Hertfordshire Partnership University NHS Foundation Trust
PUBLIC Board of Directors

Microsoft Teams

30 July 2020 10:00 - 30 July 2020 13:30

INDEX

Hertfordshire Partnership University NHS Foundation Trust

BOARD OF DIRECTORS
Meeting Held in Public

Date: Thursday 30 July 2020
Virtual
Time: 10:00 – 13:30pm

SERVICE USER STORY				
A G E N D A				
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**
1	**Welcome and Apologies for Absence:**	Chair		
2	**Declarations of Interest**	Chair	**Note/Action**	Attached
3	**Minutes of Meetings held on:** **27 February 2020** **19 June 2020**	Chair	**Approve**	Attached
4	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
5	**CEO Brief**	Tom Cahill	**Receive**	Attached
QUALITY & PATIENT SAFETY				
6	**Report from Board Assurance Sub-Committee – Covid 19 held 9 July 2020**	Chair	**Receive**	Attached
7	**Covid-19** **a) Incident Management and running of service** **b) CQC Board Assurance IPC inspection** **c) Managing our services & restoration** **d) CPAC presentation**	 Jacky Vincent Jacky Vincent Karen Taylor Asif Zia	 **Receive** **Receive** **Receive** **Receive**	 Attached Attached Attached To follow
8	**Patient Safey**	Jacky Vincent	**Receive**	Attached
9	**Trust Risk Register**	Jacky Vincent	**Receive**	Attached
10	**Research Strategy**	Asif Zia	**Receive**	Attached
11	**Quality Accounts 2020/21**	Asif Zia	**Approve**	Attached
12	**Annual Report Health, Safety and Security Compliance Report 2019/20**	Jacky Vincent	**Receive**	Attached
BREAK				
OPERATIONAL AND PERFORMANCE				
13	**Quarter 1 Performance Report**	Keith Loveman	**Receive**	Attached
14	**Quarter 1 Workforce Report**	Ann Corbyn	**Receive**	Attached

15	**Quarter 1 Finance Report**	Paul Ronald	**Receive**	Attached
16	**Annual Plan 20/21 Refresh & Update**	Karen Taylor	**Approve**	Attached
STRATEGY				
17	**Mental Health and Learning Disability ICP**	Tom Cahill	**Receive**	Attached
BREAK				
GOVERNANCE AND REGULATORY				
18	**Governance Arrangements**	Keith Loveman	**Receive**	Attached
19	**Mental Health Act Managers Annual Report**	Loyola Weeks	**Receive**	Attached
20	**Any Other Business**	Chair		
	QUESTIONS FROM THE PUBLIC	Chair		

Date and Time of Next Public Meeting:
Thursday 24 September 2020, 10.30 – 13.30, Colonnades

ACTIONS REQUIRED

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action
Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approving it
Note: For the intelligence of the Board without the in-depth discussion as above
For Assurance: To apprise the Board that controls and assurances are in place
For Information: Literally, to inform the Board

Chair: Chris Lawrence

Declarations of Interest Register

Board of Directors

30 July 2020

Members	Title	Declaration of Interest
David Atkinson	Non-Executive Director	Goldman Sachs Group Inc equity share owner Trustee of Papworth Trust Independent NED Mizuho Trustee Eternal Forest Trust
Tanya Barron	Non-Executive Director	Chair of Affinity Trust Education Development Trust
Sarah Betteley	Non-Executive Director/Deputy Chair	Director DEVA Medical Electronics Ltd
Keith Loveman	Director of Finance/Deputy CEO	Nil Return
Jane Padmore	Director, Quality & Safety	Director of Nursing Forum, National Mental Health and Learning Disability
Paul Ronald	Director of Operational Finance	Chair – MIND in Mid-Herts
Loyola Weeks	Non-Executive Director	Director O'Donovan Weeks Ltd
Asif Zia	Director, Quality & Medical Leadership	Nil Return
Chris Lawrence	Chairman	Chair, University of East Anglia Staff Superannuation Scheme Chair, Horstead Centre Director, Lambeth Conference Company
Sandra Brookes	Director, Service Delivery & Service User Experience	Nil Return
Tom Cahill	Chief Executive Officer	Nil Return

Ann Corbyn	Director, People & Organisational Development	Nil Return
Sarita Dent	Associate Non-Executive Director	Treasurer of Bipolar UK
Catherine Dugmore	Non-Executive Director	WWFUK Trustee RGB Kew Trustee Natural England Board Member Aldwickbury School Trust Limited
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
Diane Herbert	Non-Executive Director	NED HMRC Shareholder in own coaching/leadership business
Janet Paraskeva	Non-Executive Director	Chair, CLC. (Council for Licensed Conveyancers) Chair Jersey Appointments Commission Chair Regulation and Standards RICS (Royal Institute for Chartered Surveyors)
Karen Taylor	Director, Strategy & Integration	Nil Return

Agenda Item: 3

Minutes of the PUBLIC Board of Directors Meeting
Held on Thursday 27th February 2020
Da Vinci B – Colonnades

Present:

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

Item	Subject	Action
000/20	**Service User Presentation** CL welcomed Tarek who was previously a resident of Beech Unit and more recently Aston Ward. Tarek talked to the Board about his experience on Beech Unit and the support he received to attend the Making Services Better. Tarek was now living in the community and was keen to be involved in service improvements. CL thanked Tarek for his presentation and noted he had identified a number of issues that the Board would take away to consider	
020/20	**Welcome and Apologies for Absence** CL welcomed all to the meeting and apologies for absence were noted.	
021/20	**Declarations of Interest** The Declarations of Interest Log was reviewed and noted.	
022/20	**Minutes of the meeting held on 30th January 2020** The minutes of the meeting held on the 30th January 2020 were reviewed with two amendments requested.	

	The remainder of the minutes were agreed as an accurate account of the meeting and approved subject to the changes. **APPROVED** **The Minutes of the 30th January 2020 were APPROVED**	
023/20	**Matters Arising** The matters arising schedule was reviewed and updates noted.	
024/20	**CEO Report** TC presented to the Board. Key headlines were: **National Update** • The NHS continued to be under significant pressure with the referral to treatment time 18 week target creating considerable costs. • Since the NHS Funding bill 2019-21 we had seen real momentum with new capital. • Digital was a big priority and had seen the introduction of NHSX. • The NHS continued to move towards system development with focus on ICS and ICPs. • The Care Quality Commission (CQC) had published 'Monitoring the Mental Health Act in 2019/19'. • NHS England and NHS Improvement (NHS/I) had now published the operational planning and contracting guidance for 2020/21, this was later than they had previously published. **Regional and System Update** The East of England Provider Collaborative continued to press ahead with its business case. From 1st May 2020 Tracy Dowling would be the lead CEO with Tom Cahill picking up the reins from 1 November for 6 months. The Board would be kept appraised of developments. **Trust-wide Update** • Finance The Trust was broadly on track in terms of finance with assurance that we would meet the control total for 2091/20, however noting there was continuing significant pressure with out of area placements. • Performance Overall, as a Trust, performance continued to be strong with teams working very hard. Access standards for community services in all age groups and learning disabilities had been met or exceeded. Other areas of improved performance were referrals for dementia diagnosis and delayed transfer of care. However this would be hard to sustain and talks had begun with commissioners. • Care Quality Commission The Trust had been advised by the CQC that they were unlikely to visit this year. Conversations would be had with the Integrated Governance	

	Committee (IGC) and the Board to look at what we would do in-year as a Trust. • Flu Vaccine This year's flu vaccine campaign had seen a rate of 64% Trust frontline staff vaccinated with a push to try and achieve 65%. TC reported that whilst this was a better result than in previous years, as a Trust we were well behind acute and commissioning. The target for next year had been increased to 90%. The Trust would be looking at learning from this year and approaches from other Trusts. It was confirmed that AZ would be the Board level lead for next year's campaign. • PLACE Audits 2019 The results of the 2019 PLACE (Patient Led Assessment of the Care Environment) audit had been published with the outcomes being the best the Trust had ever achieved. Scores were well above both the national average and Mental Health average in every domain. However, whilst this was excellent news, we should not become complacent, and should use this to take stock and look at what more we could do. • Operations TC reported that the teams were performing extremely well considering the immense pressures they faced. During February and March the Trust would be holding a series of workshops with Service Users, Carers and staff to look at 'how we can deliver better care' and 'what can we do to help you do your job better'. The results of the workshops would be shared at a future Board. ***Action: Results of the Community Service workshops to be shared at a future Board***	**SBr**
	Our People • National Staff Survey The National Staff Survey results had shown a positive improvement across 73 out of 91 questions. • EU Exit TC advised that we had written to EU staff to ensure that we were doing everything we could to support them with responses back thanking TC for the re-assurance. • Senior Leadership Team Ann Corbyn had formally joined the Trust on the 3 February as the new Director of People and Organisational Development. TC formally recorded a thank you to Susan Young for her time with the Trust as interim. • Executive Team Restructure TC reported that since the departure of Ronke Akerele, with the Board's support a new post had been created for a Director of Operational Finance. The position was for 2 years and would be a non-voting member of the Board. Interviews were taking place on the afternoon of the 27 February 2020. TC concluded his update advising the Board that the Independent Well Led	

	Review had commenced with the self-assessment process. TC invited questions. CL commented on the PLACE outcomes, noting the pleasing result and asking the question of what we had done in terms of our relationship with Interserve. KL responded stating that three things had taken place; agreement to invest a significant amount of money into the contract; change in relationships and new appointments within the Estates and Facilities team. CL further commented raising the Accreditation of the Adult Community team, and reporting that he had also seen teams from other areas take great pride in the accreditation they had received and made a suggestion that it would be useful, as a Board, to understand why we were accredited and what it meant. TC acknowledged with agreement for this to be bought back to the board more formally. ***Action Point: AZ to write a paper for the Board on Accreditation*** **RECEIVED** **The Board discussed and RECEIVED the CEO report**	**AZ**
025/20	**Coronavirus Update** JPad took the paper as read and provided a verbal update to the Board. Key messages to note were: • Two members of staff had recently returned from affected areas, and both were self-isolating. Both had been tested for the virus with the first coming back as negative and the second results due on the 27 February. • JPad provided assurance to the Board that the Trust was fully prepared in terms of the Crisis Plan with a desktop exercise recently undertaken. • Fit testing had commenced on equipment alongside training. • The Trust had identified isolation rooms across its sites. Overall, as a Trust we were prepared and being responsive to the daily updates. and set up a daily internal call. TC commented querying if there had been any update on a vaccine. AZ advised that the virus continued to change, so was proving difficult to to produce a vaccine. LW asked about the seasonal Flu and the increase in staff sickness rates with TC replying that this was comparative to the data around the same time in the previous year. CL thanked JPad for the update and asked if there was anything that the Board could be doing. Following a brief conversation it was agreed for the Board to receive a weekly briefing. ***Action: Board to be provided with a weekly briefing on Covid19*** JPad concluded stating that Covid19 and been added to the Trust Risk Register.	**JPad**

	CD queried that should the need arise were we prepared with who would undertake a deep clean. JPad responded advising that this would be Interserve who were involved in the weekly Outbreak calls.	
025/20	**Quarter 3 Integrated Safety Report** JPad presented the report to the Board which provided assurance on actions taken in response to safety related incidents, themes and learning. JPad highlighted to the Board that, due to timings, the report had not yet been received by the Integrated Governance Committee (IGC). Key messages drawn from the report were: • Overall, the quarter had seen good progress against the annual plan priorities. • Service Users reporting that they felt safe score had not done well, however should be noted that there was significantly more data now. Following on from the Peer Experience listening piece of work further work was now underway. • The CQI project had seen a significant impact in the quarter, of note was Robin Ward who had seen the benefits through a project to reduce ligatures. A member of the CQI team had been designated specifically to safety. • Violence between Service User to Service User had seen a decrease. • A new risk had been identified as head-banging particularly on Forest House and Robin Ward. Training was underway to assist staff with head injuries. • Quarter 3 had seen a CQC visit on safeguarding with the child and adult assessment doing well. The Trust had made a substantive appointment to the named doctor for Safeguarding Children role. JPad concluded the update advising that a new ligature risk had been identified by the Trust at Albany Lodge around anchor points on doors, and this was being addressed. JPad invited questions. CL referenced page 11 (overall page 35 of 253) and the serious incident national timeframe with the Trust struggling to meet the 60 day requirement. JPad advised that the Trust used Non-Executive Directors to Chair significant cases which were very helpful. In addition, the appointment of Ethel Changa, Deputy Director for Quality and Safety was driving forward change and this was seeing an improvement in meeting the 60 day requirement. **RECEIVED** **The Board RECEIVED the report**	
026/20	**Quarter 3 Safe Staffing Report** JPad presented the paper advising the report provided the Board with the data for quarter 3 on nurse staffing for the Trust. It also provided the Board with assurance of the governance processes for rostering and appropriate level and skill mix of nursing staff.	

	Highlights from the report for the Board to note were: • The Trust carries out a '3 times per day' service check using the Safe Staff tool. Overall during the quarter levels were shown as adequate in response to unexpected demand and acuity. • The Trust continued to have challenges with recruitment in the quarter and this would remain a focus. A multifaceted approach to recruitment was being undertaken with the Trust being pro-active and working with the Health & Care Academy and being chosen as a pilot site by Health Education England. • The biggest challenge was LD Nursing and lots of training incentives had been initiated including having Hertfordshire University as a partner. KL highlighted the narrative on page 5 (overall page 66 of 253) asking for the word excessive to be changed. LW welcomed the report and stressed it would be enhanced when it included information on community services. JPad confirmed that the Trust correlates agency staffing with incidents reported. ***Action: JPad to re-word paragraph 3.12 of the report*** **RECEIVED** **The Board RECEIVED the report**	**JPad**
027/20	**Quarter 3 Guardian of Safe Working** AZ updated the Board on the Quarter 3 mandatory assurance report from the Guardian of Safe Working for Junior Doctors. Key to note for the Board were: • Dr Shane Ryan, Guardian of Safe working had now left the Trust. Dr Dinal Vekaria had covered the post on an interim basis and the substantive appointment of Dr Snehita Joshi had been made. • This quarter painted a much more positive picture than previously due reduction in the exception reports, a reduction in junior doctor WTE vacancies and an increase in bank/ agency locum bookings to cover gaps on the on-call rota. TBa raised the question as to whether clinical staff were permitted to work locum shifts for other organisations. AZ responded confirming that yes, however they were asked to declare this to us first and any unfilled shifts within HPFT should be met first. JPa asked about sickness rates and how this was monitored, KL reported that nationally all NI numbers were checked against staff and a National Fraud Exercise undertaken, the results of which are discussed in full at the Audit committee. AZ further added that a robust sickness monitoring process was in place. **RECEIVED** **The Board RECEIVED the report**	

028/20	**Community Survey** SBr presented the Community Survey advising that the paper provided the Board with an update since this was presented at the private Board in January. The 2019 Community Mental Health Survey is part of the NHS Patient Survey Programme. The results were disappointing and had now been looked at in more detail and an action plan and number of recommendations to improve the survey results had been pulled together with 5 key areas identified for immediate focus: - Ensuring service users and carers are aware of how to access crisis services - Ensuring service users are aware of who is leading their care and how to contact them and are informed of changes to care coordinators - Ensuring service users are supported to, maintain or seek employment and carry out meaningful activities - Increasing feedback from service users - CPA reviews In addition there will be a weekly focus on each area, highlighting key messages for staff and service users. A range of communication methods will be used to share the messages including; screen savers, media screens in hubs, information on the Hive and displays in the hubs. TC reported that service user experience was monitored through Having Your Say. It was noted that the actions were aimed at having an impact on the survey in 2021. **RECEIVED** **The Board RECEIVED the report**	
029/20	**Staff Survey** SY presented the Staff Survey results to the Board advising that it was a really important tool for the Trust which allowed us to hear directly from our people about their experience of working for HPFT. A significant campaign took place when SY joined the Trust which had seen our return rate improve from 41% in the previous year to 54%, meaning that we heard directly from nearly 1800 staff. On the 18 February 2020 the embargo on the results was lifted and a celebration had been held at the Colonnades with tea and cake to thank staff for their contribution. Of the 91 questions, 73 of these were above the national average compared to similar Mental Health / Learning Disability Trusts. SY referred to the graph on page 4 (overall page 98 of 253) which showed how HPFT had performed in comparison to other MH and LD Trusts in relation to the 11 themed results, noting that the Trust had scored above average on 9 of the 11 themes and continued to improve on the safety culture result. There were a number of areas that the Trust needed to improve upon and these had already been recognised by the People and OD Directorate and were outlined in the proposed responses.	

	CL thanked SY for the update and an action was given to consider how best to thank staff on behalf of the Board. ***Action:*** Consider how best to thank staff on behalf of the Board. CD raised the work around Quality, Diversity and Inclusion with TC advising that a piece of work around this was due to come to the Board in April 2020. It was noted that there had been a 6% improvement in scores for BAME but further progress was needed. **RECEIVED** **The Board RECEIVED the report**	**AC**
031/20	**Quarter 3 Performance Report** KT presented the Quarter 3 Performance Report explaining that the paper informed the Board on the Trust's performance. KT reported that overall, Trust wide performance continued to do well against a backdrop of continued increased demand for services. Areas of particularly strong performance were: • Access to services – including CAMHS and EMDASS • Workforce - Our rate of staff turnover had reached its lowest level over the last 12 months and our staff were also being supported to complete their Mandatory Training • Financial position - At the end of Quarter 3 the Trust reported a surplus of 295k YTD (against Plan of breakeven) Areas which required focus were: • Inappropriate Out of Area Placements • Service Users feeling safe • Access to IAPT Services • Sickness • PDP and appraisal reviews KT concluded stating that overall the Trust was in a strong place with focus being given to the key areas mentioned. Attendees held a brief conversation around Out of Area Placements and Bed Numbers. In response to SBe question regarding use of Host Families, TC agreed to bring an update back within the context of the crisis pathway review. ***Action: Bring update back to Board on crisis pathway review.*** **RECEIVED** **The Board RECEIVED the report**	**TC**

032/20	**Quarter 3 Annual Plan 2019/20** KT presented the Quarter 3 Annual Plan for 2019/20 to the Board advising that Quarter 3 had seen excellent progress against the plan. At the end of each quarter each objective receives two RAG ratings which provide: • An assessment of whether the Trust is on track to achieve the stated outcome(s) by the end of the year • An assessment of whether the milestones/actions planned for that quarter were achieved. The significant work that had taken place during Quarter 3 means the Trust was in a strong position with 82% of the year end outcomes on track to be fully delivered. However, there were three outcomes which were unlikely to be fully delivered by the end of 19/20. Objective 1 (safety) reflecting what our service users are telling us about their experience of 'feeling safe' on our inpatient units. Objective 2 (experience) access targets for Improving Access to Psychological Therapies Objective 2 (experience) experience for our carers CD commented on the excellent report and asked about progress with the Safety Suites and whether this was now a realistic timeline. KL responded stating that things were progressing well however it needed to go to the Finance & Investment committee for approval of the funding. **RECEIVED** **The Board RECEIVED the report**	
033/20	**Finance Report** KL presented the Board with the current financial position, the forecast financial position for the full year and the key considerations in relation to the End of Year position. Key messages to note were: The Trust was on track to achieve the control total. • Out of Area Placement beds were costing £20k per week, with beds required for not just Adult but LD and Older People, something the Trust had not seen for some time. • KL noted to the Board that it had been the right decision to not accept the 0.5% additional contingency requirement. • In summary, KL stated that this had been a very difficult start to the year, with work continuing on the 2020/21 Plan and the significant savings required given the underlying gap and the continuing growth in demand. • We continued to see positive results in terms of recruitment, which whilst this provided additional pay cost this was the right thing to do and was encouraging.	

	RECEIVED **The Board RECEIVED the report**	
034/20	**Gender Pay Gap** SY presented the report which set out for the Board the information which the Trust was required to publish on Gender Pay Gap data. The report included 4 things: The Mean and Median gender pay gaps The mean and median gender bonus gaps The proportion of men and women who received bonuses The proportion of male and female employees in each pay quartile SY advised that the Statutory Gender Pay Gap Snapshot Report would be submitted to the required Government website by the required date of 31 March 2020. Of note to the Board were: - The mean gender pay gap for HPFT 11.55% - The median gender pay gap for HPFT 4.66% - The mean gender bonus gap for HPFT 22.28% - The median gender bonus gap for HPFT 23.35% The Board should note that our gap was smaller than the national gap. SY further added that consultants at the Trust could be nominated for Clinical Excellence Awards (CEA payments) which in previous years had shown a favour towards males. Following a campaign to encourage females to apply this had started to even out. It was noted that the outcome of the CEA awards would be considered by the April Board meeting The Trust would continue to build on the progress it was making in promoting diversity and equality within the workforce and living our values of welcoming, kind, positive, respectful and professional. **RECEIVED** **The Board RECEIVED the report and APPROVED the return for submission.**	
035/20	**Operational Planning Guidance 2020/21** KT presented the paper which updated the Board on the main elements of the NHS England and NHS Improvement Operational Planning and Contracting Guidance for 2020-21 along with the associated implications for the Trust. The paper was taken as read. KT reported the below key messages: In view of the changing emphasis on 'system by default' we were likely to see the progressive erosion of the freedoms we had previously had as an FT (such as capital planning and investment) and would see this being sought to be undertaken increasingly at system level. The detail provided in the operational guidance came as no surprise and builds on the 5 year forward view. Nuances were a request for a significant requirement to develop community mental health services and CAMHS; however as a Trust we were already underway with this work. In IAPT there	

	was nothing new, however would see a bit 'step-change' in performance requirements for next year. In terms of the People Plan, this was now expected in April/May. Within the draft contract it was proposed to include a new requirement on providers to develop a plan to implement in full the NHS People Offer (which is, the core standards in relation to the work environment and experience of work for staff working in NHS services) to be published in conjunction with the final NHS People Plan. Overall the guidance builds on that previously issued relating both to changes in the governance of local systems and in particular on the future service requirements for mental health and learning disability. So, whilst there were some areas for additional attention there were no major new initiatives or requirements. It was noted that the STP would be making a submission of the System's draft operational plan on the 5 March 2020. TC made a request for the Service Transformation plan to be presented at a future Board. ***Action: Service Transformation plan to be presented at a future Board*** **RECEIVED** **The Board RECEIVED the report**	**SBr**
036/20	**STP Update** TC updated the Board on the on the current activities, issues and planned work across the Hertfordshire & West Essex (HWE) Sustainable Transformation Partnership, with the report taken as read. Of note to the Board were the below bullet points: • System by Default operating model moving forward • Continue to develop the appropriate governance and finance and contracting mechanisms • Engagement with the wider sector **RECEIVED** **The Board RECEIVED the report**	
037/20	**Report of the Audit Committee - 13 February 2020** CD 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 13 February 2020. There were no formal matters for escalation to the Board. Highlights from the meeting were: • The committee had received a Risk Topic presentation on the Internal Audit Plan 2020/21, which had been a very useful exercise. CD also recorded that RSM had been positive to work with. • Of particular note to the Board was that the Committee had agreed the 20/21 plans for Internal Audit and Counter Fraud.	

	• The committee had received an update on the 2019/20 Accounts 'Going Concern Review' which had been approved. An update would come to a future Board. • The committee had considered the annual Self-Assessment of the Committee Effectiveness. Overall feedback had been very positive. Areas for improvement were with regard to review of annual financial and accounting policies; how the committee uses external reports to undertake its responsibilities; the Committee's role in reviewing the work of IGC and FIC; and the level of analysis versus detail provided in the reports. • It was noted that the role of FIC and the Audit Committee with regard to financial policies had been clarified. Matters of Escalation: • The Committee recommends that the going concern concept is applied to the preparation of the Annual Accounts • The Committee approved the increase in the bad debt provision from £101,850 to £110,600 **RECEIVED** **The Board RECEIVED the report**	
038/20	**Trust Risk Register** JPad presented the Trust Risk Register reporting to the Board on the current and emerging risks on the Trust Risk Register (TRR). The report had been reviewed in detail at the Integrated Governance Committee (IGC) along with the changes which had been approved. Of note to the Board were: **<u>Risk score increased</u>** Finance: The Trust may not have sufficient resources to ensure long term financial sustainability (Risk 1001) • The risk has been increased in score to 16 reflecting the additional efficiency requirement and potential that this cannot be achieved without compromising service quality. The likelihood of the risk has increased from possible (3) to likely (4). **<u>Risk scores decreased</u>** Changing External Landscape: The changing external landscape and wider system pressures/agenda leads to a shift of influence and resources away from mental health & Learning Disability services and from HPFT (Risk 749) • The risk score has been downgraded from a 15 to a 12, the consequence of the risk has been downgraded from catastrophic (5) to major (4) EU Exit: Implications for the Trust of different scenarios arising from Brexit (Risk 1000) • The risk score has been downgraded from a 16 to a 12, the likelihood of the risk has been downgraded from likely (4) to possible (3)	

	Finance: The Trust is unable to ensure short term financial performance in the current year (Risk 116) • The risk score has been downgraded from a 12 to 8; the likelihood of the risk has been downgraded from possible (3) to unlikely (2) as the Trust is confident of achieving full year target. This risk is no longer included with the top ten risks on the Trust Risk Register. CAMHS: Unable to provide consistent timely access to CAMHS Community Services (Risk 1150) • The risk score has been downgraded from a 15 to 9; the likelihood of the risk has been downgraded from almost certain (5) to possible (3) as the CAMHS access targets are being achieved. Alongside the additional funding from the CCG there have been changes in the way the teams are working to ensure that access is sustained which will mitigate the risk when the additional resource cease. This risk will continue to be tracked to ensure assurance around sustainability. In addition Covid19 had been escalated to the TRR. **RECEIVED** **The Board RECEIVED the report**	
039/20	**Review of Board Effectiveness** HE reported to the Board on the outcome of the self-assessment undertaken by the Board of Directors in December 2019, advising that it was good governance for members of the Board to undertake an annual self-assessment of its effectiveness. Key to note: The survey attracted a response rate of 100%. The overall score was 89%. The highest scoring questions were: • Question 6: Does the Board ensure the Trust Risk Register is regularly reviewed and up to date? Score of 92% • Question 13: Is there effective leadership of the Board? Score of 94% • Question 17: Is the meeting conducted in a manner that means all members can contribute in meetings? Score of 92% The lowest scoring questions were: • Question 11. Does the Board effectively review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. For example: reviews by Department of Health Arm's Length Bodies? Score of 80% • Question 15: Does the Board run effectively, i.e. reports received in a timely manner with right format and content and effectively chaired? Score of 75% • Question 16: Does the Board set its agenda and workload in a sufficiently flexible way to ensure it manages items that will support delivery of Trust objectives? Score of 80% HE updated the Board on the key themes from the comments which were detailed in the report and also advised on the areas identified for development. It was considered a useful piece of work which would be knitted into the Well	

	Led Review. HE concluded noting the Council of Governors would be presented with the outcomes of the assessment. HE invited questions. KL asked for clarification for wording on 2.3 b), it was noted that this was driven by the question. **RECEIVED** **The Board RECEIVED the report**	
040/20	**Six monthly report from the Nominations & Remuneration Committee** CL presented the report which provided the Board with an overview of the work undertaken by the Nominations and Remuneration Committee for the period June to December 2019. Since June 2019 the committee had met six times with each meeting being quorate. A number of themes had emerged from the meetings: • Allowing sufficient time to read papers ahead of the meeting • Committee Terms of Reference • Greater formality in future meeting planning **RECEIVED** **The Board RECEIVED the report**	
041/20	**Board Planner 2020/21** HE presented the planner which provided the Board with a clear plan for the year ahead. All in attendance approved the plan. **APPROVED** **The Board APPROVED the Board Planner for 2020/21**	
042/20	**Any Other Business** No further business was put forward.	
Questions from the Public JW raised Place Audit Outcomes and acknowledged the good result but asking if this was something we could sustain as a Trust. KL responded advising that an on-going programme was in place which the Trust would expect to maintain. DS acknowledged the usefulness of the SU story at the start of the meeting. DS raised a question around Out of Area Placements and bed day breakdown. KL reported that there was 360 bed days per quarter, however as this was a Public Board meeting was not able to provide more in-depth data. No further questions were put forward.		
Date and Time of Next Public Meeting: The next meeting is scheduled for Thursday 30th April 2020 @ 10:30am Da Vinci B, The Colonnades		

Close of Meeting

Minutes of the PUBLIC Board of Directors Meeting
Held on Friday 19th June2020
VIRTUAL

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Christopher Lawrence | CL	Chair
Tanya Barron | TBa	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
Sarah Betteley | SBe	Non-Executive Director
Janet Paraskeva | JPa	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
Loyola Weeks | LW	Non-Executive Director
David Atkinson | DA	Non-Executive Director
DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Dr Jane Padmore | JPad	Director, Quality and Safety
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Keith Loveman | KL	Director, Finance
Paul Ronald (PR)	Director of Operational Finance
IN ATTENDANCE	
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Jane Twelves | JT	PA to Executive Directors (Minute Taker)
Sarita Dent | SD	Associate Non-Executive Director
APOLOGIES	
Ann Corbyn | AC	Director of People & Organisational Development
Dr Asif Zia | AZ	Director, Quality & Medical Leadership
Karen Taylor | KT	Director, Strategy and Integration

Item	Subject	Action
074/20	**Welcome and Apologies for Absence** CL welcomed all to the meeting. Apologies for absence from Ann Corbyn, Dr Asif Zia and Karen Taylor were noted.	
075/20	**Declarations of Interest** The Declarations of Interest Register was noted. No conflicts of interest were noted for items on the agenda. **NOTED**	
076/20	**Annual Reports 2019/20** **a) Use of Corporate Seal** Board received the 2019/20 report outlining the use of the Corporate Seal which had previously been considered by Audit Committee. There had been 8 transactions relating to contracts, estate leases and pension fund matters. CD confirmed that the final entry although dated April 2020 had been discussed at Audit Committee and refers to a previous entry in January 2020 which is within the relevant accounting year. **Board approved the report.**	

	b) Use of Waivers Board received the 2019/20 report outlining the use of Waivers which had been previously considered by Audit Committee. CD reported that the value and quantity was similar to the previous year. During the period 1st April 2019 to 31st March 2020 there were 31 Waivers total £1,439K for the Trust. There were 4 Waivers authorised that exceeded £100K which were predominately for Estates and IT works where the timescale genuinely precluded competitive tendering. Audit Committee discussed the report and requested more detail for those Waivers with a value in excess of £100K for future reports. Audit Committee also discussed the impact of Covid-19 which has seen an increase in the need for waivers to respond quickly in the exceptional circumstances and the number is now being managed back down. KL advised that where a Waiver is issued the Procurement Team always check that it offers value for money against tender pricing. **Board approved the report.** **c) Losses and Compensation Payments** Board received the 2019/20 report setting out the losses and special payments for the period 1st April 2019 to 31st March 2020 which had been previously considered by Audit Committee. Overall the total year costs are similar to the previous year. The main movements between yeas is a £4880 increase in other ex-gratia payments which predominately related to one claim for staff damaged teeth. CD confirmed that the Finance team is continually looking to improve/minimise the spend which is not expected to be covered by general NHS funds. The overall value of losses and special payments continue to be low in relation to the turnover of the Trust. **Board approved the report** **d) Treasury Management** Board received the 2019/20 Treasury Management report which had been previously considered by Audit Committee. The report sets out Treasury management activity as part of the final accounts process and in accordance with the Treasury Management policy. The key elements of the report were discussed, noting that the Trust has received more interest than expected despite the reduction of base interest rates in March 2020. Board noted that in March the interest rate had fallen to 0% and this will have an impact on 20/21. Audit Committee also discussed possible borrowing and had made clear no further borrowing will be arranged. A total of £19.2M had been drawn down against the previously agreed borrowing arrangement of £32M and was now being repaid in accordance with the schedule of payments. The Trust adheres to the Better Payment Practice Code which is monitored closely and consistently. During the Covid19 crisis, HPFT has paid particular attention to small suppliers to ensure they continue to be paid promptly. **Board approved the report**	
077/20	**NHSI Declarations** • **Compliance with Provider License** Board received a report providing evidence with the Trust's provider licence previously considered by Audit Committee. Due to Covid19 NHSE/I have	

	decided that they will not carry out any audit of completion of the self-certification this year nor take any enforcement action that will require providers to complete the self-certification for 2019/20. The paper sets out that the Head of Corporate Affairs and Company Secretary has reviewed all the evidence of assurance to support the self-certification and confirms that the Trust is compliant with each element of the conditions. **Board approved the report**	
078/20	**Annual Accounts 2019/20** **a) Draft Annual Accounts** The Director of Operational Finance presented the draft annual accounts for review which had previously been considered for approval by the Audit Committee. PR highlighted the key elements; • The audit has been completed in advance of the first submission date set by NHSI. • There were no adjustments required to the draft Accounts submission albeit the Trust has chosen to make one adjustment to its PPE valuations. • The financial position is in accordance with the regular projections presented to the Committee and is reporting a surplus of £53K. • The Trust has met the Control Total and secured £1.9m PSF to support future investment. • Income exceeds £250M for the first time. • The Trust has achieved a Financial Risk Rating of 1 and reported Agency spend below the Cap. • The Trust has continued its balanced approach in assessing provisions and in reporting income. The biggest increases in year are related to pay and additional staff numbers, extra spend on beds and investment in IAPT on-line facilities. CL thanked PR for the excellent presentation telling an impressive story. It is clear the Trust has had a strong year starting from a difficult position at Q1. High cash reserves have been achieved and consideration will be given around how to make use of these and provide further focus on addressing the gap in the Delivering Value program. **Board approved the Annual Accounts.** **b) Internal Audit Annual Report including Head of Internal Audit Opinion** Board received the 2019/20 Internal Audit Annual Report including the Head of Internal Audit Opinion which was previously considered by the Audit Committee. CD advised that the report had been discussed at the Audit Committee in April 2020. Overall RSM had given the second highest opinion which was the same as in the previous year. HPFT had received 3 partial opinions related to Appraisals, patient monies and Health and Safety. CD advised that whilst it is disappointing to receive partial opinions, the internal audit is utilised to review areas of risk. CD confirmed that Audit Committee had discussed the mitigations being put in place to address these areas. Internal Audit had completed all their allocated work and the opinion was noted in the Annual Report and Governance Statement.	

	Board approved the Internal Audit Annual Report including Head of Internal Audit Opinion **c) i) External Audit Annual Governance Report** Board received the External Audit Annual Governance report previously considered at the Audit Committee. CD noted that KPMG had expressed their thanks to PR and the Finance Team for their work with them and commented on the quality of the draft annual accounts and papers shared with them and the teams flexible approach to respond to requests in the challenging circumstances. External Audit had undertaken a thorough review looking to give 3 opinions – Financial Statement, Value for Money and Quality. The opinion on Quality had been removed under the special arrangments being applied for 19/20 submissions. A clean opinion was given for the Financial Statement and Value for Money. There had been lots of discussion in respect of the valuation of fixed assets and property. CD advised that KPMG have taken a realistic and sensible approach and Audit Committee were happy to recommend the report for approval by the Board. CL noted the "red" outstanding items; PR confirmed these are very minor and no change will be made to the primary statement. **Board received and noted that the External Audit Annual Governance Report.** **ii) Draft Letter of Representation** Board received the Letter of Representation previously considered by Audit Committee. The letter is standard with the content being largely driven by matters KPMG wish the Board to confirm to support its compliance with accounting and auditing standards. Exceptions to that are; • Paragraph 12: which is a specific representation KPMG ask of all NHS clients and supports the returns they complete to the National Audit Office on the Trust's consolidation return; and • Paragraph 13: which is a specific representation in relation to balances included within the financial statements. **Board approved the Letter of Representation.** **d) Draft Annual Report including Annual Governance Statement** HE presented the Annual Report including the Draft Annual Governance Statement for 2019/20 previously considered at the Audit Committee for Board approval. LW advised that the Annual Report and Annual Governance Statement had been discussed and agreed the Covid19 Assurance Board. HE advised that it had been a positive year which started with the announcement from the CQC. KPMG has confirmed their assurance with the disclosures and Audit Committee are requested to recommend approval to the Board.	
079/20	**Audit Committee Annual Report** Board received a summary of the work completed by Audit Committee throughout 2019/20. A series of deep dives on specific services had been undertaken which had increased the understanding and associated risks. Audit Committee provided assurance that it has complied with the duties delegated by the Trust Board.	

	Board approved the Annual Report	
080/20	**Any Other Business** No other matters were discussed.	
081/20	**Date of Next Meeting** The next meeting is scheduled for 25th June 2020	

Close of Meeting

Agenda Item 4

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 30 July 2020

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
27/02/20	**031/20**	Quarter 3 Performance Report	Crisis pathway review update to a future Board	This has been added to the Board Planner for presentation at a future Board	SBr	2020	A
27/02/20	**029/20**	Staff Survey	Consider how best to thank staff on behalf of the Board during the pandemic		AC	Complete	G
27/02/20	**026/20**	Quarter 3 Safe Staffing Report	JPad to re-word paragraph 3.12 of the report to change the word excessive		JPad	Complete	G
27/02/20	**025/20**	Covid19 Update	Board to be provided with a weekly briefing on Covid19	Weekly updates provided	JPad	Complete	G
27/02/20	**024/20**	CEO Update	Paper for the Board on Accreditation for them to understand why we were accredited and what this meant for the Trust	To be presented at a future Board	AZ	2020	A
27/02/20	**024/20**	CEO Update	Results of the Community Service workshops to be shared at a future Board	We were not able to complete prior to Covid. This is under review and we are looking at feedback and pulling together a service improvement plan which will go to the next IGC.	SBr	September 2020	A
30/01/20	**016/20**	STP Update	Alignment of NEDs to identified areas		HE	27/2/20	G
30/01/20	**015/20**	Annual Plan 2020/21	Board members to provide comments to KL by the 13th February 2020		ALL	Complete	G
05/12/19	**144/19**	Workforce & Organisational Development Report – Quarter 2	Board session to be scheduled on the Just and Learning Culture	Work underway with regard to Board workshops and topics	HE	August 2020	G

Agenda Item 4

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Meeting Date:	30 July 2020	**Agenda Item:** 5
Subject:	CEO Briefing	
Presented by:	Tom Cahill, CEO	

National update

Covid-19

Nationally we remain at incident level 4 and level 3 alert level in the UK. Nationally and locally the number of deaths of people who are Covid-19 positive is reduced significantly. This has seen a change in emphasis from continuing to manage the incident to looking forward and planning how to deliver services in a Covid-19 safe environment. This includes a change in philosophy of working from home and the opening up of most outlets.

There is significant emphasis on outbreak management and local resilience forums and the NHS are expected to have plans in place for dealing with outbreaks within organisations and local communities. Details of our plans will be made available at the next Integrated Governance Committee in August.

Payrise for Public Sector Workers

We note that the Government are planning to recognise the vital contribution of public sector workers by announcing a payrise of 3.1% for up to 900,000 staff. Full details are not yet available but it is understood that funding would be expected to come from existing departmental budgets.

Review of NHS Structures

A taskforce has been set up to draw up plans for the amendment to the roles and responsibilities of NHS England and others bodies that work with and support the NHS. It is not yet known when the taskforce will report to the Prime Minister.

£3 Billion Funding

The Government announced an additional £3 Billion for supporting the NHS through Covid and winter pressures. Detail of specific allocation is not yet clear however we will obviously work to understand the impact on mental health and learning disability services.

National Announcement of Capital

There has been a recent announcement by the Government regarding capital investment into the NHS, including the building of new hospitals. Specifically within the announcement, there is a commitment to mental health and learning disability services in the eradication of dormitory style accommodation. The Board will note that the Trust eradicated all dormitory style accommodation in our services during 2019.

Winter Flu

NHS is now currently organising and preparing for increased pressure in winter. Organisations and systems are expected to develop their winter plans to help manage any expected surge. The staff flu vaccination programme is expected to commence shortly and it is anticipated that 90% of the organisation's staff are expected to be vaccinated.

Regional and System update

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

Herts & West Essex Integrated Care System
The ICS continues to develop with discussions under way, led by Paul Burstow, Independent Chair, in establishing the governance structure. It is anticipated that the Partnership Board which will oversee ICS responsibilities will be up and running by September 2020. HPFT and other organisations across the system have had the opportunity to comment on the proposed governance structure and we note some of those comments have been taken on board.

Dr Jane Halpin, Joint Chief Executive, West Essex and Hertfordshire CCGs and the Hertfordshire and West Essex Integrated Care System has begun the process of appointing members to the ICS/CCG joint Executive Team, This includes appointments of;

- Alan Pond, Chief Finance Officer
- Beverley Flowers, Director of Transformation
- Jane Kinniburgh, Director Nursing & Quality
- Peter Wightman, Managing Director West Essex CCG
- Sharn Elton, Managing Director, E&N CCG
- David Evans, Managing Director, Herts Valleys CCG

Alan Pond and Jane Kinniburgh will take up their posts on 1 August, and Beverley Flowers, Peter Wightman, Sharn Elton and David Evans have already taken up their posts. The new appointments are a positive next step in the development of our ICS, and we look forward to working with the team.

Mental Health and Learning Disability (MH&LD) ICP
MH&LD ICP has now met a couple of times following suspension during Covid-19. The partnership has taken on responsibility on behalf of the ICS for restoring mental health and learning disability services across the system. The main focus of work will be addressing issues across Hertfordshire relating to dementia, substance misuse services, those in mental health crisis, mental health care in primary care settings, services for children and young people, people with a learning disability and those on the autism spectrum. Much of this work is already under way but the Integrated Care Partnership will help co-ordinate. Beverley Flowers, Director of System Transformation and Integration of the ICS, has agreed to co-chair the ICP with me in order to ensure that appropriate plans are in place to deliver better outcomes in each of those areas.

Provider Leadership
Recently HCT announced that Clare Hawkins, Chief Executive of Hertfordshire Community NHS Trust, would be leaving in the autumn. It is understood that the Trust will seek to appoint an interim Chief Executive to take the Trust forward over the next 12-18 months,

East of England (EOE) Provider Collaborative – New Care Models
Collaborative activities were paused from mid-March through to mid-June due to the COVID19 outbreak, with work to develop the New Care Models across Secure Services (Adult and Learning Disabilities) Eating Disorders and CAMHS now recommencing. Recognising the necessary pause to collaborative development activities over this period across the country, NHS England (NHSE) have extended the overall authorisation timetable. The EOE Collaborative is described by NHSE as a 'Main Track' site and the 'go live' date has been reset for April 2021 from October 2020 (subject to successful business case and Trust Board approvals). The Collaborative has undertaken a review of the initial financial offer made by NHS England, and this work is being taken forward by a joint Director's of Finance group across all six Trusts. Key decision points for the Collaborative (and HPFT) will be in October 2020 when the draft application is due to be submitted outlining the case for change and the draft partnership agreement, then December 2020 when we should receive a

revised financial offer from NHSE, and finally in February 2021 when the final business case is due to be submitted.

Trust-wide update

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

Covid-19: Incident Management

We continue to manage the response to the incident and are still operating the command structure set out in our Business Continuity plan. The numbers of service users suspected of having Covid at the time of the report is one within our inpatient services. We are also seeing significant numbers of staff recovering or returning from having Covid-related symptoms. We are also anticipating the end of shielding which has implications for 114 of our staff and we will work with them closely during that process. Further detail is available in the main Board Report, but our key areas of focus are;

- Infection Prevention and Control, including outbreak management
- Restoring our services back up to pre-Covid 19 levels
- Risk assessments for BAME and other high risk staff

Finance update

The position for M3 continues to report at breakeven as required under the current arrangements. Revenue is marginally higher at £22.7m in the month and there has been an increase in pay costs. The COVID cost reimbursement continues with £878k claimed in month principally relating to pay costs. We continue to have discussions with the regional team and local commissioners on securing the additional funding due under the Mental Health Investment Standard. Whilst this continues to be promised the related guidance on its computation is still not available.

We have been advised that the current financial arrangements will extend from month 4 to month 5 and probably month 6 with new arrangements for Q3 onwards. Whilst the revised details remain under discussion we understand that these changes are likely to see a tightening in the level of financial control and steps to incentivise productivity gains. There has been discussion on a cap on the level of COVID reimbursement claims and also a shift to give the STP/ICS a role in the allocation of in year resources. This will be set out in financial planning guidance expected in early August.

Whilst the current arrangements ensure a break even position there are growing challenges in terms of bed pressures which whilst being manged well in general will likely see spikes in cost during the coming period.

Further detail is provided in the Finance report later on the agenda.

Operational Services

Performance remains strong across the services and restoration of services has continued to be a key priority. Referrals into all services have increased with some now back to pre-Covid levels, although across all, are about 20% less than we would expect to see at this time. Pressure on acute adult beds had continued to rise with a high number of s136 detentions, and admissions. The GPs are now starting to refer people to both primary and secondary care services. EMDASS has been restored but there is a recovery plan in place to manage the backlog of referrals (approximately 500) due to the suspension of the service as part of the business continuity plan.

All services are working to increase the number of face to face contacts whilst continuing to provide high levels of non- face to face contacts. Referrals into IAPT remain lower than we would expect so teams are using social media and pro-actively engaging with GPs to stimulate referrals. CAMHS have seen a significant increase in referrals as the schools have started to re-open. The schools helpline remains in place and the Trailblazer teams are providing a range of interventions over the school holiday period to support children and young people and their parents with regards to emotional wellbeing and in preparation for the new school term. Across the CAMHS system

modelling of potential demand is underway to identify additional services or interventions which may be require.

Across all services we have seen an increase in acuity and new presentations. This is particularly evident in acute adult, older people and CAMHS services. The increase in the use of specialist CAMHS beds (low secure, Eating Disorders and PICU) reflects this.

Our People

The wellbeing of our staff remains vital to the success of the Trust and we continue to offer psychological and emotional support for health and care staff as well as practical support, such as access to financial advice, discounts, free gifts and access to the Spiritual Care Team. We are encouraging people to take annual leave to rest and recuperate and are also enabling people to take stock, reflect and pay witness to what has happened through Schwartz rounds and by restarting our Great Teams work. We are continuing to pay particular attention to the support to all our BAME staff in light of the recognised heightened risks for BAME people in relation to COVID-19 and recent international events. We are offering a dedicated BAME staff helpline for additional support, ran a special virtual Race Equality Schwartz Round event at the end of June and are running specific sessions for BAME staff on physical, mental and financial wellbeing.

Further to the recent clinical evidence of a disproportionate, adverse impact of COVID-19 on members of the BAME community, we developed a risk assessment with the input of our BAME staff network, taking account of national guidance and the potential impact of COVID-19 in relation to all protected characteristics, individual's own circumstances and their emotional response to the pandemic.100% of our BAME staff have been risk assessed and have had a conversation with their manager to agree actions to mitigate the risks identified. 99% of our staff overall have had risk assessment conversations and we are now working to ensure that risk assessments are regularly reviewed, according to the identified risk levels of individuals and their changing circumstances. The BAME Network as part of their ongoing work and identified areas of concern and strategy have offered to review in collaboration with the wider organisation the experience and impact of our approach to risk assessing our people, in order to help ensure that we learn from their experience and take on board their feedback.

Further information is outlined in the Workforce report within the agenda.

Quality

The Care Quality Commission (CQC) is not routinely inspecting services during the Covid-19 pandemic period and recovery phase, although will be carrying out some focused inspections. Contact is still maintained with providers via engagement calls and monitoring arrangements such as those for infection prevention and control (IPC).

We had an engagement call with CQC to discuss IPC arrangements, and found that our Trust Board is assured that we have effective IPC measures in place and that we are managing the impact of the pandemic.

Governance

In line with the decision at last month's Board, the Covid-19 Board Assurance sub-committee held its last meeting on 9th July 2020, and the report later on agenda details the areas discussed. It was also agreed that the IGC and FIC committees would re-start with their next meetings scheduled for mid-August 2020.

We held our first virtual AGM on 15th July. It was well attended with well over 70 people joining us. We provided a full overview of 2019/20, and there were detailed questions with great participation from those who attended.

We will be undertaking an external Well Led Governance Review in the autumn which has been delayed due to Covid and a report will be made available to the Board and Council of Governors in due course.

The recruitment process for the Chair and NEDs has restarted, led by the Appointments and Remuneration Committee, and we are currently on schedule to hold interviews in early September.

Tom Cahill
Chief Executive

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	30 July 2020	**Agenda Item: 6**
Subject:	Board Assurance Sub-Committee: Covid-19: Meeting held on 9 July 2020	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Sarah Betteley, Non-Executive Director, Committee Chair
Presented by:	Sarah Betteley, Non-Executive Director, Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Board Assurance Sub-Committee: Covid-19: at its meeting held on the 9 July 2020.

Action required:

The Board is asked to receive and note the report.

Summary and recommendations to the Board:

An overview of the work undertaken is outlined in the body of the report and to note the items recommended for approval and noting.

This was the last meeting of the Board Assurance Sub-Committee: Covid-19, as IGC and FIC will be reinstated from August 2020.

Recommendation:

The Board are asked to:

- Approve the Quality Report and Accounts for 2020/21
- Receive Mental Health Act Manager's Annual Report

Relationship with the Business Plan & Assurance Framework:

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

Summary of Financial, IT, Staffing and Legal Implications:

None.

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

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

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

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

None.

1. **Introduction**

1.1 The last meeting of the Board Assurance Sub-Committee: Covid-19 meeting was held on 9 July 20 in accordance with its' terms of reference and was quorate.

2. **Covid-19**

2.1 Update Report

The Committee were provided with a thorough update on the COVID 19 position building on previous papers received by Committee and the Board. The Committee were informed of the current situation with regard to trust service users and staff.

Jane Padmore outlined the arrangements in place to continue to manage the incident in particular the relentless focus on Infection Prevention and Control to help minimise risk of Covid-19 cases and outbreaks.

Antibody testing for staff was continuing alongside swab testing of symptomatic staff. The results from both tests were indicating a positive rate of 18%.

Jane Padmore reported that earlier in the week the Trust had its formal review of Infection Prevention and Control (IPC) with CQC. It had involved a formal interview with herself and Jacky Vincent as DIPC and review of Trust's IPC Board Assurance Framework (BAF). A formal report would be issued outlining if the Trust had failed or passed. Initial feedback from CQC was positive, that the Trust had completed the IPC BAF to a higher level than was required and had undertaken some innovative actions during the pandemic. The formal response would be reported to Board members when received.

It was noted that the Covid-19 Risk Register was a dynamic record and was formally reviewed on a weekly basis by tactical command.

Loyola Week and Sarah Betteley passed on their congratulations regarding the CQC review. Loyola Weeks noted that the score for core services in the risk register had reduced and we would want to continue to review it to ensure it is an accurate reflection.

Keith Loveman updated the Committee with regard to recent CQC engagement meeting, describing that these meetings were a formal part of the relationship and approach.

2.2 CPAC Update Report

The report provided an outline of all the guidance reviewed and developed since the last paper presented to the Committee. It was noted that CPAC, since its inception had produced over 100 pieces of guidance. The Committee recognised the responsive nature of CPAC and that the benefits of Service User and Carer input were clearly visible.

In response to Tanya Barron's question Billy Boland outlined that the Trust linked with the wider system as Loyola Weeks and Asif Zia were also members of the East and North Ethics Committee. Jane Padmore added that both herself and Asif Zia used their professional networks to share and learn about practice from other trusts. She reported that CPAC also made sure the Trust learnt from deaths that had

happened and the Trust would be looking at the 26 deaths in inpatient units due to Covid-19. It was agreed that the outcome of this review would be considered at a future Integrated Governance Meeting (IGC).

It was confirmed that the future role of CPAC would form part of the wider governance review due to take place and that CPAC still had the capacity to meet at short notice on an ad hoc basis if required.

2.3 Shaping Our Future

The Committee received a detailed report on the work underway to restart, restore and reshape services that built on the previous papers received at the Board of Directors and Covid Assurance Committees held in March, April and May 2020.

The focus of restoring services remains on increasing capacity across services. It was noted that all services are open and running, with new referrals being received and services were managing current demand well. It was reported that a recovery plan for EMDASS had been agreed that would see the backlog cleared in 12 weeks. IAPT was also looking to the offer of services in virtual settings to increase capacity. It was reported that referrals for Learning Disability services and other activity in the Trust had returned to preCovid-19 levels, and that performance against targets was being maintained.

The Committee were informed that the Trust was seeing an increase in the acuity of service users and a rise in number of people accessing services that were new to the Trust.

In response to Loyola Weeks' question Keith Loveman reported that recent weeks had seen an increase in GP referrals and self-referrals.

In response to David Atkinson's question Keith Loveman reported that the Trust had responded to NHSE/I's feedback and would be providing additional information as part of the next submission. The Committee were informed that the Trust was planning and capacity modelling for increased activity as a result of Covid-19.

2.4 Feedback from Advisory Internal Audits

The Committee received the final reports on the two advisory audits that had been commissioned relating to the interim corporate governance arrangements and Financial Governance and Key Financial Controls, both reports provided positive assurance.

The Committee were informed that all the actions from the interim governance arrangements report had been implemented and actions from the other audit would be considered and actioned where appropriate.

Tanya Barron provided her support for the rationale that the Trust had taken for its approach to pre-approval of expenditure. The Committee welcomed the external assurance provided by the audits and noted that the learning would be taken into the wider governance review.

3. **People and Organisational Development**

The Committee received the detailed report that set out the People and OD key areas of focus within the context of COVID-19 for the first quarter of the financial year 2020/21, including June metrics which were from the point at which the paper was written.

The Committee were advised that in the last quarter the health and wellbeing offer to staff had been prioritised, along with work on Just Culture and Leadership. Live events have been held to help engage with people and a piece of work was underway around Diversity & Inclusion which included a support line.

The Committee discussed two highlighted risks in relation to compliance with statutory and mandatory training requirements and health and wellbeing of our staff, including the mitigating actions in place..

In response to Sarah Betteley's question Ann Corbyn outlined that the Wingman initiative had been very well received and the Trust were supporting air travel staff to source roles in the NHS. The Committee noted the comprehensive approach to staff engagement during the pandemic by using live events, networks and inspire awards

4. **Feedback from Staff Risk Assessments**

The Committee received an update on the risk assessment process for all staff at the Trust, including the approach and current compliance figures.

At the time of the Committee 99% of BAME staff had completed the risk assessment and 90% of all staff. Of these 16% had been identified as having some level of risk and 23% of staff reported having a long term condition or disability.

The Committee were informed that the themes arising from the risk assessments were that staff were worried about passing Covid-19 on to vulnerable people living in their household or to those they cared for. Concerns were also raised about the inability to continue caring responsibilities for children and those requiring support if they were to become unwell with Covid-19. Lastly, some concern was raised around heightened individual Covid-19 anxiety.

The Committee noted that there would be continued support for staff by enabling working from home arrangements where possible; increased team socialisation; GP information sessions for BAME staff. It had also been agreed to re-activate the Time to Change Pledge, to ensure that our own people know 'it is OK not to be OK'.

In response to Tanya Barron's question it was confirmed that corporate compliance had improved and that a specific risk assessment for experts by experience had been developed. It was confirmed that the review of risk assessments would be part of regular conversations between managers and their staff.

5. **Strategic Investment Programme**

The Committee received an update on the 2020/21 capital programme. The plan is forecast to spend £15.4m and involves a number of steps to facilitate delivery of

planned projects. It was noted that schemes were moving ahead, including disposals.

The report outlined the changes signalled in the role of the STP/ICS in the overall management of the STP capital allocation and the importance of the Trust making the full investment of its available capital to avoid any risk of future plans being limited.

In response to Loyola Weeks question it was reported that the recent announcement for money for mental health services was to remove dormitories and HPFT would not be eligible to apply for the funding. It was confirmed that the Trust expected the resources linked to Mental Health Investment Standard to be made available by CCGs. Paul Ronald outlined that the programme of works for Forest House had come in at lower cost than had been planned for.

6. **Flu Plan 20/21**

The Committee received a report that detailed the learning from 2019/20 and outlined the planning underway for 2020/21 campaign. It was noted that the Trust would be pushing for an increased level of flu vaccination regardless of the CQUIN reporting requirement. The key learning from 2019/20 related to the significant influence at team and peer level.

The Committee were updated regarding plans for 2020/21 which involve an online booking system, use of peer vaccinators and enhanced communication messages. It was confirmed that the team were linked into national and regional fora to ensure any learning was adopted.

In response to Sarah Betteley's question it was reported that there was currently no evidence that if people had the flu vaccine this would help with immunity for Covid-19. It was noted that currently there were no reported issues with vaccine availability.

7. **CQUIN – 2010/21 - Update**

The Committee discussed the detailed report regarding CQUIN 2010/21, noting the 8 CQUIN goals. It was noted that CQUIN reporting had been suspended until end of June 2020. Billy Boland updated the Committee that within last day it had been announced that reporting would be suspended until end of March 2021 and providers were expected to receive 100% of funding linked with CQUIN.

It was agreed that a further update would be brought back to IGC.

8. Quality Accounts Quarter Four Reports

8.1 Final Draft Quality Report and Accounts 2010/21

The Committee discussed and approved the Quality Account Report for 2019/20 that includes the Quality Accounts for 20/21. The Trust decided to produce the report despite it no longer being required, in recognition of the importance of quality and to provide assurance to the Board regarding quality.

It was noted that in line with national guidance on responding to the Covid-19 pandemic, the consultation process for the Quality Account Report was not as comprehensive as in previous years. The indicators were initially discussed with the Council of Governors in March and they chose the one to be audited but no other detailed consultative work was undertaken.

Once approved the Quality Account Report for 2019/20 will be uploaded onto the Trust website and shared with our staff and stakeholders.

Committee members welcomed the report as a comprehensive account for our approach to quality and the importance the Trust puts on looking after service users.

8.2 Quality Accounts 2019/20

The Committee received a report that outlined that due to revised requirements KPMG were not required to provide assurance of the Quality Account Report for 2019/20 but as part of their planning and interim work, they carried out work on one of the mandated indicators chosen by the Trust. The Committee received a report on their findings.

It was reported that following consideration of the external audit report and its findings it has been decided to commission a review of data quality by internal audit. The aim would be to identify areas for improvement with regard to the metrics and to ensure the IGC is provided with assurance regarding data quality for 20/21. The proposal for independent review by RSM was welcomed and supported by the Committee.

9. Annual Reports 2019/20

9.1 Mental Health Act Manager's Annual Report

The Committee received the annual report that covered the activity in respect of the Mental Health Act Manager (MHAM) Service from April 2019 to March 2020.

It was noted that the use of the Mental Health Act has dropped slightly within the Trust and that this appears to be in line with some other London Trusts. In the year there had been developments in guidance from NHSE & DHSC in respect of allowing MHA Assessments to take place through a video link and use of electronic forms and signatures and COVID-19 guidance within HPFT would be updated as soon as national guidance is issued and lockdown measures eased.

It was noted that the annual report would be presented to the July Board meeting.

The Committee recorded its sincere thanks to the Mental Health Act Managers, the Trust team, Hattie Llewelyn-Davies and Loyola Weeks for all their work in supporting the MHA processes.

9.2 Health and Safety 2019/20 Annual Report

The Committee received the annual report that provided details of the health, safety and security incidents, the actions that have been taken, the assurance given and the priorities for the coming year.

HPFT had been one of the twenty care providers in the public sector to be visited, in the first quarter, by the Health and Safety Executive, to examine arrangements for Violence and aggression and musculoskeletal disorders. As a result of the visit, the Trust was issued with improvement notices. All improvement notices were attended to within time scales and led to improvements in practice.

Of note in the report is that the year has seen an increase in the number of service user to staff violence and aggression incidents although there had been a reduction in service user to service user incidents.

In response to Tanya Barron's question it was noted that items relating to service users' health and safety were reported in the Integrated Safety Report.

10. Other Business

It was reported to the Committee that the Trust has submitted its Data Security & Protection Toolkit Assessment for 2019/20 in line with the required timescale and would be reported to IGC when the results were available.

11. Recommendations

The Board are asked to:

- Approve the Quality Report and Accounts for 2020/21
- Receive Mental Health Act Manager's Annual Report

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 7a
Subject:	COVID 19 Update	**For Publication:** Yes/No
Author:	Rachel Millen: EPRR Lead Ashleigh Wiley: Tactical Support Fiona McMillan Shields: Interim MD Dr Jane Padmore: Executive Director Quality and Safety/Chief Nurse	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety/Chief Nurse
Presented by:	Jacky Vincent, Deputy Director Nursing and Quality	

Purpose of the report:

To provide the Board with an update on COVID 19 position and provide assurance on the incident control management response.

Action required:

This is for information and discussion.

Summary and recommendations to the Board:

The paper will update the Board on the Trust's ongoing Emergency Planning response position as of the time of writing. It will also provide an overview of the impact of COVID-19 on service users and staff.
This will also provide a brief update on the current position of trust in relation to the Hertfordshire County Council Outbreak Plans.
Overall the Trust is currently managing the additional requirements created by the pandemic. Challenges have continued regarding staffing and managing services.
The paper set out the details of the incident management, how the incident has progressed and will continue to be managed.

Relationship with the Business Plan & Assurance Framework:

Relation to the COVID Trust Risk Register:
Workforce: The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657)
Workforce: The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff (Risk 215)
COVID 19: The Trust may not be able to sustain operational services and maintain service user safety during the COVID19 outbreak (Risk 1253)
Relation to the BAF:
1. We will provide safe services, so that people feel safe and are protected from avoidable harm.
4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)
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

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

Individual risk assessments of BAME staff.

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

Potentially all of the above

Seen by the following committee(s) on date:

None

COVID-19 Update

1. Introduction

1.1. This paper describes the latest position on the trust response to the pandemic, noting the current status and key priorities.

1.2. This paper will begin with an overview of the situation at the time of writing (17th July 2020) in relation to service users and staff. The Trust is using the framework set out below (Figure 1).

Figure 1: Shaping our future

1.3. This paper focuses on the incident response and sits alongside the Shaping our future agenda items, the IPC BAF, the Trust risk register COVID risk and the full COVID risk register, which sets out how the Trust is reacting to the emerging situation.

2. Overview of the current situation

2.1. The Executive Team continues to maintain oversight of the incident, led by the Executive Director Quality and Safety, and an overview of the past month is summarised below.

Service Users

2.2. This section will provide an update on the Trust's position and includes details of how we are responding within the context of incident management.

2.3. Service users with a mental health problem and learning disability have died as a result of COVID 19. The total number of Covid-related deaths is 85. There have been no additional Covid-related deaths since 03/07, with the first death reported on 24/03.

2.4. **59 (69%)** of those that have died were service users in the community services and **26 (31%)** were in-patients at the time of death. Of the in-patient deaths, only **13** have been reported on the CPNS system.

2.5. Wards have been affected differently by COVID 19; some have had no affected cases, one or two cases at any one time, or a significant number over a sustained period of time (primarily in older adult and adult services).

2.6. Currently we have no Covid-positive or Covid-suspected cases on our wards.

2.7. The Trust continues to test all service users on admission to inpatient services and 72 hours prior to discharge. On admission servicers are asked to self-isolate prior to knowing the test results. Most service users adhere to this request with a small minority refusing and presenting with behaviours that challenge.

2.8. Covid-19 has brought with it new challenges for services working with people in a mental health and a learning disability setting, who are suspected of or have been tested positive for the virus. Nationally, this has been recognised as has the need for practice to evolve as we learn from experience and best practice.

2.9. There is recognised legal complexity regarding the use of the Mental Health Act, the Mental Capacity Act and the Corona Virus Act for ensuring compliance with infection prevention & control measures. Guidance and support has been shared so that teams are supported in their decision making and the legal decision making is documented appropriately.

2.10. The formal reporting structures are through SBU QRMs to the Restrictive Practice, with ethical decision making in CPAC.

Staff

2.11. No staff have died, however several had been admitted to intensive care units.

2.12. Staff absence from work has been a critical factor in determining our ability to manage services throughout this pandemic. At its most challenging, staff absence peaked at over 25% of all staff not working, with some services affected more badly than others.

2.13. The total absence rate (staff not working, including annual leave) is now around **14%** - with approximately **10%** of that made up from staff on annual leave. There are 143 staff impacted due Covid-related reasons; of which currently, 10 are off sick, 20 are self-isolating and not working, and 113 are self-isolating and working. This means **<1%** of staff are not working due to Covid-related reasons.

2.14. Our Staff have had access to Pillar 1 swabbing and Covid testing for both themselves and their household. As Covid-suspected cases decline the number of staff accessing testing through the Trust has declined. However, more than **584** have been referred directly by the Trust. Of those where we have received results; **81** were positive, **362** negative, **32** did not receive a result and **109** did not meet the testing criteria. This has resulted in an **18%** positive return.

2.15. From June the Trust instigated serum antibody testing (blood tests) and this offer ran for four and a half weeks, with 2983 staff being tested within that timeframe. Of results received to date, (only a few are now outstanding) 18.6% have returned as positive. Through oversight by the Tactical Command and Operational Commands, the Trust could confidently say all staff had been offered an antibody test.

2.16. The science on antibody testing remains uncertain and a positive test result for antibodies only indicates that an individual has had COVID-19. There is currently no evidence to indicate that someone cannot be re-infected with the virus, pass it on to others, or have protective immunity. Therefore, infection prevention and control measures continue irrespective of the presence of antibodies. Public Health England are conducting ongoing studies to establish whether antibodies detected by this test indicate immunity to COVID-19.

2.17. Keeping our staff safe at work throughout the COVID-19 pandemic is a key priority. Individual risk assessment was rolled out to help the Trust understand

individual needs; this is intended to support staff and keep them safe at work. At the time of writing, all staff in the Trust had completed their personal Risk Assessment (excluding those away from work on long-term sickness or maternity leave). Risk assessments will continue to be reviewed through BAU plans and will be hosted on Spike so that they remain live and continuously monitored. Experts by Experience and Volunteer Risk Assessment are now also in progress.

2.18. Key themes are emerging from the risk assessment process including: worry about passing Covid-19 on to vulnerable people living in their household or to those they cared for, and the inability to continue caring responsibilities if they were to become unwell. Addressing staff concerns by allowing staff to work from home and to follow Trust and Government guidance is an important part of the Trust response to reduce the risk of transmission and infection.

2.19. Workplace Risk Assessments have also been carried out across all sites room by room and risks are reviewed and discussed monthly within Trust and SBU health and safety meetings. To promote safe return and continuity of safe working practice within trust buildings, Covid Secure Risk Assessments are reviewed weekly at each SBU's H&S meeting and this will be monitored through the Trust's Health and Safety Committee.

3. Trust Incident Response

3.1. The Trust has entered its 22nd week of managing an Incident Command response to the COVID pandemic and is being managed in the context of the Trust's Major Incident and Business Continuity Plan with Executive Leadership by the Executive Director of Quality and Safety (Chief Nurse). The surge phase of the pandemic continued into May and has since declined, with significantly fewer confirmed and suspected cases within the units and fewer Covid-related inpatient or community deaths (with 3 reported within June and July to date).

3.2. The incident command structure continues to offer a clear line of reporting and accountability between the incident command structure and the Trust Executive. This structure continues to adapt to the emerging circumstances and is reviewed weekly to ensure it continues to be fit for purpose. For example; Tactical command meetings have been stepped down to once a day and many issues are being managed in relation to the restoration of services. The flow of information, action logging and continuity between the commands continues to strengthen.

3.3. The COVID 19 Risk Register is reviewed and updated on a weekly basis, with concerns raised, escalated and addressed through the command structure. The Trust continues to return daily SitReps and one off returns. There continues to be STP, regional and national engagement to share learning, understand guidance as it changes and participate in mutual aid.

3.4. The county remains at level 4 incident and the Trust will continue to operate under the major incident framework and this will be responsive to need. In practice this means streamlining the number of people and activity when it is not needed but rapidly stepping up in response to need.

3.5. This has been tested and the Trust was able to step up over a weekend when one ward had a confirmed case and the whole ward population needed to be tested and isolated.

3.6. We continue to remain vigilant in our approach by maintaining focus on Infection Prevention and Control good practice and adopting learning from the impact of the pandemic management within the trust

4. Hertfordshire Covid-19 Local Outbreak plan

4.1. At the beginning of July, Hertfordshire County Council shared the Covid 19 local outbreak plan. This outbreak plan builds on existing health protection plans and puts in place measures to contain any outbreak and protect the public's health. The plan is intended to enable agencies in Hertfordshire to prevent, manage, reduce and suppress outbreaks of COVID-19 infection across the County. The plan sets out a clear outbreak planning framework for Hertfordshire, this starts with the overarching plan which will be considered as the organisations current preparedness.

4.2. In relation to HPFT, we have created a specific action plan of all the detailed programmes in regard to the overarching Covid outbreak plan and provided a clear lead to confirm this is being completed and by what team/service. *(*Appendix 1: Hertfordshire Covid-19 Local Outbreak Plan)

4.3. The Trust is also feeding into Essex County Council, Norfolk Council, and Buckinghamshire healthcare – Health Outbreak Control Groups to ensure the actions county wide are also being managed through our incident control and noted on our current action log.

5. Conclusion

5.1. The COVID-19 pandemic has had an impact on service users, staff and the way we deliver services and this impact, although the way will materialise, will be here for the foreseeable future and therefore the response continues to adapt appropriately.

5.2. This paper has set out the current context and given the detail of the incident management that will be further strengthened as we move into the next phase.

Appendix 1: Hertfordshire Covid-19 Local Outbreak Plan

Action Plan

Last updated: 22/07/20

Programme 1: Prevent and Respond

Work stream	Purpose of Work stream	Description, priorities, key actions and reporting	Lead
Prevention Hub	- Enable work streams to be effective by ensuring provision of technical, scientific and other resource needed for them. - Provide a single source of advice and guidance on prevention and management of outbreaks - Identify gaps in preventative action and act to fill them as they arise - Provide rapid reactive support and advice as needed to settings or	**Key future activities** • Advice and guidance to workplaces, settings and communities on preventing spread of COVID-19. In particular: Updates to guidance for care settings (June 2020) • Collation of Action Cards for all settings from national and local sources (July 2020) • Identify areas of prevention where action or resource is missing and ensure action is taken • Provision of technical and scientific support, advice and guidance - reactive and proactive • Use of behavioural Sciences to inform action (Integrated into everything we do) • Development of tools and resources for other work streams to use (e.g. Care Homes Guidance) • Maintain overview of all preventive action • Resource communications functions and advice on communications strategy to populations and settings • Develop prevention guides for any settings which don't yet have them • Identify gaps in settings and areas where preventive action may need to be taken. –	Tactical Command / Clinical Professional Advisory Committee.

	work stream leads	Future –Proofing The hub will also ensure that is identifies future technologies or interventions such as the availability of vaccines and identifies work needed to deliver these.	
Care Homes (Adult care services including care homes and residential settings)	Prevent and manage outbreaks in care homes and other adult care settings	Key future activities • Strategic oversight on the number of cases, number of deaths and staffing levels across all the care homes across Hertfordshire. • Support care homes to continue to operate in order to manage and sustain capacity to deliver effective discharges from acute hospitals. • Support care homes to prevent admissions to the acute hospitals through enhanced medical support into the care homes. • Coordinate and expedite clinical advice and support around infection control to care homes and home care agencies. (Be a link with all other operational hubs that are established, in particular with the provider Hub. Where the work stream reports to; • Through Health Protection Board to SCG.	Social Work & Safeguarding Team
High Risk Settings (non-NHS) Including Workplace	Systematic Risks assessment of places and settings at higher risk of COVID.	Where work stream receives notifications from • Systematically identify settings not already specified which are at heightened risk of transmission of COVID 19 including o Workplaces o Houses of Multiple Occupation o Supported Living Settings o Places of Mass Gathering or High Human Traffic o Further and Higher Education Settings	Tactical Command (Workforce's L&D) This was completed via the staff an service user individual risk assessments

		• Risk assess and prioritise settings for preventive action • Contact settings identified proactively with advice and guidance including action cards for each setting • Ensure Check that high risk settings have registers in place to enable contact tracing (Action for tactical command discussion) • Exercise incident response and management with highest risk settings • Identify highest risk for regular advice and monitoring.	
High Risk NHS settings and Primary care work streams	• Ensure COVID-19 transmission in NHS settings is prevented • Manage COVID-19 Outbreaks in NHS Settings	Key Future activities • Systematically risk assess NHS settings for risk of transmission of COVID-19 between and among staff, visitors and patients • Identify a risk register of NHS settings at highest risk of outbreaks • Identify actions to be taken for each setting to reduce spread of the virus and a plan for each setting • Ensure every NHS Provider has taken infection and outbreak control plans through their Board	Compliance and Risk Management – Through Tactical Command
Vulnerable people and Communities. Substream: Support for people self-isolations	Ensure people self-isolating are supported to stay self-isolating and can access food, medicine and essential supplies without breaking self-isolation	Key Activities a) Arrangements to ensure people self-isolating can get essential food and medical supplies and not compromise isolation (This is being completed via community staff, so this already being completed Safe guarding) b) Identifying communities most vulnerable to COVID and working with (at risk of domestic abuse this has been carried out by safeguarding team).	Social Work & Safeguarding Team
Vulnerable people and communities. Sub work stream: systematic action on	• Identify communities at increased risk of impacts from COVID-19 (infection, severe disease, mortality) and put in place preventive and mitigation measures	Key activities underway • Co-morbidities and risk screening tool for primary care to identify people at heightened risk and take preventive action to include BAME patients (July 2020) • Identification of COVID-19 impact on shielding population and development of health improvement offer (muscle weakness recovery, strength loss recovery)	Inclusion & Engagement Team/ Allied Health Professions and Healthy Lifestyles team – feed into Tactical Command

vulnerable people and communities		• Key future activities • Identify vulnerability factors for COVID-19 (COVID Risk assessments have been considered, this has been risk assessed) • Identify populations at heightened vulnerability and identify how o Older people o Shielding populations o People with learning disabilities o People with severe mental illness o Populations of identity (travellers, migrant workers) o BAME Populations (identified below as a separate work stream) o People with co-morbidities o Establish leads in agencies for each population and o Agree action cards for each vulnerable population and agencies working with them o (Assessment of people's needs, Operational commands risk assess all people within these MDs & CDs) o Seek assurance that immunisation services are in place and prioritising vulnerable people.	
Vulnerable People and Communities Sub-work stream: BAME Populations		Key activities underway • Co-morbidities screening tool for primary care including BAME communities • Infection control advice and guidance for BAME taxi drivers Key future activities • Risk assess BAME Staff and ensure preventive measures and actions are in place, prioritising social care (all ages) and NHS staff • Identify high risk BAME workforces outside • Identify BAME led small and medium enterprises for preventive advice and support	Inclusion & Engagement Team/ Allied Health Professions and Healthy Lifestyles team – feed into Tactical Command

		• Co-produce assessment of impact with BAME communities and action plan • Ensure that seasonal 'flu and pneumococcal vaccination campaigns target BAME populations most vulnerable to infection. (Sally Judges check this ones)	
PPE	Coordination of essential PPE supplies for high risk settings such as care homes	Key future activities • Ensure any new and emerging guidance relating to PPE is communicated to the system, working with the Prevention Hub (ongoing) (ensure we are receiving this) • Consider strategic/tactical issues relating to PPE and escalate accordingly (ongoing) How this Work stream Reports SCG	Finance Department

Programme 2: Testing and Contact Tracing

Work stream	Purpose of Work stream	Description, priorities, key actions and reporting	Lead
Testing Co-Ordination and Deployment	Ensuring testing capability supports deliver of outbreak plan priorities and is easily deployable	• Identify additional capacity needed to enable every setting to have access to testing (July 2020) • Ensure a transfer of care testing pathway is in place (July 2020) • Work in collaboration with national and regional teams on test and trace to continually Passes/amend the pathways in place to enable the testing of all symptomatic individuals (ongoing) • Coordinate the local approach to antibody testing (by October 2020) **Where the work stream Reports to** • Through the Health Protection Board to SCG	Tactical Command – Led by Nursing directorate – Head of Nursing
Contact Tracing Local Capabilities	Ensuring contact tracing locally can support the national test and trace programme.	Key future activities; • Identify local elements of Contact Tracing in partnership with PHE (July 2020) • Put in place arrangements and capacity for local contact tracing (July 2020)	Tactical Command – Led by Nursing Directorate – Head of Nursing

		• Liaise with Vulnerable Peoples work streams to ensure support for people isolating (underway) • Liaise with Enforcement work stream to ensure enforcement powers can be used appropriately if needed (underway) • Receipt of escalated cases from Level 2 and 3 of the national Test and Trace service and from PHE East of England (not yet confirmed by PHE) • Receipt of contact tracing requirements directly from work streams where local intelligence identifies issues in the first instance (July 2020) • Completion of setting-specific contact tracing or escalation to appropriate setting to undertake contact tracing themselves (e.g. hospitals; fire & rescue service; police) (July 2020) • Information sharing (June 2020)	
Co-ordination with National and Regional Functions	Ensure that there is clear co-ordination and understanding of responsibilities from national to local for testing and contact tracing.	Key Activities underway • Develop standard operating procedures and agree these (July 2020) • Develop Information and communication flows from national to regional to local (July 2020) • Develop information sharing pathways and systems for patient identifiable contact data (June 2020) Where the work stream reports to: Public Health England/ ADPH Regional Hub	Via the Hertfordshire Health Economy tactical coordinating group (HHETCG)

Programme 3: Surveillance, Intelligence and data

Work stream	Purpose of Work stream	Description, priorities, key actions and reporting	Lead
Daily Surveillance meeting	To provide rapid intelligence and existing and emerging outbreaks and identify action to be taken	Key future activities • Finalise new surveillance dashboard (July 2020) (review information on a daily basis oversight) • Review information from various sources on a daily basis	Tactical Command

		• Identify any alerts and actions and information flows arising from this. • Consider whether outbreaks can be met within existing resources or need additional action	
Analytical, forecasting and Modelling	Provision of Epidemiological Intelligence and Modelling	Key future activities • Provision of regular reports on existing outbreaks and situations including standard epidemiological indicators on burden of disease, death and infection • Modelling of existing and other epidemiological indicators against interventions being taken or planned • Modelling of NHS and other service capacity needed on an ongoing basis (are we feeding into this) • Modelling of future waves of infection • Monitoring and forecasting the spread of the disease	Infection, Prevention and Control Team
Information Sharing	To ensure information sharing is effective	Key future activities • Agreement of information sharing protocols and information governance tools • Ensuring access to key systems for transfer and sharing of data and reports to enable action • Ensuring standardisation of reporting information to enable analysis • Ensuring primary Secondary data flows in from all relevant sources, including PHE, NHSE and other parts of the local health and care system Where the Work stream reports to Through Health Protection Board to SCG (Some work reports directly into SCG)	Information Governance Team

Programme 4: Engaging Communities

Work stream	Purpose of Work stream	Description, priorities, key actions and reporting	Lead

Communications	Engage the public in: Maintain public trust in measures to prevent and control outbreaks	Key ongoing activities • Develop targeted and general campaigns to support prevention and outbreak management as identified by other cells • To provide accurate and timely information throughout the course of the pandemic to the public • Ensure that health and social care staff have the right information at the right time to perform their role and enable them to respond to enquiries from the public Key future activities • • Public facing version of plan launched and communicated (June 2020) Establish and maintain confidence in the ability of Hertfordshire services to prepare and manage an effective response • Identifying future communications capacity needs for work streams Where the work stream reports to Hertfordshire COVID-19 Elected Member Engagement Board and SCG	Communications – Through Tactical Command/ Strategic Command

Programme 5: Governance and Programme Co-ordination

Work stream	**Purpose of Work stream**	**Description, priorities, key actions and reporting**	**Lead**
Hertfordshire COVID-19 Health protection board	To deliver, update and manage the outbreak plan and associated capabilities	Key future activities • Identification of actions to prevent and manage outbreaks (the plan) • The Strategic Co-Ordinating Group	Via the Hertfordshire Health Economy tactical coordinating group (HHETCG)
Programme management office	To resource the board and plan and ensure it delivers	Key future activities • To apply programme management approaches to ensure the Plan and Board are effective • To ensure programme management and deliver capabilities are provided	Strategic Command / Tactical Command

		• Agree the scope and outputs to be delivered from each work stream. • Develop the project plan, including identifying dependencies between work streams. • Identify any high level issues/ risks that threaten the success of the project and bring these to the attention of the Cell Board. • Update issues/risks logs ensuring each issue/risk is assigned an owner and is managed in accordance with HCC's risk management strategy • Monitor the progress of each work strand against the plan and report progress to the Cell Board. • Ensure that all appropriate project management documentation is produced. • Lead on ensuring workforce issues are addressed (capabilities, capacity and training) in liaison with work stream leads. Where this work stream reports Health Protection Board	
Internal Co-ordination	Support the boards by ensuring appropriate internal reporting	Key activities • Ensure the Member Board is resourced and convened • Ensure liaison with Herts Chief Executives and Recovery Co-ordinating Group • Ensure Financial Bids and Business cases managed Where this work stream Reports to Health Protection Board, SMB	Finance Department

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors

Meeting Date:	30 July 2020	**Agenda Item:** 7b
Subject:	CQC Board Assurance IPC inspection	**For Publication:** Yes
Author:	Dr Jane Padmore – Executive Director Quality & Safety	**Approved by:** Dr Jane Padmore – Executive Director Quality & Safety
Presented by:	Jacky Vincent, Deputy Director Nursing and Quality	

Purpose of the report: To update the Board of Directors on the outcome of the CQC IPC board assurance discussion.

Action required: To note.

Summary and recommendations:
This paper gives the outcome of the discussion with CQC about the board's assurance regarding the effectiveness of the trust's Infection Prevention and Control measures. Jacky Vincent, DIPC and Jane Padmore, Director Quality and Safety, were interviewed by the CQC on 7th July 2020.

Attached is a record of our conversation that includes a summary of the most important discussion points.

The information gathered will not be shared or published specifically, but will be collated and shared with key stakeholders to identify themes, trends and risks that will inform our regulatory response and national oversight in this important area of practice.

The interview looked at 11 domains and the Trust passed all of them.

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

Health and Social Care Act 2008 (Regulated Activities) Regulations

Regulation 12: Safe care and treatment
- Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible. They should review methods and measures and amended them to address changing practice.

Regulation 17: Good Governance
- Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.
- Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.
- Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.

• Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. • Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased. Care Quality Commission Key Line of Enquiry; Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions

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

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

Equality & Diversity and Public & Patient Involvement Implications:

Individual risk assessments of BAME staff.

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

None

Infection Prevention and Control Assessment

Engagement call

Summary Record

Hertfordshire Partnership University NHS Foundation Trust

Provider address	Date
The Colonnades Beaconsfield Close, Hatfield AL10 8YE	09/07/2020

Dear Hertfordshire Partnership University NHS Foundation Trust

The Care Quality Commission is not routinely inspecting services during the pandemic period and recovery phase, although we will be carrying out some focused inspections. We are maintaining contact with providers through our usual engagement calls and by monitoring arrangements such as those for infection prevention and control.

This Summary Record outlines what we found during an engagement call to discuss infection prevention and control arrangements, using standard sentences and explanatory paragraphs.

We have found that the board is assured that the trust has effective infection prevention and control measures in place. The overall summary outlines key findings from our assessment, including any innovative practice or areas for improvement.

This assessment and other monitoring activity are not inspections. Summary Records are not inspection reports. Summary Records are not published on our website.

Infection Prevention and Control – Assessment areas

1. *Has the trust board received / undertaken an assessment of infection prevention and control procedures and measures in place across all services since the pandemic of COVID 19 was declared. Does this include an assessment of the estate / isolation facilities?*	
Yes	The Board had received/undertaken a clear and comprehensive assessment of Infection Prevention and Control across all services including an assessment of the estate and isolation facilities.

2. *Are there systems in place to manage and monitor the prevention and control of infection? Do these systems use risk assessments and consider the susceptibility of service users, and any risks that their environment and other users may pose to them?*	
Yes	There are systems in place in manage and monitor the prevention and control of infection.

3. *Are there systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections?*	
Yes	There are systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections.

4. *Is there appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance?*	
Yes	There is appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

5. *Does the trust provide suitable accurate information on infections, in a timely fashion, to service users, their visitors and any person concerned with providing further support or nursing/ medical care?*	
Yes	The trust provides suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

6. *Is there a system in place that ensures prompt identification of people who have or are at risk of developing an infection, so that they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people?*	
Yes	The trust has systems to identify promptly people who have an infection, or who are at risk of developing an infection so that they receive timely and appropriate treatment.

7. *Are there systems in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection?*	
Yes	There are systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process or preventing and controlling infection.

8. *Are there secure or adequate isolation facilities?*	
Yes	The trust has effective process in place to manage the isolation of patients appropriately.

9. Is there adequate access to laboratory support?	
Yes	There is adequate and responsive access to laboratory support.

10. *Is there evidence that the trust has policies designed for the individual's care which will help prevent and control infections?*	
Yes	The trust has effective policies designed for the individual's care which will help prevent and control infections.

11. *Does the trust have a system to manage the occupational health needs of staff, regarding infection?*	
Yes	The trust has a system to manage the occupational health needs of staff regarding infection.

Overall summary record

From our discussion and other information about this location, we assess that you are managing the impact of the COVID-19 pandemic.

The trust has identified that the 2nd and 3rd lines of assurance within the BAF require strengthening. It is also the intention to RAG rate the document once this has been given thorough consideration. However, we acknowledge that the BAF document in use is a more comprehensive document than that provided by NHSE/I as a standard pro forma. We also considered the trust have produced a comprehensive Covid-19 risk register, that aligns with the corporate risk register. We considered this to be good practice. The trust has acknowledged that the BAF is a work in progress at this time and that CQC will be forwarded the document as it is further updated and strengthened.

We were impressed with the trust's plans to identify a specific ward, Elizabeth Court, to allow for cohorting of patient testing positive for Covid-19. The trust was also prepared to make this environment available to support the wider system, which demonstrated good partnership working. We were also impressed that the trust had utilised the skills of their Associate Practitioners, with specific skills from their training, to provide support to Elizabeth Court. We understand that this specific team are now providing support across the trust. We considered this an area of good practice.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 7c
Subject:	Shaping Our Future – update	**For Publication:**
Author:	Karen Taylor, Executive Director, Strategy & Integration	**Approved by:** Karen Taylor, Executive Director, Strategy & Integration
Presented by:	Karen Taylor, Executive Director, Strategy & Integration	

Purpose of the report:

To provide the committee with an update on the Shaping our Future programme of work, and an update on Phase III national planning.

Action required:

To receive the report, discussing progress made and next steps

Summary and recommendations to the Board:

This paper builds on the previous papers presented to the Trust Board on 25 June and the Covid Assurance Committee held on 9 July 2020

Restoring our Services

Although demand is beginning to increase it continues to vary by service and overall, at the time of writing this report, Trust wide referrals remain down by 20%. IAPT remains down by c.30% and CAMHS remains down by approximately 20%. Older Peoples, Learning Disabilities and Community referrals have increased to pre-covid levels, albeit there remain fluctuations on a weekly basis.

IAPT and EMDASS remain two key focus areas for the Trust. As previously reported IAPT demand dramatically reduced during the COVID19 outbreak, and capacity within the service was also reduced as staff were redeployed in line with our Business Continuity Plan. Capacity has largely resumed to pre-covid levels as staff have returned to their teams and waiting times into the service remain under 6 weeks. However, we anticipate and are planning for a surge in IAPT referrals during the Autumn period. Also as previously reported, we have a number of service users waiting to be seen within our EMDASS service reflecting the pause of the service for a short period during the initial COVID-19 outbreak. A plan is in place to ensure service users are seen, with all service users expected to be seen within the next 8-10 weeks.

CAMHS – Child and Adolescent Mental Health Services have also returned to pre-covid capacity levels. However as noted above demand levels remain low and we have been working with partners across the system to plan for the anticipated surge in referrals in the Autumn following the opening of schools. This is a key focus for us as an organisation over the forthcoming weeks and months.

As previously reported to the Committee and Trust Board, we have seen a shift across the Trust to the majority of our activity being delivered virtually. As we reassess service user needs we are looking at what the balance between face to face and virtual activity is likely to need to be moving forwards, reflecting service user needs together with our capacity available due to Infection Prevention and Control including social distancing measures. This is a key consideration for the

organisation in terms of the way we are able to deliver treatment and the impact it has on the experience and recovery for our service users.

Running our Services

The majority of the work identified at the beginning of this programme has now been completed including ensuring robust Infection Prevention and Control practice and processes are in place across the organisation; undertaking risk assessments of our buildings to enable safe working practices; ensuring all staff undertook an individual risk assessment and appropriate measures/actions agreed to support individuals working practices. The COVID19 Incident Management paper on the Board agenda provides the detail regarding ongoing 'Running' activities. Key within this is planning for any future 'surge' or 'outbreak' and the appropriate response by the Trust.

Reshaping our services

The evaluation of the major service changes we made during the incident are well under way and are expected to be completed during August. These are for:

- A&E Diversion hubs
- 24/7 helpline
- Staff helpline
- Use of technology – virtual delivery of care

Our clinically/professionally led 'Reshaping our Service' Programme is also well underway, with teams working together to identify the key priorities, innovative practice and changes needing to be made or embedded during the remainder of the year to improve care and outcomes. The main areas of focus are:

- Improving physical health
- New model for EMDASS (Early Memory Diagnosis and Assessment)
- Community model (all age) and alignment with primary care, and new model of care for those service users who would have traditionally received care through an outpatient model
- Enhanced Crisis pathway (also part of wider system work within the Hertfordshire Mental Health & Learning Disability Integrated Care Partnership – MHLD ICP)
- LD transformation across the Trust
- CAMHS (also part of wider system work within the Herts MH & LD ICP)

National Planning & Regional Submission

A further Phase III planning submission was made to NHSE/I on 14 July 2020. This built on previous submissions we have made as an organisation with the following planning assumptions asked to be modelled by NHSE:

- 10% increase on February 2020 baseline activity
- Activity increase to be demonstrated for December 2020 and March 2020
- Any financial implications of achieving the above

We have subsequently received feedback on this submission from NHSE which we will take into consideration for the final submission to region in August. The specific feedback has requested:

- Clarification on IAPT modelling

- Clarification on whether the 10% activity increase can be achieved by December 2020
- Clarification on bed modelling and alternative options

NHSE have also indicated we need to revisit our plans in the event additional capital and revenue funding is not available.

We are expecting national planning guidance to be issued imminently; and a national return is likely to be expected during August / early September. In the meantime, another return is expected to be made to East of England NHSE region on 13 August.

Conclusion and Recommendations

This report has provided an update on the key work taking place across the Trust as part of our programme of work 'Shaping our Future'. The majority of our services have been restored and are operating at pre-covid levels of capacity. However, demand remains lower than normal across the Trust and our focus remains on working with partners across the system to encourage and restore demand levels. There is also significant ongoing work underway to ensure services are ready and able to support demand as it increases to pre-covid levels; together with undertaking planning for surges in demand levels during the remainder of the year.

The Trust Board is asked to:

- Receive the update provided, noting the progress made and current areas of focus.
- Note the latest submission made to NHSE and next submission requirements

Relationship with the Business Plan & Assurance Framework:

Shaping our Future is aligned with the delivery of our Annual Plan

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

N/A

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

N/A

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

Exec Committee weekly updates, Trust Board 25 June & Covid Assurance Committee 9 July

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 8
Subject:	Patient Safety- Review of Covid death in two in patient wards- Summary	**For Publication:** Yes/No
Author:	Anne Hunt, Consultant Nurse Physical Healthcare	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety/Chief Nurse
Presented by:	Jacky Vincent, Deputy Director Nursing and Quality	

Purpose of the report:

To give the Board a summary of the work that was done in the early stages of the pandemic to understand and respond to the significant number of deaths on two of the mental health older adult mental health wards.

Action required:

This is for information and discussion.

Summary and recommendations to the Board:

This paper gives an overview of a rapid review that took place at the beginning of the pandemic in relation to a cluster of covid related deaths in two older adult in patient services.

The rapid review led to immediate changes and strengthening practice as well as the identifying good practice. As the pandemic has progressed and the services move into new ways of working the lessons and good practice is being embedded across older adult services.

Relationship with the Business Plan & Assurance Framework:

Relation to the COVID Trust Risk Register:
COVID 19: The Trust may not be able to sustain operational services and maintain service user safety during the COVID19 outbreak (Risk 1253)
Relation to the BAF:
1. We will provide safe services, so that people feel safe and are protected from avoidable harm.
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:

Executive Committee 29th July 2020

Summary of review into the Covid related deaths on two in patient mental health older adult wards.

1. Introduction

1.1. Early on in the pandemic it was noted that two wards were disproportionately affected by covid related deaths and therefore a rapid review was undertaken to establish whether there were any immediate lessons that could be learnt. This report is an overview of that rapid review.

1.2. A deep dive into the cases of people who died of Covid-19 at Lambourn Grove and Victoria Court in spring 2020 was requested by the Executive Director of Nursing. Information was gathered from

1.2.1. Paris records

1.2.2. Mortality governance report of 12 service users confirmed as deaths from Covid19 in April & May 2020 (9 from Lambourn Grove; 3 from Victoria Court).

1.2.3. Infection control fact finding reports for all suspected and confirmed Covid cases completed in May 2020.

1.2.4. Additional information obtained from the medical and nursing staff employed and redeployed to these areas during the pandemic.

2. Case demographics

2.1. 11 service users from Lambourn Grove and 8 service users from Victoria Court died during the pandemic.

2.2. Service users were aged 64 – 97 years, average age 80 years; two thirds were male.

2.3. All service users had a diagnosis of dementia. Underlying health conditions included on Paris were hypertension, stroke, type 2 diabetes and chronic kidney disease.

2.4. Frailty had not been formally assessed or documented on Paris. In the opinion of nursing and medical staff, the service users who died were more frail than those who survived Covid, although they all had similar medical problems.

2.5. Obesity, smoking and ethnic origin do not appear to be risk factors in this group:

2.6. Most service users' weight was in the desirable BMI range; several were underweight and none were in the morbidly obese BMI range of over 40 (range 16 – 31).

2.7. Paris entries showed service users having never smoked or were ex-smokers.

2.8. All service users were of white British or white Irish ethnic origin.

3. Recognition of service users with suspected Covid-19

3.1. PHE guidance was to isolate people with a high temperature and continuous cough.

3.2. The majority of service users displayed these classic Covid symptoms but there were several Covid cases on each unit whose only symptom was low oxygen saturations identified on routine monitoring or being generally unwell.

3.3. 'Silent' hypoxia is a very unusual sign not seen in other chest infections but is now recognised in Covid. Low oxygen saturations usually triggers faster breathing which would alert a carer to deterioration.

3.4. Asymptomatic and pre symptomatic transmission were not considered in guidelines until 9/4/20. The incubation period of Covid 19 is 1 – 14 days (median 5 days).

3.5. There was potential asymptomatic transmission on both units before this date including the surge to 9 cases at Lambourn Grove which happened within the incubation period from the initial three Covid cases, one of which was asymptomatic.

3.6. Staff in both units noticed softer signs of deterioration in service users such as lack of interest in food and drink, lethargy and subdued behaviours – particularly those who had previously been aggressive in personal care becoming compliant.

3.7. These service users were isolated as suspected Covid cases and had physiological observations monitored closely. Some developed symptoms and tested Covid positive on swab. One service user refused a swab but her cause of death was Covid 19.

3.8. This action by staff undoubtedly reduced further transmission.

4. Diagnosing Covid

4.1. PHE guidance was originally to take a swab after a service user had persistent cough / high temp for 24 – 48 hours.

4.2. Swab results were taking 3 – 5 days, meaning a service user could have symptoms and be nursed in isolation for 7 days before a result was known.

4.3. From 9/4/20 swabbing of asymptomatic service users commenced & swab results were received more quickly.

5. Immediate interventions & good practice

5.1. The treatment for Covid available in the inpatient units was supportive symptom control with pain / fever relief, fluids and oral antibiotics to prevent secondary infection. There is good evidence that service users received this care and those requiring a higher level of care were transferred to the acute trusts.

5.2. Service users were reviewed daily, 7 days a week, with additional consultant psychiatrist ward rounds, and increased junior doctor presence and senior nurse support on the units.

5.3. Additional staff with physical health experience who had been upskilled to work in Elizabeth Court were redeployed to support both units.

5.4. Specialist Respiratory consultant review from the Covid virtual hospital was arranged through virtual ward rounds meaning these service users had comparable medical care to patients in the acute hospitals.

5.5. Additional training was provided in house and from acute trusts and the hospice network to nursing and medical staff on both units:

- **5.5.1.** Infection Prevention and control procedures
- **5.5.2.** use of PPE;
- **5.5.3.** monitoring and recording physiological observations and soft measures;
- **5.5.4.** recognition and assessment of sick service user;
- **5.5.5.** care of service user with chest infection
- **5.5.6.** resuscitation updates
- **5.5.7.** end of life care

5.6. The frequency of physiological observations to monitor all service users was increased to a minimum of 3 times a day. This identified some asymptomatic deterioration. NEWS2 and soft measures were implemented after training.

5.7. End of life care plans including 'just in case' medicines were prescribed and regularly reviewed.

6. Challenges

6.1. Isolating service users with dementia in single rooms was difficult; it was a significant change in practice, although staff did understand the infection control requirement.

6.2. Cohorting Covid positive service users in one wing, following trust guidance was only possible when large numbers of service users tested positive or bed occupancy was reduced.

6.3. Nursing staff made repeated attempts to keep service users hydrated and nourished, although records were not complete and some service users refused to eat and drink.

6.4. Incomplete documentation of observations reflects the difficulties of recording physiological observations from service users with dementia which then undermines NEWS scoring.

6.5. Timely, accurate record keeping was challenging when nursing service users in isolation and wearing PPE.

6.6. Nursing staff felt the impact of sudden change on the Service users' routine was significant on their mental health leading to low mood:

6.7. Visiting: some Service users would normally be visited by family members for several hours every day which ceased abruptly following guidance in March.

6.8. PPE: nursing staff felt some service users were frightened when PPE was worn; they tried to mitigate this with large photos of themselves on their aprons.

6.9. Some service users rapidly deteriorated.

6.10. There was some reluctance to consider DNACPR orders in advance.

7. Good practice to continue

7.1. Frequency of service user physiological observations (vital signs) to stay at a minimum of twice a day in all older adult in-patient units.

7.2. Increased consultant psychiatrist and junior doctor presence on older adult units with teaching ward rounds and reinforcement of NEWS2 and associated escalation procedures

7.3. Standardised NEWS2 & soft measures assessment and escalation training and implementation of 'Stop and Watch' as advocated by NHSE/I.

7.4. Soft measures and 'Stop and Watch' give a structured assessment of subjective signs to indicate altered physiology where it is not possible to record objective physiological observations

7.5. 80% of in-patient nursing and medical staff will be trained by end of September.

7.6. Clear Infection prevention and control expectations

- **7.6.1.** who to isolate, when to isolate, how to isolate
- **7.6.2.** This is supported by team leaders and matrons and the infection control team
- **7.6.3.** Checklist / briefing sheet approved by CPAC for use with all staff at start of each shift
- **7.6.4.** Uniform and PPE compliance

7.7. This is a new way of working and requires ongoing support and monitoring

7.8. Seeking to retain and expand relations with the acute hospital trusts to maintain Covid virtual hospital input through virtual ward rounds and explore this service with other specialties such as frailty and cardiology.

7.9. Assessment of frailty amongst service users to inform future care will be part of the frailty pathway in progress.

8. Conclusion

8.1. This report gave an overview of a rapid review of covid related deaths early on in the pandemic and the lessons that were learnt as well as the good practice that was identified. This review and the resultant changes in practice have led to long term improvements across the mental health older adult services.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 9
Subject:	Trust Risk Register July 2020	**For Publication:** Yes/No
Author:	Nick Egginton, Compliance and Risk Manager	**Approved by:** Dr Jane Padmore, Director of Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Deputy Director Quality and Safety	

Purpose of the report:

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

Action required:

Approve: To approve the Trust Risk Register and the changes recommended

Summary and recommendations:

This report gives an update on the Trust's Risk Register. It recommends changes to grading, consideration of new risks and sets out the updates in relation to the mitigations.

The Trust risk register was last presented to the Trust Board on the 28th May 2020.

New risk for consideration for the Trust Risk Register

- Finance: The Trust is unable to ensure short term financial performance in current financial year (1301)

Risks for consideration of a reduction in score and/or downgrading from the Trust Risk Register

- Data Protection: Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident (Risk 920). It is recommend that the likelihood of this risk occurring is reduced from possible (3) to unlikely (2) resulting in a risk score of 8 on the basis there is a reduced likelihood of action imposed by the Information Governance Commissioner. Although the target score of 6 is not achieved given the reduction in score it is requested that the risk is managed locally within IM&T/IG governance structure on the IM&T/IG risk register.

- EU Exit: Implications for the Trust of different scenarios arising from Brexit (Risk 1000). There is now a transition period until the end of 2020 while the UK and EU negotiate additional arrangements, with minimal activity, it is therefore recommend that although the risk score is not changing that it is downgraded to the Emergency Planning governance structure / risk register, until such time changes nationally indicate the risk being upgraded.

- Adult Community: Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites (Risk 773). It is recommend that the likelihood of this risk occurring is reduced from possible (3) to unlikely (2) resulting in a risk score of 6 which meets the target risk rating thus this risk is being put forward to be considered for closing.

- CAMHS: Unable to provide consistent timely access to CAMHS Community Services (Risk 1150). It is recommended that this risk is downgraded from the Trust Risk Register on the basis that

CAMHS is now consistently providing timely access. The risk will remain on the E&N SBU risk register and CAMHS service risk register.

Proposal to change the following risks:

Over the next period, a deep dive in to the following risks will be undertaken to review the current position, the risk scores and the mitigation as, although significant work has been improvements have been made the risk score has not moved over.

- Workforce: The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff (Risk 215). This risk has changed over time and rather than the simplistic recruitment to vacancies to ensure safety this risk will in the future be refocused on workforce planning delivering the staff with the right skills when and where they are needed to meet our current and future needs.

- Workforce: The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657). This risk has changed over time and rather than the simplistic retention of staff this risk will in the future be refocused on the Trusts ability to establish and deliver a workforce culture fit to deliver staff expectations.

The Trust Board is asked to:

- Approve the revised Risk Register, discuss the risks, mitigating actions, risk scores and recommended changes.

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

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

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

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

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

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

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

Health and Social Care Act 2008 (Regulated Activities) Regulations

Regulation 12: Safe care and treatment

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

Regulation 17: Good Governance

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

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

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

Exec 15.07.2020

Hertfordshire Partnership University NHS Foundation Trust

Trust Risk Register Executive Summary July 2020

1. Introduction

1.1. The purpose of this report is to present the Trust Risk Register (TRR) to the Exec for discussion and approval. Consideration should be given to the current situation and the mitigations that have been put in place. The TRR identifies the high level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them. There are 9 risks currently on the Trust Risk Register.

1.2. The updates to individual risks, taken in turn, are summarised and then the TRR is set out in full with details of the controls, the early indicators and comments on the current position as well as the initial and current scores. Each Director has reviewed the risks that they are Senior Responsible Officer for. In addition, the Executive Team met to peer review the TRR as a whole, along with the scoring.

2. New risks for consideration for the Trust Risk Register

2.1 Finance: The Trust is unable to ensure short term financial performance in current financial year (1301)

2.1.1 The following risk is recommend for inclusion on the Trust Risk Register for the following reasons:

- As per the current national reporting arrangements the Trust has reported a breakeven position for each month and for the year to date.
- The current financial arrangements will ensure that the Trust achieves financial balance for the first four months of the year. What is less clear is the detail of the changes that will be made from August onwards as NHSE/I seek to bring in more certainty and grip to the system. Further guidance on this is expected during July.
- Going forwards there are clear risks in terms of the level of demand and its complexity.
- Focus is now on anticipating and responding to the future changes and to build headroom to create flexibility for the next period which will see a much tighter control on funding.
- Delivering Value Programme - The Trust has recommenced work on the programme and as services are restored those schemes previously developed will begin to be implemented.

3. Risks for consideration of a reduction in score and/or downgrading from the Trust Risk Register

3.1 Data Protection: Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident (Risk 920)

3.1.1 It is recommend that the likelihood of this risk occurring is reduced from possible (3) to unlikely (2) resulting in a risk score of 8 on the basis there is a reduce likelihood of action imposed by the Information Governance Commissioner. Although the target score of 6 is not achieved given the reduction in score it is requested that the risk is managed locally within IM&T/IG governance structure / risk register.

3.1.2 In 2019 – 2020 7 incidents were scored as 'high risk' and reported to the Information Commissioner. All cases have since been closed, and no further action has been required by the Trust. The most common theme across the financial year was 'information disclosed in error'.

3.1.3 63 data incidents were reported through DATIX in Q1. Two incidents were escalated to the Information Governance Commissioner – both have been subsequently closed with no further action for the Trust.

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

3.2.1 There is now a transition period until the end of 2020 while the UK and EU negotiate additional arrangements, with minimal activity, it is therefore recommend that although the risk score is not changing that it is downgraded to the Emergency Planning governance structure / risk register, until such time changes nationally indicate the risk being upgraded.

3.3 Adult Community: Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites (Risk 773)

3.3.1 It is recommend that the likelihood of this risk occurring is reduced from possible (3) to unlikely (2) resulting in a risk score of 6 which meets the target risk rating thus this risk is being put forward to be considered for closing based on the following mitigation:

3.3.2 It is felt that the CQI projects put in place to improve the ability to respond to demand and reduce the impact on safety, quality and effectiveness had the desired effect.

3.3.3 The Trust has increased its performance reporting from monthly to weekly focussing on the key KPIs that are likely to indicate if service changes made are adversely impacting performance. The report is presented to Exec weekly.

3.3.4 Any impact on this risk is now connected to COVID19 which is being picked up in the performance risk on the COVID risk register the review will consider closing this risk as a result.

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

3.4.1 It is recommended that this risk is downgraded from the Trust Risk Register on the basis that CAMHS is now consistently providing timely access. The risk will remain on the E&N SBU risk register and CAMHS service risk register.

4 Risk Register Update

4.1 COVID19: The Trust may not be able to sustain core operational services and maintain service user and staff safety during the COVID19 outbreak (1253)

4.1.1 The Trust may not be able to sustain core operational services and maintain service user and staff safety during the COVID19 outbreak. It has been recommended that the likelihood of this risk occurring is reduce from likely (4) to possible (3) resulting in a risk score of 15. This reduction was approved by Tactical Command on 9th June 2020.

4.1.2 This risk is fully detailed in the COVID-19 risk register item so will not be repeated here.

4.2 Finance: The Trust may not have sufficient resources to ensure long term financial sustainability (Risk 1001)

4.2.1 Additional risk descriptor has been added around the potential risk of future loss of income as a result of changes to commissioning. The Hertfordshire and West Essex Sustainability and Transformation Partnership (STP) have achieved Integrated Care System (ICS) status. The Hertfordshire and West Essex Integrated Care System (ICS) will be responsible for effective health and care services being designed and delivered in local communities in line with three geographically-based Integrated Care Partnerships (ICPs) – East and North Hertfordshire, West Hertfordshire and West Essex.

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

4.3.1 Recruitment, Retention and Reward plan has been developed which addresses the on-going challenges around recruitment and retention and lays out the commitment to our staff, their development and their working lives in HPFT. Whilst the strategy did not get launched in Q4, we have continued recruitment activity to reduce the vacancy rate down to below the target despite a further increase in our funded establishment.

4.3.2 The recruitment process has continued throughout the pandemic with the impact that the Trust vacancy rate ended Q4 below its target of 12.8%.

4.3.3 Since Q1, there has been an increase in establishment of over 100 wte, which has been matched by a corresponding increase in staff in post.

4.3.4 We have also almost doubled the number of active recruitment episodes to ensure the pipeline continues to bring in the level of starters we need, with over 250 candidates at the post offer stage. This model of utilising social media for a focused locality and/or staff group continued to be successful in recruiting to a number of hard to fill posts in Q4 against a back drop of no face to face interviews and increased use of video link interviews.

4.3.5 The time to hire during Q4 has decreased significantly to 47 days and during Q4 we had 192 new starters (compared to 156 in Q3) and only 120 leavers. This is a net gain of 72 staff.

4.3.6 This risk has changed over time and rather than the simplistic recruitment to vacancies to ensure safety this risk will in the future be refocused on workforce planning delivering the staff with the right skills when and where they are needed to meet our current and future needs.

4.4 Changing External Landscape: The changing external landscape and wider system pressures/agenda leads to a shift of influence and resources away from mental health & Learning Disability services and from HPFT (Risk 749)

4.4.1 Herts MH & LD ICP - Partnership Board established and governance arrangements at early stage of development. High level priorities agreed by partners, transformation programme being developed.

4.4.2 Herts MH & LD ICP leading system recovery of mental health and learning disability services from Covid incident.

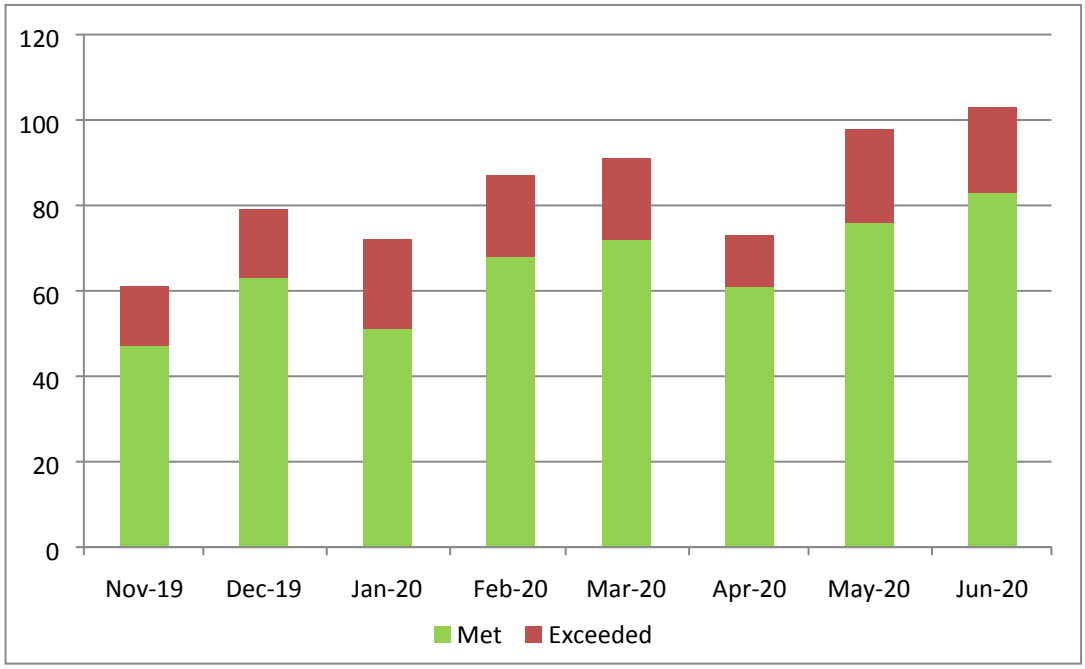
4.4.3 Given COVID19, additional national planning guidance is expected towards the end of July, and this will lead to a review of the ICS Long Term Plan submission and plans for 2020/21.

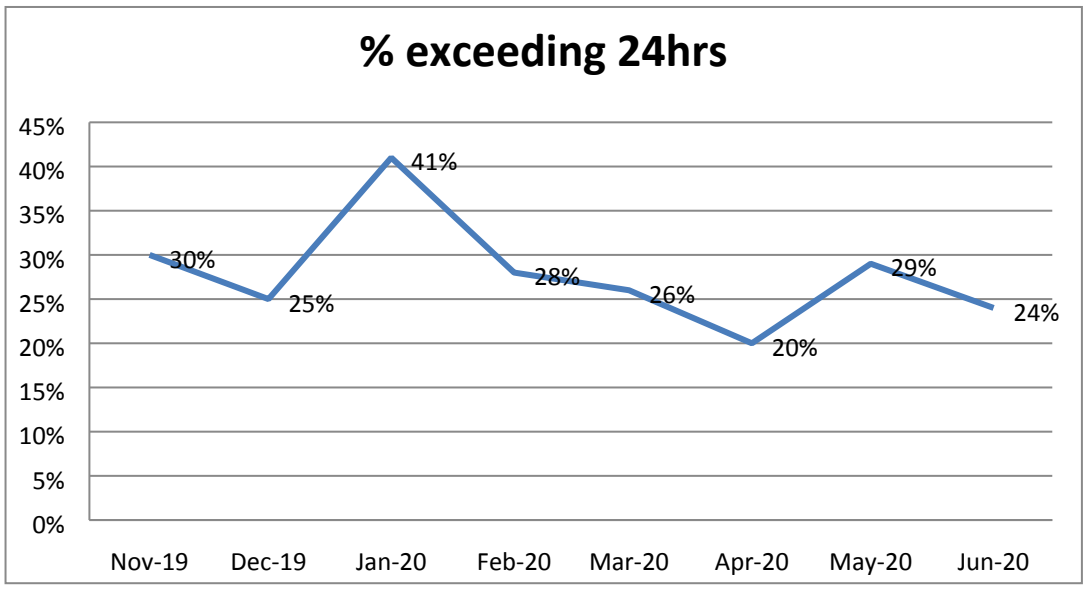
4.4.4 Herts & West Essex STP has now been designated an ICS; whilst ICS activities have been 'suspended' during the COVID19 outbreak, activities are now beginning to recommence and design of the ICS being driven through CEO and Chairs group.

4.4.5 E&N ICP and West Herts ICP activities were reduced March – July with majority meetings and activities suspended. Both ICP Boards have recently met, with recovery the key focus at this time. HPFT involved in ongoing ICP discussions and activities.

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

4.5.1 This risk remains, since November 2019 there has been a gradual increase in S136 admissions, some of this could be attributed to a return to full capacity when Oak S136 re opened in April. The number of service being detained beyond 24hrs since Nov 2019 averages at 27% per month with monthly fluctuations.





4.5.2 Recent mitigation includes:

- Improving bed flow to reduce breaches owing to bed capacity.

- The re-opening of the Oak S136 in April, which was closed for refurbishment in Q4, the increase in this capacity reduces the amount of time a service user might spend detained under S136 at an acute hospital or police station enabling access to a mental health assessment and a decision to admit or discharge in a more timely way.
- Drug and alcohol intoxication still results in breaches and the Trust continues to liaise with Change Grow Live (CGL) at locality level meetings and governance groups which includes commissioners to identify improvements that can be made in the process.
- The AMHP rota has improved so assessments are taking place in a more timely way – to enable a decision on either discharges or admissions. If an admission is required the Trust has longer to facilitate an inpatient bed within the timeframes.
- Exploration of the adoption of the Serenity Integrated Mentoring (SIM) which is an innovative mental health workforce model that brings together the police and community mental health services in order to better support people with complex mental health needs. This has started but has not been as successful as hoped; the innovation is currently paused awaiting police recruitment of a coordinator.
- S136 deep dive ongoing including looking at frequent attenders.

4.6 <u>Cyber Security: Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability (Risk 747)</u>

4.6.1 The Trust has not pursued the NHS Secure Boundaries initiative which was established about a year ago to provide an extra layer of physical firewall security to protect Trusts, especially were there has been limited investment within their infrastructure. Due to the investments that we have made in our two Data Centre's in the past two years, and in which the firewalls have been upgrade further in the last 6 months, therefore this additional layer of security would duplicate our investment. Indeed the firewalls that we have in our Data Centre's are of a higher specification to those used in the NHS Secure Boundaries solution. HBL ICT are working with NHS Digital to look at complementary services including NHS Secure Boundary.

4.6.2 Unsupported devices and software remain a cyber risk including windows 8 laptops and phones. Windows 8 laptops / windows being replaced as they reach end of life. Windows 10 upgrades and Windows Phone replacements have continued to progress. COVID 19 has paused activity to migrate SharePoint, risks remains unchanged though

4.6.3 HPFT secured 420k support from NHS Digital for further cyber security, work to be done with HBL ICT on how this is utilised, for example purchasing new network routers and network switches to upgrade any of the existing kit which are end of life or potentially vulnerable to minimise chance of cyber issues. The appropriate kit has been purchased but has yet to be installed as resources have been diverted to COVID19 IT relates activities. This will be installed as part of the site by site improvement in WIFI coverage project.

4.6.4 There were no cyber security incidents during May. Despite the pressures on the HBL ICT Service, maintaining security is of vital importance, and to this end, security patching was maintained throughout the service, including applying a number of legacy patches which were identified via a recent penetration test undertaken in February.

4.6.5 Cyber security vulnerability due to Zoom not being updated to latest version, Zoom is not centrally updated by HBL ICT but relies on the user to keep it up to date with the latest security updates. In April All 180 staff have been emailed directly requesting they update to latest version. Zoom updates have now been added to the automatic

updates sent out by HBL ICT. A request has been completed to pave the way for the paid version of Zoom to be procured which will allow greater control of updates.

4.6.6 Although Cyber security remains in a good place and the risk rating low, this continues to be monitored due to the potential likelihood.

4.7 <u>Quality and Safety: The Trust may not be able to sustain service user safety during a flu outbreak (Risk 1147)</u>

4.7.1 The CQUIN target regarding staff flu vaccinations for 2019-20 was 80% of frontline staff. The trust achieved 64% an increase from 53% from the year before. This meant that we received 20% of the potential funding. The CQUIN target for 2010-21 has increased to 90% of frontline staff. We have indications that this may change to 90% of all staff.

4.7.2 The Head of Allied Health Professions, operational lead for the flu vaccination programme, used the comments and feedback collated during the 2019-20 campaign to inform the plan for 2020-2021. Based on this learning the migration is to:

- Enable staff to book their own vaccination slot
- Send automated emails to confirm and remind them of their appointment
- Send automated email if for any reason the clinic is cancelled
- Link this system to the flu register and SPIKE so there is a regular update

4.7.3 The challenges to this year's flu campaign to protect our staff and service users are:

- Encourage more BAME staff to have the vaccination to protect them against other viral infections
- Environmental challenges in relation to space and where the vaccination could be administered
- Availability of the dedicated peer vaccinators with protected time
- Additional infection control measures which will limit the number of vaccination slots available per session
- A required shorter period of campaign with the majority of vaccinations to have been done by November 2020

4.7.4 In the 2019-2020 campaign the occupational Health service did not deliver the service agreed or expected. Clinics were frequently cancelled and there were no consistent staff provided. We have a new Occupational Health Provider, Vita Health, for this year's campaign. The performance of the new provider is untested and the contract only includes 3 days a week in October for vaccinations. We will therefore require significant input from peer vaccinators.

4.7.5 The Trust will be applying a behavioural model to bring about a change at scale using the following four principles to encourage a behaviour, make it Easy, Attractive, Social and Timely (EAST).

4.7.6 Resources for this new and improved approach are being agreed.

4.7.7 There remains an underlying risk that a low update in front line staff flu vaccinations with the potential continued COVID risk could mean an increased number of front line staff off work impacting the Trusts ability to sustain service user safety.

5 <u>For deep dive in the next period</u>

5.1 The next reporting period will see a deep dive into the two workforce risks, those of recruitment and retention. Below is an overview of the current situation. Although significant work has been undertaken, improvements have been made and mitigation put in place, over

time, the risk score has not changed as the improvements have not been sustained for a significant period.

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

5.2.1 The retention initiatives have had an impact on the numbers of people leaving the Trust and we have ended Q4 just above our target of 13.8% at 14.04%.

5.2.2 The turnover rate has decreased slightly in Q4 and it is anticipated that the retention initiatives will continue to have an impact during 2020/21 and the turnover rate will remain at target.

5.2.3 During Q4 the National NHS staff survey results were published. These results were the best we have seen as a Trust in 5 years. We had a 57.4% response rate, which is 16% higher than in 2018. The Trust has improved in 73 questions and significantly improved in 38 questions compared to 2018. All questions in 'Your Organisation' category scored significantly above average compared to similar Trusts.

5.2.4 The appraisal rate across the Trust continues to sit below target, and this will be an area of focus in Q1 and Q2 of 2020/21 at the Trust recovers from the impact of Covid-19.

5.2.5 There was a continued focus at the start of Q4 on enhancing our people's experience across the Trust; however the last month of the quarter was devoted entirely to supporting the workforce in response to the Covid-19 pandemic, this has continued into Q1.

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

5.2.7 A proposal was developed to support and develop all staff with the ability to hold confident and facilitated conversations. This is an important part of the development of the just and learning culture and will provide managers with the tools to address issues at a local level, an area of concern that was identified during the review of the disciplinary process, this will now be reviewed against the requirements of the organisation's recovery progresses.

5.2.8 Early in Q4 there was significant activity with the Great Teams programme, with 32 teams identified and many of them engaging with the programme. The work stopped in March in response to the Covid-19 pandemic.

5.2.9 A Health and Well Being strategy was drafted for ratification in Q4, however this was paused and the work of the well-being team was focused exclusively on supporting teams through the Covid-19 pandemic.

5.2.10 This risk has changed over time and rather than the simplistic recruitment to vacancies to ensure safety this risk will in the future be refocused on the Trusts ability to establish and deliver a workforce culture fit to deliver staff expectations

6 Conclusion

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

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

	Opened	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead
1	16.10.18	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability	12	16 (4x4)	8	We will make effective use of people's time and the money we have to deliver on the outcomes that matter to those we serve	Paul Ronald
2	17.02.20	1253	**Quality and Safety:** The Trust may not be able to sustain core operational services and maintain service user and staff safety during the COVID19 outbreak	25	15 (3x5)	5	Staff will report that they are able to deliver safe and effective services	Jane Padmore
3	16.10.14	215	**Workforce:** The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	15	15 (5x3)	6	We will be seen as an employer of choice where people grow, thrive and succeed	Ann Corbyn
4	30.06.16	657	**Workforce:** The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	15	15 (5x3)	6	Our staff will report feeling engaged and motivated, and recommend the Trust as a place to work	Ann Corbyn
5	02.02.19	749	**External landscape:** The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and learning disability services provided by HPFT	20	12 (3x4)	10	Mental health and learning disability will be given the same emphasis as physical health in local care planning and delivery	Karen Taylor
6	27.12.17	882	**Quality and safety:** Unlawful detention of service users under S136 breaches beyond 24hrs	12	10 (5x2)	6	Staff will report that they are able to deliver safe and effective services	Sandra Brookes
7	10.07.20	1301	**Finance:** The Trust is unable to ensure short term financial performance in current financial year	9	9 (3x3)	3	We will make effective use of people's time and the money we have to deliver on the outcomes that matter to those we serve	Paul Ronald
8	30.01.17	747	**Information Management and Technology** : Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	12	8 (2x4)	6	We will constantly learn, innovate and improve for the benefit of those we serve, including making the very best use of technology and information	Keith Loveman
9	09.08.19	1147	**Quality and safety:** The Trust may not be able to sustain service user safety during a flu outbreak	12	6 (2x3)	3	Staff will report that they are able to deliver safe and effective services	Asif Zia

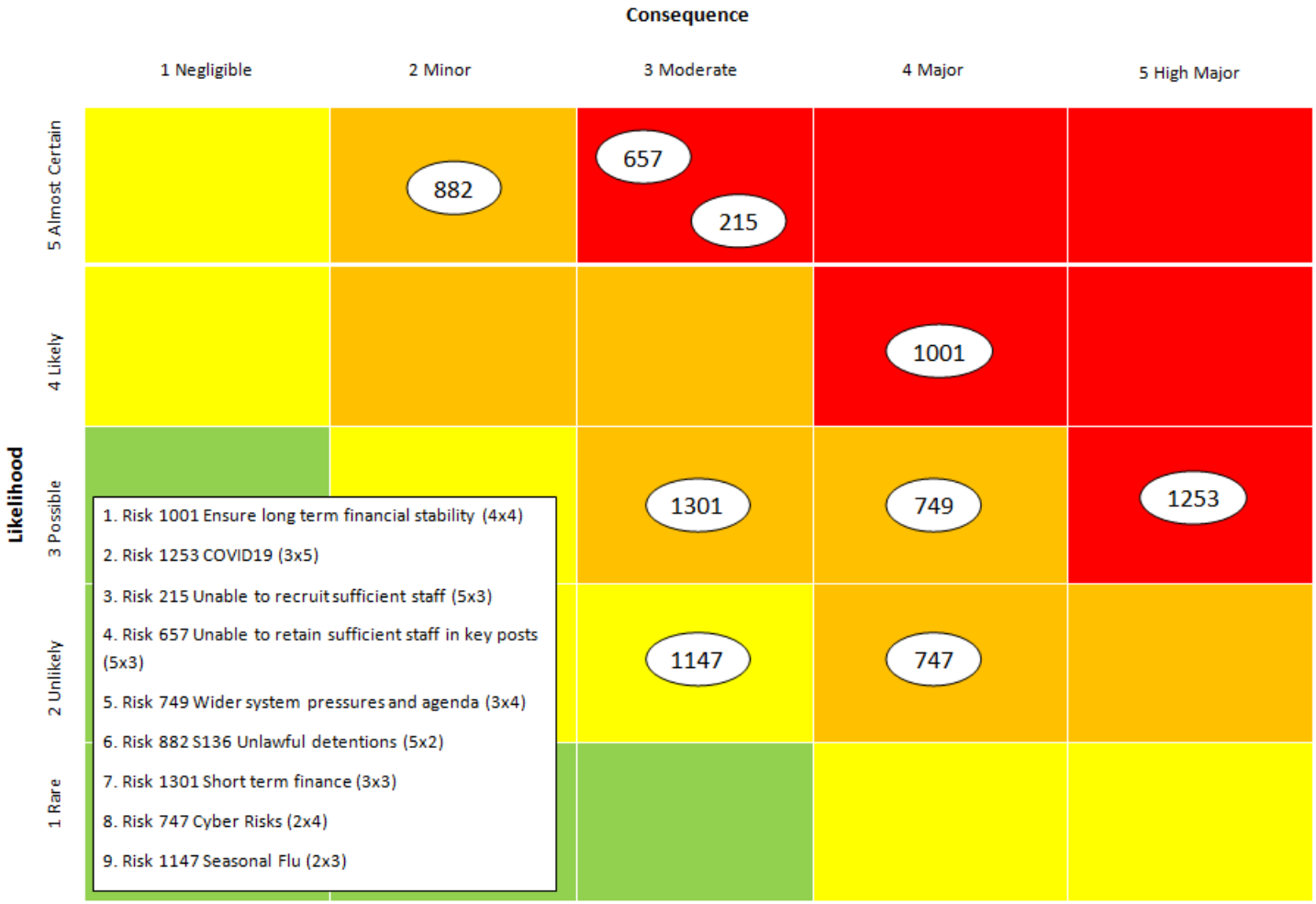
Risks requested for downgrading from the Trust Risk Register

	Opened	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead
1	01.03.18	920	**Information Management and Technology:** Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident	9	8 (2x4)	6	We will constantly learn, innovate and improve for the benefit of those we serve, including making the very best use of technology and information	Keith Loveman
2	16.10.18	1000	**EU Exit:** Implications for the Trust of different scenarios arising from Brexit	12	8 (2x4)	4	Staff will report that they are able to deliver safe and effective services	Keith Loveman
3	15.08.19	1150	**Quality and safety:** Unable to provide consistent timely access to CAMHS Community Services	15	6 (2x3)	5	People will able to access the right service in a timely way	Sandra Brookes

Risks requested for closing

	Opened	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead
1	29.03.17	773	**Quality and safety:** Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness	12	6 (2x3)	6	Staff will report that they are able to deliver safe and effective services	Sandra Brookes

Trust Risk Register Matrix



NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Risk Register
July 2020

To be reviewed by:

Integrated Governance Committee: N/A
(approved by Exec 15.07.2020)

Audit Committee: TBC

Trust Board: 30th July 2020

Risk Scoring Matrix (Risk = Likelihood x Consequence)

Step 1 Choose the most appropriate row for the risk issue and estimate the potential consequence

Consequence score (severity levels) and examples of descriptors					
	1	***2***	***3***	***4***	***5***
Domains	***Negligible***	***Minor***	***Moderate***	***Major***	***Catastrophic***
Impact on the safety of patients, staff or public (physical/psychological harm)	*Minimal injury requiring no/minimal intervention or treatment.* *No time off work*	*Minor injury or illness, requiring minor intervention* *Requiring time off work for >3 days* *Increase in length of hospital stay by 1-3 days*	*Moderate injury requiring professional intervention* *Requiring time off work for 4-14 days* *Increase in length of hospital stay by 4-15 days* *RIDDOR/agency reportable incident* *An event which impacts on a small number of patients*	*Major injury leading to long-term incapacity/disability* *Requiring time off work for >14 days* *Increase in length of hospital stay by >15 days* *Mismanagement of patient care with long-term effects*	*Incident leading to death* *Multiple permanent injuries or irreversible health effects* *An event which impacts on a large number of patients*
Quality/complaints/audit	*Peripheral element of treatment or service suboptimal* *Informal complaint/inquiry*	*Overall treatment or service suboptimal* *Formal complaint (stage 1)* *Local resolution* *Single failure to meet internal standards* *Minor implications for patient safety if unresolved* *Reduced performance rating if unresolved*	*Treatment or service has significantly reduced effectiveness* *Formal complaint (stage 2) complaint* *Local resolution (with potential to go to independent review)* *Repeated failure to meet internal standards* *Major patient safety implications if findings are not acted on*	*Non-compliance with national standards with significant risk to patients if unresolved* *Multiple complaints/ independent review* *Low performance rating* *Critical report*	*Totally unacceptable level or quality of treatment/service* *Gross failure of patient safety if findings not acted on* *Inquest/ombudsman inquiry* *Gross failure to meet national standards*

Human resources/ organisational development/staffing/ competence	*Short-term low staffing level that temporarily reduces service quality (< 1 day)*	*Low staffing level that reduces the service quality*	*Late delivery of key objective/ service due to lack of staff* *Unsafe staffing level or competence (>1 day)* *Low staff morale* *Poor staff attendance for mandatory/key training*	*Uncertain delivery of key objective/service due to lack of staff* *Unsafe staffing level or competence (>5 days)* *Loss of key staff* *Very low staff morale* *No staff attending mandatory/ key training*	*Non-delivery of key objective/service due to lack of staff* *Ongoing unsafe staffing levels or competence* *Loss of several key staff* *No staff attending mandatory training /key training on an ongoing basis*
Statutory duty/ inspections	*No or minimal impact or breech of guidance/ statutory duty*	*Breech of statutory legislation* *Reduced performance rating if unresolved*	*Single breech in statutory duty* *Challenging external recommendations/ improvement notice*	*Enforcement action* *Multiple breeches in statutory duty* *Improvement notices* *Low performance rating* *Critical report*	*Multiple breeches in statutory duty* *Prosecution* *Complete systems change required* *Zero performance rating* *Severely critical report*
Adverse publicity/ reputation	*Rumors* *Potential for public concern*	*Local media coverage – short-term reduction in public confidence* *Elements of public expectation not being met*	*Local media coverage – long-term reduction in public confidence*	*National media coverage with <3 days service well below reasonable public expectation*	*National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)* *Total loss of public confidence*
Business objectives/ projects	*Insignificant cost increase/ schedule slippage*	*<5 per cent over project budget* *Schedule slippage*	*5–10 per cent over project budget* *Schedule slippage*	*Non-compliance with national 10–25 per cent over project budget* *Schedule slippage* *Key objectives not met*	*Incident leading >25 per cent over project budget* *Schedule slippage* *Key objectives not met*
Finance including claims	*Small loss Risk of claim remote*	*Loss of 0.1–0.25 per cent of budget* *Claim less than £10,000*	*Loss of 0.25–0.5 per cent of budget* *Claim(s) between £10,000 and £100,000*	*Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget* *Claim(s) between £100,000 and £1 million* *Purchasers failing to pay on time*	*Non-delivery of key objective/ Loss of >1 per cent of budget* *Failure to meet specification/ slippage* *Loss of contract / payment by results* *Claim(s) >£1 million*
Service/business interruption Environmental impact	*Loss/interruption of >1 hour* *Minimal or no impact on the environment*	*Loss/interruption of >8 hours* *Minor impact on environment*	*Loss/interruption of >1 day* *Moderate impact on environment*	*Loss/interruption of >1 week* *Major impact on environment*	*Permanent loss of service or facility* *Catastrophic impact on environment*

Step 2 Estimate the likelihood

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency *Time framed descriptors*	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probably *Will it happened or not?*	<0.1 %	0.1 – 1%	1 – 10 %	10- 50%	>50%

Step 3 Complete the Risk Grading Matrix

	Consequence				
Likelihood	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Step 4 Escalation Process

Very Low Risks	**Low Risks**	**Moderate Risks**	**High Risks**
1-3	4-6	8-12	15 - 25
Local Risk Register	Service Line Risk Register	SBU Risk Register	Trust Risk Register

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	Current Position	Executive Lead
1001	The Trust may not have sufficient resources to ensure long term financial sustainability	Failure to maintain long term financial sustainability specifically: 1) Potential risk of future loss of income as a result of changes to commissioning. The Hertfordshire and West Essex Integrated Care System (ICS) will be responsible for effective health and care services being designed and delivered in local communities in line with three geographically-based Integrated Care Partnerships (ICPs) – East and North Hertfordshire, West Hertfordshire and West Essex. 2) Failure to secure sufficient funding from commissioners to meet service quality and/or activity requirements 3)Failure to address	12	Regular Placement Panel with cross-SBU coordination of placements pathway Provision for older peoples transformation programme in place Regular Reports are made to the Trust Board, Finance & Investment Committee, Executive Team and Trust Management Group 2020/21 Contract negotiations were underway but on hold. For the time being temporary national rules in place for health and social care contracts. Relationship management with commissioners and partners to support fair resource allocation Primary Care Mental Health pilots around demand management to	16	8	Agreed income tariff uplifts Negotiations with commissioners 3 year CRES proposals	Hertfordshire - A five year contract with an option to extend for a further two years is in place. Included in the contract are agreements in relation to access target thresholds for CAMHS and Adult services. Additionally, funding meets the Mental Health Investment Standard and allows us to meet the commitments made within the Five Year Forward View for Mental Health. Uncertainty is whether as a result of current response to pandemic there will be changes to existing commitments Second year of 5 year Department of Health funding agreement. At moment this has been substituted with temporary arrangements which see a payment based upon 19/20 contract values which is then topped up based upon current spend to cover existing costs Developed OBC for investment in new inpatient unit The Trust has been given its control totals up to 2024, this will enable longer term financial planning, however these control totals are higher than anticipated requiring a surplus of £1.5m each year rather than break even reflecting the East of England 0.5% contingency requirement. The Trust will not be signing up to this additional control total as it is not in keeping with the investment standard for MH and would impact the quality of service. The control of the Finance and Investment committee is currently not in place as it is not meeting.	Paul Ronald (Director of Finance)

		underlying demand and/or cost pressures and/or to deliver required efficiency savings such that the underlying long term financial performance is not sustainable 4) Significant unidentified QIPP requirements across the STP, this could lead to an increase in the risk score if these QIPP requirements materialise in the future 5) availability of capital funding to provide fit for purpose infrastructure to support services and staff		mitigate risk, better signposting will hopefully reduce Initial Assessment demand. Range of actions to support effective resource use; Model hospital champions promoting the use of benchmarking. Use of CQI to support process review Corporate service redesign. Five year rolling capital program developed with partners					

1253	The Trust may not be able to sustain core operational services and maintain service user and staff safety during the COVID19 outbreak	There is a significant risk that the Trust is unable to sustain operational services and maintain service user and staff safety during the COVID19 outbreak following the outbreak being declared a Public Health Emergency of International Concern on the 30th January 2020 by the World Health Organisation (WHO).	25	Staff have been advised to follow the Public Health England guidance regarding the risks associated with the virus. Public Health England posters have been sent out to display in the entrance to HPFT locations. PPE has been ordered and kits will be made up and stored in units across the organisation. Key senior staff will attend Fit Test Training. Daily COVID19 conference calls implemented to manage and oversee the Trusts preparedness. Isolation rooms will be implemented within the non-inpatient areas for self-referrals.	15	5	Increase in UK confirmed cases of COVID19 and deaths attributed to COVID19 Increase in confirmed cases of COVID19 within Hertfordshire, Buckinghamshire, Essex and Norfolk. Increase in staff self isolating at home if they have a high temperature or a new continuous cough. Changes to the situation reports (Sitreps) presented at Tactical Command.	<u>Service user and staff COVID-19 related deaths</u> • Advanced Care Plans are in place for inpatient service users so that their wishes, including do not attempt Cardiopulmonary resuscitation (DNACPR), are known should they contract and become unwell with COVID-19. • A Clinical Professional Advisory Committee (CPAC) has been established to review, advise and update clinical guidelines during the pandemic to ensure service user safety. • Evidence is emerging that the spread of infection is being significantly impacted by nosocomial transition (i.e. within hospital and care settings). This indicates the need for an increased focus on infection prevention and control practice, including universal precautions and the correct use of PPE. Work is ongoing raising awareness of this, training, and assurance. • Full guidance on staying at home and social distancing has been provided by the Trust following national guidance. Including those staff with high risk underlying health conditions. • Following updated government guidance, which restricts people's movement to reduce the risk of further transmission of COVID-19 all visiting to inpatient service areas has been stopped. Only allowing visitors by exception. • The Trust has now implemented testing of all service users on admission to inpatient services and 72 hours prior to discharge. On admission servicers are asked to self-isolate in en-suite bedrooms prior to knowing the test results. Most service users adhere to this request with a small minority refusing and presenting with behaviours that challenge. • The number of service users being swabbed is being monitored by the SBUs. • Each SBU has developed cohorting and isolation plans around what to do when they	Jane Padmore (Director Quality & Safety)

								admit patients with known or unknown COVID status taking into account capacity and compliance to adhere to self-isolation. • The Trust has reported 85 Service user deaths that are either confirmed or suspected COVID-19 related. Of these 26 deaths are from inpatient services. • Lambourn Grove (11) has had the highest number of deaths with Victoria Court (8) and Seward Lodge (5). • No new inpatient deaths reported since the 4th June 2020. • No staff related COVID19 deaths have been reported. • Antibody testing within the Trust ceased Friday 10 July 2020. As of 20th July we have received 2328 result back, 18% positive (417). • At the beginning of the COVID-19 Pandemic all the teams were asked to RAG rate their service users to enable the allocation of care and treatment based on vulnerabilities, risk and need. This was recorded in the service user risk assessments and individual teams spreadsheets. The Trust has now created a COVID Rag Rating Case Note on PARIS which enables staff to record the RAG Rating in a specific case note. The service users RAG rating will then show on their front page on PARIS. This will also enable the RAG rating for teams to be viewed on SPIKE2 to enable monitoring and to prioritise resources. It is expected that all service users will have a COVID RAG rating case note entry by the 31 July. • Review of the IPC BAF and supporting evidence took place with the CQC on 7th July 2020. Following this review the CQC have reported that the board is assured that the trust has effective infection prevention and control measures in place. <u>Increase in harm or death of service users due to mental health related illness</u>	

								• Based on the data seen, there is nothing about Q4, 2020, which strongly separates it from previous quarters. At this time the numbers do not allow any strong conclusions to be drawn but it is important to ensure additional scrutiny and the data should be reviewed more frequently. • A review of the Q1 SI data will need to take place. <u>Deterioration in core performance</u> • Overall there are lower levels of activity/demand and performance is being maintained in the majority of areas. • Weekly performance is showing considerable improvement across the majority of indicators with the exception of SPA 5 Days Waited at 77% and the number of people entering IAPT services and completing treatment (Trust wide). • Modelling has commenced on future demand for services influenced by the mental health impact of COVID19 and the economic decline, specific modelling is taking place in CAMHS. • However there remains a risk that the Trust will not be able to flex is resources to meet demand in future, this is not being felt immediately and is likely to come in waves, the key is being able to model and make sure our services reflect this demand. <u>Reduced provision of face to face mandatory training and the impact on staff compliance and consequently staff and service user safety</u> Training Trajectories up to the 31st Dec have been developed and presented at Delivery Consultant Oversight Group (DCOG) for the following courses: • Basic Life Support • Intermediate Life Support • Moving and Handling Hoist / Non Hoist • Respect Level 3 / 4 refresher • Respect Level 3b full, 4 and 5 The trajectories provide that the Trust's compliance	

								targets will be achieved by the end of Q3. <u>Unable to maintain core services</u> • Specifically for EMDASS, following the closure of the EMDASS service at the end of March 2020 to new cases created a significant backlog of those service users waiting for assessment who have not been seen. Ability to recover the service has been challenging, with multi-facetted challenges resolved throughout the restoration programme. Evidence of increase in capacity as the service restarted is apparent as facilities allowed more estates to reopen; the service was able to restart all 4 quadrants. It is recognised that working through the backlog is imperative, not only to provide a diagnosis service for our service users but also ensure contractual compliance and performance. Referrals continue to steadily be received across all quadrants with the current demand easily outstripping the capacity of the team to meet this through the current methods of operations. Therefore new ways of working have been developed to maximise service capacity. <u>Workforce - Unable to sustain safe staffing and the wellbeing of staff</u> • COVID-19 NHS England Regional Testing has become available for HPFT employees as NHS Keyworkers. This process is supported by an internal referral and support process. NHS swabbing centres in Stansted, Harpenden and Welwyn Garden City. As of 20.07.2020 584 swabbed, 81 positive. There has been a slowdown in staff being swabbed (in line with the national decline in COVID infections). • Safer Care Hotspots are monitored on a daily basis via the COVID19 situation report with immediate action taken to address any shortages. • COVID related absences either through	

								sickness or self-isolation as at 20.07.2020: - Inpatient staff: 32 (Working 16, 50%) - Community staff: 96 (Working 86, 89%) - Corporate staff: 10 (Working 9, 90%) • The peak in COVID related absences (staff in self isolation) was at the end of March and early April at 559, which has decreased to 138 on 20.07.2020 (based on the total absences including annual leave, non-COVID sickness and self-isolating). Of those self-isolating 80% are working and 20% are not working. • New Risk Assessment Tool published for staff completion. The Trust have developed an individual risk assessment form to help the Trust understand staffs individual needs so that the Trust can support staff and keep staff safe at work. Prioritising those with risk factors (including BAME staff) for completion. 100% completion: Essex & IAPT, LD&F, E&N. Outstanding: West and Corporate (small number outstanding). It is planned that managers and staff review/complete and approve the risk assessments directly on SPIKE2 therefore removing the reliance on paper processes and creating a shortened process with less steps. Any risk assessments which have resulted in an outcome of purple, amber and red need to be reviewed on a monthly basis and any risk assessments in blue and green need to be reviewed every 3 months. Staff whose shielding will be drawing to an end will need to complete their risk assessments and to meet with their managers in line with the Trust's guidance on Staff Returning from Shielding • 114 staff have shielding letters. Guidance on staff ceasing shielding has been produced and coffee morning with shielded staff in each SBU are taking place to ensure staff are	

								supported, concerns addressed and anxiety levels are reduced. A video to support shielded staff has also been shared. • Annual leave for up to 2 weeks can now be requested. The Quarantine and Annual Leave guidance was approved by Tactical and Strategic Command on 10.07.2020 and has been circulated to all staff on 13.07.2020 through the Comms Bulletin and Hive. • DSE Assessments continue to be completed. 1024 users have completed DSE training and Desk Risk Assessments, this information is being collected centrally by the Health and Safety Team. The implications and actions derived from these completed risk assessments need to be considered as the Trust continues to reinforce the message for staff to continue to work from home and only essential staff to attend work. Further communication to encourage completion to be communicated. An approach is being considered to manage demand for equipment at home for high priority groups; process is being created to manage this. • SBU and Corporate commanders have commenced plans for the completion of risk assessments for buildings around the restoration of services, to ensure the safety of staff within the context of COVID when they return. There is a building risk assessment schedule and tracking spreadsheet in place. All Priority 1 buildings have been completed and these are available on the HIVE, plan being developed for assurance. Environmental Risk Assessments Assurance – all SBU's to fill out a live spreadsheet. Each SBU to fill in the circulated spreadsheet with the following fields; date completed, risks, actions to mitigate. <u>Inability to provide essential clinical equipment</u> • The formal external FFP3 fit testing programme is now complete. 1810 people	

								tested, 88% pass rate on one of the three 3M masks used. Across both inpatient and community teams. Any remaining testing will then be via our internal trained persons, where we have 48 testers. 10 more test kits purchased to allow for easier local internal testing. • Activity to reinforce the sites to correctly use surgical masks rather than M3 masks is ongoing. • A runout model has been developed that estimates that our most under pressure mask (3M8833) will still last until Dec 2020. Note this is predicated on the sites using the masks how they have indicated. • Control of what type and when is not under our control, making strategic planning difficult. The current strategy is more around reducing usage of the current stocks. • There are twice weekly stock checks in all teams. Same for central stores. • For FFP3, any usage over 20 in a set period is escalated and challenged. • Changes to requirements to wear surgical masks in non-clinical areas has placed additional pressure on stocks but supply appears to have increased too. Stocks are therefore in a healthy position. • Beginning of July 2020, minimum stock levels will be reviewed again and we would be looking to reduce stock checks and delivery days to 1 day per week for community. Will remain at 2 days per week for inpatient for time being. • We still need to establish a longer term plan for resourcing the PPE supply chain and stock checking processes. • The impact of using masks in non-clinical areas has meant supply has increased, however not using as many as initially anticipated so stock has gone up over last week or so. <u>Unable to maintain and work within the financial</u>	

								envelope • Contingency of £700k within provisions. • Full engagement in advisory and support forums to ensure that all steps available taken to minimise risks of excessive cost impact. • SFIs and procedures are being regularly reviewed to ensure that financial control is maintained during this difficult period. All changes will be documented making clear which need to revert to normal processes once this period has passed, to ensure controls return to normal. • Focus on ensuring that purchase to pay system is kept working effectively to ensure suppliers are paid promptly. • Cash is being paid regularly for block contracts (90% plus of Trust income) based on Month 9 19/20 Agreement of Balances exercise. This should ensure the Trust has most of its expected income. • Although c. 90% of expected income will be received, this does represent a shortfall, and where new or expanded services were expecting funding from April, this has not all been forthcoming. Focus is needed to maintain financial control, particularly around recruitment, to ensure only funded posts are recruited to and any issues are flagged promptly. • All costs for COVID19 are being collected, with a dedicated senior person responsible for this, guidance to be issued to budget holders, and dedicated cost centre and account code to make tracking easier. Assurance has been given that all costs will be reimbursed. Submitted first claim for COVID19 costs on time for just under £1m, this was accepted and paid promptly, awaiting confirmation of process for second claim reported of just over £1m. • There is a twice weekly KPI report on various finance indicators including COVID spend. • The cost of extra hours worked linked to	

								COVID19 will be included as part of the COVID19 costs. • COVID spend to date is likely to be fully refunded by NHSE/I. However going forward the Trust needs to be aware of the changes in priority around COVID spend, to reduce some areas of spend whilst considering if there other areas, as indicated by NHSE/I where COVID spend might need to increase. <u>Unable to sustain the necessary support across the range of Trust infrastructure</u> • Adding a 3rd VPN line (increasing from the two VPN lines we currently have), this was completed 1st May 2020. • 1st of the 3 VPN lines bandwidth upgraded to 5GB. Second VPN upgrade now provisionally booked for 30 July; additionally network routing improvements have been completed on 13 July to improve performance. • Zoom use now being 'officially' discouraged, paid for Zoom professional license is being procured for group therapy work not supported by the other approved systems as listed in the guidance. • Attend Anywhere roll out continues. • Additional IT equipment needs fully satisfied, demand level returning to BAU levels. • Estates are visiting positive pressure rooms and are producing a longer term plan for the use of positive pressure rooms in Beech / Oak and Forest House. Estates are visiting positive pressure rooms and are producing a longer term plan for the use of positive pressure rooms in Beech / Oak and Forest House. Long term plan for replacing windows has been presented to both tactical and strategic command. Estates awaiting funding approval and instruction. Funding approved to replace 5 windows Oak, 5 windows Beech, 16 windows Forest House. Capital projects team are now working on final measure before manufacture begins. Purchase Order	

								for the Positive Pressure Rooms Windows approved 14.07.2020. <u>Unable to meet the legal and regulatory requirements</u> • Letter before action has been received from solicitors acting on behalf of the family of a service user. This is to challenge the decision of the Trust to refuse a detained patient from having contact with his parents except by telephone. Trust visitor guidance being strengthened in a formal document. • All Operational commands were asked to review their Tribunals process, ensuring sufficient support and equipment for video conferencing is in place. All SBU's were asked to provide details and assurance by Monday 22nd June 2020 to Tactical. 24th June 2020 - E&N and LD&F, Essex and IAPT have sent assurance they are compliant, West have started collecting information and will be sent through by COP today. West confirmed process for tribunals proposed closure 25th June 2020. • Guidance Document for First Tier Tribunal Hearings (Mental Health) – COVID-19 – updated 2nd July 2020 • New Laptops ordered for Oak Ward and a test call on the 2nd July for Oak Ward worked fine • The second planned inspection was of 1 and 3 Forest Lane (SRS) on the 17th June 2020. No immediate concerns raised.	

215	The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	Risk to Staff Morale and Financial Risk. Recruitment There is a risk that the organisation is not able to recruit and select the best staff and that timely recruitment to vacancies does not occur leading to increased operational pressures and a reduction in quality of care	15	SBU review regular data – HR Performance Dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate establishment and vacancy information to be accessed at all times Recruitment and Retention Group monitors recruitment and retention activities and KPI's.	15	6	Long standing number of vacancies and hotspots Increased bank /agency costs Lack of clarity to plan recruitment campaigns Increasing turnover and a falling stability index Increasing Short Term sickness absence	A Recruitment, Retention and Reward plan has been developed which addresses the on-going challenges around recruitment and retention and lays out the commitment to our staff, their development and their working lives in HPFT. Whilst the strategy did not get launched in Q4, we have continued recruitment activity to reduce the vacancy rate down to below the target despite a further increase in our funded establishment. The recruitment process has continued throughout the pandemic with the impact that the Trust vacancy rate ended Q4 below its target of 12.8%. Since Q1, there has been an increase in establishment of over 100 wte, which has been matched by a corresponding increase in staff in post. We have also almost doubled the number of active recruitment episodes to ensure the pipeline continues to bring in the level of starters we need, with over 250 candidates at the post offer stage. This model of utilising social media for a focused locality and/or staff group continued to be successful in recruiting to a number of hard to fill posts in Q4 against a back drop of no face to face interviews and increased use of video link interviews. The time to hire during Q4 has decreased significantly to 47 days and during Q4 we had 192 new starters (compared to 156 in Q3) and only 120 leavers. This is a net gain of 72 staff.	Ann Corbyn (Director of Workforce and OD)

657	The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	Risk to Staff Morale and Financial Risk Retention There is a risk that a higher number of existing staff choose to exit the organisation due to high workloads and a perceived lack of career pathways leading to increased and unplanned vacancies and a drain of knowledge and experience from the organisation.	15	SBU review data - HR performance dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate turnover vacancy information to be accessed at all times OD plan for Talent and succession planning Recruitment and Retention Group	15	6	Increased banks / agency costs High turnover / Reduced Stability Index Exit interview feedback Lack of quality PDPs, inconsistent and ad hoc supervision	The retention initiatives have had an impact on the numbers of people leaving the Trust and we have ended Q4 just above our target of 13.8% at 14.04%. The turnover rate has decreased slightly in Q4 and it is anticipated that the retention initiatives will continue to have an impact during 2020/21 and the turnover rate will remain at target. During Q4 the National NHS staff survey results were published. These results were the best we have seen as a Trust in 5 years. We had a 57.4% response rate, which is 16% higher than in 2018. The Trust has improved in 73 questions and significantly improved in 38 questions compared to 2018. All questions in 'Your Organisation' category scored significantly above average compared to similar Trusts. The appraisal rate across the Trust continues to sit below target, and this will be an area of focus in Q1 and Q2 of 2020/21 at the Trust recovers from the impact of Covid-19. There was a continued focus at the start of Q4 on enhancing our people's experience across the Trust; however the last month of the quarter was devoted entirely to supporting the workforce in response to the Covid-19 pandemic, this has continued into Q1. The approach to enhancing the staff experience is to develop an inclusive Just and Learning Culture, which is informed by the experiences highlighted in the results of the NHS national staff and local Pulse surveys, plus the annual WRES and Gender Pay Gap data. A proposal was developed to support and develop all staff with the ability to hold confident and facilitated conversations. This is an important part of the development of the just and learning culture and will provide managers with the tools to address issues at a local level, an area of concern that was identified during the review of the disciplinary process, this will now be reviewed against the requirements of the organisation's recovery progresses.	Ann Corbyn (Director of Workforce and OD)

								Early in Q4 there was significant activity with the Great Teams programme, with 32 teams identified and many of them engaging with the programme. The work stopped in March in response to the Covid-19 pandemic. A Health and Well Being strategy was drafted for ratification in Q4, however this was paused and the work of the well-being team was focused exclusively on supporting teams through the Covid-19 pandemic.	

749	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health.	The rapidly changing health and social care landscape nationally and locally creates a potential risk to the sustainability of high quality service provision for people with a mental illness or learning disability due to: • Dilution of a strong mental health and learning disability voice and presence within new models of care and systems or structures that are focused on reducing activity within general acute hospital settings • Increased sharing of risks and financial pressures across the system resulting in shifting of resources away from mental health and learning disability services	20	Active engagement with the system about MH & LD by HPFT leaders; together with leading the development of a Herts MH & LD ICP for the future Regular review of position by the Executive, Strategy Committee and Board Active monitoring and intervention by Council of Governors Strong leadership roles for key staff within local STP On-going regular dialogue with commissioners STP Mental Health & LD workstream chaired by HPFT National LTP commitments for MH documented within STP LTP	12	10	Commissioning intentions demonstrate reduced funding/intention Parity of esteem agenda not honoured within contract negotiations or lack of commitment Lack of discussion about Mental Health & LD priorities across STP, within developing geographical ICPs and in Local Delivery Boards No demography increase and / or usual commitments aren't delivered by CCG's. Insufficient attention to the recovery of mental health services from the Covid incident	MH Long Term Plan provides a roadmap for further investment and priorities and is reflected within the ICS LTP submission HPFT CEO/directors involved in key ICS decision making forums and groups. E&N ICP and West Herts ICP developing at pace; with HPFT well represented and supporting/shaping development, including MH & LD priorities within the ICPs. ICS wide MH & LD group in place, overseeing MH investment and developments across the ICS – chaired by Dir. Strategy NHSE transformation funding secured – community (Adult & older people) and crisis and service design commenced; confirmed for 2020/21 Herts MH & LD ICP - Partnership Board established and governance arrangements at early stage of development. Transformation priorities agreed across system partners, programme of activities being developed. Herts MH & LD ICP leading system recovery of mental health and learning disability services from Covid incident. EOE Provider Collaborative successfully moved through the NHSE first gateway; clinical models and business case under development. HPFT a 'founding partner' leading development of the approach with CPFT and EPUT. There remains on-going issue of system use of non-recurrent MH underspend (e.g. transformation funding for 2020/21)	Karen Taylor (Director of Strategy & Integration)

882	Unlawful detention of Service Users under S136 i.e. breaches beyond 24hrs.	From 11th December 2017, changes to Section 136 of the Mental Health Act came into force as a result of the Police and Crime Act. These changes have an impact on the Trust's responsibility to make available a qualified clinician for the Police to consult with prior to using Section 136, and for Section 136 detentions to last no longer than 24 hours (unless there are circumstances that warrant an extension of up to 12 hours). Extensions are not granted for either incomplete assessment due to clinician availability or for lack of bed availability should an inpatient admission be required. The risk, therefore, is in relation to availability of a bed to admit someone into, should this be the outcome of the	12	- Availability of Street Triage 9am - 4am 7 days a week, in order for Police to consult regarding anyone over 16. Crisis Assessment and Treatment Team available 4am - 9am. - Forest House Adolescent Unit to provide a clinician for consultation with Police regarding use of Section 136 at all times for anyone under 16. Section 136 suite dedicated to YP opens October 2019 - Dedicated Section 136 team to monitor progress against 24 hour timeframe and co-ordinate assessing clinicians; Section 136 team to monitor and note where an extension to the detention can be authorised - Between 9 - 5, Monday to Friday, AMHP Service prioritise Section 136 assessments in order to meet timescales - Presence of CATT staff in Kingfisher Court overnight, increasing	10	6	- Lack of Street Triage involvement in Police decision to detain - Use of Section 136 by Police to manage risk as a result of intoxication, rather than use of public order offence or return to home - Lack of availability of AMHP's out of hours to undertake assessment - Lack of availability of S12 approved Dr's to support AMHP if detention necessary - Numbers of people discharged from Section 136 with no evidence of mental disorder or no further action required either continues at current rate or increases - Lack of availability of S136 suites and Police waiting due to inability to move patients through - Lack of bed capacity in HPFT, as identified through OPEL status of 3/4 - Bed closure due to damage or fault, impacting on capacity	Recent mitigation includes: • Improving bed flow to reduce breaches owing to bed capacity. • The re-opening of the Oak S136 in April, which was closed for refurbishment in Q4, the increase in this capacity reduces the amount of time a service user might spend detained under S136 at an acute hospital or police station enabling access to a mental health assessment and a decision to admit or discharge in a more timely way. • Drug and alcohol intoxication still results in breaches and the Trust continues to liaise with Change Grow Live (CGL) at locality level meetings and governance groups which includes commissioners to identify improvements that can be made in the process. • The AMHP rota has improved so assessments are taking place in a more timely way – to enable a decision on either discharges or admissions. If an admission is required the Trust has longer to facilitate an inpatient bed within the timeframes. • Exploration of the adoption of the Serenity Integrated Mentoring (SIM) which is an innovative mental health workforce model that brings together the police and community mental health services in order to better support people with complex mental health needs. This has started but has not been as successful as hoped; the innovation is currently paused awaiting police recruitment of a coordinator. • S136 deep dive ongoing including looking at frequent attenders	Sandra Brookes (Director Of Service Delivery and Service User Experience)

		S136 assessment; or the lack of availability of clinicians to carry out triage and assessment in a timely way i.e. discharge from S136 within 24 hours. In order to meet these timescales and manage the requirements of the changes, the Trust has to provide 24 hour clinical coverage for the Police; to ensure that the demand for Section 136 does not increase dramatically by monitoring inappropriate or unwarranted use of S136 in cases of intoxication only or presence of no mental disorder; to ensure availability of relevant professionals (AMHP, Section 12 approved Doctor and Crisis Assessment and Treatment Team where admission indicated) in order to assess and recommend individuals.		availability for assessment - Interagency meetings and governance arrangements in place to monitor implementation of the Police and Crime Act changes to Section 136, reporting to Hertfordshire's Crisis Care Concordat Group					

		Since implementation of the legislation, there has been an increase in incidents of illegal detentions. Analysis of these incidents has identified the following themes as factors driving this increase: - Delays due to AMHP availability out of hours - The individual being too intoxicated to assess - Complex social issues such as homelessness or vulnerability, or waiting for transfer back to home area for treatment. A particularly challenge has been the presentation of children and adolescents, who are unable to return to their home Of these, only intoxication is an accepted reason for extension of the 24 hour deadline. The risk is unlawful deprivation of							

		liberty for which the legal proceedings could be brought against the Trust by an individual. From January 2019, there was an upward trajectory in numbers of people being detained under Section 136, which combined with growing pressure on the acute mental health pathway led to an increase in the numbers of people who were subsequently detained over 24 hours. Although there has been no legal recourse from any service users to date, this does remain a risk.							

1301	The Trust is unable to ensure short term financial performance in current financial year	This year has seen fundamental changes to the normal contracting and financial reporting processes and is set within the context of the overarching objective of Finance to support and facilitate the clinical response to COVID-19. All NHS Organisations have been directed to report a break-even position in each of the first four months with income being made available to fully match expenditure. The contract process for 2020/21 was suspended.	9	Provider Trusts are to be fully reimbursed for the costs incurred. NHSE/I have used a proxy budget based on 2019/20 for reporting purposes Progressing the CRES / Delivering Value Programme	9	3	There is weekly monitoring of key indicators - CAMHS Tier 4 out of area placements - PICU & Acute out of area placements - - Overheads - Agency Increased number of placements outside HPFT or increased agency indicates a future increase in costs	As per the current national reporting arrangements the Trust has reported a breakeven position for each month and for the year to date. The current financial arrangements will ensure that the Trust achieves financial balance for the first four months of the year. What is less clear is the detail of the changes that will be made from August onwards as NHSE/I seek to bring in more certainty and grip to the system. Further guidance on this is expected during July. To date the Trust has performed strongly; there has been no requirement for extra income beyond COVID-19 reimbursement and the level of this reimbursement has been well below the regional average. However going forwards there are clear risks in terms of the level of demand and its complexity. This has been evident in the last weeks with the requirement for specialist CAMHS inpatient beds. To manage the financial risk the Trust continues to: • Work with commissioners and the region to ensure the promised new investment is made • Progress work within the restoration work streams to further grow IAPT and community capacity • Progress its Delivering Value programme linking this to the opportunities being identified within the Shaping our Future work • Accelerate its capital programme which sees investment both within the estate and technology • Continuing the work on managing the level of need for external bed capacity which had previously been very successful. Focus is now on anticipating and responding to the future changes and to build headroom to create flexibility for the next period which will see a much tighter control on funding.	Paul Ronald (Deputy Director of Finance)

								The Trust's Use of Resources (UoR) framework rating is not being reported to NHSE/I under the current financial arrangements and due to the fact that Trusts are reporting a consistent break-even position. The Trust's own assessment against the previous criteria would report as 1. Delivering Value Programme - The Trust has recommenced work on the programme and as services are restored those schemes previously developed will begin to be implemented.	

747	Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability, together with a negative impact on organisational reputation and potential financial legislative penalties. Our IT infrastructure contains some vulnerability and there are some insecure working practices which are contributing to our exposure to Cyber risk.	12	Series of audits being undertaken within HBL ICT IT Security Policy in place Email and Internet Policy in place Mobile Device Policy in place Network management through Solarwinds Action in response to threats identified by HSCIC Audits findings Intrusion Prevention Sensors on all 'internet' connections Regular/periodic messaging to staff regarding potential issues, vigilance, expected behaviours and appropriate responses Information Governance mandatory training HBL ICT development of mirrored data centres Move to NHSMail	8	6	Increase in cyber security related or suspected related issues/calls logged on Service Now Advice from HBL ICT, NHS Digital or other key organisations Cyber attacks on other HBL ICT organisations, other NHS organisations and/or wider organisations	Phishing emails are the primary route for cyber-attacks and therefore represent our greatest threat. HBLICT undertook a simulated phishing campaign across the partnership in September 2019. They are planning to action another fake phishing campaign to identify which staff are clicking on links in phishing emails and then follow up with the appropriate guidance and training. The Trust remains up to date in applying critical cyber security patches The Trust has not pursued the NHS Secure Boundaries initiative which was established about a year ago to provide an extra layer of physical firewall security to protect Trusts, especially were there has been limited investment within their infrastructure. Due to the investments that we have made in our two Data Centre's in the past two years, and in which the firewalls have been upgrade further in the last 6 months, therefore this additional layer of security would duplicate our investment. Indeed the firewalls that we have in our Data Centre's are of a higher specification to those used in the NHS Secure Boundaries solution. The Trust will continue to review the benefits from the NHS Secure Boundaries initiative as it develops further. Originally, Windows 7 was coming to end of life in January 2020, resulting in a cybersecurity risk to the Trust. However, since then the NHS has agreed extended support arrangements for Windows 7 until January 2021. The upgrading of IT equipment to Windows 8 has been paused owing to COVID related activities. HPFT secured 420k support from NHS Digital for further cyber security, work to be done with HBL ICT on how this is utilised, for example purchasing new network routers and network switches to upgrade any of the existing kit which are end of life or potentially vulnerable to minimise chance of cyber issues. The appropriate kit has been purchased but has yet to be installed as resources have been diverted to COVID19 IT relates activities. This will be installed as part of the	Paul Ronald (Director of Finance)

				Updated Paper Light processes				site by site improvement in WIFI coverage project. The advent of COVID19 has resulted in the rapid implementation of a number of projects and software solutions to support remote working. To support this, a shortened data protection impact assessment has been developed. The intention is to capture any immediate risks and propose practical mitigations. On 22nd April 2020, the Executive Team approved an approach to on-going rollout and support for digital communications, addressing the existing risks and moving towards providing Microsoft Teams, Attend Anywhere and AccuRx as standard digital capabilities: - Creating a Single Point for Coordination - Formally Launch the Corporate Solutions: Similar to communications for Microsoft Teams, an all users email will be sent out introducing and launching Attend Anywhere and AccuRx Fleming. - Agree an Orderly Exit - the project will come up with a reasonable timeframe in which all use of Zoom will be replaced with the corporate solutions without compromising support for our service users and carers. This will also include the work that needs to be done to make sure these solutions are fit for purpose and remain in use after the COVID-19 measures are stood down. - Manage Risk: Proactively continue to identify individuals who have older versions of Zoom making sure they are updated to the most recent version. Interim guidance will be issued for using Zoom securely whilst staff are transitioning to the new corporate solutions. - Ensure Ongoing Support and Management: The project will also create the ongoing support and management structures for these solutions by training existing staff within HPFT M&T. These will be added to our service portfolio as planned in Our Digital Strategy. Risk of cyber-attack is ever present.	

1147	The Trust may not be able to sustain service user safety during a flu outbreak	There is a risk that the Trust is unable to vaccinate enough front line staff against flu prior to the winter of 2019-20 which if during a flu outbreak might lead to a shortage of staff and a risk that the Trust is unable to provide sufficient staff to safely care for service users. The risk in 2019 - 20 could potentially increase due to the following: - Occupational Health have informed the Trust that there would be a delay in the supply of the vaccine, with the first batch arriving in October rather than September. - Link between flu trends in Australia and the UK. The flu season in	12	Learning from the themes from the 2018-19 campaign. Flu Plan Steering Group	6	3	International / Global Flu trends	At the end of the campaign 2019 - 2020 the Trust vaccinated 65% of front line staff against the flu, this is an improvement compared to 53% for the end of the campaign for 2018-19 and above the Trusts trajectory of 60%, it compared favourably against other Mental Trusts in the region. However the trust did not achieve the CQUIN target for 2019-20 which was 80% of frontline staff. The CQUIN target regarding staff flu vaccinations for 2019-20 was 80% of frontline staff. The trust achieved 64% an increase from 53% from the year before. This meant that we received 20% of the potential funding. The CQUIN target for 2010-21 has increased to 90% of frontline staff. We have indications that this may change to 90% of all staff. The Head of Allied Health Professions, operational lead for the flu vaccination programme, used the comments and feedback collated during the 2019-20 campaign to inform the plan for 2020-2021. Based on this learning the migration is to: • Enable staff to book their own vaccination slot • Send automated emails to confirm and remind them of their appointment • Send automated email if for any reason the clinic is cancelled • Link this system to the flu register and SPIKE so there is a regular update The challenges to this year's flu campaign to protect our staff and service users are: • Encourage more BAME staff to have the vaccination to protect them against other viral infections	Asif Zia (Medical Director)

		Australia typically peaks in August, but laboratory-confirmed cases of influenza have been higher than usual so far this year.						• Environmental challenges in relation to space and where the vaccination could be administered • Availability of the dedicated peer vaccinators with protected time • Additional infection control measures which will limit the number of vaccination slots available per session • A required shorter period of campaign with the majority of vaccinations to have been done by November 2020 In the 2019-2020 campaign the occupational Health service did not deliver the service agreed or expected. Clinics were frequently cancelled and there were no consistent staff provided. We have a new Occupational Health Provider, Vita Health, for this year's campaign. The performance of the new provider is untested and the contract only includes 3 days a week in October for vaccinations. We will therefore require significant input from peer vaccinators. The Trust will be applying a behavioural model to bring about a change at scale using the following four principles to encourage a behaviour, make it Easy, Attractive, Social and Timely (EAST). Resources for this new and improved approach are being agreed. There remains an underlying risk that a low update in front line staff flu vaccinations with the potential continued COVID risk could mean an increased number of front line staff off work impacting the Trusts ability to sustain service user safety.	

Risks requested for downgrading from the TRR

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	Current Position	Executive Lead
920	Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident	Failure to maintain compliance with data protection legislation creates a risk of a data incident occuring which leads to serious or catastrophic impact on data subjects (Staff or Service users). Should the Trust then fail to comply with an enforcement notice from the Information Commissioner, it would be at risk of a fine of up to €20million. Financial compensation will also be sought by affected data subjects. This would result in a serious impact on Trust finances and reputation. There is a potential loss of trust in clinical and therapeutic relationships, leading to reduced quality of care and outcomes.	9	The Trust has an open and timely culture of reporting incidents that occur, which facilitates early intervention and management of incidents. This supports reporting to the relevant authorities (NHSD and ICO) within the statutory 72 hour timescale. In addition, the Trust has undertaken data flow mapping across the organisation, and maintains a detailed information asset register, with identified Information Asset Owners. A Data Protection Impact Assessment process is in place, which promotes visibility of new projects, and facilitates early input by the Data Protection Officer. This contributes to meeting the statutory requirements of	8	6	Increase in serious data incidents reports. Increased complaints to the Information Commissioner leading to enforcement action, including audits or financial penalties. Reduction in staff compliance with mandatory training. Projects or initiatives going live without data protection or governance oversight. Failure to maintain Information Asset Register, Data flow mapping or Care record quality audit. Reduction in compliance with Data Subject Rights requests (including Subject Access).	In 2019 – 2020 7 incidents were scored as 'high risk' and reported to the Information Commissioner. All cases have since been closed, and no further action has been required by the Trust. The most common theme across the financial year was 'information disclosed in error'. 63 data incidents were reported through DATIX in Q1. Two incidents were escalated to the Information Commissioner – both have been subsequently closed with no further action for the Trust.	Keith Loveman (Deputy Chief Executive Executive Director – Strategic Finance)

				Article 35 of GDPR (2016). All staff are made aware of their statutory and professional responsibilities to safeguard and manage data appropriately. The quality of care record management at ward/clinical team level is audited on a annual cycle.					

1000	Implications for the Trust of unforeseen consequences arising from EU Exit	There are risk implications for the trust of different scenarios arising from Brexit, particularly a 'no deal' scenario. The Trust is unable to maintain sufficient quantity and volume of key supplies and/or the unit price may rise: - Medications - Equipment - Staff	12	EU staff contacted and supported. Department of Health and Social Care (DHSC) guidance on contingency plans Self Assessment for NHS Trusts to use to identify contracts that may be impacted by EU exit Identification of Contracts at risk to be completed Highly impacted contracts and mitigating activities completed Board level lead identified - DoF DHSC EU Exit Operational Readiness Guidance framework for assessment of risks completed January 2019 Business continuity and incident management plans tested	8	4	Increase difficulty or delay in sourcing sufficient quantities of medication or equipment. Increased staff turnover of EU registered staff Increase in unit price	On 31 January 2020 the United Kingdom left the European Union and the Withdrawal Agreement concluded with the EU entered into force. NHS England has stood down daily monitoring requirements in relation to EU Exit. There is now a transition period until the end of 2020 while the UK and EU negotiate additional arrangements. The current rules on trade, travel, and business for the UK and EU will continue to apply during the transition period. On 31 December 2020, at the end of the transition period provided for in that agreement, the UK will fully recover its economic and political independence. The UK will no longer be a part of the EU Single Market or the EU Customs Union. All EU employees (c.230 staff) have been contacted and supported in completing appropriate EU settlement scheme documentation. All c.230 have been written to again regarding applying for settled status however the response has been limited.	Keith Loveman (Deputy Chief Executive Executive Director – Strategic Finance)

1150	Unable to provide consistent timely access to CAMHS Community Services	Increasing level of demand on CAMHS Community Services resulting in an increased length of time for service users to access CAMHS community services, which impacts on the clinical care and treatment provided to young people. Long waits for other parts of the CAMH system resulting in deterioration of young people and referrals from these services being sent to Tier 3. (For Example Tier 2, ASD). Lack of clear pathways for ASD 16-18 year olds and subsequent referrals to Tier 3. Limited early intervention offers within the system to support young people and their carers. Despite previous recovery plans, performance is not sustained.	15	CAMHS CQI initiative has commenced A weekly task and finish group is in place Chaired by the Executive Director of Service Delivery and Service User Experience to oversee the recovery plan. Weekly reporting to commissioners. An agency team continues to support both SPA Triage and the community quadrant teams. Intensive work is on going with the performance team to ensure data is being reported in the best possible way, to reflect the work taking place and to support our KPI requirements. Quadrant Teams continue to offer a high number of first appointments. In addition to allocated quotas, teams are offering additional slots including Saturday clinics and early	6	5	CAMHS 28 day KPI/performance Number of referrals Re-referral rates DNA rates WTE Vacancies Use of agency staff Complaints	As at 23/06/2020 All 4 quadrant teams have been 100% compliant with the 28 day for the last 4 weeks; with East and North having been compliant since 27th April. A longer period of sustainability and additional assurance re-funding for 20/21 is required before closing this risk. The impact of COVID19 on medium and longer term demand remains uncertain and has the potential to impact performance.	Sandra Brookes (Director Of Service Delivery and Service User Experience)

				evening appointments.					

Risks requested for closing

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	Current Position	Executive Lead
773	Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites	Increased risk of being unable to respond effectively to demand in Adult Community Services and providing access in a timely way. Ongoing challenge in balancing, inbound volumes of assessments with effective case management and treatment of ongoing caseload. This can result in high demand of MHAA and admissions for known service users. Limited use of social care packages to prevent crisis or support discharge. Volume, acuity and complexity of caseloads is a risk leading to increased pressures on teams and potential workforce challenges.	12	Review of staff skill mix across quadrants and introduction of new roles Primary care projects commencing to look at work before IA referral made. The number of cases pending care co-ordinator allocation in the adult community teams is tracked and monitored weekly by the Team Leaders and service users are contacted regularly to minimise risk. Performance Monitoring of these cases is now available via SPIKE. Monthly reporting of position against target including detailed action plan to improve performance across all quadrants.	6	6	Vacancy Levels Agency spend Increase in incident reporting Number of cases pending allocation Number of initial assessments Turnover of staff Increase in Complaints Performance against targets deteriorating Staff feedback/raising of concerns Increased length of time to be allocated a care coordinator Increase in the total amount of cases pending allocation or as a % of overall community team caseloads Increase in readmission rates.	It is felt that the CQI projects put in place to improve the ability to respond to demand and reduce the impact on safety, quality and effectiveness had the desired effect. The Trust has increased its performance reporting from monthly to weekly focussing on the key KPIs that are likely to indicate if service changes made are adversely impacting performance. The report is presented to Exec weekly. Prior to covid19 there were no areas for concern Any impact on this risk is now connected to COVID19 which is being picked up in the performance risk on the COVID risk register the review will consider closing this risk as a result. The volume of demand and activity across the Trust has considerably reduced, consistent with the Trusts expectations of behaviour of both referrers and self-referrals by the general population during the COVID-19 outbreak	Sandra Brookes (Director Of Service Delivery and Service User Experience)

		Service users pending care co-ordination allocation remains a risk					% rise in service users known to community services requiring MHAA and admission. High CATT caseloads as unable to pass on to community teams.		

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item: 10**
Subject:	Research Strategy	**For Publication:**
Author:	Professor Tim Gale, Research Lead	**Approved by:** Dr Asif Zia, Director Quality & Medical Leadership
Presented by:	Dr Asif Zia, Director Quality & Medical Leadership	

Purpose of the report:

To provide the Board of Directors with an overview of the Trust Research Strategy

Action required:

To receive the report.

Summary and recommendations to the Board:

The report outlines:
Our Research Activities
Strategic Aims & Objectives
Research Strategy Deliverables
Delivery of the Strategy
Implementation of the Strategy

Relationship with the Business Plan & Assurance Framework:

Summary of Implications for:

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

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

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

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

AGENDA ITEM 10 RESEARCH STRATEGY

2020 - 2025

Abstract

Prof Tim M Gale, Research Lead
Dr Asif Zia, Executive Director - Quality & Medical Leadership
Version: 0.50

as One

Our Values
Welcoming Kind Positive Respectful Professional

DOCUMENT CONTROL

This is a controlled document and is only valid on the day it was published. Please contact the document's author for location details or printing problems.

On receipt of a new version, please destroy all previous versions unless a specified earlier version is in use throughout the project.

CHANGE HISTORY		
Version	Date	Summary of Changes
0.10	16/12/2019	Initial draft
0.20	21/01/2020	Update to key aims and objectives and background information on translational research
0.30	23/01/2020	Further updates to aims and objectives. Delivery section added.
0.40	07/02/2020	Reformatted by Chetan Shah
0.50	09/03/2020	Errors corrected and other comments taken into account

STAKEHOLDER REVIEWS *This document has been circulated to the following for review before being submitted for final approval.*		
Name	Title	Date

APPROVALS *This document requires the following approvals*			
Name	Role	Date	Signature

RELATED DOCUMENTS *This document refers to the following documents which may provide additional information. Please contact the document's author for accessing these documents.*	
Document Title	Version

Research Strategy

2020 - 2025

Contents

Introduction

Background

Hertfordshire Partnership University NHS Foundation Trust (HPFT, the Trust) provides health and social care to people with mental ill health, physical ill health and learning disabilities across a large geographic area covering Hertfordshire, Buckinghamshire, Norfolk and Essex.

We have over 3,000 staff who together deliver a wide range of child and adolescent, older people and adult services within community and inpatient settings across the geography. We also provide support for carers, actively working with them to improve the way we engage families in caring for their loved ones.

In 2016, we developed our 5-year strategy, Good to Great (G2G), which emphasises our ambition to become a learning, innovating and improving organisation and desire to be a leader in the use of information and technology to deliver great care and great outcomes to our service users.

In 2019, we have launched our Quality Strategy which sets out how safe and effective services, with the service user as partner in their own care and treatment as well as service development will be achieved.

This Research Strategy builds on these and outlines our approach to research over the next five years.

National Context

Research is widely recognized as being essential for well-performing health care organizations, with benefits including: better outcomes for service users, a higher level of evidence-based intervention, better monitoring of outcomes and service evaluation and last, but not least, recruitment and retention of skilled clinical staff.

The NHS Long Term Plan[1] recognises the importance of research, not just for future medical advancement and better care for patients, but also for the UK economy's growth. HPFT is part of the National Institute for Health Research (NIHR), the research arm of the NHS, which has a vision to "improve the health and wealth of the nation through research." More specifically, the NIHR aims to:

- Establish the NHS as an internationally recognised centre of research excellence.
- Attract, develop and retain the best research professionals to conduct people-based research.
- Commission research focused on improving health and social care.
- Strengthen and streamline systems for research management and governance.

[1] NHS Long Term Plan, https://www.longtermplan.nhs.uk/, January 2019

INTRODUCTION

We are a mental health and learning disabilities trust with over 3,000 staff working across four counties. This strategy builds on our Good to Great Strategy and our Quality Strategy to outline our approach to research over the next five years.

NHS Long term plan recognises importance of research, committing to:

- Increase people registering to participate in research
- Targeted investment in transformative innovation
- Speeding up the pipeline for innovations
- Expand real world testing

In HPFT, the scale of our services, our University Trust status and our commitment to Continuous Quality Improvement uniquely positions us to advance the research agenda for the benefit of our services users and staff through:

- Monitoring preclinical foundation research
- Recruiting participants for trials
- Actively researching into new methods and their translation to practice, Informing and participating in population based studies

- Increase opportunities for patients and public to participate in, and benefit from, research.
- Promote and protect the interests of patients and the public in health research.
- Drive faster translation of scientific discoveries into tangible benefits for patients.
- Maximise the research potential of the NHS to contribute to the economic growth of the country through the life sciences industry.
- Act as sound custodians of public money for the public good.

Of particular note is the NIHR aspiration to increase the number of people registered to participate in NIHR-approved 'Portfolio' research to 1 million by 2023/24. Currently the national recruitment figure stands at approximately two thirds of this target.

HPFT benefits from a formal partnership with the University of Hertfordshire and research is one of the cornerstones of our status as a University Trust. We also have links with other Higher Education Institutions (HEIs) including University of East Anglia, University of Southampton, University College London and University of Cambridge. Over the last decade, we have achieved considerable success in attracting NIHR grant funding, successfully running and completing clinical trials, publishing a wide range of research articles, supporting joint research posts with HEIs and a sustained increase in the number of NIHR portfolio studies supported and recruited to. These achievements have, however, been underpinned by a relatively small handful of individuals within the Trust, and there is a risk they will not be sustainable in the longer term.

The NIHR agenda is supported and delivered at a local level by Clinical Research Networks (CRNs). Funding is allocated to partner organizations (POs) within each network. HPFT is a PO of CRN Eastern and receives funding to support the delivery of NIHR-Portfolio research.

The Health Research Authority (HRA) protects and promotes the interests of patients and the public in health and social care research. The HRA and Department of Health, via the UK policy for Health & Social Care Research, are committed to an environment where service users and the public are given, and take, the opportunity to participate in health and social care research, and are confident about doing so.

The Care Quality Commission (CQC) has recently outlined new lines of enquiry regarding research and improvement in a well led organisation (Reference: CQC next phase methodology 2018 Well-led), further emphasizing the national importance of embedding research within clinical practice, and the recognition that this has a direct impact on quality of patient care.

Local Context

At HPFT, our values define us and are at the heart of how we go about delivering our vision and mission. Our Good to Great Strategy describes how we are delivering our vision and achieving our mission and our Quality Strategy sets out how safe and effective services, with the service user as partner in their own care and treatment, as well as service development will be achieved. Figure 1 - HPFT Strategic Context below summarises these three pillars on which our Research Strategy is built.

Figure 1 - HPFT Strategic Context

"HPFT research and development – the story so far"

1 HPFT benefits from a formal partnership with the University of Hertfordshire with research as one of the cornerstones of our status as a University Trust. We also have links with other Higher Education Institutions (HEIs) including University of East Anglia, University of Southampton, University College London and University of Cambridge.

2 Trust's Research and Development team made up of 1 Whole Time Equivalent (WTE) Research and Development Lead, 0.6 WTE Governance Assistant and 2 WTE Clinical Research Practitioners.

3 In the past 5 years HPFT has had significant success in attracting NIHR grant funding, successfully running and completing clinical trials, publishing a wide range of research articles, supporting joint research posts with HEIs and a sustained increase in the number of NIHR portfolio studies supported and recruited to.

4 HPFT has recently invested £250k in a Continuous Quality Improvement (CQI) initiative, which is growing in size and scope.

5 HPFT formally established RADiANT in 2019(Research in Developmental Neuropsychiatry) a consortium of over 20 NHS Trusts working in collaboration with academics. It has an advisory board of around 50 drawn from service users, patients, families, charities, community leaders and a range of statutory bodies and organizations.

6 HPFT has hosted 10 NIHR Research for Patient Benefit Grants over the past 8 years resulting in in an award of approximately £2.5 million.

7 HPFT has been awarded NIHR Research Capability Funding of approximately £100K per annum.

8 HPFT have hosted an annual research showcase event for the last 5 years supporting research collaborations.

9 The vast majority of staff who are actively engaged in research have worked for HPFT for a long time. Staff turnover in the R&D Team is historically very low.

Our Research Activities

The main area of research activity of our Trust falls within the field of translational clinical research where the overall goal is to safely and rapidly turn what we learn in basic science studies into effective interventions and treatments for our service users. As clinical research generally is a continuum, the scientific community has defined a number of phases for translational research:

- ***T0*** research studies are basic biomedical research activities, including preclinical and animal studies. They do not include interventions with humans. They identify opportunities and approaches to addressing health problems.
- In ***T1*** phase these basic discoveries are moved to humans, focusing on trialling new methods of diagnosis, treatment and preventions in highly controlled settings.
- ***T2*** phase research tests these new methods in controlled clinical setting to create new clinical applications and evidence-based guidelines to be used in practice
- ***T3*** phase research tests these guidelines in real world clinical settings and include research activities such as comparative effectiveness studies, clinical outcomes research
- In the final ***T4*** phase, researches observe factors and interventions that influence health within populations looking at areas such as population level outcomes, morbidity, mortality, benefits and risks.

Although we maintain an active interest in all of these phases, our research activities mainly fall within T2 and T3 phase research.

The diagram below, adopted from the Children's Hospital of Philadelphia's diagram of Translational Clinical Research[2], illustrates the focus of our Trust's research activities.

Figure 2 - Our research activities

[2] Translational Clinical Research, https://cpce.research.chop.edu/research-methods-approaches/translational-research, Children's Hospital of Philadelphia, 2020

Strategic Aims and Objectives

In support of the overarching NHS objective of becoming an internationally recognised centre of research excellence and driving faster translation of scientific discoveries into tangible benefits for patients, we will work to strengthen research activity at a local level in the following key areas where we wish to see growth over the next five years. We will focus our efforts across the following 3 key strategic aims:

Ensuring our service users and carers continue to have access to most recent interventions that are proven to be safe and effective by

Increasing opportunities for service users and public to participate in and benefit from research

Promoting and protecting the interests of our service users and the public in health research

Improving our staff recruitment and retention by

Building research into our services and roles to improve job satisfaction

Attracting, developing and retaining the best research professionals to conduct and support people-based research

Strengthening our leadership role as a research organisation by

Strengthening our systems for research management and governance

Actively identifying, undertaking, delivering and promoting research focused on improving health and social care

Research Strategy Deliverables

Ensuring our Service Users and Carers Continue to Have Access to Most Recent Interventions	
Increasing opportunities for service users and public to participate in and benefit from research	
We will *involve service users, carers and frontline staff in all research studies* led by the Trust, recognising the value of their expertise in contributing to the formulation of research ideas, design, implementation, dissemination and strategic vision.	We will develop Staff *Research Champions and Service User Ambassadors* at the early stages of the implementation of our strategy.
We will *expand our public-facing Research and Development website* to include research interests and aspirations of key clinical academics.	We will work with our staff to make sure s*ervice users and carers are routinely informed* that we are a research active Trust, and that we *encourage them to take part in research* where relevant. We will also develop Trust posters and leaflets that explains what this means for them.
We will further develop our public-facing website to include links for *health education on key topics* targeted at the general public.	We will *set up an opt-in system* whereby we seek the consent of all new service users *to be contacted about relevant research* opportunities.
We will ensure that research , quality improvement, and service evaluations activity is showcased at Trust events.	
Promoting and protecting the interests of our service users and the public in health research	
All research taking place in HPFT will also undergo *appropriate ethical review* (i.e. through NHS research ethics committee) and has *HRA approval* in place where required which will provide further assurance the interests of our service users and the wider public has also been considered and scrutinised by people outside the immediate research teams.	Working with our colleagues in Learning and Development and Information Rights & Compliance, we will ensure that all staff involved in research at all levels of the organisation are supported and encouraged to *access appropriate research governance training* (Good Clinical Practice; GCP) and refresher-training, *designed to protect patient confidentiality and safety*. We will also ensure that staffs have access to *guidance and support on the ethical aspects of new research* at the design stage.
Where appropriate, we will ensure that investigators *include service users and carers in the design of portfolio research projects led by HPFT*, such as by inviting them to join as co-investigators, to ensure the concerns of people with lived experience are factored into the design	We will also *monitor research engagement* with service users and carers by including questions on the *Having Your Say* form that ask whether they have been offered the opportunity to participate in research

process at the earliest stage.	

Improving our Staff Recruitment and Retention	
Building research into our services and roles to improve job satisfaction	
Over the course of the implementation, we will develop a framework to ensure job descriptions for clinical posts include *detailed expectations of research activity relevant to* their *role and banding*.	We will *actively encourage and support staff from underrepresented research active professions* such as nurses, social workers and occupational therapists to become actively involved in research. We will also ensure that those *clinicians who wish to engage in NIHR portfolio research are afforded the time needed* to form partnerships with relevant research active professionals, put together and write a grant application, carry out a Principal Investigator (PI) role or disseminate their research findings in the form of written publications or oral presentations.
We will ensure that our clinicians are supported and encouraged to access *appropriate research training* (GCP, PI training) via the NIHR, CRN, R&D Department and local HEIs. In addition to strengthening our research portfolio, this is also likely to benefit our CQI activities.	We will include *research awareness in our staff induction* through a *research awareness training package* and we will incentivise and recognise participation in research through increased *recognition and awards*.
We will provide opportunities for staff *to train in medical statistics* and access to *relevant analytic software* and support to facilitate research analysis.	We will include *research sessions within Trust events* and introduce a *Celebrate Clinical Trials Day* in the Trust to raise further awareness amongst our staff.
Attracting, developing and retaining the best research professionals to conduct and support people-based research	
We will enhance our in-house talent pool by supporting *educational and training opportunities for staff* to achieve *formal research qualifications* (MPhil, MD, PhD) through links with University of Hertfordshire	We will maintain and recognise the value of our University Trust status, and build upon this by forging *stronger collaborative links with other HEIs and Applied Research Collaborations* (ARC, formerly CLAHRC).
We will continue to *develop the Research and Development team* to promote and support research among clinicians at all levels of the organisation and establish and *promote better research career pathways* within the Trust, with sufficient funding for time spent on research.	We will further strengthen the Mental Health and Learning Disability Research Network in its role of informing, supporting and encouraging researchers across disciplines in fulfilling portfolio research, with a particular focus on developing early career researchers.
We will establish *better mentoring networks* for our research active clinicians and trainees.	We will evaluate all candidates applying for *senior clinical posts in the Trust with respect their capability and interest in performing research* and, where possible, seek to *appoint new clinical academics in all professional groups* within the Trust.

<table>
<tr><th colspan="2">Strengthening our Leadership Role as a Research Organisation</th></tr>
<tr><th colspan="2">Actively identifying, undertaking, delivering and promoting research focused on improving health and social care</th></tr>
<tr><td>We will expand the number of Trust co-sponsored research studies by increasing our success rate in applying for research grants and also increase the number of portfolio studies we take on, and the number of participants recruited.</td><td>Having an outstanding research portfolio is an essential component of being an outstanding organisation. We will continue to reinforce this this through a regular scheduled items at Executive Team and Trust Board meetings..</td></tr>
<tr><td>We will expand the number of Trust co-sponsored research studies by increasing our success rate in applying for research grants and also increase the number of portfolio studies we take on, and the number of participants recruited.</td><td>We will increase the awareness of our research activities both locally and nationally by:
Develop opportunities for cross-fertilization between Research, Innovation, QI and PACE.
Including research activity in SBU reporting arrangements with commissioners.
Increasing the number of peer reviewed publications and book chapters by Trust staff.
Encouraging and incentivising our workforce to promote and publicise research outcomes.
Increasing the number of national and international scientific meetings HPFT staff present research findings at, so as to promote awareness and impact of published work.
Working with the Trust’s communications department to actively promote new research findings of public value to the widest audience using multi-media techniques.</td></tr>
<tr><th colspan="2">Strengthening our systems for research management and governance</th></tr>
<tr><td>We will establish stronger research governance and support structure, providing new roles and facilities where needed including scientific and administrative staff and an office equipped with all the up to date technology to oversee this work.</td><td>We will ensure that research activity is valued and championed at all levels of the organisation as a tool to achieve the best treatment outcomes and this is mirrored throughout the Trust in the way operational systems and clinical pathways are configured.</td></tr>
<tr><td>We will also ensure that our corporate and clinical systems are configured in a way that supports research and benchmarking exercises.</td><td></td></tr>
</table>

Delivering the Strategy

Governance

Our aspiration is to implement the Research Strategy through four work streams:

- Children and Adolescent Mental Health
- Neurodevelopmental (Learning Disabilities)
- Adult Mental Health
- Dementia and Frailty

Each of these work streams will have their own research infrastructure in place with a network of PIs, supported by the CRN funded Research and Development teams.

These work streams will report to the a Research and Development Board comprising Research and Development Lead, Medical Lead for Research and Development, Director of Quality and Medical Leadership, lead research representatives form Nursing and Allied Health Professionals and the work stream leads.

Each of these work streams will establish their own delivery plans in line with the Trusts overall implementation plan for the Research Strategy. Work streams will also encourage publications of quality improvement and service evaluations in their domain.

A new assistant manager post will be established to provide oversight of the day to day running of the Research and Development Department's activities.

The diagram below outlines the governance and delivery structures for the strategy.

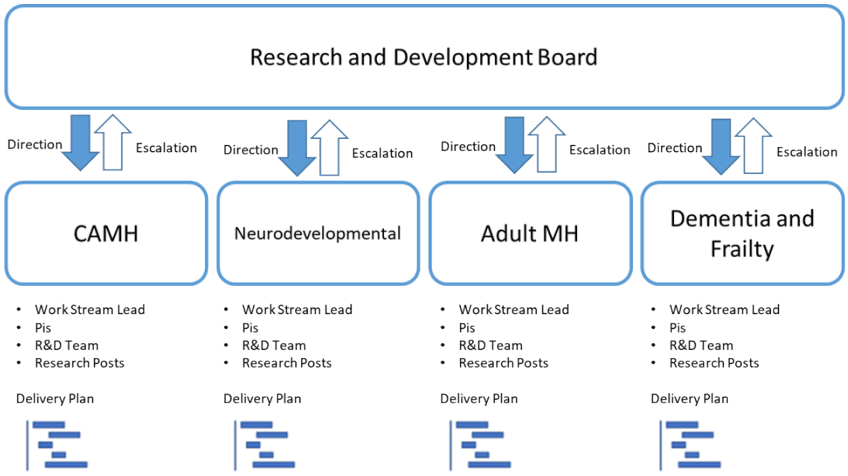


Figure 3 - Governance and Delivery Structures

DELIVERING THE STRATEGY

Overall governance of the delivery will be overseen by a newly established Research and Development Board.

Delivery will be organised across four work streams:

- Children and Adolescent Mental Health
- Neurodevelopmental (Learning Disabilities)
- Adult Mental Health Dementia and Frailty

Each work stream will have its own delivery plan in line with the overall implementation plan and will have membership including:

- Workstream Lead
- PIs
- R&D Team
- Research Posts

Implementation Plan

Each workstream lead will be responsible for developing a implementation plan as set out in appendix 1.

Appendix 1: Implementation plan

Aims	2020 – 2021	2021 – 2022	2022 – 2023	2023 – 2024	2024 – 2025
Ensuring our service users and carers are engaged with research agenda	• Establish Service User Ambassadors. • Raise the profile of research within service users and carers. • Develop Trust posters and leaflets that explains what this means for service users. • Set up an opt-in system whereby we seek the consent of all new service users to be contacted about relevant research opportunities. • We will monitor research engagement with service users and carers by including questions on the Having Your Say form that ask whether they have been offered the opportunity to participate in research	• Research Champions and Ambassadors help to improve service users recruitment to high quality research studies • Service user involvement as co-collaborators in research applications higher number of service users enrolled into research • Establishing a data base for service users who are willing to participate in research	• Broadening the research base with increased portfolio of research activity year on year	• Broadening the research base with increased portfolio	• Broadening the research base with increased portfolio
Improving our staff recruitment and retention	• Establishment of work streams • Staff linked to the work streams • We will actively encourage and support staff from underrepresented research active professions such as nurses, social workers and occupational therapists to become actively involved in research. • Ensure that those clinicians who wish to engage in NIHR portfolio research are afforded the time needed to form partnerships • Help staff with writing grant application • Include research awareness in our staff induction through a research awareness training packaged Recognition and reward • Incentivise and recognise participation in research through increased recognition and awards. • Include research sessions within Trust events • Introduce a Celebrate Clinical Trials Day in the Trust to raise further awareness amongst our staff.	• Continued from year 20/21 • Period of embedding research and raising research profile	• Increased number of staff participating in research • Increase in Number of PI joining the organisation • Increasing the research portfolio studies in collaboration or within the organisation Higher number of Grant application submitted for NIHR and ARC application • Increase in number of staff applications for post graduate qualification	• Fully funded/ part time funded research academics appointed within the organisation	• **Fully funded research academics within the organisation**

Strengthening our leadership role as a research organisation	• Identify leadership to lead on the work streams • Carry out a Principal Investigator (PI) role or disseminate their research findings in the form of written publications or oral presentations. • Develop Staff Research Champions • Engage different professional groups around research with dedicated time • Strengthen research collaboration with University of Hertfordshire • • Clinicians are supported and encouraged to access appropriate research training (GCP, PI training) via the NIHR, CRN, R&D • Developing early career researcher by: • i) Establish better mentoring networks • ii) Provide opportunities for staff training in medical statistics • iii) Access to relevant analytic software to allow research analysis to take place. • Job descriptions for clinical posts should include detailed expectations of research activity relevant to their role and banding. • Develop a research awareness training package for staff. • Staff from under represented research active professions such as nurses, social workers and occupational therapists should be encouraged and supported to become research active. • Ensure continuation of our annual Research Showcase Event, with the aim of increasing participation by Trust staff at all levels, including the Executive	• Build up a network of collaboration with other organisations carrying out research throughout the STP • Collaborate with other Academic Health Sciences network • Forging stronger collaborative links with other HEIs and Applied Research Collaborations (ARC, formerly CLAHRC). • Retain our leading academics and clinical academics, and seek to appoint new clinical academics in all professional groups within the Trust, • Clinicians who wish to engage in NIHR portfolio research are afforded the time needed to carry out a Principal Investigator (PI) role. • Build up synergy between CQI, innovation and research	• Build research time into our services, recognising the full benefits that engaging in research has for both our staff and our service users. • Support educational and training opportunities for staff to achieve formal research qualifications (MPhil, MD, PhD) through links with University of Hertfordshire. • Strengthen the Mental Health and Learning Disability Research Network in its role of informing, supporting and encouraging researchers across disciplines in fulfilling portfolio research, with a particular focus on developing early career researchers. • Incentivize the participation in research by our staff, through increased recognition and rewards. • Ensure awareness of research is included at staff induction.	• Establish and promote better research career pathways within the Trust, with sufficient funding for time spent on research.	• Recognised leadership within the Academic circles • Bigger scope and influence around research agenda regionally and nationally

	Team. • We will ensure that all staff involved in research are supported and encouraged to access appropriate research governance training (Good Clinical Practice; GCP) and refresher-training, designed to protect patient confidentiality and safety. • We will also ensure that staffs have access to guidance and support on the ethical aspects of new research at the design stage. •				

Why do we need a Research Strategy now?

Great organisations use **research** as a tool to **develop services and staff**

NHS Trusts rated as **outstanding** by CQC have a **substantial research portfolio** (e.g. ELFT, NTW)

New research **drives change and improvement** – locally and nationally

Incentive for staff **recruitment and retention**

Better clinical care - research is now very much on the **CQC agenda.**

as one

Our Values
Welcoming Kind Positive Respectful Professional

Current Context

"HPFT research and development – the story so far"

1. HPFT benefits from a formal partnership with the University of Hertfordshire with research as one of the cornerstones of our status as a University Trust. We also have links with other Higher Education Institutions (HEIs) including University of East Anglia, University of Southampton, University College London and University of Cambridge.
2. Trust's Research and Development team made up of 1 Whole Time Equivalent (WTE) Research and Development Lead, 0.6 WTE Governance Assistant and 2 WTE Clinical Research Practitioners.
3. In the past 5 years HPFT has had significant success in attracting NIHR grant funding, successfully running and completing clinical trials, publishing a wide range of research articles, supporting joint research posts with HEIs and a sustained increase in the number of NIHR portfolio studies supported and recruited to.
4. HPFT has recently invested £250k in a Continuous Quality Improvement (CQI) initiative, which is growing in size and scope.
5. HPFT formally established RADIANT in 2019(Research in Developmental Neuropsychiatry) a consortium of over 20 NHS Trusts working in collaboration with academics. It has an advisory board of around 50 drawn from service users, patients, families, charities, community leaders and a range of statutory bodies and organizations.
6. HPFT has hosted 10 NIHR Research for Patient Benefit Grants over the past 8 years resulting in in an award of approximately £2.5 million.
7. HPFT has been awarded NIHR Research Capability Funding of approximately £100K per annum.
8. HPFT have hosted an annual research showcase event for the last 5 years supporting research collaborations.
9. The vast majority of staff who are actively engaged in research have worked for HPFT for a long time. Staff turnover in the R&D Team is historically very low.

as One

Our Values
Welcoming Kind Positive Respectful Professional

Over-arching Aims & Objectives

Strategic Aims and Objectives

In support of the overarching NHS objective of becoming an internationally recognised centre of research excellence and driving faster translation of scientific discoveries into tangible benefits for patients, we will work to strengthen research activity at a local level in the following key areas where we wish to see growth over the next five years. We will focus our efforts across the following 3 key strategic aims:

Ensuring our service users and carers continue to have access to most recent interventions that are proven to be safe and effective by

Increasing opportunities for service users and public to participate in and benefit from research

Promoting and protecting the interests of our service users and the public in health research

Improving our staff recruitment and retention by

Building research into our services and roles to improve job satisfaction

Attracting, developing and retaining the best research professionals to conduct and support people-based research

Strengthening our leadership role as a research organisation by

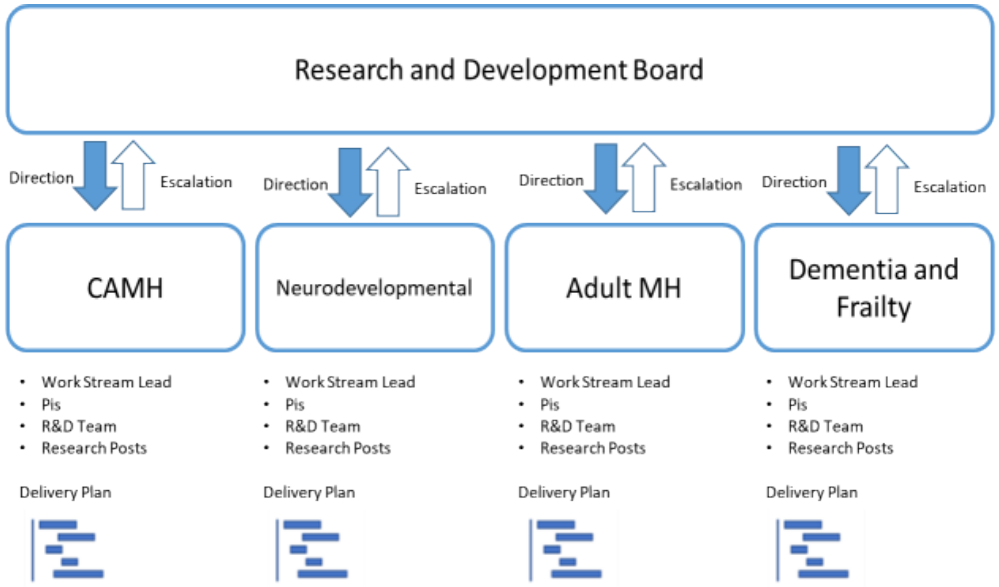
Strengthening our systems for research management and governance

Actively identifying, undertaking, delivering and promoting research focused on improving health and social care

as one

Our values
Welcoming Kind Positive Respectful Professional

Delivery Plan by Workstream



as one

Our values
Welcoming Kind Positive Respectful Professional

Delivery Plan by Aim 1

Ensuring our Service Users and Carers Continue to Have Access to Most Recent Interventions	
Increasing opportunities for service users and public to participate in and benefit from research	
We will *involve service users, carers and frontline staff in all research studies* led by the Trust, recognising the value of their expertise in contributing to the formulation of research ideas, design, implementation, dissemination and strategic vision.	We will develop Staff *Research Champions and Service User Ambassadors* at the early stages of the implementation of our strategy.
We will *expand our public-facing Research and Development website* to include research interests and aspirations of key clinical academics.	We will work with our staff to make sure *service users and carers are routinely informed* that we are a research active Trust, and that we *encourage them to take part in research* where relevant. We will also develop Trust posters and leaflets that explains what this means for them.
We will further develop our public-facing website to include links for *health education on key topics* targeted at the general public.	We will *set up an opt-in system* whereby we seek the consent of all new service users *to be contacted about relevant research* opportunities.
We will ensure that research , quality improvement, and service evaluations activity is showcased at Trust events.	
Promoting and protecting the interests of our service users and the public in health research	
All research taking place in HPFT will also undergo *appropriate ethical review* (i.e. through NHS research ethics committee) and has *HRA approval* in place where required which will provide further assurance the interests of our service users and the wider public has also been considered and scrutinised by people outside the immediate research teams.	Working with our colleagues in Learning and Development and Information Rights & Compliance, we will ensure that all staff involved in research at all levels of the organisation are supported and encouraged to *access appropriate research governance training* (Good Clinical Practice; GCP) and refresher-training, *designed to protect patient confidentiality and safety*. We will also ensure that staffs have access to *guidance and support on the ethical aspects of new research* at the design stage.
Where appropriate, we will ensure that investigators *include service users and carers in the design of portfolio research projects led by HPFT*, such as by inviting them to join as co-investigators, to ensure the concerns of people with lived experience are factored into the design	We will also *monitor research engagement* with service users and carers by including questions on the *Having Your Say* form that ask whether they have been offered the opportunity to participate in research

as one

Our values
Welcoming Kind Positive Respectful Professional

Delivery Plan by Aim 2

Improving our Staff Recruitment and Retention	
Building research into our services and roles to improve job satisfaction	
Over the course of the implementation, we will develop a framework to ensure job descriptions for clinical posts include *detailed expectations of research activity relevant to* their *role and banding*.	We will *actively encourage and support staff from underrepresented research active professions* such as nurses, social workers and occupational therapists to become actively involved in research. We will also ensure that those *clinicians who wish to engage in NIHR portfolio research are afforded the time needed* to form partnerships with relevant research active professionals, put together and write a grant application, carry out a Principal Investigator (PI) role or disseminate their research findings in the form of written publications or oral presentations.
We will ensure that our clinicians are supported and encouraged to access *appropriate research training* (GCP, PI training) via the NIHR, CRN, R&D Department and local HEIs. In addition to strengthening our research portfolio, this is also likely to benefit our CQI activities.	We will include *research awareness in our staff induction* through a *research awareness training package* and we will incentivise and recognise participation in research through increased *recognition and awards*.
We will provide opportunities for staff *to train in medical statistics* and access to *relevant analytic software* and support to facilitate research analysis.	We will include *research sessions within Trust events* and introduce a *Celebrate Clinical Trials Day* in the Trust to raise further awareness amongst our staff.
Attracting, developing and retaining the best research professionals to conduct and support people-based research	
We will enhance our in-house talent pool by supporting *educational and training opportunities for staff* to achieve *formal research qualifications* (MPhil, MD, PhD) through links with University of Hertfordshire	We will maintain and recognise the value of our University Trust status, and build upon this by forging *stronger collaborative links with other HEIs and Applied Research Collaborations* (ARC, formerly CLAHRC).
We will continue to *develop the Research and Development team* to promote and support research among clinicians at all levels of the organisation and establish and *promote better research career pathways* within the Trust, with sufficient funding for time spent on research.	We will further strengthen the Mental Health and Learning Disability Research Network in its role of informing, supporting and encouraging researchers across disciplines in fulfilling portfolio research, with a particular focus on developing early career researchers.
We will establish *better mentoring networks* for our research active clinicians and trainees.	We will evaluate all candidates applying for *senior clinical posts in the Trust with respect their capability and interest in performing research* and, where possible, seek to *appoint new clinical academics in all professional groups* within the Trust.

Delivery Plan by Aim 3

Strengthening our Leadership Role as a Research Organisation	
Actively identifying, undertaking, delivering and promoting research focused on improving health and social care	
We will *expand the number of Trust co-sponsored research studies* by increasing our success rate in applying for research grants and also *increase the number of portfolio studies* we take on, and the *number of participants* recruited.	Having an outstanding research portfolio is an essential component of being an outstanding organisation. We will continue to reinforce this this through a *regular scheduled items at Executive Team and Trust Board meetings..*
We will *expand the number of Trust co-sponsored research studies* by increasing our success rate in applying for research grants and also *increase the number of portfolio studies* we take on, and the *number of participants* recruited.	We will *increase the awareness of our research activities both locally and nationally* by: ▪ Develop opportunities for cross-fertilization between Research, Innovation, QI and PACE. ▪ Including research activity in SBU reporting arrangements with commissioners. ▪ Increasing the number of peer reviewed publications and book chapters by Trust staff. ▪ Encouraging and incentivising our workforce to promote and publicise research outcomes. ▪ Increasing the number of national and international scientific meetings HPFT staff present research findings at, so as to promote awareness and impact of published work. ▪ Working with the Trust's communications department to actively promote new research findings of public value to the widest audience using multi-media techniques.
Strengthening our systems for research management and governance	
We will establish stronger *research governance and support structure*, providing *new roles and facilities where needed* including scientific and administrative staff and an office equipped with all the *up to date technology* to oversee this work.	We will ensure that *research activity is valued and championed at all levels* of the organisation as a tool to achieve the best treatment outcomes and this is *mirrored throughout the Trust in the way operational systems and clinical pathways are configured*.
We will also ensure that our *corporate and clinical systems are configured in a way that supports research and benchmarking* exercises.	

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 11a
Subject:	Final draft Quality Account Report 2019/20	**For Publication:** No
Author:	Jacky Vincent, Deputy Director of Nursing and Quality/Director Infection and Control (DIPC)	**Approved by:** Dr Asif Zia, Director of Quality and Medical Leadership
Presented by:	Dr Asif Zia, Director of Quality and Medical Leadership	

Purpose of the report:

To present the final draft Quality Account Report for 2019/20

Action required:

The Board are asked to:

- Review the content of the report
- Review the information provided as an accurate reflection of:
  - the services the Trust delivers
  - how well the services have been delivered
  - the forward plans for 2020/21.
- Seek clarification as necessary
- Advise any additional action and/or amendments.
- Recommend the Report including the indicators for approval by the Board.

Summary and recommendations to the Committee:

Summary

In line with national guidance on responding to the Covid-19 pandemic, the consultation process for the Quality Account Report was not as comprehensive as in previous years. The indicators were initially discussed with the Council of Governors in March and they chose the one to be audited but no other detailed consultative work was undertaken.

In addition, NHSI guidance regarding the NHS accounts process for 2019/20 was revised owing to the pandemic, and our auditors were not required to give an audit opinion on the Quality Account Report indicators or undertake the testing of the Governor selected indicator. Therefore, no further audit procedures in relation to the Quality Account Report or the indicators were undertaken.

The Quality Account Report provides detail of the quality of care we provide as a Trust, and comprises of the following:

- The requirements of the quality account each year – as required by the NHS Act 2009, in terms set out in the NHS (Quality Accounts) Regulations 2010 and any subsequent amendments to those regulations, and
- NHSI's additional requirements for quality reports for Foundation Trusts.

As a Foundation Trust, we are normally required to obtain an assurance report from our external auditors on the content of the Quality Account Report; however, the need to produce one was also removed this year in the revised NHSI guidance owing to the pandemic.

As a Trust, we have decided to produce a Quality Account Report for 2019/20 and attached is the draft. This draft is a comprehensive and detailed final version which, once approved, will be uploaded onto our website and shared with our staff and stakeholders.

Recommendation
The Committee is asked to review the Report and recommend it along with the indicators for approval by the Board.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Financial, IT, Staffing and Legal Implications:

None.

Equality & Diversity and Public & Patient Involvement Implications:

None

Evidence for Essential Standards of Quality and Safety; NHSLA Standards;

Evidence of robust governance review process for the Well Led standard and contributes so safe care in relation to IPC practice.

Hertfordshire Partnership University NHS Foundation Trust

QUALITY ACCOUNT REPORT

2019/20

as One

Our Values
Welcoming Kind Positive Respectful Professional

Contents

Quality Account Report

Part 1 – Statement on Quality from our Chief Executive

(Alicia to complete)

Declaration

Data accuracy

There are factors involved in preparing this Quality Account Report that can limit the reliability or accuracy of the data reported, and we are required by NHS Improvement (NHSI), the body responsible for overseeing our Trust, to tell you about these.

- Data is taken from many different systems and processes. Not all this information is checked for accuracy by independent assessors from other organisations, or audited by the Trust every year
- Information is collected by many different teams across the Trust. Sometimes different teams apply or interpret policies differently, which means they might collect different information or, perhaps, put it in different categories
- In many cases, the information provided is based on clinical judgements about individual cases. Because clinical judgements can vary, so can the data drawn from them
- National data definitions do not cover all circumstances and some local interpretations may differ
- We sometimes change how we collect, define and analyse data and it is often difficult or impossible to adjust older data to fit with a new method. To avoid confusion, we indicate when and where we have made these kinds of changes.

The Board of Directors and Executive Team have taken all reasonable steps and have exercised due diligence to ensure the accuracy of the data reported. However, we recognise that the data is subject to the limitations described above. To the best of my knowledge, the information presented to you in this document is accurate and provides a fair representation of the quality of service delivered within the organisation.

Tom Cahill: **Date:**

Chief Executive

Background

Once a year, every NHS Trust is required to produce a Quality Account Report. This report includes information about the services the Trust delivers, how well we deliver them and our plans for the following year.

Our aim in this Quality Account Report is to make sure that everyone who wants to know about what we do can access that information. All Quality Account Reports are presented to Parliament before they are made available to service users, carers and members of the public on the NHS Choices website.

What is NHS Choices?
NHS Choices is the UK's biggest health website. It provides information about symptoms conditions, medicines and treatment, NHS services and advice about how to live as well as possible at www.nhs.uk

What the Quality Report includes

- What we plan to do next year (2020/21), what our priorities are, and how we intend to address them
- How we performed last year (2019/20), including where our services improved
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts
- Stakeholder and external assurance statements including our independent auditor's report, statements from Healthwatch Hertfordshire, Hertfordshire Valley Clinical Commissioning Group (CCG), East and North CCG and Hertfordshire County Council Health Scrutiny Committee.

Understanding the Quality Account Report

We recognise that some of the information in this Quality Account Report may be hard to understand if you don't work in health care. We've used the coloured boxes to provide explanations and examples that should help.

This is a 'What is it?' box
These explain a term or abbreviation

This is a 'Quotes from staff, service users, carers' and others box
These support and illustrate the information in the report

This is a 'Comments' box
These include quotes from regulators and other governing bodies

A full list of the acronyms (abbreviations) we use are provided at the end of the Report.

Hertfordshire Partnership University NHS Foundation Trust

We provide mental health and learning disabilities inpatient care and treatment in the community for young people, adults and older people in Hertfordshire, along with:

- Learning disability services in Buckinghamshire
- Improving Access to Psychological Therapies (IAPT) services in north Essex in partnership with as follows:
    - West Essex with Mind west Essex
    - Mid Essex with Chelmsford Counselling Foundation and mid and north east Essex Mind
    - North east Essex with north east Essex Mind.
- Forensic and learning disability service in Norfolk
- Since November 2018, we have been the lead in a partnership with Essex Partnership University Trust and Anglia Community Enterprise to deliver a new model of specialist health services for people with a learning disability across all of Essex.

Our Vision:
Delivering *great care,* achieving *great outcomes* - together

Our Mission:
We help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well

Our principles

We provide services that make a positive difference to the lives of service users and their carers and which are underpinned by the principles of choice, independence and equality.

"Supporting, professional and very dedicated…"

Our Strategy

Our *Good to Great* Strategy (2016-2021) describes how we are delivering our vision of *'Delivering Great Care, Achieving Great Outcomes – Together'.*
Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we will consistently achieve the outcomes that matter to those individuals who use our services and their families and carers, by working in partnership with them and others who support them. Furthermore, it means we keep people safe from avoidable harm, whilst ensuring our care and services are effective. That they achieve the very best clinical outcomes, support individual recovery and are of the highest quality.

Our *Good to Great* Strategy demonstrate the key areas of focus for the Trust, in terms of the people, the organisation and partnerships. It focuses on the three domains of service user quality – safety, effectiveness and experience. Through providing consistently high quality care that is joined up, individuals will be supported and empowered to recover and to manage their mental and physical wellbeing. This will enable us to achieve our mission – *'We will help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well.'*

Quality Strategy

Our Quality Strategy, which we launched during quarter 2, sets the direction for the delivery of quality services within the Trust for the next 5 years. It supports and builds upon our proven delivery of high quality services, whilst supporting our ambition for a continuous improvement of services and sustainable growth.

With the aim to put quality right at the heart of everything we do in order to deliver our *Good to Great Strategy,* it ensures that quality services are delivered in the Trust in response to the specific requirements of our service users, carers, our staff, the public, our commissioners and regulators.

It has been developed through reviewing the Quality and Service Delivery Strategy and a number of consultations and its aim is to deliver *Great Care and achieve Great Outcomes together*. It sets out 3 objectives under each of the 3 quality domains and provides details of what this will mean to our staff, service users and carers.

- **Safe**
  - Delivering safe care in top quality environments
  - Fostering a learning and just culture
  - Fostering a culture of safety
- **Effective**
  - Delivering evidence based care which is benchmarked nationally
  - Delivering recovery focused care and clinical outcomes
  - Continuously improving quality
- **Experience**
  - Responsive and accessible services
  - Embedding shared decision making
  - Co-production at the heart of service development.

In 2019/20 we continued to provide:

We provide mental health and learning disabilities inpatient care and treatment in the community for young people, adults and older people in Hertfordshire, along with:

- Learning disability services in Buckinghamshire
- Forensic and learning disability services in Norfolk
- We are the lead provider in partnership with Essex Partnership University Trust and Anglia Community Enterprise delivering a new model of specialist health services for people with a learning disability across Essex.
- Improving Access to Psychological Therapies (IAPT) services in north Essex in partnership with:
  - Mind in West Essex in west Essex
  - Chelmsford Counselling Foundation and Mid & North East Essex Mind in mid Essex
  - Mid & North East Essex Mind in north east Essex.

Across our 89 sites, we employed approximately 3,332 permanent staff, with 161 on a fixed term/temporary contract and 727 bank staff, and budgeted to spend c. £251.7m on our services.

We aim to deliver *great care* and *great outcomes* and are keen to share information about the quality of our services and how we are working to improve these. This report is one of the many ways in which we share information.

Our Partnerships

Our partnership with Hertfordshire County Council helps us to develop an approach based on a holistic assessment of each service user's health and social care needs, which focuses on recovery. Working in partnership with the Council also means we can help improve integration between mental health, physical wellbeing and social care services.

We also work with other NHS partners, including Hertfordshire Community NHS Trust (HCT), Central London Community Healthcare NHS Trust (CLCH) East and North Hertfordshire NHS Trust, West Herts Hospitals NHS Trust and East London NHS Foundation Trust (ELFT) (which sub-contracts us to provide the Hertfordshire Liaison and Diversion Service), as well as the following:

- MIND – Predominantly across our IAPT services providing Support Time and Recovery Workers, Counselling and Dynamic Interpersonal Therapy (DiT). They also assist with the New Leaf service
- Mental Health Matters – in relation to Employment Advisors in IAPT as part of the Department of Working Pensions (DWP) Initiative

- Growing People – horticultural therapy project for service users being looked after by Adult Mental Health Services at Lister Mental Health Unit in north Hertfordshire
- Reinvent Lifestyle – providing bespoke exercise to improve and maintain wellness
- Princes Trust – provision of employment and vocational support to service users with a diagnosis of First Episode Psychosis (FEP)
- IESO ~~for~~ provide additional Step 3 IAPT support with online therapists
- CHS Healthcare – providing Continuing Health Care (CHC) assessments and reviews for older adults
- BEAT – A National Eating Disorders charity commissioned to deliver a coaching and support service for CYP called 'Echo' which tackles isolation through Beat's network of telephone support coaches for families devastated by eating disorders.
- HEALIOS – online provider commissioned to pilot online ADHD assessments and post diagnostic support for Children and Young people (CAMHS).

We lead a partnership with Essex Partnership University Trust and Anglia Community Enterprise to deliver a new model of specialist health services for people with a learning disability across all of Essex.

As a University Trust, our close links to the University of Hertfordshire mean we can contribute to clinical research, and offer our staff excellent learning and development opportunities.

What is a Partnership University Foundation Trust?
NHS Foundation Trusts are not-for-profit, public benefit corporations. Like the rest of the NHS, they provide free care based on need, not ability to pay. Foundation trusts have freedom to decide locally how to meet their health care obligations, are. These trusts are accountable to local people, who can become members and governors and are authorised and monitored by an independent regulator. HPFT is a *Partnership Trust*; meaning we provide health and social care for specific groups of people – people with mental and physical ill-health, and those with learning disabilities – in partnership with local authorities, the University of Hertfordshire and with the mental health charity, Mind.

Our Commissioners

As a Trust, we continue to work closely with many organisations that commission and pay for our services. These include both the County Council and the CCGs.

What is Commissioning?
Commissioning is the process of planning, agreeing and monitoring services. The groups:
• assess the health needs of their local population
• plan care pathways for people with specific health problems
• specify which services their local populations need
• negotiate contracts with the organisations that provide these services
• make sure the services those organisations provide are good enough.

As a Trust, we have services commissioned by each of the following:

- East and North Hertfordshire CCG
- Herts Valleys CCG
- Hertfordshire County Council (HCC)
- Cambridge and Peterborough CCG
- North east Essex CCG
- Mid Essex CCG
- West Essex CCG
- Basildon and Brentwood CCG
- Southend CCG
- Thurrock CCG
- Castle Point and Rochford CCG

- Norwich CCG
- South Norfolk CCG
- North Norfolk CCG
- West Norfolk CCG
- Great Yarmouth and Waveney CCG
- NHS England Midlands and East
- Barnet CCG
- London Borough Hillingdon CCG
- Buckinghamshire CCG.

Of the Nationally Commissioned Services that NHS England commissions, the Trust delivers on the following Specialist Services:

- Tier 4 CAMHS
- Perinatal Services
- Low Secure Mental Health
- Medium and Low Secure Learning Disabilities
- Highly Specialist Obsessive-Compulsive Disorder (OCD) and Body Dysmorphic Disorder Service.

This report

If you have any questions about the content in this report, would like to comment on it or want to know more about the Trust, please contact Jacky Vincent, Deputy Director of Nursing and Quality/Director of Infection Prevention and Control (DIPC) jacky.vincent@nhs.net

This Quality Account Report was signed and approved on [date] and is available on the NHS Choices website *www.nhs.uk* and on our website: *www.hpft.nhs.uk*

If you would like a paper copy of this report, or to see it in other formats, please call our Communications team on 01707 253902, or email Helen Bond: *comms@hpft.nhs.uk*.

Freedom to Speak Up

Speaking Up is when a staff member reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. A staff member can report things that are not right, are illegal or if anyone at work is neglecting their duties, including:

- An individual's health and safety is in danger
- Damage to the environment
- A criminal offence
- The company is not obeying the law (breach of legal obligation)
- Covering up any wrongdoing.

If preferable, a concern may be raised from a distance by contacting the Freedom to Speak Up Guardian, Ethel Changa by:

- Email - hpft.speakup@nhs.net
- Telephone - 01727 804100 on the confidential "Speak Up" Line
- In writing - to the Chief Executive or any senior person stating the concern
- The Trust's incident reporting system (Datix).

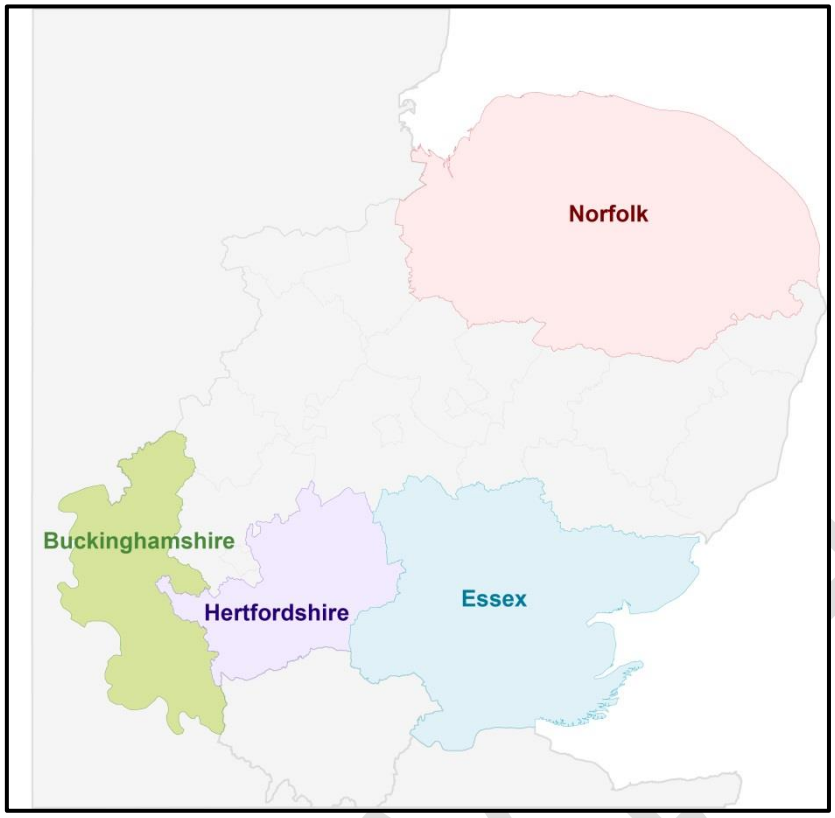
The Trust's nominated "Speak Up Champion" is Diane Herbert, a Non-Executive Director on the Board.

The Trust in 2019/20	
	**Mental Health,** Community and Learning Disability Services for children and adults
	**258,323** secondary care contacts
	**59,073** referrals through **SPA**
	**20,205 IAPT** contacts
	**137,631** occupied bed days
	**86% would recommend us** to friends and family
	**4,220 (permanent and temporary) Staff** working across **36 Trust** sites

What is SPA?
The Single Point of Access (SPA) is the telephone clinical triage service for all new referrals into the Trust. This service was set up in 2013 to ensure that that there was a single point of contact to access any our mental health care services, and it makes sure that service users are referred to the right service straight away.

"Brilliant that you can self-refer. Phone calls tailored around my work schedule – great!"

What is IAPT?
IAPT is the government's Improving Access to Psychological Therapies initiative. Our IAPT Service is part of this and aims to reduce distress and improve general mental health through teaching coping strategies based on Cognitive Behaviour Therapy (CBT). CBT is an evidence-based psychological therapy recommended by the National Institute for Health and Care Excellence (NICE). It offers service users effective techniques and skills to manage distressing emotions. The Wellbeing Service is made up of a range of clinicians and mental health professionals who deliver treatment in a variety of flexible ways.



Part 2 – Priorities for Improvement and Statement of Assurance from the Board

We are committed to delivering great care and great outcomes for our service users. To help us achieve this, we work in partnership with other organisations, for example to identify areas for improvement. These fall into three categories:

- Patient (service user) Safety
- Clinical Effectiveness
- Patient (service user) Experience.

This part of the report sets out:

- The priorities we have identified for 2020/21 and how we decided on these
- Statements of assurance from our Trust Board
- How we performed in our priority areas during 2019/20.

In this report we show:

- How we performed in our priority areas during 2019/20
- An update on how we performed against the priority areas we identified in our 2018/19 Quality Report
- Describe our priority areas for 2020/21
- Showcase notable and innovative practices that we have introduced across our services during the past year.

What is assurance?
Data quality assurance is the process of ensuring that data is as accurate, relevant and consistent as it can possibly be.

2.1 Quality priority areas for 2019/20

The table below provides an overview of our quality priority areas from last year (2018/19) and how we performed during this financial year, divided into each quarter throughout the year, and then the year end.

Patient (service user) Safety		Target	Q1	Q2	Q3	Q4	2019/20
1	The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	≥=95%	98.41%	96.99%	97.86%	98.70%	97.97%
2	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)	N/A	Reported Annually				
3	Inappropriate out-of-area placements for adult mental health services (NHSI)	150	276*	172	554	1170	2172
Clinical Effectiveness							
4i)	Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI) The percentage of service users aged: **0 to 15**	≤=7.5%	0%	0%	0.3%	0.3%	0%
4ii)	**16 or over**	≤=7.5%	7.4%	7.0%	7.1%	5.1%	6.7%
5	Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)	≥=56%	78.67%	79.41%	70.77%	77.97%	76.78%
6	The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)	≥=95%	96.92%	96.98%	96.80%	97.22%	96.97%
Service User and Carer Experience							
7	Carers feeling valued by staff	≥=75%	76.00%	82.89%	80.26%	85.39%	80.94%
8	Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family	≥= 70%	83.33%	81.01%	**N/A**	83.14%	82.45%
9	The Trust's 'service user experience of community mental health services' indicator score with regard to a service user's experience of contact with a health or social care worker during the reporting period (NHSI)		7.3/10 – About the same as other Trusts				

The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period

The first few days following discharge can be a vulnerable period of time in an individual's life and we want to support their recovery in readjusting to life in their own community. We follow up every person who is discharged from our inpatient services within 7 days. This is usually through face to face contact; under exceptional circumstances this may be via telephone. Throughout 2019/20, we exceeded the 95% target for this indicator, with an average percentage of 98%.

Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)

All incidents that occur in the Trust are reported to the National Reporting and Learning System (NRLS) which is a central database of patient (service user) safety incident reports. All information is analysed to identify any hazards, risks and opportunities to continuously improve the safety of service user care. As a Trust we regularly review all levels of harm sustained to consider areas of learning and development, agree actions for implementation and also to share lessons learned as well as areas of good practice.

Inappropriate out-of-area placements for adult mental health services (NHSI)

The Government has set a national ambition to eliminate inappropriate out of area placements in mental health services for adults in acute inpatient care by 2020/21. An out of area placement is when an individual service user with assessed acute mental health needs requires a non-specialised inpatient care (commissioned by the CCG) is admitted to a unit that does not form part of the usual local network of services.

We as a Trust have a threshold level of placements that decreases each quarter. In 2019/20 this threshold was exceeded in 3 out of 4 quarters. This reflects the extreme pressure on mental health services over the last year and is in line with the national picture. We will always support an individual accessing a bed when this is indicated for their safety or their health and wellbeing. As a Trust, we would always take safety of our service users as a priority and admit a service user, locally or in an out of area bed, where clinically needed.

"She really helped me through my darkest of times, listened to me. It felt like she never judged me and was here to help. She told me different ways of thinking. Couldn't have done it without her."

Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI)

The percentage of service users aged:

0 to 15 and 16 or over

This indicator measures the percentage of admissions across all Trust services who have returned to hospital as an emergency within 28 days of discharge after an inpatient stay. It aims to measure our success as a Trust in helping individuals to recover effectively from illness. If an individual does not recover well, it is more likely that they will require hospital treatment again within 28 days following their previous admission. Thus, readmissions are widely used as an indicator of the success of healthcare in helping individuals to recover. In 2019/20 we had 2 readmissions of children and young people below the age of 16, giving an average of 0.1% of all people discharged. 111 people aged 16 and over had been readmitted within the year – 6.7% of all people discharged.

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)

Service users referred to the Psychosis, Prevention, Assessment and Treatment (PATH) Early Intervention in Psychosis (EIP) Service require a specialist assessment to ascertain their needs. The PATH service is required to offer an assessment within 14 days of referral to 56% or more of service users.

Our PATH service has a diverse workforce of registered nurses, social workers, associate practitioners, support workers, psychologists and consultant psychiatrists, all of whom are trained in specialist assessment for First Episode in Psychosis and who work together to offer rapid assessment to service users.

PATH is able to offer a flexible approach to assessment, contacting service users and carers as soon as the referral is received, to arrange a mutually suitable time and venue, within 14 days. Our PATH service recognises that referral to the team can be a difficult time for individuals and works to ensure our offer of assessment is coupled with opportunities to address concerns, answer questions and ensure people feel as comfortable as possible when meeting our staff. This flexible partnership approach offers service users and carers to work together with us around their assessment and reduces missed appointments. In 2019/20, we exceeded this target in every quarter, with an average of 77%.

The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)

A Crisis Assessment and Treatment Team (CATT) provide intensive support for people in mental health crisis in their own home. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. Teams are required to meet all of the fidelity criteria including gatekeeping all admissions to psychiatry inpatient wards and facilitate early discharge of service users. In 2019/20 we exceeded the target in every quarter, with an average of 97%.

"You helped me through the toughest time of my life and for that I will always be grateful. You were there every day for me and my family and I can't thank you enough."

Carers feeling valued by staff

This is one of the indicators around the Triangle of Care and relates to the question 'do you feel valued by staff as a partner in care planning' and sits in our internal quality dashboard as an indicator. It was also chosen by our Carer Council. In 2019/20 we exceeded the 75% target in every quarter, with an average of 81%.

Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family

The Staff Friends and Family Test score is a good indicator of how staff feel about the services they provide and their level of engagement. We aimed to improve our scores during 2019/20 by enabling an increased level of staff engagement and continuing to improve the levels of care we provide to service users. The information for this indicator comes from our 'Pulse Survey' which we ran in quarters 1, 2 and 4. We exceeded the 70% target in all 3 quarters, with an average of 82%.

The Trust's 'service user experience of community mental health services' indicator score with regard to a service user's experience of contact with a health or social care worker during the reporting period (NHSI)

The Community Survey was reviewed during 2018/19, which resulted in a different survey during quarter 1, than for quarters 2, 3 and 4. The new survey added a question for the

Trust's 'positive' value – previously no questions were counted for 'positive'. As the value score is a composite score across the Trust's five values, this change is likely to have affected the overall score the year. However, when we reviewed the data for the year, the outlier value is 'positive', which includes questions on supporting physical health and giving opportunity to involve people who are supporting service users. For 2019/20, the work of our Carers Plan will engage more with service users around how we can improve on our involving carers. We have quarterly targets regarding improvements in how people feel they have been supported around their physical health and included in our Annual Plan.

2.2 Priorities for Quality Improvement 2020/21

Our Board agreed our x key quality priorities for 2020/21 at the Board meeting on [date].

How we chose our Quality Priorities

We:

- consulted with stakeholders including service users, carers, staff, commissioners and others
- decided to continue to build on and monitor the work we did in 2019/20 and previous years that could potentially significantly improve our services.

What is the Trust Board?
The Trust Board is the board of directors responsible for overseeing the running and management of the Trust. It is made up of Executive Directors, including the Chief Executive, who are full-time senior staff, an independent Chairman and Non-Executive Directors who do not work within the Trust.

What is a stakeholder?
A stakeholder is a person or organisation with an interest in the Trust who should be involved in our decision-making processes.

The consultation process

We started by considering:

- the feedback we have received on the quality of our services in surveys, reports and other documents
- our stakeholders' (including our commissioners') priorities.

Our consultation included a presentation to the Council of Governors, requesting their opinion as to which quality areas the Trust should focus on in the forthcoming 12 months, as top key areas, aside to the nationally mandated quality indicators. During the period of time to we requested feedback, we went into Major Incident owing to the Covid-19 pandemic. This meant that we were unable to complete our consultation process as we have in previous years.

Selection and Monitoring

NHSI provides guidance on the detailed requirements for the Quality Account Report, within which our priorities cover three indicators from each of the three areas of service user quality – Safety, Effectiveness and Experience. 5 of these are mandated by NHSI as marked in the table below as (NHSI). Below details those indicators that are not mandated by NHSI and the reasons we have chosen them:

- Crisis Assessment and Treatment Team 4 hour wait to assessment – this reflects the timeliness of treatment for people in crisis

- Safeguarding Social Care Assessments – this demonstrates a quick and efficient decision making process to investigate when a safeguarding issue is raised, ensuring that we keep people safe
- Care Programme Approach (CPA) reviews within 12 months – the CPA approach provides an additional level of support and care for those who need it, and ensuring that people have a minimum of 12 monthly reviews, with all those who are involved in their care plays a key part in this
- The rate of service users saying they have been involved in discussions about their care – this demonstrates the extent to which our service users feel involved in their care and how we are working in a recovery-focussed way
- Carers reporting they feel valued by staff in the Trust – carers form a key part of the Triangle of Care with service users and staff. It is important to us that we hear their views and ensure that they feel valued by our staff
- Staff Friends and Family Test, staff who would recommend the Trust as a provider of care to their family and friends – a key test of our success is that our staff feel confident in the services that we provide. This question, which is part of our quarterly staff survey, provides us with this evidence.

The quality priority areas for 2020/21 agreed by the Trust Board are:

Patient (service user) Safety	
1	The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period (NHSI)
2	The rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)
3	Crisis Assessment and Treatment Team – 4 hour wait to assessment
4	Safeguarding – Social Care Assessments
Clinical Effectiveness	
5	The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reported period (NHSI)
6	The rate of service users saying they know how to get support and advice at a time of crisis (NHSI)
7	The percentage of service users aged: (1) 0 to 14, and (2) 15 or over. Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI)
8	Care Programme Approach (CPA) – reviews within 12 months
Service User and Carer Experience	
9	Service User experience in the community (NHSI)
10	The rate of service users saying they have been involved in discussions about their care
11	Carers reporting they feel valued by staff in the Trust
12	Staff Friends and Family Test – staff who would recommend the Trust as a provider of care to their family and friends

Detail of each priority

The Performance Team will report on all figures once a month for goals 1, 3, 5, 6, 8, 10, 11 and 12; quarterly for goals 4 and 7 and annually for goals 2 and 9. Data quality is important in ensuring the accuracy, validity and reliability of the KPIs. Where possible, the Performance Team will undertake work to ensure this. The Performance Team is internally and externally audited annually. Auditors check a sample of cases to ensure accuracy of the data being reported.

Name of Priority	PATIENT (SERVICE USER) SAFETY
Related NHS Outcomes Framework Domain and who will report on them	7 day follow-ups
Data Definition	All adult mental health inpatients should receive a follow-up face to face appointment (or in exceptional circumstances a phone call) to ensure their wellbeing, following discharge from hospital. The measurement is the percentage of people discharged who received a follow-up within 7 days, with the day following discharge counting as day 1.
How this data will be collated	Follow-ups are recorded on the EPR, Paris, and a report is extracted monthly for reporting purposes.
Validation	Validated between performance, SBU managerial staff and clinical staff.
Performance in Q1 to Q4 in 2019/20	**Q1**: 98.41% | **Q2**: 96.99% | **Q3**: 97.86% | **Q4**: 97.70% | **2019/20**: 97.97%
Performance in Q1 to Q4 in 2018/19	**Q1**: 96.05% | **Q2**: 97.11% | **Q3**: 97.81% | **Q4**: 96.61% | **2018/19**: 96.88%
Target (national)	95%

Name of Priority	PATIENT (SERVICE USER) SAFETY
Related NHS Outcomes Framework Domain and who will report on them	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)
Data Definition	The number and rate of service user safety incidents reported within the Trust during the reporting period and the number and percentage of such service user safety incidents that resulted in severe harm or death
How this data will be collated	The Safer Care Team upload data onto the National Reporting and Learning System (NRLS) which is a central database of service user safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of service user care
Validation	This data is validated via the NRLS which is managed by NHSI
Performance in Q1 to Q4 in 2019/20	**Q1**: Severe = 2 (0.14%) Death= 10 (0.73%) | **Q2**: Severe = 2 (0.14%) Death= 13 (0.94%) | **Q3**: Severe = 1 (0.07%) Death = 14 (1.11%) | **Q4**: Severe = 1 (0.08%) Death = 10 (0.82%) | **2019/20**: Severe = 6 (0.11%) Death = 47 (0.90%)
Performance in Q1 to Q4 in 2018/19	**Q1**: Severe = 10 (0.7%) Death = 12 (0.9%) | **Q2**: Severe = 2 (0.2%) Death = 20 (1.5%) | **Q3**: Severe = 0 (0%) Death = 15 (1.2%) | **Q4**: Severe = 2 (0.2%) Death = 6 (0.5%) | **2018/19**: Severe = 14 (0.27%) Death = 53 (1%)
Target (national)	

Name of Priority	PATIENT (SERVICE USER) SAFETY
Related NHS Outcomes Framework Domain and who will report on them	Service Users referred to our Crisis Assessment and Treatment Team (CATT) will be seen within four hours for an assessment.
Data Definition	The percentage of people referred to the CATT service who are seen within 4 hours of their referral.
How this data will be collated	Manually collated by CATT service and sent to Performance for reporting.
Validation	CATT Management

Performance in Q1 to Q4 in 2019/20	

Q1	Q2	Q3	Q4	2019/20
100%	100%	100%	100%	100%

Performance in Q1 to Q4 in 2018/19	

Q1	Q2	Q3	Q4	2018/19
100%	100%	100%	100%	100%

Target (contractual)	98%

Name of Priority	**CLINICAL EFFECTIVENESS**
Related NHS Outcomes Framework Domain and who will report on them	Safeguarding – Social Care Assessments Managers to make a decision to commence a safeguarding assessment within 48 hours of a concern being raised.
Data Definition	The percentage of safeguarding assessments that are commenced within 48 hours of a concern being raised.
How this data will be collated	TBC
Validation	TBC
Performance in Q1 to Q4 in 2019/20	

Q1	Q2	Q3	Q4	19/20
59.70	45.45	34.09	53.66	49.08

Performance in Q1 to Q4 in 2018/19	

Q1	Q2	Q3	Q4	18/19
84.54	88.54	61.64	43.96	70.59

Target	

Name of Priority	**CLINICAL EFFECTIVENESS**
Related NHS Outcomes Framework Domain and who will report on them	**CATT Gatekeeping (Mandated)**
Data Definition	The percentage of people who are admitted to our acute inpatient units who have been assessed by the Crisis Assessment and Treatment team prior to admission.
How this data will be collated	Collected manually by CATT teams
Validation	Validated by Service Line Lead and Senior Service Line Lead.
Performance in Q1 to Q4 in 2019/20	

Q1	Q2	Q3	Q4	19/20
96.92%	96.98%	96.80%	97.22%	96.97%

Performance in Q1 to Q4 in 2018/19	

Q1	Q2	Q3	Q4	19/20
97.10%	96.39%	97.28%	97.26%	97.02%

Target (National)	95%

Name of Priority	**CLINICAL EFFECTIVENESS**

Related NHS Outcomes Framework Domain and who will report on them	**Rate of Service Users saying they know how to get support and advice at a time of crisis**
Data Definition	The percentage of service users who respond positively to the question of whether they know how to get support and advice at a time of crisis as part of the Trust's Having Your Say Survey
How this data will be collated	Collated by an independent company on behalf of the Trust and reports made available
Validation	Sense checked by the lead for Service User Engagement and the Performance Improvement Team
Performance in Q1 to Q4 in 2019/20	

Q1	Q2	Q3	Q4	19/20
80.23%	89.56%	84.12%	87.43%	85.25%

Performance in Q1 to Q4 in 2018/19

Q1	Q2	Q3	Q4	18/19
N/A	77.51%	81.46%	90.44%	84.11%

Target (local)	83%

Name of Priority	**CLINICAL EFFECTIVENESS**
Related NHS Outcomes Framework Domain and who will report on them	**Readmission Rate (Mandated)** **Readmissions rate of all 0 – 15 year olds who have been an inpatient in our services** **Readmission rate of all 16+ people who have been an inpatient in our services**
Data Definition	The number of readmissions within 28 days of discharge expressed as a percentage of total discharges.
How this data will be collated	Collated from our Electronic Patient Record in the form of an automated report.
Validation	Validated by the Performance Improvement Team.
Performance in Q1 to Q4 in 2019/20	

0-15	Q1	Q2	Q3	Q4	19/20
	0.0%	0.0%	0.3%	0.3%	0.1%

16+	Q1	Q2	Q3	Q4	19/20
	7.2%	7.0%	7.1%	5.4%	6.7%

Performance in Q1 to Q4 in 2018/19

0 - 15	Q1	Q2	Q3	Q4	18/19
	0.2%	0.4%	0.4%	0.7%	0.3%

16 +	Q1	Q2	Q3	Q4	18/19
	4.7%	6.3%	5.2%	7.9%	6.0%

Target	7.5% (local target)

Name of Priority	**CLINICAL EFFECTIVENESS**
Related NHS Outcomes Framework Domain and who will report on them	**Care Programme Approach – reviews within 12 months**
Data Definition	The number of mental health service users who are on CPA and receive a review within a 12 month period.

How this data will be collated	Collated from our Electronic Patient Record in the form of an automated report.
Validation	Validated by the Performance Improvement Team
Performance in Q1 to Q4 in 2019/20	

Q1	Q2	Q3	Q4	19/20
94.35%	94.87%	96.57%	92.90%	94.66%

Performance in Q1 to Q4 in 2018/19	

Q1	Q2	Q3	Q4	18/19
96.05%	96.83%	96.85%	92.37%	95.55%

Target (Local)	95%

Name of Priority	**SERVICE USER AND CARER EXPERIENCE**
Related NHS Outcomes Framework Domain and who will report on them	**Service User experience in the community (Mandated)**
Data Definition	Service user experience of nursing and social care staff, taken from the published National Service User Survey.
How this data will be collated	Collated by company who run the National Survey and published on CQC website
Validation	Validated nationally
Performance in Q1 to Q4 in 2019/20	

Q1	Q2	Q3	Q4	19/20
				7.3/10

Performance in Q1 to Q4 in 2018/19	

Q1	Q2	Q3	Q4	18/19
				7.2

Target	No target set

Name of Priority	**SERVICE USER AND CARER EXPERIENCE**
Related NHS Outcomes Framework Domain and who will report on them	**Rate of Service Users saying that they have been involved in decisions about their care**
Data Definition	The percentage of positive responses received from service users who complete the Having Your Say survey question, asking if they have been involved in decisions about their care.
How this data will be collated	Collated by an independent company on behalf of the Trust and reports made available
Validation	Sense checked by the lead for Service User Engagement and the Performance Improvement Team
Performance in Q1 to Q4 in 2019/20	

Q1	Q2	Q3	Q4	19/20
83.20%	89.02%	87.28%	84.13%	85.88%

Performance in Q1 to Q4 in 2018/19	

Q1	Q2	Q3	Q4	18/19
N/A	80.24%	86.86%	85.43%	84.38

Target (Local)	85%

Name of Priority	SERVICE USER AND CARER EXPERIENCE
Related NHS Outcomes Framework Domain and who will report on them	**Rate of Carers saying that they feel valued by staff in HPFT**
Data Definition	The percentage of positive responses received from carers who complete the Having Your Say survey question, asking if they have felt valued by staff in HPFT.
How this data will be collated	Collated by an independent company on behalf of the Trust and reports made available
Validation	Sense checked by the lead for Service User Engagement and the Performance Improvement Team
Performance in Q1 to Q4 in 2019/20	**Q1**: 76.00% | **Q2**: 82.89% | **Q3**: 80.26% | **Q4**: 85.39% | **19/20**: 80.94%
Performance in Q1 to Q4 in 2018/19	**Q1**: 73.42% | **Q2**: 81.18% | **Q3**: 81.82% | **Q4**: 84.85% | **18/19**: 80.24%
Target (Local)	75%

Name of Priority	SERVICE USER AND CARER EXPERIENCE
Related NHS Outcomes Framework Domain and who will report on them	**Staff who say that they would recommend the Trust's services to family and friends**
Data Definition	The percentage of positive responses from staff who complete the question in the Quarterly Pulse Survey asking whether they would recommend the Trust's services to family and friends.
How this data will be collated	Collated by a private company on behalf of the trust and reports made available
Validation	Sense checked by HPFT Workforce and OD Team
Performance in Q1 to Q4 in 2019/20	**Q1**: 83.33% | **Q2**: 81.01% | **Q3**: N/A* | **Q4**: 83.14% | **19/20**: 82.45%
Performance in Q1 to Q4 in 2018/19	**Q1**: 74.65% | **Q2**: 76.21% | **Q3**: N/A* | **Q4**: 76.85% | **18/19**: 75.81% *Survey did not run in Q3 as this coincides with the National Staff Survey
Target (Local)	70%

How these targets will be monitored

We will measure and monitor our progress on the implementation of each quality throughout the year. There will be additional audits to ensure that the data collected is reliable and valid.

What does reliable mean?
If data is reliable then it gives a consistent result. This means that if someone else was to collect the same information in the same way, the results would be the same.

What does valid mean?
If data is valid then it measures what it is supposed to measure.

We have put a robust reporting framework in place to make sure we keep progressing and can address any challenges that arise as early as possible. We will:

- report our results to our Board and our commissioners every quarter at our Quality Review Meeting
- engage with our key stakeholders to discuss our progress throughout the year.

Once the Board has agreed targets, we will develop plans to ensure that these priorities are achieved and progress monitored quarterly.
We will report progress towards targets through our Governance structures. Our Performance Team will check and assure the quality and accuracy of our data in accordance with Trust policies.

2.3 Statements of Assurances

This section of the report explains how we have provided assurance in relation to the services it provides. This is demonstrated through clinical networks, audit and our CQC inspection report. We have reviewed all the data available to us relating to the quality of care we provide in these services. Our total income from service users activities was c. £254.2m and out total income was c. £264.5m (including Provider Sustainability Fund (PSF) expected of £2.3m), thus 96%.

Clinical Audits

Our Practice Audit and Clinical Effectiveness (PACE) team leads on our clinical audit work, offering guidance, support and assurance for quality and service improvement.

At the start of each financial year, our PACE team consults with our leaders and managers to develop a programme of audits. This includes the audits that every NHS Trust is required to complete, those needed to monitor our contractual arrangements, and those requested by our teams to assess and improve the quality of their own work.
When an audit is completed, we develop an action plan so that we can make and monitor improvements to our services. Our Practice Audit Implementation Group (PAIG – members include the Deputy Medical Director, Chief Pharmacist and representation from other clinical disciplines) discuss and approve the reports. We then share them throughout the Trust so everyone can learn from the results.

What is a clinical audit?
Clinical audit is a way to find out if healthcare is being provided in line with standards and tells care providers and patients where their service is doing well, and where there could be improvements.

The aim is to allow improvements to take place where they will be most helpful and improve outcomes for service users.

National Clinical Audits

Participating in Healthcare Quality Improvement Partnership (HQIP) programmes and quality accreditation programmes helps us compare our performance against other mental health trusts across the country. This not only helps us to benchmark our performance, but also gives us an opportunity to provide assurances that our services are continuously striving to reach the highest standards set by the professional bodies, such as The Royal College of Psychiatrists and the National Prescribing Observatory for Mental Health (POMH-UK).

During 2019/20, there were 5 national clinical audits covered relevant health services that the Trust provides; the Trust participated in 100% of all national clinical audits it was eligible to participate in. These are as follows:

- The National Audit of Inpatient Falls (NAIF)
- POMH-UK Prescribing for Depression in Adult Mental Health
- POMH-UK Use of Depot/ LAI Antipsychotic Injections for Relapse Prevention
- National Audit of Schizophrenia (FEP)
- National Intellectual Disability Audit of ADHD in Intellectual Disability.

National Audit	Trust Participation	
	Number of cases required by the terms of the audit	Number of Cases Submitted by HPFT
The National Audit of Inpatient Falls (NAIF)	TBC	TBC
POMH-UK Prescribing For Depression in Adult Mental Health	Information not available within HPFT	134
POMH-UK Use of Depot/ LAI Antipsychotic Injections For Relapse Prevention	Information not available within HPFT	159
National Audit Of Schizophrenia (FEP)	101	101
National Intellectual Disability Audit Of ADHD In Intellectual Disability	TBC	TBC

Reports from 2018/19 which were published in 2019/20

There were 5 reports which did not form part of the work stream in 2019/20, but were published in 2019/20. These have briefly been summarised below:

National Audit		Trust Participation	
	Year	Number of cases required by the terms of the audit	Number of cases submitted by HPFT
POMH-UK Topic 18a Use of Clozapine	2018/19	Not specified by POMH-UK	94
POMH-UK Topic 6d Assessment of the side effects of depot antipsychotic	2018/19	Not specified by POMH-UK	205
POMH-UK Topic 7f Monitoring of patients prescribed lithium	2018/19	Not specified by POMH-UK	92

POMH-UK Topic 19a Prescribing for depression in adult mental health services	2019/20	Not specified by POMH-UK	134
POMH-UK Topic 17b Use of depot/LA antipsychotic injections for relapse prevention	2019/20	Not specified by POMH-UK	Report due from POMH-UK March 2020
POMH-UK Topic 9d Antipsychotic prescribing in people with a learning disability	2019/20	Not specified by POMH-UK	Report due from POMH-UK July 2020

POMH-UK 18 – The use of clozapine

The practice standards set for this audit were derived from NICE Guideline CG178 'Psychosis and schizophrenia in adults: prevention and management'.
The eligibility criteria was any person under the care of adult mental health services, irrespective of age, who is currently prescribed clozapine treatment (ascertained, for example, from the monitoring system database). This audit was carried out in June and July 2018, with the report being published in February 2019.

What did we do well?

- 100% of Trust service users treated with clozapine for less than 18 weeks had documented pre-treatment general physical examination, blood pressure and pulse
- 80% of service users were registered for off-label use with the clozapine monitoring service when prescribed clozapine 'off-label' compared to TNS of 65%
- In 75% of service users, monitoring in the first 2 weeks of treatment included at least daily assessment of temperature, blood pressure and pulse
- There was documented weekly assessment of treatment-related side effects in patients treated with clozapine for between 4 and 18 weeks in 86% of service users compared to TNS of 74%.
- In 93% of cases service users who have been on clozapine for over a year had a review conducted by senior clinician within the last year (TNS 77%).
- Documented measure of blood pressure in the previous year for service users treated with clozapine for more than 1 year was 95% (TNS 85%); and for body weight, glycaemic control and plasma lipids it was 89% (TNS 63%). There was a documented general physical examination in the previous year in 72% cases (TNS 55%).

What are the areas for development?

In 50% of Trust cases there was no documented discussion with the service users, family and/or carers about potential benefits and side effects in service users treated with clozapine for less than 18 weeks.

- Documented pre-treatment measures of body weight, glycaemic control and plasma lipids in service users treated with clozapine for less than 18 weeks were only done 38% of the time compared to 64% TNS
- There was no documented discussion of the relevant issues with the service user and/or carer for service users prescribed clozapine 'off-label', compared to TNS 41%
- There was only a documented care plan addressing the implications for change in smoking status in known smokers who were discharged from a smoke-free ward (in service users treated with clozapine for between 18 weeks and one year) in 43% of cases, although this was better than TNS (32%)

- Only 26% of service users under the care of a community mental health team had treatment with clozapine documented in their Summary Care Record (SCR) or equivalent in primary care. This was worse than TNS (58%).

POMH-UK Topic 6d Assessment of the side effects of depot antipsychotic

Audit standards for this audit were derived from NICE guideline CG178 Psychosis and schizophrenia in adults: prevention and management (2014)
https://www.nice.org.uk/Guidance/CG178
The eligibility criteria was all service users prescribed continuing treatment with depot/long-acting injectable antipsychotic medication, other than those currently under the care of an acute ward or home treatment/ crisis intervention team.
This audit was carried out in September and October 2018, with the report being published in June 2019 and distributed to Trusts in July 2019.

What did we do well?

% results	HPFT	TNS
Total Sample size	N = 205	N = 8270
Documented evidence of side-effect assessment	94%	86%
Some evidence regarding weight and/or BMI and/or waist circumference	84%	61%
Total Sample size	N = 106	N = 4435
Side-effects identified, with a documented clinical intervention/plan	81%	65%

What are the areas for development?

% results	HPFT	TNS
Total Sample size	N = 205	N = 8270
Some evidence of the assessment of movement disorder	69%	47%
Documented evidence of physical examination	33%	20%
Documented evidence of blood tests	33%	21%
Documented evidence of a rating scale or checklist	42%	23%
Some evidence of the assessment of sexual side effects	44%	20%
Total Sample size	N = 36	N = 1189
Some evidence of the assessment of menstruation.	25%	25%

POMH-UK Topic 7f Monitoring of patients prescribed lithium

The Practice Standards were based on NICE guideline CG185 Bipolar Disorder: assessment and management (2014) https://www.nice.org.uk/guidance/cg185
The eligibility criteria only included service users currently prescribed lithium. The audit was carried out in February 2019 and the report published in July/August 2019.

What did we do well?

% results	HPFT	TNS
Total Sample size – before lithium initiation	N = 25	N = 918
Documented evidence that **renal function tests** (specifically e-GFR) were conducted	80%	86%
Documented evidence that **thyroid function tests** were conducted	80%	82%
Documented evidence that **weight or BMI measurements** were conducted	72%	62%
Documented evidence, at lithium treatment initiation, that they were informed of **side effects**	76%	65%
Documented evidence, at lithium treatment initiation, that they were informed of the **signs and symptoms of toxicity**	72%	46%
Total Sample size – maintenance treatment	N = 67	N = 4899
Serum lithium every 6 months (2 or more tests documented)	76%	81%

What are the areas for development?

% results	HPFT	TNS
Total Sample size – before lithium initiation	N = 25	N = 918
Documented evidence that a **serum calcium test** was conducted	52%	63%
Documented evidence that **an ECG** was conducted	56%	73%
Documented evidence, at lithium treatment initiation, that they were informed of the **risk factors of toxicity**	64%	44%
NPSA lithium patient information pack provided	44%	34%
Total Sample Size	N = 8	N = 342
Women <50 yrs – teratogenic s/e of lithium	50%	30%
Total Sample size – maintenance treatment	N = 67	N = 4899
Renal function tests (specifically e-GFR) every 6 months (2 or more tests documented)	69%	74%
Serum calcium every 6 months (2 or more tests documented)	28%	41%
Thyroid function tests every 6 months (2 or more tests documented)	69%	69%
Weight / BMI during the last year	63%	48%

All actions and the set recommendations from the above are being undertaken and are being regularly monitored by the PACE team. The report has been disseminated to teams who participated in the audit.

Results from National Audits

The report of 1 national clinical audit was reviewed by the provider in 2019/20; 4 reports have not been published at the time of writing this report and are expected during 2020/21. The results of the national audit that has been published is summarised below along with the actions that the Trust intend to take to improve the quality of healthcare provided.

POMH-UK Prescribing For Depression in Adult Mental Health

The audit standards are derived from the NICE clinical guideline; Depression In Adults: Recognition and Management (NICE, 2009) and the British Association for Psychopharmacology guideline for Treating Depressive Disorders with Antidepressants.

No	Practice Standards
1	Depression should be managed in primary care unless it is complex, severe, treatment-refractory, or places the patient or others at risk.
2	If antidepressant medication is stopped for whatever reason: • The dose should be reduced gradually • The patient should be informed about potential discontinuation symptoms
3a	Patients prescribed continuing antidepressant medication should have a care/crisis plan that: • Identifies potential triggers/precipitating factors that could lead to a worsening of their condition, including psychosocial stressors • Refers to strategies to manage such triggers
3b	For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing: • Therapeutic response to the medication including severity and frequency of depressive episodes • Medication adherence • Medication side effects • Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders.

No	Practice Standards
4	Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered: • Increasing the dose of antidepressant medication • Switching to another antidepressant medication • Combining continuing antidepressant treatment with high-intensity psychological/psychosocial interventions, such as individual CBT/interpersonal psychotherapy • Augmentation with another antidepressant medication • Augmentation with lithium • Augmentation with an antipsychotic medication • Augmentation with ECT treatment Please note that the inclusion of questions in this data collection tool that refer to 'off-label' prescribing should not be taken as an endorsement of the use of the relevant medication for depression.

No	Treatment Target
1	Clinicians should avoid prescribing dosulepin, trimipramine or T3 for depression.

The results indicate that for 9 of the audit standards, the Trust performed above the national average; these included documented evidence of assessment of medication adherence, medication side effects and assessment of co-morbid physical illness. In two areas, the Trust's results were below the national average; these were, documented evidence of symptoms being assessed using a formal rating scale and evidence of a comprehensive treatment.

What did we do well?

% results	HPFT	TNS
Documented evidence of an assessment of symptoms and severity of depression in the last year not using a formal rating scale	84%	76%
Documented evidence of assessment of response to medication	87%	83%
Documented evidence of assessment of medication adherence	89%	71%
Documented evidence of assessment of medication side-effects	86%	66%
Documented evidence of assessment of alcohol use	77%	52%
Documented evidence of assessment of substance use	73%	46%
Documented evidence of assessment of co-morbid physical illness	80%	71%
Documented evidence of assessment of mental illness	81	76
Prescribing of dosulepin, trimipramine or T3 for depression	<1%	<1%

What are the areas for development?

% results	HPFT	TNS
Evidence of reference to strategies to manage triggers for the illness	70%	66%
Documented evidence of symptoms being assessed using a formal rating scale	5%	8%
Documented evidence of a comprehensive treatment history	40%	48%

The learning from participating within this audit has been shared widely across the Trust's services and discussed at the Drugs and Therapeutic Committee.

National Clinical Audit of Anxiety and Depression – Core Audit

The National Clinical Audit of Anxiety and Depression was developed following the findings of the National Audit of Psychological Therapies for Anxiety and Depression (NAPT) which took place between 2010-2014. The NCAAD was developed to look at the care and treatment of service users with a primary diagnosis of an anxiety and/or depressive disorder within secondary care services. The audit was managed by the Royal College of Psychiatrists' (RCPsych) Centre for Quality Improvement (CCQI).

What did we do well?

- Physical health monitoring are all above the national average
- Outcome measures were captured above the national average
- Service users were regularly followed up following discharge either in line or above national standards

What are the areas for development?

- Service users are not being referred to psychological services as frequently as national average
- Not all elements of the Discharge processes have been completed, in particular areas such as discharge letter containing details of risk to and self and/or others and providing 24 hours' notice of discharge to the carer.

A Dashboard has been developed on the Trust's reporting system which allows teams to closely monitor the input of key information on the electronic patient record (EPR). The Trust has developed a Carer policy and conducted training across the Trust, to ensure staff on the policy and implementation of the Triangle of Care. A new referral form has been developed which aims to make clearly indicate what psychological therapies that service users are receiving.
A deep dive is scheduled to take place to review the current skillset of psychology in regards to offering psychological therapies in line with NICE guidance and identify any challenges which the Trust are encountering in respect to referring service users for psychological therapies. The Trust will form a working group to agree outcome measures to measure anxiety and depression. A quarterly audit will take place focussing on the timeliness of communication with the GP following discharge.

National Clinical Audit of Anxiety and Depression – Psychological Therapies

This National Clinical Audit on Anxiety and Depression Spotlight Audit on Psychological therapies informed by the results of a previous National Audit of Psychological Therapies (NAPT), which ran between 2010 and 2014. The Audit looked to be conducted in 3 parts, a case note audit, service user feedback survey and therapist feedback survey.

What did we do well?

- 78% of service users started treatment within 18 weeks of referral
- 74% of service users felt that the wait to start treatment was reasonable
- Recording of demographic data was greater than the NCAAD average. Trust compliance ranged from 72% to 100%
- Average wait for psychological therapy was 13 weeks which is shorter than the NCAAD average of 22 weeks
- 90% of service users agreed that they were treated with empathy, kindness, dignity and respect.

What are the areas for development?

- 60% Service users agreed that they were able to get to the appointment location without too much difficulty which is lower than the NCAAD average (81%)
- 36% of service users were offered the choice of therapy they would receive and venue where it would take place. This is lower than the NCAAD average of 47%.

The actions from the audit included, informing teams of audit findings and lessons that have derived from the audit, implementing the Psychological Development programme and development of the psychological therapy referral form.

National Clinical Audit Psychosis (NCAP) Early Intervention Psychosis (EIP) Spotlight Audit (CQUIN)

In 2016, NHS England introduced the Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016). This is designed to improve access to EIP services for people experiencing First Episode Psychosis (FEP), ensure the provision of evidence-based treatments, and monitor patient outcomes. It also requires services to take part in a national quality assessment and improvement programme. In 2018/2019, it was carried out as a spotlight audit by the National Clinical Audit of Psychosis at the RCPsych.

What did we do well?

- High compliance demonstrated in the screening for smoking (99%), alcohol (99%) and substance misuse (99%)
- High compliance demonstrated in the interventions offered for smoking (100%), alcohol (100%) and substance misuse (94%)
- Approximately 85% of treatment started within 2 weeks of referral.

What are the areas for development?

- 5% of service users in the sample had taken up family interventions
- 18% of service users in the sample had taken up supported employment and education programmes.

Since the completion of this audit, the Trust has developed a service improvement plan. The plan includes devising a report for those in the First Episode of Psychosis audit which will enable data to be monitored across the service. Furthermore as part of the implementation of the report, the service have conducted a series of training sessions programme for PATH clinicians including understanding the new monitoring places in place, and ensuring that the clinicians are able to enable effective delivery of the FEP pathway. The service developed clear PATH assessment templates to promote clear recording of clinical decision making at the end of the assessment, clarifying eligibility for and acceptance into service or signposting actions.

Physical Health Monitoring of Cardio metabolic Assessment & Treatment for Patients with Psychosis

The Trust participated in this national audit and results have highlighted that the Trust is performing above the national average in both its inpatient and community service. This is an important audit topic to monitor as people with severe mental illness (SMI) are at increased risk of poor physical health, and their life expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking.

What were the findings?

	Target	Our Compliance	National Average
Inpatients	90%	78%	56.5%
Community CPA	75%	74%	48.8%

Following on from the audit, a comprehensive action plan is in place which includes a re design of the psychosis pathway incorporating physical health monitoring. The action plan also incorporates staff training and a physical health tracker for continuous monitoring.

Local Clinical Audit

As of February 2020, the PACE team have reviewed the reports of 117 local clinical audits during 2019/20. 56 were undertaken by the PACE team, as part of their annual programme and 61 were local audits registered with the PACE team by clinicians throughout the Trust. We undertook the following actions to improve the quality of healthcare provided:

- During 2019/20 the PACE team consulted with services, senior management and the Medical Director to develop and launch a Trust quality dashboard on SPIKE 2. This has enabled services from across the Trust to view key quality indicators and assess current compliance levels including benchmarking national audit results against other Trusts
- The PACE team have developed a system for monitoring and disseminating compliance figures in relation to the completion of action plans from audits. The PACE team, alongside services, are working to ensure a higher return rate in terms of actions being completed following audit. During 19/20 the Trust wide evidence implementation has risen from 56% to 70% as of December 2019
- During 2019/20, the PACE team have rolled out their new Intranet page on HIVE, allowing staff to search for completed audits by service type, enabling access to all audits at a click of a button
- The Trust celebrated Clinical Audit Awareness Week in November 2019 where services from around the Trust had the opportunity to send in their pledge cards on what clinical audit means to them and how clinical audit has benefited their service
- To continue to encourage services to conduct more clinical audits locally, the PACE team continue to provide generic and bespoke based audit training for staff
- The PACE team also continue to work closely with both the Service User and the Carer Councils to ensure that audits gain there unique perspective in order to increase richness within audit findings and action plans.

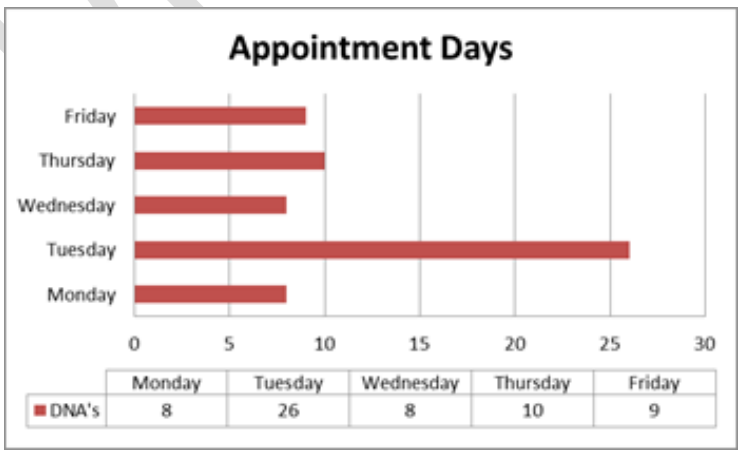
Towards the end of 2019, the PACE team were audited externally, the objective of the review was to assess the effectiveness of the Trust's clinical audit function, in particular, compliance with the Trust's Practice Audit Policy. The audit results found that clear action plans had been agreed for each audit and documented using standard audit documentation as required by the Practice Audit Policy. Each recommendation within audit reports had an associated 'SMART' action, a planned completion date, responsible owner, and an intended outcome. The PACE team have traced the actions and evidence of action completion as documented within the action plan templates to the PACE team internal audit database without exception. The overall findings were that the Trust Board could take reasonable assurance that controls are in place to undertake an effective audit programme.

Where audits said we did well

The full details of all these audits are beyond the scope of this report but detailed below are examples of the results that were found.

Early Memory Diagnosis & Support Service (EMDASS) Did Not Attend Audit

The audit analysed the number of service users that Did Not Attend (DNA) pre-booked appointments within the EMDAS service between the months of April to June 2019. The audit looked at the reasons for DNAs and trends for when these DNAs occurred.



Most DNAs occurred on a Tuesday across all 4 EMDAS services.

What did we do well?

- The findings found the total number of DNAs across 3 months for the EMDAS services was 8%, this equates to 60 from 759 pre-booked appointments.

What are the areas for development?

- Clear recording of the reasoning behind the DNAs taking place on the EPR system was found in 40 of the 60 cases

In order to improve the recording of reasons for DNAs, staff have been reminded of the importance of documenting and using the appointment booking system appropriately on the EPR.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

This audit looked at the recording of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms for service users on all of the older aged adult inpatient wards.

What did we do well?

- Number of service users with an 'Alert' on PARIS to indicate the service user has a DNACPR in place was found at 100% (59/59)
- DNACPR documented in the care plan was found in 93% (55/59)
- Inpatient wards have a Patient Status at a Glance (PSAG) board which includes vital information about the service users currently on the ward, in 97% (57/59) cases the DNACPR information had been recorded correctly.

What are the areas for development?

- The number of DNACPR forms in the paper records was found in 90% (53/59) of cases
- The number of DNACPR forms scanned onto PARIS was found at 90% (53/59) of cases.

The action plan devised post audit focussed on the areas which could be improved upon by reminding staff to scan DNACPR forms onto PARIS and to retain paper forms in service user folders.

Seclusion Trust wide Audit

This audit looked at the supervised confinement and isolation of a service user away from others, in an area from which the service user is prevented from leaving where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm.

What did we do well?

- Evidence of an on-call manager being notified post seclusion in 98% (65/66) of cases
- Evidence of interventions being documented prior to seclusion was found in 95% (63/66)
- Consistent medical reviews taking place where required in 100% (37/37)
- Evidence of 2 hourly nursing reviews taking place was found in 97% (64/66)
- Evidence of nursing observations carried out throughout seclusion was found in 98% (65/66)
- Evidence of a Post Incident Review was found in 98% (65/66).

What are the areas for development?

- Evidence of an internal Multi-Disciplinary Team review taking place was found in 55% (36/66).

Actions which were implemented following this audit included the development of a seclusion form on the EPR system. Findings of the audit have been shared widely with services in order to improve any shortfalls.

Formulations and Care Planning Approach (CPA) Recording for Forest House Admissions (CAMHS Inpatient Service)

The purpose of the audit was to assess if appropriate NICE interventions and approaches were being incorporated into care plans. The audit has also considered the quality of documentation enabling formulations to be drawn.

What did we do well?

- A biopsychosocial assessment was conducted in 100% (30/30)
- The biopsychosocial assessment included the following in 100% of cases; Current mental state, Physical Health, Family Support, Living Situation and Education/Employment
- Evidence of the care plan being developed with the young person was found in 100% (30/30)
- A risk assessment was completed during admission in 100% (30/30)
- A CPA was conducted in 100% (30/30)
- Care Plans included NICE talking interventions in 100% (30/30).

What are the areas for development?

- A CPA being conducted within 5 working days for emergency admissions was found in 88% (7/8)
- Care plans including the young person's goals and wishes where appropriate 90% (27/30)
- Formulations including the needs and difficulties identified 90% (27/30).

The action plan included sharing the findings with the Child and Adolescent Mental Health Services (CAMHS) and consideration of a standard template to capture assessments.

Research and Development

The audit looked at informed consent given by service users for clinical research and was carried out as a re-audit of a previous Trust audit carried out in 2018 to monitor if there had been an increase or decrease in Trust compliance.

What did we do well?

- A copy of the informed consent form being attached to PARIS, this increased from 64% (16/25) in the 2018 audit to 100% (17/17) in this cycle
- A copy of the patient information sheet being attached to PARIS, this increased from 32% (8/25) in the previous cycle to 100% (42/42).

What are the areas for development?

- Documentation of discussions of research projects with clinicians were found on PARIS in 81% (34/42), although this rose from the previous cycle there is still a margin for improvement here.

Actions which were implemented following this audit included regular reminder emails being sent to clinicians involved in research projects.

Where audits said we need to improve

Older aged adult inpatient supervision audit

This audit looked at the supervision of staff on the older aged adult inpatient wards. This audit was conducted in December 2019. We undertook this audit as good quality supervision supports high quality clinical practice.

	Standard	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Overall Compliance
1	Is the last supervision signed by both supervisee and supervisor?	5/7 **(71%)**	2/4 **(50%)**	6/7 **(86%)**	6/6 **(100%)**	1/8 **(13%)**	20/32 **(63%)**
2	Does the supervision cover clinical supervision? i.e. adherence to section 2.3 of the policy (Page 25 of policy)	4/5 **(80%)**	2/3 **(67%)**	2/5 **(40%)**	2/4 **(50%)**	1/7 **(14%)**	11/24 **(46%)**
3	*Does the supervision cover reflective supervision? i.e. adherence to 2.4 of the policy (Page 25 of policy)*	4/5 **(80%)**	2/3 **(67%)**	4/5 **(80%)**	3/4 **(75%)**	1/7 **(14%)**	14/24 **(58%)**
4	Does the supervision cover management supervision for OT's? As per the policy 2.1 (Appendix 8 of policy)	2/2 **(100%)**	1/1 **(100%)**	2/2 **(100%)**	2/2 **(100%)**	**N/A** *(OT refused review of Notes)*	7/7 **(100%)**
5	Does the supervision cover clinical supervision for OT's? As per the policy 2.2 (Appendix 8 of policy)	2/2 **(100%)**	1/1 **(100%)**	2/2 **(100%)**	2/2 **(100%)**	**N/A** *(OT refused review of Notes)*	7/7 **(100%)**
6	Does the supervision incorporate the headings of template Appendix 5 as per supervision policy?	7/7 **(100%)**	2/4 **(50%)**	7/7 **(100%)**	6/6 **(100%)**	0/7 **(0%)**	22/31 **(71%)**

What are the areas for development?

- There had been a 3% fall in the number of staff, knowing the name of their supervisor, from 97% (31/32) in the audit undertaken in August to 94% (30/32) in this cycle
- The frequency of supervision has fallen from 91% (29/32) in August audit to 84% (27/32) in this audit
- The auditor could not find evidence of supervision having taken place throughout 2019 for 2 staff members.

The findings of the audit generated individual actions for each ward specifically tailored to the findings, these included recommending that staff attend supervision training, incorporating and encouraging the use of supervision templates and creation of a visually displayed spreadsheet which can be used as a staff reference and reminder of when supervisions are due.

Mental Health Act Section 136

Section 136 of the Mental Health Act 1983 provides police officers in England and Wales with the authority to remove individuals who appear to be suffering from a mental disorder and need to be in a place of safety for appropriate assessment.
The audit was carried out quarterly throughout 2019/20 and considers if documentation has been completed and displayed within the EPR. It also considers if legal timeframes have been adhered to.

The table below outlines the findings across each cycle.

Areas looked at		Cycle 1 (1 January- 31 March 2019)	Cycle 2 (1 April-30 June 2019)	Cycle 3 (1 July-30 September 2019)	Cycle 4 (1 October- 31 December 2019)
S136	Triaged with 1 hour of arrival	26% (61/234)	22% (55/248)	36% (72/200)	33% (64/193)
	Detentions exceeding 24 hours	14% (33/234)	24% (60/248)	34% (68/200)	32% (62/193)
	Evidence of S132 rights	76% (178/234)	84% (208/248)	94% (188/200)	N/A
(AMHP) Approved Mental Health Professional	Requests made prior to or within 1 hour of arrival	51% (105/205)	38% (84/220)	53% (100/188)	68% (121/178)
	Assessed within 3 hours of arrival	18% (37/205)	12% (26/220)	9% (17/188)	9% (16/178)
	Evidence of a casenote or completed AMHP report	84% (172/205)	83% (183/220)	81% (152/188)	82% (146/178)

Mitigation to improve these areas included sharing and presenting the findings to staff and clinical audit leads as well as weekly discussions being held with the Section 136 teams to ensure that paperwork is completed and accurately recorded.

Dementia Pathway

This audit was conducted to provide a baseline assessment of the implementation of the dementia pathway within older aged adult inpatient services. The pathway focuses on the EMDAS service.

What did we do well?

- Diagnosis being listed on PARIS which was found in 100% (22/22)
- The admission type being recorded in 100% (22/22).

What are the areas for development?

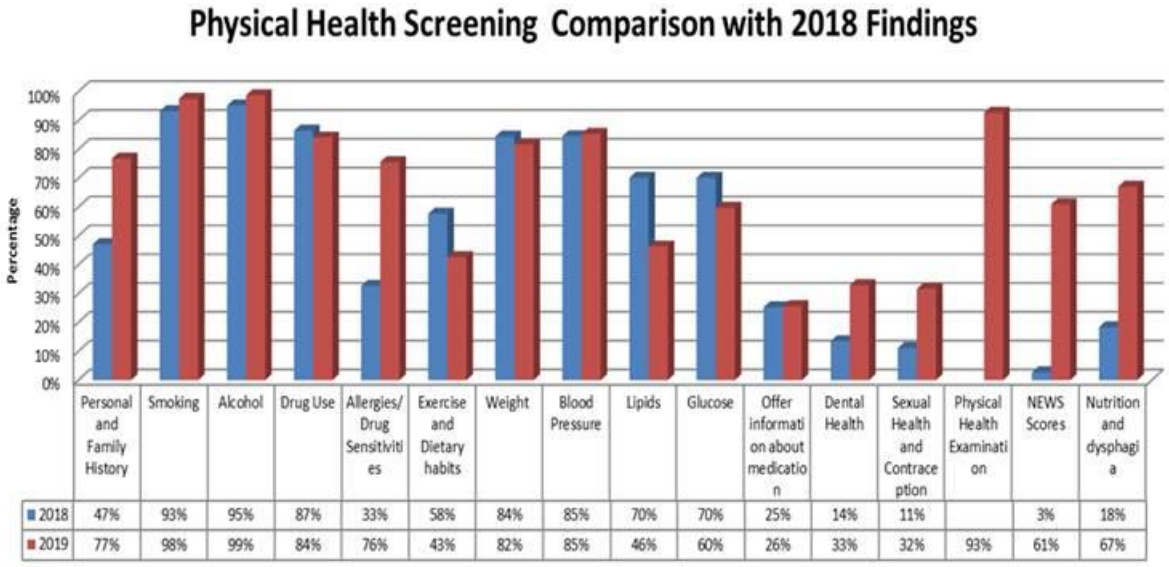
- Ceiling of Care forms being completed within 2 weeks of admission 2/22 (10%)
- Initial CPA and Discharge CPA taking place within suggested time limits 11/22 (50%)
- Recording capacity to consent to personal care 1/22 (5%)
- Capacity to consent to medication being documented 14/22 (64%)
- Falls Risk Assessment being recorded on PARIS 9/22 (41%)
- Nutrition and Dysphagia to be completed within 72 hours of admission 12/22 (55%).

To assist with improvements in practice, a checklist in the name of Ceiling of Care form will now be completed at initial CPA meetings. CPA templates have been circulated across the

older aged adult inpatient wards and a tracker will be used to improve completion of documentation.

Physical Health Monitoring on Admission

This audit reviewed practice against the Trust physical health policy. A similar audit was conducted in 2018 and this cycle makes comparisons to the previous cycle.



	Personal and Family History	Smoking	Alcohol	Drug Use	Allergies/ Drug Sensitivities	Exercise and Dietary habits	Weight	Blood Pressure	Lipids	Glucose	Offer information about medication	Dental Health	Sexual Health and Contraception	Physical Health Examination	NEWS Scores	Nutrition and dysphagia
2018	47%	93%	95%	87%	33%	58%	84%	85%	70%	70%	25%	14%	11%		3%	18%
2019	77%	98%	99%	84%	76%	43%	82%	85%	46%	60%	26%	33%	32%	93%	61%	67%

Although these results indicate some areas of good practice, the standard should be 100% across all criteria's and therefore it is clear that there is room for improvement.

What are the areas for development?

- Offer of information about medication being found and documented 26% (22/83)
- The recording of Lipids within 7 days of admission 46% (38/83)
- The recording of Glucose within 7 days of admission 60% (50/83).

The actions from the audit consisted of sharing findings with staff and staff being reminded of the importance of documenting when a physical examination has taken place on the EPR. To continue to monitor compliance and the effect of sharing the findings, a re-audit is scheduled to commence in 2020.

Research and Development

Our research portfolio is a key factor in our status as a University Trust and we continue to work at increasing the number of staff involved in research and development. We work closely with, and receive research funding from, the National Institute of Health Research (NIHR) and Clinical Research Network (CRN) Eastern to help us deliver and participate in high quality research studies. We collaborate with several academic institutions including the University of Hertfordshire, the University of Warwick and the University of Southampton. In June 2019, we jointly hosted a research showcase event on neuro-developmental disabilities with the University of Hertfordshire, which was well attended and had some excellent keynote speakers working in the field of intellectual disability. We have a research page on our Trust website detailing the studies we are currently recruiting to, as well as some recent research publications by our staff.

We are the host organisation for 3 significant research grants. The first is an NIHR award to investigate the feasibility of using Transcranial Direct Stimulation (tDCS) in the treatment of

Obsessive Compulsive Disorder (OCD). The second is also funded by the NIHR and will investigate the experiences of people with intellectual disability who have transitioned from care into community settings. And finally we have been funded by the British Medical Association (BMA) to carry out further exploratory work into the benefits of using 'Books Beyond Words' for people with Intellectual Disability who also suffer with epilepsy.

There is an obligation on all NHS Trusts to support the NIHR research portfolio and, over the last year, we have supported recruitment to 20 different research studies (an increase of 10% over the previous year). The CQC are now taking a strong interest in the promotion of research opportunities for NHS service users. All research that takes place within the Trust has the appropriate approvals in place (Health Research Authority and NHS Ethics). In 2019/20 we have recruited approximately 300 service users into NIHR portfolio studies, which is at a similar level to the previous year. We have received very positive feedback from those who took part. Most of the individuals who completed a questionnaire about their experience of participating in the Trust research rated their overall experience as very good or excellent. We are currently looking to recruit participants in to the following studies:

- **Identifying the prevalence of antibodies to neuronal membrane targets in first episode psychosis (PPiP)** – The aim of the study is to establish the prevalence of pathogenic antibodies in people with a diagnosis of psychosis and to assess the acceptability of an immunological treatment protocol for patients with psychosis and antibodies. Participants will have a blood sample taken and undergo the Positive and Negative Syndrome Scale (PANSS) assessment

- **Learning about the lives of adults on the autism spectrum and their relatives** – We are looking to develop a better understanding of the lives of adults on the autism spectrum and their relatives. Participants will be provided with a contact booklet to complete and return. Then they will be asked to complete several questionnaires which will be sent by post

- **Detecting susceptibility genes for Lewy Body Dementia** – We are looking to recruit individuals with a diagnosis of Lewy Body Dementia, and their next-of-kin. Participants with will be asked to provide a blood sample. They and their carers will also be interviewed using several questionnaires. These interviews will each take around 90 minutes

- **E-support for Families of individuals affected by psychosis (COP-e)** - This study aims to develop and evaluate online resources providing psychological support to carers of people with psychosis and ways to promote carers' well-being

- **Smartphone App-induced Habit: A treatment ingredient in HRT for OCD** - This study aims to understand more about behavioural treatment called HRT and to establish how helpful it might be in treating OCD

- **Trans Cranial Direct Stimulation in OCD** - This study aims to understand more about behavioural treatment called Trans Cranial Direct Stimulation (tDCS) and to establish how helpful it might be in treating OCD.

We will have many additional studies starting in early 2020 so please contact us for further information or if you are interested in taking part.

One of our nurses, Victoria Sharman was successfully awarded a place on the NHIR 70@70 programme which commenced in May 2019. Victoria is funded for 2 days a week until March 2022 and this protected time is being used to build a research culture within the Trust.

Following a baseline scoping exercise, the agreed year on plan is to raise awareness on research within the Trust, and the following have been implemented:

- A joint research and development/innovation hub project has commenced to enable preceptorship nurses (newly registered nurses) to implement their Imagination and Innovation assignment into practice with support from the Team Quality Improvement Leader

- The Department of Health and Social care set the Join Research Dementia 2020 Challenge with the objective that 'all relevant staff will be able to signpost interested individuals to research via Join Dementia Research'. The completion of the Join Dementia Research Awareness tool was promoted in the Trust and 50 of our staff completed the online tool. At the end of 2019, we were 8th in the NHS completions

- Stevenage in Hertfordshire has been designated research population in focus owing to the residents high health needs. To ensure the nurses are able to support research activity, Research Awareness workshops were delivered and 16 nurses working in the Stevenage area attended

- To ensure staff are aware of the Trust's research activities, there is a research and development flyer in our corporate induction pack, on the research and development website on the Hive and we also provide regular research articles in HPFT highlights.

Please contact the Research and Development Department on 01707 253836 if you would like to find out more about any of the above studies. Or alternatively, please email Research@hpft.nhs.uk. We will be taking on additional studies during 2019/20.

What is the National Institute of Health Research (NIHR)?
The NIHR funds health and care research and translates discoveries into practical products, treatments, devices and procedures. It helps patients gain earlier access to breakthrough treatments and trains and develops researchers. The NIHR is committed to involving patients and the public in all its work.

Commissioning for Quality and Innovation (CQUIN) 2019/20

What is Commissioning for Quality and Innovation (CQUIN)?
CQUIN is a payment framework which enables commissioners to reward excellence, by linking a proportion of the healthcare provider's income to the achievement of local quality improvement goals.

The Trust's CQUIN goals are agreed with our local and specialist commissioners at the beginning of each financial year. A proportion of the Trust's income is conditional on achieving these goals. Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically in '*Trust Papers'* in the *'About Us'* section of the Trust's website:
https://www.hpft.nhs.uk/about-us/our-board-papers-and-publications/other-reports-and-plans/

From 1st April 2019, the CCG CQUIN schemes were reduced in value to 1.2% of contract income from the previous 2.5%. This means that £2,486k of the Trust's NHS contract income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Trust and our Commissioners through the CQUIN payment framework as described above. This is a reduction from 2.5% of contract income (£4,509k) in 2018/19.

At the end of the 2019/20, the final amount forecast to be achieved is £2,099k (84% of the amount variable). This compares to 2018/19 for which the Trust achieved £3,839k (85% of the amount available).

Details of the CQUIN amounts for each 2019/20 contract are set out below.

	Commissioner	Value	Agreed % achieved of the goal	Amount this will earn
1	Hertfordshire IHCCT	£1,937k	80%	£1,550k
2	NHS England	£220k	100%	£220k
3	Mid Essex	£29k	100%	£29k
4	North East Essex	£50k	100%	£50k
5	West Essex	£23k	100%	£23k
6	Essex Learning Disability	£205	100%	£205k
7	Norfolk	£13k	100%	£13k
8	Buckinghamshire	£9k	100%	£9k
Total		**£2,486k**	84%	**£2,099k**

Hertfordshire CQUIN 2019/20 in relation to the main commissioner contract in Hertfordshire

	Goal	Description of goal	% allocated to goal.	Total available for this goal.	Agreed % achieved of the goal	Amount this % will earn
1	Flu Vaccination 80% of Frontline staff.	Achieving an 80% uptake of flu vaccinations by frontline clinical staff between 1 September 2019 and February 28th 2020.	20%	£387k	27%	£103k

2	Alcohol and Tobacco Screening	Inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use, and offered appropriate interventions as identified.	20%	£387k	94%	£362k
3	72 Hour follow up discharge.	80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge from a CCG commissioned service	20%	£387k	100%	£387k
4	Improved Data Quality and reporting.	Achieving a score of 95% in the MHSDS Data Quality Maturity Index (DQMI). And Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.	20%	£387k	100%	£387k
5	IAPT use of anxiety disorder specific measures.	65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	20%	£387k	63%	£244k
	Herts CCGs agreed that overall performance would be rewarded at 80%- Top up to achieve:					£66k
		Total	**100%**	**£1,937k**	**80%**	**£1,550k**

NHS England CQUIN 2019/20

	Goal	Description of goal	% allocated to goal.	Total available for this goal.	Agreed% achieved of the goal	Amount this % will earn
1.	No goal set	Agreed with NHSE that no goal would be set against this money.	9%	£19k	100%	£19k.
2.	Healthy weight in adult secure mental health services	Healthy service environment, healthy lifestyle choices for their patients, assessed through monitoring of activity, obesity and wellbeing.	83%	£165k	100%	£165k
3.	Addressing CAMHS Tier 4 Staff Training Needs	Team development programme which includes training in approaches, methods and interventions that are specific to a range of Tier 4 service settings	17%	£36k	100%	£35k
		Total	**100%**	**£220k**	**100%**	**£220k**

Norfolk CCG CQUIN 2019/20

	Goal	Description of goal	% allocated to goal.	Total available for this goal.	Agreed% achieved of the goal	Amount this % will earn
	No goal set.	Agreed with Norfolk CCG that no goal would be set against this funding.	100%	£13k	100%	£13K
		Total	**100%**	**£13k**	**100%**	**£13k**

North east Essex CCG CQUIN 2019/20

	Goal	Description of goal	% allocated to goal.	Total available for this goal.	Agreed% achieved of the goal	Amount this % will earn
1	Flu Vaccination 80% of Frontline staff.	Achieving an 80% uptake of flu vaccinations by frontline clinical staff between 1 September 2019 and February 28th 2020.	20%	£10k	0%	£0k
2	IAPT use of anxiety disorder specific measures	65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	80%	£40k	77%	£31k
	NE Essex CCG agreed that overall performance would be rewarded at 100%- Top up to achieve					£29k
		Total	**100%**	**£50k**	**100%**	**£50k**

West Essex CCG CQION 2019/20

	Goal	Description of goal	% allocated to goal.	Total available for this goal.	Agreed% achieved of the goal	Amount this % will earn
1	Flu Vaccination 80% of Frontline staff.	Achieving an 80% uptake of flu vaccinations by frontline clinical staff between 1 September 2019 and February 28th 2020.	20%	£5k	0%	£0K
2	IAPT use of anxiety disorder specific measures	65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	80%	£18k	23%	£5K
	West Essex CCG agreed that overall performance would be rewarded at 100%- Top up to achieve					£18k
		Total	**100%**	**£23k**	**100%**	**£23k**

Mid Essex CCG CQUIN 2019/20

	Goal	Description of goal	% allocated to goal.	Total available for this goal.	Agreed% achieved of the goal	Amount this % will earn
	No goal set. .	Agreed with Mid Essex CCG that no goal would be set against this funding.	100%	£29k	100%	£29K
		Total	**100%**	**£29k**	**100%**	**£29k**

Learning Disability Essex CCG CQUIN 2019/20

	Goal	Description of goal	% allocated to goal.	Total available for this goal.	Agreed% achieved of the goal	Amount this % will earn
	No goal set. .	Agreed with Essex CCG that no goal would be set against LD funding.	100%	£205k	100%	£205K
		Total	**100%**	**£205k**	**100%**	**£205k**

Buckinghamshire CCG CQUIN 2019/20

	Goal	Description of goal	% allocated to goal.	Total available for this goal.	Agreed% achieved of the goal	Amount this % will earn
	No goal set. .	Agreed with Bucks CCG that no goal would be set against this funding.	100%	£9k	100%	£9K
		Total	**100%**	**£9k**	**100%**	**£9k**

The CQUIN income estimated to be awarded in 2019/20 represents 0.83% of the total income generated from the provision of health services by the Trust in the year.

Clinical coding

We use clinical coding to categorise the information we gather about our service users and the services and treatments they receive from us. This information is then used to analyse the data that informs our quality indicators. Although we are not part of 'Payment by Results' (PbR) our clinical coding is still externally audited.

The Data Security and Protection (DSP) Toolkit

The DSP Toolkit grades organisations as 'small', 'medium' and 'large'. We are a 'large' organisation and are therefore required to undertake 100 mandatory assertions on all aspects of information governance and data security.

What is the Data Security and Protection (DSP) Toolkit?
The DSP Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' assessments. The DSP Toolkit replaced the Information Governance (IG) Toolkit.

The Trust submitted our DSP Toolkit to NHS Digital at the end of March 2020 and we are awaiting the outcome. The Toolkit covers 179 assertions based on the National Data Guardian's 10 Data Security Standards:

Personal Confidential Data
Staff Responsibilities
Training
Managing Data Access
Process Reviews
Responding to Incidents
Continuity Planning
Unsupported Systems
IT Protection
Accountable Suppliers

What is Hospital Episode Statistics (HES)?
Hospital Episode Statistics is a database containing details of all admissions, A and E attendances and outpatient appointments at NHS hospitals in England.

We submitted records during 2019/20 to the Secondary Uses Service for inclusion in the HES which are included in the latest published data. The percentage of records in the published data which included the service users' valid NHS number was:

- 99.42% for admitted patient care
- 98.62% for outpatient care.

The percentage of records in the published data which included the service users valid General Medical Practice Code was:

- 96.01% for admitted patient care
- 95.76% for outpatient care.

Ethnicity April 2019 – March 2020

The percentage of records in the published data which included the service users' ethnicity was 88.87%.

Patient Safety

This section shows how we ensure that we are providing safe care. We have continued to focus on developing a culture of safety over the last year, building safety into the heart of all we do. This has been supported through a number of safety initiatives, including:

- The development of a Simulation Training Faculty
- A facilitated review of the moderate harm panel process using CQI principles
- Embedding the use of SWARM to aid reflective learning
- The use of Structured Judgement Reviews as part of the Mortality Governance framework for reviewing and learning from deaths
- Working on 'Just Culture' with training and development sessions being delivered
- A CQI project into aggression on Oak Ward, using the Broset Violence Checklist, to allow staff to better predict when people are at risk of becoming aggressive and provide earlier intervention
- Embedding Safety huddles
- Embedding SafeWards
- Recording and monitoring of seclusion within the EPR on PARIS
- Implementing the use of Safety Pods
- A CQI project on search procedure and use of a Pro-Screen metal detector with aim to reduce self-injurious behaviours involving sharp objects
- The dissemination of guidance on head banging
- A CQI initiative for improving handovers in inpatient settings
- An internal safety alert issued on tailgating
- The appointment of a Nurse Consultant in Physical Healthcare.

The total number of incidents reported (via our incident reporting system Datix) between 1st April 2019 and 31st March 2020 was 12,846. Of these, 29 (0.2%) are recorded under the harm category as 'severe harm' and 411 (3.2%) are recorded under harm category as 'death'.

"I have always felt safe and well managed"

Restrictive Practice and our MOSStogether Strategy

Restrictive Practice refers to the implementation of any practice restricting a service user's movement, liberty and/or freedom to act. Where an individual service user's behaviour places themselves or others at imminent risk of significant harm, a restrictive practice may be necessary as a proportionate and reasonable response. To enable a reduction in the use of restrictive practice, high quality and safe services need to be provided in therapeutic environments with staff engaging in therapeutic relationships, providing value-based care that is person-centred and focuses on recovery.

To create and maintain a safe and supportive environment for staff, service users and carers, we need to ensure processes are designed and in place, learning about what works well and why, and to replicate and optimise these behaviours and processes. As a Trust we have a comprehensive training in the Prevention of Management of Violence and Aggression, which includes developing competence in both proactive and reactive approaches, focused on the best interests of the service user.

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

The MOSStogether Strategy sets out an approach which aims to ensure that safety is at the heart of everything we do in order to deliver our *Good to Great Strategy*. It ensures that safe services are provided, so that people feel safe whilst receiving our services. It sets the direction for providing safe and effective services, enabling a positive experience for those who receive our services and has been developed from and builds upon the Trust's previous Making Our Services Safer (MOSS) Strategy. This is the next stage of our journey, incorporating Continuous Quality Improvement (CQI) methodology, a just and learning culture and Shared Decision Making.

The MOSStogether Strategy describes a consistent and integrated approach to providing safe services with regards to restrictive practice. It is an enabler of the Trust's vision and is supported through the Trust's organisational development of work. Core to the MOSStogether Strategy is that *the least restrictive practice starts with a conversation.*

Keeping our service users, carers and staff safe is a key priority and we achieve this through the implementation of this MOSStogether Strategy using Shared Decision Making and promoting a just and learning culture. This means that those who use our services have choice and control over the way their care is planned and delivered, ensuring that they are supported to be as involved in the decision making process as they would wish. This includes positive risk taking. It also means that staff will make positive changes as a result of learning from incidents.

Working together, staff, individual service users and carer will enable an understanding of what is important, supporting the service users' recovery and the achievement of outcomes that matter.

The priorities of the MOSStogether Strategy are:

- To introduce the HOPE Model, resulting in the least restrictive practice being used

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

The launch of the Strategy was delayed owing to the Covid-19 pandemic; its content however being implemented, via an implementation plan, monitored by our Restrictive Practice Committee.

Culture of Safety

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

- SWARM enables a culture of openness, transparency and learning in a blame free environment. SWARM is a multidisciplinary forum which provides open support, guidance and feedback following serious incidents in order to learn from it and improve our service. SWARM creates an environment in which staff share information without fear of reprisal, and integrate the reporting of safety issues into daily work.
  It is held as soon as possible after a service user safety incident and carried out in a blame-free environment and while the incident is still fresh in everyone's mind. The meeting gives frontline staff a chance to review the facts, discuss what happened, as well as how and why it happened. This helps the team build a more accurate picture of the organisational and human factors involved, and allows staff to identify the key lessons and list actions which can be implemented immediately by the team. SWARM is identifying learning themes to be shared across the organisation, ensuring that our services are safe and we learn from our mistake
  So far 41 SWARMS have been carried out across the Trust alongside a number of training programmes for local managers such that these can begin to occur very rapidly and without the need for external support. The PACE team are supporting the learning process by collecting themes and collating material which comes back from the SWARM Process. Next year we need to do more work to tie this further into to the Safer Care and Standards framework.
- Proscreen - As a result of learning from a Serious Incident, we invested in Pro-screens, based on external advice and research undertaken. This technology uses magnetic fields for detecting restricted items, such as razor blades and weapons, inside and outside the body, and has been installed in our acute inpatient units. This work has been developed alongside a programme and the introduction of a local Standard Operating Procedure aiming to improve the quality and safety of care we provide
- Itemiser – we procured an 'airport style' trace detection machine for coverage across the range of potential narcotics within a single, rapid, non-invasive test. This has been installed in both Swift ward and our Section 136 suites helping us with the rapid and non-invasive detection of psychoactive substances. The effectiveness is being evaluated with a view to rolling this out more widely.

"We considered the Trust had had significantly improved practice in [safety], reporting had improved and lessons had been learnt that would otherwise have been missed" CQC

Duty of Candour

We are committed to the principles of openness, honesty and transparency. We aim to learn from all incidents and engage service users and families in the review process. Our Duty of Candour policy defines the incidents to which Duty of Candour applies and sets out the duties and responsibilities of senior staff after an incident.

We have reviewed and updated the policy so that, where harm has been caused or may have been caused, staff have clear guidance on their roles and responsibilities in contacting service users and families that in a way that is:

- is timely
- embraces the principles of open, honest and transparent communication.

We have also included information on how we meet the Duty for moderate harm incidents.

During 2019/20 we continued to make progress with the implementation of the Duty of Candour policy. Clinical leads are consistently contacting bereaved families to offer condolences and identify support needs when a death has been reported as a serious incident. We acknowledge the impact on families and friends who are bereaved by suicide or a sudden unexpected death.

When a Serious Incident is reported, we send a Duty of Candour letter to the person who uses our services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment affected. This is to advise on:

- our internal investigation process
- how they can contribute to establishing a factual chronology of events and help us learn from what has happened.

The person leading the investigation contacts the family and any questions or concerns the family raises are gathered, considered and included in the serious incident report. Once completed, the full report is always shared with the family and the Coroner. Trust commissioners monitor compliance with our Duty of Candour and procedures when reviewing and quality assuring serious incident reports.

National Confidential Inquiry into Suicide and Homicide (NCISH)

The NCISH is led by the University of Manchester. An annual report publishes findings and recommendations which we respond to through our internal Suicide Prevention Group and also our collaborative working across other stakeholders, including Public Health.
The NCISH process requests clinicians to complete questionnaires where a suicide is suspected or confirmed. As a Trust, we disseminate the key findings of the NCISH annual report and associated infographics via our Strategic Business Unit (SBU) governance meetings and also our Continuing Professional Development (CPD) meetings.

Learning from deaths

From April 2017, all Trusts were required to collect and publish information on deaths and serious incidents, including evidence of learning and improvements being made as a result of that information. This is part of a systematic, NHS-wide approach to reviewing and learning from deaths, being led by the Department of Health, NHS Improvement and the CQC. Guidance for Trusts was published in March 2017 to provide a consistent approach to identifying and reporting, investigating and learning from deaths, and where appropriate, sharing information with other services and organisations.

The following elements capture 'Learning from Deaths' updates as required in the quality accounts regulations:

1. The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

We capture data regarding all service users who die while they are in our services and all people who have received care in the twelve months preceding their death. During the financial year 2019/20 451 (by date of death) of our service users died. Of the 451 deaths, 97 were identified as meeting the criteria for further review either as a Serious Incident investigation (51) or as a Structured Judgement Review (SJR) (46), as detailed in the table below. A large number of the deaths reported are due to natural causes, ill health or accident and not related to the Trust.

	East & North SBU	Essex and IAPT SBU	LD&F SBU	West SBU	Total
Quarter 1	52	6	9	24	91
Quarter 2	66	14	95	19	104
Quarter 3	72	10	24	21	127
Quarter 4	93	9	10	17	129
Total	283	39	48	81	451

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 91 in the first quarter
- 104 in the second quarter
- 127 in the third quarter
- 129 in the fourth quarter.

This number is the reported deaths of all service users in the year we had contact with in the previous 12 months. The number for 2018/19 was 444. Deaths are recorded on Datix, our incident reporting system, which has a mortality section enabling reporting and recording of screening information. In 2019/20, work began on being able to access information on deaths recorded on NHS Spine via Spike 2.

2. The number of deaths included in item 1 which the Trust has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

46 case record reviews and 51 investigations have been carried out in relation to 451 of the deaths included in item 1.
None of the cases were subject to both a case record review and a Serious Incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out are detailed in the table below.

	Serious Incident Investigations	Structured Judgement Reviews
Quarter 1	9	9
Quarter 2	14	11

Quarter 3	16	20
Quarter 4	12	6
Total	51	46

3. An estimate of the number of deaths during the reporting period included in item 2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

These numbers have been estimated using the Mortality Case Record Reviews (using SJR methodology) only. In keeping with Root Cause Analysis methodology and national reporting requirements, Serious Incident investigations do not directly address the question whether the death was more likely than not owing to problems in care. Instead serious incidents reports analyse and comment on care or service delivery problems, contributory or influencing factors and a root cause where identified.

0 representing (0%) of service user deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user.

4. A summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 3.

Not applicable as none such deaths identified.

5. A description of the actions which the Trust has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 4).

Not applicable as none such deaths identified.

6. An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.

Not applicable as none such deaths identified.

7. The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 2 in the relevant document for that previous reporting period.

0 case record reviews and 32 serious incident investigations were completed in financial year 2019/20 which related to deaths which took place before the start of the reporting period.

8. An estimate of the number of deaths included in item 7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the service user, with an explanation of the methods used to assess this.

0 representing 0% of the service user deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user. This is accounting for the fact that Serious Incident Investigation reports do not make that specific judgement.

9. A revised estimate of the number of deaths during the previous reporting period stated in item 3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 8.

0 representing 0% of the service user deaths during the previous reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user.

The Learning Disability Mortality review programme (LeDeR) has been implemented in a phased way by the local areas where we provide services. During 2019/20 58 deaths have been reported by us to the LeDeR programme.

- 11 in the first quarter
- 10 in the second quarter
- 26 in the third quarter
- 11 in the fourth quarter.

Each of the Local Authority Areas implementing the LeDeR programme have done so in a phased way with different approaches to the process. A significant number of reviews have still to be finalised and this process is overseen by the Local Authority. We have a number of reviewers trained in the LeDeR methodology to support the programme. Learning from the programme is shared via our Mortality Governance Group and the Safety Committee.

2.3 Reporting against our Core Indicators

This section of the Quality Account Report sets out how we performed against our 2019/20 priorities. These are the priorities we set at the beginning of the year and are published in the 2018/19 Quality Account Report. We will look at each of these in turn after considering the nationally mandated quality indicators set by the NHSI Regulation Framework.

Core Indicators

1. The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reported period

Performance in Q1 to Q4 in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**
	98.41%	96.99%	97.86%	98.70%
Performance in Q1 to Q4 in 2018/19	**Q1**	**Q2**	**Q3**	**Q4**
	96.05%	97.11%	97.81%	96.61%
Target	95% rate of service users followed up after discharge from the Acute Care Pathway			

	Highest	**Lowest**	**National Average**	**Trust**
Q1 2019/20	100%	86.1%	95.1%	98.41%
Q2	100%	77.9%	94.5%	96.99%
Q3	100%	86.3%	95.5%	97.86%
Q4	Not published due to COVID 19	Not published due to COVID 19	Not published due to COVID 19	98.70%

Benchmarked Data

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Data is routinely checked and validated internally as well as by internal and external auditors. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by working to a 3 day follow-up standard in accordance with the CQUIN.

2. The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period

Performance in Q1 to Q4 in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**
	96.9%	97%	96.8%	97.26%
Performance in Q1 to Q4 in 2018/19	**Q1**	**Q2**	**Q3**	**Q4**
	97.1%	96.39%	97.28%	97.26%
Target	95% of those admitted to an inpatient unit should have been gate kept by CATT			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Q1 2019/20	100%	84%	98.2%	96.9%
Q2	100%	91.2%	98.2%	97%
Q3	100%	80%	97.1%	96.8%
Q4	Not published due to COVID 19	Not published due to COVID 19	Not published due to COVID 19	97.26%

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Data is routinely validated by services as well as the Performance Team on a monthly basis. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by additional validation by clinical service line leads as well as performance with regular feedback to teams on practice and recording issues.

3. The Percentage of Patients aged i). 0 – 14 and ii). 15 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

0 – 14

Performance in Q1 to Q4 in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**
	0%	0%	0.3%	0.3%

Performance in Q1 to Q4 in 2018/19	**Q1**	**Q2**	**Q3**	**Q4**	
	0.2%	0.41%	0%	0.68%	
Target	No target set				

16 and over

Performance in Q1 to Q4 in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**	
	7.4%	7%	7.1%	5.1%	
Performance in Q1 to Q4 in 2018/19	**Q1**	**Q2**	**Q3**	**Q4**	
	4.7%	5.19%	6.29%	7.85%	
Target	No target set				

Benchmarked Data – not published for 28 day readmissions

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Routine report generated from the Trust's Business Intelligence System and then validated by the Performance Team on a monthly basis. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this data and so the quality of its services, by validation and reviews of reasons for readmissions by the appropriate Service Line Lead, with appropriate learning.

4. The Trust's 'Service User Experience of Community Mental Health Services' indicator score with regard to a service user's experience of contact with a health or social care worker during the reporting period.

Performance in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**	**19/20**	
Performance in 2018/19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**	
					7.2	
Target	No target set (comparative data)					

Benchmarked Data: Not available. CQC rating is 7.3/10 which is 'about the same as other Trusts'.

Hertfordshire Partnership University NHS Foundation Trust considers that this data is as described for the following reasons: Forms part of an externally run national survey. Hertfordshire Partnership University NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by continuing to develop our recruitment and retention focus and actions and continuing to also focus on the Trust's value based training.

5. The number and, where available, rate of service user safety incidents reported within the Trust during the reporting period and the number and percentage of such service user safety incidents that resulted in severe harm or death.

Performance in Q1 to Q4 in 2019/20		**Q1**	**Q2**	**Q3**	**Q4**
		Severe = 2 (0.14%) Death = 10 (0.73%)	Severe = 2 (0.14%) Death = 13 (0.94%)	Severe = 1 (0.07%) Death = 14 (1.11%)	Severe = 1 (0.08%) Death = 10 (0.82%)
Performance in Q1 to Q4 in 2018/19		**Q1**	**Q2**	**Q3**	**Q4**
		Severe = 10 (0.7%) Death = 12 (0.9%)	Severe = 2 (0.2%) Death = 20 (1.5%)	Severe = 0 (0%) Death = 15 (1.2%)	Severe = 2 (0.2%) Death = 6 (0.5%)
Target					

Severe Harm	Highest	Lowest	National Average	Trust
Q1 & Q2	97 (2.3%)	0 (0%)	13 (0.3%)	4 (0.25%)
Q3 & Q4	To be provided by NRLS in September 2020			

Death	Highest	Lowest	National Average	Trust
Q1 & Q2	71 (1.5%)	0 (0%)	24 (0.6%)	22 (0.8%)
Q3 & Q4	To be provided by NRLS in September 2020			

Hertfordshire Partnership University NHS Foundation Trust considers that this data is as described for the following reasons: Routine report generated from the Datix system. Hertfordshire Partnership University NHS Foundation Trust has taken the following actions to improve this: encouraged a high reporting culture and scrutiny on the level of harm including the weekly Moderate Harm Review panel.

Part 3 – Other Information

This part of the report gives us an opportunity to celebrate some of the notable and innovative practice that has taken place across our services in 2019/20 and to present information relevant to the quality of the health services we provide. It is not meant to be an exhaustive list, rather a sample of the many and varied initiatives our staff, service users and carers have developed and implemented to improve the quality of our services.

Local Quality Indicators

The local quality indicators for 2019/20 are set out below with a brief narrative on each of them.

	Local Indicators
	Patient (service user) Safety
1	Ensure that the cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient wards b) EIP services c) Community mental health services (people on CPA)
2	The use of restrictive practice, including seclusion
3	Serious Incidents response times and analysis
	Effectiveness
4	IAPT: • Proportion of people completing treatment who move to recovery (from IAPT dataset) • Waiting time to begin treatment (from IAPT minimum dataset): (i) Within 6 weeks of referral (ii) Within 18 weeks of referral
5	EMDASS diagnosis within 12 weeks
6	FEP 14 day
	Service user Experience
7	Admissions to adult facilities of service users under 16 years old
8	Employment support for service users
9	Service user and carer involvement

1. Ensure that the cardio-metabolic assessment and treatment for people with psychosis is delivered

The aim is to ensure that service users with psychosis, including schizophrenia, receive comprehensive cardio metabolic risk assessments and have access to the necessary treatments/interventions. The results are recorded in their electronic care record (held by the secondary mental health provider) and shared appropriately with the individual service user, the treating clinical team and partners in Primary Care.

To ensure that staff have the skills and abilities to undertake such work, a physical health training programme was developed as well as pathways for interventions and signposting for all cardio-metabolic risk factors.

These included areas such as:

- Smoking cessation
- Lifestyle (including exercise, diet alcohol and drugs)
- Obesity

- Hypertension
- Diabetes
- High cholesterol.

In 2019/20 a Physician Associate led enhanced physical health clinic was implemented. Over a 3 month evaluation period, the clinic directly led to one service user being diagnosed with diabetes and commenced on the anti-diabetic medication metformin, two service users commencing a pre-diabetes programme with their GP. One service user being diagnosed with hyperlipidaemia and commenced on the medication simvastatin, one service user switching from cigarettes to e-cigarettes and one service user having their medication changed from Olanzapine to Aripiprazole due to metabolic side effects. One service user whose blood tests showed haematological abnormalities was referred by their GP for further investigations including an abdominal ultrasound and abdominal CT which found a mass and is being followed up in secondary care. The evaluation of the clinic demonstrated that the newly emerging profession of Physician Associates can be integrated into a community mental health multidisciplinary team and support people with serious mental illness (SMI) with their physical health through screening, intervening, referring and signposting.

2. The use of restrictive practice, including seclusion

To support greater assurance with regards to the management of restrictive practices, and that it is both proportional and least restrictive practice, a Strategy and a supportive groups that link to direct care have been developed. These include the development of and greater integration between corporate and operational services:

- The MOSStogether Strategy, offering a plan for the reduction of the use of restrictive practices
- A dedicated monthly Restrictive Practice Committee to review restrictive practice focused on data informed care approaches – supported by narrative from the SBUs, and informing the quarterly Integrated Safety reports
- A review of design for seclusion rooms has taken place. A review of policy and standards for seclusion which has included moving all reporting from a paper-based reporting to an easily auditable electronic record. This has been mirrored for Long Term Segregation with improved process for agreeing segregation, with clearer definitions and roles
- Training has evolved in the Prevention of the Management of Violence Aggression, which has resulted in accreditation of BILD ACT.

3. Serious Incidents response times and analysis

We reported a total of 112 Serious Incidents in 2019/20 which was a decrease of 14% of those reported in 2019/20. The table below shows that the most reported type of Serious Incident was unexpected deaths and the number suspected to be through suicide has reduced this year, when compared to last year.

Category	2018/19	2019/20
Unexpected or avoidable deaths	65	51
Disruptive, aggressive or violent behaviour	24	11
Apparent, actual or suspected self-inflicted harm	24	25
Slip, trip or fall	7	10
Abuse or alleged abuse of adult patient by staff	0	1
Medication incident	6	1
Unauthorised absence	4	0

Pressure Ulcer meeting SI criteria	3	1
Sub optimal care of deteriorating patient	2	1
Confidential information leak/information governance breach	1	0
Abuse or alleged abuse of adult patient by third party	1	0
Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare services	1	0
Mental Health Act paperwork	1	0
Health care associated infection or infection control	0	1
Adverse media coverage or public concern about the organisation or the wider NHS	0	1
Apparent, actual or suspected homicide	0	2
Commissioning incident meeting SI criteria		6
Diagnostic incident including delay meeting SI criteria	0	1
Total	139	112

Serious Incidents are investigated using Root Cause Analysis (RCA). At the beginning of the year, we had a significant number that were not investigated within the mandated time frame. From 1st April 2019, these reduced from 83 to 53 open Serious Incidents and with 56 overdue. At the end of the year we had 40 that were overdue. Throughout the year, work was undertaken to understand why this was proving a challenge to turn around and identified the need for setting clear expectations, timely allocation of reports and protected time for report authors. In addition the quality of the reports needed strengthening and we trained 70 staff as RCA investigators in the year.

We made progress on ensuring that Serious Incident reports are completed in a timely way through use of a Dashboard, weekly meetings with the SBUs, oversight by our Executive Director for Quality & Safety (Chief Nurse) and dedicated support for investigators from the Safer Care Team. We have continued with this focus in 2020/21.

The NHS Patient Safety Strategy was published in July 2019 and a framework for Incident Management is due to be published in Spring 2021, with all NHS organisations expected to have transitioned to using the new framework from Autumn 2021. As an organisation, we are expected to establish effective systems, processes and behaviours that enable recovery from the effects of an incident and where learning and improvement are more likely to happen. The strategy provides guidance on how to respond to patient (service user) safety incidents with a focus on a Just Culture, openness and candour, engagement of families in learning from our incidents, support for staff and trained investigators. These principles are in evidence within our existing processes, and will be built on further in 2020/21.

Learning themes from Serious Incidents in 2019/20 have been risk formulation, risk management and safeguarding. In response to this, refresher risk formulation training has been delivered to Adult Community Mental Health Teams and Crisis Assessment and Treatment Teams. An Education Task and Finish Group reviewed practice and policy relating to risk formulation.

The work of the group informed a successful business case for funding for a simulation training hub. The development of the training strategy, oversight around the work on setting up the training hub and developing case scenarios is being led by our Clinical Director for the East and North SBU and a working group is in place to take this forward into 2020/21. Bespoke training sessions have also been delivered to teams by our Safeguarding Practitioners relating to domestic abuse and self-neglect.

4. IAPT recovery rates

Our IAPT services across the Trust have expanded in line with national expectations, where commissioned to do so. This has resulted in a significant increase in the workforce and

expansion in the delivery of digital solutions and treatment pathways for people with long term conditions as well as a general increase in the numbers of people able to access psychological therapies.

Service user outcomes continue to exceed national recovery targets and individual service user feedback remains extremely positive. 6 out of 7 teams have gained or retained APPTS accreditation, the national accreditation programme for psychological therapy services by the Royal College of Psychiatrists and the British Psychological Society.

Our services have led the way within the region on a number of innovative approaches to service delivery, including use of targeted social media, and marketing campaigns to increase mental health awareness and access for hard to reach groups, developments in relation to pathway specific interventions, such as respiratory conditions, diabetes, cancer and musculoskeletal conditions.

This was demonstrated though our IAPT Showcasing Excellence Conference 2020 in February with David Clark, Ursula James and Stirling Moorey, as key note speakers and presentations by our teams covering topics such as:

- Treating Health Anxiety in a Group Setting
- Working with PTSD: Stabilisation and Complexity
- Service user involvement in IAPT
- Perinatal Mental Health.

"The service made me understand that there are people out there that listen and make sure that we are heard. They were super with me, they just spoke to me like a normal person. You are truly doing a brilliant job, thank you for everything."

5. EMDASS 12 week diagnosis within 12 weeks

The Trust's dementia whole pathway is currently being mobilised, having been completely revised to address an upsurge of demand, to address unwarranted clinical variation in service delivery and to address some gaps in our community service offer. Our diagnostic element, the EMDASS service, has undergone revision by undertaking continuous quality improvement cycles to address service operational process and flow issues that had prevented timely access. Waiting times for EMDASS have now been brought back in line with the expected standard of 12 weeks or under from referral. We are also in the process of developing a business case with commissioners regarding extending our diagnostic pathway into primary care to build on a successful model we have been deploying in one of our primary care networks.

A major focus for the whole pathway has been to enhance our capacity to support care homes and the carers of people with dementia and new staff have been recruited to provide a care home support function across Hertfordshire in line with our integrated community/frailty teams. More Admiral Nurses have been recruited and we have formalised our approach to supporting carers and involving carers in service design. The revised dementia pathway will be fully operational from April 2020 and will for the first time include recording of outcome measures and physical health checks included within the post diagnostic support offer.

Earlier this year, EMDASS East took the initiative to bring memory services closer to the service users' home in the Lower Lea Valley area. The initiative involved working in partnership with Hertfordshire Community Trust, East and North Herts CCG and Hertfordshire GP Federation. This partnership venture has seen staff from the East EMDASS team working together with local GP's trained to assess and diagnose dementia. The initiative is known as the GPwSI (GP with Special Interest) dementia pathway. 100% of

service users said that they would be completely happy to see the doctor again. 100% of service users said that the overall delivery of service was good (6%) or very good (94%).

"The whole assessment process was really interesting and I think my husband enjoyed it. How the conversations and questions teased out the stengths and gaps in his responses was really instructive. It was so nicely done. I feel a bit calmer and more 'enabled' at coping as a result of understanding better the strengths and gaps, over and above simple observation at home."

6. FEP 14 days

Our EIP Service delivers the FEP Pathway for all people referred to and accepted into the service. The FEP pathway offers a range of evidence based interventions to service users aged 14 – 65 across 3 years. Service users are offered a rapid assessment within 14 days of referral and targeted interventions to assess and improve their physical health and lifestyle. Psychological interventions focussed on Cognitive Behavioural Therapy and Family Interventions are part of the pathway alongside Employment and Vocational interventions and regular outcome measurement.

7. Admissions to adult facilities of service users under 16 years old

Young people are admitted to adult mental health wards as a last resort and when all other options have been considered; these are agreed on the basis of the individual's needs and service user safety. The decision to admit will be escalated to both a senior management and clinical level. All admissions are reported via our incident system (Datix) and will also be reportable to the CQC where the placement lasts for a continuous period of longer than 48 hours. During the year we had no under 16 admissions to our adult inpatient services.

8. Employment Support

Employment is a key determinant of wellbeing. Following a successful bid against national rollout funding June 2019 saw the introduction of Individual Placement Support (IPS) as the employment support model for all Community Adult Mental Health service users in the Trust. This is an internationally evidenced model which utilises principles such as rapid job search, in work support and proactive employer engagement to help service users to gain and maintain paid employment. This ensures a consistent and effective approach across the Trust with new Employment Specialist Roles including an Employment Services Team Leader recruited to each of the quadrants working as an integrated part of the community teams.

As part of embedding and developing the service, we are actively working to achieve IPS Fidelity status and have exceeded set activity targets for the year. Most importantly, 40 new job starts were achieved in year by our service users across a variety of employment sector

9. Service user and carer involvement

Our service user involvement programme exists to provide us with assurance that processes and services are co-produced. The programme is also closely linked to individual recovery journeys and provides opportunities to build skills, confidence, hope for the future and opportunities.

During 2019/20, our service users and carers (Experts by Experience - EbE) contributed their expertise and time to interview panels, forums, working groups and supported us with a range of activities. In total, people with experience of our services participated in 2871.50 hours of involvement activity across the activities below:

Activity	Hours
Art Projects	1.3
Learning Disability SBU meeting	4
CAMHS Parent Carer Council	16
Carer Council	169
Councils Together	40.5
Direct participation in a workshop or seminar	49
Equality Events	6.5
Trust staff induction	22.50
Interview Panel	511
Peer Experience Listening	189.5
PLACE Audit	160
Public Speaking	12
Quality Visit	9
Shared Decision Making Project	227
Service User Council	286
Sharing Story (E.g. filming, audio etc.)	19.50
Specialist participation in Trust meetings and forums	1040
Stakeholder workshop events	15
Delivering Training	2.5
Youth Council	91

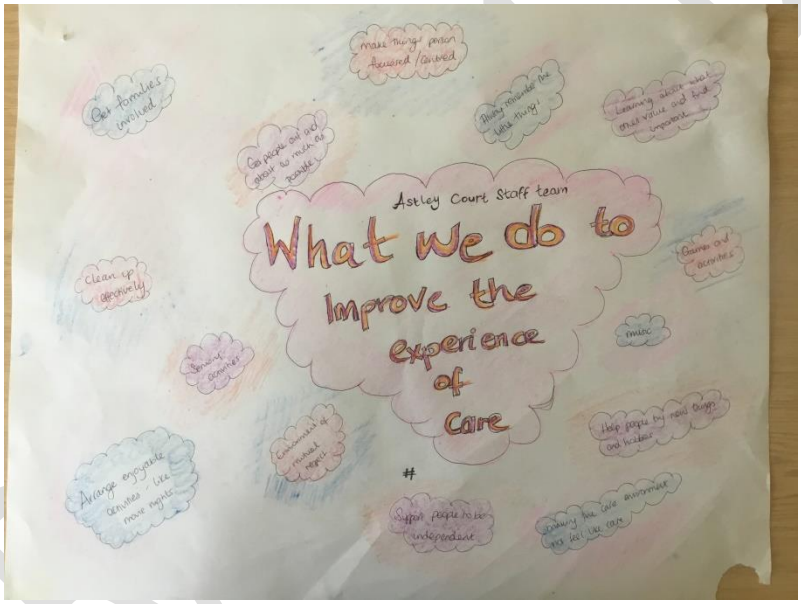
In April 2019, we launched our 3rd Recruitment and Involvement of Experts by Experience policy. It outlines the process and rewards structure for people providing their time and expertise toward our improvements as a Trust. It is also supports EBEs to be goal focused and move to different involvement opportunities as a recovery-focused aim of involvement.

Service users and carers continue to share their stories, personal accounts and suggestions with our Board and Council of Governors and through media projects within the Trust. We also continue to focus on reviewing feedback from service users and carers and working in partnership with them to develop improvements to local services. Over the coming year, we will be putting in place a new plan for service user and carer involvement/experience strategic plan that will guide local services in improvement approaches that can be taking at a local level. This will support the experience dimension of the our Quality Strategy and include a set of core priorities and principles for involvement and experience across Trust services.

There have been many experience projects throughout 2019/20, including:

- **Peer Observation Project** to gather feedback using observation techniques with EbEs visiting our older aged adult inpatient units. Completed from 1st January to 31st March 2020, the EbEs found the project to be an enlightening and very positive experience and are keen to repeat the project in the future. Some recommendations have been given about improvements to the experience of older aged adults in these units which are being shared
- **Shared Experience Library** is a central repository for service user, carer and staff stories is being set up and will be managed by the Service Experience Team. The library, which has been co-designed and co-produced together with service users, carers and staff members, will be launched in quarter 2, 2020-21

- **Mealtime Experience** work focuses on understanding what the experience is like for service users and staff at mealtimes. Observations have taken place during mealtimes on a Ward and findings are shared with the team to look as part of a quality improvement
- **Stories to the Board** - there have been 10 stories to the Council of Governors and Executive Board meetings over the year - 3 stories from carers, 6 stories from service users and 1 from a staff member. As a result of these stories many of the service users and carers have become EbEs being involved in service developments. As part of the business cycle, a full evaluation of the year's stories will take place in quarter 2, 2020-21
- **Peer Experience Listening** programme trains people with lived experience in semi structured interview listening techniques; then used to gather feedback from people currently using services. Following a number years of delivering projects across topics such as the Mental Health Act assessment, safety on inpatient wards, carer experience, experience of Dementia services, Street Triage and Community Mental Health Services, the programme underwent a review and we will be part of the wider experience portfolio to ensure that the experience work stream is strengthened as a key objective for 2020-21.



As a Trust we are a member of the *Triangle of Care* scheme and have been awarded two stars. These are awarded when the Trust has demonstrated a commitment to becoming more carer inclusive, has shown honesty about where they are now and planned where they need to be to ensure carers are better identified and supported.

Our Carer Pathway frames the approach that services take to carer support built around five principles of:

1. Identifying carers
2. Welcoming carers
3. Supporting carers
4. Involvement carers
5. Helping carers through changes.

More recently, we have co-produced a new Carer Plan up to 2021 which details a range of outcomes we are working towards in supporting carers. The Carer Plan is reported on as part of our Quality and Risk meetings in our Integrated Governance structure, charting

progress and priority areas. We have also been part of a collaborative project to improve the experience of carers when their loved one is discharged. This project is sponsored by Healthwatch Hertfordshire and has carer stakeholders and carers as part of a group that co-produces and co-reviews with the outcome of a quality improvement of carer experience.

Carer Council

The Carer Council is a group of carers (primarily with lived experience of caring for people with mental health issues) who meet 6 weekly to discuss Trust business and provide feedback on quality and areas of concern and good practice. The Council has a chair and deputy (both carers) and agrees an annual work-plan of issues important for carers.
This year has included carers plan, carers training, showcasing service projects and discussing the annual plan. The agenda is agreed by both the Council and the Trust, enabling both partners to ensure issues of importance to them are raised as part of the business cycle. Agenda planning meetings are held with chairs and deputies prior to meetings to review actions and agree agenda for future meetings.

Safeguarding adults and children at risk of abuse or neglect

In line with our Strategy of delivering '*Great care, Great Outcomes – Together'*, our Safeguarding Team aims to improve the quality of safeguarding practice so we can prevent harm and enable safety through:

- Vigilance
- Competence
- Personalised outcomes-focussed practice.

Over 2019/20, safeguarding activity for both children and adults has remained stable with consistency in the types of abuse reported. The areas where we have seen the most significant practice improvements are:

- Sexual Safety
- Self-neglect and hoarding
- Domestic Abuse

To improve our vigilance and competence in recognising and responding to potential abuse and neglect, we:

- Enhanced our safeguarding adult training to incorporate domestic abuse awareness training
- Reviewed our policies, process and practice in relation to sexual safety for both in-patient and community settings.
- Co-produced information leaflets for staff, service users and carers on sexual safety
- We successful in bidding to be a partner in the Sexual Safety Collaborative
- Developed a Child Safeguarding document to provide a central repository for all information relating to child safeguarding
- Expanded the number Domestic Abuse Champions embedded within our teams
- Produced multi-agency guidance on Emotionally Unstable Personality Disorder and impact on parenting

A clear vision for safeguarding to improve towards has laid the foundations for a focussed improvement in all aspects of safeguarding.
A further Safeguarding Improvement Plan has been developed for 2020-21, which will build on the achievements of 2019/20 and take us further towards our vision.

The Trust has been successful in a bid to join the Sexual Safety Collaborative which is hosted and facilitated by the National Collaborating Centre for Mental Health. Swift Ward will be the pilot as it provides a mixed sex communal environment.

A small project team has been set up which will meet regularly and report into the Safeguarding Strategy Committee. Members include ward staff and team leaders, service users, the Head of Nursing and the Consultant Social Worker for Safeguarding. The project sponsor is the Head of Social Work and Safeguarding. This work will also be supported by a CQI lead from the Mental Health Collaborative and will be shared through the Life QI platform.

Suicide Prevention

We continue to be a key member of the *Hertfordshire Suicide Prevention Network*, an alliance of more than 20 organisations with the shared ambition of making Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. This programme of work was reviewed in 2019 in order to achieve clearer intended outcomes from the programme and a better understanding of how these outcomes will generate positive change. 6 key priorities were identified for the focus of work over the next 5 years:

- Support for men
- Support for those bereaved or affected by suicide
- Addressing training needs
- Support for children and young people
- Reducing access to means of suicide
- Support research, data collection and monitoring.

These groups will now form the basis of the work going forward, with the Trust joining its partners in each of these workstreams.

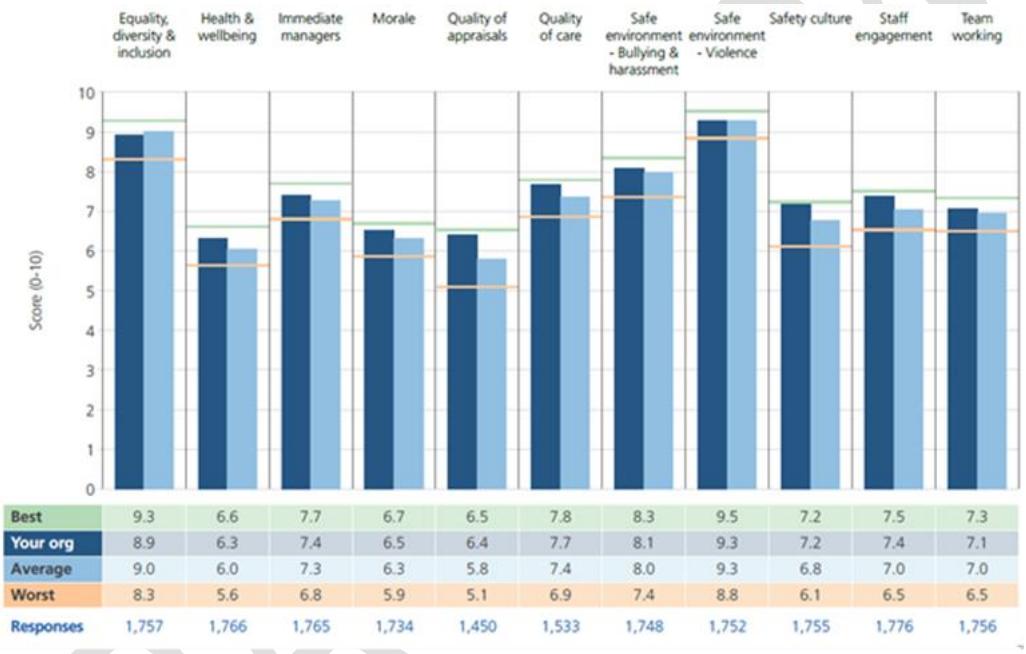
"All staff contributed towards my recovery, from the psychiatrist, who gave me confidence in their diagnosis and fully explained the steps I needed to take, to the employees of Interserve, always treating every patient with respect as they diligently clean rooms and serve meals; from the nurses, who are permanently ready with a smile and never forget pressing arrangements that have to be made, to the occupational therapists, who delivered a tailored programme of engaging activities to suit my character and interests; from the health care assistants, without whom the ward simply could not function given the countless vital tasks they perform, to the psychologists, who listen patiently and restored my self-belief. I am discharged this time much more certain of remaining well."

Workforce

National NHS Staff Survey results for 2018

Our 2019 National NHS Staff Survey results are the best we as a Trust has achieved in recent years. We improved on 73 questions and 57 are above average, compared to similar Mental Health and Learning Disability Trusts. We also performed well against the national key results provided by NHS Providers.

We scored above average on 9 of the 11 themes and continued to improve on the safety culture with a national best score for the second year running. The overall staff engagement score has remained above average compared to other Mental Health and Learning Disability Trust with a score of 7.7, marginally below the national best score of 7.5.



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

Workforce Inclusion

Our Inclusion and Engagement Team oversees the work around Equality, Diversity and Inclusion supporting professionals with understanding approaches they can take in ensuring inclusive workplaces for people and reducing the inequities in service provision.

Our Equality Plan, which was co-produced in 2018 with our stakeholders, has set key priorities up to 2022 and includes a focus on staff, services users and carers. It also contains priorities around the provision of high quality services.

We reviewed our role model programme, which focuses on staff members from certain protected groups who provided support and signposting to other staff who had less knowledge and information around a particular protected characteristic, and plan to move to the ‘Dignity at Work’ champions’ programme as part of our bullying and harassment action plan.

We have 7 staff networks across the protected characteristics and continue to encourage intersectionality. The Women’s Network has focused on International Women’s’ Day, peer

support sessions, flexible working, delivering Schwartz rounds and menstruation and the menopause. This year, the Women's' Network launched a successful campaign around menstruation sanitary provisions.

The Spirituality Staff Network was launched this year to support staff around religion, belief and no faith and connect with their spiritual self at work. From the outset, the Network has been active, already having input into a protocol for the establishment of quiet rooms and our new calendar of multi-faith festivals.

Our Outlook Staff Network (LGBT and Straight Allies) has also been involved in events for LGBT History Month, Pride Month and Trans Remembrance Day.

The Black, Asian and Minority Ethnic (BAME) Network is our longest running staff network and most recently has included focused work around the Workforce Race Equality Standard (WRES). The Network is also instrumental in the planning of our annual Race Equality at Work event in October each year. This year, we launched more local BAME and Equality Listens and they are led around the Trust by our senior managers, allowing us to support staff and take local action. We also launched Race Equality Schwartz rounds as part of our supportive offer to staff and will build on this throughout 2020-21.

The Mental Health Staff Network and Diversability Staff Network (the disabled staff network) has focused on supporting and encouraging staff to update their Employee Staff Records. They have also held 'pop up' and peer support sessions for staff based around 'time to talk' and 'Mencap' initiatives. Furthermore, both the 2 Networks worked together looking at recruitment and retention of staff and talent mapping. They have also been instrumental around our work with Workforce Disability Equality Standard (WDES).

Our WDES Annual Report and action plan were published and are available on our website. The Mental Health Staff Network and Diversability staff etwork also supported Blue Monday through Brew Monday encouraging staff to rest, break, replenish and have a conversation supporting their health and wellbeing.

We have worked on smaller projects to support WRES. In previous years, we have tried to tackle every metric and this has resulted in minor improvements. The smaller focused pieces of work will have a long standing cultural change. One focus this year was around the disciplinary panel and introducing first and second decision making panels, which have had a positive impact. Other actions include supporting staff in the recruitment process, creating a movement to a 'Just and Learning Culture' by holding focus groups, workshops and celebratory events to endorse micro-affirmations and enhancing the BAME staff experience.

As part of our Integrated Governance Structure, WRES and WDES are reported through our Equality and Information Standards Group and our strategic Equality, Diversity and Inclusion Group.

Recruitment

To overcome the recruitment challenges we face, there is an active programme of recruitment to vacancies throughout the Trust with an increased focus on hard to recruit areas and difficult to recruit to posts. A line by line partnership approach is undertaken with recruiting managers for all posts which are in the recruitment process. Our recruitment strategy includes bespoke recruitment campaigns, recruitment days, attendance at recruitment fairs, working with agencies, using our internal bank and offering students substantive roles with the Trust upon qualifying.

A significant amount of work has been undertaken to improve the on boarding process including the outsourcing of all pre-employment checks, getting all recruiting managers to undertake ID checks at interview, ensuring candidates are kept updated during the recruitment process, and ensuring all managers complete the necessary forms so that their new starter has all the equipment they need to do their job and their contract of employment on day one.

Retention

As a Trust, we recognise the importance of retaining our staff and recognise that our retention rates are higher than we would like. A number of retention initiatives have been successfully implemented these include; retire and return, flexible working, career break, moving easily around the Trust into different roles. The initiatives are popular with our staff and we are beginning to see a positive impact on staff moral and our staff retention.

Our Pulse Survey

We run the survey in June, September and March and many of the questions are based on the National NHS Staff Survey, giving us consistent quantitative feedback from staff on their experience within the Trust. It includes the Friends and Family Test questions 'would staff recommend the Trust as a place to work or receive treatment' and these have both improved significantly during 2019. The Pulse Survey questions are reviewed annually to ensure they meet the needs of the organisation and are in context with the Organisational Development Strategy.

Health and Wellbeing

During 2019/20, we have conducted a review of our existing support for staff health and wellbeing. This has included a review of currently offered programmes (including Mindfulness, Massages, Mini Health Checks, Schwartz Rounds), The Health Hub (our platform for sharing staff health and wellbeing resources and events) and existing areas of identified need. The review has resulted in a range of evaluation data and identified key focus areas for the future.

The outcomes of the review have been used alongside existing data from the National Staff Survey and Pulse Surveys to create a data benchmark for staff health and wellbeing as a baseline to measure the impacts of future initiatives against. This benchmark and qualitative data from the review has been utilised in the creation of the new Health and Wellbeing Strategy.

As well as undertaking a wide ranging review we have continued to deliver many of our existing programmes and begun to introduce new initiatives to support staff physical, mental and financial wellbeing. We will continue to build on this work and focus on improving staff engagement around Health and Wellbeing in 2020/21.

In 2019/20 we have:

- Delivered 183 Mini health checks for staff across all sites
- Facilitated monthly Schwartz Rounds providing an opportunity for over 120 staff to discuss the emotional impacts of their work
- Delivered 11 Mindfulness courses, which have shown on average a 45% reduction in stress levels and a 55% improvement in mood
- Run a survey and focus groups to inform our work to support staff experiencing symptoms of the Menopause at the Trust
- Created and shared new resources to help staff and managers support health and wellbeing within their own working environments.

Staff Support

There are a number of ways in which we offer support to staff, both formally and informally. We provide Occupational Health support and an Employee Assistance programme is available to all staff 24 hours a day, 7 days a week, 365 days of the year. We have also implemented a confidential helpline which staff can contact if they have any concerns or would like to report bullying and harassment.

We have also implemented Schwartz Rounds which are a structured forum where all staff (clinical and non-clinical) come together regularly to share their personal experiences of work. The aim is not to fix problems, but to acknowledge the emotional demands of working in healthcare. Schwartz Rounds reduce feelings of stress and isolation, which make it difficult to provide compassionate care. The benefits of Schwartz Rounds include significant

improvements to staff psychological wellbeing, improved inter professional working and more compassionate care.

Additional staff support also consists of workplace mediation, mindfulness courses, resilience training, stress management tutorials.

Where an incident has taken place, post incident support is offered on an individual as well as a team level. This is co-ordinated through the Safer Care team and continues through the serious incident investigation process to inquests and beyond.

The Spiritual Care team also contribute to staff support by offering team and individual support, particularly where a staff member or service user has died.

The importance of having support for new staff has was highlighted as needing development. As a result, a buddy scheme for new starters has been piloted in some areas of the Trust and will be rolled out over the coming months with development workshops being made available to buddies as a source of support.

Annual Staff Awards

Each year, we host our Annual Staff Awards event. The afternoon is dedicated to the development awards where we celebrate staff who had completed an academic qualification throughout the year. 150 members of staff were invited to the staff development awards with 65 members of staff attending to collect their certificates.

The evening is a black tie Staff Awards. There are 12 annual staff award categories which are as follows:

- Unsung Hero or Heroine
- Council of Governors Making a Difference Award - Nominations for this category are made by service users and carers
- Team of the Year Award
- Chair's Inspire Award

- John Lewis Valuing our Customers Team Award
- Outstanding Leader of the Year
- Rising Star Award
- Professional of the Year
- Innovation or Improvement of the Year Award
- Special Contribution Award
- Working in Partnership Award
- The John Lewis Customer Experience Award - Nominations for this award are made by service users, carers, their families and staff.

The last staff awards ceremony was held at Tewinbury Farm in November 2019 and was attended by 300 staff. Over 350 nominations for achievement awards were received with 25 members of staff either winning an award or gaining highly commended. The awards ceremony was a wonderful opportunity to celebrate the success of our staff and all the wonderful things they do to provide great care every day to service users and carer either directly or indirectly.

Inspire Awards

The Inspire Awards are a monthly staff award to recognise and reward those staff who consistently demonstrate our values. Nominations are received, with a supporting statement, from staff, service users and carers and anyone in the Trust can be an Inspire Award winner. Winners are invited to attend an informal presentation with the Chief Executive and members of the Executive Team where they are presented with a certificate, £50 John Lewis voucher and have a small buffet lunch. There have been 92 Inspire Award nominations with 51 winners.

Leadership

We provide a range of Leadership Development Programmes both internally and externally to meet the different requirements and learning styles of staff. These comprise of formalised in-house training programmes, covering basic management skills and leadership development, through to our internal Leadership Academy, which is a level 7 accredited programmes, delivered in partnership with the University of Hertfordshire and our two programmes for managers Management Fundamentals and Coaching as a Management style.

Management Fundamentals is a two day course to enhance understanding and knowledge giving an overview of the key policies and procedures. It also enables managers to build valuable relationships, meeting the in-house subject matter experts. This workshop is recommended for new and existing managers.

Coaching as a Management Style is a two day coaching workshop introducing the principles and practice of solutions-focussed coaching. It enables managers to discover the true power of coaching to improve individual and team performance. It is recommended for line managers who want to gain the best from their teams.

Leadership Academy

In Cohort 10, 8 delegates gained distinction, 11 gained a merit and 4 are yet to complete. An extension was given by the University owing to Covid-19. There were some changes to the delivery of Cohort 10. The Finance Team has facilitated a 2 day module cover topics that leaders and future leaders need to understand in order to do their jobs effectively. In addition two days previously provided by an external facilitator were delivered by internal facilitators from the Organisational Development Team, saving money and providing a much more Trust-tailored training.
We are also participating in the Mary Seacole programme within the STP, with 12 delegates from the Trust's graduating in cohort 7.

We have also participated in the Bedfordshire and Hertfordshire Accelerated Directors Development Scheme (ADDS) which is a Chief Executive sponsored scheme to identify and develop leaders for Bedfordshire and Hertfordshire, who have the potential to fill key executive director roles. It is co-designed, owned and delivered on behalf of the Bedfordshire

and Hertfordshire Talent Forum. ADDS is focused on identifying and developing high potential leaders from operational and clinical backgrounds and is a unique scheme offering automatic shortlisting for appropriate Executive Director roles, thereby linking development and job opportunities. Eleven members of senior staff from the Trust have taken part in the programme.

Staff have also participated in national programmes such as Nye Bevan – the current Executive Director for Quality and Medical Leadership, Mary Seacole, and the Chief Pharmacist Development programme – the Deputy Chief Pharmacist. A Senior Community Nurse Lead has been successful in her application, supported by the Trust, to join the 70@70 Senior Nurse and Midwife Research Leaders programme.

Internally, we have delivered a leadership programme for Service Line Leaders using a coaching and mentoring style, and Team Leader Development Days continued to run for the second year. Development days for Medical Leads have also taken place during the year and more recently for Matrons. Specific leadership development programmes are supported by additional support to managers through the coaching and mentoring networks

Our 80 senior leaders meet regularly to hear from the Chief Executive about key strategic developments and to do focused thinking around strategic and operational objectives. We are also committed to increasing equality and diversity and our Unconscious Bias training is being rolled out across the organisation.

The Monthly Educational (CPD) Programme is led by senior leaders established in community teams. The programme entails teaching on risk formulation, collaborative safety planning and role play on managing difficult clinical situations.

Organisational Development

The Organisational Development Strategy outlines how we need to develop to deliver our strategy of going from *Good to Great.* It sets out a series of planned activity that develops our organisational (as well as individual) competencies. This includes embedding the desired culture, ensuring an effective workforce and developing enabling systems and processes.
In addition to leadership development and talent management and succession planning, there are a series of staff engagement programmes which take place throughout the Trust.
These include as follows:

Big Listen

The Executive undertake a 'Big Listen' engagement twice a year, which is open to all staff. A full day is spent meeting the Executives and discussing any issues that matter to staff. Staff join the Executive to discuss 5 topics and put forward comments and suggestions how the senior leadership team can improve both the staff and service user experience around these themes. There is a 'Question Time' panel during the day where attendees have an opportunity to ask questions directly of the Executive Team, or anonymously should they prefer. These events receive excellent feedback and evaluation and there are actions taken from these events that are reported on at the following event to complement our '*You said, we did'* approach.

Long Service Awards

Two Long Service Awards were at The Colonnade and approximately 90 members of staff who had 30 or more years NHS service were recognised. Further events are planned to recognise staff with over 25 years' service.

Admin Conference

Over 80 admin staff attended the first Trust Admin Conference at The Colonnades. The day was an opportunity to recognise and celebrate our admin staff who are core to the care we deliver. The conference provided a space for staff to network, share, reflect, and to focus on their wellbeing and development.

Good To Great Roadshows

Our *Good to Great* Roadshows take place every 6 to 12 months and provide an opportunity for our Executive Team and our Senior Leadership Team to meet with staff at their work locations to discuss a certain topic. The latest *Good to Great* Roadshows asked the question **"***What more can we do to help you feel valued and supported within your teams?"* Discussions also took place amongst teams to answer the questions "*What's working well already?"* and *"What can the organisation do more of to support you?"* A total of 13 roadshows were held at 12 sites with 238 members of staff attending. 7 further roadshows were booked for March and April but were postponed owing to the Covid-19 pandemic.

Chief Executive Breakfasts

Chief Executive Breakfasts also take place throughout the year in which our Chief Executive meets with a certain staff group to understand what is going well, and what could improve their working lives. Over the last year, breakfasts have been held with 24 staff from staff groups including Heads of Departments, Corporate middle management Band 7, Charge Nurse Band 6

Statutory / Mandatory Training

Discovery is our learning management system accessed by staff either at work or at home. Staff can see at a glance what courses they are compliant in, what courses are about to become non-compliant & what courses are now non-compliant.

A comprehensive programme of statutory and mandatory training is in place across the Trust with the requirements tailored to specific job roles. Discovery has been set up to allow the individual to know which of the statutory and mandatory training modules they are required to complete and monitor their compliance against this requirement.
Discovery now hosts all our e-learning packages which offers ease of access to staff to complete their statutory and mandatory training. For those courses which still run as face to face sessions, staff are able to book onto them directly via Discovery.
Feedback from staff remains very positive and the functionality of the system allows managers to see the training compliance of their team members. Monthly reporting at all levels from Team to Trust ensures that focus can be given to any areas or courses that

require it. This focus has led to a 93% overall compliance rate across the Trust at the end of March 2020.

Apprenticeships

We are fully committed to utilising the Apprenticeship levy to provide alternative opportunities for the local workforce and increase our skill base. During 2019/20, we have engaged a number of apprentices across clinical and non-clinical roles with 127 staff studying for apprenticeships during 2019/20. Further increases will take place in 2020/21 including higher numbers of existing apprenticeship (e.g. Nursing Associates) and new apprenticeships coming on stream (e.g. wellbeing. Psychological Wellbeing Practitioner).

Medical Education

We remain strongly committed to investing in learning and development for all our staff and development sessions are run for all Medical staff with a strong focus on student doctors on rotation as well as more experienced staff. Balint Group and MRCPsych programmes are held regularly.

The Trust runs a monthly Continuing Professional Development (CPD) programme for all medical staff led by the Deputy Director of Medical Education. Through the Trust and Health Education East of England various career developmental opportunities exist for staff with bursaries or sponsorship for postgraduate courses in areas such as Medical Education, Clinical & Educational Supervision, Leadership and Management.

The challenges of the Covid-19 pandemic has led to the local academic programmes and MRCPsych Course run for junior doctors being accessed remotely which has led to an improved attendance record and better monitoring system of attendance. The monthly CPD programme for medical staff is also now delivered remotely and led to similar improved attendance.

The annual General Medical Council (GMC) Training Survey was postponed this year but previous years' survey results have put us in the forefront of mental health trusts in the region. Furthermore psychiatric trainees have continued to make steady progress in terms of their success in the Royal College of Psychiatrists' examinations. The Trust runs a peer mentoring scheme for junior doctors as well as offering mentoring training opportunities.

The Trust's International Medical Fellowship continues to be a success with the recruitment of overseas trained psychiatric trainees which has also ensured no gaps in training posts in the Trust as well as offering the overseas trained psychiatric trainees excellent training opportunities. This has been evidenced by their success in the Royal College of Psychiatrists examinations and taking on higher training opportunities and permanent employment for those who opt to stay in the United Kingdom.

Collaboration with the University of Hertfordshire has continued with the successful establishment of the Masters in Physician Associate degree programme. The Trust offers psychiatric placement to students from the university and various staff members lecturing and examining on the programme. There are also ongoing collaborative research activities between the Trust and University of Hertfordshire. The Trust also supports the University of Cambridge medical school offering psychiatric placements for their students which has been a great success from the feedback received from the university. Similar placement opportunities are also offered to St Georges University Granada medical students where a number of staff been offered honorary positions on account of their contributions to student training.

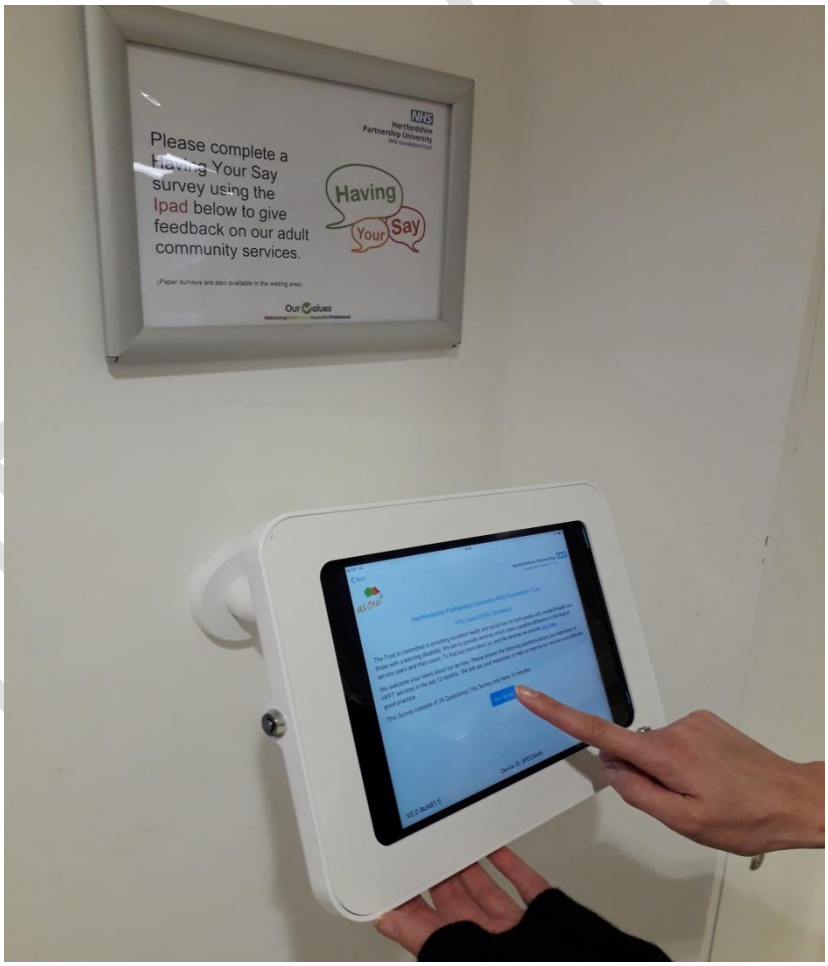
Health Education England coaching and mentoring funding 2019.20

Drs Kunle Ashaye and Rakesh Magon successfully submitted a bid to Health Education England East of England in November 2019 and were awarded £9k which will be used to support the establishment of a simulation suite at our Learning and Development Centre, The Colonnades in Hatfield. A Simulation Faculty has been set up to take this project forward and the development of a suite is underway.

Compliments, Comments and Complaints

We place great value on the comments, compliments and complaints sent in by service users, their carers, relatives, friends and advocates. We encourage people to raise concerns with staff on the units, to use the comments, compliments and complaints leaflets available on all wards and outpatient units. Alternatively they can complete a form on the Trust website at http://www.hpft.nhs.uk/contact-us/compliments-and-complaints/online-form/; email hpft.pals@nhs.net or call our dedicated phone line 01707 253916.

We also invite all service users and carers to provide ongoing feedback on their experiences by completing *'Having Your Say'* forms or Friends and Family Test (FFT) postcards, either on paper or electronically, during their recovery journey. Volunteers provide an impartial listening ear as well as support for service users and carers providing feedback.



What is the NHS Friends and Family Test (FFT)?
The NHS Friends and Family Test (FFT) was created to help providers understand the experience of care for service users and carers, where things may need to improve, providing opportunities for continuous quality improvement.

What we do with compliments, comments and complaints

We use information received through comments and complaints, together with the outcomes of any investigations to improve our services. We work closely with the Safer Care and Practice Governance Teams to ensure that lessons learnt are turned into action plans to change and develop practice.
Each quarter, every clinical team is required to produce a 'you said, we did' poster based on all the feedback they have received, sharing what they will do to improve the service with those who have taken the time to provide feedback.

We also feel it is important to celebrate what we do well, and all teams are encouraged to send details of compliments received to the Patient Advice and Liaison Service (PALS) and Complaints Team to make sure we capture the overall picture of service users and carers' experiences. We record all the compliments we receive and these are published in the e-magazine for staff. Satisfaction levels are monitored through *Having Your Say* and Friends and Family Test (FFT).

PALS

PALS provide people with advice and assistance if they have a concern or enquiry. This year we received 887 contacts – an increase of 15 (2%) on last year. The table below shows the number and main categories of PALS contacts, comparing 2019/20 with 2018/19, 2017/18 and 2016/17.

As in previous years, most contacts raised issues for resolution by the PALS team or, more commonly, by the clinical teams. However, there has been a 14% increase in enquiries, 21% increase in issues for resolution and 28% decrease in feedback.

We are being more rigorous about defining comments as feedback, informal complaints and issues for resolution which explains the changes to figures has meant an increase in contacts in that category compared to previous years.

Category	2016/17	2017/18	2018/19	2019/20
Advice	40	67	32	34
Enquiry	140	176	196	208
Feedback	100	240	156	113
Issues for resolution	446	183	272	330
Informal complaints	-	135	97	71
Other	1	0	1	0
Translation request	0	1	0	0
Non HPFT	32	59	114	126
Total	**759**	**861**	**869**	**8887**

Formal Complaints

When we investigate complaints we aim to provide a fair, open and honest response, and to learn from them, so service users and carers can benefit from the resulting changes. The number of complaints received in 2019/20 was 337 compared to 285 received in 2018/19, which is an 18% increase.

Main complaint issue	2016/17	2017/18	2018/19	2019/20
Assault / abuse	3	3	4	9
Clinical practice	93	89	113	137
Communication	35	24	49	36
Environment etc.	2	4	7	5
Staff attitude	31	26	35	31
Security	0	6	6	6
Systems & Procedures	84	54	69	113
Transport	2	0	1	0
Total	**250**	**206**	**284**	**337**

Emerging themes

Some PALS 'issues for resolution' and 'Informal complaints' are transferred to the formal complaints process, either because they cannot be resolved within one working day, or because they raise serious issues. Most issues and enquiries are dealt with immediately, or very quickly, by the clinical teams and do not result in a complaint.

The 137 complaints where clinical practice was the primary issue fell into 4 main categories. Most complaints fell into the following groups:

- Direct care (76)
- Assessment and treatment (22)
- Care planning (19)
- Diagnosis (6).

The 113 Systems and procedures complaints fell into 4 main categories. The highest numbers were for:

- Access to Treatment (48)
- Breach of Confidentiality (13)
- Mental Health Act detention (8)
- Record keeping (7).

During 2019/20 we received 4 requests for files from the Parliamentary and Health Service Ombudsman (PHSO)/Local Government Ombudsman.

During 2019/20 we received 4 requests for files from the Parliamentary and Health Service Ombudsman (PHSO)/Local Government Ombudsman; and the following 4 decisions:

- 2 not being investigated
- 2 were partially upheld.

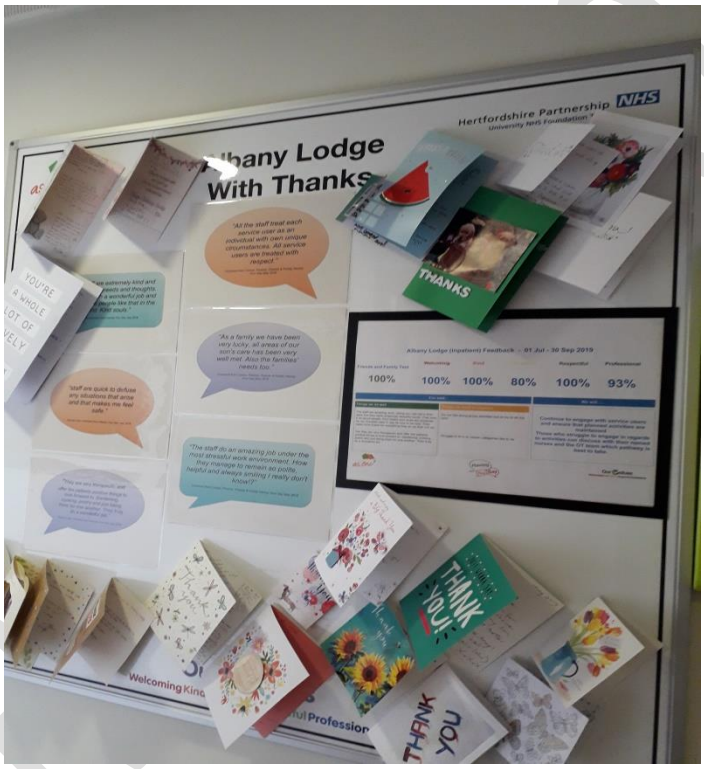
Compliments

All teams are asked to forward letters of thanks from service users, carers, advocates and visitors to the PALS and Complaints Team so that they can be logged and reported. In line with increased numbers of other contacts there has been a 27% increase in the number of compliments forwarded to the team.

- 2016/17 – 1915
- 2017/18 – 1981
- 2018/19 – 1571
- 2019/20 - 2003.

In 2019/20, we recorded nearly 6 times as many compliments as formal complaints.

"I feel so much stronger inside and I have the insight to continue to keep looking after myself."



Freedom to Speak Up

Throughout the year, we have promoted the Freedom to Speak up Guardian (FTSUG) role throughout the Trust**.** This has resulted in 35 concerns being raised, compared to 19 in 2018/2019.

Our priorities moving forwards are:

- Recruitment to the substantive post of FTSUG, incorporating the learning from the previous post holder
- Completion of the Board's Freedom to Speak Up Board Assurance Framework and action plan
- Maintaining the downward trend in anonymously reported cases, whilst ensuring all staff are aware of the role and how to raise a concern
- Reviewing the Terms of Reference and working practice of the FTSUG group in line with the findings of the Board Assurance Framework.

Clinical Networks

What is a clinical network?
These networks are dedicated to providing assurance and sharing good practice so we can improve the health service for all those who work in and use it.

We are part of the larger Eastern Clinical Research Network (CRNE) as well as an ongoing member of CRNE and contract with them annually to deliver NIHR portfolio research. Funding from CRNE supports some of our Research and Development staff. We are also the founders and members of the newly created Research in Developmental Neuropsychiatry (RADiANT) Clinical Network, and host this forum, with the RADiANT Network Manager sitting with services in Norfolk.

We are members of the following Quality Networks:

- Quality Network for Forensic Mental health Services (Adult Forensic) Community
- Quality Networks for Community Forensic Mental Health Inpatient
- Quality Networks for Early Intervention Psychosis (EIPN)
- Quality Networks for Child & Adolescent Eating Disorder Community (QNCC)
- Quality Networks for Child & Adolescent Inpatient (QNIC)
- Quality Networks Inpatients Child & Adolescent Inpatient
- Quality Networks for Peri-natal inpatients
- Quality Networks for Peri-natal community
- Quality Networks for Rehabilitation services Inpatient
- Quality Network for Psychiatric Intensive Care Units (QNPICU)
- Quality Network for Inpatient Learning Disability Services (QNLD)
- National Association of Psychiatric Intensive Care Units (NAPICU).

We also belong to the following Accreditation schemes:

- AIMS Accreditation Scheme (Royal College of Psychiatrists)
- Accreditation for Community Mental Health Services (ACOMHS)
- Accreditation Inpatient Mental Health Services Working Age Wards (AIMS WA)
- Memory Services National Accreditation Programme (MSNAP)
- Accreditation Programme for Psychotherapy Services (APPTS)
- Accreditation for Inpatient Mental Health Services-older people's wards (QNOAMHS)
- Electroconvulsive Therapy Services (ECTAS)
- The Psychiatric Liaison Accreditation Network (PLAN).

Network name and membership with number of member services participating nationally	Service Name	Accreditation Status	Number participating Nationally
Accreditation for Community Mental Health Services (ACOMHS) 32	Centenary House	In Review	32
	St Albans CMHT	In Review	32
	Cygnet House	Accredited	32

members	Holly Lodge	Accredited	32
	Oxford House	Accredited	32
	Rosanne House	Accredited	32
	Saffron Ground	Accredited	32
Accreditation Inpatient Mental Health Services Working Age Wards (AIMS WA) 128 members	Robin Ward	In Review	128
	Owl Ward	Participating but not yet undergoing accreditation	128
	Albany Lodge	In Review	128
	Aston Mental Health Unit	Participating but not yet undergoing accreditation	128
Quality Network for Inpatient Learning Disability Services (QNLD) 40 members	Assessment and Treatment Unit Lexden	In Review	40
	Dove Ward	Accredited	40
	Astley Court	Accredited	40
Quality Network for Inpatient Learning Disability Community Services (QNCLD pilot) 12 members	North Essex Community LD team	Developmental membership	12
	Mid & West Essex Community LD team	Developmental membership	12
Accreditation Programme for Psychotherapy Services (APPTS)	Health in Mind - North East Essex	In Review	
	Health in Mind - Mid Essex	In Review	
	The Wellbeing Service	Accredited	
	Healthy Minds - West Essex	In Review	
Early Intervention in Psychosis (EIPN) 9 members	Hertfordshire Early Intervention Service	Not accredited	9
Electroconvulsive Therapy Services (ECTAS) 97 members	Kingfisher Court ECT Clinic	Accredited	97
Memory Services National Accreditation Programme (MSNAP) 88 members	Early Memory Diagnosis and Support Services South West Hertfordshire	Accredited	88
	Early Memory Diagnosis and	In Review	88

	Support Services East Hertfordshire		
	Early Memory Diagnosis and Support Services North Hertfordshire	Accredited	88
	Early Memory Diagnosis and Support Services North West Hertfordshire	Accredited	88
Psychiatric Liaison Accreditation Network (PLAN) 77 members	Lister RAID (The Lister Hospital and Queen Elizabeth II Hospital)	Accredited	77
	Watford RAID Team (Watford General Hospital)	Accredited	77
Perinatal Quality Network - 21 inpatient members	Thumbswood Mother and Baby Unit	Accredited	21
Perinatal Quality Network - 57 community members	Hertfordshire Community Perinatal Team	Participating but not yet undergoing accreditation	57
Quality Network for Community CAMHS (QNCC) 67 members	Hertfordshire CAMHS Eating Disorder Service	Participating but not yet undergoing accreditation	67
Quality Network for Inpatient CAMHS (QNIC) 120 members	Forest House Adolescent Unit	Participating but not yet undergoing accreditation	120
Quality Network for Forensic Mental Health Services	Beech Ward (Kingsley Green)	Accreditation not offered by this network	127
	Broadland Clinic	Accreditation not offered by this network	127
	Eric Shepherd Unit	Accreditation not offered by this network	127
Quality Network for Psychiatric Intensive Care Units (QNPICU)	Oak Ward	Accredited	
Accreditation for Inpatient Mental Health Services-older people's wards (QNOAMHS) 75	Lambourn Grove	Accredited	75

members			
Accreditation Inpatient Mental Health Services for Rehabilitation (AIMS Rehab) 85 members	Gainsford House	Undergoing accreditation not yet accredited	85
	Hampden House	Undergoing accreditation not yet accredited	85
	The Beacon	Undergoing accreditation not yet accredited	85
	Enhanced Rehabilitation Outreach Service	Developmental members - no accreditation	85

CQC

As a Trust, we were registered with the Care Quality Commission (CQC) on 1st April 2010 to carry out the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

We were inspected by the CQC between 4th March – 27th March 2019, which included an unannounced inspection of services and a well led inspection. The Trust's report was published on 15th May 2019. We achieved an overall rating of '*Outstanding*'. The report focused on 5 different domains of quality:

- Safe
- Effective
- Caring
- Responsive
- Well-led.

The CQC's overall rating of the Trust was '*Outstanding*' because:

- The Trust responded in a very positive way to the improvements we asked them to make following our inspection in January 2018. At this inspection, the CQC saw significant improvements in the core services we inspected and ongoing improvement and sustainability of safe, good quality care across the trust. The senior leadership team had been instrumental in delivering quality improvement and there was a true sense of involvement from staff, patients and carers towards driving service improvement across all areas
- The CQC were particularly impressed by the strength and depth of leadership at the Trust. The Trust Board and senior leadership team displayed integrity on an ongoing basis. The board culture was open, collaborative, positive and honest
- The Trust's Non-Executive members of the Board challenged appropriately and held the Executive Team to account to improve the performance of the Trust. The Trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. The Board were seen as supportive to the wider health and social care system

- The Trust Strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. The Trust aligned its Strategy to local plans in the wider health and social care economy and had developed it with external stakeholders
- Leaders showed an inspiring positive culture with a shared purpose towards the vision, values and strategy, and modelled and encouraged compassionate, inclusive and supportive relationships between all grades of staff. The Trust ensured staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times
- Staff showed caring, compassionate attitudes, were proud to work for the trust, and were dedicated to their roles. The CQC were impressed by the way all staff in the trust embraced and modelled the values
- Service users told the CQC they felt safe across the Trust. The Trust promoted a person-centred culture and staff involved service users and those close to them as partners in their care and treatment. Staff provided positive emotional support to service users
- Staff felt respected, supported and valued
- Service users could access services when they needed to
- Staff kept clear records of service users' care and treatment. Service user confidentiality was maintained. Care and treatment records were clear, up-to-date and available to all staff providing care
- The Trust's governance arrangements were proactively reviewed and reflected best practice. The Trust had robust systems and process for managing patient (service user) safety.
- The CQC were also impressed by the Trust attitude towards innovation and service improvements. The delivery of innovative and evidence based high quality care was central to all aspects of the running of the service. There was a true sense of desire to drive service improvement for the benefit of service users, carers, and the wider system, evident throughout the inspection.

We devised an action plan with a list of '*Must do'* and '*Should do'* recommendations to address areas identified by the CQC of which its implementation was overseen by our Integrated Governance Committee and Board.

At the time of this report we have completed the following actions:

- Supervision recorded on Discovery
- Nurse call system installed on Aston ward
- Incorporating Rapid Tranquilisation observations into the NEWS2 chart
- Refurbishment of the Oak ward's Section 136 suite
- Continual initiatives to look to reduce the service users detained in excess of 24hrs in the Section 136 Suite
- Improved soundproofing work at Waverley Road and additional work at Holly Lodge
- Completion of all community environmental risk assessments
- Agreement for improvements to 15 Forest Lane environment, to include design of a new waiting and reception area, flooring, new refurbished kitchen and toilet areas and re-decoration resulting in a more modern and colourful look to the building.

The following core services were inspected:

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

- Wards for older people with mental health problems.

Our journey of good to great continues and we will build on this outstanding achievement together.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ May 2019	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good ↑ May 2019
Long-stay or rehabilitation mental health wards for working age adults	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015
Forensic inpatient or secure wards	Good →← Apr 2018	Good →← Apr 2018	Outstanding →← Apr 2018	Good →← Apr 2018	Outstanding →← Apr 2018	Outstanding →← Apr 2018
Child and adolescent mental health wards	Good ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019
Wards for older people with mental health problems	Good →← May 2019	Requires improvement ↓ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Wards for people with a learning disability or autism	Good →← Apr 2018	Good →← Apr 2018	Outstanding →← Apr 2018	Good →← Apr 2018	Outstanding →← Apr 2018	Outstanding →← Apr 2018
Community-based mental health services for adults of working age	Good →← May 2019	Good ↑ May 2019	Outstanding ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019
Mental health crisis services and health-based places of safety	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Specialist community mental health services for children and young people	Good →← May 2019	Good →← May 2019	Outstanding ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Community-based mental health services for older people	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015
Community mental health services for people with a learning disability or autism	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015	Good →← Sept 2015
Overall	Good ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019

You can the CQC reports at *https://www.cqc.org.uk/provider/RWR*

Our Sustainability and Transformation Plan (STP)

What is an STP?
Across England, NHS and Social care organisations have been encouraged to work together more closely to deliver more effective, joined up and affordable services. The country has been divided into 44 'Sustainability and Transformation Partnerships' or 'STP' areas by the national organisation, NHS England. Hertfordshire and west Essex is one of these 44 STP areas.

STPs were created to bring local health and care leaders together to plan around the long-term needs of local communities. They have been making simple, practical improvements like making it easier to see a GP, speeding up cancer diagnosis and offering help faster to

people with mental ill health. The mental health and learning disabilities STP work stream in Hertfordshire and West Essex has been focusing on ensuring liaison services are in all the acute hospitals, primary care mental health and crisis services are being developed and improved and improving services for people with a personality disorder.

In some areas, STPs have recently evolved to become Integrated Care Systems (ICP), a form of 'even closer' collaboration between the NHS and local councils. The NHS Long Term Plan set out the aim that every part of England will be covered by an ICP by 2021, replacing STPs but building on their good work to date. An ICP is a collaboration with NHS organisations, in partnership with local councils and others, taking collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

Developing ICPs and PCNs in Hertfordshire and West Essex

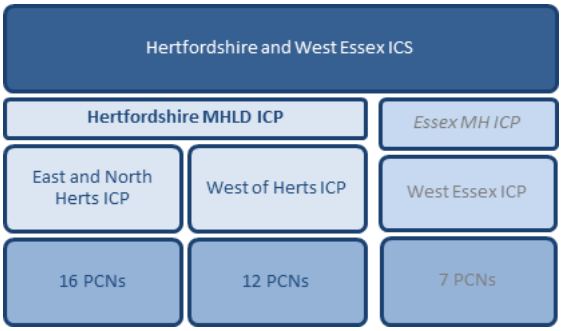
ICPs are local groups of health and care organisations, also importantly including borough councils and voluntary/community sector members, working across the existing Clinical Commissioning Group geographical boundaries. In Hertfordshire this means the two ICPs, East and North Herts ICP and West of Herts ICP, are developing their own priorities, reflecting the different needs of each local population, and thinking about how they will work differently in the future. Common themes are emerging, with more emphasis being placed on wellbeing and prevention and on breaking down the barriers between organisations. Frailty, children's services and mental health are common areas of concern. ICPs will work within the Integrated Care System (ICS). ICSs will operate on a larger footprint than current CCG boundaries, often matching STP boundaries. Locally this is the Hertfordshire and West Essex ICS.

New primary care networks (PCNs) have been established in 2019 and will form a key building block of the NHS long-term plan. They bring general practices together to work at scale for a range of reasons, including improving the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.

The Long Term Plan explicitly states that PCNs have an explicit aim to: "dissolve the historic divide between primary and community health services. Most networks are geographically based and, between them, cover all practices within a clinical commissioning group (CCG) boundary. There are some exceptions where there were already well-functioning networks that are not entirely geographically based. Some networks cross CCG boundaries.

PCNs will eventually be required to deliver a set of national service specifications and will be paid to do so.

Summary of the Hertfordshire and West Essex Integrated Care System at a glance:



What is the Hertfordshire MHLD ICP and why do we need a dedicated ICP for the population of people who have mental illness or a learning disability?

We know things get in the way of joined up care and can make it difficult to respond to physical and mental health needs in an integrated way, including institutional and cultural barriers, separate payment systems for physical and mental health care, and the trend for increasing sub-specialisation in professional education. As a result, people using services commonly find that their physical and mental health needs are addressed in a disconnected way.

The mental health and learning disabilities integrated care partnership (MHLD ICP) in Hertfordshire will connect NHS, social care and non-statutory providers with the delegated integrated commissioning functions to ensure that the services are joined up, safe and so that the high levels of complex need and risk are managed with and for individuals and on behalf of the system.

We are bringing together partners across Hertfordshire to collaborate and deliver care in a distinctly different way to how we organise and pay for care now. Building on the successes of current partnership arrangements, we believe this new Partnership will support us to work across Hertfordshire to join up the way partners deliver care.

It will help to ensure mental health and learning disability services are provided at scale where needed, whilst also ensuring care is delivered as close to home as possible where people live, learn, work and play. We will be able to break down the divide between physical health and mental health and learning disabilities, ensuring that care and support is as personalised and joined up as possible for those receiving that care.By focusing on building resilience, prevention and early intervention and on community based services and prioritising support for people early on in their lives/their illness, we will ensure people are able to live their lives to their full potential, and ongoing care needs are prevented or minimised. We will be support and care for people in the right place, at the right time, for the right reason with the right skills

Continuous Quality Improvement

Over the past 12 months, we have continued to evolve and develop our approaches to and our culture of Quality Improvement that enables us to continuously improve the safety, timeliness, effectiveness, efficiency, equity and person centredness of our services and the experience of using them.

We have successfully rolled out a programme of CQI development training for 320 leaders and coaches across the Trust. With a mix of both formal and some self-identified ‘improvement enthusiasts’ – in leading quality improvement. Also, joint working with the Organisational Development team has allowed us to run a number of Masterclasses for these coaches in leaders in areas such as Time to Care.

The CQI model has been successfully implemented, building staff capability in CQI knowledge and approaches, with 1183 staff receiving basic to advanced training. Additionally to this, we have continued to see wide use of the Innovation Hub and have rolled out a localised CQI Hub in Lexden Hospital, with at least 5 more to follow across the Trust.

Our colleagues continue to generate innovative ideas and use our Innovation and Improvement Fund to help access the financial and project development support available to progress their ideas. This year the Fund has supported ideas including:

- An electronic check-in system for CAMHS which notifies staff of their client's arrival
- A physiotherapy fitness DVD to support service users with learning disabilities and/or susceptible to falls
- The implementation of a transcription tool to assist the Executive Support team in providing high quality minute taking

CQI methodology has been instrumental in recovery, development and transformation initiatives across the year with a major push coming in service recovery following the COVID-19 pandemic.

Recovery

So this was year 13 in a journey which we can trace back seamlessly to 2006 when the Trust first became curious about the world of Recovery. That's where we started putting on annual events to celebrate amazing stories of overcoming adversity and living meaningfully in the face of the most significant health challenges. It's not all about celebration however, we also hear of poor outcomes and questionable practice and we use these to challenge ourselves to do better.

This year we stuck with the local and hopefully more personal approach and fully co-produced four events in different localities across Hertfordshire - Ware, Watford, Stevenage and Hatfield. Our theme for this year was Community and the organising group, composed largely of Experts by Experience, tried to tackle the conundrum of how it is some of us connect and find support, and others struggle and remain isolated.

In order to get into these 'thorny' issues, we organised a programme which began with a look back in history and had two local experts, Martin Brookes and Dr Mike Clarke shared their perspectives on the history of mental health services in Hertfordshire. This was a fascinating and thought-provoking look backwards, but also provided us with a lens to look afresh at the here and now. The New Leaf Wellbeing College shared their experience of developing a peer pathway within the college and we heard several touching accounts of what this had meant to people.

Perhaps the most provocative part of the programmes were dramatic pieces from May Contain Nuts - a drama group from Watford who have won a number of National awards including The Guardian award for Innovation in Healthcare. These were very powerful and personal accounts of suffering and recovering which were challenging but rewarding if you could hold onto your hat! We also heard from Hertfordshire Community Navigators who shared their skills of connecting people to support across the county – many of us were hearing of their services for the first time and many of us went away committing ourselves to spreading the word. In Watford, we were updated on a Recovery project run by Dr Pino Pini and others, which aims to help local communities develop more internal resilience in managing mental health problems Hatfield brought Dr Jorge Zimbron from Cambridge and Peterborough Foundation Trust (CPFT) to share with us the spectacular results that Shared Decision Making has been having on an inpatient ward for women with severe personality disorders. In Stevenage, there was a strong spiritual element to the programme with Andy

Smith and the Rev'd Peter Orton offering a session on this aspect of Recovery which is so important to so many of us.

Throughout all of our sessions, there was a very strong element of the voice of Lived Experience with so many people bravely sharing their personal stories of struggle and Recovery. More than once, feedback received was how inspiring these voices were for them and the hope that the speakers realised how much their voices meant to those hearing these kinds of testaments for the first time.

In terms of numbers attending, we once again broke our personal best – with 221 people attending from 287 bookings. More than half of those who came along completed a feedback form for us and the headline data around that is 97% of people rated their experience as good or excellent.

"Great to know that there is a way forward, and you are not alone"

"Good to see how many service users had great ideas and inspiring ideas. Really inspired and helped to reduce stigma"

New Leaf Recovery and Wellbeing College

New Leaf Recovery and Wellbeing College embraces the recovery approach, based on the principles of individual strength, co-production, choice, hope, opportunity and self-management. The college concept is an educational paradigm that promotes strengths and supports people to move from the role of 'patient' to 'student' or 'teacher'. It has co-production at every level. Co-production makes sure people with lived experience are equal partners, their experience and knowledge.
All courses are developed in the spirit of co-production, always including people with lived experience. All courses are ratified through the College Curriculum Board, who also oversees the curriculum development.

The numbers of registered students range from 1,200 – 2,500 within the academic year (September 2019 – July 2020). Non-active students are removed yearly to ensure unnecessary personal data is not kept. To date we have 1,350 registered students, with an average of 100 new enrolments monthly.

	Number of sessions	Number of attendees	Number of cancellations	No of DNA	Number of sessions cancelled due to low numbers	Number of sessions cancelled due to Covid-19
Autumn term 2019	49	859	274	363	0	
Spring term 2020	44	250	122	184	3	11
Summer term 2020	18	185	23	77	5	
Total	**102**	**1294**	**419**	**624**	**9**	**11**

Number of sessions, bookings and attendees

(Summer term has not finished – it runs until the end of July 2020. There is a further 15 sessions to run)

The average number of students per session is 12.5, which we have maintained for over a year. We actually have an average of 2000+ bookings over the year. Booking rates for many courses have been as high as 20+.

The college has a portfolio of 25 coproduced courses. Every year we create new courses and review existing courses to make sure the content is up-to-date and to take into consideration any student feedback. The college has revamped the Student Development and Involvement programme, offering students opportunities to become volunteers, peer tutors, peer mentors, quality observers and administrators on online courses. All students involved in the programme complete a development plan, highlighting their goals and a termly review. Alongside all peer tutors will have observations during teaching sessions and receive feedback to aid their personal development. We interviewed 3 students who had completed the development and mentoring workshops and all three were successful and are now teaching in the college.

During the Covid-19 pandemic, the college had to close its doors to classroom teaching. However, online sessions have proved very successful and we have coproduced a new course 'Keeping well in isolation'.

"Delivery by both tutor and peer tutor and content was spot on. The welcoming manner of both tutors and the break out rooms are a good idea"

"Having done many New Leaf College courses in the past, I found this on-line learning experience very good. It has surprised me to find that we stayed more focused on the course subject, and that the controlled method of speaking or communicating in the chat box, was much easier, and more controlled by the tutor and peer tutor"

"I'm really grateful for this course, especially in a time that is different and uncertain. It's nice to know that there are people who want to help us and time the time to guide us"

"First time using Zoom to attend a training course. Communication from the college beforehand was excellent. Tutors were lovely and engaging".

Physical Healthcare

Work has continued to improve the physical health of people who use Trust services. Progress includes:

- Community physical health clinics/new Physician Associate roles extended physical health clinics
- Falls prevention CQI
- NEWS2 introduction to support staff to understand and report on deteriorating physical health in service users
- SEM scanner on old age wards to prevent pressure area damage
- Integrated physical health clinics in Stort Valley working closely with GPs
- High risk medication monitoring via community pharmacist
- ECG clinics in Eating disorder service.

"Thank you so much for all your help. You have saved my life and allowed me to feel happy again. Although I am. Still going to struggle for the next 'however long', your help and support has made me feel normal again and I can now appreciate food like I used to. I cannot thank you enough."

We appointed a Nurse Consultant in Physical Health during quarter 3 for a one year contract to provide a high profile support to all our staff, ensuring compliance with our physical health policy and objectives. The post holder also supports with providing information on the physical health risks for our service users and developing and delivering health prevention strategies in line with the Long Term Plan.

The Physician Associate led enhanced physical health clinics we introduced provide support for people with serious mental illness (SM)I with their physical health through screening, intervening, referring and signposting. The service user feedback was extremely positive regarding the clinic set up and the role of Physician Associates.

A comprehensive review of our pressure ulcer and tissue viability work has led to a significant reduction in hospital acquired pressure ulcers. We are piloting innovative measures such as the use of a Sub-Epidermal Moisture (SEM) Scanner using a non-visual tissue assessment sub-epidermal moisture for pressure ulcer risk. We are now having a mini root cause analysis completed for all Grade 2 Pressure ulcers by ward staff to enhance learning and prevent progression of pressure ulcers. The Tissue Viability Nurse trained a further 27 staff from across the trust in pressure ulcer prevention and wound care.

The Trust has undertaken initial training and audit in the revised National Early Warning Score (NEWS2) to help staff identify the deteriorating patient. This includes soft measures for those service users resisting physiological observations. This is being more widely implemented for in-patient staff but local training has continued to support and upskill staff throughout the pandemic.

Frailty Pathway

In the past year we have introduced a new approach to managing our most frail population with a frailty delivery plan and have focussed on better awareness/more proactive management, clarity around expectations for staff and what they need to do if they identify someone as frail, increased opportunities for staff training new frailty link practitioners identified.
We are continuing the work with a focus in the Trust on

- Frailty Pathway Implementation
- Frailty identification / assessment and recording
- Training and Education
- Clinical Pathways – Falls, Tissue Viability, Dementia, Care Homes, End of life
- My Plan pilots
- Medicines Optimisation pilots.

We have been working closely with system partners on a collective understanding of frailty meaning that care and support can be more proactive and consistent across health and social care organisations for our frail population. Within the Trust, we have now developed and trained a new multi-professional frailty leadership team, implementing a Trust–wide delivery plan to support increased awareness and identification of frailty. We are developing a staff training model for improved recognition and assessment of frailty and physical health. We are strengthening the care we are able to provide by developing a new trust frailty pathway which will be live 2020, meaning that staff will be clear on what's expected of them once they have identified someone with frailty.

Integrated Care

We continue to be committed to bringing care together across physical and mental health and across health and social care and in the past year have expanded the work we do in the community to support staff and patients in care homes through the investment and expansion of a care home support team - this team is focussing on helping care home staff understand and manage behaviour that can be challenging and the difference between

dementia and delirium and how to meet the needs of older adults with mental illness and depression.
Our primary care mental health pilots have been expanded to cover all of Hertfordshire and two new pilots have started in Lower Lea Valley and Watford to model enhanced primary care services for people with eating disorders, personality disorders and episodes of mental illness that don't need long term coordination in secondary care services. Hertfordshire providers of children's services have been working together to introduce a much more integrated, person-centred and needs-led approach to delivering mental health services for children, young people and their families and are remodelling CAMHS services together.

Pressure Ulcers – zero tolerance

We continue with a zero tolerance approach to avoidable pressure ulcers. We have recruited a Tissue Viability Nurse (TVN) to ensure a robust care pathway in place to manage pressure damage and wound care. There continues to be a reduction in the number of incidents in 2019/20. Through the innovation bid, we are in the process of recruiting a band 4 TV Assistant One of the unit has completed a successful trial using the Sub Epidermal Moisture (SEM) scanner .This was part as part of the Pressure Ulcer Reduction Programme. We are now in a position to buy two scanners for the unit
We continue to: have :

- a robust system in place for providing medical devices, including pressure relieving mattresses, cushions and boots
- reviewed the Service Level Agreement for pressure relieving mattresses and cushions have and further improved the quality of the product that will be provided to our service users
- A dressing formulary available on each inpatient ward
- local Pressure Ulcer champions monitoring progress, who are having a positive impact promoting efficiency and evidence-based practice across our services
- continued to support the *'Heel Alert'* campaign: evidence suggests that heels are the second most common site for pressure ulcers, and that these are becoming more common
- run our annual *'Stop the Pressure Ulcer'* awareness annually across HPFT
- displayed *'React to red'* screensavers and posters and worked with the Bedfordshire and Hertfordshire Tissue Viability forum to send these out to GP surgeries across Hertfordshire, Bedfordshire and Essex
- continued to monitor pressure ulcers and to report our findings to our Safety Committee.

The procurement team and Head of Nursing for East and North Strategic Business Unit continues to monitor the purchase and use of pressure relieving mattresses and cushions, and staff continue to receive training in how to prevent and treat pressure ulcers and care for wounds.

Nutrition

Nutrition and Dysphagia Steering Group

Our Dysphagia and Nutrition Steering Group leads work across the organisation to make sure inpatient service users' nutritional needs are met. We use the CQC nutritional and hydration standards to guide our work.

Patient Led Assessment of the Clinical Environment (PLACE)

We achieved our highest ever scores for food in the PLACE audit, with scores above the national average in all areas:

- Trust overall score 96.74% against the national average of 92.10%
- Trust organisation score 96.33% against national average of 90.6% and,
- Trust ward food score 96.8% against national average of 94%.

It was positive to see the work we have implemented over the last few years reflected in the PLACE scores.

Menus

We have introduced new menus at Lexden Assessment and Treatment Unit, using Wiltshire Farm Foods to increase options specific to individual service users. We have also increased our provision to Thumbswood mother and baby unit, ensuring good nutrition to all mothers on the unit.

"To everyone at Thumbswood, my baby is now 6 months old, it feels like a big milestone and I want to thank you for helping us get there. Thank you so much for your support, kindness and respect during my very difficult transition to motherhood. The work you do is amazing, you are wonderful people. Thank you for believing in me when I wasn't able to believe in myself, you were right, I am a good mum and I really did get better. Love and thanks."

Snack provision

We used the activities delivered during last year's Nutrition and Hydration week to begin our discussions with service users and staff regarding improvements to our snack provision on all our inpatient units. New snack options have been rolled out across all our inpatient units. We have increased healthier options as well as expanding choices for service users at risk of malnutrition and requiring nutrient dense foods.

Staff initiatives

We have rolled out a new Dysphagia and Nutrition competency framework for our Assistant Therapy Practitioners (ATPs) working in our learning disabilities services. This framework was designed by our dietitians and speech and language therapists utilising evidence based practice and knowledge. We have several ATPs that have now completed the framework and our newer staff are working their way through. We have positive feedback from ATPs themselves who have found the framework very helpful in clarifying expectations and boundaries of their role. Supervisors have also found it to be a supportive approach particularly when a new ATP was joining from a different professional background.

A new Dietetic post has been established at Forest House, our adolescent inpatient unit. The dietitian provides a clinical service to young people with eating disorders and has led initiatives to improve the meals service on the unit. For example, she has worked with our facilities team and catering contractors to improve menu choices suitable for our young people, she led on piloting a dietetic assistant post on the unit to ensure sustainability of improvements, the impact of this post is currently being evaluated.

Bone Health

The Dietitian in learning disabilities inpatient services successfully made a case for Vitamin D to be prescribed for service users at high risk of Vitamin D deficiency as well as the nutritional implications following a dysphagia diagnosis. This will reduce the incidence of fragility fractures in those who have had a history of falls. The learning from this is being shared across our services.

Nutrition and Hydration week

This year we had planned to focus on encouraging staff and service users to consider low sugar and low salt options. Unfortunately, this year's Nutrition and Hydration week was postponed due to the Coronavirus pandemic. However we have all our new resources and plans ready to roll out during 2020-21.

Occupational Therapy and Pharmacy Health and Wellbeing Sessions

2019 saw the continuation of the Health and Wellbeing programme, established on the adult acute mental health wards. Devised and led by the Occupational Therapy and pharmacy teams, fortnightly sessions consisted of the following:

- Cardiovascular Disease- maintaining a healthy lifestyle
- Weight Management and exercise
- Safe use of alcohol and impact on medication effectiveness
- Sleep hygiene- adopting strategies and reducing reliance on sedatives
- Anti-Psychotics: management of side effects in daily life
- Managing agitation and anxiety: adopting strategies and reducing reliance on PRN (as required) medication
- Smoking cessation
- Medication compliance- managing this within your daily routine.

The first round of sessions started in February 2019 and the programme is now into its 4th round. The team have collated feedback from approximately 50% of all attendees and this is now being compiled by the principal pharmacist as part of a wider CQI project for the Leadership Academy. A summary of some of the highlights are shown below:

- 73 service users attended at least one session of eight during the first round of the programme
- This number increased to 103 service users by round 2
- 91% of service users have found the sessions helpful
- 76% said that they felt better after attending one or more of the sessions.

It is of no doubt that the exceptional partnership working of the acute Pharmacy and Occupational Therapy teams has been the driving force to establishing the effectiveness of these sessions. The initial outcome of embedding these sessions into the ward routine has been achieved, and several other service areas have expressed an interest to implement within their service areas, including Thumbswood Mother and Baby Unit, Inpatient Rehabilitation and Community Adult.

The plan is to develop a further session relating specifically to carers, and how they can support their loved ones to effectively manage their medication at home, whilst also encouraging a healthier lifestyle.

Joint working for safer mobility

In April 2019, Occupational Therapy staff in the older aged adult services took part in a training session with the older aged adult service Physiotherapist which enabled them to gain the competencies needed to assess and issue walking frames for service users on our inpatient units. The training was part of a Continuing Professional Development (CPD) session on using physical activity to improve health and well-being for our service users. The aim of the training was to equip the Occupational Therapy staff with the knowledge, skills and confidence to assess if a walking aid would improve mobility and safety when mobilising for service users. The outcome of the training was that staff working on inpatient units could assess for and provide an appropriate walking aid of the correct type and size more rapidly after mobility issues were identified, supporting safer mobilising and reducing the risk of falls.

Advanced Assistant Therapy Practitioner posts

The Occupational Therapy service in older aged adult services developed 2 band 5 Advanced Assistant Therapy Practitioner posts aiming to improve the provision of group interventions and parity of therapeutic activities across all four quadrants. These posts also enabled us to provide a career pathway for experienced band 4 Assistant Therapy Practitioners, using their skills and knowledge and keeping experienced staff in the Trust. The post holders were able to work across the county, supporting their colleague in Occupational Therapy to be more flexible in their provision of therapeutic group activities, with the aim of reducing waiting times for group support like Cognitive Stimulation Therapy groups for people with cognitive impairment. They have also been liaising with community organisations, developing alliances to improve carer support and the delivery of workshops for support and information in living well with Dementia.

Increasing awareness of falls risk

A community Occupational Therapist worked with her team colleagues to deliver a programme of frailty and falls awareness training as part of the older aged adult services falls awareness and assessment CQI. The pilot project involved engaging with all team members to support them with using the Falls Risk Assessment Tool as part of their mental health initial assessment. This enabled the team to identify the level of risk and take appropriate action to manage or reduce it, including referring for physical health checks and signposting for treatment such as exercise groups or falls awareness groups. The quality improvement project also resulted in an increase in referrals for Occupational Therapy assessments in the community team, enabling the Occupational Therapists to provide advice on strength and balance exercises, strategies to raise awareness and equipment in the home to help reduce the risk of falls.

Increasing Physical Activity in learning disabilities inpatient areas

Hydrotherapy has become embedded into the weekly Specialist Residential Services (SRS) therapy programme, with Trust staff completing lifeguarding training to ensure sessions are safely covered.
We are working in collaboration with Watford FC's Community Sports and Education Trust to provide a weekly sports session for service users at SRS. Coaches come in weekly to provide a variety of adapted exercises.
On Dove ward, service users make good use of the gym and the group programme includes adapted tai chi sessions.

All learning disabilities Occupational Therapy staff have attended training in adapted tai chi and chair based yoga and have introduced these as part of a sensory activity programme.

The gardening group has worked hard to make sure the improved garden at 6 Forest Lane is looking its best. The activities are graded to meet service user needs and designed to keep people active, for example using wheelchair accessible planters and outdoor tables to help with potting.

Other physical activities offered to SRS service users on a seasonal basis include carriage riding, accessible bike riding at Stanborough Lakes and horse riding.

Year Round Recovery Garden: Functional Frailty ward

Belinda Clayton, Assistant Therapy Practitioner on Wren Ward, Kingfisher Court, has been shortlisted for "The NHS Employers award for outstanding achievement by an Allied Health Professional (AHP) or healthcare science apprentice, support worker or technician" in this year's Advancing Healthcare awards.

Belinda has ensured the effective year round use of the ward garden, thinking sustainably and with the recovery of service users in mind on a short-stay functional frailty ward for older people with mental health problems. She creatively and sensitively offers opportunities for people to connect with nature, using the ward garden for promoting the health and well-being of service users through a range of ward based groups. This is not only sustainable but very cost effective and has extended beyond traditional gardening to art making sessions, quizzes to identify shrubs and cookery sessions. Not only does horticulture allow service users to retain a sense of identity by continuing to engage in a previous interest, it encourages being physically active, fresh air and a sense of connectedness.

In terms of evaluating the project, 157 people have attended 45 horticulture sessions ranging from 60-90mins in length since January 2019 (4 on the day of their admission) with a further 43 service users passively observing these sessions. 30 well-being groups have been attended by 110 service users- where nature is always central theme. Approximately 40 service users have completed Occupational Therapy specific evaluation forms, of which 93% of respondents either agreed or strongly agreed with the statement that: 'Occupational Therapy aided my recovery by helping me to engage in activities I find interesting'.

Case Studies (all pseudonyms)

- Sheila - former nursery owner and gold medal winner (chrysanthemums) at RHS Chelsea Flower Show.
  Self-neglecting, Sheila was admitted with a diagnosis of schizophrenia, with auditory and visual hallucinations and disordered thoughts. For a while, she was too anxious to engage in groups, believing the police or reporters were about to arrive to speak to her. Within a week, she started admiring flower arrangements completed by others, and the she started identifying garden shrubs. Without family, it took some weeks before we managed to glean anything of her background, but eventually we discovered that she had owned a nursery and won a gold medal at Chelsea for her Chrysanthemums. When she realised how impressed we all were with her past achievements she began sharing knowledge and giving advice. By the end of her stay, she was arranging up to 15 flower stems into oasis, and single-handedly carried out all the autumn pruning. She took particular delight in watching the Nemesia grow, from where she sat on the ward and she provided me with a daily progress report! Clearly fiercely independent, she left us a smiley, relaxed lady who was looking forward to once again pottering in her own garden and living life to the full.

- Andy- former groundsman and part-time gardener.
  Andy was diagnosed with paranoid schizophrenia and was frequently tearful. When completing an interest checklist with Belinda shortly after his admission, it was apparent that he felt he was 'useless' at everything. His knowledge gained as a groundsman was something that could be worked on to improve his self-esteem and after observing others during a gardening group, then a flower arranging session, he engaged fully in 3 flower arranging groups, independently creating attractive, artistic displays around a table with others. He was able to return to communal living when discharged, with a renewed belief in himself and his abilities.

- Sophie
  Sophie had experienced terrible trauma, both personally and from living in a war zone. She spoke and understood little English. She had been admitted to Wren Ward due to late onset psychotic episode and persecutory ideation. She had been living an isolated existence. After realising she could trust staff, she quickly started to engage in all nature-related activities, where language skills were simply not necessary. During flower arranging groups, she would make simple hand tied posies and give these to staff with a beaming smile. She let herself go creatively, with childlike enthusiasm, smiling and nodding approvingly at the work of others and pointing to where she wanted her completed artwork to be displayed. Relaxing with nature-themed activities provided a common ground where we saw Sophie able to relax, smile and laugh with others and eventually return home with hope for the future and a renewed connection with her fellow humans.

Our Physiotherapist has arranged for a training session from a Public Health England physical activity champion. This training is being offered to staff in older aged inpatient and community settings to improve their awareness on the importance of physical activity and how they can start conversations with service users about physical activity.

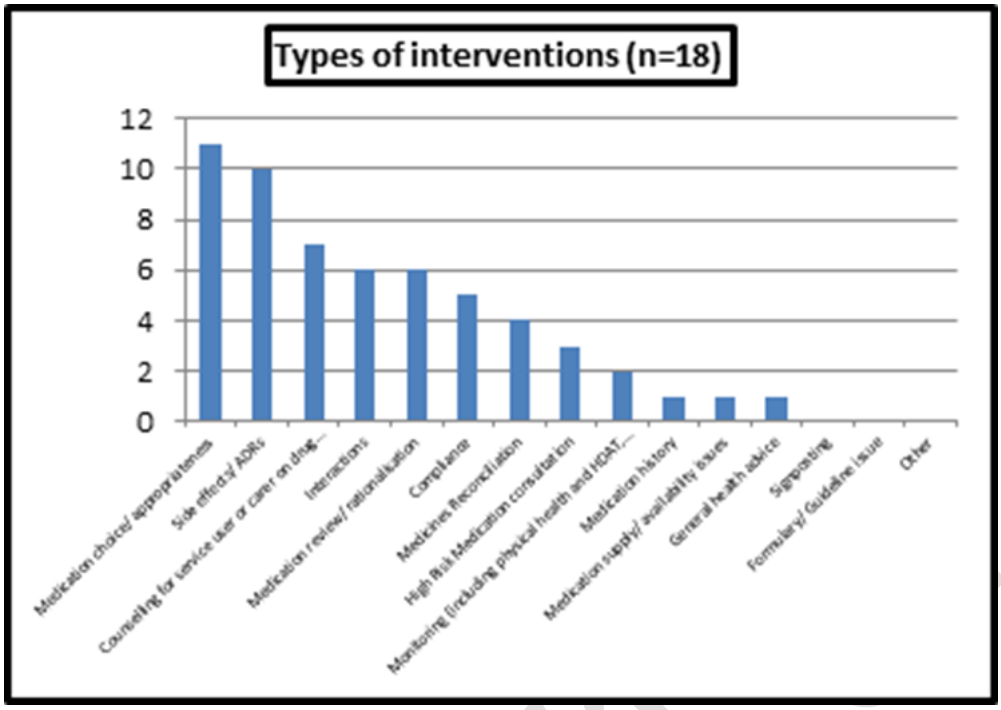
Spiritual Care Pilot

The Spiritual Care service is working collaboratively (as second professional) with psychology on an 8 month pilot to explore the effectiveness of offering family support as a key part of inpatient care. Up to 3 sessions are offered to inpatients and families/carers they identify as being significant to assess whether a systemic approach (rather than a solely service user focus) offers enhanced care.
This is an innovation fund project and is being assessed against a series of outcome measures with a view to offering it on other acute adult inpatient units. Meetings are open to all service users admitted to Albany Lodge, although are not accessed by all, for a variety of reasons. Questionnaires are administered pre and post meetings. Key data is also collated, including average lengths of stay and readmission rates is collated and will be compared to data prior to the pilot to test effectiveness.

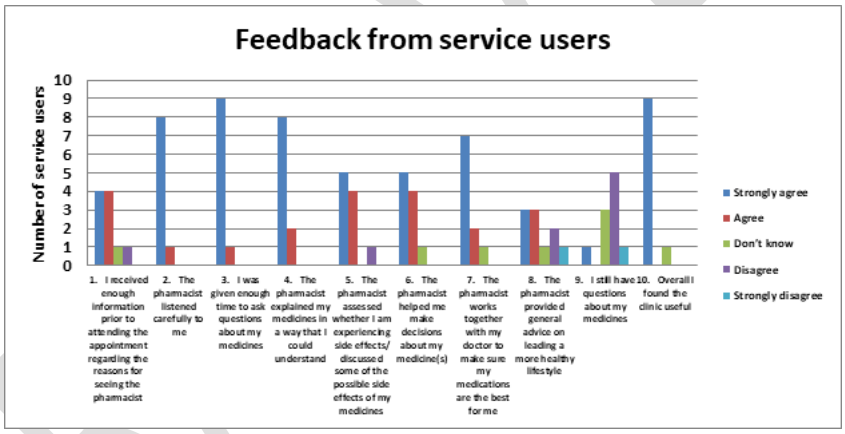
Pharmacy-led Medicines Optimisation Clinic

A Pharmacist-led medicines optimisation clinic was piloted at Colne House ACMHS. The clinic operated on a referral basis and received 30 referrals over a period of 6 months, of the 30 referrals 22 patients attended the clinic. The medicines optimisation clinic used a shared decision making approach during medication related issues were discussed. Following the appointment, the referrer was provided with feedback/ suggestions and this was saved on the electronic patient notes. The type of interventions undertaken are depicted in the table below which range from supporting the choice of medicines to general health advice. The second table below displays the service user feedback about the clinic. Some of the freetext feedback was as follows:

“felt better information about the options available and the impact of medicines”
“really good to speak to an expert about my medications”
“the flexibility in offering email advice, face to face review with patient as well as if needed see them at home is really helpful and flexible”
“excellent service which makes our prescribing safer and patients get a dedicated space to discuss their questions, concerns etc.”



Pharmacist led Medicines Optimisation Clinic interventions.



Service user feedback on Pharmacist led Medicines Optimisation Clinic

West SBU

Safety on the Ward Project

The Safety on the Wards Project has been completed by service user and carer representatives for West SBU. The aim of the project was to assess the effectiveness of safety strategies being used at Robin ward, Albany Lodge, Owl ward and Oak unit, with a focus on the Safeward methodologies.

Most service users do feel safe, most of the time, and report that incidents are dealt with very quickly. Where Safewards methods are being used, they are very successful,

Psychology in Home Treatment Teams

As part of the Hertfordshire Crisis Services Transformation Project, the development of psychological services within crisis teams has been a key part of providing a holistic approach to the assessment and treatment of service users using our crisis services. Psychology provision with our crisis teams is one part of transforming the current Crisis Assessment and Treatment Teams (CATT) into Crisis Resolution and Home Treatment Services.

Psychology has introduced a formulation driven approach to the crisis teams to provide a psychological perspective to the teams understanding of a service users difficulties. This perspective has then gone on to help shape the service user's treatment plans while under the crisis service.

Psychological services are also providing brief, evidence based psychological interventions to service users that focus on strategies that help the service user's crisis to resolve quickly. Evidence based approaches used include CBT, DBT, Mindfulness, Solution Focused techniques, psychoeducation and Motivation Interviewing.

The Assistant Psychologists are now all offering an in-depth 'Staying Well after Crisis' package to all service users. This involves relapse prevention and a number of stress management techniques to help the service user manage future stressful life events.

Occupational Therapy in Crisis Services

As part of the Hertfordshire Crisis Services Transformation Programme, the development of Occupational Therapy has been integral in being able to offer an holistic approach to the assessment and treatment of service users who access these services.

We have been able to establish and embed our provision within the existing crisis teams. There has been work with the Acute Day Treatment Unit's and the adult inpatient wards in promoting the role of Occupational Therapy within crisis services and exploring ways of better linking up our services more widely across the acute and crisis care pathway. Examples of this include providing a specific CATT Occupational Therapy 'in-reach' service to Swift ward, in order to identify early those service users who would benefit from occupational therapy when they are discharged into their respective CATT and to commence the initial screening and collaborative goal-setting from there. We have a similar model operating across our treatment wards; whereby the respective CATT Occupational Therapy liaises regularly with the treatment ward Occupational Therapy in regards to any ongoing assessment and/or intervention work that will be required when the service user is discharged home.

As well as providing an occupational therapy assessment function within the crisis teams, the Occupational Therapist's in post have also been busy in developing their 'intervention menu'. Specific interventions have been tailored and personalised as much as possible to what is meaningful to each individual, and encompassing the key areas of function that Occupational Therapist's are mostly concerned with: self-care, productivity and leisure.

Community Perinatal Team

In October 2019, the Community Perinatal Team received a Highly Commended in the Positive Practice in Mental Health awards. The National Collaborating Centre for Mental Health (NCCMH) and the Positive Practice in Mental Health (PPiMH) Collaborative work together to help identify and share examples of how good mental health care can be delivered.

The team were also finalists for her Heart Radio Hertfordshire Hero Community Award, having been nominated by one of our patients. PPiMH is a user-led multi-agency collaborative of 75 organisations including NHS trusts, CCGs, third sector organisations and service user groups. The PPiMH Collaborative's aim is to raise the profile of mental health with politicians and policy makers and to disseminate good practice in mental health care.

First Response Service

The First Response Service provides 24 hour access to mental health services for people who identify, or have been identified as being in a mental health crisis. It is an age inclusive service for people from the age of 18 years and includes adults over the age of 65 years with a functional illness.

Support is provided initially over the 'phone, where staff trained in the process of mental health triage will attempt to de-escalate the individual's crisis over the phone and formulate a safety plan for that individual. Depending on the risks and needs identified, a face to face assessment can be arranged and carried out by a Mental Health First Response clinician or appropriate locality CATT or support will be offered, advice given and referral to the appropriate services which best suit the needs of the individual.

We have recruited band 5 tele-coaches (wellbeing practitioners) who provide support initially over the phone and who are in the process of being trained in the process of mental health triage and who will attempt to de-escalate the individual's crisis over the phone and formulate a safety plan for that individual.

Mental Health Liaison Teams 48 Follow-up

The Mental Health Liaison Team have introduced a 48 hour telephone follow up service for anyone who has presented with self-harm or suicidal ideation and whose needs could be best met in Primary care. The follow-up is to ensure that patients' needs are met and are post discharge.

The teams have also introduced the process of any older person who presents with suicidal ideation or self-harm, will automatically be referred to the Crisis Function Team. This is in agreement and supported by The Crisis Function Team.

Both The Mental Health Liaison Teams based in Watford General Hospital and the Lister Hospital submitted their applications to the Psychiatric Liaison Accreditation Network (PLAN) in December 2019, and have now both received their accreditation and are part of the network PLAN is a quality improvement and accreditation network for psychiatric liaison services in the UK. PLAN is a quality improvement and accreditation network for psychiatric liaison services in the UK.

Accredited Services in West SBU

Oak Ward (PICU)

Oak Ward were successful in being awarded their Accreditation by the QNPICU (Quality Network for Psychiatric Intensive Care Units) in November 2019, The period of accreditation will last for three years is a testament to all their hard work from the Team.

Thumbswood Mother and Baby Unit

Thumbswood Mother and Baby Unit received their Accreditation from Members of the Perinatal Quality Network in September 2019 and the next review will be due in September 2022.

Electroconvulsive Therapy (ECT)

ECT based at Kingfisher Court had their ECTAS (Electro-convulsive Therapy Accreditation Service) accreditation approved by the Royal College of Psychiatrists' Combined Committee for Accreditation following their meeting on 16th December 2019. Not only did the Team evidence 100% on all Standards (243/243 Standards), but were also commended in all four domains which is a fantastic testimony to all the hard work the team put in to running a safe and secure service.

Depot Clinics

Our North West Adult Community Team has trialled the formation of a specialist multi-disciplinary mini team for service users receiving depot and clozapine medication. This has enabled a focus on the particular needs of this service user group and has created consistency of approach for people receiving long term antipsychotic medications in these categories. The mini team ensures the delivery of high quality care co-ordination for the service users to ensure care is joined up and considers mental health, physical health and social care needs in a holistic way. Early evaluations of this approach have indicated increased positive outcomes and experience for service users

Family Intervention in Early Intervention in Psychosis Services

Our PATH Team, which delivers the First Episode in Psychosis pathway for people in Hertfordshire, has increased access to Family Intervention to Psychosis (FIp) for service users on the pathway. The team has trained 19 staff to deliver FIp, through the provision of specialist training and supervision. This means the service now has a range of practitioners who are qualified to deliver this important therapy to people and their families and the service is increasingly able to ensure timely access to this therapeutic approach when families need it

Joint working with substance misuse services

Our PATH service has been working jointly with Spectrum Substance Misuse services across the year to deliver a collaborative training programme to the workforce, designed to upskill members of each service in approaches to improve interventions for people with a Dual Diagnosis. The training programme focusses on ways to support people with mental health challenges, how to deliver motivational interventions and also builds awareness of important harm minimisation messages and interventions. The work has improved knowledge bases within the teams and developed better working relationships. Evaluation work will focus on the extent to which outcomes have been improved for service users and carers.

Improved access to Adult Community Services in West Herts

Our Adult Community Teams in West Herts have succeeded in consistently improving access to services for people who require specialist assessment. They joined forces with East and North Herts to scope and run a CQI programme designed to identify and address the challenges with access. As a result of the work, access to services is now quicker, with

over 98% of service users in Hertfordshire able to access specialist assessment within 28 days by quarter 3 of 2019/20. The CQI programme also focussed on improving referral management, ensuring service users received the right intervention at the right time and got timely access to a psychiatrist when they needed to see one.

"'x' visited today. Was very informative, very patient and understanding. This service has been of great benefit to us as a family."

GP Plus development

In Herts Valleys work has continued to further develop the GP Plus scheme. GP surgeries across Herts Valleys have been able to refer service users to specialist practitioners, working in surgeries, for rapid assessment within 7 days and intervention, within 14 days. In Herts Valleys, GPs, the Trust and Hertfordshire MIND have delivered the service in partnership to ensure people can benefit from specialist assessment and structured intervention at the GP surgery and in their local communities.

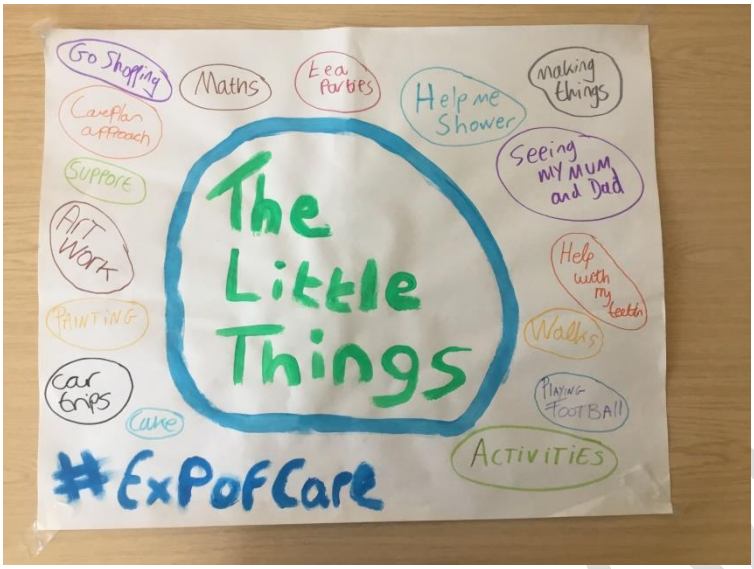
Learning Disability and Forensic SBU

We have strengthened our working relationships with social care partners in Buckinghamshire to improve health outcomes for people with a learning disability and their families and carers, through co-location at our base in Aylesbury and the development of integrated working practices during 2019/20.

We successfully established our Enhanced Rehabilitation Outreach Service (EROS) and have empowered our service users to recover in the least restrictive setting by supporting their transition from our rehabilitation units to their home in the community. This has resulted in a 10 week reduction in the average length of stay on our units.
We have also co-produced and launched our Carers Charter across our rehabilitation sites to demonstrate our commitment to involving carers in the development of care plans to support sour service user recovery.

We launched our Social Care Transformation Programme in collaboration with our system partners and our Community Mental Health teams, to oversee the rollout of the Connected Lives model, embed the principle of personalisation in our working practices and enable our service user to live as independently as possible.

We have set up the Equality Group for the Learning Disability and Forensic SBU which has been running since September 2019. The group have successfully provided a forum that encourages the exchange and generation of good practice with regard to issues relating to diversity and inclusion The group has also empowered staff through workshops/ trainings to deal with issues relating to race, culture and diversity as well as dealing with inequality in Black Asian and Minority Ethnic (BAME) recruitment and discrimination.



Other key achievements during 2019/20 from the Learning Disability and Forensic SBU include:

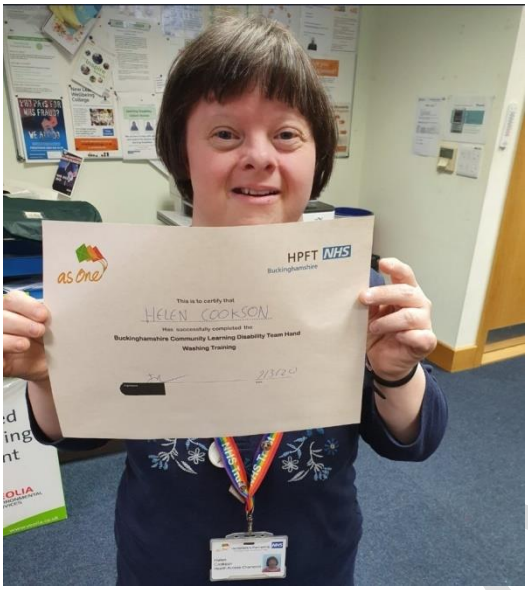
- Rehabilitation Service
  - Rollout of Enhanced Rehabilitation Outreach Service (EROS)
  - AIMS process started
  - Developing Harm Reduction capability in the workforce
  - Launch of Carers Charter
- Specialist Learning Disability Service
  - Integrated working and co-location with social care in Bucks
  - Establishment of Learning Disability Outcome framework
  - Restrictive Practice CQI project demonstrating improved practice
- Secondary Care
  - Establishment of social care transformation programme
  - D2A Discharge to Assess pilot launched
- Workforce
  - Expansion of CQI capacity and capability across SBU
  - Establishment of SBU Equality Group
- Sustainability
  - 19 month extension to the Bucks Learning Disability contract
  - Forensic New Care Models.

"I feel my wife has had all her needs met very well by the EROS team."

Buckinghamshire Services

Our team in Buckinghamshire have embraced a number of initiatives including Blue Monday. The Client Opinion Group also supported designing our new team leaflet. The Physiotherapy team have been looking into an app to provide their service users with their individual exercises.

The team continue to work towards annual health checks and may have a more active part to play in the future.



Essex Services

Specialist Health Learning Disability Services have been part of an extensive transformation programme, leading the new contract of Essex Learning Disability Partnership. The key areas of this transformation over the year include:

- Formation of governance structures across the partnership;
- Transformation of core services across the county. Specifically Enhanced Support Services, Community Forensic Services and Inpatient Services. Audited Standard Operating Procedures are in place across the county to ensure best practice;
- Formation and work across several corporate work streams including estates, workforce, technology and quality
- Coproduction has underpinned transformation across the county.

Over the past year Health Access Champions and Inclusive Communication Essex have moved over to the Trust as part of the Essex Learning Disability Partnership that further strengthen co-production and inclusiveness.
Specialist Learning Disability Services for children and young people in Essex moved over to the Trust and Essex Learning Disability Services at the beginning of 2020 and this moves towards a lifespan model for Essex.

We led a bed review across Essex Learning Disability Partnership to plan the best way to provide the contracted 11 Assessment and Treatment Inpatient beds, currently provided across two sites. A decision is expected in late summer and planning will commence immediately following that. A review of provision across the Partnership was and is a key part of the Transformation plan for learning disabilities in Essex to ensure access is available in all areas and, where possible, has taken opportunities to collocate with system partners.

"As parents of a young man with learning disabilities, our lives are a constant battle with either our child or the authorities, trying to get the relevant help we need, constantly filling out forms and proving our needs. We can't really put into words what having 'x' and 'x' on our team has done for us as a family, safe to say, we are probably still a whole family because of their input."

What is AMBIT?
This is part of the development of the Personality Disorder pathway within our Learning Disability services, led by psychology. AMBIT is a mentalisation based team approach for teams working with young people with severe and multiple needs, who do not tend to access mainstream services run by the Anna Freud Centre. The plan is to train members of the Learning Disability community teams in Hertfordshire, Buckinghamshire and Essex as trainers. It will be involving all members of the team, including psychology, Allied Health Professionals, nursing and psychiatry.

East and North SBU

High risk pathway

We have implemented a high risk pathway ensuring safe management of service users with significantly high risk of self-harm, violence or safeguarding. Cases that are high risk/complex will be highlighted in the daily review/ward inpatient Multi-disciplinary Team Meeting (community) as a case of concern. Risk Formulation Meetings chaired by the Consultant Psychiatrist or other senior clinicians will ensure a risk management plan is formulated according to the guidance from the Trust's Risk Assessment Policy. High Risk Panels are chaired by the Clinical Director and or Medical lead with Service Line Lead for further support.
We have introduced a Risk Formulation box in the risk assessment form on the EPR and offered a series of Risk Formulation training to staff to improve quality of risk assessment. A re-audit of quality of risk assessment in quarter 3 shows an improvement in the quality of risk assessment.

Medicines Management

We have undertaken significant work in relation to medicines management to ensure the safe prescribing and dispensing of medications. Medication safety reporting is now part of our wider safety reporting to our Board and commissioners.

'Specialist mini teams'

The adult community team at Rosanne house has organised staff into mini teams of a nurse, social worker and support worker, to share skills, and mutual support. This has had good staff feedback and has also allowed more specialist mini teams to develop for acute care pathway transfers to community, supporting a timely transfer of care; and for depot clinic support, providing a mini multi-disciplinary team around depot service users, instead of the 'traditional' nurse only approach.

Agile working

An agile working project has been taking place at Holly Lodge to upskill staff training in best use of existing electronic systems, provide recommended agile equipment so staff can work in an agile way, and worked with the team on the desired workplace culture to support agile working. This has supported staff to reduce travel time with the use of Skype video conferencing, and to manage diaries to work more effectively.

Depot clinics

Depot clinics traditionally use a paper diary and there have been a number of incidents of staff not noticing missed appointments. The EPR has an appointment option, and this has been utilised to set up the Holly Lodge depot clinic with electronic appointments. This has enabled an administrator to assist the depot clinic in managing appointments, and enables depot appointments to be reported with much clearer visibility on DNA for risk management. This is being rolled out to a second adult community mental health team with the view this should roll out across the Trust.

A new project has been initiated at Saffron Ground. Its purpose to provide a wellbeing clinic attached to the depot/denzapine clinics and the physical health clinic at Saffron Ground. The aim is to close the loop when health concerns are raised and ensure that we are up- to date on the treatments that our service users are receiving/not receiving so that we can assist them to receive this help via their GP's. We will introduce a hydration pathway for the service users that attend these clinics and full monitoring of bowel issues. This is part of the learning from a serious incident at Saffron Ground.

"Lambourn consistently delivers a caring, welcoming and reassuring environment."

End of Life Care

We conducted an audit of our practice around 'Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR).' This highlighted that a DNACPR form was completed for 99% of cases in older people inpatient services, a significant improvement on the previous audit. The Trust is part of a Hertfordshire wide End of Life Care Strategy Group working in collaboration with other NHS providers and local hospices.

"We are truly very happy with Dad's care and would to say a huge thank you. Dad's last few weeks were very hard for us as a family. However, it was made easier by having such compassionate and empathetic staff."

72 hour follow up

In line with national best practice the Trust introduced 72 hour follow up, moving from 7 day follow up, for people discharged from CAHMS, acute and older people inpatient wards in April 2018. Performance has been consistent and positively sustained at 90% for 72 hour follow up. This change in practice was made due to increased risk of self- harm or suicide being a known risk on transition from an inpatient mental health to a community setting. A clinical audit of discharge follow up practices, for people transitioning from inpatient to community settings, demonstrated that 89% of people who were identified as at risk of suicide were followed up within 48 hours. National best practice is identifying the first 48 hours post discharge as the time of increased risk of harm to self, and the Trust is therefore progressing plans to move to an expectation of 48 hour follow up post discharge for all service users.

CAMHS

There continues to be a focus on ensuring robust transition of young people between CAHMS and adult mental health services, in order to ensure they have a positive experience, feel supported and have a seamless transition. As this has strong national focus as a key issue, transition arrangements has formed part of the Trust's CQUIN for the past 2 years. As part of this work stream, audits have been undertaken to evaluate the quality of young people's transition processes and experience. The most recent audits having demonstrated positive transition processes with CAHMS having identified that 100% of young people had allocated keyworkers through transition to adult services and that the young person was actively involved in transition meetings and planning in 88% of cases.

The Trust has experienced a significant increase in referrals/demand for CAHMS. We have worked with staff using CQI approaches, proactively managing the risk and experience of those people waiting for assessment; changing practices around triage, providing week-end clinics, introducing DNA protocols to strengthen the management of clinical risk; implementing Primary Mental Health Care Pilots and discussions with commissioners around future care models for the services. 95% of child and young people are now assessed with 28 days of referral.

The CAMHS Home Treatment Team has won this year's HSJ Award in the Acute or Specialist Service Redesign Initiative. The Team were also Highly Commended at the Positive Practice Awards for Crisis support.

"He treated my child with such warmth and kindness and also most importantly with good humour enabling both my child and myself to relax and have a very positive discussion."

"Easy to talk to, very professional member of staff who had strategies, sympathy and was very thorough. A crucial service for anyone feeling there's no future or in need of mental health support. Thank you, thank you."

Care Home Project by MHSOP-SW Herts

The project is a finalist at this year's HSJ Awards. The team has been shortlisted in the Community or Primary Care Service redesign initiative-London and the South category. The integrated Care team was also awarded inaugural National OPMH and Dementia Awards in innovative Practice

SafeCare and eRostering update

What is eRostering?

The use of eRostering aids the management of our workforce, including service user demand, establishment management, staff working preferences, absence management, rostering, time and attendance as well as payroll integration. It also helps with the effective rostering of staff, ensuring that service requirements are met. Furthermore, it ensures that services run in a fair and efficient way, reducing errors in timesheets and ensuring staff are aware of their off duty in a timely manner.

What is SafeCare?

SafeCare is mounted onto eRoster and calculates the required staffing from service user numbers, acuity and dependency, three times a day. It provides as site-wide overview of required versus actual staffing, highlighting hotspots as well as areas that could help.

SafeCare enables the viewing of staffing status across many dimensions, including hours short/excess, missing skills, missing service user census, Care Hours Per Patient Day (CHPPD) and the cost of a shift. It also enables the tracking of attendance and sickness of all rostered staff.

During the year, we saw a continued use of SafeCare in the inpatient service areas. Census checks were undertaken three times a day, detailing the safety of the staffing levels and whether staffing hours are short or in excess of hours for the forthcoming shift.
Daily SafeCare calls manage and monitor safe staffing within each of the SBUs, redeploying staff to another unit as appropriate as well as monitoring the bank and agency usage and service user acuity levels. Furthermore, eRosters have been more clsoely scrutinised via weekly meetings, ensuring their effective utilisation and compliance.

We commenced involvement of a self-rostering pilot initiative to implement a team-based rostering system for nursing staff. This pilot is aimed at increasing nurses' input into their working patterns and improving work-life balance in the Trust and provides the nursing team with autonomy and permission to negotiate the eRoster, in the context of being open and transparent. Some of our inpatient services from each of the SBUs are participating in the pilot.

The monthly Safer Staffing Group which was reviewed last year, continued throughout the year, chaired by the Deputy Direcotr of Nursing and Quality/DIPC.

In consideration of safer staffing levels during the year, the Care Hours per Patient Day (CHPPD) showed that there were many services which had used staffing above their establishment to meet the clinical needs and demands of the services. These were predominantly owing to the aucity levels and requiring prescibed increased levels of safe and supportive observations.

The first cohort of the Trainee Nurse Associates (TNA) who completed their training last year are all working as Registered Nurse Associates (RNA) across the service areas. Staffing establishments were reviewed and the Quality Impact Assessments completed by the Heads of Nursing, ensuring the upskilling of the nursing staff with whom the RNAs work, as well as ensuring the skills from their training are fully appreciated and utilised in the service areas.

The vacancy rates of the nursing staff remained a focus, with an increased concern on the number of Registered Nurses (RN) who can retire. The Heads of Nursing have continued to closely monitor this, supporting individuals and exploring options for them to remain in the workplace.

Celebrating 100 years of the Learning Disability Nursing

Several members of our staff went along to Newmarket Racecourse to celebrate 100 years since the first *Mental Deficiency Nurses* as they were originally known, were registered. In line with the Past, Present and Next Generation theme of the conference, attendees were taken through a timeline of how the profession has changed since then. It's an exciting time to join/rejoin the profession, as the journey continues.
David Harling, National Head of Learning Disability Nursing told attendees how the profession can rise to challenges, starting with four reset actions:

- Attracting and retaining the LD Nursing workforce
- Enhancing the profile and reputation of the profession
- Developing the academic proficiency and clinical competence of the profession
- Celebrating the profession by supporting innovation and professional leadership

There were many examples and cases studies of excellence, innovation and Advocacy for people with learning disabilities. One of our newly qualified Learning Disability Nurses, Jamila Noah, impressed the room with an inspirational presentation about the obstacles she has overcome in order to qualify as a Learning Disability Nurse. Jamila is passionate about working to ensure people with a learning disability are given the tools they need to enable them to be listened to and flourish.

Our Executive Director for Quality and Safety and Chief Nurse, Jane Padmore spoke at the conference with an uplifting message for all LD nurses. She said: "Make sure your voices are heard as there are so many opportunities and so many people you can influence and impact. "Be generous with the skills, knowledge and information you have in order to support high quality care and excellent working practice."

Our Deputy Director of Nursing & Quality and Director for Infection Prevention & Control (DIPC), Jacky Vincent took questions from the floor before the conference was closed by the host for the day, Patrick Nyarumbo, Director of Nursing Leadership and Quality for NHS England and NHS Improvement (East Region). He reviewed a 'wordcloud' of why nurses are proud to call themselves an Learning Disability nurse.

Infection Prevention and Control

The year has seen some key progress including low incidence of alert organisms, implementation of the fact finding report identifying lessons learned following any suspected/confirmed outbreaks of infection and the implementation of a successful 90 day Quality Improvement initiative to improve hydration which will reduce the incidence of urinary tract infections. The year has also maintained a consistent training compliance and noted an increase in an awareness of IPC, from promotional events.

The latter part of the year has also had some significant challenges in relation to the Covid-19 pandemic. The Infection Prevention and Control team were an integral part of the Business Contingency Plan to reduce and control the spread of infection across the organisation. 2020/21 will continue to focus on the challenges relating to Covid-19, ensuring that the risks associated with transmission of this virus to service users, staff and carers is kept to a minimum.

SPIKE2

It has been 18 months since the launch of SPIKE2, our reporting and business intelligence tool. In this time, we have successfully expanded it to include other corporate reporting like Human Resources, Finance, DATIX, IAPT etc. On SPIKE2, we have about 54 dashboards across all the corporates which host ~389 KPIs/metric. It's been widely used by our staff for to meet their day to day reporting needs, as detailed in the table below.

Corporate	No. Of Views*	No Of Users*
DATIX	190	11
Finance	14,439	437
Human Resource	14,841	587
Clinical (PARIS)	398,498	1,816
Clinical (PC-MIS)	3,101	100
TOTAL	**431,069**	**1,998**

**only those staff who are currently working for the Trust at the time of the report.*

Finance

The Trust's Finance Team were accredited at Level 1 with Future Focused Finance (FFF), and one of the team won a national FFF award for delivering the most number of training hours in the country during 2019.

Modernising Our Estate

Improving and modernising our facilities

We have a number of initiatives underway to improve our community sites at Saffron Ground, Colne House, The Colonnades and Rosanne House. This includes internal refurbishment and remodelling the working areas.

A range of life-cycle decorating and minor works requirements have also been identified across 28 key sites, arising from our Patient Led Assessment of the Clinical Environment (PLACE), Senior Leaders and Big Listen feedback and also Estate led site surveys.

A full programme estimated at £2.2m has been prioritised based on need with future requirements being formalised within a rolling refurbishment programme. We have also invested in our Facilities Management contract and refreshed our Estates and Facilities in-house team to improve Estates' response time, improve response prioritisation from our outsourced supplier and focus on seclusion and Section 136 ongoing repairs and maintenance to ensure any decommissioning of critical areas is minimal

Furthermore, we have set out a significant investment programme to our seclusion facilities including refurbishment, new build and an increase in capacity to ensure we can always keep people safe during such interventions.

Approximately £1M was successfully invested in backlog maintenance projects during 2019/2020. The scope of works included:

- New energy boilers installed at 99 Waverley Road, Gainsford House, Prospect House, Albany Lodge and Victoria Court
- Refurbished staff wc facilities at 99 Waverley Road, as requested by staff at a 'Big Listen' event
- In addition, following a CQC inspection, we created a new staff observation room for the S136 suite, on Oak ward, in Kingsley Green.

We addressed the historic heating issue in the Pharmacy department at Kingfisher Court, by providing a new air conditioning system, resulting in the issue being removed from the Trust Risk Register.

The last of the 'bedroom dorms' within the Trust, were removed from Aston Ward in Lister Hospital. Every one of our inpatient now have their own single bedrooms. In Saffron Ground, we refurbished the 2nd floor reception & waiting area and at the same time extensively refurbished the 1st floor open plan office facilities.

An iHub facility was created at The Colonnades which has been warmly received and fully utilised. Work has commenced in refurbishing the current vacant space on the 1st floor of The Colonnades, which will eventually result in additional training facilities being provided on the ground floor including a new simulation suiter.

We have converted a wing within Prospect House which is the new base for the Enhanced Primary Care Team. Furthermore, we are in the process of finalising design plans for a number of new Safety Suites across the Trust's estate.

Annexe 1 – Statements from Partners

Healthwatch Hertfordshire's Response to Hertfordshire Partnership University NHS Foundation Trust (HPFT) Quality Report 2019

East and North Hertfordshire Clinical Commissioning Group

Herts Valleys Clinical Commissioning Group

Hertfordshire Partnership University Foundation NHS Trust Quality Report Statement from Herts Valleys CCG & East and North Herts CCG

Hertfordshire Partnership University Foundation NHS Trust Quality Report Statement from Seamus Quilty, Chairman Hertfordshire Health Scrutiny Committee

Annexe 2 Statement of Directors' responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.
NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2018/19* and supporting guidance *Detailed Requirements for Quality Reports 2018/19*
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2019 to March 2020
    - Papers relating to quality reported to the Board over the period April 2019 to March 2020
    - Feedback from commissioners dated xx 2020
    - Feedback from governors xx 2020
    - Feedback from local Healthwatch organisations dated xx 2020
    - Feedback from Overview and Scrutiny Committee dated xx 2020
    - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx 2020
    - The 2018 national patient survey xx
    - The 2018 national staff survey xx
    - The Head of Internal Audit's annual opinion of the Trust's control environment dated xx
    - CQC inspection report dated May 2019.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's Annual Reporting Manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the Board

……Date……..Chairman

……Date……..Chief Executive

Annexe 3 – External Audit Opinion

(Letter from KPMG)

Glossary

ACE	Anglian Community Enterprises
ADDS	Accelerated Directors Development Scheme
ADHD	Attention Deficit Hyperactivity Disorder
ADTU	Acute Day Treatment Unit
A&E	Accident and Emergency
AIMS	Accreditation for Inpatient Mental Health Services
AMBIT	A metallisation based team approach for teams working with young people
ANT	Advance New Technologies
APPTS	Accreditation Programme for Psychological Therapies Service
ASYE	Assessed and Supported Year in Employment
AWOL	Absent Without Leave
BAME	Black, Asian & Minority Ethnicity
BMI	Body Mass Index
BMJ	British Medical Journal
BNF	British National Formulary
CAMHS	Child and Adolescent Mental Health Services
CASC	Clinical Assessment of Skills and Competencies
CATT	Crisis Assessment and Treatment Team
C-CATT	Children's Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCQI	Royal College of Psychiatrists' College Centre for Quality Improvement
CEDS	Community Eating Disorders Service
CGL	Change, Grow, Live – health
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CORE	Clinical Outcomes and Research Evaluation
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPT	Community Perinatal Team
CQC	Care Quality Commission
CQI	Continuous Quality Improvement
CQUIN	Commissioning for Quality and Innovation
CREMS	Carer Rated Experience Measures
CRN	Clinical Research Network
CROMS	Carer Rated Outcome Measures
CTR	Care and Treatment review
CYP	Children and Young People
Datix	Trust incident reporting tool
DBT	Dialectical Behaviour Therapy
DiT	Dynamic Interpersonal Therapy
DOLS	Deprivation of Liberty Safeguards
DNA	Did Not Attend
DSP	Data Security and Protection
DToC	Delayed Transfer of Care
DWP	Department of Working Pensions
EbE	Experts by Experience
ED	Emergency Department
EDS	Equalities Delivery Scheme
EIP	Early Intervention Psychosis
EIPN	Early Intervention in Psychosis Network
ELDP	Essex Learning Disability Partnership

EMDASS	Early Memory Diagnosis and Support Services
EPMHS	Enhanced Primary Mental Health Services (IAPT)
EPR	Electronic Patient Record
EPUT	Essex Partnership University Trust
EROS	The new Rehabilitation pathway
EWS	Early Warning Score
FBC	Full Blood Count
FEP	First Episode Psychosis
FFT	Friends and Family Test
GMC	General Medical Council
HoNOS	Health of the Nation Outcome Scales
HCC	Hertfordshire County Council
HCT	Hertfordshire Community NHS Trust
HDAT	High Does Antipsychotic Therapy
HEE	Health Education England
HES	Hospital Episode Statistics
HMN	Herts Mind Network
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HQUIP	Healthcare Quality Improvement Partnership
HSCA (RA)	Health and Social Care Act Regulated Activities
HSCIC	Health and Social Care Information Centre
HSJ	Health Service Journal
HYS	Having Your Say
HSC	Hertfordshire Health Scrutiny Committee
HTA	Health Technology Assessment
HTT	Home Treatment Team
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Abuse Advisors
IG	Information Governance
IHCCT	Integrated Health and Care Commissioning Team
IPS	Individual Placement and Support
KPI	Key Performance Indicators
LeDeR	Learning Disability Mortality Review Programme
LFT	Liver Function Test
LQAF	Library Quality Assurance Framework
MES	Member Engagement System
MH	Mental Health
MHA	Mental Health Act
MHMDS	Mental Health Minimum Data Set
MOSS	Making Our Services Safer
MSNAP	Memory Services National Accreditation Programme
MTFP	Medium Term Financial Plan
NCISH	National Confidential Inquiry into Suicide and Homicide
NHSI	NHS Improvement
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NRLS	National Reporting and Learning System
OCD	Obsessive Compulsive Disorder
OSC	Overview and Scrutiny Committee
OT	Occupational Therapy
PACE	Practice Audit and Clinical Effectiveness
PALS	Patient Advice and Liaison Service
PAIG	Practice Audit Implementation Group
PANSS	Positive and Negative Syndrome Scale

PAP	Personalised Assessment Process
PARIS	Electronic Patient Record system
PATH	Psychosis, Prevention, Assessment and Treatment
PC-MIS	IAPT information recording system
PbR	Payment by Results
PBS	Positive Behavioural Support
PDS	Post Diagnostic Support
PELS	Peer Experience Listening Service
PEN	Patient Experience Network
PHSO	Parliamentary and Health Services Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient Led Assessment of the Clinical Environment
PLAN	Psychiatric Liaison Accreditation Network
PMVA	Management of Violence and Aggression
POMH UK	Prescribing Observatory for Mental Health – UK
PoS	Place of Safety
PPE	Protective
PREMS	Patient (service user) Rated Experience Measures
PRN	Pro Re NATA ("when required") medicine
PROMS	Patient (service user) Rated Outcome Measures
PSF	Provider Sustainability Fund
QNCC	Quality Network for Community Services
QNCC-ED	Quality Network for Community Services Eating Disorders
QNFMHS	Quality Network for Forensic Mental Health Services
QNIC	Quality Network for Inpatient Services
QNLD	Quality Network for Learning Disability Services
QNOAMHS	Quality Network for Older Adults Mental Health Services
QNPICU	Quality Network for Psychiatric Intensive Care Units
QNPMHS	Quality Network for Prison Mental Health Service
R and D	Research and Development
RAID	Rapid Assessment Interface and Discharge
RCA	Root Cause Analysis
RfPB	Research for Patient Benefit
SBU	Strategic Business Unit
SCM	Structured Clinical Management
SEVA	Senior Employment Education Advisor
SI	Serious Incident
SJR	Structured Judgement Review
SOF	Single Oversight Framework
SOP	Standard Operating Procedure
SPA	Single Point of Access
SPIKE	Reporting tool for the Trust
SSRI	Selective Serotonin Reuptake Inhibitor (a type of anti-depressant medication)
STaR	Support Time and Recovery
STP	Sustainability and Transformation Partnerships
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale
TNS	Total National Sampling
TVN	Tissue Viability Nurse
UK CRN	UK Clinical Research Network
WRES	Workforce Race Equality Standard

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 11b
Subject:	Final Draft Quality Report Account 2020/21	**For Publication:** No
Author:	Jacky Vincent, Deputy Director of Nursing and Quality/Deputy Director Infection and Control (DIPC)	**Approved by:** Dr Asif Zia, Director of Quality and Medical Leadership
Presented by:	Dr Asif Zia, Director of Quality and Medical Leadership	

Purpose of the report:

To update the Board with regard to the assurance work on the Quality Report Account for 2019/20

Action required:

The Board is asked to receive the report and to note its findings in relation to Quality Report Account for 2019/20.

The Board is asked to note the decision to commission internal audit to undertake an audit of data quality to support the audit of Quality Accounts for 2020/21.

Summary and recommendations to the Board:

Summary

Owing to revised requirements as communicated by NHSI in March 2020, KPMG were not required to provide assurance over the Quality Account Report for 2019/20. As part of their planning and interim work, they carried out work on one of the mandated indicators chosen by the Trust from a list of available indicators as specified by NHSI in its guidance namely:

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute of Health and Care Excellence (NICE)-approved care package within two weeks of referral.

In addition, KPMG carried out work on a locally selected indicator chosen by the Council of Governors. The indicator selected was the *100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital ("7 day follow-up").*

At the time the updated guidance was issued in March 2020 substantially no work had been completed in relation to the Inappropriate out of area placements indicator, and KPMG therefore have no findings to report in relation to this indicator.

Results of KPMG work

Attached is a report that sets out the key findings from their work as described above in relation to the one mandated indicator and the locally selected indicator. They assessed:

- The design and operation of the systems of control over the data against the six data quality dimensions defined by the NAO, and
- Performed testing of the underlying data quality for the period from 1 April to 31 December 2019.

They assessed these arrangements to consider whether they can be graded as:

Green: No improvement to achieve compliance with the dimensions of data quality noted.
Amber: Opportunities to achieve great efficiency or better control in compliance with the dimensions of data quality noted.
Red: Concern that systems will not achieve compliance with one or more aspects of the dimensions of data quality and therefore a limited assurance opinion cannot be provided.

Findings
The detailed findings are included in the attached report. In summary with regard to:

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute of Health and Care Excellence (NICE)-approved care package within two weeks of referral.

30 cases tested were classified by the Trust as compliant, non-compliant or exempt did not identify any concerns that data for this indicator is misstated or not produced in line with national guidance. We identified two cases where either the start or stop date used by the Trust could not be agreed back to supporting evidence we continue to report our prior year recommendation regarding the accuracy of the clock start and stop dates as open. See report for further details.

100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital ("7 day follow-up").

KPMG's consideration of the design of the Trust's system for the reporting of performance in relation to this indicator has not identified any concerns and found the process to be consistent with that used in the prior year. They undertook initial sample testing during our interim fieldwork and identified queries regarding the agreement of the clock start/stop date back to supporting evidence. These were in the process of being investigated by the Trust, with the aim of providing relevant supporting evidence, when KPMG were informed by NHSI to cease all audit procedures regarding the 2019/20 quality report. As such they have not verified whether these queries are, or are not, errors. KPMG have therefore not provided the detailed findings of our testing.

Recommendation
Following consideration of external audit report and its findings it has been decided to commission a review of data quality by internal audit. This is to identify areas for improvement with regard to the metrics and to ensure the Committee is provided with assurance regarding data quality.

The Committee is asked to receive the report and to note its findings.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Financial, IT, Staffing and Legal Implications:

None.

Equality & Diversity and Public & Patient Involvement Implications:

None

Evidence for Essential Standards of Quality and Safety; NHSLA Standards;

Evidence of robust governance review process for the Well Led standard and contributes so safe care in relation to IPC practice.

KPMG

Quality Report

Audit of indicators within the quality report

Due to revised requirements as communicated by NHSI in March 2020, we are not required to provide assurance over the quality report for 2019/20. As part of our planning and interim work, we carried out work on one of the mandated indicators chosen by the Trust from a list of available indicators as specified by NHSI in its guidance:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute of Health and Care Excellence (NICE)-approved care package within two weeks of referral

In addition, we carried out work on a locally selected indicator chosen by your Council of Governors. The indicator selected was the 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital ("7 day follow-up").

At the time the updated guidance was issued in March 2020 substantially no work had been completed over the Inappropriate out of area placements indicator, we therefore have no findings to report in relation to this indicator.

Results of our work

We have set out overleaf the key findings from our work as described above in relation to the one mandated indicator and the locally selected indicator. We assessed:

- The design and operation of the systems of control over the data against the six data quality dimensions defined by the NAO; and
- Performed testing of the underlying data quality for the period from 1 April to 31 December 2019.

We have assessed these arrangements to consider whether they can be graded as:

- **Green**: No improvement to achieve compliance with the dimensions of data quality noted.
- **Amber**: Opportunities to achieve great efficiency or better control in compliance with the dimensions of data quality noted.
- **Red**: Concern that systems will not achieve compliance with one or more aspects of the dimensions of data quality and therefore a limited assurance opinion cannot be provided.

Scepticism Challenge

DESIGN OF SYSTEM			OPERATION OF SYSTEM	
Dimension	Rating	Description of system	Rating	Results of testing
Mandated Indicator: **Early intervention in psychosis (EIP):** people experiencing a first episode of psychosis treated with a National Institute of Health and Care Excellence (NICE)-approved care package within two weeks of referral				
Accuracy	●	The accuracy of the reported data is reliant on two key dates (1) Referral Date (clock start); (2) First Treatment Date (Clock stop). Inclusion of the referral within the reported indicator is dependent on the patient having had their first episode of psychosis confirmed by a clinician and treatment having commenced in the period. These key dates are driven by the data in the Trust's patient record system, PARIS. The referral date is manually input by staff when the episode of care is created. There is a risk due to human error or lack of understanding that the wrong referral date is input. The first treatment date is automatically generated by the system and the first appointment under that episode of care is "outcomed" by the clinician. There is a risk due to human error or lack of understanding that the wrong appointment is outcomed.	●	Our sample testing of a total of 20 compliant and non-compliant cases identified two cases where either the start or stop date used by the Trust could not be agreed back to supporting evidence. When we recalculated the Trust's performance using a corroborated start/stop date, the Trust's classification of the case as compliant or non-compliant did not change.
Completeness	●	PARIS captures the Trust's patients records. Patients are allocated an "episode of care" for which FEP is its on specific category. Reports are run from the system for all FEP referrals received in the period. The report is manually reviewed by the performance team and cases considered to be an exemption are highlighted (but not deleted) and not included in the monthly and / or annual reported data. These are identified by the patient not having a treatment date or noted as "Waiter".	●	Our testing of a sample of 10 cases classified as exemptions by the Trust did not identify any misclassifications.

Scepticism Challenge

DESIGN OF SYSTEM			OPERATION OF SYSTEM	
Dimension	Rating	Description of system	Rating	Results of testing
Mandated Indicator: **Early intervention in psychosis (EIP):** people experiencing a first episode of psychosis treated with a National Institute of Health and Care Excellence (NICE)-approved care package within two weeks of referral				
Relevance	●	The annual performance percentage is calculated on a cumulative basis from monthly performance data. A report is run from PARIS using SPIKE, the Trust's performance monitoring system. The report is run to pick up (1) Referral date and (2) Appointment date. The performance team manually calculate the waiting time between the above dates and manually classify each case as compliant or non-compliant.	●	Our testing did not identify any concerns over the operating effectiveness of the Trust's systems in relation to these dimensions.
Reliability	●	The information reported is generated from PARIS, where all patient data, notes and information is recorded. The waiting time figure, used as the basis of determining the classification of compliant or non-compliant is manually performed by the Trust as the difference between treatment date and referral date	●	
Timeliness	●	Performance data is reported on a monthly basis, one month in arrears. The data reported is taken from PARIS.	●	
Validity	●	On a monthly basis the performance team perform a review of the data reports to identify cases to be classified as exempt and to verify the accuracy of the reported data for a sample of cases.	●	
Conclusion		Our testing of 30 cases classified by the Trust as compliant, non-compliant or exempt did not identify any concerns that data for this indicator is misstated or not produced in line with national guidance. We identified two cases where either the start or stop date used by the Trust could not be agreed back to supporting evidence we continue to report our prior year recommendation regarding the accuracy of the clock start and stop dates as open. See appendix one of our report for further details.		

Scepticism Challenge

DESIGN OF SYSTEM			OPERATION OF SYSTEM	
Dimension	Rating	Description of system	Rating	Results of testing
Locally selected Indicator: 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital				
Accuracy	●	All data used to compile this indicator is taken from PAIRS. The date of discharge is manual entered onto PARIS by ward teams and details are recorded in patient notes. Case workers in locality team record follow ups by logging the mode of contact within PARIS and recording details of the follow up within patient notes. The number of days between the outcome appointment and discharge date is automatically/manually calculated by the PARIS system. This data is used to determine whether the case is compliant or non-compliant assessment. The reported year end performance percentage is manually calculated by the performance team.		We undertook initial sample testing during our interim fieldwork and identified queries regarding the agreement of the clock start/stop date back to supporting evidence. These were in the process of being investigated by the Trust, with the aim of providing relevant supporting evidence, when we were informed by NHSI to cease all audit procedures regarding the 2019/20 quality report. As such we have not verified whether these queries are, or are not, errors. We have therefore not provided the detailed findings of our testing.
Completeness	●	A report is run from PARIS by the performance team to show all discharged patients in the period. The performance team manually review the generated report to identify all cases which are exempt per the indicators definition. The remaining discharge data forms the indicators denominator. The performance team receive training and guidance to determine which cases are exempt. The completeness of the data is dependent on individuals judgements to include/exclude cases.		
Relevance	●	The annual performance percentage is calculated on a cumulative basis from monthly performance data. A report is run from PARIS by the performance team to show all discharged clients in the month. The parameters of the report are set by a member of the performance team inputting the discharge start and end dates. This ensures that only data relating to the period under review is reported.		
Reliability	●	The information reported is generated from PARIS, where all patient data, notes and information is recorded.		

Scepticism Challenge

DESIGN OF SYSTEM			OPERATION OF SYSTEM	
Dimension	Rating	Description of system	Rating	Results of testing

Locally selected Indicator: 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital

Timeliness	●	Performance data is reported on a monthly basis, one month in arrears. The data reported is taken from PARIS which is live.
Validity	●	Monthly reviews of the compliant and non-compliant cases are undertaken by the Performance team to ensure the validity of the data reported. The Data Quality Officers review the PARIS report and notes any exempt cases, including CAMHS, Older Adults, Rehab and Other categories. Their work is reviewed by the Advanced Performance Improvement Analyst.
Conclusion		Our consideration of the design of the Trust's system for the reporting of performance in relation to this indicator has not identified any concerns and found the process to be consistent with that used in the prior year. We undertook initial sample testing during our interim fieldwork and identified queries regarding the agreement of the clock start/stop date back to supporting evidence. These were in the process of being investigated by the Trust, with the aim of providing relevant supporting evidence, when we were informed by NHSI to cease all audit procedures regarding the 2019/20 quality report. As such we have not verified whether these queries are, or are not, errors. We have therefore not provided the detailed findings of our testing.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors

Meeting Date:	30 July 2020	**Agenda Item:** 12
Subject:	Annual Report Health, Safety and Security Compliance Report 2019/20	**For Publication: Yes**
Author:	Melusi Nkomo, Health Safety and Security Lead	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety
Presented by:	Jacky Vincent, Deputy Director Nursing and Quality	

Purpose of the report:

To present to the Board of Directors the 2018- 2019 Annual Health, Safety & Security Report.

Action required:

For the Board to note and which was approved at the Covid Assurance Committee.

The Board to discuss and consider the contents of this report and the learning that is identified or any additional actions required to ensure the risks to the health, safety and security of service users, staff, visitors or contractors on Trust premises is managed.

Summary and recommendations:

This report provides detail of the health, safety and security incidents, the actions that have been taken, the assurance given and the priorities for the coming year.

Significant work has been over the past year and progress has been made in relation to Health and Safety. As part of a nationwide campaign, the Trust was one of the twenty care providers in the public sector to be visited, in the first quarter, by the Health and Safety Executive, to examine arrangements for Violence and aggression and musculoskeletal disorders. As a result of the visit, the Trust was issued with improvement notices. All improvement notices were attended to within time scales and led to improvements in practice.

Of note in the report is that the year has seen an increase in the number of service user to staff violence and aggression incidents. These constituted the majority of incidents reported under Reporting of Injuries, diseases and dangerous occurrences regulations (RIDDORS).

Key Priorities for 2019/20:

- Staff safety
  - Violence and Aggression to staff
  - Safety of our staff in the community, including lone worker devices
  - Staff support
- Health and safety whilst working at home and in the office

- Display Screen Evaluations
- Governance and assurance
  - Audit cycle
  - Review of the health and safety resource

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

Relation to the Trust Risk Register: Although there are no specific risks this relates to, there is a Health and Safety Risk Register that sits below the Trust Risk Register and this captures the risks detailed in this report.

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

1. We will provide **safe** services, so that people feel safe and are protected from avoidable harm.

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

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

There are risks of litigation and prosecution if the Trust does not comply with its Health and Safety responsibilities.

Equality & Diversity /Service User & Carer Involvement implications:

None

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

Not Applicable

Seen by the following committee(s) on date:

COVID Assurance Committee July 2020

Executive Summary

This report is the Annual Health, Safety and Security Compliance Report 2019/20 and provides an overview of health, safety and security incidents that were reported and the work that has been undertaken to continuously improve. The report will set out both areas of good practice and challenges as well as the priorities for the following year.

The Trust was one of the twenty Trust visited by the HSE as part of nationwide planned visits to examine arrangements for violence and aggression and musculoskeletal disorders at care providers in the health sector. As a result of the inspections, the Trust was issued with four improvements notices that required the trust to strengthen arrangements for protection of staff, contractors' staff and visitors from violence and aggression from services users. The other improvements notices were related to provision and maintenance of manual handling aids and training.

Over the year there has been an increase in service user to staff violence and aggression. It is important to note that work had been done to encourage reporting of violence to staff. As a result, the Trust has increased SWARMS to ensure swift learning from incidents and ensured staff support is in place.

Inpatient areas see the most incidents of violence and aggression, with Lexden having the highest number, followed by Lambourne Grove and Dove ward. There were a number of CQI initiatives within the mental health inpatient services for older age adults to understand the issues relating to meeting personal care needs and the risk of violence and aggression towards staff. Few incidents of violence and aggression have been reported in the community but the impact of high profile incidents in the previous year have continued along with the work to improve safety in the community.

Thirty one RIDDOR incidents were reported in 2019/20, compared to twenty-five in 2018/2019. All thirty-one incidents resulted in a 7 day absence from work, there were however no "specified injuries." Out of the thirty-one RIDDORS, twenty five of the incidents were as a result of a physical assault against staff and injuries sustained during restraint. The remaining six RIDDORs were as a result of a slip, trip and fall incident and manual handling incidents. Following guidance form Health Safety Executive, Covid19 is RIDDOR reportable where there is reasonable probability that it was acquired at work. At year end, no Covid19 reported RIDDOR incidents had been reported.

The Trust recorded a total of 33 staff slips, trips and fall incidents during 2019/20, compared to 36 in 2018/19. There were 16 incidents in relation to moving and handing, the majority were lifting a service user, closely followed by lifting or moving an object, one incident resulted in a RIDDOR.

Volvina is the Trust's preferred install of anti-ligature rails, curtain tracks and blinds. They also inspect suspended ceiling tiles, load test all collapsible rails including curtain rail tracking, shower curtain rail tracking and wardrobe rails to ensure they do not collapse under pressure and weight. Volvina continued to do audits and, this year, put systems in place to ensure the risks revealed by audits are locally owned and followed up appropriately.

The Trust continues to monitor security incidents. The majority of incidents related to the discovery of contraband objects on a person or member of public, a breach of security at entrance and exit and contraband item bought onto the ward. In an effort to continue to strengthen safety and security staff continue to do searches for contraband and the use of Metal detectors called ‘Proscreen gives the assurance metal objects are not brought into inpatient areas.

One hundred and thirty five CAS alerts were received in 2019/20 through the Central Alerting System (CAS Alerts), which is the national cascading system for patient safety alerts. Six of the alerts were relating to estates, thirty seven to Medical Devices, seventy four Drugs Alerts, five Field Safety Notices and six Patient Safety Alerts. Eleven internal alerts were also issued. All have been actioned appropriately.

Staff side undertake regular joint health and safety inspections. The joint inspections offer the Trust a value opportunity to work with staff side to continuously improve staff’s experience. They also ensure the Trust complies with the legislation that requires the employer to consult with unions and involve staff in the management of risk.

Key Priorities for 2019/20:

- Staff safety
    - Violence and Aggression to staff
    - Safety of our staff in the community, including lone worker devices
    - Staff support
- Health and safety whilst working at home and in the office
    - Display Screen Evaluations
- Governance and assurance
    - Audit cycle
    - Review of the health and safety resource

The Trust continues to ensure the Health and Safety of service users, staff and public is at the core of their activity.

Health and Safety Annual Report 2019/20

1. Introduction

1.1. This report is the Annual Health, Safety and Security Compliance Report for 2019/20 and provides an overview of health, safety and security incidents that were reported and the work that has been undertaken to continuously improve. The report will set out both areas of good practice and challenges as well as the priorities for the following year.

1.2. The report will detail the Health and Safety Executive Inspection and resultant improvement notices and actions from quarter one.

1.3. highlight areas where focused pieces of work have been undertaken both in terms of governance and assurance as well as improving practice.

1.4. A number of Health and safety processes have been reviewed. This work will continue into 2020/21, where a strategy will be developed in partnership with staff side.

2. Assurance

Health and Safety Executive inspections

2.1. The Trust was one of the twenty Trust visited by the HSE as part of nationwide planned visits to examine arrangements for violence and aggression and musculoskeletal disorders at care providers in the health sector.

2.2. As a result of the inspections the Trust was issued four improvements notices.

- Risk Assessment for violence and aggression to employees and those not in our employment from or by service users. Carry out a suitable and sufficient assessment of the risks to Health and Safety for staff whilst working with service user (a service user at Lexden was highlighted as an example but the recommendations were to expected be rolled out to all other service users).
- Put arrangements in place to ensure that all the reusable slings used for moving and handling service users are thoroughly examined at least every six months.
- Put arrangements in place to review and update moving and handling risk assessments, making these less generic and including situations where the risk of violence and aggression are increased.
- Violence and aggression against staff and need to improve processes, plans, learning and risk assessment. Produce a policy detailing how and when incidents of violence & aggression will be investigated.

2.3. The full details of this were reported to the Board and the Integrated Governance Committee. The Trust has implemented the action plans that were developed to address the improvement notices and these have all been met and response sent to Health and Safety Executive.

RIDDORs

2.4. The RIDDOR regulation requires organisations to report, to the Health and Safety Executive, staff work related injuries and diseases. The two criteria relate to

- an injury to a member of staff that results in them having an over a 7 day absence from work or if they should sustain a specified injury.
- A specified injury could include a broken bone, loss of consciousness, being admitted into hospital for more than 24 hours. It also includes specified diseases.

2.5. Thirty-one RIDDOR incidents (Chart 2) were reported in 2019/20, all these incidents resulted in a 7 day absence from work. Twenty six were as a result of violence and aggression by service users to staff in patient areas. The remaining five RIDDORs were as a result of a slip, trip and fall incident and manual handling incidents.

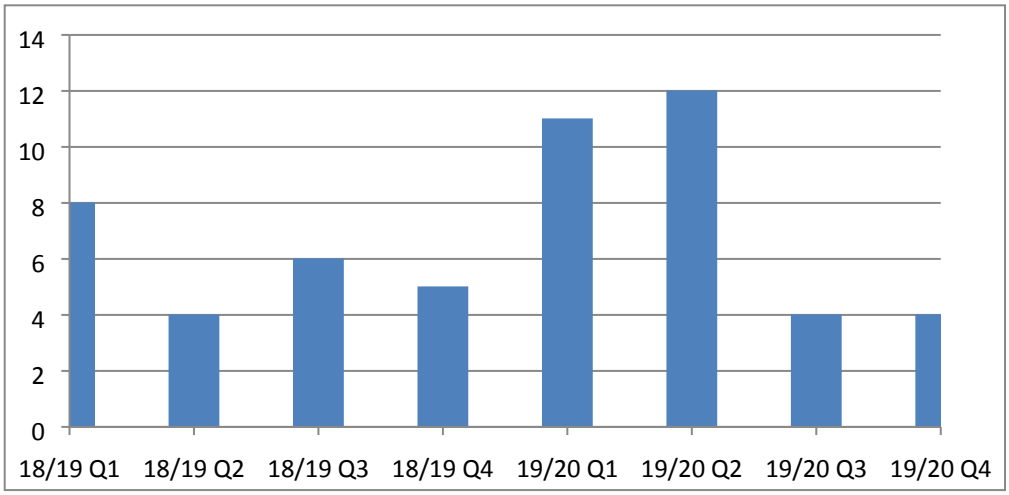


Chart 2: RIDDOR reported incidents 2018/19 and 2019/20

2.6. The Health and Safety Executive issued guidance for Covid 19 being RIDDOR reportable if, on the balance of probabilities, that it was proved to have been acquired at work. The Trust responded by formulating a reporting system which will be evaluated in the next financial year as the incident is still in progress. At the end of the year no Covid related incidents had been reported as a RIDDOR.

Safety Alerts

2.7. 143 Safety Alerts were received the Central Alerting System (CAS Alerts). Of this 143, there were 6 relating to Estates, 37 to Medical Devices, 74 Drug Alerts, 5 Field Safety Notices, 6 Patient Safety Alerts and 15 from other external sources. There were also 11 internal alerts issued.

2.8. Each alert is detailed on Datix with the actions that are taken to ensure the trust is compliant. There are currently 29 open safety alerts on the Datix system, these alerts all have action in progress.

Health and Safety & Staff side joint inspections

2.9. Staff side undertake regular joint health and safety inspections. The joint inspections offer the Trust a value opportunity to work with staff side to continuously improve the staff's experience. They also ensure the Trust complies with the legislation that requires the employer to consult with unions and involve staff in managing of risk. In the reporting year only two joint visits were carried out. All findings were communicated to teams and acted upon.

Internal audit

2.10. A joint audit on health and safety was undertaken at Hertfordshire Community NHS Trust (HCT) and Hertfordshire Partnership University NHS Foundation Trust (HPFT) as part of their internal audit plans for 2019/20.

2.11. The objective of the review was to provide assurance that the joint Estates and Facilities Team for the two Trusts has effective processes in place for ensuring legal compliance regarding health and safety requirements, with specific focus on fire and gas safety, legionella, and asbestos.

2.12. Overall, it was noted significant control weaknesses during the course of our audit. Through sample testing of 10 properties, they found one instance in which a legionella assessment had not been carried out for over two years. There were a large backlog of certificates waiting to be uploaded to Ultimate Manager, and that this impacted the use of the Ultimate Manager system, due to the inaccurate data recorded. The auditors also noted that there was not a robust process in place to monitor the remedial actions from statutory checks to completion.

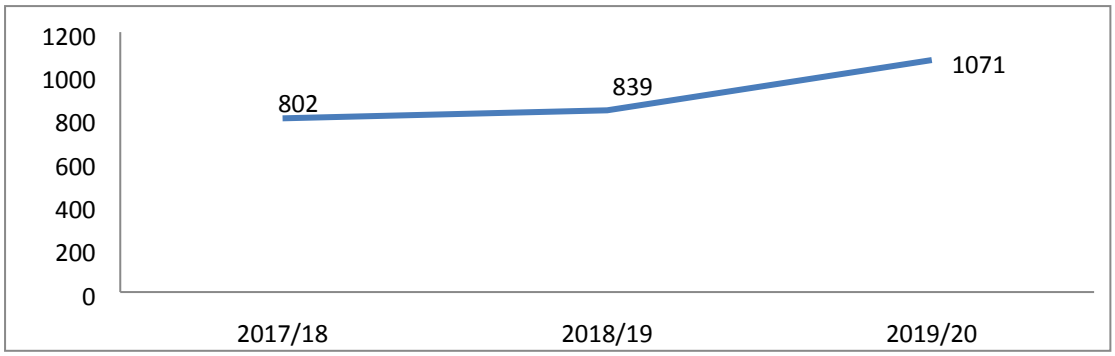
2.13. Further control weaknesses in relation to areas such as the identification and monitoring of role specific health and safety training, and the escalation of health and safety issues in relation to statutory compliance from the relevant Committee at the Trust. It was noted however, that the joint Estates and Facilities Team are aware of some of these issues and were working on rectifying these to provide assurance.

2.14. An action plan was developed in response to the findings and is being taken forward.

3. Incidents

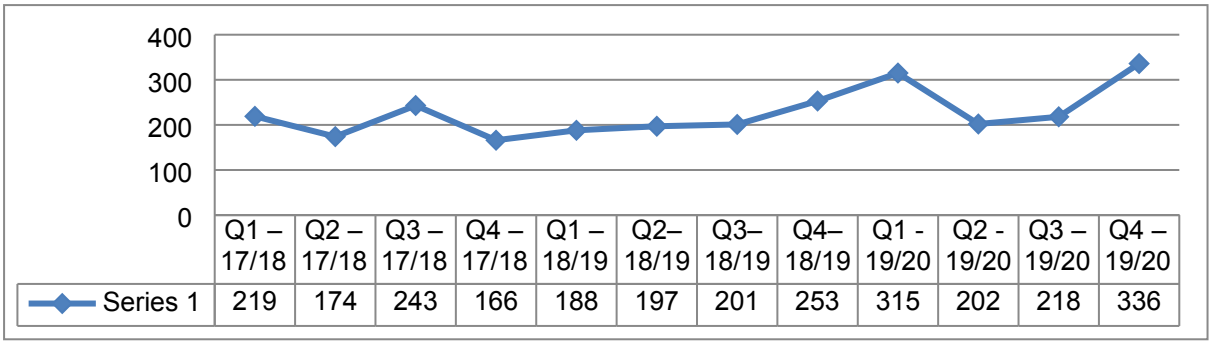
Service User to Staff Assaults

3.1. Service user to staff assault incidents reported have increased this reporting year (graph 1). The Annual Plan set a target for reducing those that resulted in moderate or severe harm so that people would not be discouraged from reporting. Work has been undertaken this year to encourage people to report all incidents of violence and aggression and not accept it 'as part of the job.'



Graph 1: Service user to staff assault data: 2017/18 to 2019/20

3.2. In addition to the increase in reporting, the breakdown, quarter on quarter (graph 2), shows a correlation with restrictive practice data and a limited number of individuals involved in multiple incidents. Of note were three service users in Lexden Assessment and Treatment Unit who accounted for 166 assaults.



	Q1 – 17/18	Q2 – 17/18	Q3 – 17/18	Q4 – 17/18	Q1 – 18/19	Q2– 18/19	Q3– 18/19	Q4– 18/19	Q1 - 19/20	Q2 - 19/20	Q3 – 19/20	Q4 – 19/20
Series 1	219	174	243	166	188	197	201	253	315	202	218	336

Graph 2: Service user to staff assault data: Q1 – 17/18 to Q4 19/20

3.3. Within 2019/20 a total of 51% of service user to staff actual assault incidents resulted in no harm. Over the year there has been decrease in incidents resulting in moderate harm by 95% and only one severe harm incident.

3.4. The Annual Plan set a target for reducing service user on staff assaults that resulted in moderate or severe harm, rather than reducing overall, so that staff would not be discouraged from reporting. Compared to the previous year's data, there has been a 27% increase in the overall number of incidents with one incident resulting in severe harm. However incidents resulting in moderate harm decreased from 48 (5.7%) in 2018/19 to 41 (3.9%) in 2019/20. 96% of service user on staff assaults resulted in no harm or low harm, 3.9% in moderate harm and 0.1% in severe harm (Table 1).

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Total %
No Harm	154	103	112	176	**51%**
Low Harm	142	84	99	157	**45%**
Mod Harm	19	14	7	1	**3.9%**
Severe Harm	0	1	0	0	**0.1%**
Total	**315**	**202**	**218**	**334**	**1069**

Table 1 – Service User to Staff Actual Assaults by Harm 2019/20

3.5. Lexden reported the highest numbers followed by older people services at Lambourne Grove (Chart 2). A large number of these are attributed to a small number of service users who present with challenging behaviour. A new method of

managing traumatic events called Trauma Risk Management (TRiM) was explored and implemented to support staffing dealing with these incidents.

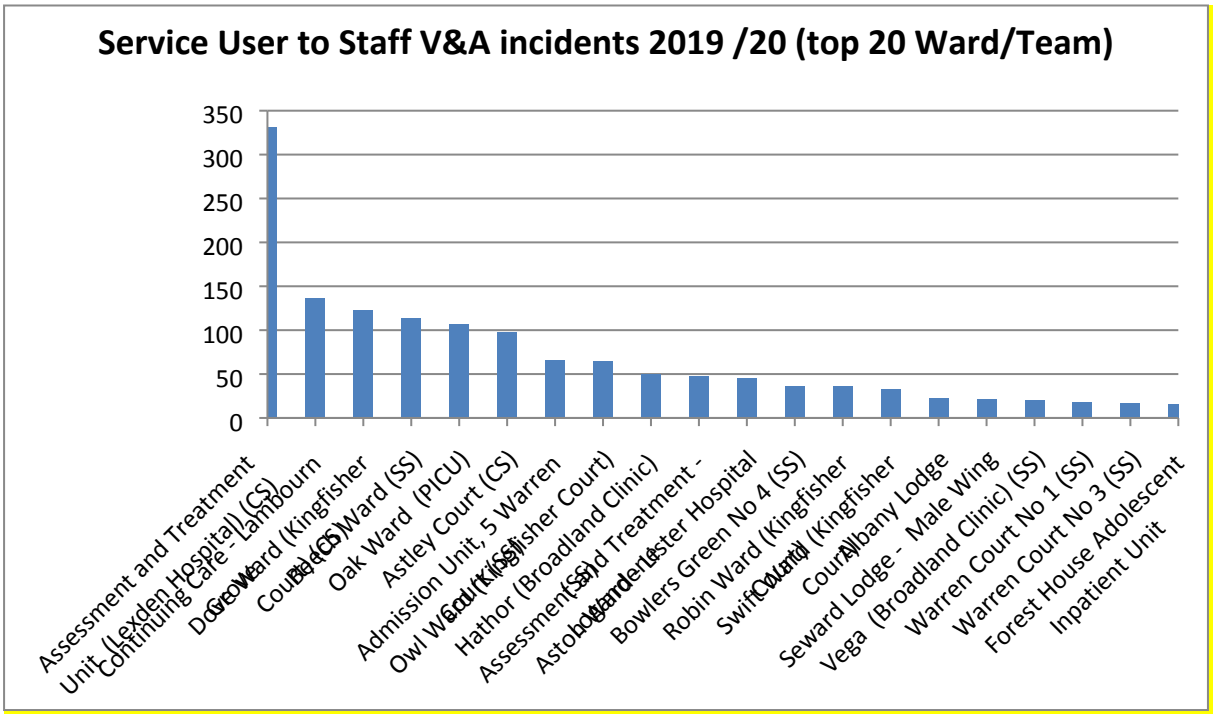


Chart 1: Service User to Staff V&A incidents 2019 /20

3.6. The Trust has responded to the increase in incidents by learning from other Trusts, the evidence base, and by listening to staff. This work has been reported through the year in the Integrated Safety Reports. The initiatives include SWARM, Safety Huddles, safety pod (a large beanbag) and the MOSS Strategy review, techniques and interventions, such as the use of Safe Wards and the recent review of RESPECT techniques.

3.7. The services also commissioned CQI projects within services for older age adults; the first is to increase incident reporting and the second to understand the issues relating to meeting personal care needs and the risk of violence and aggression towards staff, which frequently present as a complex challenge in units.

Community Violence and aggression

3.8. Over the year there were thirty nine incidents of violence and aggression in the community with none resulting in significant harm.

3.9. Two incidents of particular note in the previous reporting period, one at Rosanne House and the other at Colne House, impacted on staff confidence this year. In response to this the Trust responded by setting up meetings with staff through the Community Violence and aggression Task and Finish group. In these meetings, reception staff expressed anxiety about responding to violence and aggression in the hubs. It was recommended that reception staff undertake 3a respect training to equip them to de-escalate challenging situations. This is being taken forward into the next reporting year.

3.10. A Police Liaison group met regularly, with representation from all Strategic Business units and Police. This gave a platform for the Police and the Trust to review incidents and improve collaborating between the services.

Staff and public slip and trip and falls

3.11. Service user slips, trips and falls are reported in Annual Integrated Safety Report.

3.12. The Trust recorded a total of 33 staff slips, trips and fall incidents involving the staff and public, during 2019/20, compared to 36 in 2018/19. This was a reduction of 8% on the previous year. The majority occurred on the same level and mainly on the grounds and none were attributed to poor state of paving.

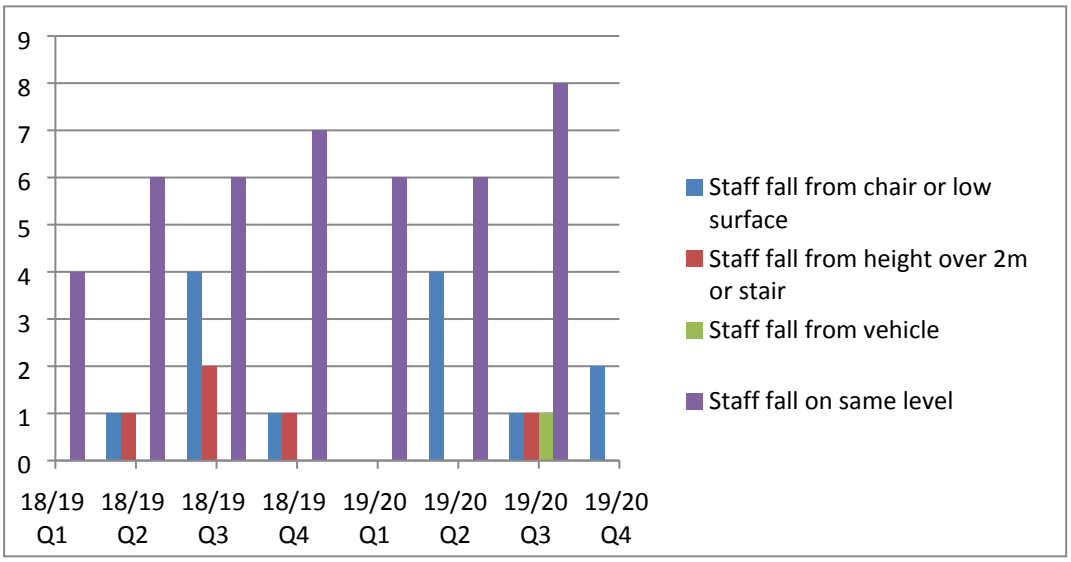


Chart 3: Staff Slips, trips and falls 2019/20 compared to 2018/19

Needle stick Injuries

3.13. There were 7 inoculation injuries in this reporting year, a similar number to the previous year. Four related to administering depot injection. One related to taking bloods and the other, an Occupational Therapist, stepped on an insulin needle in the service user home. The incidents remain low in proportion to the number of depot injections administered each year. All incidents were investigated and lessons learnt shared with staff.

Moving and Handling

3.14. There were 16 incidents relating to moving and handing, the same as previous year. Nine incidents were a result of service user manual handling and restraint incidents. The rest were as a result lifting or moving inanimate objects. One incident occurred when a member of staff was pushing a service user in a wheelchair in the community. That incident resulted in a RIDDOR.

3.15. Work was done to strengthen manual handling training compliance and an outside training provider was contracted.

4. Lone Working

4.1. When working alone the Trust approach is multifaceted and based on robust assessments of risk and appropriate actions as a result of the risk assessments. One of the tools that is given to staff to compliment other aspects of the risk management plan is the lone working device. It is important to note that lone working devices alone do not mitigate risk and overreliance can create a false sense of security if not used with other means of mitigating the risk.

4.2. That being said lone working devices is an important tool and one that the Trust has struggled to ensure staff are using consistently. The Trust a contract with a company called Reliance which ends in July 2020.

4.3. This year has focused on aligning all lone worker devices to staff members continued and increasing use, with local managers managing use through real time reports. Trust wide usage is just under 30%, with Essex SBU making most use of the devices.

4.4. It would not be expected that an individual staff member uses their device 100% of the working week. It would only be used at times when they are working alone. The usage of lone worker devices is therefore measured for every member of staff against 20 days a month. This is not a reliable way to measure usage as different patterns of work are not taken into account and therefore setting a meaningful Key Performance Indicator has been challenging. This work will be one of priorities in the next financial year as part of lone worker management improvement. A priority for the coming year will be to also be to review this contract in terms of best safety practice and value for money as well as considering how to improve the monitoring to ensure effective use.

4.5. In the reporting period, the devices were used four times to alert others to emergency situations. These were:

- A service user became aggressive, the staff contacted Reliance to request Police assistance to the relevant address, the staff managed to leave the address and was safe and the Police did not need to attend as staff was safe.
- A staff member activated his device and called the Paramedics. The male was conscious and was monitoring the service user blood pressure. The staff member requested that we monitor until the Paramedics arrive. Staff member then confirmed that the ambulance had arrived and everything was under control, he reset his device.
- A staff member activated a Red Alert because the service user became unstable and was a potential threat to self. Staff contacted Police who arrived shortly afterwards and assisted on site.

- A staff member activated a Red Alert as she was helping a woman that had fallen over and required emergency assistance. Red Alert closed safely after ambulance

5. Estate

Ligature incidents

5.1. Ligature incidents are reported in the Annual Integrated Safety Report. IN this report the assurance relating to the anchor ligature points is reported.

5.2. Volvina is the Trust's preferred installer of anti-ligature rails, curtain tracks and blinds. They also inspect suspended ceiling tiles, load test all collapsible rails including curtain rail tracking, shower curtain rail tracking and wardrobe rails to ensure they do not collapse under pressure and weight. Volvina continued to do audits and, this year, put systems in place to ensure the ligature risks revealed by audits are locally owned and followed up appropriately by Estates and facilities.

Fire

5.3. There were four small fires across different services. These were where service users set fire to papers, a hedge and a bin. All were put off by staff and no Fire rescue services attended.

5.4. There were 48 false fire alarms in the same period. Learning from these incidents let to strengthening the search procedures in relation to prohibited items, such as lighters.

5.5. All HPFT Trust sites have up to date Fire Risk Assessments which are held on individual sites as well as centrally, within Estates.

5.6. Works were reviewed and prioritised based on the recommended rectification time of 0-3, 3-6 and 6-12 months depending on RAG rating. Fire compartmentation surveys have been reviewed and RAG rating updated. Works continue on schedule for the completion of low and moderate risk non-conformance.

5.7. An action plan detailing the required year's remedial works is in place and being further developed alongside Interserve, the Facilities Management Provider for actions into 2020/21.

Management of Asbestos

5.8. A detailed Asbestos Risk Register is in place, along with systems for the safe management of asbestos risk. Prior to the start of any new works or refurbishment projects, Refurbishment and Demolition (R&D) Surveys are completed.

5.9. Asbestos Management Surveys have been completed in accordance with the Control of Asbestos Regulations 2012 (CAR) and Health & Safety Guidance 264. The Trust has also appointed an Independent advisor to audit compliance.

Water Hygiene

5.10. The Water Safety Group continued to meet in line with the Terms of Reference and this group leads on the management of Water Hygiene across the Trust. The Group reports through the trust's Infection Prevention and Control committee, providing quarterly updates.

5.11. In line with legislation, the Trust has continued to be independently audited on a quarterly basis and acted on all recommendations made by auditors.

5.12. All Trust site have water risk assessments, which are reviewed on an annual basis and rewritten every two years or earlier, if changes have been made to the water systems or occupancy. Statutory maintenance and all remedial work is carried out by Interserve and recorded on a dedicated portal for reference.

6. Security Incidents

6.1. Security incidents are monitored by the Trust so that appropriate action can be taken. The most common item discovered in a ward or unit is cigarettes. The items can be categorised (Chart 4) into:

- Broken item compromising security of building
- Discovery of inappropriate objects on person or member of public,
- Breach of security at entrance and exit.
- Inappropriate item bought onto the ward
- Inappropriate use/access to keys
- Security of staff car/personal items

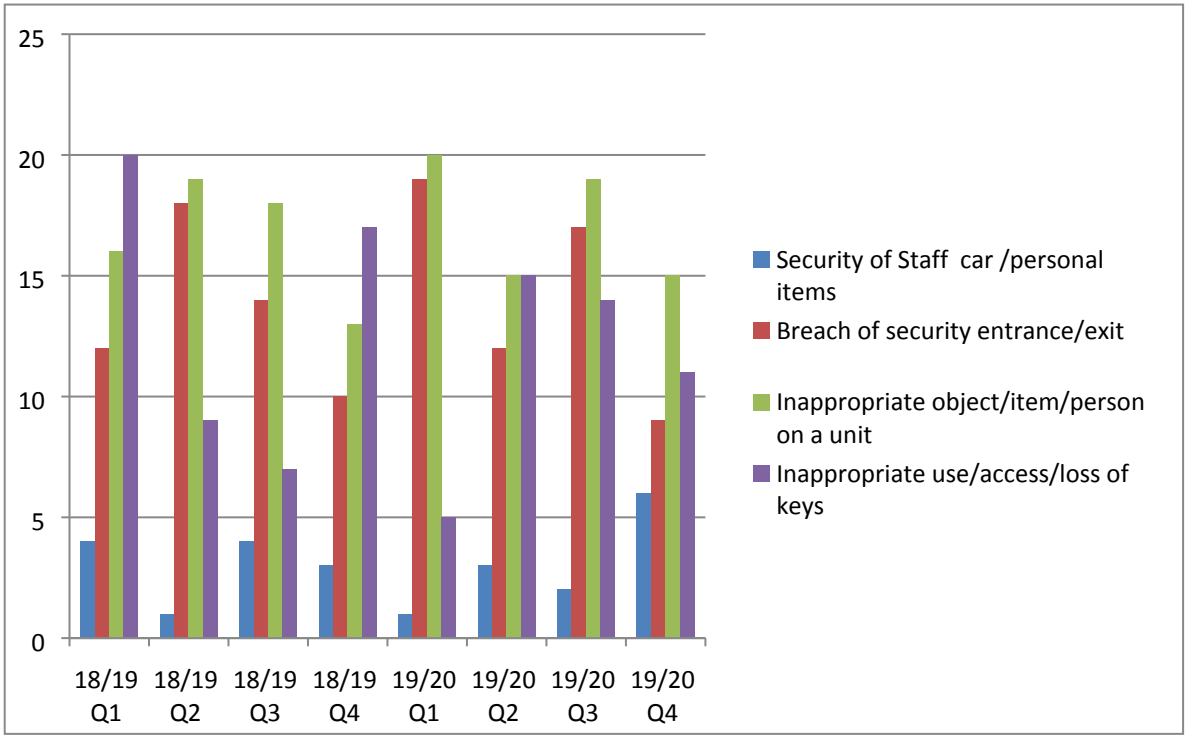


Chart 4 Security incident themes 2018/19 and 2019/20

6.2. The breach of security entrance/exit are classified as AWOLs and are reported through the Integrated Safety Report. Service users bringing prohibited items aim to be intercepted during routine searches. The main items that are recovered are cigarettes.

6.3. This year saw four thefts at Kingfisher Court and one at Holly lodge of catalytic car converters from staff cars. The incidents were reported to the police and the Trust has commissioned security after hours and during the day that patrol the car park.

7. Training

Health and Safety Training

7.1. At year end the compliance rate for the Trust for Health and Safety Training was 97% against a target of 90%. The outbreak of Covid 19 provided challenges in training that is normally face to face. Plans are in place to ensure that compliance rates are not affected, balancing the demands on staff and services.

Moving and handling and Respect

7.2. The training most affected by the pandemic was the Manual handling and Respect training modules 3b, 4 and 5.

- Moving and handling level 2 (78%) although level 3 was at 97%.
- Fire training (73% annual and 90% two year)
- Relating to people
    - Module 3a 94%
    - Module 3b 74%
    - Module 4 74%
    - Module 5 70%

7.3. Due to COVID19, face to face training was suspended in quarter 4. The compliance dates were extended by 6 months to accommodate the need to manage the pandemic and put in place the necessary safety precautions to deliver the training with social distancing. The percentages above are without the extended 6 months. Work is in progress to switch to online training whenever possible, where not possible appropriate Personal Protective equipment to be used during training

Display Screen Equipment training (DSE)

7.4. Following the implementation of Discovery, the learning and development IT system, the previous training and assessment package. The historical data relating to compliance was lost. The Trust took the opportunity to invest into a new DSE training package called Cardinus Healthy Working which offers a stronger package and enables consideration of Display Screen Equipment, such as PCs, laptops, tablets and smartphones. The launch was delayed due to the pandemic but will be prioritised in the next reporting year.

7.5. Covid19 and Government guidance has resulted in staff home working and staff at high risk shielding. Cardinus Healthy gives a chance to home workers to do basic assessments to ensure safety at home.

Fire

7.6. T&J Fire, the Trusts appointed Fire Risk Assessors and Staff Training Provider, completed training of 2,423 staff resulting in an 81% compliance rate at year end.

8. Key Priorities for 2020/21

8.1. A number of key priorities have been set for 2019/20. These focus on staff safety in relation to violence and aggression, staying healthy whilst working from home or in the office and strengthening the health and safety governance and assurance.

Staff safety in relation to violence and aggression

8.2. Reducing the harm as a result of violence and aggression by service users to staff

8.3. Increasing safety of our staff in the community, including lone worker devices

8.4. Strengthening staff support

Health and safety whilst working at home and in the office

8.5. Ensuring Display Screen Evaluations have been completed

8.6. Ensuring action is taken as a result of the DSE

Governance and assurance

8.7. Develop a robust audit cycle across all areas of health and safety

8.8. Review and strengthen the health and safety resource

9. Conclusion

9.1. The Trust continues to ensure the Health and safety of service users, staff and public is at the core of their activity. This year has highlighted the need to strengthen the governance and assurance in relation to health and safety so that action can be taken swiftly in response to increased risks and to mitigate risks. A number of processes, including lone workers have been reviewed over the year, but there is still ongoing work to embed new practices, with a chance of changing providers if deemed necessary through a procurement exercise.

9.2. In the coming year focus will be made to improve the health and safety culture and ensure Health and safety is owned by staff, and in this regard a new training for managers will be launched. Key to supporting our staff is ensuring reflection and learning from incidents and adequate support when things go wrong, in line with Trust values.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 13
Subject:	Performance Report: Quarter 1 2020/21	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director of Improvement and Innovation	**Approved by:** Sandra Brookes Director of Service Delivery and Customer Experience
Presented by:	Keith Loveman, Deputy Chief Executive Director, Strategic Finance	

Purpose of the report:

To inform the Trust Board about the Trust's performance against both the NHS Oversight Framework (NHSOF) targets and the Trust Key Performance Indicators for Quarter 1 2020/21

Action required:

To receive the report, discussing performance and action required

Summary and Recommendations

This report provides a summary of the performance of the organisation during Quarter 1 against 62 national, regional and local indicators across five key groupings:

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

Quarter 1 Performance Summary

Quarter 1 performance must be viewed in the context of the current Novel Coronavirus (COVID-19) outbreak. Overall, underlying performance has remained strong, during a period of unprecedented workforce rates and the need to deliver care in line with COVID 19 infection prevention and control practices.

The introduction of weekly performance reporting during this period has given us insight and assurance about how our services are responding to the challenges posed during the COVID outbreak and has given additional focus to key areas of access and risk during this period.

35 of the 63 (56%) performance indicators measured in Q1 are meeting or exceeding our performance standards. In light of COVID-19, referrals into the Single Point of Access service are 27% lower than referrals in Quarter 1 2019; however, there has been an increase of 27% in June from May 2020, indicating a growing demand for our services as the country moves into the recovery phase.

Areas of Strong Performance

Despite the impact of the COVID-19 outbreak the following areas saw continued strong performance in Quarter 1:

- People who were referred for treatment in to the Improving Access to Psychological

Therapies (IAPT) Service received treatment in 99.8% of cases within the 18 week referral to treat times standard (target – 95%) and 91.21% within 6 within weeks (target – 75%).

- People who were referred into our adult mental health services were assessed within 28 days in 95.78% of cases (target -95%).

- Everyone referred to the Crisis Assessment and Treatment Teams in Quarter 1 was contacted within 4 hours (target – 98%).

- Children and Young People who accessed the Priority 1(P1) Child and Adolescent Mental Health Service were seen within 7 days in 92.19% of cases (target – 75%).

- All Children and Young People in Child and Adolescent Mental Health Targeted Services were seen within the 14 and 28 day waiting period, achieving 100% (target – 85%)

- Referrals into our Single Point of Access service received an outcome within 14 days in 99.47% of cases (target – 95%).

- Across all our services 98.63% of people received treatment within the 18 week wait standard (target – 98%).

- People discharged from our inpatient acute units were followed up in 98% of cases within 7 days (target – 95%) and in 93.95% of cases within 3 days (target – 90%).

- 95.8% of our service users have up to date risk assessments ,which reflects the increased focus on risk assessments during the COVID19 outbreak

- Acute inpatients reporting that they felt safe increased to 89.58% (target 80%) in Quarter1. An increase of 18% on Quarter 4 figures.

- Staff wellbeing at work as part of the Quarter 1 Pulse Survey rose to 81.79% (target 75%), as did Staff recommending the Trust as a place to work – 78.18% (target – 61%)

Areas of Concern/Focus

At the end of Quarter 1 a number of indicators were below our performance standards. The majority of these relate to areas that were already known as underperforming and have been exacerbated as a consequence of the COVID 19 outbreak. Level 1 operational services (24/7 and urgent community work) were prioritised in accordance with our Business Continuity plan, which impacted on a range of KPIs across services.

The key areas of note for Quarter 1 were:

- Inappropriate out of area placements continued to rise significantly in Quarter 1 with a quarterly figure of 1,769 days against a target of 100. This reflects the level of acuity and ongoing demand pre and during the COVID 19 incident, however focused work was undertaken throughout June and into July which has resulted in a significant reduction.

- IAPT Services: The gap between access targets and actual rates of access has widened across all of our IAPT services during Quarter 1, due to the COVID crisis, with staff redeployment in line with the Business Continuity Plan and a reduction in GP referrals. Aggregate performance achieved 64% of the access target by the end of the quarter. Recovery rates within IAPT services have fallen, with a recovery rate of 39.9% (target – 50%) for Quarter 1, again affected by the COVID crisis with some individuals deciding not to complete their treatment and different methods of delivering therapies. As part of the Trust's reshaping and restoration work there is now specific focus on increasing the

capacity of IAPT services, including a review of redeployed staff and of the way teams are operating, maintaining any improvements as a result of COVID 19 and considering any immediate changes that need to be made.

- The rate of people on CPA who have had a review in the last 12 months has decreased to 88.85% in Quarter 1 (target – 95%) as a result of the COVID crisis and difficulty in remotely organising larger, multidisciplinary meetings. As services move into restoration this is expected to improve to target levels.

- The rate of people who were on CPA or who were experiencing First Episode Psychosis and received cardio-metabolic checks fell to 46.99% and 49.91% respectively (targets – 65% and 90%). This was as a result of COVID 19 limiting face to face appointments. The Trust is focusing on improving Physical Health over the current year, and as services move into the reshaping and restoration phase of recovery this is expected to improve.

- PDP and Appraisal rates fell to 71.79% in Quarter 1 (target – 95%). During the pandemic there has been an extension provided to appraisal deadlines. As part of the restoration of services there will be a re- launch of the appraisal requirement backed by a revised and simplified form. In addition, the data in future will exclude those ineligible for an appraisal.

Conclusion & Recommendation

The Trust Board is asked to receive the report and discuss

1. The overall Trust Performance in the context of Covid 19 incident and the overall demand and activity levels.
2. The areas of consistently strong performance across the Trust
3. The actions being taken to improve against currently underperforming indicators as we restore and reshape services.

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

Performance reflects the requirements of the Annual Plan, SBU Business Plans Assurance Framework

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

N/A

Equality & Diversity and Public & Patient Involvement Implications:

N/A

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

All targets

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

N/A

Hertfordshire Partnership University NHS Foundation Trust

Performance Report Quarter 1 2020/21

Contents

Appendix 3 – Quarter 1 Quality Account – Priority Indicators

1. Summary

1.1 Performance Overview

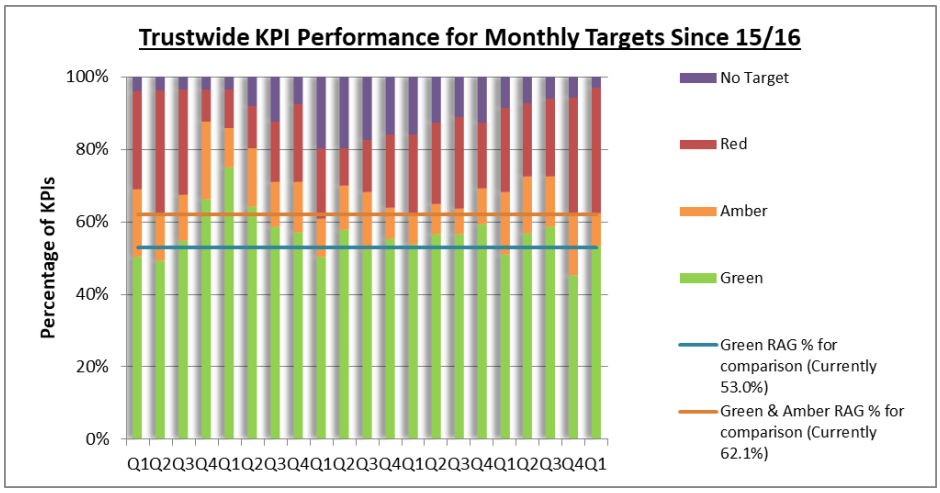
Overall, underlying performance has remained strong, during a period of unprecedented workforce rates and the need to deliver care in line with COVID 19 infection prevention and control practices.

The introduction of weekly performance reporting during this period has given us insight and assurance about how our services are responding to the challenges posed during the COVID outbreak and has given additional focus to key areas of access and risk during this period.

53% (35 out of the 66 key performance indicators monitored in Q1) are meeting or exceeding the performance level required. 11% (7 out of the 66 indicators) are close to meeting target. The remaining 33% (22 out of 66 indicators) are underperforming and are subject to recovery activity.

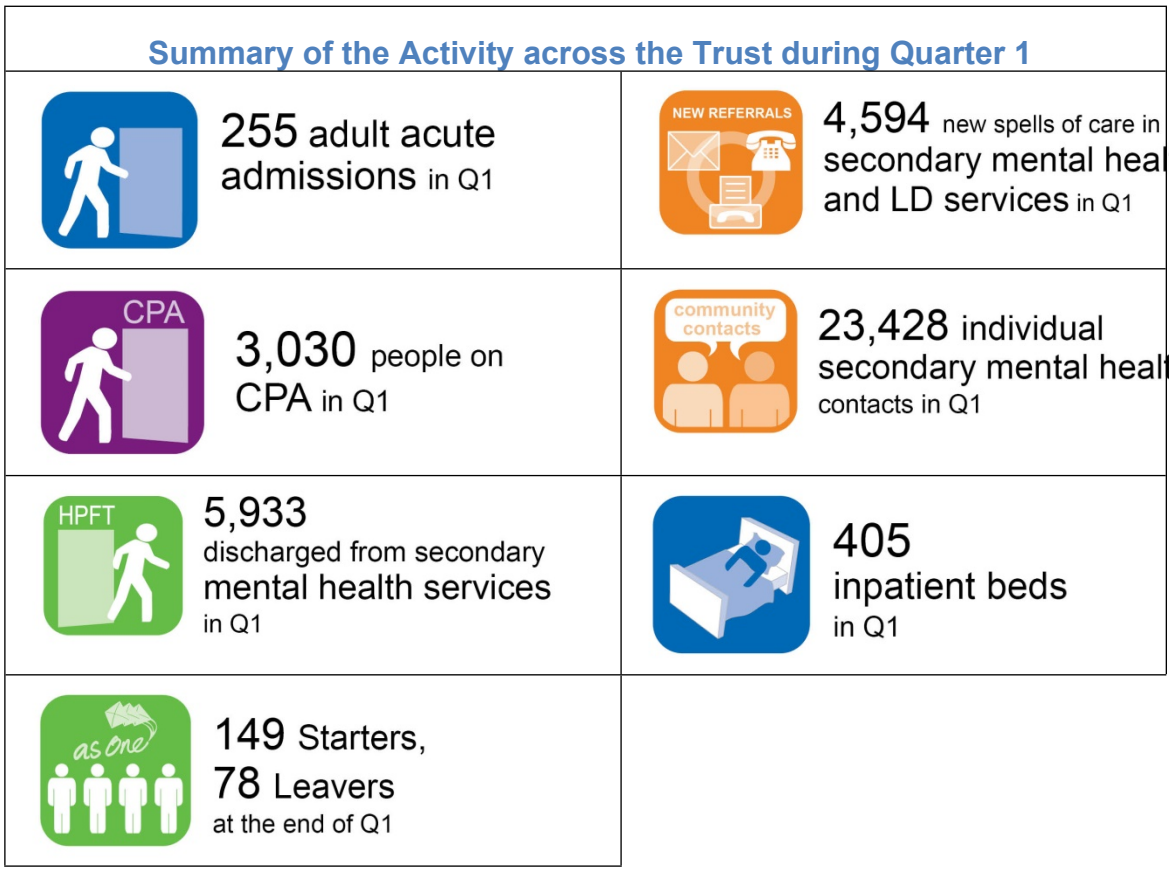
Of the 66 Key Performance Indicators currently monitored, overall performance is as follows:

- 35 (53%) are maintaining or exceeding performance levels (on target)
- 7 (11%) are almost meeting target performance levels (close to target)
- 22 (33%) are not meeting our performance standards (underperforming)
- 2 (3%) are currently monitored but no formal performance target set



1.2 Activity Summary

The table below provides a summary of some of the key areas activity across the Trust during Quarter 1. It provides a sense of the volume of work and sets some of the context for the performance of the Trust over the quarter. In light of COVID-19, referrals into the Single Point of Access service are 27% lower than referrals in Quarter 1 2019; however, there has been an increase of 27% in June from May 2020, indicating a growing demand for our services as the country moves into the recovery phase.



1.3 Reporting Categories

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

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

2. NHS Oversight Framework

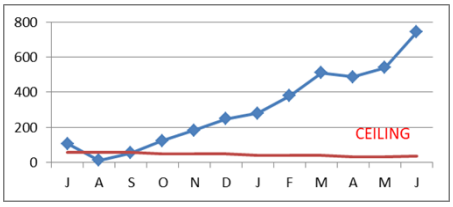
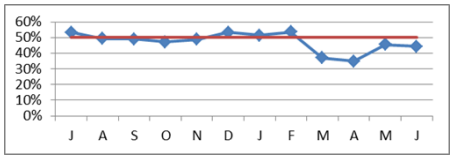
2. 1 Summary of Position

There are six Key Performance Indicators under this domain:

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

Four have been met in the quarter; two did not meet the performance standards required in Quarter 1.
The two that did not meet performance standards are:

- Inappropriate out of area placements – 1769 days against a target of 100 for the quarter.
- People receiving IAPT services that completed treatment and moved to recovery – an aggregate of 39.9% across the 5 services against a target of 50%.

KPI	Trend	Q1 Status
Inappropriate Out of Area Placements (OAPs) for adult mental health services. (Target 100 bed days)		**Q1 performance: 1769** The Quarter 1 use of Out of Area Placements reflects the extreme pressure that has been on mental health services over the last year combined with additional pressures due to the COVID crisis. Focused work in June to reduce these has resulted in a significant reduction by mid-July.
Improving Access to Psychological Therapies, proportion of people completing treatment who move to recovery (Target 50%)		**Current performance: 39.90%** The drop in performance is primarily due to the redeployment of staff from Hertfordshire IAPT services as part of Business Continuity Plan to support services. There are signs of improvement in May and June.

3. Access to Services

3.1 Summary Position

In Quarter 1 the Trust, with continued challenges faced due to COVID-19, consistently met 14 out of 24 access indicators. Accessing mental health services has been a key area during 2019 and continues in 2020. Indications are that the significant improvements that were seen in 2019 will be upheld despite the COVID challenges.

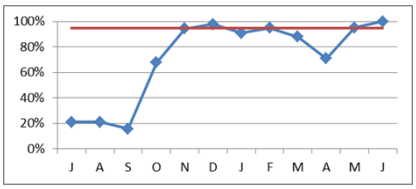
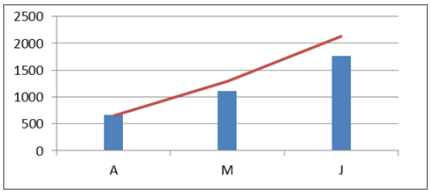
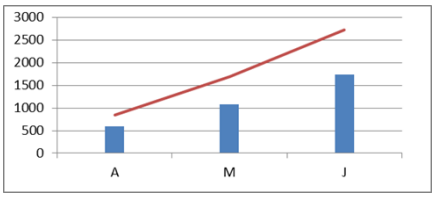
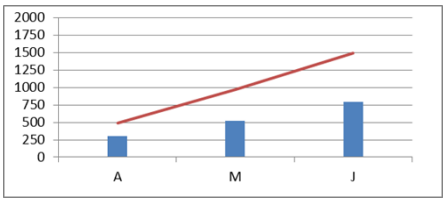
3.2 Areas of Strong/Improved Performance

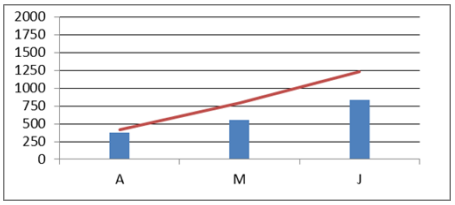
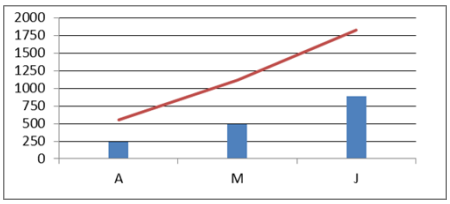
- Non-urgent people who accessed our Adult Community Mental Health Services were seen in 95.78% of cases within 28 days (target – 95%), all of our urgent referrals were seen within 24 hours (target – 98%).
- All service users who needed to access our Adult Crisis Assessment and Treatment Teams in Quarter 1 were assessed within a 4 hour period (target – 98%).
- Children and Young People who needed to access Crisis Services were seen within 4 hours in 97.31% of cases (target – 95%).
- Children and Young People who needed urgent assessment within 7 days were seen in 92.19% of cases (target – 75%)

- All Children and Young People in Child and Adolescent Mental Health Targeted Services were seen within the 14 and 28 day waiting period, achieving 100% (target – 98%)
- Referrals into our Single Point of Access service received an outcome within 14 days in 99.47% of cases (target 95%).
- Across all our services 98.63% of people received treatment within the 18 week wait standard (target – 98%)

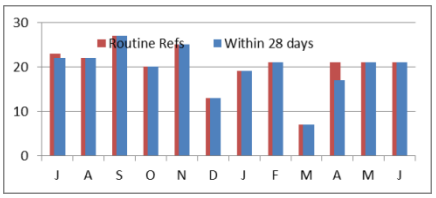
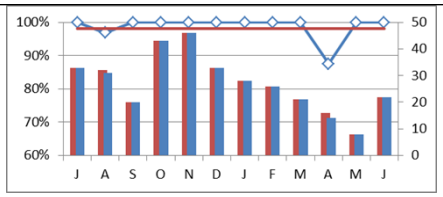
3.3 Access Indicators currently underperforming

Below is an exception summary for those Key Performance Indicators that have not achieved performance standards

KPI	Trend	Q1 Status
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS)		**Q1 performance: 85.11%** Teams re-organising and working differently due to the COVID emergency and some late pass-ons from SPA resulted in a dip in performance in April for South and West Teams. Waiting lists have since been monitored as part of the new weekly performance reporting regime which resulted in recovery in May and was sustained in June.
Number of people entering IAPT treatment (East & North Herts CCG) (Target 2133)		**Current performance – 365 below target** Adversely affected by reduced referrals due to COVID.
Number of people entering IAPT treatment (Herts Valleys CCG) (Target 2723)		**Current performance – 975 below target** Reduced number of referrals into the service as a consequence of COVID has meant the target could not be met.
Number of people entering IAPT treatment (Mid Essex) (Target 1499)		**Current performance – 704 below target** Reduced number of referrals into the service as a consequence of COVID has meant the target could not be met.

Number of people entering IAPT treatment (West Essex) (Target 1239)		**Current performance – 400 below target** A lack of GP referrals as a consequence of COVID has meant the target could not be met.
Number of people entering IAPT treatment (North East Essex) (Target 1825)		**Current performance – 938 below target** Historically, Commissioners have been more concerned about the increasing waits to start treatment, than access targets, which have now also increased with additional monies for the service. There is now an added factor of reduced number of referrals into the service as a consequence of COVID.

3.3.1 Access Indicators – Almost Met

KPI	Trend	Q1 Status
Routine referrals to community eating disorder services meeting 28 day wait (Target 98%)		**Q1 performance: 93.65%** There were some initial staff absences in April due to leave or sickness and this impacted on the ability to see 4 of the 21 service users in the 28 day window. Staffing levels have been reviewed and all service users were seen within 28 days in May and June.
Routine referrals to Specialist Learning Disability Services meeting 28 day wait		**Q1 performance: 95.65%** There were two breaches: one due to a miscaculation of the 28 period and the person was seen on Day 29. The other was down to difficulty in obtaining relevant referral information from professionals outside of the Trust. Waiting lists are being monitored to ensure people are being seen within the 28 day window and all service users were seen within the 28 day timescale in May and June.

4. Safety and Effectiveness of Services

4.1 Summary Position

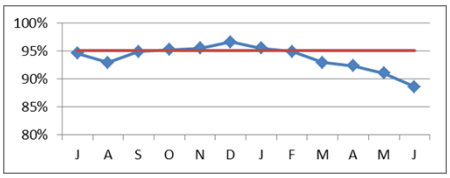
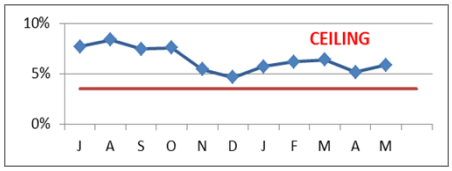
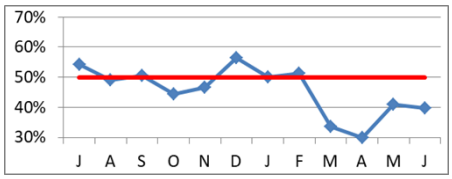
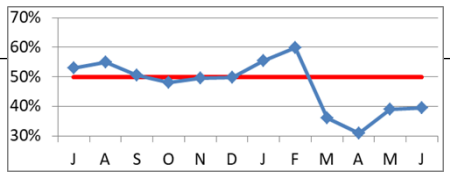
There are 24 Safety & Effectiveness Key Performance Indicators of which 12 have been fully met, 1 was almost met, and 11 where further improvement is required. The service user Friends and Family Test has not been included for Quarter 1, whilst adjustments are made to the on-line reporting system.

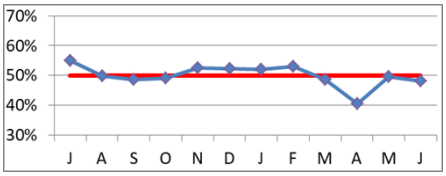
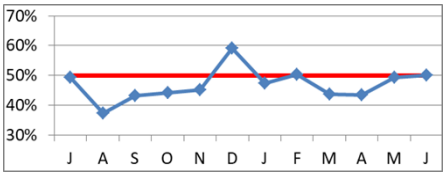
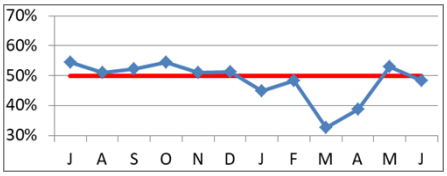
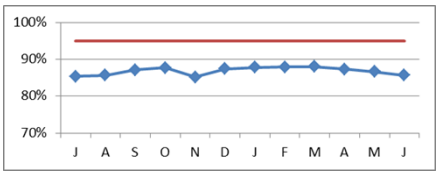
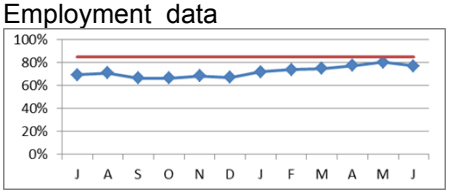
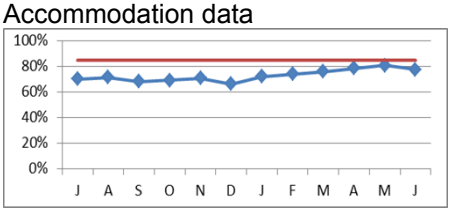
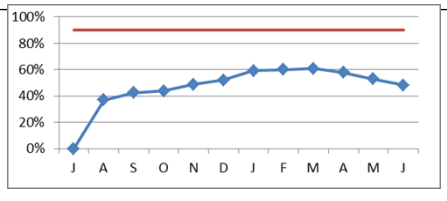
4.2 Areas of Strong/Improved Performance

- The percentage of adults who have been discharged from our inpatient services and followed up within 7 days has exceeded target at 98.09% (target – 95%). The percentage who were followed up within 3 days also exceeded target at 93.95% (target – 90%).
- 95.8% of our service users had and up to date risk assessment at the end of Quarter 1 (target 95%).
- 89.5% of our service users who used our acute inpatient services in Quarter 1 reported that they had felt safe whilst there (target – 80%).
- Our service users told us that they felt they had been treated in a way that reflected our trust values in 83% of cases (target – 80%)
- They also told us that in 84.38% of cases they knew how to get support at a time of crisis (target – 83%) and in 90.63% of cases they had been involved in discussions about their care (target – 85%)
- Carers told us that they had felt valued by staff in 85.19% of cases (target – 75%).
- Our staff reported that 84.98% of them would recommend Trust services to family and friends (target – 70%).
- Use of the Initial Cluster Tool for those entering services is above target at 96.98% (target – 95%).
- Our data quality remains strong, with 94.03% of people having their ethnicity recorded (target – 90%) and identifying metrics recorded in 99.8% of cases (target 95%).

4.3 Underperforming Indicators

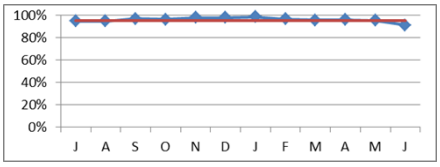
Below is an exception summary for those Key Performance Indicators that have not achieved performance standards:

KPI	Trend	Q1 Status
The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months (Target 95%)		**Q1 Performance: 88.58%** Care Programme Approach (CPA) reviews were suspended in some areas due to COVID and there were initial challenges arranging full meetings on a virtual platform. Reviews are now back to being routinely scheduled and an improvement is expected with the re-instatement of regular CPA meetings.
Delayed Transfers of Care (DTCs) (Target 3.5%)		**May Performance: 5.89% (reported 1 month in arrears)** Placements for complex service users remain difficult to source, particularly in the current COVID crisis.
IAPT % clients moving towards recovery (ENCCG) (Target 50%)		**Q1 Performance: 34.75%** Reasons related to changes in working due to COVID – redeployment of staff, changes in methods of delivery and an increased number of people dropping out of treatment. Continue to monitor and review recovery rates as services are restored.
IAPT % clients moving towards		**Q1 Performance: 34.57%** Reasons related to changes in working

recovery (HVCCG) (Target 50%)		due to COVID – redeployment of staff, changes in methods of delivery and an increased number of people dropping out of treatment. Continue to monitor and review recovery rates as services are restored.
IAPT % clients moving towards recovery (Mid Essex) (Target 50%)		**Q1 Performance: 44.92%** Reasons related to changes in working due to COVID – redeployment of staff, changes in methods of delivery and an increased number of people dropping out of treatment. Continue to monitor and review recovery rates as services are restored.
IAPT % clients moving towards recovery (NE Essex) (Target 50%)		**Q1 Performance: 47.00%** Reasons related to changes in working due to COVID – redeployment of staff, changes in methods of delivery and an increased number of people dropping out of treatment. Continue to monitor and review recovery rates as services are restored.
IAPT % of clients moving towards recovery (W Essex) (Target 50%)		**Q1 Performance: 46.36%** Reasons related to changes in working due to COVID – redeployment of staff, changes in methods of delivery and an increased number of people dropping out of treatment. Continue to monitor and review recovery rates as services are restored.
Cluster Reviews (Target 95%)		**Current Performance 85.68%** Performance against this indicator has remained relatively stable, despite the COVID crisis.
Mental Health Services Data Set submissions to NHS Digital Employment Accommodation (Target 85%)	Employment data  Accommodation data 	**Q1 mean performance: 77.06%** Recording of employment and accommodation were historically poor, but have risen steadily since the introduction of SPIKE and the data quality initiative to the highest level they have been in May. HPFT Benchmarks extremely well against other trusts for these indicators. Historically staff were unable to see when reviews were due on Paris. SPIKE dashboards now give this information on team and individual dashboards.
Cardio-metabolic		**Q1 aggregate performance: 48.15%** A decrease in performance has taken

checks for people with psychosis (Target 90% FEP 50%; Community CPA 47%)		place in Q1, which may be attributable to fewer health checks taking place with the decrease in face to face appointments. A task and finish review has commenced and is being overseen by the Physical Health Care group.

4.3.1 Safe and Effective Indicators – Almost Met

KPI	Trend	Q1 Status
Rate of service users saying that staff are welcoming and friendly (Target 95%)		**Q1 performance: 91.18%** Due to the COVID crisis a very low number of HYS responses were received. Responses to this question will be monitored in future months to see if there is a true trend emerging.

5. Workforce

5.1 Summary position

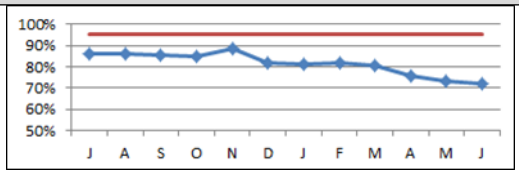
There are 7 Key Performance Indicators routinely monitored on a quarterly basis, of which three have been met, two almost met and two where improvement is needed.

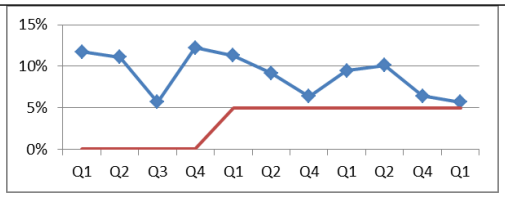
5.2 Areas of Strong/Improved Performance

- Staff recommended the Trust as a place to work in 78.18% of cases (target – 61%)
- Staff wellbeing at work in Quarter 1 was reported as being at 81.79% (target – 75%)
- Staff turnover was at 12.83% against a target of 13.9% (Quarter 4 19/20 target, not yet updated).

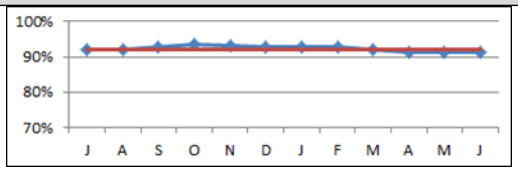
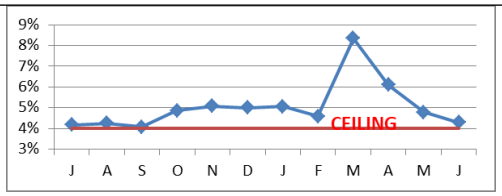
5.3 Underperforming Indicators

Below is an exception summary for those Key Performance Indicators that have not achieved performance standards:

KPI	Trend	Q1 Status
Rate of staff with a current Personal Development Plan and appraisal (Target 95%)		**Current performance: 71.79%** An online appraisal system is being considered to help capture appraisals rather than relying on manual records. However, due to the COVID-19 situation extensions to complete appraisals were agreed. A review of the documentation is underway to reduce the time taken to complete but also improve the effectiveness and the importance of carrying out appraisals is a key part of the restoration of services.

Staff experiencing physical violence from service users (Target <5%)		**Current performance: 5.66%** The overall downward trend in staff reporting that they have experienced violence from service users has continued in Q1and is now marginally above the 5% target.

5.3.1 Almost Met Key Performance Indicators

KPI	Trend	Q1 Status
Rate of mandatory training completed and up to date (Target 92%)		**Current performance: 91.32%** Mandatory training has dropped marginally below target and is likely to have been affected by COVID sickness and absence; additional pressure on staff and the inability to hold face to face training during the majority of Quarter 1.
Sickness Rate (Target <4%)		**Current performance: 4.28%** There was a significant increase in absence levels at the beginning of Quarter 1 due to COVID-19. This number has subsequently declined, with sickness marginally above target in June.

6. Financial Resources

6.1 Finance Overview

The Trust has reported a break-even positon for month 3 as required during the Covid-19 period and without recourse to additional top-up. Within this position, there is c. £3.4m of specific COVID-related expenditure for the year to date, for which Covid related top-up income is being claimed.

Both substantive and bank pay have continued to increase in month, in part due to additional full time equivalent staff recruited, in part due to high enhancements in month, and in part due to COVID costs. Agency pay spend did decrease a little in June. Secondary commissioning costs decreased in part due to there being one fewer day in the month; Acute & PICU out of area placements also reduced in cost; however CAMHS Tier 4 specialist placements have increased reflecting levels of acuity and demand. Key drivers of spend in particular out of area beds do remain high, and despite agency decreasing overall this will need close monitoring.

Financial Indicator	Target	Current Period Numbers (June 2020/21)	Current Period (June 2020/21 UNLESS STATED)	Previous Period May 2020/21 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (July 2020/21)
To Achieve Surplus in year (not including PSF)	£0k (break even)	£0k (break even)	£0k (break even)	£0k (break even)	£0k (break even)	Trust position is breakeven mainly due to the COVID top income that we receive.	↔
Use of Resources (formerly Financial Service Risk Rating)	1		1	1		Currently 1 and expecting to remain so	↔
To keep agency spend below the Trust ceiling of £5.8m spend for the year (NB NHSI agency spend ceiling is £7.3 million for the year)	TBC	N/A	£1,660	£1,145k	£515	Agency costs continue to decrease as inpatient wards are increasing their use of bank. Agency spend is still above plan both in the month and YTD.	↔
NHSI Agency Price Caps: (*wage caps no longer reported to NHSI) - monthly number of shifts breaching price caps reported weekly to NHSI in period	Reduce to Zero		304	314		Figures as per NHSI weekly submission. Figure based on full weeks that contain days in the reporting period. Current period figure includes weeks commencing; 01/06/20 08/06/20 15/06/20 22/06/20 29/06/20	↔
Delivering Value (cash releasing efficiency savings in Financial Year)	Annual savings requirement identified as £6m	Annual savings target £6m	Programme currently totals £3.5m of developed schemes and plans in progress with a further c. £1.0m of opportunities identified	Revised post-COVID savings programme totals £3m of developed schemes and plans in progress with a further c. £1.5m of opportunities identified		Schemes originally identified pre-COVID are being reassessed. There have been additional savings in areas such as staff travel and Continuing Health Care placements	↔

7. Quality Account – Priority Indicators

In Quarter 1, of the nine reportable indicators, seven were above target and one was below target. The indicator not meeting target is people on CPA having a review within 12 months, and is detailed in the main body of this report under the Safe and Effective Care section.

There are three indicators that are not reportable in Quarter 1:

- Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death – reported annually.
- Service User experience in the community – reported from annual community survey
- Safeguarding – social care assessments – the reporting detail will be finalised for Quarter 2.

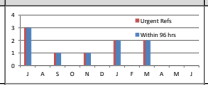
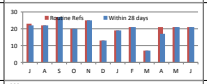
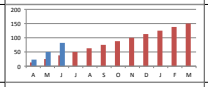
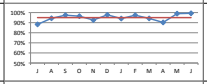
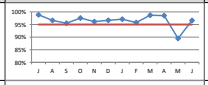
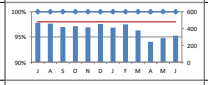
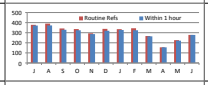
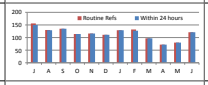
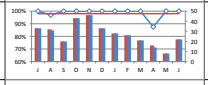
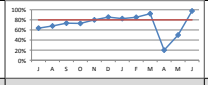
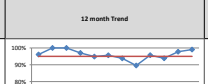
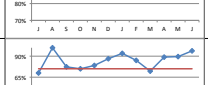
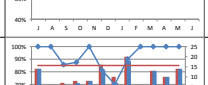
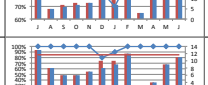
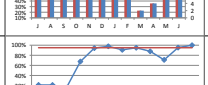
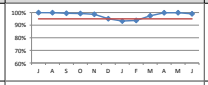
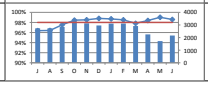
Performance against these indicators can be found in Appendix 3.

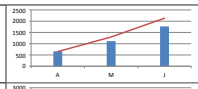
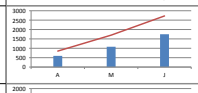
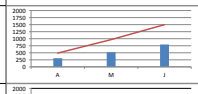
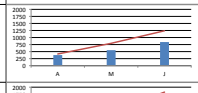
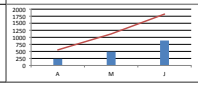
8. Conclusion

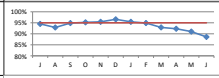
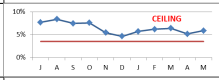
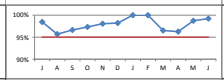
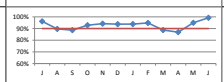
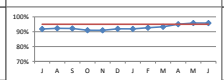
This report has evidenced the performance of the Trust during Q1 2020/21. In light of COVID-19, overall performance continues to remain strong despite the challenges faced. As COVID is managed nationally and locally over the coming months and new ways of working are implemented, performance is expected to further improve. Rebuilding and restoring services will be gradual. Referrals into Single Point of Access service have seen a drop of

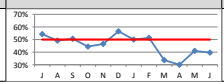
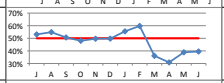
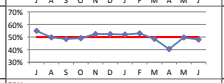
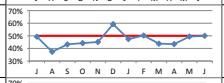
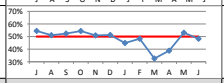
27% on referrals from Quarter1 2019; however, referrals have also increased by 27% between May and June 2020, this is likely to be due to easing of government placed restrictions, and is expected to continue as the country moves into the recovery phase. Weekly performance reporting is aiding performance improvement across services and has allowed services to be closely monitored and managed to ensure that we maintain timely and high quality interventions during this period.

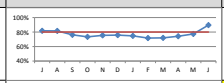
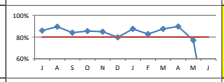
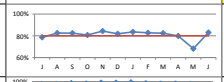
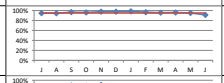
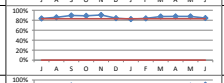
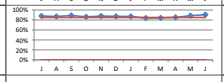
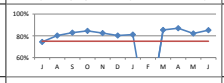
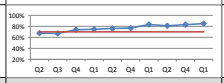
Ref	Standard[20]	Frequency	Standard[17]	Current Period Numbers (Q1 2020/21)	Current Period (Q1 20120/21 UNLESS STATED)	Previous Period (Q4 2019/20 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q2 2020/21)
SOF1	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)[22]	Monthly	>=56% as of April 2019	**64/82 (Provisional)**	**78.05% (Provisional)**	**77.97%**	**0.08%**		↔
SOF3	Data Quality Maturity Index (DQMI) – MHSDS dataset score. https://digital.nhs.uk/data-quality	Monthly	>=95%		**95.4% in March**	**95.2% in December**	**0.20%**	**DQMI data is now available by month (still a quarter in arrears) as part of a CQUIN pilot, therefore no RAG rating given until October 2019.**	↔
SOF4	Improving Access to Psychological Therapies (IAPT)/talking therapies • proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	Monthly	>=50%	**1,412 / 3,539**	**39.90%**	**44.97%**	**-5.07%**	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↑
	• waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks (3-Month Rolling)	Monthly	>=75%	**4,825 / 5,290**	**91.21%**	**72.43%**	**18.78%**	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↑
	- within 18 weeks (3-Month Rolling)	Monthly	>=95%	**5,279 / 5,290**	**99.79%**	**99.73%**	**0.06%**	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↔
SOF5	Inappropriate out-of-area placements for adult mental health services	Monthly	<= 100 for Q1 2020/21	**1,769**	**1,769 (100)**	**1,170 (125)**	**N/A**		↑

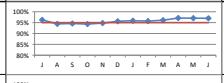
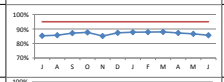
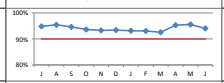
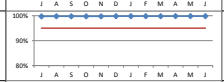
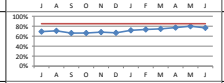
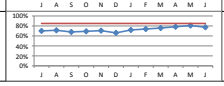
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q1 2020/21)	Current Period (Q1 20120/21)	Previous Period Performance (Q4 2019/20)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q2 2020/21)
A1	Urgent referrals to community eating disorder services meeting 96 hour wait **(Contractual)**	>=98%		N/A	Zero	100.00%	N/A	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A2	Routine referrals to community eating disorder services meeting 28 day wait **(Contractual)**	>=98%		59 63	93.65%	100.00%	-6.35%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↑
A3	Number of new cases of psychosis **(Contractual)** *Shows, from Apr-16, the number of First Episode of Psychosis (FEP) engaged with Care Co-ordinator for year to date*	150 in year (stay above cumulative threshold of 12.5 per month)		82	82 (Cumulative)	267 (Cumulative)		RAG rated against cumulative target. This number is likely to be adjusted downwards retrospectively, due to caseload maintenance being part of the threshold.	↔
A4	Routine referrals to community mental health team meeting 28 day wait **(Contractual)**	>=95%		363 379	95.78%	95.19%	0.59%		↔
A5	Urgent referrals to community mental health team meeting 24 hour wait **(Contractual)**	>=98%		6/6	100.00%	50.00%	50.00%	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
Ref	**Indicator**	**Target**	**12 month Trend**	**Current Period Numbers (Q1 2020/21)**	**Current Period (Q1 20120/21)**	**Previous Period Performance (Q4 2019/20)**	**Change on previous period**	**Comments and Data Quality Issues**	**Forecast for next period (Q2 2020/21)**
A6	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	>=95%		204 214	95.33%	97.22%	-1.90%		↔
A7	CATT referrals meeting 4 hour wait **(Contractual)**	>=98%		843 843	100.00%	100.00%	0.00%		↔
A8	RAID Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A		654 659	99.24%	96.72%	2.52%		↔
A9	RAID Response times: 24 hour wait for ward referrals (Lister & Watford combined)	N/A		273 273	100.00%	98.60%	1.40%		↔
A10	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait **(Contractual)**	>=98%		44 46	95.65%	100%	-4.35%		↑
A11	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait **(Contractual)**	>=98%		N/A	Zero	Zero	N/A	Chart - if there is a height gap between blue and red bars, that month is below 98 threshold.	↔
A12	EMDASS Diagnosis within 12 weeks (Contractual)	>=80%		84/91	92.31%	85.56%	6.75%		↔
Ref	**Indicator**	**Target**	**12 month Trend**	**Current Period Numbers (Q1 2020/21)**	**Current Period (Q1 20120/21)**	**Previous Period Performance (Q4 2019/20)**	**Change on previous period**	**Comments and Data Quality Issues**	**Forecast for next period (Q2 2020/21)**
A13	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**	>=95%		253 260	97.31%	92.62%	4.69%	Note - data audit taking place on April 2018 data has delayed the availability of this KPI for reporting	↔
A14	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**	>=75%		59/64	92.19%	80.28%	11.91%		↔
A15	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**	>=85%		37/37	100.00%	84.85%	15.15%		↔
A16	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**	>=85%		24/24	100.00%	95.83%	4.17%		↔
A17	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**	>=95%		343 403	85.11%	90.98%	-5.87%		↑
A18	CAMHS Eating Disorders - High Risk 24 hrs (Contractual) New measure - reporting T.B.C	N/A		N/A	N/A	N/A	N/A		
A19	CAMHS Eating Disorders - Urgent referrals seen within 5 Days (Contractual) New measure - reporting T.B.C	N/A		N/A	N/A	N/A	N/A		
A20	CAMHS Eating Disorders - Routine 15 day Waited (Contractual) New measure - reporting T.B.C	N/A		N/A	N/A	N/A	N/A		
Ref	**Indicator**	**Target**	**12 month Trend**	**Current Period Numbers (Q1 2020/21)**	**Current Period (Q1 20120/21)**	**Previous Period Performance (Q4 2019/20)**	**Change on previous period**	**Comments and Data Quality Issues**	**Forecast for next period (Q2 2020/21)**
A21	SPA referrals with an outcome within 14 days (Internal)	>=95%		4735 4760	99.47%	94.58%	4.90%		↔
A22	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services (Contractual)	>=98%		6135 6220	98.63%	98.35%	0.28%		↔

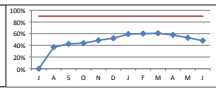
A23	Number of people entering IAPT treatment (ENCCG) **(Contractual)**	2133 to end of June			**1768 (2133)**	9,618 (10,088)	**N/A**	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↔
A24	Number of people entering IAPT treatment (HVCCG) **(Contractual)**	2723 to end of June			**1748 (2723)**	12,119 (12,242)	**N/A**		↔
A25	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**	1499 to end of June			**795 (1499)**	**6,235 (6,710)**	**N/A**		↔
A26	Number of people entering IAPT treatment (West Essex) (Contractual)	1239 to end of June			**839 (1239)**	**4,024 (4,934)**	**N/A**		↔
A27	Number of people entering IAPT treatment (NE Essex) (Contractual)	1825 to end of June			**887 (1825)**	**6,498 (7,013)**	**N/A**		↔

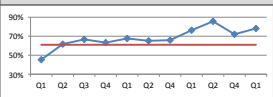
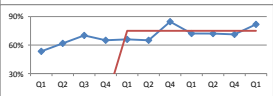
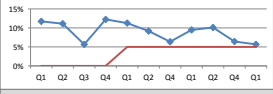
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q1 2020/21)	Current Period (Q1 20120/21)	Previous Period Performance (Q4 2019/20)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q2 2020/21)
SE1	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	>=95%		1,389 1,568	88.58%	92.90%	-4.32%		↔
SE2	Delayed transfers of care to the maintained at a minimal level	<=3.5%		20413 35016	5.83%	5.53%	0.30%	June data not available at the time of reporting. Therefore, this measure is reported with data a month in arrears	↔
SE3	Care Programme Approach (CPA): The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	>=95%		308 314	98.09%	98.70%	-0.61%		↔
SE4	The percentage of people under adult mental illness specialties who were followed up within 72 hrs of discharge from psychiatric in-patient care	>=90% As of April 2018 80% MHSDS		295 314	93.95%	92.21%	1.74%	Target introduced April 2018	↔
SE5	Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) **Seen Only**	>=95%		15,051 15,711	95.80%	93.31%	2.48%	Since Nov-15 this no longer matches the quality Schedule, as we have been able to separate Herts from non-Herts CCGs' data and improve the relevance of the QS.	↔

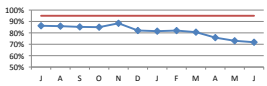
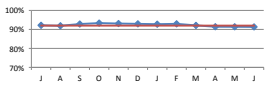
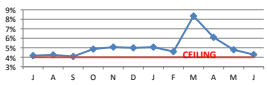
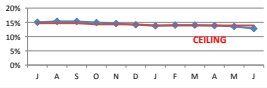
Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q1 2020/21)	Current Period (Q1 20120/21)	Previous Period Performance (Q4 2019/20)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q2 2020/21)
SE6	IAPT % clients moving towards recovery (ENCCG)	>=50%		344 990	34.75%	41.78%	-7.03%	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↔
SE7	IAPT % clients moving towards recovery (HVCCG)	>=50%		318 920	34.57%	45.12%	-10.55%	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↔
SE8	IAPT % clients moving towards recovery (Mid Essex)	>=50%		292 650	44.92%	51.19%	-6.27%	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↑
SE9	IAPT % clients moving towards recovery (NE Essex)	>=50%		305 649	47.00%	47.18%	-0.19%	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↑
SE10	IAPT % of clients moving towards recovery (W Essex)	>=50%		153 330	46.36%	40.40%	5.96%	Data taken from Trust SPIKE report (locally reported data) on 06/07/2020.	↑

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q1 2020/21)	Current Period (Q1 20120/21)	Previous Period Performance (Q4 2019/20)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q2 2020/21)
SE11	Rate of acute Inpatients reporting feeling safe **(rolling 3 month basis)**	>=80%		43 48	89.58%	71.97%	17.61%	Service users in Acute HPFT units responding "yes" to the question: "Is the unit a safe environment?" ("sometimes" currently counts as negative)	↔
SE12	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=80% (Since Apr 2018)		t.b.c		84.90%	-84.90%		↔
SE13	Rate of service users saying they are treated in a way that reflects the Trust's values	>=80% (Since Apr 2018)		480 578	83.04%	82.78%	0.27%		↔
SE14	Rate of Service Users Saying staff are welcoming and friendly (Rolling 3 months)	>= 95% from April 2019		31 34	91.18%	95.70%	-4.52%		↑
SE15	Rate of Service Users saying they know how to get support and advice at a time of crisis (Rolling 3 months)	>= 83% from April 2019		27 32	84.38%	87.43%	-3.06%		↔
SE16	Rate of Service Users saying they have been involved in discussions about their care (Rolling 3 months)	>= 85% from April 2019		29 32	90.63%	84.13%	6.50%		↔
SE17	Rate of carers that feel valued by staff **(rolling 3 month basis)**	>=75%		23 27	85.19%	85.39%	-0.21%		↔
SE18	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	>=70%		566 666	84.98%	83.14%	2.52%		↔

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q1 2020/21)	Current Period (Q1 20120/21)	Previous Period Performance (Q4 2019/20)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q2 2020/21)
SE19	Percentage of eligible service users with a PbR cluster	95%		9,737 10,040	96.98%	96.12%	0.86%		↔
SE20	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)	95%		8,249 9,628	85.68%	88.00%	-2.32%		↔
SE21	Data completeness against minimum dataset for Ethnicity (MHSDS)	90%		19,385 20,586	94.03%	92.56%	1.47%	Note: Data reported for current month is the primary MHSDS dataset and is susceptible to change (positively) when the MHSDS refresh is submitted. Previous month is refreshed. Quarterly reports shows the latest month (primary) against the last month of the previous quarter (refreshed)	↔
SE22	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • identifier metrics	>=95%		123,272 123,516	99.80%	99.79%	0.01%	Note: Data reported for current month is the primary MHSDS dataset and is susceptible to change (positively) when the MHSDS refresh is submitted. Previous month is refreshed. Quarterly reports shows the latest month (primary) against the last month of the previous quarter (refreshed)	↔
SE23.a	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • Employment	>=85%		10,911 14,224	76.71%	74.67%	2.04%	Note: Data reported for current month is the primary MHSDS dataset and is susceptible to change (positively) when the MHSDS refresh is submitted. Previous month is refreshed. Quarterly reports shows the latest month (primary) against the last month of the previous quarter (refreshed)	↑
SE23.b	• Accomodation	>=85%		11,009 14,224	77.40%	75.83%	1.57%	Note: Data reported for current month is the primary MHSDS dataset and is susceptible to change (positively) when the MHSDS refresh is submitted. Previous month is refreshed. Quarterly reports shows the latest month (primary) against the last month of the previous quarter (refreshed)	↑

SE24	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards, early intervention in psychosis services and community mental health services (people on Care Programme Approach) [23]	>=90%		663 1,377	48.15%	60.76%	-12.61%	Previously SOF2, removed from SOF framework from August 2019 Community teams: 46.99% FEP: 49.91%	↑

Ref	Indicator (Monitor/Contractual/Internal)	Target	24 month Trend	Current Period Numbers (Q1 2020/21)	Current Period (Q1 20120/21)	Previous Period Performance (Q4 2019/20)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q2 2020/21)
W1	Staff saying they would recommend the Trust as a place to work	>=61%		516 660	78.18%	72.05%	6.13%	Total responses in the quarterly Pulse survey	↔
W2	Staff Wellbeing at Work	75% as of Q2 18/19		1,505 1,840	81.79%	71.23%	10.56%	Total responses in the quarterly Pulse survey	↔
W3	Rate of staff that report experiencing physical violence from service users	5% as of Q2 18/19		32 565	5.66%	6.42%	-0.76%	Total responses in the quarterly Pulse survey	↔
W4	Staff skills and capability	95% as of Q2 18/19		N/A	Question discontinued in Pulse survey	Question discontinued in Pulse survey	N/A	Total responses in the quarterly Pulse survey	
W5	Living the Values at work	target under review		N/A	Question discontinued in Pulse survey	Question discontinued in Pulse survey	N/A	Total responses in the quarterly Pulse survey	

Ref	Indicator	Target	12 month Trend	Current Period Numbers (Q1 2020/21)	Current Period (Q1 2020/21)	Previous Period Performance (Q4 2019/20)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (Q2 2020/21)
W6	Rate of staff with a current PDP and appraisal	>=95% as of Apr 2018		2,173 3,027	71.79%	80.63%	-8.84%		↔
W7	Rate of mandatory training completed and up to date	>=92%		33,152 36,304	91.32%	92.11%	-0.80%		↔
W8	Sickness rate	<=4%		14,592 289,163	5.05%	6.04%	-0.99%		↔
W9	Turnover rate (Rolling 12 months)	13.9% for Q4 19/20		395 3,079	12.83%	14.05%	-1.22%		↔

Ref	Financial Indicator	Target	Current Period Numbers (June 2020/21)	Current Period (June 2020/21 UNLESS STATED)	Previous Period May 2020/21 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (July 2020/21)
F1	To Achieve Surplus in year (not including PSF)	**£0k (break even)**	**£0k (break even)**	**£0k (break even)**	**£0k (break even)**	**£0k (break even)**	Trust position is breakeven mainly due to the COVID top income that we receive.	↔
F2	Use of Resources (formerly Financial Service Risk Rating)	**1**		**1**	**1**		Currently 1 and expecting to remain so	↔
F3	To keep agency spend below the Trust ceiling of £5.8m spend for the year (NB NHSI agency spend ceiling is £7.3 million for the year)	**TBC**	**N/A**	**£1,660**	**£1,145k**	**£515**	Agency costs continue to decrease as inpatient wards are increasing their use of bank. Agency spend is still above plan both in the month and YTD.	↔
F4	NHSI Agency Price Caps: (*wage caps no longer reported to NHSI) - monthly number of shifts breaching price caps reported weekly to NHSI in period	**Reduce to Zero**		**304**	**314**		Figures as per NHSI weekly submission. Figure based on full weeks that contain days in the reporting period. Current period figure includes weeks commencing; 01/06/20 08/06/20 15/06/20 22/06/20 29/06/20	↔
F5	Delivering Value (cash releasing efficiency savings in Financial Year)	**Annual savings requirement identified as £6m**	**Annual savings target £6m**	**Programme currently totals £3.5m of developed schemes and plans in progress with a further c. £1.0m of opportunities identified**	**Revised post-COVID savings programme totals £3m of developed schemes and plans in progress with a further c. £1.5m of opportunities identified**		Schemes originally identified pre-COVID are being reassessed. There have been additional savings in areas such as staff travel and Continuing Health Care placements	↔

Appendix 2: Quality Account: Draft Priority Areas for 2020/21

Service User Safety		Target	Q1	Q2	Q3	Q4	2020/21
1	The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	≥=95%	98.09%				
2	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)	N/A	Reported Annually				
3	Crisis Assessment and Treatment Team – 4 hour wait to assessment	≥=98%	100%				
4	Safeguarding – Social Care Assessments	TBC	TBC				
Clinical Effectiveness							
5	The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)	≥=95%	95.33%				
6	Rate of Service Users saying they know how to get support and advice at a time of crisis	≥=83%	84.38%				
7i)	Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI) The percentage of service users aged: **0 to 15**	≤=7.5%	0.0%				
7ii)	**16 or over**	≤=7.5%	5.7%				
8	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	≥=95%	88.58%				
Service User and Carer Experience							
9	Service User experience in the community (Mandated)	N/A	Reported Annually				
10	Rate of Service Users saying they have been involved in discussions about their care	≥=85%	90.63%				
11	Rate of carers that feel valued by staff	≥=75%	85.19%				
12	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	≥=70%	84.98%				

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 14
Subject:	People, OD and Communications Quarter 1 Report	**For Publication:**
Authors:	Steve Graham (DDPOD, Projects)	**Approved by:** Ann Corbyn, Exec Director People and OD
Presented by:	Ann Corbyn, Exec Director of People and OD	

Purpose of the report:

To inform members of the People, OD and Communications activity and progress against targets during Quarter 1, April to June 2020

Action required:

Members are asked to receive the paper

Summary and recommendations to the Board:

This report is the regular quarterly report to Board on activity undertaken within the People, OD and Communications Directorate to support the commitments in the Annual Plan. This report includes a description of both internal and external Communications activity for the first time and it is the intention to incorporate this into all future Directorate reports.

Understandably, the major focus has remained the work to support and engage with our people during the pandemic and communicate our approach to our external stakeholders, members will note from the paper that progress has been made in a number of areas, notably our recruitment and retention targets and in continuing our Mary Seacole and Cohort 10 of the Leadership Academy.

Sickness Absence was clearly impacted by the pandemic, but we have seen significant reductions in the numbers absent from mid-May and that continued to reduce during June.

Our appraisal rate continues to lag behind target but there are actions underway to address this; our Mandatory and Statutory Training compliance has dipped but we have a detailed recovery trajectory plan in place and face to face training has restarted in an IPC compliant manner.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Financial, IT, Staffing and Legal Implications:

None.

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

None.

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

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

Seen by the following committee(s) on date:

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

None.

Hertfordshire Partnership University NHS Foundation Trust

People, Organisational Development and Communications Directorate Report

Quarter One: April – June 2020

1.0 Introduction

The purpose of this report is to appraise the Trust Board on the Q1 performance of the People, OD and Communications Directorate. The report summarises the activities undertaken to improve performance against the agreed targets of the annual plan and outlines the planned activities for the next period across all the functions of the Directorate.

2.0 Executive Summary

During Q1 the People and OD business continuity plan was enacted which resulted in a significant amount of resource across the Directorate during the quarter being focused on supporting the Covid-19 pandemic work. A separate report to the Covid Assurance Committee of 9th July 2020 covers the detail of the Covid associated work delivered during this period.

The main functions that maintained business as usual were the recruitment team, the medical staffing team and the bank temporary staff team. These teams had to quickly adopt new ways of working away from their traditional office bases and remote from colleagues.

The Organisational Development team, the Learning and Development team and the Employee Relations team all transferred their efforts to providing significant support to enhance the experience of our people through health and well-being initiatives and by making welfare calls to those affected by the virus.

The Great Teams programme was paused at the start of the pandemic. 32 teams had already engaged with the programme at this point. This work will be re-started in Q2 as our teams restore services and we will revisit the programme to ensure it reflects the learnings from the pandemic period and takes account of the new challenges that teams face in a world where we live with Covid and continually strive to innovate and deliver our services in a way that delivers the very best of outcomes for our service users..

We did maintain Leadership Development activity this quarter and completed the latest cohorts of the Mary Seacole Programme and Cohort 10 of the Leadership Academy.

Despite the changes required to recruitment in relation to the way the team worked and the way interviews were run, our recruitment activity throughout the pandemic has been successful with the Trust vacancy rate ending Q1 at 11.55% (against a target of 10.5%).

At the end of Q1 the Trust had an increased funded establishment of 3665 FTE with 3241 FTE in post and 432 vacancies, compared to the end of Q4 when there was a funded establishment of 3575 FTE, with 3174 staff in post and 401 vacancies.

The pandemic has also had a positive impact on retention, with reduced numbers of people leaving the Trust. We ended the first quarter with an unplanned turnover rate of 9.1% compared to the rate of 10% at the end of Q4 and against a target of 9%.

The sickness absence figure for Q1 average was 5% (this is significantly elevated by the high levels of Covid19 related absence in April). The monthly figure for May was 4.79% and for June was lower again at 4.28% (see Appendix 6). A review of the numbers of episodes of the major sickness absence reasons has shown a significant drop of the number of episodes of colds and coughs and gastrointestinal illness as a reason for absence. This is almost certainly due to the enhanced IPC protocols at the work place and at home.

The appraisal rate across the Trust continues to sit below target (See Appendix 7) and will be an area of focus in Q2 of 2020/21 as the Trust restores focus in a more business as usual manner. Revised and shortened appraisal documentation that has been co-produced will be issued during July to support the recovery of this target. We will also focus on a simpler recording process to ensure that completed conversations are easily reported.

Mandatory and Statutory training compliance dropped slightly as the impact of Covid-19 was felt on the capacity of the workforce to undertake training. There is a full recovery plan in place to bring this back on track, including a review of essential face to face training, The trajectory will ensure that the Trust is back to compliance by the end of 2020.

A Health and Well Being strategy was drafted for ratification in Q4, however this was paused and the work of the well-being team was focused exclusively on supporting teams through the pandemic with activities including sourcing food for teams, supporting the employee support line, and sourcing gifts for staff. The Health and Wellbeing Strategy will be reviewed to ensure learning from the pandemic response is included and a launch is planned for September.

3. Activity against annual plan objectives

3.1 Staff retention

Over the year, there has been an increase in establishment of over 250 fte, which has been matched by a corresponding increase in staff in post. This has resulted in a significant reduction in the vacancy rate during the year (See Appendix 1).

We have seen a significant increase in the number of active recruitment episodes to ensure that our recruitment pipeline continues to bring in the numbers of starters we need, with over consistently 250 candidates at the post offer stage.

The model of utilising social media for a focused locality and / or staff group continued to be successful during the pandemic and coupled with the introduction of video conferencing for interviews, has seen very successful recruitment activity through Q1.

The successful recruitment of 124 new starters compared with a very low rate of leavers (59 FTE) has seen another positive gain in terms of staff in post of 65 FTE (see Appendix 2 for comparison with previous year).

The two tables in Appendix 3 show the vacancies by staff group at the end of Q4 and the end of Q1. It can be seen where the increase in establishment over the quarter has had a positive impact on the vacancy rate. In particular we can see imporvement in the Nursing and Midwifery registered staff group, the Professional, Scientifc and Technical staff group and the Allied Health Professional staff group.

A focus for Q2 will be recruitment to the registered nursing staff group.

The monthly spend on bank staff has steadily increased since March, from £1.4m in Feb to £1.8m in June. Further work is being undertaken to identify the increased areas and reasons for spend to ensure that we are confident that these levels will reduce as the vacancy rates and absence rates continue to reduce. (Appendix 4 shows the increase in spend)

Another key element in supporting the retention of staff is ensuring they have regular meetings with their manager including an up to date appraisal outlining their objectives and development needs. Through Q1 (and the height of the pandemic) the compliance rate for appraisals has dropped, as managerial capacity to undertake the meetings have diminished. At the end of Q1 the rate had dropped to 72% from a rate of 81% at the end of Q4 (see Appendix 7). Whilst this is not acceptable, we also know that the initial census conversations with our people were well received and timely, and that the staff risk assessment process has been part of the continuing conversation with our people.

The recovery of the appraisal rate will be a focus for Q2 with the introduction of a revised and shortened appraisal form. The intention is to use the appraisal conversations to underpin the positive conversations that developed during the pandemic and will enable the development of an optimistic culture. It is expected that recovery to compliance will be completed by the end of 2020.

For similar reasons the mandatory and essential training rates have dropped slightly off target from 92% at the end of Q4 to 91% at the end of Q1.

ILS, BLS and Respect Training (relating to People 3b, 4 & 5) remain an area for concern due to the requirement to deliver this training face to face and the limitations living with Covid19 has placed on our ability to deliver this. This is being addressed and an action plan to ensure compliance has been developed which should bring about recovery by the end of 2020.

3.2 Supporting our Just and Learning Culture

During the pandemic we adopted a clear principle of supporting staff through this difficult time in a way that was kind and just. Our people policies and guidance introduced during Q1 to support people in the pandemic were all written from that perspective. We have no data to indicate it was well received, other than anecdotal feedback and the lowest turnover rate and number of leavers in recent times. This may be due to the difficulty in applying for roles during the pandemic; however our recruitment pipeline didn't slow down.

In addition our main intervention into supporting the development of a Just and Learning Culture was the pre-pandemic introduction of the objective disciplinary panels in to the disciplinary process.

Our review of the WRES data for both the disciplinary process and recruitment process can be seen in Appendix 5 and shows a significant reduction in the bias to non BAME staff in both disciplinary and recruitment. This indicates a real change in the experience of staff but we are developing a more targeted short, medium and long term action plan to ensure that our employee experience is consistent, regardless of ethnicity or any other characteristic.

3.3 Staff Health and Well Being

A continued focus in Q1 was to support our people during the pandemic.This saw us responding to staff concerns with food deliveries, Project Wingman lounges and identifying free treats to circulate. In addition the Employee Relations team managed welfare conversations with over 550 staff that had swabbing tests and supported delivery

of the antibody test results. The team were also very involved in providing emotional support via the Trust's support line.

Development of a Health and Wellbeing strategy that encompasses the learning from the pandemic period is underway and focuses on the 5 pillars of Wellbeing; Mental, Physical, Nutritional, Financial and Environmental.

Work has been completed within this quarter and with the STP to replace both the Occupational Health provider and the Employee Assistance Programme service. At this early stage in the new contracts, both services appear to providing a satisfactory service. Further feedback will be reviewed over the next quarter.

3.4 Organisation development

Whilst the focus of the OD team has been on supporting our people affected by the pandemic and providing support to the Health and Well Being agenda during Quarter One, other OD activity has also been undertaken. This includes .

- The delivery of the monthly Inspire awards moved to a virtual ceremony
  - ✓ April – 7 awards overall; 4 in East & North Herts, 2 in LD&F and 1 in West
  - ✓ June – 6 awards overall; 1 in West, 3 in East & North Herts, 1 in LD&F and 1 in Corporate services
  - ✓ There are plans to introduce an Inspire 'Team' Award to recognise whole team contributions

- Completion of cohorts on the Leadership Academy and Mary Seacole programmes
  - ✓ 10 delegates on Mary Seacole; 8 Female and 2 male; 4 white and 6 BAME
  - ✓ 26 delegates on Leadership Academy; 23 Female and 3 male; 15 white and 11 BAME

- Development of guidance to support home working and maintaining individual well-being is on the Hive. During Q2 we will create new ones reflecting new ways of working as we restore services and look at longer term top tips

- Support to the Trust support line
  - ✓ Number of calls to date – 237
  - ✓ HPFT Calls make up 47% of the total (112 calls)

- Development of the online 'Managing Differently' programme
  - ✓ Focused on managing in the new environment
  - ✓ Promoting manager and team wellbeing
  - ✓ Supporting agile and flexible learning
  - ✓ Understanding the impact of new ways of working on others and managing this to get the best out of a team

Q2 will see a re-start of the Great Teams programme as a major focus and a recognised driver of our collaborative and optimistic workplace culture. Work has been undertaken during early Q2 revisiting teams that have expressed an interest to work out what their current needs are, are they ready to recommence and if they are ready, what are their priorities given the learnings from the pandemic and the need to work differently in living with Covid.

Conversations have also been held with Senior Service Line (SSLL) and Service Line Leads (SLL) in all SBUs to get a fresh understanding of where they want the Great Teams programme to refocus and new teams have been identified e.g. EMDASS as a new team due to the re-engineering of their care pathway into primary care and North West Essex IAPT as they commence a period of consultation. Two other wellbeing teams have been identified for Q4 after they complete a CQI Project

By early August we will have a more detailed plan on all teams with the engagement of the SSLL & SLL ensuring accountability for the work is embedded within the SBU. Once the plan has been devised, this will directly inform the SBU Business Plans.

4. Communications

The majority of communications activity has been in response to the COVID-19 pandemic during Q1 - here are some of the highlights.

4.1 Internal communications

In early April we made a step change in the way we deliver internal communications and staff engagement, through greater use of technology, visual media and videos. New internal communications methods that were introduced included a weekly CEO video message for staff, the introduction of a regular live staff briefing and Q&A led by the CEO on MS Teams and the creation of a closed staff Facebook group. We believe this approach has enhanced our internal communications reach and improved staff engagement. We will use the responses to the staff engagement question in the quarterly Pulse survey and annual staff survey to measure and evaluate the impact of our internal communications. Significant internal communications activity included:

- Internal communications throughout the COVID-19 pandemic have been in the form of a daily **Strategic Command Bulletin** to all staff, which provides updates on guidance, policies and other key operational information. A weekly bulletin – ***Supporting You*** - which focuses on the health and wellbeing of our staff as well as sharing good news and personal staff stories has also been developed and has been well received by staff.

- Weekly **CEO video messages for staff** and weekly **CEO live briefings and Q&A sessions** with staff, the CEO and members of the Executive team were all introduced at the beginning of April 2020, making good use of MS Teams. The frequency of both of these moved to every other week from June 2020.

- A closed group for all HPFT staff has been created on **Facebook**, which gives staff the opportunity to share their news, receive updates and to keep in touch. This is proving to be popular with 300 staff signing up in the first few days.

- **Family letters** from the CEO and Chair sent to staff family members explaining how proud they are of their loved ones and how important they (and their work) are to HPFT.

- A COVID-19 section has been created on the **staff intranet, the Hive**. This is updated on a daily basis with all the latest guidance and other information. Our public website also has a Coronavirus section, with useful information, links and advice for members of the public.

- An **internal communications campaign** running over several weeks through our internal channels designed to support those working out of their home, those staff returning to work following illness or shielding, clearing the clutter to make work areas COVID-secure and keeping safe by wearing masks.

4.2 External communications

External communications activity during Q1 also focused on COVID related comms. Our social media public channels (Facebook and Twitter) received large amounts of traffic, as did our website where the most popular pages visited were the wellbeing / self-referral pages.

We promoted a number of awareness weeks through our social media channels and issued updates to our GPs and stakeholders in Herts, as well as stakeholders in Bucks, Essex and Norfolk. Press releases focused on the support that HPFT is providing for NHS staff and residents. Significant communications activity included the following:

- **Social media campaign activity,** to promote the dedicated support telephone line for all HPFT staff and NHS and social care staff working in Hertfordshire and accompanying online resources.

- HPFT's **social media channels** have been used to support national messages and campaigns including Every Mind Matters, as well as to communicate our own messages to our followers.

- **Nurses Day** on 12 May celebrated the 200th birthday of Florence Nightingale and the International Year of the Nurse and Midwife. HPFT supported the day with messages on social media, thanking our nurses and showcasing the roles of **Mental Health and Learning Disability Nurses with individual case studies**. HPFT also shared messages from senior nurses and members of the Executive team, including Tom Cahill and a short video from Dr Jane Padmore, thanking all our nurses was produced.

- HPFT has contributed to the **Local Resilience Forum stakeholder bulletin**

- **Written updates** have been sent to GPs and other stakeholders across Hertfordshire and Buckinghamshire, Essex and Norfolk.

- A COVID specific section was created on the **Trust website,** with information about visiting, appointments and how to access support and which continues to be updated regularly.

5. Conclusion

The business as usual work of the directorate was significantly affected by the Covid-19 pandemic during Q1 with many teams halting planned work and priorities, turning their attention to supporting the response to the pandemic.

Despite this we have seen the vacancy rate and retention rate continue to improve; however some other workforce metrics – such as PDP and training compliance rates – have dropped.

In addition we have supported the wellbeing of staff introducing many initiatives to aid the mental and physical health of our workforce.

Within the Communications Team, activity significantly increased with a number of new ways of communicating and engaging with staff being introduced. These new methods of delivering staff communications and engagement have enhanced the way we engage with our staff and will continue into Q2 and beyond.

The focus for Q2 will be to recover the compliance of those metrics and consolidate the work on the health and well-being of our people in line with the People and OD plan, supporting the recovery and restore work and supporting the transformation of services. Key to enabling all this work is a strong focus on the work on inclusion and culture covered by the People and OD plan.

A communications strategy will be developed during Q2, incorporating our learning from the pandemic period, which will then guide our approach to internal and external communications for the future.

8.0 Recommendation

The Board is asked to note the Q1 position and the level of activity that is being undertaken within the People and Organisational Development directorate to support the annual plan and improve the experience of our people.

The Board is also asked to note the inclusion of a review of the Communications directorate for the first time and to note that this will now be a regular feature of this overall Directorate report.

Steve Graham
Interim Deputy Director of People and OD – Projects
July 2020

Appendix 1: Establishment Data

The establishment data as at 30 June 2020, with comparisions against the previous year.

	Q1	Q2	Q3	Q4	Q1 (2020/21)
Funded Establishment =	3409	3484	3518	3575	3665
Staff in post =	2966	2973	3073	3174	3241
Vacant posts =	443	511	444.79	401	432
% Trust Vacancy rate =	13.00	14.68	12.64	11.23	11.55
Active Vacancies being recruited to =	255	292	505	440	432
% Total Turnover rate =	15.65	15.32	14.15	14.04	12.83
% Stability rate =	87	85	86	86	88

Appendix 2: Starters and Leavers gain

Quarter	Gain
Q1 (2020/21)	+65
Q4 (2019/2020)	+72
Q3 (2019/2020)	+21
Q2 (2019/2020)	-13

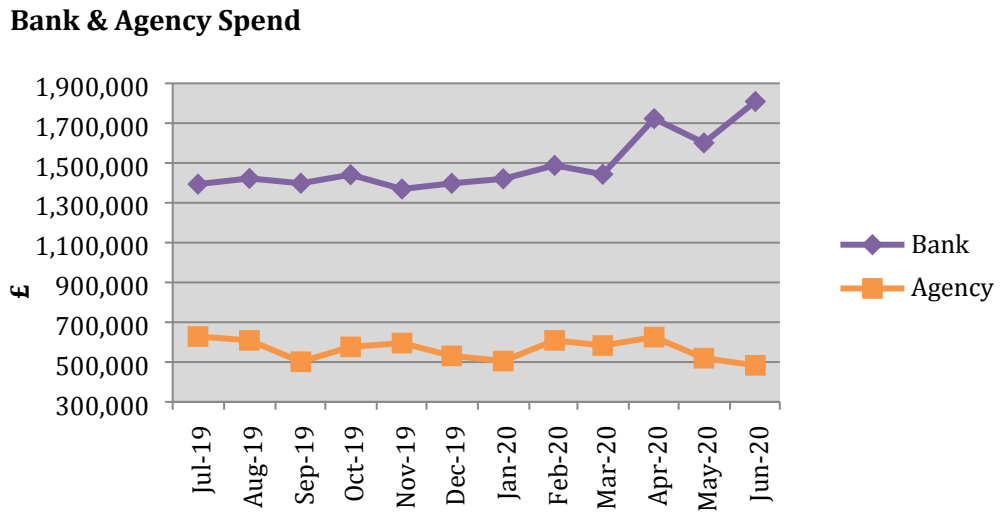
Appendix 3: Vacancy by staff group - Q1 2020/21

Staff Group	Sum of FTE Budgeted	Sum of FTE Actual	Sum of FTE Variance	% Vacancy rate
Add Prof Scientific and Technic	556.43	511.60	44.83	8%
Additional Clinical Services	1065.98	979.19	86.79	8%
Administrative and Clerical	753.35	691.98	61.37	8%
Allied Health Professionals	157.32	126.99	30.33	19%
Estates and Ancillary	25.80	22.40	3.40	12%
Medical and Dental	220.22	205.73	14.49	7%
Nursing and Midwifery Registered	886.05	703.98	182.07	21%
Students	0.00	0.00	0.00	0%
Grand Total	**3665.15**	**3241.87**	**423.28**	**11.55%**

Appendix 3: Vacancy by staff group - Q4 2019/2020

Staff Group	Position Budgeted FTE	Actual FTE In Post	Vacant FTE	Vacancy Rate %
Add Prof Scientific and Technic	509.24	500.43	8.81	1.7%
Additional Clinical Services	1050.71	924.65	126.06	12.0%
Administrative and Clerical	772.87	690.35	82.52	10.7%
Allied Health Professionals	148.93	129.79	19.14	12.9%
Estates and Ancillary	24.00	22.40	1.60	6.7%
Medical and Dental	211.99	203.06	8.93	4.2%
Nursing and Midwifery Registered	857.40	703.47	153.93	18.0%
Students	0.50	0.00	0.50	100.0%
Grand Total	**3575.64**	**3174.15**	**401.49**	**11.23%**

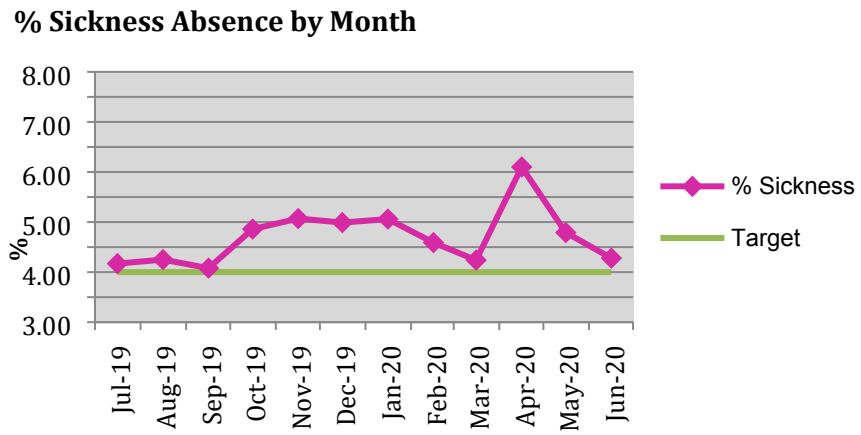
Appendix 4: Temporary Staffing



Appendix 5: WRES data

WRES indicator	2018/19	2019/20	+/- change
Relative likelihood of staff being appointed from shortlisting across all posts	1.58 times greater	1.22 times greater	-0.36
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	1.89 times greater	1.03 times greater	-0.86
Relative likelihood of staff accessing non-mandatory training and CPD	1.30 times greater	1.12 times greater	-0.18

Appendix 6: Sickness Absence rates



Appendix 7: PDP Rates

The PDP rates for each SBU are as follows:

SBU	Q1 (2019/20)	Q2 (2019/20)	Q3 (2019/20)	Q4 (2019/20)	Q1 (2020/21)
LD&F	93%	89%	89%	88%	86%
Essex & IAPTS	80%	82%	82%	78%	66%
East and North	89%	91%	87%	84%	76%
West	90%	87%	78%	76%	63%
Corporate	69%	65%	65%	75%	64%
Trust	**86%**	**85%**	**82%**	**81%**	**72%**

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 15
Subject:	Financial Position to 30th June 2020	**For Publication:** No
Author:	Sam Garrett, Interim Deputy Director of Finance	**Approved by:** Paul Ronald, Director of Operational Finance
Presented by:	Paul Ronald, Director of Operational Finance	

Purpose of the report:

The report sets out the financial position to 30th June 2020 under the exceptional financial arrangements that are being applied initially during the first four month period. The report seeks to both inform the Board of the current position and further to project the financial position for the full year in the light of the anticipated changes that may be made for the period from August onwards.

Action required:

To review the detailed provided on the current and projected financial position and assess the Trust's ongoing response to the evolving financial arrangements.

Summary and recommendations

The Trust has achieved an overall break-even position for the month and year to date as required under the current financial arrangements. The position pre-COVID-19 costs is a shortfall of £900k in month and £3.4m year to date as per A in the table below, with break-even achieved (C in the table below) after allowing for COVID-19 reimbursement (B in the table below).

	In Month Actual	Year to date Actual
Income	21.8	65.5
Expenditure	22.7	68.9
Total (A)	**(0.9)**	**(3.4)**
COVID-19 reimbursement (B)	0.9	3.4
Income Top Up	0	0
Revised Total (C)	**0**	**0**

The current financial arrangements which ensure that the Trust achieves financial balance will be extended for the first five to six months of the year. What is less clear is the detail of the changes that will be made from September or October onwards as NHSE/I seek to bring in more certainty and grip to the system. To date the Trust has performed strongly; there has been no requirement for extra income beyond COVID-19 reimbursement and the level of this reimbursement has been below the regional average. However going forwards there are clear risks in terms of the level of demand and its complexity. This has been evident through June and July with the requirement for specialist CAMHS inpatient beds, and continued demand for Adult Acute and PICU beds, though the latter have reduced in recent weeks.

To manage the financial risk the Trust continues to:

- Work with commissioners and the region to ensure the promised new investment is made
- Progress work within the restoration work streams to further grow IAPT and community capacity
- Progress its Delivering Value programme linking this to the opportunities being identified within the Shaping our Future work
- Accelerate its capital programme which sees investment both within the estate and technology
- Continuing the work on managing the level of need for external bed capacity which had previously been very successful.

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

Summary of Financial, IT, Staffing & Legal Implications:

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

N/A

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

Financial Management

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

1. Summary

1.1. As per the current national reporting arrangements the Trust reported a break-even position for Month 3 and for the year to date. In doing this the Trust has reclaimed £3.4m of COVID-19 costs in the period, of which £2.5m has been paid to date (the remainder is not yet due but has been claimed). No further income amount was required to achieve break even.

1.2. Main figures for the month as shown below:

	In Month Actual	Year to date Actual	Year to date Draft Plan
Income	21.8	65.5	65.9
Pay	15.1	44.4	42.5
Secondary Commissioning	2.9	9.0	8.3
Non Pay	3.8	12.8	12.3
Financing	0.9	2.7	2.7
Total before COVID-19 reimbursement	**(0.9)**	**(3.4)**	**0.1**
Incl. Supplementary Income:			
COVID-19 reimbursement	0.9	3.4	0
Income Top Up	0	0	0
Revised Total	**0**	**0**	**0.1**

1.3. Compared to the draft Plan submitted in March excluding the COVID-19 costs and related reimbursement:

1.3.1. Income – £400k less year to date which reflects c. £1.2m new investment not yet available offset by the national income adjustments of £800k

1.3.2. Pay – On Plan for the period as although some vacancies for new service provision remain the Plan was phased to allow for later recruitment

1.3.3. Secondary Commissioning – overspent by c. £300k reflecting additional adult beds required in the last few months and an increase in CAMHS T4 both in bed prices and more specialist (therefore more expensive) beds being needed

1.3.4. Overheads – underspent by c. £900k with savings on travel and other support costs, as well as some project delays where not related to COVID-19

1.4. The Trust's Use of Resources (UoR) framework rating is not being reported to NHSE/I under the current financial arrangements and due to the fact that Trusts are reporting a consistent break-even position. The Trust's own assessment against the previous criteria would report as 1.

2. Background

2.1. This year has seen fundamental changes to the normal contracting and financial reporting processes and is set within the context of the overarching objective of Finance to support and facilitate the clinical response to COVID-19. All NHS Organisations have been directed to report a break-even position in each of the first four months with income being made available to fully match expenditure. The specific arrangements are:

2.1.1. Provider Trusts are to be fully reimbursed for the costs incurred. This amount is largely paid in 3 payments: an initial block amount, a "Top-up" to provide a balancing figure to break-even, and a "True-up" if needed for cash purposes

2.1.2. The contract process for 2020/21 was suspended.

2.1.3. The Annual Planning process was also suspended. NHSE/I have used a proxy budget based on 2019/20 for reporting purposes

2.1.4. No new revenue business investments should be entered into unless related to COVID-19 and approved by NHSE/I

2.2. This arrangement provides a monthly block payment to HPFT of £18.3m, and a number of additional payments including Social Care of c. £3.0m. There is then an additional Top-up payment, calculated based on 2019/20, as well as further Top-up payments in respect of COVID-19 costs (see below), and in order to bring the Trust to break even. HPFT has not needed to date to utilise additional Top-up payments and it is unlikely the Trust would need to utilise the True-up process.

2.3. Specific guidance to detail arrangements beyond the initial period has not yet been published and is now expected in August. Trusts and Commissioners have been informed that the current arrangements will continue for a further month and possibly two months, with new arrangements to be put in place from September or October. It is possible that these new arrangements will:

2.3.1. Seek to tighten financial control and provide incentives for productivity gains

2.3.2. Provide a cap on COVID-19 reimbursement claims as well as potentially restricting them to particular areas of expenditure

2.3.3. Give the STP/ICS a role in the allocation of resources across the area

These arrangements could present an element of risk to HPFT and therefore it is important to manage COVID-19 costs down where possible, and ensure the full range of financial control is in place.

2.4. Additionally the Trust would have expected to receive funding for new or expanded services (as per national priorities) under the Minimum Mental Health Investment Standard (MHIS). In principle NHSE/I have stated that this investment remains both available and necessary, however to date due to the

complexities of the current arrangements it has not been possible to agree the detail. HPFT are liaising with both local commissioners, the STP/ICS, and NHSE/I directly to ensure that this issue is resolved and expansion can commence.

3. Key Variances

3.1. These variances are reported excluding the impact of COVID-19 costs.

Income

3.2. For the year to date there is £400k less income than Plan, as explained above this is due to the current method of payment, and is partly mitigated by the top-up payment process. CQUIN is included for these first five to six months at 100% with no penalties. Within the position an amount of £198k (£66k per month) is accrued for Cambridge and Peterborough CCG which has not yet been paid, though they have confirmed via IHCCT that HPFT can now invoice for this. There is also an amount of c. £70k per month relating to the re-phasing of Social Care Savings by Hertfordshire County Council; this has been agreed but not yet formally confirmed yet.

3.3. From Month 3, an additional contract for Liaison & Diversion services has been added at £1.1m per year (£92k per month), this is a sub-contract via East London NHS Foundation Trust so it is expected that this can be invoiced directly.

3.4. There remains a significant level of new investment due in year from both the MHIS and the New Care Model investments.

Pay

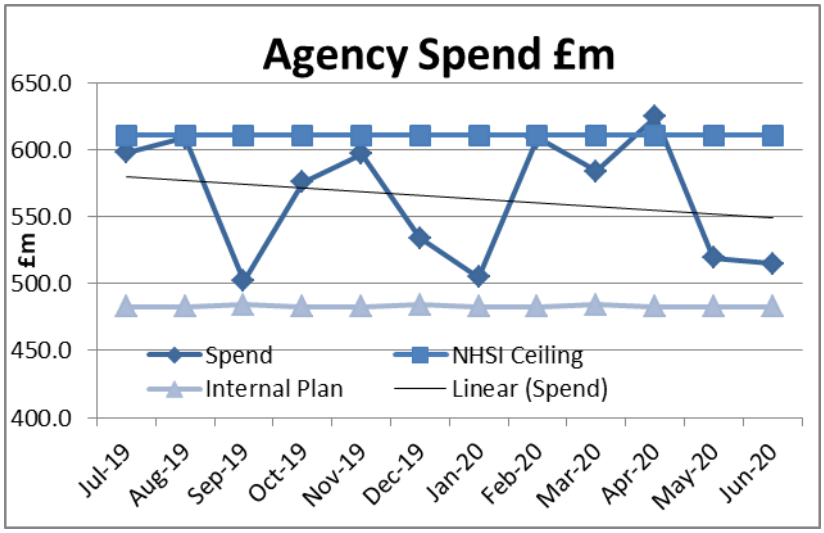
3.5. Year to date Pay would be on Plan without COVID-19 costs however it should be noted that some of these costs may continue beyond the reimbursement period. There was significant recruitment through January to March and some recruitment has continued through April and May though at a lower rate. This has meant an increase in Substantive pay spend primarily in new roles not previously covered.

Period	Starters	Leavers	Net
Dec & Jan	**114**	**-61**	**53**
February	**48**	**-33**	**15**
March & April	**72**	**-65**	**7**
May	**32**	**-21**	**11**
June	**39**	**-15**	**24**
Total	**305**	**-195**	**110**

Of the 305 starters above, c. 50 fte relate to Student Nurses who have joined the workforce early at Band 4, they should mostly join as Band 5 Nurses in the autumn when they become qualified.

Additionally, there are 40 individuals with start dates confirmed over the coming months, and a further 90 offers out to external candidates.

3.6. Agency spend having increased during the latter part of 2019/20 has now started to reduce during 2020/21, most notably Medical locums have reduced from a high last year of 12 to between 5 and 7 in June and July. The highest use of agency remains qualified nursing roles in inpatient and all qualified roles in the community; the former in particular is expected to reduce from September / October as the newly qualified nurses take up vacancies. Focus is now on increasing the conversion of agency staff highlighting the benefits of more secure employment.



Secondary Commissioning

3.7. Secondary Commissioning is overspending by £750k for the year to date of which c. £400k is being reclaimed via the COVID-19 process. The key areas are:

3.7.1. CAMHS Tier 4 out of area placements reported at £348k for June which was an increase on April and May; £148k higher than the average of £200k per month in 2019/20. The majority relates to additional placements (now at 16 versus average of 8 in the latter part of 2019/20), and these placements being in more expensive settings such as Low Secure and PICU, rather than General Adolescent. These numbers have continued at a high level in July. All are reviewed on a weekly basis by HPFT CAMHS clinicians.

3.7.2. PICU out of area placements have reduced to between 2 and 4 from a high of between 6 and 8, resulting in cost reductions of c. £80k in May and a further c. £110k in June. There has remained significant pressure on

Acute out of area placements with costs remaining high in June though some reduction in July. These placements continue to be clinically reviewed regularly to ensure appropriate care and discharge.

3.7.3. Main Health placements have also increased in cost and are now at 36 in total from a low of 30 in 2019/20, with several placements being made largely due to COVID-19 issues, and one particularly expensive 4:1 placement which has now transferred to NHSE/I funding in a more appropriate Medium Secure setting.

3.7.4. MHSOP CHC Placements have decreased in cost by c. £100k per month; these costs were already starting to reduce in Quarter 4 2019/20 and have continued to do so.

3.7.5. Social Care costs haven't changed significantly, with some impact from COVID-19 but c. £20k per month.

Overheads

3.8. Overheads are underspent by c. £900k for the year to date once costs related to COVID-19 are removed, due to savings particularly on travel and on project spend unrelated to COVID-19 being delayed.

4. COVID-19

4.1. As stated above there is a COVID-19 cost reimbursement process in place via the top-up arrangements and HPFT has claimed a total of £3.4m in year with £2.5m agreed and paid to date, and £900k for June not yet due. Just under £1.0m was already claimed and paid for March.

4.2. These costs relate to a number of areas broadly as follows:

£000	Year to date	Comments	Expected July	Comments
Pay	1,550	COVID-19 sickness cover, additional hours worked, on call, Student Nurses	450	Reduced but does remain fairly high in part projected EMDASS recovery work
Sec. Comm.	400	CAMHS T4 costs, high 4:1 care costs for one care package	150	Some costs reduced but CAMHS T4 remains high
Interserve Costs	550	Refurbishment works, security, staff meals and deep cleaning	75	Staff meals now ended, one-off work complete
Other Refurb & Security costs	550	Perspex screens, security for new sites & PPE stores, refurbishment of wards	100	Most work now complete but security remains high cost
Other	350	Including uniforms	50	
Total	3,400		825	

4.3. It is expected that additional scrutiny will be applied to this area of expenditure and reclaims going forward and it will be important to reduce costs where appropriate, and to continue to apply the same levels of governance and financial control as would be usual for the Trust. The Trust is seeking to reduce spend wherever possible in particular:

4.3.1. Investigation of continued high levels of bank and agency charged to COVID-19 costs and whether these can be reduced given levels of sickness are now very low; ensure all Additional costs to be claimed by managers have now been claimed

4.3.2. Review of security at the A&E Diversion centres which are high cost at over £100k per month

4.3.3. Ensure Student nurses who have joined early are able to cover HCA shifts from August when funding can no longer be claimed for them

4.3.4. Cost of SMS text messages to be halved from July saving at least £5k per month following advice to reduce characters

5. Delivering Value Programme

5.1. The original 2020/21 requirement was calculated at £6.0m or £500k per month. This represented circa 2.3% of the cost base and was a stretching target, reflecting the non-recurrent shortfall in 2019/20 and the much higher level of saving being applied by Hertfordshire County Council for Social Care.

5.2. The Trust has recommenced work on the programme and as services are restored those schemes previously developed will begin to be implemented. They are being reassessed as part of the Phase Two recovery work, along with those emerging areas within the Recovery cell work which could provide efficiencies and protect resources whilst improving service provision, such as reduced outpatient appointments, increased use of digital tools and increased partnership with the voluntary sector.

5.3. In addition there have been several cost reductions such as travel cost savings, continuing reduction in Continuing Healthcare placements and reduced Medical locum agency cover.

5.4. The target at £6.0m was set on an annualised basis, until 31st July the application of 1.1% efficiency has been suspended, so the target is £4.0m for the period from August but with a £6.0m annualised basis.

5.5. The list of developed schemes, plans in progress and opportunities for efficiency, identifies potential recurrent savings totalling c. £4.3m, recognising that £0.7m is identified as opportunities at this stage and that there is an element of volatility in relation to some of the more developed schemes

Level of Maturity	Indicative Annual Value £000
Developed Schemes	2,232
Proposals	1,388
Identified Opportunities	640
Current Programme total	4,260

5.6. Work is now underway, including identification of project management support, to ensure that the key work streams can be implemented at the pace required.

6. Balance Sheet and Cash Flow

6.1. Main movements in the month and since the year end are as follows:

6.1.1. Receivables increased by £3.2m in month due to income being received later than expected in Month 4, and COVID-19 and Top-up income being received on 15th July.

6.1.2. Payables and accruals decreased by £200k in the month predominately related to a fall in the level of capital payables.

6.1.3. Deferred income decreased by £300k in month related to changes in the deferral of LDA payments from Health Education England.

6.2. The current provision balances are shown below:

April 1st Balance	Provision	Current	Movement Year to Date
978	Continuing Care Appeals	978	0
600	LTPS & Legal Claims	600	0
2,008	Pensions	2,026	17
2,678	Injury Benefit	2,653	-25
169	Pay Protection	169	0
1,085	Oak Ward	1,085	0
150	SRS	150	0
1,445	Dilapidations	1,494	49
9,113	**Total Provisions**	**9,154**	**42**

6.3. Cash balances have decreased by £3.6m in month 3. This predominately relates to the increase in receivables noted above.

6.4. A cash flow forecast is required to be sent to NHSI/E every two weeks to assess how the current funding arrangements are affecting organisations' liquidity. The table below shows the forecast that was submitted at the start of June against the actual cash flow for June, and the forecasts for July and August submitted in

July. These cash flows are constantly updated and refined to be more accurate as more data is available.

	June Forecast £'000	Actual £'000	Variance £'000	Comments	July Forecast £'000	August Forecast £'000	Comments
Opening Cash Balance	81,709	81,709	0		79,515	77,232	
Receipts	19,962	18,920	(£1,042)	The April Covid top up income of £1.1m was incorrectly claimed so was not received until July where originally forecast in June	22,966	1,308	It was forecast that the NHSI funding arrangments would cease at the end of July and as income had been received a month in advance no block income would be received in August this will now be updated on the latest forecast where income will be received in August
Payments	(£20,307)	(£21,114)	(£807)	Pay costs were underestimated by £2.3m due to the timing of the pension payment forecast one week too early. This was offset by creditor payments overestimated by £1.5m	(£25,249)	(£22,612)	Creditor payments are high in July due to a 5 week month.
Closing Cash Balance	81,364	79,515	(£1,849)		77,232	55,928	

7. Capital

7.1. Cumulative net capital spend year to date for 2020/21 is £1.4m, £400k in the month.

7.2. There is a further £126k of revenue spend year to date, £31k in the month. This primarily relates to the running costs for empty buildings and the dilapidation costs for Trust leased buildings.

7.3. The main areas of capital spend planned for 2020/21 are: Safety Suites (£8.0m), new 54 bed Inpatient Unit (£3.5m), the Digital Strategy (£1.9m), and Forest House refurbishment (£1.4m).

7.4. The current year plan includes the disposal of the Stewarts and St. Pauls. The disposal amounts which won't now be received are offset by the likely timing of the planned refurbishment on Oak Ward.

7.5. The Trust is still awaiting confirmation whether its capital bid in relation to windows for several wards on the Kingsley Green site (which need replacing due to COVID-19) has been successful nationally.

7.6. Capital spend is forecast to gradually increase as the year progresses in particular at the point construction begins on the Safety Suites in Quarter 3 and potential land is acquired in Quarter 3 or 4 for the Inpatient Unit.

8. Risks and Mitigations

Income

8.1. There is increasing scrutiny over COVID-19 costs going forwards and a clear expectation that these will reduce. Mitigation is that these costs are starting to reduce and action will be taken to review and reduce as outlined above.

8.2. New guidance is awaited on the revenue arrangements for the period from September or October. Details haven't been confirmed but as outlined above it is likely that:

8.2.1. Control over costs will be tightened, with a cap on COVID-19 reimbursement

8.2.2. The STP/ICS will have a role in allocating funds

8.2.3. The additional MHIS will be included

Expenditure

8.3. As pay costs continue to increase finances will come under more pressure, and top-up funding may no longer be available. Mitigation is to monitor these costs carefully and work with HR to forecast future spend accurately.

8.4. Areas of Secondary Commissioning continue to overspend, most notably Tier 4 CAMHS where placements have currently almost doubled in addition to cost of each placement increasing; and both PICU and Acute out of area where although numbers do go down this is not sustained for a long period.

9. Forward Look

9.1. For the period to end of August or September the position will be break-even, with some increase in pay costs and CAMHs external bed requirements.

9.2. The position for the second part of the year is more difficult to predict given the lack of detail. The Trust will see an increase in income from the MHIS for IAPT and Crisis services, but it is now unlikely that additional funding to support the recovery of activity to pre COVID-19 levels will be forthcoming.

9.3. What is not clear is what other changes will be made that potentially offset this. These matters will be kept under continual review.

9.4. The mitigation to this uncertainty is to continue its work at pace on service restoration and redesign and with pushing forward the Delivering Value programme.

9.5. The Trust continues to expect to achieve break even for the year given its current performance and its current planning and progress on key actions.

Current Trading - Income Statement for Period Ended 30-June-2020

Description	2020/21 Plan	Month Jun - 20 Actual	Plan	Variance	Year to Date Jun - 20 Actual	Plan	Variance
Number of Calendar Days	365	30	30		91	91	
Contract #1 Hertfordshire IHCCT	193,520	15,739	15,877	(138)	47,216	48,277	(1,061)
Contract #2 East of England	22,944	1,912	1,912	(0)	5,734	5,736	(2)
Contract #3 Essex LD	16,911	1,470	1,409	61	4,411	4,228	184
Contract #4 Norfolk (Astley Court)	2,256	202	188	14	606	564	42
Contract #5 IAPT Essex	8,417	733	701	31	2,199	2,104	95
Contract #6 Bucks Chiltern CCG	3,783	317	315	1	950	946	4
Contracts	247,831	20,372	20,403	(31)	61,117	61,855	(738)
Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	808	70	68	3	195	203	(9)
Education and training revenue	3,399	292	283	9	921	850	71
Misc. other operating revenue	7,449	216	622	(406)	668	1,118	(451)
Other - Cost & Volume Contract revenue	5,106	443	426	18	1,330	1,277	53
Other clinical income from mandatory services	2,234	110	186	(77)	341	559	(217)
Research and development revenue	308	23	26	(3)	89	77	12
COVID Top Up Income	(0)	1,196	(0)	1,196	4,274	(0)	4,274
Total Operating Income	**267,135**	**22,722**	**22,013**	**709**	**68,935**	**65,938**	**2,996**
Employee expenses, permanent staff	(150,497)	(12,763)	(12,345)	(418)	(37,554)	(36,846)	(708)
Employee expenses, bank staff	(17,000)	(1,810)	(1,416)	(395)	(5,137)	(4,247)	(890)
Employee expenses, agency staff	(5,800)	(515)	(483)	(32)	(1,660)	(1,450)	(210)
Clinical supplies	(271)	(106)	(23)	(83)	(197)	(68)	(130)
Cost of Secondary Commissioning of mandatory services	(33,090)	(2,902)	(2,723)	(179)	(9,006)	(8,252)	(754)
Other Contracted Services	(10,682)	(756)	(890)	134	(2,573)	(2,671)	98
Drugs	(3,085)	(282)	(257)	(25)	(885)	(771)	(114)
Total Direct Costs	**(220,424)**	**(19,134)**	**(18,137)**	**(997)**	**(57,012)**	**(54,304)**	**(2,708)**
Gross Profit	46,711	3,588	3,877		11,923	11,635	
Gross Profit Margin	17.49%	15.79%	17.61%		17.30%	17.64%	
Overheads							
Consultancy expense	(112)	(14)	(9)	(4)	(21)	(28)	7
Education and training expense	(1,294)	(39)	(108)	69	(208)	(324)	115
Information & Communication Technology	(4,922)	(406)	(410)	4	(1,261)	(1,231)	(30)
Hard & Soft FM Contract	(6,387)	(624)	(532)	(91)	(1,996)	(1,597)	(399)
Misc. other Operating expenses	(8,940)	(532)	(643)	111	(2,148)	(1,933)	(215)
Other Contracts	(2,005)	(173)	(167)	(6)	(557)	(501)	(56)
Non-clinical supplies	(446)	(145)	(37)	(107)	(475)	(111)	(363)
Site Costs	(7,028)	(606)	(586)	(20)	(1,811)	(1,757)	(54)
Reserves	(1,192)	39	(99)	138	(26)	(298)	272
Travel, Subsistence & other Transport Services	(4,061)	(188)	(338)	150	(690)	(1,015)	326
Total overhead expenses	**(36,388)**	**(2,686)**	**(2,930)**	**244**	**(9,192)**	**(8,795)**	**(398)**
EBITDA	**10,323**	**903**	**947**	**(44)**	**2,730**	**2,840**	**(109)**
EBITDA Margin	3.86%	3.97%	4.30%		3.96%	4.30%	
Depreciation and Amortisation	(6,000)	(541)	(550)	9	(1,634)	(1,650)	16
Other Finance Costs inc Leases	(589)	(23)	(49)	26	(71)	(148)	77
Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Interest Income	366	3	31	(27)	(0)	92	(92)
PDC dividend expense	(4,100)	(342)	(342)	(0)	(1,025)	(1,025)	(0)
Net Surplus / (Deficit)	**0**	**0**	**37**	**(37)**	**0**	**109**	**(108)**
Net Surplus margin	**0.00%**	**0.00%**	**0.17%**		**0.00%**	**0.17%**	

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Board of Directors

Meeting Date:	30 July 2020	**Agenda Item:** 16
Subject:	Annual Plan Refresh 2020-21	**For Publication: No**
Author:	Karen Taylor – Executive Director, Strategy & Integration Directors	**Approved by:** Karen Taylor, Executive Director, Strategy & Integration
Presented by:	Karen Taylor – Executive Director, Strategy & Integration	

Purpose of the report:

This paper provides an updated Annual Plan 2020-21 for approval by the Trust Board. The plan outlines the commitments we are making for the remainder of 2020-21, taking into consideration the impact and changes required as a consequence of COVID19.

Action required:

To approve the revised Annual Plan for 2020-21, noting the changes that have been made.

Summary and recommendations:

Background

Our Annual Plan describes our commitments to our service users, our staff and our partners about what we will deliver during 2020/21. Our ambitious plan, which reflects our relentless drive to improve the quality of care we provide for our service users and carers, was approved by the Trust Board at the end of March 2020.

However, also during March 2020 we saw the Covid-19 pandemic impact across the country. Nationally the NHS declared a Level 4 incident which led to the majority of 'business as usual' activities being paused with all services diverted towards responding to the immediate incident. During this period (Quarter 1 of 2020/21) we saw the tremendous efforts of our staff to keep our service users safe. We put in place new ways of delivering care and increased the use of technology to support the way we work. At the same time, we also had to pause some of the activities we had previously been doing in order to ensure we were able to continue to provide essential services and care during this period.

As we restored our services, whilst continuing to deliver care safely with Covid-19 remaining in our communities, we have been taking stock of the commitments we made to our service users, carers, staff and stakeholders in our Annual Plan. We believe the ambitions we outlined remain relevant, but it has been important to update our plans to include Covid-19 related activities and to ensure the plans are realistic and achievable for the remainder of the year. This paper provides an updated and revised Annual Plan for 2020/21.

The main changes/updates that have been made are as follows:

- Implementing and ensuring Infection Prevention and Control best practice has been made explicit as a key priority
- Our focus on service users physical health has been strengthened further – with commitments made on training, monitoring and improving outcomes for service users
- Our focus on improving care, support and outcomes for service users who are in need of additional support/at risk of admission has been refreshed
- The priority to improve the employment experience of all of our people remains and now also outlines a commitment to support our people to rest and recover post COVID-19
- We have provided more detail regarding our commitment to ensuring all our people feel valued and supported, particularly focusing on the experience and development of our BAME staff
- The innovation /service transformation priorities have been updated to reflect the service changes made and evaluations taking place following COVID-19
- The digital and technology priorities have been updated to reflect acceleration of activities through COVID-19 period and the use of 'virtual' technology evaluation taking place
- The Mental Health & LD integrated Care Partnership priority has been updated to include overseeing the restoration and transformation of services across the system and establishing the programme of work for the ICP as we move forwards.

The measurement (how we will know) against each of the priorities identified have also been reviewed and further defined.

Conclusion

2020/21 is the fifth year of our 'Good to Great' journey and our Annual Plan describes the commitments we have made to our service users, our carers, our staff and our stakeholders. It documents the key actions we will take to this year to further develop our services and to ensure we are able to provide the highest quality care for those individuals with a mental health illness and/or learning disability.

Like the rest of the NHS, and indeed the country, we have had a challenging start to 2020/21. We are exceptionally proud of how our people responded and continued to deliver great care for our service users during this period. As we turn our focus to the future, we recognise the world has changed and some things will need to be different in the way we deliver and provide care. However, our commitment to keep our service users and staff safe, improve their experience and provide great care and outcomes remains as strong as ever and our revised Annual Plan for 2020/21 reflects this ambition.

Recommendations

The Trust Board of Directors is asked to

- Note the changes made to the Annual Plan
- Approve the revised annual plan

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

The Trust Annual Plan describes the key activities the Trust will take place to deliver the trust Strategic Objectives during 2020-21

Summary of Implications for:

Priorities contained within the annual plan have been considered in terms of financial, workforce and quality impact. The Annual plan and Trust's financial plan are aligned.

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

Contained within the plan are service changes and developments which are likely to require quality/equality impact assessments to be undertaken. Service user, carer and stakeholder engagement and involvement is embedded and expected to be undertaken across the priorities and activities within the plan

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

Executive Committee 15 July 2020

Hertfordshire Partnership University NHS Foundation Trust

Revised Annual Plan 2020/21 - Our Commitments

July 2020 - FINAL

1. Introduction

Our Annual Plan describes our commitments to our service users, our staff and our partners about what we will deliver during 2020/21. Our ambitious plan, which reflects our relentless drive to improve the quality of care we provide for our service users and carers, was approved by the Trust Board at the end of March 2020.

However, also during March 2020 we saw the Covid-19 pandemic impact across the country. Nationally the NHS declared a Level 4 incident which led to the majority of 'business as usual' activities being paused with all services diverted towards responding to the immediate incident. During this period we saw the tremendous efforts of our staff to keep our service users safe. We put in place new ways of delivering care and increased the use of technology to support the way we work. At the same time, we also had to pause some of the activities we had previously been doing in order to ensure we were able to continue to provide essential services and care during this period.

As we restore our services, whilst continuing to deliver care safely with Covid-19 remaining in our communities, we have been taking stock of the commitments we made to our service users, carers, staff and stakeholders in our Annual Plan. We believe the ambitions we outlined remain relevant, but it has been important to update our plans to include Covid-19 related activities and to ensure the plans are realistic and achievable for the remainder of the year. This paper provides an updated and revised Annual Plan for 2020/21.

2. Background - Good to Great

Our 'Good to Great' Strategy (2016-2021) describes how we are going to deliver our vision of 'Delivering Great Care, Achieving Great Outcomes – Together'. Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we consistently achieve the outcomes that matter to those individuals who use our services, their families and carers by working in partnership with them and others who support them. It also means we keep people safe from avoidable harm, whilst ensuring our care and services are effective, achieve the very best clinical outcomes and support individual recovery outcomes.

Our 'Good to Great' triangle below depicts the key areas of focus for the Trust in terms of its people, improving the way we do things, partnerships and quality (experience, effectiveness and safety).

Figure 1 - Good to Great Triangle

3. Strategic Objectives 2016-2021

The Trust has a number of strategic objectives:

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 will feel positively about their experience
3. We will improve the health of our service users through the delivery of effective, evidence based practice
4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care
6. We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

4. Our Commitments for 2020/21

The remainder of this year will see us continue to drive improvements in the safety of care we provide, the experience and the outcomes we achieve with and for our service users. This means we will be opening new safety suites to support our service users when they are at their most unwell whilst also ensuring the least restrictive practice is always used to support recovery. We will also coproduce a new approach to service user and carer involvement and embed shared decision making into our day to day practices. As we reshape our services we will ensure our service user and carer voice is at the heart of the decisions we make.

We also committed to improving the way we deliver care for those service users experiencing a crisis, those who have complex needs such as an emotionally unstable personality disorder, and to also make further improvements across our full range of services for people with a Learning Disability. We will also improve the physical health support, offer and care available for our service users across the Trust in conjunction with primary care.

We know that great care starts with our great people. Our plans for 2020-21 to support our people with their ongoing health and wellbeing continue to be important as we also now support our people to rest, recover and recuperate following the Covid19 incident and ongoing demands.

Our last staff survey told a largely positive story about our Trust, but we know we have further to go in terms of ensuring all staff, regardless of their background or circumstances, have the opportunity to have their voice heard, feel included and feel valued. During the remainder of 2020-21 we will be working with staff to identify the key issues and taking action across the organisation to address.

We will also be supporting teams and individuals to develop through implementing our 'Great Teams' model across the Trust and widening the training opportunities for our people. This together with our commitment to continuous quality improvement will support and encourage our people to make the changes they believe are needed to deliver great care.

Externally, Integrated Care Systems are developing at pace and we will continue to play a key role in the systems in which we operate. We will also be driving forward the development of Hertfordshire's Integrated Care Partnership for Mental Health and Learning Disabilities. We believe this partnership, across the statutory, voluntary and independent sectors, will play a crucial role in advocating and developing services for those with mental health and learning disability needs across the system. This, together with the development of New Models of Care for specialist services with partners across the East of England, will mean a continued focus during 2020-21 on the future development of our services and organisation – always seeking improved outcomes for our service users and carers.

These plans mean we are confident the remainder of 2020-21 will see us making significant strides along our journey to achieve 'Great Care, Great Outcomes – Together'.

5. Development of the Plan

Our 2020/21 plan took into consideration and reflected national planning guidance, Herts & West Essex Integrated Care System (ICS) priorities and Operating Plan Submission, local contract discussions and agreements. It was informed by feedback and discussions from stakeholders including our staff, our senior leadership team, the Council of Governors, our service users and cares and our commissioners. This updated plan has also taken into consideration the recent COVID-19 pandemic requirements going forward, and revised our underpinning activities and focus.

6. 2020/21 Priorities, Actions and Outcomes

The Annual Plan is split into seven sections with priorities identified for each Strategic Objective (see Table below). The actions to be taken and outcomes are clearly defined (See Appendix 1). The Annual plan is underpinned by a detailed set of milestones and outcomes by quarter for each priority.

Strategic Objective	Our 2020/21 Commitments – We will ….
We will provide safe services, so that people feel safe and are protected from avoidable harm	• Continue to work with system partners to prevent suicides • Keep service users and staff physically and mentally safe, reducing the avoidable harm they experience • Ensure we appropriately use the least restrictive practice to support service user recovery • Implement and follow best practice infection prevention & control practice across our services
We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	• Improve service users experience of accessing our services and receiving treatment • Involve our service users and carers in the design and delivery of services and their care • Provide safe, high quality environments where our service users are cared for and our staff work
We will improve the health of our service users & support recovery through the delivery of effective evidence based practice	• Improve the care, support and outcomes for service users who are in need of additional support or at risk of admission • Support our service users to be physically healthy by improving the physical health support, intervention and care available • Support our service users to live their lives as independently as possible
We will attract, retain and develop all our people with the right skills and values to deliver consistently great care, support and treatment	• Improve the employment experience of all of our people, including support to improve their health & wellbeing and to help them to rest & recover post COVID19 • Ensure all our people feel valued, included and able to fulfil their potential through the development of our just & inclusive culture • Develop our collective leadership culture through the implementation of 'Great Teams' to support our staff to feel empowered & engaged

We will improve, innovate and transform our services to provide the most effective, productive and high quality care	• Support, enable & encourage our people to continuously improve the care and services we provide • Develop, evaluate and utilise digital technology to improve service user, carer & staff experience and service effectiveness • Release time to care by supporting staff to work more effectively and flexibly, including provider better and simpler access to information
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	• Improve community adult and older peoples services and care aligned with Primary Care Networks • Improve access to services and care for those people with a learning disability across the Trust • Improve the range and access to crisis services in conjunction with Hertfordshire partners • Work with partners across Hertfordshire to deliver earlier intervention and support for Children and Young People
We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	• Lead the development of the Hertfordshire Mental Health & Learning Disabilities Integrated Care Partnership (MH & LD ICP) • Advocate for and ensure mental health & learning disability services are developed across the populations we serve • Work with regional partners to develop and deliver New Models of Care for those with specialist mental health and learning disabilities

7. Monitoring and Review

The Annual Plan priorities are cascaded via the development of Business Plans for the Strategic Business Units and Corporate Services. These, in turn, should be reflected in team plans through to individual Personal Development Plans. At Trust Board Level, progress against milestones and outcomes will be reviewed on a quarterly basis. Progress is also monitored quarterly with the Strategic Business Units.

In the event of changing factors (internal or external to the Trust) the plan may need to be adjusted/updated to ensure delivery of the required outcomes. This reflects the need to ensure the plan, although produced at the beginning of the year, remains a 'live' reflection of our work and priorities across the Trust.

8. Conclusion

2020/21 is the fifth year of our 'Good to Great' journey and our Annual Plan describes the commitments we have made to our service users, our carers, our staff and our stakeholders. It documents the key actions we will take to this year to further develop our services and to ensure we are able to provide the highest quality care for those individuals with a mental health illness and/or learning disability.

Like the rest of the NHS, we have had a challenging start to 2020/21. We are exceptionally proud of how our people responded and continued to deliver great care for our service users during this period. As we turn our focus to the future, we recognise the world has changed and some things will need to be different for us in the way we deliver and provide care. However, our commitment to keep our service users and staff safe, improve their experience and provide great care and outcomes remains as strong as ever and we hope you will agree our revised Annual Plan for 2020/21 reflects this.

APPENDIX 1

OUR REVISED ANNUAL PLAN 2020-21

Our Commitments

Strategic Objective 1 - We will provide safe services, so that people feel safe and are protected from avoidable harm

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users and staff)	Measurement (how we will know)
Continue to work with system partners to prevent suicides	• Work with public health & other partners to deliver the system Suicide Prevention Strategy, including awareness of 'Stay Alive' suicide prevention App • Further strengthen crisis care plans, including relapse prevention, through shared decision making with service users	• Service users will not feel that suicide is their only option • Service users will feel more confident about their recovery • Staff will feel confident in assessing and managing risk	• Reduction suspected suicides • < suicides by service users known to the Trust • Crisis care plans in place for all service users (quality demonstrated via audit)
Keep service users and staff physically and mentally safe, reducing the avoidable harm they experience	• Introduce service user safety huddles in all adult and CAMHS inpatient units across the Trust • Increase opportunities for meaningful activities & support across inpatient units to support recovery • Introduce the "Just Culture Guide" to support teams to embed our Just and Learning culture • Review & strengthen the approach and role of peer experience listeners on inpatient units • Reduce the time taken to investigate, share & embed learning from Serious Incidents	• Service users will feel safe when they use our services • Service users and staff will experience less incidents of violence and aggression on our wards • Staff will feel safe when they are working on our wards • Staff feel confident to speak up when things go wrong, rather than fearing blame	• 98% SI review and action plans by Day 60 post incident • 95% SI actions implemented by date set in action Plan (audit) • 85% service users report feeling safe across all adult & CYP inpatient units • < in harm as result of Service user to service user violence & aggression • < in harm as result of Service user to staff violence and aggression • > staff reporting feeling safe
Ensure the least restrictive practice is appropriately used to support service user recovery	• Embed staff and service user safety huddles as routine practice on all of our inpatient units • Adopt new approaches to engage service users enabling use of least restrictive practice • Open new seclusion/safety suites, configured to deliver best-in-class seclusion environments	• Service users will be supported using the least restrictive practice to recover & where seclusion needed, move out of seclusion as quickly & safely as possible • Staff will have capability & confidence to enable & use least restrictive practice	• Reduction in the length of time spent in seclusion per episode. • 4 new safety suites (programme to complete May 2021) • MOSS2gether implemented • Least restrictive practice audit
Implement and follow best practice infection prevention & control practice across our services	• Ensure rigorous application of existing Infection Prevention & Control policies and behaviours e.g. • Update all policies to ensure they fully best practice Infection Prevention and Control • Undertake an independent review of our practice and further improve where required	• Staff will understand and feel able to follow best IPC practice across the Trust, wherever they are working • Staff and service users will know risk of infection at work is minimised	• HCAIs are 0 over Quarter 2-4 • No member of staff contracts Covid19 as a result of their work • Independent review of IPC practice undertaken and recommendations implemented

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

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users or staff)	Measurement (how we will know)
Improve service user experience of accessing our services and receiving treatment	• Improve the time our service users wait for initial assessment and ongoing treatment e.g. IAPT and CAMHS • Develop our approach to recovery and personalisation through our 'connected lives' programme to support service users to live as independently as possible • Increase access to psychological therapies, developing a 'psychologically minded' workforce	• Service users will have improved access to assessment and treatment • Service users will have improved outcomes and less reliance on crisis services • Service users and carers will have improved outcomes	• IAPT Access KPIs met • <wait to treatment/follow up (Baseline tbc) • LD Transformation plan delivered • < number of service users admitted with an eating disorder • < social care placements made (tbc) • Care and support plans in place • > service users in employment
Involve our service users and carers in the design and delivery of services and their care	• Coproduce and put in place a new trust-wide approach to service user and carer engagement • Ensure service user & carer feedback informs service improvements and developments • Further embed Shared Decision making to support the way we involve our service users in decisions about their care • Increase the number of carers assessments undertaken across the Trust • Implement the Care and Support Plan	• Staff will be able to describe how service user and carer feedback has informed service changes and developments • Service users will feel informed, safer and have a better experience • Carers will feel their needs have been assessed and will feel supported	• >Service user rating in 'Having Your Say' • >positive feedback from Community Survey • Shared decision making captured on Paris • Staff trained in shared decision making • > staff completed "carer awareness training" • >carers assessments completed • Recording of carers across all services
Provide safe, high quality environments where our service users are cared for and our staff work	• Upgrade our inpatient facilities including Oak Ward, Forest House and Albany Lodge • Improve and extend training facilities for staff including additional space at Colonnades • Continue to enhance the working environment for our staff through improvements and creating additional space. • Complete the business case for the re-provision of adult acute beds for E&N Herts	• Staff will be able to access the clinical and office space needed to work effectively • Experience of people experiencing seclusion will improve • Service users will have a better experience of their care environment across our services	• Oak ward refurbishment implementation plan agreed and commenced • Forest House development commenced • Albany Lodge refurbishment program commenced • E & N Herts bed re-provision, full business case approved • Land purchased for E& N Herts beds • Simulation training facility commissioned and in use

Strategic Objective 3 - We will improve the health of our service users through the delivery of effective evidence based practice

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users and staff)	Measurement (how we will know)
Improve the care, support and outcomes for service users who are in need of additional support or at risk of admission	• Provide additional support & improved community interventions for those service users who are frequent users of our inpatient services • Develop an all age adult crisis service to meet the diverse needs of our service users • Develop new functional model as an alternative to outpatient clinics in line with recovery approach • Engage service users in research activity across the Trust, focusing on specific clinical pathways through our research programme	• Service users will have an improved and more consistent experience of high quality care • Our staff will be able to see more clearly how to positively impact on the outcome for our service users • Staff will use consistent pathways and measurement of outcomes	• 20% reduction in readmission rates for service users with a Personality Disorder • 20% <Section 136 attendances by those known to us by Q4 • Maintain inpatient ALOS & DTC at 2019/20 level • Social care and wellbeing plans in place and outcomes recorded • Demonstrate improved outcomes for new functional community model • > service users participating in research
Support our service users to be physically healthy by improving the physical health support, intervention and care available.	• Undertake physical health checks for service users who have started psychotropic medication • Ensure every service has targeted physical health training to support the specific needs of their service users • Develop our simulation programme to provide high quality training and support learning • Improve the physical health clinical data we record and use	• Improved quality of physical care for our service users • Service users will report being support with their physical health • Our staff will have the support and skills to better care for the physical health needs of our service users	• 95% CPA physical health checks • 90% service users (defined by a set criteria) have had a physical health check and a trajectory set for 2021/22 • Improved physical health outcomes – demonstrated through PACE audit • Simulation Training programme in place for Inpatient Services and for Community Services
Support our service users to live their lives as independently as possible	• Work with partners to support service users to gain employment and accommodation to support their recovery • Use our new social care and wellbeing plans to enable better planning and shared decision making with service users	• Service users will feel better supported in their recovery • Staff will have a fuller picture of how to support service users in their recovery	• 85%: settled accommodation for adults with a mental health problem • > service users supported into employment or to retain employment

Strategic Objective 4 - We will attract, retain & develop people with the right skills and values to deliver consistently great care & treatment

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our staff or service users)	Measurement (how we will know)
Improve the employment experience of all of our people, including support to improve their health & wellbeing and to help them to rest & recover post COVID19	• Implement a broad range of wellbeing activities & approaches • Address differences in employee experience, linked to protected characteristics • Maintain dynamic Covid risk assessments, addressing the themes that come from these	• People will actively want to join the Trust & will chose to stay working in the Trust • Our staff will have more opportunities for flexible working	• Staff Survey Health & Wellbeing score > 6.6 • My immediate manager takes a positive interest in my health and wellbeing > 80% • Unplanned turnover rate < 9% • Trusts stability rate >90% • Vacancy rate < 10.5% • Equality Impact Analysis - improving position for elements of Inclusion Agenda

Ensure all our people feel valued, included and able to fulfil their potential through the development of our just & inclusive culture	• Put in place a coproduced just & learning cultural programme to support managers and others lead & work in a culturally informed way
	• Improve representation of staff with protected characteristics across all bands/ roles
	• Continue our campaign to eliminate bullying & harassment across the Trust
	• Focus on the experience of our BAME people, broaden understanding of their experience within our wider staff group
	• Support the development of our BAME staff including developing a 'talent map'
	• Improve our recruitment approaches to attract high calibre people reflecting local communities
		• Our staff will recommend HPFT as a great place to work, regardless of ethnicity, gender or other protected characteristic
		• Our staff will benefit from a reverse mentoring programme
		• Our staff will be able to make recruitment & development choices
		• BAME staff will report an improved employment experience within the Trust
			• <2% staff report bullying/harassment by a manager
			• >75% staff recommend place to work
			• 9+ Equality, Diversity & Inclusion score
			• Reduced relative likelihood of BAME staff
			  ○ Enter formal disciplinary process compared to white staff - less than a 1.22 differential
			  ○ Appointed from shortlisting - less than a 1.15 differential
			  ○ Accessing non-mandatory training & CPD to less than 1.15
			• % of BAME staff in each AfC Bands compared with % of staff in the workforce
			• Organisation acts fairly with regard to career progression > 88%

Develop our collective leadership culture to support all of our staff to feel empowered and engaged	• Fully implement our Great Teams model • Strengthen our Distributed Leadership Model to support staff to make great decisions • Improve positive leadership behaviours at all levels in the organisation • Further develop our staff engagement activities so all our people can contribute	• Staff feel enabled to make decisions & supported to learn from mistakes • Big & Little Listen events well attended • Staff feel they can share feedback with leaders of the Trust	• >7.3 Team working score (Staff Survey) • >80% I can make suggestions to improve the work of my team • >80% 'there are frequent opportunities for me to show initiative in my role' • Staff Survey engagement score > 7.5 • Staff Survey return rate >60%

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

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how will we know)
Support, enable & encourage our people to continuously improve the care and services we provide	• Evaluate key service changes implemented during COVID19 • Use CQI methodology to support teams to improve services • Use CQI across our 'Reshaping our Services' programme • Adopt a CQI assessment tool to demonstrate improvements made • Harness the skills of our CQI leaders & coaches to target further quality improvements • Involve service user & carers in our research & service improvements	• Staff will feel supported to develop their CQI skills and knowledge • Staff will be supported to generate & test ideas and approaches to solving problems • Service users will experience improved safety, outcomes, effectiveness of inventions, timeliness to access service • Staff will be attracted to the Trust as a result of the Trust's research programme.	• COVID19 service changes evaluated • Annual Plan service improvements commitments delivered through CQI • >225 staff trained in CQI • Improvements made against the 6 CQI focus areas • 2 IHI Fellowships • 3 new CQI hubs opened • CRES delivered without a negative impact on quality
Develop, evaluate and utilise digital technology to innovate and improve service user, carer & staff experience and service effectiveness	• Use digital solutions to improve communication with GPs and service users/carers • Roll out appropriate virtual contact platforms (video) across the Trust • Put in place the 'infrastructure' required to support us to become more digitally enabled • Develop our capability to bring together information from different sources • Develop our 'population health' approach to 'support us to target & address the wider determinants of health affecting service users • Provide digital skills training for our people	• Staff will have the equipment & technology to deliver high quality, effective care • Staff will have access to improved reporting through SPIKE and will be able to make informed decisions through triangulation of data • Staff will report improved functionality and ease of access to information • Service users & carers will report easier access to the information they need • Our resources and services will increasingly be more effectively targeted	• % staff have access to an appropriate virtual contact platform • % increase of letters & discharge notes delivered within 24hrs from services in scope compared to baseline • % of the targeted staff groups with digital skills profiles and training developed • Positive feedback from service users
Release time to care by supporting staff to work more effectively and flexibly, including providing better and simpler access to information	• Develop full demand, activity and capacity modelling capacity across the Trust • Implement a Trust productivity dashboard & pathway dashboards • Deliver our 'Time to Care' programme to support staff to free up more time to care • Pilot digital solutions to support more effective ways of working	• Staff will more easily identify opportunities to improve productivity • Staff will have more time for direct service user care • Service Users will report they have more time to discuss their care • Staff will have improved access to different data sources to support delivery of care	• Mileage claims reduced by 20% • All teams operating at 55% of time for direct care • Service users report improved time to discuss their care by Q4 • CRES delivered without a negative impact on quality

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

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how we will know)
Improve community adult and older peoples' services and care aligned with Primary Care Networks	• Pilot and evaluate, taking a CQI approach, a new community model for adult & older people (in Watford & Lower Lea Valley) to inform the future community model for the Trust • Continue to develop and evaluate, adopting a CQI approach, our Primary Mental Health operating model with PCNs	• Service users will be able to access the right care and support at the tight time and in the right place to support their recovery • GPs and other primary care workers will feel able to support service users in primary care • Staff will feel able to deliver great care	• <waiting time for DBT • <crisis presentations • <inpatient admissions • >Improved service user and carer experience • Personalised care plan approach in place
Improve access and delivery of care for those people with a learning disability across the Trust	• Continue to implement the transformation of Essex LD Services including the potential bed reconfiguration • Work with partners to review and improve our Assessment & Treatment pathways across all LD services • Improve the care & support offered to service users in our Specialist Residential Services including finding more suitable environments to meets their ongoing needs	• Service users will experience more joined up care & have better access to services • Service users will have high quality care and better outcomes • Staff will feel supported & able to make improvements	• Essex Local integrated teams in place • Access to service improved through new 'Way in' service • > Service users reporting satisfaction • < Crisis admissions • <inpatient admissions
Improve the range and access to crisis services in conjunction with Hertfordshire partners	• Broaden the range of crisis interventions available and evaluate their impact • Develop an all age adult crisis service to meet the diverse needs and support for service users	• Service users will have improved access to local services & improved outcomes • Service users will experience reduced waiting times to access crisis support	• %<1 hour access in crisis • < Inpatient including out of area placements • <repeat readmissions by service users (Baseline t.b.c)
Work with partners across Hertfordshire to deliver earlier intervention and support for Children and Young People	• Ensure Mental Health Support Teams in schools are fully operational (first wave) • Develop an integrated crisis model in conjunction with system partners • Coproduce and remodel our CAMHS community services to offer earlier intervention and support wider system integration	• Children & Young people (CYP) will experience better access to services • CYP will report being satisfied with the services available to support them • Staff will report being able to provide high quality services and make improvements • Staff will feel part of a CAMHS system	• 95% CAMHS access <28 days • < CYP present in crisis in A&E • <CYP known to CAMHS presenting in crisis (Current 29%)

Strategic Objective 7 - We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how we will know)
Lead the development of the Hertfordshire Mental Health & Learning Disabilities Integrated Care Partnership (MH & LD ICP)	• Drive and oversee restoration & transformation of services across the system in line with the Long Term Plan commitments • Establish a programme of work to support the development of the MH & LD ICP • Ensure voluntary and community sector partners are involved in the development of the MH&LD ICP	• Service users will experience more joined up care, • Service users will experience better outcomes • Staff will feel motivated and able to deliver great care	• Restoration of MH & LD Services across the Herts System • Delivery of LTP/Operating Plan commitments for 2020/21 • Agreed transformation programme in place with partners engaged • Delivery of new crisis pathway & CAMHS pathways with partners across Hertfordshire
Advocate for and ensure mental health & learning disability services are developed across populations we serve	• Actively support the development of Herts & West Essex Integrated Care System including providing senior leadership support and commitment • Ensure the needs of mental health & learning disabilities are included within system plans and developments • Continue to lead the ICS mental health and LD work stream	• Service users will experience more joined up care • Service users will receive care that meets their needs • Staff will feel able to contribute to service developments	• HWE ICS continues to prioritise & invest in Mental Health & Learning Disabilities (LD) • HWE ICS population health model continues to develop • Mental Health Investment Standard is met within 2020/21 • MH & LD is overtly prioritised within the ICS strategy and delivery work streams • Place based ICPs focusing on, and including MH & LD in future delivery models
Work with regional partners to develop and deliver New Models of Care for those with specialist mental health and learning disabilities	• Work with partners across East of England to establish a strong provider collaborative • Lead the development of the CAMHS new model of care across the East of England • Advocate for and develop our Adult Mental Health & LD Secure services, Eating Disorder and CAMHS services to improve care and outcomes	• Service users will have increased local choice and provision to support them at home and in their community • Staff will be involved and feel able to shape improvements in care	• East of England (EOE) Provider Collaborative established • < Out of area placements for service users requiring specialist beds • Plans for development of services across EOE under development • <number of inpatient stays for an Eating Disorder

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 17
Subject:	Mental Health & learning Disability Integrated Care Partnership	**For Publication:** Yes
Author:	Karen Taylor, Executive Director, Strategy & Integration	**Approved by:** Karen Taylor, Executive Director, Strategy & Integration
Presented by:	Karen Taylor, Executive Director, Strategy & Integration	

Purpose of the report:

To provide an update on the development of the Mental Health & Learning Disability Integrated Care Partnership

Action required:

To receive the report

Summary and recommendations to the Board:

Background

The Mental Health and Learning Disability ICP (MHLD ICP) is one of four Integrated Care Partnerships being developed within the Hertfordshire and West Essex Integrated Care System. It brings together partners (NHS, Social Care, Third Sector) from across Hertfordshire to work together to improve care and outcomes for people living with a mental illness and / or learning disability, building on the work we have already done together and existing services/support in place across Hertfordshire

Progress and Priorities

Although at an early stage of development, the MHLD ICP has worked together to develop an initial vision and set of guiding principles (attached). During the recent COVID-19 outbreak development of the ICP itself was paused, however we continued to work closely together as partners across the system to respond and deliver care to meet the needs of our service users during this challenging period.

The ICP Partnership Board recommenced in June, and had a second meeting in July in which partners explored together the current work taking place across the system, and discussed emerging priorities. A key priority is to oversee the restoration of services and planning for the remainder of the year, given the ongoing prevalence of COVID19 in our communities. The next meeting will take place in August.

As part of the next stage of development of the ICP, Beverley Flowers, Herts & West Essex Integrated Care System Director of Transformation will now co-chair the MH & LD Integrated Care

Partnership Board alongside Tom Cahill, CEO HPFT. This joint leadership is important in terms of bringing together commissioners and providers within the ICP, together with alignment with the HWE ICS itself. Kate Linhart has also been appointed interim Head of MH&LD ICP Development.

Vision, Principles & Priorities

There is already a strong history of partners across Hertfordshire working together to achieve better care and outcomes for people living with a mental illness or learning disability. The MH & LD ICP aims to build on this further to transform care and services. The vision of the ICP is

"Supporting people living with a mental illness and/or a learning disability in Hertfordshire to live longer, happier and healthier lives"

The Guiding Principles describe the role the ICP will take across the system and the focus it will bring on:

- Providing a strong mental health and learning disabilities voice across and for the system
- Prevention people from becoming unwell and the promotion of positive health and wellbeing
- Providing safe, high quality mental health and learning disabilities support and services across Hertfordshire
- Integrating mental health and physical health support and care for people, ensuring their needs as an individual are supported

Priorities

The MHLD ICP has identified a number of key priority areas, and a programme plan is now being developed to underpin the work on these key areas:

- CAMHS
- Learning Disabilities
- Alcohol and Substance Misuse
- Autism
- Dementia
- Crisis
- Primary Mental Health

At the same time, a Development Group has been established to bring the necessary focus on the development of the Integrated Care Partnership itself. This group will be developing proposals on behalf and for consideration by the partnership on a number of key areas such as governance and commissioning.

Conclusion

The MH & LD ICP Partnership Board has now been re-established and the programme of work for the ICP is under development with partners. The remainder of 2020-21 will see the Partnership begin to establish itself more formally, particularly in respect to oversight and leadership of service change and transformation across the county. HPFT continues to play a significant and leading role in the establishment and development of the ICP and this is important in terms of providing

momentum, advocacy and voice for mental health and learning disabilities for our local populations(s).

The Trust Board is asked to receive and note the report

Relationship with the Business Plan & Assurance Framework:

The development of the MH & LD ICP links to Strategic Priorities 6 & 7 – joined up care and shaping/influencing the development of MH & LD across the system. It is identified as a key priority within the Trust's Annual Plan 2020-21.

Summary of Implications for:

N/A

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

N/A

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

N/A

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

N/A – there have been regular MH & LD ICP updates provided to Executive Committee and Trust Board

The vision for the partnership is:

"Supporting people living with a mental illness and / or a learning disability in Hertfordshire to live longer, happier and healthier lives"

Why do we want things to change?

Over the course of a year almost one in four people will have a diagnosable mental illness and around 2 in 100 people have a learning disability. For us in Hertfordshire this means around 300,000 people will have a mental illness, and 24,000 will have a learning disability. We know people with a mental illness and /or a learning disability are dying years earlier than they should. The average life expectancy of someone with an enduring mental illness or a learning disability is around 25 years lower than the general population. We don't think it is acceptable for people to live shorter, unhappy or unhealthy lives and we believe by working differently together differently we can change this.

What are we going to do?

Partners across Hertfordshire are working together to deliver care in a distinctly different way to how we organise and pay for care now. Building on the successes of current partnership arrangements, we believe this new way of working will support us to work across Hertfordshire to join up the way partners deliver care.

The Mental Health and Learning Disability Partnership will help to ensure mental health and learning disability services are provided at scale where needed, whilst also ensuring care is delivered as close to home as possible where people live, learn, work and play.

We will be able to break down the divide between physical health and mental health and learning disabilities, ensuring that care and support is as personalised and joined up as possible for those receiving that care.

By focusing on building resilience, prevention and early intervention and on community based services and prioritising support for people early on in their lives/their illness, we will ensure people are able to live their lives to their full potential, and ongoing care needs are prevented or minimised. We will be support and care for people in the right place, at the right time, for the right reason with the right skills.

Who else will be involved in the Partnership?

We are developing a way of working in partnership across NHS, social care and voluntary/charity sector partners alongside service user and carer representatives for children's, adults and older adult services. This will include those who provide and pay for services such as:

- Carers and Parent Carers in Herts
- Herts County Council
- District Councils
- Hertfordshire Mind Network
- CGL Spectrum
- Community Trust
- Age UK
- Alzheimer's' Society
- Health Watch
- Community Navigators
- Primary Care Networks
- GPs
- Community services
- Schools, colleges and children's services
- Specialist Mental Health & Learning Disability teams
- Acute Hospital Trusts
- Integrated Commissioning Team
- Police & Criminal Justice System

How will we involve service users and carers?

Shared decision-making and co-production will be at the heart of the partnership. From the start we will work in partnership with people and families living with mental illness and / or a learning disability. We will use and build on existing forums and arrangements, such as the co-production and Partnership Boards and other existing service user and carers groups, to ensure services continue to be co-designed, co-produced and co-delivered.

What will we be focusing on?

Together all partners will determine our priorities which are likely to build on work that is already underway in the following areas:

- Enhanced primary care mental health services
- CAMHS
- Dementia services
- Learning Disabilities and Autism
- Substance Misuse
- Crisis services for people with severe mental illness

We will want to check whether our current services and support is making a difference and whether people who use services feel safe and supported. We will look to understand what might need to change to help people in Hertfordshire to feel safe, healthy and happy, by working in collaboration to ensure there is a high quality care and support, to ensure we have an integrated mental health and learning disabilities workforce and to enable innovation, transformation and joined up working to deliver maximum impact and best value for the people of Hertfordshire.

How will we work with other Partnerships?

The Mental Health & Learning Disability Partnership is an integral partner of the local Integrated Care Partnerships in East & North Hertfordshire and West Hertfordshire to help design and deliver services to meet the needs of the population.

This will include working together to understand the needs of the population(s) to ensure there is appropriate mental health and learning disability services for the local population. It will also ensure there is adequate physical health support for those with the most severe and complex mental health and or learning disability Needs; aiming to tackle the inequalities in life expectancy and burden of comorbidity through working more closely and sharing information together.

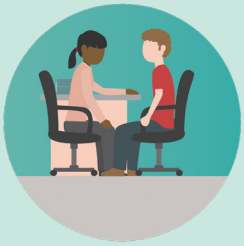
The majority of older people and adult services will be delivered locally working with the newly formed Primary Care Networks. Children's services, will be provided where children and young people live, play and learn. Some services will continue to be provided at a Hertfordshire-wide level due to their specialist nature – for example inpatient services and highly specialised care such as eating disorders. We see the design of this being undertaken with the local ICPs.

When will this happen?

Across England Integrated Care Systems (ICS) will be in place by April 2021. The plan is for the Mental Health and Learning Disability Integrated Care Partnership to be in shadow form during 2020, with the aim to be fully operational by April 2021 in line with the Hertfordshire Integrated Care System timetable.

Guiding Principles for the **Hertfordshire Mental Health and Learning Disabilities Partnership**

A strong mental health and learning disabilities voice across and for the system



- We will work in partnership with service users and carers to develop services
- Our services will be underpinned by clinical excellence and evidence based practice
- We will contribute to and align ourselves with the Long Term Plan and future development of mental health and learning disabilities services
- We will look after our people and help them live well and be rewarded for their work

A focus on preventing people from becoming unwell and the promotion of positive health and wellbeing

- We will welcome and work alongside individuals and organisations who share our mission to help people live well in the communities we serve and will actively engage with partners in communities, health, social care, housing and volunteers.
- We will focus on early intervention and care delivered as close to home as possible where people live, learn, work and play
- We will nurture and cherish what matters to people and their families and communities
- We will make sure that our money and assets are utilised to the fullest extent to deliver value for the people we serve

Safe, high quality mental health and learning disabilities support and services across Hertfordshire

- We will work to try to keep people safe from harm
- We will encourage positive risk taking
- We will recognise and support the whole person not just their illness or injury
- We will ensure that those vulnerable individuals with severe mental illness and/or learning disabilities receive care support for both their physical and mental health needs
- We will provide services that we would recommend

Integration of mental and physical health support and services

- We will work with statutory NHS and Social Care organisations, independent and voluntary organisations providing a better experience for people and their families
- We will deliver care with and around Primary Care Networks, with schools and other key organisations to support people of all ages to receive joined up care
- We will lobby for the role of mental health and learning disabilities alongside physical health - 'No health without Mental Health' - ensuring those living with a long term condition or other comorbidities are supported with their mental health

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 18
Subject:	Governance Arrangements	**For Publication: Yes**
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by**: Tom Cahill, Chief Executive
Presented by:	Keith Loveman, Deputy Chief Executive, Executive Director of Strategic Finance	

Purpose of the report:

This report will set out the interim governance arrangements that were in place from April to end of July 2020 during the Covid-19 pandemic, the outcome of the review of the interim governance arrangements and the next steps with regard to corporate governance arrangements.

Action required:

The Board are asked to:

- Receive the report and note the interim corporate governance arrangements that were in place and reviewed in June 2020.
- Note and agree the recommendation to cease interim corporate governance arrangements
- Note and support the governance review being undertaken

Summary and recommendations to the Board:

As above

Relationship with the Business Plan & Assurance Framework:

The governance arrangements of the Trust are key to supporting the delivery of the Annual Plan and support delivery of the Board Assurance Framework.

Summary of Financial, IT, Staffing and Legal Implications:

None outlined in the summary report.

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

None.

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

Evidence of robust governance review process for the NHSI/CQC Well Led Standard.

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

Not applicable

Governance Arrangements

1. Introduction

1.1 This report will set out the interim governance arrangements that were in place from April to end of July 2020 during the Covid-19 pandemic, the outcome of the review of the interim governance arrangements and the next steps with regard to corporate governance arrangements.

2. Interim Governance Arrangements

2.1 In order to respond to the Covid-19 pandemic the Trust implemented its Business Continuity policy for a Major Incident. This worked alongside the well-established corporate governance structure which sees the Board of Directors as the ultimate corporate decision making body, collectively responsible for the performance of the Trust and ensures the Trust functions effectively, efficiently and economically (The NHS Foundation Trust Code of Governance).

2.2 In line with the NHS E&I published guidance (Reducing the Burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic – appendix 1) the Trust reviewed how the Board and its sub committees operated during the pandemic. To ensure that they were supporting the Trust in its priority of ensuring that we focus all our efforts on enabling our leadership and staff to keep our service users safe and well.

2.3 The Clinical & Professional Advisory Committee (CPAC) was established at the start of the pandemic to offer expert guidance and advice relating to the clinical and practice issues in relation to COVID-19, this includes but is not limited to ethical issues, Mental Health Act, DoLS, Restraint, Admissions and physical environments.

2.4 At the Extra-ordinary Integrated Governance Committee (EIGC) meeting on 6 April 2020 the recommendation was made for the Board to approve the implementation of the following interim Governance arrangements:

- Board meetings to be held monthly and in private (Lead Governor invited to observe)
- Establish a new Board sub-committee (Board Assurance Sub Committee COVID-19) to provide the Board of Directors with assurance with regard to safety, quality, risk, financial and contract arrangements during the pandemic.
- Audit Committee continues to meet and provide the Board of Directors with assurance with regard to the Trust's systems of internal control and oversee the annual accounts and end of year process.
- Integrated Governance Committee and Finance and Investment Committee meetings deferred until after 31 July 2020, unless deemed otherwise necessary by the Board of Directors.
- Nominations and Remuneration Committee only to meet if an urgent matter requires discussion, as agreed between Chair and CEO.

2.5 At its meeting on 23 April 2020 the Board of Directors agreed the recommendation from the EIGC and noted that the arrangements were in line with Trust's Constitution and Standing Orders.

2.6 It was agreed that all the meetings would be held virtually to ensure we were in line with governmental guidance and that the meetings would be supported by detailed papers.

2.7 It was also agreed that the arrangements and their operation would be formally reviewed at the end of June 2020, and this would include an assessment of their effectiveness as well as a recommendation as to whether they need to remain in force beyond 31 July 2020 or can be stood down.

2.8 To provide assurance on the governance (corporate and financial) in place during the response to Covid-19 the Trust commissioned RSM to undertake advisory audits.

2.9 In January and February 2020 the Trust embarked on its well led review, the process was paused in March 2020 in line with NHSE/I guidance on 'Reducing the Burden'.

3. Review of Interim Arrangements

3.1 A review of the interim governance arrangements was undertaken in June 2020. The review sought the views of Board members; took account of the findings of the recent internal audit advisory audits and considered the guidance from NHS E&I. The review also considered the current and future context and what arrangements would ensure continued robust governance arrangements are in place.

3.2 The review established that:

- There had been monthly Board meetings, held in private.
- The Board Assurance Sub Committee COVID-19 had met on a monthly basis, with the last meeting scheduled on 9 July 2020. The meetings have been well attended by Committee members and all Board members invited to attend.
- Each meeting of the Board Assurance Sub Committee COVID-19 had discussed a range of issues, primarily focusing on the monitoring of safety, quality, risk, financial and contract arrangements during planning and time of the response to the COVID-19 pandemic. The meetings had been supported by an agenda and detailed reports that ensure items due to be discussed at either IGC or FIC are considered as appropriate.
- Each Board meeting received a report from the Board Assurance Sub Committee COVID-19 outlining the areas discussed, assurance received and any items for escalation or approval.
- The Remuneration Committee had met once and Audit Committee had met twice during the interim arrangements, this was in line with agreed arrangements.
- Clinical and Professional Advisory Committee (CPAC) met throughout the interim Governance arrangements in line with its Terms of Reference and provided a monthly report to the Executive Team and Board Assurance Sub Committee COVID-19. CPAC and its work has been very well received in clinical and operational teams and has been fundamental to the Trust's ability to develop and agree guidance to support safe and effective care of service users.

- The Council of Governors had met virtually on 11 June, with good attendance and engagement

- Holding the meetings virtually has been a positive experience. It has enabled great engagement and attendance, which in turn has meant an enhanced level of discussion and challenge to support assurance.

3.3 The feedback from the two advisory Internal Audits commissioned from RSM was positive, stating that:

> *"Overall, we found robust controls in place for the interim governance arrangements at the Trust".*

> *"Our review confirmed that controls were generally well designed and complied with in relation to financial governance and financial controls".*

The positive statements provided the Board with independent assurance with regard to the interim governance arrangements and financial controls.

3.4 Feedback from Board members was that the interim arrangements have provided very valuable assurance with regard to the Trust's key priority of ensuring that we focus all our efforts on enabling our leadership and staff to keep our service users safe and well. They have fed back that the agenda and reports are informative, well written and provide appropriate level of detail to enable members to feel well informed and assured.

3.5 At the Board meeting on 25 June 2020 it was agreed that the Interim arrangements have been a successful mechanism during the period that the Trust was responding to the Covid-19 incident. They had provided an opportunity to try a different approach, including best practice and reflect on what could be put in place for the longer term with regard to use of digital solutions and streamlining of governance processes. Specifically it was agreed that:

- 9 July 2020 would be Board Assurance Sub Committee COVID-19 last meeting.
- Trust Board meetings in public, including service user stories would re-start from July 2020.
- Integrated Governance Committee (IGC) and Finance and Investment Committee (FIC) meetings would restart, with their first meetings in August 2020.

4. NHS England / Improvement Guidance

4.1 On 6 July 2020 NHS England / Improvement published guidance (Stepping back up of key reporting and management function, appendix 2). With regard to governance arrangements and meetings the guidance outlined that face to face meetings should still be avoided but trusts should consider holding governance meetings virtually, providing examples such as Boards, Council of Governors and AGMs.

4.2 The approach taken by HPFT has seen Board and Committee meetings held virtually throughout the pandemic including the AGM which was held virtually on 15 July 2020, with over 70 attendees and the June Council of Governors meeting. The

Governors sub-groups will also be meeting virtually in August. All of which is in line with the national guidance and good governance practice.

5. Governance Review

5.1 The Trust will be undertaking a review of the corporate governance arrangements, in place prior to the Covid -19 pandemic. This will be led by the Head of Corporate Governance and Company Secretary. The short review will reflect on the learning from the measures put in place during the Covid-19 pandemic, consider best practice.

5.2 The review will follow the principles of streamlining processes and systems whilst maintaining the robust governance and assurance in place and ensuring compliance with statutory and regulatory requirements. It will also look to harness the opportunities offered by digital innovations.

5.3 In particular the review will consider the current information and assurance provided to IGC and FIC, review the infrastructure that feeds into the IGC, for example Quality and Risk Management Committee (QRMC) and Workforce and OD Group and will also review the role of CPAC as part of Shaping our Future work stream.

5.4 The Trust has re-started the Well Led Review process and the information from this will feed into the governance review.

5.5 The outcome of the review and any recommendations will be considered by the Board of Directors in the autumn.

6. Recommendations

6.1 The Board are asked to:

- Receive the report and note the interim corporate governance arrangements that were in place and reviewed in June 2020.
- Note and agree the recommendation to cease interim corporate governance arrangements
- Note and support the governance review being undertaken

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors Public

Meeting Date:	30 July 2020	**Agenda Item:** 19
Subject:	MHAM Committee Report to the Board	**For Publication:**
Author:	Hattie Llewelyn-Davies/Tina Kavanagh	**Approved by:** Loyola Weeks
Presented by:	Loyola Weeks, 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 2019/20

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 Business Plan & Assurance Framework (Risks, Controls & Assurance):

All MHA legislation is integrated into the Business Plan. 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.

Executive Summary

This report covers activity in respect of the Mental Health Act Manager (MHAM) Service from April 2019 to March 2020. 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.

The use of the Mental Health Act has dropped slightly within HPFT; this appears to be in line with some other London Trusts, e.g. Oxleas, SWLSTG, although nationally there continues to be an increase. All work on the MHA review has stopped for the time being due to COVID-19 however there are other developments in guidance from NHSE & DHSC in respect of allowing MHA Assessments to take place through a video link and use of electronic forms and signatures. COVID-19 guidance within HPFT is being updated as soon as national guidance is issued and lockdown measures eased.

There are currently 43 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. There has been no significant change in the figures for 2019/20 since last year, the number of discharges from section in 2019/20 rose to 5 from 3 in 2018/19.

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 continue regarding recruitment and DBS checks for MHAM.

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 and means that issues are dealt with in a transparent manner and there are clear governance arrangements around this.

The focus for the following year is to ensure that any disruption caused by the COVID-19 pandemic is minimised to ensure that patients continue to have their review and appeal hearings in a timely manner. Also, that all changes to the MHA due to COVID-19 are communicated effectively to the MHA Managers.

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.

1) Introduction

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.

The report focuses on the period April 2019 – March 2020 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

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.

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.

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:

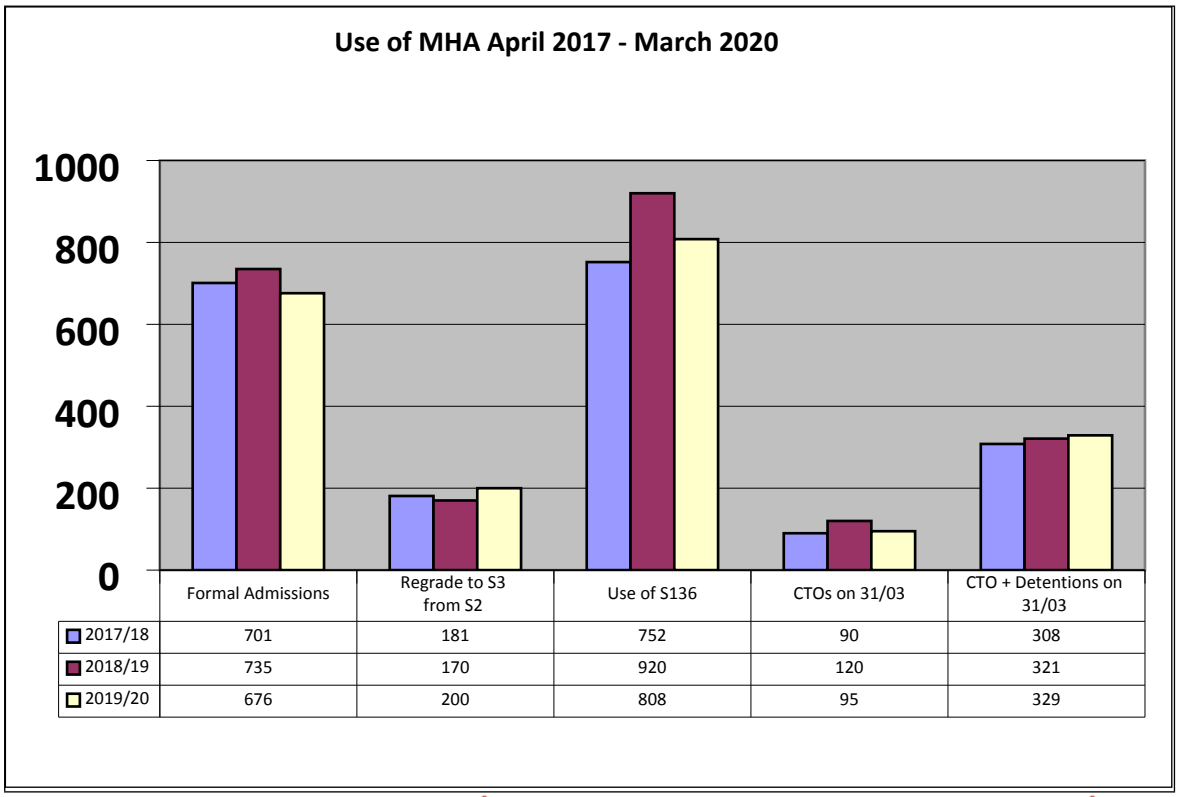
- Only non-executive directors or other non-employees appointed for the purpose can exercise this power.
- These other non-employees are referred to in HPFT as Mental Health Act Managers (MHAM).
- MHAM may be paid a fee for their role, but their role and activity within the organisation must not be such that it would amount to the MHAM being classed as an employee.

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:

The use of the MHA nationally has increased year on year which has led to a review of the MHA legislation and its use, however due to COVID-19 there has been no recent activity or progress.

The following graph shows a snapshot of the use of the MHA in HPFT during 2019/20 compared to the reporting periods of 2018/19 and 2017/18. *Please see Appendix 1 for graphs showing the use of the MHA in HPFT up to 2019/2020.*



	Formal Admissions	Regrade to S3 from S2	Use of S136	CTOs on 31/03	CTO + Detentions on 31/03
2017/18	701	181	752	90	308
2018/19	735	170	920	120	321
2019/20	676	200	808	95	329

* 8% ↓ 17% ↑ 12% ↓ 20% ↓ 2% ↑

**Changes from 2018/19 to 2019/20 reporting period.*

Although there has been a decrease of 12% in the use of S136 from 2018/19 to 2019/20 the number still exceeds that in 2017/18. The numbers shown do not include those patients who were detained and assessed in A&E; more than 200 patients were assessed at other places of safety in this reporting year.

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.

4) Legislation Update

4.1 MHA Legislation Review

There have been no further developments following the MHA Review final report published in December 2018, although two recommendations were agreed by the current government following the review:

- Nominated Person – The right to choose who you want to be informed of your treatment, this can be decided in advance or when detained.

- Advance Choice Document – Includes treatment refusals and preferences, and who to tell if you are detained. These choices will have legal protection if a patient is detained.

4.2 Liberty Protection Safeguards

The Liberty Protection Safeguards are due to replace the Deprivation of Liberty Safeguards and it was envisaged that these would be implemented in October 2020 however, due to COVID-19 this has been delayed with no indication as to when it may come into effect. The MH Legislation department (MHLD) will continue to monitor any progress through Parliament to ensure that any changes to MH Legislation are implemented and communicated in a timely manner.

5) COVID-19 and the Mental Health Act

5.1 Coronavirus Act

The Coronavirus Act was passed on 26th March 2020, within the Act there were a number of amendments to the MHA which could be enacted if they were needed in specific circumstances. The main changes would be:

- Only one doctor rather than 2 required for assessment and treatment orders
- An increase in length of time that a patient could be detained under s136
- Some court orders having their time frame increased.

Emergency changes to the current MHA legal framework, set out in the Coronavirus Act, will only be enacted if patient safety is deemed to be at considerable risk – the overarching aim of the emergency powers is to ensure that those people in critical need of mental healthcare are able to access this throughout the pandemic period.

5.2 Visitor Guidance

Due to the lockdown on 23rd March 2020 the majority of hospitals in England stopped all visitors regardless of COVID status. HPFT was challenged on this approach, the solution was for an ipad to be provided to the patient to allow access to the parents. NHSE national guidance issued shortly after this incorporated the requirement for visits to be facilitated wherever possible and alternatives sought to facilitate visits although maybe not face to face. Visitor guidance is being revised and issued by the MH Legislation department as lockdown is gradually lifted.

5.3 Section 17 Leave

Section 17 leave guidance has been updated to ensure that any s17 leave complies with relevant lockdown measures without restricting patients' ability to leave the hospital. The guidance also ensured that there were no blanket restrictions on patients s17 leave.

5.4 Guidance when patients refuse to self-isolate

Guidelines were issued to staff so that they were able to distinguish when or if MH legislation was appropriate to isolate a patient showing COVID-19 symptoms. As the MHA does not authorise treatment for a physical health need unless it is a manifestation of a mental disorder, the MHA cannot be relied upon to isolate a patient purely because they are detained under the MHA. The Mental Capacity Act would only apply if a patient did not have the capacity to understand why they needed to isolate and it was in their best interests to do so. Each case must be considered on its merits and decisions must not include blanket restrictions.

5.5 Restricted Patient Guidance

As restricted patients are unable to have leave or be transferred without Ministry of Justice approval guidance was drafted to ensure that all staff dealing with restricted patients knew who to contact and when or if there is a COVID-19 related question.

5.6 Virtual Assessments

Due to the risks associated with COVID-19 NHSE and the Department of Health issued guidance for the use of technology i.e. video links can be used for MHA assessments. In light of this guidance issued we have produced a guidance document for HPFT to outline how digital technology can be applied to the MHA process (in specific circumstances) and support teams to conduct remote assessments through the use of video. This also includes minimum standards and safeguards around the process.

While NHS England and NHS Improvement and DHSC are satisfied that the provisions of the MHA do allow for video assessments to occur, we should be

aware that only courts can provide a definitive interpretation of the law in relation to this.

The MHA makes it a legal requirement that doctors must "personally examine" a person before recommending that they be detained, and that an Approved Mental Health Professional (AMHP) must have "personally seen" the person before applying for a detention. Developments in digital technology are now such that staff may be satisfied, on the basis of video assessments, that they have personally seen or examined a person in a 'suitable manner'. Bearing in mind the need to prevent infection and to ensure the safety of the person and staff, in **some** circumstances the pandemic may necessitate the use of such digital technology for MHA assessments.

As MHA assessments inform important decisions about whether to detain a person and deprive them of their liberty, high standards are essential. Consideration will be required to ensure that the use of digital technology, particularly video, does not disadvantage a person, nor inadvertently widen inequalities.

Consideration of virtual assessments can only be made in the context of a risk of transmission of COVID 19 and **in no circumstance should a virtual assessment be carried out due to other potential risks presented by the patient.**

5.7 Electronic Forms

Regulation 3 of The Mental Health (Hospital)(England) Regulations 2008[1] clearly state the rules on how documents required under the MHA are to be served and received by a person authorised to receive these documents.[2] Although there are some cases where the Regulations allow other methods to be used, i.e. some documents provided by electronic means where the recipient agrees[3] a record of the reasons why this is necessary must be fully recorded.

The use of digital technology to support remote working arrangements during the pandemic period to allow professionals to complete and furnish statutory forms electronically, including the use of electronic signature, is a departure from the Code of Practice and The Regulations. **Therefore, in all instances, if it becomes necessary to complete any detention papers electronically there must be a clear and comprehensive record providing reasons why it has been necessary to follow this course of action**.

HPFT have drafted guidance for staff on how and when they can use electronic signatures and furnish documents electronically. The draft document also

[1] MHA Manual, 22nd edition. 2-047 page 710.
[2] MHA Code of Practice 2015. Ch 35.7 Receipt and Scrutiny of Documents
[3] Reference Guide MHA 1983. Page 35. 1.52

provides governance around the legal acceptance of papers and provides information on how electronic submission can remain secure.

5.8 Contingency Plans for MHA Office

There was a robust contingency plan put in place for the MHA Office during the pandemic. This ensured that the staff in the MHA office were able to continue to deal with statutory duties on behalf on the MHAM effectively and safely even though short staffed due to isolation, COVID sickness and other absences. Measures included reviewing how documents should be received by the office, i.e. not going onto wards and documents being scanned to our group email address. Annual audits and MHA health checks have been suspended until it is safe to go onto wards/units.

Solicitors are currently being emailed copies of clinical notes so that they do not have to attend units. Correspondence being sent to patients and clinicians has been reviewed so that only essential information is being sent. The team continues to keep in touch with the wards/units via the phone and Microsoft Teams.

5.9 Video links for MHAM hearings and Tribunals

Since the lockdown MHAM and FTT have continued in HPFT, initially hearings were held as paper reviews and discussion took place via the phone, however these have been replaced by video hearings which enable the patient to attend should they wish. All MHAM hearings are held as a “GoToMeeting” which ensures that the patient and their legal representative can be seen and heard. Community patients are able to attend the hearing at their local CMHT or arrangements can be made for them to attend one of the inpatient units.

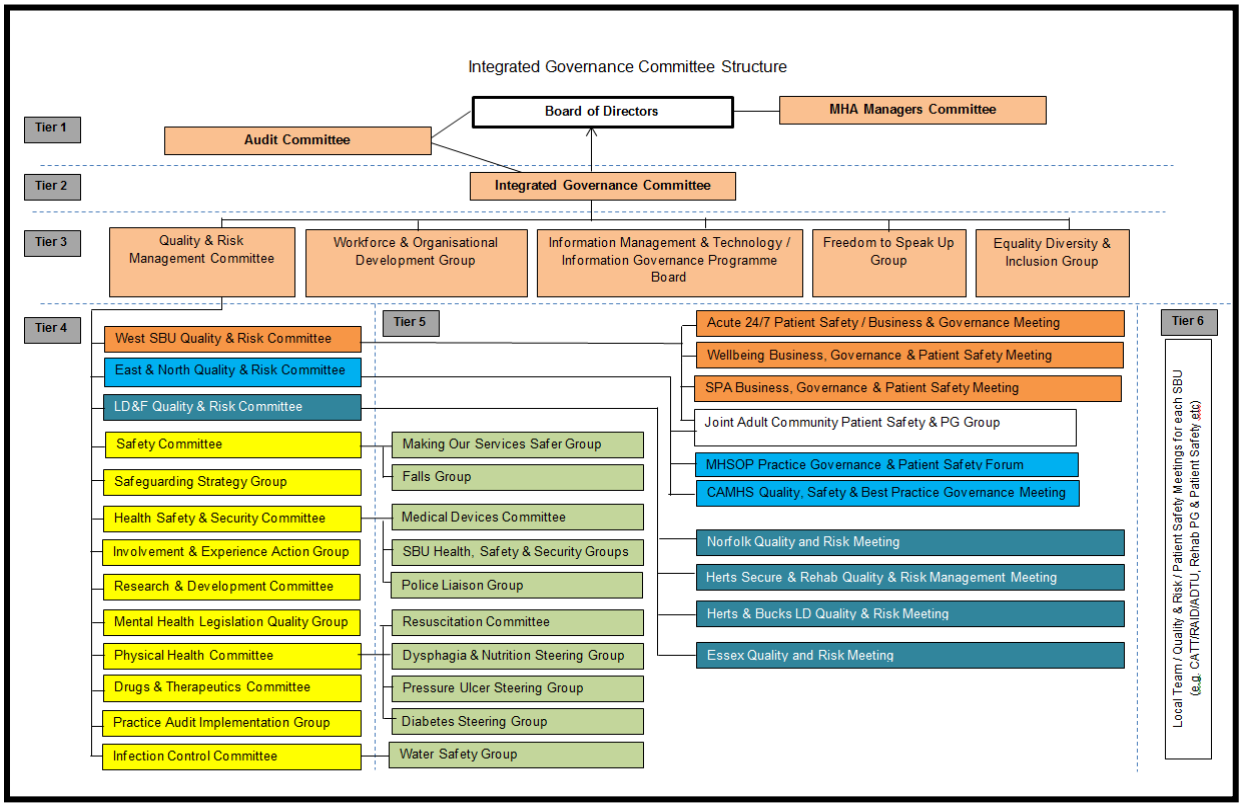
MHAM were given NHS.net accounts so that reports could be emailed securely to them with the strict instruction that they were not to be printed off.

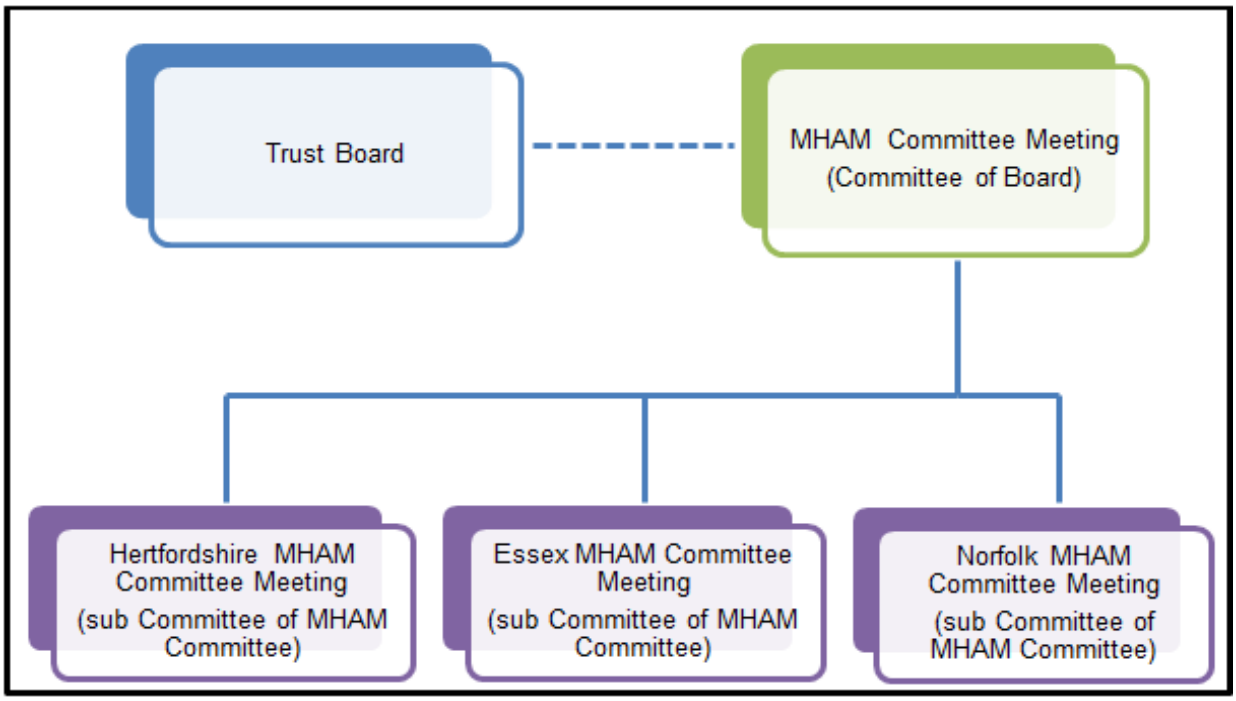
Training on how to use “GoToMeetings” and testing of equipment has been offered by the MHA office to all MHAM. IM&T department have been involved with ensuring that all units have satisfactory equipment to enable them to participate fully by video for both MHAM hearings and Tribunal Hearings.

6) MHAM Committee Meeting Structure

There is an annual Trustwide Committee meeting for all HPFT MHAM which is a Committee of the Board and membership of all NEDs is included in Terms of Reference; this meeting combines training, development and discussion events.

As well as the combined annual Committee meeting there are also Hertfordshire, Essex and Norfolk MHAM Sub-Committee meetings throughout the year.





The individual county specific Sub-Committee meetings complement the annual meeting, with an opportunity to discuss aspects of Hearings specific to their area,

and to ensure that the Trusts MHAMs are all properly trained and briefed to undertake their role.

7) The Team of MHA Managers

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.

MHAM have an annual review/appraisal to reflect on their previous year's activity. In 2019/20 these were undertaken with the Manager of the MHA Manager Service and the NED lead. 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.

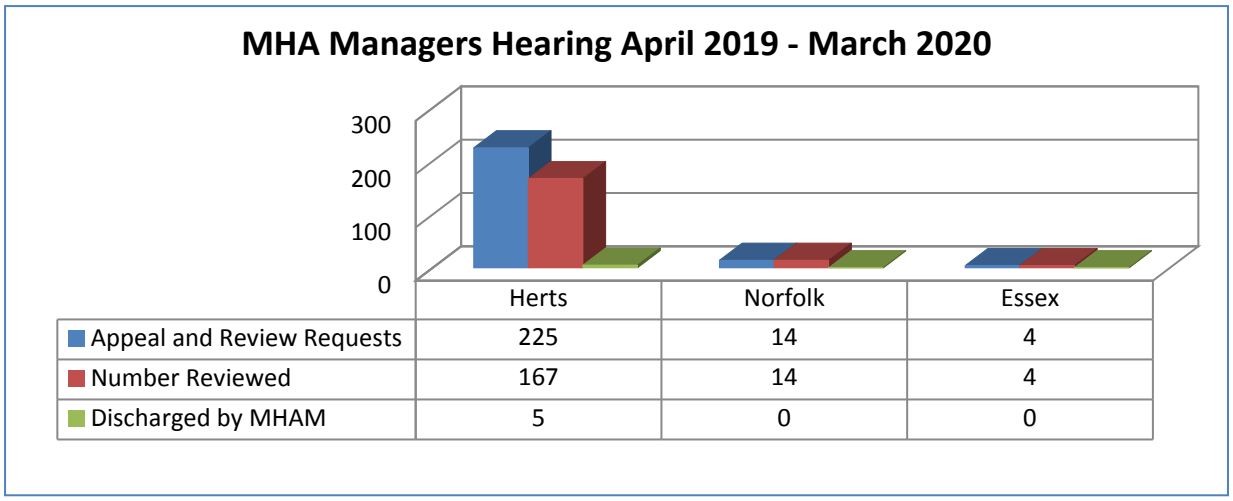
Hertfordshire Partnership University NHS Foundation Trust has 43 MHAMs as follows:

Location	Total Number of Active MHAMs	Chairs
Hertfordshire	30	13
Norfolk	8	4
N.Essex	5	3

Across the three locations the teams of MHAM has again been stable during the year.

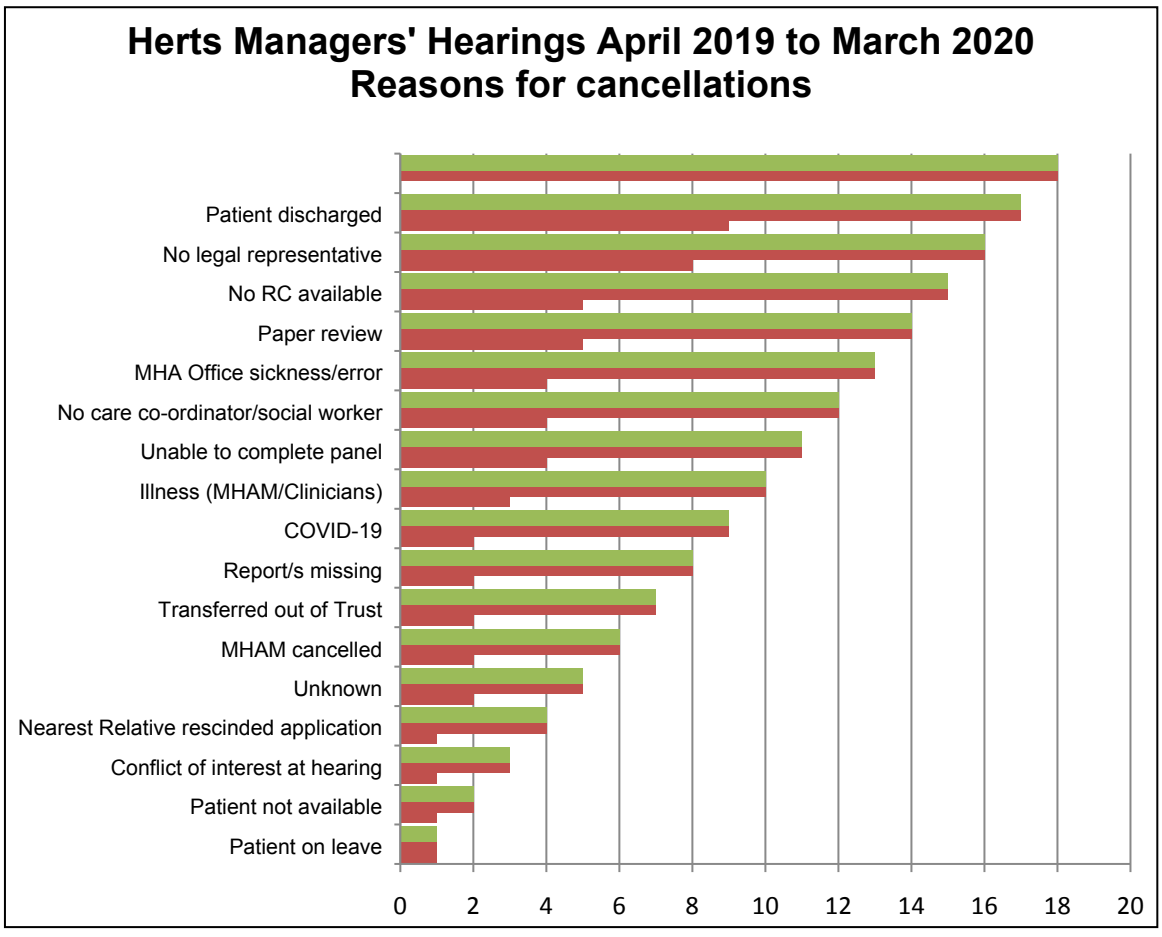
8) MHA Managers Hearings

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). The figures for 2019/20 are similar to those of 2018/19.



	Herts	Norfolk	Essex
Appeal and Review Requests	225	14	4
Number Reviewed	167	14	4
Discharged by MHAM	5	0	0

*Excludes CTO Paper Reviews
The following chart shows reasons why hearings were not held in Hertfordshire, there were no hearings cancelled in Norfolk and Essex.



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.

31 patients had their CTOs reviewed based on the reports during 2019/20, there were no adjournments for a full hearing.

9) First Tier Tribunals (FTT)

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 2019/20	Discharged by FTT
325	**196**	**20**

10) Committee Meetings, Discussion Groups and Training 2019

The HPFT MHAM Annual Committee Meeting 16th October 2019 included updates, presentations and discussions on:

Chairs' Introduction and MHAM Updates	Loyola Weeks, Hattie Llewelyn-Davis, Tina Kavanagh
Overview of the Year	Chris Lawrence – Chair of HPFT
Update from the Services	Mike Barratt – Deputy Director Service Delivery and Service User Experience
EROS Service	Alison Smith – Service Line Lead Rehabilitation Services(LD&F SBU)
Advocacy Service	Sam Slaytor, Interim Inclusion and Engagement Team Manager
Scenarios around Mental Capacity Act	Tina Kavanagh – MHL Directorate Manager Tina

In addition a Mental Health Legislation update was provided by Paul Barber on behalf of the Trust Solicitors, Bevan Brittan Solicitors, all MHAM were invited to participate in the webinar.

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 work of Hattie Llewelyn-Davies in her role as Manager of the MHAM is much appreciated and has provided cohesion in the service.

I, on behalf of the Board, 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. I would also like to thank Melina Shaughnessy and Suki Sangha for their work supporting the governance arrangements for MHAM Managers.

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.

The MHAM area of the intranet has been valued by the MHAM and our thanks to the Trust for providing this.

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.

Due to COVID-19 ways of working have had to be adapted in order for the MHAM to continue with the requirements of the Code of Practice to review all renewals and extensions. Initially all uncontested reviews were done based on the reports and discussion by 'phone, however this has developed and all hearings are held by video link, GoToMeetings. This has proven successful and is a similar way of working to how the First Tier Tribunal is currently operating. It may well be that when the pandemic subsides this could be an option for community patients to engage with the hearing process as they would not need to come to a hospital site for a hearing and could be at the CMHT or in their own home.

12) Priorities for 2020/21

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 the changes in the law.

- 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.
- 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 ethnicity.
- Continue to contribute to the London Mental Health Act Network's meetings to maintain good practice within our Trust and help to develop better practice.
- 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.

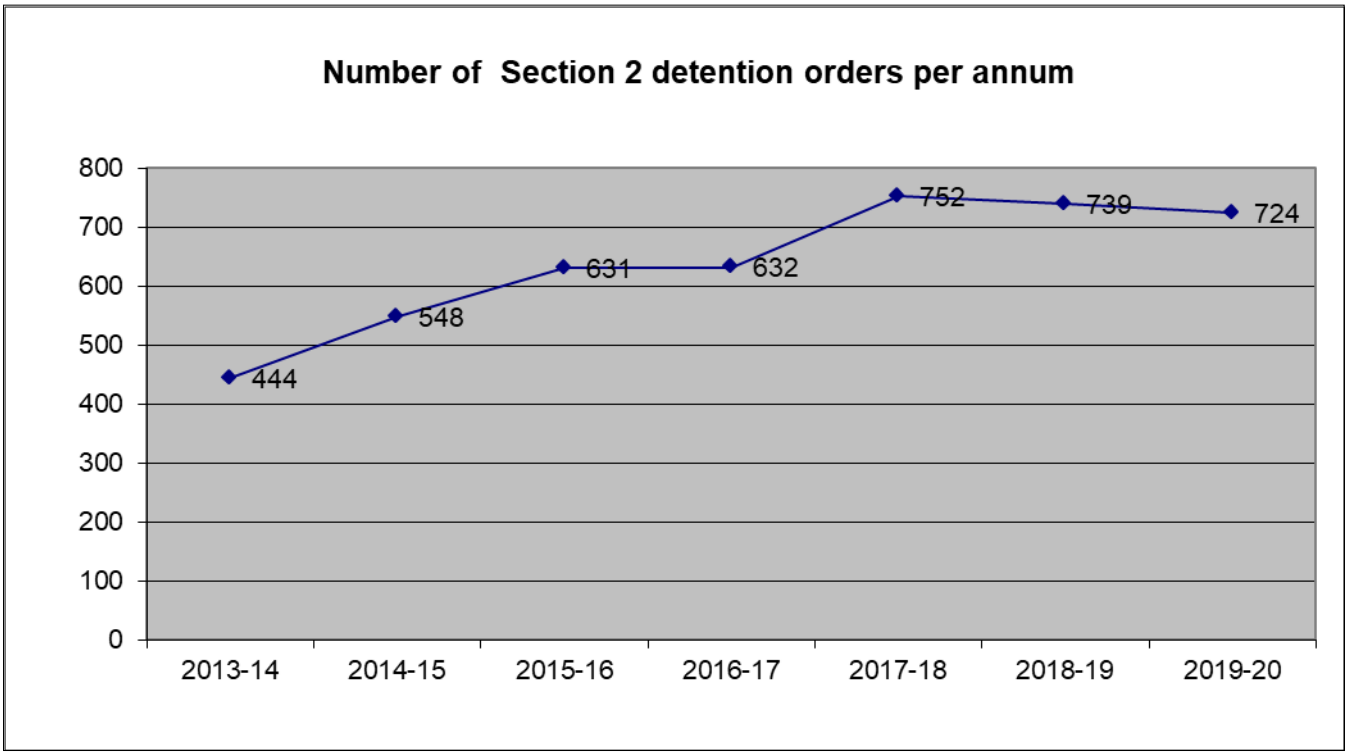
13) Future Annual Reports on the Service

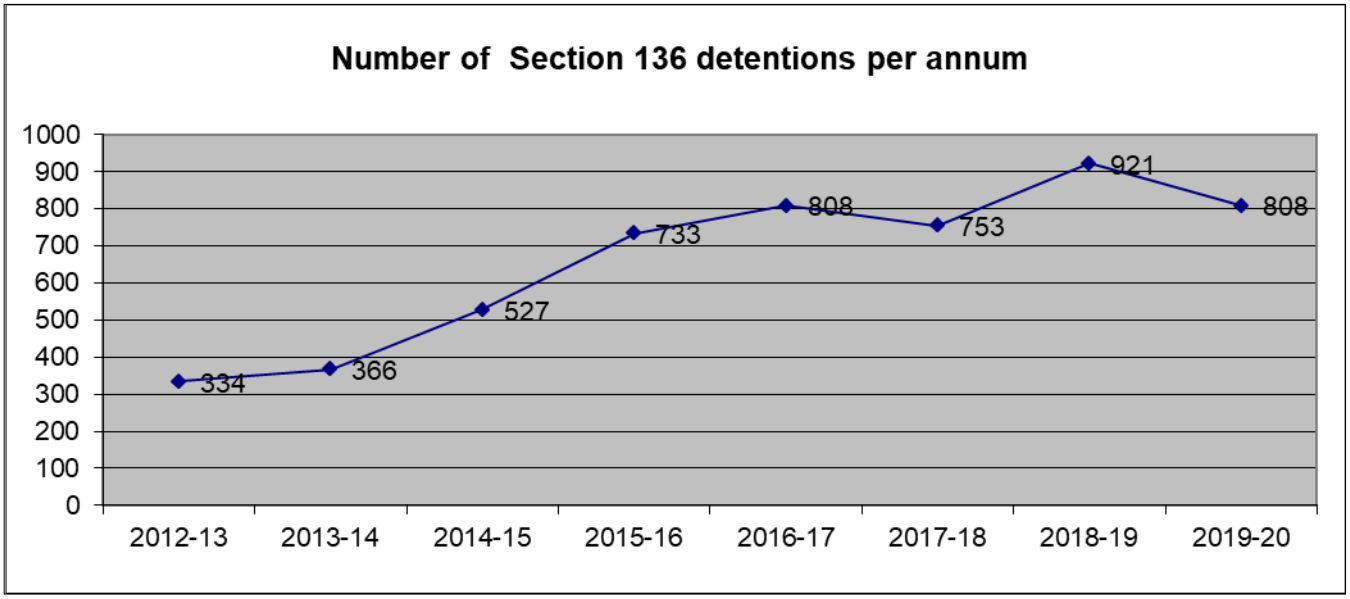
A future report will be submitted to the Trust Board in one year.

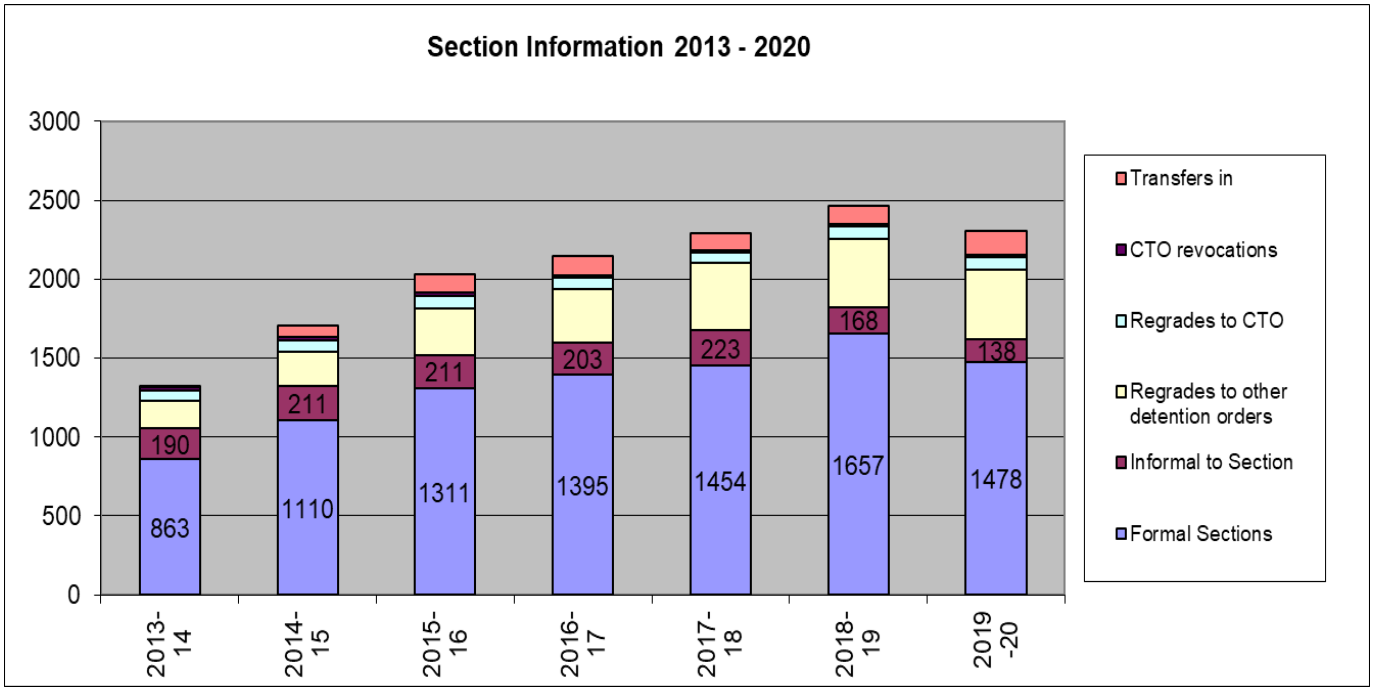
Report produced by Hattie Llewelyn-Davies/Tina Kavanagh
on behalf of Loyola Weeks
July 2020

Appendix 1

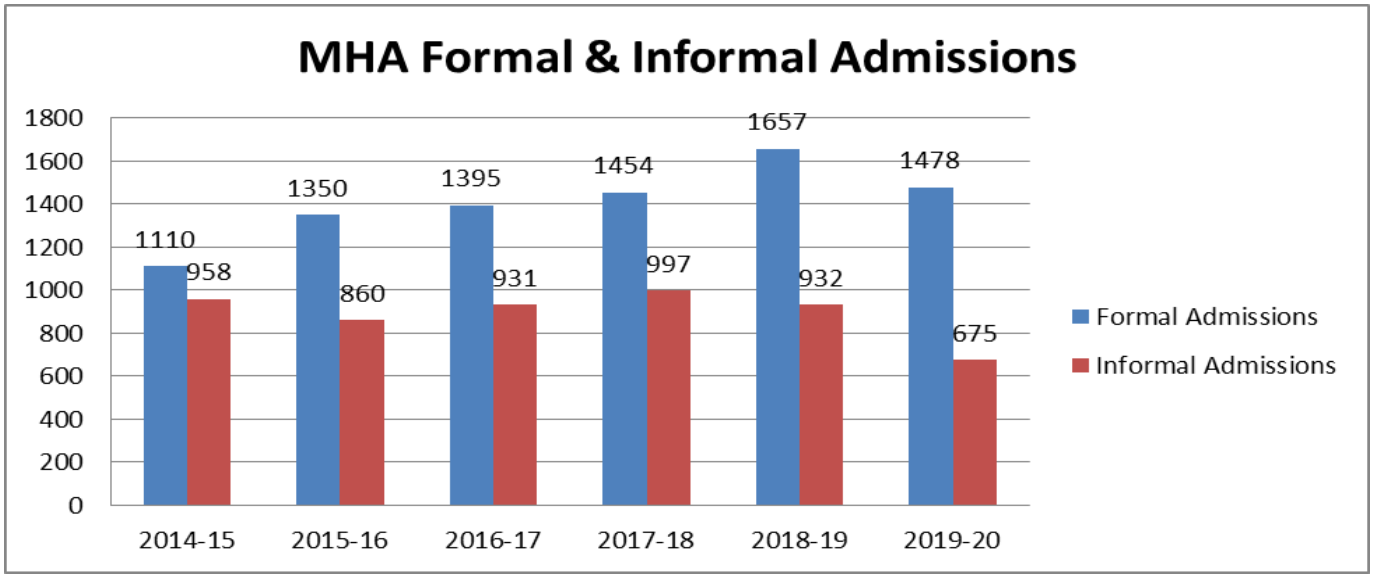
Graphs showing use of MHA detentions in HPFT

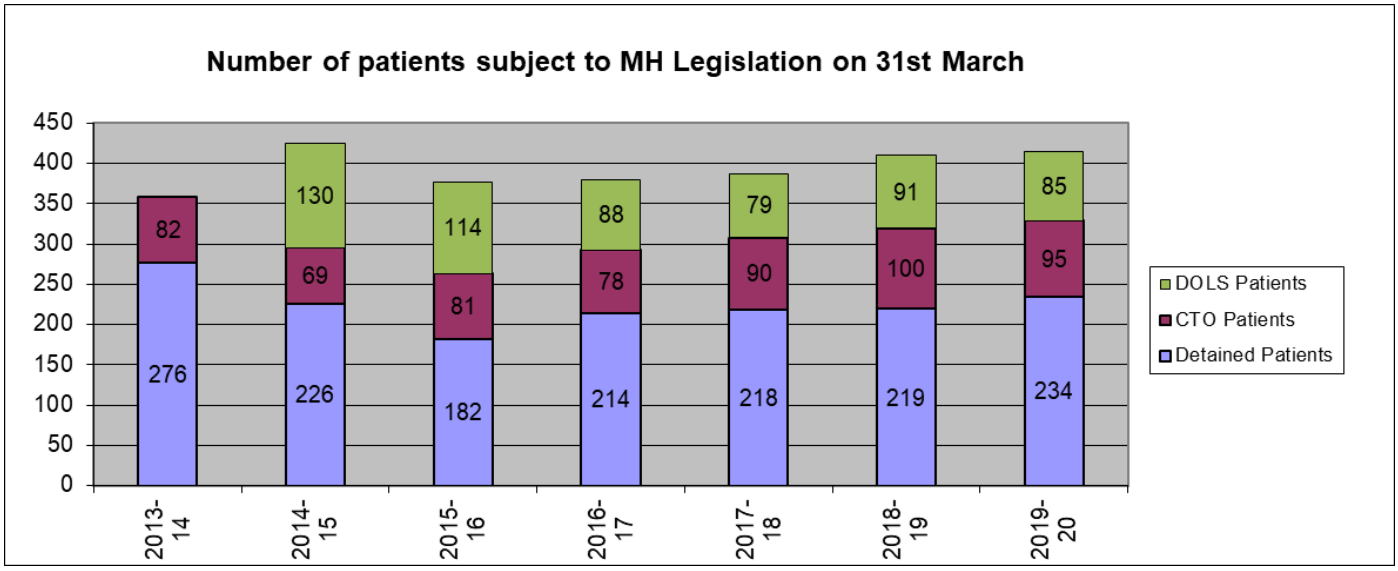






The next graph shows how the number of formal admissions has risen in contrast to the number of informal admissions.




Number of patients subject to MH Legislation on 31st March
450
400
350
300
250
200
150
100
50
0
82
276
130
69
226
114
81
182
88
78
214
79
90
218
91
100
219
85
95
234
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20
DOLS Patients
CTO Patients
Detained Patients