Hertfordshire Partnership University NHS Foundation Trust
PUBLIC Board of Directors

DaVinci Suite

6 July 2023 10:30 - 6 July 2023 13:30

INDEX

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors Meeting
Date: Thursday 6 July 2023

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

AGENDA					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
	Shared Experience – Service User				10:30
1.	**Welcome and Apologies for Absence**	**Chair**			11:00
2.	**Declarations of Interest**	**Chair**	**Note**	**Attached**	
3.	**Minutes of the meeting held: 25 May 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.	**Quality Reports** **a) Safe Staffing Annual Report** **b) Safeguarding Annual Report**	 **Jacky Vincent** **Jacky Vincent**	 **Receive** **Receive**	 **Attached** **Attached**	 11:35 11:40
8.	**CQC Inspection Update Report**	**Jacky Vincent**	**Receive**	**Attached**	11:45
9.	**Framework of Quality Assurance for Responsible Officer and Revalidation**	**Asif Zia**	**Receive**	**Attached**	11:55
	OPERATIONAL & PERFORMANCE				
10.	**Delivering of the Financial Plan**	**Phil Cave**	**Receive**	**Attached**	12:10
11.	**People** **a) People & OD Report** **b) Guardian of Safe Working Annual Report**	 **Jo Humphries** **Asif Zia**	 **Receive** **Receive**	 **Attached** **Attached**	 12:20 12:25
12.	**Performance Report**	**David Evans**	**Receive**	**Attached**	12:30
	STRATEGY				
13.	**Trust Strategy**	**David Evans**	**Approve**	**Attached**	12:40
14.	**Mental Health, Learning Disability and Autism Health Care Partnership Update**	**David Evans**	**Receive**	**Attached**	13:00
	GOVERNANCE AND REGULATORY				
15.	**Audit Committee Report meeting held: 22 June 2023**	**Phil Cave**	**Receive**	**Attached**	13:10

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Our Values
Welcoming Kind Positive Respectful Professional

16.	**Trust Risk Register**	**Helen Edmondson**	**Assurance**	**Attached**	13:15
17.	**Mental Health Act Manager's Annual Report**	**Tim Bryson**	**Receive**	**Attached**	13:20
18.	**Any Other Business**	**Chair**			13.25
19.	**QUESTIONS FROM THE PUBLIC**	**Chair**			
Date and Time of Next PUBLIC Meeting: Thursday 7 September 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

6 July 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
Philip Cave	Chief Finance Officer	Nil Return
Carolan Davidge	Non-Executive Director	Director, Carolan Davidge Ltd (trading as Carolan Davidge Coaching) Director, Arthur Rank Hospice Charity Independent Board Member, Samphire Homes Director, Arthur Rank Hospice Ltd Director, Flagship Housing Developments Ltd
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
Dipo Oyewole	Associate Non-Executive Director	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: 25 May 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 (virtual) (items 1 – 6)
Carolan Davidge | CD	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
DIRECTORS	
Karen Taylor | KT	Chief Executive Officer
Jacky Vincent | JV	Executive Director, Quality and Safety & Chief Nurse
David Evans | DE	Executive Director Strategy & Partnerships
Prof Asif Zia | AZ	Executive Director, Quality & Medical Leadership
Hakan Akozek | HA	Director Innovation & Digital Transformation
Sandra Brookes | SBr	Deputy CEO and Chief Operating Officer
Phil Cave I PC	Chief Finance Officer
Jo Humphries I JH	Chief People Officer
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chair & Company Secretary (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Maria Watkins | MW	Lead Governor

Item	Subject	Action
058/23	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. There were no apologies for absence.	
059/23	**Declarations of Interest** The Declarations of Interest Register was noted. **NOTED**	
060/23	**SU Experience** SBe thanked JS for sharing her story.	
061/23	**Minutes of Meetings held 30 March 2023** The minutes were reviewed, and subject to one typo were approved as an accurate account of the meeting. **APPROVE** **The Board APPROVED the minutes**	
062/23	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
063/23	**CEO Report** KT presented the CEO Report to the Board which was taken as read. Headline messages of note to the Board were:	

	Nationally, issues around staff pay and industrial action were still very much at the fore. The NHS Staff Council confirmed that the pay offer for NHS staff in England had been accepted. Staff would receive the pay award from 1 June 2023. Junior Doctors had planned a three-day strike starting on the 14 June with KT stating this would be a challenging period, also acknowledging our consultant body who had been tremendous with their support. The Royal College of Nursing were balloting their members as to whether they would be taking strike action. The NHS England Workforce Plan had set out that it planned to free up 15 million GP appointments over the next two years. It had also been indicated that apprentice-doctor roles may be rolled out as part of the plan. JV was leading on this piece of work for the Trust. On the 17 May 2023 Richard Meddings, Chair of NHS England had visited the Trust with KT commenting he had visited some of our LD services and provided excellent feedback. KT noted Labour leader Sir Keir Starmer's pledge regarding the future of the NHS. On the 24 May the Integrated Care Board had held a system partners conference with the Rt Hon Patricia Hewitt speaking and KT commenting it had been a positive event. The MHLDA HCP had launched the Dementia Strategy at their May Board meeting. The Crisis Care Partnership Board had met in April setting out a clear programme of work. SBr was leading on this. KT reported that a meeting had been held with senior Police colleagues and system partners to discuss the "Right Care, Right Person" model which was being rolled out across constabularies nationally. HPFT was fully engaged and reviewing the implications whilst acknowledging it was the right thing to do. The East of England Provider Collaborative CEOs had met and discussed the re-set that was needed to cover the cost-of-service provision. The Board would be kept briefed as this progressed. KT reported that the Trust had been successful in securing funding for the Norfolk community Forensic Learning Disability Service on an ongoing basis. On the 19 May 2023 KT had attended a Regional Chief Executives meeting with Sir Julian Hartley in attendance. The following day the national PCREF (Patient and Carer Race Equality Framework) team had been presented. We had agreed a piece of work with Public Health and the ICB to fund the piloting of a CGL workers in each community sector. KT also reported that the ICB had agreed to provide PMO support for a deep dive into alcohol and drug services involving CGL.	

	Operationally we continued with the recovery of our backlog and were seeing good signs of progress and stabilisation. KT reported that the World Health Organisation (WHO) had announced that Covid 19 was no longer constituted a public health emergency and had therefore stepped down its incident level. As a Trust we would also step down our own incident management whilst keeping a strong focus on IPC. The final reports for Warren Court and Oak Ward were due to be published by the Care Quality Commission on the 26 May 2023 with KT stating she was confident we were in a good place. In April and May, we held our Big and Local Conversations noting the Executive Team had been impressed with the commitments made by teams and individuals. Our staff vacancy increased slightly in April however overall good progress had been made. On the 23 May the Trust had held an Admin Conference with over 100 members of staff attending with very positive feedback. The agreed financial plan for the year is a deficit of £1.8m. During 23/24 the Trust would work to further improve against this position. At the end of month one (April) the Trust had delivered a financial deficit of £400k against a planned deficit of £200k with the key drivers for this being the use of private beds and agency staff. At their meeting in May the Council of Governors approved awarding the external audit contract to Deloitte. The Trust had marked International Nurses Day on the 12 May with Anne Hunt and JV contributing to a system wide event sponsored by the ICS. KT invited questions. In response to TB's query around 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, KT provided assurance that at a strategic level she was confident we had the correct working relationships and would strengthen training, however acknowledged the model of care was not where we wanted it to be. SBr added that we were currently trying to recruit to a paediatric liaison team. In response to AvD's query around the EoE Collaborative bed reconfiguration plans, based on the clinical model and current and forecasted demand SBr replied that we did not yet have the data and current forecast was based on historical data. **RECEIVED** **The Board RECEIVED the CEO Brief**	
064/23	**Chairs Report** SBe provided Board members with a verbal update on the work she had undertaken since the last Board meeting. The Governor annual appraisals were almost complete and Non-Executive	

	appraisals were mid-way though. SBe had also carried out KT appraisal. SBe had attended the quarterly Staff Network chairs meeting and had a useful catch up with Yusuf Aumeerally, Freedom to Speak Up Guardian. SBe had completed all sessions with her reverse mentor which she had found beneficial. SBe had undertaken a number of site visits which as always, were very insightful. The Board would be holding an Away Day in early June with SBe acknowledging Board members continued with engagement. Following a robust recruitment process, we had appointed Dipo Oyewole to the role of Associate Non-Executive Director. This had been approved by the Council of Governors at their meeting held 10 May 2023. It was hoped Dipo would start in early July. System wise SBe had attended a number of Chairs meetings including the six weekly Herts Chairs and the East & North Herts Chairs. SBe continued with visiting local MPs commenting on their different views and approach. Following a recent meeting with MP Bim Afolami, he would be visiting Kingfisher Court with SBe in June. All MPs had been supportive of the Trust new build. Following the Richard Meddings visit mentioned earlier by KT, SBe had also taken Richard to Warren Court. Later in the day SBe had joined an NHS Provider roundtable dinner led by Richard. SBe concluded the update reporting she had also attended a national NHS Chairs meeting. **RECEIVE** **The Board RECEIVED the verbal update**	
	QUALITY & PATIENT SAFETY	
065/23	**Report from the Integrated Governance Committee: 16 May 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 held on 16 May 2023. The report was taken as read with the below four key areas drawn out for attention. The Committee held a Deep Dive in medicines management presented by Prashant Sanghani the Chief Pharmacist. The Deep Dive identified areas for improvement and how these were monitored and mitigated. The Integrated Safety Report was discussed with Committee members reflecting on the challenge with regard to incidents and AWOLs. It also noted the positive outcome from the Trauma Informed Approach pilot. The Committee also noted the continued progress with recruitment and the positive impact from this. The Committee had also reflected on the recent industrial action.	

	The Committee had considered the quarter 4 and annual Experience report noting the increase in feedback received which had been assisted by digital capability. The Committee had also acknowledged the increase in complaints with the main themes from these being waiting times and poor communication. **RECEIVE** **The Board RECEIVED the report**	
066/23	**Quarter 4 Integrated Safety Report** JV introduced the report noting that it had not been included in the original pack. The report identified areas of concern, actions that had been taken and were required to be taken in response to the concerns and the priorities moving forwards. Key points were noted below. The year had shown an overall increase in the number of reported incidents however the number of serious incidents had decreased. The report highlighted that there had 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. Absence Without Authorised Leave (AWOL) continued to be challenging and a Task and Finish Group had been commissioned to identify learning. It included the risk assessment process and themes regarding reasons for individuals not wishing to return to the ward. The Trust had undertaken a review of its prevention and management of violence and aggression (PMVA) training and increased training provision. The Trust had also undertaken a review of its Making our Services Safer (MOSS) Together Strategy, introduced the Trauma Informed Approaches (TIA) work, review of the process and practice of safe and supportive observations (SASO) and the learning from the national quality programme. JV reported the Trust had been preparing for the implementation of the national Patient Safety Incident Response Framework (PSIRF. It would enable more system wide learning and be a change in the current incident process. JV reported that working with the Integrated Governance Committee would ensure future reports were more detailed with challenges, learning and actions. **RECEIVE** **The Board RECEIVED the report**	
067/23	**Quarter 4 Experience Report** SBr introduced the report which set out information on feedback received from service users and carers during Quarter 4, 2022-23 and 2022-23 annual report. The report also provided assurance about how the Trust learnt from feedback and used this information to continuously improve services. The report was taken as read and the below points highlighted. The quarter had seen an increase in complaints and a decrease in compliments. Poor communication had been a key driver for complaints and a piece of work had been commissioned to address this. Focus would also be given to waiting times.	

	In terms of involvement, we had seen significant increase in uptake, helped by the introduction of the app. We had also seen an increase in feedback, again due in part to the digital options for seeking feedback. A review of Have Your Say involving services users had stated that the survey was too long. The current version would be phased out and a new shorter form introduced, supported by a programme of bespoke work to ensure feedback on experience. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
068/23	**Annual Freedom to Speak Up Report** JV presented the report which provided the Board with information relating to Freedom to Speak Up (FtSU) cases brought to the FtSUG in 2022/23 including quarter four data. The report was taken as read. There were 133 speak up cases brought to the Freedom to Speak Up Guardian in 2022/23, the highest number seen over past years. The majority of cases included an element of worker safety or wellbeing. The National Guardians Office (NGO) had reported a steady increase in the amount of FtSU cases being received to the FtSUG since 2017 and the number of anonymous cases had fallen. Overall, it had been a positive year. JV invited questions. Board members held a short discussion around a number of themes including the triangulation of FtSU data and complaints. It was also acknowledged that the FtSU champions needed further embedding. The Board supported the consideration of using the Board reflection tool. The Trust would be holding a F2SU conference on the 27 September 2023. **RECEIVE** **The Board RECEIVED the report**	**HE**
069/23	**CQC Update Report** JV advised the reports were embargoed until Friday 25 May 2023 when the final reports for Warren Court and Oak Ward would be published alongside a media statement. JV noted she would be visiting both teams this afternoon to update them on the report findings. **RECEIVE** **The Board RECEIVED the report**	
070/23	**Review of Shared Experience** SBr presented the report which provided the Board with information on feedback received during Quarter four, 2022-23 and 2022-23 annual report.	

	It also provided assurance on how the Trust learnt from feedback to continuously improve services. The report was taken as read. The feedback received from the Board and Council of Governors had been overwhelmingly positive with SBr highlighting that service user feedback was an important part of our recovery journey, noting there was more work we wanted to do. SBe made acknowledgement to the range and mix of shared experiences received. **RECEIVE** **The Board RECEIVED the report**	
OPERATIONAL AND PERFORMANCE		
071/23	**Report from the Finance & Investment Committee held 18 May 2023** PC presented the report which provided an overview of the work undertaken by the Finance and Investment Committee at its most recent meeting held 18 May 2023. The report was taken as read. PC provided an overview of the highlights from the report. The meeting had discussed in detail the performance report, noting the progress with CAMHS. The meeting had also considered a deep dive into Clinically Fit for Discharge which had been well received. The end of year performance for the Annual Plan for 2022/23 had been discussed and it was noted that there was a paper later on the Board agenda. The committee discussed in detail the finance report for month one identifying that the next meeting would consider a deep dive into agency spend. **RECEIVED** **The Board RECEIVED the report**	
072/23	**Quarter 4 and Year End Annual Plan 22/23** DE presented the report which set out the end of year performance against the metrics of the Annual Plan for 2022/23. He reported that in quarter four the Trust had achieved 75.8% and a year end position of 70%. This was a positive position against what was an ambitious plan. At the end of the year four out of seven objectives had been fully achieved. Particular areas of achievement were transformation in primary and community services, which saw the expansion of ARRS. DE set out with regard to the Strategic Objective four related to workforce and we were reporting as green to reflect the staff survey results rather than just the pure performance against the metrics. The FIC had supported this approach noting that 'red' against the metrics did not represent the true position and that they supported them being recorded as amber. KT stated that the Annual Plan for 202/23 had been ambitious and had ended the year in a good place and we would continue to strive for even better. Board members echoed this noting their commitment to have stretching targets.	

	RECEIVE **The Board RECEIVED the report**	
073/23	**Quarter 4 Performance Report** HA introduced the report which provided the Board with an overview of the Trust's performance at the end of Quarter 4 2022-23. The report was taken as read. HA reported the quarter had been challenging however 68% of our Key Performance Indicators (KPIs) were either fully met or almost met thanks to the hard work of our staff. Key challenges were demand and acuity and delayed discharge. A key focus was to reduce length of stay. Children and Young People being seen within 28 days for a routine community appointment improved to 91% but remained short of the 95% target. Some improvement had been seen for recruitment. The Trust continued to perform well in a number of areas. We had seen recovery with staff recommending Trust services to family and friends increasing to 73% against the 70% target. Key areas of strong performance had continued in quarter 4 (detail set out it the body of the report). Questions were invited. SBr commented that the Recovery approach had made a significant difference, however noting some areas still remained challenging including Out of Area placements and delayed discharge, but overall, we were in a good position. Board members also held a brief conversation around SPC charts. **RECEIVE** **The Board RECEIVED the report**	
074/23	**Finance Report** PC presented the report which provided the Board with the financial position for month one. The report was taken as read noting it had been discussed in depth by the Executive team and Finance & Investment Committee. The below points were highlighted. The financial plan approved by the Board at the beginning of this month was a £1.8m deficit. The month one flash position was a £0.5m deficit against a £0.2m plan, which slightly improved as the final figures had come through to a £0.4m deficit. At the current spend run rate, the deficit could be around £3.4m by year end which was £1.6m off plan. The key areas of focus were on pay and agency. We had seen moderate improvement but were expecting a larger gain in this area as the year progressed. Private bed use, in particular adult acute beds, had improved	

	in month but the trend deteriorated towards the end of April and remained a risk. The Executive Team were building upon the current financial governance in the Trust and would need to remain focused to ensure delivery of the financial plan this year. SBe stressed the importance of addressing the significant challenges. KT reported that the team were focused on these areas with CD adding that the FIC had seen evidence of the rigour and approach. **RECEIVE** **The Board RECEIVED the report**	
075/23	**People and OD Report** JH presented the report which set out the Trust's Month 12 performance in relation to key People and OD metrics which supportd the annual plan. Key headlines from quarter 4 were as follows. A number of key performance indicators were showing a positive improvement. Recruitment and Retention hotspots were being focussed on and a Deep Dive with each of the Strategic Business Units was being held to look at our agency spend. JH invited questions. TB raised a comment around nursing apprenticeships with JH acknowledging the need to continue to implement this as a means of recruitment and development. KT stated we should capitalise on our great Staff Survey results and recent 'good news' stories. SBe made a request to see a breakdown of reasons for staff leaving which JH acknowledged. **RECEIVE** **The Board RECEIVED the report**	
GOVERNANCE AND REGULATORY		
076/23	**Compliance with NHS License** HE presented the report which set out for the Board the Trust's Compliance with NHSI's Code of Governance in relation to the 'comply or explain' disclosures and noting the report was for approval. Noting there were specific disclosure requirements required in the Annual Report as identified in the FT Annual Reporting Manual 2022-23. The report 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. HE asked the Board to note the evidence provided and approve a positive declaration of compliance with the Code of Governance as recommended by the Audit Committee.	

	HE invited questions. SBe referenced B.2.2 of the paper regarding Governors meeting the 'fit and proper' persons test. HE reported that she would confirm the required position. No further questions were put forward and all in attendance provided their approval. **APPROVE** **The Board APPROVED the report**	
077/23	**Audit Committee Report meeting held 24 April 2023** PC presented the report which provided the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 24 April 2023. The report was taken as read. The Committee had received a deep dive into the 2022/23 annual accounts and noted that after NHS technical adjustments the Trust had submitted a breakeven position. The Committee also noted the Trust had met its capital limit. The Committee had received individual reports to confirm the impact of IFRS 16 on the Trust and that we were preparing the accounts with the organisation as a going concern. The Committee were updated that KPMG were on track to submit the accounts to the Board on the 22 June 2023 with no key areas of risk to report. The Committee received external assurance reports from RSM on the internal audit plan and the counter fraud plan. The Committee discussed the next external audit company undertaking a healthy debate and made a recommendation to the Council of Governors to appoint Deloitte. The Committee received and discussed the Board Assurance Framework and the Trust Risk Register. The Committee also discussed, charitable funds, use of waivers and special payments. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
078/23	**Audit Committee Annual Report** DA presented the report which outlined how the Audit Committee had complied during the financial year 2022/23 with the duties delegated to it by the Trust Board through the Committee's terms of reference. The report was taken as read. DA reported that as Chair, the Committee had worked diligently.	

	The Internal and External Auditors were invited to attend all meetings along with the Local Counter Fraud Specialists. Assurances were provided for key areas including workforce. DA noted the Committee had worked well with the finance team, Exec and Board. Five meetings per annum were required and in 2022/23 six meetings were held. The Committee had reviewed its Terms of Reference in February 2023 which were reviewed, updated and approved by the Board in March 2023. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
079/23	**Integrated Governance Committee Annual Report** DH presented the annual report from the Integrated Governance Committee for 2022/23. The report was taken as read. DH reported that whist the Committee had developed a full agenda it had still allowed for space to undertake Deep Dives and hold meaningful conversations. In line with its responsibilities the Committee regularly considered the updated Risk Register and Board Assurance Framework (BAF) with DH reporting that from January 2023 the Audit Committee had taken on the responsibility for the BAF. DH made acknowledgement for the detailed papers which were provided to the Committee. Going into Quarter one 2023/24 the Committee was in a good position with a learning approach. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
080/23	**Finance & Investment Committee Annual Report** DA presented the annual report from the Finance and Investment Committee for 2022/23 on behalf of AB Committee Chair. The report was taken as read. DA reported the Committee had worked well with good oversight and control. The Committee had gained real focus on the reporting cycle which had run smoothly and was transparent when reviewing key risks and issues. The Committee had received six Deep Dives on risks or emerging risks.	

	Eight meetings were held over the year. DA made acknowledgement to Executive Directors and senior managers who had attended the meetings. CD added that the Committee had increasingly taken on board its role with regard to performance. **RECEIVE** **The Board RECEIVED the report**	
081/23	**Annual Review of Fit and Proper Person Test Checks** JH presented the report which provided annual assurance that all Board directors remained fit and proper for their roles. The Board were asked to note and record that the Annual Review of the Fit and Proper Persons Test had been conducted for the period April 2022 – March 2023 and that all Directors satisfied the requirements. SBe confirmed she had reviewed all paperwork and supported the approval. JW confirmed that he had reviewed the paperwork for SBe as chair. **APPROVE** **The Board APPROVED the report**	
082/23	**Any Other Business** No further business was put forward.	
083/23	**Questions from the Public** No questions were put forward.	
Date of Next Meeting Thursday 6 July 2023		

Close of Meeting

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors 6 July 2023

MATTERS ARISING SCHEDULE

Matters Arising from meeting held on: 25 May 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
068/23	**Freedom to Speak Up**	**HE**	Consider timing to complete Board Freedom to Speak Up Reflection tool	July 2023	
Matters Arising from meeting held on: 2 February 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
007/23	**Chairs Report**	**SBr**	Schedule Board discussion regarding Learning Disability service and future model	To be confirmed	

as One

Our Values
Welcoming Kind Positive Respectful Professional

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 5
Subject:	CEO Briefing	
Presented by:	Karen Taylor, Chief Executive Officer	

National update

The national activity is summarised below:

Industrial Action

Since the last report to the Board Junior Doctors have taken a three-day period of strike action (14 -16 June 2023) and a further five-day strike has been announced (13-18 July). The Trust responded well to the recent Junior Doctor strike action with Consultant medical staff, nurses and Allied Health Professionals ensuring the continued provision of services. However, each strike action that takes place is having an impact on Trust performance, finances and the running of services.

The outcome of the ballot of consultants by the British Medical Association (BMA) was announced on 27 June 2023. More than 20,000 consultants in England voted in the ballot, 86% of which voted for industrial action. The BMA have indicated that consultants will take strike action on 20-21 July 2023.

The Royal College of Nursing have reported the outcome of the recent ballot of members on strike action. The number of votes received did not meet the required 50% threshold to have a mandate for action. Although it is worth noting that, of those that did vote, there was a resounding majority for strike action.

The Trust continues to plan for ongoing strike action and to ensure that our service users receive safe, timely access to care.

The negotiated and nationally awarded Agenda for Change pay deal has been implemented with the government announcing work will begin on implementing the non-pay elements of the NHS pay deal for England, including looking at ways to "improve nursing career progression". The Department of Health and Social Care will work with the NHS Staff Council, NHS England and NHS Employers to bring forward the commitments including ensuring that the pay-setting process and the NHS Pay Review Body (PRB) operate effectively.

COVID – 19 Incident Management

NHS England has confirmed, in recognition of the World Health Organization recent announcement, that COVID-19 is no longer a Public Health Emergency of International Concern. As a Trust we have taken a further step down of incident management. The changes came in from 30 June 2023 and include: the COVID-19 Patient Notification System (CPNS) no longer collecting data where an individual has died from COVID-19 and the acute COVID-19 data collection process will also be stood down. NHS England are undertaking a review of the outbreak reporting process. They have noted the value of having a permanent operations structure to support services, to disseminate information and collect data during declared incidents and/or other periods of heightened risk or disruption, e.g., industrial action and winter pressures and in recognition of this NHS England's National and Regional Operations Centres will continue to operate.

Rapid Review into data on mental health inpatient settings

The Secretary of State for Health and Social Care has announced a national investigation into the safety of mental health inpatient services following the report from the rapid review to improve the way data and information is used in relation to patient safety in mental health inpatient care settings and pathways. Rapid review into data on mental health inpatient settings: final report and recommendations - GOV.UK (www.gov.uk) The review identified five themes: measuring what matters; patient, care and staff voice; freeing up time to care; getting the most out of what we have and data on its own is not enough.

The Safety Investigation Branch will undertake the national investigation into mental health inpatient services. It will investigate how providers learn from deaths, how young people are cared for in mental health inpatient settings, how out of area placements are handled, and how safe staffing models are developed.

The Secretary of State has also announced that the inquiry of around 2,000 deaths at Essex Partnership University NHS Foundation Trust over the past two decades has been given statutory status, which means staff will be required to give evidence under oath. The Inquiry will also have a new chair following Dr Strathdee's decision to step down from the role.

New Hospital Programme

The Government have announced the providers who have been successful in securing funding under the New Hospital Programme. Five new hospitals have been prioritised due to the fact that they have "significant amounts" of reinforced autoclaved aerated concrete (RAAC) which has a limited lifespan. A total of 40 providers will receive funding, including two of our local hospitals - West Hertfordshire Teaching Hospital Trust and Princess Alexandra Hospital NHS Trust. This is positive news for our local populations and also provides an opportunity for us to work with them to support people in their services with mental health and Learning Disability needs. HPFT was not one of the 40 providers to receive funding for new hospitals. It is planned that all the facilities announced through the programme will be built by 2030.

Three new capital schemes at mental health providers, Surrey and Borders NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust and Mersey Care Foundation Trust, will be receiving funding to build new clinical buildings. This has been funded from capital investments into mental health from the £150 million aimed at better mental health facilities linked to A&E and enhancing patient safety in mental health units. The new facilities will support the work to eradicate dormitory accommodation in mental health facilities.

The Trust is disappointed our proposed inpatient hospital in Stevenage was not funded, and we are working through what options are available to us and our next steps to ensure we have the right number of beds to meet ongoing demand for our services. The Board will be kept briefed as these plans develop.

Government Response- Hewitt Review and HSCC Inquiry

The government has set out its response to the recommendations put forward by the Health and Social Care Select Committee's (HSCC) inquiry on 'Integrated care systems: autonomy and accountability' published in March 2023, and the Rt Hon Patricia Hewitt's independent review of Integrated Care Systems (ICS), published in April 2023

The government accepts the need to focus on a smaller number of national priorities and states this is reflected in the new NHS mandate. Hewitt's proposed approach to the Care Quality Commission's (CQC) assessment and rating of ICSs is supported by the Department of Health and Social Care (DHSC) and the department will consider the best approach to delivering this, building on work underway by the CQC.

DHSC supports the intent of Hewitt's proposals to create High Accountability and Responsibility Partnerships (HARPs), giving greater autonomy for more mature ICSs. However, it has not committed to implementing these, mindful that ICSs are still "in their infancy". The DHSC's response acknowledges the importance of recurrent or multi-year funding streams and it commits to building on existing work to reduce the prevalence of in-year funding. The government acknowledged the desire to move away from ringfenced budgets, but also highlights their importance in some instances, for example for mental health investment. DHSC rejected suggestions to reconsider the 10% cut to the running cost allowance for 2025-

26, pointing to NHS England's plans to focus funding on the frontline. The government's response recognised the need to further review the existing capital system, particularly for primary care, private finance, and the management of the NHS estate setting out that further steps will be set out in due course. DHSC's response to recommendations on data and digital did not contain new announcements of funding to support improvements, but they did support the intent of Hewitt's recommendations around interoperability, data standards, and stated commitments for digital investment in partner organisations including social care.

New Mental Health Waiting Time Standards

NHS England has confirmed that new waiting time standards will being introduced for Children and Young People (CYP) and Adults and Older People service users referred to Community Mental Health Services, setting out targets for them to receive help within four weeks of referral. NHS England plan to publish reports detailing the position using proxy measures in quarter two, with publication against full measures planned for quarter four. The information shared with providers in quarter one is intended to identify and improve data quality issues. The Trust are considering the figures provided by NHS England, based on information the Trust has submitted. Following publication of the detailed guidance on the metrics, which is due at the end of June 2023, the team will identify areas of improvement and aim for inclusion of the new metrics in quarterly performance reports from quarter two 2023/24. The Finance and Investment Committee will consider the new standards and the Trust's performance.

NHS Workforce Plan

The Government published its 15-year workforce plan on 30 June 2023. Headlines from the plan are that there will a significant expansion of training places for health staff in England, including more university places for medical and nursing students and a greater emphasis on apprenticeships. The workforce plan will be refreshed every two years to ensure it meets future requirements.

NHS England – Equality, Diversity and Inclusion Improvement Plan

NHS England (NHSE) has published its first equality, diversity and inclusion (EDI) improvement plan which was developed in consultation with diverse staff, staff networks and stakeholders. NHS England » NHS equality, diversity and inclusion (EDI) improvement plan The six high impact actions (HIAs) set out in the plan are underpinned by a combination of success metrics. NHS England describes its central role in supporting Trusts and ICBs with guidance to implement the actions, also noting the importance of working in partnership with trade unions and staff networks. All HIAs are supported by case studies and resources uploaded to Future NHS, forming a national EDI repositor. The Trust will actively use the resources as it develops and embeds its approach to Belonging and Inclusion.

NHS Mandate 2023

The recently published mandate for the NHS NHS mandate 2023 - GOV.UK (www.gov.uk) has set out three priorities for NHS England to support the sector to deliver: cutting NHS waiting lists and recovering performance; supporting the workforce through training, retention and modernising the way staff work and delivering recovery through the use of data and technology.

There is an emphasis on transparency, choice and maximising the use of all providers of NHS healthcare to tackle the elective backlog. There were a few areas that were notable by their absence. The first is the lack of priorities centred around public health restoration, contrasted to last year's mandate where a whole objective was dedicated to population health management, preventing ill health and tackling health disparities. The second area absent from this year's mandate is around the parity of esteem between mental and physical health, which was explicitly stated in the 2022 version. Other areas of mental health were also not mentioned, including tackling the mental health waiting list or priorities around keeping people with mental health needs well and out of hospital.

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)

The Integrated Care Board (ICB) has set out that the next stage of its development will focus on the articulation of its operating framework for the ICB and 'Place', including Health Care Partnerships. This

work is in the early stages but is important for the Trust to work closely with the ICB to understand the implications in particular for the Hertfordshire Mental Health, Learning Disability and Autism (Health and Care Partnership). A System Partners Conference was held on 25 May and received a presentation from Rt Hon Patricia Hewitt who spoke about her review and the opportunities it presents for systems. The conference enabled partner organisations to meet, learn and share current best practice and opportunities for developing services for the future. The ICB Board meeting on 28 July 2023 will be focused on mental health and will receive a shared experience from a service user and her mother.

The Hertfordshire Health and Wellbeing Board met on 16 June 2023. Key topics considered at the Board included the activity to improve Women's health across the ICB, an update on the impact of Hertfordshire's Family Safeguarding Model and a programme update on Hertfordshire's Discharge to Assess activity.

The Board received a briefing on the Making Every Adult Matter (MEAM) framework which has been adopted in Hertfordshire as a way of coordinating multi-agency activity to support people experiencing multiple disadvantage including homelessness, substance misuse and mental illness. We are fully supporting this approach from a strategic and operational perspective. The meeting also discussed arrangements for joint commissioning between the NHS and Hertfordshire County Council. The Board meeting agreed that the Health and Wellbeing Board would oversee all joint commissioning activity in Hertfordshire and approved governance structures that would provide it with sufficient oversight of the activity

When the Integrated Care Partnership met in June it discussed its operating framework, including its meeting schedule and areas of focus. Jane Halpin provided an update on the outcomes of the Hewitt revie and presented the Integrated Care Strategy Plan. Priority six of the Plan relates to people with mental illness and autism. The Trust is ensuring that the profile of the priority is maintained linking it with both universal mental health provision and specialist services.

The HWE ICB first Joint Forward Plan was published on 30 June 2023. The Forward Plan describes how NHS partners across the system will work together over the next five years to meet the needs of local people. It has been developed with input from key partners including the HCPs. The Joint Forward Plan sets out four principles and six priorities for the ICB, including commitments for people with mental illness, learning disability, dementia and meeting neurodevelopmental needs.

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

At the MHLDA HCP Board meeting on 20 June 2023, the Partnership received an update on the development of the Primary and Community Mental Health Transformation Programme. The discussion focussed on the opportunities presented through the Fuller Review of Primary Care, specifically how we might best support the new Integrated Care Neighbourhood Boards so that the needs of people with mental illness and learning disabilities is prioritised. The Partnership also considered the wider role of the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector in supporting these developments so that HPFT investment and the ARRS roles could focus on supporting people with more complex needs.

The HCP also reflected on its achievements over the last six months including the strength of the partnerships it has developed, the scope of its activity and oversight and the practical changes it has made for people and communities including specific work around the cost-of-living crisis and support for refugees. The MHLDA HCP has produced its first Annual Report summarising its role, activity and ambitions for the year ahead.

Leadership Changes

The mental health portfolio at a regional level moved under Catherine Morgan, Regional Chief Nurse and there will no longer be a specific Director for mental health. Adam Cayley has been appointed as the new Regional Director of Performance.

Natalie Hammond has been appointed as the HWE ICB Director of Nursing who was previously the Director of Nursing at Essex Partnership University Trust and we are delighted she will bring this mental health expertise to the ICB leadership team.

Right Care Right Person

A number of events have been held nationally and regionally regarding the Right Care Right Person (RCRP) model being adopted by police constabularies. This includes, for example, changing the response to how people are supported when presenting with mental health need and with officers attending mental health 999 calls only when there is an "immediate threat to life". The change is aimed at releasing officers time after they have seen a significant rise in the number of mental health incidents being dealt with by the forces in the past five years.

Whilst we still await specific guidance it is clear that local police forces are likely to adopt this approach. Hertfordshire Constabulary continue to indicate that RCRP is the direction of travel for them but have assured the system that they want to work in collaboration and agree that a realistic timescale is required. Task and finish groups are being set up on the different aspects of the model. We are also working closely with our police colleagues to review our policies regarding people who are absent without leave and the requesting of welfare checks, to ensure we are using police time effectively.

Trust-wide update

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

Trust Strategy

We are looking forward to launching our new Trust strategy *'Great Together'* on 10 July 2023. A strategy that has been co-produced and developed with our service users, carers, staff, partners and local communities. It is an ambitious strategy designed to guide our journey over the next five years as we continue to work together to improve care and outcomes for the people and communities we serve.

University of Hertfordshire Partnership

Following a robust process to review the Trust's University Status, which included requirements set by the University of Hertfordshire Centre for Academic Quality Assurance, I am delighted to report that our University status has been confirmed for a further ten years. This is great news for the Trust, the students and learners who we and the University of Hertfordshire support.

Operational update

Services have continued to recover performance following the impact of a series of Bank Holidays and periods of Industrial Action. Performance is showing good signs of stabilising and for those areas that remain challenging, we are continuing to work on transformation and considering what further changes we need to make. The South West Hertfordshire quadrant continues to experience high levels of demand and particular challenges in meeting performance targets. A detailed demand and capacity analysis has been undertaken, with a refreshed recruitment plan targeting this area and additional support planned to for staff as we make further improvements.

We are continuing to work with our teams and external partners to actively review and manage the plans of a small number of service users with complex needs who have been unable to be discharged from our services due to lack of appropriate placements or housing. We have started to see some movement and will continue to focus on joint working and escalation including senior Multi-Agency Discharge Events as an approach to support our service users receive the right care in the right place.

We continue to experience high demand for beds but this has started to stabilise and the focus remains on flow management and development of virtual discharge teams.

We are seeing encouraging outcomes following a deep dive into observation levels, supporting staff to approach risk and behaviours differently whilst maintaining the safety of staff and service users at all times. This is particularly evident in Albany Lodge with positive reports from both staff and service users. This is informing the development of our future approach to risk management, with a task and finish group led by the Executive Director of Quality and Safety (Chief Nurse).

Care Quality Commission

As reported at the last Board on 26 May 2023 the final reports for Warren Court and Oak Ward were published by the Care Quality Commission, following the focused inspections that took place in the Autumn of 2022. Both services were rated Good. The reports identify significant areas of good practice but also a small number of areas for improvement. Since the inspections took place, the Trust has implemented comprehensive Service Improvement Action Plans for both services to address the areas for improvement identified.

Our People

In May, our staff in post increased by 28 FTE, which means we have a 3744 FTE strong workforce and a reduced vacancy rate of 11.8%. At the same time our overall establishment increased by 15 FTE (as per our workforce plan) and we also saw improved retention at 11.7%.

Our appraisal rates are at 85%, however this is expected at this time of year as we have reset our appraisal window which runs until 31 July. Our focus on ensuring all our people have had a great appraisal conversation has been stepped up with weekly compliance reporting taking place to maintain momentum. Our mandatory training compliance increased to 90% in May, as we continue to recover from the impact of introducing two new mandatory training modules in March 2023.

As part of our retention work, we continue to provide a comprehensive health and wellbeing support offer, including a growing financial wellbeing and benefits offer for our staff. During May, we supported participation in national walking month and promoted a range of walking and exercise related discounts. Our sickness absence rate remained at a lower level than we have seen over the last year – now at 4.4% in May.

We celebrated International Day Against Homophobia, Biphobia and Transphobia (IDAHOBIT) in May to raise awareness about LGBTQ+ rights across the world and inspire everyone to take action to support the rights of people with different sexual orientations and gender identities who make up the LGBTQ+ community. As part of this year's celebration, our Staff Outlook Network held an informative session to present and discuss the 2023 LGBTQ+ Hertfordshire Health Findings.

During May we also held our admin conference, organised by the Admin Staff Network, which was a great success. Our Chief People Officer and Head of Corporate Affairs & Company Secretary welcomed colleagues to the event, emphasising the importance of their roles in ensuring that the Trust functions well and delivers the care needed by our communities. The network was delighted to welcome keynote speakers from Strengths Focused Leadership and Microsoft as well as a number of HPFT staff to share their knowledge, expertise and experience. Workshop leaders commented how positively staff talked about solutions and ideas, developing resolutions to make things better.

Finally, the People and OD Team celebrated International HR Day in May with an awards ceremony recognising HPFT's very own HR Stars, nominated by colleagues from around the Trust.

Finance – Year End 2022/23

The Trust has successfully submitted it Annual Accounts and Annual Report for 2022/23 in line with the national deadline. The Trust accounts detailed a break-even position for 2022/23 and a unqualified audit opinion and an Annual Report that is compliant with the Annual Reporting Manual. The Accounts and Annual Report were considered and approved by the Audit Committee and Board at their meetings on 22 June 2023.

Finance 2023/24

The Trust's agreed financial plan for the year is a deficit of £1.8m, which forms part of the Hertfordshire and West Essex NHS Integrated Care System's strategy to achieve breakeven and its plan to achieve financial stability. In 2023/24 the Trust aims to identify financial improvements that will contribute to long-term sustainability while ensuring that service user care remains unaffected. However, at month 2 the Trust has incurred a financial deficit of £1.9m, exceeding the planned deficit of £0.4m by £0.15m. The primary cause of this deficit is the utilisation of private beds and the reliance on agency staffing in our inpatient areas. These factors pose significant risks to achieving the financial plan for 2023/24, and

importantly can impact on the experience and outcomes for service users. Plans are in place to address this position, and additional financial controls have been put in place across the organisation to enhance financial governance. A report later on the agenda will provide more detail.

Website Incident

The Trust was named in a national media article on 27 May 2023 as one of twenty NHS Trusts found to be using the Facebook/Meta tracking tool. The article noted that the Information Commissioner's Office was made aware of their findings of the investigation by the media outlet. The Trust undertook an initial investigation and ensured all tools were removed from its website immediately, and information was placed on our website about the incident. A fuller investigation into the events leading to the tools being attached to the website is taking place and will conclude in July. The Board will continue to be updated on the progress and findings of the investigation.

Specialist Residential Services (SRS)

The standstill period for the care provider contract has been concluded and Avenues have been awarded the contract for the future Supported Living service. Avenues have successfully transformed other hospital services into Supported Living, with positive references and they have an Outstanding CQC rating. The Trust will work with partners to ensure an effective mobilisation and transition plan, with the expected staged transfer of responsibility during autumn 2023.

Awards

I am delighted to report that two teams in the Trust have been shortlisted for national awards. The Enhanced Rehabilitation Outreach Service + team has been nominated for a Nursing Times Team Award and the Simulation Suite has been shortlisted for the Health Service Journal Patient Safety Awards. To be shortlisted from large fields is a real credit to the teams and the work they do. The next steps are to prepare and attend the next phase of the assessment and we will work hard to ensure teams are fully supported to showcase their achievements. The Trust has also made a number of submissions for the national Health Service Journal awards.

NHS 75th Anniversary

The 5 July 2023 will mark the 75th Anniversary of the establishment of the NHS. The Trust along with other NHS Trusts will be holding a number of events to mark this significant milestone. The events will bring staff, services users and our communities together to celebrate and share stories.

Karen Taylor
Chief Executive Officer

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:**	7a
Subject:	Annual Safer Staffing Report	**For Publication:**	Yes
Author:	Bina Jumnoodoo, Deputy Director Nursing and Quality	**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:

This Annual Safer Staffing Report includes quarter 4 data and is presented to the Board to provide assurance in relation to safer staffing requirements for 2022/23.

Action required:

To Approve: To formally agree the receipt of this report and its recommendations for 2022/23
For Assurance: To appraise the Board that controls, and assurances are in place.

Summary and recommendations to the Board:

This report informs the Board with the annual safer staffing update for 2022/23 across all SBUs within the Trust.

The acuity and complexity of service users, the prescribed levels of safe and supportive observations, and staff vacancies across the inpatient services continued to have an impact on the level of staffing and the use of temporary staffing. An initial establishment review for the inpatient services has been completed, learning from the safer staffing incidents and use of temporary staffing to support with additional duties and prescribed safe and supportive observations.

A focus on recruitment and retention for nursing staff has seen a positive reduction in the use of temporary staffing in some services. The Erostering team implemented Team Based Rostering across the inpatient services as part of the staff retention plan and the Trust is the first and only Trust in the region to implement it in all inpatient services. The eRostering team launched the roster rollout project to achieve level 4 in e-rostering Levels of Attainment (NHSE/I), and commenced a project to rollout HealthRoster to all Trust staff and teams.

Training compliance has made good progress, currently at 91% overall, and the Erostering team have been working with Learning and Development to assign staff to work on training dates and reduce the DNAs.

The Mental Health Optimal Staffing Tool Training delivered by NHSE/I Trainer and the Trust's Deputy Director of Nursing and Quality, saw 14 staff members successfully completing the assessment. The tool will commence implementation in quarter 1 2023/24 in West SBU's unplanned care services.

The Board are asked to note the challenges the services have experienced, the progress that has been made and the priorities for 2023/24.

Relationship with the Business Plan & Assurance Framework:

Relation to the Trust Risk Register: Workforce: The Trust is unable to retain enough staff in key posts to be able to deliver safe services (Risk 657). Workforce: The Trust is unable to recruit enough staff to be able to deliver safe services due to national shortages of key staff (Risk 215). Relation to the BAF: **1.** We will provide safe services, so that people feel safe and are protected from avoidable harm. **2.** We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support, and treatment.

Summary of Implications for:

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

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

There are no implications arising from this report.

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

QRMC 4 May 2023 IGC 16 May 2023

1. Introduction

1.1 This report provides details regarding the safe nurse staffing levels across the Trust's inpatient services and the appropriate systems in place to manage the demand. It also provides a brief regarding safe staffing, financial ramifications and forecasting against bank and agency usage and e-rostering across the Trust. Details regarding acuity, complexity and demand, impacting on safety, are reported in the Integrated Safety report.

1.2 The Trust is required to consider staffing capacity and capability and meet the National Quality Board (NQB) guidance, *'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing* (2016)'.

2. Trust's Expectation

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

2.2 Where the skill-mix and the number of staff who work is lower than planned, an agreed escalation process for reporting is in place. Staffing cover can be mitigated by an increase of staff from a different band, cross cover from co-located services and by the Team Leaders and Clinical Matrons.

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

3. Summary of findings for nurse staffing data collection

3.1 Care Hours Per Patient Day (CHPPD) data submitted by the Trust, reflects the increased staffing utilised in many of the services as a result of increased acuity and the standalone units where CHPPD is high (*appendix 1).*

3.2 There are some inpatient services where the CHPPD is more than 120% for the period, both for Registered Nurses (RN) and for Healthcare Support Workers (HCSW), impacted by an increase in service user acuity and prescribed safe and supportive observations (SASO).

3.3 There have been occasions where the CHPPD hours for the RNs have been below 80% and above 120%; the weekly scrutiny meetings ensure close monitoring and management of the skill mix and staffing levels.

4. Safer Staffing Across the SBU

West SBU

4.1 The level of complexity and demand has remained high, and with individual service users with an extended length of stay owing to challenges with placements and more comprehensive packages of care required, also impacting on the number of prescribed SASO.

4.2 Targeted support for the Team Leaders in Absence Management has seen an improvement in sickness rates, and a focus on supporting staff has increased the level of compliance with supervision, appraisal and training.

4.3 Team Leaders and Clinical Matrons have continued to support the inpatient services to maintain the effective delivery of care and safety for the service users, as well as enable a senior clinical role model for the frontline staff.

4.4 The successful introduction of Trauma Informed Approaches (TIA) in Robin ward has seen a positive impact on staff morale, length of service user stays and the number of incidents. 2023/24 will see the TIA embedded across all inpatient services Trust wide.

4.5 A Task and Finish Group developing a purposeful admission training programme for inpatient staff, has involved multi-professional disciplines, consisting of the following three streams. An update will be provided in the next report.

- generic skills training and bite size training for all inpatient staff
- Charge Nurse development programme
- HCSW development programme.

4.6 Staff vacancy and unavailability continued to be a challenge, reported on the local risk registers, with targeted work to focus on recruitment. This has seen a positive impact in some services with a reduction in the number of vacancies.

4.7 Looking ahead at 2023/24, the SBU are focusing on the following priorities:

- implementing the Mental Health Optimal Staffing Tool (MHOST) across the inpatient wards, commencing the pilot in May and for completion by quarter 2
- increased scrutiny on eroster, ensuring effective rostering processes, management of unavailability, and management of unfilled duties
- reviewing all prescribed SASO daily, with individuals on a longer period of prescribed SASO reviewed by the wider multi-disciplinary team (MDT) weekly
- ensuring high level of mandatory training and appraisal compliance
- implementing TIA across the inpatient services, with training and case discussions commencing in quarter 1
- fully implementing the initial establishment review and recruiting into all permanent posts.

East And North SBU

4.8 The SBU experienced a sustained high level of acuity across the inpatient services, impacting on the staffing levels, impacting on the use of temporary staffing. Each inpatient services' senior leads team have been working to together to review identified risk that impact on staffing and quality of care provided.

4.9 The positive impact continued, following the review of one-to-one care plans, reducing the duration and number of prescribed SASO in the older aged adult inpatient services, with staff feeling more confident in collaborative care planning and the utilising alternative interactions to higher prescribed levels of SASO.

4.10 A recruitment drive resulted in an increase in the number of substantive and a reduction in temporary staff and the monthly establishment reviews with finance and HR, have ensured that changes to posts and staff hours are accurately reflected.

4.11 The band 2 to 3 HCSW development programme has enabled 27 existing band 2 staff complete the competencies and progress to band 3 posts. Newly appointed HCSWs commence an 18-month apprenticeship program, as part of an ongoing development process for new starters to support their experience within the Trust.

4.12 Training compliance has stabilised at 91% and above, with the Team Leaders ensuring staff book to attend their face-to-face training before they have expired.

4.13 During quarter 4, the teams worked with the team rostering format, providing an opportunity for staff to plan their rotas and achieve a better work life balance. The teams also moved from a 12 to eight-week rota timetable.

4.14 Team Leaders, operational managers and Clinical Matrons received training in MHOST, with six staff members successfully completing the assessment. Implementation across the services will commence at the end of quarter 1 2023/24, with the completion in early quarter 2.

4.15 Looking ahead at 2023/24, the SBU are focusing on the following priorities:

- continuing with the recruitment of staff into post and working on the retention of RNs and HCSWs across all the inpatient services
- ensuring high level of mandatory training and appraisal compliance
- fully implementing the initial establishment review and recruiting into all permanent posts
- ensuring the right staff are in position across the services with all vacancies placed on TRAC.

Learning Disability and Forensic SBU

4.16 Reliance on temporary staffing remained a challenge owing to staff shortages and the level of prescribed SASO; the Team Leaders and Clinical Matrons continued to step into numbers to support.

4.17 Additional duties remained high, with hotspots in the Broadland Clinic, Dove ward, and The Beacon. Avoidable costs were also high particularly in the Broadland Clinic.

4.18 The international nurses working in the secure services have successfully passed their OSCE and have their Nursing and Midwifery Council (NMC) Pin numbers.

4.19 Team based rostering has been implemented across the services. The SBU continues to make recruitment and retention a top priority to arrest the unsustainable usage of agency within our services, but this is a long-term challenge.

4.20 A working group set up to support substantive HCSWs in Essex and Norfolk onto the Open University (OU) Registered Nurse Learning Disability (RNLD) training course, with agreed internal selection processes and interviews to be held in quarter 1 2023/24.

4.21 Following the aforementioned MHOST training, plans are in place to undertake the required benchmarking audit in the services.

4.22 The SBU submitted two initial inpatient establishment reviews, one in December 2022 and one early February 2023 with a view to reducing the use of temporary staffing and which are in the process of being approved.

4.23 The SBU continued to hold daily SafeCare calls; Norfolk and Hertfordshire jointly and Essex separately, including the Intensive Support Team (IST) to redeploy locally. Weekly roster scrutiny meetings also continued, reviewing safecare, finalising of duties, additional duties, bank and agency usage and a fair, effective, and safe roster on approval to ensure that each inpatient is safely staffed, and staff can maintain a work life balance.

4.24 Looking ahead at 2023/24, the SBU are focusing on the following priorities:

- encouraging agency staff members to enrol as substantive or bank staffs
- recruiting to reduce bank fill rates and unfilled shifts and unavailability
- streamlining the annual leave threshold at around 14%
- implementing team-based rostering.

5 Finance

5.1 Pay spend has averaged at around £18.5-19m per month, following the pay award and represents 60% of the Trust's total monthly expenditure. Over the last 36 months, pay spend has steadily increased; bank and agency usage, in particular, has increased substantially with temporary staffing representing 20% of staffing spend compared to 14-15% pre-Covid.

5.2 The increase in permanent pay is different to that of bank and agency, as shown in *figures 1, 2* and *3,* with a steady increase in line with investment over the last two years, but with a significant gap between substantive pay in the plan and actual spend.

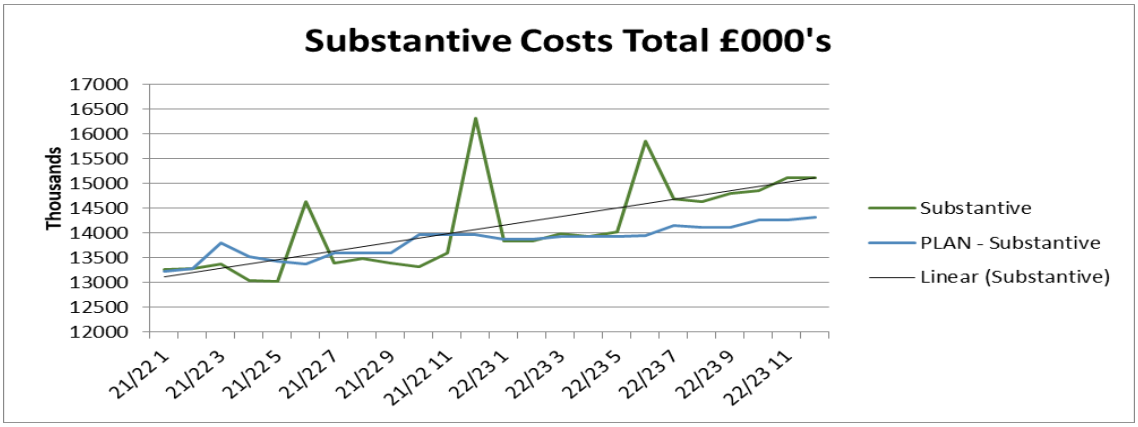


Figure 1

5.3 There has been a significant use of temporary staffing over and above the planned usage and, whilst the planned figures were reset for the 2022/23 financial year, with the Trust seeing a greater reliance on both bank and agency staff.

5.4 A number of workstreams reviewed to address the current reliance on agency staff in particular, with a focus in quarter 1 2023/24 on recruitment, reduction in prescribed SASO and roster management to reduce the reliance on agency staff.

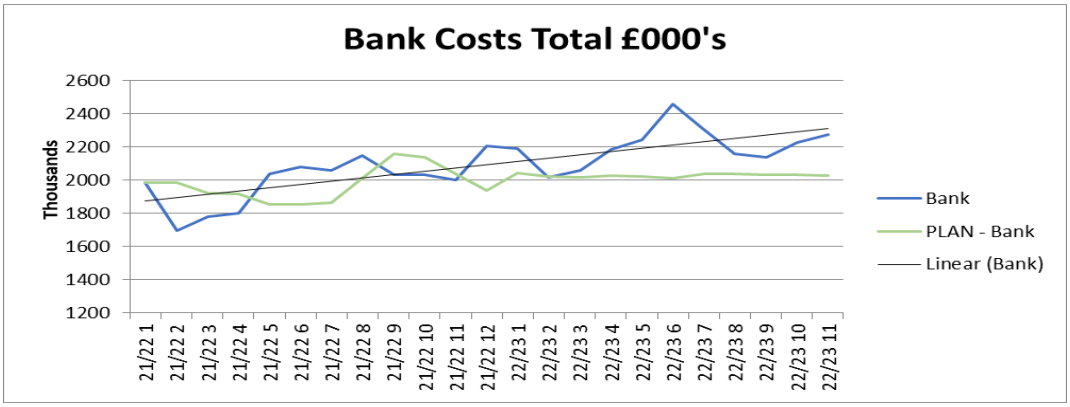
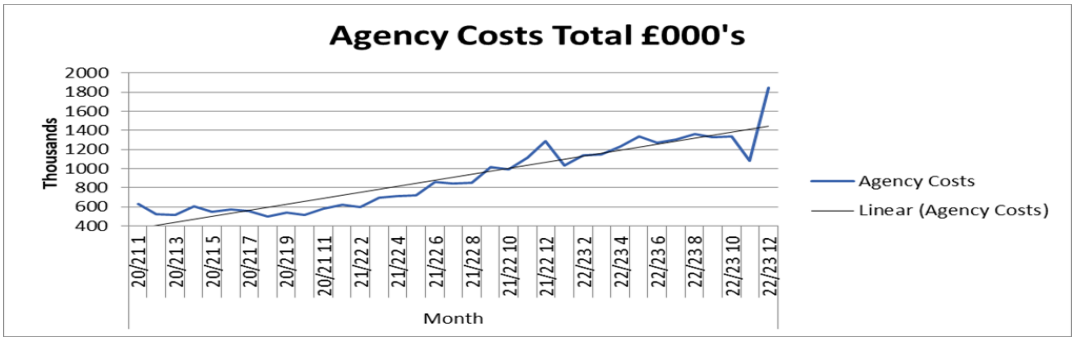


Figure 2



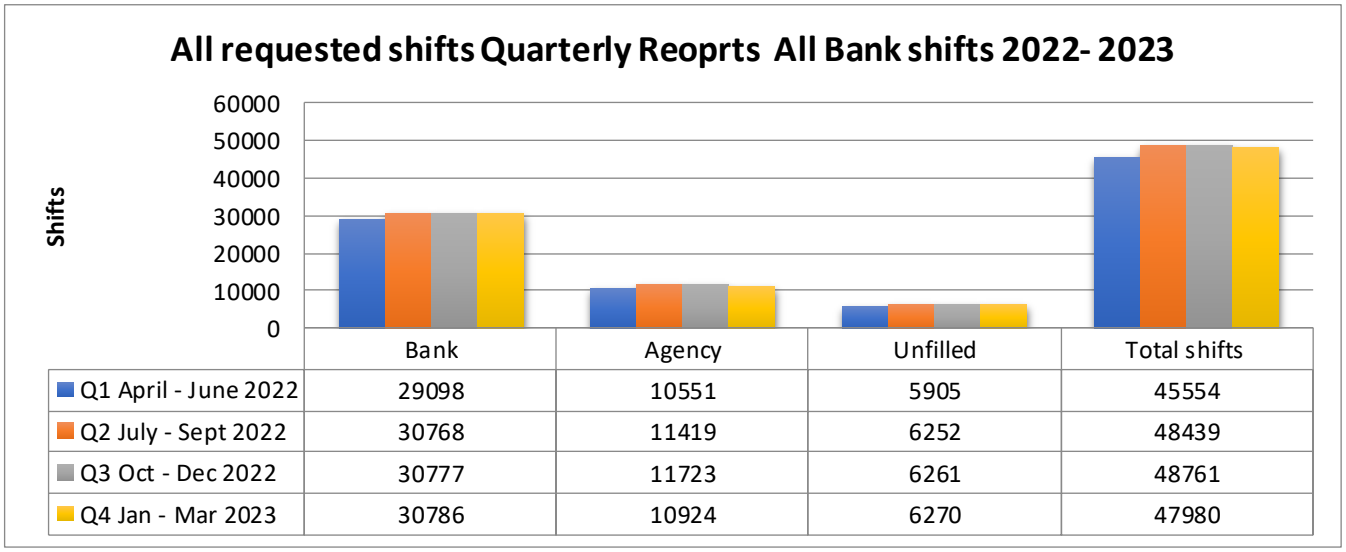
Figire 3

5.5 Looking ahead at 2023/24, working with finance, the services are focusing on the following priorities:

- effectively reviewing all additional shifts and resolving outstanding issues in a timely manner
- implementing the initial establishment reviews and applications to budget
- effectively scrutinising and continuing to challenge e-roster shift patterns and the number of staff on shift being appropriate for the acuity of service users
- effectively reporting hotspot areas of bank and agency usage to individual SBU Safer Staffing meetings, with agreed actions to reduce
- ensuring all substantive staff have their hours allocated before any bank or agency use
- ensuring any owed hours by substantive staff are used before any bank or agency use
- planning annual leave and cover within substantive staff before any bank or agency usage.

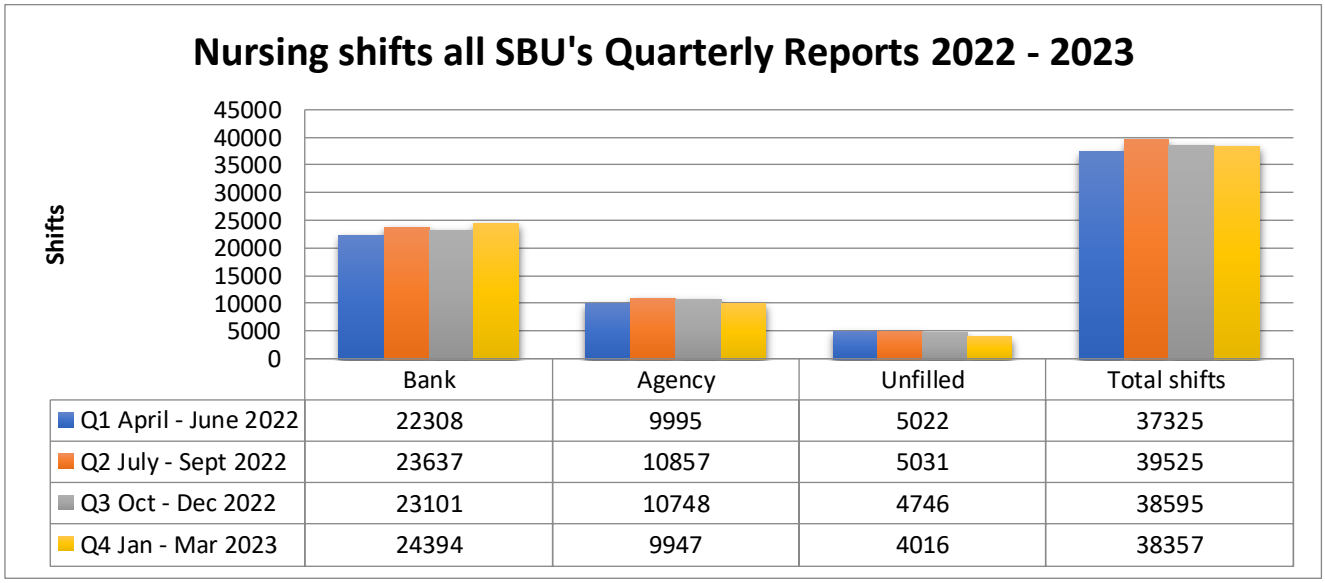
6 Temporary Staffing

6.1 The overall number of bank shifts saw a reduction in quarters 3 and 4, although the use of agency was consistent across the quarters; the RN bank shifts worked showed a slight increase in quarter 4, as detailed in *figures 4* and *5*.



	Bank	Agency	Unfilled	Total shifts
Q1 April - June 2022	29098	10551	5905	45554
Q2 July - Sept 2022	30768	11419	6252	48439
Q3 Oct - Dec 2022	30777	11723	6261	48761
Q4 Jan - Mar 2023	30786	10924	6270	47980

Figure 4



	Bank	Agency	Unfilled	Total shifts
Q1 April - June 2022	22308	9995	5022	37325
Q2 July - Sept 2022	23637	10857	5031	39525
Q3 Oct - Dec 2022	23101	10748	4746	38595
Q4 Jan - Mar 2023	24394	9947	4016	38357

Figure 5

6.2 The top five reason codes continued to be vacancy, SASO, sickness, ward activity and training

6.3 Bank Recruitment continued and all new starters completed their eLearning before working shifts.

7 Conclusion

7.1 The acuity and complexity of service users, the prescribed levels of safe and supportive observations, and staff vacancies across the inpatient services continued to have an impact on the level of staffing and the use of temporary staffing.

7.2 An initial establishment review for the inpatient services has been completed, learning from the safer staffing incidents and use of temporary staffing to support with additional duties and prescribed safe and supportive observations.

7.3 A focus on recruitment and retention for nursing staff has seen a positive reduction in the use of temporary staffing in some services.

7.4 Training compliance has made good progress, currently at 91% overall, and the Erostering team have been working with Learning and Development to assign staff to work on training dates and reduce the DNAs.

7.5 The Board are asked to note the challenges the services have experienced, the progress that has been made and the priorities for 2023/24.

Appendix 1 – CHPPD Data

April		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	99%	104%	-	-	100%	103%	-	-
	Hampden House	91%	110%	-	-	98%	106%	-	-
	Astley Court	80%	205%	-	-	83%	174%	-	-
	Warren Court	75%	81%	100%	100%	95%	93%	-	100%
	4 Bowlers Green	81%	82%	-	-	100%	100%	-	-
	Beech	109%	97%	-	-	101%	108%	-	-
	Dove	98%	134%	-	-	92%	205%	-	-
	The Beacon	91%	158%	100%	-	98%	306%	100%	-
	Broadland Clinic	114%	115%	100%	100%	122%	128%	-	-
	SRS	86%	95%	100%	100%	100%	103%	-	-
West	Albany Lodge	102%	240%	100%	100%	121%	237%	-	100%
	Aston	93%	230%	-	-	98%	213%	-	-
	Swift	97%	355%	100%	-	95%	446%	-	-
	Robin	157%	371%	-	-	147%	364%	-	-
	Owl	107%	176%	100%	100%	97%	183%	-	-
	Oak	83%	374%	-	-	97%	291%	-	-
	Thumbswood	150%	156%	-	-	100%	110%	-	-
Essex & IAPT	Lexden	102%	244%	100%	100%	97%	140%	-	-
East & North	Logandene	79%	114%	100%	100%	97%	161%	-	-
	Wren	93%	106%	-	-	100%	157%	-	-
	Lambourn Grove	94%	102%	100%	100%	89%	143%	100%	-
	Seward Lodge	88%	99%	-	-	90%	130%	-	-
	Forest House	127%	117%	-	-	145%	147%	-	-
	Victoria Court	101%	108%	-	-	100%	100%	-	-

May 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	106%	155%	-	-	101%	148%	-	-
	Hampden House	95%	112%	-	-	100%	100%	-	-
	Astley Court	62%	165%	-	-	94%	103%	-	-
	Warren Court	82%	69%	-	100%	79%	93%	-	100%
	4 Bowlers Green	67%	95%	-	-	100%	101%	-	-
	Beech	84%	99%	-	-	100%	115%	-	-
	Dove	96%	143%	-	-	96%	215%	-	-
	The Beacon	101%	158%	-	-	99%	300%	100%	-
	Broadland Clinic	108%	105%	100%	100%	110%	141%	-	-
	SRS	92%	98%	-	100%	102%	102%	-	-
West	Albany Lodge	110%	231%	100%	100%	98%	191%	-	-
	Aston	104%	264%	-	-	102%	243%	-	-
	Swift	108%	220%	-	-	95%	316%	-	-
	Robin	160%	261%	-	-	151%	298%	-	-
	Owl	106%	127%	-	100%	100%	138%	-	-
	Oak	87%	331%	-	-	88%	277%	-	-
	Thumbswood	148%	81%	-	-	100%	108%	-	-
Essex & IAPT	Lexden	85%	212%	100%	100%	98%	133%	-	-
East & North	Logandene	110%	132%	-	100%	110%	213%	-	-
	Wren	96%	106%	-	-	98%	123%	-	-
	Lambourn Grove	103%	112%	-	100%	90%	144%	100%	-
	Seward Lodge	87%	102%	-	-	93%	117%	-	-
	Forest House	145%	102%	-	-	132%	125%	-	-
	Victoria Court	84%	138%	-	-	95%	123%	-	-

June 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	101%	150%	-	-	100%	170%	-	-
	Hampden House	94%	116%	-	-	100%	107%	-	-
	Astley Court	68%	148%	-	-	97%	99%	-	-
	Warren Court	74%	83%	100%	100%	86%	90%	100%	100%
	4 Bowlers Green	71%	90%	-	-	100%	100%	-	-
	Beech	92%	104%	-	-	100%	142%	-	-
	Dove	81%	147%	-	-	95%	210%	-	-
	The Beacon	103%	163%	100%	-	100%	339%	-	-
	Broadland Clinic	107%	123%	-	100%	116%	133%	-	-
	SRS	85%	95%	100%	100%	98%	103%	100%	100%
West	Albany Lodge	108%	226%	100%	100%	100%	177%	-	100%
	Aston	101%	362%	100%	-	105%	306%	-	-
	Swift	90%	335%	100%	-	96%	384%	-	-
	Robin	161%	282%	-	-	144%	306%	-	-
	Owl	111%	130%	-	-	100%	141%	-	-
	Oak	87%	396%	-	-	97%	298%	-	-
	Thumbswood	148%	113%	-	-	100%	125%	-	-
Essex & IAPT	Lexden	106%	302%	100%	-	102%	195%	-	-
East & North	Logandene	110%	139%	100%	100%	117%	209%	-	-
	Wren	102%	101%	-	-	105%	123%	-	-
	Lambourn Grove	103%	110%	100%	-	85%	132%	-	-
	Seward Lodge	84%	97%	-	-	102%	118%	-	-
	Forest House	136%	126%	-	100%	154%	151%	-	-
	Victoria Court	81%	137%	-	-	98%	129%	-	-

July 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	99%	104%	-	-	100%	97%	-	-
	Hampden House	86%	114%	-	-	95%	110%	-	-
	Astley Court	68%	168%	-	-	102%	125%	-	-
	Warren Court	59%	75%	100%	100%	92%	90%	100%	-
	4 Bowlers Green	73%	89%	-	-	100%	100%	-	-
	Beech	96%	97%	-	-	98%	111%	-	-
	Dove	98%	135%	-	-	102%	188%	-	-
	The Beacon	85%	176%	100%	-	95%	335%	-	-
	Broadland Clinic	108%	121%	100%	100%	109%	140%	-	-
	SRS	72%	94%	-	100%	100%	101%	100%	-
West	Albany Lodge	103%	281%	100%	100%	107%	224%	-	-
	Aston	94%	328%	100%	-	106%	283%	-	-
	Swift	87%	333%	100%	-	95%	363%	-	-
	Robin	155%	306%	-	-	152%	324%	-	-
	Owl	103%	134%	100%	100%	100%	140%	-	-
	Oak	87%	378%	-	-	100%	313%	-	-
	Thumbswood	156%	177%	-	-	100%	121%	-	-
Essex & IAPT	Lexden	101%	285%	100%	100%	98%	174%	-	-
East & North	Logandene	84%	125%	100%	100%	95%	180%	-	-
	Wren	90%	106%	-	-	97%	132%	-	-
	Lambourn Grove	101%	104%	-	100%	75%	144%	100%	100%
	Seward Lodge	89%	102%	-	-	94%	121%	-	-
	Forest House	123%	112%	-	100%	145%	149%	-	-
	Victoria Court	94%	123%	-	-	98%	100%	-	-

Aug 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	99%	104%	-	-	100%	103%	-	-
	Hampden House	91%	110%	-	-	98%	106%	-	-
	Astley Court	80%	205%	-	-	83%	174%	-	-
	Warren Court	75%	81%	100%	100%	95%	93%	-	100%
	4 Bowlers Green	81%	82%	-	-	100%	100%	-	-
	Beech	109%	97%	-	-	101%	108%	-	-
	Dove	98%	134%	-	-	92%	205%	-	-
	The Beacon	91%	158%	100%	-	98%	306%	100%	-
	Broadland Clinic	114%	115%	100%	100%	122%	128%	-	-
	SRS	86%	95%	100%	100%	100%	103%	-	-
West	Albany Lodge	102%	240%	100%	100%	121%	237%	-	100%
	Aston	93%	230%	-	-	98%	213%	-	-
	Swift	97%	355%	100%	-	95%	446%	-	-
	Robin	157%	371%	-	-	147%	364%	-	-
	Owl	107%	176%	100%	100%	97%	183%	-	-
	Oak	83%	374%	-	-	97%	291%	-	-
	Thumbswood	150%	156%	-	-	100%	110%	-	-
Essex & IAPT	Lexden	102%	244%	100%	100%	97%	140%	-	-
East & North	Logandene	79%	114%	100%	100%	97%	161%	-	-
	Wren	93%	106%	-	-	100%	157%	-	-
	Lambourn Grove	94%	102%	100%	100%	89%	143%	100%	-
	Seward Lodge	88%	99%	-	-	90%	130%	-	-
	Forest House	127%	117%	-	-	145%	147%	-	-
	Victoria Court	101%	108%	-	-	100%	100%	-	-

Sep 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	99%	104%	-	-	100%	103%	-	-
	Hampden House	96%	115%	-	-	100%	113%	-	-
	Astley Court	62%	231%	-	-	86%	176%	-	-
	Warren Court	68%	84%	-	100%	94%	93%	-	100%
	4 Bowlers Green	79%	100%	-	-	102%	107%	-	-
	Beech	74%	107%	-	-	86%	136%	-	-
	Dove	105%	167%	-	-	97%	235%	-	-
	The Beacon	95%	152%	100%	-	97%	307%	-	-
	Broadland Clinic	115%	108%	100%	100%	112%	133%	-	100%
	SRS	87%	94%	100%	100%	100%	101%	-	100%
West	Albany Lodge	89%	268%	100%	100%	117%	208%	-	100%
	Aston	107%	209%	100%	-	100%	198%	-	-
	Swift	108%	325%	100%	-	111%	434%	-	-
	Robin	161%	384%	-	-	156%	349%	-	-
	Owl	91%	145%	100%	100%	98%	137%	-	-
	Oak	83%	351%	-	-	100%	277%	-	-
	Thumbswood	148%	110%	-	-	100%	117%	-	-
Essex & IAPT	Lexden	99%	253%	100%	100%	100%	156%	-	100%
East & North	Logandene	88%	103%	100%	100%	100%	110%	-	-
	Wren	89%	100%	-	-	100%	110%	-	-
	Lambourn Grove	95%	101%	100%	100%	67%	148%	100%	100%
	Seward Lodge	96%	100%	-	-	102%	132%	-	-
	Forest House	132%	134%	-	100%	151%	171%	-	-
	Victoria Court	94%	124%	-	-	97%	102%	-	-

Oct 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	107%	149%	-	-	100%	187%	-	-
	Hampden House	93%	159%	-	-	100%	129%	-	-
	Astley Court	69%	221%	-	-	97%	168%	-	-
	Warren Court	63%	83%	-	100%	97%	93%	-	100%
	4 Bowlers Green	72%	99%	-	100%	100%	109%	-	100%
	Beech	88%	98%	-	100%	97%	110%	-	100%
	Dove	100%	141%	-	-	97%	227%	-	-
	The Beacon	119%	102%	100%	-	109%	216%	100%	-
	Broadland Clinic	109%	116%	100%	100%	108%	142%	100%	-
	Lexden	101%	226%	100%	-	100%	152%	100%	-
	SRS	75%	95%	-	100%	100%	100%	-	100%
West	Albany Lodge	98%	253%	100%	100%	106%	235%	-	100%
	Aston	119%	260%	-	100%	137%	223%	-	100%
	Swift	116%	254%	-	100%	131%	402%	-	-
	Robin	166%	325%	-	-	147%	325%	-	-
	Owl	100%	131%	-	-	100%	107%	-	-
	Oak	84%	381%	-	-	112%	315%	-	-
	Thumbswood	152%	206%	-	-	100%	144%	-	-
East & North	Logandene	102%	102%	-	-	100%	144%	-	-
	Wren	95%	100%	-	-	98%	132%	-	-
	Lambourn Grove	102%	92%	-	100%	75%	141%	100%	100%
	Seward Lodge	108%	99%	-	-	105%	141%	-	-
	Forest House	133%	135%	-	100%	164%	167%	-	-
	Victoria Court	90%	105%	-	-	98%	130%	-	-

Nov 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	119%	191%	-	-	106%	206%	-	-
	Hampden House	106%	105%	-	-	100%	97%	-	-
	Astley Court	80%	214%	-	-	97%	166%	-	-
	Warren Court	67%	77%	-	100%	101%	87%	-	100%
	4 Bowlers Green	106%	110%	-	100%	100%	98%	-	100%
	Beech	95%	104%	-	100%	101%	104%	-	100%
	Dove	96%	139%	-	-	96%	211%	-	-
	The Beacon	111%	83%	100%	-	107%	187%	100%	-
	Broadland Clinic	106%	130%	100%	100%	113%	140%	100%	-
	Lexden	143%	291%	100%	-	99%	187%	-	-
	SRS	84%	94%	-	100%	100%	100%	-	100%
West	Albany Lodge	127%	173%	100%	100%	110%	185%	-	-
	Aston	141%	321%	-	100%	115%	221%	-	100%
	Swift	134%	265%	-	100%	124%	509%	-	-
	Robin	199%	299%	-	-	157%	310%	-	-
	Owl	113%	142%	-	-	103%	124%	-	-
	Oak	86%	282%	-	-	103%	240%	-	-
	Thumbswood	187%	239%	-	-	100%	201%	-	-
East & North	Logandene	131%	105%	-	100%	99%	148%	-	-
	Wren	108%	94%	-	-	100%	111%	-	-
	Lambourn Grove	111%	106%	-	100%	75%	161%	100%	100%
	Seward Lodge	103%	97%	-	-	103%	119%	-	-
	Forest House	147%	123%	-	100%	151%	170%	-	-
	Victoria Court	103%	106%	-	-	102%	146%	-	-

Dec 2022		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	105%	127%	-	-	105%	129%	-	-
	Hampden House	104%	116%	-	-	97%	113%	-	-
	Astley Court	63%	234%	-	-	80%	173%	-	-
	Warren Court	67%	101%	-	100%	97%	88%	-	100%
	4 Bowlers Green	85%	102%	-	100%	100%	100%	-	100%
	Beech	94%	96%	-	100%	87%	130%	-	-
	Dove	101%	164%	-	-	98%	226%	-	-
	The Beacon	99%	90%	100%	-	100%	206%	100%	-
	Broadland Clinic	105%	122%	100%	100%	107%	129%	-	-
	Lexden	108%	252%	-	-	105%	173%	-	-
	SRS	87%	92%	-	100%	100%	94%	-	100%
West	Albany Lodge	114%	227%	-	100%	107%	206%	-	-
	Aston	103%	277%	-	100%	114%	208%	-	100%
	Swift	134%	331%	-	100%	101%	412%	-	-
	Robin	181%	291%	-	-	155%	303%	-	-
	Owl	109%	128%	-	-	97%	122%	-	-
	Oak	100%	317%	-	-	98%	286%	-	-
	Thumbswood	185%	148%	-	-	103%	168%	-	-
East & North	Logandene	119%	101%	-	100%	101%	127%	-	-
	Wren	98%	104%	-	-	100%	120%	-	-
	Lambourn Grove	117%	93%	-	100%	81%	148%	100%	100%
	Seward Lodge	115%	93%	-	-	100%	114%	-	-
	Forest House	143%	128%	100%	-	142%	154%	-	-
	Victoria Court	100%	132%	-	-	100%	146%	-	-

Jan 2023		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	100%	116%	-	-	100%	110%	-	-
	Hampden House	103%	105%	-	-	100%	103%	-	-
	Astley Court	56%	252%	-	-	72%	197%	-	-
	Warren Court	82%	130%	100%	100%	101%	117%	100%	100%
	4 Bowlers Green	89%	110%	-	-	128%	85%	-	100%
	Beech	88%	103%	-	100%	98%	119%	-	-
	Dove	118%	168%	100%	-	103%	220%	100%	-
	The Beacon	97%	112%	100%	-	94%	230%	100%	-
	Broadland Clinic	94%	104%	-	100%	111%	113%	-	-
	Lexden	110%	223%	-	-	100%	167%	-	-
	SRS	93%	99%	100%	100%	100%	100%	100%	-
West	Albany Lodge	95%	250%	100%	100%	92%	246%	-	100%
	Aston	99%	265%	-	-	98%	260%	-	-
	Swift	135%	246%	-	100%	98%	198%	-	-
	Robin	149%	328%	-	-	149%	342%	-	-
	Owl	108%	163%	-	-	100%	172%	-	-
	Oak	90%	395%	-	-	99%	281%	-	-
	Thumbswood	100%	114%	-	-	97%	144%	-	-
East & North	Logandene	106%	106%	-	100%	102%	118%	-	-
	Wren	97%	96%	-	-	102%	111%	-	-
	Lambourn Grove	117%	92%	100%	-	70%	109%	100%	-
	Seward Lodge	114%	97%	-	-	100%	120%	-	-
	Forest House	154%	121%	-	100%	152%	154%	-	-
	Victoria Court	107%	131%	-	-	100%	150%	-	-

Feb 2023		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	105%	209%	-	-	103%	204%	-	-
	Hampden House	101%	109%	-	-	100%	100%	-	-
	Astley Court	55%	253%	-	-	79%	184%	-	-
	Warren Court	81%	115%	100%	-	102%	116%	100%	-
	4 Bowlers Green	102%	89%	-	-	100%	100%	-	-
	Beech	77%	100%	-	-	95%	133%	-	-
	Dove	120%	146%	100%	-	102%	199%	-	-
	The Beacon	111%	119%	-	-	100%	225%	-	-
	Broadland Clinic	108%	102%	100%	100%	115%	108%	100%	-
	Lexden	104%	226%	-	-	100%	127%	-	-
	SRS	99%	93%	100%	-	100%	114%	-	-
West	Albany Lodge	120%	229%	-	-	100%	248%	-	100%
	Aston	117%	488%	-	-	100%	400%	-	-
	Swift	135%	241%	-	-	101%	308%	-	-
	Robin	180%	291%	-	-	151%	312%	-	-
	Owl	105%	114%	-	-	100%	119%	-	-
	Oak	95%	352%	-	-	100%	297%	-	-
	Thumbswood	106%	118%	-	-	100%	143%	-	-
East & North	Logandene	119%	102%	-	-	100%	154%	-	-
	Wren	115%	106%	-	-	97%	159%	-	-
	Lambourn Grove	114%	96%	100%	-	83%	124%	100%	-
	Seward Lodge	114%	89%	-	-	100%	115%	-	-
	Forest House	142%	125%	-	100%	148%	165%	-	-
	Victoria Court	117%	111%	-	-	102%	142%	-	-

Mar 2023		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	97%	198%	-	-	101%	193%	-	-
	Hampden House	101%	137%	-	-	100%	116%	-	-
	Astley Court	61%	247%	-	-	89%	173%	-	-
	Warren Court	91%	149%	100%	100%	126%	136%	100%	-
	4 Bowlers Green	88%	113%	-	-	100%	100%	-	100%
	Beech	90%	94%	-	100%	100%	113%	-	-
	Dove	113%	147%	100%	-	101%	202%	-	-
	The Beacon	101%	114%	-	-	103%	203%	-	-
	Broadland Clinic	94%	86%	100%	100%	114%	104%	-	-
	Lexden	104%	249%	-	-	102%	147%	-	-
	SRS	92%	89%	100%	100%	100%	99%	-	-
West	Albany Lodge	118%	243%	-	100%	100%	240%	-	-
	Aston	99%	377%	-	-	103%	317%	-	-
	Swift	125%	259%	-	100%	100%	296%	-	-
	Robin	178%	319%	-	-	160%	349%	-	-
	Owl	102%	131%	-	-	98%	131%	-	-
	Oak	89%	368%	-	-	94%	279%	-	-
	Thumbswood	92%	158%	-	-	110%	189%	-	-
East & North	Logandene	96%	108%	-	100%	100%	123%	-	-
	Wren	92%	95%	-	-	98%	113%	-	-
	Lambourn Grove	115%	107%	100%	-	88%	144%	100%	-
	Seward Lodge	108%	98%	-	-	98%	135%	-	-
	Forest House	150%	117%	-	100%	148%	158%	-	-
	Victoria Court	120%	110%	-	-	95%	148%	-	-

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 7b
Subject:	Safeguarding Annual Report 2022 to 2023 (incorporating Q4 2023)	**For Publication:** Yes
Author:	Karen Hastings – Head of Social Work and Safeguarding	**Approved by:** Jacky Vincent, Executive Director of Quality & Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director of Quality & Safety (Chief Nurse)	

Purpose of the report:

The purpose of this report is to provide the Board with an overview of Safeguarding activity for the year 2022/23, outlining both the achievements and the challenges, and the areas for further work during 2023/24.

Action required:

To receive the report, note the achievements of the past year and approve the areas for further work for 2023/24.

Summary and recommendations to the Board:

Safeguarding Activity

Safeguarding Children

- Quarter 4 2023 saw the highest number of incidents reported in a quarter for the past four years, to 168. Possible causes include increased caseload in CAMHS, leading to increased recognition, cost of living crisis and stressors within families
- Emotional abuse remains the highest category of abuse. Deeper analysis of these concerns through Datix reporting system reveals risks around children linked to parental mental health, child's own mental health, domestic abuse and substance misuse.

Safeguarding Adults

- Trust-wide incidents: The number of incidents has also increased to an overall high of 557 in quarter 4, however, the whole financial year also reflected a rise in safeguarding adults' activity
- In terms of categories of abuse, the most significant rise in quarter 4 appears to be neglect and acts of omission, from mid-forties to 62. These allegations usually relate to care provision and paid for carers and may be linked to social care and NHS providers workforce pressures.

Statutory Safeguarding in Hertfordshire

- Numbers of concerns have shown an increase in the past year. In quarter 4, the conversion rate was lower than across previous years, at 35% conversion. This may be linked to backlog in decisions made due to winter pressures. Corporate safeguarding is monitoring and supporting teams with bespoke training
- The predominant form of abuse referred is domestic abuse, which made up 21% of concerns during quarter 4. Although not necessarily in line with national trends post Covid, there may be a heightened awareness around domestic abuse in the general public following some high-profile cases.

High Profile Safeguarding

Safeguarding Children

- The Trust is involved in one Child Safeguarding Practice Review; the report is delayed due to

ongoing court proceedings.

Safeguarding Adults

- The Trust is involved in two safeguarding adult reviews and eight DHRs, the most notable for AM who was killed by her husband and went on to die by suspected suicide. This is also subject to a Mental Health Homicide Review. Both reviews are about to submit their findings
- The Trust is also involved in a Partnership Case Review of a care leaver who murdered another young person in Stevenage. This is ongoing with learning around the difficulties of supporting children in care when they move placements frequently, across county boundaries.

Safeguarding Assurance/Section 11 Visit

The Trust hosted a successful assurance visit with the ICB in quarter 4. A number of areas of good practice were highlighted and the organisation was complemented on its commitment to *"…ensuring safeguarding is embedded in all areas of the organisation and promoting the health, safety and welfare of children, young people and adults that access services across the Trust."*

A two-year action plan is being developed in line with recommendations from the ICB which were identified as areas for development from HPFT's own self assessment audit.

Relationship with the Business Plan & Assurance Framework:

Links to Trust strategy to provide safe and effective services, achieving a good experience for service users, carers, and referrers, transforming our services, staff having a positive experience of work, and having an enviable reputation for quality and innovation

Meeting the ongoing compliance requirements of the CQC Essential Standards for Quality & Safety plus contract & quality schedules

Summary of Implications for:

Safeguarding is key to ensuring that service users, their family and friends are safe and that individual wellbeing is at the core of practice across the Trust.

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

Safeguarding is of particular relevance to minority groups who are often the victims of hate crime and bullying.

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

The issues of patient safety and information sharing with statutory agencies are central to safeguarding practice. Wellbeing is a key concept in the Care Act with particular relevance to adult safeguarding practice expressed via the principal of Making Safeguarding Personal.

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

QRMC 4 May 2023
IGC 16 May 2023

1. Introduction

1.1 The annual report provides an overview of safeguarding children and adults activity for the financial year 2022/23. The report outlines key work streams and achievements, as well as highlighting areas of challenge. It also identifies future plans for 2023/24.

1.2 Quarters 1 to 3 were reported in the quarterly Integrated Safety Report and quarter 4 is included within this annual report.

2. Safeguarding Annual Activity

2.1 The Trust has safeguarding responsibilities for children and adults across all the areas where it delivers care.

Safeguarding Activity for Children

2.2 *Figure 1* illustrates the number of safeguarding children's incidents by financial quarter. Quarter 4 saw the highest number of incidents reported in a quarter for the past four years.

2.3 A potential reason for this increase is that the case load for Child and Adolescent Mental Health Services (CAMHS) also peaked, resulting in more opportunities to identify and raise abuse of children for staff in those teams. Additionally, data around types of risk identified shows families under stress from several sources, including domestic abuse within the household (around 39% of cases audited by the Safeguarding Team) and mental health needs of either the child or a parent.

2.4 Quarter 4 also coincided with a winter season which saw an exponential rise in the cost of living, and increased strains on most households in the country[1]. This increase also aligns with available national data, where most common factors for referral for child protection, were parental mental health and domestic abuse

1 Source: ONS: Characteristics of Children in Need

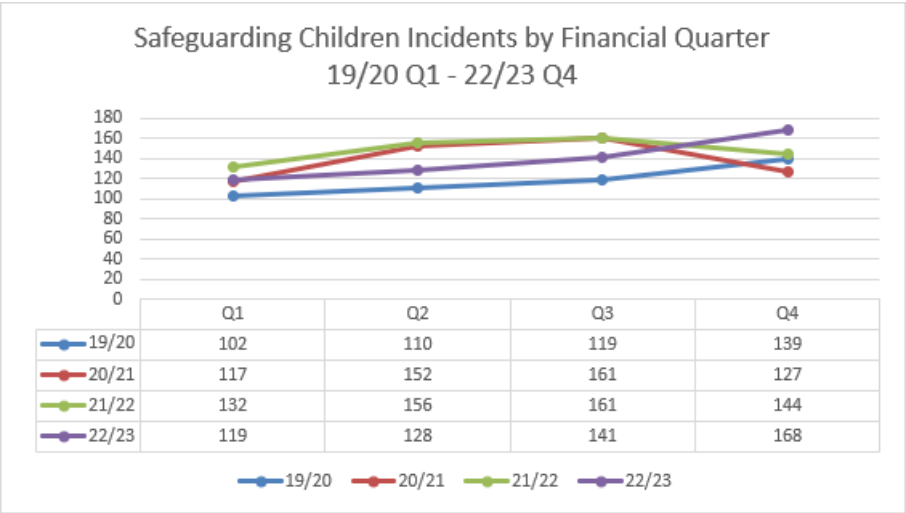


Figure 1

2.5 *Figure 2* illustrates the incidents by categories of abuse, with emotional abuse the most reported type of child safeguarding incident, with an additional ten reports of emotional abuse made in quarter 4, compared with quarter 3. Physical abuse also saw an increase from 26 to 37 reports from quarter 3 to 4.

2.6 In November 2022, the safeguarding children form on Datix was updated to capture additional information on the reported incidents. Three theme fields were created to enable deeper analysis of incidents than just the category of abuse.

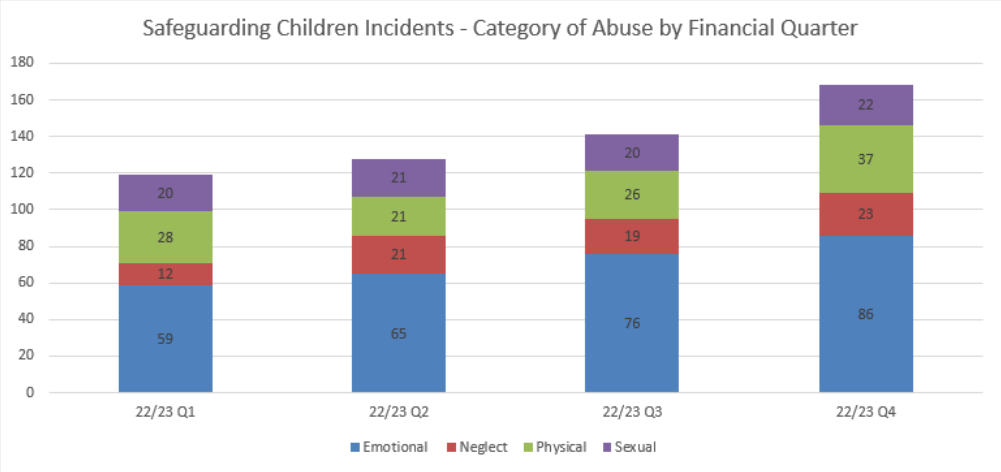


Figure 2

2.7 CAMHS Crisis Assessment and Treatment Team (C-CATT) remain the highest reporter of safeguarding children's incidents, making 50 referrals in quarter 4, with 16 as the next highest in west CAMHS West. This is linked to C-CATT working with children and families in crisis and experiencing particular strain.

Safeguarding Adults

2.8 *Figure 3* illustrates the number of Trust-wide safeguarding adults incidents notified across the previous four years, increasing to an overall high of 557 in quarter 4, and an overall rise in safeguarding adults' activity over the year. This may reflect an overall increase in referrals into mental health services, and an indicator of societal change linked to pressures on individuals through post-pandemic adjustment and cost of living crisis.

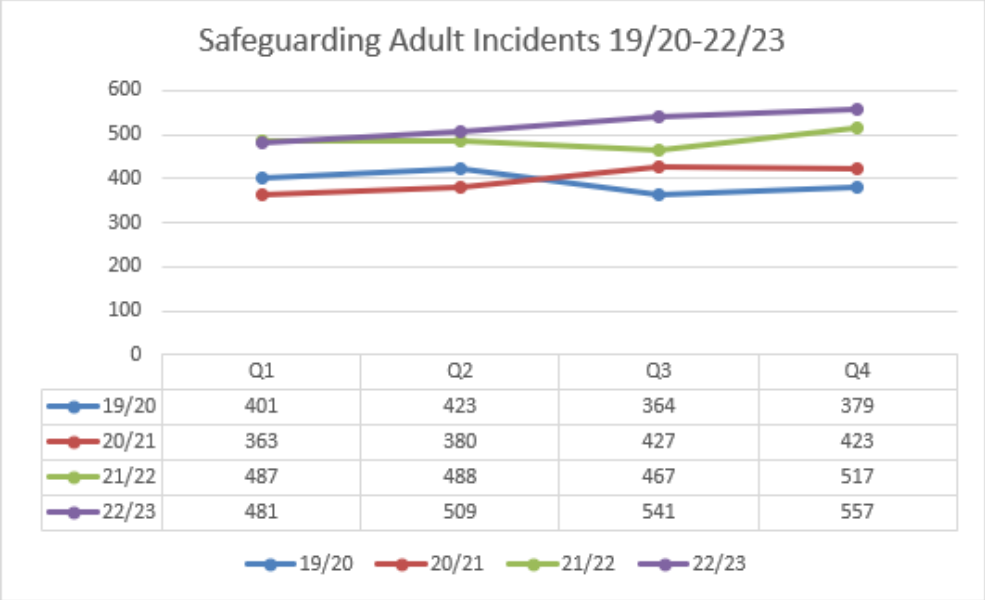


Figure 3

2.9. *Figure 4* Trust-wide data shows that physical abuse (usually linked to incidents in inpatient settings) remains the highest category of abuse. Neglect and acts of omission increased in quarter 4, from the mid-forties to 62, which usually relate to care provision and paid for carers. This may be linked social care and NHS providers workforce pressures across all sectors.[2]

2. Source: CQC State of Care 2022

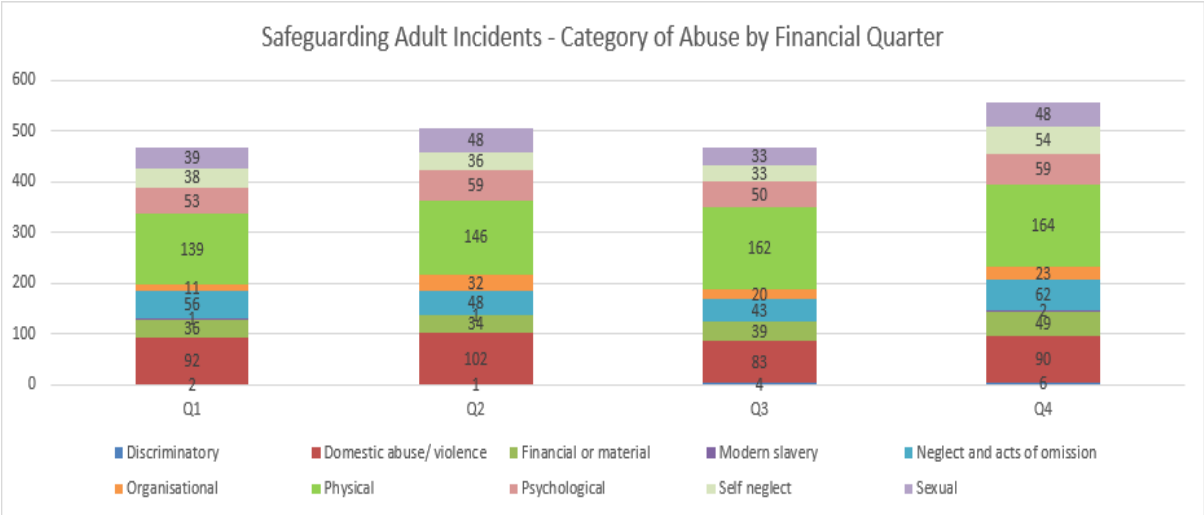


Figure 4

Statutory (Care Act) Safeguarding Adults in Hertfordshire

2.10 In Hertfordshire, the Trust carries out investigations into abuse of adults with functional mental disorders on behalf of the local authority (Hertfordshire County Council - HCC). *Figure 5* illustrates Concerns and Enquiries with a linear trajectory for each of the three series included and plotted against Axis 1, showing a gradual increase in activity across all levels.

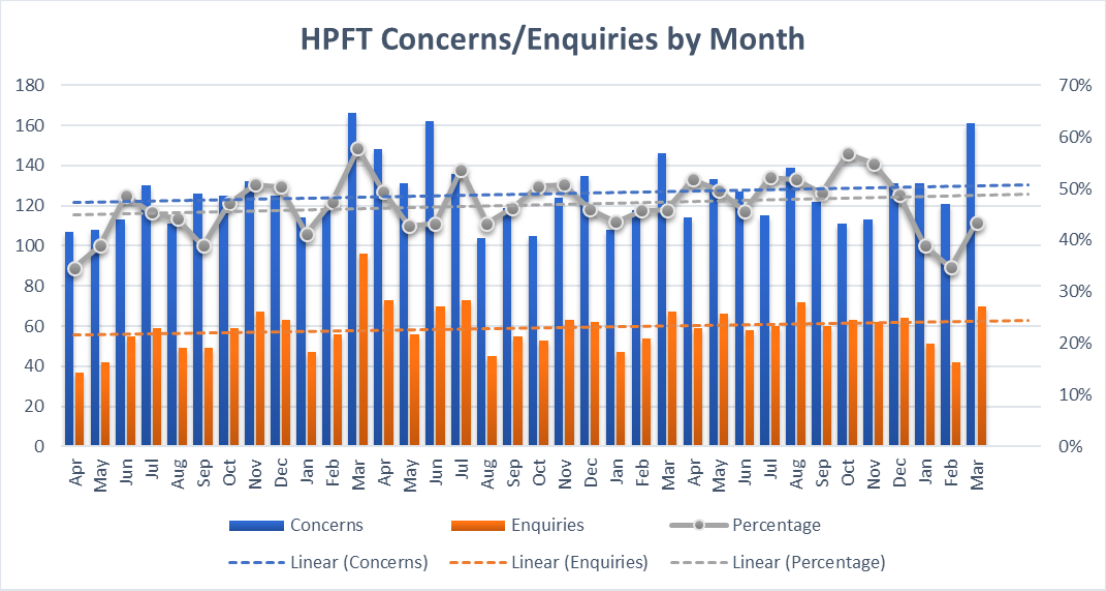


Figure 5

2.11 The Trust conversion rate has remained primarily between 40% to 55% and tended towards the lower end of this range during quarter 4, with February demonstrating a 35% conversion rate. This this may be due to winter pressures causing a backlog in decision making which will stabilise as teams complete this documentation. To mitigate against and monitor this backlog, the Trust's Corporate Safeguarding Team continue to send fortnightly lists of *'No Decision Made'* cases, allowing for trends and concerns to be identified and support offered.

2.12 Additionally, bespoke training has been offered to teams where there were needs for improvement in practice, in particular around recording and decision making. Challenges with accessing HCC Decision Maker training has been raised with training sessions online in the new financial year.

2.13 *Figure 6* illustrates the breakdown of types of abuse reported during quarter 4; the overall number of types of abuse shown will exceed the number of distinct concerns raised, as a number are multiple forms of abuse.

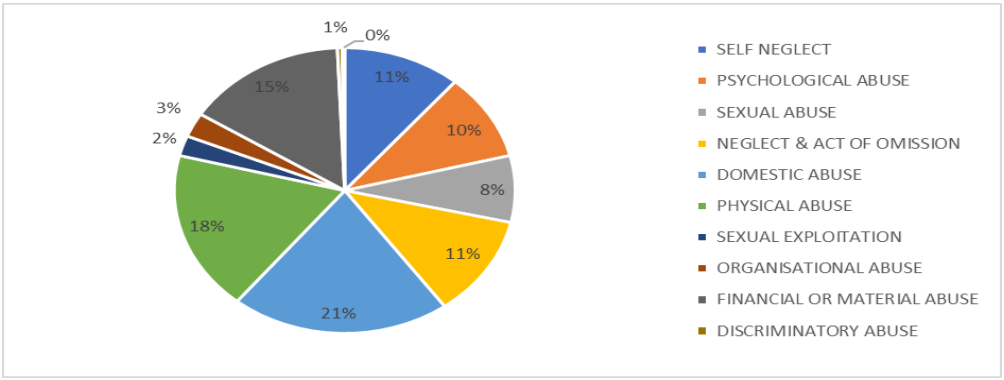


Figure 6

2.14 The predominant form of abuse referred is domestic abuse, which made up 21% of concerns during quarter 4, and is a significant factor across all age groups. Whilst national data shows numbers of reported incidents to police have decreased to pre-pandemic levels[3], the overall number of people being seen by mental health services has increased. Additionally, there may be a heightened awareness around domestic abuse in the general public following some high-profile cases (for example the conviction of Met Officer, David Carrick of a series of crimes against women).

3. Source: ONS Domestic Abuse in England & Wales overview: November 2022

2.15 Work continues within the Corporate Safeguarding Team to further develop links between HCC and the Trust services and ensure practice aligns.

3. High Profile Safeguarding

3.1 All the cases below have been anonymised.

Safeguarding Children

Child Safeguarding Practice Reviews (CSPR)

3.2 The Trust is involved in one CSPR

- Child R: criminal proceedings are ongoing, and the report will not be published until concluded; the draft report was presented to Hertfordshire Safeguarding Children's Partnership (HSCP) Executive in February. Work commenced on the recommendations, including providing health care and other staff in the partnership access to the *Infant crying is normal; Comforting methods can help; It's okay to walk away; Never, ever shake a baby* (ICON) programme.

Safeguarding Adults

3.3 For adults, high profile cases relate to people who have suffered death or serious injury through suspected abuse or neglect, with four main categories:

- Safeguarding Adults Review (SAR)
- Domestic Homicide Review (DHR)
- Partnership Case Review (PCR).
- Care Leaver Death Reviews (CLDR).

SARs

3.4 The Trust is currently involved in two active SARs:

- 'SAR Alex': referred by the Trust following his death in a house fire. He was open to Safeguarding in regard to self-neglect at the time of his death. An Independent Management Review (IMR) has been completed and will be presented in quarter 1 2023/24
- 'SAR Nancy': a 78-year-old lady with Alzheimers assaulted and killed by her husband. This case has also been referred by police as a DHR. A SAR tabletop review meeting will consider the multi-agency response, particularly in relation to issues around carer support and the impact of the Covid Pandemic.

DHRs

3.5 The Trust is currently participating in eight active DHRs with a varied level of involvement with individuals subject to the reviews:

- DHR 27: the death of a Polish lady murdered by her husband. This report is currently under review between Community Safety Partnership (CSP) and HCC
- DHR 28 WT: a 69-year-old male murdered by his estranged wife and her partner. The report has been returned from the Home Office and is under final review with the CSP
- DHR 30 JDJD: a murder suicide between a husband and his wife with Dementia. This report is under review with the Home Office
- DHR 3: JJ: a female victim, murdered at home by her son who later pleaded guilty to murder. This report is under review with the Home Office
- DHR 34 K&C: the deaths of a mother and daughter who died at the family home in the early part of the first lockdown in 2020, murdered by G (K's husband and C's father). K had some minimal contact with the Trust, who have provided an Independent Management Review (IMR) report. The review is in the final stages and action planning in progress
- DHR 35 CF: killed on 27 January 2021 and her ex-partner A, convicted of her murder in June 2021 and sentenced to 22 years in prison. A was historically known to Adult Community Mental Health Services (ACMHS) and had self-referred to Wellbeing Services just prior to the incident. The report has been finalised and an action planning meeting scheduled
- DHR 36 KD: fatally stabbed by her son who had recently been discharged from Barnet General Hospital (BGH) Emergency Department (ED), where he had previously been taken by police who believed him to be having an acute psychotic episode and requiring mental health support. The Trust provided an IMR. A draft report has been completed and is awaiting panel feedback for submission
- DHR 37 AM and KM: a murder suicide which occurred in 2021 where both individuals were known to the Trust. The review is running concurrent to a Mental Health Homicide Review. The final IMR meeting has been held and the report is being prepared by the chair.

`Partnership Case Reviews

3.7 During quarter 3, a partnership review has been started in relation to PS, an 18-year-old known to the Trust who murdered another young person. An IMR was submitted by the Trust and has been considered alongside multi-agency IMRs from Hertfordshire, Bedfordshire and Surrey. A practitioner's learning event planned.

3.8 Initial meetings have highlighted challenges of supporting an individual moving from placement to placement, with learning identified around multi-agency communication, particularly across county borders.

Care Leaver Death Reviews

3.8 The Trust is not currently involved in any of these reviews.

4. Audit

Safeguarding Children

4.1 The Corporate Safeguarding Team completed the following audits:

CAMHS Not Brought In (NBI)

4.2 Sample of 30 cases audited; ten with no children's services involvement, ten on a child protection plan (CPP) and ten children in need (CIN).

Areas of Good Practice:

- 100% of NBI appointments were documented within two days
- Evidence of discussion with senior colleagues or multi-disciplinary team (MDT) following NBI.

Areas for Improvement:

- NBI checklist completed, and documented risk considered for only 19/30 (63%) cases
- 17/30 (57%) provided a rationale for the risk assessment
- Only 5/30 (17%) informed the GP of the NBI; whilst it is acknowledged this is not always necessary, it is a decrease from 43% in the previous audit in 2021/22
- Evidence of 10/20 (50%) cases of NBI reported to child's social worker in children's services.

Actions:

- Discuss at CAMHS Practice Governance the importance of using the NBI checklist and adherence to DNA/NBI Policy.

Quarter 4 Child Safeguarding Referral Outcomes Audit

4.3 33 child safeguarding referrals from January 2023 audited; 49% for emotional abuse; domestic abuse featured in 39% of referrals. 16/33 (48%) of referrals were made by C-CATT; 25 referrals made by services using Paris as the electronic patient record (EPR).

Areas of Good Practice:

- The referral outcome was known within 2 weeks of the referral being made in 88% of cases
- 82% of cases were accepted for an assessment by children's services or linked to an existing referral.

Areas for Improvement:

- 19/25 (76%) had the 'child safeguarding referral made' alert on the record
- 19/25 (76%) opened a child safeguarding assessment (CSA) on Paris
- 10/25 (40%) informed the GP of the referral (evidenced from CSA)
- 18/25 (72%) had no evidence of supervision or management oversight of the case
- 18/25 72% referral was uploaded to Paris.

Actions:

- Non-compliant staff asked to update documentation by auditor
- Safeguarding team to continue to remind staff to record referral outcomes on the CSA.

Quarter 4 Section47/17 Information Sharing Audit

4.4 20 records were audited, where requests for information under section 47 or 17 Children Act 1989 had been made via the Trust's Single Point of Access (SPA).

Areas of Good Practice:

- 100% of information requests were located on Paris
- SPA forwarded 20/20 (100%) requests from Children's Services to relevant teams for practitioners to complete and return requests
- Community Perinatal Team, ACMHS St Albans, C-CATT, south and west CAMHS completed and returned 100% of requests within statutory timescale.

Areas for Improvement:

- 12/20 (60%) of requests were completed and returned to children's services (decrease from 100% in quarter 3)
- 9/20 45% of requests were returned within the statutory timescales (decrease from 70% in quarter 3)
- Practitioners to ensure that they attach Section 17 Consent Form to Paris.

Actions:

- Safeguarding team to continue working with SPA and clinical teams to improve documentation and completion of information sharing requests within the statutory timescales
- Specialist Safeguarding Practitioner to have oversight of all information sharing requests received
- Audit findings to be shared at Quality Review Meetings (QRM) and Practice Governance meetings
- Included in Essential Safeguarding Children training
- Communication sent out about new Section 47/17 and Multi-Agency Safeguarding Hub (MASH) case note reasons on Paris
- Develop Spike report for oversight of all Section 47/17 and MASH for safeguarding team.

Quarter 4 CLA referrals audit

4.5 45 records of children with a recent referral into CAMHS were audited.

Good Practice:

- CAMHS Dialectical Behaviour Therapy (DBT) changed one alert from CLA to CL.

Areas for Improvement:

- 23/45 (51%) attended an appointment within 28 days of the referral
- 3/45 (7%) recorded parental responsibility in service user details
- 5/45 (11%) had health action plan attached to the records
- SDQ was not uploaded to all records
- 8/12 (67%) of referrals to other organisations identified the person as CLA or CL.

Actions:

- Issues around practice for CLA escalated to the East and North Strategic Business Unit (SBU) QRM
- CLA policy ratified and available on the Hive
- Each CAMHS team has named link CLA person provided with a monitoring documentation guide and access their team's dashboard on Spike and can see the CLA alerts, to identify and monitor CLA open to their team
- Six weekly CLA link people meeting with the safeguarding team
- The Trust's Practice Audit and Clinical Effectiveness (PACE) team add CLA to 2023/24 audit schedule and adjust against the new policy
- Training on CLA and Care Leavers available for 2023/24
- Audit findings discussed at CAMHS Practice Governance meeting and individual case feedback provided to practitioners and managers.

Safeguarding Adults

4.6 Monthly safeguarding quality audits continue, highlighting areas of good practice and for learning.

Areas of good practice

- Contact with the adult at risk: good evidence in one case that consideration given to mental capacity and when the adult at risk should be contacted, to maximise their engagement with the discussion
- Voice of the adult at risk: good documented evidence in some cases to demonstrate the adult at risk had been contacted and what their views were. The voice of the adult at risk was clear in documentation
- Proportionate enquiry: good evidence in a number of cases that proportionate action was taken and in line with desired outcomes of the adult at risk.

Areas for improvement

- Evidence for decision making: in a number of cases, there was insufficient rationale provided around the process. Public law decisions should be evidence led and clearly documented
- Public Interest: important to consider public interest for cases where consent has not been given to proceed to safeguarding. Where there may be risk to other adults with care and support needs, there needs to be evidence this has been considered and, where consent is not being overridden, documented justification of the rationale for this
- Decision making: section 42(1) Care Act 2014 requires consideration of whether there is *'reasonable cause to suspect'* the three stage criteria are met. In a number of cases, elements of the three-stage decision were marked as "as yet undetermined" despite information included within the referral information which, on review by the auditor, allowed the decision maker to conclude whether this requirement was met.

Actions:

- The Trust's Corporate team disseminate learning from audits to all investigating managers, highlighting areas for improvement

- The Trust's Professional Lead for Adult Safeguarding continue to monitor practice across investigating teams and offer support/additional training
- The Trust's Professional Lead for Adult Safeguarding to raise issues around Decision Making at relevant forums
- The Trust's Head of Social Work, Social Care and Safeguarding and the Professional Lead for Adult Safeguarding to review Paris safeguarding documents to consider appropriate amendments to support practice.

5. Assurance Visit and Priorities 2023/24

5.1 The annual Safeguarding Assurance visit took place on 24 February 2023, with a follow up meeting on 3 April 2023.

5.2 The final letter from the Integrated Care Board (ICB) was received, stating:
"It was a pleasure to meet with your teams on 24 February 2023 to review the robustness of safeguarding across [the Trust]. HEWICB acknowledge the individual and collective role played by everyone in keeping families safe.
Thank you for the completion of the action plan for 2021/22 with some outstanding areas to carry over which are highlighted at the end of the report.
Once again, the Trust demonstrated ongoing commitment to ensuring safeguarding is embedded in all areas of the organisation and promoting the health, safety and welfare of children, young people and adults that access services across the Trust.
The presentation and case studies demonstrated a culture of strong leadership and of care, compassion, and innovative practice."

5.3 The visit highlighted the following areas of good practice:
- The development of the Trust Strategy with a wide range of views sought.
- The focus on Adult Community Mental Health Transformation, to improve access when moving on from secondary mental health care
- The development of the Professional Nurse Advocate (PNA) role with a successful bid to present it at the International Forum on Quality and Safety in Healthcare Copenhagen 2023. There are now 20 qualified PNAs
- The development of an App to work towards a more accurate reporting of supervision
- The creation of a Domestic Abuse Policy for staff
- Becoming the first NHS Trust worldwide to partner with the Domestic Abuse Alliance in the use of their *Weprotect* app, giving legal advice for those experiencing Domestic Abuse
- The implementation of audits to improve outcomes, for example section 17 and 47 documentations
- The appointment of a Liberty Protection Safeguards (LPS) manager with the responsibility of the operational delivery of the (Mental Capacity Act (MCA) and LPS
- The introduction of Paediatric Liaison Posts at acute hospitals
- Implementing changes in practice with the impact of Covid, including policies around remote consultations and introducing training via MS teams
- The implementation of Care Leaver practice guidance and Children Looked After Policy. The Introduction of new pathways, for example Gypsy Roma and Traveller, Refugees and Asylum Seekers.

5.4 Recommendations were made, incorporated into an action plan sent to the ICB, with a two-year timeline for delivery given the extent of the work that needs undertaking. A majority of the recommendations were based upon the Trust's own self-assessment audit, shared with the ICB prior to the visit.

6. Safeguarding Risk Register

6.1 There are two risks on the Safeguarding Risk Register:

- Prevent Training Compliance. Prevent training compliance continues to be below required levels with plans to continue improving and to reach the required levels by end of June 2023
- Safeguarding Dashboard on SPIKE 2. Dashboard inaccuracies relying on staff inputting referral information correctly on the system, rather than directly from Safeguarding Adults documents. This risk is mitigated by the Corporate Safeguarding Team sending out fortnightly emails to teams with information populated from the previous 'Legacy Report', showing when decisions yet to be made.

7. Key Safeguarding Practice Development 2022/23

Weprotect App

7.1 In quarter 3, the Trust became the first NHS organisation to roll out the use of the *Weprotect* app to all staff, which allows free access to initial legal advice to people at risk of domestic abuse. Staff can refer victims with their consent, and access this application themselves, if they are victims.

Safeguarding Training

7.2 The Trust Safeguarding Team continue to deliver a rich and varied programme of training to support practice and staff confidence around a range of issues, including monthly domestic abuse sessions.

Care Leaver Best Practice Guidance

7.3 Rolled out quarter 3, the Trust hosted a multiagency learning event to accompany the guidance.

Domestic Abuse: Policy for Staff

7.4 Policy in place to support colleagues who may be experiencing domestic abuse, which compliments the existing policy for people who use services and those who care for them.

8. Conclusion

8.1 There has been a key theme emerging has been domestic abuse, which, in some ways, is due to an improved oversight on incidents, through reporting systems being updated, for example. There is also a wider acknowledgement of this type of abuse and the impact on families, highlighted by the fact that domestic abuse has outstripped physical abuse in numbers of concerns raised to the Trust.

8.2 In 2023/24, the corporate Safeguarding Team and wider organisation will be working hard to address these harms, and continue to work closely with system partners around emerging risks to the people who may use Trust services and those who care for them.

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 8
Subject:	Care Quality Commission Update	**For Publication:** Yes
Author:	Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse)	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 update on the publication of CQC reports and actions taken by the Trust.

Action required:

Receive: To discuss and RECEIVE the report

Summary and recommendations:

Oak ward CQC Inspection

The CQC undertook a risk based focused inspection on Oak ward on 18, 19 and a night visit on 31 October 2022, following anonymous concerns raised to the CQC, and subsequently with the Trust, on 10 October 2022, alleging inappropriate and incorrect restrictive practice. The Trust received the draft report on 23 February 2023 and submitted its Factual Accuracy on 8 March 2023.

Warren Court CQC Inspection

The CQC undertook a risk based focused inspection on Warren Court on 1, 2 and 21 November 2022, following concerns raised anonymously to the CQC regarding practice and staffing. Following receipt of the draft report the Trust submitted its Factual Accuracy response on 25 January 2023.

Following receipt of both Oak ward and Warren Court's subsequent final draft inspection reports, inaccuracies in the content were noted, and the Trust agreed for a further Factual Accuracy Process for both reports with the CQC. The final draft versions were received by the Trust on 21 April 2023 and, after the Factual Accuracy process, submitted both responses on 9 May 2023. The CQC published both reports, with one proactive press release statement, on 26 May 2023. As an outcome of the inspection, the CQC identified areas for improvement and actions the Trust must and should take, to comply with its legal obligations.

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

Not applicable

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:

The reports from CQC identify improvements needed to be made with regard to service user engagement. The Service Improvement Action Plans detail the action taken to make improvements in these areas.

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

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

1 Introduction

1.1 This report provides the Board with an update on the publication of the Care Quality Commission (CQC) reports on 26 May 2023 and the actions taken by the Trust.

2 Oak ward

2.1 The CQC undertook a risk based focused inspection on Oak ward on Tuesday 18, Wednesday 19 and a night visit on Monday 31 October 2022. Following receipt of draft reports, the Trust completed the Factual Accuracy.

2.2 The Final report was published on 26 May 2023, and noted positive areas of practice, including regular safety audits of the environment, safe ward layout with risks well managed, staff knowledge of protecting service users from abuse, staff were generally discreet, respectful, and responsive when caring for service users, with a number of positive interactions observed between staff and service users.

2.3 However, the final report also noted concerns regarding continuous safe and supportive observations (SASO) practice and the allocation of staff breaks, access to clinical information, staff turnover, vacancy rates and sickness and the temperature of the ward.

2.4 As an outcome of the inspection, the CQC identified areas for improvement and actions the Trust must and should take, to comply with its legal obligations. The senior leadership team for the ward have a detailed Service Improvement Action Plan (SIAP) in place and *Table 1* provides an overview of the actions the senior leadership team have taken or are taking, to address the identified areas for improvement.

2.5 Additional leadership support is being provided by the Head of Nursing, East and North Strategic Business Unit (SBU) to support the team with the implementation of their SIAP.

2.6 Oversight and scrutiny of delivery of the SIAP is provided by the Executive Director, Quality and Safety (Chief Nurse) and the Executive Director, Quality and Medical Leadership, at a weekly meeting with the senior leadership team. Progress is also formally reported to the Executive Team on a fortnightly basis.

Requirement identified	Update on actions
Action the Trust MUST take to improve	
The Trust must ensure that staff receive regular breaks, in line with Trust policy and national guidance, when they undertake continuous enhanced observations	• All staff aware of the Trust's SASO Policy • Completion of shift planner and delegation of duties by incoming nurse in charge (NiC) • Review of the allocation of SASOs and shift planning.
The Trust must ensure that staff have easy access to clinical information	• All substantive staff have access to the electronic patient record (EPR) • Incoming NiC ensures all substantive and temporary staff on duty have access to EPR • Any access related issues escalated to Team Leader or Out of Hours Clinical Lead (OOHCL).
The Trust must ensure staff respond effectively to service users, and manage escalating risk effectively, so that service users are safe and feel safe on the ward	• Daily multi-disciplinary team (MDT) safety huddle and ward rounds • Availability of Advocacy service

	• One-to-one support with Named Nurse • Post incident debriefs for staff and service users • Weekly Clinical Matron surgery • Team Leader visibility • Weekly Mutual Help meetings • Collaborative working with the police and safeguarding team.
Action the Trust SHOULD take to improve	
The Trust should continue to ensure that, where appropriate, families and carers are suitably involved in their relatives' care and treatment	• Twice monthly Carers Group meetings • Carers invited to regular ward rounds.
The Trust should ensure that service users feel listened to, heard, and are treated with kindness	• Weekly Mutual Help meetings • Daily morning meetings to plan the day • Availability of Advocacy service • One-to-one session with Named Nurse • Regular Psychology sessions • Regular safety huddles.
The Trust should ensure that planned family visits to the wards are not unduly delayed and that any unpreventable delays are effectively communicated to those concerned in a timely manner	• Planned family visits continue to be facilitated • Reception staff communicate with ward staff to facilitate planned visit • Family room available to facilitate visits from family and carers.
The Trust should ensure that the temperature on the ward can be easily regulated, so service users and staff can be comfortable.	• Programme of improvement to the environment commenced • Replacement of the air handling conditioning unit completed in November 2022.

Table 1

2.7 As an outcome of the focused risk inspection process at Oak ward, the final report notes the rerating of the service line *Acute wards for adults of working age and psychiatric intensive care units. Table 2* identifies the ratings in the report.

	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Pre-inspection rating	Good	Good	Good	Good	Good	**Good**
Draft report rating	Requires Improvement	Good	Good	Good	Good	**Good**

Table 2

3. Warren Court

3.1 The CQC undertook a risk based focused inspection on Warren Court on 1, 2 and 21 November 2022. Following receipt of the draft report in January 2023, the Trust completed the Factual Accuracy.

3.2 The Final report was published on 26 May 2023 and noted positive areas of practice, including reinstatement of the Carers Forum, staff understanding their roles and

responsibilities under the Human Rights Act, the Equality Act, and the Mental Capacity Act. The final draft report also noted the high percentage of staff receiving supervision, the visibility of the Team Leaders and clinical managers, and their support to staff, including when staffing was short. The final draft report also noted that service user care plans and risk assessments were updated at the fortnightly MDT meetings and that the furniture on the ward was safe and appropriate for the individual's needs.

3.3 However, the final draft report noted house five required redecoration and did not provide a therapeutic environment. That there were few pictures of information notices available for service users, with no easy read format on display. Also, that staff did not always engage in meaningful activities. The final draft report also noted that staff did not complete Positive Behavioural Support (PBS) plans for all service users and the temperatures of the clinical room and fridges were not consistently monitored.

3.4 As an outcome of the inspection, the CQC identified areas for improvement and actions the Trust must and should take to comply with its legal obligations. The senior leadership team for the ward have a detailed SIAP in place and *Table 3* provides an overview of the actions the senior leadership team have taken or are taking to address the identified areas for improvement.

3.5 Oversight and scrutiny of delivery of the SIAP is provided by the Executive Director, Quality and Safety (Chief Nurse) and the Executive Director, Quality and Medical Leadership, at a weekly meeting and progress with the SIAP is formally reported to the Executive Team on a fortnightly basis.

3.6 As an outcome of the inspection, the CQC identified areas for improvement and actions the Trust must and should take to comply with its legal obligations. *Table 3* provides a brief regarding the actions the senior leadership team have taken or are taking to address them, detailed in their SIAP.

Requirement identified	Update on actions
Action the Trust MUST take to improve	
The Trust must ensure that all service users have a PBS plan which clearly identifies how staff can best meet a person's holistic needs and manage behaviors safely and effectively	• Psychologist recruited to lead on PBS and work with the SBU's PBS Strategy Lead, to develop an evidence-based approach to utilising PBS in secure services • The team working alongside the PBS Strategy Lead • Role based training, which includes PBS training, has been developed and plotted on the Eroster from early June, for staff to be trained in PBS and other areas such as Relational Security and Working with Carers.
The Trust must ensure that there is a proper and safe management of medicines	• Fridge and clinical room temperatures monitored through the weekly Quality Meetings • Team adhering to the Trust-wide weekly monitoring and auditing.

The Trust must ensure that all house 5 environment is well maintained, decorated appropriately, and provide a therapeutic environment for people using the service. This includes ensuring safety, comfort, privacy, dignity, and free access to fresh air.	• KLH Architects have been engaged and initial mood board proposals developed • Service user, carer and staff feedback collated; preferred visual and colour options identified.
Action the Trust SHOULD take to improve	
The Trust should consider reviewing whether the staffing levels on each of the houses are adequate to ensure there are enough suitably qualified, skilled, and competent staff deployed to meet the needs of all people using the service	• The service has not gone below safer staffing rates; additional shifts required due to service user acuity • Team Leaders and Clinical Matron step in numbers when required • Service uses less than 6% agency • Reduced service user occupancy • Daily, weekly, and monthly monitoring and scrutiny of rosters and staffing levels.
The Trust should ensure that ward activities are provided regularly, including during the evening and at weekend	• Ward-based activities project instigated, including activity grab sheets and additional boxes of equipment • CQI project looking at link of activity provision with incident rate • Two evening/weekend activity workers recruited • Sensory Integration room installed. • Two 'Shape Up' groups to commence end of end of April. • Health Care Support Workers (HCSW) identifying personal talents and skills to share with service users and develop talents database.
The Trust should ensure that it progressed the implementation of the carers forums and other methods that allow carers and families to feedback about the service and the care their loved ones receive	• Carers forums held • HCSW with social care background, assigned to support the ward's Social Worker to bolster work with carers • Staff training on working with carers. • Carers Month planned for June 2023, introducing newly drafted Carers Charter, a carer conversation tip-sheet and relational security exercises communicated to staff to help reflection on daily work with carers.
The Trust should ensure that all governance process operate effectively in order to provide clear oversight of improvements that are required.	• Weekly oversight meetings with SBU leadership, chaired by the Executive Director, Quality and Safety and Executive Director, Quality and Medical Leadership, to oversee actions and improvements.

Table 3

3.7 As an outcome of the focused risk inspection process at Warren Court, the final report notes the rerating of the service line *Forensic inpatient or secure wards*. *Table 4* identifies the ratings in the draft report.

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Pre-inspection rating	Good	Good	Outstanding	Good	Outstanding	**Outstanding**
Draft report rating	Requires Improvement	Good	Good	Good	Good	**Good**

Table 4

4. Conclusion

4.1 This paper provides the Board with an update on the CQC inspection activity and published reports for Oak ward and Warren Court.

4.2 The paper provides details of the findings of the final reports received, actions taken to address areas for improvement and the oversight and scrutiny of the delivery of these improvements.

PUBLIC Board of Directors

Meeting Date	6 July 2023	**Agenda Item:** 9
Subject:	Annual Quality Assurance for Responsible Officer and Revalidation 2022/2023	**For Publication:** Yes
Author:	Abiemwense Giwa-Osagie, Revalidation Co-Ordinator	**Approved by:** Prof Asif Zia, Executive Director of Quality and Medical Leadership
Presented by:	Prof Asif Zia, Executive Director of Quality and Medical Leadership	

Purpose of the report:

To update and inform the Board on Quality Assurance for Responsible Officer and Revalidation.

Action required:

To inform the Board and for the Board to discuss on the report.

Summary and recommendations to the Board:

The Framework of Quality Assurance provides an overview of elements defined in the Responsible Officer Regulation, with a sequence of the process to support the RO and their designated bodies in providing the required assurance that they are discharging their respective statutory responsibilities.

Medical revalidation was launched in 2012 to strengthen the way doctors are regulated, improve the quality and safety of care provided to patients, and increase public Trust and confidence in the medical system.

The Executive Director of Quality and Medical Leadership is the Responsible Officer and oversees the process for HPFT. As part of medical appraisal and revalidation within HPFT, a robust appraisal system for doctors incorporates trained appraisers and a bespoke IT system. All relevant policy updates from NHS England, the GMC, NHSI, GMC and the Academy of Medical Royal Colleges on the medical appraisal 2020 model.

HPFT adopted Appraisal 2020 model, with a reduced requirement for preparation by the doctor and a greater emphasis on reflection and discussion during appraisal meetings.
The Medical Appraisal Guide 2022 emphasises doctors' personal and professional well-being following the impact of COVID, and the department suggested that one of the doctors' PDP objectives must come from their personal and professional well-being.

This report informs the HPFT Board of its statutory responsibilities to ensure that all licensed medical practitioners with a prescribed connection to HPFT and HPFT as their designated body following national guidelines must keep up to date with their clinical knowledge and have all relevant information relating to the doctor's fitness to practice for quality assurance. Annual quality assurance for the responsible officer and revalidation report inform the committee that systems are in place to monitor those regular appraisals.

This report reports on quality assurance for responsible officers and revalidation carried out by HPFT as of 31st March 2023. one hundred and fifty-three (153) doctors were due for appraisal in 2022/2023; of the one hundred and fifty (150) doctors completed their appraisals within 28 days of their first appraisal. The difference among the three (3) was that two (2) doctors missed their

appraisals, and one (1) doctor had an approved missed appraisal by the RO following the GMC national guidance on reporting.

The Trust reported that three (3) doctors had missed their appraisal as defined by NHS England. The doctors were either unwell or had other well-founded reasons, with 98.04% actual compliance.

The GMC guidance on doctors due for revalidation states that forty-four doctors (24) were due for revalidation during 2022/2023. The RO approved 20 doctors with positive recommendations. The RO deferred four doctors; two doctors were on long-time sickness, one doctor was subject to an ongoing process, and one doctor was due to insufficient evidence to revalidate in line with the GMC guidance.

The Trust has 59 active, fully trained medical appraisers to appraise 182 doctors annually. The Trust trained four new appraisers through an external trainer on 30th September 2022 to ensure the ratio is four appraisees to a full-time appraiser and two or three to a part-time appraiser.
There were two Simulation Appraisal Training Workshop sessions held last year. The training sessions focused on some challenging scenarios doctors encounter during their appraisals, such as patient feedback, PDP and well-being. During the debriefing with the external appraiser trainer, the doctors reflected on ongoing challenges to support and improve the appraisal process.

This report assures HPFT's responsibilities meet the frequency and quality assurance monitoring for responsible officers and revalidation.

Relationship with the Business Plan & Assurance Framework:

It provides quality assurance for the responsible officer, revalidation and patient safety.

Summary of Implications for:

BAF
National Benchmarking

Equality & Diversity and Public & Patient Involvement Implications:

Revalidation and support to our medical staff is important for their development and the Trust has commitment to ensuring their equality of opportunity for all staff. Our approach to revalidation is in with this commitment.

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

Quality Assurance for the Responsible Officer and Revalidation linked to Quality and Safety

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

Executive team 21 June 2023

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period the 1st of April 2020 – the 31st of March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The executive management team of Hertfordshire Partnership University NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> Comments: The Executive Director of Quality and Medical Leadership is the Trust's responsible officer (RO). The Board of Directors confirmed his position on the 28th of June 2017.
>
> The Deputy Medical Director is the Lead Appraiser with the support of the Revalidation Co-ordinator. The Deputy Medical Director is responsible for all non-training grade medical staff (including NHS locums but excluding agency locums).

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the role's responsibilities.

> Yes
>
> Comments: There is a designated resource for the revalidation coordinator. The Deputy Medical Director acts as the lead appraiser. The Trust also uses the 'Allocate' system for appraisals and Job planning.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Comments: The GMC sends a notification email to the Trust to verify new doctors' connection to the Trust; the Trust verifies with the Medical Staffing department to ensure the doctor is an employee.

Internal and external verification from the Medical Staffing department and the Medical Appraisal and Revalidation department disconnect doctors within two weeks of leaving the Trust to ensure the doctor connects to their new designated body. The GMC notification email confirms the doctor's disconnection from the Trust as their designated body.

Before the RO makes a revalidation recommendation, the Revalidation Co-ordinator and the RO check the input and output of the doctor's five completed appraisals in the revalidation cycle to ensure all relevant information is available.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Comments: The GMC and the NHS England review the Medical Appraisal and Revalidation policy following the national guidelines.

The Medical Appraisal and Revalidation policy updates are subject to formal review, internal audits, and reports to the Board in line with Trust processes.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Comments: In May 2023, the Practice Audit and Clinical Effectiveness (PACE) department audited the appraisal and revalidation processes. The audit's findings will be presented to the Trust Executive Board to ensure the completion of actions. (see Q6 effective appraisal).

The Trust is organising a peer review for the financial year 2023-2024 and should be available to the Board in the following report.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Comments: The Trust offers the same level of support to all doctors in relation to their continuing professional development, appraisal, revalidation, and governance, irrespective of their post, position or contract, as it offers to those who work substantively.

The CPD programme (internally) is open to all doctors. Additionally, different grades have their teaching and training programmes to meet their clinical requirements, and their programmes are open to locum and short-term placement doctors.

Similarly, monthly Trust-wide teaching and training programmes are available to all doctors.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Comments: HPFT adopted Appraisal 2020 model, with a reduced requirement for preparation by the doctor and a greater emphasis on reflection and discussion during appraisal meetings.

The Medical Appraisal Guide 2022 emphasises doctors' personal and professional well-being following the impact of COVID, and the department

suggested that one of the doctors' PDP objectives must come from their personal and professional well-being.

After the appraisal meeting, feedback suggested that the model is preferred among doctors. The feedback from 122 out of 164 appraisal feedback forms completed as of 31/03/2022 was;

1. "The appraisal meeting was interactive, stimulating, educational, private, and professional, giving considerable time to discuss, focus and reflect on any concerns and development plans to consider the best way going forward by making realistic and achievable goals".

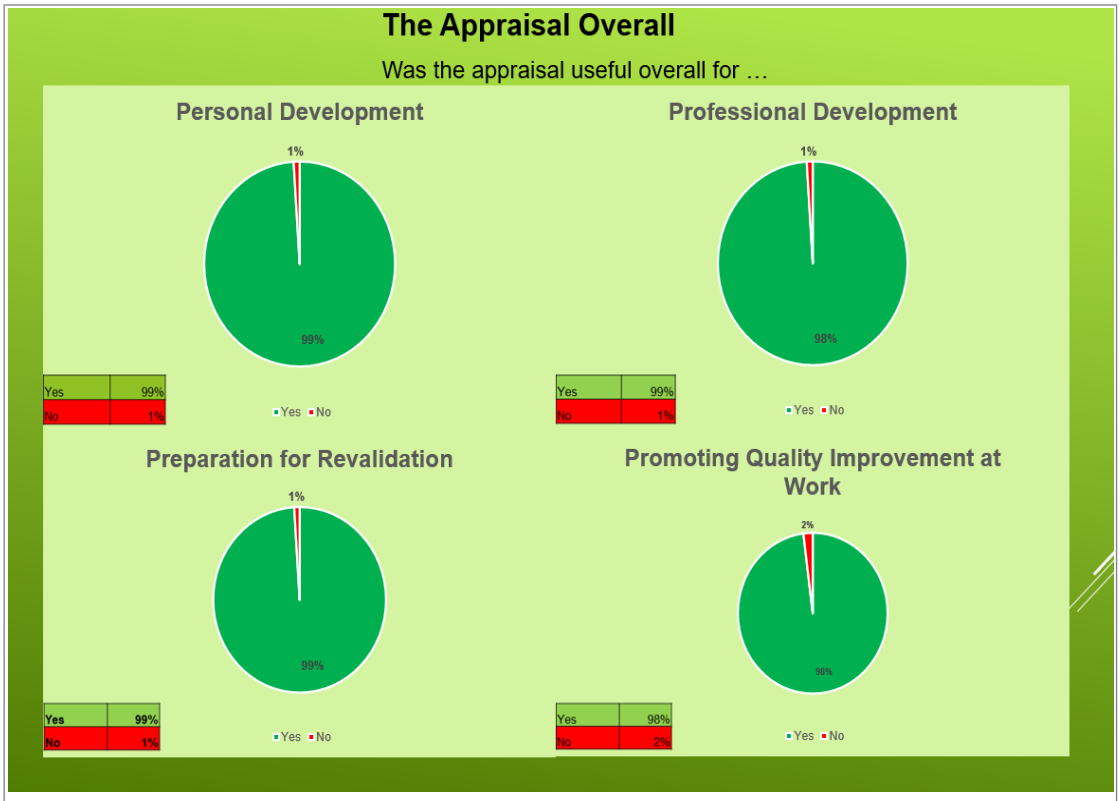
2. "Health and welfare advice and signposting regarding interventions to protect against professional burnout, with a supportive appraiser, the process did not seem like a tick-box exercise".

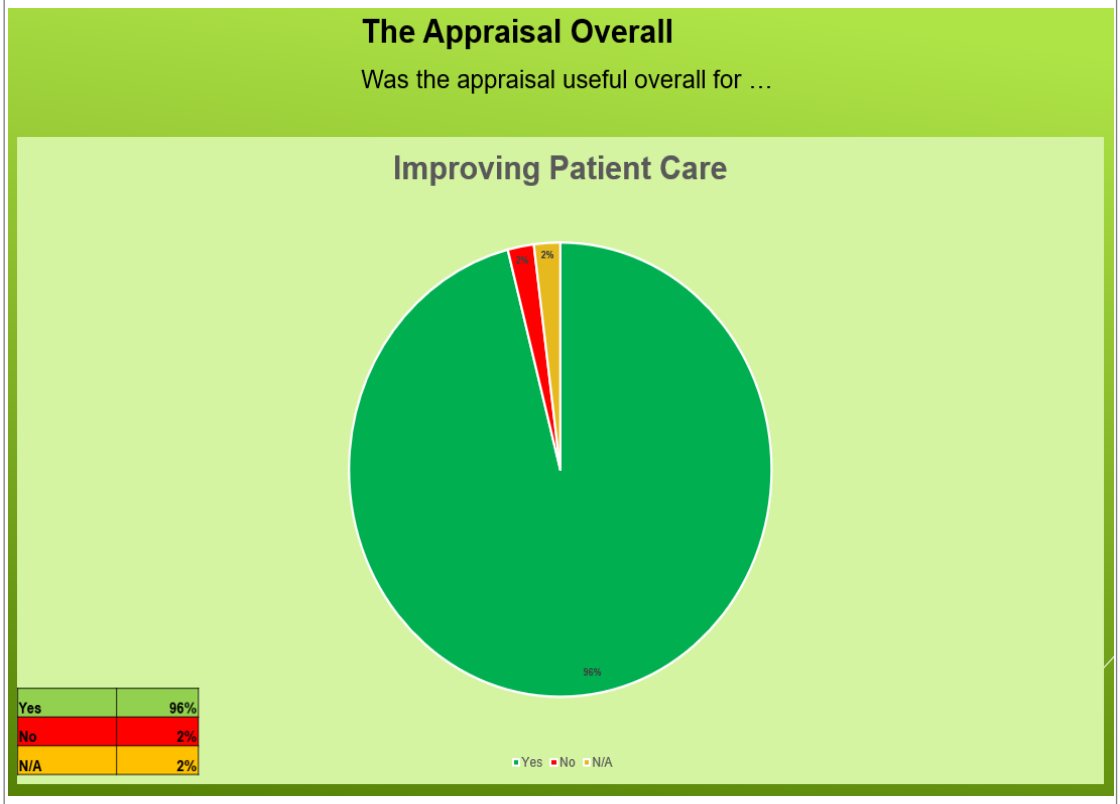
3. "Supportive, excellent, insightful, fascinating discussion and advice regarding PDP and dealing with work pressure while improving the doctor practice as a new challenge".

4. "Professional, knowledgeable, skilled, experienced, informative, sympathetic, focused and non-judgemental with practical suggestions and support for the doctor's clinical, academic and professional development skills".

5. "Sufficient time to reflect on all aspects of clinical work, relationship with patients, carers, colleagues and family. A conversation regarding workplace incidents, responsibilities and safeguarding".

6. "The overall process is very useful, reflecting on the ideas for quality of work and discussing the importance of learning, reviewing practice, reflecting, and implementing changes".


The Appraisal Overall
Was the appraisal useful overall for …
Personal Development
1%
99%
Yes 99%
No 1%
Yes No
Professional Development
1%
98%
Yes 99%
No 1%
Yes No
Preparation for Revalidation
1%
99%
Yes 99%
No 1%
Yes No
Promoting Quality Improvement at Work
2%
98%
Yes 98%
No 2%
Yes No


The Appraisal Overall
Was the appraisal useful overall for …
Improving Patient Care
2%
96%
Yes 96%
No 2%
N/A 2%
Yes No N/A

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Comments: All licensed medical practitioners must engage with the medical appraisal process annually within 28 days by providing all the necessary supporting information to ensure a possible revalidation recommendation

The Trust reported that three doctors had missed their appraisal as defined by NHS England. The doctors were either unwell or had other well-founded reasons, with 98.04% actual compliance.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Comments: The Trust Medical Appraisal and Revalidation policy V7 was updated on the 7th of September 2022 following updates from the Medical Appraisal Guide, NHS England, General Medical Council (GMC), Royal College of Psychiatrists and Academy of Medical Royal Colleges and further reviewed by May 2025.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Comments: The Trust has 59 active, fully trained medical appraisers to appraise 182 doctors annually. The Trust trained four new appraisers through an external trainer on the 30th of September 2022 to ensure the ratio is four appraisees to a full-time appraiser and two or three to a part-time appraiser.

There were two Simulation Appraisal Training Workshop sessions held last year.

The training sessions focused on some challenging scenarios doctors encounter during their apprisals, such as patient feedback, PDP and well-being. During the debriefing with the facilitator and the doctors reflected on ongoing challenges to support and improve the medical appraisal process and well-being.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Comments: The Appraiser's Network has a quarterly meeting chaired by the Deputy Medical Director with an update of the appraisal feedback report on the previous year from the RO and discusses various themes from;

1. Learning from Good Practice
2. The Appraisal, Appraiser and Appraisee Feedback Report
3. Quality Improvement Activities
4. Research and Teaching
5. The Local Audit Data
6. The Appraiser Top-Up/Refresher Training
7. The Job Planning Workshop
8. The Practice Improvement
9. Appraisal Simulation Workshop
10. Junior Doctors/Staff/GMC Surveys

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments: In May 2023, the Practice Audit and Clinical Effectiveness (PACE) department (Trust's auditors) carried out an audit of the appraisal and revalidation processes. The audit's findings will be presented to the Trust Executive Board to ensure the completion of the actions.

The Trust is organising an external peer review for 2023-2024, which should be available to the Board in the following report.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

1	Total number of doctors with a prescribed connection as at the 31st of March 2023		**182**
2	Total number of doctors that did not need an appraisal between the 1st of April 2022 and the 31st of March 2023 (following the GMC national guidance on reporting)		**29**
	New staters doctors	15	
	Doctors with HPFT less than nine months	10	
	Doctors on long-term sick leave	4	
	Maternity leave	0	
3	Total number of appraisals due between the 1st of April 2022 and the 31st of March 2023		**153**
4	Total number of appraisals undertaken between the 1st of April 2022 and the 31st of March 2023		**150**
5	Total number of appraisals not undertaken between the 1st of April 2022 and the 31st of March 2023		**3**
	Missed appraisals	2	
	Doctors on short-term sick leave	0	
	RO approved missed appraisal	1	
6	Total number of agreed exceptions		**0**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Comments: The GMC guidance Forty-four doctors (44) were due for revalidation during 2022/2023. The RO approved 39 doctors with positive recommendations. The RO deferred five doctors; two were on long-time sickness, one was on maternity leave, and two were due to insufficient evidence to revalidate in line with the GMC guidance.

1	Total number of doctors with a prescribed connection as of the 31st of March 2023		182
2	Total number of doctors due for revalidation recommendation between the 1st of April 2022 and the 31st of March 2023 (following the GMC national guidance on reporting)		24
3	Total number of doctors revalidated by the RO undertaken between the 1st of April 2021 and the 31st of March 2023		20
4	Total number of deferred revalidations between the 1st of April 2022 and the 31st of March 2023		4
	Doctors on long-term sick leave	2	
	Doctor subject to ongoing process	1	
	Doctor due to insufficient evidence to revalidate	1	
5	Total number of doctors deferred and revalidated within six months		0

The RO did not revalidate any deferred doctors within six months of their due dates.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Comments: The RO discusses all deferral with the GMC Liasion Officer before deciding to defer a doctor.

The RO and the deputy medical director will have formal conservation with the relevant doctor regarding a decision to defer or non-engagement in line with the national guidance.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Comments: All doctors must briefly describe the complaints and Serious Untoward Incident (SUI) reports relating to the individual doctors, teams and departments in their appraisal.

The Revalidation Co-ordinator generates the appraiser feedback report yearly and sends it to each appraiser to include in their appraisal portfolio.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Comments: The updated Trust Medical Appraisal and Revalidation V7 policy aligns with the national standards. The appraisal is not a performance tool but may include performance information that doctors need to reflect upon during appraisal meetings. Effective medical appraisal and subsequent revalidation will satisfy the requirements of Good Medical Practice and support the doctor's professional development.

All our doctors have their performance discussed at their job planning meetings with their line managers on an ongoing basis; this includes the key performance indicators, complaints, and SUIs within the five Strategic Business Units (SBUs). There is a mechanism for ensuring that individual doctors include the relevant complaint and SUI data in the appraisal portfolio for discussion.

MSF 360 feedback from colleagues and patients is conducted at least once during a five-year revalidation cycle (in line with GMC requirements) and may repeat the process more frequently where required or advised during the appraisal process.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Comments: The Trust has a Remediation, Rehabilitation and Re-skilling policy for Medical Staff. The key focus is on doctors with concerns regarding their practice. Excluding a doctor from work or subjecting them to disciplinary action is not always the most appropriate. This policy offers the opportunity to help doctors who need re-skilling after returning to work on a job change.

Maintaining High Professional Standards (MHPS) in the Modern NHS policy for Medical Staff is in conjunction with the Remediation, Rehabilitation and Re-skilling policy which provides a clear set of procedures which can be referred to when a concern arises about the medical staff.

The MHPS policy supports delivering a transparent and fair approach to managing the concerns of medical employees and ensuring that patient safety is the paramount consideration.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Comments: Appraisal is not a performance tool but may include performance information that requires reflection. Effective medical appraisal and subsequent revalidation will satisfy the requirements of Good Medical Practice and support the doctor's professional development.

The performance of all our doctors is reported on an ongoing basis through the key performance indicators, complaints and SUIs within the five SBUs. The MSF 360 feedback from both colleagues and patients is conducted at least once during a five-year revalidation cycle (in line with GMC

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

requirements) and may require a repeat of the process more frequently if necessary.

The Trust completes a Medical Workforce Race Equality Standard (MWRES) annually, following the national guidelines to address inequalities of protected characteristics of the doctors.

Maintaining High Professional Standards (MHPS) in the Modern NHS policy for Medical Staff is in conjunction with the Remediation, Rehabilitation and Re-skilling policy which provides a clear set of procedures which can be referred to when a concern arises about the medical staff.

The MHPS policy supports delivering a transparent and fair approach to managing the concerns of medical employees and ensuring that patient safety is the paramount consideration.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Comments: It organises RO-to-RO meetings to discuss concerns about an individual doctor. An example could be an agency Doctor.

The RO regularly consults with the GMC liaison officer when there are significant concerns about a doctor.

The RO liaise with Practitioner Performance Advice (PPA) senior adviser on the impact on a doctor's ability to perform well, which strains working relationships and leads to physical and mental health problems.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Comments: The RO has undergone unconscious bias training for overall awareness, understanding, and Maintaining High Professional Standards (MHPS) effectiveness.

The RO meets with the medical managers at the Medical Professional leads meeting to ensure HPFT maintain a high professional standard.

The RO meets with GMC Liaison and Practitioner Performance Advisors to discuss concerns about the practice and conduct of HPFT doctors.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Comments: The Medical Staffing Team undertakes all pre-employment checks.

Section 6 – Summary of comments, and overall conclusion

182 doctors linked to HPFT, 29 doctors did not require a medical appraisal following the national guideline. 153 doctors were due for a medical appraisal; only 150 had completed their medical appraisal, and three (3) had missed appraisals.

24 were due for revalidation during 2022/2023 within HPFT; The RO approved 20 doctors with positive recommendations completed on time and four deferral recommendations.

This report assures that HPFT's responsibilities meet the frequency and quality assurance monitoring for responsible officers and revalidation.

Overall conclusion:

The Board must note the report, comment, and accept (if appropriate). The report will be shared with the higher level (regional), Responsible Officer.

Section 7 – Statement of Compliance:

The executive management team of Hertfordshire Partnership Univeristy NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Hertfordshire Partnership University NHS Foundation Trust

Name: Prof Asif Zia Signed: _ _ _ _ _ _ _ _ _ _

Role: Executive Director of Quality and Medical Leadership (HPFT Responsible Officer)

Name: Karen Taylor Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: 12/06/2023

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Publication approval reference: PAR614

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 10
Subject:	Month 2 Financial Position	**For Publication:** Yes
Author:	David Flint, Head of Financial Planning & Reporting	**Approved by:** Philip Cave, Chief Finance Officer
Presented by:	Philip Cave, Chief Finance Officer	

Purpose of the report:

To present to the Trust Board the financial position for the period to 31 May 2023 (month 2), and any risks to the Trusts financial duties. The report notes the key items of variance to plan, comparisons to previous periods and with the key assumptions, the current risks and proposed mitigations.

Action required:

The Trust Board are asked to note and discuss the financial position in month 2 against the 2023/24 Trust Plan and the related assumptions and actions being taken.

Summary and recommendations

Executive Summary:

The financial plan acknowledges the challenging position for 2023/24, with a projected deficit of £1.8 million resulting from extensive negotiations with Commissioners. The plan includes an ambitious Delivering Value (DV) program of £15 million, with £10 million expected as cash-releasing efficiencies. However, several risks have been identified in pursuit of this goal, including increased demand for the Trust's services, particularly in adult acute placements, potential inflationary pressures exceeding funded levels, recruitment and retention challenges, potential shortfall on DV savings, and the risk of not attaining CQUIN levels, particularly associated with the Flu program.

The month 2 financial report reveals a deficit of £1.428 million, amounting to £1.864 million year-to-date, compared to the planned deficit of £0.14 million for the month and £0.4 million year-to-date. This significant cost escalation from the month 1 position has been primarily driven by three main factors:

1. Approximately £500,000 due to Out of Area (OOA) Adult Acute bed usage and associated observations.
2. A £500,000 increase in pay costs despite positive recruitment efforts, failing to bring about reductions in temporary staffing usage.
3. An additional £200,000 increase in overhead costs attributed to increased soft FM contract variation, training costs, and additional non-recurrent expenditures.

The Trust has a phased plan of £0.4m deficit year-to-date whereas on a straight-line basis this could be a £0.6m deficit. Since close down of the financial position the finance function have identified a double count of circa £0.2m relating to OOA beds which will be reverse next month, in addition further income recognition is expected in month 3.

The executive team are enhancing the financial control and grip of the organisation as outlined in more detail in the report.

Month 2 Reporting:

1. The Trust's primary cost drivers continue to be temporary staffing usage and out of area placements. It is advisable to implement stricter restrictions on discretionary spending.
2. While there have been positive improvements in the utilisation of agency staff across all Strategic Business Units (SBUs), these gains have not been substantial enough to offset the increased recruitment and bank usage.
3. Pay costs, especially considering the delayed start in new service activity, should ideally be further below plan.
4. Financial recovery initiatives in non-pay areas have yet to yield significant improvements.
5. Secondary Commissioning expenditure indicates a rise in comparable adult acute bed days, resulting in £679k above plan for the month and £749k year-to-date. Further analysis of placements is provided below.
6. Pay costs are £710k above plan for the month, primarily driven by increased temporary staffing usage. Positive recruitment efforts have not yet resulted in meaningful reductions in temporary staffing levels.
7. The East of England (EoE) Provider Collaborative reports a break-even position for month 2. Transformation funds are available within the Provider Collaborative for the year, and the Trust is actively preparing relevant bids to access these funds once the formal process is agreed upon.

Financial Recovery:

Although the Trust has established a workstream to support financial recovery, the pace of spend reduction falls short of what is required to achieve financial balance. Therefore, it is crucial to accelerate financial recovery efforts, focusing on the following areas throughout the year:

1. Reducing Out of Area (OOA) beds in line with the trajectory set within the Community & Acute oversight Group. While positive outcomes were observed in April, a combination of increased demand, Junior Doctor strikes, and additional bank holidays has negatively impacted patient flow, resulting in a reversal of improvements in May. The rate of placement reductions has been considerably slower than the rate of increases in recent months.
2. Implementing targeted actions to decrease the usage and cost of agency staff in line with substantive recruitment. Progress has been made in reducing agency usage; however, it has yet to align with positive substantive recruitment. This is being managed through the Agency Panel.
3. Reducing the cost of agency and bank staff through effective use of the E-roster system. Limited progress has been achieved thus far, with Month 2 showing £87k of bank shifts primarily related to hours worked in April due to delayed recording of hours in E-Roster, particularly in Mental Health Liaison and Crisis teams.
4. Exploring additional income opportunities to ensure full recovery of owed funds to the Trust and capitalise on available opportunities. The finance and commercial teams are actively pursuing this, with positive progress identified in securing further winter funding. Ongoing efforts are underway to identify recurring sources of income for 2023/24. Additionally, the Trust is working to ensure that responsible commissioners are charged for inpatient bed costs and is actively seeking support from NHSE.
5. Implementing tighter controls on non-discretionary spending in key areas.
6. The executive team is reviewing the ToR for the financial recovery group which will now report fortnightly into the executive meeting.
7. Executive led monthly financial performance meetings have been instigated in all SBUs and large corporate areas.
8. Additional internal and external financial training is being rolled out across the Trust.

Overall Comment:

The Trust's financial position remains significantly challenged, particularly in relation to Out of Area (OOA) placements and temporary staffing. However, there is reason for cautious optimism

regarding agency usage in frontline areas. Ongoing discussions with Commissioners aim to finalise contract sign-off and maximise income, with regular reporting on these matters as part of the monthly reporting cycle.

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 and Public & Patient Involvement Implications:

Ensuring that all members of our community have access to our services is paramount and ensuring we use and secure resources for those with mental health needs or a learning disability is key. Delivery of our financial plan will enable us to provide access to all who need it.

Evidence for S4BH; 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

Executive Meeting 14 June 2023

1 Financial position for the months to 31 May

The monthly financial position for May has performed below plan, with a deficit of £1,428k compared to a planned deficit of £137k. The year-to-date position is now a £1,864k deficit compared to a planned deficit of £368k, therefore £1,496k off plan.

Table 1 – Month 2 financial Position

	Month 2			Year to Date		
Financial Position to 31 May 2022 £000	Revised Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income incl. COVID-19	28,047	28,097	50	56,094	56,231	137
Income - Provider Collaborative	4,017	4,296	279	8,034	8,258	224
Pay	18,744	19,454	(710)	37,488	38,339	(851)
Secondary Commissioning	4,017	4,696	(679)	8,128	8,877	(749)
Provider Collaborative	4,017	4,296	(279)	8,034	8,258	(224)
Non Pay	2,077	1,895	182	4,153	3,878	275
Overheads	3,346	3,480	(134)	6,693	7,001	(308)
Surplus / (Deficit)	**(137)**	**(1,428)**	**(1,291)**	**(368)**	**(1,864)**	**(1,496)**

Income

Income for direct Trust services is in line with the plan both for the month and year-to-date. However, Hosted Provider Collaborative services have a variance against the plan due to higher expenditure. Currently, this poses no direct risk to the Trust's financial position, but it will be closely monitored.

The achievement of CQUIN targets in the current year will impact the Trust's plan for 2023/24. Discussions with the Commissioners are ongoing, and the CQUIN targets are accounted for at 100% at present.

Pay Costs

Pay costs have increased in May, exceeding the plan by £710k. This increase is primarily due to significant bank and agency costs. The pay award has been accounted for in accordance with National Planning guidance, with additional funding expected to bridge the gap to the full award. While there have been improvements in reducing agency and bank spend in some areas, they have not offset the increases in permanent pay spend consistently.

The establishment review has been completed and is being updated in ward establishments to improve recruitment, enhance quality, stability in inpatient settings, and reduce the reliance on temporary staff. However, a reduction in the overall number of full-time equivalent (FTE) positions, particularly in inpatient wards, is required to achieve financial balance.

Secondary Commissioning

Secondary commissioning spend is £679k above plan in Month 2 and £749k year-to-date. This increase reflects the greater usage of external beds, with an

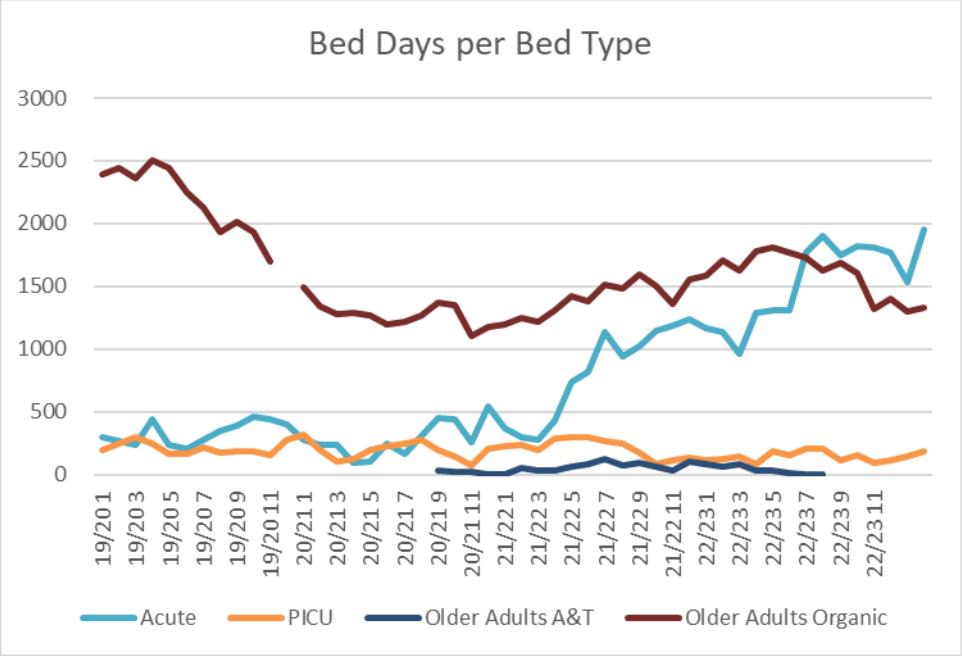
increase in the monthly average number of adult acute Out of Area (OOA) placements and adult Psychiatric Intensive Care Unit (PICU) placements.

The table below highlights the main health placement types and their associated number of placements in 2023/24. The continued volatility of these external placements poses a significant risk to the financial plan. The introduction of an Enhanced Discharge Team is expected to improve patient flow and facilitate discharges, but challenges such as bank holidays, Junior Doctor strikes, and annual leave underscore the fragility of this pathway. The five challenging delayed transfers of care remain the biggest obstacle to reducing placements and associated observation spend. Exploratory options are being pursued to ensure appropriate care settings for these service users, which is expected to yield savings once achieved, but resolving these challenges remains difficult.

Placement Type	Month 1	Month 2
High Dependency Rehab	29	31
Specialist Hospital	5	6
PICU	5	6
Acute	51	63
MHSOP - Organic	43	43
Total	**134**	**148**

There is one bed closed within adult acute wards in Kingfisher Court due to refurbishment works, resulting in a direct OOA placement until July 24, 2023.

The graph below illustrates the average number of placements in the main bed types over the past four years.



Provider Collaborative

The Provider Collaborative activity reflects a balanced position for Month 2. It continues to be closely monitored by the TACT team, and there was a strong financial improvement in Q4 of 2022/23.

Surpluses are expected within the Provider Collaborative as the year progresses, and HPFT is actively seeking appropriate funding for its associated CAMHS and Adult Secure service areas.

Overhead Costs
Overhead costs are £134k above plan for the month and £308k year-to-date.

Areas of discretionary spend are being challenged and tightened through the financial recovery group, with a particular focus on Trust maintenance spend. However, in the current month, there have been additional pressures on international recruitment, training costs, and furniture replacement, leading to increased costs against the plan.

2 Delivering Value (DV)

The Trust has an ambitious DV program for 2023/24, targeting £15m, with £10m in cash-releasing efficiencies and £5m in productivity gains. The plan is outlined below. Performance is monitored monthly by the DV Management Group and reported to the Executive team. The Financial Recovery & Delivering Value Board oversees the program weekly.

Scheme Identifier	LD&F £'000's	West - Planned £'000's	West - Unplanned £'000's	E&N £'000's	Corporate £'000's	Total £'000's
Productivity Gains	1000	1000	1000	1000	1000	5,000
OOA Placement reduction			3,000	236		3,236
Renegotiated Forest House Income				1,000		1,000
Observations/agency reduction	200		302	350		852
Social Care reductions in placements	675					675
Reduction in external Rehab bed usage	720					720
Recruitment delays in new services	100	100	100	100		400
Rates rebate					700	700
Trustwide maintenace charges reduction	100	100	100	100	100	500
Internal Transport reductions					300	300
Renegotiated Warren Court Income	200					200
Procurement					200	200
Absorption of Overheads				106		106
Estates Room booking system					100	100
Additional Interest Income					100	100
Service Review				300		300
Other under £100k schemes	100	50	162	88	267	667
	3,095	1,250	4,664	3,280	2,767	15,056

Further analysis is being conducted to review progress against the plan.

3 Mitigating actions

While the Trust expects to report a deficit in line with the planned £1.8m for the full year, cost run rate remains above plan in some areas. To address this, the Trust has implemented a financial recovery plan. Mitigation actions include:

- Continuation of fortnightly financial recovery meetings, including revised ToR

- Prioritising DV initiatives, with monthly scrutiny of schemes above £100k
- Continued development and acceleration of the 2023/24 DV program
- Monthly SBU financial performance meetings with Managing Directors
- Implementation of agency cost controls, with MDs and Heads of Nursing authorizing all agency usage
- Finalisation of establishment control reviews for inpatient services in budgets and conversion of agency staff to substantive roles
- Publishing and sign-off of financial budgets during the week commencing June 19
- Resetting and implementing robust financial control, including a revised training program on financial management for budget holders
- Maximising additional income in-year and pursuing all disputed debts to conclusion
- Improved training for all budget holders

4 Balance Sheet

The balance sheet for the month is shown below:

Statement of Financial Position	31 March 2023	Previous month 1	Movement in month 2	Current month 2	Movement YTD
	£000	£000	£000	£000	£000
Assets	259,861	261,589	4,292	265,881	6,020
Non Current Assets	**184,567**	**184,559**	**3,156**	**187,715**	**3,148**
Intangible Assets	1,389	1,359	(30)	1,328	(61)
Property Plant & Equipment	167,638	167,887	461	168,348	711
Tr & Oth Rec: Non-Nhs Rec	358	358	0	358	0
Right Of Use Assets	15,182	14,955	2,725	17,680	2,498
Current Assets	**75,294**	**77,030**	**1,136**	**78,166**	**2,872**
Inventories	60	60	0	60	0
Trade And Other Receivables NHS	17,352	14,691	1,595	16,287	(1,065)
Trade And Other Receivables Non NHS	4,337	5,397	1,301	6,698	2,361
Assets Held for Sale	1,274	1,274	0	1,274	0
Cash & Cash Equivalents GBS/NLF	52,181	55,476	(1,735)	53,741	1,560
Cash & Cash Equivalents Other	90	132	(26)	107	16
Liabilities	(90,693)	(92,858)	(5,720)	(98,578)	(7,885)
Current Liabilities	**(65,087)**	**(67,454)**	**(2,921)**	**(70,376)**	**(5,289)**
Trade & Other Payables Capital	(1,922)	(1,940)	259	(1,681)	240
Trade & Oth Payables Non-Capital	(55,170)	(57,818)	(2,700)	(60,517)	(5,348)
Borrowings	(3,023)	(3,041)	100	(2,941)	82
Provisions	(3,625)	(3,550)	75	(3,475)	150
Deferred Income	(1,347)	(1,105)	(655)	(1,761)	(413)
Non Current Liabilities	**(25,606)**	**(25,403)**	**(2,799)**	**(28,202)**	**(2,596)**
Borrowings	(19,580)	(19,337)	(2,788)	(22,125)	(2,545)
Provisions	(5,723)	(5,763)	(11)	(5,774)	(51)
Other Liabilities	(303)	(303)	0	(303)	0
Equity	(169,168)	(168,731)	1,428	(167,303)	1,865
Public Dividend Capital	**(97,959)**	**(97,959)**	**0**	**(97,959)**	**0**
Revaluation Reserve	**(42,198)**	**(42,198)**	**0**	**(42,198)**	**0**
Other Reserves	**489**	**489**	**0**	**489**	**0**
Income And Expenditure Reserve	**(29,500)**	**(29,063)**	**1,428**	**(27,635)**	**1,865**

The balance sheet for the month shows significant movements, including:

- Non-current assets increased by £3.2m, primarily due to the lease renewal for Colne House under IFRS 16. This resulted in £2.9m of Right of Use assets and Lease Obligations under Non-Current Liability Borrowings. The remaining

increase is attributed to two new Transport Lease vehicles and capital program spend exceeding depreciation.

- Current assets increased by £1.1m, primarily driven by an increase in receivables (£2.9m) offset by a reduction in cash due to the reported deficit in Month 2 (£1.7m).
- Current liabilities increased by £2.9m, mainly due to an increase in accruals (£2.4m) offset by a £0.6m increase in deferred income, resulting from the receipt of Q1 Education and Training income.

The Trust's cash position at Month 2 is £53.8m, which decreased by £1.7m due to the reported deficit in Month 2.

The Trust reports its performance under the Better Payment Practice Code (BPPC), aiming to pay 95% of suppliers within 30 days. At Month 2, the performance stands at 92% by value and 90% by number for non-NHS suppliers and 69% by value and 71% by number for NHS suppliers. Overall, it is 89% by value and 89% by number. Actions have been initiated as part of an action plan to improve these figures.

5 Capital

2023/24 Capital Funding

The total Capital Investment Programme for 2023/24 is £12.3m, with available Capital Departmental Expenditure Limit (CDEL) reducing from 2022/23. Funding breakdown:

Funding of Capital Investment Programme	**2023/24 £m**	**2022/23 £m (Comparison)**
System CDEL	9.0	10.9
National Digitisation CDEL	1.9	2.3
Total CDEL	**10.9**	**13.3**
Add: Disposals	1.4	1.3
Gross Capital Investment Programme	**12.3**	**14.6**

National Digitisation funding will be backed by CDEL cash, with the Trust applying for two drawdowns during 2023/24. The Trust has requested to be part of Drawdown 1, expected in the summer.

The investment program includes expected proceeds of £1.35m from the disposal of the Harper Lane properties, subject to the buyer obtaining planning permission for their proposed development. Completion is expected in Quarter 2.

Progress against the 2023/24 Capital Investment Programme has started, including the completion of 2022/23 schemes and new schemes for investment in Digital, Backlog Maintenance, Sustainability, Medical Devices, and Reactive Capital. Expenditure in Months 1 and 2 was £1.7m net (£1.8m gross, with approximately £109k VAT refund against the Bed Management System Scheme).

Group	Capital Investment Programme	Plan	Spend to Date at M2	Current Forecast
A	**Completion of Existing Schemes:**			
	Oak Ward	1,500	910	1,500
	Lexden A&T	159	85	159
	Kingfisher Court bathrooms Phase 2	200	73	200
	Other	0	9	0
	A Total	**1,859**	**1,077**	**1,859**
B	**Schemes Related to Patient Safety**			
	CCTV Phase 2&3	706	129	706
	Nurse Call bell system	279	0	279
	Medical Devicies	288	42	288
	Elizabeth Court refurbishment	750	12	750
	Other incuding Fire Compliance	616	0	616
	B Total	**2,639**	**183**	**2,639**
C	**Recurrent Requirements**			
	Backlog Maintenance	1,300	41	1,300
	Reactive Operational Capital	937	235	937
	Sustainability	500	229	500
	Digitisation*	1,942	-54	1,942
	Laptops & Tablets	880	0	880
	C Total	**5,559**	**451**	**5,559**
D	**Discretionary Projects**			
	MH Crisis Assessment Centre	1,350	0	1,350
	Other tbc	1,865	0	1,865
	D Total	**3,215**	**0**	**3,215**
E	**Total Further Projects**	**0**	0	**0**
	Total Gross**	**13,272**	**1,710**	**13,272**
	Disposals	-1,350	1	-1,350
	Total Net**	**11,922**	**1,711**	**11,922**
	CDEL	**10,922**	**10,922**	**10,922**
	Variance to CDEL**	**1,000**	**-9,211**	**1,000**
	*Credit YTD relates to VAT refund of £109k in Month 2			
	**Planned over-commitment of £1m at this early stage of the year to ensure that any slippage can be mitigated and CDEL is fully utilised			

6 Conclusion/Recommendations

The Trust's financial position in Month 2 reflects a deterioration in its challenging financial performance. While some improvements have been made in agency spend in SBU's, there has been an overall deterioration in pay spend and Secondary Commissioning spend compared to the plan.

Reducing the run rate deficit will remain the focus in Month 3, with specific attention to OOA Placements and pay spend.

NHS
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PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 11a
Subject:	Month 2 (May) 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 progress against the People and OD KPIs for Month 2 (May) of 2023/24.

Action required:

To receive the report.

Summary and recommendations:

The attached report sets out the Trust's Month 2 performance in relation to key People and OD metrics that support our annual plan.

The report highlights that:

- Despite our establishment increasing again in Month 2, our vacancy rate reduced to 11.8% as a result of continuing strong recruitment and retention performance.
- However, vacancies in registered nursing (23.9%) and AHP (19.4%) staff remain the most challenging areas for recruitment and retention. There are also 36 medical vacancies. The Recruitment and Retention Group is undertaking deep dives into all three to ensure robust actions continue to address the challenges and this will be closely monitored by the executive team.
- Whilst Agency spend has reduced by 1.5% since April, both Bank and agency spend remains high. The Financial Recovery Board and Agency Panel are proactively reviewing all agency use to ensure this ceases where possible.
- Mandatory training rates increased again in Month 2 and trajectories for improvement have been requested for all face to face trainings
- Appraisal compliance reduced slightly with weekly reporting to SBUs to increase momentum on improvement to achieve target compliance by end Q1.
- Our overall staff development offer continues to be strong with a further enhanced offer available from Q3
- Whilst overall absence rates are lower than we have seen for a year, mental ill health related absence is increasing. Alternative funding streams for our wellbeing offer are being explored to ensure we can continue our robust offer
- The Q1 pulse survey results remain very positive in comparison to the Picker average with a 7.2 engagement score on a 17% response rate.

The Executive 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 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

N/A

Trust People and OD Report
May 2023

Contents

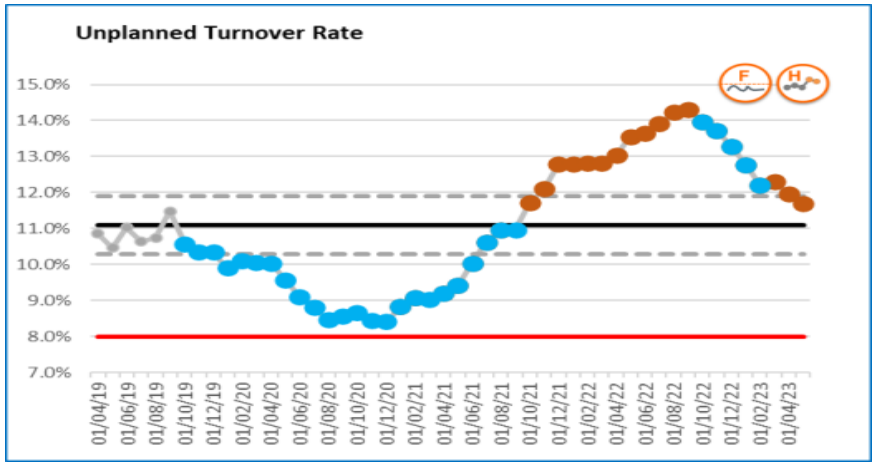
1. Overview

Metric	Previous Months											Current Month		Trend	Variation	Assurance
	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Trust Target			
Staff in Post - Headcount	3763	3730	3774	3842	3887	3921	3935	4012	4052	4083	4100	4121				
Staff in post - FTE	3392.34	3387.33	3409.92	3462.08	3501.28	3542.65	3562.67	3636.30	3664.79	3702.91	3715.75	3743.59				
Budgeted Establishment FTE	3945.14	3941.89	3940.89	4029.56	4037.67	4147.96	4162.15	4157.99	4186.74	4198.26	4230.50	4245.48				
Vacant FTE	552.80	554.56	530.97	567.48	536.39	605.31	599.48	521.69	521.95	495.35	514.75	501.89				
Vacancy Rate	14.0%	14.1%	13.5%	14.1%	13.3%	14.6%	14.4%	12.6%	12.5%	11.8%	12.2%	11.8%	10%			
Total Turnover Rate	18.2%	18.5%	18.6%	18.6%	18.3%	17.7%	17.4%	16.7%	16.0%	15.8%	15.5%	15.3%	14%			
Unplanned Turnover Rate	13.6%	13.9%	14.2%	14.3%	14.0%	13.7%	13.3%	12.8%	12.2%	12.3%	12.0%	11.7%	8%			
Starters Headcount	45	50	76	120	85	49	46	90	65	63	77	51				
Leavers Headcount	46	66	69	78	48	37	41	42	33	65	50	40				
Stability Rate	83.6%	82.9%	83.6%	83.3%	83.0%	84.0%	83.9%	84.4%	84.5%	86.0%	85.2%	85.3%				
Sickness Rate	4.7%	5.2%	4.7%	4.6%	4.9%	5.4%	5.7%	5.0%	4.9%	5.0%	4.4%	4.4%	4%			
Training Compliance Rate	91.2%	91.2%	93.1%	92.3%	92.5%	92.7%	93.0%	92.7%	92.9%	87.6%	89.0%	90.0%	92%			
Appraisal Rate	84.5%	85.3%	84.6%	83.8%	85.1%	85.5%	85.0%	85.6%	84.7%	85.9%	86.3%	85.1%	95%			
Bank Spend	£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	£2,216,972	£2,502,377				
Agency Spend	£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	£1,075,919	£1,059,957				

This report sets out the Trust's performance against key workforce performance indicators for Month 2 of 2023/4 (May 2023). The report highlights that:

- Despite our establishment increasing again in Month 2, our vacancy rate reduced as a result of continuing strong recruitment and retention performance.
- However, registered nursing, medical and AHP staff remain the most challenging areas for recruitment and retention. The Recruitment and Retention Group is undertaking deep dives into all three to ensure robust actions continue to address the challenges.
- Whilst Agency spend has reduced by 1.5% since April, both Bank and agency spend remains high. The Financial Recovery Board and Agency Panel are proactively reviewing all agency use to ensure this ceases where possible.
- Mandatory training rates increased again in Month 2, whilst appraisal compliance reduced; Weekly reporting to SBUs has been stood up to increase momentum on improvement to achieve target compliance by end Q1.
- Our overall staff development offer continues to be strong with a further enhanced offer available from Q3
- Whilst overall absence rates are lower than we have seen for a year, mental ill health related absence is increasing. Alternative funding streams for our wellbeing offer are being explored to ensure we can continue our robust offer.

2. Retention


Unplanned Turnover Rate
15.0%
14.0%
13.0%
12.0%
11.0%
10.0%
9.0%
8.0%
7.0%
F
H
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
01/10/20
01/12/20
01/02/21
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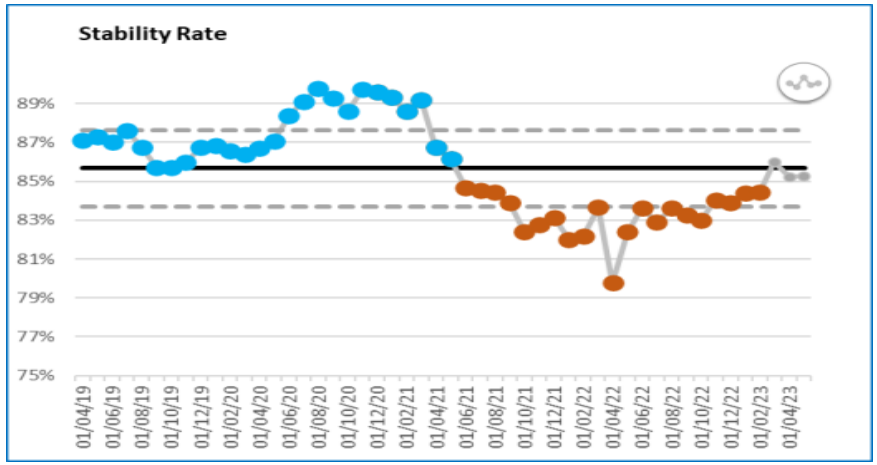
01/04/23


Stability Rate
89%
87%
85%
83%
81%
79%
77%
75%
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
01/10/20
01/12/20
01/02/21
01/04/21
01/06/21
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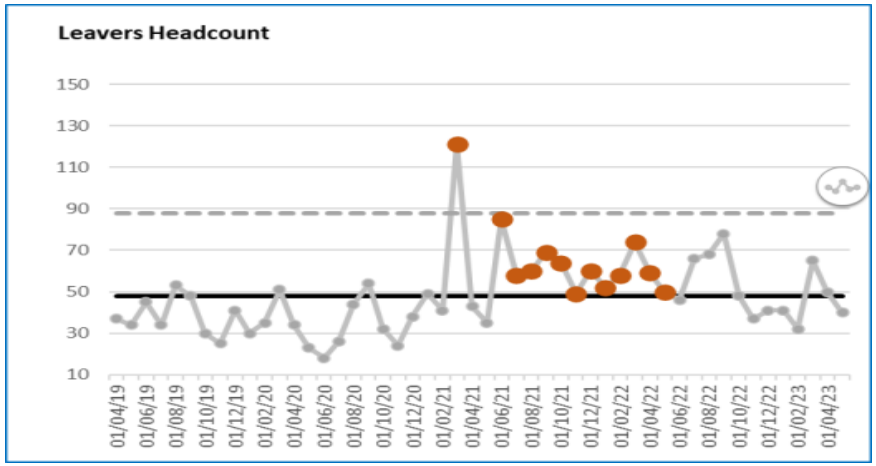
01/12/22
01/02/23
01/04/23


Leavers Headcount
150
130
110
90
70
50
30
10
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
01/10/20
01/12/20
01/02/21
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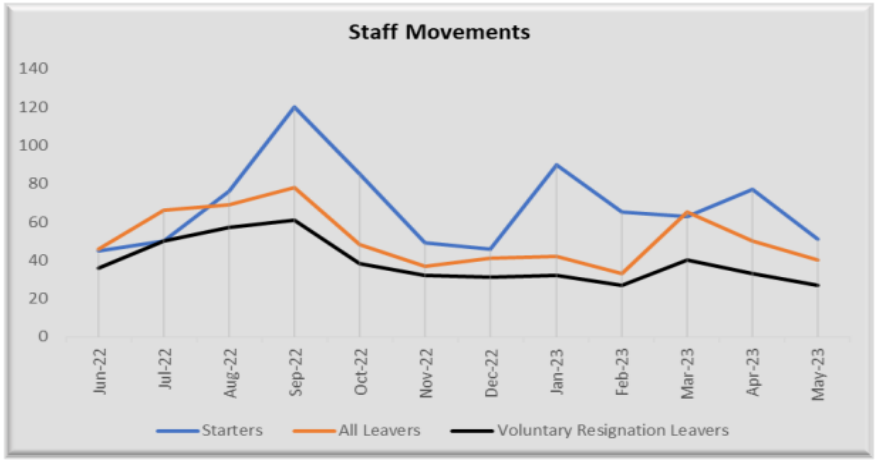
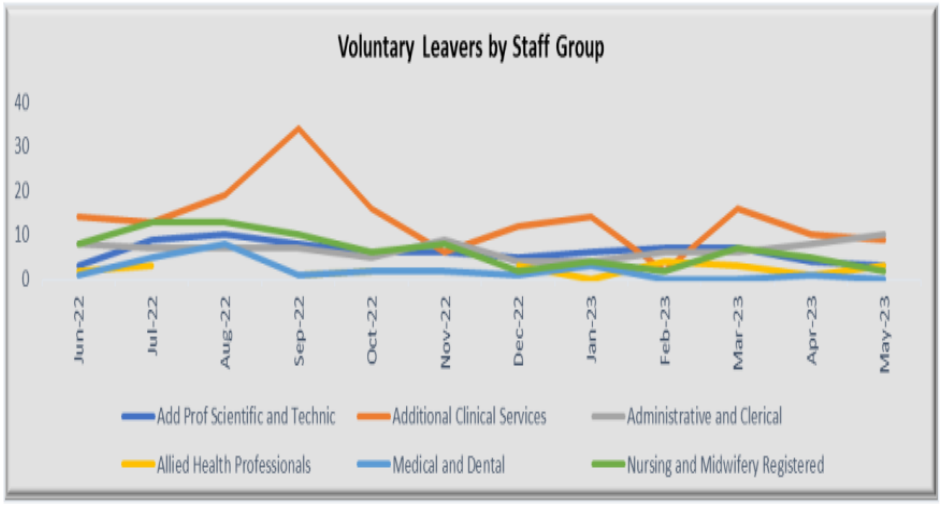
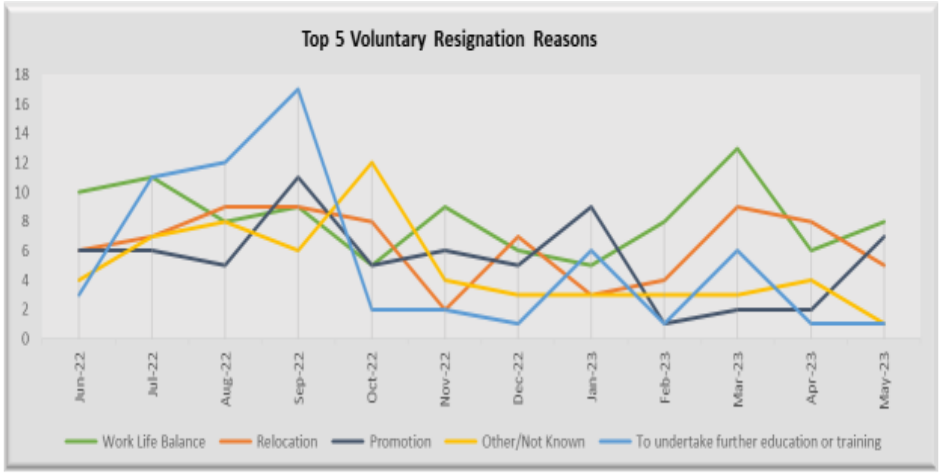
01/04/23


Staff Movements
140
120
100
80
60
40
20
0
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Starters
All Leavers
Voluntary Resignation Leavers

2. Retention





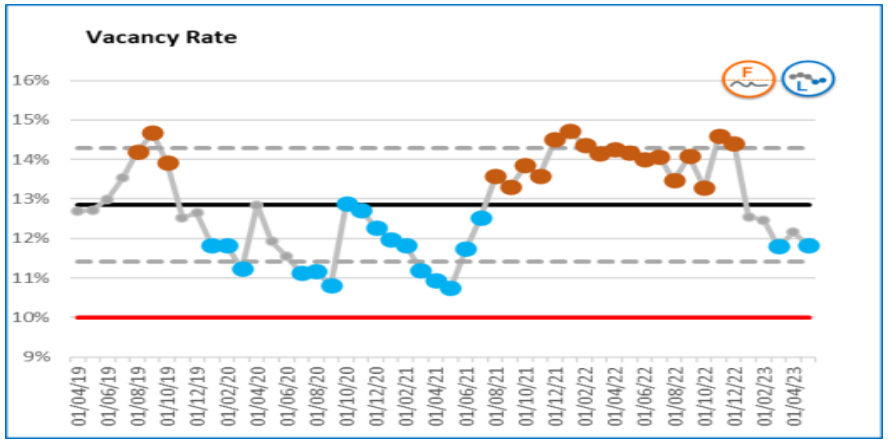
Retention has continued to improve since the end of Q2 of last year. In Month 2, it fell from 12% in April to 11.7%. Leaver rates across all staff groups have reduced.

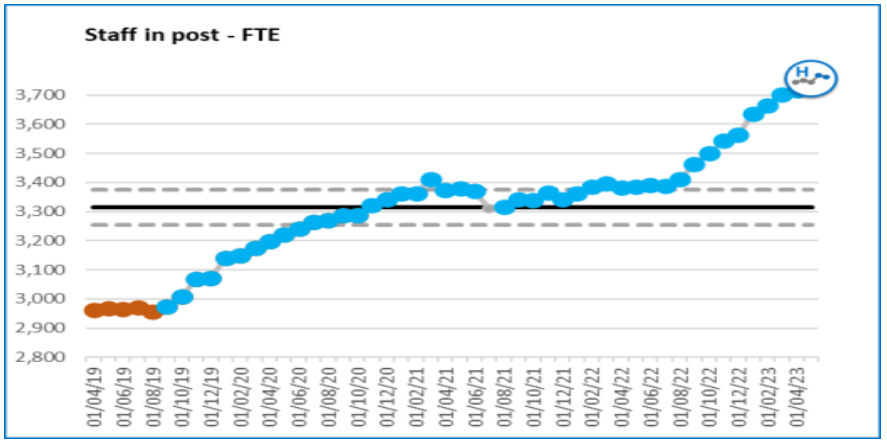
The People and OD Group and Recruitment and Retention Group have refreshed retention plans for 2023/4, centring around the Trust's annual plan key areas of:

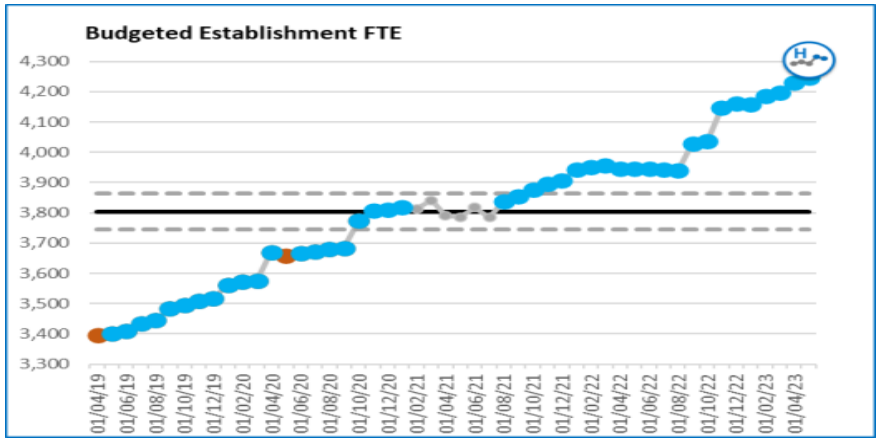
- Belonging and inclusion
- Talent management
- Collective leadership
- Resetting our fundamental standards of people management

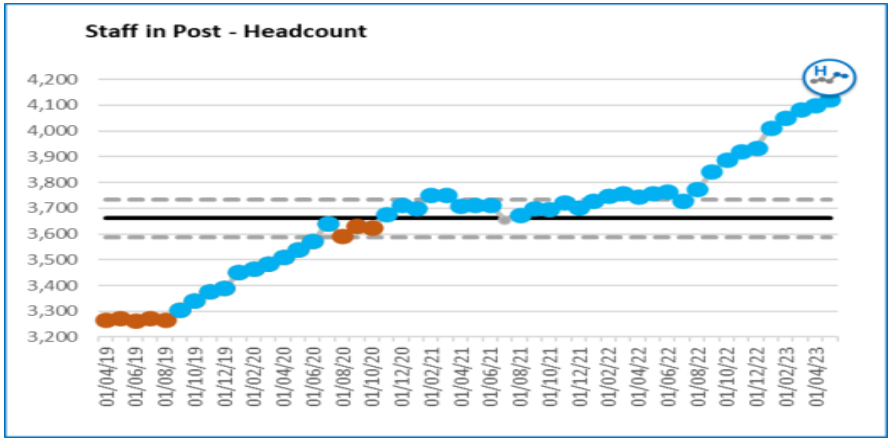
These are supported by our ongoing engagement with staff, together with our wellbeing offer, benefits and staff reward and recognition.

3. Recruitment

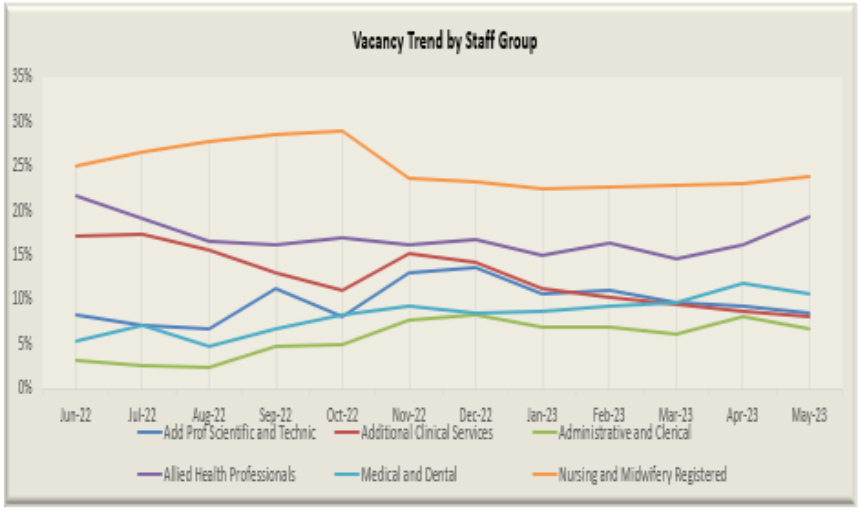








3. Recruitment



The net impact of new starters, leavers and an increase in establishment achieved an improved vacancy rate, reducing from 12.2% in April to 11.8% in May.

Vacancy rates in our key staff groups are:

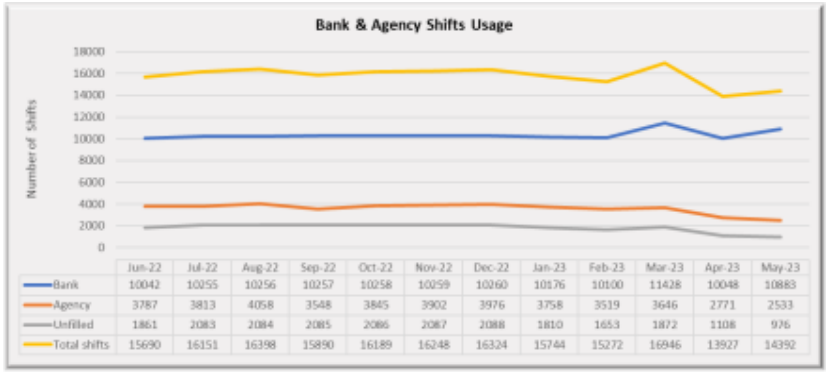
- Registered nursing – 23.87 % (up from 23.13% in April) (although staff in post increased by 3.5 FTE, this did not reduce our vacancy rate as our establishment increased by 3.5 FTE). We are actively recruiting to 281 nursing roles against 234 vacancies and an 11% nurse turnover rate. International recruitment remains a key part of our recruitment strategy, which requires further investment to ensure its success.
- AHPs –19.4% (increased from 16.2% in April). Although turnover reduced by 0.2% in May to 12.7% our establishment increased by 6 FTE and our staff in post reduced by 1.5 FTE, resulting in an increased vacancy rate.
- HCSWs – 3.4% (reduced from 4.8% in April). The establishment reduced by 2 FTE, turnover reduced further to 9.4% and there was a net increase in staff in post of 7 FTE as a result of targetted recruitment campaigns run in Quarter 4 of last year, thus reducing vacancies to 21.5 FTE.
- Medical staff – 36 medical vacancies; 16 are Consultant vacancies (2 ready to start); 20 are Specialty Doctor vacancies (4 at offer).

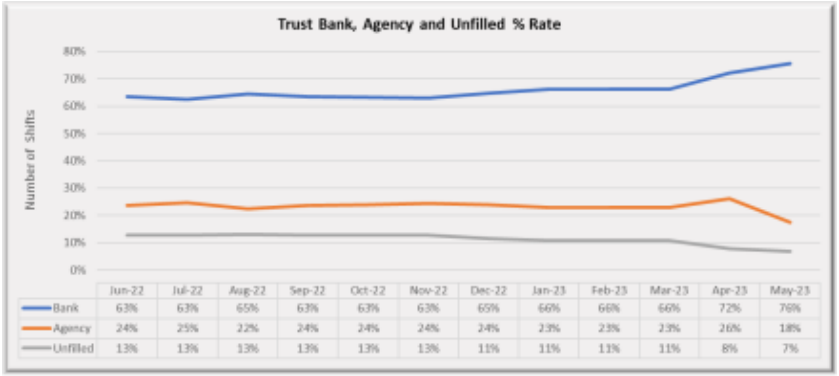
Our key recruitment metrics are as follows:

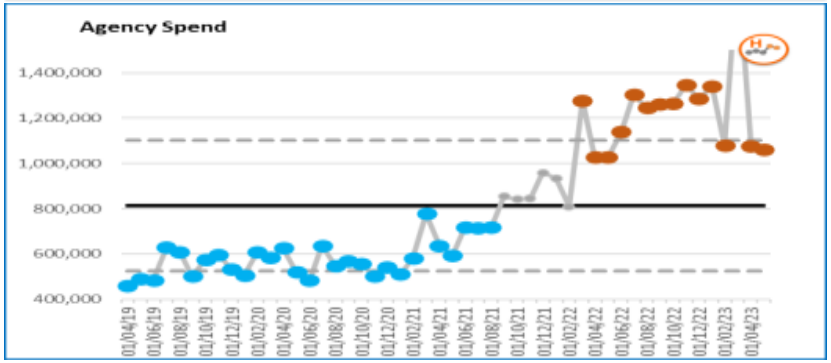
- Recruitment pipeline of 857 FTE posts (up from 830 FTE posts in April), 54% of which (459 FTE) are in the firm offer/starting phase.
- Our time to hire has further improved from 57.7 days to 53.1 days, following a deep dive to identify bottlenecks and provide targeted support and training to SBUs as well as recruiting to our full establishment within the recruitment team to increase capacity.

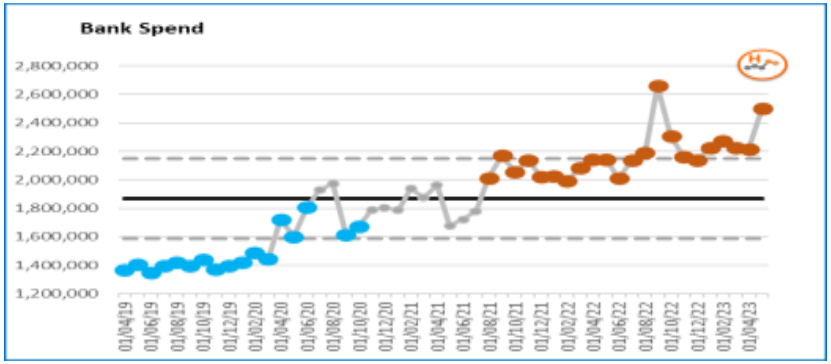
The Recruitment and Retention Group and People and OD Group monitor our recruitment metrics to ensure ongoing improvement.

4. Temporary Staffing



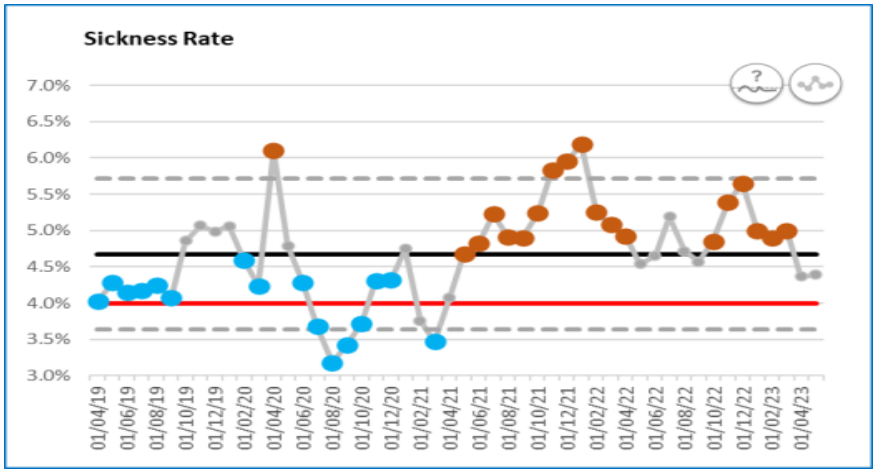


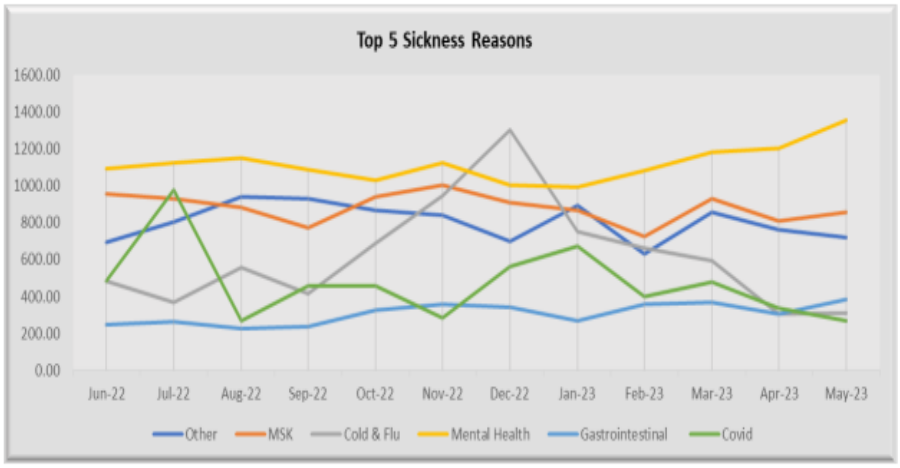




- Bank spend has increased from £2.2m to £2.5m and fill rates improved by a further 4% to 76%, the highest for over a year.
- Although overall temporary staffing demand increased, agency spend reduced from £1.1m to £1.06m, the lowest for over a year.
- 79% of agency HCSW use was for observations duties, whilst 12% was to cover vacancies and 4% to cover sickness. Agency HCSW use in inpatient services has now been ceased across the Trust, except in Norfolk and for observations for one service user in Essex.
- 83% of registered nurse agency use is to cover vacancies, whilst 11% is for observations, 2% is to cover authorised leave and 2% to cover sickness.
- All agency posts which are unadvertised ave been identified and recruitment plans for each role are being devised.
- The Financial Recovery Board and Agency Panel are scrutinising all agency spend, developing a trajectory for improvement and monitoring the impact of actions.

5. Health and Wellbeing





- Sickness absence remained at 4.4% in May. Whilst most absences reduced, mental ill health related absence increased to the highest level since March 2022.
- A deep dive has revealed the vast majority of mental ill health related absence is not work-related. However, further work is being undertaken to explore hot spot areas and staff groups. The Trust is currently reviewing the Here For You offer and continues to offer a comprehensive range of support for our staff.
- Whilst previous funding may not be available to implement a full psychologically informed approach to wellbeing this financial year, we recognise the need to identify additional funding sources especially as we expand our workforce to include greater numbers of people with lived experience of mental ill health.
- New funding sources are being explored to continue our core programme of wellbeing activities into 2023/4 as part of ill health prevention, such as mindfulness sessions, as well as our ability to carry out a wellbeing festival this year, which has been running twice a year in recent times and has proved positive in relation to morale, engagement and wellbeing.
- The People and OD Group continues to monitor the impact of our wellbeing plans. To date our work on self care has led to improvements in our annual staff survey results and pulse survey results.

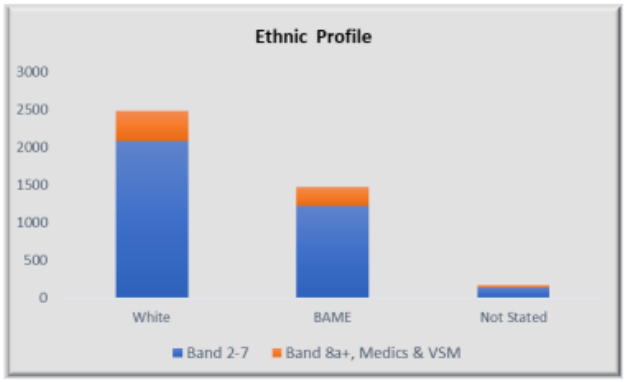
6. Employee Relations

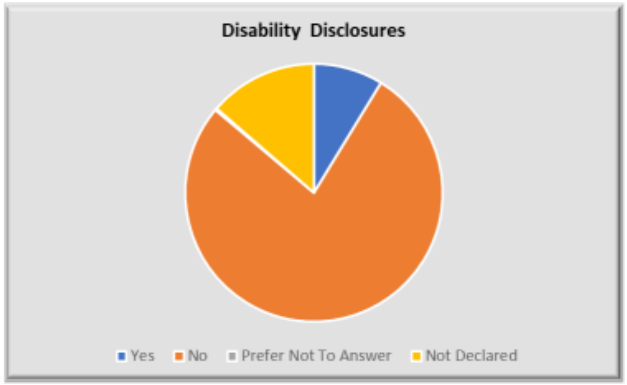
Disciplinary Cases		0 - 5 working days	6 – 10 working days	11+ working days	Notes
	Fact Find (7) (Date incident notified to date referred to decision making panel)	2		5	
	Fact Find Outcome (15) (Date decision making panel outcome to date investigation commences/letter of concern/other outcome notified to employee)	1	2	12	
		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
	Suspension		1	3	
	Alternative Duties	5		5	
	Formal Investigation (6) (Date investigating manager appointed to date investigation report sent to commissioning manager)	2	1	3	
		0 - 5 working days	6 – 10 working days	11+ working days	Notes
	Commissioning Manager Review (Date investigation report sent to commissioning manager to date employee notified of outcome)	2		4	
		0 - 7 weeks	8 - 12 weeks	13+ weeks	Notes
	Formal Hearing Stage (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 Appeal being rescheduled
TOTAL DISCIPLINARY MATTERS		33			

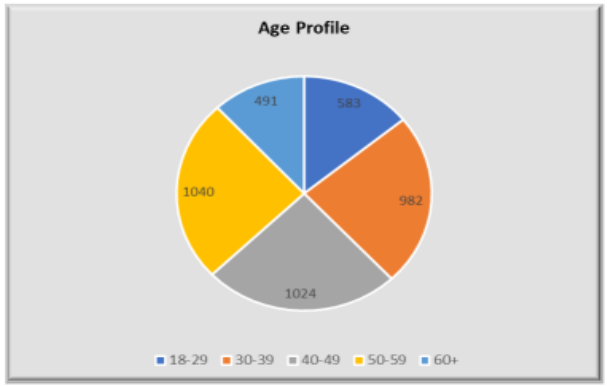
Medical Cases		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
	Medical Conduct			1	
		No. Cases			
	Medical Capability				
TOTAL MEDICAL CASES		1			
Grievances		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
	Informal Grievance		3	2	
	Formal Grievance	4		1	
TOTAL GRIEVANCE CASES		10			
Capability Cases		No. Cases			
	Informal Capability Management	0			
	Formal Capability Management	2			
TOTAL CAPABILITY CASES		2			
TOTAL OTHER CASES		1			
TOTAL EMPLOYMENT TRIBUNAL CASES		4			
TOTAL EMPLOYEE RELATIONS CASES		48			

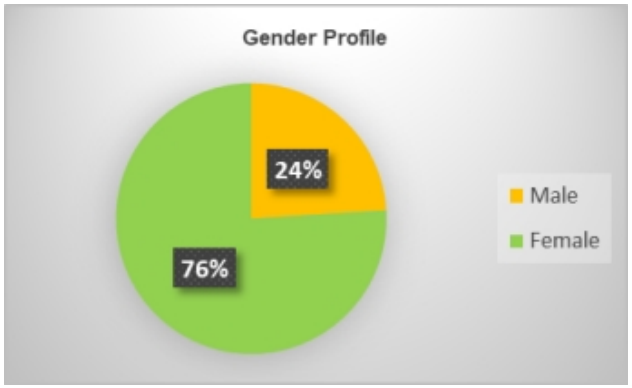
- There were 33 (reduced from 34) conduct matters being supported by the ER team in May, 6 of which were live formal investigations.
- The one medical conduct matter is due to be concluded in early July.
- Formal hearings are now being arranged in advance to avoid delay and there is increased SBU level scrutiny, as we implement the ER reset action plan agreed by the Executive Team in March. However, legacy cases continue to be reflected in the data as these are progressed.
- Suspensions remain at 4.
- Grievance cases have reduced from 11 in April to 10 in May
- There remain 4 employment tribunal cases, 2 of which are from the same claimant.

7. Equality and Inclusion



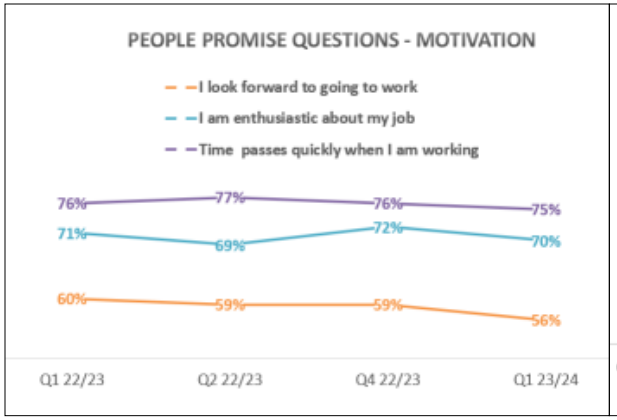


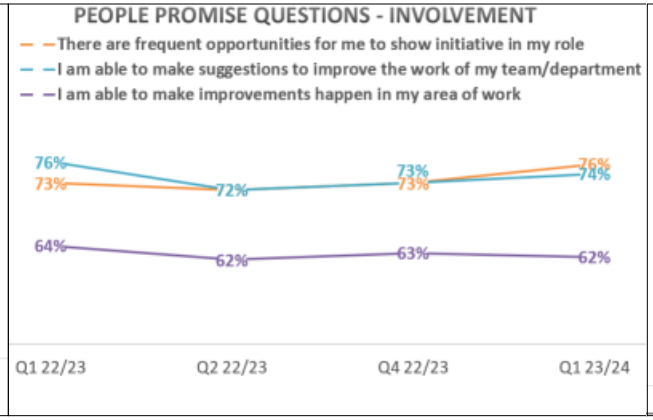


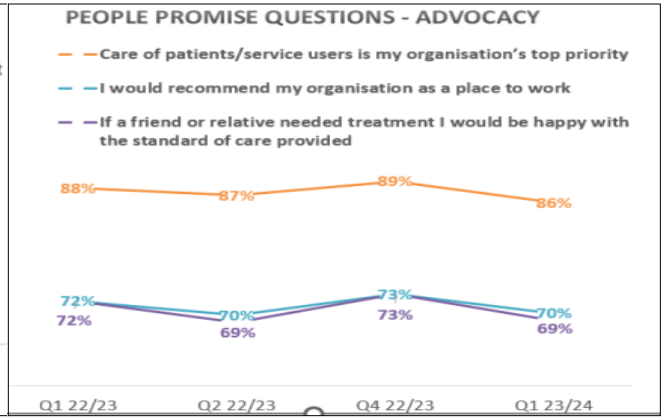


- The co-produced Belonging and Inclusion Strategy is currently being finalised.
- The strategy will be complemented by a comprehensive action plan which will:
    - Embed zero tolerance to discrimination across the Trust
    - Deliver a compassionate and caring teams programme aligned to our values
    - Implement inclusive, compassionate leadership development
- The strategy and action plan will address underrepresentation in our workforce and resolve the differing experience of staff in performance management, development and career progression so that every person feels a strong sense of belong and inclusion.

8. Q1 Pulse Survey







Overview & National Benchmarking:

NQPS scores	Data period	Provider value	Peer average	National value	National value method	Chart
Employee Engagement score	Q1 2023/24	7.2	6.7	6.5	Provider median	
Advocacy score	Q1 2023/24	7.4	6.5	6.4	Provider median	
Involvement score	Q1 2023/24	7.0	6.7	6.4	Provider median	
Motivation score	Q1 2023/24	7.2	6.9	6.8	Provider median	

There were 839 respondents to the Q1 pulse survey, a response rate of 17% (same as Q4). The highest response rate was in Corporate, with the lowest in West SBU.

Our overall results, including our staff engagement scores, remain high and higher than our national benchmarked peer groups. They also remain consistent with previous survey results.

Summary:
Our Q1 survey results remain very positive compared to the picker average for the core questions and there has been little change in the Trust overall scores since Q4.

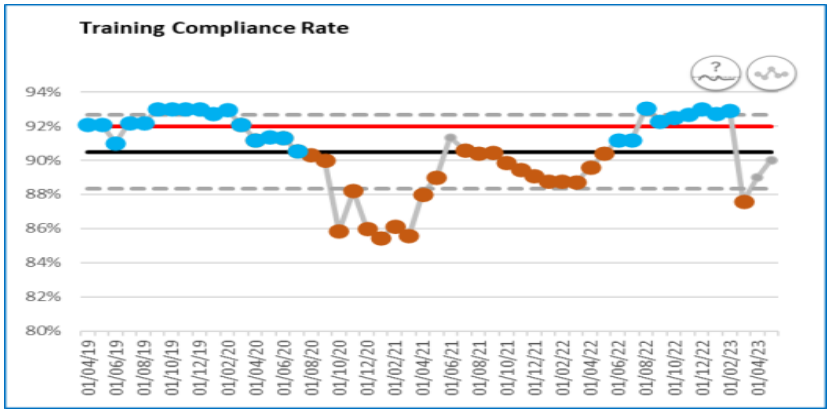
The Trustwide areas of concern remain consistent with previous reports and the actions we have put in place. This includes:

- Giving feedback to colleagues not demonstrating our values (Significant decrease of 5% compared to Q4)
- BAME staff reporting a worse overall experience than White Staff, particularly in discrimination and bullying and harassment
- Managers giving feedback on work – however, there has been a significant positive increase of 5% compared to Q4

9. Staff Development – Mandatory Training

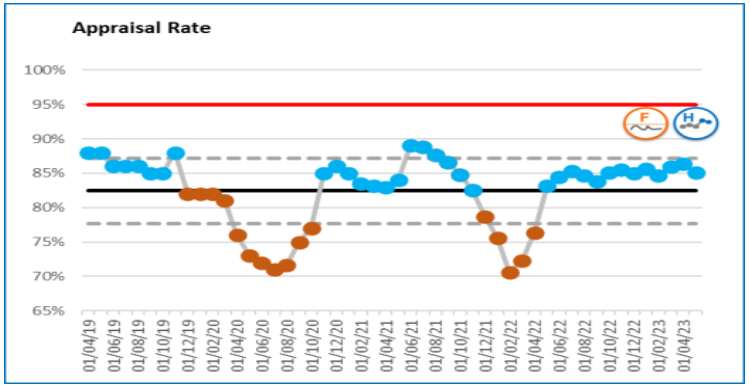
eLearning	Apr-23	May-23
Administration of Medicines M & C [3 Years]	85%	83%
Administration of Medicines RNs and Nas	94%	95%
Clinical Risk Assessment and Management [3 Years]	95%	95%
Complaints [None]	98%	98%
Data Security Awareness [1 Year]	91%	92%
Equality, Diversity & Human Rights [3 Years]	96%	96%
Fire Safety [1 Year]	93%	94%
Fire Safety [2 Years]	93%	93%
Food Hygiene [3 Years]	89%	90%
Health, Safety & Welfare [3 Years]	96%	96%
Infection, Prevention & Control Level 1 [2 Years]	93%	94%
Infection, Prevention & Control Level 2 [2 Years]	94%	94%
Ligature Awareness [3 years]	96%	97%
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	93%	93%
Mental Health Act [3 Years]	94%	94%
Moving and Handling L1 [3 Years]	95%	95%
Physical Health	93%	94%
Preventing Radicalisation Basic	62%	74%
Preventing Radicalisation Level 3	57%	68%
Safeguarding Adults Level 1 [3 Years]	97%	97%
Safeguarding Adults Level 2 [3 Years]	94%	94%
Safeguarding Adults Level 3 [3 Years]	90%	91%
Safeguarding Children Level 1 [3 Years]	97%	97%
Safeguarding Children Level 2 [3 Years]	94%	94%
Safeguarding Children Level 3 [3 Years]	96%	95%

Face to Face Training	Apr-23	May-23
BLS	85%	83%
ILS	82%	83%
PBLS	84%	29%
Advanced M&H	76%	81%
Basic M&H	83%	83%
Respect 3a	95%	95%
Respect Level 3b	72%	73%
Respect Level 4	80%	78%
Respect Level 4/5 (Norfolk)	88%	89%
Respect Level 5	74%	74%



- Mandatory training compliance has improved from 89% to 90%
- Compliance dipped below our target of 92% in March as a result of new mandatory training on Preventing Radicalisation being rolled out nationally with a relatively short implementation timeframe, replacing previous training.
- PBLS training compliance has reduced significantly due to a large number of staff being added to the requirement. Ad hoc sessions are running to increase compliance.
- Additional courses have been put on to increase compliance for Respect Modules 4 and 5 with a proposal of combining sessions to increase compliance.
- A new venue for respect level 5 training has been identified to reduce the training backlogs and enable staff to take up their role fully and promptly.
- Preventing radicalisation training compliance has improved since last month, however, continues to require significant improvement.
- 813 staff attended face to face training sessions in May
- Regular reporting of compliance is received by SBUs and corporate services together with course availability reporting.
- The People and OD Group maintains oversight on compliance.

9. Staff Development - Appraisal, Induction & CPD



- Appraisal compliance remains at 86%
- The new appraisal window opened at the start of April 2023 and runs until the end of July, when all staff must have been appraised.
- The new Appraisal App launched in March 2023 to enable us to:
  - Update compliance in real-time
  - Carry out detailed training needs analysis to inform the development offer for staff
  - Carry out detailed talent management and succession planning at all levels of the Trust
- 42% of staff have so far received an appraisal during the April – July window. Compliance reporting is now taking place weekly to ensure that all staff receive an appraisal before 31 July 2023.
- The People and OD Group will continue to monitor compliance.

Simulation Hub

- 89 staff attended simulation hub training from HPFT and partners across training on: Physical Health & Mental Health (PH/MH) Self-Harm & Suicide Prevention (Safety); PH/MH Delirium & Infections; PH/MH Substance & Alcohol Abuse; Suicide Prevention; Coroner's Inquest (MRCPsych)
- Pilot of 'Medical Emergencies' training to launch at junior doctor induction in August
- All feedback from delegates was excellent

School Liaison

- 4 young people from across Hertfordshire schools participated in work experience in May. 8 more are expected in June and July.
- Feedback included: "Made me more sure of wanting to become a psychologist. Lots of fun, everyone was lovely." and "Encouraged me more to want to become a Mental health Nurse"
- Team member is an Enterprise Advisor for Marlborough School in St Albans, working closely to support them achieving their Gatsby Benchmarks
- Participating in local careers fairs

Induction

- 57 staff attended in May
- Session rated 4.7/5
- Onboarding experience rated 4.5/5

New Care Training

- Personalised Care Support Planning Training has been coproduced and launces in June.
- Depression pathway training across the ICS has been coproduced and will launch in September

Continuing Professional Development

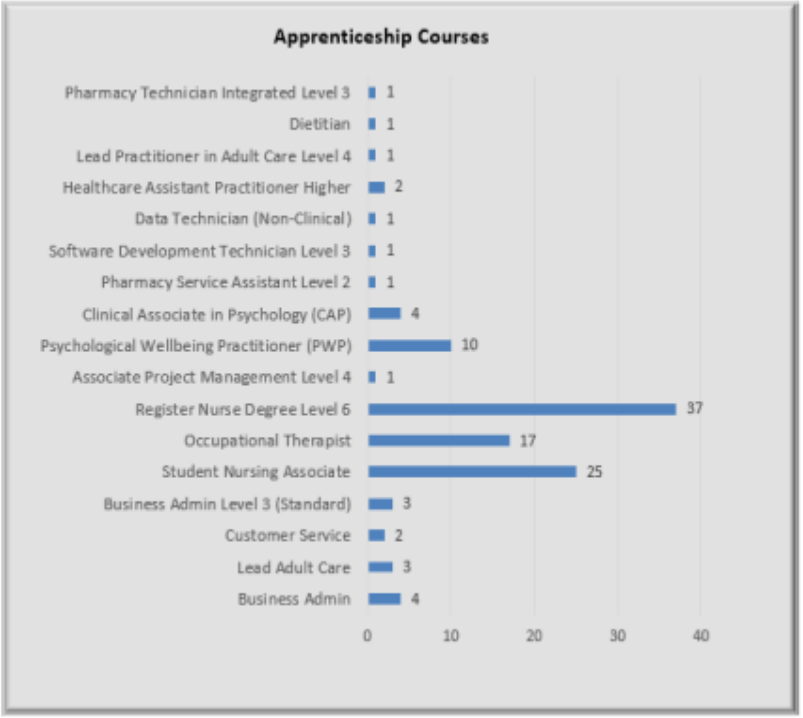
- HPFT awarded £320k by NHSE for CPD; appraisal app and consultation with heads of professions to identify training needs and plans
- Planning is taking place for our staff awards to take place in the Autumn

Medical Education

- 154 attendees at the May CPD session "10 "Truths" about suicide" delivered by the Chair of the Royal College of Psychiatrists Working Group on the effect of suicide and homicide on psychiatrists
- 353 attendees at our May Academic Teaching Programme sessions
- 126 attendees at the MRCPsych Teaching sessions
- 16 attendees at the SAS Development Day workshops to refresh knowledge on ECG
- HPFT hosted the Intellectual Disability Conference in May which was presented by renowned Intellectual Disability Consultant Psychiatrists from across the UK and generated £1300 in income

9. Staff Development - Apprenticeships

Levy Pot	
Current Funds	£1,640,063
Funds spent since Jun 22	£637,056
Estimated spend for the next 12 months	£579,772
Funds Expiring in Jun 23	£11,943



- We have 114 apprentices in May, compared to 107 in April.
- Whilst we are growing our apprenticeships, we continue not to fully utilise our levy pot. Work has started to ensure the apprenticeship pipeline is embedded within our early careers strategy, aligned to our vacancy profile and fully optimised in terms of funds utilisation.
- In addition to our apprentices, we have increased our qualified Professional Nurse Associates (PNAs) to 27. PNAs carry out restorative supervision sessions, career conversations and support improvement projects.
- We have 2 Mental Health and Wellbeing Practitioners (MHWPs) part way through their 12-month training and 13 more have recently started their training with us.
- We continue to provide in-house functional skills training to support people to undertake apprenticeships. Cohort 3 will commence in September.
- 4 staff have been accepted onto a three-year Social Worker Apprenticeship programme starting in September, which is a first for the Trust.
- The community transformation programme is expected to create further opportunities to expand our apprenticeships.
- The Trust has part funded 8 members of staff to undertake an Open University Registered Learning Disability nurse degree programme as direct action to improve the pipeline in Norfolk and Essex.

10. Conclusion

The key headlines from Month 2 (May) are as follows:

- Vacancy rates have improved, despite an increase in establishment, however, they remain higher than our target level of 10%. Retention has also improved further and there is a healthy 857 FTE recruitment pipeline, which means we are confident we will see a net positive impact through Q2.
- The Recruitment and Retention Group and People and OD Group are monitoring performance and overseeing implementation of our refreshed recruitment and retention plans for 2023/4 which will target the nurse recruitment pipeline and the potential increase of international nursing.
- Agency use mapped against recruitment activity is being scrutinised by the Agency Panel and Financial Recovery Board to generate clear trajectories to achieve the 2023/4 Trust targeted agency spend.
- The co-produced Belonging and Inclusion Strategy is being finalised and the supporting action plan will be implemented with ambitious targets for improvement across all workforce metrics which will be further developed to identify difference between our different staff groups through Q2.
- Formal employee relations cases remain low and we are seeing the impact of our action plan to re-set the approach to ER matters start to have an impact, albeit that some legacy cases will continue to be reported.
- Appraisal rates are a focus, with planned actions in place to achieve full compliance by the end of July 2023.
- Mandatory training rates are recovering following the introduction of two new training modules nationally, having improved from 89% to 90%, with additional work being undertaken to increase compliance further.
- Our staff development offer remains strong. A further enhanced offer will be developed in Q2 and launched in Q3, based on detailed training needs analysis from our new Appraisal App.

The People and OD Group continue to monitor and oversee plans to continue improvements against each of the workforce key performance indicators.

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PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 11b
Subject:	Guardian of Safe Working Hours Annual Report	**For Publication:** Yes
Author:	Dr Dinal Vekaria, Guardian of Safe Working	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Prof Asif Zia, Executive Director Quality & Medical Leadership	

Purpose of the report:

To share with the Board the Guardian of Safe Working Hours Annual Report 2022 – 2023.

Action required:

The Board are asked to RECEIVE the report.

Summary and recommendations to the Board:

Attached is a report from the Guardian of Safe Working which sets out the exception reports received in the period and work underway to support the wellbeing of Junior Doctors.

Relationship with the Business Plan & Assurance Framework:

Summary of Implications for:

Equality & Diversity and Public & Patient Involvement Implications:

Equality, diversity and inclusion plays a major role in our plans to support and train Junior Doctors, to help retain staff and improve wellbeing and morale.

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

The Integrated Governance Committee receives quarterly reports from the Guardian of Safe Working

as One

Our Values
Welcoming Kind Positive Respectful Professional

Guardian of Safe Working Hours Report

OVERVIEW June 2022 - June 2023 (all individual quarterly reports are also available)

1. Executive summary

1.1 This report provides a review of Guardian of Safe Working for the period June 2022 to June 2023, noting that the Integrated Governance committee has received quarterly updates throughout 2022/23.

1.2 During this period there were 14 exception reports raised by our Junior Doctors.

1.3 The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process. All junior doctors including Trust doctors have the ability to submit exception reports. To raise awareness around Exception reporting, a joint presentation by Medical Human Resources and Guardian was carried out at every induction for new doctors, showing the process.

1.4 In addition, the Guardian has attended monthly Junior Doctor Forums to raise the profile and also asked for trainee reps to circulate information re: Exception reporting and how to escalate on Whatsapp Groups (which are much more likely to be read over “another email”).

2. High Level Data for Junior Doctor posts

2.1 During this period, there have been a range of between 89 – 103 Junior doctors (including Trainees/ LTFT/ Trust doctors) in post.

2.2 The 1st on call rota frequencies were all 1 in 12 and 1 in 13. The 2nd on call rota was 1 in 13 with 4 Specialty and Specialist (SAS) doctors underpinning.

2.3 The table below provides details on the junior doctors in post for the period Dec 2022 to end of March 2023 across the grades.

Figures for December 2022 to end March 2023

FY1	13	CT	30
FY2	9	ST	23
GP Int	6	LAS CT	2
GP	17		
Total	45	**Total**	55
		Overall Total	100

3. Exception Reports

3.1 The main themes for the exception reports received in this period relate to staying longer over the shift end. The concerns were resolved with time off in lieu and liaison with clinical supervisors.

3.2 Over the last 6 months, there has been an increase in types of Exception reporting relating to service provision, for example cross covering doctors on wards and covering for occasional lack of Psychiatric Liaison Team input. On each occasion, the clinical supervisor has been informed and met with trainee, and Guardian has had oversight of the work to resolve.

4. Work Schedule Reviews

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

5. Fines

5.1 No fines were issued during this period

6. Benchmarking

6.1 The Trust has benchmarked itself against other mental health trusts. This information indicates that that the Trust has a lower rate of exception reports than its peers.

7. Wellbeing

7.1 Over the last year, especially since the pandemic, there has been a lot of collaborative work between the Trust Management, Education Leads and Guardian of Safe Working.

7.2 The junior doctor accommodation and out of hours facilities have been updated and improved.

7.3 There is regular prioritisation of educational/training needs with juniors encouraged to report if they cannot attend Training due to clinical overload.

7.4 Funded and supported awaydays held together with consultants.

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PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 12
Subject:	May 2023 Operational Performance Update	**For Publication:** Yes
Author:	Sally Wilson, Head of Performance Improvement	**Approved by:** Hakan Akozek, Director of Innovation and Digital Transformation; Chief Information Officer
Presented by:	David Evans, Executive Director Strategy and Partnerships	

Purpose of the report:

This report provides an overview of the Trust's operational performance against the Single Oversight Framework, Access and Safe and Effective key performance indicators at the end of May 2023. The report also includes an update on the actions being taken to improve performance in key areas in these domains.
Separate reports are provided to the Trust Board on financial and workforce performance.

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:

At the end of May, 69% (37/54) of our Key Performance Indicators across the three operational performance domains 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
- Ensuring that service users discharged from our inpatient units receive a follow-up within 48 hours.
- Gatekeeping assessments for service users referred for inpatient admission to ensure they are supported in the most appropriate care setting
- Starting treatment for psychosis within 14 days of first diagnosis
- Talking Therapies (a.k.a IAPT) clients being seen within the 6 and 18-week targets and moving into recovery
- Children and Young People needing a crisis assessment being seen within 4 hours
- Children and Young People needing assessment by the Targeted Team being seen within 28 days.
- 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 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, we are still seeing service users waiting longer than 28 days from referral to initial assessment. We continue to provide additional resources for initial assessments and address

vacancy hotspots in teams to improve our performance. Demand and capacity work is underway as part of the wider transformation programme, to maximise the flow through and capacity of our services.
We expect to recover the performance for Children and Young People in Quarter 2 and for Adult services in Quarter 3.

- Demand and acuity in our inpatient pathways and delays in discharging service users who are ready to be discharged continues to result in an increased number of service users being admitted to out of area placements. 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.
  We expect the actions we have put in place to reduce our delays and inappropriate out of area bed utilisation to the agreed levels in Quarter 4
- 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.
  The service remains on track to recover performance in Quarter 3.

Details of the actions we are taking to 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. The colours and graphics adopted in this report use the standards developed by NHSI/E to make the report more accessible to a wider audience.

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

The report includes all operational performance targets reportable May 2023.

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

Executive Team – 28th June 2023

May 2023 Operational Performance Update

1. Background

1.1. This report provides an overview of the Trust's operational performance against the Single Oversight Framework, Access and Safe and Effective key performance indicators at the end of May 2023. The report also includes an update on the actions being taken to improve performance in key areas in these domains.

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.

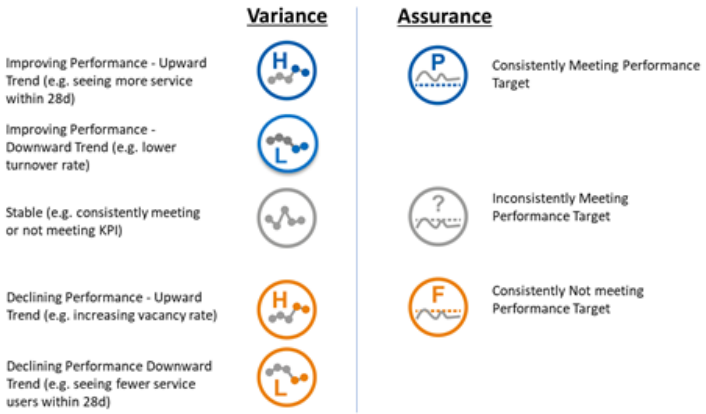


Figure 1 – SPC Icons

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. May 2023 Performance Summary

2.1. The first two months of 2023/24 we continued to see :

- Sustained 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.

2.2. Key areas of strong performance during this period include:

- Assessing people in A&E and acute hospital wards within 1 hour and 24-hour targets
- Ensuring that service users discharged from our inpatient units receive a follow-up within 48 hours.
- Gatekeeping assessments for service users referred for inpatient admission to ensure they are supported in the most appropriate care setting
- Starting treatment for psychosis within 14 days of first diagnosis
- Talking Therapies (a.k.a IAPT) clients being seen within the 6 and 18-week targets and moving into recovery
- Children and Young People needing a crisis assessment being seen within 4 hours
- Children and Young People needing assessment by the Targeted Team being seen within 28 days.
- 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

2.3. 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, we are still seeing service users waiting longer than 28 days from referral to initial assessment. We continue to provide additional resources for initial assessments and address vacancy hotspots in teams to improve our performance. Demand and capacity work is underway as part of the wider transformation programme, to maximise the flow through and capacity of our services.
  We expect to recover the performance for Children and Young People in Quarter 2 and for Adult services in Quarter 3.
- Demand and acuity in our inpatient pathways and delays in discharging service users who are ready to be discharged continues to result in an increased number of service users being admitted to out of area placements. 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.
  We expect the actions we have put in place to reduce our delays and inappropriate out of area bed utilisation to the agreed levels in Quarter 4
- 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.
  The service remains on track to recover performance in Quarter 3.

3. Single Oversight Framework

3.1. The NHS oversight framework has gone through significant changes with majority of the key performance indicators now being monitored at Integrated Care Board level. The Trust continues to monitor the only Trust level Mental Health indicator (inappropriate out of area placements) as well as five other indicators as part of this domain. At the end of May the Trust has met five out of six key performance indicators in this domain.

3.2. Our Talking Therapies (IAPT) services continue to meet 6 and 18 week targets for treatment and are achieving recovery milestones.

3.3. Inappropriate out of area placements occur when people are admitted, often in crisis, and there is no suitable local bed available. At the end of May, our inappropriate out of area bed

utilisation remains higher than plan due to ongoing high demand for inpatient services. 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 May position for our Single Oversight Framework key performance indicators. Details of actions we are taking to improve our performance as can be found in Appendix 1.

Single Oversight Framework	Month	Performance	Target	Variation	Assurance	Mean
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (National)	May-2023	67%	60%			78.8%
Data Quality Maturity Index (DQMI) – MHSDS dataset score (National)	Feb-2023	97%	95%			96.1%
Improving Access to Psychological Therapies (IAPT)/talking therapies Proportion of people completing treatment who move to recovery (National)	May-2023	53%	50%			52.7%
Improving Access to Psychological Therapies (IAPT)/talking therapies - 18 weeks (National)	May-2023	100%	95%			100%
Improving Access to Psychological Therapies (IAPT)/talking therapies Waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks (National)	May-2023	93%	75%			95.9%
Inappropriate out-of-area placements for adult mental health services (National)	May-2023	980	849	N/A	N/A	916.7

Table 1 – Single Oversight Framework KPIs

4. Access

4.1. At the end of May, the Trust has met 14 out of the 24 access key performance indicators and almost met two more.

4.2. Response times for our Mental Health Liaison Teams, supporting the Acute Hospitals, remain strong. Our Single Point of Access Service has further improved the time taken to triage assessments and move people on to the teams where they will receive assessment and treatment. Access times in the majority of our CAMHS services have maintained improvement and are meeting target.

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. As part of our Recovery Programme we have seen significant improvement across a number of measures in Children and Young People's services. We continue to focus on recovery in Adult Community, CAMHS and EMDASS services. However, ability to recruit into key roles in some of the geographical areas continues to present a risk to recovery.

4.4. Our Adult Crisis and Home Treatment Service is currently using manual process for recording and reporting against the contractual four-hour response target. We are implementing a digital solution in Quarter 2 for this service in preparation for the anticipated new national targets.

4.5. The table below summarises the end of May 2023 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.

Access	Month	Performance	Target	Variation	Assurance	Mean
Number of new cases of psychosis (National)	May-2023	54	25	N/A	N/A	N/A
CAMHS referrals meeting assessment waiting time standards - URGENT (P1 - 7 DAYS) (Contractual)	May-2023	100%	75%			82.6%
Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team (Contractual)	May-2023	98%	95%			96.6%
Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait (Contractual)	May-2023	98%	98%			98%
MHLT Response times: 1 hour wait for AandE referrals (National)	May-2023	92%	90%			94.3%
CAMHS referrals meeting assessment waiting time standards - CRISIS (4 hours) (Contractual)	May-2023	96%	95%			89.4%
CAMHS Eating Disorders - Urgent referrals seen within 7 Days. (National)	May-2023	100%	95%			49.2%
SPA referrals with an outcome within 14 days (Internal) (Internal)	May-2023	100%	95%			93%
CAMHS referrals meeting social worker contact waiting time standards - TARGETED SERVICE 14 DAYS (Contractual)	May-2023	94%	85%			92.2%
CAMHS referrals meeting assessment waiting time standards - TARGETED SERVICE 28 DAYS (Contractual)	May-2023	100%	85%			74.1%
Urgent referrals to community mental health team meeting 24 hour wait (Contractual)	May-2023	100%	95%	N/A	N/A	N/A
CRHTT referrals meeting 4 hour wait (Contractual)	Apr - 2023	100%	98%			100%

MHLT Response times: 24 hour wait for ward referrals (National)	May-2023	97%	90%		P	97.2%
Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait (Contractual)	May-2023	No Referrals	98%	N/A	N/A	N/A
CAMHS Eating Disorders - Routine 28 day Waited. (National)	May-2023	94%	95%	H	F	49.6%
Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services (National)	May-2023	95%	98%		?	94.9%
Number of people entering IAPT treatment (ENCCG) (National)	May-2023	84%	100%	L	F	89.2%
Number of people entering IAPT treatment (HVCCG) (National)	May-2023	84%	100%	L	F	85.1%
Routine referrals to community mental health team meeting 28 day wait (Contractual)	May-2023	58%	95%		F	53.4%
Number of people entering IAPT treatment (Mid Essex) (National)	May-2023	76%	100%		F	75.6%
EMDASS Diagnosis within 12 weeks (Contractual)	May-2023	59%	80%	H	F	38.1%
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS) (Contractual)	May-2023	69%	95%		?	75.7%
Routine referrals to community eating disorder services meeting 28 day wait (Contractual)	May-2023	68%	98%		?	83%
Urgent referrals to community eating disorder services meeting 96 hour wait (Contractual)	May-2023	0%	98%	N/A	N/A	N/A

Table 2 - Access Key Performance Indicators

5. Safe and Effective

5.1. At the end of May 2023, the Trust met eleven out of twenty-four key performance indicators in the Safe and Effective domain and almost met a further five.

5.2. We have seen further improvement in indicators that tell us that our carers feel valued by our staff and our service users reflected that our staff demonstrated the Trusts Values and are welcoming and friendly.

5.3. Our service users continue to recommend the Trust to members of their family or friends, should they need our services.

5.4. Following the more detailed surveys we carried out and the ward-level action plans we developed based on the results of these, we have seen a continued improvement in the number of service users who report feeling safe in our wards.

5.5. We have seen sustained 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.

5.6. The data for number of people reported as delayed in our inpatient units when they are ready to be discharged has remained high at 15%. We recognise that continued 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.

5.7. The Table below summarises the May 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
The percentage of people under adult mental illness specialties who were followed up within 48 hrs of discharge from psychiatric in-patient care (Internal)	May-2023	94%	80%			82.4%
The percentage of people under adult mental illness specialties who were followed up within 7 days of discharge from psychiatric in-patient care (National)	May-2023	100%	95%			97.3%
Rate of service users that would recommend the Trust's services to friends and family if they needed them (National)	May-2023	80%	80%			81.2%
Talking Therapies (IAPT) % clients moving towards recovery (ENCCG) (National)	May-2023	53%	50%			51.6%
Talking Therapies (IAPT) % clients moving towards recovery (HVCCG) (National)	May-2023	52%	50%			54.7%
Talking Therapies (IAPT) % clients moving towards recovery (Mid Essex) (National)	May-2023	53%	50%			50.4%
Rate of service users saying they are treated in a way that reflects the Trust's values (Internal)	May-2023	86%	80%			83.2%

Rate of Service Users Saying staff are welcoming and friendly (Internal)	May-2023	96%	95%			95.3%
Rate of carers that feel valued by staff (Internal)	May-2023	90%	75%			78.6%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Identifier): (National)	May-2023	99%	95%			99.8%
Percentage of eligible service users with a PbR cluster (Contractual)	May-2023	92%	95%			94.1%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (Contractual)	May-2023	93%	95%			81.3%
Rate of acute Inpatients reporting feeling safe (Internal)	May-2023	83%	85%			71.5%
Rate of service users with a completed up to date risk assessment (inc LDandF and CAMHS from Apr 2015) Seen Only (Contractual)	May-2023	94%	95%			91.6%
Rate of Service Users saying they know how to get support and advice at a time of crisis (Internal)	May-2023	80%	83%			79.3%
Percentage of eligible service users with a completed PbR cluster review (Contractual)	May-2023	61%	95%			68.1%
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)	May-2023	72%	95%			72.6%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services (Contractual)	May-2023	77%	90%			80.6%
Delayed transfers of care to the maintained at a minimal level (National)	May-2023	15%	3.5%			16.5%

Data completeness against minimum dataset for Ethnicity (MHSDS) (National)	May-2023	83%	90%			84.4%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation) (National)	May-2023	75%	85%			72.1%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment) (National)	May-2023	75%	85%			72.2%
Rate of Service Users saying they have been involved in discussions about their care (Internal)	May-2023	80%	85%			85.7%

Table 3 - Safe and Effective Key Performance Indicators

6. Conclusion and Recommendations

6.1. The Trust met or almost met 69% (37/54) of our key performance indicators across the three operational performance domains at the end of May 2023.

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

3 Appendices

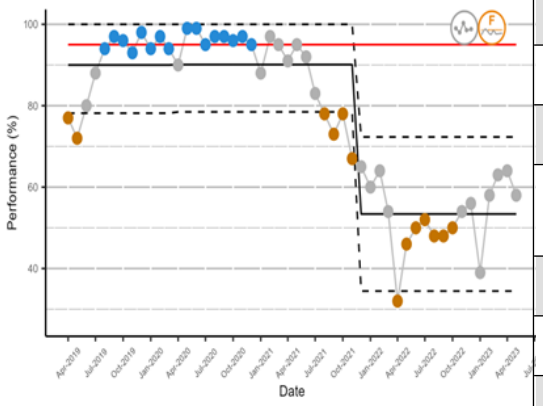
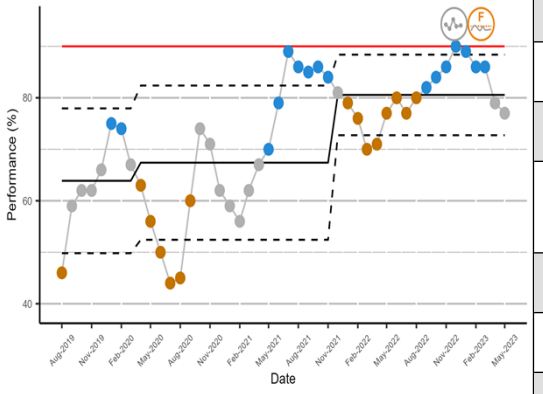
APPENDIX 1 – RECOVERY PROGRAMME UPDATE

3.1 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.

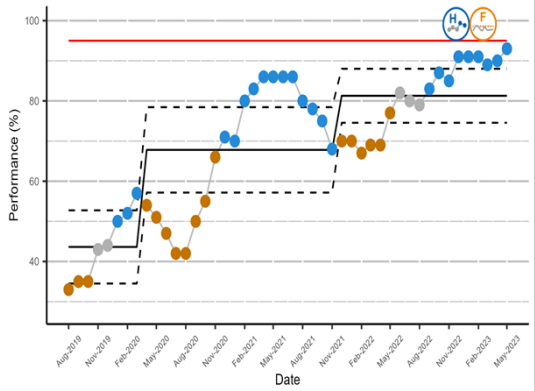
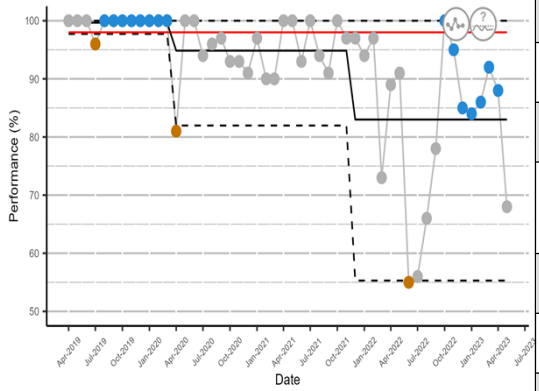
3.2 Each summary is broken into 5 sections (columns)

- 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

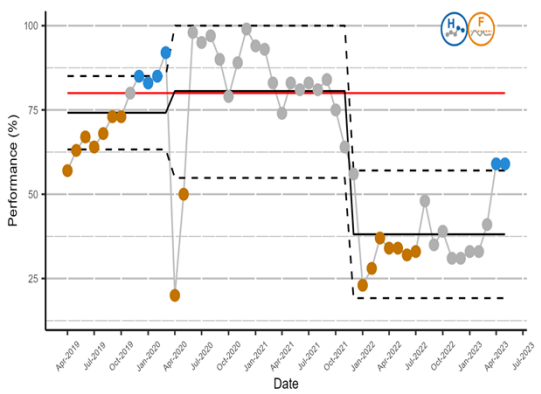
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
Routine referrals to adult community mental health team meeting 28 day wait		**May-2023** 58% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assassurance** Consistently not meeting performance target	Recovery progressing well in all quadrants except southwest where increased demand and difficulties in recruiting to vacancies is impacting on performance. Increased number of adult ADHD diagnosis referrals is also impacting on capacity. Recovery in southwest is expected in Quarter 3.	• Continue to use agency workers to meet some of the shortfall between the capacity of the substantive workforce and demand for assessment • Focus on effective and efficient triage to increase the numbers of people being signposted to more appropriate services from SPA, rather than signposted following initial assessment • Deep dive into recruitment into areas experiencing most challenge with access • Deep dive informed by CQI principles into key drivers and actions for Southwest ACMHS to recover and improve within 6 months • Continue with out of hours clinics and administrative support to 1) clear backlog and 2) manage demand • Provide proposals for commissioners to address the increase in ADHD referrals
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services		**May-2023** 77% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 90% **Assassurance** Consistently not meeting performance target	We saw improvement in performance against this indicator in 2022/23, with target reached in December 2022. Performance has declined over the last two quarters due to vacancies being covered by Nurse Consultants who usually lead on the physical health agenda.	• Nurse consultants back in permanent roles and leading physical health agenda • PH clinics are being booked across the county • 45 PATH staff attended PH training session • Data quality of incomplete forms being addressed • CN Matron now in place for specialist services

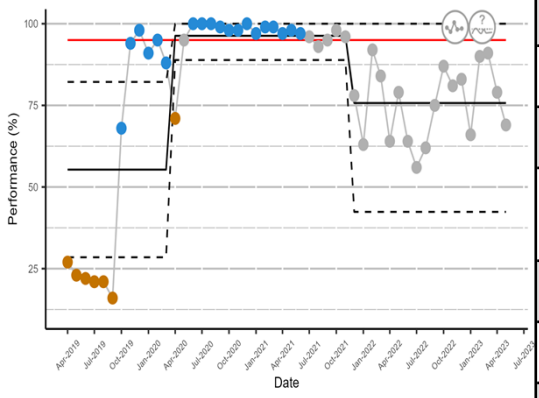
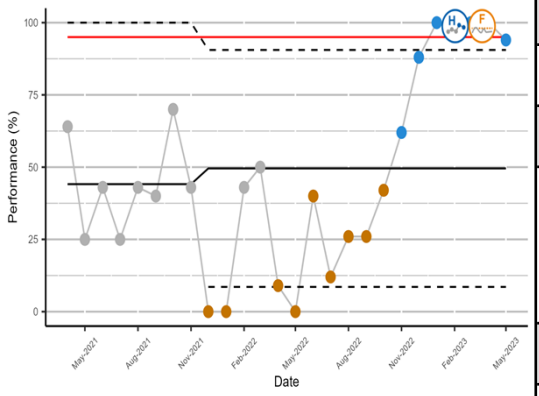
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services		**May-2023** 93% **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	We have seen improvement in performance against this indicator over the last nine months. There continue to be challenges due to a lack of resource in teams where there are vacancies combined with leave and sickness Recovery is expected in Quarter 2, but is dependent on additional resources	• All teams have plans to recover their compliance, but the concern is that some clinics may need to be cancelled over the summer period due to staffing. • Physician Associate started in Southwest providing an additional resource. • Business case in progress to secure additional specialist resource to support physical health.
Routine referrals to community eating disorder services meeting 28 day wait		**May-2023** 68% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98% **Assurance** Inconsistently meeting performance target	Referrals to service have stabilised at circa 30% higher than pre-pandemic, affecting the service's ability to see people within 28 days. Recovery is expected by the end of Quarter 2.	• We have initiated a CQI project to identify new ways of working to meet increased demand. • A new Service Line Lead has been appointed to give increased support and oversight to the service.

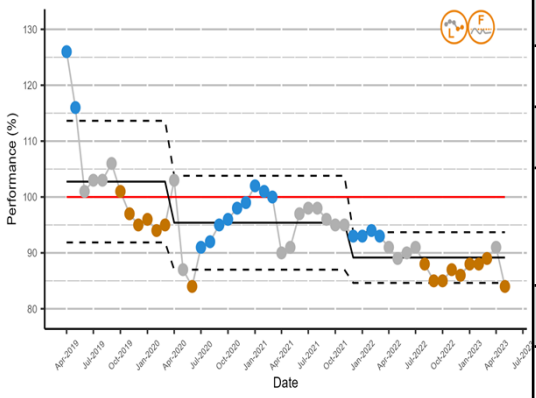
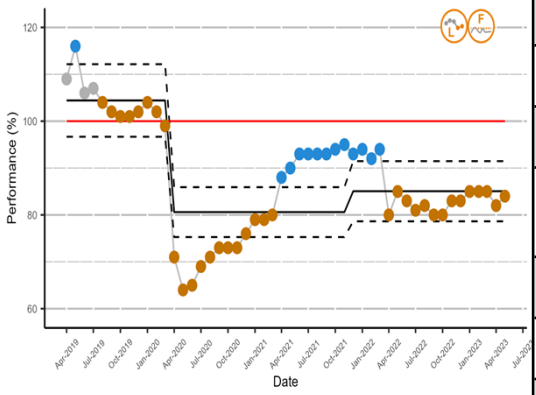
Older Adult Services

KPI	Chart	Narrative	Summary	Key Actions
EMDASS Diagnosis within 12 weeks		**May-2023** 59% **Variance Type** Special Cause Variation: Latest value above upper control limit (improvement) **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 increased the waiting list. The waiting list continues to reduce, and the service is currently on track to meet its recovery trajectory in Quarter 3.	• Recovery plan is in place that will reduce the waiting list to the optimum level in Quarter 3 2023/24 through additional weekend clinics and primary care diagnoses. • Weekly MD led meetings to monitor progress.

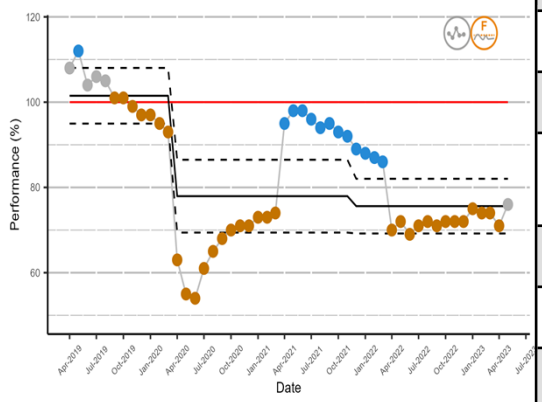
Children and Adolescent MH Services

KPI	Chart	Narrative	Summary	Key Actions
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS)		**May-2023** 69% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assassurance** 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 have seen recovery in North and West Quadrants but do not anticipate recovery for East and South Quadrants until Quarter 2 2023/24, depending on successful recruitment.	• Ongoing recruitment activity for vacancies • Weekly recovery meeting led by MD to monitor East and South Quadrant progress, including cover and replacement for current vacancies and job planning for individual care professionals
CAMHS Eating Disorders - Routine 28 day Waited.		**May-2023** 94% **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 Disorder performance has improved, with one person not seen within the 28-day timeframe in May due to difficulties in contacting the family.	No remedial actions required.

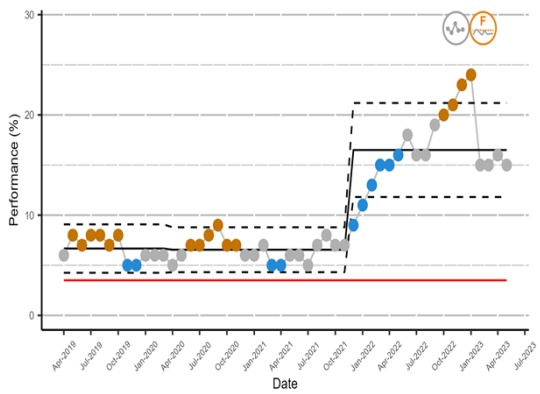
Talking Therapies (IAPT) Services

KPI	Chart	Narrative	Summary	Key Actions
Number of people entering IAPT treatment (ENCCG)		**May-2023** 84% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) **Latest Target** 100% **Assurance** Consistently not meeting performance target	Referrals into the Talking Therapies services remain below the volume needed to achieve access targets.	• There is a comprehensive communications and marketing plan which incorporates a number of actions that target referrers into the service to increase appropriate referrals, and to outreach to the public to raise awareness of the service to increase self-referrals. • We are commencing a piece of work with the regional team to look at attrition rates to identify common themes and further actions that might increase engagement with the service following a referral. • We are piloting a “Choose and Book” module on PCMIS with the Mid Essex team to see if this increases both engagement with the service and reduction in waiting times. • We have appointed a new LTC Lead for the services who will be working more closely with the LTC pathways and hospitals and community services to increase the numbers of people accessing these pathways.
Number of people entering IAPT treatment (HVCCG)		**May-2023** 84% **Variance Type** Special Cause Variation: Latest 6 data points are below mean (concern) **Latest Target** 100% **Assurance** Consistently not meeting performance target		

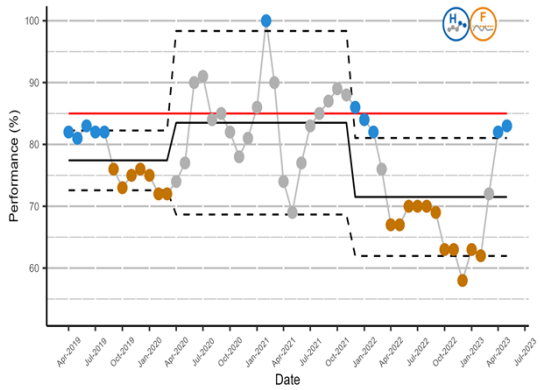
Talking Therapies (IAPT) Services

KPI	Chart	Narrative	Summary	Key Actions
Number of people entering IAPT treatment (Mid Essex)		**May-2023** 76% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 100% **Assurance** Consistently not meeting performance target		

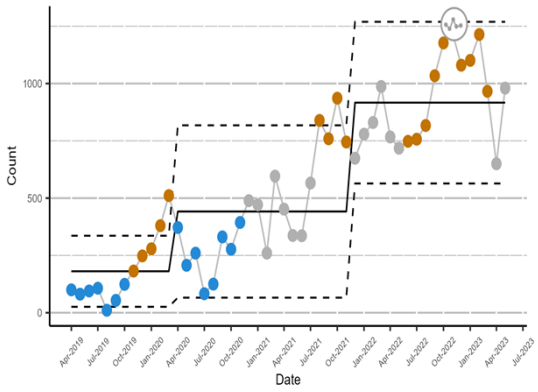
Inpatient Services

KPI	Chart	Narrative	Summary	Key Actions
Delayed transfers of care to be maintained at a minimal level		**May-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. We continue to experience difficulties in finding suitable placements and care packages for service users with complex needs. We have made changes to put social care at the forefront of the pathway and 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 4 2023/24	• 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 • Enhanced Discharge team being recruited, and ways of working developed • Wider system work, led at Executive level, to support placement of longer-term DToC • Analysis of reasons for different types of DToC and focussed action plan developed against key themes • Senior engagement / cover at DTC meetings

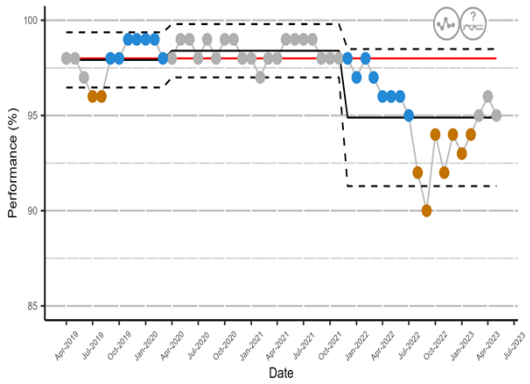
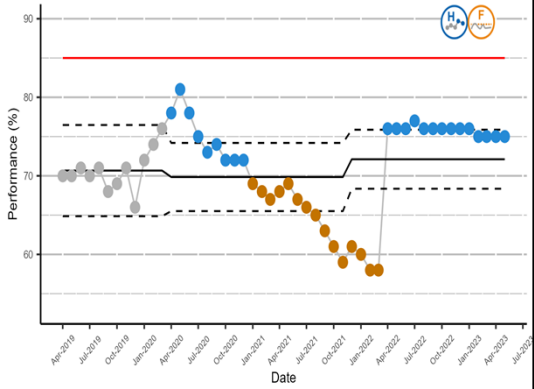
Inpatient Services

KPI	Chart	Narrative	Summary	Key Actions
Rate of acute Inpatients reporting feeling safe		**May-2023** 83% **Variance Type** Special Cause Variation: Latest value above upper control limit **Latest Target** 85% **Assurance** Consistently not meeting performance target	The number of people saying that they feel safe in our inpatient units had decreased due to high levels of acuity in our inpatient units. Following a detailed survey of reasons, we have developed ward level action plans to improve this. We have seen an improvement in April and May bringing us close to target of 85%.	The actions from the feeling safe survey which was trialled in September 2022 have moved ahead with each SBU taking forward their own action plan. The survey is presently being repeated to understand how the experience has changed and whether actions taken are showing an improvement. Actions include: • Communication passports and calm-down boxes for staff to use with service users on Dove Ward • Peer listeners to work with our Medium Secure Units on post-incident support • Calm app and support for service users whose first language is not English on Oak Ward • Groups implemented in Forest House to understand what makes children and young people feel safe • Launch of a new Patient Safety CQI project to look at reducing staff and service user experiences of violence.

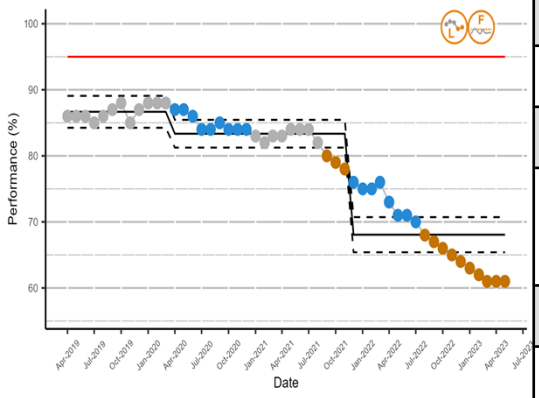
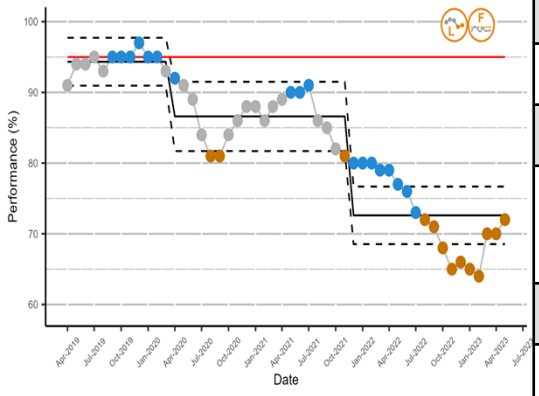
Inpatient Services

KPI	Chart	Narrative	Summary	Key Actions
Inappropriate out-of-area placements for adult mental health services		**May-2023** 980 bed days **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 849 **Assurance** N/A	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 Trust is implementing an Acute Pathway Improvement Programme and we expect to meet the target by the end of Quarter 4 2023/24.	• 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 • Development of detailed programme plan, targets for bed reduction and timelines. Reinstatement of programme management approach to manage key projects • Development of a single set of reporting data

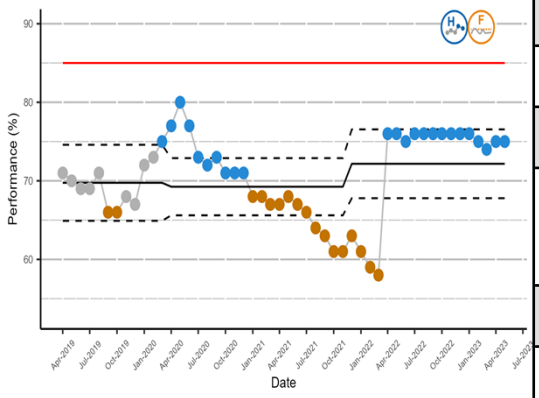
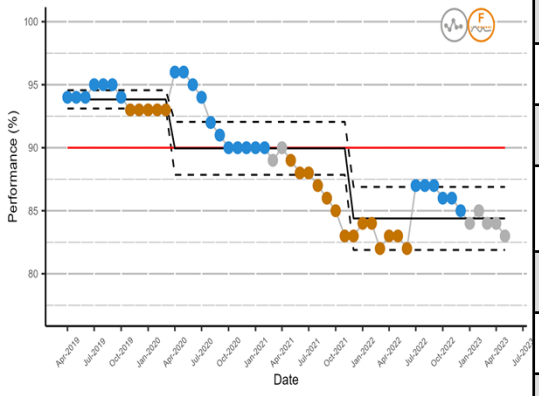
Trust-Wide Indicators

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		**May-2023** 95% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98% **Assurance** 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 have impacted on performance. .	• Focused recovery work on access times that will result in overall improvement of our referral to treatment times.
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation)		**May-2023** 75% **Variance Type** Special Cause Variation: Latest 6 data points are above mean Two of three data points within upper zone A (improvement) **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 and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in July 2023. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is captured.

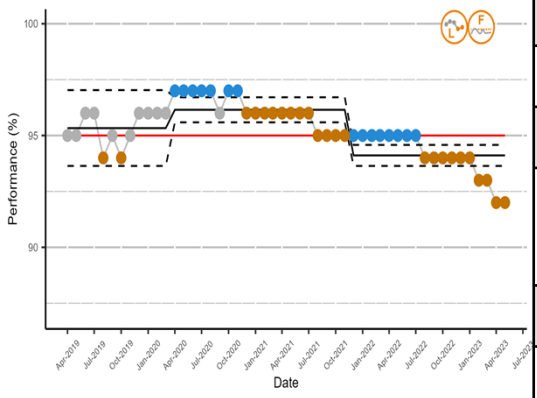
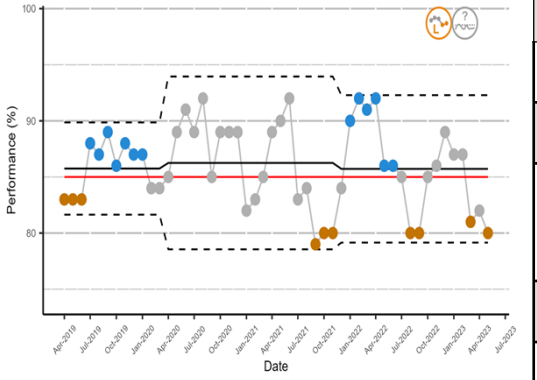
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Percentage of eligible service users with a completed PbR cluster review		**May-2023** 61% **Variance Type** Special Cause Variations (concern): Latest value below lower control limit Latest 6 data points are below mean **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		**May-2023** 72% **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 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 Quarter 2 2023/24.

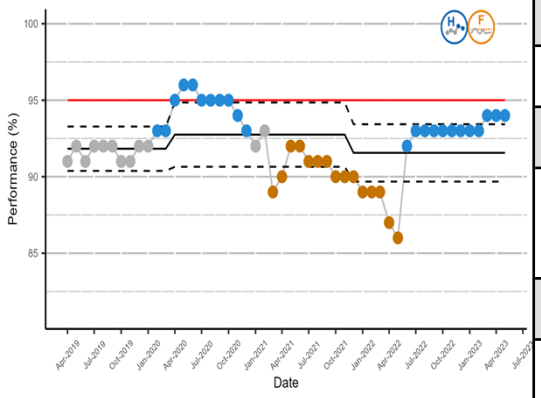
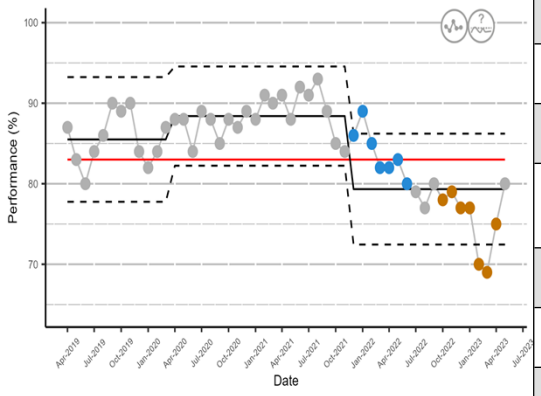
Trust-Wide Indicators

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)		**May-2023** 75% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) **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 July 2023. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is captured.
Data completeness against minimum dataset for Ethnicity (MHSDS)		**May-2023** 83% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 90% **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 July 2023. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is captured.

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Percentage of eligible service users with a PbR cluster		**May-2023** 92% **Variance Type** Special Cause Variation(concern): Latest value below lower control limit Latest 6 data points are below mean **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		**May-2023** 80% **Variance Type** Special Cause Variation: Two of three data points within lower zone A (concern) **Latest Target** 85% **Assurance** Inconsistently meeting performance 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 improve response rates

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Rate of service users with a completed up to date risk assessment (inc LDandF and CAMHS from Apr 2015) Seen Only		**May-2023** 94% **Variance Type** Special Cause Variation s (improvement): Latest value above upper control limit Latest 6 data points are above mean **Latest Target** 95% **Assurance** Consistently not meeting performance target	Pressures during COVID and increased caseloads, compounded by time consuming recording methods, resulted in people waiting longer for a review of their risk assessment. Performance improved with introduction of new recording method for risk and is now 1% below target level.	• Simulation suite training rollout continues for teams with low assessment compliance. • Survey on success of pilot of new Paris changes to ensure all new features are working as planned. Full rollout planned for July 2023 with the exception of LD&F where discussion is underway. • Additional guidance for staff added to Paris to aid completion.
Rate of Service Users saying they know how to get support and advice at a time of crisis		**May-2023** 80% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 83% **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.	• 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 improve response rates.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 13
Subject:	Our new Trust Five year strategy *"Great Together"*	**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:

To share the final draft of the fully designed new strategy for consideration by the Board.

Action required:

The Board are asked to approve the new five year strategy for the Trust.

Summary and recommendations:

Summary

Since Board approved the strategy on 25th May we have worked with a design agency to create a version of the final strategy. The final document sets out what we stand for as an organisation, our values, mission and vision and how we work in partnership with others. It summarises how we developed our strategy, taking into account what is happening around us. It then moves on to our new strategic priorities and the difference that these will make to service users, carers, our staff and communities. To illustrate the document we have used photos of our staff, service users and carers alongside artwork created by service users (both adults and young people).

In addition to the main strategy document we are creating an easy read version of the strategy and a range of material to promote the strategy and ensure that staff, service users, carers and partners understand it. We are running a series of launch events across the main Trust sites and sessions for service users, carers, governors and voluntary sector partners. We then plan to continue this engagement over the coming months as we embed the strategy throughout the organisation and use it as the basis for all that we do, setting the direction of travel over the next five years.

Recommendation

The Board are asked to approve the new five year strategy for the Trust.

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

This is the proposed new five year strategy.

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

No direct implications

Equality & Diversity and Public & Patient Involvement Implications: Development of the strategy has included significant engagement with service users, carers and underserved communities.

Last seen by:

N/A

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

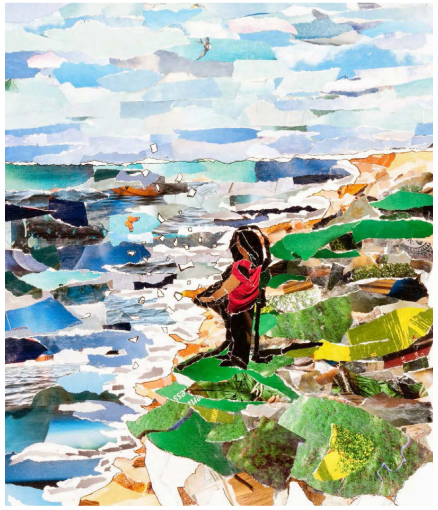
Draft – for approval

Great Together

Our Trust Strategy 2023 - 2028

as One

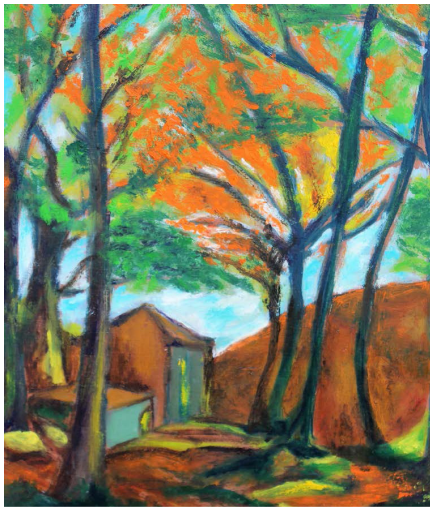
Our Values
Welcoming Kind Positive Respectful Professional

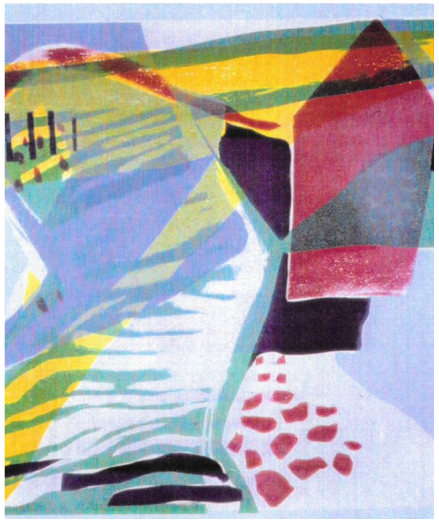


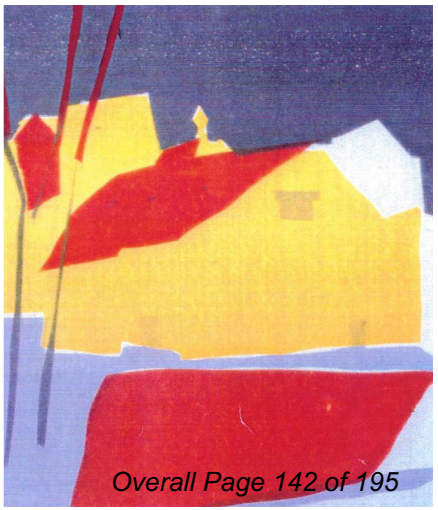
Draft – for approval

Contents

Throughout this document we have used some of the wonderful artwork that our service users have created. We would like to thank them for allowing us to use their work.







Foreword

We are delighted to present our strategy ***'Great Together'*** proudly co-produced and developed with our service users, carers, staff, partners and local communities. It is an ambitious strategy designed to guide our journey over the next five years as we continue to work together to improve care and outcomes for the people and communities we serve.

Our unwavering commitment to support people living with mental illness, learning disabilities and neurodevelopmental needs remains at the heart of our strategy. Our ambition is to support people to live their best lives, safe from avoidable harm, consistently providing the highest quality and experience of care. Our approach to innovation, research and an open learning culture will support us to achieve this.

Recovery, hope and person centred care have been themes our service users, their carers, staff and local communities have said are important and this has informed the development of 'Great Together'. Listening to the voice and experience of service users, carers and communities is important to us and will be embedded across our organisation as the way we do things.

We are proud of our strong history of working collaboratively with other organisations, including our formal partnerships with the University of Hertfordshire and Hertfordshire County Council. Our approach to partnerships with NHS, social care, voluntary and community organisations will continue as we work across the East of England, Hertfordshire, Buckinghamshire, Norfolk and Essex to improve outcomes for our local people.

Our steadfast determination to address inequalities and achieve equity for the people and communities we serve is reflected in our strategy. We will be working with partners to play our part in addressing inequalities prevalent across our society. For us as a Trust this means being a great local employer, it means building trust and extending our reach to local communities, and it also means challenging and eliminating discrimination in all that we do and how we behave.

Recognised as one of the top places to work in the NHS, every person in our organisation has a voice that matters and, through Our Values – Welcoming, Kind, Professional, Respectful, and Positive - we will continue to ensure that our actions and behaviours are rooted in compassion and empathy. This together with our focus on wellbeing, development, education and training will help all our people grow and develop, whilst also encouraging others to join our vibrant and thriving workforce.

Great Together, two words that mean so much on their own, but are so much more powerful when connected. Our strategy places service users and carers at the centre of what we do; commits us to addressing inequalities and achieving equity; focuses on developing our people and creating a vibrant learning organisation; whilst working in strong partnership with others to deliver high quality care.

Thank you for helping us to shape this strategy; we know you are as excited as we are about delivering it - together.

Karen Taylor
Chief Executive

Sarah Betteley
Chair

About us – why we do what we do

Our Vision – what we aim to achieve

"Delivering Great Care, Achieving Great Outcomes – Together"

Our vision describes our strong commitment to our service users, carers, and the communities we serve. We will always put the people who need our care, support, and treatment at the heart of everything we do. We will work together to provide the very best experience of joined up care and consistently achieve the outcomes that matter to our services users, their families and carers.

Our Mission – why we do what we do

"We support people to live their lives to their full potential by enabling them to keep mentally and physically well"

Our service users and carers told us it is important to them that we:

- **Support them to stay well**
- **Keep people safe from avoidable harm**
- **Achieve the very best individual outcomes**
- **Provide the best possible experience**

About us – our values

Welcoming, Kind, Positive, Respectful, Professional

Our Trust values underpin everything we do. Co-designed and developed with our service users, carers and staff we are proud that our values are embedded across our organisation. They guide our behaviours and actions, both individually and collectively, ensuring we treat each other with compassion and care, supporting us to provide the highest quality care to service users and carers.

"We demonstrate the values in our everyday work… easy to achieve as they are the core beliefs we hold as a team…"

Our Values
Welcoming Kind Positive Respectful Professional

We are **welcoming** so you feel *valued as an individual*

We are **kind** so you feel *cared for*

We are **positive** so you feel *supported and included*

We are **respectful** so you feel *listened to and heard*

We are **professional** so you feel *safe and confident*

Our staff, service users, carers and partners have told us how important the values are to them as we look to the future together.

About us – our organisation

We are proud to provide mental health, learning disability and autism services across Hertfordshire, Essex, Norfolk and Buckinghamshire.

Hertfordshire
Population 1.2m

- Adult Primary and Community Mental Health Services
- Talking Therapies
- Mental Health Services for Children and Young People (CAMHS)
- Mental Health Services for Older People
- Dementia Diagnosis and Support Services
- Inpatient Services for Adults with Mental Ill Health, Learning Disabilities and Dementia
- Adult Mental Health Social Care support
- Mental Health Crisis Support
- Community Learning Disability Services
- Adult Mental Health Rehabilitation Services
- New Leaf Recovery and Wellbeing College
- Low and Medium Secure services

Essex
Population 1.9m

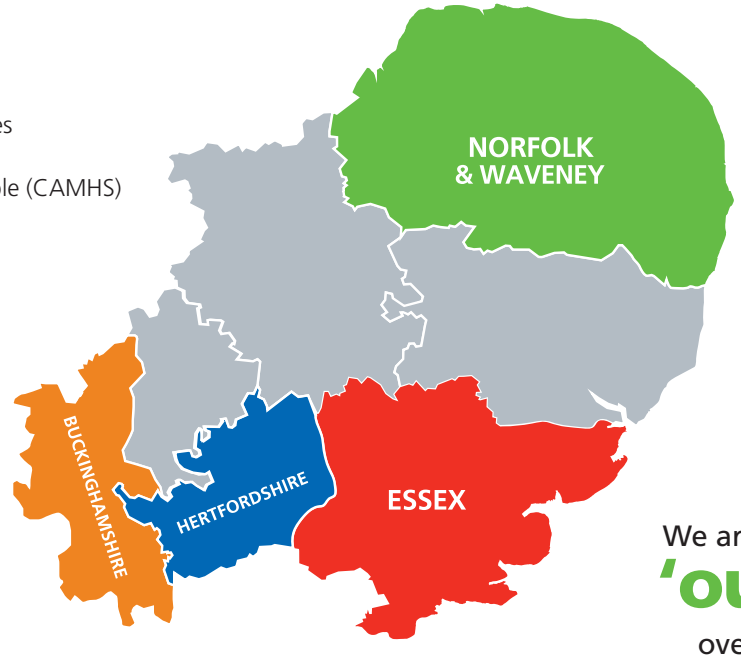
- Community Learning Disability Services
- Inpatient Learning Disability Services
- Talking Therapies (Mid Essex)

Norfolk & Waveney
Population 1.0m

- Medium Secure Services
- Learning Disability Community Services
- Inpatient Learning Disability Services

Buckinghamshire
Population 555k

- Community Learning Disability Services



We employ **4,121** staff

Our **turnover** for **2022/23** was **£393m**

Outstanding

We are **rated** **'outstanding'** overall by the CQC

We have **56** buildings across **33** sites

We are in the **top 3** **mental health trusts** to work for in the country

27,000 **People supported** through our mental health community services

About us – our partnerships

We are proud that we have a long history of working in partnership and this collaboration will continue.

University of Hertfordshire UH

Our University Trust status was awarded in 2010 and we are thrilled to have been reaccredited in 2023. Together we have provided thousands of education and training placements across a range of professional disciplines and have completed joint research programmes with participation from the Trust's service users and carers.

Hertfordshire

Our partnership with Hertfordshire County Council, which began almost 20 years ago, means we have integrated social workers and social care staff in our teams; allowing us to support people with employment, housing and wider concerns that have a big impact on their mental health. This partnership extends to children and young people too, where better mental health can have a positive impact on the whole family.

MH LDA Herts Mental Health, Learning Disability and Autism Health and Care Partnership

We are proud to have established the Hertfordshire Mental Health, Learning Disability and Autism Health and Care Partnership and to be leading it jointly with the County Council. The Partnership is with NHS organisations, other statutory partners and local voluntary and community organisations, all working together to improve care and outcomes for people with mental ill health, learning disability and autism across Hertfordshire.

In Norfolk we host the national RADiANT clinical and research network involving clinicians and academics with an interest in learning disabilities, autism and other conditions.

NHS Essex Learning Disability Partnership

Through our partnership with Essex Partnership University NHS Foundation Trust over the last five years we have been transforming care for people with learning disabilities – integrating physical, mental health and learning disability care; working with the County Council and other organisations to improve outcomes.

NHS East of England Provider Collaborative

Since 2021 we have worked with five NHS Mental Health Trusts in the East of England to develop and improve access to beds for those who need specialist inpatient care. Focused on adults with an eating disorder, adults with mental illness or a learning disability that need low or medium secure services and inpatient beds for children and young people, this collaboration has reduced the length of time people wait for beds and increased the community services available to support step down from those specialist inpatient beds.

Integrated Care Systems

We are delighted to be working collaboratively with a range of partners across the Integrated Care Systems in Norfolk, Essex, Buckinghamshire and Hertfordshire and see ourselves continuing the joint working and approach to improve outcomes for the population and communities we serve.

Developing our strategy - our approach

Over a six month period we have engaged with, involved, and coproduced our strategy with service users, carers, local communities, staff, and partner organisations. We have taken stock of local, regional and national priorities to inform this process.

Our partners told us they want us to…

- work collaboratively with them
- work together to develop and build services and join up care
- develop our workforce together
- work with and support local communities

Our staff and Experts by Experience told us they…

- come to work every day to provide the best care they can
- feel we need more staff and more development opportunities
- are proud of what they do to support service users and carers
- enjoy improving services – it gives hope for the future

Service users, carers and communities told us they…

- want us to communicate in ways that are tailored to them, reflecting their needs and preferences
- need caring, consistent staff who they trust and can build relationships with
- want us to focus on addressing inequalities & improving access for all

200 Staff Engagement Sessions

8,764 Comments

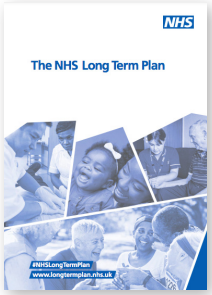
2,120 Total number of people engaged in strategy development process

50 Service User, Carer, Community and Partner Sessions

Developing our strategy - what is happening around us

Over recent years the Long Term Plan has brought a welcomed focus and expansion of services for people with mental ill health and learning disabilities. However, the profound impact of the pandemic on people's lives is still being felt with a significant impact on people's health and wellbeing, including their mental health.

The impact across the NHS includes increased demand and longer waiting times across all sectors, with ongoing workforce and financial pressures. NHS England has published its first Equality, Diversity and Inclusion plan, emphasing the importance of ensuring equity across the NHS. A workforce plan for the NHS has also been published, aiming to address the workforce challenges we face.



Quality and safety of care remains a high priority, with multiple reports and programmes focusing on addressing poor outcomes, care and culture at a national level. NHS England has also launched an 'NHS Improvement approach' signalling commitment to innovation and continuous quality improvement and leadership.

1 in 6 children had a mental health difficulty in 2021 compared to 1 in 10 in 2004

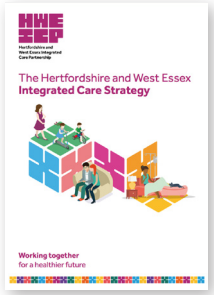
Only 1/4 to 1/3 of people with mental health difficulties receive treatment for it

The economic and social cost of mental health problems in **2019/20** was **£119billion**, and this is set to grow

The number of people with dementia is **expected to double by 2040**

Nationally, Integrated Care Systems are in place across England with partners across health, social care, voluntary and community sectors working together to improve care and outcomes for local populations. We are delighted to work across five Integrated Care Systems and our strategy is aligned with their published priorities and strategies. In our host Integrated Care System (Hertfordshire and West Essex) the Integrated Care Strategy priorities are:

- Give every child the best start in life
- Support our communities and places to be healthy and sustainable
- Support our residents to maintain healthy lifestyles



- Enable our residents to age well and support people living with dementia
- Improve support to those living with life-long conditions, long term health conditions, physical disabilities and their families
- Improve our residents' mental health and outcomes for those with learning disabilities and autism

We are committed to the delivery of all six priorities.

Key priorities across the integrated systems in which we work are:

- **Collaboration and working in partnership**
- **Developing communities, including employing local people and supporting local businesses**
- **Prevention and earlier intervention**
- **Joining up care to meet individual needs**

Our strategy – Great Together 2023 – 2028

Through the development of our strategy we identified six key Strategic Priorities with service users and carers at the heart of all that we do.

Quality

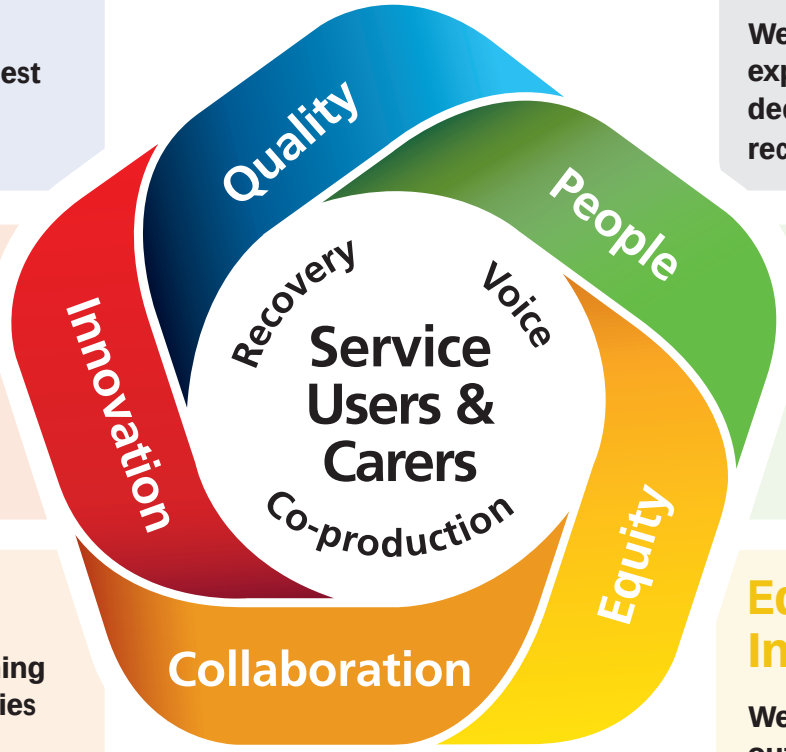
We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers

Service Users & Carers

We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery

Innovation & Improvement

We will be a learning organisation that encourages innovation, research and continuous quality improvement



People

We will attract, develop and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces

Collaboration

We will work in partnership in everything we do to meet the needs of communities and the people we support

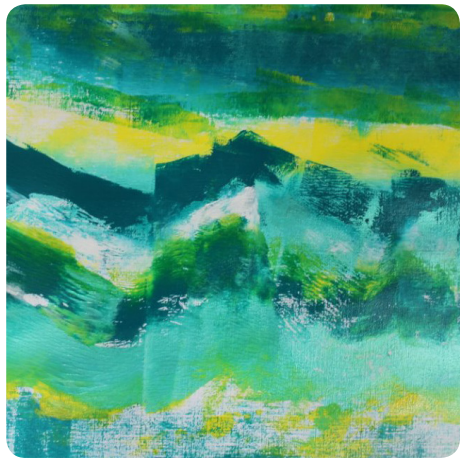
Equity & Addressing Inequalities

We will address inequalities to improve outcomes and advance equity for people from all communities

The following pages describe our key areas of focus under each strategic priority.

Service Users & Carers

We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery



We will do this by…

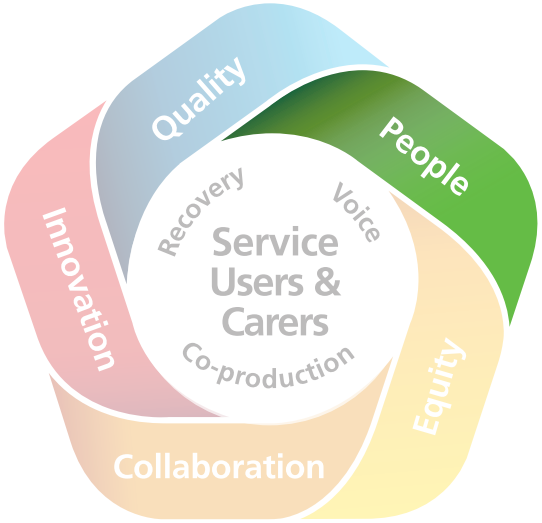
- **Using Shared Decision Making** to work in partnership with service users and carers to develop and foster positive relationships, creating an environment where everyone feels heard, valued, and respected in line with our values
- **Expanding and enhancing support for Carers,** recognising the essential and important role they have in supporting service users
- **Amplifying service user and carer voice** by expanding our approach to, and numbers of, Experts by Experience, Peer Support Workers and service user and carer advocacy groups across our organisation
- **Consistently co-producing, engaging, and involving service users, carers and communities** ensuring the voices of those with lived experience inform and influence change, shaping the design and delivery of services
- **Taking a Strengths Based Recovery approach** in all that we do by placing what matters to our services users and carers at the centre of our practice, supporting them to achieve the goals and outcomes that are important to them

Quality Care & Outcomes

We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers

We will do this by…

- **Developing our Trauma Informed Approach** to shape practice and support a positive risk culture and positive risk management
- **Embedding zero tolerance to violence and aggression** across our services, supporting our service users, carers, and staff to be and feel safe whilst receiving and providing care
- **Improving access, choice and continuity of care** that makes a difference to how people feel about their care and positively contributes to improved outcomes
- **Embedding our Connected Lives approach,** supporting people to live independent and fulfilling lives through building connections in their communities
- **Keeping people safe** and protected from harm whilst also supporting people to live full and active lives with community-based support, safety planning and the least restrictive practice driving our approach, reducing the number of suicides and self harm
- **Providing therapeutic modern environments** that are welcoming, safe, and meet diverse service user needs, including the needs of autistic, disabled and neurodiverse people



Our People

We will attract, develop and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces

We will do this by…

- **Embedding our inclusive culture, with compassionate and caring teams** where everyone feels valued and respected, fostering a sense of community and support for our workforce
- **Building a diverse workforce** representative of our service users and local communities, encouraging, and recruiting candidates with different backgrounds, including lived experience of mental ill health, cultural heritage, skills, and abilities to join our organisation
- **Adopting a zero-tolerance approach to any form of discrimination,** bullying, or harassment, ensuring our recruitment, retention, and promotion processes are fair and unbiased
- **Providing exceptional training, development and learning opportunities** across the organisation and in partnership with the University of Hertfordshire and other Higher Education providers supporting individual and team growth to enhance our ability to provide high quality care
- **Creating exciting new roles and clear career pathways,** encouraging people to join our organisation and the wider mental health & learning disability community, supporting individual career progression and the development of new skills and expertise
- **Prioritising staff wellbeing** by creating a positive and supportive work environment including training, reflective practice, peer support and flexible working opportunities built around teams

Addressing inequalities

We will address inequalities to improve outcomes and advance equity for people from all communities

We will do this by…

- **Collaborating with local communities** and community leaders to build trust and address barriers to access. Promoting equity and inclusivity and working with local communities and individuals with lived experience, to ensure that we are fair and do not discriminate
- **Developing our staff's awareness** and understanding of our local communities so that addressing inequalities and advancing equity is everyone's business
- **Taking positive action to support our local communities** by acting as an anchor institution, using local contractors and services and embedding ourselves in the areas we serve
- **Addressing the wider determinants of mental health by focusing on prevention and earlier intervention,** including housing, education, loneliness and isolation, employment, and welfare advice
- **Enhancing care and support for individuals with neurodevelopmental needs,** including those on the autism spectrum, by providing appropriate diagnosis, good mental health support, and creating autistic-friendly environments
- **Driving better Physical Health outcomes** by working with partners to implement our Physical Health strategy and encourage active and healthy lifestyles, reduce obesity and smoking, targeting screening and vaccinations

Collaboration

We will work in partnership in everything we do to meet the needs of communities and the people we support

We will do this by…

- **Working in and developing partnerships** that have a positive impact on the health and well-being of local communities and our service users, and carers including voluntary, community, faith and social enterprise groups
- **Driving the growth of the Hertfordshire Mental Health, Learning Disability and Autism Health and Care Partnership** to improve care and outcomes
- **Collaborating with schools, district councils and other local community services** to build integrated early intervention emotional wellbeing and mental health care and support
- **Partnering with public health and substance misuse services** to improve support pathways and outcomes for individuals with mental illness and substance misuse
- **Developing Learning Disability and forensic services in collaboration with partners** across the East of England to provide alternatives to inpatient care and support individuals to live in the community
- **Advocating for services, policies, and decision-making** that positively impact people with mental illness, dementia, learning disabilities and autism, and parity of esteem between physical and mental health

Innovation & Improvement

We will be a learning organisation that encourages innovation, research and continuous quality improvement

We will do this by…

- **Strengthening our culture of continuous development and improvement,** supporting all of our staff to lead and make change in their teams
- **Striving for best practice** (local, national, and international) to inform the development of services and transformation
- **Expanding our research activities and culture** across the organisation to inform practice, evaluate and improve outcomes and care
- **Exploring and adopting new technologies, artificial intelligence and innovations** to improve care across our organisation and with partners
- **Creating a Green movement for change** across our organisation and reducing our impact on the environment significantly, working sustainably and locally
- **Focusing on value, reducing waste and driving productivity** through innovation and improvement

Implementing our strategy – what will be different?

We want our service users and carers to be able to say

- I feel my care is meeting my needs and supporting my recovery
- I have been able to access care and support when I need it and it has been a positive experience
- I have felt supported as a carer, and my voice is listened to
- I have been involved in decisions about my care and I have been given choice
- My mental health and wellbeing has improved
- I am able to receive my care and support in the community, and rarely need to go into hospital to receive support

We want our workforce to be able to say

- I enjoy coming to work, it is rewarding and I am fully supported to do my job to the best of my ability
- I have received excellent training and development and I can see my future career path at HPFT
- I am treated fairly and equitably, and I feel I belong and can be myself at work
- I want to work for HPFT, they are my employer of choice
- I feel safe at work, both physically and psychologically

We want our communities to be able to say

- We can access care and support easily, and services are more tailored to meet our needs
- We can see the work HPFT has been doing with our local communities
- HPFT is somewhere we would want to work and to receive care – we have confidence and trust in them
- We feel we are actively involved in shaping and designing services locally
- We can see ourselves represented in the workforce of HPFT, it makes us feel more able to access care and support

We want our partners to be able to say

- We enjoy working with HPFT as they collaborate and always work in partnership
- We have delivered improvements and benefits for communities because of our partnership work with HPFT
- We feel our workforce is better skilled in mental health because of HPFT's support for our teams
- HPFT has really supported the voluntary and community sector to grow and develop
- We see HPFT always advocating for people with mental ill health, learning disabilities and autism in all that they do

Implementing our strategy - conclusion

We hope you are as excited as we are about our Great Together strategy. Successful implementation relies on everyone knowing the part that they play in its delivery.

We will do this through:

- Team plans and individual objectives
- Clear accountability and leadership, with regular reporting of progress and escalation of issues
- Supporting strategies with aligned programmes of work, supported by quality improvement and research
- A clear Annual Plan, detailing operational delivery priorities and measures of success for each priority
- Oversight via the Trust Board to ensure we are on the right track

We believe Great Together is an ambitious strategy that sets out our commitment to improve the lives of people with mental illness, learning disabilities and autism. As we look forward to the future, we know there will be challenges ahead and we believe this strategy will enable us to address these together to support people to live their best lives.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

as one

Our Values

Welcoming Kind Positive Respectful Professional

The Colonnades
Beaconsfield Road
Hatfield
Hertfordshire
AL10 8YE

www.hpft.nhs.uk

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 14
Subject:	Hertfordshire Mental Health, Learning Disabilities and Autism Health and Care Partnership (MHLDA HCP)	**For Publication:** Yes
Author:	Ed Knowles, Development Director	**Approved by:** Karen Taylor, CEO
Presented by:	David Evans, Executive Director Strategy and Partnerships	

Purpose of the report:

This report provides an update on the development and activity of the Hertfordshire Mental Health, Learning Disabilities and Autism Health and Care Partnership.

Action required:

The Board is recommended to note this report.

Summary and recommendations to the Committee:

The attached paper is the latest Development Director's report presented to the Hertfordshire Mental Health, Learning Disabilities and Autism Health and Care Partnership (MHLDA HCP) on 20 June 2023.

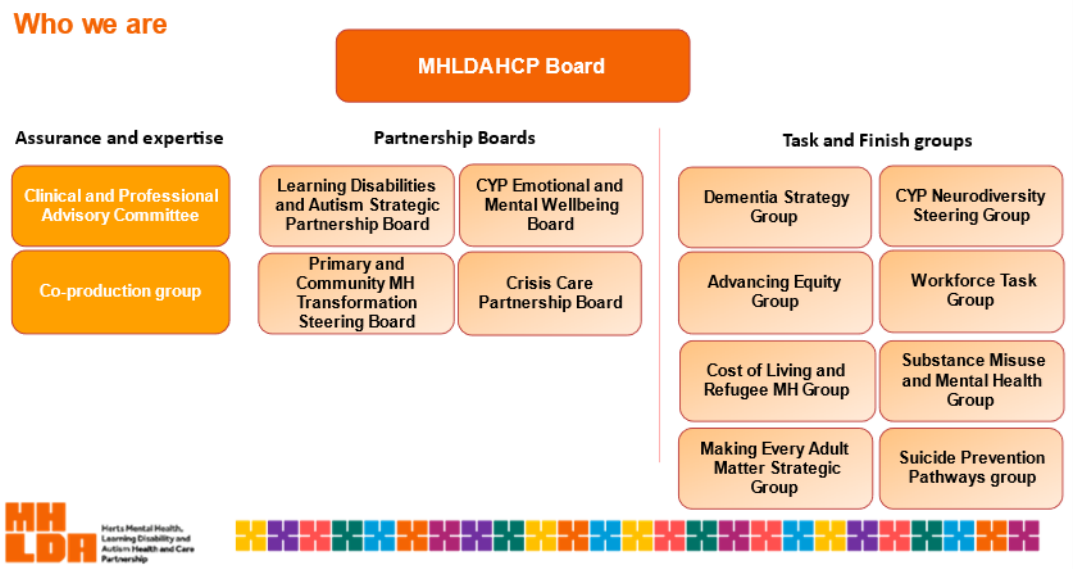
Since the last update to HPFT's Board of Directors in January 2023, the MHLDA HCP has developed both its capacity and capabilities to deliver improved outcomes for people and communities in Hertfordshire. It has strengthened existing partnerships across the NHS, Social Care and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sectors and developed new relationships with Hertfordshire Constabulary, autism and neurodiversity providers and our colleagues in Essex and the wider East of England region. The HCP has overseen tangible improvements in local services, from embedding mental health support in the Hertfordshire response to the cost-of-living crisis to supporting increased uptake of Annual Health Checks for people with learning disabilities.

The HCP has developed and successfully launched the Hertfordshire Dementia Strategy and the MHLDA Physical Health Strategy – setting ambitious objectives for the wider system and outlining the role that all HCP partners need to play to ensure that our efforts and activity is coordinated to best effect. The MHLDA HCP has provided the programme management support expertise to now move from strategy-setting to the delivery of these objectives.

The HCP Board's evolution is mirrored in the development of its Clinical and Practice Advisory Committee (CPAC) and its Co-production group. Both sub-groups operate as multi-agency partnerships, able to provide challenge and scrutiny to the work of the MHLDA HCP and assurance to the HCP Board on its priorities and areas of focus. As an HCP we have facilitated engagement activity with over 250 frontline staff and people with lived experience, hearing their voices and involving them in our thinking about Suicide prevention, Dementia, Crisis Care and the proposed national strategies related to the mental health.

The MHLDA HCP Board now provides strategic leadership and oversight of a number of existing system partnerships as well as new task and finish groups established under its auspices. It has overseen a reset of the Crisis Care Partnership Board which is now recognised as the key forum

through which partners can agree a joint approach to supporting people in crisis in the most appropriate settings.



The MHLDA HCP is recognised as one of four Health and Care Partnerships within the Hertfordshire and West Essex Integrated Care Board and is part of the ongoing system discussions around the development of the ICB and HCP structures. The MHLDA HCP is represented on the Herts and West Essex Integrated Care Partnership and plays a key role, working alongside Essex colleagues, in delivering against the key priorities of the Integrated Care Strategy.

Other key achievements and activity since the last update to the Board of Directors includes:

- Coordinating a system response to NHS operational planning and the ICB's Joint Forward Plan
- Developing and disseminating MHLDA Crisis material to support people to access appropriate services
- Co-chairing the Making Every Adult Matter approach in Hertfordshire – providing a framework for supporting people with complex needs who are experiencing multiple disadvantages
- Developing strong relationships with Hertfordshire Constabulary, supporting their ESRC bid and working with them to consider how to implement the Right Care, Right Person model in Hertfordshire
- Aligning Primary and Community Mental Health Transformation with activity to deliver the Fuller Review of Primary Care
- Developing new system structures to deliver a Children and Young People's neurodiversity model

Priorities for the forthcoming period include:

- Confirming the role of the MHLDA HCP in relation to performance, quality, finance, and commissioning
- Demonstrating progress and delivery against our key transformation programmes, including Primary and Community Mental Health transformation, Neurodiversity, Dementia, Suicide Prevention and Children and improved physical health for people with mental

illness, learning disabilities and autism
- Investing in organisational development activity to support collaboration and joint working between staff across our different constituent organisations

Recommendation
The Board is asked to note the update report.

Relationship with the Annual Plan & Assurance Framework:

The activity of the MHLDA Health and Care Partnership supports the delivery of HPFT's Strategic objective 7.

Summary of Implications for:

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

No EqIA required – there are no specific equality and diversity issues associated with the recommendations of this paper.

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

Hertfordshire Mental Health, Learning Disabilities and Autism Health and Care Partnership – Development Director's update

1. Introduction and summary

1.1 During May 2023, the MHLDA HCP has enabled greater partnership working to marshal system activity and make more efficient and effective use of staff and partner resource. Whether identifying existing gaps and potential solutions in our suicide prevention pathways, establishing a new programme approach to tackling the challenges of neurodiversity across different organisations or developing a new model for urgent assessment, the MHLDA HCP continues to lead strategic and operational transformation across Hertfordshire.

1.2 This month we have had confirmation about our system's strong performance in relation to the number of people with learning disabilities receiving their Annual Health checks – which is testament to work and dedication across MHLDA HCP partners.

1.3 Appendix A, accompanying this report is the latest version of the MHLDA HCP Programme overview, which provides an update on progress and delivery across our identified transformation priorities.

2. HCP and System developments

2.1 On 17th May the Government published the Major conditions strategy: call for evidence. This follows an announcement from January 2023, where the Government confirmed that there would no longer be a 10 -year Mental Health Strategy but that mental health would be considered within a new Major Conditions Strategy and a new Suicide Prevention Strategy.

2.2 The call for evidence is designed to complement and build upon two previous calls for evidence on mental health and cancer that were conducted in 2022. The survey that accompanies the call for evidence therefore predominantly focuses on other conditions while encouraging those who responded to the mental health and cancer calls for evidence to provide any further insight or suggestions. The survey contains a single question specifically related to Mental health: *'How can we better support those with mental ill health?'*

2.3 The call for evidence also contains a specific question related to Dementia, asking respondents to indicate which areas of work they would like to see prioritised.

2.4 The MHLDA HCP coordinated a multi-agency response to the previous call for evidence. We will now consider this call for evidence and ensure that the key messages from our previous submission are reiterated and reinforced. We will ensure that the major conditions strategy is considered through the MHLDA Clinical and Practice Advisory Committee, the MHLDA Co-production Group and through both the Dementia and Mental Health Co-production boards.

2.5 We will liaise with Hertfordshire and West Essex Integrated Care Board (HWE ICB) commissioners and with colleagues from our partners HCPs in South and West Hertfordshire and East & North Hertfordshire to ensure that our key messages are reinforced through other system responses. We will also encourage all MHLDA HCP partners to make this own submission. The call for evidence closes 11.59pm on 27 June 2023.

2.6 The HWE ICB's Mental Health and Learning Disabilities Programme Board met on 18 May 2023 and received updates on the ICS-wide Suicide Prevention and Postvention Programme, Operational Planning Priorities, and targets for 2023/24 and an overview of the Learning Disabilities and Autism landscape across Hertfordshire and West Essex. Moving forwards the MHLDA HCP will be providing a regular update on its activity and priorities to this Programme Board helping to identify opportunities for collaboration and learning with West Essex colleagues.

2.7 The MHLDA HCP Development team met with colleagues from Adult Care Services in Hertfordshire County Council to discuss the planning framework for the Better Care Fund and the parameters for the Adult Social Care Discharge Funding that has been made available.

2.8 At this meeting, it was agreed that a briefing would be developed that details how activity funded through the Better Care Fund supports improved outcomes for people with mental illness and learning disabilities. It was also agreed that mental health winter schemes, funded through NHS winter monies would be reviewed to inform a future discussion on whether these schemes could be supported through the Adult Social Care Discharge Fund.

2.9 The MHLDA HCP Development Director attended the Hertfordshire and West Essex Integrated Care Partnership (ICP) Delivery plan workshop on 15 May 2023 where he delivered an update on the activity associated with the ICP Integrated Care Strategy's strategic priority six – '*improve our residents' mental health and outcomes for those with learning disabilities and autism'*. Further activity is now underway with colleagues from Essex Partnership University NHS Trust (EPUT), Essex County Council (ECC) and West Essex HCP to finalise the delivery plan for this strategic priority and to identify the best opportunities for collaboration across the ICS footprint.

3. Communications and Engagement

3.1 MHLDA Communications and Engagement has been supporting the Advancing Equity work. An initial creative brief is in development to allow communications and engagement activity to be coordinated across the different organisations involved in this work. Alongside Impactful Governance, a leaflet has been designed that will contain information regarding services that might support the needs of members of the LGBTQIA+ community.

3.2 The draft Dementia Strategy Communications and Engagement plan has been submitted to the programme's steering group for discussion and adoption. This will, again, ensure that communications and engagement is

consistent across agencies, advances the same key messages and is sequenced and planned effectively.

3.3 Other activity include finalising the MHLDA HCP Annual Report and the development of additional communication assets to support various campaigns including our work around Suicide Prevention, the Depression Pathway and Physical Health Strategy. We have also drafted an award submission for the Health Service Journal in the category of Place-based Partnership and Integrated Care.

4. Updates from our sub-committees

4.1 **Co-production Group: –** The Co-production Reference Group met on 10 May 2023 and discussed the co-production activity that informs the Primary and Community Mental Health Transformation programme. Discussion focused on the challenges of identifying and involving people with lived experience for a programme which covers a wide range of activities, system interventions and relationships. It also considered how we ensure that the engagement of communities and people with lived experience is proportionate, and that larger transformation activity might best be considered in smaller, more comprehensible, sections.

4.2 The Co-production Development Group subsequently met on 31 May 2023 to both reflect on the output of the reference group discussions and to assess how the reference group approach had worked and what might need to change to make it as effective as possible. The Development Group welcomed the output from the reference group and acknowledged the need for further work to ensure that participants nominated for the reference group are supported in advance of the meeting both by the nominating Development Group member and through more concise information on the topic being discussed.

4.3 The Co-production Development Group will now consider the next topic for a reference group.

4.4 **Clinical and Practice Advisory Committee (CPAC): –** the CPAC met on 02 June 2023.

4.5 CPAC received a presentation on the development of the Making Every Adult Mater (MEAM) framework including an update on its proposed operational and evaluation model. CPAC acknowledged that the model had been considered in depth through Hertfordshire County Council's Research Governance and Ethics process and agreed to receive regular updates as the approach is implemented so that the lessons learnt through working with cohort of people, in respect of clinical and professional practice, could be discussed.

4.6 CPAC received an update on the development and implementation of the Community Mental Health transformation model. This update referenced the additional resources available for Primary Care and the importance of ensuring that any wider community offer is integrated with existing structures

and complement other areas of transformation, most notably the implementation of the Fuller review and the development of Integrated Neighbourhood Teams.

4.7 Finally, CPAC was briefed on the Major Conditions Strategy: call for evidence and agreed with the recommendation that the MHLDA HCP submit a response that reiterated the key messages captured during last year's call for evidence around the proposed Mental Health Strategy. For further information on the Major Conditions Strategy: call for evidence please see section 2 of this report.

5. Update from our Partnership Boards

5.1 **Crisis Care Partnership Board (CCPB): –** Weekly meetings are now in place between Hertfordshire and West Essex ICB, HPFT, WHTHT, ENHT and Hertfordshire Constabulary to discuss the Home Office's Right Care, Right Person requirements and how this would work within Hertfordshire. This group will regularly report into the Crisis Care Partnership Board.

5.2 Following the most recent meeting of the CCPB, work is underway to bring together data from across different partner organisations so that everyone is operating with the same information. In addition, different initiatives related to supporting High Intensity Users is being identified to avoid duplicative activity to ensure that, as an HCP, our approach to supporting these people feels consistent and coherent.

5.3 An Outline Business Case for a new Mental Health Urgent Assessment Centre is under development and will be discussed at the next meeting of the CCPB.

5.4 **Primary and Community Mental Health Transformation: –** Further work is underway to align this programme with the Fuller Review. In East and North Herts HCP, this is likely to be achieved through their Care Closer to home strategy which is driving the delivery of Integrated Neighbourhood Teams. In South and West Herts HCP, Hertsmere has agreed that SMI is the priority population on which to focus their integrated neighbourhood team development and so will provide a useful means of demonstrating how these two transformation agendas can work together.

5.5 Following an extensive procurement process, the HertsHelp contract has been jointly awarded to Age UK Herts and Citizens Advice Stevenage under the partnership name of Hertfordshire Advice Providers Partnership (HAPP). The HertsHelp service website (www.hertfordshire.gov.uk/hertshelp) and contact details will remain the same when the contract moves from the existing provider to HAPP in September 2023.

5.7 **Children and Young People Emotional and Mental Wellbeing Board: -** In May 2023, the Board agreed to progress the development of our CYPMHS Front Door and work will now progress on agreeing the infrastructure and establishment to progress to recruitment. We have now finalised the procurement of the digital provider who will deliver a hugely improved digital

gateway for both advice and information and automated access into the CYPMHS.

5.8 The Sandbox service, which replaced Kooth as our digital advice and support service, launched in Hertfordshire on 01 April 2023. The Sandbox is an NHS-funded service to support Children and Young People in Hertfordshire with their mental health and wellbeing, offering a website with access to games, worksheets, group chats and online events. Sandbox also provide access to internet-enabled Cognitive Behavioural Therapy (iCBT) or one-to-one support from professional therapists via phone, online chat or video call, based on a triage of the young person's needs.

5.9 We continue to work with providers to increase our CYP access in line with the LTP ambition. Whilst access across Herts has increased, we remain under our target within the LTP. We are seeking to improve our position through a range of activity including improving data quality, data capture/recording and flowing of MHSDS activity for all our providers and ensuring all newly commissioned activity (e.g., digital) is captured correctly

5.10 **Learning Disabilities and Autism Strategic Partnership Board: -** End-of-year data for LD Annual health checks indicated 79.1% delivery across Hertfordshire and West Essex ICB (East and North Herts – 75.2%, South and West Herts – 82.7% and West Essex – 79.1%). This figure exceeds the both the national average (78.1%) and the East of England average (73.3%). This is a significant achievement and the result of an ongoing system commitment to increase the quality and quantity of annual health checks.

5.11 The final report in relation to the Autism health checks pilot has been submitted to NHS England. The full findings and evaluation will be shared with Learning Disabilities and Autism Strategic Partnership Board.

5.12 The local LeDeR annual report is being prepared and will also be presented to the Learning Disabilities and Autism Strategic Partnership Board in June 2023 for sign off. The national LeDeR report is due to be published in the Autumn.

5.13 The May LeDeR Leadership group themes included recognising early signs of deterioration and reasonable adjustments for patients who do not attend/was not brought. Work is ongoing across acute and community trusts to act on this learning.

5.14 In addition, five focused 'themed' reviews have been completed for individuals with a learning disability and raised BMI. Gaps have been identified in relation to prevention of weight gain and optimising weight loss. These themes have been discussed at the Improving Health Outcomes Group (IHOG) and a working group established to develop actions. Additional IHOG updates included: the Health Equalities Nurse working on cancer screening for people with a learning disability, an update WHTHT on progress against the LD Improvement Standards and an update on the work to deliver the Oliver McGowan Mandatory Training. The presentations showed some

excellent examples of good practice and progress happening across the system.

5.15 Processes are strengthening for Commissioner Oversight Visits for those in mental health beds and for those placed by the MH bed management and placement team. Several training sessions with colleagues has taken place and regular meetings are in place to ensure a consistent approach and feedback to NHSE region's Quality Oversight Group.

5.16 Co-production events to inform the development of the All-Age Autism Strategy concluded on 02 May 2023. An on-line survey is now live to capture the views and feedback of those that could not attend the event, with a closing date of 11 June 2023. A full report coproduction report is expected to be completed by NDTI at the end of June 2023. This will be presented to the All-Age Autism Co-production Board in the first instance on 18 July 2023.

5.17 Commissioners are contributing to pre-tender discussions on the future shape of the advocacy offer and working to identify gaps in the current service for people with learning disabilities. We continue to review the advocacy offer for individuals placed out of area via commissioner oversight visits.

6. Leading on prevention and positive health and wellbeing

6.1 **Housing and Making Every Adult Matter (MEAM) approach**: – The MEAM Evaluation model was considered by HCC's Research and Governance panel on 23 May 2023. The panel was generally supportive and agreed to proceed to approval subject to seeing an easy-read participant information sheet, the escalation process and safeguarding protocol and for the evaluation team to undertake e-learning on Mental Capacity Assessments. The outcomes of this panel as well as further information on ow the model will be put into practice with an initial cohort of individuals will be considered by MHLDA CPAC at its meeting on 02 June 2023.

6.2 **Employment and employability: –** Colleagues across Hertfordshire and West Essex are due to meet to agree the next steps for this priority.

6.3 **Physical Health strategy: –**the MHDLA HCP's Physical Health Strategy was approved at May's MHLDA HCP Board meeting. Work is now underway to develop a delivery plan and promotional material to ensure that the Strategy's ambitions can be realised. The final version of the Strategy is now available online at: hertfordshire-mhlda-hcp-physical-health-strategy-2023 (hertsandwestessexics.org.uk)

6.4 **Mental Health and Cost of Living -** On 10 May 2023, after discussion with key partners, a decision was taken to stand down the Cost-of-Living Mental Health Sub-group. This was in recognition that the main activities of the Group were achieved, and considerable work had been undertaken to help people with MH conditions, which were working well.

6.5 The group agreed that the MHLDA would continue to be represented on the main Cost of Living Response Group and should activity or projects that specifically relate to people who have MHLDA conditions, or the people who

care for them or work with them, then the Sub-group would be reconvened to take those activities forward.

7. Conclusion

7.1 This report has provided a summary of the key developments and activity overseen by the MHLDA HCP since the last update provided.

7.2 We can increasingly see the outcome of strengthened partnership working through the MHDLA HCP, in our strong system performance around Annual Health Checks for people with learning disabilities or in the enthusiasm and energy of partners to come together to address Suicide Prevention. Programme management resource through the MHDLA HCP Development team is helping to knit together and rationalise system activity and provide clear structures and timescales around improvements.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 15
Subject:	Report of the Audit Committee held on 22 June 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 22 June 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 Committee meeting solely focused on the review and approval of the Annual Accounts for 2022/23 and Annual Report for 2022/23, for recommendation for approval to the Board who met on 22 June 2023.

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 22 June 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 22 June 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 all the items linked with the end of year accounts and Annual Report for 2022/23, 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 The Chair of the Committee thanked KPMG for their work with the Trust through the course of their contract, noting that from 2023/24 Deloitte would be the Trust's external auditors.

2. Annual Accounts 2022/23

2.1 The Committee considered the Annual Accounts for 2022/23, noting that the draft accounts had been considered at the Committee meeting held on 24 April 2023. The Committee noted that the accounts detailed a breakeven position and that this had not changed from the draft accounts, with a headline deficit of £17.8m. The only change from the draft accounts related to the East and North Herts inpatient beds business case needing to be treated as an impairment following the announcement from NHS England at the Trust had not been successful in securing funding.

2.2 During the year a full asset valuation had been undertaken. No changes to the provisions made in the draft accounts had been made and no issues had been raised following the external audit.

2.3 The Committee were informed that there were seven audit differences, of which six had been adjusted and one had remained unadjusted but did not meet the materiality threshold. The Committee considered each of the audit differences and approved the approach recommended by the finance team. Eight control observations had been made; the one high priority area related to Special Payments which was discussed in detail at the meeting.

2.4 External Audit and the finance team noted the detailed preparations that had preceded the audit and that this had been helpful in ensuring a smooth audit process.

3. External Reports

3.1 The Committee received reports from KPMG, including the Draft Opinion, Management Representation letter, ISA 260 report and Annual Auditors Report that included Value for Money.

3.2 External Audit confirmed it would be issuing an unqualified opinion on the accounts and that they had not identified significant weaknesses in achieving Value for Money. There were no matters of control and no other matters that would be included in their report. They highlighted their view on the valuation undertaken, noting that they did not disagree with it but that was at the lower end of valuations they had reviewed.

3.3 The Committee discussed in detail their recommendation with regard to establishing a framework for authority with regard to decisions on Special Payments. KPMG reported that they are required to notify the National Audit Office of an irregularity because at the time of the accounts being signed the Trust did not have His Majesty's approval of the Special Payment.

3.4 The Committee were updated on external audit's conclusions with regard to the local government pension schemes and their movement to being an asset. KPMG also highlighted the main change from the draft accounts relating to impairment with regard to the East and North Herts inpatient beds business case.

3.5 Committee members confirmed agreement of the Management Representation Letter. It was noted that the Annual Auditors Report will be published on the Trust website alongside the Annual Accounts and Annual Report.

4. Internal Audit Reports

4.1 Internal Audit presented an update on the progress against the Internal Audit Plan for 2022/23, noting that the two outstanding reports were in draft form and would not change the draft Head of Internal Audit Opinion.

4.2 Committee members were updated on the outstanding overdue actions following previous audits. Directors gave their commitment to reduce the number but also to be realistic when setting the timescales. It was noted that the Internal Audit plan is risk based and this impacts on the types of opinions awarded. Committee noted its continued commitment to a risk based internal audit plan

5. Annual Report 2022/23

5.1 The Committee considered and approved the draft Annual Report for 2022/23. It was confirmed that the Annual Report was compliant with the Annual Reporting Manual for Foundation Trusts and had been reviewed by Board members and external audit.

5.2 It was noted that some of the final content relating to the remuneration report, internal audit plan was subject to minor amendments in line with final external and internal audit work. It was noted that the Annual Report detailed that the Trust Annual Accounts had received an unqualified opinion, a positive Head of Internal Audit Opinion and that no significant control issues had been identified.

5.3 Following discussion of the requirement to seek approval from the Treasury for Special Payments it was agreed that approval of the wording to be included in the Annual Governance relating to this would be delegated to the Chair of the Committee and Chief Executive. External Audit noted this and would be made aware of the final wording to be included.

5.4 It was noted that the Annual Report would be submitted alongside the Annual Accounts and be laid before parliament before the summer recess.

6. Annual Reports 2022/23

6.1 To support the end of year processes the Committee received reports relating to the Use of the Corporate Seal, Use of Waivers, Losses and Special Payments and Treasury Management. The Committee noted that the reports for Waivers and Special Payments had previously been considered by the Committee at its meeting on 24 April 2023.

6.2 The Committee noted the Trust's cash balances, including the interest received and payments against an outstanding loan.

6.3 The Committee discussed the Better Payment Practice Code performance during 2022/23 noting that the standard had not been met, in part due to the Advanced cyber incident. The Committee discussed the plan in place to ensure performance improves in 2023/24 noting that the Trust Committees will receive regular updates on performance throughout the year.

7. Matters for Escalation to the Board

7.1 The Annual Accounts and Annual Report was recommended to the Board meeting held on 22 June 2023 for approval.

Appendix One: Audit Committee 22 June 2023

Declarations of Interest
Minutes of meeting held on 24 April 2023
Matters Arising Schedule
Annual Accounts 2022/23 a. Draft Annual Accounts b. External Audit i. Draft Opinion ii. Management Representation Letter iii. Report of our findings to the Audit Committee (ISA260 report) iv. Annual Audit Report (Value for Money) c. Draft Annual Report including Annual Governance Statement d. Internal Audit Annual i. Head of Internal Audit Progress Report ii. Draft Annual Report (including Head of Internal Audit Opinion)
Annual Reports 2022/23 a. Use of Corporate Seal b. Use of Waivers * c. Losses and Special Payments* d. Treasury Management
Any Other Business
Date of next meeting: 18 July 2023

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Public Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 16
Subject:	Trust Risk Register June 2023	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

For the Board to consider and approve the risks on the Trust Risk Register.

Action required:

To receive the Trust Risk Register for discussion of the risks, their scores, ordering and mitigation.
To discuss and review for approval the risks, as outlined in the Trust Risk Register, and make a recommendation on the proposal.

Summary and recommendations:

Attached is the updated Trust Risk Register, noting that it was last considered by the Trust Board at its meeting on 30 March 2023. The risks on the Register have been thoroughly reviewed by the Executive team and reflect the current challenges faced by the Trust.

The risk descriptions have been updated and the total number of risks increased from seven to eleven. The increase in the number of risks is as a result of the identification of the specific risks, to ensure there is clear sight on the impact, and the actions needed.

The table below details the updated risk on the Register, detailing the current risk score.

Risk	Score
Insufficient beds to meet demand	20
Workforce vacancies	16
Delivery of 2022/23 Financial Plan	16
Number of service users waiting	16
Drug and alcohol services	15
Increased turnover and lack of staff retention	12
Sustained levels of violence, aggression and abuse	12
Failure to develop a medium to long term financial plan	12
Insufficient understanding and oversight of regulatory standards	12
Risk that the Trust's infrastructure and information system will be compromised by a cyberattack	12
Underdeveloped relationship with key commissioners and ICBs	12

Recommendations

The Board is asked to consider and approve the updated Trust Risk Register, considering if the risks and their scores reflect the current situation for the Trust, and to note the mitigating actions in place.

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

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

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

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

There are no budgetary or financial implications in the Trust Risk Register report, however some actions taken linked to the risks may have budgetary or financial implications.

Equality & Diversity /Service User & Carer Involvement implications:

All the work of the Trust needs to ensure there is equality of access and experience and this is equally as applicable when managing the risks of the organisation.

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

Health and Social Care Act 2008 (Regulated Activities) Regulations
Regulation 12: Safe care and treatment

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

Regulation 17: Good Governance

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

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

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

Exec Team 7, 21 and 28 June 2023

1. Introduction

1.1 This report provides an overview of the recent updates to the Trust Risk Register (TRR), for discussion and approval. Consideration should be given to the current situation and the mitigations that are in place. The TRR identifies the high-level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them.

1.2 Each Executive Director has reviewed the risks that they are Senior Responsible Officer (SRO) for, and the current position and mitigation has been updated.

1.3 *Figure 1* provides the risk score matrix, for information.

		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Consequences	5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
	4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
	3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
	2 Minor	2 Low	2 Moderate	6 Moderate	8 High	10 High
	1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

2. Trust Risk Register Update

2.1 The TRR was last considered by the Trust Board at its meeting on 30 March 2023. The risks on the Register have been thoroughly reviewed by the Executive team, and reflect the current challenges faced by the Trust.

2.2 The risk descriptions have been updated and the total number of risks increased from seven to eleven. The increase in the number of risks is as a result of the identification of the specific risks, to ensure there is clear sight on the impact and the actions needed.

2.3 The additional risks are:

Drug and alcohol services
Failure to have appropriate services across the system for services users with a dual diagnosis, which may result in avoidable harm, poor experience and increased use of crisis services. Current score is 15 (3 x 5) and target score of 8 (2 x 40). The inclusion of the risk is in recognition of the learning from incidents and impact on service users.

Sustained levels of violence, aggression and abuse in our services., which could result in avoidable harm to service users and staff. Current score of 12 (3 x 4) and target score of 6 (2

x 3). The inclusion of the risk is as a result of continuing levels of incidents, and impact of these on service users and staff.

2.4 The further two additional risks are as a result of the risks from the March 2023 TRR for People and Finance, being split into two for each.

The original **financial sustainability risk** has been split into one, relating to the delivery of the financial plan for 2022/23 (score of 16) and another relating to the failure to deliver a medium to long term financial plan (score of 12). This approach is to ensure that the specific and different issues related to the short- and medium-term situation are identified separately, alongside the key mitigations, rather than them being less explicit in one overarching risk.

The original **people** risk has been split between the impact of workforce vacancies in services (score of 16) and risk of increase of turnover and lack of staff retention (score of 12). The decision to split the risk was to ensure sufficient sight of the risk and its impact and recognising the different actions that are in place to address the impact of the risks.

2.5 All the key mitigating actions for each risk have been updated, and an indication of timescale, where relevant.

3. Next Steps

3.1 The Trust is planning a Board session on risk appetite and what risk management means at the Trust. This will involve consideration of the escalation of risks from services and departments, and the process of oversight of the risks, mitigation actions and assurance gained from controls in place.

4. Recommendations

4.1 The Board is asked to consider and approve the updated TRR, considering if the risks and their scores reflect the current situation for the Trust, and to note the mitigating actions in place.

Appendix 1 - Trust Risk Register

Pos	Risk	Rating (Initial) LxC	Rating (Current) LxC	Rating (Target) LxC	Link with Strategic Objective	Key Mitigations	Executive Lead

1.	**Insufficient beds to meet demand** which leads to increased use of out of area placements, an increased number of services users in the community waiting for admission, which may also result in increased financial costs.	12	5 x 4 **20**	3 x 3 **9**	We will provide safe services, so that people feel safe and are protected from avoidable harm	• External beds commissioned 15 at Kneesworth and 17 at Elysium Potters Bar.
						• Consultant-led bed management meetings three times per day, 5 days per week.
						• Plan to develop longer term plan to ensure is additional bed capacity, following outcome of New Hospitals programme – Quarter two
						• Recruitment underway for dedicated staff to further improve access and flow and ensure sustainability across the year – Enhanced Discharge Team (EDT).
						• Transformation plan in place to reduce use of Out Of Area (OOA) beds, includes:
						  ○ EROS+ expansion
						  ○ Crisis Assessment Service implementation
						  ○ Intensive outreach team expansion (FACT)
						  ○ Flow Management System
						  ○ Crisis House implementation
						  ○ Community transformation.
						• Robust monitoring of bed usage and capacity.
						• Multi Agency Discharge Event (MADE) events with increased senior involvement.
						• Implementing best practice from the national Getting It Right First-Time programme- quarter two.
						• Care and discharge plans in place for small number of complex service users.
							Sandra Brookes (Deputy Chief Executive Officer and Chief Operating Officer)

2.	**Workforce vacancies.** Lack of ability to recruit into services means not able to fill vacancies which may have an impact on service users experience and outcomes.	12	4 x 4 **16**	2 x 4 **8**	We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support and treatment	• Robust recruitment and retention plans for all staff groups. • Targeted recruitment plans for registered nursing, including attendance at national careers events. • Targeted recruitment plans in place for South West Herts quadrant. • Targeted recruitment plans in place for Learning Disability services, including launch of Open University (OU) three-year	Jo Humphries (Chief People Officer)

						apprenticeship Learning Disability nursing course • Recruitment of 100 students from University of Hertfordshire starting post in September 2023 • International recruitment of registered nurses. • Regular meetings with SBU managers and Recruitment Partners focus on hot spot areas to increase recruitment activity. • Rolling out of development offer to staff- quarter two • Programme of engagement events with staff- quarter three	
3.	**Failure to deliver 2022/23 financial plan** which may impact on Trust's ability to provide high quality care to service users and result in breach of statutory duties	NA	4 x 4 **16**	2 x 3 **12**	We will improve, innovate, and transform our services to provide the most effective, productive and high-quality care	• Enhanced systems of financial control, including: - quarter two ○ Amendments to SFIs and SoD ○ Senior levels of expenditure approval ○ No Purchase Order, no payment policy • Increased training of budget holders to improve financial decision making – quarter two • Targeted plans to reduce use of agency staff. • The Financial Recovery and Delivering Value Group in place to scrutinise all spend, develop trajectory for improvement and monitor impact of actions. • Agency Panel in place scrutinising all agency spend, developing trajectory for improvement and monitoring the impact of actions • Formal systems to support delivery financial recovery and delivering value, including SBUs and corporate departments. • Systems in place to ensure secure all relevant income and debtors -quarte two • Effective use of e-roster to enable robust scrutiny and challenge of staffing • Delivering Value programme in place. • Work programme to reduce reliance on out of area beds	

4.	**Numbers of service users waiting** for timely assessment and treatment may mean that service users needs are not met and may lead to poorer experience and outcomes.	16	4 x 4 **16**	2 x 4 **8**	We will provide safe services, so that people feel safe and are protected from avoidable harm	• Active management of both assessment and treatment waiting lists at service level. • Increasing communication for service users about support available while waiting for Trust services. • Development of clear demand and capacity plans for the future - quarter two • Robust recovery programme, reporting performance on a fortnightly basis to the Executive Team. • Regular Performance Review meetings to monitor performance of services. • Weekly overview meetings that oversee recovery and delivery trajectories. • Analysis of benchmarking data to identify areas for improvement and good practice. • Community Transformation programme in place to develop future model. • Clear risk management processes in place in all teams to manage waiting lists safely.	Sandra Brookes (Deputy Chief Executive Officer and Chief Operating Officer)
5.	**Drug and alcohol services** Failure to have appropriate services across the system for services users with dual diagnosis which may result in avoidable harm, poor experience and increased use of crisis services.	**NA**	3 x 5 **15**	2 x 4 **8**	We will provide safe services, so that people feel safe and are protected from avoidable harm	• Pilot to embed Drug and Alcohol workers in each community team – quarter three • Joint work with Director of Public Health to analyse the increase in demand for services to support drug and alcohol users- quarter three • Additional PMO resource to support analysis of need and demand. – quarter three • Active member of Herts system Drug and Alcohol Strategic Board. • Robust internal process to ensure staff are supported in using alert on Paris. • Promotion of support materials for people who are using drugs or alcohol and who want to seek support • Promotion of available drug and alcohol services.	Asif Zia (Executive Director Quality & Medical Leadership)
6..	**Increased turnover and lack of staff retention** leads to higher vacancies and inability to provide high quality care.	16	3 x 4 **12**	2 x 4 **8**	We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support and treatment	• Clear retention plans centring focusing on Belonging and inclusion, talent management, development opportunities and collective leadership. • Development of Belonging and Inclusion Strategy supported by a comprehensive action plan including: - quarter two	Jo Humphries (Chief People Officer)

						○ zero tolerance to discrimination across the Trust ○ Delivering a compassionate and caring teams programme aligned to our values ○ Implement inclusive, compassionate leadership development • Comprehensive wellbeing offer in place. • Increased development offer for all staff supported by information from appraisals and supervision.	
7.	**Sustained levels of violence, aggression and abuse** in our services. Which could result in avoidable harm to service users and staff.	**NA**	3 x 4 12	2 x 3 **6**	We will provide safe services, so that people feel safe and are protected from avoidable harm	• Multi-agency Violence and Aggression CQI project, to review strategies to reduce violence and aggression. • Comprehensive communications plan to emphasise that the Trust will not accept physical, racial, or verbal abuse of staff. • Implementation and embedding of Trauma Informed Approaches across all services starting with all inpatient services – quarter three. • Review of Safe and Supportive Observations (SASO) • Review of Respect training- quarter two • Completion of Positive Behavioural Support (PBS) plans • Peer reviews of restrictive practice • Learning from the national quality improvement programme relating to inpatient services- quarter three.	Jacky Vincent (Executive Director, Quality and Safety (Chief Nurse))
8.	**Failure to develop a medium to long term financial plan**, will impact on the Trust's sustainability and ability to deliver high quality care.	NA	3 x 4 **12**	3 x 3 **9**	We will improve, innovate, and transform our services to provide the most effective, productive and high-quality care	• Development with HWE ICB of long-term financial plan- quarter 3 • Comprehensive use of benchmarking data including Model Healthcare Systems to support review of overhead and non-clinical costs- quarter 3 • Regular dialogue with commissioners regarding challenges and transformation. • Ensure exploration of all relevant additional income streams, benchmarking commissioned service against the service provision and identing unfunded service provision- quarter two	Philip Cave (Chief Finance Officer)

9.	**Insufficient understanding and oversight of regulatory standards** which may result in non-compliance and/or insufficient improvement against regulatory standards, which may lead to substandard care in identified units/services.	N/A	3 x 4 **12**	2 x 4 **8**	We will provide safe services, so that people feel safe and are protected from avoidable harm	• Robust Service Improvement Action Plans (SIAP), in place to support inpatient services with oversight and regular reporting to the Executive Team for Warren Court, Oak Ward, Swift Ward and Forest House. • Analysis of quality dashboard in place as early warning and to identify areas requiring additional support and scrutiny. • Increased clinical leadership and oversight across inpatient services to support and ensure fundamentals of care. • Robust programme of Quality Assurance Visits (QAV) and supportive visits in place using internally, and external expertise. • Robust governance structure in place to oversee all aspects of quality and safety. Supported by forum of senior managers to review all aspects of delivery of quality and safety programmes. • Patient Safety syllabus part of comprehensive mandatory training programme.	Jacky Vincent (Executive Director, Quality and Safety (Chief Nurse))
10.	**Risk that the Trust's infrastructure and information system will be compromised by a cyberattack** that will result in disruption to services due to inability to access key systems and potential loss and/or public disclosure of information.	3 x 4 **12**	3 x 4 **12**	3 x 3 **9**	We will improve, innovate, and transform our services to provide the most effective, productive and high-quality care	• Review of individual Business Continuity Plans to ensure impact of a cyberattack is minimised • Regular communications with staff to raise awareness of increased number of phishing attempts to reduce likelihood of a successful cyberattack • Dedicated cyber security page on Service Now with useful information on how to spot and protect themselves from falling victim to phishing campaigns • Deployment of Multi Factor Authentication (MFA) on NHS mail to reduce the risk of compromised accounts • Simulated phishing campaigns to identify and provide further advise to users likely to fall victim to phishing attempts • Patching regime in place to address known vulnerabilities and proactive monitoring of the environment and endpoints • Annual penetration test to identify and address potential weaknesses • Cyber Security Improvement Plan for 2023/24.	Hakan Akozek (Director, Innovation and Digital Transformation)

11.	**Underdeveloped relationship with key commissioners and ICBs** as a consequence of the changed landscape. May lead to reduced ability to influence and access to resources in 2022/23 and 2023/24.	12	3 x 4 **12**	2 x 3 **6**	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	• Full Stakeholder plan under development – quarter two • Development of medium-term financial plan supported by the ICB -quarters 3-4. • Active role in East of England Provider Collaborative, including lead provider for CAMHS and perinatal • Lead of MHLDA HCP with Hertfordshire County Council in next stage of development of the HCP within HWE. • Develop commercial strategy. – quarter two • Active plan to have in place relationships with commissioners in Norfolk and Buckinghamshire	David Evans (Director of Strategy and Partnerships)

PUBLIC Board of Directors

Meeting Date:	6 July 2023	**Agenda Item:** 17
Subject:	MHAM Committee Annual Report to the Board	**For Publication:** Yes
Author:	Hattie Llewelyn-Davies/Tina Kavanagh	**Approved by:** Tim Bryson, Non-Executive Director
Presented by:	Tim Bryson, Non-Executive Director	

Purpose of the report:

To report on the activity of Mental Health Act Managers (MHAM) and the use of the Mental Health Act (MHA) in HPFT during 2022/23

Action required:

As required by the Terms of Reference of the MHAM Committee meeting a report is to be presented to the Board for information about MHAM activity.

Summary and recommendations:

For information only and to provide assurance that the statutory functions of the Trust Board is carried out within HPFT in relation to the MHA.

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

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

All legislation integrated into Business Plan and covered in Standing Financial instructions
Mental Health Act
Mental Capacity Act
Deprivation of Liberty Safeguards
Any areas of concern are highlighted on the risk register

- We will provide effective legal services so that service users rights are being actively promoted.
- We will deliver a great experience of our services, so that those who need to receive our support and advice feel positively about their experience
- We will improve & innovate our services to provide the most effective, productive and high quality legal advice
- We will deliver appropriate training to staff and Managers to ensure they can meet the legislative needs of our service users across mental, physical and social care services in conjunction with our partners

We will ensure that all risks associated with MH legislation is closely monitored and update the Trust Risk Register appropriately

Board to agree that the report provides assurance that all statutory responsibilities under the MHA are undertaken.

Summary of Financial, IT, Staffing & Legal Implications:

MHAM are not employees of the Trust. There is a legal requirement for the Board to authorise individuals to exercise the power of discharge (S26(3) MHA) and to ensure that there is a scheme of delegation in place to ensure all other responsibilities of the Trust are met in respect of the MHA.

Equality & Diversity and Public & Patient Involvement Implications:

Reports published by the CQC has highlighted that, in some parts of England, people from black Asian minority ethnic (BAME) backgrounds are overrepresented in the detained service user population. We are committed to better understanding the position at the Trust and in 2023 will collate information in relation to ethnic minorities and use of the MHA to help inform future training requirements.

Executive Summary

This report covers activity in respect of the Mental Health Act Manager (MHAM) Service from April 2022 to March 2023. The MHA Code of Practice requires an annual report to the Board of MHAM activity as well as information in relation to the on-going development of processes, guidance and training requirements for the MHAM.

This report includes an update in respect of the reform of the Mental Health Act.

The use of the Mental Health Act continues to rise nationally.

There are currently 36 active MHAM covering our sites in Hertfordshire, Norfolk, N. Essex and Buckinghamshire. All patients who have had their MHA compulsory order renewed or extended must have the renewal/extension reviewed by the MHAM, they also have the right to appeal to the MHAM. All hearings have been held remotely since March 2020.

The MHAM area of the HPFT website is updated to include relevant information and useful links for the MHAM; this has been welcomed by the MHAM.

Governance arrangements are in place to ensure that all new MHAM are interviewed by the MHAM Manager and DBS checks carried out. Each MHAM will observe a minimum of three hearings before Board approval for their appointment is sought. Some Managers will go on to chair Hearings, a new training process has been implemented this year. Feedback to date is excellent.

The robust reporting system for the MHAM to raise operational/clinical concerns to ensure that issues highlighted during a review hearing by the MHAM has been working well. This ensures that issues are dealt with in a transparent manner and there are clear governance arrangements around this. There have been eight concerns raised during this reporting period, ranging from lack of attendance of a professional, to a concern about transfer of a patient to a more appropriate mental health unit.

The MHAM aim to encourage service user feedback about their experiences of MHAM hearings. The Non-Executive Lead and the Manager of the MHAM service will continue to support all MHAM and ensure a consistent and integrated service across all sites. The MHLD continue to support the MHAM despite staff shortages and thank Sarah Betteley for her email thanking them all for their service,

1) Introduction

1.1 This report covers activity in respect of the Mental Health Act Manager (MHAM) Service as required by the MHA Code of Practice (2015) and also by the Terms of Reference for the MHAM Committee, which is reviewed and reapproved by the Board for Hertfordshire Partnership University NHS Foundation Trust.

1.2 The report focuses on the period April 2022 – March 2023 and the on-going development of processes, guidance, training requirements in respect of the Mental Health Act and the evolving implications of the Mental Capacity Act 2005 (and Deprivation of Liberty Safeguards).

2) Responsibilities of the Trust Board

2.1 NHS Trusts are defined as Hospital Managers for the purposes of the Mental Health Act 1983, (as amended by the MHA 2007), in effect this is the Board of Directors made up of executive and non-executive members. It is the Hospital Managers (known as MHAM) who have the authority to detain patients under the Act and they have the primary responsibility for ensuring that the requirements of the Act are followed, in particular:

- They must ensure that patients are detained only as the Act allows;
- That treatment and care comply fully with the provisions of the Act;
- That patients are fully informed of, and are supported in exercising their statutory rights.

2.2 MHAM have various powers and duties which include:

- The power of discharge from compulsory powers (detention and Community Treatment Orders).
- Receipt and Scrutiny of Mental Health Act Documents.
- Provision for access to the First Tier Tribunal Service (Mental Health)
- Provision of information to patients and their nearest relatives.

2.3 In practice, the decisions and actions of the MHAM are actually taken by individuals (or groups of individuals) authorised by the Board to act on their behalf, in particular, decisions about discharge. Section 26(3) of the Act states that any three or more persons authorised by the Board, that are not Executive Directors of the Board or an employee of the Trust can exercise the power of discharge from compulsory powers:

- Only non-executive directors or other non-employees appointed for the purpose can exercise this power.
- These other non-employees are referred to in HPFT as Mental Health Act Managers (MHAM).
- MHAM may be paid a fee for their role, but their role and activity within the organisation must not be such that it would amount to the MHAM being classed as an employee.

2.4 The Mental Health Act Managers Committee is a Committee of the Trust Board for these purposes.

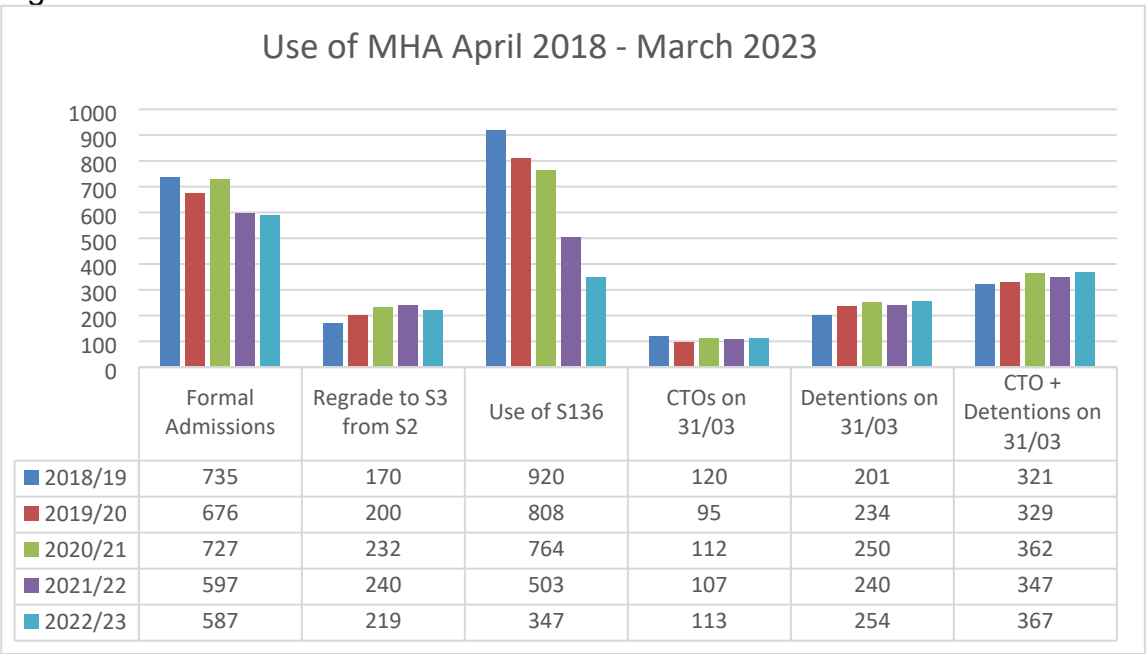
3) Information in relation to the use of the Mental Health Act within HPFT:

3.1 Although there has been an on-going national increase in the use of the MHA over the years, there appears to have been a decrease in the number of patients admitted formally to the Trust, compared to previous years. However it should be noted that the number of patients being admitted on section to general hospitals has increased due to reduced availability of mental health beds.

3.2 Data for detentions is collected nationally via MHMDS, however it continues to be acknowledged that this is not reliable as not all providers submit their data and there have been concerns about accuracy. It is therefore still not possible to undertake a national comparison.

3.3 The following graph shows a snapshot of the use of the MHA in HPFT during 2022/23 compared to previous years reporting periods.

Figure 1



	Formal Admissions	Regrade to S3 from S2	Use of S136	CTOs on 31/03	Detentions on 31/03	CTO + Detentions on 31/03
2018/19	735	170	920	120	201	321
2019/20	676	200	808	95	234	329
2020/21	727	232	764	112	250	362
2021/22	597	240	503	107	240	347
2022/23	587	219	347	113	254	367

Figure 1

* 1.7% ↓ 8.8% ↓ 31% ↓ 5.6% ↑ 5.8% ↑ 5.8% ↑

**Changes from 2021/22 to 2022/23 reporting period.*

3.4 There has been a 31% decrease in the use of Section 136 (S136) in 2022/23 from 2021/22 detained to a Trust place of safety; nationally the numbers continue to increase. The decrease in Trust numbers appears to be due to the increase in the number of people detained on S136 in the Emergency Departments (ED), i.e. if there is no capacity in the S136 suites, service users are being redirected to ED, or if they require medical assistance. From 1 April 2022 to 31 March 2023, there were 470 service users assessed and discharged from S136 in an ED; this is similar to 2021/22 where 466 service users were detained in an ED.

3.5 The Trust is actively involved in the S136 Interagency meeting, which reports into the Crisis Care Concordat, working to address increases and ensure best practice is applied.

3.6 The CQC has highlighted in several reports that, in some parts of England, people from black Asian minority ethnic (BAME) backgrounds are overrepresented in the detained service user population. It has also been noted that although this was a fundamental reason for the review of the MHA, there has been minimal work nationally to address disparities. Work will be undertaken in 2023 by the MHLD and the Inclusion and Diversity Team to collate information in relation to ethnic minorities and use of the MHA. This will help inform future training requirements.

4) Legislation Update

4.1 MHA Legislation Review

In 2017 the government commissioned a review to look at how the Mental Health Act (MHA) is used and how practice can improve, with a particular focus: (a) rising rates of detention under the Act, (b) the disproportionate number of people from black and minority ethnic groups detained

under the Act, and (c) processes that are out of step with a modern mental health care system. In 2022 the government published a draft Mental Health Bill, the MHLD produced a briefing paper for the board and submitted their response to the draft Bill in September 2022. The government intends to make any necessary amendments to respond to the recommendations of the committee with a view to introducing the Bill in 2023; the full implementation date has not been set. HPFT have requested to be part of a national QI program which will support improvements in culture and practice to meet the aims of the MHA reforms.

In order to be prepared for the potential requirement for restructuring the teams to support these changes and any additional resources that may be required, a scoping and proposal will be drawn up by the Head of Legislation & Compliance, with support from the Finance Department. The Mental Health Legislation & Compliance Quality and Policy Group, operational leads and multi professional representatives will be consulted to inform this early work.

4.2 Liberty Protection Safeguards Consultation

The introduction of Liberty Protection Safeguards was due to come into force on 1 October 2020 but has been delayed on several occasions. The Government have recently issued an update and have delayed the implementation of LPS “beyond the life of this parliament” as part of prioritising work on social care. There will be an election in 2024 and the new Government will make a decision on this.

5 Video links for MHAM hearings and Tribunals

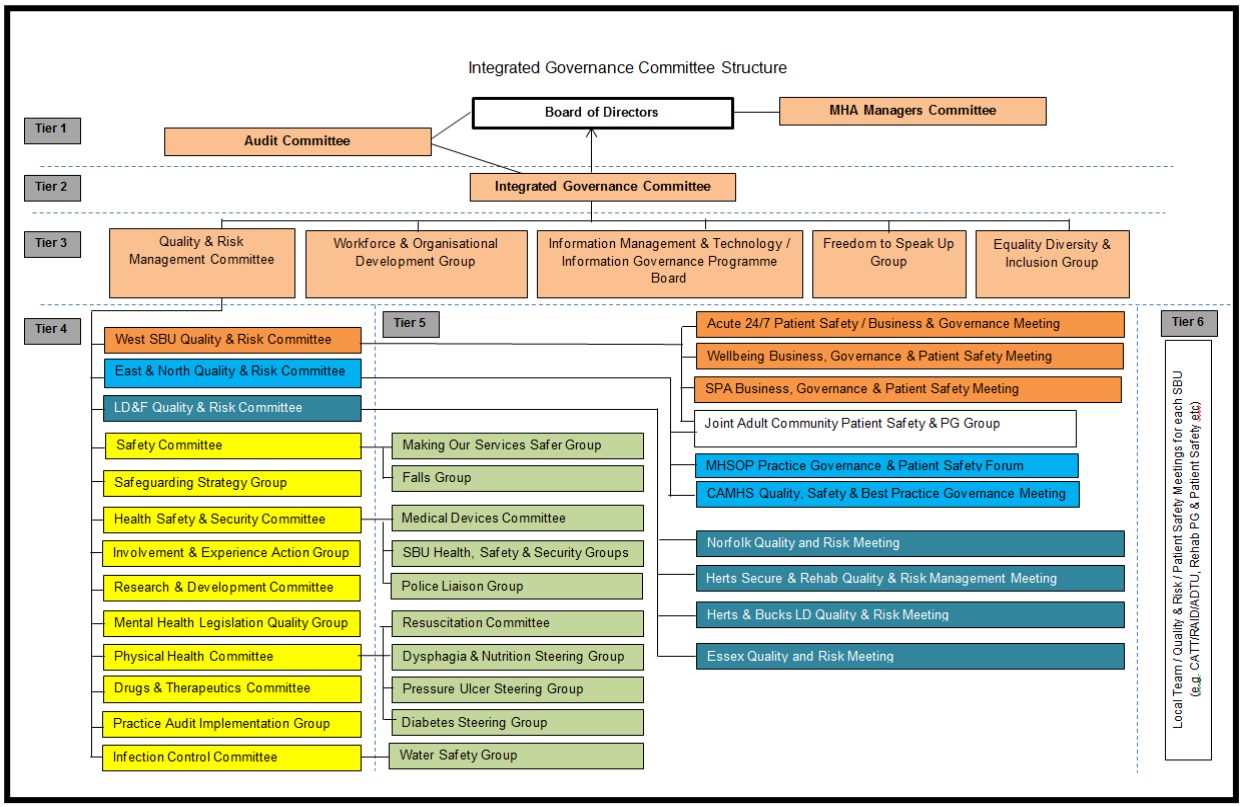
Video links for MHA Manager Hearings and Tribunals

5.1 Since March 2020 MHA Manager (MHAM) Hearings and First Tier Tribunal (FTT) hearings have been held virtually. These have worked well with the reports being sent to MHAM via secure NHS.net email accounts and attendance of patients is being facilitated by in-patient and community teams to enable service users to attend.

5.2 The Tribunal service is currently piloting a return to face-to-face hearings nationally, although there have been a number held in HPFT units the majority of Tribunal hearings are held via video link. The patient and their legal rep are offered the choice of having the hearing face to face. We will review access for patients to face to face MHA Manager hearings following the outcome of the FTT pilot.

6) MHAM Committee Meeting Structure

6.1 The Trustwide committee meeting was held on 1st November 2022 at The Colonnades. HPFT MHAM are a Committee of the Board and membership of all NEDs is included in the Terms of Reference; this meeting combined training, development and discussion events.



6.2 Since February 2021 the three sub committees of the board, Hertfordshire, Essex and Norfolk, have amalgamated so there is just one pool of MHAMs, this has worked very well for virtual hearings however may not be quite as effective if HPFT return to face-to-face hearings.

7) The Team of MHA Managers

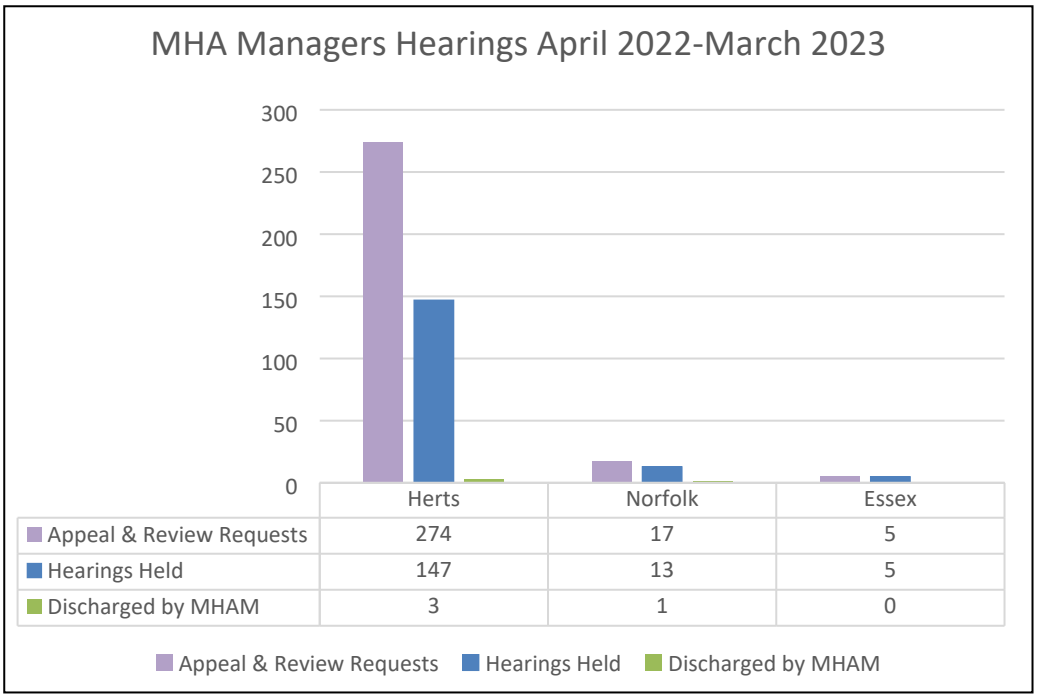
7.1 There is a NED lead for MHAM and a Manager of the Mental Health Act Manager (non-employee). These appointments continue to ensure a clear line of responsibility and accountability to the Board.

7.2 MHAM have an annual review/appraisal to reflect on their previous year's activity. In 2022/23 these were undertaken with the Manager of the MHA Manager Service. The Code of Practice states that appointments to MHAM Panels should be made for a fixed period and that any reappointment should not be automatic and should be preceded by a review of the person's continued suitability. The Trust complies with this by appointing MHAM for a further year subject to the successful outcome of the appraisal meeting. These review meetings are also used as an opportunity to identify potential new Panel Chairs and to inform the training/discussion group programme and development of the service.

7.3 HPFT has 36 active MHAM, 13 of whom are Chairs. There has been a slight increase in the number of active MHAM due to ad hoc appointments during the year, this has resulted in three new HAM appointed by the Board.

8) MHA Managers Hearings

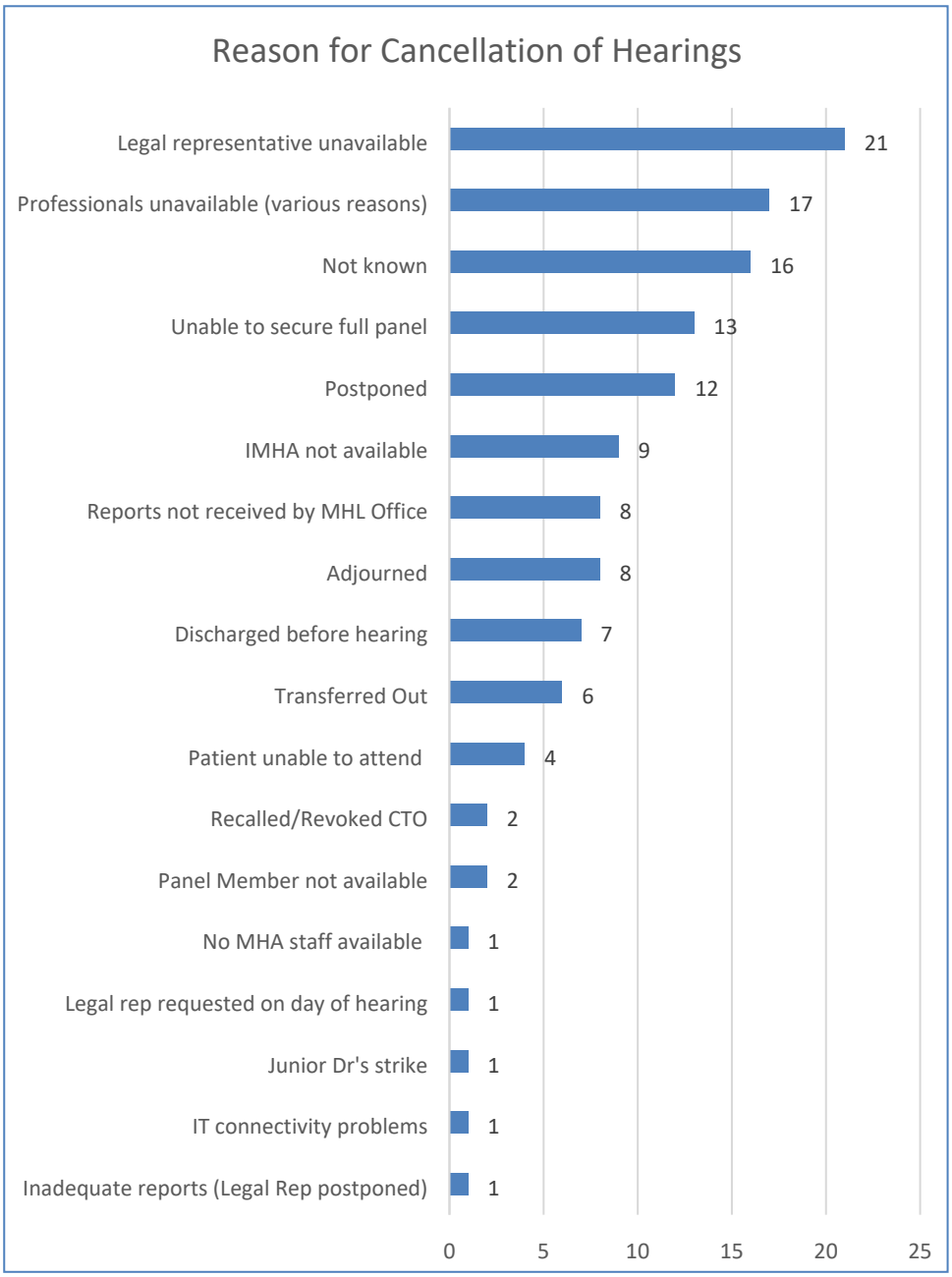
8.1 Patients subject to compulsion orders under the MHA that can be renewed or extended must have the renewal/extension reviewed by the MHAM, (patients subject to compulsion can also appeal against their section to the MHAM).



*Excludes CTO Paper Reviews

The majority of hearings are review hearings, only 19 of those requested were appeal hearings.

The following chart shows reasons why hearings were not held across the Trust.
Figure 2



8.2 If a patient subject to a CTO has the capacity to decide that they do not wish to contest the extension of their CTO and do not want to attend a review hearing the MHAM can review the decision to extend based only on reports by the responsible clinician (RC) and care coordinator (CC), a paper review. Should further information be required in order to make a decision and the RC or CC is not available on the 'phone to provide the information the MHAM will adjourn the review and request that a hearing with the RC and CC is held.

There are no more than two consecutive paper reviews before a hearing with the RC and CC is held.

In addition, there were 15 paper review hearings, one of these was adjourned as the panel believed that a full hearing was required.

Of the hearings cancelled – unable to secure a full panel due to lack of availability of a chair on 6 of the 13 occasions. As a consequence, three new chairs have been trained and appointed during the year.

9) First Tier Tribunals (FTT)

9.1 All patients subject to the MHA have the right to appeal to the FTT for a review of their section and the MHAM have a duty to refer a patient at specific intervals during their compulsion.

Appeals/Referrals Requested	Number Reviewed 2022/23	Discharged by FTT
301	219	10

10) Committee Meetings, Discussion Groups and Training 2022/23

10.1 The committee meeting in the 2022/23 period included:

- An HPFT update from Sarah Betteley and Karen Taylor,
- Discussion around the outcomes of the annual appraisals
- MH Legislation update by Tina Kavanagh

The next annual committee meeting will be held at The Colonnades on 31st October 2023.

10.2 There are now regular discussion groups both for chairs and for all managers to provide support and development for any issues that have arisen for managers in the last quarter. These have been warmly welcomed and are well attended.

11) Achievements and Acknowledgements

The year has continued to provide challenges for all involved in the provision of this service as the demand continues to rise.

The on-going efforts and improvement in the structure and contents of Responsible Clinician, Nursing and Social Care Reports is acknowledged and particularly appreciated by the MHAMs.

The process for MHAM to raise concerns directly with the Manager of the MHAM service appears to be working well. All issues highlighted as a concern when MHAM attend hearings have been dealt with in a transparent manner and there are clear governance arrangements around this.

The work of Hattie Llewelyn-Davies in her role as Manager of the MHAM is much appreciated and has provided cohesion in the service.

On behalf of the Board, I wish to thank Tina Kavanagh and the MH Legislation team, for the commitment, knowledge and professionalism that they have shown to our service users and carers.

Finally I would like to thank the MHAM who carry out this delegated role on behalf of the HPFT Board for their contribution & dedication throughout the year.

12) Priorities for 2023/24

There are a number of priorities for the forthcoming year for the MHA Manager Service

- On-going training and MH legal updates in respect of the MHA and its interface with MCA and DOLS in particular with regard to changes in the law.
- To report on ethnicity of service users who appeal to the MHAM.
- On-going work to try to gain feedback from Service Users about their experiences of MHAM Hearings and to actively take account of this feedback.
- On-going support to all MHAM to ensure a consistent and integrated service across all sites.

- To ensure that learning resources for guidance on the MHA and MCA is available electronically for the MHAM, including access to e-learning and legal webinars.
- To ensure vacancies are widely advertised in order to continue the progress being made towards achieving greater diversity in the pool of MHA Managers, particularly around age, ethnicity and disability.
- To encourage more MHAM to become chairs and further develop their training
- To ensure that MHAMs are aware of the MHA Code of Practice and that the training programme addresses the requirements of the Code of Practice overall and specifically in respect of understanding risk, in addition to all other relevant policies
- Ensuring that use of technology for hearings continues to be effective.
- Encouraging participation of community patients with hearings by the use of technology.

13) Future Annual Reports on the Service

A future report will be submitted to the Trust Board in one year.

Report produced by Hattie Llewelyn-Davies/Tina Kavanagh
on behalf of Tim Bryson
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