Hertfordshire Partnership University NHS Foundation Trust

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Chair: Sarah Betteley
Date: 2 November 2023
Time: 10.30

Da Vinci Suite

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors Meeting
Date: Thursday 2 November 2023

Venue: The Colonnades
Time: 10:30– 13:00pm

A G E N D A					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
	Shared Experience				10.30
1.	**Welcome and Apologies for Absence**	Chair - Sarah Betteley			11.00
2.	**Declarations of Interest**	Chair - Sarah Betteley	**Note**	Attached	
3.	**Minutes of Meeting held on 5 October 2023**	Chair - Sarah Betteley	**Approve**	Attached	
4.	**Matters Arising Schedule**	Head of Corporate Affairs and Company Secretary - Helen Edmondson	**Review & Update**	Attached	
5.	**CEO Brief**	Chief Executive Karen Taylor	**Receive**	Attached	11.10
6.	**Chair's Report**	Chair - Sarah Betteley	**Receive**	Verbal	11.25
	QUALITY & PATIENT SAFETY				
7.	**Report of the Integrated Governance Committee held: 24 October 2023:** **a) Quarter Two Integrated Safety Report** **b) Quarter two Experience report** **c) People Report**	Executive Director of Quality and Safety – Jacky Vincent Executive Director of Quality and Safety – Jacky Vincent Deputy CEO & COO – Sandra Brookes Chief People Officer – Jo Humphries	**Receive** **Note** **Note** **Note**	Attached Attached Attached Attached	11.35
	OPERATIONAL AND PERFORMANCE				
8.	**Report of the Finance & Investment Committees held: 27 October 2023.** **a) Quarter two: Performance Report** **b) Quarter Two: Annual Plan**	Chief Finance Officer - Phil Cave Director of Innovation and Digital Transformation - Hakan Akozek Executive Director, Strategy Partnerships - David Evans	**Receive** **Note** **Note**	Attached Attached Attached	11.55
9.	**Finance Report and Recovery Plan**	Chief Finance Officer - Phil Cave	**Receive**	Attached	12:10
	STRATEGY AND SYSTEM				
10.	**Mental Health and Learning Disability and Autism Healthcare Partnership Update**	Executive Director, Strategy Partnerships - David Evans	**Receive**	Attached	12:25

11.	**Mental Health Urgent Care Centre Business Case**	Deputy CEO and COO- Sandra Brookes	**Receive**	Attached	12:35
GOVERNANCE AND REGULATORY					
12.	**Board Assurance Framework**	Head of Corporate Affairs and Company Secretary - Helen Edmondson	**Approve**	Attached	12:45
13.	**Any Other Business**	Chair - Sarah Betteley			13.00
	QUESTIONS FROM THE PUBLIC	Chair - Sarah Betteley			
Date and Time of Next Public Meeting: Thursday 1 February 2024					

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

PUBLIC Board of Directors

2 November 2023

Members	Title	Declaration of Interest
Hakan Akozek	Director, Innovation and Digital Transformation	Shareholder in Go2Healthcare Limited Wife is an Executive Partner in South Street Surgery, Bishop's Stortford Loyalty Interests - Aware that the Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities
David Atkinson	Non-Executive Director	Independent NED Mizuho Independent Humanist funeral celebrant RNLI crew member NED on the board of the Pension Protection Fund
Anne Barnard	Non-Executive Director	Share Portfolio managed by a private client stockbroker Independent member of the Audit & Risk Committee of the Department of Health & Social Care Director and minority shareholder in Qube Information Systems Ltd Independent member of Audit & Risk Committee Latymer Foundation of Hammersmith (2 x schools)

		Independent member of Queen Mary University of London Finance & Investment Committee
Sarah Betteley	Chair	Director DEVA Medical Electronics Ltd
Sandra Brookes	Director, Service Delivery & Service User Experience	Nil Return
Tim Bryson	Non-Executive Director	Director of Tim Bryson Consultancy Services Ltd
Philip Cave	Chief Finance Officer	Nil Return
Carolan Davidge	Non-Executive Director	Director, Carolan Davidge Ltd (trading as Carolan Davidge Coaching) Director, Arthur Rank Hospice Charity Independent Board Member, Samphire Homes Director, Arthur Rank Hospice Ltd Director, Flagship Housing Developments Ltd
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
David Evans	Director Strategy & Partnerships	Nil Return
Diane Herbert	Non-Executive Director	Deputy Chair North East London ICB
Jo Humphries	Chief People Officer	Nil Return
Dipo Oyewole	Associate Non-Executive Director	Nil Return
Karen Taylor	Chief Executive Officer	NHS Providers Board Trustee
Andrew van Doorn	Non-Executive Director	Chief Executive and Company Secretary, HACT (Housing Associations Charitable Trust)

		Chief Executive and Company Secretary of HACT Housing Action Ltd. A fully owned trading subsidiary of HACT
Jacky Vincent	Director Quality & Safety (Chief Nurse)	Member Director of Nursing Forum, National Mental Health & Learning Disability Honorary Fellow at University of Hertfordshire
Jon Walmsley	Non-Executive Director	Trustee on Board of homelessness charity: 'Accumulate' (1170009) | Member of Green Angel Syndicate Independent Board Member of the University of Hertfordshire Shareholder of Farr Brew Limited
Asif Zia	Director, Quality & Medical Leadership	Nil Return

Minutes of the: PUBLIC Board of Directors
Date: 5 October 2023
Venue: The Colonnades

MINUTES	
NON-EXECUTIVE DIRECTORS	**DESIGNATION**
Sarah Betteley | SBe	Chair
David Atkinson | DA	Non-Executive Director
Carolan Davidge | CD	Non-Executive Director
Dipo Oyewole | DO	Associate Non-Executive Director
Andrew van Doorn | AvD	Non-Executive Director
Jon Walmsley | JW	Non-Executive Director & SID
DIRECTORS	
Karen Taylor | KT	Chief Executive Officer
Sandra Brookes | SBr	Deputy CEO and Chief Operating Officer
David Evans | DE	Executive Director Strategy & Partnerships
Jo Humphries |JH	Chief People Officer
Jacky Vincent | JV	Executive Director, Quality and Safety & Chief Nurse
Prof Asif Zia | AZ	Executive Director, Quality & Medical Leadership
Hakan Akozek | HA	Director Innovation & Digital Transformation
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chair and Head of Corporate Affairs & Company Secretary (Minutes)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Maria Watkins | MW	Lead Governor
Rob Croot | RC	Deputy Director Finance
APOLOGIES	
Diane Herbert | DH	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
Tim Bryson | TB	Non-Executive Director
Phil Cave | PC	Chief Finance Officer

Item	Subject	Action
106/23	**SU Experience** SBe thanked Sarah Smith who shared her story about the CAMHS Targeted Treatment Team.	
107/23	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. Apologies for absence were received from Diane Herbert, Anne Barnard, Tim Bryson and Phil Cave.	
108/23	**Declarations of Interest** The Declarations of Interest Register was noted. **NOTED**	
109/23	**Minutes of Meetings held 6 July 2023** The minutes were reviewed and approved as an accurate account of the meeting subject to one amendment to in the Chairs briefing with SBe adding an update in paragraph three to read: ***Bim Afalomi encouraged the Trust to approach him for support if we***	

	had subsequent plans developed. **APPROVE** **The Board APPROVED the minutes**	
110/23	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
111/23	**CEO Report** KT presented the CEO Report to the Board which was taken as read. Headline messages of note to the Board were: KT reflected on the Lucy Letby case noting the Department of Health and Social Care had announced there would be an independent statutory inquiry. The Trust had taken immediate steps and actions relating to support for whistle blowers; Fit and Proper Person requirements; indicators of responsiveness and further strengthening Freedom to Speak Up, acknowledging there was always more we could do but were confident we had good practices in place. A formal report would be presented to the Integrated Governance Committee which would then be reported to the Board. KT reported that Cheshire police had recently announced there would be a police investigation. Over recent weeks there had been coverage of a number of other high-profile national safety incidents and, as a Trust we had taken learning from these. In addition, there had been a number of Care Quality Commission (CQC) Inspection reports published which had highlighted failures in adhering to regulatory standards, with KT confirming she was confident we undertook the right measures as a Trust. Chris Dzikiti, CQC Director of Mental Health had set out expectations for Board leadership in the investigating and reducing of restrictive practice in Mental Health Trusts with KT confirming the Trust already had a Board member identified - Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse). Industrial Action (IA) continued with KT noting the impact on the Trust and staff morale. Recent action had seen around 20 consultants and 50 junior doctors striking. There continued to be no indication nationally of resolution and so further action was anticipated. NHS England had produced its winter plan and included ten interventions that each system was being asked to deliver on, three of which were specific to mental health providers with SBr leading on this piece of work. As a Trust we had a detailed winter plan in place covering the ten interventions. NHS England had announced £200m nationally for winter. A business case had been developed to establish a Mental Health Urgent Care Centre (MHUCC) on the Lister site (The Glaxo building) with KT confirming funding was now confirmed and mobilisation of the centre would commence over the coming months. A number of Strategies and Publications had been published and of note was the new Enforcement Guidance.	

	On 4 September 2023 NHS England had launched its first ever sexual safety charter which we had been asked to sign up to with KT noting that as an organisation we had already undertaken a lot of work on sexual safety and there was a specific item relating to this later on the agenda. KT noted the WDES and WRES data, reporting of note that was the first time the publication included individual benchmarking reports and showed that we were in the top 10% of Trusts nationally, however there was still more work for us to do. Locally, the HWE ICB had developed proposals regarding its future operating model. Key changes included a transition of Health and Care Partnerships. Financially the ICB was in a difficult place although the Industrial action impact had been recognised. The Urgent Care Centre required a capital investment of £1.35m and the annual cost of running the new service would be £3m. The business case had been presented and approved by the ICB Executive Team, ICB Finance & Investment Committee and ICB Board with KT commenting this would be a 'game changer' for crisis care. Following the Lucy Letby case regional colleagues would be visiting all mother baby units, as a Trust we welcomed this, with KT stating we had a strong unit. Operationally we continued to see ongoing high levels of demand particularly within some hotspot areas. The South West community adult and crisis services remain under pressure with high levels of vacancies and a piece of work was underway to support this. The Learning Disability & Forensic Strategic Business Unit had been placed under additional performance and support arrangements by the Trust with Warren Court now in a strong place and Broadlands seeing some positive change. KT updated on our workforce noting we needed to be cautious, as whilst the trend over the past six months had been positive it had now flat lined confirming that she had asked the Executive team to update on what the next step change would be. KT reported that the Trust had been informed by the Information Commissioners Office (ICO) that it had completed its investigation in relation to the Trust's use of a meta pixel on its website noting it had closed the case with no regulatory action for the Trust. KT made acknowledgement to HA and his team. At the September Council of Governors meeting, following recommendation from the Appointments and Remuneration Committee they had re-appointed SBe, Chair and TB and AB, NEDs for a second term. KT formally welcomed the decision noting the exceptional leadership provided. A number of teams in the Trust had been shortlisted for prestigious national awards with KT recognising this was a real credit to the teams. We had our	

	own Trust Staff Awards being held on the 20 November 2023. KT concluded the update stating that on the 22 September Amanda Pritchard, CEO, NHSE had visited the Trust and spent time at Saffron Ground with KT commenting that feedback had been hugely positive and the Trust mentioned in Amanda's weekly blog. In response to CD's question SBr reported we were developing a mobilisation plan that detailed what can be provided while the Centre was fully refurbished. **RECEIVED** **The Board RECEIVED the CEO Brief**	
112/23	**Chairs Report** SBe provided Board members with a verbal update on the work she had undertaken since the last Board meeting. SBe had attended a number of System Chair meetings along with a Chairs dinner hosted by Paul Burstow, stating this had been constructive, productive and had encouraged good frank conversations. SBe had met with MP's Gagan Mohindra and Stephen McPartland and shared with them the achievements and challenges at the Trust. SBe had attended a number of conferences with the theme running through them of being down beat and SBe noting mental health seemed to be drifting off the agenda. SBe joined a MH Chairs call led by Richard Meddings' who had acknowledged the NHS was overwhelmed and needed to focus on a collaborative approach. Internally, SBe had attended the Trust Freedom to Speak Up event which had been well attended. Dr Jayne Chidgey-Clark, National Freedom to Speak Up Guardian had attended and highlighted how advanced we were as a Trust in our F2SU work. SBe had attended a World Suicide Event run by Herts County Council, noting this had been a useful session and had also provided SBe with an opportunity to visit the Night Crisis Café. SBe had spoken at the Carer in Herts event run by Dick Lovelace commenting on the useful conversations with carers. **RECEIVE** **The Board RECEIVED the verbal update**	
QUALITY & PATIENT SAFETY		
113/23	**Report of the Integrated Governance Committee held 27 July 2023** JV presented the report which provided the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting on 27 July 2023. The report was taken as read. The Committee had received a Deep Dive into the Trauma Informed	

	Approach work which had been a pilot on Robin Ward and the plans to embed this Trust wide. The Committee had considered the Integrated Safety Report and welcomed the revised format which noted that violence and aggression and self harm were the top two themes or reported incidents. The Committee had held a discussion regarding PSIRF and PSIRP with JV noting the Plan would be presented later on today's agenda for approval. The Committee had considered a report regarding the CQUIN goals for 23/24 and provided updates on progress and mitigations for those actions not on track. The Committee had been presented and considered the Annual Research and Development report. A report was presented to the Committee on the activities in the Pharmacy department which included the safe and effective use of medicines. The Committee had considered the Quarter one People and OD report noting the positive progress on recruitment, also noting the status of the Oliver McGowan training and the impact on the Trust from the Industrial Action. The Committee had discussed the Guardian of Safe Working Quarter one report and the Freedom to Speak Up Quarter one report. The Experience of Care Quarter one report was received which included the figures for compliments and complaints, the Friends and Family Test and the review of Having Your Say approach. The Committee had approved the Trust Risk Register, noting the increase in the number of risks. There were no matters for formal escalation for the Board. JV invited questions. Board members discussed the Trauma Informed Approach work and the IGC agenda. **RECEIVE** **The Board RECEIVED the report**	
114/23	**Quarter One Integrated Safety Report** JV introduced the report which provided details of quarter one Integrated Safety report. The report taken as read. Highlighted points of note were: The Integrated Governance Committee had welcomed the revised format of the report. The report noted the top two themes from the reported incidents as violence and aggression and self-harm. The majority of the violence and aggression incidents were in the Learning Disability Assessment and	

	Treatment wards and attributed to five individual service users who were awaiting social care placements. Their induvial care plans and risk assessments continued to be reviewed to ensure appropriate support and interaction. Areas of focus identified from a CQI project were being taken forward along with the implementation of the reviewed skill mix and establishment, a Reducing Restrictive Practice Project and using the Trauma Informed Approach (TIA) work. In regard to self harm behaviour, the highest number of incidents were from Forest House, Albany Lodge and Aston ward. The main types of harm were headbanging and non-anchor ligatures. All incidents were reviewed daily and immediate learning from the analysis related to search training in relation to contraband items, further training and development on search practice and bespoke training. A Task and Finish group had been commissioned to review AWOLs which concluded that the majority were reported to the police, regardless of risk level. Overall, the number of incidents was low compared to the number of leave granted on a daily basis. As set out in section 4.5 of the report, themes were considered along with actions in response to the themes. The report also set out a number of other areas of focus and actions. JV concluded the update noting the mortality governance work which reviewed all deaths across the Trust within 30 days of discharge. In response to DO's question AZ outlined that definition of an unexpected death KT supported the updated format of the report and it was noted that the next iteration would include detail of when the agreed actions would be completed. **RECEIVE** **The Board RECEIVED the report**	
115/23	**Emergency Preparedness Resilience and Response (EPRR) Core Standards** SBr presented the report which provided the Board with an overview of the Trust's performance in relation to the EPRR Core Standards. It was noted that the assessment was expected by NHS England for 2023/24 and provided assurance regarding the Trust's annual position statement for EPRR. SBr noted the below key points. The Trust had provided additional resource into the EPRR Group. As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS	

	funded services must show they can effectively respond to major, critical, and business continuity incidents whilst maintaining services to patients. A formal internal audit of the Trust's approach to Business continuity management had been conducted. All 58 core standards and the one deep dive standards had been reviewed, and evidence to support the assessment had been identified with the Trust reporting full compliance, with all systems and processes remaining effective. SBr reported that after the Accountable Emergency Officer's review meeting with the Integrated Care Board EPRR officers, NHS England would have the opportunity to raise any issues or further clarity around the Trust's submission before it will be formally ratified. **APPROVE** **The Board APPROVED the report**	
116/23	**Quarter One Safe Staffing** JV presented the report which provided the Board with details in regard to safer staffing and actions for quarter one 2023/24. The report was taken as read. The report included more analysis relating to month three which had not been available when presented to the Integrated Governance Committee. JV stated the report noted the high levels of staffing in regard to acuity, complexity, safe and supportive observations as well as vacancies and sickness. This was also reflected in the Care hours per patient day (CHPPD) data which showed high fill rates. The revised Phase One skill mix review and establishment had considered the CHPPD data and more detail would be provided in the quarter two report. The report noted the reduction in agency use and the increase in scrutiny to ensure management of lost contracted hours. The next report would include the recently procured insight reporting in regard to roster performance. Board members stated it would be useful to have the triangulation of data explicitly set out in a report with KT acknowledging. Board members discussed the work that had been undertaken to re set the staffing base following the review of the staffing establishment. It was agreed that there needed to be a dynamic process regarding establishment and monitoring linked with acuity and need. **RECEIVE** **The Board RECEIVED the report**	
117/23	**Guardian of Safe Woking Update** AZ introduced the report noting that it had been given full analysis at the recent Integrated Governance Committee. The report was taken as read. During this quarter there were two exception reports raised by our Junior	

	Doctors with AZ stating that as a Trust our exception reporting was low when compared nationally and regionally. The Guardian of Safe working delivers a presentation at each Junior Doctor induction to ensure all trainees were aware of the exception reporting process. All exception reports from previous quarters had been reviewed by the Guardian of Safe Working and were concluded. **RECEIVE** **The Board RECEIVED the report**	
118/23	**Quarter One Experience report** SBr presented the report which provided the Board with information on feedback received from service users and carers during Quarter one, 2023-24. Headlines from the report was noted as: There had been no significant change in data since the previous quarter. CAMHS had seen an increase in service users feeling valued and there had been an improvement in service users feeling supported in Crisis. Regarding complaints two areas of note were the high numbers of complex referrals into Adult Community services for ADHD and waiting times for CAMHS ADHD. SBr noted there was lots of work to do in terms of response times and we would use CQI to look at this. Data from the Inpatient Survey Project would be presented in quarter two. Questions were invited. Board members held a discussion around the waiting times for ADHD services for both Adult and CAMHS with SBr stating that unfortunately this was a national picture. The pilot we were running was due to come to an end in March 2024 and currently there was no further funding. AZ highlighted there was currently a shortage of ADHD medication and we were working with the ICB to ensure clear communication and identification of appropriate alternatives. **An action was drawn for the NEDs to be briefed on the current position with regard to ADHD services.** **RECEIVE** **The Board RECEIVED the report**	**KT**
119/23	**Annual Infection, Prevention and Control (IPC) Report** JV introduced the report which provided detail of progress the Trust had made in relation to minimising the risks of healthcare associated infections. The report also identified the IPC priorities for 2023/24. The report was taken as read and the below pointed drawn out.	

	The report provided detail regarding Covid and outbreaks with JV noting all had been investigated, monitored and any learning taken. The report set out the IPC practice, monitoring, governance and the IPC annual plan. It also noted the education and training and the reported IPC incidents. JV highlighted the report concluded with the priorities for 2023/24. **RECEIVE** **The Board RECEIVED the report**	
120/23	**People Report** JH presented the report which set out the Trust's month four performance in relation to key People and OD metrics that support our annual plan. Key headlines were as follows: Vacancy rates had remained at 12.2%. Focus was being given to the Recruitment and Retention Group in regard to the nurse recruitment pipeline and the potential increase of international nursing and to help with hotspots. A campaign was underway setting out 'why you should come and work for us'. JH referenced page 94 of the report which set out the Employee Relation cases which remain low, but they do demonstrate a significant link with BAME staff. JH reported that the Oliver McGowan training was currently at 44%. **It was agreed that the future people report would provide detail on the Trust approach to improve recruitment and retention.** **RECEIVE** **The Board RECEIVED the report**	**JH**
121/23	**WDES and WRES data** JH presented the report which outlined the Trust's co-produced WDES, WRES and Gender Pay Gap action plans which required Board approval prior to publication on the Trust website. The reports were taken as read. The Trust was required to publish the WRES and WDES action plans by 31 October 2023. JH noted that whilst there was no formal requirement to publish our Gender Pay Gap action plan, it was considered good practice and therefore Board approval was sought for both the plan and its publication to further promote our commitment to eradicating all forms of discrimination. It was noted the WDES plan was currently embargoed so would be circulated to Board members following the meeting. SBe stated that as the Board could not approve today this would be delegated to the Integrated Governance Committee (IGC) for approval with SBr noting it was important the meeting had adequate time to consider. **RECEIVE**	

	The Board RECEIVED the report and delegated APPROVAL to the IGC	
122/23	**Patient Safety Incident Response Plan** JV introduced the paper which provided an overview of the Trust's Patient Safety Incident Response Plan (PSIRP), its aims, the data analysed and the five priority areas from the analysis. The paper also provided an overview of how Patient Safety Incident Investigations (PSII). Furthermore, it outlined the oversight arrangements and key responsibilities. The Trust had reviewed its governance structure, analysed its data and identified five priorities for improvement over the next 12 months. The PSIRP sets out how the Trust would seek to learn from patient safety incidents and builds on the work already in place. Section 3.3 of the report set out the overall aims of the PSIRP. Section 4 of the report set out the analysis the Trust had undertaken of its data relating to patient safety incidents. The outcome of the analysis had identified five priority themes for improvement for the next 12 months. 1. Violence and aggression 2. Self-harming behaviour 3. Inpatient falls 4. Medication incidents 5. Unexpected deaths. Appendix 1 set out the categories and sub-categories. Under the new framework, there would be a number of learning responses which the Trust may use, including the PSII, After Action Reviews and Swarms. Building on the already established processes in place, when reviewing incidents under the PSIRF, the Trust would discuss all incidents reported as moderate harm or above at the weekly Moderate Harm Review Panel, who would be responsible for reviewing the incidents against the framework and consider a learning response. An overview of all incidents would continue to be included in future Integrated Safety Reports, along with the data of all reported patient safety incidents, to continue to provide detailed oversight. JV, the Executive Director Quality & Safety (Chief Nurse) or AZ the Executive Director Quality & Medical Leadership would review and approve all final PSII reports. A number of the Trust's policies and procedures needed to be reviewed and updated in consideration of PSIRF and a programme of work had been developed. All policies and procedures would be reviewed and updated by the end of October 2023 ready for ratification at the QRMG in November 2023. The Trust's PSIRF policy will also be completed, following consultation, by the end of October 2023 for ratification at QRMG at the end of November 2023.	

	JV concluded advising that Appendix 3 set out the PSIRF Plan Timeline. **Following discussion an action was drawn for a review to be undertaken on the implementation of the PSIRP Plan.** **The Board APPROVED the PSIRP**	**JV**
	OPERATIONAL AND PERFORMANCE	
123/23	**Report of the Finance & Investment Committee held 28 July 2023** HE presented the report which provided the Board with an overview of the work undertaken by the Finance and Investment Committee at its most recent meeting held on 25 July 2023 and the briefing provided to Committee members on 18 September 2023. The report was taken as read and in the interest of time, the below four points were noted. The Committee considered the quarter one reports. The Committee received a report that set out the Trust financial position noting that the Trust had agreed for 2023/24 a deficit plan of £1.8m and at month three was reporting a deficit of £2.1m, £1.7 worse than plan. The Committee considered a report that set out the progress with the capital programme for 2023/24. It was reported the programme had spent £2.7m to date against a plan of £4m but that it was expected to breakeven at year end. At its meeting on the 18 September 2023 members were briefed on the developing medium term financial plan for the Trust. **RECEIVED** **The Board RECEIVED the report**	
124/23	**Quarter One Performance Report** HA presented the report which provided Board members with an update on key areas of performance and actions being taken to improve performance. HA reported we were now reporting on 63 indicators. At the end of quarter one we had met or almost met 42 of the 63 indicators (67%). Key challenges remained with demand and acuity in our inpatient and crisis pathways and delays in discharge Demand had continued into July and August; however, we were seeing the impact of the measures put in place to recover this position and at the end of August we were in line with our agreed trajectory. Providing timely access and treatment for people entering our children and young people and adult community services remained challenging. We expected to recover performance in children and young people services in quarter four and adult services in quarter three. We had seen a slow-down in recovery particularly in adult services during	

	the first two months of quarter two and we were undertaking a demand and capacity review to better understand our ability to meet the demand with current capacity. Providing diagnosis within 12 weeks also continued to be a challenge, but was improving. Although our vacancy position was improving, we still had significant issues in key areas such as nurses, AHPs and medical staff. Feedback from our service users and carers remained positive and we were seeing statistically significant improvement in other areas such as physical health checks and CPA reviews. The Board discussed that the Exec team had reviewed performance and identified areas where they were not improving. We were undertaking work to better understand capacity and demand to support modelling of new roles. **RECEIVE** **The Board RECEIVED the report**	
125/23	**Quarter One Annual Plan** DE presented the headlines for the quarter one Annual Plan update. At the end of quarter one, six out of seven objectives achieved the quarterly milestones and six out of seven objectives were forecast to meet the end of year outcomes. Six out of seven of all year-end outcomes were forecast to be on track to be delivered at the end of 2023-24 and recovery actions are in place for the remaining outcomes that are not on track in quarter one. There were challenges in delivering Strategic Objective 2 Experience which related to waiting times. It was noted that in quarter one, milestones for PSIRF were green and a recovery plan was in place for EMDASS. Although it was too early to give final results for quarter two there had been good progress in many areas (detail set out in the body of the report). DE invited questions In response to SBe's point KT advised we would work through quarter two. Will would also be explicit on the thresholds for achievement so we could be clear on where we had not achieved and detail what needed to be done. It was noted that that quarter two report and thresholds would be discussed at the next Finance and Investment Committee. **RECEIVE** **The Board RECEIVED the report**	
126/23	**Finance Report** RC presented the Month 5 report noting this was the same report which had been discussed at the recent Finance and Investment Committee and the Private Board. Key points drawn out of the report for the Board's	

	attention were: The Trust was facing a deficit of £2.9 million at the end of month five, which was £1.9 million worse than planned. The key drivers of this financial position were overspending on secondary commissioned beds and agency expenses which were above the plan. The Trust was reporting delivering forecast year end deficit plan of £1.8 million but acknowledged the possibility this could increase to £6.4 million. Month five had seen some improvement with out of area placements and a reduction in the spend run rate but there had been an increase in the run rate for continuing healthcare. An additional £600k was accounted for in month 5 in miscellaneous income associated with an early drawdown of the £1.8m ICB funding that was in the financial plan for month 12. In the wider system all Chief Finance officers were working together to review the unsatisfactory £6.5 million deficit with action to improve this position, working alongside the Finance and Investment Committee. RC referenced slide four of the deck which set out the Trusts key drivers of the 2023/24 financial position. The Mental Health Crisis Business Case would deliver some benefit, along with operational control and the specific areas the Financial Recovery and Delivering Value group were focusing on. RC concluded stating the key message for the Board was the need to remain focused on doing all we could to improve the financial position. KT reported that the Trust was looking at the growth in workforce numbers since 2019 to understand how these roles were working within transformation programmes and how they addressed and identified safety concerns. KT reported this would be considered by the Exec team. **RECEIVE** **The Board RECEIVED the report**	
	STRATEGY	
127/23	**Belonging and Inclusion Strategy** JH introduced the Belonging and Inclusion Strategy taking the report as read and set out the below key points of note. The Strategy had three clear commitments as part of our People Priority: • embedding our inclusive culture • building a diverse workforce • eliminating any form of discrimination. The Strategy would continue to embed the Trust inclusive culture, with compassionate and caring teams and eliminate any form of discrimination. The Strategy, when approved, would be launched in October 2023 KT thanked Board members for being fully committed to the co-design and co-production of the Strategy noting we were keen to launch and drive this forward. KT also made acknowledgement to JH for her work on the Strategy.	

	The Board approved the Strategy. **APPROVE** **The Board APPROVED the BI Strategy**	
128/23	**Anti-racism charter** JH presented the paper which set out the UNISON Anti-racism charter. The report was taken as read and the below points highlighted. In addition to the ongoing commitments we had, as a Trust we supported both NHSE and the East of England Anti-Racism strategies. It was proposed that the Trust entered into a new partnership agreement with UNISON. It was noted that the Charter was fully supported by the Trust Joint Consultative Negotiating Committee. The paper proposes the Trust formally sign the UNISON Anti Racism Charter to complement the launch of our Belonging and Inclusion Strategy and provide a proactive statement to all staff as part of Black History Month. Following discussion, it was agreed it would be helpful for there to be an analysis undertaken of how the Trust currently stands compared to the Charter's standards. Detail of the Charter was set out in the main body of the paper. All in attendance provided their support and approval. **APPROVE** **The Board APPROVED the Anti-racism charter**	
129/23	**Sexual Safety charter** JH introduced the paper reporting that in September NHS England published its first ever charter on sexual safety at work. It included ten pledges for organisations to follow to safeguard staff, detail set out in main body of the report. To date 75 organisations had registered their commitment. Board members provided their approval for the Trust to register their commitment. **APPROVE** **The Board APPROVED the Sexual Safety charter**	
GOVERNANCE AND REGULATORY		
130/23	**Audit Committee Report** HE presented the report which set out an overview of the work undertaken by the Audit Committee at its meetings held on 18 July and 5 September 2023. The report was taken as read, and in the interest of time, the below points set out. The Committee had met twice since the last meeting with both meetings quorate. In July the meeting had received a Deep Dive on the Data Security and Protection Toolkit (DSPT).	

	At its September meeting the Committee had received a Deep Dive from the system wide procurement service in place for the Herts and West Essex system. The Committee received the quarter one reports for assurance and approval. The Committee received a report on the implementation of the annual declaration process for key decision-makers within the Trust noting a good level of compliance. HE concluded the update reporting that at their meeting held 5 September 2023 the Trust had welcomed the Trust's new external auditors, Deloitte. **RECEIVE** **The Board RECEIVED the report**	
131/23	**Board Assurance Framework** HE presented the draft Board Assurance Framework (BAF). The Board reviewed the draft BAF and agreed that KT and DA, as Chair of the Audit Committee would meet to review the proposed changes for the Board to consider at the November 2023 meeting **RECEIVE AND DISCUSS** **The Board RECEIVED and DISCUSSED the BAF**	**KT and DA**
132/23	**Fit and Proper Person Test Framework** JH presented the report noting that NHS England had published a new Fit and Proper Persons Test Framework on 2 August 2023 alongside guidance for chairs and staff on its implementation. JH confirmed that Board members had been formally notified that their details would be included in ESR for the purposes of FPPT and the Trust would meet the full implementation deadline of the 31 March 2024. **RECEIVE** **The Board RECEIVED the report**	
133/23	**Nominations and Remuneration Committee Terms of Reference** JH presented the reviewed Nomination and Remuneration Committee (Rem Com) Terms of Reference. At their meeting on the 19 September 2023, two changes were proposed and accepted by the Nominations and Remuneration Committee to the Terms of Reference (Section 4.2 and Section 8.1) – detail set out in the body of the report. The changes were approved by the Nominations and Remuneration Committee with recommendation for Board approval. All in attendance provided their approval. **APPROVE** **The Board APPROVED the Terms of Reference**	

134/23	**Any Other Business** KT noted that following the NHS Pay Review Body and Department of Health recommending a pay award of 5.5% for all VSMs for 2023/4, the Trusts Nomination and Remuneration Committee had met and approved that all Trust VSM salaries should be uplifted by 5.5%. No further business was put forward.	
135/23	**Questions from the Public** No questions were put forward.	
Date of Next PUBLIC Meeting Thursday 2 November 2023		

Close of Meeting

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors 2 November 2023

MATTERS ARISING SCHEDULE

Matters Arising from meeting held on: 5 October 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
120/23	**People Report**	**JH**	Update to IGC on the new approaches to Recruitment & Retention	November 2023	
122/23	**PSIRP**	**JV**	Review implementation of PSIRP	March 2024	
131/23	**Board Assurance Framework**	**HE**	Review the scoring of BAF Strategic Risks and amend for Board to review	November 2023	
Matters Arising from meeting held on: 6 July 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
093/23	**CQC Inspection Update Report**	**JV**	Board to receive via IGC formal update on progress against SIAPs for Oak Ward and Warren Court	Nov 2023 New date Jan 2024	
Matters Arising from meeting held on: 25 May 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
068/23	**Freedom to Speak Up**	**HE/JV**	Consider timing to complete Board Freedom to Speak Up Reflection tool	October 2023	
Matters Arising from meeting held on: 2 February 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**

as One

Our Values
Welcoming Kind Positive Respectful Professional

007/23	**Chairs Report**	**SBr**	Schedule Board discussion regarding Learning Disability service and future model	To be confirmed	

Hertfordshire Partnership University NHS Foundation Trust

Report to the PUBLIC Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 5
Subject:	CEO Briefing	
Presented by:	Karen Taylor, Chief Executive Officer	

National update

The national activity is summarised below:

Events in the Middle East

Recent events in Israel, Gaza and across the Middle East have escalated into the humanitarian crisis being reported through news and social media channels. With many thousands of innocent civilians in the region being affected, including British citizens, with the impact reaching across the world. We are very conscious that these events will impact on our staff, service users and communities.

Trust communication with staff has focused on the importance of continuing to support each other with kindness and respect, irrespective of politics or religion, recognising that many of our staff and service users are personally affected. Needless to say, as a Trust we look after the most vulnerable people in the community from all religious and cultural backgrounds and our collective focus has to be to improve their health and wellbeing whilst treating them with utmost respect and professionalism.

Industrial Action

It has been reported that the Department of Health and Social Care and the British Medical Association (BMA) are holding talks regarding future industrial action by consultants. Detail of the discussions are not known but this is positive step forward, and the British Medical Association have said that they will not call any more strikes until November to allow time for talks. There are currently no plans for the British Medical Association and the Government to enter into discussions regarding the junior doctor's industrial action.

CQC – State of Care 2022/23

The Care Quality Commission have published the State of Care report State of Care 2022/23 - Care Quality Commission (cqc.org.uk) which is their annual assessment of health care and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve.

The report highlights the impact that ongoing challenges in health and social care are having on the quality and safety of care and on patient and user access to services. The CCQ report that the persistent problem of a system in "gridlock" has been compounded by the cost-of-living crisis, industrial action and escalating workforce pressures. It draws attention to the link between these challenges and the impact on fair and equitable care, whereby those who can afford it are paying for private sector care, while those who cannot, face longer waits and reduced access.

The report explores issues around access to care, quality of care, inequalities in health and care, and Deprivation of Liberty Safeguards. It also focuses on the wellbeing and satisfaction of health and care staff and considers the opportunities presented by integrated care systems (ICSs). The CQC's report acknowledges the efforts of health and care staff and leaders and draws the important link between operational challenges and deepening health inequalities.

With regard to mental health the reports, they state that access to care and the quality of the care remain a key area of concern. They report that the unavailability of community care continues to put pressure on mental health inpatient services, with many services struggling to provide a bed. In turn, this is leading to people being cared for in inappropriate environments. The lack of mental health beds means that people are then facing lengthy waits in an emergency department while they wait for a mental health bed to become available.

The report details that when people do get a bed in a mental health hospital, the quality of care is still not good enough, with areas of concern including the use of dormitories and mixed sex wards. Using their risk-based approach to inspection, their ratings data shows a slight decrease in the proportion of providers rated as good. At a key question level, the safety of services continues to be an area of concern, with 40% rated as requires improvement or inadequate. The report also sets out that recruitment and retention of staff remains one of the biggest challenges for mental health services, with the use of bank and agency staff higher than ever. The Trust is reviewing the report to identify areas of learning and best practice.

National Performance Publication

The latest monthly statistics on NHS performance were published in October. They give an indication of how hard staff across the NHS are working to respond to record breaking levels of demand for urgent and emergency care, despite significant disruption to services from industrial action. Key headlines are that:

- Pressure has continued in emergency departments across the country.
- Industrial action continues to have a significant impact on patients. As of 6 October 2023, a total of 1.1 million appointments had been rescheduled since industrial action began.
- Demand for cancer services continues at record levels in August 2023, with the number of urgent suspected cancer referrals at 125% of pre-pandemic levels. Cancer treatment is also at record levels.
- The NHS continues to expand mental health services to meet rising demand. More people than ever before now receive NHS support for their mental health, with five million patients accessing care in 2022/23, an increase of over one million in five years.

COVID Inquiry

The public hearings for module 2 of the UK Covid-19 Inquiry (the Inquiry) began on 3 October 2023 and will conclude on 14 December 2023. Module 2 is focused on core political and administrative governance and decision-making for the UK. It will examine the initial response, central government decision making, political and civil service performance as well as the effectiveness of relationships with governments in the devolved administrations and local and voluntary sectors. It will also assess decision-making about non-pharmaceutical measures and the factors that contributed to their implementation. The Trust continues to monitor the Inquiry and ensure it is prepared should its input be required.

Integrated Care System Boundary and Merger Procedure

NHS England has published its integrated care system (ICS) boundary changes and mergers procedure. NHSE states that this is to address a gap in the existing policy and guidance for ICSs, although there is expected to be a 'limited' appetite for changes and mergers among ICS leaders.

The document outlines:

- The factors to be considered in any proposed change to ICS boundaries, including the need for consultation and agreement between key partners.
- The application process to be followed, and the need for it to be proportionate to the proposed change.
- Where an application is approved by NHS England, the implementation steps to be followed, including those relating to the amending of Integrated Care Board (ICB) constitutions and preparing for any transfer of staff, property, liabilities, rights and responsibilities.

The process requires that an application should, at a minimum, include 'engagement with the impacted local authorities and other partner organisations within the relevant ICBs, ICPs, plus local MPs and local Healthwatch'.

Attention Deficit Hyperactivity Disorder (ADHD) Medication

The UK is experiencing a shortage in medication prescribed to people with an ADHD diagnosis. The Department for Health and Social Care (DHSC) have reported that "increased global demand and manufacturing issues" are behind the shortages. The Trust is working with the Integrated Care Board (ICB) to ensure there is clear communication with services users and also that work is undertaken to identify appropriate alternative medication.

Guiding Principles for Integrated Care System – Learning Disability and Autism

The Local Government Association and the Association of Directors of Adult Social Services, have been working alongside NHS England to develop a set of guiding principles for integrated care systems NHS England » Joint guiding principles for integrated care systems – learning disability and autism setting out how partners in local systems can work together to improve the lives and outcomes of people with a learning disability and autistic people, of all ages. It is intended that these principles encourage a partnership approach, across health, local government, and wider partners, within local systems.

It is suggested that NHS and local authority partners within every ICS consider how they meet the needs of people with a learning disability and autistic people through their commissioning arrangements and commissioned services – this could be articulated in integrated care strategies and joint forward plans. The Trust will work with system partners to review the principles, noting that there is good practice on which to build with the section 75 arrangement in place with Hertfordshire County Council, HPFT and the Hertfordshire & West Essex Integrated Care Board.

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 Board (ICB)

The Hertfordshire and West Essex Integrated Care System (HWE ICS) had set a goal to achieve financial balance this year. However, both the national NHS and our local system are encountering significant financial challenges. The Trust is working closely with partners to develop clear plans and take action together to address the financial challenges, and we are actively engaged in a series of initiatives.

These initiatives encompass the development of a comprehensive medium-term financial strategy, the refinement of financial allocation methods, the proactive management of deficits, the strategic allocation of funds from the Sustainability and Transformation Fund (SDF), the enhancement of financial reporting mechanisms, and meticulous planning of our capital funding utilisation. Over the past two months, our Trust has dedicated substantial efforts to collaborating with the system in formulating a three-year medium-term financial plan. This plan is currently undergoing review by NHS England and will inform 2024/25 financial planning.

The ICB is also working with partners to develop its future Operating Model, with the ambition to move the four Health Care Partnerships to become Accountable Business Units. The detail on the proposed operating model and the responsibilities of the new unit is being developed.

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

A report from the MHLDA HCP Development Director is on the agenda and of note is the following:

- Discussions are underway with system partners across the Health and Care Partnership to ensure the new Crisis Assessment Centre complements existing provision and to consider what changes might be made to existing pathways and practices to support its delivery, a report later on the agenda will provide further detail.
- The Partnership is piloting NHS England's new Urgent and Emergency Care Mental Health Services Assessment Tool (MEN-SAT). This has highlighted positive practice and approaches, but also how current operational pressures are impacting on pathways and the ability of partner

agencies to support one another. The analysis from NHS England will be considered at a future meeting of the MHLDA HCP's Crisis Care Partnership Board.

- The MHLDA HCP Board meeting on 13 October 2023 was dedicated to the Children and Young People's (CYP) agenda. Alongside updates on the development of the new neurodiversity pathway and Hertfordshire County Council's Making SEND Everyone's Business programme, the HCP Board received an update from its CYP Emotional and Mental Wellbeing Board which highlighted the impact of system work to improve access to Mental Health services, including a 44% increase in accepted referrals and the growth of Early Help access by 54%.

East of England Provider Collaborative

The planned meeting between NHS England and the national team to discuss Perinatal services was deferred until 23 October 2023. Nationally, it is being reported that only three (of thirteen) Perinatal Collaboratives will 'go live' in October 2023. All others are deferred with the East of England designated to go live in April 2024.

The Collaborative has reached out to seek further information from the three collaboratives going live in October 2023 to better understand their approach and the funding model. NHS England has written to the Collaborative setting out the self-assessment process for lead providers for the proposed contract April 2024 – March 2026. This sees the Collaborative needing to submit information regarding finance, quality maturity and governance by 15 December 2023. The Collaborative Support team have begun collating the required information for future Collaborative Executive Committee and Board consideration.

At the end of August, the Provider Collaborative remains in a net surplus position however is below plan year to date. The August financial position is adverse to plan and this is due to further deterioration in the Adult Secure financial position. Lead provider contract values have been increased in month five to reflect increased NHS contract inflator and to fund Independent Sector Provider price increases above inflation.

Trust-wide update

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

Operational update

Services are continuing to experience high levels of demand and complexity, and some service areas continue to have significant levels of vacancies, which together are causing considerable pressure. Such areas have comprehensive plans in place to support, and are being closely monitored. One such area is ADHD (Both adult and CAMHS) and negotiations with commissioners regarding the ongoing high demand for ADHD assessments in both adult and CAMHS services continue to progress, with a business case being pulled together regarding CAMHS provision and work underway to re- look at the adult pathway.

There has been significant improvement in the number of inappropriate beds being used, in part due to the actions being taken as part of the acute pathway transformation, and we have also agreed a contract for the use of ten beds at Baldock Manor which is located in Hertfordshire. The transformation of the acute pathway continues alongside work on 'Plan B' regarding future bed provision.

Crisis Assessment Centre

Internal and stakeholder steering groups have been established to mobilise the development of the Crisis Care Centre. Further work to understand the options to carry out estate refurbishment, whilst providing some level of provision this winter has been carried out. This proposal is being finalised and will be mobilised during November. Recruitment for the core posts is underway.

Transfer of Care to The Avenues

The handover of the first bungalow to The Avenues, the new provider of care within SRS, has taken place very successfully with the feedback from both The Avenues, commissioners and families being very positive.

Right Care Right Person

A system governance structure is being put into place to support the implementation of Right Care Right Person (RCRP) but Hertfordshire Constabulary have indicated via a letter to the Chief Executives of HPFT, WHHT & ENHT that they will no longer be staying with service users on a section 136 beyond an hour following a risk assessment from January onwards. Discussions are taking place with the Chief Constable regarding this. NHS England have asked each system to estimate the resources required to fill this gap, however this is potentially only one aspect of the implications of RCRP.

Enhanced Mental Health Services for Survivors of Sexual Assault

We have been notified that our tender for the provision of Enhanced Mental Health Services for Survivors of Sexual Assault has been successful. This service covers Hertfordshire and West Essex and is due to commence on 1st April 2024 in part alongside a period of co-produced service development with local Voluntary Community Social Enterprises.

Our People

In September, the number of staff we employ increased by 61 FTE and our turnover decreased to 11.1%. However, as expected, due to adding 110 FTE to our establishment and our vacancy rate increased from 11.7% in August to 12.6% in September. Our recruitment pipeline remains healthy, with over 700 FTE in the recruitment pipeline, of whom 247 people are new to the Trust are in the final stages of recruitment.

Our appraisal compliance rate increased from 92% in August to 93.7% in September, due to our new appraisal window and Appraisal App, which launched earlier this year. We are now undertaking a detailed training needs analysis and developing our talent management and succession plans based on our appraisal data. Our mandatory training compliance exceeded our target of 92%, increasing from 92% in August to 92.5% in September. Compliance with the newly rolled out Oliver McGowan eLearning package has now reached 51%.

In October, we also celebrated the contributions of eight staff at our monthly Inspire Awards ceremony. The awards recognise and reward those who consistently demonstrate our values and who have gone above and beyond in their support of both service users and staff. Nominations for our annual staff awards closed in October, with our award ceremony due to take place in November.

Our sickness absence rates remained slightly above our target of 4%, at 4.4% in September. During September, we launched Self-Care September across our sites and virtually to encourage everyone to look after their own wellbeing and make sure everyone feels supported to do so. During October, we have offered all staff access to a health check. We also launched our annual staff vaccination programme and reached out to all staff to offer compassion and support to those affected by international events.

Staff Survey

At the start of October, we launched the NHS annual staff survey. We are supporting and encouraging all our staff to participate, with an ambition to hear from all voices across the Trust so that we can act on feedback and keep making HPFT great, together.

Inclusion & Belonging Activities

We celebrated National Inclusion Week at the end of September, raising awareness of inclusivity across the Trust and taking time out to provide a development session for our senior leadership team. In October, we celebrated Black History Month, ADHD Awareness Month and Speak Up Month. During October, we have come together to hear from inspirational speakers, about individuals journeys and how we can all work together to keep achieving positive change to achieve a culture of belonging and inclusion and where everyone feels safe to speak up so that we can keep achieving great care and great outcomes, together.

Following Board approval of the Belonging and inclusion Strategy and Anti-Racism Charter in October, a formal launch is being scheduled for 21 November, with the University of Hertfordshire, Unison and other partners joining us as we launch the plan and commitments we have made to;

- Embedding our inclusive culture
- Building a diverse workforce

- Eliminating discrimination

Finance 2023/24

The organisation's financial plan for the year anticipated a deficit of £1.8 million. This deficit target is a critical component of the overall financial strategy for achieving breakeven in the Hertfordshire and West Essex Integrated Care System.

As of month 6, the projected deficit was £1.3 million. However, by the end of September (month 6), the Trust's financial deficit will have reached £3.4 million, exceeding the planned deficit by £2.1 million year-to-date.

The primary factor contributing to this position is the continued use of independent sector beds and a reliance on agency staffing in the inpatient areas. If this expenditure trend continues, achieving the Trust's financial plan for 2023/4 may prove to be challenging. The Trust has initiated a cost reduction program and has implemented enhanced financial governance measures, all while maintaining a steadfast commitment to prioritising safety and the quality of care.

Later in the agenda, the Board will receive a comprehensive financial report.

Emergency Preparedness Resilience and Response (EPRR) assessment 2023/24

Following the Trust's self-assessment against the EPRR standards the Trust has participated in the next phase of the assessment process, a 'check and challenge' meeting with the ICB. The meeting explored the Trust's assessment of being fully compliant and considered the evidence to support the self-assessment. A further formal meeting was held with the ICB following which, they confirmed that the Trust was fully compliant with the standards, an improved position from 2022/23.

Development Awards

On 12 October the Trust held our Staff Development Awards ceremony, the first one since Covid. The well attended event celebrated and recognised the academic and professional achievements of over 300 colleagues who have completed formal training and development courses, ranging from post-graduate to apprenticeship qualifications. It is a real credit to the individuals and their teams who have supported them on this development journey.

Karen Taylor
Chief Executive Officer

Hertfordshire Partnership University NHS Foundation Trust

Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 7
Report Title	Report of the Integrated Governance Committee held on 24 October 2023	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Helen Edmondson, Head of Corporate Affairs & Company Secretary	
Approved by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

The Board is asked to receive
To provide the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting on 24 October 2023.

Executive Summary

Report details the work of the Integrated Governance Committee which met on 24 October 2023.

There were no matters for formal escalation to the Board.

The Board is asked to note that the Committee approved the WDES, WRES and gender pay gap actions plans on behalf of the Board.

Recommendations

There were no matters for formal escalation to the Board.

Implications	
Risk and Assurance	IGC is the Committee that is responsible for providing assurance regarding risk management.
Equality, Diversity and Human Rights	The Committee considered the WRES and WDES action plans and staff equality data as part of the people report, noting the areas for improvement.
Quality	IGC is the Committee that is responsible for overseeing quality assurance and the Committee considered the quarter two integrated safety report.
Financial	No financial implications
Service Users and Carer Experience	Committee considered the quarter two experience report, receiving an update on feedback received.

People	Committee considered the quarter two people report, detailing performance against key metrics.
Legal and Regulatory	The Committee received a report on work to ensure compliance with CQC regulations and trust policies. Also recommended actions to improve this position
Digital	Committee noted positive impact of digital and technological solutions
System	The Committee received an update on PCREF and how is based on strong partnership working.
Sustainability	No implications

Strategic Objectives this report supports	**Please tick any that are relevant**
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	✓
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	✓
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	✓

Hertfordshire Partnership University NHS Foundation Trust

Report from Integrated Governance Committee held on 24 October 2023

1. Introduction

1.1 This paper provides the Board with a summarised report highlighting key 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 24 October 2023, in accordance with its terms of reference and was quorate. The meeting was chaired by Diane Herbert, Non-Executive Director.

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

2. Deep Dive

2.1 The Committee received a deep dive presentation into Patient and Carer Race Equality Framework (PCREF) and its links with the Trust's approach to Involvement. The Committee noted that the Trust's approach to involvement was part of a transformation programme, the outcome of which would be co-produced and would be reported back to the Committee in 2024.

2.2 The Committee were updated on the PCREF, which is a comprehensive approach to addressing inequalities in mental health care, and support and treatment for people from ethnically and culturally diverse communities. The presentation took Committee members through the three parts to the PCREF. In response to a question, it was confirmed that the PCREF is a partnership across the NHS, social and voluntary organisations.

2.3 The Committee discussed the data for the Trust which suggests over representation of black Asian minority ethnic (BAME) service users in Section 135, the forensic section and Community Treatment Orders (CTO). The Committee discussed the work underway to improve data quality, noting that internal audit had undertaken an advisory audit to support this work.

2.4 It was reported that, compared to the PCREF national competencies, the Trust is in a good position. Also, that mechanisms that the Trust has to receive and hear service user and carer feedback, are well established and highly effective.

2.5 The Committee discussed the importance of high-quality data. It was reported that the work to improve the quality included communications with clinical teams, to ensure they understand the importance and potential use of the data. Also, that the Trust is working with service users and carers to get their feedback regarding the best ways and times to get the data.

3. Quality

3.1 The Committee considered the quarter two Integrated Safety report, which provided the Committee with an analysis and details of the actions related to service user safety incidents. It was noted that the report has developed the revised format and reflects the five priority themes from its Patient Safety Incident Response Plan (PSIRP). Namely, unexpected or avoidable deaths, self-harm, violence and aggression, inpatient falls and medicines safety.

3.2 The Committee noted the information regarding the report also includes the implemented actions from the previous quarter and those which are in progress.

3.3 It was reported that, of the 17 Serious Incidents reported by the Trust in this period, 16 are being investigated under the Serious Incident Framework, and one as an After Action Review, in line with the Patient Safety Incident Response Framework (PSIRF).

3.4 The Committee noted that the report included the initial findings from the deep dive to examine deaths within 30 days of discharge over the last five years. It was reported that further analysis is underway to determine the split of deaths by those waiting to be seen, those open to services at the time of their deaths, those who die following discharge from service, on the day or within 30 days.

3.5 It was reported that the majority of violence and aggression incidents reported in September occurred in the learning disability and forensic services. The Committee were updated on the actions and improvements underway to reduce the number and severity of incidents, noting an update would be provided at future meetings.

3.6 The continuing high number of self-harm incidents was reported, noting the service areas which accounted for the highest number. The Committee discussed what the level of self-harm was indicating. In response to a question, it was reported that all cases of self-harm or attempted self-harm are recorded and reviewed for learning and to identify a required intervention or a change to the care plan. For example, the Forest House team have been working and supporting the young people, commencing the use of Trauma Informed Approaches, and psychologically led approaches.

3.7 The Committee were updated on the progress with the implementation of the PSIRF, noting that the PSIRP had been approved by the Board at its meeting on 5 October 2023.

3.8 It was reported that the Trust is continuing to implement the work required to transition to the PSIRF, which includes working with the Commissioners to close completed Serious Incidents on the national system.

3.9 The Committee received the quarter one Safeguarding report, which provided a summary of safeguarding adults and children activity. It was reported that safeguarding children activity stabilised during the quarter, with emotional abuse continuing to be the most reported type.

3.10 With regard to safeguarding adults, there has been a gradual increase in activity since 2021, of which physical abuse is the most common category reported, followed by domestic abuse. The Trust has also seen a slow rise in volume coming into the Trust, averaging 120 per month.

3.11 It was noted that whilst there is good compliance across the safeguarding training, there remains a focus on the PREVENT training, following amendments made to the requirements. Considerable improvement have been made with the levels of compliance.

4. Quality – Effectiveness

4.1 The Committee received a detailed presentation on the current position with regard to the actions identified following the internal audit of medicines management in 2022. It was reported that there had been significant and consistent improvement in the implementation of the actions identified in the audit report.

4.2 The report detailed the additional scrutiny, support and challenge and intensive monitoring that both medicines administration and medicine storage temperatures processes had been subject to. The Committee welcomed the sustained improvement and the information that detailed the performance by service line over both quarters one and two. The Committee were assured that the teams in both services and pharmacy were focused on the relevant areas and that the continued focus was creating a sustainable position. The positive impact of implementing ePMA was noted, as this removed many of the people/paper/pen processes.

4.3 The Committee noted that the focus would continue and would be proportionate to the issues raised, and monitoring would be escalated if there was a deterioration in performance. The Committee were updated on the next steps, of targeted challenge and support, full utilisation of digital functionality and implementation of effective remote temperature monitoring system. It was noted that the Committee would receive a further update in March 2024.

4.4 The Committee received the bi-annual Infection Prevention and Control (IPC) report. The report provided an update against the agreed actions within the IPC programme, noting areas of progress and actions prioritised. Key achievements from the first half of this year include no reports of blood stream infections of C-Diff, an improvement in IPC training compliance, and the work focused on updating key guidance on the management of Covid.

4.5 The Committee were updated on the new IPC audit of practice, which supports a better understanding of the focus areas for our services and teams. It was noted that the audit had received positive feedback.

4.6 The Committee noted the Healthcare Associated Infections and outbreaks during the period, noting the reduction in the number of Covid outbreaks.

4.7 Following a question regarding the regarding the Board Assurance Framework (BAF) compliance, more detail will be provided to the Committee regarding areas requires further work to enable full compliance.

5. Quality – Experience

5.1 The Committee considered the quarter two Experience report. It was reported that the figures for compliments and complaints had remained static. Of note was a significant increase in the number of PALS enquiries. It was reported that services were re-looking at how respond to PALS. The main themes from PALs were regarding waiting times, in particular for Attention Deficit Hyperactivity Disorder (ADHD).

5.2 The Committee were updated on the increase in the number of complaints, with the majority of complaints in Child and Adolescent Mental Health Services (CAMHS) east and Adult Community Mental Health Services ACMHS) The CAMHS east service is focusing on communicating with service users and their families about the waiting times. The Committee were updated on the work to improve responsiveness to complaints, using a Continuous Quality Improvement (CQI) approach with both services and the corporate team involved.

5.3 It was reported that the experience platform was transferring to a new provider, which meant that data was not yet available, noting that it would be available for the next report to the Committee. The change of approach to involvement had seen a reduction in involvement activity but an improvement in the type and quality of involvement. Examples were provided of work on adult acute wards with carers, and work with carers to co-produce information, all of which had seen feedback from carers that they feel more included.

5.4 The Committee received the Annual Nutrition report. The report set out a summary of the work undertaken since September last year, relating to nutrition and hydration. The Committee took assurance from the governance and assurance processes in place including the Nutrition and Dysphagia Steering Group, all of which supports compliance with the Care Quality Commission's (CQC) regulation 14. The high level of compliance with the nutrition screening tool was noted and the new tool that had been developed to meet the needs of young people at Forest House.

5.5 The Patient Led Assessment of the Clinical Environment (PLACE) food scores for 2022 were noted. Analysis showed that inconsistent use of electronic ordering led to poorer choices for food, as the full menu was not accessed and issues with sufficient salt content for specific service users. The Committee were updated on the work to encourage use of the electronic system and options for service users who need additional salt.

5.6 The Committee were assured that all reported incidents are reviewed relating to dysphagia and nutrition, this included choking incidents, with learning identified and, where appropriate, clarification of guidance and additional training.

6. Our People

6.1 The Committee considered the month five People and Organisational Development Group (PODG) report. The continued positive progress with recruitment and the impact this was having on the people metrics, was noted. It was reported that, although the vacancy rate had improved, there were hotspots and each of these areas was subject to a deep dive.

6.2 The Committee considered the continued improvement in appraisal and mandatory training rates. The increased staff development was considered, noting that it would be further informed by the detailed training needs analysis, using information from the completed appraisals.

6.3 Committee members asked for details of the Trust's approach to violence and aggression and impact on staff. It was reported that each area impacted by this would be a focus on particular action to better understand the issues and impact and agree actions to support staff.

6.4 The Committee discussed the need to track the time taken to recruit, and it was agreed that future reports would include this data, to support discussions on shortening the time taken and considering how automation and digital options could be utilised.

6.5 The importance of supporting programmes for staff wellbeing was discussed. It was agreed that the Executive team would explore using Charitable funds and work with staff to identify what they want to see in the wellbeing offer.

6.6 The Committee discussed the GMC Training Survey results for 2023. Nationally there were many positives, but the data also points to troubling trends in doctors' training experiences. For trainees, burnout levels are once again on the rise. Across the UK, two thirds are now at high or moderate risk of burnout, the highest level since this was first reported in 2018. Committee members agreed the importance of ensuring the impact of Industrial Action on staff and service users continues to be acknowledged.

6.7 Amongst the East of England mental health Trusts, the Trust's Trainers' responses were among the best for Old Age Psychiatry and Learning Disabilities. There were no negative outliers, suggesting the survey outcome regarding trainers' responses was very good though the number of trainers who did respond was below 50%. For trainees, compared to last year, out of the indicators the Trust has shown improvement in the majority. Those indicators that have improved are in relation to reporting systems, teamwork, handover, and supportive environment. Similarly, teaching educational governance, support around study leave and facilities have shown strong performance. Results are lower than previous years are in relation to clinical supervision: Induction and adequate experience.

6.8 Committee members welcomed the positive results, and it was agreed that there needed to encourage a higher level of participation in the survey.

6.9 The Committee considered the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender pay action plans, noting that responsibility for approval had been delegated to the Committee from the Board. It was reported that the action plans had been developed with involvement of staff.

6.10 The Committee discussed that the WDES, WRES and gender pay gap data identifies a number of areas of good practice and improvement, and that there remain differences in experience, based on protected characteristics. It had been agreed, in the development of the action plans, to focus on two particular areas namely equality in likelihood of appointment and equality in likelihood of entry into the formal disciplinary processes. It was agreed that the Committee would consider quarterly data on WRES and WDES.

6.11 Committee members noted that the Trust as committed to implementing the actions in the Unison Anti-racism Charter by November 2024.

7. Governance

7.1 The Committee received in the work underway to support the Trust being able to demonstrate and evidence the delivery of high-quality care, which will support compliance with CQC regulations.

7.2 The Committee were updated on the CQC's Single Assessment Framework, due to be published and to be rolled out in the south region first, and its focus on five Quality Statements. It was reported that the Trust has been supporting teams to be able to describe and evidence the care provided, with clear structures in place to enable this. Showcases in the service areas have also commenced on a weekly basis for services to describe what they are proud of and of their challenges. A fortnightly meeting with the senior leadership team also reviews progress, with Trust wide areas of improvement and troubleshooting when required.

7.3 It was reported that preparation for a separate well-led inspection is underway, including preparation for interviews, evidence gathering and a communications plan. The Committee were assured that the Executive Team continue to receive updates on the quality of services and preparation for CQC regulatory activity.

7.4 Committee members highlighted the need for the Trust to be able to clearly describe its approach to quality issues in a financially challenging environment. It was agreed that this would be covered in the briefing provided.

7.5 The Committee received a report on the current position with regard to management, oversight and governance of all procedural documents. The Committee discussed the number of policies which were out for review and the need to prioritise their completion and agree a completion schedule for

each one. Committee members also asked that the lead manager consider the review frequency and if it would be beneficial to have a document that details the approach to policy review.

7.6 The Committee considered the bi-annual Caldicott report, which provided a summary of the work undertaken by the Caldicott Guardian. It was reported that the Guardian, had been consulted on a number of issues relating to service user confidentiality and ethics of data use within the Trust, as well as having sight of all information sharing agreements signed by the Trust.

8. Matters for Escalation to the Board

8.1 There were no matters for formal escalation to the Board. It was noted that a number of quarter two reports would be considered by the Board at its' meeting on 2 November.

8.2 The Board is asked to note that the Committee approved the WDES, WRES and gender pay gap actions plans on behalf of the Board.

Appendix One: Integrated Governance 24 October 2023, agenda items

SUBJECT
Welcome and opening meeting
Apologies for absence
Declarations of Interests
Minutes and matters arising
Minutes of meetings held on 27 July 2023
Action Schedule
DEEP DIVE
Deep Dive: Approach to Involvement and PCREF
QUALITY SAFETY
Quarter Two: Integrated Safety Report
Patient Safety Incident Response Framework
Quarter One: Safeguarding Report
QUALITY EFFECTIVENESS
Medicines Management Internal Audit Actions Update
Bi -Annual Infection Control Report
QUALITY EXPERIENCE
Quarter Two: Experience of Care Report
Annual Nutrition Report 2022/23
Quarter Two: Safe Staffing Report 2022/23
PEOPLE
Month 5 People and OD Report
GMC Training Survey 2023 Report
WRES/WDES Data
GOVERNANCE AND REGULATION
CQC Preparation
Q2 Procedural Document Report
Bi-Annual Caldicott Report
TO NOTE
Quality Account: Priorities for Quality Improvement 2023/24
Q1 Information Governance Incidents/SARS/FOI
Report from PODG August and September 2023
Report from QRMG August 2023
Report from IMGS September 2023
Committee Planner
Any Other Business
Matters for escalation
Date and time of next meeting: 16 November 2023 at 13:30-16:00 at The Colonnades

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 7a
Report Title	Quarter Two Integrated Safety Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Priscilla Chikwanha – Interim Head of Safety Mandy Stevens – Interim Head of Patient Safety	
Approved by:	Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse)	

The Board is asked to
The Board is asked to receive and consider the report, which is the Integrated Safety Report for quarter 2 2023/24, presented to the Integrated Governance Committee on 24 October 2023, for scrutiny and discussion of key issues related to patient safety in the Trust.

Executive Summary
This paper provides the Board of Directors with the Quarter two 2023/24. It provides an analysis and actions related to patient (service user) safety incidents. Of note in this report are the following areas: The Trust reported 17 Serious Incidents: • nine unexpected or avoidable deaths • six apparent, actual or suspected self-inflicted harm • one slip, trip or fall • one sub-optimal care of deteriorating patient. 16 of the Serious Incidents are being investigated under the Serious Incident Framework. The other is having an After-Action Review in line with the new Patient Safety Incident Response Framework. All Serious Incidents in the Trust are within agreed timescales and deadlines. In line with the Trust's draft Patient Safety Investigation Response Plan, this report details updates on the five priority areas identified for focused areas of improvement: unexpected deaths, self-harm, violence and aggression, inpatient falls and medicines safety. This report details the data, themes, actions and improvement plans for these priority areas. The Trust is continuing the work required to fully transition to the Patient Safety Incident Response Framework from 1 October 2023, with oversight from the Executive Director, Quality and Safety (Chief Nurse), the Safer Care Team and an implementation group. As part of the transition, work has been undertaken with Trust commissioners to close completed Serious Incidents on the national system. The report details the actions that have already been implemented from the previous quarter and those in progress, as an outcome of the learning and analysis of the safety incidents and data.

Recommendations
The Board is asked to note the key themes and actions.

Implications	
Risk and Assurance	Risk regarding quality of care is included in the Trust BAF and the Trust risk register. This report describes actions put in place to reduce the risk of further incidents.
Equality, Diversity and Human Rights	There are not specific implications in relation to equality and diversity.
Quality	Risk regarding quality of care is included in the Trust BAF and the Trust risk register. This report describes

	actions put in place or in progress to reduce and mitigate risk following incidents and the continuation of the provision of high-quality care.
Financial	There are no current financial implications
Service Users and Carer Experience	Ensuring service user and carer safety is a key focus to providing a quality experience.
People	The wellbeing of our staff is a key focus to support learning, development and a positive experience.
Legal and Regulatory	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12.
Digital	There are no specific digital implications.
System	There are no specific system implications, but the ICB is aware of the data, analysis, learning and actions relating to safety.
Sustainability	There are no specific sustainability implications.

Strategic Objectives this report supports	**Please tick any that are relevant** ✓
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	✓
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	✓
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	✓
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	✓

Integrated Safety Report - Quarter Two 2023/4
October 2023

1. Introduction

1.1 This Integrated Safety Report for quarter 2 2023/24 was presented to the Integrated Governance Committee on 24 October 2023, for scrutiny and discussion of key issues related to patient (service user) safety in the Trust.

1.2 The incoming Patient Safety Incident Response Framework (PSIRF) is being introduced to the Trust; this report is now aligned to this new framework. However, the incidents and events reported in this period all fell under the previous Serious Incident Framework. Under direction of the Executive Director, Quality and Safety (Chief Nurse), the Safer Care Team will work to ensure a smooth transition of all current Serious Incidents (SI) to completion, whilst new incidents will be managed through the new framework. Both of these will be reported through the Safety Committee, and monitored by the PSIRF Implementation Group, until all historical incidents are completed and closed.

1.3 This report reviews and analyses the incidents in the Trust from quarter 2. This includes reviewing safety incidents, identifying themes, contributory factors and overview of the quality improvement plans and action to address the issues identified.

1.4 The Trust has developed a draft Patient Safety Incident Response Plan (PSIRP), which has been ratified by the Trust Board. The PSIRP includes the Trust's patient safety incident priorities, which have been identified by the Trust and key stakeholders following analysis of the Trust's incident profile. The five priority areas are: unexpected deaths, self-harm, violence and aggression, inpatient falls and medicines safety. These priority areas are scrutinised in detail in this report.

1.5 Improvements and actions already implemented and those in progress are included following from the quarter one report, as an outcome of the learning and the analysis of the data.

2. Serious Incidents

2.1 The Trust reported 17 SIs in this period; this data is shown in *Table 1* with the data from the previous two quarters for information.

Table 1

Category of serious incident	Q4 22/23	Q1 22/23	Q2 23/24
Unexpected or avoidable deaths	11	10	9
Apparent, actual or suspected self-inflicted harm	4	3	6
Disruptive, aggressive or violent behaviour	1	1	0
Slip, trip or fall	2	3	1
Sub-optimal care of deteriorating patient	2	3	1
Incident threatening organisation's ability to continue to deliver an acceptable quality of healthcare services	1	0	0
Unexpected/potentially avoidable injury causing serious harm	2	0	0
Apparent, actual or suspected homicide	0	0	0
TOTAL	**23**	**20**	**17**

2.2 *Table 2* shows the categories of SIs aligned to the clinical areas they were reported from.

Table 2

Serious Incident Category	Clinical Area
Unexpected death (9)	2 Older adult community 3 Adult community 1 PATH service (Early Intervention) 1 Mental Health Liaison Team 1 Single Point of Access 1 CAMHS community
Self-harm (6)	2 Adult inpatient 2 Adult community 1 Acute and crisis 1 Learning disability community
Inpatient fall (1)	1 Older adult inpatient
Suboptimal care of deteriorating patient (1)	1 Learning disability inpatient

2.3 From quarter 2, 16 SIs are currently being investigated under the SI framework in line with Trust policy. The other SI, which is related to self-harm, provides an opportunity for wider system learning. With agreement from the Integrated Care Board (ICB), the Trust is doing an After Action Review (AAR) under PSIRF for this SI.

2.4 Unexpected or avoidable deaths (nine) and apparent, actual or suspected self-harm (six) continue to be the top reported SI categories. Both these incident types are identified in the Trust's draft PSIRP priority areas for focused safety improvement work over the next twelve months.

2.5 Where immediate learning is identified, actions are taken prior to the SI review being completed. The Trust consistently completes SI reviews within the agreed timeframe in order to facilitate timely learning and improvement. At close of this quarter, there were no SIs outside of timeframe.

2.6 In line with the Trust's transition to PSIRF, from quarter 3 the term SI from the old SI framework will be replaced by the new term Patient Safety Incident (PSI) as defined by PSIRF.

3. Trust's five priority safety themes

3.1 The Trust's agreed five priority themes from its draft PSIRP are discussed in the following sections:

- Unexpected or avoidable deaths
- Self-harm
- Violence and aggression
- Inpatient falls
- Medicines safety.

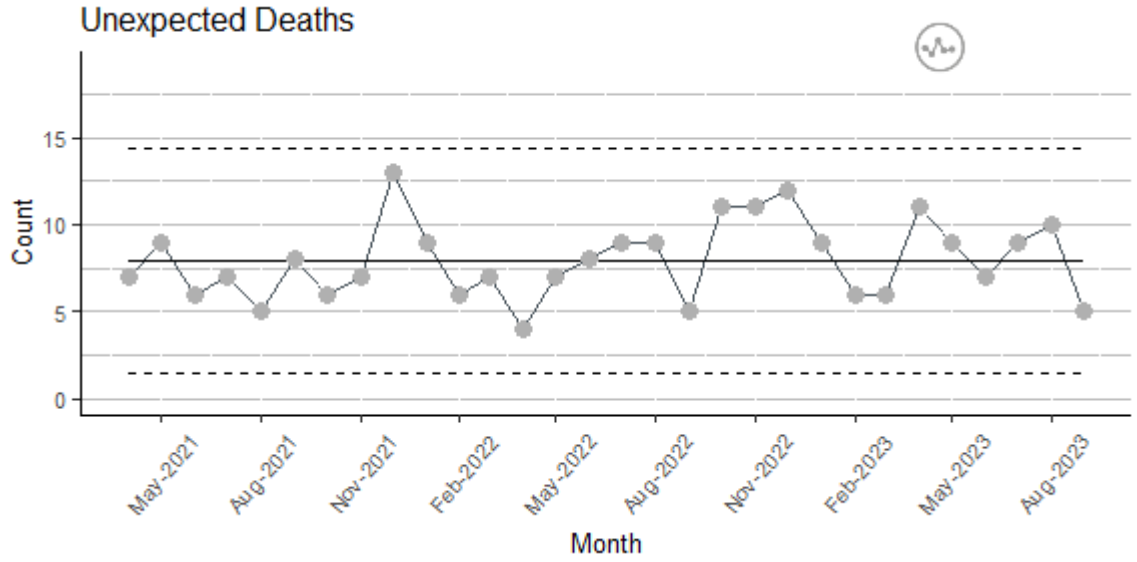
Each priority theme will be aligned to Continuous Quality Improvement (CQI) improvement projects over the next twelve months.

Unexpected or avoidable deaths

3.2 In quarter 2, there were 214 deaths reported on Datix, the Trust's incident reporting system. 24 deaths were categorised on Datix, at the time of reporting, as unexpected deaths, shown in *Figure 1* below. Nine of these 24 reported unexpected deaths were declared as SIs.

The other 15 unexpected deaths had a fact find report presented at the weekly Moderate Harm Review Panel (the panel); the panel agreed that these deaths did not meet the specific SI criteria.

Figure 1



3.3 The Trust monitor and discuss themes at the panel, the decision-making panel for SIs. The Safer Care team records learning themes on Datix and shares these with the Strategic Business Units (SBU) and with other forums. The SBUs report their themes, and actions taken in response, into the Safety Committee

3.4 Areas of action currently underway to support the reduction of unexpected deaths include:

- A Swarm huddle is undertaken following most unexpected deaths, and any additional learning is identified and shared at the Quality and Risk Meeting (QRM) held by each SBU
- Simulation training related to suicide risk has been co-produced. This is delivered to clinical staff and to multi-agency partners
- The Trust is engaged with Hertfordshire Public Health on their suicide prevention strategy. Representatives from the Trust are involved in several different workstreams
- The Trust is leading work on developing a suicide prevention pathway with system partners that is aligned to the Hertfordshire Suicide Prevention Strategy.

3.5 Following the local thematic analysis, there has been an increase in unexpected deaths related to people with mental health problems and substance misuse. A project is being led by the Planned Care SBU's Managing Director, involving embedding a Change, Grow Live (CGL) worker from the drug and alcohol service substance in the Adult Community Mental Health Services (ACMHS). This is in order to better support people with dual diagnosis who are at high risk. The go live date will be planned before December 2023.

3.6 Four ACMHS teams have been identified for the pilot, based on demographic and caseload reviews, focusing on individuals with severe mental illness and substance misuse. The project team comprises of clinical and operational leaders from both CGL and the Trust, a member of the Research Team, and representatives with lived experience. Updates will follow as the project progresses.

3.7 **Learning from Deaths**

The Learning from Deaths (LfD) group, meets bimonthly since being re-established in June 2022 following a pause during the pandemic. It is chaired by the Deputy Director, Nursing and Partnerships, with oversight from the Executive Director, Quality and Medical Leadership. The LfD group ensure due diligence in death reviews and monitor learning from

Structured Judgement Reviews (SJR). This group reports to the IGC and quarterly to the Board of Directors.

3.8 Owing to recent high profile and national media events, including the Countess of Chester incidents, there is increased media and regulatory scrutiny into mortality governance. In order to assure services in relation to this, the Trust is undertaking a deep dive to examine deaths within 30 days of discharge over the last five years. This is underway and further resource have been allocated to allow swift completion.

3.9 Initial findings from this deep dive show that, over the last five years (01/01/2018 to 02/08/2023), there have been 3,525 deaths of service users whilst open to Trust services or within 30 days of discharge from the Trust, shown in *table 3*. The data has been split by inpatient and community.

Table 3

	Number of deaths of service users during treatment or within 30 days of discharge	
	Previous 68 months up to August 2023 01/01/2018 to 02/08/2023	Previous 12 months up to end July 2023 01/08/2022 to 31/07/2023
Inpatient services	144	24
Community services	3,381	539
Total deaths	3,525	563

3.10 Analysis is underway to determine the split of deaths by those waiting to be seen, those open to services at the time of their death, those who die following discharge from service, on the day or within 30 days of discharge.

3.11 For the last year, the in-patient deaths have been reviewed in more detail; 19 (79%) of these deaths occurred in older adult services, three in adult in-patients, and two in Specialist Residential Services (SRS).

3.12 All deaths of service users during treatment or within 30 days of discharge over the past year have now been reported on Datix, reviewed by the Safer Care Team and Mortality Governance, and screened for SJRs. 86 deaths were eligible for SJR, 40 of these are complete. There is a backlog of 43 SJRs that occurred between January and September 2023; the Executive team has approved funding to clear this backlog and to increase capacity within the Mortality Governance team.

3.13 The Deep dive into learning from deaths will update in the next quarter and aims to complete by end of quarter 4 2023/24.

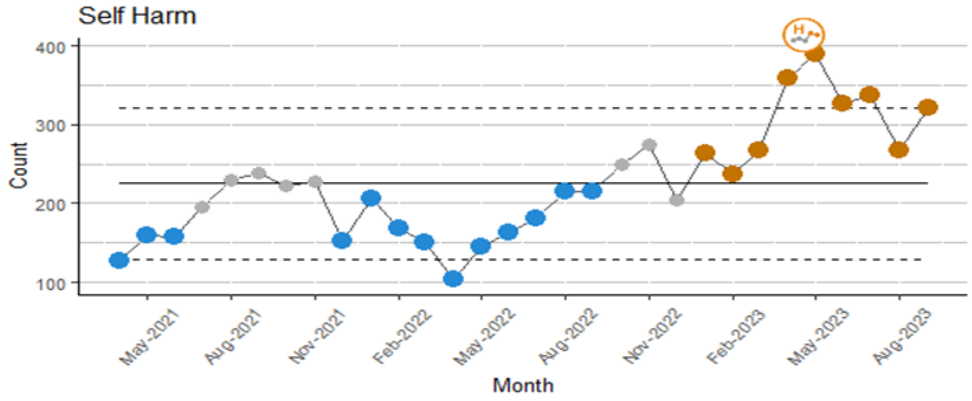
3.14 Quality improvements and actions in this quarter, resulting from previous SJRs, include:

- Request for medical teams to complete a discharge summary for each Trust in-patient who dies during an in-patient episode
- Notification on EPR to prompt qualified staff to countersign student nurse entries
- Working group to review National Early Warning Score (NEWS2) electronic data collection
- Mortality Governance team delivered ST doctor training
- Medical related learning taken to the MSC by the Executive Director, Quality and Medical Leadership

- Improved awareness of completing Datix death notifications particularly by administrative staff
- Referrals to the Medical Examiner of inpatient deaths.

3.15 **Self-harm**
Overall, 876 incidents of self-harm were reported in this quarter as detailed in *figure 2*. The data shows a step change increase in reporting, with nine data points above the mid-line.

Figure 2



3.16 Analysis of self-harm incidents revealed that Forest House accounted for the highest number of incidents, followed by Albany Lodge, and the two main types of self-harm on the inpatient service areas were headbanging and ligatures, shown in *table 4* below.

3.17 Further analysis shows that high number of incidents relate to a small number of service users in the inpatient services. For example, at Forest House, 68 of the incidents involved one young person and 85 of the reported incidents involved three other young people. 70 of the incidents involved three individuals at Albany lodge.
357 of the reported incidents involved headbanging, of which 238 involved young people at Forest House and 52 involved individuals at Albany Lodge.

Table 4

	July Head banging	July Ligatures	Aug Head banging	Aug Ligatures	Sept Head banging	Sept Ligatures	Totals
Forest House	76	110	56	49	106	30	427
Albany	17	31	14	35	21	19	137
	93	141	70	84	127	49	(564)

3.18 The Clinical Director for the Unplanned Care SBU has been leading the clinical team at Albany Lodge with taking a positive risk approach to the prescription of safe and supportive observations (SASO) on an individual basis. Early analysis indicates that whilst there has been an increase in reported self-harm incidents, these have been of low harm. This analysis and monitoring to ensure the service provides safe and quality care, whilst meeting individual's needs.

3.19 All incidents continue to be reviewed daily within the multi-disciplinary team (MDT), informing both risk assessment and acre plan reviews, and ensuring that individuals receive the appropriate support to meet their needs whilst displaying behaviours which are complex and challenging.

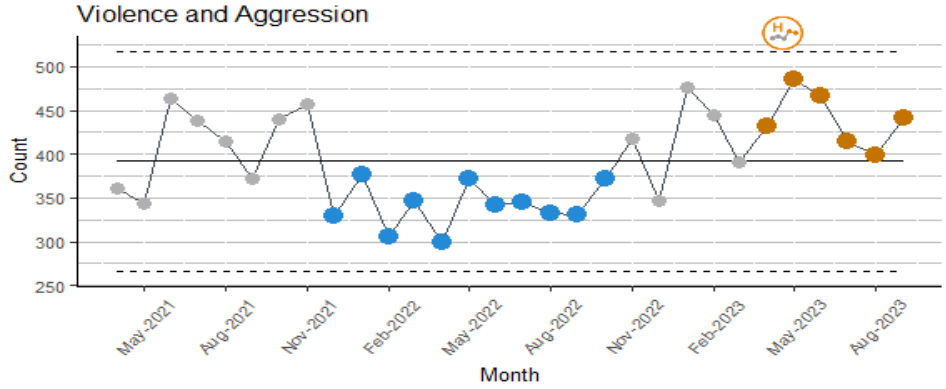
3.20 A monthly Clinical Oversight Group has been established, chaired by the Chief Nursing Officer, for the SBU clinicians to discuss individual service users with highly complex needs with a group of senior multi-professional clinicians, aiming to offer guidance and support.

3.21 The Deputy Director, Nursing, and Quality is setting up a CQI project on self-harm, this will be with patient safety partners, including representatives from children and young people's services and learning disability services.

3.22 **Violence and aggression**

Figure 3 shows the data regarding reported incidents related to violence and aggression. In order to more accurately reflect the levels of acuity across the Trust, this data now includes all episodes of violence and aggression, not just physical assaults.

Figure 3



3.23 Analysis of this data shows that 91% of the incidents in September 2023 occurred in assessment and treatment units and forensic wards.

3.24 Actions and improvements underway in the five areas with the highest number of reported incidents are detailed in *table 5.*

Table 5

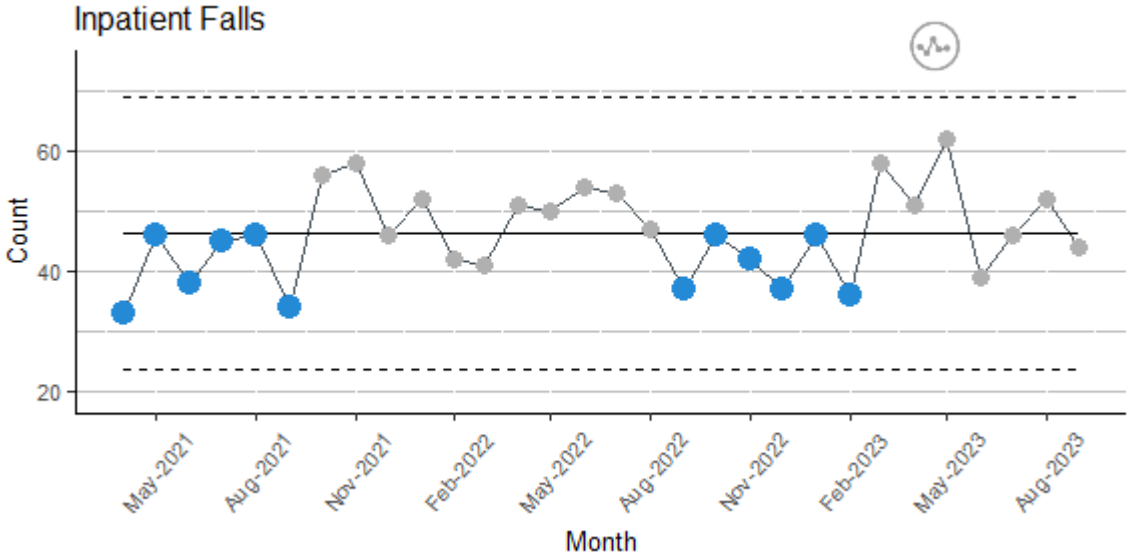
Dove Ward	There has been an increase in the number of reported incidents on Dove ward from 3.4 to 7.3 per bed, with seven individuals admitted to the ward no longer receiving active treatment and are delayed transfers of care. The LD&F SBU senior leadership and local management teams are providing increased support for Dove ward.
Hathor ward	Ongoing high acuity on Hathor, the assessment ward. A CQI approach to address racial abuse, education and support is being implemented. Individual care planning for service users with sexualised behaviour, which has been especially notable in the Broadland Clinic, is ongoing, with the implementation of health relationship education sessions and co-produced Positive Behavioural Support (PBS) Plans.
Lexden	Lexden are conducting monthly Continuing Professional Development (CPD) sessions and receiving support from a behavioural analysis.
Lambourne Grove	CQI project underway in terms of managing violence and aggression.
Forest House	CQI project underway in terms of managing violence and aggression

3.25 The Deputy Director, Nursing and Quality is leading a CQI project on violence and aggression which reports into the Safety Committee.

3.26 The Police Liaison and Security Committee with representation from Hertfordshire police and the Trust including the Local Security Management Specialist (LSMS). Ongoing projects includes working together to support prosecutions for crime in mental health settings, such as patient on staff assaults.

3.27 **Inpatient Falls**
In quarter 2, there were 137 inpatient falls, shown in *figure 4,* with the highest number being at Lambourne Grove (24), Seward Lodge (22) and Victoria Court (20), all three wards being for older adults. Two moderate harm incidents were reported on Wren ward and on Logandene, both also being wards for older adults.

Figure 4



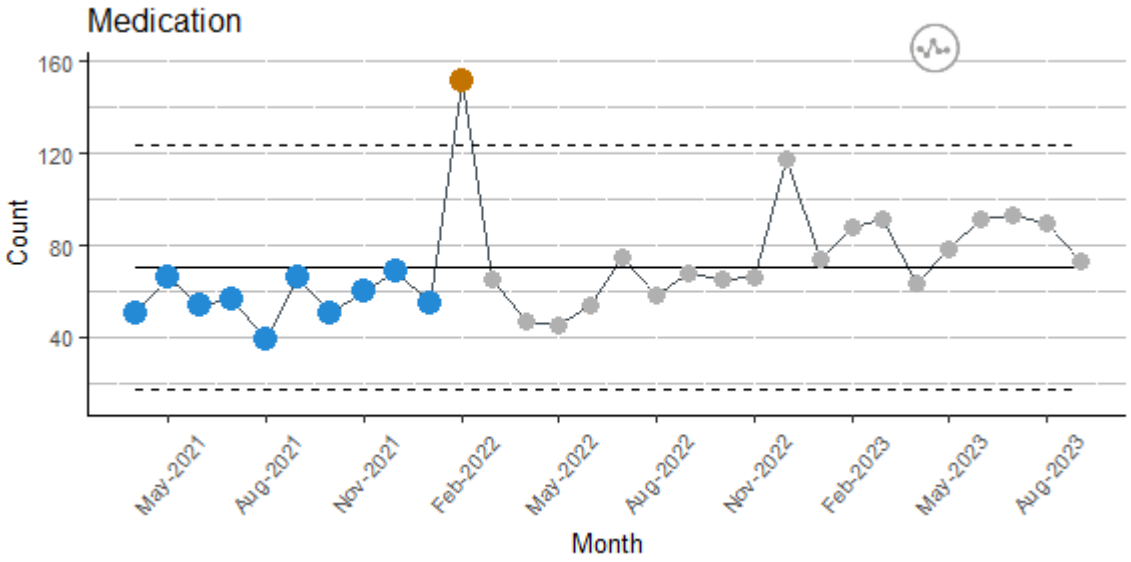
3.28 Review of these incidents indicate that 126 of the inpatient falls reported followed the falls protocol. Learning from the 11 inpatient falls where the falls protocol was not followed have included Falls simulation training, and physiotherapy supporting with the Falls protocol.

3.29 The monitoring of all falls data is overseen by the East and North SBU, reporting into the Falls Committee for increased scrutiny and learning. The use of simulation training and scenario development from this learning has commenced in the East and North SBU. The Senior Leadership for this SBU are also leading on a deep dive into falls for the Trust which should be reported in the quarter 3 report.

3.30 The quarter 1 report noted three SIs where service users in older aged adult inpatient services sustained a fall resulting in fractures. Learning and improvement actions resulting from analysis of these incidents include ensuring all service users have a physical health examination on admission. This examination is to include the use of soft measures, signs and symptoms observed or discussed, and improved recording.

3.31 **Medicines Safety**
In quarter 2, incidents related to medicines safety are shown in *figure 5*.

Figure 5



3.32 The Trust's Drug and Therapeutics Committee (DTC) is responsible for monitoring medicines safety. The DTC utilises its review of incident reports as part of its safety surveillance and notes that medicines-related reporting remains strong, indicating good staff engagement as part of an open culture, contributing to the identification of the themes and improvement actions listed below.

3.33 Audits, inspections and incident reports have highlighted priority areas, with two main themes and areas of focussed action (see *Appendix 1* for full details):

Controls over high-risk medicines

- Clozapine: monitoring and control of side-effects
- Lithium: safe prescribing and monitoring
- Valproate: safe annual assessment
- Rapid Tranquilisation: safe and appropriate use.

Controls over routine medicines-related documentation.

- Incomplete documentation of medicines administration
- Incomplete temperature logging and escalation
- Controlled Drugs record keeping.

3.34 The above priority areas for medicines safety have been articulated in the DTC's Risk Register with each having a CQI in place.

4. Patient Safety Incident Response Framework

4.1 PSIRF is a key part of the National Patient Safety Strategy, outlining how providers should respond to service user (patient) safety incidents for the purpose of learning and improvement.

4.2 The framework focuses on how patient safety incidents happen and, using a systems thinking approach, enables effective learning and improvement. It builds on how the Trust already responds to patient safety incidents, replacing the current status SI framework and supports the development and maintenance of an effective patient safety incident response system.

4.3 The Trust's Patient Safety Incident Response Plan (PSIRP) was approved by the Board in October 2023. This sets out how the Trust will implement PSIRF and learn from patient safety incidents, reported by staff, service users, families and carers, building on the work already in place to continually improve the quality and safety of the care provided.

4.4 The PSIRP was sent to the Integrated Care Board (ICB) for approval; feedback was received on 18 October 2023 and will be reviewed and incorporated in order to finalise the PSIRP.

4.5 The Executive Director, Quality and Safety (Chief Nurse) and Executive Director, Quality and Medical Leadership are co-chairing a working group held three times each week to ensure that there is coordinated actions throughout the Trust to deliver PSIRF.

4.6 Work has continued in this quarter to prepare for transition from the Serious Incident Framework to PSIRF from 1 October 2023, working with the ICB to provide the necessary assurance for closing completed SIs on the national Strategic Executive Information System (StEIS), through regular meetings between the Trust and the Integrated Care Board.

5. Areas of Focus/Other Actions

5.1 This section outlines other areas of focus and identified actions taken or being taken, in line with the Making Our Services Safe Together (MOSStogether) Strategy and learning from this quarter.

5.2 **Trauma Informed Approach and Behavioural Support Plans**

The Trauma-Informed Approach (TIA) has been systematically implemented throughout the inpatient wards in the Unplanned Care SBU, with full integration achieved in Robin ward for over a year. The other wards are progressively incorporating TIA with encouraging outcomes, which are yet to be fully analysed.

5.3 Commitment to TIA has involved the establishment of agreed-upon individual goals, discussed at safety huddles, coupled with comprehensive training for Health Care Support Workers (HCSWs), who have been allocated half a shift each week to support this initiative. A designated folder on the wards serves as a repository for all discussions and the PBS plans.

5.4 The MDT approach and case formulation has led to a substantial reduction in incidents of violence, aggression, and self-harm reported incidents. Ongoing training and reflective practice, to provide support to both staff and service users is provided, ultimately resulting in reduced trauma for individuals and fewer reported incidents involving staff. An in-depth review of the impact of TIA will be shared in the quarter 4 2023/24 report.

5.5 **Positive Risk-Taking**

Albany Lodge continues to employ positive risk taking with service users and has seen an overall reduction in the use of SASO prescribed over time, with an average of two individuals prescribed 1:1, compared to a previous average of nine at any one given time.

5.6 Led by the Clinical Director for the Unplanned Care SBU, and as part of this positive risk taking, the clinical team anticipate an ongoing high level of incidents of self-harming behaviour reported and with expectation of a reduction when the approach is embedded. The clinical team continue to closely monitor all incidents on an individual basis, ensuring that each response is proportionate and in line with the Trust's MOSSTogether Strategy.

5.7 Post incident actions continue to be consistently taken, including:

- Neuro observations, including regular review from the MDT
- Weekly physical health reviews held by the medical staff
- PBS and individual care plans for all individuals, regularly reviewed by the MDT.

5.8 **Respect Training team support**

In response to the learning identified in the last quarter report, regarding prohibited items, search training has been delivered to a number of the inpatient services across the SBUs, including Swift ward and Forest House, with a Train the Trainer course being delivered for all SBUs in quarter 3.

Whilst continuing to respond to individual training requests in some service areas, the team have also provided support, training and guidance in consideration of the level of complexity

and behaviours which are challenging in a number of service areas. During the quarter, this has been focused at Forest House, Oak, Swift and Dove wards, and Albany Lodge, supporting individuals and ensuring the least restrictive approaches.

5.9 The use of restrictive practice, particularly the use of seclusion and individuals cared for under the Long-Term Segregation (LTS) framework, continues to be monitored by the on a weekly basis, reporting to the SBUs and the Restrictive Practice Committee.

5.10 **NHS England adult inpatient guidance**
The culture of care standards for mental health inpatient services has now been drafted and is to be presented to the national oversight group on 30 October for approval. The co-produced standards have 12 core commitments developed and applicable to all mental health inpatient services, including for people with a learning disability and Autistic people. They will serve as the building blocks for supporting all providers to realise the culture of care within inpatient services which everyone wants to experience.

5.11 NHS England's programme offer to the Trust, and other organisations, to support the implementation of the standards includes executive leadership support, cross organisation quality improvement, move away from risk stratification, Team Leader (ward manager) development programme, support for staff and quality improvement for wards. Once approved, more detailed information for implementation will be provided.

6. Conclusion

6.1 The Integrated Safety Report for quarter 2 2023/24 provides an analysis of safety related incidents, identifying themes, contributory factors, and an overview of the plans to address the issues identified.

6.2 The report contains data, analysis and actions related to the five identified priority areas for PSIRF.

6.3 The Trust is ensuring careful transition to the new framework, ensuring that all current incidents and investigations are completed.

7. Recommendations

7.1 The Board is asked to note the report, the key themes and actions.

Appendix 1: Medicines Safety: Areas of focused improvement

High Risk Medicines

1. Clozapine: monitoring and control of side-effects

Concern:

- Clozapine, primarily for treatment-resistant schizophrenia, is a high-risk drug. Specialists handle its prescribing, and patient-pharmacy registration with a clozapine monitoring service is mandatory. The Trust has a comprehensive clozapine policy for safety. However, national audit and incident reports reveal compliance gaps and patient safety risks.

Mitigation in place:

- Bespoke training offered to acute Trust teams (A&E/AAU) with ongoing development for Acute Trust pharmacy teams.

2. Lithium: safe prescribing and monitoring

Concern:

- Lithium, a high-risk drug for bipolar affective disorder and resistant depression, demands close monitoring due to its narrow therapeutic index and adverse effects. The Trust has a robust 'safe use of lithium guideline' and a shared care document for primary care prescribing support. However, incident reports reveal compliance gaps and patient safety risks, especially at care setting interfaces.

Mitigation in place:

- Ongoing incident reports indicating safety concerns.
- Scoping the creation and maintenance of a lithium register to track HPFT service users on lithium.
- Work in progress to update lithium guidelines.
- Upcoming medicines education in October to cover lithium prescribing and monitoring for bipolar disorder.

3. Valproate: safe annual assessment

Concern:

- The Trust Medicines Policy mandates timely documentation of prescribed medicines post-administration in clinical areas. However, multiple compliance breaches exist in inpatient areas, affecting both paper medication charts and the electronic prescribing and medicines administration system (ePMA).

Mitigation in place:

- Improved compliance with the weekly nursing safety checklist
- Triangulating Datix reports of blank administration records with weekly checklist results to identify discrepancies and escalate to matrons/ heads of nursing
- Ongoing ePMA rollout to facilitate the identification of undefined doses (blank boxes)
- National audit and recent incident report reveal compliance gaps and patient safety risks related to valproate use in pregnancy
- Scoping the creation and maintenance of a valproate register to track service users under HPFT services using valproate
- Medicines education on bipolar disorder planned for October, including a focus on the Prevent - valproate pregnancy prevention program

4. Rapid Tranquilisation: safe and appropriate use

Concern:

- In May 2019, CQC raised concerns about physical health monitoring after Rapid Tranquilisation. Five subsequent internal audits consistently identified ongoing non-compliance with Trust guidelines, which align with NICE and Royal College best practices

Mitigation in place:

- Regular PACE audit cycles conducted against rapid tranquilisation (RT) policy
- Introduction of RT care document in EPR for recording administrations
- Improved compliance with RT policy observed when using the Paris care document template
- RT policy being updated to refer directly to the care document in Paris for guidance

Routine medicines related documentation

5. Incomplete documentation of medicines administration

Concern:

- The Trust Medicines Policy mandates timely documentation of prescribed medicines post-administration in clinical areas. However, multiple compliance breaches exist in inpatient areas, affecting both paper medication charts and the electronic prescribing and medicines administration system (ePMA).

Mitigation in place:

- Improved compliance with the weekly nursing safety checklist
- Triangulating Datix reports of blank administration records with weekly checklist results to identify discrepancies and escalate to matrons/ heads of nursing
- Ongoing ePMA rollout to facilitate the identification of undefined doses (blank boxes)

6. Incomplete temperature logging and escalation

Concern:

- Temperature management of medicines storage is a critical concern due to the need for specific storage temperatures (2-8°C or less than 25°C) to meet statutory requirements. However, both internal and external audits consistently reveal deficiencies in temperature monitoring and the escalation of out-of-range readings, resulting in multiple breaches of statutory duty and ongoing compliance gaps

Mitigation in place:

- Improved compliance with weekly medicines safety audits
- Implementation of ad hoc incident reporting to detect temperature monitoring compliance gaps
- Triangulation of incident reports with weekly audit compliance to identify and address reporting discrepancies

7. Controlled Drugs record keeping

Concern:

- Controlled drug (CD) management, encompassing storage and record keeping, must adhere to Misuse of Drugs Regulations. Internal audits and incident reports consistently reveal deficiencies in safe custody (storage) and record keeping, resulting in multiple breaches of the Trust's controlled drugs policy

Mitigation in place:

- Development and implementation of the Controlled Drug audit app in Quarter 2.
- Enhanced oversight of audits and action plans within pharmacy
- In-progress development of an SQL report for better oversight by operational SBUs
- Medium-term plan to expand the report to Spike 2 for increased accessibility to operational SBU.

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Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 7b
Report Title	Quarter Two Experience of Care Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Lara Harwood, Interim Deputy Head of Experience	
Approved by:	Sandra Brookes, Deputy CEO and Chief Operating Officer	

The Board is asked to:
Information: The Board is asked to note the quarter 2 report.

Executive Summary

This paper provides the Board with an overview of feedback: local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during quarter two 2023-24. 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.

Please note that due to the data migration to new patient experience dashboard, there is currently no information available to report the Friends and Family Test, Having Your Say and compliment data. We hope to be able to give a verbal update at the meeting.

Headlines for quarter two 2023-24
In the quarter the Trust received:

- 308 PALS contacts (252 in quarter one)
- 137 complaints (118 in quarter one)
- Feel Safe survey was conducted between 11th June and 11th July 2023. 131 surveys were completed (compared to 136 in September 2022). 79% of service users said they felt safe (compared to 71% in 2022). Reports have been submitted to each SBU to take forward actions.
- The Peer Observation Project in older peoples' inpatient services has been completed with actions being taken by MHSOP.
- The Peer Listening Project in medium secure forensic services has been completed with actions being taken by LD&F.

Key Performance Indicators

- We are unable to report on any KPIs relating to surveys due to the data migration.
- Number of working days to acknowledge complaints remained at 3 (3.5) in quarter two, unchanged from the previous quarter.
- The average number of days to respond to complaints was 42 working days compared to 40 in the previous quarter.

The most significant changes when compared with the previous quarter?

22% increase in PALS contacts compared to quarter one. This has impacted on the capacity in the Experience Team. 51 of these contacts were not for HPFT. Most PALS contacts were

received for ACMHS NW Dacorum (19 an increase of 90% compared to quarter one), ACMHS SW Watford (18), ACMHS E&SE Welwyn/Hatfield (12), SPA (9).

Most PALS enquiries related to Care and Treatment and Communication. There was no significant change to the themes this quarter.

There was an 16% increase in complaints received compared to quarter one. ACMHS NW Watford (16) received the most complaints in quarter one followed by CAMHS East (13, this was a 175% increase compared to quarter one).

The main themes of complaints were Patient Care (40) and Communication (27), with communication breakdown with patient (15) being the predominant subcategory. Values and behaviours of staff (18) was also a common theme.

Positive
- Increase in service users saying they feel safe based on the "Feeling Safe" survey conducted in June/July.

Areas for improvement
- 16% increase in complaints
- Responsiveness to PALS enquiries
- Communication with service users and carers from planned and unplanned care services.

Recommendations

The Board is asked to note the key differences in data from quarter 1, including the key points of feedback from service users and the service user and carer involvement in service improvements.

Implications

Risk and Assurance	*This report gives assurance about the quality of care as perceived by service users and carers. Assurance about providing safe services and that people have received a good experience of care. Feedback is used to innovate and improve the care we provide.*
Equality, Diversity and Human Rights	*Feedback on services includes questions about demographic status to ensure inequalities are recognised and addressed.*
Quality	*Feedback is fundamental to understanding and improving the quality of services.*
Financial	*No implications*
Service Users and Carer Experience	*This report is summarising the details of experience of care within the quarter.*
People	*No implications*
Legal and Regulatory	*The CQC KLOE: understanding how caring, responsive and effective care is from the service user/carer perspective.*

	Complying with the PHSO national complaints framework, promoting a culture that seek to learn from complaints and treats people fairly. *NHS England Patient Experience Improvement Framework - learning for improvement.* *Experience is one of the NHS pillars of quality.*
Digital	*Digital systems in place and the team are working towards more digital forms of feedback.*
System	*Partnership working trustwide to share learning and also working with third sector colleagues including advocacy services to understand experiences.*
Sustainability	*Moving towards more digital communications with a potential reduction in paper feedback.*

Strategic Objectives this report supports	**Please tick any that are relevant** ✓
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	✓
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	✓
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	✓

Experience of Care Report – Quarter Two 2023-24

1. Introduction

1.1 This report is bringing all feedback received by the Trust in quarter two 2023-24.

1.2 This includes local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during quarter two 2023-24.

2. Compliments and Surveys

2.1 Data relating to compliments and surveys is currently being migrated to the new experience platform IQVIA following a procurement exercise. Five years of historic data is being uploaded to the new platform and will be available shortly. Staff have undertaken training on the new platform so that they are able to view their experience data and share information and learning. New QR codes and links are being arranged for all existing experience surveys. The new platform will provide the benefits of the old platform with additional new reporting such as SPC (statistical process control) charts and surveys with audio facility.

3. Shared Experience Stories

4.1 One service user shared their experience at the Council of Governors meeting in September regarding the Community Perinatal Team (CPT). The service user was supported by the CPT when they were pregnant with both of their children and continues to be supported by them and is accessing family therapy which has been hugely beneficial. The service user credited the members of the team with supporting them through the most difficult time in their life and continue to use the tools and skills that they have learnt. The service user shared how reassuring, kind, considerate and understanding all the different staff members in the team are.

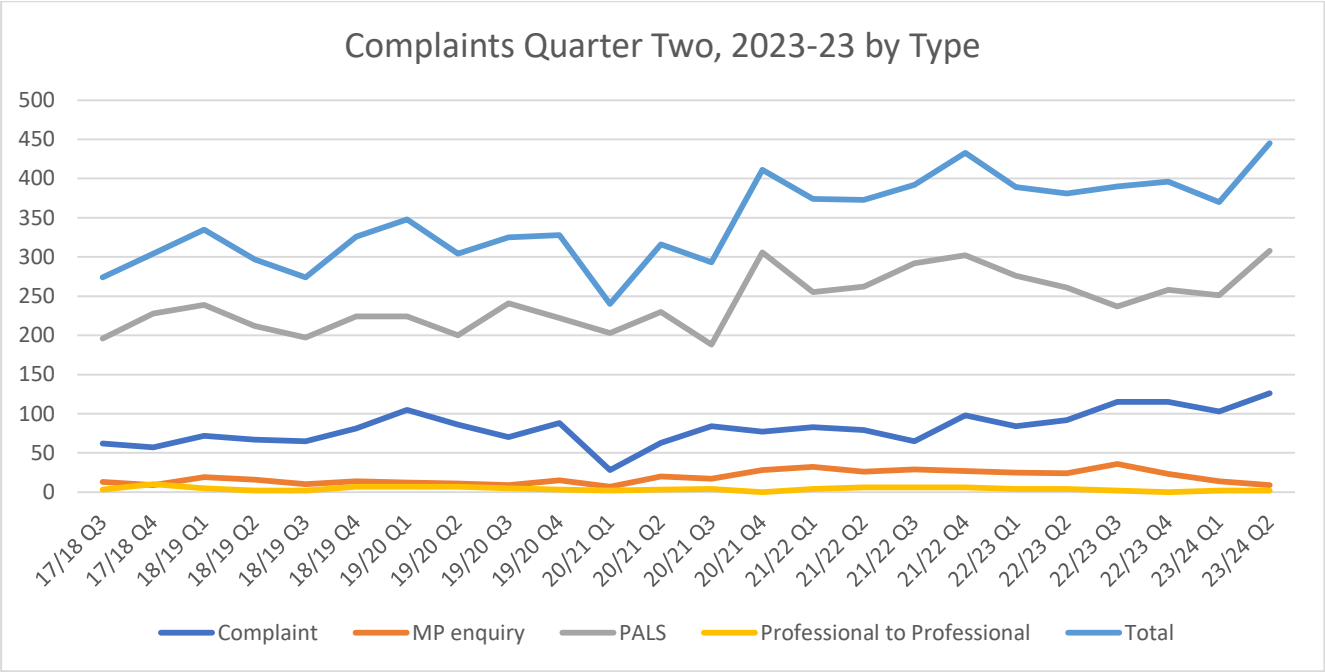
5. Complaints and PALS

5.1 In quarter two, 2023-24 we received 137 complaints compared to 118 in quarter one. This is a 16% increase compared to quarter one. Included in this figure are nine MP enquiries, which was a decrease compared to 15 in quarter one. There were two professional to professional complaints, compared to three in the previous quarter.

5.3 There were 308 PALS enquiries in quarter one compared to 252 in quarter one, a 22% increase. 51 of the PALS enquiries received were not related to HPFT compared to 64 in the previous quarter.

5.4 In the quarter one 125 complaints were closed compared to 123 complaints quarter one; three had their consent refused, 63 were not upheld, 41 were partially upheld, 15 were upheld, three were withdrawn. (Please note that complaints closed during quarter one were not necessarily received in the same quarter).

Graph 5



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

5.5 Key areas to highlight in the quarter: 46% of all complaints received were for **Adult Community Mental Health Services** (ACMHS), this is a decrease compared to 49% in quarter one. Patient care was again the main theme followed by communication, in particular communication breakdown with the service user. There has also been a noticeable number of concerns related to ADHD and ASD waiting lists.

5.6 There was an increase in complaints from **CAMHS** (29 compared to 21 in quarter one). The main concerns relate to a lack of support and access to medication. As with adult services, there have been a number of complaints relating to ADHD and ASD waiting lists. Access to services with referrals being refused by SPA as they do not meet with criteria is also continuing to be a theme.

5.7 In **Unplanned Care**, care and treatment and access to treatment or medication were the main themes of the concerns raised. Many of the complaints were received from family members and related to a lack of communication from staff.

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 (3.5) working days, it was three (3.3) 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 were closed in quarter one was 42 days, this compares to 40 in quarter one. The timeframe to respond should be 35 working days. The figure is calculated by looking at all complaints closed in the period and removing any that were withdrawn by the complainant, did not fall under the HPFT complaints procedures or where, due to the process being paused, the clock was stopped.

5.7 Equality monitoring data is requested from complainants when registering a complaint. Of the 137 complaints received in quarter two, we received six completed equality monitoring forms. One MP enquiry received in quarter two stated that there had been discrimination under the Equality Act. This enquiry has not yet been responded to.

5.8 Benchmarking data is now sent to NHS Digital annually. The submission has been made for 2022-23, results are not yet available.

5.9 Information regarding the complaints evaluation surveys returned in quarter two is not currently available due to the migration of survey data to the new platform. New links and surveys are currently being created and will be sent out to complainants following their response letter as soon as possible. A CQI project to improve the survey questions is also underway.

5.10 In quarter one the Parliamentary and Health Service Ombudsmen (PHSO) and Local Government Ombudsman (LGO) requested information regarding five complaints (compared to one in the previous quarter). Two cases were closed: one returned a decision not to investigate as it fell outside of the 12 month time limit. One case was returned as partially upheld, an apology letter and action plan are being written.

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 All teams are required to record actions following complaints on Datix in line with the process for Serious Incidents. This will ensure that teams can monitor progress of their actions through to completion. Currently, Planned Care in East and North Herts are the only teams recording their actions. There are currently 134 actions recorded on Datix, of which 114 have been completed. The main theme of the actions in progress, or completed, is communication (68).

6.4 An action plan and communications plan to improve the results of the national annual Community Mental Health Survey have been created. These are being monitored through monthly meetings. The survey has now been sent to service users and screen savers for service users and staff are currently being shown to ask service users to complete a survey should they receive one. A short video has been created with an expert by experience talking about the importance of feedback also encouraging service users to complete it. The survey closes on 1st December 2023.

6.5 Following completion of Peer Listening interviews at Warren Court and the Broadland Clinic and Peer Observation visits at older peoples' inpatient units, final reports have been shared with the LD&F and Older Peoples' services. Teams have been asked to review the reports and its recommendations and add dates to the action plan.

7. Involvement

7 .1 In quarter two, there were 454 hours of involvement activity, marking a 5% decrease from the 480 hours reported in quarter one.

7.2 Out of the total time commitment to involvement activity, interviews accounts for 30% (equivalent of 134 hours) of all activities. 22% (equivalent to 100 hours) was set aside for specialist involvement in Trust meetings. An additional 17% (equivalent to 76 hours) was committed to Service User and Carer Council meetings, while 7% (equivalent to 30 hours) was designated for CQI projects. Moreover,19% (equivalent to 84 hours) was dedicated to participation in workshops or seminars.

7.3 In addition to the these activities, EbEs were also engaged in various other tasks, such as HPFT staff inductions, peer experience projects, quality visits, SBU meetings, and sharing their personal stories.

8. Volunteering

8.1 There are currently 18 active volunteers registered in various roles across our services. Their roles include: administration, meet and greet, ward visitors, PAT dogs, gardening and music activities.

8.2 There were five volunteers recruited in quarter two and they are awaiting completion of their recruitment checks after which we will agree a start date. One role is currently out to advert.

8.3 A review of the volunteer database has revealed a significant difference in our reported numbers compared to quarter one. Work continues to ensure accurate records and robust support for our volunteers.

9. SBU Updates

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

8.2 **CAMHS**: **Forest House:** Following the garden project young people have been spending time in the space and enjoy the "real" grass. Rec room project continues, and external artists are being consulted to decorate the unit. Young people took the lead on planning groups and activities during the summer months, e.g. cooking group. The parent/carer group continues fortnightly. Young people have asked for a unit pet and plans are underway to get guinea pigs. **CCATT:** The team continue to review their feedback and update their "you said, we did" posters. Surveys have been sent out to gather feedback on improvements under the collaboration project, "Promise of Care". The intervention team continue to use innovative approached to therapy, e.g. weighing turtles in clinics. The team are working alongside the wellbeing cafes and the paediatric liaison team are linking in with the out of area crisis teams to support young people. **North:** A survey has been developed to gain views on how to redecorate the CAMHS rooms. There have been three innovation bids: digitalising therapy through interactive whiteboards to improve collaboration around care planning and improve efficiency. A nature room to enhance therapy and provide a sensory environment. The third is for a walk pad which would be used by staff and young people. Staff attended the train the trainer training about neurodiversity with the Anna Freud Centre to improve, for example, the language we use in discussions with young people. Artwork created for young people is now lining the corridors. A drop in open space is due to launch to improve a sense of belonging, feel valued and interaction with others. Feedback about the volume of the music in the waiting room has led to it being reduced.

8.3 **Older Peoples' Inpatient Units**: There is ongoing work to enhance, implement and improve the process around **Mutual Help and carers meetings**, identifying therapy and ward staff to complete this monthly and ensure actions are followed up appropriately. **DIALOG+** has been embedded into practice on Wren Ward and is discussed on a regular basis, this is also reviewed on a weekly basis to ensure quality and provide assurance of co-production. The SBU have recently completed a draft version of a job specification for an "**Experience Champion**" on each of the units. This will be a member of staff whose role is to facilitate, support and promote feedback on our units. This has been shared with PG in other SBU's for a consistent and innovative approach to feedback. The team have recently recruited to a consultant frailty nurse post, improving the experience of our service users in community and inpatient services. There are currently five **transformation projects** ongoing within MHSOP. These projects are EMDASS Recovery and Transformation, Inpatient Model of Care, Crisis Services Transformation, DTC, Access and Flow Project and Integration and Frailty to ensure high quality care is maintained. The **Peer Observation Project** final report was shared with the team in September, recommendations and actions were agreed and the team are finalising timeframes for each action.

8.4 **Unplanned Care**: An EbE who attends the Quality and Risk meeting has been attending wards and having recorded sessions with service users on observations to discuss their experience. **Safety Planning:** Following the Hertfordshire Eating Disorder Suicide Prevention Pathway Pilot Operational Steering Group, a safety plan has been devised with input from Clinical staff, MDT, people with a lived experience and carers, this is due to be piloted in the Mental Health Liaison Team and Inpatients. The aim is to have one Safety Plan that all service users use to provide consistency. Safety planning is a structured, proactive way to help plan a range of activities and sources of support to use at the right time to help prevent or manage a developing crisis. This project is being led by the Lead Professional OT and Service Line Lead for Crisis, Mental Health Liaison and Perinatal Teams. **Engagement and Activity CQI Project - Adult Acute Inpatient Wards:** As part of the Trust wide agenda around Engagement, Occupational Therapy are leading on an Engagement and Activity CQI Project on Swift and Owl Wards and planning to roll it out to the other inpatient wards. This is being led by ward staff and service users with a focus on the purpose to their admission, and to ensure that all staff on the wards can engage and initiate appropriate activities to compliment other therapies on the wards. A number of focus groups were held across various teams and staff groups to gain an understanding of people's perception of 'engagement', and the perceived barriers to engagement. A Table Tennis, Table Football and Karaoke machine have been ordered for the ward. As part of the Trauma Informed Approach roll out the Needs and Feelings training will be shared. The engagement and activity training will be shared at the Health Care Support Worker training event, as well as a brief session to be held on the ward. **Carers Involvement:** All Wards and Crisis Teams now have Carers Champions who work with the Trusts' Carers Involvement Leads (CIL) who provide initial support to OT inpatient lead and Carer Champions to facilitate carer drop-in sessions at Kingfisher Court.
Carers Focus Groups now take place fortnightly and are run by the OT Team with Ward Carer Leads supporting the sessions. The content covers Carer support in the community, discharge planning and peer support. New Carer drop-in sessions to be offered in the evening and weekends, Swift Ward, Oak Ward and Albany Lodge have already started these separately. Feedback has been positive. Ward leaflets have been updated and Carers and Service Users have been part of this process to ensure that the information they require on admission is included and a review of the Welcome Pack from both Service Users and Carers has been put together using feedback from Mutual Help Meetings and the Carers Group. **Acute Pathway Improvement Programme** continues with the aim to reduce the delays in transfers of care, reduce out of area placements and improve the experience for service users.

8.5 **Planned Care: PATH Carers' Group:** PATH run a one-day Carers workshop and an eight week carer education and support group twice per year. Positive feedback was received in relation to attendees' initial experience in supporting individuals with psychosis. Many requested subjects are covered during the Group including, psychosis symptoms; causes; treatment; recovery and available community support. Following the Group, Carers Focus Groups will be organised to capture what worked well and if there is any additional information that would be helpful. This Group is overseen by the Team Leader and supported by Associate Practitioners, with input from clinicians (consultants/psychologists). The course content is sourced from the MDT. **Physical Health:** There has been a significant improvement in the delivery of physical health checks for Service Users on CPA, over 95% achievement across all ACMHS teams. We have also started work around the remodelling of clinics and medication side effects monitoring and training has been launched for ACMHS nurses and clinical staff.

It is anticipated that the model will facilitate reporting across all physical health clinics; looking at reviews; monitoring of side effects; looking at the number of people who attend appointments/DNAs, etc. Approximately 1,300 SUs are subject to physical health monitoring.
Community Transformation: Work was co-produced with service users and carers on the referral process, part of which was to adapt communication methods at the end of that section of their pathway to a straightforward/transparent mode. An early

implementing team is preparing the project for readiness. **Outpatient Transformation:** As part of the Outpatient Transformation project a number of change ideas are being implemented including: Primary Care Liaison Clinic, Patient Initiated Follow-up (PIFU), Alternative pathway of care: Delivery of Antipsychotic Depot Clinic in Primary Care and Consultant Connect: An app which facilitates communication between primary care and specialist MH services for advice and guidance. **Low Intensity Treatment Team (LITT):** Introduced to ensure holistic support is provided to a large number of service users prescribed long-acting injectables (LAI) who are mentally well, but need frequent injections. A pilot in Welwyn Garden City and Dacorum is underway with the aim of keeping safe service users that have not had a recent crisis intervention and ensuring we are meeting all of their needs, including physical health and social care needs. A key priority for Planned Care is for all staff to complete training on Discovery to support Service Users with co-occurring drug and alcohol issues and we will be reviewing the effectiveness of the existing Planned Care pathways for service users with co-occurring drug and alcohol issues

8.6 **LD&F**: **The Making Services Better Group** have supported in the Positive Behaviour Support (PBS) strategy project, reviewing the service user and expert by experience information. The group has also reviewed the service user welcome pack for 4 Bowlers Green. They have also made suggestions on the easy-read version of the new Trust Strategy and provided feedback on the OBIS easy-read service leaflet. The group has also provided some feedback to Warren Court in relation to a poster and nomination form which is used on the ward for service users to provide feedback on the care they have received. **Easy-Read Care Plan:** A small working group has commenced to develop an improved easy-read care plan for learning disability inpatient and community services with the aim of enabling service users to better understand and input into their care. **Use of Easy-Read Software:** In some inpatient services, there is an ongoing pilot to use the easy-read software to support the local patient forums so we can better record the outcomes of these meetings and make them more engaging. There is also a gradual roll-out of the software across the LD community teams in Herts, Bucks and Essex to seek service user and carer feedback with a view to sharing this feedback with the teams monthly and agreeing what steps we need to take to improve services alongside understanding what is already working well. **Service user and Carer Feedback** - a working group is being put together to look at how to collect meaningful service user and carer feedback using bespoke surveys. This group will build on the work already completed and underway around the use of the easy read software above. **Carers Month** – following the success of Herts Secure services carers month in June, resources and best practice examples have been shared and will be used to promote carer awareness and carer engagement and involvement throughout the SBU in October. This includes the rollout of the Carers Charter that is now embedded in Rehab and Secure Services. **Astley Court 10 year anniversary celebrations** – On Friday 29th September, Astley Court held a garden party at Woodview Gardens to celebrate being open for 10 years. Service users from both Astley Court and Broadland Clinic came along to enjoy the celebrations with their families.

Appendix 1 – Complaints Themes

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Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 7c
Report Title	People & OD Month 5 Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Louise Thomas, Deputy Director, People and OD	
Approved by:	Jo Humphries, Chief People Officer	

The Board is asked to: Note
Information: To note the report for the intelligence of the Board without in-depth discussion.

Executive Summary

This paper provides the Board with the Trust's workforce performance for Month 5 (August) of 2023. The key headlines from Month 5 are as follows:

The People and OD Group continue to monitor and oversee plans to continue improvements against each of the workforce key performance indicators and note the continued improvement in:

- Appraisal rates are at a record high level, albeit that they are 2.9% lower than our 95% target. Work will continue to achieve full compliance.

- Mandatory training rates have recovered to meet our 92% target. Additional work is being undertaken to increase compliance further across all courses.

Although we are seeing continued reduction in vacancy rates (to 11.7%) and unplanned turnover (to 11.3%) at a Trust level, we have additional activity underway to further enhance recruitment performance and address underperforming vacancy hot spot areas as follows:

- Focused Hot Spot vacancy areas are scrutinised at the Trust Management Group and the Recruitment and Retention Group
- New Start Date Ready module on our recruitment management system "Trac" is now live which streamlines the recruitment process and improves the candidate experience and will reduce our time to hire
- New Facebook campaigns launching 6th November
- A new recruitment micro-site has been developed and staff promotional video collected. Final proposal being presented to the Recruitment and Retention Group Monday 30th October. This fully communicates the employee value proposition offered by HPFT and has an anticipated launch mid-November.
- A new recruitment events calendar has been created and is now live ensuring good representation of HPFT staff from all business areas at relevant recruitment fairs.
- A new diagnostic assessment approach has been designed to identify the root cause of ongoing and persistent vacancies including; market skills availability, attractiveness of job role design and workload expectations, alternative workforce structure and service delivery options within the business area, leadership and culture

opportunities, capacity to support students and apprentices, innovation and reputation for excellence, opportunities for development and career progression, estates and physical working environment, access to equipment and resources, school and higher education outreach and marketing opportunities, remuneration, recognition and appreciation options available

- New service level task and finish groups planned to specifically review
  - Inpatient wards
  - Adult Community
  - CAMHS Community
- New role level task and finish groups planned to specifically review
  - Registered Nursing
  - Allied Health Professionals
  - Social Work
  - Psychology

- Formal employee relations cases remain low and we are seeing the impact of our action plan to re-set our approach to resolving ER matters informally start to have an impact, albeit that some legacy cases continue to be reported. The majority of our outstanding grievance cases are expected to be resolved by the end of November. However, we note the overrepresentation of BAME staff within our ER cases which is echoed within our WRES data reporting in which the relative likelihood of BAME staff entering the formal disciplinary process is 3.46. This is despite having introduced a First Decision Making Panel into the formal disciplinary process and therefore a detailed reappraisal of the effectiveness of this stage will be undertaken.

Recommendations

The Board is asked to note the attached report.

Implications

Risk and Assurance	The Trust risk register notes the risk of failing to develop a sustainable workforce model means we fail to recruit and retain the right numbers of people with the right skills which will impact on quality of care and experience for our service users and our staff satisfaction levels.
Equality, Diversity and Human Rights	By making improvements to HR processes and ways of working we will continue to provide equity in outcome for all our employees
Quality	The Trust risk register notes the risk of failing to develop a sustainable workforce model means we fail to recruit and retain the right numbers of people with the right skills which will impact on quality of care and experience for our service users and our staff satisfaction levels.
Financial	A failure to recruit to the agreed establishment in all services and roles necessitates the deployment of bank and agency staff at higher rates of pay that budgeted.
Service Users and Carer Experience	The Trust risk register notes the risk of failing to develop a sustainable workforce model means we fail to recruit and retain the right numbers of people

	with the right skills which will impact on quality of care and experience for our service users and our staff satisfaction levels.
People	The Trust risk register notes the risk of failing to develop a sustainable workforce model means we fail to recruit and retain the right numbers of people with the right skills which will impact on quality of care and experience for our service users and our staff satisfaction levels.
Legal and Regulatory	A failure to maintain safer staffing levels may lead to regulatory breaches and increase the risks of employee litigation for harm caused as a result of insufficient numbers of staff or skills of staff available
Digital	Improvements in workforce reporting and creating integrated dashboards with other key performance indicators will enable better identification of the quality and safety implications of staffing levels.
System	Ensuring we have a sufficient and sustainable workforce will enable us to meet our contractual obligations.
Sustainability	This has a direct impact on the Trust financial sustainability.

Strategic Objectives this report supports	**Please tick any that are relevant** ✓
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	✓
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	✓
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	✓
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	✓

Hertfordshire Partnership University NHS Foundation Trust

Trust People and OD Report Month 5 (August 2023)

as one

Our values
Welcoming Kind Positive Respectful Professional

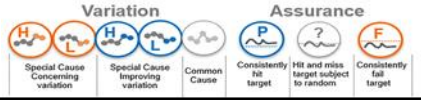
Contents

1. Overview

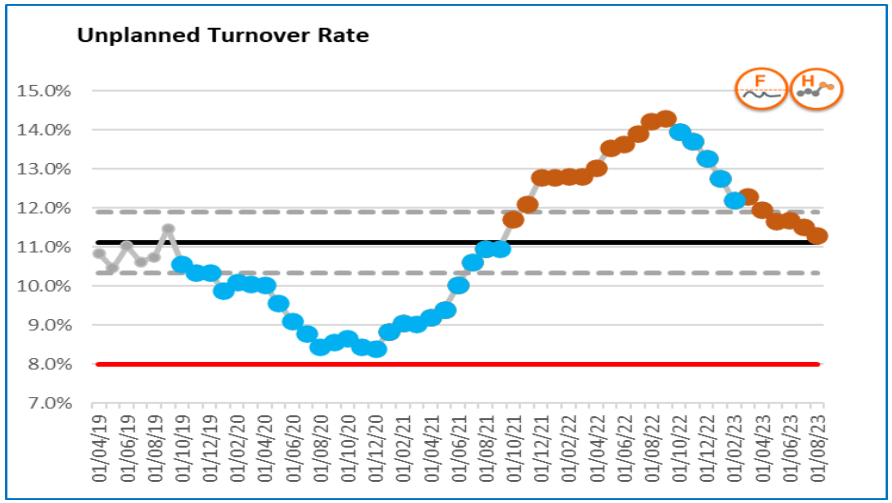
Metric	Previous Months											Current Month	Trust Target	Trend	Variation	Assurance
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23				
Staff in Post - Headcount	3842	3887	3921	3935	4012	4052	4083	4100	4121	4120	4122	4138				
Staff in post - FTE	3462.08	3501.28	3542.65	3562.67	3636.30	3664.79	3702.91	3715.75	3743.59	3739.10	3741.66	3755.56				
Budgeted Establishment FTE	4029.56	4037.67	4147.96	4162.15	4157.99	4186.74	4198.26	4230.50	4245.48	4257.85	4263.57	4254.48				
Vacant FTE	567.48	536.39	605.31	599.48	521.69	521.95	495.35	514.75	501.89	518.75	521.91	498.92				
Vacancy Rate	14.1%	13.3%	14.6%	14.4%	12.6%	12.5%	11.8%	12.2%	11.8%	12.2%	12.2%	11.7%	10%			
Total Turnover Rate	18.6%	18.3%	17.7%	17.4%	16.7%	16.0%	15.8%	15.5%	15.3%	15.5%	15.4%	15.4%	14%			
Unplanned Turnover Rate	14.3%	14.0%	13.7%	13.3%	12.8%	12.2%	12.3%	12.0%	11.7%	11.7%	11.5%	11.3%	8%			
Starters Headcount	120	85	49	46	90	65	63	77	51	42	55	79				
Leavers Headcount	78	48	37	41	44	33	67	50	43	58	58	59				
Stability Rate	83.3%	83.0%	84.0%	83.9%	84.4%	84.5%	86.0%	85.2%	85.3%	86.5%	86.1%	86.4%				
Sickness Rate	4.5%	5.3%	5.3%	5.5%	5.0%	4.9%	5.1%	4.4%	4.3%	4.4%	4.3%	4.4%	4%			
Training Compliance Rate	92.3%	92.5%	92.7%	93.0%	92.7%	92.9%	87.6%	89.0%	90.0%	91.0%	92.0%	92.0%	92%			
Appraisal Rate	83.8%	85.1%	85.5%	85.0%	85.6%	84.7%	85.9%	86.3%	85.1%	86.0%	90.4%	92.1%	95%			
Bank Spend	£2,658,620	£2,304,492	£2,159,196	£2,136,852	£2,226,630	£2,272,368	£2,226,165	£2,216,972	£2,502,377	£2,749,160	£2,464,320	£2,694,222				
Agency Spend	£1,260,585	£1,265,116	£1,346,138	£1,287,560	£1,340,857	£1,080,570	£1,869,589	£1,075,919	£1,059,957	£908,385	£943,314	£979,497				

This report sets out the Trust's performance against key workforce performance indicators for Month 5 (August) of 2023/4. The report highlights that:

- The number of staff in post has increased by 14 FTE due to more staff starting than leaving us, which means that our vacancy rate has reduced and our turnover rate has reduced further to the lowest it has been in two years.
- Our establishment reduced slightly in Month 5, but remains 25FTE higher than the start of the year. Budgets have now been finalised and uploaded. As a result, our establishment is expected to increase by 107 FTE, which will increase our vacancy rate to around 12.5% (547 FTE vacancies).
- Registered nursing, medical, psychology, social work and AHP staff remain the most challenging areas for recruitment and retention. Deep dives to implement key high impact actions are being taken forward to address the challenges specific to each staff group.
- Agency spend has increased by £36k and Bank spend has increased by £230k since July. An increase in temporary staffing is often experienced during August due to the holiday period. However, the increase in costs is usually more significant. This is likely to be as a result of the steps taken in Q1 to reform the Bank bonus scheme in anticipation of the Summer, aiming to increase Bank over agency use. The Financial Recovery Board and Agency Panel are proactively reviewing all agency use to ensure this ceases where possible.
- Mandatory training rates have remained at our 92% target. Appraisal compliance has increased to the highest rate ever achieved, following the introduction of our new appraisal App and window. Non-compliance is being further followed up to reach the 95% target.
- Our overall staff development offer continues to be strong with a further enhanced offer available during Q3.
- Whilst overall absence rates are relatively low, mental ill health related absence is continuing to increase. Alternative funding streams for our wellbeing offer are being explored to ensure we can continue our robust offer.



2. Retention


Unplanned Turnover Rate
F
H
15.0%
14.0%
13.0%
12.0%
11.0%
10.0%
9.0%
8.0%
7.0%
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
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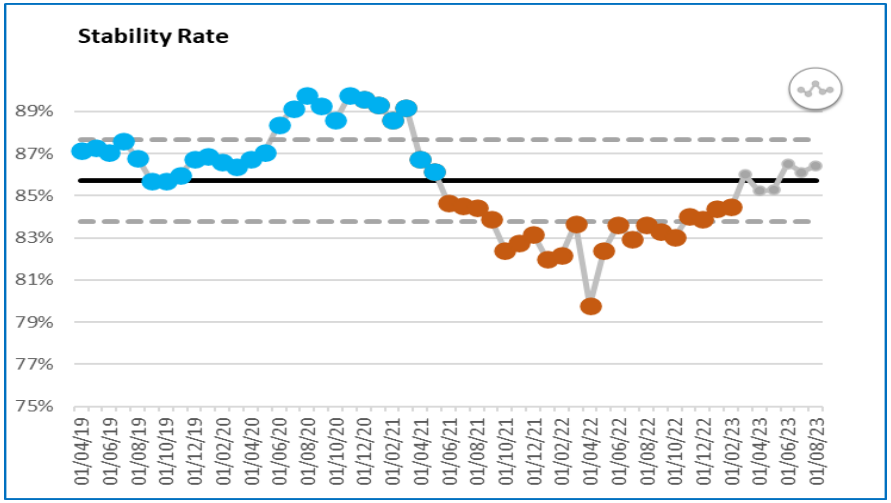
Stability Rate
89%
87%
85%
83%
81%
79%
77%
75%
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
01/10/20
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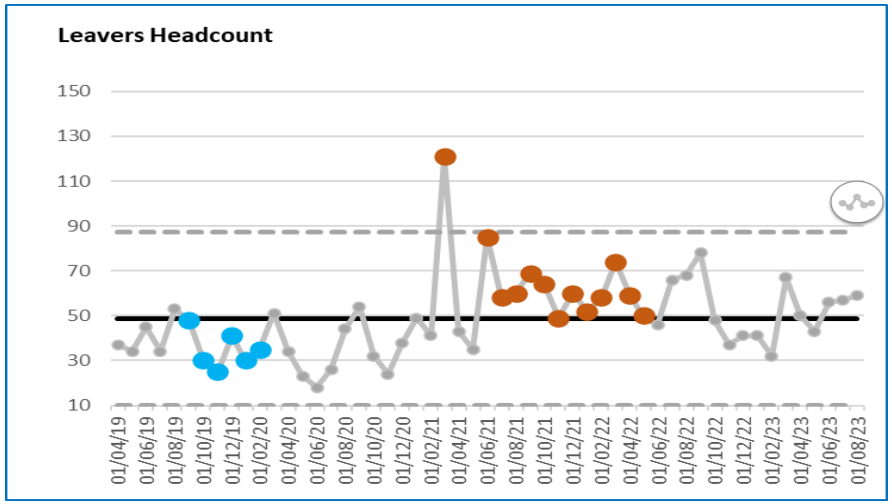
Leavers Headcount
150
130
110
90
70
50
30
10
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
01/10/20
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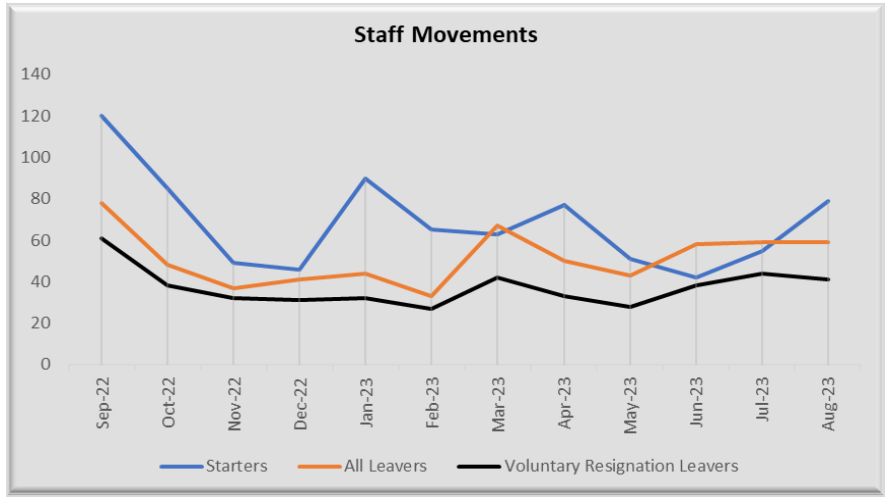
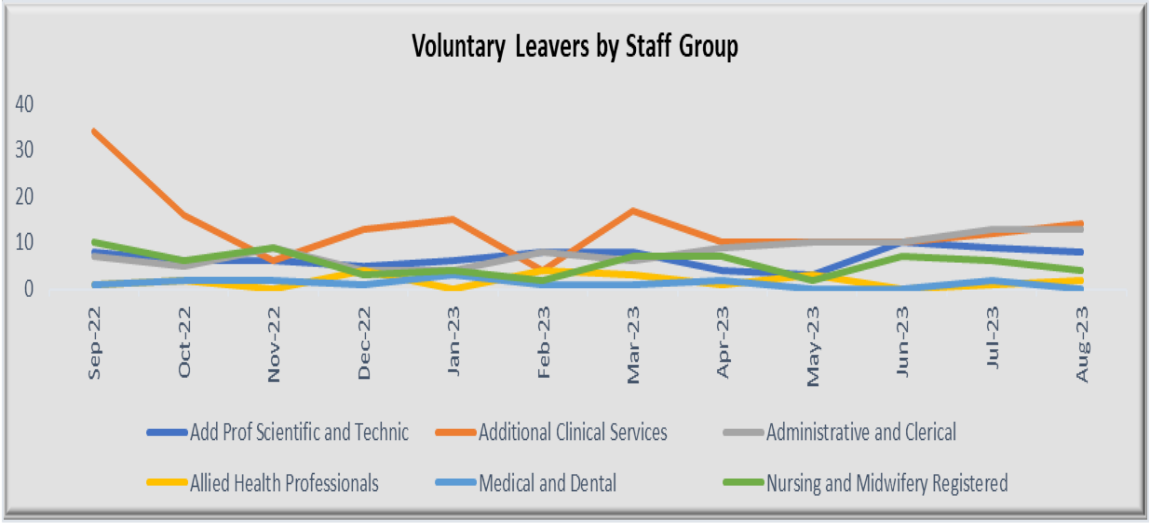
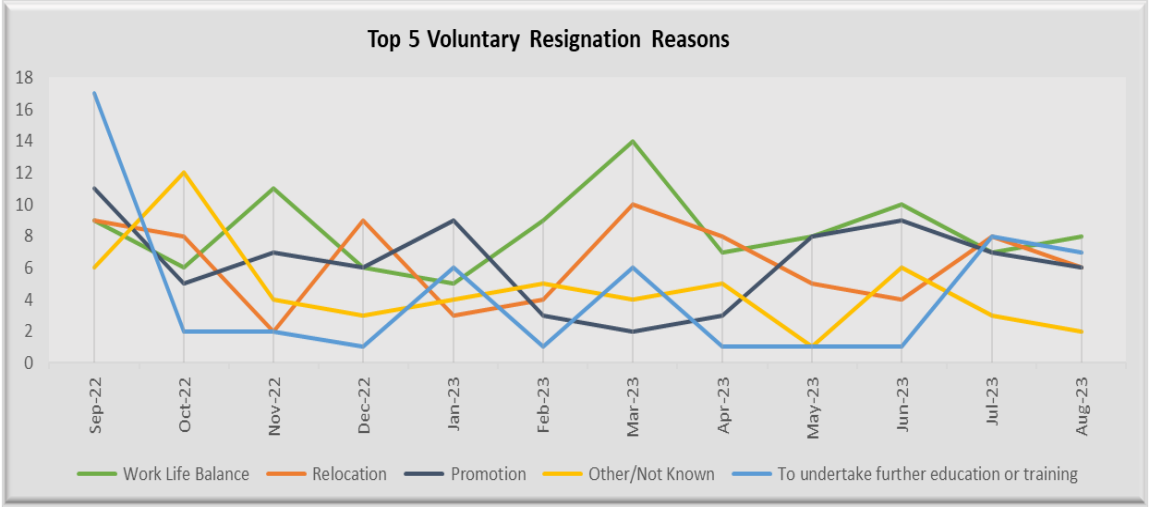

Staff Movements
140
120
100
80
60
40
20
0
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Starters
All Leavers
Voluntary Resignation Leavers

2. Retention





Turnover has reduced further from 11.5% in July to 11.3% in August, which is the lowest in two years.

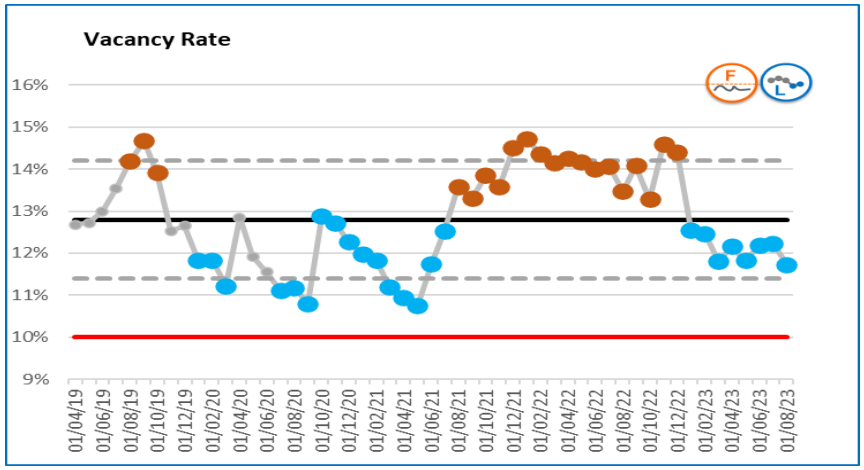
The People and OD Group and Recruitment and Retention Group have refreshed retention plans for 2023/4, centring around the Trust's annual plan key areas of:

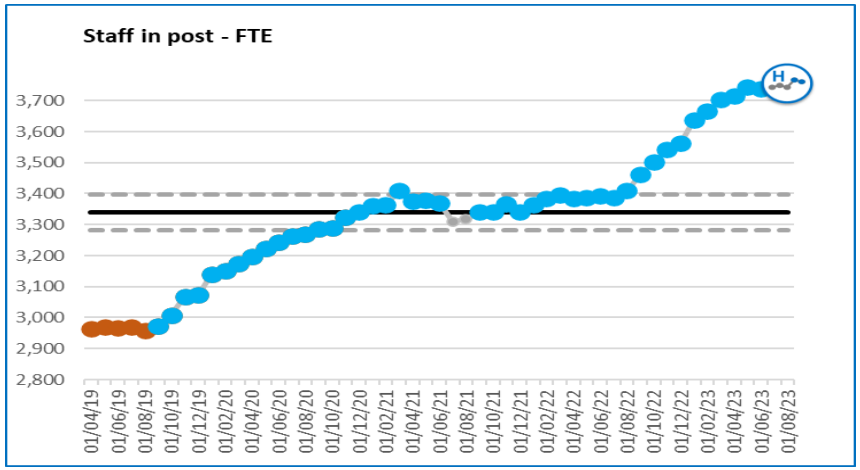
- Belonging and inclusion
- Talent management
- Leadership development
- Resetting our fundamental standards of people management

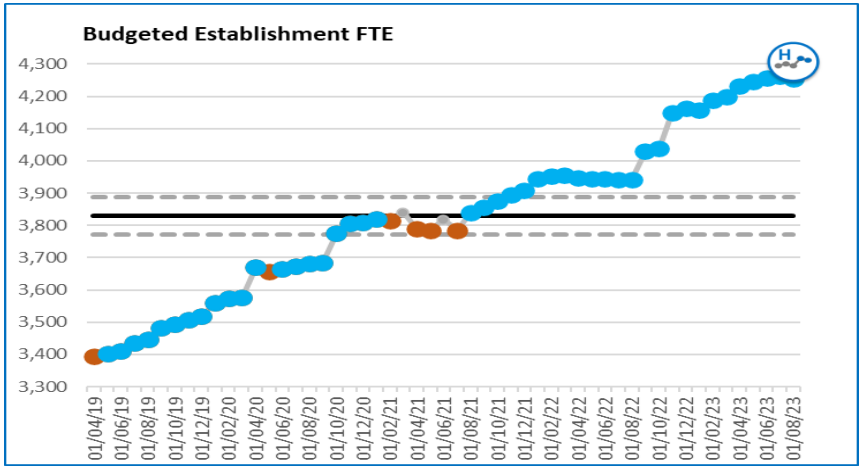
These are supported by our ongoing engagement with staff, together with our wellbeing offer, benefits and staff reward and recognition.

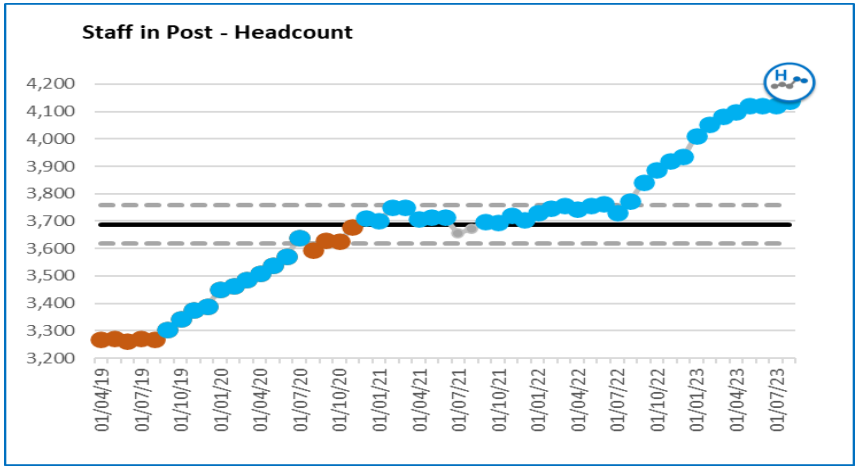
Our 2023 annual staff survey launches on 2 October. A managers toolkit has been issued to all our senior leaders to help them champion the staff survey and communicate out the actions we have taken to address feedback from the 2022 staff survey, when our people rated us as the third best mental health trust to work for in England. Last year we achieved the national average response rate of 50%. This year, our ambition is to hear from at least 75% of our people so that we hear and act on all voices so that we can keep making HPFT great, together.

3. Recruitment

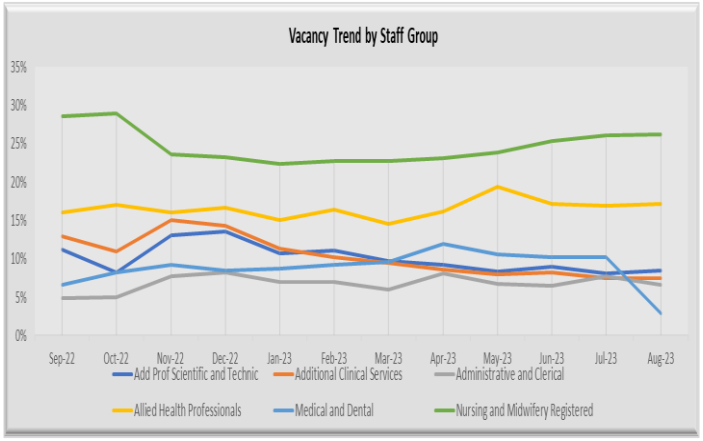








3. Recruitment



The net impact of new starters, leavers and a reduced establishment has resulted in our vacancy rate reducing to 11.7% from 12.2%. The SPC chart shows a continuing improving statistical trend, although we have not historically met our 10% vacancy target. 2023/4 budgets have now been finalised and uploaded. As a result, our establishment is expected to increase by 107 FTE, which will increase our vacancy rate to around 12.5% (547 FTE vacancies) in September.

Vacancy rates in our key staff groups are:

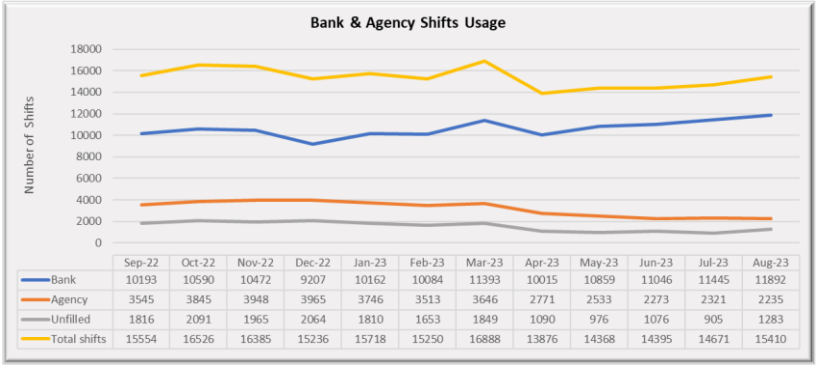
- Registered nursing – 26.2% (same as July). Staff in post reduced by 3 FTE as a result of more staff leaving than joining. We are actively recruiting to 265 nursing roles against 257 vacancies, of which 121 are external candidates in the post-interview pipeline. 2 internationally recruited nurses joined our Norfolk services in August and 13 more are in the pipeline. However, due to funding constraints, the international pipeline will not be increased further.
- AHPs –17.2% (up from 16.9% in July). The establishment remained the same, although staff in post reduced by 1.3 FTE, as a result of more staff leaving than joining.
- HCSWs – 0.5% (reduced from 1.3% in July). Staff in post continues to increase as a result of successful recruitment and retention.
- Medical staff – 39 medical vacancies (the same as in June); 22 are Consultant vacancies (up from 21 in June - 2 at offer stage); 17 (down from 18) are Specialty Doctor vacancies, with 4 at offer stage.
- Psychology – 28.4% (up from 27.5%). Establishment remained the same, whilst more leavers than joiners reduced the staff in post by 1.4 FTE and increased vacancies to 44 from 42.7 FTE
- Social Work – 19.7% (up from 18.7%). Staff in post remained the same, however, due to establishment increasing by 2FTE, vacancies increased to 32.7 FTE from 30.7 FTE.

Our key recruitment metrics are as follows:

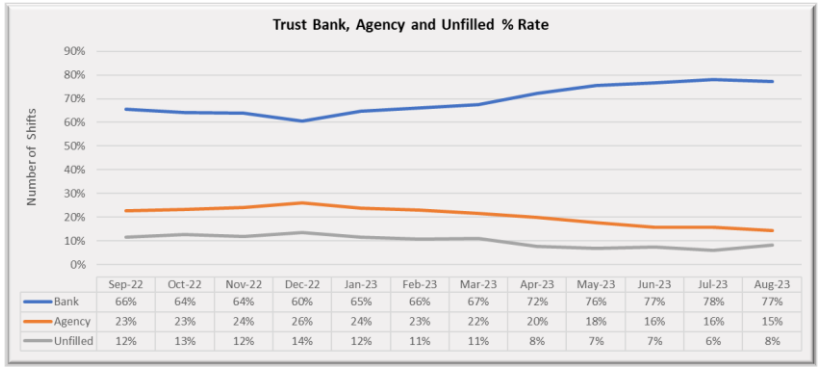
- Recruitment pipeline of 707 FTE posts, 413 of which are in the firm offer/starting phase, with 282 of these being external candidates.
- Our time to hire has increased from 49.7 days in July to 52.9 days, which is just above our target of 52 days. This was due to managers taking longer to shortlist and advise of interview outcomes, which may be linked to the holiday period. Streamlining changes as a result of a full process review will become increasingly visible in our time to hire as legacy recruitment episodes are concluded.

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

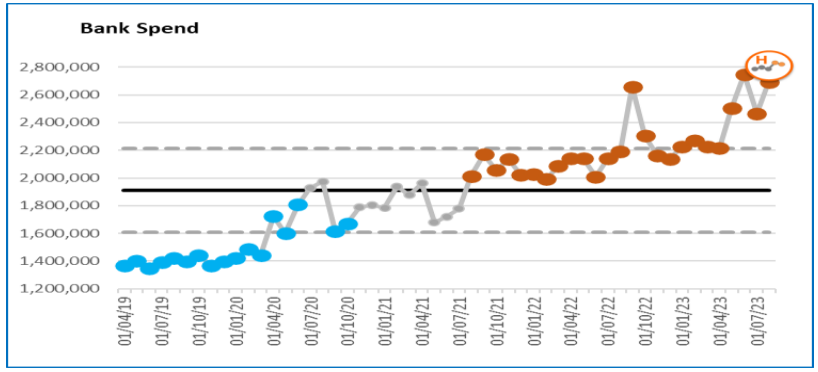
4. Temporary Staffing

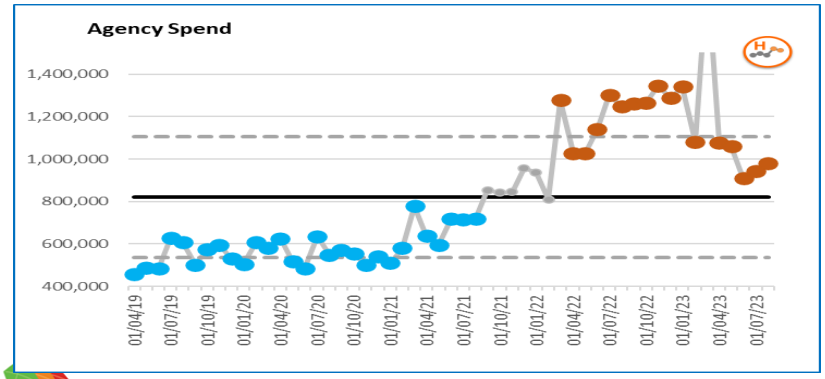


	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Bank	10193	10590	10472	9207	10162	10084	11393	10015	10859	11046	11445	11892
Agency	3545	3845	3948	3965	3746	3513	3646	2771	2533	2273	2321	2235
Unfilled	1816	2091	1965	2064	1810	1653	1849	1090	976	1076	905	1283
Total shifts	15554	16526	16385	15236	15718	15250	16888	13876	14368	14395	14671	15410



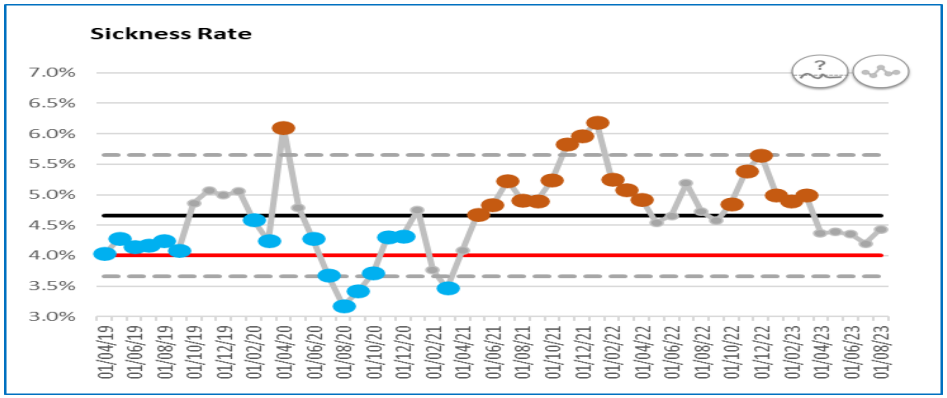
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Bank	66%	64%	64%	60%	65%	66%	67%	72%	76%	77%	78%	77%
Agency	23%	23%	24%	26%	24%	23%	22%	20%	18%	16%	16%	15%
Unfilled	12%	13%	12%	14%	12%	11%	11%	8%	7%	7%	6%	8%

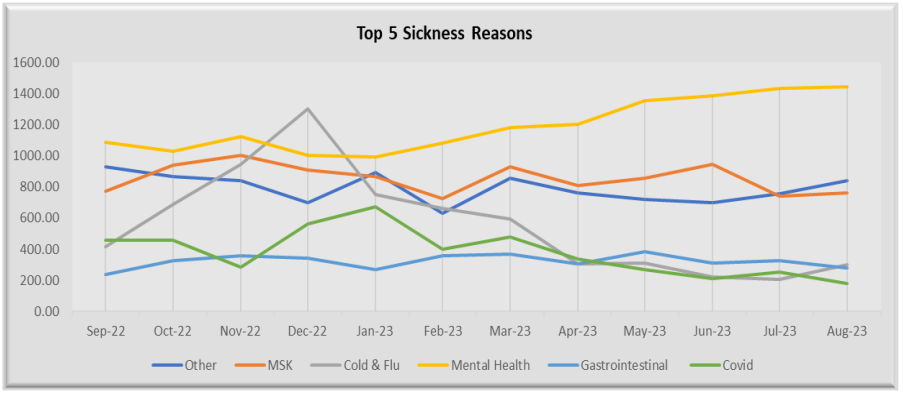




- Temporary staffing demand increased significantly in August. This increase is experienced each August due to the holiday period. However, this is usually focused on agency spend.
- This year, monthly Bank spend increased in August by £230k and fill rates have remained high. This is likely to be as a result of the steps taken in Q1 to reform the Bank bonus scheme in anticipation of the Summer, aiming to increase Bank over agency use.
- Agency spend increased by £36k in August, which is a less significant increase than is usually experienced at this time of the year.
- The Financial Recovery Board and Agency Panel are scrutinising all agency spend, developing a trajectory for improvement and monitoring the impact of actions.

5. Health and Wellbeing





- Sickness absence remained at 4.4% in August. Whilst most absences reduced, colds/flu, 'other' and mental ill health related absence increased.
- Mental ill health related absence is now at the highest level since Winter of 2021/22, when mental ill health related absence peaked at 1700 FTE days lost, which correlated with a peak in vacancy rates, followed by increased turnover.
- Whilst previous funding may not be available to implement a full psychologically informed approach to wellbeing this financial year, we recognise the need to identify additional funding sources especially as we expand our workforce to include greater numbers of people with lived experience of mental ill health.
- Some funding has been identified to continue our core programme of wellbeing activities into 2023/4 as part of ill health prevention, such as mindfulness sessions. In addition, whilst we are unable to carry out a full wellbeing festival this year, some funding has been identified to support a programme of events and site visits for Self-Care September, as well as rolling our health MOTs in October.
- A manager's toolkit for supporting staff mental health has been launched to ensure all staff are well supported.
- The People and OD Group continues to monitor the impact of our wellbeing plans. To date, our work on self care has led to improvements in our annual staff survey results and pulse survey results.

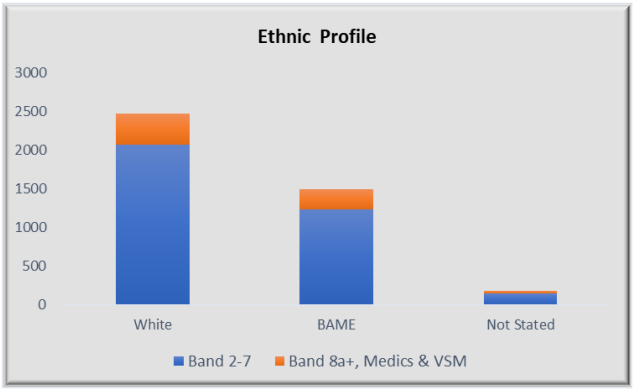
6. Employee Relations

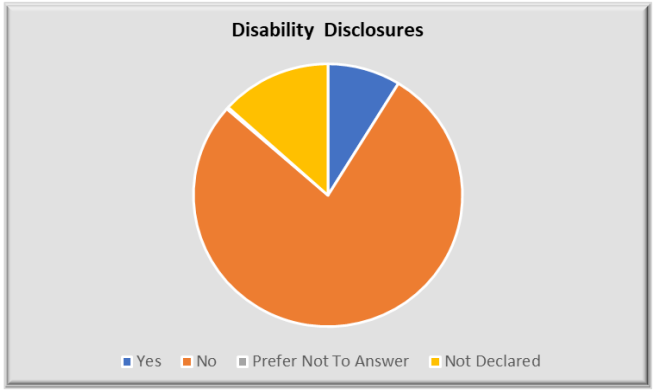
		0 - 5 working days	6 – 10 working days	11+ working days	Notes
Disciplinary Cases	Fact Find (13) (Date incident notified to date referred to decision making panel)	10	3		6 BAME 7 White
	Fact Find Outcome (13) Current investigations (Date decision making panel outcome to date investigation commences/letter of concern/other outcome notified to employee)	1	1	11	9 BAME 4 White
		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
	Suspension	3	1	2	Included in above; 2 BAME 4 White
	Alternative Duties	2	6	6	Included above; 6 White and 8 BAME
	Formal Investigation(9) (Date investigating manager appointed to date investigation report sent to commissioning manager)	4	1	4	7 White 2 BAME
		0 - 5 working days	6 – 10 working days	11+ working days	Notes
	Commissioning Manager Review (Date investigation report sent to commissioning manager to date employee notified of outcome)				
		0 - 7 weeks	8 - 12 weeks	13+ weeks	Notes
	Formal Hearing Stage (Date of decision to refer to hearing to date employee notified of hearing outcome)	1		1 rescheduled	1 BAME 1 White
	Appeal Stage (0) (Date of receipt of formal appeal to date employee notified of hearing outcome)				
TOTAL DISCIPLINARY MATTERS		35			

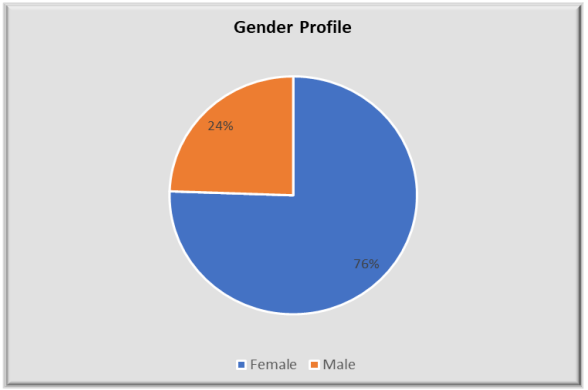
		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
Medical Cases	Medical Conduct 1			1	BAME
	Medical Capability	0			
TOTAL MEDICAL CASES		1			
		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
Grievances	Informal Grievance	4		2	3 BAME 3 White
	Formal Grievance	4	3	1	4 BAME 3 white (2 against same person)
TOTAL GRIEVANCE CASES		14			
		No. Cases			
Capability Cases	Informal Capability Management	0			
	Formal Capability Management	4			4 BAME
TOTAL CAPABILITY CASES		4			
TOTAL OTHER CASES (B&H)		2			
TOTAL EMPLOYMENT TRIBUNAL CASES		5			
TOTAL EMPLOYEE RELATIONS CASES		61			

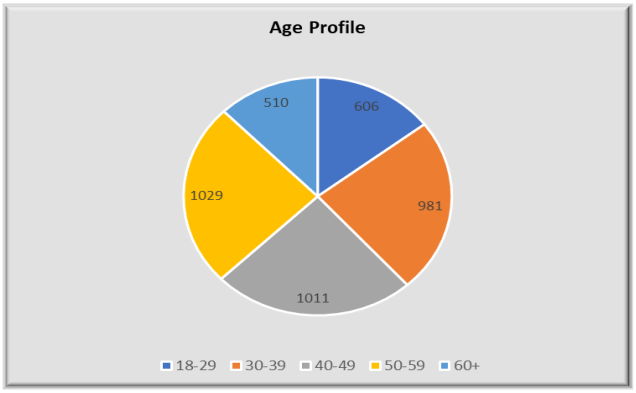
- There were 35 (increased from 31) conduct matters being supported by the ER team in August.
- The one medical conduct matter was due to be concluded in early July, however, the hearing has now been rescheduled due to ill health.
- Formal hearings are now being arranged in advance to avoid delay and there is increased SBU level scrutiny, as we implement the ER reset action plan agreed by the Executive Team in March. A further round of quarterly deep dive meetings were held with each SBU in July and will be repeated in September/October to ensure cases are being progressed swiftly and agreed actions are embedded.
- Suspensions have increased from 4 to 6.
- Grievance cases have increased from 11 in July to 14 in August
- An additional employment tribunal case was lodged in August, totalling 5 cases, of which 2 are from the same claimant.
- BAME staff continue to be overrepresented; this will be addressed through our Belonging and Inclusion Strategy.

7. Equality and Inclusion







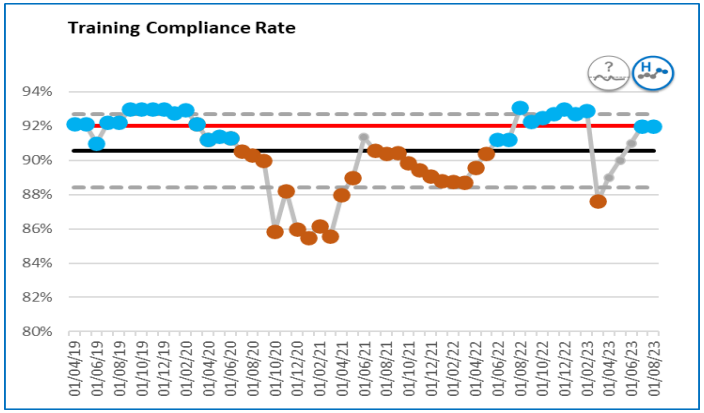


- The co-produced Belonging and Inclusion Strategy is being taken to October Board for approval.
- National Inclusion Week commenced on 25 September 2023, during which we are running an inclusion campaign and using our Senior Leadership Forum on 28 September to progress our inclusive culture.
- Our strategic plans focus on three areas:
    - Embedding an inclusive culture
    - Ensuring we have a diverse workforce
    - Eliminating discrimination
- Once finalised and launched, our strategy and action plan will address underrepresentation in our workforce and resolve the differing experience of staff in conduct and performance management, development and career progression so that every person feels a strong sense of belonging and inclusion.

8. Staff Development – Mandatory Training

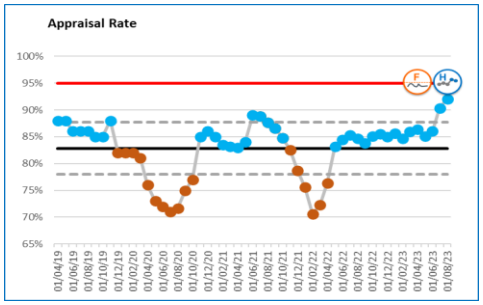
	Jul-23	Aug-23
Administration of Medicines M & C [3 Years]	82%	81%
Administration of Medicines RNs and Nas	95%	95%
Clinical Risk Assessment and Management [3 Years]	95%	95%
Complaints [None]	95%	94%
Data Security Awareness [1 Year]	91%	91%
Equality, Diversity & Human Rights [3 Years]	96%	96%
Fire Safety [1 Year]	95%	94%
Fire Safety [2 Years]	94%	94%
Food Hygiene [3 Years]	93%	94%
Health, Safety & Welfare [3 Years]	97%	97%
Infection, Prevention & Control Level 1 [2 Years]	94%	94%
Infection, Prevention & Control Level 2 [2 Years]	95%	95%
Ligature Awareness [3 years]	98%	98%
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	94%	94%
Mental Health Act [3 Years]	94%	94%
Moving and Handling L1 [3 Years]	96%	96%
Physical Health	95%	95%
Preventing Radicalisation Basic	83%	86%
Preventing Radicalisation Level 3	77%	79%
Safeguarding Adults Level 1 [3 Years]	97%	97%
Safeguarding Adults Level 2 [3 Years]	94%	94%
Safeguarding Adults Level 3 [3 Years]	91%	91%
Safeguarding Children Level 1 [3 Years]	97%	97%
Safeguarding Children Level 2 [3 Years]	94%	94%
Safeguarding Children Level 3 [3 Years]	96%	96%

	Jul-23	Aug-23
BLS	81%	81%
ILS	85%	85%
PBLS	47%	57%
Advanced M&H	84%	82%
Basic M&H	87%	87%
Respect 3a	96%	95%
Respect Level 3b	75%	74%
Respect Level 4	81%	81%
Respect Level 4/5 (Norfolk)	94%	92%
Respect Level 5	79%	79%



- Mandatory training compliance has remained at our target of 92% in August.
- Currently, additional training courses are being run for paediatric BLS, as a result of an expanded cohort of staff requiring the training and thus reducing compliance.
- Additional courses have been put on to increase compliance for Respect Modules 4 and 5. A new venue for respect level 5 training has been identified to reduce the training backlogs and enable staff to take up their role fully and promptly.
- Tier 1 Oliver McGowan eLearning launched in July. So far, we ave achieved 25% compliance. HPFT will be the first Trust in the ICS to roll out Tier 2 training from October 2023, starting with LD&F SBU staff as an initial pilot.
- Regular reporting of compliance is received by SBUs and corporate services together with course availability reporting.
- The People and OD Group maintains oversight on compliance and is scrutinising performance trajectories and actions being taken to further improve compliance.

9. Staff Development - Appraisal, Induction & CPD



- Appraisal compliance has increased from 90.4% in July to 92.1% in August
- The new appraisal window and App launched at the start of April 2023 and ran until the end of July. Whilst this has increased compliance to the highest it has ever been, we have not yet been able to achieve our 95% target and will therefore continue work to improve this.
- Our training needs analysis, talent management and succession plans will now be developed using the information from the App, with the development offer to staff refreshed in Q3.
- The People and OD Group will continue to monitor compliance and approve our training, talent management and succession plans.

Work Experience

- 2 work experience students supported to undertake placements in August

Education Planning

- 5-year education plan submitted to NHSE
- Demand scoping plan completed for Nursing, AHPs, Psychological Therapies and Pharmacy programmes and submitted to NHSE to help ensure capacity to meet demand

Simulation Hub

- New medical emergency scenarios to the Junior Doctors as part of their induction. Training was well received and will be tweaked for the next cohort in December and also rolled out wider to acute staff members
- Sim Hub has been utilised to record interviews
- First delivery of simulation training to Cambridge Medical Students. Feedback was very positive and students found the training very beneficial..

Library & Knowledge Services

- Article requests: 31
- Enquiries: 106
- Book loans: 11
- Athens registration:438
- Library membership:718

Induction

- 58 staff attended in August
- Session rated 4.5/5
- Onboarding experience rated 4.4/5

Mandatory Training

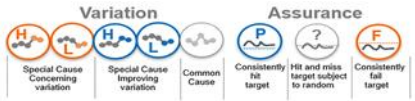
- 689 staff attended face to face Mandatory Training in August
- Highest attended = BLS = 205

Continuing Professional Development

- HPFT awarded £319,668 funding based on AHP and Nursing headcount
- Investment plan detailing how funding would be spent submitted 28th July

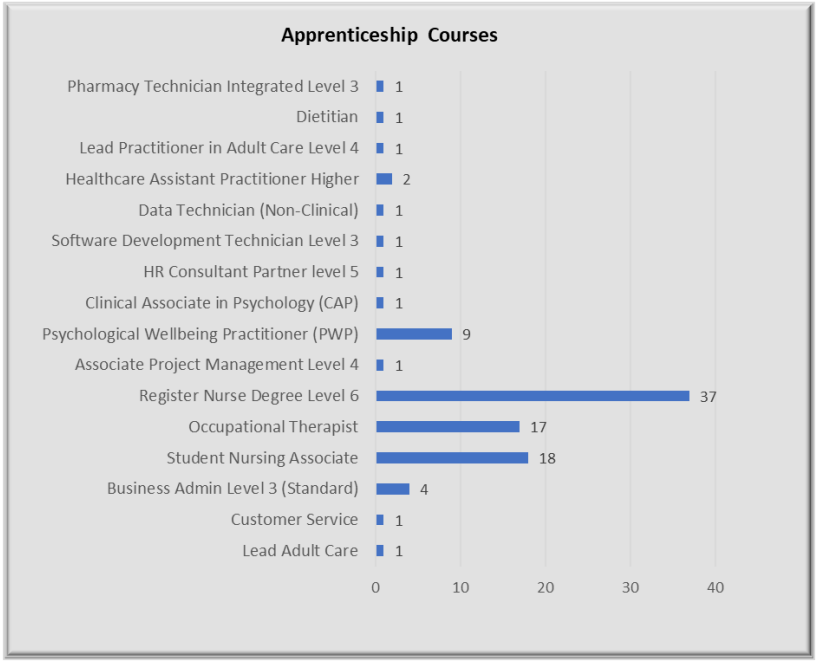
Medical Education

- Weekly Joint Academic Teaching held with total of 358 medical workforce attendees across 3 sessions
- The Balint for core trainees commenced in August and a total of 26 trainees attended
- The Cambridge Medical Students Induction incorporated with Simulation Training was held in-person in August
- The mock Clinical Assessment of Skills and Competencies (CASC) exam was held in August.



9. New Role/Apprenticeships

Levy Pot	
Current Funds	£1,798,936
Funds spent since Sep 22	£632,475
Estimated spend for the next 12 months	£494,592
Funds Expiring in Jun 23	£14,957



- We currently have 97 apprentices.
- Whilst we are growing our apprenticeships, we continue not to fully utilise our levy pot. Work has started to ensure the apprenticeship pipeline is embedded within our early careers strategy, aligned to our vacancy profile and fully optimised in terms of funds utilisation.
- In addition to our apprentices, we have increased our qualified Professional Nurse Associates (PNAs) to 28. PNAs carry out restorative supervision sessions, career conversations and support improvement projects.
- A task and finish group is being created to explore how nurse apprenticeship can be expanded to increase our supply of registered nurses.
- We continue to provide in-house functional skills training to support people to undertake apprenticeships. Cohort 3 commenced in September.
- 4 staff have been accepted onto a three-year Social Worker Apprenticeship programme starting in September, which is a first for the Trust.
- The community transformation programme is expected to create further opportunities to expand our apprenticeships.
- The Trust has part funded 8 members of staff to undertake an Open University Registered Learning Disability nurse degree programme as direct action to improve the pipeline in Norfolk and Essex.

9. Conclusion

The key headlines from Month 5 are as follows:

- Vacancy rates have reduced to 11.7%. This is as a result of larger numbers of new staff joining and turnover reducing to 11.3%, which is the lowest rate in two years. We continue to have a healthy pipeline of over 700 FTE posts, 202 of which are external candidates who have firm offers and are due to start with us shortly. However, new budgets have now been agreed and uploaded and are expected to increase our establishment by over 100 FTE and thus our vacancy rate to around 12.5% in September.
- The Recruitment and Retention Group and People and OD Group are monitoring performance and overseeing implementation of our refreshed recruitment and retention plans for 2023/4 which will particularly target the recruitment pipeline for hot spot areas and staff groups.
- Agency use mapped against recruitment activity is being scrutinised by the Agency Panel and Financial Recovery Board to generate clear trajectories to achieve the 2023/4 Trust targeted agency spend.
- The co-produced Belonging and Inclusion Strategy is being finalised and the supporting action plan will be implemented with ambitious targets for improvement across all workforce metrics which will be further developed to identify difference between our different staff groups through Q2.
- Formal employee relations cases remain low and we are seeing the impact of our action plan to re-set the approach to ER matters start to have an impact, albeit that some legacy cases will continue to be reported. The majority of our grievance cases are expected to be resolved by the end of September.
- Appraisal rates are at a record high level, albeit that they are 2.9% lower than our 95% target. Work will continue to achieve full compliance.
- Mandatory training rates have recovered to meet our 92% target. Additional work is being undertaken to increase compliance further across all courses.
- Our staff development offer remains strong. A further enhanced offer will be developed in Q2 and launched in Q3, based on detailed training needs analysis from our new Appraisal App.

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

Hertfordshire Partnership University NHS Foundation Trust

Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 8
Report Title	Report of the Finance and Investment Committee held on 26 October 2023	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Helen Edmondson, Head of Corporate Affairs & Company Secretary	
Approved by:	Philip Cave, Chief Finance Officer	

The Board is asked to receive
To provide the Board with an overview of the work undertaken by the Finance and Investment Committee at its most recent meeting on 26 October 2023.

Executive Summary
Report details the work of the Finance and Investment Committee which met on 26 October 2023. There were no matters for formal escalation to the Board. The Board is asked to note that the Committee approved the Mental Health Urgent Care Centre, which is also fully supported by the Hertfordshire and West Essex ICB but there were some concerns of the lack of commissioner commitment to ongoing funding.

Recommendations
The Board are asked to **RECEIVE AND NOTE** the report below. There are no formal escalations.

Implications	
Risk and Assurance	The Committee that is responsible for providing assurance regarding financial and commercial risks
Equality, Diversity and Human Rights	The Committee considered the Annual Plan and performance metrics which support delivery equity of provision.
Quality	The Committee that is responsible for providing assurance regarding financial and commercial risks, which are closely aligned with management of quality
Financial	The Committee considered a number of reports which detailed the financial position for the Trust.

Service Users and Carer Experience	The Committee considered annual plan delivery, performance metrics and reports on services all of which impact on service user experience
People	Ensuring the delivery of financial plan is important to ensuring positive staff experience.
Legal and Regulatory	Meeting statutory financial duties is a key legal requirement
Digital	Committee noted positive impact of digital and technological solutions
System	Increasingly the Trust works with system partners to agree priorities and funding.
Sustainability	No implications

Strategic Objectives this report supports	**Please tick any that are relevant**
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	✓
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	✓
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	

Hertfordshire Partnership University NHS Foundation Trust

Report from Finance and Investment Committee held on 26 October 2023

1. Introduction

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

1.2 The Committee met on 26 October 2023 in accordance with its terms of reference and was quorate. The meeting was chaired by Anne Barnard, Non-Executive Director.

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

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

2. Deep Dive – Commercial Strategy

2.1 The Committee received a deep dive on the developing Commercial Strategy, building on the outputs of the Board Workshop held in early August 2023. The presentation took Committee members through the expectations regarding demand for services and funding. The Committee supported the detailed strengths and weaknesses.

2.2 Committee members discussed and supported the proposed 'red lines' to underpin the commercial strategy and criteria for considering new service opportunities.

2.3 Committee members explored how expectations from system partners would align with the commercial strategy, noting that the strategy would help inform the Trust's response to opportunities.

2.4 Following discussion it was noted that the strategy was commercially confidential which impacted on the level of co-production that could be undertaken. It was reported that the commercial strategy would be developed further with the updated version being considered at a future Committee meeting.

3. Finance

3.1 The Committee received a report that set out the Trust financial position at month six. It was reported that the Trust had agreed a £1.8m deficit plan for 2023/24, that included £15m for the Delivering Value programme.

3.2 It was reported that at month six the Trust was reporting a deficit of £3.4m which was £2.1m worse position than the plan. It was noted that this position included the phasing in of additional resources from the ICB originally planned to be phased in at month twelve. The Committee noted the key drivers for the deficit position as well as the elements that were offsetting the negative run rate. It was reported that delivery of the financial plan for 2023/24 would be challenging and the Exec Team had identified areas for work to reduce expenditure and secure additional income.

3.3 The Committee were updated on the regional and ICB financial position. The forecast position was discussed and how this would play into the medium-term financial plan for the Trust.

3.4 Following discussion it was agreed that an analysis of service lines to identify the resources, activity and workforce mapped to income would be reported to the January Committee meeting.

3.5 In response to a question the position regarding winter funding was clarified. Namely that the resources were being held by NHS England and there was the expectation that the £200m that had been announced nationally was to be used to offset baseline costs rather than support development of new services.

3.6 The work underway to ensure the outcome of the establishment review had been implemented with appropriate financial controls was reported. Also, the deep dive into the use of agency staff to support services users in acute providers was reported on, noting that resolving this would be beneficial to system partners and the Trust.

3.7 Following discussion it was agreed that the next Committee meeting would consider an analysis of expenditure on all aspects of secondary commissioning.

3.8 In response to concerns on the Trust's performance with regard to Better Payment Practice Code (BPPC) the Committee considered a report detailing cumulative performance as at end of September 2023. It was reported that the Trust continued to fall slightly short of the 95% target.

3.9 The Committee were updated on the planned actions to improve the position with regards to BPPC, namely to 'no PO no payment' and the use of eroster to support authorisation of agency invoices. It was agreed that a future Committee meeting would receive an update on changes to eroster and implementation of functionality to support the payment process.

3.10 In response to feedback from the last meeting Committee members received a report that provided an update on the investments included in the Trust's Financial Plan for 2023/24. Committee members discussed the use of MHIS and SDF to support transformation and service development in line with national and local requirements.

3.11 Committee members explored their understanding of recurrent and non-recurrent aspects of MHIS and SDF. Members highlighted the opportunities but also the risk to service delivery if funding is not confirmed for future years and the importance of early negotiations with commissioners.

3.12 Committee members considered and supported the process for the development and prioritisation of investment funding for 2024/25 and future years.

3.13 The Committee received the Medium-Term Financial Plan that had been submitted to the ICB in September 2023.

3.14 Committee members discussed the system financial position. The importance of working with partners was agreed and that it was vital that the Trust has a clear position with regard to funding required to continue to provide services to meet demand. It was noted that the financial planning process was ongoing and the Medium-Term Plan was likely to be updated.

4. Performance

4.1. The Committee considered the quarter two for 2023/24 report on performance. The report set out that things remained challenging, but that of the 63 key performance indicators almost 63% of them had met or exceed the target. Committee members noted that there remained challenges in demand for crisis and inpatient services, and access for Children and Young People. In particular in CAMHS East team and Southwest Adult Community Mental Health services.

4.2. Areas of strong performance were recovery in Talking Therapies, Children and Young people in crisis receiving assessment, Single Point of Access, along with steady progress across a number of metrics including workforce. The improved position for EMDASS was noted. The positive trend with regard to services user recommending the Trust services was welcomed.

4.3. In response to a question, it was reported that the increase in demand for services for young people and adults was being raised with commissioners. Discussions were being supported by a Trust demand and capacity analysis, along with a deep dive into waiting times.

5. Annual Plan

5.1. The Committee considered the Annual Plan quarter two. It was noted that reporting of the Annual Plan had been amended to be aligned to the Great Together and the Trust's six Strategic Objectives.

5.2 It was reported that quarter two had been a challenging period for the Trust and the wider health and care system with continued demand and acuity pressures and significant periods of Industrial Action. Despite these pressures the Trust delivered against most milestones for the quarter and is on track to meet the majority of the outcomes for 2023-24. In particular four out of six objectives had achieved the quarterly milestones and five out of six objectives are forecast to meet the end of year outcomes.

5.2 Committee members discussed the proposed changes to year end metrics for Strategic Objectives one and five. The change to the Strategic Objective one was supported by Committee members noting that discussion were underway with commissioners to extend the current contract for ADHD. With regard to the year end metric for Strategic Objective five Committee members agreed the change due the decision by Region to postpone the devolvement of perinatal commissioning to the Provider Collaborative. April 2024 at the earliest.

5.3 In response to a question it was agreed that the rationale for year end forecast for Strategic Objective five being Green was explained, namely that there was confidence that the items amber at quarter two would be achieved by year end.

6. East of England Provider Collaborative

6.1 The Committee considered an update report on the East of England Provider Collaborative. It was reported with regard to Children and Young People transformation of the eating disorder pathway was underway, which includes developing 2 eating disorder beds in each general adolescent unit. The bed reconfiguration remains the priority.

6.2 It was noted that there was a delay to the launch of adult virtual eating disorders team due to recruitment issues. Positively all parts of the region had received funding for the roll out of intensive support teams for eating disorders.

6.3 It was reported that new strategy for secure services had been agreed. In support of this a revised business case is being developed by the Trust for a women's service that will have wider criteria for admission to meet the needs of service users and make it more viable.

6.4 The Committee discussed in detail the current position regarding the decision to pause delegation of responsibility for commissioning of perinatal services to the Provider Collaborative. It was reported that NHS England/region wanted the Collaborative to demonstrate its work with ICBs across the region to

commission an integrated pathway with maternity and community perinatal services. In addition, they were seeking further evidence regarding care of the babies and in meeting the needs of families who were a long distance from home. Committee members were assured that the Collaborative would be able to provide the evidence of work and was aiming for delegation to go live from April 2024. It was noted that other regions had also deferred delegation to April 2024.

6.5 The Committee were updated on the financial position of the Collaborative, with members noting it was reporting a surplus at month five however there is increasing pressure from the costs of Extraordinary Packages of Care in secure services.

6.6 It was agreed that future update report to the Committee would include details of the plans for the young people who were part of the Transforming Care Programme.

7. Urgent Care Centre Business Case

7.1 The Committee considered and supported the Business Case for the Urgent Care Centre to be based on the Lister Hospital site. Committee members welcomed the proposed model, noting it was heavily focused on ensuring 'flow' of service users across services and needed to be an integral part of the crisis offer for service users.

7.2 It was reported that the mobilisation of the Centre would be on a phased basis dependent on recruitment and estates. It was reported that there was confidence regarding recruitment.

7.3 The Committee explored the rationale for a section 136 suite not being included in the Centre. It was reported that other models nationally did not have a 136 suite as it distracted the focus from supporting flow through to other services.

7.4 Committee members noted the capital and revenue requirements, noting that an increase to the Trusts capital limit (CDEL) had been agreed by the ICB. Committee members expressed some concern that the Trust was holding all the financial risk for the Business Case. It was reported that the ICB was supportive of the business case noting the benefits for system partners as well as the Trust.

8. East and North In-patient unit update

8.1 The Committee received an update on the identification of an alternative to the development of new inpatient unit in East and North Hertfordshire. It was noted that some options had been discounted due to their location and the fact they would mean the establishment of new standalone units.

8.2 It was reported that the Trust was aiming for a preferred option to be identified by end of November. It was reported that in all options the Trust will require an increase in its capital (CDEL) and cash support. Committee members emphasised the need to maintain the standards set when planning for the original East and North Herts unit was undertaken.

9. Matters for Escalation to the Board

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

9.2 The Board is asked to note that the Committee approved the Mental Health Urgent Care Centre, which is also fully supported by the Hertfordshire and West Essex ICB but there were some concerns of the lack of commissioner commitment to ongoing funding.

Hertfordshire Partnership University NHS Foundation Trust

Appendix one – Agenda items 26 October 2023

Subject
Apologies for Absence
Declarations of Interest
Minutes of meeting held on 25 July 2023
Matters Arising Schedule
DEEP DIVE
Commercial Strategy
OPERATIONAL
Finance Report
Better Payment Code Performance
In year investment update
Performance Report
Quarter Two: Annual Plan Report
East of England Collaborative Update
STRATEGIC
Crisis Assessment Centre Case
Medium Term Financial Plan
East and North In-patient Update
Provider Selection Regime
OTHER BUSINESS
FIC Business Programme
Any Other Business
Date of next meeting: 23 November 2023

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 8a
Report Title	Quarter 2 Performance Report 2023/24	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Sally Wilson, Head of Performance Improvement	
Approved by:	Hakan Akozek, Director of Innovation & Digital Transformation	

The Board is asked to: There are no direct implications on sustainability.

The Trust Board is recommended to receive the report, discuss key areas of performance and to note actions being taken to improve performance. This report was discussed in detail at the Finance and Investment Committee on 26 October 2023.

Executive Summary

At the end of Quarter 2, 63% (40/63) of our Key Performance Indicators across the five operational performance domains were either fully met or almost met.

The Trust performed well in:

- Proportion of people receiving Talking Therapies moving into recovery and receiving treatment within specified waiting times.
- People needing our inpatient services being reviewed for less restrictive alternatives prior to their admission.
- Children and Young People in crisis receiving assessment within 4 hours.
- Children and Young People who need our eating disorder service, both urgent and routine, are seen within given timescales.
- People referred to our Single Point of Access are passed on to the appropriate service within 14 days.
- People discharged from our inpatient services receiving a follow up contact within 48 hours.
- Service users recommending the trust services to friends and family if they needed them.
- Service users saying that staff are welcoming and friendly.
- Staff with completed mandatory training.

Our key areas of focus where we have significant challenges continue to be:

- Demand for our inpatient and crisis pathways remains extremely high, and our flow through the service is adversely affected by an increased number of people clinically ready for discharge but delayed, due to a lack of appropriate placements for people with more complex needs. We have seen a notable rise in delays within Older People's services in Quarter 2, and we are working with our partners in HCC to improve this position, as well as continuing to explore alternative pathways to support discharge and prevent admission.
- We continue to focus on improving access times in our high-volume community CAMHS and Adult Services, whilst balancing the ability to provide timely and effective treatment. Whilst some localities have seen significant improvement in access times others are still experiencing difficulty in reducing waiting lists, particularly where recruitment is challenging.

In addition to our work on recruitment we are reviewing our clinical processes and workflows using demand and capacity modelling as part of the transformation of our services. This includes how we deliver ADHD services in consultation with our commissioners. We expect to recover performance in children and young people service in Quarter 4. Adult community services are also predicting recovery at the end of Quarter 4; the service has recently seen an increase in its waiting list due to increased demand. A demand and capacity assessment is being carried out to determine the short- and long-term impact of the sustained demand.

- Providing diagnosis within 12 weeks in our Early Memory Diagnosis and Support Service. We continue to provide additional clinics and have started transforming the diagnosis pathway by introducing primary care dementia diagnosis nurses to speed up access to diagnosis. We expect this to recover in the early part of Quarter 3.
- Recruiting and retaining our skilled workforce, particularly for the medical, registered nursing and allied health professional groups. We continue to focus on recruiting staff as well as ensuring that we continuously improve the experience of our people so that we retain our staff and maintain our position as one of the best mental health and learning disability trusts to work for in the country.

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

Recommendations

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

Implications

Risk and Assurance	This performance report highlights areas of both risk and assurance in the delivery of clinical services. Mitigating actions are shown against identified performance risks.
Equality, Diversity and Human Rights	There is no direct impact on equality, diversity, and human rights.
Quality	This report highlights Trust performance against national key performance indicators. A number of these relate to the quality of services that the Trust provide.
Financial	The report outlines the Trust's financial deficit of £3.4m and delivering value position.
Service Users and Carer Experience	The report highlights a number of service user experience metrics for which national KPIs are not being met, often leading to delays in services.
People	Increased demand for a number of Trust services places additional pressure on the Trust's workforce.
Legal and Regulatory	This report keeps the Board informed of the key performance position of the organisation across quality, safety, operations, workforce and finance.
Digital	There are no direct implications on digital.
System	Trust performance is aggregated within HWE System performance reporting.
Sustainability	There are no direct implications on sustainability.

Strategic Objectives this report supports	Please tick any that are relevant ✓
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	✓
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	✓
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	✓
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	✓

Q2 2023/24 Performance Report

1. Background

1.1. This report provides an overview of the Trust's performance at the end of September 2023 and an update on the actions being taken to improve performance.

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

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

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

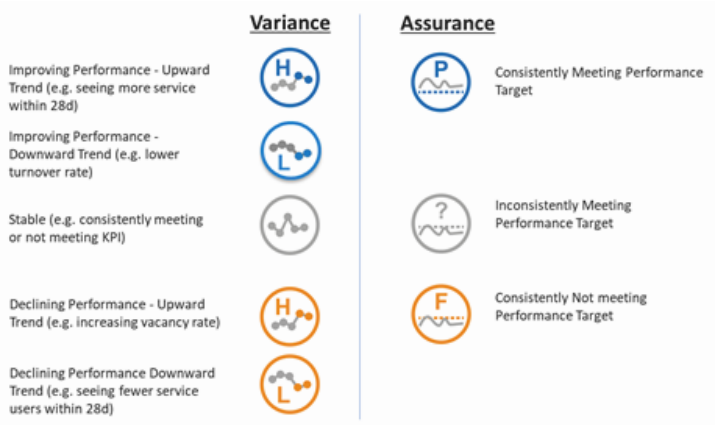


Figure 1 - SPC Icons

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

2. Quarter 2 2023/24 Performance Summary

2.1. In Quarter 2 we continued to see pressure on our inpatient services, with a continuing high number of referrals combined with a limited number of community placements suitable for people with complex needs. This resulted in more people experiencing delays in leaving our inpatient services when they were clinically ready for discharge, particularly in Older Adult Services.

2.2. We continued to focus on improving our access times whilst maintaining a balance of providing timely and effective treatment to the people who use our services.

2.3. At the end of September, 63% (40/63) of our Key Performance Indicators were either fully met or almost met.

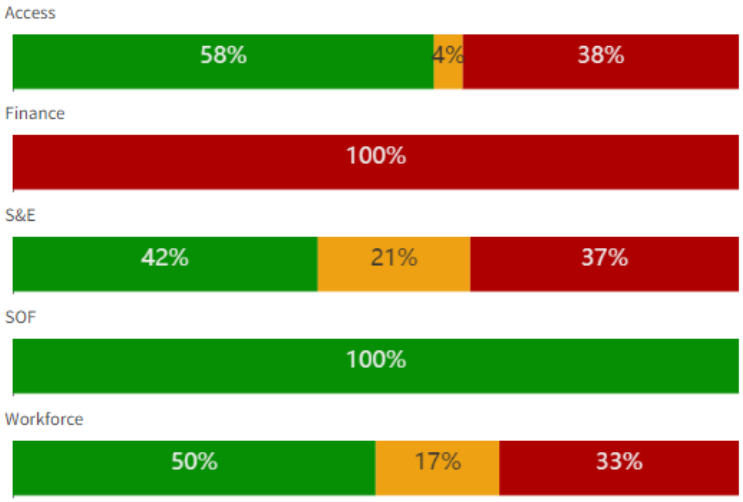


Figure 2 - Percentage of KPIs met in September 2023

2.4. Key areas of strong performance at the end of Quarter 2 include:

- Proportion of people receiving Talking Therapies moving into recovery and receiving treatment within specified waiting times.
- People needing our inpatient services being reviewed for less restrictive alternatives prior to their admission.
- Children and Young People in crisis receiving assessment within 4 hours.
- Children and Young People who need our Eating Disorder service, both urgent and routine, are seen within given timescales.
- People referred to our Single Point of Access are passed on to the appropriate service within 14 days.
- People discharged from our inpatient services receiving a follow up contact within 48 hours.
- Service users recommending the trust services to friends and family if they needed them.
- Service users saying that staff are welcoming and friendly.
- Staff with completed mandatory training.

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

- Demand for our inpatient and crisis pathways remains extremely high, and our flow through the service is adversely affected by an increased number of people clinically ready for discharge but delayed, due to a lack of appropriate

placements for people with more complex needs. We have seen a notable rise in delays within Older People's services in Quarter 2, and we are working with our partners in Hertfordshire County Council to improve this position, as well as continuing to explore alternative pathways to support discharge and prevent admission.

- We continue to focus on improving access times in our high-volume community CAMHS and Adult Services, whilst balancing the ability to provide timely and effective treatment. Whilst some localities have seen significant improvement in access times others are still experiencing difficulty in reducing waiting lists, particularly where recruitment is challenging. In addition to our work on recruitment, we are also reviewing our clinical processes and workflows using demand and capacity modelling as part of the transformation of our services. This includes how we deliver ADHD services in consultation with our commissioners. We expect to recover performance in children and young people service in Quarter 4. Adult community services are predicting recovery at the end of Quarter 4; the service has recently seen an increase in its waiting list due to increased demand. A demand and capacity assessment is being carried out to determine the short- and long-term impact of the sustained demand.
- Providing diagnosis within 12 weeks in our Early Memory Diagnosis and Support Service. We continue to provide additional clinics and have started transforming the diagnosis pathway by introducing primary care dementia diagnosis nurses to speed up access to diagnosis. We expect this to recover in the early part of Quarter 3.
- Recruiting and retaining our skilled workforce, particularly for the medical, registered nursing and allied health professional groups. We continue to focus on recruiting staff as well as ensuring that we continuously improve the experience of our people so that we retain our staff and maintain our position as one of the best mental health and learning disability trusts to work for in the country.

3. **Single Oversight Framework**

3.1. The NHS oversight framework has gone through significant changes with the majority of the key performance indicators now being monitored at Integrated Care Board level. The Trust continues to monitor the only Trust level Mental Health indicator (inappropriate out of area placements) as well as five other indicators as part of this domain. At the end of Quarter 2, the Trust has met all key performance indicators in this domain.

3.2. People with a first episode of psychosis can access our specialist PATH service within 14 days of referral in 63% of cases against the national target of 60%.

3.3. Our Data Quality Maturity Index Score was at 97% against a 95% target.

3.4. Our Talking Therapy (IAPT) services perform well for six and eighteen-week access targets as well as recovery target.

3.5. At the end of Quarter 2, we have met our inappropriate out of area bed utilisation improvement trajectory. However, ongoing high demand for inpatient services continues with an increased number of people who are ready for discharge remaining in beds due to a lack of appropriate placements that can meet their needs. We continue to work with NHS England and system partners to ensure best practice in this area and working on reducing length of stay in our inpatient services to ensure our service users are supported in the most appropriate setting.

3.6. The table below summarises the end of Quarter 2 position for our Single Oversight Framework key performance indicators. Details of actions we are taking to improve our performance as can be found in Appendix 1.

KPI	Month	Performance	Target	Variation	Assurance	Mean
Data Quality Maturity Index (DQMI) – MHSDS dataset score (National)	Jun-2023	97%	95%			96.3%
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (National)	Sep-2023	63%	60%			78.1%
Improving Access to Psychological Therapies (IAPT)/talking therapies Proportion of people completing treatment who move to recovery (National)	Sep-2023	51%	50%			52.6%
Inappropriate out-of-area placements for adult mental health services (National)	Sep-2023	430	736	N/A	N/A	N/A
Improving Access to Psychological Therapies (IAPT)/talking therapies Waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks (National)	Sep-2023	95%	75%			95.3%
Improving Access to Psychological Therapies (IAPT)/talking therapies - 18 weeks (National)	Sep-2023	100%	95%			100%

Table 1 - Single Oversight Framework KPIs

4. Access

4.1. At the end of Quarter 2, the Trust has met 14 out of the 24 access key performance indicators and almost met one more.

4.2. Our Single Point of Access Service continues to perform well, passing all referrals on to teams or signposting people to more appropriate services within 14 days of referral. Our CAMHS eating disorder service and crisis service are performing

strongly against their access targets and we continue to meet our access targets to assess people with potential mental health needs who are in A&E and general hospital wards.

4.3. We are remodelling our adult crisis service in response to the new waiting time standards that are being introduced nationally. The standard for our emergency four-hour crisis waits has changed to ensure that everybody has a face-to-face contact and we are introducing a 24-hour urgent standard that will also require face to face contact.

4.4. We have experienced some challenges in our CAMHS Targeted Team for looked after children and our Adult Eating Disorder service due to levels of vacancies and sickness. Recruitment initiatives are underway in both services and improvement is expected in Quarter 3.

4.5. We continue to work to improve access in our Core Community CAMHS and Adult Services and are seeing sustained improvement in individual teams. Services experience regional variation in the challenges they face with recruitment, particularly in the South and East of the county. We are reviewing the ways in which we can deliver services and the skill mix of staff required whilst continuing to focus on recruitment.

4.6. Our early memory diagnosis service continues to recover performance against the 12-week local waiting time standard at the same time as transforming the way it delivers the service. There is a focus on people being seen locally at their GP surgery by Primary Health Care staff supported by our specialist staff and their knowledge. Recovery of the waiting time standard continues to be predicted in Quarter 3.

4.7. The table below summarises the end of Quarter 2 2023 position for our access key performance indicators. Details of actions we are taking to improve our performance as part of our Recovery Programme can be found in Appendix 1.

Access	Month	Performance	Target	Variation	Assurance	Mean
CAMHS Eating Disorders - Routine 28 day Waited. (National)	Sep-2023	100%	95%			58.5%
Number of new cases of psychosis (National)	Sep-2023	147	75	N/A	N/A	N/A
Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait (Contractual)	Sep-2023	98%	98%			98%
MHLT Response times: 1 hour wait for AandE referrals (National)	Sep-2023	95%	90%			94.4%

Access	Month	Performance	Target	Variation	Assurance	Mean
CAMHS referrals meeting assessment waiting time standards - CRISIS (4 hours) (Contractual)	Sep-2023	99%	95%			91%
CAMHS Eating Disorders - Urgent referrals seen within 7 Days. (National)	Sep-2023	100%	95%			58.4%
Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team (Contractual)	Sep-2023	100%	95%			97.1%
SPA referrals with an outcome within 14 days (Internal) (Internal)	Sep-2023	100%	95%			94.2%
CAMHS referrals meeting social worker contact waiting time standards - TARGETED SERVICE 14 DAYS (Contractual)	Sep-2023	100%	85%			93.6%
Urgent referrals to community mental health team meeting 24 hour wait (Contractual)	Sep-2023	No Referrals	95%	N/A	N/A	N/A
Urgent referrals to community eating disorder services meeting 96 hour wait (Contractual)	Sep-2023	No Referrals	98%	N/A	N/A	N/A
CRHTT referrals meeting 4 hour wait (Contractual)	Sep-2023	100%	98%			100%
MHLT Response times: 24 hour wait for ward referrals (National)	Sep-2023	100%	90%			97.4%
Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait (Contractual)	Sep-2023	No Referrals	98%	N/A	N/A	N/A
EMDASS Diagnosis within 12 weeks (Contractual)	Sep-2023	79%	80%			44.2%
Number of people entering IAPT treatment (ENCCG) (National)	Sep-2023	77%	100%			86%
Number of people entering IAPT treatment (HVCCG) (National)	Sep-2023	85%	100%			85.5%
Number of people entering IAPT treatment (Mid Essex) (National)	Sep-2023	79%	100%			77.4%

Access	Month	Performance	Target	Variation	Assurance	Mean
Routine referrals to community mental health team meeting 28 day wait (Contractual)	Sep-2023	61%	95%			55.5%
CAMHS referrals meeting assessment waiting time standards - TARGETED SERVICE 28 DAYS (Contractual)	Sep-2023	0%	85%			68.9%
Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services (National)	Sep-2023	92%	98%			94.8%
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS) (Contractual)	Sep-2023	53%	95%			75.6%
CAMHS referrals meeting assessment waiting time standards - URGENT (P1 - 7 DAYS) (Contractual)	Sep-2023	67%	75%			74.9%
Routine referrals to community eating disorder services meeting 28 day wait (Contractual)	Sep-2023	52%	98%			82.5%

Table 2 - Access Key Performance Indicators

5. **Safe and Effective**

5.1. At the end of Quarter 2 2023/24, the Trust met ten out of twenty-four key performance indicators in the Safe and Effective domain and almost met a further five.

5.2. We continue to focus on service users' safety when they leave our inpatient services by ensuring that they receive a follow-up contact within 48 hours.

5.3. People completing a course of treatment in our Talking Therapy (IAPT) services are moving toward recovery at a rate that is above the national standard.

5.4. The number of people who are delayed in our services when they are ready to leave is currently at 16% and we recognise that this needs to improve. Delays in our older people's services have increased with difficulties in sourcing appropriate placements. Our focus is to work in partnership with Hertfordshire County Council to increase access to places for people who need more complex care in the community or who may have high social care needs. We are also recruiting additional social workers specifically to focus on delayed transfers of care and actively investigating any further Better Care Fund activity that could be pursued.

5.5. As we transition away from using our paper Having Your Say survey to a more focused approach to getting feedback, we have seen a decline in numbers of

responses, which can make the results more volatile and should be considered when interpreting the data.

5.6. We continue to focus on physical health checks for people with psychosis in our community and PATH services.

5.7. The Table below summarises the end of Quarter 2 position for our safe and effective key performance indicators with actions we are taking to improve in key areas summarised in Appendix 1.

KPI	Month	Performance	Target	Variation	Assurance	Mean
Rate of carers that feel valued by staff (Internal)	Sep-2023	79%	75%			79.8%
Rate of service users that would recommend the Trust's services to friends and family if they needed them (National)	Sep-2023	83%	80%			81%
IAPT % clients moving towards recovery (HVCCG) (National)	Sep-2023	52%	50%			54.6%
IAPT % clients moving towards recovery (Mid Essex) (National)	Sep-2023	53%	50%			50.5%
Rate of Service Users saying they know how to get support and advice at a time of crisis (Internal)	Sep-2023	87%	83%			81%
Rate of Service Users Saying staff are welcoming and friendly (Internal)	Sep-2023	96%	95%			95.6%
The percentage of people under adult mental illness specialties who were followed up within 48 hrs of discharge from psychiatric in-patient care (Internal)	Sep-2023	88%	80%			83.1%
The percentage of people under adult mental illness specialties who were followed up within 7 days of discharge from psychiatric in-patient care (National)	Sep-2023	99%	95%			97.6%
Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them (National)	2023 Q2	73%	70%	N/A	N/A	N/A

KPI	Month	Performance	Target	Variation	Assurance	Mean
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: (National)	Sep-2023	99%	95%			99.8%
Percentage of eligible service users with a PbR cluster (Contractual)	Sep-2023	92%	95%			93.7%
Ensure that cardio-metabolic assessment and treatment for people with SMI is delivered routinely in community mental health services (Contractual)	Sep-2023	93%	95%			83.5%
Rate of service users with a completed up to date risk assessment (inc LDandF and CAMHS from Apr 2015) Seen Only (Contractual)	Sep-2023	93%	95%			92%
IAPT % clients moving towards recovery (ENCCG) (National)	Sep-2023	49%	50%			51.4%
Rate of service users saying they are treated in a way that reflects the Trust's values (Internal)	Sep-2023	79%	80%			83%
Percentage of eligible service users with a completed PbR cluster review (Contractual)	Sep-2023	61%	95%			66.7%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services (Contractual)	Sep-2023	85%	90%			81%
Delayed transfers of care to the maintained at a minimal level (National)	Sep-2023	16%	3.5%			16.4%
Data completeness against minimum dataset for Ethnicity (MHSDS) (National)	Sep-2023	84%	90%			84.6%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation) (National)	Sep-2023	75%	85%			72.7%

KPI	Month	Performance	Target	Variation	Assurance	Mean
The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months (Contractual)	Sep-2023	79%	95%			73.5%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment) (National)	Sep-2023	75%	85%			72.7%
Rate of acute Inpatients reporting feeling safe (Internal)	Sep-2023	75%	85%			72.7%

Table 3 - Safe and Effective Key Performance Indicators

6. Workforce

6.1. The Trust met three out of six Workforce indicators and almost met one at the end of September.

6.2. We have continued to deliver improvements in appraisal compliance and unplanned turnover compared to the start of the year, as outlined in the tables below.

6.3. Recruiting and retaining our skilled workforce remains our biggest challenge in delivering services with similar challenges across the NHS, particularly for the medical, registered nursing and allied health professional groups. We continue to focus on recruiting staff as well as ensuring that we continuously improve the experience of our people so that we retain our staff and maintain our position as one of the best mental health and learning disability trusts to work for in the country.

6.4. Our staff in post figures and vacancy rates have significantly improved as a result of increased and successful recruitment and retention activity.

6.5. The table below summarises the end of September position for our workforce key performance indicators.

KPI	Month	Performance	Target	Variation	Assurance	Mean
Sickness rate (National)	Sep-2023	4%	4%			4.9%
Mandatory Training (Contractual)	Sep-2023	93%	92%			91%
Staff saying they would recommend the trust as a place to work (Internal)	2023 Q2	71%	70%	N/A	N/A	N/A
Rate of staff with a current PDP and appraisal (Contractual)	Sep-2023	94%	95%			83.8%
Turnover rate (Internal)	Sep-2023	11%	8%			12.9%
Rate of staff experiencing physical violence from service users (Internal)	2023 Q2	15%	5%	N/A	N/A	N/A

Table 4 - Workforce Key Performance Indicators

7. Finance

7.1. The Trust achieved an operating deficit of £520k deficit in September, which brought the year-to-date (YTD) operating position to a £3.43m deficit, £2.115m adverse to the plan. This is an improvement on the YTD position from month 5 with the costs associated with the number of OOA placements having reduced when they had been forecast to rise.

7.2. The key drivers of the financial position remain the use of Secondary Commissioned beds in both Health and Social Care and agency spend above plan driven by observations on inpatient wards and industrial action.

KPI	Period	Performance	Target
Year to Date Financial Position	Sep-2023	£3,430k deficit	0
NHS Agency Price Caps	Sep-2023	578 Breaches	0 Breaches
Year to Date Delivering Value Achieved	Sep -2023	£6,516k deficit	£1,154k

Table 5 - Finance Key Performance Indicators

8. Quality Account

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

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

8.2. In Quarter 2 we met four out of the six reportable Quality Account indicators. The indicator for staff wellbeing is reportable on an annual basis and indicators 4 and 5 require validation and will be reported in Quarter 3.

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

8.4. Urgent CAMHS referrals seen within 7 days was unmet, with two children seen out of this timescale due to capacity issues within the service.

8.5. The table below summarises the Quarter 2 position for our Quality Account Indicators.

Number	Service User Safety	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1	Rate of service users who have a completed risk assessment within the last 12 months	>=95%	94%	93%		
2	Routine referrals to Specialist Community Learning Disability Services meeting 28-day wait.	>=95%	96%	98%		
3	The percentage of service users who are followed up within 48 hours after discharge from psychiatric inpatient care during the reporting period.	>=80%	89%*	87%		
	Clinical Effectiveness					
4	Achieving high quality 'formulations' for CAMHS inpatients	>=80%	100%	TBC		
5	Reducing the need for the use of restrictive practice in adult and older adult inpatient settings.	>=80%	97%	TBC		
6	Urgent CAMHS referrals seen within 7 days	>=75%	80%	67%		
	Service User, Carer and Staff Feedback					
7	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Staff FFT)	>=68%	69%	73%		
8	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=75%	80%	80%		
9	HPFT takes positive action to support my health and wellbeing. Staff wellbeing at work (Annual Staff Survey)	>=72%				

*Updated percentages for Q1

9. Conclusion and Recommendations

9.1. The Trust met or almost met 63% (40/63) of our key performance indicators at the end of Quarter 2 2023/24.

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

10. Appendices

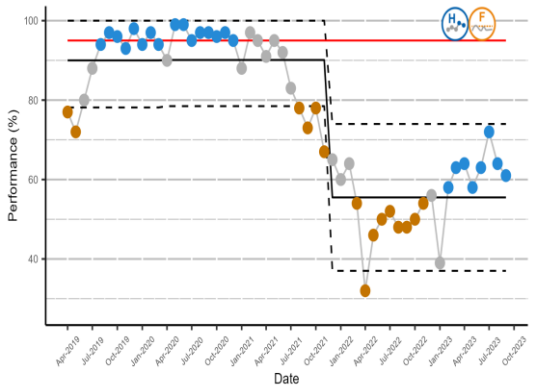
Appendix 1 – Recovery Programme Update

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

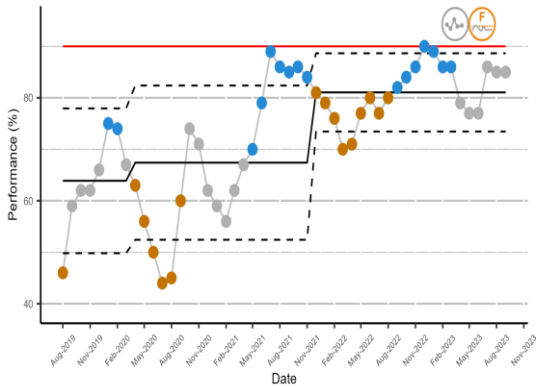
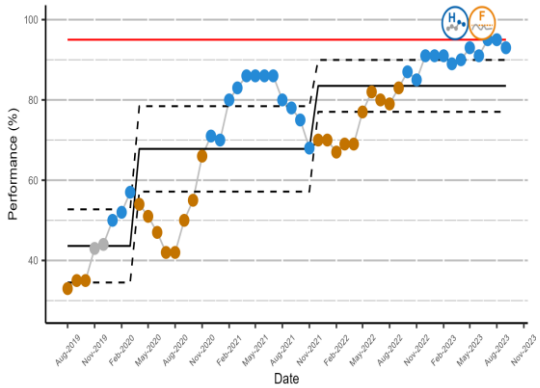
10.2. Each summary is broken into 5 sections (columns)

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

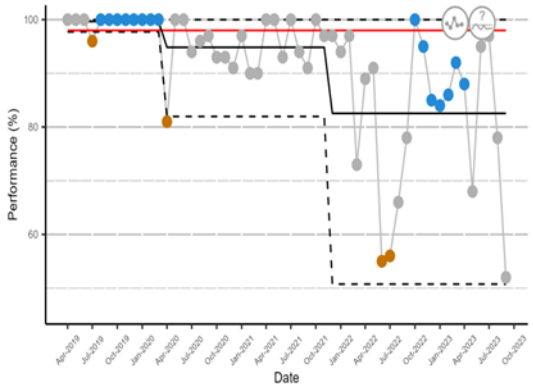
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
Routine referrals to community mental health team meeting 28 day wait		**Sep-2023** 61% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance** Consistently not meeting performance target	Recovery has progressed well in the East and North of the county and there has been significant progress for North-West. South - West remains a challenge due to leave and industrial action. As predicted, activity declined over the summer period due to leave. Increased number of adult ADHD diagnosis referrals is also impacting on capacity. Recovery in South-West has become more challenged and there is intensive work underway to understand recovery rates and realistic timescales for assessment. Recovery is predicted for the end of Quarter 4.	• Continue to use agency workers to meet some of the shortfall between the capacity of the substantive workforce and demand for assessment. • Focus on effective and efficient triage to increase the numbers of people being signposted to more appropriate services from SPA, rather than being signposted following initial assessment. • Deep dive into recruitment in areas experiencing most challenge with access. • Weekly recovery meeting for Watford with MD. • Work to reduce numbers of service users who are discharged post-SPA but pre-initial assessment. • Continue with out of hours clinics and administrative support to clear backlog and manage demand. • Working alongside commissioners to address the increase in ADHD referrals and agree business case for appropriately commissioned pathway.

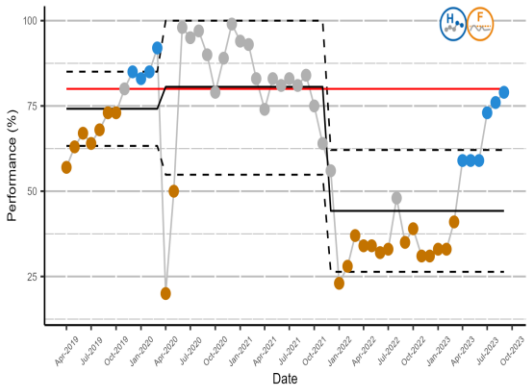
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services		**Sep-2023** 85% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 90% **Assassurance** Consistently not meeting performance target	We saw improvement in performance against this indicator in 2022/23, with target reached in December 2022. Performance declined in Quarter 4 and Quarter 1 due to vacancies being covered by Nurse Consultants who usually lead on the physical health agenda. We have seen some improvement in Quarter 2 with successful recruitment and recovery expected in Quarter 3.	• Nurse consultants back in permanent roles and leading physical health agenda • Physical health clinics are being booked across the county. • 45 PATH staff attended physical health training session. • Data quality of incomplete forms being addressed. • CN Matron now in place for specialist services
Ensure that cardio-metabolic assessment and treatment for people with SMI is delivered routinely in community mental health services		**Sep-2023** 93% **Variance Type** Special Cause Variation: Latest value above upper control limit (improvement) Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance**	Significant progress has been made on this indicator, and the 95% target was met in August, but declined slightly in September. Performance has exceeded 90% for the last 6 months.	• Strengthening nurse-led clinics to ensure consistent delivery of checks.

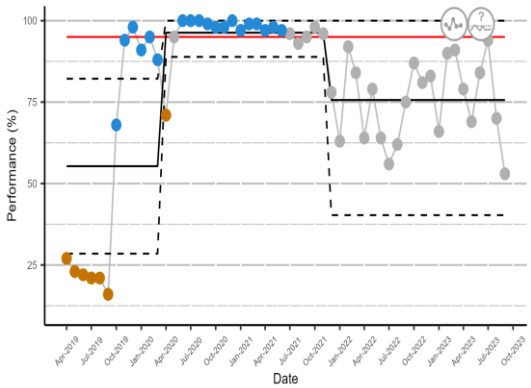
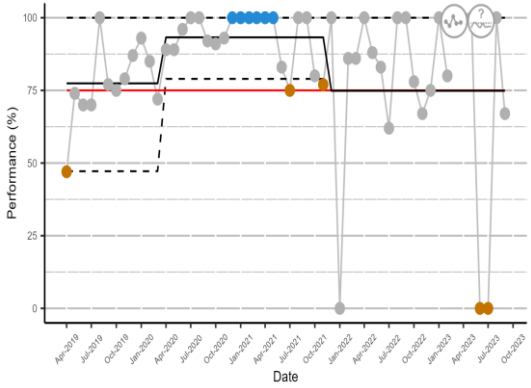
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
Routine referrals to community eating disorder services meeting 28 day wait		**Sep-2023** 52% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98% **Assurance** Inconsistently meeting performance target	Referrals to service have stabilised at circa 30% higher than pre-pandemic, affecting the service's ability to see people within 28 days. Vacancies and sickness across the workforce have affected the service's capacity to assess people within 28 days during Quarter 2. Recovery expected in Quarter 3	• Service Line Lead is now in post to give increased support and oversight to the service and is reviewing processes for booking. • Working with HR colleagues on long term sickness levels and active recruitment underway for vacancies. • Despite compromised capacity to offer referrals within 28 days we are screening for risk and urgency.

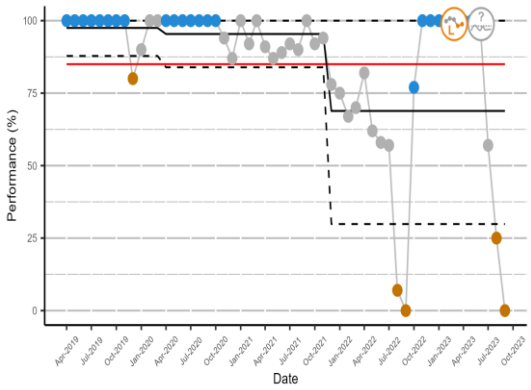
Older Adult Services

KPI	Chart	Narrative	Summary	Key Actions
EMDASS Diagnosis within 12 weeks		**Sep-2023** 79% **Variance Type** Special Cause Variation: Latest value above upper control limit (improvement) Latest 6 data points are above mean (improvement) **Latest Target** 80% **Assurance** Consistently not meeting performance target	The EMDASS service has been vulnerable to surges in demand since Covid and the clinical capacity available to meet the demand has been variable over the past few years. This resulted in an increase in people waiting for diagnosis. There was a sharp rise in referrals during June / July 2022 which increased the waiting list. Following recovery intervention, the waiting list continues to reduce, and the service is currently on track to meet its recovery trajectory in early Quarter 3 2023/24. A plan is now in place to change the clinical delivery model to make it less vulnerable to surges in demand.	• Recovery plan is in place that will reduce the waiting list to the optimum level in Quarter 3 2023/24 through additional weekend clinics and primary care diagnoses. • Weekly MD led meetings to monitor progress. • CQI actions in place to model and monitor revised pathways.

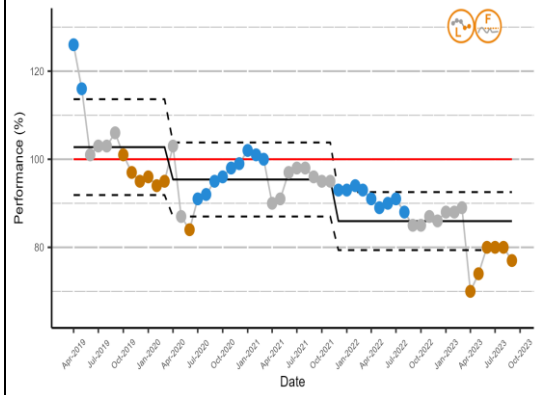
Children and Adolescent MH Services

KPI	Chart	Narrative	Summary	Key Actions
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS)		**Sep-2023** 53% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Inconsistently meeting performance target	An increase in demand, post-COVID, combined with capacity issues in our Single Point of Access (SPA) Service resulted in an increased number of children and young people waiting for an initial assessment across Hertfordshire. Referral numbers have now stabilised. We have seen recovery in North and West Quadrants but do not anticipate full recovery for East and South Quadrants until Quarter 4 2023/24, depending on successful recruitment	• Ongoing recruitment activity for vacancies • Weekly recovery meeting led by MD to monitor East and South Quadrant progress, including cover and replacement for current vacancies and job planning for individual care professionals. • Additional actions and recovery plan in place to support EAST quadrant team which is the most severely affected by vacancies.
CAMHS referrals meeting assessment waiting time standards - URGENT (P1 - 7 DAYS)		**Sep-2023** 67% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 75% **Assurance** Inconsistently meeting performance target	The service received three urgent referrals in September. Capacity issues within the CAMHS service resulted in one child being seen outside of the 7-day period in September.	• Ongoing work in CAMHS to recruit staff to vacancies and ensure capacity to see children within the 7-day timeframe.

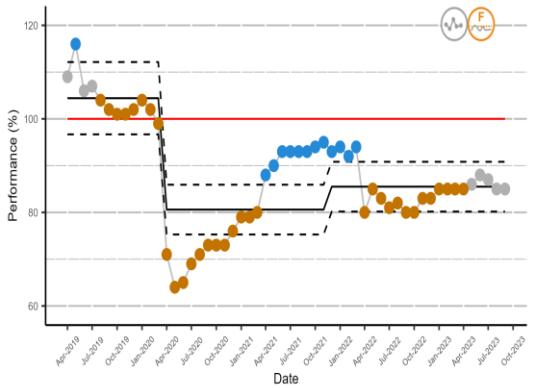
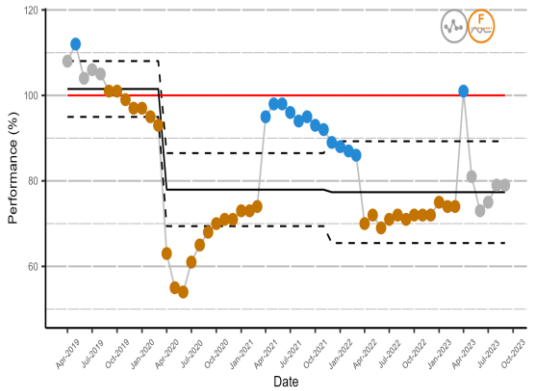
Children and Adolescent MH Services

KPI	Chart	Narrative	Summary	Key Actions
CAMHS referrals meeting assessment waiting time standards - TARGETED SERVICE 28 DAYS		**Sep-2023** 0% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) **Latest Target** 85% **Assurance** Inconsistently meeting performance target	The Targeted Team had been performing consistently on 28-day KPI until unplanned sickness and vacancies resulted in deterioration in performance. An action plan is in place with a recovery trajectory of November 2023.	• We have recruited into a Band 7 post with a further two Band 7 FTEs returning from long term leave. • Additional focus on recruitment is underway with a Band 6 FTE starting in October and interviews for another Band 7 currently taking place.

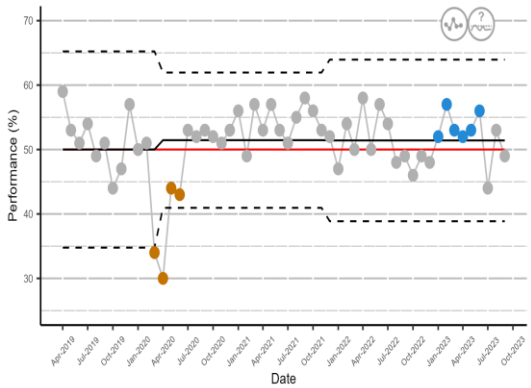
Talking Therapies (IAPT) Services

KPI	Chart	Narrative	Summary	Key Actions
Number of people entering IAPT treatment (ENCCG)		**Sep-2023** 77% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) Latest 6 data points are below mean (concern) **Latest Target** 100% **Assurance** Consistently not meeting performance target	Referrals into the Talking Therapies services remain below the volume needed to achieve access targets. We expect to be meeting our targets for all service by the end of Quarter 3, dependent on the success of the initiatives.	• There is a comprehensive communications and marketing plan which incorporates several actions that target referrers into the service to increase appropriate referrals, and to outreach to the public to raise awareness of the service to increase self-referrals. • We are commencing a piece of work with the regional team to look at attrition rates to identify common themes and further actions that might increase engagement with the service following a referral. • We are piloting a “Choose and Book” module on PCMIS with the Mid Essex team to see if this increases both engagement with the service and reduction in waiting times. • We have appointed a new LTC Lead for the services who will be working more closely with the LTC pathways and hospitals and community services to increase the numbers of people accessing these pathways.

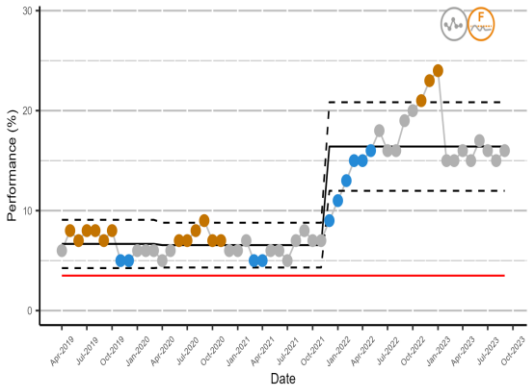
Talking Therapies (IAPT) Services

KPI	Chart	Narrative	Summary	Key Actions
Number of people entering IAPT treatment (HVCCG)		**Sep-2023** 85% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 100% **Assurance** Consistently not meeting performance target		
Number of people entering IAPT treatment (Mid Essex)		**Sep-2023** 79% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 100% **Assurance** Inconsistently meeting performance target		

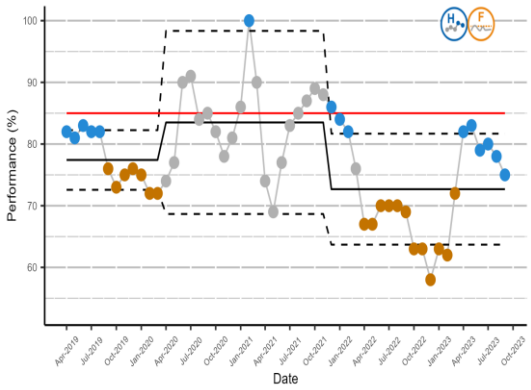
Talking Therapies (IAPT) Services

KPI	Chart	Narrative	Summary	Key Actions
IAPT % clients moving towards recovery (ENCCG)		**Sep-2023** 49% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 50% **Assurance** Inconsistently meeting performance target	Marginally below recovery target of 50% in September. Expected to recover in Quarter 3.	• Continue to review how many times clinicians contact non-attending patients before discharging. • To make use of PCMIS recovery tool/outcome feedback to help inform patients if they are heading towards recovery and help encourage them persist with the treatment. • Use supervision sessions to embed above actions.

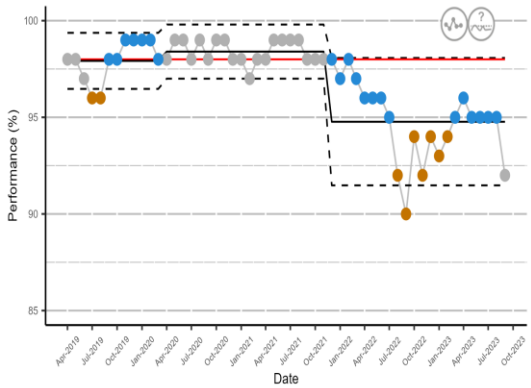
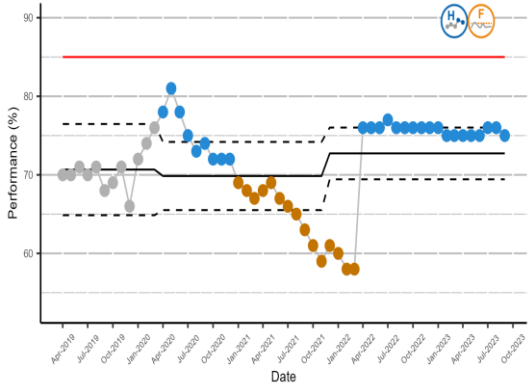
Inpatient Services

KPI	Chart	Narrative	Summary	Key Actions
Delayed transfers of care to the maintained at a minimal level		**Sep-2023** 16% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 3.5% **Assurance** Consistently not meeting performance target	The data for the number of people who are ready to move on from our inpatient services but are delayed has shown improvement over the last 5 months. We continue to experience difficulties in finding suitable placements and care packages for service users with complex needs. We have made changes to put social care at the forefront of the pathway and we expect this to have a positive effect on delays. We expect the actions we have put in place to reduce our delays in line with National expectations, to an agreed level by Quarter 4 2023/24	• Social worker now in place for Swift and 72 -hour meeting; additional support of two further social workers to be put in place to support both delayed discharges and out of area placements. • Strengthened contractual management arrangements to introduce contractual lengths of stay targets for each service, with exception reporting. • Continue to deliver MADE type events with key stakeholders. • Enhanced Discharge team almost fully recruited - ways of working developed. Home Group actively working with team as part of the EDT. • Wider system work, led at Executive level, to support placement of longer-term DToC. • Analysis of reasons for different types of DToC and focussed action plan developed against key themes. • Senior engagement / cover at DTC meetings

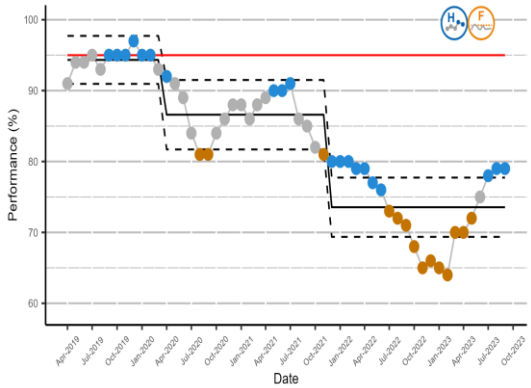
Inpatient Services

KPI	Chart	Narrative	Summary	Key Actions
Rate of acute Inpatients reporting feeling safe		**Sep-2023** 75% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) **Latest Target** 85% **Assurance** Consistently not meeting performance target	The number of people saying that they feel safe in our inpatient units had decreased due to high levels of acuity in our inpatient units. Following a detailed survey of reasons, we have developed ward level action plans to improve this. The current method of securing feedback via the Having Your Say Forms will cease at the end of Q4 as we move to the new methods of feedback.	The actions from the feeling safe survey which was trialled in September 2022 have moved ahead with each SBU taking forward their own action plan. The survey has been repeated to understand how the experience has changed and whether actions taken are showing an improvement. Actions include: • Communication passports and calm-down boxes for staff to use with service users on Dove Ward • Peer listeners to work with our Medium Secure Units on post-incident support. • Calm app and support for service users whose first language is not English on Oak Ward • Groups implemented in Forest House to understand what makes children and young people feel safe. • Launch of a new Patient Safety CQI project to look at reducing staff and service user experiences of violence.

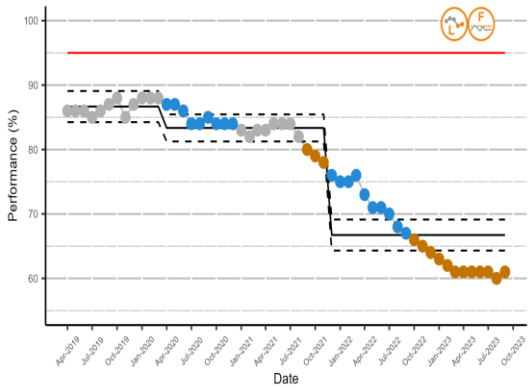
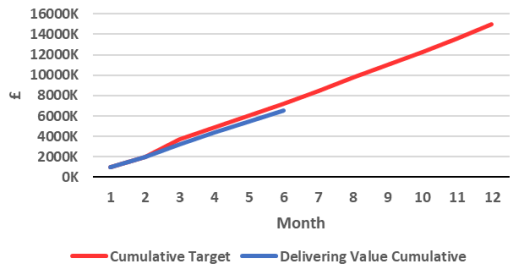
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services		**Sep-2023** 92% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98% **Assassurance** Inconsistently meeting performance target	Sustained high demand in our services and delays in initial assessments is impacting on our 18-week wait to treatment times, particularly in hard to recruit areas. Recovery of waiting list in areas that are seeing service users who have already waited more than 18 weeks have impacted on performance. Recovery expected by the end of Quarter 4.	• Focused recovery work on access times that will result in overall improvement of our referral to treatment times, including a focused piece of work in ACMHS using NHSE methodology. • Work to improve flows and caseloads within our services and improve RTT timeframes.
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation)		**Sep-2023** 75% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) Two of three data points within upper zone A (improvement) **Latest Target** 85% **Assurance**	Data quality campaign in previous quarters had limited success, increasing compliance temporarily. Recovery expected by the end of Quarter 4.	• A long-term solution has been developed to provide an app for staff, which shows their caseload and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in Quarter 3. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is captured.

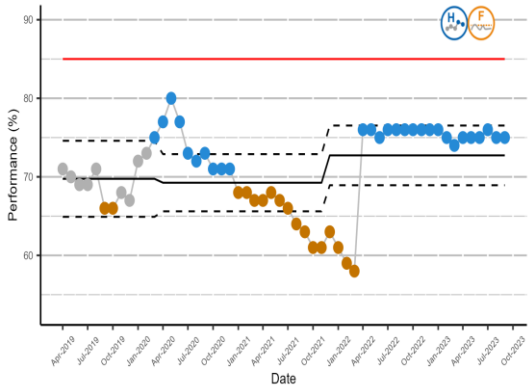
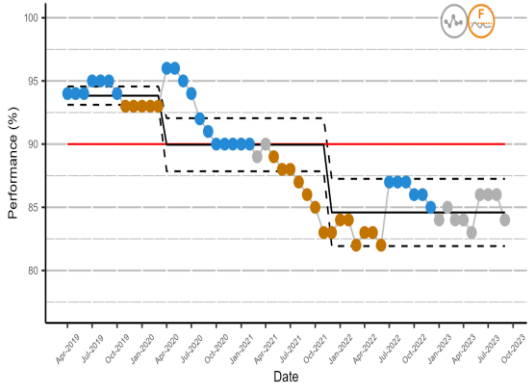
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months		**Sep-2023** 79% **Variance Type** Special Cause Variation: Latest value above upper control limit (improvement) **Latest Target** 95% **Assurance** Consistently not meeting performance target	Service users with high complexity needs having an annual Care Plan Approach review declined from the start of the pandemic. As part of the trust business continuity planning (BCP) arrangements, this time we made changes to the risk assessment, contact approach and crisis planning. This allowed us to increase contact and provide more support to service users on CPA. This practice continued post-pandemic. Our Community Transformation programme is planning the transition from CPA to PCSP in collaboration with commissioners.	• We have improved our overall risk management and care planning to meet the challenge of rising complexity in cases on every clinical contact. • We are adapting our Care Plan Approach to take advantage of this and make the CPA process more streamlined. • Nationally, the system is moving away from CPA towards personalised care and support plans (PCSP).
Percentage of eligible service users with a completed PbR cluster review		**Sep-2023** 61% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) Latest 6 data points are below mean (concern)	HONOS cluster reviews were introduced as part of the Payment by Results initiative. Performance declined over the Covid period and has not taken priority over access and safety indicators.	• Review of clinical outcome measures is underway as part of the Transformation Programme

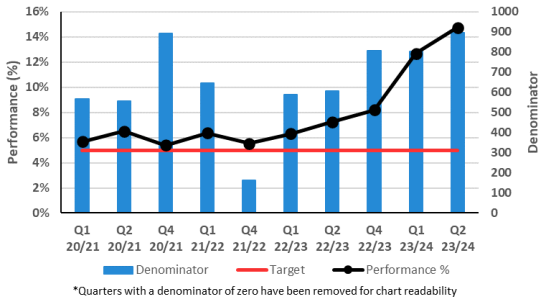
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		**Latest Target** 95% **Assurance** Consistently not meeting performance target		
Delivering Value (Year to Date)		**Sep-2023** £ 6,516k (YTD) **Variance Type** SPC unapplicable to KPI **Latest Target** £7,169k (YTD) **Assurance** N/A	The Trust achieved savings of £1.04m in September, which is £111k below Plan in month and £653k behind plan YTD. YTD underperformance reflects the non receipt of the rates rebate in line with plan, but this has now been confirmed to be receipted in October and catch up. The saving realised to date for OOA beds relates to the agreement of a contract with a private provider at a bed day rate lower than Plan, however the plan forecast increases in placements through the winter period and these are currently being held at existing levels. Recurrent savings YTD amount to £5.37m with £1.14k on a non-recurrent basis. The Trust's DV programme has the potential to	• Recover the full rates rebate. • Continue to pursue all avenues of income. • Continue with current OOA bed trajectory

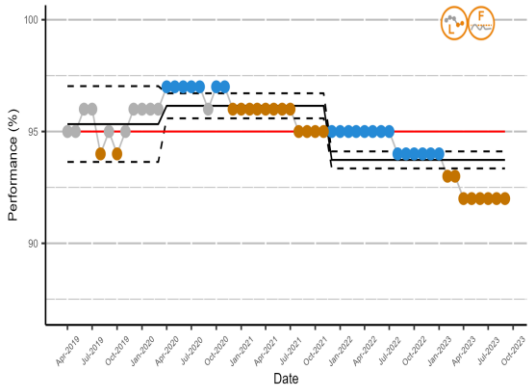
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
			deliver savings of £18.9m, if all schemes deliver in full.	
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment)		**Sep-2023** 75% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) **Latest Target** 85% **Assurance** Consistently not meeting performance target	Data quality campaign in previous quarters had limited success, increasing compliance temporarily. Recovery is expected in Q4	• A long-term solution has been developed to provide an app for staff, which shows their caseload and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in Q3. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is capture
Data completeness against minimum dataset for Ethnicity (MHSDS)		**Sep-2023** 84% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 90% **Assurance**	Data quality campaign in previous quarters had limited success, increasing compliance temporarily. Recovery is expected in Q4	• A long-term solution has been developed to provide an app for staff, which shows their caseload and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in Q3. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is captured.

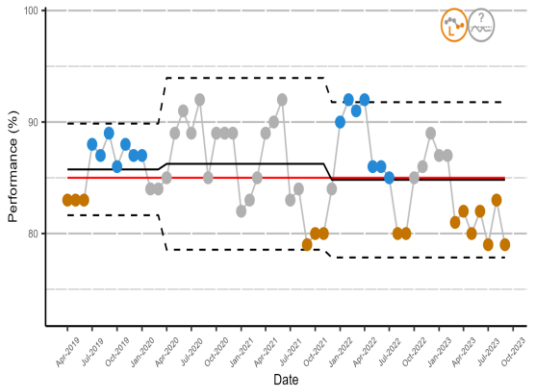
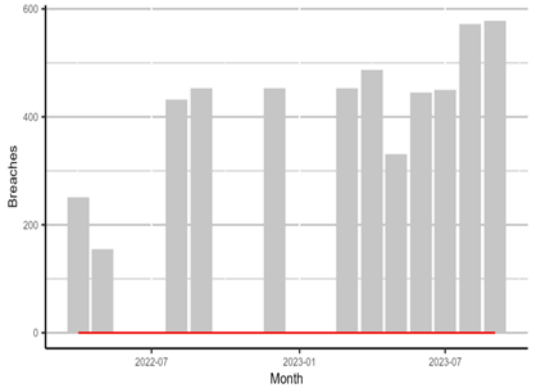
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
Rate of staff experiencing physical violence from service users		**2023 Q2** 15% **Variance Type** SPC unapplicable to KPI **Latest Target** 5% **Assurance** N/A	From Quarter 1 22/23 this measure included staff who have experienced violence from service users, carers, and members of the public. Previously members of the public were not included in this measure. Recovery expected by end of Quarter 3 in line with CQI project objectives.	• CQI project is underway which includes: • Trauma informed approach to staff training, and co-production of care with service users • A Positive Behavioural Support strategy is being developed in Learning Disabilities services with a dedicated Project Lead in the scoping phase of the project. This closely links with the trauma informed work above. • Strengthened supervision processes • Knowledge and Understanding training (KUF) for staff working with service users with complex emotional needs associated with a diagnosis of Personality Disorder is being rolled out. • An Equality and Diversity co-produced education and engagement CQI project and a Staff support following Racial Abuse CQI project are underway • Proactive work with police colleagues to educate service users and to support staff reporting to police post assault • A meaningful activities and engagement CQI programme is in progress

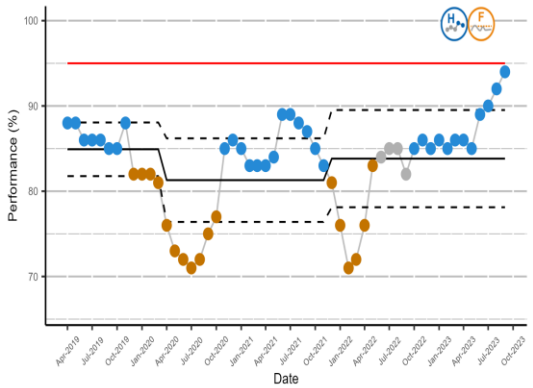
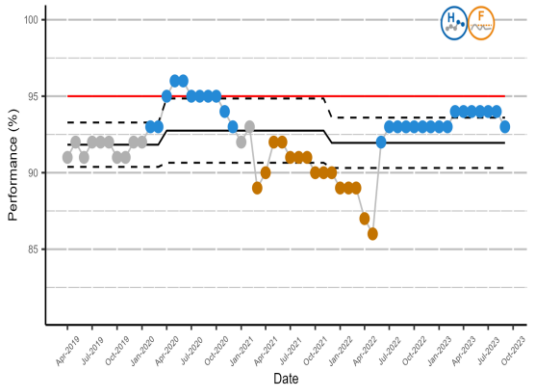
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
				• Body cameras working group is in place. CCTV is being rolled out to all wards.
Percentage of eligible service users with a PbR cluster		**Sep-2023** 92% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) Latest 6 data points are below mean (concern) **Latest Target** 95% **Assurance** Consistently not meeting performance target	HONOS assessments were introduced as part of the Payment by Results initiative. Performance declined over the Covid period and has not taken priority over access and safety indicators.	• Review of clinical outcome measures is underway as part of the Transformation Programme
Rate of Service Users saying they have been involved in discussions about their care		**Sep-2023** 79% **Variance Type** Special Cause Variation: Latest 6 data points are below mean (concern)	Performance against this indicator has been below target for the last 7 months. The response rate has fallen as the HYS process is being phased out.	• The process for gaining service user and carer experiences and feedback has been reviewed and a new methodology will be introduced in 2023/24 that is expected to improve response rates.

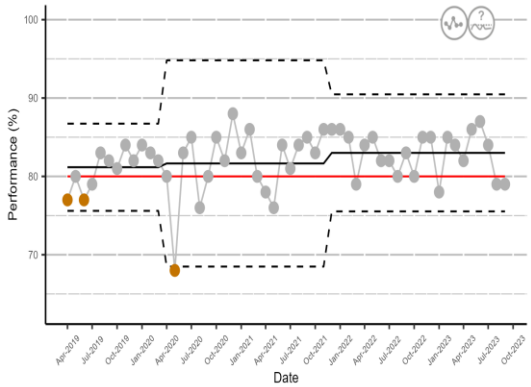
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Two of three data points within lower zone A (concern) **Latest Target** 85% **Assurance** Inconsistently meeting performance target		
NHSI agency price caps		**Sep-2023** 578 **Variance Type** SPC unapplicable to KPI **Latest Target** 0 **Assurance** N/A	Recruitment challenges in key professions such as medical and nursing are the primary drivers. Adult Community teams continue to look for innovative ways to recruit and manage current demand levels	• Continued recruitment support in difficult to recruit teams

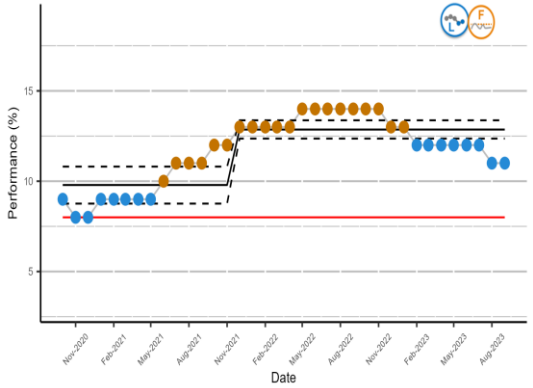
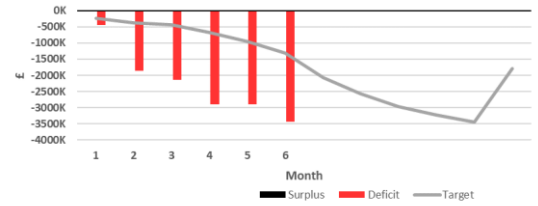
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Rate of staff with a current PDP and appraisal		**Sep-2023** 94% **Variance Type** Special Cause Variation: Latest value above upper control limit (improvement) Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance** Consistently not meeting performance target	Appraisal compliance improved significantly following the introduction of an Appraisal App and window of time to complete appraisals (April – end July). This resulted in an increase in compliance from 86% prior to the introduction of the App and window to 94% at the end of September. The SPC chart demonstrates that this is the highest compliance we have ever achieved and that we have not met our target of 95% compliance historically, including pre-pandemic. Recovery expected by end of October 2023.	• New Appraisal App • New appraisal window • A further push on achieving compliance in areas with low compliance to achieve 95+% • Monthly reporting to the Executive Team and People and OD Group
Rate of service users with a completed up to date risk assessment (inc LDandF and CAMHS from Apr 2015) Seen Only		**Sep-2023** 93% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance**	Performance has improved with the introduction of new recording method for risk and is now 2% below target level. Changes to process in LD&F resulted in a 1% drop in September. Full recovery expected by the end of Q3	• Simulation suite training rollout continues for teams with low assessment compliance. • Survey on success of pilot of new Paris changes undertaken and roll-out of new features now complete. • Additional guidance for staff added to Paris to aid completion

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
Rate of service users saying they are treated in a way that reflects the Trust's values		**Sep-2023** 79% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 80% **Assurance** Inconsistently meeting performance target	Performance against this target remains relatively stable, although marginally below target in August. Response rates have fallen since May when we began to phase out the HYS process.	• The process for gaining service user and carer experiences and feedback has been reviewed and a new methodology will be introduced in 2023/24 that is expected to improve response rates.
Turnover rate		**Sep-2023** 11% **Variance Type** Special Cause Variation: Latest value below lower control limit (improvement)	Our unplanned turnover has reduced to 11%. Our staff in post has increased by a further 61FTE in September. Our unplanned turnover rate remains significantly above the target of 8% and the SPC chart indicates that historically we have	• Staff benefits and support offer • Comprehensive wellbeing offer, focussing on self-care and including Self-care September • Staff survey 'You said, together we did' • Violence and aggression CQI project

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Latest 6 data points are below mean (improvement) **Latest Target** 8% **Assurance** Consistently not meeting performance target	not been able to meet this target. However, the SPC chart shows a positive improving trend and that whilst we expected to meet 11% turnover by November 2023, we have achieved this earlier than expected. Our annual staff survey results show us to be the joint third best mental health trusts to work for in the country. Our results also helped to reaffirm our top three areas of focus: improving self-care, reducing violence and aggression and embedding a culture of belonging and inclusion. We have launched our 2023 annual staff survey and have promoted the actions taken against the key three areas identified above, each of which have been supported by a comprehensive programme of work to further improve staff experience and thus reduce turnover.	• Launching our co-produced Belonging and Inclusion Strategy based on staff feedback. • Launched our new Appraisal App and appraisal window to ensure all our staff receive an appraisal that helps to retain them by ensuring they feel valued, supported and developed.,
Financial Position		**Sep-2023** £3,430k deficit **Variance Type** N/A **Latest Target**	£520k deficit in September, which brought the year-to-date (YTD) operating position to a £3.43m deficit, £2.115m adverse to the plan. This is a deterioration from the month 5 position, but an improvement in the monthly run rate, primarily driven by an	• Due to the unsatisfactory financial position, the executive team have enhanced a number of financial controls, including agency/vacancy controls, reduced limits for sign off and enhanced financial scrutiny and governance.

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		0	improvement in the number of Adult Acute placements. The key drivers of the financial position remains the use of Secondary Commissioned beds accounting for £1,775k of the deficit and agency spend above plan driven by observations on inpatient wards and industrial action.	
		Assurance		
		N/A		

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 8b
Report Title	Annual Plan 2023/24 Quarter 2 Progress Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Simon Pattison, Deputy Director of Strategy and Development Viv Smith, Business Manager	
Approved by:	David Evans, Executive Director, Strategy and Partnerships	

The Board are asked to:
Receive the report and note progress against the Annual Plan during Quarter Two.

Executive Summary

This report provides an overview of the progress during Quarter 2 of 2023/24 (Q2) against the Trust's Annual Plan. It also provides projected outcomes for the objectives at the end of the year.

Summary:

Following the Trust launch of Great Together, our new five year strategy, the Annual Plan objectives have been re-worked to fit underneath the new strategic objectives in advance of the Quarter 2 report.

The Annual Plan now comprises the six objectives of the Trust's 'Great Together' 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 2023/24

Quarter 2 2023/24 (Q2) has been a challenging period for the Trust and the wider health and care system with continued demand and acuity pressures and significant periods of Industrial Action. Despite these pressures the Trust delivered against most milestones for the quarter and is on track to meet the majority of the outcomes for 2023/24.

At the end of Q2:

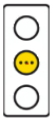
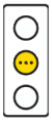
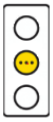
- four out of six objectives achieved the quarterly milestones
- five out of six objectives are forecast to meet the end of year outcomes

73% of all year-end outcomes are predicted to be on track to be delivered (50/69 outcomes) at the end of the 2023/24 and recovery actions in place for the remaining 27% (19 outcomes) that are not on track in Q2.

The impact of demand pressures and ongoing strikes, amongst other pressures, will again make 2023/24 a challenging year.

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

Table 1: Q2 and year end predicted achievement summary

Ref	Objective	Q2 23/24		23/24 Year End Predicted Outcomes	
		Milestone Achievement	RAG Rating	Year End Prediction	RAG Rating
SO1	We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	11/17 (65%)		Amber	
SO2	We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers	13/18 (72%)		Green	
SO3	We will attract, develop and retain a skilled compassionate workforce by creating inclusive and thriving workplaces	11/14 (79%)		Green	
SO4	We will address inequalities to improve out-comes and advance equity for people from all communities	8/12 (67%)		Green	
SO5	We will work in partnership in everything we do to meet the needs of communities and the people we support	12/16 (75%)		Green	
SO6	We will be a learning organisation that encourages innovation, research and continuous quality improvement	11/13 (85%)		Green	

Recommendations

The Board are asked to receive the report and note progress against the Annual Plan during Quarter Two.

Implications	
Risk and Assurance	The Annual Plan was developed alongside an assessment of the major risks facing the organisation with the aim of addressing these across the Trust's objectives – for example in tackling recruitment and retention issues or addressing quality concerns. Delivering the Annual Plan in full will reduce the level of risk
Equality, Diversity and Human Rights	The Annual Plan includes a focus on improving equality and equity
Quality	The Annual plan includes work programmes that aim to improve Quality
Financial	The Annual plan includes key financial targets
Service Users and Carer Experience	The Annual Plan includes many items that focus on improving service user and carer experience
People	The Annual Plan includes key People related priorities
Legal and Regulatory	Delivering the Annual Plan effectively will improve the quality of care we deliver and the experience that service users and carers have when they come into contact with us, and so will support CQC compliance
Digital	The Annual Plan includes key digital priorities
System	The Annual Plan includes key system related work
Sustainability	The Annual Plan includes sustainability targets from the Trust's Green Plan

Strategic Objectives this report supports	Please tick any that are relevant ✓
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	✓
4. We will address inequalities to improve outcomes and advance equity for people from all communities.	✓
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	✓
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	✓

TRUST ANNUAL PLAN 2023-24

QUARTER 2 PROGRESS REPORT – October 2023

1. Introduction

1.1. The Annual Plan is now aligned to the Trust's six strategic objectives. 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 2023/24 (Q2) milestones for the Trust's annual plan and the overall predicted achievement of objectives in 2023/24.

2. Achievement against Quarter 2 Milestones

2.1. Quarter 2 2023/24 (Q2) has been 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 outcomes for 2023/24.

2.2. At the end of Q2:

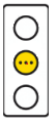
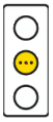
- four out of six objectives achieved the quarterly milestones
- five out of six objectives are forecast to meet the end of year outcomes

2.3. During Quarter 2 two objectives did not achieve most (70%+) of the key milestones as planned. These were:

- Strategic Objective 1 (Service users and carers) – Essex commissioners are postponing a decision on expanding Learning Disability services in South Essex until they complete a wider neurodevelopmental review. There have also been some delays in work within adult community to develop a joint pathway with primary care mental health services and in the older adult crisis model review.
- Strategic Objective 4 (Equity) – physical health training with HCT was delayed by Industrial Action and work on planning future development of autism friendly environments has been delayed.

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

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

Ref	Objective	Q1 23/24	
		Milestone Achievement	RAG Rating
SO1	We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	11/17 (65%)	
SO2	We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers	13/18 (72%)	
SO3	We will attract, develop and retain a skilled compassionate workforce by creating inclusive and thriving workplaces	11/14 (79%)	
SO4	We will address inequalities to improve out-comes and advance equity for people from all communities	8/12 (67%)	
SO5	We will work in partnership in everything we do to meet the needs of communities and the people we support	12/16 (75%)	
SO6	We will be a learning organisation that encourages innovation, research and continuous quality improvement	11/13 (85%)	

3. 2023/24 Year End Achievement Against Objectives

3.1. Five out of six of all year-end outcomes are predicted to be on track to be delivered at the end of 2023/24 and recovery actions in place for the remaining outcomes that are not on track in Quarter 2.

3.2. Now that the Trust has launched Great Together, our new five year strategy, the Annual Plan objectives has been aligned to the new strategic objectives.

3.3. The impact of demand pressures and ongoing strikes, amongst other pressures, is again making 2023/24 a challenging year.

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

3.5. Strategic Objective 1 (Service users and carers) is projected to be Amber as we are below target on CYP ADHD waits, delayed transfers of care for adult mental health, and waiting times for adult community and EMDASS.

3.6. Across the six Strategic Objectives there are a number of key outcomes at year end which are currently rated red or amber. Action is in place to address these including:

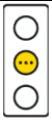
- Recovery action plans are in place to recover performance in the following areas:

- Community mental health waiting and referral to treatment times
- CAMHS 28 day waiting times
- EMDASS 12 week waiting to diagnosis times.

- Rigorous oversight of the Trust's Delivering Value plan is in place.
- We are working closely with partners through the MHLDA Health and Care Partnership to support the system wide ASD / ADHD pathway review for children and young people.
- The Trust's capital plan is being monitored closely to ensure that it is fully spent by year end.

3.7. The table below summarises the predicted year end achievement for all strategic objectives (SO) with details provided in Appendix 2. We have based this assessment on our assessment of delivery at year end. For example under SO5 there are a number of Amber metrics where further work is underway to achieve the target by year end and so we have rated this Green overall.

Table 3: 2023-24 Predicted End of year Achievement against Objectives

Ref	Objective	23/24 Year End	
		Year End Prediction	RAG Rating
SO1	We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	Amber	
SO2	We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers	Green	
SO3	We will attract, develop and retain a skilled compassionate workforce by creating inclusive and thriving workplaces	Green	
SO4	We will address inequalities to improve out-comes and advance equity for people from all communities	Green	
SO5	We will work in partnership in everything we do to meet the needs of communities and the people we support	Green	
SO6	We will be a learning organisation that encourages innovation, research and continuous quality improvement	Green	

3.8. Last year we agreed that we would review metrics at the half year point and change metrics for the following reasons:

- Where there were external factors beyond our control that meant that the metric was no longer achievable, for example a change in government policy or a delay in commissioners making a decision that was fundamental to delivery of the target.

- Where we become aware of data quality issues that weren't obvious at the point the metric was set and so are not able to report in the way that we had originally thought we would.
- Where a target is no longer achievable, and a complete reset of the target is required to allow meaningful monitoring of the priority for the remainder of the year rather than chasing an unachievable target. We would consider this when the reasons for the underachievement are fully understood and reasonable as a justification for amendment. This would need to be tested to assess whether this is just a result of factors within the control of us as an organisation.

3.9. Therefore we have reviewed the year end metrics on this basis and agreed two changes at FIC:

- Under SO1 our target is a "reduction in backlog CAMHS ADHD cases". This target was based on the business case we had agreed with the ICB for investment into a new team to carry out ADHD diagnoses and to transfer cases to an enhanced primary care service. Both services are now up and running and are working well. However the number of referrals for ADHD diagnosis has increased dramatically from the original business case. The business case was based on 48 referrals a month and we are now receiving 210 a month. Therefore we are seeing a significant increase in the waiting list for ADHD diagnosis, despite the new team and the additional capacity that they have provided. Our waiting list at the end of September 2023 was 1,772 compared to 1,097 at the end of September 2022. The investment we agreed with commissioners was sufficient to see 1,097 people and so we agreed at FIC to change this target to deliver 1,097 diagnosis assessments by the end of March 2024.
- Under SO5 our target is to have "Perinatal commissioning mobilised by end of October". This objective will not be achieved by the end of October. A great deal of preparatory work was carried out between ourselves and the East of England Provider Collaborative Transformation and Commissioning Team (TACT) and this resulted in the completion of a business case that was discussed with NHS England. NHS England made the decision to delay the transfer of perinatal commissioning to allow more time to join up perinatal inpatient, perinatal community and mainstream maternity pathways and so it is likely that this transfer will now happen in April 2024. We therefore agreed with FIC to amend this target to "All preparatory work complete to allow perinatal commissioning to transfer in April 2024"

3.10. These changes will be reflected in the Q3 reporting RAG rating.

4. Conclusion

4.1. Overall good progress has been made during the quarter against the Quarter 2 milestones and towards year end outcomes. However the ongoing impact of demand pressures and Industrial Action mean that 2023/24 is likely to remain a challenging year.

5. Recommendations

5.1. Board are asked to receive the report and note progress against the Annual Plan during Quarter Two.

APPENDIX 1 – ANNUAL PLAN 2023/24 QUARTER 2 COMMENTARY AGAINST MILESTONES AND OUTCOMES

Strategic Objective 1 **Senior Responsible Officer SB**	**Q2 Key Actions / Milestones**	**Q2 Milestones Rating**
We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery **Key Priorities:** **Address backlogs in care** across services Expand **service user and carer involvement** Strengthen our approach to **improving Service User and Carer experience** Revitalise our **Recovery approach** across all services Expand **adult crisis support and pathways** Implement an **enhanced service for older people**, including dementia diagnosis	• ADHD **(**Attention Deficit Hyperactivity Disorder) **-** new diagnosis and Enhanced Primary Care service • Recovery plan for EMDASS (Early Memory Diagnosis and Support Service) • New primary and community MH service model for adults developed and rolled out • South Essex Learning Disability expansion business case • Waits for treatment (follow-up) across services • Enhanced model of participation & co-production developed with experts by experience & carers • Co-produce user and carer involvement in transformation and service redesign • Peer support structure included in outline high level model of co-production • Expand our approach to meaningful feedback from service users and carers • Shared Decision Making (SDM) course part of the New Leaf curriculum • Review of policies to promote recovery focussed care • Shared Decision Making courses - development group designing course • Enhanced Discharge Team and Virtual Mental Health Hospital Discharge services commenced • Mental Health Crisis Assessment Service business case development and support to Lister (two priorities) • EMDASS pre-diagnostic review completion • Review of community and crisis model of older people's services commenced	 (11/17 = 65%) Amber
	Commentary: • Adult community mental health waiting list management CQI delayed and now taking place in Q3 • Commissioners are delaying a decision on the South Essex LD business case until they complete a wider neurodiversity review • Waits to treatment are at 47% for LD and 50% for adult community mental health against a target of 60%. CYP are at 69% • Experience based co design project to understand people's journey through services being discussed with transformation team • Shared decision making course will be added to the New Leaf curriculm in spring 2024 • Older adults crisis pathway review learning events to be held in Q3	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes Projection**
Continued growth in CAMHS ADHD cases is a challenge in terms of managing waiting lists and demand pressures in other services are also concerning. However good progress has been made in reducing out of area placements despite high levels of delayed transfers of care	• Reduction in backlog CAMHS ADHD cases • Proportion of adults in community mental health teams seen within 28 days • Achievement of national Referral to Treatment Times (60%) • Service user/carer positive feedback on involvement within community transformation • At least 98% of CQI projects have service users and carers involved • Service user Friends and Family Test Feedback (Target 85%) • Increase in the number of compliments received • Reduction in the number of complaints received • Increase staff and service users trained in Shared Decision Making • Reduce inappropriate out of area placements – 972 by year end • 20% reduction in delayed transfer of care (baseline 57 – 45 by year end) • Achieve 12 week maximum wait for EMDASS • Successful implementation and evaluation of county wide memory diagnosis model	 Amber

Strategic Objective 2 Senior Responsible Officer JV	Q2 Key Actions / Milestones	Q2 milestones Rating
We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers **Key Priorities:** Enhance and further embed our **safety culture** Implement suicide **prevention pathway** Focus on **'fundamentals of care'** Adopt a **Trauma Informed Approach** Implement a **new adult community model of care** Transform **Children & Young People's Mental Health** Develop our approach to **7-day working** across services	• PSIRF (Patient Safety Incident Response Framework) readiness and implementation • Violence and Aggression CQI project • National inpatient quality approach programme commencing • EPMA (electronic Prescribing and Medicines Administration) roll out • Suicide prevention work with A&E & Multi agency suicide prevention training (two actions) • Strenthening safety plans using shared decision making • Action taken on issues identified in Fundamentals of Care audits • Better respond to physical health acuity through NEWS2 audit tool and Clinical Response Guide • Trauma informed approach (TIA) roll out and training (two actions) • Community High Complexity Pathway proposal developed • Transition from adult to older adult services and enhance support for the 18-25 cohort (two actions) • Connected Lives for carers project workshops continued • CYP ARRS roll out commenced • Review of Targeted Team delayed by HCC funding discussions • 7 day working commenced in virtual Mental Health Hospital Discharge service	 (13/18 = 72%) Green
	Commentary:	
	• Further work to complete Clinical Response Guide will take place in Q3 • More work to be completed on expectations of adult and older adult services through transition in Q3 • Connected Lives for Carers workshops continued in Q2. Work on EPR system changes will commence in Q3 • Review of Targeted Team delayed by HCC funding discussions • Job descriptions for 18-25 cohort posts agreed - planned for December start date	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes Projection**
There has been solid progress in the development of the PSIRF approach, the implementation of Electronic Prescribing and the roll out of Trauma Informed Approaches in inpatient settings	• Achieve CQUIN target in relation to Restrictive Interventions • < service user to service user moderate and severe harm through violence & aggression (two targets) • < anonymous Freedom to Speak Up referrals as a percentage of the total • Increased compliance with antimicrobial prescribing quality • >50% service users who present to A&E are screened for suicide risk • Improvement in Fundamentals of Care audits across the year • Reduction in avoidable hospital admissions and A&E attendance from inpatient services • Introduction of Trauma Informed Approach (TIA) in inpatient settings and Trust wide training in place • Increase of 25% in service users on community rehab pathways • Individual Placement Support and Early Intervention Psychosis Long Term Plan priorities met (two targets) • Improve quality of Connected Lives assessments • CAMHS 28 day wait time is ≥95% sustainably achieved • Increase in number of CYP accessing support • EDT/virtual MH hospital discharge pilot evaluation and long term model development • Increase in weekend discharges as a proportion of all discharges (Target 11%) • Reduction in S136 breaches	 Green

Strategic Objective 3 Senior Responsible Officer JH	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will attract, develop and retain a skilled compassionate workforce by creating inclusive and thriving workplaces **Key Priorities:** Build an open **culture of belonging and inclusion** Establish **talent, training & development pathways and approach** Develop our **collective leadership culture** Reset our **fundamental standards** of people management	• Belonging & Inclusion strategy presented to Board in October for final sign off • New approach to zero tolerance to discrimination included within Belonging and Inclusion strategy • Compassionate and caring teams programme - design stage of programme • Leadership development programme - design stage of programme • Health and wellbeing support offer publicised in Q2 • Internal Talent Academy frameworks for LD&F admin and Allied Health Professionals developed • Training Needs Analysis, succession planning and talent management analysis in progress • Review of 'New roles' in community transformation programme • Mental Health toolkit for managers developed • Coaching as a management style workshops arranged • Leadership and development offers reviewed • Engagement with key stakeholders around collective leadership culture • ESR to be implemented as learning management system in October • Staff App launched in September	 (11/14 = 79%) Green
	Commentary:	
	• Leadership Talent Lead is discussing needs with SBUs for leadership development programme • New roles and career pathways delayed due to Community Transformation Programme stock take to determine operating model • Lived experience MH toolkit for managers developed and published • Leadership review completed to ensure a suite of leadership development appropriate for all bands • ESR to launch in October; communications and training rolled out • WRES and WDES action plans co-produced and being signed off October	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes Projection**
The quarter saw a reduction in unplanned turnover rates and completion of annual appraisals to achieve the annual appraisal rate target	• Unplanned turnover will be 11% or less: Actual for Q2 11.1% • Vacancy rates will be 11% or less: Actual for Q2 12.6% • Appraisal compliance rates will be 90% or above (94%) • Overall staff survey results will be as good or better than 2022/23 – result due in Q4 • Staff advocacy survey results will be as good or better than 2022/23 – 22/23 Staff survey 7.4 Q2 Pulse 7.5	 Green

Strategic Objective 4 Senior Responsible Officer AZ	**Q2 Key Actions / Milestones**	**Q2 Milestones Rating**
We will address inequalities to improve out-comes and advance equity for people from all communities **Key Priorities:** Work with local communities to **improve access & address inequalities** Provide a better **experience & environment for Autistic People** Enhance **preventative physical health interventions** Roll-out **evidence based pathways** to improve outcomes	• PCREF (Patient Carer Race Equality Framework) plan developed • Community engagement in Watford and Stevenage working well • Equality performance metrics for PCREF to be developed • Autism Strategy sign off • Autism assessment pathway new staff member starts in January • Development of Autism Friendly environments • Standardisation of Physical health checks • Collaborative physical and mental health education programme in partnership with HCT commenced • Depression Pathway roll out and training • Review of policies to promote recovery focussed care • Specialist Residential Services (SRS) Transition underway and on plan • Development of LD pathways	 (8/12 = 67%) Amber
	Commentary:	
	• PCREF reporting is planned to be in place for Q4 • Conversations have commenced with acute leads about autism friendly environments with the aim of including this work in plans for 24/25 • Education programme with HCT on physical and mental health postponed due to Industrial Action • Depression pathway training target achieved. eLearning 2nd edit completed. Evaluation tool approved. • New provider (Avenues) in place and transition of the first of the four SRS (Specialist Residential Services) bungalows has commenced	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes Projection**
The quarter saw progress on the roll out of the depression pathway and the start of the transition process for the SRS bungalows after a very long process. Almost 40% of staff have already undertaken basic autism training	• PCREF (Patient Carer Race Equality Framework) in place and key actions delivered • Dashboards in place to include equality analysis • Provide at least 40% of staff with basic autism training • Increase number of people on the new autism assessment pathway • Inpatient and First Episode Psychosis patients will receive a health check (Target 90%) • Physical health checks for community service users with Serious Mental Illness (Target 75%) • Increase in appropriate responses to elevated NEWS2 markers • Decrease in smoking rates by service users who attend Clozapine clinics • Depression pathway – training programme in place and evaluation undertaken	 **Green**

<table>
<tr><th>Strategic Objective 5
Senior Responsible Officer DE</th><th>Q2 Key Actions / Milestones</th><th>Q2 Milestones Rating</th></tr>
<tr><td rowspan="2">We will work in partnership in everything we do to meet the needs of communities and the people we support

Key Priorities:
Support the development and delivery of the Hertfordshire MH, LD & Autism Health & Care Partnership (HCP)

Advocate and maintain a high profile for MH, LD & Autism across Hertfordshire, Norfolk, Essex & Bucks Integrated Care Systems

Develop and deliver with the East of England Collaborative

Improve support for those with co-occurring addictions

Develop Community LD and crisis pathway</td><td>• Dual diagnosis support offer being developed in conjunction with Herts County Council and HWE ICB
• Governance structures for system All-Age Autism and CYP Neurodiversity work
• Alignment of commissioning and provision within the MHLDA HCP
• Population health reporting across HWE ICB
• Stakeholder mapping for Hertfordshire completed
• Partnership strategy development
• Relationships developed and maintained with ICBs and partners in Norfolk, Bucks and Essex
• Engagement with planning across all geographies
• Options for future LD forensic provision developed
• Commissioning of perinatal Mother and Baby Units
• Leadership of CAMHS programme for East of England Provider Collaborative
• Dual Diagnosis courses: Brief interventions training; Drug and alcohol awareness; Harm reduction training
• D&A recovery workers in adult community teams
• Development of community LD and community forensic model with partners
• Evaluation and development of future LD Assessment and Treatment Pathways and model
• Evaluation of Essex LD partnership for commissioners</td><td> 

(12/16 = 75%)
Green</td></tr>
<tr><td colspan="2">Commentary:

• Work continues to identify funding to increase substance misuse / mental health support
• The first draft of the partnership strategy will be presented to Executive in Q3
• Stakeholder mapping for wider geographies has commenced but further work to agree appropriate representation in all settings will take place in Q3
• Delegation of perinatal MBU commissioning for Mother and Baby Unit services delayed
• Recruitment to dual diagnosis roles in community teams underway and plan to appoint in Q3</td></tr>
<tr><th>Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes Projection</th></tr>
<tr><td>There has been substantial progress in the quarter on a number of key actions, with many examples of HPFT’s positive impact showcased nationally and work to improve dual diagnosis support</td><td>• Work programme around dual diagnosis delivered
• 18 week pathway agreed for CYP with ASD/ADHD and mental ill health
• Herts MHLDA HCP governance and funding model developed and in place
• Positive feedback from stakeholders (two targets)
• HPFT positive impact showcased nationally
• Change to LD secure provision agreed and sustainable model agreed for HPFT
• Perinatal commissioning mobilised by end of October
• Reduction in number of CYP in out of area placements from EoE
• Provide 40% of relevant staff with Dual Diagnosis training & increase dual diagnosis recording (two targets)
• 95% LD physical health checks completed
• Improve measurement of LD outcomes HCR20
• Improve measurement of LD outcomes as measured by LD HONOS
• Structured relationship management approach across the different geographies</td><td> 

Green</td></tr>
</table>

Strategic Objective 6 Senior Responsible Officer HA	Q2 Key Actions / Milestones	Q2 Milestones Rating
We will be a learning organisation that encourages innovation, research and continuous quality improvement **Key Priorities:** Strengthen our **approach to innovation and continuous quality improvement** Implement **new digital capabilities** Reframe our approach to **sustainability and productivity** across the organisation Expand our **research capacity and capabilities**	• Implementation of a structured programme management approach to transformation • Business case developed for implementation of a Quality Management System • CQI community of practice developed • Deployment of PARIS mobile to community services – now live in two pilot services. • Computer Systems Access app in testing • Digital Self-help Library – provider in place • Sustainability steering group progressing green plan priorities • Revised Financial training programme commenced • Development of long term financial plan underway • Capital plan delivery behind schedule • Research and Development internships secured • Research partnerships with Anglia Ruskin University and Bucks University being developed • University of Hertfordshire partnership revalidated for a further 6 years	 (11/13 = 85%) Green
	Commentary:	
	• Project management support being provided but future approach to transformation not yet agreed • Capital plan behind schedule but expected to recover by year end • Delivering value programme also behind schedule but projected to recover by year end • Memorandum of agreement to be developed with North West London National Institute for Health and Care Research (NIHR) to include HPFT as a recruitment site for novel dementia drug trials • CQI coaches' community set up for 32 coaches. Introduction to CQI session completed by 84 staff • Single, Simple interface is live in two services • Research and Development newsletter launched. NIHR funded R&D internships secured for 3 staff	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes Projection**
There has been good progress on main digital initiatives and a reduction in the use of gas and electricity across the Trust to support the delivery of the Green Plan	• 200 additional staff trained in CQI • Positive survey responses from staff and service users regarding experience of digital capabilities • Bed / Patient Flow system delivered • Demonstrable improvement in the Digital Maturity Assessment • Reduce use of gas and electricity across the Trust • Delivering Value programme delivered (£15m) • Approved capital plan delivered • Increase staff involved in research (Target >77) • Increase service users & carers "opting in" to research opportunities	 Green

APPENDIX 2 – ANNUAL PLAN 2023/24 END OF YEAR OUTCOMES

Note: Quarter One was reported on the old strategic objectives and so it is not possible to directly compare Q2 and subsequent quarters with Q1

	Objective	Predicted			EOY	Year End Outcomes Commentary
		Q1	Q2	Q3	Q4	
1	We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery					Continued growth in CAMHS ADHD cases is a challenge in terms of managing waiting lists and demand pressures in other services are also concerning. However good progress has been made in reducing out of area placements despite high levels of delayed transfers of care
2	We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers					There has been solid progress in the development of the PSIRF approach, the implementation of Electronic Prescribing and the roll out of Trauma Informed Approaches in inpatient settings
3	We will attract, develop and retain a skilled compassionate workforce by creating inclusive and thriving workplaces					The quarter saw a reduction in unplanned turnover rates and completion of annual appraisals to achieve the annual appraisal rate target
4	We will address inequalities to improve out-comes and advance equity for people from all communities					The quarter saw progress on the roll out of the depression pathway and the start of the transition process for the SRS bungalows after a very long process. Almost 40% of staff have already undertaken basic autism training
5	We will work in partnership in everything we do to meet the needs of communities and the people we support					There has been substantial progress in the quarter on a number of key actions, with many examples of HPFT's positive impact showcased nationally and work to improve dual diagnosis support
6	We will be a learning organisation that encourages innovation, research and continuous quality improvement					There has been good progress on main digital initiatives and a reduction in the use of gas and electricity across the Trust to support the delivery of the Green Plan

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 9
Report Title	Finance Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Philip Cave, Chief Finance Officer	
Approved by:	Philip Cave, Chief Finance Officer	

The Board is asked to: RECEIVE	
Receive:	To review the attached finance report and to discuss the actions being undertaken to mitigate the adverse financial position and forecast. The finance report was discussed in detail at the Executive Team meeting and at the Finance and Investment Committee on 26th October 2023.

Executive Summary

The annual plan for the Trust is a deficit of £1.8m.

The year-to-date financial position is a deficit of £3.4m which is £2.1m worse than plan. The key contributors to the financial deficit are the above planned usage of out of area independent sector acute mental health beds driven by demand and an increase in usage of agency/bank staff to support the acuity of patients in wards and in acute hospitals.

The Trust's delivering value target is £15m. For the first six months of the year the plan was to deliver £6.6m of benefit, currently the Trust is £0.4m behind plan due to timing issues on business rates rebates and under delivery of independent sector commissioned bed savings.

The report outlines a significant risk to the Trust hitting the financial plan for the year and related mitigations.

The Executive Team have reviewed the controls and approaches to improving the financial position. The key actions being undertaken by the Executive team to address the current overspend and projected overspend are:

- Cost Control Measures: Continue measures to reduce secondary commissioned beds and optimise temporary staffing expenses, focusing on agency usage for observations and managing vacancies effectively.
- Enhanced Financial Controls: Continue with the enhanced financial controls, agency/vacancy controls, reduced sign-off limits, and improved financial scrutiny and governance to address overspending.
- Income Maximisation: Pursue finalisation of all contracts and pursue income for services where services are not fully funded.
- Savings Execution: Strengthen efforts to achieve savings under the delivering value plan to realise the targeted £18.9 million. Identify any non-recurrent savings opportunities and prioritise initiatives with the potential to deliver the most significant results.
- Non-Pay Spend: Ensure non-pay approval is appropriately controlled and authorised.

Recommendations

The Board are asked:

- To review the attached finance pack.
- To note the current financial deficit and projected forecasts.
- To comment on the actions being taken to mitigate the position.

Implications

Risk and Assurance	Strategic Risk 5 on the Trust's Board Assurance Framework covers the financial risk of the organisation. This report provides one of the assurance controls by reporting to the Board on a regular basis the financial position.
Equality, Diversity and Human Rights	This report has no impact on Equality, Diversity and Human Rights.
Quality	This report does not directly impact on quality. Within the financial framework of the organisation any changes to services which had a financial impact would also have a quality impact assessment.
Financial	The report outlines the Trust's financial deficit of £3.4m, the risks to delivery of the plan and the mitigating actions.
Service Users and Carer Experience	There are no direct implications from the report on service users and carer experience.
People	All managers are expected to stay within their budgeted establishment.
Legal and Regulatory	This report fulfils the regulatory duty to keep the Board informed of the financial position of the organisation.
Digital	There are no direct implications on digital.
System	The Trust's financial plan is part of a Hertfordshire and West Essex ICS overall financial plan for the year of breakeven. If the Trust is unable to hit its plan this will have a negative effect to the system target.
Sustainability	There are no direct implications on sustainability.

Strategic Objectives this report supports	**Please tick any that are relevant** ✓
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	

September (M6) Financial Report 2023/24

2 November 2023

Pages

Executive Summary

Financial Position to 31st September £000	In Month Budget £'000	In Month Plan £'000	In Month Actuals £'000	In Month Variance to Budget £'000	Year to Date Budget £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance to Budget £'000
Income	28,586	28,047	29,570	984	171,515	168,281	174,733	3,218
Income - Provider Collaborative	4,017	4,017	4,504	487	24,104	24,102	25,521	1,417
Pay	19,599	18,744	20,547	(948)	117,303	112,464	119,563	(2,260)
Secondary Commissioning	4,106	4,251	4,289	(183)	24,081	24,595	26,288	(2,206)
Provider Collaborative	4,017	4,017	4,504	(487)	24,104	24,102	25,521	(1,417)
Other Operating Expenditure	4,976	5,130	5,130	(154)	29,793	30,780	31,288	(1,495)
Non Operating Expenses	276	293	124	152	1,656	1,758	1,029	627
Surplus / (Deficit)	**(372)**	**(371)**	**(521)**	**(150)**	**(1,318)**	**(1,316)**	**(3,435)**	**(2,117)**

- The financial plan for the year is a **deficit of £1.8m** as set out and agreed at the Board on 4th May 2023. This includes a £15m delivering value target.
- The phasing of the plan relies upon an additional £1.8m above the Trust's contract value and is subject to a system-wide memorandum of understanding. This income is phased in March 2024; hence the Trust will build up a deficit each month and then a surplus position for March. The year-to-date position includes £0.7m of the £1.8m due in month 12.
- At the end of M6 the Trust has a **deficit of £3.4m,** which is £2.1m worse than plan. The key drivers for the financial position are: an overspend on secondary commissioned beds driven mainly but the need for acute adults, and agency spend above plan driven by vacancy cover, observations on wards and industrial action. Due to the unsatisfactory financial position the executive team have enhanced a number of financial controls including; agency/ vacancy controls, reduced limits for sign off, enhanced financial scrutiny and governance. Without additional intervention the Trust could have a deficit of £6.6m but maintains its forecast to hit plan at this stage.

HPFT Key Drivers of 2023/24 Financial Position

Key Driver	YTD Impact £'m	Full Year Impact £'m	Action
Private Acute OOA beds	1.8	2.4	MH Crisis Assessment Centre Business Case/ OOA Action Plan
Provider Collaborative income	1.0	1.8	Negotiations with Commissioners
MH Patients in Acute Setting	0.7	1.4	MH Crisis Assessment Centre Business Case
Excess Inflation	0.6	0.9	Negotiations with Commissioners
Estates issues	0.1	0.5	Tighten operational control
Industrial Action	0.5	0.7	Reviewed by NHS E
CHC Inflation	0	0.2	Negotiations with Commissioners
MOU Early Release	(0.7)	0.0	
Interest receivable	(0.6)	(1.3)	Benefit of higher interest rates
Total	**3.4**	**6.6**	

- The table above sets out the key drivers of the deficit and potential out turn if action is not taken.

HPFT Key Financial Mitigations/ Actions

Key Mitigation	Full Year Impact £'m	Action Required
Cost Control		
Private Acute OOA beds	0.8	Improve by 5 further OOA beds on Current Run Rate
MH Patients in Acute Setting	0.3	Eliminate agency usage by Q4
Reductions in Observations	0.3	Reduce agency usage (250wte increase since 2023)
Estates issues	0.4	Tighten operational control on estates and facilities
Further Review of Cost Pressures		
Review of WTE increases since 2019		
Total Cost Control	**1.8**	
Income Negotiations Potential		
Provider Collaborative income	1.2	Continue Negotiations and Provider Collaborate Hold surplus
Excess Inflation	1.5	Continue Negotiations with regards to social care short fall
Industrial Action Funding	0.5	Reviewed by NHS E
Total Income Review	**3.2**	
Grand Total	**5.0**	

- The executive team have been discussing additional actions that should be taken to improve the financial position.

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Our Values
Welcoming Kind Positive Respectful Professional

Income

Block Contract Income £'000	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Contract #1 Hertfordshire IHCCT	21,396	21,938	542	128,374	129,719	1,345
Contract #2 East of England	643	663	21	3,855	3,855	0
Contract #3 Essex LD	1,557	1,617	61	9,341	9,386	45
Contract #4 Norfolk (Astley Court)	295	291	(4)	1,767	1,627	(141)
Contract #5 IAPT Essex	521	417	(104)	3,128	2,961	(167)
Contract #6 Bucks Chiltern CCG	387	473	86	2,320	2,293	(27)
Contract #7 - PC Specialised Commissioning	1,647	1,768	122	9,879	10,198	319
Total Block Income	**26,444**	**27,168**	**724**	**158,665**	**160,039**	**1,375**

Other Income	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Partnerships providing mandatory svcs (inc S3	183	320	137	1,098	1,974	876
Other - Cost & Volume Contract revenue	332	354	23	1,991	2,112	120
Education and training revenue	689	619	(71)	4,135	4,340	205
Misc. other Operating Revenue	447	721	273	2,686	3,903	1,217
Other clinical income from mandatory services	439	338	(100)	2,631	1,973	(658)
Research and development revenue	52	51	(1)	310	392	82
Grand Total	**2,141**	**2,402**	**261**	**12,851**	**14,694**	**1,843**

Commissioning Income	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Provider colloborative	4,017	4,504	487	24,104	25,521	1,417
Grand Total	**4,017**	**4,504**	**487**	**24,104**	**25,521**	**1,417**

Total income	**32,603**	**34,074**	**1,471**	**195,619**	**200,254**	**4,635**

- Plan figures have been uplifted to reflect the application of the pay awards for all members of staff. This was an additional £11.5m of additional income budget. Block contracts are broadly in line with plan with variances to plan relating to estimation differences, or in the case of the Herts contract additional income following contract discussions reaching a conclusion. The Herts block contract has the biggest increase, in line with the additional pay award income expected. This reflects CQUIN achievement at 100% and the full utilisation of SDF transformation funding. The Norfolk contract is behind plan where a re-categorisation of some income has occurred and is now shown under provider collaborative Specialised Commissioning where a service has now transferred. Essex IAPT and Bucks contracts are slightly behind plan YTD where contracts are being finalised and forecasts within the plan were above estimated changes in delivery requirements.
- Other Income is ahead of plan by £1,843k. The primary areas of additional income above plan are; CAMHS ADHD (£403k YTD matched with costs), Adult Primary Care (£284k YTD matched with costs), Patient Flow hub (£141k YTD matched to costs), Education & training income (£272k) related to trainee post salary support.
- An additional £100k was accounted for in month 6, £700k year to date in miscellaneous income associated with an early drawdown of the £1.8m ICB funding that is in the financial plan for month 12.
- Whilst the Provider Collaborative is reporting income above plan, this is matched by an increase in costs. The Provider Collaborative continues to report an underspend across all three services streams and an expectation that investment funding will be available.

Pay

Employee Expenses	WTE This Month			This Month			Year to Date			Annual
£000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget
Permanent Staff										
Registered Nursing, Midwifery and Health visiting staff	1,064	770	295	(4,833)	(3,574)	1,259	(28,976)	(21,634)	7,343	(57,909)
Allied Health Professionals	221	165	56	(884)	(775)	109	(5,307)	(4,420)	887	(10,665)
Other Scientific, Therapeutic and Technical Staff	833	700	133	(3,755)	(3,317)	438	(22,448)	(19,774)	2,675	(45,354)
Support to nursing Staff	926	832	95	(2,884)	(2,458)	427	(17,266)	(14,114)	3,152	(33,057)
Support to Allied Health Professionals	85	76	9	(216)	(219)	(3)	(1,296)	(1,255)	41	(3,820)
Support to other clinical staff	73	69	4	(195)	(189)	6	(1,170)	(1,097)	72	(2,310)
Medical and Dental	210	187	24	(1,993)	(2,613)	(620)	(11,948)	(13,421)	(1,473)	(23,922)
NHS Infrastructure Support	973	873	100	(3,939)	(3,627)	312	(23,471)	(21,589)	1,882	(46,472)
Other Pay	1	0	1	(154)	(155)	(1)	(800)	(931)	(131)	(774)
Permanent Staff Total	**4,387**	**3,672**	**715**	**(18,853)**	**(16,926)**	**1,927**	**(112,681)**	**(98,235)**	**14,446**	**(224,284)**
Bank										
Registered Nursing, Midwifery and Health visiting staff	36	109	(73)	(163)	(571)	(409)	(1,010)	(3,787)	(2,777)	(2,438)
Allied Health Professionals	0	7	(7)	(1)	(25)	(24)	(4)	(130)	(126)	(9)
Other Scientific, Therapeutic and Technical Staff	0	21	(21)		(113)	(113)		(647)	(647)	
Support to nursing Staff	149	406	(256)	(465)	(1,461)	(995)	(2,903)	(8,258)	(5,355)	(6,054)
Medical and Dental	7	11	(5)	(41)	(216)	(175)	(247)	(1,195)	(948)	(554)
NHS Infrastructure Support	15	70	(56)	(38)	(243)	(206)	(226)	(1,331)	(1,105)	(459)
Other Pay	10	0	10	(29)	(2)	27	(232)	(3)	230	(12)
Bank Total	**217**	**624**	**(407)**	**(736)**	**(2,631)**	**(1,895)**	**(4,622)**	**(15,350)**	**(10,727)**	**(9,526)**
Agency										
Registered Nursing, Midwifery and Health visiting staff		81	(81)		(537)	(537)		(3,289)	(3,289)	
Other Scientific, Therapeutic and Technical Staff		6	(6)		(56)	(56)		(305)	(305)	
Support to nursing Staff		62	(62)		(221)	(221)		(1,400)	(1,400)	
Medical and Dental		7	(7)		(91)	(91)		(565)	(565)	
NHS Infrastructure Support		2	(2)		(69)	(69)		(360)	(360)	
Other Pay		0	0		(17)	(17)		(61)	(61)	
Agency Total	**0**	**158**	**(158)**	**0**	**(990)**	**(990)**	**0**	**(5,979)**	**(5,979)**	**0**
Total	**4,604**	**4,453**	**150**	**(19,589)**	**(20,547)**	**(958)**	**(117,303)**	**(119,563)**	**(2,260)**	**(233,810)**

- Employee expenses performance is adverse to plan in September by £958k and by £2.26m YTD (1.93%). This includes the impact of the additional pay award above base plan backdated to April 23 in month 3 and the medical pay award processed in month 6. The plan has been updated by a total of £11.5m of additional budget and is forecast to be a shortfall of circa £500k across both substantive and bank staff against actual costs.
- Total expenditure on pay in September was £20.55m
- Expenditure on staffing in September increased by £528k compared to expenditure in August. The primary drivers of this increase are; the medical pay award (£400k), additional 22 Newly Qualified Nurses (c£40k),an increase mental health liaison agency shifts (£20k), a backdated recharge in Older Peoples service (£43k). Agency spend rose by £11k reflective of additional support required in the mental health liaison teams for observations of SU's in the Acute Trusts.
- The overspend area remains in Support to Nursing staff which is driven by high levels of observations in inpatient settings and support provided to the Acute Trusts
- FTE data is reflective of the hours recorded and approved within E-Roster. It is therefore the most accurate for inpatient wards (support to nursing staff) and least accurate on Medical and NHS Infrastructure support, but this will improve with the continued roll out of E-Roster and recording of staff hours.

Secondary Commissioning

Secondary Commissioning Spend	Bed Days			This Month			Year to Date			Annual
£000	Last month	This month	Change	Plan £'000's	Actual £'000's	Variance	Plan £'000's	Actual £'000's	Variance	Plan £'000's
Health Spend										
High Dependency Rehab	998	1,015	17	375	479	(103)	2,253	2,675	(423)	4,506
Cambridge Tool - Health	1,389	1,329	(60)	23	46	(23)	138	373	(235)	276
Specialist Hospital	124	103	(21)	89	30	58	532	505	27	1,063
PICU	64	85	21	144	71	72	757	569	188	1,596
Acute	1,653	1,598	(55)	967	1,074	(107)	5,466	6,770	(1,304)	12,452
MHSOP - Organic	1,271	1,178	(93)	365	368	(3)	2,190	2,260	(70)	4,380
										0
Grand Total	**5,499**	**5,308**	**(191)**	**1,963**	**2,068**	**(105)**	**11,336**	**13,153**	**(1,817)**	**24,273**
Observations										
Health Placement Observations				90	308	(219)	538	650	(112)	1,076
PICU Observations				66	33	33	349	320	29	735
Acute Observations				223	137	86	1,263	1,170	93	2,877
Grand Total				**379**	**479**	**(99)**	**2,150**	**2,139**	**11**	**4,688**
Social Care										
Personal Budgets	0	0	0	292	321	(29)	1,766	1,948	(182)	3,532
Residential Placements	4,430	4,221	(209)	609	585	24	3,654	4,010	(356)	7,307
Nursing Placements	1,023	990	(33)	200	183	17	1,201	1,100	100	2,402
Social Care other	0		0		6	(6)		27	(27)	
Social Care Supported Living placements	7,466	7,089	(377)	671	650	21	4,025	3,922	103	8,050
FNC Income	0	0	0	(8)	(2)	(6)	(50)	(12)	(38)	(100)
Grand Total	**12,919**	**12,300**	**(619)**	**1,764**	**1,742**	**21**	**10,595**	**10,995**	**(400)**	**21,191**
Grand Total				**4,106**	**4,289**	**(183)**	**24,081**	**26,288**	**(2,206)**	**50,152**

- Secondary Commissioning continues to represent a large portion of the Trusts overspend, with Acute placements in particular representing over half of that overspend YTD (£1,304k).
- There has been a large decrease in the number of Acute bed days over the last 2 months that, if held, will begin to recover this position against the budget during a winter period that forecasts an increase in bed usage. Continued high spend on rehab beds and Specialist hospital placements is emerging as a pressure area as it supports step downs from Acute bed placements.
- The £183k overspend in month against plan and £2,206k YTD reflects the continued pressure on Adult Acute beds in particular and the planned reduction of Acute placements in the early months of 2023/24 and this not being achieved.
- Overspend against Social Care budgets reflect a continuing trend of utilising social care options of personal budget and placements as an alternative to an inpatient stay. Personal budgets in particular have increased significantly over the past 12 months and whilst preferable to an inpatient stay, do now represent an additional financial challenge. Further work is being undertaken with Herts County Council to ensure Social Care work is sufficiently funded.

Non-Pay

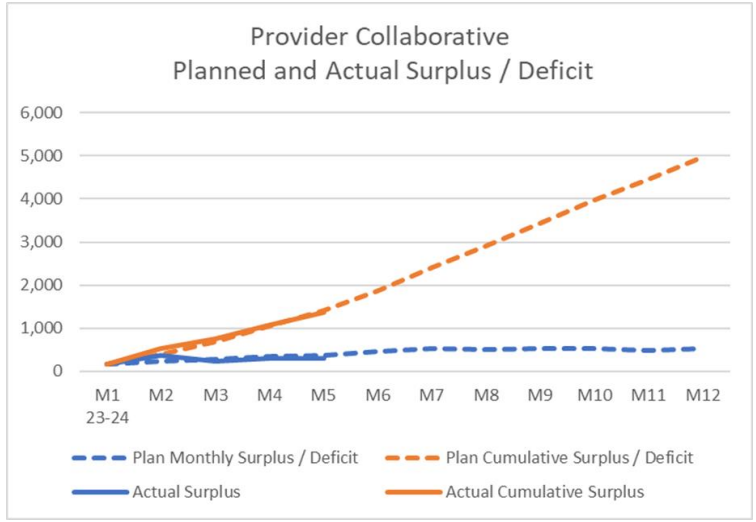
	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Clinical supplies	32	52	(19)	194	310	(116)	389
Drugs	304	326	(22)	1,821	1,998	(176)	3,643
Other Contracted Services	725	687	38	4,259	4,043	216	8,607
Consultancy expense	1	71	(70)	6	189	(183)	12
Education and training expense	91	113	(22)	546	851	(304)	1,093
Hard & Soft FM Contract	777	675	102	4,659	5,016	(356)	9,319
Additional Hard FM	117	181	(64)	700	1,279	(579)	1,401
Information & Communication Technology - Contracts	434	431	3	2,602	2,309	292	5,203
Information & Communication Technology	181	135	45	1,083	1,125	(42)	2,184
Misc. other Operating expenses	354	230	124	2,115	1,512	604	4,266
Non-clinical supplies	68	76	(8)	408	533	(124)	817
Other Contracts	252	491	(239)	1,513	2,103	(590)	3,027
Site Costs	413	483	(70)	2,474	2,865	(391)	4,950
Travel, Subsistence & other Transport Services	325	319	6	1,985	2,008	(23)	3,937
CNST/LTPS/PES	102	102	0	613	613	0	1,226
Depreciation and Amortisation - owned assets	561	543	18	3,366	3,227	140	6,733
Depreciation and Amortisation - assets held under finance leases	241	215	26	1,446	1,310	137	2,893
Total Other Operating Expenditure	**4,976**	**5,130**	**(154)**	**29,793**	**31,288**	**(1,495)**	**59,700**
Interest Expense on Non-commercial borrowings	19	28	(9)	111	119	(8)	222
Interest Income	(115)	(217)	101	(692)	(1,284)	593	(1,383)
Interest Expense on Finance leases (non-PFI)	16	11	4	93	71	22	186
PDC dividend expense	352	289	63	2,109	2,050	59	4,218
Other Finance Costs	6	7	(1)	34	35	(1)	67
Depreciation Peppercorn	-	6	(6)	-	38	(38)	-
Total Non Operating Expenditure	**276**	**124**	**152**	**1,655**	**1,029**	**626**	**3,310**
Total Non Pay Expenditure	**5,252**	**5,255**	**(2)**	**31,448**	**32,317**	**(869)**	**63,010**

- Drug spend is adverse to plan in September by £22k and by £176k YTD. Whilst not a large contributing factor YTD, this is an area that expects a material reduction in spend later in the year following the lapsing of patents on some more expensive drugs.
- Education & Training Expense - Adverse to plan by £22k in month and £304k YTD. The largest expense area here is the support to provide mandatory training within the Learning & Development team.
- Hard & Soft FM Contract – favourable to plan by £102k in month but adverse by £356k YTD. Overspend here predominantly relates to variations to contract on both cleaning and catering. Variations are being proactively managed with the Estates team and Procurement to ensure efficient contract management and variations are reduced going forwards.
- Site Costs - Adverse to plan by £70k in month and £391k YTD. This includes all utilities and associated inflationary uplifts, business rates and non IFRS 16 lease payments. Provision is being made for a rates rebate on the Kingsley Green site of £700k for the year, with a final sign off by the Valuation Office expected during the year. Further efficiencies are being made on telephone, utility expenditure and additional rates reductions that are expected to return this to balance by the end of 2023/24.
- Other Contracts - Adverse to plan by £239k in month and £590k YTD. This primarily relates to CAMHS ADHD expenditure which is matched to income.
- Interest income is favourable to plan by £101k in month and £593k YTD.

Provider Collaborative

- **NB. M5 position only supplied by provider collaborative**

Service	Lead Provider	YTD Plan	YTD Actual	Variance
CAMHS	HPFT	1,067	890	(177)
Adult Secure	EPUT	(424)	(698)	(274)
Adult Eating Disorders	CPFT	795	1,167	372
Total		**1,438**	**1,359**	**(79)**



- The Provider Collaborative has a full year budget of £151.881m spread over 3 service streams; CAMHS (£54m), Adult Secure (£85.8m) and Adult Eating Disorders (£12m). HPFT host the CAMHS Service line.

- The Provider Collaborative is reporting a net surplus to the end of August of £1,359k with a forecast position to be significant surplus of circa £5m. The Provider Collaborative continues to engage with all providers to ensure the full utilisation of this estimated underspend and HPFT are engaging to support the financial position of existing services and also seek to fund further transformation services where possible.

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Delivering Value

Delivery Summary	This Month			Year to Date		
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Planning assumptions	310	310	0	1,860	1,860	0
OOA beds	238		(238)	1,190	446	(744)
Rates rebate	-	58	58	700	348	(352)
Observations/agency reductions	58		(58)	213	87	(126)
Provider Collaborative income	-	-	0	-	-	0
Social Care & Rehab placements	56	-	(56)	206	-	(206)
Corporate schemes	41	137	96	148	487	339
Other SBU Schemes	33	-	(33)	122	93	(29)
Bank interest	-	121	121	-	703	703
Sub-total	**736**	**626**	**(111)**	**4,439**	**4,024**	**(415)**
Productivity schemes (Non-CRES)	417	417	0	2,492	2,492	0
Grand Total	**1,153**	**1,043**	**(111)**	**6,931**	**6,516**	**(415)**

- The submitted DV plan for 2022/23 is £15m. This comprises £10m of cash releasing efficiencies and £5m of productivity (non-cash releasing) benefits.
- The Trust achieved savings of £1.04m in September, which is £111k below Plan in month and £415k behind plan YTD.
- YTD underperformance reflects the non-receipt of the rates rebate in line with plan, but this has now been confirmed to be receipted in October and catch up. The saving realised to date for OOA beds relates to the agreement of a contract with a private provider at a bed day rate lower than Plan, however the plan forecast increases in placements through the winter period and these are currently being held at existing levels. Recurrent savings YTD amount to £5.37m with £1.14k on a non-recurrent basis. The Trust's DV programme has the potential to deliver savings of £18.9m, if all schemes deliver in full.

Capital

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
A Completion of Existing Schemes: Oak Ward	1,500	1,769	1,500	1,625	125
A Completion of Existing Schemes: Other	309	68	309	274	(35)
B Patient Safety Schemes: CCTV	706	929	706	721	15
B Patient Safety Schemes: Elizabeth Court	750	750	750	116	(634)
B Patient Safety Schemes: Other	1,283	1,145	693	900	207
C Recurrent: Backlog Maintenance	1,200	1,300	638	180	(458)
C Recurrent: Reactive Operational Capital	887	94	544	(90)	(634)
C Recurrent: Sustainability	500	500	252	273	21
C Recurrent: Digitisation	1,942	1,908	972	225	(747)
C Recurrent: Laptops/Tablets	880	880	438	304	(134)
D Discretionary: MH Crisis Assessment Centre	1,350	1,350	391		(391)
D Discretionary: Other	2,315	1,074	2,147	400	(1,747)
E Other		474			
E Right of Use	497	497	299	158	(141)
Total Gross Programme	14,119	12,738	9,639	5,086	(4,553)
Disposals	(1,350)		(1,350)	1	1,351
Total Net Programme	**12,769**	**12,738**	**8,289**	**5,087**	**(3,202)**

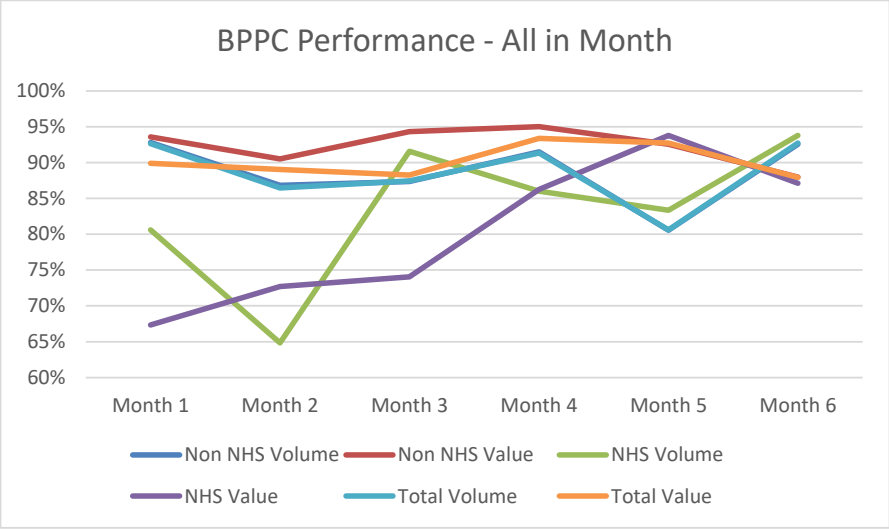
- Capital year-to-date spend to the end of Month 6 is £5.1m, against a year-to-date plan of £8.3m. This is behind Plan by £3.2m due to several key projects spending more slowly than anticipated, and significant levels of VAT reclaims received. There are several purchase orders out and spend was significantly higher at just over £1.0m in Month 6.
- The programme for 2023/24 has been divided into groups relating to: Completion of Existing Schemes; Patient Safety Schemes; Recurrent requirements (Such as backlog maintenance and digital); and Discretionary Projects.
- In addition, there is Plan allocated to the Mental Health Crisis Assessment Centre (MHCAC), which is currently being worked up and which the Herts and West Essex system have agreed to adjust the Trust's capital limit in year.
- The planned disposal of Harper Lane, expected to net £1.35m, is no longer expected in 2023/24, however there is sufficient flex in the programme to accommodate this particularly with the additional System CDEL allocated; a revised proposal is being presented to the Executive Team in October in relation to this.
- Overall, it is fully expected that CDEL will be utilised in full in 2023/24 as has been the case for the last few years.

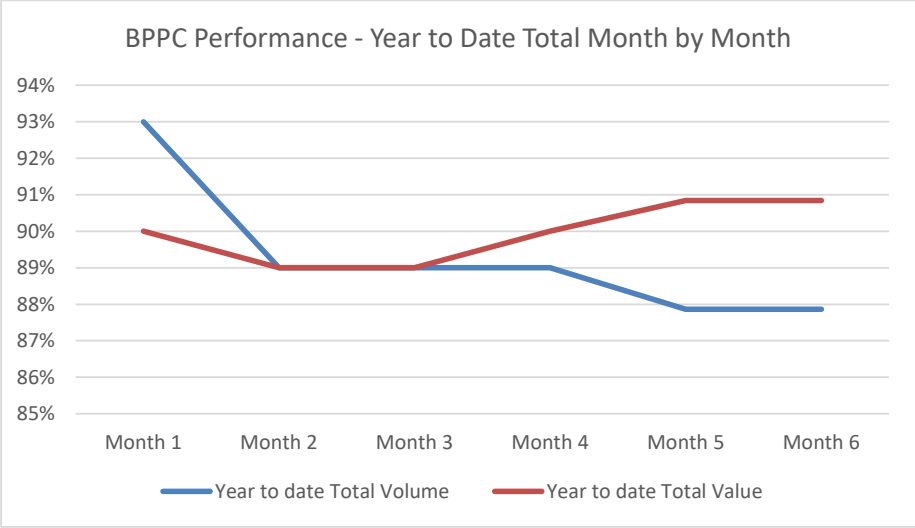
Balance Sheet

Statement of Financial Position	31 March 2023	Previous month 5	Movement in month 6	Current month 6	Movement YTD
	£000	£000	£000	£000	£000
Assets	258,189	254,349	4,146	258,495	306
Non Current Assets	**183,345**	**183,432**	**3,533**	**186,965**	**3,620**
Intangible Assets	2,975	2,809	(33)	2,776	(199)
Property Plant & Equipment	163,899	165,278	524	165,802	1,903
Tr & Oth Rec: Non-Nhs Rec	358	358	0	358	0
Other Assets	931	931	0	931	0
Right Of Use Assets	15,182	14,056	3,042	17,098	1,916
Current Assets	**74,844**	**70,917**	**613**	**71,530**	**(3,314)**
Inventories	60	60	0	60	0
Trade and Other Receivables NHS	17,352	8,460	(346)	8,113	(9,238)
Trade and Other Receivables Non NHS	4,479	15,129	4,320	19,449	14,970
Credit Loss Allowance	(591)	(591)	4	(587)	4
Assets Held for Sale	1,274	1,274	0	1,274	0
Cash & Cash Equivalents GBS/NLF	52,181	46,497	(3,409)	43,087	(9,094)
Cash & Cash Equivalents Other	90	89	45	134	43
Liabilities	(89,940)	(89,010)	(4,667)	(93,677)	(3,737)
Current Liabilities	**(64,637)**	**(64,371)**	**(996)**	**(65,367)**	**(730)**
Trade & Other Payables Capital	(1,922)	(1,915)	(379)	(2,294)	(372)
Trade & Oth Payables Non-Capital	(54,720)	(53,637)	(1,659)	(55,296)	(576)
Borrowings	(3,023)	(2,997)	82	(2,915)	108
Provisions	(3,625)	(3,123)	117	(3,006)	619
Deferred Income	(1,347)	(2,699)	842	(1,856)	(509)
Non Current Liabilities	**(25,303)**	**(24,639)**	**(3,670)**	**(28,309)**	**(3,006)**
Borrowings	(19,580)	(18,873)	(3,479)	(22,352)	(2,772)
Provisions	(5,723)	(5,767)	(191)	(5,957)	(234)
Other Liabilities	0	0	0	0	0
Equity	(168,249)	(165,339)	520	(164,819)	3,430
Public Dividend Capital	**(97,959)**	**(97,959)**	**0**	**(97,959)**	**0**
Revaluation Reserve	**(42,198)**	**(42,198)**	**0**	**(42,198)**	**0**
Other Reserves	**(641)**	**(641)**	**0**	**(641)**	**0**
Income And Expenditure Reserve	**(27,451)**	**(24,541)**	**520**	**(24,021)**	**3,430**

- Non-Current asset values reflect in-year additions (£8.2m YTD) less depreciation charges (£4.6m YTD). A full revaluation was undertaken in 22/23 and if a desktop or impairment review is required in 23/24, it will be undertaken later in the year.
- The Trust cash position is £43.2m. This is a £3.4m decrease in month. The expected receipt of £10.9m SDF funding agreed for the year was not received in month from HCC and is being chased with HCC and the ICB.
- Trade and other receivables has increased by £4m in month.
- Trade and other payables has increased by £1m in the month.
- The movement in the I&E reserve reflects the year-to-date deficit.

Better Payment Practice Code





- Performance remains below target (95% non-NHS less than 30 days), however total value paid in 30 days has increased to 91%.
- Trend is improving generally from 2022/23 lows with April, June & July averaging 88% but lower performance in May (76%) due to several large invoices.
- Overall target remains a challenge whilst volumes of agency invoices remain high.

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Summary/ Actions

- The year-to-date financial position is a deficit of £3.4m which is £2.1m worse than plan. The key contributors to the financial deficit are the above plan usage of out of area private acute mental health beds and an increase in usage of agency/bank staff to support acuity of patients in wards and in physical acute hospitals.
- The Executive Team have been reviewing the controls and approaches to improving the financial position.
- The key actions being undertaken by the Executive team to address the current overspend and projected overspend are:
  - Cost Control Measures: Continue measures to reduce secondary commissioned beds and optimise temporary staffing expenses, focusing on agency usage for observations and managing vacancies effectively.
  - Enhanced Financial Controls: Continue with the enhanced financial controls, agency/vacancy controls, reduced sign-off limits, and improved financial scrutiny and governance to address overspending.
  - Income Maximisation: Pursue contract finalisations and billing of all due recharges to maximise income, particularly in Social Care, Provider Collaborative, CAMHS ADHD, Paediatric MH Liaison, and Education & training income areas. Continued Engagement with Provider Collaborative: Maintain active engagement with the Provider Collaborative to seek additional funding to offset increased costs in Adult Forensic and CAMHS Inpatient services.
  - Savings Execution: Strengthen efforts to achieve savings under the delivering value plan to realise the targeted £18.9 million. Identify any non-recurrent savings opportunities and prioritise initiatives with the potential to deliver the most significant results.
  - Address OOA Bed Utilisation: Continuously work on reducing the usage of Out-of-Area (OOA) beds to planned levels to mitigate the financial burden.
  - Non-Pay Spend Review: ensure non-pay approval is appropriately controlled and authorised.

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Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 10
Report Title	Hertfordshire Mental Health, Learning Disabilities and Autism Health and Care Partnership (MHLDA HCP)	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Ed Knowles, Development Director	
Approved by:	David Evans. Executive Director, Strategy & Partnerships	

The Board of Directors is asked to:
Receive: To receive and discuss the MHLDA HCP report noting progress and actions.

Executive Summary

The attached paper is the latest Development Director's report presented to the Hertfordshire Mental Health, Learning Disabilities and Autism Health and Care Partnership (MHLDA HCP) at its Board meeting on 13 October 2023.

Key developments mobilised and delivered through the MHLDA HCP since the last update to HPFT's Board of Directors are summarised below.

Mental Health Crisis Assessment: Following approval by the HWE ICB on 22 September, significant work is now underway to mobilise the new Mental Health Crisis Assessment Centre. This represents a major investment in how we support people in crisis. The full model will require renovation activity on the Lister site but prior to this, the service will be partially mobilised so that it can begin to support people and patient flow over the winter period. Discussions are underway with system partners across the Health and Care Partnership to ensure that this new Crisis Assessment Centre complements existing provision and to consider what changes might be made to existing pathways and practices to support its delivery. A face-to-face, multi-agency workshop will take place on 20 October 2023 to consider the phasing of this work and the development of the model.

Crisis Care and Right Care, Right Person: The MHLDA HCP's Crisis Care Partnership Board's terms of reference and membership were refreshed earlier in the year to ensure that it provides senior, multi-agency oversight and leadership for system activity. Co-chaired by the Chief Executive of MIND in Mid-Herts and the Deputy Chief Executive of HPFT, the Board is currently progressing activity around frequent attenders, the development of Urgent Crisis Assessment provision and supporting the ICB's UEC Board in relation to winter planning. It has also been agreed with Hertfordshire Constabulary that the Crisis Care Partnership Board will oversee the tactical development and implementation of the Right Care, Right Person model of police resourcing. This will include work to review how the police handle welfare calls alongside the wider system as well as the responsibilities of the police in terms of supporting people who are admitted under Section 136 of the Mental Health.

The MHLDA HCP Board meeting on 13 October 2023, was dedicated to the Children and Young People's agenda. Alongside updates on the development of the new neurodiversity pathway and HCC's Making SEND Everyone's Business programme, the HCP Board received an update from its CYP Emotional and Mental Wellbeing Board which highlighted the impact

of system work to improves access to Mental Health services, including a 44% increase in accepted referrals and the growth of Early Help access by 54%.

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

- Brought together colleagues across Hertfordshire and Essex to align our activity and identify specific areas for collaboration in relation to the HWE Integrated Care Strategy. This includes specific activity related to employment and employability for people with serious mental illness, learning disabilities and neurodiversity.
- Responded as the MHLDA HCP to the Government's Major Conditions Strategy: call for evidence.
- Considered the clinical and practice next steps required to deliver the objectives of our Physical Health Strategy and how we ensure alignment with the findings and themes from the LeDeR Annual Report.
- Convened Hertfordshire and West Essex colleagues to assess our Mental Health Urgent and Emergency Care system through a new NHS England pilot tool.
- Confirmed the role of the MHLDA's Crisis Care Partnership Board on the development of Hertfordshire's approach to the implementation of the Right Care, Right Person model of police resourcing.
- Developed communications material to support initiatives related to advancing equity in mental health.
- Successfully implemented an element of our new approach to Co-Production – with a successful reference group meeting around the development of the Suicide Prevention pathway programme.

Priorities for the forthcoming period include:

- Support the development and operationalisation of the new Mental Health Crisis Assessment centre and its integration with wider services and support.
- Coordinate winter planning and winter funding discussions across partners so that we prioritise the most impactful activity including the refresh of MHLDA HCP winter communications materials.
- Develop the MHLDA HCP's response to system proposals around the development of HCPs and their relationship to the HWE ICB (see below)
- Finalise and confirm across MHLDA HCP partners the wider model of Primary and Community Mental Health transformation activity.
- Progress the supported employment priority for the MHDLA HCP and Hertfordshire and West Essex Integrated Care Partnership by comparing and baselining activity across HPFT and HCC
- Drive progress against the ambitions of the MHLDA HCP Physical Health Strategy
- Finalise a Hertfordshire-wide model for the triage and assessment of neurodivergent children and young people including a non-clinical support offer.

Hertfordshire and West Essex Integrated Care Board (HWE ICB) Operating Model

Since the last update, the Hertfordshire and West Essex Integrated Care Board (HWE ICB) has developed proposals regarding its future operating model. Key changes proposed include a transition of Health and Care Partnerships from the current partnerships into formal accountable business units. The HWE ICB has identified that this transition and development would include:

- A clearer definition of the role of the Health and Care Partnerships, including their decision-making processes and responsibilities and how the ICB governance structure will be adapted to enable this.

- Establishing accountable business units to drive increased integrated working within HCPs. This would involve the development of multi-organisational teams, with staff covering transformation including primary care, contracting, finance and performance. Some staff will be fully embedded in these teams and others will matrix in.
- Establishing a clear approach to budget ownership and management between Health and Care Partnerships and the HWE ICB
- Setting clearly defined commissioner and contracting responsibilities

This work is being overseen by the HCP Development Group, reporting into the ICB Board. HPFT Board will want to consider in due course the implications for both the MHLDA HCP and HPFT within the context of the development of Accountable Business Units. As it stands, there are a number of fundamental questions still to be considered and resolved – most notably a precise definition of what duties the HWE ICB is seeking to deliver through the HCPs and the scale and of the proposed budget that each HCP would take responsibility for. The issue around accountability, the format this would take (e.g., formal sub-committee, lead provider) and the agreements required are also under development.

The MHLDA HCP is actively engaged and shaping the development of how an Accountable Business Unit model might work in practice – recognising that the MHDLA HCP is one of four HCPs that will be expected to fulfil this function. The MHLDA HCP has experience and a proven track record of delivery and in many respects the MHDLA HCP already undertakes many of the roles (through its respective partners and approach taken across the Partnership) that might be expected of an accountable business unit including setting strategic direction, managing and rationing within a financial envelope, leading transformation activity, assessing performance and working across partners to develop the most appropriate means of delivery.

HWE ICB's current thinking and proposals are focussed, in the first instance, on the potential delegation of NHS financial/quality/performance/transformation accountability from HWE ICB to the HCPs. The MHLDA HCP's assumption of any additional duties or responsibilities will need to be considered in light of existing Section 75 formal relationships.

The MHLDA HCP is committed to the next stage to develop the partnership as a delivery vehicle for the HWE ICB and also on behalf of the Herts and Essex Integrated Care Partnership.

As the Accountable Business Unit model develops there are likely to be implications for the Trust. The Executive Director, Strategy and Partnerships is now a member of the HCP Development Group and a future briefing to discuss ABU developments will be arranged for the Board.

Recommendations

The Board of Directors is asked to:

Receive: To receive the MHLDA HCP report and discuss, in depth and consider implications of Accountable Business Unit development and Operating model noting the potential implications for the Board or Trust.

Implications

Risk and Assurance	N/A

Equality, Diversity and Human Rights	No EqIA required – there are no specific equality and diversity issues associated with the recommendations of this paper.
Quality	N/A
Financial	N/A
Service Users and Carer Experience	N/A
People	N/A
Legal and Regulatory	N/A
Digital	N/A
System	MHLDA HCP is a Partnership approach and future development
Sustainability	N/A

Strategic Objectives this report supports	**Please tick any that are relevant**
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	✓
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	✓
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	

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

November 2023

1. Introduction and summary

1.1 September has been a busy month for the MHLDA HCP as it continues to lead system-wide activity and deliver against its transformation priorities. Many of the MHLDA HCP's sub-boards have met, progressing a wide range of activity in support of local people. The MHLDA HCP has advocated for the key role of local government in the ICS, updated the Hertfordshire and West Essex Integrated Care Partnership on its work around employment and employability and brought together system partners to review our Mental Health Urgent and Emergency Care arrangements.

1.2 The Mental Health Crisis Assessment Centre business case, developed through the MHLDA HCP's Crisis Care Partnership Board, was approved by the Hertfordshire and West Essex Integrated Care Board (HWE ICB) on 22 September 2023. This represents a major investment in how we support people in crisis, and we will now work to develop the partnership required so that it complements and enhances existing crisis provision and support.

2. HCP and System developments

2.1 The MHLDA HCP supported the Local Government ICS workshop on 19 September 2023. This workshop directly explored the role of District/Borough Councils in improving the health and wellbeing of their local populations. Participants considered where there might be opportunities to complement existing activity across health and social care as well as the opportunities for greater involvement of local government in the development of HCPs.

2.2 The MHLDA HCP Development Director represented the MHDLA HCP at the Hertfordshire and West Essex Integrated Care Partnership (HWE ICP) on 26 September. Alongside standing updates from the HWE ICB and the HWE ICP Lead Officer Report, the HWE ICP received a presentation on information sharing and data analytics and discussed the potential to put in place a data strategy to support preventative work within neighbourhoods and communities. The HWE ICP also received an update on the Making Every Adult Matter (MEAM) programme (see section 7.1 – 7.3) and a report from the MHLDA HCP regarding the activity it is leading with Essex on improving employment and employability for people with serious mental illness, learning disabilities and autism. Further information from this report is covered in section 7.4 and 7.5 of this report.

2.3 Further work has taken place to consider the impact of the Hertfordshire and West Essex Integrated Care Board's proposals in relation to the future role of HCPs. Discussions are taking place the across the NHS and the County Council to understand the specific details of what's being proposed and, specifically for the MHLDA HCP how any future models could complement the strong integrated arrangements that already exist. A full update on this item will be considered at the MHLDA HCP Board meeting in November.

3. Communications and Engagement

3.1 To further support communications and engagement initiatives around Advancing Equality in Mental Health with partners: One Vision, Stevenage Equalities Commission and staff from HPFT, we are designing communications assets to respond to service users' questions regarding "how would taking up mental health services affect my job, health insurance." At present, a subgroup is being pulled together to discuss the impact of these assets.

3.2 The Depression Pathway e-learning animation project is in its final stages. A team comprised of experts by experience, training staff, communications as well as members of staff who have volunteered their time to review the content have begun the process of reviewing the videos to ensure that they support the programme's desired outcomes. The subgroup will determine if any additional changes or adjustments are needed after the review is completed. The e-learning tool will then be incorporated into Essential Training protocols for project partners.

3.3 A sub-group is being pulled together to support the development of tools to support the Suicide Prevention Pathway. The subgroup includes participants from partners: Lister and Watford. The subgroup has been asked to pull together a communications suite of assets that include materials to support partner staff training. The materials will be digital and printed pieces. The digital assets will be housed on HPFT's website with links to downloadable files for use by clinical staff at partner agencies.

3.4 Last year's winter crisis care campaign is being reviewed for opportunities. Discussion have been had with the ICB, HCC, HCP partners and other stakeholders to determine what opportunities exist to improve upon the campaign. MHLDA HCP Communications and Engagement is scheduled to discuss the campaign with the Crisis Care Partnership Board at its meeting on 05 October 2023 to consider how we ensure the broadest coverage for this campaign over this winter.

4. Updates from our sub-committees

4.1 **Co-production Development Group: -** the MHLDA HCP Co-production Development Group met on 25 September 2023 and discussed the outputs and lessons learned from the Reference Group discussion on Suicide Prevention that had taken place at the end of August 2023.

4.2 The Development Group observed that while there are still further refinements to the process required, the model and ways of working that have been put in place allow co-production activity across the MHDLA HCP to be more clearly highlighted and reviewed. It also ensures that the learning and outputs of co-production activity can inform similar activity taking place across the MHLDA HCP.

4.3 The Development Group observed and welcomed the fact that this entire process was itself being co-produced as Reference Group members – who are front line workers and people with lived experience themselves - contribute to the better understanding of techniques and processes that inform better interaction and engagement.

4.4 **Clinical and Practice Advisory Committee (CPAC): -** The CPAC met on 06 October 2023 and received an update on the development of a Mental Health Crisis Assessment Centre to be run from the Lister Hospital site. The CPAC noted that elements of the service are to mobilised immediately in support of winter pressures but that the full service would be phased in. The CPAC noted the concurrent meetings taking place with MHLDA HCP partners to consider the implications of this new service offer and how it could complement and best integrate with the existing services and the support available for people in crisis.

4.5 The CPAC is scheduled to hold an awayday on 03 November 2023 and discussed with partners how best to use this session. It was agreed that the awayday will focus primarily on inequalities and advancing equity.

5. Update from our Partnership Boards

5.1 **Crisis Care Partnership Board (CCPB): -**The CCPB met on 07 September 2023 and received an update on the developing proposals for the Mental Health Crisis Assessment Centre. The CCPB welcomed the proposals and noted that the business case for this Centre would be considered for approval by the HWE ICB.

5.2 The HWE ICB has subsequently approved the Business Case at its meeting on 22 September 2023 and activity is now underway to mobilise the service. The full model will require renovation activity in the Lister site. Prior to this, the service will be partially mobilised so that it can begin to support people and patient flow over the winter period.

5.3 Discussions are now taking place with system partners to ensure that this new Criss Assessment Centre complements existing provision and what changes might be made to existing pathways and practices to support its delivery. A face-to-face, multi-agency workshop is planned for 20 October 2023 to consider the phasing of this work and the development of the model.

5.4 The CCPB also considered the High Intensity Users/Frequent Attenders work taking place through the CCPB's Section 136 Interagency sub-group. A deep dive on this topic will be considered at the CCPB meeting in December 2023 to understand what the common factors might be behind these frequent attendances and how partners across the CCPB can respond.

5.5 Work continues to scope and implement the Right Care, Right Person programme. Stakeholder mapping has started with police colleagues against the four phases of the programme. It is proposed that the HWE ICB's Mental Health and Learning Disabilities programme board will provide strategic oversight across Hertfordshire and West Essex and the CCPB will provide the tactical oversight of the work related to Section 136, Transport and people walkouts. Further work is underway to consider the most appropriate forum to discuss and resolve issues related to welfare calls.

5.6 The DHSC has sent out a survey to all Integrated Care Boards to understand the impact and implications of implementing the Right Care, Right Person model. The response to this survey will be discussed as the CCPB meeting on 05 October 2023 and submitted on behalf of HWE ICB on 13 October 2023.

5.7 System partners met on 26 September to pilot the new Urgent and Emergency Care Mental Health Services Assessment Tool (MEN-SAT). Through facilitated discussions, system partners were able to have open and honest discussions about what is and isn't working well and what improvements can be made within the UEC Mental Health pathway. This highlighted positive practice and approaches, but also the how current operational pressure are impacting on pathways and the ability of partner agencies to support one another. We are expecting outputs and analysis from NHS England and will consider these at a future meeting of the CCPB.

5.8 Children and young people, parents and carers and the professionals who work with them are all invited to celebrate the launch of Herts Haven Cafés between 2pm and 5pm on Tuesday 17 October 2023.These cafés are a haven of support for children and young people in the county aged 10 to 18, offering free-of-charge, emotional wellbeing support without the requirement of a referral.

5.9 **Primary and Community Mental Health Transformation: –** The Primary and Community Mental Health Programme Board met on 11 September 2023 and approved the initial set of services that would be more formally included as part of Hertfordshire's wider model of Primary and Community mental health support. This includes Hertfordshire's Healthy Hubs programme as well as links to the complex housing multi-disciplinary team activity that already exists across the county.

5.10 The Programme Board nominated members to form a design group to undertake the work to develop the connections and working relationships between these different elements of support and provide a more cohesive and joined experience of care and support for people. The design group is due to report back to Primary and Community Programme Board on 13 November 2023 with proposed next steps.

5.11 The development of Primary Care Integrated Neighbourhood Teams (INT) priority populations continues, with both Hertsmere and Watford identifying Severe Mental Illness and Mental Health as priorities. Both Welwyn/Hatfield and Upper Lea Valley have been identified by the ICB and ENHCP as vanguard sites in E&N, with additional programme resource to support effective implementation of an INT approach.

5.12 Recognising the significant overlap in terms of support and services, the MHLDA HCP joined a workshop with Hertfordshire County Council's Adult Care Service on 19 September 2023 exploring how best to support the INT process and ensure that the needs of people with serious mental illness, learning disabilities and autism is recognised.

5.13 In recognition that both HertsHelp and HPFT's Single Point of Access handle thousands of queries related to mental ill health and its social determinants, the MH Access group agreed that both parties should explore opportunities to be more connected to improve service user outcomes. The re-tendering of Herts Help prevented an onsite visit, however the successful award to Age UK Herts and Citizens Advice Stevenage under the partnership name of ''Hertfordshire Advice Providers Partnership (HAPP), has meant that the trial opening of a telephone line between both services will go live in October to improve service user experience and continue to build upon the partnership working.

5.14 **Children and Young People Emotional and Mental Wellbeing Board: -** We have begun to roll out phase nine of our Mental Health Support Team (MHST) offer across the HWE ICB area. For Hertfordshire, this will mean that there is a MHST presence in each of the 10 district/borough areas and will increase coverage to 43% of schools, exceeding the NHS Long Term Plan ambition of 23% of schools covered by the end of 2023/24. Additionally, we have increased the reach of Special Educational Needs (SEN) support by extending the SEN MHST offer to mainstream MHST schools.

5.15 HWE ICB has been selected as one of two ICB areas to take part in the national GIRFT (Getting It Right First Time) programme. This will comprise a pilot deep dive project to help diagnose and unpick the challenges faced in the Children and Young People Mental Health System (CYPMHS) and identify solutions and best practice that can help improve pathways, treatment and care. It is anticipated that the deep dive will take approximately 12-16 weeks to complete, after which we will be presented with a set of recommendations and actions.

5.16 CYPMHS Commissioners are progressing a tabletop evaluation exercise to understand the impact of our commissioned provision, the outcomes being delivered and ensuring that this is still aligned with our system priorities and providing assurance against our local ambitions and those of the NHS Long Term Plan. This should be concluded in the coming weeks and considered at a forthcoming meeting of the Children and Young People Emotional and Mental Wellbeing Board.

5.17 Hertfordshire County Council Public Health is inviting applications from community and voluntary organisations to deliver physical activity projects that promote mental health and wellbeing and reduce inequalities among children and young people aged 5-18 or 5-25 for children and young people with special educational needs and disabilities. Building on the successes of the adult's programme, grants are aimed at innovative projects and organisations which promote metal health in Children and Young People through physical activity. Each organisation / project can apply for up to £5,000 each with projects running until the 30th June 2024. Application forms must be submitted to CYPTeam@hertfordshire.gov.uk by 12pm on 16th October 2023.

5.18 **Learning Disabilities and Autism Strategic Partnership Board: -** Recent LeDeR reviews have highlighted the following themes:

- Improved cross boundary working arrangements beyond Hertfordshire and West Essex – this needs to be strengthened
- Recognising early signs of deterioration ongoing opportunities to improve awareness continue to be explored
- Cancer screening - this gap is being addressed through the work of Health Equality Nurses in Hertfordshire with mor proactive opportunities to offer screening.
- Weight management support – opportunities for targeted work linking in with public health initiatives are being explored
- Additional support in hospital settings – through improved coordination enabled by the role of acute liaison teams for mental health and learning disabilities including the role of safeguarding
- Noted excellent practice of End-of-Life Care by providers, palliative care teams, district nurses and hospice support.

5.19 The dynamic support register is now becoming embedded with representation from ADS, 0-25, HPFT and other key stakeholders to support and prevent admission to hospital and support and plan discharge for those already in hospital. Training and support have been given to community mental health teams, Adult Disability Services and 0-25 Together team to support early identification where someone is at risk of hospital admission. It has been identified that people at risk of hospital admission are being identified too late and work continues to support relevant operational teams to identify and support people prior to an admission becoming necessary.

5.20 A report has been completed which details where referrals come from for the DSR and identified actions to improve and support the process across the system for the adult autistic population.

5.21 Autism Hertfordshire continue to provide support in the community and positive feedback has been received via Care and Treatment Reviews as well as usual contract monitoring. We are currently exploring a step-down service from the DSR and further support for those who are over 25 as this has been identified as a gap.

5.22 Work is continuing with HPFT around waiting lists in the diagnostic pathway for over 18s including collaborating with GPs around new referral form and ensuring that GPs are aware of the community support referral and waiting times.

6. Working Group updates

6.1 **Dementia: –** The Dementia Diagnosis Rate (DDR) for Hertfordshire and West Essex is continuing to gradually improve. In September, the DDR for the HWE ICB area was 64.2%. This is sitting just above the England wide DDR of 64.1% and above the region's rate of 62%. The national target is 66.7%.

6.2 Work on the Dementia Strategy delivery is now beginning to pick up pace and projects are forming around Dementia Friendly Hertfordshire brand with Alzheimer's Society support, Dementia Training activity, links with work being

taken forward by HCC Care Home commissioning, dementia friendly design standards review, and Accommodation Based services.

6.3 The Dementia Community Services Commissioning process is continuing to work with a range of organisations, service users and families to develop the new specification, and the PPME events held in early to mid-September were well attended and lively, sparking a lot of discussion and ideas.

6.4 The second round of the NHSE funding bid for Assistive Technology in Care Homes being led by HCPA is due to be announced on 5th October. The MHLDA HCP is supporting the bid by acting as the project's independent evaluation partner, with a proposal to co-evaluate with people with lived experience. If successful, there is a funding element to support evaluation activity which will be used in part to facilitate this.

6.5 **Workforce Task Group: –** the focus of activity this month has been on work to support the employment and employability priority of the HWE ICP. Further detail is provided in sections 7.4 and 7.5 of this report.

6.6 **Suicide Prevention: –** Herts Mind Network and Hertfordshire County Council's Festival of Hope to mark World Suicide Prevention Day took place on 08 September 2023 with strong representation from MHLDA HCP partners. The event heard from people with lived experience and from people involved in delivering suicide prevention services and considered how we continue to both promote and support this work.

6.7 On 11 September 2023, the Government published its new Suicide prevention strategy for England: 2023 to 2028 with a headline commitment to see the number of suicides decrease within two and a half years. The new strategy details over 100 actions aimed at saving lives, providing early intervention and supporting people in crisis. These include:

- a new national alert system to notify relevant authorities - like schools, universities, and charities - of emerging methods of suicides and risks, and any required actions that can reduce access or limit awareness
- fresh guidance issued to first responders, recognising new and emerging methods, and how such incidents should be dealt with
- near real-time surveillance of trends in tragic suicides to be introduced on a national scale this year - enabling more timely and targeted actions
- a government pledge to collaborate with countries around the world to target and stop suppliers of dangerous and lethal substances at the source

6.8 Following the launch of the national strategy, on 02 October 2023, Hertfordshire County Council's Public Health team held a Suicide Prevention Strategy consultation event to review the work undertaken as part of the 2020 Hertfordshire Suicide Prevention Strategy. Facilitated table exercises took place to focus on local priorities for action including Gambling, Domestic Violence, Online Harms & Inequalities in Vulnerable groups. The feedback will be used to help collate the Hertfordshire's next suicide prevention strategy and the system's response to the national strategy.

6.9 The Suicide Prevention pathway pilot is due to start end of January 2024. Fortnightly operational meetings are taking place with key stakeholders including Experts By Experience. A Hertfordshire Suicide Prevention Pathway framework has been created for clinicians (in draft format) and we are working with communications and engagement leads to develop a resource pack/toolkit to be stored on HPFT internet. The East of England Academic Health Science Network (AHSN) will support with periodic evaluation and data analysis of the pilot.

6.10 **Children and Young People Neurodiversity Steering Group: –** There has been considerable work ongoing across all areas of the CYP neurodiversity programme. On 12 September, the MHLDA HCP Development team convened a multi-agency workshop to clarify the different activity taking place within different organisations and to agree upon where our collective resource and attention is best placed. At the subsequent meeting on the Hertfordshire CYP Neurodiversity Transformation programme steering group it was agreed that the focus of activity for the remained of the year would be the finalisation of a combined (ASD and ADHD) clinical pathway, the development scalable operational models to deliver this pathway, work to simplify and bring together data and wider discussions across partners regarding the role and functions expected of any support offer.

6.11 Alongside the proposed combined clinical pathway, there has been discussion around the potential workforce demands recognising the different clinicians and professionals that might need to be involved depending on the presenting need of the CYP and their age.

6.12 Commissioning activity for the support offer pilots is nearing tender stage. In addition, there has been agreement for the extension of the ND Support Hub pilot through to September 2024 and we are awaiting a decision from the HWE ICB regarding whether there will be funding to support this through to the end of 2024/25.

6.13 Looking forward, the next steps for the programme are to agree the scope and criteria for the single point of entry, including co-designing the approach as much as possible with people who are likely to use the service, establish clear operational processes and how the single point of entry and clinical pathway interacts with the Support Hub and support offers, and to continue to model the number of staff and roles of staff required to meet the need.

6.14 We are intending to ‘walk through’ the whole pathway with a group of CYP and their parents / carers to test that the pathway is fit for purpose from their perspective, test assumptions around user interfaces and ease of use, to allow the best outcomes and experience throughout the assessment process.

7. Leading on prevention and positive health and wellbeing

7.1 **Housing and Making Every Adult Matter (MEAM) approach**: – the MEAM approach was presented to the HWE ICP on 26 September 2023 focusing on the opportunities it presents for more collaborative work across different agencies to support people facing multiple disadvantages including mental illness.

7.2 HWE ICP members were invited to consider how they could embed MEAM principles within their organisations and how they could introduce ‘in reach’

health and support services e.g., the 'in reach' dental health model and the Watford Meadowell GP Surgery homeless service.

7.3 **Employment and employability: –** working with the HWE ICP secretariat, the MHLDA HCP has supported the development of public sector pledge that would apply across the public sector in Hertfordshire and would establish a set of principles protocols and practice that:

- Provides framework of standards that enable, support and monitor the effective hiring and retention of people with serious mental illness, learning disabilities and neurodiversity
- Supports individual strengths, skills and ambitions, rather than focussing on disability or need
- Supports career development and progression through organisations and sectors, that work with a person's unique talents and perspectives and flexes to accommodate their individual needs
- Supports organisational development, reducing and removing barriers to employment and improving diversity within the workplace
- Supports teams, managers, support services, partners and colleagues by developing awareness of serious mental illness, learning disabilities and neurodiversity in the workplace, reducing stigma and prejudice and improving understanding and availability of reasonable adjustment and accessibility as standard

7.4 An update on this activity was presented to the HWE ICP on 26 September 2023 and ICP members we invited to consider how their organisations could support the work. Hertfordshire County Council and HPFT has already agreed to commit officer time and resource to this project.

7.5 **Physical Health strategy: –** Communications and engagement material has been drafted in relation to the Physical Health Strategy. This will highlight the key message from the strategy but also some of the key actions that organisations should be undertaking. Following last month's MHLDA HCP Board discussion regarding the LeDeR Annual Report we will ensure that key messages are coordinated and complementary.

7.6 **Hertfordshire Equity in Mental Health Steering Group: -** HPFT has continued work with One Vision, Watford and Stevenage World Forum and has implemented two community-based pilot projects, focused on improving mental health outcomes for Black and Asian communities in Watford and Stevenage. This programme of work is aligned to the Adult Community Mental Health Transformation and is focused on addressing ethnic inequalities in mental health through assets-based and community partnership approaches.

7.7 The One Vision and Stevenage World Forum pilots also offer a different range of approaches and interventions, with One Vision focusing on improving access and offering support earlier in a person's journey and Stevenage World Forum focused on offering a wider range of culturally relevant interventions. Both pilots include specific focus and bespoke interventions for improving preventative pathways of care for Black African and African Caribbean communities, who experience significantly poorer outcomes from Mental Health Services.

7.8 An outcomes framework has been agreed that focuses on qualitative and quantitative feedback to understand the meaningful impact of the pilots. A variety of mechanisms for gathering feedback have been developed and One

Vision are also working closely with HPFT's research team to evaluate the impact of the Watford pilot.

7.9 Early feedback from both pilots has been encouraging. For example, 74 people attended a recent "Four Pillars" community engagement session provided through One Vision. Following the session, 31 people reported concerns about their mental health, all of whom have been offered support through a One Vision Community Connector and will be supported into Talking Therapies or Enhanced Primary Mental Health Services if required.

7.10 The Cost-of-Living Mental Health response group was established in 2022, in response to the impact of increasing financial hardship on people's mental health, particularly those already living with, or at increased risk of mental illness. The group led on a number of initiatives focused on improving information and advice on mental health and mental health services and also to ensure access to financial advice and support for people experiencing mental illness.

7.11 In April 2023, EPMHS and HCC's Money Advice Unit (MAU) delivered a new initiative which included aligning two additional specialist MAU benefits advisers in HPFT's mental health services, alongside existing HPFT staff. This built on a previous partnership with Money Advice Unit, within Community Mental Health services which has operated successfully for 9 years.

7.12 Since the partnership began in April, the Enhanced Primary Mental Health Service (EPMHS) has made 221 referrals to the MAU Advisers. This has resulted in weekly benefits worth £4,979 (£258,908 per year) so far. There has also been an additional £34,201 in 'one-off' payments and arrears of benefits, bringing a total benefit gain of £293,109.

7.13 Feedback from both service users and staff has been excellent. Service user participation and response to the programme has amplified the importance of our services finding a way to tend to social care needs where we are able.

7.14 The MHLDA continues to support and engage with the CoL Response group, to ensure that people with MHLDA are not disadvantaged by the rising cost of living. As we move into the winter, activity from the Group, which is hosted and led by HCC, is being refocussed on warmth, food, healthy hubs, and income maximisation. Gary Vaux from MAU reported on a new project working with GPs to increase people's benefit take up which is improving their mental health as well as physical health needs.

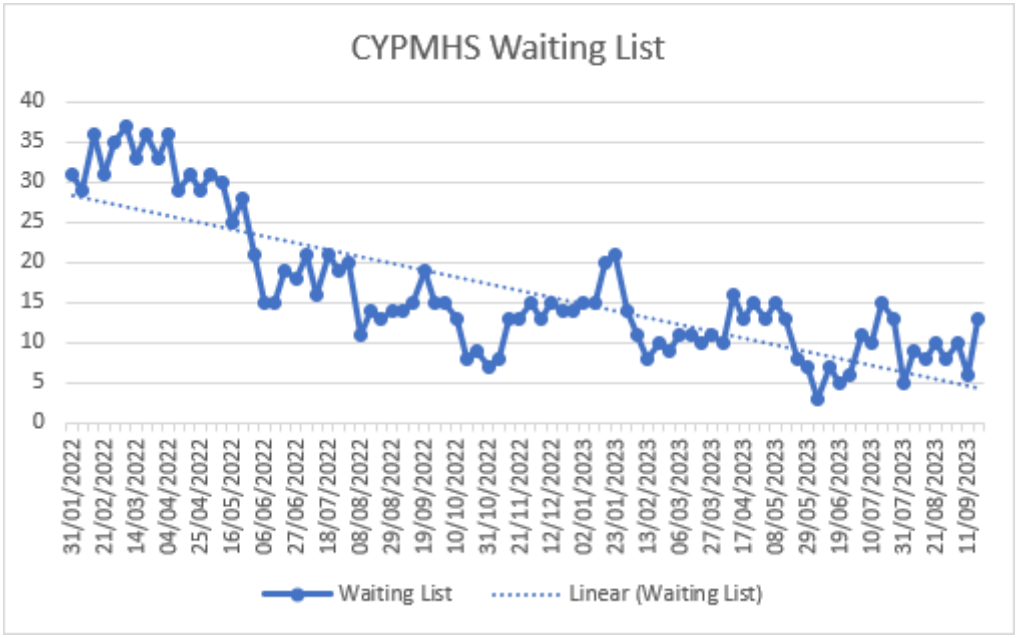
7.15 The MHLDA HCP supported a meeting on 22 September 2023 to consider the support and welfare available to asylum seekers in Hertfordshire. The meeting considered how organisations could work in partnership to support this group and how we might start framing a long-term approach to safeguarding and improving their health and wellbeing. The meeting considered how other local areas have responded and considered whether there was scope for Hertfordshire to do something similar. This will be explored further and worked into a clear through further meetings of this group.

8. East of England Regional Mental Health Provider Collaborative

8.1 On Thursday 31st August 2023 CPFT informed the Provider Collaborative of its intention to temporarily close the Phoenix CYP Eating Disorders unit in

Cambridgeshire. The closure is due to CPFT's ability to safely staff the unit. During the period of closure, CPFT will look to address recruitment to the Phoenix team, and to review the model of care offered by the unit. As our only in-region NHS specialised unit, this is likely to impact on waiting times for CYP accessing Tier 4 ED services.

8.2 The diagram below demonstrates the reduction in CYPMHS waiting list since the start of 2022. There continues to be demand for CYPMH tier 4 beds across the region and, in particular, pressure for CYP Specialist Eating Disorder Units (SEDU). There is also a national shortage of CYP Psychiatric Intensive Care Units (PICU).



8.3 There have been several reports from CYPMH Units within the region in relation to high acuity, staff shortages, and staff skill mix. This has affected the type of admission each unit has been able to safely facilitate. Case Managers and the regional Patient Flow hub are working alongside providers to support the balance of risk in patients waiting admission and the safe and effective management of each unit.

8.4 The evaluation of the existing Adult Eating Disorders Intensive Community Service pilot identified the need to strengthen and standardise the ICS model to better achieve the aims of avoiding admission and supporting early discharge. A business case will be considered by the East of England Mental Health Provider Collaborative Board.

8.5 There are emerging financial challenges in secure services. Referrals, admissions and discharges all reduced within the month. The Secure Bed Reconfiguration task and finish groups meetings continue to run on a fortnightly basis and it is anticipated that its conclusions will be presented to the clinical group during September.

8.6 NHSE regionally has decided not to devolve perinatal commissioning at the present time. NHSE colleagues have reflected on the current commissioning arrangements and has proposed to convene a working group with key stakeholders to develop a visionary model of care that includes joining-up the whole commissioning pathway.

9. Conclusion

9.1 This report has provided a summary of the key developments and activity overseen by the MHLDA HCP since the last update provided in September 2023.

9.2 The MHLDA HCP and its sub-boards are collectively driving a substantial volume of activity across Hertfordshire.

9.3 The system investment in the Mental Health Crisis Assessment Centre represents a significant investment in local provision and support. The MHLDA HCP's role in developing and maintaining strong local partnerships means that this development and other activity being progressed through the HCP has the best chance of making sustainable and effective improvements for local people.

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Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 11
Report Title	Mental Health Urgent Care Centre Business Case	**For publication:** **Yes** ☒ **No** ☐
Report Author:	Simon Pattison, Deputy Director of Strategy and Development	
Approved by:	Sandra Brookes, Deputy Chief Executive and Chief Operating Officer	

The Board is asked to:
Receive the update regarding the development of a Mental Health Urgent Care Centre

Executive Summary

This paper summarises the business case that has been developed to provide an adult mental health urgent care centre (MHUCC) for the residents of Hertfordshire (and West Essex). The centre will be based in Stevenage, operating from the Glaxo Unit based on the Lister Hospital site. It is part of the vision to create a "Mental Health Hub" comprising assessment, treatment, and inpatient care.

Recommendations

The Board is asked to:

- Receive the update of the development of a Mental Health Urgent Care Centre

Implications

Risk and Assurance	The proposal would positively impact on the system risk presented by long waits for mental health care in acute hospital Emergency Departments
Equality, Diversity and Human Rights	The Quality Impact Assessment has identified positive impacts on people with mental ill health with a variety of backgrounds and protected characteristics
Quality	The Quality Impact Assessment has identified positive impacts from the development by providing good quality mental health care in a timelier manner and in a more appropriate setting
Financial	The financial implications are set out in the report, including the key assumption that the new service will reduce the number of out of area mental health beds
Service Users and Carer Experience	The Quality Impact Assessment has identified a positive impact on service user and carer experience by providing good quality mental health care in a timelier manner and in a more appropriate setting

People	The proposal is predicated on the recruitment of additional staff
Legal and Regulatory	No implications identified
Digital	No direct implications
System	The proposal was developed to improve system working, supporting the acute hospitals with their management of mental health issues. The new service would include non HPFT staff to ensure a holistic assessment
Sustainability	No implications identified

Strategic Objectives this report supports	**Please tick any that are relevant** ✓
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	✓
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	✓
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	✓

Mental Health Urgent Care Centre Business Case

2nd November 2023

1. Introduction

1.1 This paper summarises the business case that has been developed to provide an adult mental health urgent care centre (MHUCC) for the residents of Hertfordshire (and West Essex). The centre will be based in Stevenage, operating from the Glaxo Unit based on the Lister Hospital site. It is part of the vision to create a “Mental Health Hub” comprising assessment, treatment, and inpatient care.

2. Background

2.1 The business case has been developed on behalf of the Hertfordshire and West Essex Integrated Care Board (HWE ICB (Integrated Care Board)) and Hertfordshire Mental Health & Learning Disability Health and Care Partnership (MHLDA-HCP) by HPFT, in conjunction with all partners.

2.2 Nationally it is recognised that the demand for mental health care and support has risen exponentially with increasingly complex needs and presentations. Existing services are often stretched, leading to prolonged waiting times in environments (such as emergency departments (ED) or in the service user’s own home) that are not the most appropriate place to meet people’s needs effectively. This has also led to increased admissions to mental health beds. Across Herts & West Essex the same trends are occurring.

3. Outline of proposed service

3.1 Currently 23.4% of service users attending ED with a mental health presentation will wait over 12 hours across Herts and West Essex ICS; this is the 3rd highest in England and has been increasing over time, even though MH attendances overall have reduced, demonstrating a need for a new model to support acute Trusts in managing the diversity of presenting needs within NHS emergency care settings.

3.2 We know that the longer a service user waits for support whilst in crisis the greater the likelihood of them requiring a higher level of intervention increases, which could eventually lead to a formal admission.

3.3 The model proposed will be an enhanced specialist multidisciplinary team focus on improving the experience and outcomes for service users, carers, and staff, alongside providing system efficiency in enabling the acute hospital to operate and improve ED performance and quality of care.

3.4 The service will operate 24/7 and will be a multi-disciplinary, cross sector service that is nurse-led and supported by social care, voluntary sector partners and Lived Experience Workers. The site will have a triage room and 6 separate rooms for service users with recliners (not beds).

3.5 Once on site, service users will be assessed by an experienced mental health assessor and/or an Approved Mental Health Professional (AMHP) as appropriate. Following the assessment and understanding of need, people will be directed to the most appropriate onward care which may be voluntary sector support, crisis services, community services or a formal admission.

3.6 Based on current ED activity it is anticipated that the service will support approximately 3,000 attendances per year through a multidisciplinary team made up of psychiatrists, junior doctors, nurse and AHP practitioners, social care staff, social prescribers, voluntary and community partners, receptionists and security.

3.7 The business case includes capital investment of £1.35m and additional HPFT revenue investment of £3.05m per annum (based at 23/24 pay rates and including patient transport). It is estimated that the MHUCC development will release an estimated benefit at £2.47m for year 1, rising to £4.09m per annum by year 4 (as bed reductions increase up to 14 less Out of Area beds by 2026/27).

3.8 The holistic approach offered by a MHUCC, with its timely interventions, specialised care, and therapeutic environment, presents a transformative opportunity to improve service user outcomes, alleviate the strain on EDs and EEAST, and reduce the need for formal and informal admissions to mental health inpatient beds. By bridging the gap between crisis and care, this proposed initiative not only promises improved well-being for service users in need but also represents a progressive step toward a more efficient and effective mental health care system.

4. Summary/Conclusion

4.1 The benefits of the MHUCC also provides the Herts and West Essex ICS with the ability to deliver a more compassionate approach to mental health emergencies and foster a healthier future for our communities and the individuals within them which will continue to be felt for years to come.

5. Recommendations

5.1 The Board is asked to receive the update on the development of a Mental Health Urgent Care Centre.

Hertfordshire Partnership University NHS Foundation Trust

Report to the Public Board of Directors

Meeting Date:	2 November 2023	**Agenda Item:** 12
Report Title	Board Assurance Framework	**For publication:** **Yes ☒** **No ☐**
Report Author (s)	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Approved by:	Karen Taylor, CEO Helen Edmondson, Head of Corporate Affairs and Company Secretary	

The Board is asked to:
The Board is asked to review and approve the updated Board Assurance Framework.

Executive Summary
Summary The Trust's Board Assurance Framework (BAF) has been reviewed following discussion at the Trust Board meeting held on 5 October 2023. This report sets out the proposed changes and rationale for the mitigated scores.

Recommendations
The Board is asked: a) To review the updated BAF. b) Consider the proposed format and scoring c) Approve the updated BAF

Implications	
Risk and Assurance	The BAF is a key element of the Trust's approach to risk management. The controls in place provide assurance that the risks are being mitigated against.
Equality, Diversity and Human Rights	Strategic risk two focuses on the wellbeing of staff and its importance in ensuring high quality care is provided and great staff experience.
Quality	Strategic risks three and four describe the risk to delivering high quality care and the controls in place.
Financial	There are not financial implications for this report.
Service Users and Carer Experience	Strategic risk four focuses on services user experience and the controls in place.
People	Strategic risks one and two relate to our people and the BAF details the controls in place.
Legal and Regulatory	The BAF is a key element of the Trust's approach to risk management. The controls in place provide

	assurance that the risks are being mitigated against which reduces the risk of failure to comply with regulatory requirements.
Digital	This report includes no specific implications for the Trust
System	Strategic risk seven details the risk related to partnership and sets out the controls in place.
Sustainability	This report includes no specific implications for the Trust

Strategic Objectives this report supports	**Please tick any that are relevant**
1. We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery	✓
2. We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.	✓
3. We will attract, develop, and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.	✓
4. We will address inequalities to improve out-comes and advance equity for people from all communities.	
5. We will work in partnership in everything we do to meet the needs of communities and the people we support.	
6. We will be a learning organisation that encourages innovation, research and continuous quality improvement.	✓

Hertfordshire Partnership University NHS Foundation Trust

Board Assurance Framework

October 2023

1. Introduction

1.1 The Trust strategy, Great Together sets out how over the next five years the Trust will continue to work together to improve care and outcomes for the people and communities it serves. The strategy sets out six strategic objectives for quality, service users and carers, innovation and improvement, collaboration, people and equity and addressing inequalities.

1.2 The term 'Board Assurance Framework' (BAF) is used to refer to a document that brings together in one place all of the relevant information on the risks relating to the Board's Strategic Objectives. It provides a structured means of identifying the main risks to delivery against Strategic Objectives, mapping the main sources of control and assurance in place to mitigate the risks.

1.3 The effective application of board assurance arrangements to produce and maintain a BAF, help the Board to consider the process of securing assurance using a formal process that promotes good organisational governance and accountability. The specific benefits include:

- Gaining a clear and complete understanding of the risks faced by the organisation in the pursuit of its Strategic Objectives, the types of assurance currently obtained, and consideration as to whether they are effective and efficient;
- Identifying areas where assurance activities are not present, or are insufficient for their needs (assurance gaps);
- Identifying areas where assurance is duplicated, or is disproportionate to the risk of the activity being undertaken (i.e., there is scope for efficiency gains, reduction of duplication of effort and/or a freeing up of resource);
- Identifying areas where existing controls are failing and as a consequence the risks that are more likely to occur;
- The ability to better focus existing assurance resources; and
- Providing an evidence base to assist the organisation in the preparation of its annual governance statement.

1.4 For each Strategic Risk, the following information is provided:

- A description of the risk to achieving that objective – i.e., what are the things that might potentially impact on the Trust's ability to deliver its objectives.
- The controls in place to manage the risk – these are the actions that are in place to reduce or eliminate the risks.
- The sources of assurance that the risk is being managed – these are the mechanisms we have in place to test the controls are effective and are described in three levels:

i. Level 1 – operational oversight: the way risks are managed day to day. The assurance comes directly from those responsible for delivering specific objectives and processes.
ii. Level 2 – organisational wide with Committee oversight: the way in which the organisation oversees the control framework so that it operates effectively.
iii. Level 3 – sources of external (independent) oversight / scrutiny: objective and independent assurance (e.g., internal audit) or assurance from external independent bodies (e.g., CQC or external auditors);

- The mitigating actions to address gaps in control or assurance – these are the additional actions needing to be taken, or mechanisms needing to put in place to address any gaps identified.

2. Background

2.1 The BAF is a dynamic document and tool to ensure that the Trust Board can easily identify and focus on the key strategic issues and risks.

2.2 The Trust's Board Assurance Framework (BAF) has undergone a review to ensure it accurately reflects the risks, controls in place and the assurance on the controls. The review of the BAF was undertaken by the Executive Team following discussion at the October Board meeting. The Chief Executive and Chair of Audit Committee met and reviewed the proposed changes to the BAF, including the introduction of 'mitigated risk scores' and the inclusion of a narrative to Board to explain the rationale for the scores. This has informed this latest version attached as appendix one.

3. Changes to the Board Assurance Framework – October 2023

3.1 The most significant change to the BAF previously considered is to the format of the risk ratings. The BAF now includes three risk scores:

a) Risk rating on Identification (Id) Described the risk score at the point the risk has been identified

b) Mitigated risk rating (Mit) Describes the risk score taking into consideration the controls and assurance in place

c) Target risk rating (Tar) Describes the risk rating the Trust aims to achieve, noting that in most instances it is not possible to eliminate all risk

3.2 From this point risk rating on identification will remain constant and dated. The target risk rating is likely to remain constant unless work on developing risk appetite affects it. The mitigated score should reduce over time until such a point the risk reaches the target score.

3.3 The wording of Strategic Risks 1, 2,5 and 7 have had minor wording amendments. The wording of Strategic Risk three has been amended to remove any overlap with staffing levels and focuses on regulatory and policy compliance. Strategic Risk four has been amended to recognise the impact of increased demand and Strategic Risk eight has been amended to focus on meeting requirements of section 75 rather than the impact of partnership working which is covered by Strategic Risk seven.

4. Board Assurance Framework – 26 October 2023

4.1 The BAF describes eight Strategic Risks.

4.2 All of the risks were formally identified in August 2023 and Identification risks scores allocated at this stage; and these were reviewed by the Audit Committee on 5 September 2023. The review has seen some change from the scores from March 2023 when the Board last reviewed the BAF, where relevant the rationale for the change is detailed below. These scores will now not change and will be dated August 2023.

4.3 The controls and assurances for each risk have been reviewed to inform the mitigated score. This took place in October 2023 and below is an explanation of factors that have been assessed when proposing mitigated scores. All the mitigated risk ratings therefore date from 26 October 2023.

Risk	Risk descriptor	Id	Mit	Tar
Strategic 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 the quality of care for our service users and our staff satisfaction levels.	16	16	9

Identification Risk Score
The original risk score in March 2023 was 20 (4 x 5), when reviewed in August 2023 the score moved to 16 (4 x 4) as a new baseline. The change recognises the improvement in people metrics at a strategic level.

Mitigated Risk Score
The mitigated risk score remains the same as the score when the risk was identified (L x C - 4 x 4) as the controls in place are having an impact in some services but there remain some hotspots in terms of professional groups or individual service areas. The key people metrics have also plateaued over the last six months.

Risk	Risk descriptor	Id	Mit	Tar
Strategic Risk Two: Our People	Failure to maintain positive health and wellbeing support for all our staff and failure to provide an inclusive work experience with equity of opportunity which could mean staff do not feel valued or enabled to reach their potential.	16	12	6

Identification Risk Score
The original risk score in March 2023 was 12 (3 x 4), when reviewed in August 2023 the score moved to 16 (4 x 4) as a new baseline. The change recognises the impact of continued industrial action.

Mitigated Risk Score
The mitigated risk score is reduced from the score when the risk was identified to 12 (L x C - 3 x 4) because the wellbeing programme is well established and positive feedback from staff via national and local surveys. But not at target because recent WDES data indicates that

there are improvements to be made to create a fully inclusive work experience, and the Belonging & inclusion Strategy is being launched Autumn 2023.

Risk	Risk descriptor	Id	Mit	Tar
Strategic Risk Three: Quality – Safety	Risk that we do not provide safe standards of care due to a failure to adhere to regulatory standards and agreed trust policies, meaning service users do not feel safe and are not protected from avoidable harm.	20	12	12

Identification Risk Score
The original risk score in March 2023 was 20 (4 x 5), when reviewed in August 2023 the score remained at 20 (4 x 5) as a new baseline.

Mitigated Risk Score
The mitigated risk score is reduced from the score when the risk was identified to 12 (L x C - 3 x 4) this is in recognition of the positive impact of the Service Improvement Plans and focus on teams on Fundamentals of care.

Risk	Risk descriptor	Id	Mit	Tar
Strategic Risk Four: Quality – Experience	Increased demand and lack of availability of services (community and inpatient) could lead to an increase in out of area placements, reduced access to specialist care and poor experience for services users, families and carers	20	16	6

Identification Risk Score
The original risk score in March 2023 was 16 (4 x 4), when reviewed in August 2023 the score moved to 20 (5 x 4) as a new baseline. The change recognises the current position with regard to waiting times and number of people waiting for an inpatient bed.

Mitigated Risk Score
The mitigated risk score is reduced from the score when the risk was identified to 16 (L x C - 4 x 4). This is in recognition of the controls in place that have reduced used of out of area beds. However, waiting times for a number for services remain high, and this continues to be an area of focus.

Risk	Risk descriptor	Id	Mit	Tar
Strategic Risk Five: Finance	Failure to maintain a sustainable financial position over the medium to long term, will impact on the Trust's ability to make sustained improvements and deliver high quality services consistently.	20	16	8

Identification Risk Score
The original risk score in March 2023 was 20 (4 x 5), when reviewed in August 2023 the score remained at 20 (5 x 4) as a new baseline.

Mitigated Risk Score
The mitigated risk score is reduced from the score when the risk was identified to 16 (L x C - 4 x 4). This is in recognition of the controls in place to manage expenditure and ensure robust financial governance and recognises the current deficit run rate. As work develops on the medium-term financial plan this score will be reviewed.

Risk	Risk descriptor	Id	Mit	Tar
Strategic Risk Six: Transformation	Failure to deliver transformation and continuous improvement could compromise quality, safety and experience of service users and ability to recruit staff.	16	12	6

Identification Risk Score
The original risk score in March 2023 was 12 (4 x 3), when reviewed in August 2023 the score moved to 16 (4 x 4) as a new baseline. The change recognises the risk to delivering transformation due to uncertainty of funding

Mitigated Risk Score
The mitigated risk score is reduced from the score when the risk was identified to 12 (L x C - 4 x 3). This is in recognition of the controls in place that ensure that CQI is embedded throughout the organisation and also the significant transformation programmes in the Trust.

Risk	Risk descriptor	Id	Mit	Tar
Strategic Risk Seven: System	Failure to influence partners in the new system architecture which may lead to a shift of influence and resources away from mental health, learning disabilities and neurodevelopmental services that support the services users and communities served by HPFT.	16	12	6

Identification Risk Score
The original risk score in March 2023 was 12 (3 x 4), when reviewed in August 2023 the score moved to 16 (4 x 4) as a new baseline. The change recognises the current position with regard to changes to system operating model.

Mitigated Risk Score
The mitigated risk score is reduced from the score when the risk was identified to 12 (L x C - 3 x 4). This mitigated score is due to the significant contribution the Trust makes to the system, its strong track record of partnership working and its role advocating2for people with mental health needs and a Learning Disability. The MHLDA HCP has been identified as a future 'Accountable Business Unit' within the Herts & West Essex ICB. However, further work is required to work successfully with the other ICB's in which HPFT provides services.

Risk	Risk descriptor	Id	Mit	Tar
Strategic Risk Eight: Social Care	Failure to appropriately meet section 75 requirements including implementation of social reform which may result in poorer social care outcomes for service users	16	12	6

Identification Risk Score
The original risk score in March 2023 was 16 (4 x 4), when reviewed in August 2023 the score remained at 16 (4 x 4) as a new baseline.

Mitigated Risk Score
The mitigated risk score is reduced from the score when the risk was identified to 12 (L x C - 3 x 4). This recognises the transformation work in social care underway but also that it in the early stages. There may also be an impact on the Strategic Risk from the national review of Section 75 arrangements.

5. Operational Risks

5.1 By definition the BAF is a framework that captures the risk to the delivery of the Trust's Strategic Objectives. The Trust Risk Register describes the risks to the delivery of the Trust's Annual Plan. This means that there will some overlap as each year's Annual Plan move to deliver against the Strategic Objectives

5.1 The Trust Risk Register is next scheduled to be considered by the Integrated Governance Committee at its meeting in November 2023.

6. Conclusion

6.1 Attached is the updated BAF following review by the Executive Team. The principal changes and approach have been reviewed and discussed between the Chief Executive and Chair of Audit Committee.

6.2 The updated BAF has eight risks and details the controls and assurance in place of these controls.

6.3 The Board is asked:

a) To review the updated BAF

b) Consider the proposed format, scores and controls in place

c) Approve the updated BAF

Board Assurance Framework October 2023

Strategic Risk One: Our People	**Risk rating on identification (LxC)**	**Mitigated Risk (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Integrated Governance Committee
Risk Descriptor: 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 the quality of care for our service users and our staff satisfaction levels.	**4 x 4** **16**	**4 x 4** **16**	**3 x 3** **9**	**Executive Lead**	Chief People Officer

Linked to Strategic Objective: People: We will attract, develop and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces

Key Controls in place	**Where to the controls sit? (Level of control)**	**Assurance that controls are effective**	**How Assured are we? (Levels of Assurance)**	**Date of Assurance**
Recruitment and retention plan	2nd Level	Monthly reporting to PODG and Exec Monthly R&R Group Quarterly reporting to IGC Internal Audit Report 2022 (recruitment checks) Inpatient dashboard Monthly performance reporting	Medium	Monthly
Management of recruitment pipeline, including time to hire and targeted recruitment activity	1st Level	Weekly exec led recruitment oversight meeting. Monthly reporting to PODG and Exec Monthly R&R Group Quarterly reporting to IGC	Medium	Monthly

Key Controls in place	Where to the controls sit? (Level of control)	Assurance that controls are effective	How Assured are we? (Levels of Assurance)	Date of Assurance
Comprehensive training and development offer, benefits package and wellbeing strategy	2nd Level	Monthly monitoring National staff survey Pulse Survey results	Medium	Monthly, quarterly (Pulse Survey) and annually (staff survey)
Safe Care Standard Processes and policies	1st Level	Quality assurance visit programme. Reviewed and implemented new inpatient skill mix	Medium	Quarterly
Trust workforce plan	2nd Level	Monthly workforce reports Workforce Planning Group (quarterly meetings)	Low	Monthly
SBU workforce plans	1st Level	Monitoring through PRM Workforce Planning Group (quarterly meetings)	Low	Quarterly

Mitigating actions for any significant gaps in control / assurance.	Progress	Timescale
International nurse recruitment programme	Actions in place through R&R Group	Monthly
AHP workforce programme	In place and reviewed through PODG	Quarterly
Implement recommendations for Attain report	5 year plan monitored through planning meeting and Workforce Planning Group	Quarterly
Specific medical staffing recruitment plan	Plan in place with regular monitoring	Monthly
Recruitment strategies for hard to recruit roles – including changing/reforming the way the work is done	Monthly reporting to PODG and Quarterly PRMs	Monthly and Quarterly

Strategic Risk 2: Our People	**Risk rating on identification (LxC)**	**Mitigated Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Integrated Governance Committee
Risk Descriptor: Failure to maintain positive health and wellbeing support for all our staff and failure to provide an inclusive work experience with equity of opportunity which could mean staff do not feel valued or enabled to reach their potential.	**4 x 4** **16**	**3 x 4** **12**	**2 x 3** **6**	**Executive Lead**	Chief People Officer

Linked to Strategic Objective: People: We will attract, develop and retain a skilled, compassionate workforce by creating inclusive and thriving workplaces.

Linked to Strategic Objective: Equity and addressing inequalities: We will address inequalities to improve outcomes and advance equity for people from all communities.

Key Controls in place	**Where to the controls sit? (Level of control)**	**Assurance that controls are effective**	**How Assured are we? (Levels of Assurance)**	**Date of Assurance**
Junior Doctor forums	2nd Level	GMC Training Survey Guardian of Safe Working Reports HSE visits JCNC	Medium	Monthly
Wellbeing programme including festivals	2nd Level	Pulse Survey Staff Survey Feedback to PODG	High	Quarterly and annually
Awards programme: annual staff, monthly inspire, development and long service.	2nd Level	Pulse Survey Staff Survey	High	Quarterly
Employment Assistance Programme, Occupational Health Provider and Here for You service	2nd Level	Contract review meetings Regular managements reports	High	Quarterly
Staff Survey Action Plan	2nd Level	National staff survey report	Medium	June 2023

Engagement with staff, including meet the Exec, team leader forums, SLF, Big Conversation, wellbeing festivals, JCNC and staff networks	2nd Level	Feedback from events and festivals Regular PODG items Reports to Exec, IGC and Board Quarterly Pulse Survey Staff Survey (annual) Externally commissioned well led review	Medium	April 2023
Undertaking of supervision and appraisals	1st Level	Monthly monitoring data	High	Monthly
Implementation of inclusion and belonging strategy	2nd Level	Pulse Survey Staff Survey WRES and WDES data Equality pay gap reporting	Medium	Quarterly
Freedom to speak up Guardian and systems	2nd Level	Quarterly and annual reporting to IGC	Medium	Quarterly

Mitigating actions for any significant gaps in control / assurance.	**Progress**	**Timescale**
Staff survey action Plan	In place	April 2023

Strategic Risk 3: Quality - Safety	**Risk rating on identification (LxC)**	**Mitigated Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Integrated Governance Committee
Risk Descriptor: Risk that we do not provide safe standards of care due to a failure to adhere to regulatory standards and agreed trust policies, meaning service users do not feel safe and are not protected from avoidable harm.	**4 x 5** **20**	**3 x 4** **12**	**2 x 4** **8**	**Executive Lead**	Executive Director of Quality and Safety

Linked to Strategic: Quality: We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.

Key Controls in place (what are currently doing about the risk?)	**Where do the controls sit? (Level of control)**	**Assurance that controls are effective**	**How Assured are we? (Levels of Assurance)**	**Date of Assurance**
Moderate Harm Panel, review of cases and identification of learning	2nd Level	Quarterly reporting to IGC	Medium	July 2022
SI management and monitoring processes	2nd level	Internal audit reports. Annual Governance Statement. Annual Report. Reports to Exec Reports to Private Board	High	June 2022
Mortality Governance Processes (including LEDER)	2nd Level	Internal Audit report	Low	May 2022
Safe Staffing processes	1st Level	Quarterly reporting to IGC and Board Datix reports Freedom to Speak up referrals Update inpatient staffing levels following establishment review	High	May 2023
Freedom to Speak Up practice and processes	2nd Level	Quarterly reports to IGC Participation in national benchmarking. CQC MHA Inspections Internal audit report	High	July 2023

Implementation of Making our Services Safe (MOSS) Strategy	2nd Level	Peer review of (SBU to SBU) of seclusion practice. Quarterly reports to IGC. Use of Force and Restrictive Practice Committee CQC MHA Inspections	High	Monthly
Service Improvement Plans for relevant services	1st Level	Reports to Executive Team Senior Oversight by Executive Team member	Medium	Weekly/ two weekly and monthly
Inpatient quality and safety dashboard	2nd Level	Review of inpatient dashboard Performance reporting to Executive	Medium	Monthly
PACE and National Audit programme	3rd Level	Quarterly reports to IGC Bi-annual reports to Audit	Medium	Quarterly

Mitigating actions for any significant gaps in control / assurance.	**Progress**	**Timescale**
Implementation of recommendations from Internal Audit Reports	In progress	Dec 2023
Implementation of PSIRF	In progress	Oct 2023

Strategic Risk 4: Quality - Experience	**Risk rating on identification (LxC)**	**Mitigated Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Finance and Investment Committee
Risk Descriptor: Increased demand and lack of availability of services (community and inpatient) could lead to an increase in out of area placements, reduced access to specialist care and poor experience for services users, families and carers.	**5x 4** **20**	**4x4** **16**	**2 x 3** **6**	**Executive Lead**	Chief Operating Officer

Linked to Strategic Objective: Quality: We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers.

Linked to Strategic Objective: Service Users and Carers: We will improve service user and carer experience, placing emphasis on shared decision-making, co-production and recovery.

Key Controls in place (what are currently doing about the risk?)	**Where do the controls sit? (Level of control)**	**Assurance that controls are effective**	**How Assured are we? (Levels of Assurance)**	**Date of Assurance**
Oversight and management of Out of Area Placements	2nd Level	Three times a day bed status reviews. Trust monitoring of trajectory and those waiting for admission NHSE monitoring of trajectory	Medium	Daily
Tracking of Delayed Transfers of Care	2nd Level	Performance reporting Performance reporting to Executive Team meeting	Medium	Daily Forthnightly
Performance Recovery Programme	2nd Level	Reporting on recovery trajectories	Medium	Weekly
Transformation of Community Services	2nd Level	Reporting on Transformation programme Performance reporting	Medium	Monthly

Use of benchmarking and best practice and regular performance reporting	2nd Level	GIRFT programme	Medium	Monthly

Mitigating actions for any significant gaps in control / assurance.	**Progress**	**Timescale**
Acute pathway redesign	Project underway	March 2024
Development of Urgent Assessment Centre	Project underway	Oct 2023
Procurement and implementation of a patient flow/bed management system	Procurement completed	Q3 23-24
Director level sign off of OOA placements	In place	May 2023

Strategic Risk 5: Finance	**Risk rating on identification (LxC)**	**Mitigated Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Finance and Investment Committee
Risk Descriptor: Failure to maintain a sustainable financial position over the medium to long term, will impact on the Trust's ability to make sustained improvements and deliver high quality services consistently.	**5 x 4** **20**	**4 x 4** **16**	**2 x 4** **8**	**Executive Lead**	Chief Financial Officer

Linked to Strategic Objective Innovation and Improvement: We will be a learning organisation that encourages innovation, research and continuous quality improvement.

Key Controls in place	**Where to the controls sit? (Level of control)**	**Assurance that controls are effective**	**How Assured are we? (Levels of Assurance)**	**Date of Assurance**
Financial Plan	2nd Level	Monthly financial reporting to Exec and Board against the plan, identifying risks and mitigating actions	Medium	Monthly
Annual Plan	2nd Level	Quarterly reporting to Exec, Committees and Board of progress and projections.	High	Monthly
Delivering Value programme	1st Level 3rd Level	Quarterly Reporting to Exec, Committees and Board identifying risks and mitigating actions. Internal Audit 2022 – Delivering Value	Medium	Monthly
Capital Plan	2nd Level	Quarterly Reporting to Exec, Committees and Board identifying risks and mitigating actions	High	Monthly
Budget reporting	1st Level	Monthly Reporting to budget holders and SBUs	Medium	Monthly
Enhanced systems of financial control	2nd Level	Fin Rec and DV Group Updated SFIs and Scheme of Delegation No payment no Purchase Order		

Mitigating actions for any significant gaps in control / assurance.	**Progress**	**Timescale**
Recovery plan for Out of Area placements	In progress	March 2024
Forensic monitoring of agency and bank spend	In progress	Ongoing
Enhanced financial control: e.g SFIs, SoD no PO no purchase.	In progress	July 2023
Early development of annual and financial plans for 2024/25 identifying shortfall in resources for discussion and agreement with commissioners	In progress	March 2024

Strategic Risk 6: Transformation	**Risk rating on identification (LxC)**	**Mitigated Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Finance and Investment Committee
Risk Descriptor: Failure to deliver transformation and continuous improvement could compromise quality, safety and experience of service users and ability to recruit staff.	**4 x 4** **16**	**3 x 4** **12**	**2 x 3** **6**	**Executive Lead**	Chief Operating Officer

Linked to Strategic Objective Innovation and Improvement: We will be a learning organisation that encourages innovation, research and continuous quality improvement.

Key Controls in place	**Where to the controls sit? (Level of control)**	**Assurance that controls are effective**	**How Assured are we? (Levels of Assurance)**	**Date of Assurance**
Continuous Improvement work programme	2nd Level	Internal Audit report Reports to SBU QRM meetings Reports to Trust-wide QRMC	Medium	Aug 2022
Innovation Fund	2nd Level	Innovation Fund Panel Internal Audit report Reports to SBU QRM meetings Reports to Trust-wide QRMG	Medium	Aug 2022
Digital Strategy implementation	2nd Level	Internal audit reports Board workshop Reports to Digital and Innovation Board, Transformation Board and Finance and Investment Committee Annual plan reports to Trust Board	Medium	Aug 2022
Transformation Programme Implementation	2nd Level	Bi monthly reports to the Transformation Board	Medium	Nov 2022

Mitigating actions for any significant gaps in control / assurance.	Progress	Timescale
Refreshed digital strategy and associated roadmap and investment plan	In progress with ongoing workshops with staff groups to develop the refreshed strategy	Q4 23-24
Development of Quality Improvement Approach, including CQI	Option appraisal underway	Q4 23-24

Strategic Risk 7. System	**Risk rating on identification (LxC)**	**Mitigated Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Finance and Investment Committee
Risk Descriptor: Failure to influence partners in the new system architecture which may lead to a shift of influence and resources away from mental health, learning disabilities and neurodevelopmental services that support the services users and communities served by HPFT.	**4 x 4** **16**	**3 x 4** **12**	**2 x 3** **6**	**Executive Lead**	Executive Director Strategy and Partnerships

Linked to Strategic Objective: Collaboration: We will work in partnership in everything we do to meet the needs of communities and the people we support

Key Controls in place	**Where to the controls sit? (Level of control)**	**Assurance that controls are effective**	**How Assured are we? (Levels of Assurance)**	**Date of Assurance**
Integrated Care Partnership Strategy	3rd Level	Strategy finalised. Reporting to ICP Board meetings	Medium	Dec 2022
HPFT membership of ICB Board and ICP Board	3rd Level	Regular attendance at meeting. Monthly reporting to Trust Board on ICB and ICP	High	April 2022
Mental Health, Learning Disability and Autism Health Care Partnership work plan	3rd Level	Monthly reporting on delivery of work plan to HCP Board and Stakeholders	High	April 2022
MHLDA Clinical and Professional Advisory Committee (CPAC)	3rd Level	Regular attendance by Trust clinicians and managers. Examples of delivery of transformed pathways	High	April 2022
Visibility and leadership by HPFT across health care partnerships	3rd Level	Attendance at relevant HCP meetings.	Medium	April 2022

Trust Strategy	2nd Level	New Strategy launched and being embedded in all aspects of Trust's business	High	May 2023
East of England Provider Collaborative	3rd Level	Quarterly reports to FIC Bi- annual report to Board	Medium	October 2023

Mitigating actions for any significant gaps in control / assurance.	**Progress**	**Timescale**
Development of commercial strategy	In progress	October 2023
Finalisation of stakeholder engagement plan	In development	October 2023

Strategic Risk 8: Social Care	**Risk rating on identification (LxC)**	**Mitigated Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Finance and Investment Committee
Risk Descriptor: Failure to appropriately meet section 75 requirements including implementation of social reform which may result in poorer social care outcomes for service users	**4 x 4** **16**	**3 x 4** **12**	**2 x 3** **6**	**Executive Lead**	Executive Director, Strategy and Partnerships

Linked to Strategic Objective: Collaboration: We will work in partnership in everything we do to meet the needs of communities and the people we support

Key Controls in place	**Where to the controls sit? (Level of control)**	**Assurance that controls are effective**	**How Assured are we? (Levels of Assurance)**	**Date of Assurance**
Oversight of the provision of social care	2nd Level	Attendance at Performance Oversight Group Attendance at Social Oversight Group	Medium	Dec 2022
Community Transformation	2nd Level	Regular reporting to the Transformation Board from Community Transformation work stream	Medium	Dec 2022
Social Care outcome metric reporting	2nd Level	Attendance and reporting to Adult Care Management Board Exec to Exec meeting with Hertfordshire County Council	Medium	Dec 2022 Feb 2023

Mitigating actions for any significant gaps in control / assurance.	**Actions**	**Deadline**
Development of social care outcome dashboard	In development	Q2 23/24
Enhance reporting of performance	In progress	Q1 23/24
Delivery of Transformation programme	In progress	Q4 23/24

Appendix Two

Trust Risk Register

Risk	Score
1. Insufficient beds to meet demand	**20 (5 x 4)**
2. Workforce vacancies	**16 (4 x 4)**
3. Delivery of 2023/24 Financial Plan	**16 (4 x 4)**
4. Number of service users waiting	**16 (4 x 4)**
5. Drug and alcohol services	**15 (3 x 5)**
6. Increased turnover and lack of staff retention	**12 (3 x 4)**
7. Sustained levels of violence, aggression, and abuse	**12 (3 x 4)**
8. Failure to develop a medium to long term financial plan	**12 (3 x 4)**
9. Insufficient understanding and oversight of regulatory standards	**12 (3 x 4)**
10. Trust infrastructure and information system will be compromised by a cyberattack	**12 (3 x 4)**
11. Underdeveloped relationship with key commissioners and ICBs	**12 (3 x 4)**