Hertfordshire Partnership University NHS Foundation Trust
PUBLIC Board of Directors

DaVinci Suite

24 November 2022 10:30 - 24 November 2022 13:30

INDEX

NHS
Hertfordshire Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 24 November 2022
Da Vinci A,B & C
Time: 10.30am – 13:30pm

AGENDA					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
1.	**Welcome and Apologies for Absence**	Chair			10:30
2.	**Declarations of Interest**	Chair	**Note**	Attached	
3.	**Shared Experience**				10:30
4.	**Minutes of Meeting held: 29 September 2022**	Chair	**Approve**	Attached	11:00
5.	**Matters Arising Schedule**	Helen Edmondson	**Review & Update**	Attached	
6.	**CEO Brief**	Karen Taylor	**Receive**	Attached	11:05
7.	**Chair's Report**	Chair	**Receive**	Verbal	11:20
	QUALITY & PATIENT SAFETY				
8.	**CQC Regulatory Activity**	Jacky Vincnet	**Receive**	Attached	11:30
9.	**Learning from national incidents**	Jacky Vincent	**Receive**	Attached	11:40
10.	**Report of the Integrated Governance Committee held: 10 November 2022**	Jacky Vincent	**Receive**	Attached	11:45
10a.	**Quarter two Integrated Safety Report**	Jacky Vincent	**Note**	Attached	
10b.	**Quarter two Safe Staffing Report**	Jacky Vincent	**Note**	Attached	
10c	**Quarter two Experience Report**	Sandra Brookes	**Note**	Attached	
11.	**Freedom to Speak Up six monthly report**	Jacky Vincent	**Receive**	Attached	11:55
	OPERATIONAL AND PERFORMANCE				
12.	**Report of the Finance & Investment Committee held: 17 November 2022**	Paul Ronald	**Receive**	Attached	12:00
13.	**Performance**				12:05
13a.	**Quarter two Annual Plan Report**	David Evans	**Receive**	Attached	
13b.	**Quarter two Performance Report**	Hakan Akozek	**Receive**	Attached	
14.	**Finance report**	Paul Ronald	**Receive**	Attached	12:25

15.	**Quarter two People & OD Report**	Janet Lynch	**Receive**	Attached	12:35
16.	**Winter and UEC Preparedness**	Sandra Brookes	**Receive**	Attached	12:45
	STRATEGY				
17.	**Presentation from ICB**	Paul Burstow Jane Halpin	**Receive**	To Follow	12:55
	GOVERNANCE AND REGULATORY				
18.	**Trust Risk Register**	Jacky Vincent	**Approve**	Attached	13:15
19.	**Board Assurance Framework**	Helen Edmondson	**Approve**	Attached	13:20
20.	**Nominations and Remuneration Committee Terms of Reference**	Helen Edmondson	**Approve**	Attached	13:25
	Any Other Business	Chair			13:30
	QUESTIONS FROM THE PUBLIC	Chair			
Date and Time of Next Public Meeting: Thursday 26 January 2023					

ACTIONS REQUIRED

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

Chair: Sarah Betteley

Declarations of Interest Register

Board of Directors

November 2022

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

Sarah Betteley	Chair	Director DEVA Medical Electronics Ltd
Sandra Brookes	Director, Service Delivery & Service User Experience	Nil Return
Tim Bryson	Non-Executive Director	Director of Tim Bryson Consultancy Services Ltd Chair of Family Psychology Mutual CIC
Carolan Davidge	Non-Executive Director	Non-Executive Director, East of England Ambulance Service NHS Trust Trustee, Arthur Rank Hospice Charity Independent Board Member, Samphire Homes Company Director, Carolan Davidge Ltd (trading as Carolan Davidge Coaching)
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
David Evans	Director Strategy & Partnerships	Nil Return
Diane Herbert	Non-Executive Director	NED designate at the North East London ICB
Janet Lynch	Interim Director People & OD	Harpenden MacMillan Fundraising Committee Member
Paul Ronald	Interim Director Finance & Estates	Chair Mind in mid Herts
Karen Taylor	Chief Executive Officer	Nil Return
Andrew van Doorn	Non-Executive Director	Chief Executive and Company Secretary, HACT (Housing Associations Charitable Trust) Chief Executive and Company Secretary of HACT Housing Action Ltd. A fully owned trading subsidiary of HACT

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

Minutes of the: PUBLIC Board of Directors
Date: 29 September 2022
Venue: The Colonnades and Virtual

MINUTES	
NON-EXECUTIVE DIRECTORS	**DESIGNATION**
Sarah Betteley | SBe	Chair
Andrew van Doorn | AvD	Non-Executive Director
Jon Walmsley | JW	Non-Executive Director & SID
Tim Bryson | TB	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
David Atkinson | DA	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
DIRECTORS	
Karen Taylor | KT	Chief Executive Officer
Jacky Vincent | JV	Director, Quality and Safety & Chief Nurse (Items 1 – 15)
Prof Asif Zia | AZ	Director, Quality & Medical Leadership (Item 8b onwards)
Janet Lynch | JL	Interim Director People and OD
Paul Ronald | PR	Interim Director Finance and Estates
Hakan Akozek | HA	Director Innovation & Digital Transformation
David Evans | DE	Director Strategy & Partnerships
Sandra Brookes | SBr	Deputy CEO and Chief Operating Officer
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chair & Company Secretary (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Maria Watkins | MW	Lead Governor
Sinikiwe Mungate | SM	SU Experience story (agenda item 3)
Katie Dyton | KD	Experience Lead (agenda item 3)
APOLOGIES	

Item	Subject	Action
113/22	**Welcome and Apologies for Absence** SBe welcomed all to the meeting with an extended welcome to Andrew van Doorn and Paul Ronald. SBe also welcomed Maria Watkins who was observing as Lead Governor. There were no apologies for absence.	
114/22	**Declarations of Interest** The Declarations of Interest Register was noted. **NOTED**	
115/22	**SU Experience** Sinikiwe Mungate, Charge Nurse at Gainsford House shared her story from starting out as a student nurse and her journey through the Leadership Academy.	
116/22	**Minutes of Meetings held 28 July 2022** The minutes were reviewed, and subject to some typos were approved as an accurate account of the meeting.	

	APPROVE **The Board APPROVED the minutes**	
117/22	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
118/22	**CEO Brief** KT presented the CEO Brief to the Board which was taken as read. Headline messages of note to the Board were: Since the last meeting a new Prime Minister was in post and a mini budget had been announced which would have implications for the cost of living. Nationally, regionally and locally there was a significant focus on planning and ensuring services were sustainable and resilient over the autumn and winter period. KT highlighted that it was expected the winter would be challenging. There was a particular focus on emergency services and clearing the backlog alongside the published plans to boost capacity and increase resilience. KT noted the recent pay award with a number of unions formally advising they would be seeking to ballot their members on industrial action. The NHS Staff survey had launched on the 3 October with KT commenting this would provide a good temperature check of our staff. KT reflected on the BBC Panorama programme featuring the care at Edenfield medium secure unit, part of the Greater Manchester Mental Health Foundation Trust, stating that as a Board we should look at assurances within our own services. ***An Action was drawn for this to have consideration at Board (following review at IGC) the measures in place in response to Panorama report on Edenfield*** The Cybersecurity Incident which had taken place in August and gave significant impact to NHS Organisations was now dealt with however the backlogs were still being addressed. KT made acknowledgement to our Finance department for the way in which they had handled the incident. In August 2022 NHS England had published the new Patient Safety Incident Response Framework (PSIRF). The Framework was a major step in allowing for more effective learning and improvement, and ultimately safer care for patients, with KT commenting that whilst as a Trust we did well, the framework would provide an opportunity for us to review and would be taken through the Integrated Governance Committee. David Sloman, Chief Operating Officer for the NHS had visited the Herts and West Essex ICS in September spending time visiting Watford General Hospital and met with local system leaders. David Sloman commended the system on its work noting a number of areas of best practice. The Hertfordshire Mental Health, Learning Disability and Autism (MHLDA) Collaborative had changed its name to a Health & Care Partnership and continued to drive its agenda. KT also noted the ADHD business case which was recently approved by the ICB Board.	**JV**

	The East of England Provider Collaborative was making good progress with significant improvement for service users. A mobilisation plan was being developed to support the implementation of a virtual day service for adult eating disorders across the Collaborative, led by SBr. The Secure service transformation continued to be focused on the expansion of community forensic services. Operationally demand for some of our services over the summer had eased, however this had not been systematic. We were giving focus to our recovery programme with KT able to confirm that no young person had waited beyond 28 days last month. KT continued reporting that last month was also the first in 12 months where our vacancy rate had dropped with a further pipeline of staff due to commence over the Autumn. The Trust had submitted to the CQC the response to the draft inspection report on Forest House Adolescent Unit (FHAU)and the final report published by the CQC thereafter. KT noted the Board would be kept briefed. The Trust had been shortlisted for a number of awards, including Health Service Journal (HSJ) Patient Safety Awards in October, two HSJ awards and four awards in Positive Practice in Mental Health. Recruitment continued for the Chief People Officer and Chief Finance Office. KT recorded best wishes to Maria Wheeler in her new role. KT concluded the update recording congratulations to SBr to the role of Deputy CEO. Questions were invited. In response to AB question around the restructure of the SBU's SBr reported that the SBU structure had changed with all Learning Disability services in one SBU and IAPT being managed within West and East and North SBU, to support more integrated work with primary care. **RECEIVED** **The Board RECEIVED the CEO Brief**	
119/22	**Chairs Report** SBe provided Board members with a verbal update on the work undertaken since the last Board meeting. SBe reported that herself and DE had attended the recent Chairs and CEO meeting which had been held face to face in London. At the Chairs meeting with Paul Burstow, Richard Roberts, Herts County Council had joined with detailed discussion regarding system structures. SBe continues to attend the weekly mental health chairs call's, reporting that the last call had heard from Mark Yates, Chair of Herefordshire & Worcestershire Health and Care Trust, who had shared some learning on prevention. SBe had attended the NHS Providers Round Table event which had been	

	joined by Dr Tim Ferris, Director of Transformation, NHS England who had shared his reflections on the progress of digital transformation within the NHS. SBe regularly attends the weekly Good Governance Institute (GGI) events with last week's talk being on the ICS and local government. SBe concluded the update commenting she continued with her site visits. No questions were put forward. **Appointment of Senior Independent Director** SBe reported on the recent process to appointment a Senior Independent Director. The report was taken as read with detail set out. The process had been approved by the Council of Governors with SBe recording congratulations to Jon Walmsley on the appointment. SBe further updated advising the Board that Maria Watkins had been appointed as Lead Governor. No questions were put forward. **RECEIVE** **The Board RECEIVED the verbal update**	
QUALITY & PATIENT SAFETY		
120/22	**COVID 19 and Winter Planning** SBr presented the report which provided the Board with an update on the actions in place with regard to COVID-19 and Winter Planning. The report was taken as read and the below points highlighted. We remained in Incident Management although we had stepped down some aspects. SBe provided the Board with assurance that the position would be closely monitored and confirming we were able to step up within the hour. Daily Sit reps continued. In regard to the Winter Plan this was being mobilised around five pillars, which were detailed in the body of the report. A weekly task and finish group was being established which will report directly into the Trust Management Group and then to the Executive Team. Whilst there was some winter funding money coming into the system specifically for mental health this was limited. SBr continued advising the winter plan was an opportunity to try some new ways of working so the Trust and system were able to respond effectively to demand and additional pressures for example COVID-19, and Flu. Questions were invited. In response to JW's question in regard to this being our first winter within the ICS, KT and SBr provided assurance we were in a good position with a strong winter plan. In response to AB's query around pension abatement JL confirmed there was currently no outcome from the consultation. As a Trust we had	

	potentially around 20-30 staff affected. In response to TB's question regarding surge beds SBr provided assurance stating that in addition to the 15 beds we had a contract for, we are looking to block book others to avoid spot purchasing. AZ updated Board members on access to vaccinations for Flu and COVID. Uptake for Flu last year had been 73% with a target of 93% for 2022. In response to AB's question SBr reported that IAPT provided expertise to support staff. No further questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
121/22	**Report of the Integrated Governance Committee** DH presented the report which provided an overview of the work undertaken by the Integrated Governance Committee (IGC) at its most recent meeting held 15 September 2022. The report was taken as read, noting a number of the items discussed were covered later on the agenda. The below points were drawn out for attention. The Committee undertook a deep dive into nurse recruitment with Bina Jumnoodoo updating on the extensive work being undertaken in recruit nurses along with retention. A task and finish group had been established to look at our nursing workforce, that the IGC welcomed. **RECEIVE** **The Board RECEIVED the report**	
122/22	**Quarter One Integrated Safety Report** JV introduced the report which provided detail in regard to safety incidents, themes and learning. The report was taken as read, and the below four areas highlighted to the Board. Incidents reported in the quarter decreased by 16%, with an increase in Serious Incidents (SIs). There were five reported incidents of severe harm with JV stating she was already sighted on these and the Root Cause Analysis (RCA) completed, commenting there were no trends. Of these four were reported as SIs relating to self-harm and one safeguarding linked with historical abuse. There had been eight deaths, which were thought to be as a result of suicide with JV commenting this was a reduction of eight compared to the same quarter last year. The Trust continues to review all incidents and JV stated that the introduction of the Patient Safety Incident Response Framework (PSIRF) providing an opportunity to further develop our processes in collaboration and coproduction. The quarter had seen the lowest number of physical interventions reported since quarter four 2019/20. JV highlighted one individual from 2 Forest Lane noting their LTS had now ended and they had been successfully discharged into the community.	

	In regard to safeguarding, both adult and children's referrals had decreased. The Trusts safeguarding team continued to work closely with our services and partners to ensure all aspects of safeguarding were responded to and supported. JV invited questions. In response to SBe's query an ***Action was drawn for a future Integrated Safety Report to include issues identified by CQC insight and Trust mitigations*** **RECEIVE** **The Board RECEIVED the report**	**JV**
123/22	**Emergency Preparedness, Resilience and Response Core Standards** SBr presented the paper which gave the Board an overview of the Trust's performance in relation to the EPRR Core Standards expected by NHSE/I for 2022/23 along with assurance in regards to the Trusts annual position statement for EPRR. The report was taken as read, and the below points noted by the Board. The EPRR is an annual assurance process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR core standards. The Trust EPRR group meets monthly to oversee a robust annual work plan. During October a number of Business Continuity Exercises will be undertaken. A review of the On Call arrangements has been carried out with a more robust system implemented. SBr reported that the Trust had received initial feedback from the ICS which recommended to amend the position statement to include details of the continued development of business continuity plans and training. The Board were asked to approve the Integrated Governance Committee's acceptance of the Statement of EPRR Conformity and acknowledge the Trust self-assessment of the 2022/23 NHS Core Standards for EPRR. All in attendance provided approval. **APPROVE** **The Board APPROVED the return for submission subject to the recommended changes.**	**SBr**
124/22	**WRES and WDES Report** JL introduced the report which updated the Board on the Trust's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data submission. The report was taken as read. JL provided a presentation to the Board with the following key messages of note: Our data was submitted within the deadline of 31 August 2022 and was based on locally held data as at 31 March 2022.	

	The presentation described the movement since last year's submission, which was based on data as at 31 March 2021 and the 2020 annual staff survey. Of note was that the data for this year showed that BAME staff had been 2.8 times more likely to enter the disciplinary process than white staff. In 2021, we reported a positive position for this indicator, however, it became apparent that the data for 20/21 was incorrect and we should have reported a position of BAME staff being 2.4 times more likely to enter the process. Going forward there would be quarterly reports to PODG, the Executive Team and IGC, reporting will be on all WRES and WDES data. The report set out the actions which had been taken thus far and the areas for further work. A comprehensive action plan would be co-produced to address the areas for improvement. JL invited questions. In response to DA's question regarding data quality issues SBr provided assurance that this was being addressed and discussed at IGC. JL added that work would be undertaken at induction to clarify expectations on standards of behaviour of staff. The Board discussed the value of undertaking a Deep Dive into data. **RECEIVE** **The Board RECEIVED the report**	
	OPERATIONAL AND PERFORMANCE	
125/22	**Report of the Finance & Investment Committee held: 22 September 2022** AB presented the report which provided an overview of the work undertaken by the Finance and Investment Committee at its most recent meeting held on the 22 September 2022. The report was taken as read with the below points drawn out. The Committee had received a Deep Dive on the progress with the Community Services Transformation with AB noting this had been helpful for the Committee to understand the complex landscape. The Committee received a Finance report that outlined the Trust was reporting a break-even position noting the highly challenging environment. The Committee were advised that the system were aware of the Trust's position with AB confirming FIC would continue to monitor. The Committee had considered the proposed Business Case for a female Learning Disability Forensic inpatient service and welcomed the important step forward. The Committee had approved the business case in principle subject to sufficient funding. AB recorded a thank you to the team for their presentations. It was noted that the clinical model for the service would also be discussed at the Integrated Governance Committee.	

	RECEIVE **The Board RECEIVED the report**	
126/22	**Quarter One Performance Report** HA introduced the report which provided an overview of the Trust's performance against both the NHS Single Oversight Framework targets and the Trust Key Performance Indicators (KPIs) for Quarter 1 2022-23. The report also provided an update on the actions being taken to improve performance. The report was taken as read and the below points highlighted. HA reported this had been a challenging quarter however, despite the high demand on our services, 33 indicators had been met with HA acknowledging the hard work. Key areas of focus were Out of Area Placements, Adults and Children and Young People waiting longer than 28 days from referral to assessment, feedback from our service users about how safe they feel in our inpatient units and staff vacancy and turnover rates. The report also outlined areas of strong performance which included feedback from our service users that our services were welcoming and friendly across our services. Questions were invited. Board members held a conversation around SPC Charts and the benefits we were seeing from these. In response to AvD's question SBr reported that teams access performance data via SPIKE. KT added that the adoption of SPCs was underway and there was a programme to implement throughout. Conversations were also held around work to address the Out of Area Placements with SBr commenting we remained an outlier. KT set out the importance of the recovery programme noting that there was work still to be done. **RECEIVE** **The Board RECEIVED the report**	
127/22	**Finance Report Month 5** PR introduced the report which presented the financial position for the five months to 31 August 2022 and the forecast year-end outturn. The report was taken as read. The financial position for month 5 and for the year to date was on plan, (break-even). However, this position reflected the unplanned release of an additional £432k from Trust reserves. The report set out the detail with PR providing assurance he felt confident we would deliver this year but noting next year would be a huge challenge. Key to our future delivery was the transformation programme, with PR stating the pace of delivery was important. PR also provided an update on the Delivering Value programme (DV)	

	reporting that in the five months to 31 August 2022, savings of £2.11m had been realised against a plan of £3.67m. The forecast outturn was £6.4m for the full year. He reported that we would be reviewing the forecast and that work would start shortly on the financial plan for 2023/24. **RECEIVE** **The Board RECEIVED the report**	
128/22	**Quarter One People & OD Report** JL presented the report which set out the progress against the People and OD KPIs for Month 4. The report was taken as read. Key headlines were noted as: Our vacancy rate had reduced, mandatory training was at 93% and recruitment and retention work was in place to address nurse vacancy rates with weekly recruitment meetings held. Our Wellbeing work continued with a number of key actions being taken forward, detail of which is laid out in the report. Belonging and inclusion continued to form a major element of our approach to improving staff experience, with engagement and co-production at the heart. JL noted the pay award for September advising that there would also be support for staff in relation to changes to pensions. JL concluded the update advising the Big Listen events launched next month with local events continuing in the autumn. **RECEIVE** **The Board RECEIVED the report**	
129/22	**East of England Collaborative** SBr introduced the report which provided an update on the progress of the operational, financial and contractual aspects of the East of England Provider Collaborative. The report was taken as read. Points drawn out for attention were noted as below. Lead provider for Child & Adolescent Tier 4 Services: Pressure linked with CAMHS continued with close to 44 beds currently closed which has led to spot purchasing which has impacted on finance and service users experience. We had seen significant improvement on waiting list times for CAMHS however bed closures remain a risk with slow progress on re-opening. Workforce was also a contributing factor. SBr reported that the community learning disability Forensics team posts had all been recruited to. Recruitment was going well for the Adult Eating Disorders services. She reported that the Collaborative was forecasting breakeven for year end but that overspend in CAMHS was being offset by underspends in other services. JW reported that FIC had discussed the lack of incentives in place for providers to open closed beds.	

	No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
	STRATEGY	
130/22	**Setting Trusts future Strategy** DE provided a presentation to Board members which set out the proposed approach to developing a new overarching 5 year strategy for the Trust to replace the existing Good to Great strategy. KT set out that the Good to Great strategy was still very valid and the Trust was not looking to revisit the Trust's values. HA added that the digital strategy would be reviewed and updated in line with the new Trust strategy. Board members discussed and supported the proposal. In particular the Board supported the commitment to co-production and scenario planning. **APPROVE** **The Board APPROVED the report**	
131/22	**System Update** DE introduced the report which provided the Board with updates on the system within the Herts and West Essex Integrated Care System. The report was taken as read and the below points drawn out. The Hertfordshire and West Essex Integrated Care Partnership (ICP) had commenced the development of the Integrated Care Strategy. The strategy would be developed for December 2022 with a corresponding five-year Joint Forward Plan to be agreed by March 2023 and implemented in April 2023. DE referenced point 3.7 of the report which set out the draft strategies 10 proposed ambitions (detail in body of the report). DE set out that a review of the section 75 is underway led by Hertfordshire County Council and the ICB. DE concluded the update noting the Board would be kept updated on progress, including any risks or opportunities as things progressed. It was noted that the Chair and CEO of the ICB would be attending a future Board. **RECEIVE** **The Board RECEIVED the report**	
	GOVERNANCE AND REGULATORY	
132/22	**Report of the Audit Committee held: 8 September 2022** DA presented the report which provided the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 8 September 2022. The report was taken as read with the below points drawn out for attention. The Committee had welcomed new members Andrew van Doorn and Anne Barnard.	

	The Committee were updated on the impact and Trust response to the recent cybersecurity incident. It was agreed that the Committee would receive an update on third party contracts. The Committee had received and recommended to the Board for approval the Charitable Accounts for 2021/22. The Committee were updated that the Internal Audit Plan was on target. DA concluded the update reporting that our external auditors KPMG had come to their end of term and a procurement process was underway. The outcome of this would be presented to the Committee at their December meeting. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
133/22	**Fit and Proper Person** JL introduced the report providing annual assurance that all Board directors remained fit and proper for their roles. She reported that the Chair's return had been singed off by DA as Chair of Audit Committee and in absence of an appointed SID. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
134/22	**Non-Executive Directors – Champions** HE presented the report which updated the Board in regard to the NED leads agreed in line with NHSE guidance. HE continued advising that the Trust would focus on the five champion roles. The paper set out the identified Trust NEDs for the NED champion roles and the Committees identified to oversee the other areas. The paper also outlined the Executive lead for the areas identified and detailed further work to be undertaken. Board members considered and provided approval for the NED Champion roles. **APPROVE** **The Board provided APPROVAL**	
135/22	**Annual Quality Assurance for Responsible Officer & Revalidation 2021/22** AZ presented the report to the Board which included detail on the submission. This annual report provided assurance to the Board that the Trust was maintaining its statutory responsibilities to ensure all doctors linked to the Trust kept up to date with their clinical knowledge and remained fit to practise.	

	161 doctors were due for appraisal in 2021/2022, of these 153 completed their appraisals within 28 days of their first appraisal. AZ reported a good level of compliance with revalidation and the reported detailed the reasons for any deferments. The GMC guidance on doctors due for revalidation stated that 44 were due for revalidation during 2021/2022 with the Responsible Officer approving 39 doctors with positive recommendations. The Trust currently had 63 fully trained appraisers to appraise 181 doctors annually. The Trust trained 11 new appraisers by an external trainer on the 11th of February 2022 to ensure the ratio is three to four appraisees to one appraiser. **APPROVE** **The Board APPROVED the report**	
136/22	**Mental Health Act Managers Chair's Action** SBe presented the report which sought the support and approval from the Board to appoint Annette Grunberg and Barry Canterford as Mental Health Act Managers. SBe confirmed both had successfully completed their three observations and training.as a Mental Health Act Manager. The Board provided their unanimous approval. **APPROVE** **The Board APPROVED the report**	
137/22	**Board Planner** HE advised that the Board meetings had moved to the 1st Thursday of each month commencing May 2022, noting this brought us in line with the rest of the system. All in attendance provided approval for the 2023/24 Board dates and the Board work programme. It was noted that the ICB Chair and CE would be invited to a future Board meeting. **APPROVE** **The Board APPROVED the Planner**	
138/22	**Questions from the Public** No questions were put forward.	
139/22	**Any Other Business** No further business was put forward.	
Date of Next Meeting Thursday 24 November 2022		

Close of Meeting

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Committee Meeting: PUBLIC Board of Directors

MATTERS ARISING SCHEDULE November 2022

Matters Arising from meeting held on: 29 September 2022					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
6	**CEO Brief**	**JV**	Consideration at Board (after review at IGC) measures in place in response to Panorama report on Edenfield	November 2022	**G**
9a	**Q1 Integrated Safety Report**	**JV**	Future Integrated Safety Report to include issues identified by CQC insight and Trust mitigations	November 2022	**G**
9b	**Emergency Preparedness Resilience & Response Core Standards**	**SBr**	EPRR self-assessment to be submitted with amended position statement	September 2022	**G**
15	**System Update**	**HE**	ICB Chair and CEO invited to future Board workshop	November 2022	**G**
Matters Arising from meeting held on: 28 July 2022					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
8d	**Quarter One Experience Report**	**SBr**	Revise format of experience report	November 2022	**G**

as One

Our Values
Welcoming Kind Positive Respectful Professional

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item**: 6
Subject:	CEO Briefing	
Presented by:	Karen Taylor, Chief Executive Officer	

National update

The national activity is summarised below:

National Political Landscape

Rishi Sunak has been appointed as Prime Minister following a process to choose a new leader of the Conservative party. His appointment followed the resignation of Liz Truss as Prime Minister, after seven weeks in power. The new Prime Minister has appointed a new cabinet and Steve Barclay has been appointed as the Secretary for Health and Social Care, having previously held the post July to September 2022.

Autumn Statement

On 17 November, the Chancellor of the Exchequer, Jeremy Hunt delivered the autumn statement. He set out the government's priorities as stability, growth and public services, while also protecting the most vulnerable. The Chancellor set out his vision for the NHS and that a strong NHS is essential to delivering a strong economy. He acknowledged that efficiencies alone will not address the impact of inflationary pressures and announced that the NHS budget will increase by £3.3bn in each of the next two years. He also stated that the departmental settlements as set out in the October 2021 spending review will be maintained. There will also be the publication of a long-term NHS workforce plan in 2023. £7.5bn of investment into adult social care over the next two years was also announced, targeted support to protect the most vulnerable households via 'Cost of Living' payments and uplift of the state pension and benefits in line with inflation by 10.1% this year. The detail of the impact of the statement will become clearer over the coming weeks and the Board will continue to be briefed.

Care Quality Commission (CQC)

At the end of October the CQC published its' state of Care report State of Care - Care Quality Commission (cqc.org.uk). The report provides an assessment of health and adult social care in England in 2021/22, the CQC refers to a system in "gridlock", which is unable to operate effectively. While recognising that health and care staff are doing their best to provide safe and effective care, and that most people are still receiving good care, the report highlights the chronic challenges faced by the health and care system of long term underinvestment and the absence of sustainable workforce planning. The report explores issues around access to care, health inequalities, workforce shortages, and the opportunities for systems to tackle these pressing challenges. It also highlights areas of specific concern, including maternity care, mental health services and care for people with learning disabilities. The evidence base for this report includes data from CQC's inspections and ratings, the experiences of people who use services, their families and carers, as well as national published data and reports.

The CQC also recently published a report into experiences of being in hospital for people with a learning disability and autism. Experiences of being in hospital for people with a learning disability and autistic people - Care Quality Commission (cqc.org.uk). The report followed the multi-agency review into the death of Oliver McGowan that highlighted failures in his care. The review made several recommendations for change. These included a recommendation that CQC should review how acute hospitals support people with a learning disability and autistic people, and that they look at people's experiences of care in hospitals. The review found that people found it difficult to access care because reasonable adjustments weren't always made; that providers need to provide person centred communication. The Trust is working with partners across the system to support them as they consider the report and provide specialist advice, as well as advocating for service users with a learning disability and autism.

Published National Reports

Dr Bill Kirkup CBE has published the independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust from 2009 to 2020. Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready) (publishing.service.gov.uk) The investigation was commissioned by NHS England and NHS Improvement following concerns raised about the quality and outcomes of maternity and neonatal care at the Trust. The investigation found a clear pattern of suboptimal clinical care which has led to significant harm, failing to listen to the families involved, and acting in ways which made the experience of families unacceptably and distressingly poor. The report identified four areas for action: identifying poorly performing units; giving care with compassion and kindness; teamworking with a common purpose and responding to challenge with honesty.

Three independent investigations into the care of Christie, Nadia and Emily have been published. All three young people were under the care of West Lane Hospital Publications - Tees Esk and Wear Valley NHS Foundation Trust (tewv.nhs.uk) . A total of 120 failures in "care and service delivery" across a number of agencies were found relating to their care and treatment. The Tees Esk and Wear Valley NHS Foundation Trust, who ran the services has admitted it had "unacceptable failings".

Both reports have been reviewed and areas of learning being identified for our organisation.

Industrial Action

The Royal College of Nursing has announced the outcome of its national ballot on industrial action. The outcome of the ballot for Trust will not see any RCN members at the Trust involved in industrial action. There are a number of Trusts in the region and nationally where staff have voted to support discontinuous strike action between 18 November 2022 and 2 May 2023. Within the ICS the organisations this is impacting on are: Hertfordshire Community NHS Trust and NHS Hertfordshire and West Essex ICB. The Region are coordinating the response and trusts are being required to undertake a SITREP to support regional oversight.

Unison is currently balloting their members on both strike action and action short of strike action (this includes working to rule for example) to take place between 9 December 2022 and 24 May 2023. The outcome of this ballot is expected after the closing date of 25 November 2022.

NHS England Publications

NHS England has published three set of documents: its consultation on changes to the NHS provider licence Consultation for changes to the NHS provider licence - NHS England - Citizen Space; a new suite of governance documents including a new code of governance for trusts NHS England » Trust governance guidance: Consultation response and a consultation on change to the enforcement guidance B1421-consultation-on-the-revised-nhs-enforcement-guidance-october-2022.pdf (england.nhs.uk).

The publications have arisen from changes to the statutory and operating environment, including a shift of emphasis from economic regulation and competition to system working and collaboration. The proposed changes will bring the provider licence up to date, reflecting the new legislation and supporting providers to work effectively as part of integrated care systems (ICSs) and apply to all trusts not just Foundation Trusts. The revised enforcement guidance describes NHS England's intended approach to using its enforcement powers in relation to Integrated Care Boards (ICBs), NHS foundation trusts and trusts, licensed independent providers of NHS services, and licensed NHS controlled providers.

The Trust is considering the documents, in particular the impact and what response could be provided to the consultations. The Trust is also reviewing its Constitution to ensure it is line with then new statutory and operating context, in the meanwhile the current version of the Constitution that has been in place since September 2021 will continue to be valid until the review is completed.

Regional and System update

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

Hertfordshire & West Essex (HWE) Integrated Care System

The ICB Board is met on 18 November Integrated Care Board meetings in public 2022/23 – Hertfordshire and West Essex NHS ICB when it undertook a deep dive into Urgent and Emergency Care and received update reports of finance, quality, performance and governance. Work is well underway to develop the Integrated Care Partnership (ICP) strategy. The strategy sets out its vision, scope and approach, drawing on the assessed needs of the ICS population. The draft strategy sets out ten strategic priorities which include areas relating to mental health and learning disability. The Trust will continue to be an active partner and ensure that the needs of those mental health needs and a learning disability and strongly represented.

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

As of 1 December, the Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative will be changing its name to be the Hertfordshire Mental Health, Learning Disabilities and Autism Health & Care Partnership. This reflects the development of the Collaborative over the last year and the new name will clarify the role and position of the Collaborative as one of the four Health & Care Partnerships in the ICS.

In light of operational pressures, the Collaborative has convened a Mental Health, Learning Disabilities and Autism Pathway UEC Group to review and progress specific activity to improve experience and outcome for people while supporting system flow. The Group is providing oversight of the capital investments made in the voluntary sector and the Acute Hospital Trusts and has expanded a patient audit across all three acute hospital trusts to better understand the mental health needs of people presenting in emergency departments.

The first meeting of the reconvened Collaborative Co-Production Group took place on Thursday 3 November. The Group considered the Primary and Community Mental Health Transformation Programme including the steps it had already taken to ensure service user and expert-by-experience engagement and what more might be possible.

East of England Provider Collaborative

The progress made with regards to the length of wait for CAMHS beds, the numbers on the waiting list and length of stay continues to be sustained. Plans are now underway to repatriate young people to their local inpatient units as beds become available. There has been some improvement in the number of beds closed but this remains an area of focus. The mobilisation of the virtual Adult Eating Disorder service is underway with the successful recruitment of a team manager. Recruitment to other posts continues.

Overall, the financial position of the Collaborative has improved this month mainly linked to the improved flow across CAMHS beds. Tricordant are continuing to carry out their work with the Collaborative to review progress and the strategy for the future, when this is concludes a full report will be produced for the Collaborative to consider.

University of Hertfordshire

The Trust continue to work closely with the University of Hertfordshire, to ensure that the students placed at the Trust receive rewarding and a high standard of placement. In particular recent meetings have focused on apprenticeships, increasing joint work in research, continued professional development; us of the simulation hub and supporting student wellbeing.

Trust-wide update

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

Operational update

We continue to work on our recovery programme and have seen good progress in CAMHs eating disorders, CAMHS targeted treatment team and Crisis response. Performance is strong in relation to urgent referrals but due to ongoing high levels of referrals and workforce challenges, recovery of the adult 28 day target for initial assessments has not yet been achieved. In addition, increased demand into EMDASS has resulted in a longer trajectory to achieve recovery. Demand for adult beds remains very high with ongoing use of out of area beds (OOAPs). A recent system meeting with Claire Murdoch (National Director for Mental Health) and her team, supported the many actions we are taking to reduce the number of OOAPs and we are focussing on reducing delayed transfers of care and length of stay; progressing additional discharge pathways and exploring additional crisis options.

We continue to work with the Emergency Departments (ED) to support their plans to improve the environment in which to assess people with mental health and learning disability needs. A recent audit showed a high percentage of presentations at ED being due to drug and alcohol misuse. Older people's services have seen an improvement in length of stay and have been carrying out a pilot to reduce observations. Early indications are that this has been successful.

Winter Planning

The Trust is working in alignment with the Herts and West Essex ICB level and place-based Surge, Escalation and Capacity plans and the NHSE National and Regional Operational Pressure Escalation Level (OPEL) framework.

As part of the surge and escalation plan to support winter planning the Trust has been operating within a new surge and escalation framework. This includes oversight meetings 7 days a week, which have been in place since mid-September. These help the Trust to better manage and monitor the Trust bed capacity, demand and flow. This has improved the visibility for all senior managers and the Executive team of the capacity within the inpatient pathways and bed management and allows real time insight into OPEL status and bed state, length of stay, AMPH availability, numbers wating in the community, places of safety or other hospitals for beds and overall demand much more widely than previously available and has enabled senior operational leads to focus on improvement actions.

Trust winter oversight meetings are now in place every two weeks with scheme-specific oversight strengthened. The Trust is working with partners and providers both at Place and ICB level to work on schemes that will provide alternatives to admission.

Winter planning is also in place to respond to further surges in demand for all Trust services and in the event of industrial action Business continuity plans for all services are being refreshed. In light of the industrial action planned for winter, all business units and corporate services have re-established weekly operational command structures; tactical command continues to meet weekly to oversee the continuing impact of COVID-19. The Trust incident command rota is populated until January and could be stood up as required once dates for industrial action are published. The Board will be considering a more detailed report later on the agenda.

Community Survey

The results of the community survey have been shared with the Trust and the embargo on these has just been lifted. The results have shown little improvement on the previous year apart from notable improvement in relation to medicines management and some areas have shown a deterioration. Work is underway to do further analysis of the results and to agree actions to take forwards this year. This will have a particular focus on improving communication with service users and involving experts by experience in the service improvement plans. A more detailed report will be taken to Board in due course.

Care Quality Commission

The CQC have published their report on Forest House Assessment Unit following their inspection in July 2022. The report highlights a number of improvements that have been made and documents that the Section 29A Warning Notice issued in March 2022 has been removed.

Since the last report to Board CQC has also visited three other services at the Trust, Oak Ward, the Trust's Psychiatric Intensive Care Unit, Warren Court, Medium Secure Learning Disability Unit in Hertfordshire and Victoria Court, inpatient service for older people. The CQC's approach of focused inspections in very much in line with their approach with other Trusts nationally and marks a change from process pre-COVID.

On 18 and 19 October 2022, the CQC undertook a focused inspection process at Oak ward, following an allegation made regarding restrictive practice. This was followed by a further visit on 31 October, at 21:00hours. The inspectors focused on the safe, caring, well led and effective domains and met with members of the ward's multi-disciplinary team (MDT), the leadership team and with service users. A report later on the agenda will provide further detail on the visits and the Service Improvement Action Plan (SIAP) and weekly oversight from the Executive Director Quality and Safety (Chief Nurse). A draft inspection process report will subsequently be provided to the Trust.

CQC undertook a focused inspection process on 1 and 2 November 2022 at Warren Court. This was following an anonymous concerns raised to the CQC regarding the quality of service provided regarding an individual service user and also regarding the staffing. The inspection process is focusing on the safe, well led and caring domains. A draft inspection process report will subsequently be provided to the Trust.

On 8 November 2022 CQC undertook an unannounced visit to Victoria Court following a concern raised with them about the care provided to a service user. The inspection process is focusing on the safe, well led and caring domains. A draft inspection process report will subsequently be provided to the Trust. A report later on the agenda provides more detail on the recent regulatory activity and action being taken by the Trust.

Our People

Our vacancy rate has reduced in October. This is as a result of exceptionally high recruitment activity, although our establishment has increased, we have seen a net increase in our staffing levels of 110 FTE since the end of quarter one, which included a net increase of 39 FTE in October alone. Our unplanned turnover rate has also reduced slightly from 14.3% to 13.96%.

Our appraisal rates have recovered further to 85% in October, compared to 84% in September. However, we continue our work to ensure full recovery so that every person has a strengths-based appraisal conversation each year. This work forms part of our retention plans, to ensure our people are supported to thrive and further develop their careers with us. Our work on increasing mandatory training compliance has meant that we achieved our target of 92% compliance in September and maintained this in October.

As part of our retention work, we continue to provide a robust health and wellbeing offer to our staff. We saw sickness absence increased slightly in October to 4.85% from 4.57% in September. Whilst mental ill health related absence has continued to reduce, the absence increase was largely attributable to increased incidence of colds/flu and continuing high levels of COVID-19, which mirrored the levels seen in the general population.

During October, we held our Big Listen event, which returned to a face to face format and enabled us to engage with a large number of our people. The conversations with our people focussed on belonging and inclusion as part of our work to co-create our belonging and inclusion strategy. October was also Black History Month, during which we ran a programme of activities to explore together our understanding of Black Heritage and to celebrate the many contributions and achievements of the Black community. Our Chief Executive, Chair and other Executive Directors personally supported our Black History Month events, which focussed on the theme of 'Inclusion & Belonging - Time for Change: Action Not Words'. During October, we also engaged with our staff networks to co-create our action plans for the Workforce Race Equality Standard and the Workforce Disability Equality Standard, which were approved at our November meeting of the People and OD Group.

Finance

The financial position remains very challenged with a further increase in costs in October/ November from the demand for additional adult inpatient beds and from continuing pay pressures. At month 7 the Trust has a £6.2m YTD deficit before any use of reserves. The Trust has continued to forecast a full year outturn of breakeven through the use of reserves. As previously discussed, given the continuing increase in costs there is a risk that despite the ongoing focus on managing the service pressures that there will be a deficit in year. The ICB has been advised of a risk of circa £0-3m deficit.

This is of particular significance with NHSE having just published its "Protocol for changes to in-year revenue financial forecast," which sets out the steps required should an NHS organisation wish to revise its FY22-23 Plan in relation to its Profit After Tax (PAT). This protocol, which is subject to continuing clarification questions requires local systems approval to declare a deficit as well as having a number of conditions. The current indication is that the notification of any deficit is made by M9 and therefore as well as the continuing focus on delivering the cost improvements originally planned during H2 the current end of year forecasts are being updated and monitored routinely.

Awards

The Trust was shortlisted for two HSJ awards and attended the awards ceremony on 17 November 2022. The Trust received Highly commended for our physical health check clinics for people with Learning Disability under the Innovation and Improvement in Reducing Healthcare Inequalities Award. This is a great accolade for the Essex Learning Disability team.

Executive Team Recruitment

The recruitment process for the Chief People Officer has concluded. Following a robust recruitment process which included shortlisting, stop / go, final interview, Exec team panel and stakeholder panel the Nomination and Remuneration Committee approved the appointment to the post. The appointment is subject to employment checks and will be announced when these have been completed.

The recruitment process for Executive Director of Finance and Estates is well underway with shortlisting completed and interviews scheduled for early December.

Karen Taylor
Chief Executive Officer

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 8
Subject:	Care Quality Commission regulatory update	**For Publication:** Yes
Author:	Jacky Vincent: Executive Director Quality and Safety (Chief Nurse)	**Approved by:** Jacky Vincent: Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent: Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

This paper provides an update on CQC's recent regulatory activity, in particular the inspection visits at Forest House, Oak ward, Warren Court and Victoria Court.

It also provides details of the action the Trust has taken and next steps, following the inspection visits.

Action required:

The Board is asked to RECEIVE the content of the report and action taken.

Summary and recommendations:

The CQC have undertaken a series of focused Inspection processes at Forest House, Oak ward, Warren Court, and Victoria Court.

The final Inspection Process Report for Forest House was published on 11 November, re-rating the service line overall as Requires Improvement.

The draft Inspection Process Reports for Oak ward, Warren Court and Victoria Court have not yet been received. The Trust has submitted the data requested to the CQC regarding Oak ward and is in the process of submitting requests for Warren Court.

This report provides a brief regarding the inspection processes and the actions and next steps by the Trust.

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

Strategic Objective One – safety

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

There are no financial implications

Equality & Diversity /Service User & Carer Involvement implications:

Ensuring equality of access and an inclusion experience for service users is vital to the delivery of high quality services.

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

CQC Essential Standards and the Safe KLOE.

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

The IGC have been regularly updated with regard to the focused inspections in particular on 10 November 2022

1. Introduction

1.1 This paper provides a brief regarding the recent regulatory activity in the form of focused inspections by the Care Quality Commission (CQC) at Forest House, Oak ward, Warren Court, and Victoria Court.

1.2 The approach being taken by CQC at the Trust, of focused inspections in response to concerns or complaints is one that is being replicated regionally and nationally. The approach is in line with what other mental health and learning disability Trusts are experiencing.

1.3 The Committee are asked to note the content of the report and the actions taken.

2. Forest House

2.1 Following the CQC's focused inspection process at Forest House in November and December 2021, the final inspection process report was published by the CQC on 30 March 2022. Within the report, the CQC identified actions which the Trust *must* take to comply with its legal obligations and actions which the Trust *should* take to improve the services. As a consequence of their findings, the service line (Child and Adolescent Mental Health Wards - CAMHS) was rated at the inspection as *Inadequate*.

2.2 The Trust fully accepted the findings of the CQC and took immediate action to address the quality of the service provided and remains committed to getting this right for young people and their families/carers for the future. In line with CQC process, the Trust submitted the actions it had taken within the required timeline.

2.3 The CQC subsequently undertook a two-day inspection of Forest House on 6 and 7 July and a follow up inspection on Sunday 24 July. Following the visits, the CQC requested further information, which was submitted by the Trust, in line with the required timescale.

2.4 Following informal feedback from the July inspection the Trust immediately commenced work on the capital project of installing call bells into Forest House. Preferred suppliers were identified and the survey to support the estates work completed. Owing to a delay in receiving supplies, the call bells are currently scheduled to be installed in November and the CQC have been advised of this with an agreement to keep them updated. The Trust has also completed a wider scoping exercise with other related CQC guidance to ensure compliance with all the requirements.

2.5 The Trust has also undertaken a review of seclusion practice including environment against the Mental Health Act (HCA) Code of Practice (CoP) The findings have been considered by the Integrated Governance Committee. Agreed action include the opening of the High Dependency Unit (HDU) at Forest House to provide additional space to support individuals with high acuity and complex needs and, at the time of this report, one of the HDU suites is opened for the purpose of seclusion, should it be required.

2.6 The draft Inspection Report for Forest House, following the inspection in July was reviewed by the Trust and we provided feedback and comments on factual accuracy. On 11 November 2022, the final report was published and included changes agreed

by CQC based on the factual accuracy comments submitted by the Trust. The Trust communicated the outcome of the report to service users, families and staff.

2.7 The overall rating for the service line (CAMHS wards) improved from *Inadequate* to *Requires Improvement* and the individual lines of enquiry are listed below:

- Safe – improved from *Inadequate* to *Requires Improvement*
- Effective – remained the same at *Requires Improvement*
- Caring - remained the same at *Requires Improvement*
- Responsive - remained the same at *Requires Improvement*
- Well-led - improved from *Inadequate* to *Requires Improvement*

2.8 The senior leadership team at Forest House continue to review the Service Improvement Action Plan (SIAP), there are currently fortnightly oversight from the Executive Director Quality and Safety (Chief Nurse), reporting into the Executive Team.

3. Oak ward

3.1 On 18 and 19 October 2022, the CQC undertook a focused inspection process at Oak ward, following an allegation made regarding restrictive practice by an agency staff member. A further visit took place on 31 October at 21:00hours.

3.2 The inspectors focused on the safe, caring, well led and effective domains and met with members of the ward's multi-disciplinary team (MDT), the leadership team and with service users.

3.3 The inspectors have requested to view CCTV within a requested timeline, including the date of the allegation made. They also requested data and information relating to the domains of safe, effective, caring and well led, which the Trust has submitted.

3.4 No concerns regarding safety were raised by the inspectors at the time of the inspection and the Trust is awaiting receipt of the draft Inspection Process Report.

3.5 The senior leadership team at Oak ward are implementing a Service Improvement Action Plan (SIAP), with weekly oversight from the Executive Director Quality and Safety (Chief Nurse), reporting into the Executive Team.

4. Warren Court

4.1 Following a number of anonymous concerns raised to the CQC regarding the quality of services provided at Warren Court regarding an individual service user and also regarding staffing, the CQC undertook a focused inspection process on 1 and 2 November 2022.

4.2 At the time of this report, initial verbal feedback has been provided by the inspectors and no concerns raised regarding safety. The inspectors have met with members the MDT, the senior leadership team, service users and plan to meet with families/carers.

4.3 The CQC have requested data and information relating the five domains safe, effective, caring, responsive and well-led, which the Trust is in the process of submitting. A draft inspection process report will subsequently be provided to the Trust.

5. Victoria Court

5.1 Following recent concerns raised to the CQC regarding the quality and safety of services provided in February 2022 linked with nursing practice, the CQC undertook a focused inspection process on 8 November 2022.

5.2 At the time of this report, initial verbal feedback has been provided by the inspectors and no concerns raised regarding safety. The inspectors met with members of the leadership team, staff working at Victoria Court and received feedback from carers.

5.3 The inspection process focused on the safe, caring, and well-led domains. A draft inspection process report will subsequently be provided to the Trust.

6. Conclusion

6.1 The CQC have undertaken focused inspection processes at Forest House, Oak ward, Warren Court and Victoria Court. Learning and sharing from each of the processes is considered at the weekly Delivering Safe, Quality and Effective services groups, chaired by the Executive Director, Quality and Safety (Chief Nurse).

6.2 The Trust is committed to continuing to provide high quality, safe services. The Trust's Quality Assurance Visits provide data and intelligence on areas requiring further development, any immediate action and sharing as examples of good practice. A series of 'mock inspection visits', targeted external visits focusing on preparation for further inspections are in place. This acts to provide additional information and assurance on our services, whilst also supporting staff in their preparations for future CQC inspections. This is supplemented by the visits provided by the Commissioners.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 9
Subject:	Learning from National Incidents	**For Publication:** Yes
Author:	Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)	**Approved by:** Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)	

Purpose of the report:

This paper follows the recently broadcasted BBC Panorama and Dispatches programmes and outlines the response the Trust has taken to the issues raised and the next steps.

Action required:

The Board is asked to note the content of the paper.

Summary and recommendations to the Board:

The BBC Panorama and Dispatches programmes showed service users receiving poor care and practice whilst at Greater Manchester Mental Health NHS Foundation Trust and in Essex Partnership University Trust respectively. The report also reflects on the BBC Panorama programme that described how individuals with a learning disability, were not having their physical health needs met when in acute general hospitals.

The paper provides a brief regarding the immediate national response and more locally as a Trust and details the next steps required to be confident that that the services provided are consistently safe, effective, of a high quality and maintain the standards that those who use the services would expect. Also, that the voices of both service users and carers are being heard. This includes staff conduct and behaviour, and staff consistently displaying the Trust values.

The Board are asked to note and consider the content of the paper.

Relationship with the Business Plan & Assurance Framework:

This report sets out how the Trust is performing against Business Plan Priority 1.

Summary of Implications for:

There are currently no known financial implications arising from this report.

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

This report seeks to ensure that there are no implications for service users and carers.

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

CQC Essential Standards and the Safe KLOE

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

Executive Team 5 and 12 October 2022
IGC 10 November 2022

1. Introduction

1.1 This paper follows the BBC Panorama and Dispatches programmes broadcast in the past six weeks, which showed service users receiving poor care and poor practice whilst at Greater Manchester Mental Health NHS Foundation Trust and in Essex Partnership University Trust respectively. The report also reflects on the BBC Panorama programme that described how individuals with a learning disability, were not having their physical health needs met when in acute general hospitals.

1.2 The programmes showed several issues and concerns, including:

- Poor practice – including restrictive practice settings
- Lack of care and compassion
- Not hearing service user and carer voices
- Lack of leadership
- Non-adherence to professional codes
- Lack of supervision
- Poor record keeping
- Lack of senior and clinical management visibility
- Lack of activities being provided for service users
- Poor environments
- Lack of peer reviews
- Physical health needs not being met.

1.3 This paper outlines the response the Trust has taken to the issues raised and next steps.

2. National Response

2.1 Nationally, the Directors of Mental Health, Learning Disability and Autism have set out the urgent consideration about what more can be done nationally, with regulators and the NHSE inpatient quality programme. This is whilst recognising that local providers have a responsibility to assure themselves that this is not happening in their services.

2.2 In her letter dated 30 September 2022 to all Mental Health, Learning Disability and Autism provider Chief Executive Officers (CEO), the National Mental Health Director, Claire Murdoch, stated that *"organisations who place the voice of people and families at the heart of their governance, service design and delivery and who have the mindset of this could happen here are those most likely to identify and prevent toxic and closed cultures."*

3. Trust Response

3.1 Following the programmes, a communication was sent from the Trust's CEO, Karen Taylor, to all Trust staff, reflecting on the content and expressing her view of the importance of talking about the issues raised in the Trust. The communication acknowledges the high-quality care provided and delivered, in line with the Trust's values, and the knowledge that staff will continue to both place service users at the heart of everything, and to listen to what they themselves and their families are telling about their experience and care.

3.2 It was acknowledged that incidents do happen, and that staff must continue to report these; and that the Trust, as a learning organisation, will continue to improve and make things better.

3.3 All staff were asked to use this opportunity to not walk by anything they feel is not in line with the Trust values, or where practice falls short. To continue to speak up, raising issues with line managers, contacting Karen directly, with an Executive Director or with the Trust's Freedom to Speak Up (FtSU) Guardian or one of the FtSU Champions.

3.4 Shortly after the first Panorama programme was broadcast, a discussion was held with the Executive Team and at the Trust's Board meeting, providing confidence in the good governance, scrutiny and monitoring and the positive experience for service users.

3.5 A session was subsequently held with the Trust's Senior Leadership Team (SLT), with group discussions and feedback collated, identifying key areas of focus noted by those present. Individual pledges were also made by members of the SLT regarding the action they were taking. A follow up discussion was held with the Trust's Executive Team, to agree the next actions and steps to take across the organisation.

3.6 The Executive Director Quality and Safety (Chief Nurse) Jacky Vincent, wrote to all Clinical Matrons, to remind them of the importance of consistently providing and maintaining standards in the inpatient services. Furthermore, to ensure that, as clinical leaders, they are receiving assurances, responding to any issues, and providing the necessary visibility and leadership on ensuring standards are maintained.

3.7 Local engagement with individual service users receiving inpatient care provided an opportunity discuss and reflect on the programmes.

4. Governance

4.1 The Trust's governance and assurance regarding the use of Restrictive Practice – including restraint, Long-Term Segregation (LTS) and seclusion – has continued. This includes individual frequent and regular monitoring and review, reporting into the Strategic Business Units (SBU) Quality and Safety meetings and, the Trust's Restrictive Practice Committee. A further review of individual cases also been undertaken by the Trust's Deputy Medical Director, and with oversight from the SBU's senior leaders.

4.2 An assessment against the Mental Health Act (MHA) Code of Practice (CoP) regarding seclusion was completed, confirming that the Trust's practice is compliant. This has been reported to and considered by the Integrated Governance Committee.

4.3 The Trust assesses and audits the environments, with regards to ligature risk and management, and undertakes daily checks on the emergency equipment on all areas. Furthermore, a series of mock ligature calls were held in inpatient services to ensure that staff were clear about where the required emergency equipment is held, and their response time with all required equipment to an incident.

4.4 The Trust reviews every Absent Without Authorised Leave (AWOL), and has established a Task and Finish group, led by the Trust's Head of Safety, considering any themes with risk assessment and management.

5. Next steps

5.1 The Trust needs to be confident that that the services provided are consistently safe, effective, of a high quality and maintain the standards that those who use the services would expect. Also, that the voices of both service users and carers are being heard. This includes staff conduct and behaviour, and staff consistently displaying the Trust values.

5.2 Prioritised areas of focus are overseen by the SLT and members of the Executive Team, including strengthening:

- A culture of empathy and compassion
- The service user and carer voice and positive experience
- Peer reviews of restrictive practice and settings
- The least restrictive practice and settings
- Local leadership.

5.3 The communication from Claire Murdoch asks all Mental Health, Learning Disability and Autism providers to urgently undertake actions to ensure that the behaviours and actions in the programmes are not present in our own services. All of these are being addressed within the Trust, for example the Trust's FtSU arrangements and reviewing LTS and seclusion, supporting out of restrictive settings.

5.4 A series of sessions have been held with members of the SLT and other local leaders in the service areas across the Trust, to reflect on the three programmes. These sessions look at a caring and compassionate culture, anchoring back to the Trust's values.

5.5 In addition to both Executive and Non-Executive Director visits, the already established Quality Assurance visits, an increase in SLT visibility in the service areas and unannounced visits within the SBUs will continue to provide curiosity and challenge and the opportunity to enable and empower confidence in the services provided.

5.6 The Trust's most senior clinical leaders have started to work periodic shifts alongside the frontline staff in their services.

5.7 The forums where practice is reviewed and analysed will critically challenge – with curiosity and compassion – the data, the practice, the learning and any areas of improvement and development.

5.8 The Integrated Governance Committee and Board will receive updates on the actions undertaken to enable them to be assured and monitor progress.

6 Conclusion

6.1 This paper has provided a brief regarding the issues and concerns raised in the three recently aired programmes relating to the services provided in mental health services and for people with a learning disability in the acute general hospitals.

6.2 The paper has also provided headlines regarding the immediate actions from the Trust in response to the concerns and the next stages.

6.3 The Board is asked to note and consider the report.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 10
Subject:	Report of the Integrated Governance Committee held on 10 November 2022	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting on 10 November 2022.

Action required:

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

Summary and recommendations to the Board:

An overview of the work undertaken is outlined in the body of the report.
There were no items for formal escalation to the Board.

The Board are asked to note that:

- the Committee and the Finance and Investment Committee supported the business cases for Female Forensic Learning Disability service, noting that it would be considered by the East of England Provider Collaborative
- the Committee agreed the process to undertake a self-assessment of effectiveness.

Relationship with the Business Plan & Assurance Framework:

List specific risks on BAF – 1.1, 1.2, 2.1, 5.3

Summary of Implications for:

None

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

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Integrated Governance Committee held on 10 November 2022

1. Introduction

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

1.2 Since the last Integrated Governance Committee ("the Committee") report to the Trust Board in Public, the Committee held a meeting on 10 November 2022 in accordance with its terms of reference and was quorate. Diane Herbert, Non-Executive Director, chaired the Committee.

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

2. Quality and Safety of services

2.1 At the meeting, the Committee discussed a number of reports regarding the quality and safety of the Trust's services, against the backdrop of recent media interest and increased Care Quality Commission (CQC) regulatory activity.

2.2 In particular, the Committee were assured regarding the Trust's compliance with the Seclusion Code of Practice. It was noted that seclusion is a not about a room or space but is a planned approach to supporting individuals who are presenting with behaviours which are challenging. The Committee noted the desire for early intervention to enable the least restrictive practice and prevent the use of seclusion. The Committee, at a future meeting, will receive an update on the progress with Respect training compliance.

2.3 The Committee discussed the quarter two Integrated Safety Report, noting the decrease in Serious Incidents and increase in the total number of incidents, in particular an increase in medication incidents. The Committee were updated that although further analysis was required, there were issues reported relating to storage and supply of medication.

2.4 The Committee discussed the change of approach by the CQC. Several mental health providers are seeing the CQC undertake a number of focused inspections in response to concerns raised and analysis of data. The Committee noted the recent CQC regulatory activity at the Trust that was in line with this risk focused approach. It was noted that the Trust was awaiting feedback from the CQC regarding inspections at Oak ward, Warrant Court and Victoria Court. The Committee discussed the Trust's systems to visit areas and identify issues prior to any CQC inspection and so that the Trust can be assured on the quality of services.

3. Our People

3.1 Building on the presentation at the last Committee meeting on nurse recruitment, members discussed the latest position with regarding recruitment and retention of staff. The Committee noted the positive signs for October, which saw positive net recruitment and reduction in vacancies.

3.2 The Committee discussed the outcome of the Royal College of Nursing (RCN) ballot on industrial action and that the outcome of the UNISON ballot is expected after 25 November 2022. The Committee were updated on the planning underway at the Trust and regionally, noting that the Board will receive an update at their meeting at the end of November 2022.

3.3 The Committee noted the quarterly Workforce Disability Equality Standards (WDES) and Workforce race Equality Standards (WRES) data. It was reported that the disciplinary data is based on a small number of cases and will be analysed by the Black Asian Minority Ethnic (BAME) network and the Trust's People and Organisational Development Group (PODG).

3.4 The Committee discussed the importance of staff feeling and being able to raise their concerns directly with the Trust. The Committee noted that the quarter two Freedom to Speak Up report reported an increase in referrals compared to same period last year. The Committee welcomed the increased visibility of the Freedom to Speak Up Guardian and importance of 'closing the loop' on learning and feedback to the referrer. The importance of hearing the concerns of staff and 'the whispers' from operational services was emphasised and the need for the Trust to continue to have a culture that welcomes the raising of concerns. The Committee were updated on work underway with teams at all levels to support them raising concerns and focus on engagement with staff to encourage inclusion and belonging.

4. Use of Data

4.1 A theme of the meeting was how the Committee uses data and information across its areas of responsibilities. The importance and added value of triangulating information from a range of sources was highlighted. It was reported that the quality dashboard was being piloted and would be demonstrated to Committee members in early 2023.

4.2 In response to Jon Walmsley's question, the Committee were informed that the Trust would be implementing a SPC approach to all its formal Committee and Board reports. This approach was welcomed, and it was noted that this would start to play through to Committee papers in 2023.

4.3 It was confirmed that Board members would receive a briefing and training to support the implementation of the new Patient Safety Incidence Response Framework (PSIRF).

5. Risk Management

5.1 Committee members considered the latest Trust Risk Register and the new approach to the Board Assurance Framework (BAF). Committee members reported that they supported the Strategic risks as set out for the BAF and endorsed the new approach as set out. It was noted the Board at its meeting November 2022 would be asked to approve the Strategic risks.

5.2 The Committee had a detailed discussion regarding the interface between the Trust Risk Register and BAF. It was identified that members would find it helpful to understand how risk management is approached at the Trust, and how they can be updated on the trends and themes from the SBU risk registers.

6. Matters for Escalation to the Board

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

6.2 It was noted that:

- the Committee and the Finance and Investment Committee supported the business cases for Female Forensic Learning Disability service, noting that it would be considered by the East of England Provider Collaborative
- the Committee agreed the process to undertake a self-assessment of effectiveness.

Appendix One: Integrated Governance 10 November 2022, agenda items

Apologies for absence
Declarations of Interests
Minutes of meetings held on 15 September 2022
Action Schedule
DEEP DIVE
Quality and Safety of our Services
QUALITY AND SAFETY
Seclusion – Code of Practice
Quarter Two Integrated Safety Report
Freedom to Speak Up
CQC Regulatory Activity
Patient Safety Incident Response Framework
Bi-Annual Safeguarding report
PEOPLE
Quarter Two People and OD Report
Quarter Two Safe Staffing
Quarter Two Guardian of Safe Working
QUALITY EFFECTIVENESS
CQUIN Update
CAS Alerts
Annual Nutrition Report
QUALITY EXPERIENCE
Quarter Two Experience report
Female Forensic Service
GOVERNANCE AND REGULATION
Trust Risk Register
Board Assurance Framework
Proposal for review of Committee's effectiveness
TO NOTE
Bi-Annual Caldicott Report
Quarter Two Information Governance Incidents/ SARS/ FOI
Bi-Annual Infection Prevention and Control Report
Report from PODG dated 7 September 2022 and 3 October 2022
Report from QRMC dated 4 November 2022
Report from IMGS dated 24 October 2022
National Audits Evidence Report
Annual Mental Health Legislation Report
Committee Planner
Matters for escalation

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 10a
Subject:	Quarter 2 2022/23 Integrated Safety Report	**For Publication:** Yes
Authors:	Bina Jumnoodoo, Deputy Director Nursing and Quality John Fanning, Head of Safety Nikki Willmott, Head of Safer Care and Standards Karen Hastings, Head of Social Work & Safeguarding	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

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

Action required:

Receive: To discuss the report and its implications for the Trust.

Summary and recommendations:

Feedback from IGC

This report was considered at the Integrated Governance Committee meeting held on 10 November 2022. The Committee discussed increases incidents and reduction in SIs. The reasons for the increase in medication incidents was also discussed.

Committee members noted the Trust's commitment to move to Statistical Process Control (SPC) reporting and discussed the best approach with regard to triangulation of information.

Headlines from the quarter

The number of incidents reported on Datix has increased by 15% from 2,589 to 3047:

- Incidents categorised as *moderate harm* continued to decrease from 77 to 74
- Incidents categorised as *severe harm* reduced from by one, to four
- 27 Serious Incidents were reported external to the Trust, a decrease of four
- Unexpected or avoidable deaths remain the largest category of Serious Incidents, with 19 reported, an increase of five
- Serious Incidents relating to self-harm reduced from nine to six
- 122 deaths were reported, a decrease of 17; the highest numbers reported in the East and North SBU, which includes older age adult services
- Three Covid19 confirmed or suspected deaths were reported
- There was a 38% increase in medication incidents
- There were five RIDDOR incidents, a reduction from nine.

In preparation for the transition to the Patient Safety Incident Response Framework (PSIRF) within the next 12 months, work has been undertaken with Herts and West Essex Integrated Care Board to close Serious Incidents on StEIS.

Two more safety suites were completed at Astley Court and Beech Ward and work continued on building safety suites at Lexden and Oak Ward. Two High Dependency Unit bedrooms at Forest House were completed.

The Trust received a Prevention of Future Deaths report following the inquest of a young person open to CAMHS who died by suicide in 2019. The matters of concern relating to the Trust included risk assessment training, communication and threshold criteria for the high-risk pathway. The Trust responded to the coroner within the requested timescales, confirming the actions and additional measures the Trust has taken in relation to the matters raised in the PFD, to provide the required assurance.

The Eastern Academic Health Science Network Reducing Restrictive Practice Continuous Quality Improvement project was introduced in Lexden, Dove ward and Forest House following a pilot in Astley Court.
Work has been undertaken in response to the learning from previous quarters with particular focus on racial abuse, violence and aggression, sexual safety, and restrictive practice.

There has been a focus in improving sexual safety with the development of a sexual safety work plan.

Assaults from service users to staff remain comparable to the previous quarter. A Violence and Aggression CQI project commenced to address this with input from service users, carers, staff side, front line workers and police and other stakeholders.

Seclusion incidents continue to reduce, with a 13% reduction. A task and finish group was commissioned to focus on the practice of seclusion and adherence with the Code of Practice within the Trust. This group will report back in quarter 3 with findings and proposals.

The Board is asked to receive and discuss the report and its implications.

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

Relation to the Trust Risk Register:
The Trust's Risk Register has a number of risks that relate specifically to safety which are reported in the quarterly Trust Risk Register Reports.

Relation to the BAF:
1. We will provide **safe** services, so that people feel safe and are protected from avoidable harm.
2. We will deliver a great **experience** of our services, so that those who need to receive our support feel positively about their experience
3. We will improve the health of our service users & support recovery through the delivery of **effective** evidence-based practice
4. We will **improve, innovate, and transform** our services to provide the most effective, productive, and high-quality care
5. We will deliver **joined up care** to meet the needs of our service users across mental, physical and social care services in conjunction with our partners

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

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

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

There are no implications arising from this report.

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

This report sets out actions taken in quarter 2 2022/23 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

This report has been presented to the QRMC on 4 November 2022 IGC 10 November 2022

Quarterly Integrated Safety Report Quarter 2 2022/23

Executive Summary

This report provides an overview of safety including incidents, mortality, harm free care, restrictive practice and safeguarding. It also provides a review of trends, themes and identified learning setting priorities for the work in subsequent quarters.

The Trust's annual plan objective for safety is:

We will provide safe services, so that people feel safe and are protected from avoidable harm

Key priorities were:

- *We will continue our drive to reduce suicides and prevent avoidable harm.*
- *Keep service users & carers physically and mentally safe, reducing the harm they experience*
- *Further develop our approach to managing violence and aggression & evidence-based restrictive practice*
- *Expand the training, development, and leadership of teams to keep our staff safe.*

This report is divided into the following sections:

- Part A Governance and assurance
- Part B Analysis of Incidents
- Part C Learning, Changing Practice and Priorities.

Part A- Governance and Assurance

1. Introduction

1.1 The Integrated Governance Committee (IGC) receives and scrutinises all aspects of safety on behalf of the Trust Board throughout the year. It conducts deep dives into areas that are identified as requiring additional focus and reports to the Board any matters that require escalation, as well as recommending items for the Trust's Risk Register.

1.2 The Quality and Risk Management Committee (QRMC) reports to the IGC on the work of the QRMC and its subcommittees. The Safety Committee oversees all the work relating to safety and holds the safety risk register and reports into QRMC. Medicines safety, safe staffing, safeguarding, including sexual safety in the Trust's inpatient services, feeling safe. Infection prevention and control and health and safety related matters are addressed in other annual reports and so will not be addressed here. The Restrictive Practice Committee oversees all work relating to the use of restrictive practice within the Trust.

1.3 This report will also provide additional detail relating the objectives and achieving the outcomes within the Annual Plan.

2. Priorities

2.1 A number of priorities were set in relation to safety in the Trust's 2022/23 Annual Plan:

- *We will continue our drive to reduce suicides and prevent avoidable harm*
- *We will ensure restrictive practices across the Trust are in line with best practice*
- *We will target activities to reduce violence against services users and staff.*

2.2 These are reported in the Trust's Annual Plan report and this report will provide additional detail relating to how the Trust is working to deliver the objectives and achieve the outcomes.

2.3 The priorities are also supported by the safety domain of the Quality Strategy. The principles of just culture, learning and the service user as partner in their own care and treatment as well as service development through Continuous Quality Improvement (CQI) are fundamental to this approach.

3 Trust Risk Register

3.1 The Trust's Risk Register (TRR) is reviewed regularly and has a number of risks that relate specifically to safety reported to the Integrated Governance Committee.

4 Health and Safety Executive

4.1 Following the Health and Safety Executive (HSE) inspection in May 2019, an update report was presented separately to the IGC, regarding the regulatory notices which have been formally closed. These were as follows:

- Risk Assessment for violence and aggression to employees and those not in Trust 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 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 is 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 and aggression will be investigated.

5 Safety Alerts

5.1 There were 27 Central Alerting System (CAS) Alerts received during the quarter, which have been reviewed and the learning and actions taken forward, disseminating to the relevant services, and accompanied by changes to policy and practice, where required.

5.2 None of these alerts were applicable to the Trust.

5.3 There were four Internal Safety Alerts issued by the Trust. These were following learning from incidents either within the Trust or externally and are detailed as follows:

- HPFT/2022/13 Imposter Agency Staff Safety Alert
- HPFT/2022/14 Lanyard Snatch Incident
- HPFT/2022/15 Hidden Blades
- HPFT/2022/16 Covid 19 - Lessons Learned.

6 Care Quality Commission

6.1 Following the Care Quality Commission's (CQC) unannounced inspection at Forest House Adolescent Unit in November and December 2021, the CQC undertook a re inspection at Forest House on 6 and 7 July 2022.

6.2 Following this re-inspection, the Trust was issued with a further Section 29a Warning Notice in relation to the provision of call bells for the young people and not consistently searching and clear rooms used for seclusion prior to the young people being secluded.

6.3 The Trust made a representation against this warning notice, which was upheld by the CQC, and the Warning Notice was consequently withdrawn based on the following:

- The Trust recognised that not having call bells for young people could present risks, that practice may be unsafe and therefore the Trust has taken the decision to install call bells.
- The CQC accepted the Trusts explanation that the agreed approach to seclusion could include secluding young people in whichever room is closest to the incident and that the intervention includes a full risk assessment of young people as part of their individualised care. Forest House now has a specific seclusion protocol in place.

6.4 The Trust is currently awaiting the final report from the CQC.

7. CQC Insight Report

7.1 The CQC Insight tracks trends in quality at provider, location and/or core service level to support decision making. It aims to make it easier for inspectors to monitor their portfolio and identify potential changes in quality with routine access to key information. It will also contribute to a shared view of quality across services.

7.2 The last CQC insight report was published on 16 May 2022 and there has been no report published this quarter.

7.3 For the data period April 2021 to March 2022, the CQC Insight report identified that, above or equal to 50% of CAS, had been closed late by the Trust:

- Two overdue alerts related to medicines management, requiring separate action plans and significant work which resulted in alerts going beyond deadline for completion
- One alert took longer than expected to close as clarity was sought from the Electroconvulsive Therapy (ECT) suite on the actions that had been taken
- Three alerts were interlinked and, once the first alert had been closed as not applicable, the other two should have been actioned without delay to confirm that these were also not applicable.

7.4 Following a review and the learning from the data period and the lateness of closing alerts, the following actions were implemented moving forwards:

- All alerts issued by CAS with a deadline are added to Outlook as a reminder for the Compliance and Risk Manager and Safer Care and Standards Facilitator
- The Safety Committee receives a quarterly safety alerts report, noting any alerts beyond deadline and the rationale and the agreed action with timeline and lead. This is added as a standing agenda item for monitoring every month.

7.5 The CQC Insight Report has confirmed via email that, in the latest data yet to be published (September 2021 to August 2022), the Trust is no longer flagging for this indicator. There are currently no alerts beyond deadline.

8. Conclusion

8.1 This section of the report has set out how the IGC is receiving assurance in relation to safety and how all intelligence relating to safety is triangulated effectively.

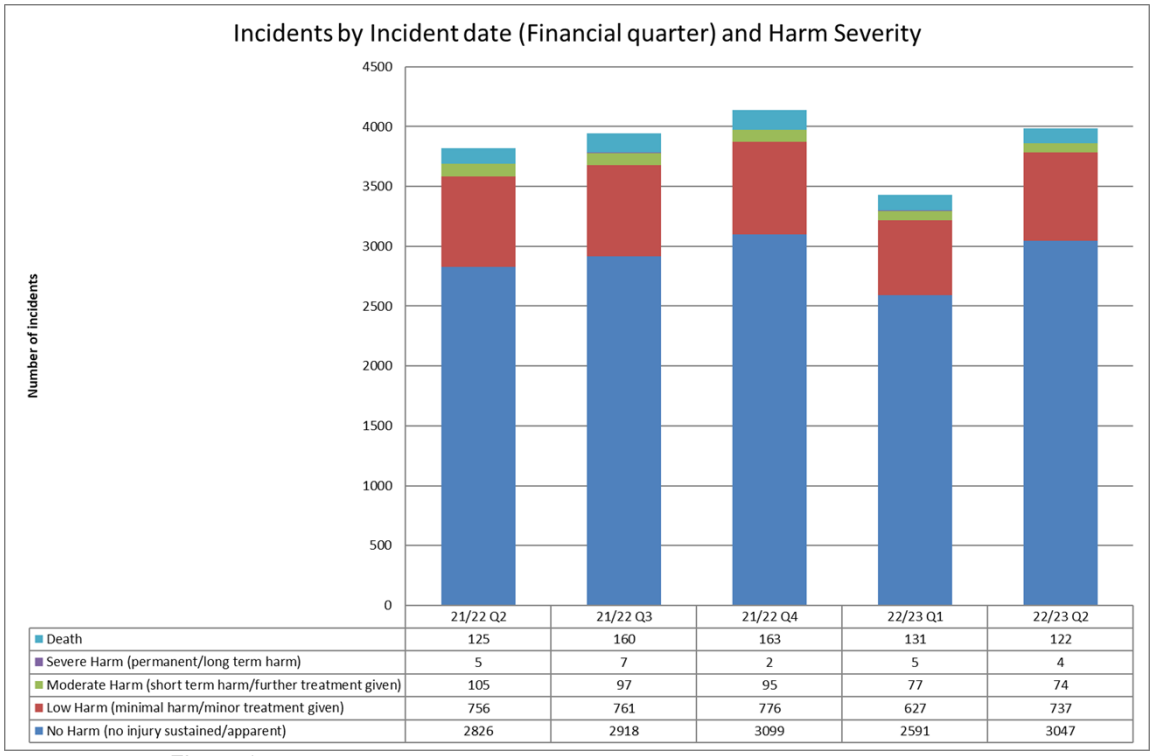
Part B- Incidents, including Serious Incidents

1. Introduction

1.1 Part B considers incidents, including Serious Incidents (SI), with an overview of reporting trends and themes, as well as severity of harm. It also includes how the Trust meets its reporting requirements in relation to Duty of Candour, mortality governance, suicide rates and Never Events.

2. Incidents

2.1 The number of incidents reported on Datix has increased by 15% (*figure 1)* from 2,591 to 3,047. Incidents categorised as *moderate harm* continued to decrease from 77 to 74. Incidents categorised as *severe harm* reduced from five to four. The weekly Moderate Harm Panel continues to review incidents resulting in moderate harm and above to identify immediate learning and agree actions required and those that meet criteria for reporting as an SI.



	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2
Death	125	160	163	131	122
Severe Harm (permanent/long term harm)	5	7	2	5	4
Moderate Harm (short term harm/further treatment given)	105	97	95	77	74
Low Harm (minimal harm/minor treatment given)	756	761	776	627	737
No Harm (no injury sustained/apparent)	2826	2918	3099	2591	3047

Figure 1

Never Events

2.2 The Trust had no incidents that would meet Never Events reporting criteria.

Eliminating Mixed Sex Accommodation (EMSA)

2.3 There were no reported breaches this quarter.

Medicines Safety

2.4 There were 201 reported medication incidents an increase of 38%. 164 were internal to the Trust, 159 (97%) resulted in *no harm,* four (2.4%) resulted in *low harm*. One incident was classified as *moderate harm*. 37 medication incidents were external and reported to the Trust, for example a medication error in a care home.

2.5 Administration incidents remained the top sub-category of those reported (*figure 2*).

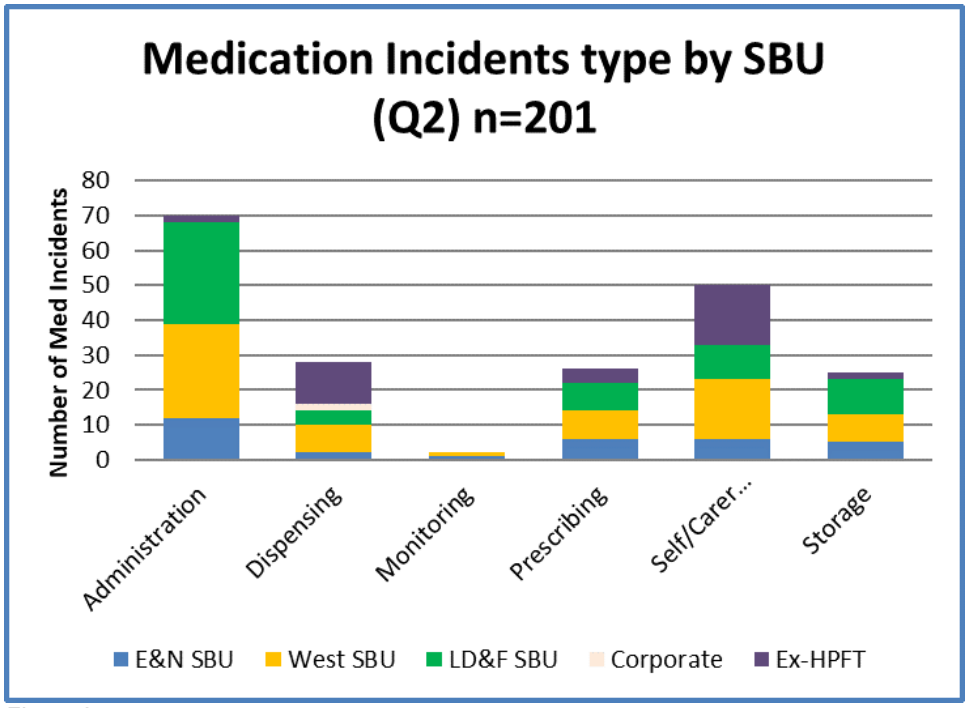


Figure 2

Serious Incidents

2.6 27 SIs were reported external to the Trust on the NHS Strategic Executive Information System (StEIS) (*figure 3*), a reduction of four.

2.7 19 unexpected or avoidable deaths were reported (an increase of five) as the largest category of SIs. SIs relating to self-harm reduced from nine to six.

2.8 Analysis indicates themes including:

- Safety plans for service users at increased risk of harm whilst awaiting an initial assessment (IA)
- Engagement with service users following discharge
- Discharged service users after repeated 'did not attend' (DNA)
- Communication with CGL regarding dual diagnosis and self-referral of service users
- Telephone/virtual contact.

2.9 A learning note was disseminated to all services for discussion at their Patient Safety meetings and Quality and Risk meetings to raise awareness of these themes and actions to take to reduce risk.

2.10 The actions from SIs are discussed at weekly meetings with each of the SBUs and feedback monthly at the Safety Committee. A summary of learning from SIs is also presented by each SBU quarterly at the Safety Committee.

2.11 A monthly action review and learning group has been convened, co-chaired by the Executive Director, Quality and Safety (Chief Nurse) and the Executive Director Quality and Medical Leadership to discuss all actions identified and associated learning from SI, Swarms, Structured Judgement Reviews (SJR), Prevention of Future Deaths (PFD), Freedom to Speak Up (FtSU) and Article 2 inquests, which is where the coroner believes there was a real or immediate risk to life that was known or ought to have been

known .It means the inquest scope is wider and the coroner will consider any systemic issues which caused or contributed to the death and state any failings in their conclusion.

2.12 Updates and actions arising form this group will be included in future reports.

Category	Q1 2022/23	Q2 2022/23
Unexpected or avoidable deaths	14	19
Disruptive, aggressive or violent behaviour	5	2
Apparent, actual or suspected self-inflicted harm	9	6
Slip, trip or fall	1	0
Apparent, actual or suspected homicide	1	0
Practice/Clinical care	1	0
TOTAL	31	27

Figure 3

2.13 31 SI reports were completed and submitted to Trust Commissioners. Actions plans are put in place to address key learning points. Weekly meetings are held with each SBU to record progress with implementation of learning on Datix supported by the Safer Care Team. Learning has informed the Safe and Supportive Observations, Risk Assessment, and Carers Continuous Quality Improvement (CQI) projects. East and North SBU have recruited additional Practice Governance staff to support implementation and embedding of learning.

2.14 In preparation for the transition to the Patient Safety Incident Response Framework (PSIRF) within the next 12 months, work has been undertaken with Herts and West Essex Integrated Care Board to close Serious Incidents on StEIS. A separate report shall be provided detailing the plans and progress.

3 Mortality

3.1 All deaths that are reported continue to be screened each week and those that meet red flag criteria undergo a SJR. There were 38 deaths in July, 46 in August and 38 in September. This is still a higher average per month than the average pre-pandemic levels.

3.2 To support the management of SJRs, the initial screening of deaths was prioritised, with 92 deaths screened. At the time of this report, 29 deaths in September are yet to be screened, which falls within the stipulated ‘initial screening within four weeks of death’, as per policy.

3.3 The Cause of Death for most of the deaths were not available at the time of reporting to provide a breakdown, therefore the reason for the peak is unclear. This is likely to be

partly due to better reporting of deaths from the Spike indicator on 'possible deaths', however it is not possible to attribute the total increase to this. Some deaths are for people who died soon after being referred, therefore were not receiving care by the Trust at the time of their death.

3.4 122 deaths were reported (*figure 4*), a decrease of 17. The highest numbers of deaths reported were in the East and North SBU, which includes older age adult services. There were three Covid-19 confirmed or suspected deaths.

	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	Total
East and North SBU	86	102	105	91	75	457
Essex & IAPT SBU	14	14	17	13	16	71
LD&F SBU	6	18	12	14	8	58
West SBU	19	26	28	21	23	117
Total	125	160	162	139	122	703

Figure 4

Structured Judgement Reviews

3.5 Training was delivered by the Mortality Governance Lead Consultant to five Consultant Psychiatrists to support with SJRs. There were 20 SJRs completed, which included deaths that occurred outside of this reporting period. Key learning themes identified were:

- Documentation
- Handover of care
- Physical health
- Medication
- Mental Health Act (MHA).

3.6 Details of learning themes are disseminated through governance structures within the SBUs and the Physical Health Committee. Mortality Governance was incorporated into the monthly medical continuing professional development (CPD) programme. Good Practice in Record keeping virtual sessions were held jointly with the Nursing and Midwifery Council (NMC) and the Mortality Governance Lead, which attracted over 200 nursing staff. The session included learning from SJRs on documentation.

3.7 The Learning from Deaths Group was re-established and meets six weekly, overseeing actions taken in response to the recommendations, actions planned and an assessment of the impact of actions taken by the SBUs, as a result of the learning identified

Learning Disability Mortality Review

3.8 There were 16 deaths of service users known to the Trust's learning disability services reported to the national Learning Disability Mortality Review (LeDeR) programme.

3.9 The Trust is supporting a strategic objective from the Hertfordshire LeDeR steering group to provide training through e-learning on pain assessment in people with a learning disability, including those who have dementia. This follows a CQI initiative led by the Trust's physical health nurse.

3.10 Training needs in epilepsy have been explored following learning from LeDeR and a suite of resources are now offered to staff with good attendance from nursing staff in the Learning Disability and Forensic SBU.

Suicide

3.11 There were nineteen deaths thought to be as a result of suicide (*figure 5*), an increase of two compared to the same reporting period last year. These figures are before the coroner has determined whether there was evidence on the balance of probability that deaths were as a result of suicide. To date, none of these deaths has been heard at inquest yet.

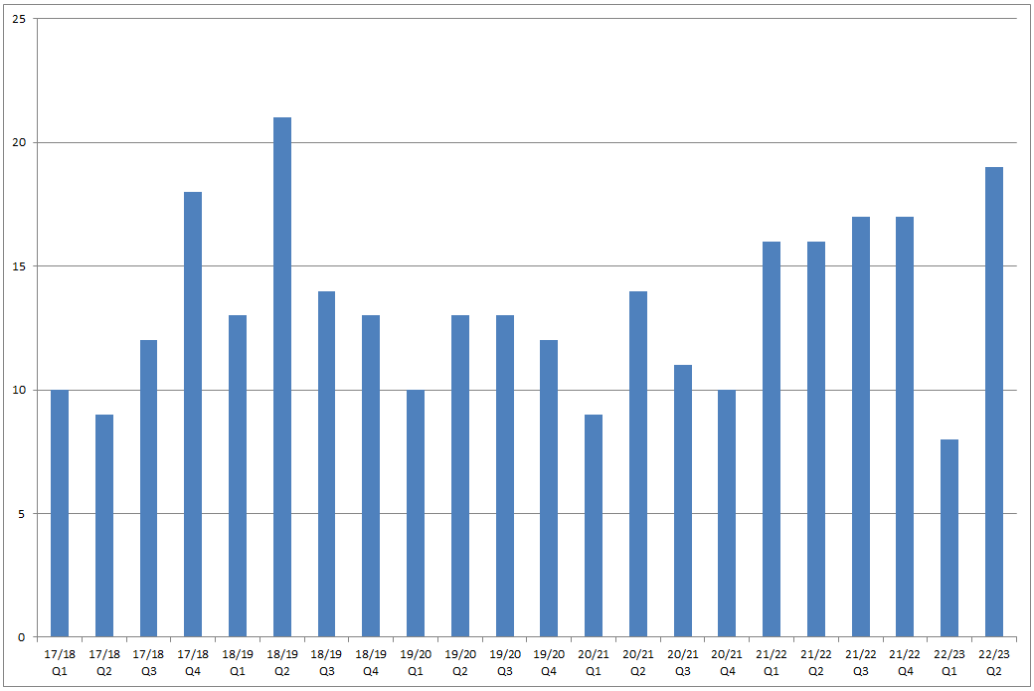


Figure 5

3.12 The Court of Appeal in 2019 ruled the standard of proof for requiring a suicide conclusion should be the civil standard (on the balance of probability) rather than the criminal standard (beyond reasonable doubt). The lowering of the threshold is expected to lead to an increase in deaths recorded as suicide and therefore data will not be comparable with previous years. As a result, only data from 2019/20 onwards will be reported.

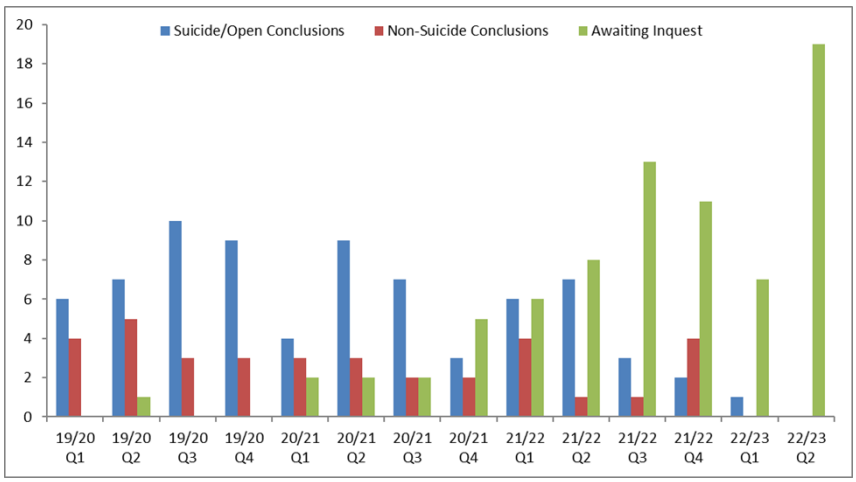


Figure 6

Prevention of Future Deaths

3.13 Whilst coroners continued to issue PFD reports, the Judiciary paused publication and dissemination whilst they upgraded their website. Publication and dissemination of PFDs will resume in quarter 3.

3.14 Learning from PFD reports will continue to be discussed at the Trust's Safety Committee and SBU Quality and Risk meetings. PFD reports also inform the Trust and wider system partners in suicide prevention work streams as well simulation and safeguarding training.

3.15 In August, the Trust and other agencies including the Royal College of Psychiatrists, Royal College of Paediatrics and Child Health, Health Education England and University College London Hospital NHS Trust, were all issued with a PFD report following the inquest of a young person open to the Child and Adolescent Mental Health Services (CAMHS) who died by suicide in 2019.

3.16 The matters of concern relating to the Trust included risk assessment and risk management training of new starters, communication of risk changes with GPs, the high threshold criteria for the high-risk pathway and communication between crisis team and CAMHS and absence of a hospital link worker to aid communication between the Trust and external agencies.

3.17 The Trust responded to the coroner within the requested timescales, confirming the actions and additional measures taken in relation to the matters raised, to provide the required assurance on learning and how the Trust will manage similar presentations in the future.

4 Least restrictive care

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

Restraint

4.2 *Figure 7* provides data regarding the use of restraint over the past four years. During this quarter, the data can be attributed to individual service users with complex needs at Lexden (43), Astley Court (73) and Forest House (157) and further exacerbated by the need for specialised services nationally.

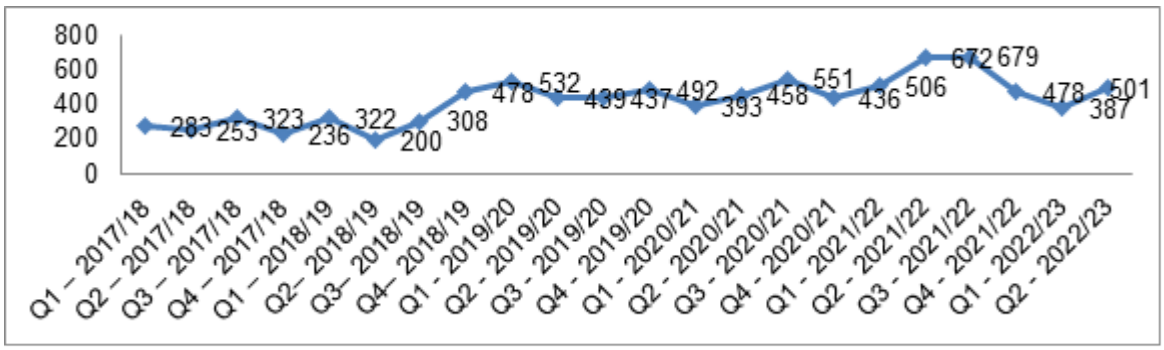


Figure 7

4.3 In consideration of the reported incidents relating to violence and aggression, there is a correlation with a decrease in service user to service user assaults but an increase in service user to staff assault.

4.4 The RESPECT training recovery plan continues, although impacted by trainer vacancies. Recruitment continues with the inclusion of local trainers in the service areas to support the trajectory.

4.5 *Figure 8* provides data of all prone restraints. Although prone restraint is not taught as part of the restraint teaching methodology, the data includes the use by the police and incidental incidents whereby the service user either falling or placing themselves into a prone position before being repositioned into a supine position, in keeping with the Trust's training techniques. Hathor Ward reported two incidents and Warren Court one incident.

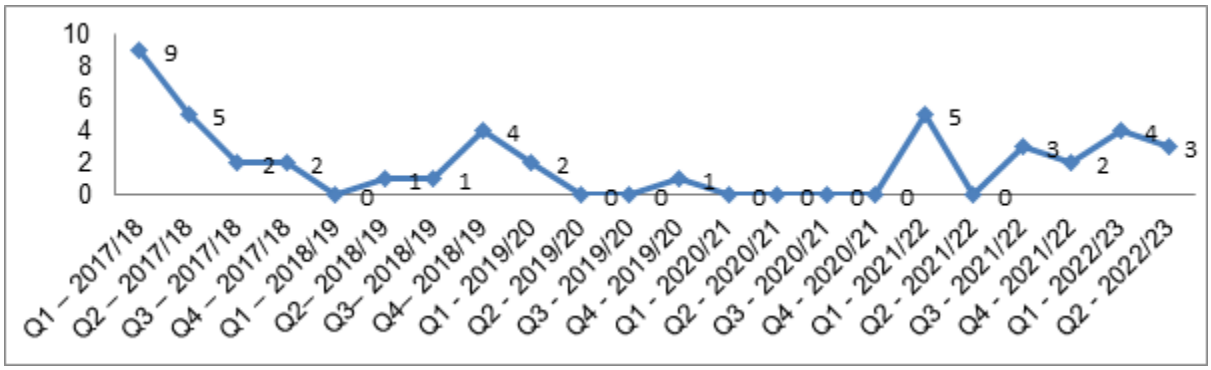


Figure 8

Seclusion

4.6 Seclusion is a restrictive practice where someone is confined, alone, in a room and is prevented from leaving. The length of time in seclusion, the number of seclusion and the practice in keeping with the Mental Health Act (MHA) and the Human Rights Act are all monitored, with the use of seclusion reviewed daily and audited on a monthly basis, both within the SBUs and the Trust's Restrictive Practice Committee. The Trust ensures it adheres to the MHA Code of Practice (MHA CoP), with the appropriate safeguards being used.

4.7 Following an increase in the previous (*figure 9*), there has been 13% decrease; 79 (77%) were within the Learning Disability and Forensic SBU. This data reflects the earlier restraint data, attributed to individual service users, owing to their complex needs and the need for specialised beds.

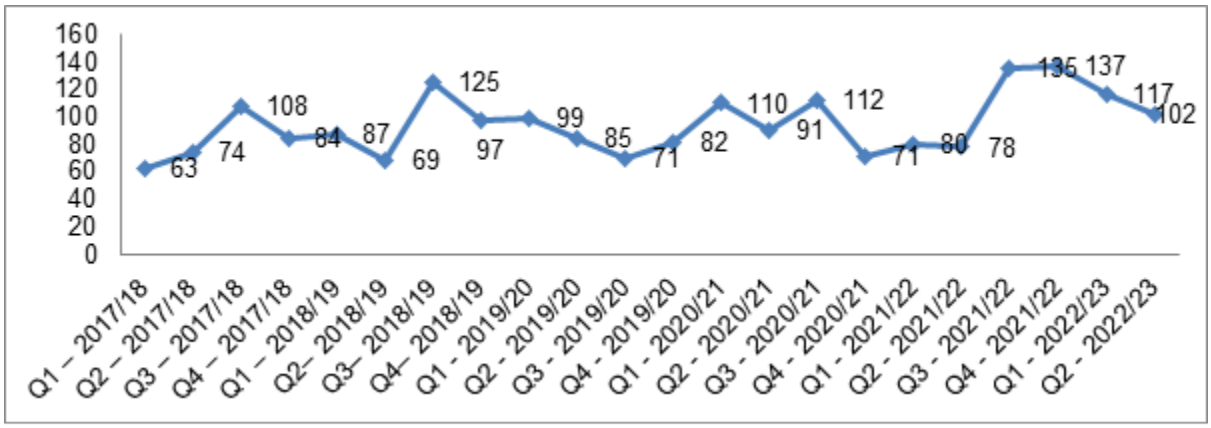


Figure 9

4.8 A task and finish group commissioned to focus on the practice of seclusion and adherence with the MHA CoP will report back in quarter 3 with findings and proposals. The IGC will receive a separate paper regarding the Trust's compliance with the CoP.

Long term segregation

4.9 LTS refers to a situation where, in order to reduce a sustained risk of harm posed by the service user to others, that is a constant feature of their presentation, a service user is cared for separately from others. All LTS reviews take place in line with the MHA CoP, including daily medical reviews, weekly MDT reviews, independent clinician reviews, and external hospital reviews as part of agreed procedural safeguards, that uphold Human Rights. As part of the national approach to monitoring the use of LTS within Trust's, all individual service users have a regular external Independent Care and Treatment Review.

4.10 *Figure 10* provides data regarding the numbers of individuals cared for under the LTS framework, with four applications this period; one individual was successfully discharged into a bespoke community placement.

4.11 The Barriers for Change Check has been used, as part of the HOPE(s) model, as well as a focus on positive and proactive approaches to reduce the level of restrictive practice.

Unit	Section	Start Date	End Date
2 Forest Lane (SRS)	3	18 02 2010	23 08 2022
Lexden	3	18 06 2021	
Warren Court	37/41	30 09 2021	
Robin ward	3	17 02 2022	
Astley Court	3	23 02 2022	
Hathor ward*	3	03 03 2022	03 08 2022
Dove ward	3	22 07 2022	
Swift ward	3	07 09 2022	
Hathor ward*	3	02 09 2022	
Beech ward	3	14 09 2022	

*Same Service User

Figure 10

Rapid Tranquilisation

4.12 RT is the use of medication to manage acute, behavioural disturbance by calming or slightly sedating an individual to reduce the risk of harm to self or others. *Figure 11* provides data over the past four years and an increase in this period.

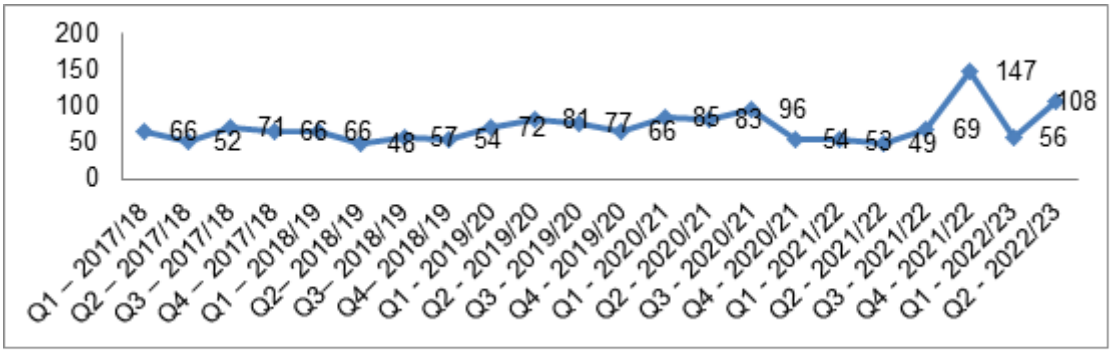


Figure 11

4.13 The MDT continue to ensure individuals are proactively supported and with proportional least restrictive practice. Associated work relating to the introduction of the National Early Warning Score (NEWS2) and the use of soft measures has supported post incident review after Rapid Tranquilisation as well as the use of Positive Behavioural Support (PBS) plans and pre-planned interventions. 36 of the reported incidents were attributed to Forest House.

4.14 As part of the ongoing governance procedures all clinical areas receive a clinical visit from a pharmacist who monitor RT prescriptions as part of their routine work. RT is included in the POMH-UK audit cycle.

5. Harm free mental health care

5.1 The Trust continues aiming to provide care where service user, staff and carers do not come to harm. In order to understand this and respond ligature incidents, Absent Without Leave (AWOL) incidents and violence and aggression incidents are considered.

Ligature Incidents

5.2 Ligature incidents can be anchor or non-anchor and take place in the community or in our services; the data in this report relates to inpatient services (*figure 12)*. There has been an increase in reported incidents within Forest House (35) and Robin ward (21) accounting for 67%.

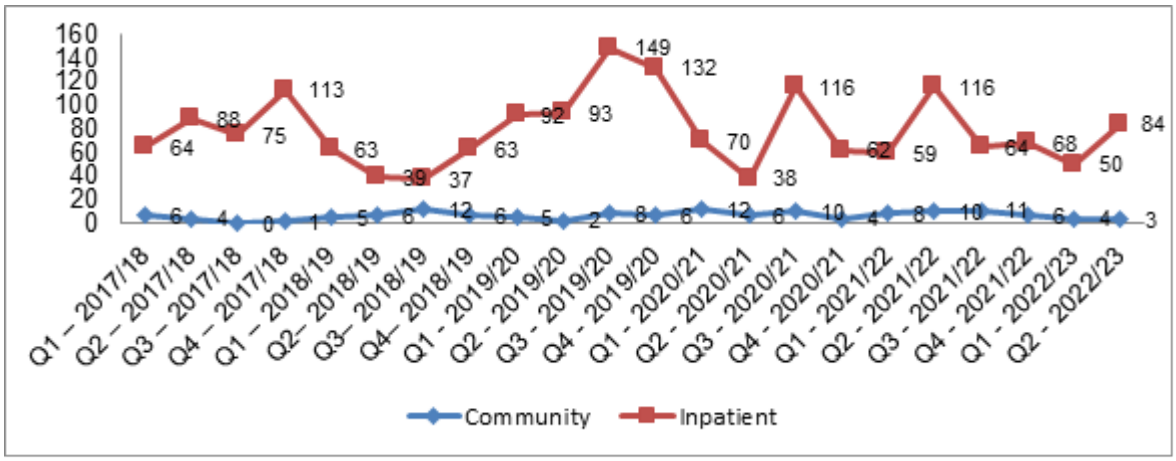


Figure 12

5.3 There were two attempted anchor point ligature incidents involving the same service user at Albany Lodge. Staff intervened and the incidents resulted in no harm. A broken table used by the service user to stand on in an attempt to place a ligature over the door was removed following the incident. Checks of other tables in use on the unit were made and all were found to be secured to the floor. Alternative doors were fitted following the incident as part of a planned replacement programme on the unit. There was also an attempted anchor point ligature incident involving a service user on Hathor ward. The anti-ligature soap dispenser came off the wall as per its design and resulted in no harm.

5.4 Ligature incidents using clothing remains the category with the highest number of incidents. An internal safety alert has been disseminated to remind staff of the need to remain vigilant around potential risk relating to ligatures using clothing. The Ligature Awareness Training was reviewed in quarter 2 and additional advice for staff on the use of ligature cutters has been included. The Trust has received a new supply of ligature cutters which include cordage cutters, wire cutters and cutters for sheets.

5.5 ANT, the review of environmental risk has further developed to improve assurance and evidence of reviews. This includes breaking the weekly audits down by SBU, so each area takes responsibility for their environment, with a lead, overseen by the Trust's Health and Safety Manager. An alternative electronic form is being introduced, allowing storage of all local weekly walk arounds and is also being applied to Community units on a monthly basis.

Absence Without Leave and Missing Persons

5.6 There has been an increase from 37 to 41 incidents of AWOL and Missing Persons incidents *(figure 13)*.

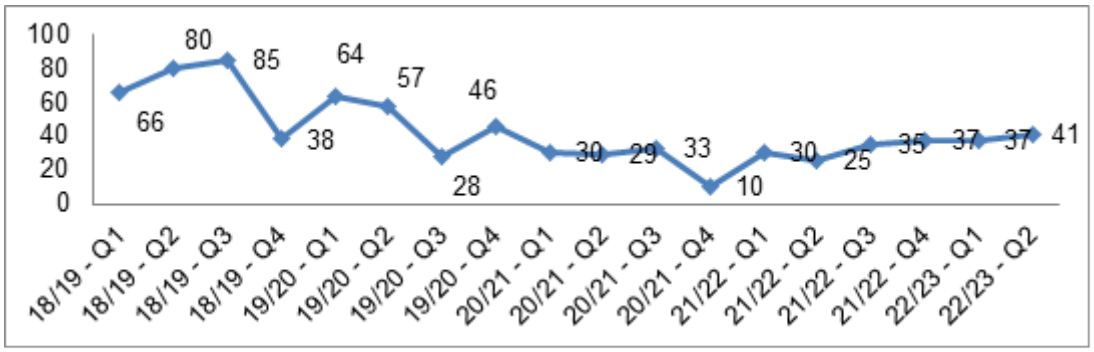


Figure 13

5.7 The quarter also saw an increase from 22 to 28 incidents whereby a detained service user either absconded or failed to return from Section 17 leave.

5.8 An AWOL CQI project will commence in Q3 with representation from HPFT inpatient staff and Hertfordshire Constabulary.

6. Violence and aggression

Service User to Staff Assaults

6.1 *Figure 14* shows an increase in the service user to staff assaults increasing year on year. The data in *figure 15* shows a correlation with restrictive practice data as previously discussed. There has been a nominal increase from 226 to 230 incidents with the three Learning Disability Assessment & Treatment Units accounting for 37% of the total incidents.

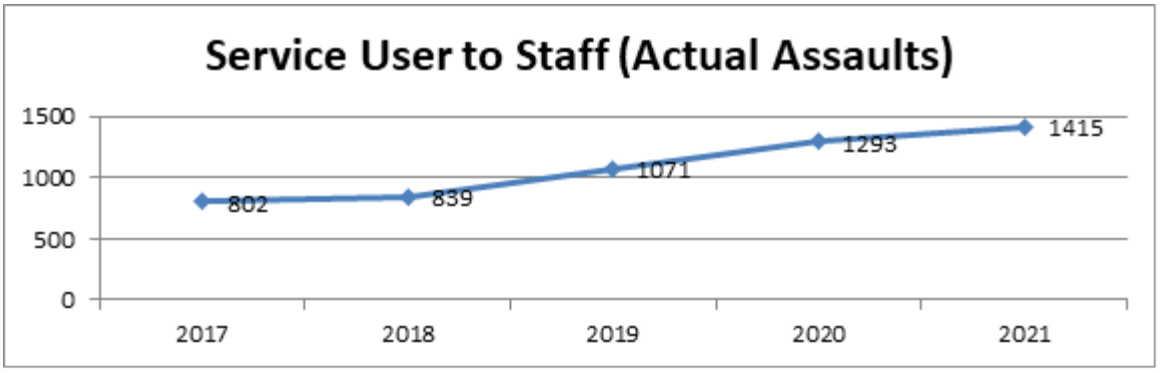


Figure 14

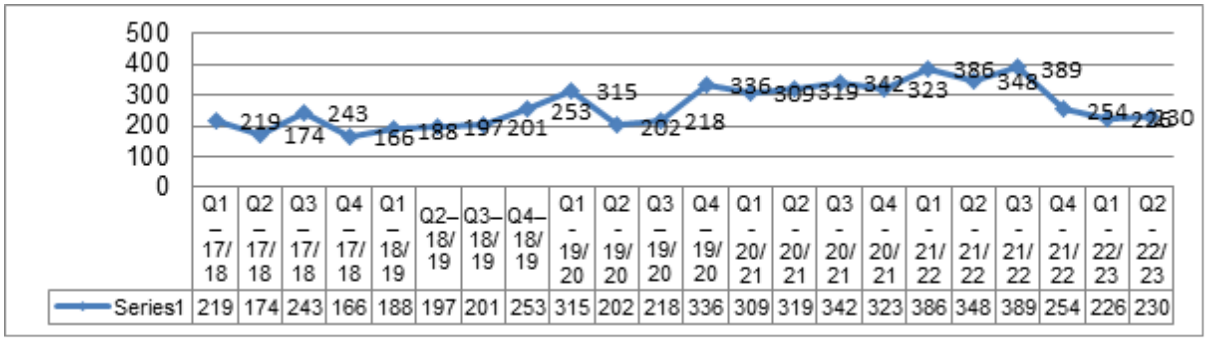


Figure 15

6.2 The Annual Plan set a target for reducing service user on staff assaults that resulted in moderate or severe harm, rather than reducing the number overall, so that staff continue with a positive reporting culture. Two service user on staff violence and aggression incidents in quarter 2 resulting in moderate harm. Support was put in place for staff affected. Fact find reports were completed. Swarm debrief sessions were held and the reflective practice has informed the work of the Violence and Aggression CQI project.

Service User to Service User Assaults

6.3 Following a steady decline in incidents, an increase from 85 to 93 has been reported in service user to service user assaults, of which 46% occurred within the Acute Mental Health Service *(figure 16)*.

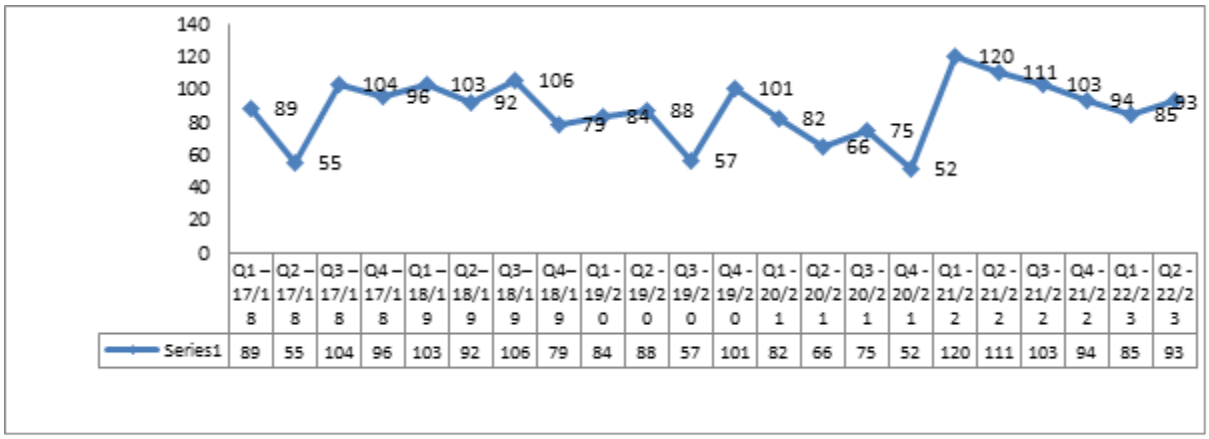


Figure 16

6.4 There were no reported service user to service user assault incidents resulting in moderate or severe harm in this quarter.

Reporting of Injuries, Diseases and Dangerous Occurrences

6.5 Five incidents were reported under Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR), a decrease of four. Four were attributable to violence and aggression and in the Learning Disability and Forensic SBU and one to slips, trips and falls which was a specified injury (fractured ribs).

Personal Accidents

6.6 There have been 30 Health and Safety related personal accidents to staff, an increase of 11 *(figure 17).*

	Total
Exposure/contact with hazard	3
Contact with object	9
Moving and handling	6
Needlestick injury	2
Slip fall or trip	10
Total	30

Figure 17

Moving and Handling

6.7 There have been six incidents in relation to moving and handling; three whilst supporting a service user and three of an inanimate object and all of which were followed up by the Moving and Handling Advisor follows up all moving and handling incidents.

Needle stick injuries

6.8 There were also two needlestick injuries reported, with advice provided by Occupational Health.

Staff Slips Trips and Falls

6.9 Ten staff and visitor slips, trips and fall incidents were reported. Seven involved staff falling from a level surface, one of which in a report under RIDDOR.

Security Incidents

6.10 *Figure 18* provides data regarding security incidents, a majority of which were discovering an inappropriate item and a breach of security. Included under breach of security is AWOL and Missing Persons discussed earlier.

	Breach of security entrance/ exit	Broken item compromising security of building	Discovery of inappropriate item/object on a ward/unit	Inappropriate item brought onto ward by service user	Inappropriate use/access to keys	Item lost/stolen from NHS property	Total
21/22 Q2	14	5	24	8	7	8	66
21/22 Q3	14	4	17	11	5	2	53
21/22 Q4	24	1	14	5	3	5	52
22/23 Q1	24	4	12	9	6	3	58
22/23 Q2	23	9	2	19	2	1	56
Total	99	23	69	52	23	19	285

Figure 18

6.11 The Memorandum of Understanding Joint Working Protocol between the Trust and Hertfordshire Constabulary to support prosecution of crime in mental health settings was launched with a series of events attended by over 500 Trust and police colleagues.

7. Harm Free Physical Health Care

Falls

7.1 The Falls Committee continues to have oversight of falls data Trust wide *(figure 19);* the falls in community are now also reported on Datix.

	22/23 Q1	22/23 Q2
East and North Hertfordshire Strategic Business Unit	101	106
Essex & IAPT SBU	1	2
Learning Disabilities & Forensic Strategic Business Unit	54	47
West Hertfordshire Strategic Business Unit	27	18
Total	183	173

Figure 19

7.2 The update Falls Strategy actions, which are regularly monitored and reviewed by the Falls Committee, included:

- analysis of the service users' journey in relation to falls on an older people's inpatient services
- creation of a joint community/inpatient process to ensure families provide service users with appropriate footwear
- audit of rooms to assess what personalisation of the environment could be offered in each room when service users are admitted
- simulation training for falls
- consideration of how the team could work with falls specialists in the MDT
- to have 75% of staff on inpatient wards compliant with new falls training.

Pressure Ulcers

7.3 There were five reported pressure ulcers acquired whilst in Trust care, which were subject to local review (*figure 20)*.

	22/23 Q1	22/23 Q2
Category 1 Device Related Pressure Ulcer (Acquired whilst in HPFT Care)	1	2
Category 1 Device Related Pressure Ulcer (Acquired outside HPFT care)	0	1
Category 2 Device Related Pressure Ulcer (Acquired whilst in HPFT Care)	2	1
Moisture Associated Skin Damage	6	1
Category 1 pressure ulcer (Acquired outside HPFT care)	1	1
Category 1 pressure ulcer (Acquired whilst in HPFT care)	0	1
Category 2 pressure ulcer (Acquired outside HPFT care)	1	3
Category 2 pressure ulcer (Acquired whilst in HPFT care)	0	1
Leg Ulcers	0	1
Unclassified	4	1
Total	15	13

Figure 20

7.4 The Tissue Viability Nurse (TVN) commenced employment in September and has started validating pressure ulcers reported on Datix and reviewing service users to ensure wounds and skin damage are classified correctly. Bitesize ward-based Tissue viability training is delivered on the older adult wards once a month.

Venous thromboembolism (VTE)

7.5 No cases of harm from VTE reported this quarter. VTE teaching was delivered to medical staffing committee by physical health team. It is noted that coagulopathy associated with the original Covid-19 virus has not been reported with the Delta and Omicron variants.

Urinary Tract Infection (UTI)

7.6 A nurse from the Trust's physical health team has joined the Hertfordshire and West Essex (HWE) Integrated Care System (ICS) Infection prevention and Control (IPC) five-year Strategy/UTI Work Stream.

8. Service Users Experience of Feeling Safe

8.1 A targeted survey asking service users about safety on the wards was used during September 2022 to gain an understanding of why service users feel unsafe. Of the responses received service users reported not feeling safe on the ward due to other service users, their own mental or physical health, the environment, and not having enough time to talk to staff. A summary of actions to be taken in response to this feedback will be reported on in quarter 3.

8.2 There were 538 compliments received, compared to 505; 17 compliments mentioned the word "safe".

"I would like to thank the staff at Gainsford House for their wonderful care which makes the patient feel happy and safe."

8.3 118 complaints were received, with four mentioning the word "safe" or "safety" from Swift ward, Forest House, Single Point of Access (SPA) and the Section 136 suites.

8.4 262 PALS enquiries were received with five mentioning the word "safe", for Watford Liaison Team, Swift ward and Adult Community Mental Health Services (ACMHS). Two concerns were relating to safeguarding of individuals not under a Trust care team.

8.5 The Peer Experience Listening and Peer Observation projects continue to progress, and training for the Experts by Experience is being planned for October. The Peer Listening project will listen to service users on medium secure forensic units to understand how safe they feel after witnessing an incident.

9. Safeguarding

Safeguarding Children

9.1 *Figure 22* illustrates the number of safeguarding children incidents by financial quarter, showing a decrease of 28 compared to quarter 2 2021/22.

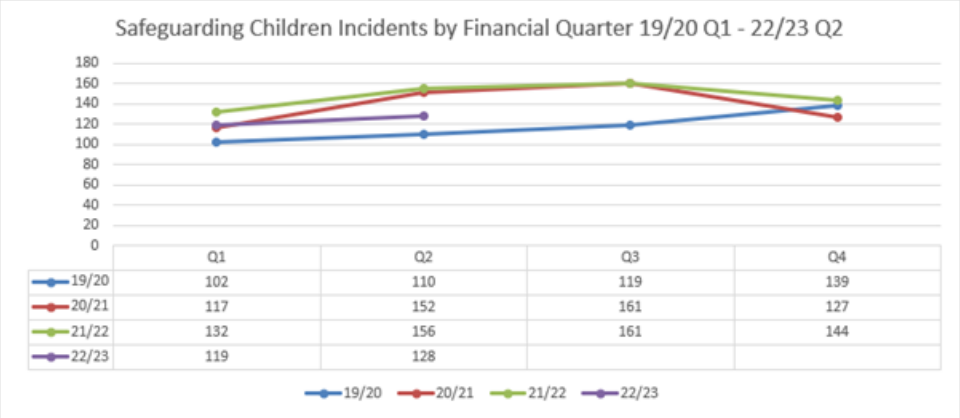


Figure 22

9.2 *Figure 23* shows the number of safeguarding children incidents in a longitudinal format, with the national lockdowns illustrated. During each of the three national lockdown periods, the number of safeguarding children incidents decreased, which was then followed by an increase in incidents.

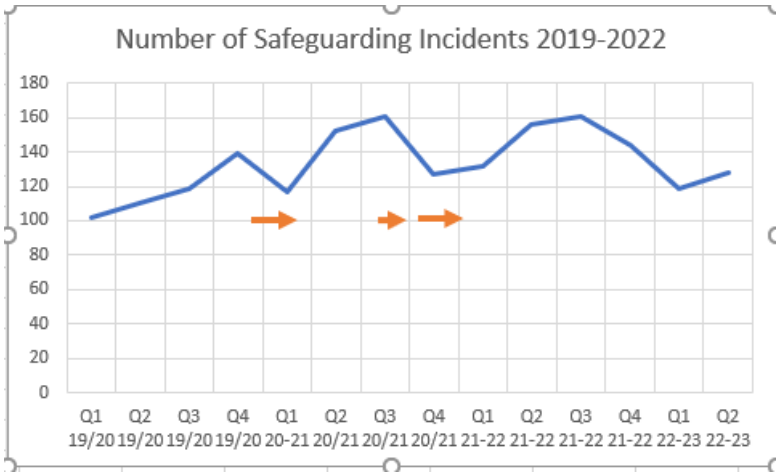


Figure 23

9.3 *Figure 24* illustrates the incidents by categories of abuse, showing emotional abuse remaining the most reported type of child safeguarding incident, unusually with the other categories of abuse receiving an equal number of incidents reported. Neglect increased by eight incidents and physical abuse decreased by eight.

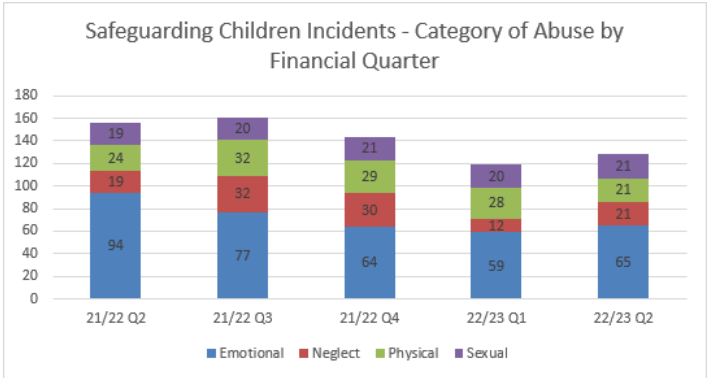


Figure 24

9.4 *Figure 25* illustrates the numbers of incidents reported by specific service areas i. As with previous quarters, the CAMHS Crisis Assessment and Treatment Team (C-CATT) have made the most referrals to child safeguarding services, owing to the demographic of their service user group. It is positive to see safeguarding children referrals being made by adult inpatient and community services across Herts, Essex and Norfolk.

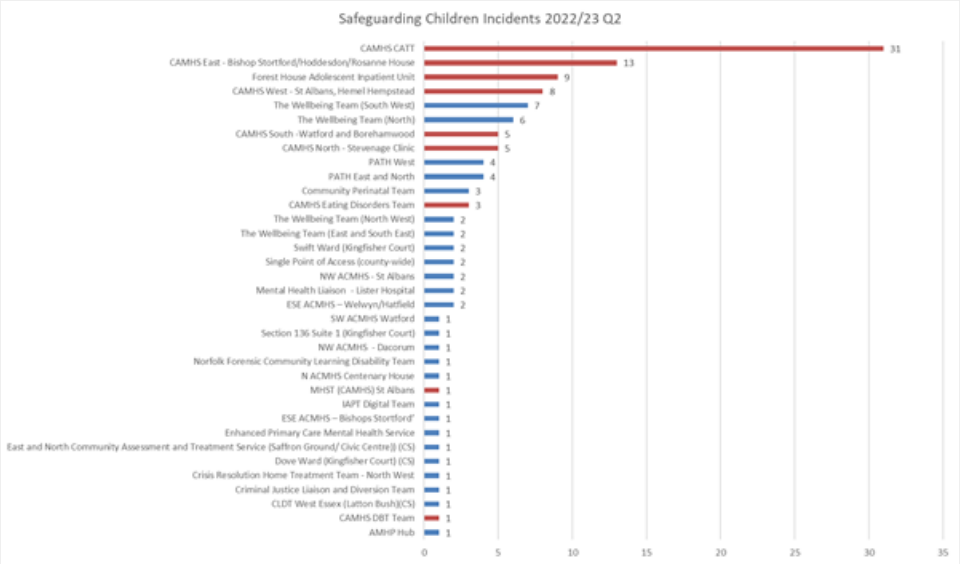


Figure 25

Hertfordshire Joint Targeted Area Inspection (JTAI) Preparation

9.5 Hertfordshire Safeguarding Children Board (HSCB) convened a multi-agency meeting on 20 September 2022 to commence planning for the possibility of a Hertfordshire JTAI. An Executive briefing document was prepared following the meeting to ensure the Trust is ready and has the resources in the case of an inspection being announced. The purpose of the inspection is to look at how partnerships work together to safeguard children in their area.

Safeguarding Adults

9.6 The rate of referrals illustrates an increase and also a higher rate than the same quarter in previous years. This is in line with the ongoing trend of increased rates of referral since 2019/20 and brings referral rates back to the levels seen during quarter 4 2021/22. The corporate safeguarding team continue to monitor this as it is unclear whether this increase indicates a return to the upward trend previously seen in rates of safeguarding referral since the onset of Covid-19 *(figure 26).*

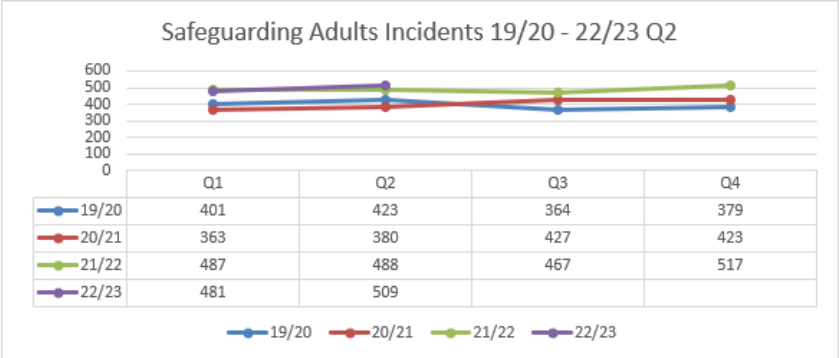


Figure 26

9.7 *Figure 27* demonstrates the breakdown of categories of abuse. Physical abuse remains the highest rated category, with domestic abuse second as per previous quarters. Rates of self-neglect concerns are at their lowest rate of referral since quarter 2 2021/22. This could be hypothesised that referrals become more frequent in conjunction with the onset of colder weather and concerns regarding individuals who may not have appropriate heating and other facilities.

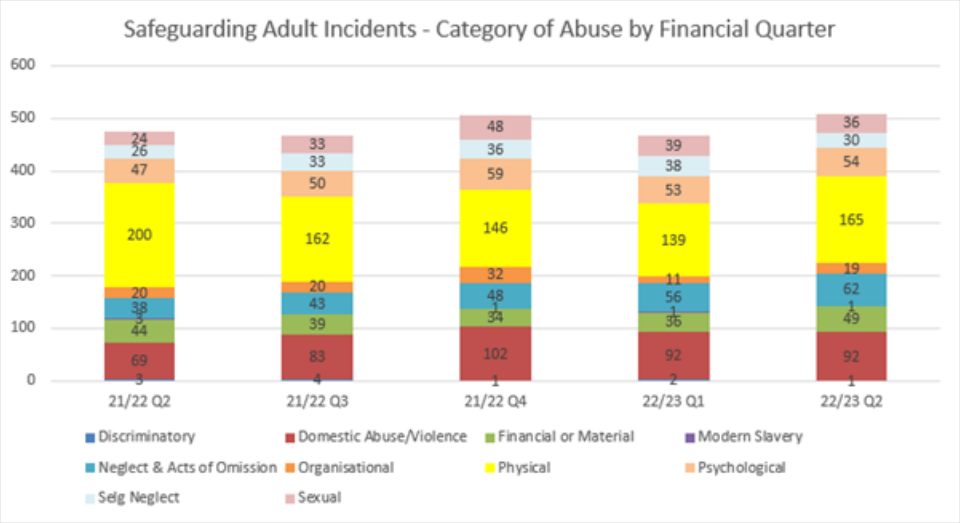


Figure 27

Section 113 Agreement

9.8 In Hertfordshire, the Trust carries out investigations into abuse of adults with functional mental disorders on behalf of the local authority (Hertfordshire County Council - HCC). *Figure 28* illustrates Concerns and Enquiries from quarter 3 2020 to current. Unlike the Safeguarding Datix information, Safeguarding referrals managed within the Trust have remained consistent and have not shown signs of resuming an upward trend.

9.9 The Trust conversion rate has remained consistently between 40% to 55%. September Conversion rate has dipped below this range however is likely to stabilise during the first half of October 2022 as outstanding decisions are completed.

9.10 The Professional Lead for Safeguarding Adults created a dashboard to display this information by quadrant, as it has been noted that there is a variation in conversion rate across different Investigating teams. This can now be monitored alongside results from the monthly quality audit in order to identify any potential locality issues in a timely manner.

9.11 The highest average conversion rate for any quadrant was 68%, noting that this quadrant also has the highest usage of the 'Other Safeguarding Enquiry' category but is also demonstrating the most consistent adherence to the 48hour decision making timeframe indicating that a higher rate of concerns are being converted into enquiry at a preventative level in this area.

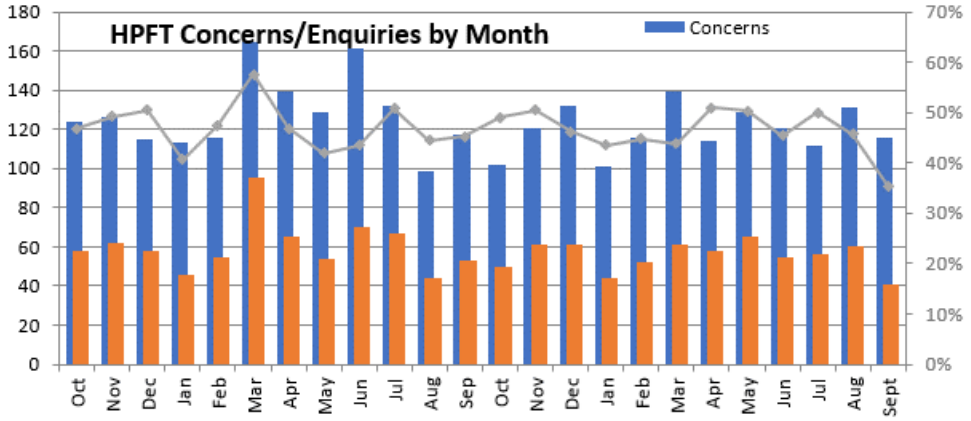


Figure 28

Safeguarding Children High Profile Cases
Referrals to Notification Panel in Hertfordshire

9.12 There was one referral where the child or family were known to the Trust.

- An 8-year-old child who died on 15th July 2022. A referral was received in SPA in January 2022, which was forwarded to PALMS for ADHD assessment, as he had learning disabilities and behavioral issues. Mother was known briefly to adult services in 2013 and 2015. Maternal uncle (deceased) had one contact with Mental Health Liaison team. Notification meeting held on 17.08.22- as this was a child looked after a notification was made to the national panel, however the case did not meet the criteria for a practice review. The case will be reviewed by CDOP & LeDeR in the usual processes & learning will be considered there.

Unexpected Child Deaths

9.13 There were four unexpected child deaths where the child or family member had been known to the Trust.

- 8-year-old child discussed above in referrals to notification panel section
- 14-year-old open to CAMHS West, found deceased with ligature on 9 July 2022. Joint Agency Response (JAR) meeting held on 14 July 2022. Meeting revealed he had one previous ligature attempt at home last summer that all professionals were unaware of. School was aware he had been experimenting wearing feminine clothing, CAMHS were not aware of this. Mother said to GP that she thinks his death was an accident. SI declared in the Trust
- A seven-month-old baby who died in Paediatric Intensive Care Unit at Great Ormond Street hospital (GOSH) on 28 September 2022. Mother and sibling were co sleeping and, when mother woke up in the morning, the baby was unresponsive. Medics managed to stabilise him, and he was transferred from Watford General Hospital to GOSH. The baby's sibling, aged 12, had been open to CAMHS west since with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and she had also been on a child in need plan due to mental and behavioural needs, and mother has been reluctant to receive support from children's services. The baby's mother had also been known to the Trust in 2019, under the PATH team. A safeguarding concern had also been investigated as she had experienced domestic abuse and her case was also heard at Multi Agency Risk Assessment Conference (MARAC). There is evidence of good practice by PATH in terms of attempts to engage the mother and also liaison with

external agencies attempting to support, including Independent Domestic Violence Advisor.

Trust High Profile Cases

9.14 Young person who is a frequent attender at Princess Alexandra Hospital (PAH) Emergency Department (ED) due to suicidal ideation and self-harm. SS' needs are very complex however she does not meet the criteria of need for a Tier 4 mental health inpatient bed, unfortunately the inpatient or residential provision for young people in these situations is limited and this has led to SS having repeated presentations to ED. SS has now been a voluntary inpatient to PAH since 27 April 2022. Application made to the Court of Protection by PAH on 7 July 2022 stating SS does not have capacity to decide on care and treatment and application states it is in her best interests to stay at PAH until a specialist placement can be found for her or further order of the court. She has been diagnosed with intellectual disability, traits of autism spectrum condition, depressive symptoms with suicidal ideation, anxiety, social anxiety and affect dysregulation. She has deliberately self-harmed whilst living at the family home on 35 occasions between September 2020 and April 2022.

Safeguarding Adults High Profile Cases
Safety and Improvement Process

9.15 East and North Provider A: Service Improvement Process (SIP) have continued for a small provider in the east and north quadrant following concerns around care provided. The Trust no longer has any service users placed in this property and following failure by the provider to make changes as required during the SIP it has been agreed that the Trust will no longer use this placement. Relevant commissioners for the remaining resident have been contacted and have decided to continue their use of this provider. Concerns around this were shared with the partnership at the September Hertfordshire Safeguarding Adult Board (HSAB) Strategic Quality Improvement Group (SQIG) meeting.

Safeguarding Adults Reviews

9.16 There are three cases relevant to the Trust

- D – Referred in by the Trust during quarter 1. Now accepted as SAR but review has not yet commenced.
- S - A service user known to the Trust was referred to SAR by police at the end of the quarter following an incident of serious self-harm shortly following discharge from Section 2 of the MHA. Following discussion at SAR subgroup, this was not taken on as SAR however an action was taken forward for the police and the Trust to meet in regard to improving communications around high-risk service users being discharged from Trust wards. A meeting has been arranged between the police and the Trust's Professional Lead for Safeguarding Adults; however, it is likely that this will tie in with existing workstreams already underway within the Trust
- 'Belinda' - A Tabletop SAR review was held in regard to 'Belinda' (anonymised name). This picked up on themes highlighted in recent Domestic Homicide Reviews (DHR) regarding intrafamilial violence. An action has been taken by the corporate team to introduce information on this aspect of Domestic abuse into all existing Domestic abuse webinars. A standalone 'Intra-familial abuse' webinar will be introduced in 2023.

Domestic Homicide Reviews

9.17 There are seven cases where individuals were known to the Trust:

- J - This DHR is now in the final stages prior to submission to the Home Office. All recommendations have been actioned
- K&C: The review is in the final stages prior to submission to the home office.
- C - The DHR report has now been drafted and the most recent panel made amendments and approved recommendations. This will be finalised at a final meeting in October 2022. There are a number of recommendations for the Trust alongside multi-agency recommendations; the corporate team plan to meet and develop an action plan
- K - The Trust have provided an Independent Management Review (IMR)
- A and K: An IMR has been requested and is due for completion during quarter 3 for this couple, both of whom were known to the Trust
- JH - This review is yet to commence
- JS - Was known to the Trust's Wellbeing team. She was known to be experiencing domestic abuse including harassment from her ex-partner. She ended her own life, and it is felt that this was caused by the coercion and control within their relationship. The Trust referred this case to DHR panel.

Areas of Good Practice

Care Leaver Best Practice Guidance

9.18 Following the ratification of the Care Leaver Best Practice guidance a launch event took place on 20 September 2022. Guest speakers from the HCC Care Leaver Team, Hertfordshire Community Trust (HCT) Children Looked After (CLA) and Care Leavers Health Team and Ohana support group for Care Leavers who are parents attended. Attendees were privileged to hear directly from four Care Leavers by experience.

9.19 The Corporate Safeguarding Team received feedback from the Safeguarding Lead at Lister Hospital, praising the communication between themselves and the locality ACMHS teams in regard to Safeguarding.

9.20 Northwest ACMHS carried out a thorough piece of safeguarding work relating to Safeguarding of a service user during transport to hospital under the MHA. This fed into wider work around transport providers and the need for CCTV in these settings to help protect both service users and staff.

9.21 Following concerns raised about care provided by a private hospital in their older adult's unit, the ACMHS and mental health services for older people (MHSOP) undertook a joint piece of work to review concerns both through seeking assurance from the provider and through visiting the property to review service users placed in this environment. Although ACMHS do not hold responsibility for this cohort, the ACMHS have a strong working relationship with the provider's Safeguarding lead and were able to support MHSOP in undertaking this review. This was an excellent example of joint working between services in order to provide the most effective response to the concerns raised.

9.22 Following September's peer supervision for Investigating managers, the Professional Lead for Safeguarding Adults received positive feedback.

Safeguarding Training

Safeguarding Children

9.23 Low compliance rates for safeguarding children training levels 2 and 3 were added to the corporate risk register. The decrease was due to the ongoing work to introduce the safeguarding training passport, where the levels of training assigned to staff were amended in quarter 4 2020/21. *Figure 29* illustrates that the Trust is now compliant for Level 2 and Level 3 Safeguarding Children training and this item was removed from the risk register in July 2022.

Training 2022-23	Q1	No. non-compliant	Q2	No. non- compliant
Preventing Radicalisation	96%	109	96%	
SG Children Level 1	95%	156	96%	137
SG Children Level 2	92%	204	94%	169
SG Children Level 3	94%	60	94%	60

Figure 29

Safeguarding Adults

9.24 Compliance around Safeguarding Adults level 3 remains below requirement *(figure 30)*. Work is in place to ensure that this compliance level improves, including engaging with the strategic business units through their Quality and Risk Meetings and emailing non-compliant staff and managers to prompt.

Trust		
Certification Name	**Sep-22**	**Does not meet requirement**
Safeguarding Adults Level 1 [3 Years]	96%	138
Safeguarding Children Level 1 [3 Years]	96%	137
Safeguarding Adults Level 2 [3 Years]	94%	170
Safeguarding Children Level 2 [3 Years]	94%	169
Safeguarding Children Level 3 [3 Years]	94%	60
Safeguarding Adults Level 3 [3 Years]	85%	197

Figure 30

Sexual Safety

9.25 There has been a clear improvement in the way that data on sexual safety incidents have been drawn down from Datix, with a demonstrable increase in incidents for East and West SBUs for both inpatient and community. This means that the Trust is now in a position to establish a baseline of incidents from which to map patterns and progress.

9.26 Members of the Sexual Safety Group attended the National Review of sexual safety incidents learning session recently. It is apparent that data is not collected routinely by mental health trusts across the board, therefore, the Trust is now in a strong position in terms of developing an understanding around the issues in our services which impact on both staff and people who use our services. Learning from this review will be shared with Safety Committee with a view to ensuring any improvements or recommendations can be adopted into services where applicable.

10 Conclusion

10.1 Part B has provided an overview of incidents reported in the quarter, demonstrating some improvements and areas requiring more increased focus in other areas during quarter 3 as detailed in Part C. There has been continued scrutiny and governance relating to LTS and other restrictive practice and providing increased support and guidance into the SBUs.

10.2 The number of deaths that were thought to be as a result of suicide, was 19 compared to 17 in the previous quarter Several of these deaths have occurred in the northwest quadrant and a task and finish group commenced to address this and extra support provided for the teams.

10.3 The systemwide Suicide Prevention group continues to work to reduce suicides and work will continue in the next quarter including learning from colleagues on the Gold Coast who have made great strides in reducing deaths through suicide.

10.4 The Trust has made progress with the Serious Incident recovery work with all reports submitted within timescale, with further work required in quarter 3 regarding the outstanding action plans and clarifications. The Trust has worked closely with HWE ICS to close any historical Serious Incidents on STEiS in preparation for the introduction on PSIRF in 2023/24.

10.5 Violence and aggression continues toward staff and service users continues to be a concern and a CQI project group has been set up to address this.

10.6 Safeguarding continues to be a priority for the Trust with engagement internally and the system.

10.7 The pandemic, and its response, continued to offer challenges to Trust teams in terms of ensuring the safety and wellbeing of our service users but ongoing monitoring of key metric ensures that concerns are responded to swiftly.

Part C Learning from Incidents and Changing Practice

1. Introduction

1.1. This part of the report summarises key actions and initiatives that have been identified for quarter 3, in consideration of the learning and the detail provided in part B. This is not a full account of the work that has taken place as the Trust's CQI approach supports and has resulted in several local initiatives.

1.2. Following the soft launch of the Trust's MOSStogether Strategy, continued implementation of the actions within the Strategy during with an increase in focus on

some of the areas including SafeWards. The report concludes with the priorities for quarter 3.

2. Learning from Incidents

2.1 A monthly Learning Action Review Group chaired by the Executive Director for Quality and Safety commenced in this quarter with an aim of oversight and assurance around sustained learning from our incidents.

Suicide prevention

2.2 Work continues with partner agencies to develop a system wide Suicide Prevention Pathway to support making every contact count with suicide specific brief interventions.

2.3 Work is ongoing with partner agencies supported by Wave 4 national funding on delivering system wide suicide awareness/prevention training using the Trust's simulation training facilities.

2.4 Suicide risk training continues to be delivered monthly to front line clinicians and teams with a focus on safety planning, dynamic risk formulation and suicide specific interventions.

2.5 The West Essex and Hertfordshire Suicide Bereavement Support Service delivered by Chums mobilised in quarter 2 which will ensure timely postvention support for people affected or bereaved by suicide.

2.6 The Trust is now receiving alerts of a potential death by suicide along with other partner organisations in Hertfordshire through the Real Time Suicide Surveillance (RTSS) system. This provides the opportunity for timely signposting to postvention support and

2.7 Themes from serious incidents in quarter 2 included suicide risk formulation, joint working with Drug and Alcohol Services, carer support and timely follow up with service users when they did not attend planned appointments. Learning has informed ongoing work on harm minimisation, the Self harm CQI project, and the delivery of Simulation Suicide Risk training.

3. Priorities for Quarter 3

- **Incident management**
  The Trust is continuing to prepare for the transition to the Patient Safety Incident Response Framework (PSIRF). The guidance was published in September 2022 and the Trust has been attending PSIRF workshops across the ICBs. A project plan is being finalised for the transition to PSIRF with full implementation by Autumn 2023.

- **Safe and Supportive Observations (SASO)**
  The SASO CQI project is continuing with a focus on staff training, service user experience, reducing potential harm to staff undertaking SASO, and updating the policy.

- **Suicide Prevention**
  Suicide prevention work including developing a system wide suicide prevention pathway is continuing alongside other partner agencies.

- **Ligatures**
  Ligature audits in community hubs are continuing.
  The Trust is working with Surrey and Borders Trust to develop a cost-effective App to assess environmental risk.

The Trust is liaising with another Mental Health Trust to learn from a HSE prosecution by the HSE following a number of ligature deaths within their inpatient services.
A regional ligature forum has been established which the Trust is represented on.

- **Violence and Aggression**
  A CQI project group has been formed to address harm from violence and aggression incidents in the Trust. Patient Safety Specialist working with staff side to understand staff experience of violence and aggression and what is needed. The focus in Q3 will be for each subgroup to work together on the different themes that has come up during different focus groups and meeting with stakeholders
  The Police Liaison and Security Group continues to meet and has focused on reviewing and relaunching the joint working protocol and ensuring staff are supported to report assaults and during the criminal process.
  A Spitting task force is focusing on reducing risks to staff from service users spitting.

- **Joint Working with Police**
  Following the launch of the Joint Working Protocol with Hertfordshire Constabulary for prosecution of crime in mental health settings a series of launch events are planned for quarter 3, to fully embed the protocol and build on existing positive working relationships between health and police.

- **Falls prevention**
  Training on falls risk and prevention using the simulation suite continues with a good uptake by staff in Older Adult services, where the majority of our falls occur. The facilitated debrief session and development of falls specific case scenarios are informed by learning from our incidents including service user and carer experience.
  The focus in quarter 3 will be to ensure staff in other SBU's attend the training.

- **Restrictive Practice**
  A RESPECT recovery task and finish group has focussed on recovering training compliance levels.
  The Mental Health Units Use of Force Act 2018 came into force in quarter 1. The Trust's Patient Safety Specialist has led a task and finish group to ensure compliance with the act. This is continued to be part of the RESPECT training

- **Feeling safe**
  The "Feeling Safe on inpatient units" survey was extended for the month of September to run for another two weeks in light of the BBC Panorama programme. An update on the survey results will be reported on in quarter 3.
  Actions in response to survey result findings of why service users don't feel safe on our wards will also be reported on in quarter 3.

- **Fire Safety and suicide prevention**
  The Hertfordshire Fire and Rescue Prevention service will be working with Trust colleagues in quarter 3 around fire safety, suicide prevention and joint working with vulnerable adults, building on work undertaken in the Simulation hub and collaborative working.

Conclusion

This section of the report has set out some of the responses to learning and quality improvement initiatives from analysis and findings, whilst considering the Trust's Annual Plan. It has then set out some of the priorities that build on those already in the annual plan, for the next quarter.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 10b
Subject:	Quarter 2 Safer Staffing Report	**For Publication:** Yes
Author:	Jinu Joseph, eRoster SafeCare Lead Bina Jumnoodoo, Deputy Director, Nursing and Quality	**Approved by:** Jacky Vincent Director of Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent Director of Quality and Safety (Chief Nurse)	

Purpose of the report:

This paper is presented to the Board to give assurance in relation to safer staffing requirements for 2022/23.

Action required:

The Board are asked to note the report

Summary and recommendations to the Board:

Feedback from IGC

This report was considered by the Integrated Governance Committee at its meeting held on 10 November 2022. The Committee noted the continued demand for services and increased acuity of services, and the impact this was having on staffing levels and use of agency staff. The use of 'Model Hospital' was discussed and how information on staffing is included in the quality dashboard.

Report headlines

This report informs the Board with a quarter 2 2022/23 update on the safe staffing across all SBUs within the Trust.

This quarter has shown continual pressure and challenges across all services with the level of prescribed SASO and staffing shortages predominantly owing to vacancies, with an increased focus on the scrutiny and governance of staffing.

A focused task and finish group for nursing recruitment and retention monitors a targeted action plan to increase recruitment and to focus on the retention of the nursing workforce**.**

Relationship with the Business Plan & Assurance Framework:

Relation to the Trust Risk Register:

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

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

Relation to the BAF:

1. We will provide safe services, so that people feel safe and are protected from avoidable harm.
2. We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support, and treatment.

Summary of Implications for:

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

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

There are no implications arising from this report.

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

N/A

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

QRMC 4 November 2022 IGC 24 November 2022

Quarter 2 Safer Staffing Report 2022/23

1. Introduction

1.1 This report provides assurance that Hertfordshire Partnership NHS University Foundation NHS Trust (the Trust) had safe nurse staffing levels across all inpatient services and appropriate systems in place to manage the demand. This report covers the reporting period for quarter 2 (July to September 2022).

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

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

2. Trust's expectation

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

2.2 Where the skill-mix and the number of staff who work is lower than planned, this may indicate a safety concern. There is an agreed escalation process for reporting any safety concerns associated with nurse staffing. If a shift remained unfilled, this is reported to the Heads of Nursing (HoN) and recorded as a safety incident on Datix.

2.3 Staffing cover is often mitigated by an increase of staff from a different band, cross cover from co-located services and by the Team Leaders and Clinical Matrons.

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

3. Summary of findings for nurse staffing data collection

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

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

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

4. Safer staffing across the SBUs

4.1 **West SBU**

4.1.1 Challenges remain regarding meeting adequate staffing (minimum staffing numbers) due to acuity requiring prescribed safe and supportive close observations (SASO) impacting on staffing has led often to Team Leaders, Clinical Matrons and management stepping down to support the wards. However, safety has been maintained during this period.

4.1.2 There has been continued use of agency across the wards in particular Robin, Owl, and Oak wards, owing to prescribed SASO, with some extended admissions owing to social/placement delays. There were 35 incidents of short staffing reported, an increase of 11 incidents.

4.1.3 The safecare module on r-roster continues to be used within the services and the inpatient staffing levels are monitored and reviewed in the daily safe staffing meetings and weekly roster scrutiny meetings.

4.1.4 Respect training compliance has been a challenge, currently at 61%; mitigations are in place to manage this safely. The HoN continues to work with the Clinical Matrons and Team Leaders to increase compliance.

4.1.5 The pay spend was inflated by £-630k, which included the pay award arrears; bank and agency spend inflated by £-357k, with 32% reliance on bank and agency for the quarter.

4.1.6 Administration support has been provided to support the recruitment pipeline and 20 newly qualified nurses (NQNs) have commenced employment in the service areas.

4.1.7 A revised staffing establishment review for inpatient services will be brought to the next Committee meeting following work led by the HoN with finance.

4.1.8 Areas of concern:

- Acuity continues to be a challenge, with increased numbers of staffing on every shift in some wards, resulting in increased spending for bank and agency
- Complex cases on wards have resulted in longer stays
- Incidents, including violence and aggression on staff continue to be reported
- Staff vacancies across both community and inpatient services, with targeted work focusing on recruitment.

4.1.9 Priorities

- Ensure tight and robust scrutiny of rosters with a focus on key performance indicators, and management of unfilled shifts
- Ensure minimum daily review of all prescribed SASO
- Continual review of delayed discharges and multiagency meetings
- Implement revised staffing establishment review
- Ensure regular swarms, reflection sessions, and huddles for staff support
- Focus on increased compliance with Respect training across all services.

4.2 **East and North (E&N) SBU**

4.2.1 The staffing for the in-patient wards is reviewed twice daily by the Safe Care call involving the Team Leaders, Clinical Matrons and the Service Line Leads and then later in the day, by the Out of Hours Clinical Leads (OOHCL).

4.2.2 The weekly e-roster scrutiny meeting is well established and continues to take place, despite the high acuity in services. There remains specific focus on any lost contracted hours and the matrons look to find solutions on how we can support staff in taking time back where they have gone over their contracted hours.

4.2.3 SASO and staff sickness remains the main reason for the additional hours on most of the wards. The management of annual leave remains the responsibility of the Team Leaders and is also monitored through the eRoster scrutiny meetings.

4.2.4 11 safer staffing incidents were reported, due to late cancellations and agency staff not reporting to work and inability to cover vacant shifts.

4.2.5 The band 2-3 HCA development programme is well under way within the older aged adult wards, with 14 existing band 2 staff completed the competency and progressed to band 3s.

4.2.6 The teams continue to build on the identified themes from their away days, working on communications within the teams and feedback, using suggestion boxes where staff make suggestion for changes within the team, staff appreciation boards recognising each other's contributions.

4.2.7 The remaining HCA vacancies are advertised and will be recruited to as part of the ICS HealthCare Support Worker (HCSW) recruitment.

4.2.8 NQNs who have accepted post within five of the six teams are due to start in the next quarter.

4.2.9 The use of the 1:1 care plan has enabled a sustained decrease in the use of 1:1s across all wards, resulting in a decrease in the use of bank and agency

4.2.10 Areas of concern:

- The acuity of service users on the wards has increased, with a number of staff completing their nurse training also having an impact on staffing

- PDP completion has reduced, with a focus on Wren ward
- The reliance on bank and agency usage has continued due to the numbers of vacancies and absences
- There has been an ongoing concern regarding late arrivals and non-attendance by agency staff after accepting shifts which are discussed at the daily 10:30 staffing meeting and attended by the Bank Bureau.

4.2.11 Priorities:

- Continuous Quality Improvement (CQI) regarding violence and aggression when supporting individuals with their individual personal care needs
- Continued engagement, ownership, and knowledge of all Team Leaders regarding their budgets
- Continue with the gains around supervision and PDP to support staff and ensuring that the teams are consistently recording on the supervision app
- Continue the recruitment and retention of RNs and HCAs across all the teams
- Continue the drive to improve and maintain the mandatory training compliance rates across the teams.

4.3 Essex and IAPT

4.3.1 There continued to be high acuity within the inpatient services and a continual challenge regarding the recruitment of RNs across the services. Senior nurses continued to meet daily to review the staffing across the services to ensure we continue to provide safe services.

4.3.2 A decrease in the overall CHPPD was reported and also a decrease in bank and agency usage as well as the total avoidable costs.

4.3.3 Five NQNs and an additional RN commenced employment, with a further two commencing in October.

4.3.4 Areas of concern:

- The on-going challenges with recruiting to the band 5 and 6 vacancies in the inpatient and community services and the total bank and agency usage
- The 14.57 WTE vacancies across the inpatient and community services
- The overall CHPPD hours remaining high.

4.3.5 Priorities:

- Continue to focus on international recruitment for the Essex learning disability services
- Continue to work in partnership with Social Care colleagues and Commissioners to ensure timely discharges
- Team Leaders and Clinical Matron to continue to review safe staffing three times a week with the overall aim of reducing staffing numbers on shift when safe to do so
- To continue support HCAs access and attend the TNA/AHP course
- Ongoing Recruitment Advertising and Quarterly Recruitment Events for 2022/23.

4.4 Learning Disability and Forensic (LD&F) SBU

4.4.1 There continued to be reliance on agency usage with staffing shortages due to SASO and Covid outbreaks. Team Leaders and Clinical Matrons regularly stepped into numbers.

4.4.2 There has been a decrease in the number of bank shifts filled and fill rates for some areas.

4.4.3 Support continued with regular redeployment via the daily safecare call.

4.4.4 Working with commissioners continued to explore options for consolidating the bungalows on SRS and enable effective management of staffing resources.

4.4.5 There has been difficulty with access to placements and limited career progression for staff working in Norfolk with a priority to review the involvement and relationship with the University of East Anglia.

4.4.6 Work with the eRostering team has enabled the implementation of team-based rostering across the inpatient services as well as stream-lining the roster template for Broadland.

4.4.7 Priorities:

- Focus engagement with agency staff to enrol as substantive bank staff
- Continued focus on recruitment to reduce the bank fill rate and unfilled shifts and reducing the unavailability percentage
- SRS Bungalow consolidations to move into four from six bungalows
- Focus into Team Based Rostering with all wards to be on board by the end of quarter 3.

4.4.8 Areas of concern**:**

- Increased reliance on agency
- Clinical Matrons and Team Leaders stepping into numbers on a regular basis
- SASO levels and additional duties
- Avoidable costs
- CHPPD fill rates for the Beacon and Dove ward.

5. Finance

5.1 The financial position shows an unplanned overspend of £1.285m year to date, reflecting a continuation of the monthly run-rate deficit of c£350k during month six. The forecast year-end outturn now reflects unplanned overspending of £1.5m, (month five forecast outturn was £2m).

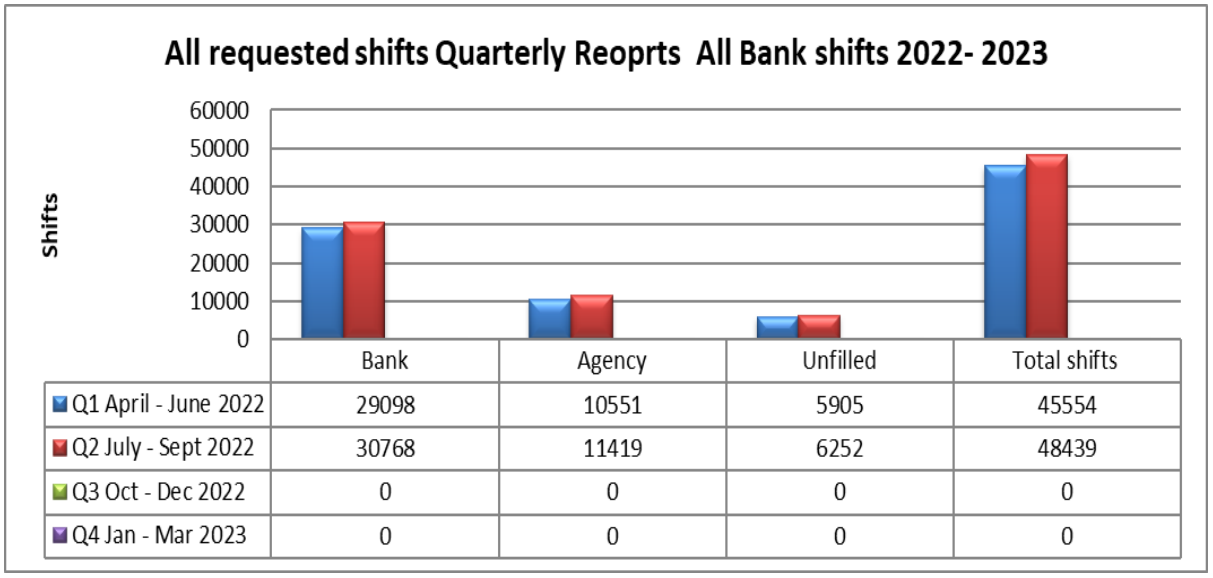
5.2 An Agency Panel has been convened to provide oversight and challenge to the use of agency staffing on a fortnightly basis with an initial focus on information flows to service leads and to SBU leadership teams. All wards and services have been challenged to reduce agency staff usage by at least 1 WTE, per unit per month.

5.3 The unplanned year to date overspends on pay is therefore £2m. This overspend reflects continued high levels of temporary staffing, (bank and agency), the cost of which exceeds the value of substantive vacancies.

6. Bank and agency

6.1 The overall requested number of Nursing, Social Working, Corporate (Admin), Allied Health Professionals (AHP) and Courier Drivers shifts was 484,439 shifts, an increase of 2,885 (table 1). There were 30,768 bank shifts worked, 11,419 agency shifts worked and 6,252 shifts unable to cover or not allowed to go not agency.

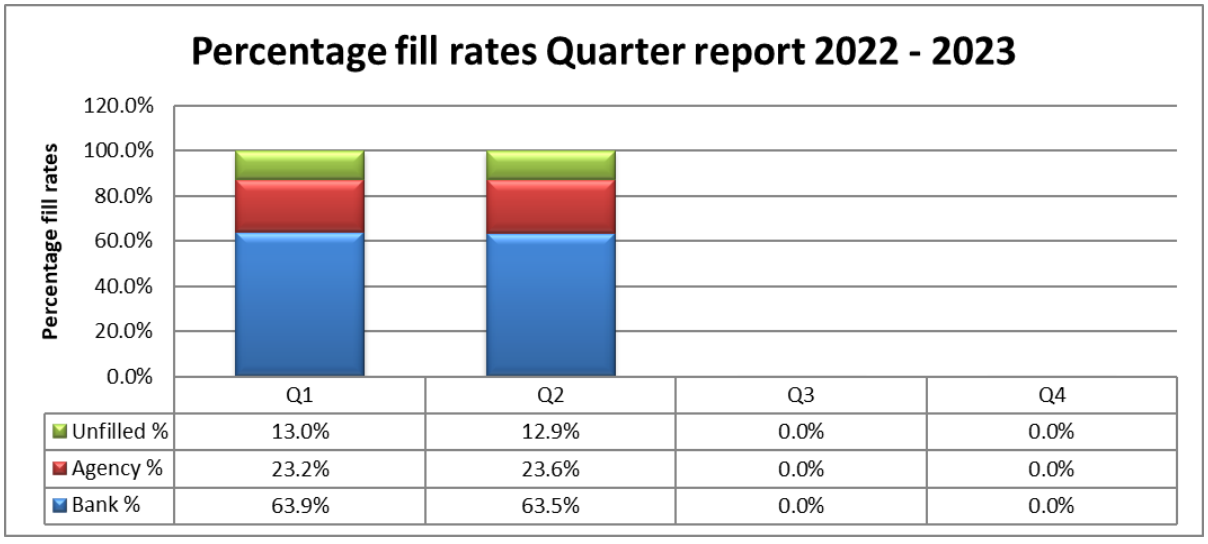
6.2 The Bonus incentives paid to inpatient areas paying to grade, has continued; the community services and Norfolk areas continue to receive this payment as per the agreement in 2015, of working 42 and 90 hrs on top of their contractual monthly hours.



	Bank	Agency	Unfilled	Total shifts
Q1 April - June 2022	29098	10551	5905	45554
Q2 July - Sept 2022	30768	11419	6252	48439
Q3 Oct - Dec 2022	0	0	0	0
Q4 Jan - Mar 2023	0	0	0	0

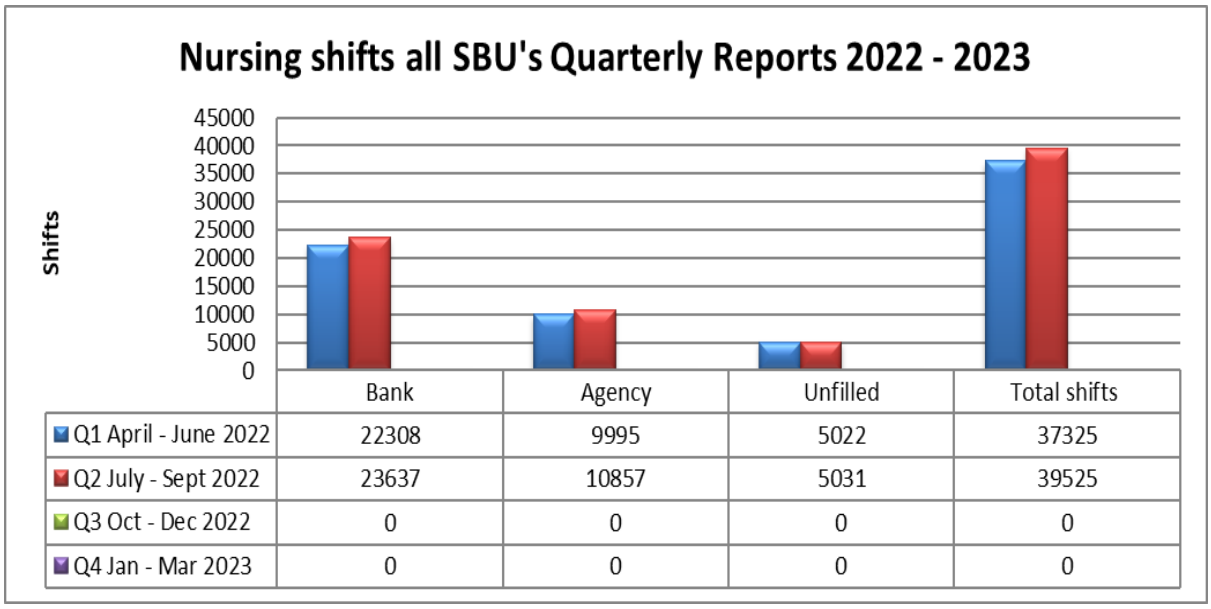
Table 1

6.3 Table 2 shows the percentage fill rates for all requested shifts and table 3 shpws month-on-month shifts for all SBUs.



	Q1	Q2	Q3	Q4
Unfilled %	13.0%	12.9%	0.0%	0.0%
Agency %	23.2%	23.6%	0.0%	0.0%
Bank %	63.9%	63.5%	0.0%	0.0%

Table 2



	Bank	Agency	Unfilled	Total shifts
Q1 April - June 2022	22308	9995	5022	37325
Q2 July - Sept 2022	23637	10857	5031	39525
Q3 Oct - Dec 2022	0	0	0	0
Q4 Jan - Mar 2023	0	0	0	0

Table 3

6.4 Bank shifts covered has increased to 23,637, as have agency shifts to 10,857; unfilled has also slightly increased to 5031 shifts. The bank nursing hours for all SBUs were seen at 224,490.2, which equates to 1381.5 WTE. Agency nursing hours were seen at 115,074.8, equating to 708.2 WTE.

6.5 Loss contracted hours are checked weekly during the roster scrutiny meetings and th services work to a 12-week roster timetable to ensure that loss contracted hours are assigned to staff before sending vacant shifts to bank to be covered.

6.6 The top reasons for requesting bank and agency are:

- Vacancy – 26,828 shifts
- SASO – 11,735 shifts
- Sickness – 1,752 shifts
- Ward activity – 1,540 shifts
- Training – 1,231 shifts.

6.7 There were 53 shifts where staff failed to attend for the booked shifts, all of which are reported back to the relevant agencies.

6.8 55 new bank HCA and two RN inductions took place and 28 transfers from agency to bank.

7. Conclusion

7.1 This quarter has shown continual pressure and challenges across all services with the level of prescribed SASO and staffing shortages predominantly owing to vacancies, with an increased focus on the scrutiny and governance of staffing.

7.2 A focused task and finish group for nursing recruitment and retention monitors a targeted action plan to increase recruitment and to focus on the retention of the nursing workforce.

NHS
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Appendix 1

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

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

NHS
Hertfordshire
Partnership University

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

Hertfordshire Partnership University NHS Foundation Trust

Appendix 2

July 2022

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex & IAPT	72.41	52.56	19.85	27.41%
Learning Disability & Forensic	209.87	153.24	56.63	26.98%
East & North	318.05	228.39	89.66	28.19%
West	302.99	219.81	83.18	27.45%
Total	**930.35**	**683.83**	**246.52**	**26.50%**
Unregistered Nursing				
Essex & IAPT	33.36	35.69	-2.33	-6.99%
Learning Disability & Forensic	193.23	155.94	37.29	19.30%
East & North SBU	242.74	196.10	46.64	19.22%
West SBU	173.35	134.24	39.11	22.56%
Total	**643.68**	**522.97**	**120.71**	**18.75%**

August 2022

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex & IAPT	72.41	53.56	18.85	26.03%
Learning Disability & Forensic	209.87	150.97	58.90	28.06%
East & North	317.05	221.41	95.64	30.16%
West	302.99	214.69	88.30	29.14%
Total	**929.35**	**670.63**	**258.72**	**27.84%**
Unregistered Nursing				

Essex & IAPT	33.36	34.89	-1.53	-4.60%
Learning Disability & Forensic	193.23	162.29	30.94	16.01%
East & North SBU	242.74	197.96	44.78	18.45%
West SBU	173.35	136.71	36.64	21.14%
Total	**643.68**	**532.85**	**110.83**	**17.22%**

September 2022

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex & IAPT	73.41	53.04	20.37	27.75%
Learning Disability & Forensic	211.87	146.97	64.90	30.63%
East & North	305.92	223.12	82.80	27.07%
West	308.59	212.69	95.90	31.08%
Total	**935.22**	**667.82**	**267.40**	**28.59%**
Unregistered Nursing				
Essex & IAPT	33.36	40.80	-7.44	-22.30%
Learning Disability & Forensic	184.63	163.91	20.72	11.22%
East & North SBU	242.74	203.47	39.27	16.18%
West SBU	173.35	142.81	30.54	17.62%
Total	**636.08**	**551.98**	**84.10**	**13.22%**

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 10c
Subject:	Experience of Care Report: Quarter 1	**For Publication:** Yes
Authors:	Lara Harwood, Experience Manager	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Sandra Brookes, Deputy CEO and Chief Operating Officer	

Purpose of the report:

This summary report provides the Board with information on feedback received from service users and carers, i.e. compliments, PALS contacts, complaints, Having Your Say and other local surveys including the Friends and Family Test, and other experience feedback during Quarter 2, 2022-23.

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

Action required:

The Board is asked to receive the report and note progress.

Summary and recommendations:

Summary

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

This summary report provides an overview of feedback: local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during quarter one 2022-23. Information is provided over time to help identify themes, trends and learning for the Trust. The report highlights the importance of services receiving feedback on the care and services they provide.

Headlines for quarter two 2022-23

In the quarter the Trust received:

- 538 compliments (505 in quarter one)
- 2,182 surveys (HYS, FFT, Attend Anywhere) - (1,958 in quarter one)
- 78% FFT Score (78% in quarter one)
- 262 PALS contacts (274 in quarter one)
- 119 complaints (113 in quarter one)
- 9% of the HPFT caseload provided feedback in quarter one (8% in quarter one)

Key Performance Indicators

- 69% service users feeling safe on adult and CYP inpatient units in quarter two – compared to 73% in quarter one
- 82% service users know how to get support and advice at a time of crisis in quarter two – compared to 80% in quarter one
- 81% service users have been involved as much as they want to be in discussions about their care – compared to 88% in quarter one
- 76% of carers feel valued by staff as a key partner in care planning – compared to 77% in quarter one

- 48 working days was the average number of days for a complaint response for those complaints closed in quarter two (54 in quarter one).

The most significant changes when compared with the previous quarter?

Positive
- 11% increase in surveys received.
- An increase in compliments received compared to quarter one.
- Decrease in number of working days to respond to a complaint.
- Increase in service users in inpatient care saying activities helped towards their recovery.

Areas for improvement
- The number of formal complaints increased
- The number of service users in community care saying information was provided about medication.
- The number of service users in community care saying they were given an opportunity to involve family and friends in their care.
- Continued low numbers of feedback surveys from carers.

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

Relation to the Trust Risk Register:

617 **CAMHS** – Failure to provide an efficient and effective CAMHS service which impacts on clinical care provided to you people.
773 **Adult Community –** Failure to respond effectively to demand in Adult Community impacting safety, quality and effectiveness – all sites
978 **Quality & Safety** – the Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff

Relation to the BAF:

1. We will provide **safe** services, so that people feel safe and are protected from avoidable harm.
2. We will deliver a great **experience** of our services, so that those who need to receive our support feel positively about their experience
3. We will **improve, innovate and transform** our services to provide the most effective, productive and high quality care

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

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

Mandated acknowledgement of complaints within three working days.

Mandated Friends and Family Test monthly submission to NHS England

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

The Trust must continue to learn from the lived experiences of those using HPFT services (NHS England Five Year Forward for Mental Health 2016), by working collaboratively with stakeholders,

staff, service users and carers to ensure that we consistently deliver services that are representative of the people using services.

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

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

Seen by the following committee(s) on date:

IGC 10 November 2022

Experience of Care Report – Quarter Two, 2022-23

1. Introduction

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

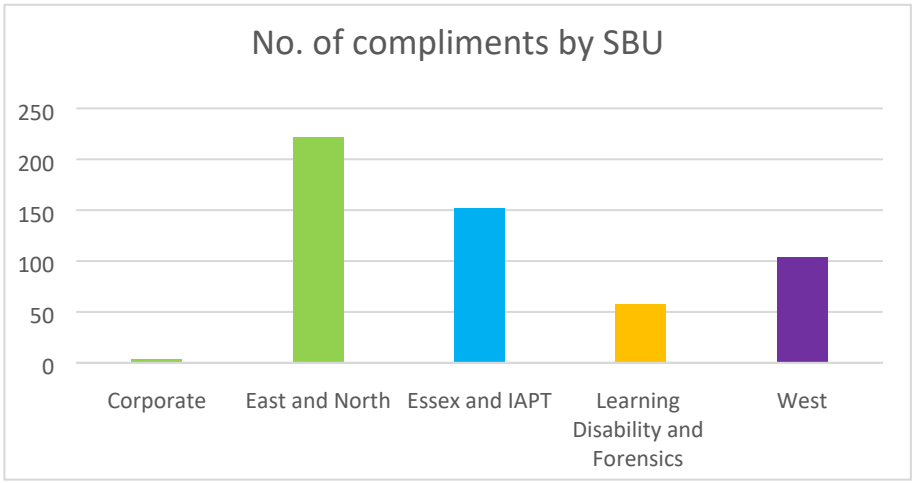
1.2 This includes local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during quarter one 2022-23.

2. Compliments

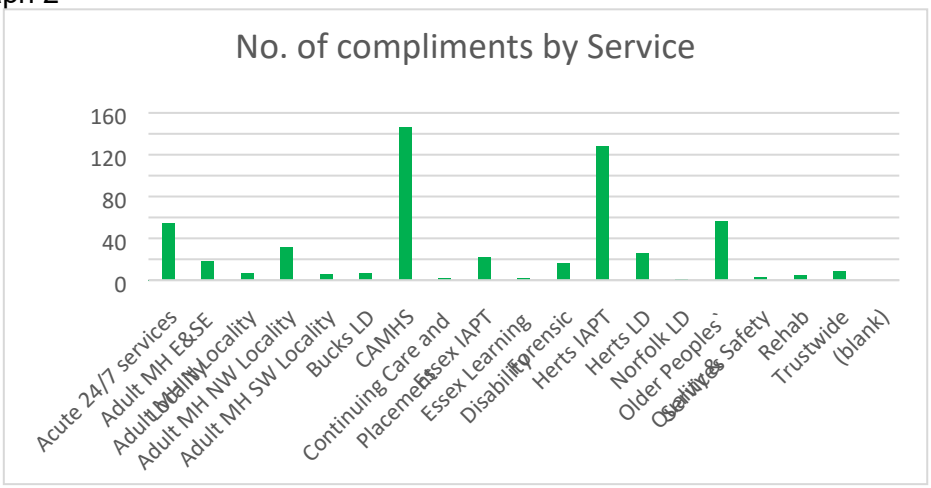
2.1 In quarter one 2022-23 we received a total of 538 compliments compared to 505 in quarter one. The majority of compliments were received for CAMHS with a total of 146 compliments, and next highest numbers were for Herts IAPT (128), Older Peoples' services (56), Acute 24/7 services (54) and Adult community north west locality (31).

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

Graph 1



Graph 2



2.3 **Compliment Themes:** "Excellent" was the most frequently used word, mentioned 35 times. Comments were given about the support and how staff have been understanding.

Robin Ward staff are very professional, work hard, listen to patients and

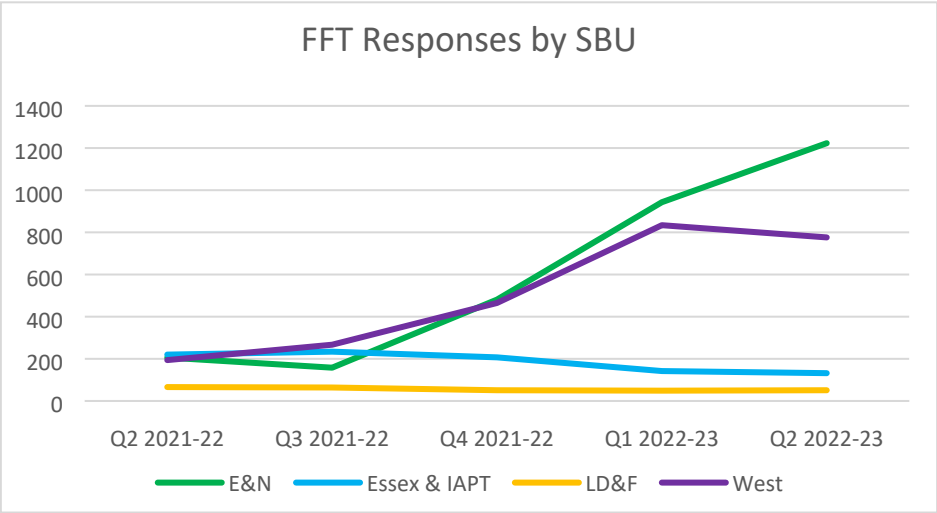
The listener clearly understood what I was saying as she was able to personally respond to every question. Gave me time.

Word Cloud 1

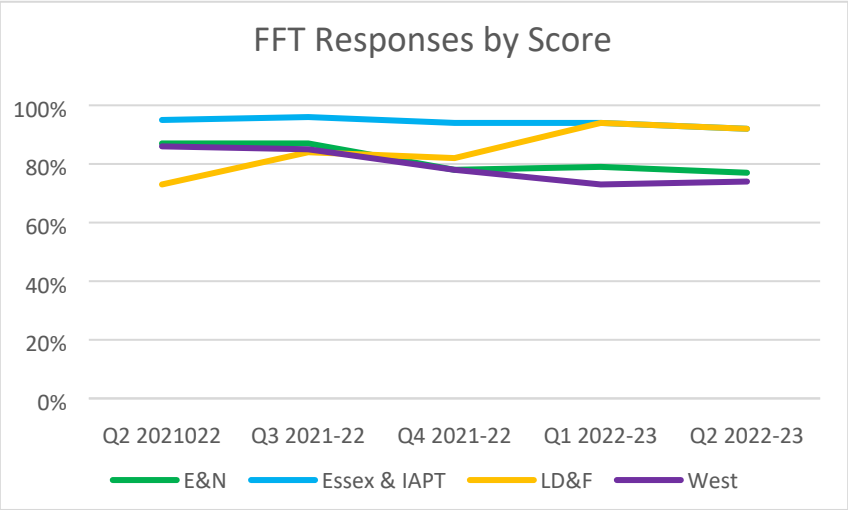
3. Surveys

3.1 During quarter two we received 2,181 responses to local surveys compared to 1,958 in quarter one. The FFT score remained unchanged at 78%. The use of SMS texting for FFT is continuing to increase the number of responses. In the quarter there was a decrease in satisfaction due to the number of "Neither good nor poor" responses received. The graphs below show the response and scores by SBU.

Graph 3

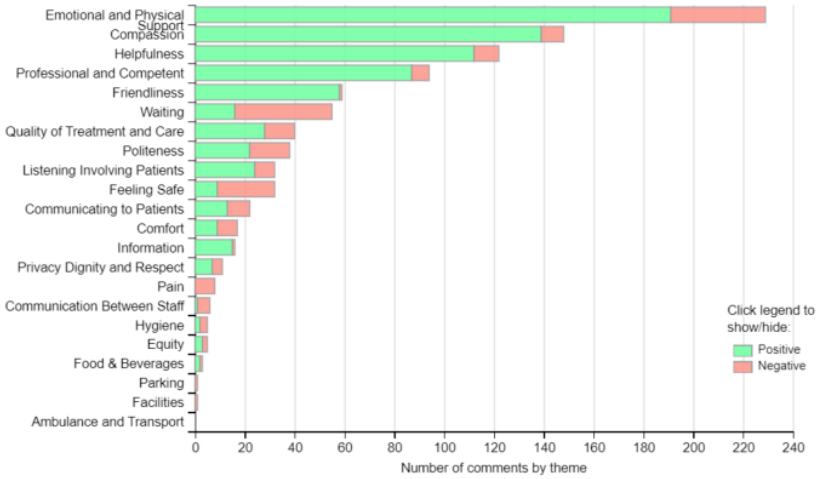


Graph 4



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

Graph 5 - all survey data



Word Cloud 2

3.3 The introduction of SMS texting for FFT in Adult Community and Older Peoples' Community services in particular has generated a significant increase in the number of responses to surveys.

3.4 Community hubs which, before COVID are re-introducing the ipads to encourage visitors to the sites to give feedback. Meet and greet volunteers are also beginning to return to community hubs to support with feedback.

4. Shared Experience

During quarter two services users provided the Trust Public Board and Public Council of Governors meeting with details of their shared experience. The story shared at the Board meeting was from two Forest House service users who shared their experience of their care on the unit. The story shared at the Council of Governors meeting was from a carer about their wife's rapidly deteriorating dementia and how Older People's services helped to intervene and care for her in an extremely emotionally distressing time. The stories were extremely well received.

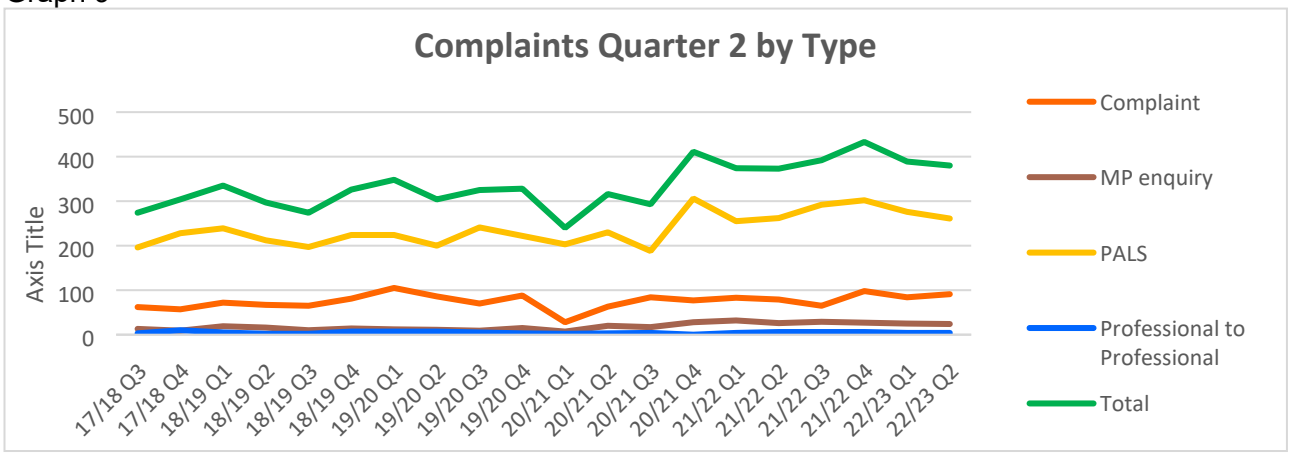
5. Complaints and PALS

5.1 In quarter two, 2022-23 we received 119 complaints compared to 113 in quarter one. Included in this figure are 24 MP enquiries and four professional to professional complaints.

5.2 There were 262 PALS enquiries in quarter one compared to 274 in quarter one. 100 of the PALS enquiries received were not related to HPFT. A sentence has been added to the public website with clarity about the Trust's role in regard to concern enquiries and there has been reduction in these since the previous quarter.

5.3 In the quarter 131 complaints were closed compared to 140 in quarter one; 19 were upheld, 37 partially upheld, 65 were not upheld, 8 were withdrawn, 2 complaints were closed as the concerns did not fall within the remit of HPFT Complaints Procedure. (Please note that complaints closed during quarter two were not necessarily received in the same quarter).

Graph 9



5.4 Appendix 1 provides detail on the complaint subjects and sub-subjects, the majority of complaints came under the themes of "clinical practice". The subjects and sub-subjects were reviewed in quarter two to match the ones required by NHS England for the Korner report.

5.5 Key areas to highlight are that in the quarter 47% of all complaints received were for Adult Community Mental Health Services, with frustrations about the lack of communication as a theme. Inaccuracies in letters and reports was also mentioned frequently. In adult acute services lack of communication with relatives, particularly when service users are moved to another ward were a theme. These themes are likely to be linked with the demand for services, staff vacancies and the increased demand for community services which we are setting. The Trust has as part of its recovery plan a programme to increase the number of staff and the number of initial assessments being undertaken. In CAMHS, concerns about waiting lists for ADHD remain a key focus for many PALS and complaints enquiries. The Trust recently had a business case to reduce the backlog for ADHD approved by the ICS and this is now being mobilised.

5.6 With regard to the key performance metrics for complaint management, the average number of days taken to acknowledge complaints in quarter two was three working days, it was two working days in the previous quarter. The nationally mandated target is three working days. The average number of days taken to respond to complaints that was closed in quarter two was 48 days, this compares to 54 in quarter one. This is above the 25 working day target. This figure is calculated by looking at all complaints closed in the period and removing any that were withdrawn by the complainant, did not fall under the HPFT complaints procedures or where, due to the process being paused, the clock was stopped.

5.7 Equality monitoring data is requested from complainants when registering a complaint. As requested by the Information Rights team, the information collected is no longer held on the Datix system but is held separately to maintain the individual's confidentiality. Of the 119 complaints received in quarter two, we received 11 completed equality monitoring forms. There were two complaints in quarter two were equality was mentioned in the concern;

- Complainant felt the staff member's language was in breach of the Equality Act and was antisemitic
- Complainant felt the trust were discriminating against her age as they were unable to assess her for ASD.

5.8 There is no updated benchmarking data available from NHS Digital for quarter two.

5.9 In the quarter 20 complaints evaluation surveys were received. Comments given said that complaints take too long to respond to and that the concerns were not always taken on board. 75% of complainants consider their complaint to be unresolved and 42% were unhappy with their final response. The team are considering how best to reach out to the complainants who have expressed their disappointment. This feedback also identifies the need for the teams to work further with complainants on the issues and desired outcomes, as well as how the Trust manages expectations for example with regard to access to services.

5.10 In quarter two the Parliamentary and Health Service Ombudsmen (PHSO) requested the case files for four complaints. The Nursing and Midwifery Council also requested one casefile. The Trust have received no outcomes from the PHSO in the quarter.

5.11 In quarter two the subjects and sub-subjects categorising complaints were revised on Datix in line with NHS England's reporting requirements and the need for the Trust to improve the access to data around themes and trends for complaints.

6. Actions and Learning from Feedback

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

6.2 The Having Your Say (HYS) review completed its focus groups and a draft report has been written with proposed outcomes. A "deep dive" feeling safety survey is underway (see 6.3) which will be treated as a PDSA cycle for the new proposed approach.

6.3 In August the Patient Safety meeting was held and the group advised that more information was required to understand how safe service users feel on our inpatient units. A short survey was produced which was used during September to gather feedback. Due to the documentaries aired over recent weeks, it was decided to extend this survey until mid-October to gather pre and post Panorama data. This data will be shared in the quarter three report.

7. Involvement

7.1 The Involvement programme continues to offer a combination of virtual and face-to-face Involvement activities. Our councils continue to meet virtually for a majority of their members, for members of the council that require additional IT support face to face meetings have been arranged and the council meetings are operating as a hybrid approach. It has been agreed that the Carers council will return to face to face meetings. Where Experts by Experience are not able to attend face-to-face or join the meeting virtually, individuals engage in activities via phone.

7.2 In Q1 434 involvement hours were completed, quarter two has seen a significant increase to 618.50 an increase of 235.5 hours, which we plan to continue to grow throughout the year. The table below outlines the hours of involvement activities have been completed in quarter two. Under 16s are not signed up to our payroll and therefore their involvement hours are not processed through the Better Impact database, however young people's involvement hours are still logged by the young person participation lead as they are paid via vouchers as recognition for their time given. During quarter two young people have completed 51 hours, taking the total of involvement hours for quarter two to 669.50.

Activity	Hours	Volunteers	Average	
EbE Activities	Carer Council	45.75	9	5.08
	CQI Projects	29.50	7	4.21
	Crisis Care Pathway Training	4.50	2	2.25
	Equality Events	2.00	1	2.00
	HPFT staff induction	3.50	3	1.17
	Interview Panel	133.10	10	13.31
	Peer Experience Listening	3.50	3	1.17
	Peer Observation Project	1.00	1	1.00
	PLACE	17.50	3	5.83
	SBU meeting	8.50	4	2.13
	Service User Council	37.50	8	4.69
	Specialist participation in Trust meetings and forums	278.15	24	11.59
	Support at events	4.50	2	2.25
	Training	47.50	6	7.92
	Youth Council	2.00	1	2.00
	Category Total Hours	**618.50**		
Total Hours		**618.50**		

7.3 The CAMHS Young People's Council had three meetings during quarter two. The Young people's Council has continued to recruit new members as the council had five members leave the council in August, due to them reaching the maximum age limit for the group.

7.4 Two Carer Council meetings were held in quarter two and two new members recruited. The carers council have written a letter to senior leads in relation to issues with the Terms of Reference and members of the council are meeting the Director of Service Delivery and Experience in quarter three. The carer council have been exploring putting in an innovation bid proposal to support development of e learning carers training to support the uptake of the carer essential training and to make it more accessible for all staff.

7.5 Three Service User council meetings have taken place during quarter two and three new members were recruited. The Service User council continues to monitor their projects via their project plan and have been working to increase and build on the information on the Trust website.

8. Volunteering

8.1 During quarter two the Volunteer Lead has focused on promoting volunteer opportunities and working closely with HPFT staff. Eight new volunteers have been recruited bringing the total volunteers up to 32 volunteers and three volunteers are in the recruitment pipeline.

8.2 The Volunteer's Lead has used quarter two to establish relationships with Team Leaders, Site Managers, and other staff members of HFPT sites who are able to develop and support volunteer roles to be created. Promoting the volunteering programme *Our Volunteers – Our Hidden Champions* is the slogan that has been created for the programme promotional material has been produce with the communication teams. External promotion has taken place at the University of Hertfordshire at their fresher's fair, Stevenage Job Centre, and Lister Hospital to also promote HPFT volunteering at their Careers fair. This event has resulted in BAME volunteers being recruited, currently the volunteer programme has low BAME representation, and this is an area the volunteer lead is keen to build on.

9. SBU Updates

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

The MHSOP Assessment and Treatment team at **Seward Lodge**: the team has an initiative to improve engagement with families in a more structured way in the form of 'bite size' care education as well as support. This will be a rolling programme where OT, physio etc will be part of the group and the team are hoping more carers will have an interest and be involved.

CAMHS Inpatient: Weekly meetings of improvement are also held, and the young people chair and take minutes of the meeting which is supported by a member of the senior nursing team and a member of the therapy team. This is an opportunity for the young people to have their voices heard collectively, receive updates on current unit issues and have an opportunity to co-produce and comment on information as required.

The group has implemented an appreciation board which involves everyone in attendance voicing an appreciation for either a staff member or young person from the previous week. These are written on a star and attached to a board for display within the unit. This is a new initiative to encourage a community experience within the unit.

CAMHS Eating Disorders Team: are now running a 'parent skills' group which is a 6 week programme (2 hours per week) offered to new referrals. These groups are averaging 7-14 parents and are receiving positive feedback. In the context of eating disorders, it covers psycho-education, using parental strengths, communication, understanding change, meal planning and managing behaviours.

The **CAMHS North team** have developed an ASD specific welcome pack and have received positive feedback from parents and young people.

IAPT: The Patient Experience Questionnaire (PEQ) offers the opportunity for service users to provide both quantitative and qualitative feedback on their experience. 598 service users completed the PEQ during Q2 which accounts for 16% of service users who completed treatment and the quantitative responses can be found in appendix 1.

Learning Disability Services: The overall return level of service user and carer feedback has been low historically within our Learning disability services. A study was therefore undertaken by

Psychologists working within the Essex Community Learning Disability Teams to explore the experience of eliciting and giving feedback by analysing interviews that were carried out with service users, carers and staff. The thematic analysis identified three key themes that were centred around the process of giving/receiving feedback, tailoring feedback to become person-centred and individualised, and clearly defining the purpose of feedback.

We have also developed a plan to upskill the Health Access Champions to act as peer educators in relation to Annual Health Check (AHC) training. This has now been completed and we are seeking to deliver AHC training in quarter three with direct support being provided to the HACs by their job coach.

The **Rehabilitation** services have started work this quarter at reviewing their carer involvement including renewing their Carers Charter in conjunction with a group of carers. This will strengthen the link with carers and is drawing on the feedback received from carers during the co-production events hosted by Inclusion Unlimited earlier in the year.

The speech and language therapist for **Broadland Clinic** has co-produced a physical health resource with service users. This pulls together easy read resources on physical health conditions and treatments into a pack to aid discussions with service users about their physical health.

A previous resident at **Warren Court** has been coming back into the service to share his successful discharge story with current service users and how he is integrating into the community. This has been a very powerful message of hope for service users who can be fearful of discharge having spent much of their adult lives in secure facilities.

Oak Ward: Occupational Therapy ATP team put together a Sports Day on Oak Ward. They had a long jump, longest plank competition (the winner went over 4 and a half minutes!), relay race, egg and spoon race, and finished the day with a garden party for all the participants and a prize giving.

Oak Ward: Service Users have been involved in the Oak refurbishment project. This has included choosing artwork, design for the garden, design for the rooms and colours for the walls. On **Thumbswood** they have worked withed with service users to design the family room.

Psychology services has been meeting Service Users and carers as part of Autism Strategy and met with VCSEs to co-produce the Strategy.

Place Audits started to take place within our **Inpatient Units**, this started with offering training to anyone who wanted to be involved. Our Experts by experience were involved from the beginning of the Audits and have offered a valuable and honest way of supporting to improve the environment of our Inpatient Units.

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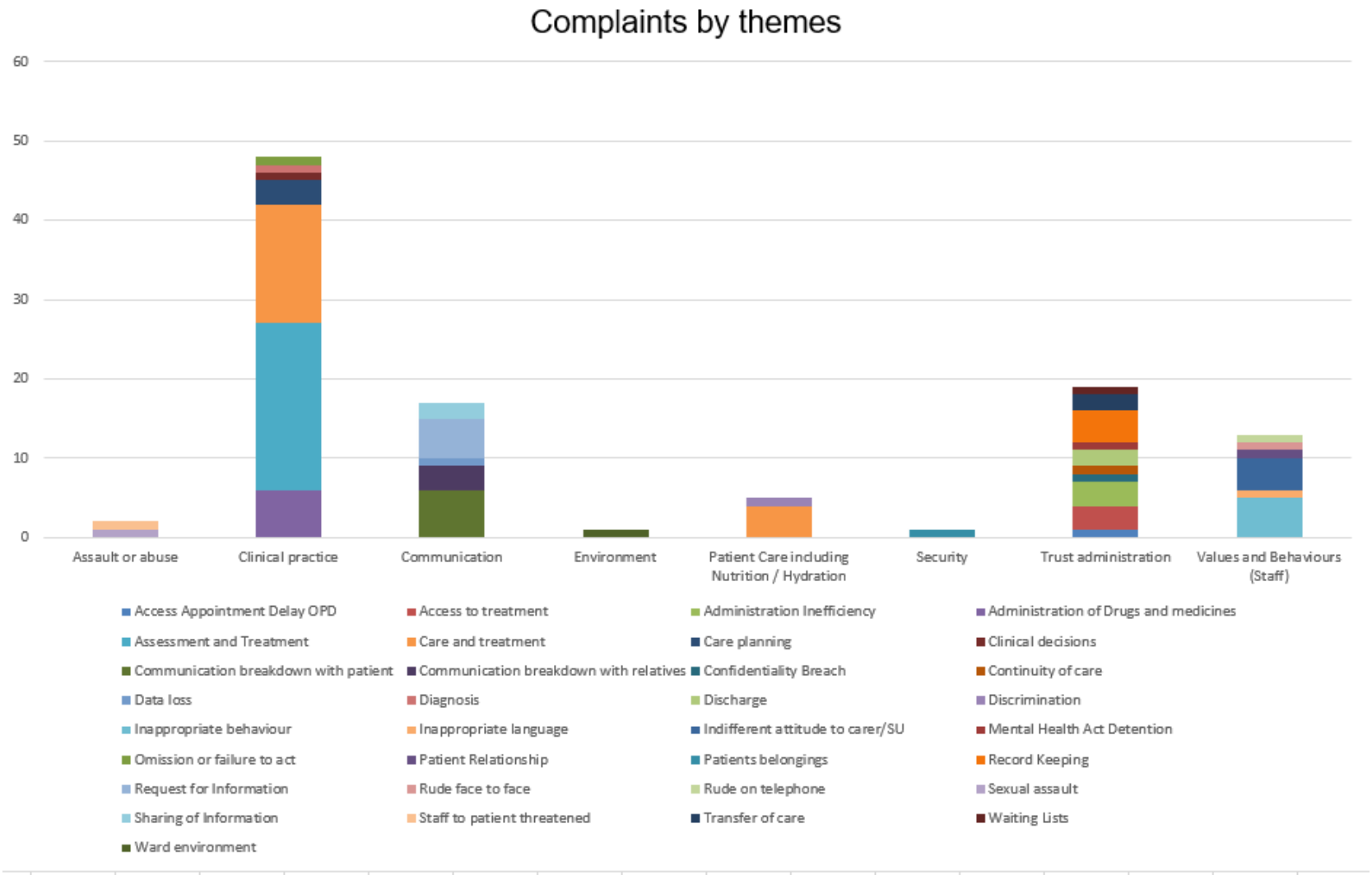
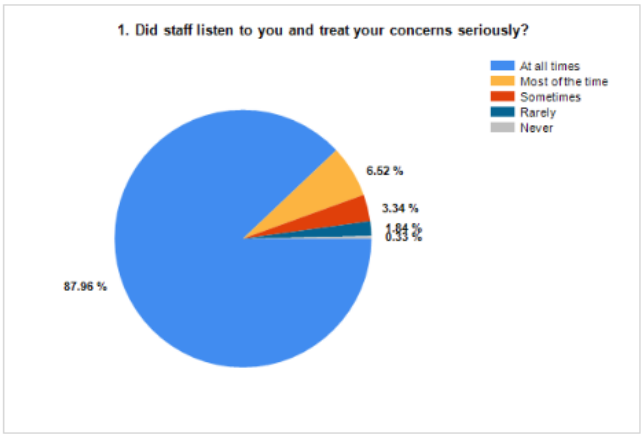
Appendix 1 – Complaints Themes

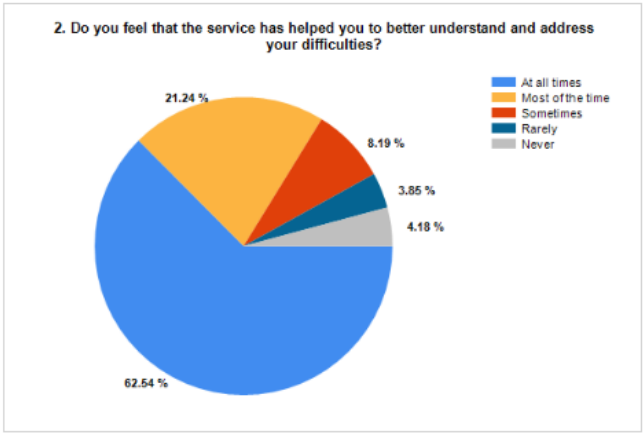


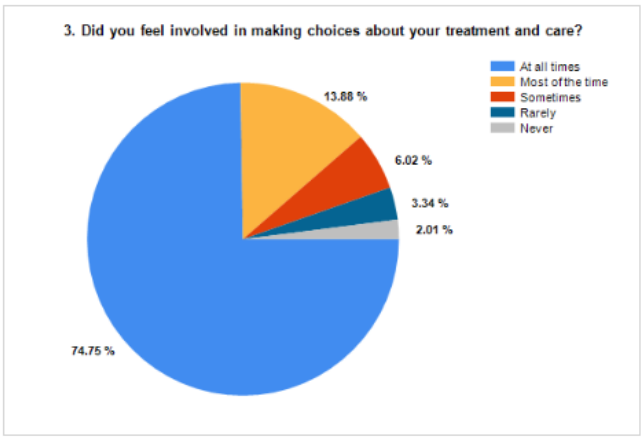
Appendix 2 PEQ Data

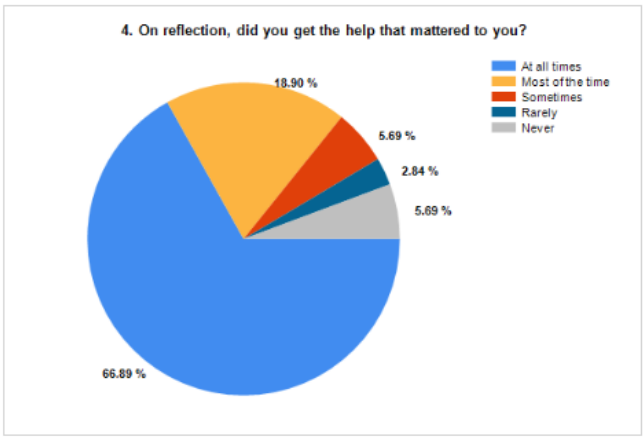
The Patient Experience Questionnaire (PEQ) offers the opportunity for service users to provide both quantitative and qualitative feedback on their experience

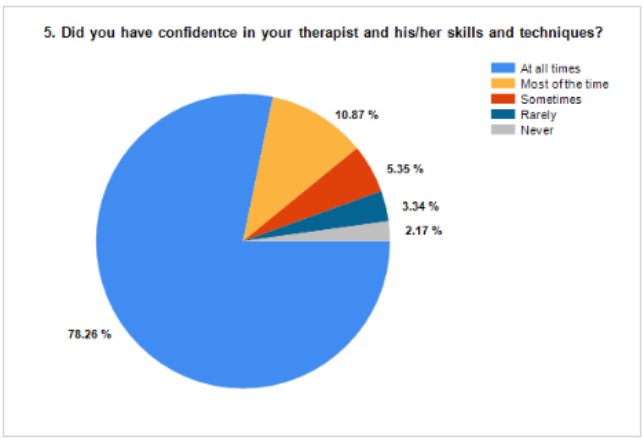
	East & North Herts	Mid Essex	West Herts	Total
Total Number Completed Treatment	1236	896	1604	3736
Total Number Completed Treatment And Completed PEQ Treatment	214	149	235	598
Return Rates for PEQ Treatment	17.31%	16.63%	14.65%	16.01%

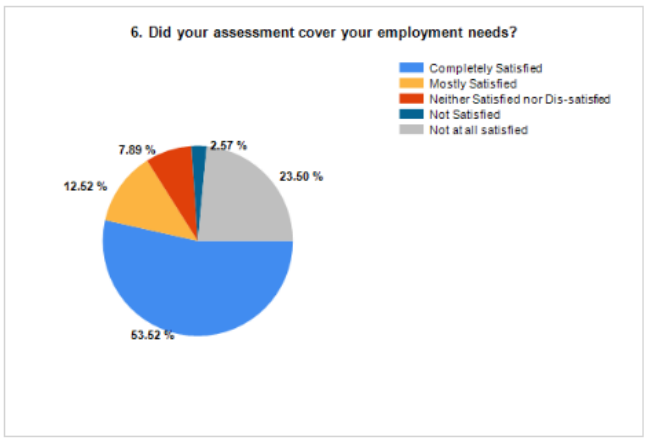












PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 11
Subject:	Freedom to Speak Up (FTSU) Report- Quarter 2 (22/23)	**For Publication:** Yes
Authors:	Yusuf Aumeerally Freedom to Speak Up Guardian (FtSUG)	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

To present to the Board the quarterly report.

Action required:

The Board is asked to receive the report

Summary and recommendations:

Feedback from IGC

This report was considered at the Integrated Governance Committee at its meeting held on 10 November 2022. The Committee discussed the increase in cases compared to the same quarter last year, and that this was likely to be linked with the increased visibility of the Freedom to Speak Up Guardian. The Committee agreed of the importance of considering the themes and closing of the 'loop' on learning and with those that had raised concerns.

Report Headlines

The report is to present to the Board so that they are aware of the number of Freedom to Speak Up (FtSU) cases brought to the Freedom to Speak Up Guardian (FtSUG). The trends and themes the speak up matters relate to are also shared.

Summary of Cases

There were 33 speak up cases brought to the Freedom to Speak Up Guardian in quarter 2 (2022/23).

Priorities

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

Conclusion

The FtSUG has been in the role full time since 16 May 2022. This is the first time the Trust has employed a full time FtSUG. Since this time there has been a marked increase in FtSU matters being brought to the FtSUG.

There were 33 FtSU cases received by the FtSUG in quarter 2 (2022/23). In the year prior, in quarter 2, there were 12 speak up cases received by the FtSUG. There are many potential

reasons for the increase in speak up matters being brought to the FtSUG which have been highlighted above in the report. This includes the role now being full time. There has been an increase in speak up cases being brought to FtSUGs nationally since 2017 according to the National Guardian Office (NGO).

Of the 33 cases brought to the FtSUG in quarter 2, 19 speak up cases are still ongoing. 11 received before quarter 2 are still ongoing with the oldest open speak up matter dated January 2021.
The majority of the FtSU cases (12) came from staff working in additional clinical services which includes Health Care Assistants/Health Care Support Workers.

The report highlights that, out of the 33 cases brought to the FtSUG, 30 of these involved an element of worker safety or wellbeing. Although the FtSUG works closely with the Patient Safety Specialist and Health and Wellbeing Lead, there is more work required from the organisation in order to address this matter.

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

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

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

A full time FtSUG has been appointed earlier this year (2022), and this has a financial and staffing implication.
We have 11 trained FtSU champions who have across the organisation so far. The role will have an impact on staffing. This role is in addition to the existing role of the member of staff. The Trust support champions having protected time to complete their role. The impact the champion role has to the individual's full time role will be regularly reviewed by the Trust.

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

Anyone who works in NHS healthcare can speak up. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.
There is literature which highlights that specific groups of individuals experience difficulties speaking up. This includes news starters, students, and staff of a BAME background. The Trust participated in research commissioned by the NGO which looked at people's experiences of accessing their Freedom to Speak Up Guardian and whether ethnicity had an impact.

The research was published by the NGO and this found that black and minority ethnic respondents were six times more likely than white respondents to say that they were more likely to

raise a concern with a Guardian of the same ethnicity as themselves. The current FtSUG is of BAME background which might be a contributing factor to the increased number of speak up matters being received by him. We continue as a Trust to recruit a diverse group of champions which will hopefully break down barriers and encourage staff to speak up.

The FtSUG works with the staff network groups within the organisation in order to strengthen the speak up culture. The FtSUG has also attended students forums, completed sessions at the University of Hertfordshire, and also recently spoken at the Black History Month for the Eastern Region Royal College of Nursing event.

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

A new national FtSU policy has been published. The Trust will use the national policy and tailor it to suit our organisation.

Seen by the following committee(s) on date:

IGC 10 November 2022

Executive Summary

1. Introduction

There were 33 Freedom to Speak Up (FtSU) cases raised in quarter 2 (2022/23). In the year prior, in quarter 2, there were 12 speak up cases raised within the Trust.

Of the 33 speak up cases raised within quarter 2, 12 were raised in relation to the services provided by the West Strategic Business Unit (SBU), nine for the East and North SBU, eight for the Learning Disability and Forensic SBU, two for Corporate Services and two for Estates.

19 speak up cases from quarter 2 are still ongoing. 11 received before quarter 2 are still ongoing with the oldest open speak up matter dated January 2021.

Conclusion

The FtSUG has been in the role full time since 16 May 2022, since this time there has been a marked increase in FtSU matters being brought to the FtSUG.

There were 33 Freedom to speak up cases received by the FtSUG in quarter 2 (2022/23). In the year prior, in quarter 2, there were 12 speak up cases received by the FtSUG. There are many potential reasons for the increase in speak up matters being brought to the FtSUG which have been highlighted above in the report. This includes the role now being full time. There has been an increase in speak up cases being brought to FtSUGs nationally since 2017 according to the National Guardian Office (NGO).

The priorities highlighted within the report are ongoing. As the FtSUG full time role is still new to the organisation and the work required to strengthen the speak up culture will take time.

Of the 33 cases brought to the FtSUG in quarter 2, 19 speak up cases are still ongoing. 11 received before quarter 2 are still ongoing with the oldest open speak up matter dated January 2021.

The majority of the speak up cases (12) came from staff working in additional clinical services which includes Health Care Assistants/Health Care Support Workers.

The report highlights that out of the 33 cases brought to the FtSUG, 30 of these involved an element of worker safety or wellbeing. Although the FtSUG works closely with the Patient Safety Specialist and Health and Wellbeing Lead, there is more work required from the organisation in order to address this matter.

Speak Up Report Quarter 2 (2022-2023)

1. Introduction

1.1 This report focuses on speak up matters received by the Freedom to Speak Up Guardian (FtSUG) in quarter 2 (2021-2022).

2. Freedom to Speak Up Governance Processes

2.1 The Freedom to Speak Up (FtSU) process ensures the confidentiality of those speaking up, if this is their preferred method (there are times when confidentiality must be overridden). However, where possible, staff are encouraged to share their details, so that speak up matters can be robustly investigated, and support can also be more easily provided to the individual. There is a high level of confidentiality, with only the FtSUG having access the database (specific part of Datix) which holds the information of the individual speaking up, and also the details of the speak up matter.

2.2 The Trust previously had a FtSU Strategy Group which aimed to meet on a three-weekly basis. The group would discuss the speak up matter and direct to the appropriate process for the matter to be resolved. This kind of group is not used in other Trusts due to the sensitive information, and the governance issues this can cause. This group is now called the FtSU Advisory Group and cases are brought to this group by the FtSUG for advice about how best to seek resolution. The group still aims to meet on a three weekly basis and does not hold any governance commitments which are instead held with the specific Strategic Business Unit (SBU). The FtSU Policy is currently being updated and will reflect the above. The FtSUG reports to the Integrated Governance Committee (IGC). The Trust has an identified Executive and Non-Executive Board member for FtSU.

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

3. Speak Up Cases- Trends and Themes for Quarter 2

3.1 There were 33 Freedom to Speak Up cases brought received by the FtSUG. In the year prior in quarter 2, there were 12 speak up cases received by the FtSUG. The increased in speak up cases brought to the FtSUG may have been impacted by the following:

- The FtSUG is now full time within the role and has raised the profile of the FtSUG and the FtSU process across the organisation. They have worked with the communications department to raise the profile
- The FtSUG has visited many different sites to talk about his role, the FtSU process, and the speak up culture we wish to strengthen within the Trust. The FtSUG attended sites as part of the Wellbeing Festival and spoke to many staff
- The FtSUG has regular meetings with the Care Quality Commission and has attended different sites as a response to concerns being raised
- The Trust now have trained FtSU Champions across the Trust. The face-to-face training sessions took place in quarter 2 in order to ensure the champions

are aware of their role, the limitations of the role, and who to contact for support. The first FtSU Champions network meeting has also taken place

- The FtSUG is of a Black Asian Minority Ethnic (BAME) background and the research the Trust were involved in last year published by the NGO found that BAME respondents were six times more likely than White respondents to say that they were more likely to raise a concern with a FtSUG of the same ethnicity as themselves. The diversity of the FtSU Champions may have also impacted on the speak up cases being revived by the FtSUG

3.2 This above list is not exhaustive, and the NGO report a steadily increased amount of FtSU cases being received to the FtSUG since 2017.

3.3 Of the speak up cases raised in quarter 2, one of these were anonymous. The NGO explains that *'workers speaking up anonymously may be an indicator that speaking up arrangements or culture need improvement. For instance, workers may choose to speak up anonymously because they are concerned about detriment for speaking up'*.

3.4 *Figure 1* highlights which SBU the speak up matters relate to. An increase amount of speak up cases raised in a specific SBU should not be seen as a negative and acknowledged as an area where strengthening of a FtSU culture could be focused.

	Q2 2022-2023
West	12
East & North	9
LD&F	8
Corporate	2
Estates	2
Total	33

Figure 1

3.5 The data is currently not broken down into service areas given the sensitivities of FtSU and the potential impact this could have to individuals speaking up.

4. Themes

4.1 All FtSU cases are recorded on Datix and categorised by theme in accordance with the NGO. It is worth noting that the categories do not always reflect the nuance of the speak up matter.
There are four main categories:

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

4.2 Some FtSU matters have more than one of the above elements included and has been recorded as such in accordance with the NGO guidance.

4.3 Figure 2 highlights the amount of FtSU cases received in quarter 2, and also the categories in which the speak up cases relate to.

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

Total number of cases in quarter	33
Number of cases raised anonymously	1
Number of cases with an element of service user safety/quality	13
Number of cases with an element of worker safety or wellbeing	30
Number of cases with an element of bullying/harassment	9
Number of cases with an element of other inappropriate attitudes or behaviours	13
Number of cases where people indicate that they are suffering detriment as a result of speaking up	0

Figure 2

4.5 19 cases are still ongoing. These need time to be resolved fully and appropriate escalation will be completed by the FtSUG if indicated. Of the 14 closed cases, only one person responded to the feedback request (*figure 3*), who advised that they would speak up again in future and did not experience any detriment.

Response to the feedback question, 'Given your experience, would you speak up again?'	
Total Number of responses	
The number of these that responded 'Yes'	
The number of these that responded 'No'	
0The number of these that responded 'Maybe'	
The number of these that responded 'I don't know'	

Figure 3

4.6 *Figure 4* highlights the professional/worker groups the speak up cases came from.

Professional/Worker Group	Definition	Number
Additional clinical services	• Staff directly supporting those in clinical roles. In addition, support to nursing, allied health professionals and other scientific staff are included. • Have significant patient contact as part of their role.	12
Additional professional scientific and technical	• Scientific staff, including registered pharmacists, psychologists, social workers, and other roles such as technicians and psychological therapists.	9
Administrative and clerical	• Non-clinical staff, including non-clinical managers, administration officers, executive board members who do not have significant patient contact as part of their role.	3
Estates and ancillary	• Non-clinical support and maintenance staff, including gardeners, plumbers, cooks and housekeepers who do not have significant patient contact as part of their role.	2
Nursing and midwifery registered	• Registered nurses and midwives.	7

Figure 4

4.8 The NGO annual report last year highlighted that the majority of the speak up cases came from Registered Nurses (RN) which accounted for 28.9% of the cases received by the FtSUG. As can be seen above, the majority of the speak up cases came from staff working in additional clinical services which includes Healthcare Assistants/Health Care Support Workers.

5. Method of Speaking Up

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

5.2 The FtSU Champions can also direct staff to the FtSUG when required.

6. Priorities

6.1 The priorities for the rest of the financial year are:

- *To continue to promote the Trust's FtSUG role Trust wide.* It is important to inform new staff and also remind existing staff how they can speak up if they wish to do so. Staff need to feel that they can speak up and that there is a culture within the Trust to do so. People speaking up can enable change, reduce risk to staff, service users and carers. Market places are now being held again for the induction of new staff. The FtSUG will try and attend these and/or send champions to speak to staff

- *To recruit and train more FtSU Champions.* The Trust only has one FtSUG and therefore the recruitment of FtSU Champions will be supportive. The Trust want to ensure that staff from all areas of the organisation have access to a Champion as well as the FtSUG. Face to face training is being offered to Champions so that there is assurance that they are aware of the responsibilities of the role and the limitations. Network meetings are being arranged and further support arrangements are being considered

- *To provide information about FtSU and how to contact the FtSUG*. October was FtSU month and during the month a lot of communication has gone out to staff and this includes the different ways in which staff can speak up

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

- *To continue to promote a speak up culture.* The FtSUG will work with the Trust to advertise and encourage staff at all levels to complete the e-learning Freedom to Speak Up in Healthcare in England programme. Champions are also being recruited to and this will support the speak up culture

- *To continue to improve the robustness and clarity of the internal FtSU processes.* This will further enable the Trust to respond effectively to speak up matters raised. The FtSU policy will be updated and taken through the governance process before being published

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

- *To continue to report the required data to the NGO.* The NGO highlights that the data contributes to learning and improvement – not just for the organisation – but also for other Freedom to Speak Up Guardians and the healthcare system more widely. The information shared also provides essential insight into the implementation and use of the Freedom to Speak Up Guardian role.

7. Conclusion

7.1 The FtSUG has been in the role full time since 16 May 2022. This is the first time the Trust has employed a full time FtSUG. Since this time there has been a marked increase in FtSU matters being brought to the FtSUG. There is ongoing work for the FtSUG to complete with the Trust to ensure the speak up culture within the Trust is strengthened, and that speak up matters brought to the FtSUG are resolved within an appropriate timeframe.

7.2 There were 33 FtSU cases received by the FtSUG. In the year prior, in quarter 2, there were 12 speak up cases received by the FtSUG. There are many potential reasons for the increase in speak up matters being brought to the FtSUG, which

have been highlighted above in the report. This includes the role now being full time. There has been an increase in speak up cases being brought to FtSUGs nationally since 2017 according to the NGO.

7.3 The majority of the speak up cases (12) came from staff working in additional clinical services which includes Healthcare Assistants/Health Care Support Workers.

7.4 The priorities highlighted within the report are ongoing. As the FtSUG full time role is still new to the organisation and the work required to strengthen the speak up culture will take time.

7.5 Of the 33 cases, 19 speak up cases are still ongoing; 11 received before quarter 2 are still ongoing with the oldest open speak up matter dated January 2021.

7.6 The report highlights that out of the 33 cases brought to the FtSUG, 30 of these involved an element of worker safety or wellbeing. Although the FtSUG works closely with the Patient Safety Specialist and Health and Wellbeing Lead, there is more work required from the organisation in order to address this matter.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 12
Subject:	Report of the Finance and Investment Committee held on 17 November 2022	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Paul Ronald, Executive Director of Finance and Estates
Presented by:	Paul Ronald, Executive Director of Finance and Estates	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Finance and Investment Committee at its most recent meeting held on the 17 November 2022.

Action required:

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

Summary and recommendations to the Board:

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

Matters for Escalation to the Board

There were no items for formal escalation to the Board.

The Board is asked to note that the Committee agreed the process to undertake a self assessment of effectiveness.

The key headlines for the Board are that:

i. the Trust will be continuing to monitor and track the year end position for 2022/23. Committee and Board members will continue to be briefed with the regard to the Trust's approach to the protocol for changes to in-year financial forecast.
ii. work is underway to develop the case for funding for the Trust to be in line with the current position with regard to demand for mental health and learning disability services. This will be used in discussion with commissioner for the next financial year's settlement.
iii. the Board will be receiving separate reports on performance and the Annual Plan, but the Committee highlighted the continuing challenging position for our services, which is generated by limited access to workforce and the acuity of our service users.

Relationship with the Business Plan & Assurance Framework:

List specific risks on BAF – 1.1, 1.2, 2.1, 5.3

Summary of Implications:

None

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

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

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Finance and Investment Committee held on 17 November 2022

1. Introduction

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

1.2 Since the last Finance and Investment Committee report to the Trust Board in Public, the Finance and Investment Committee ["the Committee"] held a meeting on 17 November 2022 in accordance with its terms of reference and was quorate.

1.3 The Committee was chaired by Anne Barnard, Non-Executive Director and welcome Carolan Davidge as a new NED member.

1.4 The Committee piloted a new approach when considering reports. A number of related reports were clustered and presented together enabling discussion across them all rather than individually. Initial feedback is that this was a helpful approach and facilitated in depth discussion on the key issues for the Trust.

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

2. Financial Year to Date and Year End forecast 2022/23

2.1 The Committee received a series of reports to support the discussion on the current financial position and forecast year end for 2022/23. These included a finance report for the period up until end of September, which highlighted that the position had deteriorated since the last report to the Committee. The deterioration is driven by use of out of area placements and increased pay costs. It was reported that there remained a level of confidence that the Trust would be able to cover the forecast costs for the year but there were a number of moving parts which may impact on this.

2.2 The report on the Delivering Value programme reflected the challenging financial position. The Committee noted the capital programme for 2022/23 and that it was on plan to spend the allocated Capital Departmental Expenditure Limit (CDEL) for the year. The Committee welcomed the delivery of schemes that improved conditions for service users and staff.

2.3 The Committee discussed in detail the implications of the recently published Protocol for changes to in-year revenue financial forecast. It was noted that more detail of the practical application of the protocol was awaited but that is demonstrated the clear desire for matters to be managed at a system level. The Committee considered the benefits and risks of the Trust seeking to apply the protocol, noting that this may be discussed in more detail at the November Board meeting.

2.4 The Committee received feedback on the recent visit from the national team with regard to Out of Area Placements (OoAPs), noting that the national team had reported that the Trust was working in the right areas. The national team provided useful feedback emphasising the importance of there being a system wide approach.

The Committee were also updated on the workstreams underway to reduce OoAPS and reduce the spend on agency as our vacancy rate reduced.

3. Finance Headline Plan for 2023/24

3.1 The Committee received a report that set out the headlines for the financial plan for 2023/24. The Committee discussed the assumptions that supported the headline plan, noting that national guidance had not yet been received.

3.2 The Committee were updated on the exercise underway in the Trust to compare the cost base between the pre COVID period and now, with the aim to better understand the changes in costs. It was agreed that this would help support discussions with commissioners with regard to the case for investment and also identify areas for the Trust to focus on manage costs more effectively. The Committee welcomed this approach and felt it would help for the contract discussions with commissioners for 2023/24.

3.3 It was noted that the Trust Board at its meeting at the end of November would consider the headline plan for 2023/24.

4. Preparation for Year End 2022/23

4.1 The Committee received a detailed report on the work underway to prepare of year end 2022/23. The Committee recognised the detailed work already completed to ensure there was robust planning in place. For example, the early engagement of the District Valuer to undertake asset evaluation and establishment of a digital asset register.

5. Financial Sustainability Audit

5.1 The Committee was provided with an update on the national exercise set by NHSE for organisations to undertake a Financial Sustainability self assessment. It was noted that the Trust's self assessment would be reviewed by internal audit who would give feedback on the evidential support for the assessment evaluation. It was noted the self assessment would be discussed in more detail at the December audit Committee meeting.

6. Annual Plan and Trust Performance

6.1 The Committee considered the quarter two reports on the Annual Plan and performance. The reports set out that quarter two had been challenging for the Trust but that the Trust had continued to meet a significant number of the outcomes set out in the Annual Plan and the KPIs in the performance report.

6.2 The Committee supported the proposals to amend some of the Annual Plan targets, noting that the proposed changes would be considered by the Board at its meeting at the end of November 2022.

6.3 The Committee discussed the progress made with elements of the Recovery Programme, in particular in CAMHs and adult risk assessments. It was noted that progress in some areas was slower than expected but there was confidence that the forensic approach the programme used demonstrated that the programme is making good progress. It was noted that the Trust were also looking to make the changes implemented sustainable

7. Deep Dive – Mental Health and Learning Disability and Autism Collaborative

7.1 The Committee received a deep dive into the work of the Collaborative. The Committee were updated on the structures and membership of the Partnership Board, as well as the transformation priorities.

7.2 The Committee welcomed the change from Collaborative to Health and Care Partnership, noting that this would put the Collaborative on an equal footing with other HCPs in the system. It would also see the Collaborative move into the commissioning space.

7.3 The importance of working in partnership was emphasised as the likelihood of the success of the required transformation was dependent on working collaboratively with partners from all sectors. It was reported that the Collaborative had good levels of engagement from partners.

8. Summary

8.1 The key headlines for the Board are that the Trust will be continuing to monitor and track the year end position for 2022/23. Committee and Board members will continue to be briefed with the regard to the Trust's approach to the protocol for changes to in-year financial forecast.

8.2 Also that work is underway to develop the case for funding for the Trust to be in line with the current position with regard to demand for mental health and learning disability services. This will be used in discussion with commissioner for the next financial year's settlement.

8.3 The Board will be receiving separate reports on performance and the Annual Plan, but the Committee highlighted the continuing challenging position for our services, which is generated by limited access to workforce and the acuity of our service users.

9. Matters for Escalation to the Board

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

Hertfordshire Partnership University NHS Foundation Trust

Appendix One: Finance and Investment Committee 17 November 2022, agenda items

Apologies for Absence
Declarations of Interest
Minutes of meeting held on 22 September 2022
Matters Arising Schedule
DEEP DIVE
Mental Health, Learning Disability and Autism Health Care Partnership
PERFORMANCE ASSSURANCE
Finance Report
Delivering Value Report
Capital Plan Update
Planning for 22/23 Year End
Finance Sustainability Audit
Quarter two Annual Plan Report
Quarter two Performance Report
Contract Update
STRATEGIC
Draft Financial Headline Plan 2023/24
Draft Capital Plan 2023/24
OTHER BUSINESS
Proposal for Committee self -assessment
FIC Business Programme
Any Other Business
Date of next meeting: 17 January 2023

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:**13a
Subject:	Annual Plan 2022-23 Quarter 2 Progress Report	**For Publication:** Yes
Author:	Simon Pattison, Deputy Director of Strategy and Development	**Approved by:** David Evans, Executive Director, Strategy and Partnerships
Presented by:	David Evans, Executive Director, Strategy and Partnerships	

Purpose of the report:

This report provides an overview of the progress during Quarter 2 of 2022-23 (Q2) against the Trust's annual plan. It also provides projected outcomes for the objectives at the end of the year.

Action required:

The Board is asked to receive the report and note the proposed changes to the year end metrics agreed at Finance and Investment Committee.

Summary and recommendations:

Introduction

The Annual Plan comprises of seven objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust aims to take and the milestones we plan to achieve, by quarter, to deliver the agreed outcomes for the year.

At the end of each quarter each objective receives two RAG ratings which indicate:

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

Quarter 2 2022-23

Quarter 2 2022-23 (Q2) has continued a challenging period for the Trust and the wider health and care system with continued demand and acuity pressures. Despite these pressures the Trust delivered against most milestones for the quarter and is on track to meet the majority of the outcomes for 2022-23. In Q2 113 of the 163 quarterly milestones were met, equivalent to 69% of all milestones.

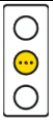
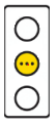
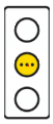
At the end of Q2:

- Four out of seven objectives fully achieved the quarterly milestones
- Five out of seven objectives are forecast to fully achieve the end of year outcomes

79% of all year-end outcomes are predicted to be on track to be delivered (42/53 outcomes) at the end of the 2022-23 and recovery actions have been agreed for the remaining 21% (11 outcomes) that are not on track in Q2. This compares to 82% of year end outcomes that were predicted to be on track at the end of Q1. Changes are proposed to a further 7 targets where new information since the start of the year means that the target needs amending with the need to remove an additional target.

Table 1 below summarises Q2 and year end position for all objectives.

Table 1 – Q2 and year end predicted achievement summary (Red: Below 59%, Amber 60-69%, Green 70+ %)

Ref	Objective	Q2 22-23		22-23 Year End Predicted Outcomes	
		Milestone Achievement	RAG Rating	Year End Prediction	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	23/30 (77%)		6/9 (67%)	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	17/28 (61%)		7/9 (78%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	19/28 (68%)		4/4 (10%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	12/19 (63%)		6/9 (67%)	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	9/12 (75%)		6/7 (86%)	
SO6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	20/28 (71%)		7/9 (78%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	13/18 (72%)		5/5 (100%)	

A wide range of improvement activity has been delivered in Q2:

- In mental health community services the expansion of the FACT team, the continued development of Enhanced Primary Mental Health Services, the creation of Additional Roles in primary care under the ARRS scheme and the expansion of specialist community perinatal and IPS (employment) teams has had a positive impact on the number and range of people that we can support with their mental health. The availability of the shared care record and progress on the physical health workstream will allow us to take a more holistic view of people's needs and support them more effectively with these
- Services for children and young people have also grown, with more support available to children and young people in schools (through Mental Health Support Teams) and in crisis. Waiting times for Eating Disorder services have reduced as capacity has grown and our work on the ARFID[1] pathway will extend support further. Outcomes monitoring for children and young people and perinatal services has expanded significantly, This will allow us to better understand how we can support children and young people more effectively in the future.
- The Trust's autism strategy and related work on training and on creating autism friendly environments in inpatient units has meant an additional focus on this area.

[1] Avoidant/restrictive food intake disorder

- Our trustwide focus on learning disabilities continues with an increased focus on physical health outcomes and the further development of the community forensic learning disability pilot.

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

- The high level of demand for inpatient beds and the related acuity of needs has an impact on service users feeling safe and on our usage of externally purchased inpatient beds.
- Recruitment and retention remains a concern and is affecting the speed at which some of the change programmes can be delivered across virtually all service areas.
- Growing demand in community services is affecting waiting times and treatment pathways with growing waits for services like Adult ADHD assessments.

Recommendation

The Board are asked to receive the report and note the proposed changes to year end metrics agreed at Finance and Investment Committee.

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

The report summarises delivery against all Trust objectives.

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

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

Equality & Diversity and Public & Patient Involvement Implications:

The report provides an update on all annual objectives some of which have impact on equality, diversity and/or public & patient involvement.

Last seen by:

Executive 9th November, Finance and Investment Committee 17th November

TRUST ANNUAL PLAN 2022-23

QUARTER 2 PROGRESS REPORT

1. Introduction

1.1. The Trust's Annual Plan comprises of seven objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust aims to take and the milestones we plan to achieve, by quarter, to deliver the agreed outcomes for the year.

1.2. At the end of each quarter each objective receives two RAG ratings which indicate:

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

1.3. The report provides an update on the Quarter 2 2022-23 (Q2) milestones for the Trust's annual plan and the overall predicted achievement of objectives in 2022-23.

2. Achievement against Quarter 2 Milestones

2.1. 2022-23 (Q2) has continued to be a challenging period for the Trust and the wider health and care system. Our demand and acuity pressures have remained, and recruitment and retention have continued to significant issues. Despite these challenges most of our milestones for the quarter have been delivered and we are on track to meet most of our year end objectives.

2.2. At the end of Quarter 2, four out of seven objectives met most (70%+) key milestones as planned. Objectives 2, 3 and 4 made progress but are RAG rated amber in Q2.

2.3. Strategic Objective 2 – Experience, was rated Amber due to slow progress in the actions designed to increase the involvement of our service users and carers in the design and delivery of care.

2.4. Strategic Objective 3 – Improving health outcomes, was rated Amber due to delays in strengthening our research work. Delays in progress on some of our actions to improve physical health and delays in the capital work at Forest House mean the objective is rate as Amber.

2.5. Strategic Objective 4 – Our Staff, is rated Amber as there have been ongoing challenges with recruitment and retention.

2.6. A wide range of improvement activity has been delivered in Q2:

- In mental health community services the expansion of the FACT team, the continued development of Enhanced Primary Mental Health Services, the creation of Additional Roles in primary care under the ARRS scheme and the expansion of specialist community perinatal and IPS (employment) teams has had a positive impact on the number and range of people that we can support with their mental health. The availability of the shared care record and progress on the physical health workstream will allow us to take a more holistic view of people's needs and support them more effectively with these.

- Services for children and young people have also grown, with more support available to children and young people in schools (through Mental Health Support Teams) and in crisis. Waiting times for Eating Disorder services have reduced as capacity has

grown and our work on the ARFID[2] pathway will extend support further. Outcomes monitoring for children and young people and perinatal services has expanded significantly, This will allow us to better understand how we can support children and young people more effectively in the future.

- The Trust's autism strategy and related work on training and on creating autism friendly environments in inpatient units has meant an additional focus on this area.
- Our trustwide focus on learning disabilities continues with an increased focus on physical health outcomes and the further development of the community forensic learning disability pilot.

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

- The high level of demand for inpatient beds and the related acuity of needs has an impact on service users feeling safe and on our usage of externally purchased inpatient beds.
- Recruitment and retention remains a concern and is affecting the speed at which some of the change programmes can be delivered across virtually all service areas.
- Growing demand in community services is affecting waiting times and treatment pathways with growing waits for services like Adult ADHD assessments.

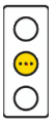
2.8. At Finance and Investment Committee we focussed on the three overarching areas of concern that impact on a number of strategic objectives and the key outcomes we are planning to achieve by year end:

- Recruitment and retention
- Managing inpatient demand and acuity
- Managing community demand over winter – e.g. through deprioritising ADHD assessments

2.9. Table 2 overleaf summarises the Q2 achievement for all strategic objectives with details of the outcomes and commentary for these in Appendix 1.

[2] Avoidant/restrictive food intake disorder

Table 2 – Q2 Achievement against Milestones (Red: Below 59%, Amber 60-69%, Green 70+ %)

Ref	Objective	Q2 22-23	
		Milestone Achievement	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	23/30 (77%)	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	17/28 (61%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	19/28 (68%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	12/19 (63%)	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	9/12 (75%)	
SO6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	20/28 (71%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	13/18 (72%)	

3. 2022-23 Year End Achievement Against Objectives

3.1. 79% of all year-end outcomes were predicted to be on track to be fully delivered (42/53 outcomes) at the end of the 2022-23.

3.2. Five out of seven objectives are RAG rated Green as projected ratings for year-end outcomes.

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

3.4. There are a number of risks to delivery over the remainder of the year. The winter period is likely to be difficult with ongoing demand and acuity challenges and wider winter pressures across the NHS. At the time of writing the outcome of industrial action covering junior doctors and Unison staff is not clear and this may have a substantial impact on service delivery. A further COVID wave and / or significant Flu outbreak could also mean that we have to focus on our response to these events and deprioritise other areas. All of these factors may make it challenging to fully deliver all of the outcomes in the Annual Plan.

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

Ref	Objective	22-23 Year End	
		Year End Prediction	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	6/9 (67%)	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	7/9 (78%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	4/4 (100%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	6/9 (67%)	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	7/8 (87%)	
SO6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	7/9 (78%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	5/5 (100%)	

4. Mid Year Review of Metrics

4.1. As we are half way through the year we have reviewed the year end metrics and identified a small number that are no longer relevant and so need amending. These are:

- SO1 – we currently have a metric of “98% of people on the suicide prevention pathway have an up-to-date crisis plan”. This pathway will not be live this year as the piece of work has moved from being a HPFT only project to a system collaborative project and so it is proposed to remove this metric
- SO2 Personalised care and support plan (including Dialog) completion – This target requires the completion of paired outcome scores from people accessing transformed mental health community services. As there were delays in initiating this process a revised target of 20% of service users with paired outcome scores (reduced from 30%) is proposed.
- SO3 Reduction in adult autism waiting list to less than 50 by end of March 2023 – This target is not achievable as we have not been able to recruit to the dedicated assessor post that we planned to utilise to make a significant reduction in the waiting list. A full review of the waiting list has also taken place and identified that the list is higher than had previously been thought to be the case. The rate of new referrals has also increased. The waiting list was over 520 at its peak and remains around 500 currently.

In mitigation a private company have been commissioned to carry out assessments for 190 people (of which 136 have been referred to date) and we are out to advert for the assessor post again. A revised target of reducing the longest wait for an assessment from 5 years to 2 ½ years by the end of March is proposed.

- SO3 Increase in the number of service users recruited to these studies (baseline 425 in 21/22 and 51 service users had been recruited by the end of Q2 in 22/23) – there has been a shift in the type of studies available for recruitment over the last year. In 2021/22 there were some large scale studies into COVID and mental health which generated high numbers of recruits as they were short studies with a large pool of people to recruit from. In the current year this has shifted to more complex interventional studies for smaller, more defined cohorts. These require more time to recruit each patient and support them through the study. Therefore, a revised target of 100 service users being recruited in studies is proposed.
- SO3 – Delivery of the CQUIN target for outcomes monitoring. Good progress is being made within CAMHS and perinatal services. However, in adult and older adult services delays in implementation have been experienced. Good progress is now being made in adult services and so it is proposed that the target is amended to just reflect performance in Q4 which can then be embedded in 2023/24.
- SO3 – physical health training. This is a process metric and so we are proposing to amend this to reflect the actual percentage of people receiving a health check as this is a better reflection of the quality of care received. The targets already agreed with commissioners that we are proposing to use are:
  - 90% of people in inpatient and First Episode of Psychosis services will receive a health check
  - 75% of people with Severe Mental Illness in the community receive a physical health check
- SO4 More than 80% of staff recommend HPFT as a good place to work. We achieved 70% in Q2. In 2021 the best performing organisation achieved 73.5% on this metric with the average Trust scoring 63.2%. Therefore, we are recommending amending this target to 70%.
- SO7 A reduction in the number of Children and Young People on the ADHD waiting list from 848 to zero. The original target was based on the business case being agreed in April or early May, but this agreement did not happen until August. With recruitment timelines the team will not go live until January. In the meantime, the number of children and young people on the waiting list have gone up to 1,126 at the end of September and is rising by around 200 a quarter. The new team is estimated to be able to assess around 200 once they are live in Q4 so a revised target of stabilising this waiting list at 1,300 by the end of Q4 is proposed.

5. Conclusion

5.1. Overall good progress has been made during the quarter against the Q2 milestones and towards year end outcomes. However the winter period is expected to be extremely challenging year with additional demand and the potential for strike action, amongst other pressures. We will continue to drive delivery of the annual plan priorities through Trust Executive.

6. Recommendations

6.1. The Committee is asked to receive the report and agree the proposed changes to the year end metrics for agreement at Board.

APPENDIX 1 – ANNUAL PLAN 2022-23 QUARTER 2 COMMENTARY AGAINST MILESTONES AND OUTCOMES

Strategic Objective 1 (Senior Responsible Officer JV)	**Q2 Key Actions / Milestones**	**Q2 Milestones Rating**
We will provide safe services, so that people feel safe and are protected from avoidable harm **Key Priorities** • We will progress our ambition to achieve zero-suicides across the populations we support • We will keep service users & carers physically and mentally safe, reducing the harm they experience • We will further develop our approach to managing violence and aggression & evidence-based restrictive practice • We will expand the training, development, and leadership of teams to keep our staff safe	• Hertfordshire Suicide Prevention Pathway approved. T&F group set up under the Suicide Prevention Board • A stakeholder session is being arranged to set up the suicide prevention pathway pilots in A&E • Back to Basics Suicide Prevention Training completed. Training was well received with good feedback • Recovery focused suicide prevention clinic is still in pilot phase and not been evaluated as yet • Dove Ward Reducing Restrictive Practice CQI project ready for launch. SASO training on Discovery • FACT pilot commenced with recruitment ongoing for remaining posts • Baseline audit of CGL and HPFT joint working protocol completed. Joint governance group continues • Fundamentals of care recommendations implemented in 2 SBUs and partially implemented in the third • Bladder and bowel training being commissioned as a result of FoC work but not yet completed • Technology reviewed with Digital Strategy Team and implementation of priority areas well underway • Ligature app in production – go live planned for Q4 • Astley and Beech safety suites to be completed in October, Lexden under construction • Oak Ward refurbishment commenced and CCTV phase 2 roll out commenced to be completed December • PBS audit completed. Business case for PBS Strategy development agreed • Complex behaviour pathway training has been undertaken across services in Essex LD. • 12 sessions of Trauma Informed Approach to care training completed and evaluated • Roll out of Trauma Informed Approach across ACMHS delayed but remediation plan in place • Recruiting and training lived experience network of trainers/clinical expert trainers commenced. • KUF launch completed (1st September) and KUF awareness training commenced • Patient Safety Syllabus Module 1 and 2 have gone live on Discovery • Review of DASA (Dynamic Appraisal of Situational Aggression) in Norfolk services undertaken • Review of different models of the Prevention and Management of Violence and Aggression underway • Mental Health Optimal Safer Staffing Tool (MHOST) work underway with data gathering phase about to start	23 green 7 amber 23/30 = 77% 
	Commentary:	
	• CQI work on restrictive practice on Dove Ward is ready to launch • Continued focus on PBS with audit completed and approach embedded in inpatient pathways • KUF awareness training launched after launch of KUF programme	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes Projection**
A number of key safety priorities have been progressed in the quarter with work continuing to develop safety suites and further roll out CCTV. The suicide prevention pathway has been approved and training completed.	• Suicides relative to total Contacts with HPFT. Baseline 0.49^{-4} % (Q2 0.61^{-4}%) • 98% of people on the suicide prevention pathway have an up-to-date crisis plan • < service user to staff moderate - severe harm through violence & aggression (<2.3% Q4) (0.83% Q2) • < service user to service user moderate - severe harm through violence & aggression (<2.3% Q4) (0.0% Q2) • Rate of service users saying they are treated in a way that reflects the Trust's values >80% (83% Q1) • Reduction in number of seclusion episodes (21/22 baseline 430) (217 Q1 & Q2 combined) • Reduction in rapid tranquilisation incidents (21/22 baseline 318) (160 Q1 & Q2 combined) • 10% reduction in the number of reported injuries, diseases and dangerous occurrences (RIDDOR) incidents as a result of violence and aggression towards staff (baseline 50 in 21/22) (9 Q1 & Q2 combined) • Staff survey health and safety climate score >6.0 • HYS “do you feel safe on the ward” score. Target 85% (69% Q1)	6 Green 3 Amber 67% Amber One target to be removed 

<table>
<tr><th>Strategic Objective 2 (Senior Responsible Officer - SB)</th><th>Q2 Key Actions / Milestones</th><th>Q2 milestones Rating</th></tr>
<tr><td rowspan="2">We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience

Key Priorities
• We will improve service user and carer experience of accessing and using our services experience of service users
• We will implement involvement of our service users and carers in the design and delivery of their care
• We will support our service users to live their lives as independently as possible</td><td>• Tendering process for VCSE led outreach workers and peer support now being led by MHLDA Collaborative
• Focussed work on older adults within IAPT to increase take up in this age group with EDI training underway
• Community outreach continued with older peoples workshops with new organisations and meetings with GPs
• 72 hour planning implemented, whiteboards trialled on Swift in September (to drive purposeful admission).
• Herts MH Access Points programme (previously the SPA review) is being led by the MHLD&A collaborative.
• User and carers strategy survey live until 19/10/22. Sub-groups to broaden carer input still need resourcing
• Work to expand FFT underway and proposals under discussion for changing Having Your Say
• Triangle of Care re-assessment delayed to January due to staff changes
• Social Care transformation programme is pulling carer support work into a single structure.
• Carers training is being promoted across all teams.
• Meeting has now been arranged to coproduce survey for use by peer experience listeners
• Recruitment event in October to encourage more Experts by Experience to become peer experience listeners
• Recruitment plans are in place & underway for IPS to expand from Q4 in line with investment.
• Community framework resources & training are being co-produced with New Leaf and experts by experience
• Comms plan in place for promotion of personalised care and support planning with Plan live in NW & E&SE
• Social Care transformation programme up and running, with workstreams identified and leads in place
• Social care quality assurance framework developed, metrics still being agreed
• Social care governance structure in place. Scoping of social care workforce & training needs in progress
• Metropolitan appointed as provider of Intensive Enablement service. Sales of The Stewarts imminent.
• Mobilisation meetings for new Midpoint service provider are progressing well.</td><td>17 Green
11 Amber
17/28 = 61%
Amber
  </td></tr>
<tr><td colspan="2">Commentary:
• Social care programme established with workstreams agreed and leads in pace and the Connected Lives tool now in use for all social care assessments
• Agreement that SPA review will be subsumed into a wider whole system review of mental health access points led by the MHLDA Collaborative
• Work with partners on enablement services is progressing</td></tr>
<tr><th>Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes Projection</th></tr>
<tr><td>Outreach to encourage more older people to access IAPT services has been progressing during the quarter. Inclusion and engagement work has been delayed by key vacancies within the service</td><td>• Reduction in complaint response times from 36 days (Q3 21/22) to 30 days (Q3 22/23) (48 days in Q2)
• IAPT, Community Perinatal & Early Intervention in Psychosis (EIP) access targets met (IAPT off track, perinatal behind trajectory, EIP above target)
• Performance against the new access standards on 28-day referral to treatment times for CYP (53%), adults (50%) and older adults (26%)
• Connected Lives audit
• Increase service user & carer engagement hours from 1,874 in 21/22 to over 2,000 in 22/23 (1,005 to end Q2)
• Increase in people saying they have been asked for their views on the quality of care from 18.2% to 25%
• Number of experts of experience led CQI projects (target 10)
• Personalised Care & Support plan (including DIALOG) completion – 30% by end of March. To be amended
• Having Your Say for carers – Do you feel valued by staff as a key partner in care planning? - 70% (79% Q2)
• At least 85% of adults with Serious Mental Illness have settled accommodation (60% Q2)</td><td>7 Green
2 Amber
7/9 = 78%
Green
One target to be amended
  </td></tr>
</table>

Strategic Objective 3 (Senior Responsible Officer AZ)	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will improve the health of our service users through the delivery of effective evidence-based practice **Key Priorities** • We will improve the care, support and outcomes for service users who need additional support needs • We will keep service users physically healthy by improving the physical health support, intervention and care available • We will train our staff in diagnosing and supporting people with Autism • We will expand our research and increase the positive impact of this on service user outcomes	• The pathway for depression has been finalised to reflect the recently published NICE guidance • The pathway will be piloted in Stort Valley PCN using CQI methodology. Agreement in place to mobilise • Plan commenced to manage CYP ADHD backlog with recruitment underway for medical posts • Joint working with Primary care to deliver management of medication(s) agreed in CYP ADHD model • Work underway with system partners through the MHLDA Collab to consider future CYP ADHD service delivery / gaps • Discussions on ADHD shared care protocol underway • ARFID pathway finalised in partnership with system partners • FHAU HDU capital work almost completed • Early version of system Physical Health strategy presented to ICP for review • Physical health offer progressed by updating clozapine clinic offer and symptom monitoring across all SBU localities • Physical health fair scheduled for 2/12/22 with Service Users and Carers engaged and involved in deciding topic areas • PHC action plan created with actions defined from SBU reports, SJRs and other incidents • Introduced new field on datix for reporting SU PH reviews following acute admissions • Opt out system for referrals to Smoking Cessation support implemented & baseline data of Service Users quitting smoking established. NRT policy & e cigarette policies updated. • LD&F have started a CQI project to proactively manage weight on inpatient units but work in other SBUs is delayed • SBU self-assessment against HEE competencies to be presented to Physical Health Committee in October • Review of physical health training needs of staff & tracking Physical Health competencies will follow self-assessment • Consultation &engagement exercise around autism completed and draft strategy co-produced with key stakeholders • 38 Psychiatrists booked for autism training staggered across 4 months to reduce pressure on system • New post of head of research and development established • JDs for new clinical research assistant posts going to Research Board for approval	19 Green 9 Amber 19/28 = 68% Amber 
	Commentary: • Progress has been made on improving the physical health of people with significant work on the strategy and work to reduce smoking • The Trust autism strategy has been co-produced with stakeholders and autism training booked for many psychiatrists	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes Projection**
Work has progressed on the CYP ADHD model with recruitment underway and discussions within the MHLDA Collaborative on the long term model	• 90% of people on Care Plan Approach having completed physical health checks in inpatient (58% Q2) and First Episode of Psychosis (82% Q2) services and 65% in community mental health teams (83% Q2) • 14% reduction in service users who smoke cigarettes (10.8% to end August) • 220 staff access the Physical health training programme (47 Q1 & Q2) • 30 staff trained in autism assessment (30 booked at end Q2) • Reduction in adult autism waiting list to less than 50 by end of March 2023 – target to be amended • Warren Court and Broadlands autism friendly environments capital work completed (expected completion by end Nov) • Increase in volume of research projects (29 21/22 and 21 by end Q2) and service users and staff involved in research (service users 425 in 21/22 and 51 by end Q2) – target to be amended • Progress against routine outcome monitoring CQUIN measures for CYP, perinatal and community mental health services (target 100% CQUIN achievement) (60.1% CYP and Perinatal, 6% Community)	4 Green 4/4 = 100% Green 4 targets to be amended 

Strategic Objective 4 (Senior Responsible Officer - JL)	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment **Key Priorities** • We will increase recruitment and offer a compelling employment experience which retains staff • We will develop our belonging and inclusion strategy and culture • We will introduce new roles and ways of working to meet acuity and demand for services • We will develop our people, teams, and leaders to enable the delivery of great care and great outcomes	• Long service awards took place in Summer 2022 • Impact of Welcome and Relocation payments reviewed which has led to the creation of a medical RRP • Q2 pulse survey undertaken in July 2022 - survey results reaffirm our existing plans for action • Internal transfer scheme launched but remains under-utilised and requires further embedding. • Medical and HCSW R&R plans were implemented during Q2. Medical recruitment is challenging but the HCSW recruitment pipeline is very healthy & should mean a significant reduction in vacancy rates. • Wellbeing Festival took place in September. The theme of self-care came from staff survey feedback. • Engagement has taken place to start coproducing our plans to embed the TRiM model, • 70 staff are now mental health first aid trainers. A further 4 training sessions are planned for 2023 • The ICS fast track physio service procurement is in progress and the Trust is participating in this. • Engagement has taken place to commence our work on a psychologically informed Wellbeing pathway. • A large number of staff have been part of focus groups to co-design our belonging & inclusion strategy • Timescale for refreshed OD strategy has changed in line with developing our new five year strategy • Training on having positive conversations and valuing feedback has been launched via eLearning. • Our retention data has been analysed to refine our retention plans, in particular in relation to BAME staff talent management. We have agreed to implement Wagestream in Q3, have updated our annual leave policy, uplifted mileage rates, provided one-off financial help to staff at Band 7 and below • Management fundamentals training has been relaunched • The new Appraisal App is in the final stages of development and testing prior to launch • Plans to expand our talent management offer are delayed due to funding delays. • Our Flex for the Future action plan is being implemented, however, roll out of self-rostering is delayed • Plans to expand our career development offer are delayed due to funding delays.	12 Green 7 Amber 12/19 = 63% Amber 
	Commentary: • Significant work on the staff wellbeing agenda with the Wellbeing Festival, increasing numbers of Mental Health First Aiders and discussions around development of the Belonging and Inclusion strategy • Recruitment and retention continues to be a focus with medical RRP payments introduced and HCSW recruitment improving • New initiatives agreed to support staff with the cost of living	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
Turnover and vacancy rates are key issues for the trust and the risk around addressing these in year leads us to project this will be RAG rated amber at the end of the year.	• The Trust takes positive action to support health and wellbeing > 85% (86% Q2) • Our Work Race Equality Standards and Work Disability Equality Standard improved • Inclusion staff survey score >7.3 • Staff Survey and pulse survey engagement score > 7.4 (7.2 Q2) • Staff survey 'we each have a voice that counts' score >7.2 • Staff survey 'negative experiences' score >7.9 and Staff survey development score >6.8 • Mandatory training >90% (92.3% Q2) • Unplanned turnover <10.5% by Q4 (14.31% Q2) • Vacancy rate <11.1% by Q4 (14.08% Q2) • > 80% staff recommend place to work (70% Q2)	6 Green 3 Amber 6/9 = 67% Amber One target to be amended 

Strategic Objective 5 (Senior Responsible Officer - HA)	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will improve, innovate and transform our services to provide the most effective, productive and high-quality care **Key Priorities** • We will embed the culture of continuous improvement and innovation across our services • We will continue to introduce new digital capabilities that improve our services • We will support the NHS to become the world's first healthcare system to reach net zero carbon emission	• 26 staff undergoing CQI have projects being implemented • Designing of the CQI coaches programme is underway • CQI is now part of Practice Audit Implementation Group (PAIG) sessions to provide support to any projects rag rated as red • 3 new ideas are currently being scoped to come to the innovation panel in October • Modelling for Improvement equalities dimension launched at Exec and SLT and is being used for the ICB equalities work • Digital communications for CAMHS has been moved to Q3 and ACMHS brought forward to Q2. This is due to EPR data cleansing required to enable automated messages in CAMHS. • Shared Care record launched and is available trust wide. Sharing of records from Paris to the ICS-wide shared care record was rescheduled to Q3 in line with the wider ICS-wide plan. • Staff App for managing HR processes and DPIA app have been launched. • Business cases for sustainability projects are being developed for approval in November 2022 • Received costs for producing a Trust Heat Decarbonisation Plan which are being reviewed • Building Management System feasibility studies have been completed for HPFT inpatient sites. A feasibility study has been completed for the installation of solar panels at Kingfisher Court. • Sustainable waste management plan yet to launch	9 Green 2 Amber 1 Red 9/12 = 75% Green 
	Commentary: • CQI continues to drive the improvement work within the Trust with a number of programmes underway • New digital solutions have been implemented including the launch of the shared care record across the Trust	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
A number of new digital developments have been implemented in Q2 such as the launch of the Shared Care record and Staff App.	• 10% increase in staff reporting involvement in CQI projects during 2022/23 • Number of trained CQI coaches increased from 0 to 23 • 20 innovation ideas received, evaluated, and considered by the Innovation Panel • Positive net score from service users using digital channels • Positive targeted survey responses from staff regarding experience of digital capabilities • Community mental health survey – > service users given enough time to discuss your needs (baseline 7.3) • Energy efficient lighting to be rolled out across the entire trust in 22/23 – KFC business case going for approval in October • Commencement of the rollout of electric car charging points – feasibility study being developed	7 Green 1 Amber 7/8 = 87% Green 

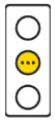
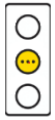
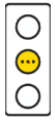
Strategic Objective 6 (Senior Responsible Officer–SB / DE)	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners **Key Priorities** • We will work with Primary Care partners to improve community services and the care of adults and older people • We will improve access and delivery of care for those people with a learning disability and/or autism across the Trust • We will ensure children, young people, adults, and older people in crisis can access support when they need it • We will work with partners to deliver earlier intervention and support for Children and Young People	• Recruitment to EPMHS expansion posts has commenced with engagement sessions in diary for Q3 • Full rollout of Quest Link is complete & report on evaluation of CMHT pilots being published in Q3. • Pilot quantitative evaluation has been completed and has informed mobilisation plans • Extensive planning for further rollout of primary care models completed and an initial integrated model for ARRS, GP+ and EPMHS has been developed. • 70% of PCNs have ARRS workers. A number of PCNs have opted out for 2022/23 • Work has commenced in partnership with Commissioners/PCNs to plan CYP ARRS model • ELDP Bed Consolidation on hold as commissioning intentions need to be revisited. • Herts LD Assessment & Treatment Pathway Work delayed – plan to engage wider system in February • Essex Dynamic Support Register - HPFT and EPUT registers being used a single information source • LD Annual Care Plan project progressing well with 58% achieved against Q2 trajectory of 60% • Commissioners going out to tender for the future provider of care provision for SRS residents. • Challenges with recruitment have delayed mobilisation of Paediatric Liaison model • HPFT are participating in the evaluation of system-wide CYP crisis provision led by Commissioners • Flowing MHST group data into MHSDS remains challenging & has been raised with the national team • Trust EPR systems configured to reflect new MHSTs & 6 senior staff starting supervisor training • All new MHST starters are set up with EPR access & majority of recruitment completed for Wave 7 • All initial schools have been selected and visits completed. 3 further intake phases planned • Recruitment to CAMHS Intake posts have still not been successful – rethinking approach with HCT • Good system wide engagement in development of the digital front door working with system partners • CYP Community Eating Disorders pathway work has improved flow, creating additional capacity • Commissioners have set up CYP Eating Disorders early intervention service (First Steps) • Further work needs to be done to agree and consistently apply the shared care protocol for ED • Community Eating Disorder Service has worked jointly with partners to develop the ARFID pathway.	20 Green 8 Amber 20/28 = 72% Green 
	Commentary: • Wave 7 of the roll out of Mental Health Support Teams in schools well underway with schools selected, supervision training underway and majority of recruitment completed • Significant reduction in number of CYP with Eating Disorders waiting for treatment • Community transformation roll out continuing with integrated model developed and 70% of PCNs having ARRS workers in place	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
We have seen good progress on increasing capacity to treat children and young people with eating disorders, leading to a significant reduction in the number waiting for an assessment. We have also seen progress in the implementation of community mental health transformation with further expansion in the enhanced primary mental health service	• Number of adults accessing new primary and community mental health (target 5062) (2566 Q2) • 70% of primary care mental health roles (ARRS roles) in post against plan (72% Q2) • No of people diagnosed through the Primary Care Dementia Pathway (target 24 per week) (4.7 Q2) • < Inpatient length of stay for people with LD (391 Q1 reduced to 253 Q2) • Routine referrals to Specialist Community LD Services meeting 28 day wait >=98% (98% Q2) • Completed annual care plans within LD community services Herts and Essex (current 70%, target 70%) • 4 hours wait for CYP crisis service (target 95%) (96% Q2) • 1,500 CYP accessing Mental Health Support Teams (967 in 21/22) (1901 Q2) • CAMHS access < 28 days (target 95%) (64% Q1)	7 Green 2 Amber 7/9 = 78% Green 

Strategic Objective 7 (Senior Responsible Officer - DE)	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s) **Key Priorities** • We will ensure the Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative continues to develop and thrive • We will advocate for mental health, learning disability & autism services are developed across our populations • We will continue transformation of services for people with a learning disability and their carers • We will work with regional partners to deliver new models of care for those with specialist mental health needs and learning disabilities	• Physical healthcare strategy scoped and being written • Dual diagnosis task and finish group set up with programme management support allocated • CYP ADHD backlog programme recruitment has commenced • Primary care engagement in CYP ADHD work being progressed through sub-contracting arrangement • ICS MHLDA programme mapping completed • Strong MH and LD input to development of HWE ICP strategy • Norfolk and Waveney IST Transformation Programme Plan steering group convened -finance allocated to be finalised • N&W Demand / Capacity / Financial modelling completed for sign off at Partnership Board • Four LD service model evaluations underway • Monthly LD CPD sessions have continued • Podcast on personality disorder and intellectual disability recorded and awaiting editing • Four LD publications contributed to so far this year • Significant work with community partners in health and social care as part of supporting alternatives to admission for CYP • Adult ED Intensive Support Team evaluation deferred to Q3 due to delays in recruitment • Community Forensic Learning Disability pilot reporting monthly with wider review due in Q3 • Ongoing work/mapping underway to establish role of ICB MH Programme Board and in turn the governance arrangements for mental health and learning disability services • Work with geographical HCPs ongoing to develop relationships and ways of working • The overall PHM model has been developed by ICS and we are continuing to work on developing the segmentation model for MHLDA population	13 Green 5 Amber 13/18 = 72% Green 
	Commentary: • Norfolk and Waveney demand and capacity work completed to inform future learning disability service development • CYP ADHD backlog programme funding agreed by the new HWE Integrated Care Board • New task and finish group created to focus on dual diagnosis (mental health and drug and alcohol) issues	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
In the last quarter good progress has been made on the CYP ADHD backlog programme in Hertfordshire and we have contributed to the development of wider system working in Hertfordshire after the implementation of the new NHS structures in July.	• Increase in number of people with SMI in employment. Baseline 14% (February 2022) (14% Q1) • HPFT's positive impact on service user outcomes showcased in 3 national reports (1 Q2) • HPFT to provide expert speakers at 3 national conferences or similar settings (4 Q2) • < number of CYP waiting for an Eating Disorder inpatient bed (baseline 6 on 9th May) (6 on 26/09/2022) • HWE ICS population health model identifies at least 2 concrete actions for the ICS on MHLDA. • Reduction in CYP ADHD backlog from 848 in South and West Herts to 0 by end 22/23. (1126 Q2) – to be amended	5 Green 5/5 = 100% Green One target to be amended 

APPENDIX 2 – ANNUAL PLAN 2022-23 END OF YEAR OUTCOMES

	Objective	Predicted			EOY	Year End Outcomes Commentary
		Q1	Q2	Q3	Q4	
1	We will provide safe services, so that people feel safe and are protected from avoidable harm					A number of key safety priorities have been progressed in the quarter with work continuing to develop safety suites and further roll out CCTV. The suicide prevention pathway has been approved and training completed.
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience					Outreach to encourage more older people to access IAPT services has been progressing during the quarter. Inclusion and engagement work has been delayed by key vacancies within the service
3	We will improve the health of service users through the delivery of effective evidence-based practice					Work has progressed on the CYP ADHD model with recruitment underway and discussions within the MHLDA Collaborative on the long term model
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment					Turnover and vacancy rates are key issues for the trust and the risk around addressing these in year leads us to project this will be RAG rated amber at the end of the year.
5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care					A number of new digital developments have been implemented in Q2 such as the launch of the Shared Care record and Staff App.
6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with partners					We have seen good progress on increasing capacity to treat children and young people with eating disorders, leading to a significant reduction in the number waiting for an assessment. We have also seen progress in the implementation of community mental health transformation with further expansion in the enhanced primary mental health service
7	We will shape and influence the future development & delivery of health and social care to achieve better outcomes for our population(s)					In the last quarter good progress has been made on setting up the CYP ADHD backlog programme in Hertfordshire and we have contributed to the development of wider system working in Hertfordshire after the implementation of the new NHS structures in July.

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 13b
Subject:	Performance Report - Quarter 2 2022-23	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director of Innovation and Improvement	**Approved by:** Hakan Akozek, Director Innovation and Digital Transformation; Chief Information Officer
Presented by:	Hakan Akozek, Director Innovation & Digital Transformation; Chief Information Officer	

Purpose of the report:

This report provides an overview of the Trust's performance against both the NHS Single Oversight Framework targets and the Trust Key Performance Indicators (KPIs) for Quarter 2 2022-23 and an update on the actions being taken to improve performance.

Action required:

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

Summary:

The second quarter of 2022-23 has been challenging with more people presenting into our services with more complex needs than before the pandemic, particularly in adult community and adult acute pathways.

The overall number of performance indicators that were met or almost met at the end of Quarter 2 (55%, 36 out of 65) is similar to Quarter 1 of 2022-23 (60%, 39 out of 65), with strong performance in:

- Assessing people in A&E and acute hospital wards within 1 hour and 24-hour targets
- Access to Adult Crisis services within 4 hours of referral
- Achieving recovery objectives in over 50% of cases after treatment in IAPT
- Carers reporting that they feel valued by our staff
- Staff reporting that they believe the Trust looks after their general wellbeing

The Trust is committed to meeting all its performance targets and in the first quarter of 2022-23, we established a Recovery Programme that brings together all the performance improvement initiatives under a single governance and support structure. At the end of Quarter 2, we are beginning to see improvements in a number of areas, including:

- Physical health checks for service users with severe mental illness
- Service users with completed and up to date risk assessments
- Completion of staff mandatory training

However, we continue to face challenges with:

- Increased number of our service users being placed in out of area beds due to high demand and acuity in our adult acute pathway. We are focusing on reducing our length of stay in our inpatient units, exploring alternative pathways to support discharge and prevent admission to reduce our need for out of area beds.

- Providing timely access to our community services within 28 days of referral. We expect this to recover in Quarter 3 for Children and Young People community services and in Quarter 4 for Adult and Older People community services. We are also focusing on transforming our adult community services to meet the increased demand we are experiencing following the pandemic.
- Recruiting and retaining the workforce we need to provide and transform our services, similar to the rest of the NHS. We are beginning to see the results of our actions in this area with a net recruitment position in September of over 40.

Further details of the actions we are taking to improve performance are summarised in the report.

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

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

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

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

There are no direct financial, staff, IT or legal implications arising from this report.

Equality & Diversity and Public & Patient Involvement Implications:

Although some of the key performance indicators have equality and diversity dimensions, there are no direct implications arising from this report. The colours and graphics adopted in this report use the standards developed by NHSI/E to make the report more accessible to a wider audience.

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

The report includes all targets reportable in Quarter 2 2022-23.

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

Executive Team – 9th November 2022
Finance and Investment Committee – 17th November 2022

Performance Report – Quarter 2 2022-23

1. Background

1.1. This report provides an overview of the Trust's performance at the end of Quarter 2 2022-23 against the NHS Single Oversight Framework targets, the Trust Key Performance Indicators (KPIs), and the Quality Account indicators and an update on the actions being taken to improve performance.

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

1.3. Tables looking at our performance since April 2019 using the SPC methodology can be found in Appendix 1. This period is chosen as it encompasses the pre-pandemic, during the pandemic and post-pandemic periods, allowing us to better understand the impact of the changes the health and care system is experiencing.

2 Performance Summary

2.1 High levels of demand continued into Quarter 2 with significant increase in referrals to our Single Point of Access compared to pre-pandemic levels, particularly for Adult Community Mental Health Services. Service users are also presenting with high levels of acuity and complex needs across our services.

2.2 In common with mental health trusts across the country, in our local system, and the wider NHS, we are focussing on improving performance and finding new ways of working that build capacity and resilience in our services whilst meeting the needs of our service users and carers.

2.3 The overall number of performance indicators that were met or almost met at the end of Quarter 2 (55%, 36 out of 65) is similar to Quarter 1 of 2022-23 (60%, 39 out of 65).

2.4 Key areas of strong performance in Quarter 2 include:

- Assessing people in A&E and acute hospital wards within 1 hour and 24-hour targets
- Access to Adult Crisis services within 4 hours of referral
- Achieving recovery objectives in over 50% of cases after treatment in IAPT
- Carers reporting that they feel valued by our staff
- Staff reporting that they believe the Trust looks after their general wellbeing

2.5 However, we continue to face challenges with:

- Demand and acuity in our adult acute pathway, resulting in increased number of our services users being placed in out of area beds. We are focusing on reducing our length of stay in our inpatient units, exploring alternative pathways to support discharge and prevent admission to reduce our need for out of area beds.
- Providing timely access to our community services within 28 days of referral. We expect this to recover in Quarter 3 for Children and Young People community services and in Quarter 4 for Adult and Older People community services. We are also focusing on transforming our adult community services to meet the increased demand we are experiencing following the pandemic, including bringing planned

care under single management, centralising initial assessment processes and redesigning the pathway to remove inefficiencies.

- Recruiting and retaining the workforce we need to provide and transform our services, similar to the rest of the NHS. We are beginning to see the results of our actions in this area with a net recruitment position in September of over 40.

2.6 Based on our latest position at the end of Quarter 2, the figure below shows the percentage of KPIs achieved in in each performance domain with green indicating targets met, amber indicating targets almost met and red indicating targets not met.

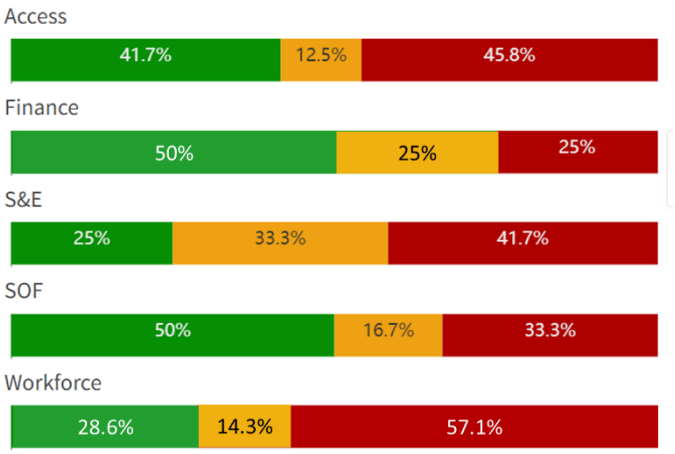


Figure 1 - RAG Breakdown by Performance Domain

3 Single Oversight Framework

3.1 At the end of Quarter 2, the Trust has met three out of six key performance indicators in this domain and almost met one.

3.2 Our IAPT services continue to benchmark in the upper quartile across the UK and have consistently achieved recovery milestones. This means that over 10,000 service users benefit from improvements to their mental health and wellbeing every year.

3.3 Inappropriate out of area placements occur when people are admitted, often in crisis, and there is no suitable local bed available. Due to increased demand, we used a higher number of out of area beds in Quarter 2 than planned. We continue to work with NHS England and system partners to ensure best practice in this area and working on reducing length of stay in our inpatient services to ensure our service users are supported in the most appropriate setting. We have also introduced new management arrangements for our unplanned care services with a new daily surge and escalation framework and are mobilising an Integrated Discharge Team to support discharge pathways.

3.4 The table below summarises the September 2022 position for our Single Oversight Framework key performance indicators. Details of actions we are taking to improve our performance as part of our Recovery Programme can be found in Appendix 2.

KPI	Month	Performance	Target
IAPT meeting treatment recovery goals	Sep-2022	52 %	50 %
IAPT referral to treatment completed in 18wk	Sep-2022	100 %	95 %
IAPT time to enter treatment 6 weeks	Sep-2022	97 %	75 %
Number of inappropriate Out of Area bed days	Sep-2022	1034	508
Quality of National Data Submission (NHSI/E rating)	Jun-2022	94 %	95 %
Suspected First Episode of Psychosis referrals seen within 14 days	Sep-2022	57 %	60 %

Table 1 - Single Oversight Framework KPIs

4 Access

4.1 At the end of Quarter 2, the Trust has met ten out of the twenty-four access key performance indicators and almost met three.

4.2 Service users who present in crisis continued to be seen consistently by the Crisis Resolution and Home Treatment Team within four hours. We also maintained consistently high levels of gatekeeping assessments prior to inpatient admissions to make sure our service users' needs are met in the most appropriate setting and our liaison teams in local hospitals continued to see service users who need our support in line with their needs.

4.3 Our Recovery Programme is making progress towards improving referral to initial assessment times for Adults, Older Adults and Children and Young People community services with recovery expected in Quarter 3 for Children and Young People services and in Quarter 4 for Adult and Older People services.

4.4 The table below summarises the September 2022 position for our Access key performance indicators. Details of actions we are taking to improve our performance as part of our Recovery Programme can be found in Appendix 2.

KPI	Month	Performance	Target
Service users experiencing a First Psychosis Episode starting our Early Intervention in Psychosis pathway	Sep-2022	63	38
CAMHS Urgent Assessment within 7d from referral	Sep-2022	100 %	75 %
Pre-inpatient admission screening complete by Gatekeeping team	Sep-2022	95 %	95 %
A&E Mental Health Triage Assessment within 1hr from referral	Sep-2022	95 %	90 %
Social Worker contact for looked after CYP within 14d from referral	Sep-2022	100 %	85 %
Adult Crisis Triage Assessment within 4hr from	Sep-	100 %	98 %

referral	2022		
Acute Hospital Mental Health Triage Assessment within 24hr from referral	Sep-2022	99 %	90 %
Urgent Adult Assessment within 24hr from referral	Sep-2022	No referrals	95 %
Adult Urgent Eating Disorders Assessment within 24 hours from referral	Sep-2022	100 %	98 %
LD Urgent Triage Assessment within 24hr from referral	Sep-2022	No referrals	98 %
CAMHS Crisis Triage Assessment within 4hr from referral	Sep-2022	94 %	95 %
LD Assessment within 28 days from referral	Sep-2022	97 %	98 %
Referrals into SPA complete Triage Assessment within 14 days	Sep-2022	91 %	95 %
Service Users Accessing IAPT in East and North Herts (recruitment against target)	Sep-2022	84 %	100 %
Service Users Accessing IAPT in Herts Valleys (recruitment against target)	Sep-2022	80 %	100 %
Service Users Accessing IAPT in Mid Essex (recruitment against target)	Sep-2022	71 %	100 %
Adult Assessment within 28d from referral	Sep-2022	48 %	95 %
CAMHS Eating Disorder Assessment within 28d from referral	Sep-2022	26 %	95 %
CAMHS Urgent Eating Disorder Assessment within 7d from referral	Sep-2022	57 %	95 %
Dementia Diagnosis within 12wk from referral	Sep-2022	35 %	80 %
Referral to treat within18wk from referral	Sep-2022	90 %	98 %
Looked after CYP Assessment within 28d from referral	Sep-2022	0 %	85 %
CAMHS Assessment within 28d from referral	Sep-2022	75 %	95 %
Eating Disorders Assessment within 28 Days from referral	Sep-2022	78 %	98 %

Table 2 - Access KPIs

5 Safe and Effective

5.1 At the end of Quarter 2, the Trust met six out of twenty-four key performance indicators in the Safe and Effective domain and almost met a further eight.

5.2 Our carers told us that they felt valued by our staff and our service users reflect that our staff demonstrated the Trusts Values. We continued to support our service users transitioning to and from our services and offer evidence-based treatment and care to support recovery in our IAPT services.

5.3 However, pressures across the health and care system led to people staying longer in inpatient facilities as appropriate placements and support packages have been harder to secure. We have increased our placement reviews with the Hertfordshire County Council to three times a week and are recruiting two additional social workers specifically to focus on delayed transfers of care and out of area pathways to help address this.

5.4 Increased demand on our services also resulted in a decline in recording information which has impacted on our data quality. It has also impacted on the undertaking some of the routine reviews.

5.5 The Table below summarises the September 2022 position for our Safe and Effective key performance indicators with actions we are taking to improve in key areas summarised in the Recovery Programme Update in Appendix 2.

KPI	Month	Performance	Target
Service users under adult mental health specialties on CPA who were followed up within 7 days of discharge from inpatient care	Sep-2022	97 %	95 %
Carers reporting that they feel valued by staff	Sep-2022	79 %	75 %
IAPT clients moving towards recovery – HV CCG	Sep-2022	56 %	50 %
IAPT clients moving towards recovery – ME CCG	Sep-2022	51 %	50 %
Service users reporting they are treated in a way that reflects the Trust's values	Sep-2022	83 %	80 %
Complete and valid submissions of identifiers in the monthly Mental Health Services Data Set	Sep-2022	99 %	95 %
Delayed Transfer of Care	Sep-2022	19 %	3.5 %
Payment by Results HONOS Cluster Assessment Reviewed	Sep-2022	67 %	95 %
Service users on Care Programme Approach (CPA) who had a CPA review within the last 12 months	Sep-2022	71 %	95 %
Having your say – Inpatient's reporting feeling safe	Sep-2022	69 %	85 %
Complete and valid submissions of accommodation status in the monthly Mental Health Services Data Set	Sep-2022	60 %	85 %
Physical Health checks for service users experiencing First Episode of Psychosis	Sep-2022	82 %	90 %
Complete and valid submissions of employment status in the monthly Mental Health Services Data Set	Sep-2022	59 %	85 %
Physical Health Check for services users with Severe Mental Illness	Sep-2022	83 %	95 %
Complete and valid submissions of ethnicity	Sep-	87 %	90 %

in the monthly Mental Health Services Data Set	2022		
Service users with a completed up to date risk assessment	Sep-2022	93 %	95 %
Service users that would recommend the Trust's services to friends and family if they needed them	Sep-2022	79 %	80 %
Service users saying they have been involved in discussions about their care	Sep-2022	80 %	85 %
Service users followed up within 48hr of discharge	Sep-2022	70 %	80 %
IAPT clients moving towards recovery – EN CCG	Sep-2022	49 %	50 %
Payment by Results HONOS Cluster Assessment Recorded	Sep-2022	94 %	95 %
Service users saying they know how to get support and advice at a time of crisis	Sep-2022	80 %	83 %
Service users saying our staff were – welcoming and friendly	Sep-2022	94 %	95 %
Staff Recommending Our Services to Friends and Family	Quarter 2 2022	69 %	70 %

Table 3 – Safe and Effective KPIs

6 Workforce

6.1 The Trust met two out of the seven Workforce indicators in the quarter and almost met one target. We recovered our mandatory training completion, and our staff tell us that we care and take action to support their wellbeing.

6.2 Recruiting and retaining our skilled workforce remains our biggest challenge in delivering services with similar challenges across the NHS. We continue to focus on recruiting permanent and temporary staff and ensuring the experiences of those already in post is as good as it can be, whilst developing new models of care and ways of working to help drive efficiency in the medium to long term. We are beginning to see the results of our actions in this area with a net recruitment position in September of over 40.

6.3 Please note that we revised our Turnover KPI in Quarter 2. Previously we reported Total Turnover with a target of 13.9%. Total Turnover included student doctors and nurses on temporary assignments as part of education and training programmes. Both groups would join at the same time in the year, every year, and leave at the same time as they move onto the next part of their training. From Quarter 2 onwards we are reporting Unplanned Turnover. The target for Unplanned Turnover is 8% and does not include staff turnover which is part of normal training and planned turnover activity. The underlying position has not changed in that our Turnover target is not being met, however the change in definition makes the link between performance and improvement activity clearer to follow.

6.4 The table below summarises September 2022 position for our Workforce key performance indicators with actions we are taking to improve in key areas summarised in the Recovery Programme Update in Appendix 2.

KPI	Month	Performance	Target
Staff completing Mandatory Training	Sep-2022	92 %	92 %
Staff Survey – Staff Wellbeing at Work	Quarter 2 2022	86 %	85 %
Staff Unplanned Turnover over the last 12 months	Sep-2022	14 %	8 %
Staff with Personal Development Plan & Appraisal	Sep-2022	82 %	95 %
Staff Sickness rate	Sep-2022	5 %	4 %
Staff Survey – Staff experiencing Violence at work	Quarter 2 2022	7 %	5 %
Staff Survey – Staff recommend Trust as a place to work	Quarter 2 2022	70 %	80 %

Table 4 – Workforce KPIs

7 Finance

7.1 In Quarter 2, the Trust met two out of the four finance key performance indicators. The financial position of the Trust going forward remains a significant challenge which is reflective of the position across the NHS with a number of systems declaring unplanned deficits for 22-23. Consequently, we are beginning to see a number of steps being taken to both increase the level of NHSE oversight and to implement central controls on expenditure. These measures and their implications will be reported as they become clearer.

7.2 For the Trust the financial Plan recognised this risk with £3m of reserves being assumed to meet a break-even position which reflected principally the increased requirement for adult inpatient beds that arose throughout H2 and additional pay pressures both in increased staffing needed in certain community teams and the rate pressures from agency and staff retention.

7.3 In response to the continuing operational pressures in Quarter 1 a further £2m was agreed on a number of targeted short term in year investments to support recovery and in Quarter 2 there is further cost pressures primarily from a further increase in the need for adult inpatient beds and in pay costs from the rate pressures and the need for additional medical staff.

7.4 To date the Trust has continued to forecast a break-even position for the End of Year but this is at risk given the ongoing increase in inpatient demand and the recovery requirements. An improved financial position is dependent upon progress on the operational recovery along with the work on recruitment and retention, resetting of the general financial controls and driving forward the Delivering Value Programme. As identified throughout the report there are a number of core workstreams to address these.

7.5 The table below summarises September 2022 position for our Finance key performance indicators.

KPI	Period	Performance	Target
To achieve surplus in year	Sept-2022	0	0
Use of resources	Sept-2022	1	1
NHSI agency price caps	Sept-2022	453	0
Delivering Value	Sept-2022	Current forecast 6,400k for the year	10.5 m

Table 5 – Finance KPIs

8 Quality Account

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

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

8.2 In Quarter 2 the Trust met seven of the 10 Quality Account indicators and almost met a further two.

8.3 Staff friends and family test (recommending service to friends and family for treatment) was not met.

8.4 The table below summarises Quarter 1 and 2 position for our Quality Account indicators.

Number	Service User Safety	Target	Quarter 1	Quarter 2
1	Rate of service users who have a completed risk assessment within the last 12 months	95%	92%	93%
2	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	>=95%	96%	95%
3	Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait	>=98%	94%	98%
	Clinical Effectiveness			
4	At least one outcome measures to be used on all LD F inpatients (HONOS in all inpatient units)	>=80%	60%	92%
5	Urgent CAMHS referrals seen within 7 days	>=75%	88%*	83%
6	The proportion of people completing treatment who move to recovery from IAPT	>=50%	54%	52%
	Service User, Carer and Staff Feedback			
7	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	≥=80%	72%*	69%
8	Rate of service users saying they are treated in a way that reflects the Trust's values	>=80%	84%	82%
9	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=70%	79%	78%
10	Trust carer caseload to have an offer of an assessment made in the last 12 months	>=45%	50%	43%

Table 6 – Quality Account Indicators

9 Recovery Programme Update

9.1 The Trust is committed to meeting all its performance targets. We established a Recovery Programme in Quarter 1 to bring together all the performance improvement initiatives under a single governance and support structure, reporting into the Executive Team.

9.2 In addition to the key performance indicators managed, the Recovery Programme also has two supporting projects:

- The Data Quality project is providing teams with administrative capacity and data support to help focus front line teams to work directly with service users, carers and families.
- The Paris Optimisation project is designed to make the task of administering care using our clinical information system (Paris) as simple and efficient as possible. Together, these projects help to support teams and ultimately release time to care.

9.3 At the end of Quarter 2 all projects in the Recovery Programme portfolio made progress. Many projects are on trajectory to recover services by the end of Quarter 3, with particularly strong progress in Children and Young People services. In Quarter 2, we have also seen improvements in a number of areas including:

- Physical health checks for service users with severe mental illness
- Service users with completed and up to date risk assessments
- Completion of staff mandatory training

9.4 Appendix 2 summarises the steps we are taking in the Recovery Programme to improve our performance in areas of key concern.

10 Conclusion and Recommendations

10.1 The Trust met or almost met 55% of our key performance indicators at the end of Quarter 2 2022-23.

10.2 The Recovery Programme is making progress in improving performance in the short term as well as providing a foundation for sustainable performance achievement in the medium to long term.

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

11 Appendices

APPENDIX 1 –STATISTICAL PROCESS CONTROL (SPC) ANALYSIS

11.1 The Trust continues to innovate in making best use of data to inform our improvement efforts. In line with NHS best practice, we are transitioning to use Statistical Process Control (SPC) techniques offering further insights into our performance by exposing the underlying variation and consistency of our key performance indicators. This approach allows us to better understand what our performance is now, the direction it is going, and provides assurance on how likely the Trust is to meet targets.

11.2 This section summarises the performance of the Trust in Single Oversight Framework, Access, Safe and Effective and Workforce domains from April 2019 up to the end of September 2022 using the SPC techniques. This period is chosen as it encompasses the period pre-pandemic, during the pandemic and post-pandemic, allowing us to better understand the impact of the changes the health and care system is experiencing.

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

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

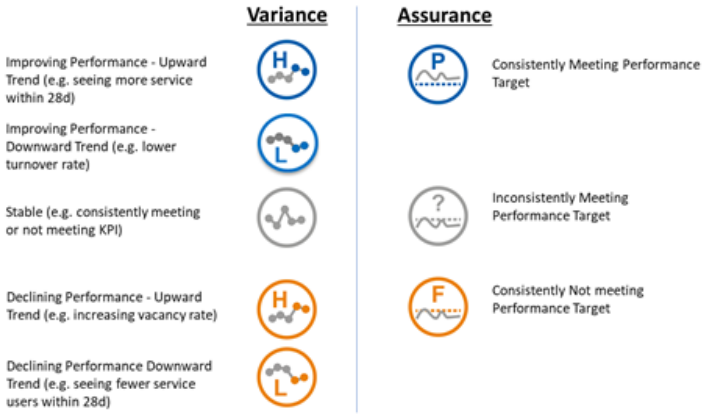


Figure 2 – SPC Icons

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

Single Oversight Framework KPI	Month	Performance	Target	Variation	Assurance	Mean
IAPT meeting treatment recovery goals	Sep-2022	52.2 %	50 %			53.4%
IAPT referral to treatment completed in 18wk	Sep-2022	100 %	95 %			100%
IAPT time to enter treatment 6 weeks	Sep-2022	97 %	75 %			95.2%
Number of inappropriate Out of Area bed days	Sep-2022	1034	508			811.1
Quality of National Data Submission (NHSI/E rating)	Jun-2022	94 %	95 %			96.6%
Suspected First Episode of Psychosis referrals seen within 14 days	Sep-2022	56.5 %	60 %			84.3%

Access KPI	Month	Performance	Target	Variation	Assurance	Mean
CAMHS Urgent Assessment within 7d from referral	Sep-2022	100 %	75 %			80.5%
Service users experiencing a First Psychosis Episode starting our Early Intervention in Psychosis pathway	Sep-2022	63	37.5			19.9
Pre-inpatient admission screening complete by Gatekeeping team	Sep-2022	95.1 %	95 %			96.1%
A&E Mental Health Triage Assessment within 1hr from referral	Sep-2022	94.7 %	90 %			94%
Social Worker contact for looked after CYP within 14d from referral	Sep-2022	100 %	75 %			86.4%
Adult Crisis Triage Assessment within 4hr from referral	Aug-2022	100 %	98 %			100%
Acute Hospital Mental Health Triage Assessment within 24hr from referral	Sep-2022	98.8 %	90 %			96.5%
Urgent Adult Assessment within 24hr from referral	Sep-2022	NA %	95 %			
Adult Urgent Eating Disorders Assessment within 24 hours from referral	Sep-2022	100 %	98 %			
LD Urgent Triage Assessment within 24hr from referral	Sep-2022	NA %	98 %			
Service Users Accessing IAPT in East and North Herts (recruitment against target)	Sep-2022	84.4 %	100 %			90.6%
Service Users Accessing IAPT in Herts Valleys (recruitment against target)	Sep-2022	80 %	100 %			86.4%
Service Users Accessing IAPT in Mid Essex (recruitment against target)	Sep-2022	70.9 %	100 %			77.6%
Adult Assessment within 28d from referral	Sep-2022	47.6 %	95 %			52%
CAMHS Eating Disorder Assessment within 28d from referral	Sep-2022	26.3 %	95 %			20.6%

CAMHS Urgent Eating Disorder Assessment within 7d from referral	Sep-2022	57.1 %	95 %			19.6%
Dementia Diagnosis within 12wk from referral	Sep-2022	35.1 %	80 %			35.9%
Referral to treat within18wk from referral	Sep-2022	90.2 %	98 %			95.5%
Looked after CYP Assessment within 28d from referral	Sep-2022	0 %	85 %			55.5%
CAMHS Crisis Triage Assessment within 4hr from referral	Sep-2022	94.1 %	95 %			84.9%
CAMHS Assessment within 28d from referral	Sep-2022	75 %	95 %			71.7%
Eating Disorders Assessment within 28 Days from referral	Sep-2022	78.3 %	98 %			79.6%
Learning Disabilities Assessment within 28 days from referral	Sep-2022	97.4 %	98 %			98%
Referrals into SPA complete Triage Assessment within 14 days	Sep-2022	90.9 %	95 %			92.1%

Safe and Effective KPI	Month	Performance	Target	Variation	Assurance	Mean
Service users under adult mental health specialties on CPA who were followed up within 7 days of discharge from inpatient care	Sep-2022	97.4 %	95 %			97%
Carers reporting that they feel valued by staff	Sep-2022	79.2 %	75 %			73.9%
IAPT clients moving towards recovery – HV CCG	Sep-2022	55.5 %	50 %			56.1%
IAPT clients moving towards recovery – ME CCG	Sep-2022	51.4 %	50 %			50.7%
Service users reporting they are treated in a way that reflects the Trust's values	Sep-2022	83.3 %	80 %			83.5%
Complete and valid submissions of identifiers in the monthly Mental Health Services Data Set	Sep-2022	99.5 %	95 %		P	99.5%
Delayed Transfer of Care	Sep-2022	18.5 %	3.5 %	H	F	14.7%
Payment by Results HONOS Cluster Assessment Reviewed	Sep-2022	66.9 %	95 %	L	F	72.1%
Service users on Care Programme Approach (CPA) who had a CPA review within the last 12 months	Sep-2022	71.3 %	95 %	L	F	76.8%
Having your say – Inpatient's reporting feeling safe	Sep-2022	68.7 %	85 %	L	F	74.1%
Complete and valid submissions of accommodation status in the monthly Mental Health Services Data Set	Sep-2022	59.6 %	85 %		F	59%
Physical Health checks for service users experiencing First Episode of Psychosis	Sep-2022	81.7 %	90 %		F	77.4%
Complete and valid submissions of employment status in the monthly Mental Health Services Data Set	Sep-2022	59.1 %	85 %		F	58.8%
Physical Health Check for services users with Severe Mental Illness	Sep-2022	83.2 %	95 %	H	F	74.6%

Complete and valid submissions of ethnicity in the monthly Mental Health Services Data Set	Sep-2022	86.6 %	90 %			84.2%
Service users with a completed up to date risk assessment	Sep-2022	92.9 %	95 %			90.1%
Service users that would recommend the Trust's services to friends and family if they needed them	Sep-2022	78.8 %	80 %			81.8%
Service users saying they have been involved in discussions about their care	Sep-2022	80 %	85 %			86.7%
Service users followed up within 48hr of discharge	Sep-2022	69.7 %	80 %			81.5%
IAPT clients moving towards recovery – EN CCG	Sep-2022	49.4 %	50 %			52%
Payment by Results HONOS Cluster Assessment Recorded	Sep-2022	94.1 %	95 %			94.7%
Service users saying they know how to get support and advice at a time of crisis	Sep-2022	80.2 %	83 %			82.5%
Service users saying our staff were welcoming and friendly	Sep-2022	94.3 %	95 %			96.7%
Staff Recommending Our Services to Friends and Family	Quarter 2 2022	69.5 %	70 %			

Workforce KPI	Month	Performance	Target	Variation	Assurance	Mean
Staff completing Mandatory Training	Sep-2022	92.3 %	92 %			90.3%
Staff Survey – Staff Wellbeing at Work	Quarter 2 2022	86.1 %	85 %			
Staff Unplanned Turnover over the last 12 months	Sep-2022	14.3 %	8 %			13.4%
Staff with Personal Development Plan & Appraisal	Sep-2022	82 %	95 %			79.6%
Staff Sickness rate	Sep-2022	4.6 %	4 %			5.1%
Staff Survey – Staff experiencing Violence at work	Quarter 2 2022	7.3 %	5 %			
Staff Survey – Staff recommend Trust as a place to work	Quarter 2 2022	69.7 %	80 %			

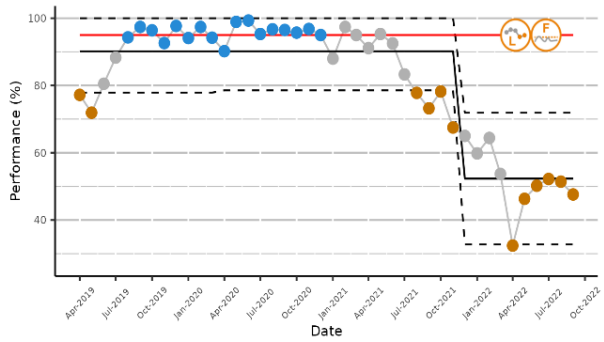
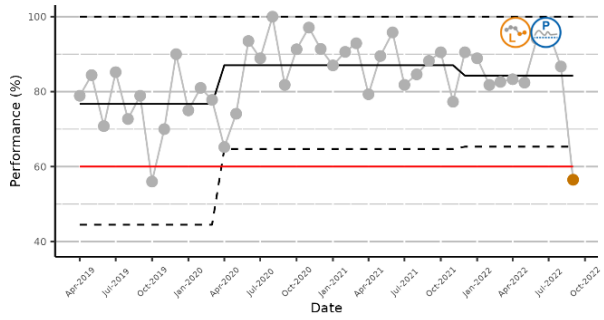
APPENDIX 2 – RECOVERY PROGRAMME UPDATE

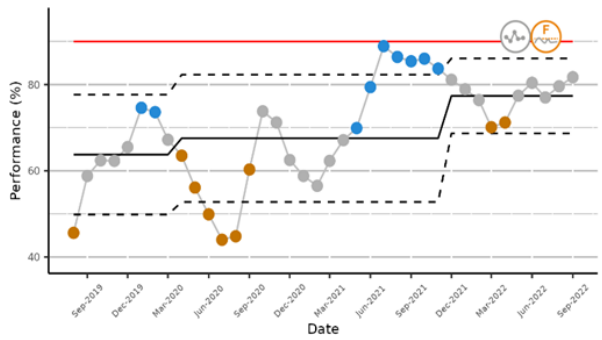
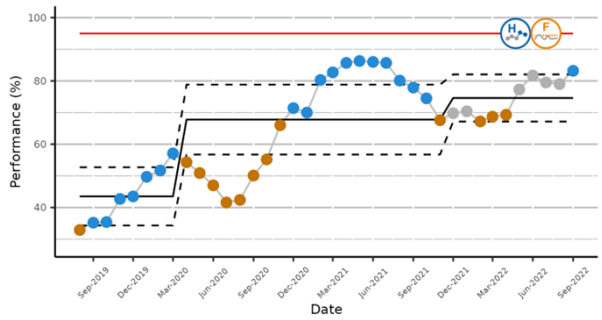
11.6 This section summarises the high priority projects in the Recovery Programme and the steps we are taking to improve performance in areas of key concern. It is organised into logical groups (Inpatient, Adults, CAMHS etc) for ease of reference.

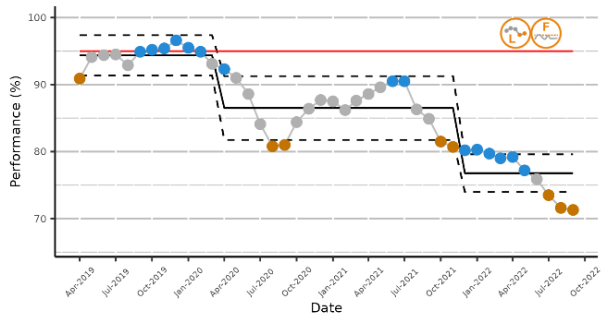
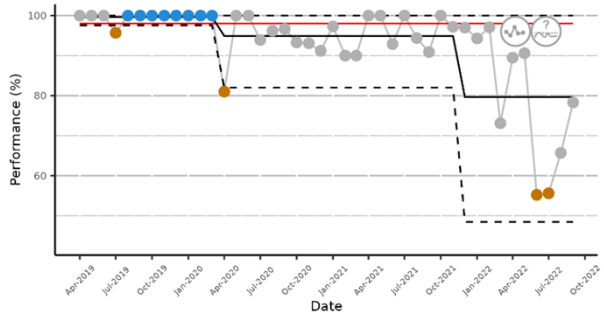
11.7 Each summary is broken into 5 sections (columns)

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

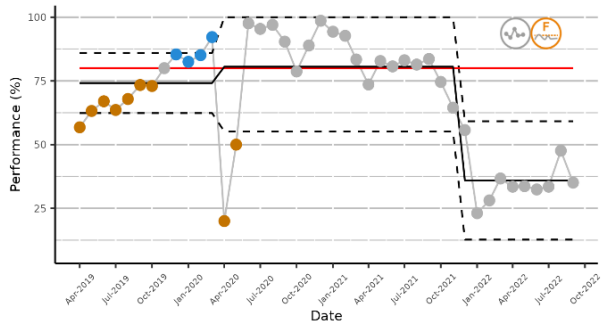
Adult Community MH Services

KPI	Chart	What the data is telling us	Summary	Key Actions
Referral to Initial Assessment time – Target 28 days		**Sep-2022** 48 % **Variance Type** Special Cause Variation: Latest 6 data points are below mean **Latest Target** 95% **Assurance** Consistently not meeting performance target	Sustained high demand has resulted in a waiting list for initial assessments, with high levels of vacancies in some teams, where recruitment is particularly challenging. In Sept 95% of service users were assessed within 56 days of referral. Recovery is expected in Quarter 4.	• 5 of 9 agency staff recruited, who are currently undertaking 90 assessments per week. Target at full recruitment is 150 Assessments per week to recover the backlog in 8 weeks. • Administrative support extended to community mental health teams • Commissioned external process efficiency consultant (Lean) to optimise current processes • Out of hours clinics to provide extra capacity from substantive staff and make access easier for service users
Suspected First Episode of Psychosis referrals seen within 14 days		**Sep-2022** 57 % **Variance Type** Special Cause Variation: Latest value below lower control limit **Latest Target** 60% **Assurance** Consistently meeting performance target	Performance fell in September due to sickness and vacancies causing capacity issues. The performance recovered to 82% in October 2022.	• Recruited 2 agency staff as a temporary measure to boost capacity and provide resilience. • Work with workforce team to expediate recruitment for substantive vacancies.

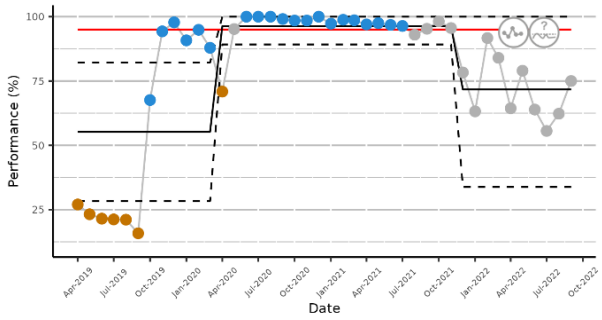
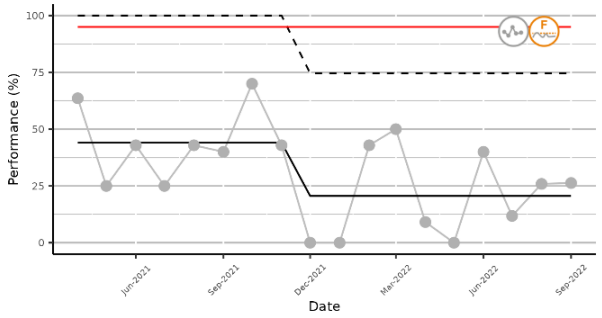
KPI	Chart	What the data is telling us	Summary	Key Actions
Service users with first episode of psychosis have received Cardiometabolic Health Check		**Sep-2022** 82 % **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 90% **Assurance** Consistently not meeting performance target	Performance impacted by workforce gaps and case load management being prioritised. Staffing improvements anticipated in near future.	• Physical health nurses to support PATH team in following up bloods and interventions to complete the partially completed checks from w/c 24/10/22 • Physical health team to assist with new PATH team members learning how to integrate physical health assessment and care with mental health care.
Service users with serious mental illness have received Cardiometabolic Health Check		**Sep-2022** 83% **Variance Type** Special Cause Variation: Latest value above upper control limit **Latest Target** 95% **Assurance** Consistently not meeting performance target	Performance impacted by vacancies in services and case load management being prioritised. Staffing improvements anticipated in near future following recruitment. There has been significant improvement in Quarter 2.	• Physical health nurses to return to supporting Watford and Borehamwood teams in following up bloods and interventions to complete the partially completed checks from w/c 17/10/22 • PH nurses to meet with E & N older adult community team in November to explore low completion of PHC and clarify meaningful actions to achieve KPI by year end • Different models of managing caseloads being explored in West SBU community. • Ongoing recruitment of staff into vacancies in community teams

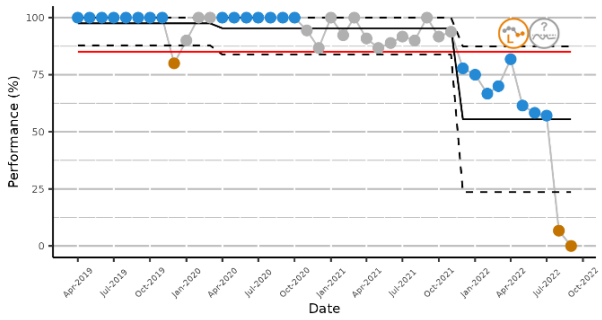
KPI	Chart	What the data is telling us	Summary	Key Actions
Multi-disciplinary Team Review for service users on Care Programme Approach		**Sep-2022** 71 % **Variance Type** Special Cause Variation: Latest value below lower control limit **Latest Target** 95% **Assurance** Consistently not meeting performance target	Pressures during COVID and increased caseloads, compounded staffing challenges resulted in people waiting longer for a multidisciplinary review. We expect the position to start improving in Quarter 3 with recovery expected at the end of Quarter 4. We are also transitioning from Care Programme Approach to personalised care and support plans.	• Captured the 'best team' model for Care Programme Approach within HPFT and commencing audit / gap analysis for all community teams to identify and meet local team needs • Case review and re-allocation for large care co-ordinator case loads • Weekly agency and bank recruitment review with Service Line Leads and Team leaders to target support to high vacancy areas
Eating Disorders Assessment within 28 Days from referral		**Sep-2022** 78 % **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98 % **Assassurance** Inconsistently meeting performance target	An increase in demand, combined with staff vacancies resulted in longer waiting times for people who had routinely been referred to the service. Recovery expected by the end of Quarter 3.	• Successful recruitment to vacancies. • Full caseload for newly recruited staff expected by the end of Quarter 3.

Older Adults Services

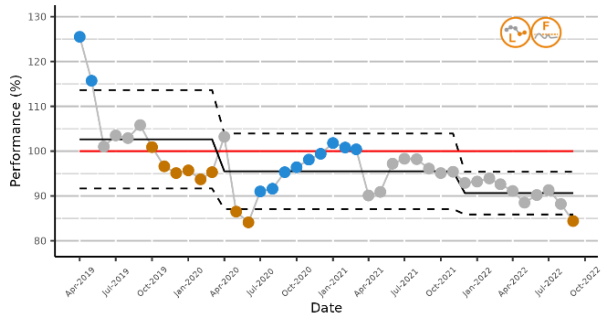
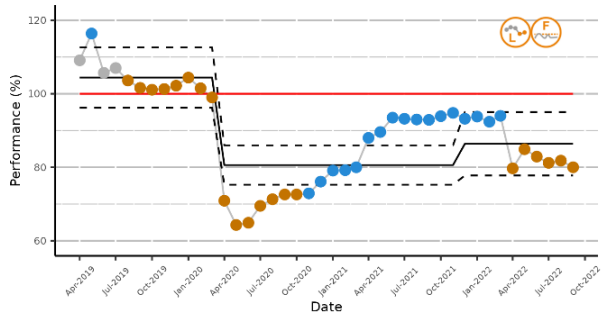
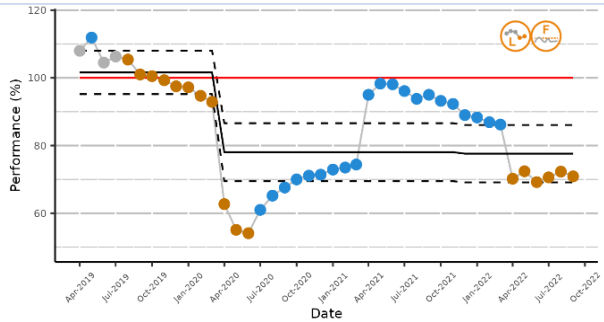
KPI	Chart	What the data is telling us	Summary	Key Actions
Dementia 12-week referral to diagnosis target		**Sep-2022** 35 % **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 80% **Assurance** Consistently not meeting performance target	For a period over the winter 2021 COVID wave EMDASS staff were required to support inpatient units. This resulted in an increase in people waiting for diagnosis. Subsequently a sharp rise in referrals during June / July created additional backlog. Expected to recover in Quarter 4	• County wide model for diagnosis to pool resources and strengthen MDT • Additional clinics for evening and weekends to see service users on waiting list • Primary care dementia diagnosis nurses improving the pathway

Children and Adolescent MH Services

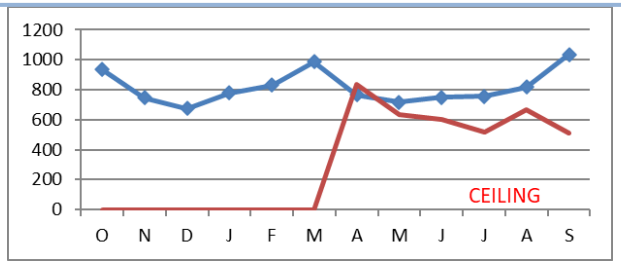
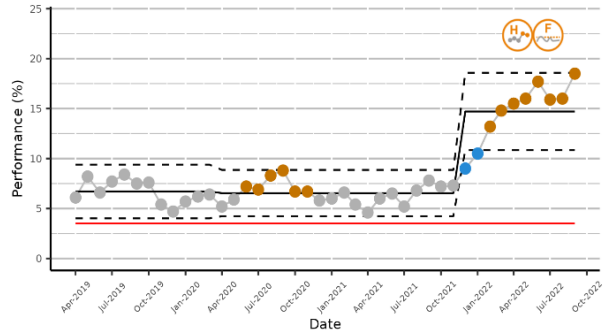
KPI	Chart	What the data is telling us	Summary	Key Actions
CAMHS Assessment within 28 days from referral		**Sep-2022** 75% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Inconsistently meeting performance target	An increase in demand, combined with capacity issues in our Single Point of Access (SPA) Service resulted in an increased number of children and young people waiting for an initial assessment. Recovery expected in Quarter 3.	• SPA Triage Tool improved to meet 5-day pass on to teams • Job planning to continue in all quadrants to ensure qualitative approach • Demand and capacity review underway to assess post-covid requirements
Eating Disorders assessments within 28 days from referral		**Sep-2022** 26 % **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Consistently not meeting performance target	Increase in demand by 47% nationally and challenges in recruitment resulted in an increased number of children and young people waiting for treatment. Recovery Expected in Quarter 3.	• Caseload acuity review and transition support for Tier 2 CAMHS and primary care • Targeted recruitment initiative. Skill mix review to be conducted to allow greater flexibility of other disciplines to widen pool of candidates. • Additional clinics supported by bank and agency staff to address increased demand and waiting list

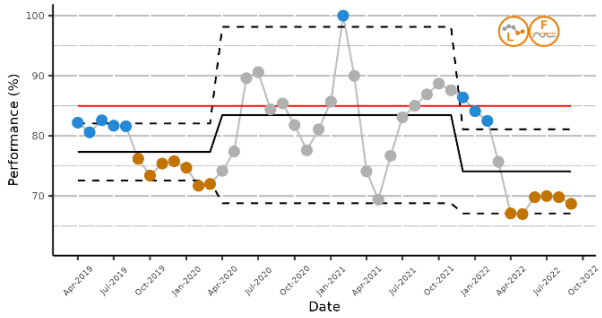
KPI	Chart	What the data is telling us	Summary	Key Actions
Looked after CYP Assessment within 28 days from referral		**Sep-2022** 0% **Variance Type** Special Cause Variation: Latest value below lower control limit **Latest Target** 85% **Assurance** Inconsistently meeting performance target	An increase in demand combined with recruitment challenges resulted in longer waits for assessment. In September, there were 10 referrals with 85% of them seen within 49 days. Performance for the 13 referrals in October has improved to 77% with 85% of the referrals being seen within 29 days. We expect this to recover in Quarter 3.	• Active recruitment drive has taken place to fill vacancies • Review of current systems & processes; adjusting variances & congestion points to improve flow and performance • Improving efficiency including job planning and focused clinical support • Protocol in place with Social Care to improve availability of social workers to undertake joint assessment.

IAPT Services

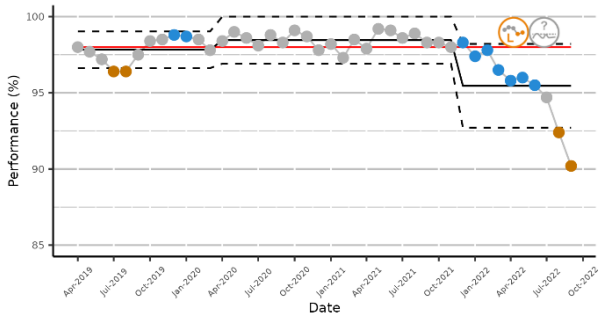
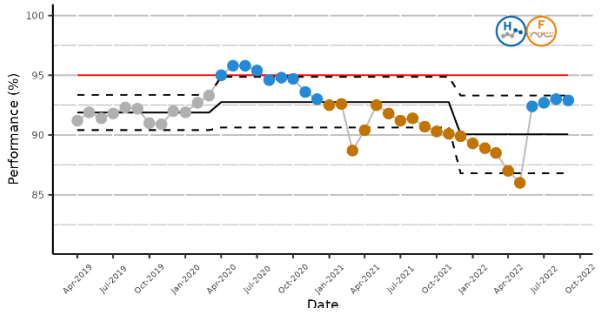
KPI	Chart	What the data is telling us	Summary	Key Actions
Commissioned treatment target East & North Herts		**Sep-2022** 84 % **Variance Type** Special Cause Variation: Latest value below lower control limit **Latest Target** 100% **Assurance** Consistently not meeting performance target	The expected increase in referrals to IAPT services post-COVID has not materialised and despite benchmarking well nationally we need more referrals to the service to meet our monthly contracted activity levels. The balance of complexity has changed between predominantly Tier 2 (lower complexity) when IAPT was first introduced, in favour of more complex needs now (Tier 3).	• Updated online campaign for direct referrals • Updated offer and marketing to GPs (key referrers) • Review connectivity issues for patient booking system to ensure appointments aren't lost. • Readjust workforce skill mix to reflect increased acuity of referrals. • Updating comms and engagement for people with long-term conditions • Requests to system partners to increase referral rates
Commissioned treatment target Herts Valleys		**Sep-2022** 80% **Variance Type** Special Cause Variation: Latest 6 data points are below mean **Latest Target** 100% **Assurance** Consistently not meeting performance target		
Commissioned treatment target Mid Essex		**Sep-2022** 71 % **Variance Type** Special Cause Variation: Latest 6 data points are below mean Two of three data points within zone A (LCL) **Latest Target** 100% **Assurance** Consistently not meeting performance target		

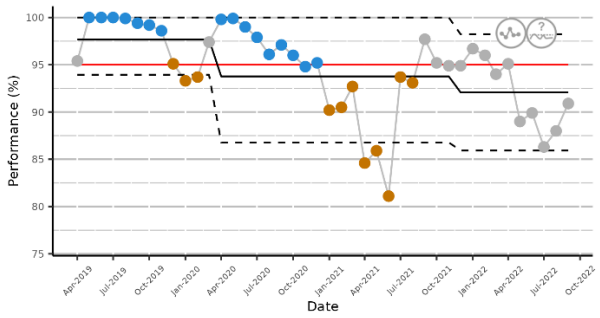
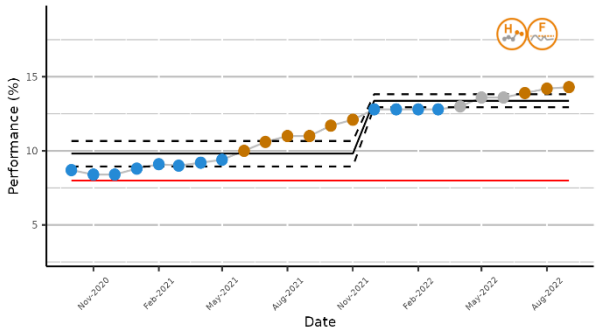
Inpatient Services

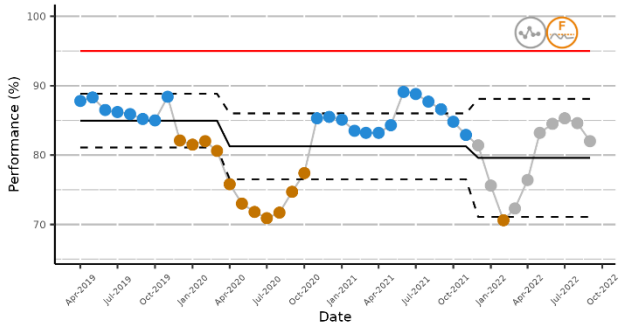
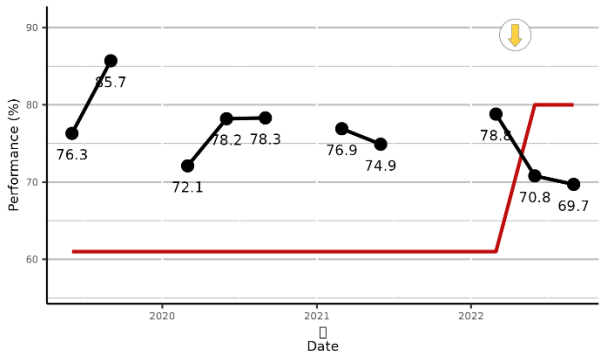
KPI	Chart	What the data is telling us	Summary	Key Actions
Number of inappropriate Out of Area bed days		**Sep-2022** 1034 **Variance Type** N/A **Latest Target** 508 **Assurance** N/A	Out of area placements (OAPs) have increased, reflecting the national picture of increased demand and acuity within mental health services. The Trust also benchmarks at the lower end for number of inpatient beds per population.	• Continuing to engage with additional expertise as part of the national Getting It Right First-Time programme to identify areas of improvement. • New arrangements in place to monitor demand and capacity. In addition, new standard operating procedures in place to standardise practice. • Mobilisation of an Integrated Discharge Team to manage all beds across the Trust with oversight across the system.
Delayed Transfers of Care		**Sep-2022** 19 % **Variance Type** Special Cause Variation: Latest 6 data points are above mean **Latest Target** 3.5% **Assurance** Consistently not meeting performance target	The number of people who are ready to move on from our inpatient services but are delayed has increased. This is due to several complex factors, including suitable placements being available for service users with complex needs and increased demand on community services.	• Joint Adult Services (HCC) & Placement team (HPFT) step-up to three times a week placement review • New role out to recruitment for two social workers specifically aligned to discharge across the Delayed Transfers of Care and out of area pathways. Expected to be in post in Quarter 3. • Strengthened contractual management arrangements to introduce contractual lengths of stay targets for each service user to facilitate step-down conversations and create flow.

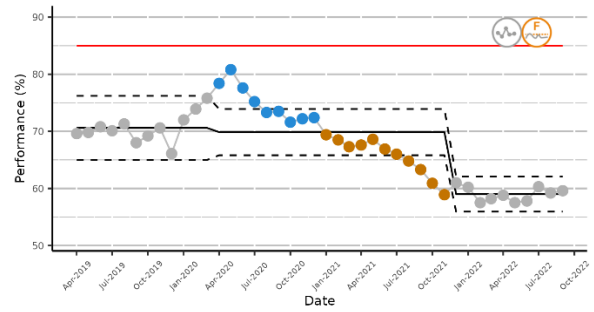
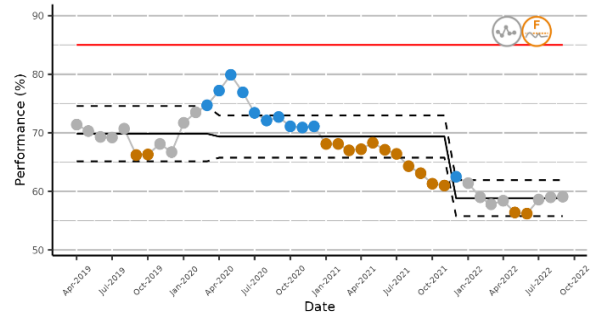
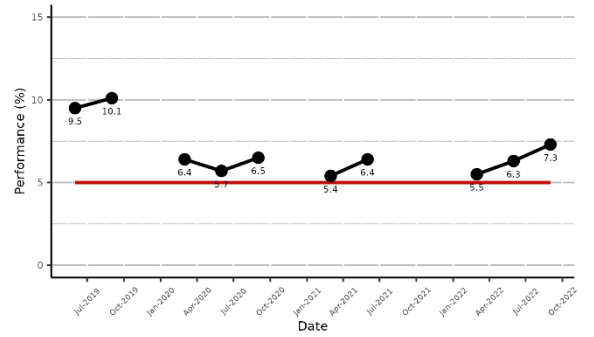
KPI	Chart	What the data is telling us	Summary	Key Actions
Service users feeling safe in inpatient services		**Sep-2022** 69 % **Variance Type** Special Cause Variation: Latest 6 data points are below mean **Latest Target** 85% **Assurance** Consistently not meeting performance target	The number of people saying that they feel safe in our inpatient units has decreased, but the number of people completing the survey is low, making the results less reliable.	• Focused survey on safety in inpatient units to ensure that we understand and address the reasons for service users not feeling safe – extended by two weeks to get feedback following the recent Panorama report. • A review of our current survey is taking place to identify ways to improve number of feedback surveys received from service users.

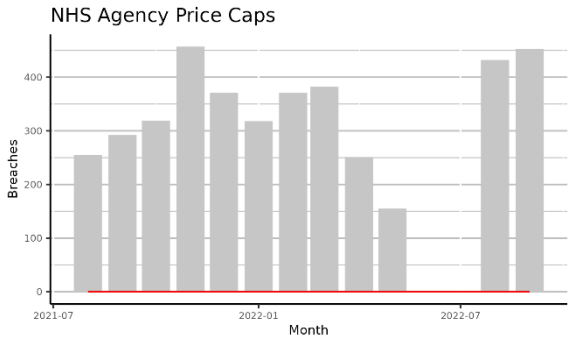
Trust-wide Indicators

KPI	Chart	What the data is telling us	Summary	Key Actions
Referral to treat within 18 weeks from referral		**Sep-2022** 90 % **Variance Type** Special Cause Variation: Latest value below lower control limit **Latest Target** 98% **Assurance** Inconsistently meeting performance target	Sustained high demand in our services is impacting on our 18-week wait to treatment times, particularly in hard to recruit areas. Recording of start of treatment in electronic records also needs improvement. We expect this to recover following the recovery of adult community target for initial assessments in Quarter 4.	• Recovery in areas that are clearing long waiting lists – EMDASS and CAMHS Eating Disorder – are impacting on performance, as expected. • Caseload review and development of caseload management tool to increase capacity overall and improve time to treatment. • Data quality project in place as part of Recovery Programme with additional support to services to address potential data quality issues
Service users with a completed up to date risk assessment		**Sep-2022** 93 % **Variance Type** Special Cause Variation: Two of three data points within zone A (UCL) **Latest Target** 95% **Assurance** Inconsistently meeting performance target	Pressures during COVID and increased caseloads, compounded by time consuming recording methods, resulted in people waiting longer for a review of their risk assessment. Expected to recover in Quarter 3	• Implementations complete for Adults, Older Adults and Children and Young People • Specification for LD&F completed, and changes being implemented • Simulation suite training rollout continues for teams with low assessment compliance • Case review and re-allocation for large psychiatry caseloads underway • Administrative support to teams with high caseloads

KPI	Chart	What the data is telling us	Summary	Key Actions
Referrals into SPA complete Triage Assessment within 14 days		**Sep-2022** 91 % **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Inconsistently meeting performance target	Increased referral volume and capacity issues in SPA adversely affected performance, particularly in older people's services. Expected to recover in Quarter 3.	• Strengthening of the triage team for older people to improve capacity and throughput • Daily monitoring of waits, using an updated waiting time report that gives greater visibility of any backlog that may be building
Staff Unplanned Turnover over the last 12 months		**Sep-2022** 14 % **Variance Type** Special Cause Variation: Latest value above upper control limit **Latest Target** 8% **Assurance** Consistently not meeting performance target	The largest group of leavers are within our registered and unregistered nursing workforce. An increase in people leaving was seen over the summer period, which is a seasonal phenomenon. We are now reporting on unplanned turnover as this measure is key to retention.	• Enhanced wellbeing support for staff including Wellbeing Festivals • Enhanced benefits and incentives to join and stay with HPFT, with Wagestream about to launch • Significant engagement with staff to act on feedback and improve experience. • Workforce redesign to tap into novel talent pools, enhance career development opportunities and enable teams to better meet heightened levels of activity. • Enhanced development offers and recruitment campaigns

KPI	Chart	What the data is telling us	Summary	Key Actions
Staff with up-to-date Personal Development Plan & Completed Appraisal		**Sep-2022** 82% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Consistently not meeting performance target	Appraisal compliance has plateaued at around 84 - 85%, reducing slightly in both August and September. Whilst this may reflect the impact of the summer holiday period, compliance is significantly lower than our target rate of 95% and our predicted recovery trajectory. Compliance within Corporate Services and West SBU is a particular focus.	• Monthly reporting to the Executive Team and People and OD Group • Scrutiny at the Safe and Effective Care fortnightly meeting • Launch of the new Appraisal App • A further push on achieving compliance to coincide with the App launch and enhanced weekly reporting
Staff Survey – Staff recommend Trust as a place to work		**2022 Q2** 70 % **Variance Type** N/A **Latest Target** 80% **Assurance** N/A	Our Quarter 2 pulse survey received a 14.2% response rate. Our overall results, remain high and exceeds that of our national benchmarked peer groups. They also remain consistent with previous pulse survey results, including the national staff survey results from Quarter 3 of 2021/22 (70.6%).	• Enhanced benefits and wellbeing support for staff, promoting self-care • Significant engagement with staff to act on feedback and improve experience. • Work on reducing violence and aggression in the Trust • Work to eliminate discrimination and ensure equity, including co-producing our belonging and inclusion strategy • Development offer for enhancing feedback skills

KPI	Chart	What the data is telling us	Summary	Key Actions
Complete and valid submissions of accommodation status in MHSDS Mental Health Services Data Set		**Sep-2022** 60 % **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 85% **Assurance** Consistently not meeting performance target	Recording of accommodation and employment status decreased during the COVID period, as staff focused on areas of greatest risk for our service users.	• Data quality campaign with information team working with services to record status for initial improvement • Longer term solution to simplify recording in our electronic patient record and ensure that staff understand the importance of recording demographic data and how it is used.
Complete and valid submissions of employment status in MHSDS		**Sep-2022** 59 % **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 85% **Assurance** Consistently not meeting performance target	Recording of accommodation and employment status decreased during the COVID period, as staff focused on areas of greatest risk for our service users.	• Data quality campaign with information team working with services to record status for initial improvement • Longer term solution to simplify recording in our electronic patient record and ensure that staff understand the importance of recording demographic data and how it is used.
Staff Survey – Staff experiencing Violence at work		**2022 Q2** 7 % **Variance Type** N/A **Latest Target** 5% **Assurance** N/A	Reducing harm from violence and aggression towards staff is a key priority for the Trust. A Co-produced CQI project is underway to reduce harm from violence and aggression towards staff.	• Members of the CQI project group the feedback received into themes and build into workstreams • Body Worn Camera scoping exercise underway learning from other Trusts – to be presented to Health Safety and Security Committee in Quarter 3

KPI	Chart	What the data is telling us	Summary	Key Actions
NHSI agency price caps		**Sep-2022** 453 **Variance Type** N/A **Latest Target** 0 **Assurance** N/A	The Trust is currently paying in excess of agency cap prices (off-framework) in two limited areas: 1. To expedite the initial assessment of service users to enhance access to care where a backlog has developed. 2. To safely staff inpatient units in Lexden Hospital. There are no further instances in which the Trust is paying above framework rates for agency staff.	• Weekly review of framework payments to agency staff • The use of off-framework agency staff to support inpatient services at Lexden Hospital is reducing, with the aim of returning to framework providers as soon as it is possible and safe to do so.

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 14
Subject:	Financial Position – Month 7	**For Publication:** Yes
Author:	David Flint, Head of Financial Performance & Reporting and Rob Croot, Deputy Director of Finance	**Approved by:** Paul Ronald, Director of Finance & Estates
Presented by:	Paul Ronald, Director of Finance & Estates	

Purpose of the report:

To present to the Trust Board the financial position for the period to October 31st, 2022 (month 7) and the projected full year outturn and any risks to the Trusts financial duties. The report notes the key items the variances to plan and previous periods and the forecast for the remainder of the year with the key assumptions and the likely risks.

Action required:

The report shows that there has been a further increase in expenditure in the period and consequently a material increase in the projected outturn. At this point the revised forecast is showing an outturn of £11.3m deficit before the release of Trust reserves. This is considered a prudent position and largely rolls forward month 7 without incorporating any of the planned savings which were originally included in the Plan as being realisable in H2. If these can be delivered as previously envisaged this would provide headroom against the risk of not meeting the Plan breakeven.
As reported to the Executive Team and discussed within the November FIC there is a new protocol implemented by NHSE to approve a change in financial Plans. The Trust will have to continue to monitor this position very closely as any further increase in overall costs is likely to result in a deficit being reported.

Summary and recommendations

Overview

The month 7 position has shown a further deterioration in financial performance from month 6 and from the flash position previously reported, of £1.7m in the month but £1.4m when adjusting for exceptional items. This is a significant deterioration in month of circa £0.6m against the Month 6 position and rolling this forward gives a forecast outturn to £11.3m, before release of Trust reserves. This represents a deterioration of £5.3m in forecast outturn from month 6.

Balancing this forecast position from reserves and one-off income sources is still assumed likely but it is stretching with minimal further headroom

The continuing headline areas of overspending are OOA bed costs which have increased sharply in month and pay costs which have begun to reduce in isolated areas, but not at the rate previously forecast and are continuing to increase in other areas.

This report highlights several key focus areas:

- Secondary Commissioning expenditure has increased in October (by circa £500k from September, with a further increase in monthly average of 14 Acute beds, 1.5 PICU beds, associated observations and an agreed uplift to a Social Care provider backdated to April 2022)
- Pay costs are £1.2m above Plan in month and £5.9m YTD
- OOA bed costs are £859k above Plan in month and £1,364k above plan for the YTD. Reflecting both an increase in spend and a further divergence from planned DV reductions.
- Provider collaborative reports a break-even position, with any projected overspend matched by underspends across the collaborative
- non-Pay costs and overheads are broadly on Plan with the forecast outturn reflecting projected utility cost increases
- In month 7 a further £1.7m has been released from reserves, making a total of £6.2m for the YTD. Of this £2.5m was included in the Trust Plan, a further £1,017k reflects pro-active investment in-year and £2.68m reflects unplanned overspending. If the current level of spend were to continue for the remainder of the financial year this would suggest an outturn requirement of £11.3m from reserves to balance.
- Delivering Value Program forecast outturn has been revised to £5.6m, to remove a planned DV of £1m in respect of reduced OOA bed numbers and costs.
- In relation to income, there is a projected carry forward on the 22-23 transformation funding of c£2.2m. All other income is being used as planned.

Other points of note:

- Financial Recovery plans have been received from SBU's but are not yet impacting expenditure.
- An Agency Panel is now in place and seeking to reduce the usage and cost of agency staff in line with substantive recruitment.

This confirms and extends the challenging position set out previously. Improvement actions will focus on securing the service and related financial benefits from the significant transformation and technology investments as well as the further actions to reduce the ongoing adult bed requirement, pay costs and the overhead cost base.

In addition, the case for the realignment of MH funding post Covid will be essential to provide a stable footing to build from. Work on this investment case will start now.
There are several investments and transformation schemes that have yet to deliver improvements in financial performance, such as the recruitment in substantive staffing over the past 2 months – which should enable a reduction in the use of bank and agency costs. In addition, funding for the additional 10 Elysium beds will be fully applied by 31 December.
It may also be beneficial to review the forward schedule of in-year investments, set out in an appendix to this paper.

The Trust has received notification from NHSE of a new protocol to be followed if the Trust were to move into a reported financial deficit position. This was shared and is subject to ongoing discussion and clarification both internally and within the ICB system

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

Delivery of Financial Plan

Summary of Financial, IT, Staffing & Legal Implications:

Delivery more than Financial Control Total

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

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

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

Executive

1 1 Financial position for the 7 months to 31 October

1.1 The financial position for the 7 months to 31 October shows a deficit of £6.156m, before the release of Trust reserves. This represents a deterioration from month 6 of £1.7m.

1.2 This deterioration in month includes several one-off costs which will not recur in future months. However, an in-month deterioration of £1.442m in run-rate drives a deterioration in forecast outturn of c£6.1m.

1.3 The impact of forecast outturn is considered below, but the in-month deterioration reflects the following additional spend, more than that incurred in the first 6 months of the year:

	£'000
OOA placements	600
Bank pay	150
Agency pay	200
Non-pay	150
Others	300
	1,400

1.4 The table below highlights the month 7 and year to date position.

		Month 7		Year to Date		
Financial Position to 31 Oct	Revised Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income incl. COVID-19	28,966	29,825	859	202,387	204,179	1,792
Pay	17,059	18,308	(1,249)	118,190	124,074	(5,884)
Secondary Commissioning	3,527	4,386	(859)	25,529	26,893	(1,364)
Provider Collaborative	3,567	3,567	0	25,171	24,622	549
Non Pay	1,999	2,136	(137)	14,115	14,239	(124)
Overheads & Reserves	2,815	3,155	(340)	19,382	20,508	(1,126)
Surplus / (Deficit)	-	**(1,727)**	**(1,727)**	**0**	**(6,157)**	**(6,157)**

Income

1.5 In month 7 income is above plan, reflecting additional funding for the 2022/23 pay award and additional winter support for OOA placements. Income has also increased in month because of several additional Health Education England trainee income schemes, with income for medical trainees, higher than plan. This increase is partially offset by continued slippage in implementing SDF funded transformation schemes.

1.6 Transformation income is released into the monthly position in line with actual spend as it is incurred, primarily on pay costs. Recruitment into these schemes continues to progress, however there is still expected to be a level of underspend

against these schemes. Further details of the utilisation of Transformation income are shown below.

Pay Costs

1.7 Pay costs have increased in month and are above plan by £1,249k and by £5.9m for the year to date, reflecting significant bank and agency costs. The costs of temporary staffing are partially offset by underspends from substantive vacancies.

1.8 An element of this overspends on pay budgets, £124k in month and £762k for the year to date, relates to pro-active investments, including bank incentives and 28-day initial assessment recovery work.

1.9 However, the *unplanned* year to date overspend on pay is therefore £5.23m. This overspend reflects continued high levels of temporary staffing, (bank and agency), the cost of which exceeds the value of substantive vacancies.

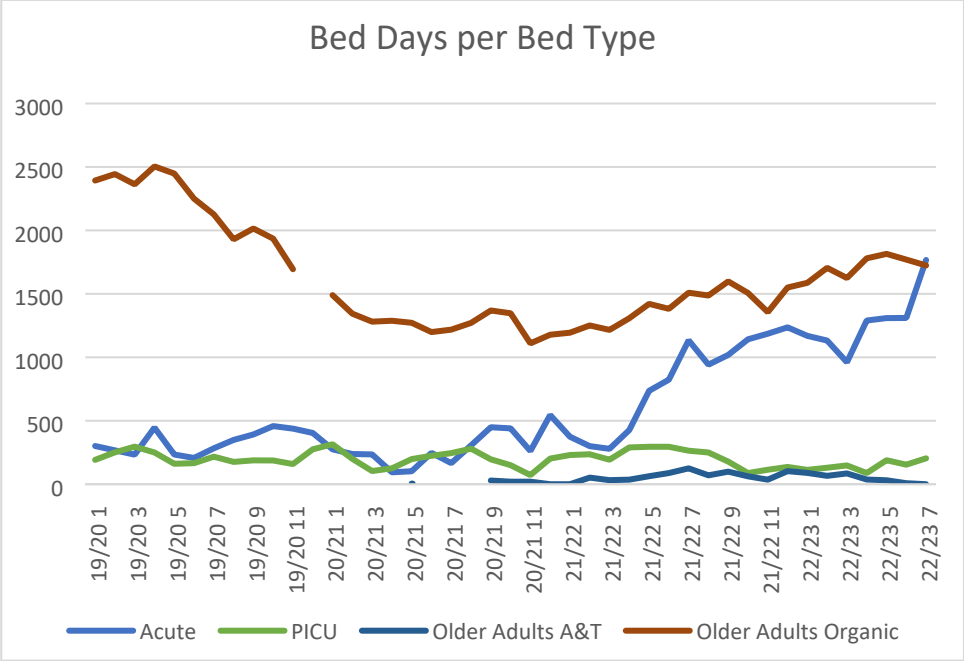
1.10 The primary driver of this overspend is the use of agency HCAs and nurses on inpatient wards. The inpatient ward with the highest pay overspends for the year to date are Dove Ward, Lexden, Oak Ward, Robin Ward, and Swift Ward.

1.11 An Agency Panel has been convened to provide oversight and challenge to the use of agency staffing. Initial focus has been on information flows to service leads and to SBU leadership teams. All wards and services have been challenged to reduce agency staff usage by at least 1 wte, per unit per month and to ensure that agency costs are reduced in line with substantive recruitment.

Secondary Commissioning

1.12 Secondary commissioning spend is £859k above plan in Month 7 and £1.36m above plan for the 7 months to 31 October. The month 7 position reflects continued high usage of external beds, with the average number of acute OOA placements increasing from 43 to 57. Other areas of external bed usage have remained relatively static, with some fluctuations from month to month, but a relatively stable average. In month 7 there has been a non-recurrent backdated payment made to Novita to reflect the final agreement on inflationary uplift. This has added an additional £120k in month with an expected ongoing increase in monthly costs of circa £30k.

1.13 The below graph illustrates the changes in the main external bed types, in bed days since the start of the Covid pandemic. This highlights the large increase in Acute bed days but also the rising costs of Continuing Healthcare claims since a historical low point during the pandemic.



Provider Collaborative

1.14 Provider collaborative activity reports a balanced position for month 7 and the year to date. This continues to be monitored closely by the TACT team, due to the number of beds currently closed in the EoE region. These closures continue to drive additional financial pressure through the increased use of independent sector beds.

1.15 There are currently 36 NHS beds closed across the EoE region, as follows:

HPFT – 8
NSFT – 6
CPFT – 9
EPUT – 14
CNWL – 0

1.16 The Provider Collaborative Board as so far been reluctant to implement the financial penalty process for closed beds and HPFT endorse this view.

1.17 It is currently forecast that there will be a small deficit across the Provider Collaborative that will be covered by Provider Collaborative accruals from prior year. The situation will continue to be monitored and reported back to the Executive Team.

non-Pay Costs

1.18 Non-Pay costs are in line with plan for the year to date, however, there has been an increase in the usage of FP10's and several one-off items within month 7 that have created a variance in month. The continued situation regarding FP10's will be monitored and explored with the teams.

Overhead Costs

1.19 Overhead costs are in line with plan before the utilisation of Trust reserves.

1.20 This reflects the application of reserves as part of the financial plan, additional, pro-active investments agreed in-year, (£1m up to month 7) and the release of £2,684k to month 7 to off-set unplanned overspending.

1.21 Year to date performance reflects CQUIN achievement at 80%, with a level of risk associated with the achievement of the national target for staff flu vaccinations.

2 Forecast Outturn

2.1 The forecast outturn position has deteriorated to £1.3m because of month 7 financial performance. This forecast is driven by the month 7 recurrent run-rate as summarised below:

M7 cumulative position (deficit before reserves)		**6,156**
M7 run-rate deficit (excluding NR items)	1,444	
extrapolate for 5 months		**7,219**
Gross FOT deficit before adjustments		**13,375**
Less: future items not in M7 run-rate		
Rates rebate	700	
IT revenue allocation	342	
HEE income	600	
Winter/capacity income	400	
NI savings on pay (income reduction already applied)	650	
		(2,692)
add: forecast cost increases in excess of M7 run-rate		
Increase in planned in-year investments (M8-M12)	215	
Non-recurrent funding for additional capacity (Elypsium beds)	510	
		725
Less: Reduction re. unequal phasing of £3.1m		**(95)**
Revised FoT		**11,313**

2.2 The table below summaries the forecast outturn position by category.

Financial Position to 31 Oct	Year to Date Plan £'000	Actual £'000	Variance £'000	Full Year Plan £'000	Forecast Outturn £'000	Variance £'000
Income incl. COVID-19	202,387	204,179	1,792	347,117	353,218	6,101
Pay	118,190	124,074	(5,884)	203,847	215,357	(11,510)
Secondary Commissioning	25,529	26,893	(1,364)	43,287	47,803	(4,516)
Provider Collaborative	25,171	24,622	549	42,319	42,319	(0)
Non Pay	14,115	14,239	(124)	24,111	24,243	(132)
Overheads & Reserves	19,382	20,508	(1,126)	33,553	34,809	(1,256)
Surplus / (Deficit)	**0**	**(6,157)**	**(6,157)**	**-**	**(11,313)**	**(11,313)**

2.3 This is a deterioration of the forecast outturn that reflects the worsening OOA placement bed position and the positive permanent recruitment and agency panel not yet leading to a reduction in agency use.

2.4 Appendix 1 sets out a schedule of in-year investments, of which a total of £2.167m has been reflected in the forecast outturn position above. Any reduction in these future investments would have a beneficial impact on the forecast outturn position.

2.5 The DV programme (risk-adjusted) forecasts full-year savings of £5.6m. This is included in the above projections and is considered further below.

3 Use of Trust reserves

3.1 The financial plan for 2022/23 was balanced by the application of £3.1m from Trust reserves. In addition to this, several investments have been made during the year, to be funded by the planned release of Trust reserves.

3.2 of £2.17m in respect of pro-active in-year investments, as set out below:

	M1 - M6 £'000	M7 £'000	M8 £'000	M9 £'000	M10 £'000	M11 £'000	M12 £'000	Total £'000
Mental Health Act posts		7	7	7	7	7	7	42
Initial Assessment agency staff	265	64	90	90	90	90	90	779
Autism Awareness training		33	33	33	33	33	33	198
R&D strategy expansion					32	32	32	96
Watford FC - Wellbeing/fitness		10		10			10	30
Medical Staff	102		20		20			142
Bank incentives	270							270
OOA beds relating to bed closure	193	63	64	63				383
Cyber Security Manager					7	7	7	21
Recruitment marketing				75				75
Additional interest income		-15	-15	-15	-15	-15	-15	-90
Director of Inclusion					13	13	12	38
Band 5 to 6 rebanding					2	2	2	6
Community teams change of base		8	8	9	8	8	9	50
Wage stream		2	2	2	2	2	2	12
Staff transfers		15	15	15	15	15	15	90
Bailey & Moore				25				25
Total	**830**	**187**	**224**	**314**	**214**	**194**	**204**	**2,167**
Cumulative	830	1,017	1,241	1,555	1,769	1,963	2,167	

4 Delivering Value

4.1 Cash releasing DV savings of £2.972m have been realised in the seven months to 31 October, with a forecast outturn (risk adjusted) of £5.6m for the full year. A scheme to reduce OOA placements through Q4 has now been removed following the further deterioration of the acute OOA bed numbers and an uptick in estimated additional interest revenue of circa £100k following the recent interest rate rises has been included. The remaining delivery is expected to be a continuation of existing schemes for the remainder of the financial year and is dependent upon the Trust's ability to manage demand for services over the winter period. Performance is monitored by the DV Management Group and reported to the Executive team monthly.

4.2 The following table summarises performance for the 7 months to 31 October 2022 and the forecast position for the full year.

	Full Year Plan	**Delivery YTD**	**Risk Adjusted FOT**
Schemes continued from 2021/22	**£'000's**	**£'000's**	**£'000's**
Connected Lives	900	440	454
Other (<£300k in value)	406		30
New schemes for 22/23			
Adult Acute Pathway review	2,500	239	239
Older Adult Delayed Discharge review	300	160	250
EROS+ Roll out	1,000	-	-
Herts income adjustment	500	250	500
Additional Interest income	600	472	1017
Inpatient Therapeutic input review	600	419	700
Overhead absorption	544	274	671
Agency reduction	450		50
Tier 4 Observations - additional income	300	41	76
Recruitment delays in new services	300	514	750
Other (<£300k in value)	1,800		863
Total	**10,500**	**2,972**	**5,600**

5 Transformation Schemes

5.1 The Financial plan for 2022/23 includes non-recurrent transformation funding of £13m from HWE ICB. The profile of plan and actual investment is summarised below:

Scheme name	Contracted new funding in 22/23	Prior year projects	Value already spent to M7	Forecast for remainder of 22/23	Total forecast 22/23 spend	Forecast under/ (over) spend
	£'000s	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Adult Community	4,694	2,930	2,705	4,112	6,817	807
Staff Wellbeing Hub*	711	344	368	348	716	339
Adult MH Crisis Liaison	208	0	0	0	0	208
Suicide Prevention	50	0	0	0	0	50
Perinatal Maternity MHS	65	0	0	0	0	65
MHSTs*	2,165	516	1026	1,304	2,330	351
Adult Mental Health Crisis	0	480	294	210	504	-24
Winter Pressures	0	891	319	91	410	481
Total	**7,893**	**5,161**	**4,712**	**6,065**	**10,777**	**2,277**
Total Funding Available		**13,054**			**10,777**	**2,277**

**These items are ringfenced funding for specific projects*

5.2 An underspend of £2.28m is forecast on transformation schemes. Whilst discussions continue with Commissioners, the optimal solution is to expedite spend and apply these monies in full during 2022/23. A proposal for the application of this forecast underspend has been accepted by the Executive team and plans will be implemented in Half 2.

6 Financial risks

6.1 The financial plan includes several key risks including the following:

- Increased demand for the Trust's services
- Inflationary pressures rising above levels funded
- Challenges in recruitment and retention
- Shortfall on DV savings
- CQUIN levels are not attained, particularly associated with the Flu programme
- Transformation monies remaining unspent at year-end

7 Mitigating actions

7.1 Mitigation actions include:

- Driving forward DV initiatives. All schemes of £100k or above are scrutinised monthly.
- Investment in vaccination programme for SU's and staff, to maximise CQUIN earned.

- Agency cost controls, currently being implemented will help to contain agency usage and costs.
- Further investment in recruitment and retention e.g., band 2 to 3s and band 5 to band 6's, over recruitment in inpatient areas, is also designed to reduce agency usage.
- A task and finish group are continuing to review inpatient establishments.
- All SBU's have been asked to submit financial recovery plans and rebalance any overspending budgets.
- Resets and applies robust financial control
- Seek to maximise additional income in-year

8 Balance Sheet

8.1 Main movements in month and year to date are:

- A significant reduction in available cash balances, reflective of the use of Trust reserves to support the current Trust position and the increase in receivables.

- An increase in Trust receivables in month and YTD because of the late receipt of the Hertfordshire block income. This was receipted on the 1st of November 2022. Future month invoicing will ensure that this cash is with HPFT in a timely fashion.

- An increase in deferred income in month reflects invoicing of Transformation income and its subsequent utilisation over the remaining months of the financial year.

- A decrease in Trust provisions where they have been utilised to support in year investments.

Statement of Financial Position	31 March 2022	Previous month 6	Movement in month 7	Current month 7	Movement YTD
	£000	£000	£000	£000	£000
Assets	279,290	266,912	7,649	274,537	(4,752)
Non Current Assets	**189,975**	**191,307**	**849**	**192,156**	**2,181**
Intangible Assets	514	417	(27)	391	(123)
Property Plant & Equipment	164,824	168,005	1,168	169,173	4,348
Tr & Oth Rec: Non-Nhs Rec	386	386	0	386	0
Right Of Use Assets	24,251	22,499	(292)	22,207	(2,045)
Current Assets	**89,314**	**75,605**	**6,800**	**82,381**	**(6,933)**
Inventories	60	60	0	60	0
Trade And Other Receivables NHS	2,874	8,979	1,480	10,459	7,584
Trade And Other Receivables Non NHS	12,156	9,466	25,940	35,405	23,249
Assets Held for Sale	2,582	2,582	0	2,582	0
Cash & Cash Equivalents GBS/NLF	71,499	54,211	(20,652)	33,536	(37,963)
Cash & Cash Equivalents Other	142	307	32	339	197
Liabilities	(107,997)	(95,620)	(7,649)	(103,245)	4,752
Current Liabilities	**(69,874)**	**(60,012)**	**(7,965)**	**(67,953)**	**1,921**
Trade & Other Payables Capital	(5,977)	(2,273)	(198)	(2,471)	3,506
Trade & Oth Payables Non-Capital	(53,949)	(50,208)	483	(53,841)	108
Borrowings	(541)	(540)	(19)	(559)	(18)
Provisions	(5,517)	(3,348)	30	(3,317)	2,200
Deferred Income	(3,890)	(3,644)	(8,261)	(7,765)	(3,875)
Non Current Liabilities	**(38,123)**	**(35,608)**	**316**	**(35,292)**	**2,831**
Borrowings	(29,408)	(26,914)	330	(26,584)	2,824
Provisions	(8,413)	(8,391)	(14)	(8,405)	8
Other Liabilities	(303)	(303)	0	(303)	0
Equity	(171,293)	(171,293)	0	(171,293)	0
Public Dividend Capital	**(95,612)**	**(95,612)**	**0**	**(95,612)**	**0**
Revaluation Reserve	**(30,889)**	**(30,889)**	**0**	**(30,889)**	**0**
Other Reserves	**489**	**489**	**0**	**489**	**0**
Income And Expenditure Reserve	**(45,281)**	**(45,281)**	**0**	**(45,281)**	**0**

9 Capital

9.1 The Trust has a delegated capital expenditure limit (CDEL) of £13.3m for 2022/23, as set out below. This is supplemented by the pproceeds from planned disposals of £3.3m to give a gross Capital Investment Programme of £16.6m.

9.2 More recently the following issues have been reflected in the forecast, reducing the gross Programme to £15.3m, as shown in the table below:

9.3 Planned development of a Female forensic unit at Bowlers Green is now likely to largely fall into 2023/24 reducing this year's forecast by just over £1.0m.

9.4 Planned disposal of Harper Lane is subject to planning permission being approved and is now expected to be completed in 2023/24, reducing disposals in 2022/23 by £1.2m.

CDEL	Plan	Forecast Outturn
System CDEL	10,948	10,948
National CDEL	2,347	2,347
Total CDEL	13,295	13,295
Disposals	3,294	2,053
Gross Spend	16,589	15,348

9.5 Generally, good progress has been made in implementing the overall programme, with expenditure to Month 7 of £7.9m; at just over 50% of the total planned expenditure this is slightly behind plan, however, spend in Month 7 was £1.7m versus an average of £1.0m per month for Months 1 to 6, indicating that monthly spend is increasing.

9.6 The forecast for the full year is an over-commitment of c. £700k against Plan, however this does include several prudent estimates which could, on return of tenders, prove to be a little lower. Because of this, and to provide some further mitigation in the event of any factors impacting scheme delivery in the latter months of the year, the Estates team is working up several proposals to be mobilised should this be possible/necessary. These works are being prioritised against several factors including those schemes which will have most impact on service users.

9.7 Overall, it is fully expected that the Trust will deploy all its CDEL by 31st March 2023.

10 Conclusion/Recommendations

10.1 The financial position for month 7 reflects a significant further deterioration in the Trust's financial performance. A forecast outturn deficit of £11.3m may be manageable in the context of Trust reserves. However, it would exhaust any capacity to mitigate further deterioration over the remaining months of the year.

10.2 The current monthly run-rate at £1.s4m deficit is not sustainable and must be addressed.

10.3 Several recovery/transformational schemes have yet to have an impact on the financial position, including net recruitment over the past 2 months of almost 100 additional substantive staff. These appointments have not yet realised a reduction in bank and agency staff costs.

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 15
Subject:	Quarter 2 (Month 6) People & OD Report	**For Publication:** Yes
Author:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Janet Lynch, Interim Executive Director, People and OD
Presented by:	Janet Lynch, Interim Executive Director, People and OD	

Purpose of the report:

To update on progress against the People and OD KPIs for Quarter 2 (Month 6 - September) of 2022/3.

Action required:

To receive the report.

Summary and recommendations to the Committee:

The attached report sets out the Trust's month six performance in relation to a range of key People and OD metrics that support our annual plan and has been discussed at the November PODG and November IGC.

The key headlines from Quarter 2 (Month 6) are as follows:

- Our staff in post figure has significantly increased following successful recruitment activity. However, increases in establishment in September have meant that vacancy rates remain similar to the end of Q1.
- Our unplanned turnover rate has slightly worsened, with nurse retention being of particular concern, leading to the establishment of a nursing recruitment and retention task and finish group.
- Our agency spend peaked in August and an agency panel has been put in place to reduce use of agency staff.
- Sickness absence rates decreased slightly, most notably with musculoskeletal and mental ill health related absence reducing, whilst Covid-19 absence started to wise at the end of Q2 and is anticipated to have peaked in October.
- Our mandatory training rates continue to have exceeded the Trust target for the first time in several years.
- Our appraisal rates have plateaued and therefore remain an area of focus, with a compliance push planned to coincide with the launch of our Appraisal App.
- Our apprenticeship levels remain healthy and are expected to grow further as workforce transformation projects will lead to the creation/expansion of new and innovative roles.

A number of key performance indicators are showing a positive improvement and the most recent data for October shows a continuation of this pattern. Recruitment and retention remains one of the most significant risks for the Trust and therefore the area of most focus.

The Board is asked to receive this report.

Relationship with the Business Plan & Assurance Framework:

Links to Strategic Objective 4: we will attract, retain and develop people with the right skills and

values to deliver consistently great care, support and treatment

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

Equality, diversity and inclusion plays a major role in our plans to recruit and retain staff and improve wellbeing and morale and there are a number of areas in the report which reference this. The November PODG focussed on belong and inclusion and examined in more detail some of the data contained in the report and plans to address issues raised.

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

N/A

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

PODG 1 November 2022 IGC 10 November 2022

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust People and OD Report
M6 - September 2022

as one

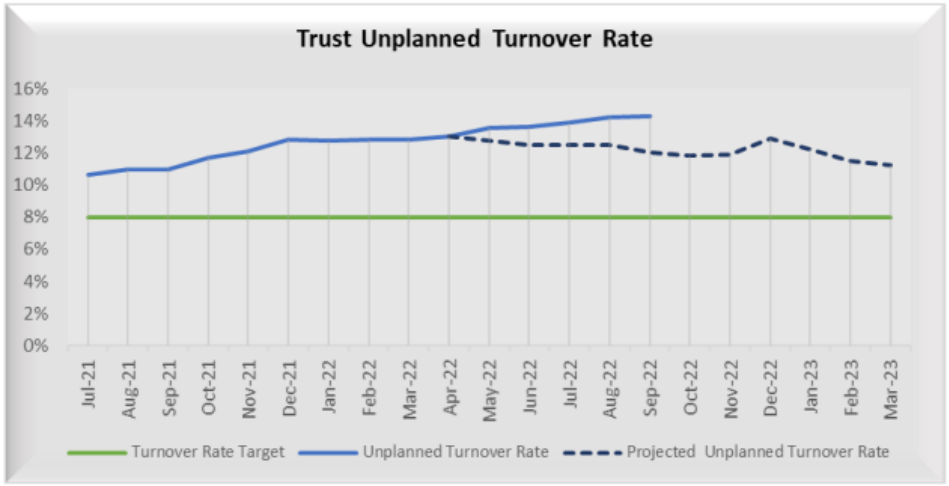
Our values
Welcoming Kind Positive Respectful Professional

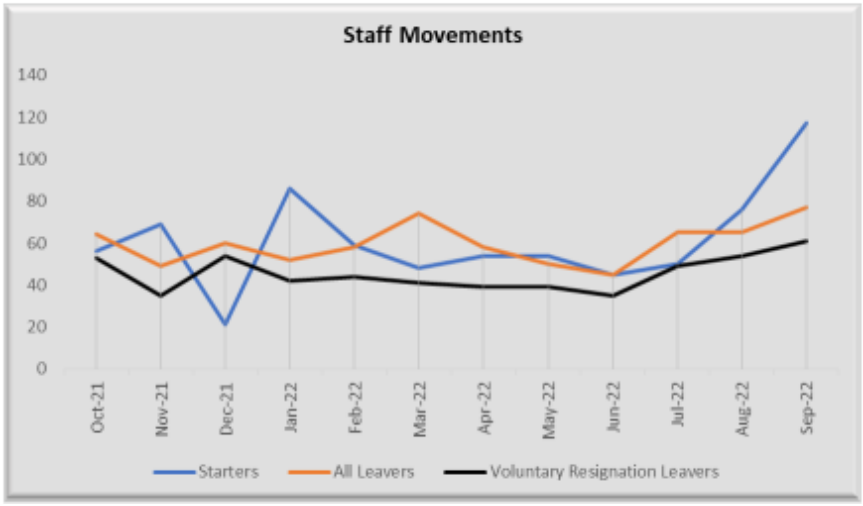
Contents

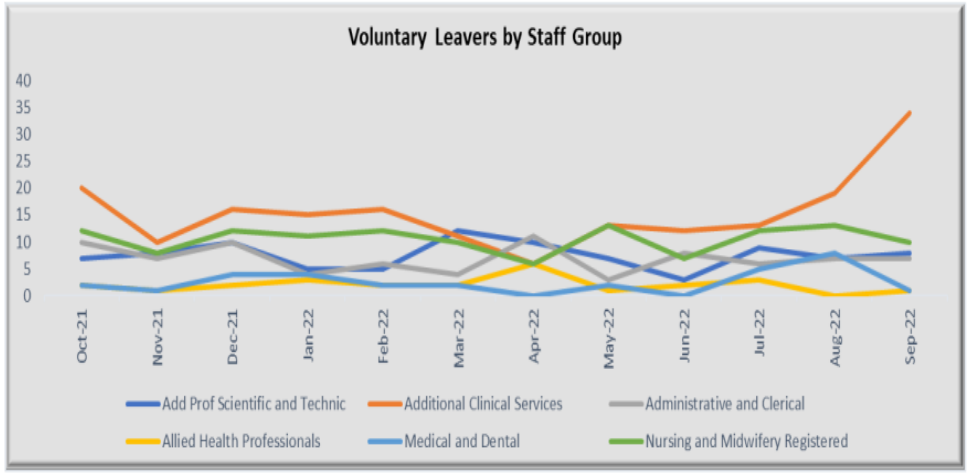
1. Overview

Metric	Previous Months											Current Month	Trend
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	
Staff in Post - Headcount	3695	3722	3703	3730	3747	3757	3744	3758	3763	3730	3774	3842	
Staff in post - FTE	3339.67	3365.63	3340.76	3363.01	3384.26	3396.34	3383.30	3386.26	3392.34	3387.33	3409.92	3462.08	
Budgeted Establishment FTE	3876.49	3894.69	3907.63	3943.42	3952.30	3955.74	3946.14	3945.14	3945.14	3941.89	3940.89	4029.56	
Vacant FTE	536.82	529.06	566.86	580.41	568.04	559.39	562.84	558.88	552.80	554.56	530.97	567.48	
Vacancy Rate	13.8%	13.6%	14.5%	14.7%	14.4%	14.1%	14.3%	14.2%	14.0%	14.1%	13.5%	14.1%	
Total Turnover Rate	20.2%	20.6%	21.0%	20.9%	20.9%	19.4%	19.8%	19.3%	18.2%	18.5%	18.6%	18.6%	
Unplanned Turnover Rate	11.7%	12.1%	12.8%	12.8%	12.8%	12.8%	13.0%	13.6%	13.6%	13.9%	14.2%	14.3%	
Starters Heacount	56	69	21	86	59	48	54	54	45	50	76	117	
Leavers Headcount	64	49	60	52	58	74	58	50	45	65	67	77	
Stability Rate	82.4%	82.8%	83.2%	82.0%	82.2%	83.7%	79.8%	82.4%	83.6%	82.9%	83.6%	83.3%	
Sickness Rate	5.2%	5.8%	6.0%	6.2%	5.3%	5.1%	4.9%	4.5%	4.7%	5.2%	4.7%	4.6%	
Training Compliance Rate	89.8%	89.4%	89.1%	88.8%	88.8%	88.7%	89.6%	90.4%	91.2%	91.2%	93.1%	92.3%	
Appraisal Rate	84.8%	82.6%	78.7%	75.6%	70.6%	72.3%	76.4%	83.2%	84.5%	85.3%	84.6%	83.8%	
Bank Spend	£2,056,040	£2,138,089	£2,022,177	£2,025,119	£1,991,660	£2,085,542	£2,142,297	£2,142,297	£2,009,843	£2,139,438	£2,192,616	£2,658,620	
Agency Spend	£841,510	£845,438	£957,992	£934,878	£810,429	£1,277,588	£1,027,222	£1,027,222	£1,139,239	£1,303,088	£1,246,626	£1,260,585	

2. Retention







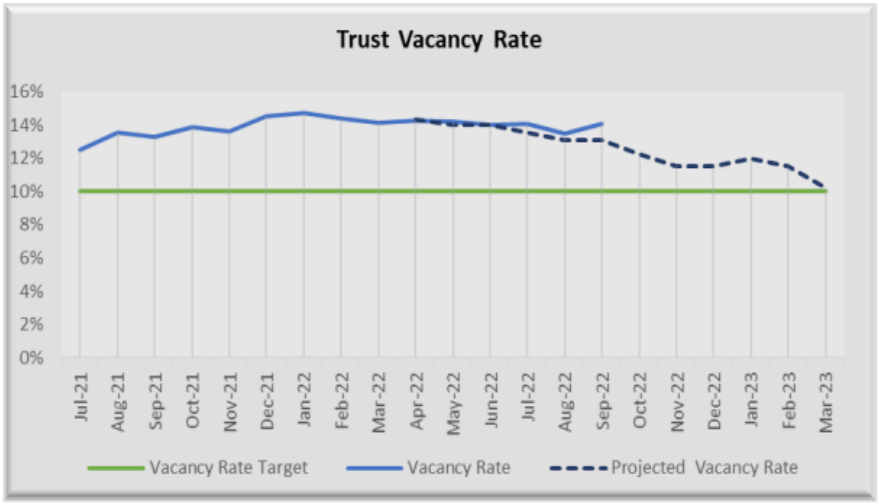
Our unplanned turnover increased slightly from 14.2% in August to 14.3% in September, significantly above the target of 9% and 0.7% higher than the end of Q1. In June and July 5 more staff left than started and in addition we saw the usual turnover caused by a high number of staff in the Additional Clinical Services group leaving to enter full time higher education courses that start at this time of year. However, recruitment efforts led to a significant number of new staff joining (117) compared to those leaving (77) in September, meaning an overall increase in staff in post of 69.74 FTE at the end of Q2 compared to the end of Q1.

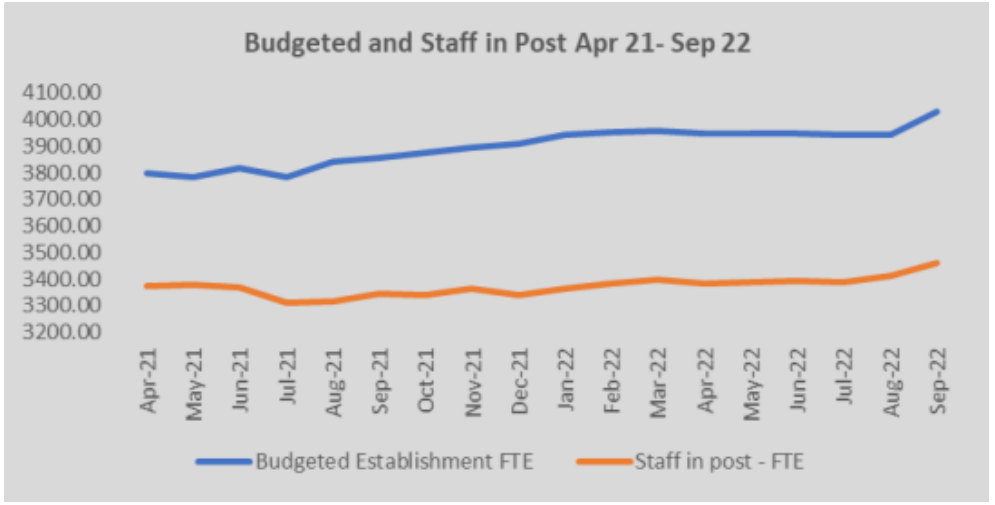
2. Retention

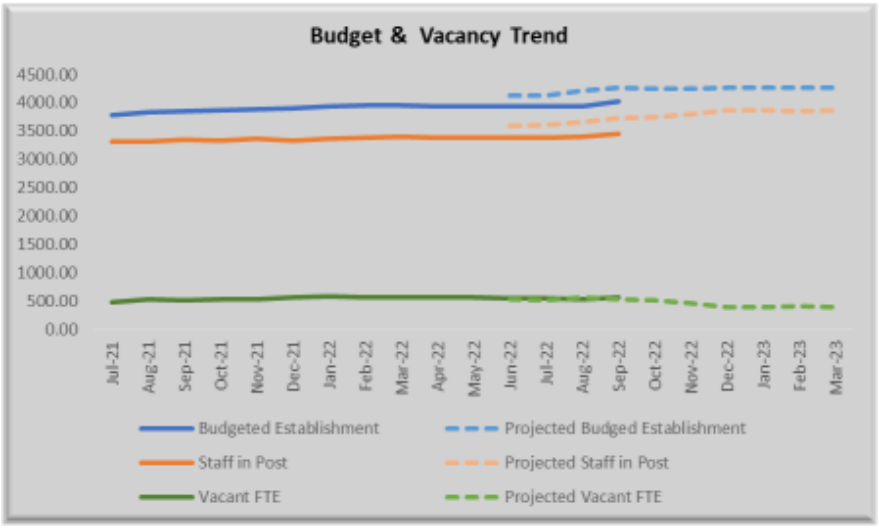
The key actions being taken to address retention are designed to address the top five reasons that people leave us and are as follows:

- Continued wellbeing support for staff including Wellbeing Festivals
- Introduction of medical RRP
- Engagement with staff to act on feedback and improve experience, including our Big Listen and Local Listen events in October and November, Black History Month engagement, staff survey and 'you said, together we did', engagement to co-produce our inclusion and belonging strategy.
- Implementation of team based rostering across the Trust
- Enhancing our talent management and career development offer, with a specific focus on inclusion and diversity and increasing use of apprenticeships, particular for unregistered nursing roles and routes into nursing.
- Developing our existing Band 2 HCSW staff into Band 3 roles.
- Refreshing our benefits offer, in particular responding to cost of living pressures, including Wagestream implementation
- Undertaking a review of recruitment and retention premia
- Developing legacy nurse support to new staff
- Established a nursing recruitment and retention task and finish group to focus on registered and unregistered nursing staff, focussing on recruitment and attraction of nurses and retention of nurses, in particular career development, flexibility and work-life balance, and our welcome, onboarding and pastoral support or nursing staff.
- Holiday of a Lifetime scheme and buying/selling annual leave introduction

3. Recruitment



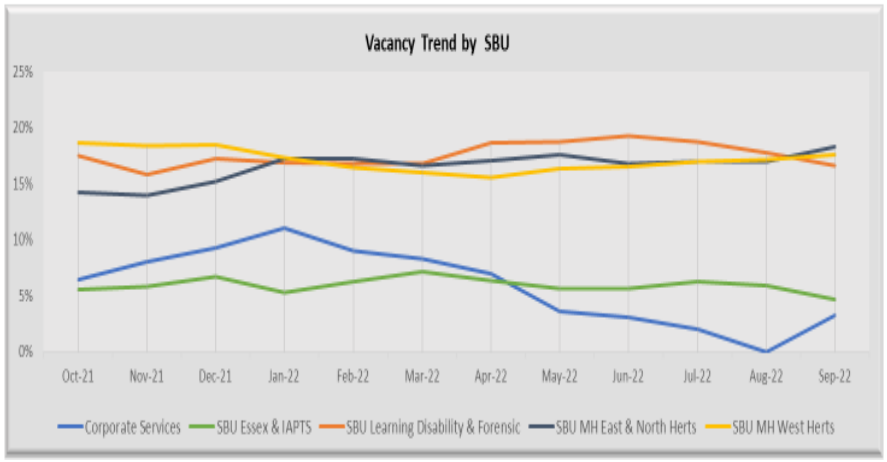


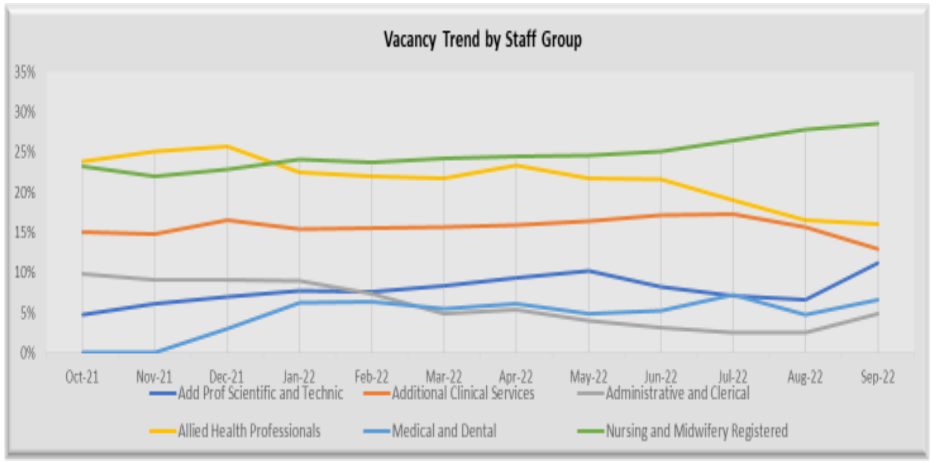


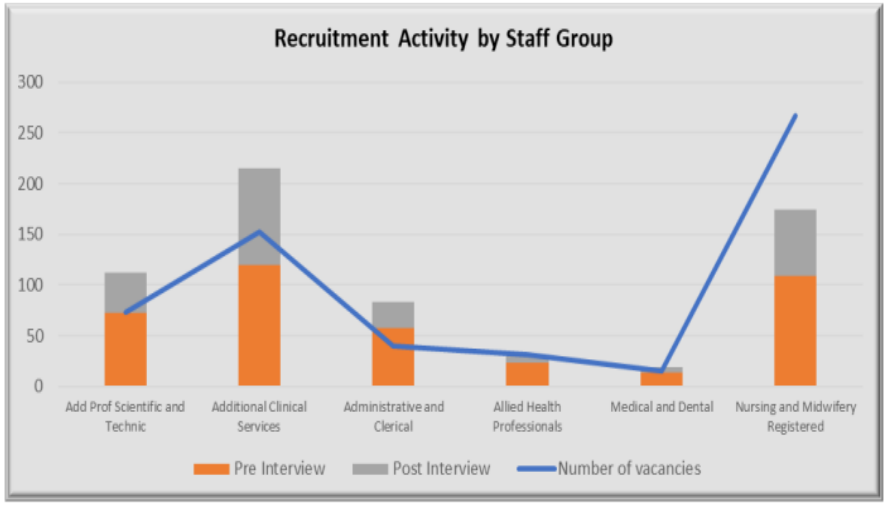
The overall vacancy rate has increased from 13.5% in August to 14.1% in September (567.48 FTE vacancies), which is the same as at the end of Q1. However, this is as a result of new budgets being uploaded, meaning that our budgeted establishment is now 4029.56 FTE (an increase of 84.82 FTE). Our number of staff in post has significantly increased by 69.74 FTE since Q1, as our recruitment activity is increasingly successful.

We have established a vacancy and recruitment pipeline oversight and scrutiny group. In particular, the group has communicated out the message to over-recruit, is ensuring that all vacancies are proactively advertised, has agreed assistance to managers so that there is automatic shortlisting of all B2 HCSW and all B5 and 6 nurse posts, is ensuring that weekly pipeline and vacancy review meetings with Service Line Leads, Heads of Nursing and Recruitment Partners take place to scrutinise each vacancy and recruitment episode within SBUs, focussing on increasing recruitment pace. Our overall pipeline remains healthy and is predicted to reduce vacancy rates during Q3.

3. Recruitment



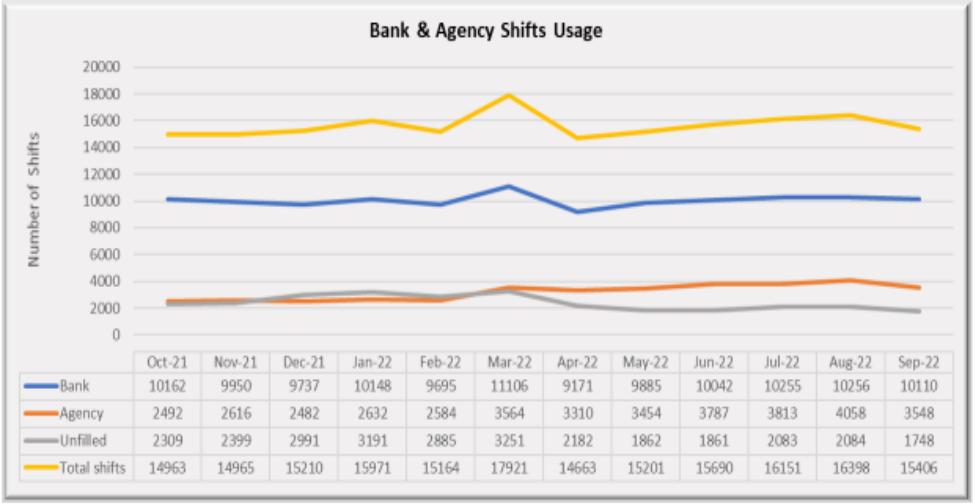




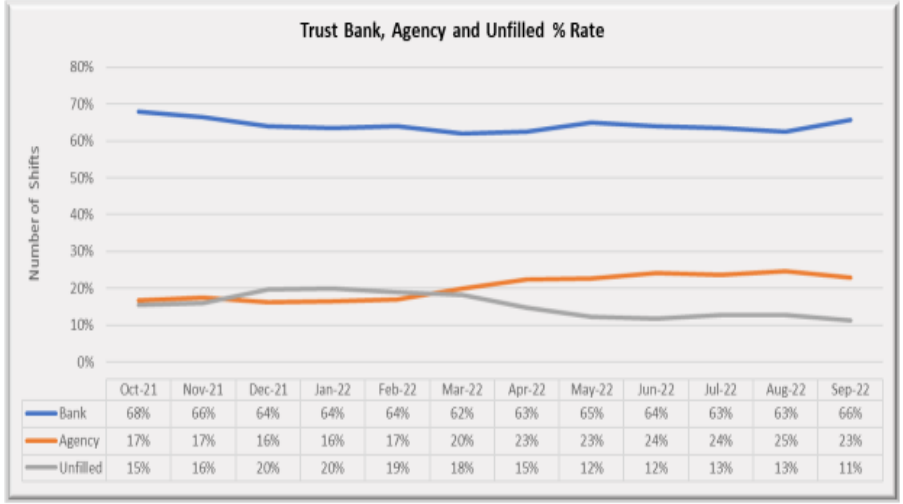
Our registered nurse vacancy rate remains a key focal point, with rates increasing from 25% at the end of Q1 (233.7 FTE) to 28.6% at the end of Q2 (267.4 FTE) as a result of continuing high turnover (16.9%). HCSW turnover has reduced to 11.8% and the vacancy rate continues to reduce significantly, from 19.2% at the end of Q1 (123.8 FTE) to 13.22% at the end of Q2 (84.10 FTE) due to significant investment in recruitment and retention funded through HEE monies. Our AHP vacancy rate reduced again from 21.6% (41.1 FTE) in Q1 to 16.1% (30.9 WTE). The key actions in place to address recruitment are as follows:

- Working with TMP Wordwide to support marketing and attraction, overhaul social media presence, landing pages, adverts, campaigns, internet search optimisation and advertising intelligence
- Reviewing the attraction and retention offer for Bank staff
- Reviewing our recruitment and retention payments
- Onboarding this year's cohort of newly qualified nurses
- Enhancing and streamlining our onboarding, including digitisation of people processes and reviewing our policies for new starter annual leave and salaries
- Further embedding the Inclusion Ambassador scheme
- Further establishing international recruitment pathways into HPFT
- Expanding our apprenticeship offer as a route into HPFT, including converting all new Band 2 HCSW posts to apprenticeships
- Implementing the Recruitment Partner model
- Providing enhanced administration support to recruiting managers to speed up shortlisting and setting up interview dates and ensuring that all vacancies are proactively advertised, particularly nursing vacancies
- Establishing our vacancy and pipeline oversight and scrutiny meeting fortnightly to increase pace and creativity in recruitment and ensure all vacancies are proactively recruited to.
- Aiming to over-recruit to all frontline posts

4. Temporary Staffing



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Bank	10162	9950	9737	10148	9695	11106	9171	9885	10042	10255	10256	10110
Agency	2492	2616	2482	2632	2584	3564	3310	3454	3787	3813	4058	3548
Unfilled	2309	2399	2991	3191	2885	3251	2182	1862	1861	2083	2084	1748
Total shifts	14963	14965	15210	15971	15164	17921	14663	15201	15690	16151	16398	15406

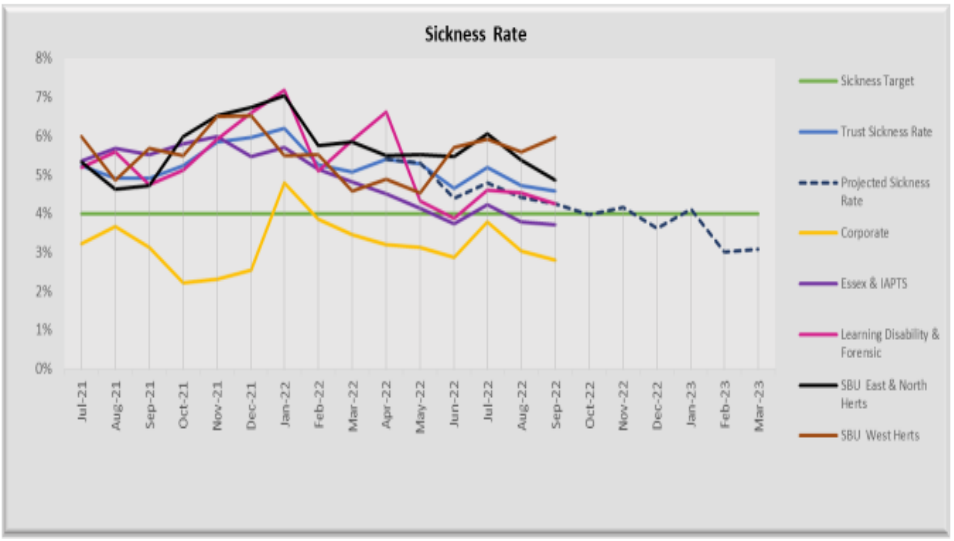


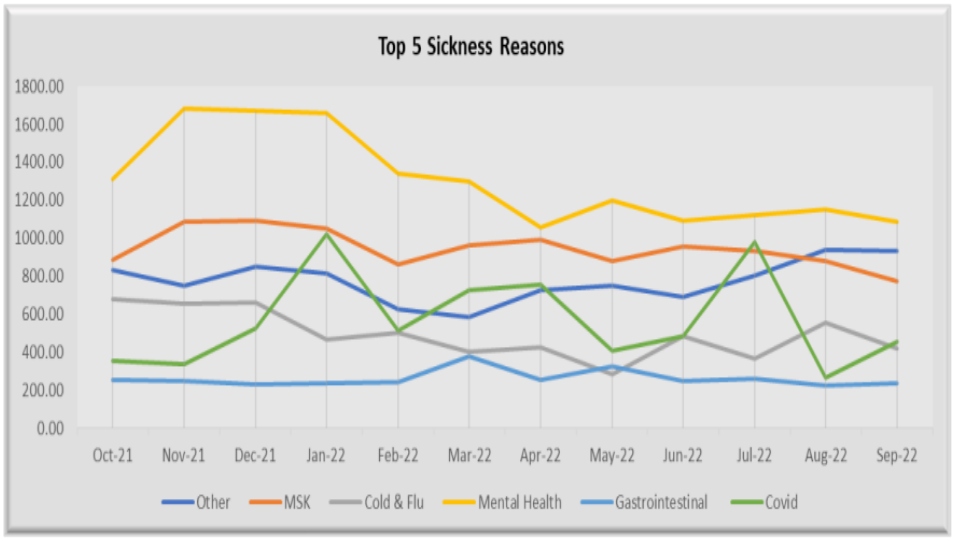
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Bank	68%	66%	64%	64%	64%	62%	63%	65%	64%	63%	63%	66%
Agency	17%	17%	16%	16%	17%	20%	23%	23%	24%	24%	25%	23%
Unfilled	15%	16%	20%	20%	19%	18%	15%	12%	12%	13%	13%	11%

Demand for temporary staffing has remained high this quarter, but peaked in August, as is often seen during holiday periods. The percentage of temporary staffing shifts filled with Bank staff has remained lower than historically, but has increased post-Summer holiday period, which has meant a slight decline in agency use, albeit that over Q2 it remained higher than in 2021/22. In order to expand our Bank pool and better recruit and retain our temporary workforce and ensure safe staffing levels, a number of actions are being taken forward:

- Proactive Bank recruitment campaigns, including converting agency staff to Bank and amending the starting salary guidance as it relates to agency staff
- Reviewing our Bank recruitment and retention plans, including our pay rates, for example, the payment of Fringe Allowance, incremental progression, incentive bonus payments and weekly pay
- As part of Winter planning, exploring reinstating the Bank bonus payment to inpatient services, 'pay to grade' arrangement for substantive staff undertaking Bank shifts and over-booking of Bank staff to create roaming temporary staffing teams to be deployed as required across our larger sites
- Exploring support from NHS Professionals for our Norfolk inpatient services to increase local Bank supply
- Establishment of an agency panel to scrutinise use of agency, reduce this and convert agency staff to substantive/Bank

5. Health and Wellbeing

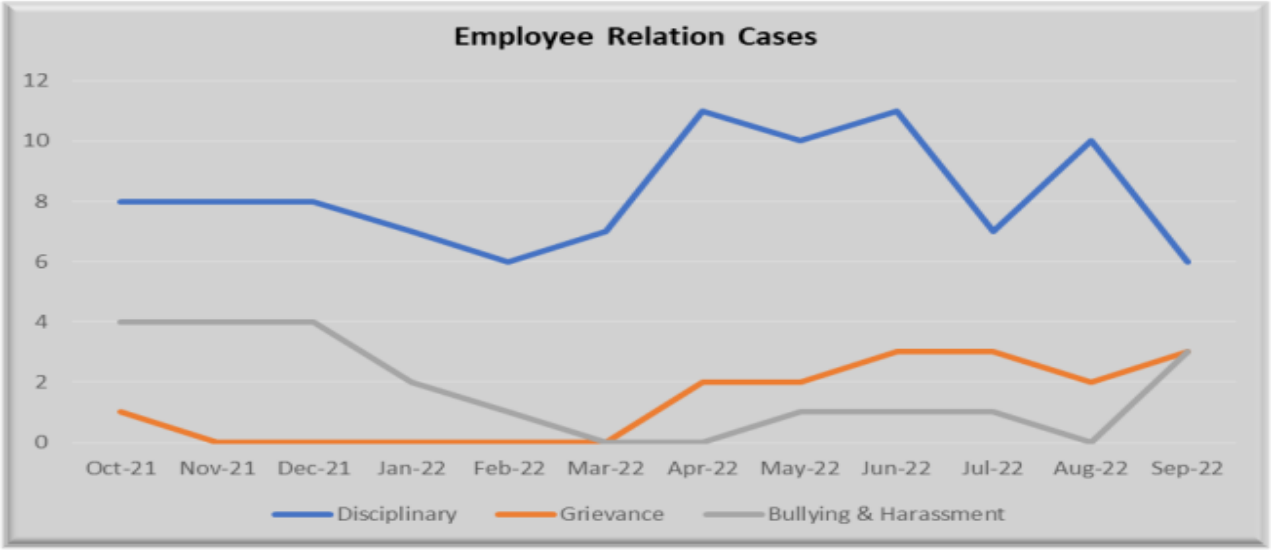




Sickness absence reduced from 4.7% at the end of Q1 to 4.6% at the end of Q2. Three key reasons for absence reduced at the end of Q2: mental ill health related absence; absence for musculoskeletal issues; and colds/flu related absence. However, we saw Covid-19 related absence start to increase and we are aware that during October this increase peaked. Whilst absence levels have broadly followed the absence predictions we set at the start of the year, absence rates had been slightly higher than predicted due to the continuing impact of Covid-19 absence, which is anticipated to continue to push us off target in terms of the absence rate projections we made at the start of the year. The key actions being taken forward to address staff wellbeing are as follows:

- Continuing our regular health and wellbeing offer to staff and adapting this in line with feedback and engagement with staff to ensure it remains relevant and supportive
- Pursuing accreditation as a menopause friendly organisation and the actions to help us achieve this
- Expanding our pool of health and wellbeing champions and mental health first aiders
- Offering on-site mini health checks and using the themes arising from these to adapt our wellbeing offer to staff
- Repeating our wellbeing festivals, aligned to the issues staff are currently facing
- Expanding our financial wellbeing and support offer to staff

6. Employee Relations

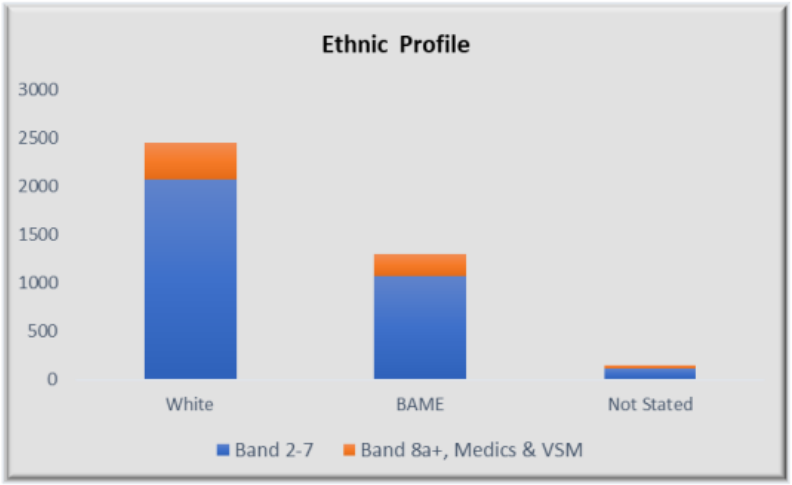


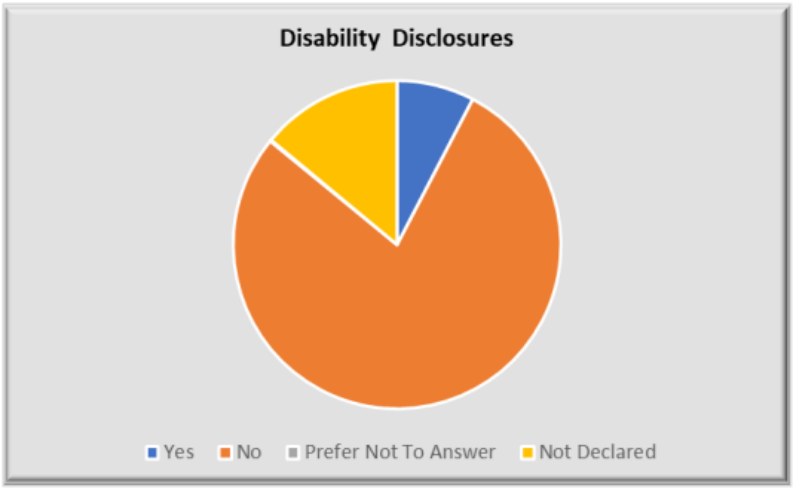
Our formal ER case numbers remain small. Our disciplinary cases reduced to 6 at the end of Q2, compared to 11 at the end of Q1. The number of grievances and harassment and bullying cases have slightly increased at the end of Q2 (6) compared to Q1 (4).

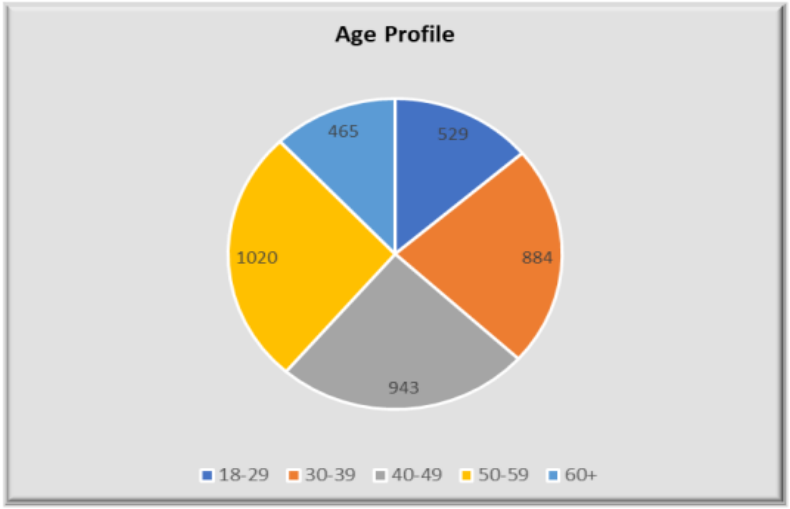
Our decision-making panel continues to consider fact finding cases in order to sift cases for formal disciplinary proceedings. Analysis of our themes and learning from cases has taken place highlighting the need for action to be taken to make improvements in the areas of disability discrimination and reasonable adjustments and inappropriate behaviour, particular amongst the unregistered nursing workforce in relation to conduct towards service users and boundary issues. A bid for funding to HEE has recently been successful in enabling us to start taking this work forward.

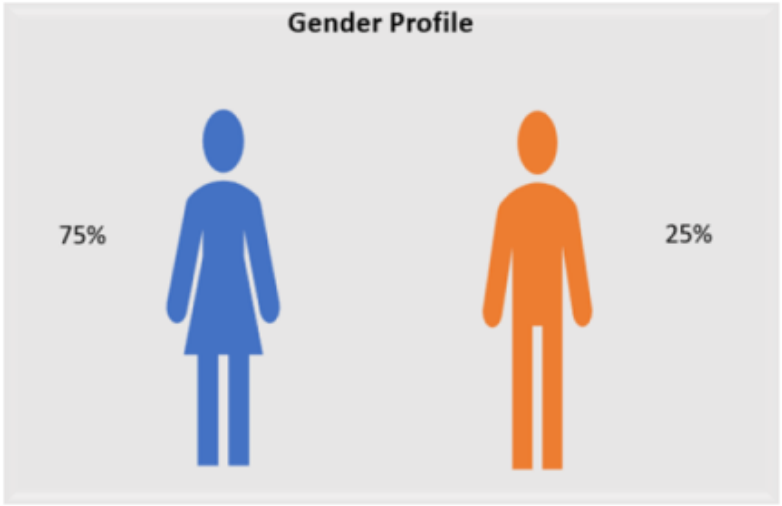
New policies have been developed in the areas of Sickness Absence, Reasonable Adjustments and Grievance which will support improvements and are due for ratification by the JCNC in November. Additional work has been undertaken to review the over-representation of BAME staff entering the formal disciplinary process, with support from the BAME staff networks and staff side colleagues, and a set of initial actions identified to address this.

7. Equality and Inclusion

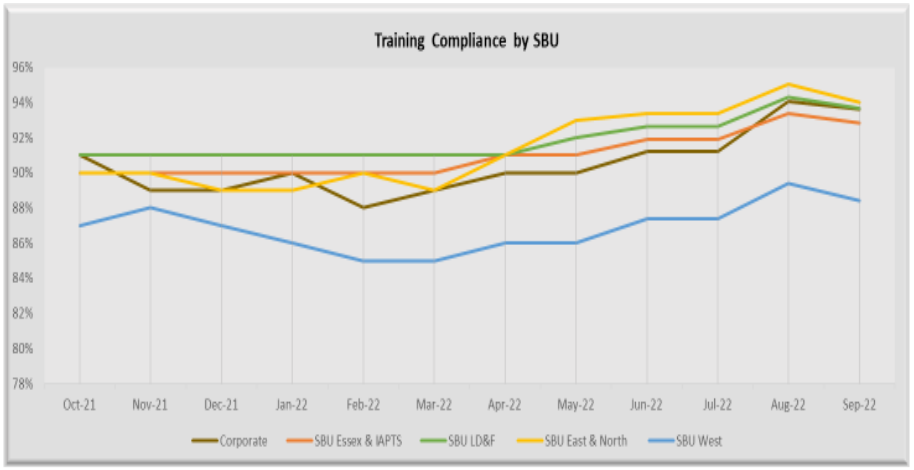








8. Staff Development

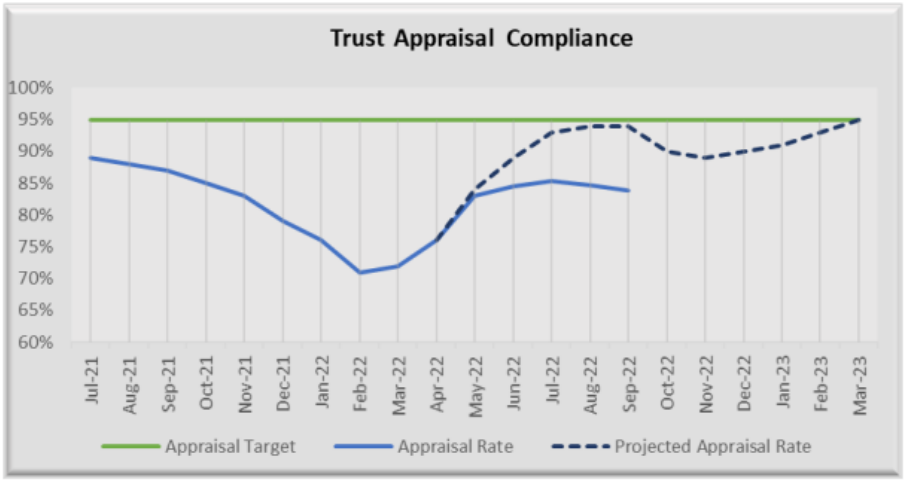


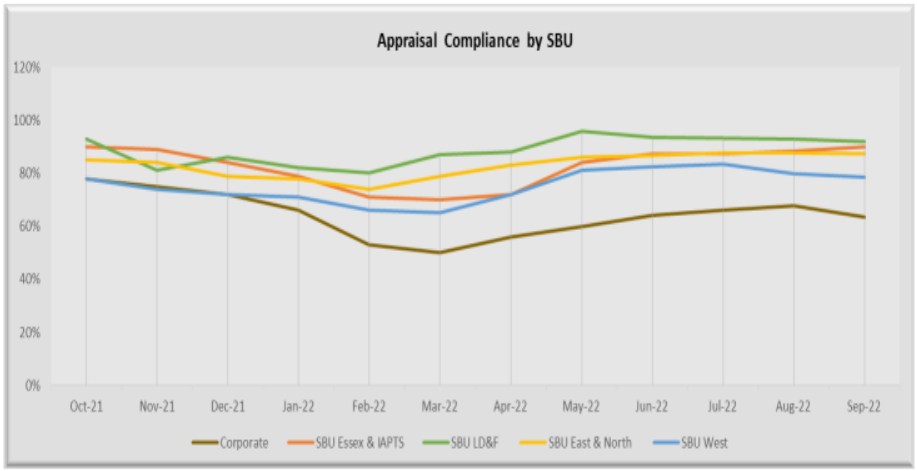
Mandatory training compliance has now exceeded our target of 92%, having increased from 91.2% at the end of Q1 to 92.3% at the end of Q2, with significant improvements in all SBUs, albeit that particular focus remains on supporting West SBU to achieve target compliance.

The actions being taken to maintain and continue to drive up compliance include:

- Weekly compliance reporting via HR Business Partners and the L&D team
- Monthly reporting to the Executive Team and People and OD Group
- Weekly reporting of face to face courses with available spaces together with details of staff who require the training.
- Increased training capacity for 22/23, including more trainers, weekend training, use of external training companies and external training venues
- Review of Respect training model to ensure fitness for purpose
- Reviewing our learning management system and integration with eRoster
- Reviewing our approach to onboarding new staff to ensure new staff can access training more quickly

8. Staff Development – Appraisals





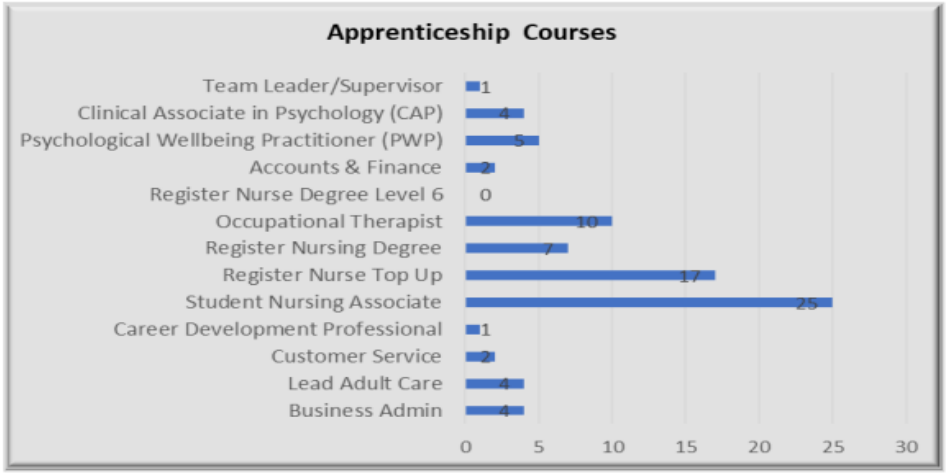
Appraisal compliance has plateaued at around 84 - 85%, reducing slightly in both August and September. Whilst this may reflect the impact of the Summer holiday period, compliance is significantly lower than our target rate of 95% and our predicted recovery trajectory. Compliance within Corporate Services and West SBU is a particular focus.

Actions to address recovery include:

- Monthly reporting to the Executive Team and People and OD Group
- Scrutiny at the Safe and Effective Care fortnightly meetings
- Launch of the new Appraisal App
- A further push on achieving compliance to coincide with the App launch and enhanced weekly reporting

9. New Role/Apprenticeships

Levy Pot	
Current Funds	£1,574,407
Funds spent since Oct 21	£555,676
Estimated spend for the next 12 months	£481,094
Funds Expiring in Dec 22	£13,062



We currently have 82 apprentices and we continue to expand our apprenticeship offer. In addition, we also have 19 qualified Professional Nurse Associates, which will increase to 25 by December. We also have two Mental Health and Wellbeing Practitioners (MHWPs) currently half way through their 12-month training and 13 more have just started their training with us. All Band 2 HCSWs who commenced with us over the last 6 months have been offered an apprenticeship and all our adverts will now offer an apprenticeship.

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

9. Conclusion

The key headlines from Month 6/Q2 are as follows:

- Our staff in post figure has significantly increased as a result of heightened, successful recruitment activity. However, increases in establishment in September have meant that vacancy rates remain similar to the end of Q1.
- Our unplanned turnover rate has slightly worsened, with nurse retention being of particular concern, leading to the establishment of a nursing recruitment and retention task and finish group.
- Our agency spend peaked in August and an agency panel has been put in place to reduce use of agency staff.
- Sickness absence rates decreased slightly, most notably with musculoskeletal and mental ill health related absence reducing, whilst Covid-19 absence started to wise at the end of Q2 and is anticipated to have peaked in October.
- Our mandatory training rates continue to have exceeded the Trust target for the first time in several years.
- Our appraisal rates have plateaued and therefore remain an area of focus, with a compliance push planned to coincide with the launch of our Appraisal App.
- Our apprenticeship levels remain healthy and are expected to grow further as workforce transformation projects will lead to the creation/expansion of new and innovative roles.

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

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PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 16
Subject:	Winter planning and UEC Preparedness	**For Publication:** yes
Author:	Fiona McMillan Shields, Managing Director	**Approved by:** Sandra Brookes Deputy CEO and Chief Operating Officer
Presented by:	Sandra Brookes, Deputy CEO and Chief Operating Officer	

Purpose of the report:

To update the Board on winter planning activity and priorities.

Action required:

To receive the report.

Summary and recommendations to the Board:

This report provides an update on the Trust and system winter activity and programmes of work aiming to address capacity, demand and flow through Trust services.

The Trust is working in alignment with the Herts and West Essex ICB level and place-based Surge, Escalation and Capacity plans and the NHSE National and Regional Operational Pressure Escalation Level (OPEL) framework.

Within the Trust, the adult acute pathway continues to face challenges with unprecedented numbers of people waiting for beds in spite of the high numbers of out of area bed usage.
The Trust has now been operating a new surge and escalation framework, with oversight meetings 7 days a week, since mid-September to better manage and monitor the Trust bed capacity, demand and flow. This has improved the visibility for all senior managers and the Executive team of the capacity within the inpatient pathways and bed management allowing real time insight into OPEL status and bed state, length of stay, AMPH availability, numbers wating in the community, places of safety or other hospitals for beds and overall demand much more widely than previously available and has enabled senior operational leads to focus on improvement actions. This will also support our attendance at the System Control Centres which will be in place from 1st December.
Trust winter oversight meetings are now in place every 2 weeks with scheme-specific oversight strengthened and the Trust is working with partners and providers both at Place and ICB level to work on schemes that will provide alternatives to admission, increase discharge options and improve service user experience.

MH A&E / MH Hub at ED models are being explored to ease ED pressures, improve service user flow, and experience.

Winter planning is also in place to respond to further surges in demand for all Trust services and in the event of industrial action. Business continuity plans for all services are being refreshed.

as one

Our Values
Welcoming Kind Positive Respectful Professional

In light of the industrial action planned for winter, all business units and corporate services have re-established weekly operational command structures; tactical command continues to meet weekly to oversee the continuing impact of Covid-19. The Trust incident command rota is populated until January and could be stood up as required once dates for industrial action are published.

A weekly meeting is held to work on improving the acute mental health pathway with partners across the ICB and reports to the ICB Urgent and Emergency Care Board.

The Board is asked to:
Receive this report; and provide feedback on the actions being taken to strengthen the Trust's winter resilience

Relationship with the Business Plan & Assurance Framework:

Links to Strategic Objective 1: We will provide safe services so that people feel safe and are protected from avoidable harm.

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

Executive – 9th November 2022

Winter Plan Update

1. System governance for winter includes Place and ICB level oversight meetings and Gold calls are stood up as required. Trust representation is as follows.

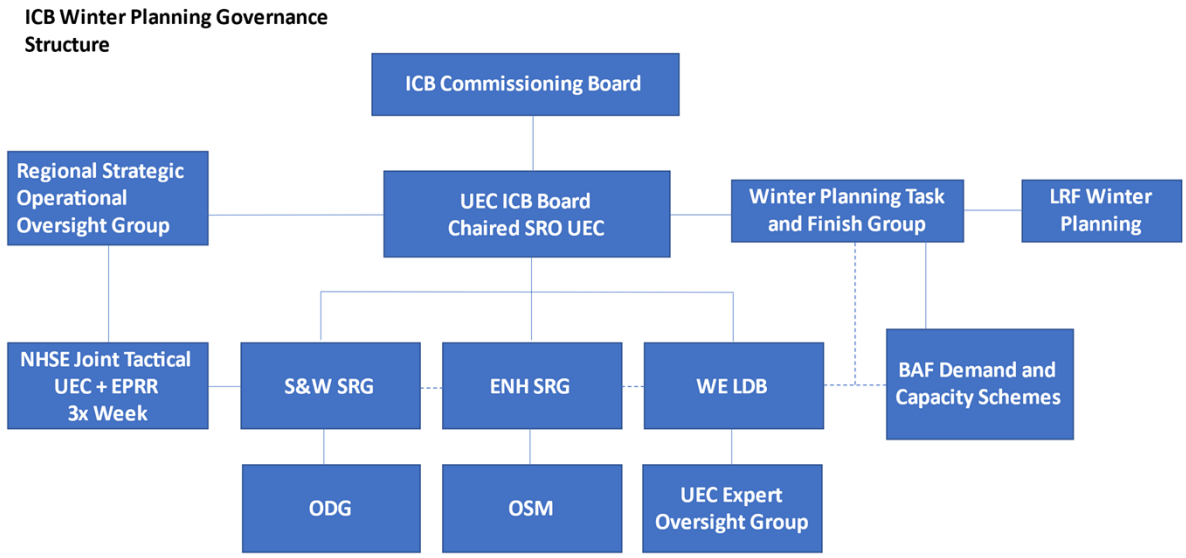

Figure 1 HWE System governance for winter

2. There are plans at ICB level to introduce a new system escalation framework and stand up daily System Control Centres in line with National guidance with an approach that will work for winter and beyond if mutual aid is required from a place or a provider, or if Place or system is OPEL 4.

3. The Trust has been operating in OPEL 4 for a number of months which is triggered amongst other things by extreme bed pressures.

4. In September 2022 the Trust established a new surge and escalation framework to oversee and manage the issues of capacity and flow that are triggering OPEL 4. There are now meetings 7 days a week to better manage and monitor the Trust's bed capacity, demand and flow. This is updated 3 times a day in the week and kept updated at weekends. All Executive and senior manager colleagues can access this through SharePoint. It provides a snapshot into the capacity within the inpatient pathways and gives real time insight into OPEL status and bed state, length of stay, AMPH availability, numbers wating in the community, places of safety or other hospitals for beds and overall demand much more widely than previously available

5. The Trust received notification of the outcome of the system winter funding schemes available and now confirm we have been funded £96k for enhanced Approved Mental Health Practitioner (AMHP) capacity and a £32k for enablement schemes which worked well last year.

6. To oversee the existing Trust winter plans, and further develop clinical/pathway change opportunities, the Trust has now instigated winter oversight bi-weekly governance meetings that report through the Trust Management Group (TMG). This has included mobilising additional EPRR capacity and resource to support the delivery of the winter plan.

   This group is mobilising resource to take forward/further scope activity arising from the 'Super September' initiatives to address delayed transfers of care, trust wide recruitment, and scoping new models to oversee out of area service users. The group has also requested that CPAC provides clarity for operational services on the use of RAG rating going into winter.

   An overview of the winter programme activity is summarised in the table below:

Identified pressure	**Funded Plan/programme to address identified pressure**
AMHP Support including Emergency Department (ED)	Designated all-age AMHP support to speed up MHA Assessments and enhance ED front door (HPFT & HCC). Following partial implementation of this scheme last winter (2-3 days per week), work is already underway to ensure that AMHP cover can be enhanced including ED to ensure timely access to assessment. Funding will be used to enhance administration and oversight and improve the rate of pay / enhancements for hard to fill shifts.
Enablement at Home	Resource to block book framework providers to guarantee outreach enablement support in the community enabling service users (adult & older adults) to stay at home. This was also successfully implemented in Winter 21/22 with 41 service users supported to remain in their homes.
Bed capacity	£600k agreed to support further block-booking of independent sector beds
Identified pressure	**Plan/programme to address identified pressure**
Improving flow and discharge	Long Stay Wednesday – super stranded reviews, planning and escalation around DToCs within older people's wards Review of 60+ day LoS patients in adult acute pathway Introducing an Integrated Discharge Team model for the adult acute pathway Introducing a discharge lounge area for Kingfisher court Exploration of working with alternative providers to increase discharge

	options.
Time to Recruit	Support resilience through winter by ensuring timeline in recruitment pipeline is optimised through new capacity in people team
Improving experience within acute Trusts for MH patients	Ensuring timeliness of mental health act assessments Scoping a new model for a 4-bed acute assessment unit for mental health pathway within ENHHT Scoping an ED alternative pathway / hot clinic or same day emergency care model
Virtual Hospital	Scoping the actions required to ensure effective oversight and review of any OOA service user and those waiting for beds
MH - 24/7 crisis alternative	Crisis House proposal under development Working in partnership with commissioners and the Voluntary Sector to better understand those using crisis hubs to help to avoid admissions via a daily hub. Reinvigorate host family provision & attract more host families

7. **UEC capital planning for 23/24 and 24/25 and Amanda Pritchard Letter: 'Going further on our winter resilience plans'.**
   Two main strands of work are in planning with system partners.
   - Working with the acute trusts – planning is underway to scope the viability of an Acute Admissions Unit for mental health patients – this is in response to the numbers of mental health patients stranded in Emergency Departments whilst waiting for a specialist mental health bed or further assessment. The acute trusts have been awarded funding to improve their ED environments and the Trust will be working with the Lister Hospital team to scope whether an area of the acute admissions unit can be utilised for mental health service users who require a longer period of assessment or whom have been assessed as requiring a specialist bed. We are also supporting the trusts to use their allocate capital to improve the environment for people with mental health and or learning disabilities within the ED.

   - Working with the ambulance trust on mental health triage of ambulance stack and other activities such as deploying mental health expertise into the control room.

8. **Business continuity and Incident command**
   All business units and corporate teams have been requested to review and refresh their service level business continuity plans by the 25th November. Any pathway or threshold changes resulting from business continuity planning will need to be recommended and considered by CPAC for quality and safety impact assessments prior to any changes being recommended for Executive approval.

   The Trust is also reviewing which services and teams fit into the critical / acute Tiers set out in our EPRR policy, as these are likely to be exempt from industrial action. In November, as

well as planning for industrial actions the Trust will be undertaking two EPRR exercises to test fire evacuation preparedness and planning for electronic patient record outage. Currently incident command is managed through a weekly Tactical oversight meeting to keep track of the impact of Covid-19. The incident control administration remains in place 7 days a week and shadow rota remain in place planned until January in order to stand up fully if required.

It is proposed that the operational command meetings are reinstated minimally weekly from the week commencing 7th November in order to prepare for industrial action and escalation of winter pressures.

9. UEC

The UEC is monitoring performance across the ICB in relation to urgent and emergency care and is pulling together its plans to develop the required "Surge and Escalation Coordination Framework". This will be the framework to establish the system control centre and escalation processes. The UEC has been stood up to meeting fortnightly due to the current pressures across the system and National expectations regarding surge and escalation.

Summary

The Trust winter plan is being mobilised and links in with the overarching ICB winter plan. A key focus is on the implementation of a new surge and escalation process and working with system partners to provide alternatives to ED presentation, whilst improving environments in ED and diverting away from ED where possible.

High levels of demand into acute mental health services will mean that the plan will need to be dynamic in order to respond to the challenges this poses.

Alongside actions in term of responding to demand the plan covers Covid and Flu planning and business continuity planning in light of potential industrial action.

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PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 18
Subject:	Trust Risk Register October 2022	**For Publication:** Yes
Author:	Nick Egginton, Compliance and Risk Manager	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

To update the Board on the risks on the Trust Risk Register.

Action required:

To receive the Trust Risk Register for discussion of the risks, their scores, ordering and mitigation.
To approve the risks.

Summary and recommendations:

Summary

The Trust currently has seven risks on the Trust Risk Register (TRR). The TRR was considered at the Integrated Governance Committee's meeting held on 10 November 2022. There have been no changes to the risk scores since the last review at the Integrated Governance Committee on 22 July 2022.

Integrated Governance Committee members supported the proposed TRR noting its close links with the Board Assurance Framework.

The Board are asked to review and approve the risks as outlined in the TRR.

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

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

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

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

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

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

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

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

Regulation 17: Good Governance

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

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

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

IGC 10 November 2022

Trust Risk Register Executive Summary, November 2022

1. Introduction

1.1 The purpose of this Executive Summary is to present an overview of the recent updates to the Trust Risk Register (TRR), for discussion. 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.

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

1.3 The Committee is asked to consider the recommendation from the Executive Team that:

- The risks and whether they reflect the current risks for the Trust
- The risk scoring and whether they are appropriate
- Whether the mitigation and actions are robust enough, offering constructive challenge to the team to ensure the risks are managed and mitigated.

2. Summary

2.1. The Trust currently has seven risks on the TRR.

2.2. The Committee is asked to review and approve the risks as outlined in the TRR, in line with the recommendation from the Executive Team.

3. Risk Updates

3.1 People

- Staff in post figures have increased significantly, although increases to establishments in September mean that vacancy rates have remained high. A Vacancy Oversight Group is in place and actions taken have included ensuring that all vacancies are proactively advertised, automatic shortlisting for some front-line roles, weekly pipeline review meetings with Heads of Nursing and Recruitment Partners and removing any barriers within the time to hire process
- Unplanned turnover also remains high with nurse retention being of particular concern. A Nursing Recruitment and Retention Task and Finish group has been established, refreshing, and reviewing progress of a targeted action plan, reporting through a sub-group which reports into PODG
- Sickness absence rates decreased slightly, most notably with musculoskeletal and mental ill health related absence reducing, whilst Covid-19 absence started to rise at the end of quarter 2 and is anticipated to have peaked in October
- Mandatory training has exceeded the Trust target for the first time in several years, although appraisal rates have plateaued and therefore remain an area of focus
- The comprehensive programme of health and wellbeing work continues to be highly rated by staff, including the recent Autumn Festival which focussed on self-care. Additional support for cost of living has also been provided to staff, including Wagestream, mileage allowances and access to other benefits.

3.2 Demand and acuity

- Adult community services are continuing to receive a high number of referrals, which is outstripping the available capacity. A recovery plan is in place to manage the backlog and increased demand levels, with additional short-term investment in place to recover performance on 28-day assessments, although progress on reducing the backlog is slow due to challenges

to recruit additional staff. Other actions currently in place include a new format for assessment, designed to improve efficiency and reduce duplication.

- The acute pathway continues to be the key focus for tackling delayed transfers of care (DTC) to improve service user flow and continue positive improvements in this area, focused piece of work being undertaken on Stranded Patients (60+),and review of LOS over the acute pathway being conducted.
- Working with acute and voluntary sector partners on a number of areas to improve the care of people with mental health needs in the acute hospitals; diversion from the Emergency department (ED), front-door triage, improved environment, additional crisis options
- A Task and Finish Group commissioned by the Chief Nurses at WHHTT, ENHT and the Trust to review support and resources for individuals presenting to ED with behaviours which are challenging
- Single Point of Access (SPA) continues to be challenged; lots of work around access for Child and Adolescent Mental Health Services (CAMHS) and Adults and looking at ways in which to support at the 'front door' ,increase in staffing planned for Adults and CAMHS pod to manage clinical triage.
- Increased medical support to crisis service as holding high caseloads in order to manage risk and avoid admission
- The Trust is to pull together an understanding of the different elements and areas for development regarding DTCs for example the Springbank model used by Cambridge and Peterborough NHS Foundation Trust, Learning Disability Forensic for Women and a need to agree cross Strategic Business Unit (SBU) actions, in order to address the continuing challenges
- An increase in local trainers for Respect to support staff in the safe and effective management of service users presenting with behaviours which are challenging, violent and aggressive
- Trauma Informed Approaches has been piloted and recruitment to resources - including individuals with lived experiences is being finalised to enable Trust wide implementation to support staff to positively engage with service users.

3.3 Insufficient beds

- Use of out of area (OOA) beds remains high and continues to impact admission in a timely manner, with OOA in older people services now a consistent pressure.Their is an increase in demand currently which is increasing OA bed use.
- Kneesworth House contingency remains in place with the focus on reducing the OOA beds external to Kneesworth before considering reducing Kneesworth beds
- NHS England remain concerned that the Trust will not be able to achieve its target of reducing OOA beds to zero by 31 March 2023, the Trust is considering the option to extend this deadline
- Approval from the Executive Team to proceed with an electronic bed management system which will release bed management staff to focus on discharges, help with decision making and use data to look at variations and inconsistences
- The Trust is looking at a number of strategies to reduce DTCs; developing better pathways and access to housing via district council, working in partnership with a housing association including supported living and looking at its crisis housing model with a wider access criteria
- Enhanced Rehabilitation Outreach Service plus (EROS+) now developed - supporting people who are at risk of going back into the acute pathway
- Forest House's bed capacity continues to be reduced; the Provider Collaborative have made progress into the waiting list, remains difficult to access specialist Eating Disorder beds for CAMHS.

3.4 Financial Sustainability

- The financial environment across the NHS will be challenging in 2022/23, as it continues to recover from the Covid Pandemic and has the added consequences of the economic pressures and uncertainty, the continuing war in Ukraine and the employment challenges. The financial pressures result from rising demands for services, the reduction in Covid funding assistance and rising inflationary pressures are significant
- The Trust planned to breakeven for the year to 31 March 2023, but this is now at risk

- Discussions continue with Commissioners to ensure the Trust secures sufficient income to meet rising demand and the increased care needs
- The financial plan includes a number of key sub risks:
    - Secondary commissioning (OOA placements) if volumes continue to increase
    - Demand for community/crisis teams exceeds plan
    - Increased acuity/complexity
    - Reduction in expected income
    - Inflationary pressures which exceed national funding
    - Challenges in recruitment and retention.

- In order to mitigate the above risks, it is important that the Trust:
    - Delivers its planned delivering value programme
    - Adheres to robust financial control
    - Minimises the use and cost of agency staffing
    - Seeks to maximise additional income in-year
    - Ensures that all transformational activities are aligned to deliver additional value.

- The 2022/23 contract with Hertfordshire commissioners has been agreed, resourcing the areas of new investment assumed in the Trust financial plan.

3.5. Quality of Care

- Forest House Oversight Group meets fortnightly. The service improvement action plan continues to be regularly reviewed and monitored, focusing on 'rebuilding to outstanding' with clear outcomes and deadlines
- Oak ward Oversight Group meets weekly. A service improvement action plan includes all concerns and actions identified both internally and externally (CQC)
- The Quality Assurance Visits (QAV) are provided up to twice weekly internally, with external visits from the CCGs and an increased visibility from the Executive Team and Senior Leadership Team. Key headings and themes are shared Trust wide for learning and assurance
- Weekly meetings regarding providing safe, quality, and effective services oversee feedback from twice weekly external mock CQC visits and also focused quality and safety visits
- Monthly action learning and review meeting, co-chaired by the Executive Director Quality and Safety and Executive Director Quality and Medical Leadership established to hold oversight of actions and learning including from SJRs, FDs, SIs, FtSU
- Revision of quality and safety governance from service area to Board underway, led by the Executive Director Quality and Safety and Executive Director Quality and Medical Leadership.

3.6. External landscape

- In the months since the establishment of the Integrated Care Board (ICB) at the start of July, the organisation has been focussed on key areas with system partners to further strengthen the joint approach to tackling the ongoing unprecedented demand on Urgent and Emergency Care, to reduce the elective waiting lists, improve performance against our cancer targets, coordinate delivery of the autumn booster programme and improve access to Primary Care
- In the coming months the ICB will continue to focus on putting in place some of the key building blocks as a system, finalising ICB structures, making significant progress with the development of the Integrated Care Strategy (ICS) strategy, progressing plans for a system elective hub, holding an event on the 4th of October to bring system leaders together to agree an approach to place based partnerships (including the mental health and learning disability and autism collaborative – MHLD&A) and implementing the winter plans to support what will be a difficult period for the entire NHS
- The Hertfordshire and West Essex Integrated Care Partnership (ICP) has commenced the development of the Integrated Care Strategy for our 'system', with two workshops being held to date to begin developing the ICS priorities. The Hertfordshire and West Essex Integrated Care Partnership (ICP) is an equal partnership between the NHS and local government set up under the new NHS arrangements. It is a statutory requirement for each ICP to develop a strategy for the ICP area and for this to be published by December 2022

- The approach will focus on ambitions over a ten-year time horizon, will ensure it dovetails with the Health and Wellbeing Strategy, and will seek to address system-level challenges focussing on prevention, wellbeing, and tackling pervasive health inequalities
- The Collaborative has continued to develop its capacity to both influence and direct system-wide activity, resulting in tangible progress in improving local services and outcomes. There has been a significant and sustained improvement in supporting children and young people who need access to specialist inpatient beds.
- The Collaborative has:
    - Successfully secured a system investment of £1.4m to deliver a Collaborative model to address the backlog of children and young people waiting for an ADHD assessment in south and west Hertfordshire
    - Secured over £1.4m investment to strengthen our Urgent and Emergency Care support for people with mental health support needs including investment in both Hertfordshire Hospital Trusts and with our local MIND organisations.
    - Progressed system work around tackling inequalities
    - Develop with the Collaborative Board the agenda and outcomes for a Collaborative Board development day, currently scheduled for November 2022
    - Alongside the geographical Health and Care Partnerships, define a trajectory and timeframe for further development of place and Collaborative arrangements with ICB Executive and system leaders
    - Progressed work in supporting individuals who have mental health and drug and alcohol support needs specifically focussed the need for more joined-up provision for people in crisis and for people who don't engage with the commissioned drug and alcohol services.

3.7 Cyber Security

- The EPRR exercise to discuss and confirm the services' EPR Business Continuity response is scheduled for 28 November 2022
- Impact assessment being carried out for the implementation of multi-factor authentication on NHS mail accounts. A pilot exercise with a representative group of users to establish the operational impact will commence in January 2023
- Deputy CIO with cybersecurity qualifications recruited and is in post.

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

Pos	Risk	Rating (Initial) LxC	Rating (Current) LxC	Rating (Target) LxC	Link with Strategic Objective	Key Mitigations	Executive Lead
1.	**People** We won't have sufficient number of staff with the right skills, due to high levels of turnover, insufficient recruitment, and limited supply of workforce. Which will impact on our ability to provide safe responsive care, avoid harm and unexpected deaths, which will also have an impact on staff's wellbeing.	12	4 x 5 **20**	2 x 4 **8**	We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support and treatment	HPFT People and OD Plan and recruitment and retention action plans, revised Q1 2022/23 Recruitment Campaigns for newly qualified nurses, healthcare support workers (HCSWs), hotspots and hard to recruit areas and international recruitment. Co-production and implementation of our staff survey action plan. Organisational development focus on further embedding our values. Redesigning of workforce structures to support attraction, and enhance career development opportunities. Support from NHSE for establishment and skill mix reviews Continuing comprehensive programme of health and wellbeing work. Launch of additional HR apps including staff details and appraisal, building on success of existing supervision app and supporting retention. Recruitment and Retention Group monitors and develops new R&R initiatives, reporting into People and OD Group. Staff engagement activities to support retention, including co-production work to support a new belonging and inclusion strategy. Nursing R&R Task and Finish Group has been established autumn 2022.	Janet Lynch (Interim Executive Director of People & Organisational Development)

						Vacancy oversight group is now in place October 2022.	
2.	**Demand and acuity.** Increase in demand for services and increase in complexity of needs of service users. Which will see a reduction in the quality of care, lengthening of waiting times and have an impact on our ability to provide safe responsive care, avoid harm and unexpected deaths.	16	4 x 5 **20**	2 x 4 **8**	We will provide safe services, so that people feel safe and are protected from avoidable harm	A recovery plan has been implemented to manage the backlog, increased demand levels and to recover performance on 28-day assessments. Additional short-term investment in place. The acute pathway continues to be the key focus for tackling delayed transfers of care (DTC) will improve patient flow and continue positive improvements in this area Working with acute and voluntary sector partners on a number of areas to improve the care of people with mental health needs in the acute hospitals; diversion from the Emergency department (ED), front-door triage, improved environment, additional crisis options Single Point of Access (SPA) continues to be challenged; lots of work around access for Child and Adolescent Mental Health Services (CAMHS) and Adults and looking at ways in which to support at the 'front door' An increase in local trainers for Respect to support staff in the safe and effective management of service users presenting with behaviours which are challenging, violent and aggressive Trauma Informed Approaches has been piloted and a work plan is in place with Trust wide implementation to support staff to positively engage with service users. HPFT has been working with the Australian Gold Coast services in developing a suicide prevention pathway delivering evidence-based suicide specific intervention. A system wide task and finish group has been formed to	Jacky Vincent (Executive Director of Quality and Safety (Chief Nurse))

						deliver our vision for every person in Hertfordshire who is in crisis to receive support and find alternatives to suicide. The pathway aims to have a consistent approach across Hertfordshire, so regardless which service a person, family or friend is in contact with they are offered support at that time. All services in Hertfordshire will acknowledge the role they have in suicide prevention and feel confident to offer help people in need support, and thereby making every contact count. Complimenting this work is our innovative Simulation based Integrated / Multiagency Suicide Prevention training being delivered to HPFT and multiple agencies including Police / Fire Services, Social services, Voluntary sector, Primary care and Acute Services. Increased focus on visibility of the Clinical Matron in all service areas, including provision of Matron Surgeries Provision of regular Quality Assurance Visits (QAV) identifying areas of good practice as well as learning and action required	
3.	**Insufficient beds** We don't have access to sufficient number of inpatient beds. Which sees an increases in use of out of area placements, an increased number of services users in the community waiting for admission and causes a financial pressure. Will also have an impact on quality of care and staff wellbeing	12	4 x 5 **20**	3 x 3 **9**	We will provide safe services, so that people feel safe and are protected from avoidable harm	Kneesworth house contingency remains in place with the focus on reducing the OOA beds external to Kneesworth before considering reducing Kneesworth beds Approval from the Executive Team to proceed with an electronic bed management system which will release bed management staff to focus on discharges, help with decision making and use data to look at variations and inconsistences The Trust is looking at a number of strategies to reduce DTCs; developing better pathways and access to housing via district council, working in partnership with a housing association including supported living and looking at its crisis housing model with a wider access criteria	Sandra Brookes (Executive Director of Service Delivery and Service Experience)

						Enhanced Rehabilitation Outreach Service plus now developed - supporting people who are at risk of going back into the acute pathway. Forest House's bed capacity continues to be reduced; the Provider Collaborative have made progress into the waiting list, remains difficult to access specialist Eating Disorder beds for CAMHS. There is a trajectory in place with regular oversight from both the SBU's leadership and the Exec (currently on a weekly basis) measured against the key principles to increase bed capacity by the Exec in December 2021	
4.	**Financial Sustainability** Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements.	12	4 x 4 **16**	2 x 3 **6**	We will improve, innovate, and transform our services to provide the most effective, productive and high-quality care	The Trust reached agreement with the ICB on financial resources for 2022/23, that at the time was considered sufficient along with £3m of internal funding would allow the Trust to deliver its annual plan. An increase in costs during M5&6 have seen this put at risk Discussions continue with commissioners in regard to rising demand and an increase in the complexity of presentation and the funding consequences. Maintaining effective management of inpatient bed requirements through the oversight of the Executive team through the community and acute meeting Minimise the use and cost of agency staffing. With increased governance on use of agency The Trust continues to develop its Delivering Value programme to mitigate rising pressures and free resources for further investment. The programme will be monitored closely through the year to ensure delivery and is being further developed through involvement in the regional efficiency group Ensure that all transformational activities are aligned to deliver additional value.	Paul Ronald Executive Director of Finance, and Estates

						Effective use of capital spending. The Trust approved its Capital plan for 2022/23 which is in line with the allocated CDEL resource limit. The Trust is currently delivering in line with plan. The programme receives oversight by the Finance and Investment Committee which is informed of progress through the year. Seek to maximise additional income in-year in order to mitigate potential cost pressures and to accelerate new service provision.	
5.	**Quality of Care** We won't be able to provide high quality care at Forest House, Warren Court, SRS and northwest adult community services, due to a number of factors including workforce, significant increases in demand and availability of beds.	N/A	4 x 4 **16**	2 x 4 **8**	We will provide safe services, so that people feel safe and are protected from avoidable harm	Weekly oversight provided to the Executive Team, measuring against the Warning Notice and 'must and should dos' identified by the CQC in their last inspection. Northwest Hertfordshire Adult Community Task and Finish Group remains in place, following on from the high level of unexpected deaths and pressures on the service The QAVs are provided weekly internally, with external visits from the CCGs and an increased visibility from the Executive Team and Senior Leadership Team. Key headings and themes are shared Trust wide for learning and assurance. Continuing to work with Hertfordshire County Council (HCC) and commissioners, as part of the Service Improvement Process (SIP) on a number of actions to improve the care in Specialist Residential Services (SRS). This is particularly focused on increasing access to activities and ensuring personalised care as the transition to a new service model continues	Jacky Vincent (Executive Director of Quality and Safety (Chief Nurse))
6.	**External landscape:** Reduction in the influence of the Trust within the system, which could see a shift in influence and resources away from mental health, learning disabilities and autism and impact on Trust's ability to deliver high quality care to service users.	20	3 x 4 **12**	1 x 3 **3**	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	Since the establishment of the Integrated Care Board (ICB) at the start of July, the organisation has been focussed on key areas with system partners to further strengthen the joint approach to tackling the ongoing unprecedented demand. In the coming months the ICB will continue to	(David Evans, Executive Director, Strategy and Partnerships)

						focus on putting in place some of the key building blocks as a system, finalising ICB structures, making significant progress with the development of the Integrated Care Strategy (ICS) strategy and progressing plans for a system elective hub. The Hertfordshire and West Essex Integrated Care Partnership (ICP) has commenced the development of the Integrated Care Strategy for our 'system', with two workshops being held to date to begin developing the ICS priorities. The approach will focus on ambitions over a ten-year time horizon. Successfully secured a system investment of £1.4m to deliver a Collaborative model to address the backlog of children and young people waiting for an ADHD assessment in south and west Hertfordshire. Secured over £1.4m investment to strengthen our Urgent and Emergency Care support for people with mental health support needs including investment in both Hertfordshire Hospital Trusts and with our local MIND organisations. Progressed work in supporting individuals who have mental health and drug and alcohol support needs specifically focussed the need for more joined-up provision for people in crisis and for people who don't engage with the commissioned drug & alcohol services	
7.	**Cybersecurity** Trust's information and systems is at higher risk of being compromised by a cyberattack due to current international events. This is also because the attacks are getting increasingly sophisticated in identifying and exploiting known and unknown vulnerabilities which if successful, may result it loss and/or public disclosure information and loss of access to critical systems.	3 x 4 **12**	3 x 4 **12**	3 x 3 **9**	We will improve, innovate, and transform our services to provide the most effective, productive and high-quality care	Cyber security audits undertaken in HBL ICT. Intrusion Prevention Sensors on all 'internet' connections. Regular/periodic messaging to staff regarding potential issues, vigilance, expected behaviours and appropriate responses.	Hakan Akozek (Director of Innovation and Digital Transformation)

						HBL continue to patch the estate in accordance with policy and guidance received from the NHS D Carecert notifications. HBL commissioned its annual penetration test during March. This time this was an 'unauthenticated' test which is more akin to what a real-world cyber-attack would look like as well as an 'authenticated' test which is an internal test where the tester has full knowledge of our network. Additional assurance sought from the Trust's EPR supplier Civica on their cyber-attack preparedness and confirmation of their recovery plan should a similar incident occur. External cyber security supplier contracted to review all 3rd party contracts and create a framework for 3rd party cyber security management Proposal made to the Exec for a new cyber security manager to increase Trust's cyber security capacity and capability The EPRR exercise to discuss and confirm the services' EPR Business Continuity response is scheduled for 28th November 2022. Impact assessment being carried out for the implementation of multi-factor authentication on NHS mail accounts. A pilot exercise with a representative group of users to establish the operational impact will commence in Jan 2023. Deputy CIO with cybersecurity qualifications recruited and is in post.	

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 19
Subject:	Board Assurance Framework Update	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To provide an update on the work underway undertake a fundamental review of the Trust's Board Assurance Framework.

Action required:

The Board is asked to:

- To note the work to date
- Support the approach as outlined.
- Provide feedback on the list of proposed strategic risks

Summary and recommendations to the Board:

Background

The Trust's Board Assurance Framework (BAF) has undergone a fundamental review to ensure it is line with best practice and acts as a clear guide for the Board on the strategic issues and risks it should be focussing on. The review was also undertaken in response to a recommendation from the externally commissioned Well-Led Review that was undertaken in 2020/2021.

The BAF is a dynamic document and tool to ensure that the Trust Board is focused on the key strategic issues and risks.

The review of the BAF has been supported by the Executive Team and has been discussed at the November meeting of the Integrated Governance Committee. As well as specific conversations with Trust Internal Auditors, RSM, and Non Executive Directors, Anne Barnard and Drew Van Doorn.

New approach

Following consideration of best practice and research of Outstanding Trusts' BAFs it has been agreed that the Trust's updated BAF includes:

- Strategic Objective
- Strategic Risk
- SRO
- Risk Descriptor
- Current risk rating
- Target risk rating
- Controls (across three levels)
- Assurance level (high, medium or low)
- Mitigating actions

It is worth stressing that the BAF will continue to develop over the coming months and will include information on trends and provision of heat maps.

The material changes from the current version, which is still live are:

- reduction in the number of strategic risks from twenty plus to nine.
- addition of current and target risk ratings.
- separate descriptions of strength of controls and strength of assurances in place

Proposed Strategic Risks
Below are listed the proposed strategic risks for the revised BAF. These have been reviewed the Executive Team and the Integrated Governance Committee and their amendments reflected in the list below:

Risk One: Our People: Failure to develop a sustainable workforce model that means we fail to recruit and retain the right numbers of people with the right skills which will impact on quality of care for our service users and our staff satisfaction levels.

Risk Two: Our People: Failure to maintain positive health and wellbeing support for all our staff and do not provide an inclusive work experience with equality of opportunity which could mean staff do not feel valued or enabled to reach their potential.

Risk Three: Quality – Safety: There is a risk that we do not provide safe standards of care due to failure to maintain agreed safe staffing levels or evidence-based pathways, meaning service users do not feel safe and are not protected from avoidable harm or deaths through suicide

Risk Four: Quality – Experience: There is a risk that due increased there is unavailability of services (community and inpatient) which could lead to an increase in out of area placements, reduced access to specialist care and poor experience for services users, families and carers.

Risk Five: Finance: Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements.

Risk Six: Transformation: Failure to deliver transformation and continuous improvement could compromise quality, safety and experience of service users and ability to recruit staff.

Risk Seven: System: Failure to influence partners in the new system architecture which may lead to a shift of focus and resources away from MHLDA services users and communities served by HPFT.

Risk Eight: Collaboration: Fail to support the Hertfordshire MHLDA Collaborative, which may mean the voice of those with mental health, learning disability and autism are not represented and may have an adverse impact on ability to meet needs and deliver improved outcomes.

Risk Nine: Social Care: Failure to engage with partners and organisations to deliver the right care with improved outcomes for service users. Including failure to implement social care reform and meet S75 requirements which may result in social care outcomes not being met.

Next Steps
At its meeting on 1 December the Audit Committee will consider the strategic risks, in its role as the owner on behalf of the Board of the integrity of the Trust's approach to risk management.

The Executive Team will then finalise the populating of the BAF the final version will be considered at the January 2023 Board meeting.

Recommendations
The Board is asked to:

- To note the work to date
- Support the approach as outlined.
- Provide feedback on the list of proposed strategic risks

Relationship with the Business Plan & Assurance Framework:

The BAF identifies the risks associated with the strategic objectives as set out in the Annual Plan.

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:

The ensuring of equality of experience and access is core to the strategic objectives. The BAF will support the Trust Board in delivering the strategic objectives

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

Evidence of robust governance review process for the NHSI/CQC Well Led Standard.

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

Exec Team 9 November 2022. Integrated Governance Committee 10 November 2022

PUBLIC Board of Directors

Meeting Date:	24 November 2022	**Agenda Item:** 20
Subject:	Committee Terms of Reference	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Helen Edmondson, Head of Corporate Affairs & Company Secretary
Presented by:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	

Purpose of the report:

The Terms of Reference of the Nominations & Remuneration Committee are required to be reviewed at least annually by the Committee and approved by the Trust Board.

Action required:

To APPROVE the attached Terms of Reference.

Summary and recommendations to the Board:

The Committee Terms of Reference were last reviewed by the Nomination and Remuneration Committee at its meeting on the 6 October 2022.

The Committee considered the Terms of Reference agreeing no changes were proposed and recommend them to the Board for approval.

Relationship with the Business Plan & Assurance Framework:

Links to Strategic Objective 4: we will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment.

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

The Committee Terms of Reference include the need to be mindful of the gender pay gap and take account of equal value and equal pay principles and legislation for the group of staff it has responsibility for.

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

N/A

NOMINATIONS AND REMUNERATION COMMITTEE
TERMS OF REFERENCE

1. Establishment

1.1 The Nominations and Remuneration Committee is a Committee of the Trust Board of Directors.

2. Purpose

2.1 The Committee is responsible for:

2.1.1 Reviewing and making recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board. It recommends to the Board of Directors the appointment of Executive Directors.

2.1.2 Setting the remuneration policy for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.1.3 Approving contracts of employment for the Chief Executive, Executive Directors, and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.1.4 Agreeing arrangements for termination of contracts, including severance payments paid to the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.2 The Committee will also be mindful of the gender pay gap and take account of equal value and equal pay principles and legislation for the group of staff it has responsibility for.

2.3 The Committee will take into account relevant national guidance and advice where necessary.

3. Membership and Quoracy

3.1 The Committee shall consist of all Non-Executive Directors of the Board of Directors.

3.2 The quorum for any meeting of the Committee shall be attendance of a minimum of three members.

3.3. The chair of the Committee shall be the Chair of the Board of Directors.

4. Attendance at Meetings

4.1 The Chief Executive will attend all meetings, except when their own performance and remuneration are under consideration.

4.2 The Chief People Officer shall be in attendance when invited by the Committee and shall provide the Committee with such information and advice as they require.

4.3 It is expected that all members will attend at least three quarters of all meetings per financial year. An attendance record will be held for each meeting and an annual register of attendance will be published.

4.4 Every effort shall be made to ensure that the decisions of the Committee are made within its properly constituted meetings. In exceptional circumstances, where very urgent and unanticipated decisions are required to be taken, these may be requested by email circulation to all Committee members. In order for a Committee decision made in this way to be effective, it shall require the prior approval of the Committee Chair that the urgent decision be made in this manner and a positive response from at least 70% of Committee members (which shall include the Committee Chair and Deputy Chair) signifying their assent to the decision.

4.5. The Chair may request attendance by relevant staff at any meeting.

5. Frequency of Meetings

5.1 Meetings of the Committee will be held at least quarterly.

5.2 Meetings will be convened by the Chair and can also be requested by the Chief Executive or their nominated deputy.

6. Authority

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference.

6.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent advice, and to secure the attendance of external individuals with relevant experience and expertise if it considers this necessary.

7. Duties

7.1 To regularly review the composition, skills and experience of the Board of Directors and to make recommendations to the Board.

7.2 To ensure appraisals are undertaken for all Executive members of the Board of Directors.

7.3 To ensure a succession plan is in place and appropriate actions are taken to ensure the continued leadership of the Trust.

7.4 To ensure an appropriate process is in place for the appointment of the Chief Executive and Executive Directors and to recommend the appointment of Executive Directors to the Board of Directors and the Chief Executive to the Board of Governors.

7.5 In conjunction with the Council of Governors Appointments and Remuneration Committee and the Council of Governors, ensure that the process for appointing the Trust Chair and Non-Executive Directors, and the process for appointing the Chief Executive and Executive Directors are aligned.

7.6 To maintain an overview of the relationship between total remuneration and that of the market equivalents for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive. The Committee will, where appropriate, commission others to collect market information on salaries and other forms of reward to ensure it is sufficient to attract, retain and motivate the relevant individuals, whilst ensuring it is not more than is necessary for this purpose.

7.7 To advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, Executive and non-voting Directors, and other senior managers reporting directly to the Chief Executive, taking account of such national guidelines as is appropriate. This will include:

- All aspects of salary (including any performance related element / bonuses).
- Provisions for other benefits, including pensions and allowances.
- Agreement of contracts of employment and if applicable terms of office.
- Arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidelines as is appropriate.

7.8 To consider a report annually from the Chair on the performance of the Chief Executive and from the Chief Executive on the performance of Executive Directors and determine any adjustment to salary.

7.9 Ensure that the right performance and talent management arrangements are in place for the individuals and groups in 2.1.2.

7.10 To agree the annual inflationary uplift on pay and reward for the Chief Executive, Executive and non-voting Directors, and other senior managers reporting directly to the Chief Executive.

7.11 Scrutinise and agree severance terms for the termination of a contract of employment for an individual covered by this Committee giving due regard to HM Treasury requirements and ensuring compliance with the NHS Improvement guidance for NHS Trusts and Foundation Trusts on processes for making severance payments.

7.12 Undertake any other duties as directed by the Board.

8. Administrative Support

8.1 The Committee will be supported by the Company Secretary, in attendance for all meetings except when issues regarding their own salary are discussed.

8.2 The administrative support in this respect will include:

8.2.1 Agreement of the agenda with the Committee Chair.

8.2.2 Collation and distribution of papers at least five working days before each meeting.

8.2.3 Taking the minutes and keeping a record of matters arising and issues to be carried forward.

8.2.4 Providing support to the Chair and members as required.

9. Accountability and Reporting arrangements

9.1 The Committee shall be directly accountable to the Board of Directors.

9.2 The minutes of all meetings shall be formally recorded and a six monthly report provided to the Board of Directors on its work in discharging its responsibilities, delivering its objectives and complying with its Terms of Reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Monitoring Effectiveness and Compliance with Terms of Reference

10.1. The Committee will carry out an annual review of its effectiveness and compliance with its Terms of Reference.

11. Review of Terms of Reference

11.1. The Terms of Reference of the Committee shall be reviewed at least annually by the Committee and approved by the Trust Board.

Date approved: **Nominations and Remuneration Committee 6 October 2022**
Approved by: **Board of Directors 24 November 2022**
Next review date: **November 2023**