Hertfordshire Partnership University NHS Foundation Trust PUBLIC Board of Directors 25May23

DaVinci Suite

25 May 2023 10:30 - 25 May 2023 13:30

INDEX

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors Meeting
Date: Thursday 25 May 2023

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

AGENDA					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
	Shared Experience – Staff				10:30
1.	**Welcome and Apologies for Absence**	**Chair**			11:00
2.	**Declarations of Interest**	**Chair**	**Note**	**Attached**	
3.	**Minutes of the meeting held: 30 March 2023**	**Chair**	**Approve**	**Attached**	11:05
4.	**Matters Arising Schedule**	**Helen Edmondson**	**Review & Update**	**Attached**	
5.	**CEO Brief**	**Karen Taylor**	**Receive**	**Attached**	11:10
6.	**Chairs Report**	**Chair**	**Receive**	**Verbal**	11:25
	QUALITY & PATIENT SAFETY				
7.	**Report from Integrated Governance Committee: 16 May 2023** **a) Quarter Four Integrated Safety Report** **b) Quarter Four Experience Report** **c) Annual Freedom to Speak Up Report**	**Jacky Vincent** **Jacky Vincent** **Sandra Brookes** **Jacky Vincent**	**Receive** **Receive** **Receive** **Receive**	**Attached** **Attached** **Attached** **Attached**	11:30
8.	**Review of Shared Experience**	**Sandra Brookes**	**Receive**	**Attached**	12:10
	OPERATIONAL & PERFORMANCE				
9.	**Report from Finance and Investment Committee: 18 May 2023** **a) Quarter Four and End of Year Annual Plan** **b) Quarter Four Performance Report**	**David Evans** **David Evans** **Hakan Akozek**	**Receive** **Receive** **Receive**	**Attached** **Attached** **Attached**	12:15
10.	**Finance Report**	**Phil Cave**	**Receive**	**Attached**	12:40
11.	**People & OD Report**	**Jo Humphries**	**Receive**	**Attached**	12:45
	GOVERNANCE AND REGULATORY				
12.	**Compliance with NHS Licence**	**Helen Edmondson**	**Approve**	**Attached**	12:55
13.	**Audit Committee Report meeting held: 24 April 2023**	**Phil Cave**	**Receive**	**Attached**	13:00
14.	**Audit Committee Annual Report**	**David Atkinson**	**Receive**	**Attached**	13:05
15.	**Integrated Governance Committee**	**Diane Herbert**	**Receive**	**Attached**	13:10

	Annual Report				
16.	**Finance & Investment Committee Annual Report**	**David Atkinson**	**Receive**	**Attached**	13:15
17.	**Annual Review of Fit and Proper Person Test Checks**	**Jo Humphries**	**Approve**	**Attached**	13:20
18.	**Any Other Business**	**Chair**			13.25
19.	**QUESTIONS FROM THE PUBLIC**	**Chair**			
Date and Time of Next PUBLIC Meeting: Thursday 22 June 2023 (Annual Accounts and Annual Report) Thursday 6 July 2023					

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

25 May 2023

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	Independent NED Mizuho Accredited Humanist funeral celebrant RNLI crew member NED on the board of the Pension Protection Fund
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
Philip Cave	Chief Finance Officer	Nil Return
Carolan Davidge	Non-Executive Director	Trustee, Arthur Rank Hospice Charity Independent Board Member, Samphire Homes Company Director, Carolan Davidge Ltd (trading as Carolan Davidge Coaching)
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
David Evans	Director Strategy & Partnerships	Nil Return
Diane Herbert	Non-Executive Director	NED designate at the North East London ICB
Jo Humphries	Chief People Officer	Nil Return
Karen Taylor	Chief Executive Officer	Nil Return
Andrew van Doorn	Non-Executive Director	Chief Executive and Company Secretary, HACT (Housing Associations Charitable Trust) Chief Executive and Company Secretary of HACT Housing Action Ltd. A fully owned trading subsidiary of HACT
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	Trustee on Board of homelessness charity: 'Accumulate' (1170009) | Member of Green Angel Syndicate Independent Board Member of the University of Hertfordshire Shareholder of Farr Brew Limited
Asif Zia	Director, Quality & Medical Leadership	Nil Return

Minutes of the: PUBLIC Board of Directors
Date: 30 March 2023
Venue: The Colonnades

MINUTES	
NON-EXECUTIVE DIRECTORS	**DESIGNATION**
Sarah Betteley | SBe	Chair
Andrew van Doorn | AvD	Non-Executive Director
David Atkinson | DA	Non-Executive Director
Jon Walmsley | JW	Non-Executive Director & SID
Tim Bryson | TB	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
Carolan Davidge | CD	Non-Executive Director
DIRECTORS	
Karen Taylor | KT	Chief Executive Officer
Jacky Vincent | JV	Executive Director, Quality and Safety & Chief Nurse
Paul Ronald | PR	Interim Director Finance & Estates
Prof Asif Zia | AZ	Executive Director, Quality & Medical Leadership
Janet Lynch | JL	Interim Director People and OD
Hakan Akozek | HA	Director Innovation & Digital Transformation
Sandra Brookes | SBr	Deputy CEO and Chief Operating Officer
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chair & Company Secretary (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Simon Pattison | SP	Deputy Director Strategy & Partnerships
Maria Watkins | MW	Lead Governor
Ire Adeosun | IA	Corporate Work Experience
Aliyah Piper | AP	Corporate Apprentice
APOLOGIES	
David Evans | DE	Executive Director Strategy & Partnerships
Diane Herbert | DH	Non-Executive Director

Item	Subject	Action
030/23	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. Apologies were received from David Evans.	
031/23	**Declarations of Interest** The Declarations of Interest Register was noted. **NOTED**	
032/23	**SU Experience** SBe thanked LJ for her story. LJ agreed to attend an ICB Board meeting to share her experience.	
033/23	**Minutes of Meetings held 2 February 2023** The minutes were reviewed and approved as an accurate account of the meeting. **APPROVE**	

	The Board APPROVED the minutes	
034/23	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
035/23	**CEO Report** KT presented the CEO Report to the Board which was taken as read. Headline messages of note to the Board were: KT reported that since the last report to the Board there had been significant discussions with the Government and Unions in regard to a pay offer. KT reported that the unions were currently consulting with their members. The offer does not relate to doctors and since the Board last met Junior Doctors had undertaken industrial action during March 2023 with KT noting this had been well managed and recorded acknowledgment to SBr and the team. As the outstanding issues remain unresolved a further period of industrial action by junior doctors was planned for the 11-15 April 2023 creating operational challenges and the reliance on the good will of our consultants. Strategic and Tactical Command would run throughout this period. The Spring Budget had been announced and had focused on getting people back into work. There was limited mention of mental health with a brief reference to Suicide Prevention money. The National Report on Safety and Wellbeing reviews and the Report on Children's mental health had been published with KT commenting these were largely in tune with what we were seeing locally. In terms of money, the national position across the NHS showed a deficit of £6bn with KT stating next year would be very challenging. On the 21 March the Trust became the first NHS Trust in the country to collaborate with the Domestic Abuse Alliance bringing together partners across the system to launch an App. KT updated that the Exec team had recently held conversations regarding the development of the Depression Pathway noting this would be leading edge. Operationally, it was still challenging but stable however demand was at a higher level than pre pandemic. Performance had started to recover and there were good signs of improvement in our workforce metrics. On 23 February 2023 Healthwatch Norfolk carried out an Enter and View visit at the Broadland Clinic with KT reporting we had received positive feedback. The Norfolk ICB had published an Expression of Interest for the provision of specialist Learning Disability (LD) services. The EOI closed at 12pm on 30 March and the Trust had submitted a response yesterday. In terms of CQC activity we anticipated that the formal reports for Warren Court and Oak Ward would be published next week. A full update would come to the May Board.	

	A three-day Inquest had concluded into the sad deaths of 20-year-old Zaiga and 19-year-old Charlie who were found deceased by use of ligature in 2017. KT advised that the Coroner had concluded that their care had not contributed to their deaths, however, as a learning organisation, the Trust would refresh and review our practices. KT concluded the update commenting this would be the last Board for Paul Ronald and Janet Lynch and recorded her sincere thanks on behalf of the Board for their valuable contributions to the Trust. KT invited questions. Following comments by DA and TB it was agreed for details of the Depression Pathway and Domestic Abuse Alliance to be provided to Board members. **RECEIVED** **The Board RECEIVED the CEO Brief**	
036/23	**Chairs Report** SBe provided Board members with a verbal update on the work she had undertaken since the last Board meeting. Governor appraisals continued with SBe noting an emerging theme was their enthusiasm and ideas for increased engagement. The Trust had recently held an International Women's Day event (IWD) which had been well attended. SBe made note of the excellent speakers, which included DH. SBe had attended a site visit to Specialist Residential Services (SRS) highlighting the level of compassionate care she'd seen. The Associate NED recruitment was making good progress with five candidates due for final interview. System wise SBe continued with her six weekly Herts Chairs calls and had also attended a Herts & West Essex Chairs call noting both conversations had focused on finances with Paul Burstow stating there would be a system event in the summer. SBe had held meetings with MPs Mike Penning and Daisy Cooper. Nationally, SBe had attended the NHS Providers Chairs and CEO event which had been held face to face in London. NHS Providers CEO Julian Hartley along with Saffron Cordery had presented a strategic policy update. Navina Evans provided an update on workforce priorities. Julian Kelly, Chief Financial Officer at NHS England had led a discussion on the 23/24 financial priorities. There was also a session on NHS reform. SBe had also attended a GGI event on 'balancing the books' and an NHSE roundtable event led by Professor Mark Radford with SBe noting her take-away was that he was interested in what did and did not work in terms of support.	

	RECEIVE **The Board RECEIVED the verbal update**	
	QUALITY	
037/23	**Report from the Integrated Governance Committee: 16 March 2023** JV introduced the report which provided the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting on 16 March 2023. The report was taken as read and the points below highlighted. JV reported the Committee had received and considered a number of items which had provided assurance including the Integrated Safety Report and Trust Risk Register. The Committee had received a Deep Dive into the positive Staff Survey results, as well as headlines of the month ten People Report and the Gender Pay Gap report. The Committee had considered the results in regard to the Workforce Race Equality Standard (WRES) data noting it had remained static and also the results of the Workforce disability Equality Standard (WDES) which had shown improvement. The Committee had received an update on the CQC's regulatory activity and the work to prepare for the Patient Safety Incident Response Frameworks (PSIRF). The Committee considered the Patient Led Assessments of the Care Environment (PLACE) and the Patient and Carer Race Equality Framework (PCREF). The Committee had reviewed the results if its recent self-assessment. JV concluded advising there was one item for escalation to the Board, namely the Committee recommended its revised Terms of Reference for Board approval. This would be a separate agenda item. **RECEIVE** **The Board RECEIVED the report**	
038/23	**Quarter 3 Integrated Safety Report** JV presented the report which provided an overview of safety following the previous headlines report presented to the Board. The paper was taken as read with the key points below drawn out. The quarter had seen a slight reduction in the number of reported incidents and those that were categorised as resulting in moderate harm. Violence and Aggression remained a concern in some hot spot areas. There had been a significant increase in the number of reported medication incidents. JV reported there had been increased focus on quality and safety, including the introduction of a live dashboard along with increased oversight of Oak	

	Ward, Warren Court and our Norfolk services which were being led by JV and AZ. We had also introduced a weekly improving care, together action group for areas requiring increased focus. JV updated on further actions in train or planned, including Trauma Informed Approaches, zero tolerance to violence and aggression with Positive Behavioural Support (PBS), JV's plans in the national inpatient quality improvement work and a focus on the fundamentals of care. JV concluded the update advising that the Integrated Safety Report design was being reviewed and in future would incorporate an increased use of SPC charts, a clearer focus on themes, trends, learning and areas for escalation and assurance. Questions were invited. In response to AB's request for the Board to be sighted on the Quality and Safety Dashboard, KT responded stating that a Deep Dive would be held as a Board workshop. ***An action was drawn for HE to identify a Board workshop to demonstrate use information/dashboards to support assurance of quality of care*** **RECEIVE** **The Board RECEIVED the report**	**HE**
039/23	**Month 10 People and OD Report** JL introduced the report which set out the Trust's Month 10 performance in relation to key People and OD metrics which supported our annual plan. JL advised the report had been discussed in detail at the Integrated Governance Committee, taking the paper as read and presenting the key headlines. This was the seventh consecutive month for our vacancy rates to have fallen and was at the lowest since June 2021, however it was acknowledged we still had some critical posts to fill. The report demonstrated the sustained progress and overall improving picture. JL invited questions. Board members held a number of conversations around the adjustment of the turnover target, it was noted that further work was being undertaken to better understand what would be appropriate but also stretch the organisation. JL reported that the largest reason given for leaving at exit interviews was promotion. JL added that the need to improve development opportunities had been included in the Annual Plan for 23/24. JL confirmed that the Trust did review ethnicity of staff subject to disciplinary action. **RECEIVE** **The Board RECEIVED the report**	
OPERATIONAL AND PERFORMANCE		

040/23	**Report from the Finance & Investment Committee held 28 February and 23 March 2023** PR presented the report which provided an overview of the work undertaken by the Finance and Investment Committee at its most recent meetings held on the 15 and 28 February and 23 March 2023. The report was taken as read. PR provided an overview of the highlights from the report. The Committee approved a business case for a patient flow and bed management system. The Committee noted the Trust would be continuing to monitor and track the year end position for 2022/23 but that the Trust was confident in delivering a break-even position. At its meeting held on 28 February 2023 the Committee received an updated on financial position for 2022/23 and planning for year-end for 2022/23. At its March meeting the Committee received a report that provided an update on the progress with the Trust's financial plan for 2023/24. The Committee had received a detailed slide deck on Financial Planning 2023/24 and details of the Financial Recovery programme. The Committee had approved the Annual Plan and recommended it to the Board for approval noting that some of the metrics were due to be finalised. The Committee recognised it was ambitious and that some elements were dependent on the final financial settlement. The Committee had considered the Saffron Ground proposal and received updates on the lease. Questions were invited. SBe recorded recognition and thanks for the level of rigour provided by the Committee. In response to TB's query regarding the Delivering Value Plan and Annual Plan being aligned SBr provided assurance that they were and noted the rigorous processes in place. AB stated it was important for us to continually monitor the Quality Impact Assessments with SBr concurring and reporting that Equality Impact Assessments was also being added to the process. **RECEIVED** **The Board RECEIVED the report**	
041/23	**Finance Report** PR presented the report which provided the Board with the financial position for month 11. The report was taken as read and the below points noted. PR reported that the Trust had stabilised its financial position and was also seeing improvement in levels of expenditure in our services.	

	The Financial Recovery Board had been established and was making a number of improvements to the internal systems and processes to secure additional income and manage expenditure. PR noted the additional income received in quarter 4. PR set out that the Provider Collaborative would reporting a surplus and that this had been passed onto members and would be reported in the Trust end of year position. PR added that the finance team were working closely with the external audit team in preparation for the submission of the draft accounts. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
042/23	**Final draft Annual Plan 2023/24** SBr presented the report which set out the Trust's proposed Annual Plan for 2023/24. SBr reported the Plan had been given in-depth discussion by the Finance and Investment Committee. SBr highlighted that it was an ambitious plan and built upon the work we were already doing with SBr highlighting our Inclusion and Belonging work. There would be significant work required around cultural change and improvement and would be key for us to articulate this well. There were a number of areas in the plan which were subject to business case development or additional funding, and these would be revisited throughout the course of the year. There was still some work to do in relation to the changed metrics (detail set out in the body of the report) with conversations being held within the Finance & Investment Committee and agreement to set out the reasons for changing the metrics and to review these at the half year point. KT commented that should we achieve even half of the plan we would still have made a significant step change for our service users and carers and stated that there should be one final review before final sign off. ***An action was drawn to ensure future reporting demonstrated links between annual plan and delivering value*** **APPROVE** **The Board APPROVED the Plan**	
043/23	**Final draft Financial Plan 2023/24** PR introduced the report which was taken as read and sought approval from the Board today following recommendation by the Finance & Investment Committee. PR set out the highlights of the plan: The primary area of focus in discussions was to reduce Out of Area activity and the use of agency. That the plan included £10m investment in the	

	Mental Health Investment Standard and that the team were working through the detail of what the investment would cover. PR reported that the Trust were also seeking additional funding for our bed position and doing all we could to ensure the system recognised the challenges of the current situation. PR stated that HWE Integrated Care Board had been chosen by the NHSE national team for a Deep Dive that would focus on how the system would get back into financial balance. In response to AvD's question SBr stated that she was confident with regard to the activity assumptions and in particular the forecasting for bed use. KT added that it was based on best estimates using the data currently available. Following a short discussion Board members provided their approval to submit the draft financial plan whilst recognising there would be further iterations. **APPROVE** **The Board APPROVED the Financial Plan.**	
044/23	**Final draft Capital Plan 2023/24** PR presented the draft Capital Programme for 2023/24 advising that the Plan would be submitted as part of the Financial Plan submission on 30 March 2023. The report was taken as read. PR asked the Board to note the reduced capital investment limit (CDEL) for 2023/24 and that it included the proceeds of the sale of Harper Lane which was expected to be completed in quarter one, bringing the total Capital Investment Programme to £12.3m for the year. The programme incorporated the completion of 2022/23 schemes, new schemes for investment in Digital, Backlog Maintenance, Sustainability, Medical Devices, and Reactive Capital, with several specific schemes planned. The figure did not include spend for the new east and north Herts hospital site, and recorded that Trust is awaiting announcement on this. PR concluded stating we had a good track record of delivering our Capital Plan. All in attendance provided their approval with no questions put forward. **APPROVE** **The Board APPROVED the Capital Plan**	
045/23	**Annual Staff Survey** JL introduced the report and slides which set out the results of the 2022 annual staff survey noting it had been discussed in detail at the recent Integrated Governance Committee. The report was taken as read and the below highlights drawn out.	

	JL reported these were a very positive set of results with strong scores for the themes, however acknowledging that not every member of staff received the same experience and as a Trust we would continue to work on this. The headline WRES and WDES outcomes showed that WRES scoring had remained static and WDES scoring decreased. Scores around pay mirrored the national picture. Whilst there was a slight deterioration in the scores for HPFT as a place to be cared for, the scores were still well above average, and scores for a place to work had improved and were amongst the highest nationally. JL commented we should be very proud of these results and in the 20 years she had been presenting the Staff Survey these were the best she had presented. SBe acknowledged the hard work and excellent results with KT echoing SBe comments whilst also noting the leadership of the Board. KT reported that the Trust had been contacted by other Trusts to better understand what we had done to achieve such positive results. **RECEIVE** **The Board RECEIVED the report**	
046/23	**Gender Pay Gap** JL introduced the report which set out the gender pay gap data as at 31 March 2022 and as required for statutory reporting. The report was taken as read and the below headlines drawn out. There was a mean gender pay gap of 8.91%, a small decrease from 9.92% in 2021. A mean gender bonus pay gap of 35.37%, an increase from 24.4% in 2021. At VSM level, our mean gender pay gap is 2.28% (a reduction of 5.39% in 2021). Our medical staff have a mean gender pay gap of 7.89% (a decrease of 0.19% in 2021 when it was 8.08%) JL commented that it was difficult to compare data with other organisations, noting the report did include a summary of trends. The report also set out the actions to be undertaken. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
047/23	**Equality Delivery System** JL presented the report which provided an overview of the recent NHS Equality Delivery System (EDS) review. This was required to be undertaken by all NHS employers. The report was taken as read. The report showed an overall rating of 'achieving' under the EDS, with JL confirming that feedback was provided via a range of different sources including involvement from the BAME network. The actions linked to this	

	report would be developed further. JL concluded commenting that next year's report would look different. Questions were invited. AvD queried what the report told us with JL reporting it demonstrated we were making good progress with positive indicators. KT added we would benchmark the report once it was published. **RECEIVE** **The Board RECEIVED the report**	
	STRATEGY	
048/23	**Strategy Development** KT provided a presentation which gave an update on the development of the new Trust Strategy 2023-2028 as part of the 'Looking Forward Together' programme of work. The Trust had set out a three-phase approach of discovery, engagement, and co-creation and were now entering the co-creation phase. The presentation provided the Board with a summary of feedback we had received, alongside the proposed themes for the new strategy and next steps. It was noted that the Board had used a recent Board workshop to discuss and contribute to the strategy. The Strategy would be presented to the Board at its May meeting. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
049/23	**ICP Strategy** SP introduced the report highlighting that the Strategy had been agreed by the HWE ICP Board on 15th December 2022 and published on the ICP website on 23rd December 2022. The Strategy has six specific priorities, which were set out in the paper. The next steps were to develop a delivery plan to support delivery of the strategy. This work would link in with the development of the 5-year Joint Forward Plan which was to be completed and published by 30 June 2023. **RECEIVE** **The Board RECEIVED the presentation**	
	GOVERNANCE AND REGULATORY	
050/23	**Trust Risk Register** JV presented the report which provided detail to the Board with regard to the current seven risks on the register. The report noted the consideration for a reduction in risk scores for People, with the consequence of this risk reduced from Catastrophic (5) to Major	

	(4), resulting in a reduction from 20 to 16. The report also noted the risk consideration for an increase in the risk score for Financial Sustainability and for Quality of Care. In regard to Financial Sustainability the likelihood of this risk had been increased from Likely (4) to Almost Certain (5), resulting in an increase from 16 to 20. The Board are also asked to note that the target had been updated from Unlikely (2) to Possible (3) and still Moderate (3). With regard to Quality of Care, the likelihood of the risk had increased from Likely (4) to Almost Certain (5) resulting in an increase in the risk score from 16 to 20. JV reported that the Integrated Governance Committee held a robust discussion and as a result a Deep Dive would be scheduled to look at the Trusts Risk Management and review processes. Board members held a short discussion with DA highlighting that the Cyber Risk would need closely watching and AvD supporting the plan for the Committee and Board to do further work on approach to risk management and appetite. **RECEIVE** **The Board RECEIVED the report**	
051//23	**Board Assurance Framework** HE presented the updated Trust Board Assurance Framework (BAF) reporting it had undergone a fundamental review which had been undertaken in response to a recommendation from the externally commissioned Well-Led Review undertaken in 2020/2021. The enclosed revised BAF outlined the eight strategic risks which were agreed by the Board at its meeting in November 2022 and had since been reviewed by the Executive Team and Audit Committee. The material changes since the previous version were set out in the body of the report. HE highlighted that the BAF would continue to develop, and the next version would include learning from the current advisory audit. All in attendance provided their approval. **APPROVE** **The Board APPROVED the Board Assurance Framework**	
052/23	**Code of Governance** HE presented a report that provided detail of the revised Code of Governance issued by NHS England. She set out that the report set out the key headlines from the Code, implications for the Trust, proposal for monitoring compliance and next steps. The report was taken as read. HE reported that the new Code applies from April 2023 and has five sections and that it would apply to all NHS providers trusts. The formal report was set out on a comply and explain position. HE proposed she presented a mid-term report to the Audit Committee and	

	Board in September, this approach was supported by the Board. **RECEIVE** **The Board RECEIVED the report**	
053/23	**Report from the Audit Committee held 9 February 2023** HE presented the report which provided an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 9 February 2023. The report was taken as read with the below points highlighted. The Committee had received and considered a number of items with appendix 1 detailing the agenda items from the meeting. The Committee received a deep dive and a number of items relating to year end 2022/23 including the year end preparation with HE noting we were in a strong position and had good engagement with KPMG. The Committee received an updated External Audit Plan for 2022/23 from KPMG and an updated draft timetable for the production of the 2022/23 Annual Accounts and Annual Report. The Committee had received a number of external assurance reports. The Committee had reviewed the BAF, approved two policy documents, reviewed its terms of reference and received an update and review of Accounting Policies. There were no items for formal escalation to the Board. **RECEIVE** **The Board RECEIVED the report**	
054/23	**Report from the Nominations and Remuneration Committee** SBe presented the report which provided an overview of the work undertaken by the Nominations and Remuneration Committee over the past year. The report was taken as read. SBe noted that the Committee's Terms of Reference would be reviewed later in the year. **RECEIVE** **The Board RECEIVED the report**	
055/23	**Audit Committee Terms of Reference** HE presented the Audit Committee Terms of Reference advising the material changes were set out in the body of the report. The Board considered and noted the suggested amendments. The meeting discussed whether minutes of the Audit Committee should be received by the Board. It was agreed that the final position on this would be agreed by DA as Chair of Audit Committee and SBe. Subject to this amendment the Terms of Reference were approved. **APPROVE** **The Board APPROVED the Terms of Reference**	

056/23	**Any Other Business** SBe thanked Paul Ronald and Janet Lynch for their hard work and commitment and wished them well for the future.	
057/23	**Questions from the Public** No questions were put forward.	
Date of Next Meeting Thursday 25 May 2023		

Close of Meeting

Committee Meeting: PUBLIC Board of Directors

MATTERS ARISING SCHEDULE - May 2023

Matters Arising from meeting held on: 30 March 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
038/23	**Quarter 3 Integrated Safety Report**	**HE**	Identify Board workshop to demonstrate use information/dashboards to support assurance of quality of care	April 2023	**G**
042/23	**Final draft Annual Plan 2023/24**	**DE**	Ensure future reporting demonstrates links between annual plan and financial planning	April 2023	**G**
Matters Arising from meeting held on: 2 February 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
003/23	**Shared Experience**	**SBr**	Contact service user have her input into community transformation programme	February 2023	**G**
007/23	**Chairs Report**	**SBr**	Schedule Board discussion regarding Learning Disability service and future model	To be confirmed	
010/23	**Quarter Three Integrated Safety Report**	**JV/JL/ SBr**	Consider how to link themes and learning included in board report (quality, experience, people)	March 2023	**G**
028/23	**AOB**	**SBr**	Ensure Board receive review of Shared Experiences they have received	May 2023	**G**
Matters Arising from meeting held on: 29 September 2022					
13	**Winter and UEC Preparedness**	**SBr**	Board to receive Forensic Female LD Business Case	tbc	**A**

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 5
Subject:	CEO Briefing	
Presented by:	Karen Taylor, Chief Executive Officer	

National update

The national activity is summarised below:

Pay Award

The NHS Staff Council which is made up of the Unions recognised in the NHS and NHS employers recommended the pay deal announced earlier in Mach for implementation on 2 May 2023, and the government has confirmed that the deal will be implemented for all staff on the NHS Agenda for Change Terms and Conditions of Service. Staff will receive the pay award from 1 June 2023. It will consist of two elements: one off non-consolidated award for 2022/23 and consolidated award for 2023/24 from 1 June 2023. Locally the Trust is making the payment for 2022/23 available in instalments where staff indicate this is their preference.

Industrial Action

Since the last report to the Board the British Medical Association (BMA) have formally notified the Trust that from 15 May, they will be balloting their consultant members about whether they would support taking strike action, the ballot will close on 27 June. The is currently no further planned Junior Doctor strike action.

The Royal College of Nursing members have rejected the pay awarded offered in March 2023 and the Trust has also received notification that they are balloting their members regarding support for further industrial action, with the ballot closing on 23 June.

The Trust continues to plan for ongoing strike action and to ensure that our service users continue to receive safe and effective care.

NHS England Workforce Plan

NHS England has set out that it plans to free up 15 million GP appointments over the next two years by increasing access to pharmacists. This announcement is part of the recovery plan to support GP services which are currently facing significant challenges. It will see pharmacists able to prescribe medication for certain common ailments. The announcement also reported that patients will be able to self-refer for certain needs such as booking for NHS physiotherapy or podiatry. It has been indicated that apprentice-doctor roles may be rolled out as part of the government's plan to help with NHS staffing issues.

NHS England Chair visit

On 17 May 2023 we were delighted that Richard Meddings, Chair of NHS England visited the Trust. He visited a number of our Learning Disability services on the Kingsley Green site and medium secure services at Warren Court.

Regional and System update

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

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

On 24 May 2023 the Integrated Care Board is holding its inaugural System Partners Conference. It will provide an opportunity for all the partners across the ICS to meet and hear about some of the work

underway to improve the health and outcomes for the local population. Rt Hon Patricia Hewitt, Chair of NHS Norfolk and Waveney ICB is speaking at the event.

Reflecting the position across systems nationally, the ICB has been through a challenging financial planning round, and contracting processes across the system continue. The ICB has submitted a breakeven plan for 2023/4, and providers have signed a Memorandum of Understanding underpinning the commitment to achieve this position together.

Hertfordshire Mental Health, Learning Disability and Autism (Health and Care Partnership (MHLDA) (HCP)

At the MHLDA HCP Board meeting on 12 May 2023, the Partnership approved a Physical Health Strategy, which sets out a clear commitment and approach to supporting people with severe and enduring mental illness, learning disability and autistic people with their physical health across Hertfordshire. In addition the Board reviewed the proposed delivery plan for the Dementia strategy, which will see partners working together to strengthen care and outcomes across health and social care, working from prevention through to specialist provision. The Crisis Care Partnership Board met in April and there is a clear programme of work, including joint work with the NHS and Hertfordshire Constabulary to improve the crisis pathway. There is a multi-agency Suicide Prevention pathway workshop scheduled for 24 May 2023.

A meeting was held with senior Police colleagues and system partners to discuss the " Right Care, Right Person" model which is being rolled out across constabularies nationally. The model is designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond. It has four key areas of focus, those being: concern for welfare; AWOLs/walk-outs from healthcare settings; places of safety; transportation. HPFT is fully engaged and involved in this and reviewing the implications of the proposed model/roll out.

East of England Provider Collaborative

Each of the care groups are continuing to develop bed reconfiguration plans, based on the clinical model and current and forecasted demand. Due to a number of Trusts indicating that current income is no longer sufficient to adequately cover the cost of service provision, a proposal to review clinical models and approach to benchmarking provision costs has been presented to the collaborative executive, with the intention to support resilient and future- proofed services. It is anticipated that this work will take 3-6 months to complete, and this will include Forest House and Warren Court.

Two new risks have been added to the collaborative risk register this month. The first is that the collaborative will not be able to commission sufficient capacity to meet the demand for Children and Young People (CYP) who require specialised eating disorder care and who have a nasogastric (NG) tube in place. There has been an increase in the number of presentations in recent weeks and there are limited beds locally as well as nationally available. The secondary effect of this is an increase in the number of these patients being treated in paediatric wards. For HPFT, work is ongoing on developing a local CYP Eating Disorder pathway that will mitigate against this risk and working with the acute trusts to consider alternatives to NG feeding.

As part of an opportunity to bid for some medium term funding NHSE has confirmed that the collaborative has been awarded £83k to establish a peripatetic dietician. This supports the plan to support General Adolescent Units to accept CYP who have an eating disorder.

The second risk is that there may be an increase in demand for male secure accommodation. NHSE report that the male prison population in England is near capacity. A weekly SITREP and escalation call have been enacted and it is likely that there will be measures to accelerate appropriate admissions to hospital from prison. The secure care group are trying to assess the potential impact of this.

Norfolk community Forensic Learning Disability Service

Following a year long pilot of this service funded by the East of England Provider Collaborative the Trust has been successful in securing long term funding. The service was set up to reduce lengths of stay, reduce number of admissions and provide a safe transition for service users from inpatient services. The pilot demonstrated good outcomes for service users, with more timely discharges, reduced length of stay and positive service user feedback. The service funding has been included in the baseline for services and is being jointly provided by the East of England Provider Collaborative and Norfolk ICB.

Midlands and East Mental Health CEOs

On 19 May 2023 a Regional Chief Executives meeting took place in Leicester, with Sir Julian Hartley attending the meeting. The following day the national PCREF (Patient and Carer Race Equality Framework) team presented the roll out of the programme and Trust's shared their approach and practice.

Trust-wide update

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

Operational update

During May we have seen a significant increase in demand again for people requiring acute admission, leading to an increase in the use of out of area beds. The teams are working hard to recover this position and bring it back in line with the trajectory. The acute pathway team are mobilising a virtual discharge team to support discharge and a senior level Multi- Agency Discharge Event is being coordinated. We are continuing to work with system partners to develop a business case to for a Mental Health Crisis Assessment Centre after visiting a number of similar services that have been established. The recovery of the adult and CAMHS 28 day position and EMDASS continues to be a priority. The South West Quadrant, across all care groups, is facing high levels of vacancies and this is a key focus in terms of a workforce plan to address; and a demand and capacity review is underway.

During April, we saw the the four day junior doctors strike action take place in line with national action. Our sincere thanks go to our consultant body who volunteered to cover the shifts, and to all teams who supported additional duties/shift and worked differently over that period to ensure we were able to continue to provide services and keep service users safe.

Care Quality Commission

The final reports for Warren Court and Oak Ward are due to be published on 24 May 2023 following the focused that took place inspections in the Autumn of 2022. Since the inspections took place the Trust has implement comprehensive Service Improvement Action Plans for both services to address the areas for improvement identified. A verbal update will be provided at the meeting.

Our People

In April and May, we held our Big and Local Conversations, the theme was 'Doing the Right Thing'. Part of our overall programme of engagement, these events provided an opportunity for all staff, at all levels, from across all professions to discuss their thoughts and ideas with the Executive Team and colleagues from across the Trust about what teams can do to improve care and outcomes for service users, carers and the communities we serve. The Executive Team were impressed with the commitments made by teams and individuals themselves, and there were some common themes emerging positively about leadership, recruitment and staff wellbeing and development across the Trust. The need to consider improvements to PARIS, further expand training and continue our drive to recruit staff across the organisation were also common themes raised - issues we will continue to address during 2023/4.

Our staff in post figures and vacancy rates have significantly improved as a result of increased and successful recruitment activity. Our staff in post has increased by 319.6 FTE (9.4%) reducing our vacancy rate from 14.3% to 11.8%, the lowest rate since June 2021. Our unplanned turnover rate has improved throughout 2022/23 with our unplanned turnover has reducing from 12.3% in March to 11.95% in April 2023.

Our appraisal rates have remained at 86%, whilst our mandatory training compliance increased to 89% in April from 87% in March. The relatively lower compliance rates in March and April are as a result of the introduction of two new mandatory training courses for all staff, the compliance for which is now improving.

As part of our retention work, we continue to provide a robust health and wellbeing support offer, including a growing financial wellbeing and benefits offer for our staff. During April, we particularly focussed our efforts on supporting Stress Awareness Month and On Your Feet Britain Day. Our sickness absence rate reduced from 5% in March to 4.4% in April.

Norfolk Learning Disability Services

The Trust has been successful in bid for the Inpatient Assessment & Treatment Service (Learning Disabilities) and Intensive Support Service (Learning Disabilities) services in Norfolk. This is a positive outcome for the Trust and the service users we support. The standstill period has ended, and the Trust is now in the mobilisation phase. The contract goes live in October 2023.

Finance 2023/24

The agreed financial plan for the year is a deficit of £1.8m. This deficit target is part of a Hertfordshire and West Essex Integrated Care system financial plan of breakeven. During 23/24 The Trust will both work to identify the plans internally to further improve against this position where possible, and will be working with the Integrated Care Board and system partners to identify service and financial improvements that will lead to longer term financial sustainability.

At the end of month one (April) the Trust has delivered a financial deficit of £400k against a planned deficit of £200k. The key drivers to this are the use of private beds and the use of agency staffing in our inpatient areas; these two items are the key risks to delivery of the financial plan in 2023/24 and are also linked to poorer experiences for service users. There is a clear plan in place to address this and a report later on the agenda will provide more detail.

External Audit

At the Council of Governors meeting held on 10 May 2023 and a decision was made to award the contract to Deloitte, the recommended company. Following this decision, the Trust will finalise the contract and agree the mobilisation plan.

International Nurses Day

The 12 May 2023 marked International Nurses Day, the Trust held a series of events in different services and also arranged and contributed to a system wide event sponsored by the ICS. It was a great day that celebrated the significant work of nurses and was a brilliant opportunity to show our appreciation to nursing colleagues for their hard work, compassion and dedication.

Karen Taylor
Chief Executive Officer

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 7
Subject:	Report of the Integrated Governance Committee held on 16 May 2023	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

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 on 16 May 2023.

Action required:

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

Summary and recommendations to the Board:

Summary

An overview of the work undertaken is outlined in the body of the report.

Recommendation

The Board are asked to note the assurance provided by the deep dive into medicines management undertaken by the Committee. Noting that it included the areas identified through the internal audit report produced in 2022/23.

Relationship with the Business Plan & Assurance Framework:

List specific risks on BAF – 3 and 4

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Integrated Governance Committee held on 16 May 2023

1. Introduction

1.1 This paper provides the Board with a summarised report highlighting key Committee business and themes arising from the meeting.

1.2 Since the last Integrated Governance Committee (the Committee) report to the Trust Board in Public, the Committee held a meeting on 16 May 2023 in accordance with its terms of reference and was quorate. Diane Herbert, Non-Executive Director, chaired the Committee.

1.4 The Committee received and considered a number of items to provide assurance. *Appendix 1* details the agenda for the meeting. Detailed below are the key areas to be highlighted to the Board and areas that the Committee discussed.

2. Deep Dive

2.1 The Committee received a deep dive presentation into medicines management. The Committee were updated on the review of medicines management, that had been undertaken by the new Chief Pharmacist. He highlighted that the areas for improvement it identified, were aligned with those that the Care Quality Commission (CQC) and internal audit had highlighted, noting that there was an open culture of reporting and a very small number of incidents that resulted in harm.

2.2 The deep dive provided detail on the areas for improvement and how they are being monitored, and the mitigations in place for risks. The team were currently concentrating on using digital solutions were indicated and intensive surveillance of compliance.

2.3 The Committee noted the targeted approach underway to support local leadership and the sharing of good practice. It was also reported the content of the mandatory module was being reviewed.

2.4 The Committee were informed that the information from medicines management incidents was triangulated with other quality and safety indicators and that senior leaders were regularly monitoring and supporting leaders to make improvements.

2.5 It was agreed that the Committee would have an update at its September meeting and that the Audit Committee would be updated on the deep dive and the assurance the Committee had received.

3. Quality

3.1 The Committee considered the quarter four and annual Integrated Safety report. It was noted that it continued to be challenging period, with the number of incidents higher than the previous quarter but that the level of harm had reduced.

3.2 The number of Absence Without Leave (AWOL) continue to be an area of concern but learning was being reviewed and changes to policy and practice implemented to mitigate the risks identified.

3.3 The Committee were updated on the pilot of a Trauma Informed Approach on an inpatient ward and the positive impact this had had. It was noted that the July Committee meeting would be having a deep dive into the roll out of this approach across the Trust.

4. Quality - Effectiveness

4.1 The Committee received an update on the national audits that the Trust had participated in over the past 12 months. There was positive progress regarding the National Clinical Audit of Psychosis especially regarding the input of Family Intervention.

4.2 With regard to the newly published national audits, the Committee noted that the Trust was working to map the learning to local services and implement relevant action plans. The Committee were also updated on upcoming national audits due in summer-autumn 2023, noting that the Committee would be updated on the findings in due course.

4.3 The Committee received an update on the development of Trust services to support service users with physical health needs. It was highlighted that the physical health team were well established and had provided significant support during the recent Junior Doctors strikes.

4.4 The focus areas of the physical health team of tobacco dependency and sleep apnea were discussed. It was reported that the tobacco dependency programme was on well-established and had secured additional funding.

5. Our People

5.1 The Committee considered the quarter four People and Organisational Development report. The continued positive progress with recruitment and the impact this was having on the people metrics, was noted. The continued high use of agency staff was highlighted, and it was agreed that a future meeting would be updated on the work underway to reduce this.

5.2 The Committee discussed the current level of employee relations cases, noting the aim for this to reduce over the coming months.

5.3 A report on the Trust's response to recent industrial action was considered. The Committee noted that the Trust had maintained access to the majority of services during the industrial action, due to excellent team working. The Incident Command structure had been used and had supported the Trust's response.

5.4 The Committee were updated on the recent correspondence from the British Medical Association (BMA) and the Royal College of Nursing (RCN) regarding balloting members about whether they would support strike action, noting that the ballots would be closing in June 2023.

5.5 The Committee received the annual Freedom to Speak Up report. The report set out that the number of referrals had increased in the year but the number which had been anonymous had reduced. The Committee were informed that the themes of the referrals at the Trust were in line with those seen nationally, namely staff wellbeing.

6. Experience

6.1 The Committee considered the quarter 4 and annual Experience report. The highlights for the year are that there has been a significant increase the amount of feedback received, assisted by digital capability. For the same period, there had been a reduction in compliments and an increase in the number of complaints.

6.2 The Committee heard that the main themes from complaints in the year relate to waiting times and poor communication. And in recent months, there had been an increase in the number of complaints relating to bed management and the use and communications surrounding these.

6.3 The actions planned to continue to improve the gathering of feedback and reduce the number of complaints were discussed.

7. Governance

7.1 The Committee received the annual Mental Health Act (MHA) Legislation Report that set out the progress regarding the compliance with the legislation, the outcome of CQC MHA visits, and provided an update on the expected new legislation.

7.2 Committee were provided with assurance regarding the process to ensure the number of services users unlawfully detained under section 136 is kept to a minimum. Committee members explored the processes in place to monitor the care and treatment plan for those under section 136.

7.3 The year end position regarding Quality Indicators for 2022/23 was presented, noting that the majority had been achieved. The Committee considered how the Annual Plan for 2023/24 will support the required progress with regard to the indicators for 2023/24.

7.4 The Committee were also updated on the current position regarding policies being in date. The Committee considered what risk this posed and agreed that this would be monitored quarterly until the position improved.

8. Annual Reports

8.1 The Committee received and took questions on a number of annual reports relating to information Governance, Safer Staffing, Guardian of Safe Working, Guardian of Safe Working, Caldicott, Claims, Patient Led Assessment of the Care Environment (PLACE) and Safeguarding.

9. Matters for Escalation to the Board

9.1 The Committee agreed to update Audit Committee members and the Board on the deep dive on medicines management and in particular that the Committee had considered the items identified through the internal audit report produced in 2022/23.

Appendix One: Integrated Governance 16 May 2023, agenda items

SUBJECT
Welcome and opening meeting
▪ Apologies for absence ▪ Declarations of Interests
Minutes and matters arising
▪ Minutes of meeting held on 16 March 2023 ▪ Action Schedule
DEEP DIVE
Medicines Management
QUALITY SAFETY
Annual Integrated Safety Report incorporating Quarter 4 2022-23
Care Quality Commission Update
QUALITY EFFECTIVENESS
National Clinical Audit Report
Bi-Annual Physical Health Report 2022-23
PEOPLE
Quarter 4 People & OD Report 2022-23
Industrial Action
Annual Freedom to Speak Up Report 2022-23
EXPERIENCE
Quarter 4 and Annual Experience of Care Report
GOVERNANCE
Annual Mental Health Legislation Report 2022-23
Quality Account Priority Indicators 2022/23 Update
Quarter 4 Procedural Document Report
TO NOTE **Reports taken as read and only questions to be taken**
Quality and Risk Management Committee Update Report 6th April 2023
People and Organisational Development Group Update Report 9th May 2023
Information Management and Governance Subcommittee Report Update Report 4th May 2023
Annual Safer Staffing Report 2022-23
Quarter 4 Guardian of Safe Working Report 2022-23
Annual Information Governance Report 2022-23
Annual Caldicott Report 2022-23
Quarter 4 and Annual Safeguarding Report 2022-23
Annual Claims Activity Report 2022-23
PLACE 2022 Outcome Report
Integrated Governance Committee Planner
ANY OTHER BUSINESS
Any Other Business
Matters for escalation
Date and time of future meetings: 27 July 2023 at 13:30-16:00

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 7a
Subject:	Annual Integrated Safety Report incorporating Quarter 4 2022/23	**For Publication:** Yes
Authors:	John Fanning, Head of Safety	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

To provide the Board with the Integrated Safety Report for quarter 4 and 2022/23, which identifies areas of concern, actions that have been taken and are required to be taken, in response to the concerns and the priorities moving forwards.

Action required:

To RECEIVE the report

Summary and recommendations:

The 2023/24 Quarter 4 and Annual Integrated Safety Report provides data relating to quality and safety across our services.

The year has shown an overall increase in the number of reported incidents, yet the level of harm, the number of Serious Incidents (SI) categorised as unexpected or unavoidable deaths, and those due to violence and aggression and self-harm have reduced.

With an increased focus during the year on ensuring the least restrictive practice is used, there has also been a reduction in the use of restraint and a slight reduction in the use of seclusion; also, a reduction in the use of rapid tranquilisation in the last quarter, after previous increases.

The level of acuity and complexity remains a concern, and, whilst the number of service user to service user and service user to staff assaults reduced (with the exception of the Learning Disability and Forensic services), a number of service users clinically ready for discharge continued to have an impact. Individual service users presenting with behaviours which are challenging (including violence and aggression and racism), required higher numbers of staff to support and meet their needs. Discussions with the ICS remain ongoing to ensure that their individual needs requiring comprehensive care packages outside of the Trust, remain a priority for action and support.

The year has also seen challenges with the management of Absence Without Authorised Leave (AWOL), and a Task and Finish Group was commissioned to identify and implement learning. This included the risk assessment process and any known historical risks, as well as the themes regarding reasons for individuals not wishing to return to the ward at the agreed time. One particular theme which is an area for review and action in the new year, is the Trust's Non-smoking policy and the impact this has on both AWOLS as well as violence and aggression.

The provision of Respect training for the prevention and management of violence and aggression (PMVA) remained a focus during the year with an increase in the number of local training provision to support staff to care for service users in the least restrictive and safe way. However, the analysis and learning from incident data has shown that staff require more skill and competence to be able to respond to service users' presentation more confidently and proactively. This led to a review of the Respect training content for more content on de-escalation techniques and also to a wider

review in the new year of PMVA training provision, working with people with lived experiences and learning from other provider organisations.

The Trust has been preparing for the implementation of the national Patient Safety Incident Response Framework (PSIRF), which will enable more system wide learning and be a change in the current incident process and learning. Plans and preparation to enable a successful implementation in September 2023 started in this year and continue.

Robin ward successfully introduced Trauma Informed Approaches (TIA), following a pilot, which saw positive impact on length of stay, staff morale and incidents reported. Building on this success, during quarter 4, other acute inpatient services started the use of TIA and in the new year, all inpatient services will embed the approach, supporting a cultural shift in staff interaction with service users. Plans for TIA across community services will also be progressed.

The number of prescribed safe and supportive observations (SASO) remained high in a number of service areas, impacted by the aforementioned individuals clinically ready for discharge and the staff confidence to support individuals with complex needs without requiring higher number of staff to observe. During quarter 4, work on reviewing SASO – both the process and practice – has identified the need for a wider review on SASO practice as a more therapeutic interaction, supported by the focused work on therapeutic activities across the service areas.

In conclusion, the year has been one of challenge and concern regarding violence and aggression and the level of acuity. Whilst there have been improvements in the number of incidents reported as noted above, the analysis and learning has informed an ambitious Annual Plan to further develop and embed a safety culture across the organisation.
This includes the embedding of TIA, the introduction of PSIRF, the review of the Making our Services Safer (MOSS) Together Strategy, the review of staff PMVA training. It also includes changes to current Safety sub committees, reporting into the Quality and Risk Management Committee (QRMC) and IGC, with revised terms of reference and co-chaired by a person with a lived experience. TIA, SASO, therapeutic activities, Positive Behavioural Support (PBS), Respect/other training will all report into the revised sub-committee.

It is important to note that this report is under review to enable greater analysis, including the use of Statistical Process Control (SPC) charts and provide the reader with a more informed understanding of the challenges and complexities in the Trust related to safety, the learning and the actions and priorities being implemented. The Quarter 1 report will reflect these changes, against the actions in the Annual Plan.

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 2022/23 and during 2022/23 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

Executive Team 3 May
QRMC 4 May
IGC 16 May 2023

Annual Integrated Safety Report incorporating Quarter 4 2022/23

1. Introduction

1.1. This Integrated Safety Report is presented to the Executive Team to provide data regarding incidents related to safety, the themes and the learning in keeping with the Quality Strategy, the Care Quality Commission (CQC) regulations, and the commitments that are set out in the Annual Plan.

1.2. This report is under review to enable greater analysis, including the use of Statistical Process Control (SPC) charts and provide the reader with a more informed understanding of the challenges and complexities in the Trust related to safety, the learning and the actions and priorities being implemented.

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.

2.2. The Trust continues to report patient (service user) 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 and staff incidents.

2.3. The number of reported incidents continued an upward trend, with an overall increase from 15,613 2021/22 to 16,236 in 2022/23 (3.99%), as detailed in *figure 1.* Incidents reported to NRLS increased by 6.62% from 5,569 to 5,938, with 1,784 reported in quarter 4, an increase of 12.7% from quarter 3.

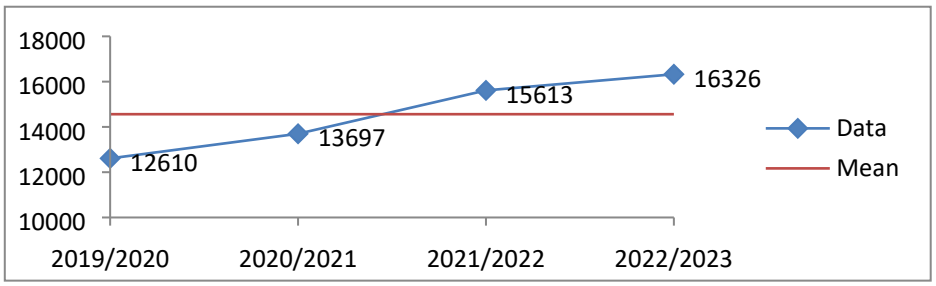
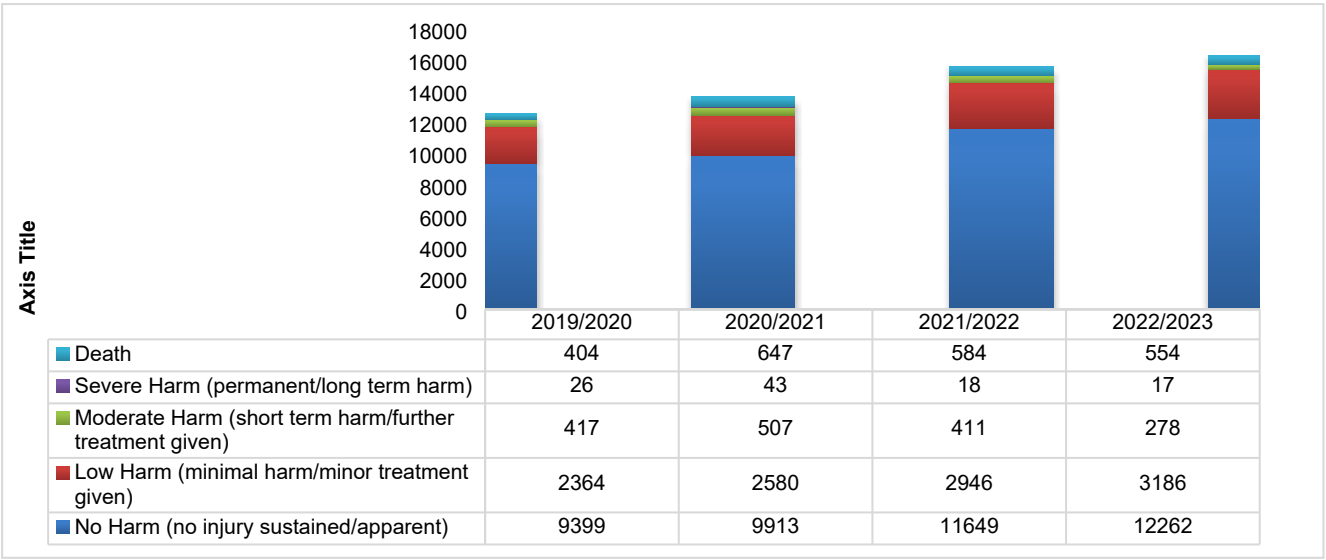


Figure 1

2.4. Incidents resulting in moderate or severe harm and death combined, decreased by 11% from 957 to 849, as detailed in *figure 2*.



	2019/2020	2020/2021	2021/2022	2022/2023
Death	404	647	584	554
Severe Harm (permanent/long term harm)	26	43	18	17
Moderate Harm (short term harm/further treatment given)	417	507	411	278
Low Harm (minimal harm/minor treatment given)	2364	2580	2946	3186
No Harm (no injury sustained/apparent)	9399	9913	11649	12262

Figure 2

3. Medicines Safety

3.1 252 medication incidents were reported in quarter 4, an increase of 0.8%, of which 233 were internal to the Trust. 229 (98%) resulted in *no harm* and four (1.7%) in *low harm*. No incidents were classified as *moderate harm*. 19 medication incidents were external and reported to the Trust, for example a medication error arising in a care home or related to GP prescribing/ community pharmacist dispensing.

3.2 As detailed in *figure 3,* administration incidents remained the top sub-category of those reported (119 incidents).

Quarter 4	E&N SBU	West SBU	LD&F SBU	Corporate	Ex-HPFT	Totals
Administration	29	48	40	0	2	**119**
Dispensing	2	4	8	0	7	**21**
Monitoring	1	6	3	0	0	**10**
Prescribing	6	15	8	0	4	**33**
Self/Carer Admin	7	12	10	0	6	**35**
Storage	4	14	15	1	0	**34**
Totals	**49**	**99**	**84**	**1**	**19**	**252**

Figure 3

3.3 *Figure 4* shows the number of medication incidents in quarter 4 remain similar to the same quarter in the previous year.

Harm severity for HPFT Medication Incidents

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
No Harm	239	119	159	210	229
Low Harm	4	2	4	6	4
Moderate Harm	0	1	1	0	0
Severe Harm	0	0	0	0	0
Total	**243**	**122**	**164**	**216**	**233**

Figure 4

4. Serious Incidents

4.1 The Trust remains committed to reduce the occurrence of avoidable harm. All incidents meeting the threshold of a Serious Incident (SI) are investigated and reviewed according to principles set out in the current framework, to ensure learning to prevent similar incidents recurring.

4.2 There were no Never Events reported during the year, which are SIs wholly preventable because guidance or safety recommendations providing strong systemic protective barriers, are available at a national level and should have been implemented by all healthcare providers.

4.3 The introduction of the new Patient Safety Incident Response Framework (PSIRF) is expected to go live in quarter 3 2023/24. The Trust is expected to establish effective systems, processes and behaviours enabling recovery from the effects of an incident and where learning and improvement are more likely to happen.

4.4 PSIRF provides guidance on how to respond to patient (service user) safety incidents with a focus on a just culture, openness and candour, engagement of families in learning from incidents, support for staff and trained investigators. These principles are in evidence within existing Trust processes and are being built on further in 2023/24.

4.5 In quarter 4, the Trust reported 23 SIs external to the Trust, as detailed in *figure 5,* of which 11 were unexpected deaths, five self–inflicted harm, three disruptive, violent or aggressive behaviour, two slips, trips or falls, one related to practice, and one related to admission discharge and transfer.

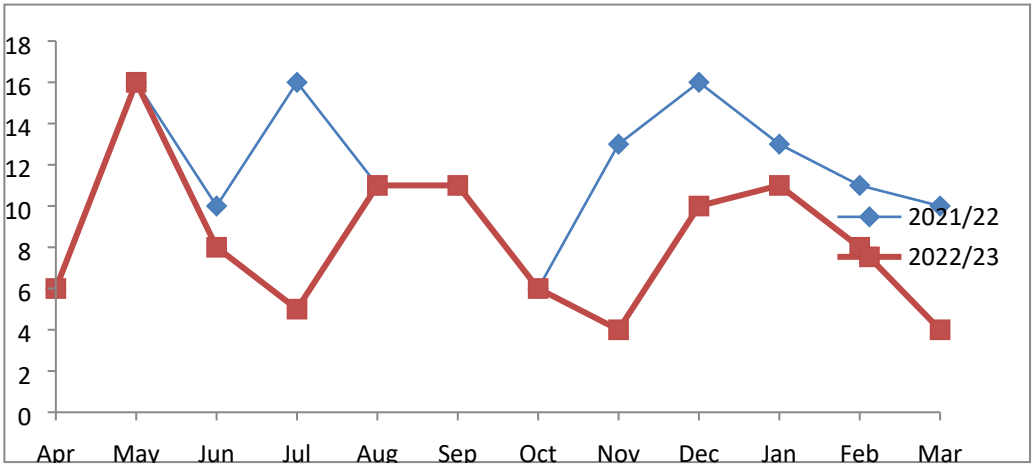


Figure 5

4.6 101 SIs were reported in the year, compared to 137 in 2021/22, as detailed in *figure 6*. The Trust's SI reports continue to 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 inform work streams in relation to bereavement support, reducing violence and aggression, falls prevention, carer support, acting on concerns, physical health monitoring, dual diagnosis, safety planning, harm minimisation, and suicide prevention.

4.7 Unexpected deaths (*figure 7*) continues to be the highest reported SI category in the year, although with a decrease of 14% from 66 to 57. The number of disruptive, aggressive or violent behaviour incidents also decreased slightly, which reflects that whilst overall incident numbers of this type have increased, those resulting in moderate harm or above has decreased.

4.8 SIs continued to be investigated using Root Cause Analysis (RCA), with all completed within the mandated 60 working day timeline and in keeping with the SI Framework. A small number of cases had extensions agreed between the Executive Director, Quality and Safety (Chief Nurse) and Commissioners, on an exception basis, for example more time to meet with bereaved families and carers.

4.9 The Trust received positive feedback from families engaged in the incident investigation, including the support offered post incident. There have also been areas where improvements could have been made, which 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.

Category	**2021/22**	**2022/23**
Unexpected or avoidable deaths	66	57
Disruptive, aggressive or violent behaviour	13	11
Apparent, actual or suspected self-inflicted harm	37	22
Slip, trip or fall	7	2
Abuse or alleged abuse of adult patient by staff	1	0
Abuse or alleged abuse of adult patient by a third party	6	0
Abuse or alleged abuse of child by a by a third party	1	0
Sub-optimal care of deteriorating patient	4	6
Apparent, actual or suspected homicide	2	1
Commissioning incident meeting SI criteria	1	0
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	0	2
TOTAL	**138**	**101**

Figure 7

4.10 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 service users, reduce the risks created by systems and practices and develop a genuine culture of patient safety.

4.11 A comprehensive virtual monthly training programme has been developed as 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 implemented across the inpatient services to enable managers to see at a glance, data relating to quality and safety within their teams and take and record appropriate actions in a timely manner.

5. Deaths

5.1 All deaths are considered in the Trust's Mortality Governance process and screened to identify whether a Structured Judgement Review (SJR) should be undertaken, completed on any death meeting red flag criteria, that is not subject to an SI. Good practice and learning themes are identified. Agreed criteria include when concerns about care are raised by family, carers or staff, a diagnosis of psychosis or eating disorder at the last episode of care, psychiatric inpatient at the time of death or discharged from inpatient care within the last month, under the Crisis Resolution and Home Treatment Team (CRHTT) at the time of death.

5.2 The Strategic Business Units (SBU) continued to hold oversight of the SJRs, cascaded to the relevant teams through the Practice Governance structures. There were no deaths in quarter 4 in which death was considered more likely than not to have resulted from problems in care delivery or service provision.

5.3 All deaths reported via the Datix incident reporting tool, continued to be screened weekly. The year saw the continual higher-than-average number of deaths, compared prior to the Covid19 pandemic, with 135 in quarter 4. All the deaths were screened, with 19 awaiting an additional screening with the Consultant psychiatrist at the time of this report. 13 SJRs were completed in quarter 4, for deaths that occurred prior to the quarter.

5.4 The 'potentially deceased' mortality dashboard on SPIKE, has aided timely recording of deaths on the electronic patient record (EPR), Datix death reporting and screening of deaths and includes deaths reported on the national spine. This has improved the timeliness of screening of deaths and updating of Trust systems, to show a person as deceased and not open to services. This has not only enabled time efficiencies, but also potentially reduced distress to family members and reduced Did Not Attends (DNA), avoiding sending letters and appointments to service users who are not previously known to be deceased. The report has been extended to improve the reporting of any deaths for the Trust's Improved Access to Psychological Therapy (IAPT) services.

5.5 There were 542 deaths (by date of death), an increase compared with pre Covid19 numbers, in the context of multiple factors, such as improved reporting. *Figure 8* shows an average rate of 45 deaths a month, with fluctuations. Of the 542 deaths, 110 were subject to further review either as an SI investigation (53) or as an SJR (57). Most deaths were due to natural causes, including deaths from Covid19.

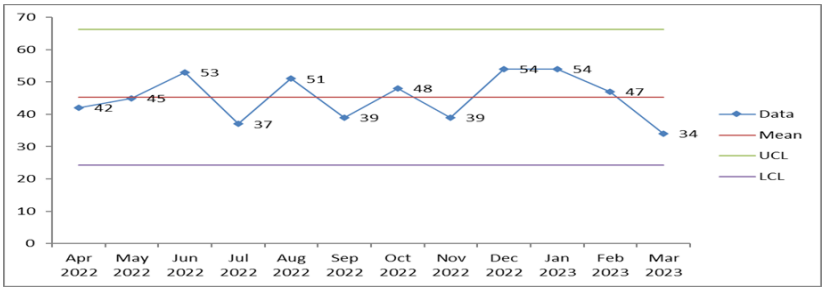


Figure 8

5.6 *Figure 9* shows that the highest numbers were in the East and North SBU, which includes older people's services. Cause of death for all deaths was not available at the time of reporting to provide a breakdown, although the majority screened were in the Expected Natural (EN1) category.

	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	Total
East and North SBU	91	77	60	73	301
Essex & IAPT SBU	13	16	5	0	34
LD&F SBU	14	10	33	33	90
West SBU	22	24	43	28	117
Total	140	127	141	134	542

Figure 9

5.7 Learning themes from the SJRs during 2022/23, included:

- Lithium monitoring, risk assessment and toxicity

- Documentation
- Handover of care (intra team)
- Mental Health Act (MHA)
- Physical Health
- Triage assessment
  Documentation surrounding death and confirmation of death
  Return from a medical ward
  Nutrition
  Recording of alerts and allergies.

5.8 Improvements made during the year from the learning included the production of a *Safe use of Lithium* guide shared with Primary Care; the Trust participating in National Lithium Audits (Prescribing Observatory for Mental Health – POMH). Local eLearning and face-to-face training content was updated to incorporate key messaging regarding Lithium monitoring and an Electronic Prescribing and Medicines Administration (ePMA) Clinical Decision Support for safe Lithium use is under development. Furthermore, Nursing and Midwifery Council (NMC) record keeping workshops were held to a number of Registered Nurses (RN) and the ePMA roll out has been driving mandatory recording of structured, comprehensive, single source of truth documentation.

5.9 There were 18 Covid19 deaths reported, all of which were in the community, with ten as confirmed cases of Covid-19. Five were in Learning Disability services, ten older people's services and three from adult community teams.

5.10 All deaths of people with a learning disability are referred by staff in the treating team to the Learning Disabilities Mortality Review (LeDeR) programme. The Trust's Deputy Director, Nursing and Partnerships is a member of the LeDeR steering group, who leads on physical health for the Trust. Recommendations from reviews are taken forward through the Physical Health Outcomes Group in the Learning Disability and Forensic SBU and the Trust's Physical Health Committee.

5.11 The Trust reported 107 deaths to the LeDeR programme in 2022/23, which will be reviewed by external professionals under the LeDeR programme and data will be reported on, once published.

6. Suicide and Suicide Prevention

6.1 The Trust continued its engagement in the work led by Public Health on improving bereavement support in Hertfordshire, and is a member of the Zero Suicide Alliance, which participates in the East of England Collaborative action learning sets, enabling sharing of innovation and best practice. There is a Support for the Bereaved by Suicide Group as part of the Suicide Prevention strategy and 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.

6.2 Funding has been agreed for a Bereavement Support Officer to work across the Integrated Care System (ICS) supporting those bereaved by suicide. During the year, CHUMS were commissioned to provide ongoing postintervention support to families, friends and professionals in Hertfordshire and West Essex (HWE) bereaved by suicide.

6.3 There were eight deaths thought to be as a result of suicide in quarter 4, as shown in *figure 10*, a decrease of ten compared to the same reporting period last year. The

number of suspected service user suicides reported is 50, 17 less than 2021/22. These figures are before the coroner has determined whether there was evidence, on the balance of probability, that deaths were as a result of suicide. To date, eight of the deaths reported have been heard at inquest, with six receiving Suicide or Open conclusions; the remaining two were concluded to have been Drug Related deaths.

6.4 The Trust will classify a death as suspected suicide until the outcome of the inquest is known; it is included in the Trust's data set and reported as an SI, subject to investigation and are followed through inquest to the outcome (*figure 11*).

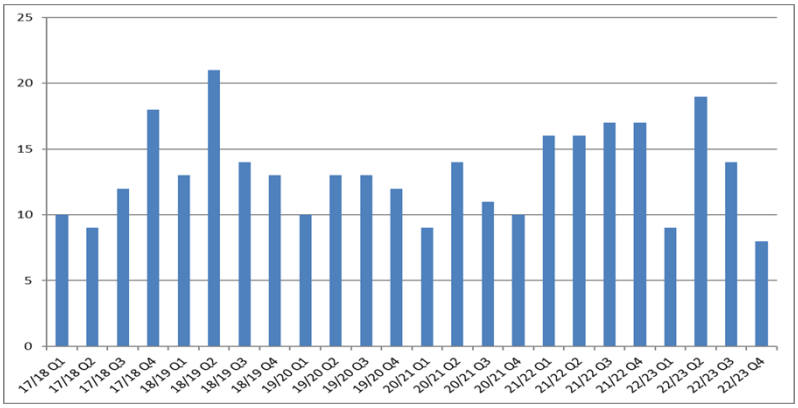


Figure 10

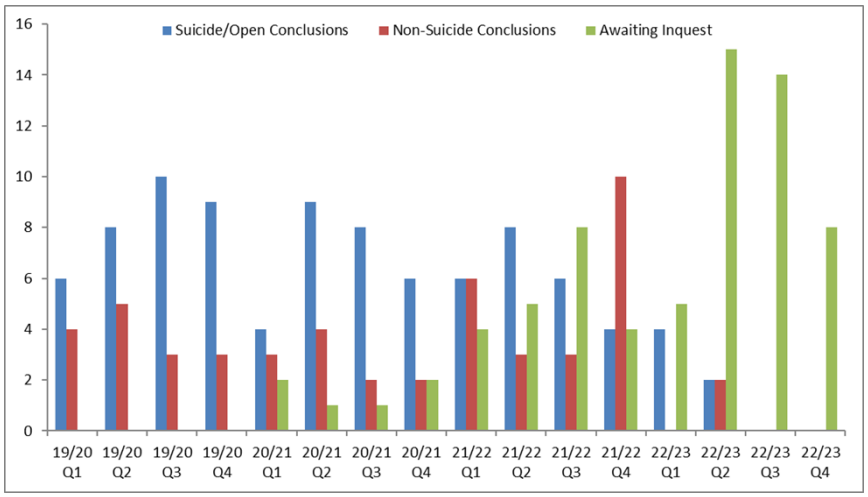


Figure 11

6.5 A deep dive of all unexpected deaths from 1 January 2022 to 31 December 2022 was undertaken in quarter 4. This highlighted evidence of Trust wide work in progress for Carer Support and Engagement, Suicide Risk Formulation, joint working with CGL and Community Transformation. It also highlighted further work on seeking assurance that learning from the Trust's SI reviews and SJRs is fully embedded and sustained across Trust services, including clearer links between learning themes, the clinical audit programme and Continuous Quality Improvement (CQI) projects.

6.6 The findings also highlighted the following key areas of focus for the Trust and other system partners:

- access to means
- suicide risk assessment and formulation
- joint working and communication with drug and alcohol services

- safety planning
- carer identification, support, and engagement
- suicide internet use
- economic adversity
- loss of contact
- service users with diagnosis of personality disorder
- inpatient admission and recent discharge from hospital being a time of risk
- service users under the age of 25
- service users who identify as LGBTQ+.

6.7 The following recommendations were made:

- To ensure continued support to service users to create a safety plan, identifying strategies to keep themselves safe. This includes access to lethal means conversations, and people to contact when they feel less in control or if they are experiencing suicidal thoughts. To also include raising awareness of the 'Stay Alive' App as part of the Simulation suicide risk training for our staff and multi-agency partners and implementation of Hertfordshire Suicide Prevention Pathway
- SBUs to implement a multi-professional process to ensure learning from SI and SJR reviews is fully embedded and sustained across services, providing assurance on learning from incidents and learning responses to the SBU Quality Risk Meetings
- To report findings to inform the development of the Trust's Patient Safety Incident Response Plan (PSIRP), as part of transition to PSIRF by 1 October 2023
- To undertake an annual thematic review of deaths by suspected suicide or those confirmed as suicide or open at inquest, to enable ongoing monitoring of emerging trends and actions taken in response
- To present the key findings of the Learning from Deep Dive Report at the Suicide Prevention Board and the Safety Committee
- To disseminate the National Confidential Inquiry into Suicide and Safety 9n Mental Health (NCISH) Executive Summary of the Annual Report 2023 and Key Clinical Messages to clinical staff within SBU governance structures, to inform discussion and clinical practice, and the ongoing programme of SBU refresher risk formulation training and the Simulation Suicide Risk training programme
- For the key findings of this Deep Dive Report and actions taken in response to learning to inform the ongoing work between CGL and the Trust, to support service users with co-existing substance misuse and mental health problems.

7. Prevention of Future Deaths Reports (PFDs)

7.1 In quarter 4, the Trust was not issued with a Regulation 28 PFD from HM Coroners. There were also no published PFDs available for dissemination from the Government website.

7.2 PFDs are shared across the Trust and with the SBU Clinical and Managing Directors for discussion at local governance meetings of the learning, as well as at the monthly learning events and the Trust's Safety Committee.

7.3 Key learning themes disseminated from published PFDs in 2022/23 were:

- Record keeping
- SI investigations
- Communication across services
- Risk assessment
- Family involvement.

8. Least restrictive care

8.1 The Trust continues with its aim to provide care to service users that is the least restrictive. Restrictive practice includes restraint, seclusion, long term segregation (LTS) and rapid tranquillisation (RT). It also includes blanket restrictions.

8.2 This year has seen a decrease in restraints from 2,331 to 2,081 (11%) in 2022/23. *Figure 12* shows the trend in reported restraint since 2017/18.

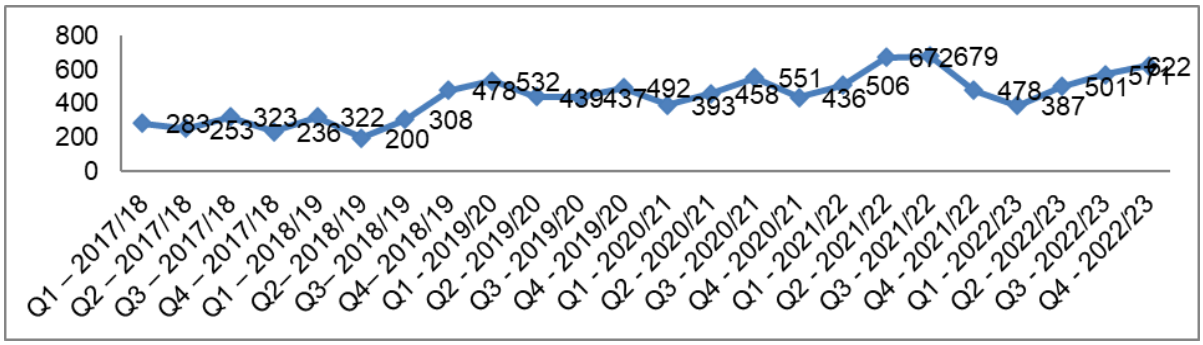


Figure 12

8.3 *Figure 13* shows an increase in the number of prone restraints from ten to 15. This is not a taught technique in the Trust, and the data includes the use by the police and incidents where the service user either fell or placed themselves into a prone position before being repositioned into a supine position. Eight of the incidents involved the same individual service user who presents as rolling/placing themselves in this position and requiring staff to reposition.

8.4 A number of the incidents are attributed to a small number of individuals who continue to present with highly complex needs in Lexden, Astley Court, Aston and Robin wards and Forest House Adolescent Unit. These increases have been further exacerbated through the lack of specialised services being available nationally and for whom, conversations have been held with the ICS for support with identifying specialised care packages.

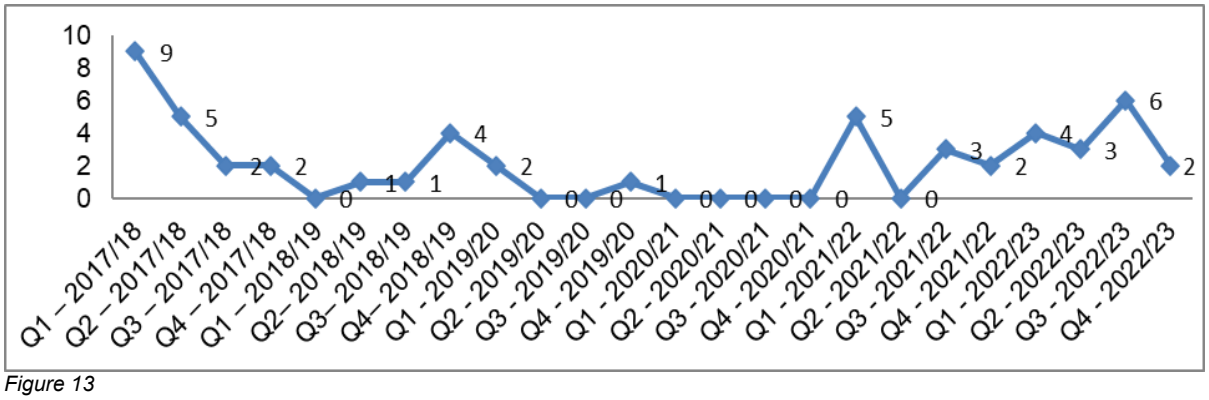


Figure 13

8.5 The use of seclusion continues to be reviewed daily and audited monthly. There has been a marginal decrease reported from the previous years (430 to 422), with 76% within the Learning Disability and Forensic SBU and a decrease within quarter 4 by 13 from quarter 3 (108 to 95), of which 70 were within the Learning Disability and Forensic SBU *(figure 14)*.

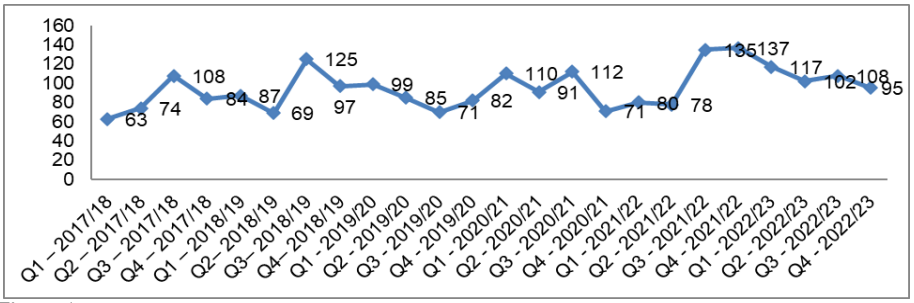


Figure 14

8.6 The mean average time spent in seclusion was 2,030 minutes (33 hours and 50 minutes), an increase of 37 minutes (1.86%) on the previous year of 1,993 minutes (33 hours 13 minutes). One individual in the forensic services was cared for in seclusion with a timeframe ranging from nine to 223,145 minutes; they were awaiting a judicial review and have since been transferred to prison.

8.7 A Task and Finish Group was commissioned to review seclusion practice in consideration of the CoP. As an outcome, support and weekly seclusion audits and reviews are held for Oak ward and a subsequent audit of seclusion highlighted significant improvements in both policy and practice. The Trust, as part of its learning from the seclusion audit, has incorporated the recording and monitoring of seclusion within the EPR.

8.8 All LTS reviews continued to take place in line with the Mental Health Act (MHA) Code of Practice (CoP), and, as part of the national approach to monitoring the use of LTS, all individual service users had a regular external Independent Care and Treatment Review. Within the year, there were nine individuals cared for under the LTS framework, with seven remaining at the years end (*Figure 15*) and two were prior to this reporting period.

Unit	Section	Start Date	End Date
Lexden	3	18 06 2021	
Warren Court	37/41	30 09 2021	30 03 2023
Robin ward	3	17 02 2022	
Astley Court	3	23 02 2022	
Dove ward	3	22 07 2022	
Swift ward	3	07 09 2022	14 11 2022
Hathor ward	3	02 09 2022	
Beech ward	3	14 09 2022	30 11 2022
Oak Ward	3	30 12 2022	
Warren Court	3	24 02 2023	27 03 2023
Beech Ward	3	27 02 2023	

Figure 15

8.9 The building of four more safety suites in the Trust ensures the provision of larger spaces, access to outside space and meaningful activities for service users requiring seclusion or LTS. The suites include separate living and sleeping areas and shower facilities, radio and TV and adjustable mood lighting.

8.10 During the year, there has been a quarter-on-quarter increase on the use of RT from quarters 1 to 3, with a slight decline in quarter 4 (*figure 16*).

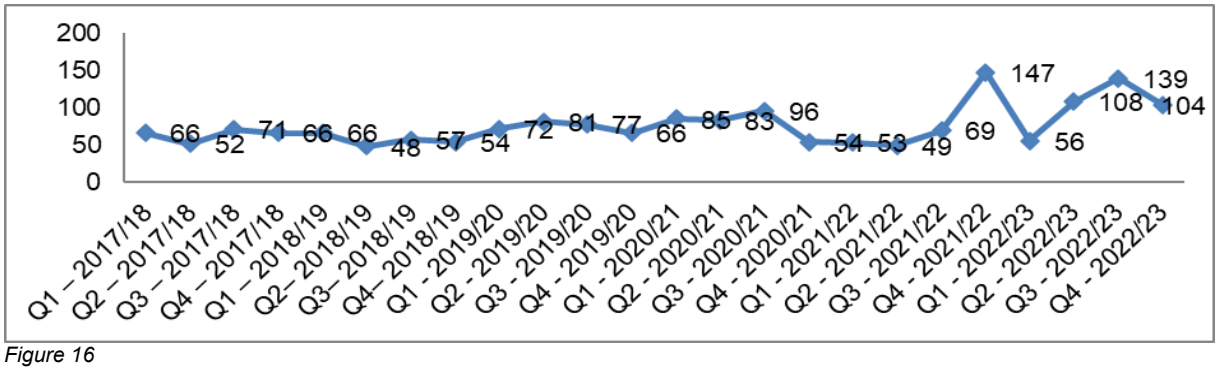


Figure 16

8.11 There is some variation in the use of RT across the SBU, owing to the use of Positive Behavioural Support (PBS) plans and pre-planned interventions within the Learning Disability and Forensic SBU. 207 of the 407 (51%) incidents within the West SBU, with 52 (13%) of these incidents relating to an individual admitted to Aston ward and awaiting external specialised placement.

8.12 The Trust pharmacy continued to monitor RT prescriptions; RT is also included in the POMH-UK audit cycle.

9. Harm free mental health care

9.1 There were 359 ligature incidents reported in the year, an increase of 307 (17%) as shown in *figure 17,* with 11 involving anchor points (*figure 18*), a decrease of two.

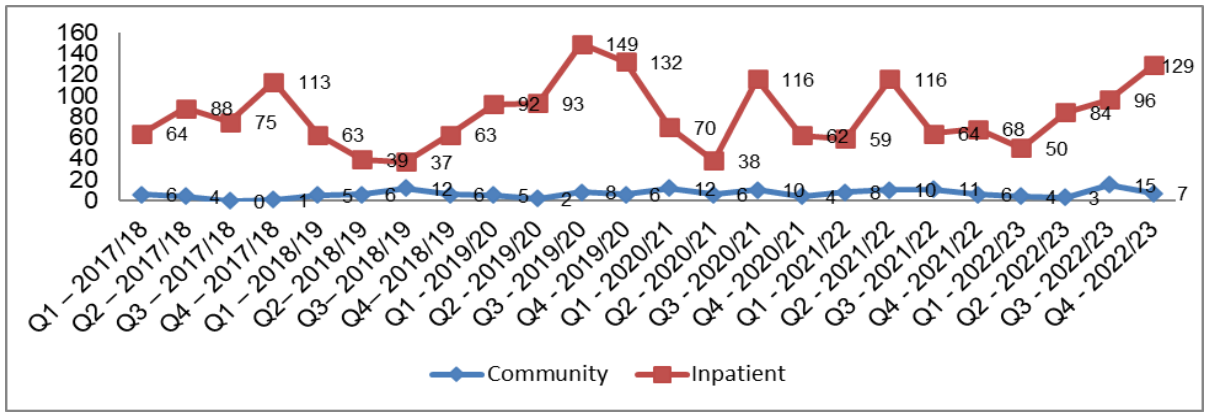


Figure 17

Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
0	3	4	4

Figure 18

9.2 Weekly ligature audits continued in the inpatient wards, monitored by the Applied New Technologies (ANT) system and, following a drop in compliance in quarter 3, improved monitoring and scrutiny has seen compliance increase above 95% in quarter 4. An alternative electronic form is being introduced allowing storage of all local walk arounds. This process is being applied to Community units on a monthly basis.

9.3 Ligature incidents using clothing remained the highest. A review of the Ligature Awareness Training took place, including additional advice of the use of ligature cutters and a new supply of ligature cutters including cordage cutters, wire cutters and cutters for sheets have been received.

9.4 ANT, the review of environmental risk has developed to improve assurance and evidence of reviews. This includes breaking the weekly audits down by SBU, so each area takes responsibility for their environment, with a lead, overseen by the Health & Safety Manager for the Trust. This did include consideration of a smart phone application for reviews, though this has been withdrawn for technical reasons and complexity at an operational level.

9.5 Work has continued to reduce self-injurious behaviours, with search training delivered. There have been incidents where service users covertly brought items onto the ward which they have then used to self-harm. A pilot for a new metal detector wand used during searches and will show an image of a metal item that has been detected.

9.6 The Trust are looking to develop a cost-effective app to assess environmental risk regarding ligatures, learning from a prosecution by the Health and Safety Executive (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.

9.7 Reported incidents of headbanging remains high in inpatient services and mirrored in other Trusts and the Trust is 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.

9.8 The quarter saw a stabilised number of AWOL and Missing Person (*figure 19*) but with an overall 24% increase reported for the year, from 127 to 158.

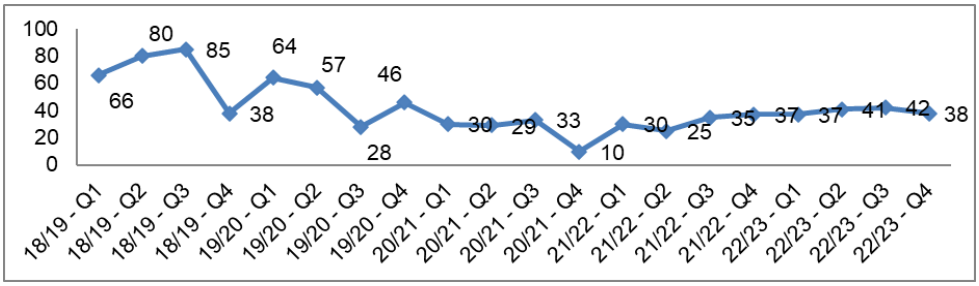


Figure 19

9.9 A commissioned AWOL Task and Finish Group, chaired by the West SBU's Clinical Director reviewed the quarter 4 data, which identified that the majority we detained service users. One resulted in death and one in Intensive Care Unit (ICU) treatment; all other incidents resulted in no harm.

9.10 A majority of the incidents were reported to the police, regardless of risk level, and occurred in acute treatment wards and rehabilitation wards, with service users who had been admitted for a long time and were on unescorted leave.

9.11 The Group continues to explore the reasons and themes, including:

- Social engagement with family/friends
- Personal needs (haircut, picking up belongings, going to a Synagogue)
- Boredom
- Use of alcohol or drugs
- Smoking
- No Paris Alert for AWOL, or specific area to highlight risk
- Section 17 leave form not attached to Paris in timely manner
- Inconsistent post AWOL review documentation and care plan.

9.12 The Group, continuing to end of May 2023, has completed a number of actions, including:

- Paris Alert in place, and Safety Alert circulated to all clinical teams
- Collaboration with the police regarding their involvement in AWOL incidents based on MHA CoP and risks
- Review of Trust policy, to include recommendation of three separate documents to support AWOL incidents:
    - AWOL of detained service users
    - Missing incidents of informal service users/Informal Leave policy
    - Managed Entry and Exit Procedure (MEEP) policy.
- Review of best practice.

9.13 The Group has identified further areas for action, including a review of the Trust's Smoking/Vaping policy and practice and for Section 17 leave forms to be care document on Paris, incorporating pre-Leave risk assessment and post leave review, including AWOL review.

10. Violence and aggression

10.1 The number of service user to staff assault incidents reported decreased in the year (*figure 20*) by 16% from 1,415 to 1,182 incidents. There was, however, an increase from 297 to 353 on quarter 4 from the Learning Disability Assessment and Treatment wards, accounting for 45% of the incidents *(figure 21)*.

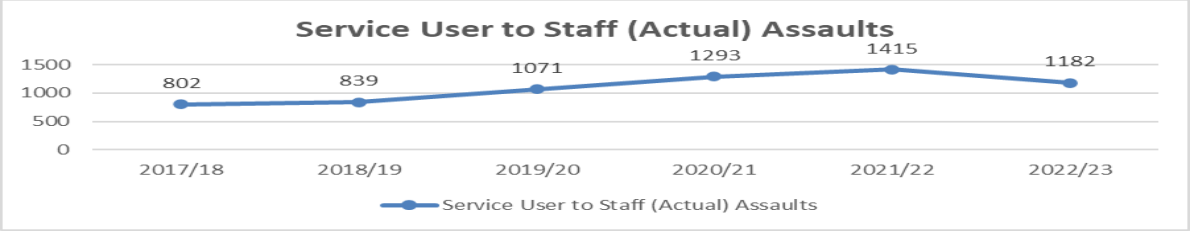


Figure 20

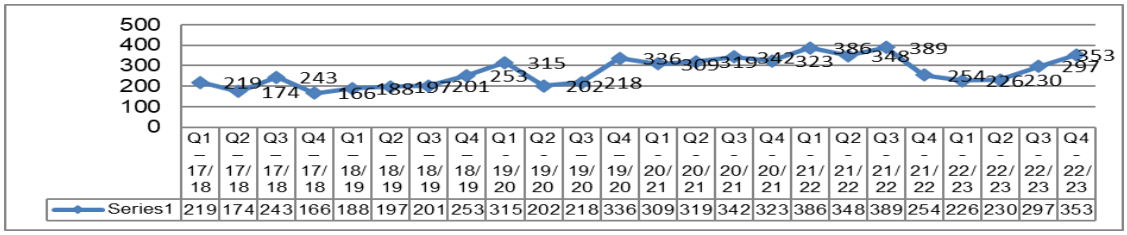


Figure 21

10.2 There were no incidents reported resulting in severe harm and those resulting in moderate harm decreased from 45 in 2021/22 to six in 2022/23 (86% decrease).

10.3 The year saw a reduction of service user to service user assaults from 428 to 365 (*figure 22)* and broken down by quarter in *figure 23.* A reduction of 48% actual assaults at moderate or severe harm was also reported from nine to four.

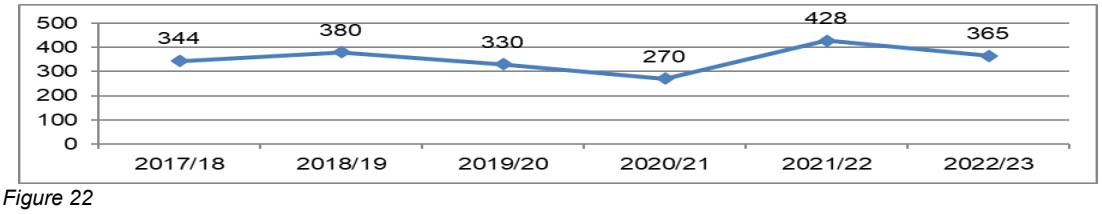


Figure 22

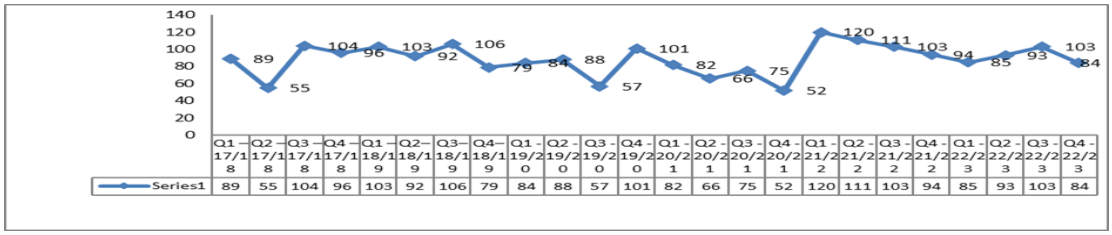


Figure 23

10.4 An ongoing multi-agency Violence and Aggression CQI project, aims to review strategies to reduce violence and aggression, including:

- Individualised activity boxes
- Increase in low stimulus areas
- Reducing Restrictive Practice Project at Astley Court
- PBS strategy for forensic services
- Revised communication training
- Relational security action plan with the police
- Increased number of safety suites and of sensory rooms
- Bitesize weekly training sessions, monthly CPD RADiANT sessions and monthly development sessions
- Healthy lifestyles project within Secure Herts services
- Increased meaningful activities with additional Activity Workers
- Equality and Diversity Recovery College course developed in response to racial abuse.

10.5 A range of posters was launched for display in inpatient and community staff, to communicate that the Trust will not accept physical, racial, or verbal abuse of staff and reminder of its values.

10.6 Trauma Informed Approaches is being introduced across service areas, noting the positive data from Robin ward.

11. Harm free physical healthcare

11.1 There have been no cases of harm from venous thromboembolism (VTE) in this reporting period. Teaching regarding Pulmonary Embolism (PE) and VTE is embedded in teaching for junior doctors and nursing staff.

11.2 There were two pressure ulcers reported in quarter 4, which were acquired whilst in the care of older people's inpatient services, a decrease from eight in quarter 3 *(figure 24).*

11.3 There were no category 3 or 4 pressure ulcers acquired and all category 2 pressure ulcers were on heels. Following the appointment of the Tissue Viability Nurse (TVN) in quarter 3, there has been education and data cleansing of reporting, with less pressure damage being described as device related and focused education for prevention and monitoring practice.

Pressure ulcers acquired in the Trust	Q1	Q2	Q3	Q4	Total
2022/2023	1	5	8	2	16
2021/2022	2	6	1	6	15
2020/2021	4	5	3	1	11
2019/2020	7	8	5	4	24

Figure 24

11.4 *Figure 25* shows the categories of pressure ulcers acquired whilst in Trust care, and *figure 26* those outside of Trust care. On analysis, there are no clear themes identified in the quarter. Moisture associated skin damage, redness in the skin or skin colour changes are being identified early and prompt referral to tissue viability for advice was adequately carried out.

11.5 Training, advice and information sharing has continued and TVN Link Practitioners upskilling commenced in quarter 4 and continues to be delivered on a monthly basis.

2022/2023	Q1	Q2	Q3	Q4	Total
Category 1 pressure ulcer		3	4		8
Category 1 Device Related Pressure Ulcer					
Category 2 pressure ulcer		1	3	1	4
Category 2 Device Related Pressure Ulcer	1	1	1	1	4
Category 3 pressure ulcer (					
Total	1	5	8	2	16

Figure 25

2022/2023	Q1	Q2	Q3	Q4	Total
Category 1 pressure ulcer	1			1	2
Category 2 pressure ulcer	1	3	2		6
Category 3 pressure ulcer					
Total	2	3	2	1	8

Figure 26

11.6 The Trust remains committed to reducing harm from falls, with work overseen by the Falls Group. The Trust is part of the ICS frailty pathway work to inform good practice and innovation around frailty and falls prevention.

11.7 The increase in falls for the year compared with 2021/22, reflects the inclusion of falls in the community; the falls in older adults' inpatient services are 6.5% lower. See *figures 27, 28* and *29.*

	2019/2020	2020/2021	2021/2022	2022/2023	Total
Acute Inpatient Psychiatry	40	57	79	83	259
CAMHS Inpatient Services	1	0	1	3	5
Elderly Inpatient Services	440	257	372	348	1,417
Hertfordshire Inpatients	14	44	23	22	103
Low Secure Services (Learning Disabilities)	18	5	5	8	36
Medium Secure Services (herts)	9	5	17	17	48
Norfolk Services	19	22	21	40	102
North Essex Inpatient Services	8	5	3	8	24
Psychiatric Intensive Care	0	1	2	3	6
Rehabilitation	24	15	14	26	79
Specialist Mother and Baby Services	2	0	0	1	3
Total	**575**	**411**	**537**	**559**	**2,082**

Figure 27

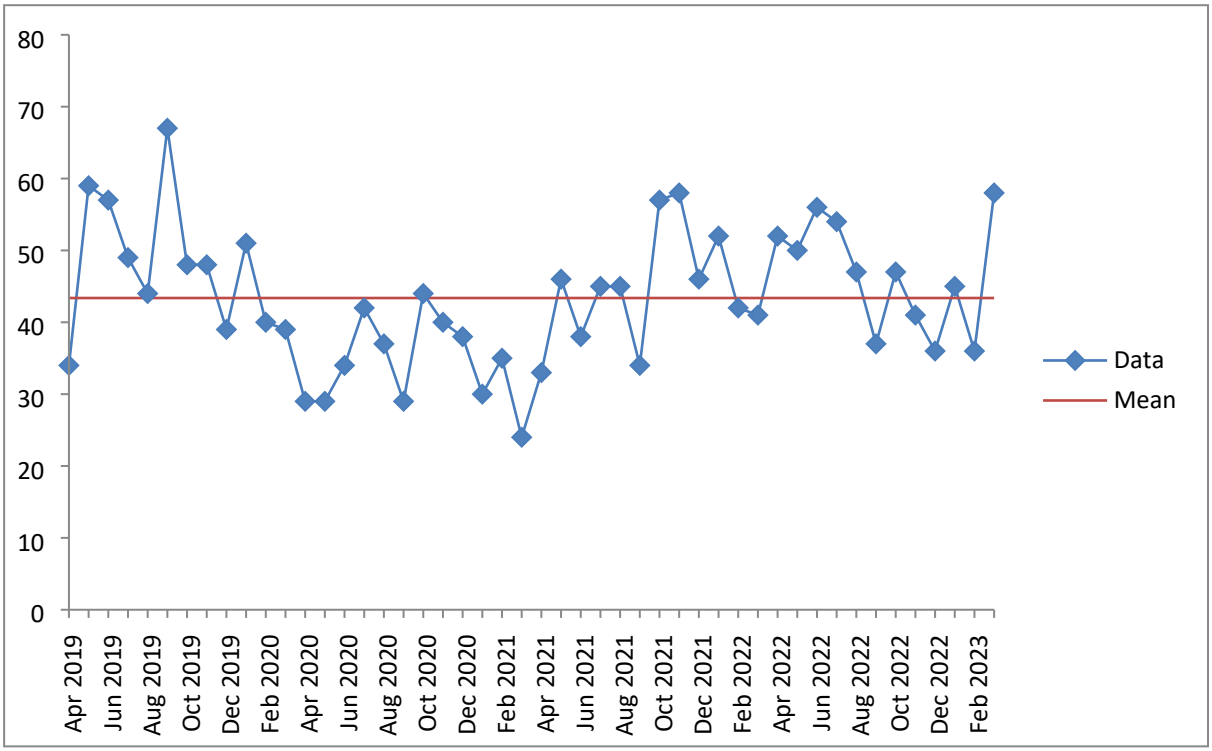


Figure 28

Trust Inpatient Falls Q4	Service user fall from bed, chair or low surface	Service user fall from height or stairs	Service user fall on same level	Service user suspected fall	Total
West SBU Planned	0	0	0	0	0
West SBU Unplanned	11	0	11	6	28
East and North	20	1	41	25	87
Learning Disability and Forensic	10	0	13	1	24

Figure 29

11.8 The Falls Committee has focused on actions aimed at decreasing slips, trips and falls by service users. CQI methodology remains the primary approach to addressing areas for improvements and this will continue into 2023/24, where the focus will be to:

- Reduce avoidable harm experienced by all service users
- Ensure our service users feel safe.

11.9 The Falls Prevention policy has been fully reviewed and updated and there is a new Paris form for the assessment of falls. The learning from falls related SIs included policy updates on sensory (hearing, visual) deficit and the emphasis on falls also affecting those under 65s as well rather than being older age related.

11.10 Six incidents were reported in quarter 4, involving urinary tract infections (UTI) and all were in the community, contributing to the cause of death of three service users, one of whom had a learning disability. UTI resulted in two admissions to hospital and one required a safeguarding referral.

12. Service Users Experience of Feeling Safe

12.1 The Trust-wide feeling safe score was 73% in quarter 4, compared to 65% in quarter 3, with an increase in responses to 124 compared from 111. For the year, the Trust-wide score was 71% (472 responses), compared to 83% (450 responses) in the previous year.

12.2 94 responses were received in the West unplanned care wards compared to 84 in the previous quarter. A focus in the ward's Mutual Help meetings aims to encourage more timely feedback and the upcoming Experience of Care Week will be an opportunity for the Experience Team to speak to service users. 30 responses were received in the Learning Disability and Forensic services compared to 26 in the previous quarter.

12.3 *Figure 30* shows the thematic emotional analysis for all comments given for Having Your Say and compliments for the last three years, showing a downward quality trend.

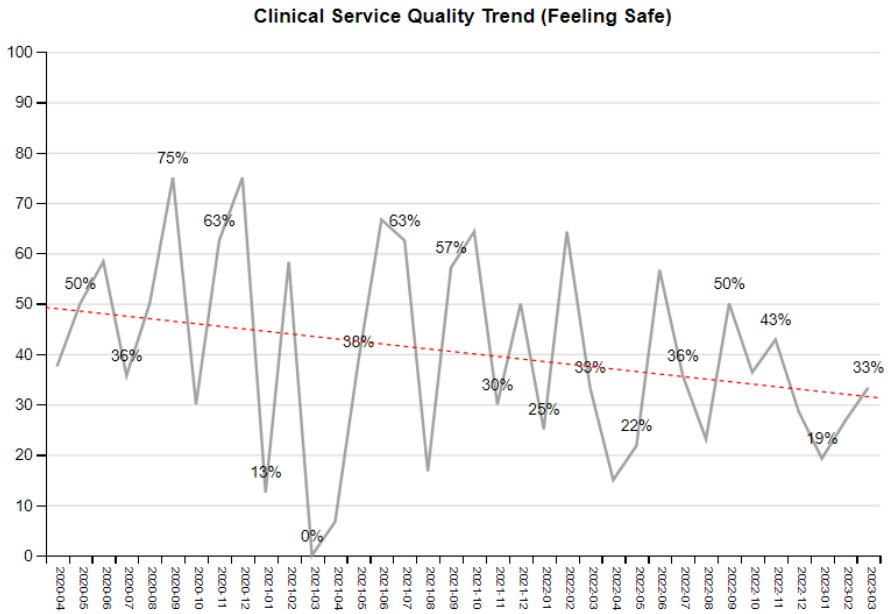


Figure 30

12.4 512 compliments were received in quarter 4, compared to 579, and 17 compliments mentioned the word “safe”. For the year, 2,134 compliments were received, 79 of which mentioned the word “safe”.

12.5 Nine complaints in the quarter (an increase from six) contained the word “safe”, “unsafe” or “safety”. Six were for planned care, two for Swift ward and one Child and Adolescent Mental Health Services (CAMHS) community. In the last year, 26 complaints were received where the words “safe”, “unsafe”, or “safety” were used, compared to 25 in the previous year.

12.6 There were no Patient Advisory and Liaison Services (PALS) enquiries recorded for the quarter, compared to 4 in quarter 3, relating to “safe”, “unsafe” or “safety”. In the last year, 24 PALS enquiries were received with the words “safe”, “unsafe”, or “safety”, compared to 16 in the previous year.

12.7 The Peer Experience Listening “Post Incident Support” project for Medium Secure Services is moving ahead to understand how supported service users were post incident. The team have worked with the Speech and Language Therapist to produce an easy read survey which can be explained to the service users prior to the interview. The Experts by Experience conducting the interviews have been given training on communicating with people with a learning disability. The virtual interviews will be scheduled in April 2023. Visits are being scheduled to take place in April after which a coproduced evaluation session will take place to draft a report.

12.8 The Experience Team are also working with older peoples’ services on the Peer Observation Project. 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. Visits are being scheduled to take place in April after which a coproduced evaluation session will take place to draft a report.

12.9 Ongoing project work to improve the experience of care includes:

- Autism/Sensory Environment Project at Forest House and an increase in support in the evenings and at weekends
- Increase in the range of activities and interventions across the adult acute inpatient services, including the gym, Tai Chi, yoga and horticultural therapy as well as psychological groupwork
- iPad for Oak ward, who have restricted access to their ‘phones and devices, for group and individual sessions, music, social integration, shopping, translation and communicating with the community team and researching own interests
- Walking group at Albany Lodge
- Trauma Informed Approach (TiA) leaflets coproduced on Robin ward with Experts by Experience
- Meaningful activities and Engagement Task and Finish Group for secure services.

12.10 The Experience Team are working with Experts by Experience on a Post Incident Support Project, trained to listen to service users in medium secure units about their experiences post incident and what support they need.

13. Central Alert System (CAS) Safety Alerts

13.1 25 CAS Alerts were received during the year, as follows:

- 1 Estates and Facilities Alerts
- 1 Field Safety Notice
- 3 Patient Safety Alerts

- 5 Medical Device Alerts
- 15 Medication / Drug Alerts.

13.2 Of the 25 alerts, the following were applicable:

- Urgent Public Health Message: Enhanced genome sequencing for hospitalised patients returning from China. Action: Alert disseminated to relevant staff
- CHT/2023/001: The NHS England Estates and Facilities Team is now accredited issuers of National Patient Safety Alerts for Estates issues
- CHT/2023/002: Provider process flow for National Patient Safety Alerts. Alert acknowledged and actioned: current HPFT policy to be updated before expiry (Sept 2023).

13.3 The following internal safety alerts have been issued in quarter 4:

- HPFT/2023/001 – Electric Profiling Bed Incident
- HPFT/2023/002 – UK Safety Pod Ultra Shield V3
- HPFT/2023/003 – Hot Water
- HPFT/2023/004 – Pen like Pop Up Blades.

13.4 In the year, the Trust received 102 safety alerts via CAS and issued 16 internal safety alerts.

14. Health, Safety and Security

14.1 The Joint Working Protocol with the police was launched and over 500 police and Trust colleagues attended launch events over a two month period.

14.2 The Police Liaison meetings have continued, and the police visited Trust services, meeting with staff to better understand the limitations of what violence and aggression incidents can be managed and improve a police response when required.

14.3 Auditing of Kingfisher Court personal alarms and pagers continues on a monthly basis, with an ongoing focus to ensure staff adhere to the Standard Operating Procedure. The contract has been renewed with Stanley for a further three years and includes CCTV coverage for car parks and communal areas within Kingfisher Court.

14.4 Phase 1 of the CCTV project is now complete at Warren Court and Albany Lodge and phase 2 is currently underway at Victoria Court, Astley Court, Dove Ward, Beech Ward and 4 Bowlers Green, with phase 3 being scoped.

14.5 The Trust received 16 new claims with Health and Safety implications over the year, an increase from 12. 12 of the new claims related to assaults by service users on staff, and four to personal accidents, in which staff members were injured. Liability has been denied in five of the claims, admissions have been made in seven, and the remaining four are under investigation.

14.6 16 Health and Safety related claims were settled during the year, at a cost of £113,762, an increase from the previous year of £40,692. The Trust successfully defended 13 of these claims. All claims are scrutinised to ensure any learning can be taken forward. Following the implementation of investigation template forms by the Trust's Health and Safety Team, claims have been investigated and settled more quickly and cost effectively.

14.7 In addition, following admission of liability in a claim received from an Interserve (former facilities management provider) employee, following a fall on a wet floor, learning was identified and followed up, ensuring the Trust's contract with its current facilities management provider, Mitie, contained an indemnity clause, in relation to actions by its employees which cause harm.

14.8 Human Resources and the Legal Services Lead meet monthly 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).

14.9 29 incidents have been reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) during the year, a decrease from 59 reported in 2021/22, equating to a 50% reduction. There have been two incidents involving two service users being injured requiring reporting under RIDDOR. 21 RIDDOR incidents have been as a result of violence and aggression towards staff, two occurred during Respect training.

14.10 There have been 68 personal accidents to staff in the year, involving moving and handling, needlestick and slips, trips and falls, an increase of 13 reported in 2021/22 (*figure 31*).

14.11 12 incidents were in relation to moving and handing, with two in quarter 4 involving the moving and handling of a service user in Inpatient services, both staff had a history of previous back pain issues. The Moving and Handling Advisor followed up all moving and handling incidents.

	Moving and handling	Needlestick injury	Slip fall or trip	Total
22/23 Q1	1	0	18	19
22/23 Q2	7	2	10	19
22/23 Q3	2	2	9	14
22/23 Q4	2	4	11	17
Total	12	8	48	68

Figure 31

14.12 The most reported themes in 2022/23 regarding security incidents were a breach of security and discovering or bringing in inappropriate items *(figure 32).*

	Breach of security entrance/exit	Broken item compromising security of building	Discovery of inappropriate item/object on a ward/unit	Inappropriate item brought onto ward by service user	Inappropriate item brought onto ward by staff	Total
22/23 Q1	24	4	12	9	3	52
22/23 Q2	23	9	27	19	4	82
22/23 Q3	13	3	18	22	2	58
22/23 Q4	15	3	12	14	6	50
Total	75	19	69	64	15	242

Figure 32

14.13 The Trust subscribed to a new version of Cardinus Plus, a Display Screen Equipment (DSE) training and assessment. 94% staff have completed their DSE training and 91% have completed their DSE risk assessment, with 595 staff are deemed 'high risk'.

14.14 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 solution with a pendant device alongside with a mobile app. The staff movement within the Trust has resulted in changes of escalation paths and the Health and Safety team updates every three months and when a request for a device is received. The team are following up the backlog of staff waiting for devices and those with devices and not using them.

14.15 NHSE provides an external fit tester for FFP3 masks and have fit tested 83% of staff with the new range of masks, with a 77% pass rate. DHSC developed a set of resilience principles and performance measures that trusts are asked to consider and implement to ensure FFP3 resilience. Tactical Command agreed to test and pass all inpatient staff on at least two masks.

14.16 The national fit test central funding ended in March 2023, and options to continue are being explored.

14.17 The Control of Substances Hazardous to Health (COSHH) training was introduced for inpatient staff in December 2022. Compliance currently sits at 13.5% (216 from 1,601) with work focused to increase compliance.

14.18 Health and Safety Audits have been completed in all inpatient wards, and two outstanding community site audits.

14.19 During quarter 4, there were 13 fire alarm activations, of which one incident has been recorded, stating attendance from the Fire Brigade occurred. There were In Q4, February 2023 there were recorded 2 unannounced Fire Drills.

14.20 Fire Risk assessments will be undertaken by a contractor, who has now been appointed.

14.21 The current Asbestos Risk register, Asbestos policy and reinspection audit are being reviewed. No issues have arisen from asbestos management surveys in the last quarter.

14.22 There have been no issues highlighted regarding water, with water sampling continues to be carried out across the Trust. As a preventative measure, service areas are required to undertake flushing of little used outlets three times weekly, recorded and then submitted to the Estates Department.

14.23 All Environment Heath Officer (EHO) visits to inpatient units have been rated at 5* for Food Hygiene and the Trust's internal Food Safety audits are up to date and conducted compliantly on a monthly/quarterly basis. The Trust and Mitie continue to work in partnership to review menu items and adjust options in line with feedback and reports received by the local food groups and patient feedback. The pictorial menus have been developed and have been distributed across the Trust's inpatient wards to support the understanding of menu options and enhance the ordering process.

15. Conclusion

15.1 The year has seen an overall increase in reported incidents, with an overall decrease by 11% of those resulting in moderate or severe harm and death and a reduction in Serious Incidents categorised as unexpected or unavoidable deaths. Serious incidents due to violence and aggression and self-harm have also reduced, as have the number of suspected service user suicides reported.

15.2 The use of restraint reduced in the year as well as a slight reduction in seclusion. The use of rapid tranquilisation saw a reduction in the last quarter after previous increases.

15.3 Whilst acuity and complexity remain high on the inpatient wards, there has been a reduction in ligature incidents involving anchor points and also in both service user to staff assaults (with the exception of Learning Disability and Forensic services) and service user to service user assaults. However, challenges with the management of AWOLs remains, and a Task and Finish Group was commissioned to identify and implement learning.

15.4 The Trust has been preparing for the implementation of the national Patient Safety Incident Response Framework and will be implementing Trauma Informed Approaches across its services, learning from the successes of the pilot on Robin ward.

15.5 2023/24 has an ambitious Annual Plan to further develop and embed a safety culture across the organisation, further developing a safety culture and to review practice relating to Making our Services Safer (MOSS) Together.

15.6 Priorities include the review of Safe and Supportive Observations (SASO), a review of the Respect training, improved and increased therapeutic engagement and activities, PBS, peer review of restrictive practice and learning from the national quality improvement programme relating to inpatient services, which the Trust's Executive Director, Quality and Safety (Chief Nurse) will co-chair the cultural working workstream.

15.7 This report is under review to enable greater analysis, including the use of Statistical Process Control (SPC) charts and provide the reader with a more informed understanding of the challenges and complexities in the Trust related to safety, the learning and the actions and priorities being implemented.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 7b
Subject:	Experience of Care Report – Quarter Four, 2022-23 and Annual Report 2022-23	**For Publication:** Yes
Authors:	Lara Harwood, Interim Deputy Head of Experience	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Sandra Brookes, Deputy CEO and Chief Operating Officer.	

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, 2022-23 and 2022-23 annual report.

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

Action required:

The Board is asked 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 2022-23 and the year 2022-23. 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.

Headlines for quarter four 2022-23

In the quarter the Trust received:

- 512 compliments (579 in quarter three)
- 2,180 surveys (Having Your Say (HYS), FFT, Attend Anywhere) - (1,923 in quarter three)
- 80% FFT Score (80% in quarter three)
- 253 PALS contacts (233 in quarter three)
- 139 complaints (149 in quarter three)
- 9% of the HPFT caseload provided feedback in quarter four (7% in quarter three)

Headlines for the year 2022-23

During the last year the Trust received:

- 2,134 compliments (2,204 in 2021-22)
- 8,283 surveys (Having Your Say (HYS), FFT, Attend Anywhere) - (3,305 in 2021-22)
- 79% FFT Score (86% in 2021-22)
- 1,028 PALS contacts (1,111 in 2021-22)
- 525 complaints (461 in 2021-22)

Key Performance Indicators

- 73% service users feeling safe on adult and CYP inpatient units in quarter four – compared to 58% in quarter three

- 71% service users know how to get support and advice at a time of crisis in quarter four – compared to 76% in quarter three
- 81% service users have been involved as much as they want to be in discussions about their care – compared to 88% in quarter three
- 81% of carers feel valued by staff as a key partner in care planning – compared to 83% in quarter three
- 42 working days was the average number of days for a complaint response for those complaints closed in quarter three (51 in quarter three).

The most significant changes when compared with the previous quarter?

Positive
- Decrease in complaints.
- Increase in service users feeling safe.
- Improvement in the number of days to respond to complaints.

Areas for improvement
- Decrease in compliments.
- Continued low numbers of feedback surveys from carers.

The most significant changes when compared with the previous year?

Positive
- 151% increase in the number of local survey responses.

Areas for improvement
- Increase in complaints
- A decrease in compliments

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.
Mandated acknowledgement of complaints within three working days.
Mandated 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:

IGC 16 May 2023

Experience of Care Report – Quarter Four 2022-23 and Annual Report 2022-23

1. Introduction

1.1 This report is bringing all feedback received by the Trust in quarter four of 2022-23 and the year 2022-23.

1.2 This includes local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during quarter four 2022-23 and the year 2022-23.

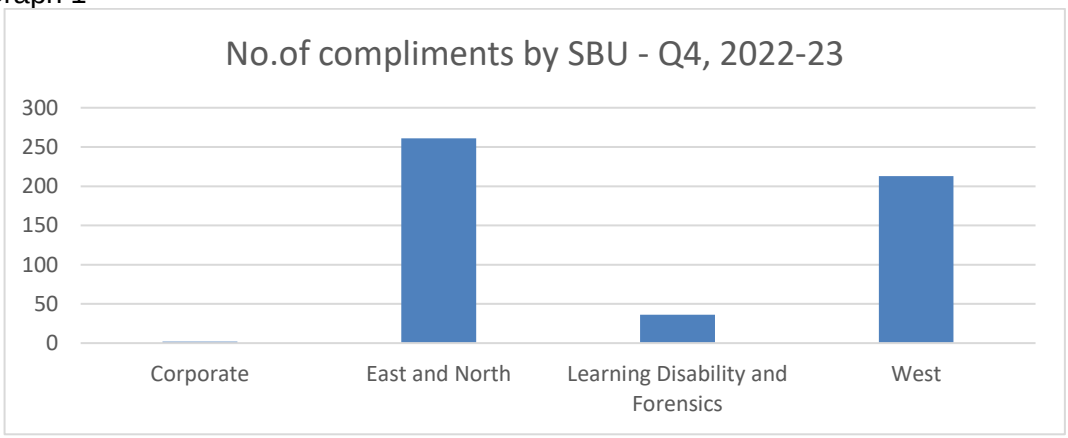
2. Compliments

2.1 In quarter four 2022-23 we received a total of 512 compliments compared to 579 in quarter three. The majority of compliments were received for CAMHS with a total of 180 compliments, and next highest numbers were for IAPT (82).

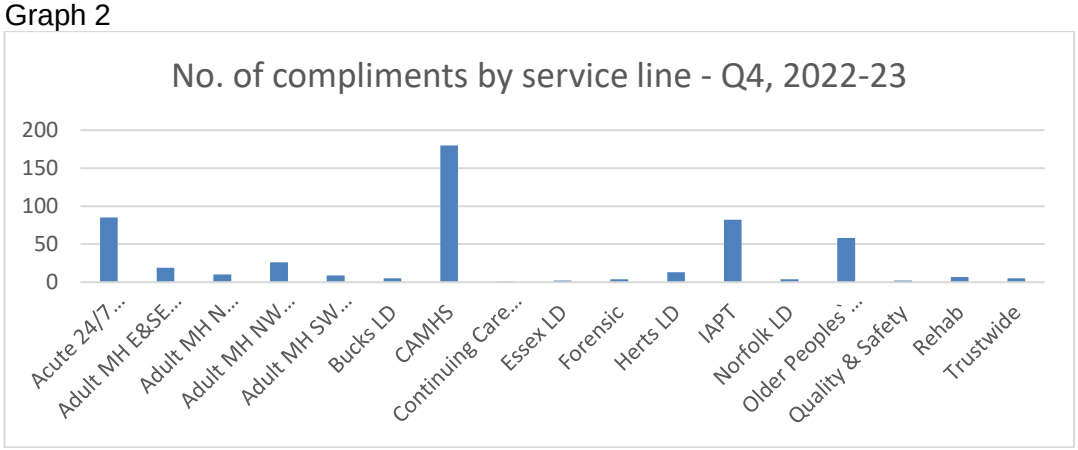
2.2 During the year we received 2,134 compliments compared to 2,204 in the previous year.

2.3 Compliments are shared with staff through The Hive and "compliment of the week" in the staff bulletin.

Graph 1



Graph 2



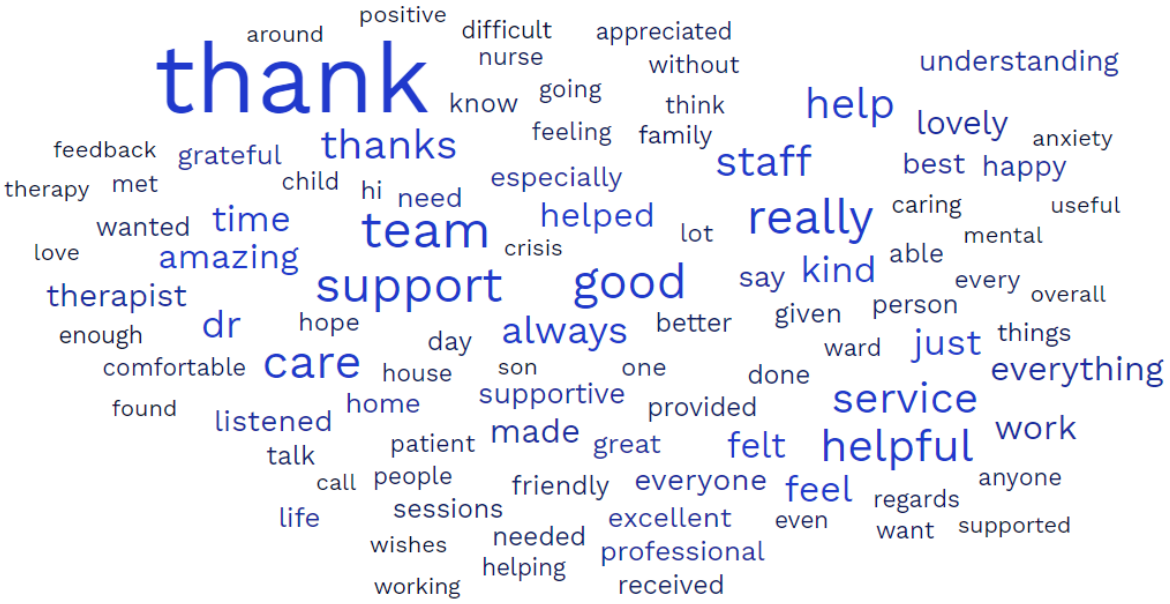
2.3 **Compliment Themes:** Words such “listening” and “support” were used frequently.

I felt so supported, comfortable, and incredibly listened to and heard. I finally felt like I really mattered… CAMHS

Just listening to me each day making me feel less in a crisis. It really has been a pleasure getting to know you all. I appreciate all the advice, tips and coping skills given, it’s been up and down but I’m good at adapting and will try to pursue a happier life.

CRHTT

Word Cloud 1

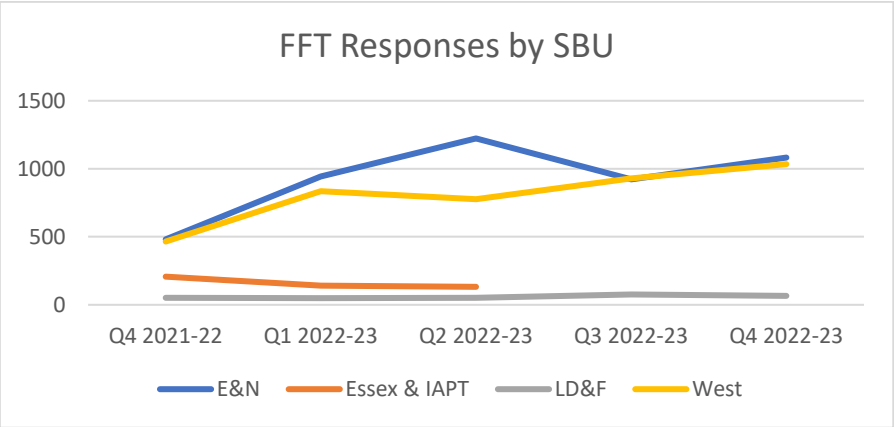


3. Surveys

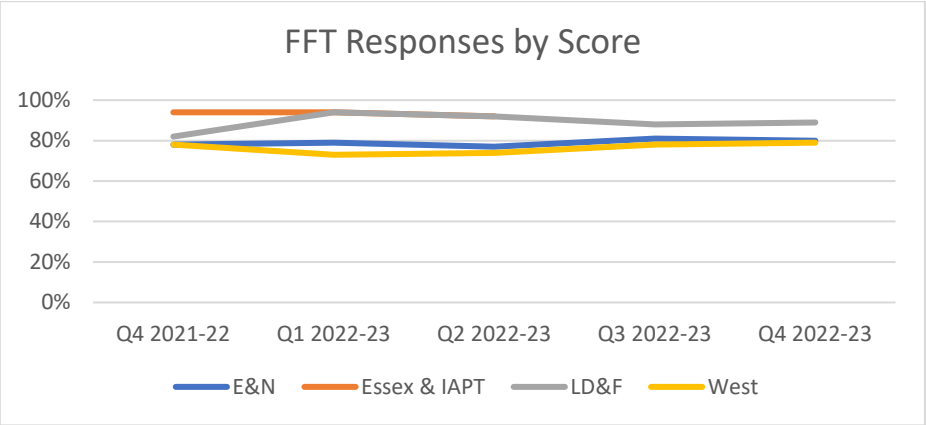
3.1 During quarter four we received 2,180 responses to local surveys compared to 1,923 in quarter three. The FFT score remained unchanged at 80%. The graphs below show the response and scores by SBU.

3.2 During the year 2022-23 we received a total of 8,283 surveys compared to 3,305 in the previous year. The FFT score was 79% compared to 86% in the previous year. The increase in responses is due to surveys being sent out by text message which began in March 2022.

Graph 3

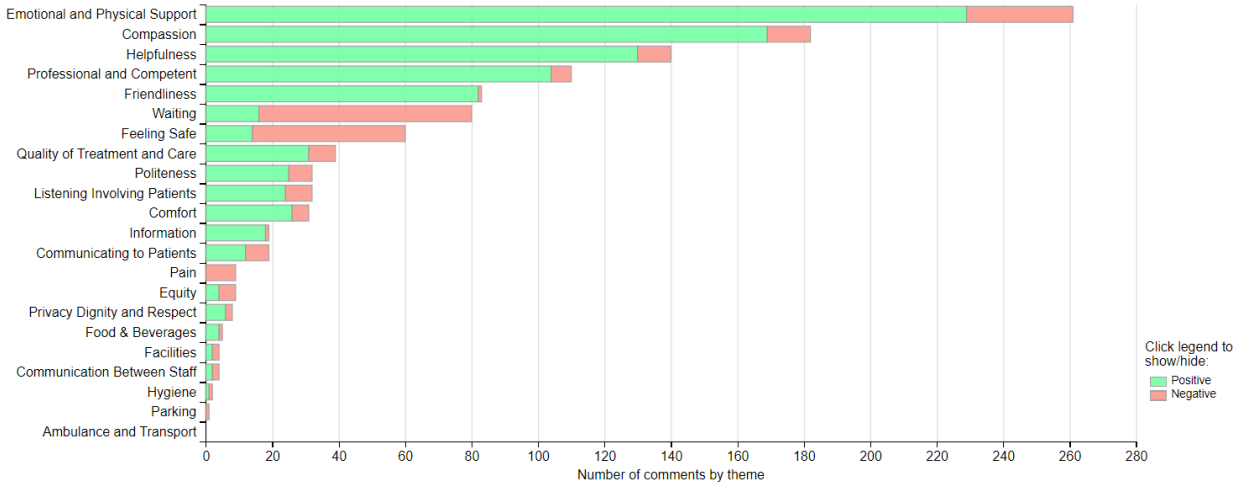


Graph 4



3.2 The majority of comments given through local surveys were positive and were categorised under the theme “Emotional and Physical Support”. The words “excellent” and “fantastic” were mentioned frequently. “Waiting” showed the highest number of negative comments alongside the theme of “Feeling Safe”. Negative comments given mentioned the words “awful”, “stressful” and “dangerous”. The diagrams below detail the themes from local surveys.

Graph 5 - all survey data



Word Cloud 2

4. Shared Experience Stories

Two service users shared their story during Q4:

4.1 One service user shared their experience of ACMHS and New Leaf College. They found it difficult to engage with ACMHS online during the pandemic and felt that their care coordinator did not establish a relationship with them. However, they found New Leaf College incredibly useful and said that the courses were very helpful and made a huge difference.

4.2 Another service user shared her journey of being an inpatient for 10 years in different hospitals in Hertfordshire, Cambridgeshire and East Sussex. They were discharged two years ago and were under EROS and then transferred to ACMHS. They shared how their care coordinator has supported them to get a direct payment so that they could buy a laptop and have a gym membership. The service user is an Expert by Experience and has been involved in trust projects and hopes to continue this.

5. Complaints and PALS

5.1 In quarter four, 2022-23 we received 139 complaints compared to 149 in quarter three. Included in this figure are 23 MP enquiries, which was a decrease compared to 34 in quarter three. There was no professional to professional complaints compared to two in the previous quarter.

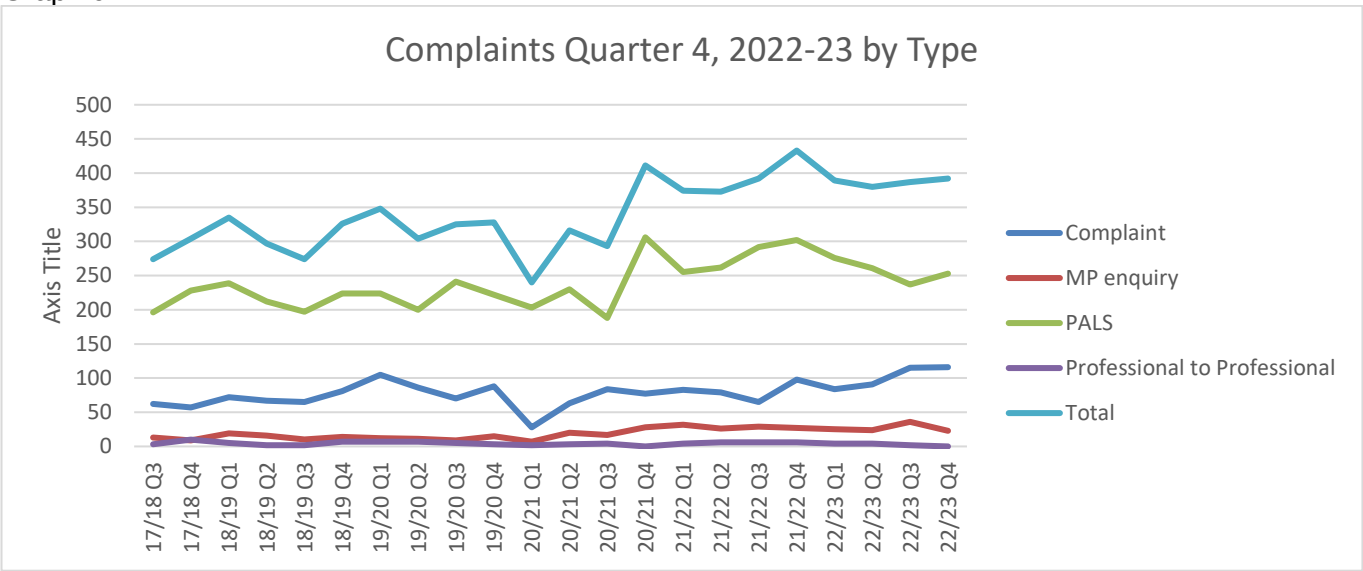
5.2 In the year 2022-23 we received 525 complaints compared to 461 in the previous year. Included in this figure were 108 MP enquiries, which compares to 114 in the previous year.

5.3 There were 253 PALS enquiries in quarter four compared to 233 in quarter three. 43 of the PALS enquiries received were not related to HPFT compared to 42 in the previous quarter.

5.3 In the year 2022-23 we received 1,028 PALS enquiries compared to 1,111.

5.4 In the quarter four 123 complaints were closed compared to 180 complaints quarter three; 8 were upheld, 37 partially upheld, 65 were not upheld, 10 were withdrawn, 3 complaints were closed as the concerns did not fall within the remit of HPFT Complaints Procedure. (Please note that complaints closed during quarter three were not necessarily received in the same quarter).

Graph 9



5.4 Appendix 1 provides detail on the complaint subjects and sub-subjects, the majority of complaints came under the themes of "care and treatment".

5.5 Key areas to highlight are that in the quarter, 55% of all complaints received were for **Adult Community Mental Health Services** (ACMHS), this is an increase compared to 50% in quarter three. Patient care was the main theme followed by communication. Complainants mentioned a lack of support, poor communication, a lack of follow up after appointments and lack of access to treatment or medication.

5.6 There was an increase in complaints from **CAMHS**. The main concerns related to access to medication. Concerns also were raised about what young people and families should do whilst they are on waiting lists.

5.7 In **Unplanned Care**, patient care and access to treatment and/or drugs were the main themes of concerns raised. Bed management saw a number of concerns raised about service users being transferred to out of county beds.

5.6 With regard to the key performance metrics for complaint management, the average number of days taken to acknowledge complaints in quarter four was three working days, it was two working days in the previous quarter. The nationally mandated target is three working days. The average number of days taken to respond to complaints that was closed in quarter four was 42 days, this compares to 51 in quarter three. This is above the new 35 working day target, prior to 1st January 2023, this target was 25 working days. The figure is calculated by looking at all complaints closed in the period and removing any that were withdrawn by the complainant, did not fall under the HPFT complaints procedures or where, due to the process being paused, the clock was stopped. It is worth noting that one of the complaints closed during quarter four was longstanding of over 100 working days.

5.7 Equality monitoring data is requested from complainants when registering a complaint. Of the 139 complaints received in quarter four, we received 8 completed equality monitoring forms. There were no complaints in quarter four that mentioned equality as a concern.

5.8 There is no updated benchmarking data available from NHS Digital, this has now moved to annual reporting.

5.9 In the quarter four, 10 complaints evaluation surveys were received. 33% of complainants found it easy to make a complaint, 78% of complainants consider their complaint to be unresolved and 43% were not happy with their final response. The team are working with the SBUs to use the action planning module on Datix to monitor actions taken, it is hoped that this will enable improved local ownership of complaints and a cycle of feedback to the complainant.

5.10 In quarter four the Parliamentary and Health Service Ombudsmen (PHSO) requested the casefiles for two complaints. One case was closed by the PHSO and was not upheld, and we were advised that one case is now moving into the investigation phase. One complaint casefile was requested by the complainant's solicitor.

5.11 Following some meetings with MPs and informal feedback from service users we are currently reviewing information provided to service users with regards to waiting times so we can provide more clarity about potential length of wait and access to support whilst waiting in line with "waiting well" initiatives.

6. Actions and Learning from Feedback

6.1 Teams are required to take local action based on the feedback received. "You said, we did" posters have now been reintroduced and teams are expected to take local ownership of their actions. The Experience team have produced an MS Teams tutorial video to guide teams to produce their own posters, this is being promoted each quarter through the Hive.

6.2 The Having Your Say (HYS) review has been completed, and work is underway to finalise a plan to confirm how feedback will be sought throughout 23/24, both on an ongoing basis and focussing on more specific aspects or services.

6.3 Following the results of the feeling safe survey, which was given to service users to complete in September 2022, SBUs are taking forward individual action plans to address the issues raised. It has been agreed that the survey will be repeated in quarter one to understand if the improvements taken are seeing an increase in service users feeling safe.

6.4 An action plan and communications plan to address the results of the national annual Community Mental Health Survey have been created. These are being monitored through monthly meetings.

7. Involvement

7 .1 There were 655 hours of involvement activity in quarter three, compared to 541 in quarter three. During the last year there has been an increase in involvement activity with the total hours being 2,498.

7.2 The Youth Council has recruited two new members and two members have moved on meaning that the membership remains at approximately eight members. There have been fewer referrals from the CAMHS teams this quarter.

7.3 The Carer Council are keen to move forward with a sub-group and conversations are ongoing with senior leaders. Work continues with the Carer Essential Training to make the training more accessible for staff.

7.4 The Service User Council have been continuing to work on the trust's website with the aim of increasing the number of people wanting to join the Council.

8. Volunteering

8.1 During Q4 the focus for volunteering has been on promoting volunteer opportunities, the trust has a total of 42 volunteers, 19 in active roles, 9 volunteers are currently going through preemployment checks and 7 volunteer roles are currently being advertised.

8.2 The team have found it challenging trying to reinstate Meet and Greet community roles and we currently have two Meet and Great volunteers.

8.3 A volunteer event was held in February with a presentation given about the Trust's strategy by the Deputy Director of Strategy and Development.

9. SBU Updates

8.1 We have seen a number of the SBUs continuing to develop more opportunities for co-production, involvement and improving service user and carer experience. Particularly of note for this quarter:

8.2 **Forest House**: During the quarter the young people have been involved in co designing the multiple garden spaces around the unit. They are also involved in the memory wall project. When our young people leave, they write their name and a message on the dining room walls which is now a mural and the young people are thinking creatively how to preserve this creation and make space for new young people. The Autism/Sensory Environment Project is focusing on the environmental challenges of the ward, and how they can be improved to create a more therapeutic ward space. The Photography Project aims to utilise the young people's skills to co-produce content for the FHAU website.

8.3 **Older Peoples' Inpatient Units**: The Experience Team are also working with older peoples' services on the Peer Observation Project. 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. Visits are being scheduled to take place in April after which a coproduced evaluation session will take place to draft a report.

8.4 **Unplanned Care**: A range of activities and interventions continue to be offered including: recreational workers to support those who struggle to engage, Occupational Activity Groups to support the individual's goals and treatment plan, physical health focused groupwork including the gym, Tai Chi, yoga, horticultural therapy, walking groups, art therapy, seated exercise groups, dance groups, and dancing and education about healthy living and drama. There are a range of psychological groupwork to allow people to explore and develop insight into their behaviour and manage their emotions. Pets as Therapy are attending the wards and New Leaf are planning to offer sessions on the wards. **Oak Ward**: have purchased an ipad which can be used with service users who have restricted access to their phones and devices. The ipad is being used for group and individual sessions, music, social integration, shopping, translation and communicating with the community team and researching own interests. A service user commented "*I feel more independent being able to contact family or care workers*". **Albany Lodge**: The walking group reported that 80% of service users who joined the group had an increase in mood after the session. **Robin Ward**: Trauma Informed Approach (TiA) leaflets have now been coproduced with Experts by Experience and given to service users as part of their care. Results show that TiA practice reduces a service user's stay on the ward by as much as 20 days. It is now being rolled out on other inpatient units. The Acute Pathway Improvement Project work continues to look at the pathway through inpatient services and the integration between inpatient and community services. Weight Management for Inpatients group is developing interventions for those at high risk of obesity and associated physical and psychological health problems. Carers Needs and Involvement Project work continues to ensure that carers are identified and that each ward has a Carer Champion. A template for welcome letters and information for carers has been agreed.

Carers Essential Training will be taking place in quarter one. A QR code has been developed for the new ward leaflets which directs carers to information on the HPFT website.

8.5 **Planned Care**: Improvements are underway to improve the running of the duty desk at **NW ACMHS** to ensure service users are contacted and given appointments in the safest way. The team are identifying the current demand for "walk-ins" and following up service users who do not attend appointments, ensuring welfare calls take place and that high risk service users are given urgent appointments. Duty desk leaflets are being coproduced. Peer Support work is starting on coproducing a job description for peer support workers and a peer support workforce implementation plan.

8.6 **LD&F**: In quarter four, Making Services Better produced a leaflet for people with asthma and participated in the development of the Trust Strategy. **Secure Services**: Dates have been set for regular carer days for carers to visit the units which had stopped during Covid. Meaningful activities and engagement task and finish group continues to ensure that service users have access to meaningful activities on the units and staff are confident to deliver this. Service users have been involved in the sensory environment project and **Warren Court** have produced a video to promote the newly opened sensory room. Collaborative risk and safety groups have started at Warren Court to promote the development of shared risk assessments and risk management plans and support greater understanding of individuals' own risks. **Broadland Clinic** have codeveloped positive behaviour support plans for service users. A conversation starter poster has been produced to support service users with social communication difficulties. A CQI project to improve the service user's understanding of physical health through the introduction of a Physical Health Library comprising easy read literature about physical health conditions. An audit has shown a huge increase in service user's understanding of their physical health needs. Post Incident Support Project: The Experience Team are working with Experts by Experience who are trained to listened to service users in medium secure units about their experiences post incident and what support they need. **Carers**: Rehab have completed their collaborative review of their Carers Charter which they are now launching. Secure services are now working on their own Carers Charter.

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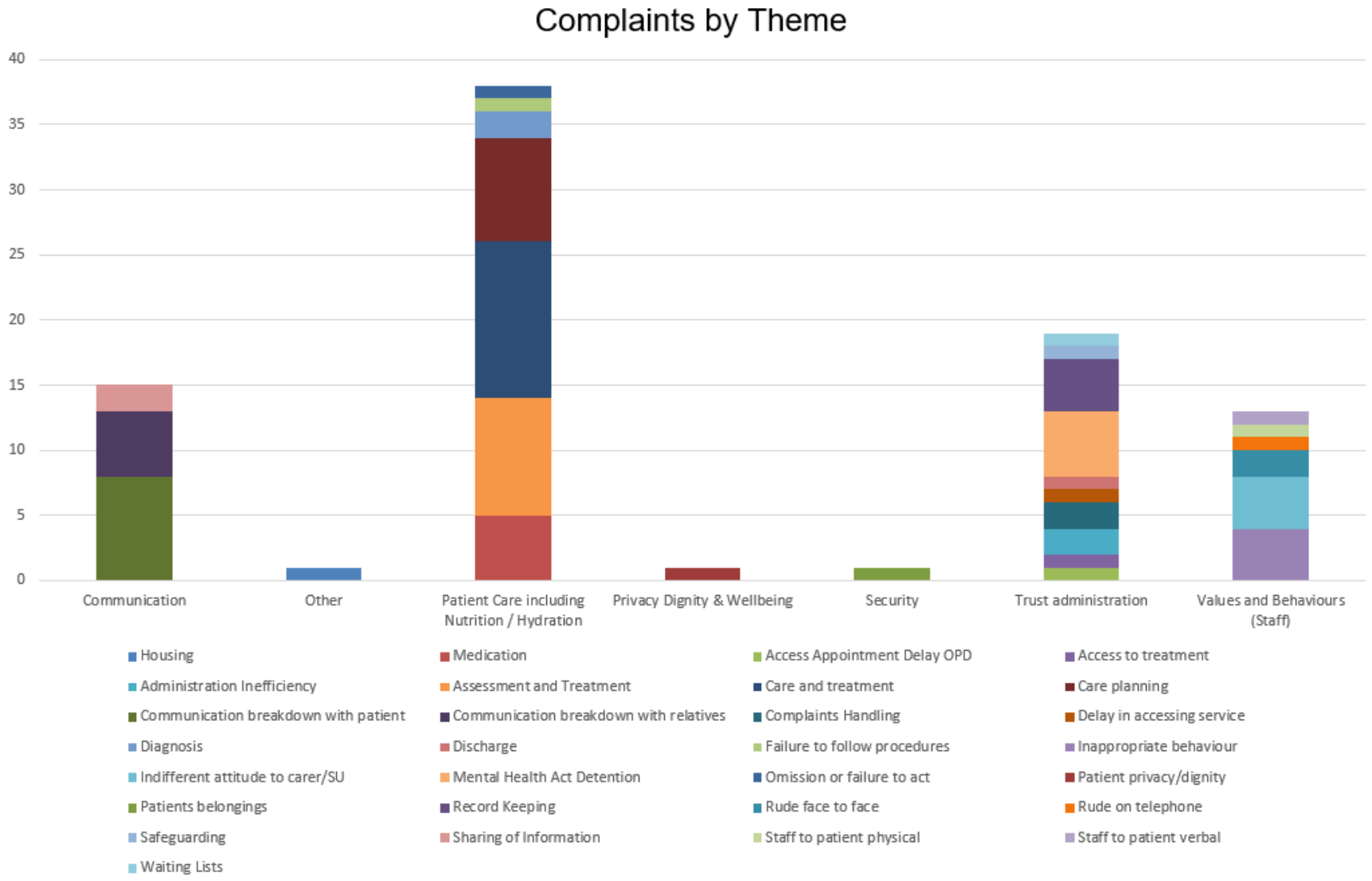
Appendix 1 – Complaints Themes



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PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 7c
Subject:	Annual Freedom to Speak Up Report (2022/23)	**For Publication:** Yes
Authors:	Yusuf Aumeerally Freedom to Speak Up Guardian	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

To provide the Board with the Annual Freedom to Speak Up Report (2022/23)

Action required:

RECEIVE

Summary and recommendations:

The report is presented to the Board so that they are aware of information related to the freedom to speak up cases brought to the FtSUG in 2022/23; it includes the quarter 4 data.

Summary of Cases

There were 133 speak up cases brought to the Freedom to Speak Up Guardian in 2022/23. This is the most speak up cases received by the FtSUG since its birth in 2016. Last year the FtSUG received 65 cases (2021/22) and 35 were received in 2020/21.
The majority of the cases included an element of worker safety or wellbeing (111), and the majority of the cases were brought to the FtSUG by administrative and clerical workers.

Priorities

- *To continue to promote the Trust's FtSUG role Trust wide.*
- *To provide information about FtSU and how to contact the FtSUG.*
- *The FtSUG to attend workplace sites and also attend relevant meetings in order to continue to promote speaking up*
- *To continue to promote a speak up culture.*
- *To continue to improve the robustness and clarity of the internal FtSU processes.*
- *To continue to participate in the Regional FtSU Network meetings.*
- *To continue to report the required data to the National Guardian's Office (NGO).*

Conclusion

The FtSUG has been in the role full time since the 16th May 2022. This is the first time the Trust has employed a full time FtSUG. Since this time there has been a marked increase in FtSU matters being brought to the FtSUG. The National Guardian Office (NGO) also report an increase nationally of speak up cases being brought to the FtSUG year on year.
The report highlights that out of the 133 cases brought to the FtSUG, the majority (111) of these involved an element of worker safety or wellbeing. Although the FtSUG works closely with the Patient Safety Specialist and Health and Wellbeing Lead, there is more work required from the organisation in order to address this matter.

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

as One

Our Values
Welcoming Kind Positive Respectful Professional

The Freedom to Speak Up process can impact on all the points raised below within 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
4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care
6. We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

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

A full time FtSUG has been appointed in May 2022, and this has a financial and staffing implication. We have 29 trained FtSU champions who work across the organisation 21 of whom are active in their role. These workers are in different roles/positions and are of different seniority. The role will have an impact on staffing. This role is in addition to the existing role of the member of staff. The Trust support champions having protected time to complete their role. The impact the champion role has to the individual's full time substantive role will be regularly reviewed by the Trust.

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

Anyone who works in NHS healthcare can speak up. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

There is literature which highlights that specific groups of individuals experience difficulties/barriers to speaking up. This includes news starters, students, and staff of a BAME background. The Trust participated in research commissioned by the NGO which looked at people's experiences of accessing their Freedom to Speak Up Guardian and whether ethnicity had an impact. The research paper is called 'Difference matters: The impact of ethnicity on speaking up' (2021).

The research 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 BAME background which might be a contributing factor to the increased number of speak up matters being received by him. We have recruited a diverse group of champions which will hopefully break down barriers and encourage staff to speak up.

The FtSUG works with the staff network groups within the organisation to strengthen the speak up culture. The FtSUG attends student forums, work areas, and will be completing workshops at the Big Discussion. The FtSUG now presents to HPFT new starters at the corporate induction.

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

A new national FtSU policy has been published. This has been personalised by HPFT, it has now been ratified and is available to all staff via the Hive.

Seen by the following committee(s) on date:

NHS Hertfordshire Partnership University NHS Foundation Trust

Executive Summary
Annual report 2022/23

1. Introduction

1.1 This is an annual report (which includes quarter 4 data) on Freedom to Speak Up. The report focuses on speak up cases received by the Freedom to Speak Up Guardian (FtSUG) in 2022/23. The FtSUG role was created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015). Sir Robert found that the culture within the NHS did not always encourage or support workers to speak up, and as a result patients and workers suffered.

1.2 Here at Hertfordshire Partnership University NHS Foundation Trust (the Trust), the FtSUG role used to be attached onto an existing role of a member of staff within the Trust. The member of staff was usually senior within the organisation. Given the increased amount of speak up cases being received by the FtSUG since 2020, the Trust decided to create a substantive role. Following a competitive recruitment process, a substantive and full-time post of FtSUG commenced in May 2022.

2 Freedom to Speak Up Governance Processes

2.1 The FtSU process ensures the confidentiality of those speaking up, 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 speak up matters can be robustly investigated and support can also be more easily provided to the individual. There is a high level of confidentiality, with only the FtSUG having access to the speak up email inbox, and also the database (specific part of Datix) which holds the information of the individual speaking up and details of the speak up matter.

2.2 A FtSU Advisory Group meets on a three-weekly basis. This group consists of the FtSUG, Patient Safety Specialist, and the Deputy Director of People & Organisational Development. The FtSUG can bring appropriate cases confidentially to the group to obtain advice about how best to seek resolution.

2.3 The FtSUG reports to the Integrated Governance Committee (IGC). The Trust has an identified Executive and Non-Executive Board member championing FtSU.

2.4 The Trust submits FtSU data to the National Guardian's Office quarterly.

3 Speak Up Cases- Trends and Themes

3.1 There were 133 Freedom to Speak Up cases received by the FtSUG in 2022/23. This is the most speak up cases brought to the FtSUG since the role began. Last year the FtSUG received 65 cases (2021/22) and 35 were received in 2020/21. The increase in speak up cases brought to the FtSUG may have been impacted by the following:

- The FtSUG is now full time within the role and has raised the profile of the FtSUG and the FtSU process across the organisation. They have worked with the communications department to raise the profile
- The Trust has trained FtSU Champions across the organisation
- The FtSUG is of a Black Asian Minority Ethnic (BAME) background and the research the Trust were involved in last year published by the National Guardians Office (NGO) 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 diversity of the FtSU Champions may have also impacted on the speak up cases being received by the FtSUG
- October was FtSU month and there were communications throughout the month. This included videos completed by the Trust's Chief Executive, Chief Nurse and Non-Executive Director for FtSU and many more staff showing their support of speaking up. The NGO usually reports an increase in speak up cases during speak up month.

3.2 This above list is not exhaustive, and the NGO report a steadily increased amount of FtSU cases being received to the FtSUG since 2017. The data of FtSU cases being brought to the FtSUG from quarter 2021/22 until quarter 4 2022/23 can be seen in *figure 1.*

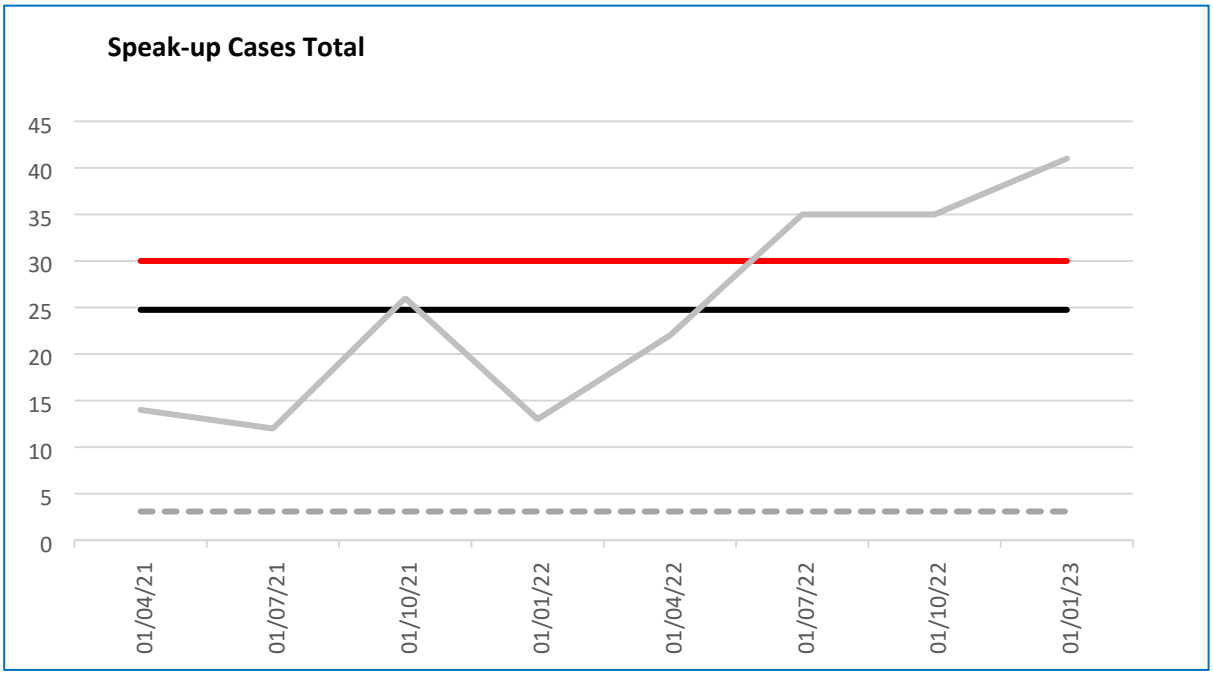


Figure 1

4. Anonymous cases

4.1 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'. Seven cases in 2021/22 were raised anonymously, compared to six in 2022/23, which may indicate that workers feel more able to share their identity when speaking up. Of note, none of the speak up cases brought to the FtSUG were anonymous in quarter 4 2022/23.

5. Detriment

5.1 The issue of detriment is one that is taken seriously. No member of staff should experience disadvantageous and/or demeaning treatment as a result of speaking up. The culture of speaking up continues to be strengthened within the Trust and the risk of experiencing detriment can influence the decision making of a member of staff not to speak up.

5.2 Of the 65 cases raised in 2021/22, five workers reported experiencing detriment as a consequence. Of the 133 cases brought to the FtSUG in 2022/23, 19 are still open/ongoing. Of the closed cases, one person reported experiencing detriment as a consequence of speaking up.

6. Themes

6.1 All speak up cases are recorded on Datix and categorised by theme, in accordance with the NGO. It is worth noting that the categories do not always reflect the nuance of the speak up matter.

6.2 There are four main categories:

- an element of service user safety/quality
- an element of worker safety or wellbeing
- an element of bullying or harassment
- an element of other inappropriate attitudes or behaviours.

6.3 Some speak up matters have more than one of the above elements included and has been recorded as such in accordance with the NGO guidance. *Figure 2* highlights the amount of speak up cases received in 2022/23, and also the categories in which the speak up cases relate to.

	2022/23
Total number of cases in Quarter	133
Number of cases raised anonymously	6
Number of cases with an element of service user safety/quality	73
Number of cases with an element of worker safety or wellbeing	111
Number of cases with an element of bullying/harassment	40
Number of cases with an element of other inappropriate attitudes or behaviours	**71**

Number of cases where people indicate that they are suffering detriment as a result of speaking up	6

Figure 2

6.4 The majority of the cases (111) included an element of worker safety or wellbeing. The FtSUG works closely with the Patient Safety Specialist and Health and Wellbeing Lead, to continue to work on this matter.

7. Learning from speak up cases

7.1 Some of the learning from speak up cases includes learning around:

- challenges with contacting newly referred service users
- reminder of the Trust values
- safe and supportive observation practice
- escalating complaints
- scheduling service user appointments
- informing line managers about HR processes
- responding to violence and aggression
- ensuring timely SWARMS with maximum attendance
- training provision for new staff.

7.2 The FtSUG is in the process of ensuring that learning from each case is captured and shared throughout the Trust. The FtSUG is part of the Action Review and Learning Group which aims to ensure learning identified by the Trust is shared throughout the organisation.

8. Feedback

8.1 Of the 114 cases closed from 2022/23, 20 workers provided feedback. 16 said that they would speak up again. Three did not answer the feedback questions, and one said that they would speak up again as there had been no resolution. This is positive and the FtSUG will continue to review how best to obtain feedback from workers for the purpose of learning.

8.2 Below is some of the feedback staff gave:

- *I felt that my concerns were taken seriously and urgently acted upon. I can see that actions have been implemented in response*
- *I was very relieved after speaking to the Freedom to Speak Up Guardian that the correct procedures were being following by my managers regarding my complaint; I was having doubts as to whether my complaint was being ignored and that nothing would come of it*
- *There is a lot of issues that I know will be rectified if staff speak up*
- *Actioning by the Freedom to Speak Up Guardian was speedy and efficient. He followed up on the case and did not stop until he has spoken to the individuals involved*

- *Thank you for your support in looking into this matter. This avenue is now staff like us feel valued and listened to*
- *Thanks for your support the other day. I have spoken to x and we are going to review the x reporting process and it would be great to have you on board with this piece of work*
- *I would speak up again and I have also found myself signposting and advocating to others about the freedom to speak up process and the importance of raising issues and also the importance of having a centralised place to log concerns even if matters are not taken further. In my particular situation there have been no disadvantages to raising any concerns, however from a learning and reflective standpoint talking to the Speak up Guardian has highlighted that we have some gaps within our x reporting process that we need to review*
- *Discussing my situation with someone confidentially has helped to seek more help.*

8.3 *Figure 3* highlights the professional/worker groups the speak up cases came from.

Professional/Worker Group	Definition	Number
Additional clinical services	• Staff directly supporting those in clinical roles. In addition, support to nursing, allied health professionals and other scientific staff are included • Have significant patient contact as part of their role	28
Additional professional scientific and technical	• Scientific staff, including registered pharmacists, psychologists, social workers, and other roles such as technicians and psychological therapists	20
Administrative and clerical	• Non-clinical staff, including non-clinical managers, administration officers, executive board members who do not have significant patient contact as part of their role	35
Allied health professionals	• Registered clinical staff providing diagnostic, technical and therapeutic patient care, including dieticians, radiographers and physiotherapists. • Includes qualified ambulance staff such as paramedics	4
Estates and ancillary	• Non-clinical support and maintenance staff, including gardeners, plumbers, cooks and housekeepers who do not have significant patient contact as part of their role	3
Medical and dental	• Registered doctors and dentists	2
Nursing and midwifery registered	• Registered nurses and midwives	33

Students	• Directly employed staff undertaking formal education, including student nurses and midwives	3
Not known	• This can include an instance when a person has not disclosed their professional/worker group to you or anonymous cases	5

Figure 3

8.4 The NGO has not yet released the data the national annual report and therefore the author cannot compare this data with the data held by the Trust. What the NGO usually reports are the highest percentage of speak up cases are from nursing and midwifery registered staff. Our data shows that the highest reporters were from administrative and clerical workers.

9. Method of Speaking Up

9.1 The Trust has a number of mechanisms by which someone can speak up to the FtSUG. They can do so by emailing the speak up account (hpft.speakup@nhs.net), calling the FtSUG directly, leaving a voice message on the 24 hour hotline, and by completing a Datix form (there is a tab on the top of the Datix form allowing staff to speak up this way). Staff have the option of speaking up anonymously using any of the above methods.

9.2 The FtSU Champions can also direct staff to the FtSUG when required. At present, there is consideration for the HPFT App to be used as another way in which to speak up.

10. Priorities

10.1 The priorities for the rest of the next financial year:

- *To continue to promote the Trust's FtSUG role Trust wide.* It is important to inform new staff and also remind existing staff how they can speak up if they wish to do so. Staff need to feel that they can speak up and that there is a culture within the Trust to do so. People speaking up can enable change, reduce risk to staff, service users and carers. The FtSUG is now presenting to new starters at the Trust's corporate induction session. A market stall is also being held at the induction day. Arrangements are being made for the FtSUG to also provide training as part of the Management Fundamentals programme

- *To provide information about FtSU and how to contact the FtSUG*. October was FtSU month and during the month a lot of communication has gone out to staff, and this includes the different ways in which staff can speak up. New FtSUG posters have been produced and all areas have been asked to clearly display these in staff only areas. Champion posters have also been produced and are being displayed in staff only areas within the specific area where the champion works. At present, there is consideration for the HPFT App to be used as another way in which to speak up

- *The FtSUG to attend workplace sites and also attend relevant meetings in order to continue to promote speaking up.* The FtSUG continues to attend different sites across the organisation to talk about speaking up

- *To continue to promote a speak up culture.* The Trust Staff Survey Benchmark report 2022 highlighted the following in relation to speaking up:
  70.7% of staff who completed the survey felt safe to speak up, which is above average (67%) and above what is recorded in the NHS Staff Survey 2022 National results briefing (61%). It is concerning to see that, whilst a high percentage of staff feel able to speak up, only 69% felt confident that the Trust would address the concerns raised. We all have a responsibility when speaking up, whether that is being brave to speak up, or follow up when receiving a speak up matter.
  The e-learning Freedom to Speak Up in Healthcare in England programme highlights everyone's responsibilities. All staff have been asked to complete the training and the FtSUG recently emailed the senior leadership team asking them to

  complete the training to set the tone of what is expected within the organisation. Champions have also been recruited and this supports the speak up culture

- *To continue to improve the robustness and clarity of the internal FtSU processes.* This will further enable the Trust to respond effectively to speak up matters raised. A new FtSU policy has been ratified and is available via the Hive. This includes a process map highlighting 'what will happen when I speak up'. Processing and closing speak up matters help improve the speak up culture within the organisation. There is ongoing work for the FtSUG to complete with the Trust to ensure that speak up matters brought to the FtSUG are resolved within an appropriate timeframe. The FtSUG is now starting to record how long cases take to close and will report this to the QRMC and IGC

- *To continue to participate in the Regional FtSU Network meetings.* This will help ensure the FtSUG is kept up to date with any relevant information related to speak up. This information can then be shared within the Trust. Information about trends and themes regionally can also be captured and shared within the Trust so that appropriate action is taken

- *To continue to report the required data to the NGO.* The NGO highlights that the data contributes to learning and improvement – not just for the organisation – but also for other Freedom to Speak Up Guardians and the healthcare system more widely. The information shared also provides essential insight into the implementation and use of the Freedom to Speak Up Guardian role. The FtSUG recently presented deep dive information to IGC about FtSU and compared the Trust data to that within the annual report completed by the NGO (2021/22).

11. Conclusion

11.1 The FtSUG has been in the role full time since 16t May 2022. This is the first time the Trust has employed a full time FtSUG. Since this time there has been a marked increase in FtSU matters being brought to the FtSUG. There were 133 speak up cases brought to the Freedom to Speak Up Guardian in 2022/23. This is the most speak up cases received by the FtSUG since its birth in 2016. Last year the FtSUG received 65 cases (2021/22) and 35 were received in 2020/21.

11.2 Of the 133 cases brought to the FTSUG in 2022/23, 19 are still ongoing. Three cases received before this with the oldest open speak up matter dated April 2021.

11.3 The majority of the cases included an element of worker safety or wellbeing (111). Although the FtSUG works closely with the Patient Safety Specialist and Health and Wellbeing Lead, there is more work required from the organisation to address this matter.

11.4 The majority of the cases were brought to the FtSUG by administrative and clerical workers. Usually, the NGO report that the majority of speak up cases come from those workers who are nursing and midwifery registered. In the Trust, nursing and midwifery registered were the second highest workers who spoke up.

11.5 The Trust Staff Survey Benchmark report 2022 further highlights the need for all workers to complete the e-learning Freedom to Speak Up in Healthcare in England programme which covers speaking up, listening up, and following up.

11.6 The FtSUG is now starting to record how long cases take to close and will report this to the QRMC and IGC. Appropriate actions should then be agreed if there are concerns about how long cases are taking to close.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS

Meeting Date:	25 May 2023	**Agenda Item: 8**
Subject:	Reviewing the Outcomes of the Service User & Carer Stories at Trust Board & Council of Governors – 2022-23	**For Publication:** Yes
Author:	Lara Harwood – Interim Deputy Head of Experience	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Sandra Brookes – Deputy Chief Executive/Chief Operating Officer	

Purpose of the report:

To review the outcomes of the Board stories at Trust Board and Governors meetings and to reflect on the stories heard over the previous year.

Action required:

The Trust Board is asked to review the Board stories programme over the last year as part of the Board's business cycle.

Summary and recommendations:

- In line with the Trust approach to service experience, as a cycle of feedback, it is important for the Board to reflect on the stories heard in the previous year.
- An annual review forms part of the Board's business cycle and features as a Board agenda item every 12 months.

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

- *Great Care, Great Outcomes* - We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy
- Great organisation - We will provide staff and teams with better access to the right information and tools to do their jobs effectively and efficiently

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

The Trust has a legal duty to involve people in services. This is one of many ways the Trust approaches this duty currently.

Equality & Diversity /Service User & Carer Involvement implications:

This strategy was co-produced; we know that 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:

N/A

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

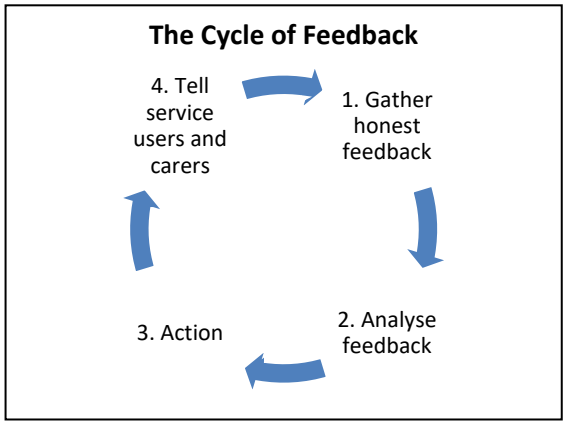
This paper has been written specifically for the Trust Board following discussion with the Director of Delivery & Service Experience.

Reviewing the Service User and Carer Stories at Trust Board and the Council of Governors

1. Background

1.1 Stories to the Board was introduced in 2015 as an opportunity for Board members to hear direct, honest experience about what has worked well for service users and carers and what improvements could be made to services. In keeping with the Trust approach to viewing service experience as a cycle, outcomes/actions are collected following each story to enable the Board to monitor how we have taken action following hearing someone's story - where needed.

1.2 As stories to Board form part of the Trust service feedback programme each year anyone who has participated in the programme, or been part of one of the meetings, is asked to give feedback on the stories programme. This ensures that we maintain the cycle of feedback, an intrinsic part of the experience approach.



2. Feedback from service users and carers

A survey was sent to all service users and carers who participated in the stories programme over the last year. We received four completed surveys.

2.1 Preparing the story

The support given by the Experience Team was welcomed by all and everyone felt fully supported throughout the experience.

"The staff member from HPFT who worked with me and my daughter made us immediately feel at ease. The room we worked in was conducive to talking about very personal matters. The staff member gave us confidence to talk freely about our story."

2.2 Presentation Day

One story sharer was grateful for the opportunity to meet in a private space where they felt able to share their story. One suggestion was to perhaps have shared some images/photographs of their journey.

The support given on the day by the Experience Team and the Board was appreciated by the story sharers.

2.3 After the meeting

Story sharers appreciated receiving feedback from members of the Board/Governors after the meeting.

"…I did receive two or three emails thanking me, the chair of the governors said she found my story inspiring."

One sharer was asked to share their story again with other professionals and another has been asked to present to the commissioners.

"The overall experience was extremely positive, and I feel will help in my recovery journey".

3. Feedback from Board members and governors

A survey was sent to all Board members and governor representatives to ask for their feedback. Four surveys were completed.

Everyone felt that the Stories to the Board programme should be continued and were a positive contribution to the Board meetings.

Comments were that the stories given by people who have a lived experience are impactful and powerful.

The story given whilst on a train journey was difficult to follow and distracting.

Staff stories linked to service user/carer stories would be welcomed.

"Hearing the stories directly from those who have experienced them is far more impactful and powerful. It also enables first hand responses to be provided."

4. Comments and suggestions

Comments and suggestions were given by those giving feedback, actions, where taken, are noted:

- Story sharers to be asked if they would like to share images, photographs (with consent) as part of their story.
- Experience Team to ensure that any offers to contact the sharer are followed up after the meeting.
- Experience Team to check just prior to the meeting, if attending virtually, that the sharer is in a quiet safe space to speak.
- Experience Team will seek stories where a service user/carer and staff experience can describe the whole experience rather than a part.

5. Updates and outcomes since the Board Stories

It will often be the case that no specific action is needed as stories mainly serve as a means to make the Board aware of the experiences of service users and carers using services whilst often providing a cathartic and recovery-relevant experience for the person sharing the story. It is often enough that the story has been heard and acknowledged. This can particularly serve as an opportunity for the Board to reflect on how services are improving.

However, where issues have been raised, the Experience team will follow-up any actions taken following the Board meeting and liaise with the service user/carer to update them.

5.1 JN – service user ACMHS SW

- Lack of face to face support options available which impacted on service user's ability to form a therapeutic relationship. Managing Director of Planned Care is meeting with the service user to discuss their experience and suggested improvements as part of the Community Mental Health Transformation Programme.

5.2 LJ and TJ – inpatient service user and carer

- Admission to out of area hospitals for a number of years that were not local to service user's family and made it difficult for them to see her in emergencies. The service user will be further sharing their story at a meeting with the ICB to help them understand the importance of local bed management.

6. Recommendations & Conclusions

6.1 It is recommended to the Board that the stories to Board programme continues in 2023/24.

6.2 All future meeting dates and times to continue to be communicated to the Experience Lead at the beginning of each year. Adequate notice (preferably at least two weeks) is given of any changes to timings, dates etc. This will help to maintain a values based approach to working with service users and carers regarding their stories. The planning for the stories will be done for the whole year and where appropriate the stories will link with items on the Board agendas and key priorities for the Trust.

6.3 The Experience Lead will continue to provide a summary of the upcoming story to the corporate team to support meeting preparation. The Deputy Chief Executive will call the sharer prior to the meeting if the sharer is in agreement with this.

6.4 The Experience and Organisational Development teams will continue to ensure the sharer is supported and will have early conversations to ensure there is a shared understanding regarding what support they should expect. The support will also cover expectations regarding the practical logistics.

6.5 The Trust will continue to develop and grow the Shared Experience Library.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 9
Subject:	Report from the Finance & Investment Committee meeting held on 18 May 2023	**For Publication:** Yes
Author:	Sandra Brookes, Deputy CEO and Chief Operating Officer	**Approved by:** Philip Cave, Chief Finance Officer
Presented by:	Philip Cave, Chief Finance Officer	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Finance and Investment Committee at its most recent meetings held on 18 May 2023.

Action required:

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

Summary and recommendations to the Board:

Summary

An overview of the work undertaken by the Finance and Investment Committee is outlined in the body of the report.

Key headlines for the Board are:

The Committee held a good discussion on the Performance report with a detailed review of key areas of concern. Focus on areas for consideration in 23/24 reporting including reduced number of KPIs emphasising those of most importance.

The Committee were pleased with recovery measures over the year -particularly in CAMHS.

The Committee discussed the need for Performance reporting and Annual plan reporting to be complementary and not duplicative. The Committee approved the metrics on this basis.

The Committee reviewed the Annual Plan and held a discussion of rating for SO4 re People. The amber rating was acknowledged but emphasised the need for transparency in Board narrative around rationale given pure mathematics suggests red rating.

The Committee received a deep dive on “Clinically ready for Discharge” with a clear and detailed presentation of issues and work being undertaking to improve the flow. The focus of questioning was around what could be done to improve the availability of suitable placements. The Committee also discussed the financial risks around this and how they could be mitigated noting they would need further consideration by the committee.

The Committee held a good discussion on the Annual Plan with some areas in which metrics could be rationalised/ improved given experience regarding the staff survey above and overall number of outcomes.

The Committee received a Finance update (YTD and annual plan) and agreed the Committee needed to focus on high-risk areas including agency/bank and delivering value in addition to OOAP. The Committee also covered a number of other areas including updates on SRS and a review of digital strategy implementation and priorities for next year with a suggestion that objectives should be considered on a multi-year basis.

The Committee agreed that it needed to understand the status of any claw back provisions for the current year for the EOE Collaborative.

Recommendation
The Trust Board is recommended to receive and note the work undertaken by the Finance and Investment Committee.

Relationship with the Business Plan & Assurance Framework:

List specific risks on BAF

Summary of Financial, IT, Staffing & Legal Implications:

There are no direct implications from the report.

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

The ensuring of equality of experience and access is core to the strategic objectives. The FIC has a key role in assuring the Board that the Trust is delivering the strategic objectives

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Finance and Investment Committee held on 18 May 2023

1. Introduction

1.1 This paper provides the Trust Board with a summarised report highlighting key Finance and Investment Committee (FIC, the Committee) business and issues arising from the meeting.

1.2 The Committee met on 18 May 2023 in accordance with its terms of reference and was quorate. The meeting was chaired by Anne Barnard, Non-Executive Director.

1.3 Detailed below are the key areas to be highlighted to the Board on the areas that the Committee discussed.

1.4 The Committee received and considered the items, detailed in appendix one. Detailed below are the key areas to be highlighted to the Board on the areas that the Committee discussed.

2. Finance – 2022/23

2.1. The Committee received detailed reports setting out the financial position at month one. The report highlighted a deficit position of £0.4m against a planned deficit of £0.2m, an adverse variance of £0.2m. The key areas of concern are agency usage and purchased private beds for the adult acute pathway and the Committee requested a deep dive in these areas in a future meeting.

2.2. The meeting also noted the work taking place to improve the financial position, including the establishment review of inpatient areas, observation review panel, additional financial controls as well as an increased focus on reducing agency expenditure.

2.3 The Committee received an update on the financial plan for 2023/24. The plan of a £1.8m deficit had been approved at the private Trust Board meeting of 4 May 2023. This is part of a Hertfordshire and West Essex Integrated Care System plan of breakeven.

3. Performance

3.1. The Committee considered the quarter four 2022/23 reports on the Annual Pan and on performance. The reports set out that despite a challenging quarter, the Trust has seen an increase the number of performance metrics met or nearly met. Three quarters of the annual plan milestones for the quarter had been delivered along with 70% of the year-end outcomes set in the annual plan.

3.2 The Committee discussed the progress made throughout 2022/23 to recover the Trust's performance noting the improvement from 55% of the key performance indicators met or nearly met at the end of quarter one to 68% at the end of the year. The Committee welcomed the recovery measures over the year -particularly in CAMHS.

3.5 The Committee received a deep dive on Clinically Ready for Discharge (formerly known as Delayed Transfers of Care, DToC) with a clear and detailed presentation of issues and work being undertaking to improve the flow. The focus of questioning was around what could be done to improve the availability of suitable placements. The Committee also discussed the financial risks around this and how they could be mitigated noting they would need further consideration by the committee. The Committee noted the actions being taken to minimise delays in adult, older people and learning disability services and future plans.

4. Annual Plan

4.1 The Committee reviewed the Annual Plan performance of 22/23 and held a discussion of rating for Strategic Objective 4 regarding People. The amber rating was acknowledged but emphasised the need for transparency in Board narrative around rationale given pure mathematics suggests red rating. The Committee noted the achievements during the year.

4.2 The Committee noted the work done to agree metrics for the Annual Plan for 23/24 highlighting that there were a lot of metrics and that it was important that metrics were complimentary to the performance report and on that basis approved the metrics.

5. Digital

5.1. The Committee received an update on the delivery of the Trust Digital Strategy, noting the solid progress with eighteen projects in the portfolio, ten projects were delivered as planned with further six projects partially delivering the year end objective for 2022/23. Benefits delivered to date from these projects were also noted.

5.2 The Committee also received details of the digital portfolio for 2023/24 and noted the dependency on national digital funding for the delivery of these projects. with a suggestion that objectives should be considered on a multi-year basis.

6. East of England Provider Collaborative

6.1 The Committee noted the work being carried out to develop a plan of bed reconfiguration across each specialist area based on data and the clinical model, which may mean that beds will be re-purposed in Bowlers Green and Warren Court going forwards.

6.2 The Collaborative are planning to do a piece of work to benchmark costs as a number of providers are stating that current income does not cover costs. This is relevant to Forest House in particular, for the Trust. It is anticipated that this may take a number of months and therefore any increase in income may not be allocated until 2024.

6.3 The Committee heard that the Trust was awaiting confirmation that the Norfolk Forensic Community Learning Disability business case had been approved.

7. Specialist Residential Services (SRS)

7.1 The Committee noted the progress made in terms of the transformation programme in relation to SRS, in particular the tender process of the care and support provider which was concluding with the plan to have a new provider in place by August 2023.

7.2 The Committee received information about the work underway with staff to support their future redeployment and the £1k retention fee agreed by the Trust Executive for staff who stay at SRS until the service is decommissioned.

7.3 It was noted that the most significant risk is the continuing work to be able to dispose of the buildings. Whilst NHSE have agreed a grant to support this there is still some work to do with commissioners to implement this.

8. Trust Strategy

8.1 The Committee provided feedback on the Trust strategy which had been previously circulated, noting it would be discussed at the private board meeting on 25 May 2023.

Hertfordshire Partnership University NHS Foundation Trust

Appendix one – Agenda items 18 May 2023

Apologies for Absence
Declarations of Interest
Minutes of meeting held on 23 March 2023
Matters Arising Schedule
2022/23
Performance **a) Quarter Four: Performance Report** **b) Annual Plan 22/23**
DEEP DIVE
Clinically Ready for Discharge
STRATEGIC
Annual Plan 23/24
Finance Report **a) Month One** **b) Financial Plan 2023/24**
SRS Update
OPERATIONAL
Trust Strategy
Digital Update
Contract Update
East of England Collaborative
TO NOTE
FIC Business Programme 2023/24
Any Other Business
Date of next meeting: 25 July 2023

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 10a
Subject:	Annual Plan 2022-23: Quarter 4 and Year End Progress Report	**For Publication:** Yes
Author:	Simon Pattison, Deputy Director of Strategy and Development	**Approved by:** David Evans, Executive Director, Strategy and Partnerships
Presented by:	David Evans, Executive Director, Strategy and Partnerships	

Purpose of the report:

This report provides an overview of the progress during Quarter 4 of 2022-23 (Q4) against the Trust's annual plan and the year-end position against our Annual Plan objectives for 2022/23.

Action required:

The Board are asked to receive the report and note performance against the 2022/23 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.

As this is the end of year report there are two RAG ratings which indicate:

- An assessment of whether the milestones/actions planned for Quarter 4 (Q4) were achieved.
- A summary of progress across the year as a whole for 2022/23.

Quarter 4 2022-23

The Trust delivered against most milestones for the quarter. In Q4 75 of the 99 quarterly milestones were met, equivalent to 75.8% of all milestones. Five objectives delivered at least 70% of their quarterly milestones and so were rated Green in the quarter.

Year End Progress against Objectives

At the end of 2022/23:

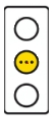
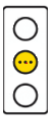
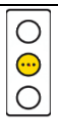
- Four out of seven objectives fully achieved the end of year outcomes
- Three further objectives were rated Amber

These are discussed in detail below

70% of all year-end outcomes were delivered (42/60 outcomes) at the end of 2022-23. This compares to 69% of year end outcomes that were predicted to be on track at the end of Q3.

Table 1 below summarises Q4 and year end position for all objectives.

Table 1 – Q4 and year end achievement summary (Red: Below 59%, Amber 60-69%, Green 70+ %)

Ref	Objective	Q4 22-23		22-23 Year End Outcomes	
		Milestone Achievement	RAG Rating	Year End Prediction	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	17/20 (85%)		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	9/15 (60%)		6/10 (60%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	12/13 (92%)		6/7 (86%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	7/9 (78%)		6/11 (54%) Amber	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	7/11 (64%)		5/8 (62%)	
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	10/14 (71%)		7/9 (78%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	13/17 (76%)		5/6 (83%)	

A wide range of improvement activity has been delivered in Q4:

- Primary and community mental health transformation has continued with expansion of primary care models and encouraging evaluation of the new roles working with GPs. This has led to positive conversations with commissioners about similar roles for Children and Young People
- The evaluation of a number of programmes of work has been positive such as the depression pathway, work to develop Trauma Informed Approaches and Child and Adolescent Mental Health Services (CAMHS) crisis service
- In Learning Disability (LD) services progress has been made in relation to physical health checks and a new service model for Specialist Residential Services (SRS)
- Continuous Quality Improvement (CQI) projects continue to increase across the organisation

Challenges remain and these can be seen in the following areas in particular:

- The high level of demand for inpatient beds and the related acuity of needs has an impact on service users feeling safe, and on our usage of externally purchased inpatient beds
- Unplanned turnover and vacancy rates remain a concern

Recommendation

The Board are asked to receive the report and note performance against the 2022/23 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.

Last seen by:

Finance and Investment Committee 18th May

TRUST ANNUAL PLAN 2022-23

QUARTER 4 AND END OF YEAR 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. As this is the end of year report there are two RAG ratings which indicate:

- An assessment of whether the milestones/actions planned for that quarter were achieved.
- A summary of progress across the year as a whole for 2022/23

2. Achievement against Quarter 4 Milestones

2.1. The Trust delivered against most milestones for the quarter. In Quarter 4 (Q4) 75 of the 99 quarterly milestones were met, equivalent to 75.8% of all milestones. Five objectives delivered at least 70% of their quarterly milestones and so were rated Green in the quarter.

2.2. A wide range of improvement activity has been delivered in Q4:

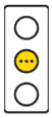
- Primary and community mental health transformation has continued with expansion of primary care models and positive evaluation of the new roles working with GPs. This has led to positive conversations with commissioners about similar roles for Children and Young People
- The evaluation of a number of programmes of work has been positive such as the depression pathway, work to develop Trauma Informed Approaches and CAMHS crisis services
- In LD services progress has been made in relation to physical health checks and in relation to SRS
- CQI projects continue to increase across the organisation

2.3. Challenges remain and these can be seen in the following areas in particular:

- The high level of demand for inpatient beds and the related acuity of needs has an impact on service users feeling safe and on our usage of externally purchased inpatient beds.
- Unplanned turnover and vacancy rates remain a concern

2.4. Table 2 below summarises the Q4 achievement for all strategic objectives with details of the outcomes and commentary for these in Appendix 1.

Table 2 – Q4 Achievement against Milestones (Red: Below 59%, Amber 60-69%, Green 70+ %)

Ref	Objective	Q4 22-23	
		Milestone Achievement	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	17/20 (85%)	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	9/15 (60%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	12/13 (92%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	7/9 (78%)	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	7/11 (64%)	
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	10/14 (71%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	13/17 (76%)	

3. End of Year Progress against Objectives

3.1. At the end of 2022/23:

- Four out of seven objectives fully achieved the end of year outcomes
- Three objectives were rated Amber

3.2. 70% of all year-end outcomes were delivered (42/60 outcomes) at the end of 2022-23. This compares to 69% of year end outcomes that were predicted to be on track at the end of Q3.

3.3. At year end four out of seven objectives met most (70%+) of the metrics. The four objectives that are Green rated are:

- SO1 Safe services. Within this metric:
  - The number of people who have died by suicide as a proportion of all people in contact with HPFT has reduced

- The proportion of violence and aggression incidents resulting in moderate or severe harm have reduced, as have injuries from violence and aggression
- Staff feel that the health and safety climate has improved
- More service users say that they are treated in line with the Trust values

- SO3 Effectiveness. Within this metric:
  - The number of people trained in autism assessments has increased, with waiting times for an assessment reducing
  - More physical health checks have been completed
  - Our recording of outcomes has improved
  - We have increased the amount of research we are involved in

- SO6 Joined up care. Within this metric:
  - More people are getting support for their mental health in primary care and in the community
  - More people with a learning disability have an up to date care plan
  - Many more children and young people are accessing support for their mental health through teams based in their schools
  - People with a learning disability are spending less time in hospital on average

- SO7 Partnerships. Within this metric:
  - More people with severe mental illness are in employment
  - We have reduced the number of children and young people with an Eating Disorder waiting for an inpatient bed
  - We have showcased our work through speakers at national conferences and through national reports
  - We have engaged with population health work in HWE ICS and started work on priority actions to reduce inequalities

3.4. The objectives that were not Green rated at year end are summarised below, with detail on both the areas where progress has been made and some of the challenges experienced.

- SO2 Experience. The four metrics that were not met covered:
  - Complaint response times – these have not reduced during the year
  - Improving Access to Psychological Therapies (IAPT) access rates – the number of people accessing IAPT in both Hertfordshire and Mid Essex did not reach commissioner targets
  - The number of people who say that they have been asked for their views on the quality of care did not increase
  - The number of adults with Serious Mental Illness (SMI) in settled accommodation remained static, rather than increasing

However the amount of engagement from service users and carers in service development has increased, more carers tell us that they feel that they are a valued

partners in care planning and we have introduced and embedded the collection of outcomes reporting in community mental health.

- SO4 Workforce. The six metrics that were not met covered:
  - Voluntary turnover did not reduce to the target level
  - Vacancy rates did not reduce as much as expected
  - Three staff survey metrics did not improve substantially, despite our overall incredibly positive staff survey performance

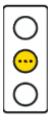
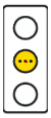
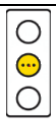
  More positively our mandatory training target was met and some staff survey metrics were achieved. This position would statistically rate us Red on this indicator, largely as a result of some of the staff survey metrics not being achieved. However our overall staff survey was incredibly positive. This put us in the top 5 mental health and learning disability trusts in the country as ranked by staff as a place to work. Compared to others, we were better than the national average on 8 out of the 9 themes in the staff survey with one the same as the national average. One was a national best ("We are always learning") and another was very close to the national best ("Staff Engagement"). Therefore on consideration we are rating this objective as Amber overall.

- SO5 Innovation. The three metrics that were not met covered:
  - Community mental health survey metric – service users feel they have enough time to discuss their needs
  - LED lighting being rolled out across the Trust – work has not progressed beyond Kingfisher Court
  - Commencement of the roll out of electric charging point – this programme has not been started

  Alongside this good progress was made in terms of staff engagement with Continuous Quality Improvement, with more staff trained and more improvement ideas coming forward. Our digital programme also received positive feedback from staff and service users.

3.5. The table overleaf summarises the year end achievement for all strategic objectives (SO) with details provided in Appendix 2.

Table 3 - 2022-23 End of year Achievement against Objectives (Red: Below 59%, Amber 60-69%, Green 70+ %)

Ref	Objective	22-23 Year End	
		Year End Actual	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	6/10 (60%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	6/7 (86%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	6/11 (54%) Amber	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	5/8 (62%)	
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	7/9 (78%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	5/6 (83%)	

4. Conclusion

4.1. Overall good progress has been made during the quarter against the Q4 milestones and against year-end outcomes, given the challenging external environment.

5. Recommendations

5.1. The Board are asked to receive the report and note performance against the 2022/23 Annual Plan.

APPENDIX 1 – ANNUAL PLAN 2022-23 QUARTER 4 COMMENTARY AGAINST MILESTONES AND OUTCOMES

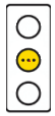
Strategic Objective 1 (Senior Responsible Officer JV)	Q4 Key Actions / Milestones	Q4 Milestones Rating
We will provide safe services, so that people feel safe and are protected from avoidable harm **Key Priorities** • We will progress our ambition to achieve zero-suicides across the populations we support • We will keep service users & carers physically and mentally safe, reducing the harm they experience • We will further develop our approach to managing violence and aggression & evidence-based restrictive practice • We will expand the training, development, and leadership of teams to keep our staff safe	• Multiagency suicide Prevention Training has been launched • Baseline audit against Suicide Prevention Pathway standards completed. Stakeholder Workshop planned • Back to Basics suicide prevention training completed across all quadrants • Further staff trained on suicide prevention in crisis teams • Reciprocal training between HPFT and CGL in place. CGL providing training in harm minimisation • All clinical matrons have completed the competency handbook. Further professional development will follow • Pro-screen Ultra detectors piloted in Forest House as part of CQI project around safety • Audit of safety suite usage completed and presented to the Quality and Risk Management Committee • Phase 2 CCTV rollout - Lambourn, Logandene, Beech Ward, Astley Court & Elizabeth Court almost complete • Positive Behavioural Support (PBS) embedded in LD inpatient services • Weekly Datix review of incidents ongoing • PBS reflective sessions continuing • PBS refresher sessions continue across community teams • Dove Ward has recruited a Band 5 Assistant Psychologist to support PBS approach on the unit • PBS Strategy Development Programme Manager appointed. Complex behaviour pathway training has been undertaken across services • Trauma Informed Approach (TIA) evaluation of pilot completed with positive outcomes • Learning from TIA evaluation has fed into development of training materials • HOPE(S)[1] Model awareness training has been delivered to LD forensic and CAMHS staff • Consideration of alternative models for Prevention and Management of Violence and Aggression underway • Review of staffing establishments still ongoing	17 green 3 amber 17/20 = 85% 
	Commentary: • Work around Positive Behaviour Support continues to be a focus for LD services • Suicide prevention training completed to support implementation of suicide prevention pathway	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes**
Good progress has been made across a number of Positive Behaviour Support (PBS) related actions and on the development of Trauma Informed Approaches.	• Suicides relative to total Contacts with HPFT. (Baseline 0.49%) (Q4 0.024%) • < service user to staff moderate - severe harm through violence & aggression (<2.3% Q4) (0.56% Q4) • < service user to service user moderate - severe harm through violence & aggression (<2.3% Q4) (1.19% Q4) • Rate of service users saying they are treated in a way that reflects the Trust's values (>80%) (82% Q4) • Reduction in number of seclusion episodes (21/22 baseline 430) (420 YTD) • Reduction in rapid tranquilisation incidents (21/22 baseline 318) (406 YTD) • 10% reduction in the number of reported injuries, diseases and dangerous occurrences (RIDDOR) incidents as a result of violence and aggression towards staff (baseline 50 in 21/22) (29 YTD) • Staff survey health and safety climate score >6.0 – Staff Survey metric 6.3 • Having Your Say "do you feel safe on the ward" score. Target 85% (72% Q4)	7 Green 2 Amber 7/9 = 78% 

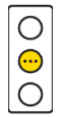
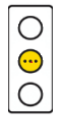
[1] HOPE(S) Model: Mersey Care NHS Foundation Trust

Strategic Objective 2 (Senior Responsible Officer - 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 and carer experience of accessing and using our services experience of service users • We will implement involvement of our service users and carers in the design and delivery of their care • We will support our service users to live their lives as independently as possible	• Reporting mechanisms in place around Dialog and in relation to pilot with One Vision (Watford voluntary organisation) • IAPT recovery rates for non-white people remain on a par with overall recovery rates • IAPT Equality, Diversity and Inclusion (EDI) leads are evaluating the range of culturally sensitive interventions. • Older Adults Transformation programme is on hold due to focus on Dementia Diagnosis recovery plan • Connected Lives has been fully implemented across all 4 quadrants • Progress on financial assessments is reported into a joint oversight group with HCC. • Service users, carers and volunteers have been part of the engagement strategy to improve how Experts by Experience engage with the Trust • Implementation of new Carers Council model delayed • Printing and distributing user / carer feedback surveys delayed • Carers Plan for 2023/26 not yet in place • Audit of care records to measure improvement in the recording of carers underway in some services • Easy read survey for people with LD was coproduced with support from Speech and Language Therapist. Survey interviews planned for April • SPIKE has been updated to reflect compliance with completion of the Care and Support Plan in order to support transition from the wellbeing plan. • Social Care Oversight Group now established with good attendance • Work on the Stewarts has been paused whilst discussions are held in relation to the appropriate service model	9 Green 6 Amber 9/15 = 60% Amber 
	Commentary: • Work around Connected Lives has progressed well within the wider community mental health transformation • IAPT services have maintained a focus on people less likely to access support	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes**
Challenges within the involvement and engagement team has slowed down progress. A new structure is now in place to manage this.	• Reduction in complaint response times from 36 days (Q3 21/22) to 30 days (Q3 22/23) (42 days in Q4) • IAPT, Community Perinatal & Early Intervention in Psychosis (EIP) access targets met (IAPT off track, perinatal at trajectory, EIP above target) • Performance against the new access standards on 28-day referral to treatment times for CYP (66%), adults (51%) and older adults (28%) • Connected Lives audit • Increase service user & carer engagement hours from 1,874 in 21/22 to over 2,000 in 22/23 (2,498 to end Q4) • Increase in people saying they have been asked for their views on the quality of care from 18.2% to 25% (17.9%) • Number of experts of experience led CQI projects (target 10) – 10 YTD • Personalised Care & Support plan (including DIALOG) completion – 20% by end of March (75.4%) • Having Your Say for carers – Do you feel valued by staff as a key partner in care planning? - 70% (81% Q4) • At least 85% of adults with Serious Mental Illness have settled accommodation (55% Q3)	6 Green 4 Amber 6/10 = 60% 

Strategic Objective 3 (Senior Responsible Officer 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 needs • We will keep service users physically healthy by improving the physical health support, intervention and care available • We will train our staff in diagnosing and supporting people with Autism • We will expand our research and increase the positive impact of this on service user outcomes	• Baseline audit to assess compliance with the Depression pathway has been finalised • Implementation of Physical Health toolkits templates complete • Physical Health Committee has developed work plan to address areas where practice should be improved • Progress on SBU implementation of local audit recommendations reported to Physical Health Committee • Plan, Do, Study, Act (PDSA) cycle for Physical Health in place • Analysis of physical health themes reported to Physical Health Committee (PHC) • PHC is monitoring implementation of learning from reviews across SBUs • Clozapine pilot developed • Progress on Strategic Business Unit (SBU) plans reported to PHC • Percentage of staff trained in physical health not monitored regularly • Implementation of some elements of the Autism Strategy have commenced • All research assistant posts have now been appointed to • Service users will receive a text asking them to opt in for future research contact which will be recorded in PARIS	12 Green 1 Amber 12/13 = 92% Green 
	Commentary:	
	• Improving physical health has been a significant focus and there has been good progress against a range of priorities • The implementation of actions to improve our support for people with autism are underway	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes**
Work on physical health continues to be a priority with significant progress in the quarter. Implementation of the autism strategy has begun	• 90% of people on Care Plan Approach having completed physical health checks in inpatient (54% Q4) and First Episode of Psychosis (84% Q4) services and 65% in community mental health teams (89% Q4) • 30 staff trained in autism assessment (30 trained at end Q4) • Reduce the longest wait for an adult autism assessment from 5 years to 2 ½ years – target met • Warren Court and Broadlands autism friendly environments capital work completed (Warren Court completed, Broadlands decorating underway) • Increase in volume of research projects (29 21/22 and 26 by end Q4), number of local Performance Indicators (baseline 19, Q4 21) and at least 100 service users involved in research (283 end Q4) • 14% reduction in service users who smoke cigarettes (4.1% to end February) • Progress against routine outcome monitoring for CYP, perinatal and community mental health services (68% CYP and Perinatal against 40% target, 45.4% Community transformation cohort against 40% target)	6 Green 1 Amber 6/7 = 86% Green 

Strategic Objective 4 (Senior Responsible Officer - JH)	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 increase recruitment and offer a compelling employment experience which retains staff • We will develop our belonging and inclusion strategy and culture • We will introduce new roles and ways of working to meet acuity and demand for services • We will develop our people, teams, and leaders to enable the delivery of great care and great outcomes	• Pulse survey completed and reported both internally and externally, showing a continuing positive trend in experience. • Work has taken place resulting in 107 final year students opting to take up registered nursing roles with HPFT. • Recruitment and Retention plans for 22/23 reviewed. Our staff in post has increased by 319.6 FTE (9.4%) this year, reducing our vacancy rate from to 14.3% to 11.8% despite an increase in our establishment of 252.12 FTE this year (a 6.4% increase). Our unplanned turnover has improved from 13% at the start of the year to 12.3% at the end of Q4. Our plans have now been refreshed in light of our latest data • Our wellbeing offer was reviewed in light of staff survey and other staff feedback and a plan agreed for 23/24 • Winter Wellbeing Festival took place in Q4 and was well received and attended • Impact of recruitment practices reviewed and refined. Plans enacted to expand our inclusion ambassador scheme. • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans implemented for actions with a due date by end Q4 • Talent management work is commencing mid-Q1 of 23/4 due to delays in funding. • Reviewing the development offer will take place once appraisal window closes in July.	7 Green 2 Amber 7/9 = 78% Green 
	Commentary: • The new appraisal App has been launched with all appraisals now taking place between April and July • A talent lead has been recruited to development an inclusive talent development strategy	

Summary:	Key Outcomes at Year End	Year End Outcomes
Turnover and vacancy rates are key issues for the trust. Progress has been made on both, however the year end targets have not been achieved.	• The Trust takes positive action to support health and wellbeing > 85% Actual 87% • Our Work Race Equality Standards and Work Disability Equality Standard improved on average • Inclusion staff survey score >7.3 Actual 7.3 • Staff Survey and pulse survey engagement score > 7.4 Actual 7.1 • Staff survey 'we each have a voice that counts' score >7.2 Actual 7.1 • Staff survey 'negative experiences' score >7.9 Actual 7.9 • Staff survey development score >6.8 Actual 6.1 • Mandatory training >90% (90.8% average across the year) • Unplanned turnover <10.5% by Q4 (12.26% Q4) • Vacancy rate <11.1% by Q4 (11.8% Q4) • > 70% staff recommend place to work Actual 73%	5 Green 6 Amber 6/11 = 54% Amber 

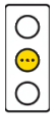
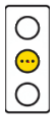
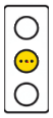
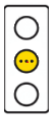
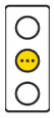
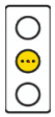
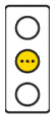
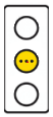
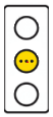
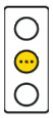
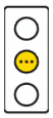
Strategic Objective 5 **(Senior Responsible Officer – HA/PC)**	**Q4 Key Actions / Milestones**	**Q4 Milestones Rating**
We will improve, innovate and transform our services to provide the most effective, productive and high-quality care **Key Priorities** • We will embed the culture of continuous improvement and innovation across our services • We will continue to introduce new digital capabilities that improve our services • We will support the NHS to become the world's first healthcare system to reach net zero carbon emission	• Continuous Quality Improvement (CQI) – 32 coaches identified, although training for some delayed due to junior doctor's strike • 26 ideas for CQI improvements received against a target of 20 for the year • Q3 CQI report published • Integrated automated dashboards containing data from HR, finance, Safety, Risk and EPR not yet in place • Electronic Prescribing and Medicines Administration (ePMA) deployment in inpatient settings was delayed due to challenges with the provider. Two pilot sites are live and the project has been re-planned for delivery in 23/24 • Digital Communications, outcomes and assessments are live Trust wide in regular usage. The online library is in development for delivery in 23/24 • ePMA community pilot is not available using the current software. ePMA board reviewing long term options • Digital Wards procurement and contractual arrangements concluded at the end of Q4 and the delivery is scheduled for 23/24 • Digital skills self-assessment is live and available via Discovery and is communicated to new starters at corporate induction • LED Lighting and Solar panel installation at Kingfisher Court completed (but not the remainder of the Trust) • New projects identified for 23/24 green plan	7 Green 4 Amber 7/11 = 64% 
	Commentary: • New digital outcome measures and digital communications are live and now in regular usage • Green plan related work on LED lighting and solar panels at Kingfisher Court has been completed	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes**
Further progress has been made on the CQI agenda with more projects identified and started. Digital improvements continue to be implemented	• 10% increase in staff reporting involvement in CQI projects during 2022/23 • Number of trained CQI coaches increased from 0 to 23 – actual 32 • 20 innovation ideas received, evaluated, and considered by the Innovation Panel (26 YTD) • Positive net score from service users using digital channels • Positive targeted survey responses from staff regarding experience of digital capabilities (73.3%) • Community mental health survey – > service users given enough time to discuss your needs (baseline 7.3, actual 6.9) • LED lighting to be rolled out across the entire trust in 22/23, Kingfisher Court to be completed in 22/23, remainder of Trust deferred to 23/24 • Commencement of the rollout of electric car charging points delayed	5 Green 3 Amber 5/8 = 63% Amber 

Strategic Objective 6 (Senior Responsible Officer–SB / DE)	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 work with Primary Care partners to improve community services and the care of adults and older people • We will improve access and delivery of care for those people with a learning disability and/or autism across the Trust • We will ensure children, young people, adults, and older people in crisis can access support when they need it • We will work with partners to deliver earlier intervention and support for Children and Young People	• Recruitment continues to Enhanced Primary Care Mental Health Service expansion posts with 12 PCNs in South and West Herts (target 20) and 6 PCNs in East and North Herts (target 12) now covered. (two milestones) • A draft Additional Roles Reimbursement Scheme (ARRS) evaluation report has been produced with recommendations for building further on the positive impact of ARRS. Development days took place in Jan and March with all EPMHS and HPFT primary care staff to describe the unified primary and community mental health model. Further development sessions are planned into 23/24 as the service continues to grow. • Plan for roll out and recruitment to CYP ARRS roles agreed with commissioners (two milestones) • Awayday held to discuss ongoing implementation of inpatient bed consolidation for LD services • New pathway on Dove Ward agreed • Increased number of service user reviews using the Annual Care Plan template in LD service completed • Approach to psychiatry input to Annual Care Plan template is being scoped • Transition process for all SRS service users progressing, with procurement live for new provider • C-CATT evaluation completed; recommendations being worked on to inform any changes in provision. (two milestones) • Work underway with commissioners on CAMHS front door model but further work required to consider staffing and interoperability with recommended digital portal • ARFID (Avoidant / restrictive food intake disorder) pathway scoping complete, waiting for decision from commissioners on next steps.	10 Green 4 Amber 10/14 = 71% Green 
	Commentary:	
	• There has been a positive evaluation of the impact of the ARRS workers in primary care, with an expansion of the primary care mental health model • Agreement has been reached with commissioners on the roll out of ARRS workers in CYP services	

Summary:	Key Outcomes at Year End	Year End Outcomes
Progress in transformation priorities continues across learning disability, adult and CYP services	• Number of adults accessing new primary and community mental health (target 5062) (target met) • 70% of primary care mental health roles (ARRS roles) in post against plan (75% Q4) • No of people diagnosed through the Primary Care Dementia Pathway (target 24 per week) (5 Q4) • < Inpatient length of stay for people with LD (391 Q1 reduced to 362 Q4) • Routine referrals to Specialist Community LD Services meeting 28 day wait >=98% (98% Q4) • Completed annual care plans within LD community services Herts and Essex (target 70%) (current 76%) • 4 hours wait for CYP crisis service (target 95%) (96% Q4) • 1,500 CYP accessing Mental Health Support Teams (967 in 21/22) (1901) • CAMHS access < 28 days (target 95%) (81% Q4)	7 Green 2 Amber 7/9 = 78% Green 

Strategic Objective 7 (Senior Responsible Officer - DE)	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 ensure the Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative continues to develop and thrive • We will advocate for mental health, learning disability & autism services are developed across our populations • We will continue transformation of services for people with a learning disability and their carers • We will work with regional partners to deliver new models of care for those with specialist mental health needs and learning disabilities	• MHLDA HCP provided input and oversight of the MHLDA elements of the NHS operational planning return • Progress against MHLDA HCP Transformation priorities considered by the Board at each MHLDA HCP Board meeting through regular programme updates. • Research has been commissioned to understand needs and experiences of the LGBTQ communities in Hertfordshire • Dual diagnosis Task and Finish group in place • Plans in development to improve outcomes for dual diagnosis service users • The ICP's Integrated Care Strategy prioritises MHLD & A as one if its 6 key priority areas. The Joint Forward Plan includes a focus on MH, LD & A • Monthly RADIANT (ReseArch in DevelopmentAl NeuropsychiaTry) Continuing Professional Development sessions have been ongoing, including sessions on self harm • RADIANT working with a graphic designer to put together content for social media platforms. • Two new journal articles published • Research Assistant for the RADIANT network appointed • Business case to increase system interoperability developed in relation to RADIANT • Joint work between RADIANT and the new Norfolk LD community forensic team has taken place • Review of Red to Green, Home Treatment Team and 72 hour pathway in CAMHS underway • The Adult Eating Disorders Intensive Support Team (IST) evaluation has commenced and will continue into Q1 23/24 due to the delay in recruiting to and therefore commencing the ISTs • Community Forensic LD Service 6 month evaluation completed • Business case for recurrent funding of the community forensic LD service is under development and due to go through governance during Q1	13 Green 4 Amber 13/17 = 76% Green 
	Commentary:	
	• Evaluations of services in learning disability are progressing well to support learning and improvement • Herts and West Essex Integrated Care Strategy and Joint Forward Plan agreed with a significant focus on mental health, learning disability and autism	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes**
Partnership work continues to be a priority for the Trust. We are effectively influencing work on population health, support for people with drug and alcohol issues and overall system strategies	• Increase in number of people with SMI in employment. Baseline 14% (February 2022) (17% Q4) • HPFT's positive impact on service user outcomes showcased in 3 national reports (3 Q4) • HPFT to provide expert speakers at 3 national conferences or similar settings (4 Q4) • < number of CYP waiting for an Eating Disorder inpatient bed (baseline 6 on 9th May) (1 on 1/4/2023) • HWE ICS population health model identifies at least 2 concrete actions for the ICS on MHLDA (2 identified) • CYP ADHD in South and West Herts maintained at 1300 by end 22/23. (Q3 1379)	5 Green 1 Amber 5/6 = 83% Green 

APPENDIX 2 – ANNUAL PLAN 2022-23 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					Good progress has been made across a number of Positive Behaviour Support (PBS) related actions and on the development of Trauma Informed Approaches. We have seen a reduction in violence and aggression incidents leading to serious harm and an increase in people saying that they have been treated in line with Trust values
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience					Challenges within the involvement and engagement team has slowed down progress. A new structure is now in place to manage this and alongside this the number of hours of engagement from service users and carers in service development has increased.
3	We will improve the health of service users through the delivery of effective evidence-based practice					Work on physical health continues to be a priority with significant progress across the year. Implementation of the autism strategy has begun and there has been an increase in our engagement in research.
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment					Turnover and vacancy rates are key issues for the trust. Progress has been made on both but the year end targets have not been achieved. Our staff survey results were very positive.
5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care					Further progress has been made on the CQI agenda with more projects identified and started. Digital improvements continue to be implemented
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					Progress in transformation priorities continues across learning disability, adult and CYP services. More adults have received support from primary and community mental health services and more children and young people are receiving support for their mental health in schools
7	We will shape and influence the future development & delivery of health and social care to achieve better outcomes for our population(s)					Partnership work continues to be a priority for the Trust. We are effectively influencing work on population health, support for people with drug and alcohol issues and overall system strategies. More people with severe mental illness are now in employment and fewer children and young people with an Eating Disorder are waiting for an inpatient bed.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 10c
Subject:	Quarter 4 2022/23 Performance Report	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director Innovation and Improvement	**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:

This report provides an overview of the Trust's performance at the end of Quarter 4 2022-23 against the NHS Single Oversight Framework targets, the Trust Key Performance Indicators (KPIs), the Quality Account indicators and an update on the actions being taken to improve performance. A summary of performance against the Trust's Key Performance Indicators during 2022-23 is also included in the recovery programme update.

Action required:

The Trust Board is recommended to receive the report, discuss key areas of performance and to note actions being taken to improve performance.

Summary:

The fourth quarter of 2022-23 has been challenging as national, regional and local systems experienced winter demand and capacity pressures, in addition to existing high demand and acuity pressures.

In Quarter 4 68% (44/65) of our Key Performance Indicators were either fully met or almost met.
In Quarter 3 62% (38/61) of our Key Performance Indicators were either fully met or almost met.

The Trust continues to perform well in:

- Assessing people in A&E and acute hospital wards within 1 hour and 24-hour targets
- Service users presenting in crisis and referred for inpatient admission are assessed by the Gatekeeping Team to ensure that there is no better alternative than an inpatient admission
- Starting treatment for psychosis within 14 days of first diagnosis
- IAPT clients being seen within the 6 week and 18 week targets and moving into recovery
- Children and Young People needing a crisis assessment being seen within 4 hours
- Carers saying that they feel valued by our staff
- Our service users saying that they are treated in a way that reflects the Trust's values
- Our staff reporting positively on their wellbeing at work

The Trust Recovery Programme continued to restore performance in Quarter 4:

- Children and young people with an Eating Disorder being seen within 28 days for a routine appointment *recovered* in January in line with the planned trajectory

- Children and Young People presenting in crisis being seen in four hours *recovered* mid-Quarter 4.
- People discharged from our inpatient services who received a follow-up contact within 48 hours *recovered* mid-Quarter 4.

Our key areas of focus where we have significant challenges are:

- Timely access to our community services for routine referrals. Although we have improved access to our Adults and Children and Young People services, service users are waiting longer than 28 days from referral to initial assessment. We continue to provide additional resources for initial assessments and addressing vacancy hotspots in teams to address this. Having brought our Adult Community Services under single management, we have also reviewed and improved our processes to improve performance in this area.
- Providing diagnosis within 12 weeks in our Early Memory Diagnosis and Support Service. We continue to provide additional clinics and have started transforming the diagnosis pathway by introducing primary care dementia diagnosis nurses to speed up access to diagnosis.
- Demand and acuity in our inpatient pathways, resulting in increased number of service users being admitted to out of area placements and delays in discharging those who are ready to be discharged. We continue to focus on reducing length of stay in our inpatient units, exploring alternative pathways to support discharge and prevent admission to reduce our need for external beds.
- Service users with high complexity needs having an annual Care Plan Approach (CPA) review. We have improved our overall risk management and care planning system and processes to meet the challenge of rising complexity in cases on every clinical contact. We are adapting our Care Plan Approach to take advantage of these improvements and to make the Care Plan Approach process more streamlined. Nationally, the system is moving away from CPA towards personalised care and support plans (PCSP). Our Community Transformation programme is planning the transition from CPA to PCSP in Q1.
- Staff recruitment and retention, particularly in nursing and medical workforce. Our workforce establishment continues to grow alongside net recruitment which means our workforce is growing to provide the capacity we need to meet new demand levels.

Our recovery programme has seen the Trust move from meeting or nearly meeting 55% of the key performance indicators at the end of the first quarter of the year to 68% at the end of Quarter 4. Details of the actions we are taking to further improve performance are summarised in the report. The Trust Board is recommended to receive the report, discuss key areas of performance and to note actions being taken to improve performance.

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

The report includes key performance indicators across multiple domains which relate to the Trust's business plan.

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:

Although some of the key performance indicators have equality and diversity dimensions, there are no direct implications arising from this report.

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

The report includes all targets reportable in Quarter 4 2022-23.

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

Executive Team – 3rd May 2023 Finance and Investment Committee – 18th May 2023

Quarter 4 2022/23 Performance Report

1. Background

1.1. This report provides an overview of the Trust's performance for Quarter 4 2022-23 against the NHS Single Oversight Framework targets, the Trust Key Performance Indicators (KPIs), the Quality Account indicators and an update on the actions being taken to improve performance.

1.2. In line with NHS best practice, we are transitioning to use Statistical Process Control (SPC) techniques offering further insights into our performance by demonstrating the underlying variation and consistency of our key performance indicators. This approach allows us to better understand what our performance is now, the direction it is going, and provides greater assurance on how likely the Trust is to meet targets.

1.3. There are two main types of information introduced as part of SPC. The first is Assurance and identifies how consistently our processes are likely to meet the target. The second is Variance which describes the trend for the trajectory over time, including statistically significant variations.

1.4. The following icons are used to represent variance and assurance in this report. Icons are colour coded for easier interpretation with blue for improvement, grey for no significant change and orange for deterioration.

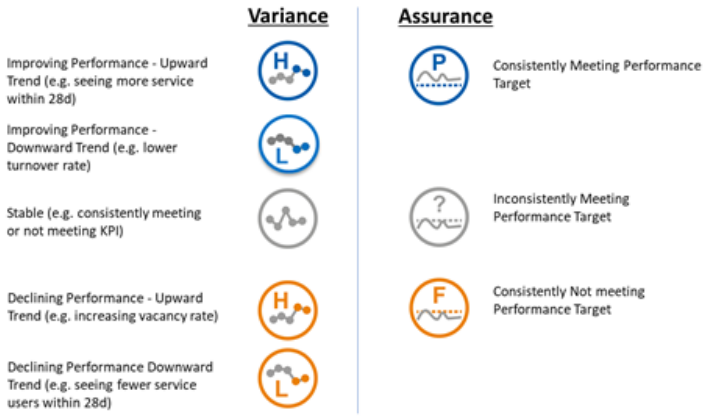


Figure 1 – SPC Icons

1.5. Some of our KPIs do not lend themselves to using SPC approach and as a result do not have the associated variation and assurance analysis. These will appear without a variation or assurance indicator in the tables.

2. Quarter 4 2022-23 Performance Summary

2.1. The fourth quarter of 2022-23 remained challenging as national, regional and local systems continued to experience demand and capacity pressures. We continued to see

- Increased demand for our Adult Community Mental Health Services
- High system demand for our inpatient services, with a limited number of integrated community support placements available to enable people with more complex needs to be discharged.
- Ongoing challenges in recruitment of nursing and medical staff due to high system demand, leading to high bank and agency usage in difficult to recruit areas.

2.2. The overall number of performance indicators that were met or almost met at the end of Quarter 4 (44/65, 68%) has improved compared to Quarter 3 (38/61, 62%). Please note that the four staff survey related KPIs that were not reported in Q3 due to the annual staff survey replacing our quarterly Pulse Survey. These are included in the Quarter 4 report, bringing the total number of indicators reported back to 65.

2.3. The figure below shows the percentage of KPIs achieved in in each performance domain with green indicating targets met, amber indicating targets almost met and red indicating targets not met.

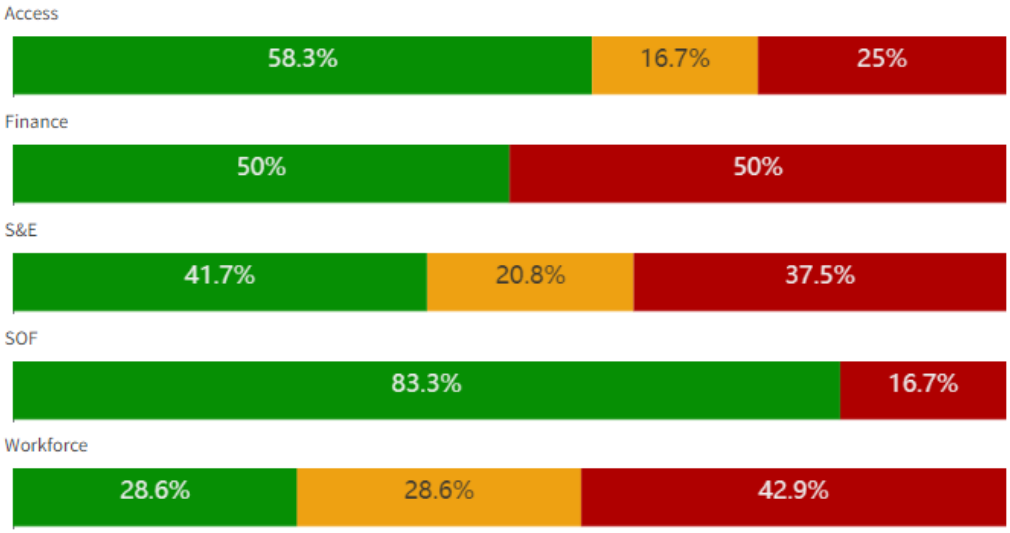


Figure 2 - RAG Breakdown by Performance Domain

2.4. In common with mental health trusts across the country, in our local system, and the wider NHS, we are focussing on improving performance and finding new ways of working that build capacity and resilience in our services to meet the needs of our service users and carers. At the end of Quarter 4, key changes to note are:

- Single Oversight Framework
    - IAPT clients moving to recovery improved to 53% against the 50% target.
- Access
    - Children and Young People with an Eating Disorder being seen within 28 days for a routine appointment *improved* to 100% against a 95% target.
    - Children and Young People presenting in crisis being seen in four hours *improved* to 96% against the 95% target.
    - Children and Young People who are experiencing a crisis being seen within one hour *improved* to 96% against the 95% target.
    - Children and Young People being seen within 28 days for a routine community appointment *improved* to 91% but remains short of the 95% target.
    - Referrals into SPA receiving an outcome within 14 days *increased* to 97%, meeting the 95% target for the first time in 15 months.
    - People seen by our Mental Health Liaison Team on an acute ward within 24 hours *improved* to 100%
- Safe and effective care
    - Service users who are discharged from inpatient services that were followed up between 24 and 48 hours in line with best practice *improved* to 84% against the 80% target.

- Service users who are Clinically Ready for Discharge but there is a delay due to issues associated with the transfer (Delayed Transfers of Care) shows an improvement. However, this is due to improved data quality following the launch of the DToC app and we have seen an increase in the second half of the quarter in the number of service users whose transfers have been delayed.
- Service users responding to the Having Your Say Survey saying that they know how to get support and advice in a time of crisis *decreased* to 69% against the 83% target.
- Service users responding to the Having Your Say Survey saying that they have been involved in discussions about their care as much as they wanted to *decrease* to 81% against the 85% target.
- Staff recommending Trust services to family and friends if they need them *increased* to 73% against the 70% target.
- Service Users with a first episode of psychosis receiving cardiometabolic assessment *decreased* to 86% against the 90% target.

2.5. Key areas of strong performance continued in Quarter 4 include:

- Assessing people in A&E and acute hospital wards within 1 hour and 24-hour targets
- Service users presenting in crisis and referred for inpatient admission are assessed by the Gatekeeping Team to ensure that there is no better alternative than an inpatient admission
- Starting treatment for psychosis within 14 days of first diagnosis
- IAPT clients being seen within the 6 week and 18 week targets and moving into recovery
- Children and Young People needing a crisis assessment being seen within 4 hours
- Carers saying that they feel valued by our staff
- Our service users saying that they are treated in a way that reflects the Trust's values
- Our staff reporting positively on their wellbeing at work

2.6. Our key areas of focus where we have significant challenges are:

- Timely access to our community services for routine referrals. Although we have improved access to our Adults and Children and Young People services, service users are waiting longer than 28 days from referral to initial assessment. We continue to provide additional resources for initial assessments and addressing vacancy hotspots in teams to address this. Having brought our Adult Community Services under single management, we have also reviewed and improved our processes to improve performance in this area.
- Providing diagnosis within 12 weeks in our Early Memory Diagnosis and Support Service. We continue to provide additional clinics and have started transforming the diagnosis pathway by introducing primary care dementia diagnosis nurses to speed up access to diagnosis.
- Demand and acuity in our inpatient pathways, resulting in increased number of service users being admitted to out of area placements and delays in discharging those who are ready to be discharged. We continue to focus on reducing length of stay in our inpatient units, exploring alternative pathways to support discharge and prevent admission to reduce our need for external beds.
- Service users with high complexity needs having an annual Care Plan Approach (CPA) review. We have improved our overall risk management and care planning system and processes to meet the challenge of rising complexity in cases on every

clinical contact. We are adapting our Care Plan Approach to take advantage of these improvements and to make the Care Plan Approach process more streamlined. Nationally, the system is moving away from CPA towards personalised care and support plans (PCSP). Our Community Transformation programme is planning the transition from CPA to PCSP in Q1.

- Staff recruitment and retention, particularly in nursing and medical workforce. Our workforce establishment continues to grow alongside net recruitment which means our workforce is growing to provide the capacity we need to meet new demand levels.

3. Single Oversight Framework

3.1. At the end of Quarter 4 the Trust has met five out of six key performance indicators in this domain.

3.2. Our IAPT services continue to benchmark in the upper quartile across the UK and are achieving recovery milestones.

3.3. Out of area placements occur when people are admitted, often in crisis, and there is no suitable local bed available. Due to increased demand, we used a higher number of out of area beds in Quarter 4 than planned. We continue to work with NHS England and system partners to ensure best practice in this area and working on reducing length of stay in our inpatient services to ensure our service users are supported in the most appropriate setting.

3.4. The table below summarises the end of quarter position for our Single Oversight Framework key performance indicators. Details of actions we are taking to improve our performance as part of our Recovery Programme can be found in Appendix 1.

KPI	Month	Performance	Target	Variation	Assurance	Mean
Data Quality Maturity Index– MHSDS dataset score (National)	Dec-2022	95%	95%			96.2%
IAPT/Talking Therapies Proportion of people completing treatment who move to recovery (National)	Mar-2023	53%	50%			52.6%
People with a first episode of psychosis begin treatment within 2 weeks of referral (National)	Mar-2023	69%	60%			81.1%
IAPT/talking therapies - 18 weeks (National)	Mar-2023	100%	95%			100%
IAPT/Talking Therapies Waiting time to begin treatment within 6 weeks (National)	Mar-2023	97%	75%			96.1%
Inappropriate out-of-area placements for adult mental health services (National)	Mar-2023	966	0			929.4

Table 1 – Single Oversight Framework KPIs

4. Access

4.1. At the end of Quarter 4, the Trust has met fourteen out of the twenty-four access key performance indicators and almost met four more.

4.2. Service users who present in crisis continued to be seen consistently by the Adult Crisis Resolution and Home Treatment Team and the Children and Young People's Crisis Team recovered performance to meet target. Response times for our Mental Health Liaison Teams, supporting the Acute Hospitals, remain strong. Our Single Point of Access Service has improved the time taken to triage assessments and move people on to the teams where they will receive assessment and treatment.

4.3. Performance for many of our access indicators declined following the pandemic period, with significant challenges in providing timely access to our community services. Our Recovery Programme continues to focus on improving access and we have seen significant improvement across a number of measures in Children and Young People's services as demonstrated by the SPC tables below.

4.4. The table below summarises the end of quarter position for our Access key performance indicators. Details of actions we are taking to improve our performance as part of our Recovery Programme can be found in Appendix 1.

KPI	Month	Performance	Target	Variation	Assurance	Mean
CAMHS Eating Disorders - Routine 28 day Waited. (National)	Mar-2023	100%	95%			43.6%
CAMHS referrals meeting assessment waiting time standards - URGENT (P1 - 7 DAYS) (Contractual)	Mar-2023	No referrals	75%			80.3%
MHLT Response times: 1 hour wait for A&E referrals (National)	Mar-2023	97%	90%			94.4%
SPA referrals with an outcome within 14 days (Internal) (Internal)	Mar-2023	97%	95%			92.3%
CAMHS referrals meeting assessment waiting time standards - CRISIS (4 hours) (Contractual)	Mar-2023	96%	95%			88.8%
Number of new cases of psychosis (National)	Mar-2023	242	137.5	N/A	N/A	
Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team (Contractual)	Mar-2023	100%	95%			96.4%
CAMHS referrals meeting social worker contact waiting time standards - TARGETED SERVICE 14 DAYS (Contractual)	Mar-2023	100%	85%			91.6%
CAMHS referrals meeting assessment waiting time standards - TARGETED SERVICE 28 DAYS (Contractual)	Mar-2023	100%	85%			70.8%

KPI	Month	Performance	Target	Variation	Assurance	Mean
Urgent referrals to community mental health team meeting 24 hour wait (Contractual)	Mar-2023	No referrals	95%	N/A	N/A	
Urgent referrals to community eating disorder services meeting 96 hour wait (Contractual)	Mar-2023	100%	98%	N/A	N/A	
CRHTT referrals meeting 4 hour wait (Contractual)	Mar-2023	100%	98%			100%
MHLT Response times: 24 hour wait for ward referrals (National)	Mar-2023	100%	90%			97.1%
Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait (Contractual)	Mar-2023	No Referrals	98%	N/A	N/A	
CAMHS Eating Disorders - Urgent referrals seen within 7 Days. (National)	Mar-2023	92%	95%			44.9%
Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services (National)	Mar-2023	95%	98%			94.8%
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS) (Contractual)	Mar-2023	91%	95%			75.9%
Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait (Contractual)	Mar-2023	97%	98%			98.2%
Number of people entering IAPT treatment (ENCCG) (National)	Mar-2023	89%	100%			89.4%
Number of people entering IAPT treatment (HVCCG) (National)	Mar-2023	85%	100%			85.3%
Number of people entering IAPT treatment (Mid Essex) (National)	Mar-2023	74%	100%			75.9%
Routine referrals to community mental health team meeting 28 day wait (Contractual)	Mar-2023	63%	95%			52.4%
EMDASS Diagnosis within 12 weeks (Contractual)	Mar-2023	41%	80%			35.5%

KPI	Month	Performance	Target	Variation	Assurance	Mean
Routine referrals to community eating disorder services meeting 28 day wait (Contractual)	Mar-2023	92%	98%			83.6%

Table 2 - Access Key Performance Indicators

5. Safe and Effective

5.1. At the end of Quarter 4, the Trust met ten out of twenty-four key performance indicators in the Safe and Effective domain and almost met a further five. This is an improved position compared to Quarter 3, reflecting the impact of the Continuous Quality Improvement initiatives and Recovery Programme.

5.2. Our carers told us that they felt valued by our staff and our service users reflected that our staff demonstrated the Trusts Values and that they would recommend our services to their friends and family, should they need them.

5.3. We have seen an improvement in the number of inpatients who report feeling safe whilst in our units. However, this remains an area of focus for further improvement. We have also seen a reduction in the number of service users who report that they feel involved in discussions about their care, know how to get support at a time of crisis and find our staff welcoming and friendly. However, our survey responses continue to be low in numbers and we are reviewing our approach to service user experience questionnaires to ensure we have input from wider group of our service users.

5.4. We have seen an improvement in the numbers of service users who receive contact within 48 hours following discharge from our inpatient services which is an important element of keeping people safe during a potentially vulnerable period of their care.

5.5. The data for number of people reported as delayed in our inpatient units when they are fit for discharge shows an improvement. However, this is due to the introduction of a new reporting application that facilitates user friendly and timely recording and improving data quality. We have seen an increase in the number of service users whose discharge has been delayed in the second half of the quarter. We recognise that improvement is necessary in this area, and we continue to focus on finding appropriate placements and support packages for our service users in partnership with the Hertfordshire County Council. We are also recruiting additional social workers specifically to focus on delayed transfers of care.

5.6. The Table below summarises the end of quarter position for our safe and effective key performance indicators with actions we are taking to improve in key areas summarised in Appendix 1.

Safe & Effective	Month	Performance	Target	Variation	Assurance	Mean
IAPT % clients moving towards recovery (HVCCG) (National)	Mar-2023	52%	50%			54.7%
The percentage of people under adult mental illness specialties who were followed up within 48 hrs of discharge from psychiatric in-patient care (Internal)	Mar-2023	84%	80%			81.4%

Safe & Effective	Month	Performance	Target	Variation	Assurance	Mean
The percentage of people under adult mental illness specialties who were followed up within 7 days of discharge from psychiatric in-patient care (National)	Mar-2023	100%	95%			97.1%
Rate of service users that would recommend the Trust's services to friends and family if they needed them (National)	Mar-2023	81%	80%			81.2%
IAPT % clients moving towards recovery (ENCCG) (National)	Mar-2023	53%	50%			51.5%
IAPT % clients moving towards recovery (Mid Essex) (National)	Mar-2023	53%	50%			50.1%
Rate of service users saying they are treated in a way that reflects the Trust's values (Internal)	Mar-2023	84%	80%			83.1%
Rate of carers that feel valued by staff (Internal)	Mar-2023	81%	75%			77.5%
Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them (National)	2022 Q4	73%	70%	N/A	N/A	
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: (National)	Mar-2023	100%	95%			99.9%
Percentage of eligible service users with a PbR cluster (Contractual)	Mar-2023	93%	95%			94.4%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services (Contractual)	Mar-2023	86%	90%			80.9%
Rate of service users with a completed up to date risk assessment (inc. LD&F and CAMHS from Apr 2015) Seen Only (Contractual)	Mar-2023	94%	95%			91.2%
Rate of Service Users Saying staff are welcoming and friendly (Internal)	Mar-2023	92%	95%			95.6%
Rate of Service Users saying they have been involved in discussions about their care (Internal)	Mar-2023	81%	85%			86.3%

Safe & Effective	Month	Performance	Target	Variation	Assurance	Mean
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation) (National)	Mar-2023	55%	85%			58.4%
Percentage of eligible service users with a completed PbR cluster review (Contractual)	Mar-2023	61%	95%			68.9%
The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months (Contractual)	Mar-2023	70%	95%			72.8%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment) (National)	Mar-2023	55%	85%			58.1%
Delayed transfers of care to the maintained at a minimal level (National)	Mar-2023	15%	3.5%			16.6%
Data completeness against minimum dataset for Ethnicity (MHSDS) (National)	Mar-2023	84%	90%			84.5%
Rate of acute Inpatients reporting feeling safe (Internal)	Mar-2023	72%	85%			70.1%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (Contractual)	Mar-2023	89%	95%			80%
Rate of Service Users saying they know how to get support and advice at a time of crisis (Internal)	Mar-2023	69%	83%			79.6%

Table 3 - Safe and Effective Key Performance Indicators

6. Workforce

6.1. The Trust met or almost met four out of the seven Workforce indicators in the quarter. A comprehensive Quarter 4 workforce report is provided to the Integrated Governance Committee and the Trust Board separately.

6.2. We have delivered significant improvements in appraisal rates and unplanned turnover compared to the start of the year, as outlined in the tables below.

6.3. Mandatory Training performance has dipped in March, due to the addition of two new nationally mandated courses in preventing radicalisation. The requirement to complete the courses has been communicated to all staff and recovery is expected by the end of Quarter 1.

6.4. Recruiting and retaining our skilled workforce remains our biggest challenge in delivering services with similar challenges across the NHS, particularly for the medical, registered

nursing and allied health professional groups. We continue to focus on recruiting staff as well as ensuring that we continuously improve the experience of our people so that we retain our staff and maintain our position as one of the best mental health and learning disability trusts to work for in the country.

6.5. Our staff in post figures and vacancy rates have significantly improved as a result of increased and successful recruitment activity. Our staff in post has increased by just over 8% this year, despite an increase in our establishment of just over 6%. The actions we are taking to improve our recruitment and retention are summarised in the Recovery Programme Update section.

6.6. The table below summarises end of Quarter 4 position for our workforce key performance indicators.

Workforce	Month	Performance	Target	Variation	Assurance	Mean
Staff saying, they would recommend the trust as a place to work (Internal)	2022 Q4	72%	70%	N/A	N/A	
Staff wellbeing at work (Internal)	2022 Q4	87%	85%	N/A	N/A	
Mandatory Training (Contractual)	Mar-2023	90%	92%			91.1%
Sickness rate (National)	Mar-2023	5%	4%			5.2%
Turnover rate (Internal)	Mar-2023	12%	8%			13.3%
Rate of staff with a current PDP and appraisal (Contractual)	Mar-2023	86%	95%			81.8%
Rate of staff experiencing physical violence from service users (Internal)	2022 Q4	8%	5%	N/A	N/A	

Table 4 - Workforce Key Performance Indicators

7. Finance

7.1. The month 12 financial position will show a break-even position and confirming the Trusts achievement of its £13.3m CDEL limit.

7.2. The financial position steadied from month 9 onwards however financial pressure areas of OOA placements and high use of agency staff have remained. The overall use of Trust resources has been £9.8m during 2022/23 against a planned use of £3.1m.

7.3. A number of areas will be taken forward under the Financial Recovery workstream, to improve the underlying run rate through to 2023/24.

7.4. The table below summarises the year end position for our Finance Key Performance Indicators.

KPI	Period	Performance	Target
Achieve Surplus in year	Mar-23	0	0
Use of Resources	Mar-23	1	1
NHS Agency Price Caps	Mar-23	466	0
Delivering Value	Mar-23	£5,5m	£10.5 m

Table 5 - Finance Key Performance Indicators

8. Quality Account

8.1. A Quality Account is a published report about the quality of services and improvements offered by an NHS healthcare provider and is reported every Quarter. We report on the quality of the services as measured by looking at:

- patient safety
- how effective patient treatments are
- patient feedback about care provided

8.2. In Quarter 4 we met eight of the ten Quality Account indicators

8.3. Rate of service users who have a completed risk assessment within the last 12 months was almost met.

8.4. Carers receiving an offer of an assessment in the last 12 months remained unmet.

8.5. The table below summarises Quarters 1, 2, 3 and 4 position for our Quality Account Indicators

Number	Service User Safety	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1	Rate of service users who have a completed risk assessment within the last 12 months	>=95%	92%	93%	93%	94%
2	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	>=95%	96%	95%	96%	98%
3	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait	>=98%	94%	98%	99%	98%
	Clinical Effectiveness					
4	At least one outcome measures to be used on all LD F inpatients (HONOS in all inpatient units)	>=80%	92%	94%	89%	92%
5	Urgent CAMHS referrals seen within 7 days	>=75%	88%	83%	74%	90%
6	The proportion of people completing treatment who move to recovery from IAPT	>=50%	54%	53%	49%	53%
	Service User, Carer and Staff Feedback					
7	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	≥=70%	72%	69%	N/A	73%
8	Rate of service users saying they are treated in a way that reflects the Trust's values	>=80%	84%	82%	83%	82%
9	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=70%	79%	78%	80%	80%
10	Trust carer caseload to have an offer of an assessment made in the last 12 months	>=45%	50%	43%	40%	38%

Table 6 – Quality Account Indicators

9. Recovery Programme Update

9.1. The Trust is committed to meeting all its performance targets. We established a Recovery Programme in the first quarter of 2022/23 to bring together all the performance improvement initiatives under a single governance and support structure, reporting into the Executive Team.

9.2. Throughout the year, we maintained a performance review system in place, including quarterly formal Performance Review Meetings (held between the Executive Team and the Strategic Business Units), and the regular reports to the Executive Team, the Trust Board and the commissioners of our service in the following areas:

- The key performance measures agreed by the Trust Board relating to the areas of operational significance. These focus on the service quality measures of access, safety and effectiveness, workforce and finance and reflect the domains of the NHS Oversight Framework. The reporting of these includes the trends in performance as well as deeper analysis into specific issues requested by the Trust Board and its subcommittees.
- Regulatory requirements from NHS Improvement and other bodies.
- The contractual measures reported regularly to commissioners and other partner organisations.
- Progress on the Trust Annual Plan and the achievement of the related objectives.
- Recovery Programme progress reporting as the Trust, in line with the broader NHS and social care system, addressed issues caused in the aftermath of COVID-19.

9.3. We strengthened our capability as a data and information-led organisation in 2022/23 with the introduction of data science and epidemiology capabilities. This has resulted better use and interpretation of our data and information assets including the rollout of Statistical Process Control techniques, regression analysis techniques, and improved visualisation and automation capabilities. Together these allow us to focus strategically on the issues that impact on our performance and provide deeper insights into issues that impact the lives of our service users and carers. Examples of these include equality diversity and inclusion analysis and action, continued improvements our information and analytics capabilities, and more timely and simple access to insights and analysis to support our Continuous Quality Improvement initiatives.

9.4. At the start of 2022/23 the Trust's performance was significantly challenged (55% of KPIs met or nearly met) as a result of the effect of the COVID 19 pandemic. In Adult Services, demand continued to rise, along with complexity. In Children and Young People's services, we saw a rise in presentations of Eating Disorders and ADHD. Older Adult Services faced challenges and suppressed demand for services created waiting list pressure at the start of the year.

9.5. At the end of the year, 68% of KPIs were met or nearly met as a result of our Recovery Programme, Continuous Quality Improvement Programme, and investments in improving service for service users across the system.

9.6. The figure below provides an overview percentage of key performance indicators met or nearly met at the end of each quarter in 2022/23.

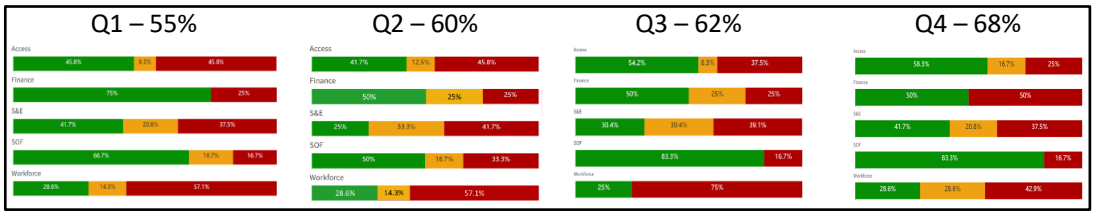


Figure 3 - Summary of end of quarter performance for 2022/23

9.7. In Adult Community Mental Health Services (ACMHS), although we have seen an increased demand, number of service users waiting for an initial assessment was successfully reduced and mean waiting times at the end of the year remained similar to those in Quarter 1.

9.8. Treatment waiting lists for ACMHS have grown during 2022/23 due to increased demand. Although services have been able to absorb this increase without a significant increase in time to treatment to date, reducing this through our community transformation programme is the key to sustainably addressing the increased demand.

9.9. In Children and Adolescent Mental Health Services (CAMHS), improvements over the year have meant that the waiting list sizes are within a sustainable range with waiting times for initial assessments and treatment reducing slightly compared to the beginning of the year. However, challenges persist in one of the quadrants where there are significant vacancies, impacting on the overall recovery of the service.

9.10. It is also worth noting that CAMHS has undertaken a number of successful improvement initiatives over 2022/23 addressing significant challenges in Eating Disorder Services and Looked After Children as well as mobilising a new ADHD service.

9.11. In older adult services, waiting list sizes remained static with no significant change to the waiting times across the year and the 12-week referrals to diagnosis target for dementia was not met throughout the year. A new recovery plan is in place for this service with reduction of the waiting lists to optimum level and recovery of performance expected at the end of October 2023.

10. Conclusion and Recommendations

10.2. The Trust met or almost met 68% of our key performance indicators in Quarter 4 2022-23.

10.3. The Recovery Programme in conjunction with our Continuous Quality Improvement Programme made good progress in improving performance during Quarter 4.

10.4. The Trust Board is recommended to receive the report, discuss key areas of performance and to note actions being taken to improve performance

4 Appendices

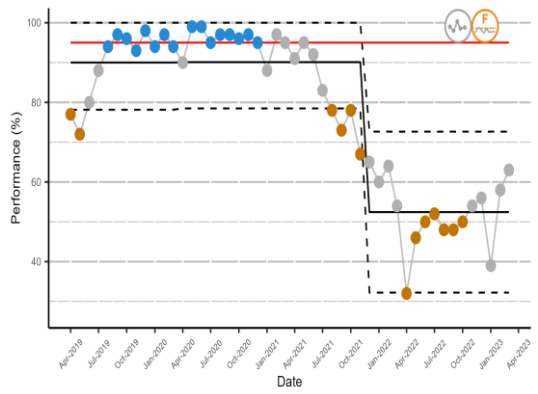
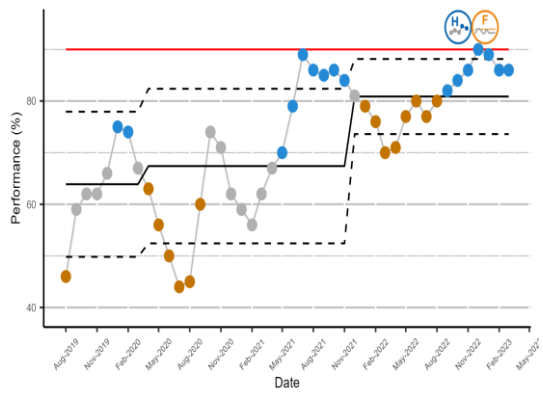
APPENDIX 1 – RECOVERY PROGRAMME UPDATE

4.1 This section summarises the high priority projects in the Recovery Programme and the steps we are taking to improve performance in areas of key concern. It is organised into logical groups (Inpatient, Adults, CAMHS etc) for ease of reference.

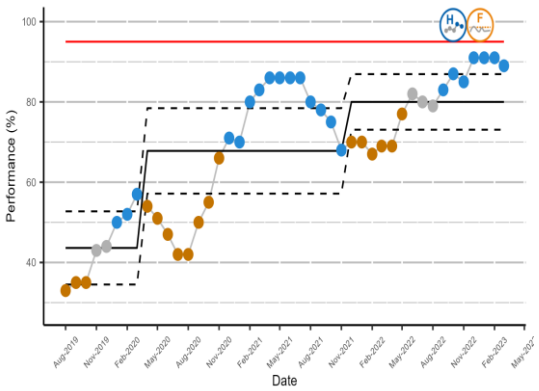
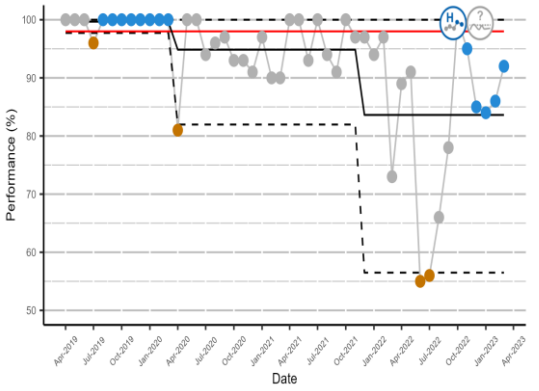
4.2 Each summary is broken into 5 sections (columns)

- KPI – Is the name of Recovery Project and the description is normally aligned to the KPI that the project aims to recover
- Chart – Statistical Process Control Chart showing the target (red line), trend line (grey / blue / orange dots joined by a grey line), and the upper and lower limits of normal variance levels (dotted grey lines). Please note that the dotted lines step up / down in accordance with changes in variation in alignment with the pre, during and post the COVID-19 pandemic.
- What the data is telling us – a written interpretation of the chart
- Summary – A brief description of the root cause / problem identified
- Key actions – the steps we are taking to recover

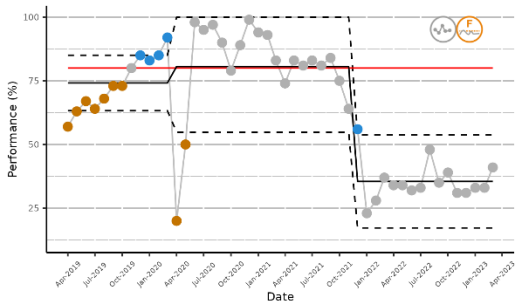
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
Routine referrals to community mental health team meeting 28 day wait		**Mar-2023** 63% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assassurance** Consistently not meeting performance target	Review of referral demand reflects growth of approximately 30% between March/April 2022 and March/April 2023, with no associated increase in workforce, therefore all actions being taken to resolve backlog and move to more sustainable position is challenging. Of note, referrals to South West have more than doubled, which is an area with one of the most challenged vacancy rates	• Agency workers are supporting recovery where available • Action plans for each team addressing demand and capacity and data quality issues • Ongoing development of pathway using LEAN principles • Work with commissioners to address the increase in ADHD referrals • Additional support for administrators to manage data and caseload clean-up • Out of hours clinics continue to increase capacity • There is an ongoing focus on recruitment of staff.
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in		**Mar-2023** 86% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) Two of three data points within upper zone A (improvement) **Latest Target** 90% **Assurance**	We have seen improvement in performance against this indicator over the last six months, with target reached in December 2022, but falling away slightly over the last quarter due to a lack of resource in teams where there are vacancies combined with annual leave and sickness.	• Individual improvement trajectories are being set for teams. • Business case in progress to secure additional specialist resource to support physical health. • Recovery expected in Q1 but dependent on additional resource

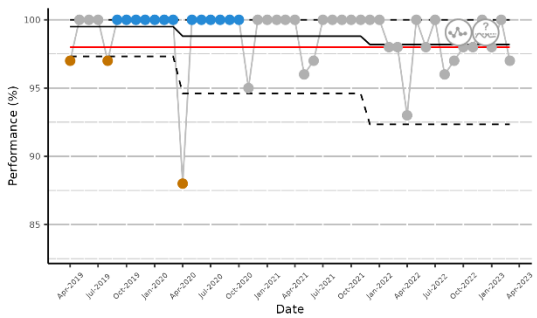
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental		**Mar-2023** 89% **Variance Type** Special Cause Variation: Latest value above upper control limit (improvement) Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance** Consistently not meeting performance target	We have seen improvement in performance against this indicator over the last six months. There continue to be challenges due to a lack of resource in teams where there are vacancies combined with annual leave and sickness.	• Individual improvement trajectories are being set for teams. • Business case in progress to secure additional specialist resource to support physical health. • Recovery expected in Q1 but dependent on additional resource
Routine referrals to community eating disorder services meeting 28 day wait		**Mar-2023** 92% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) **Latest Target** 98% **Assurance** Inconsistently meeting performance target	The Adult Eating Disorders Team has seen a 30% increased rate of referrals, compared to the pre-COVID period. There has been some improvement over the last 6 months in performance against target.	• A CQI project has been initiated to look at improvements in the service. This will include a review of demand and capacity and how the access times can be consistently met. Recovery of the target is expected for Quarter 1.

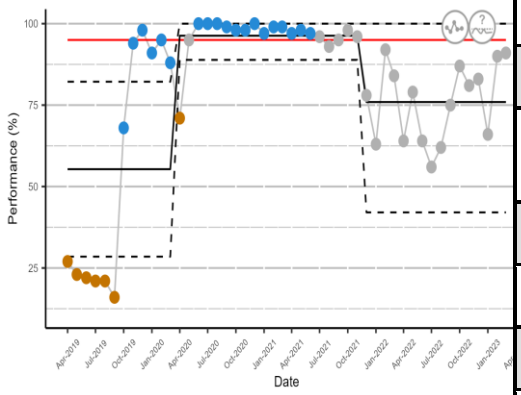
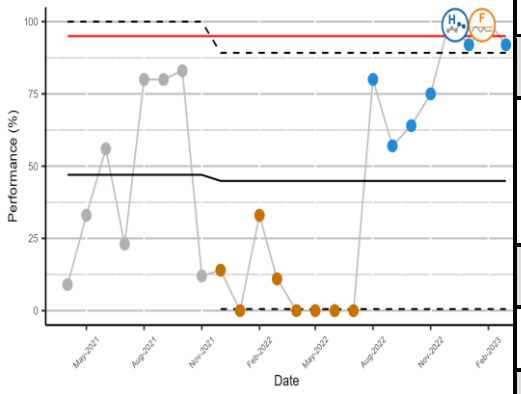
Older Adult Services

KPI	Chart	Narrative	Summary	Key Actions
EMDASS Diagnosis within 12 weeks		**Mar-2023** 41% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 80% **Assurance** Consistently not meeting performance target	For a period over the winter 2021 COVID wave EMDASS staff were required to support inpatient units. This resulted in an increase in people waiting for diagnosis. Subsequently a sharp rise in referrals during June / July created additional backlog that has stabilised at circa 400 people more than the optimum waiting list level and continues to cause delays in diagnosis.	• Recovery plan is in place that will reduce the waiting list to the optimum level by the end of October 2023 by providing additional weekend clinics and primary care diagnoses. • Weekly meetings between performance team and service to monitor demand and capacity.

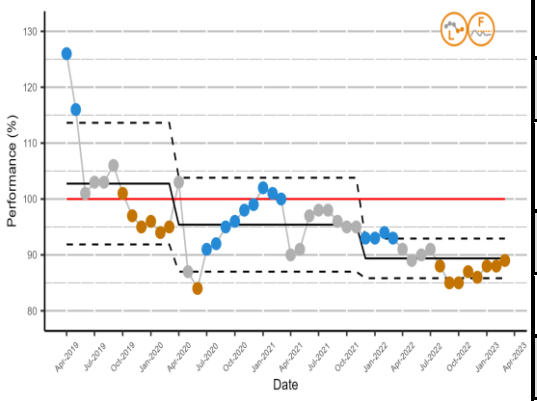
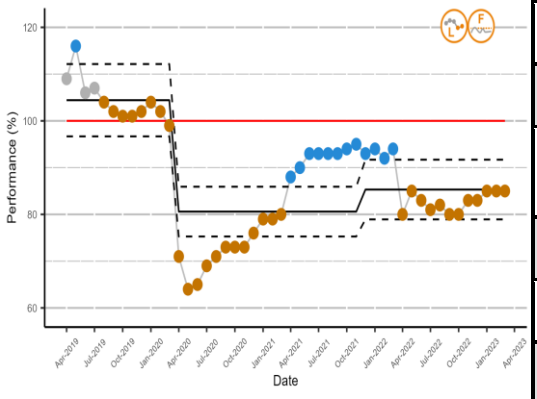
Learning Disability Services

KPI	Chart	Narrative	Summary	Key Actions
Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait		**Mar-2023** 97% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98% **Assurance** Inconsistently meeting performance target	The 28-day waiting time target is usually met, as shown in the SPC chart. In March two people were seen outside of the 28-day window. In both cases the delay was due to calculation errors in appointment times and is not expected to reoccur. Recovery expected in Quarter 1	• All staff reminded of need to calculate appointment times accurately. • Increased monitoring by management

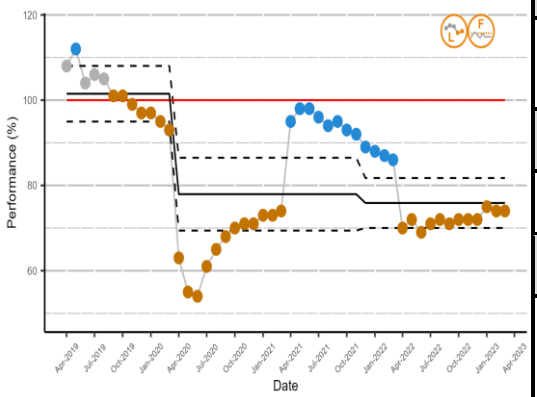
Children and Adolescent MH Services

KPI	Chart	Narrative	Summary	Key Actions
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS)		**Mar-2023** 91% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Inconsistently meeting performance target	An increase in demand, post-COVID, combined with capacity issues in our Single Point of Access (SPA) Service resulted in an increased number of children and young people waiting for an initial assessment. Referral numbers have now stabilised. We anticipate recovery in all quadrants in May, with the exception of the South Quadrant where demand exceeds capacity at present, with a significant vacancy rate.	• Additional resources mobilised across the service to support the South Quadrant • Ongoing recruitment activity for vacancies • Weekly recovery meeting led by MD to monitor and develop action plan and South Quadrant progress, including cover and replacement for current vacancies
CAMHS Eating Disorders - Urgent referrals seen within 7 Days.		**Mar-2023** 92% **Variance Type** Special Cause Variation: Latest value above upper control limit Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance** Consistently not meeting performance target	CAMHS Eating Disorders saw a significant increase in referrals post-COVID and a waiting list backlog developed. This has now been cleared, with improved progress and target has been met twice in the last four months. One child was seen outside of the 7-day target in March. Full recovery is expected in Quarter 1.	• Continued oversight and management of the waiting list to ensure all children with urgent referrals are seen within 7 days.

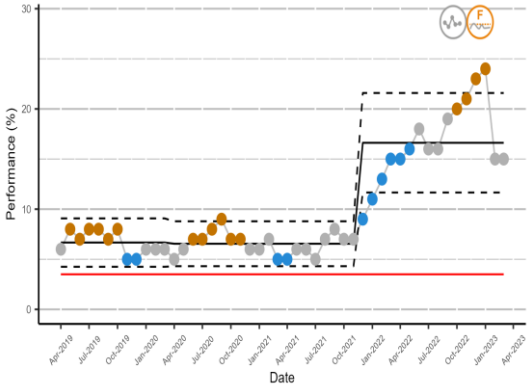
IAPT Services

KPI	Chart	Narrative	Summary	Key Actions
Number of people entering IAPT treatment (ENCCG)		**Mar-2023** 89% **Variance Type** Special Cause Variation: Latest 6 data points are below mean (concern) **Latest Target** 100% **Assurance** Consistently not meeting performance target	NHS Talking Therapies (previous known as IAPT) National change to branding announced in Jan 2023; with expected longer-term impact on service public profile. Improvement in Q4 referrals compared to previous 3 Quarters	• Significant comms and marketing activity throughout the year targeting underrepresented groups (e.g. older people and BAME groups) to increase referrals • Refocusing on long-term conditions pathways to improve physical health team engagement, appropriateness of referrals / improved outcomes • Rollout of workshops generated increase in access in Q4 to continue into 2023/24
Number of people entering IAPT treatment (HVCCG)		**Mar-2023** 85% **Variance Type** Special Cause Variation: Latest 6 data points are below mean (concern) **Latest Target** 100% **Assurance** Consistently not meeting performance target		

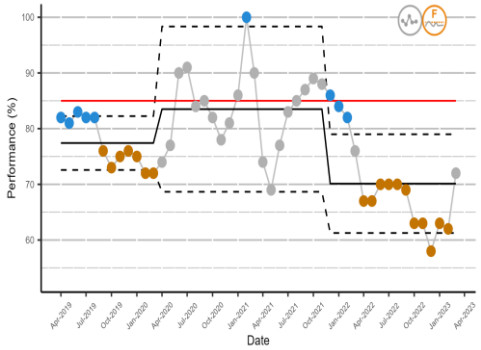
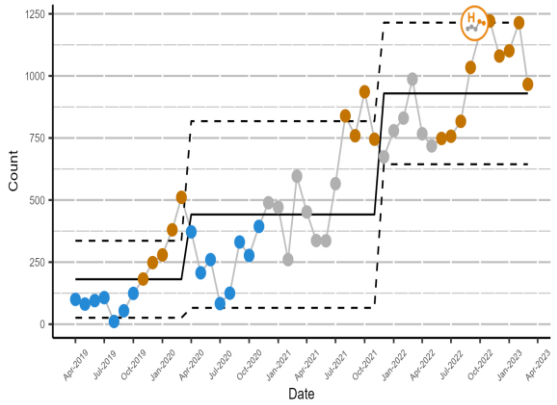
IAPT Services

KPI	Chart	Narrative	Summary	Key Actions
Number of people entering IAPT treatment (Mid Essex)		**Mar-2023** 74% **Variance Type** Special Cause Variation: Latest 6 data points are below mean (concern) **Latest Target** 100% **Assurance** Consistently not meeting performance target	NHS Talking Therapies (previous known as IAPT) National change to branding announced in Jan 2023; with expected longer-term impact on service public profile. Improvement in Q4 referrals compared to previous 3 Quarters Sustained targets for initial appointments, with service waits for step 3 breaching 90 days for treatment due to patient complexity Continued increase in patients needing step up to secondary care teams Sustained outcomes for patients (recovery rates and ADSM CQUIN)	• Significant comms and marketing activity throughout the year targeting underrepresented groups (e.g. older people and BAME groups) to increase referrals • Refocusing on long-term conditions pathways to improve physical health team engagement, appropriateness of referrals / improved outcomes • Rollout of workshops generated increase in access in Q4 to continue into 2023/24

Inpatient Services

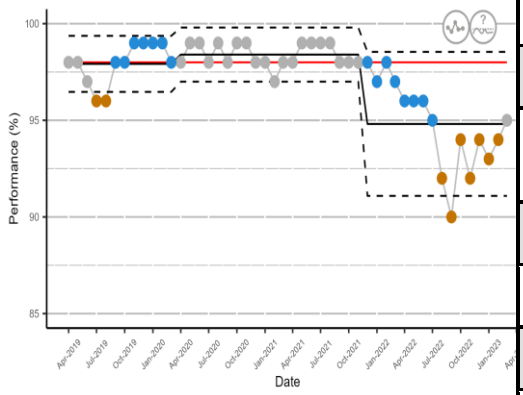
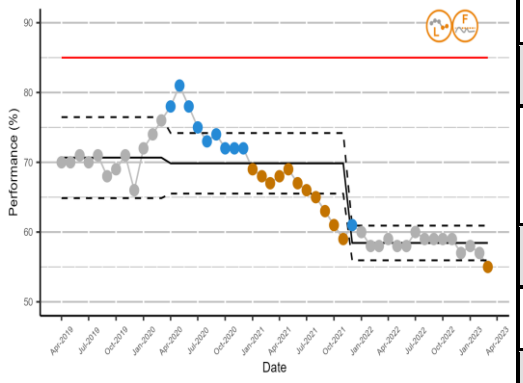
KPI	Chart	Narrative	Summary	Key Actions
Delayed transfers of care to be maintained at a minimal level		**Mar-2023** 15% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 3.5% **Assurance** Consistently not meeting performance target	The data for number of people who are ready to move on from our inpatient services but are delayed shows an improvement. This is due to the introduction of an App that facilitates user friendly and timely recording, improving data quality. We have seen an increase in the number of service users whose discharge has been delayed in the second half of the quarter We have made changes to put social care at the forefront of the pathway we expect this to have a positive effect on delays. We expect the actions we have put in place to reduce our delays in line with National expectations, to an agreed level by Quarter 3 23/24	• Social worker now in place for Swift and 72 - hour meeting; additional support of 2 further social workers to be put in place to support both delayed discharges and out of area placements. • Strengthened contractual management arrangements to introduce contractual lengths of stay targets for each service, with exception reporting. • Continue to deliver MADE type events with key stakeholders

Inpatient Services

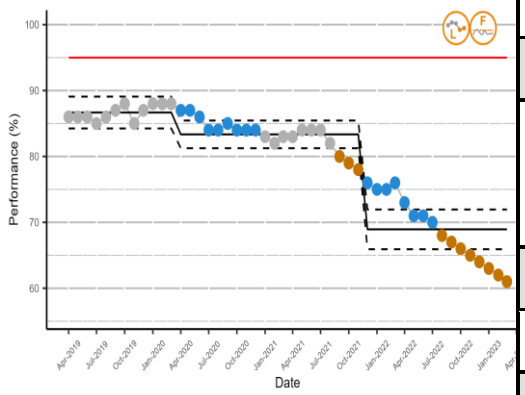
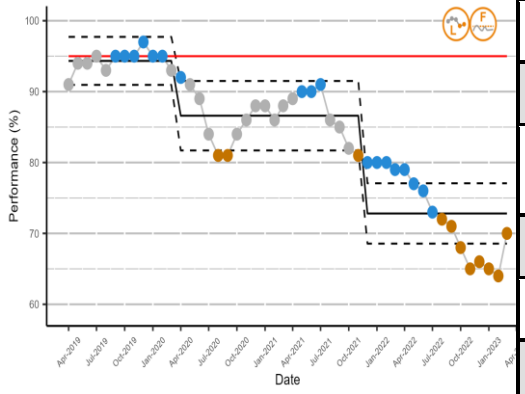
KPI	Chart	Narrative	Summary	Key Actions
Rate of acute Inpatients reporting feeling safe		**Mar-2023** 72% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 85% **Assassurance** Consistently not meeting performance target	The number of people saying that they feel safe in our inpatient units has decreased due to high levels of acuity and Mental Health Act admissions and a small but significant number of people who are particularly unwell and can cause others to feel unsafe.	• The actions from the feeling safe survey which was trialled in September 2022 are moving ahead with each SBU taking forward their own action plan. It has been agreed that this survey will be offered to service users again in May 2023 to understand how the experience has changed and whether actions taken are showing an improvement. • The Peer Experience Listening “Post Incident Support” project for Medium Secure Services is working to understand how supported service users were post incident. • The Experience Team are also working with older peoples’ services on the Peer Observation Project to understand how safe people feel in older inpatient units, particularly those service users who have dementia and may not be able to communicate their feedback.
Inappropriate out-of-area placements for adult mental health services		**Mar-2023** 966 **Variance Type** Special Cause Variation: Latest 6 data points are above mean (concern) **Latest Target** 0 **Assurance**	Out of area placements (OAPs) have remained high, reflecting the national picture of increased demand and acuity within mental health services. The Trust also benchmarks at the lower end for number of inpatient beds per population (the equivalent of 50 beds below average)	• Increased visibility for all patients out of area. Out of area placements taking place twice weekly, including Community Team involvement. • Consultant-led bed management meetings 3 times per day, 5 days per week • Process controls in place to monitor, review, and balance demand and capacity. • Recruitment underway for dedicated staff to further improve access and flow and ensure sustainability across the year - Enhanced Discharge Team. • Implementing best practice from the national Getting It Right First-Time programme

Inpatient Services				
KPI	**Chart**	**Narrative**	**Summary**	**Key Actions**
		N/A		

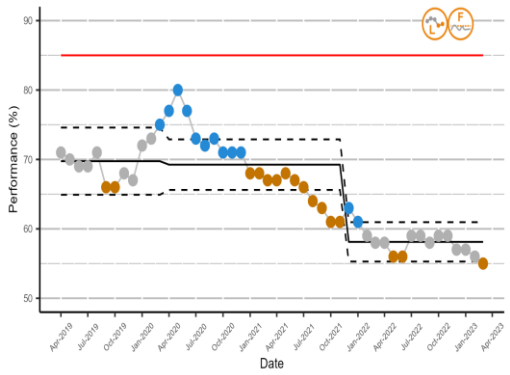
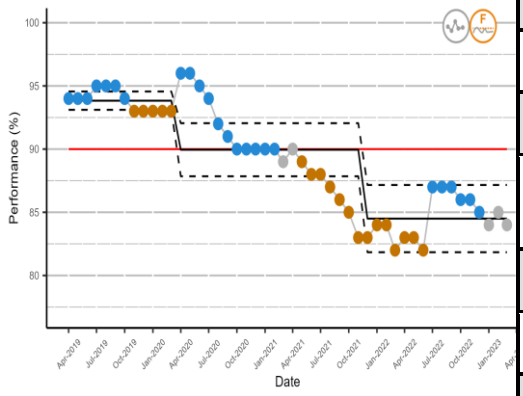
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services		**Mar-2023** 95% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98% **Assassurance** Inconsistently meeting performance target	Sustained high demand in our services is impacting on our 18-week wait to treatment times, particularly in hard to recruit areas. Recovery of waiting list in areas that are clearing long waiting lists are impacting on performance, as expected Recording of start of treatment in electronic records also needs improvement. We expect this to recover in line with our waiting times in Adult Services, CAMHS and EMDASS.	• Caseload review and development of caseload management tool to increase capacity overall and improve time to treatment. • Data quality project in place as part of Recovery Programme with additional support to services to address potential data quality issues
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation)		**Mar-2023** 55% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) **Latest Target** 85% **Assurance** Consistently not meeting performance target	Data quality campaign in previous quarters had limited success, increasing compliance temporarily.	A long-term solution is being developed to provide an app for staff, that shows their caseload with non-compliant SU's records and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in Quarter 1.

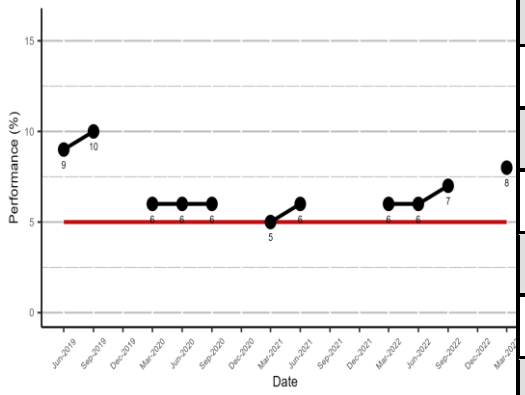
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Percentage of eligible service users with a completed PbR cluster review		**Mar-2023** 61% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) Measure has fallen 6 consecutive data points Latest 6 data points are below mean (concern) **Latest Target** 95% **Assurance** Consistently not meeting performance target	Honos cluster reviews were introduced as part of the Payment by Results initiative. Performance declined over the Covid period and has not taken priority over access and safety indicators.	Review of clinical outcome measures is underway as part of the Transformation Programme
The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months		**Mar-2023** 70% **Variance Type** Special Cause Variation: Latest 6 data points are below mean (concern) **Latest Target** 95% **Assurance** Consistently not meeting performance target	Service users with high complexity needs having an annual Care Plan Approach review declined from the start of the pandemic. As part of the trust business continuity planning (BCP) arrangements this time we made changes to the risk assessment, contact approach and crisis planning. This allowed us to increase contact and provide more support to service users on CPA. This practice continued post-pandemic.	We have improved our overall risk management and care planning system and processes to meet the challenge of rising complexity in cases on every clinical contact. We are adapting our Care Plan Approach to take advantage of this and make the CPA process more streamlined. Nationally, the system is moving away from CPA towards personalised care and support plans (PCSP). Our Community Transformation programme is planning the transition from CPA to PCSP in Q1.

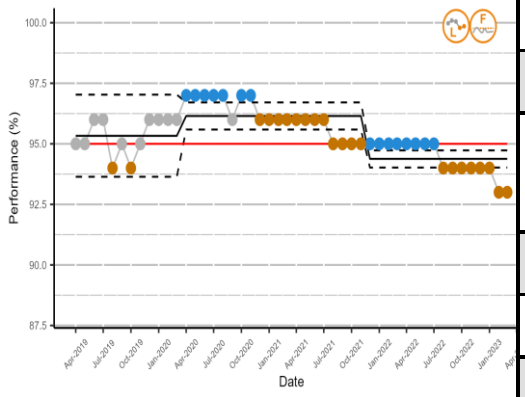
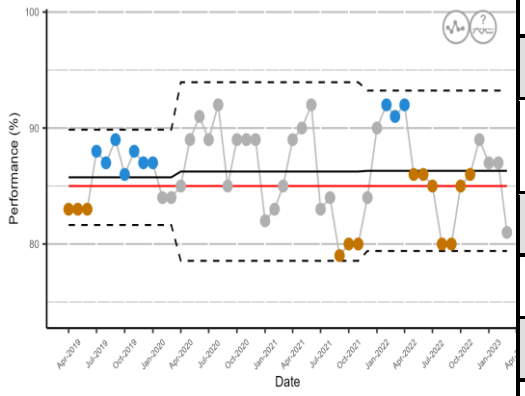
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment)		**Mar-2023** 55% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) **Latest Target** 85% **Assurance** Consistently not meeting performance target	Data quality campaign in previous quarters had limited success, increasing compliance temporarily.	A long-term solution is being developed to provide an app for staff, that shows their caseload with non-compliant SU's records and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in Quarter 1.
Data completeness against minimum dataset for Ethnicity (MHSDS)		**Mar-2023** 84% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 90% **Assurance**	Data quality campaign in previous quarters had limited success, increasing compliance temporarily.	A long-term solution is being developed to provide an app for staff, that shows their caseload with non-compliant SU's records and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in Quarter 1.

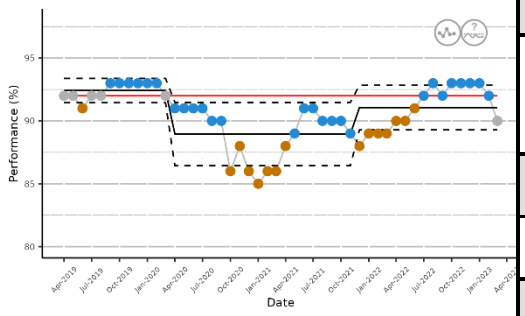
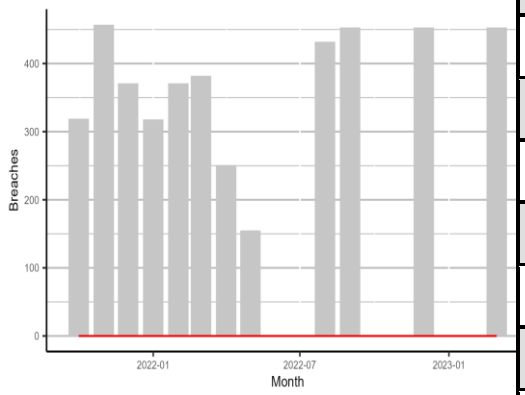
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
Rate of staff experiencing physical violence from service users		**2023 Q4** 8% **Variance Type** N/A **Latest Target** 5% **Assurance** N/A	The staff survey results for HPFT for 2022 show that 18.2 % of staff report they have personally experienced physical violence at work from service users, their relatives or other members of the public. This remains the same as the 2021 staff survey and above the average compared to other Trusts (14.5%).	The Violence and Aggression CQI project is chaired by the Deputy Director for Nursing and Quality and the project team includes senior Trust staff, experts by experience, front line staff, police and staff- side representatives. The project team have met nine times and views have also been sought form other forums including the Big Listen and from the Health Care Support Workers Development session. During the meetings, different ideas to address violence and aggression incidents were noted down and grouped into the following themes: • Communication • Culture • Innovation • Management • Operating Policy • Practice • Team working • Training Leads have been identified for each theme to drive the project forward.

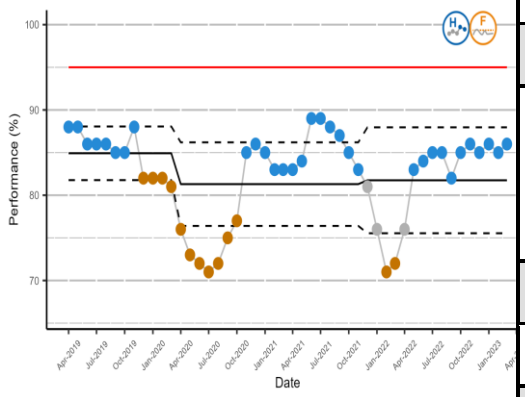
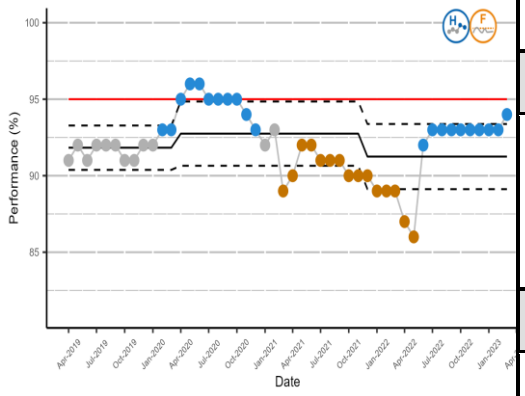
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Percentage of eligible service users with a PbR cluster		**Mar-2023** 93% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean (concern) **Latest Target** 95% **Assurance** Consistently not meeting performance target	Honos assessments were introduced as part of the Payment by Results initiative. Performance declined over the Covid period and has not taken priority over access and safety indicators.	Review of clinical outcome measures is underway as part of the Transformation Programme
Rate of Service Users saying they have been involved in discussions about their care		**Mar-2023** 81% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 85% **Assurance** Inconsistently meeting target	The completion rate for this indicator which is part of the Having Your Say Survey is comparatively low, with results fluctuating common cause variation.	The process for gaining service user and carer experiences and feedback has been reviewed and a new methodology will be introduced in 2023/24 that is expected to give more meaningful results.

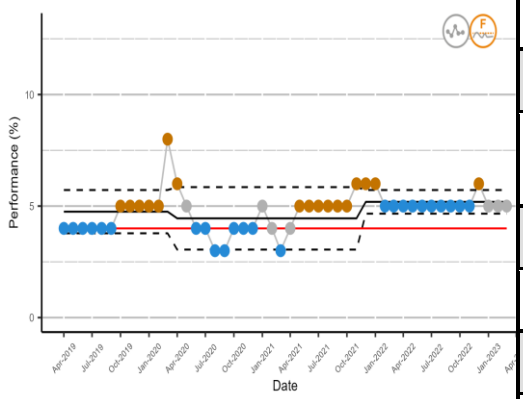
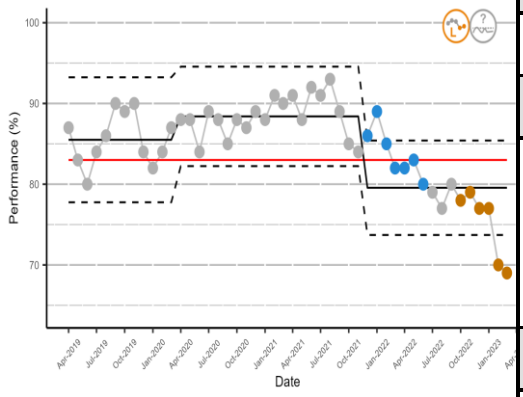
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Mandatory Training		**Mar-2023** 90% **Variance Type** Special Cause Variation: The KPI is currently undergoing common cause variation **Latest Target** 92% **Assurance** Inconsistently meeting target	The previous Preventing Radicalisation training which clinical staff completed has expired. Nationally 2 new courses have come into place since the end of last year; • Preventing Radicalisation - Basic Awareness Training – all staff to complete • Preventing Radicalisation - WRAP Level 3 – clinical Staff to complete This has resulted in compliance falling to zero for Preventing Radicalisation training as all staff now need to complete this.	Key actions that have taken place so far is a communication going out Trust- wide by the Safeguarding Team who oversee preventing radicalisation training. This explained the courses which have been added to staff profiles and the time frame in which we need the training to be completed. Monthly compliance reports are run and sent to all SB use including business partners, Modern matrons, service line leads, Team Managers etc showing a rag report of Rags records showing if they are either in or out of date with training. Further communications are being sent out to ensure compliance in order to reach our target of 92% which may take until the end of Q1 to achieve.
NHSI agency price caps		**Mar-2023** £453 **Variance Type** N/A **Latest Target** 0 **Assurance** N/A	The Trust is currently paying in excess of agency cap prices (off-framework) in two limited areas: 1. To expedite the initial assessment of service users to enhance access to care where a backlog has developed. 2. To safely staff inpatient units in Lexden Hospital. There are no further instances in which the Trust is paying above framework rates for agency staff.	Continually review the above framework payments to agency staff in support of performance improvement, on a week-by-week basis. The use of off-framework agency staff to support inpatient services at Lexden Hospital is reducing, with the aim of returning to framework providers as soon as it is possible and safe to do so.

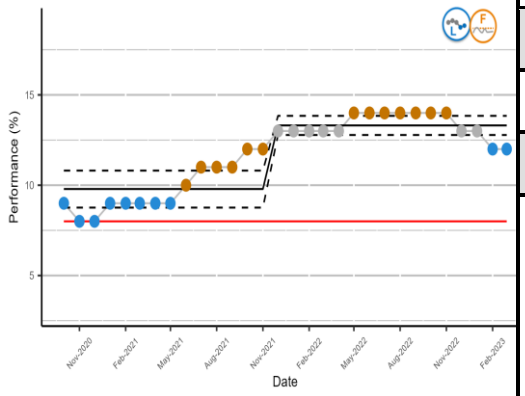
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Rate of staff with a current PDP and appraisal		**Mar-2023** 86% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) Two of three data points within upper zone A (improvement) **Latest Target** 95% **Assurance** Consistently not meeting performance target	Appraisal compliance improved slightly from 85% at the end of Q3 to 86% at the end of Q4. The SPC chart demonstrates that we have not met our target of 95% compliance historically, including pre-pandemic. However, the impact of launching the Appraisal App and potentially moving to an appraisal window will be monitored as it is expected to increase compliance significantly.	• Monthly reporting to the Executive Team and People and OD Group • New Appraisal App launched at the end of Q4 • Our new appraisal window launched at the end of Q4 and took effect from April 2023 • A further push on achieving compliance to coincide with the App and appraisal window launch and enhanced reporting
Rate of service users with a completed up to date risk assessment (inc. LD&F and CAMHS from Apr 2015) Seen Only		**Mar-2023** 94% **Variance Type** Special Cause Variation: Latest value above upper control limit (improvement) Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance**	Pressures during COVID and increased caseloads, compounded by time consuming recording methods, resulted in people waiting longer for a review of their risk assessment. Expected to fully recover in Quarter 1	• Implement phase 4 of the CQI project aimed at data cleansing • Implementation of revised format of risk form in Paris now complete • Data clean-up underway to remove people who should have been discharged. • Simulation suite training rollout continues for teams with low assessment compliance • Case review and re-allocation for large psychiatry caseloads underway • Administrative support to teams with high caseloads

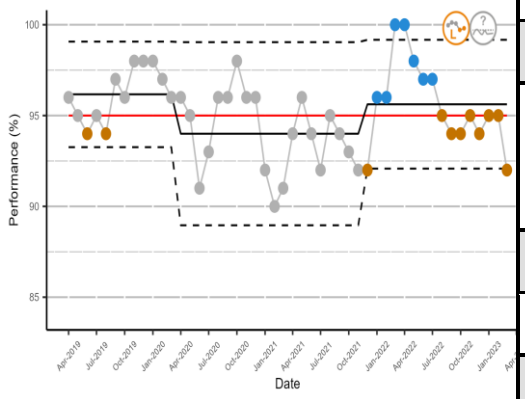
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
Sickness rate		**Mar-2023** 5% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 4% **Assurance** Consistently not meeting performance target	In Q4, sickness absence decreased from 5.7% at the end of Q3 to 5% in Q4. Mental ill health related absence continued to remain our top reason for absence, albeit at lower than historical rates, whilst colds/flu, Covid-19 and Musculo-skeletal related absence started to reduce.	• Continuing our regular health and wellbeing offer to staff • Gained accreditation as a menopause friendly organisation and continue to implement our menopause friendly action plan • Expanding our pool of health and wellbeing champions and mental health first aiders • Training more Schwartz round facilitators • Offering on-site mini health checks • Winter wellbeing festival taken place in January. • Expanding our financial wellbeing and support offer to staff
Rate of Service Users saying they know how to get support and advice at a time of crisis		**Mar-2023** 69% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) Latest 6 data points are below mean (concern) **Latest Target** 83%	The completion rate for this indicator which is part of the Having Your Say Survey is comparatively low, which will mean that the results are likely to fluctuate. Current performance shows special cause variation for 6 consecutive points below the mean.	The process for gaining service user and carer experiences and feedback has been reviewed and a new methodology will be introduced in 2023/24 that is expected to give more meaningful results. The way in which we communicate with service users as to where to get support and advice at a time of crisis will be reviewed to ensure that it is effective.

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Assurance		
		Inconsistently meeting performance target		
Turnover rate		**Mar-2023** 12% **Variance Type** Special Cause Variation: Latest value below lower control limit (improvement) **Latest Target** 8% **Assurance** Consistently not meeting performance target	Our unplanned turnover has reduced month on month since September, to 12 % in March, compared to 13% in January. Our staff in post has increased to further to 3,665 from 3,383 at the start of this year, which is an increase of 282 FTE, i.e. an 8.3.% increase and the highest it has ever been. This is in the context of an establishment which has increased by 6.1% this year Our unplanned turnover rate remains significantly above the target of 8% and the SPC chart indicates that historically we have not been able to meet this target since 2019. Our annual staff survey results show us to be the joint third best mental health trusts to work for in the country. Our results also helped to reaffirm our top three areas of focus: improving self-care, reducing violence and aggression and making sure that everyone has a positive experience, regardless of who they are or where they work	• Launched our new 'Holiday of a Lifetime' scheme • Launched our new selling of annual leave scheme • Launched new bus travel and childcare discounts for staff. • Trained our newest cohort of Inclusion Ambassadors to help us realise our vision of ensuring that recruitment panels for all our management positions will have an Ambassador to help ensure fairness and equity • Developing our Belonging and Inclusion Strategy based on staff feedback. • Launched our new Appraisal App and appraisal window to ensure all our staff receive an appraisal that helps to retain them by ensuring they feel valued, supported and developed. .

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Rate of Service Users Saying staff are welcoming and friendly		**Mar-2023** 92% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) Latest 6 data points are below mean (concern) **Latest Target** 95% **Assurance** Inconsistently meeting performance target	The completion rate for this indicator which is part of the Having Your Say Survey is comparatively low, which will mean that the results are likely to fluctuate. Current performance shows special cause variation for 6 consecutive points below the mean.	The process for gaining service user and carer experiences and feedback has been reviewed and a new methodology will be introduced in 2023/24 that is expected to give more meaningful results.

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 10
Subject:	Flash Financial Position – Month 1	**For Publication:** Yes
Author:	David Flint, Head of Financial Performance & Reporting	**Approved by:** Philip Cave, Chief Finance Officer
Presented by:	Philip Cave, Chief Finance Officer	

Purpose of the report:

This paper is to provide the Board with an early indication of the expected financial position for the month and the full year to both inform whether previously agreed actions are having the expected impact and to highlight areas where further management action is required.

Action Required

To consider the financial position for the month and speed of financial recovery and advise on it's appropriateness though the remainder of the financial year.

Report & Recommendations

The flash report shows a position of overspend against the Trust plan, primarily driven by pay spend. The position for OOA beds has improved by circa £300k per month with a reduction of 249 Adult acute bed days compared to March and is broadly in line with the revised financial plan. The financial recovery programme is having an impact in isolated areas but is yet to bring about wholesale reductions in expenditure for sustained periods.

The headline areas of overspending in month 1 are:

- Pay costs, which are no longer increasing, but are not reducing in bank and agency usage following 4 consistent months of positive net recruitment. Bank spend has remained consistent and agency costs whilst showing a modest improvement in Corporate, are not showing reductions on a scale required to meet the financial plan. Pay costs will overspend by circa £4.5m if the current levels are not reduced.
- Secondary Commissioning expenditure is £27k higher than forecast for April, the equivalent of 1 OOA placement. Whilst above plan in month, this is a significant improvement on figures reported in the previous 6 months. There is some concern as to whether this will be sustained following a sharp rise in adult acute placements through the first week of May.

The finance team are continuing to pursue the below items that will deliver a positive improvement on the Trust financial position if achieved. These are:

- £600k - £1m - The continued pursuit of the rates rebate through the District Valuer for Kingsley Green
- £600k - £2.5m - The recovery of backdated income associated with the running of SRS services from NW London ICB. NHSE EOE region are involved in pursing this the London region and agree with HPFT's assessment of the outstanding issue.

Recommendations

Continue to accelerate the financial recovery program to bring about expenditure reductions in 2023/24 and sustain them through changes in practice.

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

Delivery of Financial Plan

Summary of Financial, IT, Staffing & Legal Implications:

Delivery more than Financial Control Total

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

N/A

Evidence for S4BH; NHSLA Standards; Information Governance Standards, Social Care PAF:

Delivery of Financial Plan

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

Executive Team Meeting 10th May 2023
FIC 18 May 2023

1. Summary Headlines

1.1 This report presents an early projection of the likely financial position for April (month 1), 2023/24, with key issues and remedial actions highlighted.

1.2 The projected M1 position reflects a continued challenging financial position that is currently buoyed by a delay in the recruitment to new services. A forecast outturn for the full year is reflective of the full year plan at present and will be revised as months progress.

Financial Position to 30 April 2023	Plan	Actual	Variance	Plan	Outturn	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	28,047	28,077	30	338,362	338,362	0
Provider Collaborative Income	4,017	4,017	0	48,204	48,204	0
Pay	18,744	19,119	(375)	224,930	224,930	0
Secondary Commissioning	4,111	4,138	(27)	50,150	50,150	0
Provider Collaborative	4,017	4,017	0	48,204	48,204	0
Non Pay	2,077	1,995	82	24,926	24,926	0
Overheads	3,346	3,346	0	40,156	40,156	0
Surplus / (Deficit)	**(231)**	**(521)**	**(290)**	**(1,800)**	**(1,800)**	**0**

1.3 Secondary Commissioning costs have held broadly within the plan for month 1 but saw a notable rise in adult acute beds towards the end of the month. This has been sustained through the first week of May and is expected to create an additional cost pressure unless numbers reduce again.

1.4 The primary area of overspending in month 1 is agency costs against the Trust plan.

2. Pay costs

2.1 Pay costs are forecast to exceed plan by £375k in month 1 and this is reflective of continued high use of bank and agency staffing. A provision has been made in month for the pay award in line with national planning assumptions, with further guidance expected to raise that once the full and final pay award is agreed and funded.

2.2 Agency costs have reduced by £43k from the month 11 position but remains £408k above the plan. This is only partially offset (£136k) by vacancies within permanent pay. This reflects positive improvements in permanent staff recruitment without the subsequent reductions in bank and agency staff usage. Further analysis will look to align positive recruitment with continued agency use

2.3 Decreases in agency costs have come across corporate services where costs have halved from circa £80k per month to £40k. Other SBU changes are expected to be immaterial in month 1.

3. Secondary Commissioning

3.1 Secondary Commissioning costs are forecast to be £27k above plan. This reflects a positive start to the month but with numbers increasing as the month continued. The total number of adult acute bed days reduced in month to 1,516 from 1,765 in March which is in line with the submitted plan to have a consistently reducing number until the summer months where, historically, the Trust would expect to see an increase. The first week of May has seen a significant increase in bed usage and requires continued close monitoring.

4. Provider collaborative

4.1 The Provider Collaborative reports a balanced position year to date with scope for additional transformation schemes to be developed as the year progresses. The Trust is looking to access the transformation funding to support the Forest House and Warren Court finances where possible and are engaging with the Provider Collaborative on the process required to complete this.

5. Non-Pay costs are in line with plan for the year to date for the month. There is a recognised reduction in drugs costs forecast for month 5 onwards that is being managed through the Delivering Value Management Group and will be reported back through the finance report once actioned.

6. Overhead costs are in line with plan for the year to date with little material reduction seen in costs. This recognises the inflationary uplifts applied to the HBLICT contract and CNST contribution which have created an annual additional cost of circa £1.1m from 22/23. Trust maintenance costs have been estimated in line with 22/23 spend levels. This will be reviewed with the estates department in line with the revised controls process.

7. Delivering Value

7.1 DV savings in month 1 are being reviewed in line with the revised submitted plan on the 4th May 2023. Reductions in Adult acute bed placements are forecast to be the main delivered item in month 1 along with small reductions in agency spend across corporate teams. Continued momentum will be driven through the financial recovery board and Delivering Value Management Group to maximise potential savings and drive through the savings identified in the plan.

8. Transformation

8.1 Transformation income is released into the monthly position in line with actual spend as it is incurred, primarily on pay costs. Spend on transformation has been reviewed to reflect the full investment in Community services in year and associated support.

8.2 Additional transformation funding provided in 23/24 is being reviewed against the requested investment areas and will be agreed with Commissioners in the coming weeks.

8.3 Transformation funding will be fully utilised in 23/24.

9. Conclusion

9.1 The month 1 financial position is projected to highlight a continuation of the challenging financial position experienced during 22/23 with small improvements in the OOA placement position but minimal reductions in the use of agency staffing. Agency and bank usage above levels set out in the financial plan will continue to place pressure on the overall Trust financial position as the year progresses. Work continues to bring about reductions in bank and agency expenditure.

9.2 The finalisation of the Trusts establishment review and subsequent recruitment to additional posts will aid in the reduction of agency spend but will only reduce spend by the value of the agency premium, when the Trust needs to bring about a whole time reduction in the volume of staffing used in inpatient areas in particular.

10. Recommendations

Continue to accelerate the financial recovery program to bring about expenditure reductions in 2023/24 and sustain them through changes in practice.

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 11
Subject:	Month 12 People & OD Report	**For Publication:** Yes
Author:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Jo Humphries, Chief People Officer
Presented by:	Jo Humphries, Chief People Officer	

Purpose of the report:

To update on the progress against the People and OD KPIs for Month 12 (March) of 2022/23.

Action required:

To receive the report.

Summary and recommendations:

The attached report sets out the Trust's Month 12 performance in relation to key People and OD metrics that support our annual plan.

The key headlines from Q4 are as follows:

- Our staff in post figures and vacancy rates have significantly improved as a result of increased and successful recruitment activity. Our staff in post has increased by 319.6 FTE (9.4%) this year, reducing our vacancy rate from to 14.3% to 11.8%, the lowest rate since June 2021, despite an increase in our establishment of 252.12 FTE this year (a 6.4% increase).
- Our registered nurse vacancy rate reduced from 24.5% at the start of the year to 22.8%, whilst HCSW vacancies reduced from 17.5% to 6.7% and AHP vacancies reduced from 23.3% to 14.6%. However, our consultant vacancies have increased to 19 and remain an area of focus, alongside nursing and AHP vacancies.
- Our unplanned turnover rate has improved from 13% at the start of the year to 12.3% at the end of Q4.
- Our bank and agency use remains high and an agency panel continues to meet regularly to reduce use of agency staff.
- Sickness absence rates have remained at around 5% in Q4. The fluctuations in sickness absence rates to date have been as a result of random variation, linked to seasonal/community infection rates.
- We continue our focus on belonging and inclusion with a suite of co-produced actions being taken forward with our people and our co-produced Belonging and Inclusion Strategy now being finalised with our people.
- Our formal employee relations cases remain low, however, overall cases including informal matters and fact finding investigations are higher and the length of time taken to conclude these has been scrutinised with a reset plan now in place.
- Our appraisal rates have remained around 85%, albeit that we have consistently been unable to meet our 95% target both pre- and post-pandemic. Planned actions are in place to improve compliance.
- Our mandatory training rates have dipped to just below the Trust target as a result of changes in national training requirements requiring all staff to undertake at least one additional eLearning course within a very short timeframe. This is currently being addressed.
- Our apprenticeship levels continue at a healthy level and are expected to grow further as

workforce transformation projects will lead to the creation/expansion of new and innovative roles.

A number of key performance indicators are showing a positive improvement, however, our vacancy rates, retention and temporary staffing use remain particular areas of focus, for which there are detailed action plans to achieve recovery.

The Committee 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 and the report includes our latest EDI information.

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 g/Board / Audit

Exec – 27 April 2023; PODG – 9 May 2023
IGC – 16 May 2023

Hertfordshire Partnership University NHS Foundation Trust

Trust People and OD Report
M12 - March 2023 (Quarter 4)

as one

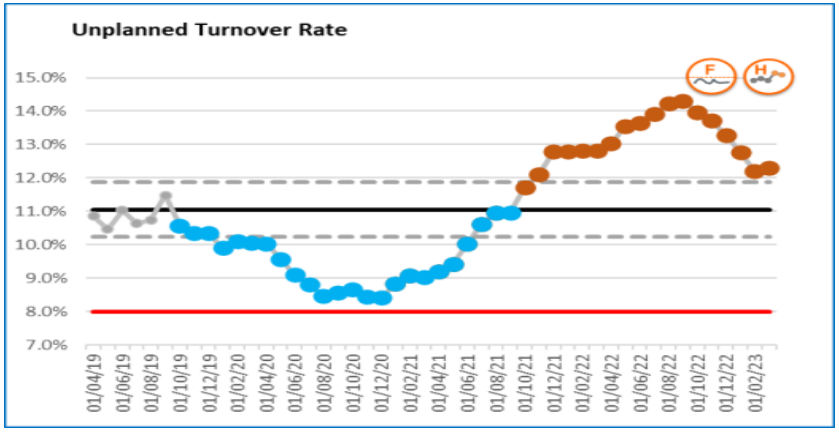
Our values
Welcoming Kind Positive Respectful Professional

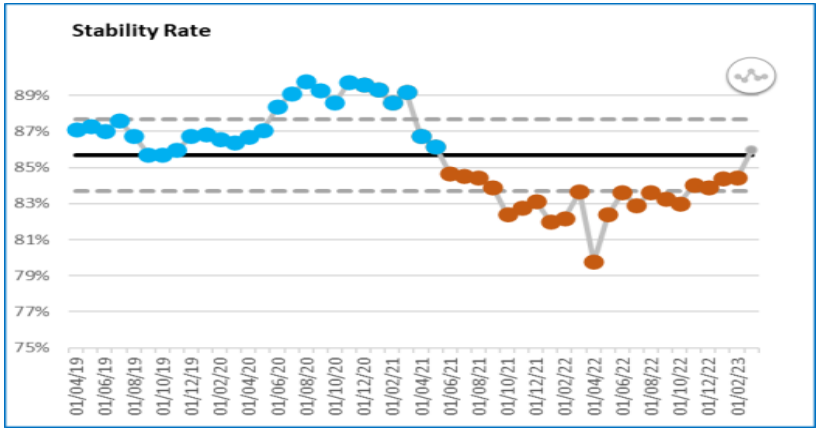
Contents

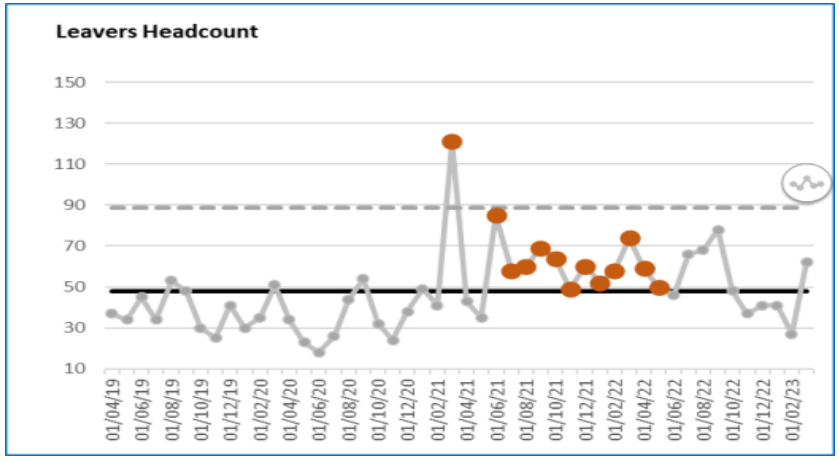
1. Overview

Metric	Previous Months											Current Month	Trend	Variation	Assurance
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23			
Staff in Post - Headcount	3744	3758	3763	3730	3774	3842	3887	3921	3935	4012	4052	4083			
Staff in post - FTE	3383.30	3386.26	3392.34	3387.33	3409.92	3462.08	3501.28	3542.65	3562.67	3636.30	3664.79	3702.91			
Budgeted Establishment FTE	3946.14	3945.14	3945.14	3941.89	3940.89	4029.56	4037.67	4147.96	4162.15	4157.99	4186.74	4198.26			
Vacant FTE	562.84	558.88	552.80	554.56	530.97	567.48	536.39	605.31	599.48	521.69	521.95	495.35			
Vacancy Rate	14.3%	14.2%	14.0%	14.1%	13.5%	14.1%	13.3%	14.6%	14.4%	12.6%	12.5%	11.8%			
Total Turnover Rate	19.8%	19.3%	18.2%	18.5%	18.6%	18.6%	18.3%	17.7%	17.4%	16.7%	16.0%	15.8%			
Unplanned Turnover Rate	13.0%	13.6%	13.6%	13.9%	14.2%	14.3%	14.0%	13.7%	13.3%	12.8%	12.2%	12.3%			
Starters Headcount	54	54	45	50	76	120	85	49	46	90	65	63			
Leavers Headcount	59	50	46	66	68	78	48	37	41	41	31	62			
Stability Rate	79.8%	82.4%	83.6%	82.9%	83.6%	83.3%	83.0%	84.0%	83.9%	84.4%	84.5%	86.0%			
Sickness Rate	4.9%	4.5%	4.7%	5.2%	4.7%	4.6%	4.9%	5.4%	5.7%	5.0%	4.9%	5.0%			
Training Compliance Rate	89.6%	90.4%	91.2%	91.2%	93.1%	92.3%	92.5%	92.7%	93.0%	92.7%	92.9%	90.1%			
Appraisal Rate	76.4%	83.2%	84.5%	85.3%	84.6%	83.8%	85.1%	85.5%	85.0%	85.6%	84.7%	85.9%			
Bank Spend	£2,142,297	£2,142,297	£2,009,843	£2,139,438	£2,192,616	£2,658,620	£2,304,492	£2,159,196	£2,136,852	£2,226,630	£2,272,368	£2,226,165			
Agency Spend	£1,027,222	£1,027,222	£1,139,239	£1,303,088	£1,246,626	£1,260,585	£1,265,116	£1,346,138	£1,287,560	£1,340,857	£1,080,570	£1,869,589			

2. Retention



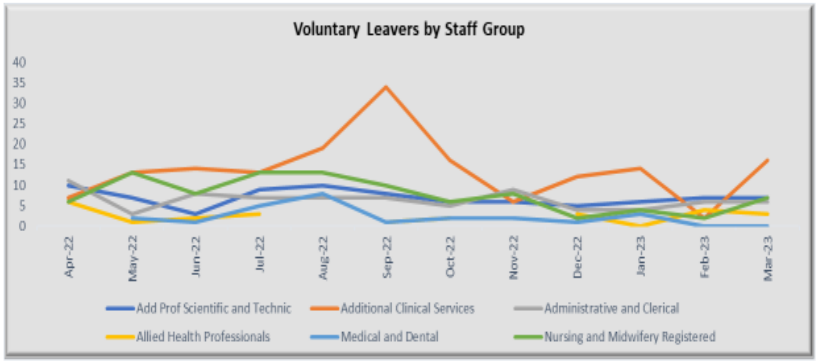


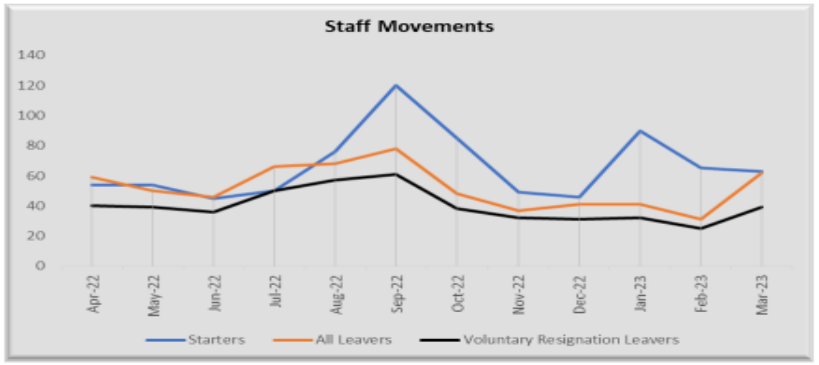


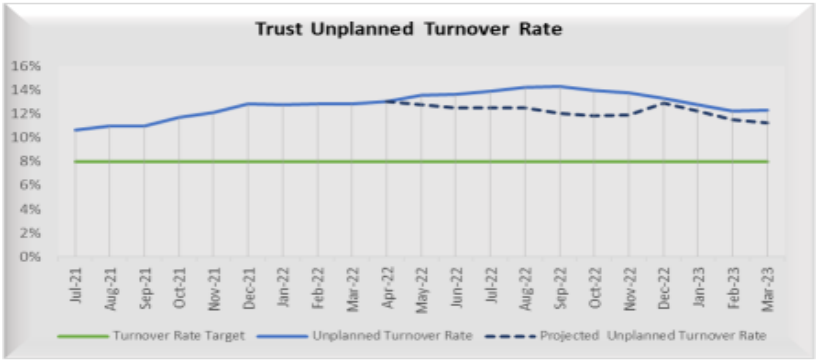
Our unplanned turnover has been reducing since the end of Q2 to 12.3% at the end of Q4, compared to 13.3% at the end of Q3. Unplanned turnover in February and March was the lowest experienced this year.

As a result of our reduced turnover, our stability rate has improved to the highest rate experienced in the last 12 months (86%). The actual number of leavers in March increased , however this was due to junior doctors on rotation leaving. Overall, our continued recruitment success has meant that our actual staff in post figure has increased to 3702.91 FTE from 3383.30 FTE at the start of this year, which is an increase of 319.61 FTE, i.e. a 9.4% increase and the highest it has ever been. This is in the context of an establishment which has increased by 6.4% (252.1 FTE) this year.

2. Retention







During Q4, we launched a number of new benefits, including our new benefits platform, a 'Holiday of a Lifetime' scheme, our blue Light card offer, the new selling of annual leave scheme, bus travel and childcare discounts, a birthday leave scheme for 2023/4 and we held our Winter Festival to help promote wellbeing and our benefits offer to staff.

We have also recruited and trained more Inclusion Ambassadors to help us realise our vision of ensuring that recruitment panels for all our management positions will have an Ambassador to help ensure fairness and equity. During Q4, we engaged with our people to play back and finalise our newly co-produced Belonging and Inclusion Strategy, which was developed based on staff feedback. Our co-produced action plan will be implemented in 2023/4.

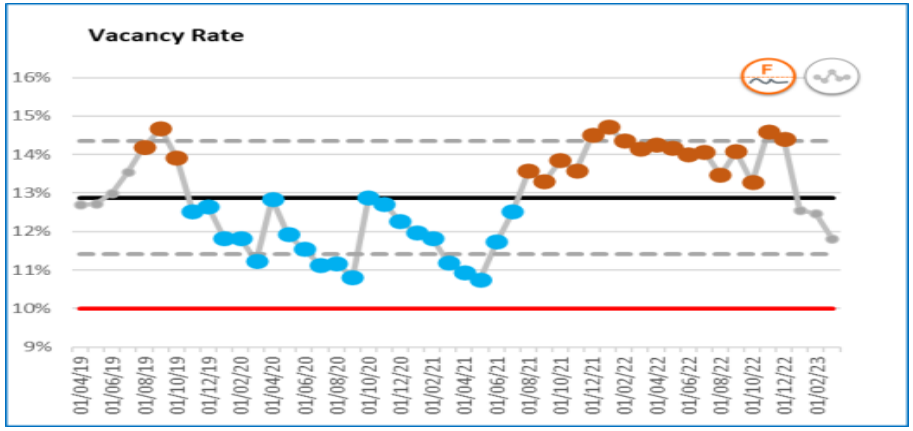
In March, we launched our new Appraisal App and appraisal window to further support compliance and ensure all our staff receive an appraisal that helps to retain them by ensuring they feel valued, supported and developed. We also held our second Healthcare Support Worker Development Day in March, which focussed on service user and carer engagement, physical health training and personal and career development learning opportunities.

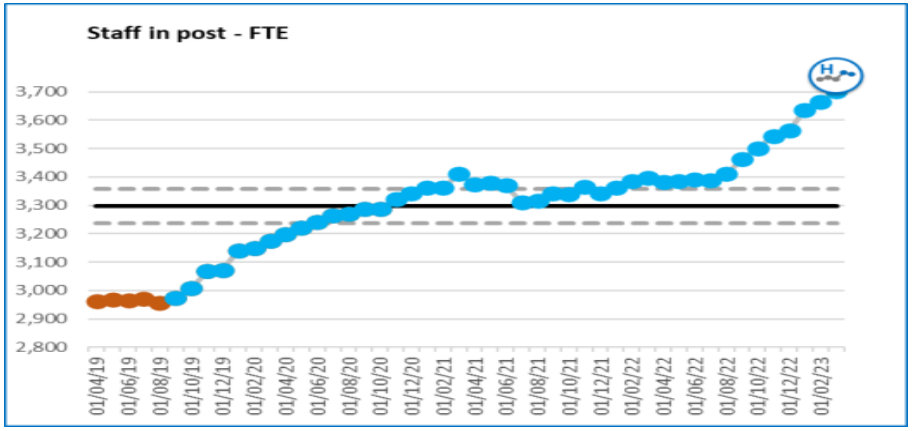
Our nursing recruitment and retention task and finish group continues to focus on registered and unregistered nursing staff, with a focus on promoting flexibly working, pastoral support and nurse career development.

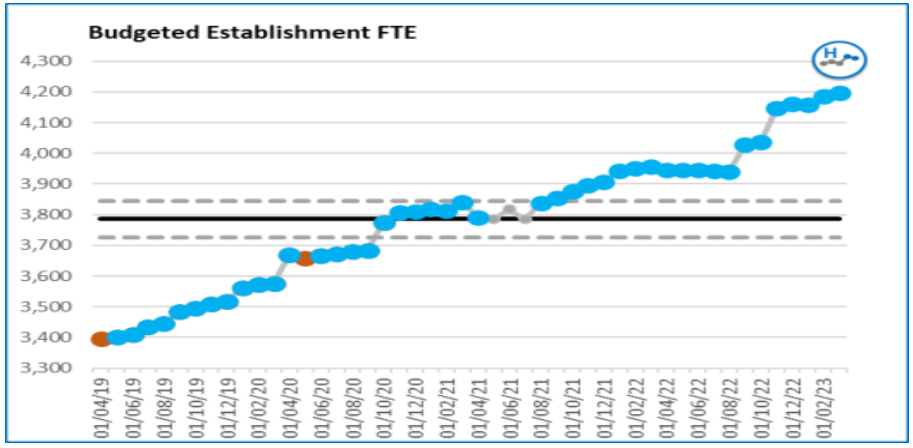
During this quarter, our staff survey results were published and we celebrated achieving some of the best scores nationally for our compassionate culture, staff engagement and motivation, our safety culture, wellbeing support and that our people rated us highly as a successful learning organisation. Our results include a national best score for people feeling that their role makes a difference to our service users. We were also proud to be identified by the Health Service Journal as one of the top 5 mental health trusts to work for in England. Our Q4 pulse survey results were equally fantastic and significantly better than the national average.

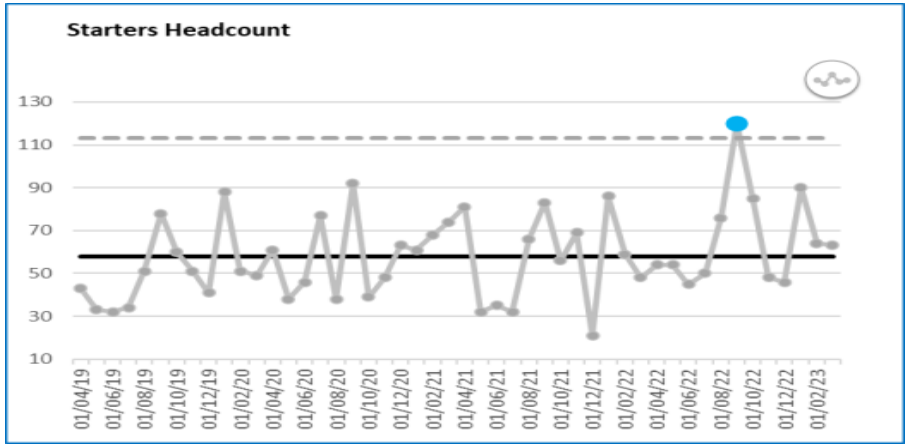
The above actions are anticipated to continue to have a positive impact on unplanned turnover and our stability rate during this Quarter.

3. Recruitment









3. Recruitment

The overall vacancy rate has reduced month on month during Q4, from 14.4% (599.48 FTE vacancies) at the end of Q3 to 11.8% (495.35 FTE vacancies), a reduction of over 100 FTE vacancies. Our budgeted establishment has continued to increase throughout the year, from 3946.41 FTE in April 2022 to 4198.26 FTE, which is an increase of 252.16 FTE (6.4%) this year and an increase of 804.5 FTE since April 2019, a growth of 23.7%. However, as a result of a 369% increase in recruitment activity since April 2019, our staff in post has increased by 9.4% (319.6 FTE) this year and by 24.9% (739.1 FTE) since April 2019.

Our recruitment pipeline remains strong, as we are proactively recruiting to 752 FTE posts, 65% of which (458 FTE) are in the firm offer/starting phase. However, our time to hire has increased from 57.8 days to 59.76 days. There are different challenges with time to hire across the different SBUs and there are being addressed through our Recruitment and Retention Group.

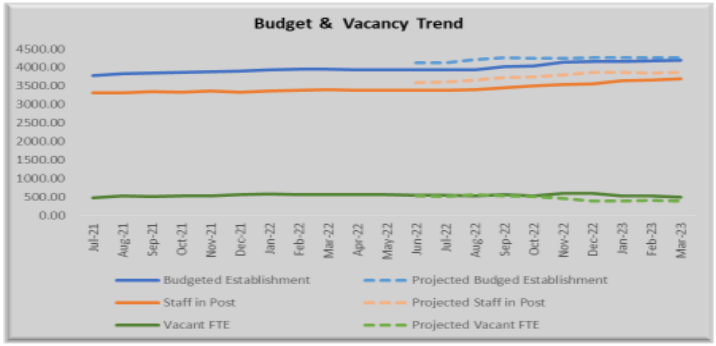
Our registered nurse vacancy rate remains a key focal point, with rates having continued to reduce in the second half of the year, from 23.22% (223.53FTE) at the end of Q3 to 22.81% (221.52 FTE) at the end of Q4. Our registered nurse vacancy rates at the start of the year were 24.5% (228.5 FTE). Leaver rates have remained lower than we experienced in H1, with our recruitment activity having increased, although we continue work to improve this. We continue to expand our international nurse recruitment, as well as our presence at careers fairs, the first of which is taking place at the end of April in West London.

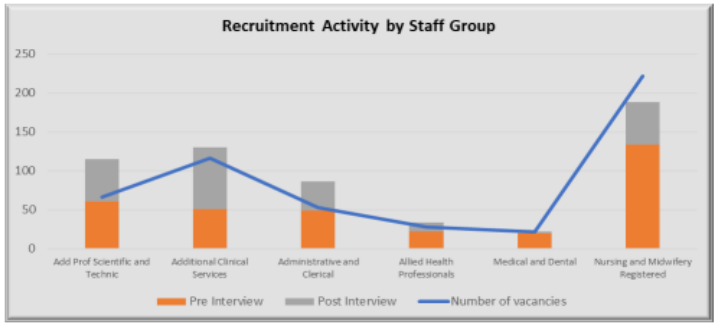
The HCSW vacancy rate has continued to reduce significantly during this year, from 13.7% (86.76 FTE) at the end of Q3 to 6.7% (42.75 FTE) at the end of Q4. At the start of this year, we had a vacancy rate of 17.5% (113.1 FTE vacancies), which have reduced by almost two thirds as a result of sustained significant recruitment, together with targeted development work to retain our HCSW workforce.

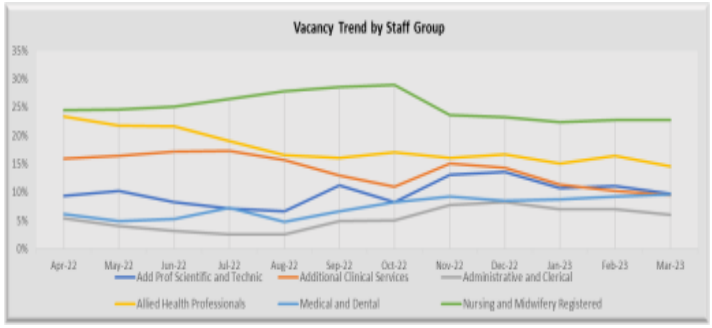
Our AHP vacancy rate reduced from 16.7% (32.04 FTE) at the end of Q3 to 14.6% (28.02 FTE) at the end of Q4. At the start of this year, the vacancy rate was 23.3% (44.48 FTE vacancies). Temporary funding is being used to provide a focus on AHP recruitment and retention, in order to accelerate and sustain improvements and this has also supported successful international AHP recruitment to help reduce vacancies.

Our medical vacancy rate has increased to 34 vacancies; 19 are Consultant vacancies, with 14 at authorisation/advertising stage, 3 at shortlisting/interview stage and 2 at offer stage; 14 are Specialty Doctor vacancies, with 2 being advertised/at authorisation stage, 7 at interview stage and 3 at offer stage. All vacancies are being proactively recruited to with the newly agreed RRP being offered and a refreshed medical recruitment and retention plan is being developed currently.

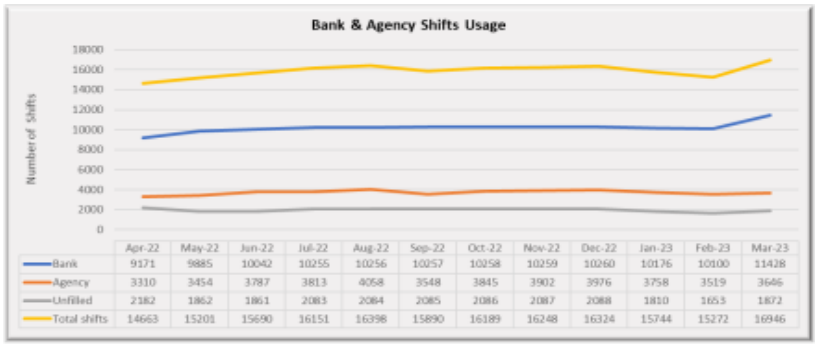
During the next quarter, we will fully launch our new marketing and attraction approach, finalise further details of our Bank recruitment and retention offer, further progress our reset of onboarding processes (including moving away from our learning management system (Discovery) to enable new staff to be booked into training in advance of starting), and launch further international recruitment campaigns.

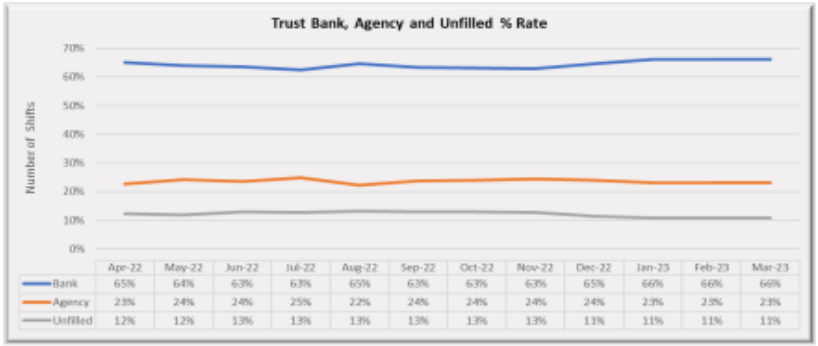






4. Temporary Staffing





Bank spend has remained at £2.2 million, although agency spend has increased to £1.9 million from £1 million last month. During this Quarter and financial year, bank and agency spend use have been consistently higher than historically, with an increasing trend. Shift demand increased to the highest level this year in March and our fill remains consistently at around two thirds Bank fill, 23% agency fill and 11% unfilled. This is despite significant improvements in recruitment and retention.

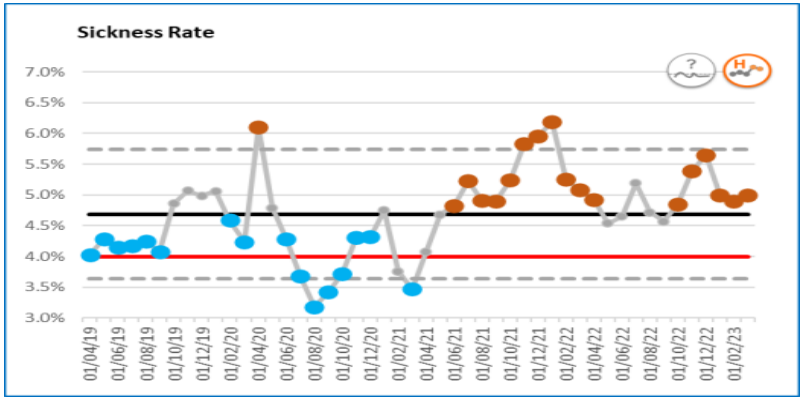
The vast majority of our agency use continues to be for HCSWs and registered nurses. For HCSWs, 14% of shift requests in March were made with less than 24 hours' notice, whilst 8% are retrospective bookings. For registered nursing, 10% of shift requests were made with less than 24 hours notice and 29% were retrospective bookings. Most shift bookings were for observations and vacancy cover.

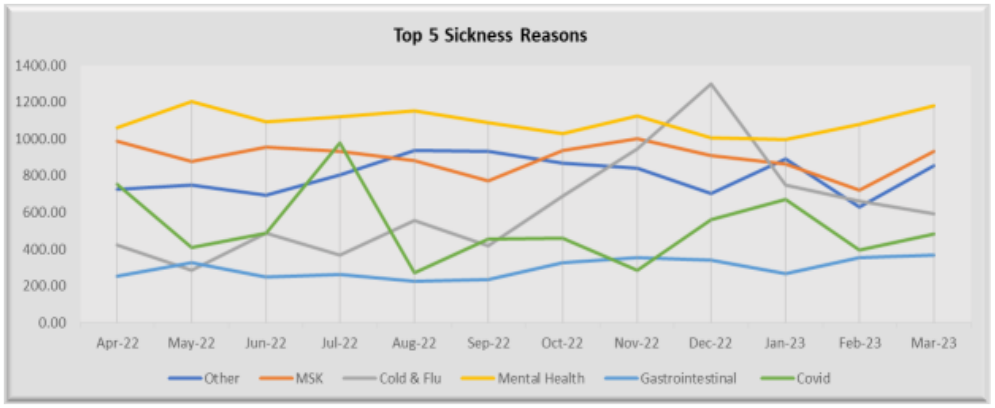
During Q4, 37 applications to convert from agency to Bank have been processed, 16 student nurses have been added to the Bank, 70 new HCSWs have been inducted, 1 new social worker, 10 new administrators and 5 new registered nurses. Overall this year, we have recruited 402 new bank only workers.

In order to reduce agency use whilst ensuring safe staffing levels, the following actions have been taken forward:

- Weekly reporting to SBUs on their Bank and Agency usage
- Proactive Bank recruitment campaigns, including streamlined process to convert agency staff to Bank
- Creation of a fast-track agency to substantive process and amending the starting salary guidance as it relates to agency staff
- Reviewing our Bank recruitment and retention plans, including our pay rates to ensure Bank working is attractive
- Establishment of an agency panel to scrutinise use of agency, reduce this and convert agency staff to substantive/Bank, particular in our highest spending areas. This panel is led by the Deputy Director of Finance with membership from the SBU Managing Directors, the Nursing Directorate and the People and OD team
- Tighter controls on the use of corporate agency staff.

5. Health and Wellbeing





Sickness absence reduced from 5.7% at the end of Q3 to 5% at the end of Q4. Mental ill health related absence continues to be our top reason for absence, albeit at lower than historical rates, but has gradually increased over this quarter. Colds/flu related absence has significantly reduced since Q4 , whilst both Covid-19 and Musculo-skeletal related absence started to increase again in March. Whilst absence levels had broadly followed the absence predictions we set at the start of the year, absence rates have been slightly higher than predicted, however, as the SPC chart above shows, this is as a result of random variation, mostly due to fluctuating factors such as the impact of rates of infection in the general population.

The key actions being taken forward to address staff wellbeing are as follows:

- Continuing our regular health and wellbeing offer to staff and adapting this in line with feedback and engagement with staff to ensure it remains relevant and supportive
- We have now gained accreditation as a menopause friendly organisation and continue to implement our menopause friendly action plan
- Expanding our pool of health and wellbeing champions and mental health first aiders
- Training more Schwartz round facilitators
- Offering on-site mini health checks and using the themes arising from these to adapt our wellbeing offer to staff
- Repeating our wellbeing festivals, aligned to the issues staff are currently facing, with our Winter festival having taken place in January.
- Expanding our financial wellbeing and support offer to staff
- Resetting our absence management policy, reasonable adjustments policy and panel and moving away from Bradford scores to simplify absence management, complemented by management training on absence management which has been very well received.
- Reporting monthly on those staff meeting absence triggers and proactively advising how to manage these

Our wellbeing offer for 23/24 was recently reviewed by the People and OD group and funding is currently being reviewed to ensure a continued robust offer.

6. Employee Relations

Disciplinary Cases		0 - 5 working days	6 – 10 working days	11+ working days	Average Length Further Detail to be provided in Q1
	Fact Find (16) (Date incident notified to date referred to decision making panel)	7		5	Plus: 4 not received yet
	Fact Find Outcome (9) (Date decision making panel outcome to date investigation commences/letter of concern/other outcome notified to employee)			9	
		0 - 12 weeks	13 – 18 weeks	19+ weeks	Average Length
	Suspension	2		5	
	Alternative Duties	1		6	
	Formal Investigation (5) (Date investigating manager appointed to date investigation report sent to commissioning manager)		1	3	Plus: 1 Agreed Outcome to be undertaken
		0 - 5 working days	6 – 10 working days	11+ working days	Average Length
	Commissioning Manager Review (4) (Date investigation report sent to commissioning manager to date employee notified of outcome)			4	
		0 - 7 weeks	8 - 12 weeks	13+ weeks	Average Length
	Formal Hearing Stage (1) (Date of decision to refer to hearing to date employee notified of hearing outcome)	1			
	Appeal Stage (2) (Date of receipt of formal appeal to date employee notified of hearing outcome)				Plus: 2 Disciplinary Appeals being arranged
TOTAL DISCIPLINARY MATTERS		37			
Medical Cases		0 - 12 weeks	13 – 18 weeks	19+ weeks	Average Length
	Medical Conduct			1	
		No. Cases			
	Medical Capability				
TOTAL MEDICAL CASES		1			
Grievances		0 - 12 weeks	13 – 18 weeks	19+ weeks	Average Length
	Informal Grievance	3	2		
	Formal Grievance	2	4	3	
TOTAL GRIEVANCE CASES		14			
Capability Cases		No. Cases			
	Informal Capability Management				
	Formal Capability Management	2			
TOTAL CAPABILITY CASES		2			
TOTAL OTHER CASES		1			
TOTAL EMPLOYMENT TRIBUNAL CASES		4			
TOTAL EMPLOYEE RELATIONS CASES		59			

6. Employee Relations

Disciplinary
There are currently 37 disciplinary or potential disciplinary matters across the Trust, comprising of:

- 25 Fact finds
- 4 Formal investigations, plus one agreed outcome to be communicated
- 4 cases with the commissioning manager for review
- 1 case is at formal hearing stage and 2 are at appeal stage
- 2 cases are not yet under the scope of our internal processes as they are subject to criminal proceedings.

Whilst 11 cases are within agreed time limits, the remainder are outside of these.
There is also one medical conduct case which has been delayed due to the individual's authorised absence to travel abroad.

Grievance
There are 14 grievances across the Trust, 5 of which are informal and 9 are formal. 5 are within the agreed timeframes set out in our policy, which 9 have exceeded these.

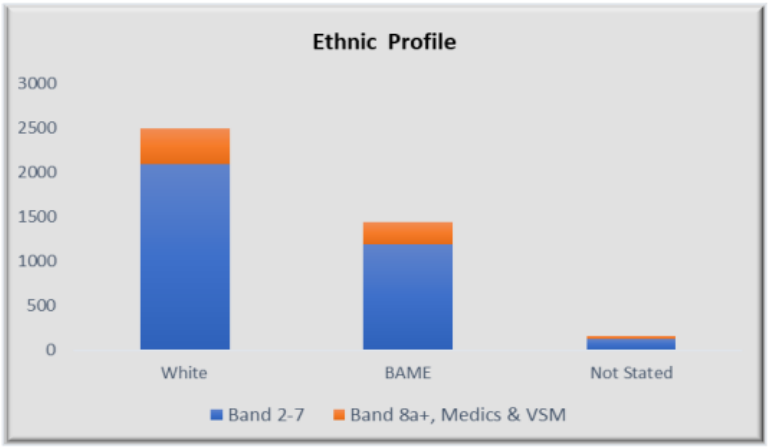
Other Cases
In addition, we have 2 capability management cases, both of which are under the formal stages of the policy, one potential dismissal for some other substantial reason and four employment tribunal cases, two of which have been submitted by the same individual.

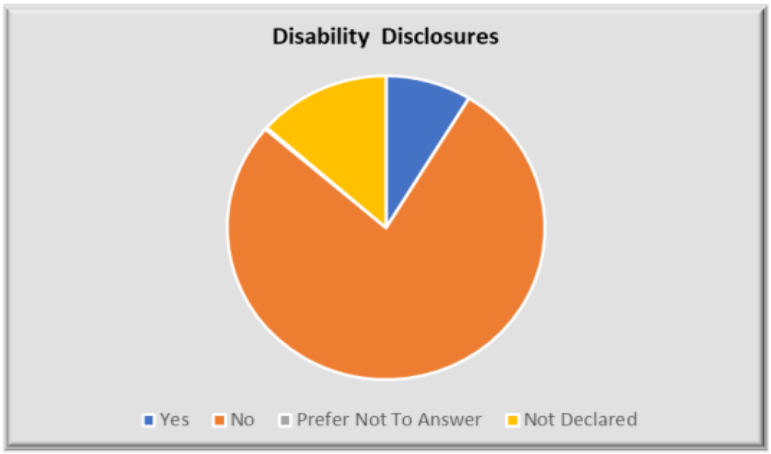
ER Case Reset
A recent ER case deep dive and reset was carried out to investigate the root causes of delays, to unblock these and to co-produce with operational and People and OD colleagues an action plan. Deep dive meetings were held with each SBU to ensure each case is managed effectively so that staff have an outcome swiftly and we keep formal cases to a minimum. A report was received by the Executive Team in March 2023 setting out the findings and an action plan was agreed across the following four themes:

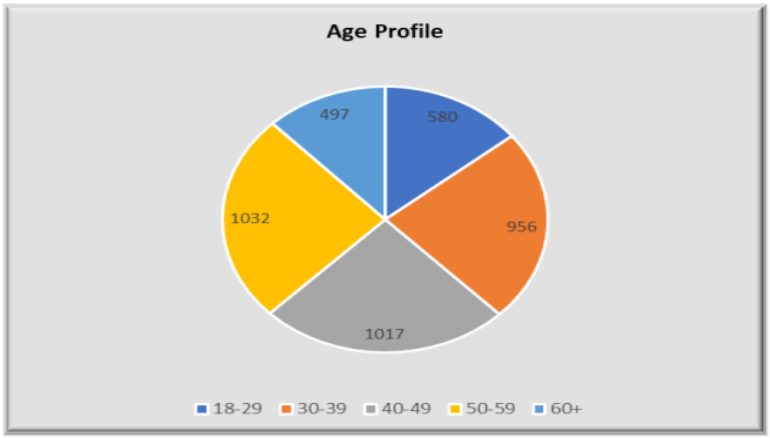
- Planning and escalation – case management forms are being updates with agreed escalation points to swiftly identify and remedy delays; hearing dates will be planned at the outset of a case; and a monthly hearing rota is in place.
- Reporting and oversight – monthly ER case review meetings with SBUs are in place; quarterly deep dive meetings will now take place; and more detailed monthly reporting of cases to the Executive is now in place.
- Training and guidance – existing training is being updated for managers; a library of example terms of reference documents is being created; guidance is being provided to supporting managers to ensure the role is carried out consistently to support staff; guidance on unauthorised absence and common issues that lead to delays in ER cases is being drawn up.
- Review of processes – our decision making panel membership and terms of reference is being reviewed.

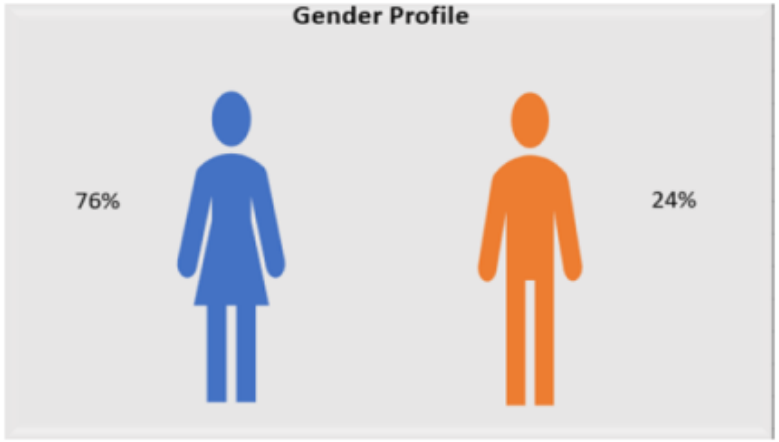
As part of the action plan, this report now includes more detailed information about ER cases and their length and this will be further developed for Q1 of 2023/4 to include average case length information. Feedback is sought on the revised reporting format.

7. Equality and Inclusion









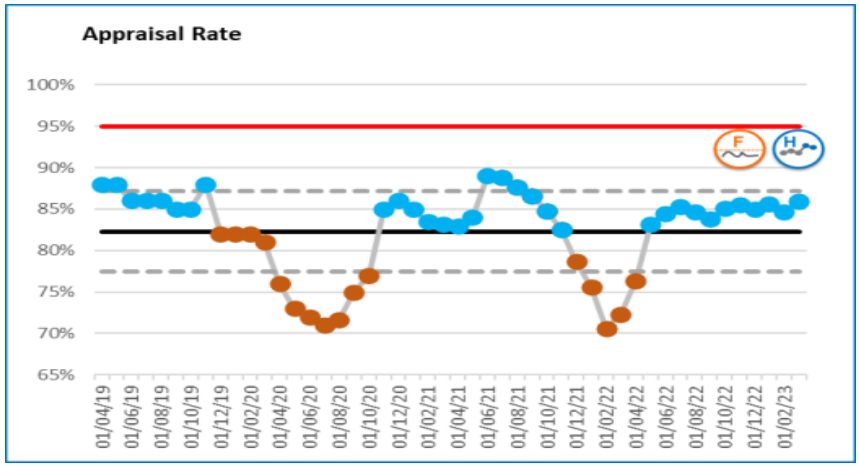
7. Equality and Inclusion

Through direct engagement with our people, feedback from the staff survey, pulse surveys and workforce information, such as our WRES and WDES data, together we have identified key equality and inclusion challenges. We have carried out significant engagement to co-produce actions to further improve equality and inclusion across the Trust, which include:

- Reverse mentoring
- Just culture – amended processes & 1st decision making panels
- Staff networks sponsored by Executive Directors
- Diversity events, including our Black History Month events in October
- Belonging and Inclusion engagement to co-produce our strategy and plan
- Career development support for BAME and disabled staff
- Targeted health & wellbeing support
- Creating better career development opportunities for our HCSW staff
- Increased frequency of reporting and scrutiny of our WRES and WDES data
- Addressing experience of racism, bullying and harassment from service users
- Expansion of our Inclusion Ambassador Scheme
- Inclusion and belonging leadership development
- Implementation of our newly ratified reasonable adjustments policy
- Creation of our reasonable adjustment panel
- Celebrating the contribution of our disabled staff, including celebrating and raising awareness of neurodiversity in the workplace
- Further embedding our App to promote staff recording their disability status on ESR
- Implementation of our refreshed co-produced WRES and WDES action plans
- Implementation of our amended recruitment and selection policy that ensures all acting up and secondment opportunities are advertised across the Trust to encourage greater diversity and equality of opportunity.

The newly established governance group will continue to regularly review these actions and our latest data to monitor the impact of our actions and amend our plans as needed.

8. Staff Development – Appraisals



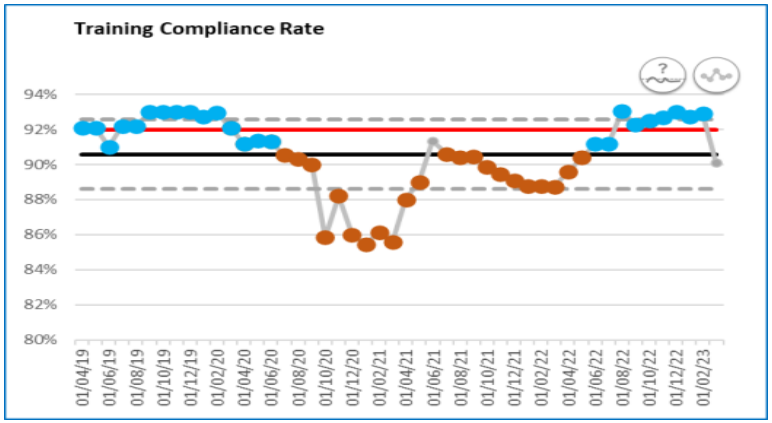
Appraisal compliance increased from 85% at the end of Q3 to 85.9% at the end of Q4. The SPC chart demonstrates that we have not met our target of 95% compliance historically, including pre-pandemic.

Moving to an appraisal window has helped a number of other trusts achieve greatly increased compliance. Thus, our move to an appraisal window with effect from April 2023 in combination with the launch of our Appraisal App is expected to increase compliance significantly by the end of July 2023.

Actions to address recovery include:

- Monthly reporting to the Executive Team and People and OD Group
- Launch of the new Appraisal App and annual appraisal window
- A further push on achieving compliance coinciding with the App launch and enhanced reporting during the new appraisal window from April to July.

8. Staff Development – Mandatory Training



	Mar-22	Mar-23
BLS	75%	85%
ILS	74%	82%
PBLS	62%	83%
Advanced M&H	55%	76%
Basic M&H	66%	83%
Respect 3a	85%	95%
Respect Level 3b	59%	72%
Respect Level 4	62%	81%
Respect Level 4/5 (Norfolk)	74%	84%
Respect Level 5	58%	77%

	Mar-22	Mar-23
Administration of Medicines M & C [3 Years]	72%	85%
Administration of Medicines RNs and Nas	88%	92%
Clinical Risk Assessment and Management [3 Years]	89%	94%
Complaints [None]	98%	99%
Data Security Awareness [1 Year]	81%	91%
Equality, Diversity & Human Rights [3 Years]	95%	95%
Fire Safety [1 Year]	88%	94%
Fire Safety [2 Years]	88%	92%
Food Hygiene [3 Years]	91%	85%
Health, Safety & Welfare [3 Years]	92%	96%
Infection, Prevention & Control Level 1 [2 Years]	83%	94%
Infection, Prevention & Control Level 2 [2 Years]	87%	94%
Ligature Awareness [3 years]	89%	96%
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	91%	93%
Mental Health Act [3 Years]	91%	94%
Moving and Handling L1 [3 Years]	88%	94%
Physical Health	69%	92%
Preventing Radicalisation Basic	N/A	46%
Preventing Radicalisation Level 3	N/A	42%
Safeguarding Adults Level 1 [3 Years]	96%	97%
Safeguarding Adults Level 2 [3 Years]	91%	94%
Safeguarding Adults Level 3 [3 Years]	94%	88%
Safeguarding Children Level 1 [3 Years]	97%	97%
Safeguarding Children Level 2 [3 Years]	91%	94%
Safeguarding Children Level 3 [3 Years]	92%	96%

Mandatory training compliance has dipped below our target of 92% to 90%. This is as a result of new mandatory training being rolled out nationally with a relatively short implementation timeframe, replacing previous training. Prior to the new training being reported, the data had been showing an improving, positive trend. Preventing Radicalisation (Basic Awareness Training) now needs completing by all staff and is at 46% compliance with a further 1978 staff required to complete this and Preventing Radicalisation (Level 3), which must be completed by all clinical staff is at 42% compliance with 991 staff still needing to complete this. Further promotion of these new requirements are underway to improve the situation in Q1.

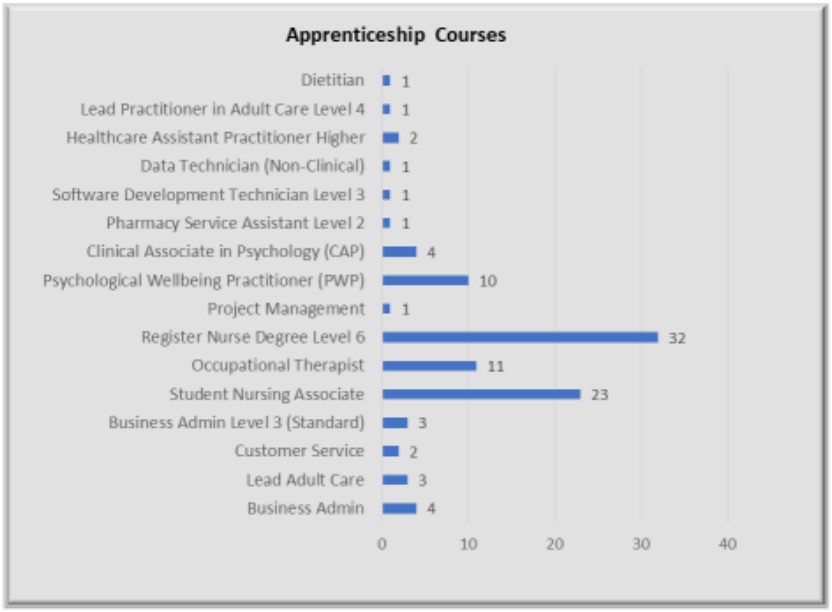
Overall, eLearning compliance (opposite) has significantly improved this year with the majority achieving our target rate. Face to face training (above) has also significantly improved but remains our particular area of focus, alongside the roll out of the new eLearning requirements.

The actions being taken to improve mandatory training compliance include:

- Trust-wide communications from the safeguarding team explaining the new preventing radicalisation training requirements
- Monthly reporting to the Executive Team and People and OD Group
- Regular reporting of face to face courses with available spaces together with details of staff who require the training
- Increased training capacity, including more trainers, weekend training, use of external training companies and external training venues
- Review of Respect training model to ensure fitness for purpose
- Moving away from Discovery (our learning management system) to ESR and integration with eRoster in July
- Reviewing our approach to onboarding new staff to ensure new staff can access training quickly
- Reviewing contracts with existing training providers – new moving and handling provider in place for 23/24 onwards and new provider being commissioned for life support skills to ensure value for money and increased compliance
- Further investigating and tackling non-attendance and proposing solutions to PODG in May 2023

9. Apprenticeships and New Roles

Levy Pot	
Current Funds	£1,688,894
Funds spent since Apr 22	£600,818
Estimated spend for the next 12 months	£621,264
Funds Expiring in Sep 23	£14,896



Our number of apprentices has reduced slightly from 102 to 90, however, we continue to expand our apprenticeship offer. In addition, we also have 20 qualified Professional Nurse Associates (PNAs), who carry restorative supervision sessions, career conversations and support improvement projects. We are training more PNAs to expand the number further. We also have two Mental Health and Wellbeing Practitioners (MHWPs) currently part way through their 12-month training and 13 more started their training with us in Q4.

All Band 2 HCSWs who commenced with us over the last 6 months have been offered an apprenticeship and all our adverts now offer an apprenticeship. We have 23 HCSWs undertaking SNA apprenticeships, 2 undertaking the Healthcare Assistant Practitioner Higher apprenticeship and we have 13 people who have taken up our functional skills training offer to enable them to undertake apprenticeships, with a further 14 on our next cohort.

The workforce workstream for the Social Care and Community Services Transformation Programme has also taken froward work to further expand our apprenticeship offer, including in social care and Allied Health Professions. In exploring the workforce we need for the future, the workstream is also exploring the expansion of roles such as volunteers, the third sector as part of our workforce, Peer Support Workers, CAPs, PWPs, MHWPs and other novel roles, together with considering whether we need to create innovative roles in order to better meet the needs of our service users and carers.

We have also agreed with two universities that the Support Time and Recovery (STAR) Worker role is a suitable apprenticeship role for a Social Worker Apprenticeship and we have put forward four of our staff for this course, subject to interviews with the university in May 2023.

10. Conclusion

The key headlines from Q4 are as follows:

- Our staff in post figures and vacancy rates have significantly improved as a result of increased and successful recruitment activity. Our staff in post has increased by 319.6 FTE (9.4%) this year, reducing our vacancy rate from to 14.3% to 11.8%, the lowest rate since June 2021, despite an increase in our establishment of 252.12 FTE this year (a 6.4% increase).
- Our registered nurse vacancy rate reduced from 24.5% at the start of the year to 22.8%, whilst HCSW vacancies reduced from 17.5% to 6.7% and AHP vacancies reduced from 23.3% to 14.6%. However, our consultant vacancies have increased to 19 and remain an area of focus, alongside nursing and AHP vacancies.
- Our unplanned turnover rate has improved from 13% at the start of the year to 12.3% at the end of Q4.
- Our bank and agency use remains high and an agency panel continues to meet regularly to reduce use of agency staff.
- Sickness absence rates have remained at around 5% in Q4. The fluctuations in sickness absence rates to date have been as a result of random variation, linked to seasonal/community infection rates.
- We continue our focus on belonging and inclusion with a suite of co-produced actions being taken forward with our people and our co-produced Belonging and Inclusion Strategy now being finalised with our people.
- Our formal employee relations cases remain low, however, overall cases including informal matters and fact finding investigations are higher and the length of time taken to conclude these has been scrutinised with a reset plan now in place.
- Our appraisal rates have remained around 85%, albeit that we have consistently been unable to meet our 95% target both pre- and post-pandemic. Planned actions are in place to improve compliance by the end of July 2023.
- Our mandatory training rates have dipped to just below the Trust target as a result of changes in national training requirements requiring all staff to undertake at least one additional eLearning course within a very short timeframe. This is currently being addressed.
- Our apprenticeship levels continue at a healthy level and are expected to grow further as workforce transformation projects will lead to the creation/expansion of new and innovative roles.

A number of key performance indicators are showing a positive improvement, however, our vacancy rates, retention and temporary staffing use remain particular areas of focus, for which there are detailed action plans to achieve recovery.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 12
Subject:	Compliance with NHSI *Code of Governance* Annual Reporting Requirements-Declarations	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	

Purpose of the report:

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

Action required:

The Board is asked to NOTE the evidence provided and APPROVE a positive declaration of compliance with the Code of Governance (the Code) as issued by NHSI as recommended by the Audit Committee.

Summary and recommendations to the Board:

Summary

NHSI's *Foundation Trust Code of Governance* operates on a '*comply or explain'* principle and there are also specific disclosure requirements required in the Annual Report as identified in the *FT Annual Reporting Manual 2022-23.*

This paper sets out the provisions of the Code and the source of evidence to support a declaration of compliance within the Annual Report in all cases.

Recommendation

The Board is asked to note the evidence provided and approve a positive declaration of compliance with the Code of Governance as recommended by the Audit Committee.

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

Summary of Implications:

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

N/A

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

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

Audit Committee 24 April 2023

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A	**LEADERSHIP**			
A.1.	**The Board of Directors** **Every NHS foundation trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS foundation trust.**			
A.1.4	The board of directors should ensure that adequate systems and processes are maintained to measure and NHSI the NHS foundations trust's effectiveness, efficiency and economy as well as the quality of its health care delivery.	Performance NHSI KPIS are set by the Trust Board to encompass all aspects of performance relating to achievement of Trust plans and priorities as well as achievement of external targets and standards including quality. Performance reports are reviewed at each of the BoD's public meeting and these are supplemented by relevant reports from external regulatory and compliance bodies such as CQC as appropriate. The Board regularly reviews its performance against regulatory requirements and receives reports from the executive outlining changes to targets/standards/guidance as they arise. Board papers are published on the Trust's website before the meeting. Performance reports are not subject to any exemptions under FOIA. The Integrated Governance and Audit Committees are responsible for testing the adequacy of the system of internal control, however, top ten scoring risks are reviewed at Trust Board level alongside the Board Assurance Framework.	• Board performance reports • Annual Planning process • Quarterly report on performance against Annual Plan • CQUIN reports • Committee reports to Board	✓
A.1.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.	The Trust has in place a performance dashboard where key metrics and milestones are collated and reported via a performance report. Trust Board receives at least quarterly report on performance and performance against the Annual Plan. Performance (quality, finance, workforce, annual plan) is also reported to FIC, IGC and Audit Committee	• Performance Reports • Annual Plan • Minutes of Board • Minutes of Committees	✓
A.1.6	The board of directors should report on its approach to clinical governance.	The Trust has a systematic approach to clinical governance which is focused on the relevant policy guidance and regulatory framework and which is supported by the Trust's Quality Strategy. The Trust's clinical governance is led by the Integrated Governance Committee which meets 6 times per year. It also receives operational clinical reports from the Quality & Risk Management Committee (QRMC). This formal assurance meeting is fed by an integrated governance framework, which permeates the organisation and facilitates the achievement of improving clinical standards through the implementation of the quality strategy. The Integrated Governance Committee scrutinises the overall system of clinical governance and the outcomes of a programme of clinical audit as part of its audit plan.	• Clinical Audit reports • Minutes of Quality & Risk Management Committee • Quality Work Plan • Quality Strategy • IGC papers	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A	**LEADERSHIP**			
A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHSE for advising the board of directors and the council of governors and for recording and submitting objections to decisions	The Chief Executive is fully aware of their responsibilities as Accounting Officer and follows the procedure as set out by NHSE and the *NHS Foundation Trust Accounting Officer Memorandum.*	Signed copy of the Annual Governance Statement and procedure within the Annual Report	✓
A.1.8	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behavior in public life.	Included in Board Standing Orders are role descriptions and code of conduct for CoG and Trust Board. Clear and transparent procedures for declaration of interests are in place and all corporate meetings require declarations to be made. The Trust's Standards of Business Conduct Policy has detailed guidance on Gifts and Hospitality, Commercial Sponsorships, Outside Work and Conflicts of Interests. The Trust's values of: Welcoming, Kind, Positive, Respectful and Professional embrace NHS values and underpin the Trust's strategic objectives and the leadership approach taken by the organisation.	• Annual Fit & Proper Persons' Test • Annual statement of compliance with Fit and Proper Person regulations • Register of Declared Interests for the Board, CoG and all decision making staff • Standards of Business Conduct Policy • Trust Strategy • Trust Values and Mission • Annual Plan	✓
A.1.9	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	The members of the Board of Directors have signed a code of conduct which is based on the spirit of the Nolan Principles. All minutes of meetings of the Board and key papers are published on the Trust's web site and only those papers which are specifically exempt under the FOIA are kept private.	• Web site – Trust Board Papers • Standards of Business Conduct Policy • Code of Conduct • Register of Declared Interests	✓
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	The Trust currently has NHSLA cover and a top up commercial policy for Directors & Officers Liability insurance.	• D & O Cover policy • NHS Resolution Agreement.	✓
CODE	**CODE PROVISION**	**TRUST POSITION**	**Evidence**	**Comply?**
A.3	**The Chairperson** **The chairperson is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.**			
A.3.1	The chairperson should, on appointment by the Council of Governors, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be chairperson of the same NHS foundation trust.	The Chair was appointed 1 January 2021 following agreed robust processes. On appointment, the chair met the independence criteria and had not previously been a chief executive of the Trust. The Chair continues to meet those independence criteria.	• Agreed CoG process for appointment of Chair • CoG's Appointment & Remuneration Committee minutes • CoG minutes • Declaration of Interest	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.4	**Non-Executive Directors** **As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board.**			
A.4.1	In consultation with the Council of Governors, the board should appoint one of the independent non- executive directors to be the senior independent Director.	The Council of Governors approved the appointment of SID at a meeting in 2022. The SID regularly attends meetings of the Council of Governors. The CoG's Policy for Engagement with the Board further defines the role of the SID in relation to the CoG escalation process.	• Council of Governors minutes/attendance • Constitution • Role description – SID	✓
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.	The Chair has met with Non-Executive Directors without the Executives present during 2022-23.	• CoG minutes • NEDs' files and dates of 1:1 with Chair. • NED briefings	✓
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	The Trust values embrace NHS values and underpin the Trust's strategic objectives and the leadership approach taken by the organisation. The role of the Senior Independent Director and Head of Corporate Affairs and Company Secretary in supporting and escalating concerns where appropriate is clearly defined within the Constitution and within the role descriptions. All Board members are encouraged to articulate their views in Board meetings and the minutes clearly and accurately reflect this. In Well Led Review board members reported that members felt able to raise issues and were supported when discussing matters at Board.	• Trust Board Minutes • Raising Concerns policy • Role of the Head of Corporate Affairs and Company Secretary • Role of Senior Independent Director	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.5	**Governors** **The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed objectives and the overall strategy of the NHS foundation trust.**			
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.	During 2022-23, the Council of Governors formally met on six occasions. The sub groups of the Council of Governors also met in the year. All business as identified in the cycle of business (based on the Governors Accountability Framework) was dealt with during the year.	• CoG minutes • Meeting Schedule • Attendance List • Cycle of Business • Annual Report	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.5.2	The council of governors should not be so large as to be unwieldy.	The CoG is deemed to be of sufficient size to discharge its duties and responsibilities and is in line with the size of other local CoGs. The Trust has a membership of just over 8500 and has a complement of 19 public governors, 5 staff governors and seven appointed governors	• Constitution • Minutes of CoG • Membership database • Close monitoring of Governors in post and need for elections	✓
A.5.4	The roles and responsibilities of thecouncil of governors should be set out in a written document.	The Council of Governors have an approved their Terms of Reference. The Role of Governor is included in induction presentations given to new Governors and is included within the Council of Governors' Terms of Reference. The Council of Governors Standing Orders form part of the Trust Constitution and detail the role of Governors.	• Standing Orders for CoG - Constitution • Induction Programme for Governors	✓
A.5.5	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other executives and non- executives, as appropriate.	The executive and non-executive directors have an open invitation to attend public CoG meetings. The Chief Exec or their appointed Deputy attends all CoG meetings (private and public). The Head of Corporate Affairs Company Secretary attends all CoG meetings (private and public) and NEDs are aligned to and attend sub groups of the CoG.	• CoG Minutes • CoG Groups' minutes • CoG attendance list • Minutes of CoG sub groups	✓
A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance	The Council of Governors agreed approach for Engagement with Board of Directors is in place.	• CoG Minutes • ARC ToR and minutes • Role of SID	✓
A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective.	The CoG has a 12 month rolling cycle of business in place to allow for timely planning and to ensure it discharges its duties and responsibilities. The Annual Plan, Quality and Performance reports/data have been regular standing items on CoG and its sub groups' agendas for 2022/23 in order to keep Governors up to date. The CoG is fully aware of the boundaries between governance and management.	• CoG Agendas • CoG Cycle of Business • CoG attendance list • Sub groups' TORs & Agendas • Training and Induction of Governors' material	✓
A.5.8	The council of governors should exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	The Trust's Constitution along with the Board Standing Orders details the process for removal of the Chair or other Non- Executive Directors.	• Constitution • Board and Council of Governors' Standing Orders • ARC ToR	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example, clinical statistical data and operational data.	The CoG receives reports on the performance, quality of services and financial position of the Trust throughout the year. It is the same information as seen by the Board of Directors. There are regular presentations/Q&A sessions Facilitated by various Trust depts/employees and external partners to further enhance Governors knowledge. During 2022-23 these included: • 2021/22 Annual Accounts • Trust Strategy • Board sub-Committee Chairs • 2022-23 Annual Plan • Quality Priorities	• CoG Agendas • CoG Cycle of Business • CoG minutes • Performance Reports • Quality Reports	✓
CODE	**CODE PROVISION**	**TRUST POSITION**	**Evidence**	**Comply?**
B	**EFFECTIVENESS**			
B.1.	**The Composition of the Board** **The board of directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.**			
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	The constitution sets out the composition of the Board of Directors. There is one Non-Executive Chair and seven other non-executive directors. There are seven executive directors including the CEO. All the NEDs are deemed to be independent.	• Annual Report • Constitution • Procedure for the appointment / reappointment of NED's • CoG Appointment and Remuneration Committee Minutes • CoG Minutes	✓
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	The constitution prevents an individual holding office as both director and governor at the same time. That situation does not pertain at the Trust.	• Constitution • Standing Orders • Register of Interests	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.2	**Appointments to the Board** **There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be 'fit and proper' to meet the requirements of the general conditions for the provider licence.**			
B.2.1	The Nomination Committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	The CoG's Appointment & Remuneration Committee considers NEDs' appointments and terms & conditions. Upon identification of a vacancy, the skills requirement is considered prior to drafting a job description and recruitment process taking place. The Board's Nominations & Remuneration Committee deals with executive appointments and terms & conditions. Upon identification of a vacancy, the skills requirement is considered prior to drafting a job description and recruitment process taking place.	• Committee ToRs • Committee minutes	✓
B.2.2	Directors on the board of directors and governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged).	The 'fit and proper' persons clause is contained within the Code of Conduct for Governors and the Code of Conduct for the Directors. These are signed and filed with the Director of HR. It is included as a clause within employment contracts and engagement letters for Board members. There is an annual revalidation process in place. All directors and governors are required to sign the Code of Conduct and be subjected to the Fit and Proper Persons' Test.	• Annual revalidation process F&PPT Declaration • Register of Interests • Contracts • Committee and Board minutes	✓
B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate.	The Trust has a Board Remuneration Committee for considering director appointments and terms & conditions. It considers the succession planning for the Directors at least annually. The CoG has an Appointment & Remuneration committee for considering the appointment and terms & conditions of non-executive directors including the Chair. There is a skills review undertaken and this is considered when replacing NEDs or appointing new ones.	• Constitution • Terms of Reference • Minutes from committees • Skills audit of NEDs	✓
B.2.4	The chairperson or an independent non-executive director should chair the Nominations Committee.	The Trust Chair chaired the Nominations Committee during 2022/23 and will continue in this role. The Lead Governor chairs the Appointment & Remuneration Committee of the Council of Governors	• Nominations Committee minutes • Attendance register • ToRs	✓
B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new chairperson and non-executive directors.	The process for appointing other NEDs and Chair is owned by both the ARC and the full CoG.	• Agreed processes • Nom & Rem com minutes • ARC minutes • CoG minutes	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist only of a majority of governors.	The CoG's ARC consists entirely of Governors. The Lead Governor Chairs the ARC. It considers the appointments of NEDs including the Chair. The Trust Chair, CEO, Director of Workforce & OD and the Head of Corporate Affairs and Company Secretary are normally in attendance. The Board Remuneration committee consists entirely of NEDs and considers the appointments of Directors and the Head of Corporate Affairs and Company Secretary.	• ToRs of ARC • Minutes • Remuneration ToRs • Minutes	✓
B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The ARC recommends to the Council of Governors potential candidates. The Board represented by the Chair, SID and Chief Executive, Director of People & OD provides input into the selection and interview process of NEDs.	• ToR • Agreed process for NED appointments • Committee Papers	✓
B.2.8	The annual report should describe the process followed by the council of governors in relation to appointments of the chairperson and non-executive directors.	Two new NEDs were appointed in2022/23. And the Annual report details the process undertaken.	• Annual Report • Agreed process for Chair appointment • Agreed process for appointment of NEDs	✓
B.2.9	An independent external adviser should not be a member of or have a vote on the Nominations Committee(s).	The Nominations Committee's Terms of Reference allow for an independent advisor to attend meetings when engaged but make it clear that they are not a member of the Committee and do not have a vote.	• ToRs • Minutes	✓
B.3	**Commitment** **All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.**			
B.3.3	The board of directors should not agree to a full-time executive directors taking on more than one non- executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation.	The Declaration of Interest process requires all Directors to declare their outside interests. The *Standards of Business Conduct* policy deals with outside employment and no outside employment can be sought or engaged in without prior agreement from the Board or relevant line manager. The Trust Constitution does not allow for a Director to be a NED for an NHS Trust.	• Register of Interests • Standards of Business Conduct Policy • Code of Conduct • Trust Constitution	✓
B.5	**Information and Support** **The board of directors and council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties**			
B.5.1	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decision they have to make.	The covering sheets of both Board and CoG give clarity over paper's salient points and the action required during the meeting. Both the BoD and CoG have annual cycles of business to ensure that all key governance information is presented in the appropriate manner at the relevant time. Further in depth information is provided to the Board's statutory and assurance committees.	• Board front Cover • CoG front cover • Cycle of Business	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.5.2	The board of directors and in particular non-executive Directors may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	The Board's Standing Orders and SFIs/SoDA and Committees' ToRs allow for the provision of professional advice where appropriate.	• Board Standing Orders / SFIs/SoD • Committee ToRs	✓
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	The Constitution and committees' terms of reference provide for external advice to be sought if deemed appropriate by all members.	• Constitution • Terms of Reference	✓
B.5.4	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of Governors is provided with sufficient resource to undertake its duties with such arrangements agreed in advance.	Allocated Trust secretariat resource supports the Trust Board, its assurance committees and the CoG	• Board/Sub-Committee structure	✓
B.6	**Evaluation**			
B.6.3	The senior independent director should lead the performance evaluation of the chairperson within a framework agreed by the council of governors and taking into account the views of the directors and governors.	The appraisal process for the Chair has been agreed by the CoG's ARC and is led by the SID and Lead Governor. Feedback is sought from both Board peers and Governors.	• Nominations Minutes • Appraisal procedure • CoG Minutes	✓
B.6.4	The chairperson, with the assistance of the Company Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties.	During 2022-23 the Board undertook a development programme with independent support. Board workshop sessions were also held including the following topics: • Inclusion • Strategy Development	• Board workshop Programme and papers • Attendance List • NED Appraisal Reports	✓
B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	The CoG regularly review its functioning.	• CoG minutes • Annual Report	✓
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiability fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Reference is made to the removal from office of a Governor under clause 15 of the Trust Constitution and also within Annex B. The CoG has an approved procedure and this is contained within the Governors Handbook.	• Constitution • CoG Minutes • Governors Handbook	✓

B.8	**Resignation of Directors** **The board of directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its license; its constitution; mandatory guidance issued by NHSI; relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board and directors and works with the council of governors to ensure there is appropriate succession planning.**			
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	There was no agreement outside of those already agreed contractually.	• Minutes of Board Remuneration Committee • Executive Contracts	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
C	**ACCOUNTABILITY**			
C.1	**Financial, quality and operational reporting** **The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.**			
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	The Directors consider a range of risk factors and also receive assurance from the Auditors at year-end and from submissions to NHSE on a monthly and quarterly basis. Audit Committee also consider and make a recommendation to the Board at its April meeting	• Annual Report and Accounts • Auditors' Opinion • NHSE Declaration	✓
C.1.3	At least annually and in a timely manner, the board of directors should set out clearly it's financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	All of this information is disseminated within the Annual Report.	• Annual Report • Board minutes	✓
C.3	**Audit Committee & Auditors** **The board of directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors.**			
C3.1	The board of directors should establish an audit committee composed of at least three members who are all independent non-executive directors.	The Audit Committee's Terms of Reference include all Non-Executives as members, one of whom is a qualified accountant by background. The Trust's Chair is not a member of the Committee	• ToRs of Audit Committee • Constitution	✓
C.3.3	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing the external	During 2022/23 the Audit Committee and the CoG reviewed the arrangements for the External Audit and agreed a procurement process for a new contract. provider	• Minutes of Audit • Committee • Minutes of CoG	✓
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	The External auditors were appointed for a period three years, plus one year prior to the final one year extension. 2022/23 is the last year of the current contract with External Audit.	• Constitution • CoG Handbook • Minutes of Audit Committee • ARC minutes	✓
C.3.7	When the council of governors ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHSI informing it of the reasons behind the decision.	Council of Governors supported recommendation from the Audit Committee to undertake a procurement exercise for external audit. extend the external audit contract for one year.	• Audit Committee notes • CoG Notes	✓

C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	The Freedom to Speak Up Lead makes independent reports to the Integrated Governance Committee and then through the Committee to the Board.	• Freedom to Speak Up policy • IGC reports • Board reports	✓
CODE	**CODE PROVISION**	**TRUST POSITION**	**Evidence**	**Comply?**
D	**REMUNERATION**			
D.1	**The level and components of remuneration** **Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead an NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.**			
D.1.1	Any performance related elements of the remuneration of executive directors should be designed to align their interest with those of patients, service users and taxpayers to give these directors keen incentives to perform at the highest levels.	No element of Executive Directors pay is performance related.	• Remuneration Committee minutes • Contracts	✓
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	The levels of remuneration are in line with other local Trusts and agreed by the CoG	• CoG Nomination Committee minutes • CoG minutes	✓
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors terms of appointments would give rise to in the event of early termination.	The current employment contracts for Directors do not allow compensation to be reduced to reflect a departing director's obligation to mitigate loss or appropriate claw-back provisions in case of a director returning to the NHS within the period of any putative notice.	• Remuneration Committee minutes	✓
D.2	**Procedure** **There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.**			
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for executive directors, including pension rights and any compensation payments.	The Board has delegated responsibility for setting executive directors remuneration including compensation payments and pension rights through the Remuneration Committee. This is reflected in the Committee's Terms of Reference and Trust's Scheme of Delegation	• Remuneration Committee ToRs	✓
D.2.3	The council of governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non- executive.	The remuneration levels of the chair and non-executive directors are in line with other comparable Trusts, however, the Council of Governors via the ARC would consult with professional advisors should any material change be considered.	• ARC minutes	✓
E	**RELATIONS WITH STAKEHOLDERS**			
E.1	**Dialogue with members, patients and the local community**			
E.1.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums	During the year 2022/23 the Trust had an Engagement Strategy in place. Service Users had several forums for giving feedback.	• Engagement Strategy • Terms of Reference	✓

E.1.3	The chairperson should ensure that the view of governors and members are communicated to the board as a whole.	The Chair of the Trust Board is also the Chair of CoG and is a great conduit for information flow between the Board and the Governors. All Non-Execs have an open invitation to attend formal open Governor meetings in order to develop an understanding of Governors' concerns. The Chair summarises the affairs of the Trust during their opening welcome at Governors meetings and presents a Key Issues Report to Board following CoG meetings.	• CoG Attendance List • CoG Minutes • Board minutes • Role of the Chair	✓
CODE	**TRUST POSITION**	**Evidence**	**Comply?**	
E.2	**Co-operation with third parties with roles in relation to NHS foundation trusts** **The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.**			
E.2.1	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	The Board has built relations with 3rd party bodies with which it has a duty to co-operate e.g. NHSE; CQC. Members of the Board and senior leadership are the nominated contacts for these organisations. Copies of all key documents e.g. Provider License, Constitution are shared with members of the Board to ensure they are up to date with latestlegislation requirements.	• Key legal documents	✓
E.2.2	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	During the year 202-23 the Trust had an Engagement approach in place which not only identified key stakeholders but also the level of engagement required and by whom e.g. service users; staff; commissioners.	• Stakeholder Engagement Strategy • Independent Well Led Review	✓

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 13
Subject:	Report of the Audit Committee held on 24 April 2023	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Phil Cave, Chief Finance Officer
Presented by:	Phil Cave, Chief Finance Officer	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 24 April 2023.

Action required:

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

Summary and recommendations to the Board:

Summary

An overview of the work undertaken is outlined in the body of the report.

The planning and preparation for year end 2022/23 has ensured Trust will be submitting a break even position in the draft accounts. Close work with external audit is continuing.

Good progress has been made with the internal audit and counter fraud programmes. With positive draft Head of Internal Audit Opinion.

Matters for Escalation to the Board

There were no items for formal escalation to the Board.

Relationship with the Business Plan & Assurance Framework:

List specific risks on BAF – 5

Summary of Implications:

None

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

The ensuring of equality of experience and access is core to the strategic objectives. The Audit Committee has an important role in assuring the Board that the Trust is delivering the strategic objectives

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Audit Committee held on 24 April 2023

1. Introduction

1.1 This paper provides the Board with a summarised report highlighting key Committee business and issues arising from the meeting.

1.2 Since the last Audit Committee report to the Trust Board in Public, the Committee held a meeting on 24 April 2023 in accordance with its terms of reference and was quorate.

1.3 The Committee was chaired by David Atkinson, Non-Executive Director.

1.4 The Committee received and considered a number of items, appendix 1 details the agenda items from the meeting. Detailed below are the key areas to be highlighted to the Board on the areas that the Committee discussed.

1.5 For the item relating to the External Audit contract both KPMG and RSM left the meeting due to a conflict of interest.

2. Year End 2022/23

2.1 The Committee received a deep dive and a number of items relating to year end 2022/23.

2.2 The deep dive set out current position with regard to draft accounts which were due for submission later that week. The Committee noted that the Trust was planning to submit a breakeven position for year end, that Capital Departmental Expenditure Limit (CDEL) had been met and the Better Payment Code had not been met. Committee members were taken through the position with regard to provisions, accruals and Statement of Comprehensive Income.

2.3 The Committee were updated on the preparatory work and the close working with the external audit team.

2.4 The Committee considered a number of year end reports that supported the year end process, such as use of waivers, losses and special payment, going concern and provision for irrecoverable debt. Committee members considered in each report in turn and scrutinised the reported position, to ensure there was a clear understanding and how it aligned in with the year end position.

2.5 The Committee considered a detailed technical report on the implementation of International Financial Reporting Standard 16. This included the implications of the new standard. The Committee were assured with regard to the work the Trust had undertaken to ensure compliance with the new standard.

2.6 The Committee received an update from External Audit Plan for 2022/23 from KPMG. The plan set out progress to date with the interim audit and Value for Money work. The Committee were updated on the small number of control issues identified, noting that the full audit had not commenced and that the financial plan for 2023/24 was not finalised. The Committee discussed the risk areas identified and were updated on the mitigating actions in place.

2.7 Internal Audit presented the draft Head of Internal Audit Opinion for 2022/23. The Committee noted that was a positive opinion and that the outstanding audits were not expected to change this.

2.7 The Committee reviewed and approved the Annual Governance Statement for 2022/23 and were satisfied that it was a fair record of the risk and control framework and the identified relevant issues.

3. External Assurance Reports

3.1 The Committee received update reports from internal audit and counter fraud, which detailed the good progress with the relevant work programmes.

3.2 It was noted that that the Counter Fraud plan for 2022/23 was complete. It was reported that the internal audit was near to completion. Also, that the planning work for the internal audit programme for 2023/24 was already well underway.

3.3 The Committee also considered a report that set out the progress with the actions identified from audit reports noting the progress with their completion. The Committee were updated on the robust tracking process in place and that internal audit were not concerned with the number of open actions.

4. Charitable Accounts

4.1 The Committee considered in detail and approved the Charitable Funds for 2022/23. The Committee noted the low level of income in the year but were supportive that the majority of the 'Captain Tom' funds had been spent in year.

4.2 The Committee discussed the benefits of moving to a more proactive approach to fund raising and use of charity noting that this was an area that the Executive team would be taking forward.

5. Governance

5.1 To support the end of year processes the Committee received the Board Assurance Framework and Trust Risk Register. The Committee noted the feedback form the Risk Management and BAF advisory audit, which had been positive and provided helpful recommendations.

5.2 The Committee considered and approved the Governance Compliance Statement for 2022/23, noting that the Trust was compliant with all the stated standards.

5.3 The Committee also noted the annual reports of the Finance and Investment Committee, Integrated Governance Committee and its own annual report.

6. External Audit Procurement

6.1 Committee members were updated on the current position regarding the securing of a new external audit company. The Chief Finance Officer outlined the recommendation to appoint one of the companies, including the rationale for the choice. The Committee considered all the factors to assures itself of the robustness of the rationale.

6.2 The recommendation was agreed, and it was noted that the recommendation would be made to the Council of Governors for approval. Prior to this a briefing would be provided to the Council along with the opportunity to meet and discuss the recommendation with the Chief Finance Officer and Head of Corporate Affairs & Company Secretary

7. Matters for Escalation to the Board

7.1 There were no items for formal escalation to the Board.

Hertfordshire Partnership University NHS Foundation Trust

Appendix One: Audit Committee 24 April 2023

Declarations of Interest
Minutes of the meeting held on 9 February 2023
Matters Arising Schedule a) Migration of legacy systems
End of Year 2022/23 a) Use of Waivers b) Losses and Special Payments c) Provision for Irrecoverable Debt d) Going Concern e) Draft Annual Governance Statement 2022/23 f) Use of the Seal quarter four
IFRS 16 and Valuation
Deep Dive Draft Annual Accounts 2022/23 Submission
External Audit a) External Audit Progress Report 2022/23
Internal Audit a) Progress and Exception report b) Draft Head of Internal Audit Opinion
Local Counter Fraud a) Counter Fraud Progress Report 2022/23
Governance Compliance Statement
Charitable Accounts 2022/23
To Note
a. Trust Risk Register and Board Assurance Framework b. Annual Report 2022/23- Update c. Annual Report from Finance and Investment Committee d. Notes of Finance and Investment Committee – 19 January 2023 di. Notes of Finance and Investment Committee – 15th February 2023 dii. Notes of Finance and Investment Committee – 28th February 2023 e. Annual Report from Integrated Governance Committee ei. Notes of Integrated Governance Committee – 27 January 2023 f. Audit Committee Annual Report 2022/23 g. Committee planner
External Audit Procurement update
Any Other Business
Matters for Escalation to the Board
Date of future meeting: 22 June 2023

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 14
Subject:	Annual Report of the Audit Committee 2022/23	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Presented by:	David Atkinson, Non-Executive Director and Audit Committee Chair	

Purpose of the report:

This report outlines how the Audit Committee has complied during the financial year 2022/23 with the duties delegated to it by the Trust Board through the Committee's terms of reference.

Action required:

To:

- Review the content of the report
- Confirm that the report provides a balanced summary of the work of the committee during the year

Summary and recommendations to the Audit Committee:

During 2022/23 Audit Committee considered a wide range of issues. As well as its compliance requirements it sought assurance with regard to risk areas for the Trust, identified through review of the BAF and Trust risk register.

The Board are requested to RECEIVE the report

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

Provides evidence robust governance and of a well-led organisation

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

Audit Committee 24 April 2023

Annual Report of the Audit Committee for the Financial Year 2022/23

1. Introduction

This report outlines how the Audit Committee has complied during the financial year 2022/23 with the duties delegated to it by the Trust Board through the Committee's terms of reference.

2. Constitution

2.1 During 2022/23 David Atkinson Non-Executive Director became Chair of the Audit Committee.

2.2 In February 2023 the Terms of Reference were reviewed and updated and approved by the Board in March 2023.

2.3 Other executive directors and senior managers of the Trust were invited to attend particular meetings to address key issues as they arose and provide deep dives. In addition, the Internal and External Auditors were invited to attend all meetings along with the Local Counter Fraud Specialists. A schedule of attendance at the meetings is provided in appendix 1. This demonstrates full compliance with the quorate requirements and regular attendance by those invited by the Committee.

2.4 Five meetings per annum are required and in 2022/23 six meetings were held. The Committee has an annual work plan with meetings timed to consider and act on regular and special items within that plan.

2.6 The Committee Chair takes formal report to each relevant Board meeting detailing the work undertaken by the Committee and draws the attention of the Board to any significant matters.

3. Achievements

3.1 In discharging its duties, the Committee has met its responsibilities through its achievements in the following areas:

3.2 <u>Assessment</u>

During the year the Committee has complied with 'good practice' through:-

- Reviewing and updating the Committee's terms of reference.
- Conducting private discussions with both sets of auditors.
- Agreeing an annual work programme for 2022/23.

- An annual review of effectiveness was carried out in December 2022 – January 2033, and feedback reported to the Committee in February 2023. The self-assessment provided a positive view of the work of the Committee and was an improvement on the previous year. It did also identify a small number of areas for improvement, including: review how Committee members are updated on the Trust's risk management approach and how this supports the Committee in its role with regard to reviewing the robustness of the assurance processes; Committee members to reflect on level of challenge offered

and how they follow up issues identified by internal and external audit and ensuring appropriate induction programme for new members.

3.3 Internal Processes

During this period no changes were made to the Trust's corporate governance arrangements.

In accordance with the Committee's authority, in addition to the Executive Director of Finance, the Executive Director for Quality and Safety/Executive Director of Quality & Medical Leadership and the Company Secretary, other executive directors and Senior Managers of the Trust were called to attend the Committee where appropriate, particularly to provide updates regarding progress on implementation of recommendations following audit and other assurance reports and reviews.

The Audit Committee also received regular updates from management in relation to the financial position and in particular key risks and issues arising during the year, and their treatment and mitigation. During the year the key risks and issues considered were:

People: in particular the Trust's work to improve the levels of retention but also improve the recruitment experience. The Committee considered the wider system people issues and workforce plan. It also considered findings and recommendations from internal audits relating to people.

Procurement: Work of the system wide procurement function in the Herts and West Essex, and its work to drive efficiency at scale and provide consistency. Reviewing the development of the new service, control brought in and next phase of the service.

Financial services: Service Auditor report for ELFS and the Trust's response to national cyber security incident that impacted on eFinancials (including the Trust ledger and procurement system) and DocMan (a system that is used by two LD teams to transfer letters to primary care).

3.9 Accounting issues – Maria Wheeler, Executive Director of Finance presented key areas of management judgement in the preparation of the annual financial statements with particular reference to:

- The changes to financial planning guidance in the year.
- Level and nature of provisions
- Deferred income levels
- Estates valuation
- Use of Waivers
- Preparation for IFRS16

For each area the approach being taken by management was set out and discussed and agreed by the committee.

3.10 Following receipt of reports from both Internal and External Auditors, the Committee sought clarification of the issues and recommendations raised, reviewed and assessed management responses, and followed up previous recommendations. The Internal Auditors continued to present a regular exception report in respect of those fundamental and significant Internal Audit and Local Counter Fraud recommendations that have not been implemented by management within the agreed timescales.

3.11 To contribute to the principles of integrated governance and support Audit Committee in its role in assuring the Board with regard to the Trust having robust governance systems, the Committee received reports from the Non-Executive Chairs and the minutes of the Integrated Governance Committee, Finance and Investment. In addition, the Chair and two members of the Audit Committee attend FIC meetings and two Committee members attend IGC meetings.

3.12 The Committee reviewed, at least six monthly the Board Assurance Framework and the Trust Risk Register. It is worth noting that the Integrated Governance Committee have primary responsibility for the Risk Register and was agreed during the year that the Audit Committee have primary responsibility for the Board Assurance Framework.

3.13 Annual Reports

The following documents in respect of the 2021/22 financial year were presented in June 2022 for the Committee's approval:

- The Financial Statements covering the year ended 31 March 2022.
- The Annual Report.
- The Annual Governance Statement.
- The Record of Losses and Compensation Payments.
- The Record of the Use of the Corporate Seal.
- The Record of the Use of Waivers.
- The Treasury Management Report

The Charitable Fund accounts and annual report for 2021/22 were presented by the Executive Director of Finance in September 2022 for the Committee's approval and were recommended to the Board for approval.

The Committee approved the following reports presented by the Executive Director of Finance for recommendation to the Board:

- The application of the Going Concern assumption
- The review of Accounting Policies

In April 2022 the Committee approved the position with regard to Provision for Irrecoverable Debts and the loses and compensations register 2021/22.

3.14 Independent Audit and Assurance

External Audit

The primary duty of the External Auditors is to audit the annual financial statements of the Trust. An unqualified audit opinion on the financial statements for the year ended 31 March 2022 was given to the Trust in June 2022.

The Committee approves the External Audit Plan in advance of the work commencing and receives regular updates on the progress of work. In addition, the Committee received, reviewed and noted the following reports in respect of 2021/22:

- Annual Audit Governance Report.
- Annual Audit Letter to Governors.

In February 2023, the Committee received an update from External Audit with regard to the forthcoming audit of financial accounts for 2022/23.

Internal Audit
The Internal Audit service is provided by RSM, a private sector professional services firm. Their primary duty is the provision of an independent and objective opinion to the Chief Executive as Accounting Officer, the Board and the Audit Committee on the degree to which risk management, internal control and governance support the achievement of the Trust's agreed objectives.

The Committee approves the content of the Internal Audit Plan. This plan is structured to facilitate the provision of the annual Head of Internal Audit Opinion, which gives an assessment of:

- the design and operation of the underpinning Assurance Framework and supporting processes;
- the range of individual opinions arising from risk-based audit assignments, contained within the Internal Audit Plan, that have been reported on throughout the year; and
- the process by which the Trust has arrived at its declaration for the Annual Governance Statement.

The Internal Audit Annual Report for 2021/22 was presented to the Committee in June 2022. This report included the Head of Internal Audit Opinion (HIAO) which stated that *'The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective'.*

During the course of the year, the Committee ensured that it received regular progress reports, including findings and recommendations, on the delivery of the Plan for 2022/23 and on the implementation of recommendations.

In February 2023, the Committee considered and approved the Internal Audit Plan for the forthcoming financial year 2023/24. The plan will be kept under regular review at meetings to ensure it remained flexible to any emerging priorities for the Trust.

Counter Fraud
As with the Internal Audit service, the Local Counter Fraud service is provided by RSM. The Committee approves the Counter Fraud Plan in advance of the work commencing.

In February 2023, the Committee considered the Local Counter Fraud Plan for the forthcoming financial year 2023/24. The Committee ensured that during the year it received regular updates on the delivery of the 2022/23 Plan, including work on the prevention and detection of fraud a number of specific investigations were conducted during that year.

The plan was kept under regular review at meetings to ensure it remained flexible to any emerging priorities for the Trust.

4 Training and Development

During the year members of the Committee undertook appropriate mandatory training. They also received a number of deep dives on particular topics identified following review of the risk registers and audit reports.

Committee members also received regular briefing documents from internal and external audit keeping them abreast of regulatory updates and issues.

5 Committee Developments

Specific issues which the Committee will address in the financial year 2023/24 include:

- Monitoring Trust's progress in respect of workforce and staffing issues identified through the internal audits
- Monitoring the work of both the IGC and FIC to seek reassurance that the issues of service quality / patient safety, operational performance and financial sustainability are being addressed in a balanced way.
- Controls and assurances in place with regard to contracts the Trust has with shared services and other service providers e.g payroll.

Appendix 1

	April 2022	June 2022	July 2022	September 2022	December 2022	February 2023
Catherine Dugmore (Chair for April meeting)	✓	✓	✓	**NA**	**NA**	**NA**
David Atkinson (Chair from July meeting)	**X**	✓	✓	✓	✓	✓
Anne Barnard	**X**	✓	✓	✓	✓	✓
Tim Bryson	✓	✓	✓	**X**	✓	✓
Carolan Davidge	**NA**	**NA**	**NA**	**NA**	✓	✓
Drew van Doorn	**NA**	**NA**	**NA**	✓	✓	✓
Kush Kanodia	**X**	✓	**X**	**NA**	**NA**	**NA**
Karen Taylor	**NA**	✓	**NA**	**NA**	**NA**	**N/A**
Hakan Akozek	✓	✓	X	✓	✓	✓
Sandra Brookes	✓	✓	**X**	✓	✓	✓
Andrea Deegan (RSM)	✓	**X**	✓	**X**	✓	✓
Helen Edmondson	✓	✓	✓	✓	✓	✓
David Evans	**NA**	**NA**	**X**	**X**	✓	**X**
Dean Gibbs (KPMG)	✓	✓	✓	**X**	✓	✓
Jessica Hargreaves (KPMG)	✓	✓	✓	✓	✓	✓
Janet Lynch	✓	**X**	✓	**X**	✓	✓
Erin Sims (RSM)	**X**	**X**	**X**	✓	**X**	**X**
Paul Ronald	✓	**NA**	**NA**	**NA**	✓	**X**
Ant Upton (RSM)	**X**	**X**	**NA**	**NA**	**NA**	**NA**
Jacky Vincent	✓	✓	**X**	**X**	✓	✓
Maria Wheeler	✓	✓	✓	✓	**NA**	**NA**
Liz Wright (RSM)	✓	✓	✓	✓	✓	✓
Dr Asif Zia	✓	✓	✓	✓	✓	**X**

Quorum: Two members (Non-Executive Directors) including one member from Finance and Investment Committee and Integrated Governance Committee.

Notes:

1. As Chief Executive, Karen Taylor attended the June meeting which deals with the Annual Accounts, Quality Accounts and the Annual Governance Statement.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 15
Subject:	Integrated Governance Committee Annual Report 2022/23	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Diane Herbert, Non-Executive Director and Chair of the Integrated Governance Committee
Presented by:	Diane Herbert, Non-Executive Director and Chair of the Integrated Governance Committee	

Purpose of the report:

This paper provides the annual report from the Integrated Governance Committee for 2022/23.

Action required:

To:

- Review the content of the report
- Confirm that the report provides a balanced summary of the committee's work during the year.

Summary and recommendations:

During 2022/23 the Integrated Governance Committee considered a wide range of issues. As well as its compliance requirements it sought assurance with regard to risk areas for the Trust, identified through review of the BAF and Trust risk register.

The Board are requested to RECEIVE the report.

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

Controls & Assurance – reporting key matters considered by the Integrated Governance Committee to the Trust Board.

Summary of Financial, IT, Staffing & Legal Implications:

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

Evidence for S4BH; NHSLA Standards; Information Governance Standards, Social Care PAF:

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

The Trust Board has received a report following each Integrated Governance Committee.
Audit Committee 24 April 2023

Annual Report of the Integrated Governance Committee for the Financial Year 2022/23

1. Introduction

1.1 This report outlines how the Integrated Governance Committee (IGC) has complied during the financial year 2022/23 with the duties delegated to it by the Trust Board through the Committee's terms of reference.

2. IGC Constitution.

2.1 Diane Herbert, Non-Executive Director continued as Chair of the Committee.

3.2 During this period the IGC met a total six times, on: 12 May, 22 July; 15 September; 10 November, 19 January 2023 and 16 March 2023.

3.3 In January 2023 the Terms of Reference of the IGC were reviewed and updated for approval by the Board.

3.4 Other executive directors and senior managers of the Trust were invited to attend meetings as appropriate to address key issues as they arose and provide deep dives. A schedule of attendance at the meetings is provided in Appendix 1. This demonstrates full compliance with the quorate requirements and regular attendance by those invited by the Committee.

3.5 The Committee has an annual work plan with meetings timed to consider and act on regular and special items within that plan.

3. Achievements-

4.1 In discharging its duties, the Committee has met its responsibilities through its achievements in the following areas:

4.2 Assessment
During the year the Committee has complied with 'good practice' through:-

- Reviewing and updating the Committee's terms of reference.
- Undertaking deep dives
- Agreeing an annual work programme for 2022/23.

An annual review of effectiveness was carried out in December 2022, and feedback was reported to the Committee in January 2023. The self-assessment provided a positive view of the work of the Committee, and an improvement on the previous year. It also identified a small number of areas for improvement, which centred on: on volume and the appropriate use of summary papers, Committee's role with regard to ensuring compliance of risk policy and developing risk culture for the organisation; identify more time to discuss, explore and debate; move to and integrated or themed approach for Committee meetings and continue to work to improve the quality of the reports and how they are presented.

4.3 Internal Processes

In accordance with the Committee's authority, in addition to the Executive Director of Finance, the Executive Director for Quality and Safety/Executive Director of Quality & Medical Leadership and the Company Secretary, other executive directors and senior managers of the Trust were called to attend the Committee where appropriate, mainly to provide updates regarding progress on implementation of recommendations following audit and other assurance reports and reviews.

The IGC also received regular updates from management concerning quality and people, particularly key risks and issues arising during the year, and their treatment and mitigation and strategic developments. The IGC provided assurance to the Board with regard to quality, information governance, people, governance - including risk management. During the year the key risks and issues considered were:

Specific Deep Dives: The Committee received six of deep dives some of which are detailed below the others ones considered were July 2022, Section 136 Suite and November 2022, Quality and Safety of in patient services.

People: The Committee received regular reports on the Trust's plans to recruit, retain, support staff wellbeing and improve their experience at the Trust. The Committee also monitored the Trust's safe staffing process and guardian of guardian of safe working reports. It also assured itself with regard to key workforce metrics and discussed actions in place to improve the position. The Committee also considered the results of the national staff survey from 2022. It also received a deep dive into Freedom to Speak Up. The Committee also received a deep dive into nurse recruitment. It also received details on the Equality reporting data and outcome from the GMC training survey, which provided positive feedback.

Quality – Safety: As the key assurance committee for Trust regarding quality it considered and discussed regular reports on infection prevention and control, incidents and health and safety. The Committee were updated on Trust compliance against the Use of Force Act and guidance on seclusions. It was updated on the Safe and Wellbeing reviews undertaken in Learning Disability services and learning form the Ockenden and EPUT inquiries. Towards the latter end of the year the Committee were updated on the implementation of Patient Incident Safety Response Framework, noting that it would continue to be updated through 2023 up until full implementation.

Quality – Effectiveness: The Committee considered regular reports on local and national clinical audit programmes The Committee was also updated with regard to CQUIN and latest position with regard to Quality Accounts. The Committee considered internal audit reports on Medicines Management and Mortality Governance, noting the audit opinions and the actions in place to respond to the recommendations.

Quality – Experience: The Committee continued to receive quarterly experience reports, which detailed all aspects of feedback on experience including complaints and FFT. It also received at its May meeting a deep dive into the CQI project in complaints. The Committee at its March meeting received details of the Patient-led Assessment of Care Environment. Increasingly the Committee considered data and guidance on inequalities and in line with this at its March meeting is receive a presentation on the Patient and Carer Race Equality Framework.

Risk: In line with its responsibilities the Committee regularly considered the updated Risk Register and Board Assurance Framework (BAF), providing feedback and noting the assurance they offered. Noting that from January 2023 the Audit Committee took on responsibility for the BAF.

CQC: During this time the CQC undertook unannounced visits to four services in the Trust and the Committee considered the reports and the actions taken to improve services.

All items that required it were escalated to the Board for discussion and approval in line with the Scheme of Delegation and Standing Financial Instructions.

4. Training and Development

During the year members of the Committee undertook appropriate mandatory training.

5. Committee Developments

Specific issues which the Committee will consider in the financial year 2023/24 include:

- People, feedback from the staff survey. Ensuring continued improvement in workforce metrics.
- Continued focus on feedback from regulatory reviews including CQC.
- Continued focus on all aspects of quality, providing assurance to the Board and escalating as necessary.
- Implementation of the Patient Incident Safety Response Framework.

Appendix 1

Cttee Member	12 May	22 July	15 Sept	10 Nov	19 Jan	16 Mar
Diane Herbert (Chair)	✓	✓	✓	✓	✓	✓
Anne Barnard	✓	✓	✓	**X**	**NA**	**NA**
Tim Bryson	✓	✓	**X**	✓	✓	✓
Drew van Doorn	**NA**	**NA**	✓	✓	✓	✓
Jon Walmsley	✓	✓	✓	✓	✓	✓
Kush Kanodia	**X**	**X**	NA	**NA**	**NA**	**NA**
Sandra Brookes	✓	**X**	✓	✓	✓	✓
Hakan Akozek	✓	**X**	✓	**X**	**X**	✓
Helen Edmondson	✓	✓	✓	✓	✓	✓
David Evans	**X**	**X**	✓	**X**	**X**	✓
Janet Lynch	✓	✓	**X**	✓	✓	✓
Paul Ronald	**NA**	**NA**	**NA**	**X**	**X**	**X**
Shahid Shabbir	**X**	**X**	✓	✓	**X**	✓
Jacky Vincent	✓	✓	**X**	✓	✓	✓
Maria Wheeler	✓	✓	✓	**NA**	**NA**	**NA**
Asif Zia	✓	✓	**X**	✓	✓	✓

Quorum: A quorum shall be five members including at least two Executive Director and two Non-Executive Director plus the Chair or a NED acting for the Chair in their absence.

Meeting Date:	25 May 2023	**Agenda Item:** 16
Subject:	Finance & Investment Committee – Annual Report 2021/22	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Anne Barnard, Non-Executive Director and Chair of the Finance & Investment Committee
Presented by:	Anne Barnard, Non-Executive Director and Chair of the Finance & Investment Committee	

Purpose of the report:

This paper provides the Board with the annual report from the Finance and Investment Committee for 2022/23.

Action required:

To:

- Review the content of the report.
- Confirm that the report provides a balanced summary of the work of the committee during the year.

Summary and recommendations:

Summary

During 2022/23 the Finance and Investment Committee considered a wide range of issues. As well as its compliance requirements it sought assurance with regard to risk areas for the Trust, identified through review of the BAF and Trust risk register.

The Board are requested to RECEIVE the report

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

The Trust Board has received a report following each Finance and Investment Committee.
Audit Committee 24 April 2023

Annual Report of the Finance and Investment Committee for the Financial Year 2022/23

1. Introduction

1.1 This report outlines how the Finance and Investment Committee (FIC) has complied during the financial year 2022/23 with the duties delegated to it by the Trust Board through the Committee's terms of reference.

2. Finance and Investment Committee (FIC) Constitution.

2.1 During 2022/23 Anne Barnard Non Executive Director became Chair of the Finance and Investment Committee.

3.2 During this period the FIC met a total of eight times, on: 10 May 2022; 21 July 2022; 22 September 2022, 17 November 2022; 27 January 2023, 15 February 2023; 28 February 2023 and 23 March 2023. Of the two meetings in February, one was an extraordinary meeting (15th) to consider a business case and the other (28th) was an additional meeting to prepare for year end.

3.3 In January 2023 the Terms of Reference of the FIC were reviewed, updated and approved by the Board.

3.4 Other executive directors and senior managers of the Trust were invited to attend particular meetings to address key issues as they arose and provide deep dives. A schedule of attendance at the meetings is provided in appendix 1. This demonstrates full compliance with the quorate requirements and regular attendance by those invited by the Committee.

3.5 The Committee has an annual work plan with meetings timed to consider and act on regular and special items within that plan.

3. Achievements

4.1 In discharging its duties, the Committee has met its responsibilities through its achievements in the following areas:

4.2 Assessment

During the year the Committee has complied with 'good practice' through:

- Reviewing and updating the Committee's terms of reference.
- Undertaking deep dives
- Agreeing an annual work programme for 2022/23.

An annual review of effectiveness was carried out in December 2022, and feedback reported to the Committee in January and March 2023. A number of new questions were introduced for 2022 and whilst the results indicated a slight deterioration in scoring compared to the previous year, it shows a positive view of the work of the Committee. It did also identify a small number of areas for improvement: continue to 'hone' Committee's role with regard to assurance regarding performance; increase profile of digital strategy and work plan; continue to improve quality of papers and ensure focus on key issues and use SPC format.

4.3 Internal Processes

In accordance with the Committee's authority, in addition to the Executive Director of Finance, the Executive Director for Quality and Safety/Executive Director of Quality & Medical Leadership and the Company Secretary, other executive directors and Senior Managers of the Trust were called to attend the Committee where appropriate, particularly to provide updates regarding progress on implementation of recommendations following audit and other assurance reports and reviews.

The FIC also received regular updates from management on the financial position and in particular key risks and issues arising during the year and their treatment and mitigation, and on strategic developments. The Committee provided assurance to the Board with regard to the areas under its responsibility.

In particular during the year the key risks and issues considered were:

Specific Deep Dives: The Committee received six deep dives. May 2022, Financial Plan 22/23 (including Delivering Value Programme); July 2022 Delivering Value Programme; Sept. 2022 Community Transformation; Nov 2022 Mental Health, Learning Disability and Autism Health Care Partnership; January 2023 Preparation for year-end; March 2023 Financial Recovery and Delivering Value Programme.

East of England Collaborative: Several meetings received an update on the Collaborative, including the clinical models, financial performance and service performance. The Committee considered the risks and opportunities and provided assurance to the Board with regard to the Collaborative.

Monitoring: At every meeting, the Committee reviewed financial performance against budget and forecast and considered updates on the contract and commercial activity of the Trust. It also regularly considered the performance of the Trust across key service delivery metrics and progress against the targets set in the Trust's Annual Plan for 22/23.

Planning: In line with its Terms of Reference the Committee considered the planning requirements for 23/24. This included consideration of and recommendation to the Board to approve the Trust Annual Plan; draft financial plan and draft delivering value programme 2023/24.

Capital programme: the Committee regularly monitored progress against the annual capital programme. It also considered specific projects for approval for example Oak Ward refurbishment, lease for Saffron Ground and Female Forensic Business Case. At its March meeting the Committee agreed to recommend Board approval of the overall capital plan for 23/24. In July 2022 and January 2023, the Committee received updates on the Digital programme including progress against the capital programme. The Committee also considered and approved for recommendation to the Board the business case for patient flow and bed management.

Finance: During the year the committee approved the updated Treasury Investment Policy. The Committee also supported the Audit Committee with its consideration of financial reporting including a detailed review of the planning and preparation for the year end 2022/23. This year the Committee additionally considered the Trust self-assessment undertaken as part of the Financial Sustainability audit.

Strategy: The Committee has also considered and input into the development of the new Trust strategy.

All items that required it were escalated to the Board for discussion and approval in line with Scheme of Delegation and Standing Financial Instructions.

4. Training and Development

During the year members of the Committee undertook appropriate mandatory training. They also received a number of deep dives on particular topics identified following review of the risk registers and audit reports.

5. Committee Developments

Specific issues which the Committee will consider in the financial year 2023/24 include:

- Continue to monitor the financial performance of the Trust against the financial plan and delivering value programme.
- Continue to monitor progress of the Trust's capital programme.
- Performance against the Trust's ambitious Annual Plan.
- Performance of the Trust including delivery of services against agreed targets and financial achievement compared to budget.
- Development of the Trust's commercial strategy.

Cmttee Member	10 May 2022	22 July 2022	22 Sept 2022	17 Nov 2022	27 Jan 2023	15 Feb 2023	28 Feb 2023	23 Mar 2023
Anne Barnard (Committee Chair from September 2022)	✓	✓	✓	✓	✓	✓	✓	✓
David Atkinson (Committee Chair until July 2022)	✓	✓	✓	✓	✓	X	✓	✓
Carolan Davidge	NA	NA	NA	✓	✓	✓	✓	✓
Catherine Dugmore	✓	X	NA	NA	NA	NA	NA	NA
Jon Walmsley	✓	✓	✓	✓	✓	✓	✓	✓
Kush Kanodia	X	X	NA	NA	NA	NA	NA	NA
Hakan Akozek	✓	✓	✓	✓	✓	✓	✓	✓
Sandra Brookes	✓	X	✓	✓	✓	✓	X	✓
Helen Edmondson	✓	✓	✓	✓	✓	✓	✓	✓
David Evans	✓	X	✓	✓	✓	X	✓	✓
Janet Lynch	✓	X	✓	✓	✓	✓	✓	✓
Paul Ronald	✓	NA	NA	✓	X	X	X	✓
Jacky Vincent	✓	✓	✓	✓	✓	✓	X	✓
Maria Wheeler	✓	✓	NA	NA	NA	NA	NA	NA
Asif Zia	✓	✓	X	✓	✓	X	X	✓

Quorum: A quorum shall be three members including at least one Executive Director and two Non-Executive Directors.

PUBLIC Board of Directors

Meeting Date:	25 May 2023	**Agenda Item:** 17
Subject:	Annual Review of Fit and Proper Person Test Checks	**For Publication:** Yes
Author:	Maria Gregoriou, Associate Director of People	**Approved by:** Jo Humphries, Chief People Officer
Presented by:	Jo Humphries, Chief People Officer	

Purpose of the report:

The purpose of this paper is to provide annual assurance that all Board directors remain fit and proper for their roles.

Action required:

Members of the Board are asked to approve the recommendation.

Summary and recommendations to the Board:

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the introduction of regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations"), the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'. The Test is carried out by way of various checks, certain of which must be repeated annually. This paper sets out the checks that must be carried out as part of the Annual Review and the outcome of the Annual Review for 2022/2023.

The Board is asked to note and record that the Annual Review of the Fit and Proper Persons Test has been conducted for the period April 2022 – March 2023 and that all Directors satisfy the requirements.

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:

The recruitment and selection process complies with the Equality Act, NHS and Trust requirements in relation to equal opportunities in recruitment and selection.

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

N/A

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

N/A

Annual Review of Fit and Proper Person Test Checks

1. Introduction

1.1 The purpose of this paper is to provide annual assurance that all Board directors remain fit and proper for their roles.

1.2 As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the introduction of regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations"), the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'.

1.3 The Fit and Proper Person Test is undertaken upon appointment to a Board role and certain checks are repeated annually. This paper presents the outcome of the checks carried out for the period April 2022 – March 2023.

2. Annual Review

2.1 As part of the Fit and Proper Person Test, the Trust is required to undertake regular reviews by way of annual checks against certain of the Fit and Proper Person Test criteria for people holding Director posts.

2.2 The Trust's agreed process (dated November 2017) sets out that the Annual Review includes the following items:

a. Confirmation of renewed insolvency and disqualified directors' checks
b. Confirmation of renewed self-declaration form
c. Confirmation of up-to-date photograph
d. Confirmation of DBS check having been carried out within the last three years.

3. Outcome of the 2022/2023 Annual Review

3.1 In Q1 of 2023/24, all Executive and Non-Executive Directors' (including the Chair and Chief Executive) insolvency and disqualified directors checks were completed. All checks were clear.

3.2 In Q1 of 2023/24, all Executive and Non-Executive Directors (including the Chair and Chief Executive) were asked to reconfirm their self declaration. All self-declaration forms have been completed and returned and were clear, i.e. none contained any self-declared reason that would mean the individual was not a fit and proper person under the Regulations.

3.3 In Q1 of 2023/24, it was reconfirmed that the Trust holds up to date photographs of all Executive and Non-Executive Directors (including the Chair and Chief Executive).

3.4 In Q1 of 2023/24, it was confirmed that all Executive and Non-Executive Directors (including the Chair and Chief Executive) have a DBS check carried out within the last three years and that these were all clear.

3.5 All self-declaration forms and annual review documentation have been sent to the Trust Chair and signed off in accordance with the Trust's agreed process. The self-declaration form for the Chair has been signed off by the Senior Independent Director.

4. Conclusion

4.1. All current and newly appointed Directors of the Trust Board satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

4.2 The next annual review will take place in March 2024 and will be reported to the Board in April 2024.

5. Recommendations

5.1. The Board is asked to note the content of this paper and record that the Annual Review of the Fit and Proper Persons Test has been conducted for the period April 2022 – March 2023 and that all Directors satisfy the requirements.