	**Approved by:** David Evans, Director of Strategy and Partnerships
Presented by:	David Evans, Director of Strategy and Partnerships	

Purpose of the report:

The purpose of the report is to present the Board with a finalised version of the Annual Plan for 22/23 for review and sign off.
The report notes those actions that will require additional commissioner investment or resources and highlights the areas of key risk. The report also notes the Trusts process for monitoring the delivery of the plan actions and how this will be routinely reported to the Finance and Investment Committee.

Action required:

To review this Annual Plan and sign this off as the Trust's Annual Plan for 2022/23.

Summary and recommendations to the Committee:

Summary

Each year the Trust develops an Annual Plan to set out our key priorities for the coming year. The Annual Plan for 2022-23 is set out below and follows previous discussions with Board members and with a wide range of other stakeholders. The Annual Plan has been developed by the wider Trust leadership team based upon various discussions and feedback from key stakeholders and within the context of the current challenging environment.
As in previous years the Annual Plan sets several stretching commitments describing how the Trust will continue in its unrelenting commitment to provide Great Care and to deliver Great Outcomes, working together with services users, carers, our staff, and other partner organisations.

Recommendation

It is recommended that Trust Board approve the attached Annual Plan.

Relationship with the Annual Plan & Assurance Framework:

This is the updated Annual Plan for 2022/23.

Summary of Implications for:

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

Development of the draft plan has been informed by engagement with users and carers through

the Service User Council and the Carers Council, and workshops with Experts by Experience. Coproduction and engagement with service users and carers will continue as the underpinning delivery plans are developed and implemented throughout the year.

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

The Annual Plan includes commitments to improve quality and safety and transform the social care services delivered by the Trust.

ANNUAL PLAN 2022/23

26th May 2022

1. Introduction

Each year the Trust develops an Annual Plan to set out our key priorities. Earlier draft versions of the Annual Plan have previously been submitted to the Finance and Investment Committee for consideration and comment as part of the extensive consultation process undertaken involving the Executive Team, the wider Senior Leadership, the Trust Board members, the Council of Governors, and external stakeholders including the Hertfordshire and West Essex Integrated Care System and our commissioners.

2. Background

The development of this plan has been informed by the national and local priorities in the different health and care systems that the Trust operates in. These include the NHS England Delivery Plan for mental health for 2022/23, the national NHS learning disability priorities, work in our local system such as the current consultations on developing new Mental Health and Dementia strategies for Hertfordshire and the refresh of the Hertfordshire Learning Disability 'Big Plan'.

Alongside the development of this Trust internal plan, we are contributing to the development of overarching system plans for 2022/23 and working with the Hertfordshire Mental Health, Learning Disability and Autism Collaborative to align our strategic direction of travel in Hertfordshire with that of the Collaborative. Contract discussions with our commissioners are also being finalised at the same time.

The Trust's well established Good to Great Strategy forms the basis for this plan, whilst recognising the ongoing impact of the Covid pandemic both over the past year and the likely impact for the coming year.

3. Overview of the Annual Plan

The Annual Plan has been developed within the seven priorities previously agreed which continue to remain relevant as set out below:

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 us support will feel positively about their experience
3. We will improve the health of our service users through the delivery of effective, evidence-based practice
4. We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support, and treatment

5. We will improve, innovate, and transform our services to provide the most effective, productive, and high-quality care
6. We will deliver joined up care to meet the needs of our service users across mental, physical, and social care services in conjunction with our partners
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

However as noted above the sustained and continuing impact of the Covid pandemic over the past two years means that this year we must:

- **Restore -** recharge and revitalise our services and support systems to address the impact on services users, carers, staff, and the whole population. We will reduce the current waiting times to access services and rebuild the capacity and resilience of those services that have been most severely affected over the period.
- **Reset**, moving on from the emergency response of the past two years we will adjust to live with the ongoing impact of Covid. We will ensure our services remain safe and consistently provide a great experience. To do this we will adapt and strengthen our leadership capability to enable the organisations to thrive and we will realign our core work programs to best meet the challenges ahead; and
- **Reshape -** the Trust has made significant strides in transforming services to provide Great Outcomes – for everyone, all the time. For our progress to both continue and gather pace, we will review and strengthen our care models, further adopt new technologies and integrated working, and embark on the significant cultural shift required to become an exemplar organisation in relation to diversity and inclusion that is focused on addressing the significant inequalities in healthcare that persist.

The Annual Plan detail reflects these requirements and is set out within in the Appendix below.

4. Key Points of Note to the Committee

In setting our Annual Plan we recognise the challenges faced both internally and within the wider system. However, many of these challenges do mean we have to seek to go further faster and in setting our plans we are seeking to balance our ambitions against the current needs of our populations. The current contract and funding discussions with the ICB in Hertfordshire and West Essex will be key in finalising our Annual Plan detail as additional short-term funding is required to recover those areas where service levels cannot currently be consistently met, to meet the current extra demand on services and to reshape our service models to what is required going forward.

Over the past two years and particularly during the last six months, the Trust has seen significant changes in the environment in which it operates. In particular.

- Increased service demand leading to longer wait times – this is from the impact of pandemic on our service users/ carers and the wider population (Mental health prevalence).
- Changes in complexity of demand- again arising from the increased societal stresses, the disruption to social support networks and the lack of contact and connection with health and other key agencies.
- Higher Clinical Risk management agenda - this is shown in the increased number of Serious Incidents, people being sectioned under the Mental Health Act, and service risks.
- Local system service capacity and capability – the emergence of major commissioning gaps, alternatives for complex cases (Low secure / PICU), social care, children/ young people need).
- Workforce supply and retention issues.
- Emergent financial challenge – linked to the above demand & complexity but amplified by the phased removal of COVID funding (around £5m a year) and the additional local efficiency requirement.
- Opportunities to use technology to improve care

The plan is based on additional investment from commissioners across many of the areas set out across the seven objectives. Some of these negotiations have not yet been completed and so there is a degree of uncertainty around these. Plans will need amending if negotiations are not concluded successfully. This is particularly the case for areas such as the primary and community transformation programme, the expansion of support for children and young people with Eating Disorders and managing the demand pressures within the Single Point of Access.

The other risks around the delivery of the plan reflect the major risks in the risk register, in particular the challenge of recruiting and retaining staff to deliver the priorities. A major focus of Strategic Objective 4 is to mitigate these risks. Another significant risk is that many of the actions need to occur in partnership with other organisations and so we are reliant on partners to support delivery. This covers areas such as suicide prevention, the development of our work around learning disabilities in Norfolk and work around population health management.

As in previous years the Trust will routinely monitor and report the delivery and outcomes from the Annual Plan implementation. To support this for each of the seven underpinning strategic objectives there is again a quarterly key milestones plan. Appendix B shows an example for Strategic Objective 4 workforce – there have been some changes to the wording of the priorities since this draft was created but it gives a sense of what is being worked on. The current quarterly progress report will continue to be provided to the Committee and to the Trust Board.

To strengthen the current oversight it is proposed that;

- Progress will be reported regularly through to the Trust Management Group for review and be supported by more in depth thematic reviews with the Senior Leadership Team.
- The progress on the annual Plan with be more closely integrated within the Trusts SBU performance review (PRM) process.
- Actions from the Annual Plan will be much more embedded within the individual annual appraisal process.
- The agendas and reporting of key work groups such as the People and Organisational Development Group (PODG) will be built around the quarterly milestones

In relation to the methods and content of the current report then this will be reviewed as part of the wider review being undertaken currently (and is an action within Strategic Objective 5).

5. Recommendations

It is recommended that Trust Board approves the attached Annual Plan.

Our Annual Plan 2022-23

1. Introduction

Our Annual Plan describes our commitments to our service users, our people, and our partners during 2022/23. Our ambitious plan reflects our relentless drive to provide high quality health and social care and achieve great outcomes for our service users, carers, and the communities we serve.

We are exceptionally proud of our people who over the last two challenging years have stepped up in extraordinary ways to ensure our service users continued to receive the care they need. Our Annual Plan details our commitment to ensure all our people feel supported to deliver great care, feel included and are able to thrive.

As we enter 2022/23, we continue to 'live' with covid in our lives and for the Trust this means learning from and keeping the best practice we have adopted during the last two years. It also means reshaping our services so we can meet, on an ongoing basis, the levels of demand and need that have arisen as a consequence of the impact of the pandemic on people's emotional and mental wellbeing.

2. Background

Our 'Good to Great' Strategy describes how we are going to deliver our vision of 'Delivering Great Care, Achieving Great Outcomes – Together'. Our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we consistently achieve the outcomes that matter to those who use our services, by working in partnership with them and others who support them. It also means we keep people safe from avoidable harm, whilst ensuring our care and services are effective, achieve the very best clinical outcomes and support individual recovery outcomes. Our 'Good to Great' triangle below depicts the key areas of focus for the Trust in terms of its people, improving the way we do things, partnerships and quality (experience, effectiveness and safety).

Figure 1 - Good to Great Triangle

3. Our Strategic Objectives

We have seven strategic objectives (framed against our Good to Great Strategy) which provide the foundation against which the Annual Plan is set.

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 all our people with the right skills and values to deliver consistently great care, support and treatment
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care
6. We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

4. Our Context

The external environment in which the Trust operates, including the broader societal context, has significantly changed in the last two years and this plan has been developed to reflect and deliver within this context.

Covid-19 Pandemic

Nationally, we have seen daily restrictions on life reduce however the impact of the pandemic continues. In health and care settings infection prevention and control procedures remain paramount as we now adopt to 'living with covid-19' and the national focus being on elective backlog recovery and urgent care demand. Across mental health and learning disability services we can see the impact of the pandemic; with higher demand levels for services, higher levels of acuity and need, with resultant care backlogs that need to be addressed. This is also true for our services across HPFT.

Societal Inequalities

The last two years has intensified social and health inequalities already inherent across society. The pandemic has had a disproportionate impact on people from black, asian and other minority ethnic groups, older people and disadvantaged communities. These are often communities that do not always feel able to easily access our services. The continuing pressures of price inflation and reducing disposable incomes may have a profound impact for lower income households and there is anticipated to be resultant impact on people's emotional and mental health.

Health and Care Workforce

The last two years have seen NHS and Social Care staff going above and beyond and although incredibly resilient, many staff have yet to fully recover from the emotional and physical toil of the pandemic. Nationally, there continues to be a workforce shortage across the health and social care sector and although we had a very positive staff survey in 2021/22 we too saw higher levels of turnover and vacancies as a Trust, particularly in the nationally recognized shortage groups of nursing and Allied Health Professionals (AHPs).

Integrated Care Systems (ICSs)

The new Health and Care Act will see Integrated Care Boards (ICBs) being established from 1 July 2022. These statutory bodies are tasked, together with partners, with overseeing the development of strategies and commissioning of services to improve the health, wellbeing and outcomes for the local population(s) they serve. Although Hertfordshire and West Essex is the main commissioning ICS for HPFT, we operate across Essex, Buckinghamshire, Norfolk and Hertfordshire – in total working across six different ICS footprints.

Within the Hertfordshire and West Essex ICS there are four 'health and care partnerships' (HCPs). HPFT co-chairs one of these partnerships – the Hertfordshire Mental Health, Learning Disability and Autism Collaborative This Collaborative brings together organisations representing users, carers, voluntary, community and statutory sector partners with the aim of improving outcomes for people with learning disabilities, autism or experiencing mental ill health in Hertfordshire.

National Funding Regime

Nationally, this year there is a shift back to normal financial operating frameworks across the NHS, with covid income reducing from 2020/21 levels and the return of normal 'efficiency' requirements. At a national level additional funding has been identified to support elective recovery and to meet increased demand on services. Additional funding for mental health, learning disabilities and autism will flow through the NHS's continued commitment to increase funding for mental health known as the Mental Health Investment Standards (MHIS) and through additional transformation funding (Service Development Funding (SDF)). Locally we have been working with commissioners to review our funding given the increased demand and acuity we are experiencing across our services, both for health and social care.

5. Development of the Plan

Our 2022/23 plan continues to align with our Good to Great Strategy and builds on the priorities we set during 2021-22. It reflects national Long Term Plan commitments together with local priorities identified with commissioners across

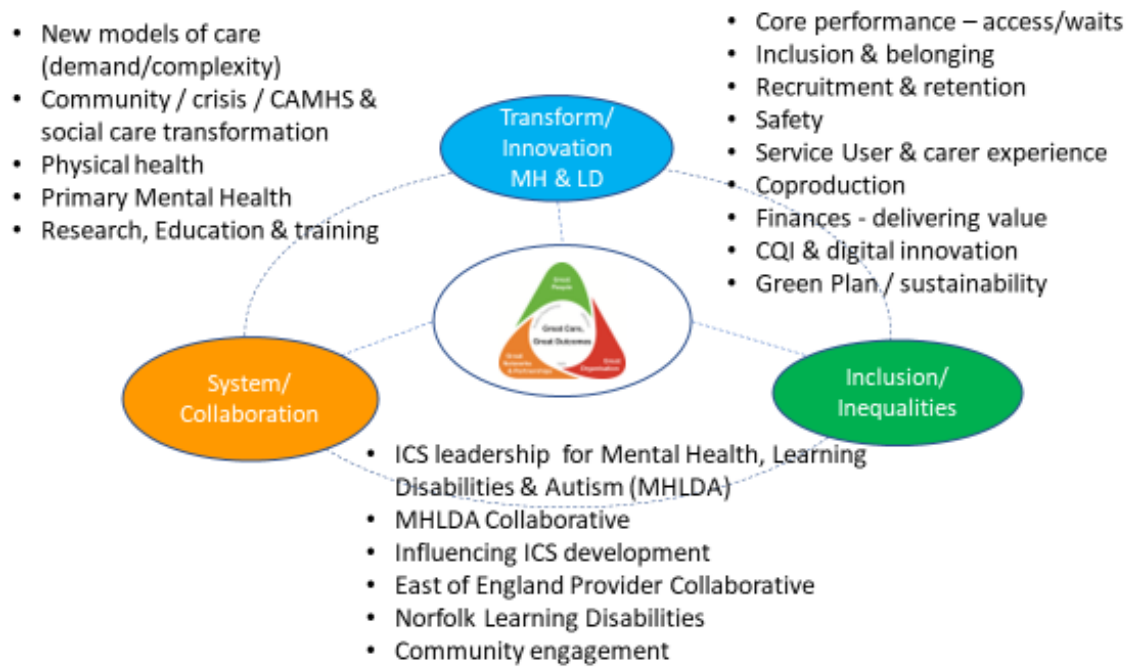
Hertfordshire, Essex, Norfolk, Buckinghamshire and the East of England Provider Collaborative.

The plan is informed by the feedback we have received from our service users and their carers and has been discussed with our Service User Council and Carers Council. Our plans have also been shaped by feedback and discussions with our people, our Council of Governors, partners from across Hertfordshire and West Essex Integrated Care System including Hertfordshire County Council and the Hertfordshire Mental Health, Learning Disability and Autism Collaborative.

6. Our Commitments for 2022/23

Our Annual Plan describes an extensive programme of work for 2022/23, framed by our Good to Great strategy, to support us to achieve our vision of providing "Great Care, Delivering Great Care, Together". The full detail of the plan is provided in Appendix 1 whilst Figure 2 below provides an overview of our strategic areas of focus

Figure 2 – Strategic Areas of Focus



Our Service Users – Our overarching commitment remains to further improve service user safety, experience and outcomes. This means we will coproduce new services, seek out innovative best practice and use research to inform how we provide care.

In 2022/23 we will:

- Drive transformation across our services including social care, adult community services and crisis support and in services for young people (CAMHS).
- Reshaping our Single Point of Access to provide earlier assessment and identification of risk.
- Working with partners to strengthen pathways of care for service users with substance misuse.
- Expanding and developing our services for people with psychosis.
- Further developing services for those who would benefit from talking therapies (IAPT) and supporting service users to find employment through expanding our Individual Placement and Support offer, and further developing our Community Perinatal and community mental health services.
- Improving our engagement and working with carers to improve services and support them in their role.
- Ensuring service users are supported to improve their physical health through further developing our offer both within the Trust and in conjunction with partners
- Work with public health to deliver the enhanced system Suicide Prevention strategy.

Addressing inequalities - We are committed to working with partners to address the significant inequalities that exist for our service users and the communities we serve

In 2022/23 we will:

- Ensure we have a better understanding of how different people access our services, so we can make changes to better meet their needs.
- Ensure every service and team uses data correctly and safely to identify and address any discrepancies in access to care.
- Engage with local communities, in conjunction with partners, to understand how we can better support mental and emotional health within that community.
- Progress the work with partners on Population Health Management to provide a richer understanding of the population's health needs.

Supporting our people – Our focus is to ensure all our people feel supported, able to grow and to create an environment within HPFT in which our people feel included and a sense of belonging

In 2022/23 we will:

- Co-produce our new belonging and inclusion program and strategy which will provide a significant cultural reset to further embed our values.
- Introduce inclusion ambassadors, an extended reverse mentoring scheme and support for staff networks.
- Reset our wellbeing support program based on staff feedback and relaunch our benefits plan and long service awards.
- Develop new roles and actively recruit into teams, including utilising recruitment and retention initiatives.
- Develop our leaders and our leadership 'offer' across the organisation, identifying and supporting people to develop as leaders.

Working in Partnership – We will work collaboratively with partners to ensure we provide services and care that meets the needs of our service users and carers

In 2022/23 we will:

- Work with partners across the Hertfordshire MHLD&A Collaborative to improve outcomes for those people with mental health needs, a learning disability or autism.
- Progress the development of improved and integrated learning disability services in Norfolk, working with local providers and local commissioners.
- Transform learning disability services in Essex in partnership with Essex Partnership University NHS Foundation Trust.
- Continue to develop the East of England Provider Collaborative to ensure a joined-up approach to transforming specialist mental health care and services for those with learning disabilities.
- Work with Health and Care Partnerships across the Hertfordshire and West Essex ICS to together improve care and outcomes of the populations we serve.

Driving Innovation and Improvement – We will continue to drive continuous quality improvement and transformation to support delivery across our organisation

- Implement digital solutions to improve effectiveness, safety and experience such as Inpatient ePrescribing and Medicines Administration (ePMA) and e-referrals (eRS) in SPA and the piloting of digital wards.

- Reset our program of work to “Release time to care” by automating processes and making processes easier for people to use.
- Implement the shared care record with partner organisations
- Invest in our estate, improving the environment for service users and ensuring staff are supported to return to sites whilst maintaining Infection Prevention and Control standards.
- Continue to progress the development of our new inpatient facility to modernise our estate and increase our bed capacity in the east of Hertfordshire.
- We have launched our Green Plan and will take the next steps in supporting our commitment to the NHS to become the world’s first healthcare system to reach net zero carbon emissions.

These plans mean we are confident that 2022-23 will see us making significant strides along our journey to achieve ‘Great Care, Great Outcomes – Together’.

7. Monitoring and Review

The Annual Plan priorities are cascaded via the development of Business Plans for the Strategic Business Units and Corporate Services. At Trust Board Level, progress against milestones and outcomes will be reviewed on a quarterly basis. Progress is also monitored quarterly with the Strategic Business Units through Performance Review Meetings (PRMs). Should achievement of the Annual Plan be judged to be at risk or there are material concerns over performance then the frequency of oversight will be increased.

In the event of significant changing factors (internal or external to the Trust) the plan may need to be adjusted/updated to ensure delivery of the required outcomes. This reflects the need to ensure the plan, although produced at the beginning of the year, remains a ‘live’ reflection of our work and priorities across the Trust. Any such proposed changes will be approved by the Trust Board.

8. Conclusion

Our Annual Plan for 2022/23 is ambitious and will support us to deliver our ‘Good to Great’ strategy and our vision “Delivering Great Care, Achieving Great Outcomes, Together”. It is supported by our values and our commitments to keep our service users and staff safe, improve their experience and provide great care and outcomes underpin all that we do.

The Annual Plan describes the commitments we have made across health and social care to our service users, our carers, our staff and our stakeholders. It documents the key actions we will take this year to further develop our services and to ensure we are able to

provide the highest quality health and social care for those individuals with a mental health illness and/or learning disability.

Importantly it also describes the role we have as stewards and advocates for the development of support and care for autistic people, people with learning disability, and those with emotional and mental health needs across the populations we serve. It also describes the focus we will bring on addressing the inequalities prevalent across society.

2022/23 will no doubt bring with it both opportunities and challenges for the Trust but we are confident, by working together with our service users, carers, our people, and our partners, we can successfully deliver our plan and deliver the commitments we have made.

ANNUAL PLAN 2022-23

Our Commitments

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

What are the key priorities?	Actions we will take (What we will do)	Outcomes (What will be different for our service users, carers, and staff)	Measurement (How we will know)
Progress our ambition to achieve zero-suicides across the populations we support	• Work with our partners to deliver the system Suicide Prevention Strategy • Coproduce a Suicide Prevention Pathway & assessment process (Gold Coast) • Make every contact count, developing increased suicide prevention capability across the workforce	Service users will • feel safe, supported, listened to • know how to access support when they need it • not feel suicide is their only option • feel more confident about their recovery • be supported to recover & move quickly & safely out of seclusion when it has been needed Staff will • have capability & confidence to prevent the need to use restrictive practice • will feel safe when they are working • feel trained to do their roles confidently and safely • will feel psychologically safe and confident to speak up when things go wrong Carers will • feel confident their loved ones are being cared for in a safe environment • feel confident their loved one's needs are understood and being supported	• Suicides relative to total Contacts with HPFT. Baseline 0.049 % (in Q4 20/21) • 98% of people on the suicide prevention pathway have an up to date crisis plan
Keep service users & carers physically and mentally safe, reducing the harm they experience	• Coproduce & strengthen meaningful activities & interventions on our inpatient units • Expand the FACT teams to support service users who find it harder to engage with our services • Strengthen pathways of care for service users with substance misuse (CGL / Public Health) • Review safety practices across the Trust & ensure best practice in place across all teams • Further improve our inpatient environments & ensure they therapeutically enhance the service user experience		• < service user to staff moderate - severe harm through violence & aggression (<2.3% Q4) • < service user to service user moderate - severe harm through violence & aggression (<2.3% Q4) • Rate of service users saying they are treated in a way that reflects the Trust's values >80%
Further develop our approach to managing violence and aggression & evidence-based restrictive practice	• Extend the positive behaviour support (PBS) planning approach across all inpatient services • Introduce a trauma informed approach to care to support service users across all inpatient services • Review & implement MossTogether Strategy across services, whilst continuing to research and implement evidence based best practice		• Reduction in number of seclusion episodes (21/22 baseline 430) • Reduction in rapid tranquilisation incidents (21/22 baseline 318) HYS "do you feel safe on the ward" score. Target 85% (21/22 baseline of 83%)
Expand the training, development, and leadership of teams to keep our staff safe	• Review & update staff training programmes to meet the increased acuity/complexity of care needs across services • Review & adapt skill mix/establishments across teams to meet acuity/complexity & demand		• 10% reduction in the number of RIDDOR reported incidents as a result of violence and aggression towards staff (baseline 50 in 21/22) • Staff survey health and safety climate score >6.0

Strategic Objective 2 - We will deliver a great experience of our services, so that those who need to receive our support feel positively about their care

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)	Measurement (How we will know)
Improve service user and carer experience of accessing and using our services	• Use population health analysis to improve our understanding of & address differential access and experience of service users • Deliver a coproduced transformation programme to respond to service user/carer needs • Improve MH services for adults across the Trust through delivery of 'Connected Lives' and the acute pathways programme • Further develop Single Point of Access to respond to increased demand levels and complexity	Service users will: • find it easier access services receive • receive their care closer to home • be less reliant on crisis services • have greater access to EIP, Community Perinatal and IAPT services • find it easy to feedback their experience & feel listened to & informed • be fully engaged in their care planning & feel better supported in their recovery Staff will • have more feedback about the care they are providing • feel confident to involve and use service user and carer feedback to inform their practice and to improve services • feel involved & able to improve services • feel able to support service users in their recovery • feel confident in their support of carers Carers will • feel listened to & informed • will feel their needs have been assessed and they are supported • feel they have an opportunity to work with us to improve services • Feel that the people they care for are being involved in their care planning and supported to achieve recovery goals	• Reduction in complaint response times from 36 days (Q3 21/22) to 30 days (Q3 22/23) • IAPT, Community Perinatal & EIP access targets met • Performance against the new access standards on 28 day referral to treatment times for CYP, adults and older adults • Connected Lives audit
Involvement of our service users and carers in the design and delivery of their care	• Coproduce a service user and carer engagement strategy • Expand the ways in which services users/carers can give and we receive feedback about the care we provide • Enhance the support to carers who are involved with our services • Provide targeted carers training for staff • Expand peer support workers across the Trust		• Increase service user and carer engagement hours from 1,874 in 21/22 to over 2,000 in 22/23 • Increase in people saying they have been asked for their views on the quality of care from 18.2% to 25% • Number of expert of experience led CQI projects (target 10)
Support our service users to live their lives as independently as possible	• Increase the employment and accommodation support provided to service users in conjunction with partners • Co-produce a new community framework to replace CPA • Launch the Intensive Reablement Service at The Stewarts in partnership with Hertfordshire County Council • Implement adult mental health social care transformation to promote recovery and support service users to live well in their communities		• Personalised Care & Support plan (including DIALOG) completion – 30% by the end of March • Having Your Say for carers – Do you feel valued by staff as a key partner in care planning? - Target 70% • At least 85% of adults with SMI have settled accommodation

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

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)	Measurement (How we will know)
Improve the care, support, and outcomes for service users additional support needs	• Implement a coproduced Depression Pathway • Further develop integrated specialised MH pathways for all age Eating Disorders and CYP ADHD • Remodel the CAMHs inpatient service • Develop and implement clinical effectiveness measures across Adult MH, CAMHS and Perinatal Services.	Service users will • Be supported to develop recovery goals & more confident about their recovery • Experience joined up care • Be supported when in crisis and when discharged to the community • Feel supported to stay physically well • Feel care is tailored to meet their needs • Feel they can participate in research • Benefit from clinical pathways that use peer reviewed evidence and outcome-based practice Staff will • Feel able to use outcomes measures to inform service delivery & design • Be able to support the physical health needs of service users, including feeling confident to identify physical health acuity and deterioration • Feel encouraged to undertake & be involved in research Carers will • Feel informed and engaged in the care planning process • Feel their needs have been assessed and that they are supported in their role	• Progress against routine outcome monitoring CQUIN measures for CYP, perinatal and community mental health services (target 100% CQUIN achievement)
Keep service physically healthy by improving the physical health support, intervention and care available	• Improve mental health input into physical healthcare pathways • Further expand personalised physical health checks and interventions • Further enhance the physical health skills of the workforce		• 90% of people on CPA having completed physical health checks in inpatient and FEP services and 65% in community mental health teams • 14% reduction in service users who smoke cigarettes • 220 staff access the Physical health training programme
Train our staff in diagnosing and supporting people with Autism	• Support Hertfordshire partners in the development of a system wide autism strategy • Develop autism friendly environments in inpatient settings • Expand autism diagnostic services • Increase the knowledge and skills of staff in relation to autism across all services		• 30 staff trained in autism assessment (ADI R / ADOS) • Reduction in adult autism waiting list to less than 50 by end of March 2023 • Warren Court and Broadlands autism friendly environments capital work completed
Expand our research and increase the positive impact of this on service user outcomes	• Embed our Research faculty, including the expansion of research assistants in the core 5 research areas. • Publicise our research to increase peer evaluation and shared learning • Expand our collaborative work with partners • Widen the type and scope of research across the Trust		• Increase in (i) the number of NIHR portfolio studies we take on (baseline 29 in 21/22), (ii) the number of local PIs (baseline 19 in 21/22), (iii) the number of service users recruited to these studies (baseline 425 in 21/22)

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

What are the key priorities?	Actions we will take (What we will do)	Outcomes (What will be different for our service users, carers, and staff)	Measurement (How we will know)
To increase recruitment and offer a compelling employment experience which retains staff	• Implement a new employment offer to emphasise HPFT benefits, including innovation, research, and a learning culture • Provide enhanced opportunities for growth and progression for all our staff • Provide best practice health and wellbeing support	Service Users will • Experience consistency in terms of who is caring for them • Experience high quality care • Experience improved communication • Feel they have an opportunity to influence the Trust culture • Feel an improved sense of belonging and inclusion Staff will • Have an increased sense of belonging and feel valued • Feel able to bring their 'whole self' to work, free from discrimination • Experience proactive support for BAME talent management • Have clear career pathways and opportunities for development • Be supported to work flexibly Carers will • Feel they can influence the culture of the organisation • Be assured that their loved ones are receiving more consistent care • Experience improved communication • Have confidence in staff	• Voluntary turnover <10.5% by Q4 • Vacancy rate <11.1% by Q4 • The Trust takes positive action to support health and wellbeing > 85%
Develop our belonging and inclusion strategy and culture	• Engage with staff and service users to codesign, implement and embed a culture of belonging and inclusion together with a refreshed EDI strategy • Improve recruitment and promotion practices to eliminate discrimination and create equality of experience		• Our WRES and WDES scores will show improved equality of experience • Inclusion staff survey score >7.3
Introduce new roles and ways of working to meet acuity and demand for services	• Review & adapt skill mix/establishments across teams • Support clinical transformation through a flexible and innovative approach to workforce design • Support efficiency and staff satisfaction through digitisation of HR processes • Create innovative roles and working patterns to respond to service needs		• > 80% staff recommend place to work • Staff Survey and pulse survey engagement score > 7.4 • Staff survey 'we each have a voice that counts' score >7.2 • Staff survey 'negative experiences' score >7.9
Develop our people, teams, and leaders to enable the delivery of great care and great outcomes	• Refresh and enhance leadership development support at all levels across the Trust • Provide an enhanced program of supervision and support to Team Leaders • Establish a diverse and representative talent & succession pipeline across the Trust • Increase opportunities for career development and personal growth, positively addressing inequalities		• Staff survey development score >6.8 • Mandatory training >90%

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

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)	Measurement (How we will know)
Embed the culture of continuous improvement and innovation across our services	• Increase spread of innovation and improve our services by creating an improvement library with evaluations of all CQI and innovation initiatives • Create dedicated time for our staff to innovate and improve our services, and CQI coaching capacity to support this • Implement a new framework to formally review, test, evaluate and implement new ideas • Develop and implement a comprehensive set of online dashboards to support staff to improve access, safety, quality, and equality across our services	Service users will • feel safer and have better outcomes • have easier access to services remotely and thereby less travel • have improved access to up-to-date information • engage in our sustainability agenda Our staff will • feel supported to innovate and improve our services • have a better understanding about the performance of their own services • will have more time to care for our service users • engage in our sustainability agenda • have greater flexibility in how care is delivered Carers will • Find it easier to access information • Find it easier to communicate with us • See ongoing improvements to services in response to feedback	• 10% increase in staff reporting involvement in CQI projects during 2022/23 • Number of trained CQI coaches increased from 0 to 23 • 20 innovation ideas received, evaluated, and considered by the Innovation Panel
Continue to introduce new digital capabilities that improve our services	• Digitise clinical assessments, outcomes and correspondence and introduce online service user and carer library with virtual healthcare assistant in CAMHS, Adult Community and Older People services • Introduce electronic prescribing and medicines administration system, digitise our wards, and implement electronic observations • Digitise and automate clinical and administrative processes and improve our workforce's digital skills • Develop a programme with partners to address digital exclusion		• Positive net score from service users using digital channels • Positive targeted survey responses from staff regarding experience of digital capabilities • Community mental health survey – > service users given enough time to discuss your needs (baseline 7.3)
Support the NHS to become the world's first healthcare system to reach net zero carbon emission	• Coproduce the design and delivery of the first stages of the Trust Green Plan • Identify key schemes to support the Green Plan delivery in 2022 as part of the capital programme • Work with partners across the ICS to support goals to achieve Zero carbon emission		• LED lighting to be rolled out across the entire trust in 22/23 • Commencement of the rollout of electric car charging points

Strategic Objective 6 - We will deliver joined up care to meet the needs of our service users across mental, physical, and social care services in conjunction with our partners

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)	Measurement (How we will know)
Work with Primary Care partners to improve community services and the care of adults and older people	• Embed a primary care mental health model consistently across Herts in conjunction with system partners • Implement the Primary Care Dementia Pathway following evaluation of the pilot • Continue the roll-out of the ARRS roles across the Primary Care Networks	Service users will • Be able to access care and support in primary care • Have easy access to secondary care services when they require them • Experience more joined up care • Be able to access crisis services more easily, including alternative to admission, and will be able to access a wider range of early interventions • Will have access to mental health support whilst in school (CYP) • Have clear plans to support their ongoing care needs Staff will • feel involved in improving services and be empowered to do so • will feel engaged in system-wide service developments • use their skills to their full potential and in different settings Carers will • feel more supported at times of crisis • feel they have an opportunity to contribute to the redesign of services and pathways based on their experience	• Number of adults accessing new primary and community mental health (target 5062) • 70% of primary care mental health roles (ARRS roles) in post against plan • No of people diagnosed through the Primary Care Dementia Pathway (target 24 per week)
Improve access and delivery of care for those people with a learning disability and/or autism across the Trust	• Plan and develop high quality in-patient facilities to support the Learning Disability Assessment treatment pathway across Essex • Work with system partners to improve the delivery of preventative and crisis response interventions, for those with a Learning disability and/or Autism. • Work with system partners to ensure the Specialist Rehabilitation Services transformation and transition programmes meet residents needs		• < Inpatient length of stay for people with LD • Routine referrals to Specialist Community LD Services meeting 28 day wait >=98% • Completed annual care plans within LD community services Herts and Essex (current 37%, target 70%)
Ensure children, young people, adults, and older people in crisis can access support when they need it	• Expand the range of crisis interventions available for children and young people in mental health crisis in conjunction with partners • Remodel CCATT and Home Treatment teams to provide a more comprehensive range of interventions at the point of crisis.		• 4 hours wait for C-CATT crisis service (target 95%)
Work with partners to deliver earlier intervention and support for Children and Young People	• Expand the number of schools with access to Mental Health Support Teams • Work with system partners to deliver a wider range early intervention • Improve the pathway and support for Children and Young People with an eating disorder		• CAMHS access < 28 days (target 95%) • 1,500 CYP accessing MHSTs (967 in 21/22)

Strategic Objective 7 - We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)	Measurement (How we will know)
Ensure the Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative continues to develop and thrive	• Lead the Collaborative with Hertfordshire County Council including developing strategies for improving the physical health of people with SMI & for adult autism • Use population health analysis to address differential outcomes across our populations based on the insights provided • Work with partners to improve outcomes for service users with dual diagnosis • Develop new pathways for CYP with ADHD	Service users will • experience more joined up care and better outcomes • feel involved and able to contribute to service developments • have better / more equitable access and outcomes • have increased local choice and provision to support them at home and in their community Staff will • feel motivated and able to deliver care together across the Hertfordshire MHLDA Collaborative and East of England Regional Collaborative • feel able to contribute to service developments • Feel able to develop partnerships to improve care Carers will • experience more joined up care for the people they care for • be able to support their loved one to access services more easily • experience a more personalised approach to care planning	• Increase in number of people with SMI in employment. Baseline 14% (February 2022) • Reduction in CYP ADHD backlog from 632 in South and West Herts to 0 by end 22/23.
Advocate for mental health, learning disability & autism services are developed across our populations	• Ensure the needs of those with mental illness, learning disabilities and autism are included within system plans and strategies • Co-lead the ICS mental health, learning disability and autism work stream, working with others to improve outcomes across the ICS		• HWE ICS population health model identifies at least 2 concrete actions for the ICS on MHLDA.
Transformation of services for people with a learning disability and their carers	• Progress the Norfolk 'Most Capable Provider to take forward clinical service transformation plans • Support improved outcomes for people with learning disabilities nationally by continuing to showcase the positive impact of our service transformation for service users		• HPFT's positive impact on service user outcomes showcased in 3 national reports • HPFT to provide expert speakers at 3 national conferences or similar settings
Work with regional partners to deliver new models of care for those with specialist mental health needs and learning disabilities	• Deliver the agreed Regional CAMHS T4 and Forensic LD transformation plans • Implement the Adult ED & Community Forensic "alternatives to admission" pilots		• < number of CYP waiting for an Eating Disorder inpatient bed (baseline 6 at 9th May)

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 12
Subject:	Impact of Adult Social Care Reform and implications for HPFT	**For Publication:** Yes
Author:	Kate Linhart, Deputy Director, Integration and Partnerships and Karen Hastings, Head of Social Work and Safeguarding	**Approved by:** Sandra Brookes, Executive Director of Service Delivery and Patient Experience
Presented by:	Jacky Vincent, Executive Director, Quality and Safety	

Purpose of the report:

To inform the Trust Board on key changes proposed in the Adult Social Care Reform White Paper and implications for our local system and for HPFT

Action required:

To note the progress and raise any issues on items detailed in the report

Summary and recommendations to the Board:

On 1st December 2021, the Adult Social Care Reform White Paper *"People at the Heart of Care"* was published, which sets out the 10 - year vision for adult social care. This follows the *"Building Back Better"* White Paper published in September 2021, outlining charging reform and how people will pay for their care.

The vision for Adult Social Care aligns with the overall national direction of travel for health and care, enabling systems to build on existing progress towards more preventative and personalised care and support. In addition to social care charging, areas of wider reform such as workforce and housing have been identified and supported with £1.7bn in funding over 3 years. Issues that have not been addressed are the immediate pressures on social care and a commitment to funding beyond the 3 - year reform period.

The implications of the reform will need to be fully understood by HPFT, the MHLDA Collaborative and the local system. The proposed reform will need to be considered in relation to the HPFT plan, emerging and existing Collaborative plans and priorities, including the ICS MHLD Covid Recovery plan. HCC are in the process of establishing several workstreams, which will involve key stakeholders, to understand the impact of the reform, what this means for us locally and the resource required to deliver the required changes. As HPFT and HCC further understand the potential impact of changes, areas for consideration would be:

- What are the resource implications for implementing reform – are any additional resources required?
- What are the longer-term service and financial implications?
- Does the proposed reform necessitate any changes to emerging and existing plans for social care transformation.

In addition to our role as a system partner, HPFT will need to work in partnership with HCC to understand the implications of the reform in relation to our s75 delegated responsibilities for providing social care to the adult mental health population in Hertfordshire. The new assurance regime, which includes the introduction of the CQC as the regulatory body for Adult Social Care, is likely to result in an enhanced focus from HCC on our current systems, processes, and quality of

practice. As the accountable body, HCC will be seeking robust assurance from HPFT that we are discharging our social care responsibilities in line with our contractual commitments and legal requirements (Care Act).

HPFT can demonstrate robust practice in some of these areas however we also have some challenges in delivery of social care responsibilities in line with legal and contractual requirements.

The Adult Mental Health Social Care transformation programme is now being reset ensuring that it aligns and supports existing transformation, will enable a proactive response to changes in demand and profile of need thereby ensuring HPFT is in a position where we can provide assurance we are meeting our contractual responsibilities

Relationship with the Business Plan & Assurance Framework:

The Health & Care Act will bring in duties for the CQC to inspect adult social care services for the first time. As partners with Hertfordshire County Council, HPFT will be subject to inspection around our delegated responsibilities under the S.75 and 113 agreement.

Links to Trust strategy to provide safe and effective services, achieving a good experience for service users, carers, and referrers, transforming our services, staff having a positive experience of work, and having an enviable reputation for quality and innovation.

Summary of Implications for:

There are implications for the Trust in terms of maintaining partnership arrangements with Hertfordshire County Council.

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

Service users and carers will be consulted and involved in the development of the social care transformation programme. Enhancing delivery of social care within HPFT will address health and mental health inequalities by providing preventive approaches, including individuals with protected characteristics.

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

The Health & Care Act aims to enhance and improve adults social care service delivery, and implementation of the measures within the Act will have positive implications for service users and the people who care for them.

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

NA

REPORT:

1. Introduction

1.1. On 1st December 2021 the Government published its Adult Social Care White Paper, "*People At The Heart Of Care",* which sets out a 10 year vision for the reform of adult social care*,* underpinned by the following three pillars of reform.

- Providing an outstanding quality of personalised care;
- Choice and control to live an independent life;
- Ensuring that care is provided in a way that is fair and accessible to everyone who needs it

1.2. This White Paper that sets out the vision and roadmap to reform is one of three key interfacing areas of adult social care as outlined in:

- Build Back Better – Charging and Fees" – sets out how people will pay for social care from October 2023
- "*People At The Heart Of Care",* which sets out a 10 year vision for the reform of adult social care,
- Integration White Paper

1.3. "The vision for the future of adult social care aligns with the current direction of travel for health and social care, reflecting the ambitions and aspirations of the Care Act 2014, the NHS LTP and other key areas of reform such as the Health and Care Bill and the Mental Health Act reform. The proposed changes focus on prevention, personalisation and tacking inequalities, including the development of the wider social care market to support these changes. The proposed reform also seeks to address long standing issues such as workforce support and supported housing. The changes brought about by the reform will therefore enable us to build on our existing strengths and transformation.

1.4. A majority of the share of the national levy has been allocated to the NHS (£25bn) with Adult Social Care receiving £5.4bn, split between Charging reform (£3.6bn) and Wider reform (£1.7bn) for which funding over the next 3 years has been allocated as follows:

- £300m to integrate housing into health and social care strategies (range of new housing options)
- £150m adoption of technology
- £500m workforce

- £25m to support unpaid carers
- £30m local innovation (new ways of working)
- £70m to increase support offer
- Practical support service to make minor repairs and changes in people's homes
- New national website to explain changes

1.5. The Local Government Association (LGA) has raised a number of concerns regarding the adequacy of funding derived from the levy to support both the impact of the charging reform and also the immediate pressures on social care, as well as allocations beyond the 3 year period. Local Authorities are therefore unable to anticipate the costs of the reform. Any shortfall in funding will be made up from Council Tax (potentially a 9% increase) and further efficiencies, which is consider unrealistic and likely to impact on promoting population wellbeing and prevention.

2. ***Key areas of reform***

2.1. *Social Care Changing*

Reform of social care charging is focused on making the system fairer and protecting people from unpredictable and unlimited costs of care through introducing a Care Cap of £86,000 and a more generous means testing system for anyone with less than £100,000 in assets.

The White Paper also reiterated the Government's commitment to introducing a 'fair rate for care' ensuring that everyone pays the same fees in the market for the same service whether they are a self-funder or have care provided by the local authority.

The financial implications of this for the social care system and the wider sector still need to be worked through however it is likely that this will be the area of most significant impact for local authorities.

2.2. *CQC Regulation of Adult Social Care*

In order to understand standards and drive up quality of social care provision the CQC will begin regulating adult social care from October 2023 with a specific focus on:

- Social Care eligibility and assessments
- Maintaining oversight of the workforce (recruitment, retention, sustainability)
- Transitions between services
- Prevention and reablement
- Safeguarding

- Leadership
- Care markets
- Carers

Assessments will by informed by a range of information and data from Local Authorities and Care Providers, including feedback from people who access care and support and their carers.

2.3. *Assurance*

It is proposed that from April 2023 regional assurance will be tightened through the following changes:-

- New self -assessment framework with better data
- CQC Regulation of Adult Social Care focusing on practice and provision, quality and working with Integrated Care Board on mandatory standards
- Powers for the Secretary of State to intervene if a Local Authority is failing.

This will require a new assurance regime that will include:

- Core Performance Indicators
- Annual Self-Assessment
- Peer review every 3 years

2.4. *Housing including supported living*

The proposed legislation recognises that every decision about social care is about housing and has therefore identified this as a key enabler of change. A £300m commitment has been made to better integrate housing into local health and care strategies, as well as £220m towards driving growth in housing with care via the Care and Support Specialised Housing Fund (CASSH) and £150m towards improving Caretech/assistive technology.

2.5. *Workforce*

£500m has been allocated for workforce development, including a new Knowledge and Skills Framework (KSF), portable Care Certificates to provide sector-wide delivery standards and investment in Social Worker training routes to support recruitment into the sector as well as Mental Health support.

2.6. *Other areas of reform*

- Accessible information and advice to public, including people who use services on social care provision, housing, charging etc
- Digital – Assistive technology, shared care records and how enablers interface – i.e. innovation (community catalysts) digital (enabling technologies) reducing/support, develop workforce

- Carers – enhanced support to informal carers, duty on Integrated Care Body to involve Carers in commissioning and service development.

2.7. Whilst the proposed reform has focused on a number of well recognised areas, significant areas have not been addressed in the White Paper such as the ongoing cost pressures and future funding of recurrent additional costs and the significant current workforce issues for both staff employed directly by the Local Authority as well as those with social care providers.

3. Impact of Change on Wider Hertfordshire System

3.1. As previously stated, further clarity is needed in key areas for Local Authorities, including Hertfordshire County Council to anticipate the full impact of the reform. What is clear is the changes in social care funding will impact on both the costs of care and the workload demand on LA's.

3.2. Changes to social care charging may disproportionally impact more affluent areas such as Hertfordshire with a larger cohort of self-funders. Fair Rates for care will mean the higher rates paid to providers by self-funders, will no longer be able to be used to subsidise the lower rates negotiated by HCC. Local Authorities will also be responsible for organising care for self-funders; a cohort that does not usually have any services delivered by the LA.

3.3. Within Hertfordshire the Adult Social Care net Budget for Adult Disabilities is £187.7m (52%) approximately two thirds of which is for Learning Disabilities (52%) and £16.3m (5%) for mental health. Older people will be the population where financial reform will have the most impact, however this will also impact on the mental health and learning disability population, particularly wider reform which can bring opportunities to enhance independence through new approaches to housing, digital and supporting carers.

3.4. HCC are in the process of establishing several workstreams to further understand the implications of the proposed changes at a local level and the work required to deliver them. Areas of focus will be service design, work with the VCSE sector, technology, workforce and markets and commissioning.

3.5. As a system we will need to work with HCC to understand the implications for our Mental Health and Learning Disability population and the risks and opportunities to our current plans and ambitions. The recognition of the intrinsic link between health and social care and the alignment of national policy will enable us to work more closely on shared agendas, using the MHLDA Collaborative to drive and enable change.

4. Impact of reform on HPFT

4.1. HPFT will work in partnership with HCC through the established workstreams to understand and respond to the impact on systems, practice and resource, both as a system partner and as the contracted provider (s75) of social care to the adult mental health population. The CQC regulation of social care will mean that HPFT will be subject to an additional CQC inspection, in respect of the delegated function although HCC will be the accountable body, however the Trust can also expect enhanced scrutiny from HCC in the following areas:

- Adult Social Care practice
- Adult Safeguarding practice
- Carers
- Data and reporting
- Financial Charging
- Social Care and Social Work Leadership
- Workforce recruitment, retention, and sustainability

4.2. HPFT can demonstrate robust practice in some of these areas however we also have some challenges in delivery of social care responsibilities in line with legal and contractual requirements. Prior to Covid we had established the Connected Lives social care transformation programme to address these challenges, alongside delivering 16% efficiency savings over 5 years from the social care budget.

4.3. Progress of the social care transformation has been impacted by the pandemic and subsequent demand and recruitment and retention issues and therefore a number of these issues have yet to be fully addressed.

5. Next steps

5.1. The Adult Mental Health Social Care transformation programme is now being reset ensuring that it aligns and supports existing transformation, will enable a proactive response to changes in demand and profile of need thereby ensuring HPFT is in a position where we can provide assurance we are meeting our contractual responsibilities.

5.2. An initial workshop was held in early May and we agreed the following drivers for change:

- Information led oversight
- Workforce Development
- Cultural change
- Practice Competency and Confidence
- Clear Polices, Procedures and Processes
- Effective Communication
- Governance and reporting
- Partnerships and relationships

5.3. A detailed action plan is now being developed with delivery being overseen by the Transformation Board.

6. <u>Conclusion</u>

6.1. The vision and ambitions of the reform align with our local vision for integration for health and social care, building on our existing strengths. Key wider areas of focus align with NHS priorities and key areas of focus so there is real opportunity to enhance and further align our work, particularly in challenging areas like housing and workforce.

6.2. As a local Hertfordshire system we will need to work together to fully understand the implications of the reform for our mental health and learning disability population, carers, social work and social care workforce and provider organisations. The presence MHLDA Collaborative provides a structure and a culture of collaboration that enables us to enhance to opportunities and mitigate risks brought by the change.

6.3. HPFT will need to review its delivery of delegated responsibilities and work in partnership with HCC on any areas that require improvement. Current social care systems, process and practice will need to be fully evaluated and improvement measures implemented across 2022/23. This will be driven through both a dedicated transformation programme aligned with relevant core community transformation programme

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PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 13
Subject:	Report from Finance & Investment Committee – held on 10 May 2022	**For Publication:** Yes
Author:	Helen Edmondson – Head of Corporate Affairs and Company Secretary	**Approved by:** David Atkinson, Non-Executive Director, Chair – Finance & Investment Committee
Presented by:	David Atkinson, Non-Executive Director, Chair – Finance & Investment Committee	

Purpose of the report:

This paper provides a summary report of the items discussed at the Finance & Investment Committee meeting on 10 May 2022.

Action required:

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

To note that three items were escalated to the Board for approval:

- Annual Plan for 22/23
- Financial Plan 22/23
- Oak Ward – Phase 2 business case

Summary and recommendations:

Summary
An overview of the work undertaken is outlined in the body of the report.

Recommendations

To receive and note the report.

To note that three items were escalated to the Board for approval:

- Annual Plan for 22/23
- Financial Plan 22/23
- Oak Ward – Phase 2 business case

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

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

Summary of Financial, IT, Staffing & Legal Implications:

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

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

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

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

Finance and Investment Committee 10 May 2022

Introduction

1. The Finance and Investment Committee (FIC) has met once on 10 May 2022 since the last report to the Board, they met in accordance with its terms of reference and were quorate.

2. Deep Dive – Financial Plan 2022/2

The Committee received a detailed presentation on the current draft of the Financial Plan for 22/23 noting that the plan had not been finalised because there remained a number of areas subject to confirmation. The Committee were updated on the context for the plan including the financial planning assumptions and exit from 21/22. It was noted that the plan detailed that income had increased due the full year effect of the Provider Collaborative, it included a significant Delivering Value Programme, the current plan sets out a deficit position.

The presentation provided an analysis of the new investment secured, including demography and non-recurrent Transformational funding. It also set out the details of the Delivering Value programme, which had been risk rated, noting that a prudent approach was being taken with regard to expected delivery. The Committee considered the risk and opportunities provided by the financial plan and the mitigations in place, including strong internal financial control.

In response to David Atkinson's question, it was confirmed that the budget process for 2023/24 would start in September 2022. Maria Wheeler updated the Committee with regard to the ongoing discussions with commissioners with regard to additional funding. It was noted that these discussions had not concluded but that the final financial plan would be presented to the Board for approval in May 2022. The Committee approved the financial plan subject to ongoing discussions with commissioners and continued internal work to identify opportunities to reduce the deficit. It was noted that the Delivering Value Programme and community transformation would be considered at a future Committee meeting

3. Operational

3.1 <u>Quarter Four Performance Report.</u>
The Committee received and considered a report that set out the summary of performance during quarter four against the national, regional and local indicators. It was noted that this had been a challenging period for the Trust and the wider health and social care system. The report set out that the Trust has seen a further increase in referrals to our Adult Community Mental Health (ACMH) services which are now higher than pre-pandemic levels.

It was reported that although overall more KPIs are maintaining or exceeding performance levels compared to last quarter, performance in the quarter has been lower than anticipated.

February 2022 national benchmarking report included in the paper clearly showed the pressures being faced from high demand and acuity.

Particular areas of strong or improved performance in the quarter were: Friends and Family Test; follow up following discharge from inpatients, in patient and crisis indicators, and 48-hour follow up. The Committee discussed challenging areas such as: Adults 28-day assessment; vacancy and turnover rates; Out of Area Placements;

CAMHS refer to treatment times and EMDAS. The Committee also considered the actions in place to improve the position in each of these areas. The importance of continuing to monitor the situation and any possible impact on quality of funding decisions by commissioners was noted.

3.2 Quarter Four and Year End Annual Plan 21/22

The Committee considered the report that set out the end of year position across the seven objectives detailed in the Trust's Annual Plan. The end of year performance was noted, in particular the improvements that were made from the quarter three position.

3.3 Acute Clinical Pathway

The Committee considered a detailed report that gave an overview of the progress of the Task and Finish Group for Acute Clinical Pathways. It was noted that the group had been commissioned to consider and agreed clinical pathways for people using in patient services and to put in place improvements in efficiency, effectiveness and experience. It was noted that the work had identified five areas of focus: service users with complex needs; diagnostically led treatment pathways; the model of care for inpatient services; discharge arrangements and community flow, with the aim of having a clear model of care for inpatient services.

The Committee were updated on the metrics being monitored and the progress against the five key deliverables, noting the signs of improvement across the metrics.

In response to Jon Walmsley's question, it was confirmed that a trauma-based approach, using a psychological approach was being rolled out in patient units and was part of the Annual Plan for 22/23.

3.4 Finance Report - Month One

The Committee received a finance report for month one of 2022/23. The Trust is reporting a deficit position for Month 1 in line with its financial plan, which is still being finalised. It was reported that month one had seen a slight reduction in Out of Area placements and pay expenditure.

3.5 Contracts Update

The Committee considered the report that provided an update on the progress on the negotiation of the Trust's contracts. It was noted that the non-financial elements of the Hertfordshire contract were agreed subject to the finalisation of the financial plan. It was noted that discussions were ongoing with Herts County Council regarding social care funding and other contract discussions with commissioners are due to be finalised by end of May. It was noted that the IAPT contract with Mid Essex was being finalised. The Committee were updated on the Most Capable Provider work in Norfolk, noting that David Evans would be taking the lead on this.

3.6 Oak Ward Refurbishment – Phase 2

The Committee considered the business case for phase 2 of the Oak Ward refurbishment. It was noted that the capital plan for 22/23 includes the resources to support the proposal. The Committee supported the business case noting that the work includes ward refurbishment, changes to room and office configuration, improvements to ventilation and seclusion facilities. The Committee recommended the business case to the Board for approval noting that it was in important opportunity to improve the quality of the environment of both services users and staff. It was confirmed that how the programme is implemented will learn from the recent capital work at Albany Lodge and Forest House.

3.7 Treasury Management Summary

The Committee considered a report that provided a summary for 2021/22. In particular it was noted that the Trust is obliged to invest surplus cash within the government banking facilities which currently offer a very low interest rate that the return of interest payable to the Trust remains at a low level and that the Trust's continued strong cash balances supports the Trust's capital investment programme.

It was noted that a future meeting the committee would review the Treasury Management Policy.

4. Strategic

4.1 Annual Plan 2022/23

The Committee considered the report that set out the latest version of the Annual Plan. It was noted that it would be subject to some very minor finalisations and the final version would be presented to the Trust Board for approval in May. The Committee were updated on the key changes that have been made from the earlier version considered by the committee.

The particular changes noted by the Committee were: strengthening pathways of care for service users with substance misuse; strengthening meaningful activities and interventions on inpatient units; expansion of the FACT team to support service users who find it harder to engage with our services; a greater focus on the social care transformation that is required to help service users stay well in their communities; ensuring we increase the use of clinical effectiveness measures across all services; an increased focus on developing our belonging and inclusion strategy and culture; developing a programme with partners to address digital exclusion and new pathways for Children and Young People with ADHD.

It was noted that the metrics column is being finalised for the version to be presented to the Board later in the month.

4.2 New Mental Health Standards

The Committee considered a report that set out that NHS England have proposed five new access standards as an extension to the existing standards for mental health. Currently, there is no clear indication when these standards will be introduced and that the metrics for monitoring these standards have not been published. The report provided an overview of current performance based on similar metrics as a proxy and potential challenges to meet them. The Committee agreed that following publication of the metrics future performance reports will report on progress with meeting new standards.

5. Committee Planner

The Committee noted the updated planner. It was agreed that it would be updated with items identified by the Committee for inclusion.

6. Recommendations

6.1 To receive and note the report.

6.2 To not the three items were escalated to the Board for approval:

- Annual Plan for 22/23
- Financial Plan 22/23
- Oak Ward – Phase 2 business case

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PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 13a
Subject:	Performance Report Quarter 4 2021-22	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director of Improvement and Innovation	**Approved by:** Hakan Akozek, Director of Innovation and Digital Transformation; Chief Information Officer
Presented by:	Hakan Akozek, Director of Innovation and Digital Transformation; Chief Information Officer	

Purpose of the report:

To inform the Board of the Trust's performance against both the NHS Oversight Framework (NHSOF) targets and the Trust Key Performance Indicators for Quarter 4 2021-22.

Action required:

The Trust Board is recommended to:

- Critically appraise the information presented.
- Consider the areas of performance noted and evaluate the associated actions.
- Seek any additional assurance or information required.

The fourth quarter of the 2021-22 fiscal year (Q4) has been a very challenging period for the Trust and the wider health and social care system across the country. The effect of the pandemic on mental health across the nation is being felt across services as more people presenting into mental health services, with a higher level of acuity than ever. We have also seen further increase in referrals to our Adult Community Mental Health (ACMH) services which is now 63% higher than pre-pandemic levels (48% at the end of Q3).

As a result, although overall more KPIs are maintaining or exceeding performance levels compared to last quarter, performance in Q4 has been lower than anticipated. Out of the 63 Key Performance Indicators monitored and rag rated in Q4:

- 31 (49%) are maintaining or exceeding performance levels (on target)
- 4 (7%) are almost meeting target performance levels (close to target)
- 28 (44%) are not meeting our performance standards (underperforming)

February 2022 national benchmarking report included in the paper clearly show the pressures we are facing from high demand and acuity are also being felt across the system, and whilst we are committed to restore, recover and reshape our services, we continue to benchmark favourably in relation to our peers.

It is anticipated the first quarter of 2022-23 fiscal year will continue to be challenging. However, we are providing additional resource in key areas including our Single Point of Access and Adult Community Mental Health Services to help meet the increasing demand and acuity whist we continue our discussion with the wider health and care system partners on longer term and more sustainable approaches to meet the needs of our service users and carers.

The Trust Board is recommended to:

- Critically appraise the information presented.
- Consider the areas of performance noted and evaluate the associated actions.
- Seek any additional assurance or information required.

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

Performance reflects the requirements of the Annual Plan, SBU Business Plans Assurance Framework

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

There are no direct financial, staff, IT or legal implications arising from this report.

Equality & Diversity and Public & Patient Involvement Implications:

A number of changes have been introduced to the report format to improve accessibility, including a traffic light system to avoid using colour as the only means of conveying information.
Although individual KPIs in this report have equality and diversity implications, these are not part of this report. As a result, the report does not have a direct impact.

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

The report includes all targets reportable in quarter four.

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

Trust Executive (4th May 2022), Finance and Investment Committee (10th May 2022)

Performance Report – Quarter 4 2021-22

1. Background

1.1. The fourth quarter of the 2021-22 fiscal year (Q4) has been a challenging period for our service users and the Trust. We have, once again, seen significant change in our demand profile across our services. For example, referrals for our Adult Community Mental Health (ACMH) services have now increased by 63% compared to pre-pandemic levels (48% at the end of Q3) as illustrated below. The demand for our crisis services has seen and maintained a step change since April 2021 with a rise of 70% and demand in our Children and Adolescent Mental Health Services (CAMHS) Eating Disorders (ED) is also growing by 44%.

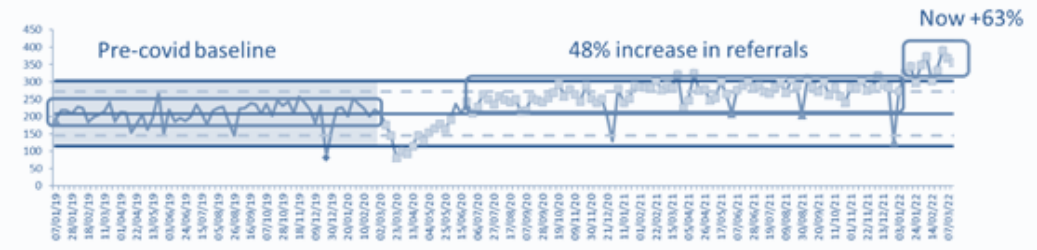


Figure 1 - Referrals into Single Point of Access for ACMH Services

1.2. There are also indications of increased acuity and complexity with increased caseloads in ACMH services and service users staying in secondary care 38% longer since the start of the pandemic (average of 18 months vs 13 months pre-pandemic) as well as the demand for out of area beds raising 2.5 times as illustrated below.

2. Activity Summary

2.1 The figure below provides a summary of some of the key areas of activity across the Trust during the third quarter. Referrals into the Single Point of Access (SPA) in Q4 2021-22 (18,792) are circa 22% higher than for the same period in 2020-21 and represent a 13% increase on Q3 referrals (16,590). This was due to an exceptionally high number of referrals being received in March 2022 (7,043), and is expected to return to the level seen in Q3 and January and February (mid to late 5,000s)

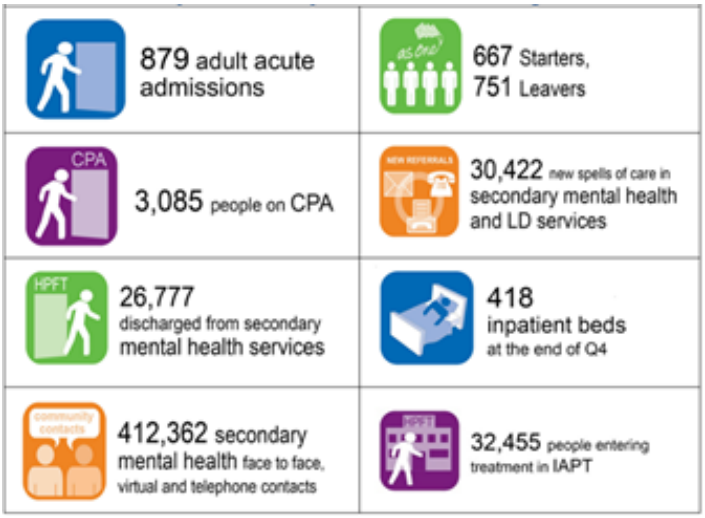


Figure 2 - Summary of 2021-22 Activity

3. Performance Summary

3.1. Quarter 4 has been a challenging period for the Trust, reflecting the wider NHS position at a local, regional, and national level. Pressures come from continued high demand (+10%) and acuity, the ongoing Covid-19 Pandemic has continued to adversely affect sickness rates. Overall performance against KPIs has improved on Q3 and returned to Quarter 1 levels (49% met).

3.2. The overall number of performance indicators that were met in Q4 saw a slight increase on Quarter 3 (Q3) performance with 49% of the KPIs meeting or exceeding the target compared to 44% in Q3. The table below summarises the performance across the five domains for key performance indicators.

Performance Domain	Status	Total of Indicators	On Target	Close to Target	Underperformed
NHS Oversight Framework		6	5 (83%)	-	1 (17%)
Access to Services		22	8 (36%)	2 (9%)	12 (55%)
Safety and Effectiveness of Services		24	13 (54%)	1 (4%)	10 (42%)
Workforce		7	2 (29%)	1 (14%)	4 (57%)
Finance		4	3 (75%)	-	1 (25%)
Total		63	31 (49%)	4 (7%)	28 (44%)

Table 1 - Q4 KPIs Performance Summary

3.3. The figure below illustrates overall quarterly performance for all metrics since 2015-16, including those that do not have a target and therefore cannot be rated.

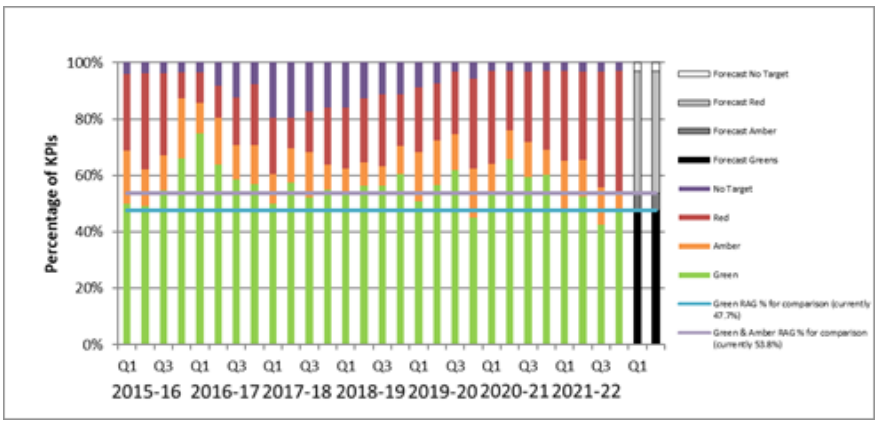


Figure 3 – Trust-wide KPI Performance for Monthly Targets

3.4. Our teams have continued to work hard across all services to provide quality care. All services remain open to referrals and admissions. Feedback from service users tells us that they feel involved in discussions about their care (91%) and find our staff welcoming and friendly in 100% of cases.

3.5. Workforce remains a key area of focus for the Trust, with an overall turnover rate of 20% (13% unplanned; 7% planned) and a wide range of initiatives are in place to improve our recruitment capacity. Feedback from our staff through pulse surveys, team meetings, and Executive Listening events tells us that whilst they are feeling under pressure, they continue to feel listened to and supported. The Festival of Wellbeing success of the summer was extended into Q4 and was very well received by staff. We continue to focus on our PDPs and appraisals and mandatory training to ensure that we are able to deliver safe, quality care.

3.6. In terms of our financial position, subject to audit we have delivered the reforecast year-end position of breakeven. This position was supported in-year by short term Covid 19 funding, winter pressure money, and transformation funding. The Trust was able to pro-actively invest in services during 2021-22 to add resilience during a period of ongoing high demand for services. Secondary Commissioning related spend has continued to be a challenge and exceeded plan in month 12 and for the full year.

Areas of Strong or Improved Performance in Q4

3.7. **Friends and Family Test**: Our service users told us that they would recommend our services to friends and family, if they needed them, in 82% of cases (target - 80%) and 91% of people said that they had been involved in discussions about their care (target – 85%)

3.8. **Displaying Trust Values:** 100% of our service users said that staff are welcoming and friendly and 83% told us that they have been treated in a way that reflects trust values (target 80%).

3.9. **Follow-ups after discharge from inpatient care:** 80% of our service users discharged from inpatient care received a follow-up contact within 48 hours and 96% received one within 7 days.

3.10. **Inpatient admissions:** People who need an inpatient admission were seen by Adult Crisis Assessment and Treatment Teams in 97% of cases to see if there was an alternative to admission.

3.11. **Crisis:** All service users who needed to access our Adult Crisis Assessment and Treatment Teams in Quarter 4 were assessed within a 4 hour period (target – 98%).

3.12. **IAPT:** People using our IAPT services met the recovery criteria in 53% of cases (target – 50%)

3.13. **LD&F**: People accessing specialist community learning disabilities services we assessed within 28 days in 98% of cases in Q4 (target 98%)

Areas of Concern or Focus

3.14. **Adults 28 Day** Assessment performance has declined in Q4 with 59% of service users assessed within 28 days of referral against a target of 95%. Currently, the average length of time between referral and assessment is 47 days, 19 days beyond our 28-day Access Standard. This is caused by an increase in new referrals (46% increase), high caseloads (6% increase), and high staff vacancies (up to 34% in some areas). The mitigation in place to manage this in the short term continues to be to focus on our highest risk service users, using the Clinical RAG rating system, where highest priority

(Red and Amber) cases are seen first, to prioritise assessments. The medium to long-term mitigation is to further improve the initial assessment and prioritisation process for new referrals by undertaking more assessments at the point of referral into SPA and by accepting trusted referrals directly into treatment.

A CQI Project is underway to improve the 28 day access position and a workshop to re-model the initial assessment process is scheduled for early May. Payment rates for bank staff are being reviewed to ensure that we are in line with other trusts and able to offer competitive rates of pay. We have also agreed additional resource in key areas including our Single Point of Access and Adult Community Mental Health Services to help meet the increasing demand and acuity.

3.15. **48-hour follow-up** post discharge – the position has improved and 82% of service users received contact post discharge in Q4 against the 80% target. We continued to exceed the national target of 72-hour follow-ups for 80% of service users post discharge. Our Deputy Medical Director is leading the second phase of a CQI project to address this for Q4. Principal changes include digital workflow improvements which provide automatic alerts to help clinical teams follow up on this critical task.

3.16. **Inappropriate Out of Area Placements** continues to challenge, despite the temporary expansion in our bed base through the contacting of 15 additional beds from the independent sector. This increase both for Adult and CAMHS beds, reflects an increase in complexity in the community. The situation in Hertfordshire is reflected nationally, with increased demand and a shortage of beds within local networks leading to an increase in out of area placements.

3.17. **Risk Assessments:** The rate of service users with an up-to-date risk assessment has decreased over Quarter 4 to 89% against a target of 95%. The primary reason for underperformance is the large caseloads held by some of our medical staff. The deputy medical directors are leading a CQI to simplify risk assessment recording in PARIS (Electronic Patient Record system) to provide a long-term solution. The use of a dynamic, case note related, recording system has now been successfully piloted and is being rolled out across all teams during May. Significant improvement is expected by the end of Q1.

3.18. **CAMHS Community:** The volume of referrals into our Single Point of Access Service has increased significantly, resulting in a significant number of children and young people waiting to access our services. These referrals have been screened and prioritised and are now being passed on to the CAMHS Quadrant Teams. As some of the referrals date back to February and March, this will adversely affect the 28 day wait performance during Quarter 1, but is expected to recover by Quarter 2. The CQI team is working with the service to review the service delivery processes to ensure that we can respond to the needs of our service users in a timely manner despite the increased demand for our services.

3.19. Details of Q4 performance against the KPIs and exception reports for underperforming KPIs can be found in Appendices A and B respectively.

4. Forecast Summary

4.1. CAMHS referrals have been consistently high across the year, we are forecasting this to continue into Q1. This increase has been in line with planning guidance from NHSI/E which proved incredibly accurate across the year for CAMHS services.

4.2. From January 2022, there has been a step change in the volume of new referrals every week into ACMH services. New referrals increased from a consistent 290 per week to a new baseline of 325 per week but this continuous increase has seen a dip in recent weeks throughout the Easter period. We are expecting the increased level of demand to continue into Q1 and Q2.

4.3. The 2021-22 planning guidance from NHS Improvement and England (NHSI/E) suggested a 10-30% increase on previous baseline figures, but our own experience is that demand has been at the higher end of this range. SPA and ACMH teams are contingency planning with these new referral volumes in mind and additional resources have been agreed to help meet the increased demand.

4.4. There has been a slight (2%) downwards trend in Older Adult referrals during the first wave of Covid19 but during 2021-22 we have seen a sustained increase of 17% which we expect to continue into this year.

4.5. There are no specific overall national volume guidelines for this year from NHSI/E, however there is an expectation that dementia services will increase to support improvements in diagnosis.

4.6. Referral volumes in Learning Disabilities and Forensic services (LD&F) have been consistent over the last 4 years. They dipped slightly during the COVID-19 period due to some referral routes slowing for a while, but quickly returned to normal levels. There are no overall volume guidelines indicating an increase or decrease in LD&F service over the next financial year.

4.7. The table below summarises the demand forecast for Q1 of 2022-23.

	Baseline *(FY 21-22)*	**Q1 Forecast** *(HPFT)*
CAMHS	189	200
ACMH	290	325
Older Adults	140	140
LD&F	9	9

Table 2 - Demand Forecast for Q1 2022-23

5. Benchmarking Summary

5.1. The NHS Benchmarking Network monitors changes in mental health and learning disability services as a result of the pandemic and publishes monthly reports.

5.2. February 2022 benchmarking data reflects the position that we are seeing across the Trust of continuing high bed occupancy in inpatient services, particularly adult services, where we have a below average number of beds and 100% occupancy. This correlates with our high number of out of area placements. Our length of stay is below the national average, indicating a relatively successful recovery rate, enabling our service users to return to their community.

5.3. We are seeing a very high caseload in our community services, 107% higher than in 2019-20. Referrals per 100,000 are below average into HPFT services. This indicates people staying in treatment for longer, presumably due to higher acuity. Our contacts per person on the caseload are in line with national figures, despite the high caseload, and we are partly managing this with a higher-than-average use of non-face to face contacts.

5.4. Conversely, our rate of CRHT referrals were 50% lower than the national average, with a slightly above average number of contacts once the person is in the service. Again, we have an above average use of non-face to face contacts.

5.5. This picture continues to suggest a disproportionate pressure on our adult community services – successfully keeping people out of inpatient services and managing increased acuity and caseloads within the community teams, rather than our crisis services.

6. Financial Resources

6.1. Subject to audit, the Trust has delivered a small surplus position of £84k against a break-even plan. This has been delivered against a backdrop of significant increases in demand and acuity, especially in the second half of the financial year.

6.2. The Trust continued to receive Covid income throughout 21-22 totalling £10.4m to support Covid related costs.

6.3. Secondary Commissioning related spend has continued to exceed plan in month 12 and for the full year.

6.4. The Trust pro-actively invested in services during 2021-22 so as to add resilience to its services during a period of ongoing high demand for its services.

6.5. Subject to audit, the Trust has delivered against its key financial targets for 2021-22 as outlined in the table overleaf.

Ref	Financial Indicator	Status	Target	Q4
F1	Achieve surplus in year (exc PSF)		£0K	£84K
F2	Use of resources		1	1
F3	Number of shifts breaching price cap		0	382
F4	Cash releasing efficiencies (full year effect)		£4.6m	£4.6m

Table 3 – Q4 Financial Performance

7. Quality Account Priority Indicators

7.1. Four out of the 10 quality account priority indicators did not meet the target in Q4. The table below summarises the Q4 performance for the ten indicators

	Ref	Indicator	Status	Target	Q4
Service User Safety	1	The percentage of service users who are followed up within 48 hours after discharge from psychiatric inpatient care during the reporting period.		≥80%	80%
	2	Reduction in the rate and percentage of service user safety incidents that result in moderate or severe harm.		10% reduction on previous year	Death 22 (includes 4 Covid 19 deaths of inpatients) (1.56%

	Ref	Indicator	Status	Target	Q4
					Severe Harm 1 (0.07%) Total incidents 1403 = 26% reduction on 20-21
	3	Rate of service users who have a completed risk assessment within the last 12 months.		≥=95%	89%
Clinical Effectiveness	4	Reduction on the number of inappropriate out of area placements.		0	2,596
	5	Reduce the readmission rate within 28 days of being discharged from adult acute hospital bed.		5%	2 %
	6	At least one outcome measures to be used on all LD F inpatients (HONOS in all inpatient units).		≥80%	88%
	7	Completed annual care plans within LD community services Herts and Essex		≥50%	46%
Experience	8	Rate of Service Users saying they have been involved in discussions about their care		≥85%	91%
	9	Appropriate Carer Essential Training undertaken by all staff at all levels		≥85%	4%
	10	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them		≥70%	75%

Table 4 - Quality Account Priority Indicator Performance

8. Recommendations

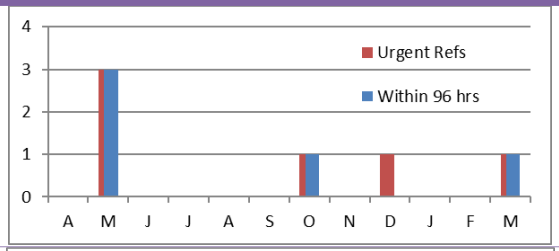
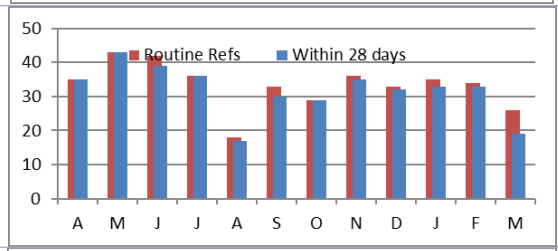
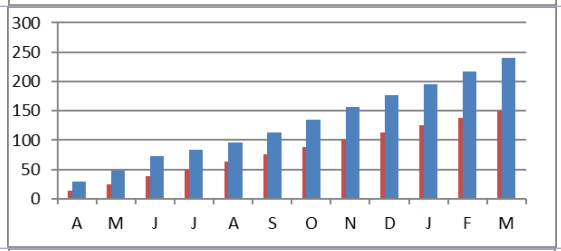
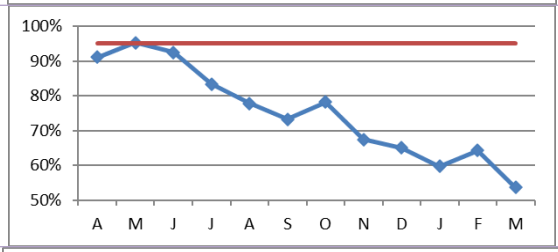
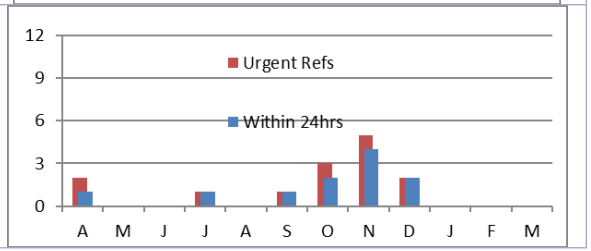
8.1. The Trust Board is recommended to:

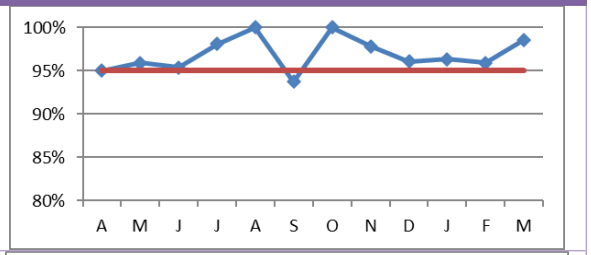
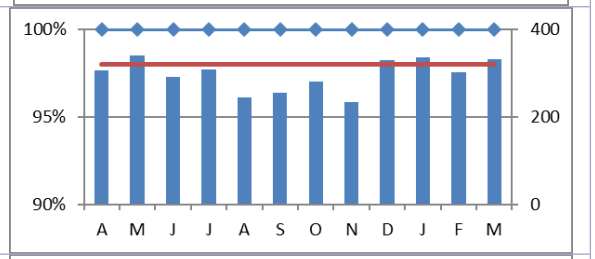
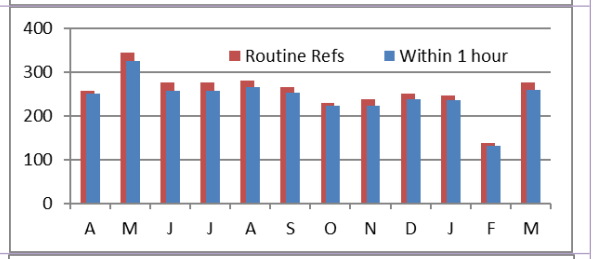
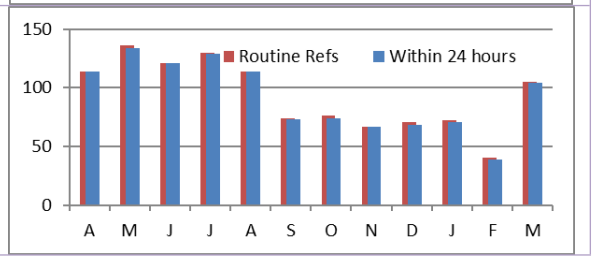
- Critically appraise the information presented.
- Consider the areas of performance noted and evaluate the associated actions.
- Seek any additional assurance or information required.

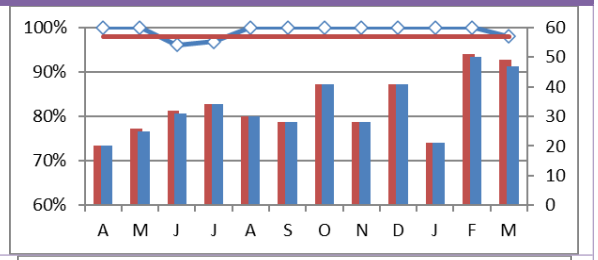
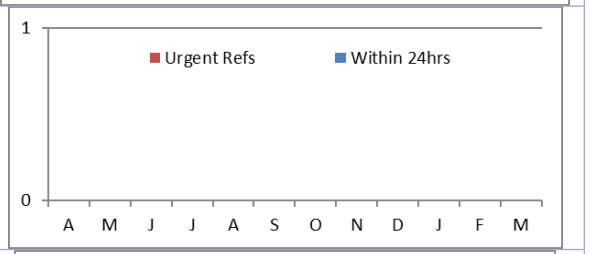
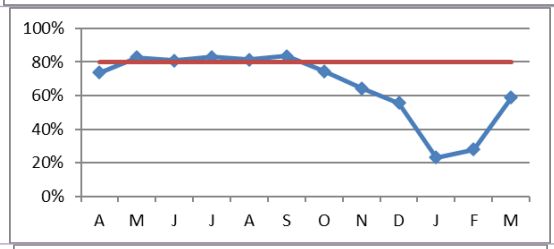
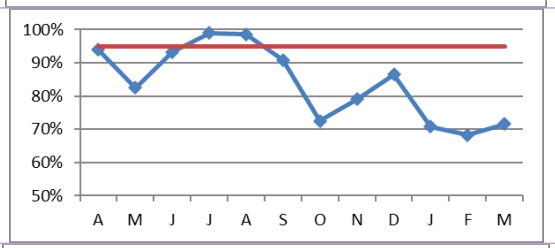
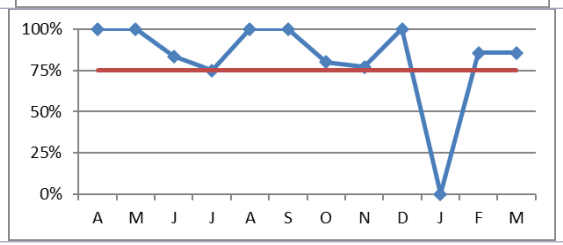
9. Appendix A – Q4 performance against the KPIs

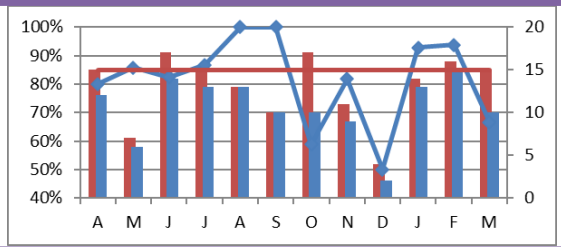
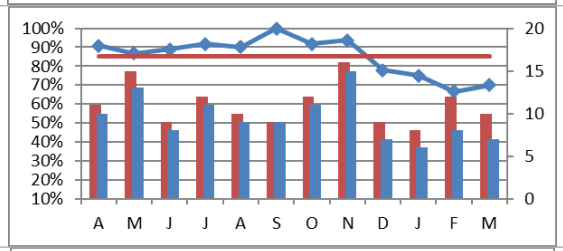
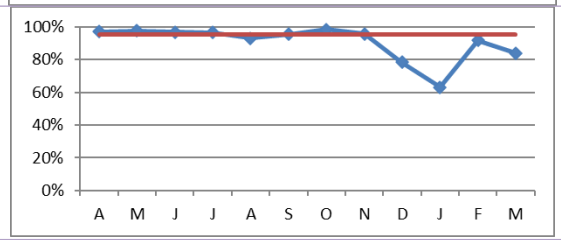
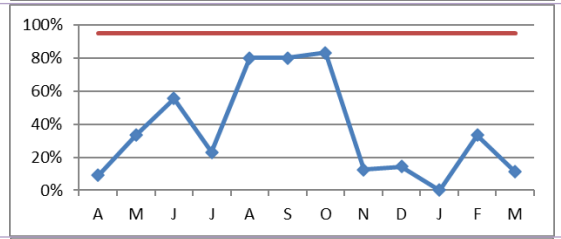
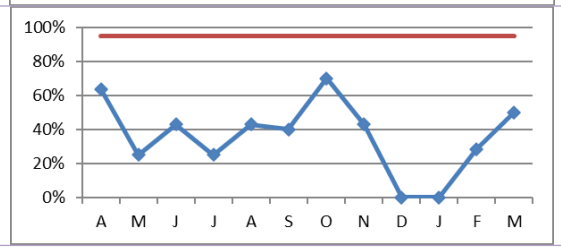
9.1. The table below summarises the Q4 performance against all indicators

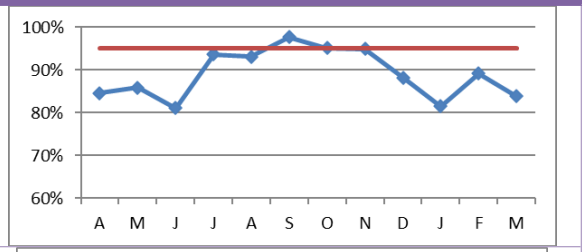
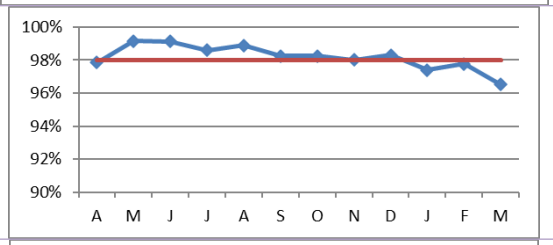
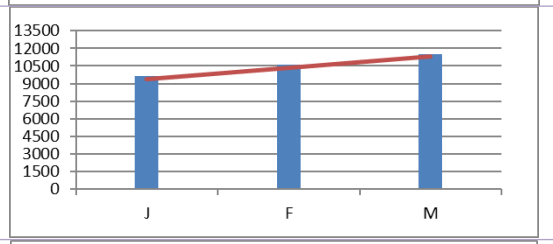
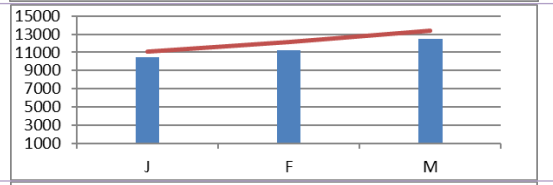
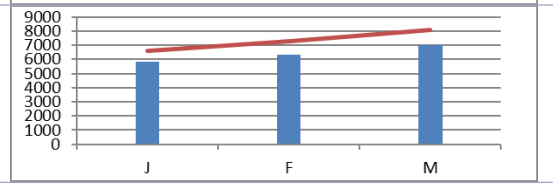
	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	**Trajectory**
NHS Oversight Framework	SOF1	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)22		≥60%	53 63	84%	↔	N/A
	SOF3	Data Quality Maturity Index (DQMI) – MHSDS dataset score.		>=95%	97%	97% (Dec)	↔	N/A
	SOF4	Improving Access to Psychological Therapies (IAPT)/talking therapies Proportion of people completing treatment who move to recovery (from IAPT minimum dataset)		>=50%	1,855 3,572	52%	↔	N/A
		Improving Access to Psychological Therapies (IAPT)/talking therapies Waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks (3-Month Rolling)		>=75%	7,528 7,721	98%	↔	N/A
		Improving Access to Psychological Therapies (IAPT)/talking therapies Wiithin 18 weeks (3-Month Rolling)		>=95%	7,718 7,721	100%	↔	N/A
	SOF5	Inappropriate out-of-area placements for adult mental health services		0	N/A	2596 (0)	↔	N/A

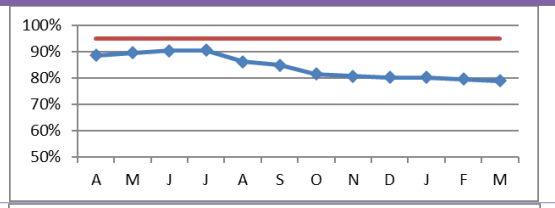
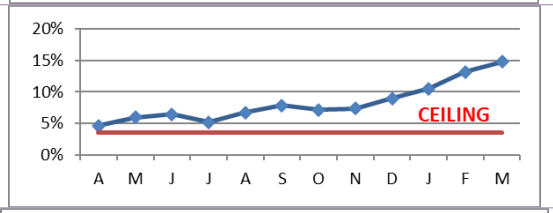
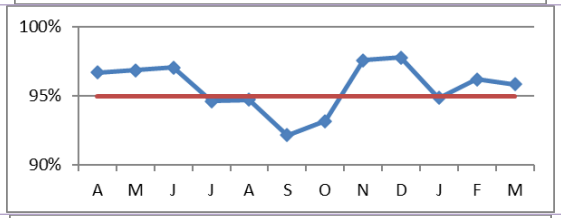
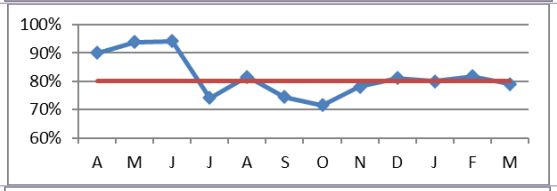
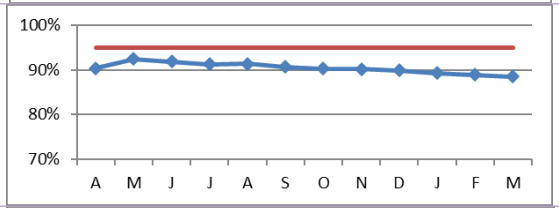
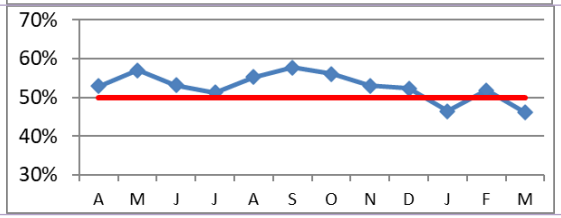
	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	Trajectory
Access	A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**		>=98%	1 1	100%	↔	
	A2	Routine referrals to community eating disorder services meeting 28 day wait **(Contractual)**		>=98%	85 95	89%	↔	
	A3	Number of new cases of psychosis **(Contractual)**		150	240	240	↔	
	A4	Routine referrals to community mental health team meeting 28 day wait **(Contractual)**		>=95%	512 863	59%	↔	
	A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**		>=98%	0 0	zero	↔	

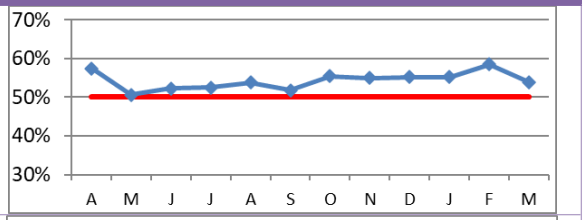
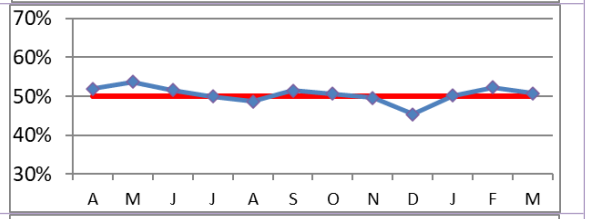
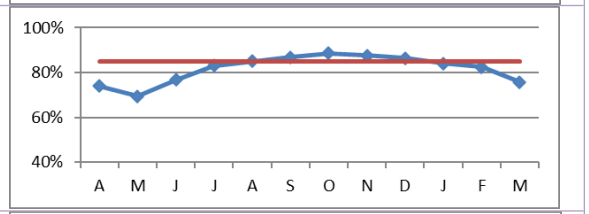
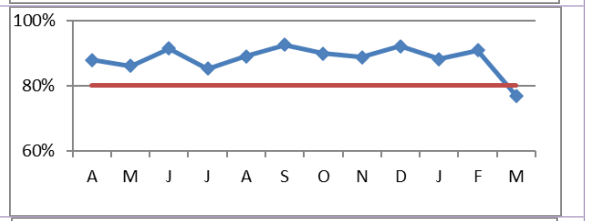
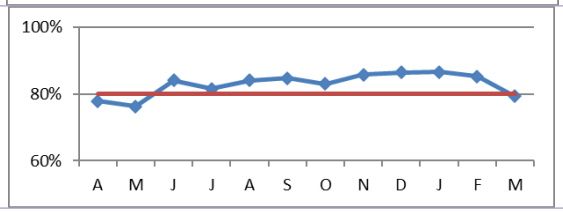
	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	**Trajectory**
Access	A6	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team		>=95%	169 174	97%	↔	
	A7	CRHTT referrals meeting 4 hour wait **(Contractual)**		>=98%	967 967	100%	↔	
	A8	MHLT Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A	N/A	627 660	95%	↔	
	A9	MHLT Response times: 24 hour wait for ward referrals (Lister & Watford combined)	N/A	N/A	214 217	99%	↔	

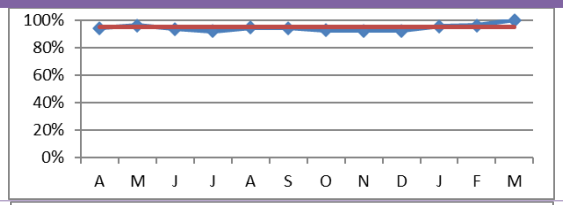
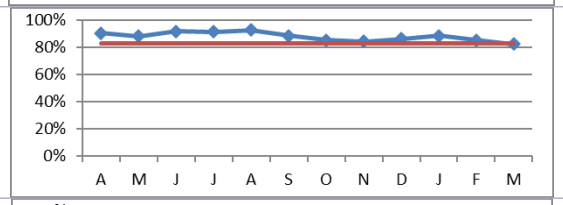
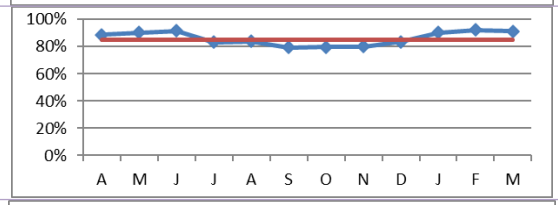
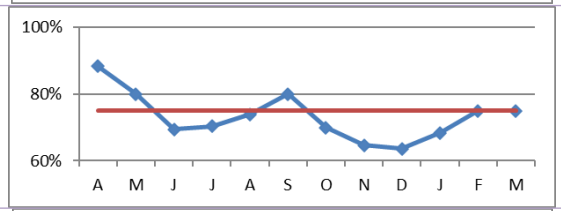
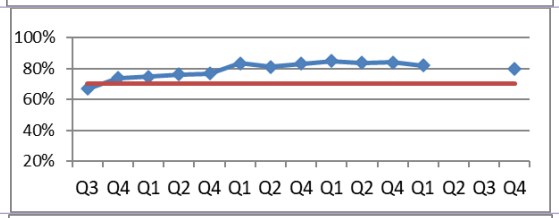
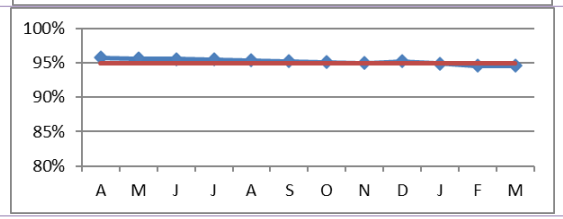
	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	**Trajectory**
Access	A10	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**		>=98%	118/121	98%	↔	
	A11	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait **(Contractual)**		>=98%	0	0	↔	
	A12	EMDASS Diagnosis within 12 weeks (Contractual)		>=80%	164/471	35%	↑	
	A13	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**		>=95%	257/366	70%	↔	
	A14	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**		>=75%	12/16	75%	↔	

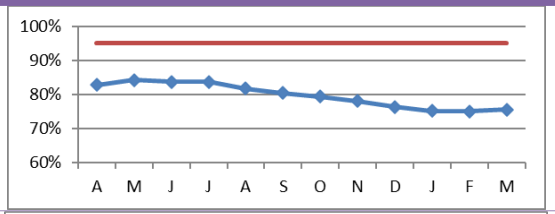
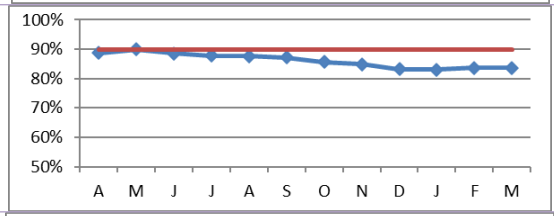
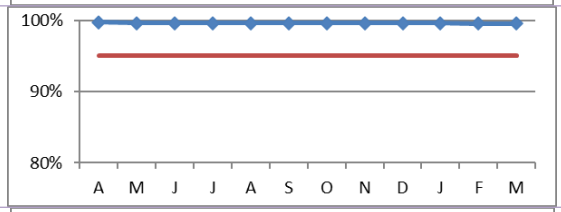
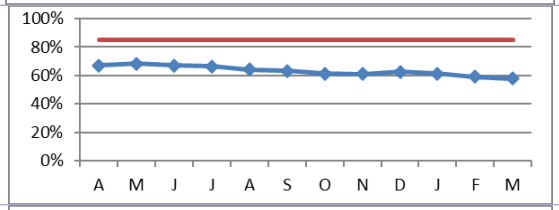
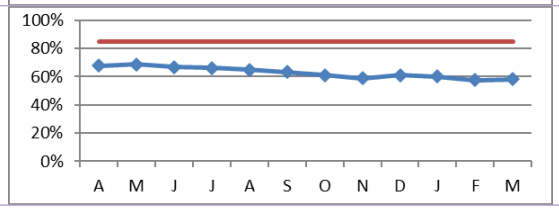
	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	Trajectory
Access	A15	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**		>=85%	38/45	84%	↔	
	A16	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**		>=85%	21/30	70%	↑	
	A17	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**		>=95%	111/143	79%	↔	
	A19	CAMHS Eating Disorders - Urgent referrals seen within 7 Days (Contractual)		>=95%	3/19	16%	↔	
	A20	CAMHS Eating Disorders - Routine 28 day Waited (Contractual)		>=95%	6/16	38%	↔	

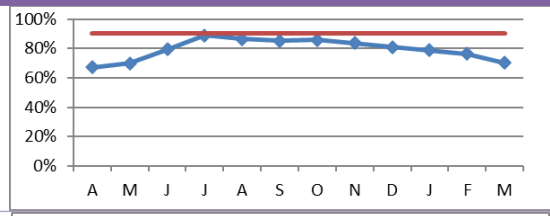
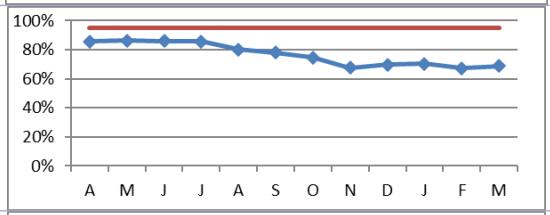
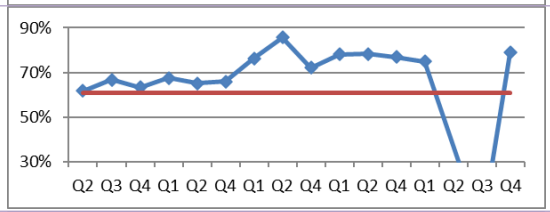
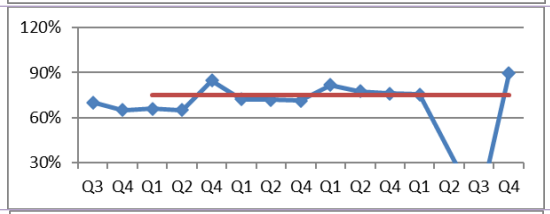
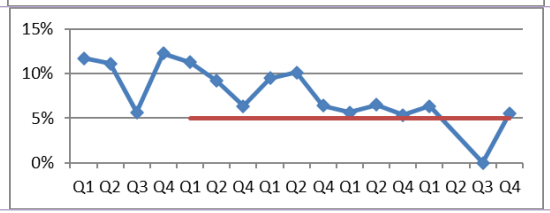
	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	**Trajectory**
Access	A21	SPA referrals with an outcome within 14 days (Internal)		>=95%	7,783 9,191	85%	↔	
	A22	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services (Contractual)		>=98%	8,533 8,782	97%	↔	
	A23	Number of people entering IAPT treatment (ENCCG) **(Contractual)**		12,478	11,559	N/A	↔	
	A24	Number of people entering IAPT treatment (HVCCG) **(Contractual)**		13,392	12,587	N/A	↔	
	A25	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**		8,112	6,993	N/A	↔	

	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	**Trajectory**
Safety and Effectiveness	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%	1,377 1,744	79%	↔	
	SE2	Delayed transfers of care to the maintained at a minimal level		<=3.5%	4,430 34,548	13%	↔	
	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%	265 277	96%	↑	
	SE4	The percentage of people under adult mental illness specialties who were followed up within 48 hrs of discharge from psychiatric in-patient care		>=80%	221 276	80%	↑	
	SE5	Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) **Seen Only**		>=95%	16,094 18,183	89%	↑	
	SE6	IAPT % clients moving towards recovery (ENCCG)		>=50%	633 1,254	50.36%	↔	

	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	**Trajectory**
Safety and Effectiveness	SE7	IAPT % clients moving towards recovery (HVCCG)		>=50%	786 1,410	56%	↔	
	SE8	IAPT % clients moving towards recovery (Mid Essex)		>=50%	438 851	51%	↑	
	SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**		>=85%	56 74	76%	↔	
	SE12	Rate of service users that would recommend the Trust's services to friends and family if they needed them		>=80%	971 1,118	82%	↔	
	SE13	Rate of service users saying they are treated in a way that reflects the Trust's values		>=80%	1949 2354	83%	↔	

	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	Trajectory
Safety and Effectiveness	SE14	Rate of Service Users Saying staff are welcoming and friendly (Rolling 3 months)		>= 95%	34 / 34	100%	↔	
	SE15	Rate of Service Users saying they know how to get support and advice at a time of crisis (Rolling 3 months)		>= 83%	28 / 34	82%	↔	
	SE16	Rate of Service Users saying they have been involved in discussions about their care (Rolling 3 months)		>= 85%	31 / 34	91%	↑	
	SE17	Rate of carers that feel valued by staff **(rolling 3 month basis)**		>=75%	12 / 16	75%	↔	
	SE18	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them		>=70%	134 / 168	80%	↔	
	SE19	Percentage of eligible service users with a PbR cluster		95%	11,308 / 11,950	95%	↔	

	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	Trajectory
Safety and Effectiveness	SE20	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)		95%	8,425 11,141	76%	↔	
	SE21	Data completeness against minimum dataset for Ethnicity (MHSDS)		90%	24,471 29,786	82%	↔	
	SE22	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital:		>=95%	177,854 178,716	100%	↔	
	SE23.a	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment)		>=85%	11,533 19,950	58%	↔	
	SE23.b	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation)		>=85%	11,606 19,950	58%	↔	

	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	Trajectory
Safety and Effectiveness	SE24	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services		>=90%	382/545	70%	↔	
	SE24.a	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on Care Programme Approach)		>=95%	638/929	69%	↔	
Workforce	W1	Staff saying they would recommend the trust as a place to work		>=61%	134/170	79%	↔	
	W2	Staff wellbeing at work		>=75%	152/170	89%	↔	
	W3	Rate of staff experiencing physical violence from service users		<=5%	9/163	6%	↔	

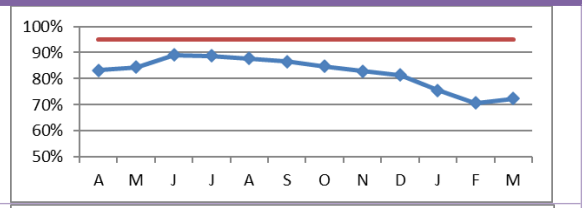
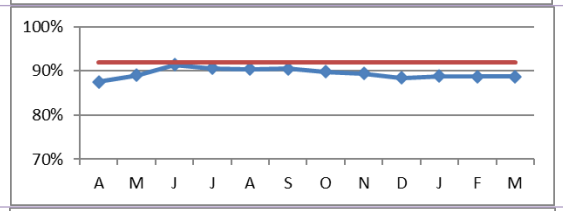
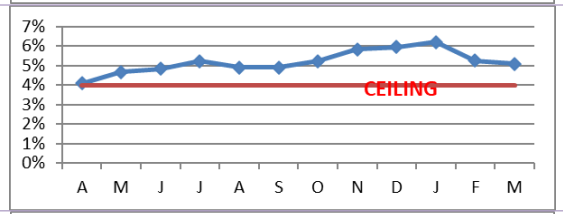
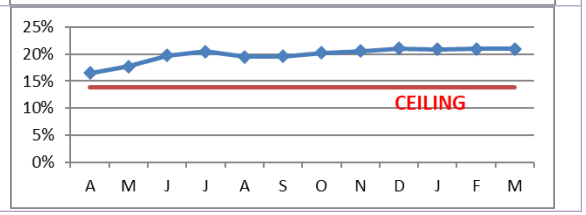
	Ref	Indicator	Status	Target	Q4 *Numbers*	Q4 *Percentage*	Q1 Forecast	Trajectory
Workforce	W6	Rate of staff with a current PDP and appraisal		>=95	2,257 3,121	72%	↔	
	W7	Rate of mandatory training completed and up to date		>=92%	34,753 39,169	89%	↔	
	W8	Sickness rate		<=4%	16,611 301,113	6%	↔	
	W9	Turnover rate (Rolling 12 months)		13.9%	705 3,366	20%	↔	

Table 5 - Q4 Detailed Performance

10. Appendix B – Q4 Exception Report

NHS Oversight Framework

10.1. The Trust met 5 out of the 6 KPIs in this domain. The table below outlines the performance and planned actions for KPIs currently underperforming.

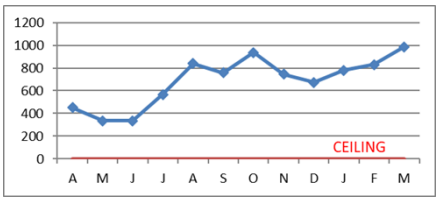
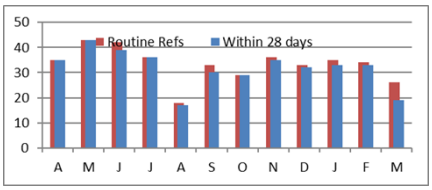
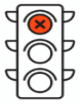
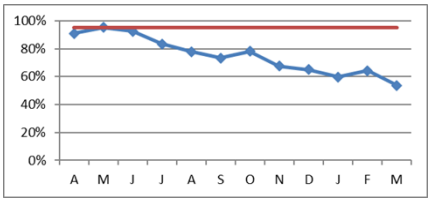
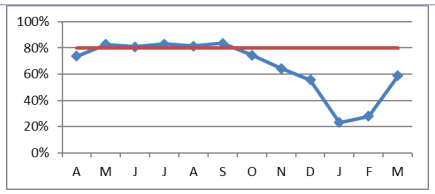
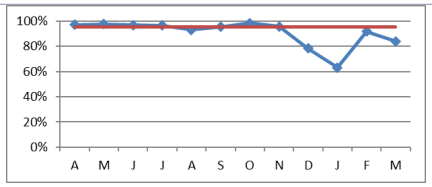
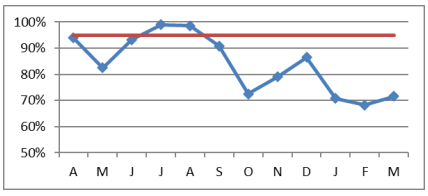
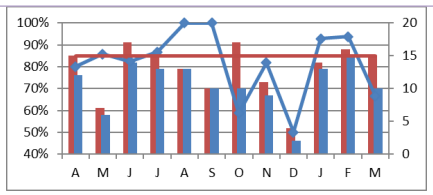
KPI	Status	Trend	Q4 Status/Action
Inappropriate Out of Area Placements (OAPs) for adult mental health services. (Target 0 bed days at end of Q4)			**Q4 Performance: 2,596** **March – 987 bed days** Performance against this target reflects the national picture of increased demand for admissions and increased acuity and complex presentations resulting in longer stays. Trajectory in place to reach 0 placements by end of Q4 was not met. **Action:** Plan in progress that will improve the position by developing alternatives to admission and facilitating early supported discharges. A revised trajectory for 2022/23 has been agreed with NHSE to reduce to 0 by the end of 2022/23. Fluctuation can be expected, dependent on demand for beds.

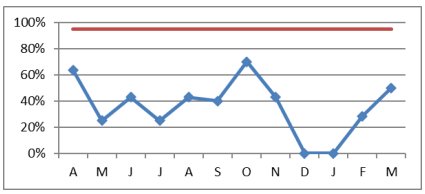
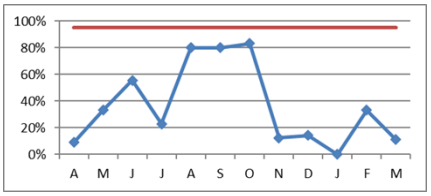
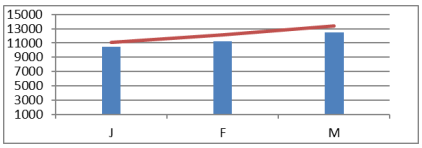
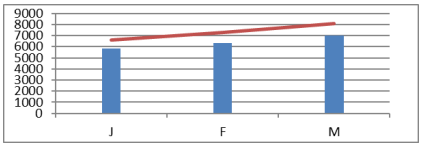
Table 6 – Underperforming NHS Oversight Framework KPIs

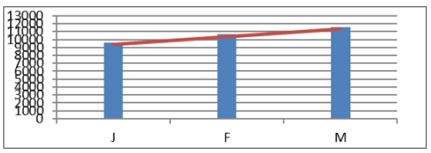
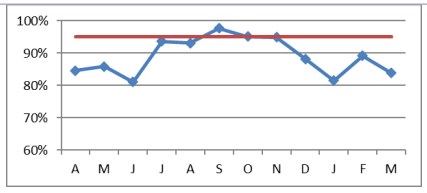
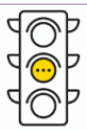
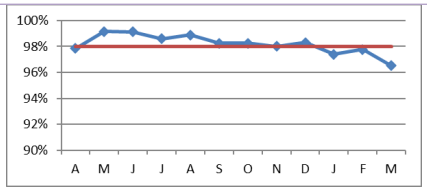
Access Indicators

10.2. The Trust met 10 out of 24 KPIs in this domain. The table below outlines the performance and planned actions for KPIs currently underperforming.

KPI	Status	Trend	Q4 Status/Action
Routine referrals to community eating disorder services meeting 28 day wait (Target 98%)			**Q4 Performance – 89%** Some late pass-ons to the team resulted in 10 people being seen after the 28 day threshold in Q4. **Action:** System put in place to identify any potential delayed pass ons at an early stage to allow booking within 28 days. Recovery expected in Q1
Routine referrals to Adult community mental health team meeting 28 day wait (Target 95%)			**Q4 Performance – 59%** Significant increase in demand and areas of high vacancy rates have contributed to capacity issues, across all teams, but with West particularly affected. Referral rates into the service remain circa 10% greater than pre-Covid and a backlog of people waiting for Initial Assessments has now built up. **Action:** A CQI project is underway to identify areas for improvement and different ways of working that

KPI	Status	Trend	Q4 Status/Action
			will allow the indicator to be met without any loss of quality for the service user. Short term plan to clear backlog is in place, with agency staff being sourced to carry this out.
EMDASS Diagnosis within 12 weeks (Target 80%)			**Q4 Performance 35%** Increased referrals and a temporary reduction in staff due to redeployment to inpatient units during the last Covid wave has caused a backlog. **Action:** Recovery plans in place, including week-end clinics and a new Primary Care Diagnosis service. A detailed trajectory predicting recovery by the end of July.October?
CAMHS referrals meeting routine 28 day wait (Target 95%)			**Q4 Performance 78%** Increased demand and capacity issues resulted in a backlog of cases that built up in SPA from January 2022. **Action:** The backlog has been cleared and a review of working processes in the CAMHS 'pod' in SPA is underway to prevent a similar occurrence in future.
CAMHS referrals meeting crisis (4 hour) waits (Target 95%)			**Q4 Performance 70%** Ability to meet this target is directly related to the number of children and young people presenting to the service. Numbers of referrals have remained consistently high (circa 90% increase on pre-Covid levels), and increased acuity has been evident. Capacity has been further affected by long and short-term sickness in the team and vacancies. **Action:** Successful recruitment has taken place to existing posts and further posts now advertised with additional funding. Agency continues to cover where possible. Crisis line is being promoted to avoid hospital admissions wherever possible.
CAMHS Targeted 14 day social work contact (Target 85%)			**Q4 Performance 84%** Increased demand and capacity issues resulted in a backlog of cases that built up in SPA from January 2022 **Action:** The backlog has been cleared and a review of working processes in the CAMHS 'pod' in SPA is

KPI	Status	Trend	Q4 Status/Action
			underway to prevent a similar occurrence in future. Recovery expected in Q1
CAMHS Eating Disorder Service meeting routine 28 day and urgent 7 day waits (Target 95%)		 	**Q4 Performance- 28 day – 38%; 7 day – 16%** Average monthly referral rate has risen from an average of 22 per month to 45 – 50 per month after the first wave of the COVID pandemic and are now averaging at around 30 – 35. Children are also becoming more acutely unwell, whilst they wait to be seen. Service is carrying a high level of vacancies due to leavers and maternity leave. **Action** Additional resource agreed and joint action plan with commissioners. Medical Monitoring Clinic being set up with an 8a) lead and establishment of Practitioner roles that will be open to more disciplines. Ongoing work with workforce to improve recruitment where it is still proving difficult.
Number of people entering IAPT treatment (Herts Valleys CCG) (Target 13,392)			**Q4 performance – 3,221/3,348** **Year end achieved 12,587/13,392 (94% of annual target)** Referrals into the service did not reach the required target levels until Q4, preventing this target from being fully achieved (referrals at 92% of that required). **Actions: for 2022/23** The target has not increased for this year, with current staffing levels access will be achieved should referral numbers remain at current levels.
Number of people entering IAPT treatment (Mid Essex) (Target 8112)			**Q4 performance – 1,736/2,204** **Year end achieved 6,993/8,112 (86% of annual target)** Referrals into the service did not reach the required target levels preventing this target from being fully achieved (referrals at 90% of that required). **Actions: for 2022/23** The local access target has been increased based on staffing capacity and remains behind NHSE and LTP trajectories due to funding levels. This is the focus of commissioning discussions, and it is anticipated that a joint plan will be agreed within the new 5 year contract to address this deficit.

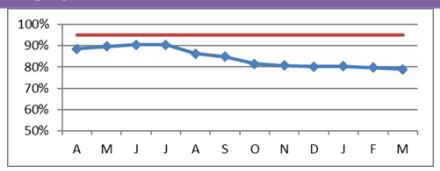
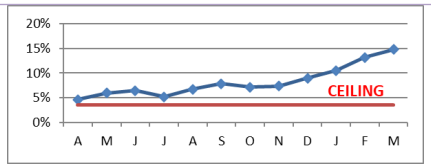
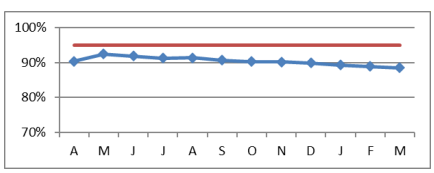
KPI	Status	Trend	Q4 Status/Action
			Additional recruitment to Trainee places has been requested but it not guaranteed, recruitment to qualified posts remains a challenge nationally.
Number of people entering IAPT treatment (East & North CCG) (Target 12,478)			**Q4 Performance – 2,862/3,120** **Year end achieved 11,559/12,478 (93% of annual target)** Referrals into the service reached the required target levels at the latter part of the year; however, fluctuations in staffing capacity and variations in referral levels throughout the year prevented this target from being fully achieved. **Actions: for 2022/23** The target has increased up to LTP targets, with current staffing levels remaining below funded levels due to vacancies. The focus will remain on the recruitment of the workforce and the management of initial appointments and treatment options within the workforce capacity. Additional recruitment to Trainee places has been requested but it not guaranteed, recruitment to qualified posts remains a challenge nationally.
SPA referrals with an outcome within 14 days (Target 95%)			**Q4 Performance – 85%** Increased referrals and capacity issues in SPA resulted in a backlog of CAMHS cases that built up in SPA from January 2022. **Action:** The backlog has now been cleared and a review of working processes in the CAMHS 'pod' in SPA is underway to prevent a similar occurrence in future. Recovery expected in Q1
Rate of referrals meeting 18 week RTT (Target 98%)			**Q4 Performance – 97%** Increased demand has resulted in longer waits to get people assessed and then into treatment. This has been compounded by higher caseloads and reduced capacity due to vacancies and sickness. There is also an element of data quality with incidences of treatment starts not being indicated in the service user's record. **Action:** Data quality issues to be resolved over Q1. CQI work on service user pathways expected to impact positively on

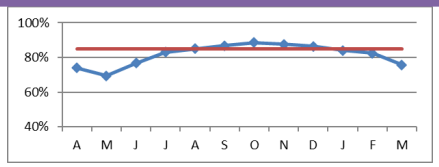
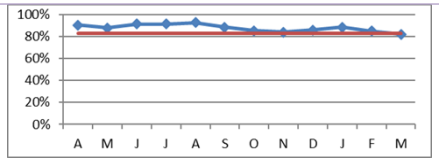
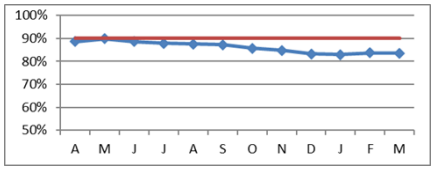
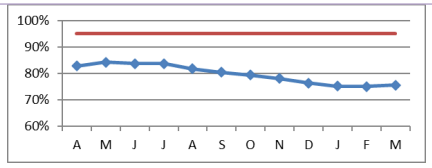
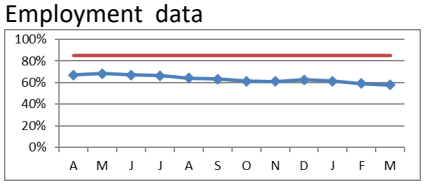
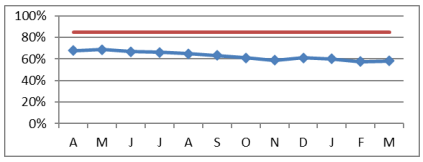
KPI	Status	Trend	Q4 Status/Action
			referral to treatment times. Recovery expected in Q1.

Table 7 - Underperforming Access Indicators

Safety and Effectiveness

10.3. The Trust met 13 out of 24 KPIs in this domain. The table below outlines the performance and planned actions for KPIs currently underperforming.

KPI	Status	Trend	Q4 Status/Actions
CPA reviews within the last 12 months for service users on CPA (Target 95%)			**Q4 Performance 79%** CPA Reviews have remained relatively stable throughout the year. E&N SBU require an additional 34 CPAs to meet target and West SBU require an additional 221. **Actions:** CQI work to improve pathways and reduce waits is expected to help capacity issues. Continuing focus in teams to schedule reviews within 12 months. Recovery expected in Q2
Delayed Transfers of Care (DTCs) (Target 3.5%)			***Q4 Performance 13%*** High levels of delay in Adult Acute services due to insufficient placements available for people with complex care needs. Shorter delays in older adults' services, but with higher turnover – some instances of placements not being able to take older adults due to COVID outbreaks **Actions:** Acute Pathway Project includes Improved Gatekeeping to ensure barriers are identified at admission and plans put in place to resolve these in the First 72 Hours. Weekly clinical reviews and escalation to external partners. Potential project with Priory to take some of the shorter term delayed service users whilst best placement is found. Trajectory in place to reduce to less than 3.5% by end of Q4.
Rate of service users with a completed up to date risk assessment (Target 95%)			**Q4 Performance – 89%** Caseloads have increased and medical caseloads are very high in some areas, making it more challenging to undertake routine reviews. **Actions:** CQI project has resulted in simplification of recording risk in a dynamic way via case-note entries. Successfully piloted and now being rolled out to all areas, with a recovery forecast for end of Q1.

KPI	Status	Trend	Q4 Status/Actions
Rate of acute Inpatients reporting feeling safe (Target 85%)			**Q4 Performance – 76%** The drop in performance in March is likely to be attributable to increased bank and agency staff on wards due to leave and COVID absences, which could leave service users feeling less safe. Additionally, there are some service users on the wards who require intensive support which could leave other service users feeling vulnerable. **Actions:** Continuing actions around MOSS and additional recruitment of Experts by Experience to better understand the issues that service users experience in the acute environment.
Rate of service users saying they know how to get support and advice at a time of crisis (Target 83%)			**Q4 Performance – 82%** This target has a history of being met and very narrowly missed target for March. No action required at present.
Data Completeness against minimum dataset for Ethnicity (Target 90%)			**Q4 Performance – 82%** Possible decreased focus on data quality during the COVID emergency **Actions:** Target to achieve 95% by the end of Q3, by culture change not achieved.
Percentage of eligible service users with a PBR cluster review (Target 95%)			**Q4 Performance: 76 %** Performance declined during COVID, but has now stabilised. Recovery predicted for Q3 and will become a focus once recovery achieved on higher risk indicators.
Mental Health Services Data Set submissions to NHS Digital Employment & Accommodation (Target 85%)		Employment data  Accommodation data 	**Q4 mean performance: 58%** The recording of these indicators has decreased due to the COVID emergency and less face to face contact. There have been 2 focussed drives conducted by the Digital Support Team in Q3 **Actions:** 1)Alternative action to Digital Support Team reminder campaign is being identified. 2)The Inclusion, Involvement and Experience Team will lead a longer term piece of work with the SBUs and their PG Leads to raise awareness of the personal, cultural and organisational value of recording comprehensively – this has not yet started.

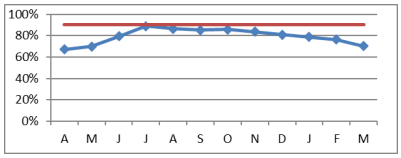
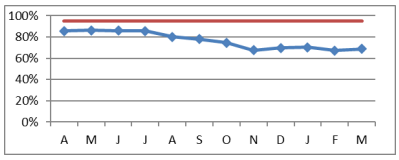
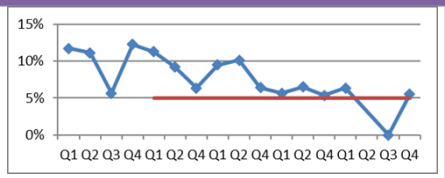
KPI	Status	Trend	Q4 Status/Actions
Cardio-metabolic checks for people with psychosis (Target 90%; FEP 90%; Community CPA 95%)		**Run Chart – FEP**  **Run Chart – Community CPA**  	**Q4 performance:** **FEP = 70%** **Community CPA = 69%** Performance on FEP has slowly decreased since November as a result of capacity issues within the teams and higher sickness rates. Performance for those on CPA has remained stable since November. **Actions:** FEP: Individual action plans for PATH Teams, supported by CDs. CPA: Increased focus on scheduling health checks, and expected to benefit from improved pathways work. Recovery expected in Q2.

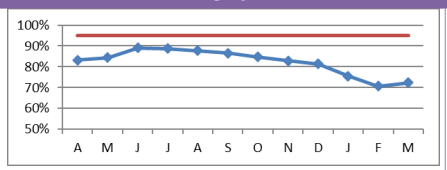
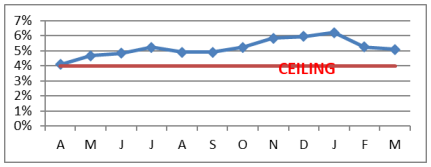
Table 8 - Underperforming Safety and Effectiveness KPIs

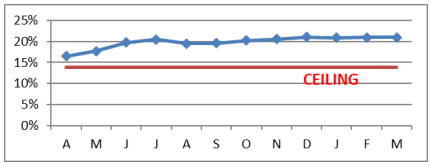
Workforce

10.4. Feedback from our staff through pulse surveys, team meetings, and Executive Listening events tells us that whilst they are feeling under pressure, they also feel listened too and supported. The Festival of Wellbeing success of the summer was repeated over Quarter 4. Food trucks and coffee vans delivering free treats and goodies during January. 37 sites across HPFT were visited with 1700 staff able to be seen.

10.5. The table below outlines the performance and planned actions for KPIs currently underperforming.

KPI	Status	Trend	Q3 Status/Action
Rate of staff that report experiencing physical violence from service users (Target 5%)		 	**Q4 Performance: 6%** 9/163 respondents reported experiencing physical violence during Q4. **Actions:** - Additional RESPECT trainer posts approved to support increased compliance with training in management and prevention of violence. - New structured violence risk assessment introduced. - Improved joint working protocol with Herts Police. PCSO post attached to Kingsley Green now reinstated. - Enhanced Risk Assessment and supporting team have gone live. This helps to manage risk at the earliest opportunity and increase safety of service users, staff and their friends and families.

KPI	Status	Trend	Q3 Status/Action
Rate of staff with a current Personal Development Plan and appraisal (Target 95%)			**Q4 Performance: 72%** Whilst significant recovery since H1 of 2020-21 has taken place, operational pressures and leave impacted compliance in late Summer 2021 and again during Winter. In addition, significant numbers of people were appraised this time last year when the new approach was launched, which means that large numbers of people were due an appraisal review in Q3 and are due review in Q1 22/23. **Actions:** Whilst weekly monitoring and reporting have continued and HRBPs continue to work with leaders to increase compliance, more significant efforts are required to ensure that good quality appraisals are taking place for all our staff, as appraisal plays a key retention role. We have therefore started a renewed drive to increase compliance from March. This drive will cover appraisal, mandatory training and supervision compliance. This has led to a slight increase in appraisal rates during March and is expected to further increase in April and May.
Sickness Rate (Target 4%)			**Q4 Performance: 6%** **Actions:** The following actions have been taken: - Significant work continues across the Trust regarding health and wellbeing to promote self-care and support staff to keep mental ill health levels as low as possible, including focussed support from the Here for You service - We continue to offer a range of health and wellbeing support and events covering exercise and diet in menopause, strategies to help manage menopause symptoms, webinars on relaxation, self-care, stress, sleep and burnout, plus activities such as arts and crafts sessions, pilates, mindfulness, hypnorelaxation, DBT sessions, yoga, wellbeing - talks, fitness sessions, and virtual pampering sessions.

KPI	Status	Trend	Q3 Status/Action
			- The Winter Wellbeing Festival took place during Quarter 4 and was a great success with food trucks and coffee vans delivering free treats and goodies during January. 37 sites across HPFT were visited with 1700 staff able to be seen. Inpatient areas were visited in the first week, followed by Community Teams during the second week. The Wellbeing Team were in attendance on site speaking to staff, having wellbeing conversations and listening to feedback and concerns to help shape our future programme of work. - All our people were encouraged to take time to rest and connect with family and loved ones during the festive period to help support their wellbeing. However, it should be noted that services are facing increased pressure as a result of the latest phase of the pandemic and as a result of Winter pressures. This in turn may continue to impact on our people and it is likely that this will lead to absence continuing at above our target of 4% during Q4.
Turnover Rate (Target 13.9%)			**Q4 Performance 20% Unplanned 13%; Planned 7%** **<u>Actions:</u>** Recruitment capacity and activity has expanded significantly with many campaigns for nurses, Support workers and AHPS across the trust. Key actions are: - Expanding our international nurse recruitment campaign - Joining a national Mental Health Workforce Retention task and finish group. - Continuing work on Flex for Future programme supported by NHSE/I - Established all Band 2 posts as Band 3 posts to tackle our 20% turnover rate amongst Band 2 staff - Focusing on equality and inclusion in recruitment and promotion practices.

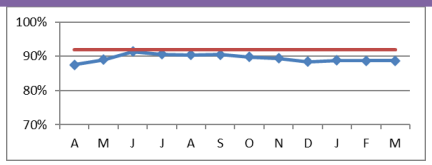
KPI	Status	Trend	Q3 Status/Action
Mandatory Training Rate (Target 92%)			**Q4 Performance: 89%** The coronavirus pandemic resulted in: a) a reduction in the ability of staff to take time to complete their training; and b) pauses in and restrictions to face to face training. The position significantly improved from June 2021. **Actions:** Reminders are being sent to staff and managers via Discovery and staff are actively booking themselves onto courses. Monthly compliance and exception reports are sent to management teams and HRBPs proactively support compliance in the SBUs. Whilst much of our mandatory training is available via eLearning, compliance with training that must be carried out face to face remains the area of lowest compliance. Respect training has been a particular focus, with six further additional trainers having now been trained who were competent by end of Q4 to increase trainer capacity, additional venues are being used and weekend training is being run. Due to increased pandemic and Winter pressures in Q3 and 4, it is likely that recovery will not be achieved until Q1 of 22/3.

Table 9 - Underperforming Workforce KPIs

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 13b
Subject:	Annual Plan 2021-22 - Quarter 4 and Year End Progress Report	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director of Improvement & Innovation Sophia Mody, CQI lead	**Approved by:** David Evans, Director of Strategy and Partnerships
Presented by:	David Evans, Director of Strategy and Partnerships	

Purpose of the report:

The report provides an update on the Quarter 4 2021-22 (Q4) milestones for the Trust's annual plan and the overall achievement of objectives in 2021-22 fiscal year.

Action required:

The Trust Board is asked to receive the report, noting delivery against the 2021-22 Annual Plan.

Summary and recommendations:

Introduction

The Annual Plan comprises of seven objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust aims to take and the milestones we plan to achieve, by quarter, to deliver the agreed outcomes for the year.

In setting the 2021-22 Annual Plan in March 2021, we recognised that there was a much higher level of uncertainty due to the ongoing pandemic. In response to this, the planning process included a mid-year review of the outcomes set.

At the end of each quarter each objective receives two RAG ratings which indicate:

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

Quarter 4 2021-22 and 2021-22-Year End Achievement

Quarter 4 2021-22 (Q4) has been a challenging period for the Trust and the wider health and care system with continued demand and acuity pressures and increased staff absences due to the COVID pandemic. However, all our services continued to remain open to admissions, including the festive period when the acuity of demand and system pressures were at their peak.

We continued to work closely with our system partners across Hertfordshire, Essex, Buckinghamshire, and Norfolk, and have achieved most of our milestones for the quarter and are on track to meet most of our year end outcomes.

61% of all year-end outcomes were fully delivered (34/56 outcomes) at the end of the 2021-22 fiscal year with actions to deliver the remining 39% (22 outcomes) that are not on target agreed in Q4.
The table below summarises Q4 and year end position for all objectives.

Table 1 - Q4 and year end achievement summary

Ref	Objective	Q4 21-22		21-22 Year End	
		Milestone Achievement	RAG Rating	Outcome Achievement	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	7/9 (78%)		3/8 (40%)	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	9/14 (65%)		5/9 (55%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	12/18 (66 %)		2/5 (40%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	7/11 (63%)		5/7 (71%)	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	9/15 (60%)		4/5 (80%)	
SO6	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	11/17 (65%)		6/9 (67%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	3/11 (30 %)		9/13 (69%)	

Recommendation
The Trust Board is asked to receive the Q4 Annual Plan Report, noting delivery against the 2021-22 Annual Plan.

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

The report summarises delivery against all Trust 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:

The report provides an update on all annual objectives some of which have impact on equality, diversity and/or public & patient involvement. Changes have also been made to the report format to improve accessibility.

Last seen by:

The Executive Team (04/05/2022) , Finance and Investment Committee (10th May 2022)

TRUST ANNUAL PLAN 2021-22

QUARTER 4 AND YEAR END PROGRESS REPORT

1. Introduction

1.1. The Trust's Annual Plan comprises of seven objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust aims to take and the milestones we plan to achieve, by quarter, to deliver the agreed outcomes for the year.

1.2. In setting the 2021-22 Annual Plan in March 2021, we recognised that there was a much higher level of uncertainty due to the ongoing pandemic. In response to this, the planning process included a mid-year review of the outcomes set.

1.3. At the end of each quarter each objective receives two RAG ratings which indicate:

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

1.4. The report provides an update on the Quarter 4 2021-22 (Q4) milestones for the Trust's annual plan and the overall achievement of objectives in 2021-22 fiscal year.

2. Achievement against Quarter 4 Milestones

2.1. Q4 has been a challenging period for the Trust and the wider health and care system with continued demand and acuity pressures and increased staff absences due to the COVID pandemic. However, all our services continued to remain open to admissions, including the festive period when the acuity of demand and system pressures were at their peak.

2.2. We continued to work closely with our system partners across Hertfordshire, Essex, Buckinghamshire, and Norfolk, and have achieved most of our milestones for the quarter and are on track to meet most of our year end outcomes.

2.3. To support a strong end of year position, a monthly review of progress was also undertaken in Q4 to provide support and to increase pace for completing plans and meeting our objectives.

2.4. At the end of Quarter 4, six out of seven objectives met most key milestones as planned.

2.5. ***Strategic Objective 7 – System working with Partners***, was rated Amber due to slow progress in implementation of the development of the Hertfordshire Mental Health & Learning Disabilities Collaborative. However, significant amount of progress has been made and this is now awaiting the final sign off. Work with regional partners to develop and deliver new models of care for those with specialist mental health and learning disabilities has also been delayed with plans are in place to recover through 2022-23. milestones.

2.6. The table overleaf summarises the Q4 achievement for all strategic objectives (SO) with details of the outcomes and commentary for these in Appendix 1.

Table 2 - Q4 Achievement against Milestones

Ref	Objective	Q4 21-22	
		Milestone Achievement	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	7/9 (78%)	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	9/14 (65%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	12/18 (66 %)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	7/11 (63%)	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	9/15 (60%)	
SO6	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	11/17 (65%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	3/11 (30 %)	

3. 2021-22 Year End Achievement Against Objectives

3.1. Despite a very challenging year, 61% of all year-end outcomes were fully delivered (34/56 outcomes) at the end of the 2021-22 fiscal year with actions to deliver the remining 39% (22 outcomes) that are not on target agreed in Q4.

3.2. Five out of seven objectives were rated Green and the remaining two were rated Amber.

3.3. ***SO1 – Safety*** is rated Amber due to the high number of unexpected deaths and incidents of violence and aggression during the year. These were reviewed individually to ensure lessons to be learned are identified and shared to improve our services and to keep our service users safe. We are also defining and implementing a suicide prevention pathway based on best practice from around the world. We continue to delivery new approaches to improve safety planning, and we are using our simulation suite for training and education for our staff as well as staff working in system partners. This work continues onto 2022-23 plans.

3.4. ***SO3 – Effectiveness*** is rated Amber due to the slower than planned progress made in implementing the personalised care plans, physical health checks, and reduction of re-admissions into inpatient services, from those on the Personality Disorder pathway.

3.5. The table overleaf summarises the year end achievement for all strategic objectives (SO) with details provided in Appendix 2.

Table 3 - 2021-22 Achievement against Objectives

Ref	Objective	21-22 Year End	
		Outcome Achievement	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	3/8 (40%)	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	5/9 (55%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	2/5 (40%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	5/7 (71%)	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	4/5 (80%)	
SO6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	6/9 (67%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	9/13 (69%)	

4. Recommendations

4.1. The Trust Board is asked to receive the report, noting delivery against the 2021-22 Annual Plan.

APPENDIX 1 – ANNUAL PLAN 2021-22 QUARTER 4 COMMENTARY AGAINST MILESTONES AND OUTCOMES

<table>
<tr><th>Strategic Objective 1
(Owner JV)</th><th>Q4 Key Actions / Milestones</th><th>Q4 Milestones Rating</th></tr>
<tr><td rowspan="3">We will provide safe services, so that people feel safe and are protected from avoidable harm

Key Priorities
• We will continue to work with system partners to prevent suicides
• We will keep service users and staff physically and mentally safe, reducing the avoidable harm they experience
• We will ensure the least restrictive practice is appropriately used to support service user recovery
• We will implement and follow best practice infection prevention & control practice across our services</td><td>• The Samaritans project for providing follow up support for service users will be in place (Green)
• Staff training for the Suicide Prevention Framework will be underway using Simulation training (Green)
• A co-produced a training programme on shared decision making with New Leaf will be developed and implemented across services (Green) (Green)
• Health Education England’s Just Culture Mandatory Training rolled out to all staff.
• EAHSN SIP focusing on reducing restrictive practice to continue (Green)
• Ensure rigorous application of existing Infection Prevention & Control policies and behaviours by providing increased support & training to staff (Green)
• Continue to support the matrons and Heads of Nursing with the quarterly reports (Green)
• Shared decisions making training for staff would be rolled out other units across the trust. (Amber)
• Monitor and follow up non-compliance with mandatory IPC training (Amber)</td><td>  </td></tr>
<tr><td colspan="2">Commentary:</td></tr>
<tr><td colspan="2">• Simulation training on suicide risk is being delivered monthly to frontline teams
• Patient Safety Syllabus Module 1 that include Just culture is live on discovery as mandatory for all staff.
• Reducing restrictive practice CQI now underway at Astley court with safety crosses baseline data collected and solutions being discussed. In addition, Forest house has also started to record the safety crosses.
• SASO policy view is underway including a brief overview training module developed and tested.
• All IPC policies have been updated in line with new national guidance and reviewed by CPAC.
• Training compliance is at >90% and is short of the target of 92%. Omicron wave affected the trust in Q4, and outbreaks were supported well. LFT testing is encouraged to identify asymptomatic cases.</td></tr>
<tr><th colspan="2">Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes Projection</th></tr>
<tr><td colspan="2">There have been 16 suspected suicides in Q4. Each is being investigated individually and thematically to understand what we can learn to prevent deaths in the future. We continue to work across the system to prevent suicide with staff training for the Suicide prevention using simulation suites. Other initiatives including ‘Spot the Signs,’ ‘Stay Alive’ and through social media to reach vulnerable individuals. Levels of harm because of violence and aggression in inpatient services are slightly higher however our staff continue to report they feel safe at work.</td><td>• 10% reduction suspected suicides Baseline < 40 for year (62 for the year) (Red)
• Suicides relative to total Contacts with HPFT. Baseline 0.049 % (in Q4) (Red)
• 85% service users report feeling safe across adult & CAMHS inpatients (76 % in Q4) (Amber)
• < service user to staff moderate - severe harm through violence & aggression (<2.3% -Q4:4.96% 13/262) (Amber)
• < service user to service user moderate - severe harm through violence & aggression (<2.3% - Q4 2.15% 13/398) (Green)
• 98% SI action plans - Day 60 post SI (Green)
• 95% SI actions implemented by date set in action Plan (80% for the year) (Amber)
• > % staff reporting feeling safe (82% baseline) (82% in Q4) (Green)</td><td>  </td></tr>
</table>

Strategic Objective 2 (Owner SB)	Q4 Key Actions / Milestones	Q4 milestones Rating
We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience **Key Priorities** • We will improve service user experience of accessing our services and receiving treatment • We will involve our service users and carers in the design and delivery of services and their care • We will provide safe, high-quality environments where our service users are cared for and our staff work	• Reach out to BAME and disadvantaged communities to ensure they have needs led access (Green) • Respond to the changing demand post Covid to ensure timely access to our services (Green) • Implement initiatives to address individual health inequalities in IAPT (Green) • Coproduce and put in place a new trust-wide approach to service user and carer engagement (Green) • Ensure service user & carer feedback informs service improvements and developments (Green) • Increase the number of carers assessments undertaken across the Trust (Green) • NHSE to provide peer review training (Green) • Oak ward & Forest House development (Green) • Albany Lodge refurbishments target completion April 2022 (Green) • Evaluate the impact of initiatives to address health inequalities in IAPT (Amber) • Implement our approach to recovery and personalisation through our 'connected lives' programme supporting service users to live as independently as possible (Amber) • Further embed Shared Decision making to support the way we involve our service users (Amber) • Implement the Care and Support Plan (Amber) • Lexden refurbishment started (Red)	
	Commentary:	
	• ASD working group established and guidance for staff developed for working with neurodiversity. 2 senior clinicians now in post to lead on EDI in IAPT services which includes Staff listening • Community psychology LD team in Buckinghamshire have reviewed their core assessment to release clinical time • Phase 2 planning to include Connected Lives Carers Assessment, Star Worker Reviews, further alignment with Transformation Programme slightly delayed to Q1 22-23. Care and support plan roll out plan for May 2022. • Service users and carers are involved in CQI projects e.g., Transition Pathway in Essex, NDD pathway, Mid Essex digital project promotional video, webinars etc.	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
Building refurbishments for Forest house, Oak, Albany Lodge are progressing and the business case for Lexden is being reviewed to ensure best value for the investment. Co-production plan is agreed with delivery plan established and Having Your Say survey result show improved engagement activity in Q4. IAPT volumes are behind commissioned targets. The number of social care placements have not reduced in Q4; however, our Connected Lives programme is reporting good progress and confidence it will continue to make progress in 2022/2 commitments.	• HYS survey results for Service users 88% baseline (Q4=95%) (Green) • Forest House development (Green) • Oak & Albany Lodge upgrade progressed (Green) • E&N Herts bed provision outline business case approved (Green) • Lexden refurbishment progressing (Amber) • Carer's awareness training carried out (Green) • IAPT access KPI (91% 31037 Target 33982) (Amber) • Reduction in the number of social care placements made (Amber) • Reduction Out of area placements (2586 in Q4) (Amber)	

Strategic Objective 3 (Owner AZ)	Q4 Key Actions / Milestones	Q4 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 care, support and outcomes for service users who need additional support or at risk of admission • We will support our service users to be physically healthy by improving the physical health support, intervention and care available • We will support our service users to live their lives as independently as possible	• Audit Frequent Attender care plan audit evaluated, and action plan defined (Green) • Agree roll out of Community rehab offer to avoid re- admission (Green) • Action plans to mitigate gaps from National audits to evaluate evidence-based care (Lithium, Epilepsy etc) (Green) • Trust staff working as study leads (principal investigators) in high quality research studies (Green) • Review existing integration and joint working with IAPT/Long Covid clinics to ensure future sustainability (Green) • Development of Inpatient Bed Consolidation Outline Business Case and plan in within timescales (Green) • Physical health facilitation with ongoing work of physical health checks: evaluate impact in Essex (Green) • Embed Integrated Physical Health model pilot in North Herts Community Team (Green) • Frailty and health co-ordination: evaluation of physical health pathway in 2 Essex CCG areas (Green) • Deliver consistent high standards of physical healthcare through support/training front line clinical staff (Green) • Evaluate Simulation scenario experience and BlueBox roll out (Green) • Implement a new integrated CYP crisis service, mobilise new service, evaluate outcome, partnership work (Amber) • Outpatient model evaluated and full roll out completed (Amber) • Evaluate and full roll out of evidence-based care (Depression, Assessment treatment, Challenging behaviour, and Personality disorder) (Amber) • Develop pathways to prevent avoidable acute trust attendances / admissions (Amber) • Rollout of a tool to PH level to share with SU/Carers to support their improvement in their Physical health (Amber) • No Smoking Day promotion event, service user's stories and evaluate e-cigarette usage to quit rates (Amber) • Evaluate personalised wellbeing care plan (Amber)	
	Commentary:	
	• Recruitment campaign for new CYP Crisis team is underway with recruitment challenges alongside demand pressures. • Outpatient model commenced with review of caseload by clinicians is underway. Inpatient ATU SOP in place in Essex. • Lexden project group being agreed and will act from April 2022 with design completed in 2022 • IAPT represented at CMH transformation group with rolling programme of stakeholder communications • Annual health checks, Frailty tool, Dynamic Health register with Health co-ordination rolled out in Essex localities with partners. • 29 NIHR research studies supported with 19 investigators, 25 Service users recruited and 50 peer reviewed publication in 21/22	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
Progress for physical health has been accelerated throughout Q4 with checks completed for all service users on the SMI register and blue box roll out. Pathway implementation work has been ongoing in Q4. 382 staff used the simulation suites in Q4. However, progress around social care and wellbeing plans are behind target with wider roll plan for Q1 22-23	• Training programme in place for Inpatient and for Community Services • Demonstrate improved outcomes on new pathways for service users (Green) • Social care and wellbeing plans in place and outcomes recorded (target is 81% Q4 75%) (Amber) • 95% CPA physical health checks (Q4 – 69%) (Amber) • Reduction in readmission for service users with PD (Base11% Q3 12%) (Amber)	

Strategic Objective 4 (Owner JL)	Q4 Key Actions / Milestones	Q4 Milestones Rating
We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment **Key Priorities** • We will improve the employment experience of our people, including support to improve their health & wellbeing and to help them to rest and recover post Covid 19 • We will ensure all our people feel valued, included and able to fulfil their potential through the development of our just & inclusive culture • We will develop our collective leadership culture to support all of our staff to feel empowered and engaged	• Further developing and implementing our Programme of wellbeing support in line with people's emerging needs (Green) • Commence engagement on our annual staff survey results to develop our 2022 action plan (Green) • Launch our Q4 pulse survey with high engagement in our Q4 pulse survey (Green) • Monitoring of feedback from staff who leave and their reasons for leaving, ensuring plans to act on their feedback to continually improve experience (Green) • Plan and commence engagement on our annual staff survey results to develop our 2022 action plan (Green) • Launch high engagement in our Q4 pulse survey (Green) • Providing OD support to embed more integrated working (Green) • Roll out an electronic CPD/non-mandatory training request and authorisation system to better monitor uptake of CPD across all protected characteristics (Amber) • Develop a longer-term benefits and reward strategy (Amber) • Launch of new appraisal window (Amber) • Commence implementation of new staff benefits provision (Amber)	
	Commentary:	
	• Winter Wellbeing Festival attended by 1700 staff across all sites with 500 staff accessing wellbeing offers in 2 months • Q4 pulse survey up by 4% to 18.5% responses. Positive responses and higher than national average. • Deep dives from feedback from staff who leave is reported and monitored at Recruitment and Retention group • CPD request system designed by ICS and roll out for 23-23. • New car and e-bike scheme launched • OD support is accesses by number of teams and Q4 to note support given to Forest House and Warren court	

Summary:	Key Outcomes at Year End	Year End Outcomes
Staff support through Wellbeing services has been further strengthened in Q4 with the 'Here for You' service and Winter wellbeing programme. Wellbeing Champions roles now in place. Vacancy rates target was not met for Q3. Staff retention & vacancy rates have made slow progress in Q4 against pre-COVID baselines; however, we have not achieved all our workforce targets for Q4. Work is underway to improve this in Q1 22-23	• Health and Wellbeing score >6.6 (Green) • < Reduction in staff reporting bullying/harassment by manager (Green) • Develop our Just and Inclusive Culture across the Trust (Green) • Significant improvement in the experience of our BAME staff and staff with a disability (Green) • Big & Little Listen events (Green) • <10.5 % vacancy rate by year end (Q4 – 14.14%) (Red) • < 9% unplanned turnover rate by year end (Q4: 12.82%) (Red)	

Strategic Objective 5 (Owner HA)	Q4 Key Actions / Milestones	Q4 Milestones Rating
We will improve, innovate and transform our services to provide the most effective, productive and high-quality care **Key Priorities** • We will support, enable & encourage our people to continuously improve the care and services we provide • We will continue to introduce new digital capabilities that will enable teams to innovate and improve service user, carer & staff experience as well as the safety and effectiveness of our services • We will continue to release time to care by supporting staff to work more effectively and flexibly, including providing better and simpler access to information	• Progress of Life QI usage with improvement in our 6 focus areas demonstrated on Life QI (Green) • 2IHI or equivalent training programme (Green) • HWE GP records available in Paris (Green) • Single Sign On is available for all staff for key systems (Green) • Digital Forms: Enabling certain assessments such as PROMs to be carried out online (Green) • Service User Portal and Hybrid Mail (Green) • Single Sign On live (Green) • Single Person View: Which will allow access to GP records for a significant proportion of the population from within Paris (Green) • Virtual Contacts: Replacing the Attend Anywhere national with MS Teams (Green) • 45 staff trained in CQI (Amber) • CQI Leaders programme for 10 Expert by Experience (Amber) • West Innovation hub established (Amber) • First wards live on the ePMA (Amber) • Single Person View and mobile interface for Paris goes live in pilot services (Amber) • Agreed HPFT SU records are available in the ICS shared care record (Amber)	
	Commentary: • 105 of 180 target staff trained in CQI by end of Q4 . All CQI Training paused in Q4 due to Omicron pressures • 170+staff signed on Life QI and 130+ projects on Life QI covering 6 focus area. • CQI coaching and mentoring with support to key projects in the trusts continued (28 days, 48 hours) • 2700 users on single sign. Digital outcome measures live in 3 services with additional 6 planned in Q1 of 22-23 • SMS text messaging message reminders are in place for Community Perinatal, Adult & older peoples community services with 9688 SMS sent	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
We continue to see an acceleration of innovation and improvement across the trust in 2021/22. CQI methodology and coproduction of improvement is progressing well. There is greater level of digital interaction with service users, our internal and external collaboration capability, automation, & improvements to data & information systems. We on target automate clinical outcomes and key BI dashboards in SPIKE.	• Digital Strategy finalised – focus for the next 5 years (Green) • Streamline & develop Electronic Patient Record system to support delivery of care and system interoperability (Green) • 180 staff trained in CQI (Amber) • 20 EBE trained in CQI (Green) • West and E&N CQI hubs established (Green)	

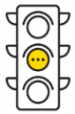
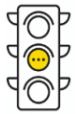
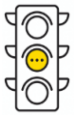
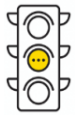
Strategic Objective 6 (Owner PW/SB)	Q4 Key Actions / Milestones	Q4 Milestones Rating
We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners **Key Priorities** • We will Improve community adult and older peoples' services and care aligned with Primary Care Networks • We will improve access and delivery of care for those people with a learning disability across the Trust • We will improve the range and access to crisis services in conjunction with Hertfordshire partners • We will work with partners across Hertfordshire to deliver earlier intervention and support for Children and Young People	• Continue to pilot and evaluate, taking a CQI approach, a new community model for adult & older people (in Watford & Lower Lea Valley) to inform the future community model (Green) • Continue to develop our Primary Mental Health model with PCNs (Green) • Continue transformation of Essex LD Services including the potential bed reconfiguration (Green) • Undertake survey to ascertain workforce view of ELDP, awareness of service priorities (Green) • Develop an integrated health and social care plan for ELDP with system partners (Green) • DSR - The risk stratification process is reviewed to ensure it is effectively identifying and contributing to the management of physical health risks (Green) • Frailty - Comparison of frailty offer in north and south Essex with outcome measures (Green) • AHC - Working with PCN's, Practices with high Qoph registers (Green) • Develop a new approach to LD Services in Norfolk in conjunction with partners (Green) • Broaden the range of crisis interventions available and evaluate their impact (Green) • Evaluation of the remodelled crisis services against the CORE Fidelity Standards (Green) • Start process of AIMS accreditation for Home Treatment Services (Amber) • Ensure Mental Health Support Teams in schools are fully operational (Amber) • Enhanced Support Service – Commence deep dive review and audit into provision (Amber) • Work with partners to review & improve Assessment & Treatment pathways across all LD (Amber) • Specialist Residential Services consultation- co-produce future care Develop an integrated crisis model in conjunction with system partners (Amber)	
	Commentary:	
	• PMH model is expanded to include ARRs implementation with developing governance and service specification • Significant stakeholder engagement has taken place to continue with Essex transformation. ELDP involved in Meaningful Lives Matter part of wider Essex enabling programme of activities. Enhanced Support TC joint meeting chaired by HPFT with commissioners, LA and service colleagues represented. • Continued involvement with system partners and commissioners to redesign CYPMH	

Summary:	Key Outcomes at Year End	Year End Outcomes
Good progress made in Q4, to ensure joined up care is taking place in all our services. Coproduction work in progressing. We have seen modest reductions in the number of inpatient admissions and length of stay in Q4 and we have good plans in place to improve out of area placements and delayed transfers of care for 22-23	• Essex Local integrated teams established, and access improved by 'Way in' service (Green) • >Improved service user and carer experience (87% average) (Green) • <inpatient admissions – baseline 365 (307 in Q4) (Green) • <LOS (Amber) • <crisis presentations (967 in Q 4) (Green) • 95% CAMHS access <28 day (78% in Q4) (Amber) • CAMHS Crisis Business case approved (Green) • Adult < reduced time to treatment and ongoing care (Green) • < out of area placements (2355 in Q3) (Amber)	

Strategic Objective 7 (Owner PW)	Q4 Key Actions / Milestones	Q4 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) **Key Priorities** • We will lead the development of the Hertfordshire Mental Health & Learning Disabilities Integrated Care Partnership (MH & LD ICP) • We will advocate for and ensure mental health & learning disability services are developed across populations we serve • We will work with regional partners to develop and deliver New Models of Care for those with specialist mental health and learning disabilities	• MHD 5yr Strategy Implementation (Green) • Review Transformation programme in view of Strategy (Green) • Continue Delivery on transformation milestones (Green) • Partnership Governance Arrangements in Place (Amber) • Partnership Agreement in place (Amber) • Delegated Budgets in place (Amber) • Financial framework in place (Amber) • Operating model in place (Amber) • Eoin Regional Patient Flow system future business case (Amber) • Review of accelerated transformation plans and benefits and ROI (Amber) • 2022-23 transformation plans reflected in provider contracts (Amber)	
	Commentary: • MH 5-year strategy out for consultation and transformation priorities agreed for 2022-23. • A memorandum of understanding has been developed and agreed by collaborative partners. • Operative model has been developed and awaiting formal sign off. • Patient Flow & Bed Management Team established and providing a service to all partners in the collaborative. Data is collected daily and weekly • Weekly regional clinical panel to review complex cases, Prioritisation tool and SOP in place • CAMHS Transformation schemes moving forward with the development of ED HTT in ELFT and CNWL, HTT in CPFT and NFST. All teams working to establish Red to Green across all in-patient services	

Summary:	Key Outcomes at Year End	Year End Outcomes
The MHLD Collaborative continues to develop and lead transformation across Herts. During the year partners have been working together to review the underpinning governance in line with the ICS development. The EOE Collaborative continues to focus on improving care and beginning to mobilise the new clinical pathways. CAMHS bed management has progressed well during Q4. Reducing the number of inpatient stays for eating disorders remain challenging.	• Transformation programme in place with partners engaged (Amber) • HWE ICS continues to prioritise & invest MH & LD (Amber) • HWE ICS population health model continues to develop (Amber) • Mental Health Investment Standard is met within 2020/21 (Amber) • MH & LD is overtly prioritised within the ICS strategy and delivery (Amber) • Place based ICPs focusing on, and including MH & LD in future delivery model (Amber) • East of England (EOE) Provider Collaborative established (Amber) • LTP/operating commitments delivered for 2020/21 (Amber) • Out of area placements for service users requiring specialist beds (Amber) • Delivery of new crisis pathway & CAMHS pathways with partners (Amber) • Delivery new Community model including PCNs (Amber) • Plans for development of services across EOE under development (Amber) • Number of inpatient stays for an eating disorder (Amber)	

APPENDIX 2 – ANNUAL PLAN 2021-22 END OF YEAR OUTCOMES

	Objective	Predicted			EOY	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					There have been 62 suspected suicides in 2021-22 and 16 in Q4. Each is being investigated individually and thematically to identify and share any learning to reduce the risk for our service users. We continue to work across the system to prevent suicide with initiatives including 'Spot the Signs,' 'Stay Alive' and through social media to reach vulnerable individuals. Levels of harm because of violence and aggression in inpatient services are slightly higher, however, our staff continue to report they feel safe at work and continue to access training in our simulation suites and Patient safety modules.
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience					Building refurbishments for Forest house, Oak, Albany Lodge are progressing and the business case for Lexden is being reviewed to ensure best value for the investment. Co-production plan is agreed with delivery plan established and Having Your Say survey results show improved engagement activity in Q3. IAPT volumes are behind commissioned targets. The number of social care placements have not reduced in Q4. However, our Connected Lives programme is reporting good progress and confidence it will continue to make progress in 2022/23 commitments.
3	We will improve the health of service users through the delivery of effective evidence-based practice					Progress for physical health has been accelerated throughout Q4 with checks completed for all service users on the SMI register, and further innovation through the BlueBox project roll out. Training in the simulation suites (382 staff) is progressing well. Research strategy launched and progressing well. However, progress around greater psychological awareness in services, and social care and wellbeing plans are improving but behind target. With wider roll plan for Q1 222-23
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment					Staff support through Wellbeing services has been further strengthened in Q4 with the 'Here for You' service and Winter wellbeing programme. Wellbeing Champions roles now in place. Revised Vacancy rates target was not met for Q4. Staff retention & vacancy rates have made slow progress in Q4 against pre-COVID baselines. Work is underway to improve this in Q1 22-23. Pulse Survey was up by 4% to 18.5%.
5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care					We continue to see an acceleration of innovation and improvement across the trust in 2021/22. CQI methodology and coproduction of improvement is progressing well. There is greater level of digital interaction with service users, our internal and external collaboration capability, automation, & improvements to data & information systems. We on target automate clinical outcomes and key BI dashboards in SPIKE.
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 partners					Good progress made in Q4, with the foundations in place for a strong end to the year. Coproduction work in progressing. We have seen modest reductions in the number of inpatient admissions and length of stay in Q4 and we have good plans in place to improve out of area placements and delayed transfers of care which will need to be implemented to meet targets in 2022-23. Work with partners to review our Assessment and treatment pathways is underway and making good progress.
7	We will shape and influence the future development & delivery of health and social care to achieve better outcomes for our population(s)					The MHLD Collaborative continues to develop and lead transformation across Herts. During the year partners have been working together to review the underpinning governance in line with the ICS development. The EoE Collaborative continues to focus on improving care and beginning to mobilise the new clinical pathways. CAMHS bed management has progressed well during Q4 however reducing the number of inpatient stays for eating disorders remain a challenge.

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 14
Subject:	Financial Position – Month 1	**For Publication:** Yes
Author:	David Flint, Head of Financial Performance & Reporting	**Approved by:** Maria Wheeler, Executive Director of Finance
Presented by:	Maria Wheeler, Executive Director of Finance	

Purpose of the report:

This paper presents the financial position for Month 1 2022/23.

Action required:

To note the financial position for Month 1.

Summary and recommendations

Financial Position

The Trust reports a deficit position for Month 1 in line with its financial plan, as summarised in the table below. At this early stage in the year there is no information to suggest any significant variance from plan.

	Month 1			Full Year		
Financial Position to 31 April 2022 £000	Plan	Forecast	Variance	Plan	Outturn	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income incl. COVID-19	24,683	24,683	0	302,199	302,199	0
Income - Provider Collaborative	3,591	3,591	0	42,038	42,038	0
Pay	17,063	17,063	0	208,820	208,820	0
Secondary Commissioning	3,787	3,787	0	43,287	43,287	0
Provider Collaborative	3,591	3,591	0	42,038	42,038	0
Non Pay	2,059	2,059	0	24,111	24,111	0
Overheads	2,954	2,954	0	35,499	35,499	0
Surplus / (Deficit)	**(1,179)**	**(1,179)**	**(0)**	**(9,517)**	**(9,517)**	**(0)**

The full year outturn reflects a planned deficit of £9.5m based on current income assumptions. Discussions continue with commissioners with a view to closing the financial gap and aligning the contractual obligations and the funding available.

The financial plan deficit reflects the expected phasing of both income and expenditure, but also of transformation and delivery of the DV programme. Accordingly, a higher deficit is planned in the early months of the year, with a lower deficit expected in the final months of the year. Thus, a planned deficit of £1.2m is shown for month 1 2022/23.

Pay costs and secondary commissioning spend is in line with plan at £17m and £3.7m respectively.

Month 1 pay costs are broadly in line with month 11 2021/22 and show a favourable variance on substantive pay of £120k which is off-set by an overspend of £135k on bank and agency costs combined.

Income received from Commissioners during April reflects the latest contract offers at c£24m per month. The balance of income, c£700k relates to deferred income released into the position to match expenditure incurred on ongoing transformation projects.

Work continues to develop project governance and to complete QIAs and EIAs for all identified Delivering Value schemes. Except for DV schemes that span both 2021/22 and 2022/23, the financial plan reflects only minimal impact from the DV programme in month 1.

Financial risks

The financial plan includes a number of key risks including the following:

- secondary commissioning (Out of area placements) if volumes continue to increase
- demand for community/crisis teams exceeds plan
- increased acuity/complexity and SU observations
- reduction in expected income
- inflationary pressures which exceed national funding
- challenges in recruitment and retention.

Mitigating actions

In order to mitigate the above risk, it is important that the Trust:

- delivers its planned DV programme
- adhered to robust financial control
- minimises the use and cost of agency staffing
- seeks to maximise additional income in-year
- ensures that all transformational activities are aligned to deliver additional value.

Forward Look

The Trust enters 2022/23 with a continuing financial pressure in the form of secondary commissioning and OOA placements. Delivering on the Trust's plan to manage and to reduce this pressure will be key to financial performance in 2022/23.

2022/23 will represent a significantly more challenging financial environment than has been experienced in recent years and there will be a significant focus on Delivering Value to mitigate the risk of further increases in demand and acuity.

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

Delivery of Financial Plan

Summary of Financial, IT, Staffing & Legal Implications:

Delivery in excess of Financial Control Total

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

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

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

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 15
Subject:	Speak Up Concerns Annual Report (2021/22)	**For Publication:** Yes
Author:	Yusuf Aumeerally, Freedom to Speak Up Guardian (FtSUG)	**Approved by:** Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)	

Purpose of the report:

To present the report to the Board of Directors.

Action required:

To receive the report.

Summary and Recommendations to the Committee:

Summary

There have been 61 speak up concerns raised this financial year, seven of which were raised anonymously.

27 FtSU cases are still being followed up, two of which are from the year (2020/21). The FtSUG envisages these cases concluding within quarter 1 (2022/23).

3. Priorities for the Freedom to Speak Up Guardian (FtSUG) for quarter 1 (2022/23):

The priorities are:

- To further promote the Trust's FtSUG role Trust wide. This will include, but not limited to, increased communication with staff, increased visibility from the FtSUG, increased visibility and communication with the Champions and their roles
- To further promote the speak up culture across the services. This will include, but not limited to, information sharing regarding the FtSUG and FtSU Champions, the process about when and how individuals can speak up and the importance of doing so; regular briefs in the HPFT News, increased visibility of the FtSUG, further recruitment to FtSU champions
- Regular and formal training provided to the FtSU Champions which is competency based as well as scenario and discussion focused
- Recruit to FtSU Champions in all service areas and teams
- To prioritise service areas and teams where the speak up culture can be strengthened
- To improve the robustness and clarity of the internal FtSU processes
- To actively participate in the regional FtSU network meetings.

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

None

Summary of Financial, IT, Staffing & Legal Implications:

A full time Freedom to Speak Up Guardian (FtSUG) has been appointed, and this has a financial and staffing implication. The Freedom to Speak Up (FtSU) champion role will have an impact on staffing. This role will be in addition to the existing role of the member of staff. Protected time for the staff member to undertake this role effectively is being considered by the Trust.

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

Earlier last year, the Trust participated in research commissioned by the National Guardian's Office (NGO). The research looked at people's experiences of accessing their Freedom to Speak Up Guardian and whether ethnicity has an impact.

The research was published by the NGO, and this found that Black and minority ethnic respondents were six times more likely than White respondents to say that they were more likely to raise a concern with a Guardian of the same ethnicity as themselves.

The current FtSUG is of black Asian minority ethnic (BAME) background, and we hope as a Trust to attract a diverse group of FtSU champions. This will hopefully enable staff to feel able and safe to speak up to a diverse range of individuals in the absence of being able to do so to their manager/supervisor.

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

CQC Well Led W3: Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.

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

IGC 12 May 2022

Freedom to Speak Up Guardian
Executive Summary

Following a competitive recruitment process, Yusuf Aumeerally has been appointed to the substantive and full-time post of Freedom to Speak Up Guardian (FtSUG).

There were 61 Freedom to Speak Up (FtSU) concerns raised this financial year (2021/22). There were 38 in the year prior (2020/21) and 35 in the year prior to that (2019/20).

Of the 61 FtSU concerns raised this year, 22 were raised in relation to the services provided by the West Strategic Business Unit (SBU), 13 for the East and North SBU, 24 for the Learning Disability and Forensic SBU and 2 for corporate services.

A higher number of FtSU concerns raised in a specific SBU should not be seen as a negative and acknowledged as an area, where strengthening of a speak up culture could be focused.

27 speak up concerns are still ongoing, two of which are from the year (2020/21). The FtSUG envisages these cases concluding within quarter 1 (2022/23).

Given the increase in the FtSU work, and the need to gain assurance that concerns are followed up appropriately, a review of the FtSU resource has taken place and a full-time FtSUG has been recruited.

Speak Up Concerns Annual Report (2021/22)

1. Introduction

1.1 This report focuses on concerns managed through the Freedom to Speak Up (FtSU) process received in the financial year (2021/22).

2. Freedom to Speak Up Governance Processes

2.1 The FtSU process ensures the confidentiality of those raising a concern, if this is their preferred method (there are times when confidentiality must be overridden). However, where possible, staff are encouraged to share their details, so that concerns can be robustly investigated. There is a high level of confidentiality, with a restricted number of people able to see details of the member of staff raising the concern, and also about the concern itself.

2.2 The FtSU Strategy Group aims to meet on a three weekly basis and the Freedom to Speak Up Guardian (FtSUG) reports to the Integrated Governance Committee (IGC). The Trust has an identified Non-Executive Board member for FtSU.

2.3 The Trust submits FtSU data to the National Guardian's Office (NGO) quarterly.

3. Speak Up Concerns and Learning for the Year (2021/22)

3.1 61 FtSU concerns were received within the above timeframe. Issue 158 of the NGO, '*The Year of the Pandemic: A summary of Speaking up to Freedom to Speak Up Guardians'* (1 April 2020 to 31 March 2021) highlights that speak up cases have risen gradually from 2017 until 2020/21.

3.2 Of the FtSU concerns raised in year 2021/22, seven were anonymous. Of these, three were raised in relation to the services provided by the West Strategic Business Unit (SBU), one for the East and North SBU and three for the Learning Disability and Forensic SBU. The NGO explains that 'workers speaking up anonymously may be an indicator that speaking up arrangements or culture need improvement. For instance, workers may choose to speak up anonymously because they are concerned about detriment for speaking up'.

3.3 The FtSUG plans to work with the services to promote a speak up culture and introduce FtSU Champions. The role of FtSU Champion has been advertised in Hertfordshire Partnership NHS University Foundation Trust (the Trust) Bulletin. There are currently 40 members of staff interested in undertaking the role from different services/teams and hold different roles within the Trust. All have been provided details of the Health Education England (HEE) FtSU training for completion. The FtSUG has provided development sessions to explain more about the role and, to date, 19 members of staff have attended the sessions.

3.4 Figure 1 highlights which SBU the FtSU concerns have been raised. An increase of FtSU concerns raised in a specific SBU should not be seen as a negative and acknowledged as an area, where strengthening of a speak up culture could be focused.

	Q1 2021-2022	Q2 2021-2022	Q3 2021-2022	Q4 2021-2022	Total
West	7	5	4	6	22
E&N	2	2	7	2	13
Essex & IAPT	0	0	0	0	0
LD&F	3	4	13	4	24
Corporate	0	1	1	0	2
Total	12	12	25	12	61

Figure 1

3.5 The data is currently not broken down into service areas. This would require further work and to agree as a Trust on the reporting in this way, considering the sensitivities of speaking up and the potential impact this could have to individuals and further embedding the speak up culture.

3.6 There is an increase in FtSU concerns within the Learning Disability and Forensic and the East and North SBUs. Following concerns raised directly to the Care Quality Commission (CQC), the FtSUG increased presence at Warren Court and Forest House Adolescent Unit (FHAU), to ensure that staff were able to speak up about their concerns and ensure that their voices were heard. The FtSUG was able to speak to numerous staff when visiting Warren Court and FHAU, and staff were happy to share concerns they had.

3.7 There are two speak up concerns yet to be closed from the year 2020/21. One of the concerns is in relation to the West SBU, and the other in corporate services. Investigations for both concerns have been completed and the FtSUG is awaiting feedback to be provided to the staff who participated in the investigations before closing the cases.

4. Themes

4.1 All concerns are recorded on Datix and categorised by theme, although the categories do not always reflect the nuance of the speak up concern. This can also be said of the categories used when the Trust submits information to the NGO. Further work is required in order for data to be captured fully and accurately.

4.2 There are three main categories:

- an element of service user safety/quality
- an element of bullying or harassment
- an element of worker safety (this category has recently been added to the NGO portal data).

4.3 It is worth also noting that some of the FtSU concerns have more than one of the above elements included. The FtSUG recognises that, given the kind of speak up concerns being raised, even if it is specifically in relation to employee relations matter, these can potentially have an element of service user safety/quality.

4.4 Figure 2 highlights the amount of FtSU concerns received per quarter, and also the categories in which the speak up concerns relate to. It is noteworthy that feedback is being provided and in quarter 2, the seven staff who did provide feedback stated that they would speak up again. Of the three responses in quarter 4, the staff also said that they would speak up again. This is a compliment to the speak up process, which is reassuring that staff will use this process if other ways in which to raise concerns are not achievable.

4.5 The issue of detriment is one that should be taken seriously by the Trust. No member of staff should experience disadvantageous and/or demeaning treatment, as a result of speaking up. The culture of speaking up needs further strengthening within the Trust and the risk of experiencing detriment can influence the decision making of a member of staff not to speak up.

	Q1	**Q2**	**Q3**	**Q4**
Total number of cases in Quarter	12	12	25	12
Number of cases raised anonymously	4	1	0	1
Number of cases with an element of patient safety/quality	0	1	8	9
Number of cases with an element of bullying/harassment	4	7	11	7
Number of cases where people indicate that they are suffering detriment as a result of speaking up	0	2	8	0
Response to the feedback question, 'Given your experience, would you speak up again?'	5 cases are ongoing	0 cases are ongoing	11 cases are ongoing	7 cases are ongoing
Total Number of responses	0	7	0	3
The number of these that responded 'Yes'	0	7	0	3
The number of these that responded 'No'	0	0	0	0
0The number of these that responded 'Maybe'	0	0	0	0
The number of these that responded 'I don't know'	0	0	0	0

Figure 2

5 Method of Raising a Concern

5.1 The Trust has a number of mechanisms by which concerns can be raised, with the majority of FtSU concerns raised directly to the FtSUG via email. Posters and information about how to speak up have been sent out to all staff. These posters should be placed in staff areas within the practice areas.

5.2 Recent communications requesting expressions of interest have also been distributed to all staff inviting them to take on the FtSU Champion role. The FtSU Champions will also have a role in receiving concerns in the near future.

5.3 40 staff have agreed to undertake the FtSU Champion role. These staff are from different services across the Trust. Three induction sessions have been held for the Champions with the FtSUG and the Executive Director, Quality and Safety (Chief Nurse). Two development sessions have also been held with the FtSUG and attended by 19 members of staff. Future sessions will also be held with a view to formally launching the FtSU Champions role once the FtSUG is fully in post.

5.4 The request for expressions of interest will remain open ended and final arrangements are being made regarding the detail and role of the FtSU Champions.

5.5 Funding to recruit to a full time substantive FtSUG has been secured and Yusuf Aumeerally has been appointed at the FtSUG.

6 Speak Up Case Conclusions

6.1 Of the 61 concerns raised this year, 25 are yet to be concluded. There are also two speak up concerns yet to be concluded from the year 2020/21. The It is important that speak up concerns are being managed appropriately and this means that more time may be required for them to be concluded. Of the 27 open speak up concerns open, the FtSUG envisages these cases concluding within quarter 1 (2022/23). The FtSUG has completed reports which highlights all the concerns raised by staff at Warren Court and Forrest House. These have been shared with the Executive Director, Quality and Safety (Chief Nurse) and will be shared with the SBUs' senior management team.

7 Priorities

7.1 The priorities for this next year are:

- To further promote the Trust's FtSUG role Trust wide. This will include, but not limited to, increased communication with staff, increased visibility from the FtSUG, increased visibility and communication with the Champions and their roles
- To further promote the speak up culture across the services. This will include, but not limited to, information sharing regarding the FtSUG and FtSU Champions, the process about when and how individuals can speak up and the importance of doing so; regular briefs in the HPFT news, increased visibility of the FtSUG, further recruitment to FtSU champions
- Regular and formal training provided to the FtSU Champions which is competency based as well as scenario and discussion focused
- Recruit to FtSU Champions in all service areas and teams
- To prioritise service areas and teams where the speak up culture can be strengthened
- To improve the robustness and clarity of the internal FtSU processes
- To actively participate in the regional FtSU network meetings.

8 Conclusion

8.1 There were 61 speak up concerns this year, seven were raised anonymously. 27 FtSU cases are still being followed up two of which are from the year 2020/21.

8.2 In consideration of the increase in the FtSU work, and to ensure that assurance regarding concerns is followed up appropriately, a review of the FtSU resource has taken place. As an outcome, expressions of interests for FtSU Champions have been received and a full-time FtSUG has been appointed. This will enable the FtSUG to fulfil the role fully, increase presence and visits to and within service areas and teams within the Trust, speak to staff and complete greater analysis of the information received.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	26 May 2022	**Agenda Item:** 16
Subject:	Well Led Review Action Plan	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To update the Board with regard to progress with the Well Led Review Action Plan.

Action required:

To receive the action plan update.

Summary and recommendations to the Executive:

Summary

In April 2021 the Trust Board received the report that provided high-level findings from the external review. The report detailed that Deloitte concur with the outstanding rating given by CQC for the well-led domain. The areas of improvement identified were in the context of an already highly effective Board.

Attached is a table of the recommendations from the report, which has been updated with the progress to date.

All actions with the exception of one have been completed. The one remaining action, recommendation seven, relates to the Board Assurance Framework and is due to be completed at the end of quarter one in line with revised timescale as agreed by Internal Audit and Audit Committee.

It is recognised that the Trust needs to ensure it continues to meet the requirements of the Well Led Framework and that a number of recommendations although completed are still valid as areas the Trust should keep under review. With this in mind the Executive Team will formally review all the recommendations on a six monthly basis.

Recommendation

To receive the progress against the recommendations in the action plan update.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Financial, IT, Staffing and Legal Implications:

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

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

Governors have a key role in the Well Led Key Line of Enquiry No. 7: "Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?" The independent reviews usually include interviews and focus groups with Governors and other key stakeholders.

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

The independent review provides assurance for the CQC Well Led standard.

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

Well-Led Review: Summary of Recommendations – Action Plan – May 2022 Update

Theme	#	Recommendation	Further Actions	May 2022 update
One Board Effectiveness	1.	The Trust should formally define the rights (including voting rights) and liabilities of Associate NEDs and outline their role in relation to Board and Committee meetings.	Annual review of constitution and Scheme of Delegation: consider formal definition of the role. **July 2021** H of CA and Comp Sec	Implemented clear induction for new Associate NED to provide clarity of their role. Supported by regular ones to one and feedback. Review of Constitution did not identify need to formalise the role. ***Completed***
	2.	NED meetings with the Chair should be retained, and consideration should be given as to how these could be expanded to support and enhance the understanding of key matters in advance of significant items for debate at Board or Committee meetings.	Ensure briefing and workshop time is well planned. **May 2021** CEO and HoCA	Established monthly NED briefing/workshops to support and enhance understanding of matters in advance of Committee and Board discussions are in place. ***Completed***
	3.	The Board should revisit its forward plan for 2021 to ensure that there is protected time for strategic debate. We would advocate the use of away day time to refresh key strategic principles, with other ongoing strategic issues typically scheduled towards the start of Board and Committee meetings.	Ensure away day time is well planned. **May 2021** CEO and HoCA	Board Away days are scheduled for June and October 2021. The time will be used to consider strategic priority areas. Programme of Board development being finalised for 2022/23 ***Completed***
	4.	Recognising the limitations of the ongoing pandemic, there remains scope to improve the levels of engagement with the Board, and in particular the NEDs. This should include increased opportunities for NEDs to engage within the Trust, as well as for staff to attend and present on specific papers at Board and Committee level.	Continue to facilitate staff visits and NED engagement with services **June 2021** HoCA	Chair and NED visits have restarted in line within IPC guidance. ***Completed***

Theme	#	Recommendation	Further Actions	May 2022 Update
Governance	5.	The impact of PODG should be kept under regular review, with a formal review undertaken in six months in order determine the impact this has made on the operation of IGC and the depth of coverage of workforce matters.	Review of PODG will be ongoing and a formal view considered by the Board during 2021. **Nov 2021** Director of People and OD Chair of IGC	Re framing of IGC agenda and change of Chair has enabled stronger focus on people items. Reporting of PODG into Executive and Board. ***Completed***
	6.	The Board should build upon the work commenced at the last Board meeting to align reporting from Committees with the relevant Board paper in order to minimise unnecessary duplication and to focus the Board's attention on key risks and areas requiring further mitigation.	Trust has implemented a streamlined approach to Committee and Board meetings. **Sept 2021** HoCA	Continue with streamlined approach to meetings. Ensure Committee and Board planners focus on relevant areas of assurance and strategy. ***Completed***
	7.	Whilst a number of improvements to the BAF have been made, there remains scope to refine the content further and to more effectively use the BAF as a tool in order to shape meeting agendas and the focus of debate. The content of the BAF should also be updated to provide consistent and accurate detail on assurance levels and expand the information within it on action to be taken and expected outcomes. Consideration should also be given to the extent to which the document enables the Board to identify progress made in relation to the management of principle risks.	Review BAF. Consider amendments that mean BAF provides structure to the work of Board and Committees. Consider clearer definition of Trust risk appetite to support discussions at Board and Committee. **September 2021** HoCA	Deep dive into BAF at Audit Committee. Working with Internal Audit to identify best practice. Agreed with Internal Audit and Audit Committee revised timescale to fit with annual assurance process ***Revised BAF will be in place for quarter one for 22/23***

	#	Recommendation	Further Actions	May 2022 Update
	8.	The Trust has adapted and evolved since the current management and governance SBU structures were put in place. There is therefore a need to ensure that they remain appropriate for the current levels of service provision, and that leadership roles within the structures are understood and consistently applied.	Continue to consider organisational structures and processes. **May 2021** Exec Team	SBU and organisational structures are regularly reviewed to ensure they support the Trust's strategic priorities. Consultation currently open on revised SBU structures ***Completed***
	9.	Given the requirement outlined in the Well-led framework that "comprehensive assurance systems should exist at all levels of the organisation" there is a need to strengthen and standardise arrangements in place at SBU level. Therefore, standardised agendas, minute templates and action logs should be used for SBU meetings. Core meetings should have a consistent administrator and report writing and minute writing training should be provided to all individuals with responsibilities in this area.	Provide standardised documents to support running of meetings for the whole organisation **September 2021** HoCA	Corporate Team reviewing best practice. Suite of corporate documents agreed. Distributed and available on the HIVE. ***Completed***
	10.	As part of the revisions to SBU governance outlined in recommendation 9, expectations in relation to the oversight of risk should be reinforced, with assurances sought via PRMs that a consistent approach is being adopted by all SBUs.	Clarity has been provided to SBUs regarding expectation of management of risks. **Nov 2021** Deputy Director of Nursing	Quality Monitoring meetings and Quality and Risk Management Committee providing assurance that expectations are clearly understood. Internal Audit of Risk Management and Board Assurance Framework provided a positive opinion. ***Completed***

	#	Recommendation	Further Actions	May 2022 Update
Three Reporting	11.	There is scope to further strengthen and streamline the quality and quantity of information provided within Board and Committee reports. This should focus on greater levels of analysis drawing the Boards attention to key matters for debate. In support of these changes a programme of training for those drafting key Board reports should be undertaken, for example some organisations have successfully implemented a Shadow Board training programme.	Consider best practice and training available to support improvement. Use CQI techniques to support identification of improvements. Implement support and training for teams. **July 2021** HoCA. Deputy CEO	HoCA delivered training sessions and developed report templates. Training Programme to continue throughout the year. Work continuing with CQI team to continuously identify areas for improvement supported by feedback from Committee self-assessments. ***Completed***
	12.	In addition to the actions outlined in R11, steps should be taken to further reduce the number of individual papers provided to Board and Committee meetings, and to further integrate reporting in order to provide a more holistic oversight of performance across a range of metrics within individual service areas and locations.	See response to recommendation 11	HoCA delivered training sessions and developed report templates. Training Programme to continue throughout the year. Work continuing with CQI team to continuously identify areas for improvement supported by feedback from Committee self-assessments. ***Completed***
C	**13.**	A range of activities should be undertaken to promote the role of the FTSUG once the new post holder is in place. In addition, consider appointing a number of F2SU champions at various grades and locations within the Trust in order to further increase awareness of and engagement with this role.	Ensure F2SU Champions in place to support the Guardian. Implement activities to promote Guardian role. **June 2021** Director of Quality and Safety	F2SU Guardian regularly attends IGC. Full time F2SU Guardian been appointed. F2SU advocates ongoing. ***Completed***

	#	Recommendation	Further Actions	May 2022 Update
	14.	A review of the current levels of accountability and autonomy should be undertaken to ensure that learning is captured. Alongside this, consideration should be given to how the CQI methodology can further support the refinement of existing ways of working to further encourage local innovation.	Trust has reflected on the learning from managing Covid, supported by CQI techniques. Trust has implemented successful new ways of working since the pandemic. **Nov 2021**	Continuing to reflect on learning from managing the pandemic supported by CQI techniques. Continuing to implement successful new ways of working. Internal Audit provided a positive opinion. ***Completed***
	15.	In further support of the already comprehensive range of mechanisms in place to support and recognise staff achievements, there remains scope to increase the extent to which achievements, innovation, and learning is shared and recognised throughout the Trust.	Implement Recovery Strategy **April 2021** Deputy Director of People and OD	Wellbeing programme implemented. Summer Wellbeing and Winter festivals delivered. Staff survey results demonstrate Trust approach to support staff wellbeing ***Completed***
Five Stakeholder Feedback	16.	As part of the planned refresh of the stakeholder map, ensure that the breadth of stakeholders and Trust leaders participating in these activities is further diversified. In addition, review any options for the Trust to further influence and inform the development of approaches within the system where relevant	Continue to populate the stakeholder map considering the most effective ways to influence. **May 2021** Director of Strategy	Stakeholder map has been refreshed. ***Completed***

Hertfordshire Partnership University NHS Foundation Trust

Meeting Date:	26 May 2022	**Agenda Item:** 17
Subject:	Committee Chairs Update	**For Publication:** Yes
Author:	Kathryn Wickham, PA to Chair and Head of Corporate Affairs & Company Secretary	**Approved by:** Helen Edmondson, Head of Corporate Affairs & Company Secretary
Presented by:	Sarah Betteley, Chair	

Purpose of the report:

To update the Board of Directors on proposed changes to the Chairs of the Audit Committee and Finance & Investment Committee.

Action required:

To receive and support the proposed change of Chairs.

Summary and recommendations to the Board/Committee [to be amended]:

Summary

Catherine Dugmore, Non-Executive Director is currently Chair of the Audit Committee. At the end of July 2022 Catherine Dugmore's term of office comes to an end and creates a need to agree a new Audit Committee Chair.

Following a discussion between the Trust Chair, Sarah Betteley and David Atkinson Non-Executive Director, it has been agreed for David to become the Chair of the Audit Committee. David Atkinson has for the past three years successfully chaired the Finance and Investment Committee and been a member of the Trust's Audit Committee.

David Atkinson will remain as a member of the Finance and Investment Committee but will step down as the Chair of the Committee. This change creates a vacancy of Chair of the Finance and Investment Committee. Trust Chair, Sarah Betteley held a conversation with Anne Barnard, Non-Executive Director who has agreed to take on the role of Chair of the Finance & Investment Committee. Anne Barnard for the past fifteen months has been an active member of the Finance and Investment Committee

It is proposed that Anne Barnard and David Atkinson will take up the new Chair roles from 1 August 2022.

Recommendation

The Board of Directors are asked to receive and support the proposed change in Committee Chairs for the Audit Committee and Finance & Investment Committee.

Relationship with the Annual 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 / it

N/A